Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING AGENDA
MEETING IN PUBLIC
10.00am – 12.00pm
Wednesday 29 May 2013

Clarence Wing Boardroom,
St Mary's Hospital,
Praed St, Paddington,
London, W2 1NY

1	**General Business**			
		Paper	**Presenter**	**Time**
1.1	Chairman's Opening Remarks	Oral	Chairman	1 minute
1.2	Apologies	Oral	Chairman	1 minute
1.3	Board Members' Declarations of Interest and Conflicts of Interest *To note the attached summary of declarations of interest and to declare any conflicts of interests at the meeting*	1	Chairman	1 minute
1.4	Minutes of the meeting held on 27 March 2013	2	Chairman	2 minutes
1.5	Matters Arising and Action Log	3	Chairman	2 minutes
1.6	Chief Executive's Report	4	Chief Executive	5 minutes
2	**Quality and Safety**			
2.1	Director of Nursing's Report: • CQC National Inpatients Survey Results • Hearing what patients and their families say about the care and treatment at the Trust • Approval of Final Quality Account 2012/13 • Clinical Risk Assessment of Cost Improvement Plans • Nurse Staffing Levels- Assurance Process	5 5A 5B 5C 5D 5E	Director of Nursing	20 minutes
2.2	Medical Director's Report:	6	Medical Director	10 minutes
2.3	Infection Prevention and Control Report	7	Director of Infection Prevention and Control	5 minutes
2.4	Cancer Recovery Implementation Plan *update requested at 27.3.13 Board Meeting*	8	Chief Operating Officer	5 minutes

3	**Academic Health Science Centre (AHSC) Report**			
3.1	AHSC Director's Report	9	AHSC Director	5 minutes
4	**Performance**			
4.1	Performance Report • 2013/14 Month 1 Report	10	Chief Operating Officer	10 minutes
4.2 4.2.1a 4.2.1b 4.2.2	Finance Report • 2012/13 Month 12 Report • Update on 2013/14 Financial Plan • Annual Accounts 2012/13: Delegation of Authority to Audit Committee	 11 12 13	Chief Financial Officer	15 minutes
4.3	Director of People and Organisational Development Report	14	Director of People and Organisational Development	5 minutes
5	**Strategy**			
5.1	2013/14 Annual Business Plan	15	Chief Financial Officer	15 minutes
5.2	Outline Business Case (OBC), to support the development of Magnetic Resonance (MR), and Nuclear Medicine Imaging at Hammersmith Hospital	16	Chief Financial Officer	
6	**Papers for information**			
6.1	Report of the Audit and Risk Committee meetings: 18 April 2013	Oral	Sir Gerald Acher,	2 minutes
6.2	Report of the Governance Committee meetings on 17 April 2013 and 15 May 2013	Oral	Sir Thomas Legg	2 minutes
6.3	Report of the Finance & Investment Committee meeting: 13 March 2013	17	Chief Financial Officer	2 minutes
6.4	Report of the Foundation Trust (FT) Board	Oral	Dr Rodney Eastwood	5 minutes
7.	**Any Other Business**			
		Oral	Chairman	2 minutes
8.	**Date of Next Meeting:**			
Trust Board Meeting in Public: Wednesday 24 July 2013, Hammersmith Conference, Centre, Maple & Ash Suite, Hammersmith Hospital Site, Du Cane Road, London W12 0NL				
11.	**Questions from the Public relating to Agenda Items**			
12.	**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 Interests

To be presented by: Stephen Guile, Head of Corporate Services, 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 arise.

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.

Board Members'Register of interests – May 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

Mr Mark Davies Chief Executive

- Wife is Managing Director and owner of Redlands Equestrian Ltd and works as a freelance Consultant for the NHS
- Director of Shelford Health Roundtable (Shelford Group)

Sir Thomas Legg Non-Executive Director

- Imperial College Healthcare Trust Charity Trustee

Professor Anthony Newman-Taylor Non-Executive Director

- Chairman, Colt Foundation
- Trustee, Rayne Foundation
- Chairman, independent Medical Expert Gp, Armed Forces Compensation Scheme MoD
- Member, Bevan Commission, Advioursy Gp to Minister of Health, Wales
- Trustee, CORDA, Preventing Heart Disease and Stroke

Mr 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

Dr Rodney Eastwood Non-Executive Director

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

- Consultant, Mazars

Sir Gerry 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

Sarika Patel Non-Executive Director
- Board – Centrepoint
- Board – Royal Institution of Great Britain
- Board – Zeus Capital
- Board – London General Surgery

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

Mr Bill Shields Chief Financial Officer
- Honorary Colonel 243 (Wessex) TA Field Hospital
- Member, Group Board, CIPFA;
- Vice Chairman, Audit Committee, CIPFA
- Member, NHS Supply Chain Board Customer Board
- Board Member, NHS Shared Business Services
- Member, NHS Confederation Hospitals Forum;
- Advisor, Hunter Healthcare (involves remuneration)

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

Professor Nick Cheshire Medical Director
- 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. .
- NICE: Member of TOPIC Selection Committee
- Veryan Medical (IC spin out) Shareholder (0.5%)
- 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 – for

- 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.

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 Trust

MINUTES OF THE TRUST BOARD MEETING

Held at 10.45am on
Wednesday 27 March 2013

In the New Boardroom,
Charing Cross Hospital,
Fulham Palace Road, Hammersmith, London

Present:	
Sir Richard Sykes	Chairman
Sir Gerald Acher	Non-Executive Director
Dr Rodney Eastwood	Non-Executive Director
Prof Sir Anthony Newman-Taylor	Non-Executive Director *(except for items 4-8)*
Jeremy Isaacs	Non-Executive Director
Sir Thomas Legg	Non-Executive Director
Sarika Patel	Non-Executive Director
Mark Davies	Chief Executive
Steve McManus	Chief Operating Officer
Bill Shields	Chief Financial Officer
Prof Janice Sigsworth	Director of Nursing
In attendance:	
Stephen Guile	Head of Corporate Services & Trust Secretary
Prof Dermot Kellegher	Principal of the Faculty of Medicine, Imperial College *(except for items 2.2.3-8)*
Prof Alison Holmes	Director of Infection Prevention and Control *(for item 2.2.2)*
Dr David Mitchell	Medical Director, Professional Development (attending on behalf of Professor Nick Cheshire, Medical Director, Clinical Services)

1.	**General Business**
1.1	**Chairman's Opening Remarks**
	The Chairman welcomed Board members and members of the public to the meeting. The Board noted the resignation of Dr Martin Knight as a Non-Executive Director, with effect from 1 March 2013.
1.2	**Apologies for Absence**
	An apology for absence was received from Prof Nick Cheshire, Medical Director.
1.3	**Minutes of the Meeting held on 30 January 2013**
	The minutes of the meeting held on 30 January 2013 were agreed as a true record.
1.4	**Matters Arising and Action Log**
	The Board noted the updates to actions in the log. Updates were discussed

	where necessary during the meeting.
1.5	**Chief Executive's Report** The Board noted the Chief Executive's report, and in particular:
1.5.1	**Shaping a Healthier future:** The Trust had confirmed its support for the decisions of the Joint Committee of PCTs (JCPCTs). The Trust was working the Chelsea and Westminster NHS Foundation Trust on changes to accident and emergency services; and was working with stakeholders on developing business cases for services and facilities, particularly at Charing Cross Hospital and St Mary's Hospital.
1.5.2	**West Middlesex University NHS Trust:** Despite press reports, no decision had been made yet on the future preferred partner for West Middlesex.
1.5.3	**Academic Health Science Partnership**: The Royal Marsden had been accepted as a member of the Partnership. .
1.5.4	**Academic Health Science Centre**: progress was being made on the Joint working Agreement with Imperial College.
2.	**Quality and Safety**
2.1	**Reports from the Director of Nursing:**
2.1.2	**Final Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) – review and Trust response**
	Janice Sigsworth introduced the report which the Board had discussed in detail and accepted at a recent seminar. The following matters were discussed: • Some 70 of the 290 recommendations applied directly to the Trust. The remainder were to be worked through by the Department of Health, Care Quality Commission, Monitor and other bodes, including government, before direct application to the Trust • The priorities were to put patents first; to listen to and learn from patients and staff; to encourage staff to report matters of concern; for Board members to question and challenge • In response to a question from the Chairman, Janice Sigsworth confirmed that the Trust accepted the duty of candour with regards to being open and transparent with patients and families, explaining what had gone wrong and by interrogation at all levels of patient care • In response to a question from the Chairman, Janice Sigsworth confirmed that nurse training currently included experience working within a hospital. She would examine carefully the report's relevant recommendations, the outcomes of pilot studies and other advice.
2.1.3	**Quality Account Priority Indicators 2013/14 sign off**
	Janice Sigsworth introduced the report which outlined the proposed quality indicators for 2013/14. There was a requirement for two indicators to be audited for data quality. One of those had to be the percentage of patient safety incidents resulting in severe harm/death. The other proposed indiactor was c*lostridium difficile.* The Chairman said that some patients arrived in hospital with C*. difficile* and perhaps one of the other two indicators would be more appropriate for audit. The Board endorsed the recommended quality indicators for 2013/14 and, after discussion, decided that the second indicator to be audited would be C*. difficile.*
2.1.4	**Update on Friends and Family Test Implementation**
	Janice Sigsworth introduced the report which outlined progress, which was broadly on track, on implementing the government's Friends and Family test within the Trust. This was being implemented in inpatient wards and for outpatients. I Track devices were being used, which from feedback from

	other trust's methods, appeared to have a relatively high response rate. The reasons for a rating were reviewed, to learn lessons and to rectify failings. Patient feedback was being incorporated into A & E care. Sir Gerald Acher proposed that performance data be displayed on the wards. The Chairman asked that all instances of feedback of 'extremely unlikely to recommend' be immediately followed up with remedial action. Janice Sigsworth confirmed that relevant feedback had been followed up with the teams concerned.
2.1.5	**Eliminating Mixed Sex Accommodation (EMSA) Compliance Declaration**
	The Board noted the report and approved the EMSA Compliance Declaration.
2.1.5	**Safeguarding Children and Young People Declaration**
	The Board noted the report and approved the Safeguarding Children and Young People Declaration.
2.2	**Reports from the Medical Director:**
2.2.1	**Patient Safety and Service Quality Report Q3**
	David Mitchell presented the report. The following matters were discussed: • CNST Level 3 had been attained, with a consequent reduction in insurance cost • Three further CQC inspections had showed Trust compliance with Standards • A further programme of work had been under way to prevent retained swabs. In response to a question from Sir Anthony Newman-Taylor, David Mitchel advised that white boards for recording of swabs were being installed, especially important when a procedure stopped and re-started: 'pause for gauze'. Sir Richard said that there should be no retained swabs and action should be taken when one occurred. David Mitchell said that he believed that the message had got through to staff- investment in procedures was taking place, including junior doctor induction; rotas; and case reviews • In response to a question from Jeremy Isaacs about a recent television programme on junior doctors' hours, David Mitchell said that the EC Working Time Directive was applied, together with appropriate rotas, workloads and supervision of large or difficult tasks. • Rodney Eastwood said that the report was comprehensive. He was seeking a summary on patient safety and how that was embedded. David Mitchell said that the Trust used to have a junior doctor handbook- and that needed to be refreshed, to make messages intelligible and capable of being assimilated. **Action: Nick Cheshire** • David Mitchell said that a tool for SI reporting was working well and was being linked with clinical practice. Rodney Eastwood said that it was important to ensure learning passed between generations. Steve McManus said that junior doctor feedback was important. • Sir Anthony Newman-Taylor said that these issues should be triangulated, with reporting to the Quality and Safety Committee, which he chaired. David Mitchell said that it was important to cover complaints, claims and serious incident reporting. • David Mitchell said that an anonymous person had contacted the CQC about two weeks ago about the operating theatres at Charing Cross hospital. When the CQC contacted the Trust, it immediately carried out inspections. None of the theatres were found to be dirty

	but a number of actions regarding storage and trolleys took place. An improvement plan had been instituted with the staff that carried out weekly audits. • The Chairman said that the Trust should do all it could to encourage staff or the public to report any concern. Janice Sigsworth said that she would review this, including how the Trust's Whistleblowing Policy was publicised on the website. Janice Sigsworth said that the NHS had a culture of bullying, which may make some staff reluctant to report concerns. Sarika Patel said that more emphasis should be given to encouraging whistleblowing. Janice Sigsworth said that the reasons why it was important for staff to speak out were emphasised at staff events. Steve McManus said that he and the Chief Executive are sometimes approached directly. The message that the Trust takes concerns seriously should be continually reinforced. **Action: Janice Sigsworth**
2.2.2	**Infection Prevention and Control Report**
	Alison Holmes presented the report. The following matters were discussed: • The importance of addressing infection prevention and antibiotic' use. • Data to the end of February showed that the Trust was below targets for MSRSA and *C.difficile* • There had been one MRSA bacteriama during February, taking the Trust to seven cases against a target of nine- the patent had had a skin condition that made them more prone to infection and exacerbated treatment. • *C.difficle* was below the target of 110 cases. In 2013/14 the target would reduce to 64 cases. • In response to a question from the Chairman, Alison Holmes confirmed that other infections were monitored, too; a record was kept of each organism identified, including catheter infections. Janice Sigsworth said that greater granularity enable deep dive action to identify the location and cause of issues. • A case review was held for each infection. • Mark Davies said that it was important that staff adhered to policies, especially ascetic non-touch. The Medical Director was identifying each doctor who had not taken up the opportunity to attend training in this technique, so that meetings could be arranged to reinforce this. • Janice Sigsworth said she believed that the low numbers of infections showed strong leadership in prevention and control. • The Chairman underlined the importance of decontamination.
2.2.3	**CQC Perinatal Clinical Alert Report**
	This item was deferred to the meeting on 29 May 2013. **Action: Nick Cheshire**
2.2.4	**Care Quality Commission (CQC Maternity Outlier Alert for Puerperal Sepsis within 42 days of delivery at ICHT**
	David Mitchell presented the report. Dr Foster analysis had showed more deaths than expected and there had been correspondence with the CQC. The Trust had met Dr Foster to review differences in the data-sets. Dr Edwards had conducted the Trust's own review of perinatal deaths over a ten year period. Discussions had taken place with the Royal College of Obstetricians and Gynaecologists. The differences in data were identified as mainly due to coding differences-it was difficult to differentiate between the continuation of treatment of cases of intrapartum pyrexia and true puerperal sepsis with its onset post-natally. The CQC had noted the outcome of the Trust's reviews and advised that it did not need to undertake any further

	enquires at this stage and that its regional team would follow up progress with implementing the action plan. David Mitchell said that if necessary a further report would be made to the Board. **Action: Nick Cheshire** The Chairman said that the report was a comfortable read and thanked Dr Mitchell for the report. The Board accepted the report. Sir Thomas Legg said that Communications Department should be ready with information if questions are raised with the Trust.
2.3	**Cancer Recovery Implementation Plan**
2.3.1	Steve McManus introduced the report provided to the Audit and Risk Committee meeting on 11 March 2013. The report set out how the Trust was improving against cancer performance standards. Macmillan funding had been obtained to prove more access to nurse specialists. The implementation plan set out a series of actions over a 100 days' period. Janice Sigsworth said that the tumour board chairs were being held to account: as an example head and neck cancers had achieved improvement. She suggested that an update be provided at the next Board seminar. **Action: Steve McManus**
2.3.2	The Chairman said that the Trust needed to improve its low levels of patient satisfaction for cancer services. Mark Davies said that he had set targets for the Trust to achieve the second quartile within two years and the top quartile in three years. The Chairman commented on the development of personalised cancer care, using an individual's genetic profile.
3.	**Performance**
3.1	**Performance Report – Month 11**
3.1.1	Steve McManus presented the report. There was strong performance on a number of patient care indicators, in particular: EMSA; Stroke; VTE and maternity. Cancer performance targets were now met in seven out of eight cases and it was hoped to have met the remaining target by the year end. In response to a question from Rodney Eastwood, Steve McManus confirmed that the incomplete cancer pathways had now been captured.
3.1.2	In response to a question from Sir Gerald Acher, Janice Sigsworth confirmed that Friends and Family findings would be published on the Trust's website. The information would also be reviewed at Clinical Quality Group meetings and with commissioners and GPs. Mark Davies referred to the importance of working with commissioners and GPs. Steve McManus said that GPs would help designing treatment pathways.
3.2	**Finance Report**
3.2.1	**Month 11 Finance Report**
	Bill shields presented the report. The Trust achieved a surplus of £8.4 million to 28 February, a favourable variance against plan of £8.3 million. The in-month surplus was £0.1 million. The revised forward outturn for the financial year was £9.745 million. The surplus to date has been achieved mainly through over-achievement of the Cost Improvement Plan, which was expected to deliver £54 million for the financial year and other cost controls. Cash was particularly strong. Some ratings that were amber now would be improved as CPG performance improved.
3.2.2	**Update on 2013/14 Financial Plan**
	Bill Shields gave a presentation, a copy of which was included in the agenda papers. This highlighted the planning that the Trust had undertaken for the coming financial year and the outstanding issues around

	commissioning and contracts for services, The challenges of a flat cash envelope and very significant changes to NHS architecture were explored. Commissioners nationally and locally were behind on the NHS timetable for realistic contract offers and agreement on levels of services and funding was likely to be some way off. When contracts were agreed, the plan would be updated to ensure the Trust met its strategic, quality, cost improvement and service objectives and its financial duties and targets. The Chairman said that moving more services into the community required clear agreed costed plans and timetables between commissioners and providers. Mark Davies said that the Trust would not be changing its capacity from April 2013. The Board accepted the update on the 2013/14 Financial Plan.
3.3	**Department of Health Single Operating Model return: February 2013**
	The Board approved the submission of the Department of Health Singe operating Model return for February 2013.
3.4	**Cerner Implementation Update report**
	A report had been made to the Audit and Risk Committee meeting on 11 March 2013. Steve McManus said that external validation of plans was being obtained before the 'Go-live' date as set This as tentatively planned for August 2013. Regular reports on progress on Cerner implementation were being made to the Management Board, to the Audit and Risk Committee and to Board seminars.
4.	**Governance**
4.1	**Corporate Risk Register and Board Assurance Framework**
	Janice Sigsworth presented the report. A report had been made to the Audit and Risk Committee meeting on 11 March 2012. The Risk management policies and the processes for identifying, managing and mitigating risk were being reviewed. Update reports would be provided to the Audit and Risk Committee and Board. **Action: Janet Sigsworth / Stephen Guile**
4.2	**Education Update and Action Plan**
	This item was deferred to the 29 May Board meeting. Jeremy Levy would be asked to review the action plan with the Medical Director. **Action: Jeremy Levy / Nick Cheshire**
5	**Papers for Information**
5.1	**Report of the Audit and Risk Committee: 11 March 2013**
	Sir Gerald Acher presented the minutes. The next meeting of the Committee was due to be held on 18 April 2013.
5.2	**Minutes of the Governance Committee meeting on 13 February 2013**
	Sir Tom Legg presented the minutes. The next meeting of the Committee was due to be held on 17 April 2013.
5.3	**Report of the Finance Committee: 4 December 2013**
	Bill Shields presented the minutes.
5.4	**Report of the Foundation Trust (FT) Board**
	Rodney Eastwood presented the report, which was noted.
6	**Items for Ratification**
6.1	**Ratification of Chairman's approval; of Department of Health Single Operation Model return for January 2013**
	The Board ratified Chairman's approval of the January 2013 SOM by Sir Richard Sykes and Mark Davies.

7	**Any other business**
	None
8	**Date and time of next meeting:**
	Trust Board Meeting at 10.45am on Wednesday 29 May 2013 in the Clarence Wing Board Room, St Mary's Hospital, Paddington**.**
	Questions from the Public:
	In response to a question from a member of the public, Janice Sigsworth confirmed that the Trust remained as committed to working with patients' groups despite the replacement of the LINks by local Healthwatch and Health and Wellbeing Boards.
	In response to a question from a member of the public, Steve McManus advised that the timing of patients' discharge was carefully managed to ensure proper care on reception at home, on a seven day basis.

Imperial College Healthcare NHS
NHS Trust

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC

27 March 2013

Minute Number	Action	Responsible	Completion Date	May 2013 update
2.2.1	Review of how we encourage staff or the public to report any concern including how the whistleblowing policy is published on the website.	Janice Sigsworth/ Jayne Mee		Being open and whistle-blowing are included the Francis Report on Mid Staffs action plan. People and Organisational Development and the Medical Director's office producing posters and small cards to give to staff alerting them to the policy and what to do if they have concerns.
2.3.1	Update on the Cancer Recovery Implementation Plan	Steve McManus	29.5.13	Report on 29.5.13 Board agenda
4.1	Updated report on Corporate Risk Register and Board Assurance Framework to Audit & Risk Committee and Board Meeting	Janice Sigsworth		An update report was presented to the 18.4.13 Audit & Risk Meeting with further update to 5.6.13 Audit & Risk Committee meeting. Risk Management Strategy is on the24.7.13 Board Agenda

30 January 2013

Minute Number	Action	Responsible	Completion Date	May 2013 update
2.2.2	A full report on the Perinatal clinical alert to be presented to the Trust Board	Nick Cheshire	27.3.13 Board meeting	Deferred from 27.3.13 meeting to 29.5.13.Board (within the Medical Director's Report)
5.1	Education Report Action plan with updates to be presented to the next Trust Board meeting in public**.**	Jeremy levy	27.3.13 Board meeting	Deferred from 27.3.13 meeting to 29.5.13 Medical Director's Report
Public question	Bill Shields to report on state of transfer lounges at the Trust.	Bill Shields	By 27.3.13 Board meeting	An oral update will be given to the Board.

28 November 2012

Minute Number	Action	Responsible	Completion Date	May 2013 update
2.1.3	Final Clinical Governance Review to be presented to the Board.	Janice Sigsworth	27.3.13 Board	There was a further, extended, discussion at the Governance Committee's 15.5.13 meeting on the review and action plan and copies will be provided to Board members.

Imperial College Healthcare NHS
NHS Trust

Chief Executive's Report

29th May 2013

1 TRUST BUSINESS

1.1 Clinical

1.1.1 The Savile Allegations

In December 2012, following a letter about the Savile allegations sent by the Department of Health, Imperial College Healthcare NHS Trust (ICHT) provided assurance to NHS London that systems and processes were in place to safeguard vulnerable people receiving care on our hospital sites. On 30th April 2013 the Trust received a further letter about the Savile allegations, this time as part of an independent oversight review. The letter has asked for any themes and issues arising within organisations in light of discussion of the findings from the Savile investigations thus far. The Trusts response, due on 30th June 2013, will be progressed via the Management Board and presented to the Trust Board at the July meeting.

Lead Director – Professor Janice Sigsworth, Director of Nursing

1.1.2 CQC Strategy

In April, the Care and Quality Commission (CQC) launched its new strategy for the next three years, which reflects the Government's initial response to the Francis Report. The strategy, entitled *Raising Standards, Putting People First,* sets out radical changes to the way CQC inspects and regulates health and social care providers to ensure they provide people with safe, effective, and compassionate care, and to encourage them to make improvements. As part of this new strategy, the CQC will appoint Chief Inspectors for hospitals and social care and support, and will focus on five key questions when inspecting services - are they safe, effective, caring, well led and responsive to people's needs. The CQC has also made a renewed commitment to work more closely with partners in the health system and form better relationships with both patients and service providers. We look forward to working with the CQC as it implements this strategy, which will help us to continue to focus on improving the quality of care and treatment that all our patients receive.

The full strategy can be found:
http://www.cqc.org.uk/sites/default/files/media/documents/20130503_cqc_strategy_2013_final_cm_tagged.pdf

Lead Director – Professor Janice Sigsworth, Director of Nursing

1.2 People and Organisational Development

1.2.1 Board Development

Following a tendering process the Trust has selected Deloitte to assist with the Board Development Programme. Jay Bevington and John Murray will lead the design and much of the delivery. Jayne Mee, Director of People and Organisation Development will now work with Jay to set up the initial round of 1.5 hour interviews and would be grateful to all Board members if they

could make themselves available for this. A Board Away Day to feedback and plan any further development will take place in the early autumn.

Lead Director – Mark Davies, Chief Executive Officer

1.2.2 Executive Development

Mark Davies and Jayne Mee have completed the tendering process for executive team development which will support the effective working of the team and our Foundation Trust application.

The Trust has commissioned David Cumberbatch from RHR, a firm of business occupational psychologists, who Jayne has found very effective in the past for this sort of development. The programme will comprise online psychometric personality and team questionnaires, interviews and an off-site event to share feedback and plan the way forward.

Lead Director – Mark Davies, Chief Executive Officer

1.2.3 Director of Governance and Assurance

Cheryl Plumridge OBE has been appointed as the new Director of Governance and Assurance and will join the Trust at the beginning of July. Cheryl is a career civil servant, who has most recently been the Director of Strategic Studies at the Ministry of Defence. Cheryl has held a number of high profile, board level and strategic posts including risk management, operational policy and crisis management, finance, programme/project management. Cheryl has worked closely with Ministers including on the private staff of the Defence Secretary. Awarded OBE in 1995, Cheryl brings a wealth of experience with her combining government and policy expertise and business skills with an excellent grasp of the health sector having worked closely with the DH and NHS in different guises throughout her extensive career.

1.2.4 Divisional Director appointments

Divisional Directors have now been appointed as part of changes that the Trust is making to the clinical structure. These four appointments underpin the continuing commitment to putting clinical leadership at the heart of the organisation. They will be pivotal over the coming years in ensuring the Trust responds effectively to the significant challenges we face. The Trust would like to thank each of the clinical programme group directors for their significant contribution and commitment to the Trust.

<u>Division of Medicine</u>

Professor Tim Orchard has been appointed as the new Divisional Director for Medicine. Tim is a consultant physician and gastroenterologist at ICHT and a Professor of Gastroenterology at Imperial College London. Tim is renowned for his work in the field of inflammatory bowel disease (IBD), and gives regular lectures on the management of IBD to trainees and consultants in the UK and overseas. Tim is an accomplished and published author of gastroenterology research in the field of inflammatory bowel disease and is committed to teaching. He has a Fellowship of the Higher Education Academy and in 2004 he received an award for Teaching Excellence for NHS staff by Imperial College London. In 2000 was also honoured with the Ralph Noble Prize by the University of Cambridge.

<u>Division of Surgery and Cancer</u>

Professor Jamil Mayet has been appointed as the new Divisional Director for Surgery and Cancer. Jamil is a consultant cardiologist and professor in cardiology, and has been working at

Imperial for more than 20 years. He is a founding member of the International Centre for Circulatory Health (ICCH), a centre of excellence set up with St Mary's Hospital and Imperial College London with an integrated clinical, research and education strategy in the field of circulatory medicine. Jamil has also led the clinical strategy of outreach cardiology services for Imperial. Jamil has keen interest in education, and in particular the academic development of clinical staff. He has been involved in the cardiology registrar training programme for the last 12 years, latterly as Training Programme Director. He has over 140 peer reviewed publications, many top ranked in journals and has been invited to speak nationally and internationally. Jamil is cardiologist to several football teams including Arsenal and the England team.

Division of Investigative Sciences and Clinical Support

Dr Julian Redhead has been appointed as the new Divisional Director for Investigative Sciences and Clinical Support. Julian is a consultant in emergency medicine with an interest in paediatric emergency medicine. He was appointed as the chief of service to the emergency medicine directorate and then as the CPG director for Medicine. He is chairman of the London Board for the College of Emergency Medicine, and sits on the council for the College of Emergency Medicine. He is involved in pre-hospital care, through the British Association of Immediate Care, and is an honorary doctor with the London Ambulance Service. Julian has an interest in sports medicine, sitting on the council for the faculty of sports and exercise medicine. He works as a doctor with Chelsea Football Club and Rugby Football Union, and his research interests are in paediatric obesity and exercise medicine.

Division of Women's and Children's

Mr TG Teoh has been appointed as the new Divisional Director of Women's and Children's. Mr TG Teoh is a consultant obstetrician and gynaecologist and set up the Obstetric Medicine service in 1997 and established the Prematurity Clinic in 2006. TG also initiated the Obstetric Perineal Clinic, co-chaired the Obstetric Risk Management Board and was instrumental in the Trust's achievement of obtaining NHS Litigation Authority (NHSLA) Level 3. TG's research interests are in prematurity and medical disease in pregnancy. He has collaborations with regional & national study groups as well as surgery & immunology and he has given many local, regional, national and international lectures in this field. TG is a senate member of the National Clinical Reference Group for Specialist Commissioning on Maternity Services and has served as Maternity Clinical Expert Panel for various NHS London Programmes. He is also the training programme director for fetal and maternal medicine and various specialties in obstetrics.

1.2.5 Florence Nightingale Foundation Chair in Clinical Practice Research

The Trust is working in collaboration with the Florence Nightingale School of Nursing and Midwifery to establish the Florence Nightingale Foundation Chair in Clinical Practice Research at King's College London. The purpose of the post is to advance research into clinical practice and patient care improvement within nursing; the Trust will work in conjunction with the College's clinical partners to support the research activities of the post holder.

2 PERFORMANCE

2.1 Month 1 Performance Summary

The Trust ended 2012/13 having achieved excellent performance in key areas. The Trust sustained good performance in all the Quality Performance Indicators such as Infection Control, Mortality, Stroke Care and reporting no mixed sex accommodation breaches for the full year. The Trust also continued to deliver the Referral to Treatment standards and in March (data reported in April) met all eight of the cancer access targets as well as achieving the 95 per cent threshold for 4 hour maximum waiting time in Accident and Emergency.

In Month 1, the Trust continues to sustain good performance. The threshold for venous thromboembolism assessments has risen from 90 per cent in 2013/13 to 95 per cent in 2013/14, and in April the Trust achieved the new standard. The Trust continues to achieve the Elective access and Accident & Emergency 4 hour maximum waiting times standards although by hospital site, Charing Cross failed to meet the 95 per cent threshold. There were no reported cases of MRSA, however the number of Trust attributed *c.difficile* cases was 12, which is above the year to date trajectory of six cases. An action plan is in place to minimise further infections.

Lead Director – Steve McManus, Chief Operating Officer

3 FOUNDATION TRUST APPLICATION

3.1 Foundation Trust (FT) Application Update

Since the last update to the Trust Board in March, the following key areas been progressed;

- Finalised programme governance structures;
- Developed work streams and programme plans and risk registers;
- Conducted Board Governance Assurance Framework baseline assessment (as reported to Trust Board seminar in April) to inform the Board Development programme;
- Commenced Quality Governance Framework baselining exercise prior to formal self-assessment later in the year;
- Agreed plan for the development of the Integrated Business Plan, centering on the clinical strategy;
- Commenced development of the Long Term Financial Model (base case scenario).

In consultation with the Trust Development Authority (TDA), the FT Programme Team will further develop the timeline and critical path to FT authorisation in the next month and report back to the Board in June.

Lead Director – Bill Shields, Chief Financial Officer

4. NWL BUSINESS

4.1 "Shaping a Healthier Future" Consultation

The Trust has established a team, with other stakeholders, to develop outline business cases as required with a target completion date before the end of 2013.

Lead Director – Bill Shields, Chief Financial Officer

4.2 West Middlesex University Hospital NHS Trust (WMUH)

The Trust was officially informed on 8 April 2013 that WMUH's Board has chosen Chelsea & Westminster NHS Foundation Trust as their preferred bidder and we offered our congratulations to Chelsea & Westminster. West Middlesex further confirmed that commissioners had no intentions to change care pathways for any specialties at WMUH including those that come to Imperial.

Lead Director – Mark Davies, Chief Executive Officer

5. RESEARCH

5.1 Application to host LCRN

The National Institute for Health Research (NIHR) Clinical Research Network (CRN) is undergoing a transition to simplify and streamline the structure, moving to 15 Local Clinical Research Networks (LCRNs) which will be aligned regionally with the Academic Health Science Networks (AHSNs). A two-stage process is underway to select host organisations for the 15 new LCRNS. Working with other providers in the region, notably the current host North West London Hospitals NHS Trust, ICHT have submitted a first-stage Pre-Qualifying Questionnaire (PQQ) on 24 April to host the new NWL LCRN. This was the only bid submitted for North West London. Formal selection decisions will be announced by the end of May 2013, stage 2 will need to be submitted by the end of June 2013, with final decisions made by end of September 2013.

If selected, ICHT will receive ~£20m-£25m per annum for disbursement among trusts 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 Network. There are opportunities to align the funding with the existing research strategies for the Imperial and Royal Marsden Biomedical Research Centres, the two Biomedical Research Units at the Royal Brompton, and the NWL CLAHRC (Collaboration for Leadership in Applied Health Research and Care).

Lead Director – Professor Jonathan Weber, Director of Research

5.2 NIHR Health Informatics Collaborative (NHIC)

The NIHR Health Informatics Collaborative (NHIC) is a challenge from Dame Sally Davies, Chief Medical Officer, to the five NHS Trusts in England with the largest Biomedical Research Centres (BRC), *i.e.* Imperial, Oxford, Cambridge, UCLH and GSST, to collaborate and demonstrate how sharing of NHS clinical information, held electronically, can facilitate more effective clinical research, and lead to benefits for patients and the public, researchers and NHS staff. The programme has started working on the requirements needed to design, build, test and deliver a new IT capability, to support the sharing and use of data and enable benefits to patients, researchers and NHS staff. In order to demonstrate the value of this new IT capability, five scientific themes have been identified (viral hepatitis, acute coronary syndrome, critical care, transplantation and ovarian cancer), with the aim of conducting studies showcasing the benefits of the new capability once it is delivered.

In parallel, work will also commence in participating NHS trusts to identify or establish scientific collaborations, to discuss local governance arrangements and to identify additional informatics work that may be necessary to acquire, extract, or manage data for specific themes. Alongside these activities, the programme will engage patients, the public and other governance stakeholders to agree an integrated governance framework that is flexible, proportionate, and serves to protect data confidentiality and uphold patient privacy at all times.

Lead Director – Professor Jonathan Weber, Director of Research

6. IMPERIAL COLLEGE HEALTHCARE PARTNERS

Imperial College Healthcare Partners has been designated by the Innovation, Health and Wealth Implementation Board at NHS England as the Academic Health Science Network (AHSN) for North West London with immediate effect. Dr. Adrian Bull, Managing Director, has congratulated those involved and has said that the designation is the result of the 'proposition that was developed and of the strength of partnership that has been established '. Sir Ian Carruthers, Chair of the Innovation, Health and Wealth Implementation Board will be meeting with each AHSN this month to feedback on all of their respective plans and a national announcement will be made following these meetings.

Lead Director – Mark Davies, Chief Executive Officer

7. IMPERIAL COLLEGE HEALTHCARE CHARITY BUSINESS

7.1 New Trustee

As Professor Matthew Swindells leaves in July, the trustees interviewed for a new trustee and, with agreement of the NTDA, have appointed Robert Creighton. Robert will be well-known to people in the NHS having worked at the Department of Health and as Chief Executive of both Great Ormond Street Hospital and Ealing PCT. Most recently he has been responsible at NHS London for the delivery across London of the transfer of NHS public health functions to local government, Public Health England and the NHS Commissioning Board. He brings a wealth of skills and experience in the development and implementation of strategy, innovation and organisational change.

7.2 Fundraising

The charity's new five year fundraising strategy has been presented to the Trust's executive team and a joint fundraising board has been established with the participation of Steve McManus, Dr. Chris Harrison and John Cryer to take forward its operations. To support the fundraising director and individual giving fundraiser, the charity is currently recruiting two fundraising managers to encourage support from companies and major donors.

7.3 Grants

Applications for one-year Research Fellowship awards for £50,000 each close on 24 May 2013.

7.4 Communications

The communications manager is reviewing projects funded by the charity to submit to the Guardian Healthcare Innovation Awards, a knowledge sharing event run by the national newspaper for healthcare organisations in the UK highlighting innovative thinking that benefits patients. There are six awards categories, with entries being judged and announced at a winner's event in October 2013. Both winners and nominees will be featured in the newspaper and online, the focus being on good practice and ideas that can be disseminated to all organisations involved in the process.

The charity will also unveil a new video at the OSC&Rs ceremony on 23 May. The video recognises some of the excellent achievements and work done by trust staff through research and healthcare projects, highlighting how they have improved care for patients.

7.5 Art

A series of new monthly art tours at Hammersmith, Charing Cross and St Mary's hospitals started in April, with the next one on 3 June 2013. The tours are open to volunteers, staff and patients to get to find out more about the charity's art collection.

The charity has accepted the gift of a tall sculpture *Core Femme* by artist Jill Berelowitz which the trust has agreed can be installed in the grounds of Charing Cross Hospital, and unveiled later in the year.

Imperial College Healthcare NHS
NHS Trust

Report Title: Director of Nursing's Report

To be presented by: Janice Sigsworth, Director of Nursing

Executive Summary:
The attached paper is a consolidated report covering the following areas:
- The Care Quality Commission National Inpatient Survey results
- Hearing what patients and their families say about the care and treatment at Imperial College Healthcare NHS Trust
- Approval of the 2012/13 Quality Account
- Clinical risk assessment of Cost Improvement Programmes (CIP)
- Nurse staffing levels –Assurance process

Key Issues for discussion: N/A
Please refer to the attached paper which summarises the key issues for discussion and the actions required.

Legal Implications or Review Needed
a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report
a. For Decision ☒
b. For information/noting

Director of Nursing's Report

29 May 2013

1. QUALITY AND SAFETY

1.1. Care Quality Commission (CQC) National Inpatients Survey Results

The CQC published the 2012 National Inpatient Survey results on 16 April. The results are based on 305 respondents from a total of 781 patients that were surveyed equating to a response rate of 39%. The results are based on patients that were discharged in July 2012. Overall, our results have not improved on the 2011 position. The Trust performed about the same as most Trusts in the country.

Looking forward, our patient experience improvement strategy and its delivery will focus on 3 key areas also known as the '3 P's':

- *Patients* (know as individuals, actively participating and expert)
- *People* (empathetic and mindful, empowered to lead, delivering safe evidence based care)
- *Processes* (these need to be reliable, efficient and standardized)

We are currently developing a Quality Strategy and improving patient experience will be a central pillar of this.

Please refer to Appendix A for a copy of the full report.

ACTION REQUIRED: To review the report

1.2. Hearing what patients and their families say about the care and treatment at Imperial College Healthcare NHS Trust

A review is currently underway of how we integrate feedback from existing sources (PALS, NHS Choices, Patient Stories and Care Connect) together with patient survey and feedback data. The Trust's Medical Director is leading an AHSC work stream and developing a quality strategy that will bring together all of these data sources to drive improvements in services for patients and their families.

Patient stories are a powerful and valuable learning tool and moving forward, it is proposed these are included at Board meetings.

Please refer to Appendix B for a copy of the full report to include two patient stories.

ACTION REQUIRED: **The Board is asked to approve the use of patients' stories at its meetings. These should show lessons learnt and examples of great care.**

1.3. Approval of the 2012/13 Quality Account

The Trust met seven of the eleven indicators set out in our 2012/13 Quality Account and very nearly met the remaining four**.** For 2013/14, there are three new indicators as follows:

- *Dementia* (achieve 90% of the CQUIN target)
- *Friends and Family Test* (achieve the Department of Health 15% response rate target)
- *Caring and Compassionate Staff* (to show an improvement on last year's score)

We have utilized the feedback we received from internal audit and have also engaged several stakeholders to review and scrutinise our Quality Account. These include; CPG Boards, Central London

Clinical Commissioning Group, the Clinical Quality Group (discussed on 22nd April), Health Watch, the Quality Account Delivery Group and relevant Overview and Scrutiny Committees.

In response to the Mid-Staffordshire NHS Foundation Trust Inquiry, all Directors together with the Chief Executive will now be required to formally sign the Quality Account prior to it's publication in June 2013.

Please refer to Appendix C for a copy of the draft 2012/13 Quality Account.

ACTION REQUIRED: To review and accept the draft 2012/13 Quality Account and agree to delegate the final approval and sign off to the Chairman, Chief Executive and Executive Directors.

1.4. Clinical risk assessment of Cost Improvement Programmes

In light of several drivers such as; The Mid Staffordshire NHS Foundation Trust Inquiry and national guidance published by the National Quality Board and NHS England, the Trust has reviewed its process of clinical risk assessment in relation to Cost Improvement Programmes (CIPs).

A revised process has been set out and outlines:

- The processes required to develop, approve and review CIPs and Quality Impact Assessments (QIAs) internally and externally
- The process by which CIPs and associated QIAs are signed off by the Divisional Medical Director and Divisional Director of Nursing
- Roles, responsibilities and timeframes in relation to the process

Please refer to Appendix D for a copy of the full report and process.

ACTION REQUIRED: To approve the process

1.5. Nurse Staffing Levels- Assurance Process

Safe levels of staffing and an adequate skill mix are central to the delivery of high quality care and Trusts must ensure that they have the right staff, with the right skills, in the right place to meet commissioning, regulatory and professional standards. In particular, the Trust Board will be expected to sign off and publish evidence based staffing levels at least every six months (NHS Commissioning Board and the Department of Health (DH), 2012).

A position statement written in 2010 has been updated to strengthen the structure and process for ensuring safe staffing and skill mix and to align it more closely to the current overall Trust Quality Governance Framework, including the management of Cost Improvement Programmes.

Following consultation with Heads of Nursing, the policy was approved by the Clinical Risk Committee and the Quality and Safety Committee.

The purpose of this policy is to outline:

- The principles and methodology that the Trust uses to inform agreed nurse staffing and skill mix establishment (**section 4**)
- The roles and responsibilities of individuals within the organisation to ensure safe nurse staffing and skill mix establishment (**section 3**)
- The process by which safe nurse staffing and skill mix establishment is ensured and assured within the organisation, including the on-going assessment of risk associated with actual or potential shortfalls in nurse staffing and/or skill mix (**section 4.5**) Including the process for managing staffing where there is an increased acuity and dependency (including the 'specialling' of patients) and escalation.

Please refer to Appendix E for a copy of the process.

ACTION REQUIRED: To ratify the process

Imperial College Healthcare NHS
NHS Trust

APPENDIX A

Director of Nursing Report: CQC National Inpatients Survey Results

1. Introduction

This paper reports on the National Inpatient Results published by the Care Quality Commission (CQC) on Tuesday 16 April. The results are based on 305 respondents from a total of 781 patients that were surveyed equating to a response rate of 39%. The results are based on patients that were discharged in July 2012.

2. Background

ICHT is committed to improving and offering a good experience of care and services to patients and their families. The Trust has undergone a series of leadership and organisational changes over the past 14 months, with the completion of the Divisional Structure by the beginning of Autumn. This will enable the organisation to build on the achievements of financial stability and improving performance, as well as embedding patients at the heart of what we do.

Central to this is making sure that our staff and patients are content and satisfied with their experiences at ICHT. The Trust Board endorsed the Patient Experience Strategy in 2012 and with the appointment of a new Director of People and Organisation Development (DoP&OD) we anticipate a refreshed approach to staff engagement and experience. All the evidence demonstrates that a positive staff experience generates a positive patient experience.

We know that our clinical outcomes and safety thermometer outcomes are some of the best in the country.

3. The Last Three Years (2009-2012)

Over the last 3 years ICHT has made steady and consistent improvement in the National Inpatient Survey (NIS) as well as the following:

i) For the National Outpatient Survey ICHT is currently 2nd Acute Trust in London.
ii) For the National Maternity Survey ICHT is currently 2nd in London.
iii) For the National Accident & Emergency Survey ICHT is currently 4 equal in London.

4. CQC Methodology

The NIS has circa 60 questions in 10 categories. Each question gets a score out of 10 and each category gets a score out of 10. The results are then classified as better, the same as or worse than other Trusts in England.

The table below sets out the score out of 10 for each category:

Category	Bart's Health NHS Trust	St. George's	Guy's & St. Thomas NHS FT	ICHT	King's	UCLH NHSFT
A&E	8.3	8.7	8.8	8.6	8.5	9.0
Waiting List	8.8	8.9	9.1	8.7	8.7	8.9
Waiting for a Bed	7.5	7.2	8.4	7.4	7.8	7.5
Hospital & Ward	8.0	8.0	8.4	8.0	8.1	8.2
Doctors	8.2	8.6	8.7	8.4	8.4	8.8
Nurses	7.7	8.3	8.5	8.0	8.1	8.3
Care & Treatment	7.2	7.6	8.0	7.4	7.6	7.6
Ops & Procedures	8.3	8.2	8.4	7.9	8.2	8.3
Leaving	7.0	7.1	7.5	7.0	7.3	7.6
Overall	4.9	5.2	5.7	5.5	5.8	5.4

The individual questions and scores can be provided should Board members wish.

5. The Results

Overall ICHT performed about the same as most trusts in the country. We are above the national average for A&E and overall care. We performed less well on operations and procedures and the London scores are generally lower than the rest of the country. Overall our results have not improved on the 2011 position. For some questions the scores have got worse.

5.1 The questions we scored less well on than most Trusts were:

i) Did you find someone on the hospital staff to talk to about your worries and fears? (Care & Treatment)
ii) Did a member of staff explain the risks and benefits of the operation or procedure? (Operations & Procedures)
iii) Did a member of staff explain what would be done during the procedure? (Operations & Procedures)
iv) Did the anaesthetist explain how he or she would put you to sleep or control your pain? (Operations & Procedures)
v) Did hospital staff take your family or home situation into account when planning your discharge? (Leaving Hospital)
vi) Did nurses talk over you as if you weren't there? (Nurses)

5.2 There was one question where we did better than most Trusts – "while in hospital were you ever asked about the quality of your care?"

5.3 Itrack Results

The real time patient feedback survey shows that there has been a plateauing out of improvement and a greater volatility in some areas which were not able to sustain improvement. We have noticed that certain factors affect sustainability. These are leadership, multi-disciplinary team-working, vacancy levels, service changes and ward moves, staffing profiles and communication.

Currently the Itrack results are being reviewed to enable service, divisional and trustwide scores to be generated in keeping with the implementation and scoring of the Friends and Family Test.

6. Our Focus Going Forward – The 3 P's @ Imperial

As part of our Foundation Trust application, we are developing a Quality Strategy and improving patient experience will be a central pillar of that strategy. This needs to be interwoven with our staff engagement and experience strategy.

There are 3 key areas we must address as part of this:

- **Patients** (know as individuals, actively participating and expert)
- **People** (empathetic and mindful, empowered to lead, delivering safe evidence based care)
- **Processes** (these need to be reliable, efficient and standardised)

The '**3 P's @ Imperial'** will drive the patient experience improvement strategy and its delivery. This plan will draw on good practice from the UK, US and private sector.

What does it feel like when we get it right? Patients say care is compassionate, empathetic and responsive, it's coordinated and integrated, with information, communication and education. Physical and emotional needs are met and friends and family are involved. We do get it right on lots of occasions for our patients and their families but our goal is to get it right every time. In this new approach we need to inspire staff to listen to patients' worries, fears and anxieties and respond with empathy and kindness. It will be the little acts of human kindness that will mean the most to patients and their families showing empathy and understanding of what it is like for them.

In the short term we have an opportunity to make some quick changes to make a difference. The next National Inpatient Survey will be in August 2013.

7. What Do We Need to Do Over the Next 3 Months

i) Clinical Programme Directors (CPD's) to present action plans in June to the Management Board, to include confirming that patient experience results are discussed at handover, team meetings and Clinical Programme Group (CPG) board meetings.
ii) Ensure a strong performance management focus on patient experience through the monthly performance meetings with CPG's reviewing improvement plans from May onwards.
iii) CPG's to complete the NHS Institute 15 step review of all wards and departments over the next few months. Dates are agreed with CPGs.
iv) CPGs to support and provide assurance that hourly rounding, quality rounds and ward notice board information is standard practice on every ward.
v) Feature improving patient experience over the coming months in team brief, talk to the top, CEO monthly message and all other team and department CPG based meetings. Focusing on communication and involvement. July will be patient experience month.
vi) Launch the "Don't Talk Over Me" poster campaign.
vii) Discuss and learn lessons from patient stories at the Trust Board and Management Board (to start May 2013), and roll this out to team, department and CPG Board meetings.

As part of the development of the quality strategy:

i) The DoP&OD to review ICHT customer care training and make immediate recommendations.
ii) The DoP&OD to review and make recommendations on the staff experience and engagement strategy.
iii) Develop the Quality Governance Framework and Quality Strategy to improve patient experience putting patient experience at the heart of all we do.
iv) Re-affirm the organisation's values and objectives via the Integrated Business Plan.
v) Review and re-launch the Patient Experience strategy and incorporate Patient Experience governance and assurance into the Quality and Safety Committee.
vi) The COO to develop plans to address improvement in our operational processes.
vii) Respond to the recommendations of the Mid-Staffordshire NHS Foundation Trust Inquiry and implementing recommendations related to learning from complaints, PALS and NHS choices feedback.

The results for ICHT are included in Appendix I.

APPENDIX I: 2012 NATIONAL INPATIENT SURVEY RESULTS

National Inpatient Survey Questions	CQC 2012 Rating
A&E	About the same
How much information about your condition did you get in the A&E department?	About the same
Were you given enough privacy when being examined or treated in the A&E Department?	About the same
Waiting List	About the same
How do you feel about the length of time you were on the waiting list?	About the same
Had the hospital specialist been given all the information about your condition/illness from the person who referred you	About the same
Was your admission date changed by the hospital?	About the same
Admission	About the same
From the time you arrived at the hospital, did you feel you had to wait a long time to get a bed on a ward?	About the same
The Hospital and Ward	About the same
Did you ever share a sleeping area with patients of the opposite sex?	About the same
Did you ever use the same bathroom as patients of the opposite sex?	About the same
Were you ever bothered by noise at night from other patients?	About the same
Were you ever bothered by noise at night from hospital staff?	About the same
In your opinion, how clean was the hospital room or ward you were in?	About the same
How clean were the toilets and bathrooms you used in hospital?	About the same
Did you feel threatened during your stay in hospital by patients or visitors?	About the same
Were hand-wash gels available for patients and visitors to use?	About the same
How would you rate the hospital food?	About the same
Were you offered a choice of food?	About the same
Did you get enough help from staff to eat your meals?	About the same
Doctors	About the same
When you had important questions to ask a doctor, did you get the answers you could undertand?	About the same
Did you have confidence in the doctors treating you?	About the same
Did doctors talk in front of you as if you weren't there?	About the same
Nurses	About the same
When you had important questions to ask a nurse, did you get the answers you could understand?	About the same
Did you have confidence in the nurses treating you?	About the same
Did nurses talk in front of you as if you weren't there?	Worse
In your opinion, were there enough nurses on duty to care for you in hospital?	About the same

Your Care and Treatment	About the same
Did a member of staff say one thing and another say something different?	About the same
Were you involved as much as you wanted to be in decisions about your care?	About the same
How much information about your condition or treatment was given to you?	About the same
Did you find someone on the hospital staff to talk to about your worries and fears?	Worse
Were you given enough privacy when discussing your condition or treatment?	About the same
Were you given enough privacy when being examined or treated?	About the same
Do you think the hospital staff did everything they could to help control your pain?	About the same
After you used the call button, how long did it usually take before you got help?	About the same
Operations and Procedures	About the same
Did a member of staff explain the risks and benefits of the operation or procedure?	Worse
Did a member of staff explain what would be done during the procedure?	Worse
Did a member of staff answer the questions about the operation or procedure?	About the same
Were you told what you could expect to feel after you had the operation or procedure?	About the same
Did the anaesthetist explain how he or she would put you to sleep or control your pain?	Worse
Afterwards did a member of staff explain how the operation or procedure had gone?	About the same
Leaving Hospital	About the same
Did you feel you were involved in decisions about your discharge from hospital?	About the same
Were you given enough notice about when you were going to be discharged?	About the same
What was the main reason for the delay?	About the same
How long was the delay to discharge?	About the same
Were you given any written information about what you should do after leaving hospital?	About the same
Did hospital staff explain the purpose of the medicines you were to take home?	About the same
Did a member of staff tell you about the medication side effects to watch for?	About the same
Were you told how to take your medication in a way you could understand?	About the same
Were you given clear written information about your medicines?	About the same
Did a member of staff tell you about any danger signals you should watch for?	About the same
Did hospital staff take your family or home situation into account when planning your discharge?	Worse
Did hospital staff give your family or someone close to you all the information they needed?	About the same
Did hospital staff tell you who to contact if you were worried about your condition?	About the same
Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	About the same
Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital	About the same

Did you receive copies of letters sent between hospital doctors and your family doctor?	About the same
Were the letter written in a way you could understand?	About the same
Overall	About the same
Did you feel you were treated with respect and dignity while you were in hospital?	About the same
How would you rate how well the doctors and nurses worked together?	About the same
Overall how would you rate the care you received?	About the same
While in hospital, were you ever asked to give your views on the quality of your care?	Better
Did you see or were you given, any information explaining how to complain to the hospital about the care you received?	About the same

Imperial College Healthcare NHS
NHS Trust

APPENDIX B

Director of Nursing Report: Hearing What Patients and their Families Say About Care and Treatment at Imperial College Healthcare Trust

1. Background

This paper reports on our proposed approach to compliments, complaints and NHS Choices feedback and gives two short patient stories.

In future months the report will include PALS contacts and NHS Choices feedback. Once Care Connect is live, information and feedback from this will be reported.

A review is currently underway of how we integrate this feedback alongside patient survey feedback and other patient feedback data. The Trust's Medical Director is leading an AHSC work stream and developing a quality strategy that will bring all of these data sources together to drive improvements in services for patients and their families.

In the Francis Report, which reviewed the failure at Mid-Staffordshire NHS Foundation Trust, Sir Bruce Keogh specifically made fourteen recommendations about the complaints process and how it should be '*at the heart of any system for ensuring that appropriate standards of care are maintained'.* Sir Bruce goes on to say that '*a health service that does not listen to complaints is unlikely to reflect its patients' needs'.* With this in mind the Trust has already mapped the complaints recommendations to its current complaints procedure to determine a detailed short and medium term action plan which forms part of the Trust's Mid-Staffordshire action plan.

2. Overview of complaints

The Trust investigated 838 formal complaints during 2012/13, representing a slight reduction of 1.6% from the previous year, and responded to 94% of its formal complaints (against a Trust target of 90%) within the deadline set by the complainant.

Overall this presents 0.06% of contacts. The vast majority of patients are happy with their care and treatment.

The main reasons for formal complaints are:

- Clinical Care 61% approx
- Delayed/Cancelled Appointments 25% approx
- Communication/Information to Patients 14% approx

Please note these three themes are common to all NHS Trusts.

In April 2013 a review of service improvements took place as a consequence of a formal complaint investigation. Since then many changes and improvements have been made, for example:

- The management of the Chest Clinic will now be reviewed to ensure patients are seen in a timely fashion.
- Nurses have been reminded to approach conversations regarding visiting hours with more empathy.
- Consideration will be given to what additional support we can provide to relatives to help them come to terms with the death of a family member.
- Extra stoma care teaching has been provided to relevant staff.
- Customer care courses have been organised for staff.
- The guidance for patients on warfarin and clopidogrel will be reviewed.
- Staff have been reminded of the importance of clearly informing patients about their discharge arrangements.
- A reflective session has occurred so that staff can consider and talk about how they are perceived when communicating to patients.
- Staff have been reminded to ensure patients have sufficient time to ask any questions regarding their procedure.
- A new Consultant led ward round on the post natal ward has been instigated.

3. Patient's Story

It is important to hear patients' views on care to see care and treatment through patients' 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. Equally getting positive feedback and descriptions of care can have similar benefits for learning. This section contains two patient stories:

3.1 Following a severe deterioration of a patient his family requested an urgent second opinion and a transfer to another hospital. Our response to the request for a second opinion was delayed and the family had concerns:-

- Support for family members.
- Deportment of staff, including a member of staff booking a social event.
- Medical explanation, including the provision of a referral process to a Senior Consultant.
- Refreshments offered to patients' relatives.
- Escalation process at PALS.

There are a number of key actions that have occurred and are due to be implemented:

- A reflective session has already occurred for all doctors and nurses involved.
- The patient's consultant has undertaken a refresher communication course.
- The nursing team has been reminded to ensure patients' relatives are offered tea or coffee when relatives cannot leave the bedside.
- Locate the member of staff who booked a social event in view of the relatives and advise of impact.
- We will consider how best to establish a policy/procedure that triggers a second opinion to a more senior member of staff.

3.2 Duncan's story….

"I'm 34 years old, enjoy drinking beer and eating pizza. Yet on 21st April, I ran the Virgin London Marathon 2013, and the reason for this act of madness is a charity named COSMIC.

The whole situation came about last year when my one-year old son (Harrison) caught croup after a family holiday. He was in and out of hospital for a few days on a mixture of steroids and oxygen before they realised he just wasn't recovering and was actually becoming much weaker. We were informed that he would have to be intubated and transferred to St Mary's hospital in London. I had no idea what 'intubation' was or even heard of St Mary's, so both my wife and I were incredibly nervous. We were told about the usual risks with intubating someone, especially someone so young and obviously this didn't help. However, after what felt like an eternity we were informed by the nurse that it had been successful and we would shortly be transferred.

The CATS team were truly brilliant in transferring him to St Mary's. It was actually quite inspiring seeing them come in and take control. Their single goal to make sure our little boy arrived at St Mary's in exactly the same condition, and that's no mean feat when you consider the amount of wires and tubes that needed to be unconnected and reconnected, coupled with the fact they couldn't really move him.

He was transferred successfully to the PICU and the moment we arrived we were immediately welcomed and reassured. A kind nurse took me to a spare bed so I could get some sleep, while my wife waited by Harrison's bedside. In the morning we were informed that we would likely be in for a few days, maybe a week, while they established what was wrong with him. We were also told that if we required it they would supply us with a hotel room across the road from the hospital. So we decided to take shifts, meaning that one of us could go home and see our four-year old daughter (Molly) who was also becoming a little distressed by the situation.

We spent a total of 12 days at St Mary's PICU, and I can't sing their praises enough. Harrison was intubated for 10 days and over that time he was observed every single minute. The nurses were incredibly kind and patient with us, especially over the first few days where we tried to establish if his symptoms looked 'normal' and whether they had seen anything similar, anything to reassure ourselves. They explained he was perfectly comfortable and that he would remain that way until they were completely sure he was ready to progress. I watched as they moved him around to prevent sores, changed him and even went in search for a fan when the weather became surprising warm.

Later in the week during my stints I noticed myself becoming part of the routine helping where I could and saying ridiculous things like "Aren't we running a little low on Midazolam?" Again, the nurses were absolutely brilliant and understanding, explaining to me how the machines worked and how the doses would be taken down slowly.

We were always provided accommodation but the waiting room becoming a sort of home from home, a place where my wife and I would meet and exchange stories about our evenings, before heading off in separate directions once again. It was also a communal place to meet the other parents whose children were on the ward. People that in any other place I would have little in common with became essential friends. We would explain how our children were doing, congratulating each other with biscuits and tea over any sign of good news and reassuring each other over bad.

The fact that it was a ward filled with children made it all so much harder. I found myself wanting to kiss all of the children goodnight, and their every cry and whimper broke my heart. I wasn't the only parent to think this.

The days when the tubes were taken out were cause of mass-celebration in the waiting room, chocolate Hobnobs would make an appearance and everyone was anxiously looking forward to the day their child was well enough to support themselves. So when the day came for Harrison's tube to come out I have to admit I was ridiculously positive. I'd seen 3 other children have the tube taken out so assumed it would be a walk in the park. I was wrong, there were a manner of problems, and he was still incredibly weak and still struggled for breath. We realised quickly that he would have to be intubated again and my heart sank. It was a massive reminder that we were in intensive care.

That night while I was sat at his bed feeling very melancholy, I took a piece of paper and a pen and decided to write a note to Molly. I wanted to try and establish in my head what I could possibly say to my daughter if Harrison didn't survive the ordeal. I knew that my parents, family and friends would take it incredibly bad, but how would I explain to a 4 year old girl that she would never see her brother again. The following morning I had a piece of paper with the word Molly written on the top. There simply was no way to say it.

But things did improve, it had simply been too early for him and a few days later everything was looking much better. One night while I was on the ward, I said to our nurse that I would have to do something to raise awareness and funds for the intensive care unit. I was then informed about COSMIC, which was set up to provide for the ward (including the parents). It was the reason I had a hotel room to stay in that night and had even provided the tea I was drinking.

I suddenly remembered that I had foolishly entered the ballot for the London Marathon. I entered after a news segment reminded it was last week for entries, and it was always something I'd considered. So I went on to the website and put my name in, thinking that I would always be able to say that "I'd tried" - the odds of getting in weren't exactly in my favour! However I suddenly felt good about my chances...this was going to be karma.

So I said to the nurse "I tell you what, if I get that ballot place in the marathon, I'll run it for COSMIC!" 3 months later I received a text from my wife announcing I'd got a place!

Since then I've been training regularly and building up sponsorship, but mostly just trying to explain to people why I am doing it. The reason still lies folded up in my wallet, a small piece of paper with one word written in it, but the reason I give is "they gave me my boy back". Those 6 words are more than enough encouragement to put my trainers on. Even as I type them I feel a little teary at the situation we found ourselves in and just how different things could have turned out. It opened our eyes to the little things we blow out of proportion and how menial our jobs were in comparison to all the wonderful people we met along our journey at St Mary's."

4. Next steps

In order to share fully the details of patients' positive feedback and complaints issues, we will need to seek permission to do so. For the purpose of this report the stories are anonymised which in turn can lose some of the emotion, feeling and power of the patient/family story. A 'consent to use' process will be implemented with patients and their families going forward.

5. Conclusion

The Board is asked to approve the telling of patients' stories at its meetings. These should show lessons learnt and examples of great care.

Imperial College Healthcare NHS Trust

Quality Accounts

2012/2013

If you need the document in a different format

This document is available in large print, audio, Braille and other languages on request. Please contact the communications team on 020 8383 3860 or email: quality.accounts@imperial.nhs.uk**.**

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

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// Chief executive statement

Providing high quality care for all our patients is central to everything we do at Imperial College Healthcare NHS Trust. It is right that we monitor and assess our performance in meeting this challenge, which is precisely what this, our fourth quality accounts, sets out to do.

The focus for 2012/13 was to make further improvements in patient safety, clinical effectiveness and the patient experience. Some priorities, for example, reducing the number of healthcare associated infections, are set nationally and others were agreed with our local primary care trusts who commissioned our services. We also developed a number of improvement priorities with our patients, staff, primary care colleagues, Local Involvement Networks (LINks) and shadow members. Going forward we will continue this work with our partner clinical commissioning groups and Healthwatch.

Progress against performance has been regularly monitored by a dedicated delivery group and through reports to the Governance Committee and the Trust board.

There have been some notable successes in meeting the standards set for the year. Our mortality rates are amongst the lowest in the country, as evidenced in the fact we are in the top 20 performing trusts for Summary Hospital-Level Mortality Indicator (SHMI) ratios and categorised as 'lower than expected' when compared with other trusts. We have also continued to reduce the number of patient falls and healthcare acquired infections (HCAIs).

In developing priority areas for 2013/14 we have reassessed where we should focus on making further improvements based on new national priorities and feedback from members of the public, patients, LINks and a wide variety of staff members.

Some of the work is already in progress and builds on our performance over the past year. By way of example, the aseptic non-touch technique (ANTT) roll-out is well underway to assist us in further driving down the incidents of HCAIs, which again features as a priority in our quality accounts. We also welcome new priorities around dementia care, looking at ensuring patients are appropriately assessed and screened.

We have considered carefully the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry and as a result will directly ask our patients if they found staff to be caring and compassionate. We believe this is fundamental to good patient care and we are continuing to review our own performance in light of this.

Our focus for 2013/14 continues to be maintaining and improving the quality of our clinical care while simultaneously becoming more efficient by eliminating waste and duplication. Strong clinical performance, financial stability and further strengthening our governance systems are fundamental in securing a sustainable future for our Trust and achieving Foundation Trust status.

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In the last year we have demonstrated our ability to drive up quality in many areas while making significant productivity improvements and cost savings. However, there is no room for complacency and many areas where we can further improve.

It is important to us that our quality accounts are accurate and accessible. I can confirm that the information included in this document has been subjected to all the appropriate scrutiny and validation checks to ensure the data is accurate. I also hope that this document is user-friendly and informative and I would like to thank everyone who contributed in its development, including members of the public, LINks, shadow members and commissioner colleagues.

We will look to further our partnership working which we see as essential in ensuring we address the issues that matter most to the people we care for. If you would like to be involved in developing our quality accounts for 2014/15 please get in touch with us.

Mark Davies (awaiting MD Sign off)
Chief Executive
Imperial College Healthcare NHS Trust

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//A guide to the structure of the report

The following report outlines the targets we have agreed for the coming year 2013/14. It also summarises our performance and improvements against the quality priorities and objectives we set ourselves for 2012/13.

We have reported against the priorities, including explanations where we have not met our targets and how we are addressing those issues.

We have worked with stakeholders and staff to establish our priorities for the year ahead and have detailed our new priorities under the headings: patient safety; clinical effectiveness and patient experience. We have explained how we decided upon our priorities and how we will achieve and measure performance against them.

Finally, we have provided other information to review that is relevant to the overall quality performance of the Trust. We have published statements from the local involvement networks (LINks), overview and scrutiny committees, commissioners and external audit, submitted in response to these quality accounts.

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//Part one - About the Trust

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust (the Trust) was formed in 2007 and comprises Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye hospitals. We are one of the largest trusts in the country and in partnership with Imperial College London, formed the UK's first academic health science centre (AHSC) in 2009.

We are committed to delivering world-leading clinical, acute hospital, and integrated care services and have developed a set of five values that define what we stand for as an organisation and what we expect from our staff. We will:

- **Respect** our patients and colleagues
- Encourage **innovation** in all that we do
- Provide the highest quality **care**
- Work together for the **achievement** of outstanding results
- Take **pride** in our success

As an AHSC we provide major advancements in patient care, clinical teaching and scientific invention and innovation. We offer a comprehensive range of high-quality acute care to the population of north-west London in our five main hospital sites as listed above. In addition we have a number of renal satellite units that provide invaluable care for people with renal disease living in the community. Information about each site can be found on the Trust's website www.imperial.nhs.uk.

In 2012/13 the majority of our services were commissioned on behalf of our local population by Ealing Primary Care Trust (PCT), Hammersmith and Fulham PCT, Kensington and Chelsea PCT, and Westminster PCT. We also provide highly specialist care that is not available in all acute hospitals, and these services are commissioned to provide patient care in other parts of London and in some cases nationally. From April 2013, the clinical commissioning groups (CCGs) and the NHS Executive will be commissioning our services.

During 2012/13, our clinical services were organised into six clinical programme groups (CPGs), with each containing a range of specialist services. As part of our commitment to driving the quality of services and ensuring we have consistency across the organisation, we are reviewing our current structures with a view to adopting a four-division model that builds on direct links with the academic structures at Imperial College London and the academic themes being developed via the AHSC. Please monitor our website for more information.

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What are quality accounts and why are they important?

Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they provide. The Trust is committed to continuously improving the quality of the services we provide to patients and the quality accounts are a report of:

- our priorities for the coming year 2013/14
- how well we performed against the targets we were set by the Department of Health, our local primary care trusts (PCTs) and those we set ourselves
- how well we performed against similar healthcare providers (where possible)
- where we need to focus to improve the quality of the services we provide

Quality for our patients

The Mid Staffordshire NHS Foundation Trust Public Inquiry has highlighted the importance of keeping our patients and the quality of care we provide at the heart of everything we do. We have considered the findings of the report and are committed to high quality patient focused care delivered by staff who are caring and compassionate. We have reflected these principles in these quality accounts.

This section provides a summary of our 2012/13 achievements which are outlined in more detail in part three of this report.

> Delivering the highest quality of care has remained the top priority and focus for the Trust board. Between April 2012 and March 2013 we have completed 205,396 inpatient episodes of care, accounting for 413,404 bed days; we have also provided for 811,444 outpatient attendances. In summary we had a total of 1,016,840 patient encounters last year (excluding A&E attendees).
>
> We had 280,017 patients attending our emergency departments.

We are committed to being one of the highest performing trusts in the country and have seen some significant achievements over the past year including:

- maintaining compliance with the 16 essential standards of care as assessed by the Care Quality Commission
- achieving NHS Litigation Authority (NHSLA) risk management standards as level three (the highest level of assurance) for our acute service; and level three for Clinical

Negligence Scheme for Trust (CNST) (the highest level of assurance) for our maternity services

- launched a new Patient and carer Experience Strategy
- improving patient safety by meeting patient assessment and treatment for venous thromboembolism (VTE) for over 90 per cent of our patients
- reducing incidents of healthcare associated infection such as Meticillin-resistant *Staphylococcus* aureus (MRSA) to nine in 2012/13 compared with 13 in 2011/12; and *Clostridium difficile (C.difficile*) from 142 in 2011/12 to 86 in 2012/13
- improvements in the staff survey regarding appraisals and training, with areas to focus on for the next year including reducing work related stress

How we monitor and report on quality

The quality accounts delivery group meets quarterly throughout the year to monitor progress on the indicators. A scorecard is produced quarterly so our CPGs can monitor their performance and establish which indicators require further work. The scorecard was reviewed by the quality and safety committee and reported to the governance committee and the Trust board.

Assurance and compliance

The Trust board is accountable for the systems of assurance, internal control and risk management and regularly monitors and reviews these at both Trust board level and via its committees. The chief executive is ultimately responsible for ensuring the Trust delivers a high quality service for all patients and for the delivery of and compliance with assurance, quality and performance targets.

This responsibility is delegated to the medical director and director of nursing for quality and governance, to the chief operating officer for operational performance and performance targets, and to the chief financial officer for financial targets.

Board engagement

The Trust board is actively engaged in reviewing the quality of our services. The chief executive and chairman take part in regular ward visits to meet staff and talk with patients. In addition, monthly leadership walkarounds assess the quality of our services and provide internal assurance that we are compliant with the essential standards of care. Throughout the year, teams consisting of executive directors, senior nurses, infection prevention and control, estates and facilities, maintenance, corporate services and operational managers visit all our sites to assess the environment and speak with staff and patients. Local and site action plans are developed and monitored as needed. Key themes and risks are reported through the quality and safety committee to the Trust board. Our 'back to the floor Friday' initiative provides senior nurses, including the director of nursing, with protected time to work clinically and lead local audits.

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The main initiatives of this are to:

- monitor standards of care
- support staff
- respond effectively to problems
- implement change effectively
- become powerful patient advocates

This has been an invaluable tool in driving the quality of care through senior nurse role modelling.

Trust board reports

The Trust board gains assurance on quality through a number of reports including:

- the monthly key performance indicators (dashboard) report
- quarterly quality and safety reports including the quality account indicators and regulatory assurance including compliance with external regulators
- patient experience/patient feedback
- board visits to wards
- patient complaints

Actions for 2013/14

- To remain focused on delivering a high quality of safe and compassionate care for our patients and their families
- To continue to make the Trust a great place to work and to attract a highly skilled workforce
- To submit an application for Foundation Trust status
- To embed a proactive risk and risk management strategy
- To review the organisational structure to strengthen leadership and governance arrangements
- To embed the non-executive directors quality walkarounds to ensure we learn and use their feedback and observations in a meaningful way

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//Directors' statement

The Trust's directors are required under the Health Act 2009 to prepare a quality accounts for each financial year. The Department of Health has issued guidance on the form and content of annual quality accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

The quality accounts have been prepared in accordance with Department of Health guidance and presents a balanced picture of the Trust's performance over the period covered. The performance information reported in the quality accounts is reliable and accurate.

The content of the quality accounts is consistent with internal and external sources of information including:

- feedback from the Central London Clinical Commissioning Group on behalf of Inner North West London Clinical Commissioning Group
- feedback from Healthwatch on behalf of Hammersmith & Fulham, Westminster and Kensington & Chelsea Local Involvement Network(LINks)
- feedback from local authority overview and scrutiny committees
- the national inpatient survey 2012
- the national staff survey 2012
- the head of internal audit's annual opinion April 2013
- CQC Registration 'without conditions' across all Trust sites
- CQC Quality and Risk Profile March 2013
- CQC inspection reports and improvement action plans
- NHSLA Risk Management Standards for Acute Trusts Level 3, Maternity Risk Management Standards Level 3
- external audit reports presented to the audit committee April 2012 to March 2013
- internal audit reports presented to the audit committee April 2012 to March 2013
- mortality rates provided by external agencies (Health & Social Care Information Centre & Dr Foster)
- the Trust's complaints report 2012/13 published under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (SI 2009 309)
- Trust board minutes and papers including, reports on patient safety and service quality, patient experience, performance presented to the Trust board April 2012 to March 2013, and made available to the public through the Trust's website

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There are proper internal controls over the collection and reporting of the measures of performance included in the quality accounts, and these controls are subject to review to confirm that they are working effectively in practice.

The data underpinning the measures of performance reported in the quality accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality accounts.

By order of the Trust board

.....Director signature

.....Director Job Title

.....Date

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//Part two - Priorities for quality improvement in 2013/14

How we decide on our priorities

Our priorities are developed in consultation with members of the public, shadow foundation trust members, Local Involvement Networks (LINks), local authority overview and scrutiny committees, PCTs, and clinical and management staff across each of the Trust's service delivery areas.

Based on feedback received during this engagement process, we have made some changes to our format and have agreed our priorities for 2013/14. The Trust board considered the proposals and agreed the priorities for 2013/14, which are set out in the section below.

Progress against these priorities will be measured and reported through the monthly quality and safety scorecard, based on the indicators from the quality accounts so our staff can be more involved in measuring their performance and help us track how well we are doing against our improvement targets. We will be review the scorecard at our monthly quality and safety committee, quarterly at the governance committee, and exception reports to the Trust board, with progress reports made available on our website.

We have made every attempt to write our quality accounts in a way that is accessible to patients, the public and our staff. If you are interested in being involved in the development of our quality accounts in the future please contact Stephanie Harrison-White via email Stephanie.harrison-white@imperial.nhs.uk or by telephone on 020 3312 3288.

Summary

The tables overleaf summarise our priorities and objectives for 2013/14 and how we will measure these. Please refer to the glossary for an explanation of all clinical terms.

All of the agreed priorities will be reported to and monitored by the quality accounts delivery group and reported to the quality and safety committee each quarter. A summary is included in the quality and safety quarterly report to the governance committee and Trust board.

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Priority quality indicators – 2013/14

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Category	Indicator	Rationale/aim	Proposed target measure
Patient safety	Venous thromboembolism (VTE) CQUIN	To be compliant with the VTE CQUIN	**VTE** - to meet the two new CQUIN indicators for 2013/14. These are: 1. Proportion of adult inpatients that have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool – target >95% 2. Number of root cause analysis on confirmed cases of pulmonary embolism or deep vein thrombosis (target 95% of incidents have a root cause analysis)
	To ensure high performance against the Safety Thermometer	To deliver 95% harm free care to our patients by reducing the number of falls, pressure ulcers and catheter related infections, as evidenced by the Safety Thermometer	**Falls** - to reduce low and minor harm falls (per 1,000 bed days) by 10% **Pressure ulcers** - to reduce the total number of grade 1 & 2 pressure ulcers by a further 10% per 1,000 bed days **Urinary catheter related infections -** to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts

Category	Indicator	Rationale/aim	Proposed target measure
	To reduce healthcare associated infections	To reduce the number of C. *difficile* infections	To achieve the Department of Health target of less than 65 cases in the Trust during 2013/14
		To reduce the number of hospital associated MRSA blood stream infections	The Trust's aim is to meet the national directive to have a zero tolerance for all healthcare associated MRSA Blood Stream infections (BSI's) across the NHS
	The use of anti-infectives	To be 90% compliant with the Trust policy for anti-infective prescribing	To be 90% compliant with the three aspects of the policy, those being: 1. A reason for starting the antibiotic clearly documented within the patients' medical notes/ drug chart 2. A stop/review date on the drug chart to optimise duration of therapy 3. Antibiotics are prescribed in line with the Trust antibiotic policy or approved by specialists from within our infection teams
	Patient safety incidents to support learning and improvement*	To create a culture of openness and learning	To be 10% above the national average for reporting patient safety incidents
	Patient safety incidents resulting in severe harm or death*	To promote patient safety	To be 10% below the national average for reporting patient safety incidents resulting in severe harm or death
	Dementia CQUIN	In England there are an estimated 670,000 people living with dementia and 550,000 friends and family acting as primary carers for	To be 90% compliant with this CQUIN

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Category	Indicator	Rationale/aim	Proposed target measure
		them. This is expected to double in the next 30 years. We want to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed.	
Clinical effectiveness	To remain better than the average for mortality rates as measured by Summary Hospital level Mortality Indicator (SHMI)*	Mortality is an important indicator to provide assurance to the public on the effectiveness of clinical care.	To be in the top ten trusts in the country for below the national average for mortality rates as measured by the Summary Hospital level Mortality Indicator (SHMI) - Publication of SHMI value and banding - Percentage of admitted patients whose treatment included palliative care - Percentage of admitted patients whose deaths were included in SHMI and treatment included palliative care (context indicator)
	To reduce the number of readmissions to hospital within 28 days of discharge	Emergency readmissions may be inconvenient and distressing for patients and could indicate a patient had been discharged too soon. We want to reduce the number of unnecessary readmissions	To remain below the national average for emergency readmissions to hospital within 28 days of discharge
	To increase patient satisfaction as measured by Patient Reported Outcome Score (PROMs)*	To increase our participation rates to above 80% for all PROMs* (groin hernia surgery; varicose vein surgery hip replacement surgery and knee replacement surgery)	All sites and all PROMs to be above 80% participation rate

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Category	Indicator	Rationale/aim	Proposed target measure
		with the aim of using this information to understand our patients' views	
Patient experience	To improve patient satisfaction with waiting times to be seen in outpatient clinics	To improve satisfaction with waiting times for patients in clinic (central outpatients)	To reduce the number of patients waiting over 30 minutes
	To improve responsiveness to inpatient needs*	Although this has improved slightly, we are performing about the same as other trusts and would aim to be one of the best performing trusts	To improve on last year's score and to be one of the best performing trusts
	To have caring and compassionate staff	Although this has improved slightly, we are performing about the same as other trusts and would aim to be one of the best performing trusts	To improve on last year's score and to be one of the best performing trusts.
	To remain above average for staff who would recommend the Trust to friends/family needing care*	Staff demonstrate that they care about their patients by showing kindness towards them	To monitor patient experience of care and compassion from nurses and midwives and to agree a target once baseline data has been collected
	Family and friends test – patient perspective*	We aim to provide the highest quality of healthcare. This indicator will tell us if we are getting it right. We will ask patients in adult inpatient and A&E departments: 'How likely are you to recommend our ward/A&E department to friends/family if they needed similar treatment or care?'	Initially to achieve the minimum Department of Health target of 15% response rate

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//Part three - Review of our services in 2012/13

This section provides details of our priorities for patient safety, clinical effectiveness and patient satisfaction and our results against the targets set. Data is generally produced quarterly and this will be represented in the tables below as Q1; Q2... We have added a RAG (RED-AMBER-GREEN) rating to the data we have provided to highlight if we have met our target or not; therefore the final column will be coloured.

Patient safety priorities

Venous thromboembolism (VTE)*

The Trust considers that this data is as described for the following reasons: we have continued to remain above our target of 90 per cent of all inpatients having been assessed for a VTE within 24 hours of admission and that patients receive the appropriate treatment as indicated by this assessment and have therefore met our target.

During 2012, we had a NHS Litigation Authority (NHSLA) level three assessment that included VTE risk assessment and procedures to be followed if a VTE was suspected. This included an assessment of live health records and we were found to be compliant with this standard. As a result of this assessment the Trust is updating its current guidance to bring it together into one document, which is based around the NICE guidance for VTE.

What is a VTE? Thrombosis is a blood clot within a blood vessel. It happens when a blood clot forms and blocks a vein or an artery, obstructing or stopping the flow of blood. A blood clot can occur anywhere in the body's bloodstream. There are two main types; venous thromboembolism (VTE) which is a blood clot that develops in a vein and arterial thrombosis which is a blood clot that develops in an artery.

VTE also formed part of the NHS Safety Thermometer in 2012/13 and the monthly spot check audits have shown high levels of harm free care.

VTE results 2012/13

Indicator	Q1	Q2	Q3	Q4	Target
Inpatients assessed for VTE	91.10%	91.11%	91.13%	91.83%	90%

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Action

The Imperial College Healthcare NHS Trust has taken action to continue to improve performance in this area and our VTE task force group continues their weekly audits of individual ward and CPG rates of VTE assessments. There has been focused activity to bring underperforming areas up to target, for example, maternity rates are now above 90 per cent. Reports are sent to CPG's, chiefs of service and the local VTE champions so they can be involved in monitoring and improving standards in their areas.

Because VTE is such a high risk to patients we will keep this indicator and report against it in 2013/14. As we have met this target and the national CQUIN target has been increased to 95 per cent for 2013/14, we will also increase our quality indicator measure for next year to reflect this.

To tackle this problem NICE have published Clinical Guideline 92: "Venous Embolism Reducing the Risk" and Clinical Guideline 144: "Venous Thromboembolic Diseases". The Department of Health framework "Commissioning for Quality and Innovations" links the uptake of risk assessment with payments.

To ensure high performance against the Safety Thermometer: reducing harm from pressure ulcers, falls and catheter related urinary infections

What is the safety thermometer? The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. The safety thermometer provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time. The safety thermometer records pressure ulcers, falls, catheters with urinary tract Infections and venous thromboembolisms (VTEs).

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Falls*

The Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: we have continued to remain below the national average rate of reported falls, that being 5.6 per 1,000 bed days. We have also met our target of having fewer than nine cases per year where falls have resulted in severe harm.

During 2012/13 we had a NHS Litigation Authority (NHSLA) level three assessment that included falls risk assessments being carried out and appropriate care plans being put in place to reduce the risk of falls. We were found to be compliant with this standard.

What are slips, trips and falls? Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year. A significant number of falls result in severe or moderate injury. Patients of all ages fall. Certain risk factors are more common in younger people (including trip hazards, faints, fits, acute illness, recovery from anaesthetic) but falls are most likely to occur in older patients, and they are much more likely to experience serious injury (NPSA 2007). The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions including delirium, cardiac, neurological or muscular-skeletal conditions, side effects from medication, or problems with balance,

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Falls results 2012/13

Indicator	Q1	Q2	Q3	Q4	Target
Remain below the national average of reported falls	3.98	3.65	3.54	3.75	Below 5.6 per 1000 bed days
To reduce the number of patient falls that result in severe harm	0	0	0	0	<9 cases

Action

The Imperial College Healthcare NHS Trust has taken the following actions to continue to improve this score and so the quality of its services by; using nursing forums to promote best

practice in falls treatment and management; monitoring falls by the number, type, severity of harm and location in order to learn from them and share this information with clinical teams. We review our compliance with our Falls care plan through our 'back to floor Friday' audit schedule and have achieved 90 percent compliance with this.

Pressure ulcers*

The College NHS

that this

the reasons: reduced of ulcers to agreed number year at or four.

the the ulcer with three and four indicating more damage (see glossary)

What is a pressure ulcer? Sometimes known as bedsores or pressure sores, are a type of injury that affect areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Healthy people do not get pressure ulcers because they are continuously adjusting their posture and position. However, people with health conditions that make it difficult for them to move their body often develop pressure ulcers. In addition, conditions that can affect the flow of blood through the body, such as diabetes, can make a person more vulnerable to pressure ulcers.

Imperial Healthcare Trust considers data is as described for following we have the number pressure less than our maximum of 22 per grade three This is an indication of severity of pressure

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Pressure ulcer results 2012/13

What is a urinary tract infection? A urinary tract infection, or UTI, is an infection that can happen anywhere along the urinary tract. Urinary tract infections have different names, depending on what part of the urinary tract is infected.

They are caused by bacteria entering the urethra and then the bladder which can lead to infection. People are at increased risk of urinary tract infections if they are diabetic; older; have a urinary catheter (a tube inserted into the urinary tract to drain the bladder); have kidney stones; are immobile or have had surgery.

Indicator	Q1	Q2	Q3	Q4	Target
To reduce the number of pressure ulcers graded 3 or 4 to an agreed target	3	4	7	4	< 22 per year

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve this rate, and so the quality of its services by ensuring that a thorough investigation of all pressure ulcers is undertaken using the pressure ulcer toolkit. Learning has been shared between the CPG's to support improvements in clinical practice. We audit our mattresses each year and replace those mattresses that no longer provide sufficient pressure relieving support. Last year we replaced 345 mattresses. We also use our risk assessment tool to identify those patients who require specialist mattresses and we order these in for patients in the wards and for those in critical care areas.

Urinary catheter related infections*

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons. We intended to start collecting data on urinary tract infections by

developing our systems to record this data. We did not intend to have reached a position whereby we could report against progress in reducing urinary catheter related infections. We did find that we had more people requiring urinary catheters than the national average reported. On average we had between 17-20 per cent of patients who required a urinary catheter as compared with the national average of 13-15 per cent. However, we were below average for the number of patients who developed a urinary tract infection. This means that although more of our patients required a urinary catheter, less of them acquired an infection. The higher number of urinary catheters may be a result of the specialist urology and critical care services we provide. This is something we will investigate further.

Action

The Imperial College Healthcare NHS Trust has taken the following actions to submit Safety Thermometer data related to urinary catheters and urinary tract infections. We intend to continue submitting this data over the next year and to compare ourselves against peer NHS organisations.

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Clostridium difficile* (C.difficile)

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: we have continued to reduce the total number of *Clostridium difficile* cases per year. We had 86 confirmed cases of *Clostridium difficile* in 2012/13 and therefore met our Department of Health target to be below 110 cases.

Over the last five years we have reduced the number of patients acquiring *C.difficile* and the 86 confirmed cases in 2012/13 is a further reduction from the 132 cases in 2011/12.

Over the past year, the Care Quality Commission (CQC) has reviewed our infection control practices in three of their planned inspections. They found the wards they inspected to be clean and that the Trust had the right systems in place to prevent and control the risk of infection.

What is *Clostridium difficile*? *Clostridium difficile* is an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow *C. difficile* to multiply and produce toxins that damage the gut. Symptoms of *C. difficile* infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel. Those treated with broad spectrum antibiotics, with serious underlying illnesses and the elderly are at greatest risk – over 80 per cent of *Clostridium difficile* infections reported are in people aged over 65 years. The bacteria can also be spread on the hands of healthcare staff and others who come into contact with patients who have the infection or with environmental surfaces contaminated with the bacteria or spores.

The inspection team found many examples of good practice in the care they observed our teams providing and did not require us to carry out any additional actions.

C.*difficile* results 2012/13

Indicator	Q1	Q2	Q3	Q4	Total	Number set by DH
To reduce the number of C.*difficile* cases as set by the Department of Health (DH)	23	20	23	20	**86**	**110 cases per year**

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve this rate and so the quality of its services.

In collaboration with our pharmacy department we continue to promote best practice in responsible effective prescribing and reviewed practice at clinical ward level to identify any areas for further training. In the autumn of 2012 we launched the 'Start Smart Then Focus' initiative. This is a national campaign to support effective management of patients requiring antibiotic treatment.

We are committed to continuing to reduce the number of cases of *C.difficile* infections by ensuring that when patients clinically require antibiotics they receive the correct type, for the most appropriate period of time to treat their infection and that these medications are reviewed and given according to the Trust antibiotic policy. The infection control team also work closely with the operations team and ward staff to ensure that patients with infectious diarrhoea are cared for in the correct care environment to minimise the spread of infection.

To reduce the risk of Meticillin-resistant *Staphylococcus aureus* (MRSA)

The Imperial College Healthcare NHS trust considers that the data is as described for the following reasons: we have continued to reduce the total number of MRSA cases per year. In 2012/13 there were eight cases of MRSA attributable to the Trust, which is below the target set by the Department of Health of nine. This shows that cases of MRSA at the Trust have fallen from 13 in 2011/12.

What is MRSA? Multiple Resistant *Staphylococcus aureus* is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure. If the bacteria enter the body illnesses which range from mild to life-threatening may then develop. Most strains are sensitive to the more commonly used antibiotics and infections can be effectively treated. MRSA was one of the original 'super bugs' and was first identified in the early 1960s. It is a variety of *Staphylococcus aureus* that has developed resistance to meticillin (a type of penicillin) and some other antibiotics that are used to treat infections.

MRSA results

Indicator	Q1	Q2	Q3	Q4	Total	Number set by DH
To reduce the number of MRSA cases as set by the Department of Health (DH)	1	1	2	4	8	9 cases per year

As noted above, over the past year the CQC has reviewed our infection control practices in three of their planned inspections. They found the wards they inspected to be clean and that the Trust had the right systems in place to prevent and control the risk of infection.

The inspection team found many examples of good practice in the care they observed our teams providing and did not require us to carry out any additional actions.

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve this rate and so the quality of its services, by continuing to deliver the actions from the infection prevention and control implementation plan and the delivery of a Trust-wide programme of aseptic non touch technique (ANTT) training and competency assessment. We deliver competency based training in how to insert intravenous devices in order to minimise infection. Standard packs for intravenous devices remain in place so that staff can easily access everything that is required to insert the devices in one go and minimise infection risks. We have also introduced competency based training in how to take blood culture samples from patients and how to reduce the risk of infection while doing this, while minimising any issues which could impact on the quality of testing from these samples. This enables us to make a correct diagnosis and provide the correct treatment.

The Trust's aim is to meet the national directive to have a zero tolerance for all healthcare associated MRSA BSI's across the NHS.

To ensure compliance with the Trust policy for anti-infectives

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: we looked at three parts of anti-infectives prescribing, including having a reason for starting the antibiotic clearly documented within their medical notes/ drug chart; a stop/review date on the drug chart to optimise the duration of therapy; and that anti-infectives were prescribed in line with the Trust's antibiotic policy or approved by a Trust infection specialist.
These three parts were chosen as they are considered to be the most important aspects of using anti-infective medications. The inappropriate use of such medications can increase the risk of infection or reduce their effectiveness in treating an infection.

What are anti–infective agents? Anti-infective agents include anti-bacterials, anti-fungals and anti-virals. These agents are often referred to collectively as antibiotics. They are extremely important and potentially life-saving therapies. However, if they are used inappropriately and excessively, drug resistant organisms can emerge, and patients are at an increased risk of developing a more resistant strain of an infection or *C. difficile*

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Results

We set our own 2012/13 target of 90 per cent compliance for each of the three areas. The Trust made significant progress with 91 per cent of our prescriptions having a documented reason for starting anti-infective medications; and 91 per cent for prescribing in line with the Trust antibiotic policy or having prescriptions reviewed by an infection specialist. Although the stop or review date target was not met, the 74 per cent achieved for 2012/13 was an increase from 38 per cent in 2011/12.

Average compliance with anti-infective policy - results 2012/13

Indicator	Audit 1	Audit 2	Target
To ensure we are compliant with the anti-infective policy	81%	89%	90% compliant with policy

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve our practices in prescribing anti-infectives. We have:

- launched the Department of Health 'Start Smart Then Focus' initiative which aims to encourage regular review of patients who are taking antibiotics
- reviewed various anti-infective policies
- updated our Trust antibiotic app for smart phones to facilitate access to our policies

Our anti-infective prescribing is monitored and reviewed at regular intervals by the Trust infection prevention and control committee, antibiotic review group and pharmacy department. These groups engage with clinical and managerial teams to promote best practice.

We are committed to making improvements in this important area and will continue to monitor this as part of the 2013/14 quality accounts in our priority to reduce healthcare acquired infections.

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Reporting of patient safety incidents

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: in the last quarter, we met our target to be above the peer average for patient safety reporting incidents and being below the national average for incidents graded as extreme and major, but our average over the year was just below our peer average of 6.9.

What are patient safety incidents?
A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care (National Patient Safety Agency). The most common types of incidents are accidents such as falls, incidents related to admission or discharge and medication errors. Patient safety incidents may vary from no harm to extreme harm. No or low harm are the most frequently occurring incidents.

Results

Quarter four of 2012/13 was the first quarter we were above our target average for patient safety reporting rates of 6.9 per 100 admissions and we must work to ensure that this trend continues. The major and extreme incidents are reported as a percentage of the overall incidents reported, therefore, it is hoped that these proportions would continue even if our overall reporting rates increased.

Patient safety incident reporting - results 2012/13

Indicator	Q1 1	Q2	Q3	Q4		Target
To remain above average for patient safety reporting rates	6.05	6.52	6.66	6.91	**6.5%**	**>6.9 per 100 admissions**
To remain below the peer average for incidents graded as extreme	0%	0.1%	0.2%	0.3%	**0.1%**	<0.1 % of average patient safety incidents reported for the Trust graded as extreme
To remain below the peer average for incidents graded as major	0.2%	0.1%	0%	0.2%	**0.1%**	< 0.5% of average patient safety incidents reported for the Trust graded as Major

Action

The Imperial College healthcare NHS Trust has taken the following actions to improve patient safety and the quality of our services:

- by meeting with the CPG quality & safety coordinators to facilitate improvement in reporting and to encourage feedback to all staff on key themes and trends
- ensuring all staff receive appropriate training in the use of the Datix system and are encouraged to report
- ensuring each ward has incident reporting and learning from incidents on the ward meeting agenda as well as their CPG quality & safety meeting agendas
- using incident reporting information to investigate links with failure to rescue
- linking incident trends and themes to service improvement

Case study: leadership walkaround

Improvements in patient care are being made by regular visits to assess the quality of our services.

Along with representatives from infection prevention and control, nursing, estates and maintenance, corporate services, and operational managers we have visited all areas of the Trust including our main sites and satellite units. We work together to review the quality of patient care, the hospital environment, and listen to patient and staff views on what it is like to be a patient in our hospital and what it is like to work here.

Teams review each other's wards and clinical areas to ensure we are meeting essential standards. We talk with patients to find out if they are comfortable, feel they are being treated with dignity and respect and if they are happy with the service we provide. We talk with staff to find out about their awareness of policies and how they feel about working at the Trust. We look at the environment and identify any areas for improvement.

Immediate verbal feedback is given to staff on the ward so that actions can be taken to make any necessary improvements and to thank staff when things have worked well. We also collate all actions from each visit to ensure we follow through to make progress. Our actions are monitored through follow up walkarounds.

Kathryn Jones, deputy director of nursing, said: "Being part of a leadership walk-around means that by working closely with colleagues and by reviewing areas together, issues can be picked up and resolved quickly.

"Taking time out to meet and talk to staff and patients and to be part of this programme helps to keep me focused on what matters most to the people in our hospitals."

Lesley Powls, head of nursing CPG 3, added, "They provide an invaluable opportunity for senior leaders to experience what our patients and staff experience, and to ensure as an organisation we can make sustainable change based on this."

Clinical effectiveness priorities

To remain better than the national average for mortality rates as measured by the Summary Hospital Level Mortality Indicator (SHMI)

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: The national average is calculated at 100 (with a range of 68-115) and the Trust is substantially below this at 75.8, indicating that we are in the top three trusts in the country, with a '*lower than expected*' SHMI during the period October 2011-September 2012 (last published data). The SHMI compares the number of patients who died at a trust, with the number that would have been expected to die, given the characteristics of the patients treated there. The categories used by the SHMI to describe the mortality ratios are: 'as expected', 'higher than expected' or 'lower than expected'.

What is SHMI? The SHMI is a national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge. This measurement takes into accounts factors that may be outside of a hospitals control, such as those patients receiving palliative care.

NHS trusts are required to examine, understand and explain their SHMI and to report against the following in their quality accounts:

- publication of the SHMI value and SHMI banding for the Trust
- the percentage of patients admitted to a hospital within the Trust whose treatment included palliative care treatment

One of the characteristics that are measured is the 'palliative care' indicator. This tells us the percentage of patients who died that were recorded as palliative care at diagnosis or speciality level. At our Trust, 33.7 percent of patients who died were recorded as being palliative care patients. This number reflects the specialities that we have at the Trust and is comparable to similar NHS Trusts.

Action

The Imperial College Healthcare NHS Trust has taken the following actions to continue to improve this rate and so the quality of its services, by continuing to focus on our failure to rescue to improve the recognition and escalation of the deteriorating patient. We have introduced the NEWS tool (that is the National Early Warning Score) and have set up a Task Force group to monitor, develop and support this work. We are committed to reducing our failure to rescue incidents and anticipate this will impact further on our mortality rates.

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Professor Nick Cheshire, medical director, said: "Using the SHMI data confirms what other less wide measures such as Hospital Standard Mortality Ratios have been telling us for a few years now – Imperial College Healthcare NHS Trust has one of the best mortality rates in England. The challenge is for us to deliver these excellent outcomes whilst ensuring we deliver a first rate experience for every patient and their families."

To reduce the number of emergency readmissions to hospital within 28 days of dicharge*

What are **emergency readmissions**? Emergency readmissions are unplanned readmissions that occur within 28 days after discharge from hospital. They may be inconvenient and distressing for patients. Sometimes it is not possible to prevent emergency readmissions as the patient's clinical needs may have changed or unforeseen circumstances may have occurred within the community.

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: we have reduced our number of emergency readmissions to hospital within 28 days of discharge in 2012/13. However, this trend has not been consistent throughout the year. When compared with our peer comparator group as presented by Dr Foster, we are slightly above the average readmission rate (peer comparator average = 6.53 per cent), although according to the statistical analysis this is not a significant difference. This has been further broken down to those aged 0-14 years, with an average readmission rate over the year of 4.42 per cent and for those aged greater than 15 years, it was 6.87 per cent.

This is a complex measure as it includes all emergency readmissions within 28 days of discharge and will include those that may be unrelated to the previous reason for admission. This can make the measure more difficult to interpret as it is not necessarily an indicator that the patient was discharged too early. However, this is a useful parameter as an indication of trend.

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Results

The number of emergency readmissions to hospital within 28 days of discharge – results 2012/13

Indicator	Q1	Q2	Q3	Q4	Target
To reduce the number of emergency readmissions to hospital within 28 days of discharge age 0-14 years	4.73	4.46	5.08	3.43	
To reduce the number of emergency readmissions to hospital within 28 days of discharge aged > 15 years	6.88	6.79	6.83	6.93	
To reduce the number of emergency readmissions to hospital within 28 days of discharge	6.68%	6.57%	6.71%	**6.59%**	National average not available but peer comparator reported as **6.53%**

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by having daily readmissions reports that are circulated to each CPG for their on-going monitoring and action. We have established a Medicine CPG Discharge Partnership Group to work with internal and external stakeholders to support effective discharge and reduce unplanned readmissions.

To increase the patient satisfaction as measured by Patient Related Outcome Scores (PROMS)*

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: we have met the participation rates of 80 per cent for three of the PROMs, these being hip, hernia and knee surgery. We have not met our target for vein surgery. The data is difficult to interpret due to the way in which it is calculated. The denominator, that is the number by which the total number of responses is divided by, is based on last years' data. The total number of responses is based on this years' data.

What are PROMs? PROMs measure quality from the patient perspective. They cover four clinical procedures - hip replacements, knee replacements, hernia and varicose veins. PROMs calculate the health gain after surgical treatment using surveys carried out before and after the operation. PROMs are measures of a patient's health status or health related quality of life at a single point in time. They provide an indication of the outcomes or quality of

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Therefore if last year there were 10 cases, the denominator would be 10. If this year there were 20 cases, this would mean there could be more responses and therefore the actual result may be greater than 100 per cent (see the example below):

10/10 x 100 = 100 per cent based on 10 responses for 10 cases.

20/10 x 100 = 200 per cent based on 20 responses (as different year and although real increase in the number of cases, the data is calculated on last year's number = 10 cases).

In relation to the varicose veins PROMs data, we did not have as many operations this year as last year which will (due to the way the denominator is calculated) and therefore this will reduce the percentage score. We also have a pilot study currently being conducted to look at new ways for patients to complete the questionnaires. This involves the questionnaires then being manually uploaded into the national database and we believe there is a time lag with this and therefore not all of the PROMs have been included in our national data. We will follow this up and anticipate we should see an increase in this data.

We have identified an area of poor compliance in relation to the groin hernia PROMs in the past quarter and are working with the relevant executive team to address this.

PROMS participation rates - results 2012/13

Indicator	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total	Target
To increase PROMS participation rate for hernia surgery	53.33%	140%	121%	**46%**	**90.08%**	Above 80%
To increase PROMS participation rate for hip surgery	111.00%	120%	151%	**91%**	**118.25%**	Above 80%
To increase PROMS participation rate for knee surgery	177.00%	246%	186%	**167%**	**195%**	Above 80%
To increase PROMS participation rate for vein surgery	54%	75%	64%	**33%**	**56.5%**	Above 80%

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve this percentage by raising the profile of PROMs completion across the Trust and working with the research team to ensure that all PROMs are uploaded onto the national reporting system. The Trust will also now focus on looking closely at the clinical data itself to identify any learning or areas for improvement. We are also working closely with the new PROMs provider to look at how the denominator score is calculated.

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Patient experience priorities

To reduce delays in outpatient clinics by the end of the year

The Imperial College NHS Trust considers that the data is as described for the following reasons: we have not been able to report against our target as the National Outpatient Survey was not undertaken in 2012/13. We have however continued to survey local views across our outpatients' clinics and review our results using the Trust's own I-track system, asking the question 'how long after the appointment time did the appointment time start?'.

It is anticipated that the National Outpatient Survey will be conducted in 2013/14 and we will report against this in our next quality accounts.

Action

The Imperial College Healthcare NHS Trust intends to take the following actions to improve on the score from the 2011 National Outpatient Survey and the quality of our services: to develop an action plan that includes improvements such as:

- looking at the capacity or numbers attending outpatients
- piloting new ways of delivering routine information to patients other than having to attend an outpatients appointment
- increasing our I-track response rates
-

These actions include using technology such as telecommunications and email to deliver routine results.

To improve the patient experience related to discharge

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: we have part met our target of 75 per cent compliance with each aspect of the discharge policy (see box below). Our average score was 75 per cent.

Discharge policy:

- anticipated date of discharge as early as possible in the patient pathway
- discharge plan in patient notes
- appropriate discharge plan followed
- patient and GP were given a copy of electronic discharge communication (EDC)

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Results

We carried out an audit of inpatient records in February 2013 and audited records of those patients who had been discharged at the time of the audit. We found that we were compliant with three of the five key aspects and not compliant with two (see table below).

We note that although we need to continue working to improve this compliance rate, we have made improvements since last year and are committed to continuing this. The table shows that we have improved from 44 per cent to 88 per cent in terms of each patient having an anticipated day of discharge (ADD) and although we need to continue to improve our documentation, we have seen a significant improvement from last year when 46 per cent of patients having a documented plan of discharge in their records to 65 per cent in 2013.

Patient experience related to discharge - results

The table below highlights the results from the 2012/13 audit. We have also included results where similar data has been collected in past audits. NR = not recorded.

Indicator	2011	2012	2013	Target
All patients have an ADD	66%	74%	88%	75%
Patients are informed of their ADD	NR	NR	57%	75%
A patient centred discharge plan is in the notes	46%	41%	65%	75%
An appropriate discharge pathway is followed	NR	NR	74%	75%
A copy of EDC to patient	NR	NR	79%	75%
A copy of EDC to GP	NR	NR	81%	75%

We have decided for 2013/14 that we will replace this indicator with caring and compassionate staff, as this was noted to be a major concern from the Mid Staffordshire NHS Foundation Trust Report. We will however continue to monitor this as part of our on-going audit programme.

Action

The Imperial College Healthcare NHS Trust has taken the following actions to improve its services and so the quality of its services, by sharing these findings with our CPG heads of nursing and require that each CPG develops action plans. These are reported to and monitored by the quality accounts delivery group.

There are examples of good practice in the Trust such as the discharge partnership group that has been set up in CPG1 and has expanded to include a wider membership with local external stakeholder engagement.

Staff involved in caring for patients with chronic obstructive pulmonary disease (COPD) have instigated a 72 hour post discharge phone call to patients to follow up on their discharge experience. The key benefits of this are outlined in the case study below.

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Case Study: 72 hour post discharge phone call for COPD patients

Staff telephone our COPD patients 72 hours after they have been discharged. They ask patients specific structured questions about how they feel, the treatment they are receiving, contact they have had with the community teams and how they feel the discharge process went. Below are some examples of feedback from patients and staff.

Patient feedback:

- 'I feel happier after being reassured'
- 'I felt cared for by the nurse calling me'
- 'I felt supported'
- 'It was good to know that somebody else was looking out for me without feeling I needed to call 999'

Staff feedback:

- 'I felt like I was making a difference'
- 'I felt good that I was able to identify vulnerable patients'
- 'Knowing I was able to be a part of readmission avoidance made me feel I was doing my job'
- 'It was nice to know although the patient was no longer in acute care, I could still be a part in their care'

To improve the responsiveness to inpatients needs*

The Imperial College Healthcare NHS Trust considers that the data is as described for the following reasons: we have our targets for this section. We have measured these indicators in two different ways. Three of the indicators were also measured using our I-Track system. This is a questionnaire the Trust has agreed to measure patient experience. A sample of our patients are also sent a survey from the DH to complete, referred to as the National Patient Survey. We have included both sets of data where possible.

Responsiveness to inpatients – results 2012/13

Indicator	Q1	Q2	Q3	Q4	Target
Were you involved in decisions about your care? (I-track results)	87.56	88.31	89.26	**88.48**	>87.13
Were you involved in decisions about your care? (from NIS**)			**7.0/10**		Range - 6.3-8.7
Did you find someone to talk to about your worries and fears? (I-Track results)	80.11	81.46	82.67	**81.67**	>80.30
Did you find someone to talk to about your worries and fears? (from NIS**)			**4.9/10**		Range - 4.2-7.8
Were you given enough privacy when discussing your condition or treatment? (I-Track results)	92.15	92.38	93.19	**92.78**	>91.86
Were you given enough privacy when discussing your condition or treatment? (from NIS**)			**9.5/10**		Range – 9.1-9.8
Did a member of staff tell you about the side effects of your medications before you went home (from NIS**)?			**5.2/10**		Range 3.4-7.5
Did hospital staff tell you who to contact if you were worried about your condition after you left hospital (from NIS**)?			**7.5/10**		Range – 6.6-9.5

** National Inpatient Survey

Action

The Imperial College Healthcare NHS Trust has taken the following actions to continue to improve these scores. We have been and continue to closely monitor our reporting and include these measures as part of the compliance monitoring of the Trust's patient & carer strategy. In addition, we intend to continue work around patient discharge, including information given to patients.

Patient quote from the kidney and renal transplant services:

"Every single person from the porters right up through to the consultant gave me tremendous confidence they knew exactly what they were doing. If there were any problems they would be able to deal with them and they were very, very kind and very thoughtful."

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To remain above the national average for staff who would recommend the Trust to friends/family needing care*

The Trust considers that the data is as described for the following reasons: we met our target to be above the national average for staff who would recommend the Trust as a place to work or to receive treatment.

Staff are asked to select from one of five options in their response to the above statements:

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

These are rated one (strongly disagree) to five (strongly agree), therefore an overall result of 3.0 would indicate the majority of staff neither agreed nor disagreed with the statements.

The figure is calculated from staff responses to the following statements:

- The care of patients and service users is my organisations top priority
- I would recommend my organisation as a place to work
- If a friend/relative needed treatment I would be happy with the standard of care provided by this organisation

Imperial College Healthcare NHS trust has seen an improvement of 0.02 as compared with the staff response for this indicator last year.

The 'family and friends' test in the National Staff Survey is question 12d. That is the percentage of staff who 'if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'. Imperial College Healthcare NHS Trust scored 69% per cent for this question as compared with the national average of 60%. This is comparable to last years' score of 70%.

Staff survey results – recommend as a place to work/receive treatment

Indicator	National average for all acute trusts	Imperial College Healthcare NHS Trust 2012
Recommend as place to work/receive treatment	3.57	3.7

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The Trust has seen an improvement of 0.02 as compared with the staff response for this indicator in 2011/12.

Action

The Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate and so the quality of its services, by sharing the findings with each CPG to ensure we have local ownership and engagement of staff. A detailed action plan will be developed and 'signed off' by the Trust Board in May 2013. We have already seen improvements in the quality and quantity of staff appraisals, but will continue to work on this in the next year.

Patient quote from the audiology services:

"I have been a patient of the audiology clinic for eight years and have always received the most efficient, courteous and prompt service that I could wish for. All the staff are kind and professional and very thorough."

Quality statements

Statements of assurance from the Trust board

During 2012/13 the Trust provided and/or sub-contracted 75 NHS services.

The Trust has reviewed all the data available on the quality of care in 75 of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents 73 per cent of the total income generated from the provision of NHS services by the Trust for 2012/13.

Review of data on quality of care

The Trust's performance against national priorities for 2012/13 is shown in appendix one.

Following identification of some issues with patient waiting times information reported during 2012/13 the Trust reviewed all its routine operational performance and activity reports and redesigned them where required, with significant input from operational managers to ensure accuracy and usability. The redesign and rebuild of the Trust's elective access suite of reports, was independently quality assured by external experts from the NHS Intensive Support Team (IST).

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Feedback from the IST was that they were particularly impressed with the comprehensive approach we had taken to testing our processes/reports and the standard of documentation of our technical processes is now amongst the best in the NHS. To mitigate data quality risks for reported referral to treatment pathways, the Trust has invested in additional pathway validation staff. The Trust has also invested in a new cancer information system to ensure that it is compliant with new national cancer reporting requirements.

The Trust's four year single equality and human rights scheme (2011-15) describes how we will improve the health and wellbeing of the local population through concentrated action on reducing health inequalities.

Participation in clinical audits

During 2012/13, the NHS services that the Trust provides were covered by **41** national clinical audits and **seven** national confidential enquiries.

During that period the Trust participated in **97.6** per cent national clinical audits and **100** per cent national confidential enquiries of the national clinical audits and national confidential enquiries that we were eligible to participate in. The remaining national audit which was not fully participated in (National Pain Database) has been addressed for immediate action and future participation.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2012/13 are listed in appendix two, along with details of those the Trust did take part in. Some audits listed in the Department of Health 'List of national clinical audits for inclusion in quality accounts 2012-13' were not active during the year.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2012/13, are listed in appendix two alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 13 national clinical audits were recorded as being reviewed by the provider in 2012/13. The Trust continues to follow up the reports from all relevant national audits to identify how we make improvements. The reports were as follows:

National clinical audit
Bronchiectasis
Carotid Interventions (CIA)
Coronary Angioplasty
Diabetes (Paediatric) (NPDA)
Heart Failure (HF)
Hip Fracture Database (NHFD)
Paediatric Asthma

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National clinical audit
Paediatric Intensive Care (PICANet)
Pulmonary Hypertension
Vascular Surgery (VSGBI Vascular Surgery Database) (NVD)
Care of Dying in Hospital (NCDAH)
CONFIDENTIAL ENQUIRY – NCEPOD Bariatric Surgery
CONFIDENTIAL ENQUIRY – NCEPOD Cardiac Arrest

Many of these audits demonstrated effective care, with no actions being required. Imperial College Healthcare NHS Trust intends to take the actions listed to improve the quality of healthcare provided.

National Clinical Audit	Description of actions
Hip Fracture Database (NHFD)	Weekly site meetings started to examine weekly performance data. Commencement of monthly reporting of mortality data.
Paediatric Asthma	Work to be undertaken to increase awareness in the Trust of the asthma discharge checklist and promote usage
Pulmonary Hypertension	Ensured future data collection and audit participation through fresh resource allocation.
Vascular Surgery (VSGBI Vascular Surgery Database) (NVD)	Minor coding training corrections enacted.
Care of Dying in Hospital (NCDAH)	Embedded use of Liverpool Care Pathway (LCP) at HH site. Training on LCP usage being enhanced at CXH.
CONFIDENTIAL ENQUIRY – NCEPOD Bariatric Surgery	All relevant recommendations of the published NCEPOD report have been implemented.
CONFIDENTIAL ENQUIRY – NCEPOD Cardiac Arrest	A programme of implementation of all applicable recommendations is being addressed through failure to rescue implementation.

The reports of 87 completed local clinical audits were reviewed by the provider in 2012/13 (out of 267 local clinical audits registered in 2012/13 or carried over from 2011/12) and the Trust records all recommendations which it intends to implement to improve the quality of healthcare provided. By the end of 2012/13, 54 of the 87 completed local clinical audits had subsequently recorded as implemented a total of 99 recommendations. It should be noted most of the planned implementation of recommendations for local clinical audits completed in 2012/13 will be on-going into 2013/14.

Local Clinical Audit	Implemented actions
Atrial fibrilation ablation (Re-audit)	Disseminated the results and information to colleagues in primary care as well as referring District General Hospitals.
	Internal feedback given to the Electrophysiology department.

Local Clinical Audit	Implemented actions
	Re-auditing undertaken following improvement in the design of audit tool.
Discharge from PICU/PHDU	Communicated to all PICU doctors that the discharge letter must accompany the patient on discharge.
	Crosschecks of drugs listed on discharge letter against the drug chart introduced.
	Launched a discharge information/expectation pack for reference.
	Standardised the essential ICIP printout required for internal patient discharges.
	Introduced use of double sided printing .
Failure to rescue (CPG1)	Re-audited all wards in CPG1.
Safeguarding children NSF	Amendments made to the inter-agency form .
	Copies of the previous Inter-agency form destroyed.
	Focussing on ethnicity and language when training.
	Training introduced on the use and completion of the Inter-agency form for both nurses and doctors in CPG5.
	Training introduced on the use of the Inter-agency form in the A&E department since the majority or referrals originate from there.
GP referrals to Paediatric Allergy OPD	Informed future 'choose and book' template and referral letter templates.
	Used information to underpin education within the integrated care pathway project.
Immunisation status documentation in Children's Ambulatory Unit at HH	Offered to administer any missing immunisations on ambulatory unit, including BCG and Mantoux.
Trust Documentation Audit 2011/12 - Re-audit	Opportunities for improving the quality of documentation enacted by senior healthcare professionals, via action planning.
	The importance of good documentation practice was emphasised to all clinicians.
	The results of this audit were raised at Clinical Risk Committee and the method assessed and discussed..
Operative vaginal delivery (October 2011)	Presented audits at the MDT audit meeting.
	Re-audited to ensure compliance was sustained.
Oxytocin use (October 2011)	Reminded and encouraged staff to document reason for delay from decision to start Oxytocin infusion via the CNST Rolling Action Plan.
	Reminded clinical staff to perform and document abdominal palpation prior to commencement of Oxytocin, via the CNST Rolling Action Plan.
Major obstetric haemorrhage	Maintained ongoing continuous audit of this criteria.

Local Clinical Audit	Implemented actions
(October 2011)	
Induction of labour (October 2011)	Presented audit findings at MDT meeting and re-audited.
VTE (October 2011)	Midwifery and obstetric staff have taken responsibility for completing the assessment form upon each admission, with special emphasis at booking and on antenatal admissions.
	Staff reminded of the need to improve on the compliance of performing VTE risk assessments for women at risk of VTE.
	The new VTE form is now filed in the same place in the notes and completed at booking.
HDU / Recovery / Severely Ill Patient (November 2011)	Fedback to the consultant meeting the need for frequent medical reviews of these women and all reviews to be documented in the notes as per guideline.
Unexpected term admission to SCBU (November 2011)	Communicated the outcome of the annual audit in the final audit report in all clinical areas.
	Ensured staff are communicated with about the outcome and learning points from SI investigations.
Perineal care (November 2011)	Reinforced with staff the requirement and relevance to document the criteria for this standard.
Vaccination status of local paediatric population	Encouraged documentation in notes as part of the training programme when new doctors and pharmacists start.
	Encouraged parents to bring in red books, especially in out-patient appointments or elective admissions.
	Recommended writing in notes if a red book is unavailable at the time of clerking or drug history taking and encouraging this to be followed up.
Fetal blood sampling (December 2011) Re-audit	Reminded staff to record intrapartum events that effect the FH on the CTG, such as FBS.
VBAC (December 2011)	Discussed with VBAC midwives the need to document method of monitoring as an individual plan.
	Introduced use of the standardised counseling proforma.
Pre-existing diabetes (December 2011) Re-Audit	Informed staff of the annual audit findings which demonstrate good standards of care.
Follow up of conservatively treated St IA1 Cervical Cancer	Continued with the current policy in treatment of cervical lesions.
Eclampsia (2011-12)	Communicated audit and recommendations to staff in the final audit report.
Declining blood products (2011-12)	Patient information group updated leaflets.
	Audit results discussed at the community midwives meeting.
	Ensured CERNER will have this option of recording patient information.

Local Clinical Audit	Implemented actions
	Included a reminder at the community midwives meeting the importance of documenting leaflets given to women.
Shoulder dystocia (2011-12)	Reminded staff to complete all aspects of the proforma in the notes.
Grade 1 LSCS (2011-12)	Changed categories of Caesarean Sections on CMiS.
Severe PET (2011-12)	Communicated audit and recommendations to staff in the final audit report.
Repatriation of stroke patients from London HASUs to SMH Stroke Unit (re-audit)	Pan-London transfer proforma Including all documentation has been suggested in pan-London guidelines, with particular emphasis on medical handovers as ameans of maintaining patient safety.
	Suggested changes to details of pan-London guidelines Bamford classification vs NIHSS Follow-up arrangements (responsibility of receiving hospital).
	Facilitated safe transfer using a pan-London contact list Including details of all HASUs and SUs, with phone numbers and bleep numbers updated regularly.
Drug allergy in childhood - penicillin (Audit and Survey)	High risk patients are now cohorted and have skin prick testing and specific IgE testing prior to a graded in hospital penicillin challenge.
	Patients with a history suggestive of a low risk of reacting to penicillins now have a graded penicillin challenge in hospital without prior testing.
	Presented to BSACI Annual meeting July 2012.
Pressure ulcer management in A&E Departments 2012/13	Audit results disseminated to service leads, Unplanned Board and QSPEC.
	Risk assessment information now included in staff handover.
	Service leads have sourced photographic equipment for A&E CXH.
	Staff have attended tissue viability rolling training programme, commencing 16th January 2013.
Management of diabetic ketoacidosis in CXH A&E	New departmental guidelines for the management of DKA created.
Gastric ulcer follow-up compliance	Clear definition of lesions agreed, including need for repeat endoscopy to be identified at time of procedure.
VTE assessment in stroke wards at CXH	Presented at MDT training session.
Symptomatic intracranial haemorrhage in patients treated with alteplase 2012/13	Continued prospective auditing of sICH as an adjuvant to the current monitoring systems of rt-PA use at Imperial Stroke Centre.
	Prospective data benchmarked against the previous 12 months as well as the SITS-MOST study incidence of sICH.
VTE risk assessment 2012/13	Ongoing weekly audits on all 3 sites have continued.

Local Clinical Audit	Implemented actions
Trust's quality account antibiotic indicators of correct use in paediatrics	Education to junior doctors at induction about the inclusion of stop/review date and indication on the drug chart at the pharmacy section of their induction begun.
	Reviewed the Paediatric Antibiotic Guideline to include more indications if appropriate.
	Presented the audit at the Paediatric Audit afternoon to the general Paediatric team.
	Presented the results to senior consultants.
Domestic violence: Maternity project	Developed and implemented social risk assessment tool for use at antenatal booking.
Colonoscopy and flexible sigmoidoscopy (2012-13)	Disseminated guidelines for endoscopic procedures to all defined referral pathways. Specific discussions conducted with the GI Surgical Unit as to defining the criteria for routine and urgent referrals.
	Further discussions conducted with the colorectal team regarding recommendations for urgent Vs elective procedures.
	Implemented a stricter policy in vetting surveillance colonoscopies.
Paediatric patient acuity audit – Grand Union Ward	Reviewed staffing levels on less demanding day shifts as a trial initiative.
Newborn infant physical examination standards	Consultant Radiologists informed re Hip Audit results for further action.
	Reinforced timing of baby check in Induction.
HTA GQ8: Risk assessments of practices and processes	SOPs without a risk assessment section are now reviewed.
The use of blood products on the neonatal unit 2012/13	Awareness given of Trust Transfusion Guideline to all new medical staff.
	Re-audited to look at monitoring during blood transfusions and compliance to trust guidelines – "Prospective Blood Transfusion Audit – use of blood products and monitoring".
Medical note keeping audit	Structured instruction section added to the operation sheet, which will allow great detail to be recorded and be used as part of the handover.
Interdepartmental patient transfer 2012/13	Imaging Lead Nurse took findings to Back to Floor Fridays and reminded ward staff that all sections of the Transfer form should be completed.
Does the parenteral nutrition (PN) practice within the Neonatal Units at QCCH and SMH meet local and national standards	Documentation of purpose of TPN encouraged amongst key staff members.
Medical record keeping on the Stroke Unit at CXH	Increased number of patient labels printed.
	Presented findings to MDT.

Local Clinical Audit	Implemented actions
	Reiterated importance of good medical record keeping.
Oncology patients case notes	Photocopy of Profile A placed in the Plastic wallet
Two week timeline from diagnosis to patients discussed in the Oncology MDT Meeting.	All details now included on the MDT sheets in order ensure accurate data collection for the Oncology databases.
	The patient list is now kept updated for future use and includes if there was a delay in diagnosis.
VTE in Orthopaedics 2012/13	Created local guidelines - VTE prophylaxis for inpatients, VTE prophylaxis on discharge.
	Reaudited, with a longer snapshot.
Fetal blood samples taken in labour	Reminded staff to record intrapartum events that effect the FH on the CTG, such as FBS.
Maternal obstetric haemorrhage	Maintaining ongoing continuous audit of this criteria.
Audit of Health Visitor referrals from A&E	The details relating to the missing forms are now communicated to the Liaison Health Visitor to enable further review and scanning to take place.
Outcomes in patients referred to Colposcopy with borderline changes in glandular cells	Wide variation of outcomes and sensitivity of diagnosis throughout London Units communicated.
CNST Audit Plan 2012/13	Trust achieved plan and Level 3.
Prolonged Jaundice Clinic - efficacy of early referral	Questionnaire given to health visitors and GPs in order to seek their opinion and recognise what they already know about prolonged jaundice clinic.
	Introduced use of the GP newsletter to promote prompt referral of babies to this service.
Audit trauma calls St Mary's MTC (re-audit)	A&E SHO now part of Trauma Team.
	Orthopaedic SHO continues to attend all trauma calls.

Participation in research and clinical trials

The number of patients receiving NHS services provided or sub-contracted by Imperial College Healthcare NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was25,677.

Participation in clinical research demonstrates Imperial College Healthcare NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

CQUIN framework & data quality (goals agreed with commissioners)

A proportion of the Trust's NHS income in 2012/13 was conditional on achieving quality and innovation goals agreed between Imperial College Healthcare NHS Trust and its main commissioners.

Further details of the agreed goals for 2013/14 can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131988 and details of last year's CQUINs can be found in the Trust board performance reports as part of the Trust board papers on our website: http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf

Comment [H1]: To be updated w/c 20/5

Care Quality Commission (CQC) registration status

The Trust is required to register with the CQC and its current registration status is 'registered without conditions' at the following sites:

Five main sites:

- Hammersmith Hospital
- St Mary's Hospital
- Charing Cross Hospital
- Queen Charlotte's & Chelsea Hospital
- Western Eye Hospital

Seven renal satellite units:

- Brent Renal Centre
- Ealing Renal Satellite Unit
- Hayes Renal Centre
- Northwick Park Renal Centre
- St Charles & Hammersmith Renal Centre
- Watford Renal Centre
- West Middlesex Renal Centre

The Trust is subject to periodic reviews by the CQC to confirm that we are delivering care in accordance with the essential standards of quality such as privacy and dignity, food and nutrition. During 2012/13 we have had four planned reviews at Western Eye, Queen Charlotte's & Chelsea, and Hammersmith hospitals, as well as St Charles & Hammersmith Renal Satellite units. The CQC's assessment of the Trust following these reviews was that we were meeting all the essential standards of quality and safety reviewed.

We have had a further responsive review at St Mary's Hospital in response to concerns arising from Never Events. We were found to be compliant with the essential standards of care that were reviewed during this review.

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The CQC carried out a follow up inspection as part of the national nutrition and dignity work at Charing Cross Hospital during 2012/13. We were found to be compliant with the essential standards reviewed.

The CQC has not taken enforcement action against the Trust during 2012/13.

During the planned review at Queen Charlotte's & Chelsea Hospital, the CQC included outcome 13: staffing, to ensure the Trust had implemented actions arising from a responsive review in 2011/12. The CQC confirmed that they were happy with our progress and were assured that we were compliant.

Statement on data quality

The Trust continues to improve its data quality and has introduced a robust governance structure for monitoring and improvement. Data quality indicators are reported to the Trust's management board and are also included within the Trust's monthly CPG performance scorecards to ensure data quality governance is aligned with the Trust's performance management framework.

An operational data quality group, which has representation from all service areas, looks in detail at a number of data quality indicators and monitors the progress of improvement. There are a total of over 200 data quality indicators in use across the Trust, which are available via a data quality dashboard tool 'Cymbio'.

Access to Cymbio is via the Trust's intranet site and is promoted regularly to staff through internal communications and training sessions. New data quality indicators continue to be developed in response to user requirements.

NHS number and general medical practice code validity

Note the data below is subject to change. Year end data is not available until mid-May.

The Trust submitted records during 2012/13 to the Secondary Users Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data to month eight of 2012/13 (latest available) that included the patient's valid NHS number was:

- 96.5 per cent for admitted patient care
- 97.9 per cent for outpatient care
- 76.6 per cent for accident and emergency care

The percentage of records in the published data which included the patient's valid general medical practice code was:

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- 100 per cent for admitted patient care
- 100 per cent for outpatient care
- 98 per cent for accident and emergency care

The Trust will be taking the following actions to improve data quality:

- Continue to implement the Trust's NHS Number Strategy, including a particular focus on NHS number compliance in A&E datasets
- Implement the new data quality strategy
- Increase the number of data quality indicators included in CPG performance score cards for review and performance management

Information governance toolkit scoring

The Trust information governance assessment report overall score for 2012/13 was 72 per cent and was graded 'satisfactory'.

This improvement from unsatisfactory last year, was largely due to the implementation of pseudonymisation, data flow mapping and the achievement of the 95 per cent target that all staff complete annual mandatory information governance training.

The improvement in performance of training was due to the development, implementation and delivery of new in-house on-line training that achieved a compliance rate of 98 per cent against the target of 95 per cent.

Clinical coding quality

The Trust was subject to the Payment by Results audit by the Audit Commission during 2012/13. The final audit report, including the error rate for clinical coding of diagnoses and treatment, is expected to be available in May 2013. The average error rate for diagnoses and procedures is 6.5 per cent based on findings in 2011/12 (the national average was 11 per cent).

Breakdown of diagnoses and procedures coded incorrectly:

- Primary procedures = 4.4 per cent
- Secondary procedures = 9.8 per cent
- Primary diagnoses = 4.0 per cent
- Secondary diagnoses = 7.8 per cent
- HRG error rate = 4.0 per cent

The highest level – attainment level three - was reached for clinical coding quality under the national information governance assessment report in 2012/13:

- Primary diagnosis coded correctly = 96.0 per cent

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- Secondary diagnosis coded correctly = 92.2 per cent
- Primary procedure correct = 95.6 per cent
- Secondary procedure correct = 90.2 per cent

//Current view of the Trust's position on quality

During 2012/13 we continued in our commitment to making quality central to all we do. We provided services that met Care Quality Commission (CQC) essential standards, reported and learnt from patient safety incidents, have reviewed the Mid Staffordshire NHS Foundation Trust public inquiry report and are working on producing an annual report that will promote openness, transparency and a duty of candour.

All of our inpatients have been cared for in single sex accommodation and we have maintained one of the lowest mortality rates in the country.

Working as an academic health science centre (AHSC) with our academic partner Imperial College London, we have harnessed clinical care, innovative practice, research and development. We have been successful in securing new developments to improve healthcare, the following are key examples:

Patient and public involvement

In July 2012 the Trust launched a patient & carer experience strategy. The strategy is comprised of three sections; our patient experience objectives; the patient experience charter; and plans for delivery and monitoring of the strategy. The strategy was developed in close collaboration with a group of key external stakeholders. The stakeholder group were asked to identify the most important factors that would lead to a good patient experience. These factors were then translated into nine common themes. These patient experience themes were then cross referred to the NICE framework for patient experience to ensure that there was a good correlation with agreed national best practice.

Since the launch of the strategy, much of the focus in the Trust has been to measure the compliance of the inpatient wards against the patient experience charter and the underpinning actions. The aim is to ensure that all wards achieve full levels of compliance with the charter and retain the levels going forward. We are currently working towards full compliance for all wards.

Friends and family test

The Trust also launched the national friends and family test (FFT). We currently include the FFT as a stand-alone survey for inpatient wards and accident and emergency departments. To support the implementation in A&E we have developed patient opinion zones at

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appropriate points on the patient exit routes from the departments. The purpose of the zones is to highlight the importance of obtaining feedback from patients and to report back our previous results. Measurement of the FFT scores began in March 2013. Going forward, this will be used as a key measure of patient experience with all wards expected to achieve a target level.

Involving patients in developing our services

A further area where we have developed significantly is involving patients both in their direct experiences of our services and helping the Trust in shaping and developing services. A good example of this type of approach has been the introduction of the Macmillan Values Based Standards across some of our cancer inpatient services. Through this initiative we have been working directly with patients to obtain their views about the services. The re-design approach also involves having similar discussions with staff and bringing both perspectives together to identify new methods and ways of working that will contribute to a better patient experience. We hope to further develop and expand this approach in 2013/14.

New Nursing & midwifery strategy 2013-16

To support staff we have also launched our new *Nursing & midwifery strategy 2013-16*

Nursing & midwifery strategy 2013-16

Objective one: Getting the basics right every time
Objective two: Helping staff to do the right job
Objective three: Valuing and developing our workforce
Objective four: Everyone's a leader

Trust clinician named as new clinical director for obesity and diabetes

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The Trust was delighted by the appointment of Dr Jonathan Valabhji, lead clinician for diabetes at the Trust, as national clinical director for obesity and diabetes at NHS England. He took up this post in April 2013. Dr Valabhji is one of 21 new national clinical directors announced by Sir Bruce Keogh, medical director of NHS England, at the NHS Innovation Expo on 13 March 2013. The national clinical directors are considered to be experts in their field and will report to NHS England's medical directorate, informing national policy and strategy for healthcare and providing in-depth information about care of the individual patient groups they cover.
During his time as lead clinician at the Trust, Jonathan has played a crucial role improving the way that we approach diabetes. In particular, he has played a key role ensuring that our clinicians are better linked up with partners in the wider community enabling us to treat more patients outside of hospital, at ground breaking clinics such as Westminster Diabetes Centre in Maida Vale.

Speaking after his appointment, Dr Valabhji said:
"As clinicians we spend most of our working lives trying to do our best for the person in front of us. The prospect of making a difference at a population level is a fantastic opportunity and a great privilege."

Commenting on Dr Valabhji's appointment, Mark Davies, chief executive of the Trust, said:
"I would like to take this opportunity to congratulate Jonathan on his appointment as national clinical director. This is a testament to the excellent work Jonathan has performed in the battle against diabetes, and the leadership he has shown both at this Trust and around the country."

Improvements to our cancer services

The Trust appointed a new deputy medical director and director of cancer, Dr Chris Harrison. Chris has a background in public health medicine and was previously medical director at The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe.

Chris joins our Trust-wide cancer leadership team working with staff to improve patient experience and performance.

Investing in our cancer teams – training opportunities

'**SAGE and THYME**' is a foundation level workshop, teaching a memorable and structured approach to talking with people who are worried and stressed.

This nine-step tool for health and social care professionals is an evidenced-based tool for health and social care workers and others involved in the most basic emotional support of distressed people. The structure enables staff to fulfil the most important objectives of emotional support: enabling patients to describe their concerns and emotions if they wish to do so, holding and respecting those emotions without suggesting solutions, identifying the patient's own ideas, solutions and support structures.

> "(Staff)…who have participated in the SAGE & THYME seminars, report increased confidence in their ability to assess and support distressed people with cancer and other serious illnesses." (Connolly, M et al 2009)

Macmillan Values Based Standard (VBS)

In 2009 Macmillan Cancer Support commissioned work to research and develop a standard for cancer care services, expressing human rights principles as specific behaviours. The standard has been developed through an 18 month engagement process with over 300 healthcare staff and people living with and affected by cancer across the country.

Our patient experience team held a Way Forward event which produced a series of actions, ranging from:

- improving ward layout, use of curtains etc.
- wider participation in multidisciplinary teams
- patient induction and potential 'buddy system'
- visual prompts and systems to encourage feedback
- more patient and family involvement in multidisciplinary team rounds

In April 2013 the team will roll out a pilot in Clinic 8 (outpatients, at Charing Cross Hospital) and will add a specific tumour site (outpatients) in June 2013.

Improvements to our maternity services

The maternity service at Queen Charlotte's & Chelsea Hospital has recently opened a new purpose built two-bedded high dependency unit (HDU). This unit will provide support for women requiring level 1 and level 2 care and will be led by the HDU midwife specialist.

In addition, the Trust received £370,000 in government funding in January 2013 to upgrade maternity facilities for our patients at Queen Charlotte's & Chelsea and St Mary's hospitals.

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Training facilities have also been improved. The maternity unit now has a new training room complete with hi-tech equipment including an interactive manikin. The simulator allows obstetric emergencies to be managed on the manikin in the clinical setting. Unannounced emergency training drills are performed in the clinical setting ensuring staff skills are refreshed and rehearsed on a regular basis.

The director of midwifery, Jacqueline Dunkley-Bent, has focused on the ongoing developments and improvements of the maternity services in close partnership with the maternity services liaison committee and support from the local communities and stakeholders. Their collaborative work has been very much appreciated over the past year.

Improving medical education

In October 2012 the Trust was awarded the prestigious Elisabeth Paice Award for Educational Excellence. The award was for the best faulty development programme, Training Tomorrow's Trainers Today (T4). This was a joint initiative with Central and North West London NHS Foundation Trust and was delivered across 10 acute trusts in north-west London.

The T4 programme offers trainers the opportunity to develop their teaching skills and present to colleagues so they are well equipped to teach the clinicians of the future.

In 2011 the Trust won the bid to become the lead provider training in nine key specialties and as from August 2012, the Trust has been the lead provider in north-west London for training in cardiology, respiratory medicine, diabetes and endocrinology, geriatric medicine, gastroenterology, renal medicine, clinical radiology, obstetrics and gynaecology, and trauma and orthopaedics.

Stroke services

The Trust's hyper-acute stroke unit at Charing Cross Hospital was ranked as the best amongst 150 stroke units in the country according to the Royal College of Physicians' quarterly Stroke Improvement National Audit Programme (SINAP) in November 2012.

Dr Arindam Kar, hyper-acute stroke unit lead at the Trust said:

"Most of our patients are returning home with less disability than ever before and our stroke thrombolysis rates and mortality rates are amongst the best in the country. With the introduction of newer cutting edge technologies, we expect to be able to provide even more improvements to the quality of care that our patients receive."

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Research

It has been another year of success and achievement for research at the Trust. Our research strategy is driven in close collaboration with Imperial College London through our AHSC partnership.

Following the largest single award for biomedical research in the country, we have completed the first full year of work in the new National Institute for Health Research (NIHR) Imperial Biomedical Research Centre (BRC). More than 600 individual research projects were active during 2012/13, and more than 250 new experimental medicine studies were approved. Our NIHR-supported clinical research studies recruited 10,000 patients in 2012, and a further 37,000 volunteers participated in the Cohort Study on Mobile Communications (COSMOS) which aims to identify if there are any health issues linked to long-term mobile phone use.

Imperial Clinical Phenotyping Centre

One of the key BRC-funded initiatives is the Imperial Clinical Phenotyping Centre. The new centre based at St Mary's Hospital and directed by Professor Jeremy Nicholson, brings together a unique collection of state-of-the-art technologies that analyse the chemical make-up of a tissue or body fluid sample to provide rapid diagnostic information. The profile of chemicals present in a sample provides a read-out of the patient's disease classification and severity. This information can inform doctors how the disease will progress in an individual patient or how the patient is responding to a particular therapy.

MRC-NIHR Phenome Centre

In 2012, Professors Jeremy Nicholson and Paul Elliott, in collaboration with colleagues at King's College London and major instrument suppliers, received a £10million award from the Medical Research Council (MRC) and NIHR to establish the MRC NIHR Phenome Centre. Closely linked to the work of the BRC and the Imperial Clinical Phenotyping Centre, the MRC NIHR Phenome Centre will provide researchers from across the UK with the analytical technology they need to study the links between a person's metabolism, their environment, and the diseases they develop. In the long-term this will lead to better diagnostic tests and tailor-made drugs for individual patients.

The centre is a partnership between industry, research funders and our researchers. In addition to the grant, there are significant contributions of staff, equipment, and technical support from the Waters Corporation and Bruker Biospin GmbH. Both companies will work

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with the centre to develop the technology and establish a major training centre.

NIHR Patient Safety Translational Research Centre

NIHR Patient Safety Translational Research Centres drive improvements in patient safety and in the safety of NHS services. The centres are partnerships between universities and NHS trusts and pull relevant advances in basic research into a more applied setting.

Following an open competition, the NIHR funded two Patient Safety Translational Research Centres for five years, beginning in August 2012. One of these was awarded to the Trust, and is worth £7.2m over five years. It is led by Professor Charles Vincent (director) and Professor Lord Ara Darzi (clinical lead). The centre will carry out research to advance and refine new ways of improving safety in hospitals, GP surgeries and in the community, which will translate into real benefits for patients including the reduction of prescription errors, improving diagnosis of cancer and rare diseases, and reducing accidents during surgery.

Public showcase of research

On 1 November 2012, the NIHR Imperial BRC opened its doors to patients, healthcare professionals, students and members of the local community, providing an opportunity to explore the variety and breadth of translational research being undertaken in the BRC.

Visitors had the chance to partake in hands-on displays that included liver monitoring, DNA extractions, neurological visual tasks, handling a biopsy gun and the operation of a robotic system used in surgical procedures. The event was also attended by our partners from the Royal Brompton and Harefield NHS Foundation Trust Cardiovascular and Respiratory Biomedical Research Units, and colleagues at the North West London Collaboration for Leadership in Applied Health Research and Care (CLAHRC).

Attendees were invited to tour the purpose-built NIHR/Wellcome Trust Imperial Clinical Research Facility and witness at first-hand the instrumentation and techniques employed there. A lively forum also took place including panellists representing Imperial College London, the Trust and the NIHR, which considered how to increase the opportunities for patient involvement in research and the research process.

Rare diseases and the NIHR BioResource

The Trust is playing an active role with other Biomedical Research Centres and Units in the establishment of the NIHR BioResource, a national initiative which will provide considerable new capacity for the carrying out of new clinical research studies. The BioResource will contain biological samples and associated clinical information from thousands of patients and healthy volunteers. It will initially focus on exploring the genetic causes of rare diseases, with a view to diagnosing these conditions at an earlier stage and then tailoring treatment for patients.

In 2012/13 the Trust also received £1.4m of NIHR funding to develop systems and processes to support the sharing of electronic patient data. This will benefit research and widen participation in clinical studies by making it easier to identify patients with common conditions and characteristics.

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Statement from Stakeholders

Feedback on our quality accounts

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Appendix one:

Acute Trust Performance Framework 2012/13

Performance Indicator	Threshold	2012/13 Performance	Period of measurement
Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	95%	97%	Full year
MRSA	9	8	Full year
C. diff	110	86	Full year
RTT - admitted - 90% in 18weeks	90%	91%	Mar-13
RTT - non-admitted - 95% in 18 weeks	95%	97%	Mar-13
RTT incomplete 92% in 18 weeks	92%	95%	Mar-13
RTT - delivery in all specialities	0	8	Mar-13
Diagnostic test waiting times	<1%	0.12%	Mar-13
All cancer two week wait	93%	95%	Feb-13
Two week GP referral to first outpatient - breast symptoms	93%	95%	Feb-13
31 day standard for subsequent cancer treatment - surgery	94%	95%	Feb-13
31 day second or subsequent treatment - drug	98%	99%	Feb-13
Percentage of patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	96%	Feb-13
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	94%	97%	Feb-13
62-day wait for first treatment following referral from an NHS cancer screening service	90%	91%	Feb-13
All cancer two month urgent referral to treatment wait	85%	72%	Feb-13
Delayed transfers of care	3.5%	1.42	Q4 2012/13
Mixed sex accommodation breaches	0%	0%	Full year

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VTE risk assessment	90%	91%	Full year

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Appendix two:

Participation in clinical audits

The following table covers:

- The **active** national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible for and participated in during 2012/13.
- **Where data collection was completed during 2012/13**, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100 / 687 – continuous dataset
Adult Asthma	Yes	Yes	100 / 52
Adult Cardiac Surgery (ACS)	Yes	Yes	Continuous dataset
Adult Community Acquired Pneumonia	Yes	Yes	Data submission ongoing till 31.05.13
Adult Critical Care (ICNARC CMP)	Yes	Yes	Continuous dataset
Bowel Cancer (NBOCAP)	Yes	Yes	Data submission ongoing till 01.10.13
Bronchiectasis	Yes	Yes	100/97
Cardiac Arrest (NCAA)	Yes	Yes	Continuous dataset
Cardiac Arrhythmia (HRM)	Yes	Yes	Continuous dataset
Carotid Interventions (CIA)	Yes	Yes	89 / 74
Comparative Audit of Blood Transfusion (Blood Sampling & Labelling)	Yes	Yes	100 / 486
Congenital Heart Disease (Paediatric Cardiac Surgery) (CHD)	Yes	Yes	100 / 34
Coronary Angioplasty	Yes	Yes	100 / 1556
Diabetes (Adult) (ANDA)	Yes	Yes	100 / 168
Diabetes (Paediatric) (NPDA)	Yes	Yes	100 / 81
Emergency Use of Oxygen	Yes	Yes	100 / 56
Fever in Children	Yes	Yes	100 / 50
Fractured Neck of Femur	Yes	Yes	100 / 33
Head and Neck Oncology (DAHNO)	Yes	Yes	Data submission ongoing till 22.11.13
Heart Failure (HF)	Yes	Yes	Continuous dataset
Hip Fracture Database (NHFD)	Yes	Yes	100 / 650
Inflammatory Bowel Disease (IBD)	Yes	Yes	Data submission ongoing

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Lung Cancer (NLCA)	Yes	Yes	Data submission ongoing till 30.06.13
National Joint Registry (NJR)	Yes	Yes	Continuous dataset
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100 / 703 (awaiting submission, needs Caldicott Guardian approval)
Non-invasive Ventilation	Yes	Yes	Data submission ongoing till 31.05.13
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	Data submission ongoing till 01.10.13
Paediatric Asthma	Yes	Yes	100 / 20
Paediatric Intensive Care (PICANet)	Yes	Yes	100 / 357
Paediatric Pneumonia	Yes	Yes	100 / 46
Pain Database	Yes	No	0 / Not known
Parkinson's Disease	Yes	Yes	Participated in 2011/12, hence no data submitted in 2012/13 as recommended by Parkinson's UK
Potential Donor	Yes	Yes	Continuous dataset
Pulmonary Hypertension	Yes	Yes	100 / 1162
Renal Colic	Yes	Yes	100 / 50
Renal Registry (UKRR)	Yes	Yes	100 / 2862 prevalent 100 / 317 incident
Renal Transplantation (NHSBT UK Transplant Registry)	Yes	Yes	100 / 167
Stroke National Audit Programme (combined Sentinel and SINAP) (SSNAP)	Yes	Yes	100 / 439
Trauma (TARN)	Yes	Yes	100 / 608
Vascular Surgery (VSGBI Vascular Surgery Database) (NVD)	Yes	Yes	100 / 69
National Audit of Dementia (NAD)	Yes	Yes	100 / 120
CONFIDENTIAL ENQUIRY – Asthma Deaths (NRAD)	Yes	Yes	100 / 4
CONFIDENTIAL ENQUIRY – Child Health (CHR-UK)	Yes	Yes	Continuous dataset
CONFIDENTIAL ENQUIRY – Maternal Infant and Perinatal	Yes	Yes	100 / 2
CONFIDENTIAL ENQUIRY – NCEPOD Alcohol Related Liver	Yes	Yes	100 / 7

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Disease			
CONFIDENTIAL ENQUIRY – NCEPOD Sub-arachnoid Haemorrhage	**Yes**	**Yes**	**100 / 16**
CONFIDENTIAL ENQUIRY – Elective Surgery (National PROMs Programme)	**Yes**	**Yes**	**Continuous dataset**

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Glossary

Anti-infectives – drugs that are capable of acting against infection.

Aseptic Non-Touch Technique (ANTT) – how staff perform a number of clinical procedures, this involves correct hand washing, wearing of gloves and aprons at appropriate time to maintain sterility of key parts to prevent infections by not touching them.

Clinical Programme Group (CPG) – is the name given to the way we divide our services, as they are divided according to different specialities.

Clostridium difficile **-** is an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow *C. difficile* to multiply and produce toxins that damage the gut. Symptoms of *C. difficile* infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel.

Clot – a soft thick lump or mass.

Dementia – dementia is a syndrome (a group of related symptoms) that is associated with an ongoing decline of the brain and its abilities. It is used to describe a collection of symptoms including memory loss, problems with reasoning and communication skills, and a reduction in a person's abilities and skills in carrying out daily living activities. Dementia affects the whole life of a person who has it as well as their family.

Duty of candour – full disclosure, not to withhold information.

Emergency readmissions - unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

Failure to rescue – failed to prevent a clinically important deterioration.

Falls – unintentionally coming to rest on the ground floor/lower level, includes fainting, epileptic fits and collapse or slip.

Meticillin-resistant *Staphylococcus aureus* (MRSA) - is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease, and is resistant to methicillin (a type of penicillin).

Patient safety incidents - is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. (National Patient Safety Agency).

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Pressure ulcer – sometimes known as bedsores or pressure sores, are a type of injury that affect areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

Grade One – Discolouration of intact skin not affected by light finger pressure

Grade Two – Partial thickness skin loss or damage

Grade Three - Full thickness skin loss involving damage of subcutaneous tissue

Grade Four – Full thickness skin loss with extensive destruction and necrosis (dead tissue)

Patient reported outcome measures (PROMS) – tools we use to measure the quality of the service we provide for specific surgical procedures. They involve patients completing two questionnaires at two different time points, to see if the procedure has made a difference to their health.

Safety thermometer - is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. It provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time. The safety thermometer records pressure ulcers, falls, catheters with urinary tract Infections and venous thromboembolisms (VTEs).

Standardised hospital mortality indicator (SHMI) – is a new national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge. This measurement takes into accounts factors that may be outside of a hospitals control, such as those patients receiving palliative care.

Stakeholder - a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

Urethra - a tube that connects the bladder to the outside of the body.

Urinary tract infection (UTI) - an infection that can happen anywhere along the urinary tract. Urinary tract infections have different names, depending on what part of the urinary tract is infected. They are caused by bacteria entering the urethra and then the bladder which can lead to infection.

Venous thromboembolism (VTE) - a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood. A blood clot can occur anywhere in the body's bloodstream. There are two main types; venous thromboembolism (VTE) which is a blood clot that develops in a vein; and arterial thrombosis which is a blood clot that develops in an artery.

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Vein- blood vessel that carries blood towards the heart.

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APPENDIX D

Director of Nursing Report: Clinical Risk Assessment of Cost Improvement Programmes

1. Introduction

The following document outlines the clinical risk assessment process in relation to implementing Cost Improvement Programmes (CIP) within the Trust. The purpose of the document is to:

- Detail the processes required to develop, approve and review CIPs and Quality Impact Assessments.
- Formalise the process by which CIPs and associated QIAs are signed off by the Divisional Medical Director and Divisional Nursing Diretcor.
- Define roles, responsibilities and governance processes in relation to CIPs.

This document must be read in conjunction with the following:

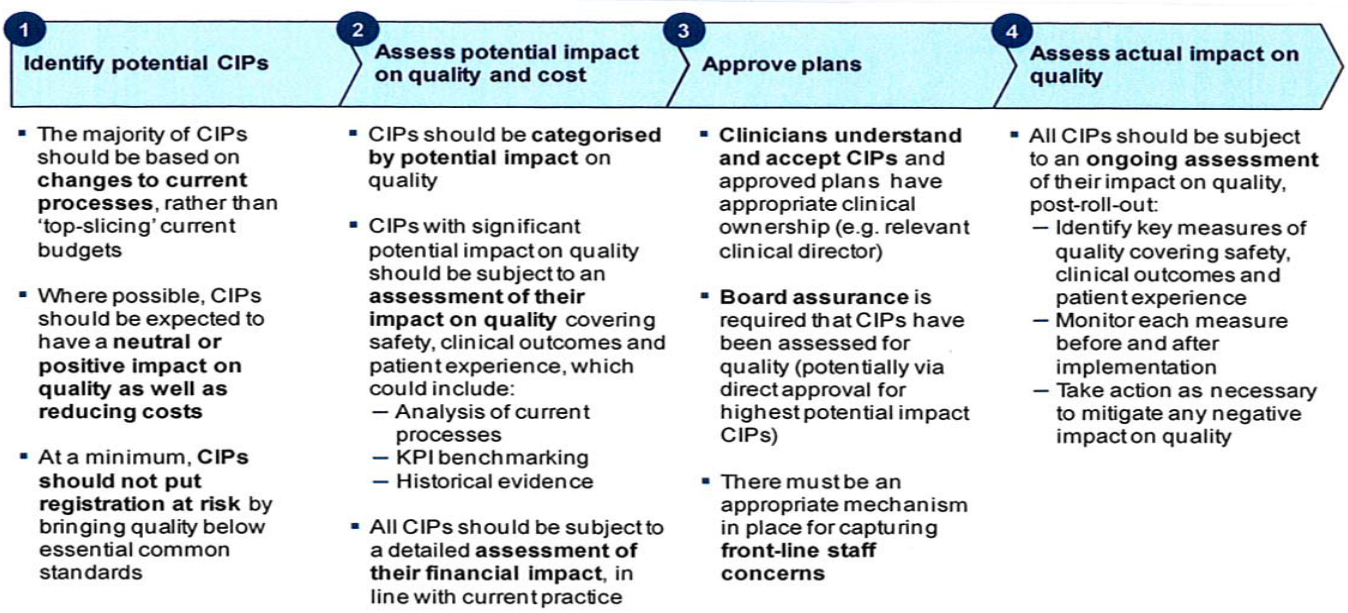
- Risk Management Strategy including Risk Management Processes 2012-13 (ICHT, August 2012);
- Cost Improvement Programme Management Arrangements Terms of Reference (ICHT, July 2012

2. Background

Following the original report into Mid Staffordshire NHS Foundation Trust (2010), there has been an increased focus on the impact of Cost Improvement Programmes (CIPs) on quality.

In February 2010, Monitor described a best practice approach for quality assurance (patient safety, clinical effectiveness and patient experience) through a CIP process, Figure 1 below outlines this.

Figure 1: Monitor best practice approach



In June 2012, the National Quality Board published a 'How to Quality Impact Assess Provider Cost Improvement Plans' guide which set out how it expects Trusts to manage the impact of service improvement on quality. It

advocates ‘a systematic exploration of quantitative and qualitative intelligence and encourages the orderly triangulation of information to help assess the quality impact of CIPs.’ The document introduces the concept of clinically led ‘star chambers’ convened at director level, to formally assess and assure quality in relation to CIPs.

The National Commissioning Board (now known as NHS England) also provided guidance in 2012 with regards to risk assessment and quality assurance for CIPs. In March 2013, Clinical Commissioning Groups (CCG) were requested to develop a process to assure themselves that provider’s CIPs are deliverable and will not adversely impact on the quality and safety of patient care.

3. CIP Database

A database will capture all of the Trust’s CIP schemes outlining progress against delivery as well as a clinical risk RAG rating determining impact on patient safety, clinical outcomes and experience. This database is currently under development by the Finance team and will be implemented over the coming month. Up until this time, CPGs/Divisions should hold clinical risk assessments of CIPs locally.

4. Roles and Responsibilities.

4.1. Divisional and Corporate Teams
(*E.g. General Manager, Business Manager, Deputies and Corporate Leads)*

- All CIP schemes need to be clinically risk assessed.
- Once a CIP scheme is identified, the lead Manager should complete a Quality Impact Assessment (QIA) for each CIP scheme using the template in Appendix 1. This will assess the proposed scheme’s potential impact on patient safety, clinical outcomes and patient experience.
- No amber or red rated scheme following risk mitigation should be implemented
- Monitor the safe and effective delivery of all Directorate CIP schemes, ensuring that any risks are identified and mitigated, escalating to the Divisional/Corporate Director as needed.
- Ensure that no clinical scheme progresses without the approval and sign-off by the multi-professional team, to include; Sister/Charge Nurse, Ward/Department Consultants and other Allied Health Professionals as appropriate.
- Ensure that frontline staff know how/who to report concerns relating to the negative impact (or potential of this) on patient safety, clinical outcomes and patient experience, of a scheme.
- Give consideration to wider discussions with patient/stakeholder interest groups as required.

4.1.1. Divisional and Corporate Directors

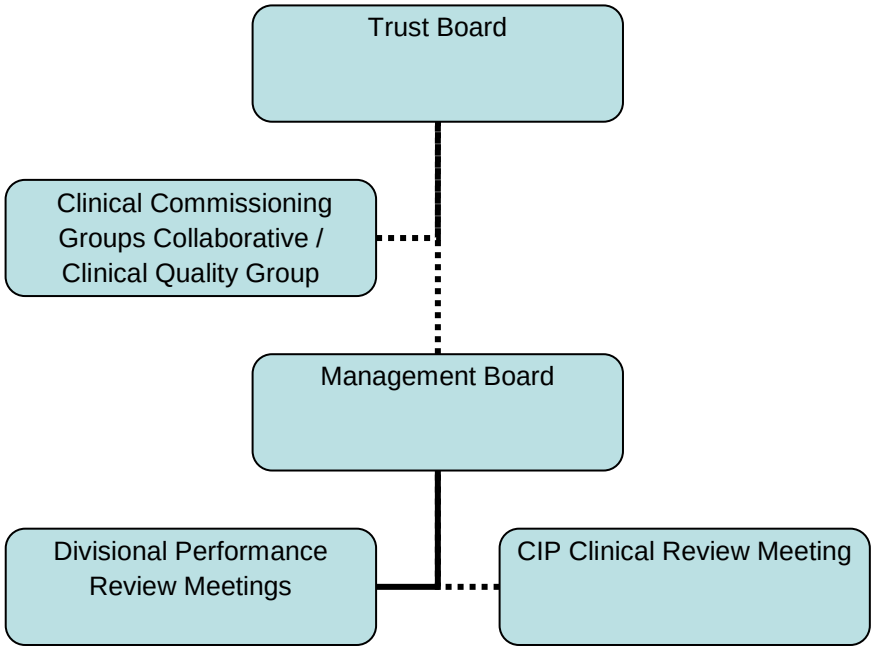
- The Divisional Medical Director and Divisional Nursing Director should sign off all CIP schemes to be implemented.
- Corporate Directors should sign off all schemes relevant to their area.
- Where a scheme spans divisions, these should be approved by each of the relevant Divisional Directors.
- Ensure no CIP scheme is progressed that could have a negative impact on patient safety, clinical outcomes and patient experience.
- Review all CIP schemes and QIAs monthly (as a minimum), reviewing compliance against Key Performance Indicators (KPIs). Please refer to Appendix 2 for further information on KPIs.
- Revise a scheme if negative impact on patient safety, clinical outcomes and patient experience is identified once a scheme is in place.
- To be responsible for ensuring that the clinical risk assessment of their division’s/area’s schemes are entered onto the CIP data base
- To provide a monthly summary report of CIP schemes and associated clinical risk assessments to the

performance review meetings.

5. Reporting Arrangements

The diagram below sets out the proposed reporting arrangements.

Figure 2: Proposed reporting structure



5.1. Divisional Performance reviews (monthly)

CIP clinical risk assessment will be discussed as a standing item at monthly Divisional Performance reviews as part of the overall CIP review. The focus will be on exceptions (i.e. those schemes which present a clinical quality risk/impact on patient safety, clinical outcomes and patient experience). Divisional leads will submit a monthly RAG rated summary report to the performance review meetings.

5.2. CIP Clinical Review Meeting (quarterly)

The purpose of this meeting is to review all clinical risk and quality impact assessments relating to CIP schemes where the risk has been graded as amber or red. The members will provide scrutiny and challenge to the scheme and ensure that the impact on quality has been robustly considered and mitigating actions have been put in place. This meeting will consist of the Medical Director/Deputy, Director of Nursing and the relevant Divisional Director.

5.3. Management Board (monthly)

The Management Board will receive a combined CIP report outlining risks in relation to implementation as well as clinical quality.

5.4. Trust Board

The Trust Board will receive a summary about the impact on quality of current CIP schemes as part of a Trust-wide CIP report.

5.5. *Clinical Commissioning Groups Collaborative (CCGC) and the Clinical Quality Group (*CQG)

The Trust will share the CIP Trust-wide report presented to our Board, with the CCGC and CQG once they are in the public domain. This will provides these groups (largely made up of Commissioner colleagues) with assurance about how the Trust is considering and managing any impact on patient safety, clinical outcome and patient experience, of our CIP schemes.

6. Summary

In line with Monitor's guidance, CIP schemes should have a **neutral or positive** impact on the quality of care provided to patients, which is why there must be a robust process to provide assurance that quality is appropriately assessed before a scheme is implemented and is reviewed on an ongoing basis.

This process will need to be reviewed in the context of the Trust's new Risk Management Strategy and the review of Trust committee structure,

Appendix 1 – Quality Impact Assessment Template

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Cost Improvement Programme - Quality Impact Assessment		**Scheme Number:**
		Scheme QIA

Please complete all fields:							
Scheme Name							
Scheme Overview							
Project Lead					**Division**		
Clinician Completing QIA							
Quality Indicator(s)							
	*** Type your free text Quality Indicator here **						
KPI Assurance - Sources & Reporting to Monitor Quality Indicator(s)							
	*** Type your free text KPI Assurance, Source & Reporting details here - this refers to the free text Quality Indicator **						

	Details	**Consequence**	**Likelihood**	**Score**
Patient Safety				
Clinical Effectiveness				

Patient Experience	**Details**	**Consequence**	**Likelihood**	**Score**

Mitigation	**Details**

Risk Scoring							
Consequence		Overall Risk Score					
Likelihood							
Signed – Divisional Medical Director					Date		
Signed - Divisional Nursing Director					Date		

Comments: Divisional Medical Director/Director of Nursing	**Date**	**Comments**

Appendix 2 - Principles and procedure for undertaking a Quality Impact Assessment on a Cost Improvement Programme

The key aims of the CIP / QIA processes are to:

- Provide robust assurance to the Trust Board that work is being undertaken to deliver the key financial sustainability targets, within a context that does not compromise delivery of clinical quality and care;
- Provide a means of holding those accountable for safe and effective delivery of CIP to account;
- Manage the delivery of sustainable financial balance through the Cost Improvement Programme;
- Provide a robust but fair challenge to the planning and performance of the programme ensuring that all projects have clear objectives, performance indicators, key milestones, savings targets (including phasing), timescales and accountability;
- Provide summary reports that highlight areas of concern and resultant contingency plans that have been implemented to mitigate the risks associated with the delivery of planned savings.

The Trust's position for undertaking risk assessment is outlines in the Risk Management Strategy. With regards to the risk assessment of CIPs and associated QIAs, This includes an outline of the programme in detail and the associated assessment of the likely quality impact and financial impact, in line with Monitor's recommendations (see **section 1.2**).

Possible Quality Assurance/Key Performance Indicators

Indicators for a QIA will include:

- Patient safety (e.g. infection rates, medication errors, falls, pressure ulcers etc.);
- Clinical effectiveness (e.g. readmission rates, mortality etc.);
- Patient experience (e.g. iTrack, complaints etc.).

- Evidence that staff and patients have been involved in CIPs and QIAs.

- Where there is a proposed change to staffing establishments and/or skill mix, evidence that proposed changes will not adversely affect quality indicators.

- Have we identified the key risks to the quality of services?

- Have these been scored appropriately (according to Trust risk matrix methodology)?

- Has sufficient mitigation to these risks been identified?

- Have satisfactory Key Performance Indicators (KPIs) to measure the above risks to the quality domains been identified?

- Have baselines for the KPIs been established?

- Can the baselines be cross-referenced or triangulated with other information streams?

- Does the QIA demonstrate how evidence based practice and/or nationally recognised standards have informed the development of the CIP?

- Does the QIA demonstrate how the CIP will help reduce variation in outcomes of care provision?

- Does the QIA demonstrate how the CIP will help eliminate waste and inefficiency?

- Does the QIA identify how the CIP will improve patient choice?

- Does the QIA identify how the CIP will impact on the compassionate and personalised care agenda (including Privacy & Dignity)?

- Has it been identified how these KPIs will be monitored and reported internally and externally?

- Has the possible impact on staff been identified? *(e.g. reduction in numbers, impact on staff in associated services, use of agency or bank.)*

- Has mitigation to reduce any staff impact been identified?

- How has the organisation's ability to deliver the CIP been assessed?

- Has the capacity of the workforce to deliver any changes been demonstrated?

- Is the organisation's assessment of its ability to deliver realistic?

- Has the scale of the CIP been identified in terms of cash value and a % of turnover (this will help indicate the level of challenge of the CIP)?

- Have cross-boundary or service issues been identified and mitigated (including those relating to social care and independent sector provision)?

Appendix 3 - References

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Monitor (2010) Amendments to Applying for NHS Foundation Trust status: Guide for applicants London: Monitor.

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Imperial College Healthcare NHS
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Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments

Author/s:	Sally Heywood, Associate Director of Nursing for Patient Safety and Quality William Gage, Lead Nurse for Practice Development and Innovation
Contact Details:	sally.heywood@imperial.nhs.uk william.gage@imperial.nhs.uk
Date written:	8th February 2013
Approved by:	Nursing and Midwifery Professional Practice Committee, Clinical Risk Committee, Quality and Safety Committee
Date Approved:	March/April 2012
Ratified by:	Management Board
Date Ratified:	
Date Policy becomes Live :	Upon ratification
Next due for revision:	2014
Target Audience:	All Trust staff
Location of Policy:	Trust intranet
Related Policies:	Risk Management Strategy including Risk management Process Risk Assessment Policy and Procedure Incident Reporting Policy and Procedure Concerns and Complaints Policy Serious Incident Policy and Procedure Raising Concerns Policy and Procedure (Whistleblowing) Roster Policy Process for the Development and Management of Procedural Documents Policy Women's and Children's CPG Maternity Risk Management Strategy Policy Setting out the Process for Establishing Safe Staffing Levels within the Maternity Service at Imperial College Healthcare NHS Trust Pressure Surge Plan Supportive Observation: of 'at risk patients' policy Vacancy Control Group (VCG) General Information Flexible Working policy and procedure

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	See also professional guidance (cited in References)

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Document Version Numbering

Version No.	Updated by	Updated On	Description of Changes
V 0.1	W Gage/ S Heywood	-	First draft
V 0.2	W Gage/ S Heywood	11.02.2013	Second draft – minor revisions
V 0.3, 0.4	W Gage/ S Heywood	13.02.2013 and 25.02.2013	Third and forth drafts – revisions following comments from Janice Sigsworth
V 0.5, 0.6	W Gage/ S Heywood	15.03.2013	Fifth draft – revisions following comments received from members of the Nursing and Midwifery Professional Practice Committee and inclusion of section 4.5 and Appendix 4
V.07. V07.1, V07.2	W Gage/ S Heywood	27.03.2013	Sixth draft following feedback from HoNs and Gerry Bolger
V0.8, V0.8.1, 0.8.2. 0.8.3	W Gage/ S Heywood	08.05.2013	Following feedback from Quality and Safety, Priya Rathod (Interim Head of Quality Governance) and to incorporate reference to Trust Pressure Surge plan and Haemato-oncology guidance

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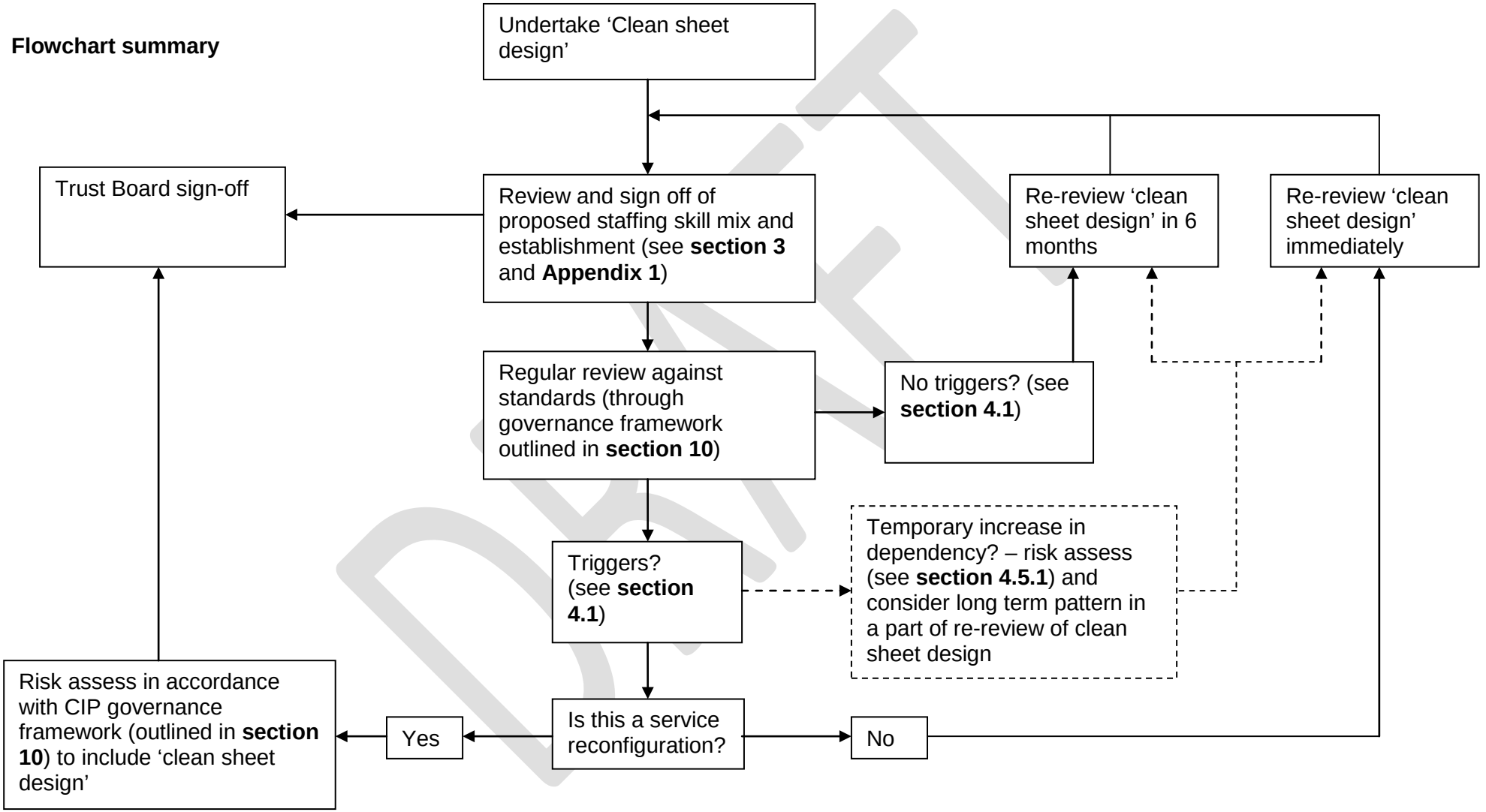
Imperial College Healthcare NHS Trust

Flowchart summary



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Imperial College Healthcare NHS Trust

1 Introduction

Safe levels of staffing and an adequate skill mix are central to the delivery of high quality care (Francis, 2013). Patients have a right to be cared for by appropriately qualified and experienced staff in safe environments, and this is enshrined in the NHS Constitution (Royal College of Nursing (RCN), 2010). Trusts must ensure that they have the right staff, with the right skills, in the right place (NHS Commissioning Board and the Department of Health (DH), 2012). This is a duty of the Board and the Trust must demonstrate safe staffing in order to comply with Care Quality Commission's (CQC) regulatory framework and standards. Furthermore, the Nursing and Midwifery Council (NMC) (2008) makes it clear that all Registered Nurses and Midwives are professionally accountable for safe practice in their sphere of responsibility, ensuring that risk is managed appropriately.

In 2011, Imperial College Healthcare NHS Trust (ICHT) agreed a position paper outlining the methodology for assuring safe nurse staffing and skill mix in in-patient areas (adapted from University College London NHS Foundation Trust's Skill Mix Methodology, 2010).

This position paper has been reviewed and fully revised and is now presented as a Trust Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishment.

2 Purpose

The purpose of this policy is to:

- Outline the principles and methodology that Imperial College Healthcare NHS Trust uses to inform agreed nurse staffing and skill mix establishment
- Outline the roles and responsibilities of individuals within the organisation to ensure safe nurse staffing and skill mix establishment
- Outline the process by which safe nurse staffing and skill mix establishment is ensured and assured within the organisation, including the on-going assessment of risk associated with actual or potential shortfalls in nurse staffing and/ or skill mix.

2.1 Exclusions

The roles, responsibilities and process for ensuring safe staffing and skill mix establishment in maternity services are outlined in the Women's and Children's CPG Maternity Risk Management Strategy and the Trust Policy Setting out the Process for Establishing Safe Staffing Levels within the Maternity Service at Imperial College Healthcare NHS Trust. However, establishment and skill mix in midwifery and maternity services will also be subject to the governance framework outlined in **section 10**.

3 Duties

3.1 Duties within the Organisation

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This policy recognises the tripartite management structure of the organisation, with the principle that responsibility for particular clinical areas is progressive (from wards to directorates to divisions) and is shared at corresponding tier of management. Additionally, professional accountability is held by individuals registered with professional bodies and this policy recognises that professional accountability gives nursing directors the ultimate authority to veto any decision with regards to nurse staffing and skill mix establishment that they deem to be unsafe.

Where one of the individuals named below is absent from a particular tier of management (for example, a directorate without a lead nurse) those responsibilities remain with the other named individuals at that level in the organisation, or in their absence with the management tier immediately above.

3.1.1 Trust Board

- The Board has a collective corporate responsibility for risk. It is able to delegate day-to-day requirements of risk management to designated individuals
- The Board sign off and publish evidence based staffing levels at least every six months (NHS Commissioning Board and the Department of Health (DH), 2012), monitor key performance indicators (KPIs) and link to quality of care and patient experience; discussing this in public Board meetings
- The Board has overall accountability for the delivery of Trust Cost Improvement Programmes (CIPs), to include ensuring that they are adequately risk assessed and that any risks identified are adequately mitigated.

3.1.2 Medical Director

- To hold responsibility, with the Director of Nursing, for ensuring CIPs are adequately risk assessed and that any risks identified are adequately mitigated, in accordance with the agreed process (see **section 4.5**)

3.1.3 Director of Nursing

- Ensuring that the organisation has an agreed position with regards to safe nurse staffing and skill mix establishment which takes into account professional and evidence based practice standards
- Final sign-off of safe nurse staffing and skill mix establishment, evidenced using the template (**Appendix 1**) and to conduct regular establishment reviews (see **section 10**) to ensure that safe staffing and skill mix are being delivered operationally
- To hold responsibility, with the Medical Director, for ensuring CIPs are adequately risk assessed and that any risks identified are adequately mitigated, in accordance with the agreed process (see **section 4.5**)

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- To receive staffing 'self assessments' from Divisional Directors of Nursing on a six monthly basis (see **section 10.2**)
- To take evidence based staffing levels to the Board for sign-off at least every six months (NHS Commissioning Board and the Department of Health (DH), 2012)
- To ensure that any proposed changes to the nurse staffing and skill mix establishment, required to deliver service redesign projects, are also discussed at Board level

3.1.4 Divisional Director of Medicine and Divisional Director of Operations

- To hold responsibility, with the Divisional Director of Nursing, for the delivery of safe nurse staffing and skill mix establishment in their division; signing-off the agreed template (**Appendix 1**) at the Divisional Management Board
- To hold responsibility, with the Divisional Director of Nursing, for managing day-to-day and potential risk in relation to nurse staffing and skill mix levels establishment in accordance with Trust policy; including adequate risk assessment of service change/ reconfiguration

3.1.5 Divisional Director of Nursing

- To undertake a nurse staffing and skill mix establishment review in accordance with **section 4.1**
- To sign-off and be professionally accountable for safe staffing and skill mix in their division, evidenced using the template (**Appendix 1**) and to ensure that these are tabled for sign-off at the Divisional Management Board
- To hold responsibility, with the Divisional Director of Medicine and Divisional Director of Operations, for the delivery of safe staffing and skill mix in their in their division.
- As accountable professionals, Divisional Directors of Nursing have the ultimate authority with regards any decision relating to nurse staffing and skill mix establishment that they deem to be unsafe
- To agree and sign-off the opening of escalation beds (see **section 4.6**)
- To hold responsibility, with the Divisional Director of medicine and Divisional Director of Operations, for managing actual and potential risk in relation to staffing and skill mix in accordance with Trust policy; including adequate risk assessment of service change/ reconfiguration and that any risks identified are adequately mitigated.
- To effectively manage adverse incidents relating to nurse staffing and skill mix establishment within their division, ensuring that there are adequate systems and processes in place to mitigate risk (see **section 10**)

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- Ensure staffing 'self assessment' is submitted to the Director of Nursing on a six monthly basis (see **section 10.2**)

3.1.6 Lead Nurses, General Managers and Chiefs of Service

- To sign-off and to be accountable for safe staffing and skill mix in the clinical area(s) that they are responsible for, evidenced using the template (**Appendix 1**)
- To hold responsibility for the delivery of safe staffing and skill mix in the clinical area(s) that they are responsible for
- To have responsibility for managing day-to-day and potential risk in relation to nurse staffing and skill mix establishment in accordance with Trust policy, escalating to the Divisional Head of Nursing, Divisional Director of Medicine and Divisional Director of Operations in the first instance
- To have responsibility for investigating adverse incident relating to nurse staffing and still mix establishment and to assist in the collation of evidence submitted as part of the staffing 'self assessment' (see **section 10.2**)

3.1.7 Sister or Charge-Nurse

- To sign-off and be professionally accountable for safe nurse staffing and skill mix establishment in the clinical area they are responsible for, evidenced using the template (**Appendix 1**)
- To hold operational responsibility with Lead Nurses, General Managers and Chiefs of Service for the delivery of safe nurse staffing and skill mix establishment in the clinical area that they are responsible for
- To have responsibility for managing day-to-day actual and potential risk in their ward or department relation to nurse staffing and skill mix establishment in accordance with Trust policy, escalating to the Lead Nurse in the first instance

3.1.8 All staff

- To report concerns regarding inadequate staffing and/ or skill mix establishment in accordance with Trust Raising Concerns Policy and Procedure (Whistleblowing)
- Take responsibility for working with colleagues to deploy staff effectively

3.2 Consultation and Communication with Stakeholders

Nursing and Midwifery Professional Practice Committee, Clinical Risk Committee, Quality and Safety Committee and Management Board

3.3 Approval of Procedural Documents

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Nursing and Midwifery Professional Practice Committee, Clinical Risk Committee, Quality and Safety Committee and Management Board

4 Policy detail

4.1 When should staffing levels and skill mix be reviewed?

- As a minimum a staffing and skill mix ratio will be undertaken six-monthly for each clinical area

  OR a review should be undertaken when there is;

- A significant change in the service e.g. change of speciality
- A planned significant change in the dependency profile or acuity of patients
- A change in profile and number of beds
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover
- If quality indicators (e.g. Infection Prevention and Control, Hospital Standardised Mortality (HSMR), Summary Hospital Level Mortality Indicator (SHMI), Service Improvement Index/ Harm Free Care report (see **section 5**), the Trust's quality and safety scorecard) demonstrate failure to safeguard quality. This review must be presented to the Divisional Management Board by the Divisional Director of Nursing.
- A Serious Incident (SI) where staffing was identified as a contributing factor
- If concerns are raised about staffing levels by patients or staff, the Divisional Head of Nursing will review and decide if a review is required. The results of any review must be presented to the Divisional Management Board by the Divisional Head of Nursing.

4.2 Nurse staffing and skill mix review process

The Trust's agreed review process is 'clean sheet design', which is underpinned by the Association of UK University Hospitals UK (AUKUH) adult acuity dependence tool (2009) (**Appendix 2**), now referred to as the Safer Nursing Care Tool (SNCT).

The recommended staffing ratio/multiplier in 'clean sheet design' is applied for dependency and this enables staffing requirements to be calculated for each area. This in turn gives a nurse per bed ratio each area (**Appendix 3**). This includes on-costs at 22% (benchmarked Ernst &Young in 2011) and the current position is summarised below (this may be subject to amendment as the tool evolves nationally):

Level 0	0.79 nurse per bed
Level 1a	1.70 nurse per bed
Level 1b	1.86 nurse per bed

Level 2	2.44 nurse per bed
Level 3	6.51 nurse per bed

4.3 Key principles

The following principles must guide any agreed nurse staffing and skill mix:

- The ratio of registered to unregistered nursing staffing will not fall below 65%:35% (RCN, 2010; RCN, 2012)
- The sister or charge nurse should be visible (in uniform) and available to patients, relatives and carers and operate in a supervisory capacity, which should be reflected in the 'clean sheet design'. They should not be expected to double up, except in emergencies as part of the nursing provision on the ward (Francis, 2013). The sister of charge nurse should work Monday to Friday (for further guidance, refer to the Trust Flexible Working policy and procedure)
- The sister or charge nurse's managerial duties should be one session per week
- When deputising for the sister or charge nurse the shift leader should also operate in a supervisory capacity
- Changes to nurse staffing and skill mix establishment must be risk assessed, in accordance with Trust policy
- A full list of agreed establishments will be maintained in the Nursing Directorate.
- Finalised staffing establishment will be updated on e-rostering system

4.4 Specialist areas

The following areas have specific nurse staffing and skill mix requirements. Individual divisions are required to agree establishments for specialist areas based on professional guidance, which is outlined here:

Specialist area	**Professional guidance (see 'References' (section 11) for complete citation)**
Paediatrics	• RCN (2003)
Paediatric Intensive Care	• Paediatric Intensive Care Society (PICS) (2001 and 2010) (SCAMPS, a validated paediatric acuity/dependency tool is tool is being developed in Scotland and should be launched later this year)
Neonates	• British Association of Perinatal Nursing (2010) and DH (2009)
Adult Intensive Care Unit	• British Association of Critical Care Nurses (BACCN) (2010)

Theatres	• In-house model agreed with the Turnaround Director
Day Surgery	• British Association of Day Surgery (BADS) (2003)
Accident & Emergency	There are no current agreed nationally recommended guidelines for minimum staffing levels
Catheter Laboratory	• British Cardiovascular Society (2007) Non-medical catheter laboratory staffing working group report
Endoscopy	• Royal College of Physicians Joint Advisory Group on gastrointestinal endoscopy (2007)
Radiology	• The Royal College of Radiologists and the RCN (2006)
Chemotherapy	• Benchmarked against peer organisations
Haemato- oncology	• British Committee for Standards in Haematology (BCSH); Haemato-Oncology Task Force (2009); FACT-JACIE (The Joint Accreditation Committee-ISCT (Europe) & EBMT) (2011); National Cancer Peer Review Programme (2012)
Renal Dialysis	• National Renal Workforce Planning Group (2002)
Adult Bone Marrow Transplant	There are no current agreed nationally recommended guidelines for minimum staffing levels for stem cell transplant/haematology wards. However, there are general agreed principles outlined in the quality measures of regulatory bodies and peer review processes that apply to nurse staffing levels in specialist haemato-oncology centres

New posts are authorised within the divisions by the Divisional Director of Medicine, Divisional Director of Operations or Executive Director and are authorised on behalf of the Trust via the Vacancy Control Group (for further details refer to the Vacancy Control Group (VCG) General Information).

4.5 Increased acuity/ dependency

4.5.1 'Specialling'

In some instances, the admission of a highly dependent patient will temporarily increase the dependency score which forms the basis of the clean sheet design, and the agreed establishment for that clinical area. In these instances, the patient must be risk assessed (further detailed guidance may be found in the Supportive Observation: of 'at risk patients' policy) and this assessment must be documented on the 'Level of Specialling Risk Assessment' form (**Appendix 4**) and filed in the health record.

Where 'specialling' is a regular requirement, this may indicate that an agreed establishment is insufficient for a particular clinical area. This must be closely monitored by the Divisional Director of Nursing and considered when re-reviewing the 'clean sheet design'.

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4.5.2 Monitoring acuity/ dependency on a daily basis

The Trust intends to monitor the acuity of patients on a daily basis and to show this against available staffing. By using the trust reporting tool the trust will capture using an acuity dashboard of patients and show this where possible against available adult inpatient (non-maternity/paediatric areas).

This dashboard is an information tool, providing as close to real-time information on the current patient acuity/dependency and available staffing. It should be seen as an information tool which should be used with other sources of information e.g. skill-base, competence & capability of available staffing, known risks of harm e.g. risk of pressure ulcers, falls, inability to deliver their activities of daily living etc.

4.6 Escalation beds (see **section 5** for definitions)

Safe levels of nurse staffing and skill mix for escalation beds will be determined as part of capacity planning and the same principles to set and approve safe nurse staffing and skill mix levels must be applied when planning and opening escalation beds, taking into account the location, case mix of patients and number of escalation beds. There should never be more than a 50% split of Trust and temporary staff, to ensure continuity of care there must be a Trust employed band 6 or above who takes charge of the area for the duration the beds are open.

The opening of escalation beds requires agreement and sign-off by the Divisional Director of Nursing. As a minimum, weekly quality assurance audits will be undertaken by a senior member of the divisional nursing team. Escalation will be managed in accordance with the Trust Pressure Surge Plan. Furthermore, beds (either escalation or beds in an existing bed base) may be closed where staffing has been deemed, by the Divisional Director of Nursing, as insufficient to maintain patient safety. The Trust accepts that this may reduce capacity on a temporary basis, during which time every effort is made to re-establish safe staffing to support agreed capacity.

The divisional team will utilise the e-rostering system to provide assurance that agreed staffing is in place at all times.

5 Definitions

Service Improvement Index/ Harm Free Care report is the nursing and midwifery clinical scorecard used to assure quality and drive service improvement. It includes key workforce metrics, presented alongside nurse sensitive outcome indicators and patient experience data

Specialling is nursing patients on a one-to-one (staff:patient) ratio due to increased acuity or dependency

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Escalation beds are additional beds which may be opened in response an increase in demand to create a temporary increase in capacity. There are two different types of escalation bed:

- Escalation beds within a existing ward, which are opened and closed (or 'flexed' up and down) to meet variations in demand
- Escalation beds opened in a stand alone ward

6 The Development of Organisation-wide Procedural Documents

6.1 Identification of Stakeholders

This policy affects all staff

6.2 Responsibility for Document Development

William Gage, Lead Nurse for Practice Development and Innovation/ Sally Heywood, Associate Director of Nursing, Patient Safety and Quality

6.3 Equality Impact Assessment (EIA)

This policy will not impact unfairly on those individuals having protected characteristics of the Equality Act 2010

7 Dissemination

This policy outlines practice which is currently well embedded in the Trust (following agreement of an original position paper in 2011). This policy will be available to all staff via the Trust intranet.

8 Implementation

This policy will be implemented through the governance framework outlined in **section 10**

9 Document Control including Archiving Arrangements

9.1 Register/ Library of Procedural Documents

These will be conducted in accordance with Trust Process for the Development and Management of Procedural Documents Policy.

9.2 Archiving Arrangements

These will be conducted in accordance with Trust Process for the Development and Management of Procedural Documents Policy.

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10 Monitoring Compliance of Procedural Documents

10.1 Process for monitoring compliance

A governance framework has been established to ensure and assure the operational delivery of this policy, which must be seen within the wider context of the assurance of quality and risk management in the Trust. Key performance indicators (KPIs) are outlined in **section 10.2** and the governance framework is summarised here (detailed Terms of Reference for each group are available):

Group or Committee	Indicators reviewed	Frequency
Nursing and midwifery establishment reviews	Agreed ward establishment and 'live' vacancy data with the nursing alongside the midwifery quality assurance framework (Service Improvement Index/ Harm Free Care report (see **section 5**) and approved staffing incident report (reported via Datix)	monthly
Local CPG (to be renamed Divisions) quality and safety boards	Determined locally	Determined locally
Nursing and Midwifery Professional Practice Committee	Nursing and midwifery quality assurance framework (Service Improvement Index/ Harm Free Care report) standing agenda item	monthly
CPG (to be renamed Divisions) performance reviews	Vacancy, turnover, sickness, bank/ agency (as a percent of spend), appraisal, stat/ man training and local performance management indicator report (every group including nursing and midwifery)	monthly
Clinical Risk Committee	Approved staffing incident report (reported via Datix)	monthly
Quality and Safety Committee	Nursing and midwifery quality assurance framework (Service Improvement Index/ Harm Free Care report) and ad hoc staffing incidents reports (reported via Datix)	monthly
Audit and Risk Committee	Nursing and midwifery quality assurance framework (Service	Tri-monthly

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	Improvement Index/ Harm Free Care report)	

10.2 Standards/ Key Performance Indicators (KPIs)

The following KPIs will be monitored to ensure effective delivery of the policy to provide the required assurance of safe nursing staffing and skill mix:

- Reduce vacancies in ward and in-patient areas to 5%
- Reduce sickness/ absence to 4%
- Reduce reliance on bank and agencies to 10%
- Reduce turnover (annual) to 10%
- All reported incidents relating to staffing are fully investigated in a timely manner (within 30 days) and acted upon

In addition, the Divisional Director of Nursing must conduct a self-assessment against other the other standards outlined in this policy, and submit it to the Director of Nursing on a six monthly basis, which at a minimum must include:

1. Confirmation that the 'Template to agree safe nurse staffing and skill mix' (**Appendix 1**) based on the principles of clean sheet design outlined in this policy (**section 4**) is up-to-date for each clinical area and that any changes have been agreed with the Director of Nursing. This must include an analysis of the frequency of specialling in a clinical area where it is pertinent
2. Summary position with regards vacancy, sickness, bank & agency usage and operational WTE
3. A summary of themes and outcomes of investigations into reported staffing incidents
4. A summary of variations in real time acuity and dependency (pending full launch of the electronic acuity and dependency monitoring tool)
5. Where escalation beds have been used, a summary of compliance against those additional standards set out in **section 4.5.2**.

and a detailed assessment of compliance with:

6. Actual staff (by band) working against agreed whole time equivalent (WTE), also known as operational WTE
7. Ratio of registered to unregistered staff
8. Percentage of unfilled shifts (by professional group)

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9. Percentage of shifts without a 'nurse in charge'

This self-assessment report must outline actions and timescale for delivery where performance has fallen below agreed thresholds. In addition to this professional scrutiny, these standards will be performance managed through the agreed governance framework outlined in **section 10.1**.

In addition, the KPIs outlined in the Trust Roster Policy will form part of the assurance process for safe staffing and skill mix levels.

10.3 Risk Assessment of Cost Improvement Programmes (CIPs)

The NHS Operating Framework 2012/13 requires Trusts to continue to deliver efficiency savings whilst driving quality improvements through transformational change and clinical service redesign. Where cost improvement programmes (CIPs) are required, these must include in-built assurance of patient safety and quality (National Quality Board (NQB), 2012).

The Trust Risk Management Strategy provides the framework for identifying and managing all types of risk, including the risk assessment of CIPs. In summary, a clinical risk assessment is included as part of each CPGs Financial Performance Pack which is discussed at a local level in the Trust at each CPG Board, as well as corporately at both the CIP Board and individual monthly CPG Performance Reviews. The CIP Board (chaired by the Medical Director and Director of Nursing) is the vehicle that leads the processes around CIP risk assessments to ensure they comply with Trust policy and are adequate to support safe delivery of the CIP work programme.

11 References

For Trust polices, please see front sheet for hyperlinks

Association of UK University Hospitals (2009) Patient Care Portfolio AUKUH acuity/ dependency tool: implementation resource pack London: AUHUK Available for download from www.aukuh.org.uk

British Association of Critical Care Nurses (BACCN) (2010) Standards for Nurse Staffing in Critical Care London: BACCN

British Association of Day Surgery (BADS) (2003) Skill Mix and Nursing Establishment for Day Surgery Norwich: Colman Print

British Association of Perinatal Medicine (BAPM) (2010) 3rd ed. Service Standards for Hospitals Providing Neonatal Care London: BAPM

British Cardiovascular Society (2007) Non-medical catheter laboratory staffing working group report London: BCS

British Committee for Standards in Haematology (BCSH) Haemato-Oncology Task Force (2009) Facilities for the Treatment of Adults with Haematological Malignancies – 'Levels of Care' London: BCSH

Department of Health (DH) (2009) Toolkit for High Quality Neonatal Services London: HMSO

FACT-JACIE (The Joint Accreditation Committee-ISCT (Europe) & EBMT) (2011) International Standards Accreditation Manual. 4th ed.

Francis R (2013) The Final Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry London: HMSO

National Cancer Peer Review Programme (2012) Manual for Cancer Services: Haematology Measures

NHS Commissioning Board and the Department of Health (DH) (2012) Compassion in Practice London: DH

National Quality Board (NQB) (2012) How to: quality impact assess provider cost improvement London: NQB

National Renal Workforce Planning Group (2002) Group The Renal Team: A Multi-Professional Renal Workforce Plan for Adults and Children with Renal Disease

Nursing and Midwifery Council (NMC) (2008) The Code: Standards for conduct performance and ethics for nurses and midwives London: NMC

Paediatric Intensive Care Society (PICS) (2001) Standards for the care of critically ill children London: PICS

Paediatric Intensive Care Society (PICS) (2010) 4th ed. Standards for the care of critically ill children London: PICS

RCN (2003) Defining staffing levels for children and young people's services London: RCN

Royal College of Nursing (RCN) (2011) Guidance on safe nurse staffing levels in the UK London: RCN

RCN (2012) RCN Safe Staffing for older peoples wards RCN summary guidance and recommendations London: RCN

Royal College of Physicians (RCP) Joint Advisory Group on gastrointestinal endoscopy (2007) BSG Quality and Safety Indicators for Endoscopy London: RCP

Royal College of Radiologists (RCR) and the RCN (2006) Guidelines for Nursing Care in Interventional Radiology London: RCR

University College London Hospital NHS Foundation Trust (2010) Skill Mix Methodology

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Appendix 1 Template to agree safe nurse staffing and skill mix establishments

Ward/ Department	
Number of beds – Level 0/1	
Number of beds – Level 2	
Number of beds – Level 3	
[Number of escalation beds]	
Specialty	
Date of last 'clean sheet' design	

Establishment and skill mix		
Band	WTE	
8a		[redacted]
7		
6		
5		
4	[redacted]	
3		
2		
Total		
Ratio (RN:unqualified) Total		
%		
Admin		

Agreed staffing levels						
Long Day						
M	T	W	Th	F	S	Su
Early						
M	T	W	Th	F	S	Su
Late						
M	T	W	Th	F	S	Su
Night						
M	T	W	Th	F	S	Su
Other (please specify e.g. 9-5)						

Approved as safe (print and sign):	
Director of Nursing	Date
Divisional Director (at Divisional Management Board)	
Divisional Head of Operations	
Divisional Director of Nursing	
Lead Nurse	
Chief of Service	
General Manager	
Ward Manager	

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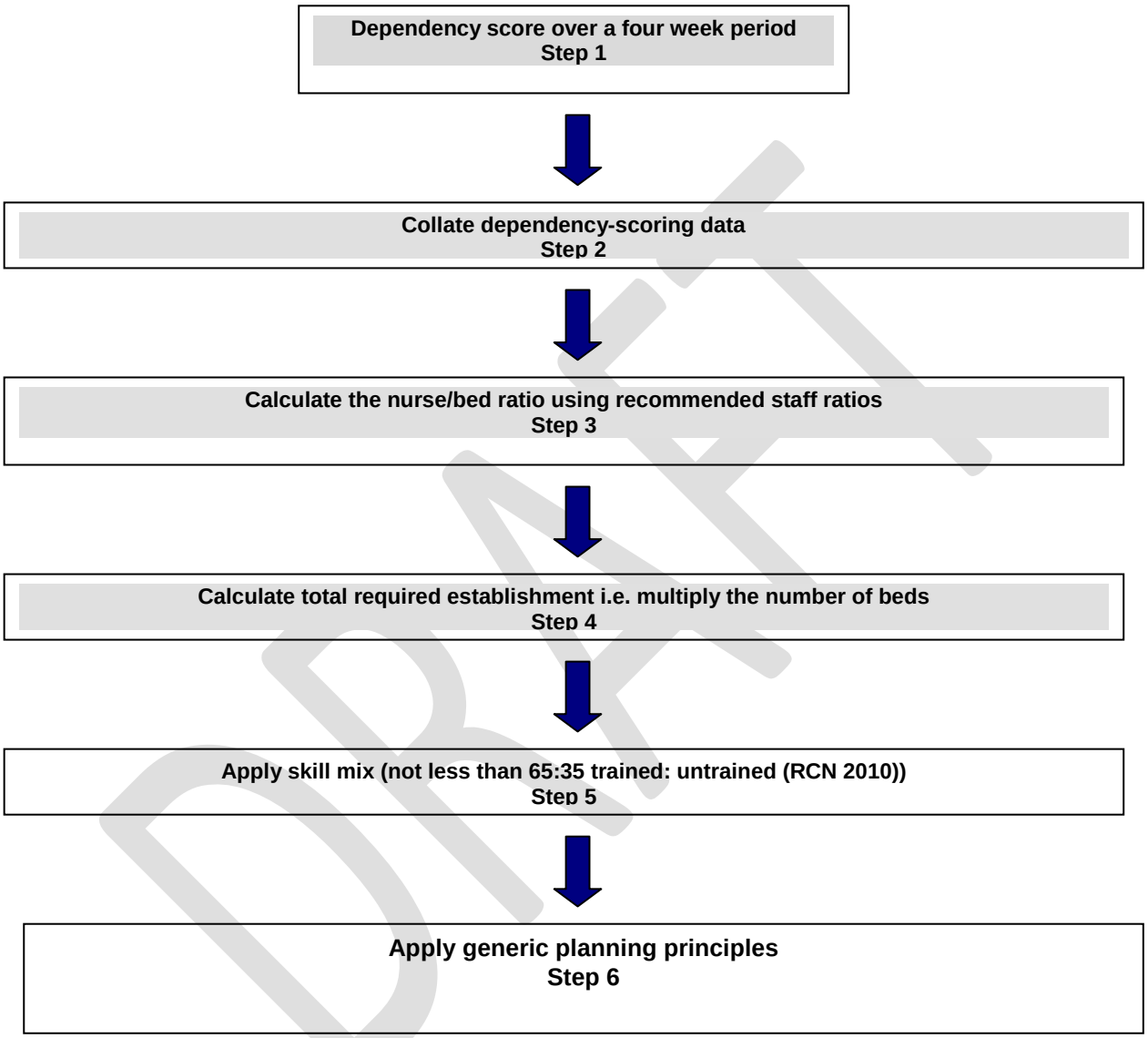
Appendix 2 Association of UK University Hospitals UK (AUKUH) adult acuity dependence tool



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Appendix 3 The recommended staffing ratio/multiplier for dependency in 'clean sheet design'

AUKUH Adult Acuity/Dependency Tool ©

Levels of Care	Inclusion Criteria	Guidance on Care Required	WTE
Level 0 Patient requires hospitalisation. Needs met through normal ward care.	Elective Medical or Surgical Admission, Routine Post Diagnostic/Surgical Procedure care, May have underlying medical condition requiring on-going treatment, Patient awaiting discharge.	Routine post-op / post procedure care (Incl ½ hry obs until stable), Regular observations 2 - 4 hourly, ECG monitoring to establish stability, Fluid management, PCA, Oxygen therapy 24 – 40% (Specialist Surgical Areas ONLY – single chest drain). Requires routine nursing assistance	0.79
Level 1 Appropriately managed on in-patient ward but requires more than baseline resources. **Level 1a** Acutely ill patient requiring intervention or those who are **UNSTABLE** with a **GREATER POTENTIAL** to deteriorate.	Observation & Therapeutic Intervention - "Step Down" from Level 2 care, Post-Op care following Emergency or Complex Surgery, or following peri-operative event. Emergency Admission requiring immediate therapeutic intervention. Deteriorating Condition or Fluctuating vital signs.	Instability requiring continual observation/ invasive monitoring, Support of Outreach Team but **NOT** higher level of care. Oxygen Therapy greater than 40% +/- Chest Physiotherapy 2 – 6 hourly. Arterial Blood Gas analysis – intermittent. 24 - 48 hours following Tracheostomy, insertion Central lines/ Epidurals/ Chest drains.	1.70
Level 1b Patients who are in a **STABLE** condition but have an increased dependence on nursing support.	Severe Infection, Sepsis, Complex wound management. Compromised Immune system. Psychological Support/Preparation. Requires Continual Supervision. Spinal Instability / Mobility Difficulties.	Complex Drug regimes, Patient and/or carers require continued support owing to poor disease prognosis or clinical outcome. Completely dependent on nursing assistance for all activities of daily living. Constant observation due to risk of harm.	1.86
Level 2 Patients who are unstable and at risk of deteriorating and should **NOT** be cared for in areas currently resourced as general wards. (May be managed within clearly identified, designated beds, resourced with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility/unit).	Deteriorating / Compromised Single Organ System, Post-op Mgt following Major Surgery, Post operative optimisation/ extended post-op care. "Step Down" from Level 3 Care. Uncorrected Major Physiological Abnormalities.	Patients requiring Non-invasive ventilation / resp support. Routine short-term post-operative ventilation. First 24 hrs following Tracheostomy insertion. Requires a range of therapeutic interventions including; Greater than 60% oxygen, Continuous ECG & invasive pressure monitoring, Vasoactive drug infusions (amiodarone, potassium, inotropes, GTN, magnesium), Haemodynamic instability. Pain Management ; IV analgesic infusions, CNS depression of airway & protective reflexes, Neuro monitoring.	2.44
Level 3 Patients needing advanced respiratory support and therapeutic support of mulitple	Monitoring and Supportive Therapy for Compromise or Collapse of two or more Organ Systems.	Respiratory or CNS depression / compromise requires Mechanical / Invasive ventilation, Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection.	6.51

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Appendix 4

Imperial College Healthcare NHS Trust

LEVEL OF SPECIALLING – RISK ASSESSMENT

(ADULT GENERAL WARDS) ***Complete and file in patient's notes***

Patient details:

SECTION 1: IMMEDIATE ACTIONS TO ASSESS AND REDUCE RISKS

Please tick - **Yes** or **No**

	Yes	No	
Recent medical / medication review?			If No – Request review
Behavioural chart completed?			If No – Chart behaviour and record triggers
▪ Have the appropriate referrals been made to the multi-disciplinary team? ▪ Is there a clear multi disciplinary management plan?			If No – Make referrals and use behavioural chart / triggers to develop a management plan
Is there a current substance (including drug and alcohol) misuse problem?			If Yes – Refer to the Alcohol Liaison Nurse Team
Have environmental concerns been considered?			If No – Reduce environmental stimuli / Move to a more observable position etc
Has the Falls screening tool and risk assessment been completed?			If No – Complete assessment (consider ultra low bed / mats etc)
Is a mental health assessment required?			If Yes – Refer to Liaison Psychiatry (adult / older people or on-call if urgent)
Can the patient's care be safely maintained within usual staffing levels?			**If No – Proceed to Section 2**

SECTION 2: RISK REASON & SPECIALLING RECOMMENDATION

Please tick appropriate risk

No.	Risk / Reason	Tick	Recommended Level of Specialling
1	Acutely ill / Complex care requiring constant observation and intervention by RN		**1:1 RN**
2	Preventable falls requiring 1:1 observation (as per Falls Risk assessment)		**1:1 HCA**
3	Confused and wandering presenting risks to self and others (patients and staff)		**1:1 HCA**
4	Pulling lines /tubes that may result in significant harm		**1:1 HCA**
5	Expressing intent or recently attempted to self harm / suicidal ideation		**1:1 RN(MH)** (to assess, plan, deliver and evaluate mental health care)
6	**Extreme** challenging behaviour (violence & aggression)		**1:1 RN(MH** (to assess, plan, deliver and evaluate mental health care)

Print Name: **Designation:**

Sign: **Date:** **Time:**

p.t.o. for continued assessments

Imperial College Healthcare NHS Trust

DRAFT

Imperial College Healthcare NHS Trust

LEVEL OF SPECIALLING – RISK ASSESSMENT
CONTINUATION SHEET

DRAFT

Imperial College Healthcare NHS
NHS Trust

RE-ASSESS RISK REASONS EACH SHIFT HANDOVER				
Date	**Time**	**Can the patient's care be safely maintained within usual staffing levels?** (circle appropriately)	**If NO – Indicate Risk Reason number (1-6)**	**Sign**
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
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		YES / NO		

DRAFT

Imperial College Healthcare NHS
NHS Trust

Report Title: Medical Director's Report

To be presented by: Professor Nick Cheshire, Medical Director

Executive Summary:

The attached paper is a consolidated report covering the following areas:

Quality Governance
Consultant Working
Education
External Reports
Perinatal Mortality: Dr Foster Alert

Key Issues for discussion: N/A
Please refer to the attached paper which summarises the key issues for discussion

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision ☐
b. For information/noting √

29 May 2013

Quality Governance

- Clinical governance 2-yr development plan (to be known as *QG15*) agreed
  - -Based on Berwick principles, comprehensive
  - -Informs reports into & organisation of, Q&S committee
  - -Replicated in divisional Q&S structure
  - -Communications plan for all staff
- New weekly incident review panel established
  - -All moderate and high risk incidents from preceding week considered by Medical Director's panel
  - -CPDs, CoS & quality managers from each CPG give report
  - -Immediate action, senior oversight
  - -Quality control of incident grading and categorisation
- New Associate Director of Quality & Safety appointed (Sue Burgis)
- iMove staff fitness campaign launched 12/5/13, in conjunction with Occupational Health Dept & 2 gym providers

Consultant Working

- Electronic team job planning pilot commenced in cardiac & vascular surgery, urology and cardiology 16/5/13
  - -ensure VFM for Trust
  - -paid sessions linked to contracted workload
  - -drive practice modernisation
- Trust cancer steering group reconfigured; Chris Harrison to chair
- Consultant ANTT deadline June 2013. Clinical exclusion for defaulters

Education

- Jeremy Levy resigned, post advertised
- Restructure; Director education now reporting to Med Dir office
- Deanery visit 16 April; changed responsibilities of
  - -cardiac surgery FY2 at HH
  - -anaesthetic CT1 at SMH
  - -ventilation cover from anaesthetic middle grades at CX
- Internal audit of junior doctor out of hours work intensity starts end May

External Relationships

- ICHT Names put forward for London clinical senate council
- ICHT accepted as a member of the Organisation of European Cancer
- Program of introductory visits to CCGs under way - key themes; transparency, communication, patient experience
- GP Steering Group established chaired by CH - four work streams 1. Timely communication 2. Accessibility of information (web based portal), 3. Hot line and email communications 4. Joint Education initiatives

Perinatal Mortality; Dr Foster Alert

- Internal 2002-12 review completed April 2013 at suggestion of RCOG
- ICHT 2012 mortality rate 6.7/1000; national rate 5.2 (2011)
- Paper seen by RCOG; recommendations to show data by presentation type
- Final paper to be re-submitted

Imperial College Healthcare NHS
NHS Trust

Report Title: Monthly Infection Prevention Summary

To be presented by: Prof. Alison Holmes

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Executive Summary:

This report includes the Trust's monthly mandatory reports of HCAI for April 2013.
It includes an update on selected activities and indicators and it highlights local infection prevention and patient safety issues.

Key Issues for discussion:

- 2012/13 objectives for MRSA blood stream infections and *C. difficile* infections were met by the Trust.
- There is a zero expectation nationally for all Trusts with regard to MRSA blood stream infections for 2013/14. In April 2013 there were no Trust acquired MRSA BSI cases reported at the Trust.
- The annual set target for *C. difficile* for 2013/14 is 65. There were 12 cases of *C.difficile* in April 2013.
- The extensive activity beyond MRSA and *C.difficile* that takes place.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

Link to the Trust's Key Objectives:

Provide the highest quality of healthcare to the communities we serve improving patient safely and satisfaction

Assurance or management of risks associated with meeting key objective:

Infection prevention and control as a core aspect of patient safety, hospital management and excellence in clinical care. The ongoing programme of infection prevention and control.

Purpose of Report

a. For Decision
b. For information/noting ☐√

Monthly Infection Prevention and Control Summary
May 2013
(April 2013 data)

Key Indicators

April 2013

	Month 2: April			CPG						
	Threshold	Trust		1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	0	0		0	0	0	0	0	0	0
MSSA BSI (>48hrs)	N/A	3		2	0	0	0	0	1	0
E Coli BSI (>48hrs)	N/A	4		1	1	0	0	1	1	0
Clostridium difficile (>72 hrs)	6	12		5	3	0	3	0	0	1

Year to Date 2013/14

	YTD 2013/14				CPG											
	Threshold		Cases													
	Year	YTD	Trust		1		2		3		4		5		6		PPs	
MRSA BSI (>48hrs)	0	0	0		3		0		1		3		0		0		0	
MSSA BSI (>48hrs)	N/A	N/A	3		2		0		0		0		0		1		0	
E Coli BSI (>48hrs)	N/A	N/A	4		1		1		0		0		1		1		0	
Clostridium difficile (>72 hrs)	65	6	12		5		3		0		3		0		0		1	

N/A = Not applicable

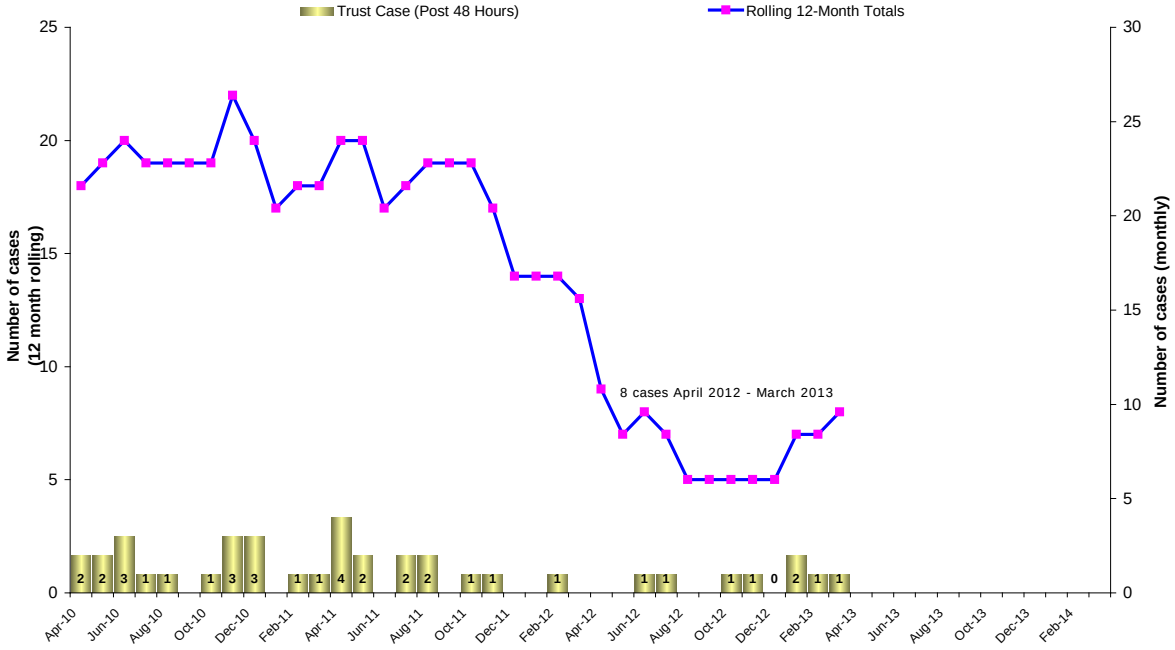
1. Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

There is a zero expectation nationally for all Trusts with regard to MRSA blood stream infections for 2013/14. In April 2013 there were no Trust acquired MRSA BSI cases reported at the Trust

1.1 Update on key elements of the MRSA BSI prevention action plan

A new assessment process has been rolled out following a successful pilot period for assessing the ANTT (aseptic non-touch technique) competence of new junior doctor's joining the Trust. New junior doctors are assessed on the collection of blood cultures on their Trust induction course.
The infection prevention and control competency framework which includes ANTT is currently being reviewed to streamline the training and competence components.

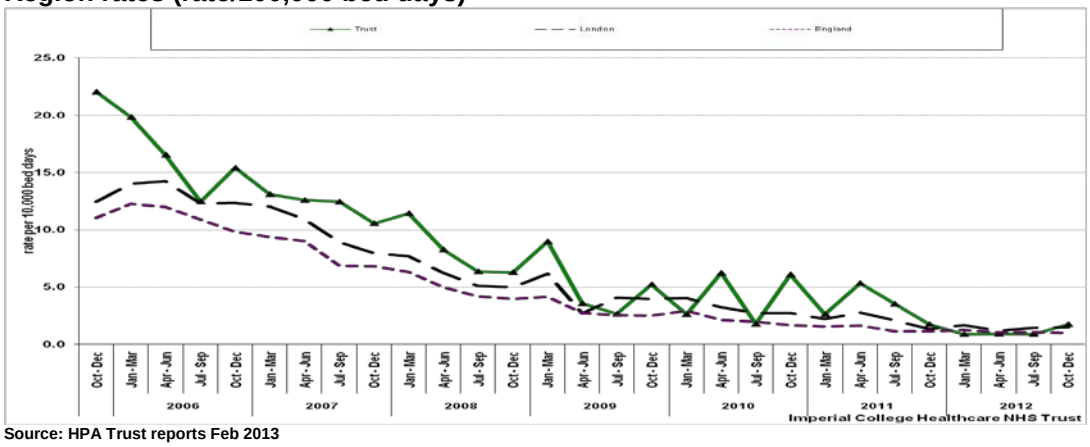
Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



1.2 Benchmarking Trust-attributable MRSA BSI rates

Provisional data presented by the Health Protection Agency (HPA) in figure 2 shows that the Trust had a quarterly rate of 1.74 per 100,000 bed compared to a regional rate of 1.44 and national rate of 0.96.

Figure 2: Trend in the Trust-attributable MRSA BSI rate compared to the national & London Region rates (rate/100,000 bed days)



Source: HPA Trust reports Feb 2013

2. *C. difficile* infections

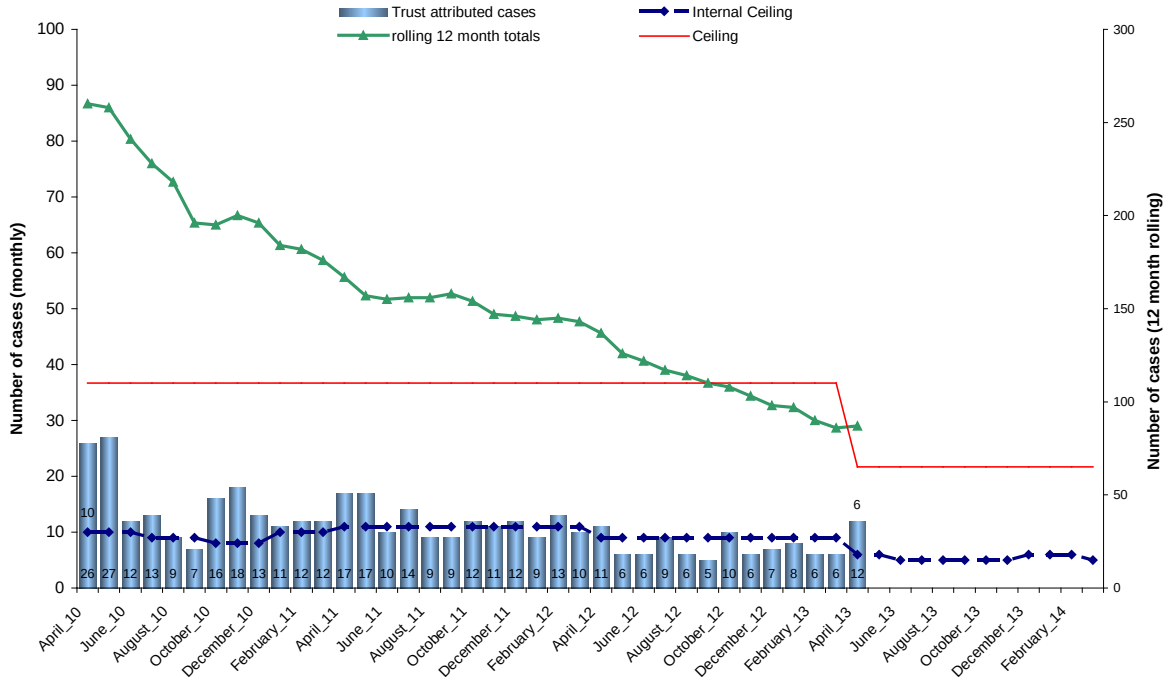
For 2013/14, the Department of Health annual ceiling for the Trust is 65 cases of *C. difficile* infection. Twenty cases were reported in April 2013, of which 12 cases were Trust attributable.

Of these 12 Trust attributable cases, nine had evidence of clinical *C.difficile* disease, while in three patients there were other reasons to which the diarrhoea was attributed.

Seven patients had received antibiotics in the preceding 14 days for a range of indications and all but one of these were prescribed in accordance with Trust policy. In four patients the antibiotics were prescribed for an infection that occurred more than 48 hours after admission.

Timely isolation in a sideroom occurred in three cases. For the remaining nine cases this was not recorded or was achieved beyond two hours of the onset of diarrhoea. The length of stay at the time of detection of *C. difficile* was within one week of admission for four patients, within two weeks of admission for three patients, and the remaining five patients had a length of stay in the range 19 - 56 days.

Figure 3: Trust attributable C.*difficile* infections and 12 month rolling total April 2010 – April 2013



2.1 Update on key elements of the *C. difficile* prevention action plan

Each case of *C. difficile* has a detailed case review undertaken to help understand the organism's prevalence and contributory factors for acquisition. This case review has now been extended to include an enhanced focus on prior antibiotic exposure and the prescribing.

The Trust diarrhoea and vomiting and *C.difficile* polices have been reviewed in light of recent revised guidance from Public Health England and the Infection Prevention Society and will be launched in May 2013. In particular, in line with national recommendations, the time to isolation for cases of suspected and confirmed infectious diarrhoea has been reduced from four hours to two hours.

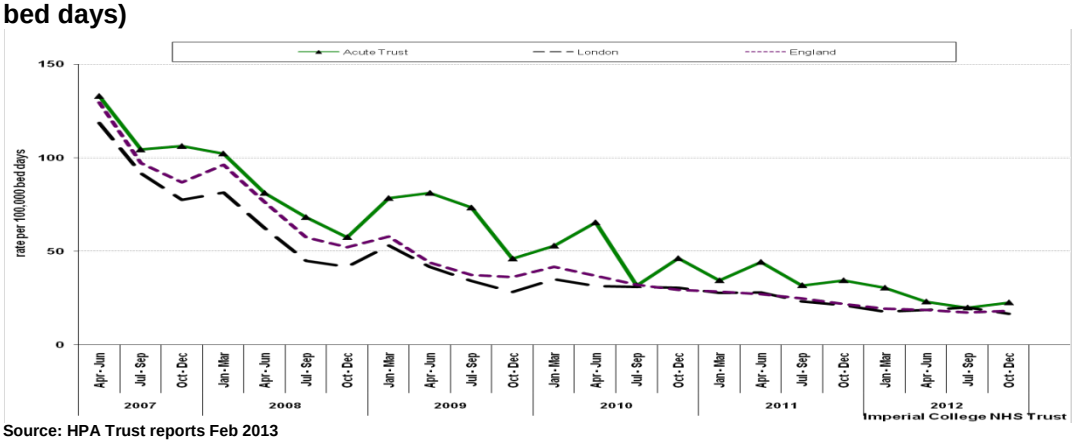
An evaluation of the methods and available products for decontaminating commodes is being undertaken with a view to making this process simpler and more effective.

The Trust is working closely with other London Trusts at the Acute London Teaching Trusts Infection Control Forum to identify and share areas of best practice with regard to *C. difficile.*

2.2 Benchmarking Trust-attributable *C. difficile* rates

Provisional data presented by Public Health England in figure 4 shows that the Trust had a quarterly rate of 22.7 per 100,000 bed days compared to a regional rate of 16.7 and national rate of 18.3.

Figure 4: Trend in Trust-attributable CDI rate compared to national & regional rate (in 100,000 bed days)



Source: HPA Trust reports Feb 2013

3. MRSA Screening

The Trust remains compliant with the Department of Health population MRSA screening requirements. Analysis at an individual patient level identified 8344 patients admitted in April 2013 who required screening of which 7300 (87.5 percent) were screened. New national guidance on MRSA screening is awaited.

Figure 5: Trust MRSA screen percentage (individual patient level)

4. Meticillin sensitive *Staphylococcus aureus* bloodstream infections (MSSA BSI)

There is no threshold for this indicator at present. In April 2013, there were six cases of MSSA BSI reported to Public Health England (PHE) of which three were Trust attributable (i.e. post 48 hours of admission) and three were non-Trust attributable. Of the three Trust attributable cases, two were related to a vascular access device and the third was due to a skin/soft tissue infection.

Figure 6a: Monthly MSSA BSI cases

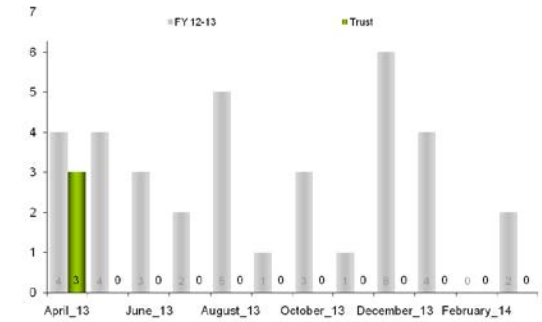
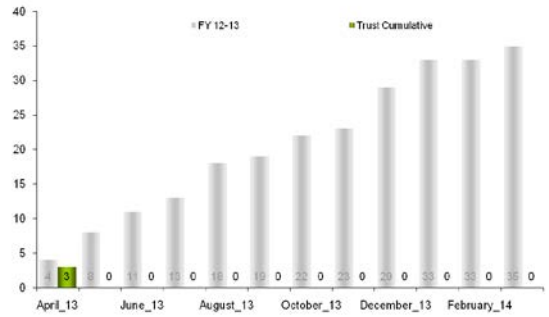


Figure 6b: Cumulative MSSA BSI cases



5. *Escherichia coli* bloodstream infections (*E. coli* BSI)

There is no threshold for this indicator at present. In April 2013 there were 24 cases of *E. coli* BSI reported to Public Health England (PHE) of which four were Trust attributable cases (i.e. post 48 hours of admission). Three of these cases were at Hammersmith hospital (on different wards) and one case was at St Marys hospital.

None of the four Trust attributable cases were related to a vascular access device. Two were related to neutropaenic sepsis, the third was due to abdominal sepsis secondary to pancreatic surgery and the fourth had the urinary tract identified as the primary source.

Figure 7a: Monthly Trust-acquired *E. coli* BSI cases

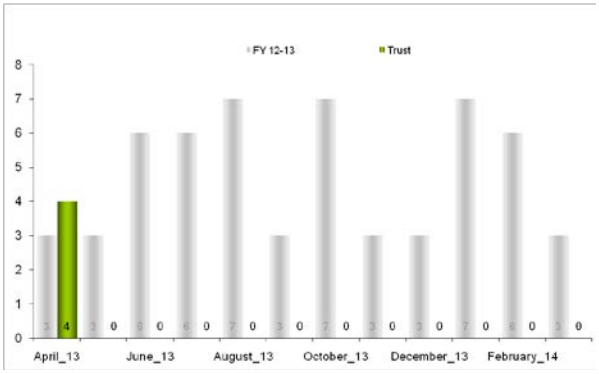
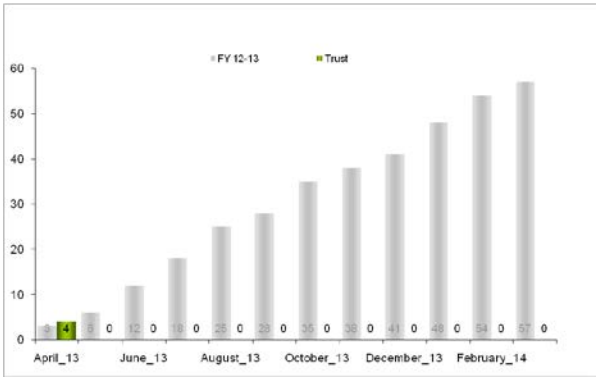


Figure 7b: Cumulative Trust-acquired *E. coli* BSI cases



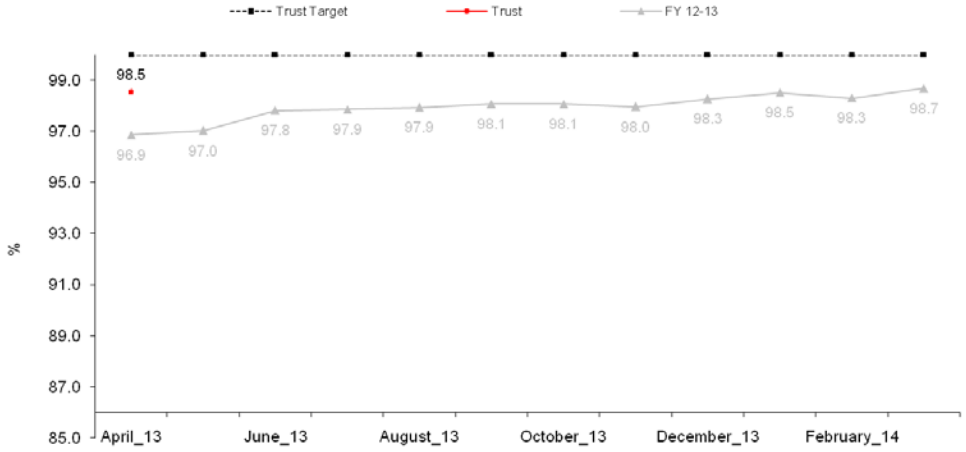
6. Hand hygiene compliance

In April 2013, 89.1 percent of clinical areas submitted a total of 6290 observations. Hand hygiene compliance (as measured by the current Trust audit procedures based on a minimum of ten observations per ward) was 98.5 percent, and compliance with bare below elbows was 98.8 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. Each audit method has its individual strengths but to provide further assurance and drive improved practice we recommend that a peer audit be introduced to triangulate this process. A monthly audit will be undertaken by the IPC Link Practitioners using the same methodology as the monthly audits but this would take place on a peer ward. This would involve protected time of half a day per month for each IPC Link Practitioner. Training and support would be provided by the IPC team to ensure consistency and reliability and facilitate timely feedback at a local level. This revised process will be reviewed in six months with a view to the eventual phasing in of a sole peer review hand hygiene audit process.

Figure 8: 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 CPG level as part of the infection prevention plan. Completion of assessments has steadily been increasing from 75 percent in March to 80 percent (4996 clinical staff) at the end of April 2013.

8. Antibiotic stewardship

Antibiotic stewardship initiatives continue and focus on engaging with healthcare professionals across the Trust and promoting the messages outlined in the Chief Medical Officers report (March 2013) on prudent prescribing. Point prevalence surveys are planned to take place in May and November 2013.

The antibiotic review group will review and develop policies including the treatment of infection, surgical prophylaxis and renal policies. The Trust antibiotic smart phone app will be updated in collaboration with the Centre of Infection Prevention and Management. Antibiotic resistance and usage data will be examined and utilised to further refine existing and new policies.

8.1 Antimicrobial resistance

Following the PHE workshop on carbapenem resistant organisms, we are working to formalise our existing systems for the laboratory detection of, clinical infection control response to and surveillance for carbapenem resistant Enterobacteriaeceae. This is in parallel to laboratory and Infection Prevention and Control Team responses to cases of carbapenem resistant (VIM-producing) Pseudomonas and our ongoing development of surveillance of resistant organisms within the Trust.

9. ICU Bloodstream infections

9.1 Adult ICU

In April there were 14 positive blood cultures in adult ICUs in the Trust. These occurred in 9 patients. 10 blood cultures were positive with coagulase negative staphylococci, three of which were considered to be central venous catheter (CVC) associated and four deemed to represent blood culture contamination. (In three cases complete data not available).

Four additional cultures were positive from three patients; one cultured a relatively sensitive *Acinetobacter baumanii* from blood and from CVC line tip and therefore represents a CVC related bacteraemia. the three remaining organisms were consistent with known infection at other sites, namely abdominal infection and pneumonia in the other two patients.

These data will be presented quarterly and rates per 1000 catheter days generated for benchmarking purposes.

9.2 Neonatal ICU

The incidence of blood stream infections on a neonatal unit is an important performance measure of neonatal care. The two neonatal units at the Trust collate these data monthly. For benchmarking purposes these data are submitted to the Vermont Oxford Network (VON), an international collaboration of more than 900 neonatal units (including 30 units in the UK). By participating in VON we have been able to monitor key outcome measures and the comparisons have been consistent over time. In addition, both neonatal units also submit data on late sepsis to the National Neonatal Audit Programme (NNAP UK).

Figure 9: Neonatal Unit blood stream infection (counts of annual cases 2008 – April 2013)

Queen Charlottes Hospital

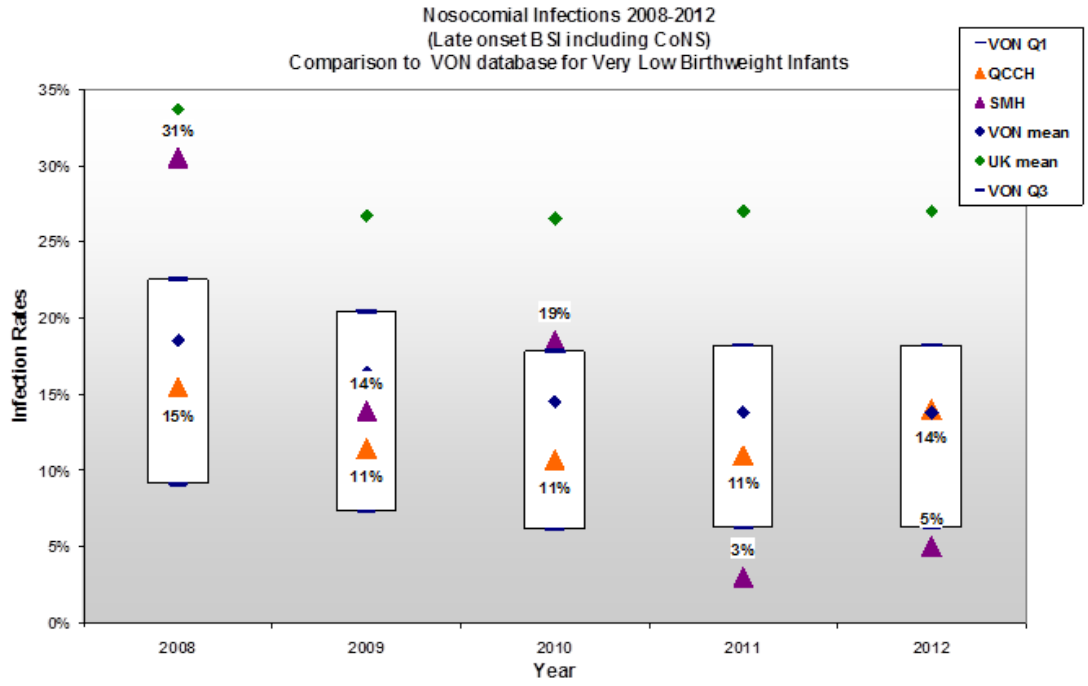
Year	Staph aureus	MRSA	Late GBS	Other	CONS	Total	Total admissions
2008	**6**	**3**	**2**	**11**	**5**	**27**	**433**
2009	**7**	**0**	**3**	**8**	**2**	**20**	**489**
2010	**3**	**1**	**3**	**10**	**4**	**21**	**485**
2011	**9**	**0**	**0**	**7**	**4**	**20**	**458**
2012	**6**	**0**	**0**	**9**	**5**	**20**	**415**
2013 Q1	**1**	**0**	**0**	**0**	**0**	**1**	**107**

St Marys Hospital

Year	Staph aureus	MRSA	Late GBS	Other	CONS	Total	Total admissions
2012	1	0	0	2	1	4	326
2013 Q1	0	0	0	1	0	1	72

GBS = Group B streptococcus; CONS = Coagulase negative staphylococcus

Differences in the number of positive blood cultures are accounted for by the different activity on each unit. All babies less than 1,000g and less than 27 weeks gestation are delivered at QCCH. This is the most vulnerable group of babies and are at high risk of developing late onset sepsis. Overall neonatal BSI rates are well below the mean for the other UK Neonatal Units and within Q1 and Q3 when compared to the whole VON network.



The various measures implemented on the two neonatal units in order to maintain a low infection rate are:

- Strict adherence to the Trust and local infection prevention and control, anti infective and vascular access policies.
- Weekly hand hygiene audits which are carried out on both sites and discussed at weekly unit meetings.
- Compliance with ANTT training and competency assessment for new and existing staff on both neonatal units
- Practicing non-invasive and less interventional neonatal care (e.g. early extubation, less invasive monitoring, reduced invasive procedures and blood tests).
- Early feeding practices on all preterm babies.

10. Other matters

10.1 Legionella

A lookback investigation is being undertaken following the identification of legionella in a patient at the Trust. The Trust has existing robust preventative water hygiene measures in place and on advice from Public Health England, additional water samples have been taken as part of the investigation. The patient had appropriate treatment and has subsequently been discharged from hospital and no other cases have been identified.

10.2 Fusarium oxyspora

A lookback exercise has commenced following the identification of fusarium oxyspora, an unusual environmental fungi, in respiratory specimens taken during bronchoscopy from three outpatients. The bronchoscope used is currently being tested and is not in use. The three patients did not require any treatment and were not admitted to hospital. A risk assessment is underway to identify any other patients who may require follow up.

10.3 Group A Streptococcus

A single case of group A streptococcus was identified by the Trust in April. A lookback investigation was undertaken by the Infection Prevention and Control Team in conjunction with Public Health England and Occupational Health. This was confirmed to be a single sporadic case, was managed appropriately and no further action was advised by Public Health England.

10.4 Measles

A lookback exercise has taken place following the diagnosis of an adult with measles in April 2013. Follow up was undertaken by the IPC team in collaboration with Public Health England and no further treatment or action was required. All healthcare staff that had contact with this patient had immunity to measles.

10.5 Chickenpox

A lookback investigation has taken place following the diagnosis of chickenpox in an adult attending an outpatient clinic in April 2013. A risk assessment involving Public Heath England, the IPC team and the Occupational Health team identified three patients who had been in contact with the index case. All three patients had known immunity to chicken pox and no further action was required.

10.6 Norovirus

An outbreak of norovirus occurred in April. This affected both patients and staff and resulted in four wards (three at Charing Cross and one at St Marys hospital) being closed to admissions and transfers until symptoms had resolved. The outbreak was recognised promptly and infection prevention and control measures implemented rapidly to control and limit the outbreak. All patients were managed appropriately and symptoms resolved as expected. Affected staff were excluded from work for 48 hours following the resolution of their symptoms as per Trust policy. The outbreak was reported to Public Health England via the norovirus outbreak in hospitals reporting scheme.

10.7 TB Lookback exercise

Two separate lookback exercises are being undertaken following the identification of TB in two patients. The investigations have been carried out in conjunction with the TB nursing team, Public Health England and Occupational Health. Patient contacts have been identified and are being followed up by the TB nursing team.

11 Applied Research, Education and Innovation.

The UKCRC Centre of Infection Prevention and Management (CIPM)

- CIPM are delighted to have received both an Imperial College Junior Research Fellowship for Claire Turner and the first BRC Clinical Research Fellowship for Infection for Luke Moore. Dr Claire Turner works in the laboratory work-stream of CIPM and the new award will allow her to conduct a project entitled "in depth analysis of *emm89 s.pyogenes.* Dr Luke Moore has been working with CIPM as an honorary research fellow on the ENIAPP project but will now be registered for a PhD with the Centre entitled, 'Investigating the role of matrix-assisted laser desorption/ionization time-of-flight mass spectrometry and whole genome sequencing in the critical care setting and the impact on antimicrobial prescribing and bacterial resistance.'

- Team members of CIPM took part in The Imperial Festival over bank holiday weekend. The stand was designed to attract people of all ages and promote research in infection prevention and included a range of activities including a UV glow-box for hands, thumb printing to agar demonstrating fomite transmission of bacteria, demonstrations of the CIPM ipad applications developed in collaboration with the Trust (iAPP & ENiAPP).

- CIPM PhD student Mark Reglinski won joint first prize at the Department of Medicine Young Scientist Day, for his poster entitled "The Immunoreactive Protein Repertoire of *Streptococcus pyogenes*'.

- CIPM was visited by representatives from its UKCRC Funders on the 16th April. Members of the Trust including its Chairman, Sir Richard Sykes, Dr Kathy Bamford (Microbiology) Ruth Holland (ICT) all took part in the visit.

- CIPM has continued to publish, most recently with a paper accepted to Clinical Infectious Diseases and another one to the Journal of Clinical Microbiology. The CID paper, entitled 'Understanding the determinant's of antimicrobial prescribing within hospitals: The role of prescribing etiquette' .The Journal of Clinical Microbiology paper is entitled 'Lethal Streptococcus pyogenes post-partum sepsis: Molecular analysis of an outbreak'. For a full list of publications see:http://www1.imperial.ac.uk/departmentofmedicine/divisions/infectiousdiseases/cipm/centre_outputs/publications/

- On May 1st CIPM and IPC, hosted a visit made by five members of the team from The Patient Safety Unit, Haukeland University Hospital, Norway to discuss addressing national antibiotic strategies and antibiotic stewardship. Their particular interest was on the application of mHealth, influencing prescribing, behavioural research and multidisciplinary engagement and the role of nurses.

- The next CIPM Annual Scientific Research Meeting will take place on the 3rd July 2013, at the Hammersmith Campus. The meeting at which the Centre and its collaborators will showcase their work on Addressing Antimicrobial Resistance (AMR) and Infection Prevention, is open to everyone with an interest in infection. The meeting is free, will be followed by a reception.

Imperial College Healthcare NHS
NHS Trust

Report Title: Cancer Recovery Implementation Plan Update

To be presented by: Steve McManus/ Janice Sigsworth

Executive Summary:
This paper is to update the Trust Board on the Cancer Recovery Implementation Plan. The purpose is to show that the original Plan is now complete and that work has begun to develop a new internal action plan which will continue to improve services and patient experience to the highest of levels going forward.

The Implementation Plan was developed jointly with NHS NWL Acute Commissioning and Performance in October 2012. The plan collates ICHT's response regarding underperformance against the national cancer standards and to drive improvement in cancer patient experience. The plan has been monitored by the Audit and Risk Committee, with a report to its meeting on 11 March 2013, and the most recent report to the Trust Board was on 27 March 2013.

In March, as per the Trajectory the Trust achieved the all eight of the National Cancer Standards.

Key Issues for discussion:

- The Trust Board to agree that the Cancer Recovery Implementation Plan is now complete?
- The impact of the next NCPES results

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision ☐
b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

Cancer Recovery Implementation Plan 2012/13

Executive Summary

In the Autumn of 2012 the Trust recognised that Cancer was a major priority, this coincided with the appointment of Steve McManus, Chief Operating Officer (COO) who quickly responded by appointing a pan Trust cancer team (Dr Katie Urch, Trust Lead Cancer Clinician, Sarah Gigg Trust Lead Cancer Nurse, and Cathy Wybrow, Trust Lead Cancer Manager) reporting directly to the COO and Director of Nursing.

The remit of this team was to respond to the 'Contract Query Notice' issued on 21 September 2012 by NHS NWL Acute Commissioning and Performance regarding poor cancer performance and patient experience. The team met with the commissioners within 5 days and produced the attached Cancer Recovery Implementation Plan (**see Appendix A**).

Since then the Trust Cancer Team, with their colleagues and support from the executive team and Nursing Office have delivered all the actions set out within the cancer remedial action plan. This has resulted in the Trust achieving all 8 national cancer standards by March 2013. Progress in meeting the trajectory has been steadily improving over the last six months as the actions from the plan were implemented. The attached graph from April 2012 to March 2013 charts the improvements in meeting the standards month on month (**see Appendix B**).

Even though it is recognised as a great improvement, there is much work to be done to sustain the performance and to improve patient experience. In terms of patient experience the plan going forward is to continue with Value Based Standards as this is proving successful, access to CNS's via and Call Centre, redesign patient pathway work of all tumour sites and the Length of Stay work on 6Nand 6S which shows a 3 day reduced length of stay.

Introduction

The Cancer Recovery Implementation Plan was divided into 5 main domains

- Pathway management
- Tumour site specific pathways
- Data Quality and completeness
- Governance and Reporting Structure
- Patient experience

A high level summary from each of these areas will be described below – please reference back to the detailed implementation plan (**see Appendix A**).

Pathway Management

A substantial amount of work has been focused on pathway validation and restructuring of MDT co-ordinators in line with tumour sites to ensure complete confidence in pathway management and data.

All MDT Meetings were observed and an MDT Standard Operating Procedure (SOP), benchmarked against the National Cancer Action Team guidance, produced which has been adopted by all clinical teams.

Tumour Site Specific Pathways

Work has started on the redesign of tumour site specific pathways. This is the major and most significant piece of work we are undertaking to ensure we sustain the March performance going forward. This work has started in LGI and Urology and is being supported by NHS London and Mckinsey. The LGI pathway went live on 15 April and we have seen demonstrable results in making sure patients are booked for endoscopy within 2 weeks, reduced DNA rate and improved patient experience.

ICHT aims to have completed all redesign work by the end of the December 2013 with all changes being implemented by no later than March 2014.

Data Quality and completeness

On the 4th April 2013 the Trust went live with a new cancer waiting times system called Somerset. All MDT admin staff are now using this new system. There is a timetable for this new system to be rolled out into all MDT meetings so that detailed clinical information can be captured.

Governance and Reporting Structure

The governance and reporting structure has been revised and a new MDT Chair Steering Group established.

Patient experience

The main interventions are the Value Based Standards and this can be evidenced by the attached I track results as well as the work on reducing length of stay on 6S and 6N which shows a reduction of 3 days from average length of stay of 8 days down to 5 days.

Conclusion

The Executive and Senior Cancer Management Team recognise much progress has been made in cancer services but that there is still more detailed work to be done. The main focus of work still to be done will fall into the following categories:

- increased access to a CNS's, this will be delivered through the call centre, focussed leadership and development of CNS practice, and the redesign of cancer pathways to allow more efficient use of Clinical nurse specialist time.
- improved communication with GPs and Patients, which will be delivered through the GP/Patient Portal as well as through the rollout of Somerset
- redesign pathway work looking at making tumour specific pathways more efficient and seamless for both cancer and non-cancer patients referred via the two week wait referral route.

An internal action plan under these headings needs to be developed and will be available from 28 June 2013

Updates and feedback from improvements are delivered at the Cancer Patient Experience and Performance Forum. The next Forum day is on the morning Friday 28 June 2013, at the W12 Conference Centre, Hammersmith, all Non-Executive Directors are welcome.

Imperial College Healthcare NHS
NHS Trust

Cancer Recovery Implementation Plan - **Appendix A**

1st October 2012 (original plan developed) updated - 14th May 2013

Authors: Dr Catherine Urch - Trust Lead Cancer Clinican
Sarah Gigg - Trust Lead Cancer Nurse
Cathy Wybrow - Trust Lead Cancer Manager

1. **Pathway Management**
2. **Tumour Site Specific Pathway**
3. **Data Quality and Completeness**
4. **Governance and Reporting Structure**

Patient Experience

5. **Performance Diagnostics**
6. **Performance Monitoring**
7. **Communication and Engagement with Key Stakeholders across the Trust (all hospital sites and CPGs)**
8. **Patient Information and Support**
9. **Patient Inclusion**
10. **Education and Training**
11. **Pathway Intervention**
12. **Governance**

Governance Arrangements for implementing this plan
- Report weekly to the Elective Access Waiting List Group
- Report biweekly to the Cancer Operational Group
- Report weekly to the Patient Experience Steering Group
- Report monthly to the Trust Cancer Board
- Report monthly to the Trust Board

Executive ownership by the Chief Operating Officer and Director of Nursing. Clinical services will be held to accountable for particular actions and will report to the above forums.

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	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	ON TRACK
	SUMMARY		
1	**PATHWAY MANAGEMENT**	**KU/CW**	**ALL ITEMS DELIVERED**
2	**TUMOUR SITE SPECIFIC PATHWAY**	**KU/CW**	**ALL ITEMS DELIVERED**
3	**DATA QUALITY & COMPLETENESS**	**KU/CW**	**ALL ITEMS DELIVERED**
4	**GOVERNANCE & REPORTING STRUCTURE**	**KU/CW**	**ALL ITEMS DELIVERED**
5	**PATIENT EXPERIENCE**	**SG**	**94% ITEMS DELIVERED. Ongoing actions added to 2013/14 action plan**

	Imperial College Healthcare NHS Trust		DELIVERY BY END OF JANUARY 2013 (WEEK ENDING)																				
		ICHT	OCTOBER					NOVEMBER				DECEMBER					JANUARY					FUTURE	ON
		DELIVERY	7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27		DATE	TRACK
1	**PATHWAY MANAGEMENT**																						
1.1	Observe all MDT meetings pan Trust	TLCC																					DEL
1.2	Develop MDT best practice pack to include MDT SOP, Escalation Policy, ECAD SOP	TLCC																					DEL
1.3	Set up tumour specific MDT PLT meetings to run weekly	TLCC																					DEL
1.4	Undertake a review of all MDT Staff to ensure clarity around Roles and Responsibilties	TLCC																					DEL
1.5	Provide MDT training for all leads.	TLCC																					DEL
1.6	Set up research project to review MDT changes.	TLCC																					DEL
1.7	Develop revised Cancer Access Policy	TLCM																					DEL
1.8	Launch revised Cancer Access Policy alongside Trust Elective Access Policy.	TLCM																					DEL
1.9	Ensure there are appropriate information reports to support proactive management of patients on their pathway so as to avoid preventable breaches by including escalation points on PTL.	TLCM																					DEL
1.10	Ensure all Outcome Clinic Slips clearly identifies Urgent Suspected Patient Pathway	TLCM																					DEL
1.11	Ensure all Urgent Suspected Cancers referred to Diagnostics are clearly identified	TLCM																					DEL
1.12	Ensure all Urgent Suspected Cancers referrals to Endoscopy are identifyable.	TLCM																					DEL
1.13	Ensure all 2 week wait referrals are entered onto Execlicare within 48 hrs of recepit	TLCM																					DEL
1.14	Start roll our using Somerset template to communicate to GPs OPD and MDT outcome (18th APRIL 2013)	TLCM										R1							R1				DEL
1.15	Agree job descriptions for MDT Chair/ Clinical Leads	TLCM																					DEL
1.16	Begin interviews / discussion for all MDT Chair/Clinical Lead around role and responsibility	TLCC/TLCM																r1					DEL

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERY BY END OF JANUARY 2013 (WEEK ENDING)																		FUTURE DATE	ON TRACK
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			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27		
2	**TUMOUR SITE SPECIFIC PATHWAY**																					
2.1	Clearance backlog - Pre 2012 - 4 patients - review all patients and manage appropriately	TLCM																				DEL
2.2	Clearance backlog - Jan - May - 19 patients - review all patients and manage appropriately	TLCM																				DEL
2.3	Clearance backlog - June - July - 37 patients - review all patients and manage appropriately	TLCM																				DEL
2.4	Clearance backlog - August - 95 patients - review all patients and manage appropriately	TLCM																				DEL
2.5	Produce capacity plans at speciality level to deal with backlog	TLCM																				DEL
2.6	Review current demand at speciality level and sign off by CPGs	TLCM																				DEL
2.7	Cross reference demand with current capacity to ensure have sufficient capacity	TLCM																				DEL
2.8	Where capacity is restricted or not available internally develop option appraisal.	COO																				DEL
2.9	Work with IST to develop speciality spectifc pathways.	COO																			04-Feb-13	DEL
2.10	Work with NHS L & McK. on 'Productivity Support Prog' identify 2 tumour H&N & Urology	COO																				DEL
2.12	Confirm urology pathway Redesign Work	TLCM																				DEL
2.13	Confirm LGI/Colorectal Pathway Redesign Work	TLCM																				DEL

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERY BY END OF JANUARY 2013 (WEEK ENDING)																	FUTURE DATE	ON TRACK
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3	**DATA QUALITY & COMPLETENESS**																				
3.1	Review the current PTL report including validating the 'Awaiting DTT' column	TLCM																			DEL
3.2	Develop a Technical SOP for the Cancer PTL	HoI																			DEL
3.2	Relaunch ICHT Cancer PTL to allow proactive management of patients.	HoI								R1											DEL
3.4	Develop a Technical SOP for the Cancer PTL (including 3.1)	HoI								R1											DEL
3.5	Complete development of a new ICHT Cancer PTL	HoI								R1											DEL
3.6	Develop DQ Measures for PTL + OE upload and Manage escalate issues at CDG	HoI								R1											DEL
3.7	Start recruitment of vacant MDT Co-ordinator posts	TLCM																			DEL
3.11	Appoint Project Manager for Somerset new cancer system to supersede Exelicare	TLCC																			DEL
3.11	Develop a training programme for rollout of Elective Access / PTL (incl. Con. Upgrades)	TLCM/HoOPD																			DEL
3.12	Begin rollout of Elective Access /PTL training programme	TLCM/HoOPD																		R1	DEL
3.14	Installation, System Build and Testing	SOMPM/ICT																			DEL
3.15	Implementation of Somerset System	SOMPM																		R2	DEL
3.16	Provision of Somerset super-user training	SOMPM																			DEL
3.17	Develop Phased Rollout of Somerset Tumour Group	SOMPM																			DEL
3.18	[rovision of MDT Somerset training	SOMPM																			DEL

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4	**GOVERNANCE & REPORTING STRUCTURE**																					
4.1	Implement new structure of Trust LCC, TLCN & TLCM	COO																				DEL
4.2	Review reporting framework for the management of cancer delivery across ICHT.	COO/CU/CW/SG																				DEL
4.3	Review Terms of Reference for the Cancer Operational Steering Group	TLCM																				DEL
4.4	Reduce number of entry points to the Trust for Urgent Suspected Cancer referrals	Head of OPD																				DEL
4.5	Establish a MDT Chair /Clinical Lead Quartery Cancer Steering Group Meeting	TLCC/TLCM																				DEL

	Imperial College Healthcare NHS Trust		DELIVERY BY END OF JANUARY 2013 (WEEK ENDING)																		ENCLOSURE 3A	
		ICHT DELIVERY LEAD	OCTOBER					NOVEMBER				DECEMBER					JANUARY				FUTURE	ON
			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27	DATE	TRACK
5	**PERFORMANCE DIAGNOSTICS**																					
5.1	Review 2011 NCS results with the National Cancer Director.	DoN																				DEL
5.2	Review of the latest MDTs performance against national peer review standards	HoPM/HoN CPG2																				DEL
5.3	Complete an analysis of narrative responses in the national cancer survey.	HoPM																				DEL
5.4	Complete nursing workforce review using M5 data of all cancer I/P & OPD areas	DoN																				DEL
5.5	Undertake a visit to E.Kent Hospitals NHS FT and GST Hospitals NHS FT	HoPM / TLCN																				DEL
5.6	Commision Quality health to run the NCPES by same methodology	HoPM																				DEL
5.7	Promote and encourage patient completion of NCPES; patient communication program	HoM																				DEL
5.8	Repeat NCPES to in-patients during June -August 2012	HoPM																				DEL
5.9	Repeat NCPES bi-monthly December 2102, February and April 2013	HoPM																				DEL
5.10	Initiate a staff survey on cancer inpatient and outpatient areas.	HoPM																				DEL
5.11	Run rapid service review / ethnographic perspective in chemotherpay units	IC PERC																				DEL
5.12	Include Friends and Family test into itrack RTM question set	HoPM																				DEL
5.13	Undertake a quantitative analysis of ratings by patient characteristics in NCPES returns.	IC PERC																				DEL
6	**PERFORMANCE MONITORING**																					
6.1	Build patient experience KPIs within Cancer dashboard (RTM, Workforce data)	HoPM/TLCN																				DEL
6.2	Report I-track results within cancer dashboard	HoPM																				DEL
6.3	Report workforce KPIs into CPG 2 Establishment & Performance Reviews	HoPM																				DEL
6.4	Report PEX feedback against VBS Pilot Wards	HoPM																				DEL
6.5	Report PEX results from key Cancer IP & OPD areas in CPG Performance reviews	HoPM																				DEL
6.6	Report on NCS 1 June 2012 – 31 August 2012 Inpatients	HoPM																				DEL
6.7	Report on 1 December – 31 December 2012 NCPES of Inpatients	HoPM																				DEL
6.8	Report on 1st - 28th February 2013 NCPES of Inpatients	HoPM																				2013.14 plan
6.9	Report on 1st – 31th April 2013 NCPES of Inpatients	HoPM																				2013.14 plan
6.10	Interim report on ethnographic study 09.11.12	IC PERC																				DEL
6.11	Instant feedback to staff following quality rounds	TLCN																				DEL
6.12	Report on Staff survey	HoPM																				DEL
7	**COMMUNICATION & ENGAGEMENT**																					
7.1	Begin high profile programme of activities of cancer specialist team in clinical areas	TLCN/HoN CPG2																				DEL
7.2	Undertake improvement workshop to core MDT members on 9 Nov.	COO/TLCC/CPG2C																				DEL
7.3	Present NCS results to Senior Nurses at Back to the Floor	TLCN																				DEL
7.4	Meet with Oncology, Haematology and Specialist palliative care CNSs	TLCN																				DEL
7.5	MDT Leads to present long term action plans against tumour specific findings.	TLCC/TLCN																				2013.14 plan
7.6	Present NCPES overview at CEO Open Hour	CEO/HoPM																				DEL
7.7	Ibegin n Brief Weekly Cancer Thursday Message	HoPM																				DEL
8	**PATIENT INFORMATION & SUPPORT**																					
8.1	Provide all trust staff with new guidance on financial support	TLCN/IM																				DEL
8.2	Provide all trust staff with MDT (CNS) contact details.	TLCN																				DEL
8.3	Accelerate PIP Project Tto Breast and Colorectal pathways (Gynae and Lung com	IM																				DEL

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8.4	Submit Funding bid to MCS for a new Information service (pod) at HH	IM																				DEL
8.5	Install patient information Service (Pod) at HH site	IM																				DEL
8.6	Subit Funding bid to MCS for a patient information service at SMH site	IM																				2013.14 plan
8.7	Recruit to MCS MDT information project post (information prescription support)	IM																				DEL
8.8	Present Funding Bid to MCS for Band 6 Information Post	IM																				DEL
8.9	Increase access to Financial Advisor at CXH	HoN CPG2/IM																				DEL
8.10	Advertise for volunteer befrienders, supported, trained and recruited by MCS.	TLCN																				DEL
8.11	Begin to issue all patients with a MCS organizer & feedback letter	TLCN																				DEL
8.12	Increase attendance at Maggie's 'what next course?' after diagnosis.	TLCN																				DEL
8.13	Refurbish 6 North to existing plan (oncology Inpatients)	HoN CPG2/LNOnc																				DEL
8.14	Hold Briefing session with MCS Design team to refurbish 6 South	HoN CPG2/LNOnc																				DEL
8.15	Design workshop , staff and ICHT patients, chaired by MCS design team.	LNOnc																				DEL
8.16	Present feasibility report re 6 south to oncology inpatient refurb board	HoN CPG2/LNOnc																				DEL
8.17	Submit OBC complete with action plan and feasibility report	HoN CPG2																				DEL
8.18	Complete refurbishment of 6 South .	HoN CPG2																				DEL
8.19	Present delivery plan & CNS teaching program in cancer areas at Pex Steering group	TLCN																				DEL
8.20	Report options to PEX steering group for a single contact system to access all CNSs	TLCN																				DEL
8.21	Deliver Trust Survivorship strategy to CCPEB and TCB	TLCN																				DEL
9	**PATIENT INCLUSION**																					
9.1	Agree Cancer Collaborative ToR, individual CPG roles & meeting dates.	TLCN																				DEL
9.2	Initiate patient/carer interviews in chemotherapy units.	IC PERC																				DEL
9.3	Report patient feedback via CCPEB, I-Track, Patient interviews to Cancer Board	TLCN																				DEL
9.4	Present cancer patient inclusion strategy to Collaborative Cancer PEX Board.	TLCN																				DEL
9.5	Recruitment of patient or representative expected in December 2012.	TLCN																				DEL
9.6	Map patient partnership groups by tumour group.	TLCN																				DEL
9.7	Erect banner stands at key access points welcoming patient feedback	HoPM																				DEL
10	**EDUCATION & TRAINING**																					
10.1	Pilot ward based micro teaching - 20 minutes every lunch time for a week	TLCC/SPC CNS																				DEL
10.2	Deliver communication skills training in oncology wards and departments.	CNE Onc																				DEL
10.3	Implementation of the Macmillan VBS (7N, 6N, 6S, Dacie & Weston).	HoPM																				DEL
10.4	Present PEX KPIs for Breast, Gynae, urology, H&N and colorectal CNSS	TLCN																				DEL
10.5	Develop PEX KPIs for all other tumour site specific CNSs teams	TLCN																				DEL
10.6	Hosting the RMH Principles in cancer care course for non-cancer trained staff .	TLCN																				DEL
10.7	Hosting a repeat of RMH Principles in cancer care course for non-cancer trained staff .	TLCN																				DEL
10.8	All MDT core staff to receive advanced communication skills training	TLCC																				2013.14 plan
10.9	All ward staff in key areas to receive I Care training (hourly comfort rounding).	Pending lead																				DEL
10.10	Complete prioritization of "Influential Ambassador " for target cancer areas	ASS DO HR																				DEL
10.11	Increase number of chemotherapy nurses on nurse prescribers training program	LCN																				DEL
10.12	Sage and Thyme train the trainer training to lead Cancer nurses and CNS.	TLCN/ASS DO HR																				DEL

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11	**PATHWAY INTERVENTION**																					
11.1	Complete audit of oncology internal pathway; oncology OPD to ward or chemo. units.	HoN CPG2																				DEL
11.2	Implement planned re-design of 6 Floor Charing Cross, oncology inpatient services.	TLCC																				DEL
12	**GOVERNANCE**																					
12.1	Initiate weekly cancer patient experience turn-around meetings	DoN																				DEL
12.2	Implement new reporting structure in cancer.	COO																				DEL
12.3	Agreed accountability of TLCN against CWT & PEX performance by tumour site CNS	DoN																				DEL
12.4	Deliver progress report on to each Trust Cancer Board	TLCN																				DEL

Task Lead Key	
DoN	Director of Nursing
CPG 2 CD	Clinical Director, CPG 2
HoN CPG 2	Head of Nursing, CPG 2
HoN CPG 6	Head of Nursing, CPG 6
HoM	Head of Marketing
HoPM	Head of Programme Management, Nursing Directorate
IC PERC	Imperial College Patient Experience Research Centre
COO	Chief Operations Officer
LCN	Lead Chemotherapy Nurse
IM	Information Manager
LNOnc	Lead nurse oncology
CNE Onc	Clincial Nurse Educator, Oncology
TLCC	Dr Catherine Urch, Trust Lead Cancer Clinician
TLCM	Cathy Wybrow, Trust Lead Cancer Manager
TLCN	Sarah Gigg, Trust Lead Cancer Nurse
GG	Gareth Gwynn, Specialty Manager for Cancer
ASS DO HR	Assistant Director of HR

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Appendix B

Cancer Waiting Times Performance 2012-13

Updated: 21/11/2012

2012-13 Cancer Standards		M1 April 2012			M2 May 2012			M3 June 2012			M4 July 2012			M5 August 2012			M6 September 2012 (internal)			M6 September 2012 (OE)**		
Commitment	**Operational Standard**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	50	11.5	77.00%	67	25	77.00%	71	23.5	64.30%	89	38	57.30%	96	21	78.10%	55	13.5	75.68%	31	10	67.7%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%	7	2	71.43%	16	8	47.60%	12	1	93.50%	20	4	80.00%	13	3	76.90%	14	1	92.86%	4.5	0	100.0%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%	186	15	91.94%	218	26	89.10%	185	14	92.43%	237	28	88.19%	181	18	90.10%	135	13	90.37%	131	14	89.3%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%	45	0	100.00%	75	1	100.00%	59	4	92.70%	37	0	100.00%	34	1	97.10%	44	0	100.00%	40	0	100.0%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	39	6	84.62%	71	10	84.60%	41	4	89.70%	42	0	100.00%	47	9	80.90%	42	5	88.10%	39	5	87.2%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%	95	4	95.79%	124	1	95.80%	111	5	96.20%	154	8	94.81%	99	4	96.00%	84	2	97.62%	83	2	97.6%
All Cancer Two Week Wait	93%	685	54	92.12%	870	58	93.20%	699	48	93.60%	844	50	94.08%	850	46	94.60%	773	52	93.27%	293	15	94.9%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	270	33	87.78%	367	25	93.40%	252	30	88.00%	255	18	92.94%	299	36	88.00%	236	20	91.53%	233	20	91.4%
62-Day Wait For First Treatment From Consultant Upgrade	85% (Local performance target	8	2	75.00%	5	1.5	70.00%	3.5	1.5	85.71%	8.5	1	88.24%	7	1	85.70%	3	0.5	83.33%	4.5	0.5	88.9%

2012-13 Cancer Standards		M7 October 2012			M8 November 2012			M9 December 2012			M10 January 2013			M11 February 2013			M12 March 2013		
Commitment	**Operational Standard**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Total Patient Seen**	**Breaches**	**Pass/Fail**	**Expected Total Patients Seen**	**Breach Tolerance**	**Pass/Fail**	**Expected Total Patients Seen**	**Breach Tolerance**	**Pass/Fail**	**Expected Total Patients Seen**	**Breaches**	**Pass/Fail**
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	74.5	16	78.5%	61.5	14.5	76.40%	56.5	11.5	79.6	62	17.0	72.60%	55	15.5	74.00%	58	8	86.10%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%	12.5	1	92.0%	12.5	1.5	88.00%	23	4	82.6	14	1.0	92.90%	11	1	90.90%	18	0	100.00%
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%	176	10	94.3%	154	10	93.5%	161	4	97.5	177	1.0	96.00%	163	6	96.30%	164	3	98.20%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%	53	1	98.1%	37	0	100.00%	41	0	100.0	70	1.0	98.60%	71	1	98.60%	64	1	98.40%
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	40	1	97.5%	48	2	95.80%	29	0	100.0	42	2.0	95.20%	57	3	94.70%	55	3	94.50%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%	143	3	97.9%	124	1	99.20%	84	0	100.0	89	2.0	97.80%	64	2	96.90%	83	1	98.80%
All Cancer Two Week Wait	93%	852	60	93.0%	825	46	94.40%	722	49	93.2	736	51.0	93.10%	749	38	94.90%	875	54	93.80%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	305	30	92.0%	281	18	93.60%	265	15	94.3	293	20.0	93.10%	257	12	95.30%	307	17	94.50%
62-Day Wait For First Treatment From Consultant Upgrade	85% (Local performance target	7.5	1.5	80.0%	13	1	92.30%	9	0	100.0	10	0.0	100.00%	14	1.5	89.30%	18	1	94.40%

**Internal figures shown only to demonstrate true activity. The totals reported in OE are significantly lower as a result of the transcription error made with the September CWT upload. The correct September position has since been re-uploaded but the nationally reported totals will remain the same.

Numbers reflect those validated and published through *Open Exeter*

Note: July & August data was updated retrospectively on 5/11/12 following validation. Pre-validation data can be found on tab 6

Contents page

Imperial College Healthcare NHS
NHS Trust

Report of the AHSC Director, Professor David Taube

Academic Health Science Centre update

29th May 2013

1. AHSC Designation Process

The Department of Health, through NIHR, announced a new, open competition to designate AHSCs in England. Pre-Qualifying Questionnaires (PQQ) are invited from English NHS provider/university partnerships which can demonstrate strategic alignment of NHS provider and university objectives, the highest volume, critical mass and world-class excellence in basic medical research; the ability to translate discoveries from basic science into excellent translational, clinical and applied research; excellence in patient care and excellence in health education.

The designated AHSCs will not provide full national geographical coverage and need to be 'nested' within AHSNs, demonstrating working with local and national AHSNs. Applications need to demonstrate that the partnerships are of appropriate size and comprise the appropriate number of organisations to facilitate close working to deliver the aims of the AHSC.

This is a two stage process, starting with a PQQ to be submitted by the **31st May 2013.** The PQQ Short listing criteria comprises evidence in support of a high performing partnership against 5 criteria: volume, critical mass and world-class excellence in basic medical research, and the ability to translate findings from basic research into excellent translational, clinical and applied research across a range of interests; excellence in patient care, excellence in health education, strength of the strategy, strength and appropriateness of governance arrangements.

Shortlisted applicants will be asked to submit a full application by late September. The designation panel will carry out interviews in October/November with confirmation of selected AHSC by November/December. AHSC designation will commence April 2014 for 5 years.

2. Progress Report

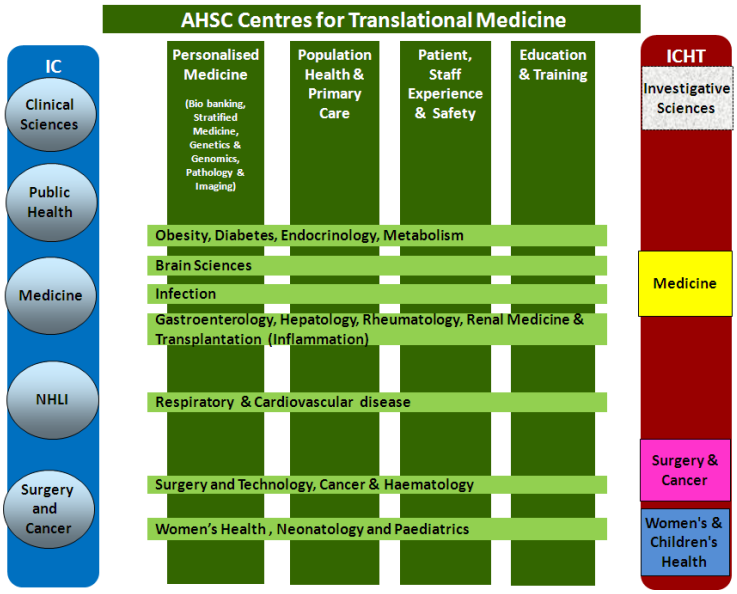
2.1. Launch of the Centres for Translational Medicine (CTMs)

Centres for Translational Medicine (CTMs) were launched on the 1st May at a successful event hosted by the AHSC Directorate. These are the AHSC Delivery Groups outlined in the Darzi review of the AHSC. They are largely developed around the well-established and funded, Biomedical Research Centre (BRC) themes. However, the CTMs will have a broader remit to allow for the consolidation of initiatives in service, education, innovation within the research theme/s to facilitate communication and partnerships. CTMs bring together the multi-professional teams to translate our strengths in discovery science through to the delivery of healthcare advances in patient care.

The remit of the CTMs is to set the local strategy and priorities to support the delivery of the AHSC objectives, to foster joint working and innovation between CTMS, to locally determine recommendations for awards and promotions and to put forward specialist or sub-speciality services they believe to be examples of flagship AHSC services, known as Programmes of Excellence described in 3.

There are a number of specific academic and clinical areas of interest that have relevance to all CTMs. These areas are 'cross cutting themes' and are essential enablers of AHSC success and include patient experience and safety, education and training, personalised medicine. Diagram 1 shows the configuration of CTMs and cross cutting themes. CTMS are led by Clinical Academics, thereby embodying the ethos of the AHSC. The appointments are in progress with Chairs to be announced by the end of May and the first meeting of the CTMs to occur by the end of June.

Diagram 1



2.2. Programmes of Excellence (PoE)

POEs are examples of AHSC flagships services delivering excellence across a range of measures such as clinical care, research, education and championing innovation and technology transfer. They are at speciality or sub – speciality level or based within a research, educational or technological specific area of expertise and are likely to be areas with strong national or international reputations and ability to influence the way in which academic healthcare is delivered. PoEs are awarded their status of distinction by an internal designation process based on a review of AHSC metrics.

3. Strategic Partnership Board (SPB)

Sir Gordon Duff, Florey Professor of Molecular Medicine at University of Sheffield, has been appointed as the independent Chair. The inaugural meeting will take place on the 24th May 2013.

4. Branding and Communications

The AHSC Directorate has established an agreement for communications services to be provided by the College communications Directorate. Sea Design has been commissioned to assist in developing the AHSC corporate identity and this will be launched with a revised AHSC website at the end of May.

Lead Director: Professor David Taube, AHSC Director

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD

Report Title: Executive Performance Report 2012/13 and Month 1 2013/14

To be presented by: Steve McManus, Chief Operating Officer

Executive Summary:

Please see attached reports for M1:

1. Executive Performance Report
2. Trust Board Performance Report

Legal Implications or Review Needed

a. Yes
b. **No** ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For Decision
b. For information/noting ✓

Executive Performance Report

Imperial College Healthcare NHS

Month 1 : April 2013 **Paper:**

Executive Summary

This report for the Trust Board summarises the Trust's Performance against key indicators. Accompanying this report is the Month 1 Trust Performance Scorecard which shows performance and monthly run-charts for all key indicators.

The Trust ended 2012/13 having achieved excellent performance in key areas. The Trust sustained good performance in the Quality Indicators such as Infection Control, Mortality, Stroke Care and reported no mixed sex accommodation breaches for the full year. The Trust also showed good improvement in the Referral to Treatment and Cancer standards with all Trust aggregate standards being achieved by the year end. The Trust showed good improvement in the 4-hour Accident & Emergency target throughout 2012/13 and achieved 97.24% year end position against the 95% threshold.

In April 2013 the Trust achieved good performance in:
- Achieving all eight cancer access standards (this relates to March 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
- Maintained position below the maximum trajectory for MRSA and Clostridium Difficile cases

Areas identified as underperforming are:
- There were 12 Trust attributed cases of C.difficule reported in April 2013, this is above the year to date trajectory of six cases. An action plan is in place to further minimise the level of infection.

Against the Department of Health 2012-13 Acute Trust Performance Framework The Trust continued to be defined as 'performing' . Against the Monitor Compliance Framework for February the Trust is now 'green' (0.0) as all performance indicators were achieved in April 2013.

Quality

Mortality 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 The experience scores for April 2013 show there has been a continued improvement on TC6 (decisions in care and treatment) and a small dip on TC7 (worries and fears) and TC8 (privacy). However, based on performance from 12/13, all questions remain on an upward improvement trajectory. In addition a new question has been added to the scorecard (TC15) "Were the nursing staff (midwives) caring and compassionate?". Initial performance on this question is very good Trust scoring 93.44 in month 1. A review of the Trust's patient experience scoring system is planned for 13/14.	**Scorecard Page 4**
Infection & Prevention Control In 2012/13 the Trust reported 8 cases of Trust acquired MRSA infection against a year end trajectory of 9 cases. For Clostridium Difficile there were a total of 86 reported and the Trust therefore remained within its trajectory to stay below the maximum 110 cases for the year. For 2013/2014 the DH has declared a zero tolerance for Trust attributable MRSA blood stream infections (MRSA BSI) for all acute Trusts and there is a threshold of 65 cases in year for Clostridium difficile (C.diffcile). There were zero cases of Trust acquired MRSA blood stream infections reported in April 2013. For C.difficile there were 12 Trust attributed cases reported in April 2013, this is above the year to date trajectory of six cases. The following additional actions are taking place to further minimise C.difficile infections: - Each case of C. difficile has a detailed case review undertaken to help understand the organism's prevalence and contributory factors for acquisition. This case review has now been extended to include an enhanced focus on prior antibiotic exposure and the prescribing. - The Trust diarrhoea and vomiting and C.difficile polices have been reviewed in light of recent revised guidance from Public Health England and the Infection Prevention Society and will be launched in May 2013. In particular, in line with national recommendations, the time to isolation for cases of suspected and confirmed infectious diarrhoea has been reduced from four hours to two hours. - An evaluation of the methods and available products for decontaminating commodes is being undertaken with a view to making this process simpler and more effective. - The Trust is working closely with other London Trusts at the Acute London Teaching Trusts Infection Control Forum to identify and share areas of best practice with regard to C. difficile.	**Scorecard Page 5**

Eliminating Mixed Sex Accommodation (EMSA) In April 2013 the Trust sustained the previous 12 months achievement of zero mixed sex accommodation breaches.	**Scorecard Page 6**
Stroke Care The Trust achieved above both national stroke care targets in April 2013. This performance has been sustained since the beginning of last financial year and the Trust expects this to be maintained.	**Scorecard Page 7**
Venous Thromboembolism risk assessments The Trust achieved above the threshold of 90% for the 12th consecutive month, achieving a score of 91.2% in March 2013. The threshold for 2013/14 has increased to 95%. In order to ensure achievement of the new target weekly VTE task force meetings were initiated in April 2013. The Trust has successfully achieved 95% in M1.	**Scorecard Page 8**
Research and Development The quarter four results reported by the Joint Research Office show enrolment of patients onto clinical trials increased 50% from the same period last year. This is significantly above the initial target of a 1% increase set by the Trust at the beginning of the year.	**Scorecard Page 9**
Safety Thermometer 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 96.7% of patients reported as 'harm free' in March 2013 and 94.01% in M1 of the new financial year.	**Scorecard Page 10**
Operations	
Accident & Emergency - 4 Hour maximum waiting time In Quarter 4 2012/13, ICHT performed above the London figure for Type 1 and all types of A&E attends. The year end position was 97.24% for all types 94.55% for Type 1 against a target of 95%. For April ICHT achieved A&E overall performance of 95.18%. April was challenged at the beginning of the month but recovered towards month end with the Trust achieving the national standard on 95%	**Scorecard Page 11**
Accident & Emergency - Clinical Quality Indicators We are still unable to run our integrated dashboard due to technical difficulties so these figures are for Type 1 attends only. Our main area of challenge is our time in department for admitted patients and we are continuing to work with our community partners with early supported discharge through the junction teams and we have also initiated a programme to boost weekend discharges with criteria for discharge being documented on Friday for follow up with the weekend teams, this has increased the number of patients able to be discharged over the weekend. Our ambulatory care plans are also progressing well and the facility at Charing Cross will be completed by the middle of June	**Scorecard Page 12**
Cancer Waiting times In April the cancer waiting time standards for March were published showing the Trust met all the 8 National Standards as well as the one local standard. This meant the Trust met it's trajectory and has now implemented the majority of the cancer remedial action plan initiatives. To ensure sustainability work continues on the redesigned pathways as well on a number of initiatives to improve patient experience going forward. Performance has improved steadily over the past six months and the team are pleased with progress. The focus and scrutiny on cancer performance will remain a high priority. Weekly meetings will continue to be held with the Chief Operating Officer and the cancer management team to track all patients on an active pathway to ensure that patients are treated within the target time and we bring breaches down to the absolute minimum. A paper updating on the remedial action plan will be presented at the May Trust Board meeting.	**Scorecard Page 13**
Elective Access - Referral to Treatment Over 2012/13, the Trust made substantial improvements to the delivery of the Referral to Treatment standards. Q4 was the first full quarter that the Trust has delivered against all aggregate measures following the reporting break. In 2013/14, the Trust will further strengthen the position with achieving all the measures at Treatment Function Code level by October 2013. The admitted performance for April was 91.27% against the 90% target for patients waiting less that 18 weeks on admitted pathways, 96.68% against the 95% target for patients waiting less than 18 weeks on non-admitted pathways and 95.04% against a target of 92% for patients waiting less than 18 weeks on incomplete pathways. The overall 'backlog' of admitted patients waiting over 18 weeks has reduced to 844. Out of the 57 treatment function codes that form part of the target regime, the trust is performing against 50. The outlying specialties are General Surgery, Urology and Trauma & Orthopaedics with trajectories and actions in place to improve performance in these areas. As part of the performance scrutiny of the referral to treatment targets, the backlog and size of the waiting list is now part of the Trust Board performance scorecard.	**Scorecard Page 14**

Diagnostic Waiting times The Trust maintained its year to date performance in March 2013 achieving over 99% performance. The Trust sustained this target in M1 2013/14.	**Scorecard Page 15**
Maternity 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 March 2013 and the same performance for April 2013.	**Scorecard Page 16**
Delayed Transfer of Care The Trust was below the 3.5% threshold for patients whose transfer of care was delayed in quarter three.	**Scorecard Page 17**
Quality, Innovation, Productivity and Prevention 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	
Progress against the Workforce key performance indicators are detailed in the Performance Report. In Q4 measures related to workforce turnover, vacancy rates and band and agency were all above plan. Linked to seasonal demand and capacity requirements this has placed additional pressures on to the workforce particularly at ward level. The Director of People and Organisational Development is leading work to prospectively manage recruitment to the workforce plan together with the Chief Operating Officer and Director of Nursing in order to support performance against these workforce measures. 2013-2014: The Workforce KPI's will become a main standing agenda item at the Senior HR Team Meetings (May 2013), held with the HR Business Partners, each month. Whereby, plans to improve performance against these key workforce KPI's will be presented and subsequent performance and progress monitored against those plans.	**Scorecard Page 19**
Workforce assurance tool	
The Workforce assurance tool is a monitoring tool that has been developed by the NHS Trust Development Authority. This encompasses 360 metrics that triangulate finance, workforce and activity data to enable the NTDA to gain assurance about quality and act as a reliable early warning sign of potential or actual failures in quality. From Month 2, the Trust Board will be provided with areas that are currently not performing well and over the next six months, further information will be provided on areas that the Trust is performing well. ICHT is one of the early adopters of the use of this tool and has been sighted as an exemplar Trust due to the depth of use and understanding compared with other Trusts and as such as been asked to be directly involved in the future development of the tool.	

Trust Board Performance Report
Report Period Month 1
(to end March 2013/14)

Trust Board on 29th May 2013

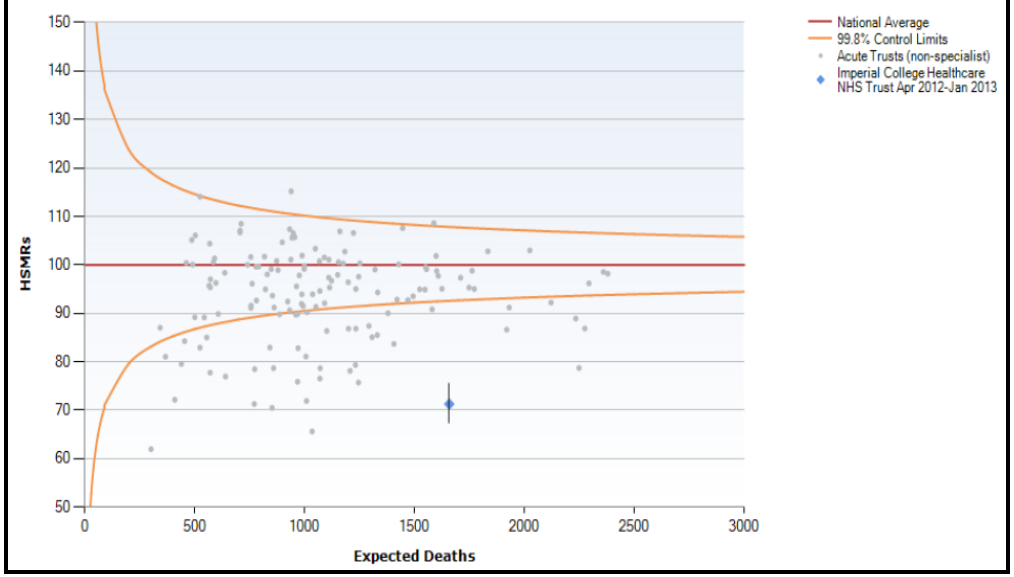
Contents

QLTY 1: Mortality - **Supports compliance with Care Quality Commission Outcome 4**

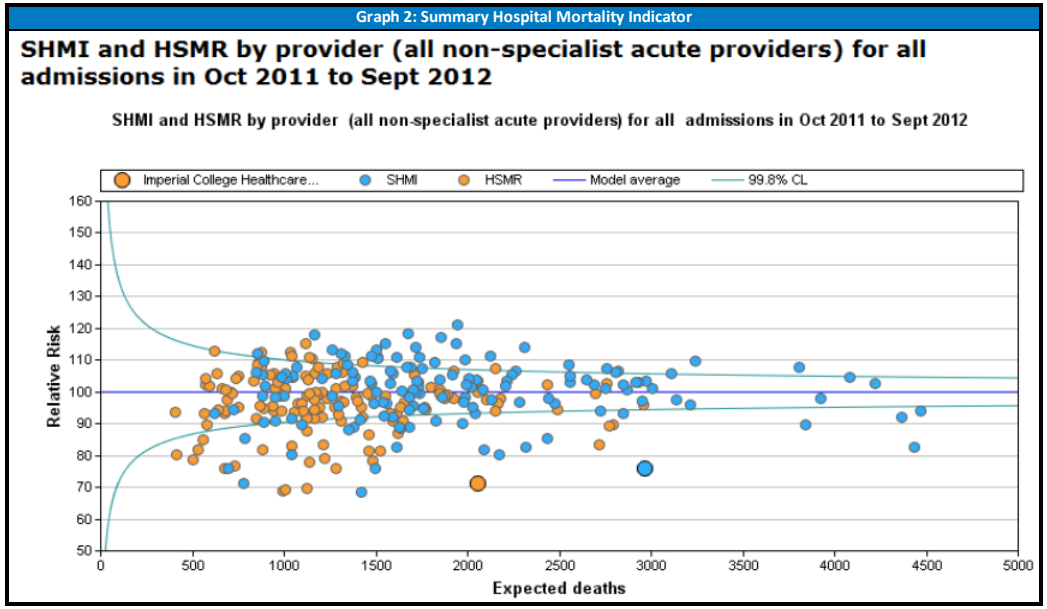
Domain	Indicator	National average	Unit	April - January 2013	Year to date
Mortality	Hospital Standardised Mortality Rate (HSMR) (*)	100	number	71	71

Indicator	National average	Unit	2011-12 Year end
Summary Hospital Mortality Indicator (SHMI)	100	number	75.8

Graph 1: Hospital Standardised Mortality Rate



Graph 2: Summary Hospital Mortality Indicator

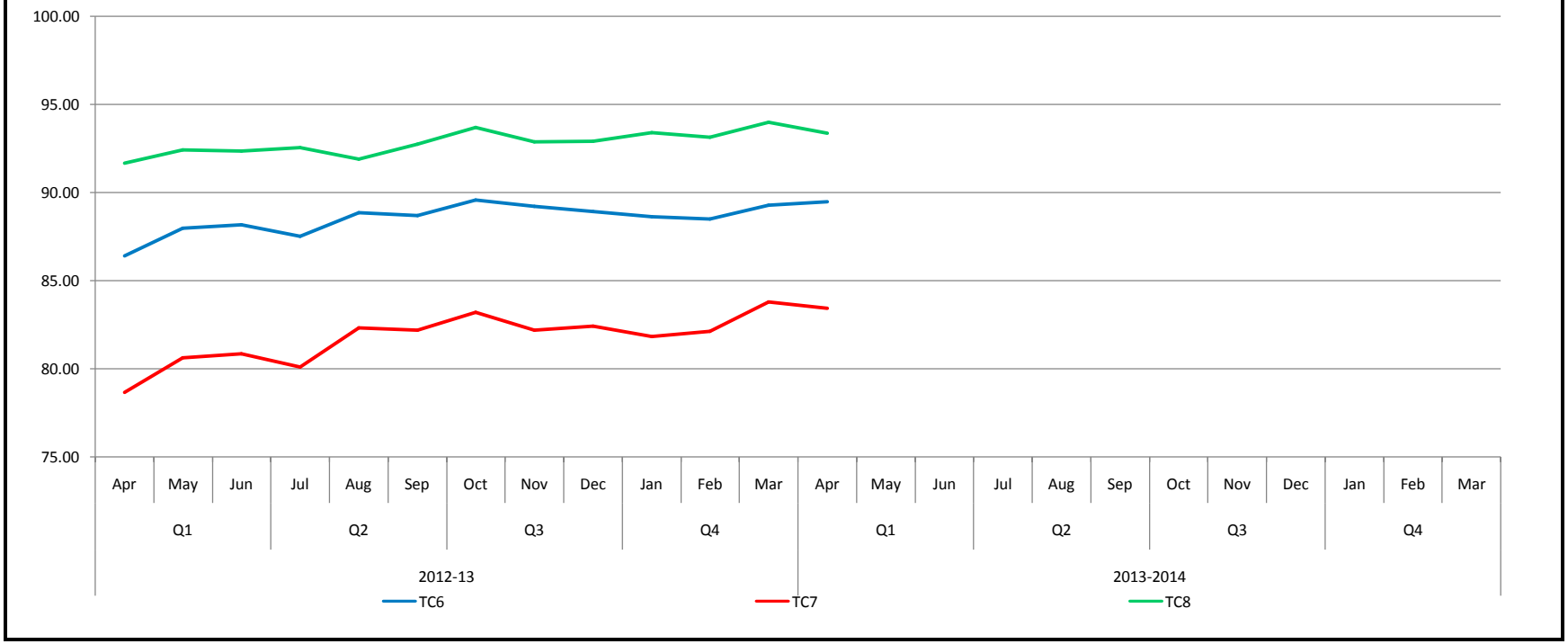


Source: Dr. Foster Intelligence

QLTY 2: Patient Experience - key questions from National Survey - **Supports compliance with Care Quality Commission Outcome 16 and 17**

Core Question	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
TC6: Were you involved as much as you wanted to be in decisions about your care and treatment?	89.5											
TC7: Did you find someone on the hospital staff to talk to about your worries and fears?	83.5											
TC8: Were you given enough privacy when discussing your condition or treatment?	93.4											

Graph 3: Patient Experience - key questions from National Survey by month

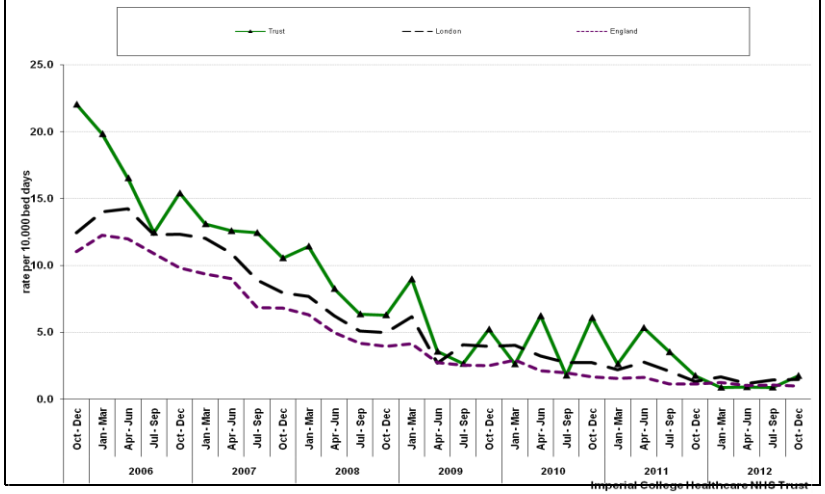


Source: iTrack

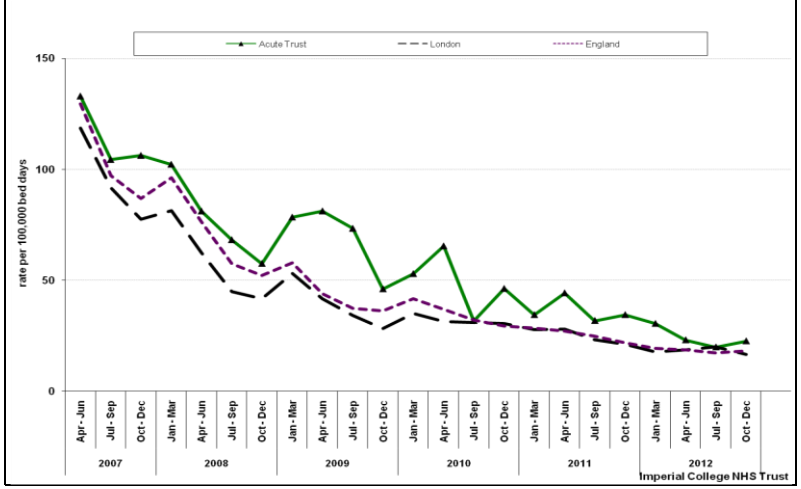
QLTY 3: Infection Prevention Control - NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 8

Domain	Indicator	Annual Trust Ceiling	Unit	Month 1		Year to date	
Infection Prevention and Control	Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream Infection (BSI) Bacteraemias	<=0	Cases	0	●	0	●
	Clostridium Difficile (C-Diff) post 72 Hours - Enzyme Immuno-Assays (EIA) - (Nationally Monitored)	<= 65	Cases	12	●	12	●

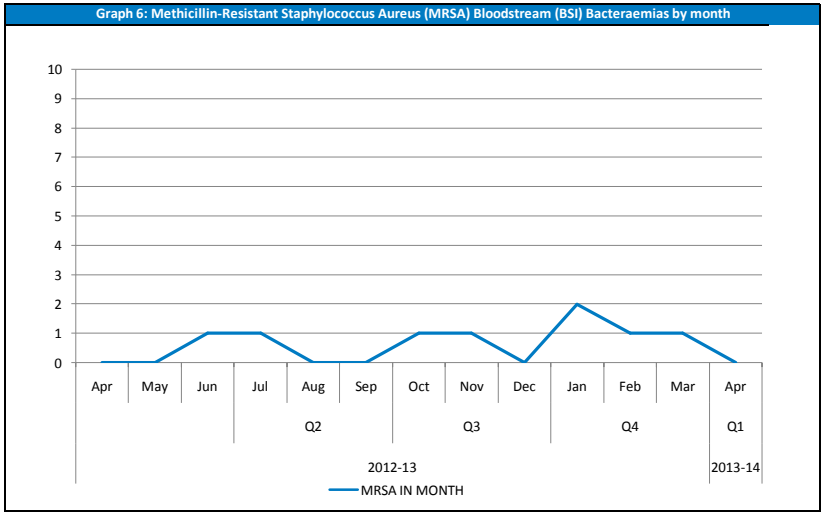
Graph 4:MRSA BSI/100 000 bed days at ICHNT compared to rates in London and England Trusts



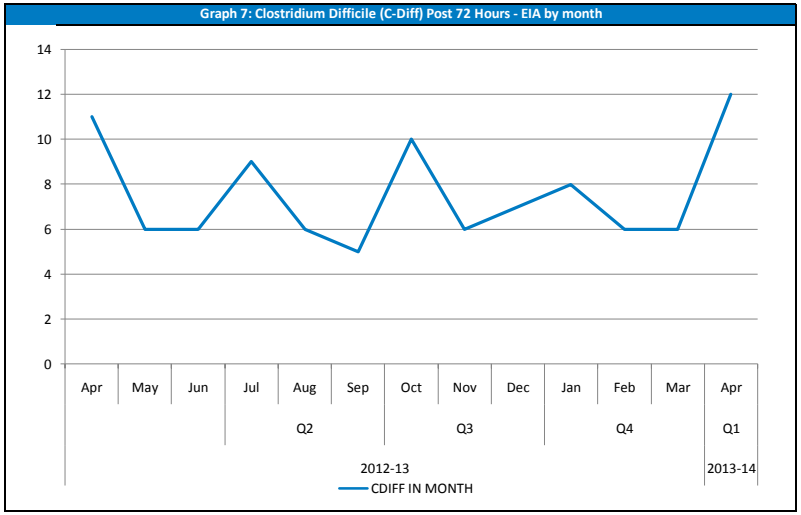
Graph 5: Clostridium Difficile cases/100 000 beddays at ICHNT compared with Trusts in London and England



Graph 6: Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream (BSI) Bacteraemias by month



Graph 7: Clostridium Difficile (C-Diff) Post 72 Hours - EIA by month

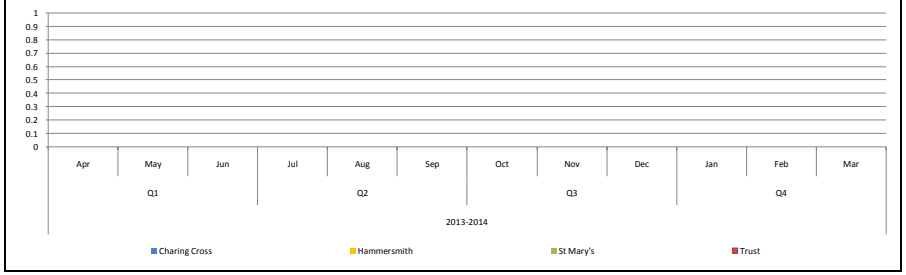


Source: Health Protection Agency & Infection Prevention Control Team

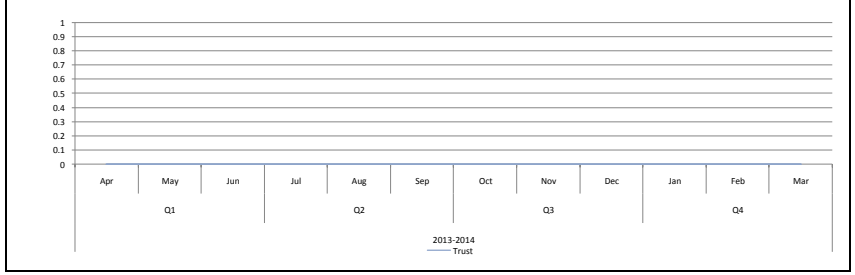
QLTY 4: Eliminating Mixed Sex Accommodation - EMSA - **NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 1		Year to date	
Eliminating Mixed Sex Accommodation	Trust - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Charing Cross- Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Hammersmith - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	St Mary's - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●

Graph 8: Number of monthly Non-Clinical/Unjustified Level 0/1 Beds



Graph 9: Trust Total Breach Days

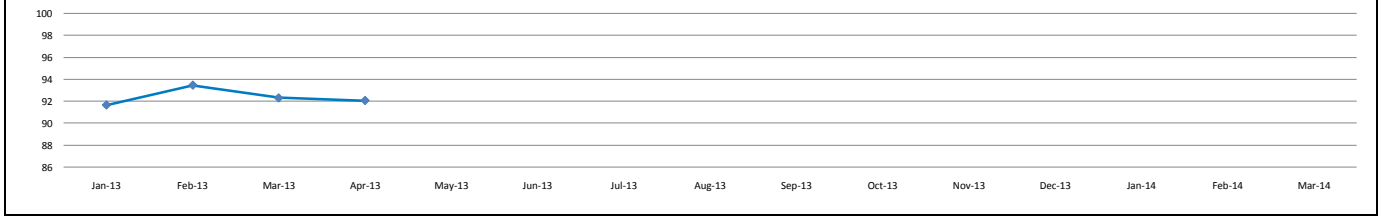


Source: Information Team

Patient experience (data take from iTrack - Trust's Patient Experience Tracking System)

		Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
TC3: When you were first admitted to a bed on this ward, did you share a sleeping area, for example a room or a bay, with patients of the opposite sex? This table shows the % of patients who thought that they did not share a sleeping area with a member of the opposite sex on admission.	Trust	92	93	92	92											

Graph 10 : Patient Experience Tracking System - TC3 by month

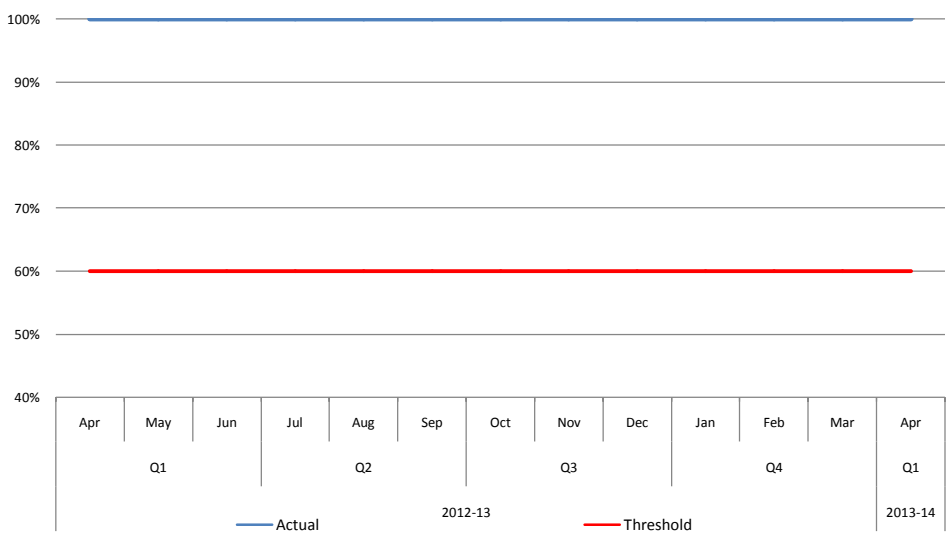


Source: iTrack

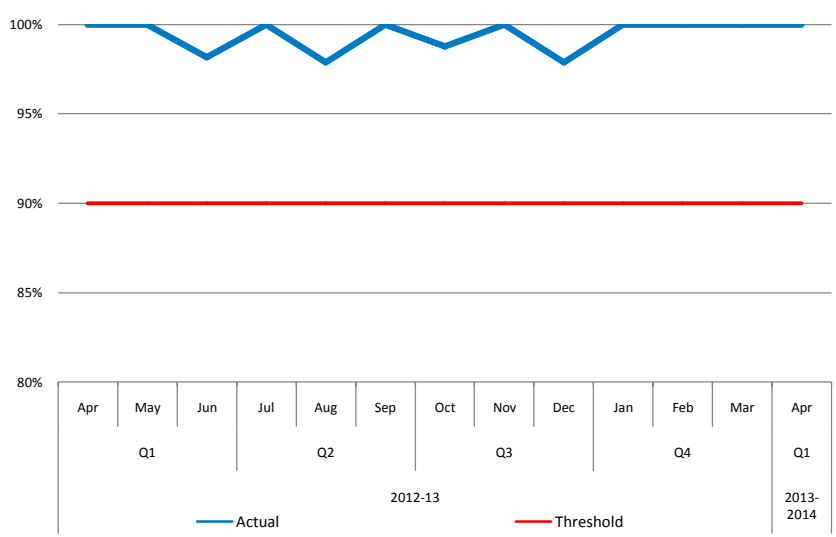
QLTY 5: Stroke Care - **Supports compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 1	Year to date
Stroke Care	Patients with high risk of Stroke who experience a TIA and are assessed and treated within 24 hours	60.0	%	100.0 ●	100.00 ●
	Patients who spend at least 90% of their time in hospital on a Stroke Unit	90.0	%	100.0 ●	100.0 ●

Graph 11: TIA patients assessed and treated within 24 hours



Graph 12: patients spending at least 90% of their time on a Stroke Ward

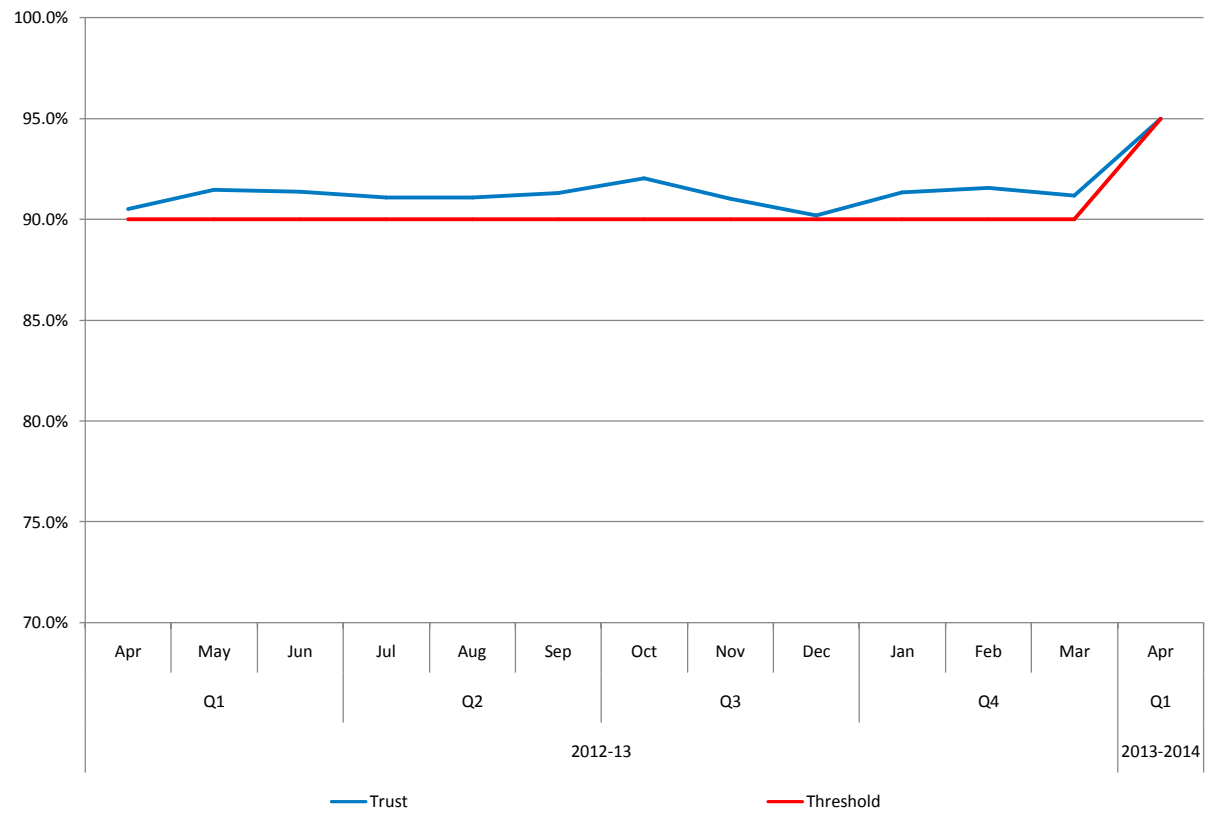


Source: Information Team

QLTY 6: Venous Thromboembolism - **NHS Performance Framework 2013/14 Indicator & Supporting Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 1	Year to date
Venous Thromboembolism (VTE) Risk Assessment	Adult Inpatients who have had a Venous Thromboembolism (VTE) Risk Assessment	95.0	%	95.00 ●	95.00 ●

Graph 13: Venous Thromboembolism (VTE) Risk Assessment - Monthly Performance

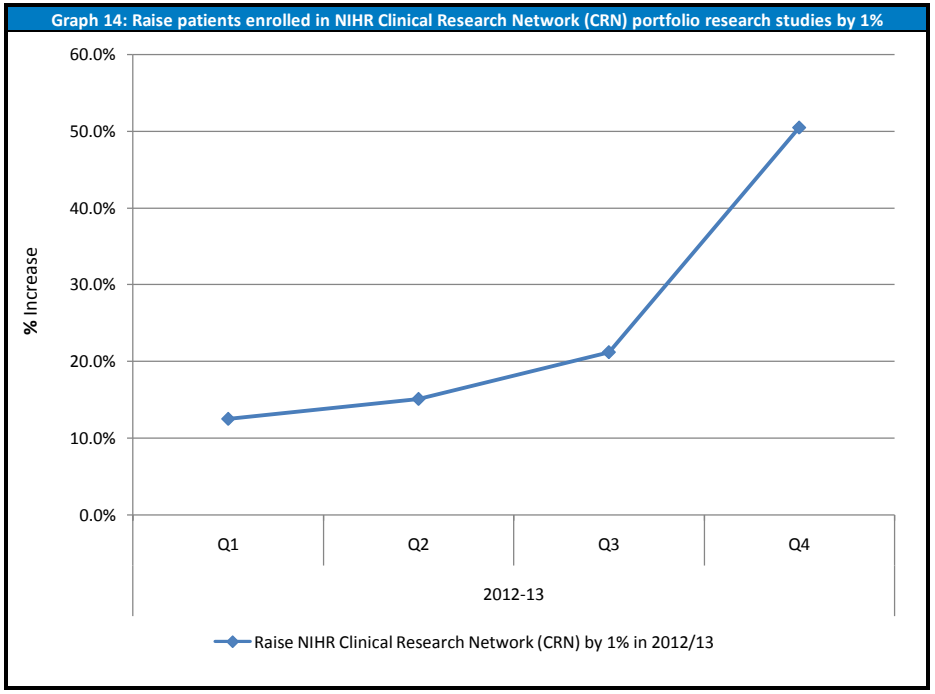


Source : Information Team

QLTY 7: Research & Development **- Supporting Compliance with Care Quality Commission Outcome 14**

Domain	Indicator	Target	Unit	Quarter 4	Year to date
Research & Development	Raise the proportion of patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%	Increase by 1% from 11/12	%	50.5 •	25.0 •

Graph 14: Raise patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%



Source: Joint Research Office

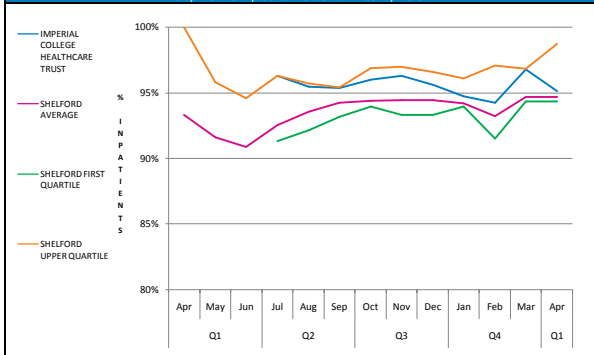
QLTY 8: Safety Thermometer - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 1	Year to date
Safety Thermometer	Harm free	-	%	94.01	94.01
	Pressure Ulcers - All	-	Number	44	44
	Pressure Ulcers - New	-	Number	10	10
	Falls with Harm	-	Number	4	4
	Catheter's & UTI	-	Number	11	11
	Catheter's & New UTI	-	Number	7	7
	New VTE's	-	Number	0	0

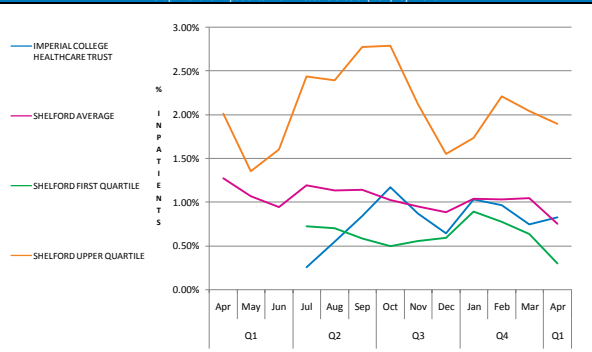
(*) - The Safety Thermometer is based on a point prevalence survey exacted the first Wednesday of each month

(**) Graph data unavailable for M12

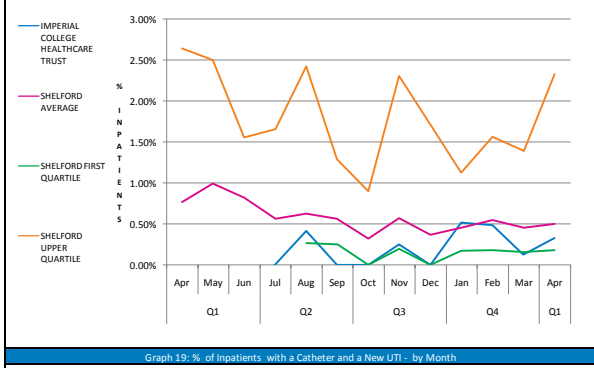
Graph 15: % of Inpatients who are Harm Free - by Month



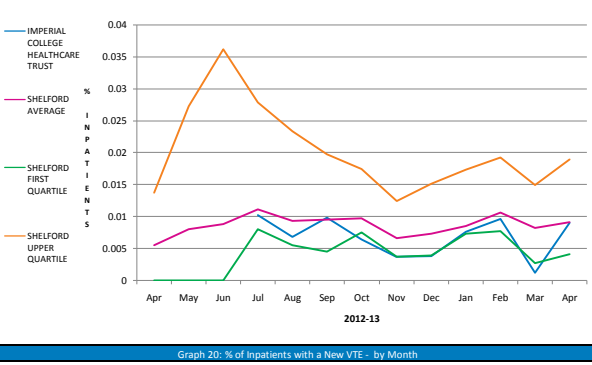
Graph 16: % of Inpatients with Pressure Ulcers (New)- by Month



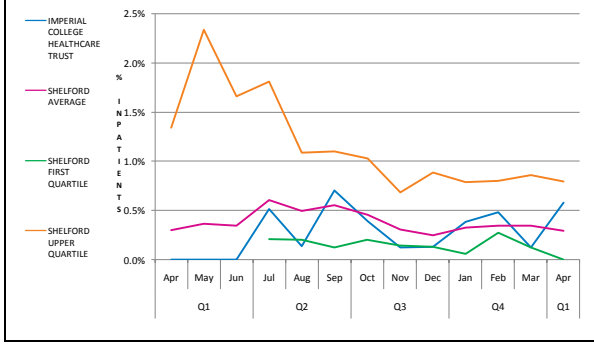
Graph 17: % of Inpatients with Harm Falls - by Month



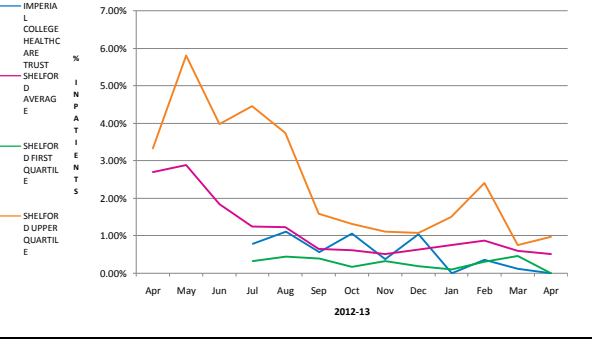
Graph 18: % of Inpatients with a Catheter and UTI (old and new) - by Month



Graph 19: % of Inpatients with a Catheter and a New UTI - by Month



Graph 20: % of Inpatients with a New VTE - by Month



OPS 1: Accident & Emergency - 4 hour maximum waiting time - **NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Site and type		Threshold	Month 1		Year to date	
4 hour maximum waiting time In Accident & Emergency	Trust	All (Type 1,2,3)	95.0%	95.2%	●	95.2%	●
	Trust	Type 1	95.0%	90.2%	●	90.2%	●
	Hammersmith	Type (1,2,3)	95.0%	95.2%	●	95.2%	●
	Charing Cross	Type (1,2,3)	95.0%	93.1%	●	93.1%	●
	St Mary's	Type (1,2,3)	95.0%	96.3%	●	96.3%	●
	Hammersmith	Type 1	95.0%	88.9%	●	88.9%	●
	Charing Cross	Type 1	95.0%	84.4%	●	84.4%	●
	St Mary's	Type 1	95.0%	93.2%	●	93.2%	●
London Ambulance Service (LAS) Handover	London Ambulance Service Patient Handover - within 60 Minutes		100%	100%	●	100%	●
	London Ambulance Service Patient Handover - within 30 Minutes		95.0%	98.0%	●	98.0%	●
	London Ambulance Service Patient Handover - within 15 Minutes		85.0%	92.1%	●	92.1%	●
	London Ambulance Service Breaches Handover > 60 Min		0	0	●	0	●

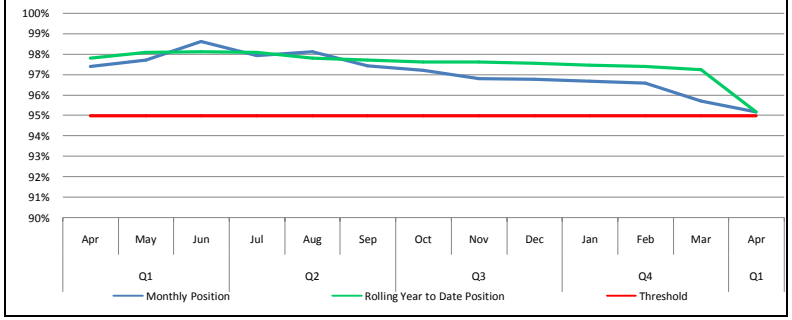
Key

Type 1 = A consultant led 24 hour service with full resuscitation facilities (known previously as 'Majors') ie those patients who attend the main emergency departments across all 3 sites

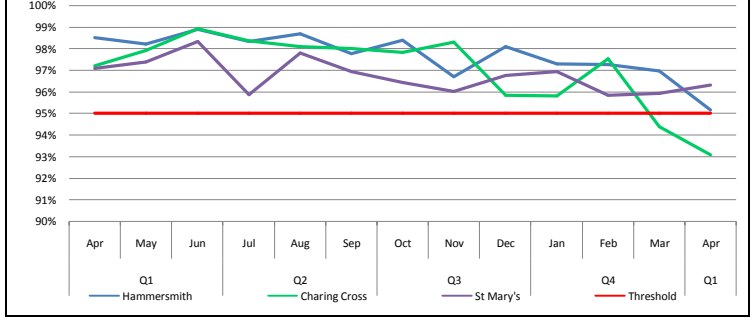
Type 2 = A consultant led single specialty accident and emergency service ie Western Eye for Ophthalmology patients

Type 3 = Other type of A&E/minor injury units (MIUs), Urgent Care Centre. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community

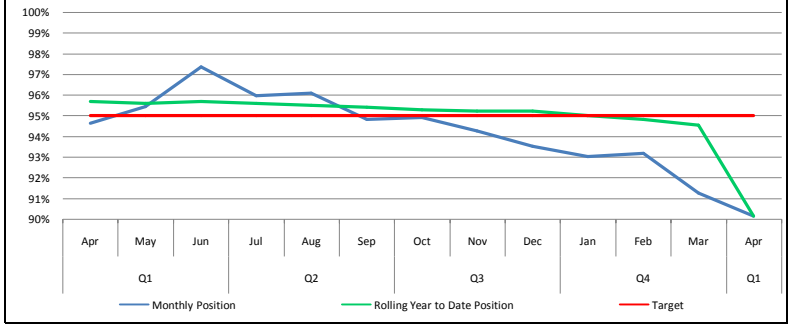
Graph 21: Total ICHNT performance (monthly and rolling YtD positions)



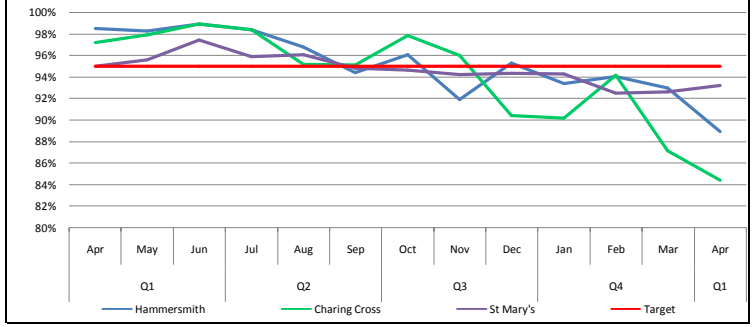
Graph 22: Site performance by All (Type 1,2,3) (monthly positions)



Graph 23: Total ICHNT performance Type 1 only (monthly and rolling YtD positions)



Graph 24: Site performance by Type 1 only (monthly positions)



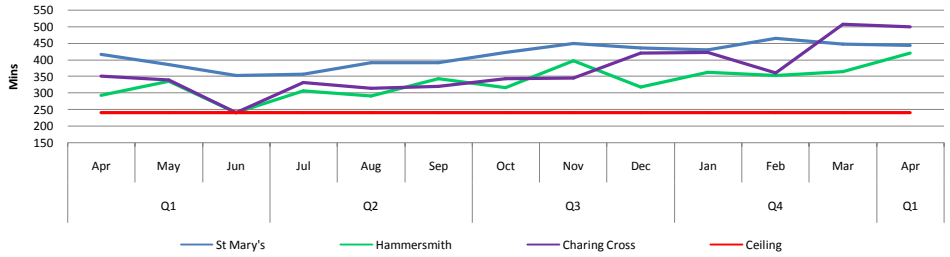
Source: Emergency Medicine

OPS 2: Accident & Emergency - Quality Indicators - **Supports Compliance with Care Quality Commission Outcome 4**

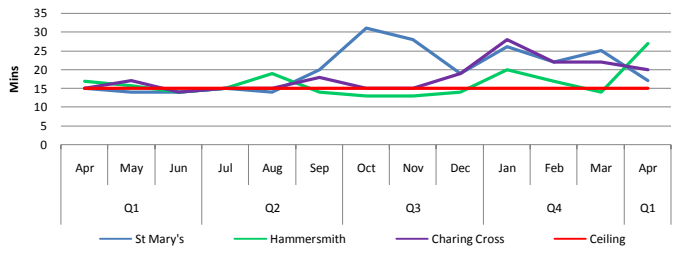
Domain	Indicator	Ceiling	Unit	St Mary's Month 1	St Mary's Year to date	Hammersmith Month 1	Hammersmith Year to date	Charing Cross Month 1	Charing Cross Year to date
Accident & Emergency - Quality Indicators	**Unplanned re-attendance at A&E within 7 days (*)**	5	%	N/A	N/A	N/A	N/A	N/A	N/A
	Total time spent in A&E								
	Admitted - 95th Percentile	240	Minutes	444 ●	444 ●	420 ●	420 ●	499 ●	499 ●
	Non-Admitted - 95th Percentile	240	Minutes	239 ●	239 ●	317 ●	317 ●	324 ●	324 ●
	Left Department Without Being Seen Rate	5	%	2.73% ●	2.73% ●	0.06% ●	0.06% ●	0.87% ●	0.87% ●
	Time To Initial Assessment (ambulance cases only)								
	95th Percentile	15	Minutes	17 ●	17 ●	27 ●	27 ●	20 ●	20 ●
	Time To Treatment In Department								
	Median Time	60	Minutes	71 ●	71 ●	59 ●	59 ●	45 ●	45 ●

(*) Data for this indicator was not available at time of publication.

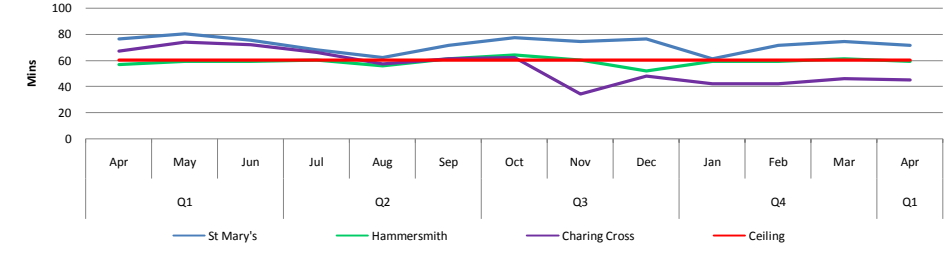
Graph 25: Total time in A&E (Admitted 95th Percentile)



Graph 26: Time to Initial Assessment (95th Percentile)



Graph 27: Time to Treatment in Department (Median)



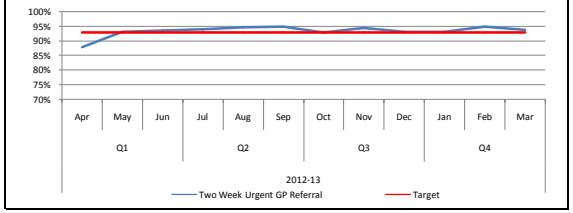
Source: Emergency Medicine

OPS 3: Elective Access - Cancer Waiting Times - NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4

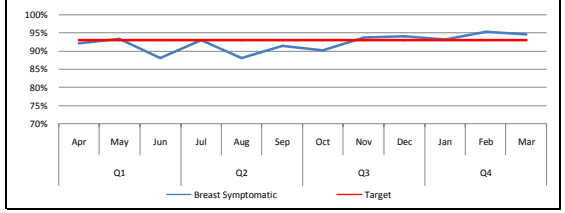
Domain	Indicator	Target	Unit	Month 12		Year to date	
Elective Access - Cancer Waiting Times (*) (**)	All Cancer two week wait	93	%	93.8	●	93.60	●
	Two week GP referral to 1st outpatient - Breast Symptoms	93	%	94.5	●	92.10	●
	First Definitive Treatment within one month (31 days) of a Cancer Diagnosis	96	%	98.2	●	92.90	●
	31 day Standard to Subsequent Cancer Treatments - Surgery	94	%	94.5	●	92.20	●
	31 day second or sebsequent treatment - Drug	98	%	98.4	●	98.40	●
	Proportion of patients waiting no more than 31 days for second or subsequent cancer Treatment - Radiotherapy Treatment	94	%	98.8	●	97.30	●
	All Cancer Two Month Urgent Referral to Treatment wait	85	%	86.1	●	70.80	●
	62-Day wait for First Treatment following referral from an NHS Cancer Screening Service	90	%	100.0	●	83.50	●

* Cancer data reported one month in arrears as shown on Open Exeter

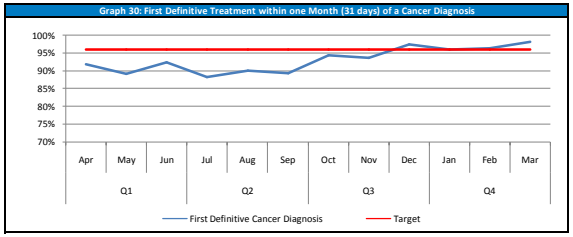
Graph 28: All Cancer two week wait



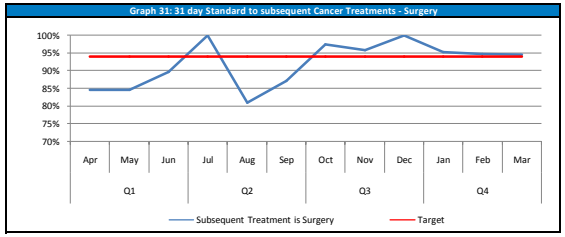
Graph 29:Two Weeks of an Urgent Referral for Breast Symptoms



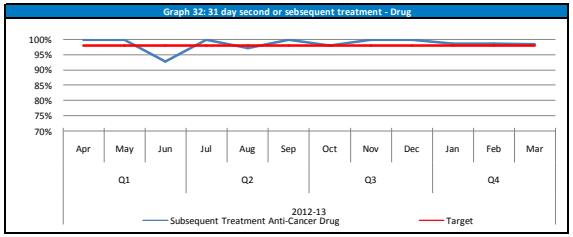
Graph 30: First Definitive Treatment within one Month (31 days) of a Cancer Diagnosis



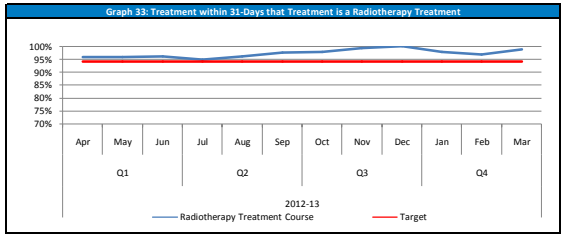
Graph 31: 31 day Standard to subsequent Cancer Treatments - Surgery



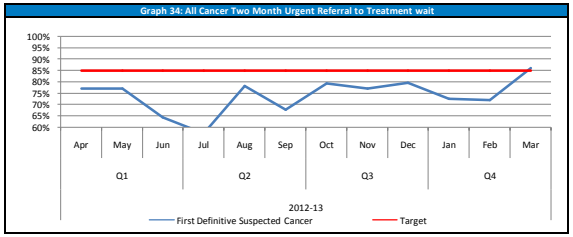
Graph 32: 31 day second or sebsequent treatment - Drug



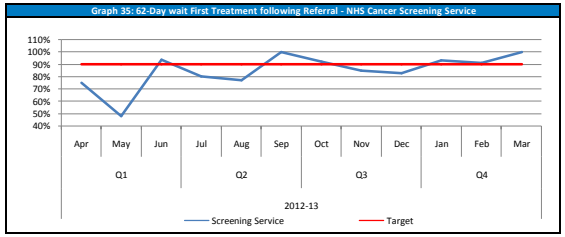
Graph 33: Treatment within 31-Days that Treatment is a Radiotherapy Treatment



Graph 34: All Cancer Two Month Urgent Referral to Treatment wait



Graph 35: 62-Day wait First Treatment following Referral - NHS Cancer Screening Service



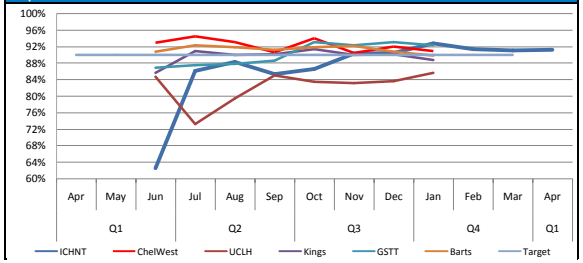
Source: Cancer Services

OPS 4: Elective Access - Referral To Treatment - **NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

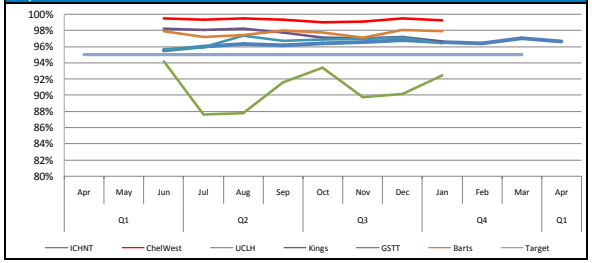
Domain	Indicator	Threshold	Unit	Month 1		Treatment Functions Not Achieving Target M1
Elective Access - Referral To Treatment	Total number of completed Admitted pathways - waiting 18 weeks or less	90.0	%	91.27	•	3
	Total number of completed Non-Admitted pathways - waiting 18 weeks or less	95.0	%	96.68	•	2
	Incomplete pathways where patients waiting less than 18 weeks	92.0	%	95.04	•	2
	Number of Treatment functions where standards are not delivered (admitted, non-admitted and incomplete pathways)	<=20	Number			7

* London Peer comparison not available from Department of Health at time of publishing

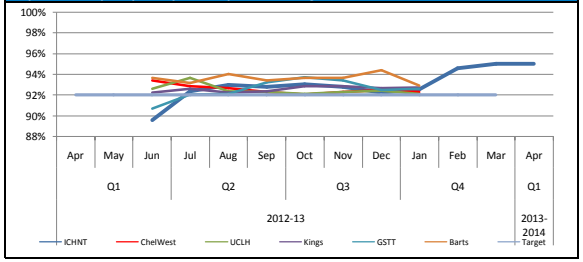
Graph 36: Patients Seen Within 18 Weeks For Admitted Treatment



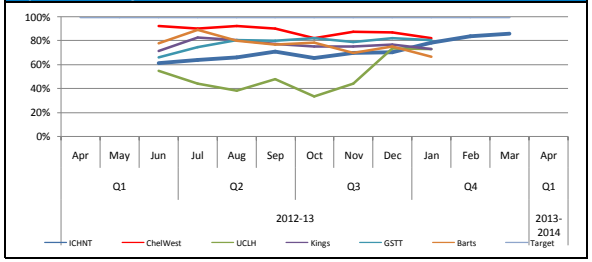
Graph 37: Patients Seen Within 18 Weeks For Non-Admitted Treatment



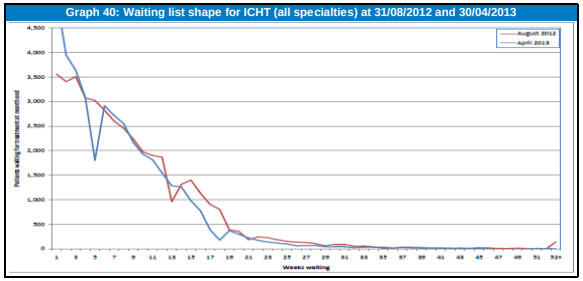
Graph 38: Incomplete pathways where patients waiting less than 18 weeks



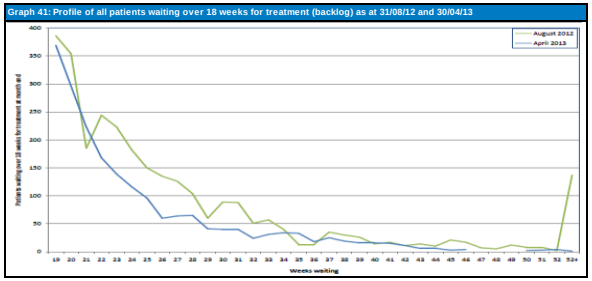
Graph 39: % Achieving TFCs



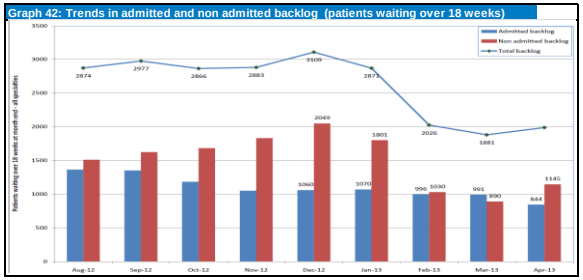
Graph 40: Waiting list shape for ICHT (all specialties) at 31/08/2012 and 30/04/2013



Graph 41: Profile of all patients waiting over 18 weeks for treatment (backlog) as at 31/08/12 and 30/04/13



Graph 42: Trends in admitted and non admitted backlog (patients waiting over 18 weeks)

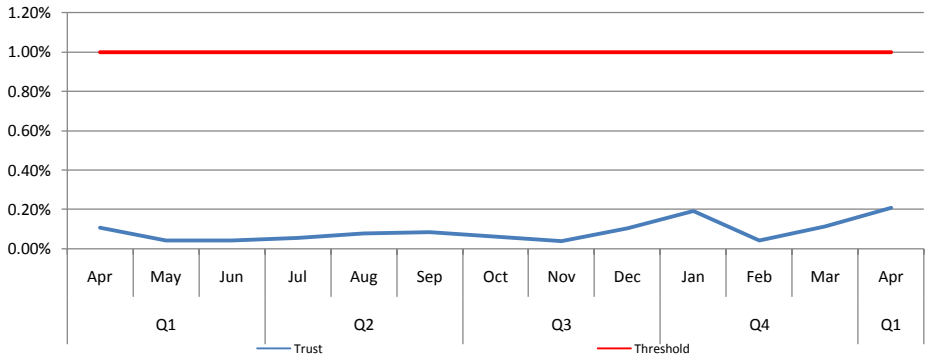


Source: Department of Health

OPS 5: Elective Access - Diagnostics - **NHS Performance Framework 2013/14 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 1	Year to date
Elective Access - Diagnostics	Patients waiting 6 weeks or more for a diagnostic test	<1	%	0.21 ●	0.21 ●

Graph 43: Patients waiting 6 weeks or more for a Diagnostic Test



Source: Information Team

Diagnostic waiting list and Breaches waiting more than 6 weeks

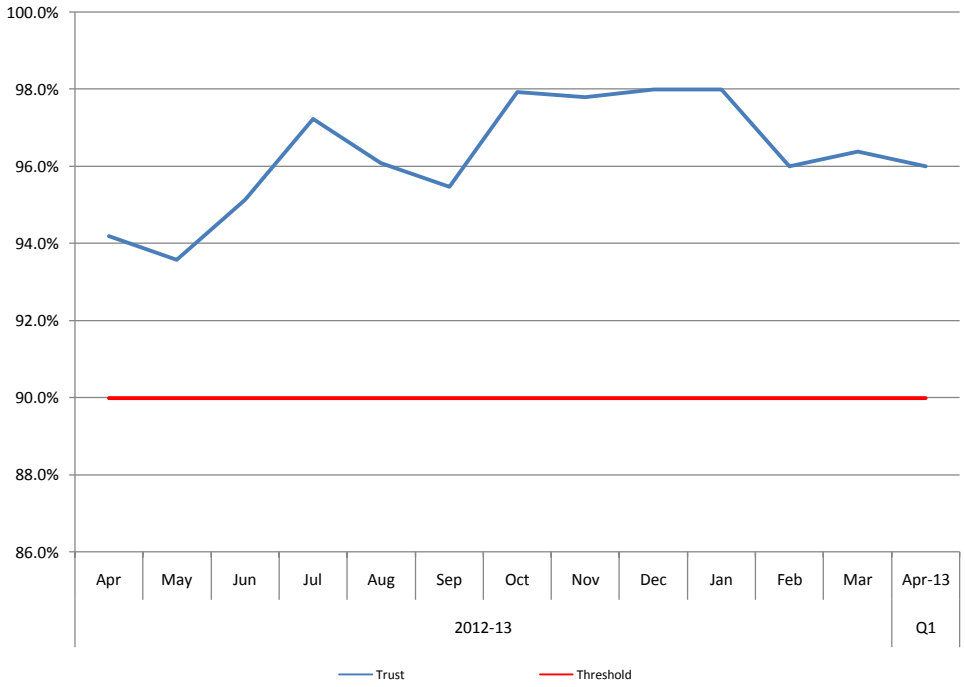
April		May		June		July		August		September	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
8576	18										

October		November		December		January		February		March	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches

OPS 6: Maternity - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 1	Year to Date
Maternity access - by 12 weeks and 6 days	Women who have seen a Midwife by 12 weeks And 6 days of pregnancy who were referred on time	90.0	%	96.00 ●	96.00 ●

Graph 44: Percentage of women seen on time per month.

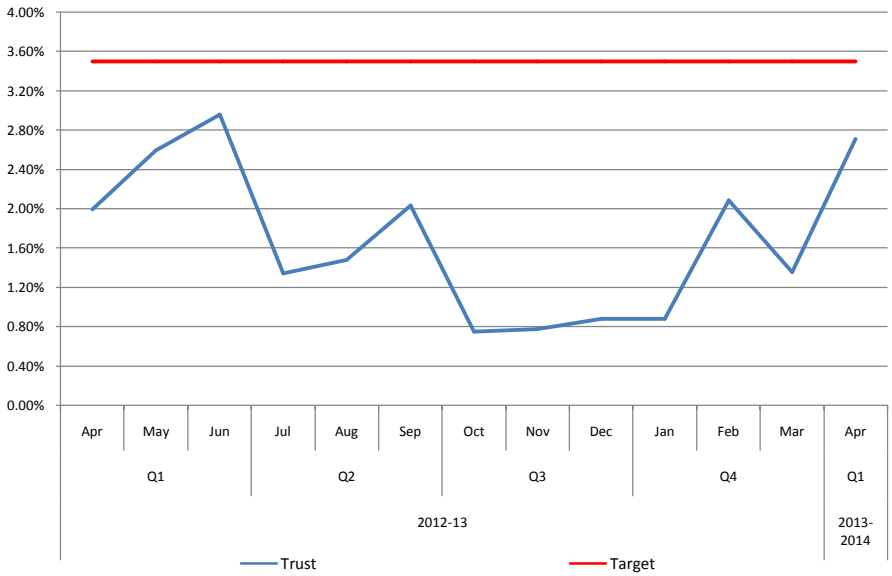


Source: Information Team

OPS 7: Delayed Transfer of Care - **NHS Performance Framework 2013/14 Indicator & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Quarter 1	Year to date
Delayed Transfer of Care	Average number of Acute patients (aged 18+) per day whose transfer of care was delayed (*)	3.5	%	2.71 •	2.71 •

ents whose transfer was delayed by month

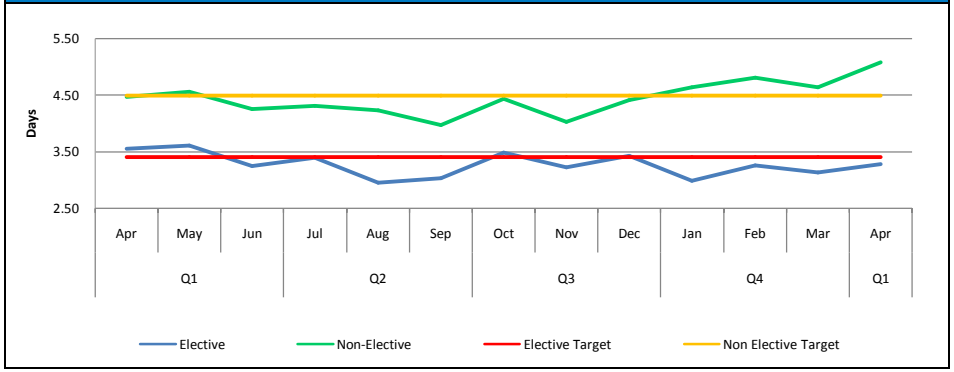


Source: Discharge Team, Clinical Site Management Team & Information Team

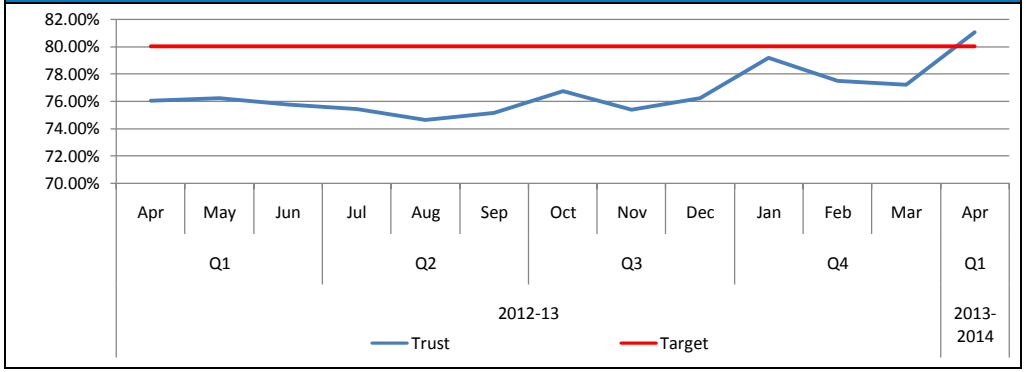
OPS 8: Quality, Innovation, Productivity and Prevention - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Target	Unit	Month 1	Year to date
Productivity	Average Elective Length of Stay	3.40	Days	3.28 ●	3.28 ●
	Average Non-Elective Length of Stay	4.49	Days	5.08 ●	5.08 ●
	Daycase Rate	80.0	%	81.03 ●	81.03 ●
	New to Follow Up Outpatient Ratio	1.67	Ratio	2.69 ●	2.69 ●
	Theatre Utilisation Rate	>= 81	%	79.11 ●	79.11 ●

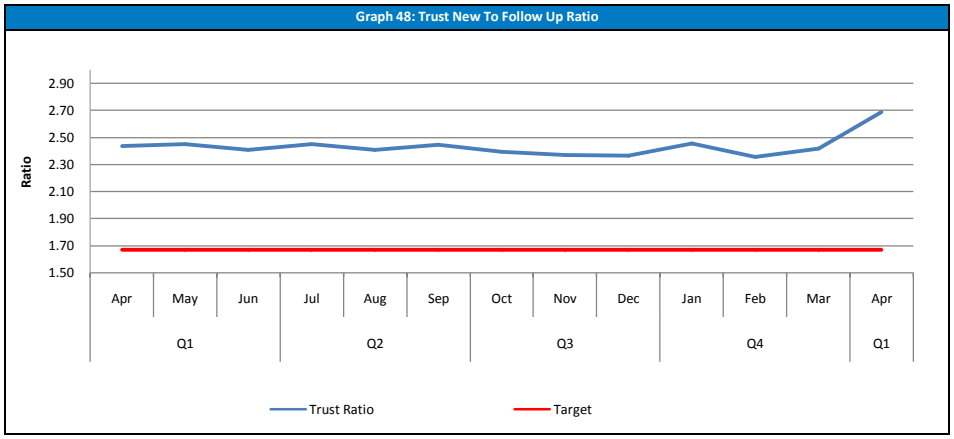
Graph 46: Trust Average Length Of Stay



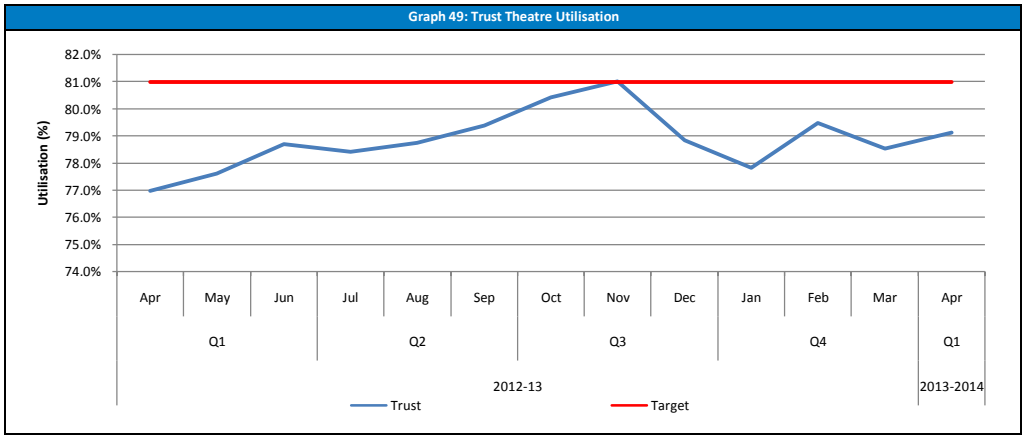
Graph 47: Trust Daycase Rate



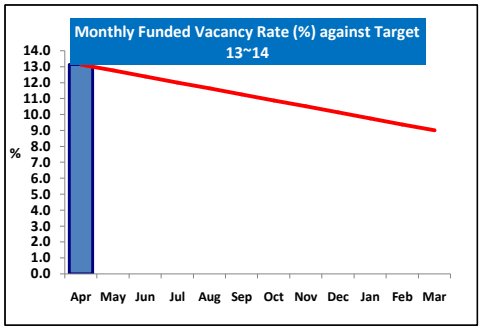
Graph 48: Trust New To Follow Up Ratio



Graph 49: Trust Theatre Utilisation

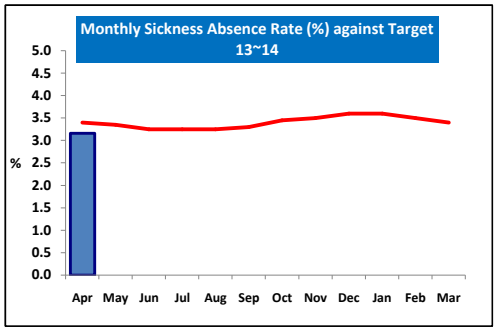


Source: Information Team, Finance Team & Theatre's Team



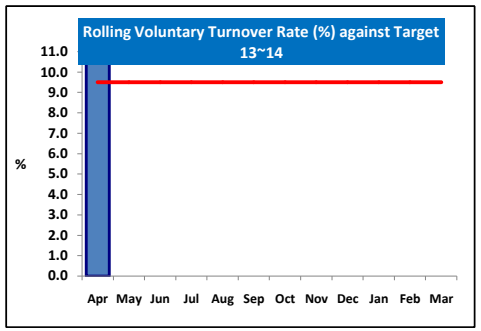
VACANCY RATE TARGET (YEAR-END)	<9.00%	
Current in-month POSITION against ta	13.13%	●

% of ESR post WTE that is vacant (ESR post WTE minus staff inpost WTE)



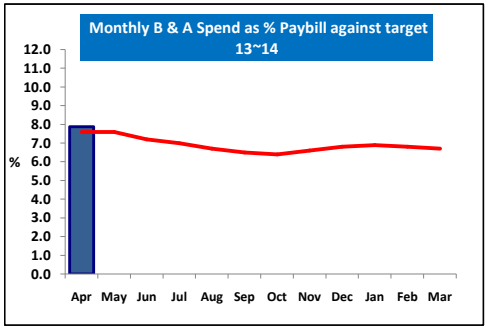
SICKNESS RATE TARGET (YEAR-END)	<3.40%	
CURRENT in-month POSITION against targe	3.16%	●
12 Month Rolling POSITION	3.54%	●

% of contracted working hours lost to sickness



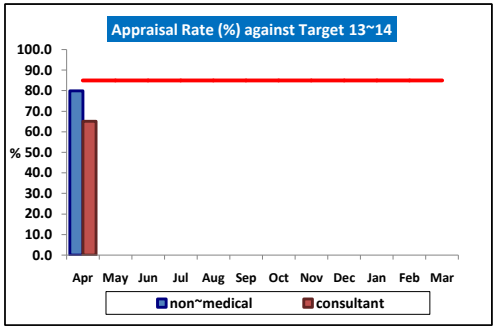
TURNOVER RATE TARGET (YEAR-END)	<9.50%	
12 Month Rolling POSITION against target	10.55%	●

voluntary leavers as % of workforce(average headcount) over 12-month period



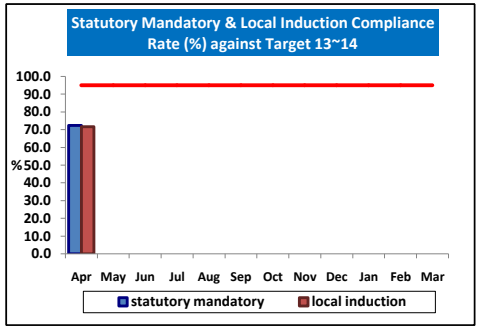
B&A SPEND as% PAYBILL TARGET (YEA	<7.0%	
CURRENT in-month POSITION against	7.88%	●
12 Month Rolling POSITION	7.73%	●

% of total paybill attributable to bank and agency spend



APPRAISAL RATE TARGET (YEAR-END)	>85.00%	
NON~MEDICAL STAFF ~ CURRENT POSITIOI	80.03%	●
CONSULTANT APPRAISAL ~ CURRENT POSIT	65.14%	●

% of current staff who have had an appraisal in the last 12 months



COMPLIANCE RATE TARGET	>95.00	
STATUTORY MANDATORY ~ CURRENT POSI	72.41%	●
LOCAL INDUCTION ~ CURRENT POSITION	71.56%	●

% of current staff with compliant with statutory mandatory training requirement
% of current staff, who joined in last 12 mths, with a local induction recorded

Staff Numbers: Substantively employed staff numbers, at the end of April, was 8665 WTE. This is 5.47WTE less than at the end of March with more marked changes seen within staff groups; A&C reducing by 19 WTE and Nursing increase by 19 WTE. CIP Plans for 13/14 (March 2013) have identified a total of 171 WTE substantive staff reductions as well as a further 175 WTE reduction in bank and agency staffing numbers.

Vacancy: Using the post establishment held on ESR, there was a vacancy rate of 13.1%; the equivalent of 1,310 WTE postitions. Forecasting of staffing demand is currently being undertaken within the CPG and Corporate Directorates and work to align the ESR post establishment with these forecast plans will be follow.

Sickness: Recorded sickness absence continued to decrease in April from 3.36 to 3.16%; April sickness was the equivalent of 275 WTE. Of the recorded sickness in April, 23% was attributable to long-term illness. The Trust target for sickness in 13/14 is 3.40%; a reduction of 5% in recorded sickness absence is required to achieve this across the year.

Turnover: During April there were 82 voluntary leavers bringing the 12-month rolling turnover rate to 10.55%. Within staff groups, this rate varies from 8 to 30% and detailed analysis work has begun to understand the reasons for high turnover action to reduce this where appropriate.

Bank & Agency Spend: During April, bank and agency spend accounted for 7.88% of total pay expenditure. This brings the 12-month rolling position to 7.88% against a target of 7.0%.

Appraisal: Non-medical appraisals across the Trust are below the 85% target at 80%, direct action and monitoring of manager performance against this key indicator is being enabled by Corporate HR. Consultant appraisal is at 65% with no real change over the past few months, revalidation and the requirement for consecutive appraisal recording to enable revalidation should see this metric improve.

Statutory Mandatory & Local Induction: Both Statutory Mandatory and Local Induction training metrics are currently underperforming. A number of actions including expansion of e-learning training modules, marketing campaign aimed at managers for pro-active booking of staff onto training and progress updates at the CPG Performance Reviews, will aim to improve compliance with these metrics.

* the figures and information contained in this analysis relates to CPG/Corporate/Private Patients only

Imperial College Healthcare NHS Trust

FINANCE REPORT - MARCH 2013

Report Title: Finance Performance Report

To be presented by: Bill Shields, Chief Financial Officer

Chief Financial Officer's message:
The Trust has achieved an unaudited surplus of £9,025k at the end of March, a favourable variance against the plan of £8,525k. This demonstrates the continued improvement the Trust has made and needs to be sustained into 2013/14 in order to deliver the financial plan.

The outturn for the year was in line with that agreed with NHS London after a number of technical accounting adjustments. The surplus to date has been achieved by the over-achievement of the cost improvement plan, which delivered £54,144k in year savings, £2,004k more than the plan requires and also through cost controls allowing for the release of the contingency set aside at the beginning of the year. The Trust has also paid off one of its Department of Health capital loans due to the improved cash position, which has a resulting positive impact upon expenditure in future years.

Key Issues for discussion:

Legal Implications or Review Needed

a. Yes	☐
b. No	✓

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objective

Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision	☐
b. For information/noting	✓

Building world class finance

innovation respect care achievement pride

Imperial College Healthcare NHS Trust

FINANCE REPORT - MARCH 2013

1 Introduction

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

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 £75k, with a year to date surplus of £9,025k after impairments and accounting for donated and government granted assets. The Trust achieved a **favourable year to date (YTD) variance** of £8,525k.

2.2 **PCT Service Level Agreement (SLA) Income** – The PCT SLA contract monitoring report for the month of March was calculated using the month 11 actual data and adjusted for known changes agreed for the year end balances exercise with other NHS organisations. It also includes the year end work in progress adjustment for partially completed spells.

2.3 **Other Operating Income** – The in-month favourable variance on R&D is linked to an equivalent overspend on expenditure to ensure a net zero impact for R&D projects. The favourable variance on other income is due to adjustments and re-categorisation of provisions.

2.4 **Expenditure** - Pay expenditure shows a **favourable YTD** variance of £5,155k. The monthly in post pay expenditure is in line with the average monthly run rate for the year. Bank & agency spend in month for nursing and technical staff. Non pay expenditure for drugs and clinical supplies is showing a **favourable YTD** variance of £7,809k which is due to managing cost pressures and changes in procurement. The increased spending in month related to R&D projects is matched by income. There was also additional spend on the purchase of IT and medical equipment; consultancy and back log maintenance.

3 Monthly Performance (Page 4 & 5)

3.1 The performance of the CPGs was in line with forecast and there are no significant variances to report in month. The notable changes in year-end forecast from last month were for Corporate Services, higher than anticipated spend on the Cerner project; agreed additional spend on backlog maintenance and reduced private patient income as a result of low activity in all specialities.

4 Cost Improvement Plan (Page 6)

4.1 The final outturn for the year is £54,144k and this was £2,004k above the planned requirement for the year of £52,140k (full year effect £62m).

4.2 Work is continuing on the schemes for 2013/14, of which over eighty per cent have been identified within the current draft plan.

5 Statement of Financial Position (Balance Sheet - Page 7)

5.1 The overall movement in balances when compared to the previous month is £15,788k.

5.2 The most significant movements in month on the balance sheet are; a decrease in non-current assets resulting from the annual property revaluation exercise; increase in debtors attributable to the advance payment of the facility management contract; decrease of creditors due to advance payment of tax and social security and payment of the PDC dividend; repayment of capital loan and changes in provisions for contractual issues.

6 Capital Expenditure (Page 8)

6.1 The final outturn of £25,041k was slightly under the agreed Capital Resource Limit.

6.2 A number of improvements to facilities were made during the year and more than £4m has been invested in backlog maintenance and energy saving measures. Flexibility within the programme has allowed the Trust to replace its fleet of anaesthetic machines.

7 Cash (Page 9)

7.1 The cash profile has been set out as per the plan to NHS London. In view of the organisational changes to the NHS due to take place in April 2013 and the resultant lack of clarity on cash receivable for that month, it was considered prudent for the Trust to retain sufficient cash to cover its April liabilities for both staff salaries and trade creditors.

8 Monitor metrics – Financial Risk Rating (Page 10)

8.1 The Trust's overall financial risk rating is a FRR of 3 based on the results in March. All risk metrics were on plan for March. A score of 3 is mandatory for Foundation Trust status.

9 Reference Costs

9.1 9.1The onus on the production of sound, accurate and timely data that is right first time rests with each NHS organisation. In 2012/13, in addition to the existing requirement for Finance Directors to sign off the data, there is a requirement for Boards, or suitable sub-committee, to approve the costing process and systems that support the reference costs submission. This Board confirmation should be obtained in advance of the reference costs submission, which is due in July. This change is designed to raise the profile of costing.

9.2 There are a number of requirements, including costing systems, processes and supporting information, that require review and sign-off. It is therefore suggested a detailed paper on these is taken to the Finance and Investment Committee at their meeting in June and the Board delegate this review to them. An update will be provided at the next Board meeting.

10 Conclusions & Recommendations

The Board is asked to note:

- The unaudited surplus for the year of £9,025k after impairment of asset and stock, and accounting for donated asset, a cumulative favourable variance of £8,525k.
- Actual achievement of new CIP schemes for the year was £54,144k which was £2,004k above the planned requirement of £52,140k.
- Delegation to the Finance and Investment Committee the review of reference costs as required by the national guidance.

Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Director of Operational Finance

Contents

Finance Performance Report for the month ending 31st March 2013

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	Actual £000s	Variance £000s
Income									
Clinical	63,234	66,614	3,379	748,559	750,896	2,337	748,559	747,344	(1,215)
Research & Development	4,381	8,527	4,146	52,561	58,050	5,489	52,561	52,561	0
Training & Education	5,302	5,137	(165)	63,616	64,692	1,076	63,616	65,151	1,535
Other	7,105	15,853	8,748	85,380	97,635	12,255	85,380	90,664	5,284
TOTAL INCOME	**80,022**	**96,131**	**16,108**	**950,116**	**971,274**	**21,158**	**950,116**	**955,720**	**5,604**
Expenditure									
Pay - In post	(39,096)	(39,071)	25	(476,744)	(472,441)	4,303	(476,744)	(474,557)	2,187
Pay - Bank & Agency	(3,684)	(5,208)	(1,524)	(45,487)	(44,635)	852	(45,487)	(40,627)	4,860
Drugs & Clinical Supplies	(17,849)	(23,729)	(5,880)	(213,774)	(205,965)	7,809	(213,774)	(196,669)	17,105
General Supplies	(3,659)	908	4,567	(43,900)	(37,086)	6,814	(43,900)	(43,131)	769
Other	(10,218)	(25,359)	(15,141)	(109,325)	(143,959)	(34,634)	(109,325)	(130,771)	(21,446)
TOTAL EXPENDITURE	**(74,506)**	**(92,459)**	**(17,953)**	**(889,230)**	**(904,086)**	**(14,856)**	**(889,230)**	**(885,755)**	**3,475**
EBITDA	**5,516**	**3,671**	**(1,845)**	**60,886**	**67,188**	**6,302**	**60,886**	**69,965**	**9,079**
Financing Costs	(5,095)	(52,053)	(46,958)	(60,386)	(107,143)	(46,757)	(60,386)	(60,220)	166
SURPLUS / (DEFICIT) before Impairment	**421**	**(48,381)**	**(48,803)**	**500**	**(39,955)**	**(40,455)**	**500**	**9,745**	**9,245**
Impairment of Assets, Stock losses & Donated Asset treatment	0	48,456	48,456	0	48,980	48,980	0	(5,945)	(5,945)
SURPLUS / (DEFICIT)	**421**	**75**	**(347)**	**500**	**9,025**	**8,525**	**500**	**3,800**	**3,300**

Surplus / (Deficit): The Trust delivered an Income and Expenditure surplus (excluding impairments and other accounting adjustments) for the year of £9,025k which was £8,525k better than plan. The surplus was the expected outturn agreed with NHS London. The actual achievement of CIP for the year was £54,144k and this was £2,004k above the required planned achievement of £52,140k.

Income: The income included the year end work in progress adjustment for partially completed spells which added £1.2m and accruals for expected over-performance in March of £1.8m. The in month favourable variance on R&D is linked to an equivalent overspend on expenditure to ensure a net zero impact for R&D projects. The variance on other income is due to adjustments and re-categorisation of provisions.

Expenditure: The monthly pay expenditure is slightly higher than the average monthly run rate as a result of higher spend on temporary staff. Non Pay is over-spent by £16,454k in month due to additional spending on IT and medical equipment, consultancy services, backlog maintenance and provisions.

Financing costs: The over-spend is attributable to the impairment on fixed assets resulting from the revaluation of the Trust's property portfolio for the Annual Accounts.

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	Actual £000s	Variance £000s
Income from Clinical Activities									
North West London Sector PCTs	37,124	37,124	(0)	443,470	443,470	0	443,470	443,470	0
Rest of London PCTs	4,466	5,520	1,054	60,705	61,388	683	60,705	61,665	960
Other PCTs	6,887	5,899	(988)	74,596	70,924	(3,672)	74,596	71,750	(2,846)
Specialist Commissioning	9,507	10,642	1,135	110,608	112,985	2,377	110,608	112,319	1,711
Other SLAs	634	341	(293)	7,127	4,109	(3,018)	7,127	3,936	(3,191)
Other NHS Organisations	758	3,228	2,470	9,514	20,592	11,078	9,514	17,321	7,807
Sub-Total NHS Income	**59,375**	**62,754**	**3,378**	**706,020**	**713,468**	**7,448**	**706,020**	**710,461**	**4,441**
Private Patients	3,409	2,734	(675)	37,139	30,477	(6,662)	37,139	30,398	(6,741)
Overseas Patients	150	150	0	1,800	1,802	2	1,800	1,803	3
NHS Injury Scheme	100	238	138	1,200	1,361	161	1,200	1,193	(7)
Non NHS Other	200	738	538	2,400	3,788	1,388	2,400	3,489	1,089
Total - Income from Clinical Activities	**63,234**	**66,614**	**3,379**	**748,559**	**750,896**	**2,337**	**748,559**	**747,344**	**(1,215)**
Other Operating Income									
Research & Development	4,381	8,527	4,146	52,561	58,050	5,489	52,561	52,561	0
Training & Education	5,302	5,137	(165)	63,616	64,692	1,076	63,616	65,151	1,535
Non patient care activities	2,833	2,908	75	33,996	33,093	(903)	33,996	33,327	(669)
Income Generation	600	436	(164)	7,200	6,011	(1,189)	7,200	5,852	(1,348)
Other Income	3,672	12,509	8,837	44,184	58,532	14,348	44,184	51,485	7,301
Total - Other Operating Income	**16,788**	**29,517**	**12,729**	**201,557**	**220,378**	**18,821**	**201,557**	**208,376**	**6,819**
TOTAL INCOME	**80,022**	**96,131**	**16,108**	**950,116**	**971,274**	**21,158**	**950,116**	**955,720**	**5,604**

Income from Clinical Activities: North West London (NWL) income reflects the block contract of £443m agreed with the NWL Commissioners. The income included the year end work in progress adjustment for partially completed spells which added £1.2m and accruals for expected over-performance in March of £1.8m.

Other Operating Income: The in-month favourable variance on R&D is linked to an equivalent overspend on expenditure to ensure a net zero impact for R&D projects. The favourable variance on other income is due to adjustments and re-categorisation of provisions.

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	Actual £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,473)	(12,812)	(339)	(153,907)	(152,551)	1,356	(153,907)	(154,239)	(332)
Nursing & Midwifery	(12,476)	(12,082)	394	(150,262)	(147,435)	2,827	(150,262)	(147,526)	2,736
Scientific, Therapeutic & Technical staff	(5,752)	(5,623)	129	(70,686)	(68,218)	2,468	(70,686)	(68,745)	1,941
Healthcare assistants and other support staff	(1,983)	(2,112)	(129)	(23,831)	(24,460)	(629)	(23,831)	(25,073)	(1,242)
Directors and Senior Managers	(2,458)	(2,487)	(29)	(29,697)	(31,032)	(1,335)	(29,697)	(31,110)	(1,413)
Administration and Estates	(3,954)	(3,955)	(1)	(48,361)	(48,745)	(384)	(48,361)	(47,864)	497
Sub-total - Pay In post	**(39,096)**	**(39,071)**	**25**	**(476,744)**	**(472,441)**	**4,303**	**(476,744)**	**(474,557)**	**2,187**
Pay - Bank/Agency									
Medical Staff	(299)	(742)	(443)	(3,617)	(7,949)	(4,332)	(3,617)	(6,195)	(2,578)
Nursing & Midwifery	(1,428)	(1,633)	(205)	(17,593)	(14,412)	3,181	(17,593)	(13,741)	3,852
Scientific, Therapeutic & Technical staff	(447)	(775)	(328)	(5,772)	(4,841)	931	(5,772)	(4,239)	1,533
Healthcare assistants and other support staff	(339)	(465)	(126)	(4,084)	(3,892)	192	(4,084)	(3,577)	507
Directors and Senior Managers	(442)	(367)	75	(5,292)	(3,931)	1,361	(5,292)	(4,320)	972
Administration and Estates	(729)	(1,226)	(497)	(9,129)	(9,610)	(481)	(9,129)	(8,555)	574
Sub-total - Pay Bank/Agency	**(3,684)**	**(5,208)**	**(1,524)**	**(45,487)**	**(44,635)**	**852**	**(45,487)**	**(40,627)**	**4,860**
Non Pay									
Drugs	(9,101)	(9,147)	(46)	(108,960)	(97,710)	11,250	(108,960)	(96,221)	12,739
Supplies and Services - Clinical	(8,748)	(14,582)	(5,834)	(104,814)	(108,255)	(3,441)	(104,814)	(100,448)	4,366
Supplies and Services - General	(3,659)	908	4,567	(43,900)	(37,086)	6,814	(43,900)	(43,131)	769
Consultancy Services	(1,041)	(2,886)	(1,845)	(12,500)	(16,363)	(3,863)	(12,500)	(13,285)	(785)
Establishment	(700)	(1,102)	(402)	(8,400)	(8,114)	286	(8,400)	(7,595)	805
Transport	(750)	(825)	(75)	(9,000)	(9,653)	(653)	(9,000)	(9,579)	(579)
Premises	(2,800)	(5,818)	(3,018)	(33,600)	(40,397)	(6,797)	(33,600)	(35,967)	(2,367)
Other Non Pay	(4,927)	(14,728)	(9,801)	(45,825)	(69,432)	(23,607)	(45,825)	(64,345)	(18,520)
Sub-total - Non Pay	**(31,726)**	**(48,180)**	**(16,454)**	**(366,999)**	**(387,010)**	**(20,011)**	**(366,999)**	**(370,571)**	**(3,572)**
TOTAL EXPENDITURE	**(74,506)**	**(92,459)**	**(17,953)**	**(889,230)**	**(904,086)**	**(14,856)**	**(889,230)**	**(885,755)**	**3,475**
Financing Costs									
Interest Receivable	18	30	12	225	287	62	225	247	22
Interest Payable	(154)	(112)	42	(1,838)	(1,792)	46	(1,838)	(1,838)	0
Other Gains & Losses	0	188	188	0	(12)	(12)	0	(200)	(200)
Depreciation	(3,135)	(3,456)	(321)	(36,860)	(37,053)	(193)	(36,860)	(36,829)	31
Impairment of asset	0	(47,505)	(47,505)	0	(47,505)	(47,505)	0	0	0
Public Dividend Capital	(1,824)	(1,198)	626	(21,913)	(21,068)	845	(21,913)	(21,600)	313
TOTAL - FINANCING COSTS	**(5,095)**	**(52,053)**	**(46,958)**	**(60,386)**	**(107,143)**	**(46,757)**	**(60,386)**	**(60,220)**	**166**

Pay: The monthly pay expenditure for in post staff is in line with the average monthly run rate for the year. Bank/agency is higher than the average run rate partly due to the reclassification of medical locum costs and higher spend across a number of areas in Nursing and Technical staff.

Non Pay: Non Pay is over-spent by £16,454k as a result of increased spending on R&D projects of £4.3m which is linked to income to ensure a net zero I&E impact. Also additional spend on IT equipment £2.5m, medical equipment £1m, consultancy £1m and backlog maintenance £0.4m. Other non pay includes a number of provisions in respect of the Carbon Reduction Commitment Energy Efficiency Scheme, employment tribunal cases and disputed contracts.

Financing costs: The over-spend is attributable to the impairment on fixed assets resulting from the revaluation of the Trust's property portfolio for the Annual Accounts. The devaluation in the value of buildings is a result of downward inflationary pressure on the building construction industry's indices (BCIS) used to calculate the cost of replacing existing buildings. The devaluation of assets has created a benefit on PDC dividend payable of £626k for this year, a full year saving of £1,647k.

Statement of Comprehensive Income (SOCI)	**Risk:**	**G**

PAGE 4 - Clinical Programme Groups Financial Performance

	Risk Rating	In Month (March)			Year To Date (Cumulative)			FORECAST
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
CPG 1 - Medicine								
Income		705	653	(52)	8,058	8,518	460	
Pay		(7,100)	(7,447)	(348)	(84,606)	(85,045)	(439)	
Non Pay		(5,373)	(5,771)	(398)	(62,906)	(66,940)	(4,034)	
TOTAL	R	**(11,768)**	**(12,566)**	**(797)**	**(139,454)**	**(143,467)**	**(4,013)**	**(4,136)**
CPG 2 - Surgery and Cancer								
Income		127	142	15	1,275	1,190	(85)	
Pay		(3,771)	(4,067)	(296)	(45,190)	(46,312)	(1,122)	
Non Pay		(2,546)	(2,651)	(105)	(30,359)	(32,272)	(1,914)	
TOTAL	R	**(6,190)**	**(6,576)**	**(386)**	**(74,274)**	**(77,394)**	**(3,120)**	**(3,277)**
CPG 3 - Specialist Services 1								
Income		220	278	58	2,659	2,786	127	
Pay		(7,275)	(7,291)	(16)	(85,210)	(84,339)	871	
Non Pay		(6,032)	(6,348)	(316)	(59,751)	(60,632)	(882)	
TOTAL	G	**(13,086)**	**(13,361)**	**(275)**	**(142,302)**	**(142,186)**	**116**	**54**
CPG 4 - Cardiac & Renal								
Income		409	555	146	4,323	5,101	778	
Pay		(5,031)	(4,768)	263	(60,932)	(59,648)	1,284	
Non Pay		(6,601)	(7,032)	(432)	(69,982)	(72,114)	(2,132)	
TOTAL	G	**(11,223)**	**(11,246)**	**(23)**	**(126,591)**	**(126,661)**	**(70)**	**0**
CPG 5 - Women's and Children's								
Income		564	792	228	6,763	6,919	156	
Pay		(5,795)	(5,868)	(73)	(68,017)	(68,036)	(19)	
Non Pay		(2,316)	(2,758)	(441)	(27,863)	(29,634)	(1,771)	
TOTAL	R	**(7,547)**	**(7,833)**	**(286)**	**(89,118)**	**(90,751)**	**(1,634)**	**(1,612)**
CPG 6 - Clinical Investigative Sciences								
Income		1,943	2,459	516	23,594	23,231	(362)	
Pay		(7,730)	(7,758)	(28)	(94,964)	(93,644)	1,320	
Non Pay		(925)	(1,147)	(221)	(4,683)	(4,348)	334	
TOTAL	G	**(6,713)**	**(6,445)**	**267**	**(76,053)**	**(74,761)**	**1,292**	**1,191**
CPG 7 - Interventional Public Health								
Income		614	606	(8)	7,808	7,460	(348)	
Pay		(370)	(410)	(40)	(4,438)	(4,375)	63	
Non Pay		(449)	(463)	(13)	(3,642)	(3,743)	(101)	
TOTAL	R	**(205)**	**(267)**	**(62)**	**(272)**	**(658)**	**(387)**	**(347)**
TOTAL FOR ALL CPGs								
Income		4,583	5,486	903	49,897	49,720	726	
Pay		(37,072)	(37,610)	(538)	(406,285)	(403,789)	1,958	
Non Pay		(24,243)	(26,170)	(1,927)	(234,943)	(243,515)	(10,499)	
TOTAL	A	**(56,732)**	**(58,294)**	**(1,562)**	**(648,064)**	**(655,879)**	**(7,815)**	**(8,127)**

No significant changes in forecast variance reported from last month

Statement of Comprehensive Income (SOCI)

PAGE 5 - Corporate Services Financial Performance

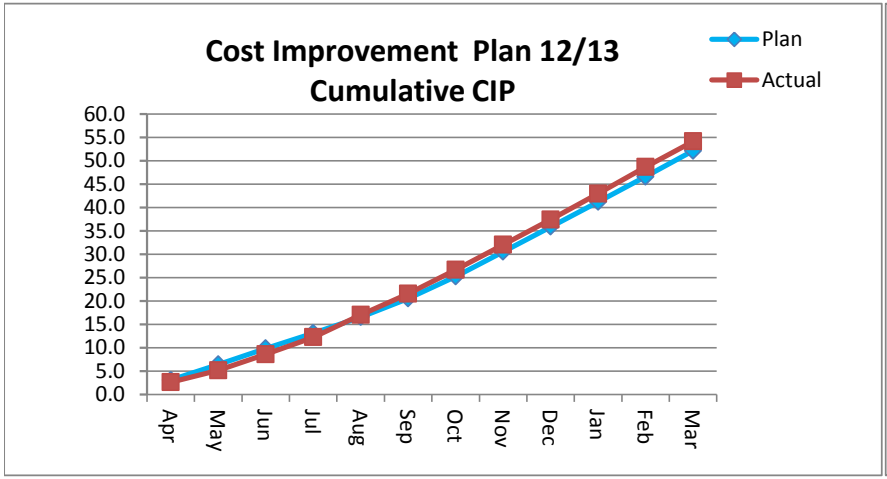
	Risk Rating	In Month (March)			Year To Date (Cumulative)			FORECAST
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s
Corporate Governance								
Income		2	0	(1)	23	21	(2)	
Pay		(106)	(78)	28	(1,275)	(1,171)	103	
Non Pay		(28)	(26)	2	(334)	(311)	23	
TOTAL	G	**(131)**	**(103)**	**28**	**(1,585)**	**(1,461)**	**124**	**120**
Chief Executive Office								
Income		226	538	312	593	1,154	561	
Pay		(163)	(442)	(279)	(1,749)	(1,876)	(127)	
Non Pay		(511)	(455)	56	(1,699)	(1,796)	(97)	
TOTAL	G	**(448)**	**(359)**	**89**	**(2,855)**	**(2,518)**	**337**	**300**
Director Of Education								
Income		22	43	21	259	280	21	
Pay		(37)	(58)	(21)	(445)	(418)	27	
Non Pay		(90)	(75)	15	(927)	(903)	25	
TOTAL	G	**(106)**	**(90)**	**15**	**(1,113)**	**(1,040)**	**72**	**70**
Director Of Operations								
Income		153	184	31	1,906	2,078	172	
Pay		(873)	(864)	9	(10,616)	(9,924)	693	
Non Pay		(391)	(454)	(64)	(4,836)	(4,756)	81	
TOTAL	G	**(1,111)**	**(1,134)**	**(23)**	**(13,546)**	**(12,601)**	**945**	**1,010**
Estates Directorate								
Income		732	884	151	8,671	10,008	1,336	
Pay		(757)	(820)	(63)	(9,466)	(9,485)	(19)	
Non Pay		(1,994)	(2,267)	(272)	(17,231)	(18,819)	(1,588)	
TOTAL	A	**(2,019)**	**(2,203)**	**(184)**	**(18,026)**	**(18,296)**	**(271)**	**(160)**
Finance Directorate								
Income		13	10	(3)	238	271	33	
Pay		(634)	(625)	10	(7,327)	(6,725)	602	
Non Pay		(1,577)	(1,641)	(64)	(11,969)	(12,247)	(278)	
TOTAL	G	**(2,198)**	**(2,255)**	**(58)**	**(19,058)**	**(18,702)**	**356**	**460**
Human Resources								
Income		257	338	81	3,092	3,503	411	
Pay		(514)	(481)	32	(6,165)	(5,837)	329	
Non Pay		(245)	(340)	(95)	(2,959)	(3,080)	(120)	
TOTAL	G	**(502)**	**(483)**	**19**	**(6,033)**	**(5,413)**	**620**	**660**
Infection Control Directorate								
Income		0	(11)	(11)	22	60	38	
Pay		(157)	(142)	15	(1,897)	(1,728)	169	
Non Pay		(10)	6	16	(658)	(681)	(23)	
TOTAL	G	**(167)**	**(147)**	**19**	**(2,533)**	**(2,349)**	**184**	**185**
Information & Comms Technology								
Income		133	129	(4)	1,591	1,625	34	
Pay		(1,150)	(1,177)	(27)	(13,218)	(12,539)	679	
Non Pay		(975)	(1,186)	(210)	(11,410)	(11,828)	(418)	
TOTAL	G	**(1,993)**	**(2,234)**	**(241)**	**(23,037)**	**(22,741)**	**296**	**600**
Medical Director								
Income		2	69	67	157	392	235	
Pay		(117)	(121)	(5)	(2,493)	(2,266)	227	
Non Pay		(73)	(120)	(47)	(914)	(947)	(33)	
TOTAL	G	**(187)**	**(173)**	**15**	**(3,250)**	**(2,820)**	**429**	**450**
Nursing & Operations Directorate								
Income		10	16	5	53	92	39	
Pay		(207)	(198)	9	(2,402)	(2,193)	209	
Non Pay		(68)	(95)	(27)	(799)	(828)	(28)	
TOTAL	G	**(265)**	**(278)**	**(13)**	**(3,149)**	**(2,929)**	**220**	**272**
Press & Communications								
Income		1	5	4	62	58	(4)	
Pay		(76)	(79)	(3)	(934)	(945)	(11)	
Non Pay		(7)	(12)	(5)	(136)	(122)	14	
TOTAL	A	**(82)**	**(86)**	**(4)**	**(1,008)**	**(1,010)**	**(1)**	**0**
Private Patients								
Income		2,444	2,019	(425)	29,190	23,009	(6,180)	
Pay		(868)	(715)	153	(10,476)	(8,386)	2,089	
Non Pay		(522)	(405)	117	(6,260)	(4,341)	1,919	
TOTAL	R	**1,054**	**899**	**(155)**	**12,455**	**10,282**	**(2,172)**	**(2,006)**
TOTAL FOR CORPORATE								
Income		3,994	4,223	228	45,857	42,551	(3,307)	
Pay		(5,659)	(5,801)	(142)	(68,462)	(63,493)	4,970	
Non Pay		(6,490)	(7,070)	(580)	(60,133)	(60,656)	(523)	
TOTAL	G	**(8,155)**	**(8,648)**	**(493)**	**(82,738)**	**(81,598)**	**1,139**	**1,961**

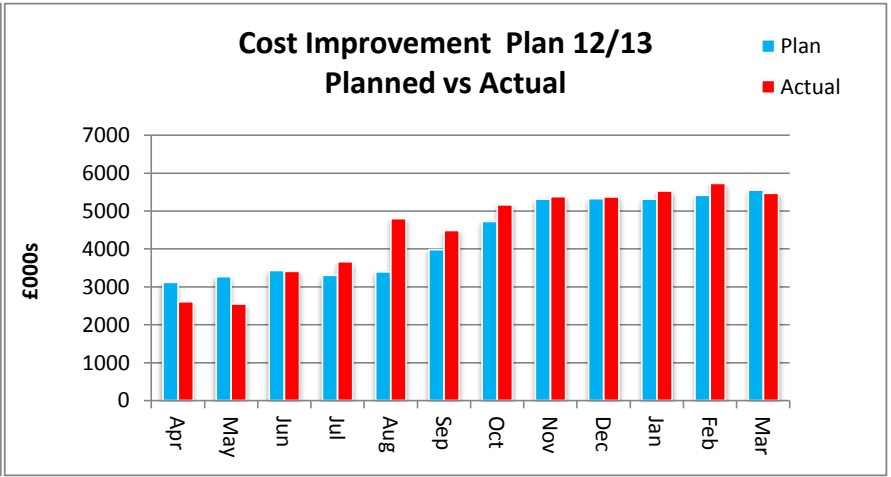
Significant changes in year-end forecast from last month:
- **Information & Comms Technology:** Higher than anticipated Cerner implementation costs
- **Estates:** Agreed additional spend on backlog maintenance
- **Private Patients** : Reduced activity levels across most specialties

Statement of Comprehensive Income (SOCI)

PAGE 6 - COST IMPROVEMENT PLAN (CIP)

CIPS	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
CPG1 - Medicine	1,015	667	(348)	7,905	6,429	(1,476)	7,905	6,324	(1,581)
CPG2 - Surgery & Cancer	462	355	(107)	4,292	3,453	(839)	4,292	3,453	(839)
CPG3 - Specialist Services	701	655	(46)	7,990	6,599	(1,391)	7,990	6,536	(1,454)
CPG4 - Cardiology & Renal	594	774	180	7,318	8,200	882	7,318	8,200	882
CPG5 - Women's & Children	471	891	420	5,046	4,751	(295)	5,046	4,259	(787)
CPG6 - CIS	863	776	(87)	7,485	7,869	384	7,485	7,869	384
Corporate Services	1,114	1,217	103	11,065	12,189	1,124	11,065	12,325	1,260
Centrally Delivered schemes	243	129	(114)	0	4,376	4,376	0	4,846	4,846
TOTAL CIP	**5,463**	**5,463**	**(0)**	**51,101**	**53,866**	**2,765**	**51,101**	**53,812**	**2,711**
Income Generation	**Plan £000s**	**Actual £000s**	**Variance £000s**	**Plan £000s**	**Actual £000s**	**Variance £000s**	**Plan £000s**	**Actual £000s**	**Variance £000s**
CPG7 - Public Health	42	(17)	(59)	498	27	(471)	498	49	(449)
Private Patients	45	22	(23)	541	251	(290)	541	253	(288)
TOTAL Income Generation	**87**	**5**	**(82)**	**1,039**	**278**	**(761)**	**1,039**	**302**	**(737)**
TOTAL	**5,550**	**5,468**	**(82)**	**52,140**	**54,144**	**2,004**	**52,140**	**54,114**	**1,974**





The final CIP outturn for the year is reported at £54.1m (a surplus of £2m above plan). The recurrent value of CIP is £62m.

There is no change from last month's forecast.

Statement of Comprehensive Income (SOCI)	**Risk:**	**G**

PAGE 7 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Revised Opening Balance (Post audit) £000s	Current Month Balance £000s	Previous Month Balance £000s	Movement in month £000s	Forecast Balance £000s
Non Current Assets	Property, Plant & Equipment	744,023	744,023	715,616	728,123	(12,507)	727,230
	Intangible Assets	579	579	1,681	378	1,303	175
Current Assets	Inventories (Stock)	17,141	17,141	17,652	17,814	(162)	17,500
	Trade & Other Receivables (Debtors)	45,711	52,701	65,462	48,258	17,204	52,705
	Cash	22,974	22,974	55,326	105,675	(50,349)	54,974
Current Liabilities	Trade & Other Payables (Creditors)	(105,681)	(104,324)	(127,930)	(146,141)	18,211	(101,787)
	Borrowings	(3,764)	(3,764)	(3,059)	(4,275)	1,216	(3,074)
	Provisions	(4,542)	(12,891)	(21,270)	(25,731)	4,461	(45,000)
Non Current Liabilities	Borrowings	(45,046)	(45,046)	(23,362)	(44,280)	20,918	(23,358)
	Provisions	0	0	(16,083)	0	(16,083)	0
	TOTAL ASSETS EMPLOYED	**671,395**	**671,395**	**664,033**	**679,821**	**(15,788)**	**679,365**

Ratio/Indicators	**Risk Rating**		
	Current Month	**Previous Month**	**Forecast**
Debtor Days	19	17	21
Trade Payable Days	39	55	43
Cash Liquidity Days	29	31	22

The movement in balances in month can be explained as follows:

Property, Plant & Equipment

- The overall change can be mainly attributed to the devaluation of buildings by £44m and increase in value of land of £27m

Trade & Other Receivables (Debtors)

- Advance Payment of the ISS facility management contract of £14m
- Ravenscourt Park Hospital 4th quarter rental income of £1.1m still to be paid
- Outstanding payment from Lloyds Pharmacy relating to transfer of drug stock for the community pharmacy scheme of £2.1m

Trade & Other Payables (Creditors)

- Payroll tax and social security costs of £10.1m paid in advance
- Payment of PDC dividend of £10m in March

Borrowing (Current liabilities)

- Second annual instalments of the DH loans were paid

Provisions (Current liabilities)

- Provision for contractual disputes £4.7m

Borrowings (Non Current Liabilities)

- Early repayment of a DH capital loan of £20.4m

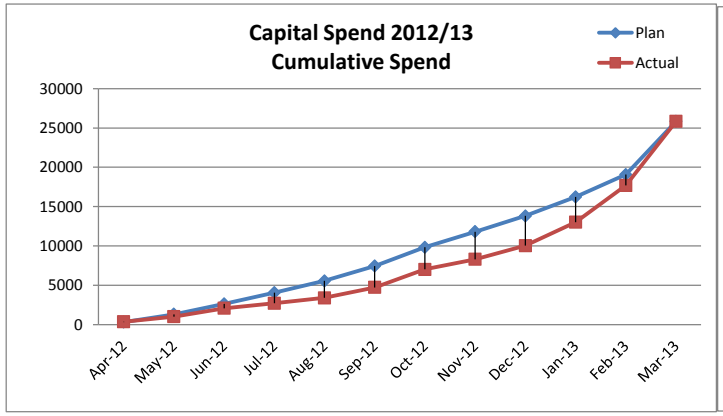
Provisions (Non Current Liabilities)

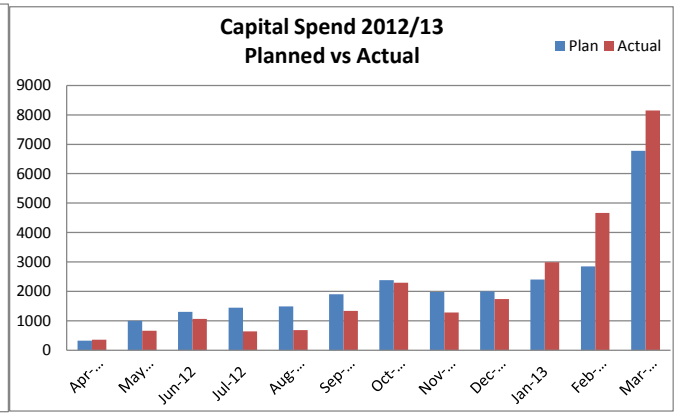
- Provision for contractual disputes of £16m

Statement of Financial Position (SOFP)	**Risk:**	**G**

PAGE 8 - 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
Lindo Wing Refurbishment	0	(254)	254	945	638	307	945	800	307
Surgical Innovation Centre	0	151	(151)	370	378	(8)	370	370	(8)
Clinical Chemistry Relocation	0	185	(185)	1,722	1,380	342	1,722	1,300	342
Paediatric Clin. Haem. Day Unit	50	183	(133)	1,680	1,583	97	1,680	1,680	97
Strategic RIS/PACS	0	2	(2)	450	121	329	450	100	329
St Mary's Electrical Infrastructure	45	95	(50)	1,295	1,322	(27)	1,295	1,500	(27)
Endoscopy Relocation	400	213	187	1,980	740	1,240	1,980	750	1,240
Relocate Cardiology Labs	87	619	(532)	322	1,079	(757)	322	750	(757)
Renal Dialysis Expansion	200	0	200	1,388	0	1,388	1,388	0	1,388
Medical Equipment	500	2,746	(2,246)	2,000	3,956	(1,956)	2,000	4,577	(1,956)
Backlog Maintenance	300	1,288	(988)	2,500	2,339	161	2,500	2,100	161
Aggregate - Estates	48	1,698	(1,650)	798	3,581	(2,783)	798	3,796	(2,783)
Aggregate - IT	600	843	(243)	4,550	6,661	(2,111)	4,550	6,136	(2,111)
Aggregate - IT Building Works	700	(224)	924	2,000	12	1,988	2,000	180	1,988
Energy Saving Schemes (Salix-funded)	0	599	(599)	0	2,055	(2,055)	0	2,042	(2,055)
Total Capital Expenditure	**2,930**	**8,145**	**(5,215)**	**22,000**	**25,845**	**(3,845)**	**22,000**	**26,081**	**(3,845)**
Net Book Value of Assets Disposed Of	**0**	**0**	**0**	**0**	**(15)**	**15**	**0**	**0**	**15**
Donation - Medical Equipment	0	0	0	0	(747)	747	0	(841)	747
Gov. Grant - Medical Equipment (ESC)	0	0	0	0	(42)	42	0	(28)	42
Total Charge against Capital Resource Limit	**2,930**	**8,145**	**(5,215)**	**22,000**	**25,041**	**(3,041)**	**22,000**	**25,212**	**(3,041)**
Capital Resource Limit					**(25,212)**		**(22,000)**	**(25,212)**	**3,041**
Over/(Under)spend against CRL					**(171)**		**0**	**0**	**0**





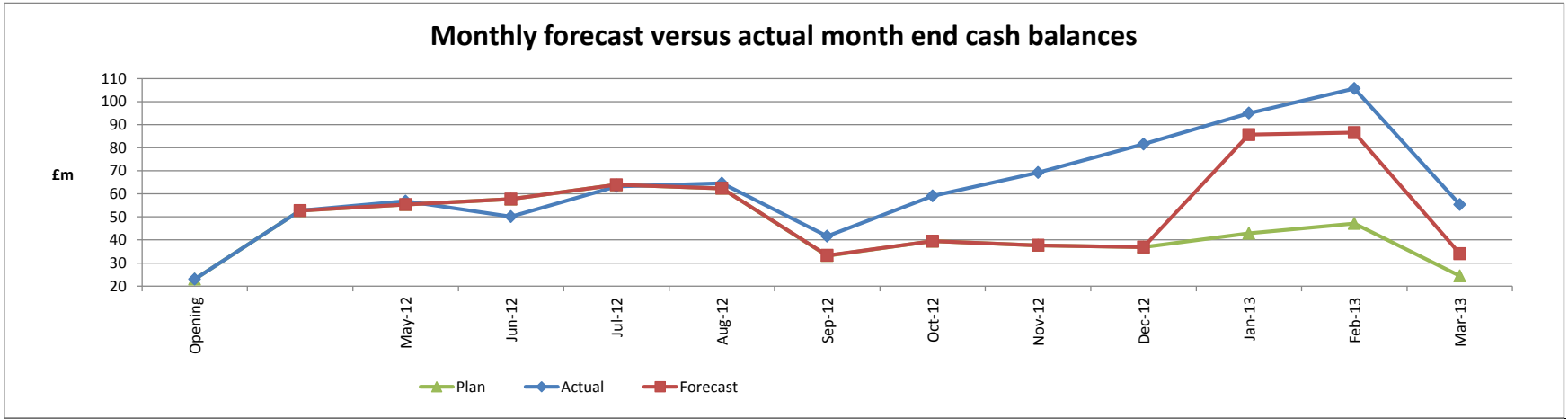
The final outturn of £25.041m is £171k (0.7%) under the approved Capital Resource Limit. Completed projects this year include relocation and improvement of facilities for Clinical Chemistry, refurbishment of the Lindo Wing, creation of a Paediatric Clinical Haematology Day Unit and enhancing power backup capacity with a new standby generator, all at St Mary's.

One of the cancer wards (6 North) has been refurbished at Charing Cross, and work on two new cardiac catheter labs at Hammersmith is well underway. More than £4m has been invested in the condition of the estate through dealing with backlog maintenance and also energy-saving measures such as low power lighting. Flexible management of the programme enabled some investments to be advanced from 2013/14 when headroom became available, such as replacing the Trust's fleet of anaesthetic machines.

The donated sums above relate primarily to a CT Scanner at Charing Cross, which was donated by the relatives of a patient.

Statement of Financial Position (SOFP) **Risk:** **G**

PAGE 9 - CASH



	Opening	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Plan	22,974	52,707	55,382	57,707	63,933	62,419	33,189	39,470	37,656	36,896	42,852	47,127	24,370
Actual	22,974	52,707	56,826	50,127	63,252	64,611	41,613	59,067	69,216	81,580	95,001	105,675	55,326
Forecast		52,707	55,382	57,707	63,933	62,419	33,289	39,470	37,656	36,896	85,699	86,598	33,974

Aged Debtor Analysis

Category	Current	30 Days	60 Days	90 Days	<= 1 Year	>1 Year - <= 2 Years	>2 Years	Total Debt
NHS	£ 11,018,211	£ 2,013,496	£ 1,366,207	£ 760,627	-£ 206,012	£ 174,839	£ 37,316	**£ 15,164,685**
Non-NHS	£ 7,047,230	£ 820,222	£ 271,905	£ 1,316,349	£ 1,067,662	£ 574,863	£ 340,124	**£ 11,438,354**
Overseas Visitors	£ 71,529	£ 90,872	£ 123,909	£ 71,678	£ 1,099,435	£ 1,111,767	£ 447,855	**£ 3,017,045**
Private Patients	£ 2,131,212	£ 1,143,329	£ 612,753	£ 728,338	£ 964,669	-£ 139,776	£ 27,549	**£ 5,468,074**
Total	**£ 20,268,182**	**£ 4,067,920**	**£ 2,374,773**	**£ 2,876,992**	**£ 2,925,754**	**£ 1,721,693**	**£ 852,844**	**£ 35,088,159**
% of Total Debt	**57.8%**	**11.6%**	**6.8%**	**8.2%**	**8.3%**	**4.9%**	**2.4%**	**100.0%**

Aged Creditor Analysis

Category	Current	30 Days	60 Days	90 Days	<= 1 Year	>1 Year - <= 2 Years	>2 Years	Total Creditors
All AP Creditors	£ 14,890,756	£ 5,097,232	£ 784,208	£ 322,780	£ 827,933	-£ 494,617	£ 112,502	**£ 21,540,794**
Total	**£ 14,890,756**	**£ 5,097,232**	**£ 784,208**	**£ 322,780**	**£ 827,933**	**-£ 494,617**	**£ 112,502**	**£ 21,540,794**
% of Total Creditors	**69.1%**	**23.7%**	**3.6%**	**1.5%**	**3.8%**	**-2.3%**	**0.5%**	**100.0%**

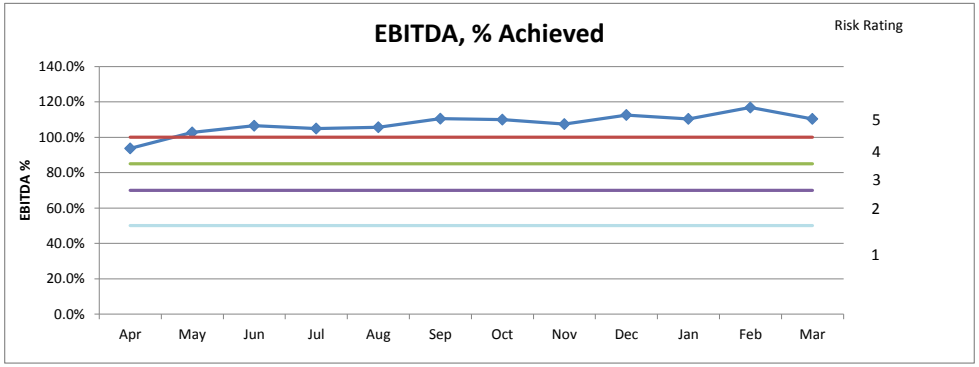
Actual cash is above plan in March because payments to suppliers (including capital) and payroll payments were £16m lower than the year to date plan. In addition, cash received was ahead of plan, predominantly due to £8.1m cash received for Project Diamond which was not included in the plan. In view of the organisational changes to the NHS due to take place in April 2013 and the resultant lack of clarity on cash receivable for that month, it was considered prudent for the Trust to retain sufficient cash to cover its April liabilities for both staff salaries and trade creditors.

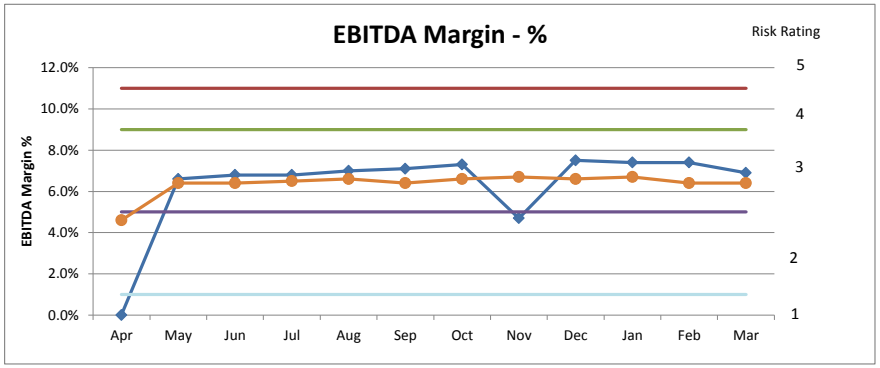
At the end of March, all investments in the National Loan Fund scheme were returned. An average rate of 0.38% was received for the money invested during the month. Total accumulated interest receivable at 31st March 2013 was £287k.

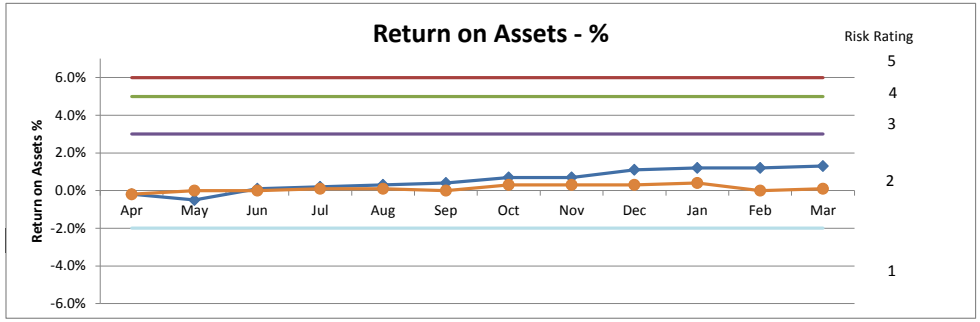
Due to the improvement in the cash position during the year, predominantly due to an improved I&E position and a reduction in capital expenditure, the Trust has been able to pay off one of its DH capital loans. This will have a positive impact upon I&E in 2013/14 of £184k.

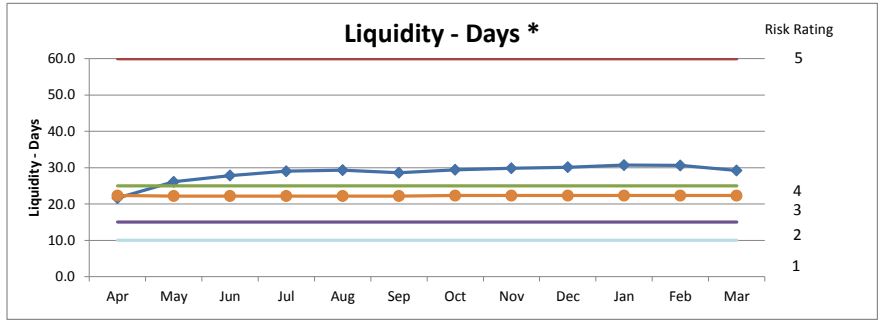
Statement of Financial Position (SOFP) **Risk: G**

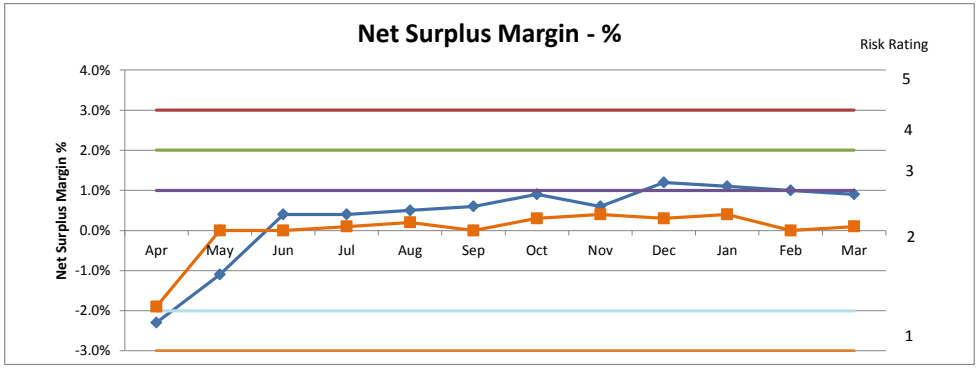
Page 10 - FINANCIAL RISK RATINGS (FRR)

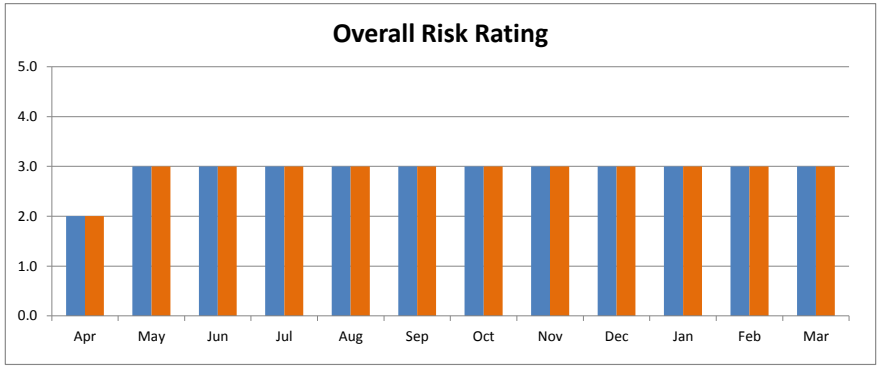












Each chart plots the current performance against each of the five Financial Risk Rating (FRR) metrics.

The Trust's overall FRR based on the results to the end of March is FRR3, as per plan. All risk metrics are on plan.

A score of 3 is mandatory for Foundation Trust status.

* This is a proxy rating assuming a 30 day working capital facility available only to Foundation Trusts.

Financial Risk Ratings **Risk:** G

PAGE 11 - SLA Activity & Income by POD (Estimate for March)

Point of Delivery	Year to Date (Activity)			Year to Date (Income)		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s
Admitted Patient Care						
- Day Cases	67,239	65,795	(1,444)	55,593	54,822	(771)
- Regular Day Attenders	12,830	13,818	988	6,264	6,759	495
- Elective	21,782	19,180	(2,602)	63,495	61,157	(2,338)
- Non Elective	86,525	91,881	5,356	166,384	166,060	(324)
Accident & Emergency	192,510	195,806	3,296	21,567	21,995	428
Adult Critical Care	44,807	42,992	(1,815)	55,532	49,596	(5,936)
Outpatients - New	231,959	234,894	2,935	47,844	49,153	1,309
Outpatients - Follow-up	515,557	511,517	(4,040)	67,241	65,265	(1,976)
PbR Exclusions	125,654	700,558	574,904	59,395	62,814	3,419
Direct Access	2,206,640	2,129,057	(77,583)	15,483	16,704	1,221
Others	363,011	428,031	65,020	152,856	153,056	200
Commissioning Business Rules	(43,329)	(54,386)	(11,057)	(15,148)	(22,937)	(7,789)
NWL London Block Adj			0		8,435	8,435
TOTAL	**3,825,185**	**4,379,143**	**553,958**	**696,506**	**692,879**	**(3,627)**

Income by Sector	Year to Date (Income)		
	Plan £000s	Actual £000s	Variance £000s
North West - London	443,470	443,470	0
North Central - London	18,650	20,205	1,555
North East - London	7,008	6,525	(483)
South East - London	6,532	6,345	(187)
South West - London	28,515	28,284	(231)
East of England	29,564	28,405	(1,159)
South East Coast	17,633	17,600	(33)
London Specialist Commissioning	110,608	109,842	(766)
SHA	2,927	2,911	(16)
Others	31,599	29,292	(2,307)
TOTAL	**696,506**	**692,879**	**(3,627)**

Income by NWL PCT's	Year to Date (Income)		
	Plan £000s	Actual £000s	Variance £000s
Hillingdon	16,889	15,963	(926)
Hammersmith & Fulham	79,948	81,895	1,947
Ealing	84,774	81,990	(2,784)
Hounslow	44,894	44,995	101
Brent	60,859	62,595	1,736
Harrow	13,544	12,820	(724)
Kensington & Chelsea	56,824	53,382	(3,442)
Westminster	85,738	81,395	(4,343)
Block Adj		8,434	8,434
TOTAL	**443,470**	**443,470**	**0**

The report is an analysis of NHS SLA Income from clinical activities excluding other NHS organisations (non England within the actuals).

The key variances are:

- Critical Care underperformance is because the plan for 2012/13 was based on 2011/12 outturn which included a significant number of long stay patients (£2.5m) that have not been treated in 2012/13 and a general underperformance of £3.4m.
- Day Case underperformance is associated with the following specialties Gastroenterology, Medical Oncology, Oral Surgery, Neurology and Paediatrics within the NWL sector.
- Elective underperformance is mainly due to General Surgery, Cardiac Surgery and Nephrology.
- Non Elective underperformance includes Geriatric Medicine, Obstetrics, Cardiology, Cardiac Surgery and Vascular Surgery. This has been partly off set by overperformance on A&E admissions.
- Other Income & contractual adjustment variance relates to the 70% emergency thresholds of £1.6m, outpatient follow-up ratios of £2.8m (this is due to the agreed revision of the outpatient ratios) and NWL block contract/risk premium of £8.4m. This assumes delivery year to date of £3.0m for consultant to consultant and maternity antenatal ratios.

NHS Service Level Agreement (SLA) Income by Point of Delivery (POD) **Risk:** **A**

Imperial College Healthcare NHS
NHS Trust

Report Title: Finance Annual Plan Update 2013/14

To be presented by: Bill Shields, Chief Financial Officer

Chief Financial Officer's message:
The Trust has planned for a surplus of £15.1m in the 2013/14 financial year. Internally, this is dependent on delivering a challenging cost improvement plan and continuing to effectively manage expenditure controls. Externally, the challenges are to manage the Trust's capacity in light of significant activity reduction plans by local commissioners, contain performance against contractual metrics and earn performance incentive monies in local service level agreements.

The planned financial performance delivers a Financial Risk Rating (FRR) at a minimum of 3 with a moderately increased capital expenditure plan and improved cash position.

A response letter from the Trust Development authority (TDA) and the Trust's Annual Plan submission is provided in Appendices B and C.

Key Issues for discussion:
The risks and opportunities to the delivery of the annual financial plan
The impact of the annual financial plan on the Trust's foundation trust application

Legal Implications or Review Needed

a. Yes	☐
b. No	✓

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objective

Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision	☐
b. For information/noting	✓

FINANCE REPORT – ANNUAL PLAN UPDATE 2013/14

1 Introduction

1.1 This paper outlines the main drivers behind the Trust's financial plan for the 2013/14 financial year.

2 Overview of Trust Financial Plan

2.1 **Statement of Comprehensive Income (I&E Account)** - The financial plan delivers a **surplus of £15.1m** before technical adjustments, with surpluses in each quarter. This is an increase of £5.5m on the 2012/13 outturn.

2.2 **Patient Care Income** - Patient care income is planned to **reduce by £6.8m** to £745.9m. This includes a planned increase in private patient income due to the full-year opening of the Lindo Wing at St Mary's Hospital and an overall reduction in NHS SLA income due to the combined effect of the NHS tariff deflator of -1.3%, commissioner demand management (QIPP) schemes and national PbR pricing changes.

Key assumptions made are:

- Demographic growth of 1%;
- Counting and coding service developments are implemented;
- PbR tariff changes are implemented; and
- Demand management (QIPP) initiative and business rules/contract metrics are delivered, delivery adjusted for estimated timing of in-year delivery.

A £9m income incentive payment for delivery against additional operational, quality and information targets has also been agreed with NWL CCGs. These are focused on:

- Capping emergency activity at 95% of 2012/13 outturn activity levels and reporting on patient admissions and discharges;
- Improving GP and Pathology information;
- Increased consultant hours across Emergency Services and Obstetrics; and
- Delivery of elective access, Cancer, infection control and friends & family targets.

2.3 **Commissioner demand management (QIPP)** - Commissioner QIPP schemes total **£24.6m**, with the financial plan assuming the impact of this is adjusted for the estimated timing of in-year delivery. Key areas are:

- Referral management and standardisation;
- Shifting outpatient activity safely and effectively into community settings; and
- Avoiding non-elective admissions and care management outside of hospital.

2.4 **Commissioner local business rules/contract metrics** - Commissioner local business rules/contract metrics total **£10.8m**, an increase of £3.9m. The key areas are in:

- Reducing internally generated demand and length of stay;
- Emergency activity - growth and readmissions; and
- Outpatient ratios.

2.5 **Other Operating Income** - Other operating income is planned to **reduce by £23.2m** to £195.3m. This reduction is due to a loss of transitional support, NIHR R&D income, MPET education and training income from reduced tariffs and trainee numbers, and other non-recurrent income.

2.6 **Expenditure** - Expenditure is planned to **reduce by £36.1m** to £926.2m. This is based upon a top-down assessment starting with 2012/13 outturn and adjusted for:

- National pay awards at 1%;

- Impact of incremental pay progression;
- Non-recurring items from prior year;
- Cost pressures;
- Service developments (includes those pending approval by Investment Committee);
- Cost Improvement Plan of £48m (5.5% for CPGs and 11% for non-Clinical Directorates); and
- Contingency of 0.5%.

2.7 **Service Developments** - There are no plans for any significant service developments in year. The focus is on smaller developments to improve patient experience and clinical outcomes including best practice tariffs. This is evidenced in the capital expenditure plan.

3 CPG and Corporate Directorate Plans

3.1 **Consolidated Trust Financial Plan** - The consolidated financial plan has been reconciled to CPG and non-Clinical Directorates plans, which have been prepared on a consistent basis to the Trust plan, replacing the legacy approach of rolling over historical budgets.

Detailed plans were submitted by Clinical Programme Groups, Estates and IT and reviewed by members of the Executive Team.

All other non-Clinical Directorates plans are based upon a top down assessment using the Trust planning assumptions but with an increased CIP requirement of 11%. A comprehensive zero-based budgeting approach will be undertaken throughout the financial year to identify opportunities to significantly reduce costs of non-Clinical Directorates. This approach will focus on identifying synergies between Directorates and benchmarking against best in class cost and processes.

3.2 **Financial Performance Management** - The Trust will adopt the principles of the Monitor Financial Compliance Framework for managing its internal performance. This will be delivered by:

- Measuring against a Financial Risk Rating (using 23 metrics to provide a broad assessment of performance in the following areas:- financial sustainability; cost control; forecasting accuracy; financial governance; working capital & assets);
- Variances will be shown against the original plan (with only a small number of changes to budget reflecting organisational changes) – this is a significant change from the legacy approach where internal budgets were subject to significant in-year changes;
- Variance against budget and CIP performance become part of the Financial Risk Rating as opposed to primary measures of financial performance;
- CPGs and non-Clinical Directorates will be required to produce detailed reforecasts of financials, workforce, activity and capacity.

4 Cost Improvement Plan

4.1 The financial plan includes £48m of cost improvement programmes (CIP), £49.2m of gross savings (reported to the Trust Development Authority (TDA) less £1.2m costs associated with income related schemes).

4.2 Savings are all relative to the 2012/13 outturn. This is a change in approach to previous years where savings where based upon historical budgets resulting in savings being declared in some areas which represented cost avoidance rather than cost reduction.

Reported savings for the Trust will be based upon:

- Evidence from Clinical Divisions and non-Clinical Directorates where cost savings have been delivered on a year to year comparison of expenditure (after adjusting for inflation, activity and investments);

- Contribution from growth in income from the previous year; and
- Release of unused contingency

4.3 Responsibility for planning, assessing and delivery of quality risk assessing CIP schemes rests operationally with the management teams of Clinical Divisions and Non-Clinical Directorates. The role of the Finance, Nursing and Medical Director's teams are to ensure that the Trust has an evidence based approach to reporting the financial and quality impact of schemes.

4.4 £9.8m of the CIP plan was reported as unidentified within the TDA financial plan submission. The total financial risk is increased for schemes which have been identified but do not have robust plans and mitigated by schemes in development which do not currently form part of the plan.

5 Statement of Financial Position (Balance Sheet)

5.1 The balance sheet is planned to remain in line with last financial year, with the exception of an unwinding of provisions relating to contractual disputes.

6 Capital Expenditure

6.1 The capital expenditure plan has been **increased by £3.9m** to £30.0m. This is below the level of planned depreciation by £5.0m, which is reflected in the cash forecast below.

7 Cash

7.1 The cash position is expected to **improve by £5.0m** to £60.3m. This is due to planned capital expenditure being below internally generated sources of cash (i.e. planned depreciation).

8 Monitor metrics – Financial Risk Rating

8.1 The Trust's overall financial risk rating (FRR) is planned to be a minimum of 3 based on the results below. A score of 3 is mandatory for Foundation Trust status.

Metric	**Q1**	**Q2**	**Q3**	**Q4**
EBITDA Margin %	3	3	3	3
Net Surplus Margin %	3	4	4	4
Return on Capital %	3	4	4	3
Liquidity Days	3	3	3	3
Achievement of Plan	5	5	5	5
Overall FRR	3	4	4	3

8.2 Monitor has recently closed consultation on a proposed Continuity of Service Rating as part of its proposed Risk Assessment Framework. This is intended to reflect short/medium term financial issues, or risks to solvency, of a provider with the metrics being:

- Liquidity ratio (excluding conditional working capital facilities); and
- Capital servicing capacity

This is relevant due to the importance in understanding the future financial performance metrics that will be required in the Trust's foundation trust application.

9 Key Risks and Opportunities

9.1 The delivery of the cost improvement plan (CIP);

9.2 The delivery of commissioner demand management (QIPP) initiatives and the ability to release associated costs from any activity reductions;

9.3 The ability to contain and improve performance against commissioner business rules/contract metrics;

9.4 The challenge and opportunity to earn NWL CCG incentive monies through the improvement in operational performance, delivery of quality outcomes and information provision externally; and

9.5 The maintenance of expenditure controls with continuing development of improvements in investment appraisal.

Appendix A – Statement of Comprehensive Income (SOCI)

STATEMENT OF COMPREHENSIVE INCOME			
	2012/13 Outturn £000s	2013/14 Plan £000s	Change £000s
Income			
Clinical	752,725	745,934	(6,791)
Research & Development	58,050	56,592	(1,458)
Training & Education	64,692	62,151	(2,541)
Other	95,806	76,597	(19,209)
TOTAL INCOME	**971,274**	**941,274**	**(30,000)**
Expenditure			
Pay - inc Bank & Agency	(522,485)	(507,431)	15,054
Drugs & Clinical Supplies	(183,421)	(178,923)	4,498
General Supplies	(37,035)	(35,551)	1,484
Other	(161,145)	(148,717)	12,428
TOTAL EXPENDITURE	**(904,086)**	**(870,622)**	**33,464**
EBITDA	**67,188**	**70,652**	**3,464**
Financing Costs	(107,143)	(56,169)	50,974
SURPLUS / (DEFICIT) before Impairment	**(39,955)**	**14,483**	**54,438**
Impairment of Assets, Stock losses & Donated Asset treatment	48,980	592	(48,388)
SURPLUS / (DEFICIT)	**9,025**	**15,075**	**6,050**

Mark Davies
Chief Executive
Imperial College Healthcare NHS Trust
The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY

16 May 2013

Dear Mark

2013/14 Operating Plan

Thank you for re-submitting your final 2013/14 Operating Plan on 30 April 2013. I would like to take this opportunity to recognise the significant work that has gone into delivering a clear and robust plan for 2013/14 during a challenging period of change and transition in the NHS.

As you know, *'Toward High Quality, Sustainable Services: Planning Guidance for NHS Trust Boards for 2013/14'* set out our expectations of NHS Trusts and the support they can expect from the NHS Trust Development Authority (TDA), in delivering high quality, sustainable services for the patients and communities they serve.

It is critical to deliver a fully integrated annual plan that:

- focuses in equal measure on delivering the core standards consistently and identifying ambitious plans to drive up standards and improve the quality of services;
- secures all this within the available resources; and
- helps to create a sustainable organisation through sound business and financial planning.

As you know, we aimed to bring to a close our assurance of the 2013/14 planning process by 10 May 2013.

Therefore, this letter confirms our recommendation to the TDA Board that the Trust's 2013/14 Operating Plan showing a surplus of £15.075m, should be accepted subject to the following three conditions:

1. The Trust having signed 2013/14 contracts with all its commissioners that materially agree to the income figures and confirmation of all material non-recurrent income streams included in the plan.

2. The Trust having identified and signed off at a Board meeting, recurrent CIP schemes with a full year effect of at least £49.255m; and having identified

mitigating non-recurrent actions to ensure it delivers the total 2013/14 CIP value in year. All schemes having signed off quality impact assessments that demonstrate any associated risks to patient safety are appropriately mitigated.

Both conditions 1 and 2 above require an appropriate Board minute as confirmation by 30 June 2013.

3. The Trust submitting accurate and consistent responses to the capital and cash questions being sent out today, and making a final financial plan submission if requested.

Next Steps

The TDA will continue to work closely with all NHS Trusts to review progress against their 2013/14 plans and in achieving a sustainable organisational form. The TDA's approach is clearly set out in the TDA's Accountability Framework, through the establishment of monthly oversight meetings when a 'single conversation' will take place each month covering progress on quality and governance, finance and delivering sustainability.

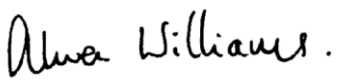
As part of the assurance of the 2013/14 planning process, the TDA has specifically requested further information and assurance relating to gaps in the quality submissions. These included: assurance about making public the Trust's performance on quality; development of the Trust's Clinical Strategy; and assurance regarding the management of clinical risks associated with CIPs. The TDA will undertake on-going quality monitoring, support and escalation as necessary against the specific areas identified in this letter and the key domains and indicators outlined in the TDA Accountability Framework for NHS Trust Boards.

This letter confirms that we will continue to work with you to develop and agree by 30 June 2013 the plan and timeline and identify milestones to achieve FT status.

Finally, the success of the TDA is intertwined with the success of NHS Trusts - our central commitment to delivering a fully autonomous provider landscape can only be achieved through your success. We will ensure that wherever possible we support you to deliver your ambitions. In return, our expectation is a simple one - that the commitments you make through this planning round and through locally agreed contracts are delivered in full.

If you wish to discuss the above or any related issues further, please contact your Portfolio Director, Mark Brice.

Yours sincerely



Alwen Williams
Director, Delivery and Development
NHS Trust Development Authority

CC:
Mark Brice, Portfolio Director, NHS TDA
Vicky Scott, Head of Delivery & Development, NHS TDA
Debbie Stubberfield, Clinical Quality Director, NHS TDA
Ian Moston, Finance Business Director, NHS TDA

Appendix C – 2013/14 Annual Plan Submission to Trust Development Authority (TDA)

Statement of Comprehensive Income (SOCI)

Imperial College Healthcare NHS Trust
Org Code: RYJ
Period: Financial Plan for 2013/14

TRU 01

Statement of Comprehensive Income	Sub Code	SIGN	2012/13 Full Year FOT (mc 01) £000s	2013/14 Full Year (mc 02) £000s	Apr (mc 03) £000s	May (mc 04) £000s	Jun (mc 05) £000s	Jul (mc 06) £000s	Aug (mc 07) £000s	Sep (mc 08) £000s	Oct (mc 09) £000s	Nov (mc 10) £000s	Dec (mc 11) £000s	Jan (mc 12) £000s	Feb (mc 13) £000s	Mar (mc 14) £000s	2014/15 Full Year (mc 15) £000s
Gross Employee Benefits	100	-	(522,485)	(507,431)	(42,027)	(42,064)	(42,061)	(42,445)	(42,090)	(42,311)	(42,381)	(42,410)	(42,358)	(42,444)	(42,297)	(42,543)	(490,227)
Other Operating Costs	110	-	(466,159)	(398,192)	(33,328)	(33,236)	(33,233)	(33,225)	(33,167)	(33,185)	(33,203)	(33,166)	(33,128)	(33,137)	(33,040)	(33,144)	(398,313)
Revenue from Patient Care Activities	120	+	752,725	745,934	60,190	61,837	61,821	63,994	61,430	63,205	64,864	63,143	61,341	63,011	58,366	62,732	736,279
Other Operating Revenue	130	+	218,549	195,340	16,279	16,279	16,278	16,279	16,279	16,279	16,280	16,281	16,280	16,278	16,277	16,271	194,064
OPERATING SURPLUS/(DEFICIT)	140	+/-	(17,370)	35,651	1,114	2,816	2,805	4,603	2,452	3,988	5,560	3,848	2,135	3,708	(694)	3,316	41,803
Investment Revenue	150	+	287	287	24	24	24	24	24	23	23	24	24	25	25	23	300
Other Gains and Losses	160	+/-	(13)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Finance Costs (including interest on PFIs and Finance Leases)	170	-	(1,791)	(859)	(72)	(72)	(71)	(72)	(72)	(71)	(72)	(72)	(71)	(72)	(72)	(70)	(811)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	180	+/-	(18,887)	35,079	1,066	2,768	2,758	4,555	2,404	3,940	5,511	3,800	2,088	3,661	(741)	3,269	41,292
Dividends Payable on Public Dividend Capital (PDC)	190	-	(21,068)	(20,596)	(1,716)	(1,716)	(1,716)	(1,716)	(1,716)	(1,718)	(1,716)	(1,716)	(1,716)	(1,716)	(1,716)	(1,718)	(21,037)
Net gains/ (loss) on transfers by absorption	195	+/-		0	0	0	0	0	0	0	0	0	0	0	0	0	0
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	200	+/-	(39,955)	14,483	(650)	1,052	1,042	2,839	688	2,222	3,795	2,084	372	1,945	(2,457)	1,551	20,255
Prior Period Adjustment	210	+/-															
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR PER ACCOUNTS	220	+/-	(39,955)	14,483	(650)	1,052	1,042	2,839	688	2,222	3,795	2,084	372	1,945	(2,457)	1,551	20,255

Reported NHS Financial Performance	Sub Code	SIGN	2012/13 Full Year FOT (mc 01) £000s	2013/14 Full Year (mc 02) £000s	Apr (mc 03) £000s	May (mc 04) £000s	Jun (mc 05) £000s	Jul (mc 06) £000s	Aug (mc 07) £000s	Sep (mc 08) £000s	Oct (mc 09) £000s	Nov (mc 10) £000s	Dec (mc 11) £000s	Jan (mc 12) £000s	Feb (mc 13) £000s	Mar (mc 14) £000s	2014/15 Full Year (mc 15) £000s
Retained surplus/(deficit) for the year	350	+/-	(39,955)	14,483	(650)	1,052	1,042	2,839	688	2,222	3,795	2,084	372	1,945	(2,457)	1,551	20,255
IFRIC 12 adjustment including impairments	360	+/-		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Impairments excluding IFRIC12 impairments	370	+/-	48,379	0	0	0	0	0	0	0	0	0	0	0	0	0	0
donation/grant receipts and depreciation of donated/grant funded assets)	380	+/-	601	592	49	49	49	49	49	49	49	48	48	49	49	55	584
Adjustments - other Net gains / (losses) on transfers by absorption	385	+/-	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjusted Financial Performance Retained Surplus/(Deficit)	390	+/-	9,025	15,075	(601)	1,101	1,091	2,888	737	2,271	3,844	2,132	420	1,994	(2,408)	1,606	20,839

Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA)	Sub Code	SIGN	2012/13 Full Year FOT (mc 01) £000s	2013/14 Full Year (mc 02) £000s	Apr (mc 03) £000s	May (mc 04) £000s	Jun (mc 05) £000s	Jul (mc 06) £000s	Aug (mc 07) £000s	Sep (mc 08) £000s	Oct (mc 09) £000s	Nov (mc 10) £000s	Dec (mc 11) £000s	Jan (mc 12) £000s	Feb (mc 13) £000s	Mar (mc 14) £000s	2014/15 Full Year (mc 15) £000s
Retained Surplus / (Deficit) for the Year	400	+/-	(39,955)	**14,483**	(650)	1,052	1,042	2,839	688	2,222	3,795	2,084	372	1,945	(2,457)	1,551	20,255
Depreciation	410	+	36,641	**34,589**	2,883	2,883	2,883	2,883	2,883	2,883	2,883	2,882	2,882	2,882	2,882	2,880	33,987
Amortisation	420	+	412	**412**	33	33	33	33	33	33	34	34	34	34	34	44	412
Impairments (including IFRIC 12 impairments)	425	+/-	48,379	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Receivable	430	-	(287)	**(287)**	(24)	(24)	(24)	(24)	(24)	(23)	(23)	(24)	(24)	(25)	(25)	(23)	(300)
Finance Costs (including interest on PFIs and Finance Leases)	440	+	1,791	**859**	72	72	71	72	72	71	72	72	71	72	72	70	811
Dividends	460	+	21,068	**20,596**	1,716	1,716	1,716	1,716	1,716	1,718	1,716	1,716	1,716	1,716	1,716	1,718	21,037
Donated/Government grant assets adjustment (donation income element of SC 380)	465	-	(789)	**(798)**	(67)	(67)	(67)	(67)	(67)	(67)	(67)	(68)	(68)	(67)	(67)	(59)	(806)
(Gains) / Losses on disposal of assets	470	+/-	13	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
(Gains) / Losses on disposal of other	480	+/-	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
Adjustments - other Net gains / (Losses) on transfers by absorption	485	+/-	0	**0**	0	0	0	0	0	0	0	0	0	0	0	0	0
EBITDA Sub Total	490	+/-	**67,273**	**69,854**	**3,963**	**5,665**	**5,654**	**7,452**	**5,301**	**6,837**	**8,410**	**6,696**	**4,983**	**6,557**	**2,155**	**6,181**	**75,396**
Restructuring costs	500	+	5,450	**11,000**	500	500	500	900	900	1,000	1,000	1,100	1,100	1,100	1,200	1,200	8,500

Balance Sheet

Imperial College Healthcare NHS Trust
Org Code: RYJ
Period: Financial Plan for 2013/14

TRU 02

Statement of Financial Position	Sub Code	SIGN	Opening Balance at 01/04/2013 (mc 01) £000s	Apr (mc 02) £000s	May (mc 03) £000s	Jun (mc 04) £000s	Jul (mc 05) £000s	Aug (mc 06) £000s	Sep (mc 07) £000s	Oct (mc 08) £000s	Nov (mc 09) £000s	Dec (mc 10) £000s	Jan (mc 11) £000s	Feb (mc 12) £000s	Mar (mc 13) £000s	Plan Year ending 31/03/2015 (mc 14) £000s
NON-CURRENT ASSETS:																
Property, Plant and Equipment	100	+	715,616	713,336	711,472	709,717	708,757	708,118	707,628	707,680	708,059	708,775	709,905	709,830	711,071	707,299
Intangible Assets	110	+	1,681	1,648	1,615	1,582	1,549	1,516	1,483	1,449	1,415	1,381	1,347	1,313	1,225	600
Investment Property	120	+	0													
Other Financial Assets	130	+	0													
Trade and Other Receivables	140	+	0													
TOTAL Non Current Assets	150	+	**717,297**	**714,984**	**713,087**	**711,299**	**710,306**	**709,634**	**709,111**	**709,129**	**709,474**	**710,156**	**711,252**	**711,143**	**712,296**	**707,899**
CURRENT ASSETS:																
Inventories	160	+	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652	17,652
Trade and Other Receivables	170	+	65,462	66,462	67,462	65,462	63,462	63,462	63,462	63,462	63,462	62,462	62,462	61,462	63,462	68,162
Other Financial Assets	180	+	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other Current Assets	190	+	0	0	0	0	0	0	0	0	0	0	0	0	0	
Cash and Cash Equivalents	200	+	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	67,326
Sub Total Current Assets	210	+	**138,440**	**154,420**	**157,216**	**160,096**	**162,309**	**163,555**	**135,960**	**144,556**	**152,118**	**153,797**	**158,942**	**163,074**	**141,440**	**153,140**
Non-Current Assets Held For Sale	220	+	0													
TOTAL Current Assets	230	+	**138,440**	**154,420**	**157,216**	**160,096**	**162,309**	**163,555**	**135,960**	**144,556**	**152,118**	**153,797**	**158,942**	**163,074**	**141,440**	**153,140**
TOTAL ASSETS	240	+	**855,737**	**869,404**	**870,303**	**871,395**	**872,615**	**873,189**	**845,071**	**853,685**	**861,592**	**863,953**	**870,194**	**874,217**	**853,736**	**861,039**

CURRENT LIABILITIES																
Trade and Other Payables	250	-	(127,930)	(142,272)	(142,144)	(142,219)	(140,625)	(140,536)	(111,747)	(116,591)	(122,439)	(124,453)	(128,774)	(135,279)	(135,775)	(125,506)
Other Liabilities	260	-		0	0	0	0	0	0	0	0	0	0	0	0	
Provisions	270	-	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(21,270)	(5,000)	(5,000)
Borrowings	280	-	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,833)	(1,459)	(806)
Other Financial Liabilities	290	-														
DH Working Capital Loan - FT Liquidity	300	-														
DH Working Capital Loan - Revenue Support	305	-														
DH Capital Loan	310	-	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)	(1,226)
Total Current Liabilities	320	-	**(152,259)**	**(166,601)**	**(166,473)**	**(166,548)**	**(164,954)**	**(164,865)**	**(136,076)**	**(140,920)**	**(146,768)**	**(148,782)**	**(153,103)**	**(159,608)**	**(143,460)**	**(132,538)**
NET CURRENT ASSETS/(LIABILITIES)	330	+/-	**(13,819)**	**(12,181)**	**(9,257)**	**(6,452)**	**(2,645)**	**(1,310)**	**(116)**	**3,636**	**5,350**	**5,015**	**5,839**	**3,466**	**(2,020)**	**20,602**
TOTAL ASSETS LESS CURRENT LIABILITIES	340	+/-	**703,478**	**702,803**	**703,830**	**704,847**	**707,661**	**708,324**	**708,995**	**712,765**	**714,824**	**715,171**	**717,091**	**714,609**	**710,276**	**728,501**
NON-CURRENT LIABILITIES:																
Trade and Other Payables	350	-														
Other Liabilities	360	-														
Provisions	370	-	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(16,083)	(11,083)	(11,083)
Borrowings	380	-	(2,540)	(2,540)	(2,540)	(2,540)	(2,540)	(2,540)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,081)	(277)
Other Financial Liabilities	390	-														
DH Working Capital Loan - FT Liquidity	400	-														
DH Working Capital Loan - Revenue Support	405	-														
DH Capital Loan	410	-	(20,822)	(20,822)	(20,822)	(20,822)	(20,822)	(20,822)	(20,022)	(20,022)	(20,022)	(20,022)	(20,022)	(20,022)	(19,596)	(18,370)
Total Non-Current Liabilities	420	-	**(39,445)**	**(39,445)**	**(39,445)**	**(39,445)**	**(39,445)**	**(39,445)**	**(37,915)**	**(37,915)**	**(37,915)**	**(37,915)**	**(37,915)**	**(37,915)**	**(31,760)**	**(29,730)**
ASSETS LESS LIABILITIES (Total Assets Employed)	430	+/-	**664,033**	**663,358**	**664,385**	**665,402**	**668,216**	**668,879**	**671,080**	**674,850**	**676,909**	**677,256**	**679,176**	**676,694**	**678,516**	**698,771**
TAXPAYERS EQUITY																
Public Dividend Capital	440	+/-	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088	696,088
Retained Earnings reserve	450	+/-	(72,899)	(73,574)	(72,547)	(71,530)	(68,716)	(68,053)	(65,852)	(62,082)	(60,023)	(59,676)	(57,756)	(60,238)	(58,416)	(38,161)
Revaluation Reserve	470	+	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844	40,844
Other Reserves	480	+/-														
Total Taxpayers Equity	490	+/-	**664,033**	**663,358**	**664,385**	**665,402**	**668,216**	**668,879**	**671,080**	**674,850**	**676,909**	**677,256**	**679,176**	**676,694**	**678,516**	**698,771**
Cash held in Government Banking Service account	500	+	55,264	70,240	72,036	76,916	81,129	82,375	54,780	63,376	70,938	73,617	78,762	83,894	60,260	67,260

Cash Flow Statement

Imperial College Healthcare NHS Trust
Org Code: RYJ
Period: Financial Plan for 2013/14

TRU 04

Statement of Cash Flows (CF)	Sub Code	SIGN	2012/13 Full Year FOT (mc 01) £000s	2013/14 Full Year (mc 02) £000s	Apr (mc 03) £000s	May (mc 04) £000s	Jun (mc 05) £000s	Jul (mc 06) £000s	Aug (mc 07) £000s	Sep (mc 08) £000s	Oct (mc 09) £000s	Nov (mc 10) £000s	Dec (mc 11) £000s	Jan (mc 12) £000s	Feb (mc 13) £000s	Mar (mc 14) £000s	2014/15 Full Year (mc 15) £000s
Cash Flows from Operating Activities																	
Operating Surplus/(Deficit)	100	+/-	(17,370)	35,651	1,114	2,816	2,805	4,603	2,452	3,988	5,560	3,848	2,135	3,708	(694)	3,316	41,803
Depreciation and Amortisation	110	+	37,053	35,001	2,916	2,916	2,916	2,916	2,916	2,916	2,917	2,916	2,916	2,916	2,916	2,924	34,399
Impairments and Reversals	120	+/-	48,932	565	47	47	47	47	47	47	47	47	47	47	47	48	589
Other Gains / (Losses) on foreign exchange	130	+/-	0	0													
Donated Assets received credited to revenue but non-cash	140	-	0	0													
Government Granted Assets received credited to revenue but non-cash	150	-	0	0													
Interest Paid	160	-	(1,791)	(859)						(430)						(429)	(811)
Dividend (Paid)/Refunded	170	+/-	(21,068)	(20,596)						(10,298)						(10,298)	(21,037)
Release of PFI/deferred credit	180	+/-	0	0													
(Increase)/Decrease in Inventories	190	+/-	(511)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Trade and Other Receivables	200	+/-	(12,136)	2,000	(1,000)	(1,000)	2,000	2,000	0	0	0	0	1,000	0	1,000	(2,000)	(4,700)
(Increase)/Decrease in Other Current Assets	210	+/-	0	0													
Increase/(Decrease) in Trade and Other Payables	220	+/-	21,557	7,280	12,501	(1,969)	(1,765)	(3,435)	(1,930)	(19,899)	3,003	4,007	174	2,480	4,664	9,449	(10,860)
Increase/(Decrease) in Other Current Liabilities	230	+/-		0	0	0	0	0	0	0	0	0	0	0	0	0	
Provisions Utilised	240	-	(1,223)	(21,270)	0	0	0	0	0	0	0	0	0	0	0	(21,270)	0
Increase/(Decrease) in Movement in non Cash Provisions	250	+/-	25,685	0												0	0
Net Cash Inflow/(Outflow) from Operating Activities	260	+/-	**79,128**	**37,772**	**15,578**	**2,810**	**6,003**	**6,131**	**3,485**	**(23,676)**	**11,527**	**10,818**	**6,272**	**9,151**	**7,933**	**(18,260)**	**39,383**

CASH FLOWS FROM INVESTING ACTIVITIES																	
Interest Received	270	+	287	287	24	24	24	24	24	23	23	24	24	25	25	23	300
(Payments) for Property, Plant and Equipment	280	-	(25,846)	(30,000)	(622)	(1,038)	(1,147)	(1,942)	(2,263)	(2,412)	(2,954)	(3,280)	(3,617)	(4,031)	(2,826)	(3,868)	(30,000)
(Payments) for Intangible Assets	290	-		0													
(Payments) for Investments with DH	300	-		0													
(Payments) for Other Financial Assets	310	-		0													
(Payments) for Financial Assets (LIFT)	320	-		0													
Proceeds of disposal of assets held for sale (PPE)	330	+		0													
Proceeds of disposal of assets held for sale (Intangible)	340	+		0													
Proceeds from Disposal of Investment with DH	350	+		0													
Proceeds from Disposal of Other Financial Assets	360	+		0													
Proceeds from the disposal of Financial Assets (LIFT)	370	+		0													
Rental Revenue	400	+		0													
Net Cash Inflow/(Outflow) from Investing Activities	410	+/-	(25,559)	(29,713)	(598)	(1,014)	(1,123)	(1,918)	(2,239)	(2,389)	(2,931)	(3,256)	(3,593)	(4,006)	(2,801)	(3,845)	(29,700)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	420	+/-	53,569	8,059	14,980	1,796	4,880	4,213	1,246	(26,065)	8,596	7,562	2,679	5,145	5,132	(22,105)	9,683

CASH FLOWS FROM FINANCING ACTIVITIES																	
Public Dividend Capital Received	430	+	1,170	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	440	-		0													
Loans received from DH - New Capital Investment Loans	450	+		0													
Loans received from DH - FT Liquidity Loans	460	+		0													
Loans received from DH - Revenue Support Loans	465	+		0													
Loans received - London RE:FIT loans (London Trusts only)	468	+		0													
Other Loans Received (including PFIs, LIFT and Finance Leases)	470	+	1,979	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	480	-	(22,772)	(1,226)						(614)						(612)	(1,226)
Loans repaid to DH - FT Liquidity Loans Repayment of Principal	490	-		0													
Loans repaid to DH - Revenue Support Loans Repayment of Principal	492	-		0													
Other Loans Repaid	500	-	(1,594)	(1,833)						(916)						(917)	(1,457)
Cash transferred to NHS Foundation Trusts	520	+/-		0													
Capital grants and other capital receipts (excluding donated / government granted cash receipts)	560	+		0													
Net Cash Inflow/(Outflow) from Financing Activities	580	+/-	**(21,217)**	**(3,059)**	**0**	**0**	**0**	**0**	**0**	**(1,530)**	**0**	**0**	**0**	**0**	**0**	**(1,529)**	**(2,683)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	590	+/-	**32,352**	**5,000**	**14,980**	**1,796**	**4,880**	**4,213**	**1,246**	**(27,595)**	**8,596**	**7,562**	**2,679**	**5,145**	**5,132**	**(23,634)**	**7,000**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	600	+/-	22,974	55,326	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
Opening Balance Adjustment	610	+/-		0													
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	620	+/-	**22,974**	**55,326**	**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**
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	630	+/-		0													
Cash and Cash Equivalents (and Bank Overdraft) at YTD	640	+/-	**55,326**	**60,326**	**70,306**	**72,102**	**76,982**	**81,195**	**82,441**	**54,846**	**63,442**	**71,004**	**73,683**	**78,828**	**83,960**	**60,326**	**67,326**

Trust Board: 29 May 2013 **Agenda Number: 4.2.2 Paper: 13**

Imperial College Healthcare NHS
NHS Trust

Trust Board:

Title: Delegated Authority to Approve 2012/13 Annual Accounts

To be presented by: Bill Shields, CFO

Executive Summary:

The audited 2012/13 annual accounts are to be submitted to the Department of Health by midday on 10th June 2013.

As the annual accounts audit is currently ongoing and the submission date is prior to the next Board meeting, the Board is requested to grant delegated authority to the Audit & Risk Committee to approve the annual accounts and annual report at its meeting on 5th June 2013.

Key Issues for discussion: N/A

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision √
b. For information/noting ☐

Imperial College Healthcare NHS
NHS Trust

Report Title: Director of People & OD's Report

To be presented by: Jayne Mee

Executive Summary: This report summaries design and delivery of key plans in line with the emerging People and OD Strategy.

Key Issues for discussion: N/A

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

a. For Decision ☐
b. For information/noting √

Imperial College Healthcare NHS
NHS Trust

Director of People & OD's Report

29th May 2013

1. BOARD DEVELOPMENT

Following a tendering process we have selected Deloitte to assist us with our Board Development Programme. Jay Bevington and John Murray will lead the design and much of the delivery. The attached Appendix A sets out the approach suggested by Deloitte. Rodney Eastwood and Jayne Mee have discussed specifics with Jay Bevington which will negate the need for Focus Groups and an External Stakeholder analysis as we already have much of the information that would be gained from both which will be shared with Deloitte. Jayne will now work with Jay to set up the initial round of 1½ hour interviews and would be grateful to all Board members if they could make themselves available for this. A Board Away Day to feedback and plan any further development will take place August/September on a date to be agreed.

2. EXECUTIVE DEVELOPMENT

Mark Davies and Jayne Mee have completed the tendering process for Executive Team Development which will support the effective working of the team and our FT application.

We have commissioned David Cumberbatch from RHR a firm of business occupational psychologists who Jayne has found very effective in the past for this sort of development. The programme will comprise online psychometric personality and team questionnaires, interviews and an off-site event to share feedback and plan the way forward.

3. ENGAGEMENT – STAFF SURVEY RESULTS AND ACTION PLANS

The NHS Staff Survey Results were presented to the Management Board on 8th April 2013 (Appendix B). For the first time every CPG Director and Director of Corporate departments were requested to brief the results to their teams and produce an action plan of what they were going to do locally to improve engagement of our people. An alternative approach has been adopted which focuses on the enablers of engagement as well as those issues that arose from the survey itself. Teams have action planned around the following key areas:

- Job Satisfaction
- Effective Team working
- Quality and Quantity of appraisal
- Support from immediate Manager
- Communication from Senior Management
- Health, well being and safety

The response has been very encouraging. All CPGs and Corporate areas have submitted a Local Plan. The plans have been well constructed and have clear anticipated outcomes which would have a positive effect on Staff Engagement**.**

The Action plans will be monitored via the Senior P&OD team and local HR Business partners on a quarterly basis to ensure delivery against key actions identified. Further plans will be developed by P&OD to introduce a more regular means of surveying more of our people to complement the national annual staff survey . It is hoped that this will provide a more accurate means of assessing progress and impact of any action at a local level. Examples of the activities included in the action plans are included in Appendix B. The important thing to mention is that we are on a journey, over time the activities are likely to become more sophisticated, but for now it will be about getting some of the basics of engagement happening which will by nature enhance engagement and contribute to the culture change that is so necessary.

4. EQUALITY & DIVERISTY TRAINING

The Trust's statutory and mandatory training needs analysis (TNA) currently identifies that equality and diversity (E&D) training should be completed by all managers within the Trust (bands 6 and above) on a three year cycle.
Current compliance rates for E&D training are relatively low compared to other statutory and mandatory training topics. For staff above band 6 (excluding doctors in training) compliance was 44% as at 31st March 2013. For all staff the compliance rate was 38%.
In light of the above and the staff survey results the Equality and Diversity Committee took the decision to extend the scope of the target audience to include all Trust staff and to run a bespoke training campaign to improve compliance rates from 38% to 95%. An e-learning package will be designed, developed and launched to facilitate the achievement of this target. The campaign will be launched on 1st July 2013.

5. CPG RESTRUCTURE AND PHASE 2

Phase 1 of the restructure is well in train with many appointments made to the new positions and a number more in train. We are on track to deliver Phase 2 of the change which will effect approx. 250 of our people. Critically, the engagement of these people during the next couple of months whilst they go through consultation and selection will be key.

Plans are well advanced to design, develop and deliver Leadership Development Programmes for all senior management in the new divisional structure. For a number this may be their first formal leadership development, this is anticipated to be well received and will contribute to our overall people experience which we anticipate will have a direct correlation to our patient experience.

6. PEOPLE AND ORGANISATION STRATEGY

Following Jayne's appointment we have been working on the strategy for the next five years, and in particular getting started with some key activities during the next year. The strategy is emerging under the following key themes, with much more detail behind which can be shared in due course.

- **Culture & Engagement**

  To engage our people behind the Trust's strategic aims, objectives, ways of working and values: through effective organisation design, support of change management, attraction & recruitment processes, and an engagement programme that we can be proud of, delivering an empowered patient centric coaching culture.

- **Organisation Development**

  To ensure that we have the leadership, talent and people capacity and capability, supported by the right organisational systems, culture and design to achieve our vision and strategy

- **Talent Development**

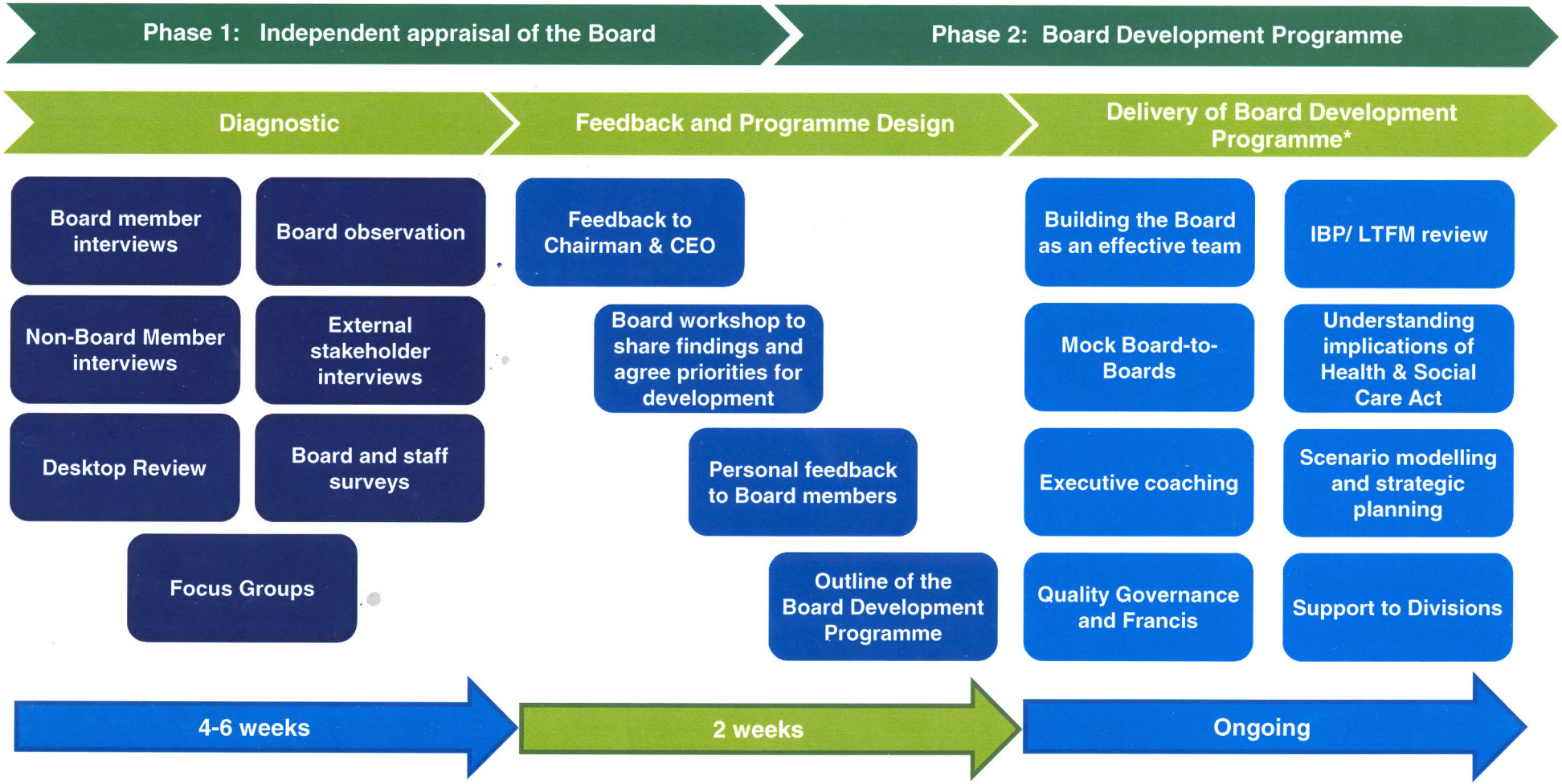
  To develop our people so that they aspire to their own full potential whilst delivering excellence in patient experience in a safe environment.

- **Health and Wellbeing**

- To promote the ethos "Fit for work, fit for life, fit for tomorrow" in all of our people

Deloitte.

Imperial College Healthcare NHS Trust



** The content of the programme will be finalised following our independent appraisal of the Board. We have, however, provided some suggestions based on our experience of supporting aspirant NHS FTs*

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NHS Trust

NHS Staff Survey Results and Action Plans 2012

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Background to the survey

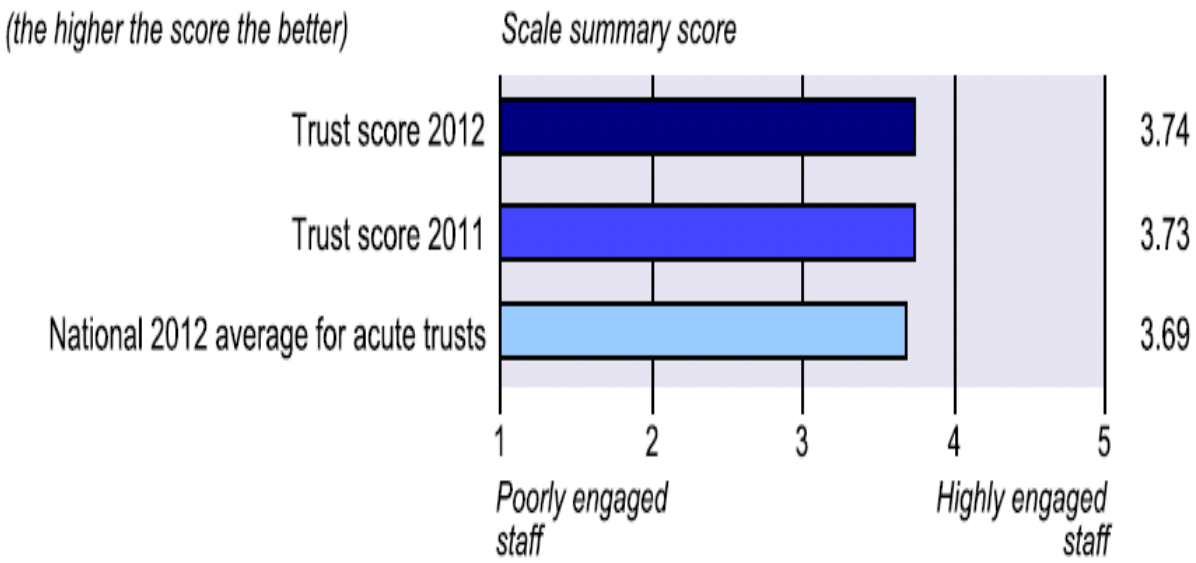
- **Completed October –December 2012**
- **Sample of 800 staff**
- **Response Rate : 51% of 800** (improvement from 42% in 2011)
  Average response rate 50%
- **Ranking of scores**

Top (best) 20%
Above(better than) average
Average
Worse than average
Worst 20%

Overall Staff Engagement Score

2011: Top 20%

2012: Above (better than) Average



An overall indicator using a number of Key Findings:-

KF22: Staff ability to contribute towards improvements at work

KF24:Staff recommendation as a place to work or receive treatment

KF25: Staff Motivation at work

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Overall Staff Engagement Score

Shelford

Highest (Best 20%)	• Kings, UCL, GSTH, Birmingham,Newcastle Cambridge
Above (better than) average	• **Imperial**, Oxford, Central Manchester
Below(worse than) average	• Sheffield

AUKUH –London/South East

Highest (best) 20%	• Kings, GSTH, UCL, • C & W, Royal Free
Above(better than) average	• St George's, **Imperial**, Oxford
Average	• Barts

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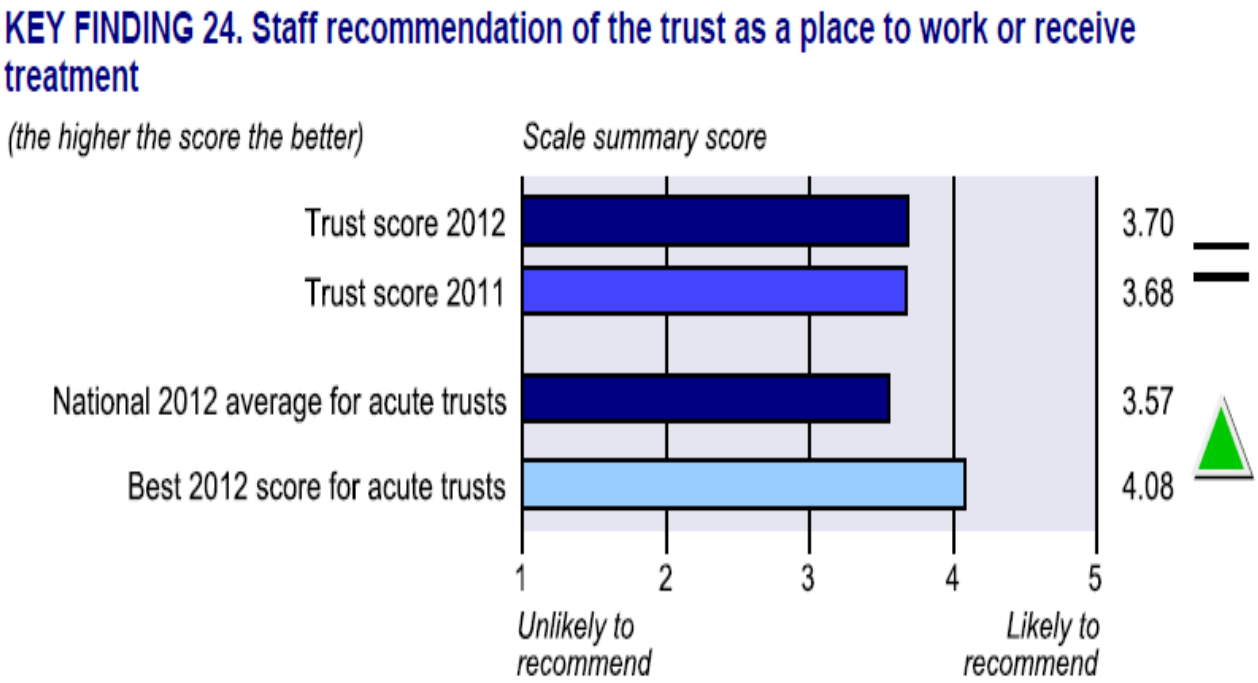
Would you recommend this Trust as a place to work or receive treatment?

2011: Highest (best) 20%

2012: Above (better than) average



Questions which make up this Key Finding

Q12a Care of patients is my organisation's top priority
Q12c I would recommend my organisation as a place to work
Q12d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

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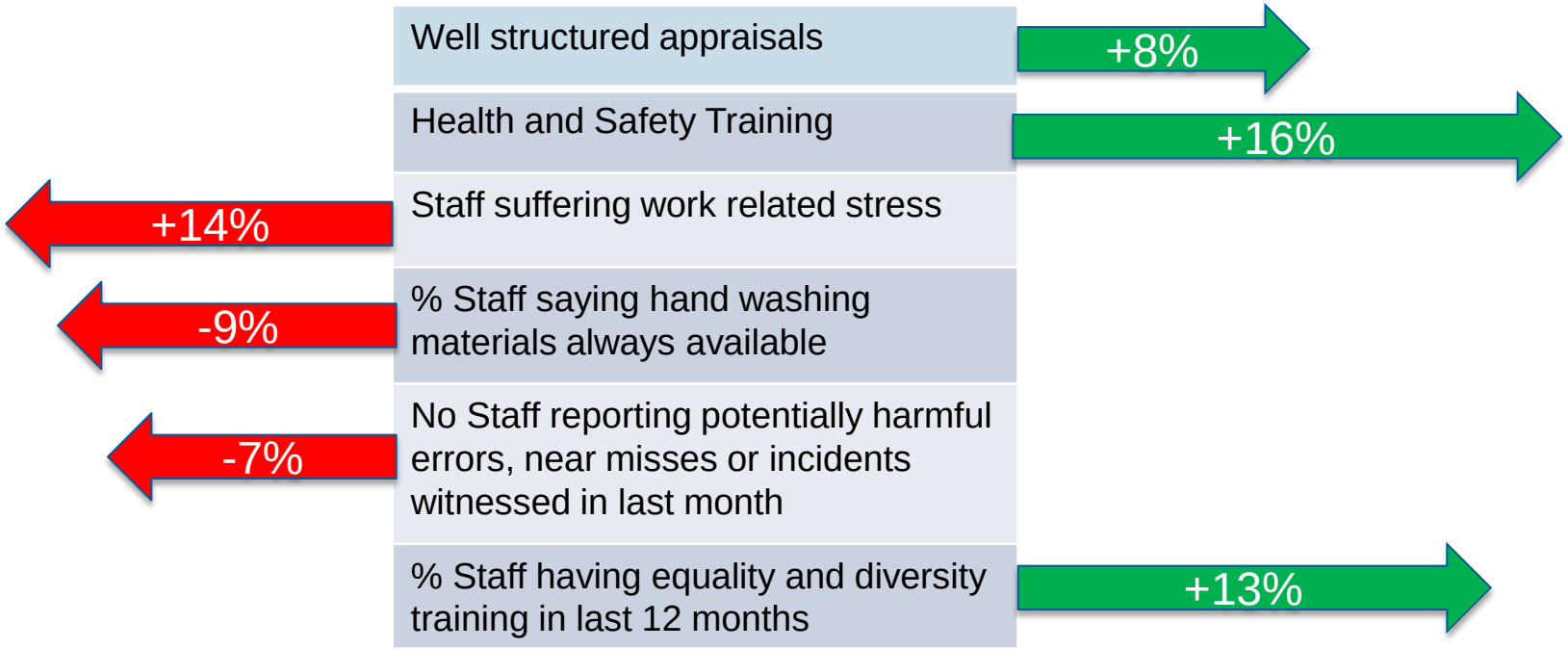
Question 12d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

QUARTILE	SCORE
4th Quartile	Score 75+
3rd Quartile	Score 63+ **Imperial – 68.734**
2nd Quartile	Score 55+
1st Quartile	Score 0-54

Most significant changes since with 2011



Imperial Top Ranking Questions

- Well structured appraisals
- Staff feel their role makes a difference to patients
- Satisfied with quality of work they are able to deliver
- % Staff working extra hours
- Staff recommend the trust as a place to work/have treatment

Imperial Bottom Ranking Questions

- Bullying/Harassment/Abuse from staff in last 12 months
- Bullying/Harassment/Abuse from patients in last 12 months
- Perception of equal opportunities for career progression/promotion
- Staff receiving health and safety training in last 12 months
- Staff experiencing discrimination at work

Update on Key Themes from 2011 Action Plan

Theme	2011 Score	2012 Score	+/-	2012 Ranking
Quantity Appraisals	81%	84%	Improved	Average
Quality Appraisals	37%	45%	Improved	Top 20%
Health and Safety Training	44%	60%	Improved	Bottom 20%
Bullying/Harassment/ Abuse - staff	*	32%	*	Bottom 20%
Bullying/Harassment/Abuse -patients	*	38%	*	Bottom 20%
Equal Opportunities for Career Progression	84%	78%	Deteriorated	Bottom 20%
Discrimination at work	17%	17%	No change	Bottom 20%

* Question changed in 2011 and cannot be compared with previous years

Key Priorities: What do we need to improve on in 2013?

Health Well-being and Safety
- Harassment, Bullying or Abuse from Staff
- Harassment Bullying or Abuse from Patients
- Work related stress

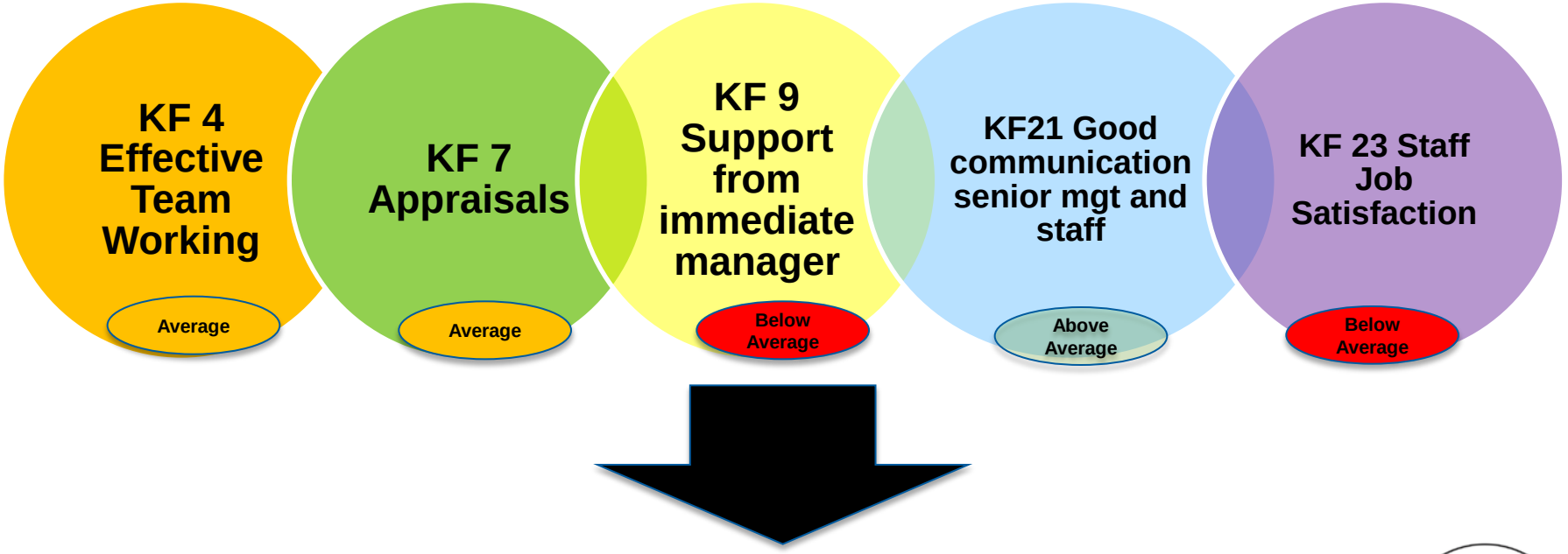
Equal Opportunities
- Staff feeling the Trust provides equal opportunities for career progression or promotion
- Staff experiencing discrimination at work

Staff Satisfaction
- Would you recommend this Trust as a place to work or receive treatment?

Development and Training
- Staff receiving Health and Safety Training
- Appraisals

Other
- Hand washing materials are always available

What are the real enablers to improved Staff Engagement?



Improved Staff Engagement

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Action Plan Template

Theme ***What are your local results saying?***	**Actions** ***What will really make the difference?***	**Outcome** ***How will I know if this has been successful?***	**Lead and timescale**
Effective Team working			
Quality and Quantity of appraisals			
Support from immediate Manager			
Good communication from senior management			
Job Satisfaction			
Health Well being and Safety			

1. EFFECTIVE TEAM WORKING

Examples of Actions	Anticipated Outcomes
Team meetings and communication •Create generic team brief template and team meeting structure •Develop team meeting structures for areas doing shift work and ensure all clinical staff have a mentor and use mentor/mentee network to cascade information •Senior management to attend team meetings •Improved communication at handovers •Better sharing of Team brief and sharing performance information •Continue to run away days at departmental level and evaluate feedback **Team Design** •Re-organise teams into more coherent units •Initiate rotation through teams •Establish more cross Directorate teams to deliver distinct projects **Stress** •Undertake stress surveys to understand and take action on stress factors	• Increased 1 to 1 support and ensure more regular cascade of information • Better communication and team working with shared vision • Improved team performance and good working relationships • Provide clarity on roles and responsibilities and maximise collaboration across teams • Greater development opportunities for team members

2. QUALITY AND QUANTITY OF APPRAISALS Examples of Actions	Anticipated Outcome
Streamline appraisal process •Make information available to staff who are responsible for appraisal reviews – staff encouraged to find out who their reviewer is •Roll out system of appraising staff in line with increment date with quarterly mini reviews •Identify OLM champions in all areas to ensure appraisal data recorded accurately •Develop departmental action plans demonstrating even distribution throughout the year **Improve quality of appraisals** •Develop an online feedback forum (survey monkey) to understand what staff are saying about the quality of appraisals •Develop anonymised appraisal feedback form for staff to complete following appraisal •Appraisals to include questions about quality at the end of the appraisal •Audit of appraisals by "grandparent" •Implement one to one meetings alongside appraisal •Audit/spot check appraisal quality **Improve skills in appraisals** •Develop targeted appraisal refreshers to be delivered locally on best practice for appraisal •All with line management responsibility to undertake training **Personal Development Plans** •Establish minimum bundle of education and development by grade and staff group **Increase commitment to Appraisal** •Send letter to all staff explaining Trust commitment to annual appraisal	Each member of staff knows who reviewer is Enables managers to be more targeted in their approach to appraisal compliance Improve appraisal quality Supports appraisal data management Provide system of feedback on quality and enables targeted action for areas receiving poor feedback Improve appraisal quality and quantity

3. SUPPORT FROM IMMEDIATE MANAGER Examples of Actions	Anticipated Outcome
Development •Develop on the job training for managers in becoming a role model/supporting their teams including observational feedback •Develop an e-learning module on E & D that can be rolled out by staff group and band •All new staff given a mentor as part of Local induction •Provide mentor training more widely •Enrol Ward Managers and Band 6 staff onto "Effective Ward manager" and "Leading to Green rolling programme •Dedicated time for on the job training/mentoring **Engagement** •Develop iPilot scheme where staff make recommendations for new initiatives discussed with SMT **Workload** •Recruitment to senior posts **Recognition** •Congratulate and praise staff for achievements and hard work •Participate in Recognition awards	Develop managers to better support, train and communicate with their teams Help to support the awareness of EO and encourage staff to feel there are EO in the Trust Greater involvement of wider team in new ways of working/cost saving initiatives Improve retention rates and support new staff

4. GOOD COMMUNICATION FROM SENIOR MANAGEMENT

Examples of Actions	Anticipated Outcome
Enhance Local Communication Structures •Increase number of Open Hour forums with CPG Director informing staff about CPG/Trust issues •Identify a divisional communication lead •Develop comms strategy including a more interactive divisional intranet site, a divisional bi monthly update email, divisional email address for employee to post feedback, Divisional Board walk around, Monthly divisional feedback and update forums, Divisional code of conduct (laminated card for all staff) •"You said we did" posters to be introduced •Introduce formal partnership working group •Improve CPG information on the Source •Share performance information with staff •Continue local Directorate monthly open Hour and newsletter •Trial weekly stand up meeting for updates **Staff Feedback** •Internal staff survey to be disseminated throughout CPG and outcomes communicated via Medicine matters •Use Open forums to ask staff how they want to be communicated with **Visibility** •Ensure a Team Briefing session done on each site each month by senior member of team •Attendance of Senior Manager at monthly staff meetings and regular walkabouts	•Increased accountability for divisional comms •Provide variety of ways for information to be communicated and range of ways for feedback •Provide support for staff wanting to speak up •Involve staff and trade unions earlier in discussions •Better engagement with staff and more visible management

5. JOB SATISFACTION Examples of Actions	Anticipated Outcome
Development of Management Skills •Review communication training including giving/receiving feedback, conversations of concern, performance management conversations •Provide clarity of roles and expectations **Recognition** •Recognise staff through Irecognise •Recognise outstanding performance in bulletins •Introduce local employee of the month scheme •Promote recognition award winners across the Directorate **Exit Data** •Identify wards with high turnover and carry out exit questionnaire/analysis and create actions plans **Development** •Support development plans and provide clarity on development opportunities •Introduce monthly “master class” sessions on specific issues **Resources** •Ensure equipment available for role/productivity	•Improved opportunity for developing staff to deal with difficult situations •Recognise achievements •Improve retention •Ensure staff feel their development is prioritised

6. HEALTH WELL BEING AND SAFETY Examples of action	Anticipated Outcome
Stress management and Support •Line managers to conduct annual stress surveys •Raise awareness of work related stress and promote support services via CPG Newsletter •Ensure all staff are aware of CONTACT and Occ Health services **Harassment, Bullying and Violence** •Relaunch Harassment and Bullying Policy and improve awareness of the need to report violence and harassment •All line managers to receive training on Bullying and Harassment and establish reporting route in CPG •Reinforce values and behaviours •Consider "Fair treatment Advisors/Buddies" to provide impartial and confidential support to staff •Review training courses available to support staff when dealing with challenging behaviours from patients/relatives •Set up regular reflective practice sessions to discuss challenging cases and share coping strategies when dealing with aggression **Working Patterns** •Review use of annualised/flexible working contracts to review how successful they are **Safety** •Organise health and safety audits •Improve staff awareness of risk assessments and hazards-Ensure that lone working is reduced	Support staff suffering stress Staff have confidence to raise issues Support staff to proactively deal with bullying harassing, violence from staff Review alternative ways to discourage staff from working excessive hours

Key Themes for Trust wide action emerging from Local Plans

- Appraisal Training for Managers
- Audit Quality of Appraisals
- Develop Equality and Diversity e-learning module
- Implement local Pulse Staff Survey/feedback process
- Publicity of CONTACT and Occ Health
- Reinforce Bullying and Harassment policy and processes

Next Steps

- Continue to build action plans
- Implement action plans
- Ensure actions map across to new Divisions and transfer to new named lead
- Feedback any further recommended Trust wide actions
- Quarterly review on progress against plan

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD

Report Title: ICHT Annual Plan 2013/14

To be presented by: Bill Shields, Chief Financial Officer

As the culmination of the 2013/14 integrated planning round, CPG and corporate directorate business plans have been aggregated to form the Trust Annual Plan for 2013/14, which will become year one of a five year Integrated Business Plan to support the Trust's Foundation Trust application.

Drafts of the Annual Plan were reviewed by the Management Board on 22 April and 15 May. The final draft is attached for the Trust Board's review and approval prior to publication on the Trust website.

The Board is asked to:

- **Review** and **approve** the final draft for publication.

Legal Implications or Review Needed

a. Yes
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For decision and approval ✓
b. For review/noting ✓

Annual Plan 2013/14 – Executive Summary

1.1. Achievements of 2012/13

During 2012/13, the strategic direction of the Trust was reviewed and refreshed. As a result the 2012/13 Business Plan was based on three main themes:

- Delivery of financial performance in line with the first year of Medium Term Financial Strategy;
- Achievement of all performance standards within the NHS Operating Plan and NHS London priorities;
- Development of a new strategic plan for the Trust.

The progress made in the last year against each of these three themes is summarised below.

1.1.1. Operational Performance

The Trust has gained recognition for its continued focus on delivery of high quality services. These achievements include:

- Achievement of Hospital Standardised Mortality Rates (HSMR) of 71 and Summary Hospital-Level Mortality Indicator (SMHI) of 76 at Month 8;
- Achievement of NHS Litigation Authority (NHSLA) Clinical Negligence Scheme for Trusts (CNST) Level 3 for all Acute and Maternity services, leading to significant savings on insurance premiums;
- Awarded full Joint Advisory Group (JAG) accreditation for Gastroenterology (GI) Endoscopy at Hammersmith Hospital (HH) and Charing Cross Hospital (CXH) demonstrating Imperial College Hospital Trusts (ICHT's) commitment to patient safety;
- Compliant with four national, five planned and three responsive Care Quality Commission (CQC), inspections;
- Hyper-Acute Stroke Unit (HASU) remains in the top quartile of performance in the country, according to the Royal College of Physicians with a score of 90.9% in the latest quarterly Stroke Improvement National Audit Programme.

After a six month reporting break and establishment of implementation plans and governance structures, 2012/13 has seen an improvement in performance against 18 week and cancer access targets. These improvements in governance structures have led to the Trust achieving against all Referral to Treat (RTT) targets for admitted, non-admitted and incomplete pathways at a Trust aggregate level, and all eight cancer targets in March 2013.

The Trust has demonstrated continued excellence in research, with 2012/13 seeing the launch of the Medical Research Council - National Institute for Health Research (MRC-NIHR) Phenome centre and the renewal of the NIHR/Wellcome Trust Imperial Clinical Research Facility for a further five years. The Trust is the most successful Trust in England for NIHR Fellowships for Nurses and Allied Health Professional (AHP) and was awarded the lead provider status for postgraduate training in a further nine specialties.

The Trust is fully CQC compliant and working towards improving its compliance with its Patient Transfer Policy.

1.1.2. Financial Performance

The Trust made significant progress in securing financial stability and improving key areas of performance during 2012/13, as well as receiving recognition for high quality standards of patient care. The Trust has implemented an integrated approach to business planning, linking together income, cost, activity, capacity, Cost Improvement Programme (CIP), quality improvement and workforce plans.

This collaborative approach contributed to the Trust delivering an £9m surplus (£13.0m normalised surplus) for the year (£8.5m ahead of plan) and the achievement of a Financial Risk

Rating of 3. This risk rating has been sustained since May 2012 and is forecast to remain at this level for the next four quarters.

The Trust has maintained a drive for efficiency in all areas and strengthened CIP governance has meant that the Trust has been able to deliver a cost saving of £54m for the year (£2m ahead of plan).

The Trust's strong financial performance this year has put it in a good position to formally commence its FT programme with a view to achieving authorisation by the end of 2014.

1.1.3. Strategic Plan

The Trust has strengthened its governance structures and processes, with the Board now at full constitution with a new Chairman, seven Non-Executive directors and five Executive Directors. The Trust now has the necessary Board and management capacity and capability to deliver its strategic aims and has a clear vision for its role in the regional health economy as a core component in a vertically integrated healthcare system.

2012/13 has seen the development of a comprehensive patient experience strategy, the launch of the Nursing and Midwifery Strategy 2013-16 and clarity on site profiles resulting from the North West London Joint Committee of Primary Care Trusts (JCPCT) decision on Shaping a Healthier Future (SaHF).

The Board is now better placed to hold staff to account for performance quality and patient care and a Clinical Risk committee was established as part of the Comprehensive Risk Management Strategy.

The Trust has also developed a consolidated Clinical Governance Action Plan. This plan aims to review compliance with the Quality Governance framework and develop a Quality Governance Strategy during 2013.

1.2. Priorities for 2013/14

The section below describes the key aims of the Trust for the coming year in operational performance, financial performance and strategy development (including a quality strategy for the Trust).

1.2.1. Operational Performance

2012/13 saw the Trust recognised for a number of achievements due to its focus on delivery and high quality services. As part of the Trust's 2013/14 Operating Plan, the following development priorities have been agreed.

1. Sustaining performance against cancer access targets
   The Trust aims to sustain achievement against all eight national targets and achieve a minimum of the national average in cancer patient experience surveys. All cancer access targets will remain a top priority, as they have represented a significant challenge through 2012/13.

2. Improving performance against RTT access targets
   The Trust aims to maintain the current achievement of all RTT targets in all specialties, and will continue to improve and sustain performance against elective access targets. Progress of these targets will be monitored both weekly and monthly.

3. Reviewing the Trust's Major Trauma model
   The Major Trauma Centre is currently not profitable, partly due to poor data capture. A clear vision for the service has been agreed and will be implemented in 2013/14. This includes a review of the data team structure and the identification of data quality issues and gaps through the development of service specific documentation to enable accurate data capture.

4. Driving continuous improvements in productivity
   The focus will be on areas where performance is below peer group average based on benchmarking against the Shelford Group and other comparable Trusts. Specific areas to target will be outpatients, reducing delays and length of stay and general surgery day case rates. Clear guidance has been given for 2013/14 financial and CIP planning, and there are plans in place to build an internal transformation team by summer 2013 to support productivity and improvement. This improvement also includes the development of the Trust capacity plan and the development of a Standard Operating Procedure for management of outpatients.

1.2.2. Quality

A key priority for the coming year will be the ongoing development of the Trust's Quality Strategy for 2013-15, known as Q15. This will be integral to the Trust's overall plan and is predicated on Don Berwick's six dimensions of quality, as described in the 2001 Institute of Medicine report on Crossing the Quality Chasm: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. This plan describes how a modernised program of Quality Governance will improve clinical care at ICHT and fulfill the Trust's aims.

1.2.3. Financial Performance

After the significant progress made during 2012/13, the main financial challenge that the Trust will face during 2013/14 is driving efficiency in all areas in order to deliver the required CIP savings. The CIP challenge for 2013/14 aims to deliver 5% (£48m, which equates to £50m full year effect) to meet the tariff provider efficiency requirement of 4% and 1% for local planning assumptions/increase in surplus.

The initial financial plan delivers a surplus (adjusted) of £15.1m, which is an increase of £6.1m on the 2012/13 outturn, with surpluses in each quarter.

1.2.4. Strategic Plan

The Trust has formally launched its bid for Foundation Status (FT), which informs a number of priorities that must be addressed throughout 2013/14, including the production of an Integrated Business Plan (IBP), a robust Long Term Financial Plan (LTFM) and responding to the recommendations in the Francis Report.

2013/14 will see the Trust developing a Trust-wide clinical strategy that is understood by all staff from ward to Board and supported by appropriate clinical engagement. The clinical strategy will be underpinned by key enabling strategies including People and OD, ICT, estates and communications.

The Trust will be delivering the service reconfigurations described in the SaHF preferred option and the implementation of the revised organisational structure whilst also working on implementing the Friends and Families test and managing the implementation of Cerner.

Imperial College Healthcare NHS Trust

IMPERIALCOLLEGE HEALTHCARE NHS TRUST

ANNUAL PLAN 2013/14

FINAL DRAFT FOR APPROVAL

Contents

DRAFT

DRAFT

Version	Status	Date	Distribution
v1	Draft	16 April 2013	Marcus Thorman Bill Shields Jayne Mee (workforce section) Helen Potton (governance and risks sections)
v2	Draft	18 April 2013	Management Board
v3	Draft	19April 2013	Planning team
v4	Draft	22April 2013	Planning team
v5	Draft	7 May 2013	Marcus Thorman Bill Shields Jayne Mee (workforce section) Janice Sigsworth & Chris Harrison (quality section) Steve McManus (capacity plan section)
v6	Draft	9 May 2013	Management Board
v7	Draft	14 May 2013	Marcus Thorman
v8	Final draft	16 May 2013	Senior Finance Team
v8mc	Final draft	16 May 2013	Senior Finance Team
v9	Final draft	17 May 2013	Senior Finance Team
v10	Final draft	22 May 2013	Trust Board

DRAFT

Glossary

AHSC	Academic Health Science Centre
AHSN	Academic Health Science Network
A&E	Accident and Emergency
AHP	Allied Health Professional
ASCOT	Anglo-Scandinavian Cardiac Outcomes Trial
BRC	Biomedical Research Centre
BAF	Board Assurance Framework
CO2	Carbon Dioxide
CQC	Care Quality Commission
CLCH	Central London Community Health
CXH	Charing Cross Hospital
COPD	Chronic Obstructive Pulmonary Disease
CCG	Clinical Commissioning Group
CNST	Clinical Negligence Scheme for Trusts
CPGs	Clinical Programme Groups
C.difficile	Clostridium difficile
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CQUIN	Commissioning for Quality and Innovation
CIP	Cost improvement Programme
DVT	Deep Vein Thrombosis
DH	Department of Health
E.coli	Escherichia coli
FT	Foundation Trust
GI	Gastroenterology
GMC	General Medical Council
HH	Hammersmith Hospital
HAT	Hospital Acquired Thrombosis
HSMR	Hospital Standardised Mortality Ratio
HASU	Hyper Acute Stroke Unit
ICHT	Imperial College Hospital Trust
ICT	Information Communication Technology
IBP	Integrated Business Plan
IST	Intensive Support Team
JAG	Joint Advisory Group
JCPCT	Joint Committee of Primary Care Trusts
KPI	Key Performance Indicator
LTFM	Long Term Financial Plan
MRC	Medical Research Council
MRSA	Methicillin-resistant Staphylococcus Aureus
MSSA	Methicillin-sensitive Staphylococcus Aureus
NICE	National Institute for Clinical Excellence

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NIHR	National Institute for Health Research
NHSLA	NHS Litigation Authority
NHS NWL	NHS North West London
PAS	Patient Administration System
PROMS	Patient Related Outcome Measures
PbR	Payment by Results
KTP	Potassium titanyl phosphate (KTiOPO4)
QIPP	Quality Innovation Productivity and Prevention
RTT	Referral to Treat
RCA	Root Cause Analyses
SOLE	Self Organised Learning Environment
SLA	Service Level Agreement
SaHF	Shaping a Healthier Future
SOM	Single Operating Model
SpR	Specialist Registrar
SMH	St Mary's Hospital
SMHI	Summary Hospital-Level Mortality Indicator
EDS	The Equality Delivery System
TUPE	Transfer of Undertakings- Protection of Employment
TDA	Trust Development Agency
VTE	Venous Thromboembolism
WTE	Whole Time equivalent

DRAFT

1. Executive Summary

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- Hyper-Acute Stroke Unit (HASU) remains in the top quartile of performance in the country, according to the Royal College of Physicians with a score of 90.9% in the latest quarterly Stroke Improvement National Audit Programme.

After a six month reporting break and establishment of implementation plans and governance structures, 2012/13 has seen an improvement in performance against 18 week and cancer access targets. These improvements in governance structures have led to the Trust achieving against all Referral to Treat (RTT) targets for admitted, non-admitted and incomplete pathways at a Trust aggregate level, and all eight cancer targets in March 2013.

The Trust has demonstrated continued excellence in research, with 2012/13 seeing the launch of the Medical Research Council - National Institute for Health Research (MRC-NIHR) Phenome centre and the renewal of the NIHR/Wellcome Trust Imperial Clinical Research Facility for a further five years. The Trust is the most successful Trust in England for NIHR Fellowships for Nurses and Allied Health Professional (AHP) and was awarded the lead provider status for postgraduate training in a further nine specialties.

The Trust is fully CQC compliant and working towards improving its compliance with its Patient Transfer Policy.

1.1.2. Financial Performance

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The Trust made significant progress in securing financial stability and improving key areas of performance during 2012/13, as well as receiving recognition for high quality standards of patient care. The Trust has implemented an integrated approach to business planning, linking together income, cost, activity, capacity, Cost Improvement Programme (CIP), quality improvement and workforce plans.

This collaborative approach contributed to the Trust delivering an £9m surplus (£13.0m normalised surplus) for the year (£8.5m ahead of plan) and the achievement of a Financial Risk Rating of 3. This risk rating has been sustained since May 2012 and is forecast to remain at this level for the next four quarters.

The Trust has maintained a drive for efficiency in all areas and strengthened CIP governance has meant that the Trust has been able to deliver a cost saving of £54m for the year (£2m ahead of plan).

The Trust's strong financial performance this year has put it in a good position to formally commence its FT programme with a view to achieving authorisation by the end of 2014.

1.1.3. Strategic Plan

The Trust has strengthened its governance structures and processes, with the Board now at full constitution with a new Chairman, seven Non-Executive directors and five Executive Directors. The Trust now has the necessary Board and management capacity and capability to deliver its strategic aims and has a clear vision for its role in the regional health economy as a core component in a vertically integrated healthcare system.

2012/13 has seen the development of a comprehensive patient experience strategy, the launch of the Nursing and Midwifery Strategy 2013-16 and clarity on site profiles resulting from the North West London Joint Committee of Primary Care Trusts (JCPCT) decision on *Shaping a Healthier Future* (SaHF).

The Board is now better placed to hold staff to account for performance quality and patient care and a Clinical Risk committee was established as part of the Comprehensive Risk Management Strategy.

The Trust has also developed a consolidated Clinical Governance Action Plan. This plan aims to review compliance with the Quality Governance framework and develop a Quality Governance Strategy during 2013.

1.2. Priorities for 2013/14

The section below describes the key aims of the Trust for the coming year in operational performance, financial performance and strategy development (including a quality strategy for the Trust).

1.2.1. Operational Performance

2012/13 saw the Trust recognised for a number of achievements due to its focus on delivery and high quality services. As part of the Trust's 2013/14 Operating Plan, the following development priorities have been agreed.

1. Sustaining performance against cancer access targets
   The Trust aims to sustain achievement against all eight national targets and achieve a minimum of the national average in cancer patient experience surveys. All cancer access targets will remain a top priority, as they have represented a significant challenge through 2012/13.

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2. Improving performance against RTT access targets
   The Trust aims to maintain the current achievement of all RTT targets in all specialties, and will continue to improve and sustain performance against elective access targets. Progress of these targets will be monitored both weekly and monthly.

3. Reviewing the Trust's Major Trauma model
   The Major Trauma Centre is currently not profitable, partly due to poor data capture. A clear vision for the service has been agreed and will be implemented in 2013/14. This includes a review of the data team structure and the identification of data quality issues and gaps through the development of service specific documentation to enable accurate data capture.

4. Driving continuous improvements in productivity
   The focus will be on areas where performance is below peer group average based on benchmarking against the Shelford Group and other comparable Trusts. Specific areas to target will be outpatients, reducing delays and length of stay and general surgery day case rates. Clear guidance has been given for 2013/14 financial and CIP planning, and there are plans in place to build an internal transformation team by summer 2013 to support productivity and improvement. This improvement also includes the development of the Trust capacity plan and the development of a Standard Operating Procedure for management of outpatients.

1.2.2. Quality

A key priority for the coming year will be the ongoing development of the Trust's Quality Strategy for 2013-15, known as Q15. This will be integral to the Trust's overall plan and is predicated on Don Berwick's six dimensions of quality, as described in the 2001 Institute of Medicine report on *Crossing the Quality Chasm:* safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. This plan describes how a modernised program of Quality Governance will improve clinical care at ICHT and fulfill the Trust's aims.

1.2.3. Financial Performance

After the significant progress made during 2012/13, the main financial challenge that the Trust will face during 2013/14 is driving efficiency in all areas in order to deliver the required CIP savings. The CIP challenge for 2013/14 aims to deliver 5% (£48m, which equates to £50m full year effect) to meet the tariff provider efficiency requirement of 4% and 1% for local planning assumptions/increase in surplus.

The initial financial plan delivers a surplus (adjusted) of £15.1m, which is an increase of £6.1m on the 2012/13 outturn, with surpluses in each quarter.

1.2.4. Strategic Plan

The Trust has formally launched its bid for Foundation Status (FT), which informs a number of priorities that must be addressed throughout 2013/14, including the production of an Integrated Business Plan (IBP), a robust Long Term Financial Plan (LTFM) and responding to the recommendations in the Francis Report.

2013/14 will see the Trust developing a Trust-wide clinical strategy that is understood by all staff from ward to Board and supported by appropriate clinical engagement. The clinical strategy will be underpinned by key enabling strategies including People and OD, ICT, estates and communications.

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The Trust will be delivering the service reconfigurations described in the SaHF preferred option and the implementation of the revised organisational structure whilst also working on implementing the Friends and Families test and managing the implementation of Cerner.

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2. Performance

This section summarises the main operational performance achievements of the Trust last year together with its plans and priorities for 2013/14.

2.1. Achievement of Operational Targets in 2012/13

The focus on quality has brought benefits to patients with performance indicators demonstrating that the Trust is maintaining and improving its performance in a range of areas. The sum of the efforts to improve clinical performance is reflected in HSMR data which shows that Trust has one of the lowest mortality rates in the country. The national average is calculated at 100% and the Trust is substantially below this at 70%.

The following section details the areas where the Trust has identified a development opportunity during 2012/13 and which will therefore require particular attention in 2013/14 to improve performance. The Trust is sustaining good performance in all other areas.

2.1.1. Accident and Emergency

The vast majority of Accident and Emergency (A&E) patients are treated, admitted or discharged within four hours and overall the Trust achieved a performance of 97.24% in 2012/13, above the national target of 95%. Attendances across the sites increased by 3.26% or 8,828 patients from 2011/12.

As well as achieving the four hour standard, A&E clinical quality indicators are now actively managed.

Key achievements in 2012/13 to reduce the number of non-elective admissions and A&E attendances include:

- Ambulatory care pathways are being reviewed with pathways now in place for Renal Colic, Deep Vein Thrombosis and Cellulitis;
- Recurring Admissions Patient Alerts link has been developed for Chronic Obstructive Pulmonary Disease (COPD) patients which will alert in hospital specialist and primary care providers when a known patient attends A&E;
- Trust is established as a key partner in the Inner North West London Integrated Care Pilot, focusing on individualised case management and fully integrated care between Primary and secondary care providers for frail elderly and diabetic patients, and to date has dedicated over 350 hours of consultant time to the pilot;
- Data sharing project with London Ambulance Service (LAS) and Westminster GPs on real time A&E attends;
- Link to allow electronic submission of A&E GP letters now in place.

Priorities in 2013/14 include:

- Maintaining the delivery of the performance targets and achieving 95% target for patients being treated, admitted or discharged within four hours across all sites
- Confirming the baselines for the Ambulatory Care quality indicators for cellulitis and DVT and agreeing with NHS North West London (NHS NWL) in the first quarter of the year a trajectory for improvement throughout the year;
- Further development of Ambulatory Care pathways for the other conditions set out by the Department of Health (DH) and College of Emergency Medicine that will provide alternative pathway to admission;

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- Further work to improve the performance against the timeliness Quality indicators particularly time in department for admitted patients and time to treatment;
- Work with community partners to reduce acute admissions and Emergency Department attendances.

2.1.2. Infection Control

Compared with 2011/12, the Trust has continued to reduce the number of Methicillin-resistant Staphylococcus Aureus (MRSA) cases and Clostridium difficile (*C.difficile*) cases. The Trust had eight MRSA cases against a threshold of nine cases and 86 *C.difficile* cases against a threshold of 110 cases.

Achievements to reduce infection rates in 2012/13 included:

MRSA

- Continuing to deliver infection prevention and control competency based assessment programme for the insertion of intravenous devices in order to minimise infection;
- Standard packs for intravenous devices remain in place so that staff can easily access everything that is required to insert the devices in one go and minimise infection risks;
- Introduction of competency based training in how to take blood culture samples from patients and how to reduce the risk of infection while doing this and to minimise any issues which could impact on the quality of testing from these samples, therefore enabling staff to make a correct diagnosis and provide the correct treatment.

C.difficile

- In collaboration with the pharmacy department, continuing to promote best practice in responsible, effective prescribing and reviewing practice at ward level to identify any areas for further training;
- Developing and recruiting the Trust's first consultant antimicrobial pharmacist;
- In the autumn of 2012, launching the 'Start Smart Then Focus initiative': a national campaign to support effective management of patients requiring antibiotic treatment;
- Developing and implementing a smart phone application to enable doctors to effectively and safely prescribe antimicrobials.

The Trust has continued to undertake mandatory reporting of Methicillin sensitive Staphylococcus aureus (MSSA) and Escherichia coli (E.coli) cases and has extended its surveillance programme for surgical site infections to more surgical specialties.

The Trust has also successfully implemented the Safety Thermometer (Harm Free Care) elements related to its service (with the aim of reducing both catheter associated urinary tract infections and pressure ulcers). Timely submission of Harm Free care in 2012/13 has meant that ICHT has achieved its Commissioning for Quality and Innovation (CQUIN) target for the collection of this data.

During last year, the Trust successfully opened and established centralised endoscope reprocessing units for improved decontamination practices on the CXH and HH sites.

Progress will continue during 2013/14 through delivering and sustaining the Infection Prevention and Control Improvement Plan and continuing to monitor performance through monthly CPG Performance Reviews, the Trust Infection Prevention Committee and the Trust Board.

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Priorities for 2013/14 include:

- Continuing to monitor and reduce the number of MRSA, *C.difficile*, MSSA and E coli cases;
- Continuing to deliver and sustain the Infection Prevention and Control practice and the Aseptic Non-touch Technique programme across the organisation;
- Developing and establishing a centralised endoscope reprocessing unit for improved decontamination practices on the SMH site;
- Developing innovative practices for controlling and preventing Healthcare Acquired Infections by collaborative working with the National Centre for Infection Prevention Management.

2.1.3.18 Week Referral to Treatment Time Target and Waiting Times for Cancer

In January 2012, the Trust Board took the rare step to approve a reporting break for data relating to the 18 week RTT target and waiting times for cancer including two week waits and diagnostics.

An independent Waiting List Clinical Review Group was established to conduct an extensive patient level review of any harm that may have occurred in identified groups of patients. The group is made up of senior clinicians external to the Trust working in partnership with senior clinicians and managers from the Trust.

The Waiting List Clinical Review Group developed the framework for the review and reported that no patient was identified as suffering harm due to a delay in treatment.

Alongside the clinical review, the reporting systems used within the Trust were rebuilt to accurately reflect waiting times. Following positive assurance from the NHS Intensive Support Team, reporting for cancer including two week waits, and diagnostics recommenced in June 2012 and for the 18 week RTT target in July 2012.

Since reporting resumed the Trust has:

- Met the six week diagnostic test standard each month (since June 2012);
- Steadily improved performance against the eight national cancer standards, from June 2012 when just three of eight standards were achieved to all eight in March 2013;
- Improved RTT performance from July to November 2012 when all three standards (admitted performance, non-admitted performance and incompletes) were achieved at aggregate Trust level. Since November, the three standards have been achieved each month at the aggregate level and by more and more specialties. In March, only three specialties were still to achieve any of the standards.

The priorities for 2013/14 include:

- Continuing to improve performance across these three key access standards and ensure performance is sustainable;
- Achieving all RTT standards in all specialities;
- Continuing to reduce the volume of patients waiting over 18 weeks for elective treatment. The Trust is now using a capacity planning tool which will enable the Trust to more accurately plan the appropriate capacity to meet its elective demand;
- Ensuring that no patient exceeds a wait of 52 weeks for elective treatment.

2.1.4. Venous Thromboembolism Risk Assessment

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During 2012/13, the Trust successfully achieved its Venous Thromboembolism (VTE) targets, consistently assessing >90% of all in patients for VTE risk on admission. This target has been attained through weekly audits of individual wards and CPG rates of VTE assessment. There has been a concerted effort to bring underperforming areas up to target e.g. maternity rates above 90% have now been achieved.

VTE has also been part of the NHS Safety Thermometer for 2012/13 and this monthly spot audit has repeatedly demonstrated high levels of harm free care.

The CQUIN goals and targets for VTE have changed for 2013/14 and will include two indicators:

- Proportion of all adult inpatients that have had a VTE risk assessment on admission to hospital;
- Number of root cause analyses (RCA) on confirmed cases of pulmonary embolism or deep vein thrombosis.

Priorities in 2013/14 include:

- Extending the contracts of the VTE Nursing Team;
- Identification of VTEs and RCA analysis of all HAT cases;
- Continuing to drive VTE awareness via the VTE specialist team;
- Continuing to performance manage and encourage completion of Electronic Discharge Summaries;
- Continuing to support clinical areas to meet their targets and VTE assessment delivery;
- Auditing of Cohorts for Quality Accounts Indicator;
- Introduction of CERNER for VTE data collection.

2.2. Achievement of Operational Targets in 2013/14

The Trust Board will continue to manage performance against national performance indicators from the NHS Performance Framework 2013/14 and those that support compliance with CQC outcomes. The Trust Board performance scorecard is currently under review to ensure that the Board can focus monthly on the key indicators.

There are a range of other indicators, including quality indicators agreed with NHS NWL in the contract for 2013/14 and internal indicators that the Trust has set for improving the quality of clinical services, patient experience and staff experience. These will be managed across the Trust throughout the year to ensure delivery and performance will be reviewed via the Management Board and monthly CPG Performance Reviews.

Figure 1 below sets out the national and local indicators that will be performance managed during 2013/14. For the indicators being rolled forward from 2012/13, the year end position is indicated where applicable as some indicators have changed from 2012/13 to 2013/14.

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Table 1: Performance Indicators to be reported to the Trust Board

Performance Indicator	Threshold 2013/14	Trust Performance 2012/13 (M12)
Mortality		
Hospital Standardised Mortality Rate	100	75.8
Patient Experience – key questions from national survey		
TC6: Were you involved as much as you wanted to be in decisions about your care and treatment?	85%	89.27%
TC7: Did you find someone on the hospital staff to talk to about your worries and fears?	75%	83.78%
TC8: Were you given enough privacy when discussing your condition or treatment?	85%	93.98%
Infection Prevent and Control		
MRSA Bloodstream Infection Bacteraemias	0 cases	8 cases (Threshold 9)
C.difficile Post 72 hours	65 cases	86 cases (Threshold 110)
Eliminating Mixed Sex Accommodation		
Elimination of mixed-sex accommodation, except when it is clearly in the patient's overall interests, or reflects their personal choice	0	0
Stroke Care		
Patients with high risk of stroke who experience a TIA are assessed and treated within 24 hours	<60%	99.5%
Patients who spend at least 90% of their time in hospital on a stroke unit	<90%	99.4%
Venous Thromboembolism		
All adult patients who have had a Venous Thromboembolism Risk Assessment to reduce avoidable death, disability and chronic ill health from venous thromboembolism	<95%	91.2%
Research and Development		
Raise the proportion of patients enrolled in a research protocol by 1% in 2012/13	<1%	Not measured
Raise the proportion of patients enrolled in National Institute for Health Research Clinical Research Network portfolio research studies by 1% in 2012/13	<1%	21% (Q3 – most recent data)
Accident and Emergency – 4 hour Maximum Waiting Time		
All types (1,2 & 3) (Trust)	<95%	97.24%
Type 1	<95%	94.55%
HH		95.01%
CXH		93.65%
SMH		94.81%
LAS Patient Handover within 15 mins	<85%	93.1%
LAS Patient Handover within 30 mins	<95%	98.4%
LAS Patient Handover within 60 mins	100%	99.9%
LAS Patient Handover within 60 mins - 'black' breaches	0 cases	0%
Accident and Emergency – Clinical Quality Indicators: Unplanned re-attendance rate within 7 days		
HH	<5%	No data for M12

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CXH SMH Left department without treatment HH CXH SMH Time to initial assessment (95th percentile) HH CXH SMH Time to treatment in department (median) HH CXH SMH Ambulatory care A&E attendance for cellulitis that end in admission: HH CXH SMH A&E attendance for DVT that end in admission: HH CXH SMH Consultant sign-off (type 1 & 2 patients only) Service experience	<5% <15mins <60mins tbc% tbc% Provision of a report	0.98% 1.60% 3.97% 15 18 18 58 58 75
Elective Access – Cancer Waiting Times Two weeks of an urgent practitioner (GP) referral for suspected cancer Two weeks of an urgent referral for breast symptoms where cancer is not initially suspected First definitive treatment within one month (31 days) of a cancer diagnosis Subsequent treatment within 31 days where that treatment is surgery Subsequent treatment within 31 days where that treatment is an anti-cancer drug regime Subsequent treatment within 31 days where that treatment is a radiotherapy treatment course First definitive treatment within 62 days of an urgent GP referral for suspected cancer First definitive treatment within 62 days of referral from an NHS cancer screening service First definitive treatment within 62 days following a Consultant decision to upgrade their priority status	>93% >93% >96% >94% >98% >94% >85% >90% >85%	93.8% 94.5% 98.2% 94.5% 98.4% 98.8% 86.1% 94.4% Not measured
Elective Access – Referral to Treatment Patients seen within 18 weeks for Admitted Treatment Patients seen within 18 weeks for Non-Admitted Treatment Incomplete pathways where patients waiting less than 18 weeks Patients waiting 6 weeks or more for a diagnostic test	>90% >95% >92% <1%	91.17% 97.02% 95.04% 0.08%
Maternity Women who have seen a midwife by 12 weeks and 6	>90%	96.18%

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days of pregnancy who were referred on time		
Delayed Transfer of Care		
Average number of acute patients (aged 18+) per day whose transfer of care was delayed	<3.5%	1.74%
Quality, Innovation, Productivity and Prevention		
Average length of stay	<3.4 days	3.3 days
Average non-elective length of stay	<4.5 days	4.4 days
Day case rate	>80%	76.3%
New to follow up out-patient ratio	<1.67	2.41
Theatre utilisation rate	>81%	78.9%
Workforce		
Bank and agency spend as percentage of paybill	<7%	7.76%
Vacancy rate	<7%	9.77%
Turnover rate (year-end)	<9%	10.28%
Sickness rate (DH reporting period Jan-Dec 2012)	<3.4%	3.1%
Staff appraisal rate	>85%	
Non-medical staff		82.29%
Consultants		66.67%
Statutory and Mandatory training	95%	79.43

2.3. Capacity plan

The Trust requires a capacity plan in order to operate its services efficiently, matching the expected level of demand with both capacity and income. A robust plan is currently in development that is based on the need to reduce high occupancy levels in general adult beds across the Trust to improve patient safety and experience as well as driving operational excellence. The Trust is planning to have a full capacity plan in place by the end of Q2 2013/14.

Once fully developed, the Trust capacity plan will cover all the main components of clinical capacity, including general adult and critical care beds, theatres and outpatient clinics for adult, paediatric and maternity services. It is important that as capacity planning capability develops, the Trust is able to review and set metrics such as occupancy and length of stay specific to these components for service areas that support the Trust position regarding capacity and average occupancy. The Trust is developing the capacity and data set to effectively develop capacity plans across all these domains to the required level of detail, so for this reason the initial plan covers general adult bed capacity.

The Trust has seen an increase in demand ahead of that expected during 2012/13 which is linked to the seasonal variation in activity. This has exerted pressure on the organisation's capacity, most notably within the medicine division.

Evidence suggests that higher occupancy rates lead to a consequential rise in the number of surgical cancellations and patients movements within the hospital for non-clinical reasons and also serious incidents, which directly affect patient safety and the quality of the patient experience. Decreasing occupancy should therefore lead to improved patient experience.

The following assumptions have been applied to develop the base case for a capacity plan:

- Activity demand based at 2012/13 outturn plus 2% growth;
- Length of stay remains static at 2012/13 outturn level (to mitigate the risk of double counting benefits against bed closure related cost reduction plans);
- No major service developments.

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Against this base case, the following options for capacity planning have been developed:

- Option One: Maintain current bed base - Level 1 bed base remains unchanged at 928 beds running at an average occupancy of 100% during Q1-3 and rising to 106% during Q4;
- Option Two: Maintain current bed base with additional capacity as proposed within CPG Business Plans – Increase bed capacity in Medicine division by 18 to create a level 1 bed base of 946 running at an average occupancy of 99% during Q1-3 and rising to 104% during Q4;
- Option Three: Deliver average occupancy of 92% - Sets the bed base at 1,000 level 1 beds in Q1-3 and 1045 level 1 beds in Q4 to deliver an annual average occupancy of 92%.

Whilst the Trust has agreed that a reduction in occupancy is desirable, the preferred option is yet to be selected. Once agreed for adult level 1 capacity, this methodology will be rolled out to create a comprehensive capacity plan for theatres and outpatients, critical care, paediatrics and maternity during 2013/14.

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3. Quality

The Francis Report into the failings at Mid Staffordshire NHS Foundation Trust strongly reinforces that quality should be at the heart of a patient-centred NHS. Quality of care provided is a key responsibility of the Boards of all NHS Trusts. As the NHS changes, quality remains as important as ever and the Trust Board must continue to focus on quality improvement, particularly in preparation for Foundation Trust authorisation.

The Quality Strategy for 2013-15, known as Q15, is integral to the Trust's overall plan and is predicated on Don Berwick's six dimensions of quality, as described in the 2001 Institute of Medicine report on *Crossing the Quality Chasm*: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. These tenets of quality are echoed in Lord Darzi's *High Quality Care for All*, published in 2008, which characterises clinical quality being based upon patient experience, patient safety and clinical effectiveness, now enshrined in the Health Act of 2009.This plan describes how a modernised program of Quality Governance will improve clinical care at ICHT and fulfill the Trust's aims.

Within this context, one of ICHT's strategic objectives must now be to provide high quality, patient-focused and efficiently delivered services for its local population. The principles underpinning this objective are set out in the Trust's quality plan for the next three years.

Central to delivery of Q15 are monthly Quality & Safety Committee meetings chaired by Sir Anthony Newman-Taylor, supported by the Office of the Medical Director and attended by senior clinical members of all divisions. This committee now regularly reviews a range of information under the headings of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.

Detailed 2013/14 priorities for delivery of improvement in patient safety, clinical effectiveness and patient experience will feature in the Trust Quality Account for 2012/13 as summarized below:

Patient Safety Priorities:

- Venous Thromboembolism;
- To ensure high performance against the Safety Thermometer;
- To reduce healthcare associated infections;
- To increase compliance with the Trust anti-infective policy;
- To increase the reporting of patient safety incidents.

Clinical Effectiveness priorities

- To remain better than the national average for mortality rates as measured by the Summary Hospital Level Mortality Indicator;
- To reduce the number of readmissions to hospital within 28 days of discharge;
- To increase patient satisfaction as measured by Patient Related Outcome Measures (PROMS).

Patient Experience Priorities

- To reduce delays in outpatient clinics by the end of year;
- To improve the patient experience related to discharge;
- To improve responsiveness to inpatient needs;

- To remain above the national average for staff who would recommend the Trust to friends/ family needing care.

3.1. Patient experience

Imperial's Patient Experience Strategy 2012-14 recognises the Trust's steady improvement in national survey scores in recent years but highlights the need to expand the overall approach to rank with the best performers in England and internationally.

The Trust's patient experience objectives are:

- To provide all patients with an excellent patient experience when they come into contact with ICHT's services using a patient experience charter to drive improvement;
- For patients to choose ICHT's services not only based on its clinical outcomes, but also based on excellent patient experience;
- To rank with other peer Trusts – in particular the Shelford Group – on patient experience results to enhance the Trust's reputation, attract the best staff and expand opportunities for commercial and third sector partnerships;
- To improve staff experience to enhance patient experience. This will be delivered within the Staff Survey Action Plan.

The strategy centres around delivery and measurement and reporting of progress against the agreed patient experience charter, described in the nine statements below. The strategy is supported by clear delineation of roles and reporting procedures.

Patient experience charter

At ICHT we want our patients to experience:

1. That we communicate well;
2. That your care is planned (whatever your route of admission);
3. That you feel safe in our care;
4. That you are receiving the right information;
5. No or the minimum of delays;
6. Always being treated with dignity & respect;
7. That our staff work as a team;
8. That we care about your environment;
9. That you receive the food you have chosen and you get help if you need it.

3.2. Equality and diversity

As a public authority the Trust is legally required 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. The Equality Delivery System (EDS) is referenced within the NHS Operating Framework for 2013/14 and the Trust's Equality and Diversity plan sets out how it will:

- Deliver improved and more consistent performance on equality for patients, carers, communities and staff. In particular, deliver better outcomes with regard to the NHS Outcomes Framework;
- Respond more readily to the Public Sector Duty of the Equality Act;
- Respond better to CQC Essential Standards;
- Ensure it delivers services that are personal, fair and diverse, and are supported to do so.

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The plan for 2013-15 is to:

- Work towards reducing inequality in health and wellbeing, prioritizing known areas of inequality;
- Ensure that services provided are accessible to all people; actively advance equality; and are free from unlawful discrimination;
- Develop services which best meet the needs of the Trust's diverse communities;
- Employ, develop and retain a workforce, which at all levels reflects the diversity and make-up of the population that the Trust serves;
- Eliminate from all services, policies and decision making, any adverse impact on the advancement of equality and cohesion or adverse effect on particular groups or communities.

The plan will be implemented using a diverse range of engagement strategies to ensure that staff and patients across all protected groups have an opportunity be involved in the decisions that affect them. The equality and diversity plan is built on a strong foundation of engagement with patients, staff, carers, the wider community and other partners to ensure the organisation remains responsive to their needs.

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4. Strategy

For some time, the Trust Board has been aware of the need to revise the organisational and underpinning clinical strategies in light of a number of internal and external factors. Following the decision of the NWL JCPCT in February 2013, which was strongly supported by the Trust, a programme of work to develop a clinical strategy for the Trust has been initiated. The clinical strategy will be a fundamental component of ICHT's overarching strategic plan, which will inform its Integrated Business Plan and its Foundation Trust application.

4.1. Trust vision

[To be developed by MD & BF by end of May]

4.2. Strategic objectives [to be refined by MD & BF by end of May]

In April 2013, the Trust Board agreed the following four strategic objectives to inform the development of the organisational strategy and position the Trust as a key player in a vertically integrated healthcare system:

- To provide high quality, patient-focused and efficiently delivered services for every patient;
- To build national and international profiles through programmes of excellence;
- To be the destination of choice for health sciences' trainees in all disciplines;
- To innovate healthcare delivery by generating new knowledge in association with Imperial College London, and by translating and disseminating new ways of working through the Academic Health Science Centre (AHSC) and Academic Health Science Network (AHSN).

4.3. Clinical strategy

The following high level strategy developed following the JCPCT's decision was discussed by the Trust Board in April as platform for further development:

- SMH will be one of the five major acute hospitals in the NWL sector, with a 24/7 A&E and Urgent Care Centre, largely focusing on emergency activity, with a co-located Hyper Acute Stroke Unit, Major Trauma Centre and centre of excellence for neurosciences. Under this model, SMH should see reduced levels of admissions through improved triage and supporting community models;
- HH will be developed in line with the specialist hospital model of care, and will include specialist medicine and surgical hubs and specialist cardiac and cancer centres. It will continue to be a centre of excellence for post-graduate medical education, research and highly specialist services as a regional and national provider;
- CXH will be developed in line with the proposed local hospital model of care and will include a 24/7 Urgent Care Centre. Further proposals for CXH are being developed with the local Collaborative Commissioning Groups (CCG). The Trust is keen that these services include a centre of excellence for elective surgery, ambulatory care and surgical innovation for high procedures;
- Opportunities for partnership with primary care will be explored to enable provision of appropriate services closer to patients' homes, operating under population-based and disease-based models e.g. frail elderly, sick children, diabetes and cardiovascular disease.

The next phase of the clinical strategy development programme will be to develop how the platform described above will be delivered at service level, identifying the impact of emerging

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plans on the local healthcare economy and on the Trust's estate. It is anticipated that this will be complete during the course of 2013/14. This programme of work will feed into the development of business cases for investment in all three sites to ensure their fitness for purpose.

As part of the overarching strategy, the following programmes of work are planned for 2013/14 as the Trust prepares to become a FT:

- Refinement of the Trust's strategic objectives;
- Development and implementation of enabling strategies e.g. workforce, ICT, estates, commercial, research, education and capacity plan;
- Development and implementation of private patients strategy;
- Analysis of risks to achieving the Trust strategy once finalised.

4.4. Service development plans

To support the implementation of the Trust's emerging clinical and site strategies, the Trust Board has agreed three Trust-wide service developments to be initiated during 2013/14, as detailed below. Trust-wide plans have been developed based on a clear understanding of the national and local policy context and will be designed to support ongoing delivery of Lord Darzi's vision for the NHS in London as described in *A Framework for Action*, published in July 2007.

In addition, the CPGs' annual business planning process for 2013/14 has yielded a number of more local service developments and divestments which are also listed below.

4.4.1. Trust-wide service developments

1. Wards as business units
The Trust plans to establish wards as discreet business units to drive operational excellence and maximise efficiency.

2. Systematised ambulatory surgical model
The Trust plans to systematise certain planned, high volume, low complexity ambulatory surgical procedures to improve quality of care, patient outcomes and experience whilst simultaneously increasing operational efficiency.

3. Ambulatory emergency care model at SMH
To support the early prevention agenda, this initiative would see the development of an on-site GP service at SMH and would aim to deliver up to 60% of current A&E activity on that site in primary care. Evidence suggests that this model could improve patient experience and reduce pressure on resources through decreasing hospital stays by up to 40%.

4.4.2. CPG service developments

Medicine

- **Haven (rape or sexual assault support) service** – delivery of the Haven service for both adults and children will now be commissioned through Kings College Healthcare NHS Foundation Trust as the single provider from 1 April 2013. Some services will continue to be provided at SMH, but with all staff providing services to be employed by Kings (consultation and Transfer of Undertakings- Protection of Employment (TUPE) process);
- **Domiciliary sleep study pathway**–implementation of this new pathway will lead to 650 less inpatient spells per year. This service will rather be delivered through one first and one follow up outpatient appointment per patient.

Cancer & surgery

- **Ambulatory care pathways**– new ambulatory care pathway were developed during 2012/13 for a selection of non-elective conditions at SMH. This will likely reduce length of stay for minor cases from one to zero days and improve patient experience. During 2013/14, this model will be rolled out to a number of services including oncology.

Specialist services

- **KTP & CO2 laser clinic**–laser treatments are interventional procedures and are not normally funded. As such individual funding requests must be submitted. These forms are administratively excessive and the acceptance rate is less than 10%. This programme is unsustainable and will no longer be offered;
- **Ranibizumab in diabetic macular oedema** – following National Institute for Clinical Excellence (NICE) approval, diabetic macular oedema will now be treated using Lucentis. This will necessitate approximately 720 additional outpatient attendances per year plus additional drug costs;
- **Dementia clinic**– investment in a nurse-led follow up clinic for dementia patients is planned, with an expected throughput of approximately 420 attendances per year;
- **Oral surgical services** –the Trust will be extending an existing partnership with the Eastman Dental Hospital from April 2013 to consolidate oral surgical services between Imperial Healthcare NHS Trust and Eastman Dental Hospital based on shared consultant and Specialist Registrar (SpR) cover for outpatient activity at Imperial and shared clinical governance;
- **Orthopaedic trauma**–negotiations are currently underway to formalise the running of a dedicated Orthopaedic Trauma list on Saturdays. This would take place on the SMH site and enable the Trust to deliver a seven day a week service.

Circulation sciences & renal medicine

- **Varicose vein surgery**–the new planned procedures with a threshold criteria for varicose veins will reduce the number of patients eligible for NHS treatment. Therefore there will be a reduction in varicose vein surgical capacity by 10%;
- **Cardiology centralisation**–the Trust's cardiology services are to be centralised, with the electrophysiology services moving to the newly built Cardiac Catheterisation laboratory facilities at the HH site in June 2013. This will fully integrate all cardiology services onto a single site.

Clinical & investigative sciences

- **Outpatient pharmacy provision** – there will now be a commercial partner (Lloyds) providing outpatient dispensing which has been designed to improve patient experience. The Trust dispensary service will now focus on the clinical needs of inpatients, improving the discharge process and inpatient experience;
- **Dispensing at Central London Community Health**–the Trust will be ending the Service Level Agreement for dispensing and advice by pharmacy for Central London Community Health (CLCH). CLCH now plans to provide in-house service;
- **Parenteral nutrition**–the Trust is currently reviewing the provision of parenteral nutrition to determine whether it is potentially cheaper to disinvest in this service rather than plan a small reduction in staffing numbers;
- **Faecal calprotectin**–the application of faecal calprotectin for diagnosis and monitoring patients with lower GI disease is becoming more accepted by gastroenterologists. There are, however, few NHS laboratories, and no private sector laboratories, in the UK offering this test as a routine diagnostic service.

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5. Finance

5.1. Overall Financial Position

Table 2 below summarises the Trust's financial position in 2012/13 and financial plan for 2013/14.

Table 2: Overall Financial Position 2012/13-2013/14

£'000s	Plan 2012/13	Outturn 2012/13	Plan 2013/14
Revenue from patient care activities	748,559	752,725	745,934
Other operating revenue	186,557	197,049	195,340
Operating expenses	-911,090	-914,189	-894,623
Operating surplus	**24,026**	**35,585**	**46,651**
Other gains and losses	0	-13	0
Investment revenue	225	287	287
Finance costs	-1,838	-1,791	-859
PDC dividends payable	-21,913	-21,068	-20,596
Underlying surplus for the year	**500**	**13,000**	**25,483**
Transitional funding & other NR Income	15,000	8,000	0
Impairments	0	-47,505	0
Other Net non Recurring transactions & adjustments	-15000	-13,450	-11,000
Retained Surplus/Deficit for the year	**500**	**-39,955**	**14,483**
Surplus for the year - before Impairments	**500**	**7,550**	**14,483**
Other technical adjustments for NHS financial performance purposes *	0	1475	592
Surplus after technical adjustments	**500**	**9,025**	**15,075**

* The trust's reported NHS financial performance position is derived from its retained surplus/(deficit), but is adjusted for impairments to property, plant, equipment and stock as impairments are not considered part of the organisation's operating position.

The Trust planned for a surplus of £0.5m in 2012/13. The un-audited forecast outturn is a surplus of £9.0m, £7.6m before technical adjustments and impairment charges (£13.0m underlying surplus) which is an improvement of £8.5m against the plan. The major reason for this improvement is the inclusion of Project Diamond funding (£8m) which the former NHS London required to be excluded from the 2012/13 plan. NHS London did not provide transitional funding of £7m for Cerner as planned, which was offset by net improvements in other income and costs. The financial results are underpinned by the delivery of a £54.1m Cost Improvement Programme (CIP).

After allowing for transitional funding of £8m, technical adjustment less an impairment charge of £47.5m and a number of non-recurring transactions totaling £13.5m (net), this gives an underlying surplus of £13.0m. The major non-recurrent transactions in-year were:

- Transitional funding for long term strategy;
- Acton Hospital, receipt of overage from sale;
- Release of provisions for impairments on bad debt and deferred R&D income;
- Provisioning, mainly for Ravenscourt Park Hospital;

- Planned non-recurring expenditure programme, including redundancies, Cerner implementation plus consultancy costs;
- Non-recurring CIPs;
- Other non-recurring transactions.

A summary of revenue planning assumptions is shown in table 3 below.

Table 3: Income Bridge 2012/13 to 2013/14

Income	Income from patient Activities - NHS	Income from patient Activities - Other	RTE	Other Income	NR Income	Total
£m's						
FOT 2012/13	**715.3**	**37.4**	**122.7**	**74.4**	**21.5**	**971.3**
Tariff	-9.2	0.4		0.8		**-8.0**
Net SLA changes	4.0					**4.0**
CQUIN	0.0					**0.0**
Service Changes	-6.2	2.0		0.0		**-4.2**
CIP/IG				1.9		**1.9**
Other	2.2		-4.0	-0.4	-21.5	**-23.7**
Plan 2013/14	**706.1**	**39.8**	**118.7**	**76.7**	**0.0**	**941.3**
Movement	**-9.2**	**2.4**	**-4.0**	**2.3**	**-21.5**	**-30.0**
Tariff/Inflation	-1.3%	1.1%	0.0%	1.1%	0.0%	-0.8%
Net SLA changes	0.6%	0.0%	0.0%	0.0%	0.0%	0.4%
CQUIN	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Service Changes	-0.9%	5.3%	0.0%	0.0%	0.0%	-0.4%
CIP/IG	0.0%	0.0%	0.0%	2.6%	0.0%	0.2%
Other	0.3%	0.0%	-3.3%	-0.5%	-100.0%	-2.4%
Total % movement	**-1.3%**	**6.4%**	**-3.3%**	**3.1%**	**-100.0%**	**-3.1%**

Bridging movements are detailed in the following sections.

5.2. Clinical Revenue

Table 4 summarises clinical revenue received in 2012/13 and planned for 2013/14.

Table 4: Clinical Revenue 2012/13-2013/14

Revenue from Patient Care Activities:	2012/13 Forecast Outturn	2013/14 Plan
£'000's		
Strategic Health Authorities (for comparatives)	5,746	
NHS Trusts	723	723
National Commissioning Board (including Specialist Commissioning)		283,046
Clinical Commissioning Groups (PCTs for comparatives)		396,073
Primary Care Trusts (comparatives only)	686,890	
Foundation Trusts	4,097	4,097
Local Authorities	0	9,529
Department of Health	4,529	0
NHS Other (including Public Health England and Prop Co)	13,312	12,649
Recurring NHS Income from Activities	**715,297**	**706,117**
Non NHS: Private Patients	30,477	32,801
Non-NHS: Overseas Patients (non-reciprocal)	1,802	1,820
Injury Cost Recovery	1,361	1,373
Non NHS: Other	3,788	3,823
TOTAL Revenue from Patient Care Activities	**752,725**	**745,934**

5.3. Tariff / Price Changes

The Operating Framework for the NHS in 2013/14 confirmed the Department of Health's high level plans for Payment by Results (PbR). These plans are intended to:

- Increase the link between payment and quality of care and drive integration of services;
- Support the expansion of a more transparent rules based funding system;
- Incentivise best clinical practice and better patient outcomes.

The final tariff, issued on the 28 February 2013, provides the prices that underpin these proposals and the guidance that organisations need to support implementation.

Guidance provides for national and local prices to be deflated by 1.3% (-£9.2m), which after allowing for funding of underlying cost pressures results in a net price reduction of -£7m. This assumption has been incorporated in the income plan.

The Market Forces Factor (MFF) of 24.17% remains unchanged for 2013/14.

5.4. Service Level Agreement Baseline Assumptions

Planning assumptions include the following changes to our 2012/13 baseline:

- Demographic growth of 1%;
- Coding and Counting and PbR tariff changes, estimated for known notifications to the Trust's commissioners in SLA negotiations;
- Demand Management (QIPP) initiatives and business rules, adjusted for estimated timing and in-year delivery;
- Loss of hosting of Haven service and Screening services.

These assumptions represent the Trust's view of likely outcomes for key elements of the SLA negotiations and expected in-year performance against them. They also constitute key risks to delivery of the planned financial position, particularly if demand management schemes are implemented earlier or later than assumed.

5.5. Private Patients, Other Non-NHS Clinical Income

The Lindo Wing has been refurbished and subsequently re-opened during the 2012/13 financial year. Additional income of £2m is planned, due to the full year impact of re-opening. Inflation of 1% has been allowed for in our pricing.

5.6. Other Revenue

Table 5 summarises other revenue received in 2012/13 and planned for 2013/14.

Table 5: Other Revenue 2012/13-2013/14

£'000	Plan 2012/13	Outturn 2012/13	Plan 2013/14
Research and development	53,317	57,592	56,592
Education and training	62,856	65,151	62,151
Other	70,384	74,306	76,597
Total Recurring Income	**186,557**	**197,049**	**195,340**
Non Recurring Income inc Transitional funding – NWL	8,000	21,500	0

5.6.1. Research and Development

The priming element of the National Institute for Health Research Capability (Flexibility & Sustainability) funding is planned to reduce by £1m. No inflationary increase has been allowed in the planning assumptions.

5.6.2. Education and Training

The £3m reduction from 2012/13 outturn has resulted from:

- £2.0m reduction for the transitional implementation of new tariff arrangements for MPET;
- £1.0m volume reduction for fewer trainees;

No inflationary increase has been allowed in the planning assumptions.

5.6.3. Other income

Our plans include income generation of +£1.9m offset by -£0.4m reduction in Project Diamond funding. An inflationary increase of 1% (+£0.8m) is planned for this income category.

5.7. Expenditure

Table 6 summarises other expenditure incurred in 2012/13 and planned for 2013/14.

Table 6: Bridge from 2012/13 Outturn to 2013/14 Plan

Expenditure Bridging Table FY13 to FY14

Expenditure	Pay	Drugs	Clinical Supplies	Non Clinical Supplies	Capital Charges	Non Recurring	Total Exp
£m's							
FOT 2012/13 (before impairments)	**517.1**	**96.6**	**99.7**	**163.6**	**59.7**	**27.0**	**963.7**
Inflation	10.3	2.8	4.5	5.9	1.7	0.0	**25.2**
SLA Activity changes	-1.0	-0.2	-0.2	-0.3	0.0	0.0	**-1.7**
Service Changes	-0.6	0.0	0.0	-4.2	0.0	0.0	**-4.8**
CIP (net of costs)	-23.4	-3.6	-8.4	-10.7	0.0	0.0	**-46.1**
Other	0.0	0.0	0.0	7.2	-5.2	0.0	**2.0**
Additional NR programme	0.0	0.0	0.0	0.0	0.0	-16.0	**-16.0**
Contingency	0.0	0.0	0.0	4.5	0.0	0.0	**4.5**
Plan 2013/14	**502.4**	**95.6**	**95.6**	**166.0**	**56.2**	**11.0**	**926.8**
Movement	**-14.7**	**-1.0**	**-4.1**	**2.4**	**-3.5**	**-16.0**	**-36.9**
Inflation	2.0%	2.9%	4.5%	3.6%	2.8%	0.0%	2.6%
SLA Activity changes	-0.2%	-0.2%	-0.2%	-0.2%	0.0%	0.0%	-0.2%
Service Changes	-0.1%	0.0%	0.0%	-2.6%	0.0%	0.0%	-0.5%
CIP (net of costs)	-4.5%	-3.7%	-8.4%	-6.5%	0.0%	0.0%	-4.8%
Other	0.0%	0.0%	0.0%	4.4%	-8.7%	0.0%	0.2%
Additional NR programme	0.0%	0.0%	0.0%	0.0%	0.0%	-59.3%	-1.7%
Contingency	0.0%	0.0%	0.0%	2.8%	0.0%	0.0%	0.5%
Total % movement	**-2.8%**	**-1.0%**	**-4.1%**	**1.5%**	**-5.9%**	**-59.3%**	**-3.8%**

Pay costs are planned to reduce by £14.7m. The major changes are detailed as follows:

- Additional costs from pay inflation and pressures £10.3m

Less:

- Reduced costs from CIP – original plan £23.4m
- Reduced costs from recurring SLA activity changes £1.0m
- Reduced costs from recurring non-SLA activity changes £0.6m

Drugs costs are planned to reduce by £1.0m. The major changes are detailed as follows:

- Additional costs from drug inflation £2.8m

Less:

- Reduced costs from CIP – original plan £3.6m
- Reduced costs from recurring SLA activity changes £0.2m

Clinical Supplies and Services costs are planned to reduce by £4.1m. The major changes are detailed as follows:

- Additional costs from inflation £4.5m

Less:

- Reduced costs from CIP – original plan £8.4m
- Additional costs from recurring SLA activity changes £0.2m

Other costs are planned to rise by 2.4m. The major changes are detailed as follows:

- Additional costs from inflation £5.9m
- Other £7.2m
- Contingency £4.5m

Less:

- Reduced costs from CIP – original plan £10.7m
- Reduced costs from recurring SLA activity changes £0.3m
- Reduced costs due to service changes £4.2m

Overall, Capital Charges are planned to reduce by £3.5m, the main components of this reduction are:

- Depreciation costs are planned to reduce by £2.1m – resulting mainly from a reduction in the valuation of buildings as at 31st March 2013;
- Interest payable costs are due to fall by £0.9m - due to repayment of a Capital Loan in March 2013;
- PDC Dividend costs are due to fall by £0.5m – due to a reduction in net relevant assets.

Other non-recurring costs are planned to be £11m, consisting of:

- Cerner implementation £4.5m;
- Redundancies £5.0m;
- Transformation Costs £1.5m.

5.8. Key Assumptions

5.8.1. Service Developments

The Trust continues to develop services to improve patient experience and clinical outcomes and has proposed to commissioners that it adopts clinical best practice with respect to vascular access for haemodialysis. The Trust plans to work closely with its commissioners to develop clinical pathways, improve patient care and support the development of out-of-hospital strategies. This will require the Trust to appropriately downsize the organisation to release associated costs.

The Trust is developing plans for the systemization of ambulatory surgery as well as other initiatives and will appraise the relative financial and non-financial benefits and implications as these are better understood.

5.8.2. Activity

The baseline dataset is 2012/13 month 6 (frozen), uplifted to 12 months of activity using a methodology agreed with the CSU and CCGs for the 2013/14 SLA. Some small alterations have been made to the resulting 2012/13 projected outturn for in year developments which started in Q2 of 2012/13.

5.8.3. Demand Management and Metrics

The Trust has planned for a reduction of £13m from the 2012/13 baseline for the in-year impact of demand management schemes, and a corresponding cost saving of 50%. This is based on a view on timing of delivery. The key themes with the biggest impact on activity include:

- Referral management and standardization;
- Shifting outpatient activity safely and effectively into community settings;
- Avoiding non-elective admissions and care management outside of hospital.

5.8.4. Activity Projections

Table 7 below provides a breakdown of activity projections to 2013/14.

Table 7: NHS Inpatient, Outpatient and Accident & Emergency Activity 2012/13-2013/14

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Point of Delivery (Spells / Attendances)	Outturn 2012/13	Activity Plan 2013/14	Change +/-
Day case/planned same day	67,507	66,405	-1,102
Elective inpatient	19,593	19,532	-61
Emergency	72,893	64,377	-8,516
Regular day attender	13,552	13,983	431
Inpatient Total	**173,545**	**164,297**	**-9,248**
New outpatient	238,524	224,449	-14,075
Follow-up outpatient	534,423	413,374	-121,049
Outpatient Total	**772,947**	**637,823**	**-135,124**
Critical Care	**57,233**	**57,734**	**501**
A&E	**197,050**	**196,549**	**-501**
Direct Access Pathology & Radiology	**2,121,615**	**2,192,489**	**70,874**
Others	**942,603**	**988,414**	**45,811**

Note: Activity includes commissioner demand management (QIPP) where activity has been provided
A&E activity includes SMH Urgent Care Centre walk in patients

The Trust's elective inpatients, day cases and regular day attenders are planned to be broadly in line with 2012/13, aside from day case reductions due to demand management schemes. Emergency inpatients are planned to fall, in part due to admission avoidance demand management schemes and the change in maternity pathway coding.

The Trust's planned outpatient activity has reduced due to commissioner re-provision of outpatient activity in the community, demand management schemes and the change in maternity pathway coding.

The Trust has initiated a comprehensive programme of work aimed at improving the patient experience and productivity in outpatients by reducing hospital initiated cancellations, reducing new to follow up ratios, reducing DNA rates, improving outpatient procedure coding, reviewing booking rules, centralising administrative function and ensuring that capacity and demand are better aligned. The opportunity to align inpatient and outpatient capacity in light of new-to-follow-up ratios, and improved performance reducing activity that is not paid for, is on-going.

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6. Education

Imperial College remains amongst the world's best universities, according to the Times Higher Education University World rankings (2012-13). These rank the College 3rd in Europe and 5th in the world for clinical, pre-clinical and health studies. The College has been awarded 197 Academic Clinical Fellows and 72 Clinical Lecturers, which is overall the highest number in the country[1]. The AHSC is the lead provider in North West London for post-graduate training in cardiology, respiratory medicine, diabetes and endocrinology, geriatric medicine, gastroenterology, renal medicine, clinical radiology, obstetrics and gynaecology, and trauma and orthopaedics.

As lead provider for postgraduate medical training in North West London, Imperial has already led innovations in many training programmes in close collaboration with other Trusts in the sector. Imperial aims to become the lead provider for postgraduate medical training across most specialties, including at the interface of primary and secondary care and possibly using models separating training in acute from elective settings.

The Trust's educational capabilities are enabled by the integrated AHSC model. Shared governance and unified posts create a suitably supportive infrastructure where objectives can be aligned, for example Dr Jeremy Levy, sits on the strategic education committee of the College and represents the provider side of undergraduate and postgraduate teaching and education at the AHSC joint executive group. Postgraduate education is strategically led within the AHSC by the Director of Education with strong links with the Health Science Academy at the College and postgraduate academic training committee.

6.1. Priorities for 2013/14 [to be strengthened by NC]

In the coming year, the Trust aims to:

- Improve postgraduate medical education performance as measured by a reduction of 20% in red flags in the 2013 GMC national trainees survey and enhanced undergraduate teaching as measured by 20% improvement in SOLE scores;
- Improve patient safety by providing monthly multi-disciplinary simulation-based training focused on complaints and clinical incidents;
- Increase the number of innovations education by 30% by March 2014.

[1] NIHR Biomedical Research Centre 2011 - Full Application Form

7. Research

In partnership with our academic partner, Imperial College London, the Trust has continued to improve the quality and quantity of clinical research being undertaken. As the UK's first AHSC, the Imperial partnership has an unparalleled track record in leading NIHR-funded clinical research programmes. Our research excellence is attested by our NIHR Biomedical Research Centre (BRC), awarded through national competitions in 2007 and 2012, on both occasions with the highest awarded funding over a broad research agenda. The new BRC programme has just completed its first full year of operation - 15 distinct research themes supported by core infrastructure in biobanking, genomics, stratified medicine, and imaging. We also host the NIHR/Wellcome Trust Clinical Research Facility on the Hammersmith campus, which represents the hub of a £70m investment in a purpose-built experimental medicine facility. Clinical trials are coordinated through the Imperial Clinical Trials Unit (ICTU), which is fully accredited by the UK Clinical Research Collaboration.

Imperial also leads and hosts other national NIHR centres and programmes. The MRC/NIHR Phenome Centre was formally launched in 2012/13. This unique facility, based at Hammersmith Hospital, operates in partnership with King's College London, analytical technology companies, and public funders. The Centre will analyse thousands of samples of blood, urine and tissue to discover how our genes interact with our environment to cause and affect the course of disease. On the St Mary's campus, the NIHR Patient Safety Translational Research Centre was also recently renewed for a further five years – one of only two in the country.

In addition, the Trust has been extremely active in recruiting patients into NIHR Clinical Research Network portfolio studies. Including the population-based COSMOS study which is looking at the potential health implications of long-term mobile phone usage, we have recruited more than 47,000 patients and healthy volunteers in 2012/13 – more than twice the number recruited last year. The Trust has also focused on increasing commercial clinical trials activity; over the past year we have doubled the number of patients recruited to commercial studies.

7.1. Priorities for 2013/14

In the coming year, the Trust aims to:

- Successfully apply for re-designation of our Academic Health Science Centre;
- Successfully apply to host the new North West London Local Clinical Research Network ;
- Appoint Heads of Research within the newly reconfigured Division structure;
- Continue work towards meeting performance benchmarks for ensuring faster, easier clinical research, and in delivering commercial studies to 'time and target';
- In partnership with Imperial College London and Chelsea & Westminster NHS Foundation Trust, successfully renew the North West London Collaboration for Leadership in Applied Health Research and Care (CLAHRC);
- Establish a joint research initiative with the BRC at the Royal Marsden NHS Foundation Trust.

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8. Risks

This section describes the Trust's approach to risk management and mitigation, both financial and non-financial.

8.1. Risk management

Having identified some degree of variation across the organisation, the Trust has recently commissioned a review of its risk management structure and processes. The review will inform any changes required to the corporate and local risk registers and the Board Assurance Framework (BAF) to ensure that risk management is undertaken in a consistent way across the organisation and is properly embedded within the day to day management of the Trust. Initial findings of the review were reported to the Audit & Risk Committee on 18 April.

The review of the BAF needs to be informed from the Trust's Strategic Objectives to ensure that it is fit for purpose. Alongside this process, the Trust Board will need to agree its appetite for different types of risk including financial, operational and quality driven risks, to inform the prioritisation and allocation of resource to support mitigation plans.

8.2. Risk analysis

Table 7 below describes the Trust's assessment of the key risks currently facing the organisation, together with mitigation plans and an assessment of impact.

Table 6: Risk analysis

Description of Key Risk	Mitigation	Impact
Not being able to maintain high standards of care and achievement of performance goals during a period of unprecedented challenge	• There is an executive lead for performance together with individual clinically leads to ensure appropriate attention is targeted at, for example MRSA, patient experience etc. • A revised risk assessment process has been devised for the CIPs to ensure that they are all clinically assessed	• Poor patient experience • Breach of infection thresholds • CQC registration with conditions
Failure to achieve agreed CIPs for 2013-14	• The Trust has established a CIP Board and invested in its senior finance team and introduced revised financial reporting • The CIP Board undertakes regular reviews of the CIPs with performance management arrangements in place and delivering and benchmarking undertaken • Enhanced controls have been put in place for appointment of staff and ordering of goods and services	• Impact on financial position, FT authorisation and AHSC mission

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Description of Key Risk	Mitigation	Impact
Demand management does not effectively mitigate risk of non-funded activity in changing health economy	• Contract negotiations are proceeding together with collaboration and engagement with GPs/commissioners • The Trust is revising its demand and capacity plans	• Financial losses, operational pressures and impact on the quality of patient care
Inability to reconcile the complexities of the Trust and current uncertainties of the health economy with the specific requirements of the FT application process	• The Foundation Trust Programme Board has been established as a committee of the Board • A revised timeline for progression through the Foundation Trust process has been agreed with the TDA • Work has commenced on the Quality Governance Framework and the Board Governance Assurance Framework • Managing Director of AHSC has been appointed and the organisational structure is now in development • The AHSC reaccreditation timetable has been released	• Failure to progress the AHSC strategic mission and realise benefits of becoming a Foundation Trust
Failure to implement Cerner System Patient Administration System (PAS) system and maternity system within agreed timescales	• The Trust has established a Cerner Programme Board with the Chief Operating Officer as the Senior Responsible Officer • Testing and repeat testing is underway with a go live date to be agreed	• Inability to produce quality data including performance data • Impact upon services provided to patients • Financial losses
Mismatch in staff levels in maternity relative to activity	• A head of Midwifery has been appointed and an effective workforce strategy and implementation plan is in place with staffing level discussions continuing at divisional level • Midwife-led triage has been instigated at QCCH to reduce pressures on the labour ward • Review of the model of care for maternity is to be conducted	• The Trust could fall outside of recommended ratios by NHS London and patient safety/experience could be affected Midwifery Whole Time equivalent (WTE) does not meet recommended requirements for 1:1 care in established labour (DH08, CEMACH 08, Kings Fund 08)
Loss of management stability during the restructure with potentially disenfranchised /demotivated staff and potential gaps in the senior management structure and loss of organisational memory	• A project group with representation from all affected areas has been set up • There are regular one to ones with affected staff and weekly updates at the Management Board	• Quality consequences • Financial issues

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Description of Key Risk	Mitigation	Impact
Mismatch between activity and capacity due to variation in seasonal demand leading to additional unfunded (escalation) bed capacity	• Escalation space is reviewed on a daily basis by CPG and site teams, and periodically by Executive Leads • Additional capacity has been added to nursing, therapy support and diagnostic to support both sustaining the capacity whilst needed and discharge • On-going regular review by Chief Operating Officer • In addition substantive capacity has been identified within CPG business plans for 2013/14 and the 2013/14 Capacity Plan has made proposals to reduce occupancy levels • The clinical estate will be reviewed to improve efficiency and utilisation across the three main sites	• Impact upon the quality of clinical services, finances and staff/patient experience

8.3. Sensitivity analysis

Detailed sensitivity analysis and financial mitigation planning will take place as part of the development of the Trust's LTFM during 2013.

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9. People and Organisational Development

The Trust's leadership and workforce development plan is driven by a vision of promoting bench to bedside translational research to benefit the Trust's patients and the wider community in North West London and the UK. The organisation's strategies for patient care, research and education underpinning this vision rely to a very significant extent on creating an effective organisation. This organisation requires world-class leadership and workforce, operating within a framework of the shared values of respect, innovation, care, achievement and pride.

9.1. Workforce planning

Workforce numbers are anticipated to change over the next five years, primarily in response to changes in the local healthcare economy, planned service and planned reconfiguration of acute health services in North West London. The Trust will improve its levels of productivity significantly by delivering more and higher quality services within an envelope of resources which reduces in real terms over the life of the plan and beyond.

A key to improving productivity will be by increasing the stability of the workforce. This will be achieved through reducing the level of vacancies and the consequent dependency on agency staff. The Trust plans to reduce the level of sickness absence from 3.6% to 3.0% or less over the period of the plan to 2015/16.

The Trust is currently operating with a 9.7% vacancy rate and compensating with a level of temporary staffing which equates to nearly 8% of the total pay bill. Plans are in place to reduce the current level of vacancies to 7% over the course of the next five years, with a particular focus on band 2-6 posts. This will reduce dependence on the use of bank, and especially agency, staff to around 5.5% of payroll, 4% bank including medium term locums and 1.5% agency to ensure sufficient flexibility in overall staffing costs. There will be a reduction in the levels of employed staff based on current activity assumptions. Reductions will be clinically led with no compromise to service quality or patient safety. Based on the planning forecasts for 2013/14, a net reduction in staffing of 346 in year is projected, half of which are within temporary staffing groups. Further staffing reductions and projections will be modeled for the remaining years of the five year plan, through the joint Finance and Workforce work stream.

The workforce projections of this plan are set out in Figure 1 below.

Figure 1: Workforce Projections 2011 – 2014 (Staff in Post WTE)

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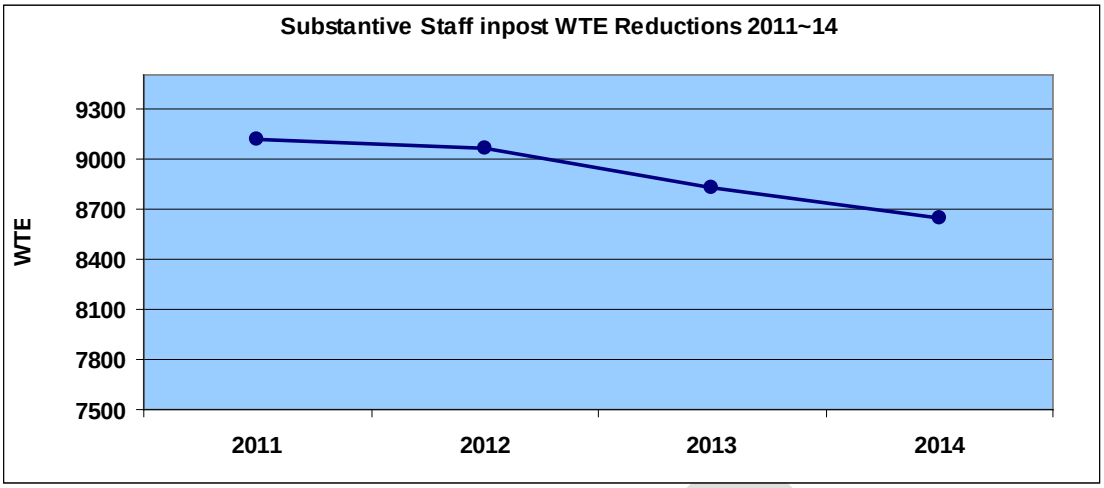


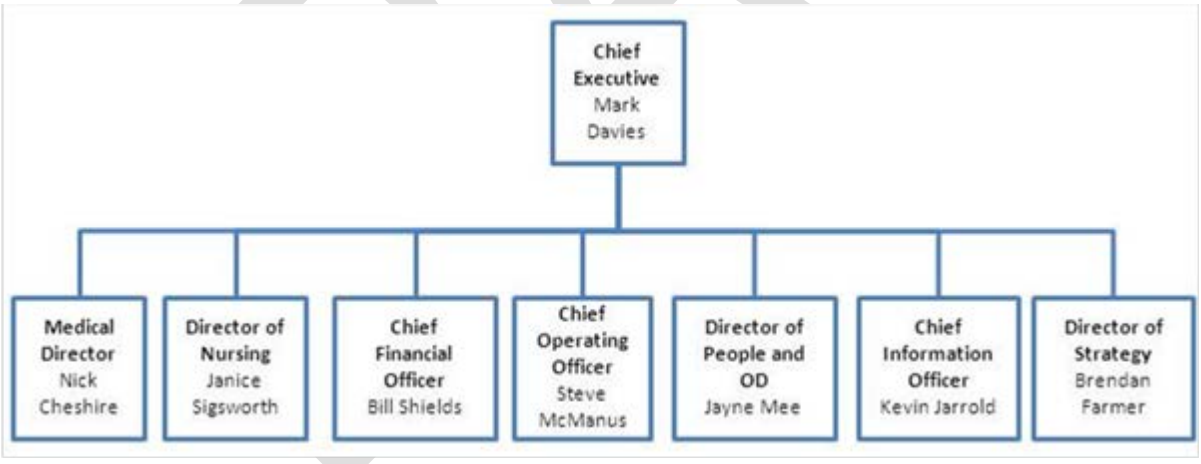
The Trust plans to maintain, and where possible increase, its investment in training and development of all staff especially those in leadership roles, including plans to develop the AHSC as an educational academy with our partner Imperial College.

The leadership will actively seek to increase the level of engagement with all staff groups and local communities in the emerging plans to ensure that the Trust is able to respond flexibly and positively to the opportunities and challenges as they arise.

9.2. Management arrangements

Figure 2 below illustrates the corporate management structure of the Trust.

Figure 2: Management Structure as at 31 March 2013



The Trust will be moving to a Divisional structure of four clinical groups from autumn 2013. The Divisional management structure will enable the Trust to:

- Improve patient pathways by adopting consistent structures, roles and responsibilities, making it easier for staff, patients and other external stakeholders to work together effectively;
- Create an environment that supports succession planning of capable, high calibre staff and removes inconsistencies in grades;
- Ensure changes are consistent with the wider modernisation and organisation development of the Trust, reflecting the strategic areas of clinical excellence in the structure;

- Align the Trust more closely with Imperial College, furthering the AHSC mission for excellence in service, research and education;
- Define a clear, accountable senior management structure that is consistent across divisions, thereby addressing external review feedback that highlighted risks of the current CPG structures;
- Ensure there is a sufficient pool of management capability to support strategic aspirations including the Foundation Trust process.

To achieve this:

- Each Division will be an autonomous business unit responsible for its own clinical, research and financial performance;
- Clinicians will manage each Division to ensure it is able to identify and respond to emerging clinical needs and focus research efforts on the areas where it will make the most significant impact;
- Divisional Directors and the Heads of Divisions will set challenging, measurable goals that span the demands of the College and Trust in order to drive improved performance;
- Divisional Directors manage the service in each area effectively through service line reporting.

9.3. Foundation Trust opportunities

The process of applying for FT status will provide opportunities for members of staff to shape the future of the Trust. As a FT, ICHT aims to use the new opportunities and governance arrangements to involve staff in new ways to:

- Review the robustness and effectiveness of governance arrangements, business planning and risk management systems, the sustainability of financial assumptions and management and Board capability;
- Engage staff in developing the People & OD strategy and the wider strategic agenda, to influence the development of the organisation over the coming years;
- Create a membership and governing body of stakeholder representatives (both including members of the workforce), to influence the culture of the Trust. Bringing service users and other stakeholder representatives into closer contact with staff will make the organisation and its workforce more aware of the needs and expectations of different stakeholders;
- Encourage Divisions within a framework of Trust policies to improve clinical services, patient experience and efficiency through innovation and stakeholder involvement.

This will benefit the workforce as:

- Staff will benefit from working in a Trust which is structurally secure and financially robust because of the scrutiny associated with applying for, and operating as, a FT;
- Meetings of members and the governing body will provide valuable opportunities for staff members to hear the views of stakeholders and to influence and be influenced by them;
- The creation of the membership and Board of Governors will create a large pool of additional resource on which the Trust intends to draw as the Trust engages with patient representatives over the design and delivery of services;
- Divisions will wherever possible retain some of the resources released for reinvestment, to provide the necessary incentives to encourage staff involvement in further service improvement;
- Freedom to introduce new approaches to reward practice will be utilised to recognise exemplary contribution to the introduction of best practices within the Trust. There

are no plans to move away from the national pay structures. However, any subsequent developments will be done in consultation with staff representatives.

9.4. People strategy

The Trust's People Strategy supports delivery of the vision of providing excellent patient care services, research and education. This relies on building a strong organisation, which in turn relies on developing world-class leadership and workforce. ICHT's People Strategy is focused on recruiting, retaining, developing and organising the best staff and leaders. This philosophy is at the core of all that ICHT does and all that it plans to do. The People Strategy underpins the organisational strategy and develops the talent and culture proactively to provide a sustainable business and opportunities for advancement and development for all.

The People Strategy depicted in figure 3 below is central to the Trust's ambitions for its patients and population.

Figure 3: People Strategy

Leadership and workforce development will be achieved through integrated plans for:

1. Culture & Engagement:
   - Engagement;
   - Equality & Diversity;
   - Employee Relations;
   - Recognition.

2. Organisation Development:
   - Organisation Design;
   - Workforce Planning and Productivity;
   - Performance and Capability Management;
   - Appraisal;
   - Employer Branding – attraction, recruitment and retention;
   - Reward.

3. Talent Development:
   - Education, Training and Development;

- Succession Planning;
- Leadership Development;
- Apprentices & Graduates.

4. Health & Well-Being

5. Workforce governance.

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10. Governance

The role of the Board is to maintain overall corporate responsibility for the Trust's strategies, actions and finances. As an NHS Trust Board, it is the custodian of a national asset, provides stewardship and remains publicly accountable. Following the appointment of Sir Richard Sykes as Chairman and Mark Davies as Chief Executive, the Trust Board has been further strengthened, with the appointment of new Non-Executive Directors and Executive Directors. This has helped to bring a diversity and range of capabilities and capacities to bear on Trust Board business and Trust wide leadership.

The Board has an Assurance Framework system in which significant risks to the Trust major objectives are managed. The Board meets in public bi-monthly and holds private seminars in the intervening months to review Trust matters in more detail.

The Board has reporting to it committees responsible for audit and risk, governance, finance and remuneration. The structure of the committees and sub-committees of the Board is currently under review, with a view to streamlining the structure and improving effectiveness during 2013 in readiness for the Trust's FT application.

The Governance Committee provides the leadership and strategy which integrates all aspects of governance processes to support the Trust in providing safer, high quality care in the best environment which meets business objectives, manages the risks necessary to innovation in healthcare and uses accurate clinical information to bring about improved outcomes ensuring regulatory compliance.

Following the Level 3 assessment of the Trust's general acute services by NHS Litigation Authority (NHSLA) in August 2012, the Trust's maternity units at Queen Charlotte's & Chelsea Hospital and St Mary's Hospital achieved Level 3 in the CNST risk management standards for maternity services in November 2012, administered by the NHSLA. This makes ICHT the largest maternity care provider on two sites in London to have achieved CNST level 3.

Under the FT programme, the Trust will develop a plan for the establishment of a Board of Governors together with a FT membership recruitment strategy. In addition, a Board Development programme will support the ongoing strengthening of the Trust's governance practices throughout 2013/14.

10.1. Performance management

The Trust Board discusses the following performance report on a bi-monthly basis at Trust Board meetings and receives them for information in the intervening months:

- Trust Board performance scorecard, covering a range of quality, operational and workforce indicators;
- Finance performance report, covering the metrics used to inform Monitor's Financial Risk Rating and a detailed financial risk analysis;
- A range of clinical quality reports from the Medical Director and the Director of Nursing;
- Single Operating Model (SOM) self-certification return.

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The following controls are in place to support the Board's ability to track and gain assurance around performance related issues:

- Following advice from the NHS Intensive Support team (IST) there is now a comprehensive performance monitoring system in place with regular reports to the Trust Board based on performance meetings within the organisation;
- Monthly reporting of performance and Single Operating Model (SOM) at the Trust Board include a concerted focus on patient experience and clinical outcomes;
- Monthly trends of real-time patient experience provides early warning of any emerging clinical risk issues;
- By monitoring trends and real-time patient experience, early warning is provided on any emergent clinical risk issues;
- The Trust undertook a series of eight reviews associated with the RTT reporting break. In November 2012, the Trust Board received a report that outlined all the recommendations referencing the evidence of each KPI and demonstrated completion;
- KPIs have been established and are monitored to flag potential problem areas and show progress;
- Monthly CPG reviews, chaired by an Executive Director, have been specifically designed to challenge performance across a full range of performance areas;
- The Management Board and Trust Board receive regular updates across all performance areas, including a monthly Performance Scorecard and Finance Scorecard.

10.2. Financial governance

The Finance Committee (to become the Finance & Investment Committee) provides detailed review and scrutiny of the medium and longer term financial issues facing the Trust. The role of the committee is to focus on trends in financial performance and the impact of these trends on the future performance of the Trust. In particular, the committee concentrates on the financial risk profile of the Trust and the measures that are needed to assess and manage financial risk.

The Committee reviews proposals relating to organisational strategy, a long term strategic financial review, the SOM and updates to the LTFM. In addition, the Committee reviews the draft financial plan and the risks associated with it.

Financial controls are derived from the Trust's Standing Orders, Standing Financial Instructions and Schemes of Delegation. Any weaknesses in these controls will be identified through the current review of Risk Management processes and the coming review of the BAF and associated action plans.

10.3. Audit

Following a risk assessment exercise, the Management Board reviewed a proposed internal audit plan for 2013/14-2015/16, to be considered by the Audit & Risk committee in May. The plan will undergo further refinement as the Trust's Assurance Framework and Risk registers are drafted for 2013/14. The draft internal audit plan for the three year period is included in Appendix 1.

The Audit & Risk Committee has primary responsibility for all aspects of internal control including a key focus on financial standing, reporting, management, financial risk and value for money. It retains an oversight function for clinical risk. The Audit & Risk Committee receives reports from the external auditor, Deloitte LLP, in respect of their audit of the Trust's financial statements. The external auditors also report to the Audit & Risk Committee on the

findings from procedures they perform in respect of the Trust's quality account and the arrangements the Trust has in place to deliver economy, efficiency and effectiveness through its use of resources.

The Committee reviews the BAF, the corporate Risk Register and the Quality Accounts. It reviews and triangulates risks around Nursing Quality, Junior Doctor Local Inductions, use of Doctors at night, the implementation of Cerner, and clinical risk assessments on CIPs. It also receives Harm Free Care Reports which triangulate workforce, experience, infection and nurse sensitive indicators.

10.4. Compliance framework

Monitor is currently revising its Compliance Framework following a public consultation that concluded in April 2013. Once a new Framework is published, the Trust will put plans in place to ensure its compliance in readiness for FT authorisation. It should be noted that the Trust has maintained a Financial Risk Rating of 3 since May 2012 and its Governance Risk Rating, reported monthly via the SOM return, has steadily improved throughout 2012/13 to reach 1 (green) in February 2013.

10.5. IT systems

Risks associated with the Trust's IT systems are actively managed by the Management Board and the Audit & Risk Committee, which provides assurance to the Trust Board. The implementation of Cerner and the associated operational risks are being carefully monitored, managed and mitigated through these structures.

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Imperial College Healthcare NHS Trust

Appendix 1 – Draft Internal Audit Plan 2013/14-2015/16

REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14AUDITS TBC	RAG RATING (APPDX A)/ BASIS
Core Financial Systems (Annual)									
1	Financial Reporting, Planning & Budgetary Control	20	25	20	Budget setting, forward planning and financial modelling; Adequacy of management information for effective decision making, follow-through of actions taken to variances in budget versus actual.	AF Objective Five, ER48	CFO	Q2 and Q4	MA
2	Service Line Reporting	**20**	**15**	**15**	Robust management review of financial data and reporting system Qlikview to support service line reporting; also continued development of SLR accuracy to enable the Trust to develop patient level costing and associated recharges.	AF Objective Two, ER12	CFO	Q3	MA, MC
3	Commissioning & SLA Income	**25**	**25**	**25**	Commissioning income received matched to SLAs / Contracts with Commissioners, process for ensuring data quality of coding activity.	AF Objective one,	CFO	Q2	MA
4	Financial Ledger and feeder Systems.	**15**	**18**	**16**	General ledger reconciliation to the debtors system, management of aged debts.	AF Objective Two, AF Objective Five, ER33	CFO	Q3	MA
5	Accounts Payable and Receivable	**25**	**30**	**30**	Adequate management of Trust non-pay and stock expenditure focused on exceptions based on predetermined parameters; monitoring validity of high value payments.	AF Objective Two, AF Objective Five, ER33	CFO	AP – Q2 AR – Q1	MA

REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14AUDITS TBC	RAG RATING (APPDX A)/ BASIS
6	Treasury Management	**15**	**12**	**12**	Periodic reconciliation of nominal ledger to creditors system; Independent review of monthly bank reconciliations, cash position, investment position and cashflow; Adequate policies and procedures to support investment decisions; Access to bank accounts is strictly controlled and any amendments to transactions or access is only via written instruction with two authorised signatories; Ensure robust controls to prevent breach of loan covenants and to assess limits on borrowing; Only authorised staff can update or amend the financial ledger and feeder systems.	AF Objective Two, AF Objective Five, ER33	CFO	Q2	MA
7	Payroll	20	20	20	Monthly reconciliations of the financial ledger to the payroll system are completely and independently reviewed; Starters, leavers and changes are processed within stated deadlines; Adequate measures are established to reduce the risk of salary overpayments.	N/A	CFO	Q2 & Q3	MA
34c	World Class Finance Programme	20							
8	Stock; controls over stock, purchasing and Tender Waivers.	5	10	10	Overview of periodic independent stock counts; MC - Review of Pharmacy stock control, purchases, management of disposal and incident reporting. Review validity of tender waivers, both before presentation to Audit Committee plus any additional ones selected by AC.	N/A	CFO	Q1, Q4	MA, MC
	Sub-total	**165**	**155**	**148**					

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REF	AUDIT TOPIC	13/14	14/05	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
Governance/Risk Management Reviews									
9	Board Assurance Arrangements for HIAO	16	16	14	Initial review of 2013/14 BAF, then a year-end review.	Assurance Framework as a whole	DOG	Q1, Q4	IA
10	Clinical Governance/Clinical Audit	20	20	15	Review Trust accreditation level and provide support to maintain and reach highest accreditation.	AF Objective Two	DOG	Q1	Best-practice
11	CQC Assurance	14	14	12	Interim and year-end review of Trust self-assessment process, plus focused checks on individual standard areas.	AF Objective One, AF Objective Two, AF Objective Five ER34	DOG/ DON	Q2, Q4	IA
12	Quality Accounts	20	20	10	Links with Performance Management audit- expected emphasis on assurance re specific quality accounts measures.	AF Objective Two	DOG	Q1	MA
13	Corporate Governance ▪ Monitor Compliance ▪ Risk Management ▪ Governance Committee	17	22	12	Review of the Trust progress towards achieving Foundation Trust status and supporting them in achieving this objective. Local CPG-level risk registers, as well as communication and reporting to the Trust-level risk register. Attendance at/contribution to Governance Committee- increased days reflects expectation that Internal Audit will play a more active role in	AF Objective Five Risk register as a whole AF/RR as a whole	DOG	Q1	Best-practice

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REF	AUDIT TOPIC	13/14	14/05	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
					addressing some of the matters arising from Governance Committee meetings.				
	Sub-total	**87**	**92**	**63**					

REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
Key Business Systems									
14	Estates (incProcurement), Facilities & Waste Management	34	40	40	Review controls over planned and preventative maintenance, purchases, stock control and staff management. MC - Review of waste management as part of a cyclical review of arrangements.	N/A	DOE	Q1	MC
15	Capital Expenditure ▪ Accounting ▪ Capital Schemes	20	25	25	Controls over the tendering, management of projects, financial performance monitoring of capital projects; Accounting of capital assets is accurate and up to date.	AF Objective One, ER9, ER30, ER37	CFO	Q3	MC
16	Human Resources	15	15	15	To review systems in place for HR planning; recruitment and what progress for appraisals has been made.	N/A	DOPOD	Q1	Best-practice
17	Temporary Staffing	10	13	13	Controls are adequate to monitor performance of 3rd party service provider for both internal and external temporary staff; E-Rostering controls	N/A	DOPOD	Q1	MA

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REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
					are effective in identifying vacant shifts.				
18	Private Patients/Overseas	10	21	21	Ensure that robust procedures support the collection of non-NHS income as well as the business development of improving the growth of private patient income; including possible development of analytical review/benchmarking.	N/A	CFO	Q1	MC
19	Patient Experience	10	15	15	Focus on CPG-level processes in ensuring high patient satisfaction, with specific reference to the risks surrounding patient discharge.	N/A	MED/ DON	Q1	MC
20	Safeguarding Adults/ Children	15	15	15	Review of arrangements in place for the protection of children and vulnerable adults as well as testing staff awareness of the arrangements.	N/A	MED/ DON	Q2	Best-practice
21	NHSLA	5	21	21	The Trust is currently at NHSLA 3 and is due to be reassessed in 2012/13- with risk of consequential increase in premiums if Level 3 accreditation not maintained. Our work will look to support the Trust through an independent appraisal of the evidence and an action plan,	AF Objective One, Two, Four, Five	DOGCA	Q1	Best-practice
22	Performance Management	20	20	20	To be defined; likely to include targeted work on waiting list management assurance in Q2/3. This will take into account alternate sources of assurance from addressing of issues in these areas.		DOP	Q2/3	MC
23	Complaints	11	12	12	Analytical review		DOGCA	Q2	MC

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REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
24	Clinical Coding/Data Quality (15 each)	30	30	30	SUS reconciliation, information provision analytical review, other data quality controls evaluation and data validation.		CFO	Q3	MC
25	Research	20	16	16	Trust adequate management and monitoring of funding use in conjunction with the Joint Research office; meaningful and timely financial research reporting.	N/A	DOR	Q4	MC
26	Education	20	16	16	Management and monitoring of funding streams and any lead provider arrangements in place.	N/A	DOE	Q4	MC
27	Statutory & Mandatory Training	15	16	16	Processes for managing delivery of training and maximising attendance/take-up; focus to include specific NHSLA level 3 considerations	N/A	DOPOD	Q1	MC
28	Policy Development Compliance	30	26	26	Independent assurance re processes and/or input into development of standing orders and other key policy documents.	AF/RR as a whole	DOGCA	Q4	Best-practice
29	Junior Doctors Rotas and Induction	25	0	0	Identifying the work undertaken by Junior Doctors and whether this hours worked affects patient care	Objective 4	TD	Q1/Q4	HT
	Sub-total	**290**	**301**	**301**					

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REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
IT Audit Reviews									
30a	Information Governance	15	15	15	To assess whether the IGT return is valid and represents an adequate level of attainment. The audit will also examine selected areas of compliance.	-	CIO	Oct 2013 and Feb 2014	COBIT
30b	IT Management Arrangements	16	12	12	To assess whether the arrangements for managing IT services are adequate. It will look at the top-level organisation, policies and procedures in ICT. It will consider how these arrangements integrate with other related areas such as Information Department, user departments – especially those that host /manage systems – and external providers. A major programme of system enhancement and replacement has begun to support the aims of the AHSC		CIO	-	COBIT
30c	Change Control	5	12	12	Follow Up of Limited Assurance Report.		CIO		COBIT
30d	User Support	-		10	To assess whether there is adequate IT support covering: - helpdesk - inventory - installation and maintenance. - software licensing (follow-up earlier work)		CIO	-	COBIT
30e	BCDR (i) Disaster Prevention and Recovery Planning	0	11	11	To assess the planning for preventing and coping with a major disaster, covering procedures in IT services,		CIO		COBIT MC

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REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
					including ICT, departments that host/ manage systems and external providers. As the Trust deploys more integrated, comprehensive and paperless systems, it will become increasingly dependent on them being available with minimal disruption. .				
	PC Replacement Programme	15			To assess the controls in place for the disposal and replacement programme in accordance with IG rules and guidance. This will include attempts to recover data from the disks degauzed by the Trust (by our forensics unit). NB: to check whether any disks are removed by third parties.			Q3	
	Registration Authority	3	10		Registration Authority follow Up of work carried out in 2012/13.		CIO	Follow Up of RA advisory work carried out in 2012/13	MC
	Network Resilience and Access Controls	12	10	-	To assess whether physical access to Trust IT services and data via the network is adequately controlled to prevent unauthorised or inappropriate access		CIO	May 2013	
	Enterprise Data Warehouse	4	9		Follow Up of Limited assurance Report.		CIO	-	MC
30f	Cerner Programme	15			To continue the work undertaken		CIO	Q1/2/3	MC, COBIT

DRAFT

REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
	Support				during 2012/13 and support the Trust in their readiness for Cerner Implementation and during the implementation phases. This work includes expert advice and attendance at Project Board (and other appropriate meetings).				
	Cerner Project Review	15			To carry out a review of the implementation of one of the Cerner phases, to be decided. The audit could cover project controls, data migration, integrity checks etc.			On Going	
	Software Licensing			19	To assess whether the Trust has effective controls to ensure all software in use is properly licensed.		CIO	Q2	MC
32	IT Audit Mgt& Follow-Up		21	21	IT Audit planning and reporting on progress to management	N/A	CIO	Ongoing	MC
	IT Risk Assessment	15			Complete a rebasing of previous risk assessments using a CObIT framework and consequently provide a new Strategic IT Audit Plan. Will include review of key documentation, audit findings, other assurances and meetings with key staff.			April 2013	MC
	Data Quality	15			To conduct interrogations on the quality of Trust data. Selecting a system to review, data will be extracted and tests performed using Computer Assisted Audit Techniques to determine the completeness of data fields and whether those fields conform to certain queries set by management.			Q2	MC

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REF	AUDIT TOPIC	13/14	14/15	15/16	INDICATIVE SCOPE AND OBJECTIVES	BAF/RR REF	EXECUTIVE LEAD	TIMING FOR 13/14 AUDITS TBC	RAG RATING (APPDX A)/ BASIS
	Data Leakage and Secondary Uses (CCGs)	15			To review the Trust grade 5 Nicholson incidents and assess the control framework around the protection of Person Identifiable Information to identify areas for improvement, which should in turn reduce the number of incidents. Include within here the 251 Exemptions – to ensure that our arrangements for the submission of PII for secondary use is still regarded as legal and appropriate			Q1	MC
	Remote Working (The Cloud, Dropbox)	12			To review the controls in place at the Trust for remote working. In particular to ensure that the controls are sufficient to protect Trust data.			Q4	MC
	General Follow Up	6			Review of Recommendations completed throughout the year.				
	Pseudonymisation	5			Follow Up of Limited assurance Report			Q4	
31	Other Topics (to be defined)	0	10	10		-	CIO		
	Sub-total	**168**	**110**	**110**					

DRAFT

Imperial College Healthcare NHS
NHS Trust

Report Title: Outline Business Case (OBC), to support the development of Magnetic Resonance (MR), and Nuclear Medicine Imaging at Hammersmith Hospital

To be presented by: Bill Shields, Chief Financial Officer

Executive Summary:

This OBC seeks permission to proceed with a capital investment of £8.6 million. This comprises two elements; an investment of £7.9 million over three years to replace imaging equipment beyond its serviceable life and to develop and expand existing Imaging facilities at Hammersmith Hospital (HH) site. The second component is the additional electrical infrastructure work required to support the new equipment. This has been costed separately at £0.7million and will support all departments located in A Block.

In line with NHS Trust Development Authority (TDA) guidance, this OBC has been prepared using the Treasury agreed standards and format for business cases, the Five Case Model, which comprises the following key components:

- The strategic case - sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme;
- The economic case - demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM);
- The commercial case - outlines the content and structure of the proposed contract(s);
- The financial case - confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation;
- The management case - demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.

A summary of the full case has been set out in this paper with the executive summary of the full OBC included as *Essential Supporting Information.* The full OBC with supporting appendices are available on request.

In accordance with *Delivering High Quality Care for Patients: The Accountability Framework for NHS Trust Boards*, published by TDA 8 April, requires NHS TDA Director of Finance approval as it is between £5-10m in value.

Key Issues for discussion:

The Board is asked to;

1. Approve the submission of this OBC to the TDA;
2. Support the internal approval and commitment to the design phase and development of this OBC within the £780K 2013/14 capital plan allocation.

3. Note that:
   - This business case was approved by both the Management Board and Investment Committee on 28th January 2013
   - The preferred option requires a total capital spend of £8.6million and is currently budgeted within the capital programme as follows: £780k in 2013/14, £2.95m in 2014/15, £4.9m in 2015/16, £75k in 2016/17.

Legal Implications or Review Needed

a. Yes
b. No ✓

Details of Legal Review, if needed

n/a

Link to the Trust's Key Objectives: All

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For Decision ✓
b. For information/noting ✓

1. OBC Summary

1.1 Introduction

The Imaging service at HH is the least resilient of all the Imperial College Healthcare Trust (ICHT) sites. Two Imaging Reviews (2009 and 2011) supported the need for improved resilience on the HH site in order to cope with the increasing demand and complexity of cardiac and renal referrals.

The current single MR scanner is overdue for replacement and the failing Gamma Cameras are older than those on the other sites. This unsustainable MR service, which results in the loss of MR scanning facilities on the HH site when a single scanner is unavailable for either preventative maintenance or breakdown, is the top CPG clinical safety risk and therefore priority.

There is insufficient spare capacity within the current Imaging Department at HH to expand or redesign the facilities to provide adequate capacity for the additional equipment required to manage waiting times, provide resilience, realise the possible benefits to patients or make the environmental improvements required to meet Eliminating Mixed Sex Accommodation (EMSA) requirements.

By investing in new technology, the Imaging Department aims to improve diagnosis and treatment for patients, improve productivity by being able to scan patients more efficiently, improve patient throughput and offer a variety of appointments in and out of hours.

The key reasons for investment are as follows (further detail is given in section 2.3):

- Reduction in clinical risk and improved operational resilience;
- Improve patient experience and reduce waiting times;
- Provide sufficient capacity to meet existing demand and enable growth in external referrals, the existing MR scanner needs to run additional sessions just to meet the existing demand;
- Maximise operational efficiency and improve cost management.

1.2 Investment Criteria

The Investment committee uses three criteria for assessing whether the Trust should invest in a particular proposal; Patient benefit, Reduction of major risk, and Financial return (Return on Investment).

Proposals are assessed against each criterion individually, not as an overall score. This OBC scores 2Bs, 1C, 1D and 1E. The investment programme is deemed *manageable with business as usual procedures* and the commentary against other criteria are given below;

1. Patient benefit - These changes will have an impact on a minimum of 7,800 patients per year (in 2012/13 over 5,500 MR Scans and 2,300 Nuclear Medicine investigations were performed at HH). The design solution will also improve the waiting facilities and patient experience for the whole department and as such impact on tens of thousands of patients
2. Reduction of Risk - The failure to provide a sustainable MR Service, which results in the loss of MR scanning facilities on the HH site when a single scanner is unavailable for either preventative maintenance or breakdown is listed as 'Reference IM59' on the CPG risk register with a rating of 9 HIGH (likelihood 3 x consequence 3). This is the top clinical safety risk and therefore priority for the CPG.
3. Financial Return – Nil.

2. The Strategic Case

2.1 Reduce clinical risk and improve operational resilience

There is no spare capacity on the MR scanner on the HH site. Therefore the ability to provide a timely MR diagnostic service is compromised by the frequent breakdown of the single MR scanner; data in July and August 2012 shows this scanner broke down five times and took up to four days to repair on each occasion.

Both Imaging Reviews (2009 and 2011) support the need for improved resilience on the HH site in order to cope with the increasing demand and complexity of cardiac and renal referrals. Operating a single scanner means there is no back up and therefore no resilience. Both the other main hospital sites have three MR scanners.

In addition, both Gamma Cameras are beyond their expected working life and have broken down over twenty times in the last 12 months. The poor camera image quality presents a clinical risk as diagnostic opportunities may be missed. A nuclear medicine service can only run during office hours as it is dependent on the delivery and very short half-life of the isotopes used to generate the images.

2.2 Improve patient experience and reduce waiting times

The 2011 Review specifically identified the single MR machine at the HH site as the cause of the ongoing failure to deliver local waiting times targets and subsequent poor patient experience. The average actual waiting times for outpatient MR by site demonstrate that HH is the outlier. Radiology Information System (RIS) data for the financial year 2012/13 shows that HH has an average outpatient wait of 20 days compared with 14 at SMH and 18 at CXH. The Trust target is 10 days and the additional scanner will improve MR access across all sites. While ICHT has avoided any penalties to date it is important to note that there is a potential financial penalty of £500 per patient for breach of the diagnostics 6-week target.

While recovery areas and imaging recovery are not specifically covered under EMSA at present other than under 'patient choice', it is likely that this will change in the near future and therefore the Trust EMSA strategy is to review compliance in all new builds. In this OBC, we intend to 'future proof' the imaging department by ensuring we meet the requirements for undressed patients in that 'undressed patients should not have to pass through or by the opposite gender'.

I-Track Patient 2012/13 survey data consistently supports the need to improve waiting facilities. Patients are specifically asked to rate the waiting facilities and the results have returned an average score of 79% against a target of 90%. The design solution in this case addresses all imaging patient wait areas, not just those associated with MR and NM.

2.3 Provide sufficient capacity to meet existing demand and enable growth in external referrals

The existing MR scanner needs to run additional sessions just to meet the current demand. Over the last three years MR referrals to the Trust have grown by 40%, and activity at HH site has more than doubled with 2834 scans in 09/10 compared with 5693 scans in 12/13 (RIS April 2013).

2.4 Maximise operational efficiency and improve cost management

By co-locating the two new MR scanners in close proximity a number of efficiencies can be realised. A shared control room maximises use of space and also reduces the staffing requirements. The replacement of the existing MR scanner will achieve efficiencies in scanning time with the development of improved technology. It is anticipated

that a routine MR scan will be performed in 20-25% less time than our existing MR scanner. In addition the co-location of two scanners increases the flexibility of case management and therefore patient throughput, again further improving the overall MR performance.

From the staffing perspective the collocation of the MR scanners will improve the staff to equipment ratio from the existing 3:1 to 2.5:1. There will also be improved opportunities for teaching and training.

3. The Economic Case

Over several years a total 17 of options were developed; of these three main schemes were considered viable and as such taken forward to the shortlist. A significant proportion of the investment of these schemes are the cost of the scanners; a typical SPECT CT cost is £750K and 1.5T MR is £875K excluding VAT and so each option was developed with a Lease (A) & Purchase (B) option hence the short list of six as outlined below.

Table 3.1 Options shortlist

No.	Title	Description
2A	Do minimum (lease)	Replace existing 1.5 T MR and SPEC-CT in existing locations with leased equipment
2B	Do minimum (purchase)	Replace existing 1.5T MR and SPEC-CT in existing locations with purchased equipment.
6C	Develop Unit to include an addition MR scanner & replace existing equipment (lease)	Using existing Nuclear Med (NM) space and @half vacated Endoscopy space with the addition of the existing corridor, reception area and second MR scanner, via leased equipment. A two-phase project; Phase 1 - Reconfigure existing vacant Endoscopy unit to create space for SPEC-CT with supporting rooms and a main reception area. Phase 2 – Reconfigure existing nuclear medicine space to create space for two 1.5T MRs and supporting rooms. Works also to upgrade and increase recovery bays.
6D	Develop Unit to include an addition MR scanner & replace existing equipment (purchase) PREFERRED OPTION	As above with purchased equipment
7A	Do Maximum (lease)	Using existing Nuclear Med (NM) space, the existing corridor and reception and @ two-thirds of vacated Endoscopy space, with leased equipment. A Single phase Project to build a 5-scanner room unit to include two 1.5T MR, one 3T MR, SPEC-CT and PET-CT
7B	Do Maximum (purchase)	As above with purchased equipment

3.2 Economic evaluation

This comprises of three main elements; non-financial benefits, risk and economic evaluation. A benefit criteria, weighting and risk register were drafted; against which each option was scored (further detail of how they were identified and the main sources and assumptions can be found in the support information document section 1.3.30). An economic appraisal was carried out by calculating the equivalent annual cost for each option and expressing this as a ratio to the economic benefits.

The scores of each option appraisal were ranked from one to five; with one being the preferred and five the least favourable. The overall ranking was then assigned with number one being the preferred option as it received the highest number of favourable ranking scores.

Table 3.2: Economic Evaluation Overall Ranking

Evaluation Results	Option 2A	Option 2B	Option 6C	Option 6D	Option 7A	Option 7B
Economic appraisals	5	4	2	1	3	3
Benefits appraisal	3	3	2	2	1	1

Risk appraisal	4	5	1	1	2	3
Overall ranking	**5**	**5**	**2**	**1**	**3**	**4**

3.3 The preferred option

Following evaluation Option 6D was nominated as the preferred option. Option 6C, the leased equipment version of this option, was rated second primarily as the cost associated with the lease and likely term of contract reduces the value for money.

4. The Commercial Case

The Trust, in looking to obtain best value for money through its contractual arrangements, is using the Joint Contracts Tribunal (JCT) Contract procurement route as the best value procurement method. It is proposed that the preferred option would undergo a fully co-ordinated design process with design reviews at key gateway stages, before sign off by both the design team and the clinical group. This would then proceed to tender on a fully designed scheme along with Bills of Quantities leading to a contractor appointment under a traditional JCT 2011 contract.

The costs and programme in the business case are based upon proceeding with this procurement route; however, the Trust will continue to monitor the relative value for money of procurement route options to ensure that best value is achieved.

5. The Financial Case

There is no direct relationship between imaging demand and income to the Trust with the exception of direct access contracts which exclude the inpatient work. The majority of users at HH are not direct access patients and, as such, no income stream can be accurately identified. All options therefore have a negative Net Present Value. The primary criteria for financial appraisal are cost, the option with the cheapest solution and life cycle cost achieves the highest evaluation. Funding for this project will be through internal resources, accommodated within existing plans and therefore have no impact on current financial plans or the Trust's balance sheet.

6. The Management Case

The implementation of the project will be managed overall by Rona Buxton, clinical service manager for the Imaging Unit at HH.

Table 6.1 Key dates in the programme are:

Milestone	**Date**
Internal OBC Approval Process – [ICHT Investment Committee/Trust Board]	Feb 2013/ April 2013
NHS Trust Development Authority London Approval process	July 2013
FBC Approval Process -Trust	Feb 2014
NHS Trust Development Authority London Approval process	May 2014
Start on Site	June 2014
Completion	July 2015
Commissioning	September 2015
Occupation	September 2015

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Outline Business Case (OBC)

To support the development of Magnetic Resonance (MR) and Nuclear Medicine (NM) Imaging at Hammersmith Hospital

Version No: 4.0

Issue Date: 18 April 2013

innovation respect care achievement pride

CONTENTS

1 EXECUTIVE SUMMARY

1.1 INTRODUCTION

The Trust seeks approval to proceed with a capital investment of £8.6 million over three years to replace equipment beyond its serviceable life and to develop and expand its existing Imaging facilities at the Hammersmith Hospital (HH) site.

This Outline Business Case (OBC) is for the construction of a new Magnetic Resonance (MR) & Nuclear Medicine (NM) unit within the existing Imaging department and an area within the former Endoscopy department at HH. This proposal includes the installation of two new MR scanners and one SPECT-CT.

A recent review of the A Block electrical infrastructure, which will be needed to support this and a number of adjacent diagnostic departments, has shown that significant upgrade is needed to support the electrical demand. This necessitates the installation of an additional high voltage substation. It is recommended that these works be carried out prior to the installation and commissioning of any new imaging equipment. The additional electrical infrastructure work has been costed separately at £0.7million and is referred to within this OBC as option 9. The total cost of the Imaging Department OBC and the recommended electrical work is £8.6million.

1.2 STRATEGIC CASE

1.2.1 THE *STRATEGIC* CONTEXT

The Imaging service at HH is the least resilient of all the Imperial College Healthcare Trust (ICHNT) sites. Two Imaging Reviews (2009 and 2011) supported the need for improved resilience on the HH site in order to cope with the increasing demand and complexity of cardiac and renal referrals.

The current single MR scanner is overdue for replacement and the failing Gamma Cameras are older than those on the other sites. In order to cope with current demand the current single MR scanner is scheduled to run an additional seven sessions a week (a total of 17 sessions per week).

An unsustainable MR Service which results in the loss of MR scanning facilities on the HH site when a single scanner is unavailable for either preventative maintenance or breakdown, is listed as 'Reference IM59' on the CPG risk register with a rating of 9 HIGH (likelihood 3 x consequence 3). This is the top clinical safety risk and therefore priority for the CPG.

There is insufficient spare capacity within the current Imaging Department at HH to expand or redesign the facilities to provide adequate capacity for the additional equipment required to manage waiting times, provide resilience, realize the possible benefits to patients or make the environmental improvements required to meet Eliminating Mixed Sex Accommodation (EMSA) requirements.

By investing in new technology the Imaging Department aims to improve diagnosis and treatment for patients, improve productivity by being able to scan patients more efficiently, improving patient throughput and offering a variety of appointments in and out of hours.

The reasons for requiring investment fall under four main headings; these are discussed in full in Section 2 *the Strategic Case* but a summary is given below;

- Reduce clinical risk and improve operational resilience;
- Improve patient experience and reduce waiting times;
- Provide sufficient capacity to meet existing demand and enable growth in external referrals, the existing MR scanner needs to run additional sessions just to meet the existing demand;
- Maximise operational efficiency and improve cost management.

1. Reduction in clinical risk improved operational resilience

There is no spare capacity on the MR scanner on the HH site. Therefore the ability to provide a timely MR diagnostic service is compromised by the frequent breakdown of the single MR scanner; data in July and August 2012 shows this scanner broke down five times and took up to four days to repair on each occasion.

Both Imaging Reviews (2009 and 2011) supported the need for improved resilience on the HH site in order to cope with the increasing demand and complexity of cardiac and renal referrals. Operating a single scanner means there is no back up and therefore no resilience. Both the other main hospital sites have three MR scanners.

In addition, both Gamma Cameras are beyond their expected working life and have broken down over twenty times in the last 12 months. The poor camera image quality presents a clinical risk as diagnostic opportunities may be missed. A nuclear medicine service can only run during office hours as it is dependent on the delivery and very short half-life of the isotopes used to generate the images.

2. Improve patient experience and reduce waiting times

The 2011 Review specifically identified the single MR machine at the HH site as the cause of the ongoing failure to deliver local waiting times targets and subsequent poor patient experience.

The average actual waiting times for outpatient MR by site demonstrate that HH is the outlier (Radiology Information System (RIS) data for the financial year 2012/13).

While ICHT has avoided any penalties to date it is important to note that there is a potential financial penalty of £500 per patient for breach of the diagnostics six week target.

Site	One month snap shot of average days wait (actual) - from referral to scan (OPD only) March 2013	ICHNT Target (working days)
CXH	18	10
HH	20	10
SMH	14	10

While recovery areas and imaging recovery are not specifically covered under EMSA at present other than under 'patient choice', it is likely that this will change in the near future and therefore the Trust EMSA strategy is to review compliance in all new builds. In this OBC we intend to 'future proof' the imaging department by ensuring we meet the requirements for undressed patients in that 'Undressed patients should not have to pass through or by the opposite gender'.

I-Track Patient 2012/13 survey data consistently supports the need to improve waiting facilities. Patients are specifically asked to rate the waiting facilities and the results have returned an average

score of 79% against a target of 90%. The design solution in this case addresses all imaging patient wait areas, not just those associated with MR and NM.

3. Provide sufficient capacity to meet existing demand and enable growth in external referrals
The existing MR scanner needs to run additional sessions just to meet the existing demand. Over the last three years MR referrals to the Trust have grown by 40%, and activity at HH site has more than doubled with 2834 scans in 09/10 compared with 5693 scans in 12/13 (RIS April 2013).

4. Maximise operational efficiency and improve cost management
By co-locating the two new MR scanners in close proximity a number of efficiencies can be realised. A shared control room maximises use of space and also reduces the staffing requirements. The replacement of the existing MR scanner will achieve efficiencies in scanning time with the development of improved technology. It is anticipated that a routine MR scan will be performed in 20-25% less time than our existing MR scanner. In addition the co-location of two scanners increases the flexibility of case management and therefore patient throughput, again further improving the overall MR performance.

From the staffing perspective the collocation of the MR scanners will improve the staff to equipment ratio from the existing 3:1 to 2.5:1. There will also be improved opportunities for teaching and training.

1.2.2 THE INVESTMENT COMMITTEE CRITERIA

This OBC scores 2B's, 1C, 1D and 1E. The commentary against the three key types of criteria of assessment is given below:

1. Patient benefit - These changes will have an impact on a minimum of 7,800 patients per year (In 2012/13 over 5,500 MR Scans and 2300 NM investigations were performed at HH). The design solution will also improve the waiting facilities for the whole department and as such impact on tens of thousands of patients

2. Reduction of Risk - The failure to provide a sustainable MR Service, which results in the loss of MR scanning facilities on the HH site when a single scanner is unavailable for either preventative maintenance or breakdown is listed as 'Reference IM59' on the CPG risk register with a rating of 9 HIGH (likelihood 3 x consequence 3). This is the top clinical safety risk and therefore priority for the CPG.

3. Financial Return – Nil.

Table 1.1: Investment criteria

	Score				
	E	**D**	**C**	**B**	**A**
Operational safety / Patient safety	not applicable / no significant risk "business as usual" procedures	Manageable within "business as usual" procedures	Significant risk to patient or operational safety or high number and level of incidents	Major infection control failure / multiple level 4 (major) or level 5 (catastrophic) incidents	Recent Serious Incident and / or imminent forced closure of a major clinical service

Clinical benefit (e.g. clinical outcomes /length of stay)	None	Marginal benefits	Significant benefit / hundreds of patients	Major clinical benefit / thousands of patients per year	Major clinical benefit / tens of thousands of patients per year
Statutory / regulatory compliance	not applicable / no significant risk "business as usual" procedures	Manageable within "business as usual" procedures	Improvement notice / legal proceedings in 2-3 years	Improvement notice / legal proceedings within a year	Improvement notice issued / successful prosecution likely
Patient Experience	None	Marginal benefits	Significant improvement / hundreds per year	Major improvement/ thousands of patients per year	Major improvement/ tens of thousands of patients / visitors / staff per year
Return on Investment (payback period)	More than 5 years	3 – 5 years	2 - 3 years	1 -2 years	Less than 1 year
Score /grade	**1E**	**1D**	**1C**	**2B**	**0A**

1.3 ECONOMIC CASE

1.3.1 SHORT LIST

The following short list of options emerged:

Table 1.1 Shortlist of options

OPTION		COMMENTS TO SUPPORT SHORT-LIST RESULT
No	**SUMMARY**	
2A	**DO MINIMUM** *with LEASED EQUIPMENT* Replace existing 1.5T MR and SPEC-CT in existing locations (x1 SPECT-CT replacing two gamma cameras)	Current state but replaces existing failing equipment. Lowest capital expenditure as leased equipment.
2B	**DO MINIMUM** *with PURCHASED EQUIPMENT* Replace existing 1.5T MR and SPEC-CT in existing locations (x1 SPECT-CT replacing two gamma cameras)	Current state but replaces existing failing equipment. Capital cost includes the purchase of scanners.
6C	**Floor plan design as 6A** *with LEASED EQUIPMENT* Two phased project – Phase 1 - Reconfigure existing vacant Endoscopy unit to create space for SPEC-CT with supporting rooms and a main reception area. Phase 2 – Reconfigure existing nuclear medicine space to create space for two 1.5T MRs and supporting rooms. Works also to upgrade and increase recovery bays. This work would be carried out over 3 financial years and require temporary decants. HH Nuclear medicine will have to relocate to SMH for duration of 12 – 16 weeks prior to phase 1	As 6A Work in 2 phases extends the delivery time of the full solution over 3 years and increases the total cost over option 6A. Provides the least clinical disruption/risk as NM department only closed for a short period

	works completing.	
6D	**PREFERRED OPTION** Floor plan design and phasing of works programme as 6C *with PURCHASED EQUIPMENT*	As 6C, with additional capital cost of the purchase of scanners.
7A	**Using existing Nuclear Med (NM) space, the existing corridor and reception and @ two-thirds of vacated Endoscopy space** *and LEASED EQUIPMENT.* Build 5-scanner room unit to include two 1.5T MR, one 3T MR, SPEC-CT and PET-CT, all supporting rooms, corridor reception and recovery bays. This option is a single phase project. Existing HH Nuclear medicine will have to relocate to SMH for SMH for some of the works.	This option was developed as the do maximum solution to include the full range of both MR & NM scanning. Unaffordable.
7B	**Floor Plan design as 7A** *with PURCHASED EQUIPMENT*	As above. This is the most expensive solution.

1.3.2 ECONOMIC APPRAISAL

The DH Generic Economic Model (GEM) was used to estimate the net present cost of each of the options. Costs were estimated in accordance with HN Treasury and DH guidance. The table below summarises the key assumptions used. An economic appraisal has been carried out by calculating the equivalent annual cost for each option and expressing this as a ratio to the economic benefits.

Table 1.2 Generic Economic Model assumptions

Years for economic appraisal	All options have been appraised over 15 years
Opening and Residual land values	The site is owned and this refurbishment, which is on the second floor of an existing building, has no impact on land values which have therefore been set to zero.
Capital expenditure	Capital costs of for all options are based on Quantity Surveyors estimates and include VAT and optimism bias
Optimism Bias	Optimism bias adjustments have been applied to Options 6, 7, 8 & 9, as the design is yet to move into Detailed Design and therefore not complete (at OBC sign off stage). Optimism bias of 9.75% has been applied to Options 2, 6, & 9 with an increased level of 22% to option 7 Planning Contingency has been applied to Options 6, 8 & 9. A Planning Contingency of 10% has been applied to Options 6 and 9 with a planning Contingency of 15% applied to option 7. A fully costed risk register has been produced for Option 6D.
VAT	VAT has been excluded from all capital and lifecycle costs
Revenue costs	Revenue costs for all options have been estimated either (in the case of staffing) from a bottom-up model for the staffing requirements of the new unit compared to the current staffing model or (in the case of non-pay costs) from the Trusts service line reporting data for HRGs.
Capital charges	Capital charges have been excluded from the net present value calculations.

Table 1.3: Summary of Capital spend (based on OB forms)

		£ Cost Inc. VAT				
	Capital Costs	**Option 9** *In addition to 6C,6D,7A, & 7B*	**Option 6C**	**Option 6D** *Preferred*	**Option 7A**	**Option 7B**
1	Departmental Costs	*NIL*	1,354,056	1,354,056	2,414,227	2,414,227
2	On Costs	*380,779*	1,352,089	1,279,738	1,800,000	1,800,000
3	Total Works Costs	*380,779*	**2,706,145**	**2,633,794**	**4,214,227**	**4,214,227**
4	Provisional location adjustment	*60,925*	432,983	421,408	674,276	674,276
5	Fees	*148,144*	769,314	632,184	397,571	397,571
6	Equipment Cost	*NIL*	77,194	3,327,362	6,339,600	6,3389,600
7	Planning Contingency	*44,170*	313,913	406,342	733,276	733,276
8	Optimism Bias	*64,162*	429,782	409,676	2,933,934	2,933,934
9	Inflation Adjustments	*16,858*	75,835	87,446	Not detailed	Not detailed
	Forecast Outline Business Case Total	***720,001***	**4,810,000**	**7,940,000**	**15,854,884**	**15,854,884**

1.3.3 OVERALL FINDINGS: QUALITY AND OTHER ECONOMIC BENEFITS

Evaluation of the non-financial benefits was carried out using the following weighting for each of the benefits criteria, the results are shown below.

Table 1.3 Non-Financial Criteria and weighting

Criterion	**Weighting %**
Quality of clinical care (effectiveness)	25
Privacy & Dignity	15
Capacity to deliver increased patient activity	15
Improve throughput (efficiency)	10
Research and teaching	10
Flexibility	5
Implementation	5
People, handling and management	5
Reduce cost (economy)	5
Strategic Fit	5
	100

Table 1.4 Non-Financial Criteria and weighting by option

Criterion	Option 2A	Option 2B	Option 6C	Option 6D	Option 7A	Option 7B
Quality of clinical care (effectiveness)	5	5	17	17	25	25
Privacy & Dignity	5	5	15	15	15	15
Capacity to deliver increased patient activity	5	5	12	12	15	15
Improve throughput (efficiency)	0	0	8	8	10	10
Research and teaching	0	0	8	8	10	10
Flexibility	0	0	3	3	5	5
Implementation	5	5	1	1	1	1
People, handling and management	0	0	4	4	5	5
Reduce cost (economy)	3	3	5	5	5	5
Strategic Fit	0	0	5	5	5	5
Total	**23**	**23**	**78**	**78**	**96**	**96**
Rank	**3**	**3**	**2**	**2**	**1**	**1**

1.3.4 OVERALL FINDINGS: ECONOMIC EVALUATION

Risk adjusted Equivalent Annual Cost (EAC). This assessment defines the highest ranking option as the option which has the lowest Risk Adjusted Net Present Cost per benefit point (or Risk Adjusted Equivalent Annual Cost per benefit point if the period over which each option is assessed is not the same).

The table below shows the cost per benefit point of the short-listed options and further supports the preferred option.

Table 1.3: Risk adjusted EAC

	Option 2A	Option 2B	Option 6C	Option 6D	Option 7A	Option 7B
EAC	0.9	0.7	0.9	0.8	1.7	1.7
Benefit Points	23	23	78	78	96	96
EAC per benefit point	0.039	0.030	0.012	0.010	0.018	0.018
Rank EAC per benefit point	**5**	**4**	**2**	**1**	**3**	**3**

1.3.5 OVERALL CONCLUSIONS

Table 1.3: Overall Findings

Evaluation Results	Option 2A	Option 2B	Option 6C	Option 6D	Option 7A	Option 7B
Economic appraisals	5	4	2	1	3	3
Benefits appraisal	3	3	2	2	1	1
Risk appraisal	4	5	1	1	2	3
Overall ranking	**5**	**5**	**2**	**1**	**3**	**4**

1.4 COMMERCIAL CASE

1.4.1 PROCUREMENT STRATEGY

This section of the OBC outlines the proposed deal in relation to the preferred option outlined in the economic case.

This is for the construction of a new MR & NM unit within the existing Imaging department and an area within the former Endoscopy department at HH. This proposal includes the installation of 2 new MR scanners and one SPECT-CT under a Traditional Intermediate Joint Contracts Tribunal (JCT) Contract.

The Trust, in looking to obtain best value for money through its contractual arrangements, is using the Traditional JCT procurement route as the best value procurement method. It is proposed that the preferred option would undergo a fully co-ordinated design process with design reviews at key gateway stages, before sign off by both the design team and the clinical group. This would then proceed to tender on a fully designed scheme along with Bills of Quantities leading to a contractor appointment under a traditional JCT 2011 contract.

The costs and programme in the business case are based upon proceeding with this procurement route; however, the Trust will continue to monitor the relative value for money of procurement route options to ensure that best value is achieved.

1.5 FINANCIAL CASE

1.5.1 FINANCIAL EXPENDITURE

There is no direct relationship between imaging demand and income to the Trust with the exception of direct access contracts which exclude the Inpatient work. The majority of users at the HH are not direct access patients and as such no income stream can be accurately identified. It has been assumed that there are no maintenance costs in the 1st year of purchase.

All options have a negative Net Present Value. The primary criteria for financial appraisal are cost, the option with the cheapest solution and life cycle cost achieves the highest evaluation.

1.5.4 OVERALL AFFORDABILITY AND BALANCE SHEET TREATMENT

Funding for this project will be through internal resources, accommodated within existing plans and therefore there would be no impact on current financial plans or the Trust's balance sheet.

1.6 MANAGEMENT CASE

1.6.1 PROJECT MANAGEMENT ARRANGEMENTS

The implementation of the project will be managed overall by Rona Buxton, clinical service manager for the Imaging Unit at HH. Please see Appendix H for the master programme indicating the key dates for the development of the scheme including approval schedules. Key dates in the programme are:

Table 1.6 key programme dates –

Milestone	Date
Internal OBC Approval Process – [ICHT Investment Committee/Trust Board]	Feb 2013/ April 2013
NHS Trust Development Authority London Approval process	July 2013
FBC Approval Process -Trust	Feb 2014
NHS Trust Development Authority London Approval process	May 2014
Start on Site	June 2014
Completion	July 2015
Commissioning	September 2015
Occupation	September 2015

To date the design team appointment has been for work stage 0 of the project as set out in the 'Agreement for the appointment of architects, surveyors and engineers for commissions in the NHS (1995 Edition)'

The Trust proposes to procure the works using Traditional Procurement. It is proposed that the preferred option would undergo a fully co-ordinated design process with design reviews at key gateway stages, before sign off by both the design team and the clinical group. This would then proceed to tender on a fully designed scheme along with Bills of Quantities leading to a contractor appointment under a traditional JCT 2011 contract.

Internal monthly reviews will be held with the Design Team, Trust PD and PM, Client Cost advisor and Trust finance to ensure control of the budget is maintained.

Building Control – Local Authority Building Control Approvals will be sought.

The Design to date has been worked up in accordance with HTMs, HBN's and EMSA.

1.6.2 BENEFITS REALISATION

A review of the risks will take place at fortnightly implementation team meetings, led by the clinical service manager for the Imaging Unit at HH, during implementation and mitigations and actions will be agreed at each meeting.

Evaluation of the achievement of benefits set out in this business case will take part on a monthly basis by the Directorate Executive Group (DEG) and will be summarised for the CPG Board on a quarterly basis.

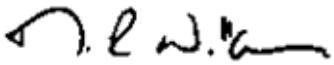
1.6.3 POST PROJECT EVALUATION ARRANGEMENTS

In line with Trust Post Project Evaluation (PPE) policy a review to assess project progress will take place six months post Investment Committee approval of OBC with a further review of benefits realisation at six months post project completion.

1.7 RECOMMENDATION

The Project Board makes the recommendation for approval to proceed with the design phase to develop the FBC with the £780K 2013/14 capital plan allocation. The total capital spend of £8.6 million over three years is to construct a new Magnetic Resonance (MR) & Nuclear Medicine (NM) unit within the existing Imaging department and an area within the former Endoscopy department at HH. This proposal includes the replacement of the single MR with the purchase of two new MR scanners and the existing two Gamma Cameras with one SPECT-CT. This OBC also improves the waiting facilities for the whole imaging department.

This new unit will create a sustainable MR and nuclear medicine service at HH and improve clinical quality and patient experience while maximising operational efficiency.



Signed:

Name: Martin Wilkins (Senior Responsible Officer)

Date: 18/04/13

Imperial College Healthcare NHS
NHS Trust

Board: **29 May 2013** **Agenda number: 6.3**

Report Title: Report from the Finance Committee

To be presented by: Bill Shields, Chief Financial Officer

Executive Summary:

The key agenda items discussed at the Finance Committee of 13th March 2013

- Future structure of the committee and standing agenda items
  - Committee to be a Finance and Investment Committee – proposal required on delegated limits with regards to investments
  - Financial reporting and LTFM now to be added as standing items
  - Meeting to be moved to bi-monthly from quarterly
- Strategic Outline Case for SaHF – timeline for review of SOC agreed
- FT trajectory – detail shared as per agreement with TDA
- Financial Planning Guidance – details shared on the framework for the planning cycle within the Trust
- Financial Compliance Framework – discussion on the KPIs that will be measured within 2013/14 for the CPGs
- Draft financial plan – assumptions agreed that will form the plan to the TDA, with agreement the plan is to be signed off by the Board at the end of March
- Current financial performance – update on the financial position of the CPGs
- Cash framework review – discussion on updating the way in which cash and working capital is reported within the Trust
- Financial risks – key risks discussed with a focus on those that had moved

Action required:

The actions required from the Committee Meeting

- Formation of a Finance and Investment Committee with updated terms of reference and delegated limits to be agreed
  - Updated SFIs and SoD to be approved by the Audit Committee
- Review of the key financial risks