Imperial College Healthcare NHS
NHS Trust

Annual General Meeting
9 September 2015/6

Members of the Trust board present:

Sir Richard Sykes	Chairman
Dr Andreas Raffel	Non-executive director
Dr Tracey Batten	Chief executive
Steve McManus	Deputy chief executive / chief operating officer
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing

Members of the executive team in attendance:

Kevin Jarrold	Chief information officer
Ian Garlington	Director of strategy and redevelopment
Michelle Dixon	Director of communications
Karen Charman	Interim director of people and OD
Dr Julian Redhead	Representing Prof Chris Harrison

The Chairman, Sir Richard Sykes welcomed members of the public and staff to the meeting, which was a key opportunity to reflect on what the Trust had achieved for patients and local communities in 2014/15, to consider priorities for 2015/16, and to account for how the Trust had used its valuable resources.

Dr Tracey Batten then provided an overview of the Trust's performance and achievements in 2014/15, as well as looking ahead to the challenges and opportunities for 2015/16. She reiterated that the Trust sought to provide the very best care and support for its patients and local communities, to help them be as healthy as possible throughout their lives. She noted that this was within a society that was living longer, with an increasing incidence of long-term health conditions. Dr Batten reflected that individual patients' experience of the Trust may not always be that which she outlined, but confirmed it was where the Trust wanted to be, and proceeded to outline areas where important progress had been made:

- Providing more opportunity for the 10,000 staff to be involved in shaping what the Trust did and how services were delivered, recognising that frontline staff were closest to the patients and understood well what was working and what wasn't. Staff engagement and recognition programmes were having an impact, with the overall 'engagement score' above average and rising.
- Making a major investment in a Trust-wide digital patient records system, working towards a 'paper-lite', rather than paperless, system by spring 2016, which would ultimately allow both clinicians and patients to have real-time access to health data.
- Having been awarded the contract to be the lead health provider for a community independence service for three London boroughs, working in partnership across acute, community, mental health and primary care. Other services had also developed community-based services over the past year or so, including gynaecology and ophthalmology.
- Working closely with commissioners on the changes to A&E services, including the planned closure of the emergency department at Hammersmith Hospital and extension of the urgent care centre to a 24/7 service. In recognising some local anxiety, she assured the audience that this had enabled the delivery of a safer emergency service, though acknowledging that some patients attending A&E had experienced longer waiting times.
- Continuing, in association with Imperial College, to innovate and rapidly translate research breakthroughs into better patient care.

- Developing and implementing the Trust's improvement plan following the inspection by the Care Quality Commission, where the Trust received an overall rating of 'requires improvement', a disappointing rating, but the report itself was viewed as being extremely constructive. It clearly set out the Trust's challenges while recognising the great care provided to patients, and served as a catalyst for the Trust to redouble its efforts to get the essentials right.

Dr Batten then outlined the key points in quality and operational performance in 2014/15:

- Continuing low patients deaths (against the national average) and real progress on cancer care, was balanced by challenging performance in a number of other areas.
- Along with many trusts across England, the Trust struggled to meet A&E waiting time targets through the second half of 2014/15. On average, across the year, just under 94 per cent of our patients were assessed, treated, admitted or discharged in under four hours, against a national standard of 95 per cent. By working to improve all aspects of emergency pathways, the Trust had managed to get back to, or close to, the 95 per cent standard. Staff were working hard to make further improvements to emergency pathways, and there would be further significant investment in additional consultants in the autumn of 2015.
- The Trust saw challenges in reporting on its waiting time standards throughout 2014/15 during the introduction of a new patient administration system, and in some specialties, the Trust needed to have a particular focus on reducing the number of patients who had already been waiting over 18 weeks. Dr Batten reporting good progress, with the Trust having met the standard of 92 per cent of patients waiting under 18 weeks since June 2015.

Looking ahead, Dr Batten reflected that 2015/16 and 2016/17 were likely to be characterised by more challenge and change, making the Trust's focus and progress against both immediate improvement plans and our longer-term strategy even more important:

- Noting the establishment of the clinical strategy in 2014, she outlined the approval of the new quality strategy, designed to drive up quality and enable continuous improvement, and developed with input from patients, staff and other stakeholders. It set clear goals and measures for what the Trust would seek to achieve between 2015 and 2018. Dr Batten commented that driving up quality was especially important when under financial pressure; her long personal experience in health care had shown that the best way to improve efficiency was to deliver better quality care.
- The Trust sought to encourage more of the great staff and patient-led projects seen in 2014/15 such as the development of the carer's passport by the dementia team, which enabled carers to provide essential support by visiting outside of normal hospital visiting times.
- Implementation of the core strategies – clinical, quality and financial - was being supported by refreshed organisational values and behaviours. Through a major engagement programme, staff had made it clear that they wanted the Trust to develop an organisational culture that better supported improvement and excellent patient care; a culture that supports all staff to be kind, collaborative, expert and aspirational.
- Increasing the involvement and engagement of patients, GPs and other stakeholders in the Trust's plans and decisions was a further priority, pressing ahead with developing an active and engaged membership to help shape our thinking and actions. Having launched a new member newsletter in the spring, the Trust sought to continue to expand its membership and provide more opportunities for members to get involved.

Dr Batten closed by again thanking members of the public and staff for taking the time to attend the annual general meeting.

Sir Richard Sykes then introduced Mr Richard Alexander, chief financial officer, who had joined the Trust from University College Hospitals NHS Foundation Trust in August.

Mr Alexander took to the rostrum to present the Trust's annual accounts for 2014/15. He started by confirming that the Trust had once again successfully met the statutory financial performance targets and had delivered efficiency savings of £39.7m (out of a planned £49.3m) in 2014/15. He outlined the financial performance metrics relating to the statutory financial duties.

Duty	Requirement	Achievement
1. Breakeven duty	To ensure total expenditure does not exceed income	Achieved – surplus of £15.4m, after adjusting for impairments
2. External financing limit (EFL)	To remain within DH borrowing limit	Achieved – cash outflow of £6.2m
3. Capital absorption rate of 3.5 per cent	To pay a dividend of 3.5 per cent to the DH	Achieved
4. Capital resource limit (CRL)	To ensure capital expenditure is within the limit set by DH	Achieved – Net spend of £32.9m

Capital expenditure (excluding externally funded schemes) for the period had been £32.9m; with schemes aimed at achieving a balance between maintaining and replenishing the asset infrastructure, reducing risk, investing in information technology, and improving the patient experience.

The Trust's total operating income was £1,000.6m; an increase of £21.3m compared to the previous year. This increase included Project Diamond funding of £24.4m. This payment reimbursed the Trust for the excess costs of treating specialist patients not funded in national tariff. New funding was also received from NHS commissioners to support reduction in patients waiting for treatment and to meet extra demand for patient care services over winter. Sales of non-essential assets also contributed to this income growth.

The total operating expenditure was £1,109.9m including an asset impairment of £123.8m and donated asset adjustment of £0.9m. After adjusting for the impairment and donated asset adjustment, overall expenditure has increased by £21.0m when compared to the previous year. This increase has been driven by the cost of delivering additional activity, the cost improvement programme, and new investment in increased staffing levels on wards and in the Trusts A&E departments.

The Trust's efficiency programme focused on new initiatives that aimed to deliver savings in excess of 4.5 per cent of costs deemed influenceable in the short and medium-term planned turnover (£39.7m achieved). These were carefully planned and implemented through the Trust's executive committee, where any potential risks to patient safety and patient experience are rigorously assessed to ensure that none would have a detrimental impact on service quality and patient experience. Key themes were for clinical pathway redesign, medicines management, negotiating better prices with suppliers and reviewing supply chain arrangements, exploiting commercial opportunities to increase income and reducing overheads.

The Trust continued to invest in its capital infrastructure to help achieve its strategic service objectives. During 2014/15 the Trust invested a total of £36.5m to modernise its estate, deal with backlog maintenance issues, purchase new and replacement medical equipment and upgrade IT equipment and infrastructure. Significant schemes in 2014/15 included: backlog maintenance of £6.3m; medical equipment of £8.6m; IT investment of £5.1m; and imaging investment of £4.2m.

The Trust maintained a strong cash position throughout the year; remaining within its external financing limit (EFL), with a year-end cash position of £43.3m. This is £12.3m less than the level anticipated when the cash plan was developed at the start of the financial year and, for the most part, this is because the Project Diamond funding will now be received in the next financial year.

Financial outlook

Bring his presentation to a close, Mr Alexander looked forwards, highlighting that the five year forward view strategy document published by NHS England has called for improvements of approximately £22bn from within the health service. With a further £8bn promised by the end of this new parliament from the taxpayer the financial challenge to the whole health service had been clearly set out. The Trust recognised that this meant thinking very differently about its services and how these must provide value for money if it is to meet its share of that challenge and if the Trust is to make the major investments in its estate and services that are needed. In 2015/16 the Trust would be significantly expanding its approach to delivering long-term financial sustainability. The Trust, with support from its CCGs, had set aside funding for investment in a programme of clinical service transformation. This would mean changing the way services were delivered at every level of the organisation and would involve front line staff, patients and key stakeholders even more in making improvements that would improve the quality and value of services.

Sir Richard Sykes then invited Mr Steve McManus, chief operations officer and deputy chief executive, Professor Janice Sigsworth, director of nursing, and Dr Julian Redhead, deputy medical director to the rostrum. He then invited questions from the floor:

Question	Response
Whilst the low mortality rate should be celebrated, concern was expressed at the apparent complacency exhibited by the Trust in relation to A&E and other waiting times, particularly in relationship to the sickest patients waiting in A&E, and expressed concern as to how the times may be longer over the winter. She also noted poor performance in ambulance arrival times.	Mr McManus assured the public that the Trust was not complacent, and strove for continuous improvement, highlighting reductions in recent waiting times for the Trust's sickest patients. This was being achieve by increased numbers of emergency department consultants, extension of ambulatory services to seven days, and increasing the resource of the discharge team, thus freeing beds for emergency admissions.
It was noted that two of the theatres were being upgraded, although it was her understanding that services at Western Eye were to transfer longer-term to St Mary's.	Dr Batten confirmed that the Trust planned to transfer Western Eye services to St Mary's longer-term, but explained that on-going essential maintenance and upgrading continued across the site whilst awaiting funding to progress with the desired redevelopments.
A patient at St Mary's, explained that she was expecting her next elective procedure to be planned for Charing Cross Hospital, which would be awkward for her to access. She asked if it would be possible to have this undertaken at St Mary's.	Mr McManus confirmed that the Trust offered elective orthopaedic services on both sites, and asked her to make herself know to a member of staff at the end of the meeting for this to be resolved.
Noting that the Trust board had agreed to the short-term co-location of stroke services at Charing Cross Hospital, which had been mainly welcomed by patients and the public, assurance was sought that a risk-assessment had been undertaken in relation to the further move of all stroke services to St Mary's.	Dr Redhead commented that it was pleasing to here that the move to co-locate stroke services had been positively received, especially that patients and the public could see the benefits of clinical adjacency. Clinical staff were very supportive of the approach being taken. The long term plan remained that all stroke services would be relocated to Mary's to be co-located with major trauma services which shared a number of diagnostic and clinical requirements.
A patient at Charing Cross Hospital expressed concerned that the additional	Diane Dunn, lead nurse for cancer, explained that the service had been introduced as a one year pilot

Question	Response
lymphedema services provided were not being offered to all patients.	(extended by four months), jointly with St John & St Elizabeth Hospital, funding for which had ceased. The Trust had sought funding from the commissioners for continuing the services, but not all had been willing to support this, hence not being directly available to all patients. Patients not able to access this service were directed to other services.
Further details of the proposed service changes at Charing Cross were requested.	Dr Batten confirmed that each of the main hospital sites had a key role for future health services in NW London: Charing Cross, as a local hospital; Hammersmith, as a specialist hospital; and St Mary's, as a major acute hospital. The timings for planning had been discussed at the public board meeting in July 2015; the Trust was bidding for capital support and commencing working on business cases for each site. When funding had been secured, there would be further community engagement with the detailed planning.
Concern was expressed that as more of the population get older and more poorly, there may be no further clinical treatment for them, and they could be discharged from hospital with no further care plan.	Dr Redhead agreed that hospital is often not the best place for patients to receive care, and that the Trust worked with commissioners and other providers to try and ensure appropriate services could be made available to patients at home or as close to their homes as possible. This is particularly true for palliative care services.
A patient who had experienced a stroke had been told their care would be provided at Charing Cross but had heard no further information.	Professor Sigsworth asked her to make herself know to a member of staff at the end of the meeting for this to be resolved.
Further information was requested in relation to: the increase in impairments outlined in the annual accounts; and whether a good CQC inspection report or becoming a foundation trust would be more important 3-5 years hence.	Mr Alexander noted that the impairment changes resulted mainly from land valuation amendments, but suggested he could be contacted outside the meeting should further information be desired. In relation to priorities, he confirmed that his priority as chief finance officer was clear: patient outcomes and care were of foremost importance; along with this the Trust needed to be financially responsible and create a sustainable future. Dr Batten added that becoming a foundation trust was a balance of financial sustainability, quality of care, and strong governance, noting the symbiotic relationship between efficiency and quality.
The tremendous work done by, and care given to patients, was acknowledged, as was the contribution of the Charity and the Friend. Concern was expressed that computer errors meant that there was incorrect information in the discharge letters being provided to GPs.	Dr Batten commented that the Trust was only as good as the 10,000 staff providing care and the services that supported this, and that the Trust recognised and welcomed the support of the Charity and the Friends. Dr Batten outlined that the Trust was moving towards introducing services across all seven days of the week, but noted that it had substantial

Question	Response
An enquiry was made as to why the waiting list was not being reduced by undertaking weekend operating.	implications for staffing. However, she outlined that to reduce waiting times, there had been weekend elective surgery. Kevin Jarrold explained that the Trust was in the process of introducing a new computer system, and that at times there had been significant challenges. Eventually he hoped that there would be no requirement for the paper that was currently created as part of the patient process, and welcomed a further direct conversation after the meeting.
Noting the strengths of the integrated care approach being taken by the Trust, concern was expressed as to how this could continue and grow given the shortage of GPs and reducing budgets of community trusts. Concern was expressed that the Trust would struggle to attract staff if accommodation was not available.	Dr Batten confirmed that developing integrated care services was vital and key to the Trust's strategy. The Trust was working closely with a wide range of health and social care providers to address a range of anachronistic processes to improve care for patients across the community. Dr Batten acknowledged that housing was a major issue for public sector employers across London, and noted that the local councils were seeking to address this issue.

Bringing questions to a close, Sir Richard Sykes then introduced Professor Sian Harding, Professor of Cardiac Pharmacology at Imperial College London and Director of the Imperial British Heart Foundation Cardiovascular Regenerative Medicine Centre.

Professor Harding provided the audience with a fascinating exposition on medical research developments in relation to heart failure. She particularly highlighted recent developments in research on heart cells, and the potential to help patients with poor heart function. She explained the work that had been taking place for some time on the beating muscle of the heart and the cells that make up that muscle – cardiomyocytes. When the heart was damaged, for example by a heart attack, the patient could initially recover, but finally the patient develops heart failure.

Professor Harding outlined two complementary strategies: gene therapy, where the aim was to reverse the changes in the remaining cardiomyocytes, restoring the beating force of the heart; and cell therapy, where the intention was to give new cardiomyocytes to the heart and so reverse the damage itself. This was seen as a real breakthrough that could improve treatment for heart failure patients.

Professor Harding responded to questions from the floor, including:

- confirming that she had been involved in the development and use of ventricular devices, which could provide rest to cells which could increase their power; and
- noting that the work being undertaken could potentially have a real impact on the local population, both in engaging in clinical trials (which were advertised on the Trust website), and longer term from more cost-effective treatments.

Sir Richard Sykes closed the meeting by extending thanks to Professor Harding, the board and executive speakers, the production team, staff who had provided the stands, and the members of the public and staff who had attended. He asked attendees to provide feedback on the event to enable continued improvement, and confirmed that the proceedings of the meeting would be made available on the Trust website.