TRUST PUBLIC BOARD AGENDA
30 July 2014
10am – 12.30pm
Oak Suite,
W12 Conference Centre, Hammersmith Hospital,
London W12 0HS

Agenda Number		Presenter	Timing	Paper Number
1	**Administrative Matters**			
1.1	Chairman's Opening Remarks	Chairman	10.00	Oral
1.2	Apologies	Chairman		Oral
1.3	Board Member's Declarations of Interests	Chairman		Oral
1.4	Minutes of the meeting held on 28 May 2014	Chairman		1
1.5	Matters Arising and Action Log	Chairman		2
2	**Operational Items**			
2.1	Patient Story		10.05	Oral
2.2	Chief Executive's Report	Chief Executive	10.15	3
2.3	Operational Report	Chief Operating Officer	10.25	4
2.4	Integrated Performance Scorecard	Chief Operating Officer	10.35	5
2.5	Finance Report	Chief Financial Officer	10.40	6
3	**Items for Decision**			
3.1	Revised Vision & Strategic Objectives	Chief Executive	10.50	7
3.2	Unlocking our potential to transform Health and Care, Clinical Strategy 2014-2019	Director of Strategy	11.00	8 Presentation
3.3	NHS Trust Development Authority Self-Certifications • Compliance April • Board Statement April • Compliance May • Board Statement May	Chief Financial Officer	11.10	9
3.4	2014/15 Workforce Plan	Director People and Organisation Development	11.15	10
3.5	Hotel Services Tender	Director of Strategy	11.20	11
4	**Items for Discussion**			
4.1	Update on progress towards the safe closure of the Emergency Unit at Hammersmith Hospital	Chief Operating Officer	11.25	12 Presentation

4.2	Monitor's NHS Foundation Trust Code of Governance Assessment	Director of Governance & Assurance	11.40	13
4.3	CQC Chief Inspector of Hospitals' Assessment September 2014	Director of Nursing	11.45	14
4.4	Responsible Officer's Annual Report	Associate Medical Director	11.55	15
4.5	Monthly report on safe Nurse/Midwife staffing levels at Imperial College Healthcare NHS Trust	Director of Nursing	12.00	16
4.6	Update on Progress with the Implementation of Cerner	Chief Operating Officer	12.05	17
4.7	Annual Programme of Work	Director of Governance & Assurance	12.10	18
5	**Board Committee Items**			
5.1	Quality Committee To note the report of the meeting of 11 June 2014	Prof Sir Anthony Newman Taylor	12.15	19
	To receive the minutes of the meeting of 13 May 2014			20
	To receive the minutes of the meeting of 11 June 2014			21
5.2	Audit, Risk & Governance Committee To note the report of the meeting of 18 June 2014	Sir Gerald Acher		22
	To receive the minutes of the meeting of 28 May 2014			23
5.3	Finance & Investment Committee To note the oral report of the meeting of 24 July 2014	Sarika Patel		Oral
	To receive the minutes of the meeting of 22 May 2014			24
5.4	Foundation Trust Programme Board To note the report of the meeting of 17 June 2014	Dr Rodney Eastwood		25
	To receive the minutes of the meeting of 29 April 2014			26
5.5	Remuneration and Appointments Committee To note the report of the meeting of 25 June 2014	Jeremy Isaacs		27
6	**Items for Information**			
7	**Any other Business**			
			12.20	
8	**Questions for the Public relating to Agenda items**			
9	**Date of Next Meeting**			
	24 September, 10am – 12.30pm, Oak Suite, W12 Conference Centre, Hammersmith			

	Hospital
10	**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 1960

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

10.00am – 12.30pm
Wednesday 28 May 2014
Oak Suite, W12 Conference Centre
Hammersmith Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerald Acher	Non-Executive Director
Dr Rodney Eastwood	Non-Executive Director
Jeremy Isaacs	Non-Executive Director
Sarika Patel	Non-Executive Director
Andreas Raffel	Non-Executive Director Designate
Dr Tracey Batten	Chief Executive Officer
Prof Chris Harrison	Medical Director
Steve McManus	Chief Operating Officer
Bill Shields	Chief Financial Officer
Prof Janice Sigsworth	Director of Nursing
In attendance:	
Ian Garlington	Director of Strategy
Kevin Jarrold	Chief Information Officer
Prof Dermot Kelleher	Principal of the Faculty of Medicine of Imperial College
Cheryl Plumridge	Director of Governance and Assurance
Peter Lightbown	Interim Deputy Board Secretary (Minutes)
JE	Service User – agenda item 2.1 only

1	**General Business**
1.1	**Chairman's Opening Remarks** The Chairman welcomed Board members, staff and members of the public to the meeting.
1.2	**Apologies for Absence** Apologies had been received from Sir Thomas Legg, Sir Anthony Newman Taylor, Michelle Dixon and Jayne Mee.
1.3	**Board Members' Declarations of Interest and Conflicts of Interest** There were no additional conflicts of interests declared at the meeting other than the standing declarations.

1.4	**Minutes of the Meeting held on 26 March 2014** The minutes of the meeting held on 26 March 2014 were agreed as a true record.
1.5	**Matters Arising and Action Log** The Board noted the updates to the action log.
2	**Operational Items**
2.1.1	**Patient Story** JE provided a report to the committee on her recent experience as a patient at Hammersmith Hospital. She had been suffering severe pain and had therefore called an ambulance, receiving excellent care from the paramedics. She had arrived at Hammersmith Hospital during staff changeover period at the Emergency Unit and then spent time waiting in a hospital cubicle prior to her consultation.
2.1.2	The consultation was well managed although there was a sense that her views as the patient were not taken into account as much as should have been the case, for example, in terms of the strength of painkiller she required. Two days later she had to return to the Emergency Unit and was kept in overnight on a well-staffed ward and where she witnessed some excellent examples of good practice including an elderly patient on their own but being cared for exceptionally well by staff, and contractor staff, in particular a porter, who went out of their way to be very helpful. The quality and choice of food on the ward was also very good.
2.1.3	Sir Richard Sykes asked whether JE would recommend Hammersmith Hospital to family and friends. JE said she would.
2.1.4	JE's husband commented that it would be useful to have data measuring the number of patients who had to return to the Emergency Unit after initial treatment. All staff had been very helpful but the five-hour wait for drugs to be delivered to the ward before his wife could be discharged was less than satisfactory. He suggested that, where feasible, the patient or carer could pick up the drugs subsequently or delivery could be provided by porters. JE added that during the delay in obtaining drugs prior to discharge her hospital bed remained unavailable to new admittances.
2.1.5	Prof Chris Harrison stated that JE's experiences reinforced the need to provide a consultant led service able to provide innovative solutions for patients and be decisive regarding patient treatment options. Steve McManus thanked JE for her description of treatment received and agreed that processes regarding pharmacy operations needed further consideration particularly in light of holidays, out of hours requirements, and the logistics of drug delivery.
2.2	**Chief Executive's Report**
2.2.1	Dr Tracey Batten introduced her report in a revised format. Of note was how keen staff were to be engaged in discussions about how best to deliver an excellent service. Dr Batten highlighted key areas of her report including key priorities and issues on the horizon.
2.2.2	Sir Richard Sykes asked for an update on the current position of Project Diamond and Bill Shields explained it could not be assumed that on-going funding would continue to be provided.
2.3	**Operational Report**
2.3.1	Steve McManus introduced the report in the new format linking to the performance scorecard and outlined key operational headlines for April 2014. The new process shadowed Monitor performance standards.
2.3.2	Andreas Raffel requested information on current theatre utilisation. Steve McManus said he was concerned about both efficiency and utilisation and this was an area targeted for improvement.
2.3.3	Sir Gerald Acher asked about delays in dispensing drugs. Steve McManus stated that processes had been changed as part of the partnership with Lloyds which resulted in improved turnaround times for getting drugs to wards and for discharge

	but other areas needed improvement which included logistics, portering services and facilities management and which should impact favourably on pharmacy performance.
2.3.4	Sir Richard Sykes asked why more complex services e.g. medical tests were completed more quickly than dispensing drugs. Steve McManus replied this was an area that needed improvement and Prof Janice Sigsworth said that the new Cerner system would assist in improving performance. **Action** - Sir Gerald Acher suggested that pharmacy performance be considered at a future meeting of the Audit, Risk and Governance Committee.
2.3.5	Steve McManus provided details on HR issues including vacancy rates, sickness absence and bank and agency spending. Sarika Patel commented on the significant overspend on bank and agency staff and that this required attention. Dr Tracey Batten advised that there was a detailed review underway the outcome of which would be reflected in future performance reports. Sir Richard Sykes asked whether there were any particular areas of the Trust where staff turnover was high: stable staffing helped provide better services. Prof Janice Sigsworth said turnover tended to be from staff who had been in the Trust a year or more but actions to improve retention were being developed.
2.3.6	Sarika Patel requested information on a recent MRSA case and Steve McManus and Prof Chris Harrison provided details on how these incidents were managed and lessons learned. Sir Richard Sykes highlighted that there had been a significant improvement in the reduction of infection rates at the Trust. Andreas Raffel added that it was vital that statutory and mandatory training rates remained high and Steve McManus confirmed that this was closely monitored.
2.4	**Integrated Performance Scorecard**
2.4.1	Steve McManus introduced the report which provided key headlines on performance indicators from Monitor, CQC and TDA frameworks as well as a number of contractual indicators and some internal KPI's, and provided a brief update on a range of indicators.
2.5	**Finance Report**
2.5.1	Bill Shields introduced the report. There were disappointing results for April '14 especially in relation to Cost Improvement Programmes (CIPs) being behind plan. Cerner implementation expenditure was higher than expected and higher temporary staff pay costs continued due to on-going use of additional winter pressure beds.
2.5.2	Looking forward it was important to have better control on bank and agency costs via improved processes without which there would be a significant impact on the forecasted surplus for 2014/15. He added that actions were already underway including regular CIP reviews and meetings scheduled with directors to monitor expenditure. Sir Richard Sykes asked whether the current Trust vacancy rate reduced the impact of the overspend but Bill Shields stated that more robust processes were needed to understand the relationship between vacancies and the requirement for agency and bank.
2.5.3	Jeremy Isaacs stressed the importance of accountability for use of bank and agency and asked whether this process was better managed centrally. Bill Shields stated that there was a significant number of agency and bank staff requests per month and hence central control would be difficult. Dr Tracey Batten said it was important accurately to identify establishment numbers, and control bank and agency costs. By the time of the next Board meeting there should be transparency of the processes in place to achieve this.
3	**Items for Decision**
3.1	**Revised Vision & Strategic Objectives**
3.1.1	Dr Tracey Batten updated the Board on the revision of the Trust's vision and strategic objectives to bring greater clarity and simplification and to provide a clear

	strategic context for the clinical strategy. Feedback from staff had been good and she was keen to be able to hear more comments and bring a final version back to the Board in July for consideration.
3.1.2	Sir Jerry Acher congratulated Dr Tracey Batten on the revisions and asked her to ensure feedback be provided to staff on the changes that had been made. Dr Tracey Batten confirmed that this would be communicated via staff forums and in next month's newsletter. Andreas Raffel said it was important to add in the Trust's defining services. Dr Tracey Batten agreed but said discussion was still underway about how best to do this especially as the defining services continued to evolve. **Action** – Dr Tracey Batten to submit revised Vision & Strategic Objectives to the July 2014 Board meeting
3.2	**Closure of the Emergency Unit at Hammersmith Hospital**
3.2.1	Steve McManus provided an update to the Board on the scheduled closure of the Emergency Unit at Hammersmith Hospital on 10 September 2014. Formal consultation with staff needed to begin and a further report would be made to the Board in July. Prof Chris Harrison emphasised that the changes were designed to provide better and a higher quality service and to remove problems of consistency in cover.
3.2.2	Sir Richard Sykes asked whether clinicians were content with the proposed timetable and Prof Chris Harrison said they were and risks were being mitigated as part of the on-going planning. Jeremy Isaacs asked how the changes would affect a typical patient and Steve McManus explained the process by which London Ambulance Service triage prior to a patient being taken to the most suitable facility, either acute medical (Emergency Unit at Hammersmith Hospital) or the full A&E service at St Mary's. Andreas Raffel said that it was important to highlight the advantages of this change to the community and Jeremy Isaacs enquired about economic consequences. Steve McManus stated that this was cost neutral with transition costs to be picked up by the Shaping a Healthier Future project.
3.2.3	Sir Gerald Acher asked for assurance on transitional planning and that risks were being mitigated. Dr Rodney Eastwood asked for details of 'up-skilling' referred to in the document and Prof Chris Harrison provided details including the specific training needs that would be identified for GP's as a vital part of this redesigned service. The Board **approved** the programme of work to close the Emergency Unit at Hammersmith Hospital and expand and enhance the UCC, with a planned date for the transition to take effect of 10th September 2014. The Board **approved the** start of a formal consultation with the staff directly affected by the planned closure on 29th May 2014. The Board **approved** the request to note a further report with an update on progress and assurance would be provided for its meeting in July.
3.2.4	**Action** – Mr Steve McManus to provide an update report on any financial impact of these changes at the next meeting of the Finance and Investment Committee on 24 July 2014 **Action** – Mr Steve McManus to provide a more detailed implementation plan to the Board's July meeting.
3.3	**Safe Nurse / Midwife Staffing Levels**
3.3.1	Prof Janice Sigsworth provided an update to the Board explaining the report was in two parts: the Trust's progress in meeting National Quality Boards expectations and a summary of nursing and midwifery establishments for all inpatient ward areas. The Board **approved** the following recommendations: • To sign off all inpatient NHS funded ward establishments • The shortfall of 10.10 WTE to be included in 2014/15 business planning

	• That the posts will be funded for 2014/15 • That the actual staff available versus planned staffing levels would be brought to the public board meeting in July.
3.4	**NHS Trust Development Authority Self-Certifications**
3.4.1	The Trust Board **approved** the following Self-certifications: • February 2014 Compliance • February 2014 Board Statement • March 2014 Compliance • March 2014 Board Statement
3.5	**Draft Quality Accounts 2013 – 14**
3.5.1	Prof Chris Harrison updated the Board saying the draft accounts were currently with stakeholders for comment and delegated authority was required for the Chairman and Chief Executive to sign these off once comments had been received and incorporated. The Board **noted** this document in preparation for publication at the end of June 2014 and **approved** delegated authority to the Chief Executive and Chairman for final sign off prior to publishing.
4	**Items for Discussion**
4.1	**Update on Clinical Strategy and Outline Business Case for Clinical and Estate Transformation** Ian Garlington introduced the paper noting the issue would be brought back to the Board's July meeting. In answer to Sir Richard's Sykes, Dr Tracey Batten said she was confident the July Board would see a better clinical strategy based on consultation with staff and a site strategy that benefitted from a fully worked up clinical strategy. **Action** –Ian Garlington to provide a finalised clinical strategy and outline business case to the Board's July 2014 meeting.
4.2	**Annual Summary of the Trust's quality impact assessment process for cost improvement programmes (2013/14)** Introducing the paper, Prof Chris Harrison said he and the Director of Nursing had requested divisions and corporate areas to undertake a formal post-implementation review of the 2013/14 schemes, using a range of KPI's and to present the findings at a future executive committee meeting.
4.3	**Annual Report on implementing the recommendations from the Francis Inquiry (2013)** Prof Janice Sigsworth presented the annual report to the Board. Good progress was being made in meeting the recommendations set out by the Francis Inquiry (2013) with 44 of the 50 actions identified completed. Responding to a question from Sir Richard Sykes, Prof Janice Sigsworth confirmed there were no outstanding significant issues and the timetable for completion of all outstanding actions was on track.
4.4	**2013 National Inpatient Survey Results** Prof Janice Sigsworth introduced the report. In discussion, Sir Richard Sykes said it was important to see patients as individuals and Prof Sigsworth said it was often the peripheral issues that made a difference such as assistance with practical issues and acts of kindness.
4.4.1	Sir Gerald Acher encouraged the Trust to actively identify areas for improvement that would have a positive impact on these measures in order to create improvements as soon as possible. Dr Rodney Eastwood asked whether the survey could be undertaken at an alternative time of year from August when staff could be on leave and might not represent the vast majority of inpatient experiences. Prof Sigsworth confirmed that external guidance required the survey to be undertaken in July or August each year.
4.5	**AHSC Update Review 2013 – 14**

	Prof Dermot Kelleher introduced the paper and highlighted the challenges for the next five years.
4.6	**Final report of the Foundation Trust Consultation** Bill Shields updated the Board. A summary of the results of the consultation and the Trust's response and a full outcome report on the consultation providing more information on the process, what people said and how the Trust responded had been published and circulated.
4.6.1	Dr Andreas Raffel asked whether the Trust was near to meeting its target membership of three and a half thousand by June 2014 and Mr Shields confirmed that this work remained on-going. Ms Cheryl Plumridge added that a recruitment drive at all Trust sites and civic sites and targeted at the need to reflect area demographics had just concluded. Another recruitment event was scheduled for the end of June 2014.
4.7	**Complaint Report**
4.7.1	Cheryl Plumridge introduced the paper. There had been an overall increase in complaints of 2.7% compared to last year but, more specifically, the number of formal complaints investigated had increased each quarter throughout 2013/14 and by 5.6% over the year whilst the number of informal complaints resolved by PALS had reduced by 19.4%. These figures demonstrated the trend in increased complaints overall with a tendency to more complex complaints. She added that Prof Janice Sigsworth would henceforward be assuming responsibility for managing Trust complaints and Dr Rodney Eastwood had agreed to be the Non-Executive Director lead.
5	**Board Committee Items**
5.1	**Quality Committee** **The Board noted the report of the meeting of 13 May 2014** **The Board received the minutes of the meeting of 6 March 2014**
5.1.1	Sir Gerald Acher provided an update report of the Quality Committee held on 13 May 2014 on behalf of Sir Anthony Newman Taylor saying that more work was required to bring clinical risk management in line with other areas of risk within the Trust. Sir Richard Sykes asked for assurance that identified risks were being mitigated: Sir Gerald Acher confirmed. Dr Tracey Batten said that more work on risk was required and this would be undertaken over the next few months. The report was **noted** by the Board.
5.2	**Audit, Risk & Governance Committee** **The Board noted the report of the meeting of 22 April 2014** **The Board received the minutes of the meeting of 12 March 2014**
5.2.1	Sir Gerald Acher presented the update report of the Audit, Risk and Governance Committee held 22 April 2014. He added that a key issue raised at the committee was the higher than expected bad debt provision within Trust accounts. This had been reviewed and agreed by auditors. Sir Gerald Acher also requested confirmation that the Audit, Risk and Governance Committee had delegated authority to sign off Trust accounts. The report was **noted** by the Board and The Board **approved** for the Audit, Risk & Governance Committee to have delegated authority to sign off the Trust accounts.
5.3	**Finance & Investment Committee** **The Board noted the oral report of the meeting of 22 May 2014** **The Board received the minutes of the 20 March 2014**
5.3.1	Ms Sarika Patel provided an update report to the Board highlighting an excellent set of results for 13/14 including Private Patient income increasing significantly. There was a significant shortfall in meeting CIP targets in the first month of 14/15. Further details were provided in relation to recent contractual agreements and issues related to the Long-Term Financial Model and Estates maintenance

	backlog costs. The report was **noted** by the Board.
5.4	**Foundation Trust Programme Board** **The Board noted the report of the meeting of 29 April 2014** **The Board received the minutes of the meeting of 18 March 2014**
5.4.1	Dr Rodney Eastwood provided an update to the Board and noted it was vital that an independently assessed quality score of less than 4 was attained in order to meet the needs of the Monitor application. Dr Tracey Batten stated that in conjunction with Prof Chris Harrison and Prof Janice Sigsworth she would undertake an informal internal assessment and scoring exercise in the next few days. At the appropriate time Grant Thornton would be invited back to provide an independent external assessments to establish a potential quality score. The report was **noted** by the Board.
6	**Items for Information** There were no items.
7	**Any other Business** No other business was submitted
8	**Questions from the Public relating to Agenda Items**
8.1	A number of questions were asked by members of the public in relation to the proposed closure of Hammersmith Hospital Emergency Unit. These included: • Whether this project was financially driven; • Care in the community – exactly how this would work; and • Whether the public were being informed of proposed changes to services at Charing Cross Hospital. Sir Richard Sykes said that there had been considerable consultation in relation to this project as part of Shaping a Healthier Future. Opportunities for consultation were advertised in the local media and as part of the recent foundation trust consultation sessions.
9	**Date and time of next meeting** Wednesday 30 July 2014, 10am - 12.30pm, W12 Conference Centre, Hammersmith Hospital, London W12 0HS.
10	**Exclusion of the Press and the Public** The Board resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act 1960

Imperial College Healthcare NHS
NHS Trust

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
28 May 2014

Minute Number	Action	Responsible	Completion Date	July 2014 Update
2.3.4	The performance of pharmacy scripts specifically during out of hours to be considered at an Audit, Risk & Governance meeting.	Chief Operating Officer		**Completed.** On Audit, Risk & Governance Committee Forward Plan.
3.1.2	Revised Vision & Strategic Objectives to be submitted to the July 2014 Board meeting.	Chief Executive Officer		**Completed.** Agenda item.
3.2.5	Closure of the Emergency Unit at Hammersmith Hospital An update report on any financial impact of the changes to be reported to the Finance & Investment Committee.	Chief Executive		**Completed.** On Finance & Investment Committee forward plan for 24 July 2014 meeting.
3.2.5	Closure of the Emergency Unit at Hammersmith Hospital An update report to be reported to the Audit, Risk & Governance Committee	Chief Operating Officer		**Completed.** On Audit, Risk & Governance Committee forward plan 10 Sept 2014.
4.1	Clinical Strategy and Outline Business Case for Clinical and Estate Transformation. A finalised report to be presented to the 30 July 2014 meeting of the Board.	Director of Strategy		**Completed.** Agenda Item
4.2	Annual Summary of the Trust's quality impact assessment process for cost improvement programmes (2013/14) Post-implementation reports to be submitted to the Trust Board for review.	Medical Director		**Completed.** On Forward plan for 24 Sept 2014 Trust Board.

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	2.2
Title	Chief Executive's Report
Report for	Noting
Report Author	Dr Tracey Batten, Chief Executive
Responsible Executive Director	Dr Tracey Batten, Chief Executive
Freedom of Information Status	Report can be made public

Executive Summary:

This report outlines the key strategic priorities for Imperial College Healthcare NHS Trust (Trust) and provides an environmental scan of the opportunities and threats facing the Trust.

Recommendation(s) to the Board/Committee:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Key Strategic Priorities

1. **Clinical Strategy/Outline Business Case (OBC)**

Over the last two months, there has been significant work undertaken to engage our staff across all our sites and services in the finalisation of our clinical strategy. Overall, more than 2,500 staff have been directly engaged in providing feedback on the draft clinical strategy and giving guidance on the critically important clinical adjacencies of our services. This has greatly improved the robustness of the strategy and the staff understanding of our strategic direction. We have also incorporated staff feedback in the revised vision statement and the four strategic objectives.

We have engaged with our key external stakeholders and have co-produced the resultant outline business case for our site redevelopments with the clinical commissioning groups and NHS England.

The vision statement, strategic objectives, clinical strategy and outline business case are presented to the Board this month for consideration and approval and are the subject of separate papers.

Following approval, work will commence on the Clinical Transformation Programme that will be required over the next few years to effect the changes in the models of care required to implement our clinical and sites strategy.

2. **Chief Inspector of Hospitals Visit**

As Directors are aware, the next major milestone in our progress towards Foundation Trust status is the Chief Inspector of Hospitals visit scheduled for the first week in September 2014. A detailed action plan has been developed which includes a communication plan to engage our staff and leadership walkarounds across all our sites. A planning meeting has been held with our Lead Inspector, Tim Cooper, and the detailed data request has been received and is currently being collated.

We are undertaking our own Desktop Review to develop an internal assessment of our performance across the eight pathways by site and by the five domains (safe, effective, caring, responsive and well-led). This review will highlight areas of outstanding performance and areas where there are opportunities identified for further improvement. The review will be considered in detail at both the Executive and Board Quality Committee meetings.

At this stage, we have been advised that one on one interviews will be held during the week of the visit with the Chairman, Chair Board Quality Committee, CEO, Medical Director, Nursing Director, COO and Director People & OD.

3. **Cerner Implementation**

The Cerner Patient Administration System (PAS) went live across the Trust over the Easter break. Overall, the cut-over to the new system was successful and demonstrated an enormous team effort by our staff. However, post implementation, a number of anticipated issues have continued to challenge the stabilisation process. The two key issues relate to

data quality and outpatient clinics.

The data quality issues stem from the more complex workflows for staff to enter patient activity into the new system. This has resulted in apparent under-recording of patient activity which is having a consequent impact on our revenue for the quarter. This is not an unusual problem to experience post implementation of a new PAS and our commissioners have agreed to extend our data freeze dates to enable us to retrospectively correct the data entry issues to appropriately record our activity and therefore earn the appropriate revenue for the quarter.

The second issue relates to outpatients and, in particular, the availability of medical records in the outpatient clinics. This has been a cause of significant frustration for our staff and patients and relates to the functionality in Cerner for tracking paper records. A programme of work has been put in place to improve the quality of the pulling lists for clinics and to improve the skills of staff to track health records within the system. This will be critically important for our CIH visit.

The focus now is to transition back to a steady state business as usual operation for our PAS to enable the next stages of rollout of Cerner to commence. These include clinical documentation, medications management, the ED module and the theatre module.

4. **Financial Sustainability**

At the end of the first quarter for 2014/15, the Trust is reporting a deficit of £2.5m which is an adverse variance to plan of £3.7m. The main reasons for the adverse variance relate to cost improvement plans (CIPS) being behind target, expenditure on Cerner implementation being greater than expected and bank and agency staff costs being higher than plan. In addition, there is some risk to revenue recognition given the data quality issues related to Cerner discussed above.

Given the financial performance, a number of additional controls have been implemented for the approval of bank and agency expenditure, discretionary expenditure and approval of new appointments. In addition, considerable work is underway to focus on the delivery of CIPS and to validate data to improve the recording of activity. The financial performance will be discussed in detail at the Board Finance & Investment Committee. It is anticipated that the actions outlined above will stabilise the financial performance in the next period.

5. **Hammersmith A&E Closure**

The Trust remains on track to close the Hammersmith A&E department on 10 September 2014, as approved by the Board at the May Board meeting. A detailed implementation plan is in place which includes changes to the clinical pathways at the Hammersmith Hospital and capacity enhancements at St Mary's and Charing Cross Hospitals. These changes have been tested and assured by the relevant clinicians to support a safe closure. In addition, the Urgent Care Centre at Hammersmith Hospital has extended its hours of operation to 24/7. A detailed paper on the preparedness for the changes at Hammersmith A&E is included in the Board agenda.

6. **Executive Development Day**

An Executive Development Day will be held on 23 July 2014. The day will be facilitated by David Cumberbatch who commenced work with the executive team in early 2013 to focus on senior team effectiveness and performance. David's approach is focused on alignment of the team around a clear purpose and expected behaviours. The three key topics for discussion will include:

- The annual operating plan – to discuss and agree the key projects for the year
- The corporate risk register – a workshop with the divisional directors to discuss and agree the key strategic risks
- Corporate service adjacencies – to discuss the organisation of our corporate service to support and align to the clinical strategy

A verbal update will be provided at the Board meeting.

7. **Staff Engagement Survey**

The third staff engagement survey ran over 3 weeks in May. The response rate increased from previous surveys to 31% but the overall engagement scores showed a decrease from 39% to 37%. There was no change in the lowest scoring questions which remained:

- The senior managers here empower and inspire me to deliver exceptional performance (24%);
- In general, my job is good for my health (25%);
- My organisation takes positive action on health and wellbeing (28%); and
- At work, my opinions seem to count (35%).

The survey now includes the mandatory Friends and Family Test questions which show:

- 78% of staff are likely or extremely likely to recommend the Trust as a place for care or treatment; and
- 57% of staff are likely or extremely likely to recommend the Trust as a place to work.

The results have been disseminated and action plans updated based on the latest results. The timing of the third survey in relation to the implementation of Cerner may have had an impact on the results.

The fourth staff engagement survey is due to roll out shortly. Given this follows the significant level of staff engagement in the development of the clinical strategy, it is hoped that this may increase the overall engagement scores.

8.**OSC&Rs**

The fifth annual OSC&Rs awards were held on Wednesday 16th July 2014 in the Grand Connaught Rooms with the support of generous sponsorship from the Imperial College Healthcare Charity and DSL. The OSC&Rs recognise staff for their outstanding service, care and research efforts. This year, there were over 300 nominations from colleagues, patients and families. Twenty finalists were selected with one winner in each of the categories of our values respect, innovation, care, achievement and pride. The evening was a great success thanks to the excellent efforts of the Communications Team.

9. **Stakeholder Engagement**

We have continued to engage a range of external stakeholders on the development of our clinical strategy and other key issues, such as the closure of Hammersmith A&E. This includes meetings with Karen Buck MP, Mark Field MP, Andy Slaughter MP, Westminster's Councillor Robathan and Councillor Harvey, Kensington and Chelsea's Councillor Weale, Hammersmith and Fulham's Councillor Cowan, Councillor Lukey and Councillor Carlebach, and Ealing's Councillor Byrne. We also met with the tri-borough Healthwatch. In addition, Karen Buck MP and Mark Field MP visited St Mary's A&E to be briefed on preparedness following the planned closure of Hammersmith A&E. The Trust were invited to attend the first meeting of the new H&F Council's meeting of the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee where we presented our readiness plans for the closure of Hammersmith A&E and an overview of our clinical strategy.

10. **St Mary's Hospital Major Trauma Centre (MTC)**

I am delighted to advise that the most recent publication of the MTC's peer review scores at the National Peer Review Conference identified St Mary's as the highest performing MTC in England. In terms of outcomes, the St Mary's MTC is performing more than 3 standard deviations from the national mean survival scores. Our MTC has a Ws score of 2.4, which means that there are more than two additional survivors for every 100 patients treated.

This is an excellent outcome for the service and a real credit to the team that has worked extremely hard since the unit opened in 2010 and now sees 2,500 trauma cases per annum.

A quote from the Peer Review states: "Overall the North West London Trauma Network is an outstanding model which needs to be much-admired. There are fantastic examples of innovations and drivers to move this highly-performing MTC and Network even further forward. There is a sense of attention to detail and of sensible pragmatic solutions to logistical problems. These features, together with strong clinical leadership and very supportive management, demonstrate a system that is evolving well and showing very good outcomes."

11. **Academic Health Sciences Centre (AHSC)**

Professor David Taube steps down as Academic Health Science Centre (AHSC) Director on 31st August 2014. Professor Jonathan Weber has agreed to take on the role of interim AHSC Director for a period of 12 months, as agreed at the recent AHSC Joint Executive Group (JEG) held on 17th July 2014. This appointment will be critical in implementing outcomes arising from the forthcoming external BRC mid-term review taking place in Autumn 2014 and allow us to bring the Biomedical Research Centre into the centre of the AHSC. The NIHR Imperial BRC is entering its third year of the current award (2012-17, £112M). As part of the feedback accompanying the NIHR award, there is an expectation that the AHSC uses BRC funds dynamically, influencing and responding to both an evolving AHSC research portfolio and changing external research landscape. As the AHSC will respond to a NIHR call for BRCs in 2016, FY2014/15 is critical in terms of ensuring delivery of current award objectives and shaping the future direction.

The review committee will be drawn from a range of clinical and non-clinical experts external to Imperial AHSC, including representation from industry, the Trust (Dr Tracey Batten) and will be chaired by Prof Dermot Kelleher. The draft report will be presented to the AHSC Research Committee for discussion and response prior to consideration by the AHSC JEG.

It is expected that the interim AHSC Director will take a lead role in supporting the review process and in particular in ascertaining how rationalisation and alignment between the BRC structures and AHSC Centres for Translational Medicine will be achieved including any gaps in clinical academic capability, joint investment and clinical informatics in advance of the external review.

Key Strategic Issues

1. **Whole Systems Integrated Care (WSIC)**

We continue to explore the potential the WSIC work has for us and coupled with the Better Care Fund (BCF), we see the opportunity to genuinely support the redesign of a system. The timing aligns with our plans to redevelop our sites as we deliver our clinical strategy.

The Early Adopters are now going into a design phase, working toward models that can be placed into commissioning intentions during October, for shadow running in April 2015. We are actively engaging with our clinical teams to ensure that our innovation and voice is significant.

2. **Genomics 100k Project**

NHS England embarks on £100m DNA project to unlock genetic secrets of cancer

The Independent reports that the government has chosen a US company, Illumina, to carry out the sequencing of up to 100,000 NHS patients at its site in Cambridge, according to regulatory papers filed in the US. Although other countries are also pursuing mass DNA sequencing projects, the ambitious 100K Genome Project has been described as unique in scale and scope. Through the programme, volunteers will discover intimate details about their genome, such as the presence of any high-risk cancer genes. All records will then be published online as a free tool for scientists. Researchers say the risk to privacy is outweighed by the benefits of the huge-scale research, which could unlock the genetic secrets to cancer and other diseases.

ICHT has a significant credibility in providing this level of stratified medicine and we will be tendering to support the main provider as we develop our own clinical solution. Through our AHSC, we host the NIHR Imperial Biomedical Research Centre (BRC) worth £113m over five years, which works to translate new research discoveries into improvements into patient care and patient outcomes. The BRC strategy is to drive translation of our inventions in highly characterised patient populations, facilitating the development of personalised medicine. This strategy begins with the enhancement of our product pipeline by focusing on pulling through new chemical entities, diagnostics, devices and interventions from Imperial College, including support for product development partnerships via Imperial Innovations, industrial partnership and through facilitating external

funding. The Trust is already working to put new advances in this area into practice.

3. **Seven Day Services**

Sir Bruce Keogh, the NHS England medical director, has pledged that by March 2017 patients will get the same treatment at weekends as they receive during the week. "The NHS is owned by the people of this country. It needs to respond to society's demands and it is quite clear that the people of this country want us to give considerable thought to how we can improve the services at the weekend," he said.

As a partner within the North West London seven day pioneer collaboration, we are working to make sure that our strategic and operational plans deliver this benefit consistently through our services. Some of our services already operate in this way (HASU).

4. **Better Care Fund**

During the period, we have participated in the National Audit Office (NAO) review of the progress made by health and wellbeing boards in developing plans to ensure the Better Care Fund promotes effective local integration of health and social care. The review will also consider how effectively central government is supporting health and wellbeing boards to oversee delivery of the Better Care Fund's objectives.

The NAO are specifically looking to gain additional feedback from trusts on the following 3 issues:

- What has your experience of the better care fund planning process been locally? (What has worked well and what have been the barriers?)
- How engaged have providers been in the process locally?
- What have been the benefits and challenges of the HWB's role within the process?

They are commissioned to respond in short order and we expect to be able to consider their findings within the next period.

5. **Dalton Review**

Linking with the work we are involved in with the WSIC and BCF, The Secretary of State has appointed Sir David Dalton to undertake a review into securing the clinical and financial sustainability of providers of NHS care through offering new options for organisational forms.

The review will consider the potential for providers of NHS services to develop different organisational forms, and recommend how to incentivise the providers to work in new ways to provide better care, more efficiently, and help support struggling providers.

This review will fully involve acute, mental health and community service providers, both inside and outside the NHS, in the development of options. These may include:

- the potential for providers of NHS care to develop different organisational forms
- enabling local and non-geographical networks of providers or services

- enabling and incentivising the best teams and providers to take on extended responsibilities with struggling providers
- the extension of buddying and mentoring schemes.

The review will not develop a blueprint of the future provider landscape nor direct providers towards the adoption of a particular model regardless of local circumstances.

The work aims to report by October 2014.

6. **The Keogh Urgent and Emergency Care Review**

NHS Medical Director, Professor Sir Bruce Keogh, announced in early 2013 a comprehensive review of the NHS urgent and emergency care system in England. This is one of the priorities in the planning guidance for clinical commissioning groups (CCGs) called Everyone Counts: Planning for NHS services 2013/14.

The review is looking to draw on the experience of patients and all professionals in the NHS and across social care. Phase one is complete and establishes the need for specialist services to be configured on a geographic basis. A second phase is presently in hand, reporting at timely intervals, and ultimately as it publishes, will help ICHT in determining how the Emergency Care services for a local hospital will be configured.

7. **Local Elections**

The local elections gave a change of controlling party for the Hammersmith & Fulham constituency, and we are actively engaged with our new colleagues within the labour administration. Meetings have taken place and we and our commissioners are clear the challenge that the council will place before us and the appropriate level of evidence we will need to present in order to gain their full understanding.

Further opportunities to meet and develop relationships are being planned.

8. **National Election**

It is reasonable to predict that the Government's record on the NHS will be at the heart of the national election debate in May 2015. Commentators suggest that a positive spin from the coalition is that the unprecedented slowdown in NHS funding since 2010 has not had a serious, adverse impact on patient care.

The role of competition and the private sector in health is also likely to have considerable political value, with Labour spokespersons already arguing that Part 3 of the Health and Social Care Act 2012 should be repealed to limit the role of competition regulators and reduce the threat of legal action if commissioners decide to place contracts with NHS providers instead of testing the market.

The cost and timeliness of transition from hospital based care to new models of health and social integrated care will be fiercely debated, with key themes around the need for the NHS to be given more time, more support and more funding to deal with real pressures felt by patients in the present system.

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	2.3
Title	Operational Report
Report for	Monitoring/Noting
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made public

Executive Summary: This is a regular report to the Board and outlines the key operational headlines that relate to the reporting month of June 2014.

Recommendation(s) to the Board/Committee: The ExCo is asked to note the contents of this report. A discussion is recommended as to the appropriate domain lead for the Efficiency section.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Title : Operational Report

Purpose of the report: Regular report to the Board on Operational Performance

Introduction: This report relates to activity within M3 (June) 2014/15.

A. Shadow Monitor compliance

Foundation Trust governance risk rating (shadow): Amber

Rationale: The Trust did not achieve the three RTT standards in June and the Cancer breast symptomatic two week wait referral standard in May (cancer data reported one month in arrears)

B. Safety

Mortality Rates & Incidents

Mortality Rates:

- The Trust's Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Mortality Index (SHMI) remain amongst the lowest nationally;
- The HSMR is 62.1 for the latest data available (Februay 2014). This is the second lowest nationally for the second month running;
- For the latest SHMI data available (Q2, 2013/14), the Trust SHMI rate is 70.3 which is a fall from the previous quarter's figure of 75.7;
- There were no high relative risk mortality alerts or negative Dr Foster alerts in February 2013.

Incident Reporting:

- The Datix system was upgraded and a training programme undertaken from 1st April. This has resulted in an increased incident reporting rate (number of incidents per 100 admissions). For the first time, the Trust's reporting rate has now exceeded the peer reporting rate.
- Harm to patients caused by incidents remains lower than our peers (peers 25% harm, ICHT 20% harm) and has not increased alongside the reporting rate.

Serious Incidents & Never Events:

- 5 serious incidents were reported in June; the year to date reported total of SIs is 20 compared with 36 last year;
- 1 Never Event was reported in June;
- The following are recent examples of actions being taken as a result of SI investigations to prevent issues re-occurring and improve awareness:
  - Emergency stop anti tamper covers to be placed on all generators across each site;
  - Audit of cases where patients have been subsequently diagnosed with invasive ductal carcinoma with previously reported B1 biopsies. Guidance to be updated as per audit findings;
  - To create local guidance incorporating a process for agreeing the discharge of patients without full blood results.

Infection Prevention & Control

Methicillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):

- There is a national expectation of zero MRSA blood stream infections for all Trusts for 2014/15;
- During May 2014 2 cases were allocated to the Trust;
- There were no Trust associated cases confirmed during June 2014.

Clostridium difficile infections:

- The Department of Health annual ceiling for the Trust is 65 cases for 2014/15; to date the Trust has reported 25 cases associated with the Trust;
- 9 Trust associated cases were reported to Public Health England (PHE) in May, with a further 9 in June 2014;
- Actions arising from multidisciplinary review of these cases include a communication programme to raise staff awareness of the isolation policy and a review of PPIs within the community sector.

Methicillin sensitive Staphylococcus aureus bloodstream infections (MSSA BSI):

- There is no threshold for this indicator at present;
- In May 2014 six cases were reported to PHE, of which three were Trust attributable (i.e. post 48 hours of admission);
- In June 2014 there were six cases of which two cases were Trust attributable.

Escherichia coli bloodstream infections (E. coli BSI):

- There is no threshold for this indicator at present;
- The steep rise in E. coli BSIs nationally is a cause of significant concern;
- In May 2014 there were 28 cases reported to Public Health England (PHE), of which four were Trust attributable;
- In June 2014 there were 27 cases of which two were attributed to the Trust.

Carbapenemase Producing Organisms:

- The Trust identified 2 cases in May and 3 in June. The total for 2014/15 so far is 6;
- In line with the guidance issued by PHE and NHS England, the Trust has developed an action plan to ensure that the tool kit is embedded into practice, this will include implementation of isolation facilities;
- The Trust closed the patient safety alert on 26/06/14.

Fungal Infection Surveillance:

- At the chairman's request, candida blood stream infection surveillance has now commenced with one Trust case reported for April 2014 and one case in June 2014.

Cost Improvement Programme Quality Impact Assessments

The Medical Director and Director of Nursing met with all four divisions and the corporate area of Information Communication Technology in June to discuss and approve the QIAs for 2014/15 CIP schemes. Currently, there are no CIP QIAs that have a risk assessment

score above 9 and where risk has been identified, mitigating actions are in place. All the QIAs presented were approved at these meetings.

The next set of meetings will take place in September and will focus on undertaking a post-implementation evaluation of schemes implemented in 2013/14. The outputs of this will be reported to the Board.

In order to reflect the change**s** to the CIP QIA process, the '*Guidance on the Trust's process of undertaking Quality Impact Assessments for Cost Improvement Programmes'* has been revised and can be found in Appendix 1. The document was approved as a policy by the Executive Committee (Quality and Safety) on 8th July 2014.

C. Patient Centeredness

The trust continues to deliver good Friends & Family Test response rates and the Q1 CQUIN performance targets were met. The FFT scores continue to be better than the London average, particularly in A&E.

The ward based real-time feedback survey questions continue to be high scoring. It is worth noting that the question related to finding someone to talk to about worries and fears that has been highlighted as a risk in the CQC intelligent monitoring report, is on an upward trend scoring above the threshold for the whole of Q1.

The trust is seeing increasing numbers of complaints and PALS enquiries. The reasons for this appear to be multifactorial for example a heightened awareness around NHS performance in the press and public domain and increasing pressures on services and waiting. In addition, since April the move to Cerner has been associated with a rise in complaints related to appointment times and cancellations; this does however seem to be settling now. The increase in volume, combined with some vacancies in key divisional governance posts, has led to a deterioration in performance in response time targets. Improving this and closing outstanding complaints has been a priority for the central complaints team over the last month and divisional appointments have been made. It is anticipated that this will improve over the next quarter.

D. Effectiveness

WHO Checklist:

- An assessment has been completed on usage of and compliance with the WHO checklist;
- Results showed variation in audit processes and overall compliance;
- The Division of Investigative Sciences is leading a monthly audit programme measuring compliance which will be reported in the Safety and Effectiveness report.

E. Efficiency

Performance against some of the key efficiency measures is reported in the Integrated Performance Scorecard. Theatre utilisation, length of stay, day case rates and Did Not Attend (DNA) rates could be improved to maximise resources.
Supported by the Medical Director and Chief Operating Officer and as part of the Planned Care workstream of the Trust's Clinical Transformation Programme (CTP), the Clinical Transformation Office (CTO) will lead an elective improvement focused on delivering:

Outpatient pathway improvement

- Ten outpatient specialities have been selected for focused improvement. These are specialities where there is high patient volume and poor efficiency performance, such as DNA rates and Cancellations (patient and hospital initiated);

Elective inpatient pathway improvement

- The Trust has recently piloted the use of Tactical Planning (TP), an improvement programme focussing on improving patient flow across outpatient, theatre and bed resources through structured planning. This pilot is going to extend to include the theatres suite on the Charing Cross Hospital site and will help the Trust to improve theatre utilisation rates.

F. Timeliness

In June, the Trust continued to deliver the 4-hour waiting time standard in our A&E department. The Trust consistently delivers this standard each month. The Trust is currently bidding for money to support resilience over the winter period that is available nationally.

Reported Referral to Treatment (RTT) performance was challenged in June and the Trust underperformed on all three standards. Since implementing a new Patient Administration System (PAS) in April, the trust is going through a period of stabilisation and familiarisation. It was expected that there would be a number of data quality issues that would need to be resolved following the switch over. These issues are being managed during weekly meetings with divisional teams. However, there are still some challenges with both ensuring that staff record data correctly onto the system, and the volume of validation that needs to happen to ensure appropriate prospective monitoring of patients waiting for treatment. There was one patient recorded as waiting over 52 weeks for treatment. The patient has now been treated and will be recorded as an under 52 week treatment for July due to patient choice being taken into account (this is not the case for reported incomplete pathways).

The Triparite (NHS England, Trust Development Authority and Monitor) recently announced £400m that is available to Trust to reduce RTT waiting times. The allocation for ICHT is £2.3m and will be used to support increased activity and to focus on the validation of data following the implementation of our new PAS system.

The Trust has received a letter from NHS England with regards to 62 week cancer waits. Given the performance over Q4 2013/14 and Q1 2014/15, the Trust is well placed and is confident that performance for this standard can be sustained.

In June, performance is reported for the cancer waiting times standards in May. The Trust continued to match the improvements seen in the 62-day 1st treatment standard in quarter 4 of 2013/14 and in April 2014. Overall, the Trust achieved 7 of the 8 cancer waiting times standards. Performance for the treatment standards (both 62-day and 31-day) was sustained. This was achieved through maintaining a low number of long-waiters on the cancer PTL, through continuing to build stronger relationships with other hospitals referring patients into Imperial for treatment and through making diagnostic pathways more efficient. The Trust failed the breast symptomatic two week wait standard. This was a result of unplanned consultant absence and a loss of flexibility in the provision of ad hoc capacity which had previously maintained this standard. The service has addressed this through the

provision of nurse-led rapid access clinics to increase capacity for new referrals, commencing in August.

G. Equity

A key focus in Q1 has been strengthening the process for recording adult safeguarding referrals and increasing the level of compliance with adult safeguarding training. There is now a greater level of confidence in the reported adult safeguarding incidents and these number appear consistent with an organisation of this size. It is anticipated in the next few months NHS England (London) will introduce new guidance around reporting community acquired pressure ulcers which may impact the trust reporting arrangements.

Significant work has been undertaken to increase the uptake of adult safeguarding training including visits to wards by the inclusion and vulnerability team and 3 planned “loop” days where a number of sessions will be repeated through the day.

H. People

Talent Development

PDR

In March we launched the new Performance Development and Review Programme. This has been well received and we now have over 1100 managers booked onto the training and over 450 have completed to date. Feedback on the training has been very strong.

The first wave of PDRs were completed by the end of June by the most senior managers with over 95% compliance by the first deadline for completion. A new reporting tool (ePDR) has been rolled out to enable mangers to record their PDR ratings electronically. The rest of our managers will be carrying out their first PDRs in the new process between now and December.

Resourcing

Employer Branding

The implementation group met for the first time in June to get the project underway. We have a good spread of senior colleagues from Divisions and Directorates who are really engaged in this. The first milestone is to develop our Employer Value Proposition to start to build some creative. We expect to have something to share with the Executive Committee late July/early August.

HR Operations

Establishment Controls

As part of our continuous drive to understand and control our people landscape a Trust wide exercise to review all vacant posts is underway with the aim of ensuring that only those posts which are both funded and support current service delivery are active on ESR and available for recruitment. This will ensure that our vacancy rates are reported accurately and that we remove risk of recruitment to posts which have no funding. In addition to this, the review will also align the use of temporary and contingent workers against our vacant establishment and understand what the future recruitment intention is.

Health & Wellbeing

Occupational Health Consultant Appointment
Dr Basil Assoufi has been appointed to replace Professor Harrison's clinical case load, he will commence in post 1st September. He joins the team with wealth of experience of both NHS and private sector Occupational Health and most recently has split his time between Kingston Hospital, Surrey Borders Partnership and the Police. Thanks to Tony Newman Taylor who supported the panel and will mentor Basil.

Introduction of blended physiotherapy provision for our people
The aim of the service is for the Physiotherapy intervention to positively impact our peoples return to work and improve productivity for those off sick, on modified duties or at work with pain due to a musculoskeletal conditions. Currently the service is offered by in-house provision often with long waits and with no proactive intervention for our people to manage their own conditions. Physiotherapy Advice Line (PAL) is an innovative, over the phone treatment solution offered by Physio Med, designed to empower and heal our people whilst reducing costs to cover absence through bank and agency.

Broadly speaking, after referral from OH, the patient is called by a member of Physio Meds dedicated PAL team who will triage the individual to ascertain their appropriateness to the service - this takes place within 2 working days of initial contact and is a structured initial assessment by a Chartered Physiotherapist that will take up to 45minutes.

Following successful completion of the initial assessment, the patient will be given the following (PASS):

- Personalised exercise programme
- Advice about their work station, working environment or home life style
- Self-management plan which includes education on their condition do's and don'ts
- Support throughout the PAL process by our dedicated PAL team

This is one of a number of interventions being introduced by the Health and Wellbeing team.

Smoke Free Hospital
The inaugural Smoke Free Project Meeting took place with a range of stakeholders across various professional groups. The focus of Smoke Free agenda is our people and patients in ICHT but remit of group extends beyond that into the community.

A range of actions materialised from the meeting including:

- The creation of a brand to promote the stop smoking, through eye catching signage and messaging
- The training of our people to provide Smoking cessation clinics across hospital sites for staff
- The exploration of Level 1 training as part of mandatory training
- The collective agreement to a significant launch with all stakeholders for staff and patients in line with Stoptober (in October)

I. Finance

The Trust's Income & Expenditure (I&E) position at the end of June was a deficit of £2.5m (after adjusting for the impairment and donated assets), an adverse variance against plan of £3.7m. Despite raising serious concerns in last month's report, the position continues to deteriorate and presents a major challenge to delivery of the Trust's objectives for the year, including achievement of Foundation Trust status. The financial position this month was supported by the release of old year accruals which has a one-off benefit to I&E but significantly weakens the balance sheet. In addition accrued income of £5.1m for the full payment of the SLA performance fund and for un-coded activity relating to problems with reporting in Cerner has been included but both can be assumed to be at risk.

The main reasons for the adverse variance are:-

- Cost Improvement Plans (CIPs) are behind plan by £6.7m (65%);
- Expenditure on Cerner implementation was much greater than expected;
- Temporary staff pay costs were significantly higher than plan due to lack of effective controls.

J. Education

Undergraduate Education - Follow-up Governance and Education Monitoring Visit meeting – 12th June 2014:

- The visit team recognised the dedicated efforts made by the DCSs and the clinical teams;
- They reported that they were impressed with the progress made, particularly in Oncology and Obstetrics and Gynaecology.

Postgraduate Education - Pan London Quality Regional Unit Visit – 2nd-3rd June:

- Issues raised by the visit are already known about by the Trust and will be dealt with through the education transformation programme;
- The Medical Director met with divisional teams, the Chief Operating Officer and the DMEs to address areas of immediate concern immediately after the visit took place.

Medical Education Forum:

- The first Medical Education Forum took place on Friday 4th July, with attendees from all divisions, members of the Executive team and external representatives from HENWL and ICL;
- Outcomes from discussions at the forum will be collated, reported at ExCo and will feed into the transformation programme.

Education Restructure:

- The new structure will be implemented following consultation with affected staff. Interviews for the posts will take place in August.

Community Education Provider Network:

- ICHT have recently been awarded funding from HENWL to establish a new Community Education Provider Network (CEPN) entitled "Creating a continuous culture of improvement: Improving Discharge Processes through Quality Improvement Training";

- The focus will be on improving the discharge process by enhancing the integrated working of services and agencies in Hammersmith and Fulham.

K. Research

LCRN:

- The annual plan for the network was approved by the National Institute of Health Research Network Coordinating Centre on 30th June 2014;
- In the recent Guardian League table of annual research activity Imperial was ranked 2nd amongst the London trusts with 330 studies open during 2013-14 and total recruitment of nearly 12000 patients into portfolio studies;
- The Network Executive Committee meet bimonthly and have approved plans for expenditure for £611K of Research Capability Funding based on value for money and divisional priority areas, Imperial received £420k. The Committee also agreed an allocation model for contingency funds of £500k based on activity during the previous calendar year. Imperial received 45% of the total allocation.

NIHR Imperial Biomedical Research Centre (BRC):

- The BRC is contributing to a pilot study run by Genomics England. The aim of this project is to position Britain at the forefront of genomic medicine so that NHS patients are early beneficiaries of the therapeutic advances derived from genomic medicine;
- A mid-term external review of BRC progress is planned for 2nd October 2014. This review will inform the remaining two and a half years of the programme and plans for re-application in 2016.

L. Health and Safety

Executive Director level responsibility for Health & Safety (H&S) has recently transferred from the Director of Estates & Facilities to the Director of Governance & Assurance. H&S is structured around Departmental Safety Coordinators and Fire Safety Wardens in clinical and non-clinical areas. A governance structure is in place providing for a number of specialist committees e.g. Radiation and an over-arching Trust-wide H&S Committee meets quarterly, now chaired by the Director of Governance & Assurance.

The Trust has a specialist contract in place to provide H&S support: over the coming months the aim is to develop some in house H&S expertise to supplement that provided via the contract.

The top three causes of H&S incidents have remained constant over the last 18 months: abuse, needle stick injuries, and slips and falls. In the last 6 months, there had been three RIDDOR (i.e. reportable incidents) – two slips each resulting in fractured ankles and a member of staff handling the Brucella Melitensis culture. Incident reporting is done via DATIX and analysis shows the percentage of incidents resulting in serious harm is zero whilst the percentage for low-medium harm is 90%.

Looking ahead, management focus will be on ensuring there are resilient methods for ensuring Departmental Safety Coordinators are in place across the Trust, increasing the uptake of statutory and mandatory H&S training, raising the visibility of H&S within the Trust, and increasing the level of reporting and near misses of H&S incidents. We know

from our (Mar '14) staff engagement survey that only 30% of staff thought the organisation took positive action on health and wellbeing and just 28% thought their job was good for their health: whilst an element of this reflects occupational health issues, practical H&S measures have a role to play and the Trust needs to act to address both issues and perceptions. Recent examples of positive action include the paper and action plan taken by Management Board on Violence and Aggression in the Emergency Department at St Mary's Hospital.

It is the intention that going forward, H&S will play a far more prominent role within the Trust and there will be regular reports to the Executive Committee, and the Board including an annual deep dive on H&S.

Recommendation to the Board: The Board is asked to note the contents of this report.

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	2.4
Title	Integrated Performance Scorecard
Report for	Monitoring
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made public

Executive Summary: *This is a regular report to the Board that outlines the key headline performance indicators from Monitor, CQC, and TDA frameworks as well as a number of contractual indicators as well as some that have internally generated. This report is designed to be reviewed in conjunction with the Operational Report.*

Recommendation(s) to the Board/Committee: *The Board are asked to note the contents of this report*

Trust strategic objectives supported by this paper: ***Retain as appropriate:***

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

Imperial College Healthcare NHS Trust

Title : Integrated Performance Scorecard

Purpose of the report: The Board is asked to note the contents of the Integrated Performance Scorecard.

The Integrated Performance Scorecard brings together finance, people and quality metrics. The quality metrics are subdivided into the 6 quality domains as defined in the Trust Quality Strategy.

The indicators for each domain have been specifically selected and agreed by the quality domain leads as those that the Board should be sighted on.

Regulatory reforms

The NHS Trust Development Authority has recently published *Delivering for Patients: the 2014/15 Accountability Framework for NHS trust boards*, which sets out how the TDA will work alongside trusts to support the delivery of high quality, sustainable services for patients. The methodology for rating is subject to an element of subjectivity. Once the rating for ICHT is published, this will be also published in the Integrated Performance Scorecard.

Leading/lagging indicators

Leading indicators are those where future performance may be affected e.g. patients referred via the two week wait suspected cancer route will be reported under the 62 day standard if diagnosed with cancer, or VTE risk assessment rates could have a direct impact on clinical outcomes.

Lagging indicators are those where the final outcome is reported e.g. mortality rates or 30 day readmission rates.

Source framework

The source framework is cited for each of the published indicators. This is highlighted within the scorecard e.g. Monitor, CQC, NTDA, contractual or internally generated.

Future development

In the coming months, the scorecard will be further enhanced including:

- Ensuring that all indicators have a threshold so it is clear in the summary pie charts how the indicator is performing. Where no threshold is available, an explanation will be provided in a definitions page about how the indicator has been rated;
- Include further comparison data, when this becomes available to allow benchmarking to be made with other London Trusts, the Shelford Group and against the national average;
- Further development of the definitions page, which will describe the Monitor governance framework as well out outline some definitions on the indicators that have been selected and rationale for including them;
- It is proposed that the Integrated Performance Scorecard is developed into a QlikView application with an initial version to be presented to the Trust Board in September 2014.

This will allow for the complex data feeds to be fully embedded into the scorecard and will allow full testing of the iPad friendly version of QlikView which is soon to be released. QlikView will allow Trust Board members to drill down into further detail into the indicators that are presented. This could be to divisional or speciality level;

Recommendation(s) to the Board/Committee: The Board is asked to note the contents of the Integrated Performance Scorecard.

Trust Board Performance Report
Report Period Month 3
(to end June 2014)

Trust Board Wednesday 30th July 2014

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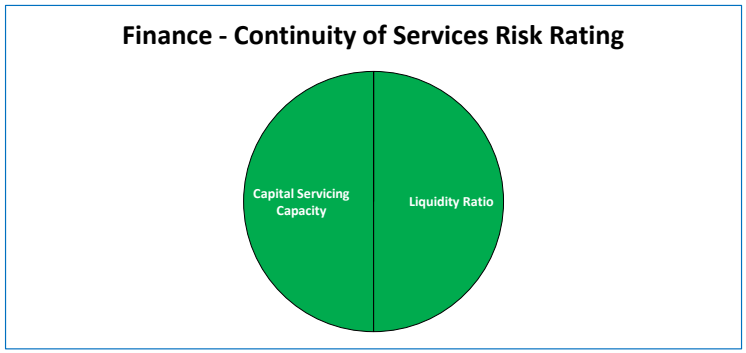
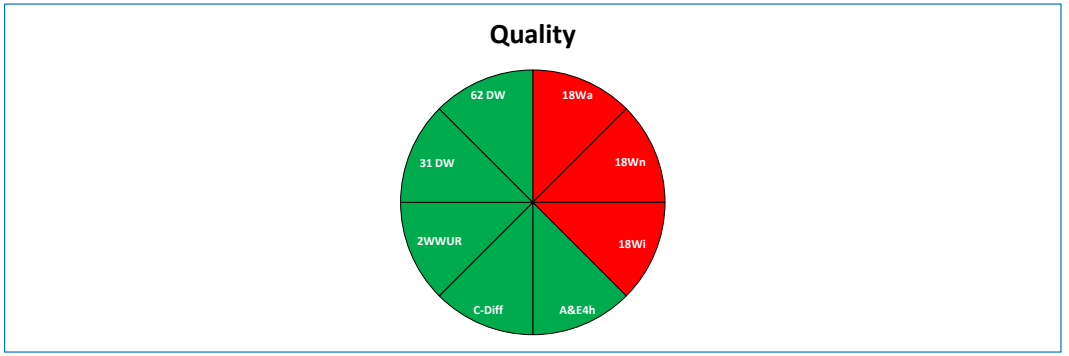
Imperial College Healthcare NHS Trust

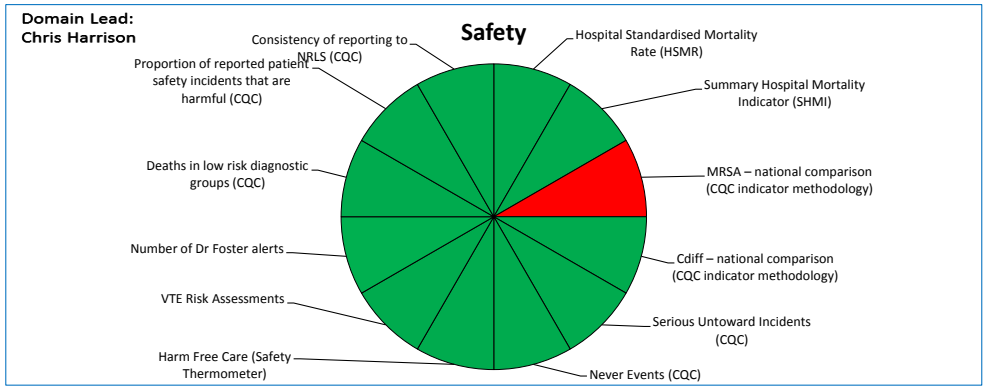


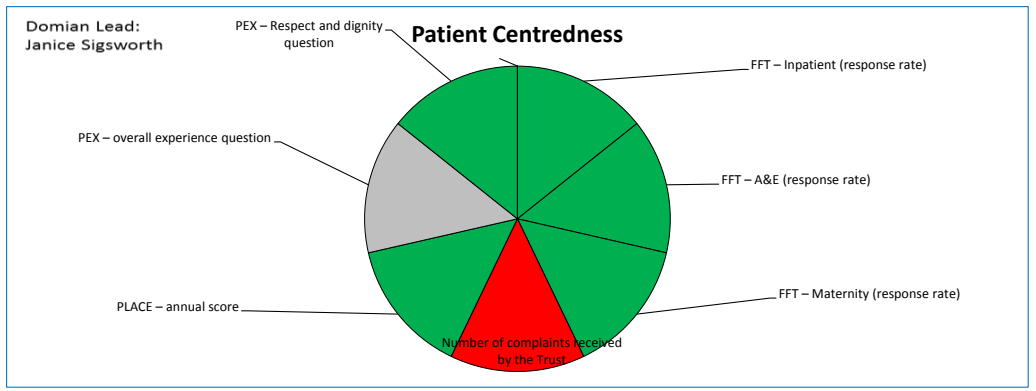


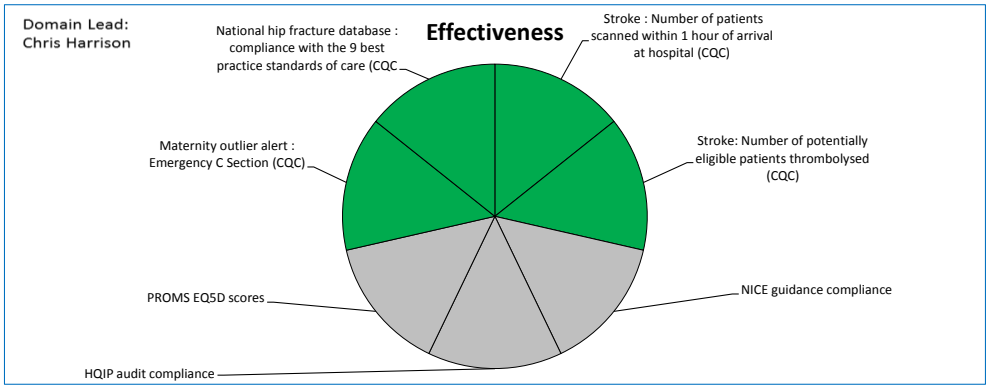
2014/2015			Performance to date 14/15	*Forecast*		
Area	**Indicator**	**Threshold**	**Q1**	***Qtr 2 14/15***	***Qtr 3 14/15***	***Qtr 4 14/15***
Finance	Capital Servicing Capacity		3			
	Liquidity Ratio		3			
	Continuity of Services Risk Rating		3			
Access	18 weeks referral to treatment - admitted	90%	88.90%			
	18 weeks referral to treatment - non admitted	95%	94.31%			
	18 weeks referral to treatment - incomplete pathway	92%	92.20%			
	2 week wait from referral to date first seen all urgent referrals	93%	94.15%			
	2 week wait from referral to date first seen breast cancer	93%	91.45%			
	31 days standard from diagnosis to first treatment	96%	98.00%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.35%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	95.35%			
	62 day wait for first treatment from NHS Screening Services referral	90%	97.50%			
	62 day wait for first treatment from urgent GP referral	85%	92.10%			
	A&E maximum waiting times 4 hours	95%	95.90%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	25			
	Governance Risk Rating					

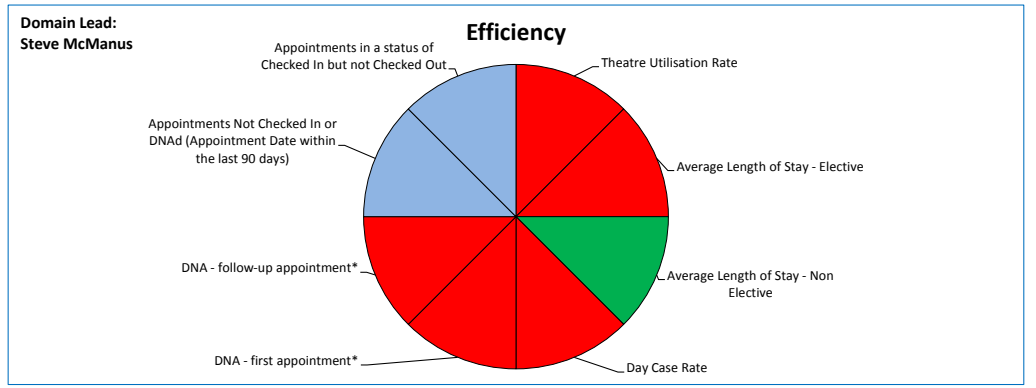
Other triggers of governance concern not addressed in Integrated Performance Scorecard

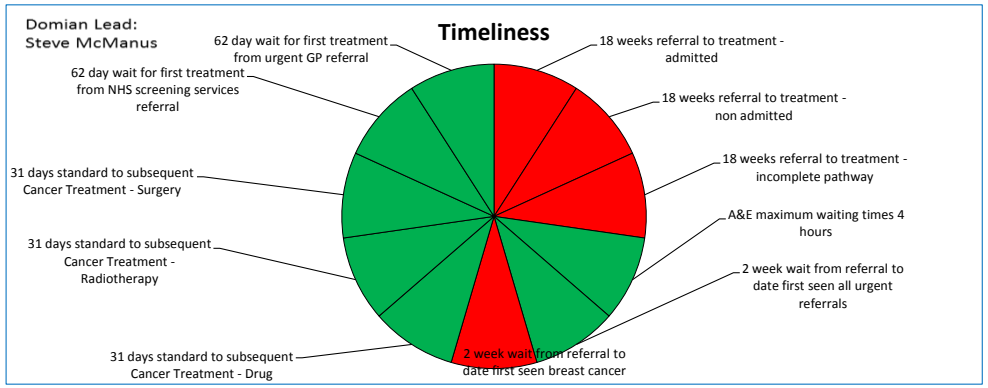
CQC judgements - warning notice issued, civil and/or criminal action initiated	None			
Third party reports from e.g. from GMC, the Ombudsman, medical Royal Colleges etc - judgement based on severity and frequency of reports	None			

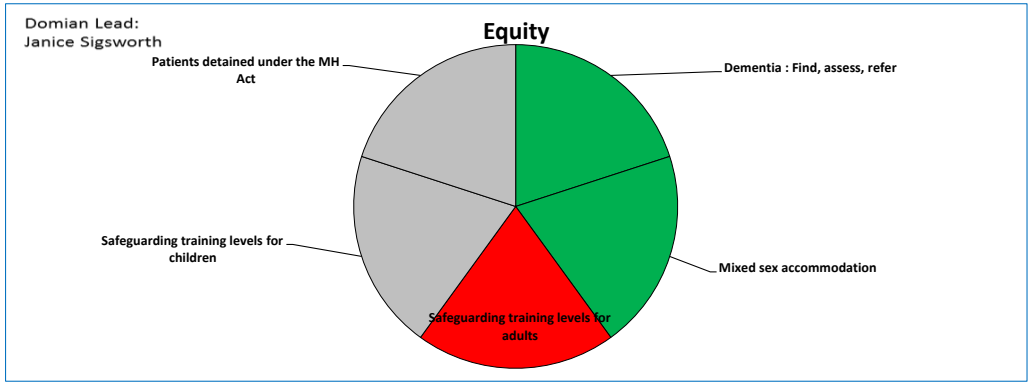






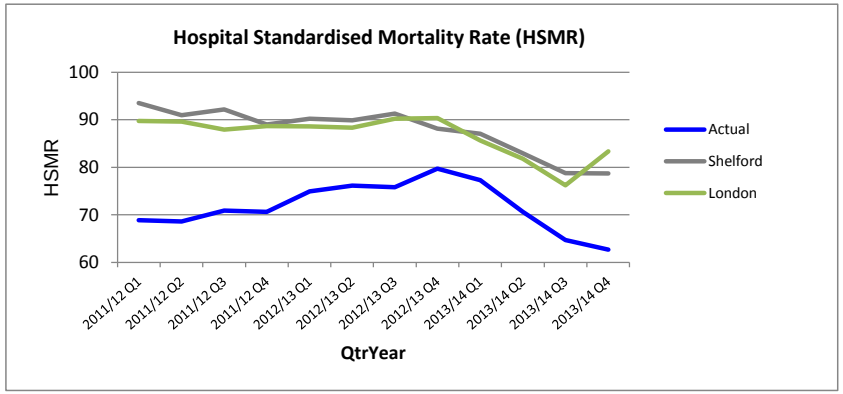


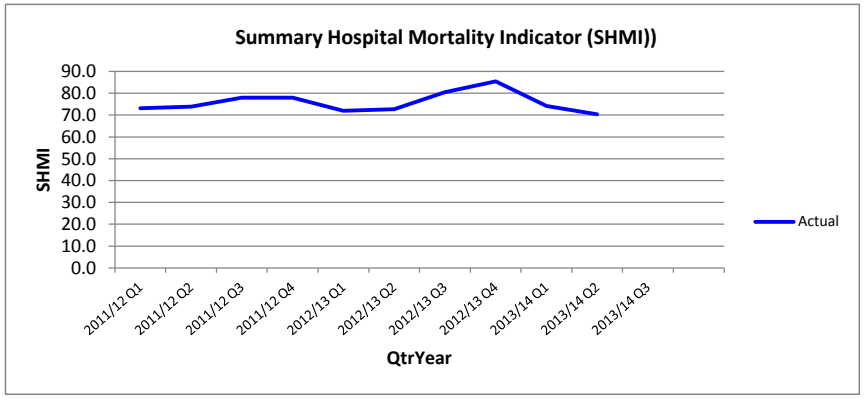


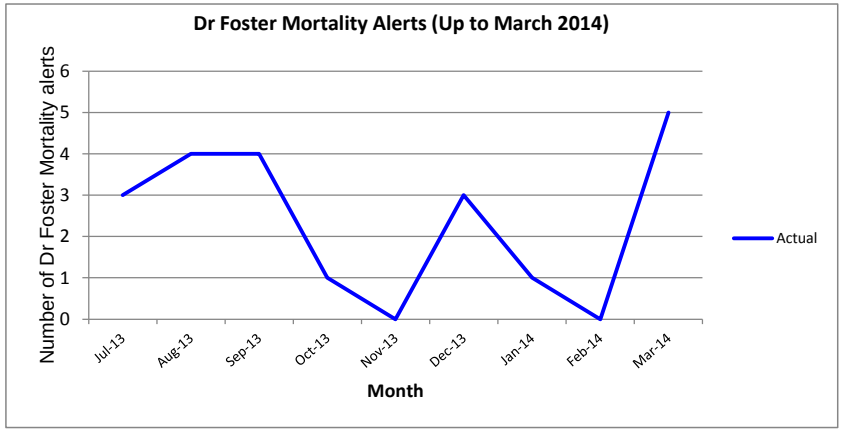


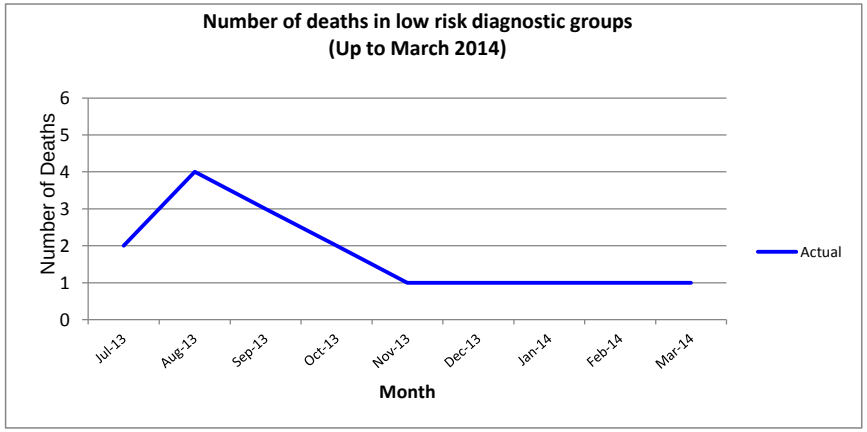
CQC/Threshold met
CQC/Threshold NOT met
To be developed (NO Data - NO Threshold)
Have Data - NO Threshold

Indicator	Leading	Frequency	2012/2013 Qtr4	Performance in 2013/14 Q1	Q2	Q3	Q4	YTD	Forecast Qtr 1 14/15	Qtr 2 14/15	Qtr 3 14/15	Source Framework
Mortality Indicators												
Hospital Standardised Mortality Rate (HSMR)	-	Qtr	79.70	77.32	70.63	64.70	62.70					CQC
Summary Hospital Mortality Indicator (SHMI)	-	Qtr	85.52	74.10	70.30							CQC
Dr Foster Alerts												
Number of Dr Foster mortality alerts	-	Qtr	n/a	9	11	4	6	30				CQC
Deaths in low risk diagnostic groups												
Number of deaths in low risk diagnostic groups	-	Qtr	n/a	6	9	4	3	22				CQC

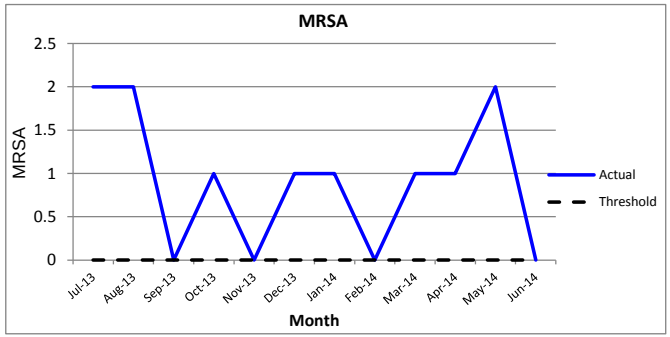


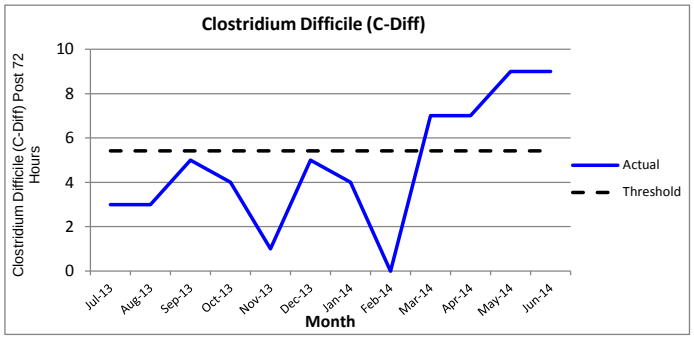


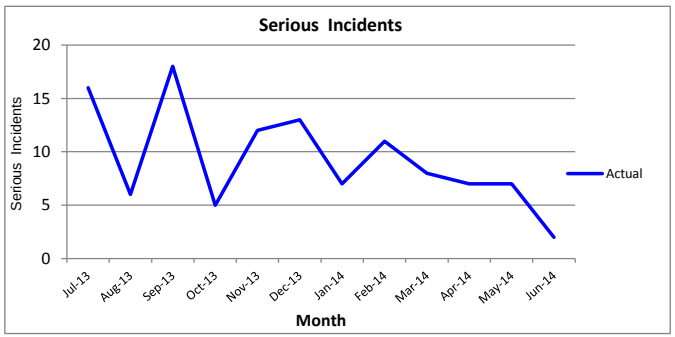


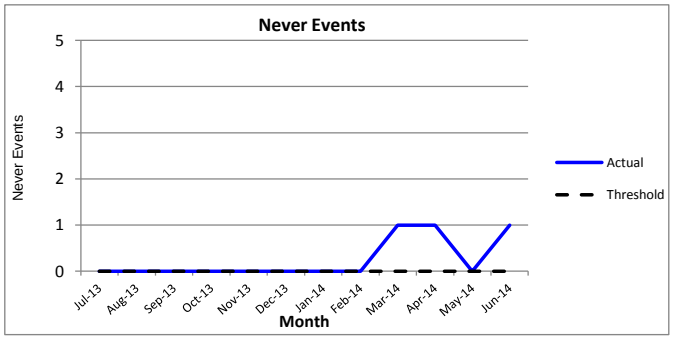


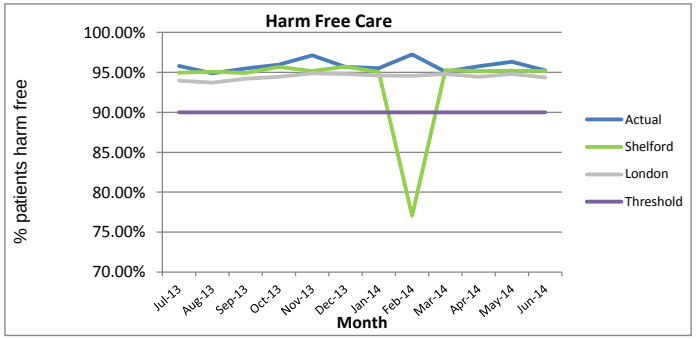
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Infection Control															
MRSA	-	Mth	0	1	5	0	3				3				TDA, CQC
MRSA (latest CQC report)	-	Qtr	0	n/a	n/a	-									TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	-	Mth	65 p/a	8	26	9	25				25				Mon, TDA, CQC
Clostridium Difficile (latest CQC report)	-	Qtr	0	n/a	n/a	-									Mon, TDA, CQC
Incidents															
Never Events	-	Mth	0	1	1	1	2				2				TDA, CQC
Serious Untoward Incidents	-	Mth	*tbc*	14	33	2	16				16				TDA, CQC
Safety Thermometer															
Harm Free Care (Safety Thermometer)	-	Mth	90%	94.7%	95.2%	95.25%	95.78%				95.78%				TDA, CQC
VTE															
VTE Risk Assessments*	✓	Mth	95%	95.4%	95.1%	95.05%	95.30%				95.30%				CQC, Contractual

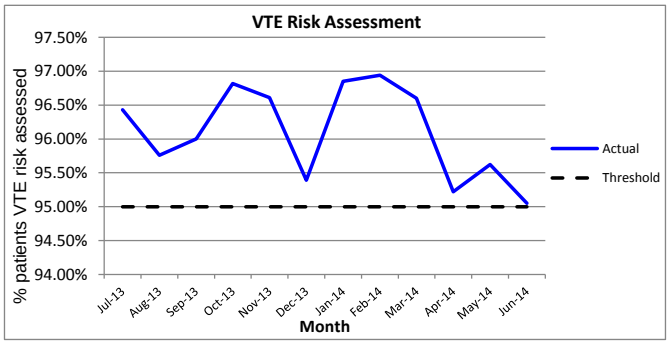












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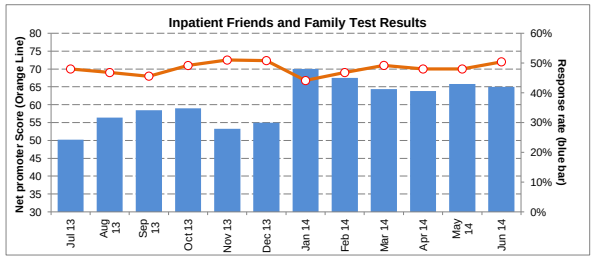
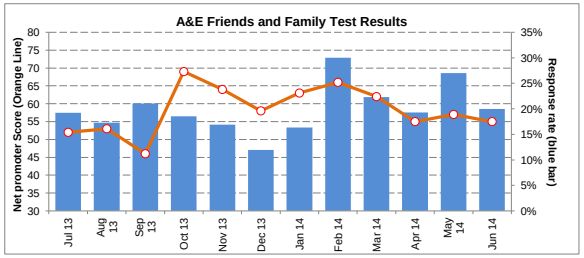
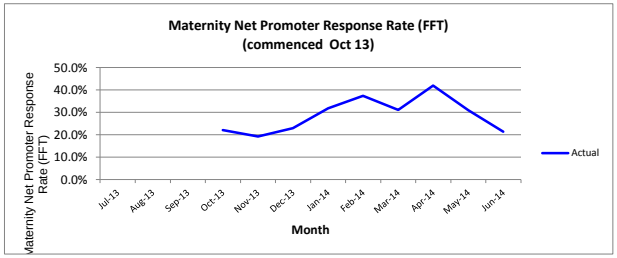
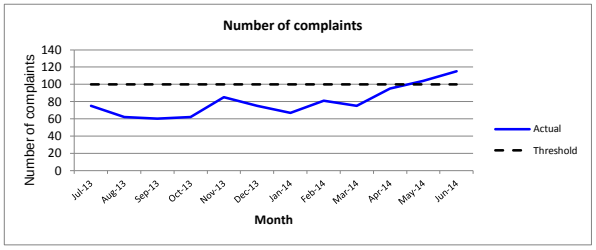
Friends & Family Test															
Inpatients Net Promoter Score (FFT)	✓	Mth	*tbc*	71	70	72	212				212				Contractual
Inpatients Net Promoter Response Rate	✓	Mth	25%	23.37%	25.09%	42.00%	41.86%				41.86%				
A&E Net Promoter Score (FFT)	✓	Mth	*tbc*	55	49	55	167				167				Contractual
A&E Net Promoter Response Rate	✓	Mth	15%	16.53%	17.93%	20.00%	22.10%				22.10%				
Maternity Net Promoter Score (FFT)	✓	Mth	*tbc*	n/a	n/a	55	186				186				Contractual
Maternity Net Promoter Score Response Rate	✓	Mth	15%	n/a	n/a	21.40%	31.47%				31.47%				Contractual
Complaints & Compliments															
Number of complaints received	-	Mth	100	53	192	115	314				314				CQC
Environment															
PLACE - Cleanliness	-	Annual	*95%*	99.03%	Aug-13	Survey due Aug 14									*tbc*
PLACE - Food	-	Annual	*84%*	80.91%	Aug-13	Survey due Aug 14									*tbc*
PLACE - Privacy, Dignity & Well being	-	Annual	*82%*	88.60%	Aug-13	Survey due Aug 14									*tbc*
PLACE - Facilities	-	Annual	*83%*	89.22%	Aug-13	Survey due Aug 14									*tbc*
Patient Experience															
(LQ36) Have you been treated with dignity and respect by staff on this ward?	-	Mth	*85%*	97.13%	97.63%	95.9%	96.30%				96.30%				CQC
Safeguarding															
Safeguarding Adults : Referrals per month	-	Mth	*tbc*	30	107	43	109				109				CQC

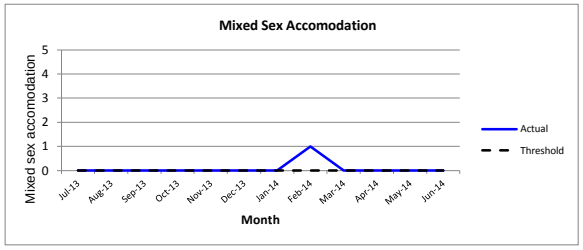
Indicators to developed
Patient Exp. - Overall experience
Patient Exp. - Cancer

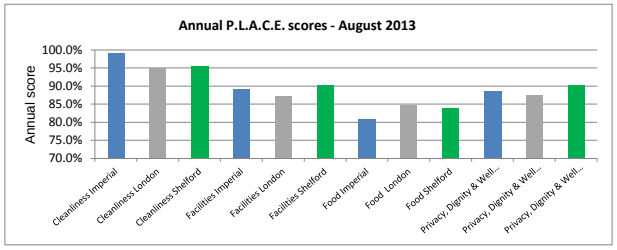


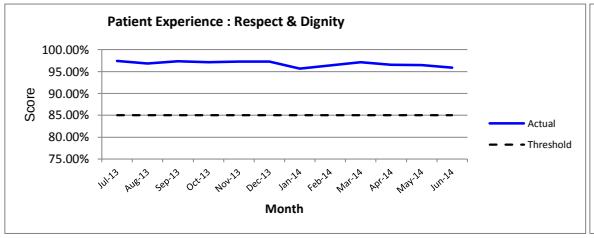


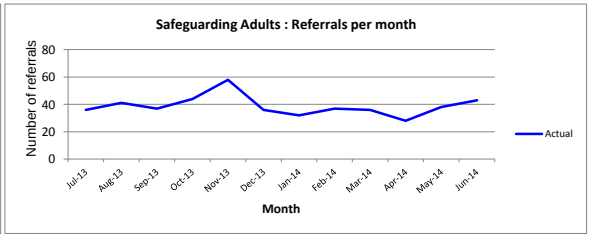












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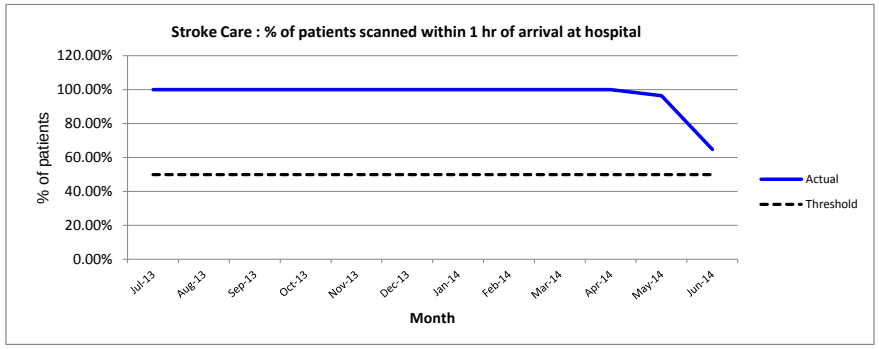
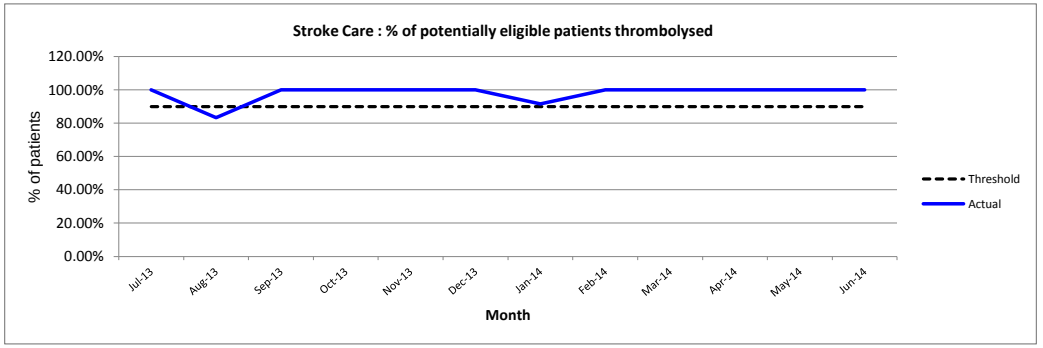
Stroke Care															
Stroke Care : % of patients scanned within 1 hr of arrival at hospital	-	Mth	50%	100.0%	100.0%	64.78%	87.09%				87.09%				CQC
Stroke Care : % of potentially eligible patients thrombolysed	-	Mth	90%	100.0%	92.3%	100.00%	100.00%				100.00%				CQC

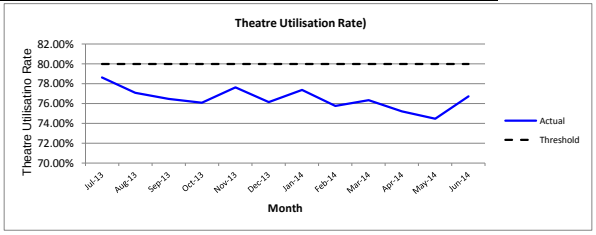
Indicators to developed
Nice Guidance Compliance
HQIP Audit Compliance
PROMS ESQD Scores
Maternity outlier alert : Emergency C section
National Hip Fracture Database : Compliance With 9 Best Practice Standards

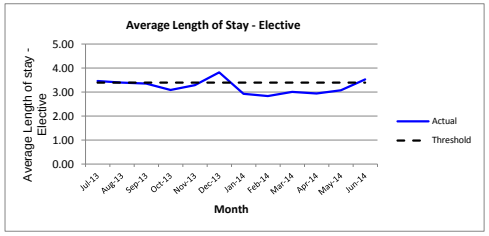


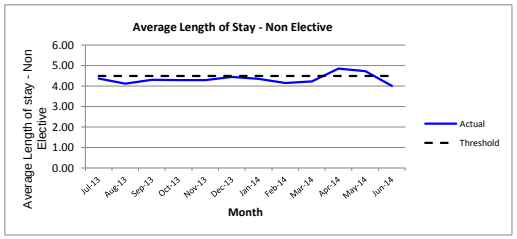


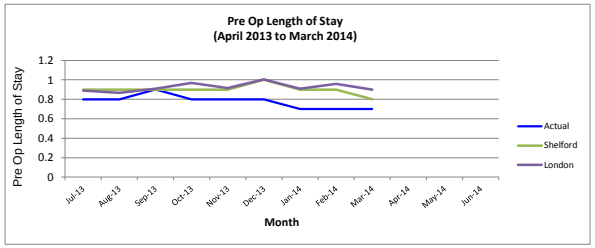
Indicator	Leading	Frequenc	Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Productivity															
Theatre Utilisation Rate	✓	Mth	81.00%	78.36%	77.74%	76.73%	75.48%				75.48%				CQC
Average Length of Stay - Elective	✓	Mth	3.40	3.11	3.23	3.53	9.55				9.55				CQC
Average Length of Stay - Non Elective	✓	Mth	4.49	4.65	4.78	4.01	13.59				13.59				CQC
Pre Op Length of Stay	✓	Mth	*tbc*	0.90	0.90	0.70									Define
Post Op Length of Stay	✓	Mth	*tbc*	4.10	4.33	3.30									Define
Day of Surgery Admission	✓	Mth	*tbc*	87.30%	87.17%	87.10%									Define
Day Case Rate	✓	Mth	80.00%	78.88%	79.90%	76.71%	76.91%				76.91%				CQC
DNA - first appointment	✓	Mth	12.31%	13.90%	13.82%	17.37%	17.63%				17.63%				Internal
DNA - follow-up appointment	✓	Mth	11.33%	12.97%	12.80%	18.17%	17.20%				17.20%				Internal
Hospital Appointment Cancellations (hospital instigated)	✓	Mth	*tbc*	1.98%	1.88%	1.33%	4.04%				4.04%				Internal
Data Quality															
Appointments Not Checked In or DNAd (Appointment Date within the last 90 days)	✓	Mth	*tbc*	n/a	n/a	1827	2754				2754				Internal
Appointments in a status of Checked In but not Checked Out	✓	Mth	*tbc*	n/a	n/a	1201	1535				1535				Internal

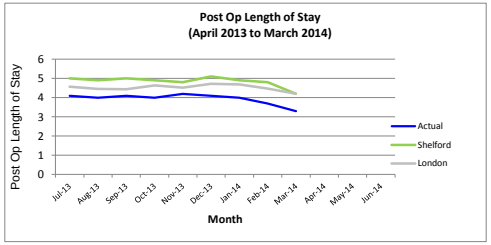
Indicators to developed
*BADS Day Case Rate - Paediatric**

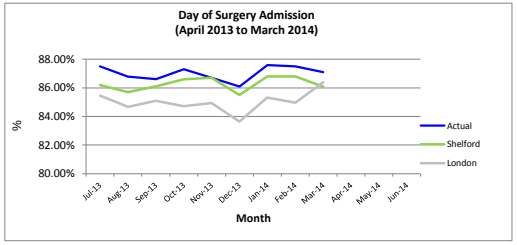


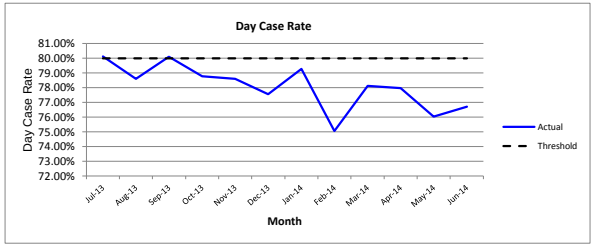


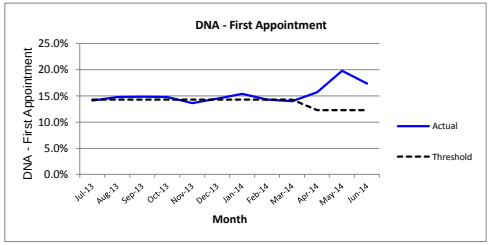


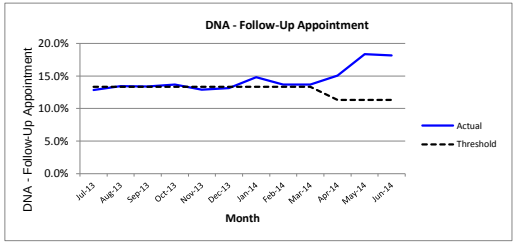


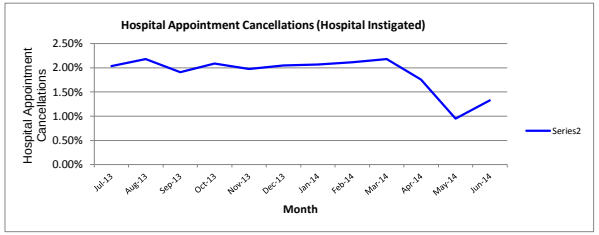


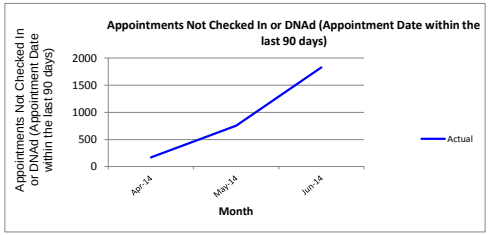


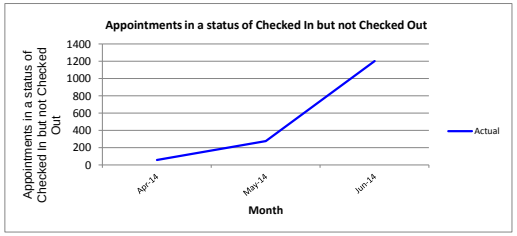




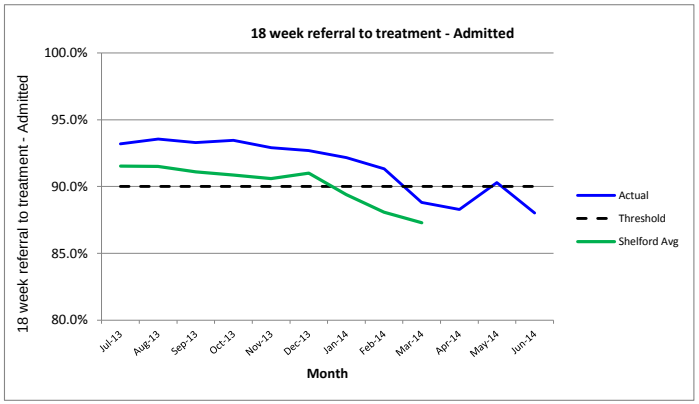


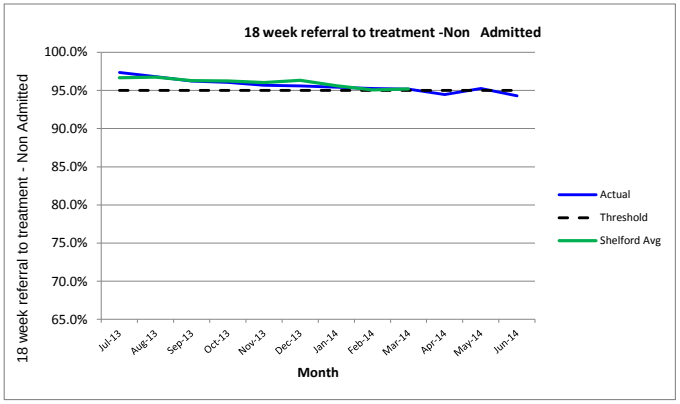


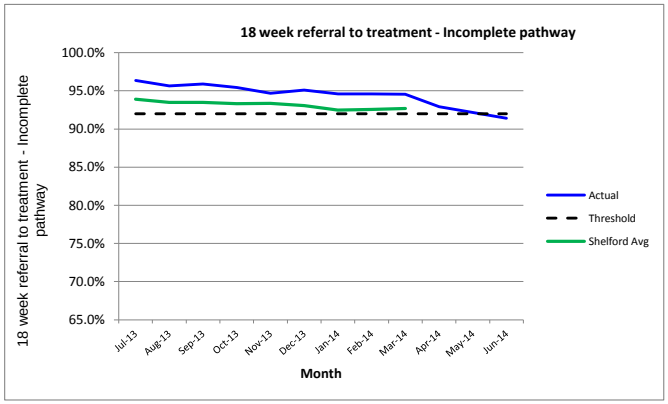


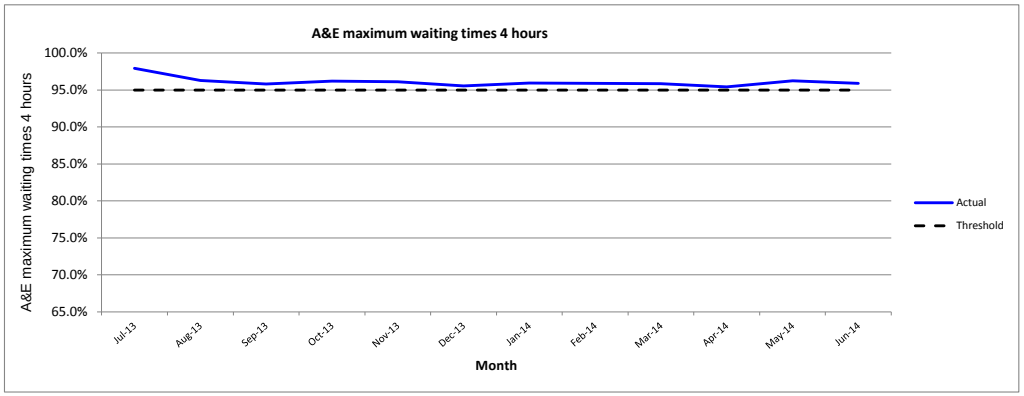


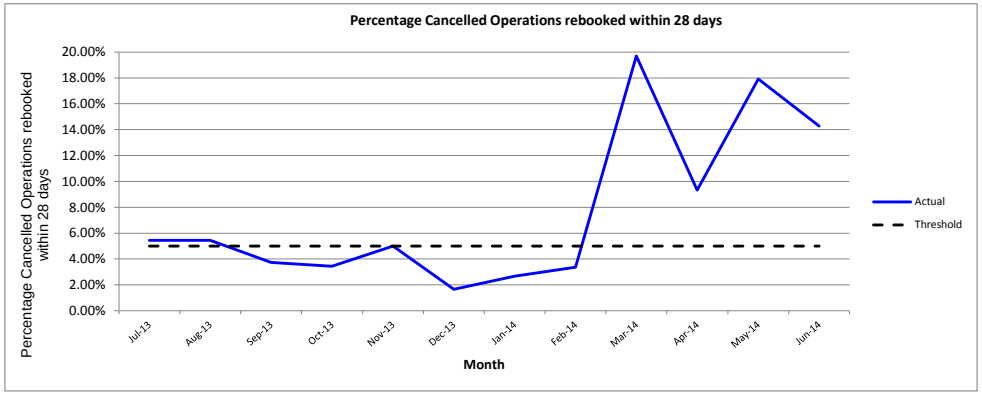
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Elective Access															
18 weeks referral to treatment - admitted	-	Mth	90%	93.3%	92.5%	88.0%	88.87%				88.87%				Mon, TDA, CQC
18 weeks referral to treatment - non admitted	-	Mth	95%	96.8%	96.8%	94.3%	94.66%				94.66%				Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	-	Mth	92%	96.5%	96.0%	91.4%	92.15%				92.15%				Mon, TDA, CQC
A&E Quality															
A&E maximum waiting times 4 hours	✓	Mth	95%	96.6%	96.2%	95.9%	95.86%				95.86%				Mon, TDA, CQC
Other Access Measures															
Percentage Cancelled Operations rebooked within 28 days	✓	Mth	<5%	9.1%	9.4%	14.3%	13.61%				13.61%				TDA, CQC



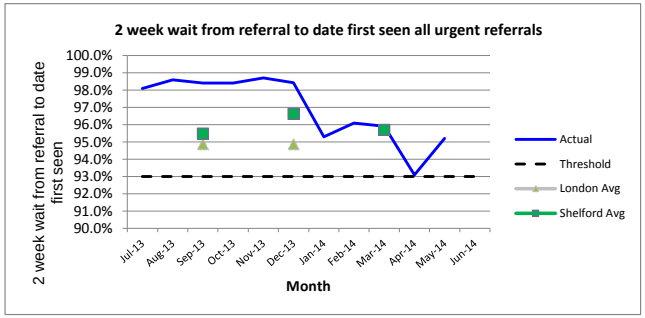


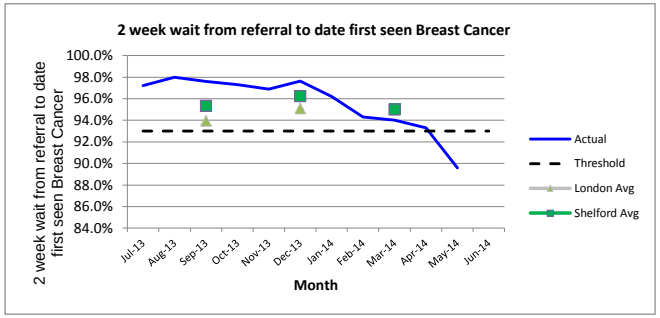


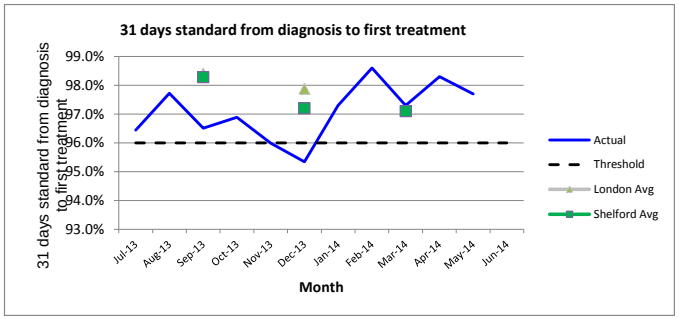


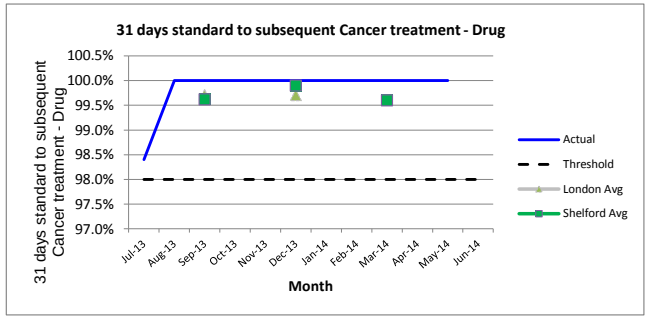


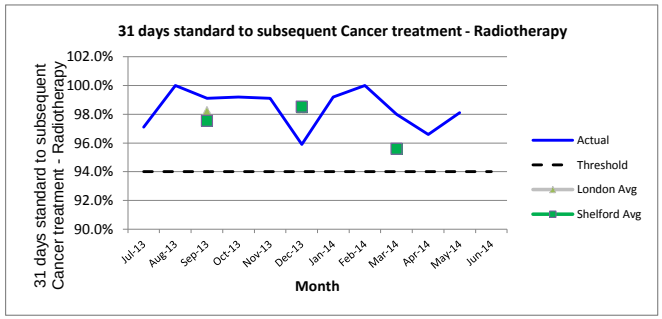
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 May	Performance in 2013/14 Q1-13	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Source Framework
Cancer Access Waiting Times															
2 week wait from referral to date first seen all urgent referrals	✓	Qtr	93%	97.9%	98.3%	95.2%					94.2%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer	✓	Qtr	93%	98.0%	97.6%	89.6%					91.5%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment	-	Qtr	96%	91.7%	94.4%	97.7%					98.0%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug	-	Qtr	98%	100.0%	100.0%	100.0%					100.0%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy	-	Qtr	94%	97.8%	97.5%	98.1%					97.4%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery	-	Qtr	94%	95.7%	96.1%	96.4%					95.4%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral	-	Qtr	90%	97.4%	91.3%	97.1%					95.7%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral	-	Qtr	85%	74.5%	74.3%	90.3%					92.1%				Mon, TDA, CQC

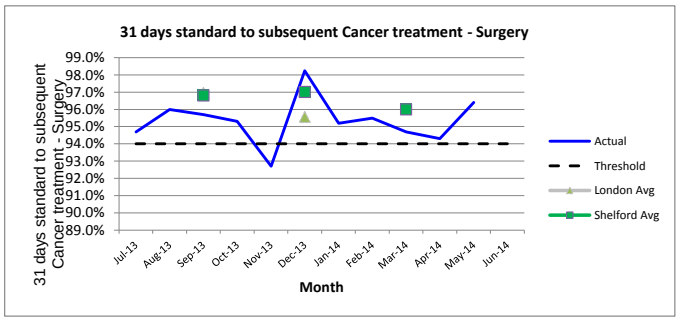


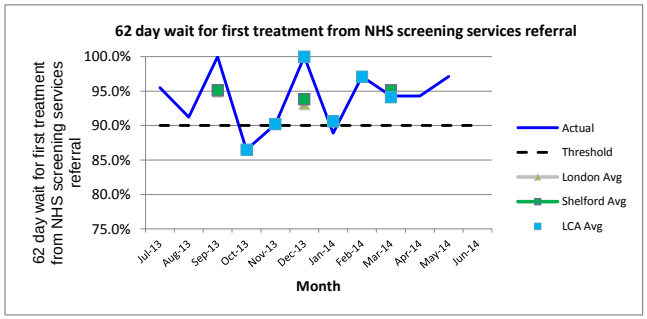


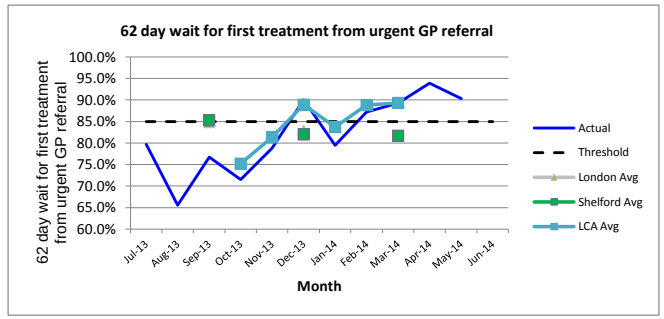




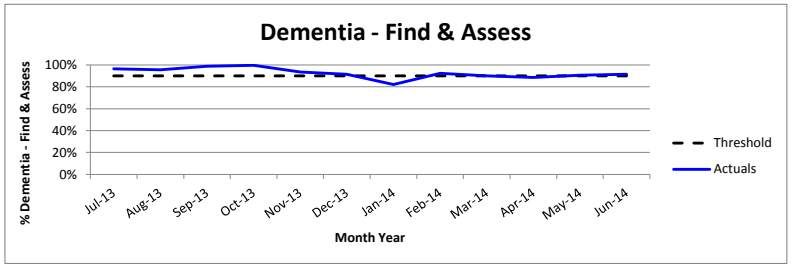


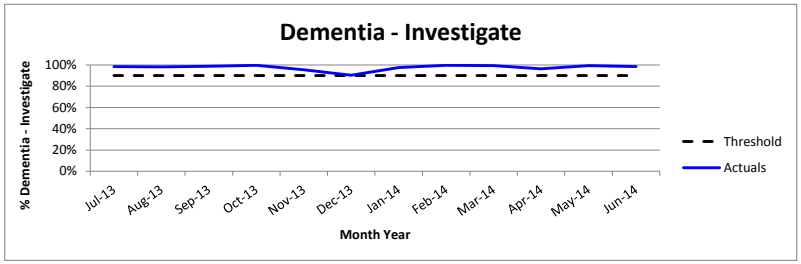


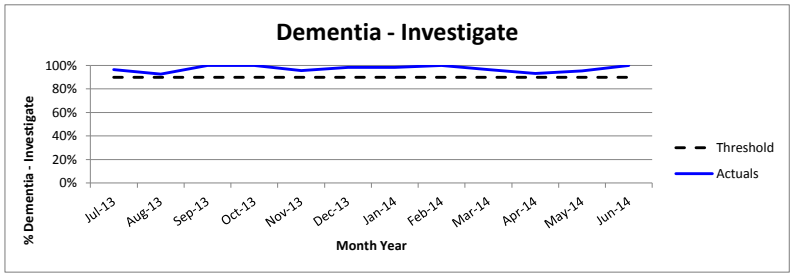


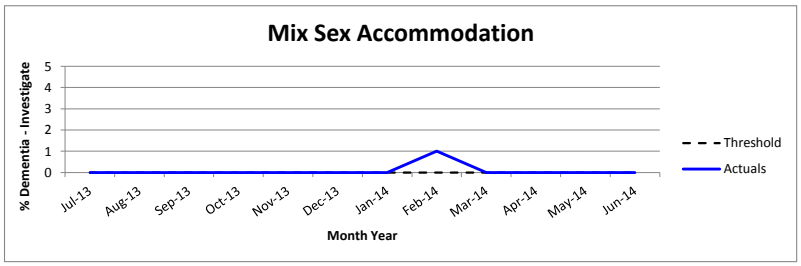


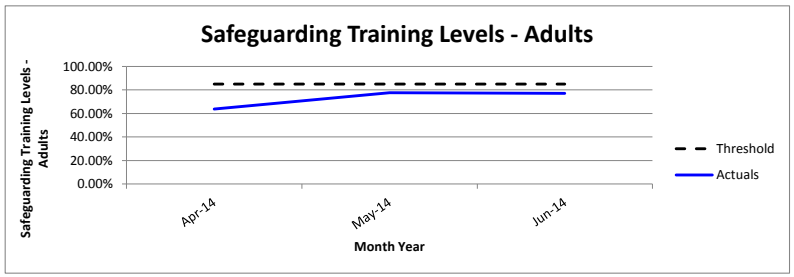
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
CQUIN - Dementia															
CQUIN - Dementia - Find & Assess	-	Mth	90%	96%	94%	91%	90.22%				90.22%				Contractual
CQUIN - Dementia - Investigate	-	Mth	90%	98%	97%	99%	98.07%				98.07%				Contractual
CQUIN - Dementia - Refer	-	Mth	90%	96%	94%	100%	96.18%				96.18%				Contractual
Accomodation															
Mixed Sex Accommodation	-	Mth	0	0	0	0	0				0				TDA
Safeguarding Training Levels															
Safeguarding Training Levels Adults	-	Mth	85%	n/a	n/a	77.01%	72.87%				72.87%				Define
Indicators to developed															
Safeguarding Training Levels Children															
*Patients detained under the MH Act **															

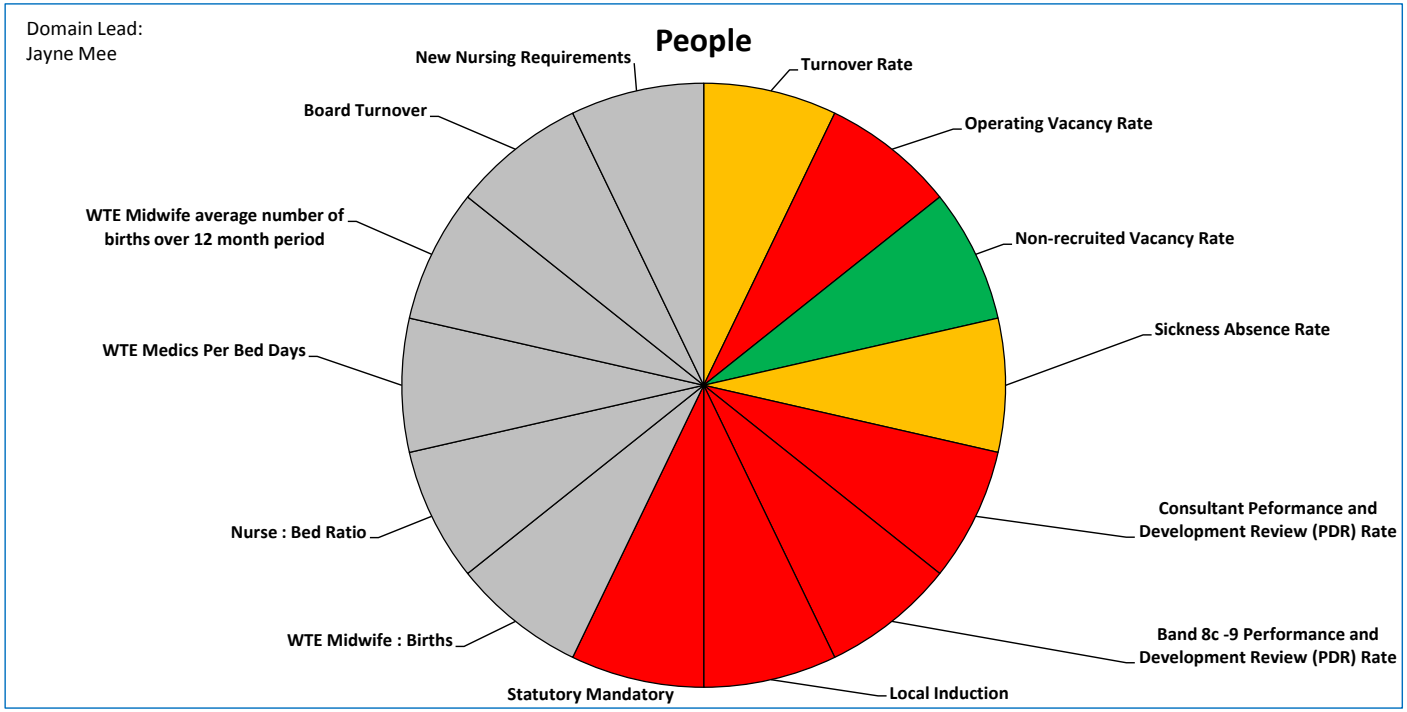












*Clarity as to how these indicators are measured and which domain they are included in is being proposed and will be refreshed in the next integrated performance scorecard.

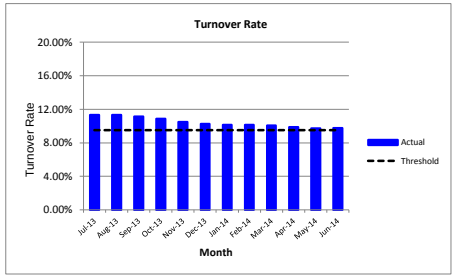
Current performance which meets or exceeds target

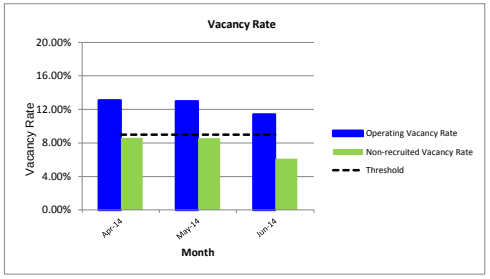
Current performance which is not meeting target but is within 10% of target

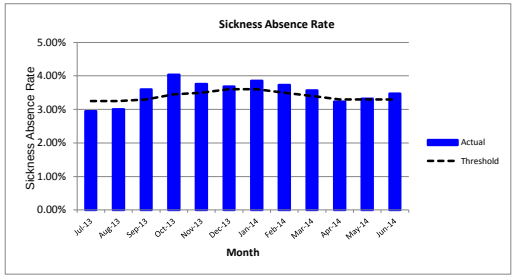
Current performance which is not meeting target within 10%

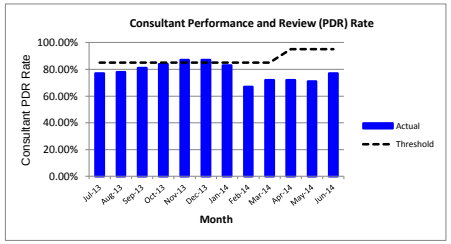
Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	Rolling 12 Months Position	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Turnover & Vacancy Rate															
Turnover Rate	✓	Mth	<9.50%	11.60%	11.61%	9.76%	9.78%				9.76%				TDA
Operating Vacancy Rate	✓	Mth	<9.00%	n/a	n/a	11.42%	12.50%								CQC
Non-recruited Vacancy Rate	✓	Mth	<9.00%	n/a	n/a	6.14%	7.77%								CQC
Sickness Absence Rate	✓	Mth	<3.4%	3.14%	3.13%	3.47%	3.34%				3.50%				CQC
Appraisal Rates															
Consultant Peformance and Development Review (PDR) Rate	✓	Mth	>95.00%	75.00%	70.84%	77.00%	73.33%								Define
Band 8c -9 Performance and Development Review (PDR) Rate	✓	Mth	>95.00%	n/a	n/a	96.08%	43.48%								Define
Training Compliance															
Local Induction	✓	Mth	>95.00%	73.94%	74.04%	78.20%	77.01%								Define
Statutory Mandatory	✓	Mth	>95.00%	71.58%	71.82%	68.55%	69.20%								Define
Bank and Agency Spend															
Bank Spend (%)	✓	Mth	<7.00%	n/a	n/a	5.84%	5.61%				11.23%				Define
Agency Spend (%)	✓	Mth	<7.00%	n/a	n/a	7.76%	8.10%								Define
Corporate Welcome															
Corporate Welcome Attendance	✓	Mth	>100.00%	n/a	n/a	77.85%	79.68%								Define

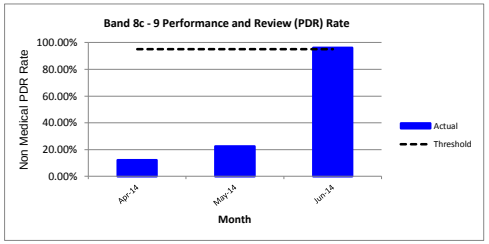
Indicators to be developed
WTE Midwife : Births
Nurse : Bed Ratio
WTE Medics Per Bed Days
WTE Midwife average number of births over 12 month period
Board Turnover
New Nursing Requirements

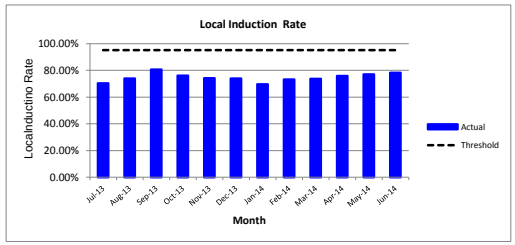


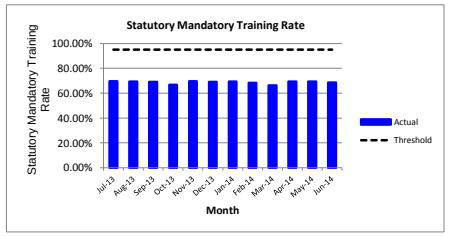


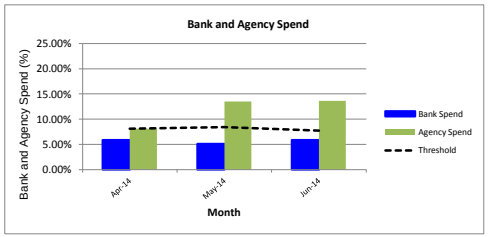


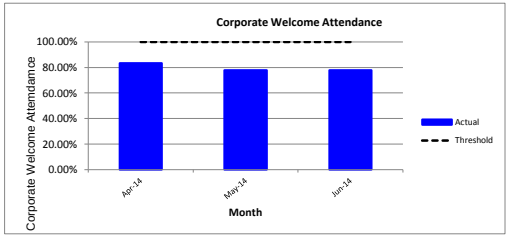










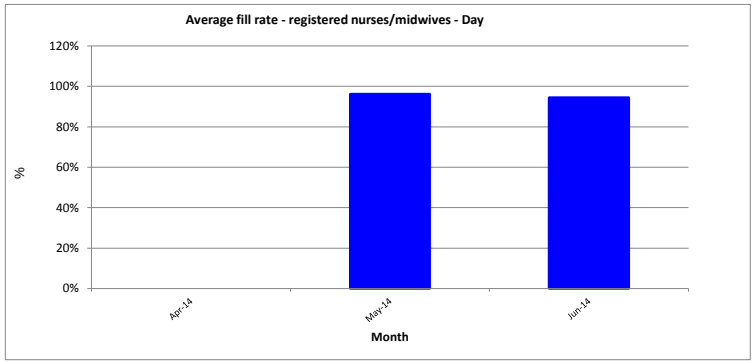


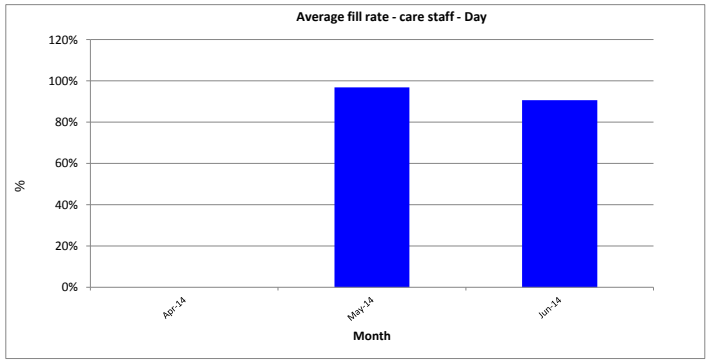
People KPI Report ~ Current Performance - June 2014

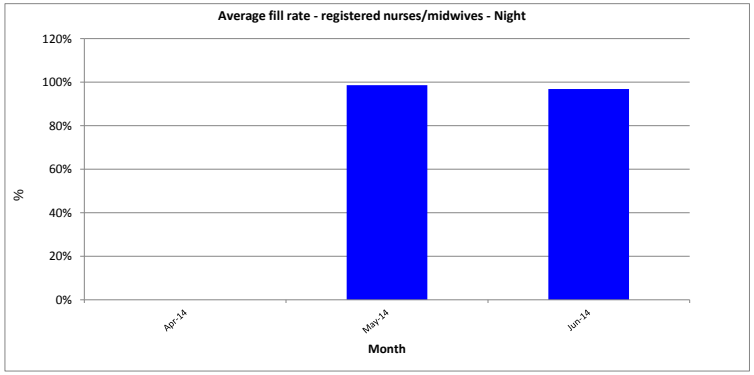
Establishment & People	General Ledger (GL) Establishment WTE	ESR Established WTE	Variance GL & ESR Post WTE	ESR Inpost WTE	Worked Bank WTE	Worked Agency WTE	Total People WTE (inpost/b&a)	Variance Total People against ESR Establishment	Variance Total People against GL Establishment
Trust Overview	9,822	10,068	246	8,918	552	1,024	10,494	426	672

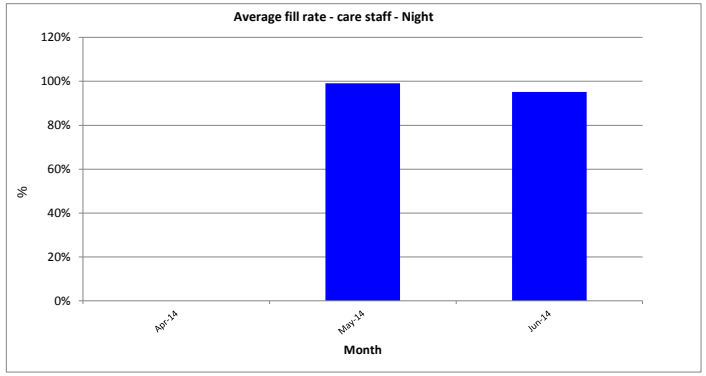
Month 3 June 2014	Period	KPI Target	Current Performance	Performance Flag	Current Performance and Plans to Improve
Vacancy Rate %	in month	9.00%	11.42% operational vacancy rate & 6.14% non-recruited to vacancy rate	red - operating vacancy rate & green non-recruited vacancy rate	As a result of the recent vacant post audit across the Trust, and an additional 42 WTE directly employed, the Trust's overall operating vacancy rate at the end of June decreased from 12.99% to 11.42%. The vacant post audit identified posts to the value of 150 WTE which have been removed from the ESR post establishment. The remaining vacant posts are either involved in the recruitment process or are due to begin the recruitment process shortly. Cerner support during June was provided through 144 WTE agency workers which will be replaced with 67 WTE substantive employees over the coming months (funded for 14/15 & 16/17) working within the Divisions. We currently have 532 successful candidates waiting to join the Trust which adjusts the vacancy rate to a non-recruited rate 6.14%. The new centralised recruitment , along with rolling recruitment campaigns continue to work to fill active vacancies throughout the Trust and reduce the requirement for bank and agency workers. Supporting this are the bespoke Strategic People Planning models for each Division.
Ward / Inpatient Staffing Levels	current operating band 2~6 vacancy rate on ward/inpatient areas is 13.65% (down from 14.26% in May) with an adjusted non-recruited vacancy rate of 4.71%, taking into account candidates waiting to join including those from the recent Division of Surgery recruitment campaign to India				In month, the band 2-6 vacancy level for Nursing and Midwifery staff within our ward and inpatient areas decreased from 14.3% to 13.65%; due to an increase of 25 WTE in the numbers directly employed. There are currently over 290 WTE Nursing & Midwifery candidates waiting to join the Trust, bringing the non-recruited to vacancy rate for this occupational group to 4.71%. Monitoring of the band 2-6 vacancies within our Divisions continues to be supported by detailed monthly reporting at Divisional, ward and banding level as well as the development and use of a bespoke strategic people plan for each Division, to pro-actively manage the vacancies and turnover associated with this specific group. The central Resourcing Team continue to work with the Divisions to facilitate these plans through the centralised recruitment process, actively supported by the Nursing & Midwifery Recruiters.
B & A Spend as % of total paybill	in month	7.20%	13.60% (7.76% agency & 5.84% bank)	red	Bank and agency spend, as a % of our total paybill, increased marginally from to 13.53% in May to 13.60% in June ; 7.76% agency spend and 5.84% bank spend. As part of the Task & Finish Roster Group, best practice guidelines for managing bank and agency are being discussed, and when agreed will be implemented across all Divisions. During June, total requests for Nursing & Midwifery temporary staffing reduced to 705 WTE (down from 757 WTE) of which 584 WTE was filled and worked (down from 613 WTE). Support for Cerner also reduced during June from 237 WTE to 144 WTE with recruitment commenced to recruit 67 WTE (2-year funded) Cerner support posts. In terms of spend, a total of £6.26m was spent during June on bank and agency by the Divisions and Corporate Directorates, which shows a significant increase from the £3.71m spent during the same period last year (equivalent of 8.80% of the June 2013 paybill).
	rolling 12-mths	7.00%	11.23%	red	
Turnover Rate %	rolling 12-mths	9.50%	9.76%	amber	Voluntary turnover (rolling 12-month period) has remained at 9.76% in June although still showing a decrease on the position in June 2013 of 10.58%. Our voluntary turnover rate is the second lowest when compared to 5 other London Acute Teaching Trusts. Information from exit interviews and Engagement Survey's are being used by the Divisions to understand why our people chose to leave with appropriate actions plans put into place to improve our people experience. Supporting this is the information received from our new on boarding survey which goes to all of our new people when they have been with us for 3 months. Reducing times to recruit, managing sickness absence and ensuring that our people are recognised through the Make a Difference scheme all work to improve our people experience which will also reduce levels of unwanted turnover.
Sickness Absence Rate %	in month	3.15%	3.47%	amber	Recorded sickness absence increased in month from 3.32% to 3.47%; bringing the rolling 12-month position to 3.50% against 14/15 target of 3.30%. Significant increases (19.0%) were seen in-month in sickness absence for anxiety/stress and back related illness; both these illness reasons have been analysed and assessed as part of the Well-Led Desktop Assessment in preparation for the CIH inspection in September and areas where the levels are higher than expected are being fed back to the Divisions. Across the organisation, sickness absence levels vary in-month; within Divisions from 3.1% to 4.0%, within Corporate Directorates from 0.0% to 4.3%. Also by occupational group, ranging from 0.10% for our Consultants to 3.0% for Qualified Scientific & Technical to 6.8% for Unqualified Nursing & Midwifery support.
	rolling 12-mths	3.30%	3.50%	amber	
Performance & Development Review (PDR) % - bands 8c~9	in month	95.00%	96.08%	green	The end of June saw the completion of the first milestone for the new Performance Development and Review (PDR) process. All of our band 8c - 9 people were expected to have had a PDR review with their manager and the overall compliance rate for the Trust for this cohort is 96.08%; outstanding PDR's for this group have been scheduled to take place as soon as possible. The next milestone is the end of September when we expect all of our band 7 - 8b people to have had a PDR. Over 1120 Trust managers have booked to attend the bespoke PDR training which accompanies the new process, of which, 727 have already attended, completed and been licensed to carry out PDR's with their people. The first new monthly PDR report will be delivered to the Divisions and Corporate Directorates during July, looking not just at the compliance rate but also the rating spread of the completed PDR's.
Consultant Appraisal %	in month	95.00%	77.00%	red	The Consultant PDR rate has risen in-month from 71% to 77% but remains significantly below the 95% target. With the process for revalidation requiring PDR's to be completed and evidenced, there is a risk that with revalidation will not being approved if the PDR's have not been completed. The Medical Director's office are proactively monitoring the compliance rates through Divisional reporting along with a personal invitations to non-compliant Consultants to meet with the Medical Director. Chiefs of Service, within the Divisions are leading the drive within the Divisions to ensure compliance of this core people metric.
Corporate Welcome	in month	75.00%	77.61%	green	The performance measurement, for this new metric, has been revised to reflect more accurately the numbers of new joiners who attend Corporate Welcome when they join the Trust. All new joiners are required to attend Corporate Welcome within the first 8 weeks of their employment, with the expectation that they attend as soon possible. The metric now measures performance against the expectation that at least 75% of new joiners attend a Corporate Welcome session within a month of joining the Trust. Monitoring of this metric, at departmental / ward level, is done monthly through the MPI report for each Division and Corporate Directorate with some areas linking joining dates with Corporate Welcome sessions to ensure their new joiners attend on their first day at the Trust.
Statutory Mandatory Training Compliance (non-medical) %	in month	95.00%	68.55%	red	Statutory & Mandatory training compliance for all of our people (excluding doctors in training) decreased from 69.52% to 68.55% during the month of June. This decrease is due to a large number of people becoming non-compliant as their refresh date passed. The central Statutory & Mandatory training team is working in partnership with the Divisions to resolve queries and address issues supported by ongoing work in four main areas to increase compliance; (1) Review of ESR and ICT systems and processes which affect data quality of mandatory training data (2) Review of reporting tool (3) Improving completion of e-learning rates for new starters and those due for refresher training (4) Review of the denominator for Mandatory training. The Divisions and Corporate Directorates use the monthly MPI report to identify and focus effort on individual department and wards; agreeing improvement action plans with managers who have low compliance rates for this important metric.
Local Induction Compliance %	in month	95.00%	78.20%	red	Local Induction compliance increased from 76.99% to 78.20% in June, the fifth consecutive month of improvement. However, this performance remains significantly below the 95% target. A number of strategies have been put into place within the Divisions to increase compliance for this key people metric. A main area of focus is ensuring that the OLM coordinators are equipped with information data to target, contact and educate the managers regards the training requirements and completion of this training. Weekly and monthly monitoring discussions, with line managers responsible for areas with low compliance, are taking place with locally agreed improvement plans for progress. Also identifying departments with specific issues to focus support and help in improving their performance against this metric.

Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Staffing: Nursing, midwifery and care staff															
Average fill rate - registered nurses/midwives (%) - Day		Mth	tbc	n/a	n/a	94.40%	95.56%				95.56%				Contractual
Average fill rate - care staff (%) - Day		Mth	tbc	n/a	n/a	90.71%	93.77%				93.77%				Contractual
Average fill rate - registered nurses/midwives (%) - Night		Mth	tbc	n/a	n/a	96.82%	97.72%				97.72%				Contractual
Average fill rate - care staff (%) - Night		Mth	tbc	n/a	n/a	95.23%	97.08%				97.08%				Contractual



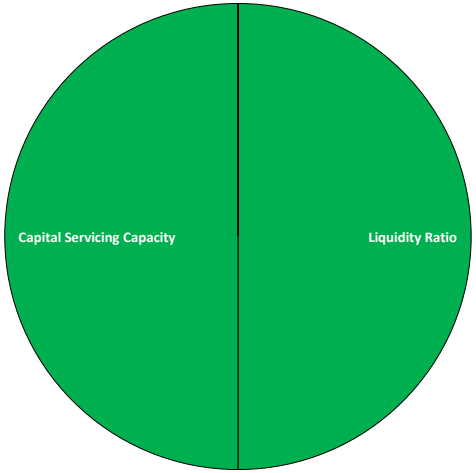






Domain Lead:
Bill Shields

Finance - Continuity of Services Risk Rating



Quality Principles - Finance 8.1

Financial & Continuity of Service Risk Rating

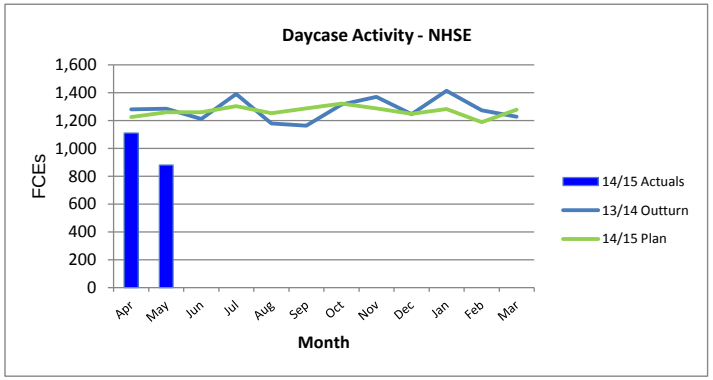
Imperial College Healthcare NHS Trust

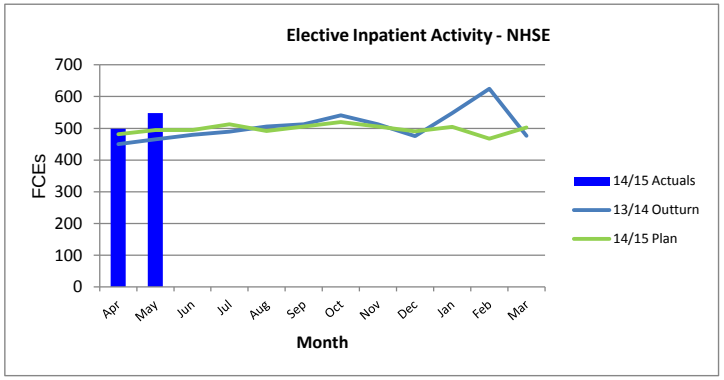
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 June	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Continuity of Service Risk Rating														
Liquidity Ratio		Mth	50%	n/a	4	3	3							
Capital Servicing Capacity		Mth	50%	n/a	4	3	3							
Overall Continuity of Service Risk Rating						3	3							

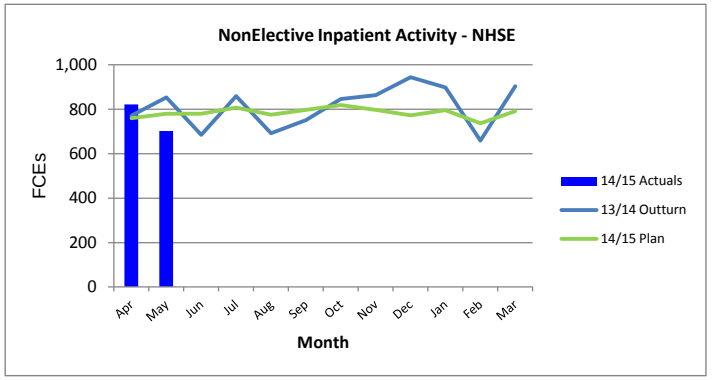
Activity performance against plans commissioned by NHSE

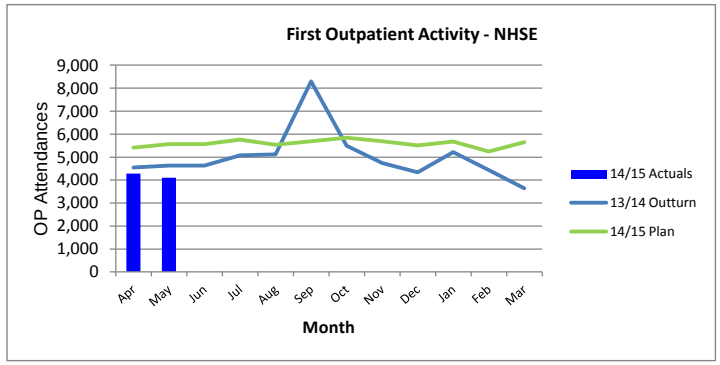
Imperial College Healthcare NHS Trust

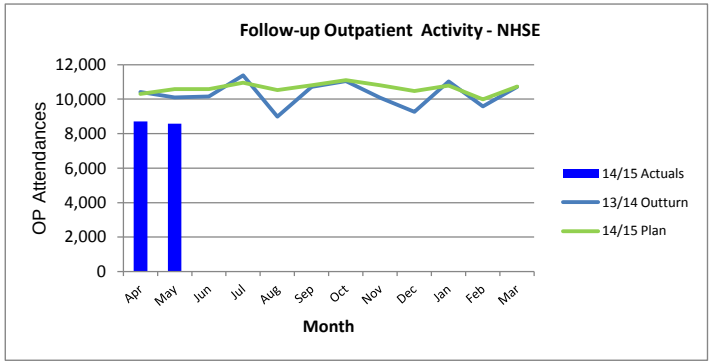
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 May	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Daycase		Mth	1,259	1,285	3,775	880					1,989				Contractual
Elective Inpatients		Mth	495	465	1,394	548					1,046				Contractual
NonElective Inpatients		Mth	780	853	2,310	702					1,524				Contractual
First Outpatient		Mth	5,564	4,630	13,813	4,098					8,380				Contractual
Follow-up Outpatient		Mth	10,581	10,100	30,674	8,578					17,278				Contractual
Adult Critical Care		Mth	1,373	1,325	4,378	1,277					2,312				Contractual

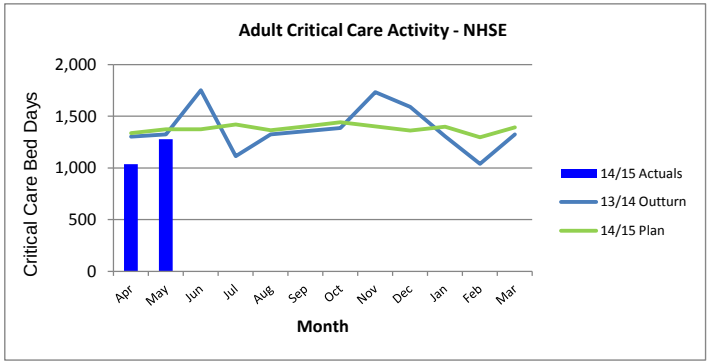






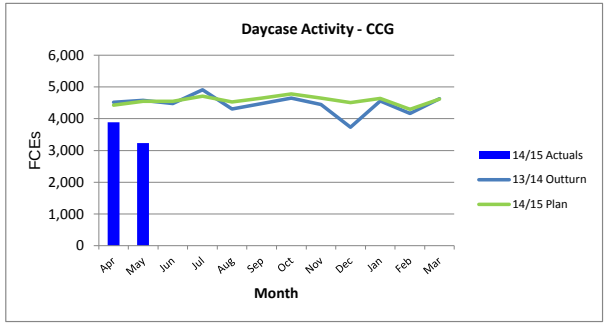


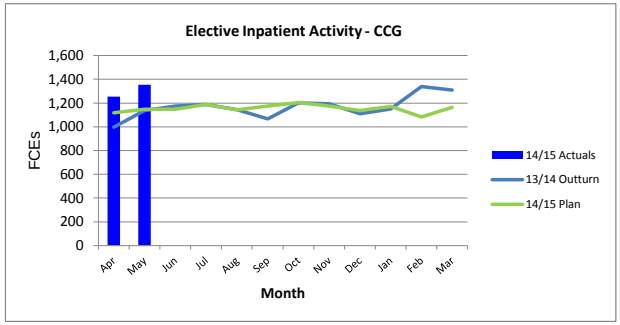


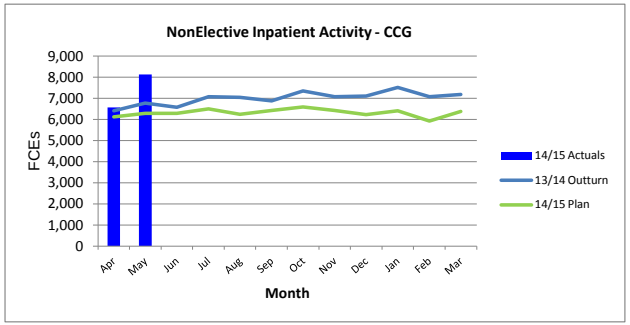


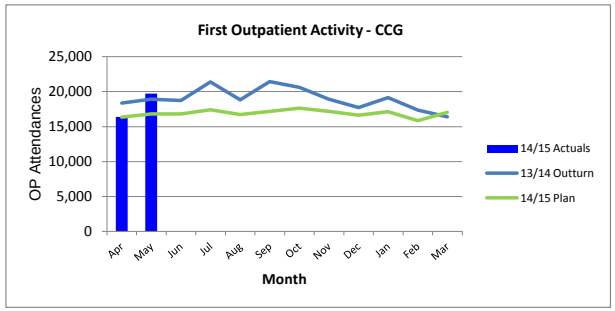
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are not included. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently not shown.

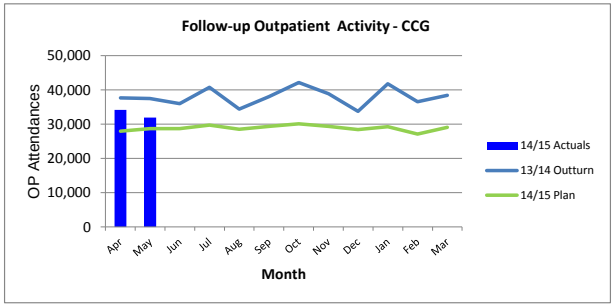
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 May	Performance in 2013/14 Qtr1	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Source Framework
Daycase		Mth	4,551	4,576	13,574	3,231					7,121				Contractual
Elective Inpatients		Mth	1,148	1,136	3,307	1,355					2,610				Contractual
NonElective Inpatients		Mth	6,281	6,771	19,740	8,128					14,689				Contractual
First Outpatient		Mth	16,801	18,909	56,007	19,725					36,122				Contractual
Follow-up Outpatient		Mth	28,698	37,440	111,085	31,885					66,054				Contractual
Adult Critical Care		Mth	1,873	1,950	5,567	1,910					4,076				Contractual
A&E Attendances		Mth	16,626	16,917	50,068	17,593					35,018				Contractual

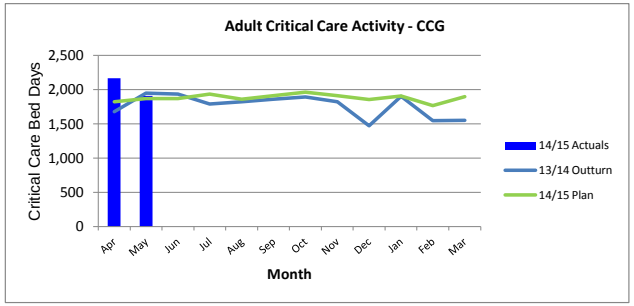


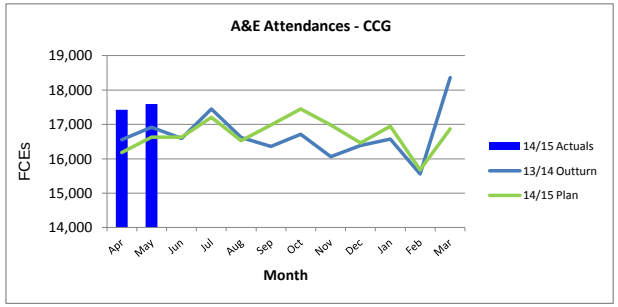












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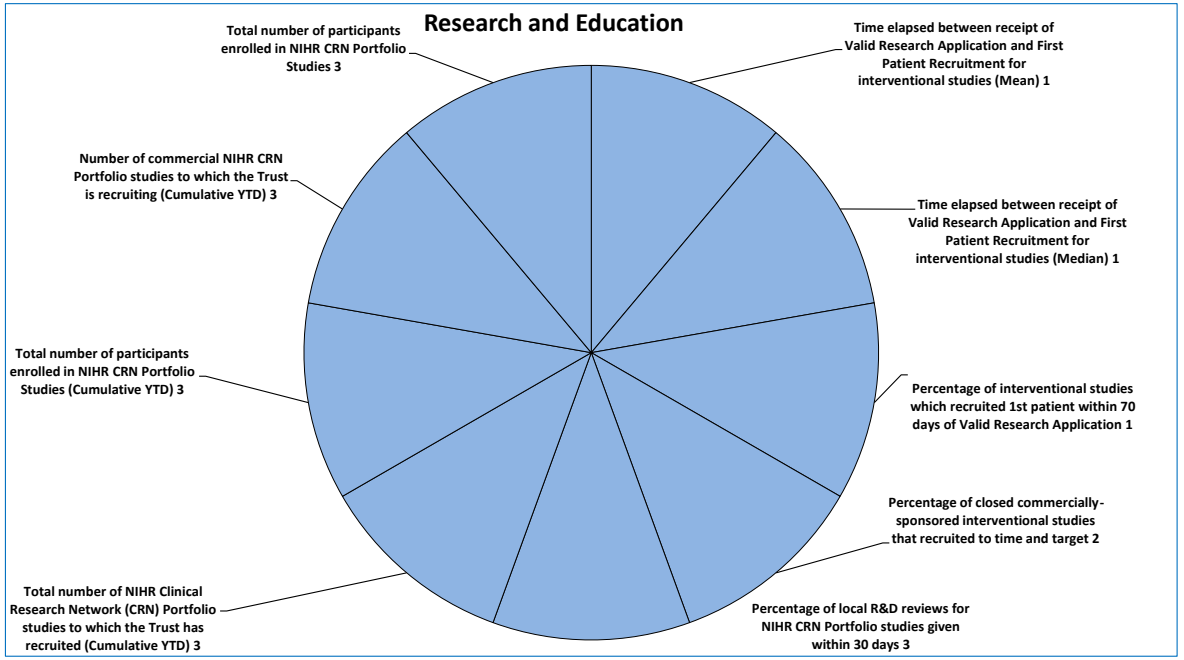
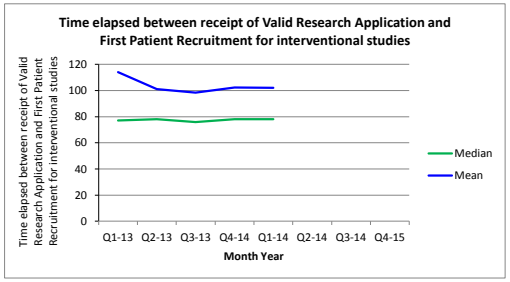

Research and Education
Total number of participants enrolled in NIHR CRN Portfolio Studies 3
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Mean) 1
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Median) 1
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 1
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 2
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 3
Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days 3

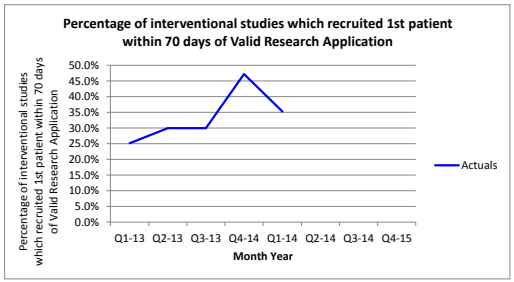
Indicator	Leading	Frequency	Threshold	Performance in 2013/2014 Q1	Performance Current Q1-14	Q2-14	Q3-14	Q4-15	YTD	Forecast 2014/15 Q1	2014/15 Q2	2014/15 Q3	Source Framework
Research & Development													
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Mean)** [1]		Qtr	*tbc*	114	102				102				Define
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Median)** [1]		Qtr	*tbc*	77	78				78				Define
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application [1]		Qtr	*tbc*	25.2%	35.3%				35.3%				Define
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 2		Qtr	*tbc*	28	46				46				Define
Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days [2]		Qtr	*tbc*	58.00%	52.00%				52.00%				Define
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) [3]		Qtr	*tbc*	182	145				145				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) [3]		Qtr	*tbc*	2857	1792				1792				Define
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) [3]		Qtr	*tbc*	18	19				19				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies [3]		Qtr	*tbc*	101	85				85				Define

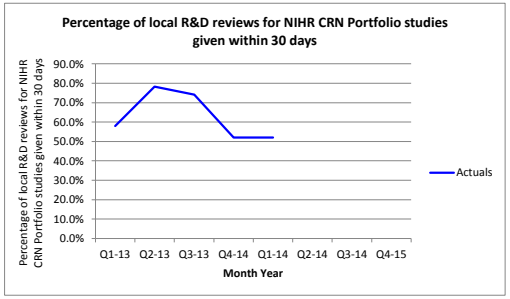
[1] Data source: IC BRC quarterly returns to NIHR CCF.

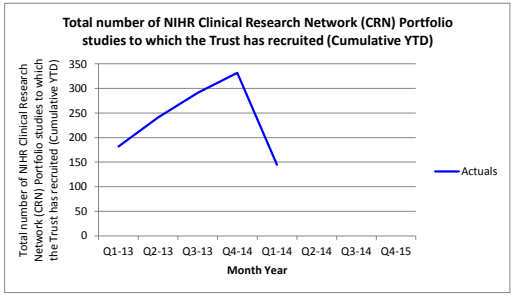
[2] Data source: monthly performance reports from NWL CLRN; data include all study suspensions.

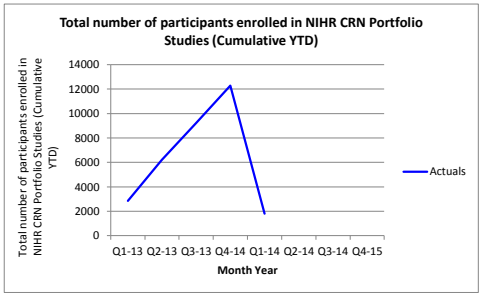
[3] Data source: CLRN Recruitment Summary – Individual CLRNs reports from NIHR portal for 15 March 2014. Period analysed = Q1 (April to June); Q2 (April to September); Q3 (April to December) in each FY. COSMOS study not included in recruitment totals.

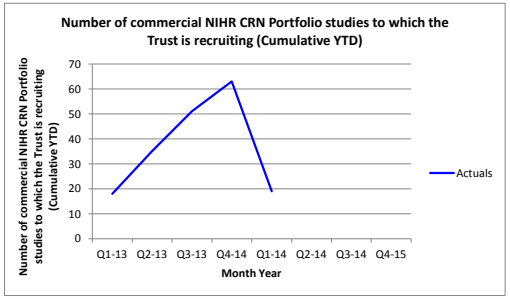


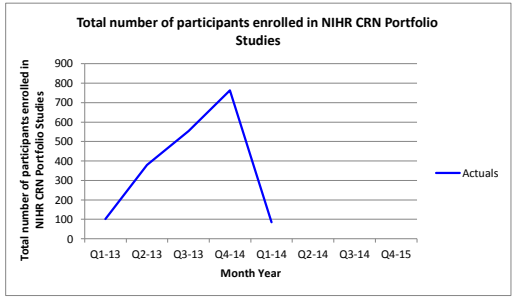












Page number	Indicator title	Description	Rating
3	Capital Servicing Capacity	The degree to which the provider can meet its financing obligations	Scored between 1-4: '4' – Low risk '3' – Emerging or residual financial concern '2' – Financial position may require '1' – as with '2' and may instigate
3	Liquidity ratio	The fundamental working capital position of the organisation	as with Capital Servicing Capacity
3	18 weeks referral to treatment	The percentage of patients that received treatment within 18 weeks of referral on the relevant pathway.	Operational standards: Admitted ≥90% Non-admitted ≥95% Incomplete pathway ≥92%
3	2 week wait from referral to date first seen all urgent referrals	The percentage of patients that were seen within 2 weeks for a referral of suspected cancer.	Operational standards: ≥93%
3	2 week wait from referral to date first seen breast cancer	The percentage of patients that were seen within 2 weeks for a referral of suspected breast cancer.	Operational standard: ≥93%
3	31 days standard from diagnosis to first treatment	The percentage of patients that were treated within 31 days of diagnosis of cancer	Operational standard: ≥96%
3	31 days standard to subsequent cancer treatment	The percentage of patients that received subsequent cancer treatment within 31 days of decision to treat.	Operational standard: Drug-based ≥98% Radiotherapy ≥94% Surgery ≥94%
3	62 day wait for first treatment from NHS Screening Services referral / GP referral	The percentage of patients that received first definitive treatment within 62 days of referral for suspected cancer	Operational standard: NHS Screening Services ≥90% GP referral ≥85%
3	A&E maximum waiting times 4 hours	The percentage of patients that were admitted, treated, or discharged within 4 hours of presenting to A&E services.	Operational standard: ≥95%
3	Clostridium Difficile (C-Diff) Post 72 hours	The number of cases of *Clostridium Difficile* within the Trust	Threshold: 65 cases
3	CQC Judgements – warning notice issued, civil and / or criminal action initiated	TBD	TBD
3	Third party reports from e.g. GMC, Ombudsman, medical Royal Colleges etc – judgement based on severity and frequency of reports	TBD	TBD

5	Hospital Standardised Mortality Rate (HSMR)	The Trust's mortality rate, after being adjusted for a variety of factors, including *population size, age profile, level of poverty, range of treatments and operations provided, e* tc.	TBD
5	Summary Hospital Mortality Indicator	The ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. A high rate may indicate problems with the safety and quality of care.	TBD
5	Number of Dr Foster morality alerts	TBD	TBD
5	Number of deaths in low risk diagnostic groups	A high rate of deaths for conditions normally associated with a very low rate of mortality may indicate potential risks in the quality and safety of care	TBD
6	MRSA	Methicillin-resistant Staphyloccocus Aureus (MRSA) is a type of bacterial infection that is resistant to a number of widely used antibiotics. This rating indicates the number of cases of MRSA infections within the Trust during the previous calendar month	Operational Standard: 0 incidences
6	MRSA (latest CQC report)	The number of cases of Methicillin-resistant Staphyloccocus Aureus (MRSA) infections reported in the latest CQC report	Operational Standard: 0 incidences
6	Clostridium Difficile (C-Diff) Post 72 Hours	C-Diff is a type of bacterial infection that can affect the digestive system. This rating indicates number of cases of C-Diff that are identified 72 hours after admission	Operational Standard: 65 incidences per annum
6	Clostridium Difficile (latest CQC report)	This rating indicates the number of cases of C-Diff infections reported in the latest CQC report.	Operational Standard: 0 incidences
6	Never Events	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The incidence of never events may indicate unsafe care. This rating indicates the number of never events that have occurred within the Trust during the reporting period.	Operational Standard: 0 incidences
6	Serious Untoward Incidents (SUI)	An SUI is a serious incident or event which led, or may have led, to the harm of patients or staff. This rating indicates the number of SUIs that have occurred within the Trust during the reporting period.	TBC
6	Harm Free Care (Safety Thermometer)	The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing incidences of: Pressure Ulcers; Falls; Urinary Tract Infections (UTIs) in patients with a catheter; & new Venous Thromboembolisms (VTEs). 'Harm Free Care' is the absence of all four harms. This rating notes the percentage of patients that remained Harm Free whilst under our care.	Operational Standard: ≥90%
6	VTE Risk Assessments	The percentage of patients that have been risk assessed for Venous Thromboembolism within 24 hours of admission.	Operational Standard: ≥95%

7	Inpatients Net Promoter Score (FFT)	This is an indicator of overall patient experience of the service received as an inpatient. Patients would recommend service to others if they have had a good experience. Patients and family should all have access to this survey	TBC
7	Inpatients Net Promoter Response Rate	This indicates the response rate regarding the Inpatient Friends and Family Test.	Response rate: Total trust-level respondents,
7	A&E Net Promoter Score (FFT)	This is an indicator of overall patient experience of the service received in A&E. Patients would recommend service to others if they have had a good experience. Patients and family should all have access to this survey	TBC
7	A&E Net Promoter Response Rate	This indicates the response rate regarding the A&E Friends and Family Test.	Response rate: Total trust-level respondents,
7	Maternity Net Promoter Score (FFT)	This is an indicator of overall patient experience of the service received in the maternity service. Patients would recommend service to others if they have had a good experience. Patients and family should all have access to this survey	TBC
7	Maternity Net Promoter Response Rate	This indicates the response rate regarding the Maternity Service's Friends and Family Test.	TBD
7	Number of complaints received	**TBD**	**TBD**
7	PLACE – Cleanliness	**TBD**	**TBD**
7	PLACE – Food	**TBD**	**TBD**
7	PLACE – Privacy, Dignity, & Well being	**TBD**	**TBD**
7	PLACE – Facilities	**TBD**	**TBD**
7	(LQ36) Have you been treated with dignity and respect by staff on this ward?	**TBD**	**TBD**
7	Safeguarding Adults : Referrals per month	**TBD**	**TBD**
8	Stroke Care : % of patients scanned within 1 hr of arrival at hospital	NICE Guideline Recommendation: Brain imaging should be performed immediately (ideally the next slot and definitely within 1 hour, whichever is sooner) for people with acute stroke	Operational standard: ≥50%
8	Stoke Care : % of potentially eligible patients thrombolysed	**TBD**	**TBD**
9	Theatre Utilisation Rate	**TBD**	**TBD**
9	Average Length of Stay - Elective	**TBD**	**TBD**
9	Average Length of Stay – Non Elective	**TBD**	**TBD**
9	Pre Op Length of Stay	**TBD**	**TBD**
9	Post Op Length of Stay	**TBD**	**TBD**
9	Day of Surgery Admission	**TBD**	**TBD**
9	Day Case Rate	**TBD**	**TBD**
9	DNA – first Appointment	**TBD**	**TBD**
9	DNA – follow-up appointment	**TBD**	**TBD**
9	Hospital Appointment Cancellations (hospital instigated)	**TBD**	**TBD**
9	Appointments Not Checked In or DNA'd (Appointment Date within the last 90 days)	**TBD**	**TBD**
9	Appointments in a status of Checked In but not Checked Out	**TBD**	**TBD**

10	18 weeks referral to treatment	The percentage of patients that received treatment within 18 weeks of referral on the relevant pathway.	Operational standards: Admitted ≥90% Non-admitted ≥95% Incomplete pathway ≥92%
10	A&E maximum waiting times 4 hours	The percentage of patients that were admitted, treated, or discharged within 4 hours of presenting to A&E services.	Operational standard: ≥95%
10	Percentage Cancelled Operations rebooked within 28 days	Where patients' operations are cancelled at the last minute, they must be provided with a new date to occur within 28 days of the cancelled operation date.	Operational standard: <5%
11	2 week wait from referral to date first seen all urgent referrals	The percentage of patients that were seen within 2 weeks for a referral of suspected cancer.	Operational standards: ≥93%
11	2 week wait from referral to date first seen breast cancer	The percentage of patients that were seen within 2 weeks for a referral of suspected breast cancer.	Operational standard: ≥93%
11	31 days standard from diagnosis to first treatment	The percentage of patients that were treated within 31 days of diagnosis of cancer	Operational standard: ≥96%
11	31 days standard to subsequent cancer treatment - Drug	The percentage of patients that received subsequent cancer treatment within 31 days of decision to treat.	Operational standard: Drug-based ≥98% Radiotherapy ≥94% Surgery ≥94%
11	62 day wait for first treatment from NHS Screening Services referral / GP referral	The percentage of patients that received first definitive treatment within 62 days of referral for suspected cancer	Operational standard: NHS Screening Services ≥90% GP referral ≥85%
12	CQUIN – Dementia – Find & Assess	**TBD**	**TBD**
12	CQUIN – Dementia – Investigate	**TBD**	**TBD**
12	CQUIN – Dementia – Refer	**TBD**	**TBD**
12	Mixed Sex Accommodation	**TBD**	**TBD**
12	Safeguarding Training Levels Adults	**TBD**	**TBD**
14	Turnover Rate	**TBD**	**TBD**
14	Operating Vacancy Rate	**TBD**	**TBD**
14	Non-recruited Vacancy Rate	**TBD**	**TBD**
14	Sickness Absence Rate	**TBD**	**TBD**
14	Consultant Performance and Development Review (PDR) Rate	**TBD**	**TBD**
14	Band 8c-9 Performance and Development Review (PDR) Rate	**TBD**	**TBD**
14	Local Induction	**TBD**	**TBD**
14	Statory Mandatory	**TBD**	**TBD**
14	Bank Spend (%)	**TBD**	**TBD**
14	Agency Spend (%)	**TBD**	**TBD**
14	Corporate Welcome Attendance	**TBD**	**TBD**
15	Agency fill rate – (*registered nurses / midwives; care staff)* (%)	**TBD**	**TBD**
	– (*day; night)*	**TBD**	**TBD**

18	Liquidity Ratio	**TBD**	**TBD**
18	Capital Servicing Capacity	**TBD**	**TBD**
19	Daycase	**TBD**	**TBD**
19	Elective Inpatients	**TBD**	**TBD**
19	Non Elective Inpatients	**TBD**	**TBD**
19	First Outpatient	**TBD**	**TBD**
19	Follow-up Outpatient	**TBD**	**TBD**
19	Adult Critical Care	**TBD**	**TBD**
20	Daycase	**TBD**	**TBD**
20	Elective Inpatients	**TBD**	**TBD**
20	Non Elective Inpatients	**TBD**	**TBD**
20	First Outpatient	**TBD**	**TBD**
20	Follow-up Outpatient	**TBD**	**TBD**
20	Adult Critical Care	**TBD**	**TBD**
20	A&E Attendances	**TBD**	**TBD**
22	Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (mean)	**TBD**	**TBD**
22	Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (median)	**TBD**	**TBD**
22	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	**TBD**	**TBD**
22	Percentage of closed commercially-sponsored interventional studies that recruited to time and to target	**TBD**	**TBD**
22	Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days	**TBD**	**TBD**
22	Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD)	**TBD**	**TBD**
22	Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD)	**TBD**	**TBD**
22	Total number of participants enrolled in NIHR CRN Portfolio Studies	**TBD**	**TBD**

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	2.5
Title	Finance Performance Report – June 2014
Report for	Monitoring
Report Author	Marcus Thorman – Director of Operational Finance
Responsible Executive Director	Bill Shields – Chief Financial Officer
Freedom of Information Status	Report can be made public

EXECUTIVE SUMMARY

1. The Trust's Income & Expenditure (I&E) position at the end of June was a deficit of £2.5m (after adjusting for the impairment of fixed assets and donated assets), an adverse variance against plan of £3.7m. Despite raising serious concerns in last month's report, the position continues to deteriorate and presents a major challenge to delivery of the Trust's objectives for the year, including achievement of Foundation Trust status. The financial position this month was supported by the release of old year accruals which has a one-off benefit to I&E but significantly weakens the balance sheet. In addition, accrued income of £5.1m for the full payment of the SLA performance fund and for un-coded activity relating to problems with reporting in Cerner has been included but both can be assumed to be at risk.

2. The main reasons for the adverse variance are:-

- Cost Improvement Plans (CIPs) are behind plan by £6.7m (65%);
- Expenditure on Cerner implementation was much greater than expected;
- Temporary staff pay costs were significantly higher than plan due to the continued use of additional escalation beds and lack of effective controls.

3. Recommendations to the Trust Board: The Board is asked to note:-

- The Year to Date (YTD) deficit of £2.5m represents an adverse variance against plan of £3.7m;
- Significant improvement in delivery of CIPs is required to achieve the financial plan surplus of £11.2m. This is key as the monthly requirement needs to increase by £3m going forward to achieve the plan target of £49m ;
- Despite the overspend to date, Cerner expenditure overall, must return to plan;
- Cerner reporting issues need to be resolved before the freeze date for month 2 activity reporting to CCGs and NHS England (NHSE) if further income reductions are to be avoided;

- Additional controls over the booking of bank and agency in line with the separate paper covering this area must be introduced.

4. Trust strategic objectives supported by this paper:-

To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

1. Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 30th June 2014.

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

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 was a **deficit** of £0.2m; this was an **adverse** variance of £1.2m in month. The Year to Date (YTD) deficit of £2.5m represents an adverse variance against plan of £3.7m.

2.2 **CCGs/NHS England Service Level Agreement (SLA) Income**: The CCG & NHS England SLA contract income for the month was calculated using the month two flexed activity data. It has been assumed that the performance fund of £2.1m, with North West London (NWL) CCGs, and currently un-coded activity of £3m, with NHSE, will be paid, but both can be deemed to be at risk.

2.3 **Other Operating Income:** Research income is behind plan, but is matched to expenditure to ensure a net zero impact.

2.4 **Expenditure:** Pay expenditure shows an **adverse** YTD variance of **£7.4m** as a result of under-achievement of CIPs and a failure to reduce bank and agency costs due to continued use of escalation beds and lack of effective controls. In fact, pay expenditure has increased by £1m when compared to last month and by £2.9m when compared to the monthly average for last year. Non pay expenditure was showing a **favourable** YTD variance of **£7.3m** due to the under-spend on R&D projects of £1.8m, the inclusion of the contingency and un-utilised funding to support service developments, and the release of balance sheet accruals. After adjusting for the release of accruals, non-pay expenditure has increased by £1m when compared to last month, mainly on drugs and clinical supplies.

3. Monthly Performance (Page 4 A to C)

3.1 The Divisions are reporting a year to date overspend against plan of **£7.6m** which is a deterioration in month 3 of £4.0m. This is driven by an increase in expenditure run rates of £2m rather than any budget or cost improvement plan profiling issues.

3.2 Medicine is overspent by **£3.1m** YTD which is a significant deterioration in month of £1.4m. This position is driven by under delivery of CIP YTD of £1.1m alongside escalating pay costs in every staff group.

3.3 Women's and Children's is overspent by **£1.2m** YTD which is a deterioration in month 3 of £0.5m. The year to date position is driven by under delivery of CIP of £0.5m alongside continuing escalating pay costs in nursing and scientific & technical staff.

3.4 Investigative Sciences is overspent by **£0.6m** YTD, a deterioration in month 3 of £0.3m. The YTD position is driven by CIP non delivery of £0.4m and the remaining £0.2m bottom-line position being driving by the provision of additional theatre capacity.

3.5 Surgery and Cancer is overspent by **£2.7m** YTD which is a significant deterioration in month of £1.8m. £0.8m of the YTD position is driven by under delivery of CIPs and £0.8m relates to the provision of additional ITU capacity on the Hammersmith site. The remaining variance is driven by increases in medical staffing costs and increasing clinical supplies and drugs costs.

3.6 The corporate directorates are reporting a year to date overspend against plan of **£1.3m** which is an improvement of £0.3m in month 3. The overspend and improvement are driven by the Cerner project. It is anticipated that in future months the project will underspend with forecast expenditure still in line with the original plan.

3.7 The Divisional & Corporate Services' financial performance has not been included this month as the Financial Risk Ratings are being reviewed with the intention of including weightings and over-riding rules to make it more targeted.

4. Cost Improvement Plan (Page 5)

4.1 The CIP plan for the year is £49.1m; actual CIP delivered in month was £1.4m against a plan of £4.3m, an **adverse** variance of £2.8m. Delivery against the YTD CIPs was behind plan by £6.7m with all areas forecasting over achievement in future months to recover the position and current forecasts showing a year end risk of £4.6m under achievement against the plan which needs to be mitigated. This figure has not been adjusted to reflect the risk ratings of schemes, however, and divisions are still continuing to pursue income opportunities above cost reduction. The current forecast should, therefore, be considered a best case scenario.

4.2 Work continues with the divisions to refine the risk ratings of schemes to inform the underlying position. Directorates are continuing to develop mitigating schemes with £2.2m of opportunities in the pipeline. The Finance team will continue to work alongside operational colleagues to identify additional schemes.

5. Statement of Financial Position (Page 6)

5.1 The overall movement in year balance was a decrease of £2.9m and was, predominately, due to the depreciation charge on non-current assets. The variance from plan of £140m was due to the delay in the revaluation of assets and the subsequent expected impairment. The valuation will be subject to the outcome of the options appraisal in the Shaping a Healthier Future business case.

6. Capital Expenditure (Page 7)

6.1 The YTD Expenditure was £5.7m, behind plan by £0.7m. Expenditure is expected to catch up in future months. The Trust's annual Capital Resource Limit (CRL) is £30m.

7. Cash (Page 8)

7.1 The cash balance at the end of the month was £45.6m; £4.6m behind the TDA plan, due to delay in payment from Local Authorities and an advance payment to the Trust facilities management provider. Cash is monitored on a daily basis and surplus cash is invested in the National Loan Fund scheme.

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

8.1 Monitor's Continuity of Service Risk Rating score of 3 is acceptable as the Trust currently has sufficient cash to service debts and liabilities as they fall due.

9. Conclusions & Recommendations

9.1 The Trust Board is asked to note:-

- The Year to Date (YTD) deficit of £2.5m represents an adverse variance against plan of £3.7m;
- Significant improvement in delivery of CIPs is required to achieve the financial plan surplus of £11.2m. Current levels of delivery will leave a significant shortfall;
- Despite the overspend to date, Cerner expenditure overall, must return to Plan;
- Cerner reporting issues need to be resolved before the freeze date for month 2 activity reporting to CCGs and NHS England if further income reductions are to be avoided;
- Additional controls over the booking of bank and agency in line with the separate paper covering this area must be introduced;
- A Vacancy Control Group has been established to approve all appointments;
- All discretionary expenditure requires CEO/CFO sign off with immediate effect

Contents

Finance Performance Report for the month ending 30th June 2014

PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income									
Clinical	64,268	61,011	(3,257)	190,136	187,947	(2,189)	773,942	773,942	0
Research & Development & Education	10,182	9,644	(537)	30,288	28,486	(1,802)	121,200	121,200	0
Other	5,479	5,955	476	17,465	18,194	729	72,920	72,920	0
TOTAL INCOME	**79,929**	**76,610**	**(3,318)**	**237,889**	**234,627**	**(3,263)**	**968,062**	**968,062**	**0**
Expenditure									
Pay - In post	(40,377)	(40,242)	135	(121,822)	(119,559)	2,263	(484,333)	(484,333)	0
Pay - Bank	(1,147)	(2,787)	(1,640)	(3,491)	(7,895)	(4,405)	(13,910)	(13,910)	0
Pay - Agency	(2,011)	(3,576)	(1,564)	(5,188)	(10,466)	(5,278)	(20,671)	(20,671)	0
Drugs & Clinical Supplies	(19,106)	(17,038)	2,068	(58,286)	(55,642)	2,645	(230,055)	(230,055)	0
General Supplies	(3,481)	(3,255)	225	(10,537)	(9,531)	1,006	(41,769)	(41,769)	0
Other	(9,007)	(5,827)	3,181	(25,640)	(22,027)	3,614	(118,197)	(118,197)	0
TOTAL EXPENDITURE	**(75,129)**	**(72,724)**	**2,405**	**(224,964)**	**(225,119)**	**(155)**	**(908,935)**	**(908,935)**	**0**
Earnings Before Interest, Tax, Depreciation & Amortisation	**4,800**	**3,887**	**(913)**	**12,925**	**9,508**	**(3,417)**	**59,127**	**59,127**	**0**
Financing Costs	(4,030)	(4,266)	(236)	(12,090)	(12,383)	(293)	(49,269)	(49,201)	68
Impairment of Assets	(154,538)	0	154,538	(154,538)	0	154,538	(154,538)	(105,967)	48,571
SURPLUS / (DEFICIT) including Impairment & donated asset treat	**(153,768)**	**(380)**	**153,388**	**(153,703)**	**(2,875)**	**150,828**	**(144,680)**	**(96,041)**	**48,639**
Impairment of Assets & Donated Asset treatment	154,648	110	(154,538)	154,869	331	(154,538)	155,867	107,228	(48,639)
SURPLUS / (DEFICIT)	**880**	**(270)**	**(1,150)**	**1,166**	**(2,544)**	**(3,710)**	**11,187**	**11,187**	**0**

Surplus / (Deficit): The Trust's financial performance in Month 3 was a deficit of £270k, adverse variance of £1,150k. The Year to Date (YTD) position was overall deficit of £2,544k, adverse variance of £3,710k. The continuing deterioration of the financial performance can be attributed to:-

1. Actual achievement of CIP YTD was £3,578k, behind plan by £6,748k.
2. Pay spend and in particular bank/agency spend being £9,682k more than the YTD plan
3. Income was behind plan mainly due to problems with reporting of clinical activity in Cerner and R&D income which was matched with expenditure to ensure net zero impact on the bottom-line.

Income: Within income we have assumed 100% payment of the performance fund of £2.1m and un-coded activity of £3m as a result of problems with the initial reporting of activity data from Cerner both can be assumed to be at risk.

Pay: Bank/Agency monthly spend increased this month by £792k when compared to last month, predominately on Medical, Nursing and Admin staff.

Non Pay: Spend was lower than the previous month as a result of the one-off release of balance sheet accruals following a review of prior period adjustments. The actual spend before this adjustment was additional £1m more than last month and can be attributed to the increase spend on PbR excluded drugs, HIV drugs and clinical supplies.

Finance costs: The revaluation of Trust's property was delayed and subject to further discussion and clarification as part of the Shaping a Healthier Future business case. Changes have been made to the forecast figure based on the retention of the current Charing Cross buildings.

Statement of Comprehensive Income (SOCI)	**Risk:**	**R**

PAGE 2 - INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income from Clinical Activities									
Clinical Commissioning Groups	33,620	33,879	259	101,065	100,506	(559)	414,946	414,946	0
NHS England	25,495	21,265	(4,231)	73,699	69,883	(3,817)	297,393	297,393	0
Other NHS Organisations	454	1,030	576	1,390	3,033	1,644	5,514	5,514	0
Sub-Total NHS Income	**59,569**	**56,173**	**(3,396)**	**176,154**	**173,422**	**(2,732)**	**717,852**	**717,852**	**0**
Local Authority	903	800	(102)	2,590	2,394	(197)	10,509	10,509	0
Private Patients	3,234	3,406	172	9,702	10,319	617	38,824	38,824	0
Overseas Patients	183	330	147	550	723	173	2,200	2,200	0
NHS Injury Cost Scheme	130	173	44	389	406	17	1,557	1,557	0
Non NHS Other	250	127	(122)	751	683	(68)	3,000	3,000	0
Total - Income from Clinical Activities	**64,268**	**61,011**	**(3,257)**	**190,136**	**187,947**	**(2,189)**	**773,942**	**773,942**	**0**
Other Operating Income									
Education, Research & Development	10,182	9,644	(537)	30,288	28,486	(1,802)	121,200	121,200	0
Non patient care activities	2,664	2,452	(211)	7,992	7,307	(685)	31,980	31,980	0
Income Generation	355	314	(42)	1,066	929	(137)	4,264	4,264	0
Other Income	2,460	3,189	729	8,408	9,958	1,551	36,676	36,676	0
Total - Other Operating Income	**15,661**	**15,600**	**(61)**	**47,753**	**46,680**	**(1,073)**	**194,120**	**194,120**	**0**
TOTAL INCOME	**79,929**	**76,610**	**(3,318)**	**237,889**	**234,627**	**(3,263)**	**968,062**	**968,062**	**0**

Clinical Income behind plan due to activity reporting problems in Cerner. Actual income includes accrrual for the full payment of the performance fund of £2.1m and an estimate of £3m for currently un-coded activity.

Other Operating Income behind plan mainly due to R+D income which has been matched to expenditure to ensure net zero impact on the position.

Statement of Comprehensive Income (SOCI)	**Risk:**	**R**

PAGE 3 - EXPENDITURE

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,883)	(12,902)	(20)	(38,782)	(38,592)	189	(153,799)	(153,799)	0
Nursing & Midwifery	(12,622)	(12,607)	15	(38,099)	(37,395)	704	(151,724)	(151,724)	0
Scientific, Therapeutic & Technical staff	(5,813)	(5,493)	319	(17,547)	(16,558)	988	(69,865)	(69,865)	0
Healthcare assistants and other support staff	(2,401)	(2,408)	(7)	(7,208)	(7,115)	93	(28,596)	(28,596)	0
Directors and Senior Managers	(2,472)	(2,604)	(132)	(7,433)	(7,456)	(24)	(29,913)	(29,913)	0
Administration and Estates	(4,185)	(4,226)	(41)	(12,754)	(12,442)	312	(50,436)	(50,436)	0
Sub-total - Pay In post	**(40,377)**	**(40,242)**	**135**	**(121,822)**	**(119,559)**	**2,263**	**(484,333)**	**(484,333)**	**0**
Pay - Bank/Agency									
Medical Staff	(508)	(1,371)	(864)	(1,544)	(3,680)	(2,137)	(6,111)	(6,111)	0
Nursing & Midwifery	(851)	(2,186)	(1,335)	(2,601)	(6,518)	(3,917)	(10,272)	(10,272)	0
Scientific, Therapeutic & Technical staff	(471)	(763)	(292)	(1,446)	(1,880)	(435)	(5,753)	(5,753)	0
Healthcare assistants and other support staff	(161)	(614)	(453)	(490)	(1,780)	(1,290)	(1,878)	(1,878)	0
Directors and Senior Managers	(9)	(179)	(170)	(37)	(391)	(355)	(23)	(23)	0
Administration and Estates	(1,159)	(1,249)	(90)	(2,562)	(4,112)	(1,549)	(10,543)	(10,543)	0
Sub-total - Pay Bank/Agency	**(3,158)**	**(6,363)**	**(3,204)**	**(8,679)**	**(18,361)**	**(9,682)**	**(34,581)**	**(34,581)**	**0**
Non Pay									
Drugs	(8,844)	(8,097)	746	(26,415)	(25,086)	1,330	(106,516)	(106,516)	0
Supplies and Services - Clinical	(10,262)	(8,941)	1,322	(31,871)	(30,556)	1,315	(123,539)	(123,539)	0
Supplies and Services - General	(3,481)	(3,255)	225	(10,537)	(9,531)	1,006	(41,769)	(41,769)	0
Consultancy Services	(1,223)	(1,064)	158	(3,840)	(3,321)	519	(15,269)	(15,269)	0
Establishment	(634)	(601)	33	(1,946)	(1,901)	45	(7,637)	(7,637)	0
Transport	(943)	(939)	4	(2,851)	(2,865)	(14)	(11,317)	(11,317)	0
Premises	(3,030)	(2,965)	64	(9,204)	(9,358)	(154)	(36,390)	(36,390)	0
Other Non Pay	(3,177)	(256)	2,921	(7,800)	(4,583)	3,217	(47,584)	(47,584)	0
Sub-total - Non Pay	**(31,594)**	**(26,120)**	**5,474**	**(94,464)**	**(87,199)**	**7,265**	**(390,021)**	**(390,021)**	**0**
TOTAL EXPENDITURE	**(75,129)**	**(72,724)**	**2,405**	**(224,964)**	**(225,119)**	**(155)**	**(908,935)**	**(908,935)**	**0**
Financing Costs									
Interest Receivable	20	19	(1)	60	58	(2)	244	246	2
Receipt of Grants for Capital Acquisitions	0	0	(0)	0	0	(0)	0	0	0
Interest Payable	(0)	(99)	(99)	(0)	(236)	(236)	(810)	(810)	0
Other Gains & Losses	(0)	1	1	(0)	4	4	0	4	4
Impairment on Assets	(154,538)	0	154,538	(154,538)	0	154,538	(154,538)	(105,967)	48,571
Depreciation	(2,875)	(2,836)	39	(8,625)	(8,507)	118	(34,599)	(33,830)	769
Public Dividend Capital	(1,175)	(1,352)	(177)	(3,525)	(3,703)	(178)	(14,104)	(14,811)	(707)
TOTAL - FINANCING COSTS	**(158,568)**	**(4,266)**	**154,302**	**(166,628)**	**(12,383)**	**154,245**	**(203,807)**	**(155,168)**	**48,639**

Pay: In post spend was £257k more than last month mainly on Senior managers and admin staff. Bank/Agency monthly was higher than the previous month when additional beds were open to cope with capacity issues.

Non Pay: Spend was down when compared to last month due to the release of balance sheet accruals, the underlying spend was up by £1m mainly on drugs and clinical supplies.

Finance costs: The revaluation of Trust's property was delayed and therefore no impairment was included in the Accounts for this month. The forecast impairment value assumes retention of the CXH buildings but this is subject to further clarification of the options in the Shaping a Healthier Future business case.

Statement of Comprehensive Income (SOCI) **Risk:** **A**

PAGE 4 (a) - Clinical & Non Clinical Divisions

		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
Clinical Divisions	Income	3,838	3,990	152	11,275	11,633	357	48,558	48,558	0
	Pay	(36,753)	(39,377)	(2,624)	(110,159)	(116,310)	(6,151)	(440,635)	(440,635)	0
	Non Pay	(13,517)	(14,996)	(1,478)	(40,457)	(42,279)	(1,822)	(159,238)	(159,238)	0
Clinical Divisions Total		**(46,432)**	**(50,383)**	**(3,951)**	**(139,341)**	**(146,956)**	**(7,615)**	**(551,315)**	**(551,315)**	**0**
Corporates	Income	6,538	6,714	176	19,576	19,624	48	78,269	78,269	0
	Pay	(5,638)	(5,137)	501	(16,781)	(16,291)	489	(64,065)	(64,065)	0
	Non Pay	(6,424)	(6,821)	(398)	(19,318)	(21,190)	(1,872)	(76,593)	(76,593)	0
Corporates Total		**(5,524)**	**(5,244)**	**280**	**(16,523)**	**(17,857)**	**(1,334)**	**(62,389)**	**(62,389)**	**0**
Income	Income	63,193	58,443	(4,750)	188,014	180,578	(7,436)	759,419	759,419	0
	Pay	0	0	0	0	0	0	0	0	0
	Non Pay	(77)	(77)	0	(232)	(232)	0	(929)	(929)	(0)
Income Total		**63,115**	**58,365**	**(4,750)**	**187,782**	**180,346**	**(7,436)**	**758,490**	**758,490**	**(0)**
Private Patients Directorate	Income	2,559	2,755	196	8,078	8,202	123	35,406	35,406	0
	Pay	(908)	(927)	(19)	(2,724)	(2,616)	109	(10,898)	(10,898)	0
	Non Pay	(840)	(977)	(138)	(2,490)	(2,605)	(115)	(9,785)	(9,785)	0
Private Patients Directorate Total		**811**	**851**	**40**	**2,864**	**2,981**	**117**	**14,724**	**14,724**	**0**
Research	Income	4,538	3,863	(675)	13,615	11,123	(2,492)	54,459	54,459	0
	Pay	(1,044)	(683)	362	(3,071)	(1,944)	1,128	(12,285)	(12,285)	0
	Non Pay	(1,843)	(1,404)	439	(5,429)	(3,896)	1,532	(21,707)	(21,707)	0
Research Total		**1,651**	**1,777**	**126**	**5,115**	**5,283**	**168**	**20,467**	**20,467**	**0**
Reserves, Financing Cost & Other Contingencies	Income	(1,244)	394	1,638	(4,191)	1,539	5,730	(14,135)	(14,135)	0
	Pay	983	(291)	(1,274)	2,760	(230)	(2,990)	11,067	11,067	0
	Non Pay	(8,553)	(1,554)	7,000	(25,519)	(15,565)	9,954	(117,696)	(117,696)	(0)
Reserves, Financing Cost & Other Contingencies Total		**(8,815)**	**(1,451)**	**7,364**	**(26,951)**	**(14,256)**	**12,695**	**(120,764)**	**(120,764)**	**(0)**
Hosted services	Income	507	451	(56)	1,521	1,928	407	6,085	6,085	0
	Pay	(180)	(196)	(16)	(540)	(546)	(6)	(2,160)	(2,160)	0
	Non Pay	(334)	(285)	50	(1,003)	(1,416)	(413)	(4,012)	(4,012)	(0)
Hosted Services Total		**(7)**	**(29)**	**(22)**	**(22)**	**(33)**	**(11)**	**(87)**	**(87)**	**(0)**

Earnings Before Interest, Tax, Depreciation & Amortisation		**4,800**	**3,887**	**(913)**	**12,924**	**9,508**	**(3,417)**	**59,127**	**59,127**	**(0)**

EBITDA: The Trust delivered a deficit against the EBITDA plan of £913k. The Year to Date (YTD) position is a deficit against plan of £3,417. The continuing deterioration in the financial performance can be attributed to:-

1. Actual achievement of CIP YTD is £4,585k and this is behind plan by £6,748k.
2. Divisions' show a year to date adverse variance to plan of £7,615k. These figures now include the Divisions' full CIP targets. YTD Divisional CIPs delivery is £2,903k which is £2,841k behind plan. The remaining Divisional adverse variances are predominantly driven by pay overspends on Bank and Agency staffing.
3. Corporate departments show a YTD adverse variance to plan of £1,334k which is driven by previous overspend on the Cerner programme, there has been a recovery to the position in month 3 with the full year Cerner spend foreast to be on plan.
4. Other relates to the release of accruals to mitigate the bottomline.

Clinical & Non Clinical Divisions	**Risk:**	**R**

PAGE 4 (b) - Clinical Divisions

		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
Division Of Medicine	Income	980	938	(42)	2,936	2,674	(263)	11,302	11,302	(0)
	Pay	(10,651)	(11,825)	(1,174)	(32,085)	(34,854)	(2,769)	(127,907)	(127,907)	0
	Non Pay	(4,755)	(4,973)	(218)	(14,255)	(14,346)	(91)	(56,181)	(56,181)	(0)
Division Of Medicine Total		**(14,425)**	**(15,860)**	**(1,435)**	**(43,404)**	**(46,527)**	**(3,123)**	**(172,786)**	**(172,786)**	**(0)**
Division Of Women And Children	Income	268	482	214	802	1,311	510	6,399	6,399	0
	Pay	(5,350)	(5,928)	(579)	(16,050)	(17,590)	(1,540)	(64,951)	(64,951)	0
	Non Pay	(1,576)	(1,671)	(95)	(4,779)	(4,943)	(164)	(18,944)	(18,944)	0
Division Of Women And Children Total		**(6,657)**	**(7,117)**	**(460)**	**(20,027)**	**(21,222)**	**(1,195)**	**(77,496)**	**(77,496)**	**0**
Investigative Sciences & C S	Income	2,137	2,251	114	6,433	6,469	37	26,397	26,397	0
	Pay	(8,741)	(8,796)	(55)	(26,228)	(26,464)	(235)	(104,838)	(104,838)	(0)
	Non Pay	(3,508)	(3,825)	(317)	(10,381)	(10,828)	(448)	(41,146)	(41,146)	0
Investigative Sciences & C S Total		**(10,113)**	**(10,370)**	**(257)**	**(30,177)**	**(30,823)**	**(646)**	**(119,587)**	**(119,587)**	**(0)**
Surg, Canc & Cardiovasc Div	Income	452	318	(134)	1,105	1,178	73	4,460	4,460	0
	Pay	(12,011)	(12,828)	(817)	(35,796)	(37,402)	(1,606)	(142,939)	(142,939)	(0)
	Non Pay	(3,678)	(4,527)	(848)	(11,043)	(12,161)	(1,119)	(42,967)	(42,967)	(0)
Surg, Canc & Cardiovasc Div Total		**(15,237)**	**(17,037)**	**(1,799)**	**(45,734)**	**(48,385)**	**(2,652)**	**(181,446)**	**(181,446)**	**(0)**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(46,432)**	**(50,383)**	**(3,951)**	**(139,341)**	**(146,956)**	**(7,615)**	**(551,315)**	**(551,315)**	**(0)**

DIVISIONAL POSITION: The Divisions' reporting an in month overspend of £3,951k bringing the year to date overspend against plan to £7,615k.

1. Medicine is overspent by £3,123k which is driven by under delivery of CIP alongside escalating pay costs (particularly Nursing and Admin) which in previous months was offset by underspends on drugs which has not continued.
2. Women's and Children's is overspent by £1,195k YTD which is driven by under delivery of CIP alongside escalating pay costs (Nursing & A&C).
3. Investigative Sciences is overspent by £646k YTD, CIP delivery is starting to fall below with the bottom-line position also being driving by the provision of additional theatre capacity.
4. Surgery and Cancer is overspent by £2,652k YTD which is driven by some under delivery of CIPs alongside the provision of additional ITU capacity on the Hammersmith site and an escalation in medical pay costs.

PAGE 4 (c)- Financial Performance - Non Clinical Divisions

		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
Corporate Governance	Income	0	0	0	0	1	1	0	0	(0)
	Pay	(106)	(0)	106	(311)	(257)	55	(983)	(983)	0
	Non Pay	(53)	(5)	48	(59)	(11)	48	(235)	(235)	(0)
Corporate Governance Total		**(159)**	**(5)**	**154**	**(370)**	**(266)**	**104**	**(1,218)**	**(1,218)**	**0**
Director Of Operations	Income	176	436	261	527	831	305	2,106	2,106	0
	Pay	(778)	(723)	55	(2,145)	(1,892)	253	(8,314)	(8,314)	0
	Non Pay	(67)	(117)	(50)	(201)	(226)	(25)	(804)	(804)	0
Director Of Operations Total		**(670)**	**(404)**	**266**	**(1,819)**	**(1,286)**	**533**	**(7,011)**	**(7,011)**	**0**
Directorate of Strategy	Income	48	0	(48)	48	0	(48)	191	191	0
	Pay	(102)	(94)	8	(102)	(94)	8	(406)	(406)	(0)
	Non Pay	0	0	0	0	0	0	0	0	0
Directorate of Strategy Total		**(54)**	**(94)**	**(40)**	**(54)**	**(94)**	**(40)**	**(215)**	**(215)**	**0**
Estates Directorate	Income	935	934	(1)	2,784	2,746	(38)	11,088	11,088	0
	Pay	(763)	(768)	(5)	(2,299)	(2,219)	80	(9,038)	(9,038)	0
	Non Pay	(5,006)	(5,078)	(72)	(15,092)	(15,254)	(161)	(61,325)	(61,325)	0
Estates Directorate Total		**(4,833)**	**(4,911)**	**(78)**	**(14,608)**	**(14,727)**	**(119)**	**(59,276)**	**(59,276)**	**0**
Finance	Income	10	34	24	126	91	(35)	503	503	0
	Pay	(779)	(676)	102	(2,634)	(2,306)	328	(10,140)	(10,140)	(0)
	Non Pay	(312)	(343)	(31)	(877)	(1,074)	(197)	(3,456)	(3,456)	0
Finance Total		**(1,081)**	**(986)**	**95**	**(3,386)**	**(3,289)**	**96**	**(13,093)**	**(13,093)**	**(0)**
Human Resources	Income	280	248	(32)	824	857	33	3,309	3,309	0
	Pay	(527)	(510)	17	(1,537)	(1,522)	15	(5,999)	(5,999)	0
	Non Pay	(183)	(232)	(49)	(517)	(548)	(31)	(1,939)	(1,939)	(0)
Human Resources Total		**(430)**	**(495)**	**(65)**	**(1,230)**	**(1,213)**	**17**	**(4,629)**	**(4,629)**	**(0)**
Information & Comms Technology	Income	183	171	(12)	550	428	(122)	2,198	2,198	(0)
	Pay	(1,706)	(1,500)	206	(5,201)	(5,387)	(186)	(18,684)	(18,684)	0
	Non Pay	(590)	(757)	(166)	(1,933)	(3,396)	(1,463)	(6,279)	(6,279)	(0)
Information & Comms Technology Total		**(2,113)**	**(2,086)**	**27**	**(6,585)**	**(8,355)**	**(1,770)**	**(22,765)**	**(22,765)**	**(0)**
Medical Director	Income	4,881	4,851	(29)	14,642	14,559	(83)	58,568	58,568	(0)
	Pay	(553)	(510)	43	(1,672)	(1,648)	23	(6,744)	(6,744)	0
	Non Pay	(168)	(249)	(81)	(504)	(545)	(41)	(2,016)	(2,016)	(0)
Medical Director Total		**4,160**	**4,092**	**(68)**	**12,466**	**12,365**	**(101)**	**49,808**	**49,808**	**(0)**
Nursing directorate	Income	25	30	5	75	84	9	299	299	0
	Pay	(244)	(251)	(7)	(652)	(707)	(55)	(2,797)	(2,797)	0
	Non Pay	(36)	(38)	(2)	(107)	(111)	(4)	(427)	(427)	0
Nursing directorate Total		**(255)**	**(259)**	**(4)**	**(684)**	**(734)**	**(50)**	**(2,925)**	**(2,925)**	**0**
Press & Communications	Income	1	10	9	2	28	26	7	7	0
	Pay	(82)	(106)	(24)	(227)	(260)	(32)	(960)	(960)	0
	Non Pay	(9)	(3)	7	(28)	(26)	2	(112)	(112)	(0)
Press & Communications Total		**(91)**	**(99)**	**(8)**	**(254)**	**(258)**	**(4)**	**(1,066)**	**(1,066)**	**0**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(5,524)**	**(5,244)**	**280**	**(16,523)**	**(17,857)**	**(1,334)**	**(62,389)**	**(62,389)**	**(0)**

CORPORATE POSITION: The corporate departments are reporting a year to date overspend against plan of £1,334k which is driven by an overspend YTD against the Cerner project. it is anticipated that in future months the project will underspend with forecast expenditure still in line with the original plan. There is also a YTD underspend in Director of Operations driven by a number of vacancies.

PAGE 5 - Cost Improvement Programme

		In Month			Year to Date (Cumulative)			Forecast Outturn		
Division / Corporate directorate	Responsible Director	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Medicine	Steve McManus	680	277	(402)	1,971	861	(1,110)	8,332	4,872	(3,460)
Surgery	Steve McManus	597	270	(327)	1,792	979	(813)	8,733	7,990	(744)
WAC	Steve McManus	314	139	(175)	829	327	(503)	3,657	3,378	(279)
DISCs	Steve McManus	399	174	(225)	1,152	737	(415)	5,735	4,182	(1,553)
Private Patients	Bill Shields	333	306	(28)	1,000	996	(5)	4,000	4,396	396
Corporate Governance	Cheryl Plumridge	6	1	(5)	18	2	(16)	185	15	(170)
Director of Operations	Steve McManus	4	0	(4)	199	0	(199)	764	147	(618)
Estates Directorate	Ian Garlington	121	73	(47)	300	182	(118)	3,762	2,971	(791)
Finance Directorate	Bill Shields	93	93	0	280	222	(59)	1,236	1,170	(66)
Human Resources	Jayne Mee	64	42	(22)	184	118	(65)	741	677	(64)
ICT	Kevin Jarold	84	36	(48)	253	102	(152)	1,182	1,059	(123)
Medical Director	Chris Harrison	33	15	(18)	98	44	(54)	282	314	32
Nursing Directorate	Janice Sigsworth	5	2	(4)	16	8	(9)	71	88	18
Press & Communications	Michelle Dixon	9	0	(9)	28	10	(18)	117	92	(24)
Central schemes (inc internal phasing adjustment & mitigations)		1,523	0	(1,523)	3,214	0	(3,214)	10,304	13,120	2,816
Total		**4,267**	**1,428**	**(2,839)**	**11,333**	**4,585**	**(6,748)**	**49,100**	**44,471**	**(4,629)**

COST IMPROVEMENT PROGRAMME: Delivery against the CIP programme currently sits at 40% resulting in quarter 1 position which is £6,748k behind plan. However most areas are forecasting over achievement in future months with current forecasts showing a year end risk of £4.6m under achievement against the plan which needs to be mitigated. However this figure has not been adjusted to reflect the risk ratings of schemes and divisions still continue to pursue income opportunities above cost reduction and so current forecast should be considered a best case scenario. Divisions are continuing to develop mitigating schemes with £2.2m of opportunities in the pipeline. Work will continue by the Finance team alongside operational colleagues to identify further mitigating schemes.

Cost Improvement Programme (CIP)	Risk:	R

PAGE 6 - STATEMENT OF FINANCIAL POSITION

		Opening Balance 1st April 2014 £000s	Plan as at June £000s	Actual Previous Month Balance £000s	Actual Current Month Balance £000s	Actual In Year Movement £000s	Variance to Plan as at June £000s	Actual Monthly Movement £000s
Non Current Assets	Property, Plant & Equipment	595,639	449,804	593,765	592,940	(2,699)	143,136	(825)
	Intangible Assets	1,413	1,593	1,343	1,309	(104)	(284)	(34)
Current Assets	Inventories (Stock)	14,214	15,006	14,231	14,247	33	(759)	16
	Trade & Other Receivables (Debtors)	96,256	100,849	84,575	92,993	(3,263)	(7,856)	8,418
	Cash	50,449	49,739	60,421	45,631	(4,818)	(4,108)	(14,790)
Current Liabilities	Trade & Other Payables (Creditors)	(128,280)	(132,029)	(127,140)	(121,813)	6,467	10,216	5,327
	Borrowings	(2,701)	(2,701)	(2,701)	(2,701)	0	0	0
	Provisions	(25,091)	(24,626)	(25,090)	(24,843)	248	(217)	247
Non Current Liabilities	Borrowings	(20,709)	(20,709)	(20,709)	(20,709)	0	0	0
	Provisions	(17,149)	(15,888)	(17,149)	(15,888)	1,261	0	1,261
	TOTAL ASSETS EMPLOYED	**564,041**	**421,037**	**561,546**	**561,166**	**(2,875)**	**140,129**	**(380)**

Ratio/Indicators	Risk Rating		
	Current Month	Previous Month	Change in month
Debtor Days	36	32	(4)
Trade Payable Days	50	50	(0)
Cash Liquidity Days	23	26	3

The increase in debtors for the month is predominantly due to:

- Increase in NHS debtor accruals of £3.6m predominantly due to £2.1m accrual for Q1 transitional funding, R&D MFF of £0.8m and Project Diamond of £0.6m
- Increase in prepayments of £6.1m mainly due to a three month payment in advance made to ISS in month
- Decrease in non NHS debtors of £1.6m mainly due to delays in raising invoices based on actual data to Local Authorities. Additionally, there were delays in raising invoices as purchase order references from Local Authorities are required.
- Increase in Private Patients debtor of £0.7m
- Decrease in debtors due to an Increase in the bad debt provision of £0.4m

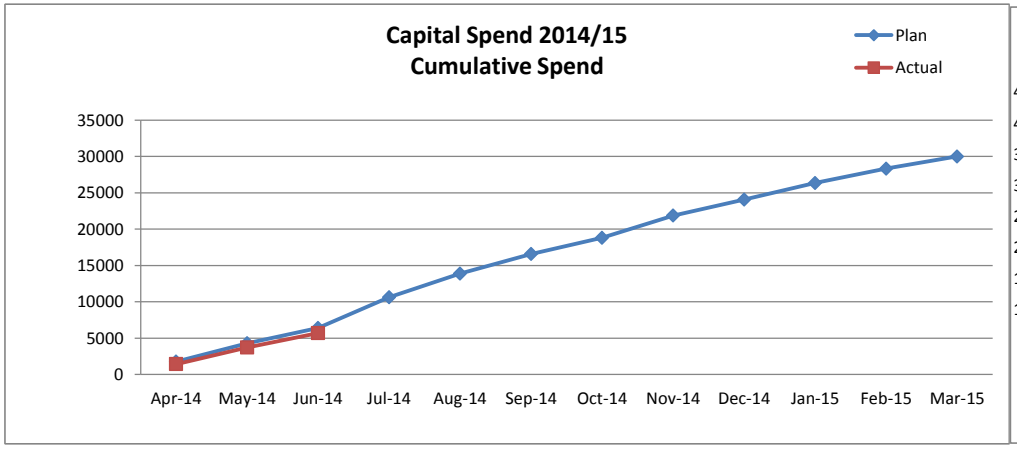
The decrease in creditors for the month is predominantly due to:

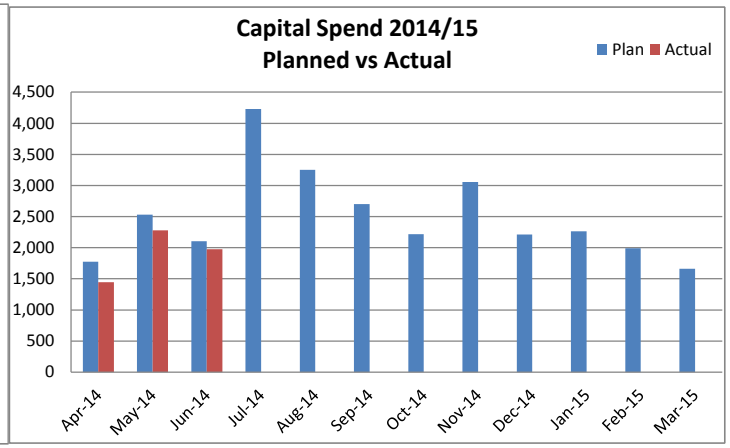
- Decrease in NHS deferred income of £4.8m, of which £4.5m relates to the release of one month LDA MDECS income
- Decrease in trade creditors of £1.4m
- Decrease in non NHS creditor accruals of £2.1m mainly due to a decrease in the accrual for goods receipted not yet invoiced
- Increase in non NHS deferred income of £1m resulting from an increase in R&D non-commercial income
- Increase in PDC accrual of £1.4m
- Increase in NHS creditor accruals of £0.6m

Statement of Financial Position (SOFP) **Risk: G**

PAGE 7 - CAPITAL EXPENDITURE

By Scheme	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Endoscopy provision QEQM level 2 (SMH)	0	245	(245)	330	932	(602)	330	966	(636)
Site Redevelopment	300	290	10	730	707	23	2,192	3,200	(1,008)
Capital Maintenance (Backlog & Statutory) - CXH	230	15	215	460	107	353	2,520	3,160	(640)
Capital Maintenance (Backlog & Statutory) - HH	170	(88)	258	490	126	364	2,020	2,540	(520)
Capital Maintenance (Backlog & Statutory) - SMH	190	336	(146)	380	463	(83)	2,090	1,950	140
Imaging Review	0	301	(301)	0	304	(304)	2,650	2,500	150
Medical Equipment purchases	220	321	(101)	440	1,010	(570)	2,420	4,600	(2,180)
Theatre Refurbishment Programme	100	(4)	104	200	136	64	1,000	560	440
ICT investment programme	693	490	203	3,015	1,492	1,523	7,226	6,500	726
Minor Works (below £50k)	45	20	25	90	194	(104)	500	500	0
Improving the cancer inpatients experience (6 North and 6 South)	0	(4)	4	0	(4)	4	700	960	(260)
Private Patient Facility improvements	100	8	92	150	19	131	250	50	200
Waste compound relocation (HH)	0	0	0	0	0	0	500	0	500
Development of Business Cases/Feasibility Studies	20	2	18	40	40	0	220	250	(30)
PICU St Mary's	0	4	(4)	0	12	(12)	2,583	232	2,351
Private Patients Refurbishment	0	0	0	0	0	0	878	0	878
Other site developments	0	14	(14)	0	128	(128)	0	547	(547)
Imaging Improvements (HH) - providing expanded Imaging in A-Block	38	6	32	87	11	76	1,921	239	1,682
C Block North (Building 114) refurbishment	0	20	(20)	0	26	(26)	0	1,250	(1,250)
Total Capital Expenditure	**2,106**	**1,976**	**130**	**6,412**	**5,703**	**709**	**30,000**	**30,004**	**(4)**
Donations	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	(4)	0	0	(4)	4
Total Charge against Capital Resource Limit	**2,106**	**1,976**	**130**	**6,412**	**5,699**	**709**	**30,000**	**30,000**	**0**
Capital Resource Limit							**(30,000)**	**(30,000)**	**0**
Over/(Under)spend against CRL							**0**	**0**	**0**

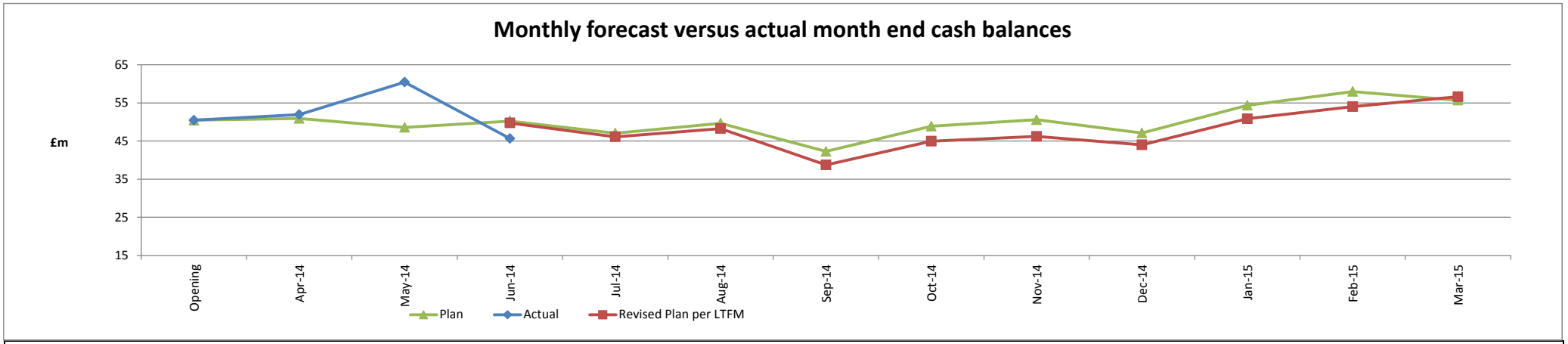




Expenditure was slightly behind plan, due to delays in approval of the overall capital budget.
The forecast outturn reflects the latest position. The forecast spend for PICU St Mary's shows a significant reduction of £1.15m from last month due to changes in the works delivery programme. Building 114 refurbishment scheme has been added to the report following approval by the Strategic Investment Group.

Statement of Financial Position (SOFP) **Risk:** G

PAGE 8 - CASH



	Opening	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Plan	50,449	50,914	48,591	50,245	47,044	49,636	42,286	48,863	50,577	47,091	54,358	57,958	55,701
Actual	50,449	51,917	60,421	45,631									
Revised Plan per LTFM				49,739	46,109	48,273	38,717	44,943	46,199	43,992	50,825	53,993	56,605

Aged Debtor Analysis (£'000)

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total	Previous Month Total
NHS	25,484	11,827	1,688	14,228	2,917	461	56,605	52,952
Non-NHS	4,495	3,271	165	5,517	1,140	742	15,330	16,713
Overseas	204	249	65	499	526	1,765	3,308	3,416
Private Patient	3,077	973	768	2,213	1,383	197	8,611	7,877
Total	**33,260**	**16,320**	**2,686**	**22,457**	**5,966**	**3,165**	83,854	80,958
% of Total Debt	**39.7%**	**19.5%**	**3.2%**	**26.8%**	**7.1%**	**3.8%**	**100.0%**	
Memo - Salary Overpayments	**145**	**4**	**2**	**30**	**46**	**333**	**560**	**560**

Aged Creditor Analysis (£'000)

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total	Previous Month Total
NHS	20,734	1,774	1,073	1,591	826	444	26,442	27,918
Non NHS	3,294	650	968	1,127	528	163	6,730	6,555
Total	**24,028**	**2,424**	**2,041**	**2,718**	**1,354**	**607**	33,172	34,473
% of Total Creditors	**72.4%**	**7.3%**	**6.2%**	**8.2%**	**4.1%**	**1.8%**	**100.0%**	

As a result of the requirement to provide an age analysis of trade receivables and payables including accruals to the TDA on a monthly basis, the aged debtor and creditor analysis above now includes accruals so that it is consistent with the TDA return. The sales ledger for salary overpayments is not included in trade payables in the accounts and therefore shown as a memo item for information.

The cash balance at 30th June 2014 was £4.6m lower than plan. The variance was made up of a short fall of income of £1.3m, due to delay in raising invoices to Local Authorities as the need to await for purchase order to be issued before an invoice can be raised and payments in excess of plan of £3.3m as additional 3 months advance payments to ISS were made in month 3.

At the end of June the balance of cash invested in the National Loan Fund scheme totalled £41m. This amount was invested for 7 days at an average rate of 0.39%. Total accumulated interest receivable at 30 June 2014 was £58k.

Statement of Financial Position (SOFP) **Risk: G**

Page 9 - FINANCIAL RISK RATINGS (FRR)

Continuity of Service Risk Rating

Metric	Weighting	Metric Description	April	May	June
Liquidity Ratio	50%	Liquidity ratio (days)	3	3	3
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	2	3	3
Overall Continuity of Service Risk Rating			**3**	**3**	**3**

This month we have excluded the TDA's Financial Risk Rating table as the Trust is longer measured against these risk ratings.

Monitor's continuity service risk rating is green due the Trust's current strong cash position.

Financial Risk Ratings	**Risk:**	**G**

PAGE 10 - SLA Activity & Income by POD (Estimate for June 2014)

Point of Delivery	Year to Date (Activity)			Year to Date (Income)			Forecast		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Admitted Patient Care									
- Day Cases	17,473	15,064	(2,409)	14,590	12,509	(2,081)	58,864	58,864	0
- Regular Day Attenders	982	2,674	1,692	1,767	1,072	(695)	2,971	2,971	0
- Elective	4,936	5,464	528	16,897	15,329	(1,568)	68,551	68,551	0
- Non Elective	20,439	22,834	2,395	39,633	43,484	3,851	160,186	160,186	0
Accident & Emergency	41,406	41,835	429	4,899	4,792	(107)	19,699	19,699	0
Adult Critical Care	9,856	9,738	(118)	11,674	11,727	53	47,359	47,359	0
Renal Dialysis	62,510	60,371	(2,139)	9,333	9,025	(308)	37,864	37,864	0
Outpatients - New	74,904	67,566	(7,338)	13,460	12,023	(1,437)	53,758	53,758	0
Outpatients - Follow-up	120,283	110,542	(9,741)	17,061	15,186	(1,875)	68,004	68,004	0
Ward Attenders	1,280	1,751	471	211	251	40	854	854	0
PbR Exclusions	0	0	0	22,601	23,439	838	91,512	91,512	0
Direct Access	556,747	563,810	7,063	3,966	4,003	37	16,088	16,088	0
CQUIN	0	0	0	3,619	3,474	(145)	14,516	14,516	0
Others	531,002	533,965	2,963	18,460	19,600	1,140	82,536	82,536	0
National Rules	0	0	0	(2,644)	(3,492)	(848)	(10,728)	(10,728)	0
Contractual Rules		(3,437)	(3,437)	(1,037)	(875)	162	(4,207)	(4,207)	0
Transformation Fund	0	0	0	2,082	2,082	0	8,446	8,446	0
NWL Balance to Agreed Baseline	0	0	0	695	630	(65)	0	0	0
SLA Income	**1,441,818**	**1,432,177**	**(9,641)**	**177,267**	**174,259**	**(3,008)**	**716,273**	**716,273**	**0**
Less Non English Organisations	0	0	0	(3,268)	(3,076)	192	(13,658)	(13,658)	0
Less Fundation Trust Income	0	0	0	(902)	(824)	78			0
Adjustment to Central Income				(2,693)	30	2,723	(7,777)	(7,777)	0
TDA Over performance	0	0	0	2,282	0	(2,282)	9,254	9,254	0
Other Divisional SLA	0	0	0	2,078	0	(2,078)	8,247	8,247	0
TOTAL	**1,441,818**	**1,432,177**	**(9,641)**	**174,764**	**170,389**	**(4,375)**	**712,339**	**712,339**	**0**

Income by Sector	Year to Date (Income)			Forecast		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
North West - London	84,345	84,345	0	339,251	339,251	0
London - Others	10,063	9,772	(291)	40,816	40,816	0
Non London	4,562	4,278	(284)	18,506	18,506	0
NHS England	71,771	69,883	(1,888)	291,315	291,315	0
Foundation Trust			0			0
Non Contracted Activities	2,144	1,878	(266)	8,124	8,124	0
Out of Area Treatment	233	233	0	946	946	0
Adjustment to Central Income	(2,714)		2,714	(4,120)	(4,120)	0
TDA Over performance	2,282		(2,282)	9,254	9,254	0
Other Divisional SLA	2,078	0	(2,078)	8,247	8,247	0
TOTAL	**174,764**	**170,389**	**(4,375)**	**712,339**	**712,339**	**0**

The report is an analysis of NHS SLA Income from clinical activities.
Year to Date position was an adverse variance against plan of (£7.0m). The main reasons are :-
- Decrease in Day case activity with the key under performing service lines being Clinical Haematology (£0.5m), Nephrology (£0.3m), Urology (£0.3m), Reproductive Medicine (£0.2m) and Obstetrics, Trauma & Orthopaedics, Paediatrics and other(£0.7m).
- Elective activity was below plan by (£1.5m). The key under performing service lines were Adult BMT (£0.7m), Cardiac Surgery (£0.4m) and Trauma & Orthopaedics (£0.4m).
- Non Elective work was above plan by £3.8m with the key over performance on Midwifery Episodes £0.7m, General Medicine £0.6m, Gastroenterology £0.6m,

Imperial College Healthcare NHS Trust

Trust Board

30 July 2014

Agenda Item	3.1
Title	Revised vision and strategic objectives
Report for	Decision
Report Author	Michelle Dixon, Director of Communications
Responsible Executive Director	Michelle Dixon, Director of Communications

Executive Summary: *As part of the work to develop our clinical strategy, we have been seeking to sharpen and simplify the Trust's vision and strategic objectives. The intention is to agree more accessible and impactful versions to demonstrate more clearly the strategic context for the clinical strategy, the outline business case and the related transformation programme. A refined vision and objectives will also help address one aspect of feedback from our recent Foundation Trust application consultation which indicated that many find some of our currently worded objectives difficult to understand.*

Recommendation(s) to the Committee: *The Board is asked to review and approve the refined vision and strategic objectives, updated following input from staff and others over the clinical strategy engagement period.*

Revised vision

To be a world leader in transforming health through innovation in patient care, education and research.

Revised objectives

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

Current vision

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

Current objectives

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

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	3.2
Title	Unlocking our potential to transform Health and Care, Clinical Strategy 2014-2019
Report for	Decision
Report Author	Ian Garlington, Director of Strategy
Responsible Executive Director	Ian Garlington, Director of Strategy
Freedom of Information Status	Report can be made public

Executive Summary: Work on the clinical strategy has been progressing at pace, in parallel with its development so has the implementation of the strategy through the production of the Outline Business Case for ICHT's response to 'Shaping a Healthier Future'.

This paper describes the clinical strategy and relates its implementation to our sites and services. The strategy document will illustrate to the Board how the strategy has been constructed, at service level by:

- Understanding the way we deliver services today
- Exploring internationally for best models of care, and adapting them to suit ICHTs ability to innovate
- Planning our implementation to deliver the clinical transformation

All of these elements are brought together with the business intelligence and governance into the OBC that supports the capital & revenue investment required to deliver transformation.

Further work is required in refinement of the strategy, notably in the areas of Neurosurgery, local A&E services at CXH, and the full configuration of the systematised surgical centre. These areas will be worked through in parallel with the development of the Full Business Case (FBC)

Recommendation(s) to the Board/Committee: The Board is asked to approve the clinical strategy, its development in co-production with our healthcare teams, our commissioners and its implementation through the clinical transformation programme as part of the Outline Business Case (OBC) and operational teams within ICHT.

Imperial College Healthcare NHS Trust

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

Clinical strategy 2014–2020

Unlocking our potential to transform health and care

Draft for presentation to Imperial College Healthcare NHS Trust Board

July 2014

Foreword

The NHS, like other healthcare systems across the developed world, is facing a massive challenge. While continuing to provide excellent urgent and emergency services, we have to transform the way that we care for the vastly increasing number of people with long-term conditions, such as diabetes or heart disease, and for our growing frail, elderly population.

Too many people with long-term or multiple conditions are simply not getting the right support. A fifth of over-75s end up back in hospital as emergencies within 28 days of discharge from hospital – this is bad for patients and bad for the NHS.

We believe we can respond to these challenges – but we have to have the right services, in the right place, in the right facilities. Our estate hasn't had the development it has needed over the past decade or so – a large part of our building stock is now over 100 years old. We have to get it right this time.

This clinical strategy reflects the well-evidenced principles of what good future NHS care will look like. This means more local and integrated services, to improve access and help keep people healthy, and more concentrated specialist services where necessary, to increase quality and safety. We've already seen many more lives saved by centralising major trauma, stroke and heart attack centres across the capital, including at our hospitals.

We have had a huge input to this strategy from doctors, nurses and other clinicians and staff across the Trust. We recognise that to develop our strategy further and to implement it successfully, we need to do much more to explain our thinking and to listen and respond to the views and concerns of patients and local communities. And we have to make sure that we have community capacity in place before we reduce inpatient hospital services. But, as clinicians, we are certain that the biggest threat to the NHS – and to the great care we are here to provide – will come if we don't change to meet new demands.

Dr Tracey Batten, chief executive

Professor Chris Harrison, medical director
Professor Jamil Mayet, divisional director of surgery, cancer and cardiovascular
Mr Steve McManus, chief operating officer
Professor Tim Orchard, divisional director of medicine
Dr Julian Redhead, divisional director of investigative sciences and clinical support
Professor Janice Sigsworth, director of nursing
Mr TG Teoh, divisional director of women's and children's

1 Introduction

Imperial College Healthcare NHS Trust is one of the largest NHS trusts in England, with 10,000 staff in five hospitals providing a range of acute and specialist health services for the residents of north west London and beyond.

The Trust was formed from a merger of St Mary's and Hammersmith Hospitals NHS Trusts in 2007. In 2009, we became the first organisation to be awarded academic health science centre (AHSC) status in the UK, and our partnership for education and research with Imperial College London remains a fundamental part of who we are. All of our hospitals have an incredible heritage, with a track record of continuous innovation in medicine and healthcare dating back to the days of the voluntary hospitals.

Along with the rest of the NHS and other healthcare systems, we are now facing a very difficult set of challenges – most significantly, the need to transform healthcare to meet the needs of many more people living longer and epidemic levels of chronic conditions such as diabetes and heart disease. At the same time, scientific and clinical innovation is hugely extending our ability to save lives, especially around the potential for personalised medicine linked to rapidly expanding knowledge of the human genome. We have to ensure these breakthroughs remain available to everyone, according to need, not ability to pay.

This clinical strategy sets out how we propose to organise, deliver and develop our services over the next five years to meet these challenges. The strategy has been led by senior clinicians across the Trust and draws on detailed evidence and input from a wide range of sources, including a very large proportion of our clinical staff. We have worked particularly closely with our local clinical commissioning groups and with NHS England.

The clinical strategy is a core product of the Trust's wider strategy. Its development has been guided by our organisational vision and strategic objectives (see Fig. 1) and, in turn, it is influencing the development of other Trust-wide strategies, such as those for estates, people informatics, education, research and patient and public engagement. Our clinical ambition is such that implementing the clinical strategy will require far-reaching organisational transformation over the next five years.

The clinical strategy also sits within the wider strategic context of the *Shaping a healthier future* programme. Led by the eight clinical commissioning groups responsible for commissioning NHS care for the population of north west London, *Shaping a healthier future* sets out a framework for service change across the region to improve the quality of primary, community and specialist care.

North west London is also one of 14 Whole System Integrated Care Pioneer areas in England, selected by a wide range of national organisations, including NHS England. Along with other providers, we are working closely with commissioners across the region to design innovative solutions to enable greater integration of health and social care services.

In addition, our strategy is guided by the priorities of a rich network of research and education partnerships and collaborations focused around our AHSC, our wider Academic Health Science Centre Network (Imperial College Health Partners) and our role in providing undergraduate and postgraduate education. These include the National Institute for Health Research (NIHR) Imperial Biomedical Research Centre, North West London NIHR Clinical Research Network, the Collaboration for Leadership in Applied Health Research and Care (CLAHRC), and Health Education North West London.

Fig. 1: Our organisational vision and strategic objectives

Our vision is to be a world leader in transforming health through innovation in patient care, education and research.

We will achieve this vision by delivering our four strategic objectives:

- to achieve excellent patient experience and outcomes, delivered efficiently and with compassion
- to educate and engage skilled and diverse people committed to continual learning and improvement
- as an academic health science centre, to generate world-leading research that is translated rapidly into exceptional clinical care
- to pioneer integrated models of care with our partners to improve the health of the communities we serve.

2 Our starting point

2.1 Our performance and achievements

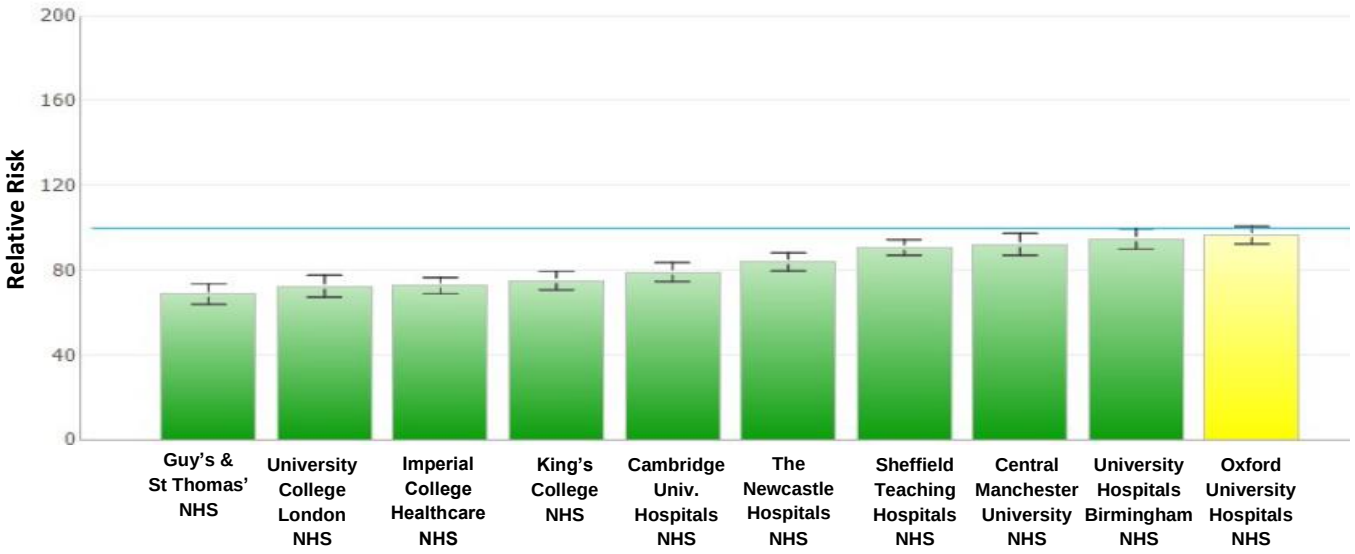
We have strong foundations on which to build our new clinical strategy. Our links with clinical research and education to facilitate the development of specialist care and the implementation of medical breakthroughs are long-standing. More recently, we have also been focusing on building our information technology and clinical leadership capacity.

We provide care for patients at every stage of their lives, with over 55 specialist services for both children and adults. The Trust provides over a quarter of all outpatient and inpatient care for the 2.2 million population of north west London, with over 1 million outpatient contacts and 192,000 inpatients in 2013/14.

The Trust's services have been attracting a greater proportion of referrals from local GPs, while demand for our specialist centres, including renal, stroke, major trauma and cardiology, has also grown over the past five years in comparison with other similar providers.

The Trust delivers excellent clinical outcomes for our patients. Our mortality rates are consistently among the lowest in the UK. Hospital standardised mortality ratios (HSMR) are a mortality indicator where each patient has a 'risk' of death calculated based on specific factors. Risks are aggregated to give an expected number of deaths for each Trust and compared against actual deaths. The Trust's HSMR for 2013 is 73, which means that we are 27 points below the expected number of deaths in our hospitals. The average for all hospitals in the Shelford Group – made up of 10 leading NHS multi-specialty academic healthcare organisations – is 86 (see Fig. 2).

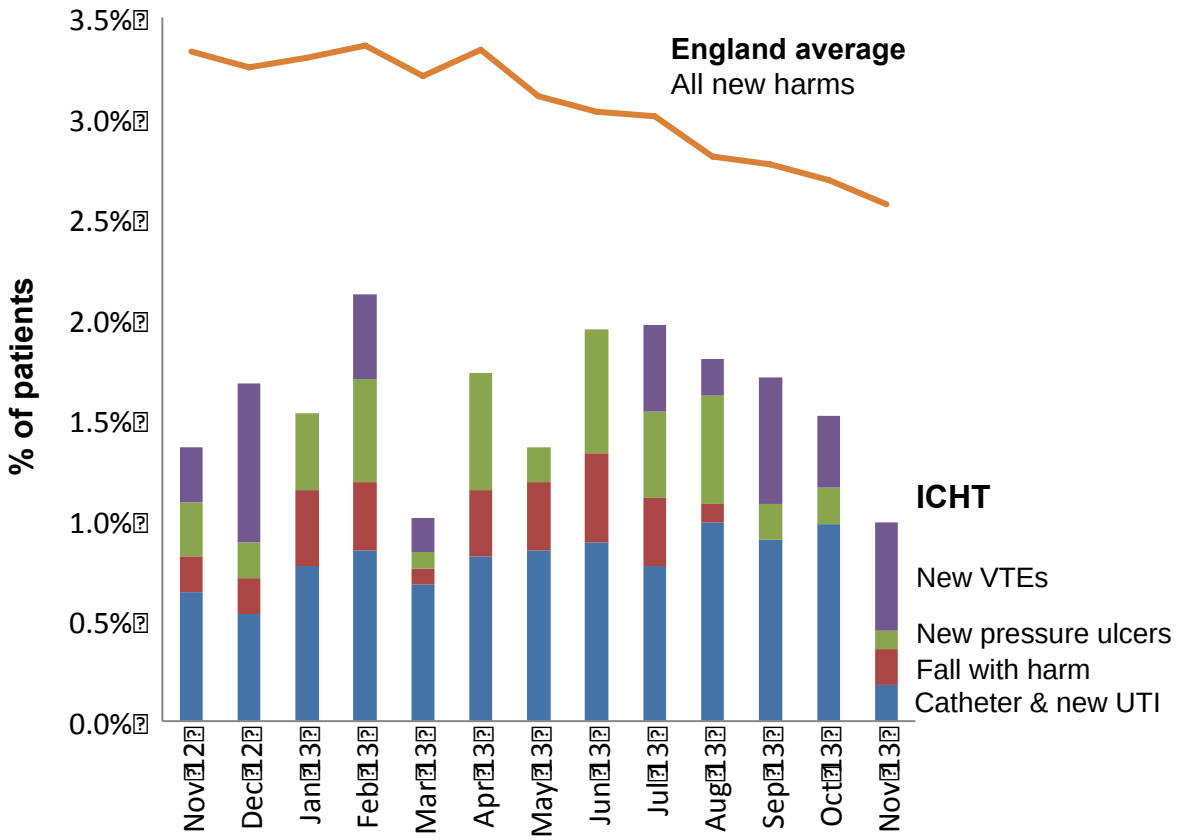
Fig. 2: Hospital standardised mortality ratios (HSMR) in the Shelford Group, January–December 2013



The Trust also performs well in comparison with our peers in the NHS 'safety thermometer' measures. The safety thermometer is an improvement tool for measuring, monitoring and analysing patient harm and harm-free care.

We had between 95–97 per cent harm-free care in 2013/14. This compares with the national average of between 92–94 per cent for the same year. This means that patients in our hospitals are less likely to experience harm when compared with other Trusts. Fig. 3 below shows this, with performance measured against the national average.

Fig. 3: Imperial College Healthcare NHS Trust harm-free performance versus the national average



Source: NHS Safety Thermometer Report, 2012/13

We consistently achieve the 95 per cent four-hour A&E wait standard, including throughout winter. We have a good track record on overall referral to treatment (RTT) standards, currently meeting all three. In the past six months, we have turned around our cancer referral performance and have achieved all national targets each month so far in 2014/15.

We are making real progress on improving patient experience, and are ranked just above average on staff and patient national 'Friends and Family' tests that ask whether individuals would recommend the Trust to others.

We achieved a major financial turnaround in 2012/13. For the last financial year, we delivered a surplus of £15.1 million on an annual turnover of £979m and achieved cost improvement programmes totalling £45.8m.

This year, we implemented the first stage of a single electronic patient administration system. This opens up the possibility for step changes in real-time data accuracy and access and, further on, data sharing, including with our clinical partners and, importantly, our patients. We successfully reapplied for AHSC status in 2013 and we are one of only six AHSCs in the UK, which brings direct benefits to patients (see Fig. 4). And we are one year on from a major organisational restructure that strengthened clinical leadership through the creation of four operational divisions, each lead by a practising consultant, supported by their own multi-disciplinary clinical and managerial leadership teams.

We have made good progress in our application to become an NHS Foundation Trust, having completed a number of key stages of the application process, including our public consultation.

Fig. 4: Examples of research into practice through Imperial AHSC

Saving babies from brain damage
Around three in every 1,000 babies suffers from birth asphyxia, in which the brain suffers from a shortage of oxygen during the birth. In severe cases, 25–50 per cent of babies may die, and those who survive are at risk of disabilities like cerebral palsy, blindness and epilepsy. Following a sustained programme of laboratory and clinical research, Professor David Edwards and Professor Denis Azzopardi showed that a treatment that cools the brain by a few degrees, called hypothermic neural rescue, improves babies' chances of surviving without brain injury by 50 per cent. This simple, low-cost treatment is now used at Imperial College Healthcare NHS Trust and has been adopted nationally at more than 40 UK hospitals as well as being incorporated into NICE guidance. It is also used across the world and is being tested in developing countries where more babies suffer from birth asphyxia. An Imperial College London study led by Professor Denis Azzopardi and published in the New England Journal of Medicine in July 2014 showed that hypothermic neural rescue means that babies treated in this way are 60 per cent more likely to avoid brain injury and disabilities in later childhood.

Preventing bowel cancer
A clinical trial led by Professor Wendy Atkin showed that a screening programme for people aged 55–64 was effective at preventing bowel cancer. Eleven years after a single flexible sigmoidoscopy (FS) examination, the incidence of bowel cancer was reduced by a third and deaths from bowel cancer cut by 43 per cent compared with the group who were not screened. After the trial results were published, the UK National Screening Committee approved a bowel cancer screening programme using FS, aiming to achieve 30 per cent coverage by the end of 2014, 60 per cent by 2015 and full coverage by 2016.

Improving survival for chronic myeloid leukaemia
Chronic myeloid leukaemia (CML) is a rare cancer that affects white blood cells. Professor Jane Apperley's group contributed to the development of treatments called tyrosine kinase inhibitors (TKI) that have changed the outlook from a fatal disorder to a chronic disease with normal life expectancy. They went on to show that rigorous monitoring using a test developed at Imperial could identify patients who will need different types of TKI to have a similar life expectancy. The group is now focusing on enabling people with CML to have a better quality of life thanks to a better management of side effects, cutting down on hospital visits through telephone clinics and remote monitoring, and developing studies looking at discontinuing treatment. A particular interest is to manage and monitor treatment so that younger patients are able to have children.

Safer removal of liver tumours
Liver cancer is the sixth most common cancer worldwide, and the main treatment is surgery to remove the tumour and surrounding tissue. The liver is full of blood vessels, so minimising blood loss is a serious concern. Professor Nagy Habib, working with researchers at Imperial's Faculty of Engineering, developed devices that use radio frequency energy to clot blood inside the liver along the line that is to be cut. This allows the surgeon to take out the tumour with as little bleeding as possible. Clinical trials show that this technique improves recovery, reduces the time patients spend in hospital and keeps patients out of intensive care. As well as helping to care for our patients at the Trust, these devices are now being used in many other UK hospitals.

2.2 Our challenges

We identified a number of challenges for the Trust that also need to be considered in relation to the clinical strategy:

- *Staff engagement*: Our reorganisation into four clinical divisions in 2013 has already delivered benefits in terms of greater clinical leadership and accountability. But our own staff surveys show that we have a significant way to go to achieve the levels of active and positive engagement that are required to make a difference to staff experience, which, evidence shows, will make a difference to patient experience.

- *Patient and stakeholder engagement*: We recognise that we need to focus much more on building two-way relationships with our patients, the local community and wider stakeholders, particularly as we embark on significant change. Working closely with local commissioners, we know that we need to find effective ways of using external views, concerns and ideas to help shape our plans from the start, as well as doing more to share and explain our thinking.

- *Physical infrastructure*: We have not carried out any major estate redevelopment since the merger in 2007. Much of our estate is over 100 years old and much is not fit for modern healthcare and a good patient experience. It is becoming increasingly difficult to maintain. This is in contrast to a number of our AHSC peers who have invested significantly in recent years in estate redevelopment to support modernisation of services and improved patient experience, for example at UCLH and Guy's and St Thomas'.

- *Funding*: The NHS remains subject to significant funding pressures. Over the past 3 years, Imperial College Healthcare Trust has achieved over £127m of recurrent savings whilst delivering increased demand and improving quality and safety.

  Over the medium term, the Trust must continue to deliver savings through efficiency measures in the order of 4 to 4.5 per cent, per annum, as required by Monitor's, the TDA's and NHS England's planning guidance. This will mean delivering further recurrent savings, in today's money, in excess of £207m over the next five years.

- *Administration and management processes*: The Trust was created in 2007 through the merger of St Mary's NHS Trust and Hammersmith Hospitals NHS Trust. However, it's apparent that we're still experiencing legacy issues from the merger due to the variability of many of our internal systems and processes as well as different ways of working across our sites. This sometimes results in poor experiences for our patients and people with, for example, over 30 different patient call centres for the booking of elective activity alone.

2.3 Our wider health economy

North west London is served by eight clinical commissioning groups who have come together to form two commissioning entities: CWHHE Collaborative (made up of Central London; West London; Hammersmith & Fulham; Hounslow; and Ealing CCGs); and BHH Federation (made up of Brent; Harrow; and Hillingdon CCGs). They work closely with the eight local authorities in the region through the Health and Wellbeing Boards and with local healthcare providers, pioneering major service reorganisation through the *Shaping a healthier future* programme and co-ordinating the area's successful application to be one of 14 Whole System Integrated Care Pioneer areas across England.

There is a wide range of organisations providing NHS care across north west London, including:

- **General acute NHS trusts** (West Middlesex, Hillingdon, Chelsea and Westminster, North West London Healthcare). As general providers, many are facing challenges in maintaining the critical volumes to retain clinical effectiveness. As part of Imperial College Health Partners, we will explore potential further benefits to be achieved by working as part of a network

- **National and world-recognised specialist centres** (Royal Brompton, Royal Marsden, Royal National Orthopaedic Hospital). They rate highly on outcomes and patient

experience, with world-recognised brands. This represents opportunities for collaboration with our Trust – to import their specific expertise for some of our service lines, such as cancer, while providing them with access to our acute service capabilities and linked specialty services

- **Adjacent AHSCs** (University College London (UCL), King's Health Partners (KHP)). They provide services into north west London and are looking to extend their services further, either around particular defining specialties or through new community-based models of care
- **Community/mental health/integrated care providers.** As well as the established NHS mental health and community providers, the largest being Central and North West London NHS Foundation Trust, there is a range of other providers and collaborations increasingly looking to develop specialist healthcare and integrated care services within the community, drawing on new models of care. This includes GPs, other primary care providers and social care providers, operating out of traditional statutory sector organisations, as well as out of charities or new organisational models, such as mutuals. Many of the new organisations are not yet mature in their capabilities and present additional opportunities for partnership working.

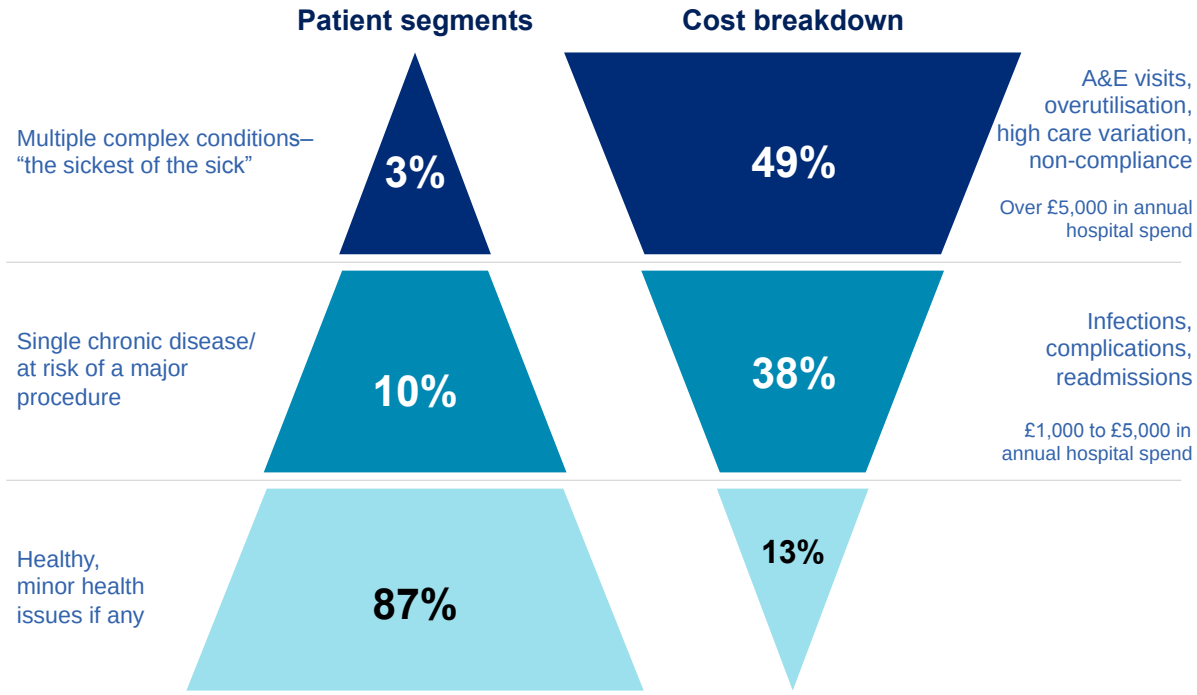
2.4 The future of healthcare

Along with the rest of the NHS and other healthcare systems, we are facing a very difficult set of challenges in terms of meeting future health and healthcare needs.

The main drivers of these challenges are outlined below.

The changing population: Chronic diseases are now the most common cause of death and disability in England, with more than 15 million people living with conditions for which there are no cures. People with chronic conditions account for a significant proportion of NHS resource, including half of all GP appointments and 64 per cent of outpatient appointments. Although the prevalence of long-term conditions rises with age, in absolute terms there are more people living with long-term conditions under the age of 65 than in older age groups. While clearly identifiable and with clearly anticipated needs, many patients with long-term conditions do not receive the care they need, in the right place and at the right time. In north west London, half of secondary care spend is now driven by three per cent of the population (see Fig. 5). Also in north west London, 20 per cent of over-75s are readmitted unplanned to hospital within 28 days of discharge from hospital. Nationally, 60 per cent of people currently die in hospital, although only 8 per cent of people would choose to die in hospital, fuelled by significant gaps in end-of-life planning and community care provision for end-of-life patients.

Fig. 5: Breakdown of NHS spend by patient segment in north west London



Source: HES, 2011. Patients whose GP practices span Brent CCG, Central London (Westminster) CCG, Ealing CCG, Hammersmith and Fulham CCG, Harrow CCG, Hillingdon CCG, Hounslow CCG, West London CCG

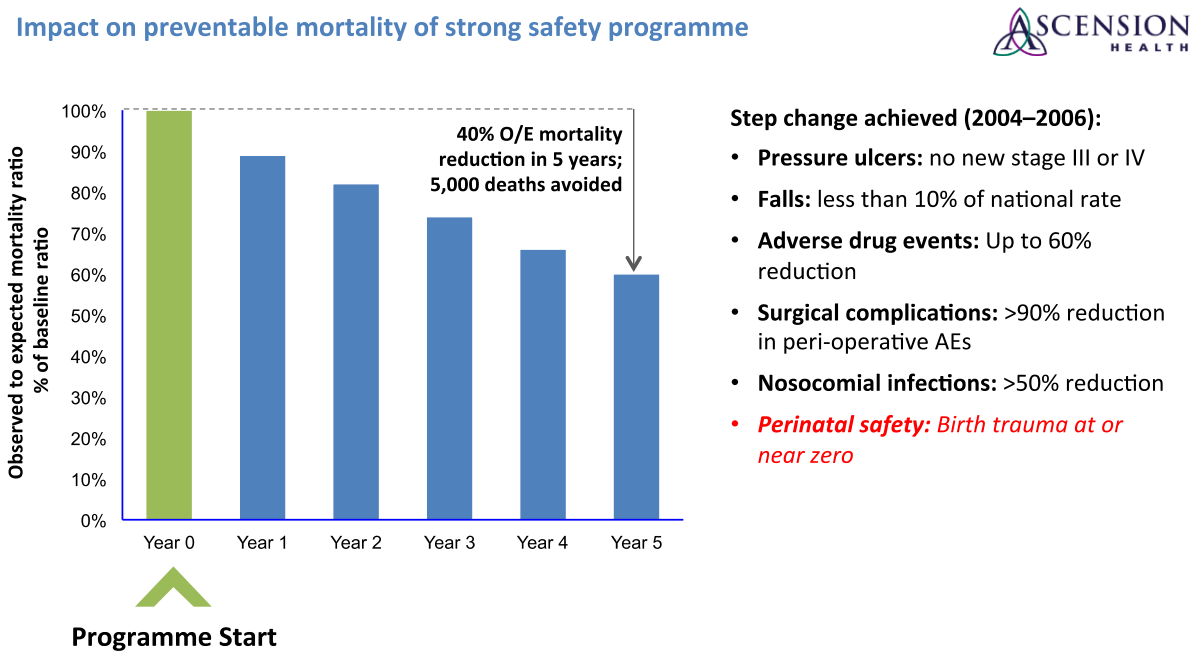
Rapidly evolving technologies and clinical understanding: The development of new technologies and treatments is continuous and rapid, and the NHS sometimes struggles to adopt, disseminate and adjust to these advances at the same pace. We also do not always involve patients and the public sufficiently in considering how these advances impact on the system as a whole, for example with advances in surgery enabling many more procedures to be undertaken on a day-case basis, resulting in the need for fewer inpatient admissions.

Continued pressure on public spending: The financial outlook for the NHS and the wider public sector in the UK is extremely challenging. In his Autumn Statement, the Chancellor of the Exchequer indicated a period of austerity lasting for at least 10 years despite a return to economic growth. Against this backdrop, the Trust must plan for continued efficiency savings of at least 4 per cent, per annum. It is unlikely that this level of saving can be made from traditional means and it is, therefore, vital that clinical efficiencies, where cost is reduced at the same time as quality improvement, are at the heart of future Cost Improvement Programmes.

Expectations of improved quality, responsiveness and patient control: Patient and public expectations are rising. Service industries such as banking have transformed over recent years and now provide customers with much more control over their own accounts, and have enabled them to interact in more convenient ways through the use of new technology. Rightly, NHS patients increasingly expect to have control over their own care and to have access to a range of information about their care and the options open to them, as well as to have convenient and personalised services.

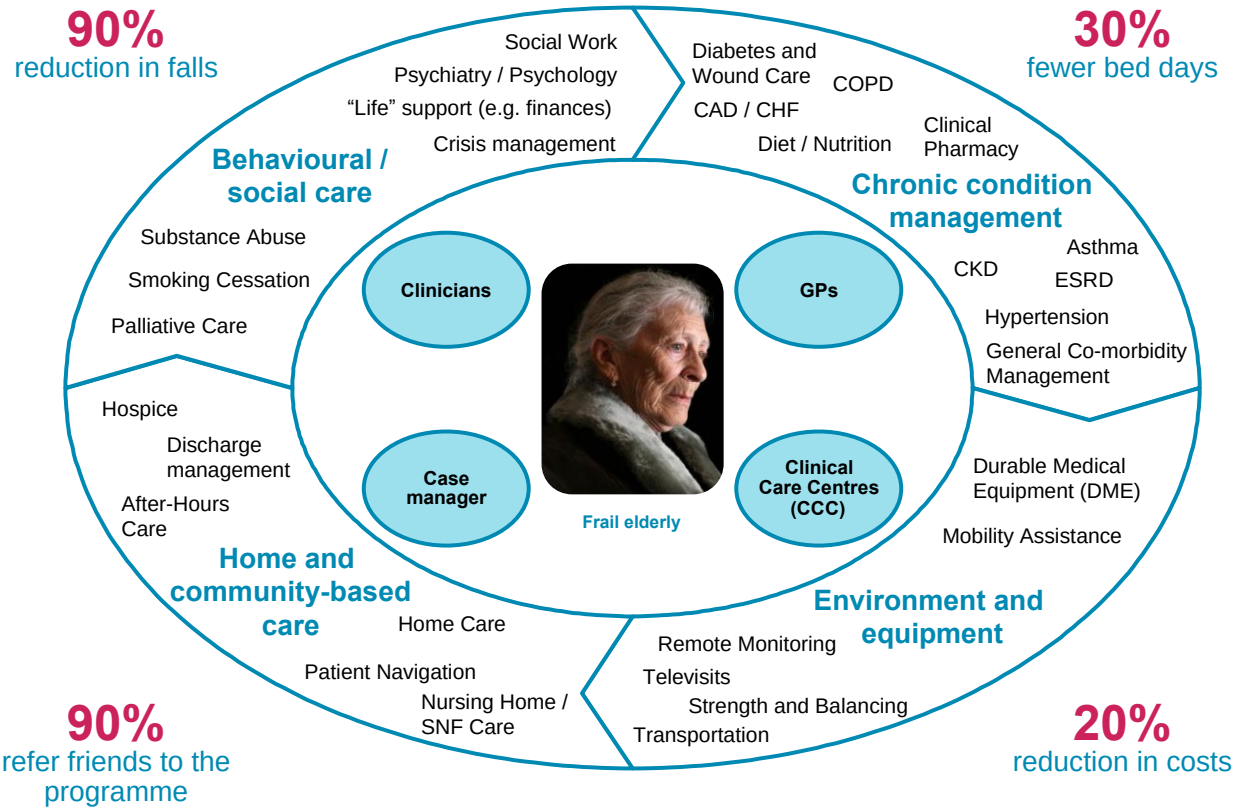
There have been many attempts at regional and local transformation initiatives within the NHS over recent years. Some have achieved significant improvement; others have achieved very little. But we have not yet seen sustainable improvement of the scale achieved in some other health systems. For example, Ascension Health in the United States avoided 5,000 deaths over a five-year period through a new safety improvement programme that introduced 'huddles' – real-time safety incident reviews, and a structured approach to audit, measurement and improvement interventions (see Fig. 6). This programme improved quality and experience while reducing cost.

Fig. 6: Case study of healthcare transformation – Ascension Health's safety improvement programme



In another example, at CareMore in the United States, the introduction of a frail elderly integrated management programme reduced falls by 90 per cent and time spent in hospital by almost a third, while also reducing costs by a fifth (see Fig. 7). CareMore introduced 'extensivists' – doctors who lead the care of small groups of patients across hospital and community settings, supported by integrated information technology systems.

Fig. 7: Case study of healthcare transformation – CareMore's frail elderly integrated management programme



In the UK, a good example of transforming the co-ordination of care for people with multiple chronic illness is the three chronic care management demonstrators in Wales, which led to a reduction in the total number of bed days for emergency admissions for chronic illness of 27 per cent, 26 per cent and 16.5 per cent for the three years 2007–2009. This represented an overall cost-reduction of more than £2m.

It is that order of transformation that is required at Imperial College Healthcare NHS Trust and across the whole of the north west London health economy, essentially to rebuild care around patients.

NHS England and the *Shaping a healthier future* programme have set out very clear and complementary frameworks for how future healthcare needs to evolve to meet the challenges we face, generally and locally (see Fig. 8 and Fig. 9).

As an AHSC with an associated AHSC network, we have a great opportunity to help facilitate change across the whole health system. We need to work with partners to demonstrate to our

patients and communities that we can provide the routine care they need, when and where they need it, at the same time as providing access to world-leading specialties.

Fig. 8: NHS England's six characteristics of future care (*Everyone Counts – planning for patients 2014–19*)

- Citizen participation and empowerment
- Wider primary care, provided at scale
- A modern model of integrated care, especially for patients with complex care needs
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

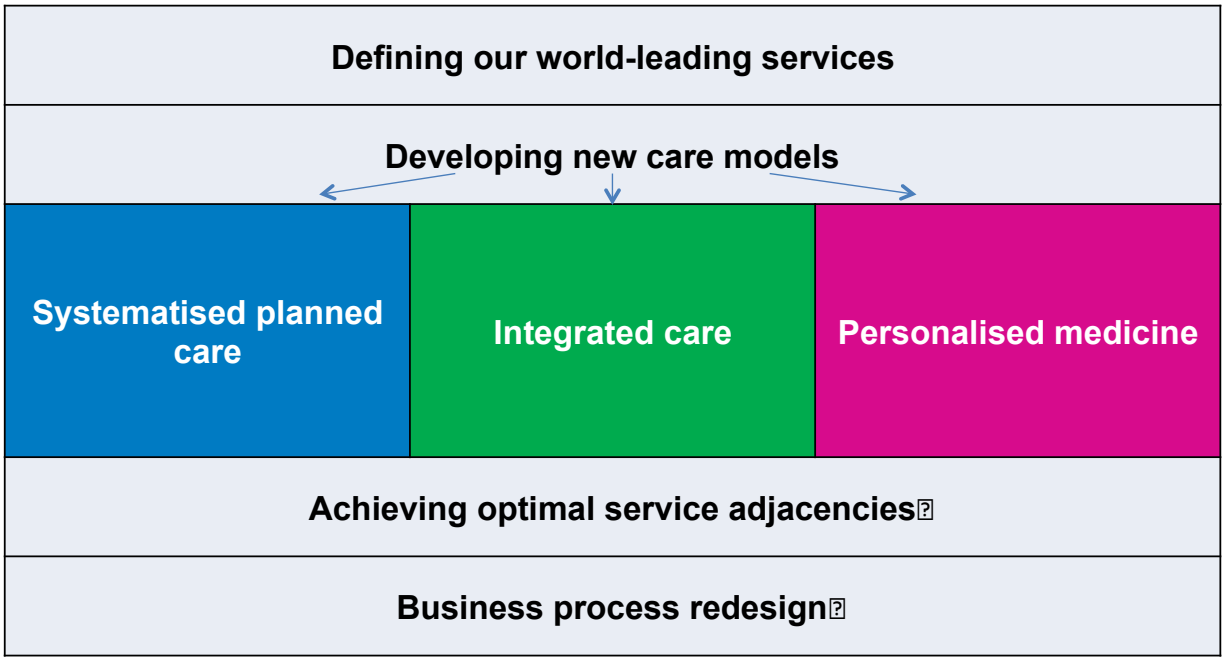
Fig. 9: *Shaping a healthier future* programme – four main principles

- Localisation of routine medical services will mean patients have better access closer to home with improved patient experience.
- Centralisation of most specialist services will mean better clinical outcomes and safer services for patients.
- Where possible, care should be integrated between primary and secondary care, with involvement from social care to give patients a fully co-ordinated service.
- The system will look and feel personalised to patients – empowering and supporting people to live longer and live well.

3 Clinical strategy framework

We have established a framework setting out the core elements of the clinical transformation that we need to achieve in order to meet the very significant challenges facing health systems in general and the particular challenges facing us and north west London in particular (see Fig. 10).

Fig. 10: Clinical strategy framework



3.1 Service adjacencies and site model

Clinical engagement across the Trust reignited a debate about balancing the safety and efficiency advantages of centralising services against the access and responsiveness advantages of localising services. For the majority of our specialties, clinicians were clear that a one-site option would be the safest and most efficient approach. But they also recognised that we have to understand and respond to patients' views and we have to fit within the wider strategic context of north west London.

Section 4 of this document, on service strategies, provides the detail on how specialties should best be organised to deliver the three-site model set out – and consulted upon – in *Shaping a healthier future*. See below for a summary of that model.

Our clinical strategy will need to develop continually to respond to changing needs and clinical advances. As part of this work, through public engagement, research and practical learning, we will also consider how we might evolve to a more consolidated 'hub and spoke' model. This would involve bringing together more core specialty services and inpatient facilities onto one

'hub' site, while expanding access to diagnostics, assessment and routine treatment through specialty outreach services on our other sites and beyond.

3.1.1 The three-site model

St Mary's Hospital: the major acute centre for the region

While we expect our clinical strategy to help deliver a large overall reduction in hospital admissions, our role as a regional specialist centre for a number of acute conditions will necessitate maintaining significant inpatient facilities. We believe the key to improved quality and efficiency in these areas will be scale and the introduction of new clinical roles to ensure patients are cared for holistically.

We will consolidate the Trust's hyper acute stroke unit (HASU) with our main accident and emergency department, major trauma centre and intensive care unit at St Mary's, alongside acute medical and surgical specialties. This will provide the scale to provide affordable and continuous 24/7 senior expert cover on site. This will also provide an excellent training ground and allow us to continue to attract the best emergency clinicians. For specialties with significant acute workload but insufficient scale to be viable over two sites, elective services will also be provided at St Mary's Hospital. This includes neurosurgery, vascular and paediatrics, as well as ophthalmology (through the relocation of the Western Eye Hospital). In addition, we will continue to provide maternity and outpatient services at St Mary's.

The success of our reconfigured acute site will also rely on rolling out new clinical ways of working, such as team-based consultant general physicians present daily on emergency and acute wards to ensure enhanced continuity of care, efficient discharge processes and effective leadership of acute medical training. Daily specialist medical input on the acute wards will be instituted. This model of care will avoid the multiple handovers and process breaks that challenge continuity of care and efficient discharge processes.

We will also build further on our designated specialist centres, where consolidating acute expertise has been demonstrated to save lives. An independent audit published in July 2014, commissioned by NHS England and produced by the Trauma Audit and Research Network, shows that patients in England have a 30 per cent improved chance of surviving severe injuries since the introduction in April 2012 of regional trauma networks across England, including the medical trauma unit at St Mary's Hospital. This equates to 600 more lives saved than in 2012.

Hammersmith Hospital: a world-leading specialist centre

Linking closely with our academic partners at Imperial College, Hammersmith Hospital will act as the main hub for a range of specialties, including renal, haematology, cancer and cardiology. Much of our complex surgery will also take place at Hammersmith. To ensure truly sustainable, world-leading care, many of these services will need to grow, primarily by extending their reach

as ‘defining’ services (see 3.3). In addition, we will continue to provide maternity services at the co-located Queen Charlotte’s and Chelsea Hospital.

Again, we will build on the consolidation of specialist expertise such as that in our designated heart attack centre. The Hammersmith heart attack centre was established over 20 years ago and was a pioneer centre for the acute treatment of heart attacks with primary angioplasty. Over this time period, the mortality rate of patients with major heart attacks has reduced from 15 per cent to 5 per cent in these specialised centres. The success of the early programmes has led to the spread of this 24/7 specialist treatment approach across London, representing an innovative city-wide approach to acute cardiac care. Following on from heart attack centralisation, the London Ambulance Service now diverts all patients with a cardiac arrest where the heart has stopped to the heart attack centres. As a result, discharge survival rates for this group of patients has improved from 30 per cent to 66 per cent.

Charing Cross Hospital: a pioneering local hospital

The redevelopment of Charing Cross Hospital is intended to lead the way for a new type of hospital, providing dedicated access to a wide range of specialist planned care on an outpatient or day-case basis. This will include an elective day-case surgery centre alongside specialist assessment and treatment and care co-ordination. It will facilitate the rapid development of outpatient – or ambulatory – and day-case services as part of a much more integrated healthcare approach across secondary, community and primary care. As such, the hospital site will also house primary care services, diagnostics and pharmacy, transitional care and rehabilitation, and education and wellbeing services. Urgent and emergency care services appropriate to a local hospital will also be provided at Charing Cross, as well as existing mental health and cancer support services.

The Trust’s three-site model will also support a new approach to out-of-hospital care for the area, as set out in *Shaping a healthier future*. In this new approach, services will be delivered in four key ways: at home, in a GP practice, across a network of GP practices, and in an ‘integrated care’ hub. The hubs are new settings, offering a range of on-site services provided by various types of clinicians and other health professionals, as well as a base from which those clinicians and health professionals can reach out further into the community. They are also likely to house some relocated general practices over time.

Charing Cross Hospital will provide many of the features of a ‘super’ integrated care hub, as well as planned specialist care and surgery. Local commissioners are also planning for there to be an integrated care hub co-located on the St Mary’s site.

3.2 Models of care

3.2.1 Systematised planned care

Currently, the majority of NHS providers use the same operating model for almost all surgical procedures regardless of acuity, volume and specialty. The multi-specialty environment makes it hard to measure quality and operational performance. This drives a higher potential for poor patient experience and variable clinical outcomes.

New models of systematised surgery are emerging that can transform quality while reducing costs by over 30 per cent (see Fig. 11 and Fig. 12). These are predicated on the redesign of clinical space, processes and roles to facilitate a higher throughput of patients and low cancellation rates. These clinics can be either inpatient or day-case (ambulatory), although day-case tends to predominate as it brings greater benefits. A threshold requirement for operating in this way is sufficient volume; the Trust is unique in north west London in having sufficient scale to operate a true systematised unit in major specialities. We will develop very high quality ambulatory care units and explore opportunities for consolidation.

Fig. 11: Ambulatory systematised surgery clinics provide efficient and convenient care for straightforward procedures at 30–40% lower cost

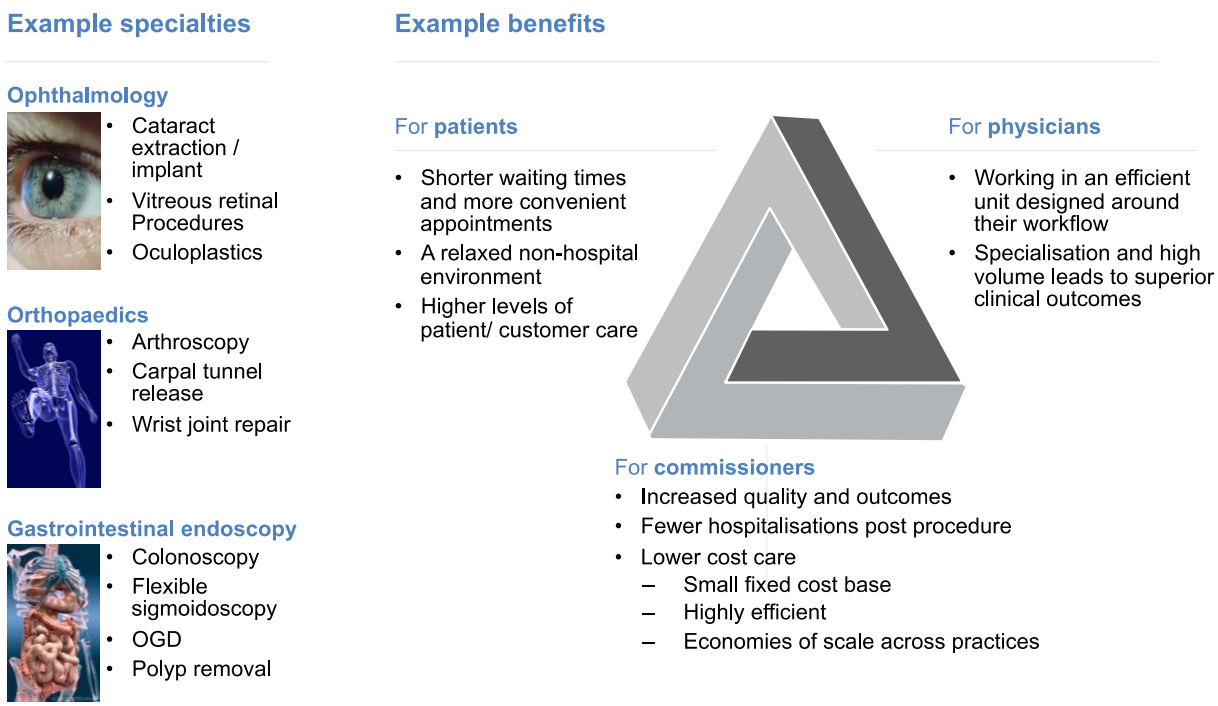
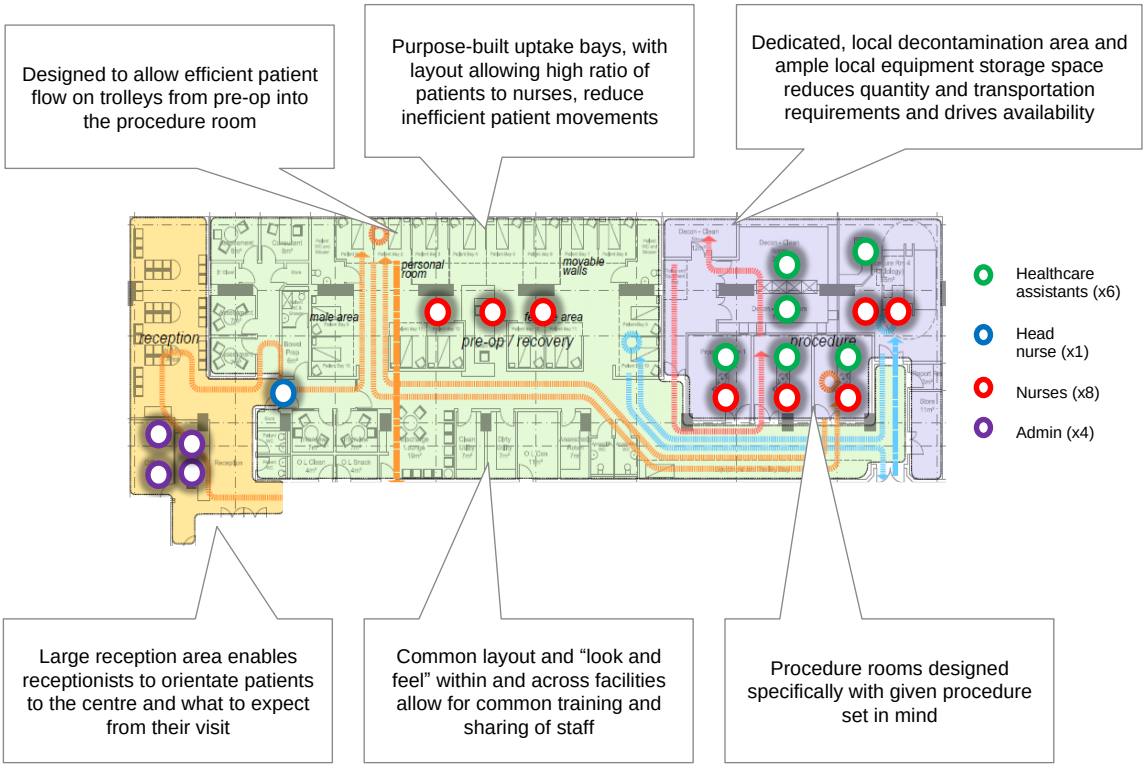


Fig. 12: Example facility plan and staffing map – four theatres at full capacity



3.2.2 Integrated care

As a major provider within a national pioneer area for integrated care, we have a great opportunity to help transform care for patients with multiple and complex needs spanning the health and social care sectors – both frail, elderly patients and younger patients with chronic conditions.

We will develop a model of elderly care that has been proven internationally to transform the quality of care – for example, with 30–40 per cent reductions in hospital admissions and a similar reduction in bed days (see Fig. 7 and 13). This is at the same time as reducing costs by up to 20 per cent. At the centre of the model is the patient. They have a single point of accountability for their health and social care needs, as well as for their overall health and social care budget. Clinicians will lead multi-disciplinary teams and be accountable for delivering excellent care and outcomes for all of our elderly patients with complex care needs. Where appropriate, care will be delivered in community-based clinics or in patients' homes, using the resource of the acute site only when absolutely necessary.

Fig. 13: Care clinics can focus on frail and elderly patients with the most significant needs

- Frail and elderly overview

- Highest need patients aged over 65 at risk of catastrophic decline
- Uncoordinated care and inadequate access leads to unnecessary admissions and poor disease management
- Drive seven times more spend than the population average

3%
Of the LHE population

~£5,800
per capita

- Patient segmentation

>2 comorbidities[1]

- Myocardial Infarction
- Congestive Heart Failure (CHF)
- Peripheral Vascular Disease
- Cerebrovascular Disease
- Dementia
- Chronic Obstructive Pulmonary Disease (COPD)
- Connective Tissue Disease
- Ulcer Disease
- Diabetes
- Hemiplegia
- Moderate to Severe Renal Disease
- Liver Disease
- Cancer – *all types*
- HIV / AIDS
- Multiple Sclerosis

>1 risk factor

- Hypertension
- Obesity
- Severe Recurrent Major Depressive Disorders
- Schizophrenia
- Bipolar Disorder
- Addiction – *substance or alcohol*

Source: Hospital Episodes Statistics, Office of National Statistics, Oliver Wyman analysis
1. Defined according to Charlson Index, multiple sclerosis also included due to high complexity of patient needs

With our health and social care partners, we will also develop pathways and multi-disciplinary care teams to support patients with chronic conditions through proactive, highly co-ordinated care. Care managers will be available for all our chronic patients who will act as the single point of contact and co-ordinate all of their care needs. A single care plan will be developed jointly with our patients, supported by multi-channel education and engagement. We will build on existing programmes and areas of best practice to ensure that all of our patients have access to the best care pathways for their condition. We will work closely with our local community providers to ensure that care is well integrated and, where appropriate, provided close to patients' homes or at home, ensuring they have access to the best acute facilities when needed.

Successful programmes have shown that high-quality interventions that support patients before they become acutely unwell can reduce non-elective admissions and slow progression of a disease. This can contribute to a 20 per cent reduction in overall care costs through the removal of acute beds when a critical mass of out-of-hospital solutions are in place. In addition, examples show that up to a 50 per cent reduction in missed work days can be achieved, having a positive impact on social and welfare costs, plus business workforce productivity.

Through these initiatives, we will drive significant reductions in the number of days that our patients spend in hospital on an unplanned basis, significantly reducing the cost of unplanned

care while maintaining or improving safety and quality for our patients.

3.2.3 Personalised medicine

Personalised – or stratified – medicine is an emerging, potentially revolutionary approach to healthcare provision that takes advantage of advances in our understanding of health and disease at a genetic and molecular level. We are increasingly able to target and tailor the treatments that are most effective for particular individuals, or small groups of individuals, based upon analysis of genomes, clinically expressed traits and characteristics (known as 'phenotypes'), and identification of key biological markers. This is also enabling new approaches to identifying individuals at risk of disease and developing preventative responses.

As an AHSC, we host the NIHR Imperial Biomedical Research Centre (BRC), worth £113m over five years, which works to translate new research discoveries into improvements into patient care and patient outcomes. The BRC strategy is to drive translation of our inventions in highly characterised patient populations, facilitating the development of personalised medicine. This strategy begins with the enhancement of our product pipeline by focusing on pulling through new chemical entities, diagnostics, devices and interventions from Imperial College London, including support for product development partnerships via Imperial Innovations, industrial partnership and through facilitating external funding. The Trust is already working to put new advances in this area into practice.

The BRC directly supports the Imperial Clinical Phenome Centre, which brings together a unique collection of state-of-the-art technologies for rapid molecular analysis in the hospital setting, aiming to put them at the heart of clinical decision-making for individual patients. It links closely to the MRC-NIHR National Phenome Centre, which carries out similar studies at a population level. Projects underway include metabolic phenotyping for surgical patients, critical care and cancer patient journeys.

The BRC also funds the AHSC Clinical Genome Laboratory, which runs a comprehensive service for genetic and genomic research into common and rare hereditary disorders, and the BRC supports novel scanning techniques in PET and MRI. As future innovation will be increasingly personalised, the ability to undertake detailed patient characterisation on a large scale is central to our programme of experimental medicine. Therefore, our strategy for translation of our innovative products is based on establishing sufficient capacity to characterise our patient populations through our platforms of phenotyping, genotyping and imaging.

3.3 Defining services

While it is a clear strategic priority for the Trust to provide excellent patient outcomes and experience across all of our services, we want to make the most of our strengths by identifying a subset of our services that will be truly world-leading in terms of innovation, education and reputation.

Our track record in a number of service areas has already attracted additional investment and support, accelerating performance improvement and developments. For example, our nationally designated specialist centres include units for major trauma, heart attack, hyper acute stroke and fetal medicine.

Our focus on a subset of defining services will also be driven by relative research potential and so will be linked strongly to the AHSC's Centres for Translational Medicine (CTMs). Recognising a need for structured, close collaborations between NIHR Imperial Biomedical Research Centre theme leads, other researchers, and educational and clinical service leads, the AHSC has established seven CTMs as delivery mechanisms to fulfil a central role in integrating research, education, clinical care and innovation through locally developed work programmes (see Fig. 14).

Our defining services will also need to:

- address the major causes of morbidity and mortality within our local community and the wider health economy
- be financially sustainable
- be supported by commissioners for development
- have established partnerships for delivery where necessary.

Further work is underway to determine our defining services and how they will be developed over the next five years.

Fig. 14: AHSC Centres for Translational Medicine

- Metabolic medicine
- Brain sciences and disease
- Respiratory and cardiovascular diseases
- Infectious diseases
- Inflammatory diseases
- Surgery and technology, cancer and haematology
- Women's health, neonatology and paediatrics

3.4 Business process redesign

There was strong clinical support for renewed efforts to ensure the administrative and operational processes that underpin our clinical care are fully fit for purpose. Developments are being identified at a service-, directorate- and organisation-wide level that will produce a step change in how we organise our work, ensuring patient need is the primary driver. A major project is the development of a new patient service centre to hugely simplify contact points for patients and other audiences.

4 Service strategies

Strategies for each clinical service feed into and out of the overarching clinical strategy framework. Knowledge and views at a service level have been explored in detail to ensure we have the most accurate information and assumptions about future need, optimal clinical adjacencies, new models of care, opportunities for consolidation and collaboration, and potential in terms of education and research.

The vast majority of the service strategies detailed below have arrived at a firm clinical consensus about the best models of care and clinical adjacencies within the clinical strategy framework.

The details for two specialties are awaiting the outcome of external developments. In emergency services, we are awaiting further guidance from NHS England on a national strategy to help guide the development of emergency services appropriate for a local hospital, specifically for our new local hospital at Charing Cross. In orthopaedics, we are awaiting further developments on the proposal for an elective orthopaedic centre for the region at Central Middlesex Hospital.

More detail is provided under the relevant specialty.

4.1 Investigative and clinical support sciences

Investigative and clinical support sciences provide a wide range of services critical to the successful diagnosis and holistic management of our patients. Investigative services need to respond to the detailed plans for our services and sites as they evolve. The main themes for the future include:

- routine provision of seven-day services
- specialist radiological services for the early identification and minimally invasive treatment of conditions
- integration with community services, allowing easy access and seamless management across primary, secondary and community care
- development of theatre estate to reflect modern operating practices
- development of patient administration services to reflect the modern needs of patients and use of digital technology to improve patient engagement and interaction.

4.1.1 Imaging

The department performs and reports approximately 450,000 examinations per annum, with a high proportion of complex imaging and procedural radiology.

Currently, the Imaging department offers a comprehensive range of diagnostic and interventional procedures on all three sites to support all aspects of clinical management. Although community services will continue to be offered at all three sites, the specialist modalities will be tailored to reflect the clinical priorities of the sites. The unified reporting system allows clinicians to view the images obtained from any of the sites. We will continue to offer direct access to GPs for plain radiographs, CT, MRI and ultrasound on all our sites and provide specialist services for a number of external organisations.

We have responded to a particular growth in demand over the past three years for CT, MRI and hybrid imaging (PET/CT and SPECT/CT). We are an early adopter of new techniques and minimally invasive therapies, many of which are not widely available. Many of these have been, or are being developed through, translational research links via the AHSC. For example;

- first UK centre to perform F-18 florbetapir PET/CT imaging for dementia
- renowned expertise in cardiac CT and MRI
- established use of focused ultrasound in treatment for uterine fibroids
- renowned expertise in interventional radiology.

Our training scheme is one of the most sought after in the UK, with a high level of trainee satisfaction, based on internal and external surveys.

4.1.2 Pathology

We will consolidate the pathology service into a major hub with small outreach facilities on each of the hospital sites for delivery of urgent investigations and clinical liaison. This hub is likely to include partners from a number of organisations in north west London. This opportunity has arisen as a result of pathology modernisation across the north west London sector.

We also aim to expand specialist pathology, both in terms of continued introduction of cutting-edge specialist investigations and of expansion of its referral networks and partnerships – to develop into a national/international referral centre. With improvements in the quality of our specialist services, we have seen increased demand from external clients within the UK. This increased demand, along with the internal expertise, creates the opportunity to expand our specialist services. Pathology works closely with many academic units within Imperial College London, with a good proportion of staff holding joint appointments or honorary appointments with the College. This gives us the opportunity to expand molecular pathology and genomic pathology. This will allow the further development of personalised medicine.

We have an excellent opportunity to develop our pathology capability into an ‘Institute of Personalised Investigative Medicine’. Investigative medicine has evolved from providing

individual results of investigations into the provision of integrated diagnostics/prognostics that provide personalised information to each patient, dictating personalised management. This needs close collaboration between clinical groups, clinical trials units, various academic groups in medicine, biology and engineering, and industry. We also have a leading role to play in teaching and training in all pathology disciplines, involving both doctors and biomedical/clinical scientists.

4.1.3 Therapies

Therapy services are a key clinical service, supporting the identification of vulnerable patients to benefit from targeted treatment. With the increasing emphasis on preventative medicine, the role of the therapies will need to expand and integrate with community services, allowing patients to remain at home, with early identification of risk factors for deterioration. Specialist therapy services for speech and language, stroke, trauma, neurology and dietetics will be reviewed and strategies developed to support the expanding specialist fields.

4.2 Medicine

4.2.1 Specialist medicine

The majority of specialist medicine services have a long history of providing community-based care as well as out-of-area access through established networks or nationally commissioned specialist services. There are opportunities to develop the hub and spoke model for more medicine specialties, consolidating specialist services at a centralised hub while extending access through planned assessment and ambulatory care in community-based facilities.

Specialist respiratory, endocrine, thoracic, rheumatology and HPB services will be based on the Hammersmith Hospital site, improving patient pathways and exploiting efficiencies through co-location with thoracic surgery, haematology and renal services. In addition, we will develop a co-located specialist cardiothoracic medicine and surgery centre alongside the oncology lung cancer centre.

In line with St Mary's as the major acute site, hepatology/liver failure and acute gastroenterology services will be based there. We will also keep the allergy service in its historical location at St Mary's so that it is co-located with the hyper acute and paediatric services.

Sleep studies will remain at Charing Cross, accommodated within the established medicine planned investigation unit (PIU). Dermatology will continue to be provided as a predominantly outpatient-only service with focused specialist services in selected locations.

Growth areas have been identified in hepatology with the increasing burden of disease and through a strengthened clinical pathway, both through internal and external referral. The respiratory service has created a niche in the field of endobronchial ultrasound. As one of the few providers in London, continued growth is forecast. The Trust already runs an established and highly successful bowel cancer screening service that will expand into new areas of activity

due to the lowering of the screening age. Growth is planned to take place for appropriate day cases in the successful PIU service.

4.2.2 HIV, sexual health and infection

Our infection services include specialist outpatient clinics at both Charing Cross and Hammersmith Hospitals, offering urgent referral services and an inpatient facility at Hammersmith to care for patients with severe infections and fever who might require isolation or high-level medical treatment and monitoring.

With strong links to the department for infection prevention control and tuberculosis and microbiology services, the infection specialty is well positioned to focus on embedding a Trust-wide integrated approach to the prevention, recognition and management of infection across all hospital sites. Our services ensure and promote excellent antibiotic stewardship and the prevention and management of healthcare acquired infections (HCAIs). We will continue to provide high-quality inpatient care to patients with complex infections, and rapid access to specialists and clear clinical pathways across all sites. Future opportunities for development include building on the success of our current outpatient antibiotic therapy (OPAT) services based at the Charing Cross and St Mary's sites. We aim to develop this service area to ensure comprehensive access to OPAT across all specialties and to offer direct access to these clinics by primary care providers in order to improve patient safety and patient experience, reduce length of stay and prevent hospital admissions. Infection outpatient services will continue to be provided at St Mary's, Charing Cross and Hammersmith Hospitals.

The HIV and sexual health services are based at St Mary's Hospital, with inpatient facilities in the main hospital and multiple specialist clinics in the Jefferiss Wing. Together, they offer comprehensive services for patients with sexually transmitted infections, HIV and related problems, while being fully integrated with Imperial College's departments of genitourinary medicine and communicable diseases. The clinical trials centre was established in 1991 and is one of the leading HIV and sexual health research units in the UK, located in the Winston Churchill Wing.

Our HIV service was the first of its kind to be set up in the country and it remains one of the largest in the UK. We are able to offer consultant-led care for both outpatients and inpatients, with 24-hour access to fully trained staff across the wider multi-disciplinary team, as well as specialised medical and surgical care. Treatment outcomes are above average in the UK. Multiple specialist clinics exist, often in collaboration with other specialist services within the Trust and across the north west London network – for example, comprehensive liver services in collaboration with hepatology, infectious diseases and HIV; a metabolic service with endocrinology, joint neurology and TB clinics; and services for adolescent transitioning from paediatrics to adult care.

The service will continue to focus on reducing the morbidity and mortality associated with late diagnosis of HIV infection through leadership of a comprehensive integrated programme of HIV prevention, testing and management across community, primary and secondary care

settings. In addition, we aspire to be the leading site in the UK of a programme to realise a functional cure for HIV and further development of preventative and therapeutic HIV vaccines. We continue to engage with and play a lead role in pan-London and national developments that are reviewing the configuration and funding arrangements for both inpatient and outpatient HIV services in the UK.

A sexual health service has existed at St Mary's Hospital since the original Venereal Diseases Regulations of 1917 and has developed a comprehensive range of specialist services with allied clinical specialities across the Trust (including dermatology, paediatrics, urology, gynaecology and Haven Sexual Assault Centre). The service is a key provider of open access and specialist sexual health services in London and its impact is far reaching – supporting not only the achievement of wider public health outcomes, but also promoting the safeguarding agendas for vulnerable adults, young people and children. We tailor services through patient engagement and rapid sexually transmitted infections (STI) diagnostic approaches, in line with new clinical developments and local community requirements. For example, the service established the nationally renowned Jane Wadsworth sexual dysfunction service and Praed Street sex worker project. As a result of changes to the commissioning structures for sexual health services, continued engagement of local authority/public health commissioners remains a priority for future successful tendering processes and we are directly involved in shaping these developments. The aim for the future is continued growth and streamlining of current clinical pathways services and developing community models of care and provision of a fully integrated sexual healthcare service for contraception and STI management.

The HIV and sexual health services serve a large proportion of the local community and, in addition, the special expertise and reputation of the centre attracts patients from other areas in London and wider, from across the UK. Our aim is to continue to expand and develop these services, and the location at St Mary's Hospital of the main service hub, as well as advantages of co-location with key services such as hepatology and respiratory medicine, provides this opportunity. We will continue to work with local communities and our health and social care partners to improve public health.

4.2.3 Renal

Hammersmith Hospital is one of the largest specialist renal and transplant centres in Europe. While lengths of stay for some categories of treatment are longer than those for some other providers, our renal service delivers some of the lowest mortality rates in the world, while remaining cost effective. We are introducing a new model of consultant inpatient care that will enhance quality and deliver a reduced length of stay.

The case mix at St Mary's Hospital results in patients who still have ongoing dialysis needs stepping down from level 2 or 3 care to level 1 care. In addition, patients who are on long-term dialysis will continue to have treatment needs that can only be met through an inpatient stay at St Mary's. To provide these patients with continuing dialysis care, there is a need to develop facilities for inpatient dialysis on the St Mary's site.

Below are some other key growth/developments areas:

- Opportunity to develop, with the Royal Marsden, the regional complex kidney cancer service (an already strong local collaboration with established patient pathways); and develop in parallel north west London's specialist centre for all urological malignancies with kidney dysfunction, building on our inpatient dialysis capacity and specialist renal care.
- Need to respond to increasing demand from commissioners and other providers for us to provide care for patients with vasculitis and systemic lupus erythematosus (SLE). We have longstanding research expertise in SLE and an integrated clinical service for lupus pateints in the Lupus Centre for Imperial College London, where we have pioneered the use of steroid-sparing regimes in lupus nephritis.
- Increasing the number of annual live-donor transplants by training up the remaining two (of four) transplant surgeons who are not yet able to undertake this surgery.
- Increasing the level of home dialysis. The service should be aiming for 10 per cent home dialysis. However, there are challenges around current fistula first targets, as there are significant patient concerns that would need to be overcome.
- Developing specialist clinics for other providers to offer through their facilities, anticipated to be in line with the forthcoming Dalton review. Currently, Trust consultants provide some of their time to other providers through a recharge arrangement.
- There is market share growth potential around acute kidney injury. At present, a significant proportion of this work throughout north west London is provided through the level 3 capacity of other providers. This creates pressure on level 3 beds that could be eased by increasing level 2/1 beds at Hammersmith Hospital, providing large savings from the reduction in extra-regional level 3 transfers.

4.2.4 Stroke and neurosciences

There is strong clinical consensus that providing inpatient stroke and neurosciences services across three sites is not sustainable from a safety and quality perspective. As the most critical clinical adjacencies are with A&E, major trauma and the hyper acute stroke unit, all stroke and neurosciences services – specifically neurosurgery, neuroradiology and acute neurology – will be based alongside those services on the St Mary's major acute site. This will also include neurosciences elective services, as there is not sufficient scale to separate out elective from acute services safely and efficiently. Further work is underway to understand the best location or locations for other specialties with important links to neurosciences, particularly head and neck/base of skull surgery that is currently to be located at Hammersmith Hospital (see page 32).

Further clinical design work is underway to ensure we minimise disruption to elective services co-located with acute services and that we continue to provide high quality and responsive neurosciences support to specialist services based at Hammersmith Hospital, in particular:

- oncology
- malignant spinal cord compression
- brain metastatic disease
- CNS tumour management
- endocrinology for pituary.

4.2.5 Emergency medicine

The emergency medicine service strategy is built around St Mary's as the major acute centre for the region, with an urgent care centre at Hammersmith Hospital and the development of an emergency service appropriate for a local hospital at Charing Cross Hospital. The service is also expanding ambulatory care pathways on all of its sites, closely co-ordinated with specialist teams across the Trust, to help more people to be treated without having to be admitted as inpatients.

Our aspiration is to ensure patients with emergency and urgent conditions are treated by the right practitioner, in the right place, at the right time, with a focus on treatment in the community wherever possible, alongside good access to specialist services whenever required. Our unique integrated urgent care network allows us to have joint governance and training for staff and flexible working patterns, attracting some of the best clinical staff.

Critical to the success of the emergency medicine strategy will be the development of new models of care across the Trust, particularly more streamlined pathways for frail elderly patients. We also need to ensure there is an improved transport strategy (see section 5.3) to ensure efficient transfer of patients to relevant sites once stabilised and that we respond to growing demand for paediatric emergency services, including a dedicated assessment or clinical decision unit.

4.2.6 Acute medicine and medicine for the elderly

In line with the overarching clinical strategy, our service vision is to provide acute care at all three of our sites:

- *St Mary's Hospital*: our hyper acute centre managing complex medical admissions for north west London. The innovative acute medical model for the delivery of acute services will ensure enhanced continuity of care and efficient discharge processes, with team-based consultant general physicians present daily on the emergency and acute wards. The model will allow the institution of daily consultant specialist medical input onto the acute wards.

- *Hammersmith Hospital*: a centre for inpatient specialist medicine with facilities for specialist medical admissions and medicine for the elderly.
- *Charing Cross Hospital*: a local, mostly outpatient-based service, but retaining the medicine for the elderly step up/down enablement beds.

Critical to the delivery of this stratified service will be:

- an enhanced older persons assessment team (OPAT) on each site to ensure that medicine for the elderly patients are managed in the most appropriate environment, avoiding unnecessary hospital admission
- further development of a single referral process for primary care physicians to the Trust, and cross-site bed management systems to allow the care of each patient in the optimal clinical setting
- specialist elderly medicine reablement services at the Hammersmith site.

4.3 Surgery, cardiovascular and cancer

The surgery, cardiovascular and cancer division delivers a wide spectrum of care, from managing the sickest patients presenting as emergencies to our regional 24/7 major trauma and cardiac units, to visiting chronically unwell patients in their homes to fine tune treatments and prevent deteriorations. We deliver complex tertiary and quaternary care, providing not only the best routine treatments, but, via our academic programmes, truly cutting-edge developments. As well as providing care at our main hospital sites, we are increasingly delivering outpatient and diagnostic services at local sites throughout north west and south west London. We are planning to deliver most of our care in these local settings. However, when patients need an operation or procedure, we deliver that care in our regional specialist hubs. There, we focus our expertise and our consultants are able to sub-specialise to provide the most expert care when patients are at highest risk.

We are at the forefront of delivering seven-day consultant-led care to our patients across our major specialties and we are large enough to be able to do this in a sustainable way, while still delivering high-quality elective services. This will be a challenge for the smaller hospitals around us and there will be a consolidation of emergency surgical and cardiac services to a smaller number of sites as the current provision across London is unsustainable. As a result, our specialist emergency market share is likely to increase. In parallel, we will expand our network of local outpatient services across north west and south west London. We will be in a strong position to bid for these services as they are tendered, because we will be able to ensure that patients who come in as emergencies smoothly feed into the local services so patient pathways are co-ordinated without duplication.

We are aiming to collaborate with local specialist hospitals to benefit patients. There are also many synergies that can be realised by close collaboration with our neighbouring general

hospitals and, with them, we would aim to deliver a network of clinical services across the sector.

4.3.1 Circulation sciences

Hammersmith Hospital is the major emergency cardiac centre in west London and is the only hospital in the sector to provide both 24/7 heart attack and arrhythmia services. Our clinical strategy has been to position ourselves as the single place to come if you have an acute cardiology problem. Hammersmith Hospital has an innovative cardiac surgical programme emphasising novel valvular surgical techniques, aortic surgery and minimally invasive approaches. We contribute to delivering the regional aortic dissection service.

Both St Mary's and Hammersmith Hospitals have a proud cardiac heritage. The first human ECG was recorded by Augustus Waller at St Mary's. Our cardiovascular department has major coronary and electrical academic programmes, with a world-renowned translational programme and several 'first in human' developments over the past few years. These programmes are underpinned by collaborations with many science and engineering departments across the Trust. We have a world-leading cardiovascular risk department based at the International Centre for Circulatory Health, which has published many trials over the past few years that have changed clinical practice around the world. We have developed a strong academic training programme and have established ourselves as the place where our brightest young doctors come to receive cardiac academic and clinical training.

Our clinical strategy is to grow the acute coronary and electrical services by providing the best and safest place for emergency patients. Our surgical strategy is to increase the capacity of the thoracic surgery service and develop a more integrated approach with respiratory and cancer services, building on our excellent lung cancer outcomes. Electively, we are aiming to expand our community cardiology service model, working with commissioners to develop innovative integrated care pathways to improve outcomes and reduce costs.

The regional vascular surgical service is situated at St Mary's Hospital, based on its emergency emphasis and the alignments with the major trauma and acute interventional radiology services. It was a pioneer centre in the development of aortic stenting and has developed novel technology for stenting in collaborative work with the Trust engineering department. Our ongoing strategy for vascular surgery is to build on our expertise and reputation to grow the aortic surgical programme.

4.3.2 Plastics, orthopaedics, ENT and major trauma

The major trauma centre at St Mary's Hospital sees over 2,500 major trauma calls per annum (around a third of all London trauma patients) and provides dedicated expert care across multiple specialties, including neurotrauma, extremity reconstruction and pelvic trauma. Our unit was the top rated in the country on peer review in 2014. Our strategy is to consolidate our cadre of consultant trauma surgeons; to consolidate neurotrauma onto the St Mary's site; to site a helipad at St Mary's; to continue to integrate with military medical expertise; and to increase our

academic profile. We will also raise our national/international profile by linking with centres in the US and continuing to contribute to UK-run trauma education programmes. We aim to develop an Institute of Trauma Research, including an appointment of a chair of traumatology.

The orthopaedics service will continue to provide acute trauma care, including supporting the major trauma service, as well as developing a systematised, planned care, orthopaedic pathway. We are working with our commissioners to explore whether a regional elective orthopaedic centre can be set up on the Central Middlesex Hospital site.

We plan to build on our areas of specialist trauma expertise: hand and wrist, pelvis, spine, shoulder and paediatrics. We aim to enhance capacity to deal with the increasing trauma workload, including using existing resources more efficiently – for example, through ensuring there is daily consultant review of all patients on our wards and providing extended operating hours.

Our plastics service has a growing reputation for excellence in complex reconstruction after trauma and cancer. We are about to publish the best outcomes for the management of severe lower limb injuries that have been reported in worldwide literature; we want to build on this to develop an international reputation for limb reconstruction. We are expanding our hand surgery service to include hand trauma and we are setting up a hand transplant programme with the aim of performing London's first hand transplant in the next 18 months to consolidate our reputation in this area.

We aim to become one of two head and neck cancer centres in London and expand our current activity to manage the whole range of facial reconstruction, including craniofacial trauma. We intend to increase our breast reconstruction activity by developing more referral links within our sector. In addition, the service aspires to continue to grow our academic performance and have a chair of plastic and reconstructive surgery within the next five years.

Our ENT department is the oldest in the world and has a worldwide reputation for excellence and innovation. Several members of the team are recognised as international experts in their field. As a result, patients are referred from all over the UK and worldwide. The Trust is the regional centre for head and neck and thyroid cancer. Our supra-regional skull base surgery centre treats the largest number of patients in the UK with malignant anterior skull base disease and our national centre for adult airway reconstruction is the largest in Europe. We also provide on-site paediatric or adult ENT services for the Brompton, Chelsea and Westminster and Ealing Hospitals. Complex head and neck and skull base surgery will be further centralised in London over the next few years and we should be at the forefront of this development with a dedicated cancer centre and support services. Our strength lies in cross-speciality collaborative work with neurosurgery, plastic reconstructive surgery and others. More skull base and invasive sinonasal disease will be treated endoscopically, avoiding the need for craniotomy. We will be continuing to expand the airway service and also envisage the creation of a dedicated salivary gland centre.

Hammersmith Hospital will provide specialist plastics/oncology and ENT, with a centralised head and neck centre to be developed for West London.

Neurotrauma step-down will be enhanced, aligned with the acquired brain injury unit and grown to develop a neuro-rehabilitation centre. Potential acute post-surgical rehabilitation also developed and grown in a partnership/integrated model.

4.3.3 Surgery

The Trust has the foremost academic surgery department in the UK and is world renowned, with high-profile programmes in robotic surgery, surgical training and safety. The Trust has some of the best surgical outcomes – for example, upper gastrointestinal cancer surgery outcomes are matched only by some Japanese centres.

At present, acute surgery is provided at St Mary's and Charing Cross Hospitals. However, with sub-specialisation, an increasing out-of-hours workload (particularly with the trauma service) and the need to increase the amount of acute care provided by consultants across the whole week, the service is not sustainable on two sites. We aim to have a single acute surgical site at St Mary's providing a world-leading consultant-run general and trauma surgical service. Elective short-stay surgery will be consolidated at the Charing Cross site, with a systemised surgical centre providing a high-volume, efficient programme with an excellent patient experience. The Trust has a very large and growing urology service, which is consolidated at Charing Cross. As we develop Hammersmith as a cancer and complex elective surgical centre, urological surgery will collocate here with lower gastrointestinal and gynaecological cancer surgery to deliver the synergies required to provide a high-quality pelvic surgical service. We are aiming to build on the recent growth in complex urological cancers by attracting referrals from outside London.

We anticipate a growth in upper gastrointestinal surgery with consolidation of small services in our region at the Trust, building on our excellent outcomes. We also anticipate a growth in bariatric surgery, as there will likely also be a consolidation of smaller services. Our strength is based on our good outcomes coupled with our ability to provide a comprehensive service. The Trust is the national centre for male-to-female gender reassignment and we anticipate this service growing to meet the increasing national demand.

The Trust has a large breast service seeing over 600 new patient referrals a month in clinics at St Mary's and Charing Cross Hospitals. We also invite 40,000 well women for screening each year. We had an increase of 18 per cent of breast cancer operations in 2012 and plastic surgery's breast work has doubled in the past year. With four breast surgeons trained in oncoplastic techniques, we are aiming to become a training centre in oncoplastic surgery. Breast services must be provided in both a local and specialist setting. For our local patients, our aim is to be a centre of choice, using the most up-to-date diagnostic techniques and providing all women with cancer the option of oncoplastic surgery, or mastectomy and immediate reconstruction. For that increasing number of young women with breast cancer, we already provide a specialist young woman's service using the expertise of other services, such as fertility preservation, which we are fortunate to have at the Trust. We would aim to develop this as a regional service. We aim to maintain a single multi-disciplinary breast unit, including the screening and symptomatic service, active in training, staff development and research co-located with oncology and plastic surgery.

4.3.4 Clinical haematology and cancer

The world's first stem cell transplant was performed at Hammersmith in 1975. Over the past 35 years, we have built an international reputation in the management of blood-related disorders by allogeneic (from another person) and autologous (from the same person) transplant. About 100 transplants are performed each year, principally for chronic and acute leukaemias, lymphoma and myeloma. Our programme is one of the largest and most innovative in Europe, and is supported by a state-of-the-art facility for cell collection and manipulation. We plan to increase the capacity of the department to accommodate the local and international demand for this service.

With the imminent closure of the A&E department at Central Middlesex Hospital, we anticipate an increase in the demand for haematology services and, in particular, the number of patients with sickle cell anaemia needing acute treatment. We are aiming to expand the opening of our ambulatory haematology unit to provide a seven-day-a-week service to help deal with the increasing demand.

Clinical and medical oncology are closely linked together through an academic and clinical research partnership. The clinical and medical oncology departments treat an average of 2,100 patients per annum, delivering a total of approximately 2,700 courses of treatment. The clinical oncology service treats a full range of adult malignancies and supports the haematology services.

Hammersmith Hospital has a rich radiotherapy history, having hosted the MRC radiotherapy Unit. The first linear accelerator designed for medical use was at the Hammersmith Hospital, with the first patient being treated in 1953. We were also one of the first centres to develop and use stereotactic radiotherapy for the management of brain tumours. Main research areas have been in radiobiological research. Significant growth in the need for radiotherapy services is expected, primarily linked to the aging population.

The medical oncology department supports care for the major cancer types, as well as the national gestational trophoblastic disease service, and links these major cancer types to Cancer Research UK and other national research charities (for example, Ovarian Cancer Action, prostate cancer charity). We have strong academic programmes in breast, ovarian, colorectal and prostate cancer; there is also an active pancreatic/HPB unit, as well as a successful and active Phase I clinical trials unit. The lung and upper GI services have some of the best clinical outcomes in the country. The breast cancer clinical oncology team has nationally developed the use of gating in the management of breast cancer patients. We have a large colorectal cancer practice and provide leadership for the regional anal cancer service. The west London gynaecological cancer centre is the best performing gynaecological oncology unit in the London Cancer Alliance and is internationally renowned for its clinical and academic excellence, being linked to the largest dedicated ovarian cancer research centre in Europe. In gynaecological oncology we are committed to the creation of an integrated surgical/medical/clinical gynae oncology unit that co-locates inpatients of all three branches of gynae oncology in a truly integrated unit, with the possible additional integration of the GTD and women's germ cell tumour units.

Radiotherapy is delivered through linear accelerators, of which we have four with integrated imaging facilities and the ability to deliver state-of-the-art adaptive radiotherapy treatment, stereotactic treatment in addition to non-sealed source treatments and brachytherapy. The vision is for radiotherapy to be consolidated on the Hammersmith site within a specialist cancer service that allows expert clinicians and scientists to work collaboratively to develop new cancer treatments. We plan to develop an integrated cancer research/trials space on the Hammersmith site. The four linear accelerators will be consolidated at Hammersmith Hospital due to the co-location requirement with oncology and haematology oncology inpatients. Hammersmith will also provide a merged and expanded ambulatory care service for oncology and haematology. The co-location with other specialities, such as renal and complex cancer surgery, is clinically significant for the new model to run effectively.

Charing Cross Hospital's outpatient and short-stay services include chemotherapy day-case, outpatient and home care services and oncology ambulatory care, with both rapid access pathways, in support of admission avoidance, and local outpatient services, including diagnostic rapid access pathways. A responsive acute oncology service will be developed at St Mary's Hospital to support the acute medicine unit and emergency department in assessment and discharge or admission.

4.3.5 Critical care, anaesthetics and pain

We provide care for the sickest patients in the hospital, and we are the leading London provider of pain management services. We also offer a consultant-led anaesthetic service providing comprehensive out-of-hours cover (including on-site consultant cover at the acute hub.

The national trend for critical care is upwards. The Trust also expects an increase in demand in line with planned increases in neurosurgery and natural growth in major trauma.

We will consolidate the provision of critical and high-dependency care throughout the Trust to improve safety, flexibility and efficiency. This means co-locating all ITU and HDU patients at both St Mary's and Hammersmith Hospitals and closing satellite HDUs on ward areas.

At Hammersmith Hospital, we will provide a critical care unit to support the following specialities: renal, urology, cardiovascular, haematology, oncology, obstetrics and complex gynaecology.

Critical care beds will support emergency care in all acute specialities at St Mary's. While there is no plan for a critical care unit at Charing Cross, there will be a locally based medical emergency team to provide a cardiac arrest service. Cover will be provided on site for deteriorating patients through a retrieval service from the acute site. A robust pre-operative service will also be provided at Charing Cross to ensure the highest-risk patients are not operated on at this site, where the focus will be on highly efficient, high-volume surgery with an excellent patient experience. The sickest patients will be operated on at the St Mary's and Hammersmith sites, where there will be maximum support. Further design work is required to determine the most effective model for critical care outreach on all sites.

In the outpatient chronic pain service, we will forge links with primary care and we will build an acute pain service for adults and children.

We will continue to strengthen the academic profile of the department, building on our high-quality training, as evidenced in a recent GMC survey and deanery visit. We particularly want to increase research within the anaesthetic department, both by supporting other specialties and driving research inside the specialty with the development of further academic posts.

4.4 Women's and children's

Across two hospitals (Queen Charlotte's and Chelsea Hospital on the Hammersmith site and St Mary's Hospital), we are one of the largest providers of maternity and neonatal services nationally, with the second largest gynaecology service in the UK. Our integrated models of care ensure that care is locally provided where possible and specialist services are centralised at our hospitals.

As a centre of excellence, our tertiary maternal, fetal medicine, preterm labour and gynaecological cancer services provide specialist care that attracts regional and national referrals. The provision of integrated neonatal and paediatric care also attracts many specialist commissioned paediatric services, and regional, national and international referrals.

4.4.1 Paediatrics and neonates

The first mobile paediatric intensive care transport service for very sick children in England was established at St Mary's in 1993 and now has become the standard of care with the CATS (Children's Acute Transport Service) team for north London.

In the 1990s, the paediatric intensive care unit (PICU) team at St Mary's pioneered the management of sepsis and meningococcal disease, leading to the lowest documented mortality rate worldwide and management guidelines for care that have been disseminated internationally.

In 1991, the first family clinic for comprehensive care of HIV in children, pregnant women and parents was established at St Mary's. The family clinic has an international reputation and continues to lead the way in HIV multi-disciplinary care.

Allergy and immunotherapy research has been undertaken at St Mary's for the last century. Over the past two decades, the paediatric allergy team has continued to develop new therapies for severely allergic children.

In 1939, the first human milk bank in the UK was started at Queen Charlotte's and Chelsea Hospital and is one of the 16 human milk banks in the UK.

In 1993, the Weston Neonatal Research Group was founded. The group has pursued a dual track of combining clinical and laboratory research. The laboratory has been successful in

making important discoveries, including the role of apotosis in hypoxic-ischaemic perinatal injury, the reduction in this apotosis by hypothermia, the nature in intrauterine infection and preterm delivery and, more recently, the potential of fetal stem cells for brain repair.

In 1996, the first 1.0T MRI system especially for preterm babies was built at Queen Charlotte's and Chelsea Hospital's neonatal unit for brain research. For over a decade of research, it was the only high-field MR scanner in the world fully integrated into a neonatal unit. The research done using 1.0T MR redefined the nature and understanding of brain injury in preterm infants and created a new direction for researchers across the world. This scanner was replaced in 2006 with a state-of-the-art 3.0T MR scanner within the neonatal unit at Queen Charlotte's and Chelsea Hospital.

Clinical research on serious childhood illness is at the core of paediatrics at the Trust and the Paediatric Research Unit established in 1998. The first research unit in the UK dedicated only to children, it is an excellent resource for promoting access to clinical trials and new treatments for children.

The haematology team at St Mary's is pioneering the management of children with haemaglobinopathies and bone marrow failure in the UK. In 2012, the team undertook the first unrelated haemoglobinopathy transplant and the first combined maternal haplo/mismatched unrelated cord for aplastic anaemia. They were the first centre in the UK to establish automated red cell exchange for children, and they have established the first Diamond Blackfan clinic worldwide.

We are looking to consolidate our position as the specialist paediatric and neonatal hub in west London, to involve:

- co-locating the paediatric intensive care unit (PICU) with our high-dependency unit in a modern purpose-built facility, for the sickest children, including those with surgical conditions and major trauma
- as the largest neonatal intensive care unit (NICU) service in the regional network, linked to tertiary fetal medicine, continuing to provide expert care for extreme premature infants and specialist neurological care, and supporting the needs of the maternity services
- continuing to develop our research-led, NHS England-commissioned services for critical care, allergy, bone marrow transplant, clinical haematology, infectious diseases, nephrology, neurology, sleep, ENT, surgery and opthalmology
- continuing our work innovating new pathways for general paediatrics across primary and secondary care, including Connecting Care 4 Children (CC4C) and supporting A&E services for children
- extending our co-design work with young people with chronic diseases (such as allergy, diabetes, sickle, HIV and epilepsy) to improve transitional care for adolescents, as well as to maximise care out of hospital

- building on our recognised expertise in education and simulation for all healthcare staff
- continuing to expand clinical research in allergy, infection, neonates and intensive care, recruiting children to clinical trials, and improving access to new treatments, within the unique academic resource of the clinical paediatric research unit.

A specialist paediatric service with a level three PICU and a level three NICU will be provided at St Mary's. Queen Charlotte's and Chelsea on the Hammersmith site will provide a level two NICU service with a paediatric outpatient and ambulatory care unit being provided at Hammersmith Hospital.

Ealing's maternity service closes in summer 2015. Modelling to date assumes that all activity will move to West Middlesex and Northwick Park Hospitals, but we anticipate some emergency and specialist activity will come to St Mary's.

4.4.2 Gynaecology

The gynaecology service has a strong heritage – St Mary's was the first hospital to appoint a reproductive endocrinologist to a permanent academic consultant post, and the first in the world to develop low-dose ovulation induction therapy for infertility. Furthermore, our expertise in clinical management and research into polycystic ovarian syndrome is acknowledged internationally.

The combined service is the second busiest in the country with specialist services in acute gynaecology, recurrent miscarriage, colposcopy, urogynaecology, fibroids infertility for endometriosis, family planning and gynaecology oncology. It serves the local, regional and international population.

Our community-based gynaecology clinic, mutually developed with Brent CCG, is an innovative and efficient pathway that we wish to explore with our other stakeholders.

In line with the Trust strategy and co-located services, St Mary's will provide emergency gynaecology services and will be the site for most complex, benign gynaecology, while Queen Charlotte's and Chelsea will continue with its tertiary gynaecology cancer services and in-hours emergency gynaecology.

4.4.3 Obstetrics

The maternity service aspires to build on its international reputation as a leader in the provision of high-risk, tertiary-level maternity care to women with complex medical diseases and to managing babies with complex fetal problems. We also provide maternity care to low-risk women, giving them the choice of where they deliver.

St Mary's was the first hospital to introduce fetal blood sampling and monitoring systems in labour and also led the development of specialist clinical services in the management of

gestational diabetes. The computerised maternity database first developed at St Mary's was adopted by many maternity units in London and revolutionised our ability to analyse maternity statistics.

At Queen Charlotte's and Chelsea, the service also has a very strong heritage of innovation, developing obstetric anaesthesia as a distinct subspeciality, pioneering the use of mobile epidurals for pain relief in labour, and being the first hospital in the UK to use combined spinal epidural (CSE) for labour.

The service has strong academic roots, too. We have one of only two clinically active UK professors of obstetric medicine, and we were one of the first obstetric medicine units in the UK with obstetric physicians working alongside maternal medicine specialists and specialist midwives. We have an established international reputation in the field of laboratory and translational research in prematurity and established one of the first prematurity clinics in the UK. The Centre for Fetal Care is one of a handful of units in the UK performing laser treatment in cases of twin-twin transfusion syndrome. In addition, the service provides the only community deinfibulation service for women with female genital mutilation in the UK.

A two-site model has been designed for the future provision of this service, to include a large (6,000 births per year) tertiary-level unit at St Mary's, linking in with the PICU and level three NICU, and a smaller (4,000 births per year) unit at Queen Charlotte's and Chelsea Hospital on the Hammersmith site. Both sites would offer consultant-led and midwife-led services. A high-volume antenatal clinic is required on both sites. Our midwives provide care to the community by advocating deliveries for low-risk women, antenatal care in children's centres and postnatal services to the community.

4.5 Private patient services

The Trust provides private healthcare services at all three of its main sites, at the Lindo Wing at St Mary's Hospital, the Sainsbury Wing at Hammersmith Hospital and on the 15th floor at Charing Cross Hospital. Around £39m of our total income comes from private care and we would seek to increase this up to twofold in five years. This is in response to demand and to help us fund investment to meet our strategic objectives. The Trust's private patient strategy will align with and support the clinical strategy for the Trust. As clinical services are consolidated and sites redeveloped, opportunities for co-location of our private services with our NHS services will be explored to improve patient choice. Further expansion of the Trust's private services will, however, require some upfront investment to increase bed space and supporting infrastructure.

5 Implementation

Pulling together the service strategies with the overarching clinical strategy enables us to create an estate redevelopment strategy for St Mary's, Hammersmith and Charing Cross Hospitals. As well as a new estates strategy, there are a number of other supporting or enabling strategies that are essential to the development and implementation of the clinical strategy. Most notably, these include people, patient transport, informatics, education and research, and public and patient engagement.

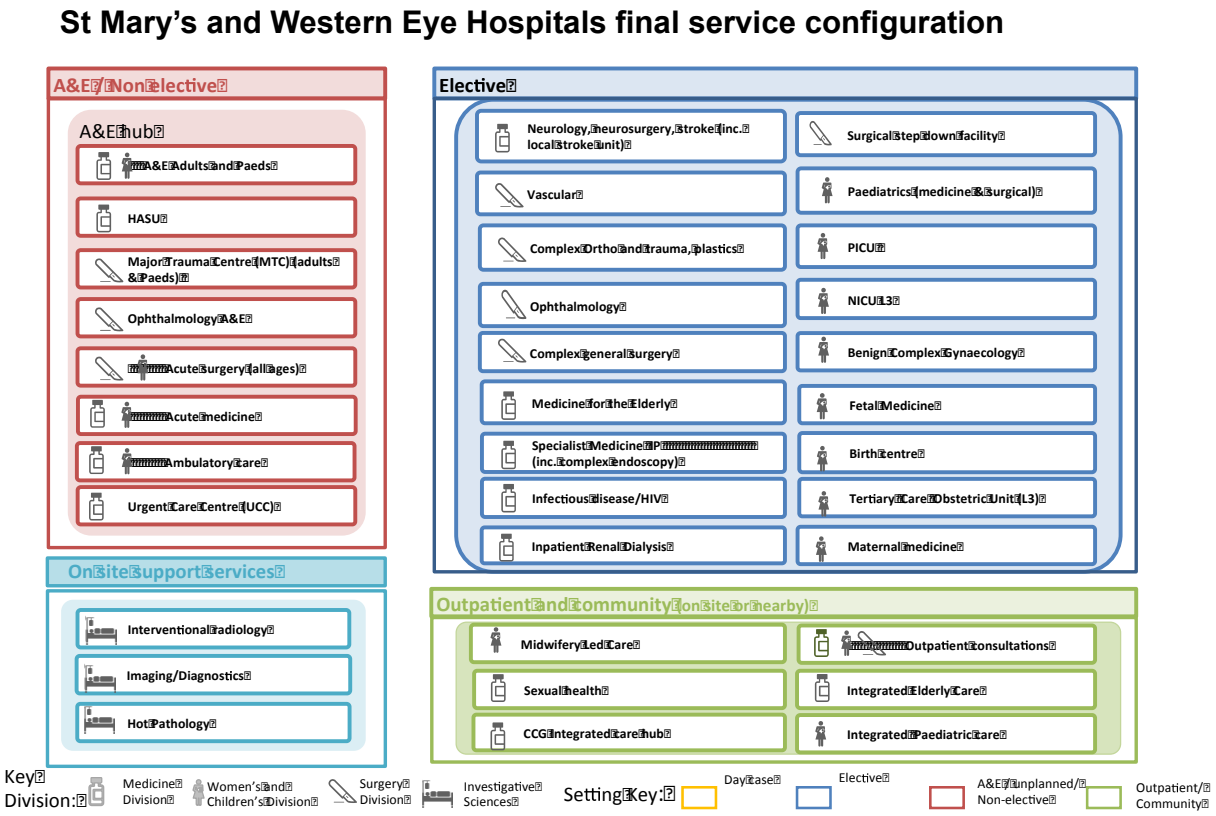
We have also begun to create a clinical transformation office to act as the engine room for ensuring and facilitating a whole organisation response to delivering the clinical strategy and achieving the step change in patient outcomes and experience that we seek over the next five years.

5.1 Estates strategy

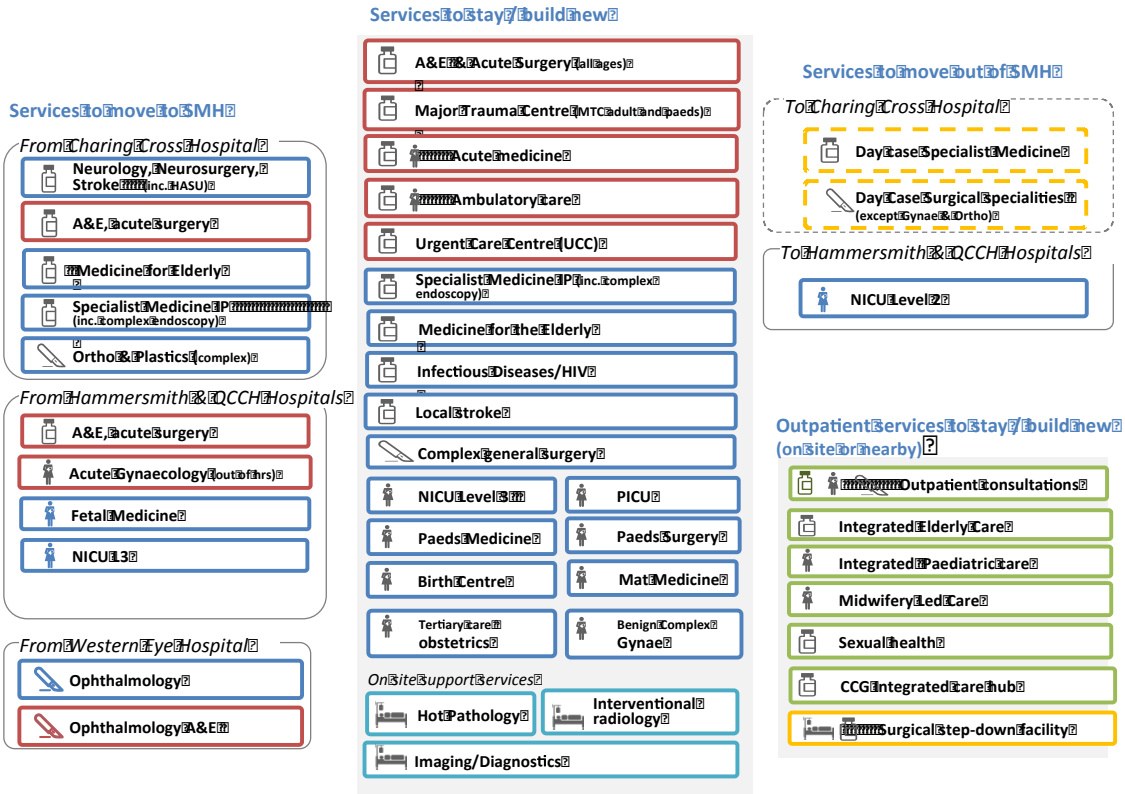
Implementation of the clinical strategy will require a fundamental overhaul of our physical estate. Detailed work has been underway to develop an outline business case to begin the process to secure the capital funds for redevelopment of our estate in the best way to deliver our clinical strategy through the three-site model. Our preferred option would see significant redevelopment and new build on the St Mary's and Charing Cross sites, with Western Eye Hospital relocating to the St Mary's site, and a smaller redevelopment on the Hammersmith site (where the Queen Charlotte's and Chelsea Hospital would remain co-located). The Western Eye Hospital site, around 55 per cent of the Charing Cross site and around 45 per cent of the St Mary's site would be sold to fund just over 40 per cent of the redevelopment costs. The net capital costs – approximately £408m – would be sought through a Treasury-approved loan following business case approval by the NHS Trust Development Authority.

The following sections show how clinical services are intended to move between our sites and what the final service configuration would be.

5.1.1 St Mary's site plan

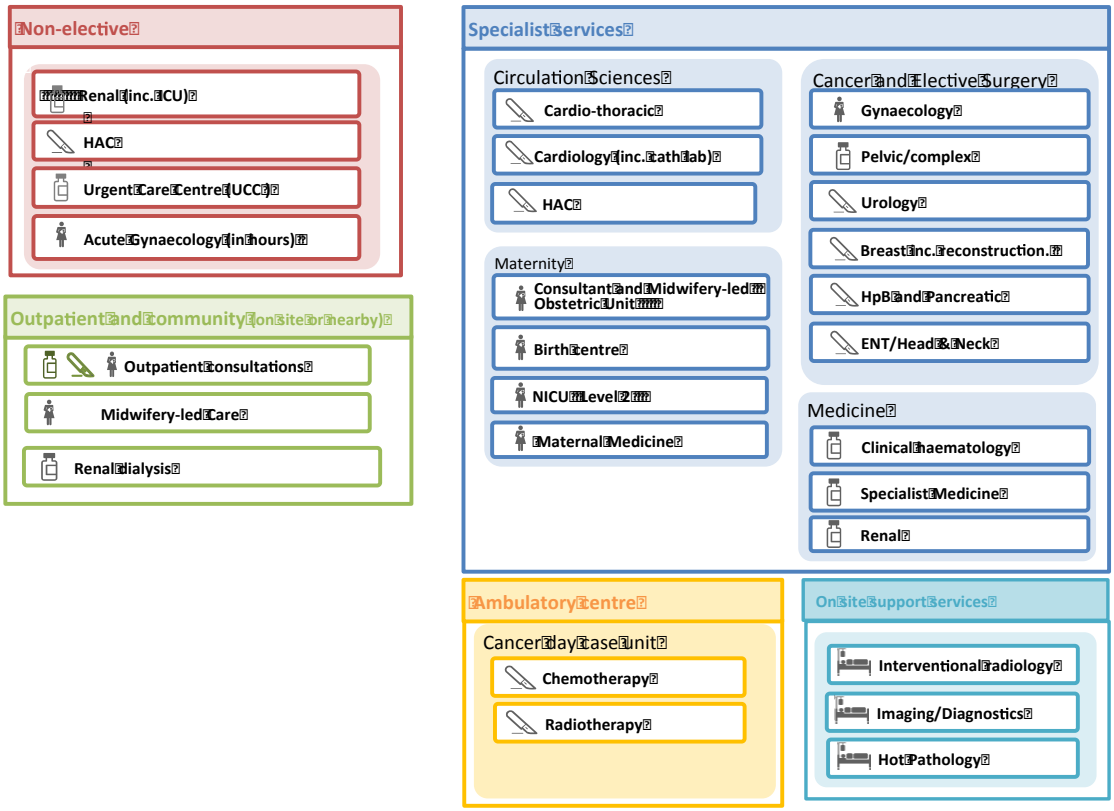


Service movements at St Mary's and Western Eye Hospitals

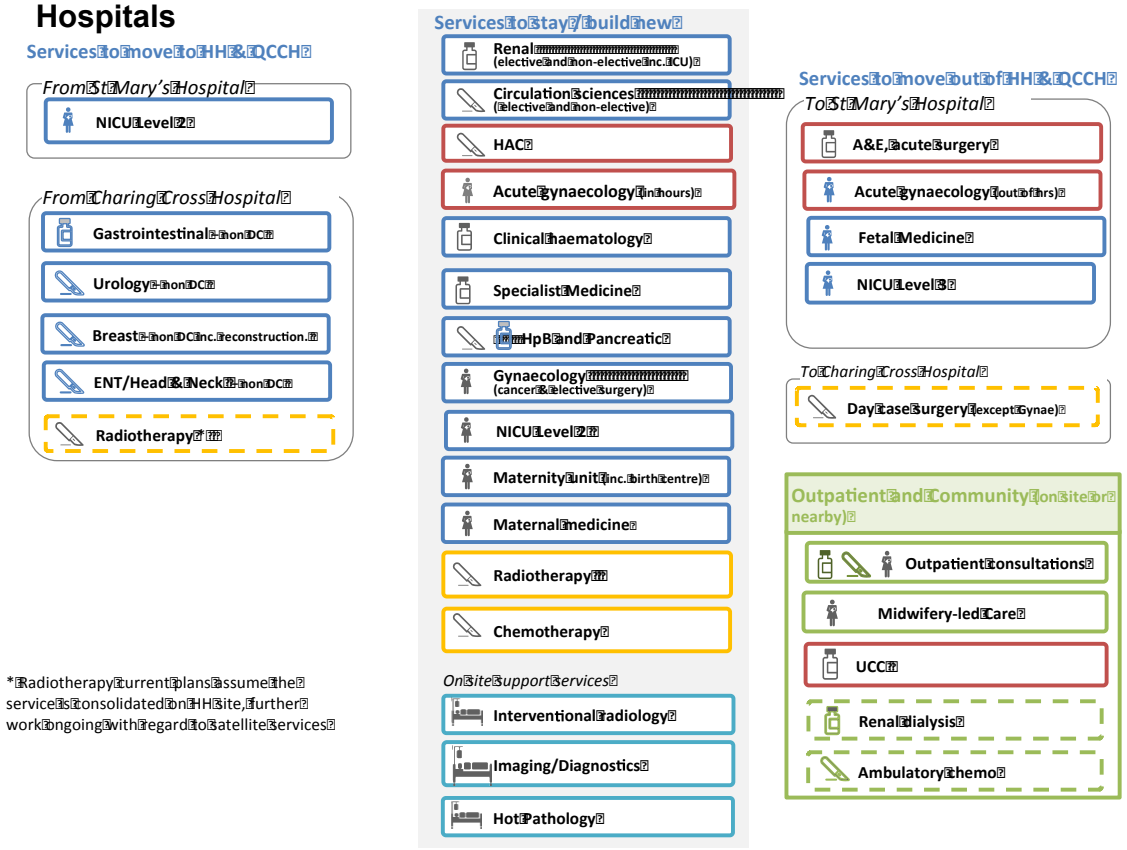


5.1.2 Hammersmith site plan

Hammersmith and Queen Charlotte's and Chelsea Hospitals final service configuration

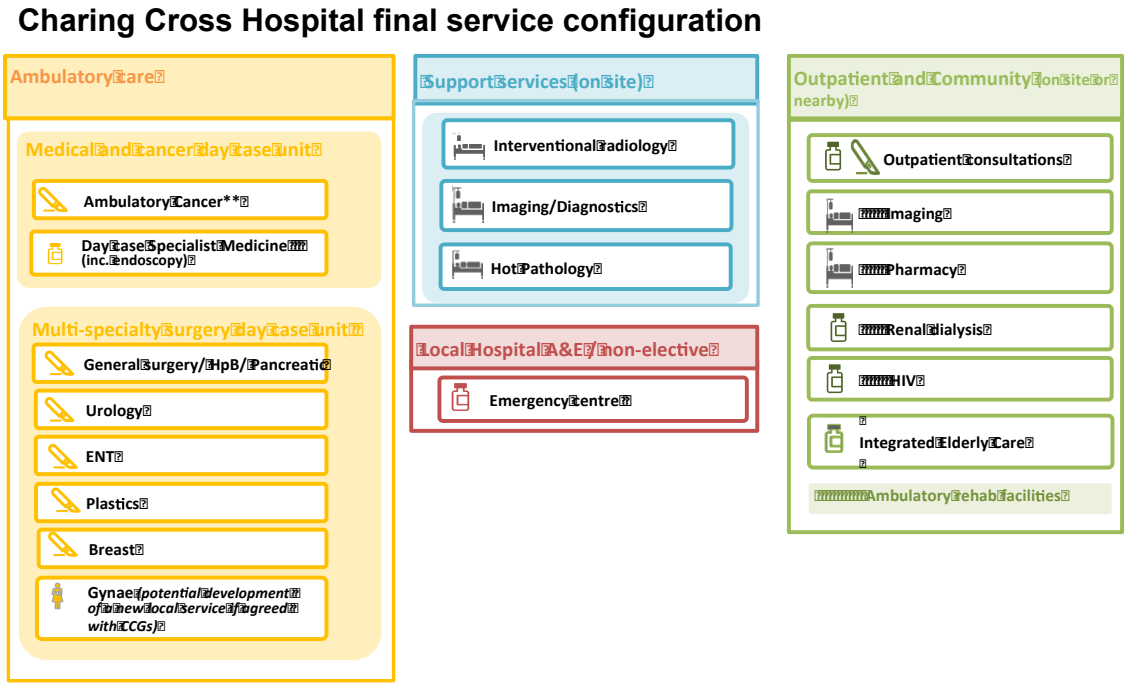


Service movements at Hammersmith and Queen Charlotte's and Chelsea Hospitals



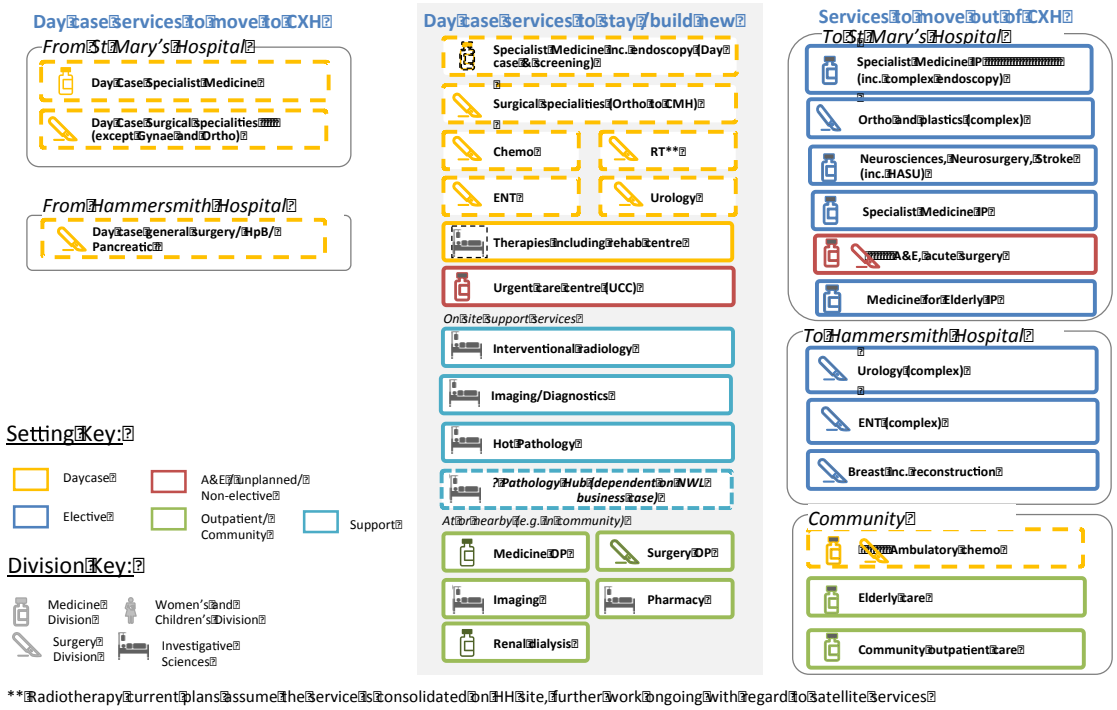
*Radiotherapy current plans assume the service is consolidated on HH site, further work ongoing with regard to satellite services

5.1.3 Charing Cross site plan



**Radiotherapy current plans assume the service is consolidated on HH site, further work on-going with regard to satellite services

Service movements at Charing Cross Hospital



**Radiotherapy current plans assume the service is consolidated on HH site, further work ongoing with regard to satellite services

The site plans include updated estimates of inpatient and day-case bed numbers as a key requirement for the scale of future facilities. To fully specify the shape and size of our facilities, these figures have been combined with outline requirements for theatres, clinics and therapy spaces, and for research and education activities, to enable us to deliver our clinical strategy. (See Fig. 15).

Fig. 15: Proposed scale and shape of Trust estate by 2020 (current scale and shape in brackets)

	Inpatient beds	Day-case beds	Theatres	Total space m^2
Charing Cross	24 (360)	86 (41)	6 (11)	25,000 (109,000)
Hammersmith	427 (406)	39 (39)	11 (11)	99,500 (98,000)
St Mary's	507 (401)	33 (40)	17 (14)	108,500 (92,000)
Total	958 (1,167)	158 (120)	34 (36)	233,000 (299,000)

In the space requirements and costings for Charing Cross, we have also allowed for a further approximately 40 beds that local CCGs have indicated they would like to commission as part of improved integrated care provision. We have also considered the needs of our partners on the site, include Maggie's Centre, the mental health service, Imperial College London, and the residential landlord A2 – and have assumed that their services will continue on the site - but we have not yet had detailed engagement with them.

We anticipate that it will take until 2020 to obtain necessary funding approvals, planning approvals, and to complete all building works. Planning will continue through the business case process to refine the design of our facilities and to determine the intricate sequence of moves that will enable us to maintain safe and high-quality patient care during the construction works.

Key milestones in implementation of the estates strategy include approval of the outline business case at the end of 2014/15, approval of the final business case at the end of 2015/16, the start of main construction at the beginning of 2016/17, and the end of all construction at the end of 2019/20.

5.2 People strategy

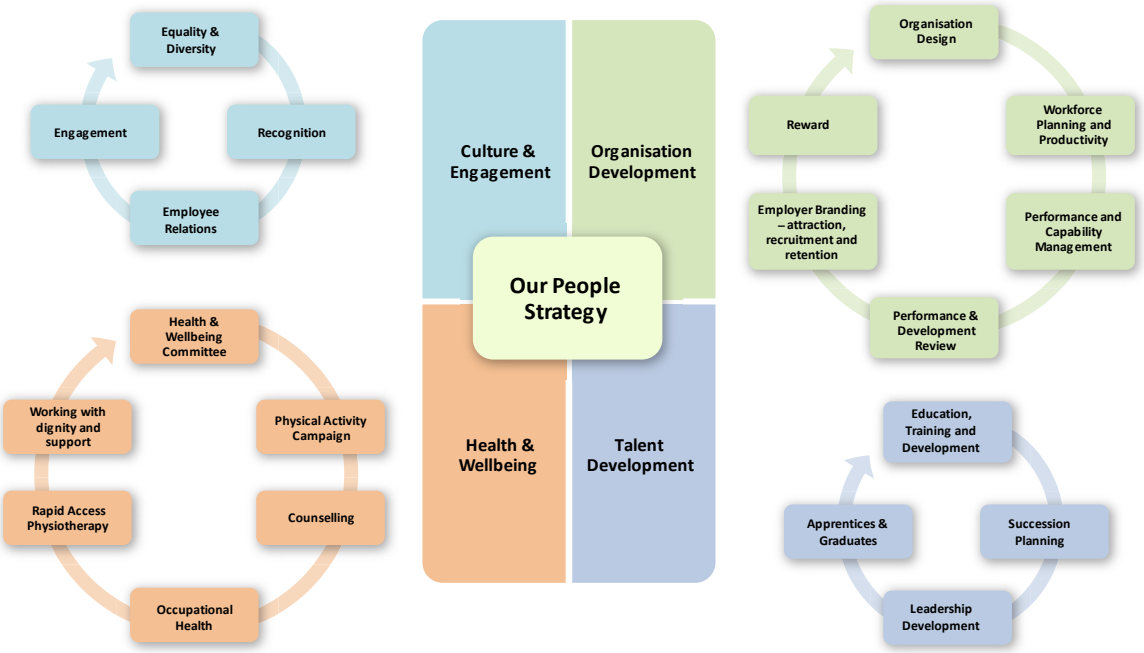
The Trust's vision to be a world leader in transforming health through innovation in patient care, education and research requires leadership and a workforce that is also world class.

The Trust's people strategy is focused on recruiting, retaining, developing and organising the staff and leaders with the right skills and experience, in the right place. It seeks to develop the talent and culture of the organisation to provide a sustainable business and advancement and development opportunities for all.

The people strategy consists of four broad areas, each with a number of elements (see Fig. 16). It details the actions the Trust will undertake against each element with expected outcomes.

Delivery of the clinical strategy will be through a workforce plan, which is supported by the people strategy.

Fig. 16: Imperial College Healthcare NHS Trust people strategy



5.3 Patient transport strategy

Improving patient transport to and between our sites has been highlighted as a priority throughout the development of the clinical strategy.

While smoother pathways and new models of care will reduce the need for transfers between sites, it is essential that we provide a fast, safe and high-quality service for those patients who need to be transferred to a more appropriate facility – for example, to move to a reablement bed nearer home after a period of emergency care. To access more centralised specialist services, patients – and their friends and families – may have to travel further and we will work with partner agencies to help ensure this is made as easy as possible.

We will work through requirements in detail, taking account of the specific needs of particular groups – for example, women in labour who need quick and easy access to our birthing services and so would benefit from on-site parking near the birth centre.

5.4 Informatics strategy

The informatics strategy will enable the transformation of the provision of healthcare and the promotion of health envisaged by the clinical strategy. As such, patients will be fully informed and equal participants in their own care. They will be able to interact with clinicians in ways that suit their lifestyles, coming into hospitals only when they and their clinician think it is necessary.

GPs, hospital clinicians and community healthcare professionals will work together, often remotely, on planning and delivering care for patients. AHSC and Biomedical Research Centre (BRC) research professionals will have access to a wealth of information for translational research. Trust managers will plan efficient and effective service delivery, making use of comprehensive information about our services.

The informatics vision is to enable patients and healthcare professionals across north west London to fully embrace digital technology for access to information and engagement. Ultimately, patients will be able to view their digital healthcare records with the facility and share and add comments. This will allow them to make informed judgements about their own care. They will be able to communicate with administration staff and healthcare professionals electronically, through the use of telehealth and telecare technologies where appropriate. Clinical staff will have remote access to patient records from the point of care, whether that is the hospital bedside, community settings or patient homes.

Informatics strategy: the five themes	
Theme 1	Improve patient safety and quality of care by providing clinical staff with a holistic view of a patient's medical condition from anywhere and at any time
Theme 2	Support integrated models of care through the ability to share information and interact electronically, across organisational boundaries, with health and social care partners and patients
Theme 3	Improve quality and efficiency of service by providing complete, accurate, real-time business intelligence via a single access point to support operations and research
Theme 4	Enable the Trust to achieve its translational research and education objectives
Theme 5	Provide the capability for smarter, safer, more effective and more efficient ways of working

New models of care will require the appropriate sharing of information with all those involved in a patient's care pathway. This cannot be achieved with paper health records. Where information is held digitally, it is currently in a variety of systems in primary, secondary and social care. The Trust is committed to moving from the current predominantly paper-based approach to health records to a paper-light way of working over the coming two years. The foundations for the electronic patient record is already in place, and development work is underway to provide comprehensive health records that contain all the information the Trust holds about a patient. This will allow the safe and secure transfer of information within and outside the Trust so that it is accessible whenever and wherever there is clinical need and that patient confidentiality is protected. This has the power to transform the delivery of healthcare.

5.5 Education and research strategy

A major focus on education and research is a central and consistent characteristic of the Trust and its constituent hospitals. It is what led to the Trust becoming the first academic health science centre (AHSC) in the UK and to its recent successful application to maintain that status. The Trust and Imperial College London have a deeply connected relationship as partners in the delivery of medical undergraduate education, translational research, and a large clinical academic programme, as well as College clinical academic staff delivering patient care.

The Trust's vision and strategic objectives are fully aligned with the AHSC's vision and strategic objectives (see Fig. 17).

Fig. 17: Imperial AHSC vision and strategic objectives

Vision

- To improve measurably the quality of life of patients and populations by taking the discoveries that we make and translating them into advances and new therapies and techniques in as fast a timeframe as possible

Strategic objectives

- To utilise the research strengths of Imperial College combined with the critical mass of the Trust to enhance healthcare for patients and populations
- To create powerful new interdisciplinary synergies spanning Imperial College, AHSC and the AHSN to transform healthcare through translational science, bioengineering and informatics
- To educate and train the future generation of multi-disciplinary clinical scientists capable of utilising new technologies for enhanced healthcare
- To translate research into new policies for the benefit of patients nationally and internationally
- To create new wealth through innovation in healthcare in discovery science and in population-based translation

Across the AHSC, we have first-class facilities in which to undertake clinical research, recognised by our NIHR Biomedical Research Centre award and for which we will apply for further funding in 2017.

We are committed to improving the quality and quantity of clinical research. Our research strategy is fourfold:

- To engage effectively with all of the faculties of Imperial College London in order to maintain a pipeline of new medical interventions, diagnostics and devices to improve the health outcomes of our patients
- To enhance the quality and increase the quantity of our clinical research

- To increase engagement with commercial partners, ensuring that patients have access to newly developing therapies
- To carry out studies faster, to ‘time and target’.

The Trust’s education strategy, currently being reviewed, will provide the framework to transform multi-professional education across the organisation in line with the clinical strategy.

Our aim is to provide excellent education to all members of the multi-disciplinary team and undergraduate students. The key areas that will be prioritised are:

- building excellent opportunities for students in clinical practice
- improving the environment for doctors in training
- building supportive ‘coach and mentor’ relationships
- creating productive and exciting learning environments that meet student/trainee needs
- improving patient safety by optimising the opportunities for education to support Trust-wide learning, across all staff groups
- ensuring clarity of education time allocation through robust job planning
- increasing innovation in education and embedding within training programmes.

The Trust’s new education strategy will be fed by the education transformation programme that is currently underway and has already seen progress, including:

- the restructure of the education team to support improvement plans in education
- the appointment of cohort of Darzi fellows to help drive clinical transformation
- the creation of the hospital at night project board
- the review of SPA and educational tariff to give clarity on the resource needed to deliver excellent performance in education.

5.6 Public and patient engagement

Working closely with our commissioners, and building on previous engagement and consultation, we will develop an engagement programme specifically around the implementation of our clinical strategy. We will look to build awareness and understanding of the key elements of the strategy and, most importantly, bring in the views and ideas of stakeholders to help shape our future plans. This will cover new models of care, improving patient pathways and systems, and our estates design and implementation.

We are also developing a wider communications strategy that seeks to improve opportunities and channels for two-way communications for our audiences, especially through the development of digital communications.

5.7 Clinical transformation programme

The success of this clinical strategy will be measured by our ability to transform clinical care and patient experience, specifically:

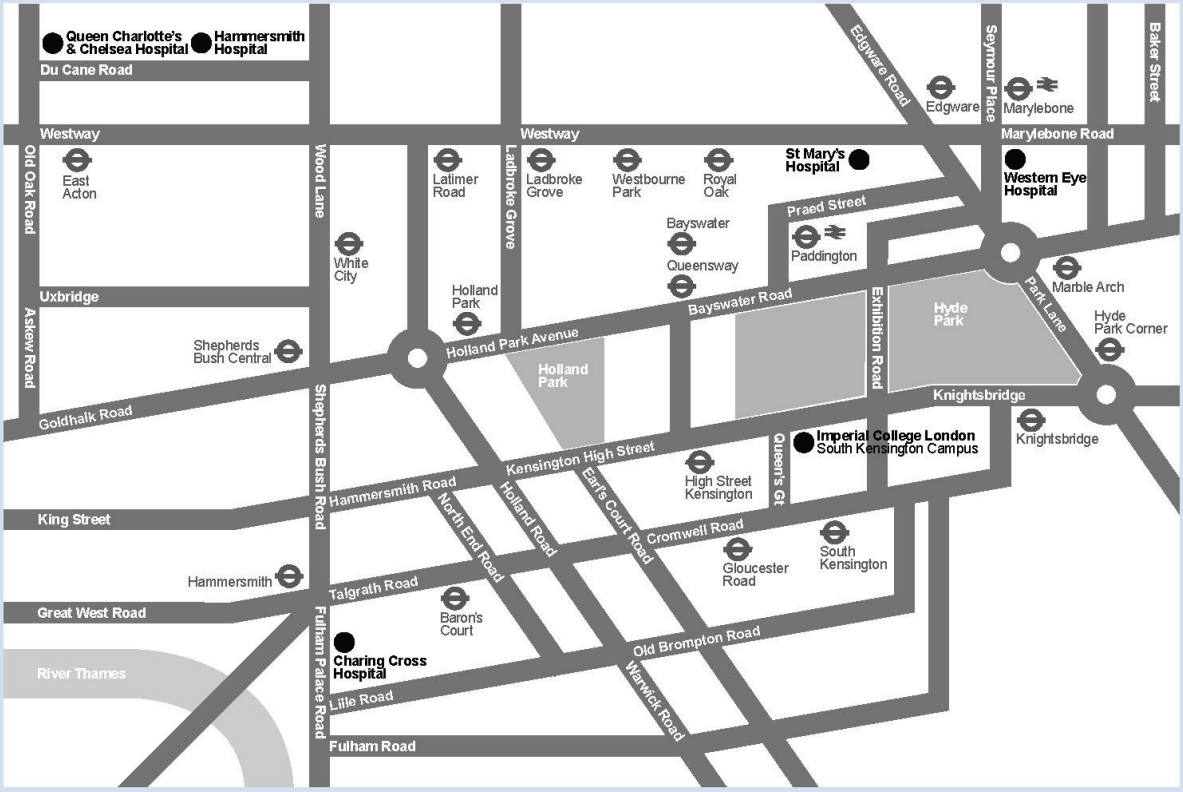
- to implement new models of care
- to fully realise our AHSC strengths to deliver world-class patient outcomes and experience, especially within our defining services
- to successfully reconfigure our services to deliver the three-site model and support the wider aims of the *Shaping a healthier future* programme
- to modernise our business processes.

We are establishing a clinical transformation programme (CTP) to act as the engine room for ensuring and facilitating a whole organisation response to delivering the clinical strategy and achieving the step change in patient outcomes and experience that we seek over the next five years.

The CTP will comprise of five workstreams:

- *Excellence in urgent care*: reducing unnecessary unplanned admissions through increasing emergency department consultant cover and developing ambulatory emergency pathways, and reducing inpatient length of stay by providing seven-days-a-week access to diagnostics and therapy.
- *Excellence in planned care*: reducing outpatient attendances through alternative service models and enhanced integration with community services, and eliminating on-the-day cancellations for elective patients.
- *Defining services*: harnessing the work of the AHSC to develop and grow services of clinical, academic and research distinction that are recognised by patients and commissioners as leaders nationally and internationally.
- *Quality and safety*: designing and implementing systems and processes to improve further the management of risk across all clinical services to ensure that the care all patients receive is of the very highest quality and safety.
- *Embedding learning and improvement*: fostering a culture where all staff are encouraged and rewarded for promoting learning and embracing improvement, leading to a highly motivated and skilled workforce as well as the early adoption and diffusion of clinical best practice.

Contact us and map of Trust sites



Contact us

Charing Cross Hospital
Fulham Palace Road
London W6 8RF
Tel: 020 3311 1234

Hammersmith Hospital
Du Cane Road
London W12 OHS
Tel: 030 3313 1000

Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12)HS
Tel: 020 3313 1111

St Mary's Hospital
Praed Street
London W2 1NY
Tel: 020 3312 6666

Western Eye Hospital
Marylebone Road
London NW1 5QH
Tel: 020 3312 6666

Imperial College London
South Kensington Campus
London SW7 2AZ
Tel: 020 7589 5111

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	3.3
Title	NHS Trust Development Authority Self-Certifications for February 2014 and March 2014
Report for	Trust Board
Report Author	Alex Williams, Head of Planning and Business Development
Responsible Executive Director	Bill Shields, Chief Financial Officer
Freedom of Information Status	Report can be made public

Executive Summary:

As part of the on-going oversight by the NHS Trust Development Authority (TDA) and in preparation for the Trust's application for Foundation Status, the Trust is required to submit two self-certified declarations on a monthly basis.

The Board is asked to retrospectively approve the April 2014 and May 2014 submissions.

Recommendation to the Board:

The Board is asked to note the Trust Development Agency self-certifications for April 2014 and May 2014.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.

Introduction

As part of the on-going oversight by the NHS Trust Development Authority (TDA) and in preparation for the Trust's application for Foundation Status, the Trust is required to submit two

self-certified declarations on a monthly basis. These self–certification declarations have replaced the Single Operating Model (SOM), which the Trust completed and submitted to NHS London, up until the end of 2012/13.

The two returns being submitted monthly are:
Oversight: Monthly self-certification requirements – Board Statements;
Oversight: Monthly self-certification requirements – Compliance Monitor.

Under the new oversight model, all performance is reported one month in arrears, with the exception of cancer which is reported two months in arrears.

The April 2014 and May 2014 returns were approved by the Chief Financial Officer (CFO) prior to their submissions.

This process has been agreed with the TDA for approval of retrospective Board sign off/approval assuming Executive sign off had already been given.

There have been no changes to the compliance monitor returns since July 2013.

Please note as per previous months, Q10 (related to performance) has been updated to reflect current status on MRSA, C. difficile and Cancer, as approved by Steve McManus.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: April 2014 ,Submitted 30/05/2014

1. Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. Condition G5 - Having regard to monitor guidance.
3. Condition G7 – Registration with the Care Quality Commission.
4. Condition G8 – Patient eligibility and selection criteria.
5. Condition P1 – Recording of information.
6. Condition P2 – Provision of information.
7. Condition P3 – Assurance report on submissions to Monitor.
8. Condition P4 – Compliance with the National Tariff.
9. Condition P5 – Constructive engagement concerning local tariff modifications.
10. Condition C1 – The right of patients to make choices.
11. Condition C2 – Competition oversight.
12. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence
COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICT Response: Yes** **Comment: None** **Explanation:** All Governors and Directors pass the fit and proper persons test.	Jayne Mee, Director of People and Organisational Development.
Q2. Condition G5 Having regard to monitor guidance. **ICT Response: Yes** **Comment: None** **Explanation:**	Bill Shields, Chief Financial Officer
Q3. Condition G7 Registration with the Care Quality Commission. **ICT Response: Yes** **Comment: None** **Explanation:**	Cheryl Plumridge Director of Governance.
Q4. Condition G8 Patient eligibility and selection criteria. **ICT Response: Yes** **Comment: None** **Explanation:** This condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals or determining the manner in which services are provided. The Trust fulfils this condition through a range of methods including; use of the ICHT access policy which sets out transparently how the Trust manages referrals and access to services, co-design with CCGs and NHSE of the eligibility criteria for access to specialist tertiary services and publication of these criteria to health care professionals and patients, use of specific processes to seek funding approval for those procedures where contractually prior commissioning approval is required, compliance with the standards set out within the NHS Constitution.	Steve McManus, Chief Operating Officer.
Q5. Condition P1 Recording of information. **ICT Response: Yes** **Comment: None** **Explanation:**	Bill Shields, Chief Financial Officer
Q6. Condition P2 Provision of information. **ICT Response: Yes** **Comment: None** **Explanation:**	Bill Shields, Chief Financial Officer
Q7. Condition P3 Assurance report on submissions to Monitor. **ICT Response: Yes** **Comment: None** **Explanation:**	Bill Shields, Chief Financial Officer
Q8. Condition P4 Compliance with the National Tariff.	Bill Shields, Chief Financial Officer

ICT Response: Yes **Comment: None** **Explanation:**	
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICT Response: Yes** **Comment: None** **Explanation:**	Bill Shields, Chief Financial Officer
Q10. Condition C1 The right of patients to make choices. **ICT Response: Yes** **Comment: None** **Explanation:** This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have choice of provider. ICHT achieves this condition through a range of initiatives including; publishing waiting times through Choose & Book to support patients and their GP in making informed decisions in the GP surgery, working closely with CCGs and NHSE to draft and implement referral criteria/pathways for access to specialist services.	Steve McManus, Chief Operating Officer.
Q11. Condition C2 Competition oversight. **ICT Response: Yes** **Comment: None** **Explanation:**	Bill Shields, Chief Financial Officer
Q12. Condition IC1 Provision of integrated care. **ICT Response: Yes** **Comment: None** **Explanation:** This condition states that the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care. ICHT works in partnership with commissioners to develop integrated care and whole systems approaches to developing patient pathways including; co-design and piloting of a virtual ward, development of joined community and secondary care outpatient services, improvements to electronic communications relating to patient records.	Steve McManus, Chief Operating Officer.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: April 2014, Submitted 30/05/2014

CLINICAL QUALITY
FINANCE
GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.
In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICT Response: Yes** **Comment: None** **Explanation:** Governance arrangements in place to assure quality of care with clear accountability and reporting.	Chris Harrison, Medical Director.
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICT Response: Yes** **Comment: None** **Explanation:**	Cheryl Plumridge, Director of Governance & Assurance.
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICT Response: Yes** **Comment: None** **Explanation:** Responsible officer in place with governance arrangements to provide assurance.	Chris Harrison, Medical director.
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICT Response: Yes** **Comment:** The Trust remains a going concern as defined by the most up to date accounting standards. **Explanation:** The Board considers annually the Going Concern of the Trust as per IAS 1. The accounts for 2013/14 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.	Marcus Thorman, Director of Finance.
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICT Response: Yes** **Comment: None** **Explanation:** A review of the NTDA Accountability Framework and the NHS Constitution was undertaken in February this year by Governance/FT Team. In respect of NTDA Accountability Framework, this document sets out how the TDA will work with the Trust on a day to day basis and how it will measure etc. As an aspirant FT, we have regular involvement and meetings with TDA. The review looked at the themes and approval model and concluded the Trust was on track which was in part supported by the work undertaken for the QGF and BGAF. In respect of the NHS Constitution this consists of 7 principles, 6 values and a number of identified rights for public and patients. We reviewed each element and confirmed that appropriate processes or procedures were in place to enable the Trust to confirm that it complies with the NHS Constitution.	Cheryl Plumridge, Director of Governance and Assurance.
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICT Response: Yes** **Comment:** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation. **Explanation:** The Trust has a Risk Management Framework in place and risks identified as part of the FT process have	Cheryl Plumridge, Director of Governance and Assurance.

been identified and documented with appropriate actions in place to deliver.	
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.* **ICT Response: Yes** **Comment:** The Annual Governance Statement identifies significant issues for the coming year. **Explanation:** Comment 6 applies. In addition the risk management framework includes a rigorous review of scoring and review of controls and mitigation.	Cheryl Plumridge, Director of Governance and Assurance.
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICT Response: Yes** **Comment: None** **Explanation:**	Cheryl Plumridge, Director of Governance and Assurance.
Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICT Response: Yes** **Comment: None** **Explanation:** The AGS has gone through a rigorous process, is overseen by the Audit Risk & Governance Committee, and is tested and challenged by internal and external audit.	Cheryl Plumridge, Director of Governance and Assurance.
Q10. *The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* The Trust reported 58 cases of Trust attributable C. difficile in 2013/14 (the Department of Health annual ceiling for the Trust is 65 cases). In April there were 7 Trust attributable cases reported to PHE. The Trust reported 13 cases of MRSA BSI in 2013/14. Four of these cases were reallocated to the Trust following the post infection review process (2 were pre 48 hour contaminants, one was a deep seated infection in a cardiology patient and one was an orthopaedic surgical wound). Of the remaining nine cases, five were due to invasive devices, one was a chest trauma, two were contaminants and the final case was an unknown source. Referral to Treatment performance was challenged in April and the Trust underperformed on both admitted and non-admitted RTT standards. This was primarily due to the implementation of a new system for recording patient activity during the middle of April and the familiarisation period for staff both recording and validating activity within the system. The main focus for validation was for patients still waiting for treatment and the Trust maintained performance above the required threshold for this standard. There were no patients waiting over 52 weeks and validation of our data continues throughout May to ensure that a more accurate position can be reported in Month 2. In April, performance is reported for the cancer waiting times standards in March. The Trust had continued to see improvements in the standards throughout 2013/14. In March and for quarter 4 of 2013/14 overall, the Trust achieved all 8 cancer waiting times standards and are in a position where this performance can be sustained. The Trust has achieved this by working to significantly reduce the backlog of patients and improving pathways of care with earlier access to diagnostics etc. The Trust has also worked directly with hospitals that refer to us to ensure that delays are minimised.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICT Response: Yes** **Comment:** The Trust is compliant and re-submit the toolkit return on 31 March 2014. **Explanation:** The Trust is compliant and re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICT Response: Yes** **Comment: None** **Explanation:** We update the register of interests continuously. It is taken to every public Trust Board for Board	Cheryl Plumridge, Director of Governance and Assurance.

members. We refresh this by requesting a new return every other Board. Responsibility for making declarations for all staff is advertised periodically – the last one took place in March '14 via the Source which included information on the requirement and how to make a declaration. All Board positions are in place. Reviews have been undertaken on the governance structure and continue to be undertaken which in part consider the effectiveness of the governance structure.	
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICT Response: Yes** **Comment:** A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills. **Explanation:** A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills.	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICT Response: Yes** **Comment:** A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan. A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year. **Explanation:** A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan. A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.	Jayne Mee, Director of People and Organisational Development.

Building world class finance

TDA Oversight: Monthly return of April 2014 submitted 30/05/2014

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: May 2014 ,Submitted 30/06/2014

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4. Condition G8 – Patient eligibility and selection criteria.
5. Condition P1 – Recording of information.
6. Condition P2 – Provision of information.
7. Condition P3 – Assurance report on submissions to Monitor.
8. Condition P4 – Compliance with the National Tariff.
9. Condition P5 – Constructive engagement concerning local tariff modifications.
10. Condition C1 – The right of patients to make choices.
11. Condition C2 – Competition oversight.
12. Condition IC1 – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence
COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICHT Response: Yes** **Explanation:** All Governors and Directors pass the fit and proper persons test.	Jayne Mee, Director of People and Organisational Development.
Q2. Condition G5 Having regard to monitor guidance. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q3. Condition G7 Registration with the Care Quality Commission. **ICHT Response: Yes** **Explanation:**	Janice Sigsworth, Director of Nursing
Q4. Condition G8 Patient eligibility and selection criteria. **ICHT Response: Yes** **Explanation:** This condition requires licensees to set and publish transparent patient eligibility and selection criteria and to apply these in a transparent manner. This includes criteria for determining patient eligibility for particular services, for accepting or rejecting referrals or determining the manner in which services are provided. The Trust fulfils this condition through a range of methods including; use of the ICHT access policy which sets out transparently how the Trust manages referrals and access to services, co-design with CCGs and NHSE of the eligibility criteria for access to specialist tertiary services and publication of these criteria to health care professionals and patients, use of specific processes to seek funding approval for those procedures where contractually prior commissioning approval is required, compliance with the standards set out within the NHS Constitution.	Steve McManus, Chief Operating Officer.
Q5. Condition P1 Recording of information. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q6. Condition P2 Provision of information. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q7. Condition P3 Assurance report on submissions to Monitor. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q8. Condition P4 Compliance with the National Tariff. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer

Q10. Condition C1 The right of patients to make choices. **ICHT Response: Yes** **Explanation:** This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have choice of provider. ICHT achieves this condition through a range of initiatives including; publishing waiting times through Choose & Book to support patients and their GP in making informed decisions in the GP surgery, working closely with CCGs and NHSE to draft and implement referral criteria/pathways for access to specialist services.	Steve McManus, Chief Operating Officer.
Q11. Condition C2 Competition oversight. **ICHT Response: Yes** **Explanation:**	Bill Shields, Chief Financial Officer
Q12. Condition IC1 Provision of integrated care. **ICHT Response: Yes** **Explanation:** This condition states that the licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care. ICHT works in partnership with commissioners to develop integrated care and whole systems approaches to developing patient pathways including; co-design and piloting of a virtual ward, development of joined community and secondary care outpatient services, improvements to electronic communications relating to patient records.	Steve McManus, Chief Operating Officer.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: May 2014, Submitted 30/06/2014

CLINICAL QUALITY
FINANCE
GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.
In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICHT Response: Yes** **Explanation: Governance arrangements in place to assure quality of care with clear accountability and reporting.**	Chris Harrison, Medical Director
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICHT Response: Yes** **Explanation: Robust process and governance arrangements in place and are part of the preparation and project management of the upcoming Chief Inspector of Hospitals visit, scheduled in early September).**	Janice Sigsworth, Director of Nursing
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICHT Response: Yes** **Explanation: Responsible officer in place with governance arrangements to provide assurance.**	Chris Harrison, Medical director
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICHT Response: Yes** **Explanation: The Trust remains a going concern as defined by the most up to date accounting standards.** **The Board considers annually the Going Concern of the Trust as per IAS 1. The accounts for 2013/14 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.**	Marcus Thorman, Director of Finance
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICHT Response: Yes** **Explanation: A review of the NTDA Accountability Framework and the NHS Constitution was undertaken in February this year by Governance/FT Team. In respect of NTDA Accountability Framework, this document sets out how the TDA will work with the Trust on a day to day basis and how it will measure etc. As an aspirant FT, we have regular involvement and meetings with TDA. The review looked at the themes and approval model and concluded the Trust was on track which was in part supported by the work undertaken for the QGF and BGAF. In respect of the NHS Constitution this consists of 7 principles, 6 values and a number of identified rights for public and patients. We reviewed each element and confirmed that appropriate processes or procedures were in place to enable the Trust to confirm that it complies with the NHS Constitution.**	Cheryl Plumridge, Director of Governance and Assurance.
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICHT Response: Yes** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation. **Explanation: The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver.**	Cheryl Plumridge, Director of Governance and Assurance.
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.*	Cheryl Plumridge, Director of Governance and Assurance.

ICHT Response: Yes **Explanation: The Annual Governance Statement identifies significant issues for the coming year. The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver.In addition the risk management framework includes a rigorous review of scoring and review of controls and mitigation.**	
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICHT Response: Yes** **Explanation: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICHT Response: Yes** **Explanation: The AGS has gone through a rigorous process, is overseen by the Audit Risk & Governance Committee, and is tested and challenged by internal and external audit.**	Cheryl Plumridge, Director of Governance and Assurance.
Q10. *The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* MRSA BSI In May the Trust reported 1 case of MRSA blood stream infection, this was a contaminated sample, this brings the number of cases to 2 for the financial year. There has been an additional case that has been attributed to a '3rd party' this is a new allocation which was implemented by PHE in April 2014, this is when the acute provider and CCG agree that the case cannot be allocated to either party. '3rd party' allocations go through an arbitration process and we await the final allocation for this case. C. difficile For 2014/15, the annual ceiling for the Trust is 65 cases of C. difficile infection. In May there were 9 cases attributed to the Trust. Year to date 16 Trust attributable cases have been reported to the PHE. In April, the Trust met all three RTT standards at an aggregate level. The Trust currently experiences capacity challenges at a treatment function code level for four key specialities (orthopaedics, urology, general surgery and ENT) and in agreement with local commissioners and in communication with the TDA and NHSE, has put in place a recovery plan to bring performance back in line from October 2014 onwards. There remain some short-term operational challenges relating to the validation of patient pathways subsequent to the implementation of Cerner which increase the level of risk to achievement of the aggregate standards in June and July. These challenges are being carefully managed with increased numbers of staff validating the data and a daily review of progress. The Trust has a 'backlog' of patients in several speciality areas and recent discussions with commissioners indicate that as part of a national drive to reduce patient numbers on waiting lists ICHT may be asked to increase capacity for the purpose of reducing waiting list numbers. This has the potential to negatively impact on aggregate standards performance for the short term. In May, performance is reported for the cancer waiting times standards in April. The Trust had continued to see improvements in the standards throughout 2013/14. In April, the Trust continued to achieve all 8 cancer waiting times standards and is in a position where this performance can be sustained. The Trust has achieved this by working to significantly reduce the backlog of patients and improving pathways of care with earlier access to diagnostics etc. The Trust has also worked directly with hospitals that refer to us to ensure that delays are minimised.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICHT Response: Yes** **Explanation: The Trust is compliant and re-submit the toolkit return on 31 March 2014.**	Kevin Jarrold, Chief Information Officer.
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICHT Response: Yes** **Explanation: We update the register of interests continuously. It is taken to every public Trust Board for Board members. We refresh this by requesting a new return every other Board. Responsibility for making declarations for**	Cheryl Plumridge, Director of Governance and Assurance.

all staff is advertised periodically – the last one took place in March '14 via the Source which included information on the requirement and how to make a declaration. All Board positions are in place. Reviews have been undertaken on the governance structure and continue to be undertaken which in part consider the effectiveness of the governance structure.	
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICHT Response: Yes** **Explanation: A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills.**	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response: Yes** **Explanation: A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan.** **A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.**	Jayne Mee, Director of People and Organisational Development.

Building world class finance

TDA Oversight: Monthly return of May 2014 submitted 30/06/2014

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	3.4
Title	2014/15 Workforce Plan
Report for	Decision
Report Author	Pen Parker – Head of People Planning & Information
Responsible Executive Director	Jayne Mee – Director of People & Organisation Development
Freedom of Information Status	Report can be made public

Executive Summary:

The purpose of this report is to attain specific Board approval of the 14/15 Workforce Plan in line with the TDA requirement as set out in the letter from Alwen Williams, Director of Delivery & Development at the TDA, on 11th June 2014.

Recommendation to the Board:

The Board is asked to approve the 14/15 Workforce Plan which has been created from the detail contained within the Divisional and Corporate Directorate business plans for 14/15 along with agreed Trust-wide initiatives.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Imperial College Healthcare NHS Trust

Trust Board Approval of the 14/15 Workforce Plan

Purpose: The purpose of this report is to attain specific Trust Board approval of the 14/15 Workforce Plan.

Introduction: In line with the TDA requirement, as set out in the letter from Alwen Williams, Director of Delivery & Development - TDA to the Trust on 11th June 2014, the Trust is required to gain Trust Board approval of the 14/15 Workforce Plan. This requirement sits within the Quality Domain under the Safe heading.

Background: In January 2014, work commenced to build a workforce plan reflective of service requirements, delivery of safe care and financial requirements for 14/15. Using plans created, agreed and owned by the Clinical Divisions and Corporate Directorates, elements pertaining to the Trust's workforce were extracted and compiled into a composite workforce plan. This plan reflects the workforce affecting changes under the following themes;

- Clinical Division & Corporate Directorate Cost Improvement Plans (CIP's)
- Agreed Service Developments (including Cerner)
- Investments to deliver CIP's
- Cost Pressures affecting whole time equivalents (WTE)
- Filling of vacancies with substantive employees with related reduction in bank and agency use.

The Workforce Plan for 14/15 was then reviewed and agreed by both the Medical Director and Director of Nursing before first submission to the TDA in January 2014. In March 2014, as part of the TDA 2-year Workforce Plan submission, the 14/15 plan was updated and approved for a second time by the Medical Director and Director of Nursing. It also formed the first year of the TDA 5-year Workforce Plan submission and the HENWL 5-year Workforce Plan, both submitted in June 2014.

Ownership of the 14/15 Workforce plan sits with the Clinical Divisions and Corporate Directorates with granular detail held at departmental /ward level; with understanding of the specific occupational group / band / grade of our workforce affected by the changes within each theme, along with the expected month of delivery for the planned changes.

The table below shows a summary of the 14/15 Workforce Plan by occupational group and by workforce type within those groups;

Imperial College Healthcare NHS
NHS Trust

Workforce Plan 14/15 Workforce WTE reductions	ALL Staff WTE March 2014 (substantive / agency / bank)	Substantive WTE reduction	Bank WTE reduction	Agency WTE reduction	ALL Staff WTE March 2015 (substantive / agency / bank)	Total WTE reduction 14/15	WTE Reduction as % of ALL Staff ~ March 2015
Admin & Clerical	1574.05	-31.20	0.00	-54.68	1488.17	-85.88	-5.46
Allied Health Professional (Qualified)	515.45	2.00	0.00	-0.28	517.17	1.72	0.33
Allied Health Professional (Unqualified)	50.57	0.00	0.00	0.00	50.57	0.00	0.00
Doctor (Career Grade)	30.71	0.00	0.00	0.00	30.71	0.00	0.00
Doctor (Consultant)	574.44	5.95	0.00	0.00	580.39	5.95	1.04
Doctor (Training Grade)	1066.72	-1.22	0.00	-2.21	1063.29	-3.43	-0.32
Estates	112.43	18.00	0.00	-18.00	112.43	0.00	0.00
Nursing (Qualified)	3441.71	259.64	-186.17	-65.41	3449.77	8.06	0.23
Nursing (Unqualified)	873.94	61.20	-64.66	-0.50	869.98	-3.96	-0.45
Pharmacist	108.83	5.00	0.00	0.00	113.83	5.00	4.59
Scientific & Technical (Qualified)	686.37	6.00	0.00	-0.46	691.91	5.54	0.81
Scientific & Technical (Unqualified)	229.52	10.10	0.00	-0.55	239.07	9.55	4.16
Senior Manager	384.65	2.00	0.00	0.00	386.65	2.00	0.52
Total WTE Workforce reductions	9649.40	337.47	-250.83	-142.09	9593.95	-55.45	-0.57

Recommendation to the Board:

The Trust Board is asked to agree this workforce plan in line with the specific TDA request of 11th June 2014.

Imperial College Healthcare NHS
NHS Trust

Trust Board Public

30 July 2014

Agenda Item	3.5
Title	Hotel Services Tender – Recommended Supplier
Report for	Ratification of Decision
Report Author	Christopher O'Boyle Director of Estates & Facilities
Responsible Executive Director	Ian Garlington Director of Strategy
Freedom of Information Status	Report can be made public

Executive Summary:

This report seeks Trust Board retrospective endorsement to:

- **Ratify** the appointment of Sodexo to provide hotel services to the Trust, mainly comprising patient catering, cleaning and portering, across all sites. This has already been approved at a Trust Board Strategy Seminar under Chairman's executive Standing Orders authority 5.2, '*Urgent decisions, emergency powers and chairman's actions'*
- **Note** that this recommendation was discussed and agreed at ExCo on 25 June 2014.
- **Note** that this represents a reduction in the annual cost of service and that in future years costs have a built-in efficiency deflator, calculated at CPI minus 4%.
- **Note** a services start date in October 2014 when, approximately 1100 staff, will be TUPE-transferred from the incumbent contractor to the new supplier, and that the CIH inspection will take place within the transition period.
- **Note** that submissions for services for Imperial Private Healthcare, mainly comprising catering, cleaning and portering across all sites, are still being evaluated

Extensive qualitative and financial assessments have been carried out by Estates & Facilities, Finance, Nursing, HR, Purchasing and Divisional staff, in accordance with OJEU procurement regulations, and concluded with the above recommendation. A PLACE patient assessor also attends the Project Executive.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Imperial College Healthcare NHS
NHS Trust

Title : Hotel Services Tender – Recommended supplier

Purpose of the report: To brief the board on the selection of a new service provider

Introduction:

The main hotel services contracts covering cleaning, portering, patient catering, mail room and private healthcare have been retendered.

An open public procurement under OJEU rules was initiated, and five companies were successfully carried through the process to the point of final selection.

The five companies were: Carillion, ISS, Medirest, Serco, Sodexo

All run significant portfolios of outsourced public sector contracts.

The tender assessment was based on best value for money, rather than lowest cost with the intent of improving catering in particular. The tender specification was developed in consultation with Trust staff, and included a 24-page “voice of the customer” document, which captured quotes from patients and staff about the manner of service delivery and its current quality.

Performance measures were also developed to ensure that contract management would focus on the important aspects of service delivery, and inform the application of financial sanctions as a last resort.

The tender assessment was carried out by stakeholders from a multi-disciplinary Trust background and overseen by a Project Executive group of senior Trust representatives.

The assessment was based on written submissions, and split into subject-specific assessor groups. Each requirement was scored on a scale of 1 to 5, bidders were invited to present their bids, and then each stakeholder group had a moderating session to address any major divergences of scoring.

Financial assessment was kept separate from quality assessment. The assessment was made for the five-year period of the contract, to take into account annual efficiency improvements that are built in to the pricing mechanism.

The value for money rating was calculated mathematically by dividing the quality score for each bidder into their price.

Tender Assessment Outcome

The best value for money bid over the contract period of five years was received from Sodexo, and the Project Executive group recommended them as the preferred supplier which was subsequently endorsed by ExCo.

Risks

The primary risk is that:

- The service change takes place over the CIH inspection period and impacts service standards

Risk mitigation plans are in place and include; selection of a healthcare organisation that has a catering heritage and is a specialist in designing, managing and delivering a range of services which enhance patient care through the consistent delivery of a safe and effective catering service; early operational mobilisation; high acceptance of TUPE transfer to the new provider; active staff communication and consultation programmes and active engagement between the Trust team and service providers throughout the process. We are also applying lessons learnt from recent Cerner mobilisation and business continuity planning.

CIH Inspection

The CIH inspection is scheduled for 2-5th September, and the new service will start in October 2014. The transfer affects 1100 existing ISS staff, creating a heightened risk of the hotel services workforce being unsettled and anxiousness. This position has been reflected on the Transition risk register, and mitigations identified by Trust executives.

Recommendation

Trust Board are invited to:

- **Ratify** the appointment of Sodexo to provide hotel services to the Trust, mainly comprising patient catering, cleaning and portering, across all sites which has already been approved at a Trust Board Strategy Seminar under Chairman's executive Standing Orders authority 5.2, '*Urgent decisions, emergency powers and chairman's actions'*
- **Note** that this recommendation was discussed and agreed at ExCo on 25th June 2014.
- **Note** that this represents a reduction in the annual cost to the NHS and that in future years costs have a built-in efficiency deflator, calculated at CPI minus 4%.
- **Note** a services start date in October 2014 when, approximately 1100 staff, will be TUPE-transferred from the incumbent contractor to the new supplier, and that the CIH inspection will take place within the transition period.
- **Note** that submissions for services for Imperial Private Healthcare, mainly comprising catering, cleaning and portering across all sites, are still being evaluated

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	4.1
Title	Update on progress towards the safe closure of the Emergency Unit at Hammersmith Hospital
Report for	Decision
Report Author	Professor Tim Orchard, Divisional Director – Medicine
Responsible Executive Director	Mr Steve McManus, Chief Operating Officer
Freedom of Information Status	Report can be made public

Executive Summary: The purpose of this paper is to update the Trust Board on progress with plans to close the Emergency Unit (EU) at Hammersmith Hospital on 10th September 2014. The EU will remain open and fully staffed until this date, by which time all new facilities and service changes to support its safe closure will be in place and any outstanding staffing gaps addressed.

A detailed risk assessment of the service changes has been undertaken and systems have been developed to monitor any quality, safety, patient experience and performance impacts post closure.

Capacity has been enhanced at St Mary's and Charing Cross hospitals. The new pathways and operating procedures designed to support the closure have been tested and assured by the appropriate clinicians.

Recommendation to the Board: The Trust Board is asked to endorse the recommendation that the closure of the EU proceeds as planned on 10th September 2014.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.

Imperial College Healthcare NHS
NHS Trust

Update on progress towards the safe closure of the Emergency Unit at Hammersmith Hospital

Purpose of the Paper

The purpose of this paper is to update the Trust Board on progress with plans to close the Emergency Unit (EU) at Hammersmith Hospital and to seek approval to continue with a planned closure date of 10th September 2014.

Introduction

The vision for modernising and improving healthcare in North West London described in Shaping a Healthier Future (SaHF) includes closure of the emergency units at Hammersmith (HH) and Central Middlesex (CMX) hospitals during the early phase of implementation. The Secretary of State for Health announced on 30 October 2013 that the departments would close 'as soon as practicable'.

These changes, put forward by clinicians, are needed to:

- Modernise and improve the delivery of health care fit for the 21st century;
- To deliver much needed care at home and in the community;
- To concentrate specialised services to provide higher quality teams.

Modernised and improved healthcare in North West London will ensure that when someone does need emergency care they are seen by a specialist more quickly and will have better access to diagnostics whatever the time of day.

Hammersmith is a general hospital and is well known for its research achievements, hosting a large community of Imperial College London postgraduate medical students and researchers. The hospital hosts the heart attack centre for North West London.

We see Hammersmith Hospital developing as a specialist hospital - providing specialist care for particular conditions - and including a 24 hour/7 day Urgent Care Centre (UCC).

Hammersmith Hospital is home to one of London's eight heart attack centres, providing specialist 24 hour/7 day emergency care and treatment for anyone suspected of having a heart attack in the west London area.

Hammersmith Hospital's current emergency service combines:

- The EU, open 24 hours a day, 365 days of the year, providing a coordinated service for the assessment, reception, referral and discharge of patients who have suddenly become very ill;
- A UCC seeing patients with minor injuries and illnesses. With effect from 23rd June 2014 the UCC has operated 24 hours a day, 365 days a year.

It is recommended that the two emergency departments (HH and CMX) plan so that they close on the same day. This is to avoid the potential impact of one closing and those patients being diverted to the remaining one as it prepares to close. As such, both units currently plan to close on 10th September 2014.

Governance Structure

The Hammersmith Hospital Emergency Unit Transition Project Delivery Board has been established with the specific remit of managing both the safe closure of the EU and the successful transition of activity from the EU to other providers, ensuring that clinical safety and quality are maintained throughout the planning and transition period.

The project delivery board includes representation from the Trust, the SaHF Programme Team, Hammersmith & Fulham Clinical Commissioning Group, London Ambulance Service and Health Education North West London.

This group reports into the following forums:

- Charing Cross and Hammersmith Non-Elective Transition (CXH NEL) Steering Group (which in turn reports into the SaHF Programme Board);
- ICHT Urgent Care Board (which in turn reports into the Tri-Borough Urgent Care Programme Board);
- ICHT Division of Medicine Committee (which in turn reports into the Imperial Trust Executive Committee);
- Hammersmith and Fulham CCG Governing Body.

The Hammersmith Hospital Emergency Unit Transition Project Delivery Board has established a number of work streams to deliver a safe service closure. These include:

- Clinical Pathways;
- Urgent Care Centre Reconfiguration;
- Communications and Engagement;
- Workforce and Education;
- Equalities, Access and Infrastructure.

There are also readiness groups to consider preparedness for additional emergency department and inpatient activity at St Mary's and Charing Cross.

In addition to the above, a weekly Hammersmith EU Closure Committee, attended by the ICHT Senior Responsible Officer, Programme Director, key Executive Directors and members of the Division of Medicine management team, has been established to oversee and coordinate delivery of the Trust's actions in relation to the EU closure.

Clinical Pathways

The detail of the new clinical pathways has now been agreed and approved by the Hammersmith EU Closure Committee. An exercise has been undertaken with a multi-disciplinary team of clinicians to test each pathway.

In addition to this, a pilot for the Medical Referral Telephone Service is due to start in August based on the Hammersmith site. This will take all GP medical referrals for the trust and will direct patients to the most appropriate site. In so doing, the Medical Referral Telephone Service will feed in patients to the Specialist Medicine Assessment Centre that will be based on B1 ward following the EU closure.

Other clinical pathways are as follows:

- Known Haematology or Renal patients will be able to self-present on the Hammersmith site following telephone contact and agreement by the relevant team.
- Cardiology patients will continue to be transported by LAS to the Heart Attack Centre.
- LAS will convey patients to the UCC on the Hammersmith site according to the agreed North West London protocol.
- All other LAS patients will be taken to an Emergency Department.
- Cardiac patients that have acute medical conditions will be referred to the medical team on the Hammersmith site.
- Gynaecology patients will continue to have access to the EPAU during working hours. Emergency patients out of hours will be managed at St Mary's.
- Paediatric pathways will continue as at present.
- Medical patients may be transferred from either Charing Cross or St Mary's to the Hammersmith site following consultant post take review for appropriate specialist input.
- Patients who present at the Emergency Departments at Charing Cross or St Mary's and need urgent specialist care on the Hammersmith site will be treated and transferred.

Urgent Care Centre Pathways

All patients who self-present at the Urgent Care Centre (UCC) will be assessed on arrival by a GP.

The UCC has developed, in conjunction with ICHT, a series of pathways that have been tested with specialties. These pathways allow groups of patients with particular needs (children, pregnant women, gynaecology conditions, haematology, renal and cardiology) to access specialist care at Hammersmith during working hours.

In a similar way to GPs, the UCC will have the option to refer into the Medical Referral Telephone Service for medical admission. Surgical, serious trauma and patients with mental health conditions have their own pathways from the UCC.

In preparation for the closure of the Emergency Unit, the UCC transitioned to a 24 hour service on 23rd June 2014. Recruitment has been successful into the GP and Emergency Nurse Practitioner posts required to support this.

Workforce and Education

The staff consultation has been completed for staff currently working in the Hammersmith EU and all staff have been slotted into suitable posts. The ward establishments for the

new Specialist Medicine Assessment Centre and the Hammersmith Medical Unit are now fully staffed. In addition, some staff have chosen to be transferred to additional posts in the Emergency Departments at Charing Cross or St Mary's.

Due to the trainee doctors finishing their allocation on 6th August 2014 there is a six week period where the EU will require additional staff to be able to remain operational. Although the ability to secure sufficient staff was flagged as a serious risk in the previous Trust Board paper, significant progress has been made and both the SHO and Registrar level rotas have been filled.

Estates, Access and Infrastructure

The following estates work is on schedule to be completed before the EU Closure:

- Work to create an additional majors and resuscitation cubicle in the St Mary's Emergency Department;
- Cosmetic improvements to B1 ward before being opened as the Specialist Medicine Assessment Centre;
- Review of signage on the Hammersmith site to reflect the EU closure and new department names;
- Lewis Lloyd ward to be returned to clinical specification for inpatient care at St Mary's;
- Ambulatory Care at Charing Cross to be relocated and additional trolley assessment space created;
- Installation of patient monitoring on C8 Ward at Hammersmith to enable sick level 1 patients to be managed there.

St Mary's Readiness

<u>Staffing</u>

- 3 additional Core Medical Trainees will be added to the acute medical team;
- 6 additional Band 5 nurses will be added to the Emergency Department establishment;
- 2 additional clerical posts will be created to enable weekend and evening working on the admission wards;
- An additional 8A Senior Nurse for Elderly Medicine has been appointed to provide leadership on Lewis Lloyd ward.

<u>Infrastructure</u>

The following infrastructure changes are planned within the St Mary's Emergency Department to ensure that increases in activity following the EU closure can be absorbed:

- Theatre cubicle being converted to enable it to be used as an extra resuscitation trolley space;
- Creation of additional cubicle in majors area;
- Transfer of the Ambulatory service to alternative facility to decompress the ED;
- Move the primary care out of hours facility to the existing ambulatory care area to maximise the streaming facility at busy times in the ED.

Medical Bed Capacity
Table 1 shows the beds that are currently in place and additional beds that will be in place following the EU closure.

Ward	Current beds	Beds post closure	Type
JTO	16	16	
AMU	9	9	
HDU	5	5	
CDU	12	12	
Manvers	26	26	
Thistle	15	20	Winter escalation
Rodney	8	8	
Samaritan	0	8	Winter escalation
AWR	14	14	
Witherow	14	14	
SLA	16	21	Winter escalation
Lewis Lloyd	0	15	New capacity
TOTAL	**135**	**168**	**= 33 Additional beds**

Table 1: Bed capacity at St Mary's

Charing Cross Readiness

Staffing
- 3 additional Core Medical Trainees will be added to the acute medical team working across medicine for the elderly, ambulatory care and acute medicine;
- 3 additional Band 5 nurses in the Emergency Department;
- A new role of Pathway Co-ordinator to help patient flow both in and out of the hospital.

Infrastructure
The following infrastructure changes are planned within the Emergency Department at Charing Cross Hospital to ensure that increases in activity following the EU closure can be absorbed:

- Relocation of ambulatory care clinic;
- Conversion of vacated ambulatory care space to 8 medical assessment unit trolleys to allow the decant of patients from the main Emergency Department;
- Conversion of X-ray changing rooms to provide single sex toilet facilities;
- Older Persons Rapid Access Clinics and Frailty Unit to be developed on 4 south ward which will be accessible by Emergency Department to avoid admission.

Medical Bed Capacity
Table 2 shows the beds that are currently in place and additional beds that will be in place following the EU closure.

The following table shows the beds that are currently in place and additional beds that will be in place post Hammersmith closure.

Ward	Current beds	Beds post closure	Type
CDU	10	10	
5 West	26	26	
5 South	9	9	
8 South	26	26	
8 West	22	22	
9 South	20	26	Winter escalation
Lady Skinner	15	15	
4 South	16	26	Winter escalation and Frailty Unit
TOTAL	**144**	**160**	**= 16 Additional Beds**

Table 2: Bed capacity at Charing Cross

Summary of Readiness

The EU will remain open and fully staffed until 10th September 2014, by which time all new facilities and service changes to support its safe closure will be in place and any outstanding staffing gaps addressed.

A detailed risk assessment of the service changes has been undertaken and systems have been developed to monitor any quality, safety, patient experience and performance impacts post closure.

Capacity has been enhanced at St Mary's and Charing Cross hospitals. The new pathways and operating procedures designed to support the closure have been tested and assured by the relevant clinicians.

Communications

A major integrated information campaign has been developed in partnership with Central Middlesex Hospital and the *Shaping a healthier future* team. The key messages for the campaign have been developed through public research and testing. Some aspects of the campaign have already begun, including a series of meetings with and letters to GPs and letters to parents via local schools. There is also a programme of meetings and communications with a wide range of community groups and with political stakeholders. The general public campaign via outdoor and print advertising, door-drop leaflets and media is due to begin on 28 July. It involves 285,000 leaflets and 312,000 pharmacy bags, putting ads on 30 bus routes, and over 100 poster and billboard sites. Tailored leaflets for groups of Hammersmith Hospital patients with long term conditions, to ensure they know how to continue to get direct admission to their specialist service where appropriate, will be distributed in August. Staff communications have been underway for some time, and have been widened out to all Trust staff over recent weeks. This includes a new information hub on the intranet. There will be evaluation of the campaign at key points to assess levels of awareness of the changes and to guide any additional or amended communications activities.

Risks

The risks identified in the update paper to Trust Board in May 2014 have been mitigated and are no longer of significant concern.

Current key risks associated with the EU closure include:

- Transport – the planned arrangements for the transfer of patients who present at St Mary's and Charing Cross and are deemed to require specialist, but not critical, care on the Hammersmith site require finalisation to ensure the service is timely. Response times will be monitored on an on-going basis to mitigate the risk of unnecessary delays.
- Performance – there is a risk that additional demand on the emergency departments will compromise performance against the 4 hour waiting time standard. The clinical pathways and operational arrangements described in this paper have been designed to mitigate this risk.

Legal and Compliance issues: None

Implications for Equality, Diversity and Human Rights: None

Recommendation(s) to the Board

The Trust Board is asked to endorse the recommendation that the closure of the EU proceeds as planned on 10th September 2014.

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	4.2
Title	Monitor's NHS Foundation Trust Code of Governance Assessment
Report for	Noting
Report Author	Helen Potton, Interim Corporate Governance Manager
Responsible Executive Director	Cheryl Plumridge, Director of Governance & Assurance
Freedom of Information Status	Report can be made public

Executive Summary: A well governed organisation should, on an annual basis, undertake a review of the effectiveness of its governance structures. The Board Governance Memorandum (BGM) also identifies a need to undertake a review against Monitor's Code of Governance to enable the Trust to understand what additional processes need to be put in place to enable it to be a well run Foundation Trust.

The attached assessment document has been produced referencing Monitor's Code of Governance and the individual Code and Regulatory Provisions required to meet the Code. It is proposed that work is undertaken jointly by the Lead Directors referenced within the assessment document and the Corporate Governance team to undertake this assessment and bring its conclusions to the Trust Board in September 2014.

Recommendation to Board: The Board is asked to note and discuss the intention to undertake a review and to bring the findings to the Board in the autumn.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

Monitor's NHS Foundation Trust Code of Governance Assessment

The attached document takes each element of Monitor's NHS Foundation Trust Code of Governance ("the Code") and assesses whether or not the Trust complies with the Code provisions and relevant statutory requirements. Where the Trust does not comply or only partially complies, details of what action will be taken to ensure compliance at the time of authorisation as a Foundation Trust must be included. If it is the intention that the Trust will not comply with a Code provision then narrative needs to be provided to "comply or explain" why the Trust is not intending to comply with best practice. Please note that all statutory requirements must be complied with.

Where it is indicated that the Trust does comply, evidence to support that assessment must be listed against each of the Code provisions or relevant statutory requirements.

The document is assessed using a standard Red, Amber, Green rating for the whole section as follows

	The Trust complies with the main principles or has a robust reason for not complying in accordance with Monitor's "comply or explain" principles.
	The Trust has a robust action plan in place which will enable it to comply with the main principles at the time of authorisation.
	The Trust does not comply with the main principles and will not comply at the time of authorisation.

The document is intended to be read alongside the Code.

A. Leadership									
A.1.	**The role of the Board of Directors**								
Main Principles	**A.1.a**. Every NHS foundation trust should be headed by an effective Board of Directors. The Board is collectively responsible for the performance of the NHS foundation trust.								
	A.1.b. The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.								
Code provisions									
A.1.1	Yes/no	**A.1.2**	Yes/no	**A.1.3**	Yes/no	**A.1.4**	Yes/no	**A.1.5**	Yes/no
A.1.6	Yes/no	**A.1.7**	Yes/no	**A.1.8**	Yes/no	**A.1.9**	Yes/no	**A.1.10**	Yes/no

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Jayne Mee	

A. Leadership (Continued)		
A.2	**Division of responsibilities**	
Main Principle	**A.2.a**. There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the Boards of Directors and the Council of Governors, and the executive responsibility for the running of the NHS foundation trust's affairs. No one individual should have unfettered powers of decision.	
Code Provisions		
A.2.1	Yes/no	
Relevant statutory requirements		
A.2.2	Yes/no	

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Cheryl Plumridge	

A. Leadership (Continued)		
A.3.	**The Chairperson**	
Main Principle	**A.3.a.** The chairperson is responsible for leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.	
Code Provisions		
A.3.1	Yes/no	

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Cheryl Plumridge	

A. Leadership (Continued)								
A.4	**Non-executive Directors**							
Main Principle	**A.4.a.** As part of their role as members of a unitary board, Non-Executive Directors should constructively challenge and help develop proposals on strategy. Non-Executive Directors should also promote the functioning of the board as a unitary board.							
Code Provisions								
A.4.1	Yes/no	**A.4.2**	Yes/no	**A.4.3**	Yes/no			
Assessment			**Evidence**		**Action Required**		**Lead Director**	**RAG rating**
							Cheryl Plumridge / Jayne Mee	

A. Leadership (Continued)									
A.5	**Governors**								
Main Principles	**A.5.a.** The Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. This includes ensuring the Board of Director's acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.								
	A.5.b. The Council of Governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.								
	A.5.c. Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.								
Code Provisions									
A.5.1	Yes/no	**A.5.2**	Yes/no	**A.5.3**	Yes/no	**A.5.4**	Yes/no	**A.5.5**	Yes/no
A.5.6	Yes/no	**A.5.7**	Yes/no	**A.5.8**	Yes/no	**A.5.9**	Yes/no		
Relevant statutory requirements									
A.5.10	Yes/no	**A.5.11**	Yes/no	**A.5.12**	Yes/no	**A.5.13**	Yes/no	**A.5.14**	Yes/no
A.5.15	Yes/no								

Assessment	**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
			Cheryl Plumridge	

B. Effectiveness								
B.1	**The composition of the Board**							
Main Principle	**B.1.a.** The Board of Directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.							
Code Provisions								
B.1.1	Yes/no	**B.1.2**	Yes/no	**B.1.3**	Yes/no	**B.1.4**	Yes/no	

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Jayne Mee	

B. Effectiveness (Continued)									
B.2	**Appointments to the Board**								
Main Principle	**B.2.a.** There should be a formal, rigorous and transparent procedure for the appointment of new Directors to the Board. Directors of NHS foundation trusts must be “fit and proper” to meet the requirements of the general conditions of the provider licence.								
Code Provisions									
B.2.1	Yes/no	**B.2.2**	Yes/no	**B.2.3**	Yes/no	**B.2.4**	Yes/no	**B.2.5**	Yes/no
B.2.6	Yes/no	**B.2.7**	Yes/no	**B.2.8**	Yes/no	**B.2.9**	Yes/no	**B.2.10**	Yes/no
Relevant statutory requirements									
B.2.11	Yes/no	**B.2.12**	Yes/no	**B.2.13**	Yes/no				

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Jayne Mee	

B. Effectiveness (Continued)						
B.3	**Commitment**					
Main Principle	**B.3.a.** All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.					
Code Provisions						
B.3.1	Yes/no	**B.3.2**	Yes/no	**B.3.3**	Yes/no	

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Jayne Mee	

B. Effectiveness (Continued)						
B.4	**Development**					
Main Principle	**B.4.a.** All Directors and Governors should receive appropriate induction on joining the board of directors or the Council of Governors and should regularly update and refresh their skills and knowledge. Both Directors and Governors should make every effort to participate in training that is offered.					
Code Provisions						
B.4.1	Yes/no	**B.4.2**	Yes/no			
Relevant statutory requirements						
B.4.3	Yes/no					
Assessment		**Evidence**		**Action Required**	**Lead Director**	**RAG rating**
					Jayne Mee / Cheryl Plumridge	

B. Effectiveness (Continued)									
B.5	**Information and support**								
Main Principle	**B.5.a.** The Board of Directors and the Council of Governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the board of directors to the council of governors are provided in *Your statutory duties: A reference guide for NHS foundation trust governors.*								
Code Provisions									
B.5.1	Yes/no	**B.5.2**	Yes/no	**B.5.3**	Yes/no	**B.5.4**	Yes/no	**B.5.5**	Yes/no
B.5.6	Yes/no	**B.5.7**	Yes/no						
Relevant statutory requirements									
B.5.8	Yes/no								

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Cheryl Plumridge	

B. Effectiveness (Continued)	
B.6	**Evaluation**
Main Principles	**B.6.a.** The Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.
	B.6.b. The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chief executive should take the lead on the evaluation of the Executive Directors.
	B.6.c. The Council of Governors, which is responsible for the appointment and re- appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chairperson and the Non-Executives, with the chairperson and the Non-Executives. The outcomes of the evaluation of the Non-Executive directors should be agreed with them by the chairperson. The outcomes of the evaluation of the chairperson should be agreed by him or her with the senior independent director. The outcomes of the evaluation of the Non-Executive Directors and the chairperson should be reported to the Governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chairperson.
	B.6.d. The council of governors should assess its own collective performance and its impact on the NHS foundation trust.

Code Provisions									
B.6.1	Yes/no	**B.6.2**	Yes/no	**B.6.3**	Yes/no	**B.6.4**	Yes/no	**B.6.5**	Yes/no
B.6.6	Yes/no								

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Jayne Mee	

B. Effectiveness (Continued)							
B.7	**Re-appointment of Directors and re-election of Governors**						
Main Principle	**B.7.a.** All Non-Executive Directors and elected Governors should be submitted for re- appointment or re-election at regular intervals. The performance of Executive Directors of the Board should be subject to regular appraisal and review. The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors.						
Code Provisions							
B.7.1	Yes/no	**B.7.2**	Yes/no				
Relevant statutory requirements							
B.7.3	Yes/no	**B.7.4**	Yes/no	**B.7.5**	Yes/no		
Assessment			**Evidence**		**Action Required**	**Lead Director**	**RAG rating**
						Cheryl Plumridge	

B. Effectiveness (Continued)					
B.8	**Resignation of Directors**				
Main Principle	**B.8.a.** The Board of Directors is responsible for ensuring ongoing compliance by the NHS Foundation Trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its Board and Directors and works with the Council of Governors to ensure there is appropriate succession planning.				
Code Provisions					
B.8.1	Yes/no				
Assessment		**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
				Jayne Mee / Tracey Batten	

C. Accountability								
C.1	**Financial, Quality and Operational reporting**							
Main Principle	**C.1.a.** The Board of Directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.							
Code Provisions								
C.1.1	Yes/no	**C.1.2**	Yes/no	**C.1.3**	Yes/no	**C.1.4**	Yes/no	

Assessment	**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
			Bill Shields / Steve McManus / Chris Harrison	

C. Accountability (Continued)						
C.2	**Risk Management and Internal Control**					
Main Principles	**C.2.a.** The Board of Directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.					
	C.2.b. The Board of Directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHS foundation trust's assets, and service quality. The board should report on internal control through the Annual Governance Statement (formerly the Statement on Internal Control) in the annual report.					
Code Provisions						
C.2.1	Yes/no	**C.2.2**	Yes/no			
Assessment			**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
					Cheryl Plumridge	

C. Accountability (Continued)									
C.3	**Audit Committee and auditors**								
Main Principle	**C.3.a.** The Board of Directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS Foundation Trust's auditors.								
Code Provisions									
C.3.1	Yes/no	**C.3.2**	Yes/no	**C.3.3**	Yes/no	**C.3.4**	Yes/no	**C.3.5**	Yes/no
C.3.6	Yes/no	**C.3.7**	Yes/no	**C.3.8**	Yes/no	**C.3.9**	Yes/no		

Assessment	Evidence	Action Required	Lead Director	RAG rating
			Cheryl Plumridge / Bill Shields	

D. Remuneration								
D.1	**The level and components of remuneration**							
Main Principle	**D.1.a.** Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.							
Code Provisions								
D.1.1	Yes/no	**D.1.2**	Yes/no	**D.1.3**	Yes/no	**D.1.4**	Yes/no	

Assessment	**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
			Jayne Mee	

D. Remuneration (Continued)						
D.2	**Procedure**					
Main Principle	**D.2.a.** There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual Directors. No Director should be involved in deciding his or her own remuneration.					
Code Provisions						
D.2.1	Yes/no	**D.2.2**	Yes/no	**D.2.3**	Yes/no	
Relevant statutory requirements						
D.2.4	Yes/no					
Assessment		**Evidence**		**Action Required**	**Lead Director**	**RAG rating**
					Jayne Mee	

E. Relations with Stakeholders									
E.1	**Dialogue with members, patients and the local community**								
Main Principles	**E.1 a.** The Board of Directors should appropriately consult and involve members, patients and the local community.								
	E.1.b. The Council of Governors must represent the interests of trust members and the public.								
	E.1.c. Notwithstanding the complementary role of the governors in this consultation, the Board of Directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.								
Code Provisions									
E.1.1	Yes/no	**E.1.2**	Yes/no	**E.1.3**	Yes/no	**E.1.4**	Yes/no	**E.1.5**	Yes/no
E.1.6	Yes/no								
Relevant statutory requirements									
E.1.7	Yes/no	**E.1.8**	Yes/no						

Assessment	**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
			Janice Sigsworth / Chris Harrison / Cheryl Plumridge	

E. Relations with Stakeholders (Continued)						
E.2	**Co-operation with third parties with roles in relation to NHS Foundation Trusts**					
Main Principles	**E.2.a.** The Board of Directors is responsible for ensuring that the NHS Foundation Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.					
Code Provisions						
E.2.1	Yes/no	**E.2.2**	Yes/no			
Assessment			**Evidence**	**Action Required**	**Lead Director**	**RAG rating**
					Chris Harrison	

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	4.3
Title	CQC Chief Inspector of Hospitals' Assessment September 2014
Report for	Noting
Report Author	Dr Senga Steel, Deputy Director of Nursing
Responsible Executive Director	Professor Janice Sigsworth, Director of Nursing
Freedom of Information Status	This report can be made public

Executive Summary:

The purpose of this report is to provide an update to the Committee on the plans for the CQC Chief Inspector of Hospitals visit.

The Chief Inspector of Hospitals' will visit ICHT between the 2nd and 5th September 2014.

This paper sets out the current plans that have been put in place to ensure organisational readiness for this visit.

Recommendation(s) to the Board:

To note the paper

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Imperial College Healthcare NHS Trust

CQC Chief Inspector of Hospitals Assessment: 2nd – 5th September 2014

1. Background

1.1 On the 2nd May 2014 Professor Sir Mike Richards confirmed in writing to the Trust that we would be inspected by the CQC as part of the Quarter 2 Acute Hospital Inspection Programme (Appendix 1).

The new inspection methodology differs from previous years and will see large numbers of inspectors from various professional and lay backgrounds as part of the inspectorate team. We are expecting *circa* 40 inspectors during our visit. Eight key service areas will be inspected and these are:

- A&E: acute medical pathways;
- Older people's care;
- Acute surgical pathways;
- Critical care;
- Maternity and family planning;
- Services for children and young people;
- End of life care;
- Outpatients.

The inspectors' focus will be across the patient pathway and sites. The Chief Inspector of Hospitals' (CIH) team will inspect against 5 domains. They will assess whether we are:

- Safe;
- Effective;
- Caring;
- Responsive to people's needs;
- Well led.

1.2 The inspection team will undertake visits to departments and will walk patient pathways in and out of hours. They will visit every medical and elderly care ward. The CQC will set up a local stakeholder meeting in a community setting to hear from the public and patients.

Potential outcomes of the inspection are as follows:

- Outstanding;
- Good;
- Requires improvement;
- Inadequate.

We will need to achieve 'good' or 'outstanding' in all areas to proceed with our Foundation Trust application.

2. Project Plan

2.1 An organisational project plan has been put together outlining milestones in planning for the inspection. The areas of the plan include:

- Managing the Trust visit in September;
- Organisational preparedness;
- Assurance and pre-assessment data pack request;
- Communications;
- Post inspection – Quality summit.

2.2 Intelligence sharing has already assisted our preparation through feedback received from Bart's NHS Trust and Croydon NHS Trust. The executive team visited Oxford University Hospitals that underwent an inspection in February 2014.

3. Managing the Trust Visit

3.1 Head of Hospital's Inspector for ICHT visit

We have met with the Head of Hospital Inspections for ICHT (Tim Cooper) who will lead the inspection team in September. This 'start up visit' was held on 18th July and outlined the logistical elements of our preparation.

4. Organisation Preparedness

4.1 Divisional leads have produced plans of their own preparation. Similar plans have been requested and received from the following corporate departments:

- Medical Records;
- Human Resources;
- Estates.

4.2 The Director of Nursing and Chief Operating Officer have led two Senior Leadership 30 Day Events to support the delivery of the CIH visit. A number of other briefing events are planned to ensure our people are prepared.

4.3 A weekly Task and Finish group has been set up. The purpose of the group is to oversee the operational delivery of the inspection.

The following activities will support organisational preparation:

- We will continue with our leadership Walk rounds across ICHT sites with a focus on pathways;
- July and August Back to the Floor Fridays will focus on areas of concern that are being identifies from the walkabouts;
- There will be a focus on out-of-hours activity with over 300 hours of senior cover shifts planned;
- Desk-top assurance self-assessment.

4.4 Preparing our people

Our plan is to make sure all our people are aware that the visit is happening and are able to meet and greet the inspection teams whilst protecting patients.

It is likely that the CQC will request one to ones with some members of the Board.
They will also ask to speak to our people during the inspection either one to one or as part of a focus group. They are likely to set-up focus groups to speak with:

- Consultants;
- Junior Doctors;
- Nurses;
- Allied Health Professionals;
- Health Care Assistants.

5. Assurance and Pre-assessment Data Pack

5.1 We have received the request for data which the CQC will use as part of their assessment of our performance in the five domains. We are currently collecting the data and this will be submitted to them on 8th August. All information will be fully validated before it leaves the Trust.

The CQC will assess the information and triangulate it with other data sources obtained from commissioners and other partners, such as Healthwatch and NHS Choices. They will pull together a data pack in relation to ICHT, which we will receive to scrutinise for factual accuracy.

Once the visit is completed we will be given basic feedback about any particular areas of concern. We will then receive a written report of the inspection some six to ten weeks after the visit. It is likely we will receive a report for each site and also a Trust-wide report. We will have approximately one week to check the report for factual accuracy and report our corrections to the CQC. It is at this stage we will get an indication of our grade.

The data pack will provide a general overview of ICHT's performance and issues by pathway and domain. The Intelligent Monitoring Report for March already highlights the following issues:

Elevated Risk	Incidence of Meticillin-resistant Staphylococcus aureus (MRSA)
Risk	Proportion of patients who received all the secondary prevention medications for which they were eligible
Risk	Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10)
Risk	All cancers: 62 day wait for first treatment from urgent GP referral
Risk	NHS Staff Survey – KF10. The proportion of staff receiving health and safety training in last 12 months
Risk	Composite risk rating of ESR items relating to staff stability

5.2 The draft Intelligent Monitoring Report for July has been sent to us for factual accuracy checking and includes one new risk (Never Events) and one risk we expected to be resolved; 'proportion of patients who received all secondary medications for which they were eligible.' We are currently discussing the removal of this particular risk as we believe it has now been resolved. One risk that appeared in the March report has now been

resolved 'all cancers: 62 day wait for first treatment from urgent GP referral' and therefore will not appear in the July report. We are still waiting for the publication of the July Intelligent Monitoring Report.

Additional risks include:

- Compliance with WHO checklist;
- Feedback from incident reporting to staff;
- Medical records and documentation.

Action plans to address these issues are in place and will be reviewed.

6. Desk-top Assurance Exercise

An important part of the preparation for the inspection has been assessing our own performance within the services that will be inspected. A desk-top assurance exercise has been completed that used indicators published in the CQC technical manual to assess performance across our services in each of the five domains. We asked Executive Directors to become a domain lead and review data relating to the pathways for that domain using these indicators. The assessments were validated at Divisional based quality summits with the domain lead and the Divisional Director leads who are devising action plans to rectify any areas of concern noted.

7. Communications

We have a plan in place to ensure our people are prepared and know what to expect during the inspection and understand the inspection process. We have a mixture of briefing sessions and guidance for staff published on the 'The Source'.

8. Post Inspection: Quality Summits

8.1 Purpose of the Quality Summit

After the inspection phase a Quality Summit will be arranged to discuss the findings of the inspection. The purpose of the Quality Summit is to present recommendations and develop a plan of action based on the inspection team's findings as set out in the inspection report. This plan will be developed by partners from within the health economy and the local authority. The Quality Summit will consider:

- The findings of the inspection;
- Whether planned action by the Trust to improve quality is adequate or whether additional steps need to be taken;
- Whether support should be made available to the Trust from other stakeholders such as commissioners to help them improve.

8.2 Likely representation of people who will be required to attend is listed in Appendix 2. In the case of serious concerns being raised about a provider, Team Leaders/HHI's must identify any relevant third party providers and ensure they are invited.

8.4 Draft Report

The draft report will be shared in confidence with NHS England, Monitor and/or TDA at the same time as it is shared with the Trust for factual accuracy comments, unless there are legitimate reasons not to share the draft report. Before sending the report to us CQC will inform us with whom the draft report is being shared. If the Chief Inspector of Hospitals' recommends entry/exit of special measures, this should be raised with NHS England, Monitor and TDA during the Quality Summit pre-meeting.

9. Conclusion

Plans are underway for the inspection in September 2014. We are currently compiling the data that will inform the development of the ICHT data pack that will be sent to us prior to the inspection and will help to guide the CQC's Key Lines of Enquiry during the inspection.

Appendix: 1

Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Telephone: 03000 616161
Fax: 020 7448 9311
www.cqc.org.uk

2nd May 2014

Tracey Batten
Chief Executive
Imperial College Healthcare NHS Trust
St Mary Hospital
Pread Road
London
W2 1NY
Dear Tracey

Quarter 2 acute hospital inspection programme: July – September 2014

I have now been the Chief Inspector of Hospitals at CQC for 10 months and we have carried out 41 acute trust inspections using the new approach that I outlined when I was appointed, with a further 16 scheduled to be inspected by the end of June.

On 2nd September 2014 I will be publishing a list of 12 acute trusts (and 2 ambulance trusts) that we will inspect between July - September 2014.

We will be inspecting your trust using the new CQC model as part of our quarter 2 schedule. My colleagues will be in touch within the next fortnight regarding what this means in practical terms and with dates for our planned inspection. Please note that we will not be carrying out any comprehensive inspections between 14th July – 1st September 2014.

I wanted to let you know about your inclusion in 'Q2' and thought it would be helpful if I gave you an overview of what our new model entails.

The new inspection teams will be large (over 20 people) and will be headed by a senior NHS clinician or executive, working alongside senior CQC inspectors. The teams include professional and clinical staff and other experts, including trained members of the public ('experts by experience'). Many of these are volunteers who came forward when I launched my new approach in July 2013.

The teams will spend at least two full days at the trust inspecting every site that delivers acute services, and eight key service areas: A&E; acute medical pathways including older people's care; acute surgical pathways; critical care; maternity and family planning; services for children and young people; end of life care and outpatients. The teams will look at other services where necessary, including community services where applicable.

The inspections are a mixture of announced and unannounced and may include inspections in the evenings and weekends, when we know people can experience poor care. Our inspection teams make better use of information and evidence to direct

resources where they're most needed. Our analysts have developed new triggers to guide the teams on when, where and what to inspect. Before they inspect, the teams assess a wide range of quantitative data, including information from our partners in the system, and information from the public.

Each inspection will provide the public with a clear picture of the quality of care in their local hospital, exposing poor and mediocre care and highlighting good and excellent care. We will look at whether the trust and each of the core services are safe; effective; caring; responsive to people's needs and well-led.

I will decide whether hospitals are rated as outstanding; good; requires improvement; or inadequate. If a hospital requires improvement or is inadequate, I will expect it to improve. Where there are failures in care, I will work with my colleagues at Monitor and the NHS Trust Development Authority to make sure that a clear programme is put in place to deal with the failure and hold people to account.

My inspection of services at your trust will include ratings of each of the eight core services, and of the trust overall. By the end of 2015 my teams will have inspected and rated all acute hospitals in this way.

You can find out more details about our new inspections on our website. In particular we encourage you to participate in our consultation on how we regulate, inspect and rate services. The consultation opened on Wednesday 9th April and closes on Wednesday 9th June. You can access all the consultation materials by clicking on this link.

I have made my choices for this quarter of inspections based on a number of criteria, including Band 1 or 2 trusts in our intelligence monitoring. We have also considered the views of our regional teams as well as Monitor and the NHS Trust Development Agency. Finally, we have included trusts that have been low risk (band 6) on our intelligence monitoring methodology in both October 2013 and March 2014, in order that we can test whether our monitoring is effective in identifying lower risk providers.

You will receive a follow up from CQC explaining in more detail what this will mean for you and your trust, including the dates on which we intend to inspect.

The relevant CQC Head of Hospital Inspection will be in touch with you very shortly and should be able to answer any questions about the Inspection.

Thank you in advance for your co-operation, and I look forward to working with you in the near future.

Yours sincerely,

Professor Sir Mike Richards
Chief Inspector of Hospitals

Appendix 2: Quality Summit Attendees -The Quality Summit will include the following people:

Attendees:
Inspection Chair
CQC Inspection Team Leader/Head of Hospital Inspection
Regional Director for the relevant CQC region or CQC relationship holder (if not the Head of Hospital Inspections)
Clinical Expert from Inspection Team
Expert by Experience or public and patient representative from Inspection team
Trust representatives (Chair, Chief Executive, Medical Director, Director of Nursing)
Monitor/TDA representative
NHS England Area Team representative
Quality Surveillance Group representative
CQC representative
Overview and Scrutiny Committee representative
Local Healthwatch representative
CQC Recorder

Imperial College Healthcare NHS Trust

Trust Board

30 July 2014

Agenda Item	4.4
Title	Responsible Officer's Annual Report
Report for	Noting
Report Author	Dr David Mitchell, Associate Medical Director and Responsible Officer
Responsible Executive Director	Professor Chris Harrison, Medical Director

Executive Summary:

The submission of the Responsible Officer's Annual Report to the Executive Team is required by NHS England. It summarises the Trust's compliance with the Responsible Officer Regulations for the year ending 31st March 2014.

All doctors employed by the Trust must revalidate every 5 years via the GMC, which includes the requirement for an annual medical appraisal.

The first Annual Organisational Audit (AOA) was submitted to NHS England in May 2014, which outlines the Trust's compliance with the Responsible Officer Regulations. There were some areas for development noted and subsequently an action plan has been developed.

NHS England monitors compliance with Responsible Officer Regulations via the Framework of Quality Assurance for Responsible Officers (FQA). As part of these requirements, the Trust's Executive Team are required to sign & submit an annual statement of compliance. This report serves to outline the Trust's performance against the standards to enable the Executive Committee to make an informed assessment such that the statement of compliance can be signed off.

Recommendation(s) to the Board/Committee:

The Board is asked to note this report and the attached statement of compliance, which has been signed by the Chief Executive and confirms that *"the organisation, as a designated body, is in compliance with the FQA regulations"*. This statement of compliance will then be submitted to NHS England by 31st August 2014.

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Report can be made public

Imperial College Healthcare NHS Trust

Title: Responsible Officer's Annual Report

Purpose of the report:
Revalidation via the General Medical Council (GMC) is a statutory requirement for all doctors registered with the GMC. The GMC has delegated responsibility for GMC Revalidation to the individual organisation, "designated bodies", each of whom has a Responsible Officer (RO) who must act in accordance with the Responsible Office Regulations.

NHS England monitors compliance with Responsible Officer Regulations via the Framework of Quality Assurance for Responsible Officers (FQA). A requirement of the FQA is that the Responsible Officer (RO) for any Designated Body (DB), must submit an annual report on compliance with these regulations for approval to the Trust's Executive Team. The Executive Team must agree the report and sign a related statement of compliance for submission to NHS England.

The purpose of this report, is to provide the Board with an overview of the Trust's compliance with the FQA standards and that the CEO has signed the statement of compliance (See Appendix A).

1. Background

The GMC has delegated responsibility for revalidation to "designated bodies", of which the trust is one, each of which has a Responsible Officer (RO) who must act in accordance with the Responsible Officer Regulations.

All doctors must have a "prescribed connection" to a "designated body". All designated bodies must have an appointed Responsible Officer (RO) who submits revalidation recommendations to the GMC for all doctors with a prescribed connection to the organisation.

On 5th June 2014 the Chairman of the Trust received a letter from the GMC, CQC, Monitor and the NHS Trust Development Authority setting out the statutory responsibilities which the organisation has to ensure all our doctors keep up to date and remain fit to practice. Revalidation via the General Medical Council (GMC) is the process by which doctors demonstrate that they are up to date and fit to practice. The letter reinforced the trust's requirement to develop local systems to support medical revalidation which operate effectively.

A key element for revalidation is regular appraisal. The Responsible Officer has a duty under the Regulations to ensure that the trust carries out regular appraisals on medical practitioners working in the trust. All doctors must revalidate every 5 years via the GMC. Annual appraisal is the mechanism by which revalidation is assured.

Revalidation recommendations for doctors in training are dealt with by the Local Education Training Board (LETB).

2. *Governance Arrangements* – Item 1 & 2 on the Statement of Compliance

Imperial College Healthcare NHS Trust is a recognised designated body. The Trust's RO is currently Dr David Mitchell, Associate Medical Director, who has received the appropriate RO training. Professor Chris Harrison, who has also received the appropriate RO training, will replace Dr Mitchell as RO on 1st August 2014. An Associate Medical Director is being appointed to provide support to Professor Harrison and act as a clinical lead for Appraisals and Revalidation. The AMD will also receive the necessary training in revalidation.

The Revalidation Support Team is part of the Office of the Medical Director and reports to the Responsible Officer and the Chief of Staff. The Revalidation Support Team maintains an accurate record of all doctors with a prescribed connection to ICHT using the GMC Connect database.

The Division's compliance with medical appraisals is reported monthly in the Trust Board scorecard. Regular appraisal compliance information is provided to all the Divisions to support them in ensuring that appraisal is carried out and that the Divisions have appropriate numbers of trained appraisers.

3. Statutory Requirements & External Reporting

NHS England requires designated bodies, as part of the FQA, to adhere to a set of Core Standards (Appendix B). To evidence this, we are required to submit quarterly and annual data returns.

External reporting requirements are:

- Annual Organisational Audit (AOA) return, due in May each year;
- 'Information Template' (see Appendix C), due quarterly, due by the end of the month following each quarter end;
- Annual statement of compliance due by 31 August each year.

NHS England requires that the Executive team of a designated body oversees compliance with the Responsible Officer Regulations by completing and signing the Statement of Compliance by 31 August 2014.

3.1. Summary of 2013-14 AOA return submitted to NHS England

The first Annual Organisational audit report (AOA) was submitted by ICHT to NHS England in May 2014. Areas for improvement to note from the AOA are:

- An approved Medical appraisals and Revalidation policy is not in place, although a draft policy is awaiting LNC and Trust approval
- A reason for missed appraisals is not routinely recorded
- Appraisal compliance rate (62%) appraisal compliance rate reported for all doctors including non-consultants.

4. Medical Appraisals

4.1. Appraisal and Revalidation Performance 2013-14 – item 5 on the Statement of Compliance

As well as being a contractual requirement, annual appraisal for doctors is a requirement for GMC Revalidation. At 31st March 2014:

- 896 doctors with a prescribed connection
  - o 535 appraisals were completed

- 361 missed or incomplete appraisals
  - 48 (5.4%) were unavoidably missed due to long term absence (maternity, sickness etc).
  - 52 (5.8%) were as a result of the doctor having been in post less than 12 months which is expected in terms of compliance

Of the 29% showing as missed appraisals without an apparent valid reason

- A proportion are doctors who have connected with the trust via GMC Connect in error – this data is under constant validation
- A proportion have completed their appraisal on paper which requires transfer into the electronic system to be recorded as compliant
- A proportion of honorary doctors may have left the trust but remain connected to the trust via GMC connect
- A small number (3) are in disciplinary processes where appraisal is not appropriate
- The remainder are genuinely missed appraisals for which there is no acceptable reason. The individual cases have been escalated to the Divisional Directors and clinical manager and their appraisers. Individual doctors have been instructed to expedite necessary actions.

If doctors remain non-compliant with their contractual requirements this will be treated as a disciplinary matter. We expect the appraisal compliance rate to continue to improve through these actions.

4.2. Appraisers & Quality Assurance – item 3 & 4 on the Statement of Compliance

The RO has commissioned an external audit from MIAD to review the quality of appraisals, as well as the Trust's internal quality assurance processes for appraisal and revalidation. Their report will be available on 22nd July.

A sample of appraisal portfolios is reviewed by the RO prior to making Revalidation recommendations and feedback is giving to appraisers and appraisees as appropriate

As of 31st March 2014 there were 215 trained appraisers. In some specialties, there was a shortage of trained appraisers; a further 42 were trained in June 2014. Further training will be organized as necessary. The appraiser training curriculum includes information for appraisers on how to conduct and quality-assure appraisals.

5. Recruitment and engagement background checks - item 9 on the Statement of Compliance

The Trust currently holds NHSLA Level 3 which includes assurances that it conducts appropriate pre-employment, registration and right to work checks.

All appropriate pre and post-employment clearances are carried out by HR and the recruiting managers in line with NHS Employers guidance and Trust policy to ensure that all licensed medical practitioners have qualifications and experience appropriate to the work performed. Agency doctors are booked via agreed framework agencies who comply with NHS Employers guidance.

6. Monitoring Performance – item 6 on the Statement of Compliance

Performance is managed through the clinical divisions' local quality structures. Clinical outcome data, such as directorate specific mortality reports, are provided to Heads of Specialty and Chiefs of Service. Clinical Governance information is provided to doctors and the RO by the Safety and Effectiveness Team according to DOH, NHS England and NICE guidelines.

7. *Responding to Concerns about Doctors* - item 7 on the Statement of Compliance

The Trust has a published Raising Concerns policy. There is an established process within the Trust for dealing with any concerns about doctors' fitness to practice; all concerns and investigations are logged electronically.

8. *Sharing of Information between Responsible Officers* - item 8 on the Statement of Compliance

There is a procedure in place for obtaining and sharing information about doctors between our RO and those of other designated bodies, and with the GMC. The Trust uses the approved NHS Medical Practice Information Transfer form (MPIT) form to share this information.

9. *Development Plan* - item 10 on the Statement of Compliance

A number of key achievements have been made during 2013-14:

- Recruitment of the Revalidation Support Team following the restructure of the Office of the Medical Director
- Improved Provision of Resources / Support for doctors including tutorials, webpages and guides
- Commissioning an external quality improvement audit for medical appraisals
- Agreement of an electronic collection solution for patient feedback via iTrack
- Cross validation of data on appraisals and revalidation

Several key challenges have been identified through the year, including:

- The absence of an approved Medical Appraisal and Revalidation policy has resulted in a lack of clarity for appraisees, as well as those managing appraisals locally, on both the requirements for revalidation and appraisal and the escalation procedures available.
- Doctors identified a need for increased support in the provision of appropriate evidence and negotiating the electronic system
- Non-standard processes for collection of patient feedback across specialties
- Significant data quality issues in ESR which compromises the cross-validation of doctors for whom the Trust should be responsible.

The following action plan has been established to address the above issues and areas of non-compliance reported in the AOA:

- Approvals of the draft Medical Appraisal and Revalidation Policy
- Creation of an appraisers forum to share good practice and ideas
- Creation of intranet and external internet site to host resources
- Launch of tutorials and training sessions on the appraisal system and procedures
- Implement electronic collection of patient feedback via iTrack
- Departmental meetings with specialties where patient feedback collection is more problematic (e g anaesthetics, microbiology, radiology)
- Engage further with medical personnel and workforce planning to continue data validation
- HR is establishing an improved process for ensuring the creation and termination of all honorary contracts are logged electronically.

10. *Recommendations*

The Board is asked to note this report and the attached statement of compliance, which has been signed by the Chief Executive and confirms that *"the organisation, as a designated body, is in compliance with the FQA regulations"*. This statement of compliance will then be submitted to NHS England by 31st August 2014.

Imperial College Healthcare NHS Trust

Annual Report Appendix A

Statement of Compliance

Designated Body Statement of Compliance

The executive management team of Imperial College Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

   Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

    Comments: Yes

Signed on behalf of the designated body

Name: _Dr Tracey Batten __ Signed: _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _21/07/14 _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Annual Report Appendix B

Core Standards

1	The Designated Body and the Responsible Officer	Mandatory	Good Practice
1.1.1	The designated body has nominated or appointed a responsible officer in compliance with the Responsible Officer Regulations. The responsible officer is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.	X	
1.1.2	The designated body has nominated or appointed an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection	X	
1.1.3	The responsible officer has sufficient time to carry out the role including the training, support and quality assurance requirements	X	
1.1.4	The designated body provides the responsible officer with sufficient funds, capacity and other resources to enable the responsible officer to carry out the responsibilities of the role.	X	
1.1.5	The responsible officer ensures an accurate record is maintained of all doctors with a prescribed connection to the designated body.	X	
1.1.6	The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer	X	

1.1.7	The responsible officer is actively involved in peer review and networking for the purposes of calibrating decision-making and organisational systems and processes	X	
1.1.8	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the *Responsible Officer Protocol*. Ideally at the beginning of the 3 month notice period.	X	
1.1.9	The responsible officer considers all relevant information from the doctor's full scope of work and through the complete revalidation cycle in making a recommendation about a doctor's fitness to practise.	X	
1.1.10	The responsible officer ensures that accurate records are kept of all relevant actions and decisions relating to the responsible officer role	X	
1.1.11	The responsible officer has mechanisms in place to assure the quality of the processes underpinning the Responsible Officer Regulations	X	
1.1.12	The responsible officer provides a report to the designated body's board (or an equivalent governance or executive group) and the higher level responsible officer, on compliance with the Responsible Officer Regulations and any other statutory requirements.	X	
1.1.13	The responsible officer provides the designated body's board (or an equivalent governance or executive group) with a development plan that addresses any identified weaknesses or gaps in compliance with the Responsible Officer regulations to agreed timelines.	X	
1.1.14	The responsible officer includes the report on compliance and resulting development plan in their own appraisal and revalidation portfolio.	X	
1.1.15	The responsible officer ensures that the designated body's medical revalidation policies and procedures comply with equality and diversity legislation.	X	

1.1.16	Where the responsible officer role is outsourced, the designated body must be satisfied that the service specification for the role (including responsible officer training, support and review) meets the required core standards.	X	
1.1.17	The responsible officer has completed a recognised training programme before making revalidation recommendations.		X
1.1.18	The responsible officer attends three out of four regional networking events each year.		X
2	**Appraisal**	**Mandatory**	**Good Practice**
2.1	**Policy, Leadership and Governance**		
2.1.1	The responsible officer ensures that a medical appraisal policy is in place which is ratified by the designated body's board (or an equivalent governance or executive group), with core content which is compliant with national guidance (GMC Guidance, Medical Appraisal Guide, Responsible Officer Guidance, etc.)	X	
2.1.2	The responsible officer ensures that every doctor participates in the annual medical appraisal process	X	
2.1.3	The responsible officer ensures that every doctor with a missed or incomplete medical appraisal have an explanation recorded	X	
2.1.4	The responsible officer ensures that appraisals will be undertaken according to professional standards (as laid out in *Providing a Professional Appraisal, RST*)	X	

2.1.5	The responsible officer ensures that there is a written protocol for the handling of information for appraisal and revalidation which complies with information governance, confidentiality and data protection requirements.	X	
2.1.6	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified	X	
2.1.7	The responsible officer ensures that there is a process for the allocation of appraisers and the scheduling of appraisals.	X	
2.1.8	The responsible officer ensures that no appraisals are carried out by an appraiser who is not trained to undertake the role.	X	
2.1.9	The responsible officer ensures that steps are taken to ensure the objectivity of the appraisal.	X	
2.1.10	The responsible officer ensures that the appraiser submits the completed appraisal outputs within 28 days of the appraisal meeting.	X	
2.1.11	The responsible officer ensures that there is a process for quality assuring the inputs and outputs of appraisal to ensure that they comply with GMC requirements and other national guidance.	X	
2.1.12	The responsible officer ensures that all doctors with whom the designated body has a prescribed connection are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria	X	
2.1.13	Where some or all of the functions required for the medical appraisal system are commissioned externally (e.g. from an appraisal provider), the responsible officer must be satisfied that the service specification including appraiser training, support and review meets the required core standards.	X	

2.1.14	The responsible officer ensures that the designated body's medical appraisal policy is reviewed to ensure continued alignment with national guidance.		X
2.1.15	The responsible officer ensures that a doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser		X
2.1.16	The designated body has guidance on the expected time requirements to prepare for, undertake and complete documentation for appraisals (for both doctors and appraisers).		X
2.1.17	The responsible officer ensures that there is a named clinical appraisal lead.		X
2.2	**Capacity and Capability**		
2.2.1	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection	X	
2.2.2	The responsible officer ensures that medical appraisers are recruited and selected in accordance with national guidance (Quality Assurance of Medical Appraisers).	X	
2.2.3	The responsible officer ensures that medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals.	X	
2.1.4	The responsible officer ensures that all appraisers have access to medical appraisal leadership and support.	X	

2.2.5	The responsible officer ensures that there is a system in place to obtain feedback on the appraisal process from the doctors being appraised.	X	
2.2.6	The responsible officer ensures that medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers)	X	
2.2.7	The responsible officer ensures that there is a process for responding to concerns about appraisers and the appraisal process.	X	
2.2.8	The responsible officer ensures that the initial training programme is competency based and those who cannot demonstrate the competencies do not become/are not appointed as medical appraisers.		X
2.2.9	The responsible officer ensures that there is an initial review of performance for appraisers covering the first three appraisals followed by an initial review.		X
2.2.10	The responsible officer ensures that appraiser to doctor ratios lower than 1:20 and higher than 1:5 are recorded and justified.		X
2.2.11	The responsible officer ensures that there is a written role description, person specification and terms of engagement for medical appraisers		X
2.2.12	The responsible officer ensures that appraisers have access to regular appraiser assurance groups or networks, which will include agreement about expectations of attendance.		X
2.3	**Appraisal standards for trainees**	**Mandatory**	**Good Practice**

2.3.1	**Policy, Leadership and Governance**		
2.3.1.1	The responsible officer ensures that medical appraisal and Educational Supervision policies are in place and ratified by the by the designated body's Board, with core content, which are compliant with standard national guidance. (GMC, MAG or equivalent)	X	
2.3.1.2	The responsible officer ensures that every doctor participates in the ARCP process and those with a missed or incomplete ARCP have an explanation recorded	X	
2.3.1.3	The responsible officer ensures that there is a process for the management of education in the LETB including ARCPs.	X	
2.3.1.4	The responsible officer ensures that there is a written protocol for the handling of information for ARCPs and revalidation which sets out information governance and data protection requirements.	X	
2.3.1.5	The responsible officer ensures that there is a process for quality assuring the inputs and outputs of appraisal and ARCPs to ensure that they comply with GMC requirements and other national guidance.	X	
2.3.1.6	The responsible officer ensures that a doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser	X	
2.3.1.7	The designated body has guidelines on the expected time requirements to prepare for, undertake and complete paperwork for ARCP (both doctors and Educational Supervisor) and twice yearly exception and exit reports.	X	
2.3.1.8	The responsible officer ensures that each LEP has a Director of Medical Education or equivalent		X

2.3.2	**Capacity and Capability**		
2.3.2.1	The responsible officer ensures that each designated body has access to sufficient numbers of trained clinical and educational supervisors to carry out the regular educational supervisor reports and assessments for all trainee doctors with whom it has a prescribed connection.	X	
2.3.2.2	The responsible officer ensures that Educational Supervisors are selected and approved in accordance with national GMC guidance.	X	
2.3.2.3	The responsible officer ensures that Educational Supervisors are trained to approved GMC standards.	X	
2.3.2.4	The responsible officer ensures that Educational Supervisors educational training and development activities are part of CME.	X	
2.3.2.5	The responsible officer ensures that the ARCP decision making process has access to all the information needed to make a revalidation recommendation for the doctor at the final ARCP panel	X	
2.3.2.6	The responsible officer ensures that there is a process for responding to concerns about Educational Supervisors and the educational process.	X	
2.3.2.7	The responsible officer ensures that Educational Supervisors contribute to local educational arrangements including local faculty, ARCPs and recruitment meetings.		X
3	**Monitoring Performance and Responding to Concerns**	**Mandatory**	**Good Practice**

3.1	**Policy, Leadership and Governance**		
3.1.1	The responsible officer ensures that there is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection.	X	
3.1.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group), with core content which is compliant with national guidance (Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice), and where necessary compliant with Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003)	X	
3.1.3	The responsible officer ensures that there are formal procedures in place for colleagues to raise concerns.	X	
3.1.4	The responsible officer identifies any issues arising from routinely collected information (such as complaints, significant events and outlying clinical outcomes) and ensures that the designated body takes steps to address such issues.	X	
3.1.5	The responsible officer ensures that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.	X	
3.1.6	The responsible officer ensures there is a process established for initiating and managing investigations of capability, conduct, health and fitness to practise concerns which complies with national guidance (*How to conduct a local performance investigation*, NCAS)	X	
3.1.7	The responsible officer ensures that a doctor who is subject to investigation procedures is kept informed about progress, the doctor's comments are taken into account and appropriate support mechanisms are in place.	X	

3.1.8	The responsible officer ensures that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, HR and occupational health.	X	
3.1.9	The responsible officer ensures that there is a process in place for key items of information (such as complaints, significant events and outlying clinical outcomes) to be included in the doctor's appraisal portfolio and discussed at the appraisal meeting.	X	
3.1.10	The responsible officer ensures that any steps necessary to protect patients are taken.	X	
3.1.11	The responsible officer ensures that the locally agreed approach and actions are a proportionate response to a concern and take into account patient safety, the doctor's needs and the needs of the service or designated body.	X	
3.1.12	The responsible officer ensures that where issues have been identified, measures are initiated to address concerns which may include re-skilling, re-training, rehabilitation services, supervision, mentoring, coaching etc. in line with relevant national guidance	X	
3.1.13	The responsible officer ensures that where necessary a recommendation is made to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.	X	
3.1.14	The responsible officer ensures that where necessary measures are taken to address systemic issues within the designated body that may contribute to concerns identified.	X	
3.1.15	The responsible officer is proactive in sharing relevant information relating to a doctor’s fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.	X	
3.1.16	The responsible officer refers serious concerns about a doctor's fitness to practise to the GMC	X	

3.1.17	The responsible officer ensures that where a doctor is subject to conditions imposed by, or undertakings agreed with, the GMC, systems are in place to monitor compliance with these conditions or undertakings.	X	
3.1.18	The designated body's board (or an equivalent governance or executive group) makes provision for the cost and impact of investigating and responding to concerns about doctors' practice	X	
3.1.19	The responsible officer ensures that arrangements for the sharing of relevant information about a doctor's practice exist between all organisations in which a doctor works, which complies with information governance, confidentiality and data protection requirements	X	
3.1.20	Where some or all of the functions required for the responding to concerns system are commissioned externally (e.g. from a Professional Support Unit, etc.), the responsible officer must be satisfied that the service specification including case investigator and case manager training, support and review meets the required core standards.	X	
3.1.21	The responsible officer ensures that the Responding to Concerns policy and pathway are shared within the designated body and are publicly available.		X
3.1.22	Systems are in place to monitor data about a doctor's practice on an on-going basis to enable the early identification of trends, and to respond appropriately when variation in individual performance is identified.		X
3.1.23	The responsible officer ensures that frameworks are in place to describe the process for categorising risk and thresholds for investigations.		X
3.1.24	The responsible officer ensures that individuals monitoring, supervising or supporting practitioners are appropriately qualified and indemnified		X
3.1.25	The responsible officer or appointed case manager takes the lead in drafting, implementing and monitoring action plans to address the identifiable needs.		X

3.1.26	The responsible officer ensures that appropriate arrangements are in place to support for the re-entry of appropriate practitioners to the designated body		X
3.1.27	The responsible officer compares patterns of handling and concerns through their responsible officer network.		X
3.1.28	The responsible officer co ordinates a quality assurance look back process of cases.		X
3.1.29	The responsible officer ensures that there are mechanisms are in place to define the success criteria for interventions and processes and to demonstrate that the organisation learns from experience.		X
3.2	**Capacity and Capability**		
3.2.1	The responsible officer ensures that the designated body has access to sufficient numbers of trained case investigators and case managers, whether they are sourced internally or externally.	X	
3.2.2	The responsible officer ensures that case investigators and case managers are recruited and selected in accordance with national guidance (*Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice*, RST)	X	
3.2.3	The responsible officer ensures that case investigators and case managers have completed a suitable training programme, with essential core content (Ref RST training specification - including equality and diversity, information governance) before starting to perform investigations.	X	
3.2.4	The responsible officer ensures that individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (ref RST guidance)	X	

3.2.5	The responsible officer ensures that personnel involved in responding to concerns have sufficient time to undertake their responsibilities	X	
3.2.6	The responsible officer ensures that case investigators and case managers have a regular programme of updates and skills development.		X
3.2.7	The responsible officer ensures that case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance.		X
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.		X
4	**Recruitment and Engagement**	**Mandatory**	**Good Practice**
4.1	The responsible officer ensures that when entering into contracts of employment or contracts for the provision of services, the designated body has policies and procedures in place to ensure that:	X	
4.1.1	The doctor has qualifications and experience relevant to the work being performed	X	
4.1.2	Appropriate references are obtained and checked	X	
4.1.3	Any steps necessary to verify the identity of doctors are taken	X	

4.1.4	Doctors have sufficient knowledge of the English language for the work to be performed	X	
4.1.5	All pre-employment checks recommended In national guidance are performed (ref NHS Employers Guidance)	X	
4.1.6	Any other relevant information is obtained from the doctor, the previous responsible officer, the GMC or other sources to enable a judgement to be reached about the doctors suitability for the proposed role	X	

Imperial College Healthcare NHS Trust

Annual Report Appendix C

Quarterly Information Template

Framework of Quality Assurance for Responsible Officers and Revalidation, **Quarterly Information Template (Q1)**

Please complete this quarterly information template for the period 1 April 2014 to 30 June 2014 and return to [insert e-mail for office of higher level RO] by [insert date].

	Indicator	Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	Designated Body Name		
2	Number of doctors with whom the designated body has a **prescribed connection**			
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.			
3.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period			
3.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period [These to be carried forward to next reporting period]			
	Data entry checker			
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**			
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**			
	Data entry checker			
4	**Any Comments** you wish to raise (e.g. new RO, new appraisal lead etc.):			

Imperial College Healthcare NHS
NHS Trust

Trust Board Public

30 July 2014

Agenda Item	4.5
Title	Monthly report on safe Nurse/Midwife staffing levels at Imperial College Healthcare NHS Trust
Report for	Noting
Report Author	Priya Rathod, Associate Director – Chief of Staff (Nursing Directorate)
Responsible Executive Director	Janice Sigsworth, Director of Nursing
Freedom of Information Status	Report can be made public

Executive Summary:

This paper was presented to the Executive Committee on 8th July and to the Quality Committee on 9th July.

The Board received a paper on safe nurse/midwife staffing at its meeting on 28th May 2014.

Following the publication in November 2013 of the Government's full response to the Mid-Staffordshire Inquiry, the National Quality Board published a document titled *How to ensure the right people with the right skills are in the right place at the right time (2013)*. Subsequently, a series of letters have been sent by the chief nursing officer and chief inspector of hospitals, setting out the requirement for Trusts to publish monthly data on the actual nursing and midwifery staff available versus the planned level for each inpatient ward area. This information should be published on the Trust's website as well as on the NHS Choices site.

Since June 2014, the Trust has submitted two data sets (for the months of May and June) on the actual nursing/midwife staff available versus the planned staffing levels for all inpatient ward areas. The information is reported in hours and then an average fill rate calculated. This information is presented by hospital site, ward and speciality and is split out by registered and unregistered staff and also by day and night.

The information was published on the NHS choices website (for each hospital site) alongside other quality and safety metrics and also on the Trust's website on 24th June.

Overall the Trust reported above 95% for the average fill rate for registered and unregistered nursing/midwife staff during the day and night for the month of May and above 90% for June.

For both months there were some ward areas where the fill rate was below 90%. Key reasons for this include; vacancies and/or inability to fill with temporary staff due to specialist skills required (e.g. chemo training), patients requiring unplanned one to one care, small numbers in some areas which

showed a bigger impact on the overall fill rate for that area and complexities with how to reflect case mix change and/or reduced bed occupancy on the roster.

On these occasions senior nurses have made decisions to mitigate any risk to patient safety by strategies such as using the cover of supernumerary staff, reducing activity e.g. in the chemo suite, reducing bed occupancy where appropriate and redeploying staff from other areas.

During May and June, the impact on patient safety/quality as a result of staffing fill rates was assessed by undertaking the following:

- Analysing the harm free care report indicators and triangulating the data with the staffing data for that month.
- The director of nursing meeting monthly with each divisional director of nursing to talk through the performance of each ward area and any concerns.
- Analysis and confirmation by the divisional directors of nursing, the divisional director and director of operations about any impact on safety as a consequence of staffing fill rates.
- Executive analysis and sign off by the director of nursing, chief operating officer and the director of people and organisation development prior to external submission and publication.

Having undertaken the above process which will be continued every month going forward, it was deemed that there was no adverse impact on patient safety/quality during May and June.

The safe nurse/midwife staffing requirements have introduced a new way of working for Trusts and will take a period of time to be embedded both locally and nationally. The information therefore presented in the early phases of this work may be somewhat subject to change as processes and systems are refined and bedded in to every day practice.

Next steps

- Review the implications of the recently published NICE safe staffing guideline, for the Trust.
- In order to systematically assess and triangulate the impact of staffing fill rates on safety and quality outcomes, from July the information will be presented alongside the harm free care report indicators. The outputs of this will be presented to the Quality Committee in August.
- Transfer management of the monthly safe staffing data to the performance team from September.
- Internal audit to review safe nurse/midwife staffing reporting in late 2014.

Recommendations to the Board:

- Note the paper and next steps

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

Imperial College Healthcare NHS Trust

Monthly report on safe Nurse/Midwife Staffing levels at Imperial College Healthcare NHS Trust

1. Background

1.1 Following the publication in November 2013 of the Government's full response to the Mid-Staffordshire Inquiry, the National Quality Board published a document titled *How to ensure the right people with the right skills are in the right place at the right time (2013).* Subsequently, a series of letters have been sent by the chief nursing officer and chief inspector of hospitals, setting out the requirement for Trusts to publish monthly data on the actual nursing and midwifery staff available versus the planned level for each inpatient ward area. This information should be published on the Trust's website as well as on the NHS Choices site.

1.2 The national guidance states that the monthly dataset should include all members of registered nursing/midwifery and care staff on the duty rota including supervisory ward/team leaders, staff specifically booked to special a patient (provide one to one care) and staff doing additional hours on top of their booked shift.

1.3 The information is reported in hours and then an average fill rate calculated for each inpatient ward area. This information should presented by hospital site, ward and speciality and split out by registered and unregistered nursing/midwifery staff and also by day and night.

1.4 Within the Trust, the current method of collecting actual nursing and midwifery staffing data against planned levels is undertaken using the eroster system. A process of validation, analysis and sign off is then undertaken within clinical divisions and at executive level.

1.5 For the months of May and June, the Trust submitted the data via the national reporting system UNIFY, ahead of the national deadline set.

1.6 The Executive Committee received a paper on 17th June summarising NHS England's intention to publish a range of patient safety data alongside the safe nurse/midwife staffing data.

1.7 This information was published on the NHS choices website (for each hospital site) and on the Trust's website on 24th June. Please refer to Appendix 1 for a screenshot of the information available on NHS Choices.

1.8 Currently, the staffing data has not been nationally RAG rated and no parameters or thresholds have been set in terms of performance.

1.9 It is important to note that on 15th July 2014 the National Clinical Institute for Health and Care Excellence (NICE) published a guideline on *Safe staffing for nursing in adult inpatient wards in acute hospitals*. In essence, the guideline makes recommendations about the factors that should be systematically assessed at ward level to determine the nursing staff establishment. It then recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period.

1.10 The guideline also makes recommendations for monitoring and taking action according to whether nursing staff requirements are being met and, most importantly, to ensure patients are receiving the nursing care and contact time they need on the day. The guideline recognises that

"there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs".

1.11 The guideline describes a series of 'red flag' events that should trigger a Trust to undertake early analysis of its performance related to nursing indicators such as; falls, pressure ulcers and national inpatient survey results. Work is currently underway to understand the implications of this guideline for the Trust.

2. Purpose of the report

2.1 The following report provides the Board with an overview of the actual nursing/midwifery staff availbale versus planned staffing levels for the months of May and June 2014.

3. Summary of performance for May and June 2014

3.1 The table below summarises the Trust's performance based on the information submitted for 64 inpatient ward areas.

- **May**

	Day						Night					
Division	Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)
Medicine	48897.63	46970.64	96.05%	20005.50	19407.50	96.83%	34508.00	34015.50	98.63%	18289.50	18232.50	99.62%
Surgery & Cancer	54258	52338.4	95.52%	13423.70	12967.70	96.35%	42312.00	41624.00	98.52%	8898.50	8728.50	98.62%
Women's & Children's	29649.15	29163.15	98.33%	5193.25	5033.18	98.30%	25443.00	25204.25	99.10%	4719.50	4577.50	98.62%
TRUST TOTAL	**132789.8**	**128426.2**	**96.24%**	**38622.45**	**37408.38**	**96.93%**	**102217.00**	**100797.75**	**98.67%**	**31907.50**	**31538.50**	**99.08%**

- **June**

	Day						Night					
	Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Division	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled (Average)
Medicine	48063.38	44355.51	92.29%	20232.75	18264.28	90.27%	34033.00	32527.50	95.58%	17652.00	16892.50	95.70%
Surgery & Cancer	54290.43	51490.85	94.84%	13634.33	12180.80	89.34%	41608.94	40310.47	96.88%	8309.03	7741.53	93.17%
Women's & Children's	28915.57	28066.78	97.06%	5070.25	4874.90	96.15%	24939.50	24547.67	98.43%	4531.50	4404.50	97.20%
TRUST TOTAL	131269.38	123913.14	94.40%	38937.33	35319.98	90.71%	100581.44	97385.64	96.82%	30492.53	29038.53	95.23%

3.2 Overall the Trust reported above 95% for the average fill rate for registered and unregistered nursing/midwife staff during the day and night for the month of May and above 90% for June.

3.3 For both months there were some ward areas where the fill rate was below 90%. Key reasons for this include; vacancies and/or inability to fill with temporary staff due to specialist skills required

(e.g. chemo training), patients requiring unplanned one to one care, small numbers in some areas which showed a bigger impact on the overall fill rate for that area and complexities with how to reflect case mix change and/or reduced bed occupancy on the roster.

3.4 On these occasions senior nurses have made decisions to mitigate any risk to patient safety by strategies such as using the cover of supernumerary staff, reducing activity e.g. in the chemo suite, reducing bed occupancy where appropriate and redeploying staff from other areas.

3.5 During May and June, the impact on patient safety/quality as a result of staffing fill rates was assessed by undertaking the following:

- Analysing the harm free care report indicators and triangulating the data with the staffing data for that month.
- The director of nursing meeting monthly with each divisional director of nursing to talk through the performance of each ward area and any concerns.
- Analysis and confirmation by the divisional directors of nursing, the divisional director and director of operations about any impact on safety as a consequence of staffing fill rates.
- Executive analysis and sign off by the director of nursing, chief operating officer and the director of people and organisation development prior to external submission and publication.

3.6 Having undertaken the above process which will be continued every month going forward, it was deemed that there was no adverse impact on patient safety/quality during May and June.

3.7 During July there has been a continued focus on; managing eroster in real time, refining roster templates and ensuring that staffing is managed in a robust and proactive way.

3.8 The safe nurse/midwife staffing requirements have introduced a new way of working for Trusts and will take a period of time to be emebedded both locally and nationally. The information therefore presented in the early phases of this work may be somewhat subject to change as processes and systems are refined and bedded in to every day practice.

4. Next steps

4.1 Review the implications of the recently published NICE safe staffing guideline, for the Trust.

4.2 In order to systematically assess and triangulate the impact of staffing fill rates on safety and quality outcomes, from July the information will be presented alongside the harm free care report indicators. The outputs of this will be presented to the Quality Committee in August.

4.3 Transfer management of the monthly safe staffing data to the performance team from September.

4.4 Internal audit to review safe nurse/midwife staffing reporting in late 2014.

5. Recommendations to the Board:

5.1 Note the paper and next steps

Imperial College Healthcare NHS Trust

Appendix 1 – Screenshot of information (May 2014) published on NHS Choices on 24th June 2014

Topics: Safety
Sort by: Nearest
Update results

	Infection control and cleanliness	Care Quality Commission national standards	Recommended by staff	Safe Staffing	Patients assessed for blood clots	NHS England patient safety notices	Open and honest reporting
St Mary's Hospital (HQ) Remove **Tel: 020 3312 6666** Praed Street London Greater London W2 1NY **0.35 miles away | Get directions**	OK As expected	All standards met **Visit CQC profile**	OK Within expected range with a value of 69.08%	98% of planned level	96.80% of patients assessed	Good - All alerts signed off where deadline has passed	OK As expected
Western Eye Hospital Remove **Tel: 020 3312 6666** 153-173 Marylebone Road London Greater London NW1 5QH **0.88 miles away | Get directions**	Among the best	All standards met **Visit CQC profile**	OK Within expected range with a value of 69.08%	n/a Data not available	96.80% of patients assessed	Good - All alerts signed off where deadline has passed	OK As expected
Hammersmith Hospital Remove **Tel: 020 3313 1000** Du Cane Road London Greater London W12 0HS **2.39 miles away | Get directions**	OK As expected	All standards met **Visit CQC profile**	OK Within expected range with a value of 69.08%	97% of planned level	96.80% of patients assessed	Good - All alerts signed off where deadline has passed	OK As expected
Queen Charlotte's Hospital Remove **Tel: 020 3313 1111** Du Cane Road London Greater London W12 0HS **2.44 miles away | Get directions**	OK As expected	All standards met **Visit CQC profile**	OK Within expected range with a value of 69.08%	100% of planned level	96.80% of patients assessed	Good - All alerts signed off where deadline has passed	OK As expected
Charing Cross Hospital Remove **Tel: 020 3311 1234** Fulham Palace Road London W6 8RF **3.18 miles away | Get directions**	OK As expected	All standards met **Visit CQC profile**	OK Within expected range with a value of 69.08%	97% of planned level	96.80% of patients assessed	Good - All alerts signed off where deadline has passed	OK As expected

Imperial College Healthcare NHS
NHS Trust

Trust Board Public

30 July 2014

Agenda Item	4.6
Title	Update on Progress with the Implementation of Cerner
Report for	Monitoring/Noting
Report Author	Kevin Jarrold – Chief Information Officer
Responsible Executive Director	Kevin Jarrold – Chief Information Officer

Executive Summary: The purpose of this paper is to provide the Trust Board with an update on progress with the implementation of the Cerner Millennium Patient Administration System and Maternity functionality. Following a complex and successful cut-over to the new system which took place over the Easter weekend of 17th-22nd April 2014 the Trust has been going through the anticipated post go-live stabilisation process. The paper describes the background to the deployment, the challenges through the cut-over phase and the progress that has been made in the transition back to steady state business as usual operation.

Recommendation(s) to the Board/Committee: The Trust Board is asked to note the very significant efforts made by staff across the whole organisation in ensuring the success of the implementation. Inevitably with the implementation of a complex new system there have been some bedding in issues as users adapt to new ways of working and teething problems with the new system are ironed out. The issues that have been experienced have impacted upon patients, clinicians and the quality of the data that we have been able to report to commissioners. The Board is asked to note the approach being taken to address these issues and the progress being made.

Trust strategic objectives supported by this paper:

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

Title : Update on Progress with the Implementation of Cerner

1. Purpose of the report:

The purpose of the report is to provide the Trust Board with an update on progress with the implementation of Cerner PAS and Maternity functionality. The intention is that this report provides an interim post project evaluation three months after the system has been taken into live operation.

2. **Introduction:**

The Trust has had a long standing commitment to the implementation of a modern electronic patient record. The first phase of this was the implementation of the Cerner Millennium system for the electronic ordering and results reporting of pathology and radiology. This module was successfully implemented in August 2011. The next phase involving the implementation of a new Patient Administration System and Maternity functionality went live over the Easter Weekend of the 17-22 April 2014. This came at the end of a period of focussed activity that had involved the mobilisation of staff across the trust from September 2013 when the go live date was set. This paper will provide a brief overview of the deployment and then a more detailed summary of progress with the post-go live stabilisation.

3. Bringing the Patient Administration System and Maternity into Live Operation

The implementation of the Cerner Millennium PAS and Maternity System involved a complex technical challenge because of the need to migrate two systems (the legacy PAS and the Cerner Millennium Order Communications solution) into the new solution and the requirement to re-number patient records so that each patient should have a single Trust number rather than a separate number for each site. This meant that 32 downstream systems that take demographic details from the Patient Administration System were required to re-number patients during the cut-over period. The detailed plans for data migration, reporting and to address challenges with complex workflows – especially the diagnostic workflow – were all delivered successfully.

Running alongside the technical challenges was an equally complex set of operational challenges that had to be addressed. This involved the development of Standard Operating Procedures, the implementation of new workflows and the delivery of Change Action Plans. While maintaining service delivery thousands of staff had to be released to undertake training and there was a programme of advanced training for the hundreds of Cerner Champions identified across the organisation. The detailed plans for the cutover from the old PAS to the new system and for managing the period of downtime was honed through a series of table top exercises in which wards and departments worked through the issues to be addressed.

An innovative approach to post-go live support saw the recruitment and training of 250 floorwalkers who worked alongside 100 more experienced floorwalkers sourced from a specialist supplier.

Following a review of the Cerner Programme by Deloitte as part of their Value for Money work the Trust adopted a formal gateway review process to ensure that at each stage of

the programme all the requirements had been fully met before the next stage commenced. This approach was applied rigorously. It was only when there was formal confirmation that the Gateway 5 criteria had been met on Thursday 17th April that the Trust commenced downtime procedures and the cutover to the new system got underway.

The detailed preparation resulted in a successful cutover and by close of play on Tuesday 22nd April the Cerner Millennium PAS and Maternity functionality had been brought into live operation.

The Trust had excellent support throughout the process from the Health and Social Care Information Centre, BT and Cerner.

4. **Cerner Millennium Post-Go Live Stabilisation**

It is inevitably the case that the implementation of a complex new patient administration will involve an extended period of bedding in as users get familiar with the new system and the teething problems are resolved.

Prior to go live it had been anticipated that there would be issues with the following:

- Smartcards and role based access
- Printers and printing
- End user familiarisation with the system and workflows
- The virtual hospital build
- Health Records
- Data quality

Plans were put in place to deal with each of these issues in the immediate post-go live phase. For example, outpatient activity was reduced by 50% in the first week and by 25% in the second week to enable staff to adjust to the new system. The network of floorwalkers proved to be highly successful and many have now been recruited into longer term roles in the Trust.

The process of managing the transition to stable business as usual operation with Cerner has been managed through a coordinated effort from the Chief Operating Officer, the Divisional teams and the Cerner Programme Team. Using a set of Key Performance Indicators progress has been tracked through regular review meetings.

The use of gateway criteria has continued and Gateway 7 – Return to Stable Business As Usual Operation is now scheduled for the end of September but we do not expect to resolve all of the data quality issues until the end of December 2014. Detailed plans for any criteria not currently RAG rated as green are being addressed in detailed ‘Go to Green’ plans for each of the Divisions and the corporate teams.

These plans have categorised issues under three headings:

- Issues that have arisen as a result of the implementation of the new PAS
- Issues that have been exacerbated by the implementation
- Opportunities to address pre-existing issues

The two areas requiring the greatest focus at present concern:

- Data Quality
- Outpatients

5. Data Quality

The fact that the data migration from the old PAS to the new system went extremely well and the Trust also had a robust reporting solution in place from Day 1 meant that there was a good starting point at go live and there has been access to a detailed set of Key Performance Indicators on data quality. Despite this there have been some challenging issues with data quality as users have adjusted to complex new workflows and become familiar with some of the idiosyncrasies of the new system. This continues to be an area of focus in the stabilisation plans for each Division.

Some examples of the issues that have arisen with data quality include:

- Point of delivery classification – for example some elective patients have been incorrectly recorded as non-elective admissions
- A&E attendances being routinely recorded at the lowest tariff
- Maternity pathway issues
- Outpatient under recording of procedures

The challenges of adjusting have impacted upon the ability of the trust to deliver high quality data to commissioners within agreed timescales. There has been a constructive dialogue with our North West London commissioners and they have agreed a data quality recovery plan that will provide the trust with flexibility through an extension of the freeze dates for the delivery of information through to the Month 9 freeze date with the monthly freeze dates applying thereafter.

The data quality issues arising with the Cerner implementation have also impacted upon the ability to deliver on the 18 week referral to treatment targets.

6. Outpatients

The outpatient services have now become the focus for stabilisation efforts. Priorities include:

- Improving the routine management of clinics in the context of the use of the Cerner Millennium solution. This is to ensure that utilisation is optimised.
- Outpatient letters - there is on-going work to improve the content of letters and to ensure that it provides the accurate information that patients need.
- Health records - a programme of work has been put in place to improve the quality of the pulling lists, to improve the knowledge and skills across the organisation with Health Records tracking within the system.

The implementation of Cerner has had a significant impact on our outpatient services and our consultant medical staff have faced a number of challenges and have put in a significant effort to minimise the impact for patients. Patients have also found it more difficult to contact our outpatient departments to rearrange appointments while staff have been adjusting to the new system which has resulted in increased ‘did not attend’ rates.

Conclusion and Summary

Following a successful cutover from the legacy PAS to the new Cerner Millennium Patient Administration the Trust is now focussing efforts on ensuring that there is a managed return to stable business operation. While good progress has been made there are outstanding issues with data quality and outpatients that are going to require continued focus to drive to resolution. The Trust Board are asked to note the progress made to date and the approach being taken to drive the issues to resolution. This mirrors the approach that was taken in the run up to the cut over with clearly defined criteria tracked using a RAG rating approach with progress measured through a gateway process.

Imperial College Healthcare NHS
NHS Trust

Trust Board Public

30 July 2014

Agenda Item	4.7
Title	Annual Programme of Work
Report for	Noting
Report Author	Helen Potton, Interim Corporate Governance Manager & Cheryl Plumridge
Responsible Executive Director	Cheryl Plumridge, Director of Governance & Assurance
Freedom of Information Status	Report can be made public

Executive Summary:

The attached is the first draft of the Annual Programme of Work for the Trust which sets out the non-standard agenda items which need to be reported on an annual or cyclical basis to the Trust Board. This has been produced by reviewing the previous year's business, reference to Monitor's Code of Governance, best practice, and regulatory requirements. In addition, we have included a number of deep dives into issues such as Health & Safety and IT which we propose are taken on an annual basis. Executive Directors have been consulted and had the opportunity to input.

Some of the items are time of year specific – others not so. We have tried to ensure a smoothing of business across the year but inevitably there will be some requirement for further smoothing in line with the ebb and flow of other business. We have not at present included Board Strategy Seminars in the planning cycle: this is the next step and it may be that some of the business in the attached may be more appropriate for a seminar. We will be considering this for the next iteration of the programme of work.

We are also giving further thought to the timing of next year's Boards so the months indicated on the attached are indicative only. In setting next year Board's dates we will be taking into account performance reporting cycles, Monitor's reporting requirements and best practice for Foundation Trusts including the frequency and timing of meetings of Governors. We are working with the Chief Executive and Chairman on this and expect to be in a position to propose a calendar of next year's dates shortly.

Recommendation(s) to the Board/Committee:

The Board is asked to note and discuss the attached programme.

Imperial College Healthcare NHS
NHS Trust

Trust strategic objectives supported by this paper:

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

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Draft Annual Programme of Work 15/16

Date	Board Meeting
May	Quality Accounts Sign off
	Patient Centredness Strategy
	Safe Nurse Staffing 6 monthly report
	Annual Report
	Review of Standing Orders, SFIs and Scheme of Delegation
	Annual Accounts – Delegation of Authority to Audit, Risk & Governance Committee
	Annual Governance Statement
	"Going Concern" Assessment
	Annual approval of Operating Plan (incl. review of vision and objectives)
	Annual approval of budget
	Annual review of Risk Register
	Quarterly Report on PALS/Complaints
	Annual Code of Conduct Review including Nolan principles
	Annual Report on use of Trust Seal
	Review of Market Analysis (Strategy Seminar)
	Annual report on implementation of clinical strategy
July	ICHT Healthcare Charity Annual Review
	Annual Revalidation and AOA Return
	Deep dive – IT Review
	Research Annual Report
	Annual Report of Board Committees
	Annual Report on Complaints, Claims and Inquests
	Review against Monitor's Code of Governance for NHS Foundation Trusts
	Engagement survey
	National inpatient patient experience survey
	Six monthly review of Board reporting process
	Annual Estates Report
September	Annual Education Report
	Winter Plan
	Deep Dive - Communications
	National cancer patient experience survey
	Quarterly Report on Pals/Complaints
	Engagement Survey
	Budget setting process
November	Annual Equality & Diversity Report
	Annual Safeguarding reports • Adults • Children
	Emergency Preparedness Annual Report
	IG Mid-year toolkit review

	Integrated Planning Framework
	Deep Dive – Data quality
	National A&E Patient experience survey
	Review of Market Analysis (Strategy Seminar)
January	Quarterly Report on Pals/Complaints
	Deep Dive – Workforce Issues
	Annual Fire Compliance return
	Deep Dive – Clinical Safety
	Engagement survey
	Draft Quality Accounts
	IG Mid Year Toolkit Review
March	Safeguarding of Children and Young People Annual Declaration
	Talent review/succession planning
	Annual Plan
	Deep Dive – Health & Safety
	Calendar of Meetings
	Cycle of Business
	Annual Review of Committee Terms of Reference

Imperial College Healthcare NHS
NHS Trust

Report Title: Quality Committee Chairman's Report

To be presented by: Prof Sir Anthony Newman Taylor, Chairman

1. Introduction

The Quality Committee met on 9 July and the main issues discussed set out below.

2. Significant issues of interest to the Board

The following issues of interest are highlighted for the Trust Board:

- The committee received a summary report on the results of Survey 3 of the staff engagement survey. Overall Survey 3 had had fewer positive ratings than Survey 2, with the engagement score still on a downward trend. However the results of the Friends and Family Test questions, as required by the DH which had been included in the survey for the first time, were positive with 78% of staff saying they would recommend the Trust to friends and family if they needed care or treatment but 57% of staff surveyed saying they would recommend the Trust as a place of work.
- The committee received an update on preparation for the CQC Chief Inspector of hospitals visit scheduled for 2-5 September. Rolling briefs are being focused on preparing those likely to be interviewed and action plans are in place to address known hot spots, such as patient experience of cancer services. The Trust's self-assessment will be considered at the next Quality Committee on the 20 August.
- The committee received an update on the patients' experience work plan: an action plan had been drawn up with the aid of Macmillan (the national cancer charity) on ways cancer patient experience could be improved following the poor standing of the Trust in the National Cancer Patient Experience Survey. A memorandum of understanding is being drawn up for an on-going collaborative partnership with Macmillan.
- The committee discussed methods of presenting patient stories to the Board and agreed that a variety of methods could be used.
- The committee received the May monthly report on safe Nurse/Midwife staffing levels: the Trust had achieved above 95% for the average fill rate for both day and night for nurse and midwife staffing against the national target of 90%. However ten wards across the divisions of medicine and surgery were identified as outliers with a fill rate of 80-90%> The committee was, however, assured that were no concerns about patient safety or experience from these wards.
- A report on patient safety and effectiveness was received from the medical directorate team providing an excellent overview of patient safety in the Trust. One issue arising is that medicines optimisation needed further investigation.
- The committee discussed the presentation given to NHS England and the TDA on 1 July on emergency cover at Hammersmith Hospital. The committee heard that NHS England and the TDA had been assured of the effective management and

governance of this complex project.

- The Committee considered a review of organisational learning from the Trust's approach to managing winter pressures in 2013. The Trust had achieved top quartile success for the four hour A&E wait, the most used measure of performance for effective management of winter pressures. Daily sitrep analysis and the winter office had proved highly effective in robustly managing patient discharge. In preparation for winter 2014/15 the urgent care centre was now open 24 hours a day and plans are in to open additional capacity at the St Mary's site.

3. Key risks discussed

The following risks and mitigations were discussed:

- Hammersmith Emergency Unit closure
- Level 2 capacity at Hammersmith Hospital
- Provision for screening patients having travelled or received care overseas
- Additional support for emergency services at Charing Cross until the Chelsea and Westminster Hospital has increased its capacity in 2016
- Temporary MRI scanners had been sourced to enable work on the chiller units to be undertaken without any reduction in MRI capacity
- PICU risk: a business case is being prepared covering mitigation of the risk.

4. Key decisions taken

The following key decisions were made:

None.

5. Agreed Key Actions

The committee agreed actions in relation to:

- Janice Sigworth to present the Trust's self- assessment for the CQC inspection to the August committee
- Chris Harrison and Janice Sigworth to provide a breakdown of serious incidents in relation to staffing levels by Division to the August committee
- Tim Orchard to provide an update on the screening facilities for patients who had travelled or had been in receipt of care overseas to the October committee
- Chris Harrison to provide a paper on medicines optimisation to the October committee.

6. Recommendation

The Trust Board is asked to note the contents of this paper.

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE QUALITY COMMITTEE

Tuesday 13 May 2014
10:00am – 1.00pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Prof Sir Anthony Newman Taylor	Chairman
Sir Gerald Acher	Non-Executive Director
Dr Rodney Eastwood	Non-Executive Director (until item 3.2.3)
Sir Thomas Legg	Non-Executive Director (until item 3.3.2)
Dr Tracey Batten	Chief Executive (until item 3.5)
Steve McManus	Chief Operating Officer
Prof Janice Sigsworth	Director of Nursing
Prof Chris Harrison	Acting Medical Director
Cheryl Plumridge	Director of Governance & Assurance
TG Teoh	Divisional Director: Women & Children
Prof Jamil Mayet	Divisional Director: Surgery & Cancer
Prof Tim Orchard	Divisional Director: Medicine
Dr Julian Redhead	Divisional Director: Investigative Sciences & Clinical Support
In Attendance:	
Sue Grange	Associate Director of Talent (item 3.3.2)
Dr Eimear Brannigan	Infectious Diseases & Infection Control Consultant (item 3.2.3)
Linda Burridge	Head of Marketing (item 3.1.2)
Jackie Baxter	Supervisor of Midwives (item 3.2.7)
Peter Lightbown	Interim Deputy Board Secretary (Minutes)

1.	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Prof Sir Anthony Newman Taylor welcomed all present to the meeting and extended a warm welcome to the new Chief Executive.
1.2	**Apologies for Absence**
	Apologies had been received from Jayne Mee and Alison Holmes.
1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared.
1.4	**Minutes of the Committee's meeting on 6 March 2014** The minutes of the meeting held on 6 March 2014 were approved as a true record.
1.5	**Matters Arising and Action Log** The committee noted the updates to the action log. Minute number 1.4.4 – perinatal issue – this report would be submitted for consideration at the Quality Committee once completed. Minute number 3.2.3 – update on NICE guidelines – Prof Chris Harrison to progress Minute number 1.5 – TDA Director to attend future Quality Committee – Director of Nursing to adopt lead for this item.
1.6	**Chief Executive's Introduction**

	Dr Batten explained that she had looked at quality across the organisation specifically in relation to executive responsibilities. In future the Medical Director would be responsible for Quality, supported by the Director of Nursing. The Director of Nursing would lead on preparations for the September 2014 visit of the Chief Inspector of Hospitals and the Director of Governance and Assurance would be the executive lead on health and safety issues.
1.6.1	The committee structure was being reviewed and there would in future be one executive committee covering all aspects of quality which would meet monthly. The domains of quality would be overseen by this one committee. All papers for the Quality Committee would in future be reviewed by the executive committee to ensure the executive was sighted on and owned the issues and there would be a greater differentiation between management issues and assurance.
1.6.2	In discussion, it was confirmed that the Director of Nursing was the executive lead on adults and children safeguarding. Sir Gerald Acher was supportive of these new arrangements but highlighted the need for the Trust to continue to improve its management and oversight of risk including consistency of risk registers across the Trust. Dr Batten confirmed that the restructured executive committees would include one committee per month on Strategy, Risk and Audit and that an improved Corporate Risk Register would be available to the Audit, Risk and Governance Committee in June.
1.7	**CIP QIA process 2013/14** Janice Sigsworth introduced the paper. Prof Sir Anthony Newman Taylor asked about the scoring system and was informed that where risk assessments resulted in scores above 9 subsequent risk mitigation actions were developed and implemented. The Divisional Directors confirmed they had no CIPs with a risk rating of higher than 9. Dr Rodney Eastwood stated that in governance terms it was important to have a CIP review process which recorded accept/reject decisions. Prof Sir Anthony Newman Taylor asked whether there was potential for unacceptable impacts on quality where proposed capital programmes were rejected. Dr Batten advised that the capital programme projects list was being reviewed the following week in order better to understand risk ratings and to provide assurance to the next meeting of the Quality Committee on 11 June 2014. **Action** – Dr Batten to consider potential impacts on quality related to the progression of the current capital programme and to present findings at the Quality Committee on 11 June 2014.
2.	**CLINICAL RISK**
2.1	**Update on Key Risks from Divisional Directors** Each Divisional Director presented a report on their key risks:
2.1.1	**Surgery & Cancer**
2.1.1.1	Prof Jamil Mayet highlighted his key risks. These included the provision of emergency surgery cover at Charing Cross Hospital and delays in patients waiting for vascular surgery as a result of a spike in acute vascular patients and a high number of chronic vascular patients. In discussion, it was noted that the executive committee would be reviewing all risks and assurance about the provision of safe services would be provided at future Quality Committee meetings.
2.1.2	**Investigative Sciences & Clinical Support**
2.1.2.1	Dr Julian Redhead updated the committee on the key risks including RIS/PACS, estate infrastructure, increased demand on MRI, and capacity pressures at SMH recovery. Dr Redhead also highlighted an issue with the delay in delivery of appointment letters by 2nd class postage to patients and the development of a system to provide text message services to patients to ensure timeliness of delivery of information regarding their appointment details.
2.1.3	**Women & Children**
2.1.3.1	TG Teoh provided an update on the key risks including midwifery staffing levels, anaesthetic day and night time cover at St Mary's Hospital, and the potential infection risk and cramped

	conditions on PICU. Prof Chris Harrison provided an update to the committee on the recent suspected Never Event. He confirmed to the committee that, on closer scrutiny, the incident did not fall within the criteria of a Never Event but would nevertheless be investigated thoroughly. Prof Harrison also highlighted the need to revise policy and learning in terms of communication between theatre and ward to maximise patient safety.
2.1.4	**Medicine**
2.1.4.1	Prof Tim Orchard presented his Division's key risks including post Cerner implementation issues, and the arrangements for managing the future closure of the Emergency Unit (EU) at Hammersmith Hospital. In discussion, Prof Sir Anthony Newman Taylor emphasised that the arrangements for closing the EU must put patient safety first which the Committee agreed. The Chief Executive confirmed that a plan would be developed to ensure these issues were addressed and that an update would be provided to Quality Committee at its July 2014 meeting. **Action** – Prof Orchard to brief on the plan to support the transition of services to St Mary's Hospital from Hammersmith EU at the Quality Committee on 9 July 2014.
3	**QUALITY OVERSIGHT**
3.1	**Quality**
3.1.1	**Quality Accounts** Cheryl Plumridge provided an update on the development of draft Quality Accounts 2013/14. The draft Quality Accounts were currently with stakeholders for comment and there was currently discussion with internal and external auditors whose comments would be included in the final version of the accounts. In discussion, it was recognised that work was on-going to populate several areas of the accounts and that the Medical Director would henceforward be responsible for the Quality Accounts as part of the reorganisation to centralise accountability for quality within the Trust. Dr Eastwood highlighted higher than expected HRG error rates in clinical coding and Steve McManus confirmed that work continued to improve on these error rates noting they did fall within acceptable performance boundaries.
3.1.2	**Annual Report** Linda Burridge provided an update on the approval process for the signoff of the Trust annual report 2013/14. The draft report was still work in progress with additional details to be added in relation to performance statistics, the annual governance statement once approved, financial accounts, final financial amounts and sustainability prior to final approval and submission. It was agreed that Mark Davies' declaration of interests would be included in the accounts but that the Clinical Programme Directors' interests would not as these posts had been replaced by the Divisional Director posts in July 2013.
3.2	**Safety**
3.2.1	**Safety and Effectiveness Board Update** Chris Harrison confirmed that a combined quality report would in future be considered by the executive committee prior to submission to the Quality Committee"
3.2.2	**Never Event** Chris Harrison confirmed that the suspected Never Event did not , on closer scrutiny, meet the criteria for a Never Event but would nevertheless be investigated thoroughly. See Minute Number 2.1.3.1.
3.2.3	**Infection Prevention and Control** Dr Eimear Brannigan updated the committee reporting a quality improvement programme for vascular device management was being developed. The Trust continued to develop the carbapenem-resistant Enterobacteriaceae (CRE) and the Surgical Site Infection Committee (SS) was reviewing practice and policy to ensure full compliance with surgical safety NICE guidelines with an assurance statement provided by June 2014. Prof Sir Anthony Newman Taylor asked about numbers of cases of CRE. Dr Brannigan replied that the numbers were low.

3.2.3.1	Dr Eimear Brannigan highlighted that Deloittes were satisfied with the Trust's data integrity for recording reportable infection. Prof Sir Anthony Newman Taylor said that Monitor would seek assurance on data used for managing quality.
3.2.4	**Summary of the Critical Care Staffing restructure and Failure to Rescue final trend report** **Action** – Steve McManus reported that an update would be submitted for consideration to the Audit, Risk and Governance Committee on 18 June 2014.
3.2.5	**Dr Foster Mortality Report** Prof Chris Harrison provided an update highlighting that the coding and classification of deaths within the Trust was currently under review.
3.2.6	**Safe Nurse & Midwifery Staffing** Prof Janice Sigsworth introduced her paper and said the Trust was meeting the workforce requirements on nurse and midwifery staffing flowing from recommendations issued in November 2013 'Hard Truths: a commitment to putting the patient first'. The report was in two parts: one related to the Trust's progress in meeting the National Quality Board expectations and the second providing a summary of nursing and midwifery establishments for all in-patient ward areas. Arrangements required to meet these two key requirements were detailed within the report and related to board responsibility, adequate processes in place, evidence-based tools to support planning, required culture, involvement of staff in planning establishments, adequate cover arrangements, adequate reporting to the board, details provided to the public on staff establishments and evidence of adequate arrangements in place to acquire the appropriate workforce. A third element not included within the update report related to analysis of planned versus actual establishment numbers. A rota system was under development which would be reliant on good quality data so that planned shift arrangements could easily be checked against actual attendance. This proposed system would be reviewed by the Quality Committee prior to implementation.
3.2.6.1	In discussion, Prof Sir Anthony Newman Taylor questioned the shortfall of approximately 10 WTE nursing posts within the Trust and whether this was detrimental to patient care and whether the Trust had difficulty in recruiting appropriate staff to fill vacancies. Prof Orchard stated that these unfilled posts did not impact adversely on patient care.
3.2.7	**Supervisors of Midwives Annual Audit 2013** The Supervisor of Midwives, Jackie Baxter, in providing a report to the committee referred to the annual audit of supervision of midwifery being made up of 4 key domains: • the interface of statutory supervision of midwives with clinical governance • the profile and effectiveness of statutory supervision of midwives • team working • leadership and development and supervision of midwives, the interface with service users
3.2.7.1	The audit had been successful in each of the domains with all criteria met and a commendation to supervisors on the quality of evidence provided. Looking forward, areas for development had been identified including on call arrangements and a review of the website.
3.3	**Patient Centredness & Equity**
3.3.1	**Patient Centredness Board Update** Prof Janice Sigsworth reported that the Patient Centredness Strategy had been updated. The board now had a reduced membership but at a more senior level. End of life care was a key theme and all complaints relating to end of life care were reviewed by the board. The team were working with Healthwatch. The next meeting would focus on staff engagement and as part of the review of the meeting structure, consideration was being given to fold the work of the board in to the revised new executive meeting structure.

3.3.2	**Our People: Experience and Engagement** Sue Grange, the Associate Director of Talent, provided a summary of the first two quarters' survey, identifying key priorities and providing examples of actions undertaken to respond to issues raised. In addition, details were provided of changes made to the survey template as a result of feedback following quarter 3 survey which was completed on 16 May 2014.
3.3.2.1	In discussion, Sir Gerald Acher commented that it was vital that any actions with regard to the Trust identified within the first two surveys were progressed as soon as possible to develop confidence in staff that action would be taking as a result of feedback. Prof Sir Anthony Newman Taylor stated that the response rate to the survey needed to be increased and any opportunities to increase response rates should be pursued. Attention was drawn to the fact that the survey was undertaken during a significant period of change at the Trust and this may have had an impact on response rates. The 3rd staff survey was launched on 28 April 2014 and results would be available in June 2014 when they would be reviewed at the executive committee and subsequently reported at a future Quality Committee. A recent survey had been undertaken with junior doctors within the Trust which had a response rate above 90% as it was a compulsory element of the junior doctors training programme. An action plan would be developed as a result of this feedback. **Action** – Jayne Mee to report the results of the 3rd quarter staff survey to a future meeting of the Quality Committee.
3.3.3	**National Inpatient Survey 2014 Results** Prof Janice Sigsworth introduced the paper. The learning from the survey would be built into the patient centredness strategy and reviewed by the executive committee before being presented to the Quality Committee. Detailed results were provided within the report that indicated that the Trust had performed about the same as most other Trust's but with 3 categories performing less well than most other Trusts. These included: • Did nurses talk in front of you as if you weren't there? • Were you told how you could expect to feel after you had your operation or procedure? • Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?
3.3.3.1	In discussion it was agreed that change was required including to the estate, culture and values, the system of sending appointment letters, and to pathways. The Trust was not complacent. A time lag since the survey had been done meant that many improvements had already been made but more were needed. An action plan was required to drive changes.
3.3.4	**Post Francis Annual Report** Prof Janice Sigsworth introduced the report. The Trust remained on track to meet all recommendations from the Francis Report and of the 50 actions originally identified, 44 had now been completed with additional work being required in the following areas: • feedback and learning from complaints • nurses/midwives to be in supervisory capacity • feedback from students and trainees • clinical audit – mortality • clinical audit – efficacy of treatment • certifying death
3.4	**Efficiency & Timeliness**
3.4.1	**62 day Cancer Waits** - see Timeliness Board update at 3.4.3
3.4.2	**Update on Winter Pressures** It had been agreed this item would be taken at the meeting on 11 June as part of a winter-pressures look-back review.

	Action - Steve McManus to provide winter-pressures look back paper to Quality Committee on 11 June 2014.
3.4.3	**Timeliness Board Update** Steve McManus reported that in terms of the 62 day Cancer Waits the 8 national standards had been met in both February and March 2014 and the Trust's quarterly performance would also meet these criteria. April and May's performance was also looking solid. A Cancer Experience event was scheduled for 27 June 2014 to which Trust commissioners had been invited. The Trust had recently met with Macmillan in order to develop a Memorandum of Understanding with a view to agreeing investment to further improve cancer care pathways.
3.5	**Effectiveness (monitoring and improving clinical performance)**
3.5.1	**Assurance** Prof Chris Harrison said there were 6 aspects of clinical effectiveness and in order to meet these it was vital to improve both assurance and clinical audit processes. Historically audits were allocated to Divisions to undertake but Divisions were under-resourced to carry out this work. Proposals were being worked up to provide more robust resourcing arrangements.
3.6	**Equity**
	There were no agenda items to report.
4	**ANY OTHER BUSINESS** None
5	**ITEMS FOR FUTURE MEETINGS & COMMITTEE WORK PLAN**
6	**DATE OF NEXT MEETING**
6.1	Wednesday 11 June 2014 10.00am - 1.00pm, Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE QUALITY COMMITTEE

Wednesday 11 June 2014
10:00am – 11.30am
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Prof Sir Anthony Newman Taylor	Chairman
Dr Rodney Eastwood	Non-Executive Director
Sir Thomas Legg	Non-Executive Director
Dr Tracey Batten	Chief Executive
Prof Chris Harrison	Medical Director
Prof Alison Holmes	Director of Infection Prevention and Control
Prof Jamil Mayet	Divisional Director: Surgery & Cancer
Steve McManus	Chief Operating Officer (from agenda item1.5)
Jayne Mee	Director of People and Organisation Development
Prof Tim Orchard	Divisional Director: Medicine
Cheryl Plumridge	Director of Governance & Assurance
Dr Julian Redhead	Divisional Director: Investigative Sciences & Clinical Support
Prof Janice Sigsworth	Director of Nursing
TG Teoh	Divisional Director: Women & Children
In Attendance:	
Helen Potton	Interim Corporate Governance Manager (Minutes)

1.	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Prof Sir Anthony Newman Taylor welcomed all present to the meeting.
1.2	**Apologies for Absence**
	Apologies had been received from Sir Gerald Acher and Nick Sevdalis.
1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared.
1.4	**Minutes of the Committee's meeting on 13 May 2014** The minutes of the meeting held on 13 May 2014 were approved as a true record.
1.5	**Matters Arising and Action Log** The committee noted the updates to the action log. In addition it was noted that: • Action 2.1.6 was included within the agenda. • For action1.5, Prof Janice Sigsworth advised that Bethan Graf of the Care Quality Committee (CQC) had given a very good presentation and that this might be more relevant than the Trust Development Authority (TDA) presentation and she would investigate this further. • Action 2.1.4.1 would be discussed in agenda item 2.1.
1.6.1	**Chief Executive's Introduction** Dr Tracey Batten highlighted some governance changes which had introduced a monthly

	Executive Quality meeting which would give executives an opportunity to discuss important issues prior to coming to Board Committees and the Trust Board. She advised that the six quality domains were represented, four within the Executive Committee (ExCo) and the other two by committees led by Bill Shields and Steve McManus and suggested that once the structure was better embedded, it would be appropriate to review the frequency of Quality Committees meetings.
1.6.2	The Chief Inspector of Hospital's (CiH) visit would be reported using a matrix approach which would set out the five key questions under the eight Service Lines including reference to site. Prof Janice Sigsworth advised that a preparatory meeting would take place two months before the visit at which time further details would be available including details of who would be required for interview. She stressed that feedback from other Trusts was clear and indicated that it was important that in the Chief Executive's opening presentation it should be open and transparent about what was good within the Trust together with areas of concern, setting out how the Trust was intending to address those areas.
2.	**CLINICAL RISK**
2.1	**Update on Key Risks from Divisional Directors** Steve McManus provided an overview of divisional risks noting that the Trust was moving towards a Chief Operating Officer's Risk Register which would include the top divisional risks reviewed during the divisional performance reviews and ExCo on a monthly basis. There would also be periodic sessions to moderate the top risks to ensure consistency. He noted the top risks for the Divisions and invited the Divisional Directors to provide a short update on: • Hammersmith Emergency Unit closure • Surgical Management • Estates infrastructure impact on clinical establishment • PICU
2.1.1	**Surgery & Cancer**
2.1.1.1	Prof Jamil Mayet confirmed that the plans in place for Charing Cross surgery continued to be effective and that there was no change from the previous month. Steve McManus highlighted that there was a small amount of Shaping a Healthier Future (SaHF) transitional funding that had been identified to assist with the changes required. Dr Tracey Batten indicated that this would be one of the risks that would be developed further in a risk workshop to understand how it could be reduced in severity.
2.1.2	**Investigative Sciences & Clinical Support**
2.1.2.1	Dr Julian Redhead noted that the Chiller units for MRIs had failed again and that it would be necessary to undertake a full service which would result in the utilisation of mobile scanners to facilitate this at a cost to the Trust. Steve McManus highlighted that this was part of a programme for high risk areas all of which could impact on Trust services to enable the Trust to understand how its estate could be released in a proactive way.
2.1.3	**Medicine**
2.1.3.1	Prof Tim Orchard noted that irrespective of SaHF the Trust's view was that the Hammersmith Hospital Emergency Unit was not a sustainable department to run long term due to a number of factors. Plans were in place to close the unit on the same day as Central Middlesex and there were staffing issues to address to ensure a safe transition. Further work was required on the clinical pathways to enable patients to go straight to Hammersmith Hospital without first going through St Mary's Hospital. On 23 June there would be a 24/7 emergency care unit established which would enable the Trust to test the facility and up skill where necessary prior to the closure.
2.1.4	**Women & Children**
2.1.4.1	TG Teoh noted that the PICU risk remained the same as previously reported. Prof Alison Holmes advised that the baby milk preparation at the centre of the recent nationally reported cases was not used by the Trust.

3	**QUALITY OVERSIGHT**
3.1	**Quality**
3.1.1	**Quality Accounts** Prof Chris Harrison presented the Quality Accounts which had been through a robust process of development under the guidance of Cheryl Plumridge. The current version included comments and responses by stakeholders to which the Trust would respond. It was agreed that the responses on pages 75 and 89 could be strengthened with more detail of the work that the Trust had undertaken and it was noted that there was a typo on page 61. The revised version would go to the Audit, Risk & Governance Committee on 18 June. Generally the comments were good and they would be helpful in terms of the CiH visit as this would be a document that they would consider.
3.1.2	**Quality Governance Action Plan: Progress report – June 2014** Prof Janice Sigsworth presented the Quality Governance action plan which was based on Grant Thornton's recommendations and noted that the Trust had to achieve a score of 3.5 or less but was on track to achieve this. A re-assessment would take place July/August and go back to the Trust Board in September. **Action**: Prof Janice Sigsworth to present the Quality Governance Framework Assessment to Trust Board meeting in September
3.1.3	**Chief Inspector of Hospitals** Prof Janice Sigsworth noted that this item had been discussed earlier in the meeting. As part of the preparation for the Board she would summarise potential questions that could be asked and indicate where she believed the Trust currently was in relation to them, noting that there was already a number of emerging areas around patient safety issues, estates and transport. An initial risk register was in place which would be reported fortnightly to ExCo and also to each Quality meeting. In addition a steering group had been established to drive this forward and an expert, who had previously led a team of inspectors, had been engaged to provide further support.
3.1.4	**Capital Programme 2014/15** Dr Tracey Batten presented a paper that had been discussed at ExCo earlier in the week which set out the logic behind risk assessment in respect of capital funding. It identified that there was Trust wide governance arrangements in place and highlighted the significant gap between capital bids and potential spend. The paper had also been presented to the Finance & Investment Committee and was presented to the Quality Committee as part of the risk assessment process. Going forward the Executive would sign off the capital programme on a regular basis to ensure appropriate control over expenditure. She suggested that the paper was very helpful in that it provided examples of the margins which enabled an understanding of what sort of level of expenditure the Trust would have to say no to. She would ask Ian Garlington to provide an example for each area. **Action:** Ian Garlington to provide an example for each area.
3.2	**Safety**
3.2.1	**Safety and Effectiveness Report** Prof Chris Harrison presented the report which was intended to reflect the Safety and Effectiveness Goals which were outlined in the Trust's Quality Strategy. He highlighted in particular that guidance had changed in respect of the definition for Never Events which needed to be better reflected, and that a plan was being put in place to deal with out of date guidelines the importance of which had been brought into sharp focus following out of date guidelines resulting in a serious incident that was currently being investigated.
3.2.2	**Review of Neonatology Service** TG Teoh advised the Committee of the review conducted by Professor Kate Costeloe following observations that the Queen Charlotte and Chelsea Hospital (QCCH) was an outlier in the Dr

	Foster report for 2011/12 in respect of increased neonatal mortality. The review found that the data used was flawed due to coding problems and that the methodology used by Dr Foster was not reliable for comparing outcomes for babies in different hospitals. It suggested that the only reliable data was that submitted to the Vermont Oxford Network which concluded that QCCH was within the expected range for 2011 and 2012. In addition he reported that the review had made nine recommendations all of which had been followed including validating the data by meeting with Dr Foster.
3.2.3.1	**Safe Nurse & Midwifery Staffing** Prof Janice Sigsworth provided an oral update noting that the establishment had all now been signed off and that by 10 June the Trust would be reporting real time data on what the staffing should be and what it actually was. At the present time only three clinical areas were showing that they were below 95% for registered nursing cover. Plans were in place to report staffing on the Trust scorecard and a further paper would come to the next Quality Committee and to the next Trust Board. **Action**: Prof Janice Sigsworth to provide an updated report to next Quality Committee Meeting and the July Trust Board.
3.2.3.2`	Prof Sir Anthony Newman Taylor asked if there were any particular areas that would cause concern and Prof Janice Sigsworth advised that on a day to day basis the Trust needed to get vacancy levels down and highlighted that in midwifery, labour took precedence on post natal care which resulted in some issues and complaints and that there was an identified cultural issue at QCCH which was being addressed. They were looking to move to a ratio of 1:30 but she stressed that the care given was safe and that the issue was around behaviour, possibly caused by being short staffed.
4	**ANY OTHER BUSINESS** There were no items of any other business.
5	**ITEMS FOR FUTURE MEETINGS & COMMITTEE WORK PLAN**
6	**DATE OF NEXT MEETING**
6.1	Wednesday 9 July 2014 10.00am - 1.00pm, Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS
NHS Trust

Report Title: Audit, Risk & Governance Committee Chairman's Report

To be presented by: Sir Gerald Archer, Chairman

1. Introduction

The Audit, Risk and Governance Committee met on 18 June 2014. The main issues discussed are as follows.

2. Significant issues of interest to the Board

The following matters of interest are being highlighted to the Trust Board:

- A private meeting will now take place twice a year with both internal and external audit partners and non-executive members of the Audit, Risk and Governance Committee in accordance with good audit practice.
- An update on eTendering was given: the eTendering module is already subscribed to by the Trust as part of other packages it buys and is in line with the financial rules on procurement recommended by the Department of Health. However Standing Financial Instructions (SFIs) would need to be amended and a paper to do this will come back to the committee in September.
- An update on the implementation of the Cerner system was provided. The Trust was in week 8 of live operation and user confidence was growing following exceptional staff engagement and a successful implement user the floor walker model. A project evaluation would be presented to the Finance and Investment Committee later in the year to see how lessons learnt could be applied to other major projects in the Trust.
- The progress report on safeguarding adults showed that the Trust was compliant and an annual report on safeguarding adults will be presented to the committee later in the year.
- The committee considered and approved the Quality Accounts which will go live on NHS Choices website on 30 June.
- The committee considered and approved the report on Trust data quality and agreed the recommendation to implement a rolling programme of performance data quality audits with a timetable and prioritisation of areas to be considered at the committee in September.
- The committee considered the summary of the critical care staffing restructure and failure to rescue final trend report. It was noted that the critical care vacancy had been up to 30% and particularly challenging at the Hammersmith site. However since the Director of Critical Care's programme had been initiated it was expected that the vacancy rate would fall to 5% by the end of June/early July. A critical care steering committee has been set up to ensure an effective long term strategy.
- The committee considered a revised corporate risk register (CRR). A workshop was scheduled for the executive team on 23 July to further develop the CRR.
- Junior doctors local induction was discussed particularly the specific issue around induction on the wards.
- The Head of Internal Audit Opinion TIAA has given a finding of "Significant Assurance" for internal controls during 2013/14.

- The Internal Audit strategy audit plan was discussed. It was noted that the Trust had exceeded its budget for consultancy and agency spend and Internal Audit have been asked to review reasons and controls for this expenditure.
- TIAA (Internal Auditors) had investigated why recommendations from previous internal audits had not been implemented or escalated where necessary. A target for clearing all outstanding actions by August was set.
- The annual counter fraud report highlighted that the Trust had a slightly higher number of referrals and counter fraud investigations compared with others: this was attributed to having almost double the number of staff compared with other trusts within the client base. The most common cases of fraud were working whilst sick and illegal worker cases. The Trust has been asked to consider purchasing ID scanning technology to identify false documents and prevent illegal workers.
- The tender waivers report was considered.
- The losses and special payments register was considered. It was noted that 14 patients accounted for over half of the value of the write offs. It was agreed that an update on private patient write-offs would be given to the Finance and Investment Committee.

3. Key risks discussed

The main areas of concern that arose from the internal audit work during the year related to:

- private patients
- renal dialysis transport
- estates and facilities
- accounts payable
- informatics (data leakage)
- PC disposal
- Education.

4. Decisions and actions

The following decisions and action were agreed:

- Standing Financial Instructions (SFIs) to be amended to accommodate requirements of the new eTendering system. These will be submitted to the September meeting.
- A timetable for undertaking and reporting on data quality audits will be agreed at the September meeting.
- A deep dive into the effectiveness of the junior doctor induction process will be considered at the December meeting,

5. Recommendation

The Trust Board is asked to note the contents of this paper.

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE

Wednesday 28 May 2014
1.30pm – 2.30pm
Oak Suite, W12 Conference Centre
Hammersmith Hospital

Present:	
Sir Gerald Acher (Chairman)	Non-Executive Director
Sarika Patel	Non-Executive Director (not for Agenda Item 2.4)
Andreas Raffel	Non-Executive Director Designate
In Attendance:	
Dr Tracey Batten	Chief Executive
Bill Shields	Chief Financial Officer
Dr Chris Harrison	Medical Director
Steve McManus	Chief Operating Officer
Prof Janice Sigsworth	Director of Nursing
Cheryl Plumridge	Director of Governance & Assurance
Marcus Thorman	Director of Operational Finance
Helen Potton	Interim Corporate Governance Manager (Minutes)
Heather Bygrave	Deloitte
Jonathan Gooding	Deloitte
Paul Grady	TIAA
Ian Sharp	Regional Managing Director, TIAA
Linda Burridge	Head of Marketing (not for Agenda Item 2.4)

1	**GENERAL BUSINESS**
1.1.1	**Chairman's Opening Remarks** Sir Gerald Acher welcomed members to the meeting.
1.2	**Apologies for Absence**
	Apologies were received from Sir Thomas Legg, Sir Anthony Newman Taylor, Arti Patil and John Cryer.
1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared at the meeting.
1.4	**Minutes of the Committee's meeting on 22 April 2014** The minutes of the meeting held on 22 April 2014 were approved as a true record.
1.5	**Matters Arising and Action Log** This item would be dealt with at the next full meeting of the Audit, Risk and Governance Committee.
2	**GOVERNANCE & RISK BUSINESS**
2.1.1	**Draft Annual Governance Statement** Cheryl Plumridge presented the Draft Annual Governance Statement which had been seen by the Committee previously and had incorporated the committee's comments and those of both internal and external audit. Sir Gerald Acher noted that the Statement read well except at

	page 11 and risk D - Failure to deliver Cost Improvement Programmes, as he believed that the rating of catastrophic was incorrect and should be changed. It was agreed that the Statement would be amended to reflect that whilst the scoring was accurate and approved by the Board as at the end of March 2014, the risk was now scored as a major consequence.
2.1.2	Dr Chris Harrison advised that the wording on page 11 also required amendment as it was now known the incident referenced did not meet the definition of permanent and irreversible harm. The Committee **approved** the AGS subject to the minor amendments identified.
2.2.1	**External auditor's report to the Audit, Risk and Governance Committee on the audit of the financial statements** Heather Bygrave presented the External Auditor's report on the audit of the financial statements highlighting the conclusions reached on page 3 of the document and noting that they were on track to sign off the documents the following Tuesday. She anticipated issuing an unqualified opinion.
2.2.2	Sir Gerald Acher questioned the wording given in the conclusion for the NHS revenue recognition and debt provisioning and in particular the use of the words "less prudent" and Ms Bygrave agreed to revisit the wording prior to issuing the final opinion. She also highlighted that although there was agreement of balances with NHS debtors this was not a guarantee that they would be paid. Bill Shields commented that he had a level of assurance that the monies would be paid as the Trust was in the process of signing new contracts based on last year's outturn giving confidence that the figures were accepted by the Trust's commissioners as being accurate.
2.2.3	The committee noted that this was the second year running that the auditors had provided an unqualified opinion for the value for money assessment.
2.3	**External auditor's report to the Audit, Risk and Governance Committee on the audit of the quality report** Heather Bygrave presented the External Auditors report on the audit of the quality report noting that the limited assurance review was limited by what they had undertaken for the report and was not providing a limited assurance conclusion. The Friends and Family indicator had been selected as one of the two indicators for audit but over the year it had become nationally accepted that this was unauditable and had been replaced by the Severe Harm and Death indicator. She noted, however, that from the work undertaken on the Friends and Family indicator the auditors had found no issues with their findings. She highlighted that the *C-Difficile* indicator had been undertaken and reported differently by Trusts as some Trusts were testing everyone and not just those who were required to be tested and were then disclosing the total of that cohort. Advice had been given that Trusts should state clearly within their report the basis of the reporting. This indicator had concluded as Green which was an improvement on the previous year. The committee discussed the data provided and it was noted and agreed that this should be updated which would provide a better picture than currently stated.
2.4	**Head of Internal Audit Opinion** Paul Grady presented the Head of Internal Audit Opinion noting that it was consistent with the Annual Governance Statement. Sir Gerald Acher noted that there was a number of audits which had received limited assurance and asked that in the auditor's opinion was this number consistent with a well governed organisation. In discussion, it

	was noted that this suggested the Trust was open and transparent and had not tried to steer the auditors away from areas that might provide limited assurance. The Committee noted that at its June meeting it would receive a report of all internal audit recommendations that had not been progressed by the Trust. **This item was discussed at the end of the meeting when the Committee was no longer quorate.**
3	**FINANCIAL & OTHER BUSINESS**
3.1	**Annual Accounts 2013 –14** Bill Shields presented the Annual Accounts for 2013–14 noting that the Committee had considered draft accounts at their previous meeting and that there had been no material changes. He advised that at the Private Board Meeting prior to the Audit, Risk & Governance Committee meeting, the Board had approved the Going Concern Assessment. He confirmed that there had been no significant changes to accounting policies during the year. The Committee **approved** the Annual Accounts 2013-14.
3.2.1	**Annual Report 2013 – 14** Sir Gerald Acher introduced the Annual Report for 2013 –14 and referred to the amendments made in respect of exit packages which had been the subject of discussion and challenge by the auditors and would be subject to a double check in respect of pension figures. Sarika Patel also had a number of small points which she would feed back for amendment.
3.2.2	The Committee noted that in terms of governance arrangements the report did not mention the other Board Committees and it was agreed that these would be included. It was also noted that Jeremy Isaacs' interests declaration needed updating to ensure consistency with that provided to the Public Board meeting. The Committee requested that for future years it would want to see the financial summary incorporated into the report. The Committee **approved** the Annual Report 2013-14
3.3	**Draft Quality Accounts** Chris Harrison presented the draft Quality Accounts noting that they were included within the papers as a reference for the External Auditor's report and had been taken and discussed in the Private Board Meeting.
4	**ANY OTHER BUSINESS** Sir Gerald Acher thanked attendees for their hard work in producing the documents for approval a week earlier than required.
5	**DATE OF NEXT MEETING** Wednesday 18 June 2014, 10.00am – 1.00pm, Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE FINANCE & INVESTMENT COMMITTEE

Thursday 22 May 2014
4.00pm – 6.00pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Sarika Patel	Non-Executive Director (Chair)
Dr Andreas Raffel	Non-Executive Director
Dr Tracey Batten	Chief Executive
Bill Shields	Chief Financial Officer
In Attendance:	
Marcus Thorman	Director of Operational Finance
John Cryer	Director of Estates & Facilities
Kevin Jarrold	Chief Information Officer
Cheryl Plumridge	Director of Governance & Assurance
Neil Callow	Head of Commercial Finance and Supply Chain
Sandra Easton	Deputy Director of Finance (Business Planning)
Jonathon Evans	Deputy Director of Finance (Financial Planning)
Mark Collis	Deputy Director of Finance (Financial Services)
Dr John Wood	Programme Director, NW London Pathology Modernisation
Peter Lightbown	Interim Deputy Board Secretary

1.	**GENERAL BUSINESS**
1.1	**Chairman's Opening Remarks** Ms Sarika Patel welcomed all present to the meeting, with a special welcome to Dr Tracey Batten, Dr John Wood and Mr Peter Lightbown attending their first meeting of the committee. Ms Patel noted it would be the last meeting for Neil Callow and John Cryer and thanked Mr Callow for his work in developing Cost Improvement Programmes (CIP's) and Mr Cryer for all his work in relation to estates management.
1.2	**Apologies for Absence**
	Apologies had been received from Mr Jeremy Isaacs and Mr Steve McManus.
1.3	**Declarations of Interest or conflicts of interest**
	There were no declarations of interest declared at the meeting.
1.4	**Minutes of the Committee's meeting on 20 March 2014** The minutes of the meeting held on 20 March 2014 were approved as a true record.
1.5	**Matters Arising and Action Log** **Items 2.4 to 2.8** – March 2014 meeting – action list to be updated. **Addition to action log – Minute Number 2.7** – 20 March 2014 – Treasury Management Policy –policy to be amended to be time bound and investment cycles short term as current policy allowed investments over £5m without time constraint, contrary to Trust financial guidelines.
2.	**MAIN ITEMS**

2.1	**Finance Report – Month 12 & Income & Expenditure Update Month 1**
	Mr Bill Shields introduced the report for month 12 and in discussion provided details of the Trust's income, expenditure and current surplus, stating that a favourable variance against plan had been achieved. He added that CIPs ended the year behind plan, however, this was offset by over-performance income on Clinical Commissioning Groups (CCGs) and NHS England contracts. Other financial targets including External Finance Limit and Capital Resource Limit were achieved. Overall the Trust Financial Risk Rating was 4 out of 5 and Monitor's Continuity of Service Risk Rating was 4.
2.1.2	Ms Sarika Patel queried the overspend on staff pay. Mr Bill Shields agreed, noting the planned overspend for winter pressures had not reduced. Ms Patel noted a discrepancy between SLA Activity and Income and this needed more work. There was also a high amount of debt owed to Imperial College. Mr Mark Collis stated that there had been significant progress with Imperial College but there remained a number of outstanding invoices which the college had to provide sufficient detail on to enable payment. Work continued to rectify this problem.
2.1 a	**Month 1 Update – 2014/15**
	Mr Shields provided an update highlighting the high run rate especially on pay compared to last year relating to the continued operation of the winter beds. Risks existed in income and at current run rate, the surplus would not be delivered, so it was important to address expenditure overspends now. Delivery on CIPs and control of expenditure, particularly nurse bank and agency was an issue. It had been agreed there would be no discretionary investment until the financial position became clearer. Following discussion, it was agreed that the FIC would receive an update in July after ExCo had reviewed the position. **Action** – update on bank and agency controls and costs to July 2014 Committee.
2.2	**Annual Accounts Review 2013/14**
2.2.1	Mr Marcus Thorman introduced the paper saying that the report set out key movements in income and expenditure between 2012/13 & 2013/14.
2.2.2	Mr Thorman stated that he had recently met with auditors and had received outline agreement that the accounts were in a position to be signed off for 2013/14. Ms Patel commended staff for their work to produce the accounts and Mr Thorman stated that pharmacy and finance staff had recently been nominated for a Trust award.
2.2.3	Dr Raffel asked whether provisions remained the same year-on-year and Mr Thorman stated that overall provisions had increased slightly in year but had been reviewed by auditors and agreed.
2.3	**Cost Improvement Programme**
2.3.1	Mr Thorman introduced an updated paper and provided details of various issues related to 2014/15 CIPs including governance, reporting, risks, outturn forecasts and targets. Ms Patel raised concerns that 100% of CIPs had not yet been identified and requested identification of the top ten schemes by value, and also asked to have CIP information sent to her electronically every month.
2.3.2	Dr Raffel asked how CIP targets were set and agreed with Divisions and Mr Thorman stated that the Trust had set a 4% target for all areas and Finance worked closely with Divisions to ensure targets were realisable. Dr Raffel asked whether this blanket target was easier to achieve for some Divisions than others, Mr Thorman replied that reporting tools have been developed to ensure identification of areas for improvement to assist Divisions and Mr Shields said additional resource was being brought in to deal with CIPs.
2.3.3	Ms Patel asked whether the 4% savings target had been agreed across the Trust and Dr Batten replied this had been discussed at ExCo - all Divisional Directors owned their own targets and plans would be available in June detailing how targets would be met. A clear process had been completed but there was still a danger that too many savings initiatives related to revenue income. Ms Patel proposed a Board seminar be held to discuss all CIP schemes.

	Action – **Mr Bill Shields** Cost Improvement Programme updates to be provided electronically to agreed circulation list on a monthly basis and a list of top ten CIPs by value to be provided to the FIC by 24 July, and to discuss with the Chairman and Chief Executive arrangements for the Board to be briefed on CIPs, possibly in a dedicated seminar, when the Exec team had identified all CIP schemes.
2.4	**Site Redevelopment Outline Business Case**
2.4.1	Mr Shields introduced the report providing a position statement in terms of progress on the Site Redevelopment Outline Business Case (OBC). Significant progress had been made developing details required to underpin the Clinical Strategy and the Trust was working closely with the eight North West London CCG commissioners and NHS England to ensure the business case provided viable clinical and economic options for Board consideration.
2.4.2	Mr Shields confirmed that in a meeting with commissioners, the Trust's preferred option had not been agreed. He added that both options 3 and 4 could deliver the clinical strategy, but that commissioners were unlikely to agree to option 3 and there were reservations about the higher costs of option 4. The OBC would now be reviewed and revised for submission to Trust Board at the end of July 2014.
2.4.3	Dr Raffel stated that unaffordable options could not go ahead irrespective of the wishes of the commissioners and asked if there was potential to develop an option that applied a more even investment at both St Mary's Hospital and Charing Cross Hospital. Mr Shields replied that there had to be an emphasis at St Mary's Hospital on clinical effectiveness. Further discussions considered budgetary provision and cost/benefit analysis as well as details on project dependencies once underway. Action – **Mr Bill Shields** to ensure OBC to returns to FIC in July with greater clarity on options.
2.5	**Service Line Reporting and PLICS**
2.5.1	Mr Shields introduced the report informing the committee of the on-going progress in developing profitability reporting through Patient Level Costing (PLICS) and integrated Service Line Reporting (iSLR). He highlighted that engagement to inform these developments was being undertaken via the Profitability User Group. Mr Callow highlighted that these reporting tools would allow Imperial to manage care more effectively.
2.5.2	Dr Raffel asked whether current figures within current reporting could be confirmed and Mrs Sandra Easton replied that figures still required additional work before confirmation. Ms Patel requested clarification of information within the report and stated that once the reporting methodology was properly embedded she would welcome an internal audit review post 6 months of implementation.. **Action** – **Bill Shields** to commission an internal audit on iSLR by November 2014 or 6 months post implementation.
2.6	**Commissioners Contract Position**
2.6.1	Mr Shields introduced the paper setting out key issues and risks within the Trust's two main contracts. He added that through the North West London CCGs the Trust had an income guarantee but there was variable income of £18.5m for CQUIN, Incentive Schemes and the Clinical Transformation Office. NHS England did however have a full Payment by Results (PbR) contract and the key risk was activity within the contract falling below plan.
2.6.2	Mr Shields added that non-elective activity in line with commissioner requirements would need to be reduced by approximately 2.5% this year for NWL CCGs. Ms Patel stated that the report contained details of proposed activity reduction from April to October 2014 and Mr Shields confirmed that these issues were additional to the requirement to reduce overall non-elective activity by 2.5% this year. Action - **Mr Bill Shields** to update committee on all contracts in July.
2.7	**North West London Pathology Partnership Summary Update**
2.7.1	Dr John Wood introduced the report highlighting that an agreement in principle had been reached to enter into a North West London Pathology Partnership subject to various conditions

	being met. Compliance with these conditions included the Trust committing to contributing to initial transitional funding of £665k for 2014/15 and £1,163k for 2015/16. Work to develop proposals had been developed in conjunction with PricewaterhouseCoopers (PwC) and would be presented for consideration to the Trust Board in July 2014.
2.7.2	Dr Raffel asked why the Trust did not undertake delivery of the service alone and queried the Trust's veto rights. Ms Patel stated that within the Decision-Making slide in the 'Reserved Matters' bullet point it was vital that the Trust ensured this option was taken up otherwise the Trust would carry significant responsibility for decisions taken by the other parties. Dr Batten confirmed that details would be in the Outline Business Case (OBC) assessing options to deliver services alone or in partnership. Ms Patel commented there was a risk other Trusts would not renew their services with ICHT, including the do nothing option and the potential reputational risk, to be set out in a paper for the Trust Board in July.
2.7.3	Ms Patel asked whether within the Commercial Model the percentages of activity and therefore share, properly compare like with like and Dr Wood confirmed that this was the case. Mr Thorman confirmed that this had been assessed by PwC was correct and Ms Patel requested this information was reflected in the board paper submitted for consideration in July 2014.
2.7.4	Dr Raffel asked whether the Trust was considering the development of additional private income at the Hub and Mr Thorman confirmed that at this point only a base case was in place but revenue opportunities would also be considered. Dr Raffel requested that this information be reflected within the Board paper. Mr Shields stated that even applying conservative revenue figures significant savings could still be made. **Action** – **Mr Steve McManus** to provide paper for the Trust Board meeting on 30 July 2014.
2.8	**Cerner Project re-procurement (business case)**
2.8.1	Mr Kevin Jarrold introduced the report detailing the Full Business Case (FBC) for the procurement of an Electronic Patient Record system beyond the current centrally funded contract provided by the National Programme for IT which expires in October 2015. This business case outlined proposals and costs associated with delivering a directly funded Electronic Patient Record solution until June 2022.
2.8.2	Mr Thorman added that this proposal identified areas within the new system where savings were expected to be made in order to provide a contribution to funding the project. Ms Patel stated that it was vital that delivery of benefits are clearly reported to the committee in six months' time. **Action – Mr Kevin Jarrold** to provide an update on the delivery of benefits arising from Cerner and a full post project implementation review to the FIC in November 2014.
2.9	**Estates – Maintenance Backlog Costs**
2.9.1	Mr John Cryer introduced the report highlighting that the current maintenance backlog was £143m of which £21m was in the highest two categories of risk. He added that the Estates Division had strengthened its compliance inspection regime over the last 18 months and implemented a programme of preventative maintenance to limit the probability of unexpected failures that could impact on hospital operations. Some remedial work was identified that needed urgent resolution to minimise risk of failure and a substantial increase in capital funding had been proposed amounting to £7.6m. Longer term it will be vital to better align investment in estate condition more closely with depreciation that arises from it.
2.9.2	Ms Patel thanked Mr Cryer for the clarity of the report but asked whether enough was being spent on backlog maintenance. Dr Raffel asked whether the proposed funding to reduce the highest risk maintenance issues potentially affecting Trust operations would remove those risks following this investment. Mr Cryer confirmed that this would be the case for the majority of those risks. Mr Shields said that as a Trust we could only spend £35M on this based on retained depreciation, unless the Trust borrowed money. This which would impact its Foundation Trust (FT) application and future ability to borrow for the site redevelopment and therefore an unlikely path..
2.9.3	Ms Cheryl Plumridge raised concerns regarding lower categorised risks still potentially

	impacting on Trust operations and requested the next Trust Board paper include the next highest risk category for consideration. Ms Patel stated that it was vital to clarify all options available and potential risks where expenditure is not provided. **Action** – **Mr Ian Garlington** to provide an update report on estate maintenance backlog with reference to the funding envelope and other priorities to be provided to the Trust Board in July 2014.
2.10	**Financial Risks**
2.10.1	Mr Shields introduced the report highlighting that this updated the committee on progress, lessons learned and on-going work to support the Trust in analysing its financial risks as part of its application for FT status. This process included significant engagement with risk owners and analysis of impact on Trust income as a result of potential risks coming to fruition.
2.10.2	Mr Shields added that a series of risk meetings had been undertaken in order to gather information to populate the Long Term Financial Model (LTFM) with further meetings scheduled in order to provide input into the next iteration of the LTFM and Integrated Business Plan (IBP). Main risks continue to be non delivery of CIPS and the contractual commitment by NHS England on Project Diamond and Market Forces factor.
	ITEMS FOR READING
3	**GOVERNANCE ITEMS -** These items were sent out to the committee members to read and raise any queries or questions of which there were none.
3.1	**Work Plan Review -** The committee requested this be updated, prior to the next meeting.
3.2	**Summary of the Investment Committee -** No queries or questions were raised for this item.
3.3	**Long Term Financial Model (**LTFM**)**
3.3.1	Mr Thorman provided an update to the committee stating that the report summarised the expected changes to the LTFM to be submitted alongside a revised IBP to the Trust Development Authority on 20 June 2014. The LTFM remained a work in progress requiring additional work to reflect impacts of planned service developments, local planning and unquantified risks. The LTFM approved for submission to TDA.
3.3.2	Ms Patel expressed her thanks to Mr Thorman for his work undertaken as acting Chief Financial Officer whilst Mr Shields was acting Chief Executive Officer for the Trust.
4	**FINANCE ITEMS**
4.1	**Capital Report – Month 12 -** No queries or questions were raised for this item.
4.2	**Cash Flow Report – Month 12 -** No queries or questions were raised for this item.
5	**ANY OTHER BUSINESS** None raised.
6	**DATE OF NEXT MEETING**
6.1	24 July 2014 4.00pm – 6.00pm, Clarence Wing Boardroom, St Mary's Hospital.

Imperial College Healthcare NHS
NHS Trust

Foundation Trust Programme Board - Committee Chairman's Report

To be presented by: Rodney Eastwood, Chairman Foundation Trust Programme Board Committee

1. Introduction

The Foundation Trust Programme Board met on the 17th June 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

- An overview was given of the FT Programme timeline based upon the Chief Inspector of Hospitals' visit taking place during the week of September 2nd and a Readiness Review with the TDA at the end of October. Members asked whether individuals are aware of the list of documents required by the TDA in advance of the Readiness Review and their responsibility for creating them; it was confirmed that Execs are aware and that a further action plan would be presented at the next FTPB.

- It was confirmed that work is on track to enable a rescore of the outstanding actions following the BGAM/QGAF assessment by Grant Thornton in March 2014. It has been confirmed that Grant Thornton will review only those elements that had scored less well and that the company will be asked to do this in the near future.

- A Membership update was provided. The second and final recruitment exercise delivered by our membership recruitment company was scheduled to take place during the second and third week in June, with this focussing upon specific categories to ensure the membership is representative of the population. At the end of this process we should have recruited to our target number of members.

- The Chief Financial Officer provided an overview of the IFR action plan that has been put together following KPMG's review of the Trust. (IFR1). There remain a number of actions to be undertaken by the executive, which will be reviewed by the Chief Executive Officer. The Chief Financial Officer highlighted that the deadline for completion of this work is also the end of September given that it will be needed as evidence for the Readiness Review. He further added that the Trust will need to consider when it invites KPMG back into the organisation to undertake its second review - IFR2. This will be a forwards facing review of the IBP and LTFM, as compared to IFR1 which in the main was backwards facing (i.e. historical).

- The interim Integrated Business Plan (IBP) was presented to the Programme Board for review. It was noted that the IBP does not at this stage include any major service developments or the Pathology project. The document is also being submitted as an "interim" IBP because the clinical strategy is not yet completed or agreed. A number of recommendations for future iterations of the IBP were made and they will be taken on board by the teams responsible for it.

3. Key risks discussed

The Programme Board reviewed the programme risk register and noted no significant new risks to the project.

4. Key decisions taken

The Programme Board gave approval for the interim IBP to be submitted to the NHS Trust Development Authority. No additional key decisions were taken.

5. Agreed Key Actions

The Programme Board agreed actions in relation to:

- Updating the FT timeline
- Ensuring that the BGAM/QGAF and IFR exercises are completed in a timely and adequate manner
- Developing the 5 year Cost Improvement Plan (CIP plan)

6. Future Business

The Programme Board will focus on the following areas in the next three months:

- Integrated Business Plan
- CIP programme
- BGAM/QGAF rescore and IFR exercises.
- Preparation for TDA readiness review.

7. Recommendation

The Trust Board is asked to note the contents of this paper.

Imperial College Healthcare NHS
NHS Trust

Minutes of the Foundation Trust Programme Board
Tuesday 29th April 2014
14:00 – 16:00
Clarence Wing, Board Room. SMH.

ATTENDEES: Rodney Eastwood (RE) (Chair), Tracey Batten (TB), Bill Shields (BS), Jayne Mee, Janice Sigsworth (JS), Steve McManus (SM), Chris Harrison (CH), Cheryl Plumridge (CP), Marcus Thorman (MT), Michelle Dixon (MD) Ian Garlington (IG).

IN ATTENDANCE: Mick Fisher (MF), Alex Williams (AW), Helen Potton (HP), Vicky Scott (VS), Richard Cook (RC).

1. Apologies: Sir Tom Legg (TL), Sir Anthony Newman Taylor (ANT), Mark Bryce (MB).

2. Minutes of last meeting

The minutes were accepted as a correct reflection of the meeting held on 18th March 2014.

3. Matters Arising

The Action Log was reviewed and the following updates provided to the meeting;

Action 20: The composition of the Council of Governors - invitation to NHS England still outstanding.

- **ANT** has confirmed that Lord Turnberg has been named as the nominated representative of the independent medical charity.
- **AW and MT** will speak with the main commissioning lead for NHS England – London office to secure their proposed nominee for the Council. **BS** suggested that we hold off from making an approach to NHS England until after the current commissioning round is completed.

Action 26: Further work needs to be done to deliver the five year CIP plan

- **MT** stated that themes are being developed for years 4 & 5 CIPs and that these will need to link with the Trust strategy, Shaping a Healthier Future (SaHF), the Clinical Strategy and the Operational Excellence programme.

Action 49: The question of whether the Trust will need to obtain permission to use Imperial College name…. SG to review Joint Working Agreement with the College.

- Update from **ANT** to follow

Action 81: Voluntary organisation representation on Council of Governors

- In addition to speaking directly with Carers UK, **HP** will also make contact with other Foundation Trusts to establish how they have engaged and involved Carers UK to ensure carer representation on the Council.

Action 90: MF will also produce a public facing document summarising the consultation and outcomes. A formal consultation report will also be needed.

- **MF** confirmed that in addition to posting the consultation summary on the Trust website and intranet, there is a specific Annex to the IBP that will be completed describing the consultation process, outcomes etc.

4. Foundation Trust Programme Plan Update

MT gave an overview of the FT Programme.

The TDA has clarified that the Trust is expected to score 3.5 or less on its QGF assessment before it can proceed onto the Readiness Review. **MT** reminded the Programme Board that independent verification of the score is required.

The timetable for the application remains relatively fluid particularly with the uncertainty around the timing of the Chief Inspector of Hospitals (CIH) visit which is still unknown.

The paper provided to FTPB describes the "best case" timeline for the application and assumes that the QGF score can be reduced by July 2014 after changes have been embedded.

VS confirmed that the TDA are continuing to prioritise the CIH visit for Q2.

MT has contacted Finance Directors of other applicant FTs to understand their experience of the CIH visit. Hull has experienced a 2-week delay in the receipt of the CIH report.

TB added that Oxford has recently been inspected and has now received its draft report. Oxford has offered to share its recent experience with ICHT and has invited TB and team to visit. FTPB agreed that this would be useful.

Action: TB to organise visit to Oxford University Hospitals Trust to take up their offer of sharing their experience of the CIH visit.

BS queried the timescale for the independent review of the QGF score. Monitor has revised its processes and as a result, it could be invited in by the Trust to undertake its review of QGF which would then be used as the independent evidence of the Trust having achieved the rating of 3.5 required by the TDA.

BS expressed the view that Monitor should be invited to undertake this assessment so the Trust would have greater clarity over whether it is ready to proceed onto the next stage of the FT application process.

VS added that if Monitor is to be invited to undertake this review there would be a 6 weeks lead in time before the review could commence and that the review itself typically takes 3 months. She suggested that a direct conversation should be held with Monitor if the Trust proposes to take the review forward with Monitor.

TB asked how long the Grant Thornton review took. It was confirmed that the previous review lasted one month with a further two weeks for the finalisation of the report that was received by the Board.

MT suggested that the Trust could host an independent review at the same time as the longer Monitor review was underway.

Grant Thornton indicated in March that the Trust could take between 3 and 6 months for various elements to embed identified quality elements.

Concerns were expressed by the Programme Board at the potential impact upon the timeline if Monitor was asked to undertake the independent review.

It was suggested that Grant Thornton could be invited back into the Trust in July to enable the Trust to demonstrate to the TDA a revised QGF score of 3.5 to enable progression onto a September readiness review and that if 3.5 is not achieved at this point the timeline would be revised backwards anyway.

BS said that Monitor is keen to pilot its approach to assessment with a "good" Trust and that it might be a positive for the Trust to put itself forward as a pilot site.

TB asked whether Grant Thornton is the preferred option for the Trust.

CH said that Grant Thornton are preferred as they already know the Trust and would be reviewing only those aspects of the QGF that were flagged as amber/red as opposed to reviewing everything as Monitor would.

MT asked VS to confirm that the independent review of the QGF score need only consider those elements identified as amber as opposed to revisiting every element.

VS confirmed that the follow up review would only need to consider those areas identified in the Grant Thornton review reported in March as needing further work or evidence of embededness.

TB stated that her preference and suggestion would be for the Trust to use Grant Thornton for the follow up QGF review because Monitor may cause further delay to the process.

Action: MT confirmed that he will contact Grant Thornton and establish the notice period required to invite them back in to the Trust to undertake the follow up QGF review. MT will liaise with **CH** regarding this aspect of the timeline so that Grant Thornton are invited at the point the Trust is confident systems have embedded to the required point.

CH said that an internal rescore is likely to take place again in June/early July.

Action: TB suggested that as a "new pair of eyes", she would be happy to review evidence as part of the internal assessment of whether the Trust believes it is ready for the follow up QGF review.

RE queried whether further actions are also required to ensure any issues identified during the BGAF review have been addressed.

CP confirmed that she has produced an action plan and that she will bring this to the next FTPB to provide assurance that issues are being addressed.

Action: CP to bring the BGAF action plan to the next FTPB meeting

HP added that the red flag identified in BGAF related to the Trust having a better understanding of the future role of Governors within the Trust and that this would be addressed through further papers to FTPB in May and June outlining Governor development and role outline.

Action: HP to provide a paper to May FTPB outlining a draft Governor Development Programme.

5. Integrated Business Plan (IBP) refresh and Long Term Financial Model (LTFM)

BS presented his paper highlighting a number of issues raised by KPMG in their review of the IBP that are now being addressed.

Of principal concern is the interface between the IBP and LTFM and the Shaping a Healthier Future (SaHF) business case.

Initially our IBP planning assumptions had been based upon a steady state with two service developments, SaHF and the Pathology project.

KPMG have indicated that this will not be acceptable to Monitor and that various alternative outcomes relating to the implementation of SaHF will need to be modelled, for example what would happen if the commissioners' intentions are not fully implemented.

The Trust is required to submit a 5 year IBP and LTFM as part of the planning submissions to the TDA. The FTPB is being asked to consider whether to meet to consider the submission prior to its formal review at Trust Board on May 28th or whether to enable iterations to be circulated by email for approval prior to the Board meeting.

MT confirmed that he is meeting with the TDA next week regarding the variations on SaHF that will be required.

BS highlighted that whilst Central Manchester were approved as an FT against a background of similar uncertainty, this was prior to the economic downturn. For ICHT the delivery of SaHF depends upon Treasury capital being available.

A further round of discussions about the Charing Cross site is needed with commissioners. The Trust is not yet at the point where it is able to articulate its preferred option and this may be different to that of the commissioners. It is recognised that we will need to work with them on this and that the capital required for any redevelopment may not be forthcoming.

SM asked for further clarity about what is being asked for based upon the KPMG review.

MT replied that the Trust has been asked to outline various scenarios, i.e. if Treasury funding is not available to deliver the SaHF requirements. The KPMG review has highlighted the need for the Trust to have a credible base case from which to be able to model a series of scenarios.

RE added that his understanding is that the Trust needs to be able to outline how the Trust is able to adjust to a range of different scenarios.

BS cautioned that very few applicant FTs have been authorised where uncertainty exists about capital requirements and funding sources, further clarity is needed from commissioners about how this will be supported. A lack of funding will fundamentally affect the strategy.

MT added that all of the SaHF OBC options require ICHT to take out a loan that will require Treasury sign off.

BS said any OBC options must ensure the Trust can deliver a minimum £15m surplus and that the phasing of the development will be a significant issue. The Trust will need to demonstrate integration with the NWL commissioner requirements.

TB advised that the Trust will need to have discussed the SaHF business case options with the CCGs and NHS England before the end of May when the OBC is reviewed by the Trust Board.

There is currently a divergence of views between the Trust and commissioners regarding the future of Charing Cross hospital and this will need to be addressed before the ICHT SaHF business case can be signed off, this could also affect sign off of the IBP by commissioners.

BS suggested that further discussions are needed with the TDA to ensure an understanding that the IBP that is submitted to TDA in June will continue to be updated after this date.

MT highlighted that RC is currently refreshing the IBP chapters.

TB asked what the timeline is for the IBP update.

RC replied that we are working to ensure the refreshed IBP is ready for submission on June 20th.

FTPB confirmed that it will meet on May 20th to review the IBP prior to submission to Trust Board for approval on May 28th.

TB and **RE** asked that other NEDs be advised and invited to attend the May FTPB to receive the draft IBP.

Action: RC to ensure all NEDs are invited to attend the next meeting of the FTPB to receive latest draft of the IBP

6. Quality Governance Framework (QGF) Rescore Update

CH presented the paper outlining the internal rescoring exercise that was held w/c 28 April reviewing progress against the QGF and stressed that this needs to be the Boards self assessment.

RE said that the Board would need to see the revised assessment prior to the external reassessment.

CH added that the QGF score will also need to be reviewed at each of the relevant Trust Committees.

JS said that it would be interesting to see Oxford's experience of the process given that the review is not an exact science. The FTPB shared the view that ICHT has taken a robust approach to its self-review.

RE queried whether the FTPB was happy with the action plan detailed in Appendix 3 and asked whether BS was the correct lead for the first action listed (Question 1b;Action " establish the internal governance arrangements for managing quality KPIs)

CH confirmed BS was the correct lead although it was recognised that the wording needed to be changed to reflect that it is referring to quality wording within the contract with commissioners.

MT added that there are a huge number of KPIs in the contract relating to quality, there are 155 quality KPIs this year.

JM referred to action point 2a to advise that quality has been implicit in all Board development as opposed to a specific issue.

JS asked that the latest QGF review be widely issued for people to be aware of the score.

CH stressed that actions need to be owned by Directors.

Action: Directors to review the QGF action plan for those areas upon which they have been identified as leads to ensure progress towards QGF score of 3.5

7. Trust Development Agency (TDA) Monthly Returns

AW introduced the item as it had been requested by FTPB that this should be a regular agenda item**.**

The returns are submitted each month to the TDA as a "shadow" means of demonstrating compliance with the requirements of the Monitor Provider licence. Individual Directors are

asked to supply information to populate the template that is signed off by the relevant director.

VS confirmed that this is then used by the TDA as part of their overall review of Trusts and enables the identification of risks and tracking of any mitigations.

8. Key Issues Surrounding Governor Recruitment and Engagement

HP gave an overview of her paper and informed the Programme Board that membership recruitment has now started using the external membership recruitment company MES. The FTPB noted that a proportion of those recruited will be followed up to check on the quality of the process followed by the recruiters.

A discussion followed about how the role of Governors can be developed at ICHT.

SM suggested that a shadow Council of Governors should be established prior to FT authorisation and that existing Governors could be invited to attend and talk to them about their experiences of the role.

JS suggested that the Trust should identify certain elements that would make sense to involve Governors in and also that they would benefit from some form of structured induction.

HP confirmed her intention to bring a paper to the next meeting outlining a Governor development programme.

RE queried whether we have a budget to support the Governors.

HP confirmed that a budget exists and that the membership manager would undertake the support of Governors as part of their role. There are also various Foundation Trust Network events that the Trust can take advantage of.

JS asked how we plan to support a membership of 7000.

HP said that we will use our membership database to identify the interest of members and the degree to which they want to be involved in supporting the Trust.

IG queried how we plan to manage relationships with existing stakeholders given that we currently engage with various patient representatives through different organisations.

CH stressed that members can be advantageous to our organisation and we need to make good use of them as ambassadors for the Trust.

MD added that the Communications Strategy would help guide how we communicate with members and governors.

RE asked whether we have an internal group looking specifically at these issues

CP confirmed that she will establish an internal group.

Action: CP to establish a working group to develop plans for Governor and membership engagement and involvement.

8. Draft Constitution

HP provided an overview of the draft constitution that has been provided to the FTPB, with changes tracked to highlight difference from the model constitution provided by Monitor, for further consideration.

RE asked in relation to page 45 of the constitution whether we have received guidance on the interface with the AHSC. The number of AHSC representatives should state "up to 3" so that if the AHSC grows in future the Trust will not then be required to amend its constitution. He added that the constitution needs to reflect the unique partnership between the college and the Trust.

HP confirmed that currently the AHSC comprises ICHT and Imperial College but could in future include other NHS Trusts which including the wording "up to 3" would address.

JS queried whether we want to enable other Trusts to join our Governing body.

HP confirmed that it is common practice for other Trusts to have AHSC partners (i.e. other NHS organisations) as members of the Council of Governors.

Action – HP to instruct legal advisers to reword table on Page 45 to reflect that there will be up to 3 representatives of AHSC partner organisations**.**

HP moved on to highlight the Trust's proposed arrangements regarding the Appointments Committee highlighting that previous legal advice that suggested the Trust could not include the President of Imperial College was incorrect.

HP advised that the Trust will need to explain why it is seeking to establish different arrangements for its Appointments Committee to those outlined in the model constitution which is based upon the Code of Governance and reflects best practice.

HP clarified that the Appointments Committee needs to have a majority of Governors and that if we want to include Imperial College we will need to specify that the Partner Governor involved in the process must be from Imperial College.

RE added that for the appointment of the ICHT chairman it will be important that the college has confidence in the governance of the Trust and that the President of the college needs to sit on the appointments committee.

TB queried whether any such reciprocal arrangement exists between the Trust and the College.

RE confirmed that whilst currently the ex-chairman of ICHT sits on the College Council there is not currently a formal agreement of this kind between the two organisations.

Action: **HP** to refine with the Trust's legal advisors the wording within the constitution to ensure that the President of Imperial College is the named representative of Partner Organisations to be included on the Appointments Committee for the Chairman.

The FTPB went on to review specific issues raised by various members about the draft constitution.

Page 9. Section 2 - Name: TB asked if the FTPB should consider whether the current name of the Trust needs should be changed, perhaps to Imperial Health and asked if this would help with the branding of the Trust.

RE replied that most other Trusts that are part of an AHSC use the college name within their own.

MD said that the branding consideration is important and that if the Trust is considering a name change this would be best undertaken as part of the FT process.

HP said that if the Trust is considering changing its name it will need to secure Department of health approval beforehand.

Action: ALL It was agreed to further consider the name of the Trust over the next two months.

Page 12. Section 8.2 – Staff Constituency: RE said that the wording does not reflect the position as stated within the consultation document in that staff not directly employed by the Trust are not eligible for inclusion as staff members but can be encouraged to join the membership as public members.

Action: HP to ensure wording of section 8.2 is changed to make clear that Staff membership is only open to staff directly employed by the Trust for a period of 12 months or longer and that those ineligible to become staff members may be considered as Public members.

Page 16. Section 13.4 – Council of Governors Composition: **RE** highlighted that the wording should be changed to reflect that the CCGs need to agree amongst themselves which organisation has a seat on the Council of Governors.

Action: HP to ensure wording of section 13.4 reflects that the Trust will invite the eligible CCGs to nominate from amongst themselves two representatives to join the Council of Governors.

Page 19. Section 16.1.3 – Council of Governors Disqualification and Removal: RE queried whether the wording should state "British Islands" as this would include Eire.

HP replied the wording in the constitution is as drafted by Monitor.

The FTPB agreed to remove reference to British Islands such that the wording reflects that "a person who has been convicted of any offence etc"

Action: HP to ensure wording of section 16.1.3 is amended to remove reference to the British Islands such that it reads "a person who has been convicted of any offence" etc.

Page 22. Section 24.2.1 (ii) – Board of Directors Composition

RE asked that the constitution specify that the President of the college should nominate the NED representing the college.

RE also queried within the same section the statement "one of whom may be selected by board of Directors as deputy chairman of the Trust"

RE highlighted that this contradicts section 29.1 which states that "The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non executive directors as a deputy chairman".

RE stressed that consistency is required and the Trust would prefer for the Board of Directors to appoint a deputy chairman and not the Board of Governors.

HP said that she will clarify with the Trust's legal advisors whether this is possible and advise.

Actions: HP to ensure wording of section 24.2.1 (ii) is amended to reflect that the President of the College will nominate the college representative NED.
HP will clarify with the Trust's legal advisors whether the Board of Directors can appoint the Deputy Chairman and ensure the wording of the constitution is amended as necessary.

Page 23. Section 24.3 – Board of Directors Composition

RE asked that the wording be amended to reflect that the number of NEDs including the Chairman will always exceed the number of Executives.

Page 23. Section 24.4 – Board of Directors Composition

RE queried the appointments process described for the appointment of the NED nominated by the College and expressed the view that the nominee needs to be approved by the Appointment Committee for recommendation to Council.

RE asked whether there are any conflicts between the arrangements proposed in the Constitution and the Relationship Agreement with the college.

The FTPB queried who amongst the Board holds the relationship agreement.

MT said that the previous Director of Strategy was involved in drawing up the Agreement.

IG said that this was not something that had been handed over to him by the previous Director of Strategy but agreed to look through papers within his Directorate for the Agreement.

Action: HP to draft wording that gives the Appointments Committee a veto over the College nomination for its NED. IG to establish whether copy of the Relationship Agreement with Imperial College exists within the Strategy Directorate.

Page 26. Section 31.1 – Board of Directors – appointment and removal of initial chief executive.

TB queried the use of the term Chief Officer.
It was agreed to replace this with the title Chief Executive and also to replace references to "he" with "she".

Action: HP to ensure reference to Chief Officer within the constitution are replaced with the title Chief Executive and that references to "he" in the context of Chief Executive be replaced with "she".

Page 34. Section 44.7 – Annual report Forward plans and non-NHS work.

RE asked that the wording be changed so that it reads "A Trust which proposes to increase by 5 *percentage points* or more the proportion of its total income……"

Action: HP to ensure wording of section 44.7 is changed so that it reads "A Trust which proposes to increase by 5 percentage points or more the proportion of its total income……"

Page 81. Section 4.1.2.2 – Vacancies on the Council of Governors

RE identified that the wording as drafted doesn't make sense highlighting that if the individual with the next highest number of votes takes up the vacant post there will no longer be an unexpired period that will require an election to fill.

HP agreed that the wording was confusing and agreed to instruct the legal advisors to provide a clearer form of words.

Action: HP to instruct legal advisors to refresh wording in Section 4.1.2.2 (page 81) to improve clarity.

9. FT Project Budget

MT presented and gave an overview of the FT project Budget and highlighted that a budget of almost £1m is required for 2014/15.

MT also clarified that the sum of £12,000 listed as FT Awareness in financial year 2013/14 and also shown in 2014/15 will be an on-going cost to the Trust as this reflects the cost of

membership of the Foundation Trust Network which is a resource the Trust can draw upon during and after the application phase.

The FTPB agreed the budget proposed.

10. Risk Register

The FTPB reviewed the Risk Register and updates. The following points were raised:

Risk Number 2

MT highlighted that in relation to the development of CIPs, progress has made but the Trust is not yet ready for the HDD Stage 2 review

Risk 6

TB asked whether the Trust Commissioners are aware of the FT application and supportive

MT confirmed that this was the case and that support had been expressed during the FT Consultation process..

11. Any Other Business

AW asked that the FTPB note that a FT Working Group is being established that will meet weekly to enable progress and traction in delivery of elements required for the FT application. He added that the aim is for the group to be action focused and will keep to a minimum administrative systems and processes seeking to use a simple Action Log as a record of its meetings.

Date of Next Meeting: Tuesday May 20th 2014 15:00 – 17:00

Imperial College Healthcare NHS Trust

Trust Board Public

30 July 2014

Agenda Item	5.5
Title	Remuneration & Appointments Committee Chairman's Report
Report for	Noting
Report Author	Jayne Mee, Director of People & Organisation Development
Responsible Executive Director	Jayne Mee, Director of People & Organisation Development
Freedom of Information Status	Report can be made public

Executive Summary: *The purpose of this report is to advise the Trust Board on the discussions and recommendations of the Remuneration & Appointments Committee meeting held 25 June 2014.*

Recommendation(s) to the Board/Committee: *The Trust Board is asked to note the contents of this paper.*

Trust strategic objectives supported by this paper:

1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

1. Introduction

The Remuneration & Appointments Committee met on 25 June 2014. The main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The proposed remuneration package for Dr Chris Harrison, Medical Director, was noted and formally approved. A paper reviewing the Executive Team annual salary benchmarking report and recommendations was noted and approved.

3. Key risks discussed

There were no risks discussed.

4. Key decisions taken

Approved Medical Director's remuneration package.

Imperial College Healthcare NHS Trust

5. Agreed Key Actions

No further actions.

6. Future Business

N/A

7. Recommendation

The Trust Board is asked to note the contents of this paper.