Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
28 January 2015
13:30 - 15:00
Clarence Wing Boardroom, St Mary's Hospital

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's Opening Remarks	Chairman	13:30	Oral
1.2	Apologies	Chairman		Oral
1.3	Board member's declarations of interests	Chairman		1
1.4	Minutes of meeting held on 26 November 2014	Chairman		2
1.5	Matters arising and action Log	Chairman		3
1.6	Minor amendment to governance arrangements	Chairman		4
2	**Operational items**			
2.1	Patient Story	Director of Nursing	13:45	5
2.2	Chief Executive's Report	Chief Executive		6
2.3	Operational Report and Integrated Performance Scorecard	Chief Operating Officer		7
2.4	Finance Performance Report	Interim Chief Financial Officer		8
3	**Items for decision**			
3.1	Values, behaviour and promise project (Bob Klaber and Pippa Nightingale presenting)	Director of Communications	14:20	9
3.2	2014 Emergency Preparedness, Resilience and Response (EPRR) assurance process	Chief Operating Officer		10
3.3	NHS Trust Development Authority self-certifications (Compliance October, November; Board Statement October, November)	Interim Chief Financial Officer		11
3.4	Standing Orders	Company Trust Secretary		12
4	**Items for discussion**			
4.1	CQC Inspection - follow up and action plan	Director of Nursing	14:35	13
4.2	Research Review for 2014 (Prof Jonathan Weber presenting)	Medical Director		14
5	**Board committee reports**			
5.1	Quality Committee - report of 14 January 2015	Committee Chair	14:55	15
5.2	Audit, Risk & Governance Committee - report of 10 December 2014	Committee Chair		16
5.3	Finance & Investment Committee Minutes of the meeting of 20 November 2014	Committee Chair		17
5.4	Foundation Trust Programme Board Report & Minutes of the meeting of 10 December and Minutes of the meeting 18 November 2014	Committee Chair		18
6	**Items for information**			
6.1	Report of items discussed at confidential Trust Board 26 November & 17 December 2014	Chairman		19
7	**Any other business**			
			14.50	
8	**Questions from the public relating to agenda items**			
9	**Date of next meeting**			
	25 March 2015, Oak Suite, W12 Conference Centre, Hammersmith Hospital, W12 0HS			

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	1.3
Title	Board members' declarations of interests
Report for	Noting
Report Author	Tracy Walsh, Committee Clerk
Responsible Executive Director	Tracey Batten, Chief Executive

The Trust's Standing Orders and Standards of Business Conduct policy require directors to declare interests which are relevant and material to the Trust Board.

The declarations of interests register shall be considered by the Trust Board on a quarterly basis (May, July, November and March) with any changes in interests between these meetings to be declared at the next Trust Board meeting following the change occurring.

Recommendation to the Board: The Trust Board is asked to note the paper.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

10.00am – 12.30pm
Wednesday 26 November 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
Sir Anthony Newman Taylor	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:	
Jan Aps	Trust Company Secretary (Minutes)
David Crundwell	Chairman, Imperial College Healthcare Charity (to item 4.1)
Michelle Dixon	Director of Communications
Ian Garlington	Director of Strategy
Ally Fuller	Service User (item 2.1 only)
Kevin Jarrold	Chief Information Officer
Prof Dermot Kelleher	Principal of The Faculty of Medicine of Imperial College
Jayne Mee	Director of People and Organisation
Jane Miles	Chief Executive, Imperial College Healthcare Charity (to item 4.1 only)
Helen Potton	Interim Trust Company Secretary

1	**General business**	**Action**
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 for absence were received from Sir Thomas Legg and Prof Dermot Kelleher.	
1.3	**Board members' declarations of interest and conflicts of interest** There were no additional conflicts of interests declared at the meeting.	
1.4	**Minutes of the meeting held on 24 September 2014** The minutes were **agreed** as an accurate record, with the following amendment to the minutes of the meeting on 30 July 2014: • Item 3.2 – the majority of undergraduate teaching would move from the Charing Cross site to the St Mary's site if the SaHF outline business case was approved to support the implementation of the clinical strategy.	**JA**
1.5	**Minutes of the Annual General Meeting held on 24 September 2014**	

	The minutes of the meeting were agreed as an accurate record.	
1.6	**Matters arising and action log** The Board noted the updates to the action log.	
2	**Operational items**	
2.1	**Patient story**	
	The chairman welcomed Ally Fuller to the Board meeting who had kindly agreed to explain her patient experience at both St Mary's and Hammersmith Hospitals. Prof Janice Sigsworth explained that Ms Fuller had recently shared her experiences at a cancer patient event. Ms Fuller explained that she had been a patient since 2013 and had two inpatient stays, one each on Charles Pannet and A8; she had found very contrasting experiences, which had surprised her. On Charles Pannet (St Mary's Hospital) she experienced a lack of warmth and empathy from staff, particularly at night, with her call bell being placed out of reach, poor pain control, and personal needs not attended to. She felt vulnerable and unable to complain whilst a patient, although she did mention her concerns to the consultant. On A8 (Hammersmith Hospital), her experience had been completely different, an entirely positive experience when she felt totally cared for. Ally Fuller had made a formal complaint after about five months, the delay a result of wanting to get back to a normal life as soon as possible. She felt her complaint had been well handled, and had particularly appreciated being taken back to the ward to see the improvements made as a result of her comments – her sole aim in complaining had been to ensure other patients did not have a similar experience. Dr Tracey Batton noted that it was good that improvement had been made as a result of the complaints, but queried how the Trust could ensure such events did not happen at all. Prof Janice Sigworth outlined that ward managers (seen as sufficiently far removed to be a 'safe' place for complaint or comment) were now touching base with each patient every few days; this would provide an opportunity to make changes quickly. In response to questions from the Non-Executive Directors, Prof Janice Sigworth outline the changes made: a new ward manager had been appointed; a number of staff were no longer working at the Trust; and regular review of ward staffing, particularly given that Charles Pannet was one of the busiest acute wards in the Trust. The Chairman apologised to Ally Fuller for her experience at the Trust and thanked her for both her complaint and the positive impact it had had on patient care on the ward, and for attending the Board to share this experience.	
2.2	**Chief Executive's report**	
	Dr Tracey Batten particularly highlighted the following items: • The draft Chief Inspector of Hospitals report had been received by the Trust and was being checked for factual accuracy; a response would be sent to CQC week commencing 1 December 2014. The Quality Summit, with CQC and stakeholders, would then be held in mid-December, with the CQC rating confirmed and the report published after this. • The bedding of the Cerner patient administration system implementation was progressing well with data quality continuing to improve. Clinical documentation was being piloted and would start to be rolled out during the Spring 2015, together with electronic prescribing at which point the Trust would observe greater benefits and efficiencies from the system. • Jan Aps was welcomed as the incoming Trust Company Secretary and thanks were extended to Helen Potton (Interim Trust Company Secretary) for her contribution and for having ensured a smooth transition. • The mid-term review of the Biomedical Research Centre (BRC) had demonstrated the importance of clear alignment of the BRC and the Academic Health Sciences Centre (AHSC); Prof Jonathan Weber had been appointed as the Director of the AHSC and arrangements were in hand to invite him to present to the Board early in 2015.	CH

	The Non-Executive Directors expressed some concern as to the scale of saving / efficiency requirements highlighted in the NHS Five Year Forward View. The Board noted the report.	
2.3	**Operational report**	
	Steve McManus presented the operational report and integrated performance scorecard together, particularly highlighting the following items: • The Trust had clear Ebola procedures in place, with staff appropriately trained and personal protective equipment available. • The Trust was experiencing an increase in the average length of delay for patients in relation to repatriation and transfer to more appropriate environments for care; this was adversely affecting the length of stay performance. Daily escalation arrangements were now in place and it was expected that closer relationships with stakeholders (social work staff now on site seven days a week; joint funding of 18 beds with Central London Community Health NHS Trust; early successes with the implementation of whole systems integrated care) would see an improvement in this position. • Work continued to reduce the number of patients who did not attend for procedures to support improvement in theatre utilisation. • Trust A&E 4-hour wait performance had been at 93.2% for October (short of the 95% target). A comprehensive action plan was in place including increasing step down resource at Charing Cross Hospital and moving the urgent care centre to allow further space within the A&E at St Mary's Hospital. Steve McManus assured the Board that there was appropriate executive focus on this issue, and noted that the volatility in activity had exacerbated the performance issues. • The Trust had delivered all eight cancer standards in quarter 2 and it was expected that this would be the position for quarter 3. • The continued low Friends and Family test response rate in A&E was considered to be due to staff handling increased levels of activity in the department; the response rate had improved slightly in November; the indicator was subject to weekly review by the executive team. Dr Rodney Eastwood queried the reported declining performance on 18 week referral to treatment (RTT) time given that overall inpatient and outpatient activity had not decreased. Steve McManus confirmed that the issues in data quality following implementation of the Cerner patient administration systems had manifested as a reduction in performance, and outlined that it was expected that this would be resolved in the December performance report. It was acknowledged that there was currently an amnesty on RTT reporting across the NHS to reduce the backlog of patients waiting. It was confirmed that all indicators in the scorecard would be ascribed thresholds, representative of peer benchmarks wherever possible; these would be reported in the next scorecard. The board noted that the Trust performance to date, and likely trajectory, demonstrated that the Trust was unlikely to achieve the C difficile threshold. It was noted that there was no evidence of cross contamination, and the executive were confident that antibiotic usage, and C difficile testing arrangements were appropriate. It was noted that the *FFT – A&E response* segment should be amber on page five of the report. Prof Chris Harrison outlined that education governance arrangements were aligned closely with the university, through the AHSC – Sir Anthony Newman Taylor asked that this be reflected in the education governance structure. Jayne Mee confirmed the clear focus on recruiting to the hard to recruit specialties where the high vacancy rates reflected this difficulty. Steve McManus would demonstrate the click through scorecard at the January Board. The Board requested a trend analysis on A&E performance at the January Board meeting.	SMcM SMcM

	The board noted the report.	
2.4	**Integrated Performance Scorecard** - discussed as part the operational report.	
2.5	**Finance Performance Report**	
	Bill Shields noted that the Trust had achieved a year to date (YTD) surplus position, although it remained behind plan by £8m. Expenditure had increased slightly to address winter resilience and also in bank and agency spend, and there was a significant gap in cost improvement plan achievement. The executive was prioritising action in the area through the new quality and efficiency support (QuES]) team building deliverable plans for 2015/16 by year end. It was expected that the planned year-end position would be received partially by using non-recurrent income, (land sales and additional activity) provisions and accruals. This would depend on Project Diamond income (total of £18m) being achieved; the market forces factor (MFF) element was considered to be at risk. Dr Rodney Eastwood suggested that support be sought from academic partners in relation to research and development income. The Board noted the finance performance report.	
3	**Items for Decision**	
3.1	**Proposal for a public and patient engagement programme**	
	Michelle Dixon introduced the paper highlighting that it have been developed in close liaison with the clinical teams, in order to 'paint a picture' for the public about the future of the Trust and the way in which patient pathways would be delivered. Progress and impact would be reviewed in four months, with feedback provided to the public to demonstrate that the Trust was listening. It would be important to achieve a strategic shift, in that engagement would be embedded as part of all areas of the Trust. The Non-Executives considered this could be more difficult in relation to Charing Cross Hospital given that plans were not yet complete, but agreed that this would be very helpful in relation to pathways rather than sites. Michelle Dixon confirmed that the review and upgrade of the website would be encompassed in this programme. The Board approved the proposed engagement programme.	
3.2	**NHS Trust Development Authority self-certifications**	
	Bill Shields presented the self-certifications, seeking retrospective approval from the board, noting that there had been no material changes, and confirming that the responses related to the first six months of the financial year. The Board approved the self-certifications.	
4	**Items for Discussion**	
4.1	**Imperial College Healthcare Charity and Trust working together**	
	The Chairman welcomed David Crundwell and Jane Miles to the meeting. David Crundwell started by expressing the Charity's commitment to continuing to work in partnership with the Trust. He outlined the focus of the charity: improved patient experience; direct impact on health of local people; addressing health inequalities; and creating and disseminating learning. Jane Miles outlined some of the ways in which the charity supported the Trust (staff engagement and experience; research fellows; art; patient experience and engagement), and explained the way in which the Charity assess the impact and effectiveness of projects that they have supported. The key focus for the next three years would be GP health informatics, cancer survivorship, the art collection, the delivery of the five year fund-raising strategy for the St Mary's paediatric intensive care unit (PICU) and other Trust capital developments. In response to a question from Sir Gerald Acher, Jane Miles explained that grant requests were channelled through the joint fundraising board, and that the Charity tried to be clear in communications as to what grants it was likely to support (measurable and	

	sustainable), to minimise wasted energy in bid development. Support from Marks & Spencer plc would be sought in relation to the PICU development; they had previously supported a number of Trust developments. Jane Miles would also explore crowd funding options. The Chairman extended the Board's recognition and thanks to Jane Miles as she was stepping down from the role, and noted that Ian Lush would be the incoming Chief Executive.	
4.2	**Synopsis of the NHS England *5 Year Forward View***	
	Ian Garlington presented a summary of the recently published NHS England *5 Year Forward View*, noting particularly that the Trust's clinical strategy was clearly in line with the key proposals. In response to a question from the Chairman about how politically influenced the Forward View had been he suggested that there had been a significant level of listening to the views directly from the NHS and other stakeholders, in a way that had perhaps not been replicated in other NHS strategy documents. The Board noted the report.	
4.3	**Synopsis of the London Health Commission (LHC) *Better Health for London***	
	Ian Garlington presented a summary of the recently published LHC *5 Year Forward View*, again noting the alignment with the Trust's strategic plan. The paper highlighted those recommendations of the 64 which were of greatest relevance to the Trust. The Board noted the report.	
4.4	**Monitor's NHS Foundation Trust *Code of Governance* assessment**	
	Dr Tracey Batten introduced the assessment which had been undertaken as part of the Trust's preparation for Foundation Trust status, noting that it had been reviewed I detail at the Foundation Trust Programme Board. Following approval by the Board, a detailed action plan would be developed. In response to a question from Andreas Raffel, Jayne Mee explained that the guidance on 'fit and proper persons' had recently been received by the Trust, and arrangements were being put in place to ensure compliance. The Board reviewed and noted the Code of Governance assessment.	
4.5	**Annual Safeguarding Reports 2013/14 – Adults and Children & Young People**	
	Prof Janice Sigsworth presented the 2013/14 Adult Safeguarding Report, noting the improvement in training and awareness of safeguarding amongst staff. She outlined that further work undertaken by the internal audit team would be presented to the Audit Risk and Governance Committee in early 2015. She then presented the 2013/14 Children and Young People's Safeguarding Report, which reflected the significant work undertaken in this area, with strengthened practice in A& E, and greater cover from health visitors. The team had undertaken visits to discuss youth violence and female genital mutilation. In response to a question from Sarika Patel, she noted that the 85% target for training was currently being met, but there was an intention to deliver training to all front line staff, including non-clinical staff, to improve identification of potential safeguarding incidents. The board noted the report.	
4.6	**NHS Genomics Medicine Centre**	
	Prof Chris Harrison reported the progress achieved in agreeing with partners that the Trust would be the Lead Organisation in the bid for the West London NHS Genomic Medicine Centre, the partners being Royal Marsden, Royal Brompton & Harefield and Chelsea & Westminster NHS Foundation Trusts. There would be an ongoing assessment process. This was an area in which the Trust was at the vanguard of development and a continued growth in relationship with other partners would be of importance. The final application (ITT stage 2) had been submitted on 7 November. Dr Tracey Batten commended the achievements in engaging Royal Marsden NHS Trust in the Centre bid. The board noted the report.	

4.7	**Improvements to the Timeliness of the Provision of Medication at Discharge**	
	Steve McManus outlined the improvements which had been introduced to reduce the delay that patients experienced in receiving their medication at discharge; this would address concern often expressed by patients in feedback. It was now the case that 90 per cent of all medication was available to the patient within two hours, which was seen as a good practice position. Further attention was now being paid to the entire pathway, and the planned introduction of electronic prescribing would further reduce patient waits. The Board was pleased to note the improvements, but asked that this remain an area where continuous improvement was sought to enhance the patient experience at discharge. The Board noted the report.	
5	**Board Committee Items**	
5.1	**Quality Committee** Professor Sir Anthony Newman Taylor particularly highlighted that an investment proposal to ensure sustainable surgical rotas at Charing Cross would be developed by the end of December. He also noted the dramatic improvement in the staff survey response rate. The Board noted the report of the meeting on 12 November 2014 and received the minutes of the meetings on 20 August and 8 October 2014.	
5.2	**Finance & Investment Committee** Sarika Patel highlighted that the Non-Executive Directors were concerned about the Trust's financial position, and had asked to see an analysis of costs in relation to patient activity, and a further finance statement which stripped out non-recurrent funding and cost items. The committee had approved the planning process for 2015/16 in principle, but awaited further details on commissioning intentions. The committee noted that piloting of world class procurement had saved £200k in one theatre, and this was now being rolled out to other theatres. Patient transport was identified as an area of continued overspend; work continued to ensure that the procedures were correctly adhered to. Sir Gerald Acher considered that a clearer line between clinical need and commissioner payment needed to be in place, with Trust departments being directly charged. Dr Tracey Batten had outlined the proposal to enhancing the use of electronic rostering, which following review of the system had demonstrated real opportunities to improve both patient safety and efficiency by reducing reliance on bank and agency staff. A proactive and more timely recruitment approach was in place, and a centralised recruitment team had been introduced who were working with the divisions to understand and address their strategic workforce needs. Jayne Mee reported that the Trust had one of the lowest vacancy rates in London. The Board noted the oral report of the meeting on 20 November 2014, and received the minutes of the meeting on 18 September 2014.	
5.3	**Foundation Trust Programme Board** Dr Rodney Eastwood noted that the programme board continued to progress the integrated business plan (IBP) chapters and all other areas required as part of the preparation for foundation trust authorisation. He reported that there was greater clarity as to the composition of the Council of Governors, and that the Trust had over 7000 shadow members. The Board noted the oral report of the meeting on 18 November 2014, and received the minutes and report of the meeting on 16 September 2014.	
6	**Items for information**	
	There no items for information	
7	**Any other business**	

	There were no items of any other business	
8	**Questions from the public relating to Agenda items** Concern was expressed by a member of the public that the Trust may be putting profits before patient care in it approach to reconfiguration of services. This was rebuffed by Dr Tracey Batten who confirmed that reconfigurations were framed by national and NW guidance and had been subject to public consultation. She confirmed that the Trust had not discussed sale of the Charing Cross tower block with developers. Bill Shields referred back to his earlier comments on the increased spend on bank and agency spend, when a question was asked in this regard, adding that bank and agency staff had often been used in the short-term to support expansion in services. Dr Tracey Batten confirmed that her planned visit to New York and Boston, arranged by the clinical commissioning groups, would not be funded by the Trust [post meeting note: Dr Batten did not undertake the trip]. Poor A&E target performance in one particular week in November at St Mary's A&E raised by a member of the public was acknowledged by Steve McManus; he explained that improving performance was a priority and that additional senior clinical cover had been introduced to improve patient experience.	
9	**Date and time of next meeting** The next meeting would be held on Wednesday 28 January 2015, at St Mary's Hospital at 13.30, venue to be confirmed.	
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 Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Update – January 2015	Meeting date & minute number	Responsible
A&E performance The January performance report would include a trend analysis on A&E activity and performance	This would be included in the January performance report	26 November 2014 2.3	Steve McManus

FORWARD PLAN

Report due	Report subject	Meeting at which item requested	Responsible
January 2015	**Clinical research** A report on the Trust's research activities would be presented to the Trust Board	24 September 2014 2.3.10	Chris Harrison
June 2015	**Academic Health Sciences Centre (AHSC)** Prof Jonathan Weber to be invited to present to the board development session	26 November 2014 2.2	Chris Harrison
March 2015	**On-line performance scorecard** Demonstration of the Qlik view scorecard (This would be presented as part of the presentation of the performance report)	26 November 2014 2.3	Steve McManus
March 2015	**Leadership development** Consideration to be given to implementing a Trust-based graduate training scheme	27 November 2013 3.4.2	Jayne Mee
April 2015 - seminar	**Board seminars** A discussion on organisation culture and staff engagement to be included on the agenda for a future board seminar	24 September 2014 3.1.4	Jayne Mee
May 2015	**Cost improvement programme: quality impact assessment** An annual summary of post-implementation reports to be submitted to the Board for review	28 May 2014 4.2	Chris Harrison

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	1.6
Title	Finance & Investment Committee - minor amendment to governance arrangements
Report for	Approval
Report Author	Jan Aps, Trust Company Secretary
Responsible Executive Director	Tracey Batten, Chief Executive

It has been proposed by the chair of the Finance and Investment Committee, Sarika Patel, and supported by the Chairman, Sir Richard Sykes, that Rodney Eastwood becomes an additional member of the Finance and Investment Committee.

Recommendation to the Board: The Trust Board is asked to approve Rodney Eastwood becoming a member of the Finance and Investment Committee.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	2.1
Title	Patient Story
Report for	Noting
Report Author	Guy Young, Deputy Director of Patient Experience
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary:

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

NH is 18 years old and has been receiving care at Imperial for his diabetes for around 6 years. NH's care is about to move from the paediatric to adult services. NH's parents will tell his story.

Recommendation to the Board:

The Board is asked to note the patient story

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Patient Story

Background

The use of patient stories at board and committee level is increasingly seen as a positive way of reducing the "ward to board" gap, by regularly connecting the organisation's core business with its most senior leaders. There is an expectation from both commissioners and the Trust Development Authority that ICHT will use this approach. Thus far, the Board has received ten patient stories. The first seven were presented by the Director of Nursing and the last three were presented by patients in person.

The perceived benefits of patient stories are:

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

NH's story

NH is 18 years old and was diagnosed as diabetic in 2009, since when he has been under the care of the paediatric diabetes team. NH has dyslexia and had a statement of Special Educational Needs in school. He is an accomplished model maker, being a member of the International Plastic Modelling Society and Barnet and Harrow Modelling Societies. He is a keen model railway enthusiast and a member of the Bluebell Preservation Railway. He is a science fiction fan, particularly Star Wars and Dr Who and an "*Awful*" – Adult Friend of Lego.

NH's story centres on his outpatient care. Both he and his parents are very complimentary about this and the experiences of the staff they have been involved with. There are issues about administration and they feel that there is sometimes unnecessary waste that could be reduced.

The main pressing concern at the moment, which they will discuss, is NH's transition from paediatric to adult services when he turns nineteen in March. His needs have been comprehensively met to this point and his and their hope and expectation is that the transition will be seamless.

NH is understandably anxious about coming to the board and his parents will tell his story. NH may or may not be present at the meeting, but if he is he may be willing to take questions.

Actions arising out of previous patient stories

At the November Board meeting the patient, AF, described her differing experiences on two wards in the trust. Her care on one ward was such that she felt compelled to make a formal complaint, her sole aim being to ensure that other patients did not have a similar experience. She found the way in which her complaint was handled to be very effective. In particular, the opportunity to revisit the ward and see the changes that had been introduced following her complaint made her feel that making her complaint was a valuable thing to

do.

ICHT is currently reviewing its approach to how complaints are managed, both in response to local performance and feedback and to a number of recent national reports. These reports from the latter part of 2014 are from the Patients Association (*Handling complaints with a human touch*), the Ombudsman and Healthwatch (*My expectations for raising complaints and concerns*) and the CQC (*Complaints matter*). They highlight the need for NHS organisations to have a timely, responsive and humane approach to handling patients' complaints and concerns.

There is a range of recommendations arising from these reports but key themes include:

- Patients want to talk to someone about their concerns (not to get bogged down with formal written correspondence)
- Where possible patients simply want their issue resolved quickly
- Patients want the process of making a complaint to be simple
- Patients want to be listened to, treated with dignity and respect and, where appropriate, receive a genuine apology
- Patients want their complaint to be taken seriously and properly investigated
- Patients want to see that their complaint has made a difference; that it may help to improve things for other patients
- There should be visibility of complaints throughout the organisation with clear identification of themes and evidence of learning and improvement arising from complaints

In essence, all complaints need to be handled in the way that AF described to the Board. The current approach at ICHT does not support all of these recommendations all of the time.

A paper setting out potential changes to the complaints systems and structures went to the Executive Committee earlier this month and option to explore centralisation of the complaints function was endorsed. A further more detailed paper exploring this option will be taken to the Executive Committee in February.

Recommendation to the Board:
The Board is asked to note the patient story

Imperial College Healthcare NHS Trust

Trust Board - Public

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

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

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

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- 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.

Key Strategic Priorities

1. Chief Inspector of Hospitals Visit

Following a Trust-wide CQC inspection in September 2014 and a CQC Quality Summit in December 2014, the Trust received an overall rating of 'requires improvement'. While we are disappointed with our overall rating of 'requires improvement', we think the report is extremely constructive. It clearly sets out our challenges while also recognising the positive impact of our work over the past year and highlighting the great care that we already provide.

Overall, the findings show that our major improvement programmes are moving us in the right direction. It's clear that we now have to redouble our efforts in a number of areas and services, but the report also shows that there is a lot of great care and clinical practice that we can build on. Most importantly, our staff are consistently seen by patients as caring and compassionate and we achieve some of the best results for patients, including in our specialist centres for stroke and major trauma.

Following the re-inspection of the St. Mary's accident and emergency (A&E) department in November 2014, the CQC are now satisfied that the Trust is compliant. A comprehensive action plan to address the findings of the CQC report has now been developed and was submitted to the CQC for review on 19 January 2015. The action plan is included in the Board papers at agenda item 4.1.

2. Shaping a Healthier Future (SaHF) Outline Business Case (OBC)

The North West London investment making business case (IMBC) to deliver the Shaping a Healthier Future (SaHF) programme was approved by the CCG's in late December 2014. The IMBC will shortly be forwarded to NHS England for consideration. It is anticipated that NHS England will provide feedback on the business case in the spring.

The Trust's preferred option (option four) of its SaHF outline business case – namely the major redevelopment of St Mary's Hospital (including the relocation of the Western Eye Hospital), a new local hospital at Charing Cross Hospital and modest investment at Hammersmith Hospital – is the option reflected in the CCG's preferred option in the IMBC. Work on the SaHF full business case (FBC) will not progress until feedback on the IMBC has been received from NHS England.

3. Community Independence Service (CIS) Tender

The Trust has been awarded the lead health provider role (subject to contract) for the tri-borough Community Independence Service (CIS), to be financed through the Better Care Fund. This represents an important opportunity for the Trust to lead the shaping of integrated and intermediate care across the sector, in line with its clinical strategy and in support of the Whole Systems Integrated Care agenda.

To enable the service to go live on 1 April 2015 as planned, the Trust's immediate priorities are:

- Building a high-performing programme team that is representative of the partnership that supported the Trust's lead provider bid
- Agreeing and establishing a robust and workable governance model
- Negotiating and agreeing contracts with local commissioners, the Lead Social Care Provider and the sub-contract partners in the healthcare supply chain

- Development of a joint implementation and investment plan.

The Trust Board discussed and approved the tender at its meeting on 26 November 2014.

4. Financial Sustainability

The Trust's financial position for month nine was breakeven which is an adverse variance of £0.2m in the month. The Year to Date (YTD) surplus of £5.9m is an adverse variance against plan of £4.6m. Pay expenditure shows an adverse YTD variance of £24.4m with higher than planned usage of bank and agency staff. Significant work is underway to look at our rostering practices across the Trust to support the delivery of CIPs. The financial position continues to assume full payment for project diamond funding.

5. Accident and emergency (A&E) performance

A&E performance against the 95 per cent four-hour wait standard target remains challenged across the Trust. Further measures to increase capacity are being put in place. The executive committee last week agreed to a plan which will aim to open some additional capacity at Charing Cross Hospital by late February. Estates work is on track to convert the space adjacent to the QEQM building at St. Mary's Hospital for the relocation of the urgent care centre (UCC) by the end of January (with the clinical commissioning for the service being complete by mid-February). An additional 12 winter beds at St Mary's Hospital were also opened on 5 January 2015.

The Trust is also participating in a wider independent review of A&E services across London which is being led jointly by NHS England, NHS Trust Development Authority, and Monitor, the aim of which is to support the improvement of A&E performance.

6. Cerner Implementation

The Trust continues to make good progress with the resolution of the Cerner data quality issues. A number of indicators are now back to or better than the levels recorded before the Cerner PAS was brought into live operation last April. Other areas requiring focus are now being managed as part of the routine business as usual process. The decision was made at the last Cerner Programme Steering Committee to pass through Gateway seven and to proceed with the pilot roll out of clinical documentation and electronic prescribing. The implementation of the Cerner modules for theatres management and for the emergency department are on track to go live in early March. Planning is now getting underway for the transfer of the data centre in September.

7. Foundation trust application

As a result of the outcome of the Care Quality Commission (CQC) inspection, the Trust has put on hold its foundation trust application to focus on the implementation of the CQC action plan. A re-inspection by the CQC is anticipated within 12 months at which point a rating of 'good' will need to be achieved to recommence the foundation trust process.

Authorisation as a foundation trust remains a development priority for the Trust. The Trust will continue to further strengthen its governance systems and processes to ensure that it can demonstrate compliance with Monitor's "Well Led" framework for foundation trusts which is likely to be used by the TDA to assess NHS Trust's in future. In essence, delivery of the "Well Led" framework enables the Trust to demonstrate compliance with many of Monitor's requirements for aspirant trusts.

8. Stakeholder Engagement

We have continued to engage a range of external stakeholders, particularly on the clinical strategy and future engagement plans, plus other key issues such as the performance of our urgent and emergency care services and the CQC inspection. This includes meetings with: the 'Save our Hospitals' campaign executive; Westminster Members of Parliament Karen Buck and Mark Field; and, an initial discussion with the researchers to the Mansfield Commission on north west London healthcare established by four local councils in December. The Trust also attended Westminster Council Adults and Health Scrutiny Committee in November to discuss various issues including winter resilience planning, A&E performance, clinical strategy and the CQC inspection next steps.

Following the publication of the CQC's inspection report we briefed a group of councillors from the tri-borough area of Hammersmith & Fulham, Kensington and Chelsea, and Westminster. Forthcoming attendances at Hammersmith & Fulham Council's health overview and scrutiny committee are planned in both January and February, as well as further meetings with MPs, councillors and Healthwatch.

9. Engagement survey

The Trust's on-going roll out of engagement surveys continues and the results of the fifth survey were received in December. In summary the survey saw the highest response rate to date at 49%, and a total of 1209 responses. The engagement score remains consistent with the previous survey at 37% (a 1% drop from Survey four) and there was an increase in the number of respondents who believe action will be taken as a result of the survey

The friends and family test (FFT) question recommending the Trust as a place for treatment decreased slightly from 78% to 77%. The FFT question recommending the Trust as a place to work also reduced slightly from 60% to 58%.

In addition, the four lowest scoring questions remain consistent with previous surveys, namely questions relating to health and wellbeing, senior leadership and "at work my opinions seem to count". The results have been widely circulated across the Trust and the divisions/directorates are reviewing their action plans. The results of the National NHS Staff Survey are due in early February which will provide some valuable benchmarking data.

10. Genomics medicine centre

ICHT has recently received confirmation that it has been successful in bidding to become an NHS Genomics Medicine Centre (GMC), in partnership with the Royal Marsden, Royal Brompton and Chelsea & Westminster. The GMCs will deliver the Prime Minister's 100K Genomes initiative, before the end of 2017. 11 Trusts/consortia were selected nationally in this first "wave".

Contract negotiations are ongoing, with the current intention to begin consenting patients with common cancers and a number of inherited rare diseases in February 2015. DNA will be extracted from blood and tumour samples, and sequenced by an external provider. ICHT will receive a payment for each patient successfully consented and sequenced, as well as a capital award for IT and pathology-related infrastructure.

This is an NHS transformation initiative in the first instance, and any clinically relevant

findings from the sequencing of DNA will be fed back to patients via their clinician. However, research opportunities from the 100K Genomes project will arise through the Genomics England Clinical Interpretation Partnership (GeCIP), the mechanism through which funders, researchers, trainees and clinicians will collaborate – forming a community of disease-specific and function-specific domains – with the overarching aim of analysing and constantly refining the clinical interpretation of the 100,000 genomes dataset. Genetic data, samples, and associated clinical datasets, will be stored in a biorepository in Oxford for future access by research teams from the public and private sectors. The aim is to use genetic data on a mass scale to stratify diagnostic and therapeutic approaches within patient populations.

11. Surgical Innovation Centre

The Trust's Surgical Innovation Centre will be officially launched on 28 January 2015 at a ceremony attended by many of our stakeholders. The Centre, a cutting edge translational research facility within the Institute of Global Health Innovation at Imperial College London, is within the Paterson Building at St Mary's Hospital. It embodies the three principles of our academic health science centre – research, training and education, and clinical delivery. Patient care at the Centre includes bariatric, breast, gastroenterologiocal and urological surgery, many performed laparoscopically and as day cases, meaning patients can return home quickly after expert care.

The launch will also include a visit to the Helix Pop-Up centre currently at St Mary's Hospital in Norfolk Place which is a collaboration between the Royal College of Art and Imperial College London to identify patient centred and cost-effective solutions to pressing healthcare challenges.

12. First successful newborn organ donation

The Trust received widespread positive national media coverage after our doctors pioneered the first organ donation in the UK from a newborn baby. With the support of the baby's parents, the doctors and organ donation team were able to make donations of kidneys, which were transplanted into a patient with renal failure, and liver cells (hepatocytes), which were transfused into a further recipient. Supported by the organ donation team, the nursing staff and the hospital's psychologist, the parents gave their consent for their daughter's kidneys and liver cells to be used for the benefit of other sick patients.

13. Macmillan funding agreement

The Trust has developed a strategic partnership with Macmillan in order to support improvement in the patients' cancer journey and their experience as a cancer patient in the Trust. A project was outlined to deliver solutions to improve patient experience and through a series of stakeholder events, a range of interventions have been agreed including the development of a patient navigator role and increased clinical nurse specialist (CNS) provision.

On Tuesday 23 December the executive committee endorsed the sign off of the Macmillan Funding Agreement and supported the inception of the program. The Trust has now successfully negotiated the funding agreement with Macmillan, agreeing the delivery of funding to the Trust in phase 1 of the program. Recruitment has commenced to the new posts with initial appointments taking effect from April 2015.

14. Senior Leadership team

A strategy workshop for the executive committee took place in December to discuss two key topics: the strategic positioning of the organisation and its 2015/16 Annual Plan. The executive committee examined the concept of strategic positioning, and after considering the results of a pre-workshop survey of the group, agreed that ICHT's strategic position should be defined by two key concepts; patient experience and population health outcomes. These concepts will require further development with wider consultation planned. The intention is to review in further detail at the next leadership forum in March prior to discussion and consideration by the Board.

On Monday 5 January, Alan Goldsman and Vincent Doherty both joined the Trust as interim chief financial officer and interim director of operational finance respectively. Alan Goldsman joined the Trust from The Royal Marsden NHS Foundation Trust where he had been the director of finance/deputy chief executive for the past 12 years. Prior to this, Alan was deputy director of finance at Guy's and St Thomas NHS Foundation Trust for 12 years. Vincent Doherty joined the Trust from Barts Health NHS Trust where he has been for the past two years. At Barts, he has held a number of positions including turnaround finance lead and operational finance director. The recruitment for the substantive chief financial officer is in progress.

The executive committee approved a proposal to restructure the position of IPH within the wider trust, creating a fifth division under the chief operating officer and setting parallel governance and performance reporting arrangements to the other clinical divisions. This has been important to ensure consistent clinical governance and quality and safety oversight by the executive team. The Director of IPH has also now joined as a member of the executive team consistent with the other four divisional directors.

15. Non-executive, Sir Thomas Legg's retirement

Sir Thomas Legg retired from the board of ICHT on 31 December 2014. Sir Thomas joined Hammersmith Hospitals NHS Trust as Chairman in 2000, until the merger in 2007, at which time he was appointed Vice Chairman and Senior Independent Director of Imperial College Healthcare NHS Trust. As well as deputising for two Chairmen over a period of eight years, Sir Thomas was a member of the Audit, Risk and Governance Committee, Quality Committee, the Foundation Trust Board, and the Remuneration and Appointments Committee.

Key Strategic Issues

1. Senior leadership changes in the NWL sector

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing (CWHHE) Clinical Commissioning Groups have confirmed the appointment of Clare Parker as their new Accountable Officer. Clare started in her new post in January and was previously Deputy Accountable Officer and Chief Finance Officer of CWHHE Clinical Commissioning Groups.

2. Changes to Imperial College health leadership roles

Please see attached the press release from Imperial College (appendix one), which outlines the changes to Vice President (Health) and Dean of Medicine roles at Imperial College. The Chief Executive has been invited to join the interview panel for the role of the

Dean of Medicine.

3. Mansfield Commission on north west London healthcare

Four Labour controlled local authorities in Hammersmith & Fulham, Ealing, Brent and Hounslow have jointly funded an inquiry into healthcare services in north west London through a commission chaired by Michael Mansfield QC. According to the commission's draft terms of reference, it will review the findings of previous studies relating to 'Shaping a Healthier Future' and other NHS plans for the future of healthcare services in north west London and consider evidence from stakeholders, experts in the field and other interested parties.

The commission will review and report on the likely impact of the Imperial College Healthcare NHS Trust's Clinical Strategy 2014-20, and any equivalent plans from London North West Healthcare NHS Trust or its predecessors, on the residents of North West London. It will also review the Out-of-Hospital strategy and wider plans to treat more patients in the community to see if the plans can accommodate an increase in demand as a result of reduction in acute provision.

Steve McManus and Michelle Dixon met with the commission's research consultants for an initial discussion on 7 January and the commission held its first meeting on Saturday 10 January. The commission will publish its findings in a report within one month of the completion of evidence hearings and consideration of all written evidence - which is expected to be in late March.

4. 2015 UK election guidance

The 2015 UK Parliamentary General Election will be held on Thursday 7 May, covering all 650 parliamentary constituencies. The 2015 UK Local Government elections will also be held on the same date, but these do not include the 32 London boroughs.

The general principle is that NHS bodies should remain politically impartial during the period of an election campaign and ensure that conduct and procedures during this period do not call this impartiality into question. The period of time from when an election is announced until after the election is held has been known as 'purdah' traditionally, but is now more often referred to as the 'pre-election period'. Typically it is a six- week period.

The period of sensitivity preceding the elections is not fixed to any particular date, but the general convention is that particular care should be taken from the date of the publication of notice of election: which for the forthcoming elections is no later than Monday 30 March 2015. Guidance issued in relation to the 2010 General Election from the Cabinet Office stated that it came into force from the moment the election is officially announced until the day after the election; in the case of the 2015 general/local elections, this would mean the period from Monday 30 March until Friday 8 May 2015.

5. Five Year Forward View (FYFV) into action

NHS England published the implementation plan for the FYFV in December 2014. This provides a number of strategic opportunities for the Trust to consider as well as signposting planning priorities for the 15/16 year.

Recommendation to the Board:

The Board is asked to note this report.

Appendix one

Imperial College press release – 19 December 2015

President Professor Alice P. Gast today announced two senior posts, which will be responsible for taking forward the College's agenda in academic health leadership, and in delivering its emerging Health and Wellbeing strategy.

The post of Vice President (Health) will become the sole focus of Professor Dermot Kelleher, who currently also serves as Dean of the Faculty of Medicine. Professor Kelleher joined Imperial in 2012 as Dean and was additionally appointed Vice President (Health) in 2013. Following the elevation of the Vice President (Health) post to a College-wide role, the College will move swiftly to appoint a new Dean of the Faculty of Medicine.

Professor Kelleher's new remit as Vice President (Health) will include supporting and growing multidisciplinary approaches to health-related research across all of the College's academic disciplines, and developing strong external support and relationships for these efforts, with both international and domestic institutions. He will engage with healthcare partners in generating new strategic opportunities for the College.

To assist him in his responsibilities Professor Kelleher will convene and chair a new cross-College Health Cabinet which shall promote multidisciplinary work in health-related areas including, for example, innovative approaches to public health, cancer, musculoskeletal medicine, and to the use of data sciences in health-related research and healthcare.

He will report directly to the President and will become a member of the Executive Group of the President's Board.

Announcing the new role to the College community, President of Imperial Professor Alice Gast said:

"I am pleased to announce the elevation of the role of Vice President (Health) to a College-wide leadership position intended to position Imperial as the leader in higher education institutions in this area."

"Imperial, through the development of its strategy for Health and Wellbeing, has strongly embraced the requirement for a new approach to health that transcends disciplinary boundaries. As a STEM university with a leadership role in medicine the College is in a unique position to develop in this area.

"The Vice President will spend considerable effort and energy on developing the strategic relationships and partnerships, with both international and domestic institutions, that are essential to our mission. I very much look forward to working with Dermot in his new role."

Vice President (Health), Professor Dermot Kelleher said:

"At Imperial we believe that the major developments in health-related research and in the delivery of healthcare will come from concerted inter-disciplinary work involving a wide range of expertise from multiple and diverse sources.

"Imperial has outstanding strengths in the quality of its faculty right across the science, engineering, medicine and business fields and I look forward to working with Imperial colleagues and collaborators around the world to develop interdisciplinary research that stands to improve the quality of healthcare."

As a result of the refocused role of Vice President (Health), a new Dean of the Faculty of Medicine will be appointed to lead the Faculty's management and academic processes. The Dean shall report to Imperial's Provost, Professor James Stirling CBE FRS, and will join the President's Board, Provost's Board and the College Council. The changes will become effective upon the appointment of the new Dean.

Imperial College Healthcare NHS Trust

Trust Board - Public

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

Executive Summary:

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

Recommendation to the Board:

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

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- 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.

Imperial College Healthcare NHS Trust

Operational Report

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

Introduction: This report relates to activity within M9 (December) 2014/15.

A. Shadow Monitor compliance

Foundation Trust governance risk rating (shadow): Amber

Rationale: The Trust under-delivered on *a number* of the RTT standards, two of the cancer standards and the 4 hour A&E waiting time standard

*RTT standards are subject to further validation before the submission date on 26 January but is it likely that the Trust will under deliver on at least one of the standards

B. Safety

Mortality Rates & Incidents

Mortality Rates:
The Trust's Hospital Standardised Mortality Ratio (HSMR) is statistically low for Q1 2014-15 at 64.37.

There was one mortality alert for August 2014 compared to three alerts in July 2014. The alert was for Cystic Fibrosis. The division has been given the relevant patient information to enable investigation of this alert. The results will be reported to ExCo through the Quality Report.

Serious Incidents (SIs) & Never Events:
In December 17 SIs were reported, meaning the year to date total remains in line with last year. The SI policy is currently being updated to streamline the process. This will be presented at ExCo – Quality for approval in February.

No never events were reported in December.

Deaths in Low risk diagnostic groups
'Low risk diagnostic group' analysis measures performance in diagnosis groups associated with a very low rate of mortality (consistently below 0.5% crude death rate for the group).

Across the last year of data, ICHT has yet to experience a month with more deaths in 'low risk' groups than expected given case mix.

For the most recent month, July 2014, the relative risk was 63.56, which is within expected range. However, for the last year of data, there is a significantly low relative risk for these diagnosis groups of 40.16, with 23 deaths observed against an expected 57.27 given case mix.

Safety Thermometer

The Trust's Safety thermometer rate is 96.98% harm free care, which is above the threshold of 90%.

Sign Up To Safety

In June 2014, the Secretary of State for Health launched a new campaign called 'Sign up to Safety', building on the recommendations of the Berwick Advisory Group, with the aim to make the NHS the safest healthcare system in the world.

To take part, the Trust was asked set out what we will do to strengthen patient safety by publishing our response to five key pledges, which were approved at ExCo in November. Following on from this, organisations are asked to create a safety improvement plan which will show how we intend to save lives and reduce avoidable harm for patients by 50% over the next three years.

The Trust's Sign Up To Safety Improvement Plan was approved by ExCo in January. Following a review of our current safety improvement plans and analysis of our claims and incident data, the following areas of focus have been chosen to feature as the Trust's Sign Up To Safety improvement plan:

- Building a safety culture
- HCAIs
- Pressure Ulcers
- Maternity (CTG traces)
- Promoting Safer Surgery
- Failure to act on abnormal results

As part of the campaign, the NHS Litigation Authority, which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. In order for our Safety Improvement Plan to be considered for a discretionary NHS LA incentive payment, we were asked to complete a template demonstrating how the relevant elements of our plan will reduce claims and outlining how the discretionary payment will be spent. If the bids are successful, the Trust will receive funds to support the improvement plans in time for the new financial year in April 2015.

As Executive Lead for Safety, the Medical Director will have executive responsibility for the Trust's participation in the Sign Up To Safety campaign, which will be led overall by Justin Vale, Associate Medical Director for Safety & Effectiveness. Progress with the action plans will be monitored through the divisional performance reviews and quality boards on a monthly basis, with an update provided quarterly to ExCo in the Quality Report. The Trust's Sign Up To Safety Improvement Plan will be a key element of the Safe domain in our revised Quality Strategy.

Infection Prevention & Control

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

- To date 4 cases of MRSA BSI have been allocated to the Trust (one case in April, two cases in May and one case in November);
- The third case that was reallocated in May is currently being contested by the Trust and CCG; we are still waiting for the final outcome from Public Health England;
- One case of MRSA BSI is currently being investigated. This December case is in a

patient who had an emergency caesarean section and was subsequently transferred to ITU. This case has been provisionally been allocated to the Trust.

***Clostridium difficile* infections:**

- The Department of Health's annual ceiling for the Trust is 65 cases for 2014/15; at the end of December we had reported 60 cases attributed to the Trust;
- The number of Trust attributable cases of C. difficile that arose due to a 'potential lapse in care' whilst at ICHT will be reported to the board from January 2015. The definition of a 'potential lapse in care' is currently being finalised and agreed with the CCG. A sample of Trust attributable C. difficile cases from quarter one has been subject to a collaborative review with the CCG and this methodology will be repeated for cases in Quarter two in January 2015.

Meticillin sensitive *Staphylococcus aureus* bloodstream infections (MSSA BSI):

- The cumulative figure for this financial year (end of December 2014) is 22 Trust attributable cases compared to 30 this time last year (FY 2013/14);
- The IP&C team undertake reviews of all Trust attributable cases of MSSA BSIs, findings and subsequent learning are discussed with divisional and clinical teams and any device related BSIs are reviewed at the line safety committee.

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

- The cumulative figure since the beginning of April 2014 to the end of December 2014 is 56 Trust attributable cases compared to 59 this time last year (FY 2013/14).

Carbapenemase Producing Organisms:

- The total for 2014/15 until the end of December 2014 is 26;
- In line with the guidance issued by PHE and NHS England, an action plan is in place to ensure that the tool kit is embedded into practice.

Fungal Infection Surveillance:

- We continue to collect Candida blood stream infection surveillance data, the rolling total for 2014/15 until the end of December is 15.

Ebola preparedness

- Significant resource has been required to support the Trust in ensuring all sites are fully prepared, IP&C are working with the emergency planning team.
- Training on the use of PPE is being delivered to all hospital sites.
- A simualtion exercise will take place on the Charing Cross site in the next two weeks.

Group B streptococcal infection

- During November, two babies on the neonatal unit were identified with late onset group B streptococcal infections.

The investigation is still underway. A full report will be available next month.

Dementia

A summary of the outcome of the audit of carers of patients with dementia is included in appendix 2. This is a requirement for the national CQUIN.

C. Patient Centeredness

Friends and Family Test
FFT response rates continue to be above the CQUIN threshold. Concerns about St Mary's A&E response volumes appear to have been resolved. FFT scores remain consistent and acceptable. During December, demonstrations were given by providers tendering for the provision of future FFT collection and real-time feedback as the current contract ends in March 2015. A decision on awarding the contract will be made in January 2015.

Complaints & PALS
The overall volume of formal and PALS complaints fell slightly in December, although there was a slight increase in formal complaints. Both PALS and complaints have seen an increase in the volume of complaints related to the cancellation of elective admissions related to the pressures on the emergency pathway.

The divisions continue to work hard to clear a backlog of complaints to improve the response rate within the timeframe; at 69 per cent this is the highest it has been for 6 months.

D. Effectiveness

National Clinical Audit
A Corporate Clinical Audit plan is being developed and will be presented at the Executive Committee for Quality and Safety.

Results of the available National Clinical Audits that have been reviewed at the Divisional Quality and Safety Committees will be included in next month's Quality report.

E. Efficiency

Performance against some of the key efficiency measures is reported in the Integrated Performance Scorecard. Both elective and non-elective length of stay has remained higher in quarter three than in previous quarters within 2014/15 and above threshold. Elective length of stay was 3.79 days in December against a threshold of less than 3.5 days but had reduced by nearly two days from the data reported in November. Non-elective stay was 4.91 days in December against a threshold of less than 4.5 days.

Theatre utilisation rates have deteriorated by 4 per cent since November. A review is taking place as to the best way to monitor theatre utilisation to ensure that the data published can drive improvement in productivity.

Since the implementation of Cerner, the Trust had to turn off its text messaging reminder service for patients as there were technical reasons which needed to be resolved. The service was partially switched on at the end of September and the did not attend (DNA) rate is now comparable with rates prior to the implementation of Cerner.

F. Timeliness

Accident and Emergency

In December, performance remained challenged against the standard for 95 per cent of Emergency Department patients to be seen within four hours. This is consistent with performance challenges with other Trusts in London and across the country.

The Trust has further increased capacity in a number of key areas to improve flow across the hospital. In-patient bed capacity has been opened at St Mary's Hospital and Charing Cross Hospital in January.

Actions for the resilience plan are reviewed weekly at the Trust winter operational group, the A&E meeting and at Executive Committee as well as through daily and weekly performance review meetings with local commissioners.

Referral to treatment (RTT)

Data for December RTT performance has an agreed submission date of 26 January. The Trust has been working towards the delivery of the performance measures through additional activity and validation of data.

It is anticipated that the Trust will return to achieving the admitted standard. This was following a period of national investment in RTT capacity to treat patients who had been waiting over 18 weeks and in validation resource.

A significant amount of work to improve data quality, by resolving technical issues with Cerner reporting, has taken place throughout December and the early part of January, as well as improving the workflow on Cerner so that it is more difficult to input correct data. Due to the above, there remains a risk in relation to the non-admitted and incomplete performance at this stage.

A team of validators are continuing to support the Trust with correction of data.

Cancer

In January, performance is reported for the cancer waiting times standards in November. In November the Trust achieved six of the eight cancer standards.

The Trust failed to meet the 62-day screening standard. This was the result of a number of treatments being delayed in other organisations after patients had been repatriated to them from the breast screening service hosted at Charing Cross hospital. However, performance will remain challenged in December as a result of the low breach threshold for this standard.

The Trust also failed to meet the 62-day GP referral to treatment standard. This was a result of sustained high numbers of late transfers to Imperial from other trusts. We are continuing to work with other NWL providers to address these delays and we are receiving support from the CWHHE performance group to deliver this. Internally, we are undertaking pathway review work in urology and UGI and we will be extending this work to colorectal and gynaecology in Quarter 4 to further reduce any internal pathway delays. The Trust expects to meet the 62-day GP referral to treatment standard in December.

Diagnostic waiting times

The Trust did not meet the six week wait for diagnostic test standard in December. This

was as a result of a number of issues:

- There were some neurophysiology patients remaining to be seen as a result of the Cerner related issue that was reported in October
- There was issue with our Radiology Information System resulting in a number of referrals to imaging not being appropriately tracked.
- There were a higher number of cystoscopy breaches than we would normally expect.
- An issue has been identified that has affected Echocardiography tests where there has been a difficultly in scheduling patients within the Cerner system. There were a small number of breaches in December but it is expected that there will be additional breaches in January while the service clears a backlog of work.

A recovery plan is in place to ensure that these patients who have waited over six weeks, have their tests in January

G. Equity

No update to report.

H. People

People & Organisational Development

Challenge 2015 / ichallenge

The over-indulgence during the Christmas period leads many of us to start the New Year with our heads full of resolutions aimed at undoing some of potential damage we've done to our bodies over Christmas. How are we going to shift those extra pounds? How can we reduce our alcohol intake? Or perhaps you've been smoking more than you'd like, and you're worried about what it's doing to your health and to the health of those around you. Well, the HWB team is on a mission to help our people achieve their resolutions, which is why we are launching **Challenge 2015/ichallenge.**

It is our aim to attract at least 2,015 people to come forward to make a pledge to do something to improve their wellbeing. We will use this as a platform to promote all of the new initiatives that are already in place and being offered by HWB, or indeed that are underway and evolving at pace. Challenge 2015 will culminate in a large scale summer event, so essentially something for people to work towards. Our promotional tag is ichallenge ; i – as in the individual, i – Imperial and i challenge (you to get involved too).

We will generate competition and camaraderie amongst colleagues and teams. We are working in collaboration with the Comms team on this project and have significant plans for the event which will evolve over the coming months which may also include collaboration with the Trust's Charity too.

Flu vaccination
At the end of December we had achieved 4,371 doses administered against 6,000 doses ordered. This is up 500 on last year's total. The DH frontline target is set at 75 per cent of which we have achieved 3685 doses, which is 45 per cent. There now appears to be little or no interest and we are consciously aware that unless an outbreak of flu occurs we are unlikely to see much more by way of uptake.

PDR
We are continuing the roll out of our new Performance Development and Review process across the Trust. Since April, over 1,500 of our managers people have received PDR training and their licence to conduct performance reviews. Training will continue throughout 2015 for new managers.

We have now achieved over 95 per cent completion for Bands 7 to 9 and the deadline for completing all other PDRs (Band 2-6) was 31st December 2014. The final percentage will be known on Monday January 12th. We will shortly be commencing an evaluation of the training and the impact that it has had at local level with our managers, through focus groups, interviews and surveys in order that we can continue to offer the appropriate support to them during 2015**.**

A calibration of the PDR Ratings has also taken place for bands 8c-9 and Bands 7-9 to review consistency and the results of this are being fed back to Divisions and Directorates. There has been an increase in the number of formal performance management cases opened as a result of the PDR exercise and these cases are being managed through our Employee Relations Team (ERAS).

'My Benefits': expanding voluntary benefits through salary sacrifice
As part of our engagement strategy, we are expanding the range of tax-efficient methods of remuneration that we offer to our people. 81 of our people have bought bikes through our cycle to work scheme since 1 April 2014. On 24 November 2014, we launched our home electronics salary sacrifice scheme which enables people to buy anything on the Currys PC World list: we have already approved 128 transactions. From 2 February 2015 our people will be able to choose from a range of fully maintained and insured cars over a lease period of 36 months.

In the future we may use salary sacrifice schemes for car parking fees and learning loans. Our people can access the full range of benefits offered by the Trust through our new *my benefits* intranet pages. All information we provide about our salary sacrifice schemes includes appropriate warnings about the impact on pension entitlement.

The Cultural Leadership Organisation index
The Cultural Leadership Organisation index (CLOi) will be launched at the end of January to Chiefs of Service and General Managers. CLOi is a new and innovative way of looking at a range of indices on culture and leadership using a combination of patient experience, staff engagement and people management key performance and activity indicators. Jayne and Penny will share at ExCo on January 27th.

Industrial action
UNITE, UNISON, the Royal College of Midwives (RCM) and the Society of Radiographers (SoR) called a series of four hour strikes in October in November 2014 with minimal impact

on our ability to deliver normal services. The national leadership of these unions have decided to escalate their campaign against government public sector pay policy. On Thursday 29 January, Unison and Unite will strike for 12 hours from 9am and the SoR will strike for 6 hours from 8 am. The RCM on the other hand have announced a two hour stoppage starting at 1pm subject to cover for safety. Unison and Unite have also announced a 24 hour strike on Wednesday 25 February.

Vocational Training
We have been successful in bidding to HENWL for a post to support a review of our current Apprentice programme. The national apprentice funding is subject to constant change and it is timely to review our current apprentice scheme, including the types of NVQ we offer, the departments who take apprentices and the terms of employment for the apprentices themselves so that we can continue to offer high class placements and to maximise the benefits of apprentices as a source of talent for future roles. The post will be recruited to in early 2015.

Mandatory Training

Intense work is underway in Mandatory training to roll out the new reporting system, WIRED 2 in February. This has been developed by the National Skills for Health Academy. It offers improved functionality to report Mandatory training. We will be fully live with reporting during March.

Health and Safety

Health and Safety Committees
The inaugural Strategic Health and Safety Committee (SHSC) took place on 18 December 2014 and included senior representatives from each of the divisions and corporate functions. Terms of reference have been discussed along with a revised health and safety governance structure. Sub committees will also be setup in the new year to discuss health and safety issues at a divisional and functional level; understand and priorities key health and safety risks; and establish divisional action plans in order to drive health and safety forward.

Health and Safety Team
The recruitment campaign for three new health and safety managers to support the head of health and safety has started. The new team will be a focused on delivering a proactive health and safety service on a strategic and operational level and working with senior and line managers to deliver health and safety projects, practical solutions in addition to responding to accidents, incidents and complaints and developing a positive health and safety culture within the trust.

Health and Safety Training
Current health and safety training compliance for the trust is 79 per cent against a target of 95 per cent.
Sanjay is in discussion with the Talent team to review the health and safety training needs for the trust to ensure employees are competent, understand their health and safety responsibilities and ICHT's health and safety tools and management system.
Health and safety training in the new year will include:

- Senior Managers
- Department Safety Coordinators (DSCs)

- Stat-Mand training, including the e-learning module
- Health and safety element within the corporate induction
- Practical health and safety training e.g. fire warden, first aider, lifting and handling and hazardous substances.
- First aid and fire safety training

Policies and Procedures

There is a project underway to update and simplify ICHT's health and safety procedures in order to provide better information for managers. The documents will also be structured in such a way that they are logical, systematic and easy to implement.

Discussions are also taking place with Comms regarding the health and safety intranet site and increasing Trust/employee engagement in health and safety.

Key health and safety actions for 2015

- Develop and implement ICHT health and safety action plan
- Set up Divisional/Corporate Functions health and safety committees
- Set up Joint Trade Union health and safety committee
- Establish health and safety risk profiling for ICHT divisions and functions
- Update health and safety policies, procedures, guidance and documentation, including ICHT health and safety intranet site
- Update and refresh health and safety training for employees at all levels
- Review Datix health and safety reporting systems and improve where necessary
- Provide suitable and sufficient health and safety management information for relevant Boards and Committees
- Review fire warden and first aid arrangements across the trust (in conjunction with Estates). Increase provisions where necessary
- Complete audits for divisions, directorates, sites and service areas.
- Share data, information and best practice across the Trust
- Strengthen ICHT's health and safety culture.

Safe Nurse/Midwife Staffing

Performance in December

In December, the Trust reported the following:

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

Please refer to Appendix 1 for ward level detail. Areas where the fill rate was below 90 per cent for registered staff and below 85 per cent for care staff are highlighted in red. For these areas, there is an accompanying narrative included.

The month of December was particularly difficult for nursing and midwifery staffing and this month showed the lowest fill rate since the reporting of this data began in May 2014 - particularly for care staff.

Key reasons for this are:

- Increased vacancy rate for band 2-6 staff
- An increase in the acuity of patients which has resulted in additional staff to support not only general acuity but also those patients who require specialling, particularly to manage falls and confused patients.
- Opening additional beds and increasing capacity and therefore requiring additional staff to support this.
- Reliance on bank and agency staff and a substantial increase in the number of requests. This has impacted on the fill rate adversely where such shifts have not been filled.
- Small numbers of unfilled shifts in some areas which has shown a bigger impact on the overall fill rate for that area.

Key actions undertaken include:

- Reviewing staffing on a daily basis
- Ward managers and sisters working clinically but are therefore not always able to supervise care.
- Redeploying staff from other areas, where possible.

Divisional Directors of Nursing have confirmed that the levels of care provided during December were safe, effective and caring.

I. Finance

Contained within the Finance report.

J. Education

The first education report will be submitted to ExCo – Quality in February. Performance will be managed through the divisional structures with assurance on progress through the Medical Director. This will include delivery of action plans resulting from GMC trainee surveys and quality visits.

K. Research

Local Clinical Research Network

Hyper-acute Stroke Research Centre
Imperial has been designated as a Hyper-acute Stroke Research Centre for the first time, one of only 8 such centres in the UK. Professor Roland Veltkamp, Research Delivery Manager Reuben Lewis and the team are to be congratulated for their efforts in putting together the successful application.

LPMS
The procurement of EDGE as a Local Portfolio Management System has been approved by ExCo on 13th January 2015. We are waiting for procurement letters to go out to the suppliers on Friday 16th January and a ten day standstill period will follow as part of procurement rules.

Performance Report

The following are the highlights from December's CRN: North West London performance report:

- North West London has recruited 20,432 patients according to figures available in the Open Data Platform as of January 12th 2015 (83 per cent of target). The overall recruitment puts NW London in the 12th position among the 15 LCRNs. When adjusted for population, however, NW London is in the 2nd position.
- All but one Trust in North West London have recruited to CRN Portfolio research this year.
- Brompton, CNWL and Hillingdon are three Trusts that are aiming to increase their recruitment compared to last year and are on track to do so. The highest recruiting organisation is Imperial, at 98 per cent of its year-to-date target.
- Renal, Anaesthesia, Gastroenterology, Ophthalmology, Respiratory and Surgery are the specialties that are aiming to recruit more than last year and are ahead of their year-to-date target. Infectious diseases are the highest recruiting specialty.
- North West London is almost on track (97 per cent) to recruit to 150 commercial studies by the end of the financial year.
- 72 per cent of study-wide CSP reviews are completed within 15 calendar days (50 per cent by Trust R&D staff and 86 per cent by CRN core staff).
- The greatest challenges remain recruiting to time and target, speedy recruitment of the first patient and achieving the dementias and neurodegenerative study recruitment target.

NIHR Imperial Biomedical Research Centre (BRC)

KPI Scorecard Metrics

There are 9 R&D indicators on the scorecard which relate to ICHT performance in terms of clinical research study numbers, patient recruitment, and set-up times. 6 out of 9 indicators are green, showing that ICHT is hitting its targets for;

- the mean and median times taken to recruit the first patient to interventional clinical trials;
- the percentage of closed commercially-sponsored clinical trials which have delivered to time and target;
- growth in the total number of NIHR Portfolio studies carried out at ICHT, and numbers of patients recruited to those studies;
- growth in the number of commercially-sponsored NIHR Portfolio studies carried out at ICHT.

Two indicators are amber, which shows that there is still some progress to be made a) in the proportion of interventional clinical trials which take less than 70 days to recruit their first patient (the key BRC contract metric), and b) in the proportion of local CSP reviews completed within 15 calendar days (NW London CRN High Level Objective 4). However, the general trend is still upward and improving for these two indicators over the year, and there is a well-understood 'lag' in the statistical reports. We expect both these indicators to have improved by Q4.

The single red indicator relates to the number of patients recruited to NIHR Portfolio

commercial studies, which is significantly down on the same period last year. The reasons for this are not yet clear, given that the actual number of commercial studies recruiting at ICHT is higher than last year. We will review this closely on a month-by-month basis and carry out further analysis as to the reasons behind it.

2014 Research Excellence Framework (REF)
December 2014 saw the release of the results of the most recent Research Excellence Framework (REF) – the periodic exercise to assess the quality of research in UK universities. REF results are also linked closely to core research funding provided by the Higher Education Funding Council for England (HEFCE).

In the College's best ever performance in a research assessment exercise, Imperial was judged to have improved in every Unit of Assessment (submitting more than 1,200 whole-time research staff). In particular, the REF's new *impact* measure ranks Imperial's research the highest of any major university. Moreover, eight of Imperial's 14 REF-assessed research areas are top or joint-top for "outstanding" or "very considerable" impact. Overall, Imperial comes fourth out of major UK universities for 4* or "world-leading" research, behind the London School of Economics, Oxford and Cambridge, and just ahead of UCL.

91 per cent of Imperial research is classed as "world-leading" (46 per cent achieved the highest possible 4* score) or "internationally excellent" (44 per cent achieved 3*) – the highest proportion of any major university. Imperial was ranked top or joint-top for providing an environment conducive to producing "world-leading" or "internationally excellent" research in all of the Units of Assessment to which it made submissions;

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

Imperial College Healthcare NHS Trust

Trust Board – Public

Agenda Item	2.3
Title	Integrated Performance Scorecard
Report for	Monitoring
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer

Executive Summary:

This is a regular report to the Trust 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 to the Board:

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

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- 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.

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 Trust Board should be sighted on.

This month the Integrated Performance Scorecard includes additional efficiency measures. The safe staffing figures are also presented as appendices to this report.

Regulatory reforms

There are new regulatory reforms for the Board to note.

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

The Board will recall the fact that the scorecard in its current form was introduced 12 months ago, following benchmarking with other organisations in relation to best practice and consultation with Board members.

It was intended that the content and format would be reviewed annually.

An initial review has commenced, particularly focussing on the core key performance indicators that support the Board's required level of scrutiny, and also the format that this should be delivered through with a particular consideration to the further development of the Trust quality strategy.

It is envisaged that the integrated performance scorecard will be revised between now and April following input from Trust Board colleagues etc over this next period.

Recommendation to the Board:

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

Appendix 1

December

Monthly planned nursing/midwifery staffing hours versus nursing/midwifery hours actually worked

			Day						Night						
			Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff			
Division	Hospital Site Name	Ward Name	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Exception Narrative
Medicine	Charing Cross Hospital - RYJ02	10 North Ward	1746.416667	1534.42	87.86%	632.5	552	87.27%	954.5	954.5	100.00%	517.5	483	93.33%	Equates to 13 LDs and 5 short days. Hours not filled = 187 hours and % is 89.3%. PIU unfiled 53 hours - ward and PIU do cross cover from MS suite and visa versa.
Medicine	Charing Cross Hospital - RYJ02	11 South Ward	2715.5	2582.5	95.10%	483	437	90.48%	2300	2209.5	96.07%	517.5	517.5	100.00%	
Medicine	Charing Cross Hospital - RYJ02	4 South Ward	1726.5	1580.5	91.54%	920	816.5	88.75%	1127	1081	95.92%	897	851	94.87%	
Medicine	Charing Cross Hospital - RYJ02	5 South Ward	1861	1861	100.00%	0	0	100.00%	1747.33	1747.33	100.00%	11.5	11.5	100.00%	
Medicine	Charing Cross Hospital - RYJ02	5 West Ward	2463	2321.5	94.25%	897	759	84.62%	2185	2070	94.74%	791.5	745.5	94.19%	Equates to 11 shifts which is 126 hours all for special acuity and calculates to 85.9%
Medicine	Charing Cross Hospital - RYJ02	8 South Ward	2016.5	1835.83	91.04%	1426	1211.5	84.96%	1184.5	1058	89.32%	1115.5	1058	94.85%	Care staff during the day 18 shifts mainly for specials which equates to 207 hours and a percentage of 85.5%. RN nights equates to 10 shifts =115 hours with a percentage of 90.29%
Medicine	Charing Cross Hospital - RYJ02	8 West Ward	1548.5	1514	97.77%	1368	1274	93.13%	1115.5	1092.5	97.94%	1012	977.5	96.59%	
Medicine	Charing Cross Hospital - RYJ02	9 North Ward	2918.5	2510.5	86.02%	1173	887.5	75.66%	2070	2001	96.67%	575	540.5	94.00%	DDN manual adjustment added in 63 hours as CNS and Senior nurse worked in the numbers when short .
Medicine	Charing Cross Hospital - RYJ02	9 South Ward	1944	1757.5	90.41%	820.5	613.5	74.77%	1069.5	989	92.47%	977.5	920	94.12%	This is accurate and equates to 18.5 shifts = 207 hours not covered for care staff during the day. This was cover for both sickness and specials.
Medicine	Charing Cross Hospital - RYJ02	9 West Ward	1403	1322.5	94.26%	747.5	711	95.12%	713	701.5	98.39%	897	862.5	96.15%	
Medicine	St Mary's Hospital (HQ) - RYJ01	Almroth Wright Ward	2061.5	1923	93.28%	1070.5	897	83.79%	1575.5	1518	96.35%	736	713	96.88%	Not sure which data set this is looking at as AWR and RPW are now combined. Across both areas there were 15 shifts = 173.5 hours not covered but for AWR 7 HCA shifts = 80.5 hours not covered. Staff is shared across both AWR and RPW
Medicine	St Mary's Hospital (HQ) - RYJ01	AMU	1476	1235.5	83.71%	603.5	409.5	67.85%	1207.5	1121.5	92.88%	425.5	368	86.49%	Increased activity so extra shifts added mostly earlys which were not filled. RN day 105 hours not filled were for escalation/ extra activity early shifts. 103.5 hours for sickness and 38.5 hours for specials. Care staff day 129 hours added for escalation / increased activity and 42 hours for specials.
Medicine	Hammersmith Hospital - RYJ03	C8 Ward	1910	1793.5	93.90%	724.5	605	83.51%	1794	1633	91.03%	690	586.5	85.00%	DDN manual adjustment 101.5 hours added into actual RN hours worked as Senior nurse and Ward Manager worked in December.
Medicine	Hammersmith Hospital - RYJ03	Christopher Booth Ward	2129	1883.5	88.47%	762.5	648	84.98%	1092.5	1092.5	100.00%	414	368	88.89%	DDN manual adjustmen 82.5 hours added in actual RN hours worked as Ward manager worked.
Medicine	St Mary's Hospital (HQ) - RYJ01	Douglas Ward SR	2145.5	1959	91.31%	0	0	100.00%	1966.5	1863	94.74%	23	23	100.00%	
Medicine	Hammersmith Hospital - RYJ03	Dewardener Ward	1492.5	1470	98.49%	0	0	100.00%	1426	1426	100.00%	0	0	100.00%	
Medicine	Hammersmith Hospital - RYJ03	Fraser Gamble Ward	1533.5	1382	90.12%	1146	954.5	83.29%	1081	1035	95.74%	1123.833333	1020.33	90.79%	HCA = 201.5 hours not filled 144.35 hours for Specials
Medicine	St Mary's Hospital (HQ) - RYJ01	Grafton Ward	1160.5	1160.5	100.00%	1067.5	926.5	86.79%	1058	1058	100.00%	713	690	96.77%	
Medicine	Hammersmith Hospital - RYJ03	Handfield Jones Ward	1420.25	1296	91.25%	743	708.5	95.36%	1058	989	93.48%	379.5	356.5	93.94%	
Medicine	Hammersmith Hospital - RYJ03	John Humphrey Ward	1478	1455	98.44%	716.5	674	94.07%	770.5	759	98.51%	862	850	98.61%	
Medicine	St Mary's Hospital (HQ) - RYJ01	Joseph Toynbee Ward	1503	1382	91.95%	551	322	58.44%	1311	1230.5	93.86%	563.5	517.5	91.84%	229 hours not filled. 183 hours specials, 34.5 hours sickness and 11.5 hours patient transfer
Medicine	Hammersmith Hospital - RYJ03	Kerr Ward	1486	1421.5	95.66%	1036.5	764.5	73.76%	1058	1023.5	96.74%	644	643.17	99.87%	DDN manual adjustment added in 59.5 hours as there an overlap with early and late requests of which 3.5 hours which are not required.
Medicine	Charing Cross Hospital - RYJ02	Lady Skinner Ward	1083	1056.5	97.55%	392	392	100.00%	701.5	701.5	100.00%	793.5	793.5	100.00%	
Medicine	St Mary's Hospital (HQ) - RYJ01	Manvers Ward	1422	1353	95.15%	713	655.5	91.94%	1414.5	1345.5	95.12%	713	712.5	99.93%	
Medicine	Hammersmith Hospital - RYJ03	Peters Ward	1360	1249.25	91.86%	890.5	770.5	86.52%	816.5	782	95.77%	529	494.5	93.48%	DDN manual adjustmen added in 98.5 hours into actual hours worked for senior nurse hours who rked in the numbers.
Medicine	St Mary's Hospital (HQ) - RYJ01	Lewis Lloyd	1219.5	1185	97.17%	1029.5	828	80.43%	713	713	100.00%	1081	1046.5	96.81%	201.5 hours HCA not filled , 144.5 hours for specials
Medicine	St Mary's Hospital (HQ) - RYJ01	Samuel Lane Ward	1637	1516.5	92.64%	771	663	85.99%	1138.5	1127	98.99%	770.5	736	95.52%	
Medicine	St Mary's Hospital (HQ) - RYJ01	Thistlewaite Ward	1550.5	1457	93.97%	906.5	837.5	92.39%	1083	1012.5	93.49%	644	619.5	96.20%	
Medicine	St Mary's Hospital (HQ) - RYJ01	Witherow Ward	1230	1201.5	97.68%	961.5	789	82.06%	736	727.5	98.85%	1042.666667	1007.67	96.64%	168 hours HCA not filled 121 of which were for specials
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	10 South Ward	2216.5	2031.83	91.70%	735.5	669.99	91.09%	1426	1370.42	96.10%	34.5	23	66.67%	DDN manual adjustment to reflect low activity- care staff reflects one unfilled special
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	6 North Ward	2330.5	2001.5	85.88%	921	655.5	71.17%	1150	1138.5	99.00%	575	517.5	90.00%	DDN manual adjustmento reflect senior Nurse who worked.
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	6 South Ward	1416.5	1296.75	91.48%	696	578	83.05%	989	955.33	96.60%	115	80.5	70.00%	DDN manual adjustmen of 2 shifts to reflect activity
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	7 North Ward	2099	2027	96.57%	759	620	81.69%	1427	1404	98.39%	828.75	782.75	94.45%	12 shifts
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	7 South Ward	2054	1857	90.43%	776	697	89.82%	1069.5	1000.5	93.55%	391	345	88.24%	DDN manual adjustment to reflect closed beds
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A6 CICU	3471.8	3471.8	100.00%	0	0	100.00%	3157.5	3152.25	99.83%	0	0	100.00%	
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A7 Ward & CCU	2175	2167.5	99.66%	390	322	82.56%	1794	1771	98.72%	379.5	368	96.97%	6 shifts
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A8 Ward	1644.5	1536.5	93.43%	833.75	794	95.23%	1204.5	1112.5	92.36%	264.5	195.5	73.91%	DDN manual adjustmen- 7 beds closed over Xmas- Care is 6 shifts
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A9 Ward	1434.5	1430.5	99.72%	414	333.5	80.56%	1092.5	1081	98.95%	402.5	391	97.14%	7 shifts
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Albert Ward	1941	1651	85.06%	885.5	717	80.97%	1115.5	1023.5	91.75%	931.5	862.5	92.59%	Care not compromised
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Charles Pannett Ward	2454.5	2317	94.40%	701.5	626.5	89.31%	1863	1817	97.53%	759	747.5	98.48%	
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	D7 Ward	1345.5	1333.5	99.11%	348	336	96.55%	693	693	100.00%	319	319	100.00%	
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Dacie Ward	1822	1688.5	92.67%	174	163.5	93.97%	1004	971	96.71%	165	165	100.00%	
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	Intensive Care CXH	4912	4546.25	92.55%	940	940	100.00%	4830	4636.5	95.99%	621	621	100.00%	
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Intensive care HH	4917.25	4686	95.30%	789.5	778	98.54%	4945	4762.25	96.30%	241.5	241.5	100.00%	

Appendix 1

December

Monthly planned nursing/midwifery staffing hours versus nursing/midwifery hours actually worked

			Day						Night						
			Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff			
Division	Hospital Site Name	Ward Name	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Exception Narrative
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Intensive Care SMH	5226.55	5226.55	100.00%	851	851	100.00%	5185.5	5142	99.16%	747.5	747.5	100.00%	
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Major Trauma Ward	1885.5	1722.5	91.36%	415	327	78.80%	1518	1460.5	96.21%	621	483	77.78%	care day 7 shifts, night 12 shifts
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Patterson Ward	1259.5	1137	90.27%	611.5	506	82.75%	747.5	724.5	96.92%	356.5	333.5	93.55%	extra shifts for acuity- 9 shifts, actual rostered numbers correct
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	Riverside	2818	2544	90.28%	1231.5	1040	84.45%	1449	1276.5	88.10%	644	575	89.29%	DDN manual adjustment adjustment to reflect activity
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Valentine Ellis Ward	2009.5	1814	90.27%	848.5	699	82.38%	1528.5	1449	94.80%	644	563.5	87.50%	Shifts on MAPS to cover extra bed- unopened
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Weston Ward	1618	1476.25	91.24%	306	276	90.20%	1001	968	96.70%	11	11	100.00%	
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Zachary Cope Ward	2472.5	2258	91.32%	701.5	648	92.37%	2139	2047	95.70%	758	723.5	95.45%	
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Aleck Bourne 2 Ward	4470.5	4269.65	95.51%	1234.75	1119	90.63%	3944.5	3839.48	97.34%	1368.5	1195.25	87.34%	
Women and Children's	Queen Charlotte's Hospital - RYJ04	Birth Centre QCCH	1032	1032	100.00%	149.5	149.5	100.00%	701.5	701.5	100.00%	299	299	100.00%	
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Birth Centre SMH	1045.5	1031	98.61%	57.5	57.5	100.00%	816.5	805	98.59%	253	230	90.91%	
Women and Children's	Queen Charlotte's Hospital - RYJ04	Edith Dare Postnatal Ward	2266	2191	96.69%	1089	1074	98.62%	1781.27	1751.25	98.31%	713	690	96.77%	
Women and Children's	St Mary's Hospital (HQ) - RYJ01	GRAND UNION WARD	2349	2235	95.15%	0	0	100.00%	2139	2081.5	97.31%	0	0	100.00%	
Women and Children's	St Mary's Hospital (HQ) - RYJ01	GREAT WESTERN WD	2545	2468.5	96.99%	402.5	379.5	94.29%	2277	2185	95.96%	414	402.5	97.22%	
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Lillian Holland Ward	1181	1187	92.00%	523	522.17	99.84%	715.5	715.5	100.00%	368	356.5	96.88%	DDN manual adjustmen as educator and managers worked clinically.
Women and Children's	Queen Charlotte's Hospital - RYJ04	Neo Natal	4076.79	4069.29	99.82%	254	231	90.94%	3864	3864	100.00%	23	23	100.00%	
Women and Children's	St Mary's Hospital (HQ) - RYJ01	NICU	2093	1994.5	95.29%	322	310.5	96.43%	2058.5	2058.5	100.00%	264.5	216.25	81.76%	Neonatal costs and staff flexed to ensure esafe staffing
Women and Children's	St Mary's Hospital (HQ) - RYJ01	PICU	3749	3263.5	87.05%	0	0	100.00%	3760.5	3314	88.13%	0	0	100.00%	Poor fill rates/educators/nurse in charge mobilised to the floor
Women and Children's	Queen Charlotte's Hospital - RYJ04	QCCH labour	4143.5	4120.25	99.44%	852.75	775	90.88%	3955	3691.5	93.34%	713	701.5	98.39%	
Women and Children's	Hammersmith Hospital - RYJ03	Victor Bonney Ward	1947	1837	94.00%	506	347	68.58%	1000	943	94.30%	322	299	92.86%	DDN manual adjustment as educator and managers worked clinically. Re: HCA fill rate, day surgery staff were moved and covered.

Day						Night					
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)
51857.17	48232.33	93.42%	23288.50	19776.99	86.57%	37893.83	36432.75	96.44%	19494.50	18536.17	94.41%
56810.1	53490.75	93.76%	14977.5	13176.5	88.91%	44549	43126.81	96.55%	11442.75	10568	92.73%
25395.79	24397.04	95.50%	4006.75	3696.67	93.96%	22367.27	21409.25	96.59%	3070.5	2918.75	95.48%
134063.0567	**126120.12**	94.23%	**42272.75**	**36650.16**	89.81%	**104810.1**	**100968.81**	96.53%	**34007.75**	**32022.92**	94.21%

Dementia Care and CQUIN at Imperial – Supporting Carers of Patients with Dementia

The Dementia Care Team has been in place in the Trust since December 2012, primarily to ensure Imperial College Healthcare NHS Trust (ICHT) meets the requirements dementia CQUIN (Commissioning for Quality and Innovation) but also to improve dementia care across the Trust.

Imperial College Healthcare NHS Trust has signed up to the Dementia Action Alliance to signify its strong commitment to improving the lives of people with dementia. To support this aim and meet the requirements of one of this year's CQUIN indicators, the Dementia Care Team has implemented a strengthened dementia training programme across the Trust.

Supporting Carers of People with Dementia

There are four national CQUIN goals for 2014/15. The national Dementia CQUIN goal consists of 3 indicators, the details and requirements of these indicators are as follows:

1. *Find, Assess, Investigate and Refer* (FAIR): this indicator is a composite of dementia screening, risk assessment and onward referral for specialist diagnosis for patients aged 75 years and over admitted as an emergency (all elements have a 90% target)
2. *Clinical Leadership*: Providers must confirm a named lead clinician and a planned training programme for dementia to be delivered in-year.
3. **Supporting Carers of People with Dementia**: This indicator requires the completion of a monthly audit of carers to test whether they feel supported. The content of the audit is to be agreed with local commissioners. Findings from these audits are to be reported to the Board two times in the year.

To meet the requirements of the third indicator, the Dementia Care Team, with input from stakeholders both internal and external to the Trust, has devised an audit questionnaire to be given to carers of patients with dementia at least 24-48 hours prior to discharge.

Audit of Carers of Patients with Dementia

The audit is currently being piloted on five wards (one admission ward, three care of the elderly wards and one rehabilitation ward) and is to be rolled out to other wards once established.

The questionnaire consists of five questions and can be completed either alone, face-to-face, or over the phone. The questions focus, as required, on whether the carer felt supported during the stay in hospital of the patient for whom they are caring, and whether they received sufficient information regarding patient diagnosis, physical health and discharge care planning. There is also a 'free text' box at the end of the questionnaire where carers can provide additional comments.

The audit responses and findings will be collated monthly and reported to the board biannually. A total of fifty two responses have been collected so far. A copy of the questionnaire is attached at the end of this report.

Initial findings

The monthly breakdown of responses is presented in the table below. 58% of surveys were completed by telephone, 30% were completed face-to-face and for the remaining 12% the carer completed the questionnaire alone.

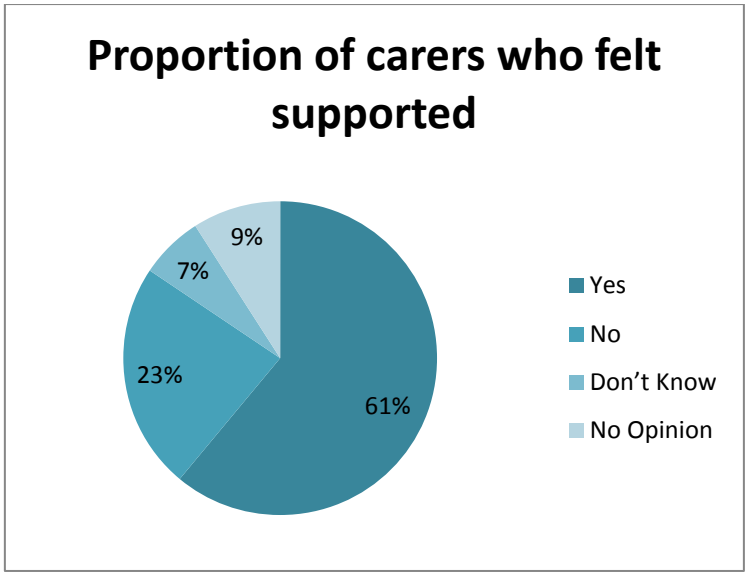
Year	Month	Total Responses
2013	October	9
	November	3
	December	11
2014	January	9
	February	6
	March	9
	April	12
	May	3
	June	0
	July	6
	August	5
	September	2
	October	1
	November	1
Grand Total		**77**

The key question in relation to the CQUIN indicator is question 2: *During the patient's admission in hospital, do you feel that you have been supported in relation to their existing diagnosis of dementia?* 61% of recipients said that yes, they felt supported. The responses to this question are presented in the graph below.

Of the 77 respondents, 47 reported that health professionals (HCP) spoke to them about the patient's diagnosis of dementia (*question 3*). Of those 47 respondents, 37 stated that they had received sufficient information.

51% of respondents stated they had received enough information in relation to how patients' physical health impacts on their dementia (*question 4*).

In terms of discharge planning and onward care, 60% (or 46 out of 77) of carers surveyed stated they were involved in this process and provided with information about services (*question 5*).



Of those carers who felt supported, 74% (or 35 out of 47 respondents) stated they had been spoken to by a health professional in relation to the patient's dementia, whereas of the 18 respondents who stated they did not feel supported, 5(or 28%) had been spoken to by a health professional.

In addition to the five core questions in the audit questionnaire, respondents are also given the opportunity to provide additional comments. A selection of these comments is presented below.

"This is a very difficult time. It's hard to know what to think with all the decisions that need to be made"

"Excellent care at hospital. I'm learning from the Nurses/Healthcare staff how to manage agitation in my relative with dementia by observing them"

"Staff are very patient and try to keep her [the patient] calm"

"I found the nurses to be helpful, they showed empathy on Witherow ward"

"Really good with him. Brilliant. They understand what he's got. He likes the staff and gets on with them"

"Not enough staff to look after all these people"

Where appropriate, any 'negative' comments that are received are being relayed to the services in question

Next steps

The Dementia Care Team has developed a Carer's Pack consisting of useful information for carers of people with dementia. This pack is now available on *The Source* for staff to access and also available on the Trust's website. A hard copy can also be purchased through the Trust eProcurement program.

The Dementia Care Team will work to increase the amount of Carers Questionnaires being completed. Unfortunately due to changes in staffing (junior doctors rotating) the collection of questionnaires has stopped in May and June. The Dementia Care Team will liaise with Ward Managers and Therapists, and gain support from the CQUIN team to increase the amount collected.

The Dementia Care Team have commenced 'Dementia Drop-in' Sessions on all 3 sites. These sessions are for staff, patients and relatives/carers who are worried about a loved one's dementia, themselves, or want more information or signposting about dementia.

The audit will continue throughout the year, with subsequent findings being reported to the Trust Board on a twice-yearly basis

The Audit Questionnaire

Date:

Imperial College Healthcare NHS
NHS Trust

☐ Phone ☐ Face-to-face ☐ Completed alone

Dear Carer,
We are committed at Imperial College Healthcare NHS Trust to improving the quality and standard of care we give to patients with dementia and their carers and families. Your feedback and comments are very important and can help us improve our services.

In the questionnaire below, 'the patient' refers to the person your care for, or your family member.

Carer questionnaire (please tick)

Q1. Would you be willing to complete this questionnaire?

☐Yes ☐No

Q2. During the patient's admission in hospital, do you feel that you have been supported in relation to their existing diagnosis of dementia?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Q3. Did any health professionals talk to you about the patient's diagnosis of dementia during this admission?

☐Yes ☐No

If yes,

Do you feel that you received sufficient information?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Q4. Do you feel that you had received enough information about how the patient's physical health can impact on their dementia during this admission?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Q5. Prior to the patient's discharge, were you involved with care planning and given information about services regarding their dementia?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Additional comments regarding the above questions and dementia care:

Please return this questionnaire to the nurse in charge, and thank you for your time

innovation respect care achievement pride

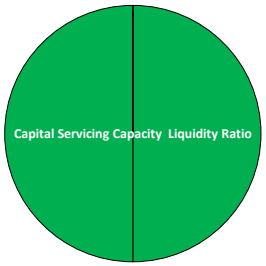
Trust Board Performance Report
Report Period Month 9
(to end December 2014)

Trust Board Wednesday 28th January 2015

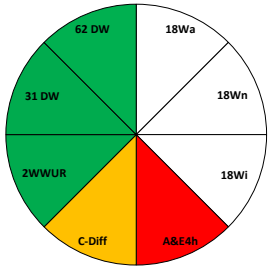
Table of Contents

Imperial College Healthcare NHS Trust

Finance - Continuity of Services Risk Rating



Quality

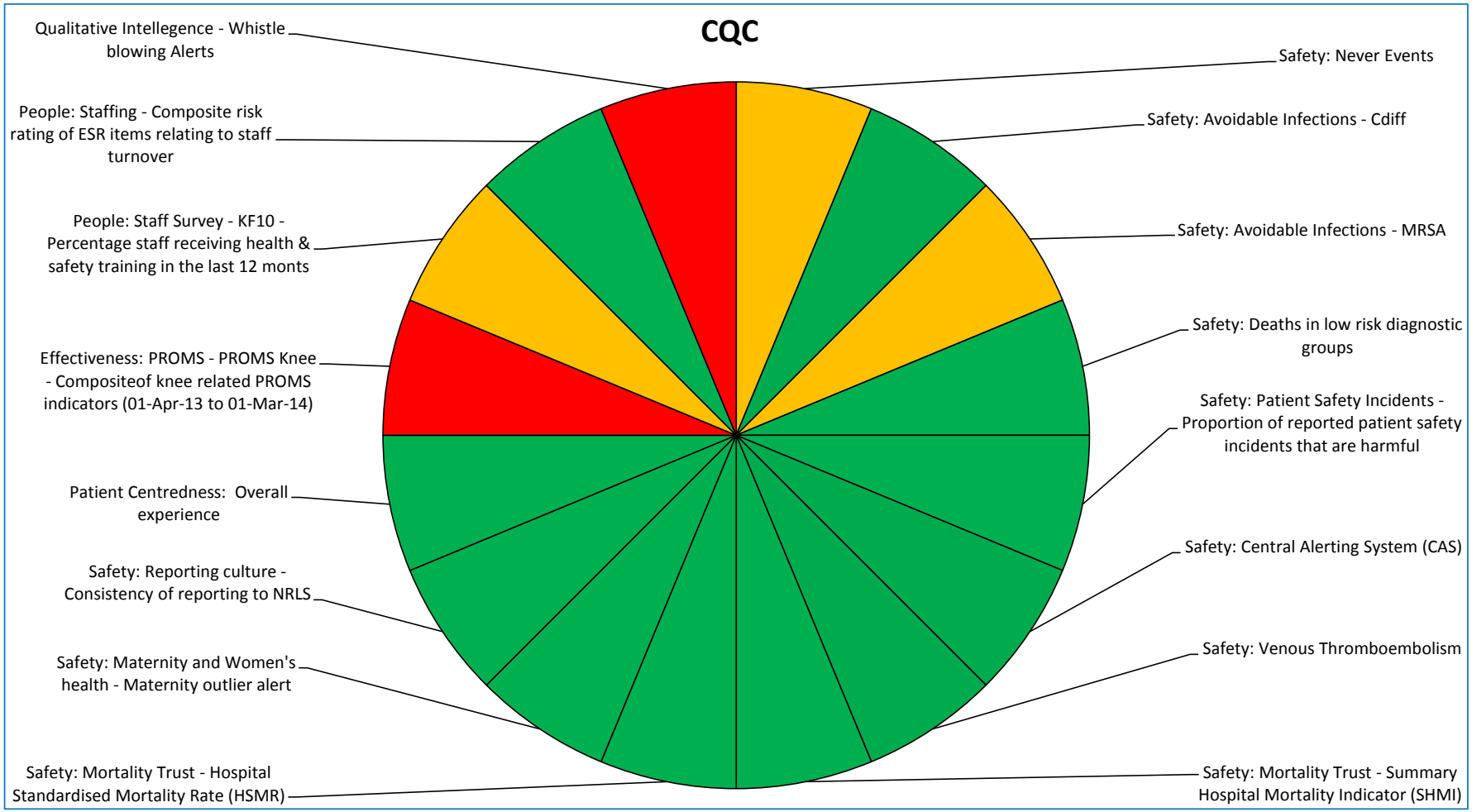


2014/2015			Performance to date 14/15			*Forecast*		
Area	Indicator	Threshold	Q1	Q2	Q3	*Qtr 4 14/15*	*Qtr 1 15/16*	*Qtr 2 15/16*
Finance	Capital Servicing Capacity		3	3	3			
	Liquidity Ratio		3	4	4			
	Continuity of Services Risk Rating		3	4	4			
Access	18 weeks referral to treatment - admitted	90%	88.87%	83.88%	81.22%			
	18 weeks referral to treatment - non admitted	95%	94.66%	94.35%	91.87%			
	18 weeks referral to treatment - incomplete pathway	92%	92.15%	87.14%	81.49%			
	2 week wait from referral to date first seen all urgent referrals	93%	93.70%	94.90%	95.20%			
	2 week wait from referral to date first seen breast cancer	93%	88.40%	93.10%	94.90%			
	31 days standard from diagnosis to first treatment	96%	97.40%	97.60%	97.10%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	99.60%	100.00%	100.00%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.60%	99.30%	100.00%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.90%	95.30%	94.95%			
	62 day wait for first treatment from NHS Screening Services referral	90%	91.00%	93.90%	87.35%			
	62 day wait for first treatment from urgent GP referral	85%	85.40%	85.20%	83.90%			
	A&E maximum waiting times 4 hours	95%	95.86%	95.47%	91.17%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	25	20	15			
	Governance Risk Rating							

	Threshold met
	Threshold NOT met

	Some areas of concern
	Data not available

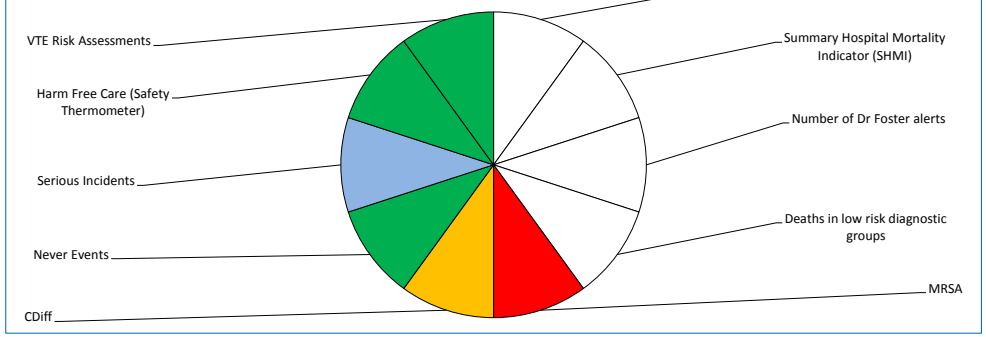
Care Quality Commission (CQC) Rating as at December 2014



No evidence of Risk | Risk | Elevated Risk

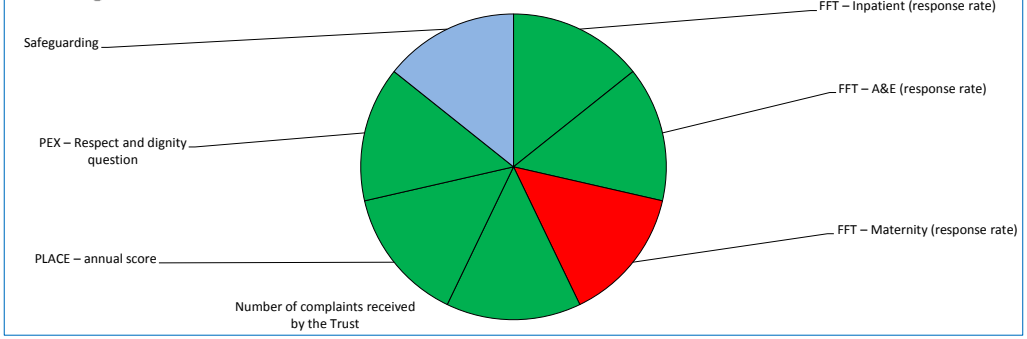
Domain Lead:
Chris Harrison

Safety



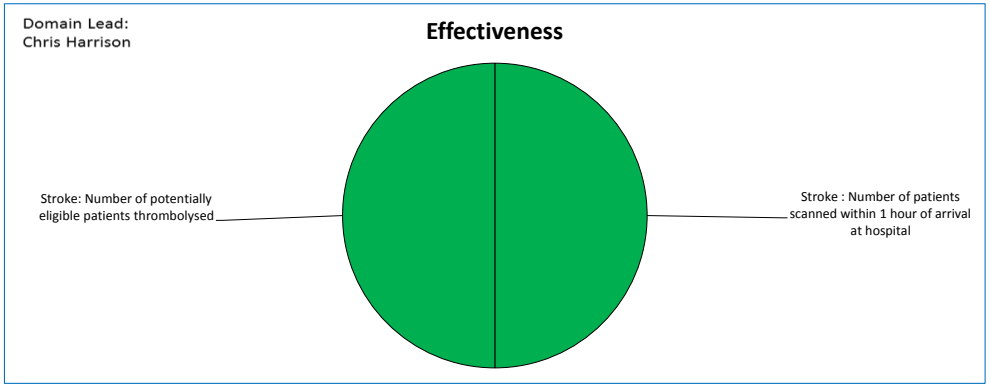
Domian Lead:
Janice Sigsworth

Patient Centredness



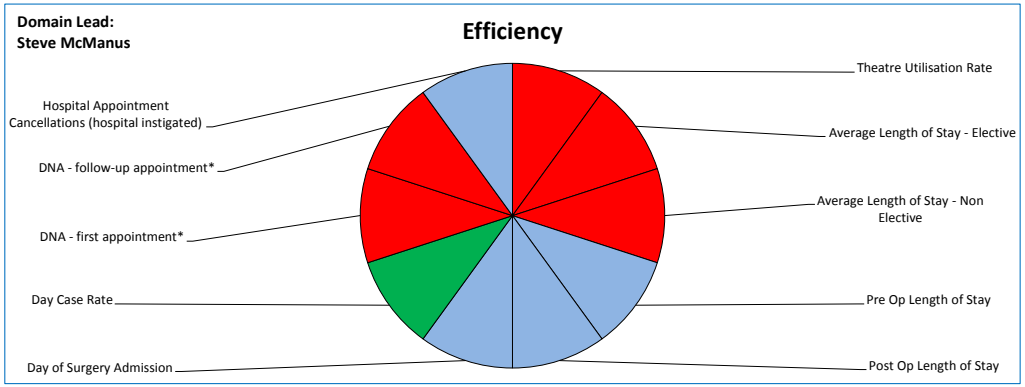
Domain Lead:
Chris Harrison

Effectiveness



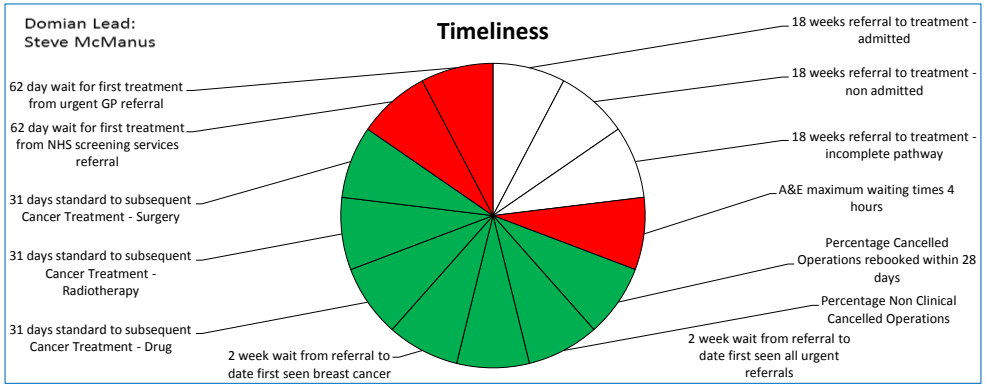
Domain Lead:
Steve McManus

Efficiency



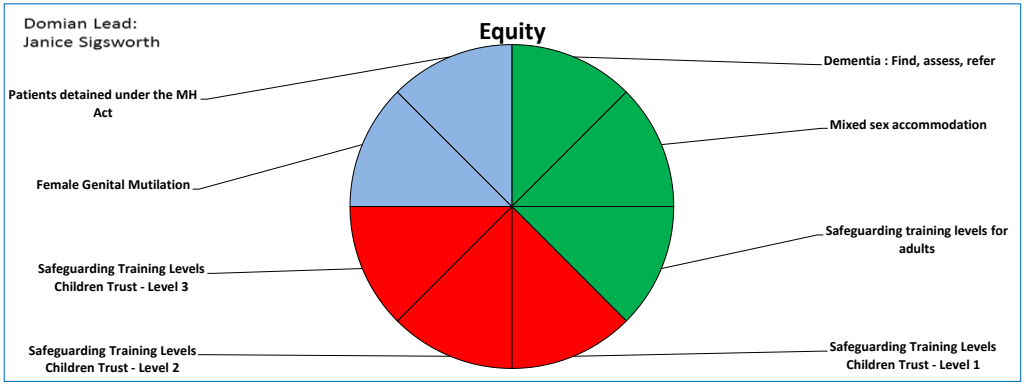
Domian Lead:
Steve McManus

Timeliness



Domian Lead:
Janice Sigsworth

Equity



	Threshold met
	Threshold NOT met

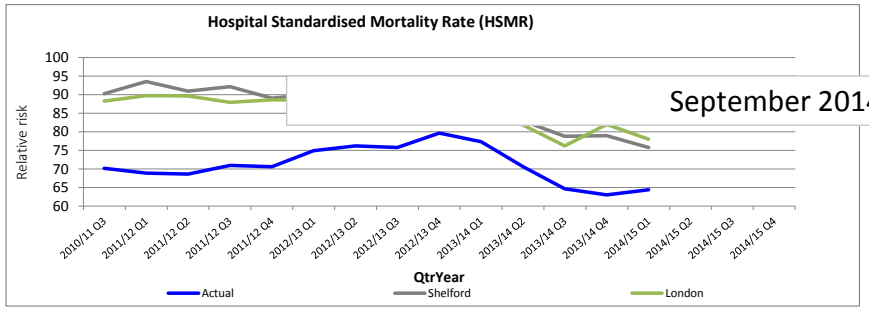
	Have Data - NO Threshold
	Data not available

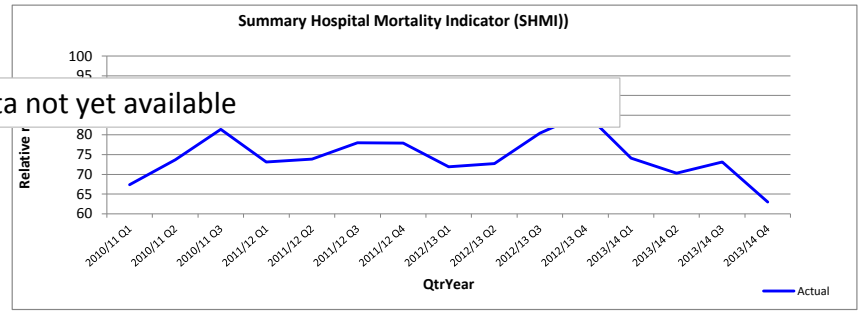
Indicator	Leading	Frequency	2013/2014 Qtr1	Performance in 2014/15 Q1	Q2	Q3	Q4	YTD	Forecast Qtr 2 14/15	Qtr 3 14/15	Qtr 4 14/15	Source Framework
Mortality Indicators												
Hospital Standardised Mortality Rate (HSMR)*	-	Quarterly	77.32	64.37	September 2014 data not yet							CQC
Summary Hospital Mortality Indicator (SHMI)*	-	Quarterly	74.10	Not yet available								CQC

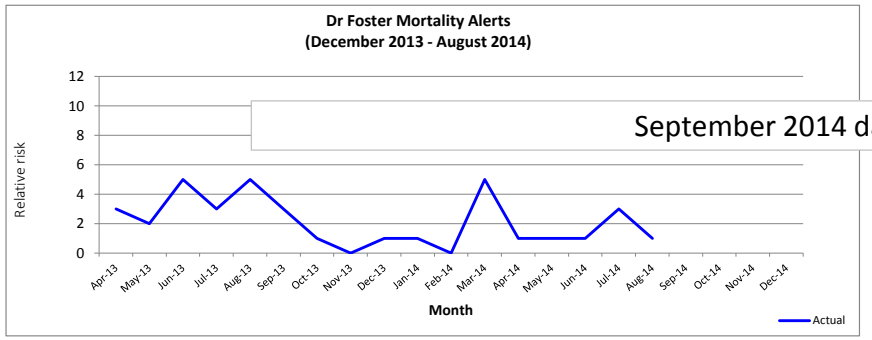
* Dr Fosters data is 3 months in arrears

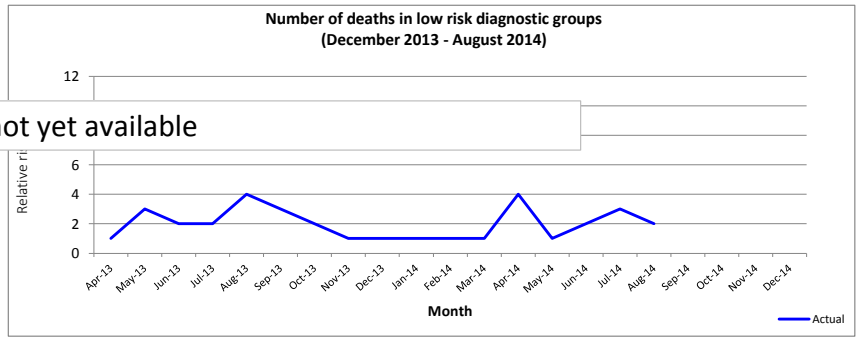
Indicator	Leading	Frequency	Performance in Aug-13	Qtr1 13/14	Performance Current Current Month Aug-14	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	YTD	Forecast Qtr 2 14/15	Qtr 3 14/15	Qtr 4 14/15	Source Framework
Dr Foster Alerts														
Number of Dr Foster mortality alerts*	-	Quarterly	5	10	September 2014 data not yet	3	4			7				CQC
Deaths in low risk diagnostic groups														
Number of deaths in low risk diagnostic groups*	-	Quarterly	2	6		7	5			12				CQC

* Dr Fosters data is 3 months in arrears









Relative risk refers to the ratio of observed deaths divided by the risk adjusted expected deaths in a given metric, multiplied by 100. On this basis, a figure of 100 represents the NHS England average for a metric. Anything lower than 100 means the relative risk is lower than expected.

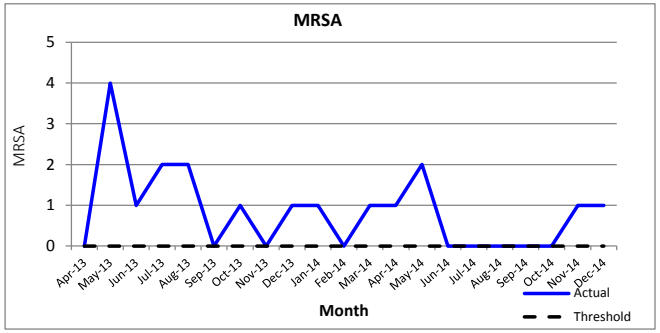
Deaths in low risk diagnosis group is the relative risk for the combined 200 diagnosis groups that have low mortality outcomes.

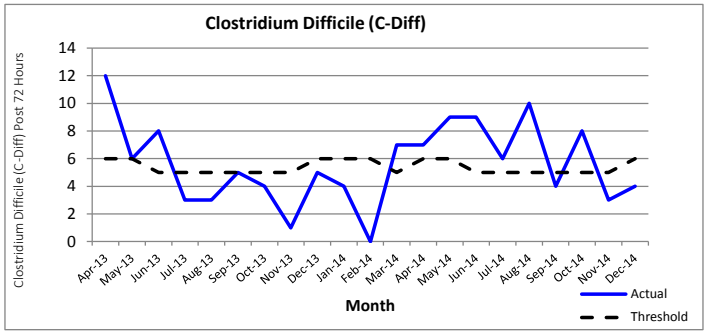
In Hospital Mortality - "various" conditions covers the combined mortality risk for similar diagnosis groups in a specialty (e.g. vascular, haematological). This metric has been developed to replicate the CQC composite mortality indicators wherever possible. This is based on the diagnosis of admission.

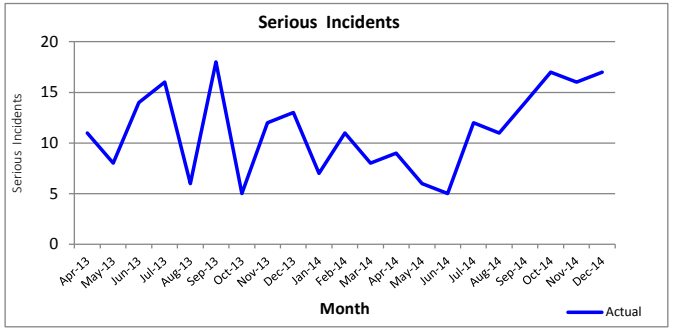
Dr Foster rebases data every 12 months to ensure that performance data reflects a trust's relative performance against NHS standards (HSMR, or Relative Risk for instance). This remodelling is done against the last full financial year of data. This means that if the performance across the NHS for stroke mortality improves, this may mean rebasing makes a trusts stroke relative risk rises.

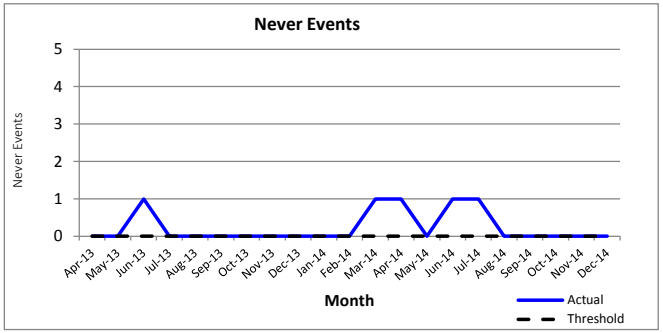
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Infection Control*															
MRSA	-	Monthly	0	1	2	1	3	0	2		5				TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	-	Monthly	<65 p/a	5	10	4	25	20	15		60				Mon, TDA, CQC
Incidents*															
Never Events	-	Monthly	0	0	0	0	2	1	0		3				TDA, CQC
Serious Incidents	-	Monthly	n/a	13	30	17	20	37	50		107				TDA, CQC
Safety Thermometer*															
Harm Free Care (Safety Thermometer)	-	Monthly	>90%	95.7%	96.3%	96.98%	95.78%	96.87%	96.21%		96.29%				TDA, CQC
VTE															
VTE Risk Assessments	✓	Monthly	>95%	95.4%	96.3%	97.97%	95.30%	95.92%	97.02%		96.08%				CQC, Contractual

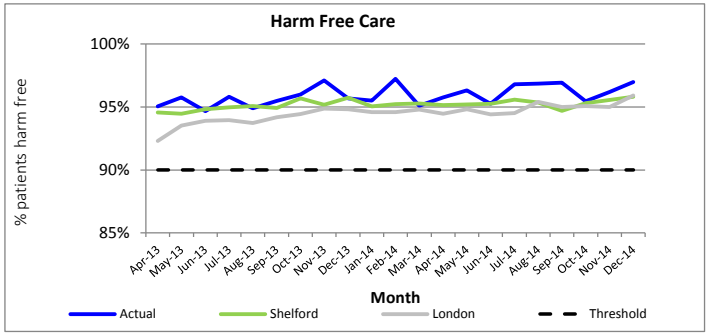
*** Includes Private Patients**

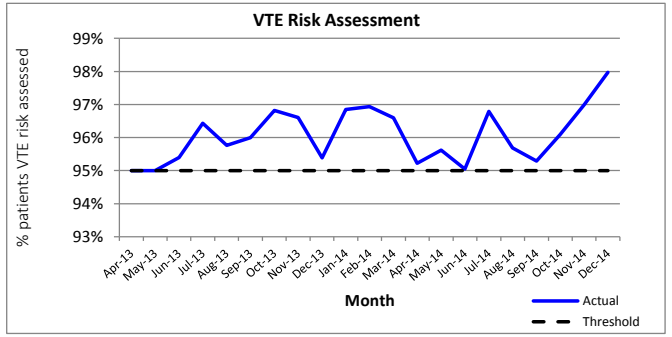






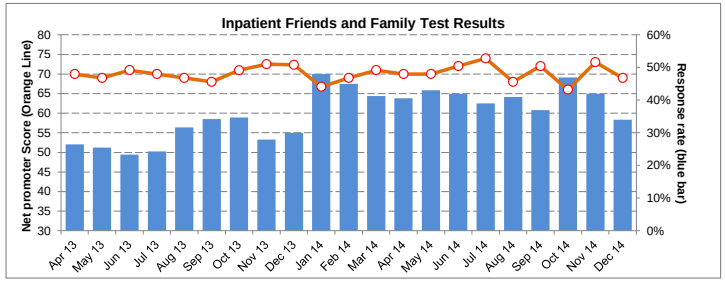


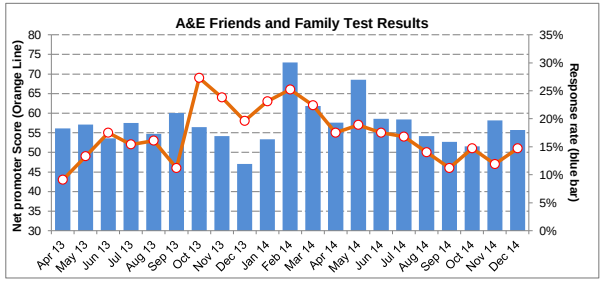


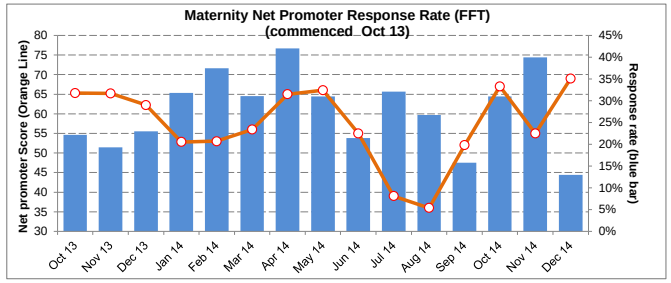


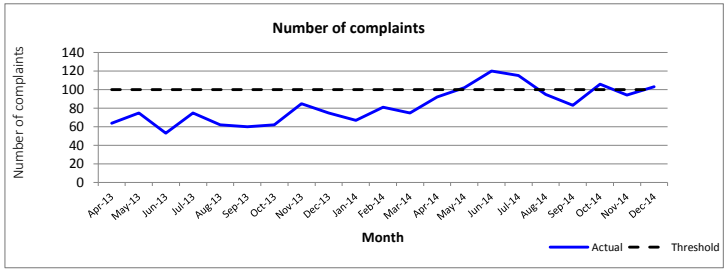
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Friends & Family Test															
Inpatients Net Promoter Score (FFT)	✓	Monthly	>50	72	72	69	71	71	69		70				Contractual
Inpatients Net Promoter Response Rate	✓	Monthly	>25%	29.95%	30.89%	34.00%	41.86%	39.00%	41.00%		40.62%				
A&E Net Promoter Score (FFT)	✓	Monthly	>50	58	64	51	56	50	50		52				Contractual
A&E Net Promoter Response Rate	✓	Monthly	>15%	11.93%	18.96%	18.00%	22.10%	17.57%	17.60%		19.09%				
Maternity Net Promoter Score (FFT)	✓	Monthly	>50	n/a	n/a	69	62	42	64		56				Contractual
Maternity Net Promoter Score Response Rate	✓	Monthly	>15%	n/a	n/a	13.00%	31.47%	24.87%	28.00%		28.11%				Contractual
Complaints & Compliments*															
Number of complaints received	-	Monthly	<100	75	222	103	314	293	303		910				CQC
Environment															
PLACE - Cleanliness	-	Annually	>95%	99.03%	Aug-13	98.19%	n/a	98.19%	n/a		98.19%				*tbc*
PLACE - Food	-	Annually	>84%	80.91%	Aug-13	88.18%	n/a	88.18%	n/a		88.18%				*tbc*
PLACE - Privacy, Dignity & Well being	-	Annually	>82%	88.60%	Aug-13	77.75%	n/a	77.75%	n/a		77.75%				*tbc*
PLACE - Facilities	-	Annually	>83%	89.22%	Aug-13	87.26%	n/a	87.26%	n/a		87.26%				*tbc*
Patient Experience															
(LQ36) Have you been treated with dignity and respect by staff on this ward?	-	Monthly	*>85%*	97.27%	97.23%	96.3%	96.28%	97.12%	96.14%		96.52%				CQC
Safeguarding															
Safeguarding Adults : Referrals per month	-	Monthly	*n/a*	36	138	35	109	134	105		348				CQC

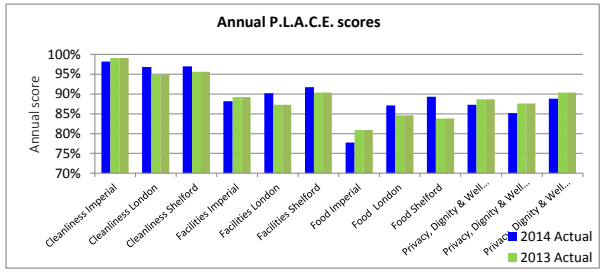
*** Includes Private Patients**

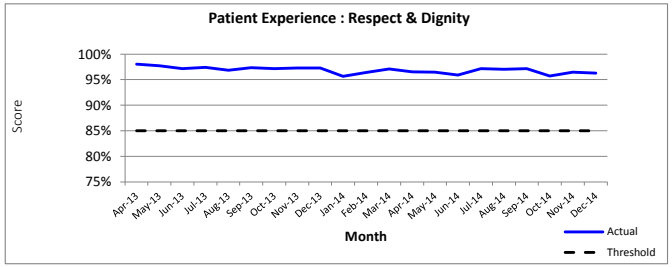


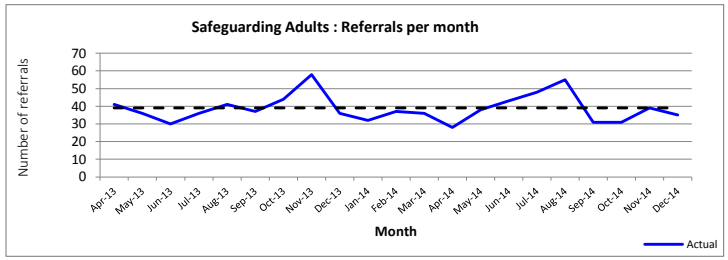




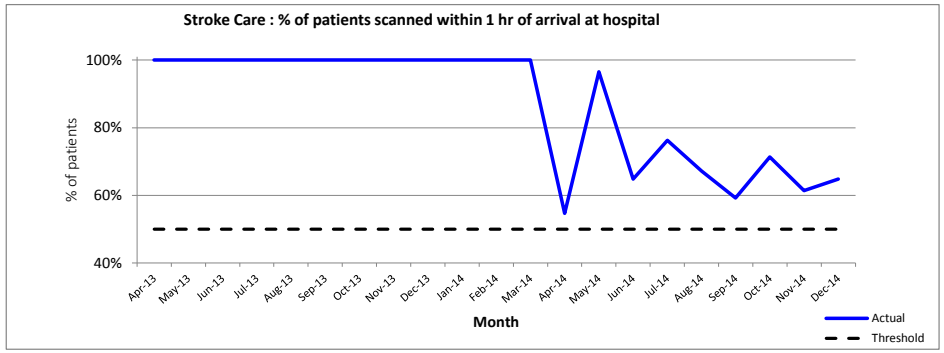


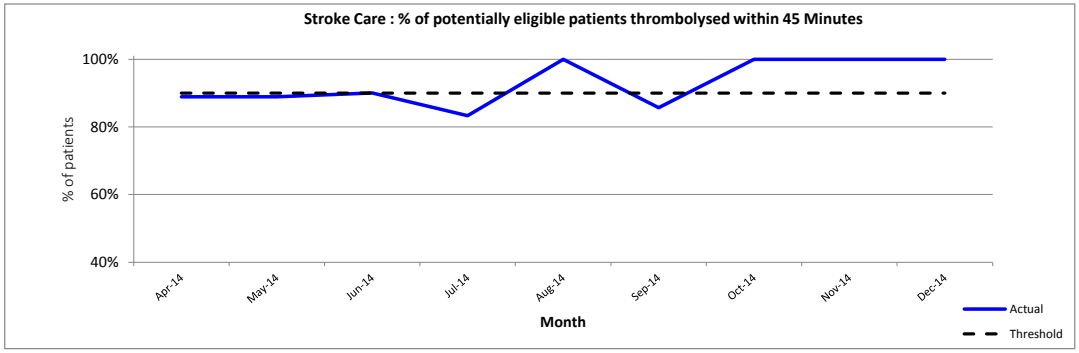






Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Stroke Care															
Stroke Care : % of patients scanned within 1 hr of arrival at hospital	-	Monthly	>50%	100.0%	100.0%	64.80%	71.99%	67.55%	65.83%		68.46%				CQC
Stroke Care : % of potentially eligible patients thrombolysed within 45 Minutes	-	Monthly	>90%	n/a	n/a	100.00%	89.26%	89.68%	100.00%		92.98%				CQC





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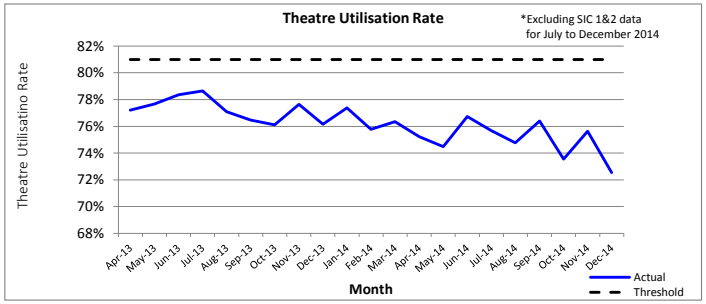
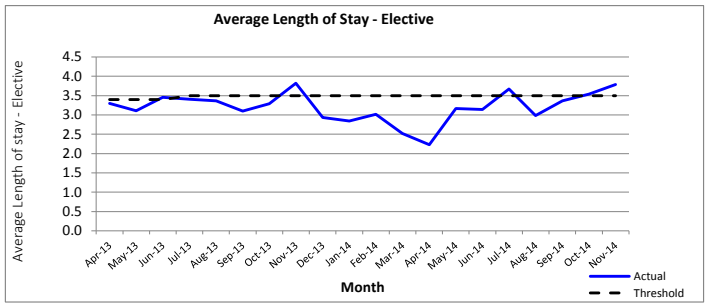
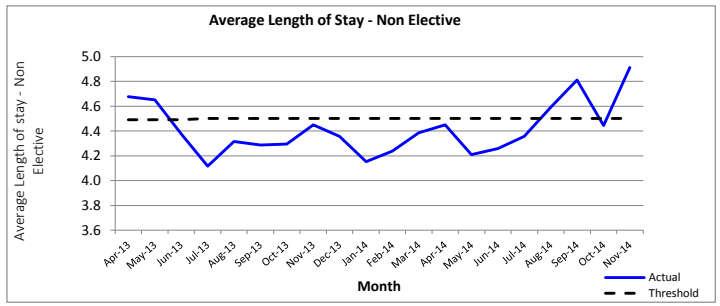
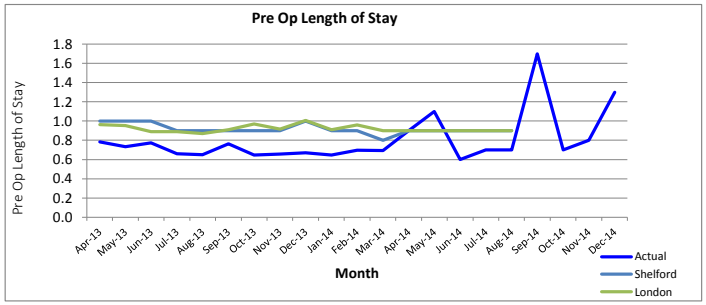
Productivity															
Theatre Utilisation Rate	✓	Monthly	>81%	76.17%	76.64%	72.55%	75.48%	75.62%	73.91%		75.00%				CQC
Average Length of Stay - Elective	✓	Monthly	<3.5	3.82	3.39	3.79	2.61	3.24	3.54		3.11				Internal
Average Length of Stay - Non Elective	✓	Monthly	<4.5	4.45	4.34	4.91	4.35	4.40	4.73		4.49				Internal
Pre Op Length of Stay*	✓	Monthly	*tbc*	0.67	0.66	1.50	0.87	1.05	0.82		0.94				Define
Post Op Length of Stay*	✓	Monthly	*tbc*	4.68	4.52	6.20	4.33	4.50	5.30		4.71				Define
Day of Surgery Admission*	✓	Monthly	*tbc*	88.83%	88.90%	87.75%	87.71%	89.15%	89.35%		88.47%				Define
Day Case Rate	✓	Monthly	>80%	77.57%	78.36%	80.11%	73.36%	76.37%	78.97%		76.33%				CQC
DNA - first appointment	✓	Monthly	<12.31%	14.51%	14.32%	14.28%	17.58%	16.90%	14.75%		16.42%				Internal
DNA - follow-up appointment	✓	Monthly	<11.33%	13.15%	13.27%	12.62%	17.28%	17.33%	13.77%		16.13%				Internal
Hospital Appointment Cancellations (hospital instigated)	✓	Monthly	*tbc*	2.05%	2.03%	1.01%	1.31%	1.11%	1.03%		1.15%				Internal

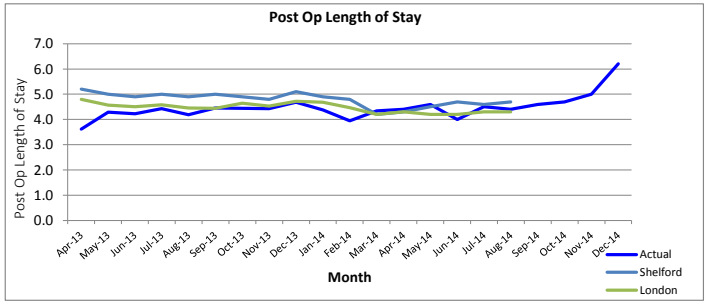
*** London and Shelford Averages obtained from Dr Fosters - hence 3 months in arrears**

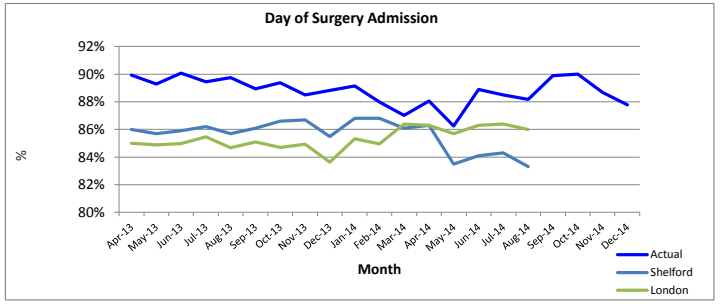


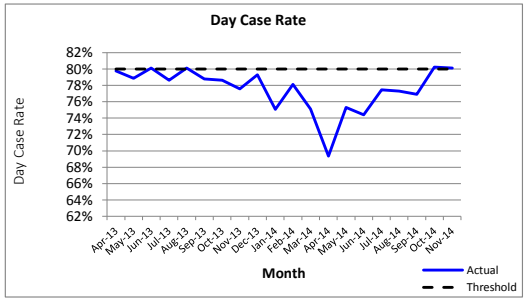


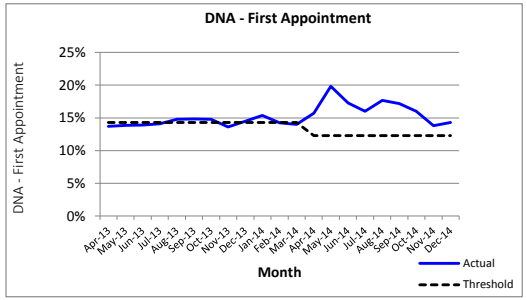


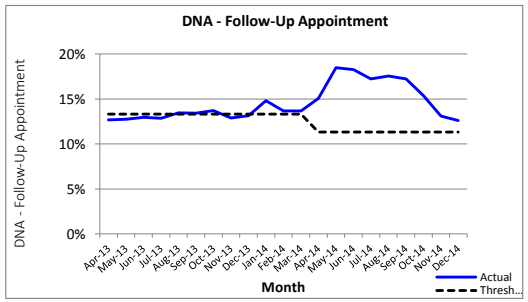


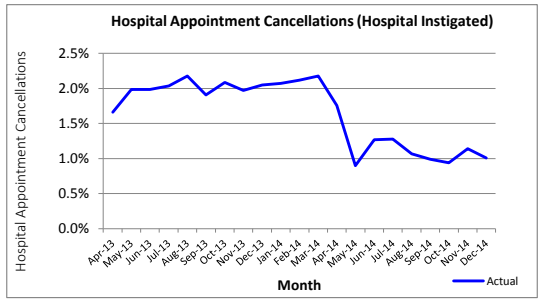




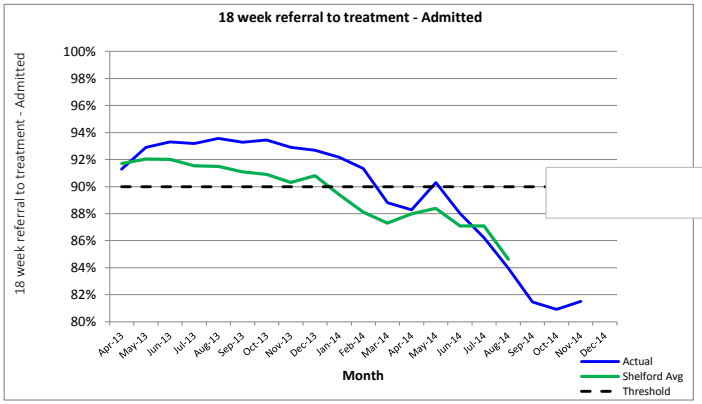


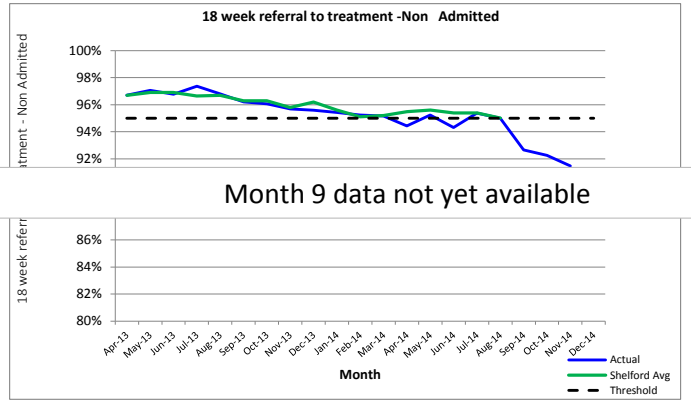


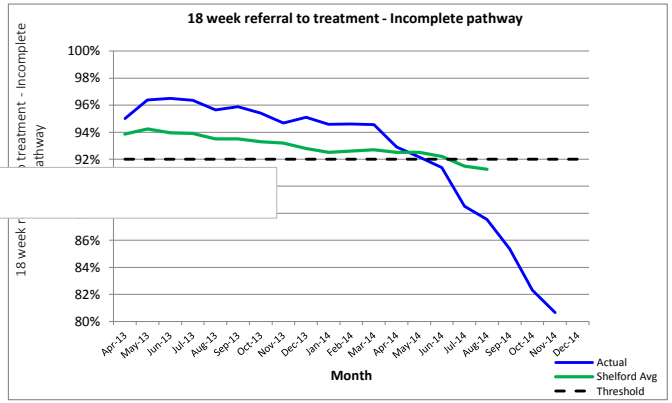


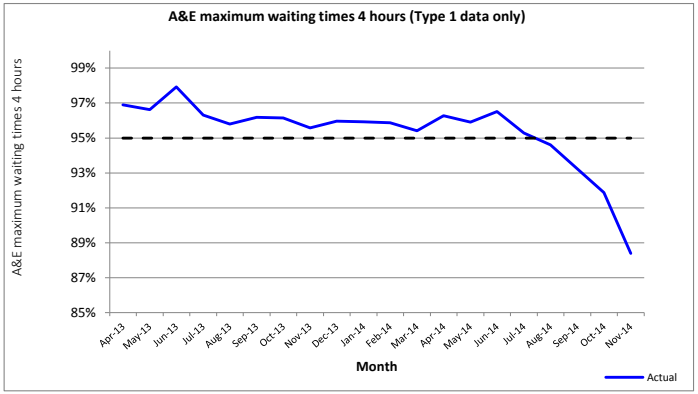


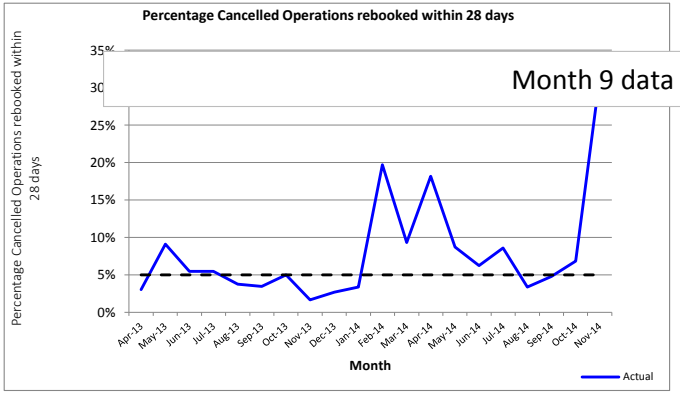
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Elective Access															
18 weeks referral to treatment - admitted	-	Monthly	>90%	92.7%	93.2%	Month 9 data not yet available	88.87%	83.88%	81.22%		85.08%				Mon, TDA, CQC
18 weeks referral to treatment - non admitted	-	Monthly	>95%	95.6%	95.8%		94.66%	94.35%	91.87%		93.85%				Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	-	Monthly	>92%	95.1%	95.1%		92.15%	87.14%	81.49%		87.61%				Mon, TDA, CQC
A&E Access															
A&E maximum waiting times 4 hours	✓	Monthly	>95%	95.6%	96.0%	88.4%	95.86%	95.47%	91.17%		94.17%				Mon, TDA, CQC
Other Access Measures															
Percentage Cancelled Operations rebooked within 28 days	✓	Monthly	<5%	1.7%	3.4%	Month 9 data not yet available	12.30%	5.70%	16.21%		12.44%				TDA, CQC
Percentage Non Clinical Cancelled Operations	✓	Monthly	<0.8%	0.8%	0.7%		0.82%	0.69%	1.24%		0.92%				Define

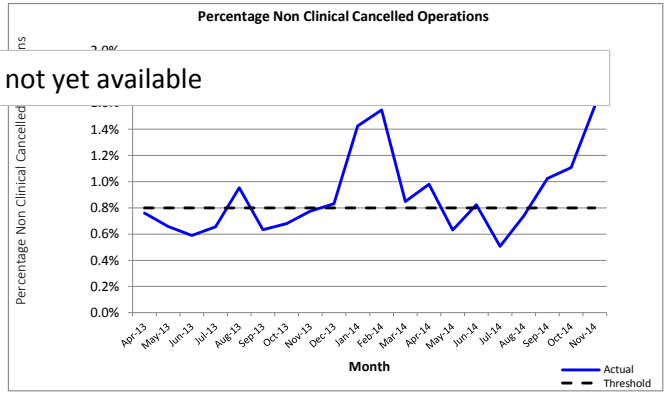




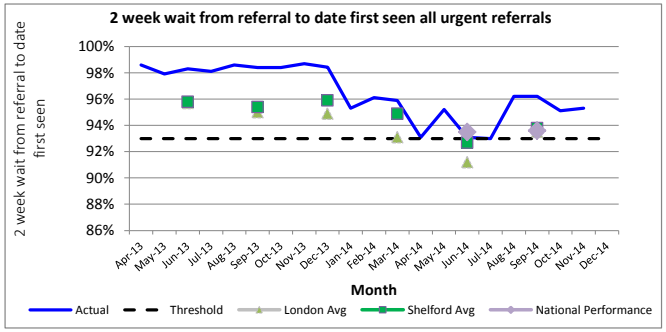


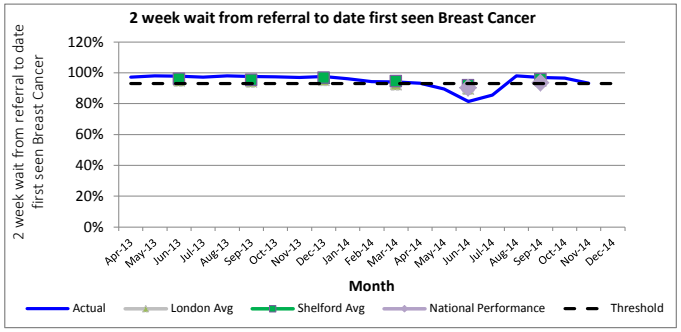


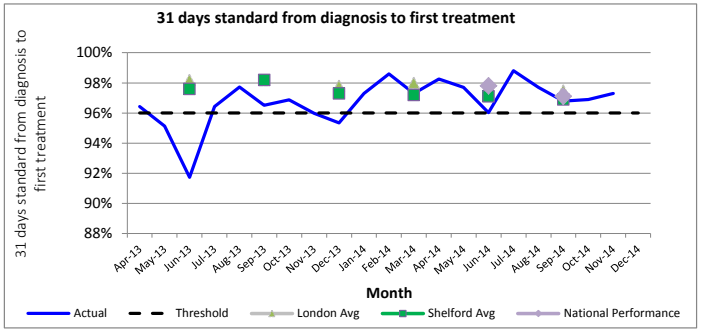


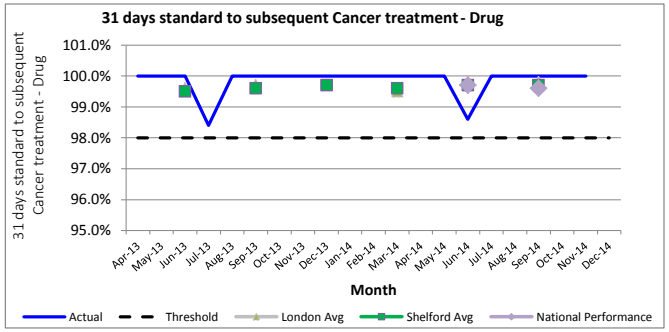


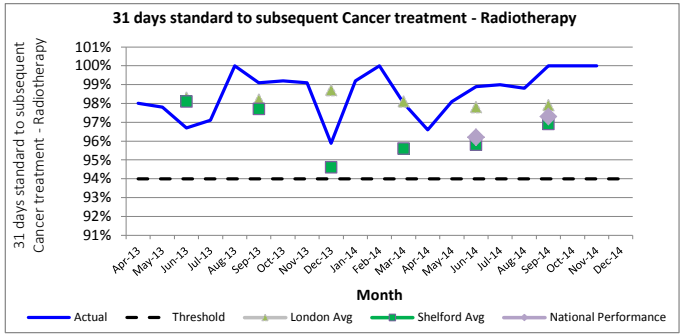
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Nov-13	Performance in 2013/14 Q2-13	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Source Framework
Cancer Access Waiting Times															
2 week wait from referral to date first seen all urgent referrals	✓	Monthly	>93%	98.6%	98.5%	95.3%	93.7%	94.9%	95.2%		94.7%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer	✓	Monthly	>93%	98.0%	97.3%	93.3%	88.4%	93.1%	94.9%		91.9%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment	-	Monthly	>96%	97.7%	96.1%	97.3%	97.4%	97.6%	97.1%		97.4%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug	-	Monthly	>98%	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%		99.8%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy	-	Monthly	>94%	100.0%	98.1%	100.0%	97.6%	99.3%	100.0%		98.9%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery	-	Monthly	>94%	96.0%	95.4%	94.8%	96.9%	95.3%	95.0%		96.0%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral	-	Monthly	>90%	91.2%	92.2%	85.0%	91.0%	93.9%	87.4%		90.9%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral	-	Monthly	>85%	65.6%	80.1%	82.5%	85.4%	93.7%	94.9%		85.0%				Mon, TDA, CQC

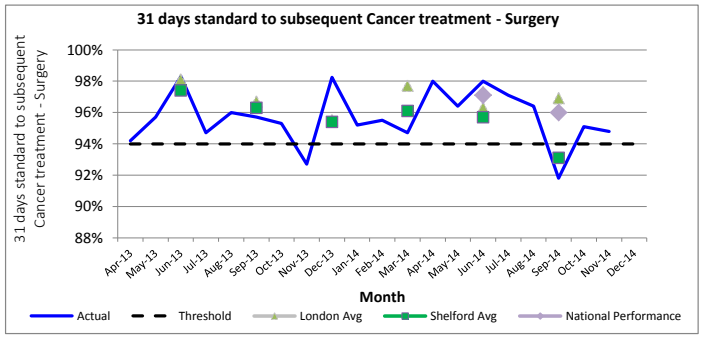


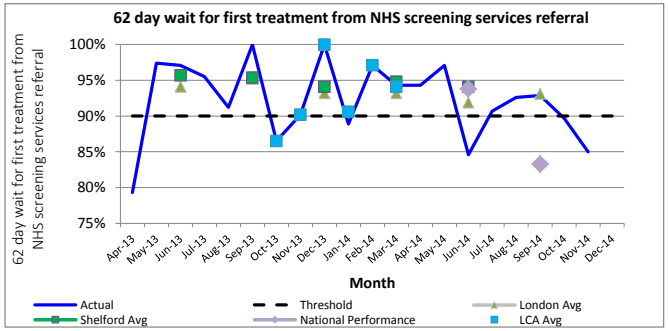


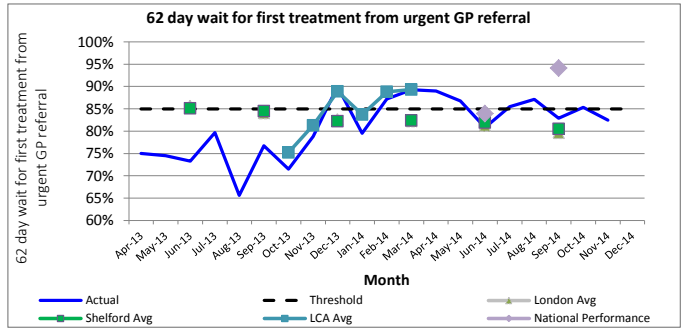






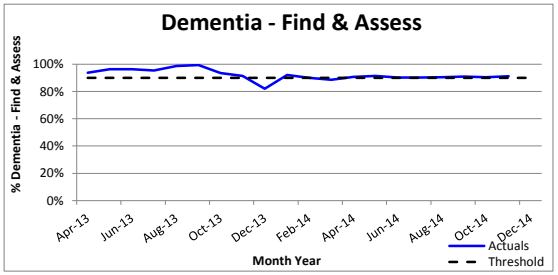


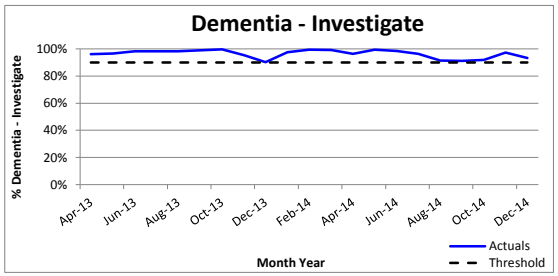


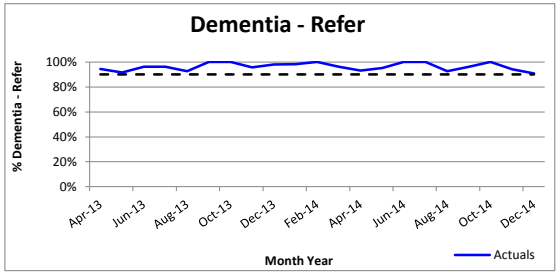


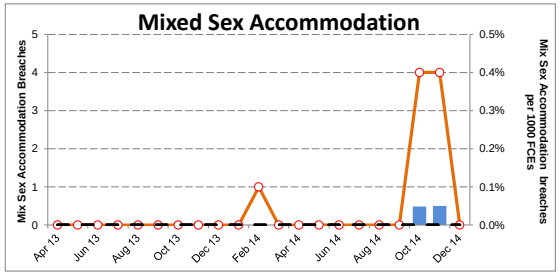
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
CQUIN - Dementia															
CQUIN - Dementia - Find & Assess	-	Monthly	>90%	92%	95%	91.10%	90.19%	90.35%	90.77%		90.40%				Contractual
CQUIN - Dementia - Investigate	-	Monthly	>90%	90%	95%	93.36%	97.98%	92.91%	94.15%		95.14%				Contractual
CQUIN - Dementia - Refer	-	Monthly	>90%	98%	95%	90.91%	96.50%	97.03%	97.33%		96.87%				Contractual
Accomodation															
Mixed Sex Accommodation	-	Monthly	0	0	0	0	0	0	8		8				TDA
Mixed Sex Accommodation Rate per 1000 FCEs	-	Monthly	0	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%		0.01%				TDA
Safeguarding Training Levels*															
Safeguarding Training Levels Adults	-	Monthly	>85%	n/a	n/a	86.00%	72.87%	79.60%	82.69%		78.39%				Define
Safeguarding Training Levels Children Trust - Level 1	-	Monthly	>80%	n/a	n/a	73.0%	n/a	n/a	73.0%		73.0%				Define
Safeguarding Training Levels Children Trust - Level 2	-	Monthly	>80%	n/a	n/a	57.0%	n/a	n/a	57.0%		57.0%				Define
Safeguarding Training Levels Children Trust - Level 3	-	Monthly	>80%	n/a	n/a	57.0%	n/a	n/a	61.0%		61.0%				Define
Female Genital Mutilation Caseload															
Female Genital Mutilation Caseload	-	Monthly	0	n/a	n/a	279	n/a	147	721		868				Define
Mental Health Act detentions															
Patients detained under the Mental Health Act	-	Monthly	0	n/a	n/a	8	21	16	16		53				Define

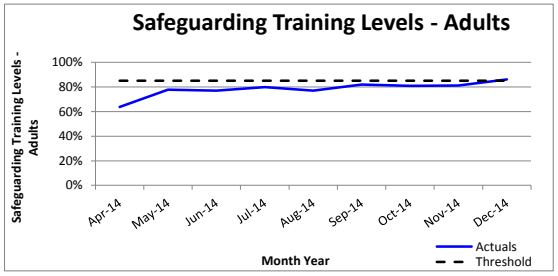
* Revised methodology used as at December 2014

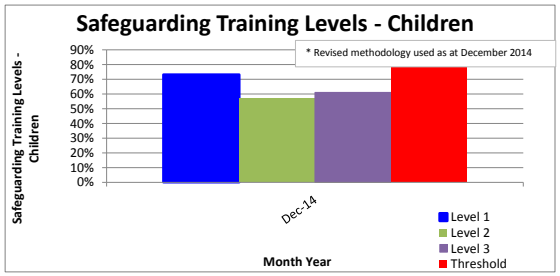


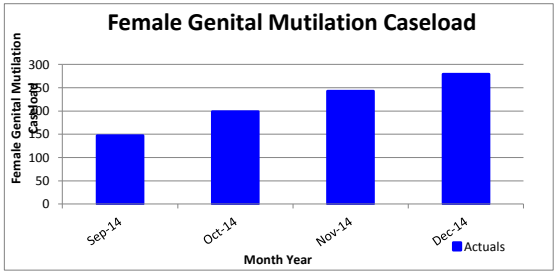


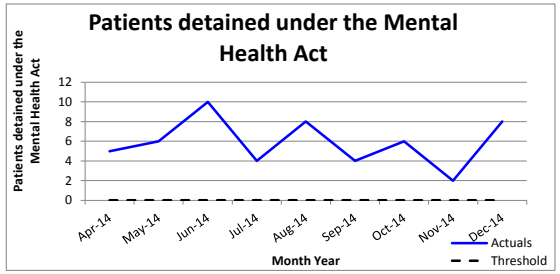




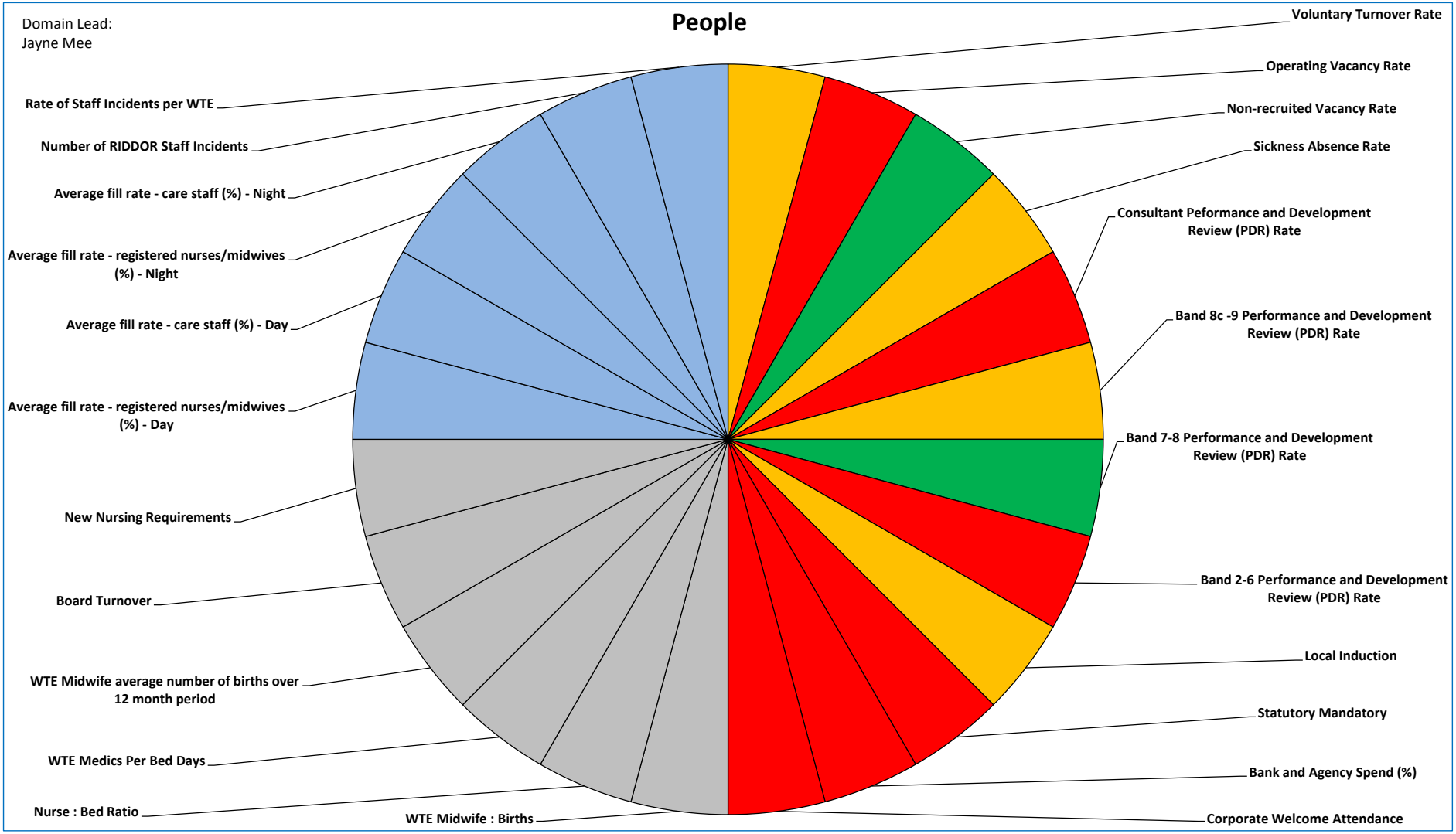








Domain Lead:
Jayne Mee



*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.

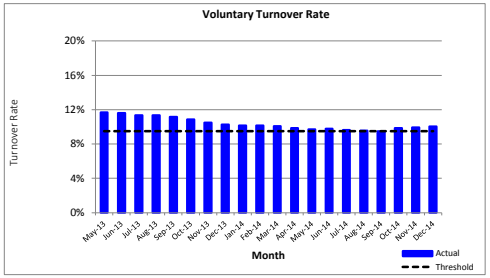
Current performance which meets or exceeds target

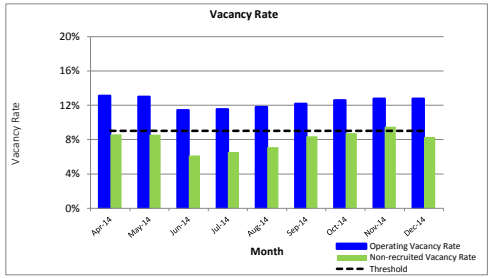
Current performance which is not meeting target but is within 10% of target

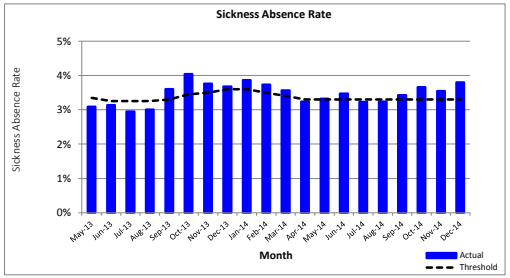
Current performance which is not meeting target within 10%

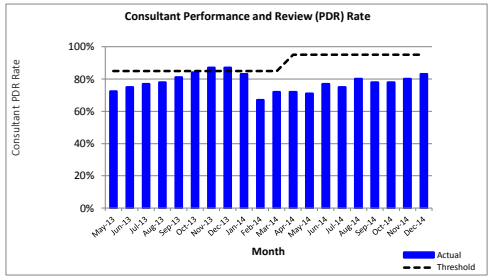
Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	Rolling 12 Months Position	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Turnover & Vacancy Rate															
Voluntary Turnover Rate	✓	Monthly	<9.50%	10.25%	10.53%	10.04%	9.78%	9.55%	9.93%		10.04%				TDA
Operating Vacancy Rate	✓	Monthly	<9.00%	n/a	n/a	12.75%	12.50%	11.83%	12.71%						CQC
Non-recruited Vacancy Rate	✓	Monthly	<9.00%	n/a	n/a	8.30%	7.77%	7.35%	8.85%						CQC
Sickness Absence Rate	✓	Monthly	<3.4%	3.68%	3.83%	3.80%	3.34%	3.30%	3.67%		3.49%				CQC
Appraisal Rates															
Consultant Peformance and Development Review (PDR) Rate	✓	Monthly	>95.00%	87.00%	86.00%	83.00%	73.33%	77.67%	80.33%						Define
Band 8c -9 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	94.00%	96.08%	93.96%	94.67%						Define
Band 7-8b Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	96.00%	n/a	83.00%	93.00%						Define
Band 2-6 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	80.00%	n/a	11.00%	80.00%						Define
Training Compliance															
Local Induction	✓	Monthly	>95.00%	73.92%	74.79%	87.00%	77.01%	84.70%	88.00%						Define
Statutory Mandatory	✓	Monthly	>95.00%	69.15%	68.50%	73.00%	69.20%	71.08%	73.33%						Define
Bank and Agency Spend															
Bank Spend (%)	✓	Monthly	tbc	n/a	n/a	5.48%	5.61%	5.04%	5.23%		12.35%				Define
Agency Spend (%)	✓	Monthly	tbc	n/a	n/a	5.53%	8.10%	7.01%	6.35%						Define
Corporate Welcome															
Corporate Welcome Attendance	✓	Monthly	>100.00%	n/a	n/a	88.00%	90.27%	95.00%	93.33%						Define

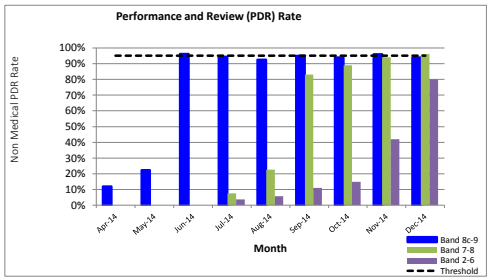
Indicators to be developed
WTE Midwife : Births
Nurse : Bed Ratio
WTE Medics Per Bed Days
WTE Midwife average number of births over 12 month period
Board Turnover
New Nursing Requirements

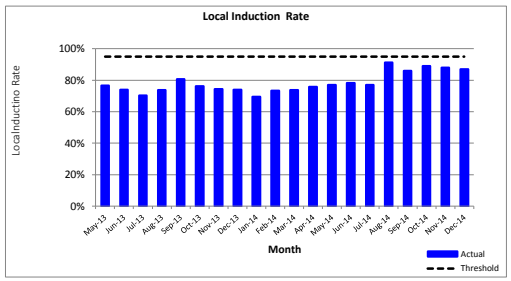


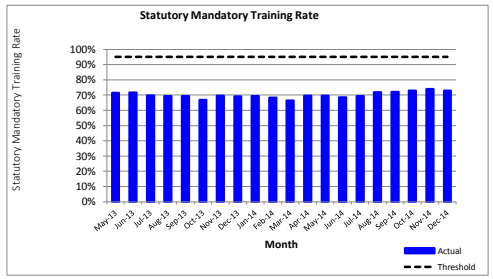


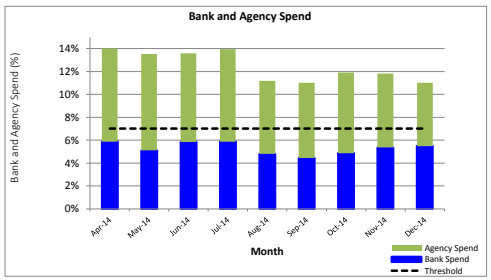


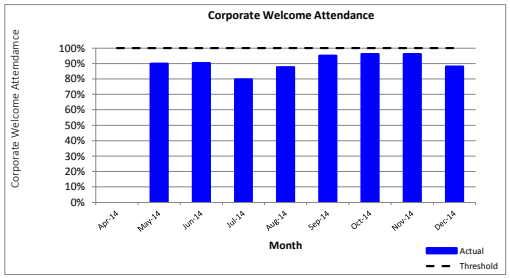












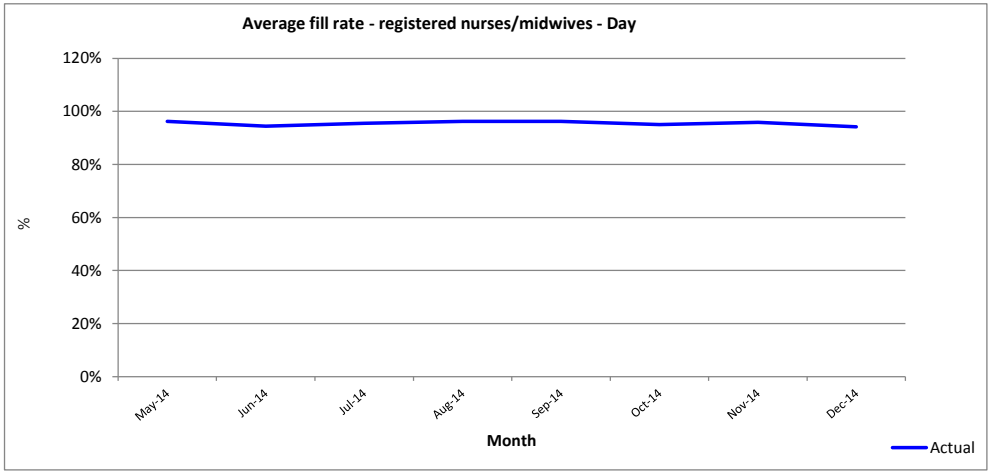
Imperial College Healthcare NHS Trust

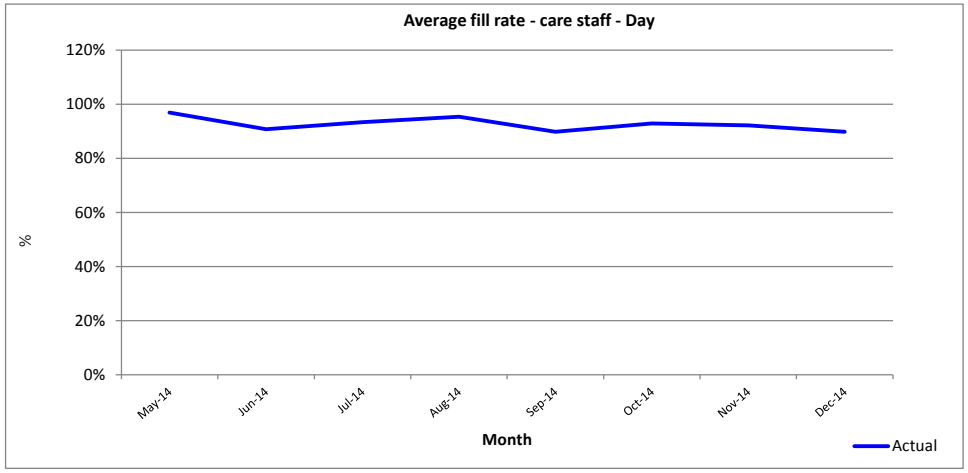
People KPI Report ~ Current Performance - December 2014

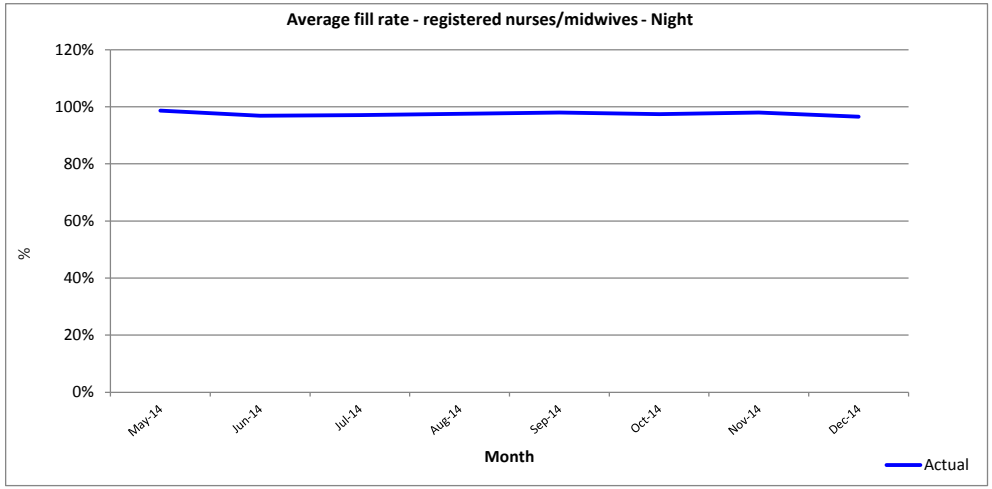
Establishment & People	General Ledger (GL) Establishment WTE	ESR Established WTE	Variance GL & ESR Post WTE	ESR Inpost WTE	Worked Bank WTE	Worked Agency WTE	Total People WTE (inpost/b&a)	Variance Total People against ESR Establishment	Variance Total People against GL Establishment
Trust Overview	9,994	10,346	352	9,027	559	643	10,228	-118	235

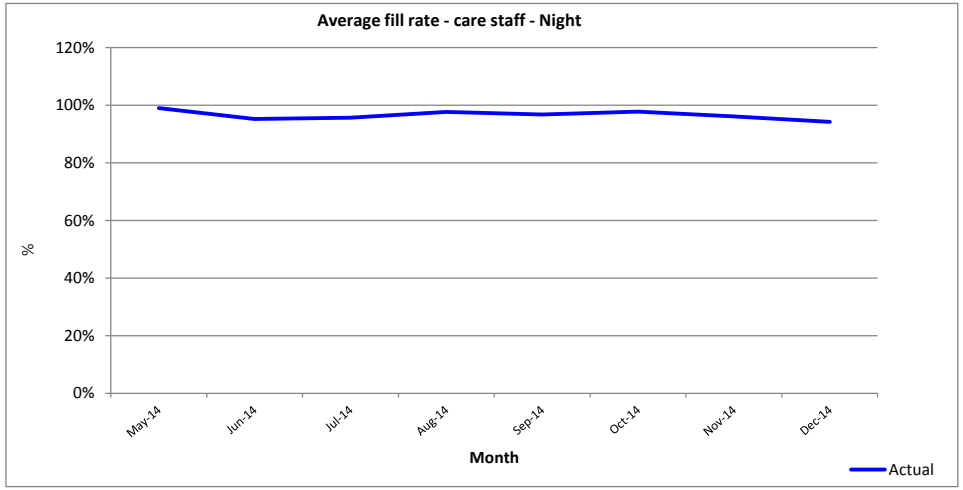
Month 9 - December 2014	Period	KPI Target	Current Performance	Performance Flag	Current Performance and Plans to Improve
Vacancy Rate %	in month	9.00%	12.75% operational vacancy rate & 8.30% non-recruited to vacancy rate	red - operating vacancy rate & green - non-recruited vacancy rate	At the end of December, we directly employed (excl.hosted services) 9,027 WTE. This is 16 WTE more than reported in November. The post establishment increased by 15 WTE during December, these additional posts were approved through the ERAF process and supported by Finance BP approval. The overall effect has been that the operating vacancy rate has decreased marginally from 12.78% to 12.75%. We currently have 460 successful candidates who are waiting to join the Trust, which adjusts the vacancy rate to a non-recruited figure of 8.30%. Our pipeline candidates are split across the occupational groups as; 90 A&C/Est/Snr.Mgr, 213 Nursing & Midwifery, 85 Trust appointed Doctors & Consultants, 72 AHP/S&T/Pharmacists. The ERAF approval process continues to work to support recruitment that is appropriate and required for the delivery of safe high quality care for our patients. Across the divisions, key Trust and Training grade medical posts have been identified and are exempt from the ERAF process; supporting recruitment and minimising disruption to rota cover and delivery of care to our patients.
Ward / Inpatient Staffing Levels	Current operating band 2~6 vacancy rate on our wards is 14.63% with an adjusted non-recruited vacancy rate of 9.35% taking into account 126 candidates waiting to join including 37 from the recent Division of Surgery recruitment campaign to India				Across our wards, there are 349 WTE vacancies within bands 2 - 6 roles giving an operating vacancy rate of 14.63%. There are currently 126 WTE band 2 - 6 Nursing & Midwifery candidates waiting to join the ward establishments, bringing the non-recruited to vacancy rate for this group to 9.35%. 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 use of a bespoke strategic people plans (SPP's) for each Division. Reducing our ward based vacancies to 5% is a key priority for the Divisions, Resourcing Team and Nurse Recruiters who are working in partnership to achieve this. At the end of December, a further 104 WTE band 2~6 nursing staff were required to reach the 5% vacancy rate target with a further 18 appointments each month to mitigate expected turnover within this cohort of staff.
B & A Spend as % of total paybill	in month	6.40%	11.01% (5.48% agency & 5.53% bank)	red	Bank and agency spend, as a % of our total paybill, decreased from 11.82% to 11.01% in December ; 5.48% agency spend and 5.53% bank spend. During December, total requests for Nursing & Midwifery temporary staffing increased from 715 WTE in November to 766 WTE, of which, 597 WTE was filled and worked (down from 605 WTE in November). Support for Cerner continues to reduce, down from 39 WTE in November to 31 WTE in December, with fixed-term recruitment continuing to the remaining established (2-year funded) Cerner support roles. In terms of overall spend, a total of £4.92m was spent during December on bank and agency by the Divisions and Corporate Directorates (£5.31m in November). When compared to the same month last year, December's bank & agency spend shows £927k more ; £207k more agency spend & £720k more bank spend. For the period April 14 - December 14, the average usage for temporary staffing is 555 WTE per month for bank workers and 782 WTE per month for agency workers (for December 559 WTE bank & 643 WTE agency).
	rolling 12-mths	7.00%	12.35%	red	
Turnover Rate %	rolling 12-mths	9.50%	10.04%	amber	Voluntary turnover (rolling 12-month period) for the 12-month period ending at the end of December is at 10.04%; above the 9.50% target rate. During December, a total of 96 of our people voluntarily left the Trust which is 17 more than for the same month last year. Whilst we have seen a small increase in turnover over the past few months, our voluntary turnover rate remains one of the lowest when compared to other London Acute Teaching Trusts and remains significantly below the 11.61% recorded in June 2013. The Trust's stability index (measuring the retention of our people with more than 12 months service) has increased steadily since June 2013, rising from 78.93% to 85.24%. Information from exit interviews and Engagement Survey's continue to be used within the Divisions to understand why our people choose to leave with appropriate action plans put into place to improve our people experience. Supporting this is the information received from our on-boarding survey. In addition, bespoke turnover analysis looking at length of service, banding spread and reasons for leaving are created, as requested, for identified hot-spot areas.
Sickness Absence Rate %	in month	3.40%	3.80%	red	Recorded sickness absence increased in December to 3.80%, up from 3.55% in November showing a 7% increase and marginally higher than the 3.76% recorded in December 2013. This months increase is primarily due to a 45% increase recorded for coughs/cold and respiratory type illness and a 27% increase in recorded back problems. This brings the rolling 12-month position to 3.48% against the 14/15 target of 3.30%. A total of 56,600 working hours were lost to illness during December which is the equivalent of 348 WTE, of which 93 WTE is related to long-term illness (27%); sickness episodes of 28 days or more. Across the organisation, sickness absence levels vary in-month; within Divisions from 3.50% in Investigative Sciences to 4.53% in Women's & Children's, within Corporate Directorates from 1.70% in Press & Communications to 6.95% in Estates. Also by occupational group, ranging from 0.43% for our Doctors in Training to 3.71% for Administrative & Clerical, 6.43% for Unqualified Nursing & Midwifery support and 9.64% for Estates & Maintenance workers. Monitoring of safe staffing levels, to ensure that sickness absence has minimal impact, is done through daily reviews with the GM's and the Site team as well as monthly meetings with managers to ensure proactive management of sickness absence. Ensuring that our new managers attend the Understanding Workforce Policies training, as well as refresher training for existing managers, will ensure that they are confident and supported in the pro-active management of sickness absence
	rolling 12-mths	3.30%	3.49%	amber	
Performance & Development Review (PDR) % - bands 8c ~ 9 - bands 7 ~ 8b - bands 2 ~ 6	in month	95.00%	94% bands 8c~9 & 96% band 7~8b & 80% bands 2~6	amber bands 8c~9 green bands 7~8b red bands 2~6	December saw the completion of the final Performance Development Review (PDR) milestone for all of our people within bands 2 - 6. The compliance rate for this group reached 80% across the Trust at the end of December. Within the other groups, PDR compliance for our band 8c - 9 people is at 94% (below target) in December with those within bands 7 - 8b at 96% (above target) giving a combined compliance of 95% for both these groups. Pro-active management of those PDR's still to be carried out will ensure that the PDR's are completed as soon as possible. To support this, a weekly report continues to be sent to the Divisions detailing all of those who fall within this category. Since April, over 1500 of our managers people have received PDR training and their licence to conduct performance reviews and this training will continue throughout 2015. The Division's and Corporate Directorates receive a monthly report looking at the compliance rates and banding spread for all three banding groups, showing comparison to Trust performance.
Consultant Appraisal %	in month	95.00%	83.00%	red	The Trust Consultant Appraisal rate has risen from 80% to 83% in December. Revalidation is based on annual appraisal over a 5 year cycle and deferral is necessary if appraisal outputs have not been completed. Across the Divisions, compliance for this people metric varies from 77% in the Division of Medicine (up from 73%) to 89% in the Division of Investigative Sciences & Clinical Support (up from 87%)with the Division of Women's & Children's at 83% (up from 82%) and Surgery, Cancer & Cardiovascular at 85% (up from 81%).The Medical Director's Office is targeting specialties where appraisal rates are low through Divisional reporting and work with individuals and their clinical managers and appraisers. The new Revalidation and Appraisal policy will help to support this. There is a contractual responsibility to comply with annual appraisal and job planning and these metrics are being used to improve compliance in both areas.
Corporate Welcome	October Joiners	100.00%	88% in-month & 96% YTD	red - in-month compliance & amber - YTD compliance	All new joiners are required to attend a Corporate Welcome session within the first 8 weeks of their employment, with the expectation that they attend as soon possible. The metric measures performance against this expectation with a 100% compliance target. The December compliance figure of 88% is reporting on those who joined us during October who, depending on when in October they joined, had until the end of December to attend a Corporate Welcome event. Full detail, of those joiners who have not yet attended a Corporate Welcome, is provided on the monthly MPI report to all Divisions and Corporate Directorates. The YTD compliance rate is at 96% and varies across the Divisions from 96% in Surgery & Cancer, 97% in Investigative Sciences with Medicine and W&C at 94%. Within the Corporate Directorates, the compliance rates vary from 91% to 100%. The central Statutory & Mandatory Training Team do a monthly audit of all individuals who are non-compliant with a full diagnostic as to the contributing reasons for that non-attendance; following up either directly with the individual or recruiting manager requesting urgent attendance.
Statutory Mandatory Training Compliance (non-medical) %	in month	95.00%	73% full compliance & 83% including partial compliance	red - fully compliant & red - full & partial compliance	Full Statutory & Mandatory training compliance for all of our people (excluding doctors in training) decreased from 74% to 73% during the month of December. This remains below the target of 95% however, when you add to this those who have partially completed their Statutory & Mandatory training, the compliance rate increases to 83%. All those who are partially compliant are detailed within the monthly MPI report to all Divisions and Corporate Directorates for directed management. Supporting this are the Compliance Surgeries which the Head of Statutory & Mandatory Training holds within all of the Divisions and Corporate Directorates to work through recording issues, to direct completion of partial training and resolve queries. Intense work is underway in Mandatory training to roll out a new reporting system, WIRED 2 which has been developed by the National Skills for Health Academy. It offers improved functionality to report Mandatory training. A project group has also been established bringing together ICT, Resourcing and Mandatory training to resolve many of the system and process issues which affect the quality of Mandatory training data. It is hoped that both work streams will bring improved accuracy of reporting.
Local Induction Compliance %	in month	95.00%	87%	amber	Local Induction compliance stands at 87% at the end of December; down from 88% in November. All of our new joiners are expected to have completed a local induction within their first 4 weeks of employment; the December figure represents all those who joined in the 12 months to the end of November 2014. To improve compliance for this metric, the Divisions and Corporate Directorates continue to use a detailed (employee level) monthly report to focus efforts in areas where there compliance is low. In addition, a number of strategies are in place within the Divisions to ensure compliance for this key people metric; weekly and monthly monitoring discussions, with line managers responsible for areas with low compliance, take place with locally agreed improvement plans for progress, also departments are identified that have specific issues to focus support and help improve their performance against this metric. Within the Divisions, compliance ranges from

Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr2	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Staffing: Nursing, midwifery and care staff															
Average fill rate - registered nurses/midwives (%) - Day		Monthly	tbc	n/a	n/a	94.23%	95.32%	95.97%	95.05%		95.46%				Contractual
Average fill rate - care staff (%) - Day		Monthly	tbc	n/a	n/a	89.81%	93.82%	92.82%	91.61%		92.62%				Contractual
Average fill rate - registered nurses/midwives (%) - Night		Monthly	tbc	n/a	n/a	96.53%	97.75%	97.55%	97.30%		97.50%				Contractual
Average fill rate - care staff (%) - Night		Monthly	tbc	n/a	n/a	94.21%	97.16%	96.74%	96.06%		96.59%				Contractual

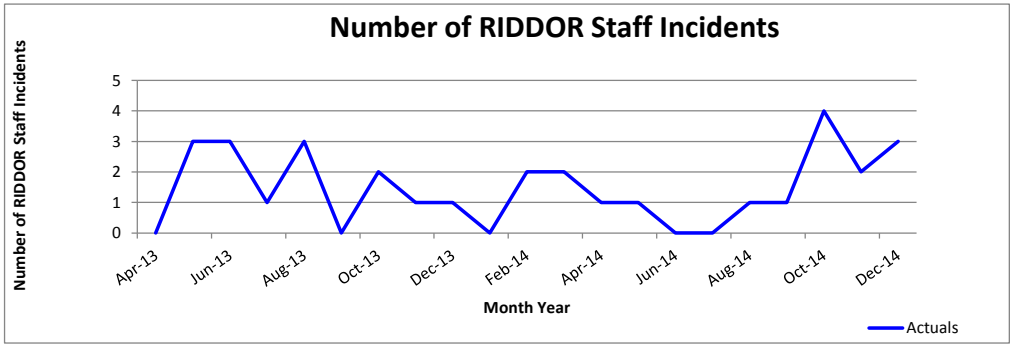


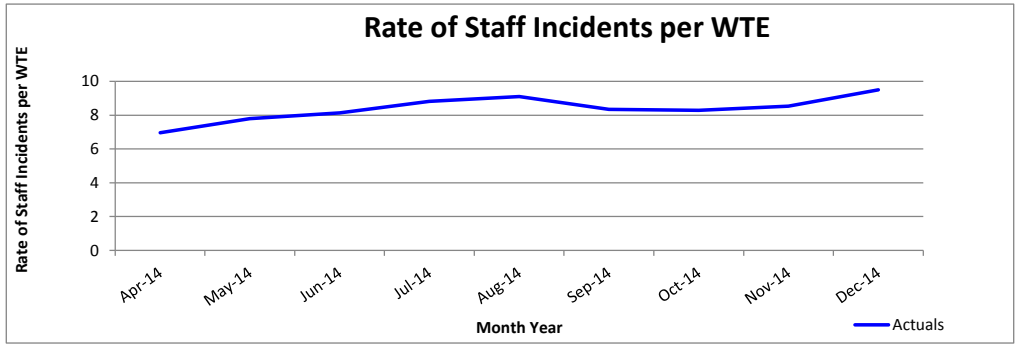






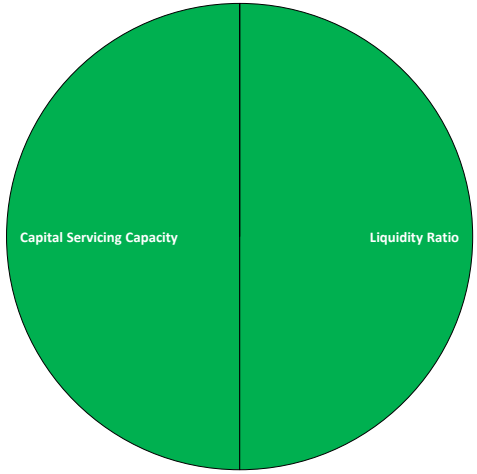
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Health and Safety															
Number of RIDDOR Staff Incidents	-	Monthly	tbc	1	4	3	2	2	9		13				Internal
Rate of Staff Incidents per WTE	-	Monthly	tbc	n/a	n/a	9.50	7.93	8.76	8.78		8.39				Internal





Domain Lead:
Alan Goldsman

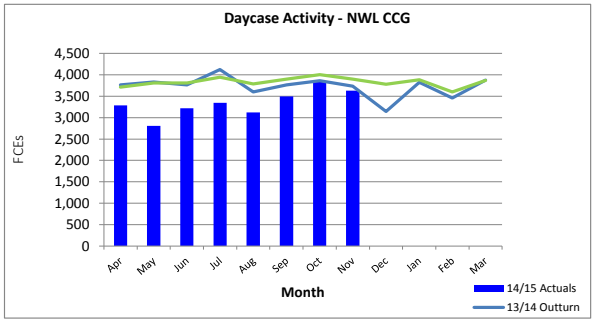
Finance - Continuity of Services Risk Rating

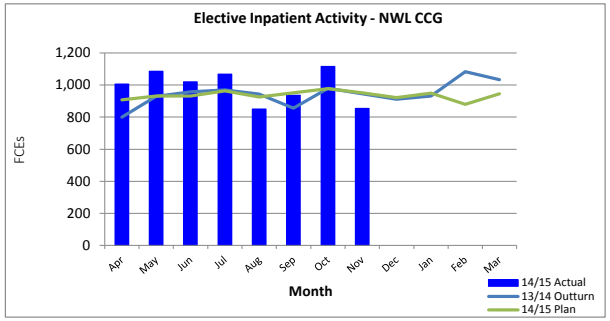


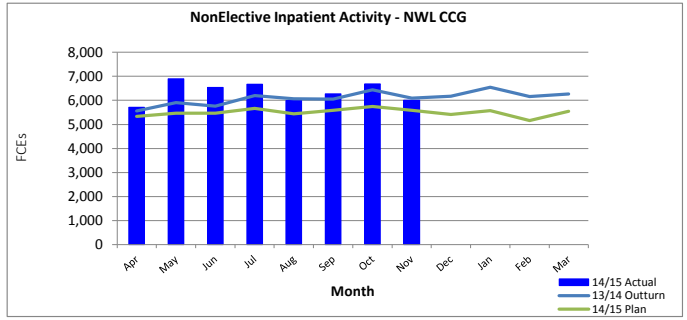
Indicator	Leading	Frequency	Weighting	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Performance Current Year To Date Q1	Performance Current Year To Date Q2	Performance Current Year To Date Q3	Performance Current Year To Date Q4	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Continuity of Service Risk Rating														
Liquidity Ratio		Monthly	>50%	n/a	2	3	3	3	3					
Capital Servicing Capacity		Monthly	>50%	n/a	2	4	3	4	4					
Overall Continuity of Service Risk Rating						4	3	4	4					

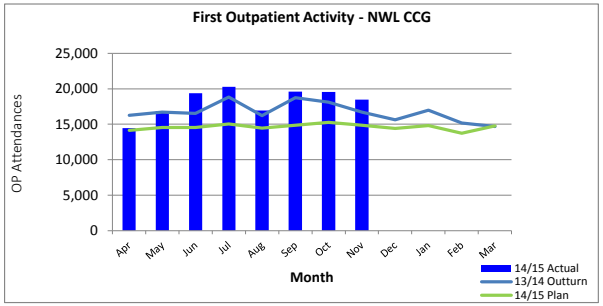
Activity performance against plans commissioned by NWL CCG

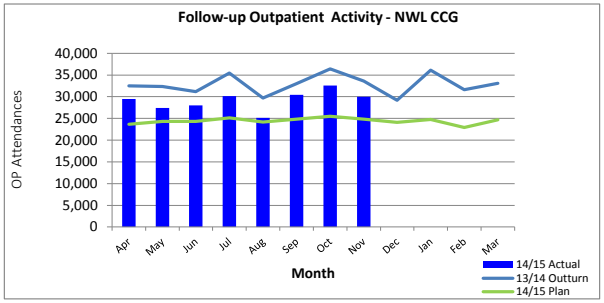
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Nov	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Source Framework
Daycases		Month	>3896	3,736	11,490	3,628	9,304	9,963	7,484		26,751				Contractual
Elective Inpatients		Month	>952	946	2,769	855	3,113	2,856	1,972		7,941				Contractual
NonElective Inpatients		Month	>5591	6,098	18,316	6,008	19,157	18,932	12,698		50,787				Contractual
First Outpatient		Month	>14854	16,700	53,760	18,461	50,658	56,839	38,021		145,518				Contractual
Follow-up Outpatient		Month	>24822	33,634	98,110	29,979	84,919	85,657	62,547		233,123				Contractual
Adult Critical Care		Month	>1610	1,536	4,667	1,539	5,259	5,429	3,345		14,033				Contractual
A&E Attendances		Month	>11971	10,869	35,547	10,106	34,487	31,346	20,403		86,236				Contractual
Regular Day Attender		Month	>227	248	670	150	854	653	323		1,830				Contractual

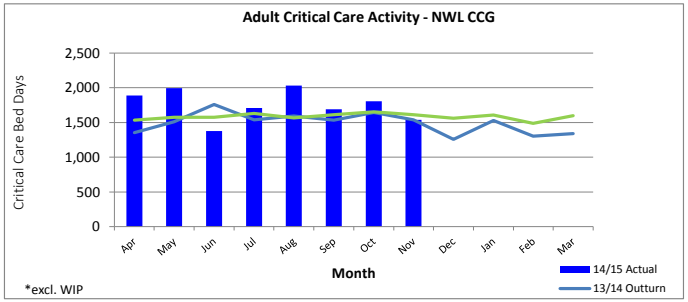


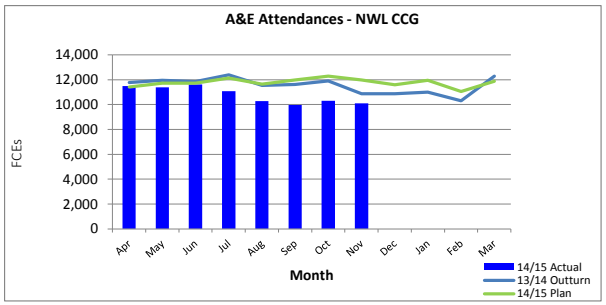


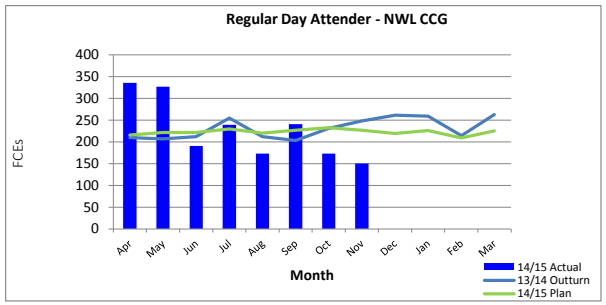












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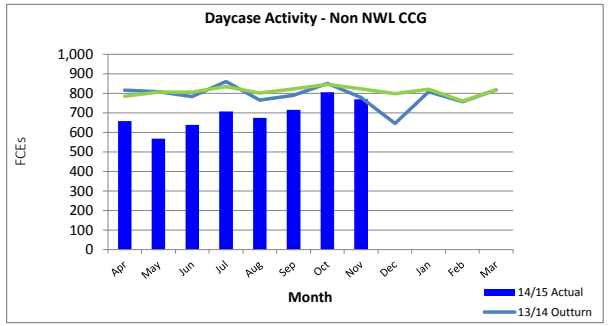
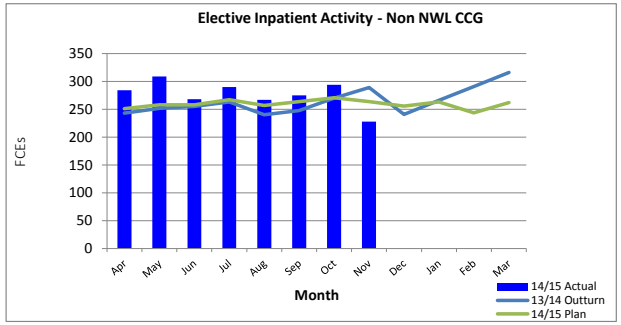
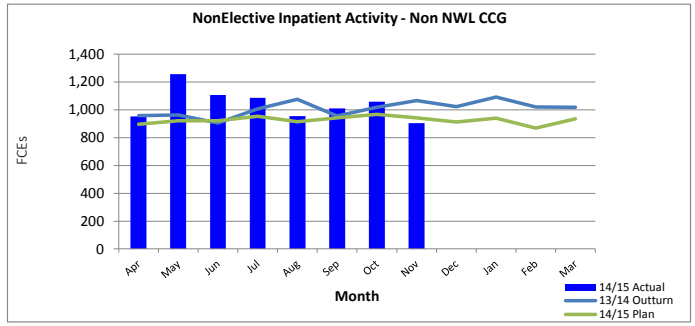
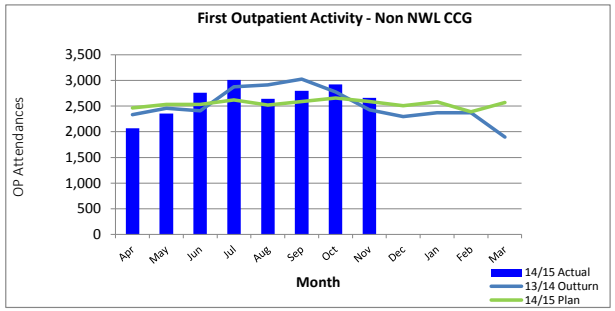
Activity performance against plans commissioned by Non NWL CCG

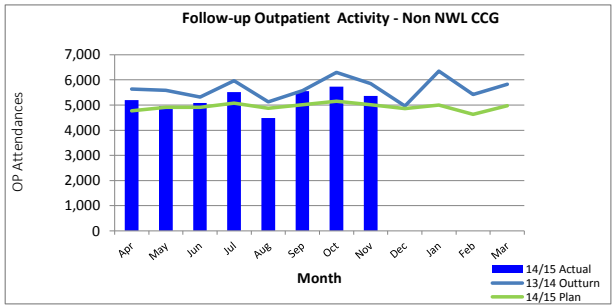
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Nov	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Source Framework
Daycase		Month	>824	779	2,417	769	1,864	2,096	1,574		5,534				Contractual
Elective Inpatients		Month	>264	289	751	228	861	832	522		2,215				Contractual
NonElective Inpatients		Month	>941	1,067	3,036	904	3,316	3,049	1,962		8,327				Contractual
First Outpatient		Month	>2588	2,426	8,810	2,660	7,181	8,441	5,584		21,206				Contractual
Follow-up Outpatient		Month	>5012	5,851	16,674	5,359	15,234	15,550	11,088		41,872				Contractual
Adult Critical Care		Month	>347	305	962	235	837	882	658		2,377				Contractual
Regular Day Attender		Month	>34	50	97	58	248	177	114		539				Contractual

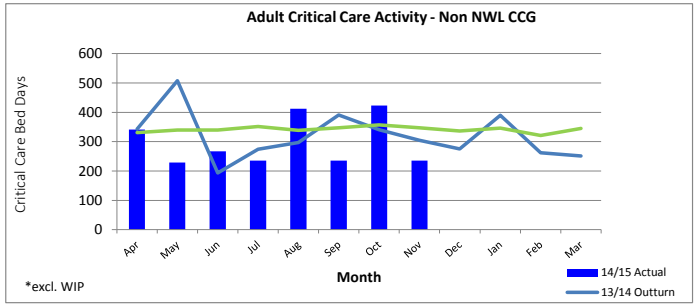


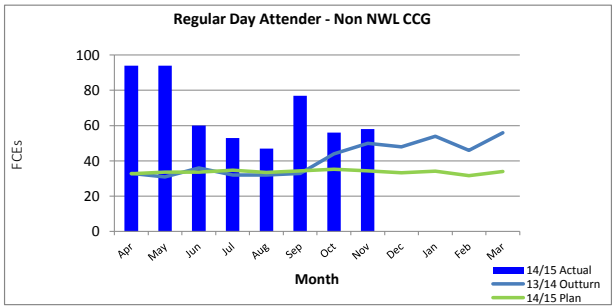












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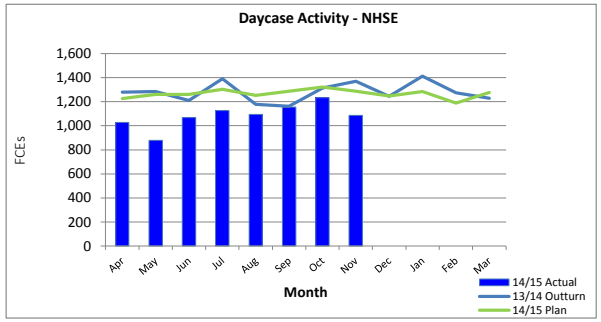
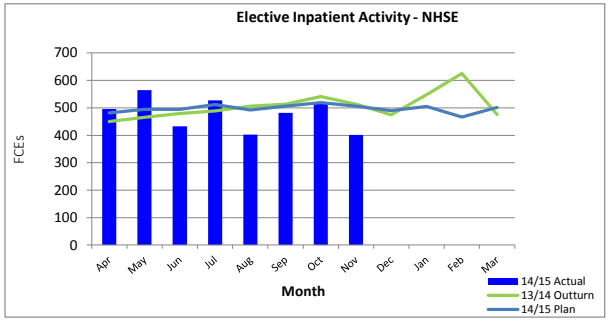
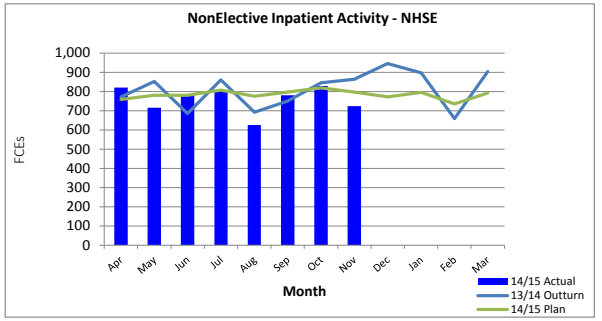
Activity performance against plans commissioned by NHSE

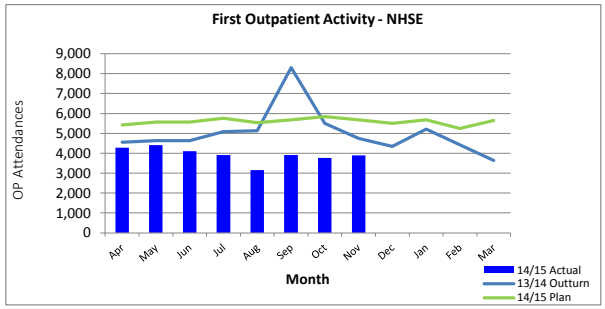
Imperial College Healthcare NHS Trust

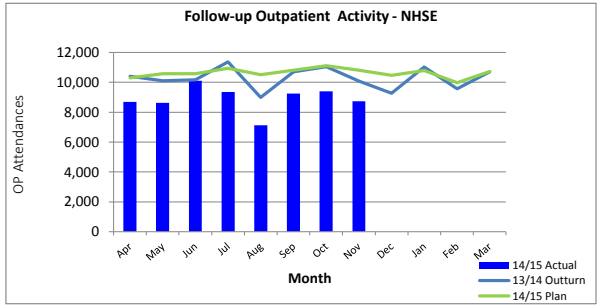
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Nov	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Source Framework
Daycase		Month	>1286	1,369	3,732	1,086	2,974	3,372	2,318		8,664				Contractual
Elective Inpatients		Month	>506	513	1,508	401	1,494	1,411	919		3,824				Contractual
NonElective Inpatients		Month	>797	864	2,303	724	2,319	2,211	1,553		6,083				Contractual
First Outpatient		Month	>5685	4,747	18,502	3,891	12,790	10,979	7,651		31,420				Contractual
Follow-up Outpatient		Month	>10811	10,076	31,084	8,741	27,431	25,737	18,131		71,299				Contractual
Adult Critical Care		Month	>1403	1,733	3,795	1,113	3,756	5,638	2,505		11,899				Contractual
A&E Attendances		Month	>2	0	9	2	7	6	3		16				Contractual
Regular Day Attender		Month	>1032	999	3,201	850	2,452	2,455	1,717		6,624				Contractual

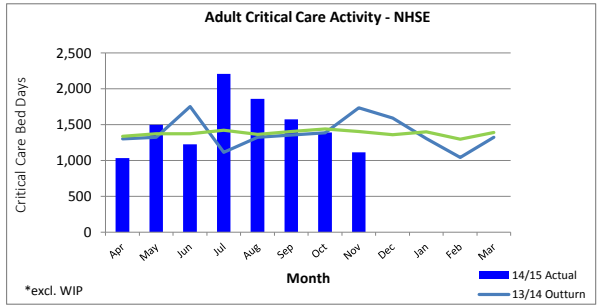


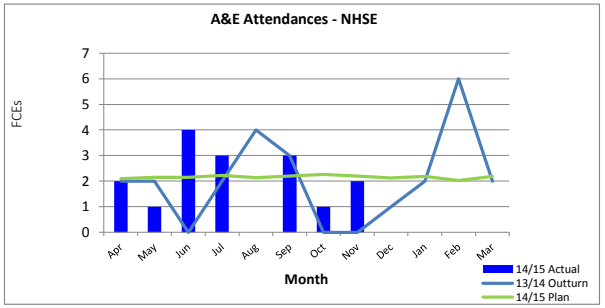


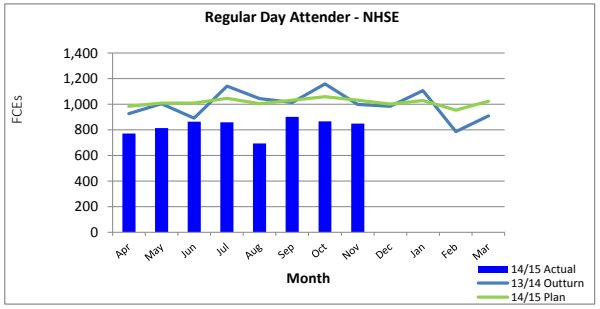












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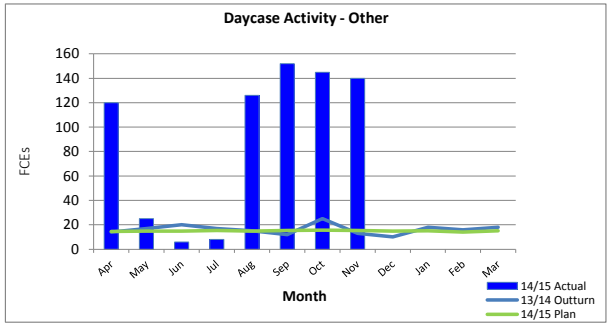
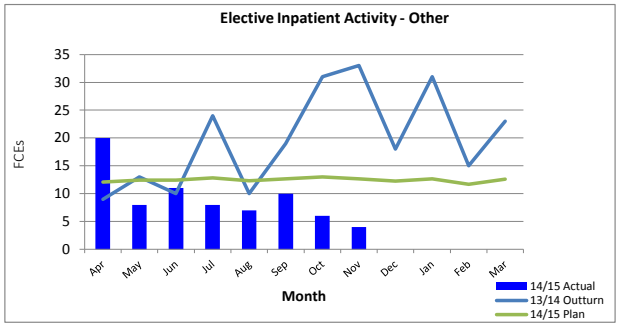
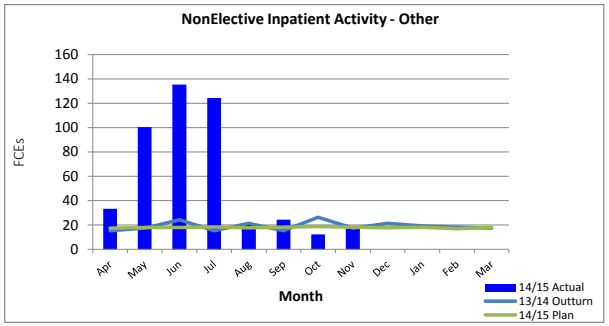
Activity performance against plans commissioned by Other

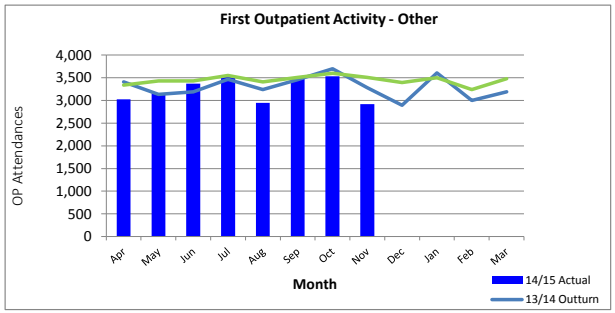
Imperial College Healthcare NHS Trust

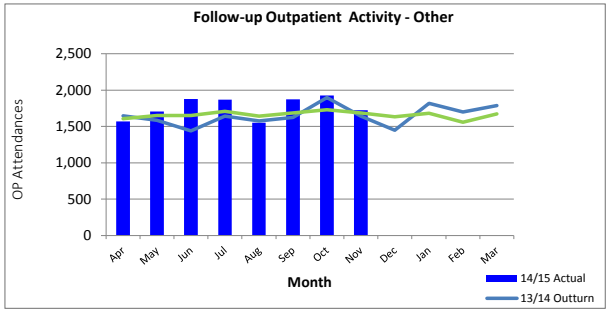
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Nov	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 3 14/15	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Source Framework
Daycases		Month	>15	13	44	140	151	286	285		722				Contractual
Elective Inpatients		Month	>13	33	53	4	39	25	10		74				Contractual
NonElective Inpatients		Month	>18	17	52	17	269	169	30		468				Contractual
First Outpatient		Month	>3504	3,283	10,159	2,918	9,544	9,957	6,451		25,952				Contractual
Follow-up Outpatient		Month	>1687	1,641	4,845	1,726	5,154	5,297	3,652		14,103				Contractual
Adult Critical Care		Month	>22	8	52	0	70	24	3		97				Contractual
Regular Day Attender		Month	0	0	0	0	30	5	1		36				Contractual

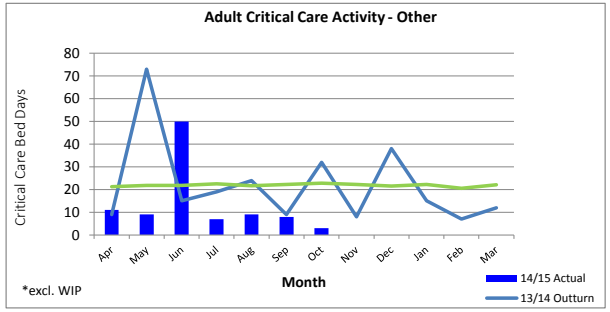


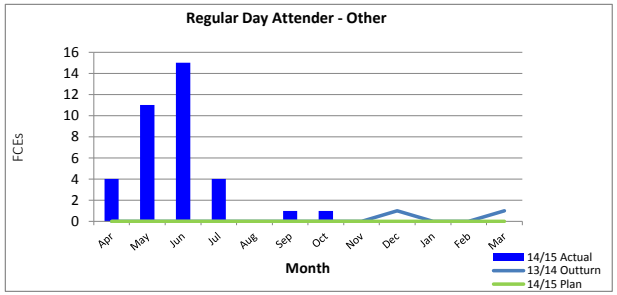












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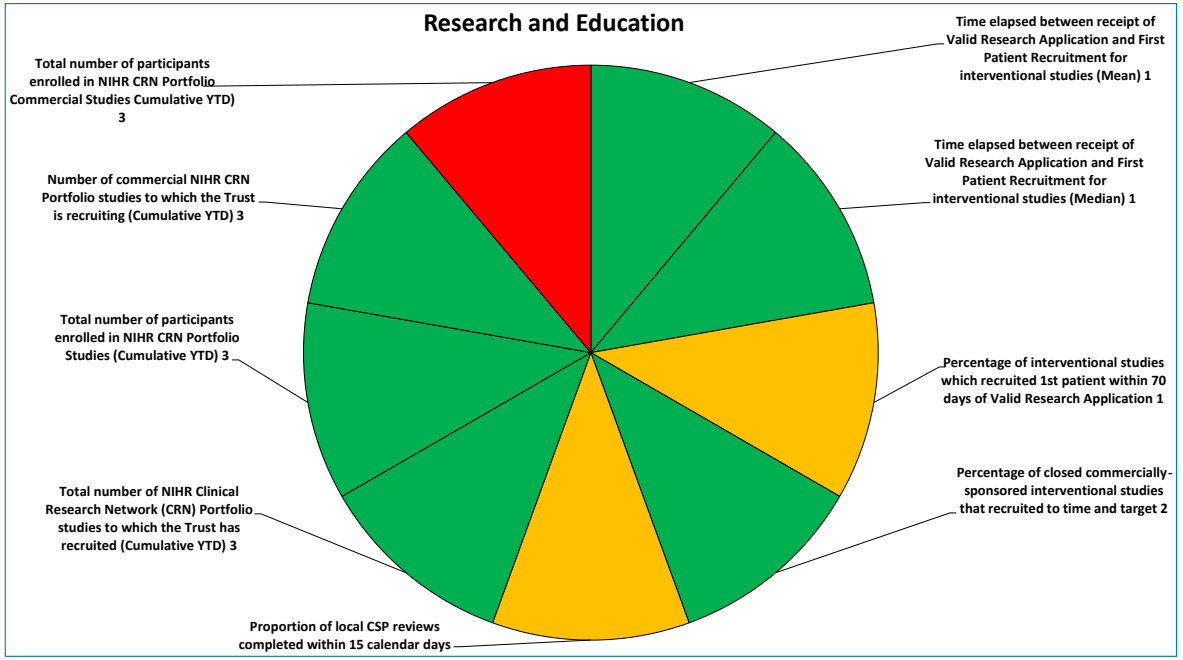

Research and Education
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Mean) 1
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Median) 1
Percentage of interventional 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
Proportion of local CSP reviews completed within 15 calendar days
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 3
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3
Total number of participants enrolled in NIHR CRN Portfolio Commercial Studies Cumulative YTD) 3

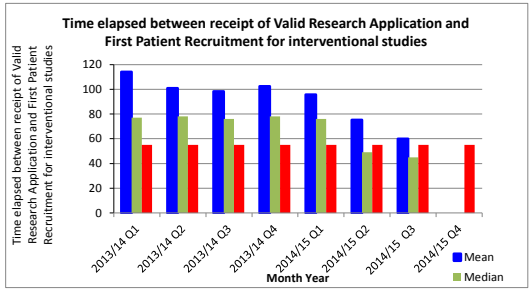
Indicator	Leading	Frequency	Threshold	Performance in 2013/2014 Q3	Performance Current Q1-14	Q2-14	Q3-14	Q4-15	YTD	Forecast Qtr 4 14/15	Qtr 1 15/16	Qtr 2 15/16	Source Framework
Research & Development													
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Mean)** 1		Quarterly	<=70	98	95.7	75	60		77				Define
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Median)** 1		Quarterly	<=55	76	76.0	49	45		57				Define
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 2		Quarterly	>=70%	30.0%	57.1%	63.5%	67.5%		62.7%				Define
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 1		Quarterly	>=60%	60.6%	70.4%	72.2%	75.5%		72.7%				Define
Proportion of local CSP reviews completed within 15 calendar days 3		Quarterly	>=70%	74.2%	47.2%	59.2%	56.5%		54.3%				Define
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 4		Quarterly	>291	291	176	235	296		236				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3		Quarterly	>9211	9211	2933	5929	8887		5916				Define
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3		Quarterly	>51	51	24	40	53		39				Define
Total number of participants enrolled in NIHR CRN Portfolio Commercial Studies Cumulative YTD) 3		Quarterly	>554	554	128	308	395		277				Define

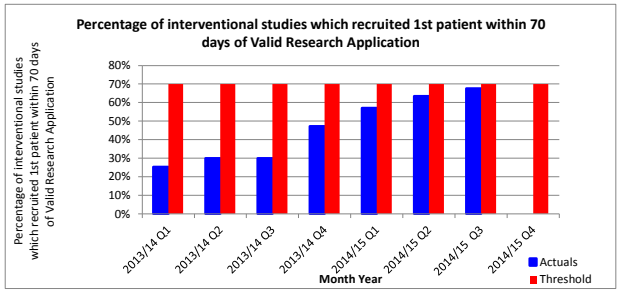
[1] Data source: ICHNT quarterly returns to NIHR CCF (Q3 data is provisional and subject to NIHR verification – Q3 return due to be submitted end of January 2015)

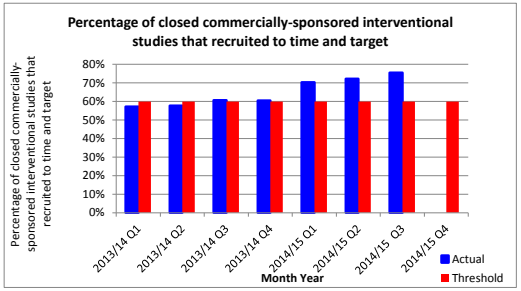
[2] Data source: Q2 14/15 Mean and median are verified and final figures from the NIHR CCF Q2 Report. Figure on percentage of studies that recruited in <70 days under KPI #2 is provisional and is being reviewed by NIHR.

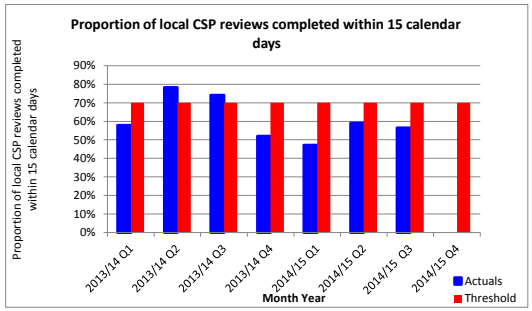
[3] Data source: NIHR Open Data Platform download for current YTD (13Jan2015)

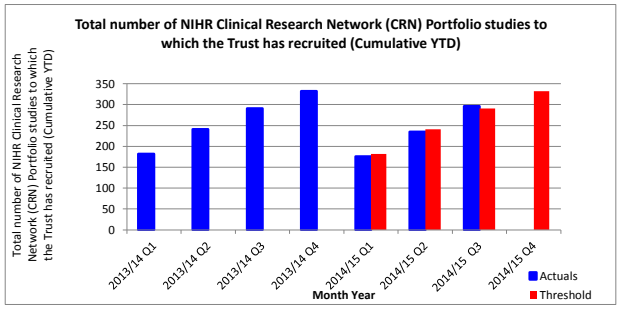
[4] Data source: NIHR Open Data Platform www.odp.nihr.ac.uk/ Period analysed = Q1 (April to June); Q2 (April to September); Q3 (April to December) and Q4 (April to March) in each FY.

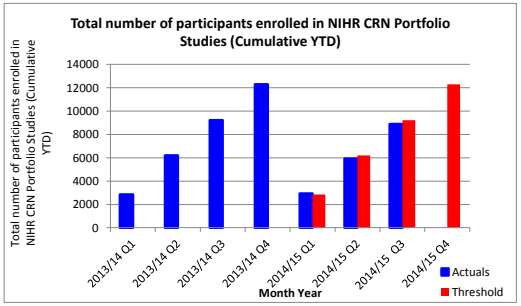


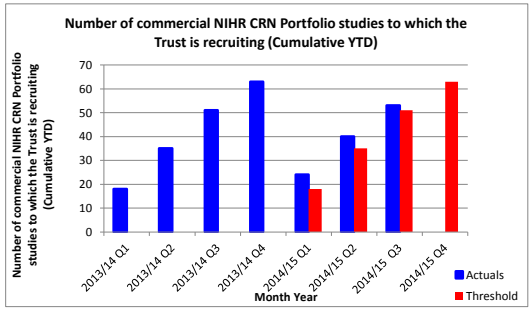


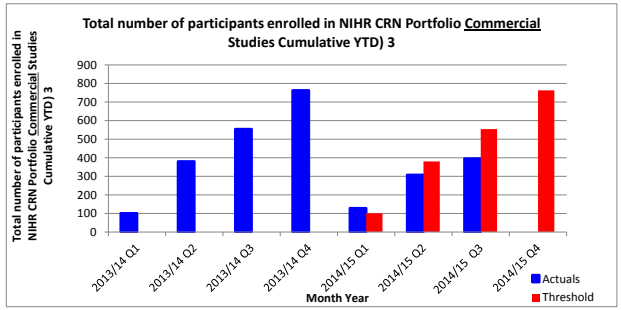




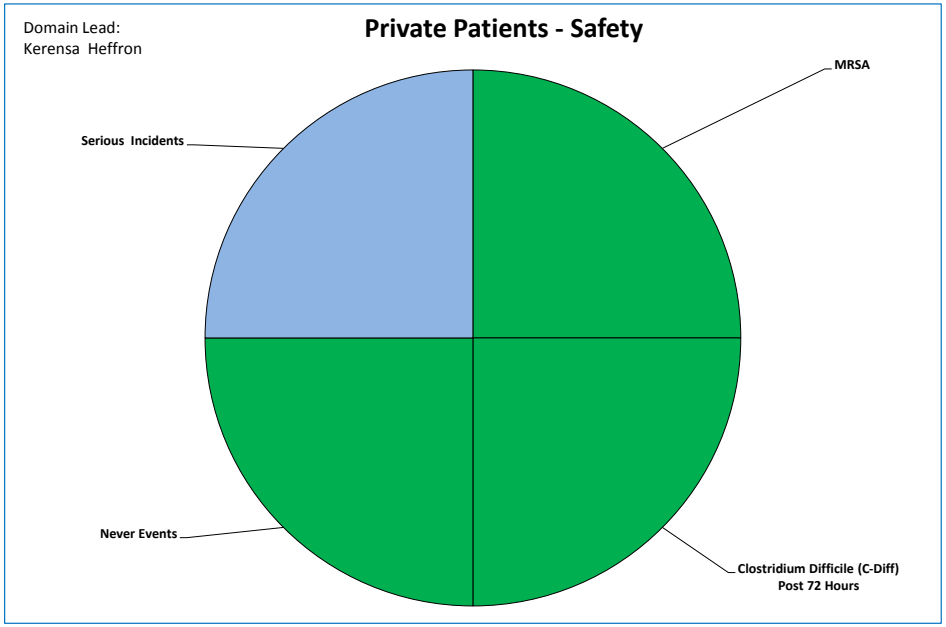








Domain Lead:
Kerensa Heffron



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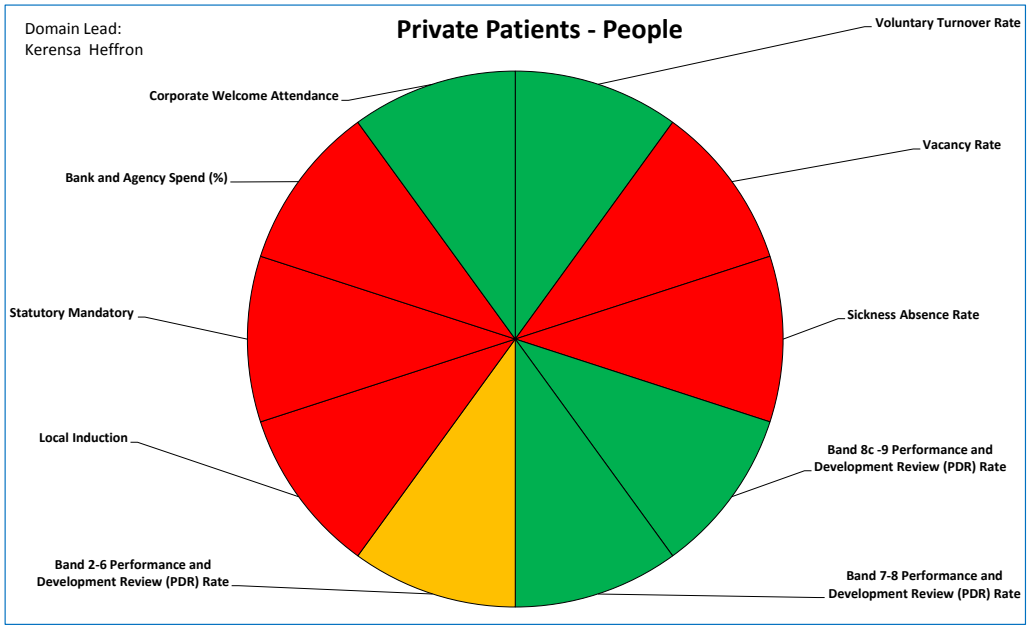
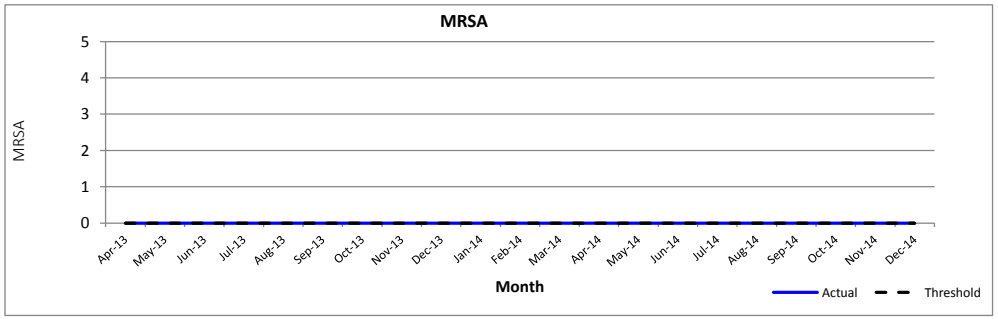
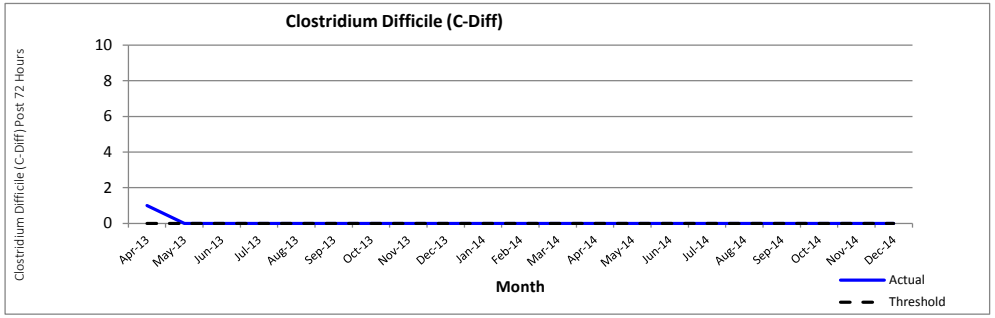
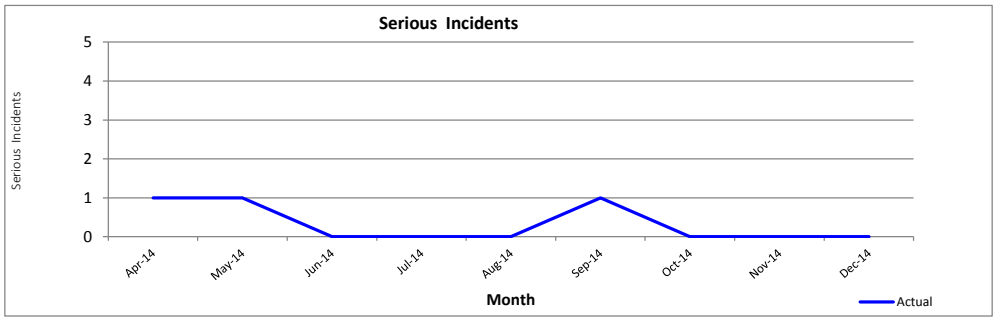
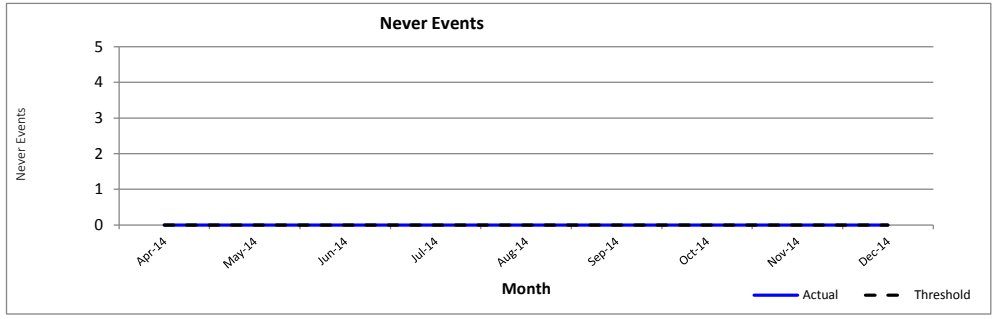


Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Infection Control															
MRSA	-	Monthly	0	0	0	0	0	0	0		0				TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	-	Monthly	0 p/a	0	0	0	0	0	0		0				Mon, TDA, CQC
Incidents															
Never Events	-	Monthly	0	0	0	0	0	0	0		0				TDA, CQC
Serious Incidents	-	Monthly	n/a	0	0	0	2	1	0		3				TDA, CQC

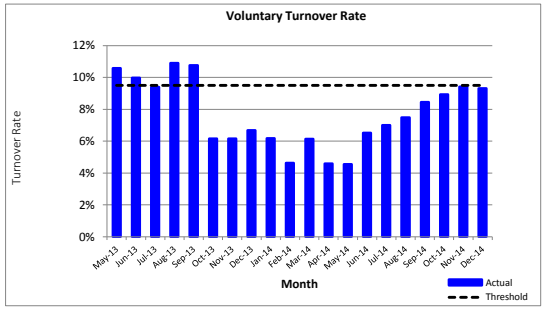


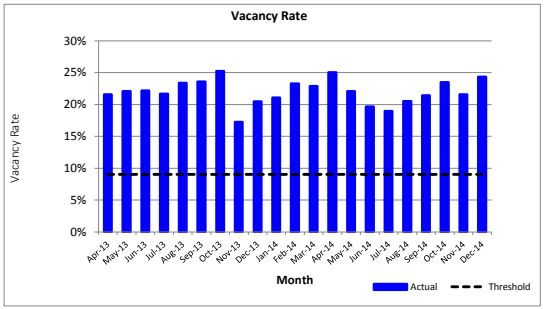


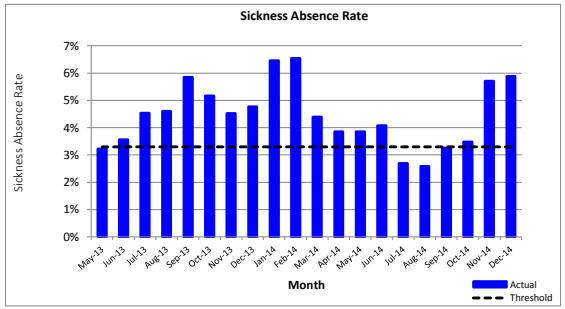


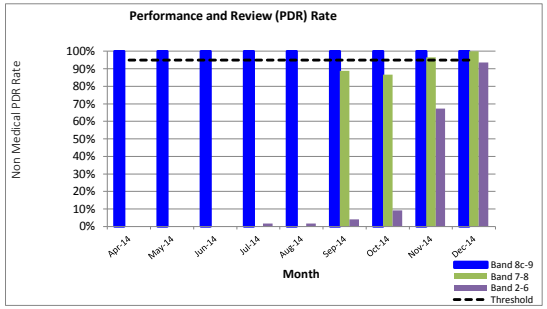


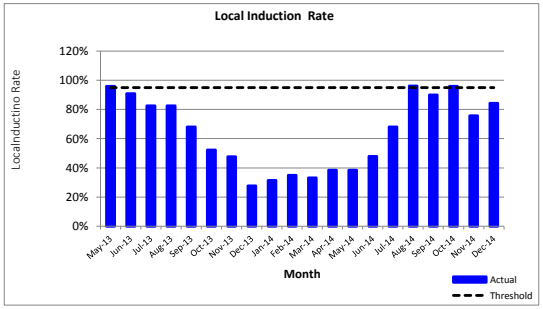
Indicator	Leading	Frequency	Monthly Threshold	Performance in 2013/14 Dec-13	Performance in 2013/14 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Q4	Rolling 12 Months Position	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Turnover & Vacancy Rate															
Voluntary Turnover Rate	✓	Monthly	<9.50%	6.68%	6.33%	9.32%	5.22%	7.65%	9.22%		9.32%				TDA
Vacancy Rate	✓	Monthly	<9.00%	20.47%	20.99%	24.32%	21.43%	20.28%	23.12%						CQC
Sickness Absence Rate	✓	Monthly	<3.4%	4.77%	4.82%	5.88%	3.93%	2.85%	5.02%		4.37%				CQC
Appraisal Rates															
Band 8c -9 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	100.00%	100.00%	100.00%	100.00%						Define
Band 7-8 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	100.00%	n/a	88.89%	94.41%						Define
Band 2-6 Performance and Development Review (PDR) Rate	✓	Monthly	>95.00%	n/a	n/a	93.57%	n/a	4.02%	93.57%						Define
Training Compliance															
Local Induction	✓	Monthly	>95.00%	27.78%	42.59%	84.38%	41.64%	84.70%	85.41%						Define
Statutory Mandatory	✓	Monthly	>95.00%	66.67%	65.90%	78.68%	66.32%	67.70%	77.30%						Define
Bank and Agency Spend															
Bank Spend (%)	✓	Monthly	<7.00%	n/a	n/a	9.21%	10.85%	8.42%	9.03%		18.29%				Define
Agency Spend (%)	✓	Monthly	<7.00%	n/a	n/a	15.47%	9.50%	14.66%	13.46%						Define
Corporate Welcome															
Corporate Welcome Attendance	✓	Monthly	>100.00%	n/a	n/a	100.00%	70.84%	100.00%	100.00%						Define

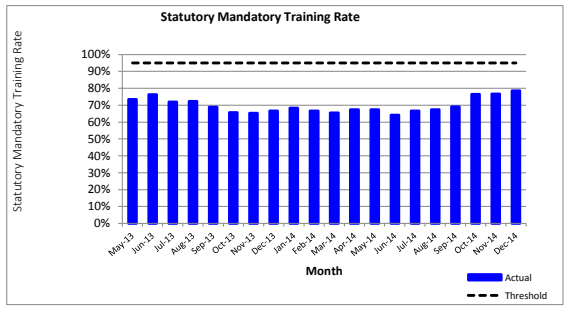


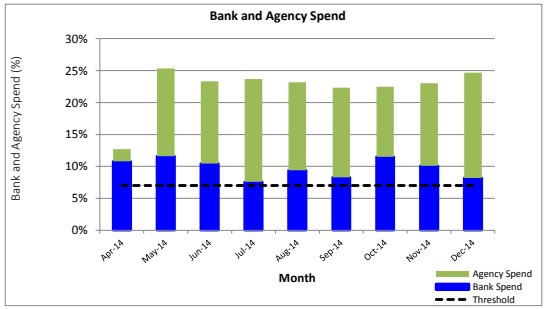


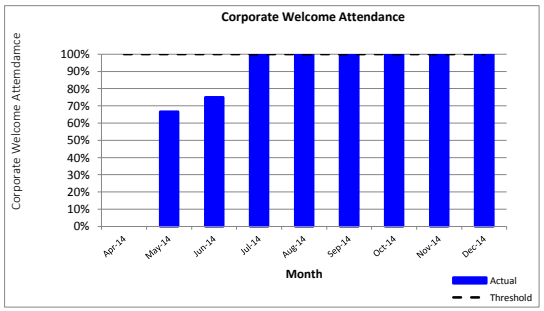












Domain	Sub-domain	Page number	Indicator title	Description
Summary	Finance	3	Capital Servicing Capacity	The Capital Servicing Capacity indicates the degree to which the organisation's generated income covers its financing obligations. A high rating indicates that the Trust has a low risk of defaulting.
Summary	Finance	3	Liquidity ratio	The Liquidity ratio is based on a calculation of the Trust's available capital against outstanding debt. A high rating indicates that the Trust has a low risk of defaulting.
Summary	Access	3	18 weeks referral to treatment	Patients have a legal right to commence NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate to do so. The Trust's service-level waiting times can be compared to other Healthcare Providers across England.
Summary	Access	3	2 week wait from referral to date first seen all urgent referrals	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where cancer is suspected.
Summary	Access	3	2 week wait from referral to date first seen breast cancer	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where breast cancer is suspected.
Summary	Access	3	31 days standard from diagnosis to first treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat to the start of their treatment.
Summary	Access	3	31 days standard to subsequent cancer treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat to their subsequent treatment.
Summary	Access	3	62 day wait for first treatment from NHS Screening Services referral / GP referral	In cases where a patient has been referred for suspected cancer, and where cancer has subsequently been confirmed, patients have a right to commence NHS treatment within a maximum of 62 days from referral for suspected cancer.
Summary	Access	3	A&E maximum waiting times 4 hours	Patients should be seen, treated, admitted, or discharged in under four hours of presenting at A&E. The national target is 95%.
Summary	Outcomes	3	Clostridium Difficile (C-Diff) Post 72 hours	Clostridium Difficile (C-Diff) is a type of infectious diarrhoea that can be difficult to treat due to antibiotic resistance. This rating indicates the number of cases of C-Diff infections within the Trust during the reporting period. A high number may be indicative of infection control issues, such as hand hygiene.
Summary	Governance	3	CQC Judgements – warning notice issued, civil and / or criminal action initiated	In Foundation Trusts, Monitor can assign a red rating for governance concern based on CQC warning notices issued or Civil and/or criminal action initiated
Summary	Governance	3	Third party reports from e.g. GMC, Ombudsman, medical Royal Colleges etc – judgement based on severity and frequency of reports	In Foundation Trusts, Monitor can assign a red rating for governance concern based on ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports, Health & Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges etc. The judgement would be based on the severity and frequency of reports.
CQC	CQC	4	MRSA (latest CQC report)	This rating indicates the total number of incidences of MRSA within the Trust, as reported in the most recent CQC report.
CQC	CQC	4	Clostridium Difficile (latest CQC report)	This rating indicates the total number of incidences of C-Diff within the Trust, as reported in the most recent CQC report.

Domain	Sub-domain	Page number	Indicator title	Description
Quality	Safety	6	Hospital Standardised Mortality Rate (HSMR)	The HSMR is an indicator of healthcare quality that measures the number of deaths in the Trust, during the patients' stay at the Trust, and which is adjusted for a variety of factors (i.e. age, poverty, treatments offered).
				A score of 100 indicates that the number of deaths within the Trust is similar to what you would expect. A higher score means more deaths than expected, which may result from patient safety or clinical quality issues.
Quality	Safety	6	Summary Hospital Mortality Indicator	The SHMI is an indicator of healthcare quality that measures whether the number of deaths in the Trust, or within 30 days of the patient's discharge, is higher or lower than you would expect.
				A score of 100 indicates that the number of deaths within the Trust is similar to what you would expect. A higher score means more deaths than expected, which may result from patient safety or clinical quality issues.
Quality	Safety	6	Number of Dr Foster morality alerts	Dr Foster Mortality alerts are sent to the Chief Executive of the Trust when the HSMR has, on at least one occasion in the preceding three months, reached double the expected rate for a particular diagnosis or procedure.
				This rating indicates the total number of Mortality alerts that have been sent to the Chief Executive of the Trust and may require investigation of the safety and quality of clinical care provided.
Quality	Safety	6	Number of deaths in low risk diagnostic groups	This indicator aims to identify deaths that are likely to be attributable to health care errors by measuring deaths in patients admitted with, or for, a condition or procedure that has a low associated risk of death (i.e. headaches; tonsillectomy).
				This rating indicates the total number of deaths in low risk diagnostic groups during the reporting period.
Quality	Safety	7	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 total number of incidences of MRSA within the Trust during the reporting period.
Quality	Safety	7	Clostridium Difficile (C-Diff) Post 72 Hours	Clostridium Difficile (C-Diff) is a type of infectious diarrhoea that can be difficult to treat due to antibiotic resistance.
				This rating indicates the number of cases of C-Diff infections within the Trust during the reporting period. A high number may be indicative of infection control issues, such as hand hygiene.
Quality	Safety	7	Never Events	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (i.e. wrong site surgery; wrong route administration of chemotherapy; retained instrument post-operation). 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.
Quality	Safety	7	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 (i.e. Grade 3/4 pressure ulcer; data loss; HCAI outbreak; Never Events)
				This rating indicates the number of SUIs that have occurred within the Trust during the reporting period.
Quality	Safety	7	Harm Free Care (Safety Thermometer)	Delivering Harm Free Care is a core component of the care that we provided to our patients. Harm Free Care is care that is provided in the absence of the four common harms: Pressure Ulcers; Falls; Catheter Associated Urinary Tract Infections (CAUTIs); and Venous Thromboembolism (VTE).
				This rating indicates the percentage of patients that received Harm Free Care at the Trust. A decreasing trend may indicate issues with the quality and safety or care provided to patients.
Quality	Safety	7	VTE Risk Assessments	A VTE (Venous Thromboembolism) is a blood clot that forms within a vein and is a serious, potentially fatal, medical condition. VTE Risk Assessments should be undertaken for every patient within 1 hour of admission.
				The rating indicates the percentage of patients that had a VTE risk assessment undertaken within 1 hour of admission.
Quality	Patient Centredness	8	Inpatients Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's Inpatient services to their friends and family if they needed similar care or treatment.
				The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.
Quality	Patient Centredness	8	Inpatients Net Promoter Response Rate	It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas.
				The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.
Quality	Patient Centredness	8	A&E Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's A&E services to their friends and family if they needed similar care or treatment.
				The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.
Quality	Patient Centredness	8	A&E Net Promoter Response Rate	It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas.
				The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.
Quality	Patient Centredness	8	Maternity Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's Maternity services to their friends and family if they needed similar care or treatment. Women will be asked for their views on their maternity services at three touch points: antenatal care; birth and care on the postnatal ward; and postnatal community care.
Quality	Patient Centredness	8	Maternity Net Promoter Response Rate	The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.
				It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas.
				The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.
Quality	Patient Centredness	8	Number of complaints received	When things do not go according to plan, a patient may decide to formally complain to the organisation. This will usually result in an investigation into the concerns raised and a formal response to the complainant.
				This rating indicates the total number of complaints received by the Trust within the reporting period. A high number of complaints, or an unexpected or prolonged rise in complaints, may warrant extra investigation into the matter.
Quality	Patient Centredness	8	PLACE – Cleanliness; Facilities; Food; Privacy, Dignity, & Well being;	PLACE (Patient-led Assessments of the Care Environment) replaced the PEAT (Patient Environment Action Team) inspections in 2013. These are undertaken annual by teams, which include local people, to assess how the environment supports the patients' privacy and dignity, food, cleanliness, and general building maintenance.
				This rating indicates how the Trust fared for each of the separate areas (i.e. cleanliness, food). The higher the percentage, the better the score.

Domain	Sub-domain	Page number	Indicator title	Description
Quality	Patient Centredness	8	(TC6) Involvement in care	"The most important goal of a modern health service is to achieve authentic patient participation. The lessons of the Francis inquiry into Stafford hospital are that the absence of patient participation is the root cause of poor care." - Tim Kelsey, Director, NHS-England. Engagement increases the likelihood of successful treatment, whilst also improving our patients' experience.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff have involved patients in the development of their treatment plans.
Quality	Patient Centredness	8	[illegible]	Patients attending the Trust may require support in dealing with their worries and fears during their visit. Overcoming these obstacles is more likely to increase patient engagement with our services, whilst also improving their overall experience.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff provide sufficient support to patients to overcome their worries and fears.
Quality	Patient Centredness	8	(LQ35a) Did you get enough help from staff to eat your meals?	Some people may require extra help to ensure that they receive adequate nutrition whilst in hospital. It is important that we identify these patients and support them appropriately, as eating and drinking well while in hospital can help our patients get better sooner and reduce the risk of complications.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff assisted our patients to eat their meals.
Quality	Patient Centredness	8	(CLQ14) Do you think hospital staff did everything they could to help control your pain?	Good pain control can help to reduce risks and reduce the patient's length of stay in the hospital. If it is not well controlled, patients may, for example, not be able to breathe deeply or cough, increasing their risk of developing a chest infection; or they may not be able to walk or sit out in a chair, thereby increasing their risk of developing a deep vein thrombosis.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff are suitably skilled to ensure that our patients were as comfortable, and pain free, as possible during their stay.
Quality	Patient Centredness	8	(CLQ29) Did you have confidence and trust in the doctors treating you?	It is important that patients have confidence in our doctors, and that they feel that they can trust them. This provides an element of security for the patient and allows them to engage with the service, i.e. by making informed choices about their care.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that patients trust our doctors to treat them.
Quality	Patient Centredness	8	(CLQ10) Did you have confidence and trust in the nurses treating you?	It is important that patients have confidence in our nurses, and that they feel that they can trust them. This provides an element of security for the patient and allows them to engage with the service, i.e. by making informed choices about their care.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that patients trust our nurses to treat them.
Quality	Patient Centredness	8	(LQ36) Have you been treated with dignity and respect by staff on this ward?	It is important to ensure our patients are treated with dignity and respect, as evidence has shown a link between a failure to do so with a drop in both the patient experience and the quality of care that they experience.
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that the organisation treats our patients with dignity and respect in a consistent manner.
Quality	Patient Centredness	8	Safeguarding Adults : Referrals per month	The NHS has a key role to play in preventing all forms of harm, abuse and neglect, to our patients. Where abuse is suspected (whether physical, verbal, sexual, financial, or neglect), there is a duty to report this by raising a Safeguarding Alert. Safeguarding alerts generally regard external organisations (i.e. nursing homes; NHS providers).
				This rating indicates the total number of safeguarding adults referrals were made in the previous month. A significant increase in the number of referrals may warrant further investigation and escalation to our commissioners, whilst a significant decrease may indicate underreporting of safeguarding concerns.
Quality	Effectiveness	9	Stroke Care : % of patients scanned within 1 hr of arrival at hospital	Stroke is a preventable and treatable disease that affects approximately 110,000 people in England each year. A stroke occurrs when the blood supply to part of the brain is cut off, which can be caused by a blockage within one of the vessels within the brain or a bleed in the brain. Early intervention is linked with better patient outcomes, including reduced morbidity and dependency.
				This rating indicates the proportion of patients that had a brain scan within 1 hour of arrival at the hospital. A higher percentage means that we are ensuring that our patients are receiving the right diagnostic intervention at the right time.
Quality	Effectiveness	9	Stroke Care : % of potentially eligible patients thrombolysed within 45 Minutes	Thrombolysis is the use of drugs to break up a blood clot. When given in a timely manner, this can significantly improve the outcome for patients, such as a decreased likelihood of complications.
				This rating indicates the proportion of eligible patients that were treated with thrombolysing drugs within 45 minutes of arrival at the hospital.

Domain	Sub-domain	Page number	Indicator title	Description
Quality	Efficiency	10	Theatre Utilisation Rate	Theatres are used to undertake surgical procedures. Well-organised theatres can treat more patients within the same timeframe, making them more efficient. Low utilisation rates may indicate problems with the environment, staff attendance, or poor organisation. This can then impact on the timeliness of care provided to patients awaiting surgery.
Quality	Efficiency	10	Average Length of Stay - Elective	This indicator aims to highlight the average number of days a patient spends in the hospital in relation to a specific elective surgery. An elective surgery is surgery that is scheduled in advance because it does not involve a medical emergency (i.e. a mastectomy or inguinal hernia surgery). Shorter lengths of stay indicates more efficient and effective care, whilst also meaning that the patient is able to return home earlier and recuperate in a familiar surrounding.
				This rating denotes the average number of days a patient spends in hospital in relation to an elective surgery.
Quality	Efficiency	10	Average Length of Stay – Non Elective	This indicator aims to highlight the average number of days a patient spends in the hospital in relation to a specific non-elective surgery. A non-elective surgery is surgery that occurs as a result of a medical emergency (i.e. an injury or illness that is acute and poses an immediate risk to a person's life or long term health). Shorter lengths of stay indicates more efficient and effective care, whilst also meaning that the patient is able to return home earlier and recuperate in a familiar surrounding.
				This rating denotes the average number of days a patient spends in hospital in relation to non-elective surgery.
Quality	Efficiency	10	Pre Op Length of Stay	The number of days that a patient stays in an overnight bed prior to an operation
Quality	Efficiency	10	Post Op Length of Stay	The number of days that a patient stays in an overnight bed following an operation
Quality	Efficiency	10	Day of Surgery Admission	The percentage of patients that are admitted on the day of their surgery
Quality	Efficiency	11	Day Case Rate	The percentage of patients who are admitted to hospital for a planned surgical procedure, returning home on the same day.
Quality	Efficiency	11	DNA – first Appointment	A DNA (Did Not Attend) occurs where a patient fails to attend an arranged appointment without cancelling it beforehand. DNAs cost the NHS an average of £108 per appointment. When a patient DNAs their first appointment, they may be discharged back to their GP.
				This rating details the proportion of first appointments that were marked as 'DNA'.
Quality	Efficiency	11	DNA – follow-up appointment	A DNA (Did Not Attend) occurs where a patient fails to attend an arranged appointment without cancelling it beforehand. DNAs cost the NHS an average of £108 per appointment. When a patient DNAs two follow-up appointments, they may be discharged back to their GP.
				This rating details the proportion of follow-up appointments that were marked as 'DNA'
Quality	Efficiency	11	Hospital Appointment Cancellations (hospital instigated)	Appointments are sometimes cancelled by a service within the hospital. This should only occur in very limited circumstances - such as in an emergency or when a member of staff is ill. Hospital instigated cancellations also impact on the hospital's efficiency and potentially delays treatment for our patients.
				This rating details the proportion of appointments that were cancelled by the hospital. A high percentage may indicate areas of concern which require further investigation.
Quality	Efficiency	11	Appointments Not Checked In or DNA'd (Appointment Date within the last 90 days)	Within any organisation, it is important to monitor and investigation incidences of data quality issues. This indicator aims to highlight potential data quality issues regarding registering patients upon their arrival to the hospital.
				This rating indicates the total number of appointments showing as either 'Not Checked In' (i.e. arrived at the hospital) or 'DNA' (Did Not Attend) within the last 90 days.
Quality	Efficiency	11	Appointments in a status of Checked In but not Checked Out	Within any organisation, it is important to monitor and investigation incidences of data quality issues. This indicator aims to highlight potential data quality issues regarding registering patients upon their arrival to the hospital.
				This rating indicates the total number of appointments showing as 'Checked In' (i.e. arrived at the hospital) within the last 90 days, but where they have not been 'Checked Out' (i.e. had their appointment)

Domain	Sub-domain	Page number	Indicator title	Description
Quality	Timeliness	12	18 weeks referral to treatment	Patients have a legal right to commence NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate to do so.
				The Trust's service-level waiting times can be compared to other Healthcare Providers across England.
Quality	Timeliness	12	A&E maximum waiting times 4 hours	Patients should be seen, treated, admitted, or discharged in under four hours of presenting at A&E. The national target is 95%.
Quality	Timeliness	12	Percentage Cancelled Operations rebooked within 28 days	Where a patient's surgery appointment has been cancelled by the hospital, they have a right to be provided a new appointment date that occurs within 28 days of the original operation.
				This rating indicates the percentage of cancelled operations that were rebooked to occur within 28 days of the original operation.
Quality	Timeliness	12	Percentage Non Clinical Cancelled Operations	Surgical operations may be cancelled for both clinical and non-clinical reasons. The former relates to, for example, where a patient is too unwell to undergo surgery, thereas the latter might occur in instances whereby the theatre is required for an alternate emergency operation. Whilst some cancellations may be unavoidable, it is important to minimise these as it reduces the efficiency of Trust and may be distressing and inconvenient for patients.
				This rating provides a percentage of operations that were cancelled for non-clinical reasons.
Quality	Timeliness	13	2 week wait from referral to date first seen all urgent referrals	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where cancer is suspected.
			2 week wait from referral to date first seen breast cancer	These ratings indicate the percentage of patients that were seen within the 2 week target.
Quality	Timeliness	13	31 days standard from diagnosis to first treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat (either as initial or subsequent treatment) to the start of their treatment.
			31 days standard to subsequent cancer treatment	
				This rating indicates the percentage of patients that were treated within 31 days of a cancer diagnosis, or within 31 days of deciding that subsequent treatment is required.
Quality	Timeliness	13	62 day wait for first treatment from NHS Screening Services referral / GP referral	In cases where a patient has been referred for suspected cancer, and where cancer has subsequently been confirmed, patients have a right to commence NHS treatment within a maximum of 62 days from referral for suspected cancer.
				This rating indicates the percentage of patients that were treated within 62 days of referral for suspected cancer.
Quality	Equity	14	CQUIN – Dementia: Find & Assess; Investigate; & Refer	Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older, and usually occurs in people over the age of 65. Most types of dementia cannot be cured, but its progression can be slowed down it detected early. Therefore, it is important to assess patients at risk of developing patients for signs of dementia, as well as undertaking investigations and referring patients to memory specialists if appropriate.
				This indicator is a combination of three ratings. The first indicator highlights the percentage of eligible patients that were risk assessed. The second highlights the percentage of appropriate patients that underwent further investigation, with the third being the percentage of appropriate patients that were referred onto specialist services.
Quality	Equity	14	Mixed Sex Accommodation	Being in mixed-sex hospital accommodation can be difficult for some patients for a variety of personal and cultural reasons. Therefore, all providers of NHS-funded care are expected to eliminate mixed-sex accommodation (except where it is in the overall best interest of the patient or reflects their personal choice). Hospitals can face a fine of up to £250 for breaching same-sex accommodation guidance.
				This rating highlights the total number of times that the same-sex accommodation guidance was breached during the reporting period.
Quality	Equity	14	Safeguarding Training - Adults; Children (levels 1 - 3)	Everyone has a responsibility for safeguarding vulnerable people, whether children or adults. Safeguarding is the protection of our patients from maltreatment, such as neglect; emotional, physical, sexual, discriminatory, institutional or financial abuse. Our responsibilities include training our staff to ensure that they are competent to identify, and then act on, safeguarding concerns.
				This rating indicates the percentage of staff that have attended their Safeguarding training within the last 3 years.
Quality	Equity	14	Female Genital Mutilation Caseload	The total number of patients identified as having FGM before the Reporting Period Start Date, who are actively being treated on the Trust active caseload
Quality	Equity	14	Patients detained under the Mental Health Act	The number of patients detained under the Mental Health Act 1983 in month

Domain	Sub-domain	Page number	Indicator title	Description
People	People	16	Voluntary Turnover Rate	The turnover rate highlights the rate at which an employer loses and gains employees. A certain amount of turnover is unavoidable, although too much may indicate areas of concern within the organisation. this metric measures the numbers of people who choose to leave the Trust voluntarily and is shown as a percentage of the average numbers of people employed. A certain level of turnover is expected and unavoidable and this metric is used to monitor this and to highlight potential areas of concern, within the organisation, where turnover appears to be higher than expected.
People	People	16	Operating Vacancy Rate	this metric measures the number of positions within the Trust which are vacant and is shown as a percentage of the total number of positions which are required to deliver the Trusts services. It is used to monitor levels of directly employed people, linking to service changes, future requirements and areas where recruitment may be difficult.
People	People	16	Non-recruited Vacancy Rate	this metric measures the number of positions within the Trust which are vacant and which have no appointed candidate waiting to join. It is used to understand levels of recruitment activity and the expected numbers of new joiners in the future.
People	People	16	Sickness Absence Rate	this metric measures the amount of working hours lost to sickness absence and is shown as a percentage of total contracted hours available. It is used to monitor levels of sickness absence, highlighting potential areas of concern when sickness is higher than expected and directing further analysis to understand trends or specific health at work issues.
People	People	16	Consultant Performance and Development Review (PDR) Rate	appraisal is an essential element of the revalidation process and this metric measures the number of Consultants, within the Trust who have had an appraisal during the past year; shown as a percentage of the total number of Consultants within the Trust. This metric is used to monitor compliance and to focus attention on areas where compliance is below expected levels.
People	People	16	Band 8c-9 Performance and Development Review (PDR) Rate	all Trust employees are required to have a PDR each year; reviewing performance over the past year, setting new objectives and creating a personal development plan. This metric allows us to understand and monitor the numbers of completed PDR's and to focus attention on areas where compliance is below expected levels.
People	People	16	Band 7 - 8a Performance and Development Review (PDR) Rate	all Trust employees are required to have a PDR each year; reviewing performance over the past year, setting new objectives and creating a personal development plan. This metric allows us to understand and monitor the numbers of completed PDR's and to focus attention on areas where compliance is below expected levels.
People	People	16	Band 2-6 Performance and Development Review (PDR) Rate	all Trust employees are required to have a PDR each year; reviewing performance over the past year, setting new objectives and creating a personal development plan. This metric allows us to understand and monitor the numbers of completed PDR's and to focus attention on areas where compliance is below expected levels.
People	People	16	Local Induction	when new people join us, it is essential they are fully briefed locally about policies procedures and protocols in the form of a local Induction. This metric measures how many people have completed their local induction and allows us to focus on areas where compliance is lower than expected
People	People	16	Statutory Mandatory	Certain training courses are mandatory and are designed to ensure the safety and well-being of all our staff and patients. It also ensures that staff keep up to date with professional standards. The training includes, amongst others, Fire Training; Safeguarding Training; & Equality and Diversity Training. this metric shows us how many people have completed their statutory (i.e. fire) and other mandatory training. There are over 20 different topics of training which healthcare staff need to complete on a 3 yearly cycle. The metric shows us how many people are up to date with their training and highlights areas where training compliance is below expected levels.
People	People	16	Bank Spend (%)	this metric shows the percentage of the paybill which is attributed to temporary bank and agency workers. It is used to understand levels of temporary staffing required to cover vacancies, sickness absence and increases in activity or capacity alongside the resources available and expected levels of use.
People	People	16	Agency Spend (%)	this metric shows the percentage of the paybill which is attributed to temporary bank and agency workers. It is used to understand levels of temporary staffing required to cover vacancies, sickness absence and increases in activity or capacity alongside the resources available and expected levels of use.
People	People	16	Corporate Welcome Attendance	The Corporate Welcome Attendance is mandatory for all new staff and is an opportunity for staff to familiarise themselves with the Trust, meet new colleagues, and undertake face to face mandatory training courses. this metric shows us how many of our new joiners have attended our essential Corporate Welcome event. This is an important event enabling us to welcome our new joiners and to share with them core Trust messages around patient experience, quality and safety. This metric shows us how many people have competed corporate welcome within 8 weeks of joining.
People	People	18	Average fill rate – nurses / care staff; day / night	The Francis report explicitly stated that poor staffing levels at Mid Staffordshire led to poor quality care. Organisations are now required to publish details of staffing levels on each of their wards every month, including the percentage of shifts that met the safe staffing requirements. This rating indicates the percentage of shifts that met the agreed safe staffing requirements.

Domain	Sub-domain	Page number	Indicator title	Description
Finance	Finance	20	Liquidity ratio	The Liquidity ratio is based on a calculation of the Trust's available capital against outstanding debt. A high rating indicates that the Trust has a low risk of defaulting.
Finance	Finance	20	Capital Servicing Capacity	The Capital Servicing Capacity indicates the degree to which the organisation's generated income covers its financing obligations. A high rating indicates that the Trust has a low risk of defaulting.
Finance	Finance	21 - 23	Daycase	Daycases are elective surgeries that do not usually require a patient to be admitted to hospital (i.e. have an overnight stay). Elective surgeries are scheduled (i.e. a mastectomy or inguinal hernia repair). This rating denotes the total number of daycase surgeries that were undertaken during the reporting period.
Finance	Finance	21 - 23	Elective Inpatients	Elective inpatients includes all patients that were admitted to hospital (i.e. had an overnight stay) for a scheduled surgical procedure (i.e. a mastectomy or inguinal hernia repair). This rating denotes the total number of elective inpatients during the reporting period.
Finance	Finance	21 - 23	Non Elective Inpatients	Non-elective inpatients includes all patients that were admitted to hospital (i.e. had an overnight stay) for emergency medical intervention (i.e. an injury or illness that is actue and poses an immediate risk to a person's life or long term health). This rating denotes the total number of non-elective inpatients during the reporting period.
Finance	Finance	21 - 23	First Outpatient	First outpatient appointment are primarily for the patient to discuss their concerns with an appropriate clinician and to coordinate their future care plan with the clinician (including which diagnostic tests to undertake, or which medical intervention is required). This rating denotes the total number of first outpatient appointments that took place during the reporting period.
Finance	Finance	21 - 23	Follow-up Outpatient	Follow up outpatient appointment are primarily for the patient to discuss any new concerns with a clinician, to discuss any investigations that may have been undertaken, and, if appropriate, to agree an appropriate treatment plan. This rating denotes the total number of follow up outpatient appointments that took place during the reporting period.
Finance	Finance	21 - 23	Adult Critical Care	Adult critical care encompasses patients that require high dependency or intensive care following, for example, surgical interventions or serious illnesses or traumatic injuries. In the UK, it costs around £1,328 per bed, per day, for an adult intensive care unit. This rating denotes the total number of adult patients that required critical care during the reporting period.
Finance	Finance	22 - 23	A&E Attendances	There are over 21 million attendances at A&E (Accident & Emergency) departments in England each year. A&E departments assess and treat patients with serious injuries or illnesses (i.e. loss of consciousness; chest pain; severe bleeding that cannot be stopped). This rating denotes the total number of A&E attendances in the Trust during the reporting period.
Research & Education	Research & Education	25	Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (mean)	Research is a major priority at Imperial College Healthcare NHS Trust. Medical research is essential for developing new and improved medical treatments to improve the health of both adults and children. It is, therefore, important that research is undertaken in a timely manner after research applications have been approved. There are two ratings associated with this indicator - the mean and median. The mean provides the average length of time elapsed between receipt of a valid research application and the first patient recruitment, whilst the median provides the 'middle number' in a list of these times. The median indicator are used to ensure that anomalous results have not significantly affected the average (i.e. skewing it).
Research & Education	Research & Education	25	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	This indicator is identical to the above, although the rating indicates the percentage of studies which recruited their first patient within 70 days of a Valid research application.
Research & Education	Research & Education	25	Percentage of closed commercially-sponsored interventional studies that recruited to time and to target	Imperial College Healthcare NHS Trust works closely with commercial enterprises, such as pharmaceutical companies, in the undertaking of medical research to develop and improve new treatments. It is, therefore, important that research is undertaken in a timely manner after applications have been approved, in accordance with bespoke targets to the research item involved. This rating provides a percentage of commercially-sponsored interventional studies that recruited to time and to target.
Research & Education	Research & Education	25	Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days	Local R&D review is a measure of the time taken by the Trust to give approval for clinical research studies to take place at any of our sites. This is a legal requirement, which aims to ensure that all studies taking place at ICHT are appropriately resourced and meet our own standards and policies. However, it is also important to ensure this process is completed in a reasonable timescale, to allow study sponsors to set up studies as quickly as possible and for patients to enter these studies. The NIHR Clinical Research Network Portfolio is a major
Research & Education	Research & Education	25	Total number of NIHR Clinical Research Network (CRN) portfolio studies to which the	The NIHR Clinical Research Network Portfolio is an important subset of all the clinical research studies undertaken at ICHT, these having been reviewed nationally for scientific quality and applicability to the NHS. It is our strategic aim, and that of the NIHR, to grow the number of studies being carried out at ICHT year on year, enabling more of our patients to take part in research. This indicator aims to demonstrate that growth.
Research & Education	Research & Education	25	Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD)	The NIHR Clinical Research Network Portfolio is an important subset of all the clinical research studies undertaken at ICHT, these having been reviewed nationally for scientific quality and applicability to the NHS. It is our strategic aim, and that of the NIHR, to enable more of our patients to participate in research. This indicator aims to demonstrate that growth.
Research & Education	Research & Education	25	Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting	Commercially-sponsored / funded clinical research is an important part of our overall R&D strategy, and that of the NIHR. It is important for the UK to be competitive on the global stage in attracting commercial investment in clinical research. Growing the number of commercial studies at ICHT is an important indicator of our ability to do this.
Research & Education	Research & Education	25	Total number of participants enrolled in NIHR CRN Portfolio Studies	Commercially-sponsored / funded clinical research is an important part of our overall R&D strategy, and that of the NIHR. It is important for the UK to be competitive on the global stage in attracting commercial investment in clinical research. Enabling more of our patients to take part in commercially-sponsored studies at ICHT is an important indicator of our ability to do this.

Imperial College Healthcare NHS
NHS Trust

Trust Board - Public

Agenda Item	2.4
Title	Finance Performance Report – December 2014
Report for	Monitoring
Report Author	Vince Doherty – Director of Operational Finance
Responsible Executive Director	Alan Goldsman – Chief Financial Officer

EXECUTIVE SUMMARY

1. The Trust's Income & Expenditure (I&E) position at the end of December a Year-to-Date (YTD) surplus of £5.9m (after adjusting for the impairment of fixed assets and donated assets), an adverse variance against the plan of £4.6m. This is supported by the realisation of £3.6m of one-off and non-recurrent income for estate related items and the assumption of full payment for winter resilience, additional waiting list and Project Diamond monies.

   The breakeven position in-month has been due to a continuation of spend above plan and in line with previous months, along with a benefit from released prior year accruals of £2.8m and a transfer from capital to revenue of IT costs of £0.8m.

2. There was an increase in total pay expenditure in the month of £0.2m, in line with previous forecasts but noticeably above the agreed month 6 Financial Recovery Plan (FRP) and above levels seen in 13/14.

3. Non-pay expenditure has decreased by £2.6m, compared to the previous month, due to the release of prior year provisions of £2.8m.

4. YTD variances to plan are due to:
   - Cost Improvement Plans (CIPs) are behind plan by £12.8m (64% of plan);
   - Benefit from additional payment for elective activity, subject to delivery;
   - One-off income from estate related items of £3.6m; and
   - Release of prior year balance sheet items

5. There is on-going dialogue with the TDA and NHS England about the impact of the proposed Project Diamond funding reductions on the Trust's financial position in both current and future years, totalling £17.2m.

Any reductions in Project Diamond funding will mean that the Trust's I&E control total will have to reduce accordingly which will also have an impact upon cash. Currently full payment is assumed, with £4.1m being offered by NHS England. This leaves a risk of £13.2m to the Trust.

Recommendations to the Trust Board: The Board is asked to note:

- The Year to Date (YTD) surplus of £5.9m represents an adverse variance against the plan of £4.6m – breakeven compared to the previous month. However, this has been delivered through retrospective corrections to activity data of £1.0m and a one-off provision release of £2.8m in-month, rather than through improved cost control and cost reduction;
- A further tightening of expenditure controls, in line the Financial Recovery Plan (FRP) agreed at Month 6, is required to achieve the financial plan surplus of £11.2m. This requires a significant improvement in expenditure run-rate, particularly on nursing, medical and admin & clerical costs back to 2013/14 rates, as well as the delivery of CIPs in-year to deliver an improved underlying position;
- Delivery of the agreed additional activity to meet elective activity waiting list (RTT) operational performance targets must be delivered in full and within the existing forecast of costs;
- Despite the overspends to date, Cerner and Estates expenditure overall, must return to plan;
- Outstanding Cerner reporting issues need to be resolved as, despite improvements in month, these remain material in a number of areas. Work on retrospective changes has not delivered the anticipated improvement in income, so further work is required to prevent longer term income reductions;
- Delivery of performance to ensure payment of Local Incentive Scheme and CQUIN monies as agreed in the investment case for the Clinical Transformation Office (CTO) and other divisional investments to support clinical transformation; and
- Improved management of overall staff levels, in particular matching the booking of bank and agency staff to agreed vacancies only, is required, with pay costs remaining at levels seen at the start of the financial year.
- Failure to improve the current run-rate of expenditure and income will result in an underlying deficit going into the 15/16 financial year.

Trust strategic objectives supported by this paper:

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

1. Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 31st December 2014.

1.2 The narrative report is intended to provide a focused statement of the main drivers of the financial performance and direct readers 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 **breakeven** at £0.0m; this was an **adverse** variance of £0.2m in month. The Year to Date (YTD) surplus of £5.9m represents an adverse variance against plan of £4.6m.

In month there was a continuation of spend above plan and in line with previous months, a transfer from capital to revenue in IT of £0.8m, along with a benefit from released prior year accruals of £2.8m. In the previous month there were a number of one-off and non-recurrent items in the reported financial position, including:

- Sale of lease at Point Pleasant (£1.8m)
- Rights to light payment from Royal Mail Group (£1.6m)
- Profit on sale of two of the flats at Ravenscourt Park (£0.2m)

Together these have improved the year-to-date position by £3.6m.

In previous months there has also been the impact of additional waiting list (RTT) (£5.8m) and winter resilience (£0.7m), which were not planned for and have improved the year to date income position.

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 eight flexed activity data, including a refreshed and updated dataset following the implementation of Cerner. SLA income shows a **surplus** YTD variance of £2.0m. This is due to the corrections to activity data in-month totalling £1.0m. Other NHS income improved by £1.5m due to a movement from Other Income of £1.5m.

Non-activity related and unplanned income assumptions are that the following total of £23.0m is delivered in line with the investment case to fund the Clinical Transformation Office (CTO) and the other divisional investments which support clinical transformation. .

- Local incentive fund for NWL CCGs of £8.4m
- CQUIN of £14.5m

Other major income assumptions are:

- Additional waiting list (RTT) monies (£5.8m to date and in total) are received in full; the required number of "clock-stops" are needed to secure this income and will be at risk if not delivered
- Additional Winter Resilience monies (£0.7m to date and £2.4m total) are received in full
- Project Diamond monies (£12.9m to date and £17.2m total) are received in full.
- All income has been profiled in line with expected delivery times.

2.3 **Private Patient Income**: In Month 9, total Private Patient income was **£0.2m adverse** to plan for the first time this financial year. The deterioration in month 9 along with the reduced level of overperformance in month 8 now presents a risk to the forecast outturn position.

2.4 **Other Operating Income:** Research income was below plan by £0.3m, but is matched to expenditure to ensure a net zero impact. There was also an increase in provisioning and movement of income to NHS Income of £1.5m.

2.5 **Expenditure:** Pay expenditure shows an **adverse** YTD variance of **£24.4m** as a result of under-achievement of CIPs and continued escalated pay costs compared to 2013/14. Pay costs have increased in month by £0.2m, with reductions in nursing & midwifery (£0.1m) offset by increases medical staff costs (£0.1m). Current levels of spend are not reducing in line with levels expected to meet the forecast set at Month 6 and create an increasing risk to delivery going forward.
All areas of nursing & midwifery, medical and admin & clerical have shown noticeable increases above 2013/14 levels.

2.6 Non-pay expenditure is showing a **favourable** YTD variance of **£13.3m** due to the under-spend on R&D projects of £2.0m, the inclusion of the contingency and the release of balance sheet provisions and accruals. Overall Non-Pay spend has reduced by £2.6m, due to the release of prior year provisions of £2.8m.

3. Monthly Performance (Page 4 A to C)

3.1 The Divisions report an in month **overspend** of **£1.6m**, bringing the YTD **overspend** to **£17.3m**. This is in line with the Divisions forecasts for the month. However a number of issues have emerged during month 9 that represent a risk to the outturn position within the Divisions. These risks relate to additional unfunded bed capacity on the St Marys site, the agreement and cost of outsourcing MRI capacity, additional high cost drugs expenditure and risks around income to support the St Mary's Urgent Care Centre (UCC).

3.2 Medicine is **overspent** by **£7.3m** YTD, a **deterioration** of **£0.7m** in month against the plan. The level of expenditure is consistent with levels seen in month 8 which are lower than quarter 1. However, levels of expenditure remain above 2013/14 levels and above plan especially in unqualified nursing. In addition, there continues to be significant under delivery of CIP.

3.3 Women's and Children's is **overspent** by **£2.9m** YTD, including an in-month **deterioration** of **£0.3m** against the plan, which is consistent with the division's forecast for the month. The YTD position is driven by continued under delivery of CIP and pay overspends predominantly in nursing and midwifery.

3.4 Investigative Sciences is **breakeven** in month and YTD is **overspent** by **£0.1m**. The forecast underspend in month was not achieved is due to the failure of a medicines fridge in pharmacy and the resultant loss of medicines.

3.5 Surgery and Cancer are **overspent by £7.0m** YTD an in month **deterioration** of **£0.5m.** The in-month position of £0.5m adverse is driven by £0.3m under delivery of CIP, £0.1m overspend on ITU relating to on-going increased capacity predominantly on the Hammersmith site and £0.1m continuing overspend on Trust drugs. The Division needs to fundamentally review its position this year compared with the previous year as activity is broadly the same.

3.6 The Corporate Directorates are reporting a year to date **overspend against plan** of **£3.7m**. This is a deterioration in month relating to the transfer of £0.8m IT costs from capital to revenue. The remaining YTD position relates to the Cerner implementation programme and Estates expenditure in relation to the Care Quality Commission (CQC) inspection. Forecast expenditure is now expected to reduce in these areas however with only 3 months of the year remaining this represents a significant risk to the forecast position.

4. Forecast Outturn (All Pages)

4.1 The Trust is currently planning for an I&E surplus of £11.2m (after adjusting for the impairment of fixed assets and donated assets).

Key assumptions made to deliver the forecast outturn are as follows:

- Full receipt of Project diamond monies of £17.2m;
- Delivery and receipt of CQUIN and Local Transformation Fund monies in line with the case for investment in the Clinical Transformation Office (CTO);
- Full payment for delivery of additional activity to meet waiting list (RTT) operational performance targets;
- No increase in contractual penalties; and
- Reductions in expenditure in ICT and Estates to come back to plan

5. Cost Improvement Plan (Page 5)

5.1 CIP delivery in month 9 is higher than the previous month, leading to a **favourable variance** of **£1.7m**. This is due to central schemes, such as realising profit from sales of assets. However, private patients schemes are showing a £0.3m reduction in CIP actuals this month and a forecast CIP reduction of £0.9m. The clinical divisions have also reduced their forecast by £0.8m.

5.2 The YTD shortfall on CIPs has improved bringing the **YTD adverse position** to **£12.8m** (64%). The forecast CIP delivery remains below the full year plan, as mitigation for all slippage in schemes have not been found. CIPs are forecast to be £6.7m below plan at year end, this is a deterioration of £1.8m from the forecast reported at month 8. To achieve the forecast position of £42.6m, CIP delivery must be maintained at the rate reported this month.

5.3 Non-recurrent mitigation of significant under performance will result in additional financial pressure next financial year, due to three of the clinical divisions and a number of non-clinical areas non-delivery in-year.

5.4 From November, the newly established QuEST team has started to work alongside operational colleagues to identify and support delivery of an on-going efficiency programme.

6. Statement of Financial Position (Page 6)

6.1 The overall movement in year balance was a decrease of £158m and was, predominately, due to the impairment charge on assets of £123.8m. The variance from plan of £24.5m was primarily due to the impairment loss being lower than expected and, as at month 9, movements between cash, creditors and debtors.

7. Capital Expenditure (Page 7)

7.1 The YTD Expenditure was £17.3m, behind plan by £6.7m. As it was last month, expenditure was behind plan mainly due to slippage on the capital maintenance

and ICT programmes, accounting for £6.0m of the variance. Expenditure is expected to catch up in future months. The Trust's annual Capital Resource Limit (CRL) has potentially been increased from £30m to £32m, although confirmation from the TDA is still required after agreement is achieved with the Department of Health. This would increase the overall capital programme to £35m.

8. Cash (Page 8)

8.1 The cash balance at the end of the month was £41.3m; £5.7m below the TDA plan. This was made up of:

- a shortfall in income of £13.9m, primarily due to non-receipt of Project Diamond monies, and;
- a reduction in payments of £8.2m, despite a £13.9m payment in advance to DHL in November. This is due to slippage against the capital programme of £4.9m and delays in payments to suppliers since outsourcing the Accounts Payable function.

Cash is monitored on a daily basis, with surplus cash being invested in the National Loan Fund scheme.

9. Monitor metrics – Continuity of Services Risk Rating (Page 9)

9.1 The Trust currently scores a 4 (out of 4) on Monitor's Continuity of Services Risk Rating, showing that the Trust currently has sufficient cash to service debts and liabilities as they fall due.

10. Conclusions & Recommendations

10.1 The Trust Board is asked to note:

- The Year to Date (YTD) surplus of £5.9m represents an adverse variance against the plan of £4.6m – breakeven compared to the previous month. However, this has been delivered through retrospective corrections to activity data of £1.0m and a one-off provision release of £2.8m in-month, rather than through improved cost control and cost reduction;.
- A further tightening of expenditure controls, in line the Financial Recovery Plan (FRP) agreed at Month 6, is required to achieve the financial plan surplus of £11.2m. This requires a significant improvement in expenditure run-rate, particularly on nursing, medical and admin & clerical costs back to 2013/14 rates, as well as the delivery of CIPs in-year to deliver an improved underlying position;
- Delivery of the agreed additional activity to meet waiting list (RTT) operational performance targets must be delivered in full and within the existing forecast of costs;
- Despite the overspends to date, Cerner and Estates expenditure overall, must return to plan;

- Outstanding Cerner reporting issues need to be resolved as, despite improvements in month, these remain material in a number of areas. Work on retrospective changes has not delivered the anticipated improvement in income, so further work is required to prevent longer term income reductions;
- Delivery of performance to ensure payment of Local Incentive Scheme and CQUIN monies as agreed in the investment case for the Clinical Transformation Office (CTO) and other divisional investments to support clinical transformation; and
- Improved management of overall staff levels, in particular matching the booking of bank and agency staff to agreed vacancies only, is required, with pay costs remaining at levels seen at the start of the financial year.
- Failure to improve the current run-rate of expenditure and income will result in an underlying deficit going into the 15/16 financial year.

Contents

Finance Performance Report for the month ending 31st December 2014

Building world class finance

innovation respect care achievement pride

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	64,052	65,411	1,359	583,062	592,336	9,274	773,942	792,250	18,308
Research & Development & Education	10,096	9,803	(293)	90,864	88,911	(1,953)	121,200	119,542	(1,658)
Other	6,181	3,969	(2,212)	53,016	51,540	(1,476)	72,920	69,527	(3,393)
TOTAL INCOME	**80,329**	**79,183**	**(1,146)**	**726,942**	**732,786**	**5,844**	**968,062**	**981,319**	**13,257**
Expenditure									
Pay - In post	(40,351)	(40,511)	(160)	(363,972)	(361,684)	2,288	(485,722)	(483,822)	1,901
Pay - Bank	(1,168)	(2,518)	(1,350)	(10,421)	(22,148)	(11,727)	(13,910)	(29,035)	(15,125)
Pay - Agency	(1,530)	(2,916)	(1,386)	(14,718)	(29,728)	(15,010)	(19,281)	(37,690)	(18,408)
Drugs & Clinical Supplies	(18,959)	(20,081)	(1,122)	(173,211)	(178,619)	(5,408)	(230,055)	(238,481)	(8,426)
General Supplies	(3,468)	(3,130)	338	(31,378)	(28,363)	3,015	(41,769)	(37,332)	4,437
Other	(10,723)	(6,437)	4,286	(86,526)	(70,798)	15,728	(118,197)	(96,272)	21,926
TOTAL EXPENDITURE	**(76,199)**	**(75,593)**	**606**	**(680,226)**	**(691,341)**	**(11,114)**	**(908,935)**	**(922,631)**	**(13,697)**
Earnings Before Interest, Tax, Depreciation & Amortisation	**4,130**	**3,590**	**(540)**	**46,716**	**41,446**	**(5,270)**	**59,127**	**58,687**	**(440)**
Financing Costs	(4,041)	12,215	16,256	(191,294)	(160,130)	31,164	(203,807)	(172,390)	31,417
SURPLUS / (DEFICIT) including donated asset treatment	**89**	**15,806**	**15,717**	**(144,578)**	**(118,684)**	**25,894**	**(144,680)**	**(113,703)**	**30,977**
Impairment of Assets	0	(15,752)	(15,752)	154,538	123,818	(30,720)	154,538	123,818	(30,720)
Donated Asset treatment	111	(51)	(162)	553	764	211	1,329	1,072	(257)
SURPLUS / (DEFICIT)	**200**	**3**	**(197)**	**10,513**	**5,898**	**(4,615)**	**11,187**	**11,187**	**0**

Surplus / (Deficit): The Trust's financial performance in Month 9 was a surplus of £0.0m, a deficit variance to plan of £0.2m. The Year to Date (YTD) position shows a surplus of £5.9m, an adverse variance to plan of £4.6m. The maintained financial performance this month can be attributed to:

1. Pay costs were £2.9m above plan across all categories of staff, worsening by £0.2m compared over month 8. Pay costs remain noticably above those seen in 2013/14 for nursing, medical and Admin & Clerical staff groups;
2. Non-Pay spend was better than plan by £3.5m due to the release of prior year provisions of £2.8m;
3. Income was below plan by £1.1m, including the benefit of backdated data corrections following the implementation of Cerner of £1.0m. Actual YTD income assumes payment of the local performance incentive fund and CQUIN in line with the investment case for the Clinical Transformation Office (CTO) and also assumes winter resiliance, additional elective activity and Project Diamond monies are paid in full. The YTD position includes £3.6m of one-off and non-recurrent items from month 8.
4. An updated revaluation of the Trust's estate has resulted in a reduction in impairment charges of £15.8m in month.

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	33,329	33,768	439	308,112	313,592	5,480	408,064	417,191	9,126
NHS England	24,819	25,534	714	227,427	223,904	(3,523)	301,886	302,714	828
Other NHS Organisations	1,268	1,705	438	5,687	10,075	4,388	8,262	12,982	4,720
Sub-Total NHS Income	**59,416**	**61,007**	**1,591**	**541,226**	**547,571**	**6,345**	**718,212**	**732,887**	**14,675**
Local Authority	864	900	36	7,916	7,589	(327)	10,509	10,070	(439)
Private Patients	3,238	3,001	(237)	29,122	31,132	2,010	38,824	41,929	3,105
Overseas Patients	183	99	(84)	1,650	2,548	898	2,200	2,908	708
NHS Injury Cost Scheme	130	88	(41)	1,168	1,417	249	1,557	1,821	265
Non NHS Other	220	316	95	1,980	2,079	99	2,640	2,635	(5)
Total - Income from Clinical Activities	**64,052**	**65,411**	**1,359**	**583,062**	**592,336**	**9,274**	**773,942**	**792,250**	**18,308**
Other Operating Income									
Education, Research & Development	10,096	9,803	(293)	90,864	88,911	(1,953)	121,200	119,542	(1,658)
Non patient care activities	2,664	2,672	8	23,978	22,619	(1,359)	31,980	30,237	(1,742)
Income Generation	355	348	(7)	3,197	2,718	(480)	4,264	3,578	(686)
Other Income	3,162	948	(2,214)	25,841	26,204	362	36,676	35,712	(964)
Total - Other Operating Income	**16,277**	**13,772**	**(2,505)**	**143,880**	**140,451**	**(3,430)**	**194,120**	**189,069**	**(5,051)**
TOTAL INCOME	**80,329**	**79,183**	**(1,146)**	**726,942**	**732,786**	**5,844**	**968,062**	**981,319**	**13,257**

Clinical Income is ahead of plan in month due to the benefit of backdated data corrections following the implementation of Cerner of £1.0m, and increased PbR exclusions of £0.3m and movement of income from Other Income £1.5m. Actual YTD income assumes payment of the local performance incentive fund and CQUIN in line with the investment case for the Clinical Transformation Office (CTO) and also assumes winter resiliance, additional elective activity and Project Diamond monies are paid in full. Winter resiliance and additional elective activity monies are in addition to plan and contribute £6.5m to YTD overperformance.
Other Operating income includes the movement of income from Other Income to NHS income of £1.5m and increased provisioning. R&D income was below plan by £0.5m, offset by a reduction in expenditure. The YTD position includes £3.6m of one-off and non-recurrent items from month 8.

Income **Risk:** **A**

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	(12,750)	(13,128)	(378)	(115,438)	(117,633)	(2,195)	(153,689)	(156,783)	(3,094)
Nursing & Midwifery	(12,547)	(12,475)	72	(113,447)	(111,730)	1,718	(151,724)	(149,695)	2,028
Scientific, Therapeutic & Technical staff	(5,835)	(5,543)	291	(52,340)	(49,681)	2,659	(69,865)	(67,244)	2,621
Healthcare assistants and other support staff	(2,368)	(2,441)	(74)	(21,452)	(21,823)	(371)	(28,596)	(29,062)	(466)
Directors and Senior Managers	(2,506)	(2,544)	(38)	(22,504)	(22,803)	(300)	(30,023)	(30,584)	(562)
Administration and Estates	(4,345)	(4,379)	(34)	(38,791)	(38,014)	777	(51,826)	(50,453)	1,373
Sub-total - Pay In post	**(40,351)**	**(40,511)**	**(160)**	**(363,972)**	**(361,684)**	**2,288**	**(485,722)**	**(483,822)**	**1,901**
Pay - Bank/Agency									
Medical Staff	(507)	(867)	(360)	(4,589)	(9,109)	(4,521)	(6,111)	(11,547)	(5,437)
Nursing & Midwifery	(872)	(2,006)	(1,134)	(7,755)	(18,350)	(10,595)	(10,272)	(24,209)	(13,937)
Scientific, Therapeutic & Technical staff	(460)	(606)	(146)	(4,372)	(5,710)	(1,339)	(5,753)	(7,367)	(1,615)
Healthcare assistants and other support staff	(151)	(616)	(465)	(1,425)	(5,348)	(3,923)	(1,878)	(6,764)	(4,885)
Directors and Senior Managers	1	(133)	(134)	(30)	(1,413)	(1,384)	(23)	(1,698)	(1,675)
Administration and Estates	(708)	(1,205)	(497)	(6,969)	(11,945)	(4,976)	(9,154)	(15,139)	(5,985)
Sub-total - Pay Bank/Agency	**(2,698)**	**(5,434)**	**(2,736)**	**(25,139)**	**(51,876)**	**(26,737)**	**(33,191)**	**(66,725)**	**(33,534)**
Non Pay									
Drugs	(8,780)	(9,448)	(668)	(80,178)	(82,067)	(1,889)	(106,516)	(110,193)	(3,678)
Supplies and Services - Clinical	(10,179)	(10,634)	(454)	(93,033)	(96,552)	(3,519)	(123,539)	(128,288)	(4,749)
Supplies and Services - General	(3,468)	(3,130)	338	(31,378)	(28,363)	3,015	(41,769)	(37,332)	4,437
Consultancy Services	(1,269)	(1,253)	16	(11,467)	(9,822)	1,645	(15,269)	(11,633)	3,636
Establishment	(631)	(752)	(121)	(5,741)	(5,849)	(108)	(7,630)	(7,834)	(204)
Transport	(940)	(1,030)	(90)	(8,501)	(9,261)	(760)	(11,317)	(12,504)	(1,187)
Premises	(3,019)	(3,567)	(549)	(27,345)	(29,562)	(2,217)	(36,390)	(39,590)	(3,200)
Other Non Pay	(4,864)	166	5,030	(33,473)	(16,305)	17,168	(47,591)	(24,710)	22,880
Sub-total - Non Pay	**(33,150)**	**(29,648)**	**3,502**	**(291,115)**	**(277,781)**	**13,335**	**(390,021)**	**(372,085)**	**17,936**
TOTAL EXPENDITURE	**(76,199)**	**(75,593)**	**606**	**(680,226)**	**(691,341)**	**(11,114)**	**(908,935)**	**(922,631)**	**(13,697)**
Financing Costs									
Interest Receivable	20	17	(3)	177	166	(11)	244	236	(8)
Receipt of Grants for Capital Acquisitions	0	157	157	0	192	192	0	192	192
Interest Payable	(0)	(68)	(68)	(417)	(614)	(197)	(810)	(810)	(0)
Other Gains & Losses	(0)	1	1	(0)	211	211	0	211	211
Impairment on Assets	0	15,752	15,752	(154,538)	(123,818)	30,720	(154,538)	(123,818)	30,720
Depreciation	(2,886)	(2,857)	29	(25,941)	(25,422)	519	(34,599)	(33,911)	688
Public Dividend Capital	(1,175)	(786)	389	(10,575)	(10,845)	(270)	(14,104)	(14,490)	(386)
TOTAL - FINANCING COSTS	**(4,041)**	**12,215**	**16,256**	**(191,294)**	**(160,130)**	**31,164**	**(203,807)**	**(172,390)**	**31,417**

Pay: Pay spend was £0.2m higher than last month, with increases of in-post costs of £0.2m. There are decreases in nursing and midwifery costs of £0.1m, offset by increases in medical staff of £0.1m. Pay continues to run a levels above plan due to non delivery of CIPs and increases in run-rate spend above 2013/14 levels.
Non Pay: Overall Non-Pay spend was £2.6m lower than last month due to realease of prior year provisions of £2.8m.
Finance costs: An updated revaluation of the Trust's estate has resulted in a reduction in impairment charges of £15.8m, to £123.8m year to date.

Expenditure **Risk:** **R**

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	4,133	4,162	29	36,652	37,149	497	49,112	50,135	1,023
	Pay	(37,211)	(38,265)	(1,054)	(334,695)	(346,459)	(11,763)	(446,101)	(462,393)	(16,293)
	Non Pay	(13,194)	(13,765)	(571)	(120,254)	(126,276)	(6,023)	(159,656)	(167,831)	(8,175)
Clinical Divisions Total		(46,272)	(47,868)	**(1,596)**	(418,297)	(435,586)	**(17,289)**	**(556,645)**	**(580,089)**	**(23,444)**
Corporates	Income	6,448	6,262	(186)	58,307	58,542	235	77,754	77,594	(159)
	Pay	(5,035)	(5,020)	15	(47,386)	(47,101)	285	(62,541)	(61,739)	802
	Non Pay	(6,465)	(7,456)	(991)	(57,271)	(61,520)	(4,249)	(76,634)	(80,021)	(3,387)
Corporates Total		(5,052)	(6,214)	**(1,162)**	(46,350)	(50,080)	**(3,729)**	**(61,422)**	**(64,165)**	**(2,744)**
Income	Income	61,556	61,297	(259)	566,413	567,168	754	751,046	758,984	7,939
	Pay	0	0	0	0	0	0	0	0	0
	Non Pay	(77)	(77)	0	(697)	(697)	0	(929)	(929)	(0)
Income Total		61,478	61,219	**(259)**	565,716	566,471	**754**	**750,117**	**758,055**	**7,939**
Private Patients Directorate	Income	2,950	2,290	(661)	25,804	24,299	(1,504)	35,406	32,906	(2,500)
	Pay	(908)	(961)	(52)	(8,173)	(8,153)	20	(10,898)	(10,998)	(100)
	Non Pay	(753)	(764)	(11)	(7,410)	(7,611)	(201)	(9,785)	(10,177)	(392)
Private Patients Directorate Total		1,289	565	**(725)**	10,220	8,535	**(1,685)**	**14,724**	**11,732**	**(2,992)**
Research	Income	4,538	4,016	(523)	40,844	36,109	(4,735)	54,459	49,724	(4,735)
	Pay	(1,024)	(940)	84	(9,214)	(6,539)	2,675	(12,285)	(9,610)	2,675
	Non Pay	(1,809)	(1,623)	186	(16,282)	(14,213)	2,068	(21,707)	(19,638)	2,069
Research Total		1,706	1,453	**(252)**	15,348	15,356	**8**	**20,467**	**20,475**	**9**
Reserves, Financing Cost & Other Contingencies	Income	196	800	603	(5,643)	5,365	11,007	(5,799)	6,301	12,100
	Pay	1,304	(597)	(1,902)	11,932	(3,726)	(15,657)	15,009	(3,726)	(18,734)
	Non Pay	(10,513)	(5,769)	4,744	(86,145)	(64,874)	21,271	(117,236)	(89,857)	27,379
Reserves, Financing Cost & Other Contingencies Total		(9,012)	(5,567)	**3,445**	(79,856)	(63,235)	**16,621**	**(108,026)**	**(87,282)**	**20,744**
Hosted services	Income	507	354	(153)	4,564	4,150	(413)	6,085	5,674	(411)
	Pay	(180)	(167)	13	(1,620)	(1,631)	(11)	(2,160)	(2,148)	13
	Non Pay	(334)	(186)	148	(3,009)	(2,535)	473	(4,012)	(3,565)	447
Hosted Services Total		(7)	1	**8**	(65)	(16)	**49**	**(87)**	**(38)**	**49**
Earnings Before Interest, Tax, Depreciation & Amortisation		**4,130**	**3,589**	**(541)**	**46,716**	**41,445**	**(5,271)**	**59,127**	**58,687**	**(439)**

The Trust delivered a deficit against the EBITDA plan of £0.5m in month. The year to date (YTD) position is a deficit to plan of £5.3m. The movement in month and YTD position can be attributed to:

1. Divisions continue to overspend against plan as a consequence of non delivery of CIP and an escalation in pay costs compared to 2013/14. The in month divisional overspend was £1.6m bringing the YTD overspend to £17.3m. The current forecast position for Divisions is a year end overspend of £22.5m however a number of issues have emerged which put this at risk.
2. Corporate departments reported an overspend of £1.2m resulting in a YTD position of £3.7m. £0.8m of the in month position is riven by the reallocation of IT costs from capital to revenue. The forecast overspend is £3.2m, delivery of which now requires underspends in future months.
3. The private patient YTD position does not include £6.9m of PP income held within the divisons.

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	937	1,177	240	8,478	9,081	603	11,302	12,287	986
	Pay	(10,719)	(11,528)	(809)	(96,336)	(103,346)	(7,010)	(128,691)	(137,741)	(9,051)
	Non Pay	(4,635)	(4,753)	(117)	(42,295)	(43,215)	(921)	(56,181)	(58,192)	(2,011)
Division Of Medicine Total		(14,417)	(15,103)	**(686)**	(130,152)	(137,480)	**(7,327)**	**(173,570)**	**(183,646)**	**(10,076)**
Division Of Women And Children	Income	582	468	(114)	5,206	4,579	(627)	6,953	6,379	(574)
	Pay	(5,644)	(5,811)	(168)	(51,020)	(52,865)	(1,845)	(67,390)	(70,572)	(3,181)
	Non Pay	(1,567)	(1,623)	(56)	(14,300)	(14,711)	(411)	(19,062)	(19,539)	(477)
Division Of Women And Children Total		(6,629)	(6,967)	**(338)**	(60,114)	(62,997)	**(2,883)**	**(79,500)**	**(83,732)**	**(4,233)**
Investigative Sciences & C S	Income	2,242	2,142	(100)	19,632	19,928	296	26,397	26,496	99
	Pay	(8,818)	(8,670)	147	(79,174)	(78,798)	377	(105,763)	(105,265)	499
	Non Pay	(3,465)	(3,555)	(90)	(31,132)	(31,883)	(750)	(41,446)	(42,294)	(848)
Investigative Sciences & C S Total		(10,041)	(10,084)	**(43)**	(90,674)	(90,752)	**(78)**	**(120,812)**	**(121,063)**	**(251)**
Surgery, Cancer & Cardiovasc Div	Income	372	375	3	3,335	3,560	225	4,460	4,973	513
	Pay	(12,031)	(12,255)	(225)	(108,165)	(111,450)	(3,285)	(144,256)	(148,815)	(4,559)
	Non Pay	(3,526)	(3,833)	(307)	(32,526)	(36,467)	(3,941)	(42,967)	(47,806)	(4,839)
Surg, Canc & Cardiovasc Div Total		(15,185)	(15,714)	**(529)**	(137,356)	(144,357)	**(7,001)**	**(182,763)**	**(191,648)**	**(8,885)**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(46,272)**	**(47,868)**	**(1,596)**	**(418,297)**	**(435,586)**	**(17,289)**	**(556,645)**	**(580,089)**	**(23,444)**

The Divisions report an in month overspend of £1.6m - which is consistent with month 8 - bringing the YTD overspend to £17.3m.

1) Medicine is overspent by £7.3m YTD, a deterioration of £0.7m in month against the plan. this maintains the improvement we have seen over the last 4 months and expenditure run rates have improved since the first quarter, although they remain significantly higher than last financial year. Under delivery against the CIP plan remains a concern.

2) Women's and Children's is overspent by £2.9m YTD including an in-month deterioration of £0.3m against the plan. The YTD position is driven by continued under delivery of CIP and pay overspends predominantly in nursing and midwifery

3) Investigative Sciences are overspent by £0.1m YTD

4) Surgery and Cancer are overspent by £7m YTD and in month deterioration of £0.5m**.** The in month position was in line with forecast. The Division needs to fundamentally review its position this year compared with the previous year as activity is broadly the same but costs have risen despite delivery of CIP without real explanation.

Clinical Divisions	**Risk:**	**R**

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
Director Of Operations	Income	176	74	(102)	1,580	2,886	1,306	2,106	3,369	1,262
	Pay	(674)	(490)	184	(6,319)	(6,373)	(54)	(8,341)	(8,281)	60
	Non Pay	(67)	(481)	(414)	(603)	(933)	(329)	(804)	(1,085)	(281)
Director Of Operations Total		(565)	(897)	**(332)**	(5,343)	(4,420)	**923**	**(7,039)**	**(5,997)**	**1,042**
Directorate of Strategy	Income	899	1,196	297	8,307	8,451	144	11,088	11,238	151
	Pay	(780)	(743)	36	(7,114)	(7,122)	(8)	(9,452)	(9,485)	(33)
	Non Pay	(5,266)	(5,376)	(110)	(45,528)	(46,919)	(1,390)	(61,325)	(62,056)	(731)
Directorate of Strategy Total		(5,146)	(4,923)	**223**	(44,336)	(45,590)	**(1,255)**	**(59,690)**	**(60,303)**	**(613)**
Finance	Income	13	16	3	140	208	68	179	269	91
	Pay	(792)	(715)	77	(7,815)	(7,110)	705	(10,194)	(9,504)	690
	Non Pay	(276)	(421)	(145)	(2,526)	(3,466)	(940)	(3,309)	(4,445)	(1,136)
Finance Total		(1,055)	(1,120)	**(65)**	(10,201)	(10,368)	**(167)**	**(13,324)**	**(13,680)**	**(356)**
Human Resources	Income	271	230	(41)	2,478	2,228	(250)	3,309	2,906	(404)
	Pay	(513)	(487)	26	(4,571)	(4,419)	152	(6,116)	(5,885)	231
	Non Pay	(150)	(103)	47	(1,458)	(1,377)	81	(1,949)	(1,656)	292
Human Resources Total		(392)	(360)	**32**	(3,552)	(3,568)	**(16)**	**(4,755)**	**(4,636)**	**119**
Information & Comms Technology	Income	183	109	(75)	1,649	1,261	(388)	2,198	1,634	(564)
	Pay	(1,336)	(1,755)	(418)	(13,220)	(13,567)	(347)	(17,283)	(17,445)	(162)
	Non Pay	(451)	(790)	(339)	(4,952)	(6,476)	(1,524)	(6,279)	(7,593)	(1,313)
Information & Comms Technology Total		(1,605)	(2,437)	**(832)**	(16,523)	(18,782)	**(2,259)**	**(21,364)**	**(23,404)**	**(2,040)**
Medical Director	Income	4,881	4,616	(264)	43,926	43,192	(734)	58,568	57,789	(778)
	Pay	(591)	(485)	106	(5,348)	(5,468)	(120)	(7,122)	(7,140)	(18)
	Non Pay	(192)	(170)	22	(1,765)	(1,723)	42	(2,342)	(2,314)	27
Medical Director Total		4,097	3,961	**(136)**	36,813	36,001	**(812)**	**49,104**	**48,335**	**(769)**
Nursing directorate	Income	25	35	10	224	229	5	299	300	1
	Pay	(258)	(252)	6	(2,241)	(2,298)	(57)	(3,001)	(3,014)	(13)
	Non Pay	(53)	(44)	9	(355)	(356)	(1)	(515)	(493)	21
Nursing directorate Total		(286)	(261)	**25**	(2,372)	(2,426)	**(54)**	**(3,217)**	**(3,208)**	**9**
Press & Communications	Income	1	(14)	(14)	5	87	82	7	89	82
	Pay	(91)	(93)	(2)	(758)	(743)	15	(1,032)	(984)	48
	Non Pay	(9)	(71)	(62)	(84)	(271)	(187)	(112)	(378)	(266)
Press & Communications Total		(100)	(178)	**(78)**	(837)	(927)	**(90)**	**(1,137)**	**(1,273)**	**(136)**
Earnings Before Interest, Tax, Depreciation & Amortisation		**(5,052)**	**(6,214)**	**(1,162)**	**(46,350)**	**(50,080)**	**(3,729)**	**(61,422)**	**(64,165)**	**(2,744)**

The Corporate Directorates are reporting a year to date overspend against plan of £3.7m, a deterioration in month of £1.2m. the in month position is driven mainly by £0.8m transfer of IT costs from capital to revenue. the YTD position predominantly relates to the Cerner implementation programme and Estates expenditure relating to the Care Quality Commission (CQC) inspection. Forecast expenditure is now expected to reduce in these areas however with only 3 months remaining this financial year this is a significant risk.

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

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	Variance %
Medicine	Steve McManus	753	422	(331)	6,117	3,040	(3,078)	8,332	4,474	(3,857)	**-46%**
Surgery	Steve McManus	811	532	(279)	6,299	3,950	(2,349)	8,733	7,148	(1,585)	**-18%**
WAC	Steve McManus	330	197	(134)	2,359	1,394	(965)	3,876	2,204	(1,672)	**-43%**
DISCs	Steve McManus	556	628	72	4,088	4,533	445	5,755	6,416	661	**11%**
Private Patients	Bill Shields	335	124	(211)	3,017	2,891	(127)	4,023	3,489	(534)	**-13%**
Corporate Governance	Janice Sigsworth	0	0	0	0	0	0	0	0	0	**0%**
Director of Operations	Steve McManus	56	0	(56)	591	0	(591)	759	0	(759)	**-100%**
Estates Directorate	Ian Garlington	413	353	(61)	2,696	1,267	(1,429)	3,936	2,907	(1,029)	**-26%**
Finance Directorate	Bill Shields	108	115	7	945	830	(116)	1,269	1,174	(95)	**-8%**
Human Resources	Jayne Mee	62	46	(16)	558	509	(50)	746	699	(47)	**-6%**
ICT	Kevin Jarold	116	64	(53)	833	364	(470)	1,182	739	(443)	**-37%**
Medical Director	Chris Harrison	34	25	(9)	319	261	(58)	423	364	(58)	**-14%**
Nursing Directorate	Janice Sigsworth	6	5	(1)	52	41	(11)	71	61	(10)	**-14%**
Press & Communications	Michelle Dixon	10	8	(2)	87	68	(19)	117	100	(17)	**-15%**
Central schemes (inc internal phasing adjustment & mitigations)		843	3,600	2,757	7,586	3,600	(3,986)	10,115	12,824	2,709	**27%**
Total		**4,435**	**6,119**	**1,684**	**35,549**	**22,747**	**(12,802)**	**49,335**	**42,598**	**(6,737)**	**-14%**

CIP delivery in month 9 is higher than the previous month, leading to a favourable variance of £1.7m. This is due to central schemes, such as profit from sales of assets. However, private patients schemes are showing a £0.3m reduction in CIP actuals this month and a £0.9m reduction in the forecast CIP. The clinical division have also reduced their forecast by £0.8m.

The YTD shortfall on CIPs has improved to £12.8m (64%), due to central schemes. The forecast CIP delivery remains below the full year plan, as mitigation for all slippage in schemes have not been found. CIPs are forecast to be £6.7m below plan at year end. To achieve the forecast position of £42.6m, CIP delivery must be maintained at the rate reported in month 9.

Significant under performance is forecast in three of the clinical divisions and a number of non-clinical areas. In year these are partly mitigated non-recurrently by central schemes but need to be addressed on a recurrent basis in 2015/16. This will increase the CIP requirement in 2015/16 if the Trust is to remain in financial balance.

Cost Improvement Programme (CIP)	**Risk:**	**R**

PAGE 6 - STATEMENT OF FINANCIAL POSITION

		Opening Balance 1st April 2014 £000s	Plan as at December £000s	Actual Previous Month Balance £000s	Actual Current Month Balance £000s	Actual In Year Movement £000s	Variance to Plan as at December £000s	Actual Monthly Movement £000s
Non Current Assets	Property, Plant & Equipment	595,639	401,230	411,455	424,707	(170,932)	23,477	13,252
	Intangible Assets	1,413	1,740	1,752	1,730	317	(10)	(22)
Current Assets	Inventories (Stock)	14,214	15,006	15,039	14,648	434	(358)	(391)
	Trade & Other Receivables (Debtors)	96,256	89,991	133,146	133,695	37,439	43,704	549
	Cash	50,449	47,091	45,255	41,349	(9,100)	(5,742)	(3,906)
Current Liabilities	Trade & Other Payables (Creditors)	(128,280)	(125,224)	(150,432)	(149,792)	(21,512)	(24,568)	640
	Borrowings	(2,701)	(2,327)	(2,327)	(2,327)	374	0	0
	Provisions	(25,091)	(12,817)	(27,664)	(24,851)	240	(12,034)	2,813
Non Current Liabilities	Borrowings	(20,709)	(19,546)	(19,546)	(19,546)	1,163	0	0
	Provisions	(17,149)	(13,366)	(14,627)	(13,366)	3,783	0	1,261
	TOTAL ASSETS EMPLOYED	**564,041**	**381,778**	**392,051**	**406,247**	**(157,794)**	**24,469**	**14,196**

Ratio/Indicators	Risk Rating		
	Current Month	Previous Month	Change in month
Debtor Days	51	46	(5)
Trade Payable Days	59	58	(1)
Cash Liquidity Days	29	29	0

The increase in Property, Plant & Equipment is predominantly due to the revaluation of the Trust's property portfolio resulting in a net increase of £15.7m

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

- Increase in NHS debtors of £18m mainly due to invoices raised for NHS England for R&D MFF of £7.6m, Project Diamond of £5.4m, Clinical Excellence of £2.9m and Q2 over performance of £1.4m.
- Decrease in NHS Debtor accruals of £12m, due to invoices raised for R&D MFF and Project Diamond
- Decrease in non NHS Trade debtors of £2.4m predominantly due to £1.7m rent received from Imperial College
- Decreased in non NHS Debtor accruals of £4.4m predominantly due to cash received relating to the sale of the Point Pleasant lease for £1.8m and the "right to light"at St Mary's £1.6m
- Increase in bad debt provision of £1.5m
- Decrease in prepayments of £0.9m due to the release of DHL payment in advance
- Accounting adjustment of £3.3m re Agreement of Balances exercise
- Increase in work in Progress of £0.6m

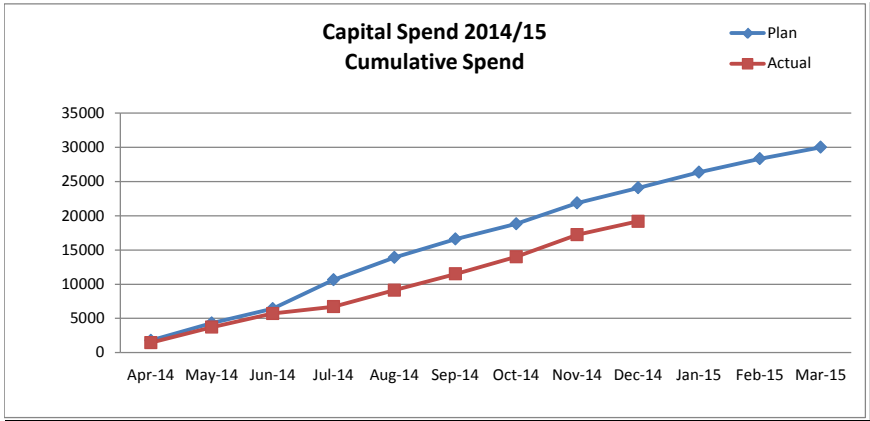
The Increase in creditors for the month is predominantly due to:

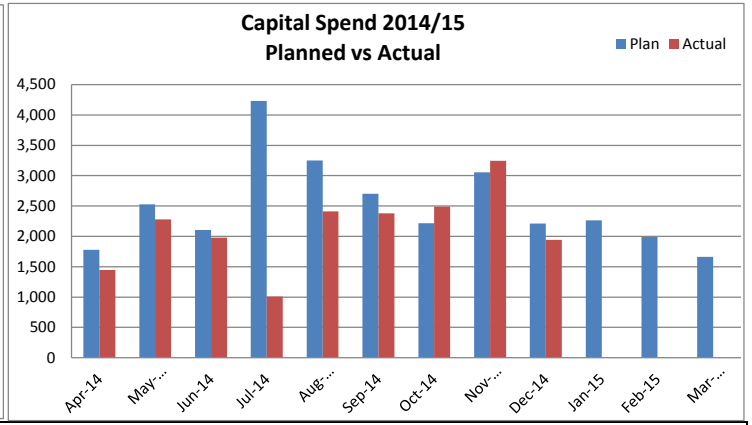
- Decrease in Trade Creditors of £3.2m
- Increase of NHS creditor accruals of £1.6m, predominantly due to invoices received but not yet processed
- Increase in non NHS creditor accruals of £0.9m
- Decrease in deferred income of £3.7m due to release of Q3 LDA and MDEC accruals
- Increase in PDC accruals of £0.8m
- Increase in capital accruals of £0.9m
- Accounting adjustment of £3.3m re Agreement of Balances exercise

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	(2)	2	330	1,102	(772)	330	1,250	(920)
Site Redevelopment	100	40	60	1,930	1,827	103	2,192	2,700	(508)
Capital Maintenance (Backlog & Statutory) - CXH	230	6	224	1,840	446	1,394	2,520	3,000	(480)
Capital Maintenance (Backlog & Statutory) - HH	170	563	(393)	1,510	1,353	157	2,020	2,300	(280)
Capital Maintenance (Backlog & Statutory) - SMH	190	(4)	194	1,520	972	548	2,090	1,884	206
Imaging Review	250	(21)	271	2,100	1,427	673	2,650	2,500	150
Medical Equipment purchases	220	566	(346)	1,760	3,605	(1,845)	2,420	4,600	(2,180)
Theatre Refurbishment Programme	100	0	100	800	6	794	1,000	313	687
ICT investment programme	30	(328)	358	7,031	3,178	3,853	7,226	6,500	726
Minor Works (below £50k)	45	47	(2)	360	619	(259)	500	738	(238)
Improving the cancer inpatients experience (6 North and 6 South)	0	30	(30)	700	255	445	700	960	(260)
Private Patients Facility Improvements	0	0	0	250	147	103	250	150	100
Waste compound relocation (HH)	200	0	200	400	0	400	500	0	500
Development of Business Cases/Feasibility Studies	20	53	(33)	160	265	(105)	220	270	(50)
PICU St Mary's	320	185	135	1,600	284	1,316	2,583	680	1,903
Private Patients Refurbishment	0	0	0	878	0	878	878	0	878
Other site developments	0	160	(160)	0	957	(957)	0	2,185	(2,185)
Imaging Improvements (HH) - providing expanded Imaging in A-Block	336	203	133	913	215	698	1,921	400	1,521
C Block North (Building 114) refurbishment	0	284	(284)	0	348	(348)	0	1,250	(1,250)
New Linear Accelerators	0	100	(100)	0	318	(318)	0	485	(485)
Replacement Ct Scanners in QEQM SMH	0	61	(61)	0	1,457	(1,457)	0	1,650	(1,650)
Other Equipment	0	0	0	0	397	(397)	0	1,402	(1,402)
Total Capital Expenditure	**2,211**	**1,943**	**268**	**24,082**	**19,178**	**4,904**	**30,000**	**35,217**	**(5,217)**
Donations	0	0	0	0	(133)	133	0	(133)	133
Government Grant	0	0	0	0	(59)	59	0	(59)	59
Disposals	0	(1,630)	1,630	0	(1,653)	1,653	0	(3,025)	**3,025**
Total Charge against Capital Resource Limit	**2,211**	**313**	**1,898**	**24,082**	**17,333**	**6,749**	**30,000**	**32,000**	**(2,000)**
Capital Resource Limit							**(30,000)**	**(32,000)**	**2,000**
Over/(Under)spend against CRL							**0**	**0**	**0**



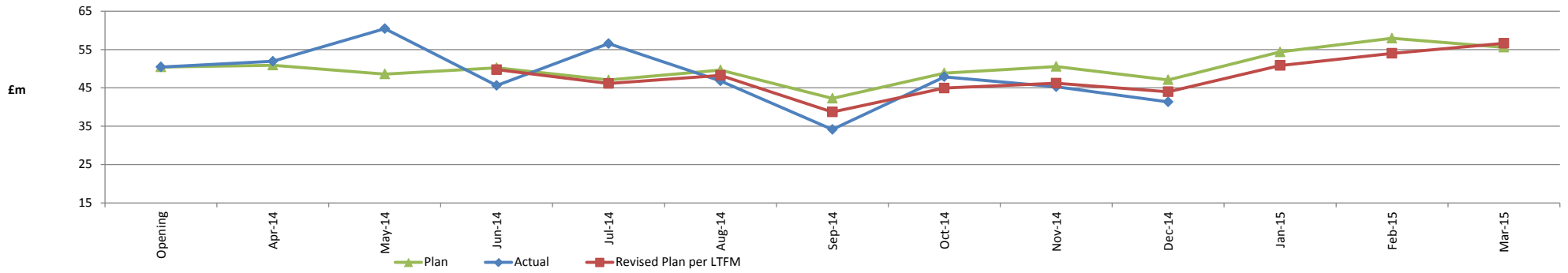


Overall spend is at £19.178m against a plan of £24.082m. The year to date variance of £4.9m mainly relates to both the ICT investment and Capital Maintenance programmes being behind their year to date plans. It is expected that slippage on both these expenditure streams will be recovered.

Capital Expenditure **Risk:** **G**

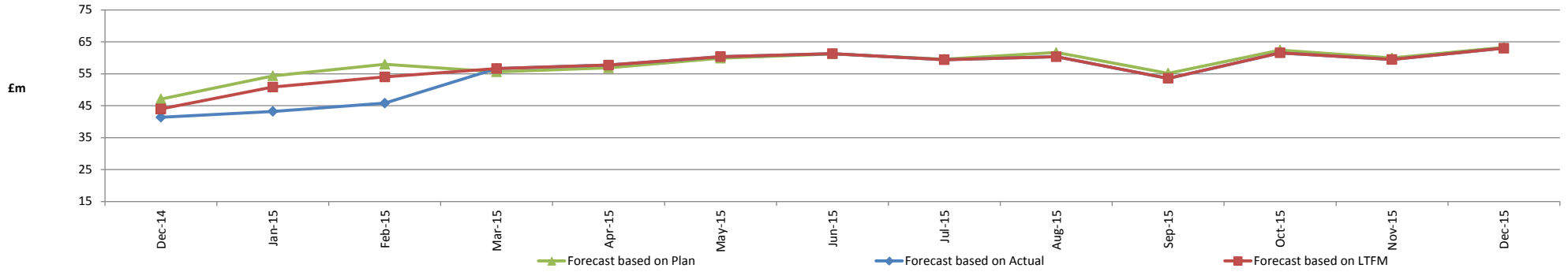
PAGE 8 - CASH

2014/15 monthly forecast versus actual month end cash balances



	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	55,590
Actual	50,449	51,917	60,421	45,631	56,521	46,802	34,149	47,879	45,255	41,349			
Revised Plan per LTFM				49,739	46,109	48,273	38,717	44,943	46,199	43,992	50,825	53,993	56,605

Twelve month rolling cash flow forecast for the period ending 31 December 2015



	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Forecast based on Plan	47,091	54,358	57,958	55,590	56,834	59,859	61,224	59,589	61,646	55,157	62,422	59,929	63,252
Forecast based on Actual	41,349	43,187	45,787	56,605	57,708	60,367	61,300	59,412	60,336	53,568	61,531	59,451	63,003
Forecast based on LTFM	43,992	50,825	53,993	56,605	57,708	60,367	61,300	59,412	60,336	53,568	61,531	59,451	63,003

The cash balance at 31 December 2014 was £5.7m below plan. The variance was made up of a short fall of income of £13.9m and payments under plan of £8.2m. The short fall of income is largely due to the Project Diamond and MFF monies included in the plan, now invoiced but for which the cash has not yet been received. Discussions continue to be ongoing at Director level regarding the receipt of this income. Despite the £13.9m payment in advance made to DHL in November, payments remain behind plan. This is due to £4.9m slippage on the capital programme and the outsourcing of the Accounts Payable function to ELFS at the beginning of October resulting in delays to payments as the new systems and processes bed in.

At the end of December the balance of cash invested in the National Loan Fund scheme totalled £40.3m. This amount was invested for 7 days at an average rate of 0.38%. Total accumulated interest receivable at 31 December was £166k

Cash **Risk:** **G**

PAGE 9 - DEBTORS AND CREDITORS

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	57,058	9,154	4,099	6,632	9,824	2,773	89,540	82,368
Non-NHS	8,415	4,062	71	3,405	3,482	895	20,330	20,682
Overseas	114	126	227	510	690	2,033	3,700	4,134
Private Patient	3,310	908	627	1,924	2,281	480	9,530	8,871
Total	**68,897**	**14,250**	**5,024**	**12,471**	**16,277**	**6,181**	**123,100**	**119,499**
% of Total Debt	**56.0%**	**11.6%**	**4.1%**	**10.1%**	**13.2%**	**5.0%**	**100.0%**	**100.0%**
Memo - Salary Overpayments	**80**	**38**	**37**	**74**	**122**	**277**	**628**	**665**

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	21,707	3,422	3,173	2,196	1,216	-11	31,703	29,957
Non NHS	4,943	863	219	1,557	2,042	329	9,953	10,418
Total	**26,650**	**4,285**	**3,392**	**3,753**	**3,258**	**318**	**41,656**	**40,375**
% of Total Creditors	**64.0%**	**10.3%**	**8.1%**	**9.0%**	**7.8%**	**0.8%**	**100.0%**	**100.0%**

Aged Debtor Analysis

The aged debtor analysis above includes all sales ledgers, excluding salary overpayments (shown as a memo item), private patients, accruals and work in progress. This is for consistency with the figures reported to the TDA for trade receivables. For month 9 Agreement of Balances purposes, it has been necessary to make an accounting adjustment transferring £2.0m of credit balances on the sales ledger and £1.2m accruals and WIP from NHS Debtors to NHS Creditors.

The top 2 debtors based on sales ledger only are:

NHS Hammersmith and Fulham CCG	£9.6m of which £9m is overdue
London International Hospital Ltd	£5m of which all is overdue

Aged Creditor Analysis

The aged creditor analysis includes the accounts payable ledger, invoice register accruals and other accruals. This is consistent with the figures reported to the TDA for trade payables.

The Trust's largest overdue creditor, based on accounts payable ledger and invoice register only, is Imperial College with £3.9m (total outstanding balance £4.4m). Work with Imperial College is ongoing, with both parties continuing to resolve outstanding queries and disputes to enable invoices to be processed for payment.

Debtors and Creditors	**Risk:**	**A**

Page 10 - CONTINUITY OF SERVICES RISK RATING (CoSRR)

Continuity of Service Risk Rating (CoSRR)	Weight	2014/15 Actual Q1	Actual Q2	Actual Previous Month	Actual Q3 YTD	Forecast Q4 Outturn
Liquidity	50%	(7.3)	(3.8)	(2.7)	(0.7)	(1.8)
Liquidity Risk Rating		2	3	3	3	3
Capital Servicing Capacity	50%	2.58	3.81	3.76	3.82	3.26
Capital Servicing Capacity Risk Rating		4	4	4	4	4
Overall CoSRR		3	4	4	4	4

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

Continuity of Services Risk Ratings (CoSRR)	Ris

PAGE 11 - SLA Activity & Income by POD (Estimate for December 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	53,261	51,120	(2,141)	44,400	43,367	(1,033)	58,864	56,842	(2,022)
- Regular Day Attenders	2,999	7,533	4,534	5,439	4,450	(989)	2,971	5,763	2,792
- Elective	15,044	15,126	82	51,489	53,268	1,779	68,551	71,613	3,062
- Non Elective	62,303	72,953	10,650	120,753	125,145	4,392	160,186	163,830	3,644
Accident & Emergency	125,842	117,604	(8,238)	14,880	13,611	(1,269)	19,699	18,247	(1,452)
Adult Critical Care	30,080	32,409	2,329	35,625	38,353	2,728	47,359	50,013	2,654
Renal Dialysis	191,003	180,446	(10,557)	28,518	26,910	(1,608)	37,864	35,678	(2,186)
Outpatients - New	207,737	211,610	3,873	34,784	31,351	(3,433)	53,758	41,157	(12,601)
Outpatients - Follow-up	376,148	438,230	62,082	52,068	56,058	3,990	68,004	73,041	5,037
Ward Attenders	3,909	10,994	7,085	643	738	95	854	921	67
PbR Exclusions			0	68,201	74,611	6,410	91,512	100,506	8,994
Direct Access	1,701,170	1,685,408	(15,762)	12,117	12,697	580	16,088	16,691	603
CQUIN			0	11,051	10,933	(118)	14,516	14,474	(42)
Others	1,642,852	1,687,337	44,485	62,370	75,707	13,337	82,536	101,985	19,449
National Rules			0	(8,080)	(7,150)	930	(10,728)	(9,289)	1,439
Contractual Rules			0	(3,845)	(2,491)	1,354	(4,207)	(2,696)	1,511
Transformation Fund			0	6,362	6,362	0	8,446	8,446	0
TDA Over performance				8,283		(8,283)	10,485		(10,485)
Balance Agreed Baseline			0	2,123	(14,628)	(16,751)	0	(11,638)	(11,638)
SLA Income	**4,412,348**	**4,510,770**	**98,422**	**547,181**	**549,292**	**2,111**	**726,758**	**735,584**	**8,826**
Less Non English Organisations	0	0	0	(1,975)	(2,079)	(104)	(3,554)	(3,307)	247
Less Foundation Trust Income	0	0	0	(2,021)	(2,224)	(203)	(2,682)	(2,953)	(271)
Less Local Authority	0	0	0	(7,741)	(7,589)	152	(10,275)	(10,092)	183
Others	0	0	0	95	96	1	(297)	673	970
TOTAL	**4,412,348**	**4,510,770**	**98,422**	**535,539**	**537,496**	**1,957**	**709,950**	**719,905**	**9,955**

Income by Sector	Year to Date (Income)			Forecast		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
North West - London	255,342	260,410	5,068	338,018	347,202	9,184
London - Others	31,652	32,134	482	40,740	42,624	1,884
Non London	14,010	14,318	308	19,718	18,417	(1,301)
NHS England	219,144	223,905	4,761	291,401	302,715	11,314
Non Contracted Activities	6,395	6,016	(379)	8,642	8,001	(641)
Out of Area Treatment	713	713	0	946	946	0
TDA Over performance	8,283		(8,283)	10,485	0	(10,485)
TOTAL	**535,539**	**537,496**	**1,957**	**709,950**	**719,905**	**9,955**

The report is an analysis of NHS SLA Income from clinical activities. We have applied changes for Cerner Corrections including POD mapping.
Year to Date position is a favourable variance against plan of £1.7m. The main reasons are :-
- Decrease in Day case activities of (£1.0m) with the key under performing service lines being Reproductive Medicine (£1.1m), Nephrology (£0.9m), Obstestrics (£0.7), over performing on Medical Oncology £1.5m, Nephrology £0.5, Vascular £ 0.4m and others £0.3m.
- Elective activity was above plan by £1.8m. This includes £1.8m for 18weeks funding.
- Non Elective work was above plan by £4.4m. There is a change in classification at service line there is a overall change on Obstretrics £2.0m and Paediatrics £ 1.6m.
- Outpatient first appointments were below plan by (£3.4m). The main under performing service line is the Diagnostic Imaging.
- Outpatient follow up appointments have increased against plan by £4.0m which includes OP procedures and 18week funding £ 1.3m. Other variances include Dermatology £ 2.0m, Thoracic Medcine £ 3.0mand Gynaecology £ 0.25m.
- Drugs are above plan £ 6.4m. These include increase in usage and new drugs approved by NICE.
- Full delivery of CQUIN, Local Performance Incentive £6.4m and additional waiting list monies £5.8m is included within the POD classifications but assumed to be delivered in line with the investment case for the Clinical Transformation Office (CTO).

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

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.1
Title	Values, behaviour and promise project
Report for	Review and approval
Report Authors	Dr Bob Klaber, Consultant Paediatrician Michelle Dixon, Director of Communications
Responsible Executive Director	Michelle Dixon, Director of Communications Jayne Mee, Director of People and OD

Executive summary:

We are proposing to launch a project to help develop an organisational culture where all our people feel they are part of a shared endeavour to achieve a compelling vision, and to be able to reflect this in all of our interactions with external audiences. Achieving this type of organisational culture and positioning will be critical to achieving the sustainable quality improvement that our new quality strategy is being tasked to deliver as well as the clinical transformation set out in our clinical strategy.

In practical terms, to achieve these goals, the project will first need:

- To build a shared understanding internally about what drives us an organisation and how that is manifested in what we do and say – our values and behaviours.
- To articulate a compelling and differentiating central narrative for what the Trust offers and what we stand for – our promise.

This paper summarises the project approach and timelines, including a major element of internal and external engagement, with key points for input and approval by the board. The board is asked to review and approve this proposal.

Recommendation to the Board: The Trust Board is asked to review and approve the paper.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- 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.

Background

There are three key drivers for the project:

- In 2014, the second cohort of the Horizons development programme, representing emerging senior clinical and managerial leaders across the organisation, identified an urgent need to refresh our current organisational values (developed in 2009) and to articulate how the values translate into behaviours for everyone. They felt this was key to creating the sense of shared purpose and collective responsibility across the trust that would facilitate continuous quality improvement and support clinical transformation and organisational change. They were keen to take on a leadership role themselves in initiating and delivering this piece of work, recognising that their 'day jobs' put them in an ideal position to lead the engagement element, creating a genuinely 'bottom up' as well as 'top down' process.

- As discussed at the November trust board meeting, the communications review showed that the Trust needs to do more to articulate a clear, overarching vision that resonates with all our audiences – one that places our hospitals, and increasingly our community-based services, within a single organisation where the whole is more than the sum of the parts and where care, research and education are working synergistically for the benefit of our patients and local communities. The board agreed that we should develop a work programme for 2015/16 to help us understand what matters most to our patients, partners and stakeholders about the care we provide and how we provide it, and how best to articulate what we do and what we stand for as an organisation.

- The CQC inspection identified that we need to make improvements to ensure the trust is well led at all levels of the organisation. The inspection reports touched on the need to translate values into actions, the continuation of silo working and the need for a continued focus on increasing staff engagement. Development of the new quality strategy being led by the medical director will include a focus on creating a common organisational culture that supports continuous quality improvement.

Purpose and goals

We are proposing to launch a project to help develop an organisational culture where all our people feel they are part of a shared endeavour to achieve a compelling vision, and to be able to reflect this in all of our interactions with external audiences. Achieving this type of organisational culture and positioning will be critical to achieving the sustainable quality improvement that our new quality strategy is tasked to deliver as well as the clinical transformation set out in our clinical strategy.

In practical terms, to achieve these goals, the project will first need:

- To build a shared understanding internally about what drives us an organisation and how that is manifested in what we do and say – our values and behaviours.
- To articulate a compelling and differentiating central narrative for what the Trust offers and what we stand for – our promise.

The engagement process to help define the organisational values, behaviours and promise will be as important as the outputs themselves. The focus will be on widespread staff engagement for defining our values and behaviours and to also include further understanding of the perceptions and views of external stakeholders to achieve the right positioning for our promise.

Effective implementation of the values and behaviours will be key for sustainable improvement and an implementation plan will be developed as part of the project. Delivery of these objectives will deliver immediate and stand-alone benefits for the organisation, including using the values and behaviours to shape how we recruit and appraise staff, to determine what we reward and recognise and to help set our priorities for education, learning and development. This work will also enable us to develop a 'service architecture', to help us and our various audiences understand and orientate our various and evolving services, and a 'corporate identity' – or 'look and feel', to help the organisation communicate coherently and consistently in everything we do.

Project outline

Phase	Activities	Timescale
Project initiation	Setting up detailed project plan Engagement with key internal stakeholders and partners – unions, charity, college	To end Jan
Gather/analyse initial inputs and develop and test format and materials for staff and stakeholder engagement	Working with specialist agency, review existing documentation and staff/audience research plus 1-2-1s with a number of board members Working with specialist agency, create 10-15min 'interventions' (to 'gatecrash' existing meetings and for opportunistic 1-2-1s) plus 60min workshops, as well as means for gathering feedback consistently Specific workshops with executive committee, full project team (including Horizons cohort), leadership forum	Feb – March
Roll out of phase I of wider engagement, led by Horizons cohort	Horizons cohort to facilitate 1-2-1 sessions and workshops with wide range of staff, supported by communications team with corporate level events (overall target – at least 1,000); plus smaller number of adapted workshops with stakeholders – patients, GPs, key partners;	Feb - April
Analysis of inputs and creation of draft values, behaviours and promise	Working with specialist external agency, creating the draft outputs and developing presentation and other materials to use in further engagement Specific workshop with the trust board	April
Roll out of phase II of wider engagement, led by Horizons cohort	Getting input and feedback on draft values, behaviours and promise (target – at least 1,000 staff)	May - June
Approvals and sign off	Ultimately, by the trust board	July
Launch and implementation	Implementation action plan to be developed as part of the project	August onwards

Governance

Project sponsors: Director of people and OD, director of communications

Project oversight group: Director of people and OD, director of communications, Bob Klaber and Pippa Nightingale (from Horizons group), Sue Grange (people and OD), plus senior representatives from strategy, medical directorate, nursing and operations.

Steering group/full project team: Full Horizons cohort (10 people), corporate communications representative (project co-ordinator), internal communications representative, Sue Grange (people and OD). We are also considering additional members, specifically to incorporate junior doctors and other trainees.

Core project team: Bob Klaber, Pippa Nightingale (Horizons group), corporate communications representative (project co-ordinator), internal communications representative, people and OD representative

Review/sign offs – project team, steering group, executive committee, 29 July trust board

Resources

Specialist external agency support

Recommendation to the Board: The Trust Board is asked to review and approve the paper.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.2
Title	2014 Emergency Preparedness, Resilience and Response (EPRR) assurance process
Report for	Monitoring and Noting
Report Author	Nicola Grinstead, Director of Operational Performance
Responsible Executive Director	Steve McManus, Chief Operating Officer

Executive Summary:

NHS Trusts are expected to participate in an annual Emergency Preparedness, Resilience and Response assurance process carried out by NHS England. In July 2014 NHS England issued a new document; *"NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)"* which sets out the minimum EPRR standards NHS organisations must meet. This new document supersedes *"The NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR), January 2013"* and defines a new set of standards.

In London, the assessment was carried out in November with results shared with individual Trusts in December. Against 66 measures, ICHT scored 55 'green' ratings, 11 'amber' ratings and zero 'red' ratings giving the Trust an overall compliance rating of 'substantial'. London wide results will not be published until March 2015 and as such at this point it is not possible to determine how ICHT results compare to other providers. Whilst the standards have materially changes for this year making a direct comparison with our own performance from last year challenging, overall the proportionality of green to amber ratings is broadly the same.

An action plan for the 'amber' ratings has been prepared and its delivery will be co-ordinated and overseen by the Emergency Planning team.

One important standard to draw attention to is the Trust's ability to respond to urgent communications. An exercise is carried out monthly by NHSE.

Recommendation to the Board:

1. Acknowledgement of the revised 2014-15 EPRR assurance process and standards
2. Acknowledgement of the outcome of the ICHT 2014 EPRR Assurance Assessment and specifically that out of 66 indicators ICHT achieved 55 green ratings, 11 amber ratings and zero red ratings resulting in a single overall level of compliance of 'Substantial'
3. Acknowledgement of the key areas where improvement is required to the amber rated indicators and note a detailed action plan is in place and will be co-ordinated and overseen by the Trust's Emergency Planning Team.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

1. Introduction and Context

1.1. The Civil Contingencies Act (2004) requires category one responders, such as ICHT, to show they can deal with a wide range of incidents such as a prolonged period of severe pressure, extreme weather conditions, an outbreak of an infectious disease or a major traffic accident.

1.2. On 1st July 2014 NHS England issued a new document; *"NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)"* which sets out the minimum EPRR standards NHS organisations must meet. This new document supersedes *"The NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR), January 2013"* and defines a new set of EPRR standards.

1.3. 12 core standards (8 general and 4 specifically related to hazardous materials) are grouped into 66 individual measures which must be met by Trust's. Adequate assurance must be provided through an annual assessment process.

2. Emergency Preparedness, Resilience and Response Core Standards

2.1. The 12 core standards are detailed in the table below.

No	Standard
	General EPRR standards
1	Governance
2	Duty to assess risk
3	Duty to maintain plans (emergency and business continuity)
4	Command and Control
5	Duty to communicate with the public
6	Information sharing
7	Co-operation
8	Training and exercising
	Hazardous Materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN)
9	Preparedness
10	Decontamination
11	Equipment
12	Training

2.2. The 12 core standards are comprised of 66 measures against which a Trust's performance is assessed.

2.3. To enable a national-level overview of EPRR capability each organisation is asked to provide a single self-assessed Level of Compliance, approved by the AEO (Accountable Executive Officer – Steve McManus). This is intended to summarise whether organisations believe they are fully, substantially, partially or non-compliant against the core standards as a whole. The definitions of each term are detailed below:

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes that the organisation is expected to achieve.
Partial	The plans and work programme in place do not adequately address several core standard themes that the organisation is expected to achieve.
Non-compliant	The plans and work programme in place do not appropriately address multiple core standard themes that the organisation is expected to achieve.

3. 2014 EPRR Assurance Assessment

3.1. In November 2014, the NHS England London EPRR team undertook a review of the emergency preparedness activities at Imperial College Healthcare NHS Trust against the 12 nationally defined EPRR core standards.

3.2. Trusts were required to submit evidence in relation to the 12 core standards by demonstrating how they meet 66 indicators. ICHT achieved 55 green ratings (83%), 11 amber ratings (17%) and zero red ratings. This is a marginal improvement on the previous year whereby we achieved 82% green ratings 18% amber ratings and zero red ratings although peer comparison is not available to us yet.

3.3. The single overall Level of Compliance, approved by the AEO, was self-assessed to be 'Substantial' and confirmed by NHS England.

3.4. The 11 amber areas requiring improvements include:

- Consulted and shared risk assessment is in alignment with the Trust's new risk management process and register
- Corporate and service level business continuity arrangements further developed to comply with recently revised ISO 22301 standards
- Improved planned arrangements for Surge and Escalation Management (including links to appropriate clinical networks e.g. Burns, Trauma and Critical Care),
- Consultation and sign off of evacuation plans
- Revision of critical services, utilities, IT and telecoms business continuity plans and centralisation within the Strategic Business Continuity Plan.
- Improved engagement and co-operation of interested parties and key stakeholders who have a role in the plan and securing agreement to its content
- Concurrent arrangements in place for resilient communications
- Improved evidence of incident commanders (on-call directors and managers) maintenance of continuous personal development portfolio demonstrating training and/or incident /exercise participation.
- Internal training based upon current good practice and using material that has been supplied as appropriate specifically in relation to staff personal protective equipment in the management of contagious incidence.

4. Action Plan

4.1. A detailed action plan has been put in place to ensure all amber rated indicators can be improved. The action plan will be further developed, co-ordinated and implemented by the Emergency Planning team.

4.2. The key components of the action plan include;

Already completed;

- Critical care network details referenced within the EPRR strategy.
- Internal personal protective equipment training (specifically facemasks and the roll out of training and fit-testing) for targeted staff groups
- Gold commander training

Within 2 months;

- Alignment, and sign off, of current EPRR risk assessment with the Trust risk management process. Completion of separate HAZMAT/CBRN decontamination risk assessment in relation to the used equipment.
- Delivery of refreshed silver commander training

Within 6 months

- Official sign-off of strategic business continuity plan
- Sign-off of the, currently draft, Trust evacuation plan
- Completion and official sign-off of core draft business continuity plans
- Improved engagement and co-operation of interested parties and key stakeholders who have a role in the plan and securing agreement to its content through forum involvement
- Concurrent arrangements in place for resilient communications, particularly in relation to NHS England command and control
- Improved Trust wide engagement in business continuity

Recommendation to the Board:

1. Acknowledgement of the revised 2014-15 EPRR assurance process and standards
2. Acknowledgement of the outcome of the ICHT 2014 EPRR Assurance Assessment and specifically that out of 66 indicators ICHT achieved 55 green ratings, 11 amber ratings and zero red ratings resulting in a single overall level of compliance of 'Substantial'
3. Acknowledgement of the key areas where improvement is required to the amber rated indicators and note a detailed action plan is in place and will be co-ordinated and overseen by the Trust's Emergency Planning Team.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.3
Title	NHS Trust Development Authority Self-Certifications
Report for	Approval
Report Author	Anna Bokobza, Head of Planning and Business Development
Responsible Executive Director	Alan Goldsman, Chief Financial Officer

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.

Recommendation to the Board:

The Board is asked to retrospectively approve the October 2014 and November 2014. No changes have been made.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: October 2014, Submitted 28/11/2014

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.**	Bill Shields Chief Financial Officer
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.**	Helen Potton Interim Trust company Secretary
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.**	Janice Sigsworth Director of Nursing
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*	Janice Sigsworth Director of Nursing

these risks to ensure continued compliance. **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: There are risk management processes in place and the management of strategic risks is currently undergoing review. Recommendations from the Audit, Risk & Governance Committee are followed up on and the actions reported at each Audit, Risk & Governance Committee.**	Bill Shields Chief Financial Officer
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.**	Helen Potton Interim Trust company Secretary
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.* **Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI):** • To date 3 cases of MRSA BSI have been allocated to the Trust (one case in April and two cases in May); • A case of MRSA BSI was identified during October. This is currently being investigated. The final allocation will be determined once the review is complete. ***Clostridium difficile* infections:** • The Department of Health's annual ceiling for the Trust is 65 cases for 2014/15; to date we have reported 53 cases attributed to the Trust; • Eight Trust attributable cases were reported to Public Health England (PHE) in October 2014. **Referral to treatment (RTT)** There is currently a national amnesty on delivery of the three RTT standards. This has been put in place and agreed at a national and local level to allow Trusts to clear as many over 18 week patients as possible to add resilience into the system going into the winter period. The Trust has put on additional capacity to treat long waiters and therefore a dip in performance is expected. This applies to data submitted for performance in October and November. In October, as planned, all three standards were under delivered. As well as putting extra capacity in some challenged specialities to reduce the numbers of patients waiting over 18 weeks, there have been a number of data quality challenges that the Trust has experienced since the implementation of a new patient administration system in April 2014 (Cerner). The Trust has an action plan in place to recover the position: • Resolving any technical issues that relate to Cerner that are preventing the Trust from reporting an accurate position e.g. ability for the Trust to report social adjustments and some treatments; • Intensive training to support staff to correctly input data at the front end; • Ensuring that the workflow on Cerner is such that it is difficult to input incorrect data; • A team of validators are in post to assist with the correction of data; • Additional capacity has been commissioned over October and November to clear a backlog of patients waiting over 18 weeks. This is to add extra resilience into the system. The Trust is confident that an accurate position can be reported from December 2014 and the Trust anticipates that the standards will be achieved.	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 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**	Helen Potton Interim Trust company Secretary

Imperial College Healthcare NHS Trust

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.

Imperial College Healthcare NHS Trust

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: October 2014 Submitted 28/11/2014

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). **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	Steve McManus, Chief Operating Officer.

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.	
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.

Imperial College Healthcare NHS Trust

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: November 2014, Submitted 31/12/2014

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.**	Bill Shields Chief Financial Officer
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.**	Jan Aps Trust company Secretary
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.**	Janice Sigsworth Director of Nursing
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.* **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**	Janice Sigsworth Director of Nursing

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: There are risk management processes in place and the management of strategic risks is currently undergoing review. Recommendations from the Audit, Risk & Governance Committee are followed up on and the actions reported at each Audit, Risk & Governance Committee.**	Bill Shields Chief Financial Officer
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.**	Jan Aps Trust company Secretary
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.* **Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI):** • To date 3 cases of MRSA BSI have been allocated to the Trust (one case in April and two cases in May); • Two cases of MRSA BSI are currently being investigated; 1 in October and 1 in November. The November case is currently under review as per the PIR process and is likely a contaminant. ***Clostridium difficile* infections:** • The Department of Health's annual ceiling for the Trust is 65 cases for 2014/15; at the end of November we had reported 56 cases attributed to the Trust; • The number of Trust attributable cases of C. difficile that arose due to a 'potential lapse in care' whilst at ICHT will be reported to the board from January 2015. The definition of a 'potential lapse in care' is currently being finalised and agreed with the CCG. A sample of Trust attributable C. difficile cases from quarter one has been subject to a collaborative review with the CCG and this methodology will be repeated for cases in Quarter two in January 2015. **Referral to treatment (RTT)** There is currently a national amnesty on delivery of the three RTT standards. This has been put in place and agreed at a national and local level to allow Trusts to clear as many over 18 week patients as possible to add resilience into the system going into the winter period. The Trust has put on additional capacity to treat long waiters and therefore a dip in performance was expected. This applies to data submitted for performance in November. As planned, all three standards were under delivered. As well as putting extra capacity in some challenged specialities to reduce the numbers of patients waiting over 18 weeks, there have been a number of data quality challenges that the Trust has experienced since the implementation of a new patient administration system in April 2014 (Cerner). The Trust has an action plan in place to recover the position: • Resolving any technical issues that relate to Cerner that are preventing the Trust from reporting an accurate position e.g. ability for the Trust to report social adjustments and some treatments; • Intensive training to support staff to correctly input data at the front end; • Ensuring that the workflow on Cerner is such that it is difficult to input incorrect data; • A team of validators are in post to assist with the correction of data; • Additional capacity was commissioned over October and November to clear a backlog of patients waiting over 18 weeks. The Trust is confident that an accurate position can be reported from December 2014 and the Trust anticipates that the standards will be achieved.	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 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.**	Jan Aps Trust company Secretary

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: The Board development programme is being reviewed and will continue in to 2015.**	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.** **The development sessions will continue in 2015.**	Jayne Mee, Director of People and Organisational Development.

Imperial College Healthcare NHS
NHS Trust

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: November 2014 Submitted 31/12/2014

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). **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	Steve McManus, Chief Operating Officer.

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.	
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.

Recommendation to the Board:

The Board is asked to retrospectively approve the October 2014 and November 2014. No changes have been made.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.4
Title	Standing Orders
Report for	Decision
Report Author	Jan Aps, Trust Company Secretary
Responsible Executive Director	Alan Goldsman, Interim Chief Financial Officer

Executive Summary:

As part of the foundation trust application process, the finance and corporate governance teams sought to review a number of corporate governance documents, including the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Schedule of Reserved Powers.

The Executive Committee and the Audit, Risk and Governance Committee approved the revised Standing Financial Instructions in December (with a small number of outstanding amendments which have now been addressed).

The revised Standing Orders attached have been reviewed by the Executive Committee, and minor amendments made following feedback. There are no major changes from previous versions, but the document has been revised following review of national good practice.

There are no specific financial issues arising from the Standing Orders. Adherence to these and Standing Orders and associated governance documents should reduce the Trust's expose to risk on number of fronts, and ensure a greater level of legal compliance .

The Scheme of Delegation and Schedule of Reserved Powers will be presented for approval over the next couple of months, the former to Executive Committee and the Audit, Risk and Governance Committee and the latter to Executive Committee and the Trust Board.

Recommendation to the Board:

The Trust Board is asked to approve the Standing Orders.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust
Standing Orders

Trust Standing Orders

Date Adopted	January 2015
Version	V5.0
Review Deadline	January 2016

Purpose - NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.

High standards of corporate and personal conduct are essential in the NHS. Standing Orders, should be read alongside the Standing Financial Instructions (SFIs), Schedule of Reserved Powers (SRP) and Scheme of Delegated Authorities (SoDA) identify who in the Trust is authorised to do what.

Key messages

- The consolidated document provides a single source of the key rules under which the Trust is managed and governed.
- The regulations which determine the way that the Trust Board operates and the Trust is governed are spelt out in the Standing Orders.
- Financial responsibilities and authorities are described in the SFIs and SoDA
- All employees of the Trust need to be aware of their responsibilities and authorities described in this document.

You may also need to refer to the following policies and guidance –

Various legislation is relevant to the contents of the SOs and these are identified in the text. The SOs refer to the following Trust Policies:

- Policy Standards of Business Conduct, incorporating anti-bribery and corruption policy; and the recognition and treatment of conflicting interests, gifts and hospitality
- Counter Fraud and Corruption Policy

Who should read this policy?

- All individuals employed or engaged by the Trust who have been given resource management and decision making authorities need to have a reasonable understanding of the extended SOs.
- All should be aware that the SOs exist and what they contain.

Core accountabilities	
Policy drafting	Trust Company Secretary
Review and approval	For approval by Executive Committee and Trust Board
Adoption	Trust Board
Dissemination	Trust Company Secretary
Compliance	All staff and individuals providing services in the name of the Trust

Version history

V3.1	Apr 2010	Programmed update
V4.0	May 2014	Programmed update, plus update for the NHS Act, 2006 (2012 provisions) and other new legislation. Not implemented – updated to V5.0
V5.0	January 2015	As 4.0 plus further minor amendments

Contents

This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures.

Foreword to Standing Orders

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money. The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

Additional documents, which form part of these "extended" Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Schedule of Reserved Powers to the Trust Board
- Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

These extended Standing Orders set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

All Executive and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.

Introduction

I. The Imperial College Healthcare NHS Trust (the Trust) is a body corporate which was established under The Imperial College National Health Service Trust (Establishment) Order (the Establishment Order) 2007 No 2755 (and amendment order 2012 No 755).

II. The principal place of business of the Trust is The Bays, South Wharf Road, St Mary's Hospital, London W2 1NY.

III. NHS Trusts are governed by statute, mainly the National Health Service Act 2006 and the Health and Social Care Act, 2012.

IV. The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and Schedule 4) and in the Establishment Order.

V. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health. The Trust also has a common law duty as a bailee for property held by the Trust on behalf of patients.

VI. The Code of Accountability for NHS Boards (DH, revised April 2013) requires that boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior managers. The Code of Accountability makes various requirements concerning possible conflicts of interest of Board directors.

VII. The Code of Practice on Openness in the NHS (NHS Executive, 1995), as revised by the Freedom of Information Act, 2000 and the Environmental Information Regulations, 2004 sets out the requirements for public access to information on the NHS.

VIII. Through these Standing Orders, the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of the Standing Orders; or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State for Health may direct.

Interpretation

IX. The Chairman of the Trust is the final authority in the interpretation of Standing Orders on which the Chief Executive, guided by the Trust Company Secretary, shall advise him.

X. The following definitions apply for this document.

Legislation definitions:

- the **2006 Act** is the National Health Service Act, 2006
- the **2012 Act** is the Health and Social Care Act, 2012
- **Membership and Procedure Regulations** are the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI(1990)2024), as amended.

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Other definitions:

- **Accountable Officer** is the officer responsible and accountable for funds entrusted to the Trust; and is responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive, or their appointed replacement, is the Accountable Officer for this Trust.
- **Budget** is the plan, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- **Chairman of the Trust** is the person appointed by the Secretary of State for Health, acting through the NHS Trust Development Authority to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall, if the Chairman is absent from the meeting or otherwise unavailable, be deemed to include the **Deputy Chairman of the Trust**, or other Non-Executive Director as is appointed in accordance with Standing Order 12.
- **Chief Executive** is the chief officer of the Trust.
- **Committee** is committee appointed by the Trust Board.
- **Committee Members** are formally appointed by the Trust Board to sit on, or to chair specific committees.
- **Clinical Directors** are specialty leads reporting to and accountable to the Chief Operating Officer, with professional oversight from the Medical Director. They are ***excluded*** from the term "Director" for the purposes of this document, unless specifically stated otherwise.
- **Deputy Chairman** means the Non-Executive Director appointed by the Trust to take on the Chairman's duties if the Chairman is absent for any reason.
- **Director** means the member of the Trust Board and for the avoidance of doubt includes the Chairman, Executive Directors, and Non-Executive Directors only.
- **Director of Facilities** is the Director of Estates Facilities and Capital Planning
- **Chief Financial Officer** undertakes the responsibilities of the Director of Finance and is a member of the Trust Board.
- **Establishment Order** is the Imperial College National Health Service Trust (Establishment) Order (the Establishment Order) 2007 No 2755 (and amendment order 2012 No755).
- **Executive Director** means an Executive member of the Trust Board.
- **Funds Held on Trust** are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
- **Motion** is a formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
- **NHS Trust Development Authority (NTDA)** is responsible for the oversight of NHS trusts, excluding NHS foundation trusts; and has delegated authority from the Secretary of State for Health for the appointment of the Non-Executive Directors, including the Chairman of the Trust.
- **Nominated Officer** is the officer charged with the responsibility for discharging specific tasks within the Standing Orders and Standing Financial Instructions.

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- **Non-Executive Director** is a person appointed by the Secretary of State for Health, exercised through the authority vested in the NHS Trust Development Authority, to help the Trust Board to deliver its functions.
- **Officer** (or **staff**) means an employee of the Trust or any other person holding a paid appointment or office with the Trust. (This includes all employees or agents of the Trust, including medical and nursing staff and consultants practising upon the Trust's premises and shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust)..
- **SFIs** are the Standing Financial Instructions.
- **SOs** are the Standing Orders.
- **Standards of Business Conduct** is the NHS "Standards of Business Conduct, incorporating anti-bribery and corruption; and the recognition and treatment of conflicting interests, gifts and hospitality" or as amended
- **Trust** is the Imperial College Healthcare NHS Trust.
- **Trust Board** (or the **Board**) is the Chairman and Non-Executive Directors and Executive Directors.
- **Trust Company Secretary** is the officer appointed to provide advice on corporate governance issues to the Board and the Chairman; and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.
- **Working day** means any day, other than a Saturday, Sunday or legal holiday

XI. Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

XII. All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

Standing Orders for the regulation of the proceedings of Imperial College Healthcare National Health Service Trust

Part I – Membership

1. Name and business of the Trust

1.1. All business shall be conducted in the name of Imperial College Healthcare NHS Trust ("the Trust").

1.2. The Trust has the functions conferred on it by Schedule 4 of the 2006 Act.

1.3. The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, which may include members participating by video or telephone. These powers and decisions are set out in the Schedule of Decisions Reserved for the Trust Board, and have effect as if incorporated into the Standing Orders.

2. Composition of the Trust Board

2.1. The membership of the Trust Board shall comprise the Chairman and seven Non-Executive Directors, together with five Executive Directors (in accordance with the Establishment Order). At least half of the membership of the Trust Board, shall be independent Non-Executive Directors (this can include the Chairman).

2.2. In addition to the Chairman, the Non-Executive Directors shall normally include:

- 2.2.1. one appointee nominated to be the Deputy Chairman
- 2.2.2. one appointee nominated to be the (shadow) Senior Independent Director. This role will become fully established once the Trust has achieved Foundation Trust status
- 2.2.3. in accordance with the Establishment Order, one appointee from University College, in recognition of the Trust's status as a teaching hospital
- 2.2.4. one or more appointees who have recent relevant financial experience.

Appointees can fulfil more than one of the roles identified.

2.3. The Executive Directors shall include:

- 2.3.1. Chief Executive
- 2.3.2. Chief Financial Officer, or equivalent
- 2.3.3. Medical Director
- 2.3.4. Director of Nursing, or equivalent
- 2.3.5. Up to one other Executive Director to be awarded voting rights.

2.4. The Board may ask for regular attendance of other senior officers at Trust Board.

3. Appointment of the Chairman and directors

3.1. The Chairman and Non-Executive Directors of the Trust are appointed by the NHS Trust Development Authority (NTDA), on behalf of the Secretary of State for Health.

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3.2. The Chief Executive shall be appointed by the Chairman and the Non-Executive Directors.

3.3. Executive Directors shall be appointed by a committee comprising the Chairman, the Non-Executive Directors and the Chief Executive.

3.4. Where more than one person is appointed jointly to an Executive Director post in the Trust, those persons shall become appointed as an Executive Director, jointly, and the joint appointees will have the power of one vote; and shall count for the purpose of Standing Order 2 as one person.

4. Deputy Chairman

4.1. To enable the proceedings of the Trust to be conducted in the absence of the Chairman, the Trust Board may elect one of the Non-Executive Directors to be Deputy-Chairman, for a period that does not exceed the remainder of their appointed term as a Non-Executive Director of the Trust.

4.2. Any Non-Executive Director so elected may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The appointment as Deputy Chairman will end with the termination for any reason of that Non-Executive Director's period of office as a director. On such resignation or termination the Trust Board may then appoint another Non-Executive Director as Deputy Chairman, in accordance with the provision of this Standing Order.

4.3. When the Chairman is unable to perform his duties due to illness or absence for any reason, his duties will be undertaken by the Deputy Chairman.

5. Tenure of office

5.1. The regulations governing the period of tenure of office of the Chairman and Non-Executive Directors and the termination or suspension of office of the Chairman and Non-Executive Directors are contained in the Membership and Procedure Regulations and as directed by the NTDA, under its delegated authority from Secretary of State for Health.

6. Code of Conduct and Accountability and the Trust's commitment to openness

6.1. All directors shall subscribe and adhere at all times to the principles contained in the Trust's "Policy Standards of Business Conduct, incorporating anti-bribery and corruption policy; and the recognition and treatment of conflicting interests, gifts and hospitality" (the Policy Standards of Business Conduct).

7. Functions and roles of Chairman and directors

7.1. The function and role of the Chairman and members of the Trust Board is described within these Standing Orders and within those documents that are listed previously to be read in association with these Standing Orders.

Part II – Meetings

8. Ordinary meetings of the Trust Board

8.1. All ordinary meetings of the Trust Board shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

8.2. Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may from time to time determine. A minimum of six meetings shall be held each year.

8.3. The Chairman shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press to ensure that the Trust Board's business may be conducted without interruption and disruption.

8.4. Without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Trust Board resolving as follows: "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

8.5. Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

8.6. The Chairman may invite any member of staff of Imperial College Healthcare NHS Trust, any other NHS organisation, an officer of the local council(s), or any other individual acting in an advisory capacity to attend meetings. These invitees shall not count as part of the quorum or have any right to vote at the meeting.

8.7. An annual public meeting shall be held on or before 30 September in each year for the purpose of presenting audited accounts, annual reports and any report on the accounts.

8.8. The Trust Board may, by resolution, exclude the public from a part or the whole of a meeting whenever publicity would be prejudicial to public interest by reason of the confidential nature of the business to be transacted.

8.9. The provisions of these Standing Orders relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to seminars or workshops or other meetings attended by members of the Trust Board.

9. Extraordinary meetings of the Trust Board

9.1. The Chairman may call a meeting of the Trust Board at any time. Directors may ask the Chairman to call a meeting of the Trust Board at any time.

9.2. A meeting may be called forthwith, by the directors who are eligible to vote, if the Chairman refuses to call a meeting after such a request has been presented to him,

signed by at least one third of the whole number of directors who are eligible to vote (including at least one executive and one Non-Executive Director); and has been presented to him at the Trust's principal place of business. The directors who are eligible to vote may also call a meeting forthwith, if, without refusing, the Chairman does not call a meeting within seven days after receipt of such request.

10. Notice of meetings

10.1. The Trust shall set dates and times of regular Trust Board meetings for the forthcoming calendar year by the end of November of each year.

10.2. A notice of the meeting, specifying the business proposed to be transacted, shall be posted before each meeting of the Trust Board. This notice shall be signed by the Chairman, or by a director or officer of the Trust authorised by the Chairman to sign on his behalf. The notice shall be delivered to every director, by the most effective route, including being sent by post to the usual place of residence of the director, or sent electronically to the usual e-mail address of the director. The notice shall be delivered to each director at least three working days before the meeting. Notice shall be presumed to have been served two days after posting and one day after being sent out via email.

10.3. Lack of service of such notice on any individual director shall not affect the validity of a meeting. However, failure to serve such a notice on at least three directors who are eligible to vote will invalidate the meeting.

10.4. In the case of a meeting called by directors in default of the Chairman, see Standing Order 9, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

10.5. Where a part or the whole of a meeting is to be open to the public, official notice of the time, place and agenda of the meeting shall be announced in public. Notice will be given by one or more of: an announcement in the local press and on the Trust's internet website; displaying the notice in a conspicuous place in the Trust's hospitals or other facilities; displaying the notice in other public places. The Trust Board may decide to limit publication to details of the items on the meeting agenda that will be considered in the part of the meeting to be held in public. A copy of the notice including the agenda may also be sent to local organisations that will have an interest in the decisions of the Trust Board. These organisations include bodies responsible for commissioning acute NHS services locally, patient and public representative groups and local councils.

10.6. Notice will be given at least three working days before the meeting. Failure to do so will render the meeting invalid.

11. The agenda

11.1. The Trust Board may determine that certain matters will appear on every agenda for an ordinary meeting of the Trust Board; and that these will be addressed prior to any other business being conducted at the discretion of the Chairman. On agreement by the Trust Board, these matters may change from time to time.

11.2. A director may request that a matter is included on an agenda. This request should be made in writing, including by electronic means, to the Chairman, Chief Executive, or

the Trust Company Secretary at least seven working days before the meeting, subject to Standing Order 10. Requests made less than seven working days before the meeting may be included on the agenda at the discretion of the Chairman, or to the extent that this discretion is delegated to the Chief Executive and the Trust Company Secretary.

11.3. Notwithstanding Standing Order 17 a director may with the consent of the Chairman of the meeting, add to the agenda of any meetings any item of business relevant to the responsibilities of the Trust, under "Any Other Business".

12. Chairman of meetings

12.1. The Chairman shall preside at any meeting of the Trust Board, if present. In his absence, the Vice Chairman shall preside.

12.2. If the Chairman and Deputy Chairman are absent, the directors present, who are eligible to vote shall choose a Non-Executive Director who shall preside. An Executive Director may not take the chair.

12.3. The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the Standing Orders shall be final. In this interpretation he shall be advised by the Chief Executive and the Trust Company Secretary and in the case of Standing Financial Instructions he shall be advised by the Chief Financial Officer.

13. Voting

13.1. It is not a requirement for decisions to be subject to a vote. The necessity for a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chairman shall be responsible for deciding whether a vote is required and what form this will take.

13.2. Where it is necessary to take a vote to determine an issue, the decision shall be determined by a majority of the votes of the directors present and eligible to vote. If the result of the vote is equal, the Chairman of the meeting shall have a second or casting vote.

13.3. All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may be held, if a majority of the directors present and eligible to vote so request. Unless specifically agreed beforehand, the voting record of each individual director will not be made public, or recorded.

13.4. The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

13.5. If a director so requests, his vote will be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded.

13.6. In no circumstances may an absent director vote by proxy.

13.7. An officer who has been appointed formally by the Trust to act up for an Executive Director during a period of incapacity, or temporarily to fill an Executive Director

vacancy, shall be entitled to exercise the voting rights of that Executive Director. An officer attending the Trust Board to represent an Executive Director during a period of incapacity or temporary absence, but without formal acting up status, may not exercise the voting rights of that Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

13.8. Where the office of a director who is eligible to vote is shared jointly by more than one person:

13.8.1. either or both of those persons may attend and take part in the meetings of the Trust Board.

13.8.2. if both are present at a meeting they will cast one vote if they agree.

13.8.3. in the case of disagreement no vote will be cast.

13.8.4. the presence of either or both of those persons will count as the presence of one person for the purpose of establishing a quorum.

13.9. Where necessary, a director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

14. Quorum

14.1. No business shall be transacted at a Trust Board meeting unless at least four of the Directors who are eligible to vote (including at least one Executive Director and one Non-Executive Director) are present.

14.2. An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

14.3. A Director will not count towards the quorum on a matter where he is ruled to be ineligible to participate in the discussion, or vote, due to the declaration of a conflict of interest, see Standing Order 21 and 22. If a quorum is not available for the passing of a resolution on any matter, that matter may be discussed further at the meeting, but no resolution can be made. That position shall be recorded in the minutes of the meeting. The meeting shall then proceed to the next business.

15. Record of attendance

15.1. The names of the directors and others invited by the Chairman, in accordance with Standing Order 8, present at the meeting, shall be recorded in the minutes.

15.2. If a Director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

16. Minutes

16.1. The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

16.2. There should be no discussion on the minutes, other than as regards their accuracy, unless the Chairman considers discussion appropriate.

16.3. Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

17. Notice of motion

17.1. Subject to the provision of Standing Order 20, a director of the Trust desiring to move a motion shall give notice of this, to the Chairman, at least seven working days before the meeting. The Chairman shall insert all such notices that are properly made in the agenda for the meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

18. Motions

18.1. When a motion is under discussion or immediately prior to the discussion it shall be open to a Director to move:

- 18.1.1. an amendment to the motion.
- 18.1.2. the adjournment of the discussion or the meeting.
- 18.1.3. that the meeting proceed to the next business.
- 18.1.4. the appointment of an ad hoc committee to deal with a specific item of business.
- 18.1.5. that the motion be now put
- 18.1.6. a motion resolving to exclude the public (including the press).

18.2. The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the seconder and the consent of the Trust Board.

19. Right of reply

19.1. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

20. Motion to rescind a decision of the Trust Board

20.1. Notice of a motion to rescind any decision of the Trust Board (or general substance of any decision) which has been passed within the preceding six calendar months, shall bear the signature of the Director who gives it and also the signature of four other directors who are eligible to vote.

20.2. When the Trust Board has debated any such motion, it shall not be permissible for any Director, other than the Chairman to propose a motion to the same effect within a further period of six calendar months.

21. Declaration of Interests and Register of Interests

Declaration of Interests

21.1. In addition to the statutory requirements relating to pecuniary interests dealt with in Standing Order 22, the Trust's Policy Standards of Business Conduct requires directors to declare interests which are relevant and material to the Trust Board. All existing Directors and any senior officers who may act up into an Executive Director post should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and senior officers appointed subsequently should declare these interests on appointment.

21.2. Interests, which would be regarded as "relevant and material", are:
- 21.2.1. directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).
- 21.2.2. ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
- 21.2.3. majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- 21.2.4. a position of authority in a charity or voluntary organisation in the field of health and social care.
- 21.2.5. any connection with a voluntary or other organisation contracting for NHS services.

21.3. Subject to the requirements stated in Standing Order 22, there is no requirement for the interests of directors' spouses, partners, or other family members to be disclosed.

21.4. If directors have any doubts about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

21.5. Annual declarations of interests should be considered by the Trust Board and retained as part of the record of the Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

21.6. If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the Director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

21.7. Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

Register of Interests

21.8. The Trust Company Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and Non-Executive Directors.

21.9. These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

21.10. The Register of Interests will be published on the Trust's website.

21.11. With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), this Standing Order also applies in full to any committee or sub-

committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

22. Disability of Directors in proceedings on account of pecuniary interest

22.1. Subject to Standing Order 21 and the provisions of this Standing Order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

22.2. The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to him to be in the interests of the NHS that the disability should be removed.

22.3. The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

22.4. Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

22.5. For the purpose of this Standing Order a Director shall be treated, subject to Standing Order 2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

22.5.1. he, or a nominee of his, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or,

22.5.2. he is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

22.5.3. and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

22.6. A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

22.6.1. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

22.6.2. of an interest in any company, body or person with which he is connected as mentioned in Standing Order 22.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

22.7. This Standing Order shall not prohibit a Director from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it, if:

22.7.1. he has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, **and**

22.7.2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, **and**

22.7.3. the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of the class.

This does not affect his duty to disclose the interest.

22.8. This Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a Director).

23. Standards of Business Conduct

23.1. All staff must comply with the NHS Standards of Business Conduct, and the seven principles set out by the Committee on Standards in Public Life, published by the Professional Standards Authority, November 2012. The following provisions should be read in conjunction with the Register of Interests Policy and Hospitality Policy.

23.2. All staff shall declare any relevant and material interest, such as those described in Standing Order 21. The declaration should be made on appointment or, if the interest is acquired, or recognised subsequently, at that time to the Executive Director, clinical director, or senior manager to whom they are accountable. Such director or senior manager shall ensure that such interests are entered in a Register of Interests, kept for that purpose.

23.3. Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the placing of contracts by the Trust, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

23.4. If an officer becomes aware of a potential or actual contract in which he has an interest of the nature described in Standing Orders 21 and 22 and this Standing Order, he shall immediately advise the Chief Financial Officer formally in writing. This requirement applies whether or not the officer is likely to be involved in administering the proposed, or awarded contract to which he has an interest.

23.5. Gifts and hospitality shall only be accepted in accordance with the Hospitality Policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

23.6. All gifts and hospitality, other than those that are of clearly minimal value, should be declared in a Register of Gifts and Hospitality kept by the Chief Executive or nominated officer, and departmental managers for that purpose. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act, 2006 and the Bribery Act 2010.

23.7. In addition to Standing Orders 21 and 22 and this Standing Order, an officer must also declare to the Chief Executive any other employment, business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

Part III – Arrangements for the exercise of functions by delegation and committees

24. Exercise of functions

24.1. Subject to Standing Order 3 and any such directions as may be given by the Secretary of State for Health, the Trust Board may delegate any of its functions to a committee or sub-committee appointed by virtue of Standing Order 25, or to a Director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

Emergency powers

24.2. The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chairman acting jointly and, if possible, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Trust Board.

Delegation to committees

24.3. The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

Delegation to officers

24.4. Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.

Schedule of Decisions Reserved for the Trust Board

24.5. The Trust Board shall adopt a Schedule of Decisions Reserved for the Trust Board setting out the matters for which approval is required by the Trust Board.

24.6. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule after each review.

24.7. The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub-committee shall be subject to and qualified by the reserved matters contained in that Schedule.

Scheme of Delegated Authorities

24.8. The Trust Board shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them.

24.9. Subject to Standing Order 44, the Trust Board shall review such Schedule, as far as it pertains to matters reserved to itself at such times as it considers appropriate; and shall update such Schedule in after each review. Similarly for all matters delegated to the Chief Executive or other Executive Directors accountable to her , the Chief Executive shall periodically review the schemes of delegated authorities and no less than annually and shall update such Schedule after each review.

24.10. The direct accountability, to the Trust Board, of the Chief Financial Officer and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

25. Appointment of committees

25.1. Subject to Standing Order 3 and such directions as may be given by, or on behalf of, the Secretary of State for Health, the Trust may, and if directed by him, shall appoint committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

25.2. A committee appointed under Standing Order 25 may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include Directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include Directors of the Trust).

25.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration, to meetings of any committee or sub-committee.

25.4. The Trust Board shall approve the terms of reference of each such committee. Each committee shall approve the terms of reference of each sub-committee reporting to it. The terms of reference shall include details of the powers vested and conditions, including reporting back to the committee, or Trust Board. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to review every two years, at least, by that committee; and adoption by the Trust Board.

25.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

25.6. The Board shall approve the appointments to each of the committees and sub-committees that it has formally constituted. Where the Board determines that a committee shall include members who are neither directors nor officers, the Board shall determine the terms of such appointment. The payment of travelling and other allowances shall be in accordance with the rates as may be determined by the

Secretary of State for Health, with the approval of the Treasury (see Part 11, paragraph 233 of the 2006 Act).

25.7. Minutes, or a representative summary of the issues considered and decisions taken, of any committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

25.8. The committees to be established by the Trust will consist of statutory and mandatory; and non-mandatory committees.

Statutory and Mandatory Committees

Role of Audit Committee

25.9. The Trust Board shall appoint a Committee to undertake the role of an Audit Committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, guidance and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook.

25.10. The terms of reference of the Audit Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Remuneration Committee

25.11. The Trust Board shall appoint a committee to undertake the role of a Remuneration Committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior officers, and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

25.12. The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

25.13. The terms of reference of the Remuneration Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Non mandatory committees

25.14. The Trust Board shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

25.15. The terms of reference of these committees shall have effect as if incorporated into these Standing Orders. The approval of the terms of reference shall be recorded in

the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

25.16. The membership of these committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the committee and shall be subject to approval by the Board.

25.17. At the time of adoption of this version of Standing Orders (January 2015), the following Non-Executive Director led, non-mandatory committees are in place:

- Finance and Investment Committee
- Quality Committee
- Risk and Governance Committee (managed as an integral part of the Audit Committee)

These are subject to change at the discretion of the Trust Board. All new, or amended non-mandatory committees will have the same standing and will be subject to the same standing orders.

26. Proceedings in committee to be confidential

26.1. There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

26.2. Committee members should normally regard matters dealt with, or brought before the committee as being subject to disclosure, unless stated otherwise by the chairman of the committee. The chairman shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

26.3. A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

26.4. Regardless of this Standing Order 26, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services.

27. Election of chairman of committee

27.1. Each committee shall appoint a chairman; and may appoint a deputy chairman from its membership. The terms of reference of the committee shall describe any specific rules regarding who the chairman should be. Meetings of the committee will not be recognised as quorate, if the chairman, or deputy chairman, or other suitably qualified, nominated member of the committee is not present to undertake the role.

27.2. Each committee shall review the appointment of its Chairman, as part of the annual review of the committee's role and effectiveness.

28. Special meetings of committee

28.1. The Chief Executive shall require any committee to hold a special meeting, on the request of the Chairman, or on the request, in writing of any two members of that committee.

Part IV – Custody of seal and sealing of documents

29. Custody of seal

29.1. The common seal of the Trust shall be kept by the Chief Executive, or Appointed Officer in a secure place.

30. Sealing of documents

30.1. The Seal of the Trust shall only be attached to documents where the sealing has first been approved by the Trust Board, or the Chairman, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegated Authorities.

30.2. The seal shall be affixed in the presence of the signatories.

30.3. General guide:

30.3.1. all contracts for the purchase of land and/or building

30.3.2. all contracts for capital works exceeding £250,000

30.3.3. All lease agreements where the annual lease charge exceeds £250,000 per annum or the total payable under the lease is greater than £1million

30.3.4. Any contract or agreement with organisations other than the NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £250,000.

30.4. Where use of the seal is authorised, it must be witnessed by either two Executive Directors, or one Executive Director and the Trust Company Secretary.

31. Register of sealing

31.1. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. The entry shall be signed by the persons who approved and authorised the sealing of the document; and who attested the seal.

31.2. An annual report of all sealing shall be made to the Trust Board, or a committee delegated to oversee the register at periods of its discretion. The report shall contain details of the seal number, the description of the document and date of sealing.

Part V – Appointment of directors and officers of the Trust

32. Canvassing of, and recommendations by, directors

32.1. Canvassing of any director of the Trust or member of a committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate from such appointment. Where the Chairman or any such director or committee member is so canvassed he shall notify the Chief Executive in writing. The purpose of this Standing Order shall be included in any form of application or otherwise brought to the attention of candidates.

32.2. No director of the Trust shall solicit for any person any appointment under the Trust or recommend any person for such appointment; but this shall not preclude a director from sharing knowledge about the availability of potential candidates prior to the commencement of recruitment, nor from giving a written testimonial of a candidate's ability, experience or character for submission to the appropriate panel or committee of the Trust Board.

33. Relatives of directors or officers of the Trust

33.1. Candidates for any appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any director or senior officer of the Trust. Failure to disclose such a relationship is likely to disqualify a candidate and, if appointed, render him liable to instant dismissal.

33.2. Every director and senior officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that director or senior officer is aware. It shall be the duty of the Chief Executive to report to the committee with responsibility for oversight of remuneration and terms of service any such disclosure made.

33.3. Where the relationship to the director or senior officer of the Trust is disclosed, Standing Order 21 (Interest of directors in contracts and other matters) shall apply.

33.4. This Standing Order applies to circumstances where a candidate or candidate's partner or spouse is an immediate family relation or dependent of the director or senior officer of the Trust, or their partner or spouse.

Part VI – Tendering and contracting procedures

34. General

34.1. The Trust will adopt and maintain a procurement strategy.

34.2. Every contract made by or on behalf of the Trust shall comply with the procedures and requirements of:

- 34.2.1. these Standing Orders
- 34.2.2. the Trust's Standing Financial Instructions
- 34.2.3. any direction by the Trust Board.

34.3. Wherever possible and provided it protects the Trust's position adequately, contracts made will reflect the most up to date and relevant model Standard Conditions that are provided by the Department of Health. These models may be amended to develop bespoke contracts.

34.4. Directives of the Council of the European Union (EU) for awarding all forms of contracts shall take precedence over all other procedural requirements and guidance and shall have effect as if incorporated in these Standing Orders. The EU Procurement Rules apply to public authorities, as defined by the Public Sector Directive, 2004/18/EC. The rules set out detailed procedures for contracts where the value equals or exceeds specific thresholds. These thresholds are exclusive of VAT and relate to the full life of the contract.

34.5. The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Trust Board may also determine from time to time those in-house services should be market tested by competitive tendering.

34.6. Contract procedures shall take account of the Trust's Policy Standards of Business Conduct and the necessity to avoid any possibility of collusion or allegations of collusion between contractors and suppliers; or between contractors and suppliers and staff of the Trust.

34.7. The application of the provisions of this part of the Standing Orders to contracts and purchases may be varied by resolution of the Trust Board from time to time.

35. Delegated authority to enter into contracts

35.1. The Trust Board shall have power to accept tenders and to authorise the conclusion of contracts. It may delegate such authority subject to financial limits set in accordance with Standing Order 36.2 to:

35.1.1. a committee appointed under sections 24 and 25 of these Standing Orders

35.1.2. the Chief Executive

35.1.3. to the Chief Executive jointly with the Chairman

35.1.4. the directors or nominated officers.

35.2. The financial limits determining whether quotations (competitive or otherwise) or sealed bid tenders must be obtained shall be set in accordance with the procedure in the Standing Financial Instructions the current thresholds being set out in the Trust Scheme of Delegated Authorities (Appendix 3).

36. Competition in purchasing or disposals – procedures

36.1. The Trust Board shall from time to time adopt procedures which shall be regarded as being incorporated into these Standing Orders and which shall take account of Standing Financial Instructions, the Trust's Procurement Policy and Rules and Regulations implementing EC Directives on Public Procurement and which shall deal with:

36.1.1. Tender process selection
36.1.2. methods for inviting tenders
36.1.3. the manner in which tenders are to be submitted

36.1.4. the receipt and safe custody of tenders
36.1.5. the opening of tenders
36.1.6. evaluation
36.1.7. re-tendering
36.1.8. such other matters in connection with tendering as the Board considers appropriate

37. Disposals of land and buildings

37.1. Land and buildings that are owned by the Trust, or are otherwise recorded as being part of the estate of the Trust, shall be disposed of in accordance with the most recent rules and guidance issued by the Department of Health. Disposal will require the approval of the Trust Board.

Part VII – Miscellaneous

38. Suspension of Standing Orders

38.1. Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health, any one or more of the Standing Orders, except for Standing Order 40 which may not be suspended, may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present vote in favour of suspension.

38.2. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

38.3. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

38.4. No formal business may be transacted while Standing Orders are suspended.

38.5. The Audit Committee shall review every decision to suspend Standing Orders.

39. Variation of Standing Orders

39.1. These Standing Orders shall be varied only if:
39.1.1. A notice of motion under Standing Order 17 has been given **and**
39.1.2. no fewer than half of the appointed Non-Executive Directors vote in favour of such variation **and**
39.1.3. at least two-thirds of the Directors who are eligible to vote are present **and**
39.1.4. the variation proposed does not contravene a statutory provision or direction made by the Secretary of State for Health.

39.2. Standing Order 40 (this Standing Order) may not be varied.

39.3. Any financial limits in these Standing Orders and the Schedule of Decisions Reserved for the Trust Board and the Scheme of Delegated Authorities may be varied by resolution of the Trust Board at any time.

39.4. Where financial limits are varied the Chief Financial Officer will advise the Audit Committee, and internal and external audit.

40. Availability of Standing Orders

40.1. The Trust Company Secretary shall make available a copy of the Standing Orders to each director of the Trust and to such other employees as the Chief Executive considers appropriate.

40.2. A copy of these Standing Orders will be held, with unrestricted access to all staff, on the Trust's intranet site.

41. Signature of documents

41.1. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall be signed by the Chief Executive, or by any Executive Director of the Trust duly authorised for that purpose by the Board in accordance with the Scheme of Delegated Authorities, unless any enactment otherwise requires or authorises differently.

41.2. The Chief Executive or nominated directors shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

41.3. In land transactions, the signing of certain supporting documents will be delegated to Managers, but this will not include the main or principal documents effective the transfer, or any document which is required to be executed as a deed.

42. Standing Financial Instructions

42.1. Standing Financial Instructions adopted by the Trust shall have effect as if incorporated in these Standing Orders.

43. Review of Standing Orders

43.1. Standing Orders shall be reviewed annually, or earlier, if developments within or external to the Trust indicate the need for a significant revision to the Standing Orders. The requirement to review extends to all documents having the effect as if incorporated in Standing Orders.

43.2. Any change will be reviewed by the Chief Executive before a recommendation is made to the Trust Board for adoption.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	4.1
Title	CQC Chief Inspector of Hospitals' Inspection – follow up and action plan
Report for	Monitoring
Report Author	Dr Senga Steel, Deputy Director of Nursing
Responsible Executive Director	Professor Janice Sigsworth, Director of Nursing

Executive Summary:

The purpose of this report is to update the Trust Board on the outcomes of the CQC inspection. This includes delivery of the CQC action plan as a result of the outcomes of the inspection.

The attached CQC action plan was approved by the Executive Committee on 13th January 2015 and ratified by the Quality Committee on 14th January 2015. The action plan was submitted to the CQC on 19th January 2015. We are awaiting feedback.

Recommendation to the Board:

The Board is asked to note the report.

Trust strategic objectives supported by this paper:

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

CQC CIH Inspection Update

1 Background

The CQC carried out an inspection of the Trust in September 2014. The inspection assessed whether our services were:

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

By services, the CQC defines the eight 'core' services it has identified for NHS acute trusts as:

- Urgent and emergency services
- Medicine (including older peoples' care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

2 Inspection

Four hospital sites and the eight core services were inspected between 2 – 5 September 2014 as part of the announced component of the inspection. Unannounced visits took place between 1st and 11 September 2014; five of the eight unannounced visits took place out of hours.

3 Responding to Initial Feedback

Following the conclusion of the announced component of the inspection, on 5 September 2014 the CQC delivered brief, high level feedback. Four areas of concern were highlighted:

- Inconsistent monitoring of the temperatures of fridges where medicines are stored
- Incomplete or missing documentation which is required in relation to Do Not Attempt CPR orders
- A backlog of letters for patients and GPs with medical secretaries in Gastroenterology
- Cleanliness and infection control in the A&E department at St. Mary's Hospital

Action plans were immediately put in place to address these concerns. The Executive Committee monitored the performance in these areas to ensure these improvements were sustained.

The CQC served the Trust with a Warning Notice in September 2014 which related to aspects of cleanliness and infection control in the A&E department at St. Mary's Hospital. An action plan to address these concerns has now been fully executed. The Chief Executive wrote to the CQC in October 2014 to confirm that all of the actions in this plan had been completed.

The A&E Department has been subsequently re-inspected by the CQC and an updated CQC report for St Mary's for urgent and emergency services was published on the 7 January 2015. The re-inspection looked at the safe domain, which improved from 'inadequate' to 'requires improvement'. The overall rating for this service at St Mary's has not changed.

4 Inspection Report and Final Outcome

The final report of the September inspection was published on 16 December 2014 with an updated version published on 7 January. The updated report included actions that undertaken by the Trust to improve the Emergency Department issues found during the inspection.

The Trust overall received a 'requires improvement' rating; a rating of 'good' was received for caring and effective, safe, responsive and well-led received a rating of 'requires improvement'. Each hospital site was rated. Charing Cross, Hammersmith and St Mary's received 'requires improvement' and Queen Charlotte's and Chelsea was rated 'good'.

Of the services inspected Women and Children's and end of life care were rated as 'good'. The full report can be accessed on the CQC website http://www.cqc.org.uk/provider/RYJ

5 Areas of Outstanding Practice

Areas of outstanding practice were noted in the inspection reports. These are as follows:

- NIHR Biomedical Research Centre has a strong focus on translational research; hosting and leading national projects. An example of this is the evaluation of MRI to predict neurodevelopment impairment in pre-term infants
- The impact of the new CEO and senior leadership team and the evident optimism among staff
- The leadership programmes available to staff which aims to drive exceptional performance through engaged people
- Nationally leading outcomes in Trauma and Stroke services at Charing Cross

6 Quality Summit

Prior to the publication of the report, on December 12 2014 a Quality Summit was held to discuss the inspection findings with key stakeholders and the CQC with a particular focus on action planning. This was a positive event with offers of support made from all stakeholders to implement key actions. The action plan was then drawn up addressing all the identified actions and was submitted to the CQC on 19 January 2015. We are awaiting feedback.

7 Action Plan in Response to Inspection Findings

There has been much detailed work to develop and finalise the action plan. The Trust has actions in place and on-going work addressing many of the areas highlighted and further attention will be given to accelerating the pace of change to bring about the required improvements quickly.

A top priority for the Trust over the next year is to implement the CQC action plan. The plan will be monitored by exception and will form a key aspect of the new Quality Strategy during 2015/16. This will be driven forward by the Executive Committee and reported by exception to the Quality Committee and the Trust Board. The CQC will review the Trust's action plan and give formal sign off. Discussions are underway to agree how the CQC will monitor implementation of the plan and when we will be re-inspected.

8 Sharing the Outcomes of the Report

Staff briefing sessions were arranged following publication of the report which were led by the CEO on all the hospital sites, as well as divisional and 'back to the floor briefings' during December. Staff are now engaged refining the action plan.

9 Going Forward from the CQC Inspection

9.1 Improving Quality of Care

A framework will be developed to ensure that the Trust continues to meets the thirteen regulations set out as essential standards by the CQC. The framework will include activities and timelines for the year to ensure that assurance is provided that quality of services is good. The framework is likely to include:

- Review of compliance against the thirteen CQC regulations
- Core service reviews
- Divisional quality of care assessments
- Quality assurance exercise to test our assurance

The draft framework will be presented to the Executive Committee early February 2015. The framework will be embedded in the new Quality Strategy and be a key assurance mechanism of assurance. Internal audit and examples of good practice from other hospital trusts will be used to support this development.

Recommendation to the Board: The Board is asked to note the report.

Draft action plan in response to CQC inspection findings: January 2015

Actions that MUST be taken			
SAFE			
S1 Compliance Action: <u>In the A&E at St. Mary's Hospital</u>, equipment must be suitably maintained and checked by an appropriate person before use. *See page 118 in the SMH report.* Links to S12.			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
1.1 Clarify roles and responsibilities and improve processes to ensure equipment is always clean and maintained • Review Medical Devices Management Policy and Procedure (cleaning and decontamination of equipment) o Ratify changes through Executive Committee • Disseminate reviewed policy to divisional multi-disciplinary teams **Director Lead** Janice Sigsworth, Director of Nursing		Revised MDPP to be ratified by April 2015	• Extended Professional Practice Committee for nurses on 15 October addressed nursing responsibilities • Audit undertaken 25 October 2014 o Divisional action plans generated based on outcomes o Review of audit outcomes with Sodexo being arranged
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
1.2 One of two anaesthetic machines in the department not working for six days prior to the inspection	Anaesthetic machine to be replaced **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine	Machine is due to be received by 31 Jan 2015	
1.3 An examination lamp head in one cubicle was significantly dented with resultant sharp edges. There was no light bulb so the equipment was unusable.	Lamp repaired and light bulb put in on 1 December **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine	COMPLETE	
1.4 There were a number of items of broken	Broken equipment identified for repair or	COMPLETE	From October 2014, weekly cleaning

equipment, held together with tape, for example a drip stand and a patient monitor in one cubicle.	replacement as appropriate. Reported to Executive Committee as part of weekly assurance report. **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine		and decontamination audits also identify whether any equipment is in need of repair or replacement. Audit outcomes are reported to the Executive Committee as part of the 'Emergency performance – recovering operational performance' action plan
1.5 One brake on one patient trolley did not work	Brakes on all patient trolleys were reviewed and repaired or replaced as required. **Divisional Leads** Sally Heywood, Divisional Director of Nursing, Medicine	COMPLETE	
1.6 There were insufficient wheelchairs which led to patients missing their appointments, for example for radiology.	Number of wheelchairs available reviewed in November and December 2014 **Divisional Lead** Sally Heywood, Divisional Director of Nursing, Medicine	COMPLETE	Next review of wheelchair numbers will be in Feb 2015. Spot checks will continue to be done during DDN visits to the department.
1.7 The floor in the resuscitation area was lifting in the gap between door and floor.	Flooring was replaced as part of the A&E refurbishment in October 2014 **Divisional Lead** Ian Taylor, General Manager, Medicine	COMPLETE	
1.8 There were two movable chairs in the psychiatric holding room	Fixed chairs have been ordered **Divisional Lead** Ian Taylor, General Manager, Medicine	Ordered w/c 16 Jan with 2 week delivery timeframe	The moveable chairs were removed from the room in December 2014. The Trust's mental health team consulted on the appropriate chairs to purchase.

S2 Compliance Action: The high vacancy rates for nursing staff and healthcare assistants on some **medical wards at Charing Cross Hospital** must be addressed. *See page 23 in the CXH report.*		
OVERALL ACTIONS BEING TAKEN	**DUE**	**PROGRESS**
2.1 In October 2014, the People and Organisational Development team was restructured to align with divisions, and additional administrative support was added. • Review vacancy management **Director Lead** Jayne Mee, Director of People and Organisational Development	Restructure COMPLETE Audit to be completed by Apr 2015	The restructure and new admin support have reduced the total time to hire from advert to start date • It has been agreed that Internal audit will carry out an audit of vacancy management for the Division of Medicine and Investigative saciences
2.2 Develop a new e-roster policy which includes key indicators through theQuEST quality improvement team • Provide 'masterclass' sessions for managers on principles and practice of good rostering (through QuEST and Allocate • Report KPIs through o the The QuEST programme board, which reports monthly at the Executive Committee o Divisional performance meetings and by continuing with the existing weekly Operational Resilience Report, which reports at the Executive Committee **Director Lead** Jayne Mee, Director of People and Organisational Development	Masterclasses will take place in Mar and Apr 2015 New policy with KPIs to be ratified Jan 2015	A lead had been assigned to the QuEST project and nursing support is currently being identified.
2.3 Align staffing with the Trust bed capacity plan for 2015 / 16 (part of the Trust's business plan) • A demand and capacity assessment will be factored into divisional business plans to ensure staffing establishments match bed capacity • The plan will be monitored via weekly Operational Resilience meetings **Director Lead** Steve McManus, COO	Trust board to sign off bed capacity plan May 2015	Establishments to be signed off no later than March 2015 by Nurse Director
2.4 Deputy Chief Nurse from NHS London to review recruitment plans for the Division of Medicine and provide feedback. **Director Lead**	April 2015	Meeting arranged with Deputy Director and Director of Nursing 13 January

Janice Sigsworth, Director of Nursing			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

2.5 High vacancy rates were on the divisional risk register but it was not clear what action was being taken to address them	• Review Vacancy levels for bands 2 to 6 at divisional performance reviews monthly using
	  o A performance trajectory with an end goal of 5% by December 2015
	  o More detailed workforce summaries (for example, by division by site)
	• Instigate monthly meetings between the Director of Nursing and Divisional Director of Nursing for Medicine to review vacancies
	  o Division of Medicine to present detailed action plan to reduce vacancy rate to 5%.
	  o Report and monitor to the performance management meeting monthly
	  o To align business planning with bed capacity and staffing requirements throughout the year
	  o Review staff establishment plans with COO and Divisional Director / Director of Nursing if changes are required
	  o Update the safe nursing and midwifery staffing policy to provide clarity around revised processes; particularly seasonal variation
	• Deputy Director of HR to ensure (bands 2-6) recruitment plans for Medicine
	• Division of Medicine to establish a Task and Finish Group to meet fortnightly to oversee the vacancy reduction plan
	
	Director Lead
	Jayne Mee, Director of People and Organisational Development
		A recruitment / vacancy reduction plan will be presented in Feb 2015	• First meeting with DDHR and DDN took place 7 January
			• General Managers in Medicine will begin meeting in February 2015
			• The Trust Risk Manager meets quarterly with the Executive Team and monthly with Divisional Governance Leads
			• Divisional, HR and the corporate risk registers were updated January 2015 to reflect the current vacancy situation and will be used to manage workforce risks going forward
			  o Divisional and HR risk registers are presented quarterly at the Executive Committee and monthly at the Quality Committee for assurance

	Divisional Leads Tim Orchard, Divisional Director, Medicine Sally Heywood, Divisional Director of Nursing, Medicine Gemma Glanville, HR Business Partner for Medicine		
2.6 High vacancy rates for nurses in the following specialties: ➢ Stroke (9N and 9W) ➢ Acute medicine (9S and 4S) ➢ Elderly medicine (8W and 8S) ➢ Oncology (Weston)	• Recruit to 5 % vacancy level for bands 2 to 6 • Attain bank fill of 90% by improving management of requests (receipt, booking, etc.) and developing a business case to address day rates **Director Lead** Jayne Mee, Director of People and Organisational Development **Divisional Leads** Tim Orchard, Divisional Director, Medicine Sally Heywood, Divisional Director of Nursing, Medicine	Existing vacancies will be filled by mid-March 2015 Bank fill to be reviewed between Jan and Mar 2015	• A nursing and midwifery vacancy plan is being developed • All current vacancies advertised • A schedule has been developed for the cycle of continuous recruitment, including events to target specialties o Will be presented at the divisional performance review in February o Event dates have been arranged and hiring managers advised
2.7 High vacancy rates for healthcare assistants in neurology	Same actions as for S2.6		

S3 Compliance Action: The level of medical staffing out of hours for ICU and level 2 beds in **Critical care at Charing Cross Hospital** must be addressed. *See pages 47 and 48 in the CXH report.*

This links to S10.

OVERALL ACTIONS BEING TAKEN	DUE	PROGRESS
3.1 As part of the Trust's 2015 / 16 business plan, the Critical Care Committee (which meets monthly) has carried out a strategic review which has recommended that critical care 'hubs' will be created on each site o External stakeholders across the Critical Care Network will be engaged in the redesign o Co-location of levels 2 and 3 beds (agreed at Quality Summit) o Reconfiguration of the service to increase capacity o Side by side management of HDUs and ICUs, including improvement of timely access to airway-trained staff **Director Lead** Steve McManus, COO With regard to the workforce issues below in addition and covering all the issue we have commissioned internal audit to review medical/nursing cover of critical care service	March 2016	Our latest assessment of critical care services found that we are complying with current critical care standards

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
3.2 A Registrar was not always available out of hours on the ICU so cover was sometimes provided by junior doctors (the most senior would be a CT2). At the time of the inspection, none of the junior doctors had ventilation training	• Review availability of registrar out of hours in the ICU (will be addressed under 3.1) • Junior doctors to have undertaken airway training in accordance with national curriculum • Develop an action plan to address the reconfiguration of CC services **Divisional Lead** Jamil Mayet, Divisional Director, SCCS	Aug 2015	
3.3 The on-call consultant could take up to 30 minutes to arrive, which means immediate support is not always available.	Review the appropriateness of this and whether there are any alternatives **Divisional Lead** Jamil Mayet, Divisional Director, SCCS	May 2015	

3.4 The consultant often stayed late (until midnight) due to the lack of a Registrar.	This will be addressed under S3.1		
3.5 Although there is a medical consultant for the HDU, there were no critical care medical staff dedicated to the HDU or other level 2 beds.	This will be addressed under S3.1		
3.6 There was support from Site Ops team but not all site practitioners were airway trained and were often preoccupied out of hours with bed management. Additionally, although there were two anaesthetists covering theatres out of hours, they were not ICU trained.	• Review scope of practice for Site Practitioners to determine whether the appropriate airway training is being met (all should be ALS trained –will be addressed under 3.1). • Ensure that staff have current details (contact information, procedure) for accessing airway support **Senior Management Lead** Nicola Grinstead, Director of Operational Performance	April 2015	Will be reviewed at the Quality Committee on 1 April 2015
3.7 Out of hours, there was a general medical registrar and two senior house officers, none of whom were airway trained.	This will also be addressed under S3.1 • Confirm that the Trust has sufficient numbers of airway-trained staff (all medical staff should be ALS trained) and that access out of hours is appropriate to meet patient needs • Ensure that staff are aware of who to call and what to do when they need airway support Undertake an audit of practice **Divisional Lead** Tim Orchard, Divisional Director, Medicine	COMPLETE Feb 2015 Mar 2015	According to the RCP curriculum, medical registrars and Site Practitioners are not required to manage complex intubated patients, although both are ALS-trained

S4 Compliance Action: The high number of vacant nursing and healthcare assistant posts on some **medical wards at Hammersmith Hospital** must be corrected. *See page 16 in the HH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
4.1 High vacancies were on the divisional risk register for Medicine	This will be addressed under S2		
4.2 Unfilled shifts were specifically mentioned on B1, Fraser Gamble, John Humphrey, De Wardener and Weston wards.	This will be addressed under S2		• B1 was closed in October 2014 • Weston has zero vacancies as of Jan 2015

S5 Compliance Action: The staffing levels in **Maternity and Neonatal Services at QCCH** must be reviewed and action taken in order to ensure they are in line with national guidance. *See pages 11 / 12 and page 24 in the QCCH report.*

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS

5.1 Inadequate midwifery staffing levels were lower than the national average and did not meet the recommended ratio on postnatal wards.
 	
Pages 11 and 12
	Midwifery staffing plan being implemented from 1 April 2015 will bring midwife to patient ratio to 1:30
	
	• Monthly recruitment open days will be held on an on-going basis
	  o Centralised team with 'offer on the day' to improve process efficiency and reduce withdrawals between interview and offer.
	  o Candidates will be ready to start within eight weeks
	• Review recruitment plans and processes by the Deputy Chief Nurse for NHS London
	
	Director Lead
	Jayne Mee, Director of People and Organisational Development
		Recruitment began Jan 2015
		
		All posts filled with midwives ready to start Apr 2015
			• Business case for recruitment agreed September 2014
			• Recruitment campaigns are now underway for a total of approximately 60 midwifery, nursing and midwife support worker posts – recruitment has begun
			• Two recruitment open days (Feb and Mar 2015) have been arranged
			• The recruitment plan review by NHSL is currently being scoped and will align with an overall nursing and midwifery vacancy plan which is being developed
			• quarterly with the Executive Team and monthly with Divisional Governance Leads
			• Divisional, HR and the corporate risk registers were updated January 2015 to reflect the current vacancy situation and will be used to manage workforce risks going forward
			  o Divisional and HR risk registers are presented quarterly at the Executive Committee and monthly at the Quality Committee for assurance

5.2 Neonatal services did not have the	• Review 24 to 27 cot capacity as part of		• Current recruitment phase for

establishment recommended by the BAPM. *Page 24*	business planning in 2015 / 16 o Action plan to be developed in a paper for review by the W&C Divisional Management Team o Produce a business case to support recruitment of additional nurses to achieve BAPM standards (note - this is still under review by NHS England) o Monitor progress through directorate and divisional Quality and Safety Committees and Management Committees o Any increase staffing required will be addressed under S5.1 **Director Lead** Janice Sigsworth, Director of Nursing **Divisional Leads** Jacqueline Dunkley-Bent, Divisional Director of Nursing, W&C Natalie Dowey, HR Business Partner, W&C	Feb 2015	neonatal services concludes on 29 Jan • Progress is the same as set out in 5.1

S6 Must do: <u>In Surgery at St. Mary's Hospital</u>, the number of cases submitted to the audit programme for the WHO surgical safety checklist must be increased, in order to increase compliance with the 'Five steps to safer surgery'. *See page 46 in the SMH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

6.1 The low number of cases using the checklist means there is false assurance about the safety of surgical procedures.	Review the policy to clarify roles and responsibilities for the use and completion of the checklist
	
	Director Lead
	Chris Harrison, Medical Director
	
	• Launch communication programme on '5 steps to safer surgery'
	• Consolidate the practice of team brief prior to commencement of surgery
	• Introduce new moodle module for maternity which includes overall WHO checklist procedures
	• Review, streamline and centralize process for auditing use of WHO checklist and create and annual programme
	  o Informed by NHS England Task Force report (Feb 2014)
	• Audit compliance and report by division in the monthly quality report, for review at the Executive Committee and Quality Committee
	  o Results to also be available by individual surgeons / anaesthetists
	
	Director Lead
	Chris Harrison, Medical Director
	
	Divisional Leads
	Jamil Mayet, Divisional Director, SCCS
	Kikkeri Naresh, Divisional Director, ISCSS
		Policy to be reviewed by June 2015
		
		The comms prog will be launched Mar 2015
		
		The team brief will be re-introduced June 2015
		
		The new audits will commence June 2015
			• The WHO checklist is one of the Trust's objectives in its proposal for *Sign up to Safety*. A related paper which sets out next steps is being prepared for presentation at the Executive Committee and Quality Committee in Jan / Feb.
			• Roles and responsibilities have been added directly to the checklist for reference when it is being used
			• Working Group set up with representation from surgery, theatres and anaesthetists to address problems and support improvements
			  o Next meeting will be focused on setting a minimum number of cases to be audited monthly

6.2 The leadership team had not taken effective	Incorporate audit outcomes into annual PDRs	Audits will	Processes are now in place for

action to manage the associated risks	regarding compliance for individual surgeons and anaesthetists **Director Lead** Chris Harrison, Medical Director **Divisional Leads** Jamil Mayet, Divisional Director, SCCS Kikkeri Naresh, Divisional Director, ISCSS	start as above – will be incorporated into annual PDRs beginning 2015 / 16	addressing individual non-compliance at the time a checklist is identified as not fully completed.

S7 Must do: The level of anaesthetic consultant support / on-call availability in **Maternity at St. Mary's Hospital** must be in line with national recommended practice. *See page 70 in the SMH report.*

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
7.1 Anaesthetic consultant support or on-call availability was not in place 24 hours a day, which is not in line with national recommended practice.	• Review the level of anaesthetic consultant support on call and address gaps in cover • Put anaesthetists with obstetrics experience in place out of hours / on-call **Director Lead** Steve McManus, COO **Divisional Leads** Jamil Mayet, Divisional Director, SCCS Tg Teoh, Divisional Director, W&C	June 2015	• Lindo wing anaesthetists with obstetrics experience currently provide support if necessary (this is not a formal arrangement) • Meeting arrangements with the Division of Surgery are underway

S8 Must do: On **medical wards and across Outpatients services at St. Mary's Hospital**, arrangements for medicines storage must be reviewed and medicine management protocols must be adhered to. *See pages 31 and 110 in the SMH report.*

Director Lead
Janice Sigsworth, Director of Nursing

Senior Management Lead
Ann Mounsey, Chief Pharmacist

OVERALL ACTIONS BEING TAKEN	DUE	PROGRESS
8.1 Review policies and regulatory requirements relating to medicines management through the Trust's Medicine Optimisation Committee	COMPLETE	
8.2 Audit programme for medicines storage in Medicine and outpatients departments at SMH to be established by the Pharmacy team • Deliver education and training for staff to adhere to policies. To be delivered by: o Divisional Directors of Nursing for Medicine and ISCSS o Presentations at Back to the Floor Fridays (e.g. on the agenda every six months) o In response to audit outcomes • Report audit outcomes and subsequent improvement plans to the Medicines Optimisation Committee at their quarterly meetings	To begin Apr 2015	
8.3 TDA Pharmacist to review our plans with the Chief Pharmacist and confirm they are satisfactory	Mar 2015	

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
8.4 Medicines are not always stored securely (not locked, in outpatients and both on the ward and for patients' own) *Pages 31 and 110*	This will be addressed under S8.2		
8.5 Medicines are not always stored correctly (room too warm, fridge temperatures too warm / not monitored consistently on medical *Pages 31 and 110*	This will be addressed under S8.2		
8.6 There is limited evidence that ward managers took action in response to medication audits on	• Report audit outcomes and improvement plans at Divisional Quality and Safety Committees	This links to S8.2	

medical wards *Page 31*	where actions will be agreed • Audits and action plans will be overseen by the Medicines Optimisation Committee		
8.7 No staff spoken to on medical wards knew about the insulin passport *Page 31*	Review and re-launch insulin passport via the Trust's Diabetes Team **Divisional Leads** Sally Heywood, Divisional Director of Nursing, Medicine Francis Bowen, Chief of Service	Re-launch in April 2015	
8.8 Some staff spoken to on medical wards didn't know how to support self-medicating patients *Page 31*	• Review policy to ensure it is fit for purpose, including consultation with DDNs • Review and re-launch self-medication policy, to align with education to staff by DDNs	June 2015	
8.9 No staff spoken to in outpatients at SMH knew about the Trust policy on safe medicine storage *Page 110*	This will be addressed under S8.2		

S9 Must do: There must be adequate isolation facilities on **medical wards at St. Mary's Hospital** to minimize the risk of cross-contamination. *See pages 30 and 39 of the SMH report*

This links to S11 and E2.

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
9.1 There were insufficient isolation facilities on medical wards which meant that on some occasions, patients with HCAIs were unable to be isolated. *Page30*	Review the Trust policy to ensure it is fit for purpose **Director Lead** Alison Holmes, Director of Infection Prevention and Control	COMPLETE	• Additional single rooms are already flagged to be part of any future site development or buildings (part of our current 3-5 year clinical strategy) – supported at Quality Summit • Patients are assessed and isolated in accordance with current Trust policy • Site team / infection control teams review isolation needs on a daily basis and provide reports to divisions, including delays to isolation • Cross infections are reported and reviewed monthly at the Medicine Infection Prevention and Control Committee • Risks are escalated to divisional Infection Prevention and Control Committee and the Medical Director
9.2 The lack of isolation facilities is on the trust risk register but there was no clear indication of what was being done to address the problem. *Page 39*	This will be addressed by S9.1		A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the Director of Nursing.

S10 Must do: Consultant cover in **Critical care at St. Mary's Hospital** must be sufficient, including that staff are supported where there are vacancies. *See page 61 of the SMH report.*

This links to S3.

OVERALL ACTIONS BEING TAKEN		DUE	PROGRESS
10.1 Critical care committee to review the provision of level two care at St Mary's This will be addressed under S3.1			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
10.2 Level 2 patients were seen by junior doctors only	This will be addressed under S3.2		
10.3 Medical staff covering the HDU were not always airway trained, which meant they relied on the outreach team or ICU staff.	This will be addressed under S3.7		

S11 Must do: The environment of the **Grand Union ward at St. Mary's Hospital** must be reviewed to ensure it is fit for purpose. *See page 82 in the SMH report.* This links to S9.			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
11.1 Cubicles could become cramped with staff and equipment in emergencies.	Review foot print to assess opportunity to improve current space utilisation **Director Lead** Chris O'Boyle, Director of Estates and Facilities	Jan 2015	A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the Director of Nursing.
11.2 Some immune-compromised patients were placed at risk due to the lack of en-suite facilities.	Review of Grand Union ward to address en suite facilities and keep risk register updated accordingly • Develop business plan to refurbish the area to ensure compliance with NHS England standards for neutropaenic patients **Director Lead** Steve McManus, COO **Divisional Lead** Tg Teoh, Divisional Director, W&C	Risk register has been updated Business plan will be developed for 2016 / 17	Estates actions are underway to review water piping and water testing • New showerheads installed and 3 x daily pipes flushes done to improve water flow and reduce the risk of *Pseudomonas sp.* • Water quality is monitored monthly If these interventions are unsuccessful, further works will be identified.
11.3 The negative air pressure system was faulty and had been temporarily replaced with portable HEPA filter machines. Repair of the negative air pressure system had been awaited for a month at the time of the inspection.	Repair the negative air pressure system **Director Lead** Chris O'Boyle, Director of Estates and Facilities	COMPLETE	Portable HEPA filter machines have been removed from the ward

S12 Warning Notice: Standards of cleanliness of premises and equipment, and infection control practices, in the **A&E department at St. Mary's Hospital** must be improved. *The warning notice and its related findings were set out in the original SMH report published 16 December 2014. Following re-inspection of the A&E on 25 November, an updated report was published on 7 January 2015 - see pages 16 to 18.*

The CQC served a Warning Notice to the Trust on 19 September, with deadline for compliance of 17 October. This links to S1.

OVERALL ACTIONS BEING TAKEN	DUE	PROGRESS
An action plan in response to the Warning Notice was overseen by the Executive Committee and is now complete. In addition to this plan: • Sodexo User Group to be set up • PLACE Steering Group to be established • Sodexo to carry out cleaning audits and issue monthly cleaning reports at ward level as part of their contract **Director Lead** Chris O'Boyle, Director of Estates and Facilities	June 2015	

EFFECTIVE			
E1 Must do: Staff in **Medicine and Surgery services at St. Mary's Hospital** must be up to date with mandatory training. *See pages 32, 43 and 46 in the SMH report.* **Director Lead** Jayne Mee, Director of People and Organisational Development			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
1.1 Measure and report only the core skills framework mandatory modules		COMPLETE	10 core modules identified (nationally recognized and in line with other trusts)
1.2 Implement Wired2 IT enhancement and evaluate effectiveness		Implementation Feb 2015 Evaluation July 2015	Implementation is on track
1.3 Compliance to be reviewed at divisional performance meetings • To be presented at the Executive Committee by exception for actions to agreed		From Mar 2015	Follows implementation of WIRED2
1.4 Target for compliance of 90%		June 2015	Initial campaign to target areas mentioned in the inspection reports to be completed by March 2015
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
1.5 Nurses and doctors in Medicine had low compliance *Page 32*	This will be addressed under E1.2	Mar 2015	
1.6 In Surgery, little evidence of training of senior managers in investigating incidents and complaints, or in having difficult conversations *Page 43*	SCCS to undertake review and make recommendations **Divisional Lead** Jamil Mayet, Divisional Director, SCCS	Mar 2015	
1.7 In surgery, worse than average compliance among consultants but not being addressed *Page 46*	This will be addressed under E1.2	Mar 2015	

E2 Must do: The **paediatric intensive care environment at St. Mary's Hospital** must be reviewed to ensure it meets national standards. *See page 82 in the SMH*

report.			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
2.1 The environment was not compliant with the Paediatric Intensive Care Society recommendations on configuration and size	Complete works in accordance with the approved business case (see progress column) **Director Lead** Steve McManus, COO **Divisional Lead** Tg Teoh, Divisional Director, W&C	Two year build programme from autumn 2015 (Sept 2017)	• Refurbishment was carried out in 2013 to maximise the infection prevention and control that can be achieved in the current environment • The environment has been reviewed and a business case for re-development was approved by the Trust board in October 2014 • Application to the TDA for this spend was submitted Jan 2015
2.2 Bed spaces are 50% less than current Paediatric Intensive Care Society standards	This will be addressed under E2.1		Clinical risk issues are escalated to the divisional management team
2.3 Patients were not protected from cross-contamination due to the cramped space and only one designated isolation cubicle	This will be addressed under S9 and E2.1		• Cross infections are reported and reviewed monthly at the W&C Infection Prevention and Control Committee • Site team / infection control teams review isolation needs on a daily basis and provide reports to divisions, including delays to isolation • A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the Director of Nursing.

RESPONSIVE		
R1 Compliance action: <u>In Outpatients services across the Trust</u>, problems associated with the administration of appointments which were leading to unnecessary delays must be addressed. *Page numbers for each report are below.* Links to R3.		
OVERALL ACTIONS BEING TAKEN	**DUE**	**PROGRESS**
1.1 To consolidate OPD redesign and improvement programme, which will be set out in a project plan and accelerate its implementation. To include: Review management accountability of outpatient facilities to provide consistent leadership Roll out centralized booking, scheduling and call Centre functions to streamline effectiveness of admin support to OPD Phase 1 • Expand technology support to OPD to improve check-in and booking function locally • Appoint lead clinician (Chief of Service) • Review nursing leadership • Create dashboard and performance trajectories against plan • Divisional General Managers oversee related action plans Phase 2 • Implement patients services centre project • Outpatient and divisional scorecards will be generated, with exception-based reporting at the Executive Committee and Trust board • Further external review will be commissioned to support implementation of the programme (agreed at Quality Summit) o CCGs and Healthwatch to help co-design outpatients and help obtain patient input (agreed at Quality Summit) • Single point of access to be established for Outpatients o GP utilization of Choose and Book to be increased o Patient Service Centre to centralize telephone access (one number for all Outpatient services) with 8am-8pm opening hours o Options appraisal to be reviewed at Exco in March 2015 o Full case to Trust board June 2015 o Internal audit to undertake a review of CQC compliance and our plans for OPD in Sept 2015	Feb 2015 April 2015 June 2015	• The business case related to this programme will be signed off by the Trust Board in May 2015 • A Darzi fellow has been appointed who will review the booking system • **QS** TDA to 'broker' a tri-partite approach to share learning and, potentially, initiatives

Director Lead: Steve McManus, COO			
Director Lead Steve McManus, COO **Divisional Lead** Kikkeri Naresh, Divisional Director, ISCSS		Feb 2015	
1.3 CQC to identify good practice in outpatients in other NHS trusts (agreed at Quality Summit) **Director Lead** Janice Sigsworth, Director of Nursing		COMPLETE	Met with Sue Walker and made request in writing 8 Jan
SPECIFIC FINDINGS **Director Lead for all specific findings below** Steve McManus	**ACTIONS**	**DUE**	**PROGRESS**
1.4 Performance in outpatient services was not monitored *See pages 113 to 116 in the SMH report, 68 to 71 in the CXH report, 68 to 70 in the HH report*	• Introduce a single OP improvement forum under executive leadership to drive and monitor all OPD improvement actions • Set/agree a single policy for clinical attendance and scheduled OP clinics to ensure timely service via consistent availability of clinical staff • Create and maintain divisional performance dashboards with improvement trajectories and report progress to the Executive Committee • Every clinic will have a named senior leader with responsibility for overseeing performance • KPIs will be developed for outpatients and incorporated into the Trust scorecard	Feb 2015 April 2015 June 2015 April 2015 April 2015	A Planned Care Board is co-chaired by a Trust consultant and an external GP, and is attended by GPs from Trust CCGs o Meets monthly to discuss outpatient pathway performance
1.5 Capacity has not been increased to meet increased demands, either in the number of clinics or the number of medical staff. Patients are waiting longer to be given an initial appointment.	A capacity and demand review is included in the 2015 / 16 business plan, including a review of the delivery of access targets against national standards	This will be addressed as part of 1.1	We currently meet or exceed national targets for access, but Cerner has caused reporting problems due to issue with data integrity in the system

See pages 108 and 111 to 114 in the SMH report, pages 67 and 69 in the CXH report, pages 66 and 67 in the HH report	• Continue Wait list monitoring by the Operational Performance team and divisional General Managers		
1.6 Trust targets for sending appointment letters to patients must be met. Some patients did not receive their letters or received them after their appointment had been scheduled to take place. *See pages 113 / 114 in the SMH report, page 69 in the CXH report, page 68 in the HH report*	Working group established for on-going monitoring and will be built in to the outpatient scorecard	This will be addressed as part of 1.1	
1.7 Trust targets for sending discharge summaries to GPs must be met. *See page 112 in the SMH report, page 67 in the CXH report, 67 and 68 in the HH report*	• Monitoring will be built in to the outpatient scorecard • Deliver improvements through CQUIN targets and metrics (new CQUIN for 2015)	This will be addressed as part of 1.1	
1.8 There is no process for ensuring appropriate clinical coverage for clinics. As a result, there could be long waits once patients arrived for clinics and clinics routinely overrun. *See pages 111 and 113 / 114 in the SMH report, pages 67 and 69 in the CXH report, pages 66 to 68 in the HH report*	This will be addressed as part of 1.1		
1.9 Doctors consistently turn up late for clinics with no warning or explanation *See pages 114 / 115 in the SMH report, page 68 in the CXH report, page 67 in the HH report*	This will be addressed as part of 1.1		
1.10 Clinics are cancelled at short notice and the reason(s) is not always given *See page 69 in the CXH report, page 67 in the HH report*	• Reduce clinic cancellations to less than 7% o Improve compliance with the Trust's current target for clinic cancellation (at least six weeks in advance) – Develop an SOP outlining expectations and	June 2015	

	processes ISCSS Medical Director to ensure team working to improve coverage of clinics when a doctor will be away		
1.11 Appointment cancellation rates are higher than the national average *See page 114 in the SMH report, page 69 and 70 in the CXH report, page 68 in the HH report*	This will be addressed as part of 1.1		A Darzi fellow has been appointed who will review urgent appointment access

R2 Compliance action: The significant delays for patients awaiting **elective surgery at Hammersmith Hospital** must be reduced (note that this does not apply to day surgery). *See pages 32, 51 and 52 of the HH report.*			
OVERALL ACTIONS BEING TAKEN		**DUE**	**PROGRESS**
2.1 CQC to identify good practice in the assessment and management of surgical wait lists, and in monitoring the clinical impact of surgical delays (agreed at Quality Summit) **Director Lead** Janice Sigsworth, Director of Nursing		COMPLETE	Met with Sue Walker and made request in writing 8 Jan
2.2 Audit of patient records to determine the impact of surgical delays on clinical outcomes to be incorporated into the Trust clinical effectiveness programme (this will be adopted from the same audit programme already in place for cancer care) **Director Leads** Steve McManus, COO Chris Harrison, Medical Director		To begin Apr 2015	
SPECIFIC FINDINGS **Director Lead for all specific findings below** Steve McManus, COO	**ACTIONS**	**DUE**	**PROGRESS**

2.3 Referral to treatment was often not being met
 	
Pages 51 and 52
	• RTT targets were being met with the exception of a few treatment functions, prior to the introduction of Cerner
	• Cerner is affecting data integrity
	  o An IT team has been established to address this
	  o Data quality KPIs have been established and are assessed weekly in the Operational Resilience Report which is presented at the Executive Committee
		May 2015	• An RTT remedial action plan is already in place for the three / four areas which have not consistently met RTT targets
			  o NHS England has now set new targets and we expect to be meeting these by the end of the activity year
			• This will also be addressed within the demand and capacity assessment (S2.3)
			• The Cerner plan started six months ago and the current phase is due to conclude in Jan 2015. We will then move on to the next phase of

			‘business as usual’ Cerner implementation.
2.5 Cancellation of surgical procedures is higher than national average. This is linked to problems with pre-operative assessments. *Page 32*	• Establish Elective Access Waiting Group • Ensure sign-off of all cancellations • • Develop pre-operative assessment improvement plan that ensures consistency and best practice for pre-op care.	May 2015	• An Elective Access Waiting Group has been established and meets weekly to ensure re-booking takes place within 28 days • The Site Operations team signs off cancellations (started six months ago) to coordinate bed availability • A Darzi fellow has been appointed who will focus on surgical pathways, including pre-operative assessments • This will also be addressed within the demand and capacity assessment (S2.3)

R3 Must do: Systems and processes must be implemented to reduce the rate of patients who do not attend **outpatient appointments and surgical procedures at St. Mary's Hospital.** *See pages 53 and 114 of the SMH report.*

Director Lead
Steve McManus, COO

SPECIFIC FINDINGS	ACTIONS	DUE	PROGRESS
3.1 In outpatients, the reason(s) for this is unknown due to lack of performance monitoring *See page 114 of the SMH report*	• Implement 8am-8pm opening hours for outpatient call centre and admissions office to improve patient access • Implement text reminders and increase Choose and Book utilization by GPs • DNA rates to be monitored and reviewed monthly o Oversight by new Chief of Service with exception reporting at the Executive Committee o North West London sector dashboard, on which action plans are created o Performance Contracting Executive (commissioner-chaired)	This will be addressed under 1.1	
3.2 In surgery, this was linked to problems with pre-operative assessments *See page 53 of the SMH report*	This will be addressed in part under R3.1. Additionally, a pilot for preoperative same day 'see and assess model' has been introduced to reduce rate of cancellations / DNAs on the day.	This will be addressed under 1.1	

R4 Must do: The capacity of the **maternity and neonatal units at QCCH** must be reviewed to ensure they meet service demands. *See pages 11 / 12 and 29 in the QCCH report.*			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
4.1 Lack of sufficient nursing staff numbers has led to reduction in number of available beds, resulting in patients being refused.	This will be addressed under S5		

WELL-LED			
W1 Must do: Divisional risk registers for **Services for children and young people at St. Mary's Hospital, and Maternity and Neonatal services at QCCH**, must be reviewed to ensure risks are resolved in a timely manner. *Page numbers in each report are below.* **Director Lead** Steve McManus, COO			
SPECIFIC FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
SMH **1.1** Seven risks had been on the risk register for five years. **1.2** Lack of inpatient facilities for adolescents had been on the risk register since 2009. *See page of 85 and 93-95 of the SMH report*	• A standardized approach to managing the risk register will be developed, including a review of the risk management policy • Divisional governance lead and risk manager to review risk register to ensure it is up to date and accurate • Board representation of the service to be established	April 2015	• Divisional review of risk register completed December 2014 • The risk manager will attend an upcoming W&C divisional quality and safety meeting to discuss risk management
QCCH **1.3** The failure to meet BAPM recommendations for staffing establishments had been on the risk register since 2011. **1.4** Inability to meet NICE guideline 137: Epilepsy due to the lack of a neuropsychologist had been on the risk register since 2006. *See pages 24, 29 and 30 of the QCCH report*	This will be addressed in part under S5. Additionally: • A new SLA with CNWL will include neuro-psychology support and epilepsy management. • A dedicated clinical risk and audit nurse will support NICU during Q1 of 2015 / 16 and focus on risk management • Divisional governance lead and risk manager to review risk register to ensure it is up to date and accurate • Board representation of the service to be established	June 2015	• Divisional review of risk register completed December 2014 • NICU risk register to go to the next W&C performance review (Feb) for executive oversight • The risk manager will attend an upcoming W&C divisional quality and safety meeting to discuss risk management
Actions that SHOULD be taken			

SAFE			
A: <u>On the Grand Union Ward at SMH</u>, the Trust should ensure that staff adhere to the Trust's policies and procedures for the double-checking process for medication. *See page 83 of the SMH report.* **Director Lead** Janice Sigsworth, Director of Nursing			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
The service operated 'double check' processes whereby two nurses independently checked medication to ensure it had been prescribed, prepared and administered correctly. However, the approach to double checking was informal and did not provide assurance that the double-check process was suitably robust to safeguard children.	• Head of Nursing for Paediatrics will review the double checking process (which is for oral medication only) and amend as appropriate • Staff will be educated about the updated process • Audit compliance and ensure actions are put in place to address non compliance	June 2015	Head of Nursing for pediatrics tasked with leading this review and changes in practice. Deputy Chief Nurse to provide professional advice and support on evidenced based practice in this area.

B: The availability of case notes / medical records in **<u>Outpatient services at St. Mary's Hospital</u>** should be monitored and action taken in a timely manner where necessary *See page numbers below* **Director Lead** Steve McManus, COO **Divisional Lead** Naresh Kikkeri, Divisional Director, ISCSS			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
This cannot be located in the SMH report, but it appears in the CXH and HH reports *See page 66 in the CXH report and page 65 of the HH report*	This will be addressed in part within the Cerner plan (R2.3). Additionally, case note availability audits are regularly carried out by the health records team with support from the Medical Director's office. Improvement plans will be developed as a result of audit findings and reported through to Executive Committee via the OP performance dashboard	COMPLETE	

C: A standardized approach to mortality review in **Medicine and Surgery at St. Mary's Hospital** should be developed, including reporting to divisional boards and the executive committee. *See pages 29, 35 and 43 in the SMH report*

Director Lead
Chris Harrison, Medical director

Divisional Leads
Tim Orchard, Divisional Director, Medicine
Jamil Mayet, Divisional Director, SCCS

FINDINGS	ACTIONS	DUE	PROGRESS
• In Medicine, divisional mortality and morbidity meetings took place at specialty level and issues or concerns were reported through the directorate committee meetings. There was no standardised approach to mortality reviews or standard written records from those meetings. *Pages 29 and 35* • In Surgery, mortality and morbidity meetings were varied in quality and frequency. Meetings took place at a specialty level, with reporting to the quality and safety committee by exception. Actions and lessons arose from these meetings but no action plans produced. *Page 43*	• Develop terms of reference for formal mortality reviews and review SOP • Develop standardized methods for collecting mortality and morbidity data across the Trust o To be approved at the Executive Committee o To be audited for effectiveness • Establish standardised approaches for o Reporting mortality and morbidity data and analyses o Monitoring action plans which result • Establish a process for disseminating information and sharing lessons learnt from mortality and morbidity reports • Implement a process for recording mortality and morbidity discussions in patient notes	Sept 2015	• Darzi fellow currently in place who is leading the review of morbidity and mortality meetings • Support has been offered by London NTDA to review our morbidity and mortality plan

D: The current matrix for statutory and mandatory training in **Surgery and Services for children and young people at St. Mary's Hospital, and in Neonatal services at QCCH,** should be reviewed in order to improve the recording system, to ensure that local (ward) and Trust-wide records are consistent

FINDING	ACTIONS	DUE	PROGRESS
	This will be addressed under Must-do E1		

E: Ensure the WHO checklist is embedded in practice in **Surgery at Charing Cross Hospital**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do S6		

F: How staff in **Neonatal services at QCCH** can learn from minor incidents and near misses should be explored in order to avoid similar incidents occurring. *See pages 21 and 30 in the QCCH report*

Director Lead
Chris Harrison, Medical Director

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	• Will be covered within the 2015 / 16 Quality Strategy • A dedicated clinical risk and audit nurse will support NICU during Q1 of 2015 / 16 and will focus on ways to share learning	June 2015	Reviews of low level incidents and near misses are currently undertaken • Discussed at local risk meetings • Actions arising are discussed at directorate Quality and Safety meetings, and by exception to the divisional Q&S Committee • Reported in monthly newsletters (Children's Indicator and maternity's Risky Business)

G: Ensure that patient records **<u>across the Trust</u>** are always appropriately completed. *See page numbers below.*

Director Lead
Chris Harrison, Medical Director

FINDINGS	ACTIONS	DUE	PROGRESS
• DNACPR forms were not consistently completed *See page100 in the SMH report,55 and 57 /58 in the CXH report, page 54 of the HH report* • On the Christopher Booth ward, monitoring forms such as stool and fluid charts were not completed for one patient and NEWS charts were not completed for another. Additionally, risk assessments were not fully completed for a number of patients. *See pages 14 / 15 and 15 of the HH report*	• Review Trust-wide record keeping policy and standard o Trust-wide documentation assurance audit programme to be commenced as part of the overall audit and improvement programme • Disseminate expectations of good clinical record keeping • Commence regular DNACPR audits • Develop improvement plans for areas of non-compliance with the standard	Policy to be reviewed by June 2015 and related comms to follow Audit programme begins Q1 2015	

H: Ensure learning from investigations of patient falls and pressure ulcers is proactively shared **T<u>rust-wide</u>.** *See page numbers below.*

Director Lead
Janice Sigsworth, Director of Nursing

FINDING	ACTIONS	DUE	PROGRESS
See page 43 of the SMH report, pages 21 and 31 of the CXH report and page 25 of the HH report	Review mechanism for learning and sharing across ICHT via the nursing patient safety and improvement committee	May 2015	

I: Ensure cleaning of equipment is always carried out **in <u>Critical care at Hammersmith Hospital</u>**

Director Lead
Ian Garlington, Director of Strategy

Divisional Lead
Jamil Mayet, Divisional Director, SCCS

FINDING	ACTIONS	DUE	PROGRESS
	This links to Must-do S1 and S12	COMPLETE	Revised cleaning and decontamination schedule formally launched across the Trust in December 2014

EFFECTIVE

J: Ensure that there is a single source of up to date guidelines in the **<u>A&E department at St. Mary's Hospital</u>**. *See page 21 of the SMH report.*

Director Lead
Chris Harrison, Medical Director

FINDING	ACTIONS	DUE	PROGRESS
Trust policies were based on up-to-date guidelines available on 'The Source'. However, the A&E department had some systems of its own outside this system. Trainee doctors used a USB storage drive containing separate guidelines written by A&E seniors; those guidelines on the USB storage drive were different to those on the intranet and some were out of date. An audit of USB drive use did not include use of the guidelines accessible from this drive. A third set of guidelines was located in the A&E manual. Paper printouts were found filed in the handover room. We noted that there was often more than one protocol for a given condition and guidelines contained different referral routes. This presented a risk that patients might receive treatment which did not reflect current best practice.	• Collate guidance into a single comprehensive document which contains the most up to date information • Ensure out of date guidelines are removed from all Trust documentation, including the Intranet and hard copies held by staff	Sept 2015	Clinical guideline and policy review across the Trust is one of the Trust's objectives in its proposal for *Sign up to Safety*.

K: Patients who undergo non-urgent emergency **surgery at St. Mary's and Charing Cross hospitals** should not be left without food or fluids for excessively long periods. *See page numbers below*

Director Lead
Janice Sigsworth, Director of Nursing

Divisional Lead
Jamil Mayet, Divisional Director, SCCS

FINDING	ACTIONS	DUE	PROGRESS
See page 49 of the SMH report and page 37 of the CXH report.	• Review 'nil by mouth' policy • Provide education and training for staff about policy requirements • Audit practice and develop improvement plans against audit results	June 2015	

L: Patient readmission and length of stay rates in **A&E, Medicine, Surgery and Critical care at St. Mary's Hospital** should be reviewed in order to identify issues which may lead to worse than average results. *See pages 21, 39, 50, 52 and 64 of the SMH report.*

Director Lead
Steve McManus, COO

Divisional Leads
Claire Braithewaite, Divisional Director of Operations, Medicine
Jamil Mayet, Divisional Director, SCCS

FINDING	ACTIONS	DUE	PROGRESS
	Develop a standardized, structured process for review of data at divisional performance reviews which ensures action is taken where needed	To begin by June 2015	Appropriate data is already provided at Trust and division level

CARING			
M: The handover area for ambulances in the **A&E department at St. Mary's Hospital** should be improved in order to preserve patient dignity and confidentiality. *See page 23 of the SMH report.* **Director Lead** Steve McManus, COO **Divisional Lead** Tim Orchard, Divisional Director, Medicine			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	• The UCC is relocating and will be operational mid-February 2015, which will release some space • Review the process for patient movement based on the additional space to determine whether using alternate route into A&E will address this	June 2015	• A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the PLACE Steering Committee

RESPONSIVE			
N: Improve links with primary care to keep people out of the **A&E department at St. Mary's Hospital.** *See page 24 of the SMH report*. **Director Lead** Steve McManus, COO **Divisional Lead** Claire Braithewaite, Divisional Director of Operations, Medicine			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
• Different responsiveness of the five boroughs the Trust works with • Lack of clinical engagement with CCGs • Arrangements not yet in place with GPs for frequent A&E attenders	• Six week programme is underway (Jan 2015) to review emergency pathways, including the interface with primary care • Adopt improvements to integrated care made available by the community independent service contract recently awarded to the Trust (this is in partnership with a number of GP confederations)	COMPLETE	• Review workstreams agreed early Jan 2015 • A System Resilience Group is in place with representatives from CCGs and primary care • An Urgent Care Board is in place which is co-chaired by a CCG and the Trust's Deputy Medical Director

	QS NHS England, CCGs and Heathwatch to work with the Trust to create a systematic approach to integrated care practice • To reduce admissions • To minimize delayed discharges		• We have an existing relationship with our ECIST for external support

O: Reduce the backlog of patients awaiting **elective surgery at Hammersmith Hospital.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R2		

P: Consider reviewing the current arrangements to ensure there is parity in **children's Outpatient services across Hammersmith Hospital.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed in part under Must-do R1. Additionally, a review of current space will assess capacity and condition of the estates and facilities.	June 2015	

Q: Improve flow from the **A&E at St. Mary's Hospital,** including analysis of re-attendance within seven days. *See page 22 of the SMH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Claire Braithwaite, Divisional Director of Operations, Medicine

FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	Six week programme is underway (Jan 2015) to review emergency pathways	Review to be completed by March 2015	Review workstreams agreed early Jan 2015

R: Clear the backlog of letters and reduce the waiting times for patients to have an initial appointment in **Gastroenterology at Hammersmith Hospital.** *See page of the 67 of the HH report*

Director Lead
Steve McManus, COO

FINDING	ACTIONS	DUE	PROGRESS
	Clear the backlog of letters	COMPLETE	

S: Monitor the clinical impact of **surgical delays at Hammersmith Hospital.** *See page 31 of the HH report.*

FINDINGS	ACTIONS	DUE	PROGRESS
• Patients who wait a long time for surgical procedures must be clinically managed. • There is no designated emergency theater at HH, which could lead to delays.	This will be addressed in part under Must-do R2		

T: Ensure **adolescent services and facilities at St. Mary's Hospital** meet patient needs. *See pages 92 and 93 of the SMH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
A lack of dedicated space for adolescents / young people in children's outpatients at SMH, limited inpatient facilities for adolescents – no dedicated unit – had been on the risk register since 2009.	Review current space to assess capacity and condition of estates and update risk register	June 2015	• A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the PLACE Steering Committee • Links to current clinical and estates strategies

U: Ensure same sex accommodation is available on the **Witherow ward at St. Mary's Hospital.** *See page of the 38 SMH report.*

Director Lead
Steve McManus, COO

FINDING	ACTIONS	DUE	PROGRESS
	• Review EMSA policy • Assess layout and service delivery on the ward	COMPLETE	

V: Reduce number of out of hours transfers and discharges in **Medicine at Charing Cross and Hammersmith Hospitals.** *See page 27 of the CXH report and page 19 of the HH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Claire Braithewaite, Divisional Director of Operations, Medicine

FINDINGS	ACTIONS	DUE	PROGRESS
• CXH transfers are from gastroenterology and medical oncology • HH transfers are from cardiology, nephrology, gastro • CXH discharges are from endocrinology, gastroenterology and medical oncology • HH discharges are from cardiology, clinical haematology and nephrology	This will be addressed by the following: • Demand and capacity assessment (Must-do S2.3) • A review of emergency pathways is underway (Jan 2015)	May 2015	• Managed during daily Site Operations team meetings • Reported weekly at the Executive Committee via the Operational Resilience Report

W: Ensure that patients are not cared for in inappropriate areas overnight such as **recovery at Hammersmith Hospital.** *See page 31 of the HH report*

Director Lead
Steve McManus, COO

Divisional Lead
Kikkeri Naresh, Divisional Director, ISCSS

FINDING	ACTIONS	DUE	PROGRESS
	Identify related incidents and create action plan	COMPLETE	No incidents in past 12 months

X: Ensure parents and carers can be accommodated when children are being treated in the **PICU, NICU and Great Western ward at St. Mary's Hospital.**
See page 80 and 93 of the SMH report.

Director Lead
Steve McManus, COO

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
	Undertake a review of space for children's services at SMH as part of the clinical strategy in 2015 / 16, including a need for patient / carer accommodation • Continue to use local hotel accommodation (paid for by charity and NHS) in the interim.	Review to be completed by June 2015	• By the bed side accommodation for parents and carers is already provided on Great Western. • A Director of Planning and Redevelopment joined the Estates team in Jan 2015. Assessments of estates and environment will be carried out and reported to the PLACE Steering Committee

Y: <u>Across the Trust</u>, patient information (literature, menus) should be available in languages other than English. *See page numbers below.* **Director Lead** Michelle Dixon, Director of Communications			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
See page 36 of the SMH report and page 50 of the HH report	Complete current patient information stock-take and agree action plan (this includes access to information in languages other than English)	Action plan to be agreed by Feb 2015 Phase 1 to be delivered by Sept 2015	

Z: Increase capacity to meet demand in **<u>Outpatient services at Charing Cross Hospital</u>.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

AA: Ensure that targets for sending appointment letters to patients from **<u>Outpatients services at Charing Cross Hospital</u> are met.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

BB: Ensure that targets for sending discharge summaries to GPs from **<u>Outpatients services at Charing Cross Hospital</u>** are met.			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

CC: Increase capacity in **<u>Surgery across the Trust</u>** so patients admitted are seen promptly and receive the right level of care. *See page numbers in reports below.*			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**

• Difficulty accessing an appropriate bed in SMH, CXH surgery – cared for in non-surgical wards *See page 53 of the SMH report and page 40 of the CXH report* • High cancellations in surgery in May 2014 and inability to accept patients from other hospitals for vascular surgery *See page 53 of the SMH report* • Lack of surgical beds CXH and HH – led to being cared for on non-surgical wards and long delays in recovery (delays in recovery were on the divisional and Trust risk registers) *See pages 39 and 40 of the CXH report and page 32 of the HH report*	This will be addressed under Must-do S2.3		

DD: Avoid cancelling **<u>Outpatients clinics at Charing Cross Hospital</u>** at short notice**.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

EE: Improve patient transport from **Outpatient services at Hammersmith Hospital** so the wait to go home is reduced**.**

Director Lead
Ian Garlington, Director of Strategy

FINDING	ACTIONS	DUE	PROGRESS
This is particularly an issue for vulnerable patients. *See pages 64, 67 and 69 of the HH report.*	Review patient transport policies and practice with particular reference to prioritizing vulnerable patients to ensure a more responsive service	Sept 2015	

FF: Improve the management of medicines on **medical wards at Hammersmith Hospital.**

FINDING	ACTIONS	DUE	PROGRESS
	This will be addressed under Must-do S8		

GG: Improve access to specialist pain treatment and support **at the Trust.** *See page 111 of the SMH report.*

FINDING	ACTIONS	DUE	PROGRESS
Patients could not always access the pain clinic when they needed it because only one clinic in the Trust (which is at CXH).	This will be addressed under Must-do R1		

HH: The operating times of the **David Harvey Unit at Hammersmith Hospital** should be reviewed to ensure the service is accessible (i.e. opening hours) to the population it serves. *See page 49 of the HH report.*

Director Lead
Steve McManus, COO

Divisional Lead
Tg Teoh, Divisional Director, W&C

FINDING	ACTIONS	DUE	PROGRESS
Staff estimate that the peak time of need is approximately 7 PM but the unit closes at 5 PM.	• Review paediatric pathways • Review the mandate for the unit and determine if it is being fulfilled • Assess paediatric UCC attendance rates between 5 and 9 PM	June 2015	

II: Ensure there is accurate performance information from the **Outpatients department at Hammersmith Hospital.**			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do R1		

WELL-LED			
JJ: Coherent governance arrangements are needed in **Outpatients services at Charing Cross and Hammersmith Hospitals** in order to manage performance and risk more effectively. *See page 71 of the CXH report, and pages 69 and 70 of the HH report*			
FINDINGS	**ACTIONS**	**DUE**	**PROGRESS**
Assign responsibility to effectively manage quality and risk in outpatients – it is currently dispersed among the other services (different leaders for each specialty or managed by an outpatient team).	This will be addressed under Must-do R1		

KK: Robust and fit for purpose risk management is needed in the **NICU at QCCH.**			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
See pages 24, 29 and 30 of the QCCH report	This will be addressed under Must-do W1		

LL: Services for children and young people and Neonatal services should be represented at Board level. *See page 96 of the SMH report and page 31 of the QCCH report.*			
FINDING	**ACTIONS**	**DUE**	**PROGRESS**
	This will be addressed under Must-do W1		

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	4.2
Title	ICHT Annual Research Review 2014
Report for	Noting
Report Author	Prof Jonathan Weber (AHSC Director) & Dr Paul Craven (Head of Clinical Research Operations)
Responsible Executive Director	Dr Chris Harrison (Medical Director)

Executive Summary:

This report presents a review of research highlights across Imperial College Healthcare NHS Trust (ICHT) and the Imperial Academic Health Science Centre (AHSC) in 2014. As well as specific examples of research progress with the potential to benefit patients, the report also includes the successes achieved in growing ICHT research capacity and capability, and in developing collaborations across the NW London sector. It also outlines the challenges upcoming in the next 12-24 months.

Recommendation to the Board:

The Board is asked to note the annual research review for ICHT.

Trust strategic objectives supported by this paper:

- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.

Imperial College Healthcare NHS
NHS Trust

ICHT Annual Research Review 2014

Purpose of the Report

To present highlights of research progress from the 2014 calendar year, which has been a pivotal year for research within the Imperial Academic Health Sciences Centre (AHSC). It is the third year of the current 5-year NIHR Imperial BRC programme and a key period for investment to deliver outputs before the re-application process begins in 2016. 2014 also saw the launch of NHS Genomics Medicine Centres (to deliver the Prime Minister's 100K Genomes initiative) and the outcomes of the most recent Research Excellence Framework (REF), the national assessment of research quality and impact in UK universities.

Introduction

The following research highlights are covered in more detail in this report;

1. 2014/15 is the midpoint of the current NIHR Biomedical Research Centre;
    a). we present a number of 'real world' exemplars of translational clinical research progress from within the BRC;
    b). with the help of an international panel of experts we carried out an in-depth strategic review of the BRC;
    c). we have developed a new structure for the BRC from April 2015 onwards;
    d). the NIHR Health Informatics Collaborative has seen significant developments in terms of collaboration and data sharing across 5 NHS Trusts / BRCs;
2. 2014 saw the launch of the Imperial Joint Translation Fund, a scheme to accelerate clinical and biomedical translation, which is worth £1.3m (contributions from MRC, Wellcome Trust, EPSRC , Imperial Innovations, Royal Marsden and Chelsea & Westminster);
3. ICHT was successful in a competitive process to host the NW London Clinical Research Network from 1 April 2014, following a national re-organisation of the NIHR Clinical Research Network;
4. Beginning April 2014, and following a national competition, Imperial was awarded four new NIHR Health Protection Research Units (HPRUs) worth £12m over 5 years, in partnership with Public Health England (PHE); these will provide centres of excellence in multi-disciplinary health protection research;
5. Following a separate competition, Imperial was also awarded an NIHR Diagnostic Evidence Collaborative (DEC), worth £1m over 5 years;
6. In December 2014, it was announced that ICHT had been successful in bidding to host one of the first wave of NHS Genomic Medicine Centres – the mechanism by which the NHS will deliver the 100,000 Genomes Project;
7. December 2014 also saw the release of the results of the most recent Research Excellence Framework (REF) – the periodic exercise to assess the quality of research in UK universities – in which Imperial College produced its best ever performance.

1. NIHR Imperial Biomedical Research Centre (BRC)

The NIHR Imperial BRC (£23m p.a.; 2012-17) supports key clinical academic salaries and core infrastructure across the Imperial AHSC, as well a wide range of discrete projects in areas of strategic importance;

Facilities:

- Dedicated speciality Clinical Research Facilities
- Biobank
- Imperial Clinical Trials Unit (ICTU)
- Patient Experience Research Centre (PERC)

Platform technologies:

- Genotyping
- Imaging (PET, MRI)
- Molecular phenotyping
- Informatics

Projects:

- ~600 ongoing clinical research studies (phase 0, I or II) at any time
- 15 specialty / disease Themes

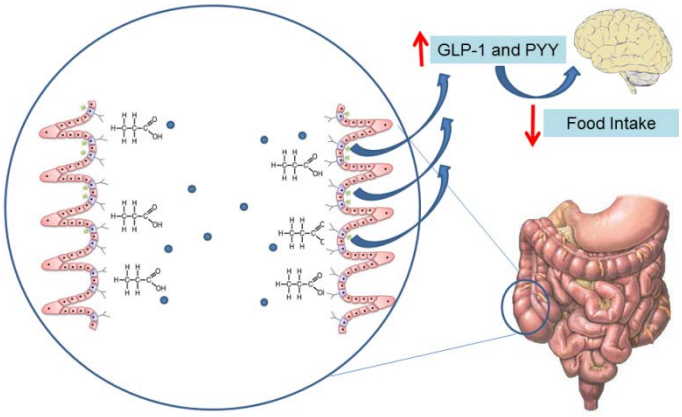
Training:

- Chain-Florey Fellowships and Lecturers
- EPSRC Doctoral Training Centre jointly-funded PhDs
- Fellowships for nurses, midwives, AHPs, pharmacists and scientists

1 a) BRC Research Highlights

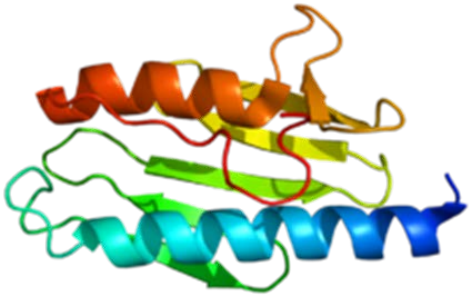
The following recent highlights have been selected from the across the BRC Themes:

A). **Dietary supplementation with specific amino acids to treat obesity (Frost *et al.*, *Nature Communications* 5; doi:10.1038/ncomms4611; Apr 2014)**



In the Obesity, Diabetes, Endocrinology and Metabolism Theme, investigators have developed a novel way of delivering short chain fatty acids (SCFA) to the colon. They have conducted first-in-human studies and demonstrated that this molecule increases the release of the gut hormones GLP-1 and PYY and suppresses appetite, and have gone on to demonstrate that this molecule limits weight gain in overweight people.

B). **Potential therapy for Friedrich's ataxia (Libri *et al*., The Lancet, vol. 384, issue 9942, 9–15, pp504–513, Aug 2014)**

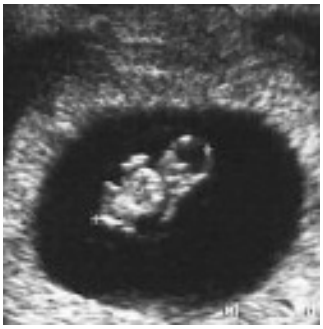


Friedreich's ataxia is a progressive degenerative disorder caused by deficiency of the frataxin protein (see diagram). In the Neuroscience Theme, this BRC-funded phase 1 study has led to the first therapeutic modification of the epigenome in non-cancerous disease, and the potential of nicotinamide as a treatment for patients with this condition.

C). **Development and validation of the I-Knife for surgical decision-making (Balog *et al.*, Sci Transl Med. 2013)**

In the Surgery and Stratified Medicine Themes, work on development of the iKnife has demonstrated 0% margins and is now undergoing a breast and glioma clinical trial. As well as cost savings in terms of avoiding return surgery, this technology will positively impact on improving patient experience, by improving cosmetic and functional outcome, and reducing surgical trauma and unnecessary removal of healthy tissue.

D). **Early pregnancy outcome study (Doubilet *et al.*, N Engl J Med. Oct 2013 10;369(15):1443-51 / Kyrgiou et al., BMJ 2014 Oct 28;349:g6192. doi: 10.1136/bmj.g6192)**



Work in the Women's Health Theme on criteria to diagnose miscarriage led to an immediate change in national guidelines in the UK in 2012 and has subsequently been incorporated into NICE guidelines. This change will lead to several hundred wanted pregnancies in the UK currently being terminated in error surviving. The importance of this work was recognised in a review in the New England Journal of Medicine.

E). **New trigger for ovulation could make IVF safer (C Jayasena, D Ashby, S Bloom, W Dhillo *et al*., J. Clin. Inv., Vol. 124 Issue 8, p3667, Aug 2014)**

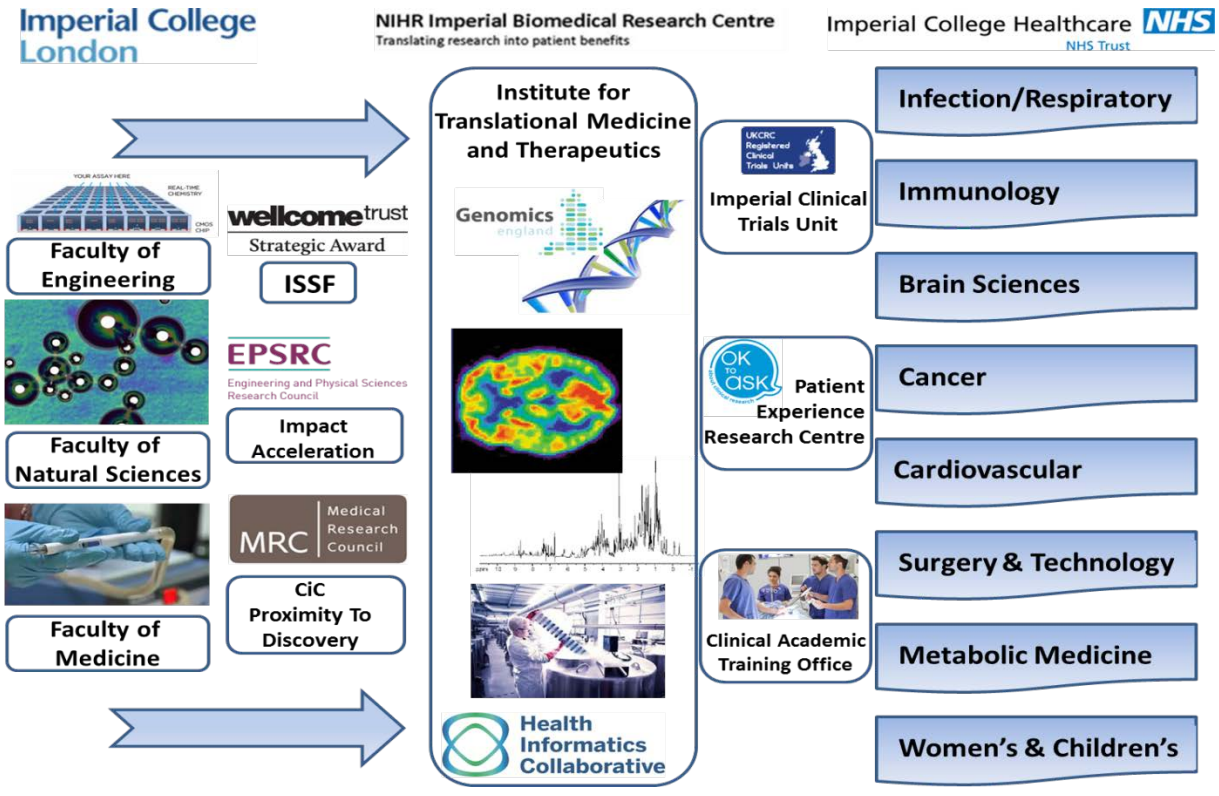
Kisspeptin is a naturally occurring hormone that stimulates the release of other reproductive hormones inside the body. In a BRC-funded proof of concept study 53 infertile women were given a single injection of kisspeptin to induce ovulation during IVF treatment. 96% women had successful egg maturation of the participants. 12 healthy babies were born, including baby Heath – the world's first kisspeptin-induced baby. http://www.bbc.co.uk/news/uk-england-london-22953488

1 b) BRC Mid-Term Review and Outcomes

- In responding to the expected NIHR call for BRCs in 2016, 2014/15 is critical in ensuring delivery of current award objectives and shaping future direction;
- An external mid-term review of the BRC took place in October 2014 with an external Review Panel of international experts, including the ICHT Chief Executive;
- Our successful strategy in the early-stage discovery science 'pipeline' is a considerable strength; being able to reach into the Imperial College Faculties of Natural Sciences and Engineering distinguishes Imperial BRC;
- Wide support for the cross-cutting BRC technology platforms and the need to augment with a 'big data'/informatics capability – encouraged to initiate the Institute for Translational Medicine and Therapeutics (ITMAT);
- Focus on fewer Themes; the current structure risks spreading investment too thinly
- Focus on 'bang for buck' – must continue to deliver relative to our size;
- Our training schemes are innovative and successful (e.g. Chain-Florey).

1 c) Proposed BRC Structure for 2015 and Beyond

- Following the mid-term review, we developed an optimum future configuration of disease Themes and technology platforms to provide the best chance of success during re-application in 2016/17 – see diagram below;
- Plan to integrate cross-cutting Themes / technology platforms – with informatics – into ITMAT to drive translation of new discovery science from disease Themes;
- Revised structure for the BRC to be established from 1 April 2015.



1 d) NIHR Health Informatics Collaborative (NIHR HIC)

- NIHR HIC conceived *to show that data collected in the course of routine patient care across the five largest BRCs (Imperial, UCLH, Oxford, Cambridge, Guy's) can be re-used for collaborative, translational research*;
- Five therapeutic areas selected, each representing an area of research interest, and each with its own challenges in terms of data acquisition and standardisation;
- informatics teams at each site have established clinical data repositories to extract and link data to match these shared standard;
- established a governance framework for data sharing across the five sites;
- in the next 12 months, research and informatics teams will work together to deliver data for exemplar research studies in each of the therapeutic areas;
- Solutions provided by this programme are designed to be scalable and re-usable and will provide the template for wider roll out across the NHS.

2. Joint Translation Fund

- 2014 saw the launch of the Imperial Joint Translation Fund, a scheme to accelerate clinical and biomedical translation through competitive project calls;
- £1.3m per annum with contributions from MRC, Wellcome Trust, EPSRC , Imperial Innovations, Royal Marsden and Chelsea & Westminster, funding ~20 projects p.a.;
- Chair: Professor Roberto Solari (GSK)
- *Novel inhibitors of MAP4K4 (HGK): a therapeutic target in cardiac muscle cell death* (Prof M Schneider); £2.5M Wellcome Trust Seeding Drug Discovery award
- *Clinical validation of an advanced bolus calculator for diabetes* (Dr P Vinas); commercial engagement with Roche, Cellnovo and Dexcom

3. NW London Clinical Research Network

- ICHT was successful in a competitive process launched by the NIHR to host the new regional Clinical Research Networks (CRNs);
- NWL Clinical Research Network (£12m p.a.) team now based at Hammersmith;
- Currently supports the delivery of over 500 NIHR Portfolio research studies;
- More than 20,000 participants recruited in the NWL CRN in 2014/15 YTD, of which ICHT has contributed almost 9,000.

4. NIHR Health Protection Research Units

- Again through a national competitive process, Imperial was awarded four NIHR Health Protection Research Units (13 awarded nationally);
- Total funding from HPRUs to Imperial is ~£12m over 5 years;
- HPRUs support Public Health England in delivering its objectives;

- Imperial HPRUs are in Healthcare Associated Infections and Antimicrobial Resistance (Prof A Holmes), Respiratory Infections (Prof A Lalvani), Modelling Methodology (Prof N Ferguson) and Health Impact of Environmental Hazards (Prof P Elliott; with Kings College London)

5. NIHR Diagnostic Evidence Collaborative

- Led by Prof G Hanna, Imperial was also successful in bidding for one of the four national NIHR Diagnostic Evidence Collaboratives (DECs)
- DECs enable NHS and industry to collaboratively generate clinical validity, clinical utility, cost-effectiveness and care pathway benefits of in vitro diagnostics (IVDs);
- Worth £1m over 4 years.

6. NHS Genomics Medicine Centre

- ICHT recently received confirmation that it has been successful in bidding to lead one of the eleven regional NHS Genomic Medicine Centres (GMC) in cancer and inherited rare diseases;
- Partnership with the Royal Marsden, Royal Brompton and Chelsea & Westminster;
- Prof G Thomas will lead the GMC and governance will operate through Imperial College Health Partners;
- GMCs will deliver the Prime Minister's 100K Genomes initiative, before end of 2017.

7. 2014 Research Excellence Framework (REF)

- December 2014 saw results of the most recent Research Excellence Framework (REF) – the periodic exercise to assess the quality of research in UK universities;
- Imperial College's best ever performance; judged to have improved in every Unit of Assessment (submitted >1200 WTE research staff);
- REF's new *impact* measure ranks Imperial's research the highest of any major university – 94% of Clinical Medicine impact case studies, 88% of case studies in Public Health, and 80% of case studies in Neuroscience scored 4* ('world-leading');
- Faculty of Medicine ranked either 3rd or 4th nationally (by grade-point average).

8. Patient and Public Involvement and Engagement (PPI/E)

- PPI/E activities run through all workstreams of the NIHR Imperial BRC;
- Cross-sector PPI Forum (through ICHP) for best practice and joint projects;
- Imperial Patient Experience Research Centre (PERC) leading on exemplar projects in PPI – Consent to Contact and Genomics & Informatics.

Recommendation to the Board: Board is asked to note the 2014 ICHT research review.

Imperial College Healthcare NHS Trust

Report to**:** **Trust Board**

Report from**:** **Quality Committee (14 January 2015)**

KEY ITEMS TO NOTE

CQC Inspection visit September 2014: action plan
The A&E Department at St Mary's had been re-inspected 7 January which had led to an improvement in the rating for the safe domain from *inadequate* to *requires improvement*, although the overall rating had not changed. The action plan would be submitted to the CQC on Monday 19 January and provide the basis for a CQC compliance framework to ensure the Trust met the 13 regulations set out as essential standards by the CQC. A series of deep dive reviews would be presented to the Committee aligned to areas of risk within the board assurance framework, and covering issues highlighted by the CQC inspection and action plan. The Committee ratified the action plan.

Duty of Candour policy
The Duty of Candour statute had come into force for all NHS bodies on the 27 November 2014, explaining what providers should do to make sure they are open and honest with people when something goes wrong with their care and treatment. It was noted that compliance with the policy may require additional resources. The Committee ratified the policy.

Charing Cross Hospital surgical rotas
An update report was received on the issues affecting the surgical rotas at Charing Cross Hospital. Additional investment in consultant, registrar and nurse practitioner level had been approved to support the Emergency Surgery service at Charing Cross Hospital with all posts expected to be in place by June/July 2015.

Action requested by Trust Board

The Trust Board is requested to:

- Note the report

Report from: Prof Sir Anthony Newman Taylor, Chairman, Quality Committee
Report author: Tracy Walsh, Committee Clerk
Next meeting: 11 February 2015

Imperial College Healthcare NHS Trust

Report to**:** **Trust Board**

Report from**:** **Audit, Risk & Governance Committee (10 December 2014)**

KEY ITEMS TO NOTE

Corporate Risk Register & Board Assurance Framework
The Committee reviewed the risk register in detail and discussed a number of the issues, risks and mitigating actions, recommending a number of amendments to descriptions and control scores. The first 'deep dive' from the risk register took place.

Standing Financial Instructions (SFIs)
The SFI's were approved by the Committee, noting they would only be enacted upon once the Standing Orders and Scheme of Delegation had been approved by the Trust Board.

Cerner update
Intensive training had commenced in December to address the backlog and the backlog was being analysed to understand whether it was due to a problem in the initial training or in the data. A small pilot of the clinical documentation functionality was taking place in Gynaecology at St Mary's Hospital, with a planned rollout across the whole organisation during 2015.

Action requested by Trust Board

The Trust Board is requested to:

- Note the report

Report from: Sir Gerald Acher, Chairman, Audit, Risk & Governance Committee
Report author: Tracy Walsh, Committee Clerk
Next meeting: 11 March 2015

Imperial College Healthcare NHS Trust

UNCONFIRMED MINUTES OF THE FINANCE & INVESTMENT COMMITTEE

Thursday 20 November 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 (until item 2.6)
Jeremy Isaacs	Non-Executive Director
Dr Tracey Batten	Chief Executive
Steve McManus	Chief Operating Officer (until item 2.2)
Bill Shields	Chief Financial Officer
In Attendance:	
Sandra Easton	Deputy Director of Finance (Business Partnering)
Jonathan Evans	Deputy Director of Finance (Financial Planning)
Ian Garlington	Director of Strategy
Marcus Thorman	Director of Operational Finance
Tracy Walsh	Committee Clerk (minutes)

1.	GENERAL BUSINESS	Action
1.1	**Chair's opening remarks** The Chair welcomed everyone to the meeting. The Committee expressed continued concern as to the timely receipt of papers and Sarika Patel confirmed that in future late papers would not be accepted and the agenda item withdrawn. The Chair noted that Trust Chairman, Sir Richard Sykes, had requested, in July, that the Committee review the Private Patients Strategy; the item had yet to be submitted. **Action**: Bill Shields to ensure Strategy provided early in 2015. It was agreed that where tenders from CCGs were received at very short notice, the Committee could be convened by teleconference or if appropriate tenders approved by Chair's action.	**BS**
1.2	**Apologies for absence**	
	No apologies for absence had been received.	
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 meeting on 18 September 2014** The minutes were approved as an accurate record, subject to the amendments below: • 1.5 to read "Sarika Patel requested that a date be agreed with the Chairman to discuss the CIP schemes at a Board seminar". • 2.2.4 to read "….issues around Cerner. The impact of not receiving monies from Project Diamond would result in the Trust needing to review its surplus provision downwards".	

Imperial College Healthcare NHS Trust

1.5	**Matters arising and action log** The action log was noted. At 1.5, CIP Schemes at a Board seminar had been scheduled for February 2015.	
2.	**MAIN ITEMS**	
2.1	**Finance report – Month 7**	
	Bill Shields introduced the report and noted that the month 7 income & expenditure position was a surplus of £0.8m; an adverse variance of £8.0 against the plan. There had been an increase in pay expenditure in month in medical, estates, senior management and bank and agency staff. Weekly meetings were being held with divisional directors to discuss controls on pay expenditure. The delivery of Cost Improvement Plans (CIPs) remained a concern although staff were now more engaged with the financial recovery controls. The current financial position presented a significant challenge if further reductions in expenditure could not be achieved. Additional income would come from the sale of a lease at Point Pleasant, rights to light on the sale of the Royal Mail Group building and the profits of the sale of residential dwellings at Ravenscourt Square, Hammersmith. The Trust has also had additional income for delivering RTT activity in October and November, from which a contribution margin would be made. Finally in order to deliver the financial plan for the year there was some flexibility on the balance sheet with regards to provisions and accruals which were being generated by the purchase ordering system and a release of provisions from last year. Steve McManus outlined the position for the Divisions: • Medicine's pay and non-pay expenditure had improved in months 6 and 7 as had its CIP position. There would be a technical adjustment to the Division's forecast due in part to an overstatement of the HIV budget • Women's and Children's forecast had improved by £2 million and expenditure levels were being maintained following controls implemented in quarter 1 • Investigative Sciences were forecast to breakeven; a £100,000 overspend was currently being investigated. Divisional forecasts remained unchanged but budget baselines would need to be clarified for each Division next year. It was reported that the reasonably high substantive vacancy rate required the use of bank and agency staff to ensure safe staffing levels and it was recognised that rostering on wards could be improved and work was taking place around this. Bank and agency staff arrangements to address additional winter activity 2013/14 had remained in place during summer 2014. It was noted that Jon Schick had commenced the role of QuEST Manager (Quality and Efficiency Support Team) to support Divisions in achieving quality and cost improvement. **Action**: The next finance report would demonstrate the underlying run-rate (any non-recurrent items to be removed) and a comparison to the previous year. The Committee noted the Finance report for month 7.	**BS**
2.2	**Financial risks**	

	Bill Shields introduced the paper and reported that it would be used in shaping the Long Term Financial Model (LTFM). The paper was not the final position and it was agreed that scores and risk descriptions would be reviewed. The Committee noted the financial risks paper.	
2.3	**Shaping a Healthier Future OBC process update**	
	Ian Garlington introduced the paper and reported that the McKinsey assurance team (on behalf of the commissioners) had requested a further option, which would focus on the building of a new hospital on the Charing Cross site. The Trust would respond in writing advising that it was not feasible for the Trust to endorse such an option but highlighting that the original option 2 allowed for a substantial new build on that site. The Committee noted the Shaping a Healthier Future OBC process update.	
2.4	**Integrated Planning Framework 2015/16**	
	Sarika Patel welcomed the planning framework. Noting a request for a contingency budget, Bill Shields reported that there was a contingency of 0.5% which was a statutory requirement. Other considerations were the Cost Improvement Programme (CIP) and the level of investment required for new services. That planned surplus for 2015/16 would be 0.5% (1% in prior years), and this would drive the CIP requirement. The draft plan would be submitted to the TDA in January 2015 and the final plan in April 2015. The economic modelling figure from NHS England was 4.5%, which was believed achievable for next year but concern was expressed (similarly to other Trust) in relation to the 4% economic modelling figure in future years. The Committee noted that the QuEST team were working on a plan for the next 5 years. **Action:** Steve McManus would present this to the Committee at an appropriate time. Marcus Thorman reported that a revised tariff, which included Project Diamond, would be in place from April 2016; discussions were taking place between the Shelford Group, NHS England and the Secretary of State to agree a funding position for 2014/15. Bill Shields advised that an analysis produced by KPMG had been shared with NHS England, TDA and Monitor which highlighted that the impact on the Trust (as for all trusts with a high level of specialist activity) was higher than initially expected. At the most recent Integrated Delivery Meeting with the TDA it had been noted that, given the scale, DH were likely to be involved in the approval of the SaHF business case. **Action**: Bill Shields to ensure July annual capital requirement report included requirements for backlog maintenance. The Committee noted the Integrated Planning Framework 2015/16.	**SM** **BS**
2.5	**World Class supply chain**	
	Marcus Thorman introduced the paper and highlighted: • Inventory management – in early November stock management cabinets had been implemented in 4th floor theatres at QEQM; these had been well received by staff and would result in the ordering of 3-5% less stock. Roll out to orthopaedic and trauma products would take place late November and ICU in January 2015 • Contract management – amalgamation of income and expenditure would	

	enable full oversight of the expenditure baseline • Purchase to pay – accounts payable had been outsourced to East Lancashire Financial Services (ELFS) which would reduce transaction costs. It was noted that the Purchasing Strategy had been updated but Trust Board approval was not considered necessary given the operational nature of the changes. The Committee noted the World Class supply chain update.	
2.6	**Patient Transport review update**	
	Ian Garlington reported that 65% of activity was from patients using renal services; the eligibility criteria were to be reassessed with an expected saving of approximately £25,000 per month. The Committee noted the Patient Transport review update.	
2.7	**Land Valuation briefing paper**	
	Bill Shields reported that at the September Audit, Risk and Governance Committee meeting the external auditors Deloitte LLP had expressed concern with the valuation of the land; a conference call had been held with Deloitte in early November 2014 to discuss their concerns. The valuers had looked at the least expensive alternative site in West London to determine the land value given that the alternative site would be hypothetical. This reduced the value of the dividend which the Trust would be required to pay (a reduction of £3 million in 2014/15 and a further £3 million in 2015/16). Marcus Thorman reported that should the Trust plan to sell the land in the future, the land would have to be valued at open market value and the Trust would then pay dividends for that value. The Committee noted the Land Valuation briefing paper.	
2.8	**Transition of Maternity and Neonatal Services from Ealing Hospital business case**	
	As the paper had not been made available to the Committee in sufficient time the Chair had withdrawn this item from the agenda. Post-meeting minute: The paper was circulated to Committee members on 20 November 2014 and a meeting held by conference call on 24 November at which Professor TG Teoh presented the business case. The Committee approved the business case subject to confirmation that pathology costs were captured in the business case, assurance that appropriate project management would be in place to manage this transition and that ICHT would be protected against any inadvertent adverse costs associated with this transition.	
	ITEMS FOR READING	
3	**GOVERNANCE ITEMS** Committee members noted the items circulated - no queries or questions were raised in the meeting.	
3.1	**Summary of the Strategic Investment Group** The Committee noted the summary of the Strategic Investment Group.	
3.2	**Workplan review** The Committee noted the workplan review.	
4	**FINANCE ITEMS**	

4.1	**Capital programme** The Committee noted the Capital programme.	
4.2	**Estates Strategy update** Ian Garlington reported that a comprehensive re-evaluation of the maintenance backlog was being undertaken, and would be reported in February 2015. There had been increased activity in preventative maintenance which in future would be included in the risk profiled expenditure requirement. The Committee noted the Estates Strategy update.	
5	**ANY OTHER BUSINESS** The Committee thanked Marcus Thorman for his hard work and commitment to the Trust, particularly while acting Chief Financial Officer and wished him well in his new role.	
6	**DATE OF NEXT MEETING**	
6.1	22 January 2014 4.00pm – 6.00pm, Clarence Wing Boardroom, St Mary's Hospital.	

Imperial College Healthcare NHS Trust

Report to**:** **Trust Board**

Report from**:** **Foundation Trust Programme Board (16 December 2014)**

KEY ITEMS TO NOTE

Quality Governance Framework (QGF) rescore:
Grant Thornton attended the meeting and reported that they had revisited the Trust to review their initial QGF assessment reported to the Board in March 2014. A revised score of 3.5 points was proposed (from 5.5 points) and, whilst this was 1.5 points higher than that scored by the Trust in its own self-assessment, was accepted by the FTPB. Grant Thornton advised that they considered that an overall score of 2 could be achieved by June 2015 with the potential for a zero score by September 2015.

Foundation Trust membership update:
The Trust Company Secretary reported that a review of the membership database would continue to ensure that it accurately reflects the current membership. A regular briefing process for the membership would be developed by the Trust Company Secretary and Membership Manager.

The Foundation Trust application process:
A discussion paper was received outlining the impact of the recent CQC inspection outcome on the foundation trust application timetable. The FTPB noted that the authorisation process may be delayed by up to eighteen months, and that there would be a greater degree of certainty once the Trust has agreed its post inspection action plan with the CQC. The FTPB agreed that the "pause" should be used to embed CQC compliance, renew the Quality Strategy and embed revised governance processes; it recognised that the elements required for a successful application would follow from a strengthened quality and organisational framework. The Trust Company Secretary would review the Trust's corporate governance systems and processes against the Monitor "Well Led" framework and this would be used to drive improvements whilst supporting the foundation trust application.

Post meeting note: It was agreed at the Trust Board on 17 December 2014 that the FTPB would be suspended and meetings would be reintroduced at an appropriate time.

Action requested by Trust Board

The Trust Board is requested to:

- Note the content of this report and that future meetings of the FTPB have been cancelled until further notice.

Report from: Rodney Eastwood, Chairman, Foundation Trust Programme Board
Report author: Richard Cook, Foundation Trust Programme Manager
Next meeting: No further meetings are scheduled

Imperial College Healthcare NHS
NHS Trust

Minutes of the Foundation Trust Programme Board (FTPB)
Tuesday 16th December 2014
15:00 – 17:00
Clarence Wing, Board Room. SMH.

ATTENDEES: Rodney Eastwood (RE) (Chair), Tracey Batten (TB), Sir Anthony Newman Taylor (ANT), Kevin Jarrold (KJ), Chris Harrison (CH), Janice Sigsworth (JS), Jan Aps (JA), Bill Shields (BS)

IN ATTENDANCE: Vicky Scott (VS), Anna Bokobza (AB), Richard Cook (RC) Mick Fisher (MF) Mark Fletcher, Wendy Cookson and Bill Upton from Grant Thornton attended the meeting to present item 4 and left after this point on the agenda.

1. **Apologies:** Ian Garlington (IG), Michelle Dixon (MD), Sir Tom Legg (TL), Steve McManus (SM) Jayne Mee (JM),

2. **Minutes of last meeting**

The minutes were accepted as a correct reflection of the meeting held on 18th November 2014.

3. **Matters Arising**

The Action Log was reviewed and the following updates provided to the meeting:

It was noted that all actions previously allocated to Helen Potton would transfer to Jan Aps, Trust Company Secretary.

Action 81: Voluntary organisation representation on the Council of Governors.

- **JA** confirmed that she is aware of the issue of securing Carer representation on the Council of Governors.

Action 100: **ANT** clarified the action noted and agreed that he would write to the new President of Imperial College with the offer of a meeting to provide an overview of the ICHT application to become a Foundation Trust.

Action 114: Securing letters of external support

- **TB** advised that this would be pursued at the appropriate time in the application process.

Action 120: NEDs awareness of succession arrangements for Sir Tom Legg

- **RE & ANT** agreed that this would be discussed with the Chairman during the private session of Trust Board in December and that the matter would be removed from the Action Log.

Action 121: "Independence" of NEDs

- **JA** advised that there was still further work to do in relation to the Constitution in this area – this would be dealt with as part of the wider review of Constitution that **JA** is undertaking.

4. Quality Governance Framework (QGF) Rescore

Mark Fletcher (Associate Director, Healthcare Advisory with Grant Thornton) gave an overview of the QGF assessment process. Grant Thornton (GT) undertook their initial assessment 9 months ago and recently revisited the Trust to review those elements of the QGF that had scored above zero in the original inspection. Mr Fletcher thanked the members of the FTPB for their participation in the process; he advised that the findings presented to the meeting had been arrived at without consideration of the outcome of the CQC Inspection and that these would need to be taken into account. He added that it was obvious that steady progress had been made by the Trust.

Mr Fletcher outlined the headlines of the review: that GT consider the Trust QGF score to be now at 3.5 points (from 5.5 in March) which is 1.5 points higher than the Trust itself arrived at in its self-assessment, although he considered that by June 2015 the Trust could achieve an overall score of 2 and lower still by September 2015.

There were three areas where the GT assessment score differed from the ICHT self-assessment:

- Quality driving Trust strategy (1a) – FTPB agreed with the GT assessment that the score needs to reflect that the quality strategy implementation plan needs revising and that the strategy will need to link with the outputs of the CQC review. A revised score of 0.5 was accepted.
- Processes for escalating issues and managing performance (3b) – the GT revised score of 1 was accepted by FTPB, based upon inconsistent action plans and lack of clarity as to process for signing off policies and clinical guidelines. CH advised that the Trust had agreed a business case to address issues with policies and monitoring clinical audit and that recruitment was underway for staff to undertake the work required. Wendy Cookson of GT suggested that the Trust needed to consider the role of ExCo in signing off policies.
- Analysis of quality information (4a) – FTPB agreed with the GT score of 0.5 based on observation that there had been insufficient progress since February in developing quality metrics. GT advised that they had not observed papers going to the Board identifying the impact of specific projects on patients – the visibility of these considerations needs addressing. **CH** advised that significant detail was included in the quality report presented to the Quality Committee but noted that was not reported at the Board report.

GT advised that the Trust needed to aim for a "buffer" in its final QGF score before proceeding to the Monitor assessment stage given that Monitor had particularly challenging requirements in QGF scoring.

GT presented their suggested "timeline for zero" for each of the domains under review; noting that given that there was now an agreed business case for the review of policies the timeline for domain 4b could be brought forward from September 2015 to June 2015.

GT confirmed that a detailed report would be produced for each domain taking account of the CQC report. The team had reviewed at a high level the CQC report and identified those areas that affect the QGF although it was not considered that this would affect the overall scores. A draft report should be available by mid-January and finalised by the end of January 2015.

Wendy highlighted that during the course of this review there were elements suggested by staff interviewed that they would like to see introduced by the Trust – these would be included within the report for information but not as a requirement or recommendation (e.g. staff having easy access to minutes of the Quality Committee).

TB thanked the GT team for their presentation adding that it has been helpful in assisting the Trust to prioritise and flag progress that has been made. (The GT team then left the meeting.)

5. Membership Update

JA presented a paper updating the FTPB on membership of the Trust and highlighted the work that is on-going to cleanse the database given that a significant proportion of existing members were recruited a long time ago.

JA stressed the need for the Trust to be clear about what we expect to be able to offer to members and how we plan to use them. The Trust should not "oversell" membership and needed to be careful about timings of recruitment in that the Trust risked losing support if members were recruited too early.

There was a need to be clear about how the Trust would communicate with its members – all members with email would be contacted and updated on the CQC inspection result. **JA** would look to establish a system of regular briefing to members by email.

FTPB noted high representation of over 65s age group on members database. **JS** suggested various avenues by which we might target younger people using Trust services and encourage them to become members of the Trust.

6. The foundation trust application process – discussion paper

BS opened the agenda item by stating that the purpose of the paper was to stimulate discussion about the foundation trust application and to enable the Board to consider its next steps given the impact of the outcome of the CQC inspection on the authorisation timeline.

BS said that at times the foundation trust process had felt rather like a tick box exercise rather than a developmental process. Whilst foundation trust status was likely to be the

main organisational form for provider bodies in the future, authorisation for the Trust could now be 12 to 18 months away.

TB said that the Trust would have greater certainty of the timescale for foundation trust authorisation after submission of its post inspection action plan to the CQC – the Trust would need to request its re-inspection only when it is absolutely confident that it had addressed all issues raised and that it would secure a rating of at least "good". **TB** added that around a third of the actions identified, such as improvements to the outpatient service, would require a significant amount of work.

FTPB shared the view that the Trust must not underestimate the effort that would be needed to galvanise the organisation for the length of time that the foundation trust application was likely to take. The Trust needed to focus on its governance systems and processes – **JA** will be reviewing the Trust against the Monitor "Well Led" framework and this would be used to drive the required improvements.

The question was raised whether the FTPB should continue in its present form given the delay to the application timetable; it suggested that improvements to governance processes could be reviewed at the Audit, Risk and Governance Committee. **TB** suggested that this be discussed at the Trust Board meeting on Wednesday 17 December.

JA said that the biggest shift of focus for the Trust would be towards assessing its business "through the lens of risk" and ensuring board processes provided assurance rather than an additional management tier; once this was been achieved, the elements required for a successful foundation trust application would fall into place through a strengthened quality and organisational framework.

It was agreed that this pause should be used to embed CQC compliance, renew the Quality Strategy and embed revised governance processes; whilst continuing to understand (and deliver) the key requirements of the foundation trust authorisation process, these should not drive the Trust priorities.

The meeting ended with agreement that the future of the FTPB will be discussed at Trust Board.

Date of Next Meeting: *Tuesday 20th January 2015*
15:00 – 17:00 Clarence Wing Board Room

[post meeting note – following Trust Board discussion, it was **agreed that this and future meetings of the FTBP would be cancelled**. Meetings would be re-introduced at an appropriate time].

Imperial College Healthcare NHS
NHS Trust

Minutes of the Foundation Trust Programme Board (FTPB)
Tuesday 18th November 2014
15:00 – 17:00
Clarence Wing, Board Room. SMH.

ATTENDEES: Rodney Eastwood (RE) (Chair), Tracey Batten (TB), Sir Anthony Newman Taylor (ANT), Kevin Jarrold (KJ), Chris Harrison (CH), Jayne Mee (JM), Janice Sigsworth (JS) (left the meeting after item 4), Marcus Thorman (MT), Helen Potton (HP), Mick Fisher (MF).

IN ATTENDANCE: Vicky Scott (VS), Anna Bokobza (AB), Richard Cook (RC).

1. **Apologies:** Ian Garlington (IG), Michelle Dixon (MD), Sir Tom Legg (TL), Bill Shields (BS), Steve McManus (SM)

2. **Minutes of last meeting**

The minutes were accepted as a correct reflection of the meeting held on 16th September 2014.

3. **Matters Arising**

The Action Log was reviewed and the following updates provided to the meeting:

Action 81: Voluntary organisation representation on the Council of Governors.

- **HP** confirmed that given the difficulties experienced in contacting Carers UK regarding the potential for them to represent voluntary organisations on the Council she is developing a contingency plan and will have this in place before she leaves the Trust.

Action 100: Establishment of a working group to develop plans for Governor and membership engagement.

- **RE** queried why the action plan stated that it had been decided not to convene a sub-group to progress this work.
- **HP** confirmed that the Director of Governance had decided not to progress this action prior to her leaving the organisation and that the membership Manager and Communications team are progressing with engagement plans.
- **RE** asked that a paper be presented to the December FTPB providing a timetable for engagement and membership development to provide assurance that the Trust is on track to deliver the required areas.
- **HP** provided verbal assurance of actions to date including the distribution of the Annual Review and a survey to all registered members of the Trust – the purpose being to update the membership on the progress of the FT application and establish the degree of involvement each would wish to have with the Trust in the future. (Action logged as Action 126)

- **RE** asked that consideration is also given to how the Trust will communicate and update organisations from where Appointed Governors will be drawn.
- As part of these discussions **ANT** agreed to write to the new President of Imperial College.

Action 109: Relationship Agreement with Imperial College

- **HP** confirmed that she has reviewed the Relationship Agreement and established that there are no conflicts between this and the arrangements proposed in the Constitution. (This can now be closed on the Actions Log.)

4. FT Project Sponsor report

MT gave an overview of the Report and added that the Executive had met with the TDA on Friday 7th November as an "informal" update on the Trust's application and in preparation for the Readiness Review scheduled for March 2015.

The timing of the second Independent Financial Review (IFR2) has been discussed with KPMG. **MT** clarified for FTPB that the Trust has access to one Review paid for by Monitor as part of the authorisation process – if our application is delayed and a further review is required the costs will need to be met by the Trust. The timing of the review is therefore dependent upon the outcome of the CQC inspection – the result of which will be known in the next two weeks.

The Long Term Financial Model is being finalised ready for submission to Trust Board on 17th December. Chapters 6 and 7 of the IBP reflect the LTFM and will be submitted to FTPB for review at the 16th December meeting.

MT advised that because of on-going work with the Board in finalising the Corporate Risk Register (CRR) the mitigated downside for the LTFM will not be finalised in time for the December Trust Board meeting – this work will continue over December and will need presenting at the January Trust Board prior to submission to the TDA on 1st February in advance of the Readiness Review in March. It was noted that the CRR will be reviewed at the November Trust Board.

MT added that currently the size of the CIPs required going forward is unknown until the LTFM projections are complete. Fortnightly meetings are being held with divisions to develop further CIPs and track progress.

The Board noted that further communications and engagement activities are planned. **RE** asked whether our staff feel positive about the FT application.

TB reflected that at the Chief Executive Briefings where she has shared updates on progress staff appear keen for the Trust to secure FT authorisation.

The Board went on to discuss the potential impact upon the FT timetable should the CQC inspection return a report in which requires improvement to be made.

VS confirmed that should this be the case the minimum delay to the authorisation timetable would be at least 6 months in that this is the earliest date from receipt of the final report that a re-inspection can be requested and that depending upon the reasons for requirements being made some Trust have rearranged follow up inspections after a longer period.

5. Quality Governance Framework (QGF) Rescore

FTPB noted the report advising on outcome of the latest self-assessment of the QGF and subsequent rescore that has resulted in Grant Thornton returning to undertake the independent assessment.

FTPB retrospectively approved the self-assessment score as previously agreed by the Quality Committee

6. Board Governance Memorandum (BGM) Progress Update

HP introduced the paper identifying that Appendix One shows the initial action plan and that Appendix Two summarises the Grant Thornton review of Governance (BGAF) and subsequent action plan. **HP** further updated:

- Appendix 1 Item 1.2: JM has confirmed that a skills audit is now in place;
- Appendix 1 Item 2.1: A desktop review of the Trust against Monitors Code of Governance has now taken place – and is an agenda item at today's FTPB;
- Appendix 1 Item 4.2: further examples of how our people have been involved in the development of the IBP include the involvement of around 80 clinicians and managers in the development of the SWOT and PESTLE and in refining the Strategic Objectives and identification of performance measures**.**

TB highlighted that in her meeting with Grant Thornton they discussed item 2.4 within the BGAF and clarified that the requirement for 360 degree appraisal only applies to the Executive Directors.

7. Effectiveness Review against Monitor's Code of Governance

HP summarised the desk top review she had undertaken against Monitor's Code of Governance.

The review had identified a number of "Amber" indicators although much of this related to the Council of Governors and can only turn to green as this group becomes established. It was also stressed that a number of the other 'Amber" indicators are all interrelated and as one becomes green a number of others will also.

Action: ***HP and the new Trust Company Secretary will develop an action plan to address the issues identified by the Code of Governance Review.***

Further Discussion regarding Code of Governance review took place after item 8 on the agenda but is recorded at this point for ease of review of the minutes:

ANT and **RE** queried that within the self-assessment was reference to a decision having been made that when Sir Tom Legg's term of office as a NED ends he will not be replaced. Neither **ANT** nor **RE** recalls having been formally informed of this decision. This item needs discussing further with the Chairman.

Action: ***TB to flag with Chairman that the NEDs are unaware of decision not to replace Sir Tom Legg.***

Discussion followed about the position of "Independent" NED. ANT clarified that he is an Independent NED and was appointed as such as the representative of Imperial College on the Trust Board.

RE clarified that he is also classed as an Independent NED.

HP stated that the Trust will need to ensure that anyone identified as "independent" needs to meet the criteria that is used to define independence and advised that this can sometimes be difficult to demonstrate the longer an individual has an association with the Trust.

Action: ***HP will provide the checklist that is used to establish whether a Non-Executive Director can be classed as being "Independent".***

8. Independent Financial Review (IFR1)

MT introduced the paper and drew attention to the front sheet that summarises the RAG rating for the various themes of the IFR1 report. This shows progress that has been made in addressing the issues with three themes remaining "Red", CIPs, Risk and Working Capital.

MT confirmed that CIP issues will be dealt with before the Readiness Review.

MT clarified that the LTFM and papers submitted to the TDA will differ to those subsequently submitted to Monitor because financial information is updated quarterly.

The Risk RAG rating will change upon completion of the downside mitigations in December and early January.

The Working Capital issues will be addressed closer to the timing of the Readiness Review and the rating will change at that point.

9. Integrated Business Plan (IBP) Draft Chapters 2,3,4,5 & 9.

RE commented that reviewing the volume of papers since receipt has been extremely difficult and requested that the document be provided with all changes tracked to make it easier for the Board to identify where changes had been made.

Action: ***FTPB members to send through to RC any suggested amendments to the chapters that they have received for review.***

RC to ensure that subsequent versions of the Chapters from this point forwards to be submitted for review with changes tracked.

TB gave an overview of the documents that had been circulated:

- Chapter 2 has been refreshed to reflect the current position of the Trust;
- Chapter 3 requires further update as this Chapter will in effect replace a previous overview of the Trust's Strategy that had been produced at the beginning of 2014;
- Chapter 4 will require a further draft that relates back the strategy to the market assessment;
- Chapter 5 has been updated to reflect the SWOT undertaken at the Leadership Forum and aside form inclusion of additional financial data is practically complete;
- Chapter 9 has been updated to reflect governance arrangements and is practically complete.

ANT reflected that the Trust should be more transparent about some of its performance data, adding that if there are difficulties in the delivery of a particular target (such as the A&E transit time) this should be reflected in the IBP with assurances about how the issue is being addressed.

ANT and **RE** made further suggestions:

- Page 4: The research income figure appears low and should be revised;
- Page 36 Section 3.4.2.1: more explanation of Systematised Planned cared is required. Similarly examples about Personalised Medicine should be provided. Examples were provided such as work underway within the field of chronic myeloid leukaemia and how molecular analysis of genetic abnormalities is helping treatment. The point was made that if the Trust is stating it is a world leader more information needs to be provided that supports this;
- Education and Research (Chapter 3): most of the section is about training. The Trust is an undergraduate teaching hospital and hosts least 1000 undergraduates at any one time, this needs reflecting in the IBP;
- Chapter 9: The Association of Medical Charities is actually the Association of Medical Research Charities and should be corrected;
- Quality Principles: it should be noted that these are being refined and will be updated in March/April 2015.

Action: ***RC to ensure suggested amendments are made to the IBP.***

10. Governance Rationale

HP introduced the Governance Rationale that will comprise an appendix to the IBP and which summarises arrangements within the Constitution. The following comments/amendments were suggested:

- Page 7: add "and appointed Constituencies";

- Reference to the geographical area within which offences are classed has been changed to the EU. FTPB requested that this be changed to the UK and also reflected as such in the Constitution;
- Page 13: the definition of the Association of Medical *Research* Charities to be used in the Constitution**.**

Action: ***HP to make suggested changes to the Governance Rationale and amend the Constitution where relevant.***

11. FT Constitution

HP introduced the paper stating that she had been in considerable debate with Capsticks (legal advisors) regarding the eligibility criteria for members to stand as Governors. Capsticks have stated that if a Member is eligible to stand for election at the start of the election process they remain eligible to serve as Governor for the duration of the elected term. HP is of the view that eligibility to serve as a Governor is dependent upon the individual continued eligibility to belong to the associated membership category. The issue remains outstanding.

HP agreed to speak directly with the Foundation Trust Network on the issue.

Other issues that were raised during discussion on this item:

- Honorary Contracts: individuals with an Honorary Contract with ICHT will be eligible for automatic membership of the Staff Constituency. It was confirmed that the Trust is able to establish when honorary contracts, and therefore eligibility, ceases;
- Facilities Management Staff: it was confirmed that individuals employed by other agencies, such as hotel services staff, are not included in the Staff constituency – particularly given some of the data protection rules associated with needing to maintain an up to date staff data base using records from another organisation. These staff will have the opportunity to apply to ICHT for public membership if they meet the geographic eligibility criteria;
- AHSC Appointed Governors: HP brought to the attention of the Board that the revised wording at 13.12 should be disregarded give that if this was followed it would preclude Imperial College from having representation under its AHSC status given that it has a place on the Council of Governors in its own right. HP clarified that 3 places exist for the AHSC one of which will be a representative of Imperial College – this will be in addition to the place specified for the College;
- It was queried whether Appointed Governors can also hold an Honorary Contract with the Trust as this would mean that they would be eligible to become a governor across both the elected and appointed constituencies. ***HP will check with Capsticks the impact of Appointed Governors holding an honorary contract with the Trust;***
- Significant transactions: how is significant defined? **HP** advised that on Page 31 Para 47 the definition of significant rests with the Board of Directors;
- Page 19 Para 24.5: legislation states that the appointment committee should be made up of Governors. ***HP will clarify arrangements for the Appointments Committee particularly those relating to arrangements for chairing the***

meeting. A suggestion was made that the wording should reflect that the meeting would "normally' be chaired by the Trust Chairman and that when the Chairman is being discussed the meeting would be chaired by the Senior Independent Director. It was also felt appropriate that the Chief Executive should attend these meetings;

- In the case of NED Appointments it was suggested that the CEO should attend the Appointments Committee;
- Para 24.4.2: The FTPB was of the view that for the appointment of the Chairman the Appointments Committee should comprise the Senior Independent Director as Chair, one or more other NEDs and with the CEO in attendance. ***RE agreed to write to the Chairman to outline the proposed governance arrangements and to seek his views. HP will check with Capsticks the composition of the Appointments Committee for the Chairman***;
- Page 22: ***HP will ensure that the definition of the geographic area at Para 32.4 is restated as the United Kingdom and not the European Union***;
- Page 38: ***HP will ensure that the description of AHSC eligibility as a Stakeholder Organisation is tidied up.***

Actions: ***HP agreed to speak directly with the Foundation Trust Network to seek further clarification upon an individual's eligibility to serve as a Governor.***

HP will progress further refinements to the Constitution and raise specific queries identified with Capsticks. The revised Constitution will return to FTPB on 16th December prior to Trust Board on 17th December.

12. Risk Register

The Risk Register was reviewed and the following noted:

- **Risk ID Number 2:** QuEST (Quality Efficiency Support Team) will work to drive forward the CIP programme.
- **Risk ID Number 6:** Stakeholder Engagement – The FT Application has good support form Commissioners. Hammersmith & Fulham Council continues to express concerns about the Trusts plans for the change of focus for Charing Cross Hospital.
- **New Risk:** Internal Capacity – needs a risk number adding. The impact of the CQC inspection report will need adding to the Internal Capacity risk and the potential impact on the FT application timeline.

Action: RC to make required changes to the FT Risk Register

13. Any Other Business

TB advised the FTPB that this is Helen Potton's last meeting as Interim Trust Board Secretary. TB commended Helen for the high quality and volume of work she has produced in support of the FT application and more generally and that she has provided a very professional service. The FTPB thanked Helen and wished her well for the future

Date of Next Meeting: Tuesday 16th December 15:00 – 17:00 Clarence Wing Board Room.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	6.1
Title	Record of items discussed at the confidential Trust Board 26 November and 17 December 2014
Report for	Noting
Report Author	Jan Aps, Trust Company Secretary
Responsible Executive Director	Tracey Batten, Chief Executive

Executive Summary:
Decisions taken during the confidential sessions of a trust board are reported (where appropriate) at the next trust board held in public. Those issues of note and decisions taken at the trust board's confidential meetings held on 26 November and 17 December 2014 are outlined below:

- Corporate risk register: The Board agreed the corporate risk register, and agreed to the proposed reporting arrangements to the Trust Board (corporate risk register: six monthly at Board; board assurance framework: six monthly review at Board).
- Tender submission – community independence service (CIS): The Board authorised the submission of the tender offer to act as lead provider for the provision of a community independence service.
- Amendments to Board governance arrangements: The Board approved the following:
    - Sir Gerald Acher appointed as Deputy Chairman, and Senior Independent Director;
    - Dr Andreas Raffel formalised as a member of the Audit, Risk and Governance Committee, and member of the Remuneration and Appointments Committee;
    - Alan Goldsman appointed as interim Chief Financial Officer from 5 January 2015, and would be a member of the Trust Board;
    - All Board Committees shall have a minimum of three Non-Executive Director members;
    - Confidential 'Part II' of the Trust Board meeting would be held prior to the Public Board; and
    - Foundation Trust Programme Board would be suspended until such time as revised timescale had been confirmed in relation to the foundation trust assessment process.

Recommendation to the Board:
The Trust Board is asked to note the report.