Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING AGENDA
MEETING IN PUBLIC
10.45am – 1.00pm
Wednesday 27 March 2013

New Boardroom,
Charing Cross Hospital,
Fulham Palace Road, Hammersmith

1	**General Business**			
		Paper	**Presenter**	**Time**
1.1	Chairman's Opening Remarks	Oral	Chairman	5 minutes
1.2	Apologies	Oral	Chairman	1 minute
1.3	Minutes of the meeting held on 30 January 2013	1	Chairman	2 minutes
1.4	Matters Arising and Action Log	2	Chairman	2 minutes
1.5	Chief Executive Report	3	Chief Executive	5 minutes
2	**Quality and Safety**			
2.1	**Reports from the Director of Nursing:**			
2.1.2	Final Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) – review and Trust response	4	Director of Nursing / Medical Director	10 minutes
2.1.2	Quality Account Priority Indicators 2013/14 sign off (SHW)	5	Director of Nursing	5 minutes
2.1.3	Friends and Family Test Progress Report	6	Director of Nursing	5 minutes
2.1.4	Eliminating Mixed-Sex Accommodation (EMSA) Declaration – *Trust Board approval*	7	Director of Nursing	5 minutes
2.1.5	Safeguarding Children and Young People Declaration – *Trust Board approval*	8	Director of Nursing	5 minutes
2.2	**Reports from the Medical Director:**			
2.2.1	Patient Safety and Service Quality Report Q3	9	Dr D Mitchell for Medical Director	
2.2.2	Infection Prevention and Control Report	10	Director of Infection Control and Prevention	5 minutes
2.2.3	CQC Perinatal Clinical Alert Report	Oral	Dr D Mitchell for Medical Director	5 minutes

2.2.4	Care Quality Commission (CQC) Maternity Outlier Alert for Puerperal Sepsis within 42 days of delivery at ICHT	11	Dr D Mitchell for Medical Director	5 minutes
2.3	Cancer Recovery Implementation Plan *copy of report to 11 March 2013 Audit and Risk Committee*	12	Chief Operating Officer	5 minutes
3	**Performance**			
3.1	Performance Report • Month 11 Report	13	Chief Operating Officer	10 minutes
3.2	Finance Report • Month 11 Report • Update on 2013/14 Financial Plan	14 15	Chief Financial Officer	10 minutes
3.3	Department of Health Single Operating Model return: February 2013	16	Chief Financial Officer	2 minutes
3.4	Cerner Implementation Update report	Oral	Chief Information Officer	5 minutes
4	**Governance**			
4.1	Corporate Risk Register and Board Assurance Framework	17	Trust Secretary	10 minutes
4.2	Education Update and Action Plan	18		5 minutes
5	**Papers for information**			
5.1	Report of the Audit and Risk Committee: 11 March 2013	Oral	Sir Gerald Acher,	5 minutes
5.2	Minutes of the Governance Committee meeting on 13 February 2013	19	Sir Thomas Legg	5 minutes
5.3	Report of the Finance Committee: 4 December 2013	Oral	Chief Financial Officer	5 minutes
5.4	Report of the Foundation Trust (FT) Board	20	Dr Rodney Eastwood	5 minutes
6	**Items for Ratification**			
6.1	Ratification of Chairman's' approval: of Department of Health Single Operating Model return for January 2013	Oral	Chief Financial Officer	1 minute
7.	**Any Other Business**			
		oral	Chairman	2 minutes
8.	**Date of Next Meeting:**			
Trust Board meeting in Public: Wednesday 29 May 2013, Clarence Wing Boardroom, St Mary's Hospital, Paddington				

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 30th January 2013
Clarence Wing Boardroom,
St Mary's Hospital, Paddington

Present:
Sir Richard Sykes, Chairman
Sir Thomas Legg, Non-Executive Director
Dr Martin Knight, Non-Executive Director
Dr Rodney Eastwood, Non-Executive Director
Professor Sir Anthony Newman Taylor, Non-Executive Director
Sir Gerald Acher, Non-Executive Director
Mr. Jeremy Isaacs, Non-Executive Director
Mrs Sarika Patel, Non-Executive Director
Mr. Mark Davies, Chief Executive
Mr. Bill Shields, Chief Financial Officer
Professor Nick Cheshire, Medical Director
Ms Janice Sigsworth, Director of Nursing
Mr Steve McManus, Chief Operating Officer

In Attendance:
Mr. Sam Armstrong (Minutes)
Professor Alison Holmes, Director of Infection Control and Prevention (item 2.2.1)
Dr Jeremy Levy, Director of Education (item 5.1)
Mr. Stephen Guile, Head of Corporate Services and Trust Secretary

1. GENERAL BUSINESS

1.1 Chairman's Opening remarks

The Chairman opened the meeting at 10.50 a.m.

The Chairman welcomed Mrs Sarika Patel to her first meeting as a Non-Executive Director and noted that the Trust now has its full quota of non-executive directors (seven). He also welcomed Mr. Stephen Guile, the newly appointed Head of Corporate Services and Trust Secretary; he has succeeded Mr. Sam Armstrong who was thanked for his service to the Trust.

1.2 Apologies

There were no apologies.

1. 3 Minutes of Previous Meeting

The minutes of the meeting held on 28th November 2012 were approved.

1.4 Actions

The action sheet was noted.

1.5 Chief Executive's Report

Mr. Mark Davies presented the report. It was noted that NHS London had written to the Trust acknowledging the implementation of stronger systems from the Clinical Governance Review.

The senior team continues to be refreshed: Dr Chris Harrison will join the Trust in March from the Christie NHS Foundation Trust, a leading cancer centre. This will strengthen the Trust and provide good support to the Medical Directorate. Ms Jayne Mee will join the Trust as the new Director of People and Organisational Development; Mr. Mark Davies thanks Mr. Jeremy Isaacs for his assistance in the recruitment and selection of this post.

It was noted that the Joint Committee of PCTs will meet on 19th February 2013 to decide on the future configuration for services in North West London. Option A is expected to be supported. The Trust supports the new clinical model, which will reduce its A&E services from three sites to one. The Trust will continue to respond as a part of the Academic Health Science Centre (AHSC). Subject to the selected option, the Trust will then conduct thorough due diligence on the effects of revenue and costs of any new model.

The Joint Working Agreement between the College and Trust to form the AHSC has been agreed. Mr. Mark Davies extended the Trust's welcome to Ms Josephine Job, the new fundraising director for the Trust Charity. He also acknowledged and thanked the outgoing Trust Charity Chairman who is moving to the USA.

The Chairman added congratulations and thanks to the Trust HASU, which ranked first out of 150 across the UK. He noted that this service does not just save the lives of stroke patients, it restores a significant quality of life to them through treatment.

The Trust Board noted the Chief Executive's report.

2.1 Report from the Director of Nursing
2.1.1 National A&E Patient Survey Results
Ms Janice Sigsworth presented the report. It was noted that it had been a difficult year for the A&E departments at the Trust. Comparisons to Shelford Group and other London hospitals were noted and the Trust is situated around the middle of these tables. The Trust was amongst the highest performing for Leaving A&E and performed poorly on Travelling by Ambulance and Ward and Environment. The Trust score deteriorated since the last survey on Doctors and Nursing Talking over Patients and Waiting Times questions.

In answer to a question from Mrs Sarika Patel, Ms Janice Sigsworth stated it was unclear when the next survey would be; the last survey was five years ago, however the Trust does undertake monthly reviews of its internally acquired data and feedback. Sir Gerald Acher suggested that goal scores be established by the Trust and worked towards irrespective of comparisons. In response to a question from the Chairman, Ms Janice Sigsworth stated that Urgent Care Centres (UCC) have taken the less serious cases away from A&E, however the more anxious patients still present to A&E. Mr. Bill Shields added that some non-elective activity has moved from private patients to UCC. Mr. Steve McManus added that changes in GP hours have resulted in more patients presenting to A&E and UCCs.

The Trust Board noted the report.

2.1.2 Family and Friends Test Implementation
Ms Janice Sigsworth presented the report. It was noted that the implementation of the test is expected to attract a very high profile. The NHS Commissioning Board will be supporting the implementation and the Policy and NHS Development Authority will be tracking progress. The questions and the implementation requirements were noted.

The Trust has been awarded a pilot site in maternity and paediatrics along with Guy's and St Thomas' NHS Foundation Trust. The Trust's hand-held devices are well imbedded and these will be used to collect Family and Friends Test data. The Trust is required to achieve a 15% response rate: it is thought that A&E will need a productive approach to achieve this. In answer

to a question from Sir Gerald Acher, Ms Janice Sigsworth confirmed that the feedback was transparent and that feedback from negative experiences is sought. A free text section is being added to the data collection, which will provide qualitative data. In answer to a question from Mrs Sarika Patel, Ms Janice Sigsworth stated that the questions had been set by the NHS. Professor Nick Cheshire added that the feedback often highlights problem areas in the Trust, which can then be rectified through a focused response. Mr. Steve McManus stated there is evidence to suggest that the i-tracker feedback motivates staff to improve.

The Trust Board noted the report.

2.1.3 Care Quality Commission (CQC) Inspection Reports
Ms Janice Sigsworth presented the report. It was noted that the reports confirmed that the CQC has now visited all of the Trust main sites and two renal satellite units. All of the sites inspected were found to be compliant with the Essential Standards of Quality and Safety, in line with the Trust's own compliance submission. There are no outstanding actions.

The Trust Board noted the report.

Report from the Medical Director
2.2.1 Infection Prevention and Control Report
Professor Alison Holmes presented the report. It was noted that the Trust had recorded zero cases of MRSA in December and the total cases year-to-date are four against a ceiling of nine. The target next year will be zero. Mr. Bill Shields added that all trusts will have the same ceiling next year and that the penalty has changed from a fine to non-payment for the affected patient's treatment. The Trust continues to roll out antiseptic non-touch technique to keep instances of MRSA down.

There were seven cases of *C. difficile* in the Trust in the last month, resulting in a year-to-date total of 66 against an annual ceiling of 110. The ceiling for next year will be 65. There was an outbreak of norovirus at Charing Cross Hospital, which led to two ward closures. The staff were commended for their rapid response which limited the outbreak. In answer to a question from Dr Rodney Eastwood, Professor Alison Holmes stated the Trust was performing well for MSSA levels and is low in comparison to Shelford Group hospitals. Root cause analysis is conducted on all cases and it is different to MRSA. *E.coli* continues to be monitored.

The Trust Board noted the report.

2.2.2 CQC Clinical Alert.
Professor Nick Cheshire provided an update. It is believed that the alert is in error and Dr Foster has reviewed two years of Trust data, which indicates the Trust is in the 95% threshold. It was noted that the Trust has an overly complex case mix, which possibly skews the outcomes data. In answer to a question from Dr Rodney Eastwood, Professor Nick Cheshire stated the Trust's view on the alert has not yet been communicated to the CQC; it will be done as soon as Dr Foster have completed analyses on the last year of Trust data. Mr. Jeremy Isaacs indicated it was hard to take comfort in the standard at this stage and it was agreed that a full report would come to the next Trust Board in public.

Action: Full report to be presented to the next Trust Board meeting in public.

The Trust Board noted the report

2.2.3 Never Event
Professor Sir Anthony Newman Taylor provided the details of the never event, which was a retained swab. It was noted that there were a number of interruptions during the procedure and

the WHO checklist was not fully complied with. From the investigation he chaired, 11 recommendations were made, which the Trust has accepted and are implementing.

The failure appeared to conform to the typical circumstances where a failure occurs. In answer to a question from Mr. Jeremy Isaacs, Professor Sir Anthony Newman Taylor stated that there needs to be a balance between creating an open culture where staff can report events and be held appropriately accountable. Professor Nick Cheshire stated that in the past junior doctors and nurses have been held responsible, which is unacceptable as the surgeon needs to take responsibility. Sir Gerald Acher added that sanctions, as an option, for these cases would be necessary. Ms Janice Sigsworth added that personal accountability exists through professional registration. Mrs Sarika Patel suggested that a system of responses be developed. Mr. Mark Davies stated that an earlier audit demonstrated a lack of compliance to policy and all breaches need to be reviewed for HR implications to the individual involved. The Chairman stated that the related policy needs to include consequences for not following it. It was agreed that this report, and any future never event investigations, be presented to the Chief Executive and that he review them with the Medical Director and Director of Nursing.

Action: Never event report to be sent to Chief Executive and reviewed by him, Medical Director and Director of Nursing.

The Trust Board noted the report.

3.1 Performance Report
Mr. Steve McManus presented the month 9 report. It was noted that in December the Trust had underperformed in the A&E 4-hour wait target for type 1 achieving 93.5% against the 95% target, however for all types performance it achieved 96.8%. The Trust maintained achievement of 5 out of the 8 national Cancer targets for November.

The Trust achieved good performance in 18-week referral to treatment waiting time target for admitted and non-admitted patients as well as those on incomplete pathways. The Trust achieved targets for providing national care standards for stroke and maternity patients and venous thromboembolism assessment rates and also achieved the national diagnostics waiting time target. The Trust continued to be defined as 'performing' for the Department of Health Acute Trust Performance Framework.

It was noted that appraisal rates are lagging. Mr. Steve McManus and Mr. Mike Griffin will write to all managers and unless there is mitigating circumstances any manager that does not complete their necessary appraisal targets by the time of their own appraisal, will be judged as ‘under performing’. In answer to a question from the Chairman Mr. Steve McManus stated that it is an existing requirement that managers will perform appraisals of their staff. To follow up questions he clarified that the target is 85%, which takes into account legitimate reasons, such as long-term absence, for not completing an appraisal; the target is effectively 100% of all available staff.

The Trust Board noted the performance report.

3.2 Finance Report
3.2.1 Month Report
Mr. Bill Shields presented the month 9 finance report. It was noted that the Trust has achieved a surplus of £8.3m at the end of quarter 3. The in-month surplus was £2.9m and yields a favourable year-to-date variance of £5.9m. The forecast outturn for the year has been revised to £11.5m.

The CIP plan was noted. The CIP target for next year has not yet been confirmed. In answer to a question from Mr. Jeremy Isaacs, Mr. Bill Shields confirmed the current year recurrent CIP

was £52m with an additional £10m in non-recurrent savings. In answer to a question from Mrs Sarika Patel, he confirmed the budget planning and authorisation process for the coming year. He added that CPGs will be required to meet KPIs next year rather than just budgetary performance targets. It was noted that £8.1m was received from Project Diamond and it is thought this will reduce to £6m next year.

The Trust Board noted the finance report.

3.2.2 Single Operating Model (SOM)
Mr. Bill Shields presented the December 2012 SOM Returns. It was noted that the governance risk rating pertaining to c.difficle and MRSA are believed by the Trust to be incorrect. The SOM process attributes a 'fail' on the basis of breaching the minimum level instead of breaching the ceiling. The Trust has corrected the SOM and highlighted this to the Board. The finance risk rating is a solid '3'.

There are two remaining issues on the Board statement. The item relating to Information Governance Tool Kit is still rated as 'no' and is expected to remain. After a discussion, it was agreed to leave item 11 as rated 'no', primarily due to a degree of uncertainty about the Cerner roll out. The FT timetable was noted. The Trust will aim for authorisation by either October 2014 or April 2015, depending on potential effects of wider North West London configurations. It is anticipated that Deloitte will assist the Trust with its Board governance assurance framework for the FT authorisation process, however this needs to be approved by the Audit Commission as they are currently the Trust's external auditor. In answer to a question from Mr. Jeremy Isaacs, Mr. Bill Shields stated that an election could add complexity to the FT timeline.

The Trust Board approved the presented version of the SOM.

4.1 Cerner Implementation Update Report
Mr. Steve McManus presented the update in place of Mr. Kevin Jarrold, who extended his apologies to the Board. It was noted that the virtual hospital trials had produced useful feedback and after trial load 3, it was apparent that the go-live date would be delayed to June or July 2013. In response to a question from Mr. Jeremy Isaacs, Mr. Steve McManus stated that there were no cost implications by delaying the go-love date. Dr Rodney Eastwood noted this was the second postponement and warned staff may lose confidence in the process; he suggested a communications strategy be developed for this. In answer to a question from him Mr. Steve McManus stated that the training period was 16 weeks in total and would lead up to completion on the revised go-live date. In the meantime time, the Trust will continue to standardise workflows in preparation for go-live. In answer to a question from Sir Gerald Acher, Mr. Steve McManus stated that internal and external audits would review the roll out preparations.

The Trust Board noted the report.

5.1 Education Update Report
Dr Jeremy Levy presented the report. It was noted that education and training brings in £60m p.a. for the Trust and beyond this, there is a reputational need to provide good medical training at the Trust. The Trust remains the first choice for many training programmes, however feedback on clinical training has been poor and specific problems were highlighted. The Trust has now established a good reputation as Lead Provider for postgraduate medical education across a number of medical specialties. The number of nurses and midwives with degrees in the Trust has risen. The creation of Local Education and Training Boards (LETBs) was noted.

The issue of available space at St Mary's Hospital was highlighted. In answer to a question from Dr Martin Knight, Dr Jeremy Levy stated that he needs to seek the assistance of executive colleagues to find space on the site that is useful for teaching. There are current

plans to refurbish an old ward, which may help. Professor Nick Cheshire added that it appears possible the Trust could use the surgical simulation facility, which Lord Darzi leads, and an arrangement should be pursued.

Mr. Mark Davies noted the GMC survey results and commented that it reflects on senior staff teaching within the Trust. Professor Nick Cheshire and he will take up the issue with clinicians at their newly established monthly meeting. Professor Nick Cheshire added that like patient feedback, these results often highlight a problem within a specific area in the Trust, which can then be focused on for improvement. Dr Rodney Eastwood suggested that an action plan with updates be presented to a future Board meeting, which was agreed. It was noted that the decline in the number of junior doctors needs to be addressed and arrested. Dr Jeremy Levy added that detailed action plans have been regularly presented to the Management Board and work to achieve further improvements in education continues.

Action: Action plan with updates to be presented to the next Trust Board meeting in public.

The Trust Board noted the update.

6.1 Report of the Audit and Risk Committee
Sir Gerald Acher presented the report. It was noted that changes in the risk management process are needed with the departure of key personnel: Ms Janice Sigsworth is now taking responsibility for risk management throughout the Trust and she will be assisted by Professor Nick Cheshire. An annual programme for NEDs to visit Trust services is being produced. The role of internal audit requires review and the working arrangements of the Governance Committee and Audit and Risk Committee is being reviewed.

The Trust Board noted the report.

6.2 Report of the Quality and Safety Committee
The report was taken as read.

The Trust Board noted the report.

6.3 Midwifery Local Supervisory Report
The report was taken as read.

The Trust Board noted the report.

7.1 Management of Concerns and Complaints Policy

The Trust Board ratified the policy.

Questions from the public.
In answer to a question from a member of the public Mr. Bill Shields said he would look into the state of the transfer lounges at the Trust, and particularly at Charing Cross Hospital, and report back to the Board. Sir Gerald Acher suggested transfer lounges be added to the leadership walk-abouts and i-trackers be available to patients waiting in them.

Action: Mr. Bill Shields to report on state of transfer lounges at the Trust.

In answer to a question from a member of the public Ms Janice Sigsworth stated that the i-trackers are only in English at present, however there are plans now to review and add different languages to them.
The meeting concluded at 1.05 p.m.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING: 27 March 2013 **AGENDA NUMBER:1.4**

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC

30 JANUARY 2013

Agenda Item	Action	Responsible	Completion Date	March 2013 update
2.2.2	A full report on the Perinatal clinical alert to be presented to the Trust Board	Nick Cheshire	27.3.13 Board meeting	An oral update will be given to the Board on 27.3.13, with a written report to the 29.5.13 Board meeting
2.2.3	Never event report (retained swabs) to be sent to Chief Executive and reviewed by him, Medical Director and Director of Nursing.	Nick Cheshire	By 27.3.13 Board meeting	Report sent to CEO – review meeting being organised for early April
5.1	Education Report Action plan with updates to be presented to the next Trust Board meeting in public.	Jeremy levy	27.3.13 Board meeting	See report on 27.3.13 Board agenda
Public question	Bill Shields to report on state of transfer lounges at the Trust.	Bill Shields	By 27.3.13 Board meeting	An oral update will be given to the Board on 27.3.13,

28 NOVEMBER 2012

Agenda Item	Action	Responsible	Completion Date	March 2013 update
2.1.3	Final Clinical Governance Review to be presented to the Board.	Janice Sigsworth	27.3.13 Board	The final Clinical Governance Review report was presented to the Governance Committee and to NHS North West London's Clinical Quality Group for monitoring.

2.2.2	Cancer strategy working party to be established.	Steve McManus	February 2013	Director of Strategy has been leading Cancer Strategy performance with the Cancer Team. Medical Director has established and chairs a Trust Cancer Board

26 SEPTEMBER 2012

Agenda Item	Action	Responsible	Completion Date	March 2013 update
3.2.1	Mr Steve McManus to present trajectories for all cancer standards in performance report to the Board	Steve McManus	30.1.13 Board	Included within Performance Report on this agenda & see attachment to this Actions Summary

30 MAY 2012

Agenda Item	Action	Responsible	Completion Date	March 2013 update
3.2.1	Report on private patients to be presented to a future Trust Board.	Bill Shields	Revised March 2013 Board	Reported to 11.3.13 Audit & Risk Committee and on the agenda for 27.3.13 Board Meeting

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Cancer Waiting Times Performance 2012-13

Updated: 21/11/2012

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

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

Trajectory...

2012-13 Cancer Standards		M7 October 2012			M8 November 2012			M9 December 2012			M10 January 2013				M11 February 2013				M12 March 2013			
Commitment	Operational Standard	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Expected Total Patients Seen	Breach Tolerance	Known Breaches	Pass/Fail	Expected Total Patients Seen	Breach Tolerance	Known Breaches	Pass/Fail	Expected Total Patients Seen	Breaches	Known Breaches	Pass/Fail
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	74.5	16	78.5%	61.5	14.5	76.40%	56.5	11.5	79.6	69	10.3	17	72.00%	68	10.2	8		68	10.2	1	
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	90%	12.5	1	92.0%	12.5	1.5	88.00%	23	4	82.6	14	1.4	1	92.30%	14	1.4	1		14	1.4	0	
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers	96%	176	10	94.3%	154	10	93.5%	161	4	97.5	181	7.3	7	96.00%	181	7.2	1		181	7.2	0	
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%	53	1	98.1%	37	0	100.00%	41	0	100.0	47	0.9	1	98.50%	47	0.9	0		47	0.9	0	
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	40	1	97.5%	48	2	95.80%	29	0	100.0	44	2.7	2	95.00%	44	2.7	0		44	2.7	0	
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	94%	143	3	97.9%	124	1	99.20%	84	0	100.0	113	6.8	2	97.80%	113	6.8	0		113	6.8	0	
All Cancer Two Week Wait	93%	852	60	93.0%	825	46	94.40%	722	49	93.2	791	55.4	51	93.10%	791	55.4	0		791	55.4	0	
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)	93%	305	30	92.0%	281	18	93.60%	265	15	94.3	281	19.7	20	93.20%	281	19.7	0		281	19.7	0	
62-Day Wait For First Treatment From Consultant Upgrade	85% (Local performance target	7.5	1.5	80.0%	13	1	92.30%	9	0	100.0	7	1.1	0	100.00%	7	1.1	0		7	1.1	0	

Numbers reflect those validated and published through *Open Exeter*

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

Contents page

Imperial College Healthcare NHS
NHS Trust

Chief Executive's Report

27th March 2013

1 TRUST BUSINESS

1.1 CLINICAL

1.1.1 Healthwatch

Healthwatch will be established in April 2013 as the consumer champion for health and social care. Underpinned by the Health and Social Care Act 2012, it will exist in two forms: local Healthwatch and Healthwatch England. Local Healthwatch will build on the legacy of Local Involvement Networks (LINks) to establish relationships with local authorities, Clinical Commissioning Groups (CCGs), patient representatives, the voluntary/ community sector and service users. For ICHT this will mean forging new partnerships with local Healthwatch in lieu of existing relationships with local LINks.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.2 Equality Delivery System (EDS)

In 2011 the Trust adopted the NHS Equality Delivery System (EDS). The EDS is a four year national equality & diversity performance improvement programme which covers a range of patient and workforce outcomes. In 2011/12, the Trust was rated as 'achieving' the flexible working outcome and as 'developing' for the equal pay outcome. By 2012/13 the Trust was rated as 'achieving' both outcomes which demonstrates a strong improvement over the past year. With regards to patient outcomes in both 2011/12 and 2012/13, the Trust was assessed as 'developing' across the following outcomes; health needs and patient access and experience. We are continuing to engage with key stakeholders both internally and externally to improve the Trust's position against the patient and staff outcomes for next year. The Trust has published stakeholder assessments for patient and workforce outcome areas on web site by 31st January 2013 to meet the Public Sector Equality Duty (PSED) and will by 4th April 2013 to meet the EDS reporting deadline.

Lead Director – Janice Sigsworth, Director of Nursing

1.1.3 Care Connect

In order to promote a proactive culture of customer service and to encourage the importance of openness and transparency, the NHS Commissioning Board is funding a new online patient feedback service (Care Connect). Based on US models like 'Open 311' that provide citizens with real-time insight into how problems with public services are being dealt with, Phase 1 will be an online service where patients and the public can flag problems, ask questions and feedback on their experiences of healthcare services. NHS London is inviting Trusts to consider being part of the first wave of implementation, which will commence in May 2013 and ICHT has expressed an interest. The second wave will begin in July 2013 and Care Connect will be rolled out nationally by autumn 2013.

Lead Director – Janice Sigsworth, Director of Nursing

1.2 PEOPLE

1.2.1 Deputy Medical Director and Director of Cancer and External Clinical Relationships commences in post

As a highly experienced clinician and healthcare leader, Dr. Chris Harrison joined Imperial on 18 March from The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe, where he has been medical director since 2006. He has for the past two years also been clinical director for cancer for NHS London. He will support Professor Nick Cheshire and play a pivotal role in developing external clinical relationships. The experience he brings, both from cancer and his background in public health, will be invaluable to the Trust as we seek to improve cancer services and build strong external relationships that will enable us to improve our patients' journeys both in and out of hospital.

1.2.2 Director of People and Organisation Development commences in post

Jayne Mee has been appointed as the Director of People and Organisation Development and joined the Trust on 18th March 2013. Jayne is a highly experienced human resources and organisation development professional who has held senior appointments in a wide range of businesses, most recently Barratt Developments PLC and prior to that Spirit Group Ltd as well as Royal Mail Group. Jayne brings a wealth of experience to this role, combining private sector expertise and business skills with an excellent grasp of the business challenges faced by public sector organisations.

2 PERFORMANCE

2.1 Month 11 Performance Summary

The Trust continued to sustain good performance in all of the Quality Performance Indicators particularly venous thromboembolism assessments, infection control and stroke care and continues to report no mixed sex accommodation breaches.

The Trust has successfully delivered on the Referral to Treatment standards since November for admitted, non-admitted and incomplete pathways.

The 4 hour maximum waiting time in Accident and Emergency for the 'type 1' target of 95% was missed by 1.8% in February, with Charing Cross, Hammersmith and St Mary's Hospitals falling below target. All sites achieved over the 95% target for 'all types' Our year to date achievement of the 95% target for 'all types' is above the threshold for all three sites.

The Trust achieved 7 of the 8 national standards for cancer waiting times, including maintaining its performance in the 2 week wait for urgent cancer referrals. The Trust has a robust plan in place to enable continued performance improvement for all cancer standards.

Lead Director – Steve McManus, Chief Operating Officer

3 FINANCE

3.1 Month 11 Financial Summary

The Trust has achieved a surplus of £8.4m at the end of February, a favourable variance against the plan of £8.3m. This is based on a surplus in month of £0.1m.

The forecast outturn for the year has been revised to £9.745m following agreement with NHS London over reporting of a number of technical accounting adjustments. The surplus to date has been achieved by the over-achievement of the cost improvement plan, which is expected to deliver £54m in

year savings, £2m more than the plan requires and through cost control therefore not requiring the contingency set aside at the beginning of the year. The continued focus on cost improvement is required into 2013/14, despite the over-achievement in year. The Trust has also paid off one of its Department of Health loans due to the improved cash position, which has a resulting positive impact upon expenditure next year.

Lead Director - Bill Shields, Chief Financial Officer

4 FOUNDATION TRUST APPLICATION

4.1 Foundation Trust Application Update

On 14 February, the Trust received formal approval to proceed with its Foundation Trust (FT) application following a comprehensive review of the Trust's readiness by the NHS Trust Development Authority (NTDA). The NTDA has provisionally approved the principles underpinning the Trust's proposed FT trajectory, based on an earliest planned authorisation date of August 2014. This represents a significant acceleration of the timescales set out in the Trust's extant Tripartite Formal Agreement, due to the improvements the Trust has demonstrated in operational performance, financial sustainability and the plans it has in place to develop an organisational strategy and strengthen its governance structures.

The FT Programme has now formally been established and governance structures put in place. The FT Programme Board, chaired by Dr. Rodney Eastwood, will direct the programme and provide assurance to the Trust Board. The FT Programme Team, led by the Head of Planning & Business Development, will lead the management and execution of the programme through a number of key work streams. A detailed programme plan is currently in development, progress against which will be reported to the Trust Board on a regular basis.

Lead Director – Bill Shields, Chief Financial Officer

5 NWL BUSINESS

5.1 "Shaping a Healthier Future" Consultation

The Joint Committee of PCTs (JCPCT) met on 19 February and approved the 11 recommendations made in the Shaping a Healthier Future Decision Making Business Case and additionally commended the further proposals from Hammersmith & Fulham CCG and Ealing CCG. Hammersmith & Fulham Council have supported the recommendations while Ealing Council have rejected them. The Trust is establishing a team, with other stakeholders, to develop Outline Business Cases as required and this is expected to be completed before the end of 2013.

Lead Director – Brendan Farmer, Director of Strategy

5.2 West Middlesex University Hospital NHS Trust (WMUH)

The Trust still awaits the decision of the WMUH's Board.

Lead Director – Mark Davies, Chief Executive Officer

6 AHSC – AHSN BUSINESS

6.1 Academic Health Science Partnership (AHSP) Development

At its board meeting on 6 March, The Royal Marsden and the 8 PCTs (as legal hosts of the Clinic Commissioning Groups for now) in North West London were formally welcomed as members of the Partnership. The Board also welcomed Dr. Adrian Bull MD to his first meeting as Managing Director,

in advance of taking up his appointment on 1 April. Plans are in place to recruit quickly a permanent dedicated team to support the development of the Partnership. The announcement from DH/NHS Commissioning Board on AHSN designation, including on the amount of resources that will accompany it, are now expected in April. The web link for the partner's new website is: www.imperialhealthpartners.com

Lead Director – Mark Davies, Chief Executive Officer

6.2 Academic Health Science Centre Development

Good progress is being made to build a focused team under Professor Taube, the AHSC Director, to enhance the AHSC, including taking forward the implementation of the Joint Working Agreement between Imperial College and the Trust such as over arrangements for managing Intellectual Property and establishing the new Strategic Partnership Board. Current priorities involve shaping the AHSC's brand and strategy and preparatory work ahead of an AHSC re-designation process expected at some point this year.

The Joint Executive Group (JEG) is now up and running and meeting every two weeks at the new AHSC headquarters at Hammersmith Hospital.

Lead Director – Mark Davies, Chief Executive Officer

7 IMPERIAL COLLEGE HEALTHCARE CHARITY BUSINESS

7.1 Trustees

Matthew Swindells leaves as trustee and chair of the charity on 4 July 2013 when he moves to the US in his role as Senior Vice President Population Health and Global Strategy for Cerner Limited. The Charity and the Trust would like to thank Matthew for his hard work and wish him every success for the future. A new trustee with previous senior NHS operational management experience is being sought – closing date 19 April. http://www.ntda.nhs.uk/2013/02/22/imperial-college-healthcare-charity-trustee/

7.2 Grants

The Charity has agreed funding of £228,000 a year for the next two years for a range of awards that will directly benefit the trust's staff. These include long service awards, retirement events, learning and development awards as well as a contribution towards volunteers' expenses and religious festivals. Included within the sum is an award for the OSC&Rs annual awards dinner which has been increased significantly so that a further 100 staff will be able to attend this year and next.

Due to the success with which former research fellows have gone on to further their careers, advance their research and contribute to publications, trustees have decided once again to provide a number of research fellowships. The invitation for this year's applications opens on 22 March.

7.3 Art

As a result of a donation, artist in residence, Anne Harild will be working with children in the new paediatric haematology day care unit at St Mary's, creating together a series of animations to distract and amuse young patients many of whom spend many hours there having chemotherapy and blood transfusions, awaiting bone marrow transplant

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.1.2**

Report Title:

final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report)

To be presented by:

Janice Sigsworth – Director of Nursing and Professor Nick Cheshire – Medical Director

Executive Summary

Robert Francis QC, Chairman of the Inquiry, published his final report, following consideration of over 250 witnesses and over one million pages of documentary evidence on 6 February 2013.The Inquiry has made 290 recommendations designed to change this culture and make sure patients come first by creating a common patient centred culture across the NHS. The following link gives Board members access to the c120 page Executive Summary and the three volumes of the full report:
http://www.midstaffspublicinquiry.com/home

The recommendations are far reaching and all organisations across the NHS will need time to consider these and agree how to respond. Any recommendations we develop will; support the work we are undertaking to achieve Foundation Trust status, underpin our Quality Governance framework and will need to include engaging with our users, LINKs and our Commissioners.

There are 290 recommendations covering a variety of organisations such as DH, Commissioners, CQC, Monitor and Professional regulators. From a comprehensive internal review, about 20% of the recommendations require direct action from the Trust.

Work has already started at the Trust in response to the findings. An action plan has been created and will be overseen by the Governance Committee going forward, as part of an overall integrated quality governance work plan for 2013-2015.

Key areas for discussion:

This paper provides an initial summary of the Trust's response and actions to the findings..

Legal Implications or Review Needed

a. Yes TBC ☐

Details of Legal Review, if needed

Government's and other regulatory bodies' responses currently awaited.

Link to the Trust's Key Objectives:

- Provide the highest quality of healthcare to the communities we serve, improving patient safety and satisfaction.
- Provide world leading specialist care in our chosen field.
- Achieve outstanding results in all our activities

Purpose of Report

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

Publication of the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

1. Purpose of the report

The following paper provides a summary of the key findings outlined in the Mid Staffordshire NHS Foundation Trust Public Inquiry and outlines what steps the Trust has taken/will take going forward to address these.

2. Background

Robert Francis QC, Chairman of the Inquiry published his final report following consideration of over 250 witnesses and over one million pages of documentary evidence on 6th February 2013. The Inquiry has been examining the commissioning, supervisory and regulatory bodies in relation to the monitoring of Mid Staffordshire hospital between January 2005 and March 2009. It has been considering why the serious problems at the Trust were not identified and acted on sooner, and identifying important lessons to be learnt for the future of patient care. It builds on Robert Francis's earlier report, published in 2010.

The report examines how the situation happened, the roles of various parts of the NHS and other organisations and 'how the system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system'.

.

3. The findings and associated recommendations

3.1 The key aims of the findings

The Inquiry has made 290 recommendations designed to change culture and ensure 'patients not numbers come first' by creating a common patient centred culture across the NHS. Francis says no single one of the recommendations is on its own the solution to the many concerns identified. The essential aims of what has been suggested are to:

- Foster a common culture shared by all in the service of putting the patient first.
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff that have to provide the service.
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service.
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

3.2 Overarching themes from the recommendations

There has been vast comment and analysis of the report and associated recommendations. The central defining core is that the patient is to be put at the centre of everything the NHS does. All the other points follow from that and include:

- The merger of the regulation of care into one body so there is a single regulator for patient safety, quality, finance and governance
- A common culture of care, clear standards of service and an increased role for NICE to set standards, working with professional bodies
- Senior managers to be given a code of conduct and the ability to disqualify them if they are not fit to hold such positions. There is to be a fit and proper test for directors
- Hiding information about poor care to become a criminal offence as would failing to adhere to basic standards that lead to death or serious harm
- A statutory obligation on doctors and nurses for a duty of candour so they are open with patients about mistakes
- An increased focus on compassion in the recruitment, training and education of nurses, including an aptitude test for new recruits and regular checks of competence as is being rolled out for doctors
- Staffing level guidance for nursing, regulation of health care assistants, and a supervisory role for the ward sister
- Training only to take place where there is good care, and in medical training greater integration of deanery functions and regulators
- Leadership development for staff
- Improvements and openness in handling of complaints
- Improvements in the professional regulation of fitness to practice

4. Organisational responses and actions to the report

4.1 The NHS Commissioning Board

The recommendations are far reaching and all organisations across the NHS will need time to consider and agree how to respond. As an immediate first step, the NHS Commissioning Board Medical Director, Sir Bruce Keogh, is to conduct an investigation into fourteen hospitals who have been outliers on Summary Hospital-level Mortality Indicator (SHMI) data for two successive years to 2012.

This analysis features for the first time in an experimental report; S*ummary Hospital-level Mortality Indicator (SHMI) – Deaths associated with hospitalisation, England, Experimental Statistics Supplementary Report, July 2010 – June 2012*.

The SHMI compares the actual number of patients who die following hospitalisation at a trust with the number who would be expected to die, given the characteristics of the patients treated there. It categorises them as; 'as expected' as, 'higher than expected 'or 'lower than expected'. It differs from other mortality indicators because it considers all deaths that take place in a trust as well as those taking place within 30 days of discharge. As a result, it offers a more comprehensive picture of deaths following hospital care.

The fourteen hospitals to be investigated are:

- Colchester Hospital University NHS Foundation Trust
- Tameside Hospital NHS Foundation Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- North Cumbria University Hospitals NHS Trust

- United Lincolnshire Hospitals NHS Trust
- George Eliot Hospital NHS Trust
- Buckinghamshire Healthcare NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- The Dudley Group NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Medway NHS Foundation Trust
- Burton Hospitals NHS Foundation Trust

Other actions include:

- A national quality dashboard will be developed to identify safety failures in providers.
- A duty of candour has been included in the NHS contract.
- Implementation of the "compassion in practice" nursing strategy
- The friends-and-family test will gather the views of all patients on whether they recommend a hospital to someone close to them. The NHS Leadership Academy will bring together clinical and management leadership.
- The NHS Commissioning Board will begin publishing consultant level outcomes data in ten surgical specialties, including mortality rates.

The NHS Commissioning Board recognizes that "there is much more to do but we hope people can see that the journey has begun. We are determined to repair the damage to public confidence" (NHS Commissioning Board 6th February 2013).

4.2 The Government

In response to the Mid Staffordshire NHS Foundation Trust Public Inquiry, David Cameron announced that the Government will study the 290 recommendations and respond in detail in March 2013 but he announced the following immediate actions:

- The introduction of new role of a Chief Inspector of Hospitals that is recommended to sit within the Care Quality Commission. It is envisaged that Sir Bruce Keogh's mortality rate review of the 14 Trusts will provide a model for the future Chief Inspector of Hospitals.
- A national review of complaints led by Ann Clwyd MP and Tricia Hart, CEO South Tees Hospitals NHS Foundation Trust and member of the Francis inquiries. This will report by the summer recess. The Government creating a single failure regime where the suspension of the Board can be triggered by failures in care, as well as failures in finance.
- Patients, carers and members of staff will be given the opportunity to say whether they would recommend their hospital to family and friends, with the results being published and the Board held to account for their response.
- Where a significant proportion of patients or staff raise serious concerns about what is happening in a hospital, immediate inspection will result and suspension of the hospital board may follow.
- There will be a new hospital inspection regime which examines the quality of care and makes a clear and publicly-available judgment on it. The new role of chief inspector of hospitals will take personal responsibility for this task and be created by the CQC with the new system of hospital regulation will beginning in the autumn.
- The Secretary of State for Health has also invited the Nursing and Midwifery Council (NMC) and General Medical Council (GMC) to explain what steps they will take to strengthen their systems of accountability in light of the Mid Staffordshire NHS Foundation Trust Public Inquiry and the Law Commission will also be asked to advise on 'sweeping away the NMC's outdated and inflexible decision making processes.
- The Prime Minister also raised the possibility of linking pay to the quality of care provided rather than just time served at a hospital and cited the need for a style of leadership from senior nurses which means poor practice is not tolerated and is driven off the wards.

It was announced on 13th March 2013 that International patient safety expert Don Berwick is due to complete a broad review of all 290 of Robert Francis QC's recommendations – and of how the health service can improve its 'whole system' approach to safety – in July. The review of trusts with consistently high mortality rates as outlined in section 3.1 of this paper, is expected to report in the same month.

4.3. Imperial College Healthcare NHS Trust

The recommendations cover a variety of organisations such as DH, Commissioners, CQC, Monitor and Professional regulators. After carrying out a comprehensive internal review of all 290 recommendations, approximately 20% of the recommendations require direct action from the Trust. The key themes and related messages for the Trust at this stage are:

- Putting the patient first
- Governance, compliance and assurance
- Fundamental standard of behaviour
- Responsibility for, and effectiveness of, healthcare standards (e.g. information in our quality accounts and reporting of inquests to the CQC)
- Effective complaints handling
- Medical training and education
- Openness, transparency and candour
- Nursing and workforce
- Caring for the elderly
- Information
- Coroners and inquests

The Director of Nursing will be leading the Trust's review of the Mid Staffordshire NHS Foundation Trust Public Inquiry working with colleagues across the Trust.

The Trust has already taken several actions in response to the report which include:

- Carrying out a comprehensive self-assessment against the recommendations to determine which ones are relevant to the Trust and creating an action plan.

- The actions have been assigned to a lead Director/Senior Manager and progress against these will be overseen by the Governance Committee going forward, as part of an overall integrated quality governance work plan for 2013-2015

- Reviewing our standardised hospital mortality rate which shows that we are classified as 'lower than expected'

- Discussions at the; Trust Board Seminar (27th February 2013), Governance Committee (13th February 2013) and the Management Board (11th February 2013).

- Formally responding to NHS London regarding what action the Trust is taking with regards to talking and listening to staff. We have engaged with staff at various forums such as;

    - The Chairman's patient experience walkabouts talking to staff about raising concerns
    - Chief Executive Officer open hour discussions
    - Inclusion of information in the Nursing and Midwifery matters newsletter to staff
    - Team meetings
    - Back to the floor Friday

Actions going forward will include:

- Creating a Quality Governance Strategy incorporating the key aspects of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

- The Foundation Trust fitness test which includes; the Board Governance Assurance Framework and a self-assessment against the Quality Assurance Framework will be carried out and will relate to the Mid Staffordshire NHS Foundation Trust Public Inquiry action plan where relevant.

- An annual report outlining progress against the work plan will be produced and published

- The Trust's quality account for 2013/14 will reflect the work being carried out.

Trust Board members are encouraged to read the report which is available online at:
http://www.midstaffspublicinquiry.com/report

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.1.2**

Report Title: Quality Accounts Priority Indicators 2013/14

To be presented by: Janice Sigsworth, Director of Nursing

Executive Summary:

The paper presented outlines the proposed Quality Indicators for the 2013/ 2014 Quality Accounts. In addition, the board needs to confirm the quality indicator for data quality assurance purposes, as part of the external audit requirements, for the Quality Accounts.

The Board is asked to approve the quality indicators for 2013/14 and agree the indicator that will be scrutinised as part of the external audit process for the 2012/13 Quality Accounts.

Key Issues for discussion:

Quality Indicators 2013/14

To agree quality indicators for external data quality scrutiny for 212/13 Quality Accounts

Link to the Trust's Key Objectives:

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

Assurance or management of risks associated with meeting key objective:

Purpose of Report

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

Imperial College Healthcare NHS
NHS Trust

Quality Accounts 2013-14 Priority Indicators and External Audit

1. Introduction

Each year, the Trust reviews and agrees their quality indicators for the next Quality Accounts, through a process of engagement with stakeholders and staff. The key themes emerging from these discussions are reviewed and collated into measurable outcomes. The board is required to review and agree the new Quality indicators (appendices 1 & 2).

As part of publishing our Quality Accounts, external auditors are required to review the accounts and conduct 'substantive testing' of the data quality of at least two indicators. One of these indicators is mandated and the other must be agreed by the board. The board is required to review the proposed specified indicators and confirm the additional indicator to be reviewed.

2. National Requirements

2.1 New National Guidance

In January 2013 new guidance was published from the Department of Health confirming the core set of Quality indicators to be included in the 2012/13 Quality Accounts and outlining a standardised statement that must be included.

The indicators are based on recommendations by the National Quality Board, align closely with the NHS Outcomes Framework and are based on data already available nationally. The intention is that trusts will be required to report on their performance against these indicators, the national average and a supporting commentary which will explain variation from the national average and any steps taken or planned to improve quality.

3.1 Proposed Changes to Existing Measurements 2012/13 (appendix 1)

3.1.1 Patient Experience

- General consensus that we should *keep the current indicators* with the *exception* of discharge.

3.1.2 Clinical Effectiveness

- Stakeholders and staff were in agreement that we should *continue with the existing indicators* in this section. They did not suggest any additional indicators to be included.

3.1.3 Patient Safety

- General consensus that we should keep the current indicators

3.2 Proposed Patient Experience Indicators 2013/14 (appendix 2)
3.2.1 Patient Experience

- The Mid Staffordshire Report (2013) highlights the importance of staff attitudes on the patients' experience. We propose that we should include *caring and compassion* as a new indicator.
- It was agreed that the Trust will include the new *Family and Friends test* as a new indicator.

  Proposed new indicators – Caring and Compassionate staff and Family & Friends Test

3.2.2 Clinical Effectiveness

- No changes

3.2.3 Patient Safety

- Dementia care - was felt this should be considered as a potential indicator of good quality care. Stakeholders and staff felt that dementia care had been highlighted as an area of concern across health and social care settings and that we should be demonstrating to the public how we are addressing this.

  One way of demonstrating this would be through the dementia CQUIN. Not only would this enable national comparisons to be made but more importantly it would show the public that we are ensuring that our patients are assessed and receive the appropriate care.

  Proposed new indicator – Dementia CQUIN

4. Engagement Process
4.1 An engagement process ran in February 2013 with various internal and external stakeholder groups to discuss their views on what should be included in this years Quality Accounts and any improvements that could be made to the format of the document. They included the following participants:

- Shadow members/members of the public/patients
- Junior doctors
- Therapists
- Nurses
- Outpatients staff
- Pharmacists
- LiNKS representatives

A total of 6 workshops were held alongside 6 local engagement meetings. In addition the Trust website was used to promote the initiative and as a means to submit views electronically or via telephone interviews. In – Brief was used to promote opportunities for staff to become involved.

4.2 Key themes identified
In addition to the proposed indicators, stakeholders were keen to include a measurement on the quality of food and nutrition. We had discussions about the difficulties in measuring a potentially subjective indicator and decided at present not

to include this. We recognise that this is important to patients and we will consider the best way to capture this through the existing ISS audits and back to floor Friday (BTF) audits.

4.3 Improvements/ comments on the document

These were noted as:

- Stakeholders liked the case study examples used in the report, but felt that there was too much text and that the use of tables would make the document more meaningful.
- Detailed contents page needed to direct the reader to the individual priorities Attendees thought that strong sub-headings should be used throughout the document so that people can signpost their way through without confusion.
- It was thought that the amount of information included in the Quality Accounts was currently too vast and repetitive. It was recognised that the Trust has to comply with certain external regulations but thought that the document would be more accessible and useful if it had a lower quantity of more direct information.
- A short summary leaflet should be available outlining our performance and targets for the upcoming year

5. External Audit Requirements

The Quality Accounts will be subject to a formal external audit. One of the indicators is mandated, that being; the % of patient safety incidents resulting in severe harm/ death. The other indicator must be selected by the Trust from the following list:

- % patients readmitted within 28 days of discharge from hospital
- % of patients risk assessed for VTE
- Rate of Clostridium difficile

It is proposed that the rate of *Clostridium difficile* should be considered by the Board as the indicator put forward to external audit. Infection prevention and control continues to be an important indicator of the quality of care delivered. We understand the challenges faced each year to continuously reduce our infection rates and would value the external scrutiny of our data to provide additional assurance to the Board.

We recognise the importance of the other two proposed indicators and would propose that the chair of the VTe Task Force Group, Dr Chris Baker, works with internal audit to conduct a review of the VTE cohort data and that internal audit review the 28 readmission data, focusing on areas of over-reporting.

6. Action

The Management Board is asked to review the draft priority indicators for inclusion in the Quality Accounts and **to approve** for 2013/14.The approved indicators will then be presented to the Trust Board on 27 March 2013.

The Management Board is asked to agree the quality indicator that will form part of the external audit process.

A draft report will be presented to the Management Board, Audit & Risk Committee and Trust Board in April 2013, prior to submission for external audit and commissioner and LINks review.

Appendix 1

Current Quality Account Improvement Priorities 2012-13

Ref	Indicator	Plan for 2013/14
	PATIENT SAFETY DOMAIN	
PS1	To ensure high performance against the Safety Thermometer (VTE, falls, pressure ulcers, catheter infections)	**To remain**
PS2	To reduce the rate of C-difficile	**To remain**
PS3	To achieve national average reporting rates for patient safety incidents to support learning and improvement	**To remain**
PS4	To reduce the rate of MRSA Blood Stream Infection (BSI)	**To remain**
PS5	To ensure compliance with trust policy for appropriate use of anti-infectives	**To remain**
PS6	To remain below national average for the percentage of patient safety incidents resulting in severe harm or death	**To remain**
	CLINICAL EFFECTIVENESS DOMAIN	
CE1	To remain better than the national average for mortality rates as measured by the Summary Hospital level Mortality Indicator (SHMI) - Publication of SHMI value and banding - Percentage of admitted patients whose treatment included palliative care - Percentage of admitted patients whose deaths were included in SHMI and treatment included palliative care (context indicator)	**To remain**
CE4	To reduce the number of Emergency readmissions to hospital within 28 days of discharge	**To remain**
CE5	Patient Reported Outcome Scores for - Groin Hernia Surgery - varicose vein surgery - hip replacement surgery - knee replacement surgery	**To remain**

Ref	Indicator	Plan for 2013/14
	PATIENT EXPERIENCE DOMAIN	
PExp1	To improve satisfaction with waiting time for patients in clinic (Central Outpatients)	**To remain**
PExp2	To improve the patient experience related to discharge	To remove as an indicator and replace with caring and compassion but continue to monitor through BTF
PExp4	Responsiveness to inpatients personal needs	**To remain**
PExp5	To remain above average for the percentage of staff recommend Trust to friends/ family needing care	**To remain**

Appendix 2

Proposed Quality Account Improvement Priorities 2013-14

In addition to continuing with the above indicators, the following indicators are proposed for inclusion next year.

Ref	Indicator	Selection Criteria
	PATIENT EXPERIENCE DOMAIN	
	Caring and compassionate staff	Local as agreed by engagement feedback
	Family and Friends test – Patient perspective	**Mandatory** and agreed by engagement feedback
	PATIENT SAFETY DOMAIN	
	To ensure patients with suspected dementia are assessed and appropriate care put in place – Dementia CQUIN	Local as agreed by patient feedback

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.1.3**

Report Title: Update on Friends & Family Test (FFT) Implementation

To be presented by: Janice Sigsworth, Director of Nursing

Executive Summary: On 25 May 2012 the Prime Minister announced the introduction of the Friends and Family Test (FFT) with the aim of improving patient care and highlighting best performing hospitals in England. From 1 April 2013 Standard NHS Contracts will include a requirement for FFT to be captured by providers of all NHS funded acute inpatient services and A&E departments.

The Friends & Family Test (FFT) Implementation Plan was presented at the Trust Board on 30 January following publication of the FFT Implementation Guidance in December 2012. The FFT Reporting Guidance was published on 7 February. This confirmed that FFT will apply Net Promoter Methodology which is different from the current Itrack reporting method.

This paper presents a summary of the implementation actions that have been delivered to date, risks against 1 April and Q1 compliance and further steps that can be undertaken if required.

The report includes the following:

i) National Commissioning Board Audit of FFT State of Readiness.
ii) FFT Implementation Actions Delivered to Date.
iii) FFT CQUIN (2013/14.
iv) FFT Responses
v) Management of Residual Risks.
vi) FFT Scores
vii) Benefits of Adopting FFT Approach Across Itrack.
viii) Further Proposals for the Development of Itrack

Key Issues for Discussion:

i) Consider the progress to date.
ii) Consider the residual risks and mitigation plans.
iii) Consider the next steps.

Details of Legal Review, if needed Not required.

Link to the Trust's Principal Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safely and satisfaction.
2. Provide world-leading specialist care in our chosen field.
3. Achieve outstanding results in all our activities.

Action required by the Board: To agree the implementation plan.

FRIENDS & FAMILY TEST IMPLEMENTATION
& FUTURE PROPOSALS FOR ITRACK
UPDATE FOR THE TRUST BOARD ON 27 MARCH 2013

1. Background

On 25 May 2012 the Prime Minister announced the introduction of the Friends and Family Test (FFT) with the aim of improving patient care and highlighting best performing hospitals in England. From 1 April 2013 Standard NHS Contracts will include a requirement for FFT to be captured by providers of all NHS funded acute inpatient services and A&E departments.

The Friends & Family Test (FFT) Implementation Plan was presented at the Trust Board on 30 January following publication of the FFT Implementation Guidance in December 2012. The FFT Reporting Guidance was published on 7 February. This confirmed that FFT will apply Net Promoter Methodology which is different from the current Itrack reporting method.

This paper presents a summary of the implementation actions that have been delivered to date, risks against 1 April and Q1 compliance and further steps that can be undertaken if required.

2. National Commissioning Board Audit of FFT State of Readiness

In line with the high profile status of FFT, the National Commissioning Board audited all Trusts for their state of readiness for 1 April implementation. The ICHT audit took place on 13 February and the results were reported back on early March. ICHT achieved 100% compliance for the state of readiness.

3. FFT Implementation Actions Delivered to Date

To date the following FFT actions have been undertaken:

i) The FFT Implementation Group has been established with all key stakeholders represented.
ii) The FFT question has been included on I track as a single mini-survey on all Inpatient & A&E devices.
iii) A Trust – wide Communications Plan has been initiated including articles on the Source, In Brief, Team Brief and 360.
iv) Friends & Family 'Zones' have been created in all four A&E Departments (St. Mary's Hospital, Charing Cross Hospital, Hammersmith Hospital & Western Eye Hospital) as follows:
    - Zones are located on patient exit pathways from Major (Treatment Areas) & Minor (Treatment Areas).
    - Wall-mounted mini-plasma screens have been installed within all Zones to capture the Friends & Family Question.
    - Sign posting and communications has been erected around the Zones to attract patients to the plasma screens to provide feedback. This includes the Friends & Family Question Poster (included in Appendix A). (Feedback has indicated that patients are reluctant to complete a test).
v) Regular reporting of FFT is carried out to identify high risk areas.

4. FFT CQUIN (2013/14

Compliance against FFT will be measured by a National CQUIN. The total value of this CQUIN will be around £850k. For 2013/14 the CQUIN for FFT includes three parts:

- PART A: 30% of value will be awarded for increasing the response rates from Q1 to Q4 (based on a minimum of response of 15% in Q1).
- PART B: 40% of value will be awarded for rolling out FFT to other specified services (Maternity has already been announced for October 2013 and ICHT is a national pilot).
- PART C: 30% of value will be awarded for increasing the FFT score in the 2013/14 Staff Survey compared to the 2012/13 baseline or remaining in the top quartile of Trusts for Staff FFT. (Refer to section 6.1).

5. FFT Responses

ICHT uploaded the first submission to UNIFY (National Reporting System) in March for the responses received from patients in February FFT. This was a voluntary submission as the information is not yet mandated. The response numbers were as follows:

i) Compliance of Inpatient Wards = 20%.
ii) Compliance of Accident & Emergency = 2.7%.

A breakdown of responses is included in Appendix B.

6. Management of Residual Risks

6.1 Residual Risks

In line with the February number of responses there is a risk to A&E response numbers compliance and the improvement required for staff recommending ICHT to Friends & Family.

Risk	Actions
PART A: Risk to achievement of 15% response rates numbers in A&E.	i) Monitor the number of monthly responses every 48 hours. ii) Assess the level of risk on a weekly basis of non – compliance for Q1 of 15% response rate. iii) Take additional steps to achieve compliance levels in line with the level of risk: - Provide additional sign posting for patients. - Display the FFT results in the zones. - Talk to patients about their experience to explain FFT. - Directly encourage patients to provide feedback. - Ensure all patient information boards are kept in line with PEX Team standards.

Risk	Actions
PART C: Staff recommending ICHT to Friends & Family.	i) Assessment of score in 2012/13 Staff Survey results. ii) Determine if ICHT is in top quartile. iii) Develop a plan of approach to mitigate risks of non-achievement.

7. FFT Scores

FFT Scores are calculated using the Net Promoter methodology which takes the optimum response (i.e. very likely) minus the total number of neutral and negative responses. The March results are included in Appendix B. To note that any wards with a total response of below 6 have not been included.

The results from Net Promoter can range from 100 to -100. There are no wards with a negative score. The highest rated ward is 9 North, CXH and the lowest rated is Charing Cross A&E Department.

8. Benefits of Adopting FFT Approach Across Itrack

Currently Itrack uses a likert scale scoring method to calculate wider patient experience scores. The benefits of using the Net Promoter approach across Itrack are as follows:

i) There will be a single method of reporting patient experience scores.
ii) There will be a consistent approach of scoring across all questions and response sets.
iii) The scoring method will be easier to communicate.
iv) The scoring will have greater resonance with all staff.
v) ICHT will maintain competitive advantage with patient experience reporting.

9. Further Proposals for the Development of Itrack

In addition to changing the scoring method and question methodology it is also proposed that the number of Itrack surveys is rationalised from around 40 surveys to 9 surveys (Inpatient, Outpatient, General Service, Maternity, Paediatric Inpatient, Paediatric Outpatient, Values Based Standard Inpatient and Values Based Standard Outpatient) to enable the following to take place:

i) Cost effective incorporation of languages to comply with EDS requirements.
ii) Further benchmarking of services via results comparison.

10. Next Steps

The proposed next steps are as follows:

i) Continue to review the position for responses for inpatient and Accident & Emergency responses. (**Action: PEX Team & CPG 1 Management Team ongoing).**
ii) Take steps to mitigate any risks of non-compliance as outlined in the risks management plan. **(Action: PEX Team & CPG 1 Management Team ongoing).**

iii) Develop a risk management plan for Staff & FFT. **(Action: DoP & HR and PEX Team by the end of April).**

iv) Revise all Itrack surveys. (**Action: PEX Team by end of April).**

v) Include in Itrack and on Qlikview. **(Action: PEX Team by end of June).**

vi) Establish ICHT targets for FFT and begin the process of triangulation results with other indicators. **(Action: PEX Team & CPGs by end of June).**

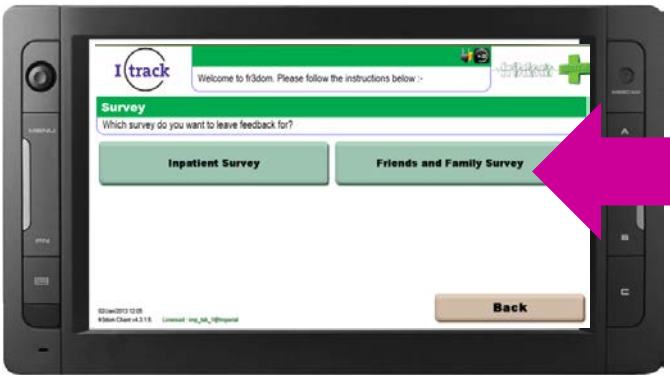
vii) Report progress to Trust Board. **(Action: DoN in July).**

APPENDIX A: FRIENDS & FAMILY QUESTION CURRENT POSTER

Imperial College Healthcare NHS
NHS Trust

Friends and Family Question

Please tell us how you would recommend your experience in this department to your friends and family.



Please complete the Friends and Family Survey

Please use the iTrack device before you leave and we will include your feedback in our results.

innovation respect care achievement pride

APPENDIX B: FFT SCORES FOR INPATIENT WARDS – FEBRUARY 2013

Wards	1 - Extremely Likely	2 - Likely	3 - Neither likely or unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Total Responses	Total Don't Know	Responses minus Don't Know	Total Eligible to Respond	% Responses	% Positive Rating	% Negative Rating	Net Promoter Score
9 North Ward	14	1	0	0	0	0	15	0	15	93	16.1	93	0	93
John Humphrey	13	1	0	0	0	0	14	0	14	62	22.6	93	0	93
Fraser Gamble	7	1	0	0	0	0	8	0	8	63	12.7	88	0	88
10 North Ward	19	3	0	0	0	0	22	0	22	45	48.9	86	0	86
Riverside	17	1	0	1	0	0	19	0	19	170	11.2	89	5	84
6 North Ward	9	2	0	0	0	0	11	0	11	69	15.9	82	0	82
9 West Ward	4	1	0	0	0	0	5	0	5	15	33.3	80	0	80
Almroth Wright	8	2	0	0	0	0	10	0	10	28	35.7	80	0	80
Rodney Porter &	4	1	0	0	0	0	5	0	5	52	9.6	80	0	80
8 West Ward	26	8	0	0	0	0	34	0	34	49	69.4	76	0	76
Weston Ward	7	0	1	0	0	0	8	0	8	21	38.1	88	13	75
Z. Cope / S. Lane	11	4	0	0	0	0	15	0	15	135	11.1	73	0	73
Lady Skinner	13	5	0	0	0	0	18	0	18	18	100.0	72	0	72
A7 Ward & CCU	5	2	0	0	0	0	7	0	7	91	7.7	71	0	71
Christopher Booth	17	7	0	0	0	0	24	0	24	80	30.0	71	0	71
South Green Ward	20	5	1	0	1	0	27	0	27	138	19.6	74	7	67
Major Trauma	4	2	0	0	0	0	6	0	6	30	20.0	67	0	67
7 South Ward	3	2	0	0	0	0	5	0	5	75	6.7	60	0	60
A8 Ward	3	2	0	0	0	0	5	0	5	84	6.0	60	0	60
Marjorie Warren	9	4	0	1	0	0	14	0	14	80	17.5	64	7	57
11 South Ward	39	16	4	1	0	2	62	2	60	98	63.3	65	8	57
A9 Ward	9	7	0	0	0	0	16	0	16	84	19.0	56	0	56
Dacie Ward	9	7	0	0	0	0	16	0	16	20	80.0	56	0	56
Vallentine Ellis	13	8	1	0	0	0	22	0	22	42	52.4	59	5	55
Handfield Jones	2	2	0	0	0	1	5	1	4	56	8.9	50	0	50
Lillian Holland	4	1	1	0	0	0	6	0	6	11	54.5	67	17	50
Samaritan Ward	3	4	0	0	0	0	7	0	7	102	6.9	43	0	43
10 South Ward	7	10	1	0	0	2	20	2	18	100	20.0	39	6	33
D7 Ward	12	13	3	0	0	0	28	0	28	38	73.7	43	11	32
Joseph Toynbee	6	2	1	1	1	0	11	0	11	118	9.3	55	27	27
7 North Ward	6	8	1	0	1	0	16	0	16	111	14.4	38	13	25
B1 Ward	3	4	1	0	0	0	8	0	8	51	15.7	38	13	25
EAU	5	5	3	0	0	0	13	0	13	196	80.0	38	23	15
6 South Ward	3	10	1	1	0	0	15	0	15	105	14.3	20	13	7
Total	**334**		**19**	**5**	**3**		**517**		**512**	**2530**	**20.4**	**65**	**5**	**60**

APPENDIX B CONTINUED: FFT SCORES FOR ACCIDENT & EMERGENCY DEPARTMENTS – FEBRUARY 2013

Wards	1 - Extremely Likely	2 - Likely	3 - Neither likely or unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't Know	Total Responses	Total Don't Know	Responses minus Don't Know	Total Eligible to Respond	% Responses	% Positive Rating	% Negative Rating	Net Promoter Score
HH	11	4	1	0	0	0	16	0	16	1001	1.6	69	6	63
WEH	19	14	0	0	1	0	34	0	34	2663	1.3	56	3	53
SMH	75	51	6	4	9	7	152	7	145	2634	5.8	52	13	39
CXH	4	2	1	3	0	0	10	0	10	1605	0.6	40	40	0
Total	**109**	**71**	**8**	**7**	**10**	**7**	**212**		**205**	**7903**	**2.7**	**53**	**12**	**41**

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.1.4**

Report Title: Eliminating Mixed Sex Accommodation (EMSA) Compliance Declaration 2013

To be presented by: Janice Sigsworth, Director of Nursing

Executive Summary

To ensure continued delivery and improvement of same sex accommodation, it is best practice for all Trusts to publish on their websites an annual EMSA compliance declaration. (The February 2011 Department Health (DH), *Eliminating Mixed-Sex Accommodation – Declaration Exercise* - Gateway 15552 is the reference document.)

The NHS Commissioning Board – *Everyone Counts: Planning for Patients 2013 / 14: Technical Definitions, December 2012* – expects all providers of NHS funded care to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient.

Key areas for discussion:

- To provide evidence to assure the Board of the Trust's ongoing compliance against DH EMSA standards;
- To approve the Trust's declaration and action plan to deliver same sex accommodation during 2013 / 2014.

Legal Implications or Review Needed

a. Yes √
b. No

Details of Legal Review, if needed

Link to the Trust's Key Objectives:

- To provide the highest quality care to the communities we serve;
- To achieve outstanding results in all our activities.

.

Purpose of Report

a. For Decision √
b. For information/noting

Eliminating Mixed Sex Accommodation (EMSA)
Compliance Declaration 2013

1. Background

To ensure continued delivery and improvement of same sex accommodation, it is best practice for all Trusts to publish an annual EMSA compliance declaration on their websites. (The February 2011 Department Health (DH), *Eliminating Mixed-Sex Accommodation – Declaration Exercise* – gateway 15552 is the reference document.) This requires a declaration statement and an action plan.

1.2 Definition of EMSA 2013

The NHS Commissioning Board – *Everyone Counts: Planning for Patients 2013 / 14: Technical Definitions, December 2013* – expects all providers of NHS funded care to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3 (Gateway 15024).

The 2013 EMSA compliance declaration applies to the following areas:

- Sleeping and toilet / bathroom accommodation in level 1/0 beds
- Sleeping / recovery and *'passing by or passing through'* in day care areas (Endoscopy, Cardiac Catheter Labs and Day Surgery units)
- Delayed step down from a Level 3/2 bed to a Level 1/0 bed
- Discharges home from mixed sex recovery units
- All Trusts must be able to demonstrate that they have an exception reporting system to identify, and then report breaches.

In 2013 / 2014 Unify 2 reporting is for EMSA breaches of sleeping accommodation only. However NHS providers are required to monitor locally all justified mixing in sleeping accommodation and all mixed sex sharing of bathrooms and toilets (including passing through accommodation or toilets / bathrooms used by the opposite gender). For performance monitoring the EMSA breach rate per 1,000 Finished Consultant Episodes (FCE), as well as the numbers of breaches will continue to be monitored.

2. EMSA Progress in 2012 / 2013

2.1 Trust EMSA Position 2011 / 2012

The Trust reported 177 breaches, 191101 FCEs = 0.09% on Unify 2.

2.2 Trust EMSA Position in 2012 / 2013.

From April 2012 to the end February 2013 the Trust reported 0 breaches on Unify 2. This was achieved by:

- reviewing patients' experiences at monthly performance meetings;
- adapting our operational management and patient pathways;
- establishing a weekly focus at the Capacity Meeting;
- undertaking spot checks on Back to the Floor Fridays.

The clinical exemptions for the Endoscopy Unit on the St Mary's Hospital site were extended by the NWL Clinical Quality Group on 20 February 2013 for the duration of the rebuilding of the unit, which is due for completion by end March 2014.

3. Supporting our EMSA Compliance Declaration

Two data sets are included to inform the recommendation made at the end of this paper. These are as follows:

- Bathroom and toilet monitoring;
- Patient's views.

3.1 Bathroom and toilet monitoring

The Clinical Programme Groups have undertaken a self-assessment of bathroom and toilet facilities and the following 2005 DH criterion (**publication format:** electronic only) was used to assess compliance:

- Patients do not pass through areas occupied by members of the opposite sex to reach toilets and washing facilities;
- Separate male and female toilets and washing facilities are available in all patient areas and are clearly labelled either male or female.

All areas which were visited were deemed compliant against the DH standards.

3.2 What do patients say?

In 2012 / 2013 iTrack results show an average score of 92 out of 100 patients saying that; *'when they were first admitted to a bed in a ward they didn't share a sleeping area (e.g. a room or a bay, with patients of the opposite sex)'.* We know that this question is open to some degree of personal interpretation, in March 2013 it will be simplified to: 'w*hile staying on this ward, did you share a sleeping area, for example a room or a bay, with patients of the opposite sex?'*

3.3 Trust EMSA Policy

The policy is being updated to reflect revised internal and external performance monitoring processes.

4. Conclusion

The Trust Management Board are asked to approve the action plan (Appendix 1).and EMSA compliance declaration 2013 (Appendix 2).

.

Appendix 1

Imperial College Healthcare NHS
NHS Trust

Eliminating Mixed Sex Accommodation – Action Plan 2013 / 2014

Introduction

This delivery plan is underpinned by the Trust's policy which is also available on the internet/intranet. The policy will provide patients and staff with the day to day operational detail, including internal escalation mechanisms and supporting patient information. The actions included in this document are high level indicators supported by LINks representatives and agreed by the NWL commissioning partnership and the Trust Board to support this declaration, to sustain and continually improve patient experience in this specific area.

Plan

Statement	Action	Key performance indicators	Timeframe & Leads
Clinical leads to work in partnership with Estates leads to maximise compliance	To ensure that any new inpatient refurbishments or new capital schemes meet EMSA standards	EMSA requirements incorporated into any new capital scheme	**Ongoing Named Estates and CPG clinical leads for the project.**
System and processes will be used to improve and sustain EMSA compliance	**Endoscopy specific plan – St Mary's Hospital Unit** New purpose built facility which will include gender split pre and post procedure pathways	Single gender lists taking place no passing by or passing through areas of the opposite gender.	**CPG 1 Clinical Director**

Appendix 2

Declaration of Compliance

Imperial College Healthcare NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in High Dependency Units and Intensive Care Units), or when patients actively choose to share.

If our care should fall short of the required standard, we will report it. We will also set up an audit mechanism to make sure that we do not mis-classify any of our reports. We will publish the results of that audit in the monthly Trust Board Performance report.

The Trust will focus on improving Endoscopy facilities on the St Mary's Hospital site in 2013 / 2014.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.1.5**

Report Title: SAFEGUARDING CHILDREN & YOUNG PEOPLE SERVICE INTERIM REPORT 2012/13

To be presented by: Professor Janice Sigsworth

Executive Summary:
In August 2012 Imperial College Healthcare NHS Trust (ICHT) published its Safeguarding Children and Young People Annual Report.

This interim report confirms that the Trust meets all the requirements set out in David Nicholson's letter of 16th July 2009 whereby Trusts are required to publish an annual declaration.

It provides a progress update against the key priorities identified for 2012/13.

Key Issues for discussion:
1. Progress against key priorities
2. Safeguarding children and young people declaration 2013

Legal Implications or Review Needed
a. ~~Yes~~ ☐
b. No ☒

Details of Legal Review, if needed: n/a

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

Assurance or management of risks associated with meeting key objective:

Purpose of Report:
1. To provide assurance of progress against key priorities
2. Safeguarding Children & Young People declaration for approval.

SAFEGUARDING CHILDREN & YOUNG PEOPLE SERVICE
INTERIM REPORT 2012/13

1. BACKGROUND

In August 2012 Imperial College Healthcare NHS Trust (ICHT) published its Safeguarding Children and Young People Annual Report.

This is an interim report and confirmation that the Trust meets all the requirements set out in David Nicholson's letter of 16th July 2009, whereby Trusts are required to publish an annual declaration.

2. KEY PRIORITIES FOR THE NEXT SIX MONTH PERIOD

In addition to reporting on developments and achievements during 2011/12, the Annual Report identified key priorities for the following six months - September 2012/February 2013 and progress against these is summarised as follows:

2.1 Audit the safer recruitment practice within the relevant areas.
As a KPI, it was identified that the way this was previously reported did not provide assurance that a member of staff on each recruitment panel has undertaken recruitment training, and therefore after discussions with the Human Resources department this specific measurement will be included on future reports commencing at the next ICHT safeguarding children board on Wednesday 8th May 2013.

2.2 Audit compliance to the safeguarding supervision policy.
As a KPI, the provision of safeguarding supervision focuses on the requirements of CPG 5 (Women and Children) and CPG 1 (Medicine) as priority areas within the trust. It continues to provide data illustrating the productivity of the safeguarding team and responsiveness to incidents/events

2.3 Continue the design work with CERNER CRS to support the implementation of the CQC (2009) recommendation that all health professionals ask patients whether they have children at home and to assess that they are being cared for.
This 'caring question' has been incorporated into the maternity services CERNER rollout.

2.4 Continue the design work with CERNER CRS to support the implementation of a trust wide flagging system for NWL children with a child protection plan.
The safeguarding team continue to work closely with CERNER in order to influence the programme design to include the electronic flagging system of all local children and young people with a child protection plan wherever they present across the trust.

ICHT currently meets the CQC standard in that the A & E departments have a flagging system; however it is not possible to extend this to a system for the whole Trust due to the current information systems available, an issue that has been raised at the ICHT

Quality and Safety Committee. With the implementation of a Trust wide information system it is envisaged that it will be possible to implement an electronic system across ICHT. The work to progress this has continued, led by a project manager funded by the Imperial Charity. Working closely with an LSCB representative, Caldicott Guardian, medical records lead, IT teams, the safeguarding team and Head of Nursing for paediatrics, this work is moving forward to find an electronic system both before CERNER is implemented and then to secure this process afterwards.

2.5 To sustain training roll out, with a specific focus on Level 2 multidisciplinary programme.

ICHT has continued to prioritise safeguarding children and young people training during 2012 with significant success in achieving improved training statistics in both level 2 and level 3 groups:

Level 1 training is required for all non clinical staff
Level 2 training is required for all clinical staff who have any contact with children, young people, their parents and carers and pregnant women
Level 3 training is required for all staff who work predominantly with children, young people and pregnant women.

	Staff in post	Staff requiring training per annum	Staff trained	% compliance
Level 1	**1825**	**608**	**664**	**109%**
Level 2	**6457**	**2152**	**1748**	**81%**
Level 3	**1072**	**357**	**335**	**94%**
Overall compliance				**88%**

The Trust has therefore achieved overall 88% compliance for safeguarding children training in the last rolling year, at the end of December 2012.

2.6 Maintain the rolling clinical audit programme and implement the findings of the audit review.

The ongoing auditing of safeguarding referral activity and practice has been further developed. This data and analysis is presented to the safeguarding children and young people board by the Named Nurse and Named Midwife. The key recommendations of the Park Hill audit review have been addressed and are complete.

An internal programme of continuing audit has been established and is presented to the safeguarding board on a quarterly basis. This data is also be utilised to populate the Inner North West London Commissioning Cluster Acute Trust Monitoring Safeguarding Children Template.

2.7 Complete action plans that may arise from the Serious Case Review and Domestic Homicide Reviews in progress.

A safeguarding team action plan work tracker is produced for the monthly safeguarding children operational group meeting which ensures that required actions are RAG rated and prioritised. There are two actions outstanding for the maternity department related to an IMR for Brent and these will be completed by the end of April 2013.

2.8 Continued partnership working with our Inner North West London colleagues.

Representatives of the safeguarding children and senior management teams continue to represent the trust at relevant safeguarding meetings and have participated in the

implementation of the tri borough Local Safeguarding Children's Board and the relevant subgroups.

3 FUTURE REPORTING

The intention is to report to the Board with a Safeguarding Children and Young People Annual Report in August 2013.

REFERENCES

Care Quality Commission July 2009 *Safeguarding children: A review of arrangements in the NHS for safeguarding children*; London CQC http://www.cqc.org.uk/sites/default/files/media/documents/safeguarding_children_review.pdf

Appendix 1

Imperial College Healthcare NHS Trust

Safeguarding Children and Young People Declaration March 2013

1. Introduction

Imperial College Healthcare NHS Trust (ICHT) is committed to the protection and safeguarding of all patients, including children and young people; ICHT work closely with multi-agency partners to ensure that robust safeguarding children and young people arrangements are in place.

These include:

Imperial College Healthcare NHS Trust meets statutory requirements in relation to Criminal Records Bureau checks. All staff employed at the Trust undergo a CRB check prior to employment and those working with children undergo an enhanced level of assessment.

The Imperial College Healthcare NHS Trust Safeguarding Children & Young People policies and systems are up to date and are reviewed on a regular basis. The last review was September 2011.

The Trust has a process in place for following up children who miss outpatient appointments within any speciality to ensure their care and wellbeing is not affected in any way. In addition the Trust has a system in place for flagging children for whom there are safeguarding concerns.

All eligible staff undertake relevant safeguarding training and this is regularly reviewed to ensure that it is up to date. The Trust has a robust training strategy in place with regard to delivering safeguarding training. The percentage compliance with training at end December 2012 is as follows against a target of 80%:

	Staff in post	Staff requiring training per annum	Staff trained	% compliance
Level 1	**1825**	**608**	**664**	**109%**
Level 2	**6457**	**2152**	**1748**	**81%**
Level 3	**1072**	**357**	**335**	**94%**
Overall compliance				**88%**

2. Named Professionals for Safeguarding Children and Young People

The Safeguarding Team is led by a Named Doctor, Named Nurse and Named Midwife. They are clear about their roles, and have sufficient time and receive appropriate support and training to undertake their roles. This team is supported by sessions from a consultant paediatrician, a clinical nurse specialist, a midwife and nurse covering maternity/neonates and an administrator.

The team comprises:

Named Nurse	1 wte
Named Midwife	1 wte
Clinical Nurse Specialist	1 wte
Specialist Midwife	0.6wte
Specialist Nurse (Maternity/NNU)	1wte
Named Doctor	0.4 wte
Paediatric Consultant	0.1 wte
Administrative support	1wte

3. Executive Director Lead for Safeguarding Children and Young People

The Director of Nursing is the Trust Executive Lead for safeguarding children and young people and ensures that the Trust Board fulfils its corporate responsibility and continues to provide direction in relation to the Safeguarding of Children and Young People within ICHT.

The Director of Midwifery/Head of Nursing for the Women and Children's Clinical Programme Group chairs the ICHT Safeguarding Children and Young People's Board which reports to the Trust Board on safeguarding children and young people. The Trust Board takes the issue of safeguarding extremely seriously and receives an annual report on safeguarding children issues. The Safeguarding Children and Young People Annual Report was received by the Trust Board on the 22nd August, 2012. The minutes of all public Trust Board meetings where safeguarding has been discussed can be found at http://www.imperial.nhs.uk/aboutus/ourorganisation/boardmeetings/index.htm

Mark Davies
Chief Executive Officer
March 2013

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.2.1**

Report Title: Patient Safety and Service Quality Report Q3

To be presented by: Professor Nick Cheshire, Medical Director

Executive Summary:

The Quarter 3 report analyses the Trust's performance in relation to regulatory compliance, patient safety, clinical effectiveness, patient experience (complaints), claims, Quality Accounts and service quality report from the National Reporting and Learning System (NRLS). (Data extracted as at 3rd January 2013 for incidents and complaints and as at 8th January 2013 for claims. Please note that data has been refreshed for Q2 only. All data will be refreshed at the end of the year to capture changes post investigation and retrospectively reported activity).

Headlines to note are:

The Trust was awarded CNST level 3 in maternity services in November 2012.

The Trust remains registered without conditions by Care Quality Commission (CQC). During Q3 there were three planned CQC inspections, at HH, WEH and QCCH. The Trust was compliant in all areas reviewed and has received the final reports which were very positive.

Incident reporting rate has increased, moving closer to peer average and importantly we reported less major and an equal amount of extreme incidents to our peers.

Reductions have continued to be seen in the number of serious incidents reported however there was one never event in Q3 (retained vaginal swab – QCCH). The actions from this are being taken forward by CPG5.

Incidents reported relating to staffing levels have increased in Q3 (22% increase from Q2) with a peak noted in October and decreasing numbers to quarter end. This is being further reviewed with HR and senior nursing colleagues and is a key performance measure included in nursing establishment and executive performance reviews.

Incidents relating to the inadequate response to a change in patient status (failure to rescue) have also increased. A number of improvement actions have been put in place including proactive reviews of high risk wards by the site management team out of hours and the COO is leading an improvement taskforce with key actions.

Formal complaints have shown a marginal reduction across the trust to 0.39 per 100 admissions (0.48 per 100 admissions in Q2). Response rates remain above the internal target at 94%. The number of new claims increased by 16% in the quarter, however this follows a large reduction in August 2012 and so the trend will continue to be monitored in conjunction with the other indicators of satisfaction.

Issues are highlighted in the detailed report with completion of national clinical audits, completion of actions arising from Trust designated clinical audits, and the NICE compliance rate. An action plan to address these issues is in development.

Key Issues for discussion: The current performance across the indicators for patient safety and service quality.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objectives:

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

Purpose of Report

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

Patient Safety and Service Quality Report Q3 2012/2013

The quarterly report analyses the Trust's performance in relation to regulatory compliance, patient safety, clinical effectiveness, patient experience (complaints), claims, Quality Accounts and service quality report from the National Reporting and Learning System (NRLS). (Data extracted as at 3rd January 2013 for incidents and complaints and as at 8th January 2013 for claims. Please note that data has been refreshed for Q2 only. All data will be refreshed at the end of the year to capture changes post investigation and retrospectively reported activity).

1. REGULATORY COMPLIANCE

1.1 Care Quality Commission (CQC)

1.1.1 Registration

The Trust remains 'registered without conditions' across all sites.

1.1.2 Inspections

During Q3 there were three planned CQC inspections, at HH, WEH and QCCH. The Trust was compliant in all areas reviewed and has received the final reports which were very positive.

1.1.3 Trust Leadership Walkrounds – Key Themes

Leadership walkrounds involving multi – professional teams of Trust staff were carried out at QCCH, HH, WEH and the renal satellite units during Q3. A number of themes were identified including;

- Cleanliness of equipment and correct use of green stickers
- Poor patient experience in some areas
- Poor maintenance of premises (especially in the renal satellite units)
- Failure to escalate

Improvements have been seen as a result of the leadership walkround programme including, clarity of decontamination processes, improvements to premises (both completed and planned) and re-launch of escalation processes in paediatrics.

1.1.4 CQC Quality and Risk Profile

There were no red or amber risk ratings for the 16 overall outcomes for essential standards. The Trust remains rated as 'low risk of compliance failure'.

1.2. CNST Risk Management Standards Level 3 Assessment

The Trust was awarded the 'gold standard of safety' (CNST level 3) at the first attempt, following a successful assessment conducted at the beginning of November 2012 in maternity services.

Performance was measured against 50 standards across the maternity services, including live record checks, undertaken on SMH and QCCH sites. 46 out of 50 standards passed. The areas highlighted as a focus for improvement were around the quality of documentation related to intermittent auscultation and continuous electronic fetal monitoring and tissue

viability assessments for obese women. While we provide good levels of information to patients, the documentation that the information has been provided could be improved.

2. HEADLINES

2.1 Patient safety

- The clinical incident reporting rate has increased from Q2 (6.5) to Q3 (6.6) compared to an updated NRLS benchmark of 6.9 incidents reported per 100 admissions across the Acute Teaching Trust cluster (our peers).

- In Q3 we reported less no harm incidents and more minor and moderate incidents when compared to our peers. Notably, we reported less major and an equal amount of extreme incidents.

- Inadequate staffing incidents increased from Q2 (170) to Q3 (208) by 22%. Increases were noted at all sites except for SMH and WEH and all CPGs except for 1 and 3.

- Falls remain lower than the national average. A decrease in falls per 1000 occupied bed days was noted from Q2 to Q3. Falls from height, bed or chair have also decreased.

- The percentage of falls that resulted in no harm has increased from 33% to 36% from Q2 to Q3. No falls resulted in major or extreme harm in Q3.

- Inadequate response to change in patient status (failure to rescue) incidents have increased from Q2 (20) to Q3 (21). Site increases have been identified at SMH and HH whereas CXH and QCCH have seen decreases. At CPG level 1, 5 and 6 have increased whereas 2 and 3 have decreased.

- Patient identification incidents have decreased by 53% from Q2 to Q3. All sites and CPGs 1, 2, 3 and 5 have noted a decrease in the number of reported incidents. One incident resulted in moderate harm to the patient.

- Medication incidents have decreased by 16% from Q2 to Q3. From the 317 incidents in Q3 none resulted in either major or extreme harm. 1.3% of the incidents resulted in moderate harm, 24.6% in low harm and 74.1% in no harm

- There has been a reduction in SIs. In Q3 there were 18 SIs. This compares to 20 in Q2. The top themes for SIs Trustwide in Q3 were pressure ulcer (6), maternity (4) and infection control (2).

- There was one Never Event in Q3. This was a retained vaginal swab that occurred in October at QCCH.

- 51 new claims were opened in Q3. This compares to 44 in Q2 representing an increase of 16%. The area with the greatest increase was CPG3. The only area that saw a decrease in new claims was PP.

- 11 claims were settled in Q3. This compares to 12 in Q2.

- For the NRLS 378,166 incidents were reported by NHS Organisations in Q3. This shows an increase of 6.8% compared to Q3 of 2011/12.

2.2 Clinical effectiveness

- Trust compliance with NICE guidance for Q3 is 80%. This is the same level of compliance as was seen in Q2.

- 99.7% of CAS alerts have been closed to deadline.

- In Q3 there was 98% reported participation in National clinical audits listed by the DH as eligible for the Quality Account 2013.

- 56.3% of priority clinical audits were completed to deadline and 66.7% of actions from priority clinical audits due for completion in Q3 have been completed. All outstanding items have been escalated to the respective CPGs for immediate action.

2.3 Patient experience

- The number of complaints received in Q3 was 185 (1.66 complaints per 1000 occupied bed days and 0.39 complaints per 100 admissions).This compares to 223 complaints in Q2.

- The response rate was 94%, against an internal target of 90%.

- The key themes for complaints Trustwide were:

1. All aspects of clinical treatment (57%)
2. Communication/information to patients (8%)
3. Appointment delay/cancellation (outpatients) (7%)

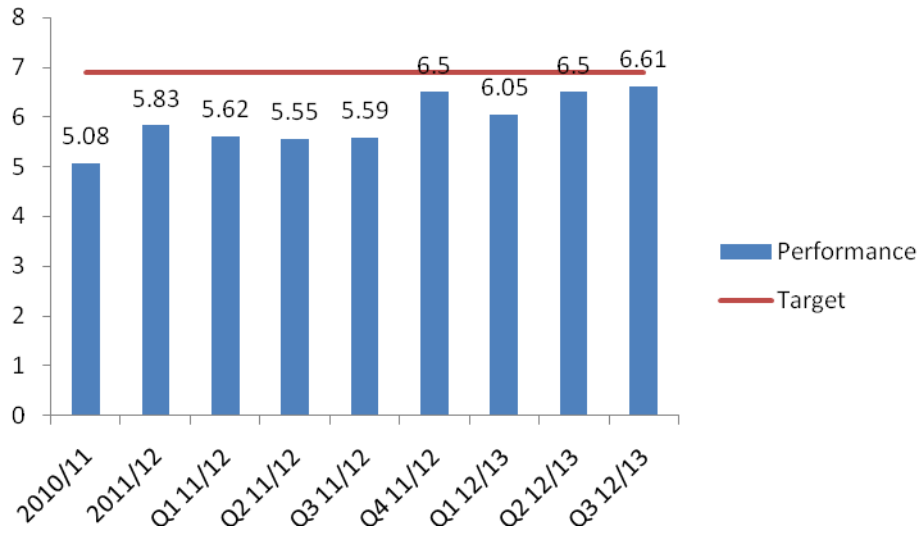
- The number of re-opened complaints was 31. Versus 47 in Q2.

2.4 NRLS: Service Quality

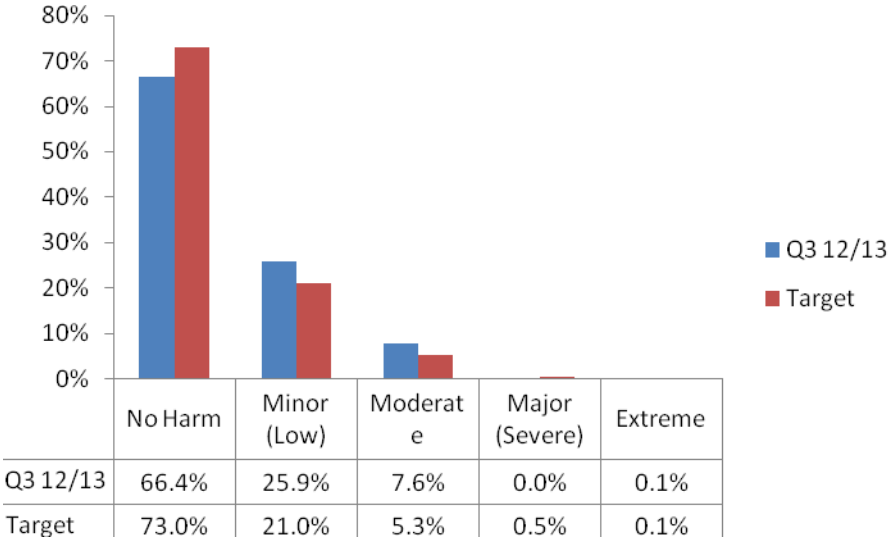
- The NRLS Team has successfully and timely performed, managed and delivered all agreed NRLS functions and outputs for the quarter against the performance schedule proposed in the Memorandum Of Understanding (MOU)

3. PERFORMANCE

Graph 1. Clinical Incident Reporting Rate against NRLS Peer Rate

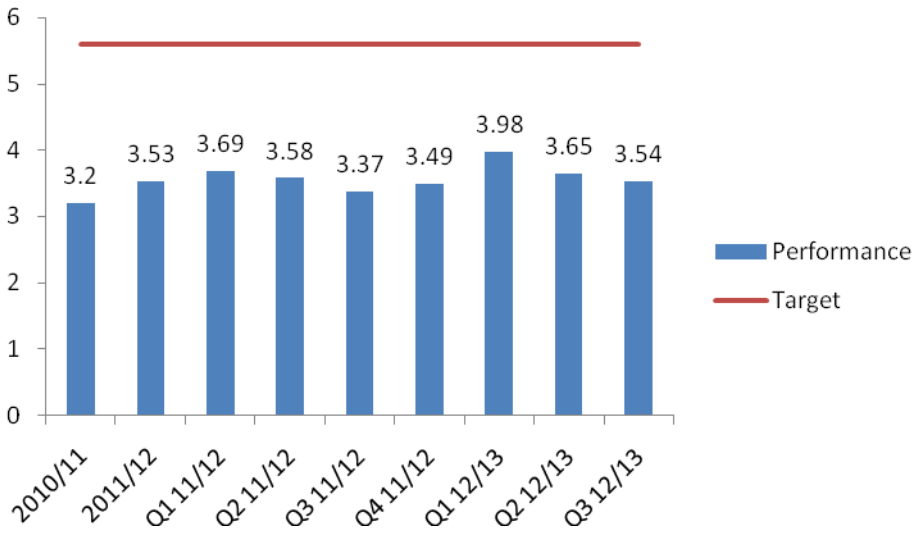


Graph 2. Clinical Incidents by Degree of Harm against NRLS Peers

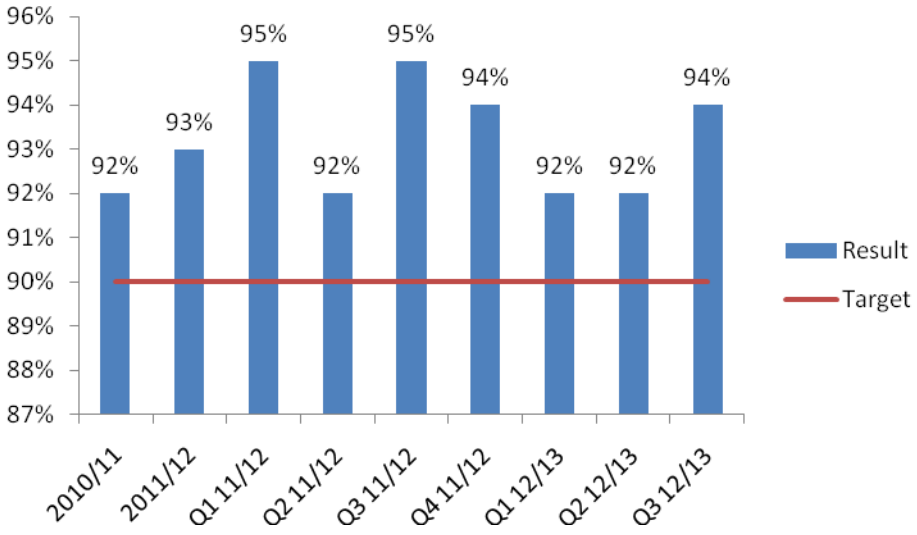


	No Harm	Minor (Low)	Moderate	Major (Severe)	Extreme
Q3 12/13	66.4%	25.9%	7.6%	0.0%	0.1%
Target	73.0%	21.0%	5.3%	0.5%	0.1%

Graph 3. Falls per 1000 Occupied Bed Days against NRLS National Average



Graph 4. Complaints Response Rate against Internal Target



4. TRENDS OVER TIME USING STATISTICAL PROCESS CONTROL (SPC)

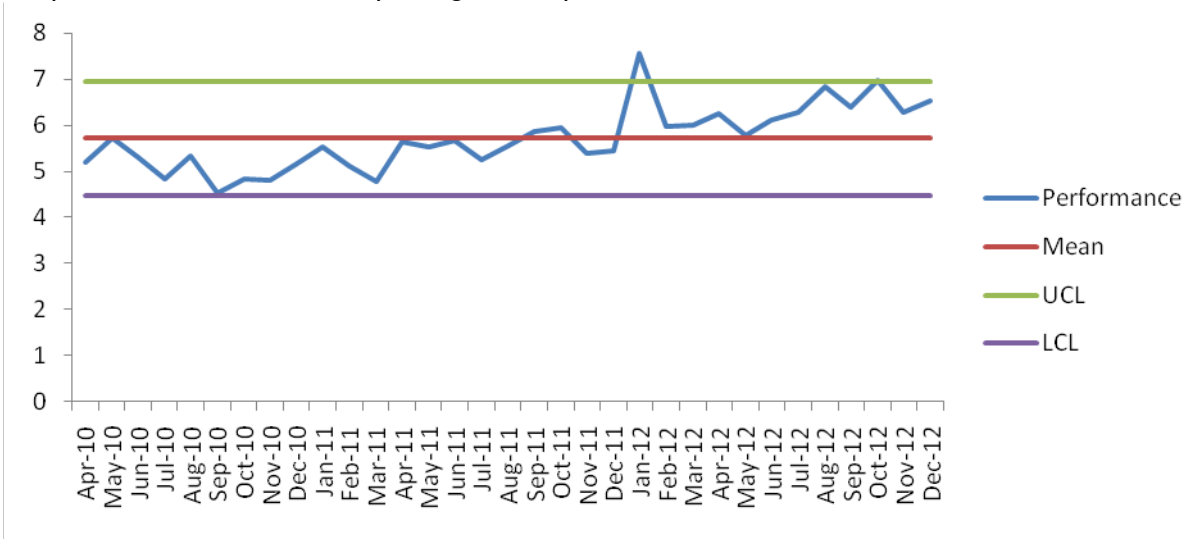
SPC charts were created for each individual indicator to look at variation over a period of 33 months (the data included for analysis is by month for 2010/11, 2011/12 and Quarters 1, 2 and 3 2012/13).

4.1 Introduction to SPC

The purpose of the SPC analysis is to identify significant variation against background, routine or "normal" variation, to ensure that important effects and trends are investigated and that resources are targeted at making improvements in areas of need. The upper control limit (UCL) represents three standard deviations above the mean and the lower control limit (LCL) represents three standard deviations below the mean.

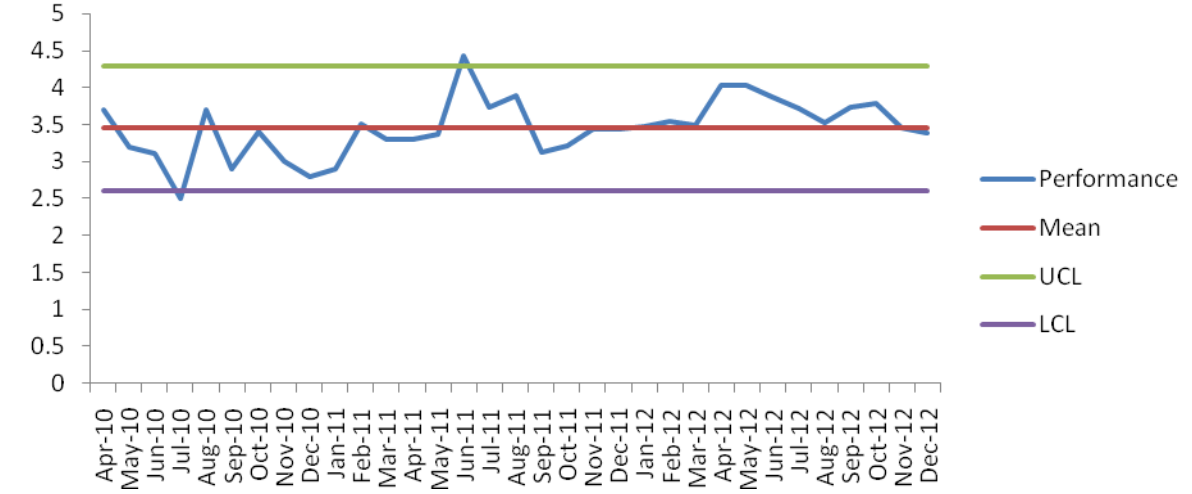
4.2 Patient safety

Graph 5. Clinical Incident Reporting Rate April 2010 – December 2012



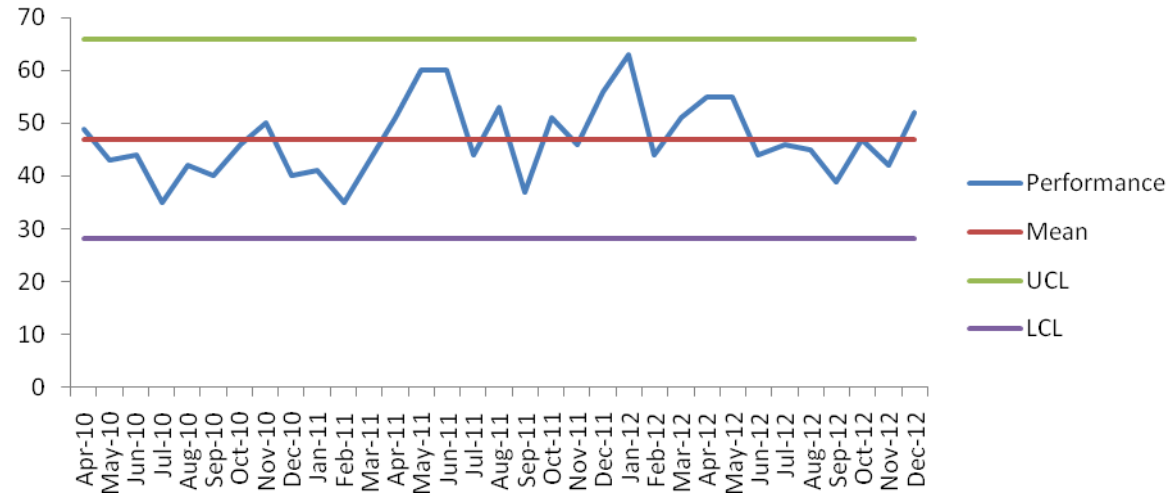
In October the reporting rate reached the upper control limit (positive). Further efforts to increase reporting are ongoing through the monthly reporting counts walk-rounds led by the Quality and Safety Team.

Graph 6. Falls per 1000 Occupied Bed Days April 2010 – December 2012



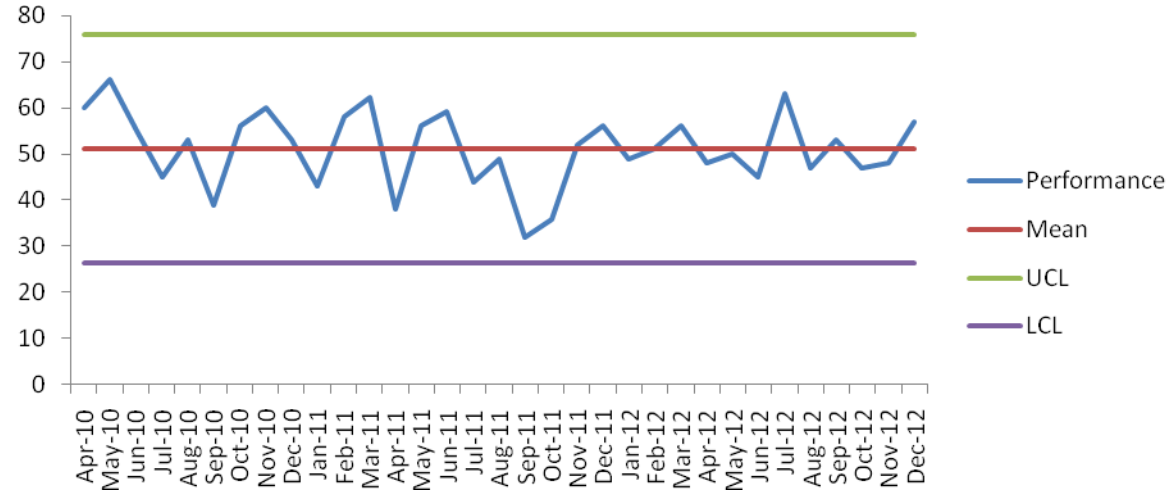
The number of reported falls fell below the mean in December for the first time since October 2011, however for Q3 the number reported has remained above the mean.

Graph 7. Falls with Harm April 2010 – December 2012



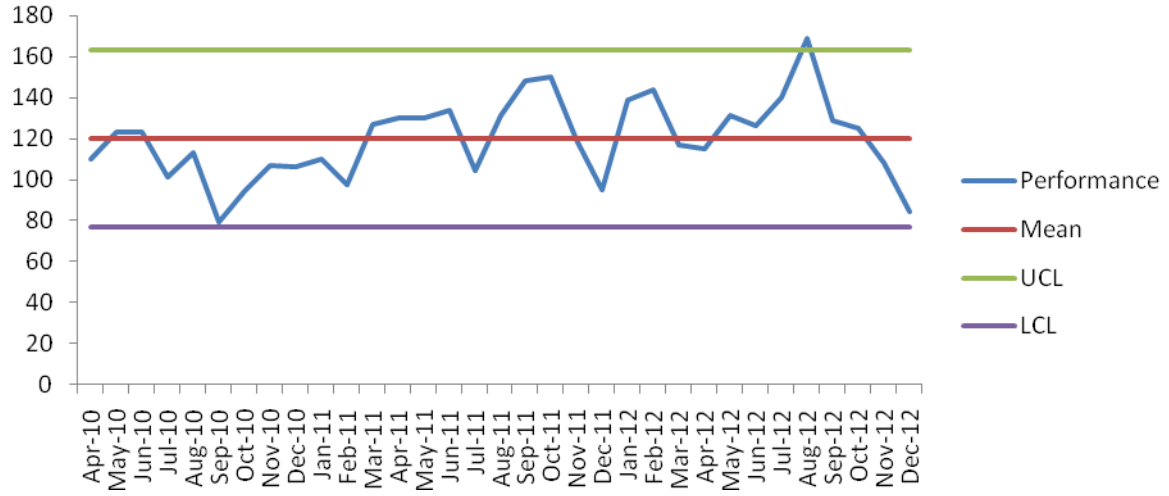
The number of falls with harm increased to above the mean in December for the first time since May 2012, however for Q3 the number reported has remained below the mean.

Graph 8. Falls from Height, Bed or Chair April 2010 – December 2012



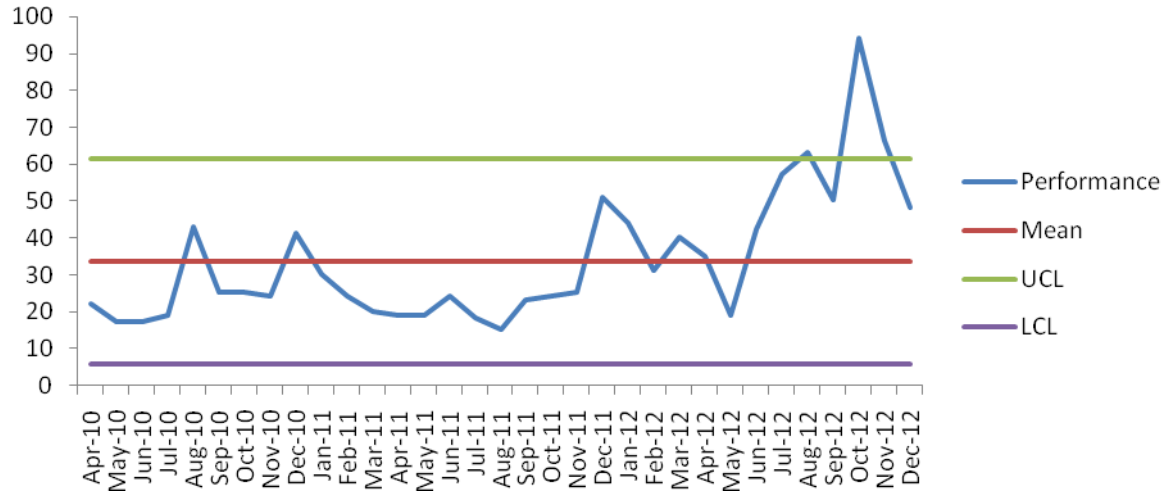
The number of falls from height have shown no significant variation from the mean since July 2012, although it should be noted that there was an increase in December.

Graph 9. Medication Errors April 2010 – December 2012



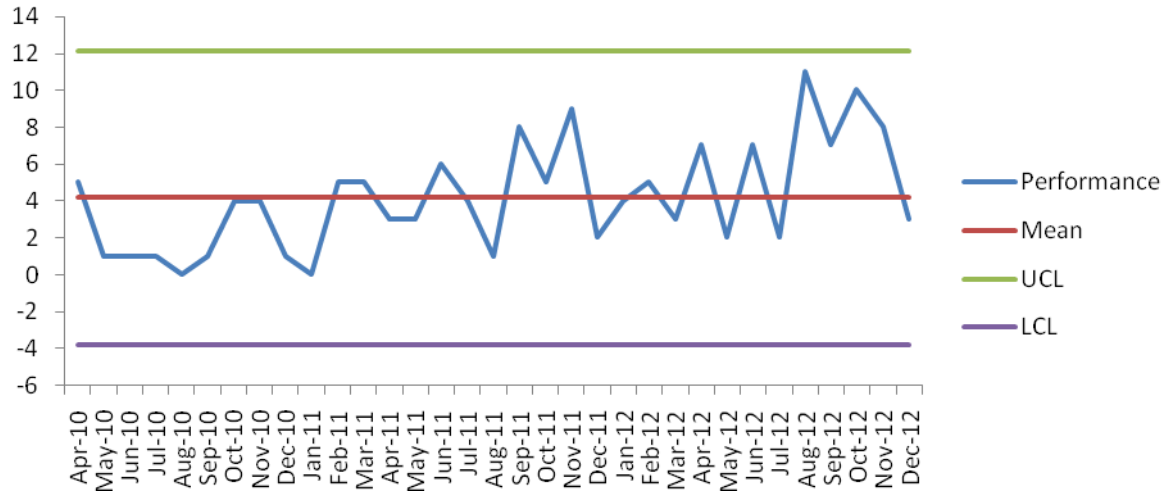
There was a significant increase in the number of medication errors reported in August 2012, however it is notable that there has been a month on month decrease in the following months.

Graph 10. Inadequate Staffing Incidents April 2010 – December 2012



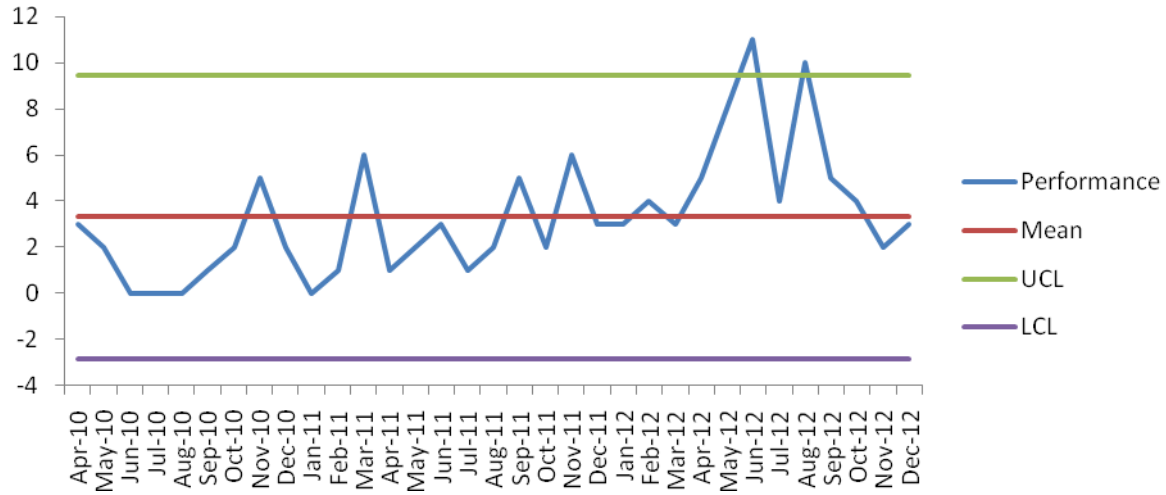
There was a significant increase in the number of reported staffing incidents in October, these incidents are monitored through the Nursing Directorate and actions implemented with the HoNs to resolve the issues identified, there has been a significant decrease in November and December.

Graph 11. Inadequate Response to Change in Patient Status Incidents April 2010 – December 2012



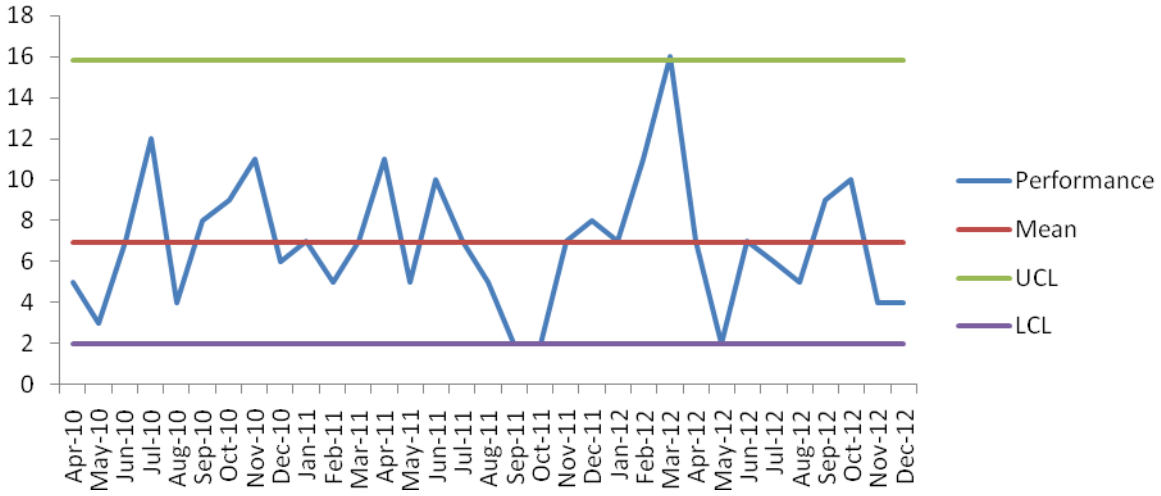
There was a peak of incidents relating to inadequate response to change in patient status in August 2012, following actions taken which are highlighted in section 5.14 there has been a notable decrease in the following months.

Graph 12. Patient Identification Incidents April 2010 – December 2012



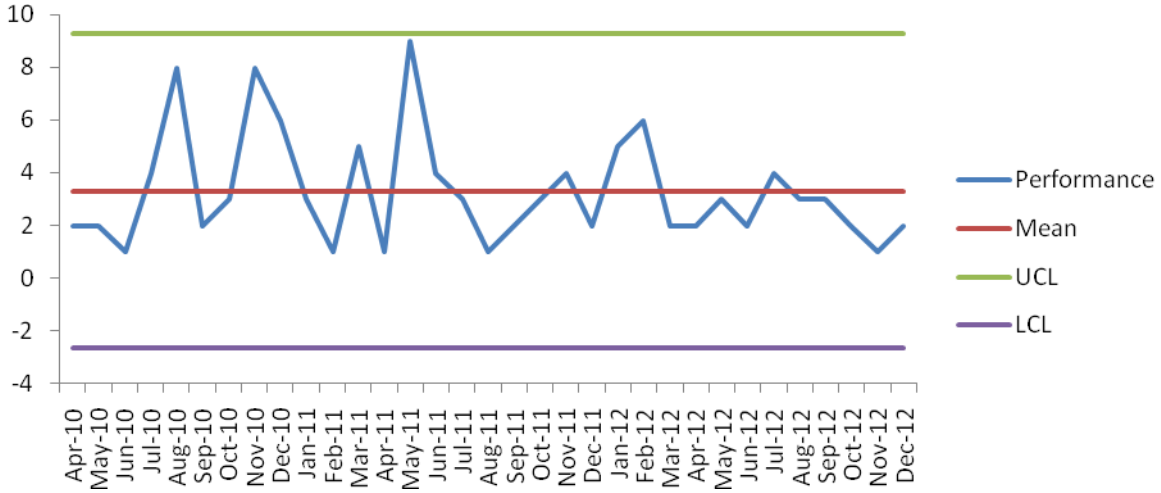
There was a significant increase in the number of ID incidents in June and August. However, following actions taken which are highlighted in section 5.14 there has been a notable decrease in the following months.

Graph 13. SIs April 2010 – December 2012



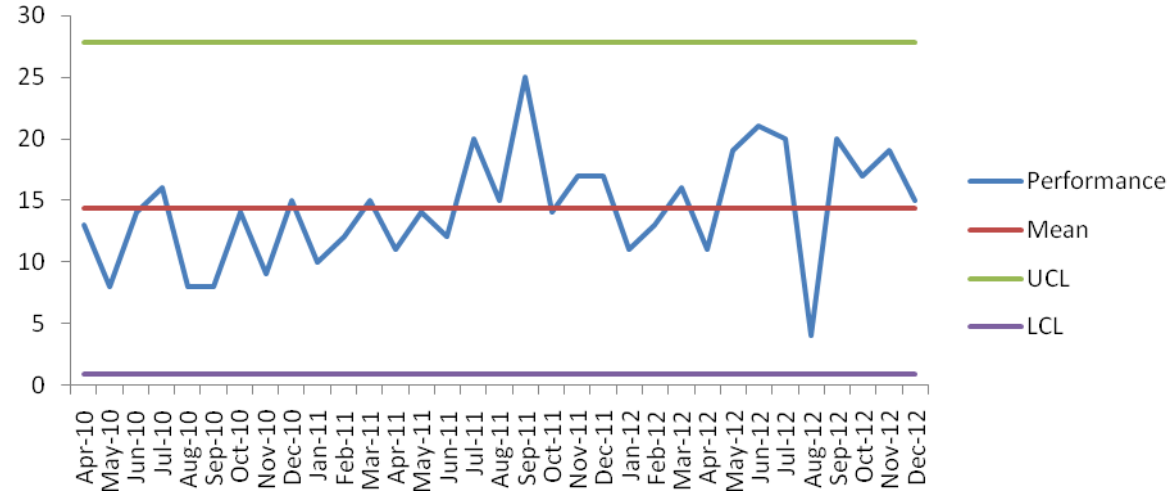
There was an increase in the number of Sis reported in October compared to Q2 followed by a decrease in November and December. It should be noted that there is significant variability in the number of Sis each month throughout the year and that there does not appear to be and trends relating to causation.

Graph 14. Maternity SIs April 2010 – December 2012



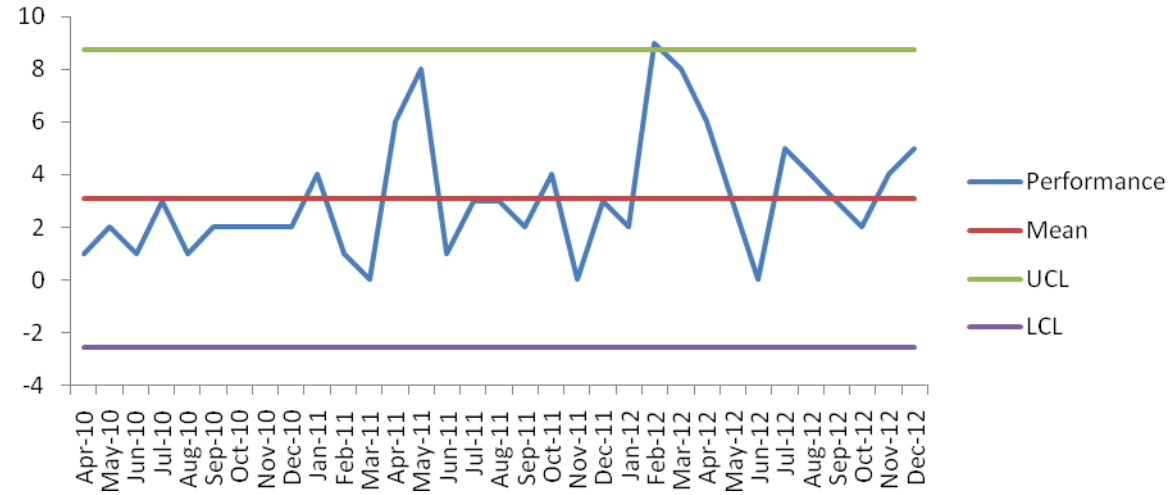
The number of maternity SIs have remained consistent since March 2012.

Graph 15. New Claims April 2010 – December 2012



There was a significant decrease in the number of new claims in August 2012, in Q3 the number of new claims has remained consistent.

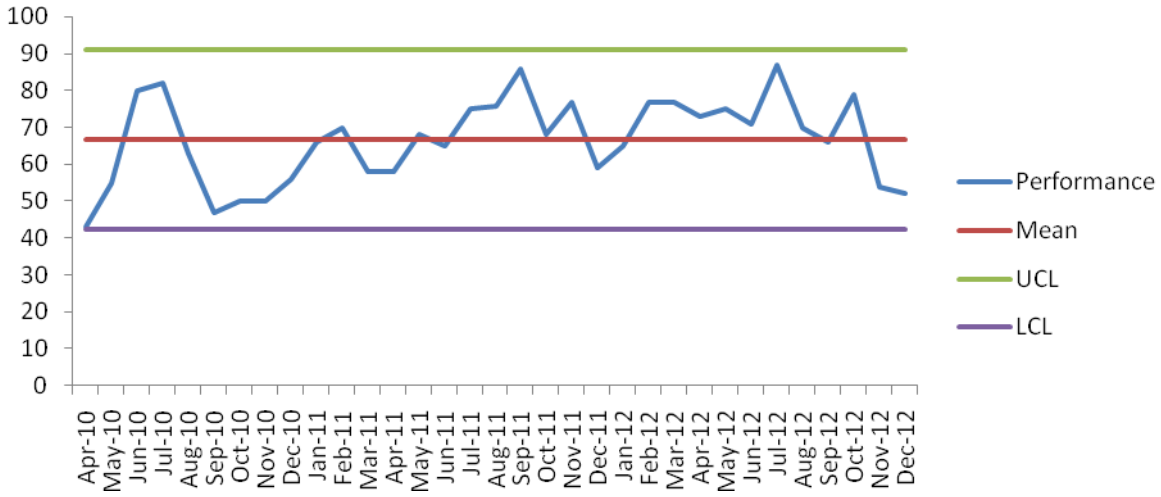
Graph 16. Settled Claims April 2010 - December 2012



The number of settled claims remains variable, this is due to the nature of the claims process and the length of time it takes to settle some claims.

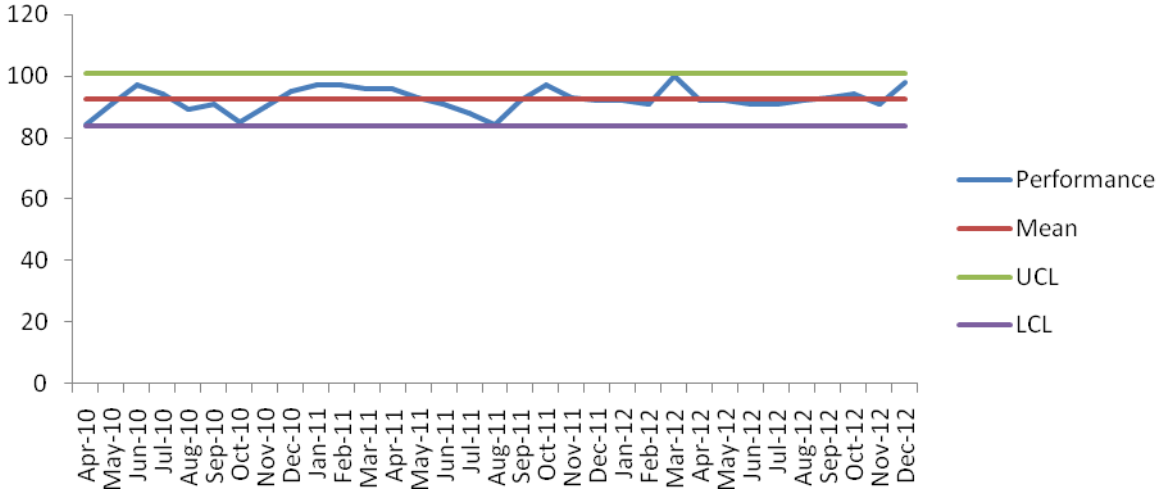
4.3 Patient experience

Graph 17. Complaints April 2010 – December 2012



There has been a notable decrease in complaints throughout Q3.

Graph 18. Complaints Response Time (%) April 2010 – December 2012



Complaint response time have remained consistent throughout Q3

5. DETAILED ANALYSIS OF Q2 DATA

5.1 Patient safety

5.1.1 Incident Reporting

The NRLS publishes six monthly public reports on the number and type of clinical incidents at each Trust. The average incident reporting rate across our peers - Acute Teaching Trusts is 6.9 per 100 admissions.

The Trust clinical incident reporting rate for Q3 is 6.6 per 100 admissions.

The incident reporting rate has increased from Q2 when it was 6.5 per 100 admissions. Further work in promoting incident reporting is ongoing through the reporting counts 'walkrounds' conducted by the Quality and Safety Team. The next walkround is due to take place on the 15th February 2013.

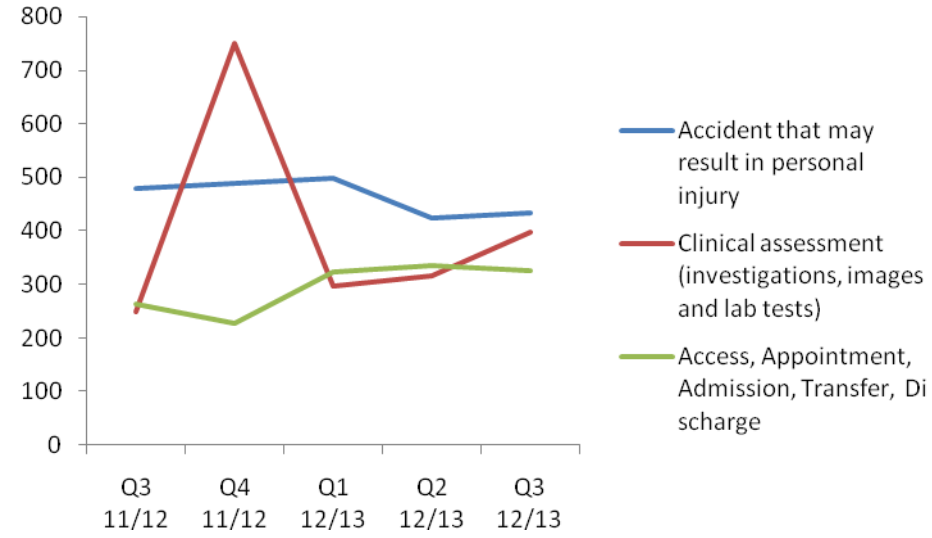
5.1.2 Severity (grade of harm) Reported Incidents

The most frequently reported category of harm for incidents remains 'no harm' at 66.4% for Q3, with minor harm reported in 25.9% of all incidents, moderate harm at 7.6%, major at 0.% and extreme at 0.1%.

5.1.3 Incident Themes

In Q3 there has been a change in the top three categories of incidents reported. The top three themes for this quarter are accident that may result in personal injury, clinical assessment (investigations, images and lab tests) and access, appointment, admission, transfer, discharge. In Q2 the top three themes were accident that may result in personal injury, medication and labour and delivery.

Graph 19. Top Three Themes for Clinical Incidents



From Q2 to Q3 incidents categorised as accident that may result in personal injury and clinical assessment (investigations, images and lab tests) have increased. Across the same time period, incidents categorised as access, appointment, admission, transfer, discharge have decreased very slightly.

Table 1. Accident that may result in personal injury top three by sub category

Sub-classification	Total 10/11	Total 11/12	Q3 11/12	Q4 11/12	Q1 11/12	Q2 12/13	Q3 12/13
Slips, trips, falls and collisions	87.8%	85.2%	84.1%	88.8%	86.2%	93.1%	90.8%
Accident caused by some other means	9.1%	8.9%	10.9%	5.5%	7.8%	5.7%	7.4%
Exposure to electricity, hazardous substance, infection etc	0.5%	1.3%	1.7%	1.2%	0.01%	0.9%	1.4%
Total all incidents in category	21.0%	17.9%	18.3%	15.5%	18.4%	13.9%	13.9%

It is notable that the top theme is consistently slips, trips, falls and collisions.

The most recent NRLS benchmarking data shows that this is also the top theme for our peers (23.1%).

Table 2. Clinical assessment (investigations, images and lab tests) by sub-category

Sub-classification	Total 10/11	Total 11/12	Q3 11/12	Q4 11/12	Q1 11/12	Q2 12/13	Q3 12/13
Laboratory investigations	64.0%	41.8%	72.2%	20.4%	69.2%	82.0%	85.1%
Images for diagnosis (scan/x-ray)	14.3%	7.3%	9.7%	2.9%	12.5%	7.3%	6.8%
Administration of assessment	4.7%	35.9%	10.5%	60.1%	5.4%	6.0%	3.5%
Total all incidents in category	6.5%	12.5%	18.0%	54.5%	9.7%	10.4%	12.7%

The most recent NRLS benchmarking data shows this category to be the 8th most frequently reported incident type for our peers (6.3%).

Table 3. Access, appointment, admission, transfer, discharge top three by sub category

Sub-classification	Total 10/11	Total 11/12	Q3 11/12	Q4 11/12	Q1 11/12	Q2 12/13	Q3 12/13
Discharge	23.6%	26.2%	21.3%	26.0%	24.5%	30.1%	35.8%
Transfer	21.1%	28.1%	33.5%	25.1%	25.7%	25.0%	26.3%
Appointment	12.0%	13.7%	14.1%	11.5%	17.6%	16.1%	16.2%
Total all incidents in category	9.6%	9.9%	10.0%	7.2%	10.6%	11.0%	10.5%

The most recent NRLS benchmarking data shows this category to be the 6th most frequently reported incident type for our peers (6.8%).

See appendix one for improvement actions linked to the Trustwide top three themes.

Site Specific Top Themes for Incidents

St Mary's Hospital: access, appointment, admission, transfer, discharge; labour and delivery; infrastructure or resources (staffing, facilities and environment)

Charing Cross Hospital: accident that may result in personal injury; clinical assessment (investigations, images and lab tests); implementation of care or ongoing monitoring or review

Hammersmith Hospital: accident that may result in personal injury; medication; clinical assessment (investigations, images and lab tests)

Queen Charlottes and Chelsea Hospital: labour and delivery; infrastructure or resources (staffing, facilities and environment); medication

Western Eye Hospital: access, appointment, admission, transfer, discharge; diagnosis failed or delayed; infrastructure or resources (staffing, facilities and environment);

5.1.4 Other Incident Types
Inadequate staffing reports have increased from Q2 (170) to Q3 (208) by 22%.

SMH has reported the most incidents of this type 81 (39%), followed by CXH 54 (26%). SMH reported the most incidents of this type in Q2.

CPG 5 reported the most incidents in relation to staffing 57 (27%). CPG 1 reported the most incidents of this type in Q2.

Slips, trips and falls are the most frequently occurring incident nationally (NPSA, 2011). The Trust has continued to report fewer falls compared to the national average of 5.6 falls per 1,000 occupied bed days. The Q3 rate was 3.54, compared to 3.65 falls per 1000 occupied bed days in Q2.

CPG1 consistently report the highest number of falls; this is possibly due to the nature of patients treated.

In Q3 there were 152 (39%) falls from height. This compares to 163 (41%) in Q2.

Inadequate response to change in patient clinical status (failure to rescue):
In 2011/12 a total of 52 failure to rescue incidents were reported across the Trust, of which 48 were graded as resulting in all levels of harm, 92%. (NRLS grading). For Q1 (16), Q2 (20) and Q3 (21) 2012/13 a total of 57 failure to rescue incidents were reported, 22 were graded as resulting in all levels of harm, 39%.

In Q2 there was 5 reported case graded as extreme/severe harm and in Q3 there was 1 cases graded as extreme/severe harm.

In Q3 SMH reported the highest number of failure to rescue incidents (9), 1 extreme, 4 moderate 3 minor and 1 no harm, an increase when compared to Q1 and 2. This increase could be attributed to the failure to rescue ward rounds being undertaken by the outreach teams to support staff in identifying any issues and assist with appropriate management.

Failure to rescue incidents were reviewed in Q2 to address contributory factors resulting in a series of meetings and immediate actions to minimise recurrent events. These included; site team proactive ward visits to high risk areas, review of medical rotas, inclusion of cases in future training for junior doctors, highlighting the need for progress around rationalising critical care/outreach services across the Trust and continued awareness raising. Additional actions approved for long term improvements include; a hospital at night improvement and change programme, increase support for junior doctors, immediate interim collaborative working model for critical care/outreach services, creation of an effective handover tool and further engagement of CPGs.

Patient Identification: There were 9 incidents in Q3, a decrease of 53% from Q2. None of the incidents were classified as extreme, major, or minor harm, 1 was classified as moderate and 8 as no harm. All incidents related to patients wrongly identified are reviewed monthly at the Clinical Risk Committee to identify any themes and Trust wide learning.

5.1.5 Serious Incidents (SIs)

In Q3 there were 18 SIs. This is a decrease on Q2 total of 20. It is notable, however, that SIs classified under Pressure Ulcers have increased.

The top themes for SIs Q3 were pressure ulcer (6), maternity (4) and infection control (2).

Data is refreshed monthly, since Q2 3 further Sis have been reported relating to incidents in Q2, the figure of 17 in the Q2 report has been updated to 20. The additional SIs are:
Unexpected Death/Failure to escalate; Wrong diagnosis; Grade 3 pressure ulcer.

5.1.5.1 Actions arising from investigated SIs

Of the 18 SIs that occurred in Q3, 8 investigations are complete with 100% compliance with NHS London investigation deadlines. The remaining 10 are within deadline and are currently under investigation, within deadlines.

The total number of completed actions at Q3 were 51 out of 83 due which represents 63% completed to deadline. Please see appendix two for a record of all SI actions from Q3.

Compliance with the being open policy in Q3 was 100%, all patients where appropriate received a letter informing them that an investigation was being undertaken, were offered a copy of the report and a meeting with clinical staff.

5.1.6 Never Events

Never Events are often serious, largely preventable patient safety incidents that should not occur. They are reportable events to the Commissioners and to NHS London. They include: retained swabs, wrong site surgery, wrong procedure and mis-placed naso – gastric tube. The date of reporting the event is based on when the Never Event was identified and in the case of retained swabs may be some months post initial procedure. Never Events and all other types of performance notices are reviewed by the Commissioners with the Trust at monthly meetings. One never events was reported in Q3. This was a retained vaginal swab which occurred in October at QCCH.

5.1.7 Claims

There were 51 new claims received during Q3 and 6 claims settled. Of the new claims received, 45 relate to alleged clinical negligence while the remaining six relate to personal injury.

New Claims top theme The top theme across the Trust and CXH, and joint top at SMH, was a failure/delay in treatment. This was also the top theme in CPG3. Additionally, three claims were received that related to failure to recognise a complication of treatment within CPG3. No further themes were evident across the sites or CPGs in Q3.

Settled Claims top theme A significant percentage of claims settled in Q3 involved a failure to recognise a complication of treatment and inappropriate treatment across the Trust. The numbers for these themes were cumulative across the different sites and CPGs. No single site or CPG had a high number of claims settled in this period.

Table 7. Top three themes for new clinical claims

	2010/11	2011/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13
Failure to diagnose/delay in diagnosis	16%	22%	18%	21%	17%	17%	9%
Failure to recognise complication of treatment	13%	11%	11%	15%	11%	9%	9%
Failure/delay in treatment	11%	9%	9%	9%	8%	6%	13%
Totals	118	161	45	45	36	35	45

NB Some claims have multiple themes

Table 8. Top three themes for new non-clinical claims

	2010/11	2011/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13
Slips, trips, falls and collisions	46%	48%	67%	33%	40%	22%	17%
Lifting accidents	8%	9%	0	17%	13%	11%	0
Injury caused by physical or mental strain	4%	9%	0	17%	13%	0	0
Totals:	24	23	3	6	15	9	0

NB Some claims have multiple themes

Appendix one shows improvement actions from two of the settled claims

5.1.7.1 Risk Management Reports

One risk management report was received from the Trust Panel Solicitors in Q3:

Table 9. Risk management issues and action points

Risk Management Issues	Suggested Action Points
Alleged negligent peri-operative and post-operative monitoring and record keeping	Training
Alleged staff shortages	Review Trust staffing procedures: training
Alleged equipment failures	Audit of relevant equipment (blood gas machines and cardiac arrest trolleys)

The NHSLA is exploring various options to improve upon its work in assisting Trusts to learn from incidents that lead to claims and ensure that appropriate steps are taken to improve patient safety going forward. A proposed expert feedback pilot is currently being considered as a potential replacement for the Solicitor's Risk Management report project which will help provide the Trust with more focused and relevant opinion. This will help us to consider possible changes to avoid similar incidents occurring in the future.

The experts' feedback also has the benefit of assisting the NHSLA in collating data to assess the underlying features of Trusts' claims as well as being able to prepare case studies for the benefit of the Trust and/or the wider NHS.

5.2 Clinical effectiveness

5.2.1 NICE Guidance

Table 10. NICE Guidance Q3

	2011/12 Year end	Q1 2012/13	Q2 2012/13	Q3 2012/13
Number of 'live' NICE guidance	750	759	776	794
Not applicable to ICHT	235 (31.3%)	234 (31%)	237 (31%)	244 (31%)
Applicable to ICHT	515	525	539	550

Compliant	417 (81.0%)	420 (80%)	431 (80%)	439 (80%)
Partially Compliant	33 (6.4%)	34 (7%)	34 (6%)	33 (6%)
In progress	15 (2.9%)	16 (3%)	18 (3%)	18 (3%)
Blanks (awaiting confirmation of compliance)	50 (9.7%)	55 (11%),	56 (10%)	60 (11%)

NICE compliance activity has maintained the pace of new publications. The full Quarterly Report has been modified to clarify which guidance requires priority review by CPGs, via a summary table of NICE guidance items for which no compliance declaration has been received and recorded.

5.2.2 CAS alerts (National Safety Alerts)

There have been 937 CAS alerts issued since 2004. 99.7% of these have been closed to deadline. The three alerts overdue for closure are all Medical Devices Alerts awaiting CPG responses. All NPSA and EFA alerts have been closed.

5.2.3 Clinical audit

National Clinical Audits

The National Clinical Audit Programme is administered by HQIP and the DH and is included as an indicator in the Quality Account. As at Q3, assurance has been received from the CPGs that the Trust is participating in 49 out of the 50 audits for which the Trust is eligible (98%). The project for which assurance continues to be sought is the National Pain Database. The CPG Director is aware of current participation status.

Trust Priority Clinical Audits

The 2012/13 CPG Priority Clinical Audit Programme has commenced. Each project was been given an anticipated date of completion by the respective CPG and thus far, 56.3% of priority clinical audits have been completed to deadline in Q3. Recommendations are monitored for implementation status following audit completion. As at Q3, 66.7% of actions from priority clinical audits due for completion in Q3 have been recorded as being completed. All overdue items have been escalated to the respective CPGs for immediate action. The principle causes are over-ambitious target deadlines being set and unforeseen delays in completion of projects due to competing priorities.

Local Clinical Audit

The registration of local clinical audit continues. Since April 1st 2012, in addition to National audits and local priority audits, a further 139 local clinical audits have been registered on the Clinical Audit Projects Database.

5.3 Service quality (Patient experience)

5.3.1 Complaints

A total of 212 formal complaints were received in Q3. 185 were formally investigated and 27 low risk grade cases were investigated by PALS. The numbers of formal complaints managed by the Complaints Department in Q3 fell by 17% when compared to Q2 (223 formal complaints).

5.3.1.1 Number of complaints per CPG

The fall in the number of formally investigated complaints reflected a reduction of complaints for CPG3 (down 54%), CPG5 (down 21%) and CPG6 (down 62%). CPG1 and CPG2 remained relatively static whilst CPG4 and 'others' increased in Q3.

CPG4 formal complaints increased 57%, in part due to an increase in complaints concerning vascular surgery, up from 1 to 6 complaints. Service improvements following the formal complaint investigation include:-

- Food will no longer be kept in fridges in the cath labs. A number of meals will be ordered from the catering team at lunch time and, if food is required at other times of day, it will be requested on individual basis. If there is a point where it becomes necessary to store food in the ward fridges, a rota for checking food items in the fridges will be used. Staff will also be reminded of the importance of checking the 'Eat By' date on food before giving it to patients
- Staff have been reminded of the importance of clearly conveying information to patients about the wards' features and facilities. Staff have also been reminded of the importance of reminding relatives when patients have been transferred between wards and hospital sites as soon as the transfer arrangements have been confirmed. It has also been made clear to staff the need to make every effort to make contact with next of kin and to document in the notes exactly what efforts have been made.
- The My Action 'End of Programme' letters have now been reviewed so that they now clearly state how many sessions an individual has attended. Also the pre-class documentation made available to patients has been updated. Additionally the ambulatory blood pressure monitoring unit has been advised that patients can attend My Action exercise classes should they wish
- The Vasular Surgery MDT has now reminded its members of the importance of entering accurate information on the electronic discharge form
- Discussions among staff members have taken place regarding the importance of providing patients with detailed information about post-procedure care. Highlighting the availability of documents and leaflets. Nurses have also discussed the importance of encouraging patients to raise any questions or concerns about post-procedure recovery before the patient leaves the ward
- General discussions have taken place with nurses on the ward about the importance of dignity and respect, and specifically the need to support patients in a dignified way when they need to be assisted in the bathroom. Also it has been reiterated to staff that it is not appropriate to administer injections in the waiting room.

'Others' complaints increased by 66% (6 to 10) due to an increase in complaints concerning Estates & Facilities, up from 2 to 8 complaints. Service improvements following the formal complaint investigation includes:-

- Communication methods throughout the patient transport process have now been fully reviewed by the management team to try and improve communication within their various teams and with patients
- Our IT systems manager will review why some of our appointment letters have provided incorrect instructions. Additionally, the Outpatient Service Manager and Service Manager - Outpatient Access have reminded their staff of the importance of providing an explanation to patients when agreed appointment times are changed
- Doctors and managers from the Allergy and Dermatology Departments have now met to discuss the pathways for patients who are referred into their services to try and find a better way of managing their care. It is planned to reduce waiting times and make it clear to patients and referring doctors which service patients should be referred too
- The Booking Office team have now reviewed their processes and procedures to help ensure patients choices through the Choose and Book system are highlighted and adhered to where possible.

Appendix one provides further examples of improvement actions from complaints.

5.3.1.2 Response rate

The Trust has set an internal target of responding to 90% of complaints within a timescale agreed by the complainant. The Trust can ask for one extension of this timescale. Complaint responses sent out after the response date (if not extended) or after the extended response date are recorded as a 'breach' of this target. For Q3 94% of all formal complaint responses were completed within the agreed timescale.

5.3.1.3 Top Themes

The top three themes for Q3 were all aspects of clinical treatment, communication/information to patients and appointments, delays/cancellation (outpatients). The same pattern was seen in Q1 and Q2 2012/13.

Table 11. Top three themes complaints

Theme	2010/11	2011/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13
All aspects of clinical care	46%	46%	38%	57%	43%	51%	57%
Communication / Information to patients	5%	12%	20%	19%	24%	17%	8%
Appointments, delays / cancellation (outpatients)	16%	12%	8%	10%	19%	8%	7%

Table 12. All aspects of clinical care top three sub-categories by CPG

CPG	1st Sub Category	2nd Sub Category	3rd Sub Category
CPG1	Poor Clinical Care (13)	Poor Nursing Care (6)	Ineffective treatment (2)
CPG2	Poor Clinical Care (10)	Poor Nursing Care (4)	Misdiagnosis (2)
CPG3	Poor Clinical Care (5)	Poor Nursing Care (5)	Results not available (2)
CPG4	Poor Clinical Care (6)	Poor Nursing Care (3)	Operation Delayed (1)
CPG5	Poor Nursing Care (9)	Poor Clinical Care (5)	Lack of treatment (2)
CPG6	Results not available (3)	N/A (0)	N/A (0)

Table 13. All aspects of clinical care top three sub-categories by site

Site	1st Sub Category	2nd Sub Category	3rd Sub Category
Charing Cross	Poor Clinical Care (12)	Poor Nursing Care (9)	Ineffective treatment (2)
Hammersmith	Poor Clinical Care (5)	Poor Nursing Care (3)	Incorrect Drugs Given (3)

Queen Charlotte	Poor Nursing Care (5)	Poor Clinical Care (1)	Lack of Treatment (1)
Satellite	Poor Clinical Care (1)	Lack of Treatment (1)	N/A (0)
St Mary's	Poor Clinical Care (20)	Poor Nursing Care (10)	Ineffective treatment (2)
Western Eye	Results Not Available (1)	Refused Treatment (1)	N/A (0)

Table 14. Communication/information to patients top three sub-categories

Sub-Category	Q3
Incorrect information given to patient	46%
Information not given to patient	26%
Other information	16%

Table 15. Appointments, delays/cancellation (outpatients) top three sub-categories

Sub-Category	Q3
wait	31%
Delay in follow up appointment	23%
Appointment cancelled – not notified	15%

The top themes of complaints for each site in Q3 were:

SMH, **CXH**, **HH** and **QCCH** displayed the same top two themes as Trustwide, the third top theme was attitude of staff.

WEH displayed the same pattern as the Trust wide top themes.

5.3.1.4 Severe Complaints

There was one high risk grade complaint in Q3 which is currently under investigation:

CPG2 Possible SI (alleged missed diagnosis)

5.3.1.5 Second Stage Reviews

Complainants can request that the Associate Director of Service Quality to review their complaint if they remain dissatisfied with the outcome of their complaint investigation. One request for a second stage request occurred in Q3 for CPG2 regarding our decision not to provide surgery. This case is now with the Parliamentary and Health Service Ombudsman for review.

5.3.1.6 Inquests

In Q3 there were two inquests which produced significant learning for the Trust, which can be found in appendix one.

6. RISK PROFILE

The risk profile analyses the top theme for incidents, complaints and claims at Trust level, at individual CPG level and at individual site level.

Trustwide top themes for incidents, complaints and settled claims have not changed from those identified in Q2. For new claims the top theme has changed from failure to recognise complication of treatment to failure/delay in treatment.

Incidents top themes vary from Q2 to Q3. CPG 2 has changed from medication to infrastructure or resources, CPG 3 has changed from accident that may result in personal injury to treatment, procedure, CPG 4 has changed from medication to accident that may

result in personal injury, SMH has changed from medication to access, appointment, admission, transfer, discharge and WEH has changed from infrastructure or resources to access, appointment, admission, transfer, discharge.

Complaints top themes have not changed from Q2 to Q3 except for CPG 6 which changed from communication/information to patients to all aspects of clinical treatment. It is notable that at every level of analysis all aspects of clinical treatment was the top theme for complaints.

New Claims top theme The top theme across the Trust and CXH, and joint top at SMH, was a failure/delay in treatment. This was also the top theme in CPG3. Additionally, three claims were received that related to failure to recognise a complication of treatment within CPG3. No further themes were evident across the sites or CPGs in Q3.

Settled Claims top theme A significant percentage of claims settled in Q3 involved a failure to recognise a complication of treatment and inappropriate treatment across the Trust. The numbers for these themes were cumulative across the different sites and CPGs. No single site or CPG had a high number of claims settled in this period.

Improvement actions are to be agreed at the Clinical Risk Committee. The full risk profile can be found in appendix three.

7. QUALITY ACCOUNTS

Appendix four presents the Trust Quality Accounts scorecard. The Q3 scorecard contains performance against all agreed targets excluding those where the data is annual or bi annual.

Data for emergency readmissions is now available for benchmarking however the national average will not be known until the end of the year when the Department of Health publish it. SHMI data is only available up until March 2012.

In Q3 a number of priorities are on or above target including falls, C-difficile rates, MRSA rates, pressure ulcers and incidents graded as major and extreme.

We continue to meet our quarterly and annual targets for C-difficile and MRSA; however in the last quarter we have seen an increase in both. This is partly due to seasonal variations and the impact of increased surveillance due to the recent outbreak of Norovirus. Infection control continue to work closely with the wards to ensure good infection control measures are in place especially during these higher risk times.

There are a number of priorities which are not meeting targets.

Indicator 1: The quarterly target for pressure ulcers graded 3-4 is 5.5. The key performance indicator for the past quarter was 6. Overall, our annual target is 22 and we are currently at 12.

Indicator 2: The Trust is currently below the national average for the patient safety reporting rates, although it is on an upward trend. There are site specific differences for reporting rates. Reporting rates are being addressed via the Quality and Patient Safety Team

walkarounds to promote the importance of incident reporting and identify barriers to reporting. The next one takes place on the 15th February 2013.

Indicator 3: The Trust is above its quarterly and annual target for the total number of failure to rescue incidents. At present our annual target was <52 and we are currently at 57. It is predicted that the next quarter may increase as a consequence of the intensive teaching programmes in the Trust during January and the launch of the new EWS observation chart. This will inevitably increase our reporting in the short term but is anticipated to improve practice and reduce these incidents in the longer term.

10. NRLS SERVICE QUALITY REPORT

From April 2012 The Trust took over the operational management of the NRLS for a 2 year period. The NRLS team is based within the Governance department.

The following reflects NRLS Team's performance during the period between 01/10/2012 and 31/12/2012 against agreed performance targets with the NHS Commissioning Board.

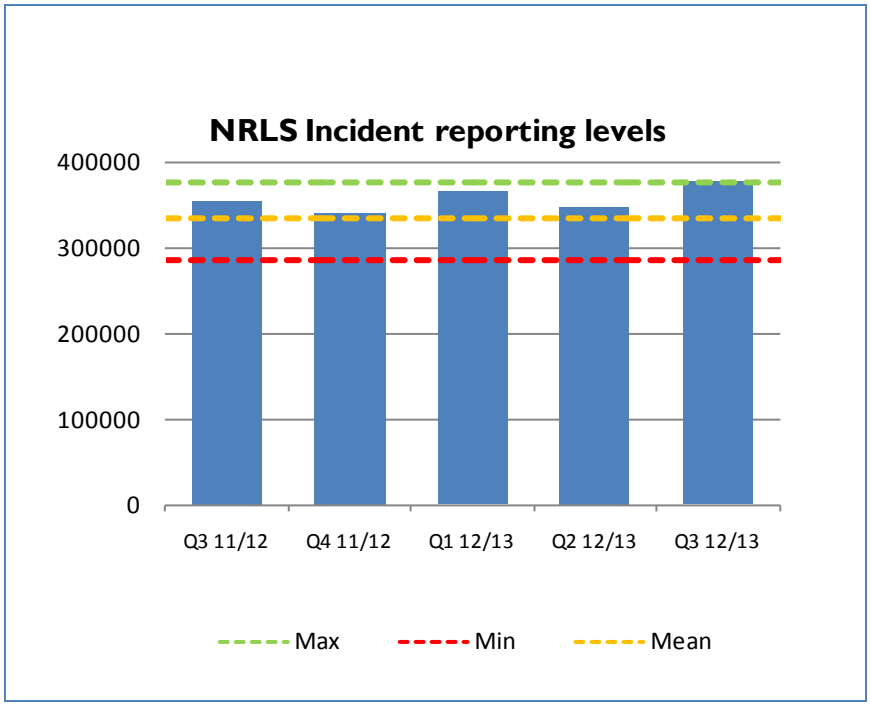
10.1 Key Updates

- During Q3 of 2012/13 NHS organisations reported 378,166 incidents to the NRLS; It is an increase of 6.8% above 2011/12 Q3;
- The NRLS Team has successfully and timely performed, managed and delivered all agreed NRLS functions and outputs for the quarter against the performance schedule proposed in the Memorandum Of Understanding (MOU)
- The timeliness of incidents being reported has remained in the low thirties for the previous seven months;
- A additional field to capture Never Events was added to the NRLS taxonomy together with other enhancements to the current system delivered in 2012/13 Q3;

10.2 National Incident Reporting

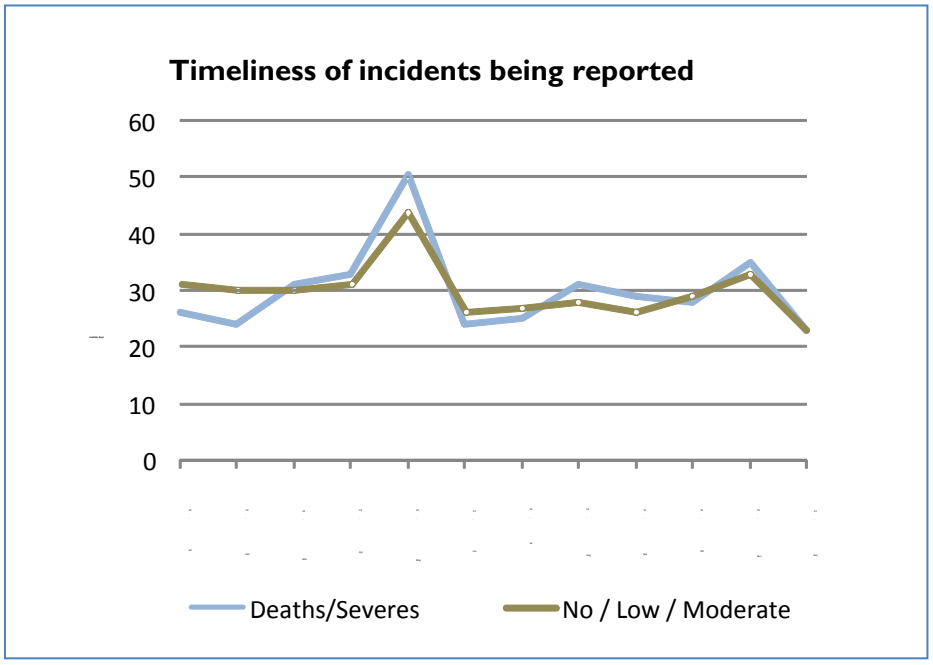
During Q3 of 2012/13 NHS Organisations reported 378, 166 incidents to the NRLS. This shows an increase of 6.8% compared to Q3 of 2011/12, and an increase of 8.9% compared to Q2 of 2012/13.

Graph 19. NRLS Incident Reporting Levels



The reporting trends shows that peaks occur in Q1 and Q3, possibly due to the deadline for submitting incidents to the NRLS for inclusion in the Organisational Patient Safety Incident Reports (OPSIRs), therefore the increased in the number of reports received in Q3 when compared to Q2 of 2012/13 was expected. It was expected that November would exceed the number of incidents received in May 2012, however the data show that the increase was better distributed across previous months resulting a much better result on the timeliness of incidents being reported as the graph below shows.

Graph 20. Timeliness of incidents being reported



10.3 Delivery against Agreement

All NRLS outputs agreed on the MOU were delivered on time and to expected quality.

The number of ad hoc requests has fluctuated within the capacity predicted on the MOU.

Appendix One: Example improvement actions from incidents, complaints and claims

Example improvement actions from reported incidents linked to top three themes

Accident that may result in personal injury

- Continued use of bed and chair alarms for patients who are at high risk of falling
- Continued use of 1-1 nurses for patients who are at high risk of falling
- Patients who are at high risk of falling positioned in a bed closer to nurses station where possible
- Provide patient with hospital slipper/socks if available.
- Continue to advise and encourage patients to call for help if they feel unsafe / unstable to mobilise.
- CPG 1 are piloting a root cause analysis investigating tool for the investigation of inpatient falls.

Clinical Assessment

- Staff reminded to follow Standard Operating Procedures and Guidelines
- Improved communication lines for admin and MDT. Staff agreed to stagger appointments and double check all labelling
- Cell Path always needs a request form, this was reiterated to the sender. This requirement is also cascaded to new starters at the Trust nurse induction.
- To reduce the likelihood of confusing the two solutions in the future the bottles of wash concentrate and Trigger will be stored in physically separate areas so staff are required to go to different areas to collect the bottles.
- MLA staff have been reminded of the importance of attention to detail when labelling patient samples. Staff have been trained to label samples so that the patient label is not covered by the laboratory label

Access, Appointment, Admission, Transfer, Discharge

- Night porters have been advised to handover to day staff and not to leave the hospital until staff has arrived to take over.
- Significant delay in diagnosis and treatment of patients as only one bed lift working in the QEQM.
- Delay in porter's arrival of nearly two hours causes delay in the patient's treatment.
- There have been twenty cases of patients absconding in Q3 - Yr 12/13.
- Lack of beds availability in the Renal Unit causes a number of patients not being unable to be transferred from the external hospitals.

Example improvement actions from complaints linked to top three themes

All Aspects of Clinical Care

- Each consultant has now been reminded by email how to correctly cancel blood tests, which they can share with their teams
- A&E is currently investigating how we can stop the creation of multiple sets of notes for patients. Also the importance of polite and clear communication has been discussed at a staff meeting
- ICU has created a difficult airway trolley to keep all airway equipment in one place so that it is easily available in the event of an emergency. Also a

percutaneous tracheotomy protocol has been written which will include standards for staffing, equipment and monitoring and improve access to surgical help if required

- To help improve the care provided an additional midwife has been allocated to the Triage Unit / Delivery Suite, which will help ensure 1:1 care is provided for wormen in labour. Additionally, a senior midwife for the Delivery Suite has been appointed to improve the patient experience
- Theatre staff have been informed by Theatre Manager to be vigilant of the hazards of burns from light leads and diathermy leads
- The importance of checking a woman's drug allergies before writing a prescription and of the importance of listening to women will be highlighted to all doctors and midwives via the maternity newsletter
- We are now reviewing the availability of paediatric PCA pumps to increase avilability and will acquire new pumps. We have also re-iterated to our medical and nursing teams how important good pain control is for children, and that they must put this as a very high priority in organising care of their patients.
- Infants with rapidly rising head circumference will now have a same day head ultrasound scan

Communication/Information to Patients

- Staff have been reminded of the importance of sharing information in a sensitive manner when doing a hand over at the bed side
- All nursing staff on Rodney Porter ward have now received electronic discharge training
- Nursing staff have been reminded to inform patients if they need to disturb their sleep to take observations. Also staff have been reminded that same sex care must be provided if requested, otherwise their line manager must be informed
- Riverside Ward now provide a morning and afternoon nurse ward round undertaken by the nurse in charge to help improve the patient experience. They introduced themselves to patients and respond to any concern they may have
- The clinical nurse specialists will be more explicit in explaining to patients the importance of informing the department of any investigations or procedures that may contraindicate their medication

Appointments, delays/cancellation (outpatients)

- The Urodynamics Clinic will in future now rebook patients' appointments on the day of cancellation to help reduce any delay in being seen. Additionally, the Urodynamic Service is now being supported with more nurses to help reduce the time patients have to wait for their procedure
- Administrative staff at the Western Eye Hospital have been reminded of the importance of sending appointment conformation letters in a timely fashion
- The appointment system for the Plastic Surgery Clinics has been reviewed due to an increase in the number of patients seen to help minimise delays

- Secretaries looking after the paediatric service have been reminded to escalte backlogs to thier line manger so that extra resouce can be obtained to ensure patiebts receive their correspondence as quickly as possible
- Women who have suffered a recent bereavement will no longer be asked to attend routine phlebotomy clinics
- A combined neonatal/paediatric clinic for children with complex needs will now be established to help improve the care we offer
- Referring teams have been reminded that requests for urgent scans, or the suggested date by which they are required, should be indicated on referrals

Proposed service improvements following inquest heard in Q3 for CPG5

- Staff should be aware that SHO rotation and changeover can cause issues which suggests that at these times in the year the condition for errors is multiplied because of new staff
- Leadership of a medical cases should seek reasons behind symptoms to help give direction
- New staff should understand the inter-relations - for example between PICU and the wards and communication between PICU and wards and at a clinician level
- We need to increase awareness about myocarditis presentations especially as similar to sepsis
- The Trust should review it's post-natal policy against DoH information concerning cot-deaths and raise awareness with midwives if changed
- The Trust should review and decide practically how the risk of co-sleeping is conveyed to women on the postnatal ward and consider if further training is required so that our staff know what to do when a baby sleeps with mother.

Two settled claims had improvement actions in Q3:

Failure to diagnose/delay in diagnosis

- Detailed examination of the palate was added to the Newborn Physical Examination Maternity Guidelines;
- There is currently ongoing dialogue between CPGs 1 and 6 on ways to ensure a greater percentage of fractures are identified and acted upon following X-rays.

Slips, trips and falls

- The pavement around the Mary Stamford Wing was repaired following the incident.

Surgical foreign body left in situ

Some of the recommendations implemented following the completion of an SUI report:

- Perineal repairs following a vaginal delivery need to be treated the same as any other operative procedure

- A policy was developed for swab counting in the maternity setting, which included who the accountable person was for counting and documenting the swabs and instruments used
- A proforma for instrumental deliveries was implemented which includes the NPSA recommendation of double signatory and audit compliance
- The contents of the procedure packs were reviewed to ensure that small swabs are no longer a part of the pack and medium swabs with a tape are supplied as standard
- The WHO surgical safety checklist was reviewed for use when performing perineal repairs in theatre
- The whiteboard in the Labour Ward theatre was reviewed to ensure there is permanent space for swab counts
- The learning from this case was added to the doctors induction and the maternity mandatory training
- There was a Section in the maternity newsletter ‘Risky Business’ on swab counting

Table 4. Actions from Q3 SIs

STEIS ID	CPG	Site	Reporting criteria	Description	Action	Lead	Deadline	Progress
2012_22641	5	SMH	Maternity Services	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_24727	5	QCH	Maternity Services	Unexpected neonatal death	No actions	No actions	No Actions	No actions
2012_25176	1	SMH	Infection control	C-Diff on part 1a of death cert	Clinical Director to circulate the current Clostridium Difficile policy to all medics within the CPG.	Clinical Director CPG 1	31st January 2013	Within timeframe
2012_25176	1	SMH	Infection control	C-Diff on part 1a of death cert	Reminder to all clinical teams that when a patient is positive for clostridium difficile a senior review should be initiated.	Clinical Directors all CPGs	31st January 2013	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	All staff regardless of start date to attend local induction that includes education regarding the swab count policy and to sign local induction checklist re understanding an complying with Trust policies	Practice development midwives College tutors	Jan-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	A4 sized white boards to be purchased for all delivery rooms on delivery suite	Labour ward matrons	Jan-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	Swab counts performed in delivery rooms to be recorded pre-procedure on new A4 white boards by individual who opens swabs. Post-procedure swab counts to be performed by surgeon and witness, ensuring consistent with documented swab count on white board. Confirmation of number of swabs used in procedure and accuracy of final count to be recorded in maternity notes.	Head of Midwifery, Chief of Service Obstetrics	on arrival, by end Februarys 2013	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	All used swabs to be placed in a disposable kidney dish in delivery rooms from where they will be counted post-procedure	All staff performing perineal repair	Jan-13	Within timeframe

2012_25937	5	QCH	Never Event	Retained vaginal swab	Inform all staff that person performing suturing is responsible and accountable for all swabs before, during and after the procedure	Head of Midwifery, Chief of Service Obstetrics	Jan-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	Develop structured handover guidance in the revised maternity swab count policy re patients who requires transfer to theatre and with heavy bleeding from local vaginal trauma, a vaginal pack can be used for haemostasis and needs to be handed over to theatre team. Swabs not to be inserted in vagina during transfer to theatre	Head of Midwifery, Chief of Service Obstetrics	Feb-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	Adapt and then relaunch WHO checklist used in theatre. Final sign out to be confirmed by scrub nurse and surgeon	Chief of Service Obstetrics	Feb-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	Revise swab counting policy and swab counting booklet with above amendments and then relaunch policy. All staff to confirm policy has been read and understood and comply with, develop an audit programme and feedback mechanism to staff	Lead Midwife	Feb-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	Clarify and communicate across both sites clinical indicators for the use of tampons	Chief of Service Obstetrics	Feb-13	Within timeframe
2012_25937	5	QCH	Never Event	Retained vaginal swab	Refer staff involved in the care to line managers/supervisors to identify and address any HR issues related to non-compliance	Director of Midwifery, Chief of Service Obstetrics	Feb-13	Within timeframe

Table 5. Actions from Q1 SIs

STEIS ID	**CPG**	**Site**	**Reporting criteria**	**Description**	**Action**	**Lead**	**Deadline**	**Progress**
2012_10134	5	QCH	Maternity Services	Maternal admission to ITU	Feedback to clinical staff regarding the documentation of a plan of care	Clinical lead	30th June 2012	Complete

2012_10134	5	QCH	Maternity Services	Maternal admission to ITU	Ensure all staff are aware of the procedure to contact interpreters as per policy	Clinical lead / Midwifery lead	30th June 2012	Complete
2012_11642	3	SMH	Unexpected death	Unexpected death	Implement updated Trust tracheostomy guidelines in ITU SMH	Critical Care Nurse Consultant	31st August 2012	Complete
2012_11642	3	SMH	Unexpected death	Unexpected death	Roll out an education for all of July with the aim to have 75% of ITU nursing and physiotherapy staff educated before implantation in the change of practice (the use of inner cannulas for all tracheostomies) is commenced.	Clinical educators Senior ITU physiotherapist	Teaching: July 1st - July 31st New practice: August onwards	Complete
2012_11642	3	SMH	Unexpected death	Unexpected death	ITU physiotherapists will change their Trust teaching information to reflect and incorporate the use of inner cannulas.	Senior ITU physiotherapist	31st July 2012 - Ongoing	Complete
2012_11642	3	SMH	Unexpected death	Unexpected death	Remind staff on the unit about the importance of accurate documentation	Senior Nurse ITU	31st July 2012	Complete
2012_11664	1, 4	CXH/ SMH	Communicable disease	TB lookback	Communicate with medical staff in respiratory medicine and emergency services that if TB is suspected, the patient needs to be investigated and isolated until the diagnosis is proven	Chief of Service, Clinical Infection and Respiratory Medicine and Chief of Service for Emergency Services	31st July 2012	Complete
2012_11664	1, 4	CXH/ SMH	Communicable disease	TB lookback	Explore with Medical Records the feasibility and timeframe for patients at Imperial College Healthcare to have a single set of health records.	Patient Safety Manager	31st July 2012	Complete
2012_11664	1, 4	CXH/ SMH	Communicable disease	TB lookback	Ensure the Trust is aware of all the results from the 27 people identified as requiring screening	TB lead consultant and Consultant Infectious Diseases	31st August 2012	Complete
2012_11664	1, 4	CXH/ SMH	Communicable disease	TB lookback	Ensure the staff who have tested positive have been offered appropriate support	Occupational Health and Heads of Nursing, CPG 1 and 4	31st July 2012	Complete
2012_11664	1, 4	CXH/ SMH	Communicable disease	TB lookback	Ensure communications department are aware of this incident.	TB lead consultant and Consultant Infectious Diseases	05/04/2012	Complete

2012_9839	5	SMH	Never Event	Retained swab	New maternity adapted Count policy to be implemented and include instructions for tampon use	Midwifery lead	10/07/2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	All midwifery staff required to complete and return an assessment of the maternity count policy to ensure that they have knowledge and understanding of the policy	Midwifery lead	10/07/2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	All tampons and small swabs (10x10) removed from the delivery and suture packs	Ward manager	10/07/2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	Midwifery lead to discuss the findings of the investigation and reflection of involvement	Ward manager	20th July 2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	Chief of service to discuss performance, accountability and reflection with registrar 1, and for the incident to be discussed with the registrar's supervisor so that it can be recorded at their end of year review	Chief of Service	20th July 2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	Format of the 'Record of Perineal Repair/Trauma' proforma documentation to be amended to highlight tampon use	Midwifery Lead	10/07/2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	Instrumental delivery proforma to include information on the use of tampons	Midwifery lead	10/07/2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	Perineal Trauma and Repair guidelines to be updated to reflect changes to the proforma	Midwifery lead	10/07/2012	Complete
2012_9839	5	SMH	Never Event	Retained swab	Include swab count policy in mandatory training for all staff	Midwifery lead	Apr-13	Within timeframe
2012_9839	5	SMH	Never Event	Retained swab	Audit of maternity documentation regarding swab count	Risk lead	30th November 2012	Outstanding
2012_11655	5	SMH	Maternity Services	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_12836	5	QCH	Maternity Services	Unexpected admission to NNU	Discussion with SHO involved in resuscitating the baby.	Consultant Neonatologist investigating this case.	15th August 2012.	Complete
2012_13266	5	QCH	Maternity Services	Unexpected admission to NNU	No actions	No actions	No Actions	No actions
2012_18433	1	CXH	Communicable disease	Member of staff with TB	No actions	No actions	No Actions	No actions

2012_18435	1	HH	Communicable disease	Patient with TB	Infection Prevention and Control Team to work with the ward to ensure learning is delivered on isolation precautions	Senior Infection Control Nurse HH Site	Complete at time of writing report	Complete
2012_18435	1	HH	Communicable disease	Patient with TB	Feedback the findings of this SI investigation to the teams involved in her care regarding: 1. Radiological evidence of TB. 2. Use of PCR in patients who are likely to have TB medications resistance.	Consultant in Infection Prevention and Control, Senior Nurse for CPG1 wards at Hammersmith Hospital	31st October 2012	Complete
2012_18432	1	SMH	Infection control	Outbreak C-Diff	Local training on appropriate isolation on the ward	Infection prevention and control team	30th November 2012	Complete
2012_18432	1	SMH	Infection control	Outbreak C-Diff	Continued liaison between the ward and the infection prevention and control team	Ward managers and infection prevention and control team	Ongoing	Complete
2012_18507	5	SMH	Maternity Services	Unexpected maternal admission to ITU	No actions	No actions	No Actions	No actions
2012_17507	5	QCH	Maternity Services	Unexpected admission to NNU	Case to be discussed at monthly maternity/obstetric meeting	Chief of Service	Completed	Complete
2012_17507	5	QCH	Maternity Services	Unexpected admission to NNU	Case to be discussed at weekly birth centre meeting	Birth Centre Midwifery Consultant	Completed	Complete
2012_17507	5	QCH	Maternity Services	Unexpected admission to NNU	Midwife 1 to reflect on the case with her Supervisor of Midwives	Supervisor of Midwives	Completed	Complete
2012_17507	5	QCH	Maternity Services	Unexpected admission to NNU	Registrar 1 to reflect on the case with Chief of service Obstetrics	Chief of service	Completed	Complete
2012_17507	5	QCH	Maternity Services	Unexpected admission to NNU	Review of patient's declining care guidance to include escalation when patients refuse medical advice	Consutlant Obstetrician	31st October 2012	Complete
2012_18521	5	SMH	Maternity Services	Unexpected admission to NNU	To feedback to the doctors involved regarding their interpretation of the CTG in context	Maternity Clinical lead,	31st October 2012	Complete
2012_18521	5	SMH	Maternity Services	Unexpected admission to NNU	To reinforce the need for escalation when appropriate at the next labour ward meeting	Head of Midwifery	31st October 2012	Complete

2012_18521	5	SMH	Maternity Services	Unexpected admission to NNU	To review the guidelines for Persistent Pulmonary Hypertension of the Newborn (PPHN) and share the revision with all staff	Neonatal lead	31st December 2012	Outstanding
2012_12961	3	CXH	Unexpected Death	Tracheostomy	Local training and induction of ITU staff regarding available equipment	Senior Nurse, ITU	31st August 2012	Outstanding
2012_12961	3	CXH	Unexpected Death	Tracheostomy	All equipment to be tested regularly (monthly)	Clinical Technologist	31st July 2012	Outstanding
2012_12961	3	CXH	Unexpected Death	Tracheostomy	ITU monitors to be updated to ensure all have capnography available	Clinical Technologist	31st August 2012	Outstanding
2012_12961	3	CXH	Unexpected Death	Tracheostomy	Report the incident to the company who produce Dolphin sets	ITU lead consultant	Complete, MDA issued	Complete
2012_12961	3	CXH	Unexpected Death	Tracheostomy	Develop a standard operating procedure for the insertion of tracheostomies in ITU	ITU lead consultant	31st August 2012	Outstanding
2012_12961	3	CXH	Unexpected Death	Tracheostomy	Review of options within the bed contract to change the bed type in ICU	Associate Director, Quality and Safety	31st August 2012	Complete
2012_12961	3	CXH	Unexpected Death	Tracheostomy	Feedback the learning and recommendations to staff involved in the incident	ITU lead consultant	31st July 2012	Complete
2012_12961	3	CXH	Unexpected Death	Tracheostomy	Review of ICUs for compliance with the recommendations from NAP4	ITU lead consultants	31st August 2012	Complete
2012_13055	1	SMH	Pressure Ulcer	Grade 3 ulcer	Raise the profile of skin assessment daily at ward handover. Emphasize in bed side handover if any documentation/ assessments have not been completed	Ward Manager and Lead Nurse	31st August 2012	Complete
2012_13055	1	SMH	Pressure Ulcer	Grade 3 ulcer	Stress the importance of assessment within 6 hours of arrival on to each ward area, during handover and ward meetings.	Ward Manager and Lead Nurse	31st August 2012	Complete
2012_13055	1	SMH	Pressure Ulcer	Grade 3 ulcer	Undertake a local audit of completion of risk assessments and make recommendations based on the outcome	Ward Managers and Lead Nurses	31st August 2012	Complete
2012_13055	1	SMH	Pressure Ulcer	Grade 3 ulcer	TVN will include importance of how to grade/ identify pressure damage in the pressure ulcer study day	TVN	31st August 2012	Complete
2012_13055	1	SMH	Pressure Ulcer	Grade 3 ulcer	Senior sister/charge nurse to feed back to clinical area the importance of grading/properly identifying	Ward Managers	31st August 2012	Complete
2012_13055	1	SMH	Pressure Ulcer	Grade 3 ulcer	Staff to be reminded to document care at times using the appropriate documentation tools.	Ward Managers and Lead Nurses	31st August 2012	Complete
2012_15642	Trust	Trust	Waiting List	Breach	TBC	TBC	TBC	TBC

2012_18146	5	SMH	Communication issue	Biopsy without consent	Feedback the findings and learning from this investigation to the teams involved – to specifically include the completion of WHO checklist	Chief of Service, Paediatrics	31st October 2012	Complete
2012_18146	5	SMH	Communication issue	Biopsy without consent	Review checking process for procedures agreed against procedures booked	MDT lead	31st October 2012	Outstanding
2012_17057	5	QCH	Maternity Services	Unexpected admission to NNU	Case to be discussed at monthly maternity/obstetric meeting	Chief of Service	Completed	Complete
2012_17057	5	QCH	Maternity Services	Unexpected admission to NNU	Case to be discussed at weekly birth centre meeting	Birth Centre Midwifery Consultant	Completed	Complete
2012_17057	5	QCH	Maternity Services	Unexpected admission to NNU	Midwife 1 to reflect on the case with her Supervisor of Midwives	Supervisor of Midwives	Completed	Complete
2012_17057	5	QCH	Maternity Services	Unexpected admission to NNU	Registrar 1 to reflect on the case with Chief of service Obstetrics	Chief of service	Completed	Complete
2012_17057	5	QCH	Maternity Services	Unexpected admission to NNU	Lead midwife to ensure and discuss at next caseload meeting that two midwives should be present at labour when an alternative birth plan is made	Lead midwife	30th September 2012	Complete
2012_17057	5	QCH	Maternity Services	Unexpected admission to NNU	Review of patient's declining care guidance to include escalation when patients refuse medical advice	Consutlant Obstetrician	31st October 2012	Complete
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	All dialysis connections to be double checked by Auchi dialysis registered nurses and signed on the dialysis chart	Head of Nursing (CPG4)	Sep-12	Outstanding
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	Audit of double signatures on dialysis chart by Auchi dialysis staff	Head of Nursing (CPG4)	Oct-12	Outstanding
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	Venous disconnection to be discussed by ward managers with all staff at staff meeting and process of double checking re-iterated	Head of Nursing (CPG4)	Completed	Complete

2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	Morbidity and mortality meeting addressing the need for directly observed inpatient dialysis (including satellite units)	Renal Governance Lead	Completed	Complete
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	To carry out a formal risk assessment regarding the management of 'eliminating mixed sex accommodation' requirements, and formalise a process for the effective monitoring of patients receiving dialysis	Head of Nursing (CPG4) and the Renal team	Sep-12	Outstanding
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	A supportive conversation regarding compliance of Trust policy regarding double checking dialysis with staff nurse 1	Head of Nursing (CPG4)	Aug-12	Outstanding
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	All renal staff to be reminded of compliance with the Trust policy regarding double checking dialysis machines	Head of Nursing (CPG4)	Aug-12	Outstanding
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	Staff involved to be given feedback following investigation and subsequent learning discussed	Head of Nursing (CPG4)	Aug-12	Outstanding
2012_13033	4	HH	Accident whilst in Hospital	Disconnected Tesio line - patient bled and could not be resuscitated	Consider feedback from the investigation to be given to the patient or her family	Consultant lead for SI	Sep-12	Outstanding
2012_13029	4	HH	C Diff and related HC infections	C-Diff on part 1a of death cert	No actions	No actions	No actions	No actions
2012_15394	3	SMH	Serious Incident	Anaesthetic issue	Feedback the events and learning of this case to anaesthetic and intensive care departments	CoS, Anaesthetics	31st October 2012	Outstanding

2012_15394	3	SMH	Serious Incident	Anaesthetic issue	All central lines(whether placed with ultrasound guidance or using landmark techniques) to be confirmed by blood gas analysis and/or transduction	CoS, Anaesthetics	31st October 2012	Outstanding
2012_15394	3	SMH	Serious Incident	Anaesthetic issue	Review induction of temporary staff in theatres	Lead Nurse, theatres	31st October 2012	Outstanding
2012_15394	3	SMH	Serious Incident	Anaesthetic issue	Confirm follow up of patient with GP	Medical Director	31st October 2012	Complete
2012_15394	3	SMH	Serious Incident	Anaesthetic issue	Ensure that the national standard "Checking Anaesthetic Equipment – 2012" by the AAGBI is used in all anaesthetic areas	CoS, Anaesthetics, Lead Nurse, theatres	31st October 2012	Outstanding

Table 6. Actions from Q2 SIs

STEIS ID	CPG	Site	Reporting criteria	Description	Action	Lead	Deadline	Progress
2012_18602	5	QCH	Maternity Services	Unexpected admission to NNU	Midwife 1 to discuss her practice with her supervisor of midwives.	Midwife 1 and her SOM	Complete at time of writing report	Complete
2012_18602	5	QCH	Maternity Services	Unexpected admission to NNU	Labour ward coordinators should be supernummary on a shift in order to allow them to manage effectively.	Head of Midwifery	1st October 2012	Complete
2012_18602	5	QCH	Maternity Services	Unexpected admission to NNU	The maternity unit should implement the findings of the review of labour ward staffing to try and ensure that 1:1 care for labouring women can be undertaken.	Head of Midwifery	30th April 2013	Within timeframe
2012_18602	5	QCH	Maternity Services	Unexpected admission to NNU	The Trust should be moving towards the recommended ratio of 1 midwife to 30 deliveries in order to improve 1 to 1 care ratios on labour ward.	Head of Midwifery	30th April 2013	Within timeframe
2012_18599	PP	SMH	Maternity Services	Unexpected maternal admission to ITU	Midwifery lead to discuss with midwife 1 the importance of appropriate documentation each time the patients are reviewed	Senior Midwife Lindo Wing	Completed	Complete
2012_18599	PP	SMH	Maternity Services	Unexpected maternal admission to ITU	Discussion with midwives on the unit regarding the mechanisms and importance of sending blood to the laboratory	Senior Midwife Lindo Wing	31st October 2012	Complete
2012_24437	5	SMH	Maternity Services	Unexpected admission to NNU	No actions	No actions	No Actions	No actions

2012_18659	5	SMH	Maternity Services	Unexpected maternal admission to ITU	To document in the maternal notes total fluid consumption at least every 4 hours unless clinically indicated (appropriate amount is approximately 200 mls per hr)	Consultant midwife/LW managers	31st October 2012	Complete
2012_18659	5	SMH	Maternity Services	Unexpected maternal admission to ITU	To educate staff on fluid balance and ketonuria by holding a multi disciplinary seminar and review of the evidence.	Head of Midwifery	31st October 2012	Complete
2012_18659	5	SMH	Maternity Services	Unexpected maternal admission to ITU	To conduct an RCT investigating appropriate fluids for latent phase/early labour	Midwifery research fellow	Oct-13	Within timeframe
2012_18659	5	SMH	Maternity Services	Unexpected maternal admission to ITU	Patient's with unresponsive ketonuria to be escalated and reviewed by the medical team	Lorna Phelan/Pauline Cooke	31st October 2012	Outstanding
2012_19685	5	SMH	Maternity Services	Unexpected neonatal death	Individual learning for Midwife 5 in terms of checking handover sheet for babies on transitional care observations	Supervisor of Midwives.	Oct-12	Complete
2012_22622	5	QCH	Maternity Services	Unexpected neonatal death	No actions	No actions	No Actions	No actions
2012_22626	5	QCH	Maternity Services	Unexpected admission to NNU	Include in Risky Business Newsletter that when your plan is to reassess a woman you ensure you do this.	Risk Management Midwife	31st December 2012	Complete
2012_22626	5	QCH	Maternity Services	Unexpected admission to NNU	Refer case to Supervisor of Midwives for review of management and take action as appropriate.	Lead Midwife	Case referred at time of writing report. Complete review and Action plan – 31st December 2012	Outstanding
2012_22626	5	QCH	Maternity Services	Unexpected admission to NNU	Individual learning to be undertaken by registrar involved regarding following planned reviews.	Consultant Obstetrician, Risk Lead QCCH	Complete at time of writing report.	Complete
2012_22626	5	QCH	Maternity Services	Unexpected admission to NNU	Individual learning to be undertaken by Midwife in terms of escalation of an abnormal CTG.	Lead midwife	As part of supervisory investigation – 31st December 2012	Outstanding
2012_25175	1	CXH	Infection control	MRSA death	No actions	No actions	No Actions	No actions

2012_23997	3	SMH	Unexpected Death	Unexpected death	Review current provision of the outreach service. In the interim, introduce an outreach ward round on a Friday evening.	Head of Nursing CPG 3	31st December 2012	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Training team to review the working patterns of the FY1s and their areas of responsibilities	FYI training lead	30th January 2013	Within timeframe
2012_23997	3	SMH	Unexpected Death	Unexpected death	Liaise with FY1 induction co-ordinator to ensire the Medical Director has a slot on induction to discuss failure to escalate	Patient Safety Manager	31st December 2012	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Director of Nursing to brief nursing population that if they are concerned they should escalate above the FY1. Out of hours, if an FY1 is called to review a patient, then the site management team must also be called.	Director of Nursing	31st December 2012	Outstanding
2012_23997	3	SMH	Unexpected Death	Unexpected death	Medical Director to inform all consultants Trustwide that a daily registrar ward round to review all patients must take place at weekends.	Medical Director	31st December 2012	Outstanding
2012_23997	3	SMH	Unexpected Death	Unexpected death	Senior Nurse to conduct twice daily ward rounds at weekend	Lead Nurse Orthopaedics	31st December 2012	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Increase the number of senior nursing (Band 6) out of hours on the orthopaedic unit.	Lead Nurse Orthopaedics	31st December 2012	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Design and implement a handover proforma for the FY1s	Karen Frame	31st December 2012	Outstanding
2012_23997	3	SMH	Unexpected Death	Unexpected death	Nurse-in-charge to be supernumerary	Ward Manager	Complete at time of writing report	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Write a guidance document in addition to the induction session for FY1s on recognising the deteriorating patient and when to escalate.	FYI training lead	31st December 2012	Outstanding
2012_23997	3	SMH	Unexpected Death	Unexpected death	In orthopaedics, initiate weekend consultant ward rounds to review all patients.	Chief of Service, Orthopaedics	Complete at time of writing report	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Ward manager to ensure all nursing staff are ILS trained.	Ward manager	Jun-13	Within timeframe
2012_23997	3	SMH	Unexpected Death	Unexpected death	Clinical educator from ICU to spend time on the ward educating staff on early warning scores, triggering and how to pre-empt problems.	Lead Nurse Orthopaedics	Complete at time of writing report	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Refer the staff involved for a review of their practice in terms of the care provided	Senior Nurse and FYI training	15th December 2012	Complete

					to this patient.	lead		
2012_23997	3	SMH	Unexpected Death	Unexpected death	Ensure there is individual learning for the staff involved in this case.	Senior Nurse and FYI training lead	15th December 2012	Complete
2012_23997	3	SMH	Unexpected Death	Unexpected death	Liaise with the communications team regarding launching screensavers in terms of escalation	Patient Safety Manager	31st December 2012	Complete
2012_24722	5	SMH	Maternity Services	Unexpected maternal admission to ITU	Midwife educator and HDU midwifery lead to continue mandatory sessions on the use of the MEWS chart for all midwifery staff.	Midwife Educator and HDU midwifery lead	Ongoing	Complete
2012_24722	5	SMH	Maternity Services	Unexpected maternal admission to ITU	Section in Risky Business regarding the MEWS chart and escalation	Risk Management Midwife	28th February 2013	Within timeframe
2012_24722	5	SMH	Maternity Services	Unexpected maternal admission to ITU	Refer case to Supervisor of Midwives for review.	Lead Midwife	31st December 2012	Complete
2012_24722	5	SMH	Maternity Services	Unexpected maternal admission to ITU	Refer to midwifery management for developmental support period.	Head of Midwifery	30th September 2012	Complete
2012_24722	5	SMH	Maternity Services	Unexpected maternal admission to ITU	Monthly audit of maternity recovery health records	HDU midwifery lead	Ongoing	Complete

Appendix Three: Risk Profile Q3 2012-13

The 2012/13 key areas of focus were developed in the annual report through the use of a risk profile. The top theme for incidents, complaints and claims were analysed at Trust level, at individual CPG level and at individual site level. The outcomes were then aggregated to provide a risk profile.

Trustwide top themes for incidents, complaints and settled claims have not changed from those identified in Q2. For new claims the top theme has changed from failure to recognise complication of treatment to failure/delay in treatment.

Incidents top themes vary from Q2 to Q3. CPG 2 has changed from medication to infrastructure or resources, CPG 3 has changed from accident that may result in personal injury to treatment, procedure, CPG 4 has changed from medication to accident that may result in personal injury, SMH has changed from medication to access, appointment, admission, transfer, discharge and WEH has changed from infrastructure or resources to access, appointment, admission, transfer, discharge.

Complaints top themes have not changed from Q2 to Q3 except for CPG 6 which changed from communication/information to patients to all aspects of clinical treatment. It is notable that at every level of analysis all aspects of clinical treatment was the top theme for complaints.

New Claims top theme The top theme across the Trust and CXH, and joint top at SMH, was a failure/delay in treatment. This was also the top theme in CPG3. Additionally, three claims were received that related to failure to recognise a complication of treatment within CPG3. No further themes were evident across the sites or CPGs in Q3.

Settled Claims top theme A significant percentage of claims settled in Q3 involved a failure to recognise a complication of treatment and inappropriate treatment across the Trust. The numbers for these themes were cumulative across the different sites and CPGs. No single site or CPG had a high number of claims settled in this period.

Table 16. Trust Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 14%	All aspects of clinical treatment 57%	**NEW:** Failure/delay in treatment 13% **SETTLED:** Failure of follow-up arrangements 30%

Table 17. CPG 1 Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 30%	All aspects of clinical treatment 55%	**NEW:** No theme **SETTLED:** No theme

Table 18. CPG 2 Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Infrastructure or resources 21%	All aspects of clinical treatment 65%	**NEW:** No theme **SETTLED:** No settled claims

Table 19. CPG 3 Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Treatment, procedure 13%	All aspects of clinical treatment 58%	**NEW:** Failure/Delay in Treatment 27% **SETTLED:** No theme

Table 20. CPG 4 Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 22%	All aspects of clinical treatment 59%	**NEW:** No theme **SETTLED:** No theme

Table 21. CPG 5 Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Labour or Delivery 40%	All aspects of clinical treatment 59%	**NEW:** No theme **SETTLED:** No theme

Table 22. CPG 6 Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Clinical assessment (investigations, images and lab tests) 48%	All aspects of clinical treatment 50%	**NEW:** No theme **SETTLED:** No claims settled

Table 23. SMH Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Access, appointment, admission, transfer, discharge 13%	All aspects of clinical treatment 60%	**NEW:** No theme **SETTLED:** Failure to diagnose/delay in diagnosis 50%

Table 24. HH Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 19%	All aspects of clinical treatment 56%	**NEW:** No theme **SETTLED:** No claims settled

Table 25. CXH Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Accident that may result in personal injury 20%	All aspects of clinical treatment 53%	**NEW:** Failure/Delay Treatment 25% **SETTLED:** Failure to recognise complication of treatment 75%

Table 26. QCCH Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Labour or Delivery 49%	All aspects of clinical treatment 66%	**NEW:** Birth Defects 50% **SETTLED:** No theme

Table 27. WEH Risk Profile Q3

	Incidents	**Complaints**	**Claims**
Theme	Access, appointment, admission, transfer, discharge 40%	All aspects of clinical treatment 50%	**NEW:** No theme **SETTLED:** No claims settled

NB – Some claims have multiple themes.

Table 28. Action plan – to be discussed at Clinical Risk Committee

Issue	**Action**	**Lead**	**Deadline**	**Monitoring forum**

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER:2.2.2**

Report Title: Monthly Infection Prevention Summary

To be presented by: Prof. Alison Holmes

.

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

Key Issues for discussion:

- There was one Trust-attributable MRSA blood stream infections (BSI) in February, the total number YTD is seven. The annual set objective is nine.
- There were six cases of *C.difficile* in February, the total YTD is 80. The annual set objective is 110.
- The Trust is below YTD thresholds for both MRSA BSI and *C. difficile*
- Antibiotic stewardship activity

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

Link to the Trust's Key Objectives:

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

Assurance or management of risks associated with meeting key objective: Infection prevention and control as a core aspect of patient safety, hospital management and excellence in clinical care. The ongoing programme of infection prevention and control.

Purpose of Report

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

Monthly Infection Prevention and Control Summary
March 2013
(February 2013 data)

Key Indicators

February 2013

	Month 2: February			CPG						
	Threshold	Trust		1	2	3	4	5	6	PPs
MRSA BSI (>48hrs)	0	1		0	0	0	1	0	0	0
MSSA BSI (>48hrs)	0	0		0	0	0	0	0	0	0
Clostridium difficile (>72 hrs)	9	6		2	2	2	0	0	0	0
Hand hygiene compliance	100 %	98 %		98 %	99 %	98 %	99 %	98 %	97 %	100 %

Year to Date 2012/13

	YTD 2012/13				CPG											
	Threshold		Cases													
	Year	YTD	Trust		1		2		3		4		5		6		PPs	
MRSA BSI (>48hrs)	9	8	7		3		0		1		3		0		0		0	
MSSA BSI (>48hrs)	NA	NA	33		6		5		7		6		5		2		2	
Clostridium difficile (>72 hrs)	110	101	80		40		9		12		14		5		0		0	
Hand hygiene compliance	100%	100%	98%		98 %		98 %		97 %		99 %		97%		97 %		99 %	

n/a = Not applicable

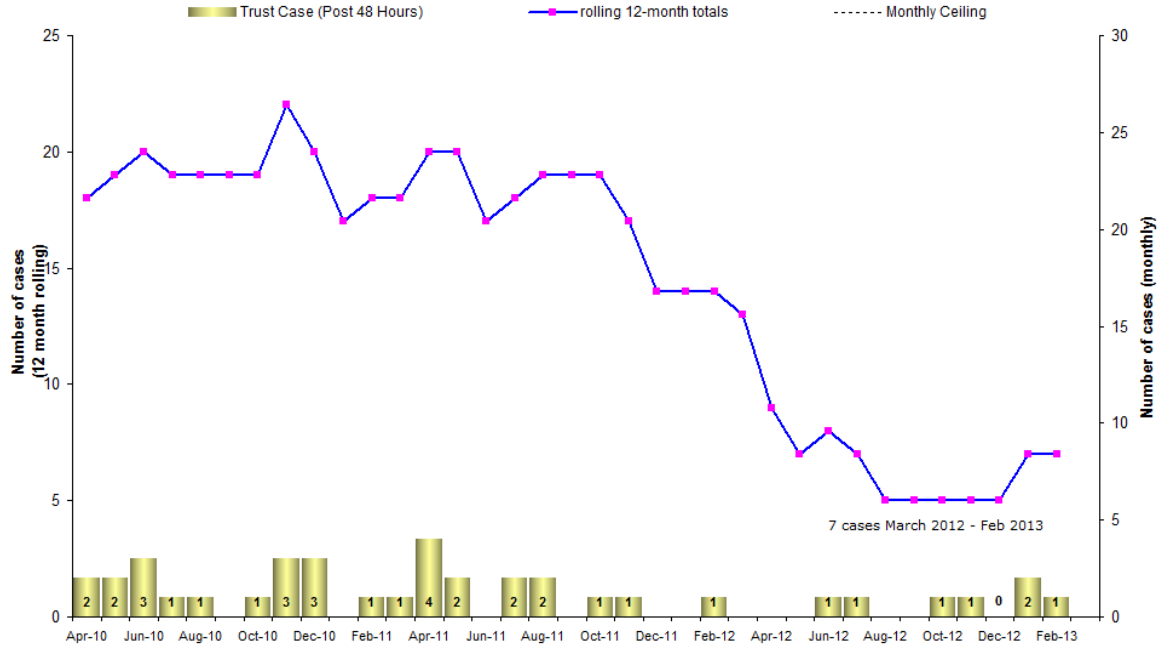
1. Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

For 2012/13 our 'MRSA objective' has been set at nine Trust-attributable cases of MRSA BSI. In February 2013 there was one Trust acquired MRSA BSI case reported. Year to date we have reported seven Trust-attributable cases. Four cases were associated with a medical procedure or device, one case was related to the patient's pneumonia, one case was due to contamination and the source of infection for the fourth case could not be determined

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

The plan is underpinned by professional and personal accountability for all groups of staff through Clinical Programme Groups (CPGs) and by the promotion of local ownership at CPG, ward and unit level supported by information provision and communications. The process for investigating each case has been modified to strengthen accountability of the patient's consultant.
The planned programme of assessing competence in aseptic non touch technique (ANTT) for all clinically facing staff continues with a focus on senior medical staff.

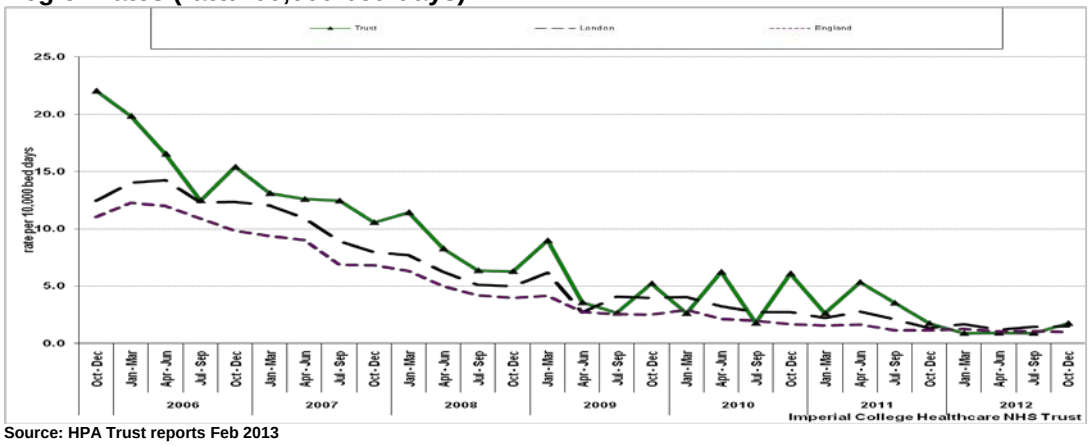
Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



1.2 Benchmarking Trust-attributable MRSA BSI rates

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

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



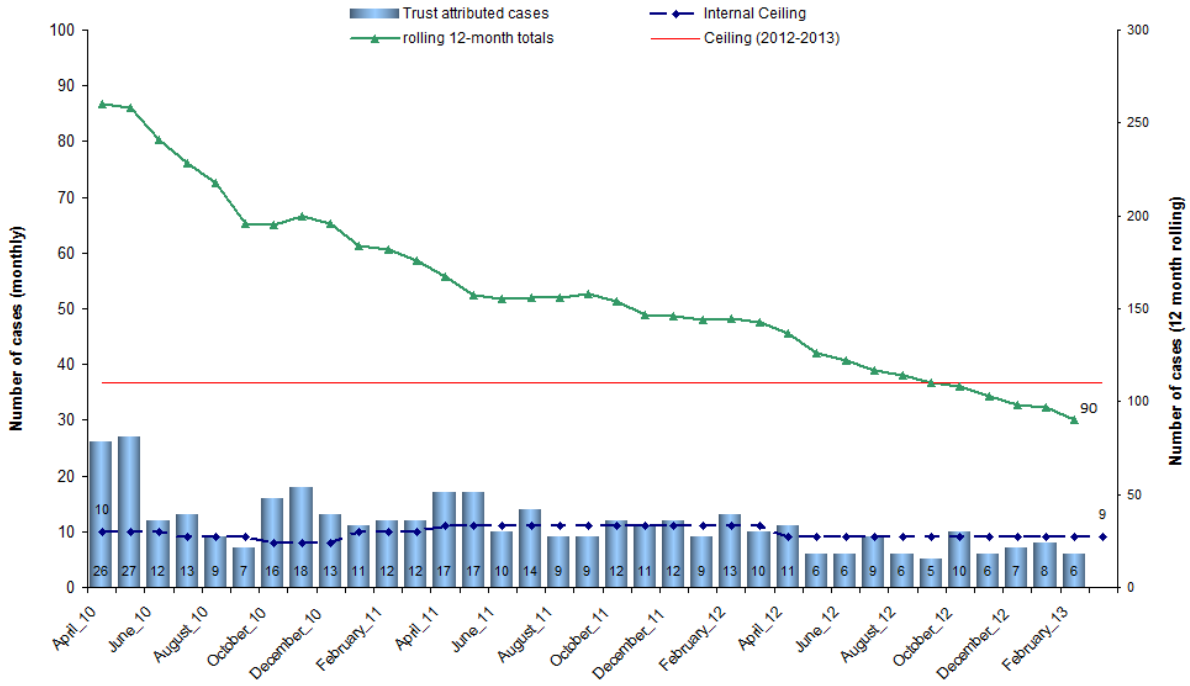
Source: HPA Trust reports Feb 2013

Next year there will be no reduction target set for Trusts, but a zero tolerance approach .

2. *C. difficile* infections

For 2012/13, the Department of Health annual ceiling for the Trust is 110 cases of *C. difficile* infection (CDI). Year to date there have been 80 cases. In February 2013, 17 cases of CDI were reported to the HPA of which six cases were Trust attributable.

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



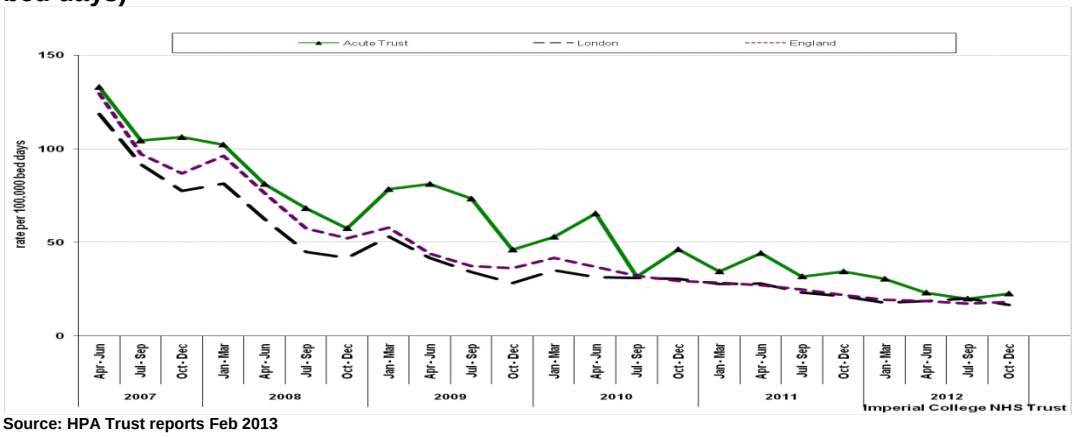
2.1 Update on key elements of the *C. difficile* prevention action plan

The plan is underpinned by professional and personal accountability for all groups of staff through Clinical Programme Groups (CPGs) and by the promotion of local ownership at CPG, ward and unit level supported by information provision and communications.
Detailed antibiotic information is now being collated for each patient with *C. difficile*, along with the time to isolation, which will be used to inform preventative actions.

2.2 Benchmarking Trust-attributable *C. difficile* rates

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

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



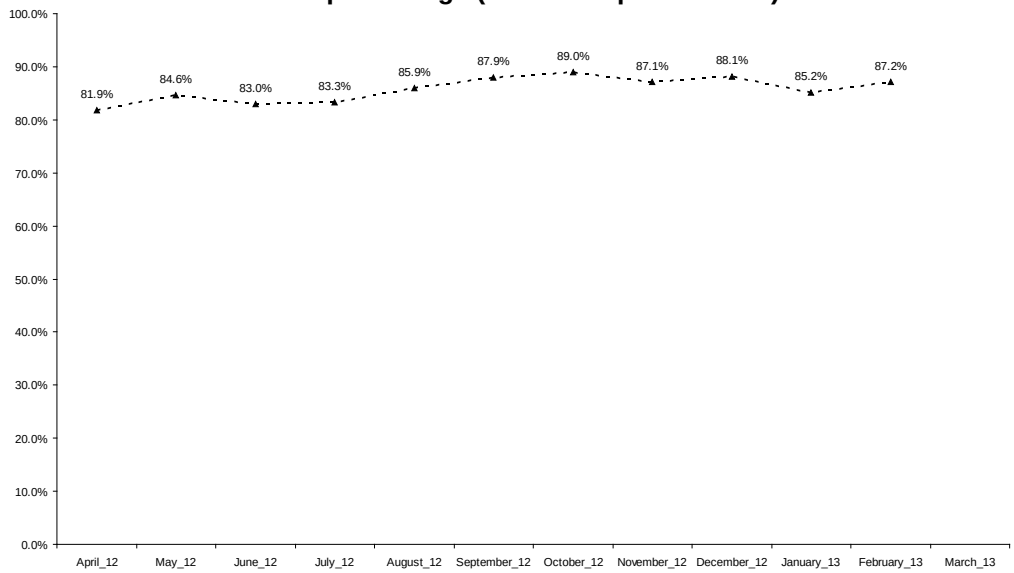
Source: HPA Trust reports Feb 2013

Next year the maximum threshold for CDI cases set for the Trust is 64.

3. MRSA Screening

The Trust remains compliant with the Department of Health population screening requirements. Analysis at an individual patient level identified 8262 patients admitted in February 2013 who required screening of which 7205 (87.2 percent) were screened. New national guidance on MRSA screening is awaited.

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



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

There is no threshold for this indicator at present. In February 2013, there were six cases of MSSA BSI reported to the HPA, of which six were non-Trust attributable and zero were Trust attributable.

Figure 6a: Monthly MSSA BSI cases

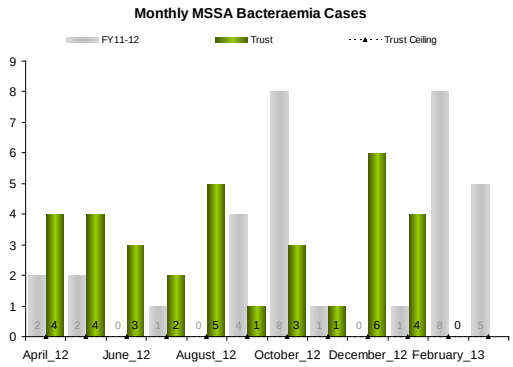
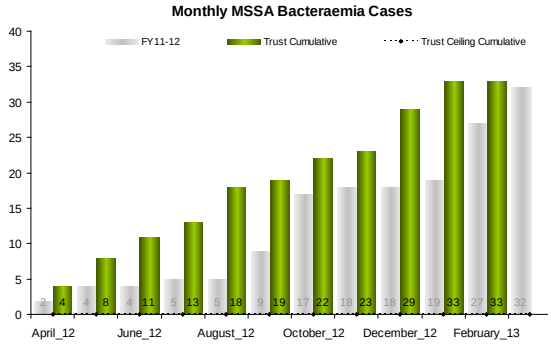


Figure 6b: Cumulative MSSA BSI cases



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

Mandatory surveillance of *E. coli* bloodstream infections commenced in June 2011.
There is no threshold for this indicator at present. In February 2013 there were 19 cases of *E. coli* BSI reported to the HPA, of which six were Trust attributable cases (i.e. post 48 hours of admission), four cases were at Hammersmith hospital (on different wards) and one case each at St Marys and Charing Cross hospitals. There were 13 non-Trust attributable cases.

There is much national interest in the rising incidence of *E.coli* BSI which accounts for 36 % of BSIs in England, Wales and Northern Ireland (versus MSSA 9.7 % and MRSA 1.6%) April 2001- March 2012.

Trust rates are consistently low compared with Shelford Group Trusts and nationally.

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

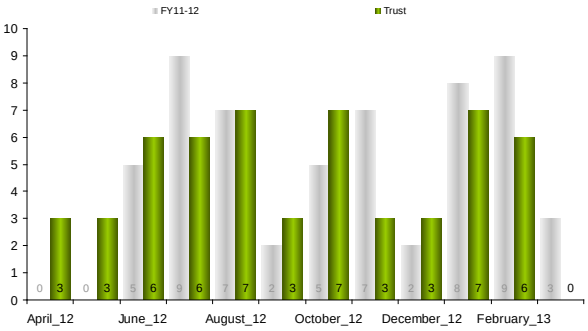
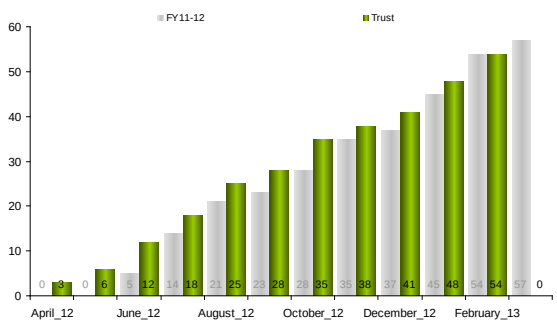


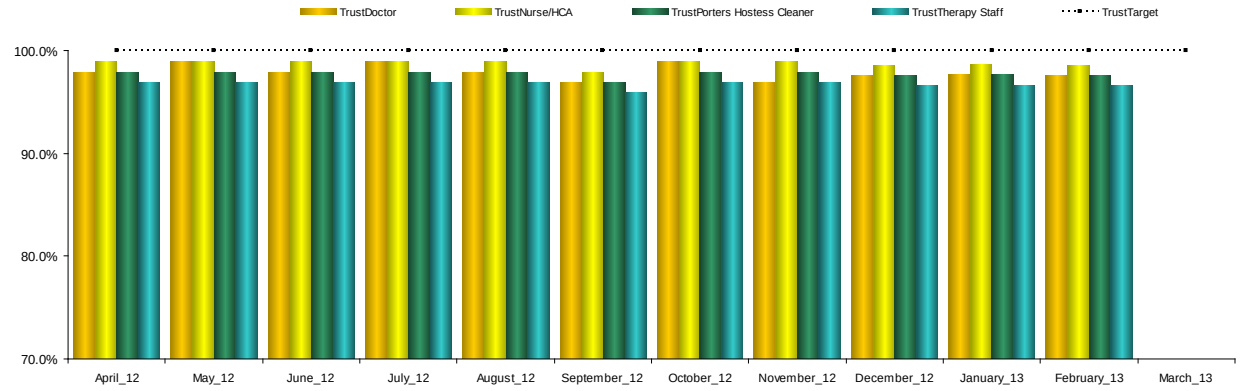
Figure 7b: Cumulative Trust-acquired *E. coli* BSI cases



6. Hand hygiene compliance

In February 2013, 89.4 percent of clinical areas submitted a total of 5020 observations. Hand hygiene compliance (as measured by the current Trust audit procedures based on a minimum of ten observations per ward) was 98.3 percent, and compliance with bare below elbows was 98.8 percent.

Figure 8: Staff group average performance of hand hygiene practice



7. ANTT

The Trust continues a rolling programme of the aseptic non-touch technique (ANTT) competency assessment programme at CPG level as part of the infection prevention plan. Completion of assessments has steadily been increasing to 75 percent (4765 clinical staff) at the end of February 2013.

8. Antibiotic Stewardship

Point prevalence survey on anti-infective use

The Trust's 9th point prevalence survey on anti infectives was carried out in November 2012. Pharmacists collected data for every inpatient prescribed at least one systemic anti-infective (anti-bacterial, anti-fungal or anti-viral) on the day of the study. Results are presented for the Trust as a whole and according to individual Clinical Programme Groups (CPGs).

A total of 430 of 1063 (40.5 percent) of patients of whose drug charts were available were scheduled to receive at least one anti-infective on the day of the study, with a mean of 1.7 anti-infectives per patient. A total of 713 anti-infectives were prescribed with 59 percent administered intravenously (an average of 51 percent across all previous studies).

The Department of Health guidance for antimicrobial stewardship in hospitals 'Start Smart Then Focus' has been launched in the Trust and the following prevalence results address the '*Start Smart'* component:

- 90 percent of anti-infectives were prescribed within policy or approved by microbiology or infectious diseases. This met the Trust target of 90 percent
- 94 percent of prescriptions had an indication documented on the drug chart or in the medical notes. This is the highest rate across all previous studies and was above the Trust target of 90 percent of prescriptions to have indication on the drug chart or in notes
- 84 percent of anti-infectives had stop/review date or duration documented on the drug chat. This is also the highest rate across all previous studies and increased from 64 percent in the last study. The Trust target is 90 percent.

The following results address the *'Then Focus'* component*:*

- 91 percent of anti-infective prescriptions had been administered for a duration within Trust recommendations stated in policy or recommended by microbiology/ID; this is the highest rate across all previous studies.

9. Other matters

9.1 Norovirus

Norovirus activity had an impact on the Trust in January 2013. This affected both patients and staff and resulted in four wards (three on one site and one at another) being closed to admissions and transfers until symptoms had resolved. The outbreak was recognised promptly and infection prevention and control measures implemented rapidly to control and limit the outbreak. All patients were managed appropriately and symptoms resolved as expected. Affected staff were excluded from work for 48 hours following the resolution of their symptoms as per Trust policy. The outbreak was reported to the Health Protection Agency via the norovirus outbreak in hospitals reporting scheme.

9.2 Pertussis

A lookback exercise has taken place following the diagnosis of a child with pertussis in January 2013 which identified one other patient who had been in contact with the child. Follow up was undertaken by the IPC team in collaboration with the Health Protection Unit. Healthcare staff that had contact with this patient have also been followed up by the Occupational Health team and had their immunity assessed.

9.3 *Acinetobacter baumannii*

Possible transmission of a multi-drug resistant strain of *A. baumannii* was identified in an adult intensive care unit in February 2013. Outbreak management measures were promptly put in place including isolation of the positive patients, additional screening and increased infection control team support with full engagement from the multidisciplinary teams. There have been no further cases of acquisition identified. The IPC team will continue to support the unit with education and audit.

9.4 Increased incidence of *C. difficile* on two wards

An increase in *C. difficile* was identified on a surgical ward and a medical ward from December 2012 to March 2013. Patients were managed appropriately both in terms of treatment and infection prevention and control interventions. All isolates are undergoing ribotyping to establish if they are epidemiologically linked and these results are awaited. Risk assessment identified environmental and practice issues on the surgical ward and a programme of intensive teaching around hand hygiene and *C. difficile* has been implemented. In addition access to hand washing sinks has been improved throughout the ward. Audits of practice since these interventions have found significant improvement in practice and the IPC team will continue to support the ward with education and audit.

9.5 Measles

A lookback exercise has taken place following the diagnosis of an adult with measles in February 2013 which identified one other patient who had been in contact with the patient but was not admitted. Follow up was undertaken in collaboration with the Health Protection Unit and no further treatment or action was required. All healthcare staff that had contact with this patient had immunity to measles.

9.7 Addressing potential novel coronavirus

A patient admitted with respiratory infection was investigated for novel coronavirus, due to symptoms and recent travel history to a risk region. The patient was managed appropriately based on the current Health Protection Agencies guidance and the Trust was fully able to deliver recommended practice. Testing was completed within 24 hours and the patient was confirmed negative for novel coronavirus and positive for influenza A.

9.8 Update on water hygiene monitoring

Water hygiene monitoring continues at the Trust including monitoring for *Pseudomonas aeruginosa* in high risk clinical areas in line with Department of Health guidance. Following expert advice from the Health Protection Agency, some remedial work has now been completed in clinical areas and a programme of regular testing is in place. No clinical infections have been identified.

9.9 Surgical site infection surveillance

The Trusts surgical site infection surveillance programme continues in the orthopaedic, cardiothoracic and neurosurgery specialties. Data for 2012 demonstrated a reduction in surgical site infection for coronary artery bypass graft (CABG) surgery with infection rates below the national average. Neurosurgery surveillance commenced on the 1st January 2013 and cardiothoracic surveillance will be extended to include all cardiac surgery from April 2013.

10 Applied Research, Education and Innovation.

10.1 The Centre of Infection Prevention and Management (CIPM)

CIPM, with Trust IT Solutions Unit and its head, John Kelly, held a number of workshops in February across the Trust, to gather and share information about the numbers and types of APPs under development and to start a dialogue about coordination, support and governance. The workshops were well attended and CIPM and IT are now working on taking their findings forward

On 7th March, CIPM held a joint symposium with two other UKCRC Centres – The Translational Microbiology Consortium from Cambridge and the electronic self testing instruments for STIs Consortium from St Georges. The meeting, which was opened by Dermot Kelleher Principal of the Imperial Faculty of Medicine was a great success allowing the Centres to hear about each others work and find potential areas of synergy and collaboration.

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

We reported four grant successes in January, including an award from the Tropical Health Education Trust (http://allafrica.com/stories/201303180327.html).

The first BRC Infection Theme Clinical Research Training Fellowship, to commence in April 2013 has been awarded to Dr Luke Moore, who will be undertaking a PhD on " Investigating the role of matrix-assisted laser desorption/ionization time-of-flight mass spectrometry and whole genome sequencing in the critical care setting and the impact on antimicrobial prescribing and bacterial resistance'

10.2 Health Foundation Corporate Award

Imperial's awarded project 'Improving care quality through workforce analysis and planning'
Is funded by the Health Foundation's Shared Purpose programme which aims to identify improvements, build knowledge and skills, and create new approaches to help transform the quality of healthcare in the UK. The set up phase of the Imperial project has been completed. There is good stakeholder support particularly from the intensive care areas. Data mapping of workforce and clinical outcome data has started, supported by an epidemiologist/health economist. A three month delay in recruitment to the statistician and data analyst has been mitigated partially through epidemiologist support. Recruitment is now underway. The next steps involve data collection and analysis.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA NUMBER: 2.2.4**

Report Title: Care Quality Commission (CQC) maternity outlier alert for puerperal sepsis within 42 days of delivery at ICHT

To be presented by: Dr David Mitchell, on behalf of the Medical Director

Executive Summary:

The Trust was alerted by the CQC in October 2012 that they had identified significantly high rates of puerperal sepsis within 42 days of delivery with increased rates in the caesarean section group – see attachment 1.

In response to this the Trust has undertaken an investigation by reviewing the case notes of the cases of puerperal sepsis in this group which occurred between April 2011 and February 2012. See attachment 2. The methodology of the case note review is outlined in appendix 1, the proforma used in appendix 2, and the findings in appendix 3.

Of the total cases reviewed (n=33), 3 were excluded as they were either delivered vaginally or in another organisation. The final number reviewed in detail was therefore 30. See Figure 1 of attachment 2.

The results show that 20% of caesarean section delivery cases were coded correctly as "puerperal sepsis" (code 085) [Tables 1-3, attachment 2]. Each of these cases had between 2 and 5 risk factors for developing an infection and no care issues were identified. The remaining 80% of the case notes were inaccurately coded. These had alternative diagnoses with the majority related to intrapartum pyrexia or sepsis which required completion of the course of antibiotics postnatally (50%). 5 cases (17%) were given prophylactic antibiotics or had other puerperal infections postnatally, 3 cases (10%) had infections antenatally and one case (3%) was given antibiotics prophylactically intrapartum (Table 1, attachment 2). All patients reviewed had an epidural for analgesia.

Intrapartum pyrexia are presumed to be related to true infection, usually chorioamnionitis, although microbiological confirmation of this is often not sought or yields no growth. Intrapartum pyrexia will also be increased in units which have a high epidural usage for analgesia in labour such as Queen Charlotte's and Chelsea Hospital. Such patients will be given antibiotics as it is impossible in the intrapartum scenario to distinguish between true infection and epidural related pyrexia.

The findings therefore show that the puerperal sepsis rate is lower than reported and would be in keeping with that expected. However, we have identified that coding remains an issue despite previous action plans in CPG5 to address this. It can be difficult for coders to distinguish between the continuation of treatment in cases of intrapartum pyrexia and true puerperal sepsis with its onset postnatally. This has been fed back to the CQC to ascertain whether this is indeed an issue in other units. An action plan has been written to address the issues raised.

The findings have been reported to the CQC and a response has been received (attachment 3). CQC will monitor progress with our action plan implementation, but will not take any further action at present.

Key Issues for discussion: To note the alert, report and findings.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Details of Legal Review, if needed

N/A

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
5. Achieve outstanding results in all our activities.

Purpose of Report

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

Jones

40, RESTRICTED

Care Quality Commission
Finsbury Tower
103 – 105 Bunhill Row
London
EC1Y 8TG
www.cqc.org.uk

Mark Davies, Chief Executive
Imperial College Healthcare NHS Trust
The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY

18 October 2012

Our reference: C101/AH

Dear Mr Davies

Re: Care Quality Commission maternity outlier alert for puerperal sepsis within 42 days of delivery at Imperial College Healthcare NHS Trust

We are writing to notify you of the fact that analysis of maternity indicators undertaken by the Care Quality Commission has indicated significantly high rates of puerperal sepsis within 42 days of delivery at your trust.

The Care Quality Commission has conducted its own analysis of this alert and considered the results alongside other relevant information held internally (see appendix 1). Based on the findings of this analysis, we would like to request information from the trust to enable us to review the matter further. In particular:

1. Any explanation you may have for the significant change in outcomes around April 2011 at your trust for rates of puerperal sepsis within 42 days of delivery, as indicated in our analysis (shown in Figures 1 and 2 of Appendix 1).
2. Evidence of any analysis you have undertaken to assess this alert. We expect this to include the details and findings of a case note review. Our analysis showed that the rate of puerperal sepsis following a caesarean section was significantly raised, whereas rates following other delivery methods appeared to be within expected limits (see Table 5 in Appendix 1). We would therefore request that you focus your review on cases of puerperal sepsis following a caesarean section, and recommend that a random sample of at least 30 of the 45 cases between April 2011 and February 2012 are included. Please refer to Appendix 3 for further guidance on the information we expect to be included in your review, and the level of detail we would like to see.
3. You will be aware that we have previously written to you regarding a maternity outlier alert for an overlapping diagnosis group, 'puerperal sepsis and other puerperal infection within 42 days of delivery'. However, at that time our analysis showed rates of puerperal sepsis (ICD-10 O85) to be within expected limits, and we asked you to focus on cases of 'other puerperal infection' (ICD-10 O86). Please could you provide

us with an update on the actions you planned to implement following that alert. In particular, we note that you had planned to undertake a further audit in March 2012, and we would be interested to see the findings from this.

4. Please could you let us know details of any additional improvement activity for this service that you have taken or are planning in response to this alert or your own performance monitoring. Please include details of how these actions will be implemented, and provide timescales for completion and the names or roles of the personnel responsible for each of the actions planned. Can you also ensure that the actions address all areas where a need for improvement was highlighted by the review.

5. Please could you provide information about the infection control procedures you have in place at the trust, particularly relating to surgery.

We would be grateful if you could provide this information by 15 November 2012. If you foresee any difficulty in complying with this request, please contact me to discuss the matter.

We do not necessarily expect you to have determined the cause of this alert. However, we would expect to see the evidence that assured you that either there were no concerns regarding the clinical care of these patients and/or, if you have identified areas where quality of care could be improved, that you have plans in place to address each of these areas, with clear timescales for completion and names of lead personnel.

We anticipate that the findings from your review will be incorporated into your clinical governance arrangements so that any learning points are disseminated within the trust, and we would like to have some assurance from you that this has happened or is planned.

If you have difficulty in identifying the relevant patients, please contact us as soon as possible on receiving this letter and we will able to provide further detail.

Please continue to communicate with your regular Care Quality Commission regional contacts with regards to general trust matters, but liaise directly with me with regards to these specific enquiries.

We look forward to receiving the information requested and anything additional you would like to provide.

This letter (excluding appendices), will be shared with your Care Quality Commission regional contacts, the PCT Cluster and the SHA for their information.

If you would like to discuss the content of this letter in more detail, please do not hesitate to contact me.

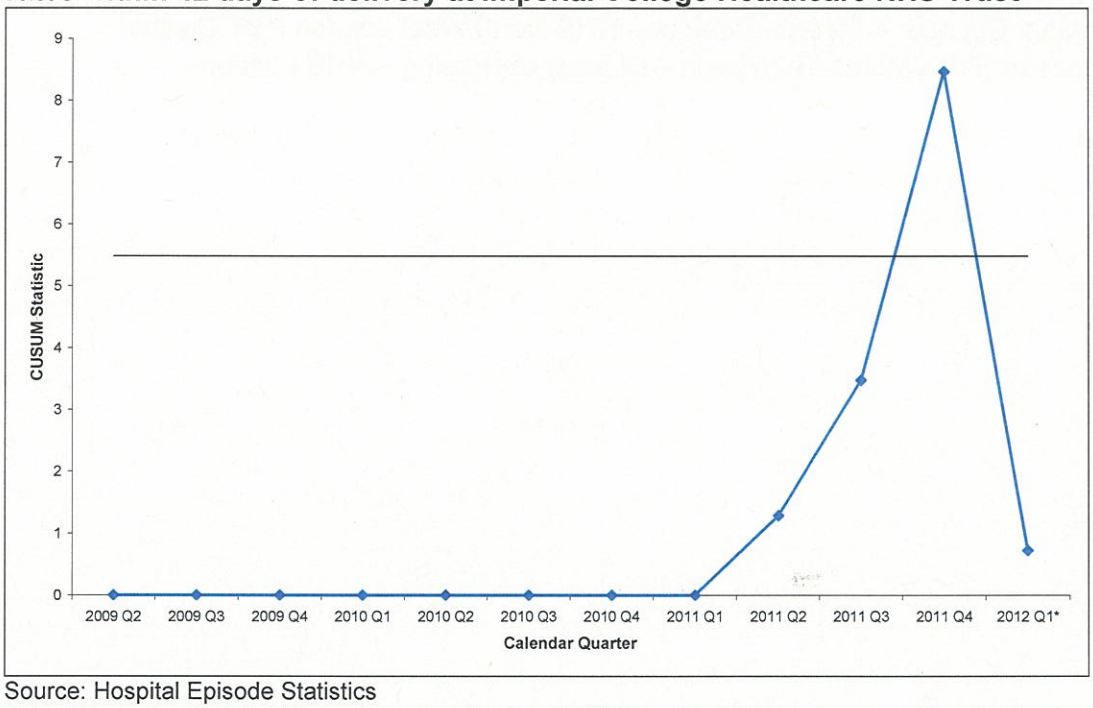
Yours sincerely

Mr Chris Sherlaw-Johnson
Surveillance Manager
020 7448 4547
outliers@cqc.org.uk

cc: Margaret Flaws – Compliance Inspector – Care Quality Commission
Gale Stirling – Compliance Manager – Care Quality Commission
Michele Golden – Compliance Manager – Care Quality Commission
Sarah Seaholme – Head of Regional Compliance (London) – Care Quality Commission
Dr Anne Rainsberry – Chief Executive – NHS North West London PCT Cluster
Dr Mark Spencer – Medical Director – NHS North West London PCT Cluster
Professor Trish Morris-Thompson – Director of Nursing – NHS London

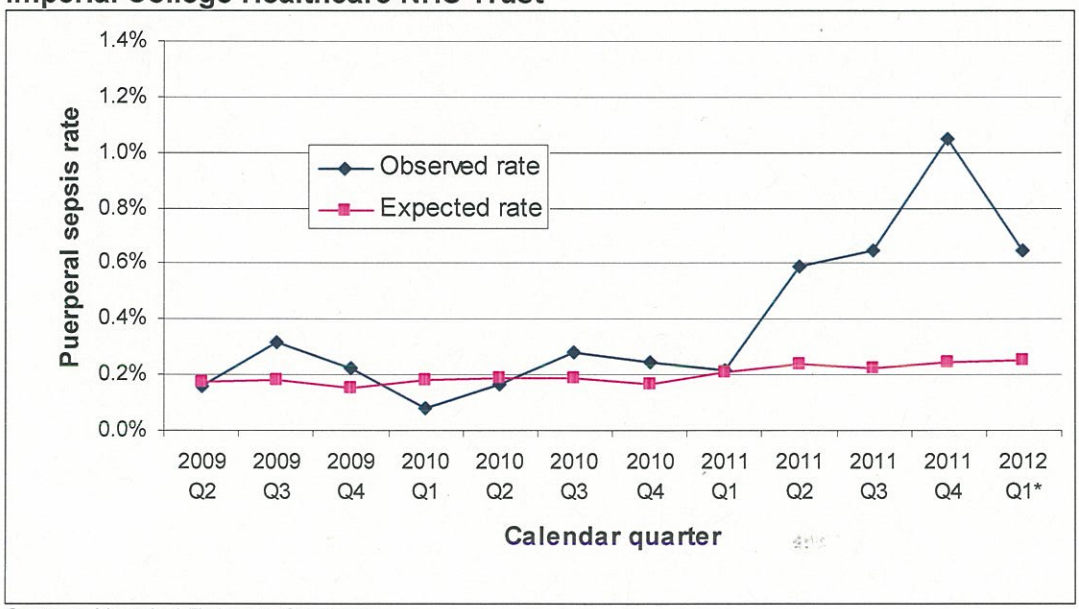
Trust	Maternity Alert
Imperial College Healthcare NHS Trust (RYJ)	Puerperal sepsis within 42 days of delivery (ICD-10 diagnosis code O85)

Figure 1: CUSUM Statistical process control chart for standardised puerperal sepsis rates within 42 days of delivery at Imperial College Healthcare NHS Trust



Source: Hospital Episode Statistics
Note: See appendix 2 for information regarding the CUSUM methodology; rates are indirectly standardised for the age profile of the women delivering at the trust; *2012 quarter 1 only includes data to February 2012.

Figure 2: Observed and expected puerperal sepsis rates within 42 days of delivery at Imperial College Healthcare NHS Trust



Source: Hospital Episode Statistics
Note: See appendix 2 for information regarding the expected rate; *2012 quarter 1 only includes data to February 2012.

Summary

- Analysis of deliveries at the trust showed an older profile of women, a high proportion of multiple deliveries, and a low normal birth rate. In response to previous maternity alerts, the trust has provided information demonstrating the complexity of their case mix, as they are a tertiary referral centre for maternal and fetal medicine.
- Rates of puerperal sepsis have shown a significant increase from 2011 quarter 2 onwards.
- Our analysis found that rates of puerperal sepsis following both emergency and elective caesareans were significantly higher than expected at the trust.
- We have previously written to the trust about a similar patient group and, at that time, the puerperal sepsis rate was well within expected limits.
- It is notable that the increase in rates of puerperal sepsis started in 2011 quarter 2, the quarter following the CUSUM signal for the wider group 'puerperal sepsis and other puerperal infections' (2011 quarter 1). At that time when writing to the trust we only asked them to look at 'other puerperal infections' (O86), as our analysis showed the puerperal sepsis (O85) rate to be well within expected limits.
- Our analysis has shown that the increase in puerperal sepsis (O85) has not been accompanied by a corresponding decrease in 'other puerperal infections' (O86).

1. Introduction

Outlier status

Imperial College Healthcare NHS Trust alerted, using the CUSUM time series technique (see appendix 2 for method), for significantly high rates of puerperal sepsis within 42 days of delivery, signalling in 2011 Q4 (see figure 1). Figure 2 shows how the rates at the trust have compared to the expected rates since 2009 quarter 2.

The indicator is defined as follows:

- **Puerperal sepsis (ICD-10 O85)** within 42 days of the start of the delivery episode. This indicator looks for puerperal sepsis recorded within the delivery spell, or in any subsequent hospital admission. The indicator is standardised to account for the age profile of women delivering at the trust.

The indicator detailed above, and the analysis within this report, is based on births that took place in-hospital. Home births are excluded, as the level of information recorded in HES for these births is not detailed enough to be used in our analysis.

Please note that the analysis of this indicator will look at discharges up until February 2012. Discharges in March and April 2012 cannot be analysed, as data is not yet available to look at the 42-day period following delivery needed for this indicator.

ICD-10 primary diagnosis code

- O85.X Puerperal sepsis

Description of puerperal sepsis

Puerperal sepsis is any bacterial infection of the genital tract which occurs after the birth of a baby. It is usually more than 24 hours after delivery before the symptoms and signs appear. If, however, the woman has had prolonged rupture of membranes or a prolonged labour without prophylactic antibiotics, then the disease may become evident earlier.

Symptoms and signs of puerperal sepsis include:

- Fever (temperature of 38°C or more)
- Chills and general malaise
- Lower abdominal pain
- Tender uterus
- Subinvolution of the uterus
- Purulent, foul-smelling lochia.
- Light vaginal bleeding
- Shock

Source: *World Health Organization. 2008. Managing puerperal sepsis.*

2. Clinical Negligence Scheme for Trusts - Maternity Risk Management Standards

The following information is taken from the most recently available level 2 assessment report for this trust, based on visits carried out on 19 and 20 November 2009.

Overall summary of the maternity service's compliance

Imperial College Healthcare NHS Trust was successful in demonstrating compliance with the Level 2 requirements of the *Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2009/10*, scoring 40 out of 50.

Key Recommendations for the future

The maternity service had more committees and reporting processes than those documented in the *Maternity Risk Management Strategy* dated July 2009. The organisational structure would benefit from a more accurate description and the inclusion of an organisational structure chart. This caused a substantial delay in the initial part of the assessment whist the assessors attempted to unravel the structure and assure themselves that the trust board lead executive communicated with and obtained assurance from the maternity service.

The maternity service had numerous proformas in use which sometimes meant that there were several places that one aspect of care could potentially be recorded leading to variances and inconsistencies within the health records. The maternity service may like to consider whether this creates more risks than it avoids and whether guidance within the approved document could clearly indicate which part of the maternity records the information must be recorded on.

Some of the approved documents were loosely worded and consequently led to variances in the language used in the health records e.g. caesarean section classifications were referred to as grade and/or category which made it difficult to determine the implementation. The maternity service should consider using consistent terminology and ensure that it is used throughout the maternity service.

During the assessment of various criteria the assessors found other result records in the designated cardiotocograph (CTG) envelope, particularly ph results, which is in direct conflict with the approved documents. The maternity service should ensure that this does not occur in the future.

The maternity service is reminded that during the Level 2 assessment, with the exception of the minimum requirements carried forward, the Level 1 requirements of the approved documentation were not reviewed or assessed, and as many of the criteria and minimum requirements were pilot these may not have been included within the documentation. It is therefore recommended that, prior to any future assessment, the maternity service reviews the approved documents in relation to the minimum requirements at Level 1 to ensure that all documents have clearly written and comprehensive processes for all the minimum requirements.

3. Information about a previous related maternity outlier alert for 'puerperal sepsis and other puerperal infections' within 42 days of delivery at the trust

In September 2011 we wrote to the trust regarding a maternity outlier alert for 'puerperal sepsis and other puerperal infections' within 42 days of delivery. We found that the trust had persistently higher than expected rates for this indicator since April 2008. The standardised ratio was lowest in 2010 quarter 1 but had increased each quarter since, leading to a CUSUM signal in 2011 quarter 1 (January to March 2011).

When the diagnoses were analysed individually, between July 2010 and March 2011, it was found that the 'other puerperal infections' (O86) rate was raised, whilst the rate for puerperal sepsis (O85) at the trust in the same time period was similar to expected. In particular, high rates were seen at the trust within the detailed diagnoses of O86.0 (Infection of obstetric surgical wound), O86.4 (Pyrexia of unknown origin following delivery) and O86.2 (Urinary tract infection following delivery). Therefore, when we wrote to the trust in September 2011, we asked them to focus their review only on patients recorded with other puerperal infections (O86).

Given that the rate of puerperal sepsis (O85) at this time was within expected limits, we did not ask the trust to include this diagnosis in their review. We therefore have not received any previous information from the trust regarding this specific diagnosis. Since this previous alert, the rate of puerperal sepsis has significantly increased (see figures 1 and 2).

The trust carried out a case note and coding review of women recorded with 'other puerperal infections' (O86). The trust identified coding issues in 55% of the cases as well as some areas for improvement in terms of clinical care. These included:

a. Updating staff on correct suture techniques for perineal wounds
b. Updating staff of correct techniques for ensuring sterility during urinary catheterisation and operative procedures in labour ward rooms and in theatre
c. Coders to be informed of use of correct coding
d. Repeat case note review of patients coded puerperal sepsis/other puerperal infections in March 2012
e. Prospective analysis of puerperal infection rates with quarterly updates
f. Puerperal infection rates to be reported to Division of Maternity on a quarterly basis as a standing item

The trust provided an action plan with timescales and leads responsible. All of these actions were due for completion by March 2012. The case was closed in December 2011 with regional follow up of the action plan.

The trust also provided some evidence to support their claim that they would actually expect a higher rate of puerperal infections compared to the average rates across England in view of the more complex case mix they deliver on our two sites. The factors causing this included:

- The age profile at the trust is older when compared to nationally with over 30% of mothers delivering at the trust being aged 35 years or older compared with approximately 20% nationally *(Note that our analysis already adjusts for this).*
- They are a tertiary centre with a national referral base for maternal medicine and fetal medicine services as well as being a level 3 unit for neonatal care. As a result, the women who they deliver have more medical co-morbidities than the national profile, which increases their overall vulnerability to infection.

- The trust has a combined spinal epidural (CSE) analgesia rate of 50%, which is higher than the 33.3% national rate. A high proportion of women who have a CSE require urinary catheterisation, a well-recognised complication of which is the development of urinary tract infection.

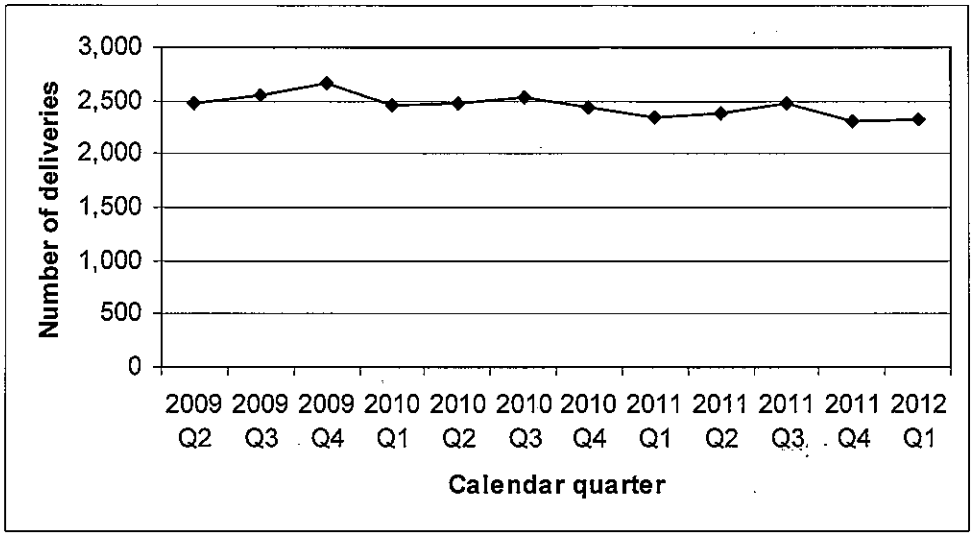
It is notable that the increase in rates of puerperal sepsis started in 2011 quarter 2, the quarter following the CUSUM signal for the wider group (2011 quarter 1). Our analysis has shown that the increase in puerperal sepsis (O85) has not been accompanied by a corresponding decrease in the rate of other puerperal infections (O86). It is also important to note that the trust did not receive any communication from us regarding this alert until September 2011.

4. Deliveries at the trust

Volumes of deliveries

- Figure 3 shows the number of deliveries by quarter at the trust since April 2009.

Figure 3: Quarterly numbers of deliveries at Imperial College Healthcare NHS Trust (April 2009 to March 2012)



Source: Hospital Episode Statistics

Proportions of delivery methods

- Table 1 shows the profile of delivery methods at the trust, as derived from the recorded primary procedure.
- The recorded normal delivery rate at the trust was lower than the national rate (52.5% compared with 61.2%). This was due to raised rates across a number of other delivery methods, notably a ventouse rate of double the national rate (12.1% compared with 6.3%).
- The trust has previously alerted as an outlier for their rate of elective caesarean sections and the case was closed in June 2011. As part of their response, the trust stated that the patient population for both its sites includes tertiary referrals to its specialist maternal and fetal medicine service as well as a large proportion of private patients. They have already put a number of actions in place to try to reduce their caesarean rates.

Table 1: Proportion of deliveries by recorded delivery method (April 2011 to February 2012)

	England	Imperial College Healthcare NHST	
	Deliveries (%)	Deliveries (n)	Deliveries (%)
Elective caesarean delivery	10.0%	1,076	12.4%
Other/Emergency caesarean delivery	14.6%	1,517	17.4%
Breech Extraction delivery	0.0%	7	0.1%
Other Breech delivery	0.4%	23	0.3%
Low Forceps cephalic delivery	2.9%	413	4.7%
Other Forceps Delivery	3.6%	16	0.2%
Ventouse (Vacuum) delivery	6.3%	1,054	12.1%
Spontaneous other delivery	0.4%	2	0.0%
Normal delivery (Spontaneous vertex)	61.2%	4,572	52.5%
Other/unrecorded delivery method	0.5%	24	0.3%
Total deliveries	100% (n=606,777)	8,704	100%

Source: Hospital Episode Statistics
Notes: Delivery methods are derived from primary procedure.

Profile of all deliveries at the trust

- The proportion of women delivering at the trust who had a multiple pregnancy was 2.5%, compared with 1.6% nationally.
- The age distribution of women delivering at the trust was older compared to the national profile. Over 30% of the mothers giving birth at the trust were aged 35 years old or over compared with nearly 20% nationally.
- These findings are in line with analysis carried out for previous maternity alerts at the trust.

Table 2: Profile of all deliveries (April 2011 to February 2012)			
	England	Imperial College Healthcare NHST	
	Deliveries (%)	Deliveries (n)	Deliveries (%)
Single or multiple births			
Single	98.4%	8,488	97.5%
Multiple	1.6%	216	2.5%
Gestation Period			
Under 24 weeks	1.3%	6	0.1%
Pre term 24-36 weeks	7.2%	559	6.6%
Term 37-42 weeks	91.2%	7,880	93.1%
Post Term >42 weeks	0.3%	21	0.2%
Mother's age			
Under 20	5.1%	172	2.0%
20-34	75.4%	5,717	65.7%
35-39	15.7%	2,154	24.7%
40+	3.9%	661	7.6%
Length of stay			
Median length of stay	2 days	2 days	
Total number of deliveries			
Total number of deliveries	606,777	8,704	

Source: Hospital Episode Statistics

Notes: A single birth includes any delivery where there is no indication of a multiple birth; analysis of gestation periods excludes deliveries where this information was unrecorded (13.0% nationally compared to 2.7% at the trust).

5. Triggering Indicator: Puerperal sepsis within 42 days of delivery (ICD-10 diagnosis code O85)

This indicator measures puerperal sepsis both during the delivery spell and at any admission to hospital within 42 days following delivery.

Quarterly activity

- Table 3 shows that rates of puerperal sepsis at the trust have significantly increased from 2011 quarter 2, with at least twice the expected number of cases occurring in each quarter. In 2011 quarter 4 (when the CUSUM signal occurred), there was more than 4 times the expected number.

Table 3: Quarterly cases of puerperal sepsis at Imperial College Healthcare NHST (April 2009 to February 2012)

Quarter	Deliveries	Puerperal sepsis	Expected puerperal sepsis	Standardised Ratio (SR)
2009 Quarter 2	2,480	4	4.2	95.6
2009 Quarter 3	2,548	8	4.5	176.7
2009 Quarter 4	2,655	6	3.9	153.0
2010 Quarter 1	2,464	2	4.5	44.4
2010 Quarter 2	2,471	4	4.6	87.0
2010 Quarter 3	2,529	7	4.8	147.0
2010 Quarter 4	2,432	6	4.1	147.5
2011 Quarter 1	2,341	5	4.9	101.2
2011 Quarter 2	2,373	14	5.7	246.3
2011 Quarter 3	2,484	16	5.5	289.0
2011 Quarter 4	2,297	24	5.6	432.2
2012 Quarter 1*	1,547	10	3.9	253.8

Source: Hospital Episode Statistics
Note: *2012 quarter 1 only includes data to February 2012.

Puerperal sepsis and other puerperal infections rates (April 2010 to February 2012)

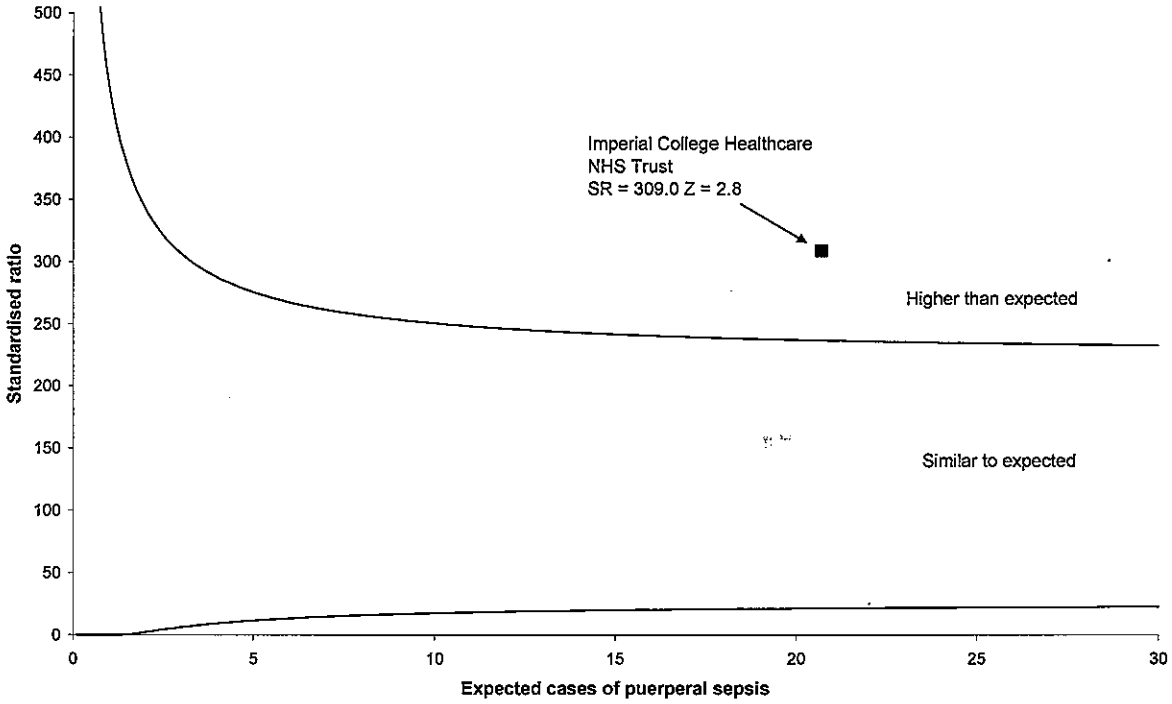
- During the time period April 2011 to February 2012, the puerperal sepsis rate at the trust was significantly higher than expected, using a 95% control limit (SR = 309.0, z = 2.8) (see Table 4 and Figure 4). This was a significant increase from the previous year (April 2010 to March 2011), when the rate was well within expected limits (SR = 119.9, z = 0.3).
- Given that the previous alert at the trust showed a significantly high rate of the related diagnosis 'other puerperal infections' (O86), analysis was carried out to see if this rate has remained high. Table 4 shows that standardised outcomes have remained similar during April 2011 to February 2012 when compared to the previous year.

Table 4: Puerperal sepsis and other puerperal infection rates

	England	Imperial College Healthcare NHS Trust		
	Rate	Number of cases	Rate	Standardised Ratio (SR)
Puerperal sepsis (O85)				
April 2010 to March 2011	0.2%	22	0.2%	119.8 (Z = 0.3)
April 2011 to Feb 2012	0.2%	64	0.7%	309.0 (Z = 2.8)
Other puerperal infections (O86)				
April 2010 to March 2011	1.4%	255	2.6%	183.6 (Z = 1.8)
April 2011 to Feb 2012	1.6%	265	3.0%	184.8 (Z = 1.6)

Source: Hospital Episode Statistics

Figure 4: Cross sectional funnel plot of standardised puerperal sepsis within 42 days of delivery among all trusts (April 2011 to February 2012)



Source: Hospital Episode Statistics

Timing of puerperal sepsis (April 2011 to February 2012)

- Cases of puerperal sepsis were analysed by the time at which this was diagnosed i.e. whether this diagnosis occurred in the delivery spell or in another admission to hospital occurring within 42 days of the delivery.
- Over half (59.4%) of the women who had puerperal sepsis (O85) recorded at the trust within 42 days of delivery had this diagnosis recorded during the delivery spell. This was nearly double the national proportion (30.2%). The remaining women had puerperal sepsis diagnosed on subsequent admissions to hospital.

Length of stay at delivery (April 2011 to February 2012)

- The median length of stay at delivery for women who had a puerperal sepsis diagnosis (O85) recorded within 42 days of delivery was 4 days at the trust compared with 3 days nationally.

Puerperal sepsis by delivery method (April 2011 to February 2012)

- Table 5 shows that 38 women were recorded with puerperal sepsis following an emergency caesarean at the trust. This was a significantly high rate when compared to nationally (2.5% compared with 0.6%).
- Similarly, the trust had a significantly high rate of puerperal sepsis following elective caesarean section (0.7% compared with 0.2%).
- 12 women were recorded with puerperal sepsis following a normal delivery at the trust. However, this was not significantly higher than expected.

Table 5: Puerperal sepsis rate by recorded delivery method (April 2011 to February 2012)

	England	Imperial College Healthcare NHST	
	Rate	Puerperal sepsis (n)	Rate
Elective caesarean delivery	0.2%	7	0.7%
Other/Emergency caesarean delivery	0.6%	38	2.5%
Breech Extraction delivery	0.0%	0	0.0%
Other Breech delivery	0.5%	1	4.3%
Low Forceps cephalic delivery	0.3%	1	0.2%
Other Forceps Delivery	0.3%	0	0.0%
Ventouse (Vacuum) delivery	0.3%	5	0.5%
Spontaneous other delivery	0.1%	0	0.0%
Normal delivery (Spontaneous vertex)	0.2%	12	0.3%

Source: Hospital Episode Statistics
Note: Delivery methods are derived from primary procedure.

Appendix 2: Glossary

Cross-sectional analysis
The cross-sectional analysis measures the standardised ratio (SR) for a chosen single period and the extent to which it deviates from the norm. SR's are presented on a funnel plot. The control limits, with their distinctive funnel shape, represent a specified significance level.

CUSUM
This technique identifies persistent deviations from expected values over time. If outcomes are lower than the national average plus a predefined tolerance level then the plot will stay at zero. If higher, the CUSUM plot will move upwards. If a significant run of high values is detected, the plot crosses a fixed 'control limit' and the plot is then reset to zero. Resetting the plot after an alert allows for further runs of high values to be detected.

Expected cases of puerperal sepsis
Expected numbers of puerperal sepsis are calculated by comparing rates at a given trust to national rates on a quarterly basis. Within this comparison, indirect standardisation is carried out to adjust for differences in the age of women delivering at the trust.

HES data
Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contain details of all NHS outpatient appointments in England.

Outlier Status
An outlier is a trust performing significantly differently than expected on a given measure - here this generally relates to standardised rates in comparison to national levels. The method used to identify outliers among the basket of maternity indicators was a type of statistical process control (a methodology that is used to identify significant deviations from a predefined standard) called CUSUM (short for Cumulative Sum).

Small numbers
Due to reasons of confidentiality, numbers less than 6 may have been suppressed and replaced with '*'.

Spells
A spell of treatment is a continuous period of treatment within a single hospital provider (a period commencing with admission to hospital and ending on discharge) and can be made up of a number of care episodes.

Statistical Process Control
Statistical process control (SPC) is a methodology that uses control charts to identify significant deviations from a predefined standard. These methods originated in manufacturing industry and are now regularly applied to the monitoring of healthcare.

Z Score
The z-scoring approach enables us to measure outcomes on a common scale. The z-score measures the number of standard deviations away from the mean, preceded by a plus or minus depending on whether it is respectively above or below the mean (the mean value is commonly the average value for all trusts, or all trusts of a specific type). High z-scores indicate worse outcomes and low z-scores good outcomes. Z-scores correspond to p-values in that a p-value of 0.01 is equal to a z-score of 2.3 and a p-value of 0.001 matches a score of 3.0.

INFORMATION REGARDING CASE NOTE REVIEWS

When a trust carries out a review of case notes in order to establish whether there have been any concerns about the quality of care provided to their patients, it is very useful for the Care Quality Commission to be provided with information regarding the methodology used, as well as the full findings.

Please ensure that the following level of information is included in the report of any case note review that is carried out in response to an outlier alert: -

- Whether the case notes for all the patients concerned were examined or a sample was identified. If a sample was used, details should be given of how it was chosen.
- Whether all the cases identified were available for review. If they were not, details should be given as to why.
- Whether all available cases were actually reviewed. If they were not, please give details as to why.
- The roles of those involved in extracting the clinical information from the notes should be provided.
- The extent of medical and/or clinical involvement should be described.
- Where possible, those involved in reviewing the case notes should be independent of those responsible for the patients' treatment.
- An assessment of the quality of care given should be included for each of the patients reviewed.
- Please give details of the process used and evidence for the conclusions drawn, including if the review considered whether:
    - Any adverse events were avoidable.
    - The diagnosis and care provided could have been improved.
- Anonymised individual patient level summaries and any proforma used should be provided.
- When a proforma is used, the response should include the findings for each of the aspects covered.
- Details and/or reference(s) to any published methodology used for the review.
- Whether changes were made to the clinical coding as a result of the case note review. If so, please provide details of these changes.
- How **all** areas identified for improvement will be addressed. Please include details of how these actions will be implemented, and provide timescales for completion and the names or roles of the personnel responsible for each of the actions planned. It should also be clear how you plan to assess the impact of these actions.

Queen Charlotte's and Chelsea Hospital
Du Cane Road
London
W12 0HS

P: 020 3313 5094
F: 020 3313 8557
E: mandish.dhanjal@imperial.nhs.uk
W: www.imperial.nhs.uk

Mr Chris Sherlaw-Johnson
Surveillance Manager
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

15th December 2012

Your reference: C101/AH dated 18 October 2012

Dear Mr Sherlaw-Johnson

Re: Care Quality Commission maternity outlier alert for puerperal sepsis within 42 days of delivery at Imperial College Healthcare NHS Trust (ICHNT)

Thank you for alerting us that you have identified significantly high rates of puerperal sepsis within 42 days of delivery at our Trust.

Your analysis showed an increased rate of puerperal sepsis following a caesarean section. We have therefore followed your recommendation and performed a detailed case note review focussing on cases of puerperal sepsis following caesarean section between April 2011 and February 2012. Appendix 1 outlines the methodology of the case note review. Appendix 2 shows the full proforma that was used for extracting the clinical information. Appendix 3 shows the findings for the analysis of the case note review at ICHT.

The total number of cases reviewed were 33. Of these 2 cases (6%) were delivered vaginally and were excluded. 1 case (3%) was booked and delivered elsewhere. She attended Queen Charlotte's and Chelsea Hospital postnatally. The case notes of this patient were reviewed and analysed to ensure there were no factors related to ICHT that contributed to their coding. No contributing factors were found. These data were excluded from the final analysis which therefore included a total of 30 cases. (Figure 1).

Our case review analysis has shown that 20% of caesarean section delivery cases were coded correctly as "puerperal sepsis" (code 085) [Tables 1-3]. Each of these cases had between 2 and 5 risk factors for developing an infection and no care issues were identified. The remaining 80% of the case notes were inaccurately coded. These had alternative diagnoses with the majority related to intrapartum pyrexia or sepsis which required completion of the course of antibiotics postnatally (50%). 5 cases (17%) were given

prophylactic antibiotics or had other puerperal infections postnatally, 3 cases (10%) had infections antenatally and one case (3%) was given antibiotics prophylactically intrapartum (Table 1).

Many cases of intrapartum pyrexia are presumed to be related to true infection, usually chorioamnionitis, although microbiological confirmation of this is often not sought or yields no growth. Intrapartum pyrexia will also be increased in units which have a high epidural usage for analgesia in labour such as Queen Charlotte's and Chelsea Hospital. This is a result of patient choice, and it is prudent to note that all women who laboured in this case review had an epidural for analgesia. Such patients will be given antibiotics as it is impossible in the intrapartum scenario to distinguish between true infection and epidural related pyrexia.

Previous alert: "other puerperal infections" (ICD-10 O86)
Following our previous alert as an outlier in "other puerperal infections" (ICD-10 O86) we had an action plan to reduce the puerperal infection rates at ICHNT. In addition we performed an audit of all the cases from March 2012 (Table 4). The updated action plan and key findings from the audit are outlined in Appendix 4, and comparison is made to the results of the previous case note review we performed from March 2011. In March 2012 eleven cases were identified compared to 37 in March 2011. Two sets of case notes could not be located and therefore 9 cases were analysed. All cases of wound infection (O86.0) and urinary tract infection (O86.2) were coded correctly, although only half the cases of pyrexia of unknown origin (O86.4) were coded correctly. Overall the coding had improved from 43% to 67%. (Table 5).

Infection control procedures in place at the Trust
We have a robust system of infection control at the Trust with comprehensive policies on various aspects of infection. There are 30 guidelines on different aspects of infection and all clinicians are trained and assessed in Aseptic Non Touch Techniques (ANTT) and hand hygiene.

To summarise, in response to the current alert we have identified that our puerperal sepsis rate is lower than reported and would be in keeping with that expected. We have identified that coding remains an issue. It can be difficult for coders to distinguish between the continuation of treatment in cases of intrapartum pyrexia and true puerperal sepsis with its onset postnatally. It is an issue that will be relevant to all maternity units. We would welcome an opportunity to establish if other Trusts have also highlighted this as an issue and if so, if you have been informed of any robust methods to deal with this. We have produced a new action plan which is at Appendix 5.

We thank you again for alerting us that we are an outlier for puerperal sepsis. We hope that our analysis of cases has reassured you that our puerperal sepsis rate is not as high as originally coded. Please be assured that we take infection and its prevention very seriously. We hope that you approve of the measures we are taking to improve reporting and coding. Please contact us directly if you require any further information.

Yours sincerely

Miss Mandish Dhanjal
Chief of Service Obstetrics, Queen Charlotte's and Chelsea Hospital

cc: Margaret Flaws, Compliance Inspector, Care Quality Commission
Gale Stirling, Compliance Manager, Care Quality Commission
Michele Golden, Compliance Manager, Care Quality Commission
Sarah Seaholme, Head of Regional Compliance (London), Care Quality Commission
Dr Anne Rainsberry, Chief Executive, NHS North West London PCT Cluster
Mark Spencer, Medical Director, NHS North West London PCT Cluster
Professor Trish Morris-Thompson, Director of Nursing, NHS London

Appendix 1

Methodology of case note review

- All cases identified with the codes indicating elective and non-elective caesarean section and the puerperal sepsis code 085 and in the months April 2011 to February 2012 were requested.
- The total number of cases identified were 38 with 34 cases at Queen Charlotte's and Chelsea Hospital (QCCH) and 4 cases at St Mary's Hospital. All 34 of the case notes from QCCH were requested.
- One set of case notes could not be located, therefore 33 case notes were analysed.
- The audit was performed in its entirety by the Chief of Service in Obstetrics, from devising the proforma, extracting the required information from the notes and analysis of the extracted information.
- The Chief of Service in Obstetrics was involved in a minority of the cases but not exclusively
- A proforma was used – see Appendix 2
- The review looked at quality of care issues including the risk factors putting the patients at risk of puerperal sepsis and whether the adverse events were avoidable.
- As a result of the case note review it was apparent that the coding of puerperal sepsis was accurate in 20% of the cases. The other 80% had alternative codes.

.

Appendix 2

Excel Proforma used for Care Note Analysis at Queen Charlotte's and Chelsea Hospital

Hosp No	El/ Em CS	Age	Ethnicity	Para	Gest	Risk Factors	no of sweeps	IOL	No of VEs before ROM, excl sweep	No of VEs after ROM	Dilat del	indication for CS	Del by	Timing of temp	Max temp	Sx	Senior Dr involvement	Full Infect Screen	Micro results					Other Ix	Rx	When AB start	Micro Involvement	FU	Stand of Care Optimal	Code	Code Correct	Comments
																			Wound Swab	Blood Culture	MSU	HVS	placental swab									

Appendix 3 Results of case review on puerperal sepsis (code O85) April 2011 to February 2012 ICHNT

Figure 1. Summary findings of case note review into puerperal sepsis

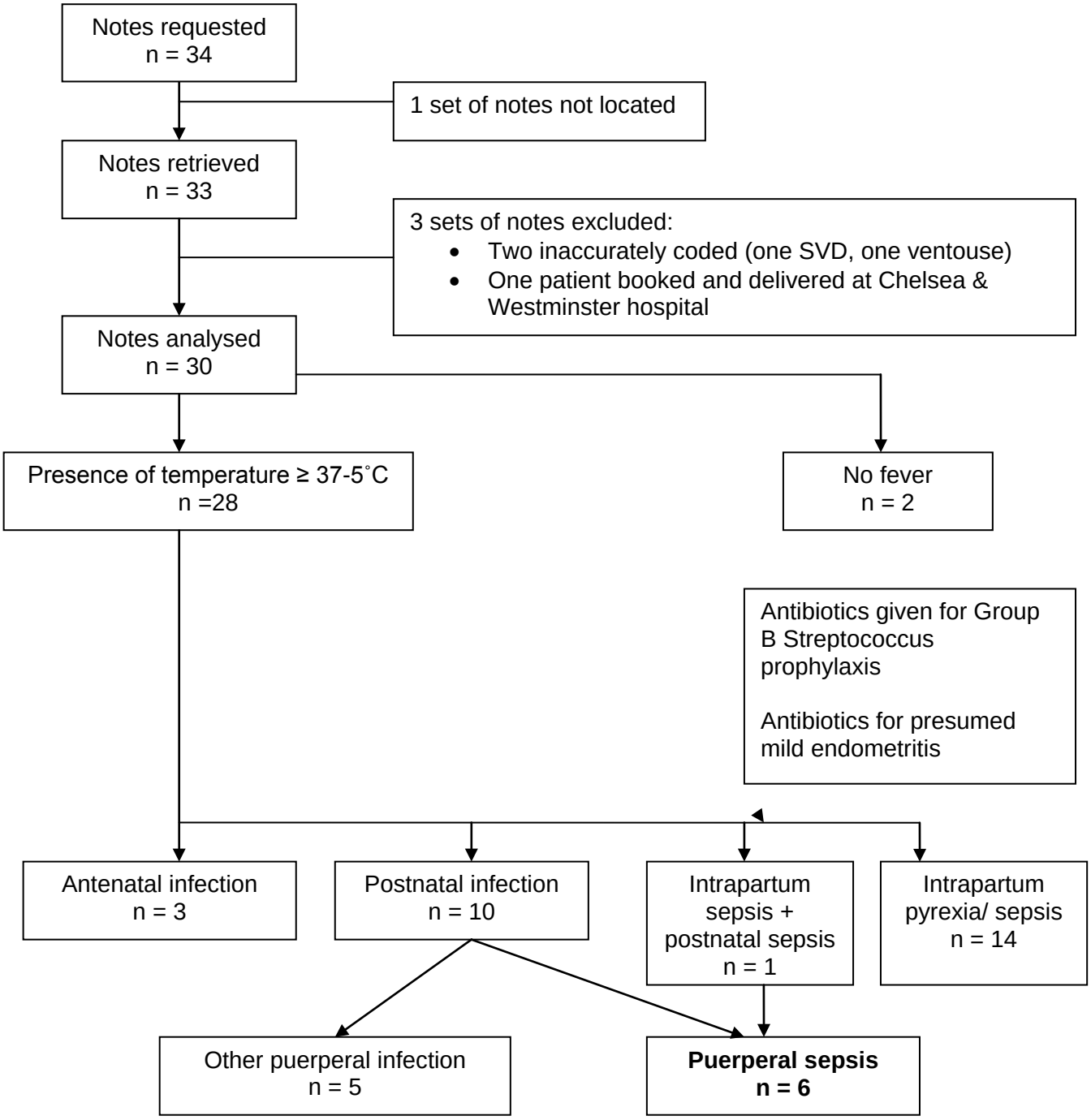


Table 1. Case note analysis of 30 notes at ICHT for puerperal sepsis (code 085) and caesarean section

Timing of Infection	Diagnosis	Number of cases
Antenatal	Urinary tract infection 39/40 (enterococcus)	1
	Acute appendicitis 36+6/40	1
	Pyelonephritis & pneumonia 36/40	1
Intrapartum	Intrapartum pyrexia ≥37.5˚C +/- intrapartum sepsis	11
	Chorioamnionitis +/- Maternal intrapartum sepsis	5*
	Antibiotic prophylaxis for Group B streptococcus carriage	1
Postnatal	Urinary tract infection	1
	Readmission with urinary tract infection + intrapartum pyrexia	1
	Urinary tract infection + mastitis	1
	Wound infection	1
	Presumed mild endometritis (afebrile)	1
	Puerperal sepsis	**6***

* One patient had intrapartum sepsis followed by ongoing pyrexia which worsened and developed ?infected intraperitoneal small collections

Table 2. Puerperal sepsis rates at ICHNT compared to England

	Expected rate (England)	ICHNT rate	Incorrect coding % (n)		Correct coding % (n)
			Alternative diagnosis/code	No diagnosis	
Puerperal Sepsis Code 085 + caesarean section	0.2%	0.7%	80% (24)	0% (0)	20% (6)

Table 3. Case note analysis of 6 notes at ICHT where coding for puerperal sepsis was accurate- relevant clinical points

											Microbiology results							
El/ Em CS	Ethnicity	Para	Ges of del	Risk Factors	Dilat at del	Del by	Timing of Temp	Max temp ˚C	Sx	Full Infect Screen	Wound Swab	Blood Culture	MSU	HVS	placental swab	Other Investigations	Antibiotic treatment	Comments
Em CS	Polish	0+0	40+	Sepsis in labour, 1L PPH, severe PET on protocol	9cm	EP/ CR	Labour 37.9 + worse PN	39.3 (D3)	none	yes	NG	Haemo-philus para-influenzae (blood cult in labour)	not done	n/a	GBS, lactose fermenting coliform	USS: 2 intra-peritoneal collections, 4 subcutan collections	Clindamycin --> amikacin, ciprofloxacin, clindamycin> Cef, met, vancomycin	Intrapartum sepsis + possible PN infected collections
Em CS	Romanian	0+0	40+	prolonged labour, 1.2L PPH	9cm	EM/ MA	D0 PN	38.4	none	yes	not done	NG	NG	not done	n/a	CXR N	augmentin, gentamicin	prolonged labour, 1.2L PPH
Em CS	Phillipino	0+0	26	severe PET, preterm mild RF low albumin	n/a	BJ/ RB	D4 PN	38.4	none	yes	not done	Staph aureus	E Coli UTI	GBS, staph aureus	n/a		Augmentin --> tazocin, vancomycin	IUT SMH, PET, NND Level 2 Critical care
Em CS	afrocarib	0+0	40	BMI 30, asthma	2cm	CN/ HB	D1 PN	39.1	none	yes	n/a	NG	NG	normal flora, yeast	n/a		augmentin, gentamicin	thick mec at del
Em CS	White British	0+0	35	DCDA twins, PIH, PPROM	n/a	SU/ TR	D1 PN	37.9	none	no	not done	NG	not done	NG	n/a		augmentin	Full infect screen not needed with temp <38. PN high BP
El CS	Iranian	2+1	38+	BM1 31, prev CS, smoker 20/d	n/a	DP/ EP	D2 PN	38.3	abdo pain	yes	not done	NG	NG	GBS, lactose fermenting coliform, yeast	n/a		augmentin	

El = elective; Em = emergency; CS = caesarean section Ges = gestation; Sx = symptoms; PPH = postpartum haemorrhage; PET = pre-eclampsia; NG = no growth; GBS = Group B Streptococus; USS = ultrasound scan; RF =renal failure; PIH =pregnancy induced hypertension; PPROM =preterm prelabour rupture of membranes

Appendix 4

Action plan for reduction in Puerperal infection rates at ICHT

Theme	Detail/action	Responsible	Progress/ deadline
Repair techniques/ ensuring sterility	Updating staff on correct suture techniques for perineal wounds and caesarean section wounds	Practice development midwives All consultant obstetricians	Complete
	Updating staff of correct techniques for ensuring sterility during urinary catheterisation and operative procedures in labour ward rooms and in theatre	Mandish Dhanjal Tg Teoh Pippa Nightingale	Complete
	Analysis of impact of using disposable suture pack for perineal repair as is used at SMH compared to opening multiple separate instruments for suturing at QCCH	Lisa Breton	Complete
Coding	Coders to be informed of use of correct coding	Nusrat Fazal Lorna Phelan	Complete
Audit	Repeat case note review of patients coded other puerperal infections	Nusrat Fazal Lorna Phelan Mandish Dhanjal	Complete
	Prospective analysis of puerperal infection rates with quarterly updates	Nusrat Fazal Lorna Phelan	Complete
Monitoring and information	Puerperal infection rates to be reported to Division of Maternity on a quarterly basis as a standing item	Mandish Dhanjal Tg Teoh	Complete following monitoring
	Action plan to be monitored in Division of Maternity	Chiefs of Service Obstetrics	Complete

Table 4. Audit of cases of "other puerperal infections" code O86 from ICHNT March 2012

Other Puerperal Infection	Case	Comment	Coding Correct	Actual coding
Wound infection O86.0	1	Emergency CS. Readmitted with symptoms of wound discharge. Wound swab grew lactose fermenting coliform	Yes	
	2	Emergency CS. Slight erythema around wound. Wound swab: no growth	Yes	
Urinary tract infection O86.2	1	Normal delivery. Urinary symptoms. MSU grew group B streptococcus	Yes	
Pyrexia of unknown origin O86.4	1	Spiked temperature once. No other symptoms. No antibiotics required	No	Nil
	2	Emergency CS. Postpartum pyrexia. No growth on blood cultures, swabs and MSU. Given antibiotics	Yes	
	3	Intrapartum pyrexia due to chorioamnionitis. Given antibiotics. Emergency CS. Placental swab grew group B streptococcus	No	Chorio-amnionitis
	4	Emergency CS. Postpartum pyrexia. Staphylococcus aureus in blood culture and vaginal swab	Yes	
	5	Intrapartum pyrexia due to chorioamnionitis. Given antibiotics. Emergency CS. Readmitted postnatally with peripheral oedema.	No	Chorio-amnionitis
	6	Emergency CS. Postpartum pyrexia. No growth on blood cultures, swabs and MSU. Given antibiotics	Yes	
Total cases	**9***		**67%**	

* 11 cases identified, 9 case notes located and analysed

Table 5. Comparison of case note review from March 2011 and audit from March 2012 of "other puerperal infections" code O86 at ICHNT

	Overall Total		Wound Infection O86.0		Urinary Tract Infection 086.2		Pyrexia of unknown origin 086.4	
	n	**Accurate code n (%)**	n	Accurate code n (%)	n	Accurate code n (%)	n	Accurate code n (%)
March 2011	**37**	**16 (43%)**	19	10 (53%)	10	4 (40%)	8	2 (25%)
March 2012	**11 (9*)**	**6 (67%)**	2	2 (100%)	1	1 (100%)	6	3 (50%)

* 11 cases identified, 9 case notes located and analysed

Appendix 5

Action plan following CQC maternity outlier alert for puerperal sepsis within 42 days of delivery at (ICHNT)

Theme	Detail/action	Responsible	Progress/deadline
Coding	Coders to be informed of use of correct coding	Mandish Dhanjal Tg Teoh	January 2013
Audit	Repeat case note review of patients coded puerperal sepsis	Mandish Dhanjal Tg Teoh	Perform audit for month of March 2013
Monitoring and information	Regular meetings with coders and clinical staff to go through a sample of cases to check on accuracy of coding	Serap Akmal Chrissie Yu Maternity coding team	June 2013
	Audit results to be reviewed at Division of Maternity Meeting June 2013	Mandish Dhanjal Tg Teoh	June 2013

Care Quality Commission
Finsbury Tower
103 – 105 Bunhill Row
London
EC1Y 8TG
www.cqc.org.uk

Mandish Dhanjal, Chief of Service Obstetrics
Imperial College Healthcare NHS Trust
The Bays, South Wharf Road
St Mary's Hospital
London
W2 1NY

28 February 2013

Our reference: C101/AH

Dear Miss Dhanjal

Re: Care Quality Commission maternity outlier alert for puerperal sepsis within 42 days of delivery at Imperial College Healthcare NHS Trust

Thank you for your e-mail, dated 17 December 2012, and associated report.

As you are aware, analysis of maternity indicators undertaken by the Care Quality Commission has indicated significantly high rates of puerperal sepsis within 42 days of delivery at your trust. We wanted to be certain that the high rates in this area had been recognised, explanations explored and appropriate actions taken by the trust in a timely manner to ensure the future safety of patients.

We have reviewed the information you have provided, considered it against our own findings and do not feel that we need to undertake additional enquiries at this time. However, our regional team will follow up on your progress with implementing the action plan. Should you become aware of any further issues relating to this alert, we would ask you to let us know.

We note that coding was identified as a factor in this alert, and in particular you found that it can be difficult for coders to distinguish between the continuation of treatment in cases of intrapartum pyrexia and true puerperal sepsis with its onset postnatally. This specific matter has not been raised with us before, although there have been a number of other coding issues which have arisen in response to these alerts. Generally trusts have addressed these areas by improving the quality and clarity of information in patient notes to allow accurate coding, increasing interaction between coders and clinicians, and undertaking regular coding audits.

This letter will be shared with your Care Quality Commission regional contacts, the PCT Cluster and the SHA Cluster for their information.

If you would like to discuss the content of this letter in more detail, please do not hesitate to contact me.

Yours sincerely

Mr Chris Sherlaw-Johnson
Surveillance Manager
020 7448 4547
outliers@cqc.org.uk

cc: Mark Davies – Chief Executive – Imperial College Healthcare NHS Trust
Anne Farley – Compliance Inspector – Care Quality Commission
Gale Stirling – Compliance Manager – Care Quality Commission
Michele Golden – Compliance Manager – Care Quality Commission
Sarah Seaholme – Head of Regional Compliance (London) – Care Quality Commission
Dr Anne Rainsberry – Chief Executive – NHS North West London PCT Cluster
Dr Mark Spencer – Medical Director – NHS North West London PCT Cluster
Professor Trish Morris-Thompson – Head of Nursing – NHS London

Imperial College Healthcare NHS
NHS Trust

Audit and Risk Committee: 11 March 2013 **Agenda number: 5.4**

Report Title:	Cancer Recovery Implementation Plan

To be presented by:	Steve McManus, Chief Operating Officer

Executive Summary:

The Cancer Recovery Implementation Plan is delivering against a number of key activities in all the domains. This summary paper sets out progress and specific actions relating to cancer patient experience results and the national cancer performance standards.

There is evident improvement across the cancer performance standards as published for December 2012 whereby the Trust met six out of the eight national targets. The Trust's latest performance for January 2013 shows further improvement as the Trust is now meeting seven out of the eight national targets. The target where we continue to underperform is the '62 day wait for first treatment' standard, however, the Trust continues to maintain the trajectory regarding the delivery of all standards by March 2013. See appendix 1.

A cancer improvement and patient experience workshop was held on 1st March with over 90 staff attending. The themes that came out of the day can be categorised into three areas; 1. Performance, pathways and processes 2. Access to a Clinical Nurse Specialist and 3. Communication with and between GP, Patient and Team. Please see appendix 2 which sets out specific actions in relation to the bespoke cancer patient experience survey results.

It was agreed that over the next 100 days the following actions would take place:

Performance, pathways and processes

- Roll out new diagnostic pathways ie LGI and Urology
- Establish new pathway groups ie H&N, Breast, Prostate, Lung
- Roll out Somerset – to enable MDT real time reporting from April 2013
- Meet all national cancer standards by the March 2013 trajectory
- Recruit additional MDT / survivorship team (interviewing in April)

Access to a Clinical Nurse Specialist

- Ensure there is equitable CNS teams across all tumour sites
- Set up a Cancer Specific Call centre for GPs and Patients (pilot set up for April for LGI patients)

Communication, GP, Patient and Team

- Real time GP communication to deliver against our CQUIN
- 90% all patients must have Patient Information Prescription

- Increased use of Maggie's and MacMillan
- High profile representation on LCA
- Job Plans – need to have KPI; Ethos; training as core standard

In terms of the patient experience survey the above actions are intended to drive improvement by at least 2% each quarter. This has been achieved in the last quarter with results from patients surveyed in June to August 2012. If this level of performance can be met and sustained ICHT will be performing at the average in 12 months and upper quartile in 2 years. The next set of results will be available by the end of April ahead next Audit and Risk Committee.

Also attached is the cancer recovery implementation plan, please see appendix 3, which shows the actions that will take place, as well as the archived section which shows the completed actions. Weekly sessions will continue with the cancer team and the COO and DoN to ensure that the plan is being implemented and that the Trust is on target to hit all 8 national standards by the end of March as well as improve the patient experience survey results at a minimum of 2% per quarter. The plan is shared with CCG/Commissioners on a monthly basis. It needs to be updated as a result of the new actions that came out of the 1st March workshop.

Action required:

The Audit and Risk committee to receive regular updates regarding delivery against the cancer remedial action plan.

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

APPENDIX : 1

Cancer Waiting Times Performance 2012-13

Updated: 21/11/2012

2012-13 Cancer Standards		M1 April 2012			M2 May 2012			M3 June 2012			M4 July 2012			M5 August 2012			M6 September 2012 (internal)		
Commitment	Operational Standard	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail
62-Day First	85%	50	11.5	77.00%	67	25	77.00%	71	23.5	64.30%	89	38	57.30%	96	21	78.10%	31	10	67.7%
62-Day Screening	90%	7	2	71.43%	16	8	47.60%	12	1	93.50%	20	4	80.00%	13	3	76.90%	4.5	0	100.0%
31-Day First	96%	186	15	91.94%	218	26	89.10%	185	14	92.43%	237	28	88.19%	181	18	90.10%	131	14	89.3%
31-Day Chemo	98%	45	0	100.00%	75	1	100.00%	59	4	92.70%	37	0	100.00%	34	1	97.10%	40	0	100.0%
31-Day Surgery	94%	39	6	84.62%	71	10	84.60%	41	4	89.70%	42	0	100.00%	47	9	80.90%	39	5	87.2%
31-Day Radiotherapy	94%	95	4	95.79%	124	1	95.80%	111	5	96.20%	154	8	94.81%	99	4	96.00%	83	2	97.6%
2WW	93%	685	54	92.12%	870	58	93.20%	699	48	93.60%	844	50	94.08%	850	46	94.60%	293	15	94.9%
2WW Symptomatic Breast	93%	270	33	87.78%	367	25	93.40%	252	30	88.00%	255	18	92.94%	299	36	88.00%	233	20	91.4%
62-Day Consultant Upgrade	85% (Local performance target	8	2	75.00%	5	1.5	70.00%	3.5	1.5	85.71%	8.5	1	88.24%	7	1	85.70%	4.5	0.5	88.9%

Trajectory.....

2012-13 Cancer Standards		M7 October 2012			M8 November 2012			M9 December 2012			M10 January 2013				M11 February 2013				M12 March 2013			
Commitment	Operational Standard	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Total Patient Seen	Breaches	Pass/Fail	Expected Total Patients Seen	Breach Tolerance	Known Breaches	Pass/Fail	Expected Total Patients Seen	Breach Tolerance	Known Breaches	Pass/Fail	Expected Total Patients Seen	Breaches	Known Breaches	Pass/Fail
62-Day First	85%	74.5	16	78.5%	61.5	14.5	76.40%	56.5	11.5	79.6	66	9.9	21	72.00%	68	10.2	8		68	10.2	1	
62-Day Screening	90%	12.5	1	92.0%	12.5	1.5	88.00%	23	4	82.6	13	1.3	1	92.30%	14	1.4	1		14	1.4	0	
31-Day First	96%	176	10	94.3%	154	10	93.5%	161	4	97.5	181	7.2	7	96.00%	181	7.2	1		181	7.2	0	
31-Day Chemo	98%	53	1	98.1%	37	0	100.00%	41	0	100.0	47	0.9	1	98.50%	47	0.9	0		47	0.9	0	
31-Day Surgery	94%	40	1	97.5%	48	2	95.80%	29	0	100.0	44	2.6	2	95.00%	44	2.7	0		44	2.7	0	
31-Day Radiotherapy	94%	143	3	97.9%	124	1	99.20%	84	0	100.0	113	6.8	2	97.80%	113	6.8	0		113	6.8	0	
2WW	93%	852	60	93.0%	825	46	94.40%	722	49	93.2	738	51.6	51	93.10%	791	55.4	0		791	55.4	0	
2WW Symptomatic Breast	93%	305	30	92.0%	281	18	93.60%	265	16	94.0	281	19.7	20	93.20%	281	19.7	0		281	19.7	0	
62-Day Consultant Upgrade	85% (Local performance target	7.5	1.5	80.0%	13	1	92.30%	9	0	100.0	7	1.1	0	100.00%	7	1.1	0		7	1.1	0	

Numbers reflect those validated and published through *Open Exeter*

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

Contents page

Agenda number 5.4 Appendix 2

Patient Experience the next 100 days as an outcome of the 1st March Cancer Improvement and Patient Experience Workshop

Bespoke NCS survey June – August 2012 results:

To address NCS questions	Patient Experience (PEx) Action
Diagnostic tests : • Staff gave complete explanation of purpose of test (79% - Red) • Staff explained completely what would be done (81% - Red) • Given easy to understand written information (77% - Red) • Given complete explanation of results (72% Red)	PEx via process /pathways - the reason for improving diagnostic pathways is to improve patient experience, reduce waits, MDT process and decision making. Work into improving patient pathways – CNS involved, information, explanation, next steps. MDT working – decision making, team communication
• Got understandable answers to important questions (doctors and nurses) • Patients never thought they were given conflicting information • Able to discuss their worries or fears • Always treated with dignity • Patient did not feel that they were treated as a set of cancer symptoms • Hospital staff definitely gave patient enough emotional support	PEx via training: the rationale to train staff in communication skills (ie Sage and Thyme); Macmillan (VBS) Value Based Standard is to improve the patient's experience
• Hospital staff worked well together • Patients rating of care excellent or very good	PEx via engagement: improve and develop patient groups, representatives to increase patient voice in decisions
• Waited no longer than 30 minutes for OPD appointment • Patient thought doctor spent the right time with them	PEx via environment: improvement to 6N, changing inpatient oncology pathway (single ward consultant), clinic 8 improvements

• Doctor had the right notes with them • Given clear information about post-discharge	
• Patients offered a written care plan • Given the right amount of information • Offered a written assessment and care plan • Patients given the name of their CNS • Find it easy to contact CNS	PEx via information: greater use of Patent Information Prescriptions (PIP); leaflets ++; Heath Needs Assessment (HNA) given out by reception staff; CNS lead clinics

2011 NCES & 2012 BESPOKE SURVEY (JUNE TO AUGUST PTS)	NCES	NCES	BESPOKE		
	2010	2011	JUNE - AUG 2012		
Seeing Your GP	**Result**	**Result**	**Result**	**Change**	**Rating**
Saw GP once / twice before being told had to go to hopital	71%	69%	69%	0%	
Patient thought they were seen as soon as necessary.	70%	76%	77%	1%	
Patients health got better or remained the same while waiting.	68%	71%	73%	2%	
Diagnostic Tests					
Staff gave complete explanation of purpose of test(s)	77%	76%	79%	3%	
Staff explained completely what would be done during test.	80%	78%	81%	3%	
Given easy to understand written information about test.	79%	74%	77%	3%	
Given complete explanation of test results in an understandable way.	71%	68%	72%	4%	
Finding Out What Was Wrong With You					
Patient told they could bring a friend when first told they had cancer.	63%	60%	65%	5%	
Patient felt they were told sensitively that they had cancer.	81%	77%	78%	1%	
Patient completely understood the explanation of what was wrong.	68%	68%	67%	-1%	
Patient given written information about the type of cancer they had.	60%	58%	64%	6%	
Deciding the Best Treatment for You					
Patient given a choice of different types of treatment.	81%	77%	82%	5%	
Pts views definitely taken into account by docs & nurses discuss. treat.		64%	67%	3%	
Possible side effects explained in an understandable way.	68%	67%	71%	4%	
Patient given written information about side effects.	71%	73%	74%	1%	
Patient definitely involved in decisions about care and treatment.	68%	65%	67%	2%	
Clinical Nurse Specialist					
Patient give the name of the CNS in charge of their care.	76%	84%	83%	-1%	
Patient finds it easy to contact their CNS.	66%	60%	64%	4%	
CNS definitely listened carefully the last time spoken to.	87%	85%	88%	3%	
Get understandable answers to import. questions all / most of the time.	86%	84%	87%	3%	
Support for People with Cancer					
Hospital staff gave information about support groups.	76%	75%	78%	3%	
Hospital staff gave information on getting financial help.	52%	50%	48%	-2%	
Hospital staff told patient they could get free prescriptions.	71%	72%	76%	4%	
Cancer Research					
Taking part in cancer research discussed with patient.		47%	47%	0%	
Patient glad to have been asked about taking part in cancer research.		94%	92%	-2%	
Pt. would like to have been asked about taking part in cancer research.		53%	56%	3%	
Operations					
Admission date not changed by hospital.	82%	83%	85%	2%	
Staff gave complete explanation of what would be done.	79%	81%	79%	-2%	
Patient given written information about the operation.	57%	63%	61%	-2%	
Staff explained how operation had gone in understandable way.	70%	70%	67%	-3%	
Hospital Doctors					
Got understandable answers to import. questions all / most of the time.	75%	73%	78%	5%	
Patients had confidence and trust in all doctors treating them.	78%	76%	78%	2%	
Doctors did not talk in front of patients as if they were not there.	77%	71%	74%	3%	
Patient's family definitely had the opportunity to talk to doctor.	61%	58%	59%	1%	
Ward Nurses					
Got understandable answers to import. questions all / most of the time.	60%	59%	67%	8%	
Patients had confidence and trust in all nurses treating them.	54%	54%	58%	4%	
Nurses did not talk in front of patients as if they were not there.	73%	71%	76%	5%	
Always / nearly always enough nurses were on duty.	55%	55%	57%	2%	

APPENDIX A CONT.: COMPARISON OF JUNE TO AUGUST 2012 PATIENTS TO 2011 NCES

2011 NCES & 2012 BESPOKE SURVEY (JUNE TO AUGUST PTS)	NCES	NCES	BESPOKE		
	2010	2011	JUNE - AUG 2012		
	Result	Result	Result	Change	Rating
Hospital Care & Treatment					
Patient did not think hospital staff deliberately misinformed them.	79%	77%	81%	4%	
Patient never thought they were given conflicting information.	73%	69%	71%	2%	
All staff asked patient what name they preferred to be called by.		33%	36%	3%	
Always given enough privacy when discussing condition or treatment.	75%	78%	81%	3%	
Always given enough privacy when being examined or treated.	89%	91%	94%	3%	
Patient was able to discuss worries or fears with staff during visit.		45%	52%	7%	
Hospital staff did everything to help control pain all of the time.	79%	76%	79%	3%	
Always treated wirth respect and dignity by staff.	75%	73%	75%	2%	
Information Given to You Before You Left Hospital					
Given clear written info. about what should / should not do post disch.	72%	72%	75%	3%	
Staff told patients who to contact if worried post discharge.	85%	86%	88%	2%	
Family definitely given all information needed to help care at home.	49%	49%	53%	4%	
Patient definitely given enough care from health or social services.	43%	43%	46%	3%	
Hospital Care as a Day Patient / Outpatient					
Staff definitely did everything to control the side effects of radiotherapy.		67%	68%	1%	
Staff definitely did everything to control the side effects of chemo.	82%	73%	76%	3%	
Staff definitely did everything they could to help control pain.	78%	71%	73%	2%	
Hospital staff definitely gave patient enough emotional support.	62%	57%	59%	2%	
Waited no longer than 30 minutes for OPD appointment to start.	54%	54%	53%	-1%	
Pt thought that doctor spent about the right amount of time with them.	91%	88%	89%	1%	
Doctor had the right notes and other documentation with them.	94%	92%	94%	2%	
Care from Your General Practice					
GP given enough information about patient's condition and treatment.	92%	89%	91%	2%	
Practice staff definitely did everything they could to support patient.	62%	57%	62%	5%	
Your Overall NHS Care					
Hospital & staff always worked well together		49%	49%	0%	
Given the right amount of information about care & treatment		82%	82%	0%	
Patient offered written assessment & care plan		23%	24%	1%	
Patient did not feel that they were treated as a set of cancer symtoms		69%	69%	0%	
Patient rating of care excellent & very good		80%	80%	0%	
Average	**74%**	**67%**	**69%**		

Cancer Recovery Implementation Plan - Appendix 1
Produced 22nd October 2012 - Updated 6th March 2013

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

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

Patient Experience

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

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

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

	Imperial College Healthcare NHS Trust	ICHT DELIVERY	DELIVERED BT WEEK ENDING APRIL 2013																	FUTURE DATE	ON TRACK
			JANUARY				FEBRUARY				MARCH					APRIL					
			6	13	20	27	3	10	17	24	3	10	17	24	31	7	14	21	28		
	CANCER RECOVERY ACTION PLAN (ACTIVE)																				
1	**PATHWAY MANAGEMENT**																				
1.6	Set up research project to review MDT changes.	TLCC																			
1.15	Set up Email communication with MDT C from clinic to advise if patitent pathway closed	TLCM																			On Track
1.16	Developing method to enable electronic comms. With GPs.	TLCM													R1						On Track
1.17	Confirm use of Somerset template to communicate to GPs OPD and MDT outcome	TLCM						R1							R1						On Track
1.18	Agree job descriptions for MDT Chair/ Clinical Leads	TLCM												R1							On Track
1.19	Begin interviews / discussion for all MDT Chair/Clinical Lead around role and responsibility	TLCC/TLCM												r1							On Track
1.20	Complete interviews / discussion for all MDT Chairs/Clinical Lead	TLCC/TLCM																		End april	On Track

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED BT WEEK ENDING APRIL 2013																	FUTURE DATE	ON TRACK
			JANUARY				FEBRUARY				MARCH					APRIL					
			6	13	20	27	3	10	17	24	3	10	17	24	31	7	14	21	28		
	CANCER RECOVERY ACTION PLAN (ACTIVE)																				
2	TUMOUR SITE SPECIFIC PATHWAY																				
2.11	Work with NHS L & McK. On value for improvement project : Lower GI, Urology	COO																		TBC	On Going
2.12	Confirm urology pathway Redesign Work	TLCM																			On Track
2.13	Confirm LGI/Colorectal Pathway Redesign Work	TLCM																			On Track
2.13	Confirm prostate pathway	TLCM																		TBC	
2.14	Confirm breast pathway	TLCM																		TBC	
2.15	Confirm lung pathway	TLCM																		TBC	
2.16	Confirm upper GI pathway	TLCM																		TBC	
2.17	Confirm H&N pathway	TLCM																			
2.18	Include tumour work plans following March 8 workshop	TLCM																			On Track

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED BT WEEK ENDING APRIL 2013																	FUTURE DATE	ON TRACK
			JANUARY				FEBRUARY				MARCH					APRIL					
			6	13	20	27	3	10	17	24	3	10	17	24	31	7	14	21	28		
	CANCER RECOVERY ACTION PLAN (ACTIVE)																				
3	**DATA QUALITY & COMPLETENESS**																				
3.7	Start recruitment of vacant MDT Co-ordinator posts	TLCM																			On track
3.11	Develop a training programme for rollout of Elective Access / PTL (incl. Con. Upgrades)	TLCM/HoOPD																		April	On track
3.12	Begin rollout of Elective Access /PTL training programme	TLCM/HoOPD																		May	On track
3.15	Implementation of Pilot Somerset System : Urology, Breast, Lung. All sites March.	SOMPM												RI							On track
3.16	Provision of Somerset super-user training	SOMPM																			On track
3.18	[rovision of MDT Somerset training	SOMPM																			On track
3.17	Phased Rollout by Tumour Group	SOMPM																			On track

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERY BY END OF MARCH 2013 (WEEK ENDING)																		FUTURE DATE	ON TRACK
			DECEMBER					JANUARY				FEBRUARY				MARCH						
			2	9	16	23	30	6	13	20	27	3	10	17	24	3	10	17	24	31		
	CANCER RECOVERY ACTION PLAN (ACTIVE)																					
4	**GOVERNANCE & REPORTING STRUCTURE**																					
4.5	Establish a MDT Chair /Clinical Lead Quartery Cancer Steering Group Meeting	TLCC/TLCM																			April	On track

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED BT WEEK ENDING APRIL 2013																	FUTURE DATE	ON TRACK
			JANUARY				FEBRUARY				MARCH					APRIL					
			6	13	20	27	3	10	17	24	3	10	17	24	31	7	14	21	28		
	CANCER RECOVERY ACTION PLAN (ACTIVE)																				
6	**PERFORMANCE MONITORING**																				
6.1	Build patient experience KPIs within Cancer dashboard (RTM, Workforce data)	TLCN / ADoHR																		June	On track
6.2	Report I-track results within cancer dashboard	HoPM																		June	On track
6.12	Report on Staff survey	HoPM					R1					R2									On track
6.13	Report on NCES (Local) 1 September – 30 November 2012 Inpatients to MB	HoPM																		April	On track
6.14	Report on NCES (Nationall) 1 September – 30 November 2012 Inpatients to MB	HoPM																		September	On track
6.15	Report on NCES (Local) 1 December 2012 – 28 February 2013 Inpatients to MB	HoPM																		July	On track
6.16	Report on NCES (Local) 1 March 2013 – 31 May 2013 Inpatients to MB	HoPM																		September	On track
6.17	Report on NCES (Local) 1 June 2013 – 31 August 2013 Inpatients to MB	HoPM																		TBC	On track
6.18	Report on NCES (National) 1 September 2013 – 30 November 2013 Inpatients to MB	HoPM																		TBC	On track
7	**COMMUNICATION & ENGAGEMENT**																				
7.1	Begin high profile programme of activities of cancer specialist team in clinical areas	TLCN/HoN CPG2																			Ongoing
7.5	MDT Leads to present long term action plans against tumour specific findings.	TLCC/TLCN																		TBC	
8	**PATIENT INFORMATION & SUPPORT**																				
8.5	Install patient information Service (Pod) at HH site	IM																			On track
8.6	Submit Funding bid to MCS for a patient information service at SMH site	IM																		April/May	TBC
8.7	Recruit to MCS MDT information project post (information prescription support)	IM																			On track
8.12	Increase attendance at Maggie's 'what next course?' after diagnosis.	TLCN														R2				Spring 2013	Delayed
8.13	Refurbish 6 North to existing plan (oncology Inpatients)	HoN CPG2/LNOnc													R1					Mar-13	On track
8.16	Present feasibility report re 6 south to oncology inpatient refurb board	HoN CPG2/LNOnc																			On track
8.17	Submit OBC complete with action plan and feasibility report	HoN CPG2																			On track
8.18	Complete refurbishment of 6 South .	HoN CPG2																		June	TBC
8.19	Present delivery plan & CNS teaching program in cancer areas at Pex Steering group	TLCN						R1				R2									TBC
8.20	Report options to PEX steering group for a single contact system to access all CNSs	TLCN																		April 2013	TBC
8.21	Deliver Trust Survivorship strategy to CCPEB and TCB	TLCN																		May 2013	On track
8.22	Report progress agaisnt nurse-led calls post chemotherapy (Pilot following Cycle one)	LCN																		Apr-13	TBC
8.23	Commence triage assessment service in clincial haematology	LN CH																			TBC
8.24	Recruit to MCS vollunteer befriender project.	TLCN																		Sep-13	On track
9	**PATIENT INCLUSION**																				
9.3	Report patient feedback via CCPEB, I-Track, Patient interviews to Cancer Board	TLCN																		TBC	Delayed
10	**EDUCATION & TRAINING**																				
10.2	Deliver communication skills training in oncology wards and departments.	CNE Onc - TBC																			On Going
10.7	Host a repeat of RMH Principles in cancer care course for non-cancer trained staff .	TLCN																		April 2013	On track
10.8	All MDT core staff to receive advanced communication skills training	TLCC																		TBC	
10.10	Complete Ambassador training in priority areas	HofL																		Mar-13	TBC
10.11	Increase number of chemotherapy nurses on nurse prescribers training program	LCN																		TBC	
10.12	Sage and Thyme train the trainer training to lead Cancer nurses and CNS.	HofL/SM																		Mar-13	On track

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED BT WEEK ENDING APRIL 2013																	FUTURE	ON
			JANUARY				FEBRUARY				MARCH					APRIL					
			6	13	20	27	3	10	17	24	3	10	17	24	31	7	14	21	28	DATE	TRACK
10.13	Delivery of Sage & Thyme in priority areas (Phase 1 and phase 2)	SM																		Jul-13	Delayed
10.16	Implement Clinical Haematology CNS education pathway	LN Clin. Haem.																		Ongoing	TBC
11	**PATHWAY INTERVENTION**																				
11.1	Complete audit of oncology internal pathway; oncology OPD to ward or chemo. units.	HoN CPG2																			On track
11.2	Implement planned re-design of 6 Floor Charing Cross, oncology inpatient services.	TLCC																			On track
11.3	Impliment pathway redesign in clinical haematology (ambulatory care pathway)	LN Clin. Haem.																		TBC	
11.4	Review Clinci space and functions within Charing Cross ENT clinic	HOO.CPG3																		TBC	
12	**GOVERNANCE**																				
12.4	Deliver progress report on to each Trust Cancer Board	TLCN																		TBC	Delayed

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

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED TO DATE FROM OCTOBER TO JANUARY																			FUTURE	ON
			OCTOBER					NOVEMBER				DECEMBER					JANUARY								
			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27		DATE	TRACK
	CANCER RECOVERY ARCHIVE PLAN (ACTIONS DELIVERED)																						
1	**PATHWAY MANAGEMENT**																						
1.1	Observe all MDT meetings pan Trust	TLCC																					DEL
1.2	Develop MDT best practice pack to include MDT SOP, Esc. Policy, ECAD SOP	TLCC																					DEL
1.3	Set up tumour specific MDT PLT meetings to run weekly	TLCC																					DEL
1.4	Review of all MDT Staff to ensure clarity around Roles and Responsibilties	TLCC																					DEL
1.5	Provide MDT training for all leads.	TLCC																					DEL
1.7	Develop revised Cancer Access Policy	TLCM																					DEL
1.8	Launch revised Cancer Access Policy alongside Trust Elective Access Policy.	TLCM						R1															DEL
1.10	~~Develop local tumour spec. pathways which identify key event milestones and esc. points Urology, Lower GI, Upper GI, Gynaecology, Head & Neck.~~ REPLACED	TLCM																					On Track
1.11	Ensure all Outcome Clinic Slips clearly identifies Urgent Suspected Patient Pathway	TLCM																					DEL
1.12	Ensure all Urgent Suspected Cancers referred to Diagnostics are clearly identified	TLCM																					DEL
1.13	Ensure all Urgent Suspected Cancers referrals to Endoscopy are identifyable.	TLCM																					DEL
1.14	Ensure all 2WW referrals are entered onto Execlicare within 48 hrs of recepit	TLCM																					DEL
2	**TUMOUR SITE SPECIFIC PATHWAY**																						
2.1	Clearance backlog - Pre 2012 - 4 patients - review all patients and manage appropriately	TLCM																					DEL 30/10
2.2	Clearance backlog - Jan - May 2012 - review all 19 pts and manage appropriately	TLCM																					DEL
2.3	Clearance backlog - June - July - review all 4 patients and manage appropriately	TLCM																					DEL
2.5	Produce capacity plans at speciality level to deal with backlog	TLCM																					DEL
2.6	Review current demand at speciality level and sign off by CPGs	TLCM																					DEL
2.7	Cross reference demand with current capacity to ensure have sufficient capacity	TLCM																					DEL
2.8	CPGs to review capacity requirements including cancer & report back their findings	TLCM/HOO/GMs																					DEL
2.9	Where capacity is restricted or not available internally develop option appraisal.	COO					R1																DEL
3	**DATA QUALITY & COMPLETENESS**																						
3.1	Review the current Cancer PTL report including validating the 'Awaiting DTT' column	TLCM																					DEL
3.3	Establish Cancer Data Reporting Group	HoI																					DEL
3.2	Relaunch ICHT Cancer PTL to allow proactive management of patients.	HoI								R1													DEL
3.4	Develop a Technical SOP for the Cancer PTL (including 3.1)	HoI								R1													DEL
3.5	Complete development of a new ICHT Cancer PTL	HoI								R1													DEL
3.6	Develop DQ Measures for PTL + OE upload and Manage escalate issues at CDG	HoI								R1													DEL
3.11	Appoint Project Manager for Somerset new cancer system to supersede Exelicare	TLCC																					DEL
3.14	Installation, System Build and Testing	SOMPM/ICT																					DEL
3.15	Implementation of Pilot Somerset System - new Cancer Information System : Urology, Breast, Lung, All sites March	SOMPM																					DEL
4	**GOVERNANCE & REPORTING STRUCTURE**																						
4.1	Implement new structure of Trust LCC, TLCN & TLCM	COO																					DEL
4.2	Review reporting framework for the management of cancer delivery across ICHT.	COO/CU/CW/SG																					DEL
4.3	Review Terms of Reference for the Cancer Operational Steering Group	TLCM																					DEL
4.4	Reduce number of entry points to the Trust for Urgent Suspected Cancer referrals	Head of OPD																					DEL

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED TO DATE FROM OCTOBER TO JANUARY																			FUTURE DATE	ON TRACK
			OCTOBER					NOVEMBER				DECEMBER					JANUARY						
			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27		
5	**PERFORMANCE DIAGNOSTICS**																						
5.1	Review 2011 NCS results with the National Cancer Director.	DoN																					DEL 7/10
5.2	Review of the latest MDTs performance against national peer review standards	HoPM/HoN CPG2																					DEL 7/10
5.3	Complete an analysis of narrative responses in the national cancer survey.	HoPM																					DEL 7/10
5.4	Complete nursing workforce review using M5 data of all cancer I/P & OPD areas	DoN																					DEL 7/10
5.5	Undertake a visit to E.Kent Hospitals NHS FT and GST Hospitals NHS FT	HoPM / TLCN																					DEL 7/10
5.6	Commision Quality health to run the NCPES by same methodology	HoPM																					DEL 7/10
5.7	Promote and encourage patient completion of NCPES; patient communication program	HoM																					DEL 7/10
5.8	Repeat NCPES to in-patients during June -August 2012	HoPM								D													Del 110113
~~5.9~~	~~Repeat NCPES bi-monthly December 2012, February and April 2013~~ REPLACED	~~HoPM~~																				~~& TBCs~~	~~On track~~
5.10	Initiate a staff survey on cancer inpatient and outpatient areas.	HoPM																					Del 020113
5.12	Include Friends and Family test into itrack RTM question set	HoPM							R1		R2												Del 23/01/13
6	**PERFORMANCE MONITORING**																						
6.3	Report workforce KPIs into CPG 2 Establishment & Performance Reviews	HoPM																					DEL
6.4	Report PEX feedback against VBS Pilot Wards	HoPM																					DEL 28/10
6.5	Report PEX results from key Cancer IP & OPD areas in CPG Performance reviews	HoPM																					DEL 21/10
6.6	Report on NCS 1 June 2012 – 31 August 2012 Inpatients to MB	HoPM								D													Del 28/01/13
~~6.7~~	~~Report on 1 December – 31 December 2012 NCPES of Inpatients~~ REPLACED	~~HoPM~~																				~~TBC~~	
~~6.8~~	~~Report on 1st - 28th February 2013 NCPES of Inpatients~~ REPLACED	~~HoPM~~																				~~TBC~~	
~~6.9~~	~~Report on 1st – 31th April 2013 NCPES of Inpatients~~ REPLACED	~~HoPM~~																				~~TBC~~	
6.10	Interim report on ethnographic study 09.11.12	IC PERC																					DEL 9/11
6.11	Instant feedback to staff following quality rounds	TLCN																					Ongoing
7	**COMMUNICATION & ENGAGEMENT**																						
7.1	Begin high profile programme of activities of cancer specialist team in clinical areas	TLCN/HoN CPG2																					Ongoing
7.2	Undertake improvement workshop to core MDT members on 9 Nov.	COO/TLCC/CPG2CD																					DEL 11/11
7.3	Present NCS results to Senior Nurses at Back to the Floor	TLCN																					19.10
7.4	Meet with Oncology, Haematology and Specialist palliative care CNSs	TLCN																					DEL 15.10
7.6	Present NCPES overview at CEO Open Hour	CEO/HoPM																					DEL
7.7	Ibegin n Brief Weekly Cancer Thursday Message	HoPM																					DEL
8	**PATIENT INFORMATION & SUPPORT**																						
8.1	Provide all trust staff with new guidance on financial support	TLCN/IM																					DEL 08.10
8.2	Provide all trust staff with MDT (CNS) contact details.	TLCN																					DEL 08.10
8.3	Accelerate PIP Project to Breast and Colorectal pathways (Gynae and Lung com	IM																					Del Jan 13
8.9	Increase access to Financial Advisor at CXH	HoN CPG2/IM																					Delivered
8.15	Design workshop , staff and ICHT patients, chaired by MCS design team.	LNOnc																					DEL 12.10
9	**PATIENT INCLUSION**																						
9.1	Agree Cancer Collaborative ToR, individual CPG roles & meeting dates.	TLCN																					DEL 15.10
9.2	Initiate patient/carer interviews in chemotherapy units.	IC PERC																					DEL 15.10

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED TO DATE FROM OCTOBER TO JANUARY																		FUTURE	ON
			OCTOBER					NOVEMBER				DECEMBER					JANUARY					
			7	14	21	22	28	4	11	18	25	2	9	16	23	30	6	13	20	27	DATE	TRACK
9.7	Erect banner stands at key access points welcoming patient feedback	HoPM									R1											DEL 23/11
10	**EDUCATION & TRAINING**																					
10.1	Pilot ward based micro teaching - 20 minutes every lunch time for a week	TLCC/SPC CNS																				DEL 07.10
10.3	Implementation of the Macmillan VBS (7N, 6N, 6S, Dacie & Weston).	HoPM																				DEL 4/11
10.6	Hosting the RMH Principles in cancer care course for non-cancer trained staff .	TLCN																				DEL 29.10
10.9	All ward staff in key areas to receive I Care training (hourly comfort rounding).	CPG 2 HoN																				Del 20.02.13
11	**PATHWAY INTERVENTION**																					
12	**GOVERNANCE**																					

	Imperial College Healthcare NHS Trust	ICHT DELIVERY LEAD	DELIVERED TO DATE FROM FEBRUARY TO MAY 2013																	FUTURE DATE	ON TRACK
			FEBRUARY				MARCH					DECEMBER				APRIL					
			3	10	17	24	3	10	17	24	31	2	9	16	30	7	14	21	28		
	CANCER RECOVERY ARCHIVE PLAN (ACTIONS DELIVERED)																				
1	**PATHWAY MANAGEMENT**																				
2	**TUMOUR SITE SPECIFIC PATHWAY**																				
3	**DATA QUALITY & COMPLETENESS**																				
4	**GOVERNANCE & REPORTING STRUCTURE**																				
5	**PERFORMANCE DIAGNOSTICS**																				
6	**PERFORMANCE MONITORING**																				
7	**COMMUNICATION & ENGAGEMENT**																				
8	**PATIENT INFORMATION & SUPPORT**																				
9	**PATIENT INCLUSION**																				
9.5	Recruitment of patient or representative expected in December 2012.	TLCN		R2																	Del 11.02.13
10	**EDUCATION & TRAINING**																				
10.4	Present PEX KPIs for Breast, Gynae, urology, H&N and colorectal CNSS			R1																	Del 20.02.13
10.5	Develop PEX KPIs for all other tumour site specific CNSs teams																				Del 20.02.13
11	**PATHWAY INTERVENTION**																				
12	**GOVERNANCE**																				

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: March 2013 Agenda Number:3.1

Report Title: Executive Performance Report M11

To be presented by: Steve McManus, Chief Operating Officer

Executive Summary:

Please see attached reports for M11:

1. Executive Performance Report
2. Trust Board Performance Report

Legal Implications or Review Needed

a. Yes
b. **No** ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

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

Purpose of Report

a. For Decision
b. For information/noting ✓

Executive Performance Report

Imperial College Healthcare NHS Trust

Month 11:February 2013 | **Paper:**

Executive Summary

This report for the Trust Board summarises the Trust's Performance against key indicators. Accompanying this report is the Month 11 Trust Performance Scorecard which shows performance and monthly run-charts for all key indicators.

In February 2013 the Trust achieved good performance in:
- National 18 week referral to treatment waiting time target for admitted, non-admitted patients and patients on incomplete pathways.
- Maintaining year to date position of having zero mixed sex accommodation breaches.
- Achieving above target for providing national care standards for stroke and maternity patients.
- Achieving venous thromboembolism assessment rates.
- Achieving the national diagnostics waiting time target.
- Sustained good scores for patient feedback.
- Maintained position below the maximum trajectory for MRSA and Clostridium Difficile cases.

Areas identified as underperforming are:
- The A&E 4 hour wait for type 1 monthly performance in January was 93.2%, against the 95% target however for all types performance was 96.6% against the 95% nationally reported target. YTD against all types we have maintained above the 95% threshold.
- The Trust achievement of 7 out of the 8 national Cancer targets for January (Cancer targets reported one month in arrears). This was an improvement on the previous month where 6 out of the 8 targets where achieved and a huge improvement from our position at Month 6 (September 2012) where the Trust only acheived 3 out of the 8 national Cancer targets. Performance is continuing to improve and there is a trajectory for sustained achievement of all 8 measures by end of quarter four.

Against the Department of Health 2012-13 Acute Trust Performance Framework The Trust continued to be defined as 'performing' but it is important to note that The Trust has seen the position strenghten further in February 2013. Against the Monitor Compliance Framework for February the Trust continues to be 'amber-green' (1.0).

Quality

Mortality The Trust continues to have one of the lowest mortality rates in England, based upon the Hospital Standardised Mortality Rate and Standardised Hospital Mortality Indicator.	**Scorecard Page 3**
Patient Experience The Trust continued to receive positive feedback. Patient experience results and improvement plans at ward level are discussed in detail during the monthly Clinical Programme Group Performance Reviews and progress is monitored by the Trust's Patient Experience Team.	**Scorecard Page 4**
Infection & Prevention Control For 2012/13 the Trust MRSA objective set by the Department of Health is a maximum of 9 Trust attributable cases in a year. MRSA incidents are escalated to the most senior management level in the Trust and are treated as a priority by the Infection Control and Prevention team. 1 case of Trust acquired MRSA infection was reported in February 2013, bringing the year to date total to 7, compared with 14 cases being reported at the same time last year 2011/12. The Trust remains within its trajectory to stay below the maximum 9 MRSA cases for the year. For Clostridium Difficile there were 6 cases reported in February 2013 bringing the year to date total to 80. The Trust remains within its trajectory to stay below the maximum 110 cases for the year.	**Scorecard Page 5**
Eliminating Mixed Sex Accommodation (EMSA) In February 2013 the Trust sustained its year to date achievement of zero mixed sex accommodation breaches.	**Scorecard Page 6**
Stroke Care The Trust achieved above both national stroke care targets in February 2013. This performance has been sustained since the beginning of the financial year and the Trust expects this to be maintained.	**Scorecard Page 7**

Venous Thromboembolism risk assessments The Trust achieved above the threshold of 90% for the 11th consecutive month, achieving a score of 91.56% in February 2013. The threshold for 2013/14 is to increase to 95% and the Trust is implementing plans to ensure that performance improves to the required level by April 2013. In order to help the Trust acheive this, weekly VTE task force meetings will be held from April 2013 until the step change that is needed in performance is realised.	**Scorecard Page 8**
Research and Development The quarter three results reported by the Joint Research Office show enrolment of patients onto clinical trials increased 21.3% from the same period last year. This is significantly above the initial target of a 1% increase set by the Trust at the beginning of the year.	**Scorecard Page 9**
Safety Thermometer The Trust continues to perform extremely well against peers and has one of the best rates of Harm Free care in comparison to the Shelford Group with 95.0% of patients reported as 'harm free' in February 2013.	**Scorecard Page 10**
Operations	
Accident & Emergency - 4 Hour maximum waiting time For February ICHT performance was 93.17% for Type 1 and 96.59% overall. Performance has been challenged with higher acuity patients and peaks of activity through our Emergency Departments. For the year to date ICHT 's overall performance remains above 95% at 97.32%, this is above the current London and National figure.	**Scorecard Page 11**
Accident & Emergency - Clinical Quality Indicators The figures reported relate to our type 1 attends only as we are still experiencing difficulties integrating our Type 1 and Type 3 attends. Our time to treatment at SMH has been challenged with peaks of attends especially in the evenings, as part of our winter plans though our UCC remains open until 22.00 and we have increased consultant presence in the ED into the evenings. Our Time to initial assessment has increased this month but we continue to perform well when measured using the London Ambulance Service Hospital alert system. We are continuing to address our time in department for admitted patients by development of alternative pathways in line with our ambulatory care aspirations and also the case management of patients with a length of stay greater than 10 days.	**Scorecard Page 12**
Cancer Waiting times In February the cancer waiting time standards for January were published showing the Trust achieved 7 out of the 8 National cancer standards, including maintaining performance of the 2 week wait for urgent cancer referrals, 2 week wait for breast symptomatic and the 31 day wait first treatment and for subsequent chemotherapy, radiotherapy and surgery. The standard not met was 62 day wait from diagnosis to first treatment for all cancers. A number of the cancer remedial action plan initiatives have been implemented. Performance has improved steadily over the past six months and there is a trajectory for sustained achievement of all 8 measures by end of quarter four. Weekly meetings are currently being held with the Chief Operating Officer and the cancer management team to track all patients on an active pathway to ensure that patients are treated within the target time.	**Scorecard Page 13**
Elective Access - Referral to Treatment The Trust maintained all three standards for February 2013. The admitted performance for February was 91.39% against the 90% target for patients waiting less that 18 weeks on admitted pathways, 96.45% against the 95% target for patients waiting less than 18 weeks on non-admitted pathways and 94.59% against a target of 92% for patients waiting less than 18 weeks on incomplete pathways. The overall admitted 'backlog' of patients waiting over 18 weeks reduced from 1,070 in January 2013 to 996 in February 2013. As part of the performance scrutiny of the referral to treatment targets, the backlog and size of the waiting list will be part of the Trust Board performance report when presented at the April 2013 session.	**Scorecard Page 14**
Diagnostic Waiting times The Trust maintained its year to date performance in February 2013 achieving over 99% performance, with	**Scorecard**

3 reported waiting time breaches out of 7,143 diagnostic pathways. The breaches were all in urodynamics.	**Scorecard Page 15**
Maternity The maternity service continued to achieve the 90% target for pregnant women see a midwife within 12 weeks and 6 days of pregnancy, at 96.0% in February 2013.	**Scorecard Page 16**
Delayed Transfer of Care The Trust was below the 3.5% threshold for patients whose transfer of care was delayed in quarter three.	**Scorecard Page 17**
Quality, Innovation, Productivity and Prevention The Cost Improvement Programme is driving the delivery of savings as a result of improved efficiencies in key productivity indicators, including staffing, diagnostic demand management, theatre and bed utilisation and outpatient productivity.	**Scorecard Page 18**
Workforce	
Progress against the Workforce key performance indicators are detailed in the Performance Report.	**Scorecard Page 19**

Trust Board Performance Report
Report Period Month 11
(to end February 2012/13)

Trust Board on 27th March 2013

Contents

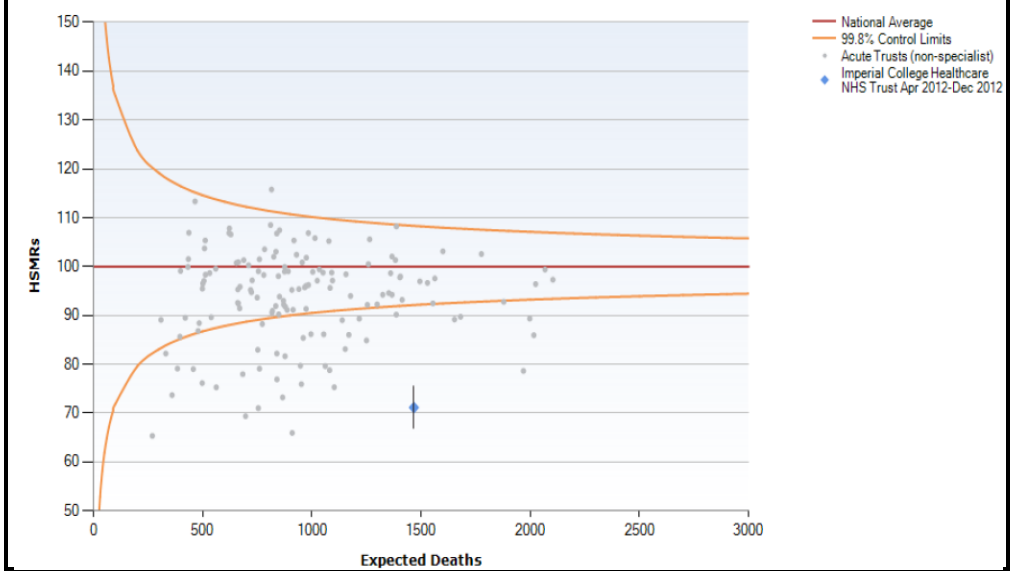
Quality	QLTY 1	Mortality	**Page 3**
	QLTY 2	Patient Experience - key questions from National Survey	**Page 4**
	QLTY 3	Infection Prevention Control (MRSA and Clostridium Difficile)	**Page 5**
	QLTY 4	Eliminating Mixed Sex Accomodation	**Page 6**
	QLTY 5	Stroke care	**Page 7**
	QLTY 6	Venous Thromboembolism	**Page 8**
	QLTY 7	Research & Development	**Page 9**
	QLTY 8	Safety Thermometer	**Page 10**
Operations	OPS 1	Accident & Emergency - 4 hour maximum waiting time	**Page 11**
	OPS 2	Accident & Emergency - Quality Indicators	**Page 12**
	OPS 3	Elective Access - Cancer Waiting Times	**Page 13**
	OPS 4	Elective Access -Referral to Treatment	**Page 14**
	OPS 5	Elective Access - Diagnostics	**Page 15**
	OPS 6	Maternity	**Page 16**
	OPS 7	Delayed Transfer of Care	**Page 17**
	OPS 8	Quality, Innovation, Productivity and Prevention	**Page 18**
Workforce	WF 1	Bank and Agency Spend	**Page 19**
	WF 2	Pay Expenditure	**Page 19**
	WF 3	Vacancy Rate	**Page 19**
	WF 4	Turnover	**Page 19**
	WF 5	Sickness Absence	**Page 19**
	WF 6	Appraisals	**Page 19**
	WF 7	Statutory Mandatory Training and Local Induction	**Page 19**

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

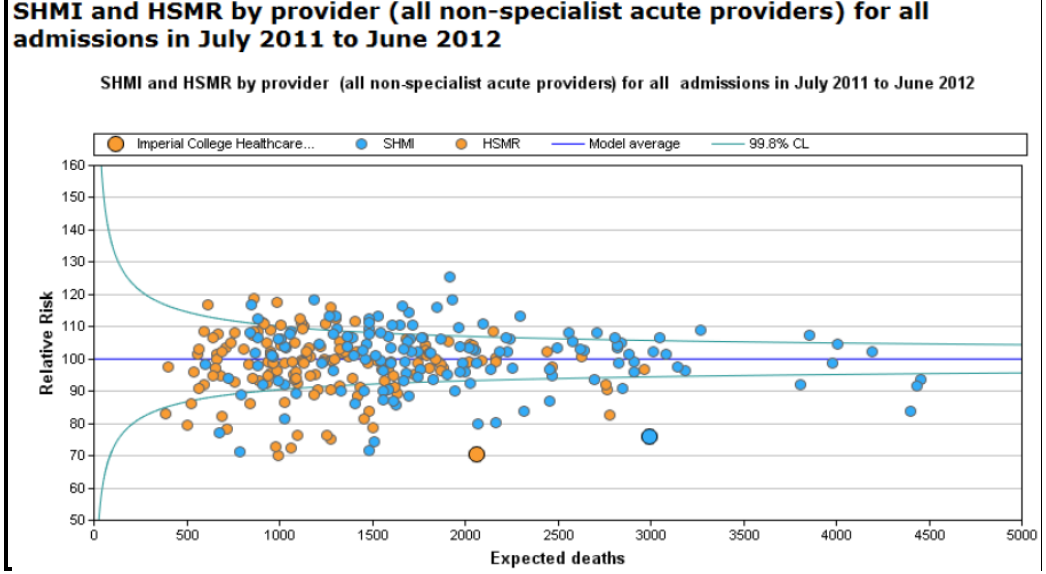
Domain	Indicator	National average	Unit	April - December 201	Year to date
Mortality	Hospital Standardised Mortality Rate (HSMR) (*)	100	number	71	71

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

Graph 1: Hospital Standardised Mortality Rate



Graph 2: Summary Hospital Mortality Indicator

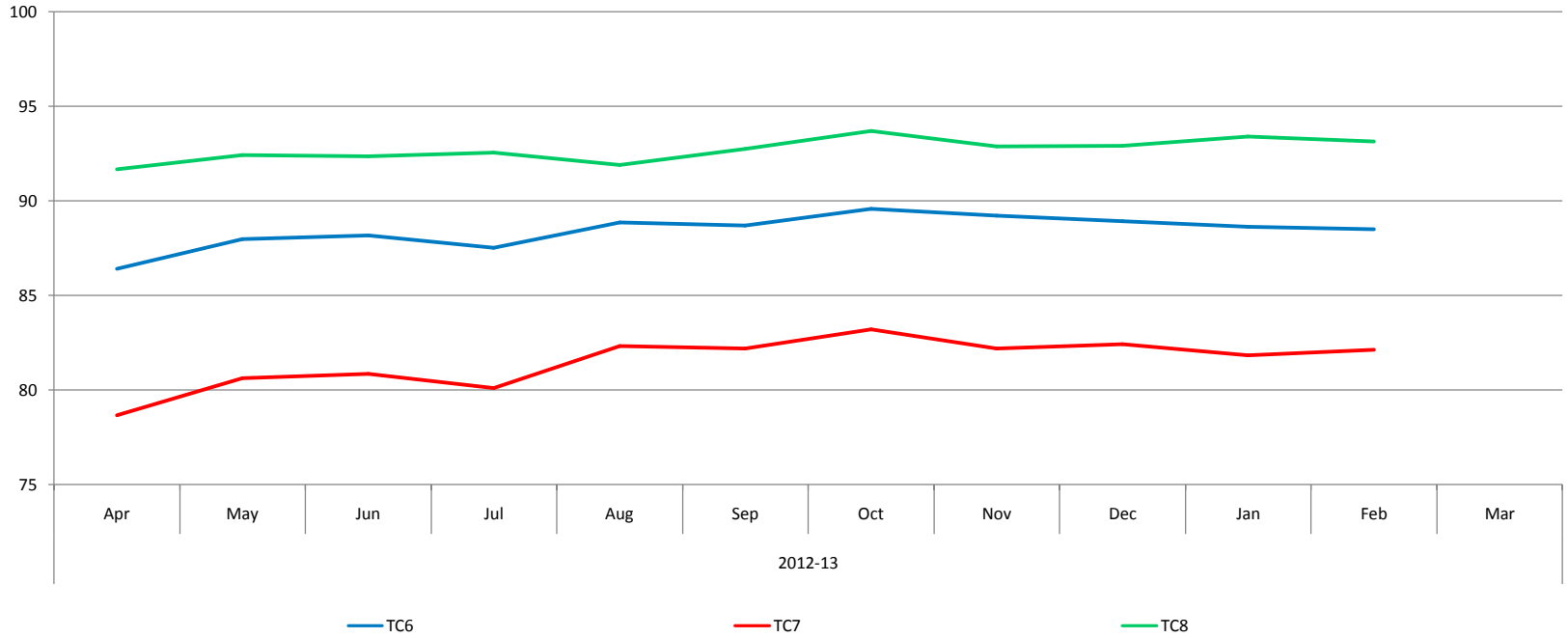


Source: Dr. Foster Intelligence

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

Core Question	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
TC6: Were you involved as much as you wanted to be in decisions about your care and treatment?	86.4	88.0	88.2	87.5	88.9	88.7	89.6	89.20	88.93	88.64	88.5	
TC7: Did you find someone on the hospital staff to talk to about your worries and fears?	78.7	80.6	80.9	80.1	82.3	82.2	83.2	82.19	82.42	81.85	82.12	
TC8: Were you given enough privacy when discussing your condition or treatment?	91.7	92.4	92.3	92.5	91.9	92.8	93.7	92.88	92.89	93.39	93.14	

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



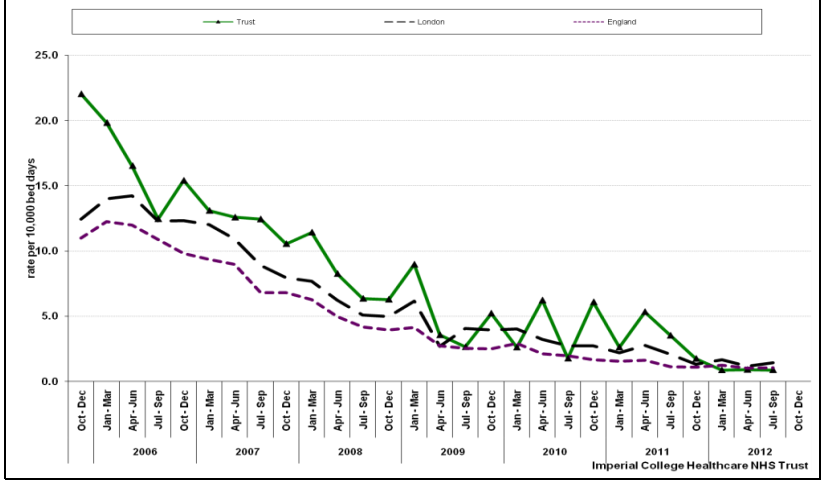
Source: iTrack

QLTY 3: Infection Prevention Control - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 8**

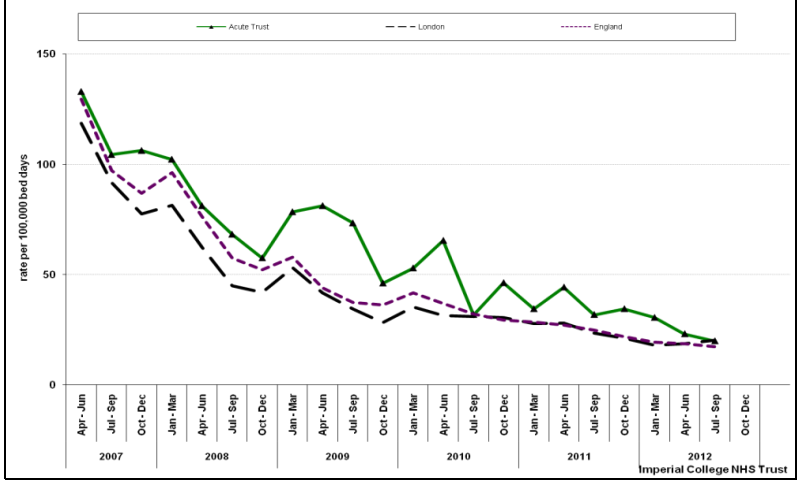
Domain	Indicator	Annual Trust Ceiling	Unit	Month 11		Year to date	
Infection Prevention and Control	Methicillin-Resistant Staphylococcus Aureus (MRSA) Bloodstream Infection (BSI) Bacteraemias	<=9	Cases	1	●	7	●
	Clostridium Difficile (C-Diff) post 72 Hours - Enzyme Immuno-Assays (EIA) - (Nationally Monitored)	<= 110	Cases	6	●	80	●

(*) data available to M9 only

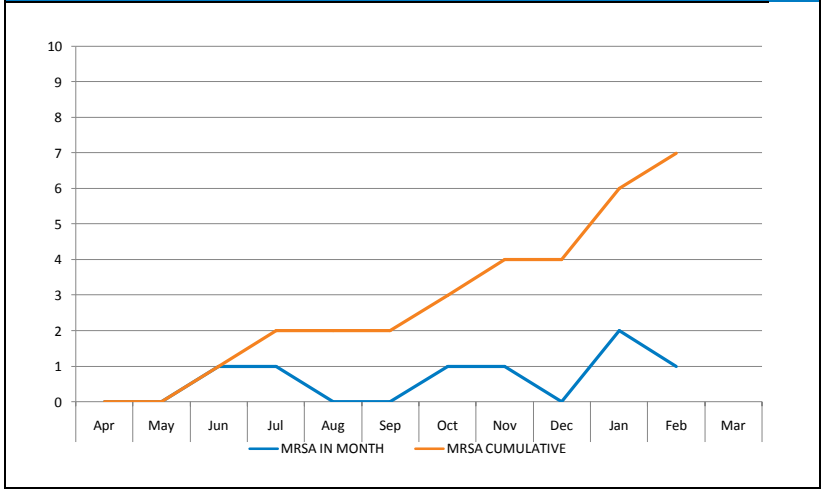
Graph 4:MRSA BSI/100 000 bed days at ICHNT compared to rates in London and England Trusts



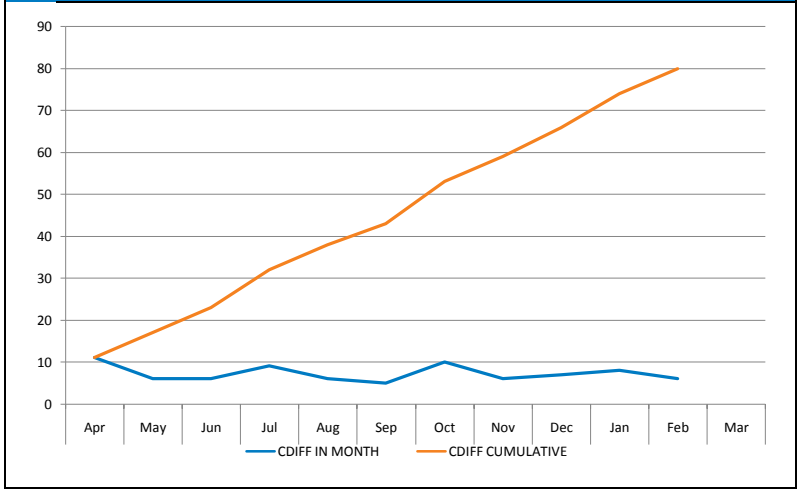
Graph 5: Clostridium Difficile cases/100 000 beddays at ICHNT compared with Trusts in London and England



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



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

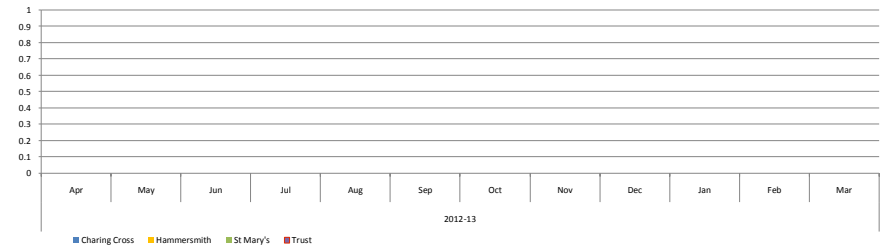


Source: Health Protection Agency & Infection Prevention Control Team

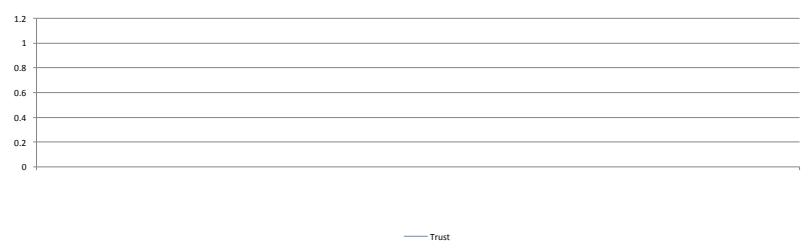
QLTY 4: Eliminating Mixed Sex Accommodation - EMSA - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 11		Year to date	
Eliminating Mixed Sex Accommodation	Trust - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Trust - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Charing Cross- Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Charing Cross - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	Hammersmith - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	Hammersmith - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●
	St Mary's - Total patients affected - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total breach days - Eliminating Mixed Sex Accomodation	0	number	0	●	0	●
	St Mary's - Total Finished Consultant Episodes that resulted in breaches	0	number	0	●	0	●

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



Graph 9: Trust Total Breach Days

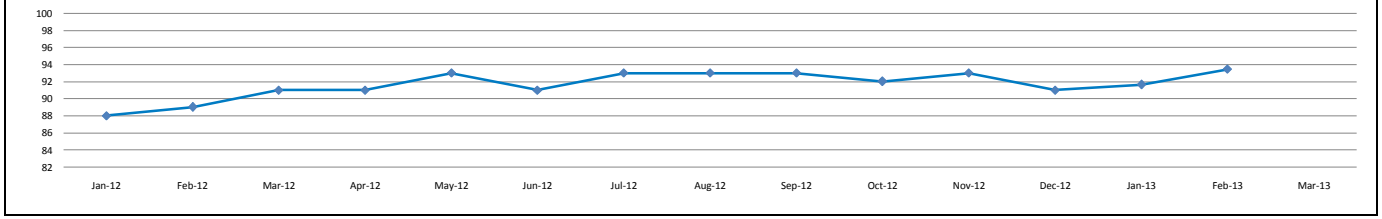


Source: Information Team

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

		Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
TC3: When you were first admitted to a bed on this ward, did you share a sleeping area, for example a room or a bay, with patients of the opposite sex? This table shows the % of patients who thought that they did not share a sleeping area with a member of the opposite sex on admission.	Trust	88	89	91	91	93	91	93	93	93	92	93	91	92	93	

Graph 10 : Patient Experience Tracking System - TC3 by month

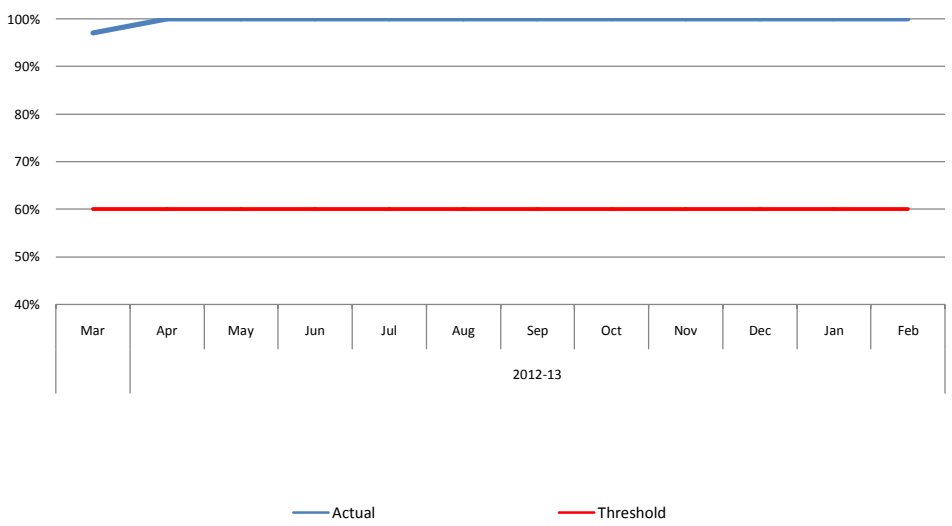


Source: iTrack

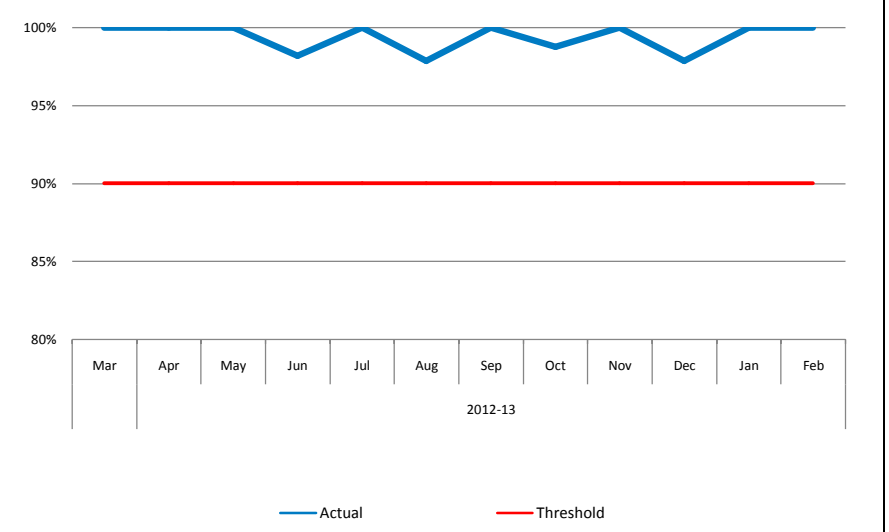
QLTY 5: Stroke Care - **Supports compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 11	Year to date
Stroke Care	Patients with high risk of Stroke who experience a TIA and are assessed and treated within 24 hours	60.0	%	100.0 ●	100.0 ●
	Patients who spend at least 90% of their time in hospital on a Stroke Unit	90.0	%	100.0 ●	99.3 ●

Graph 11: TIA patients assessed and treated within 24 hours



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

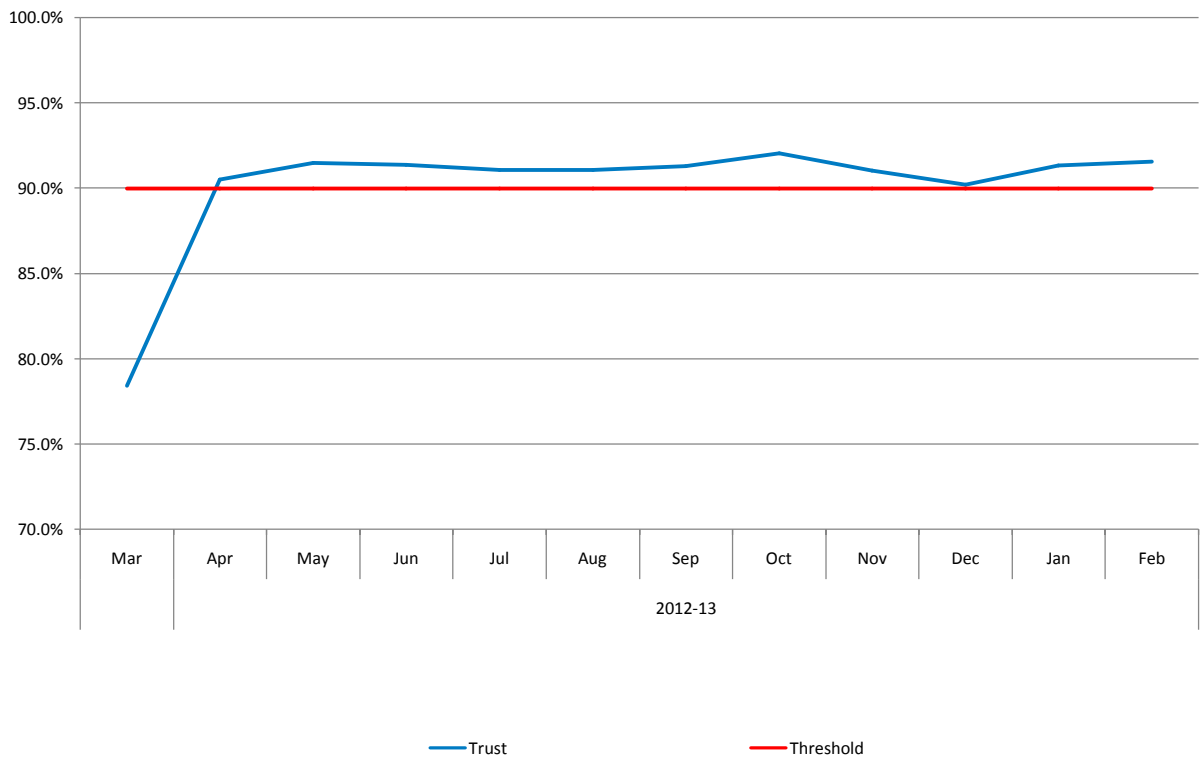


Source: Information Team

QLTY 6: Venous Thromboembolism - **NHS Performance Framework 2012/13 Indicator & Supporting Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 11	Year to date
Venous Thromboembolism (VTE) Risk Assessment	Adult Inpatients who have had a Venous Thromboembolism (VTE) Risk Assessment	90.0	%	91.6 ●	92.7 ●

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

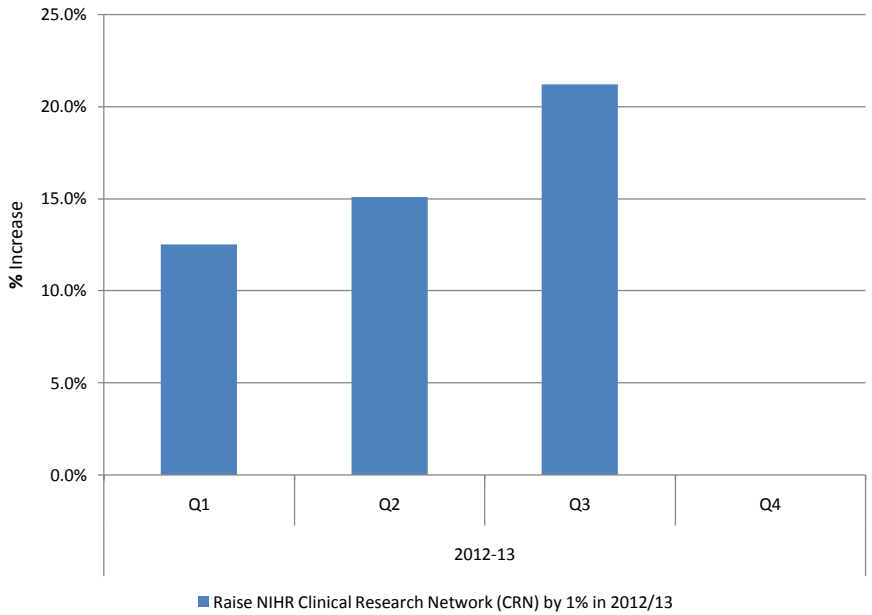


Source : Information Team

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

Domain	Indicator	Target	Unit	Quarter 3	Year to date
Research & Development	Raise the proportion of patients enrolled in NIHR Clinical Research Network (CRN) portfolio research studies by 1%	Increase by 1% from 11/12	%	21.3 •	16.0 •

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



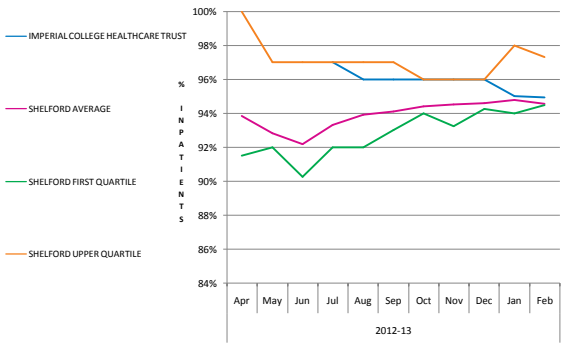
Source: Joint Research Office

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

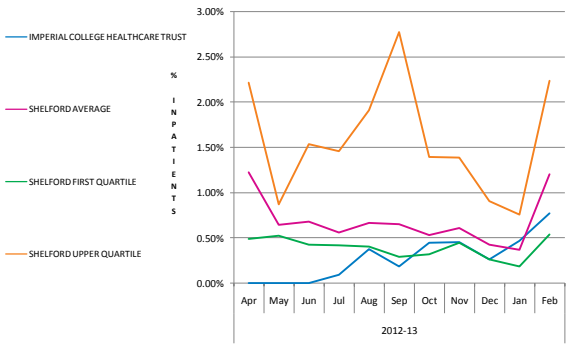
Domain	Indicator	Threshold	Unit	Month 11	Year to Date
Safety Thermometer	Harm free	-	%	95.0	96.0
	Pressure Ulcers - All	-	Number	38	23.8
	Pressure Ulcers - New	-	Number	9	5.6
	Falls with Harm	-	Number	6	2.5
	Catheter's & UTI	-	Number	11	6.5
	Catheter's & New UTI	-	Number	6	3.3
	New VTE's	-	Number	5	4.8

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

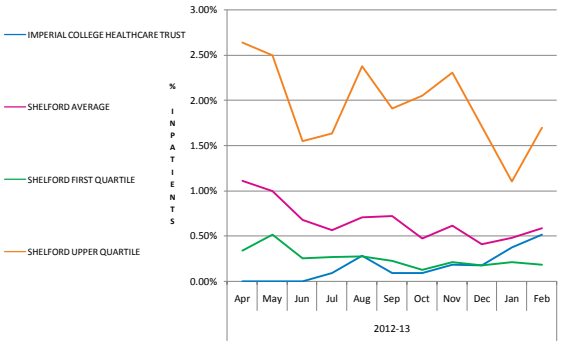
Graph 15: % of Inpatients who are Harm Free - by Month



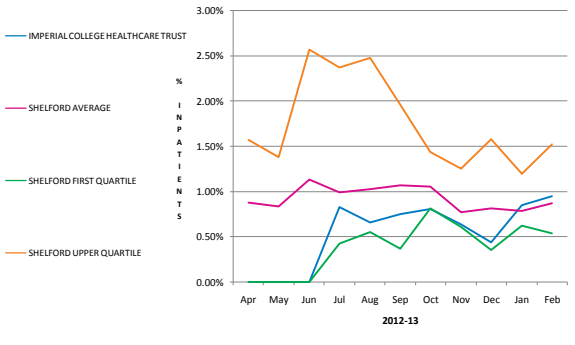
Graph 16: % of Inpatients with Pressure Ulcers (New)- by Month



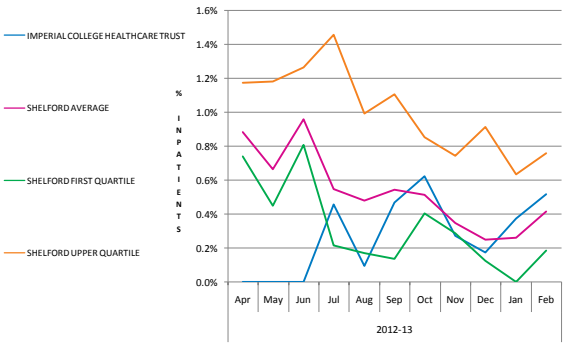
Graph 17: % of Inpatients with Harm Falls - by Month



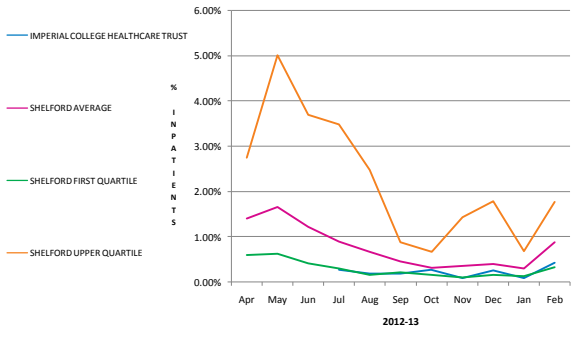
Graph 18: % of Inpatients with a Catheter and UTI (old and new) - by Month



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



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



OPS 1: Accident & Emergency - 4 hour maximum waiting time - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Site and type		Threshold	Month 11		Year to date	
4 hour maximum waiting time In Accident & Emergency	Trust	All (Type 1,2,3)	95.0%	96.6%	●	97.4%	●
	Trust	Type 1	95.0%	93.2%	●	94.8%	●
	Hammersmith	Type (1,2,3)	95.0%	97.3%	●	98.0%	●
	Charing Cross	Type (1,2,3)	95.0%	97.5%	●	97.6%	●
	St Mary's	Type (1,2,3)	95.0%	95.8%	●	96.9%	●
	Hammersmith	Type 1	95.0%	94.0%	●	96.0%	●
	Charing Cross	Type 1	95.0%	94.2%	●	95.6%	●
	St Mary's	Type 1	95.0%	92.5%	●	95.0%	●
London Ambulance Service (LAS) Handover	London Ambulance Service Patient Handover - within 60 Minutes		100%	100%	●	99.9%	●
	London Ambulance Service Patient Handover - within 30 Minutes		95.0%	98.6%	●	98.4%	●
	London Ambulance Service Patient Handover - within 15 Minutes		85.0%	89.5%	●	93.1%	●
	London Ambulance Service Breaches Handover > 60 Min		0		●		●

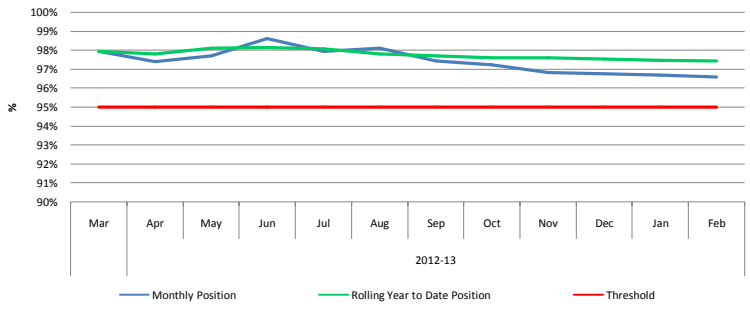
Key

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

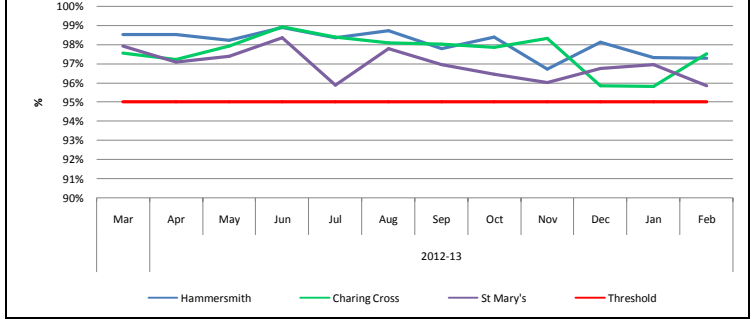
Type 2 = A consultant led single specialty accident and emergency service ie Western Eye for Ophthalmology patients

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

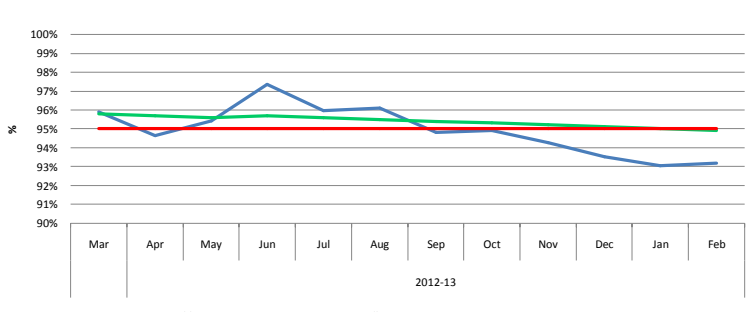
Graph 21: Total ICHNT performance (monthly and rolling YtD positions)



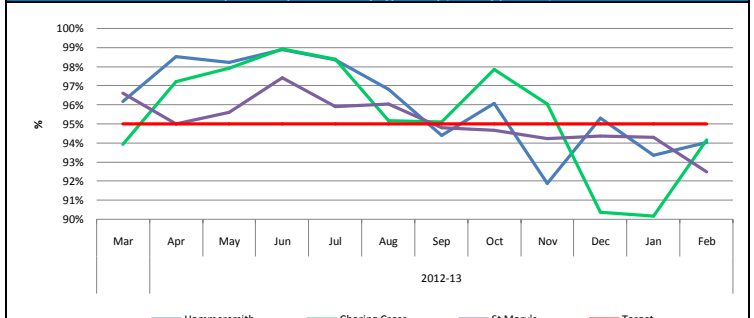
Graph 22: Site performance by All (Type 1,2,3) (monthly positions)



Graph 23: Total ICHNT performance Type 1 only (monthly and rolling YtD positions)



Graph 24: Site performance by Type 1 only (monthly positions)



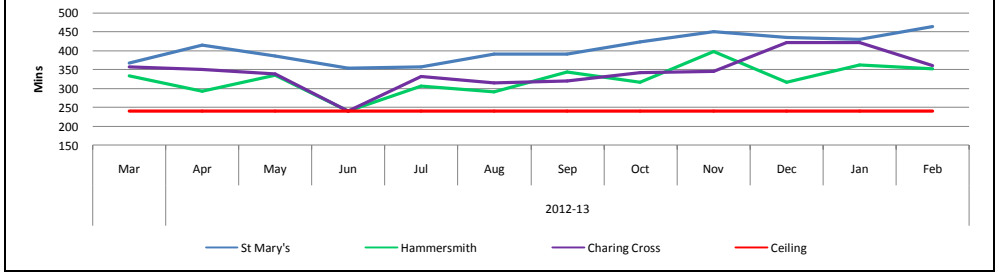
Source: Emergency Medicine

OPS 2: Accident & Emergency - Quality Indicators - **Supports Compliance with Care Quality Commission Outcome 4**

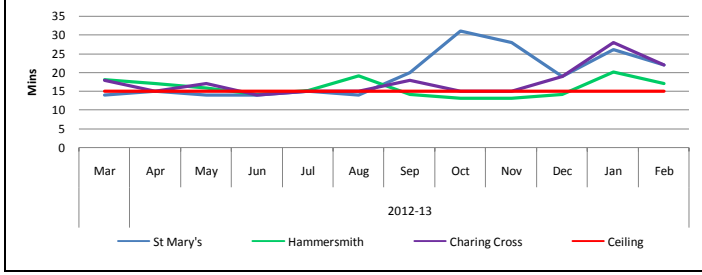
Domain	Indicator	Ceiling	Unit	St Mary's Month 11	St Mary's Year to date	Hammersmith Month 11	Hammersmith Year to date	Charing Cross Month 11	Charing Cross Year to date
Accident & Emergency - Quality Indicators	**Unplanned re-attendance at A&E within 7 days (*)**	5	%		●		●		●		●
	Total time spent in A&E										
	Admitted - Median Time	240	Minutes	237	●	●	233	●	●	229	●	●
	Admitted - 95th Percentile	240	Minutes	464	●	●	353	●	●	360	●	●
	Admitted - Longest Time	360	Minutes	792	●	●	520	●	●	655	●	●
	Non-Admitted - Median Time	240	Minutes	159	●	●	189	●	●	184	●	●
	Non-Admitted - 95th Percentile	240	Minutes	239	●	●	240	●	●	239	●	●
	Non-Admitted - Longest Time	360	Minutes	1117	●	●	536	●	●	781	●	●
	Left Department Without Being Seen Rate	5	%	0	●	●	0	●	●	0	●	●
	Time To Initial Assessment (ambulance cases only)										
	Median Time	15	Minutes	5	●	●	2	●	●	5	●	●
	95th Percentile	15	Minutes	22	●	●	17	●	●	22	●	●
	Longest Time	15	Minutes	154	●	●	59	●	●	92	●	●
	Time To Treatment In Department										
	Median Time	60	Minutes	71	●	●	59	●	●	42	●	●
	95th Percentile	60	Minutes	181	●	●	174	●	●	148	●	●
	Longest Time	60	Minutes	513	●	●	309	●	●	341	●	●

(*) - Type 1 indicators for Re-attendance are pre validated prior to April 2012
(**) Figures for month 10 are Type 1 only

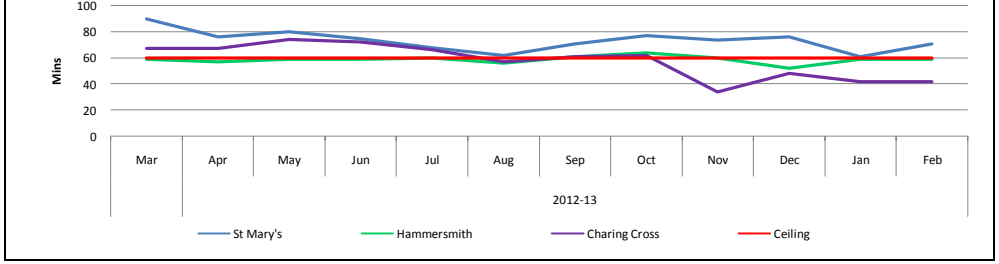
Graph 25: Total time in A&E (Admitted 95th Percentile)



Graph 26: Time to Initial Assessment (95th Percentile)



Graph 27: Time to Treatment in Department (Median)



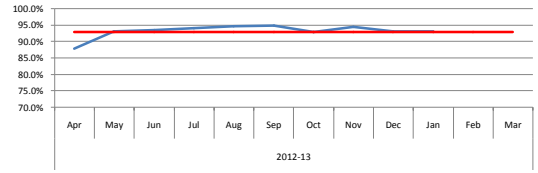
Source: Emergency Medicine

OPS 3: Elective Access - Cancer Waiting Times - NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4

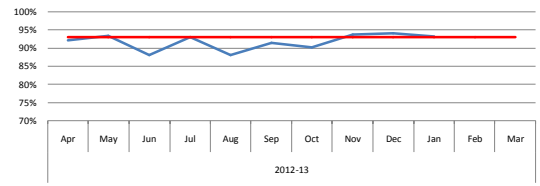
Domain	Indicator	Target	Unit	Month 10	
Elective Access - Cancer Waiting Times (*) (**)	All Cancer two week wait	93	%	93.1	●
	Two week GP referral to 1st outpatient - Breast Symptoms	93	%	93.2	●
	First Definitive Treatment within one month (31 days) of a Cancer Diagnosis	96	%	96	●
	31 day Standard to Subsequent Cancer Treatments - Surgery	94	%	95	●
	31 day second or sebsequent treatment - Drug	98	%	99	●
	Proportion of patients waiting no more than 31 days for second or subsequent cancer Treatment - Radiotherapy Treatment	94	%	97.8	●
	All Cancer Two Month Urgent Referral to Treatment wait	85	%	72.6	●
	62-Day wait for First Treatment following referral from an NHS Cancer Screening Service	90	%	92.9	●

* Cancer data reported one month in arrears as shown on Open Exeter

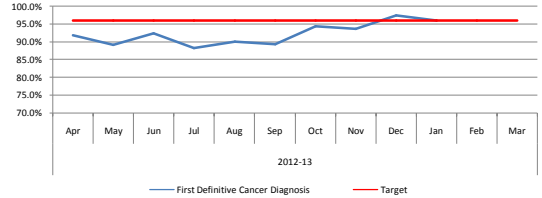
Graph 28: All Cancer two week wait



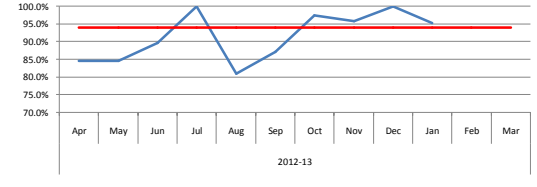
Graph 29:Two Weeks of an Urgent Referral for Breast Symptoms



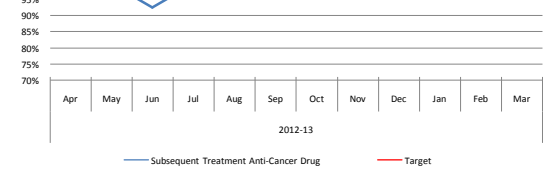
Graph 30: First Definitive Treatment within one Month (31 days) of a Cancer Diagnosis



Graph 31: 31 day Standard to subsequent Cancer Treatments - Surgery

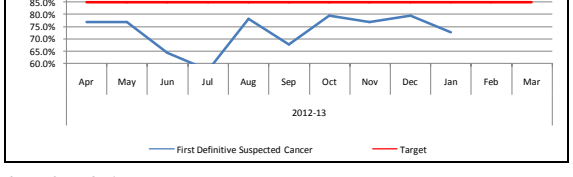


Graph 32: 31 day second or sebsequent treatment - Drug

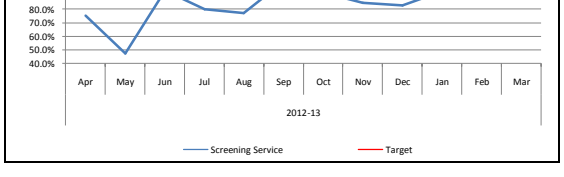


Graph 33: Treatment within 31-Days that Treatment is a Radiotherapy Treatment

Graph 34: All Cancer Two Month Urgent Referral to Treatment wait



Graph 35: 62-Day wait First Treatment following Referral - NHS Cancer Screening Service

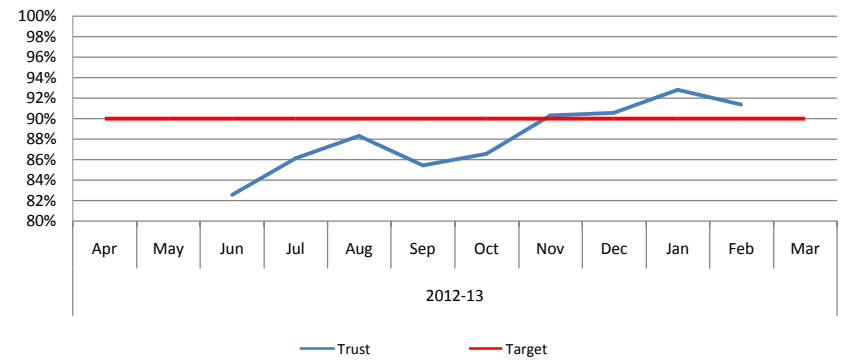


Source: Cancer Services

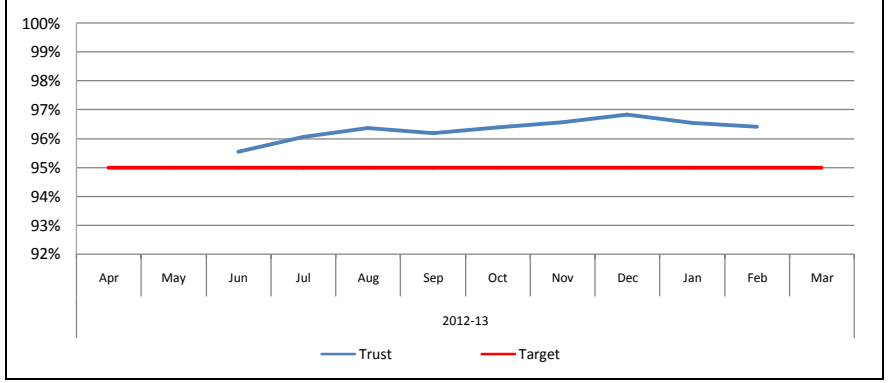
OPS 4: Elective Access - Referral To Treatment - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 11	Treatment Functions Not Achieving Target M11
Elective Access - Referral To Treatment	Total number of completed Admitted pathways - waiting 18 weeks or less	90.0	%	91.39	2
	Total number of completed Non-Admitted pathways - waiting 18 weeks or less	95.0	%	96.45	4
	Incomplete pathways where patients waiting less than 18 weeks	92.0	%	94.59	3
	Number of Treatment functions where standards are not delivered (admitted, non-admitted and incomplete pathways)	<=20	Number	9	

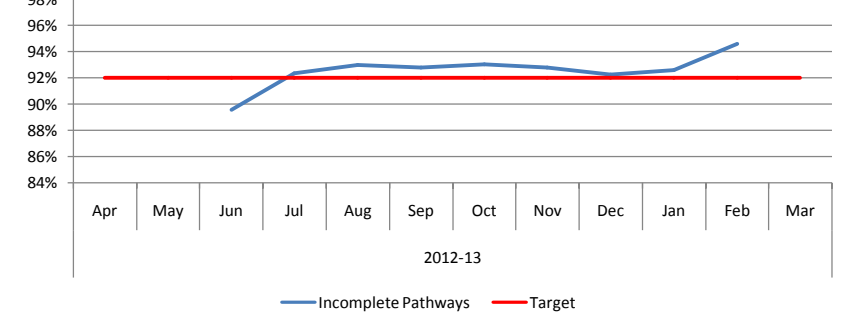
Graph 36: Patients Seen Within 18 Weeks For Admitted Treatment



Graph 37: Patients Seen Within 18 Weeks For Non-Admitted Treatment



Graph 38: Incomplete pathways where patients waiting less than 18 weeks

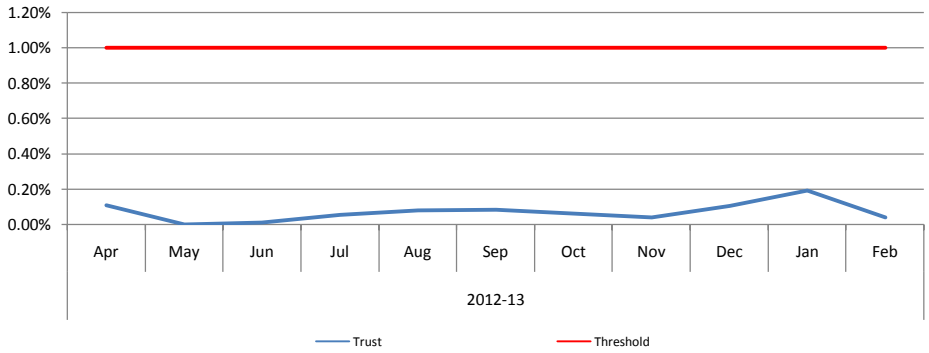


Source: Information Team

OPS 5: Elective Access - Diagnostics - **NHS Performance Framework 2012/13 Indicators & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 11
Elective Access - Diagnostics	Patients waiting 6 weeks or more for a diagnostic test	<1	%	0.04

Graph 39: Patients waiting 6 weeks or more for a Diagnostic Test



Source: Information Team

Diagnostic waiting list and Breaches waiting more than 6 weeks

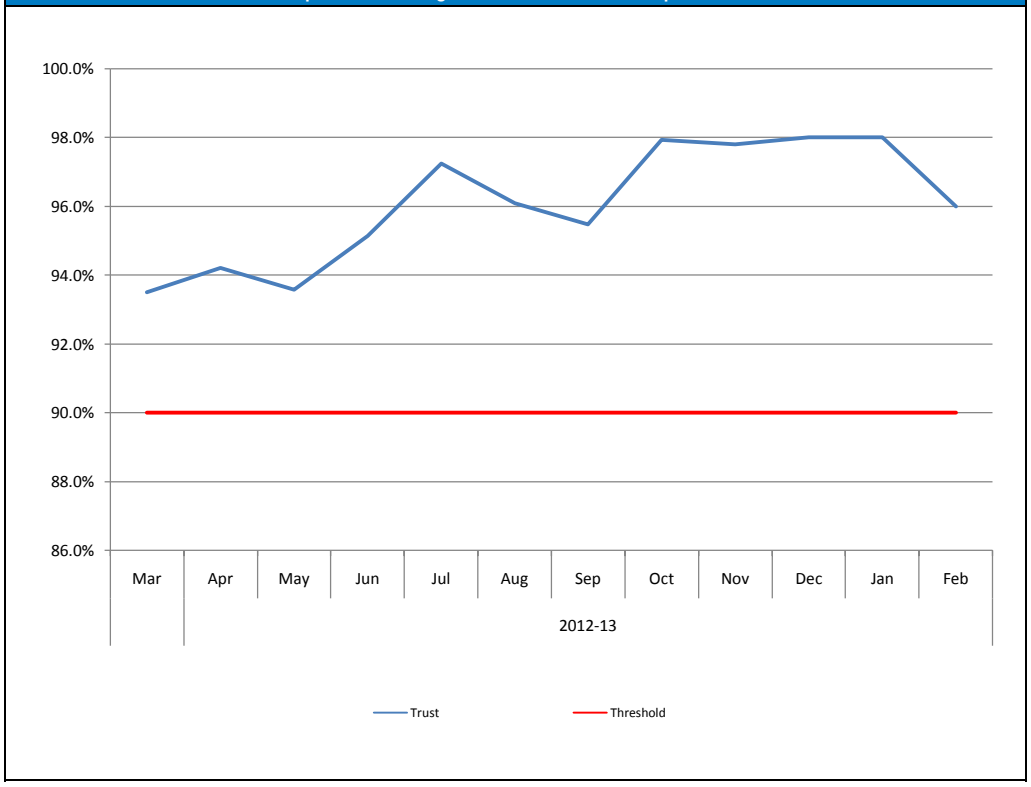
April		May		June		July		August		September	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
7379	8	7393	3	7287	3	7237	4	7632	6	7057	6

October		November		December		January		February		March	
Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches	Attended	Breaches
7978	5	7745	3	6717	7	6212	12	7143	3		

OPS 6: Maternity - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Month 11	Year to Date
Maternity access - by 12 weeks and 6 days	Women who have seen a Midwife by 12 weeks And 6 days of pregnancy who were referred on time	90.0	%	96.0 ●	96.3 ●

Graph 40: Percentage of women seen on time per month.

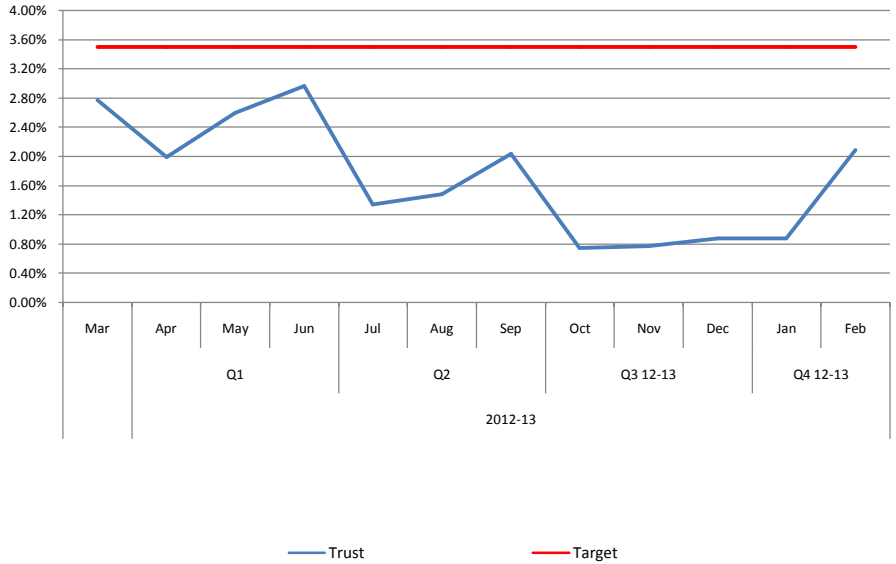


Source: Information Team

OPS 7: Delayed Transfer of Care - **NHS Performance Framework 2012/13 Indicator & Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Threshold	Unit	Quarter 3	Year to date
Delayed Transfer of Care	Average number of Acute patients (aged 18+) per day whose transfer of care was delayed (*)	3.5	%	0.8 •	1.64 •

Graph 41: Average number of patients whose transfer was delayed by month

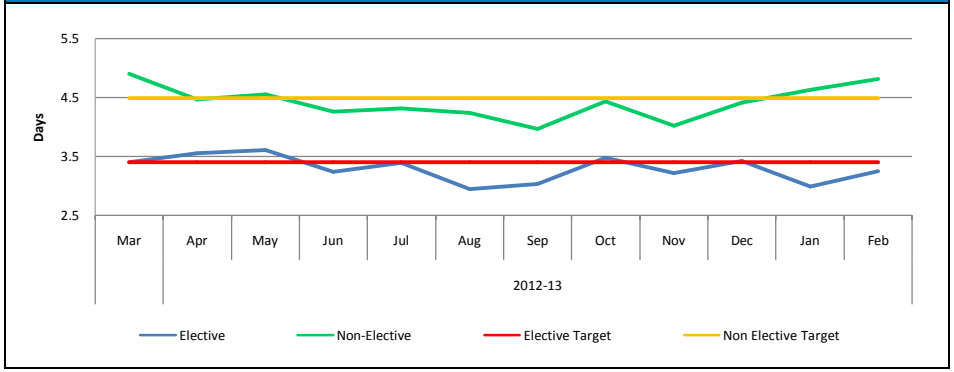


Source: Discharge Team, Clinical Site Management Team & Information Team

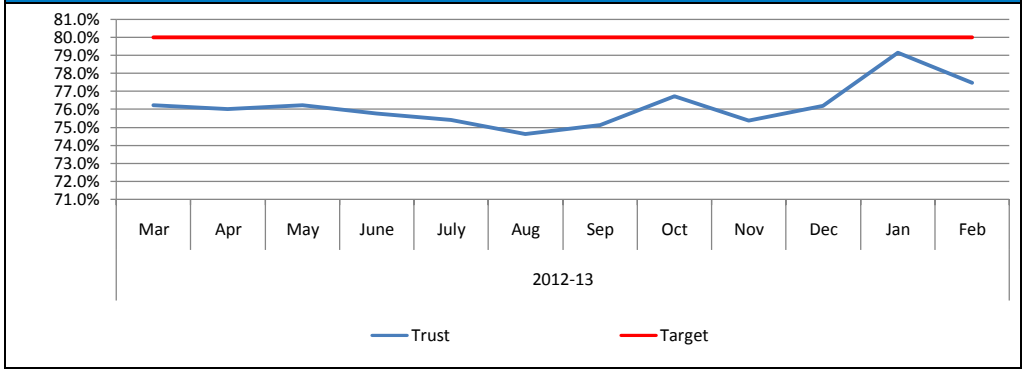
OPS 8: Quality, Innovation, Productivity and Prevention - **Supports Compliance with Care Quality Commission Outcome 4**

Domain	Indicator	Target	Unit	Month 11	Year to date
Productivity	Average Elective Length of Stay	3.40	Days	3.25 ●	3.29 ●
	Average Non-Elective Length of Stay	4.49	Days	4.81 ●	4.37 ●
	Daycase Rate	80.0	%	77.47 ●	76.2 ●
	New to Follow Up Outpatient Ratio	1.67	Ratio	2.36 ●	2.41 ●
	Theatre Utilisation Rate	>= 81	%	79.48 ●	78.7 ●

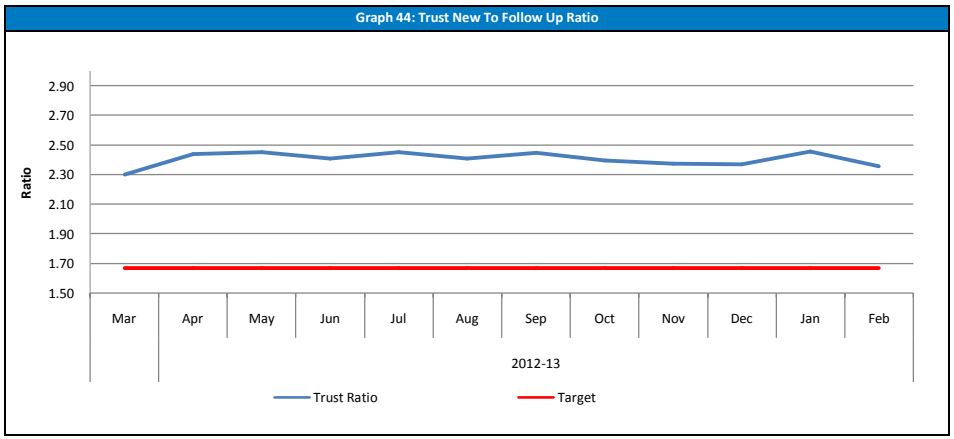
Graph 42: Trust Average Length Of Stay



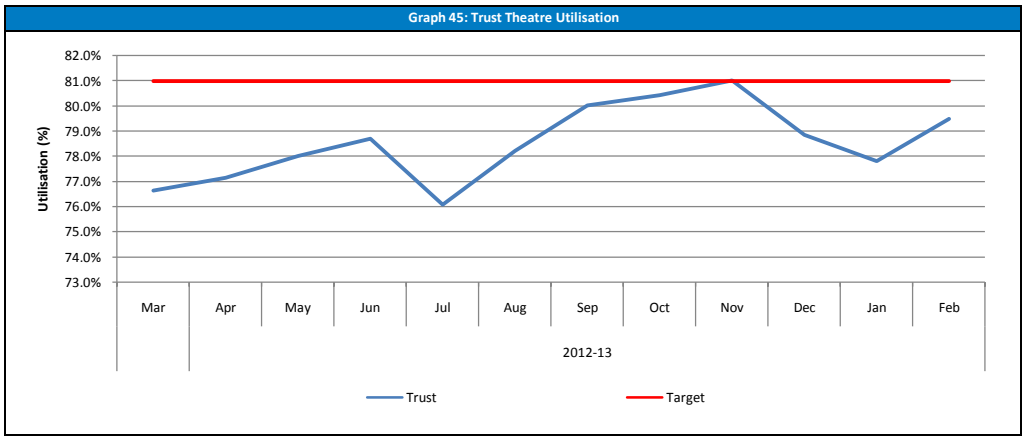
Graph 43: Trust Daycase Rate



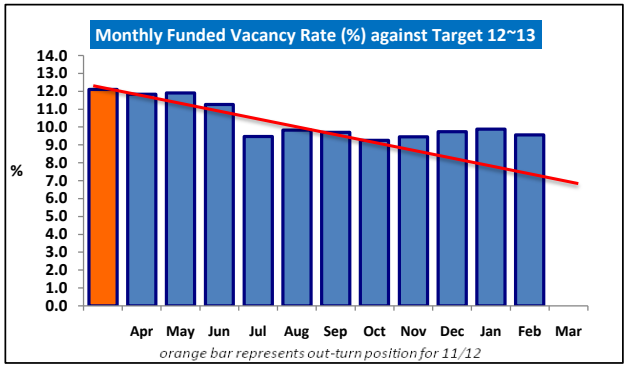
Graph 44: Trust New To Follow Up Ratio



Graph 45: Trust Theatre Utilisation

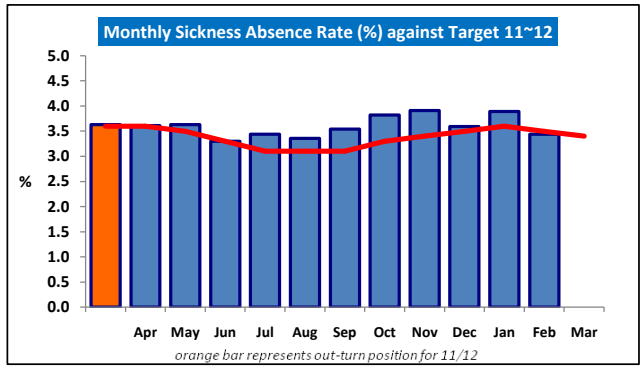


Source: Information Team, Finance Team & Theatre's Team



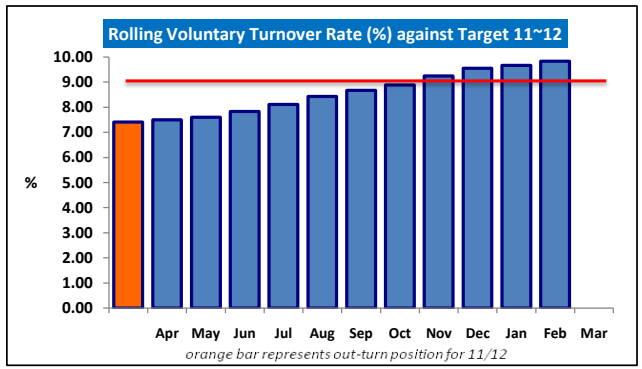
VACANCY RATE TARGET (YEAR-END)	<7.0%	
In month POSITION against target	9.57%	●

vacancy rate derived from GL WTE and ESR staff inpost WTE



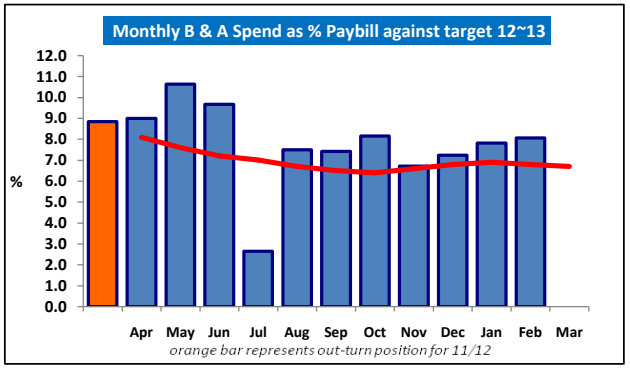
SICKNESS RATE TARGET (YEAR-END)	<3.4%	
CURRENT in-month POSITION against target	3.44%	●
12 Month Rolling POSITION	3.62%	●

sickness rate respresents % of contracted hours lost to sickness

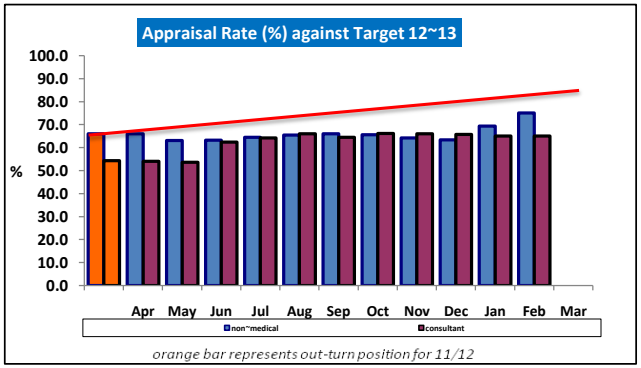


TURNOVER RATE TARGET (YEAR-END)	<9.0%	
12 Month Rolling POSITION against target	9.83%	●

note that from April 2012, 'retirement' is now included in voluntary

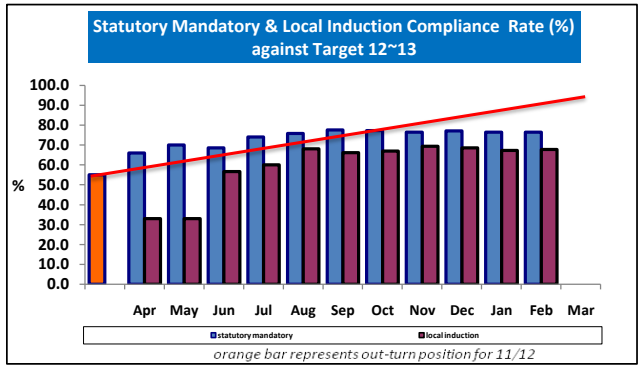


B&A SPEND as% PAYBILL TARGET (YEAR-END)	<7.0%	
CURRENT in-month POSITION against target	7.82%	●
12 Month Rolling POSITION	7.72%	●



APPRAISAL RATE TARGET (YEAR-END)	>85.0%	
NON~MEDICAL STAFF ~ CURRENT POSITION	75.00%	●
CONSULTANT APPRAISAL ~ CURRENT POSITION	64.98%	●

% of current staff who have had an appraisal in the last 12 months



EWTD COMPLIANCE RATE TARGET	>95.0	
STATUTORY MANDATORY ~ CURRENT POSITION	76.55%	●
LOCAL INDUCTION ~ CURRENT POSITION	67.75%	●

Staff Numbers: Substantively employed staffing numbers, at the end of February, was 8685 WTE; this is 218 WTE fewer than at the end of March 2012 (2.45% reduction). Within the staff groups, this reduction is seen as follows; A&C/Snr.Mgr = 82 WTE,
Forecast Pay Spend: The year-end forecast for total pay expenditure shows a favourable variance of £8.65m.
Bank & Agency Spend: YTD bank and agency spend accounts for £34.34m or 7.45% of the total YTD paybill; against a full-year target of 7.0%. Of the spend in Month 11, £2.17m is attributable to agency spend with £1.18m attributable to bank spend. When
Pay Expenditure: Total pay expenditure in Month 11 was £41.62m; giving an underspend of £505k. The YTD pay spend against budget position is a favourable variance of £8.02m.
Vacancy: The vacancy rate against the funded WTE establishment (as stated on the General Ledger) was 9.57% at the end of February. This is the equivalent of 919 WTE; the majority of which were covered by temporary staff leaving 48 WTE unfilled (0.50% of
Turnover: There were a total of 59 voluntary leavers in February, bringing the 12-month rolling turnover position to 9.83%; against a full-year target of 9.0%. On average, we have seen 20 more leavers per month since April 2012; a reflection of the inclusion
Sickness: Recorded sickness absence decreased in February from 3.89 to 3.44%; equivalent to 301 WTE. Of the February recorded sickness, 24% is attributable to long-term illness. Against target, the 12-month rolling position of 3.62% remains significantly
Appraisal: The non-medical appraisal rate rose from 69% at the end of January to 75.0% at the end of February, with CPG's ranging from 66 to 88% and Corporate Directorates from 7 to 100%. All managers, with a non-medical appraisal rate of less than 85%,
Statutory Mandatory & Local Induction: Statutory Mandatory training compliance for non-medical staff remains at 77% with Local Induction up from 67.3 to 67.8% in month; both measures are currently below target.

* the figures and information contained in this analysis relates to CPG/Corporate/Private Patients only

TRUST BOARD: MARCH 2013 **AGENDA NUMBER: 3.2.1**

Report Title: Finance Performance Report: Month 11- February 2013

To be presented by: Bill Shields, Chief Financial Officer

Chief Financial Officer's message:
The Trust has achieved a surplus of £8.4m at the end of February, a favourable variance against the plan of £8.3m. This is based on a surplus in month of £0.1m.

The forecast outturn for the year has been revised to £9.745m following agreement with NHS London over reporting of a number of technical accounting adjustments. The surplus to date has been achieved by the over-achievement of the cost improvement plan, which is expected to deliver £54m in year savings, £2m more than the plan requires and through cost control therefore not requiring the contingency set aside at the beginning of the year. The continued focus on cost improvement is required into 2013/14, despite the over-achievement in year. The Trust has also paid off one of its Department of Health loans due to the improved cash position, which has a resulting positive impact upon expenditure next year.

Key Issues for discussion:
Continued improvement required in future months through improved performance against CIPs.

Legal Implications or Review Needed

a. Yes	☐
b. No	✓

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objective

Achieve outstanding results in all our activities.

Assurance or management of risks associated with meeting key objective:

Purpose of Report

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

Building world class finance

innovation respect care achievement pride

FINANCE REPORT - FEBRUARY 2013

1 Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 28th February 2013.

1.2 The narrative report is intended to provide a more focussed statement of the main drivers of the financial performance and direct the audience to the appendix for further explanation.

1.3 This month's finance report includes the revised forecast surplus of £9.745m agreed with NHS London. The forecast Income & Expenditure now reflects the technical accounting adjustments for fixed asset impairments, stock losses and donated assets.

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

2.1 **Statement of Comprehensive Income (I&E Account)** - The Trust's financial position for the month is a **surplus** of £62k, with a year to date surplus of £8,427k. The Trust achieved a **favourable variance** of £2,764k in month

2.2 **PCT Service Level Agreement (SLA) Income** – The PCT SLA contract monitoring report for the month of February was calculated using the month 10 actual data and adjusted for the new planned monthly profile within the SLA. The Trust received extra funding of £987k for additional winter pressures activity.

2.4 **Expenditure** - Pay expenditure shows a **favourable** variance of £6,654k year to date. The monthly pay expenditure is in line with the average monthly run rate for the year. Non pay expenditure for drugs and clinical supplies is showing a **favourable** variance year to date of £13,690k which is due to managing the cost pressure and changes in procurement.

3 Monthly Performance (Page 4 & 5)

3.1 The performance of the CPGs and Corporate Services reflects the agreed budget allocations. The focus is on the forecast outturn and reducing run rates of expenditure rather than just the position against the original plan. This month the CPGs overspent mainly as a result of increased drug and agency spend when compared to last month, but overall deliver an improved forecast outturn when compared to the previous month.

3.2 There needs to be continued focus on CIP delivery thereby reducing unit costs and securing a reduction in the current expenditure run rate which is key to delivering the financial plan targets going forward into next year.

3.3 The Corporate Directorates' expenditure is, on the whole, in line with the plan. Despite CIP phasing being more heavily weighted towards the end of the year, continued focus has meant this has been delivered.

4 Cost Improvement Plan (Page 6)

4.1 The CIP plan for the year is £52.1m, (full year effect £62m). Expected forecast outturn is £54.1m.

4.2 Actual achievement of new CIP schemes in February was £5.7m (year to date £48.7m). To date there is a favourable variance of £2.1m and this will be maintained to year end.

4.3 The CIP Delivery Board is closely monitoring the position and plans are in place to ensure delivery of the 2012/13 target. In addition, work is continuing on the schemes for 2013/14, of which over eighty per cent have been identified within the current draft plan.

5 Statement of Financial Position (Balance Sheet - Page 7)

5.1 The overall movement in balances when compared to the previous month is £0.1m.

5.2 The most significant movements on the balance sheet are a decrease in debtors of £15.6m and an increase in cash of £10.7m relating to the payment of outstanding NHS debt.

6 Capital Expenditure (Page 8)

6.1 Expenditure in month was £4.7m (£17.0m year to date) which is a favourable variance to the plan.

6.2 After an initial slow start ICT capital expenditure has significantly accelerated £3.7m in month. The Trust has agreed a forecast outturn with NHS London to meet its Capital Resource Limit (CRL).

7 Cash (Page 9)

7.1 The cash profile has been set out as per the plan to NHS London. Cash is ahead of plan at month 11 due to payments to suppliers (including capital) and payroll payments being lower than the year to date plan, and payment of outstanding NHS debt.

8 Monitor metrics – Financial Risk Rating (Page 10)

8.1 The Trust's overall financial risk rating is a FRR of 3 based on the results in February. All risk metrics were on plan for February. A score of 3 is mandatory for Foundation Trust status.

9 Conclusions & Recommendations

The Board is asked to note:

- The surplus of £62k for the month of February, the cumulative surplus of £8,427k, a cumulative favourable variance of £8,347k
- Actual achievement of new CIP schemes in month 11 was £5.7m which is now above the average monthly run rate required of £4.4m to achieve the full year target of £52.1m.
- This month's finance report includes the agreed forecast surplus of £9.745m before impairments stock losses and donated asset treatment with NHS London.

Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Director of Operational Finance

Contents

Finance Performance Report for the month ending 28th February 2013

Page	Description	Risk		Report Status
		Month 11	Month 10	
1	Statement of Comprehensive Income (SOCI)	G	G	Attached
2	Income Report	G	G	Attached
3	Expenditure Report	G	G	Attached
4	Clinical Programme Groups Financial Performance	A	A	Attached
5	Corporate Services Financial Performance	G	G	Attached
6	Cost Improvement Plan	G	G	Attached
7	Statement of Financial Position (Balance Sheet)	G	G	Attached
8	Capital Expenditure Report	A	A	Attached
9	Cash Flow Report	G	G	Attached
10	Financial Risk Rating	G	G	Attached
11	SLA Activity & Income Performance	A	A	Attached
12	Risk Analysis	G	G	Attached

PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income									
Clinical	58,767	59,771	1,003	685,325	684,282	(1,043)	748,559	747,344	(1,215)
Research & Development	4,380	5,224	844	48,180	49,523	1,343	52,561	52,561	0
Training & Education	5,301	5,430	129	58,314	59,556	1,242	63,616	65,151	1,535
Other	7,105	10,755	3,650	78,275	81,782	3,507	85,380	90,664	5,284
TOTAL INCOME	**75,553**	**81,180**	**5,627**	**870,094**	**875,143**	**5,049**	**950,116**	**955,720**	**5,604**
Expenditure									
Pay - In post	(39,194)	(38,994)	200	(437,648)	(435,150)	2,498	(476,744)	(474,557)	2,187
Pay - Bank & Agency	(3,655)	(3,564)	91	(41,803)	(37,647)	4,156	(45,487)	(40,627)	4,860
Drugs & Clinical Supplies	(16,691)	(17,847)	(1,156)	(195,925)	(182,236)	13,689	(213,774)	(196,669)	17,105
General Supplies	(3,658)	(3,001)	657	(40,241)	(37,994)	2,247	(43,900)	(43,131)	769
Other	(9,961)	(11,630)	(1,669)	(99,107)	(117,471)	(18,364)	(109,325)	(130,771)	(21,446)
TOTAL EXPENDITURE	**(73,159)**	**(75,035)**	**(1,876)**	**(814,724)**	**(810,498)**	**4,226**	**(889,230)**	**(885,755)**	**3,475**
EBITDA	**2,394**	**6,145**	**3,750**	**55,370**	**64,646**	**9,275**	**60,886**	**69,965**	**9,079**
Financing Costs	(5,096)	(4,953)	143	(55,291)	(55,090)	201	(60,386)	(60,220)	166
SURPLUS / (DEFICIT) before Impairment	**(2,702)**	**1,191**	**3,893**	**79**	**9,556**	**9,476**	**500**	**9,745**	**9,245**
Impairment of Assets, Stock losses & Donated Asset treatment	0	(1,129)	(1,129)	0	(1,129)	(1,129)	0	(5,945)	(5,945)
SURPLUS / (DEFICIT)	**(2,702)**	**62**	**2,764**	**79**	**8,427**	**8,347**	**500**	**3,800**	**3,300**

Surplus / (Deficit): The Trust delivered an Income and Expenditure surplus in month of £62k, a favourable variance of £2,764k against the plan. Cumulatively, at month 11, the Trust has delivered a surplus of £8,427k. The actual achievement of CIP schemes in month 11 was £5,726k, cumulative £48,675k. This is £2,084k above the required planned achievement of £46,591k and the expected forecast outturn of £54,144k is £2,004k greater than plan.

Income: There was an over-performance which relates to additional funding of £987k for winter pressures activity; R&D £844k linked to an equivalent overspend on expenditure to ensure a net zero impact for R&D projects; and adjustment of £4m for provisions.

Expenditure: The monthly pay expenditure, is in line with the average monthly run rate for the year. Continued focus is required by Clinical Programme Groups to ensure this is continued into 2013/14. Non Pay is over-spent by £2,167k in month due to additional spending on consultancy services, backlog maintenance and equipment.

Forecast Outturn: The forecast outturn for the year has been revised to £9.745m following discussion with NHS London to take into account technical adjustments relating to the treatment of donated assets, stock losses and fixed asset impairments.

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

PAGE 2 - INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income from Clinical Activities									
North West London Sector PCTs	34,580	34,580	(0)	406,348	406,349	1	443,470	443,470	0
Rest of London PCTs	4,734	4,996	262	55,552	55,869	316	60,705	61,665	960
Other PCTs	5,807	6,053	246	68,026	65,025	(3,001)	74,596	71,750	(2,846)
Specialist Commissioning	8,555	8,003	(552)	101,752	102,342	590	110,608	112,319	1,711
Other SLAs	526	467	(59)	6,211	3,768	(2,443)	7,127	3,936	(3,191)
Other NHS Organisations	1,013	2,723	1,711	8,756	17,362	8,605	9,514	17,321	7,807
Sub-Total NHS Income	**55,215**	**56,822**	**1,607**	**646,645**	**650,715**	**4,069**	**706,020**	**710,461**	**4,441**
Private Patients	3,102	2,497	(605)	33,730	27,742	(5,988)	37,139	30,398	(6,741)
Overseas Patients	150	150	0	1,650	1,652	2	1,800	1,803	3
NHS Injury Scheme	100	151	51	1,100	1,123	23	1,200	1,193	(7)
Non NHS Other	200	151	(49)	2,200	3,050	850	2,400	3,489	1,089
Total - Income from Clinical Activities	**58,767**	**59,771**	**1,003**	**685,325**	**684,282**	**(1,043)**	**748,559**	**747,344**	**(1,215)**
Other Operating Income									
Research & Development	4,380	5,224	844	48,180	49,523	1,343	52,561	52,561	0
Training & Education	5,301	5,430	129	58,314	59,556	1,242	63,616	65,151	1,535
Non patient care activities	2,833	2,609	(224)	31,163	30,185	(978)	33,996	33,327	(669)
Income Generation	600	356	(244)	6,600	5,575	(1,025)	7,200	5,852	(1,348)
Other Income	3,672	7,790	4,118	40,512	46,023	5,511	44,184	51,485	7,301
Total - Other Operating Income	**16,786**	**21,409**	**4,623**	**184,769**	**190,861**	**6,092**	**201,557**	**208,376**	**6,819**
TOTAL INCOME	**75,553**	**81,180**	**5,627**	**870,094**	**875,143**	**5,049**	**950,116**	**955,720**	**5,604**

Income from Clinical Activities: North West London (NWL) income reflects the block contract of £500m agreed with the NWL Commissioners. In month the Trust received funding of £987k to support additional winter pressures activity. Private Patient income for the month is consistent with previous months at £605k behind plan in month, YTD adverse variance of £5,988k. A detailed assessment of monthly forecast income is currently being undertaken to identify key risks and opportunities.

Other Operating Income: The in month favourable variance on R&D is linked to an equivalent overspend on expenditure to ensure a net zero impact for R&D projects. The variable variance on other income is due to adjustments and re-categorisation of provisions.

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

PAGE 3 - EXPENDITURE

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,511)	(12,670)	(159)	(141,434)	(141,519)	(85)	(153,907)	(154,239)	(332)
Nursing & Midwifery	(12,492)	(12,172)	320	(137,786)	(135,353)	2,433	(150,262)	(147,526)	2,736
Scientific, Therapeutic & Technical staff	(5,742)	(5,571)	171	(64,934)	(62,595)	2,339	(70,686)	(68,745)	1,941
Healthcare assistants and other support staff	(1,979)	(2,080)	(101)	(21,848)	(22,347)	(499)	(23,831)	(25,073)	(1,242)
Directors and Senior Managers	(2,469)	(2,498)	(29)	(27,239)	(28,546)	(1,307)	(29,697)	(31,110)	(1,413)
Administration and Estates	(4,001)	(4,003)	(2)	(44,407)	(44,791)	(384)	(48,361)	(47,864)	497
Sub-total - Pay In post	**(39,194)**	**(38,994)**	**200**	**(437,648)**	**(435,150)**	**2,498**	**(476,744)**	**(474,557)**	**2,187**
Pay - Bank/Agency									
Medical Staff	(235)	(547)	(312)	(3,318)	(5,426)	(2,108)	(3,617)	(6,195)	(2,578)
Nursing & Midwifery	(1,445)	(1,218)	227	(16,165)	(12,779)	3,386	(17,593)	(13,741)	3,852
Scientific, Therapeutic & Technical staff	(446)	(407)	39	(5,325)	(4,066)	1,259	(5,772)	(4,239)	1,533
Healthcare assistants and other support staff	(339)	(297)	42	(3,745)	(3,427)	318	(4,084)	(3,577)	507
Directors and Senior Managers	(442)	(248)	194	(4,850)	(3,564)	1,286	(5,292)	(4,320)	972
Administration and Estates	(748)	(848)	(100)	(8,400)	(8,384)	16	(9,129)	(8,555)	574
Sub-total - Pay Bank/Agency	**(3,655)**	**(3,564)**	**91**	**(41,803)**	**(37,647)**	**4,156**	**(45,487)**	**(40,627)**	**4,860**
Non Pay									
Drugs	(8,427)	(7,968)	459	(99,859)	(88,562)	11,297	(108,960)	(96,221)	12,739
Supplies and Services - Clinical	(8,264)	(9,878)	(1,614)	(96,066)	(93,673)	2,393	(104,814)	(100,448)	4,366
Supplies and Services - General	(3,658)	(3,001)	657	(40,241)	(37,994)	2,247	(43,900)	(43,131)	769
Consultancy Services	(1,042)	(2,193)	(1,151)	(11,459)	(13,477)	(2,018)	(12,500)	(13,285)	(785)
Establishment	(700)	(601)	99	(7,700)	(7,012)	688	(8,400)	(7,595)	805
Transport	(750)	(773)	(23)	(8,250)	(8,828)	(578)	(9,000)	(9,579)	(579)
Premises	(2,800)	(3,825)	(1,025)	(30,800)	(34,579)	(3,779)	(33,600)	(35,967)	(2,367)
Other	(4,669)	(4,237)	432	(40,898)	(53,574)	(12,676)	(45,825)	(64,345)	(18,520)
Sub-total - Non Pay	**(30,310)**	**(32,477)**	**(2,167)**	**(335,273)**	**(337,701)**	**(2,428)**	**(366,999)**	**(370,571)**	**(3,572)**
TOTAL EXPENDITURE	**(73,159)**	**(75,035)**	**(1,876)**	**(814,724)**	**(810,498)**	**4,226**	**(889,230)**	**(885,755)**	**3,475**
Financing Costs									
Interest Receivable	18	33	15	207	257	50	225	247	22
Interest Payable	(153)	(139)	14	(1,684)	(1,680)	4	(1,838)	(1,838)	0
Other Gains & Losses	0	0	0	0	(200)	(200)	0	(200)	(200)
Depreciation	(3,135)	(3,065)	70	(33,725)	(33,597)	128	(36,860)	(36,829)	31
Public Dividend Capital	(1,826)	(1,783)	43	(20,089)	(19,870)	219	(21,913)	(21,600)	313
TOTAL - FINANCING COSTS	**(5,096)**	**(4,953)**	**143**	**(55,291)**	**(55,090)**	**201**	**(60,386)**	**(60,220)**	**166**

Pay: The monthly pay expenditure is in line with the average monthly run rate for the year. Pay expenditure and workforce forecasts are now fully aligned. Differences between Electronic Staff Records (ESR) establishments and workforce forecasts are reported through Performance Reviews with a clear objective that differences are minimised. An integrated reporting Qlikview application is scheduled to be developed in Quarter 1 2013/14. This will bring together all elements of financial and non-financial workforce reporting into a single application for managers.

Non Pay: Non Pay is over-spent by £2,167k in month is due to additional spending on consultancy services, backlog maintenance and equipment.

Financing costs: Due to the underspend on the capital plan as at the end of quarter 3 (Dec 2012), there is an in year saving on depreciation and Public Dividend Capital payment.

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

PAGE 4 - Clinical Programme Groups Financial Performance

	Risk Rating	In Month (Feb)			Year To Date (Cumulative)			FORECAST	Change in Forecast from Last Month	Previous Month FORECAST
		Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Variance £000s	Variance £000s	Variance £000s
CPG 1 - Medicine										
Income		864	1,072	208	7,353	7,865	512			
Pay		(6,731)	(7,054)	(322)	(77,506)	(77,598)	(91)			
Non Pay		(5,414)	(5,438)	(24)	(57,533)	(61,169)	(3,636)			
TOTAL	R	**(11,281)**	**(11,420)**	**(138)**	**(127,686)**	**(130,902)**	**(3,216)**	**(4,136)**	**299**	**(4,435)**
CPG 2 - Surgery and Cancer										
Income		108	33	(74)	1,147	1,048	(100)			
Pay		(3,666)	(3,848)	(182)	(41,419)	(42,245)	(826)			
Non Pay		(2,508)	(2,738)	(230)	(27,813)	(29,621)	(1,808)			
TOTAL	R	**(6,067)**	**(6,553)**	**(487)**	**(68,085)**	**(70,818)**	**(2,734)**	**(3,277)**	**40**	**(3,317)**
CPG 3 - Specialist Services 1										
Income		220	248	28	2,439	2,508	69			
Pay		(7,148)	(6,986)	161	(77,935)	(77,048)	887			
Non Pay		(4,681)	(4,817)	(136)	(53,719)	(54,284)	(565)			
TOTAL	G	**(11,608)**	**(11,555)**	**53**	**(129,215)**	**(128,824)**	**391**	**54**	**(22)**	**76**
CPG 4 - Cardiac & Renal										
Income		353	391	38	3,915	4,546	632			
Pay		(5,068)	(4,840)	228	(55,901)	(54,880)	1,022			
Non Pay		(5,819)	(6,087)	(267)	(63,382)	(65,082)	(1,700)			
TOTAL	G	**(10,535)**	**(10,536)**	**(1)**	**(115,368)**	**(115,415)**	**(47)**	**0**	**0**	**0**
CPG 5 - Women's and Children's										
Income		564	624	60	6,199	6,127	(72)			
Pay		(5,665)	(5,506)	159	(62,222)	(62,168)	54			
Non Pay		(7,073)	(7,224)	(150)	(25,547)	(26,877)	(1,329)			
TOTAL	R	**(12,174)**	**(12,106)**	**68**	**(81,570)**	**(82,918)**	**(1,347)**	**(1,612)**	**368**	**(1,980)**
CPG 6 - Clinical Investigative Sciences										
Income		1,943	1,844	(99)	21,650	20,772	(878)			
Pay		(7,706)	(7,700)	6	(87,234)	(85,886)	1,348			
Non Pay		(497)	(585)	(87)	(3,757)	(3,202)	556			
TOTAL	G	**(6,260)**	**(6,440)**	**(180)**	**(69,341)**	**(68,316)**	**1,025**	**1,191**	**(17)**	**1,208**
CPG 7 - Interventional Public Health										
Income		634	593	(41)	7,194	6,854	(340)			
Pay		(369)	(344)	25	(4,068)	(3,965)	103			
Non Pay		(272)	(277)	(5)	(3,193)	(3,281)	(88)			
TOTAL	R	**(7)**	**(29)**	**(22)**	**(67)**	**(391)**	**(325)**	**(347)**	**13**	**(360)**
TOTAL FOR ALL CPGs										
Income		4,685	4,805	119	49,897	49,720	(177)			
Pay		(36,353)	(36,278)	74	(406,285)	(403,789)	2,496			
Non Pay		(26,264)	(27,165)	(900)	(234,943)	(243,515)	(8,572)			
TOTAL	A	**(57,932)**	**(58,638)**	**(707)**	**(591,332)**	**(597,585)**	**(6,253)**	**(8,127)**	**681**	**(8,808)**

The most significant variance in month is CPG 2 - Surgery & Cancer with an adverse movement of £487k which relates to:

- Increase in agency costs of £162k compared to the previous month (back dated medical costs for Major Trauma)
- PbR excluded drugs continue to be above plan

The following changes in forecast variances over £250k from last month are reported:

- CPG1 Medicine : An improvement of £299k in the forecast position due to negotiation of increased SLA income from Royal Fre e NHSFT, reduced HIV PbR excluded drugs, reduced medical locum costs offset by increased diagnostic recharges
- CPG5 Women & Children: Improvement of £368k relating to CNST premium savings (transferred from Corporate), BMT private income and restatement of agency accruals

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

PAGE 5 - Corporate Service Financial Performance

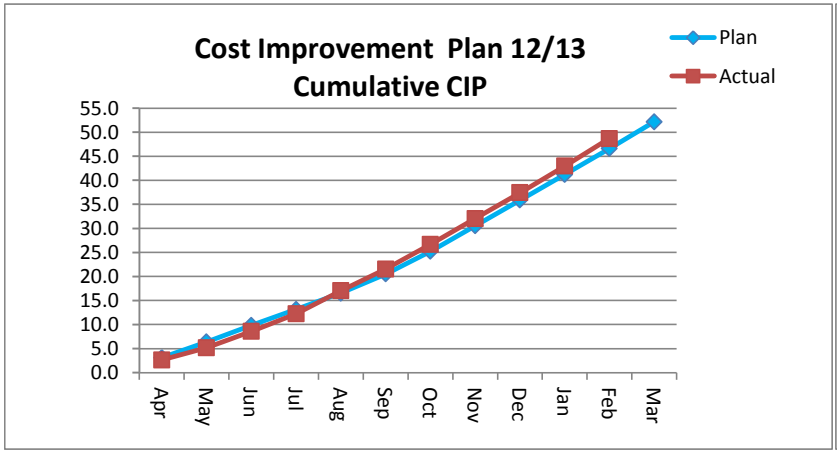
	Risk Rating	In Month (Feb) Plan £000s	In Month (Feb) Actual £000s	In Month (Feb) Variance £000s	Year To Date (Cumulative) Plan £000s	Year To Date (Cumulative) Actual £000s	Year To Date (Cumulative) Variance £000s	FORECAST Variance £000s	Change in Forecast from Last Month Variance £000s	Previous Month FORECAST Variance £000s
Corporate Governance										
Income		2	0	(2)	21	20	(1)			
Pay		(106)	(88)	18	(1,169)	(1,093)	76			
Non Pay		(28)	(22)	6	(306)	(285)	21			
TOTAL	G	**(131)**	**(110)**	**21**	**(1,454)**	**(1,358)**	**96**	**120**	**45**	**75**
Chief Executive Office										
Income		111	111	0	368	616	249			
Pay		(184)	(158)	26	(1,586)	(1,434)	152			
Non Pay		(205)	(181)	24	(1,188)	(1,341)	(153)			
TOTAL	G	**(277)**	**(228)**	**50**	**(2,407)**	**(2,158)**	**248**	**300**	**100**	**200**
Director Of Education										
Income		22	22	0	238	238	0			
Pay		(37)	(28)	9	(407)	(360)	48			
Non Pay		(90)	(90)	0	(837)	(828)	9			
TOTAL	G	**(106)**	**(96)**	**9**	**(1,007)**	**(950)**	**57**	**70**	**15**	**55**
Director Of Operations										
Income		153	175	22	1,753	1,894	141			
Pay		(874)	(841)	33	(9,743)	(9,060)	683			
Non Pay		(391)	(422)	(31)	(4,446)	(4,301)	144			
TOTAL	G	**(1,113)**	**(1,088)**	**24**	**(12,435)**	**(11,467)**	**969**	**1,010**	**10**	**1,000**
Estates Directorate										
Income		732	833	101	7,939	9,124	1,185			
Pay		(757)	(753)	4	(8,709)	(8,665)	44			
Non Pay		(1,906)	(2,086)	(180)	(15,237)	(16,552)	(1,315)			
TOTAL	A	**(1,931)**	**(2,006)**	**(75)**	**(16,007)**	**(16,093)**	**(87)**	**(160)**	**12**	**(172)**
Finance Directorate										
Income		13	12	(1)	225	261	36			
Pay		(633)	(585)	49	(6,692)	(6,100)	592			
Non Pay		3,854	3,835	(19)	(10,392)	(10,607)	(214)			
TOTAL	G	**3,234**	**3,262**	**29**	**(16,860)**	**(16,446)**	**414**	**460**	**(140)**	**600**
Human Resources										
Income		257	272	15	2,835	3,165	330			
Pay		(514)	(505)	8	(5,652)	(5,355)	297			
Non Pay		(245)	(247)	(2)	(2,714)	(2,740)	(25)			
TOTAL	G	**(502)**	**(480)**	**22**	**(5,531)**	**(4,930)**	**601**	**660**	**(10)**	**670**
Infection Control Directorate										
Income		0	0	0	22	71	49			
Pay		(157)	(147)	10	(1,740)	(1,586)	154			
Non Pay		(30)	(29)	1	(649)	(687)	(38)			
TOTAL	G	**(187)**	**(176)**	**11**	**(2,367)**	**(2,202)**	**165**	**185**	**20**	**165**
Information & Comms Technology										
Income		133	127	(6)	1,458	1,496	38			
Pay		(1,150)	(1,084)	67	(12,067)	(11,362)	706			
Non Pay		(856)	(863)	(7)	(10,434)	(10,642)	(208)			
TOTAL	G	**(1,874)**	**(1,820)**	**54**	**(21,043)**	**(20,507)**	**536**	**600**	**(30)**	**630**
Medical Director										
Income		31	53	23	155	323	168			
Pay		(207)	(198)	8	(2,376)	(2,144)	232			
Non Pay		(101)	(126)	(24)	(841)	(826)	15			
TOTAL	G	**(277)**	**(270)**	**7**	**(3,062)**	**(2,648)**	**415**	**450**	**(100)**	**550**
Nursing & Operations Directorate										
Income		9	15	5	43	76	33			
Pay		(206)	(196)	10	(2,195)	(1,995)	201			
Non Pay		(68)	(65)	3	(731)	(732)	(1)			
TOTAL	G	**(265)**	**(247)**	**18**	**(2,884)**	**(2,651)**	**233**	**272**	**2**	**270**
Press & Communications										
Income		41	44	3	57	53	(5)			
Pay		(76)	(71)	5	(858)	(866)	(8)			
Non Pay		(47)	(49)	(1)	(125)	(110)	15			
TOTAL	A	**(82)**	**(76)**	**6**	**(926)**	**(923)**	**3**	**0**	**12**	**(12)**
Private Patients										
Income		2,444	1,875	(568)	26,746	20,991	(5,756)			
Pay		(868)	(711)	157	(9,607)	(7,672)	1,936			
Non Pay		(522)	(375)	146	(5,738)	(3,936)	1,803			
TOTAL	R	**1,054**	**789**	**(265)**	**11,401**	**9,383**	**(2,017)**	**(2,006)**	**(252)**	**(1,754)**
TOTAL										
Income		3,948	3,539	(408)	41,859	38,328	(3,531)			
Pay		(5,769)	(5,365)	404	(62,803)	(57,692)	5,111			
Non Pay		(636)	(720)	(84)	(53,639)	(53,586)	53			
TOTAL	G	**(2,457)**	**(2,545)**	**(88)**	**(74,583)**	**(72,950)**	**1,633**	**1,961**	**(316)**	**2,277**

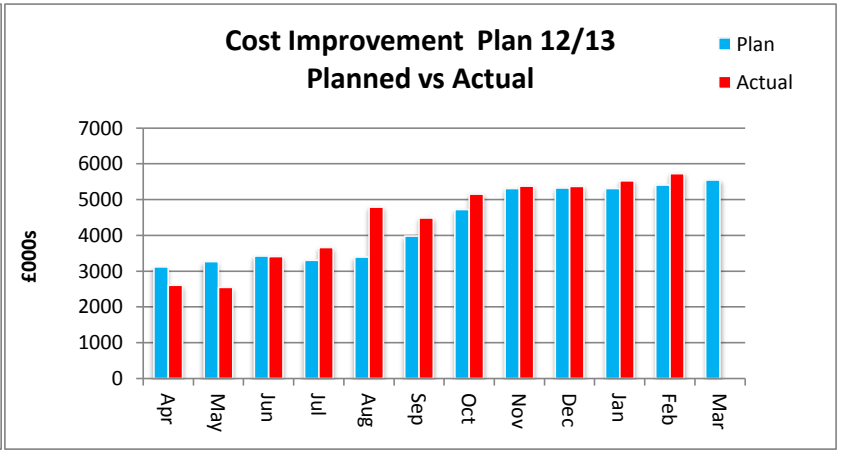
The most significant variances in month and change in forecast relates to Private Patients. Income for January and February is £300k per month lower than the average for the previous quarter. A detailed assessment of monthly forecast income is currently being undertaken to identify key risks and opportunities

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

PAGE 6 - COST IMPROVEMENT PLAN (CIP)

CIPS	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
CPG1 - Medicine	936	901	(35)	6,891	5,763	(1,128)	7,905	6,428	(1,477)
CPG2 - Surgery & Cancer	468	353	(115)	3,830	3,098	(732)	4,292	3,452	(840)
CPG3 - Specialist Services	695	654	(41)	7,289	5,944	(1,345)	7,990	6,598	(1,392)
CPG4 - Cardiology & Renal	599	790	191	6,724	7,426	702	7,318	8,216	898
CPG5 - Women's & Children	402	412	10	4,575	3,860	(715)	5,046	4,260	(786)
CPG6 - CIS	822	763	(59)	6,622	7,093	471	7,485	7,859	374
Corporate Services	1,058	1,223	165	9,951	10,973	1,022	11,065	12,179	1,114
Centrally Delivered schemes	243	601	358	(242)	4,245	4,487	0	4,850	4,850
TOTAL CIP	**5,223**	**5,697**	**474**	**45,640**	**48,402**	**2,762**	**51,101**	**53,842**	**2,741**
Income Generation	**Plan £000s**	**Actual £000s**	**Variance £000s**	**Plan £000s**	**Actual £000s**	**Variance £000s**	**Plan £000s**	**Actual £000s**	**Variance £000s**
CPG7 - Public Health	42	5	(37)	456	44	(412)	498	49	(449)
Private Patients	45	24	(21)	495	229	(266)	541	253	(288)
TOTAL Income Generation	**87**	**29**	**(58)**	**951**	**273**	**(678)**	**1,039**	**302**	**(737)**
TOTAL	**5,310**	**5,726**	**416**	**46,591**	**48,675**	**2,084**	**52,140**	**54,144**	**2,004**





CIP outturn for the year is projected at £54.1m - no change from last month. (The Full Year Effect £62m plan is forecast to be delivered in full).

Actual achievement of CIP schemes in February was £5.7m (YTD £48.7) which is £416k ahead of plan for the month (YTD £2.0m ahead of plan).

The CIP Delivery Board is closely monitoring the position and plans are in place to ensure delivery of the 2012/13 target.

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

PAGE 7 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Revised Opening Balance (Post audit) £000s	Current Month Balance £000s	Previous Month Balance £000s	Movement in month £000s	Forecast Balance £000s
Non Current Assets	Property, Plant & Equipment	744,023	744,023	728,123	726,481	1,642	727,230
	Intangible Assets	579	579	378	415	(37)	175
Current Assets	Inventories (Stock)	17,141	17,141	17,814	17,877	(63)	17,500
	Trade & Other Receivables (Debtors)	45,711	52,701	48,258	63,845	(15,587)	52,705
	Cash	22,974	22,974	105,675	95,001	10,674	54,974
Current Liabilities	Trade & Other Payables (Creditors)	(105,681)	(104,324)	(146,141)	(156,445)	10,304	(101,787)
	Borrowings	(3,764)	(3,764)	(4,275)	(4,275)	0	(3,074)
	Provisions	(4,542)	(12,891)	(25,731)	(18,858)	(6,873)	(45,000)
Non Current Liabilities	Borrowings	(45,046)	(45,046)	(44,280)	(44,280)	0	(23,358)
	TOTAL ASSETS EMPLOYED	**671,395**	**671,395**	**679,821**	**679,761**	**60**	**679,365**

Ratio/Indicators	**Risk Rating**		
	Current Month	**Previous Month**	**Forecast**
Debtor Days	17	26	21
Trade Payable Days	55	67	43
Cash Liquidity Days	31	31	32

The decrease in trade debtors is predominantly due to:

- Decrease in NHS receivables of £9.9m, as a result of efforts to clear outstanding debts with PCTs and SHAs
- Release of ISS advance payment of £2.5m
- Release of Private Patient CNST advance payment of £903k and a number of other advance payments totalling £1.5m

The decrease in trade creditors is due to:

- Increase in PDC accrual of £1.7m. PDC dividend is paid to the Department of Health in September and March each year.
- Increase in capital accruals of £3.3m relating to ICT assets
- Increase in NIHR deferred income of £2.1m
- Decrease in respect of release of NHS deferred income of £6.7m re invoices raised in advance for MADEL, SIFT, Project Diamond and transitional funding.
- Decrease of £12.5m due to remapping of accruals to provisions
- Net increase in other accruals £1.8m

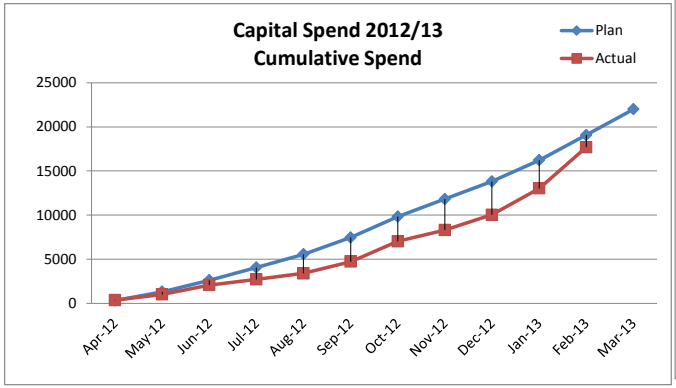
The increase in provisions is due to:

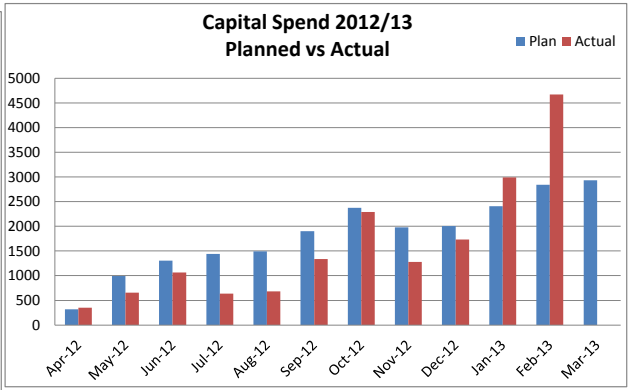
- Increase of £12.5m due to remapping of accruals to provisions
- Decrease in respect of the release of provisions no longer required £8.3m

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

PAGE 8 - CAPITAL EXPENDITURE

By Scheme	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Lindo Wing Refurbishment	0	5	(5)	945	893	52	945	800	145
Surgical Innovation Centre	0	62	(62)	370	227	143	370	370	0
Clinical Chemistry Relocation	62	10	52	1,722	1,195	527	1,722	1,300	422
Paediatric Clin. Haem. Day Unit	167	6	161	1,630	1,400	230	1,680	1,680	0
Strategic RIS/PACS	0	58	(58)	450	119	331	450	100	350
St Mary's Electrical Infrastructure	50	(24)	74	1,250	1,226	24	1,295	1,500	(205)
Endoscopy Relocation	400	99	301	1,580	527	1,053	1,980	750	1,230
Relocate Cardiology Labs	40	154	(114)	235	460	(225)	322	750	(428)
Renal Dialysis Expansion	338	0	338	1,188	0	1,188	1,388	0	1,388
Medical Equipment	188	105	83	1,500	1,209	291	2,000	4,577	(2,577)
Backlog Maintenance	300	81	219	2,200	1,052	1,148	2,500	2,100	400
Aggregate - Estates	50	245	(195)	750	1,883	(1,133)	798	3,796	(2,998)
Aggregate - IT	650	3,742	(3,092)	3,950	5,902	(1,952)	4,550	6,136	(1,586)
Aggregate - IT Building Works	600	9	591	1,300	151	1,149	2,000	180	1,820
Energy Saving Schemes (Salix-funded)	0	120	(120)	0	1,456	(1,456)	0	2,042	(2,042)
Total Capital Expenditure	**2,845**	**4,671**	**(1,826)**	**19,070**	**17,699**	**1,371**	**22,000**	**26,081**	**(4,081)**
Donation - Medical Equipment	0	0	0	0	(680)	680	0	(841)	841
Gov. Grant - Medical Equipment (ESC)	0	0	0	0	(28)	28	0	(28)	28
Total Charge against Capital Resource Limit	**2,845**	**4,671**	**(1,826)**	**19,070**	**16,991**	**2,079**	**22,000**	**25,212**	**(3,212)**
Capital Resource Limit							**(22,000)**	**(25,212)**	**3,212**
Over/(Under)spend against CRL							**0**	**0**	**0**





We have brought forwards the procurement of new anaesthetic machines and associated monitors, previously approved by Investment Committee for 2013/14 but flexibility in the programme has enabled earlier procurement. It has also accommodated measures to improve cancer radiotherapy.

Backlog maintenance has progressed more slowly than anticipated, partly because of open escalation wards at St Mary's preventing work from starting on a key bed lift.

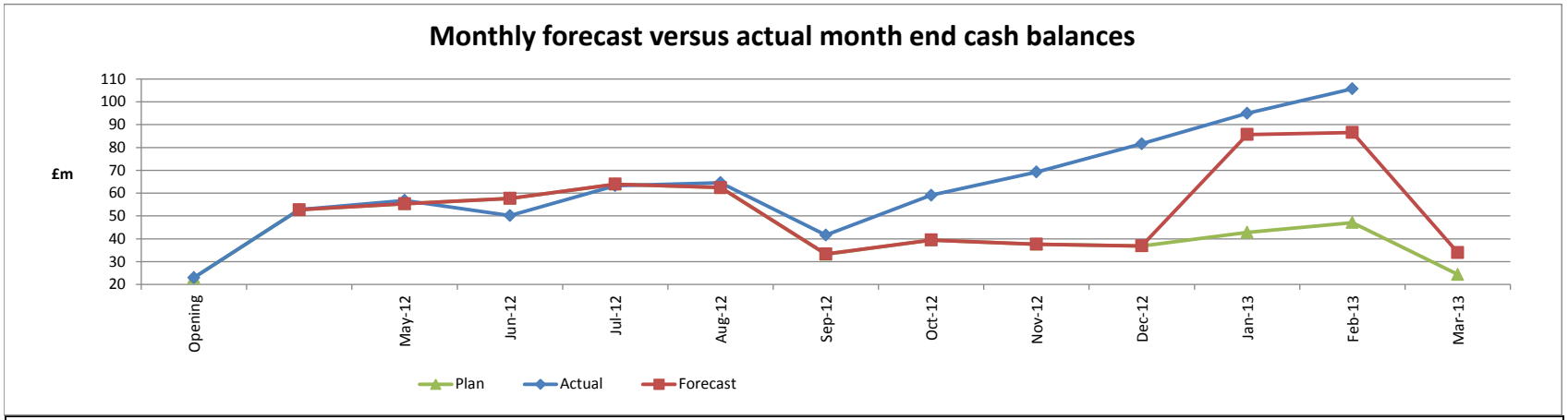
Aggregate Estates has increased to encompass works to create the new community pharmacies at each site, and improvements to maternity areas being developed with new funds from DH.

Lindo expenditure will fall slightly as defect retention accruals held over from the failed contractor (Kilby & Gayford) are not now needed.

After an initial slow start of ICT capital programme, spend has significantly accelerated and the in month expenditure can be summarised as follows:- £0.5m for wireless network, £1.7m spent on new IT equipment, £0.6m on infrastructure support for readiness for Cerner implementation and data centre deployment and migration £0.9m.

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

PAGE 9 - CASH



	Opening	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Plan	22,974	52,707	55,382	57,707	63,933	62,419	33,189	39,470	37,656	36,896	42,852	47,127	24,370
Actual	22,974	52,707	56,826	50,127	63,252	64,611	41,613	59,067	69,216	81,580	95,001	105,675	
Forecast		52,707	55,382	57,707	63,933	62,419	33,289	39,470	37,656	36,896	85,699	86,598	33,974

Aged Debtor Analysis

Category	Current	30 Days	60 Days	90 Days	<= 1 Year	>1 Year - <= 2 Years	>2 Years	Total Debt
NHS	£ 10,227,204	£ 7,517,573	£ 2,352,204	-£ 1,260,264	£ 6,107,607	£ 60,525	£ 60,806	**£ 25,065,654**
Non-NHS	£ 1,302,387	£ 1,185,737	£ 1,352,255	£ 177,537	£ 1,064,385	£ 876,882	£ 203,719	**£ 6,162,902**
Overseas Visitors	£ 94,450	£ 124,543	£ 77,894	£ 86,468	£ 1,080,868	£ 1,107,398	£ 582,445	**£ 3,154,066**
Private Patients	£ 1,621,956	£ 1,311,615	£ 1,226,278	£ 433,684	£ 923,237	-£ 203,265	£ 79,778	**£ 5,393,282**
Total	**£ 13,245,997**	**£ 10,139,468**	**£ 5,008,631**	**-£ 562,575**	**£ 9,176,096**	**£ 1,841,541**	**£ 926,747**	**£ 39,775,905**
% of Total Debt	**33.3%**	**25.5%**	**12.6%**	**-1.4%**	**23.1%**	**4.6%**	**2.3%**	**100.0%**

Aged Creditor Analysis

Category	Current	30 Days	60 Days	90 Days	<= 1 Year	>1 Year - <= 2 Years	>2 Years	Total Creditors
All AP Creditors	£ 2,717,880	£ 504,813	£ 148,526	£ 64,848	£ 341,131	£ 240,245	£ 113,394	**£ 4,130,837**
Total	**£ 2,717,880**	**£ 504,813**	**£ 148,526**	**£ 64,848**	**£ 341,131**	**£ 240,245**	**£ 113,394**	**£ 4,130,837**
% of Total Creditors	**65.8%**	**12.2%**	**3.6%**	**1.6%**	**8.3%**	**5.8%**	**2.7%**	**100.0%**

Actual cash is significantly above plan in February because payments to suppliers (including capital) and payroll payments were £46.5m lower than the year to date plan. In addition, cash received was £12.1m ahead of plan, predominantly due to £8.1m cash received for Project Diamond which was not included in the plan. Due to changes in the invoicing of specialist commissioning as a result of the transfer of clinical services, the Trust owes a number of PCTs a total of £1.7m which is being reclaimed either by refund or deduction from SLAs in March.

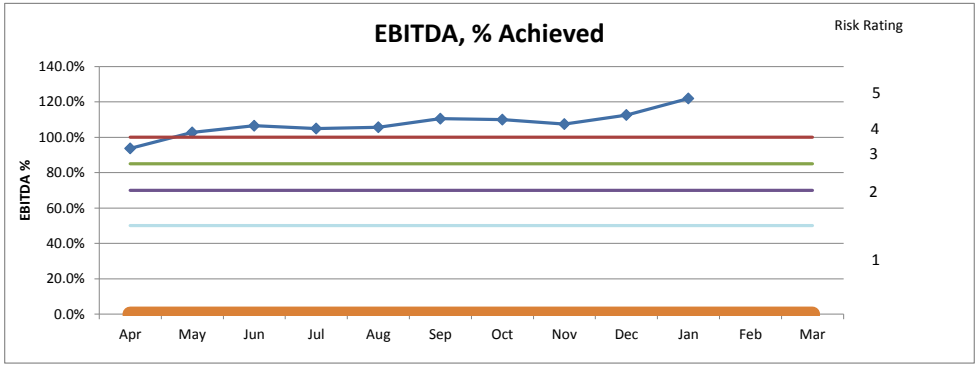
Creditors on the Accounts Payable ledger are significantly lower than in previous months due to efforts to clear the backlog of invoices.

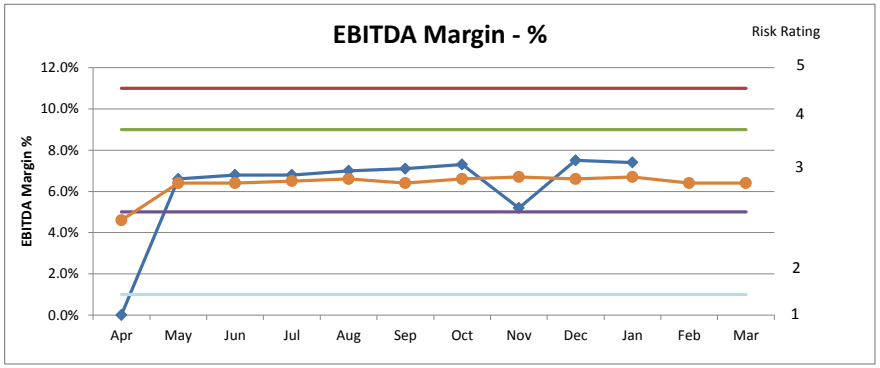
At the end of February, the balance of cash invested in the National Loan Fund scheme totalled £102m. This amount was invested for 7 days at an average rate of 0.35%. Total accumulated interest receivable at 28th February 2013 was £257k.

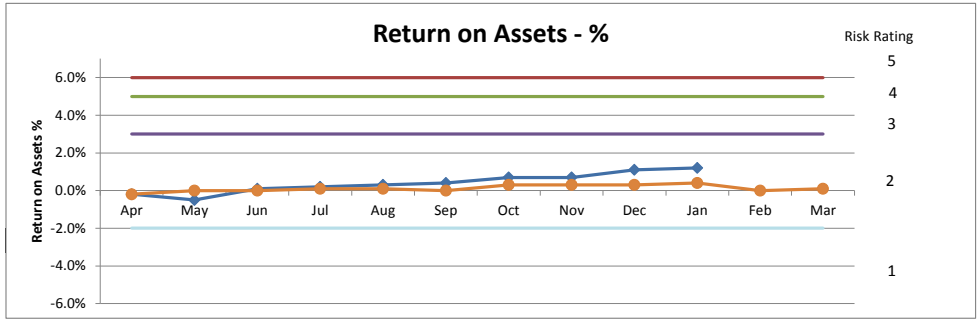
Due to the improvement in the cash position during the year, predominantly due to an improved I&E position and a reduction in capital expenditure, the Trust has been able to pay off one of its DH loans. This will have a positive impact upon I&E in 2013/14.

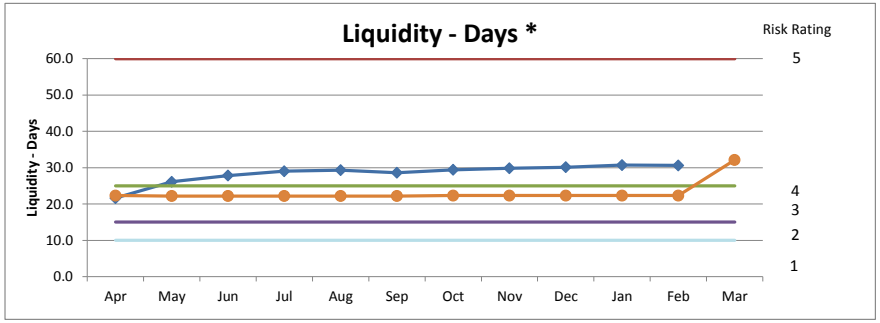
Statement of Financial Position (SOFP) **Risk:** **G**

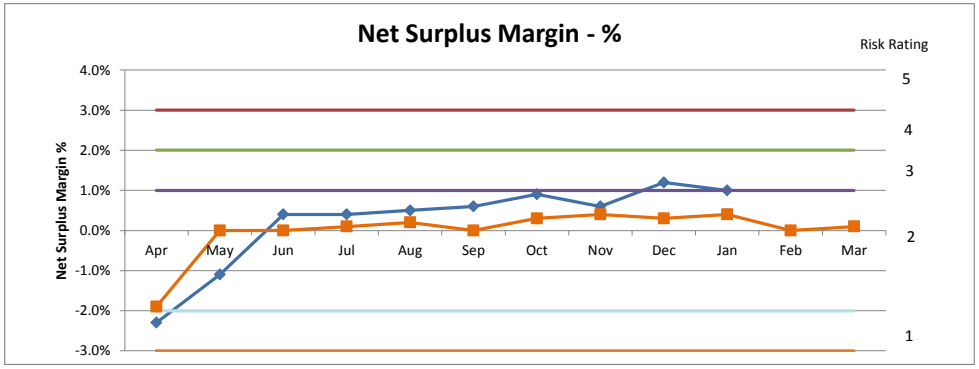
Page 10 - FINANCIAL RISK RATINGS (FRR)

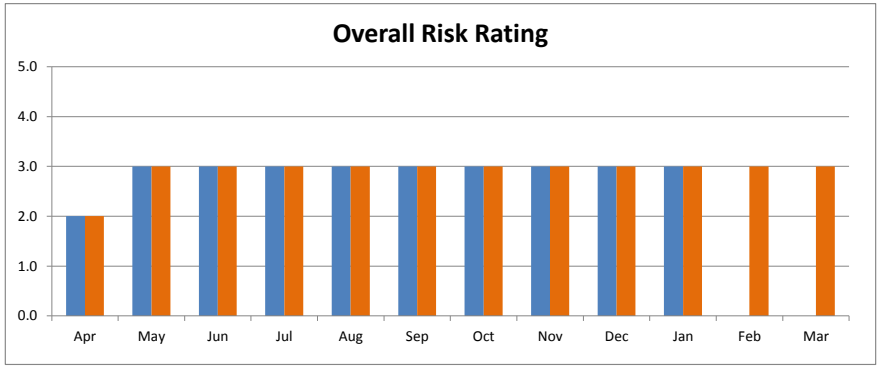












Each chart plots the current performance against each of the five Financial Risk Rating (FRR) metrics.

The Trust's overall FRR based on the results to the end of February is FRR3, as per plan. All risk metrics are on plan.

A score of 3 is mandatory for Foundation Trust status.

* This is a proxy rating assuming a 30 day working capital facility available only to Foundation Trusts.

Financial Risk Ratings **Risk:** G

PAGE 11 - SLA Activity & Income by POD (Estimate for February)

Point of Delivery	Year to Date (Activity)			Year to Date (Income)			Forecast Outturn		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Admitted Patient Care									
- Day Cases	61,860	60,967	(893)	51,146	50,805	(341)	55,593	54,946	(647)
- Regular Day Attenders	11,739	12,660	920	5,732	6,320	588	6,264	6,978	714
- Elective	19,862	18,808	(1,053)	57,898	56,154	(1,744)	63,495	62,377	(1,118)
- Non Elective	79,171	84,227	5,056	152,242	152,697	455	166,384	167,023	639
Accident & Emergency	176,147	178,987	2,841	19,734	20,258	524	21,567	22,298	731
Adult Critical Care	40,998	37,027	(3,971)	50,811	45,822	(4,989)	55,532	50,670	(4,862)
Outpatients - New	213,402	220,896	7,494	44,016	46,027	2,011	47,844	49,737	1,893
Outpatients - Follow-up	474,312	480,850	6,538	61,863	61,626	(237)	67,241	65,603	(1,638)
PbR Exclusions	114,973	650,965	535,992	54,347	56,729	2,382	59,395	61,627	2,232
Direct Access	2,018,347	1,929,370	(88,977)	14,167	14,683	516	15,483	16,520	1,037
Others	332,884	347,717	14,833	139,792	137,415	(2,377)	152,856	149,812	(3,044)
Commissioning Business Rules	(39,646)	(50,232)	(10,586)	(13,860)	(19,970)	(6,110)	(15,148)	(26,014)	(10,866)
NWL London Block Adj			0		4,787	4,787		11,563	11,563
TOTAL	**3,504,048**	**3,972,242**	**468,193**	**637,889**	**633,353**	**(4,536)**	**696,506**	**693,140**	**(3,366)**

Income by Sector	Year to Date (Income)			Forecast Outturn		
	Plan £000s		Variance £000s	Plan £000s	Actual £000s	Variance £000s
North West - London	406,348	406,348	0	443,470	443,470	0
North Central - London	17,079	18,176	1,097	18,650	20,022	1,372
North East - London	6,414	5,548	(866)	7,008	6,676	(332)
South East - London	5,970	5,888	(82)	6,532	6,435	(97)
South West - London	26,089	26,227	138	28,515	28,532	17
East of England	27,057	26,621	(436)	29,564	29,633	69
South East Coast	16,142	16,122	(20)	17,633	17,668	35
London Specialist Commissioning	99,030	99,620	590	110,608	112,319	1,711
SHA	2,678	2,669	(9)	2,927	2,589	(338)
Others	31,082	26,134	(4,948)	31,599	25,796	(5,803)
TOTAL	**637,889**	**633,353**	**(4,536)**	**696,506**	**693,140**	**(3,366)**

Income by NWL PCT's	Year to Date (Income)			Forecast Outturn Income		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Hillingdon	15,467	14,703	(764)	16,889	15,434	(1,455)
Hammersmith & Fulham	73,255	74,082	827	79,948	80,868	920
Ealing	77,666	75,804	(1,862)	84,774	81,267	(3,507)
Hounslow	41,118	40,706	(412)	44,894	43,381	(1,513)
Brent	55,768	56,803	1,035	60,859	63,231	2,372
Harrow	12,404	11,905	(499)	13,544	12,777	(767)
Kensington & Chelsea	52,072	50,115	(1,957)	56,824	53,552	(3,272)
Westminster	78,598	75,984	(2,614)	85,738	82,031	(3,707)
Block Adj		6,245	6,245		10,929	10,929
TOTAL	**406,348**	**406,348**	**0**	**443,470**	**443,470**	**0**

The report is an analysis of NHS SLA Income from clinical activities excluding other NHS organisations (non England within the actuals).

The key variances are:

- Critical Care underperformance is because the plan for 2012/13 was based on 2011/12 outturn which included a significant number of long stay patients (£2.3m) that have not been treated in 2012/13 and a general underperformance of £2.7m.
- Day Case underperformance is associated with the following specialties Gastroenterology, Medical Oncology, Oral Surgery, Neurology and Paediatrics within the NWL sector.
- Elective underperformance is mainly due to General Surgery, Cardiac Surgery and Nephrology.
- Non Elective underperformance includes Geriatric Medicine, Obstetrics, Cardiology, Cardiac Surgery and Vascular Surgery. This has been partly off set by overperformance on A&E admissions.
- Other Income & Contractual adjustment variance relates to the 70% emergency thresholds of £2.0m, Outpatient follow-ups ratio of £2.2m (this is due to the agreed revision of the outpatient ratios) and NWL block contract/risk premium of £6.2m.

NHS Service Level Agreement (SLA) Income by Point of Delivery (POD) **Risk:** **A**

Page 12 - Risk Analysis for 2012/13

DESCRIPTION OF RISKS	MITIGATION
Penalties for "Never Events" and breaches of performance targets.	The Trust is robustly managing performance to minimise any breaches and SLA penalties.
TOTAL	

Risk Analysis	**Risk:**	**G**

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING: 27 March 2013 **AGENDA ITEM 3.2.2**

Report Title: Final Operating Plan 2013/14

To be presented by: Bill Shields, Chief Financial Officer

Executive Summary:

All NHS Trusts must submit final Operating Plans with underpinning Financial Plans for 2013/14 to the NHS Trust Development Authority (NTDA) by 5 April, against which they will be performance managed through the year.

The Trust submitted a first draft plan on 25 January, followed by a second draft developed with guidance from the NTDA on 28 February. The letter responding to the draft, acknowledging the Trust's progress and providing feedback and further actions for the Trust to implement, is included in Appendix 1 to this paper.

The Board is asked to approve the submission of the final Operating Plan, a summary of which is set out in this paper. In reviewing the summary, the Board is asked to note that negotiations with commissioners are progressing slower than anticipated and that the current plan is based on a broadly "flat cash" basis which will need to be revisited as discussions with commissioners progress. An internal financial plan will be agreed once contract negotiations have concluded.

1. Operational performance

- The Trust has improved its performance and is now achieving against all 18 week and six of the eight cancer access targets. The cancer access targets are due to be fully delivered from April;
- The Trust plans to continue improving and sustaining the performance against elective access targets in line with remedial action plans;
- Achievement of all 18 week targets in all specialities and all cancer access targets remains a top priority.

2. Financial performance

- The Trust is sustaining an overall Financial Risk rating of 3 and has a FOT surplus of £8.5m which is £8m ahead of plan;
- FOT on CIP delivery is £54m, £2m ahead of plan;
- CIP scheme are being developed to cover three years and are focusing on three headings: clinical, workforce and non-clinical;
- The CIP target for 13/14 is 5%, £48m; however this is dependent on SLA negotiations;
- The draft 2013/4 financial plan delivers a surplus of £14.2m;
- This financial plan takes into consideration the pay award of 1%, inflation at a rate of 2.7% and tariff reduction of 1.3%.

3. NWL Contract

- NHS income for patient activity is planned on a broadly "flat cash" assumption.

Legal Implications or Review Needed

a. Yes
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

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

Purpose of Report

a. **For decision and approval** ✓
b. **For review/noting** ✓

Imperial College Healthcare NHS
NHS Trust

Operating Plan 2013-14

Final draft – 27 March 2013

Building world class finance

Introduction

- All NHS Trusts must submit final Operating Plans with underpinning Financial Plans for 2013/14 to the TDA by 5 April, against which they will be performance managed through the year
- The Trust has been developing its plans iteratively with support and feedback from the TDA since January
- A summary of the final plan is presented to the Board for approval, following approval by the Finance Committee and prior to final submission
- Where not dependent on the outcome of the SLA negotiations, the final submission will take account of the additional detail requested in the feedback letter from the TDA dated 14 March (see Appendix 1), including action plans to address the data capture issues identified under the Major Trauma Centre Review

Summary

- ICHT has made significant progress in securing financial stability and improving key areas of performance during 2012-13, as well as receiving recognition for high quality standards of patient care

- There remain some important challenges for the Trust to address during 2013-14 and beyond as the organisation prepares for Foundation Trust application

- To accompany ICHT's draft Operating Plan for 2013-14, this presentation sets out:
  - Highlights of the past year
  - Priorities and challenges for the coming year
  - Summary financial plan

Highlights of 2012-13

Imperial College Healthcare NHS
NHS Trust

- Recognition for continued focus on delivery of high **quality** services
  - Achievement of HSMR of 71 and SMHI of 76 at Month 8
  - Achievement of NHSLA CNST Level 3 for all Acute and Maternity services, leading to significant savings on insurance premiums
  - Awarded full JAG accreditation for GI Endoscopy at HH and CXH demonstrating ICHT's commitment to patient safety
  - Compliant with 4 national, 5 planned and 3 responsive CQC inspections
  - Best Hyper-Acute Stroke Unit in the country, according to the Royal College of Physicians with a score of 90.9% in the latest quarterly Stroke Improvement National Audit Programme
  - Good progress in improving patient experience as evidenced by results recent survey and safety thermometer results and launch of patient experience strategy 2012-14
- Improvement in **performance** against 18 week and cancer access targets and recommenced reporting following 6 month break and establishment of remedial action and implementation plans and governance structures
  - Achieving against 6 out of 8 cancer targets by Month 8
  - Achieving against all RTT targets for admitted, non-admitted and incomplete pathways by Month 8

Highlights of 2012-13 (cont'd)

- **Financial** performance sustaining overall Financial Risk Rating of 3
  - FOT surplus of £8.5m at Month 10 (£8.0m ahead of plan)
  - FOT CIP delivery of £54m at Month 10 (£2m ahead of plan)
- Emerging clinical and organisational **strategy**
  - Development of detailed clinical strategy for cancer services as proof of concept for strategy development methodology for rollout
  - Clarity on site profiles resulting from NWL JCPCT decision on Shaping a Healthier Future (SaHF)
  - Launch of Nursing & Midwifery Strategy 2013-16: Every one Counts
  - Start of bidding negotiations for partnership and potential merger with WMUH
- Continued excellence in **research**
  - Launch of MRC-NIHR Phenome Centre - a biomedical research facility that enables analysis of patient- and population-based samples for biomarker discovery and validation, improved patient stratification and early identification of drug efficacy and safety
  - NIHR/Wellcome Trust Imperial Clinical Research Facility renewed for a further five years with £10.9m of funding from the NIHR
  - 6,500 patients recruited into >230 studies during 2012

Highlights of 2012-13 (cont'd)

- Recognised as leading provider of medical and nursing **training**
  - Awarded Lead Provider status for postgraduate medical training in a further 9 specialties in addition to the provision of training in Core Medicine, Core Surgery and Core Psychiatry and a GP pilot for North West London Sector
  - Most successful Trust in England for NIHR Fellowships for Nurses and AHPs
- Sustained improvements in **management culture** and **staff engagement**
  - Significant reductions in vacancy levels and usage of Bank and Agency Staff
  - Continued increase in both quantity and quality of Staff Appraisals
  - Real efficiency gains secured with active partnership working with staff-side colleagues
  - In top 20% of acute Trusts in National Staff survey staff engagement index
  - In top 20% of acute hospitals for staff recommending the Trust as a place to work and receive treatment

Challenges and priorities for 2013-14

- Continuing to improve and sustain performance against elective access targets in line with remedial action plans
  - Achievement of all 18 week RTT targets in all specialities and all cancer access targets remains a top priority as this has represented a significant challenge during 2011/12 and 2012/13
- Continuing to improve patients experience of care, especially in cancer services and implementation of the Friends and Families test
- Continuing to drive efficiency in all areas to deliver the 2013-14 CIP challenge of 5% (£48m) to meet the tariff provider efficiency requirement of 4% and 1% for local planning assumptions/increase in surplus
- Increasing the robustness of the Trust's CIP risk assurance processes
- Implementing the revised organisational structure for management of clinical services with appropriate staff consultation (see Appendix 1)
- Development of a Trust-wide clinical strategy that is understood by all staff from ward to Board, supported by appropriate clinical engagement
  - High level site profiles, based on SaHF decision, to be discussed at April Board seminar
  - More detailed specialty level plans to be developed by September 2013 to feed into draft IBP

Challenges and priorities for 2013-14 (cont'd)

- Delivery of service reconfigurations to implement outcome of the NWL SaHF programme
- Managing the risks associated with the implementation of Cerner
- Implementing a zero tolerance approach to never events
- Ensuring a positive outcome to the 2013-14 contracting round with a new set of commissioners
- Establishing FT programme to drive development of Integrated Business Plan (including workforce strategy), Long Term Financial Model, Board Development and membership recruitment
- Responding to the recommendations in the Francis Report
- Reduce Nursing and Midwifery band 2 – 6 vacancies to below 5% for inpatient areas

Challenges and priorities for 2013-14 (cont'd)

- Ensuring 95% of staff undertake mandatory Information Governance training
- Continuing to ensure all staff are subject to regular appraisal and meet statutory and mandatory training requirements
- Reducing sickness absence levels to below 3.5%
- Implementing new clinical leadership development programme

Financial Plan for 2013/14

Imperial College Healthcare NHS Trust

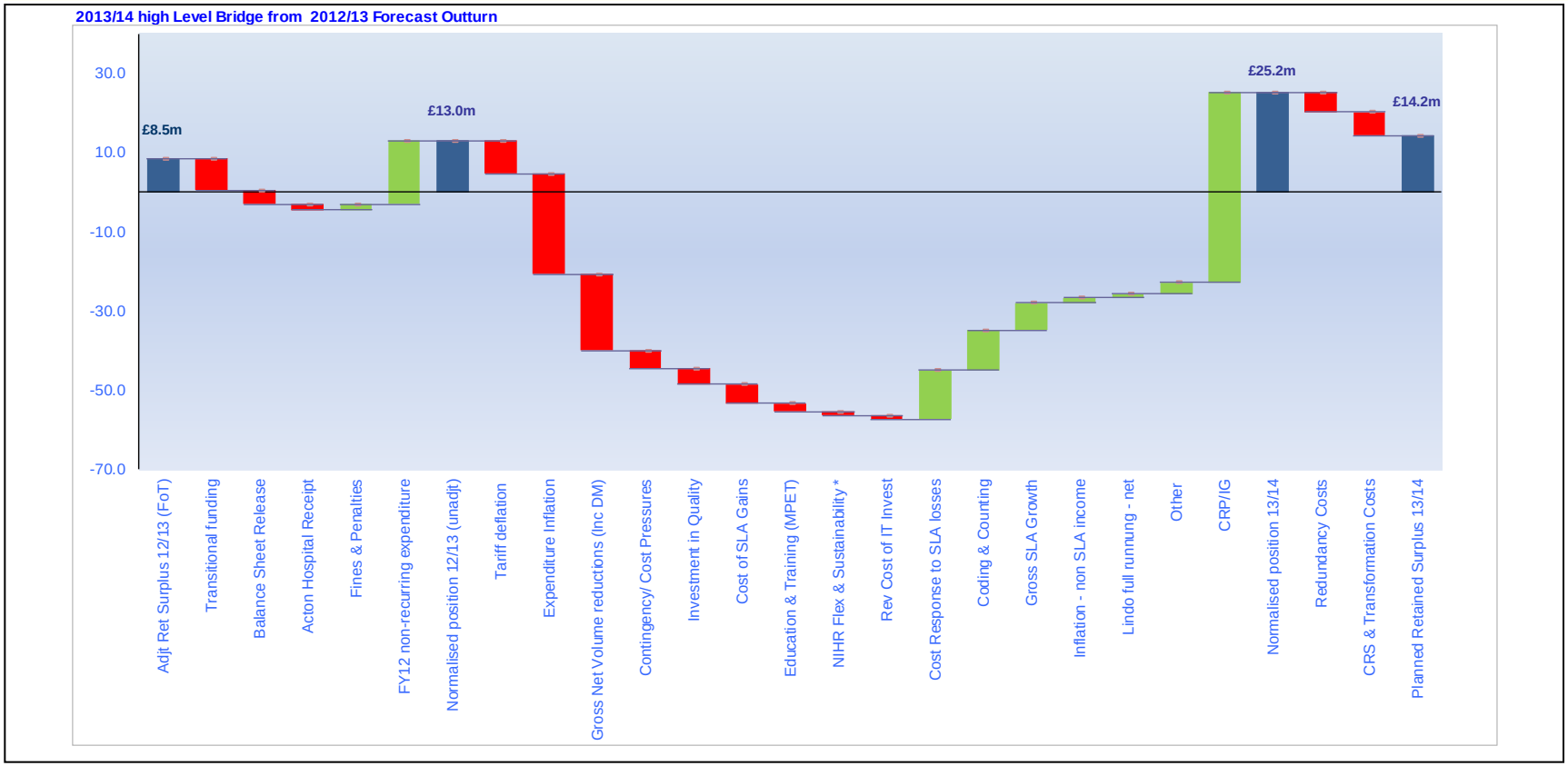
Statement of Comprehensive Income	2012/13 FOT	2013/14 Plan	Apr 13 Plan	May 13 Plan	Jun 13 Plan	Jul 13 Plan	Aug 13 Plan	Sep 13 Plan	Oct 13 Plan	Nov 13 Plan	Dec 13 Plan	Jan 13 Plan	feb 13 Plan	Mar 13 Plan
£m's														
Gross Employee Benefits	-515.2	-499.0	-41.6	-41.6	-41.6	-41.6	-41.5	-41.6	-41.7	-41.6	-41.5	-41.6	-41.4	-41.7
Other Operating Costs	-357.8	-354.5	-29.3	-29.6	-29.6	-30.1	-29.3	-29.8	-30.2	-29.7	-29.3	-29.7	-28.4	-29.5
Recurring Operating Costs	**-873.0**	**-853.5**	**-70.9**	**-71.2**	**-71.2**	**-71.7**	**-70.8**	**-71.4**	**-71.9**	**-71.3**	**-70.8**	**-71.3**	**-69.8**	**-71.2**
Revenue from Patient Care Activities	751.1	749.1	60.5	62.1	62.1	64.3	61.7	63.5	65.1	63.4	61.6	63.3	58.6	62.9
Other Operating Revenue	195.1	189.7	15.8	15.8	15.8	15.8	15.8	15.8	15.8	15.8	15.8	15.8	15.8	15.9
Recurring Operating Income	**946.2**	**938.8**	**76.3**	**77.9**	**77.9**	**80.1**	**77.5**	**79.3**	**80.9**	**79.2**	**77.4**	**79.1**	**74.4**	**78.8**
EBITDA	**73.2**	**85.3**	**5.4**	**6.7**	**6.7**	**8.4**	**6.7**	**7.9**	**9.0**	**7.9**	**6.6**	**7.8**	**4.6**	**7.6**
Investment Revenue	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1
Other Gains and Losses	-0.2	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Depreciation & Amortisation	-36.8	-36.8	-3.1	-3.1	-3.0	-3.1	-3.1	-3.0	-3.1	-3.1	-3.0	-3.1	-3.1	-3.0
Finance Costs	-1.8	-1.7	-0.1	-0.1	-0.2	-0.1	-0.1	-0.2	-0.1	-0.1	-0.2	-0.1	-0.1	-0.3
Dividends Payable on Public Dividend Capital (PDC)	-21.6	-21.8	-1.8	-1.8	-1.8	-1.8	-1.8	-1.9	-1.8	-1.8	-1.8	-1.8	-1.8	-1.9
Underlying Surplus	**13.0**	**25.2**	**0.4**	**1.7**	**1.7**	**3.4**	**1.7**	**2.9**	**4.0**	**2.9**	**1.6**	**2.8**	**-0.4**	**2.5**
Non recurring Income	9.5	0	0	0	0	0	0	0	0	0	0	0	0	0
Non recurring Expenditure	-14	-11	-0.5	-0.5	-0.5	-0.9	-0.9	-1	-1	-1.1	-1.1	-1.1	-1.2	-1.2
Retained Surplus before Impairments	**8.5**	**14.2**	**-0.1**	**1.2**	**1.2**	**2.5**	**0.8**	**1.9**	**3.0**	**1.8**	**0.5**	**1.7**	**-1.6**	**1.3**

- The 2013/14 plan delivers a surplus of £14.2m (increase of £5.7m over 2012/13 Forecast) with surpluses in each quarter
- The SLA for 2013/14 has not been agreed and there is considerable variance between the Trust's income assumptions and NWL's current offer
- The draft financial plan was submitted to the TDA on 28 February, for which a summary response is included as Appendix 1

Key assumptions 2013/14

- National planning guidance
  - Pay award of 1% - confirmed by NHS Employers
  - Inflation at 2.7%
  - Tariff reduction of 1.3%
- CNST premiums increase of 5%
- CQUIN no change from 2012/13 (total 2.5% of SLA value)
- Non recurrent expenditure removed. No non recurrent income planned
- Project Diamond funding of £7.7m treated as recurrent
- A Training and Education reduction of income of £2m
- Contingency of 0.5% included within the plan
- CIP of £48m which equates to £50m full year effect
- Capital plan of £30m, below level of internally generated cash
- Year end cash of up to £65m, which will mitigate any cash flow delays due to late agreement of the 2013/14 SLA
- A proxy Monitor Financial Risk Rating of 3 for all quarters

Bridge from 2012/13 FoT to Initial Plan 2013/14



The bridge summarises the main drivers that move the Trust from the forecast £8.5m surplus in 2012/13 to a planned surplus of £14.2m in 2013/14.

NWL Contract for Healthcare 2013/14

Key assumptions in initial plan

- NHS income for patient activity is planned on a broadly “flat cash” assumption. The NWL element of the plan is also expected to be the same value as 2012/13 after the changes to the NCB
- Key changes from 2012/13 include:
  - Growth of £7.0m
  - Counting and coding changes of £10m
  - FYE of QIPP schemes from 2012/13, plus a small element of new ones
  - Tariff deflator of -£9.2m
  - Activity changes of -£1.5m
  - CQUIN no change from 2012/13 (2.5% of SLA value)
  - Business rules have yet to be agreed. Supporting pathways changes will need to be agreed through clinician engagement. Realistically, this will not be resolved until the first quarter of 2013/14
- NWL has issued a proposal that is £39m less than the 2012/13 contract value. This has £26m of QIPP schemes which are a Commissioner risk and £13m increased local contract metrics which have to be negotiated

CIP summary 2013/14

- CIP is being developed to cover 3 years, and reviewed constantly
- Initial focus on bigger savings which are easier to deliver
- Following themes to pursue:

Clinical	Workforce	Non-clinical
• Reduce length of stay and bed base; • Improve theatre utilisation; • Improve OP clinic utilisation; • Review clinical pathways and remove non value-added steps.	• Align workforce to capacity requirements; • Improve attendance management; • Reduce overtime and agency use; • Improve rostering efficiency; • Improve productivity: review working practices and use of the "Productive series".	• Estates rationalisation; • Procurement: pricing and product rationalisation; • Outsourcing; • Income review; • Benchmarking; • Management review.

CIP summary 2013/14 (cont'd)

- CIP Target - in year delivery - £48m depending on SLA negotiations.
- CIP Profile (net) is £11.4m in first quarter followed by £12.2m per quarter thereafter
- Position in draft financial plan:
  - £36.7 million of schemes developed by CPGs and non-Clinical Directorates (including £10.8 million relating to the full year impact of residual schemes from 2012/13)
  - £11.3 million of unidentified schemes (£4.0m within CPGs and NCDs and £7.3 million bridging the gap to the overall £48 million Trust target)
  - CPG plans and NCD plans deliver 5% and 7.4% of net operating costs respectively (although the target for NCDs is 10%)
- The planning gap of £7.3m will be assigned to CPGs and NCDs by increasing the CIP percentage of operating costs (CPGs to 5.5% and NCDs to 11%)

14 March 2013

Mark Davies
Chief Executive
Executive Offices, Trust HQ,
Imperial College Healthcare NHS Trust,
The Bays Building, St Mary's Hospital,
South Wharf Road,
London, W2 1NY

Dear Mark

Thank you for resubmitting a further draft iteration of your 2013/14 Operating Plan on the 28 February for Imperial College Healthcare NHS Trust. Your revised draft has been helpful in providing greater understanding of the challenges you face and how you are planning to address them in 2013/14. In my last letter I provided specific comments where further information and evidence was required in the final submission of your plan. What follows here is a brief note acknowledging progress in those areas, some further finance and planning feedback based on your resubmission and a summary of next steps.

Finance

Thank you for clarifying the contract timetable with your commissioners for us. We recognise that the timetable negotiations are progressing more slowly than was hoped. We are conscious that the quantum of change in funding proposed by commissioners requires considerable work to allow you a good understanding of the detail of the proposals, and that there remains some risk to the timetable as a result.

We recognise that your current plan resubmission remains on a broadly flat cash basis and that this will need to be revisited as discussions with commissioners progress. Completion of these negotiations are also important as this allows a triangulation exercise to be completed by the Trust between its activity, income and related costs and to inform later iterations of the 2013/14 plan.

First round amendments to the 2013/14 plan have been actioned in response to our initial feedback and subsequent meeting between the Trust and TDA finance teams. Thank you for your assistance in moving these forward.

Planning checklists, priorities and presentation

Your revised Overarching Presentation and Improvement Priorities provide helpful insight on your plans for 2013/14. In particular I am pleased to see more detail around the

benchmarking and action plan on Priority 1 (Cancer performance). On Priority 3 (Major Trauma Centre review) you now identify data capture as an issue contributing to income loss for this service. It would be helpful to see some further plans or actions around how the Trust's data collection processes can be improved to address this priority in your final plan submission.

Thank you for revising your Performance checklist to address feedback against cancer, RTT and cancelled operations. The additional information provided gives assurance that the current position in these areas is being closely monitored, and that plans and processes are or will be in place to achieve and sustain standards where necessary. Our previous feedback on Quality and Workforce checklists should also be addressed in your final submission. Where there are gaps on QIPP plans and Innovation checklists, we acknowledge that these are due to ongoing commissioner negotiations and contract agreements, again we would expect to see these areas addressed in your final submission.

Next steps

Along with the previously communicated requirements for this planning round, I would like to use this opportunity to inform you of NTDA's intention to under take a reconciliation of contract values between Trusts and Commissioners as part of the 2013/14 Operating Planning process. Your Director of Finance should have received a Contract Reconciliation form for completion and submission to TDAreturns@southwest.nhs.uk by midday 15 March 2013.

While there is still work to be done prior to reaching contract agreement with commissioners and finalising your Operating Plan, you have provided a timeline that indicates you will submit a final plan to NTDA by the 5 April 2013 deadline. I look forward to your Trust's final plan by that date, which should take into consideration the feedback given here and on your first submission where relevant. In practical terms, as before, this should be submitted through the central email address (TDAreturns@southwest.nhs.uk) except for your financial plans which should be submitted to (TDAfinance@dh.gsi.gov.uk).

Yours sincerely,

Mark Brice

Portfolio Director (North West London) TDA

Cc.
Alwen Williams, Director of Delivery and Development, TDA
Azara Mukhtar, Deputy Director of Finance and Investment, NHSL
Julie Halliday, Head of Quality, TDA

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **AGENDA ITEM: 3.3**

Report Title: Department of Health Single Operating Model: Fenbruary 2013

To be presented by: Bill Shields, Chief Financial Officer

Executive Summary:

As part of the Foundation Trust application process the Department of Health introduced the Single Operating Model (SOM) earlier this year. The SOM supports and assures Trusts through their Foundation Trust (FT) applications by drawing on best practice to introduce one common set of tools, processes and guidance for FT development and application, which is more closely aligned with Monitor's authorisation approach. It will also support transition to management by the NHS Trust Development Authority (TDA) and operational delivery and planning for 2013/14.

As part of the compliance with Part 2 of the SOM the Trust is required to submit self-certification templates to NHS London on a monthly basis in line with their timetable. The SOM model requires that self certification templates are approved by the Trust Board before submission.

The last submission, covering the month of January 2013, was made on March 19th 2013 using the templates provided by NHS London. The next submission, covering Trust performance in the month of February 2013, will be made on April 15th 2013 and is enclosed for discussion by the Board.

The Board is asked to note that:

- Having received formal approval from the TDA to proceed with its FT programme, the Trust will need to renegotiate the terms of its Tripartite Formal Agreement (TFA) and the milestones therein following the conclusion of the 2013/14 contracting round. For the time being, the TFA section of the SOM relates to the extant agreement, dated August 2012;
- The proposed Governance Risk Rating has remained steady at 1 driven by the improvement in cancer performance since December;
- The Trust has maintained a Financial Risk Rating of 3 since May 2012.

The Board is asked to agree;

- That cancer access performance and Information Governance level 2 performance require further improvement before the end of the year and response to the associated Board Statements should remain as "No".

Following discussion the document will be signed on behalf of the Trust Board by the Chair and Chief Executive Officer, or appointed deputies, before submission to the TDA.

Legal Implications or Review Needed

a. Yes
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

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

Purpose of Report

a. For decision and approval ✓

b. For review/noting

SELF-CERTIFICATION RETURNS
Organisation Name:
Imperial College Healthcare NHS Trust
Monitoring Period:
February 2013
NHS Trust Over-sight self certification template

Returns to som@london.nhs.uk by the last working day of each month

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Imperial College Healthcare NHS Trust	Period:	February 2013

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	AG
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	3

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

Please complete **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by :		Print Name :	Sir Richard Sykes
on behalf of the Trust Board	Acting in capacity as:	Chairman of the Board	
Signed by :		Print Name :	Mark Davies
on behalf of the Trust Board	Acting in capacity as:	Chief Executive Officer	

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**Although there has been improvement cancer access targets, further improvement is still required.**
Action :	**Agreed performance trajectories and remedial action plans with commissioners**

Target/Standard:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	**Underperformance against mandatory IG Training target and behind plan for anonymisation**
Action :	**Implementing agreed IG action plan with staff incentives and reviewing anonymisation plan**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Imperial College Healthcare NHS Trust

February 2013

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	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, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO	**Mark Davies**		
Chair	**Sir Richard Sykes**		

QUALITY

Information to inform discussion meeting

Imperial College Healthcare NHS Trust

Insert Performance in Month

	Criteria	Unit	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Board Action
1	SHMI - latest data	Score					76.0	76.0	76.0	70.0	75.8	75.8	75.8	75.8	
2	Venous Thromboembolism (VTE) Screening	%					91.08	90.93	91.3	92.03	91	90.2	91.3	91.6	
3a	Elective MRSA Screening	%													
3b	Non Elective MRSA Screening	%													
4	Single Sex Accommodation Breaches	Number					0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number								10	4	4	2	6	
6	"Never Events" occurring in month	Number								1	0	0	0	0	
7	CQC Conditions or Warning Notices	Number													
8	Open Central Alert System (CAS) Alerts	Number													
9	RED rated areas on your maternity dashboard?	Number							4	4	4	4		4	All improvement areas are being addressed and overseen by local midwifery teams, led by the Director of Nursing who is an Executive Board member. Both St. Mary's and Queen Charlotte's are outliers for consultant cover and in recognition of this a proposal to increase consultant presence on both labour wards to 98 hours a week ,went before the Investment Committeein February, chaired by the Chief Financial Officer, where it was approved and is now being implemented.
10	Falls resulting in severe injury or death	Number								0	0	0	0	0	
11	Grade 3 or 4 pressure ulcers	Number								4	2	0	1	0	Detailed root cause anaylsis completed and reported to the Quality and Safety committee which in turn reports to the Governance committee and Trust Board. Monthly Pressure Ulcer Improvement Group reviews all grade 2-4s with representation from all CPGs, and feeds into the Nursing and Midwifery Professional Practice Committee
12	100% compliance with WHO surgical checklist	Y/N													Timescales for measuring compliance TBC
13	Formal complaints received	Number								79	54	54	67	74	Each quarter the Board receives a Quality and Service Report that details key learning outcomes and service improvements following a formal complaint investigation. The top threee themes are also reviewed by site to help generate a risk profile. The Quality and Service Report is reviewed by the Clinical Risk Committee and the Trust Quality and Safety Committee before it is presented to the Board. In addition to this, learning from complaints is shared at the complaints forum. The Trust's response rate to formal complaints has been above the internal target of 90% in each month and complaints are not considered an area of underperformance.
14	Agency as a % of Employee Benefit Expenditure	%						7.5	7.4	8.2	6.7	7.2	7.2	7.8	
15	Sickness absence rate	%					3.4	3.4	3.5	3.8	3.9	3.6	3.6	3.4	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

FINANCIAL RISK RATING

Imperial College Healthcare NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	3	3	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4	4	4	4	
Weighted Average		**100%**						**3.5**	**3.5**	**3.5**	**3.5**	
Overriding rules												
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule							
3	Plan not submitted on time	No						
3	Plan not submitted complete and correct	No						
2	PDC dividend not paid in full	No						
2	Unplanned breach of PBC	No						
2	One Financial Criterion at "1"							
3	One Financial Criterion at "2"							
1	Two Financial Criteria at "1"							
2	Two Financial Criteria at "2"							

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Imperial College Healthcare NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No			
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No			
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes			Delay in payment from NHS London for the R+D MFF which has been received in March.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes			There are some invoices being disputed and, separately, a company has gone into administration and the Trust is awaiting for confirmation from the company administrator.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No			
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No			
9	Capital expenditure < 75% of plan for the year to date	No	Yes	Yes	No	No			
10	Yet to identify two years of detailed CIP schemes	No	No	No	No	No			

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	N/a	No	No	Yes	Yes			Trust Board maintains firm grip on performance against RTT access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief Operating Officer is held to account.
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	N/a	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	N/a	Yes	Yes	Yes	Yes			
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	N/a	No	Yes	Yes	Yes			Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief Operating Officer is held to account. Cancer data reported one month in arrears therefore February data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	N/a	No	No	No	No			Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief Operating Officer is held to account. Cancer data reported one month in arrears therefore February data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	N/a	No	No	Yes	Yes			Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief Operating Officer is held to account. Cancer data reported one month in arrears thereforeFebruary data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	N/a	Yes	No	Yes	Yes			Trust Board maintains firm grip on performance against cancer access targets through receipt and interrogation of monthly Performance Scorecards. The Board has agreed a recovery trajectory against which the Chief Operating Officer is held to account. Cancer data reported one month in arrears therefore February data represents a pre-validated position prior final submission. Robust cancer remedial action in place with trajectory to achieve all targets for cancer in Q4.
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	Yes	Yes	Yes			

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call – emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes			
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes			
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No			
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No			
				TOTAL		**0.0**	**3.5**	**3.0**	**1.0**	**1.0**	**0.0**	**0.0**	
						G	AR	AR	AG	AG	G	G	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

GOVERNANCE RISK RATINGS

Imperial College Healthcare NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
Overriding Rules - Nature and Duration of Override at SHA's Discretion													
i)		Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters			No	No	No	No	No			
ii)		Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.			No	No	No	No	No			
iii)		RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter			N/a	N/a	N/a	N/a	N/a			
iv)		A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.			No	No	No	No	No			
v)		Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter			N/a	N/a	N/a	N/a	N/a			
vi)		Ambulance Response Times	Breaches: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter			N/a	N/a	N/a	N/a	N/a			
vii)		Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter			N/a	N/a	N/a	N/a	N/a			
viii)		Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.			N/a	N/a	N/a	N/a	N/a			
			Adjusted Governance Risk Rating			**0.0**	**3.5**	**3.0**	**1.0**	**1.0**	**0.0**	**0.0**	
						G	AR	AR	AG	AG	G	G	

CONTRACTUAL DATA

Information to inform discussion meeting

Imperial College Healthcare NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes			
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes			
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	Yes	Yes	Yes	Yes	Yes			Transitional funding has been received but this falls within the terms of the block contract for 2012/13
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes			
5	Are there any disputes over the terms of the contract?	No	No	No	No	No			
6	Might the dispute require third party intervention or arbitration?	N/a	N/a	N/a	N/a	N/a			
7	Are the parties already in arbitration?	No	No	No	No	No			
8	Have any performance notices been issued?	No	Yes	No	Yes	Yes			Performance Notices in Q2 12/13 for cancer performance breaches, patient experience in cancer and application of the non PbR marginal rate. Performance Notice issued 23/1/13 in relation to 18 Wk RTT Performance
9	Have any penalties been applied?	Yes	No	Yes	No	No			Penalty in Q1 and Q3 12/13 for Never Events. Penalty for Non-achievement of Cancer targets to be issued.

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Mar-13

Imperial College Healthcare NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Board Action
1	Trust returns FY final accounts (deficit position)	Jun-12	Fully achieved in time	
2	Trust letter of support to NWL Cluster re public consultation	Jun-12	Fully achieved in time	
3	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-12	Fully achieved in time	
4	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-12	Not fully achieved	Board maintains clear oversight of financial and performance issues through regular finance and performance scorecard reports and hold responsible Executive Directors to account. Team leading remedial plans to turn around cancer performance and Elective Access programme for RTT report directly to Chief Operating Officer (Executive Board member). Executive Board members participate in monthly review of performance with each CPG as preparation for Board reporting.
5	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-12	Will not be delivered on time	Board maintains clear oversight of financial and performance issues through regular finance and performance scorecard reports and hold responsible Executive Directors to account. Team leading remedial plans to turn around cancer performance and Elective Access programme for RTT report directly to Chief Operating Officer (Executive Board member). Executive Board members participate in monthly review of performance with each CPG as preparation for Board reporting.
6	JCPCT decision on NWL Shaping a healthier future consultation	Jan-13	On track to deliver	NWL PCT reconfiguration programme remains on track following the decision of the JCPCT.
7	Board Governance Assurance Framework commences	Feb-13	On track to deliver	Chief Financial Officer (lead director for FT application) has commissioned the FT programme team to deliver a baseline assessment of the Board governance function to report to the Trust Board in April.
8	Quarterly review of finance (including achievement trajectory on CIPs (12/13)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-13	On track to deliver	
9	Trust returns FY13 final accounts (financially balanced position)	Jun-13	On track to deliver	Board and Finance Committee maintain firm grip on financial performance through receipt of monthly finance report and holding Chief Financial Officer, Director of Operational Finance and responsible senior managers to account
10	NWL Shaping a healthier future OBCs complete (assuming no appeal)	Jul-13	On track to deliver	NWL PCT reconfiguration programme remains on track in light of the decision made in February 2013.
11	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-13	On track to deliver	
12	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-13	On track to deliver	
13	NWL Shaping a healthier future FBC complete (assuming no appeal)	Dec-13	On track to deliver	NWL PCT reconfiguration programme remains on track in light of the decision made in February 2013.
14	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-13	On track to deliver	
15	Board sign off first draft of IBP and LTFM	Apr-14	On track to deliver	
16	Quarterly review of finance (including achievement trajectory on CIPs (13/14)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-14	On track to deliver	
17	Historic Due Diligence part 1 (HDD1). To be completed May-June 14	Jun-14	On track to deliver	
18	Trust returns FY14 final accounts (financially balanced position)	Jun-14	On track to deliver	
19	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-14	On track to deliver	
20	NWL Shaping a healthier future FBC approved by Treasury (assuming no appeal)	Sep-14	On track to deliver	NWL PCT reconfiguration programme remains on track in light of the decision made in February 2013.
21	Historic Due Diligence part 2 (HDD2). To be completed September-October 14	Oct-14	On track to deliver	
22	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-14	On track to deliver	
23	IBP/LTFM submitted to NHS TDA	Dec-14	On track to deliver	
24	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Dec-14	On track to deliver	
25	Board to Board	Jan-15	On track to deliver	
26	FT application submission to Secretary of State	Apr-15	On track to deliver	
27	Quarterly review of finance (including achievement trajectory on CIPs (14/15)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Apr-15	On track to deliver	
28	Trust returns FY15 final accounts (financially balanced position)	Jun-15	On track to deliver	
29	Monitor and working capital review commences	Jun-15	On track to deliver	
30	Quarterly review of finance (including achievement trajectory on CIPs (15/16)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Jul-15	On track to deliver	
31	Quarterly review of finance (including achievement trajectory on CIPs (15/16)), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust	Oct-15	On track to deliver	
32	Anticipated FT authorisation date	Nov-15	On track to deliver	
33				
34				
35				
36				
37				
38				
39				
40				

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Imperial College Healthcare NHS
NHS Trust

Trust Board: 27 March 2013 **Agenda Number: 4.1**

Report Title: Corporate Risk Register and Board Assurance Framework

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

Executive Summary: The Audit & Risk Committee reviewed the Corporate Risk Register (CRR) (previously known as the Extreme Risk Register) at its meetings on 3 December 2012 and 11 March 2013. It also reviewed the Board Assurance Framework (BAF) which had previously been before the Trust Board at its meeting on 26 September 2013. Both documents before the Trust Board are the documents presented to the Audit & Risk Committee without amendment at this stage.

Six risks have been identified for closure and are highlighted in grey on the register. The risk reference and reason for removal are set out below,

ER49 –Contract has been underperformed removing the risk – Marcus Thorman
ER27 –The Olympic games demonstrated resilience with business as usual – Janice Sigsworth
ER43 Risk arose prior to funding for Cerner being approved. Full Business Case approved by Trust Board in March 2012 – Kevin Jarrold.
ER24 –Use of consultants/contactors contrary to procurement, risk has been managed – Marcus Thorman
ER30 –No longer relevant – Marcus Thorman
ER47 –Duplicate of ER48 – Marcus Thorman

There is one new risk to be added in respect of the implementation of the CPG restructure which will be reviewed and scored as part of the review discussed below.

The CRR and BAF, the latter of which provides a simple but comprehensive method for the effective and focused management of the principal risks to the Trust's objectives, are subject to a comprehensive review of how the Trust manages risk to generate an organisation that is continually learning and improving. In addition the Trust's objectives are being reviewed as part of the development of the Integrated Business Plan (IBP) a key element to the Trust's application for Foundation Trust Status.

The Risk Review is currently at the initial investigatory stage and will report back preliminary findings to the Audit & Risk Committee at its meeting on 18 April 2013 with the report to the Trust Board at its meeting in May. The report will include recommendations for the future development and management of Risk within the Trust. It is envisaged that as part of the review the Risk Management Strategy will require amendment and that a revised document will be brought to the Trust Board.

Initial findings indicate that there are some areas for further review in relation to risk, namely:

1 Disaster Recover
2 Business Continuity Planning
3 Issues around Never Events

4 Escalation Beds
5 Compliance Culture
6 Shaping a Healthier Future
7 Contracting

This will be supported as part of the review.

Key Issues for discussion: The paper is for updating with no key issues identified.

Details of Legal Review, if needed : Not Required

Link to the Trust's Key Objectives:
1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction
2. Provide world-leading specialist care in our chosen field
3. Achieve outstanding results in all our activities.

Purpose of Report
For information/noting √

IMPERIAL COLLEGE HEALTHCARE NHS TRUST

CORPORATE RISK REGISTER

As reported to the Audit and Risk Committee March 2013

Imperial College Healthcare NHS Trust
Board Level Risk Register
March 2013

Risk ID	Risk Category	Risk Source	Date Risk First Identified	Description of Risk	Risk Score			Existing Controls in place	Risk Treatment Plan	Responsible Person	Resource Required	Residual Risk			Progress Report	Review Date	Completion Date
					Likelihood	Con'qce	Total					Likeli - hood	Con'qce	Total			
ER7 (inc ER8) BPObj:1&5	Financial, Operational/Performance Targets, Patient Safety, Reputational	Risk Assessment	Jun-07	Achieving high standards of care and meeting performance goals during period of unprecedented challenge. Full compliance with targets required, workload overtakes performance as a priority, eye taken off performance	5	4	20	Exec lead for performance, local and national reports, internal and external audit reviews, collaboration with clinical leads, exception reports, local level scorecards and monitoring forums	Target specific leads, Cross Cutting Themes clinically led, MRSA and C-diff improvement plans, contingency plans, 18 week local and PCT plans, Patient experience programme. CQC Registration without conditions and continuous monitoring process . Daily monitoring A&E target. Revised risk assessment process for CRPs. Elective Access Programme supported by IST in progress incorporating Waiting List, Access, Cancer and Information and reporting. New Chief Operating Officer to be recruited, Restructure of Departments to focus on improvements, external review to be conducted. Reporting breach re waiting list management 18 Weeks, 62 Cancer Day Cancer Waits and Diagnotic Waits agreed with NHSL and Cluster, dedicated management support, waiting lists management initiatives, CEO to commission external review, Revised quality and safety impact assessment introduced.	COO	tbc	2	4	8	External review completed and to report soon. Reporting break lifted. COO appointed and reviewing the updated Performance Management Framework	Dec-12	Jan-13
ER 48 BPObj:1&5	Reputational, Financial , Operational/Performance, Strategic	Risk Assessment	Mar-12	Failure to achieve agreed Cost Improvement Schemes (CIPs) in full 2012-13. Impact on financial position, FT authorisation and AHSC mission.	4	5	20	CIP Board, investment in senior finance team, revised financial reporting,	Regular reviews by CIP Board, new seconded post from April	CFO	tbc	1	3	3	CIP plans in place. Turnaround Director appointed Accountability framework is being developed top level now clear through the Scheme of Delegation. Performance management arrangements in place and delivering. Financial performance on track. Continuous development of CCTs is in place and significant plans in place to deliver next year's target. Benchmarking work has driven this. Enhanced controls in place for appointment of staff and ordering of goods and services	Dec-12	Mar-13
ER 49 BPObj:1&5	Financial	Risk Assessment	Feb-12	Demand management does not effectively mitigate risk of non - funded activity in changing health economy. Financial losses, operational pressures, impact on quality of patient care	4	4	16	Contracts team, clinical involvement, activity monitoring processes, collaboration and engagement with GPs/commissioners	Contract negotiations, revised Trust demand and capacity planning, further relationship development with GPs/commissioners	CFO	nil	2	3	6	A block contract was negogiated this year to negate the risk associated with a year of major transition for both the Commissioners and the Trust. Continued dialogue and collobaration with the Commissioners this year will assist in delivering a plan for 2013/14.	Dec-12	Mar-13
ER 40 BPObj:1-5	Finance , Reputational, Business/Strategy	Risk Assessment	Mar-11	Inability to reconcile the complexities of the Trust and current uncertainties of the health economy with the specific requirements of the FT application process. Failure to progress the AHSC strategic mission and realise benefits of FT status	3	5	15	FT Project Board, Board agenda item,FT Shadow members	Appoint Trust lead, early engagement re strategy, cost reduction plan monitoring, confirm date to continue recruitment of shadow members, Board approval March 2011 Tripartite agreement - Trust/SHA/Commission-ers, management consultancy to support process, strengthen internal processes, capacity and capability of top team. Tripartite agreement - Trust submitted to NHS London; awaiting views of DH. Revised Timeline agreed. Complete Monitor Board Quality Assurance Framework Q4 2012	CEO	TBC	2	5	10	Recommenced FT project. Managing Director of AHSC recently appointed and organisational structure now in development. NHS London approval to proceed to revised FT timetable (aiming to be authorised as an FT by Autumn 2014); FT Programme Board membership appointed, with NED Chair. FT programme Team appointed; FT Project Plan in preparation; Baseline Governance Assessment to be reported to 27 March 2013 Board meeting.	Dec-12	01/03/2015 revise to December 2014?
ER27 BPOBj:1	Reputational, Financial , Operational/Performance Targets, Patient Safety	Risk Assessment	Nov-08	Failure to effectively manage a major incident. Major incident resulting in operational and safety sub optimum service delivery and care, either from attack on Trust premises or Trust acting as a receiving centre	3	5	15	Collaborative, sector wide approach, including PCTs, LAS, police, prison service, major incident committee, delegated risk leads, local leads, national risk log, CPG leads, NHS London e-learning tool, major incident training. Site Partners Forum established, chaired by Medical Director	Complete rationalisation of incident response plans including Hammersmith site partners. Plans agreed, signed-off and placed on the Source. Continue participation in multi agency exercises, develop shared protocols. Chemical, Biological, Radiological, Nuclear (CBRN) plan agreed and awaiting sign-off. Site partners comms exercise in Feb-12. Major trauma exercise Apr-12, multi-agency exercise May-12. Submit Olympics plan to NHS London. To review level of risk on completion of exercises, feedback on submission	Director of Nursing	tbc	2	5	10	After much planning, the Trust demonstrated resilience and business as usual durign the recent Olympic Games and continues to manage well during the current staging of the Paralympics. Is there a continuing risk upon which to re-focus?	Dec-12	Mar-13

Imperial College Healthcare NHS Trust
Board Level Risk Register
March 2013

Risk ID	Risk Category	Risk Source	Date Risk First Identified	Description of Risk	Risk Score			Existing Controls in place	Risk Treatment Plan	Responsible Person	Resource Required	Residual Risk			Progress Report	Review Date	Completion Date
					Likelihood	Con'qce	Total					Likeli - hood	Con'qce	Total			
ER22, (ER19) BPObj1,3,4,5	Reputational, Financial , Operational/Performance Targets, Patient Safety	Risk Assessment	Jun-07	An unsuccessful implementation of the Cerner patient administration system causes disruption to the management of patient flows resulting in patient harm, inability to accurately report activity and the filure to cover income and meet national targets.	3	5	15	COO has taken on the role of Senior Responsible Owner. Governance arrangements and project team have been strengthened. Robust assurance process in place regarding the decision to take the Cerner Patient Administration System into live operation.	Revised approach to implementation, new governance forums, increased clinical input, strenghthened asssurance process.	COO	TBC	3	3	9	The implementation of the Cerner Patient Administration System is recognised by the Management Board as a key risk and weekly updates on progress are received and acted upon. The COO is the Senior Responsible Owner and provides the operational leadership for the implementation. the programme team led by the CIO has been strengthened. Investment is being made in the IT infrastructure to support Cerner.	Dec-12	Mar-13
ER 43 BPObj1,3,4,5	Reputational, Financial , Operational/Performance Targets, Patient Safety	Local Risk Register	Jul-11	Implementation of CERNER system exceeds allocated funding. There will either be a significant overspend of approx. £1m on revised budget or the project will have to be halted midway through implementation .	5	4	15	Project and finances regularly monitored	SHA has been approached for funding to bridge gap through the London programme for IT UPDATED: Revised budget agreed. Business case to Board March 2012 re ITC infrastructure	CIO	£1m	2	3	6	This risk was raised prior to the Management Board and Trust Board agreeing a revised approach to the implementation of Cerner and agreeing funding of £14m over a three year period. Business Case approved by Board. NHS London refused 2012/13 funding	Dec-12	Mar-13
ER 45 BPObj:1,2,5	Reputational, Financial , Operational/Performance Targets, Patient Safety	Local Risk Register	31/07/2004	Mismatch in staff levels in maternity relative to activity. The Trust could fall outside of recommended ratios by NHS London and patient safety/experience could be affected. Midwifery WTE does not meet recommended requirements for 121 care in established labour (DH08, CEMACH 08, Kings Fund 08)	4	5	20	Capping in place at QCCH to manage activity and ongoing recruitment in place. A head of Midwifery has been appointed, effective workforce strategy and implementation plan in place	Recruitment and retention programme continues, staffing level discussions to continue at divisional level. Review of model of care to be conducted.	CPD for CPG5	£1.5m	3	3	9	UPDATE 24/05/2012 ongoing recruitment and retention, effective workforce plan instigated. Staffing escalation policy reinforced and in place from March 2012 to support management at times of unusually high demand. Effective commissioning bids presented to increase income and staffing. UPDATE July 2012, effective workforce strategy and implementation plan have been implemented and active recruitment is in place to reduce vacant posts. Midwifery-led triage instigated at QCCH from July 2012 to reduce pressures on labour-ward. UPDATE 02/08/2012 Business Plan approved by the Trust Investment committee to fund a further 5.6 WTE midwives funded by HDU commissioning income, to be instigated from January 2013. Active recruitment for support worker posts to support qualified workers. Update required.	Dec-12	01/12/2012
ER 39 BPObj:5	Reputational, Finance	Risk Assessment	Sep-10	Ravenscourt Park Hospital continuation of development by tenant and ability to fulfil sub - lease requirements in full. Financial consequences	3	5	15	Executive lead, legal advisors, NHS London and Board briefings	Continue negotiations with landlord and tenant, NHS London involvement. Negotiations continue. Careful monitoring and Audit Committee regular briefings	CFO	£20m	4	4	16	The tenant has requested a two quarter deferral in rent. Discussions are ongoing with the tenant and the parent company guarantor with regard to this. The CFO has written to NHS London and the TDA regarding the process to date. There is a risk that the tenant will default on the payments as they have to date been unable to secure a funder to back their plans for redevelopment.	Dec-12	Mar-13
ER9 BPObj:1-5	Financial, strategic/Operational/ Performance , Patient Safety, Reputational , Health & Safety	Risk Assessment	Jun-07	Inability to secure investment to redevelop the Trust's Estate.Delayed or non - realised efficiency savings, Impact on recovery plan, savings, failure to attract patients, world class staff and researchers.	3	4	12	Strategic priorities identified, interim estates strategy Board approved, prioritised backlog maintenance programme, capital programme, Board approved borrowing	Detailed proactive and reactive maintenance programme, prioritised backlog maintenance programme, Estates KPIs, Compliance with estate code condition B, annual investment programme, plans to minimise disruptions to patient experience. Review process to prioritise spend 2011/12. Align with FT application and Integrated Business Plan. Tender awarded for strategic modelling. Capital & Investment Committee to be established, Prioritisation criteria for schemes to be introduced.	CFO	tbc	1	4	4	The 6 facet survey is currently being revised and updatedand will form the estate plans of the future in conjunction with the estate strategy and SaHF.	Dec-12	Mar-13

Imperial College Healthcare NHS Trust
Board Level Risk Register
March 2013

Risk ID	Risk Category	Risk Source	Date Risk First Identified	Description of Risk	Risk Score			Existing Controls in place	Risk Treatment Plan	Responsible Person	Resource Required	Residual Risk			Progress Report	Review Date	Completion Date
					Likelihood	Con'qce	Total					Likeli - hood	Con'qce	Total			
ER10 BPObj:1,2,5	Financial, Operational/Performance/ Strategic Patient Safety, Reputational, Health & Safety	Risk Assessment	Jun-07	Failure to anticipate and prevent specific healthcare acquired infections. Outbreak /spread of infection, ward/unit closure, extended length of stay, increase in waiting lists, cancelled admissions/operations. Increased morbidity, complaints, litigation, impact on targets and ratings	4	3	12	Executive Lead Director of Infection Prevention and Control, governance framework, CPG Leads, performance monitoring system, Board focus, improved laboratory diagnostics, increase in isolation rooms to be included in all new builds and refurbishments. Regular Executive and operational walk arounds are in place. Active CPG ownership, Trust Infection Prevention Control Committee (TIPC) representation and increased communications with CPGs, regarding HCAIs at ward and MDT level. HCAI performance monitoring role incorporated into the Trust Performance Board. Trust HCAI reduction plan in place, monitored through TIPC. Comprehensive aseptic non-touch technique training being rolled out across the Trust to minimise blood stream infections. Rolling programme of antibiotic prescribing, monitoring and improvement in place, results disseminated to CPGs	Executive Walkrounds and Operational Walkrounds. Data monitoring aligned across sites, surveillance data on other organisms through new IT system. Updated, improved performance reports available at ward level. All Trust attributable MRSA cases have root cause analysis to drive improvements, actions plans to address vascular access and antibiotic monitoring.	DIPC	Funding for a band 7 vascular access nurse to continue to support delivery of competency assessment and education in vascular access (£51K).	3	3	9	Trustwide ANTT (means?) competency assessment programme in place, additional temporary resource to set up and provide competency assessments. CQC HCAI inspection at CXH site in January 2012 very positive, no further actions. NHS London Peer Review carried out in February 2012, highlighed that all actions required were in place, suggested refinements to ensure maximum impact. Trust currently below threshold for Trust aquired MRSA BSI's and C.difficile infections year to date (July 2012). Trust reporting C.difficile infections as per new DH reporting requirements. Trust IPC link nurse programme re-launched in June 2012. Next update: This will include the launch of the 'Smart Then Focus' campaign for appropriate prescribing of antibiotics and to encourage regular review of patients taking antibiotics with a view to reducing rates of healthcare associated infectionssuch and antibiotic resistance. Also IPC will be focusing on the further development of surgical site infection (SSI) surveillance. Update required	Jan-13	Mar-13
ER11 BPObj:1,2,5	Reputational , Financial, Performance	Risk Assessment	Jun-07	Failure to establish a formal performance monitoring framework for business plan objectives. Failure of the Trust to meet objectives and identify performance outside expected levels at earliest opportunity and deliver AHSC vision.	4	3	12	Performance exec lead, engagement and collaboration with CPG leads, collaboration with Dr Foster, develop drill down performance report , service priorities identified, Assurance Framework in place	New clinical structures in development. Benchmarks to be identified re AHSC aspirations. Performance management framework Integrated Business Plan in development, finalise speciality level reporting and AHSC indicators. AHSC governance processes under review . Implementation of monthly CPG reviews chaired by the Medical Director and CFO. Recruitment to Chief Operating Officer post, business planning function transferred to CFO	CEO (or COO?)	nil	2	3	6	A new Performance Dashboard has been created this year that assists in reviewing the performance of the Trust. This is part of the refreshed Performance Management Framework, which includes monthly performance reviews for each of the CPGs. The new COO started in August. Update required	Dec-12	Mar-13
ER24 BPObj:5	Reputational, Financial	Risk Assessment	Sep-08	Use of consultants/ contractors contrary to procurement and/or involving fraud or poor value for money. Trust fails to follow legal requirement	3	4	12	Counter fraud service, standing orders, internal and external audits	Improve procurement communication and knowledge, co-ordinate spot check audits, review tender waivers, link to register of interests scrutiny. Counter Fraud improved scores to be maintained. Local fraud training plans in place. Bribery Act Self Assessment. Register of Interests Policy revised and approved January 2012, revised Hospitality Policy approved March 2012 Board. Quarterly updates	CFO	nil	1	4	4	The procurement controls have been strengthened and continue to be reviewed as part of the Building World Class Finance agenda.	Dec-12	Mar-13
ER30 BPObj:2,5	Reputational, Financial , Performance Patient Safety, Partnership, Strategic	Risk Assessment	Jul-09	Failure to provide sufficient investment in specialist areas to maintain and improve world- leading capability. Loss of income, research opportunities and ratings.	4	3	12	Working closely with Trustees to identify leading edge equipment opportunities, AHSC objectives	Constant review of clinical needs and market position Vs competition to assess investment needs. Business cases for specialists presented to OSC. Continuing dialogue with stakeholders. Commercial Strategy in development, collaboration in development of sector strategy	CFO	TBC	2	3	6	A review of the Clinical Strategy is underway, linking to the NWL reconfiguration and the Commissioners ongoing requirements.	Dec-12	Mar-13
ER34 BPObj:1, 2,5	Reputational, Financial	Risk Assessment	Jul-09	Patient experience falls below an acceptable standard and results in patients choosing to go elsewhere. Income loss, patients perceptions and selection of Trust as preferred provider poor	3	4	12	Patient experience Committee, work programme, Local trackers survey action plan, Back to the Floor Fridays, Exec lead	Regular feedback with spot surveys large numbers of patients to identify and react to emerging patient issues Investment in training for all front line staff in how to help patients and improve their experience. Roll out PET timescale agreed. Agreement to revise Patient Experience Committee to strengthen CPG leadership and link to improvement works in staff satisfaction, remains key area of focus, CQC planned inspection report to CXH overall positive, privacy and nutrition inspection at SMH positive. Review of CPG Patient Experience - work in progress.	Director of Nursing	tbc	2	4	8	CQC In-Patient Survey results published and presented to May 2012 Trust Board: improved results from 2011. Cancer patient survey results recently released are static and will be discussed at the September Trust Board meeting. Comprehensive position statement and improvement plan reported to the Trust Board at their meeting on 27 February. Further report is due to the Trust Board in May 2013.	Dec-12	Mar-13

Imperial College Healthcare NHS Trust
Board Level Risk Register
March 2013

Risk ID	Risk Category	Risk Source	Date Risk First Identified	Description of Risk	Risk Score			Existing Controls in place	Risk Treatment Plan	Responsible Person	Resource Required	Residual Risk			Progress Report	Review Date	Completion Date
					Likelihood	Con'qce	Total					Likeli - hood	Con'qce	Total			
ER 42 BPObj:1,2,5	Patient Safety, Reputational	Risk Assessment	Mar-11	Failure to maintain CQC registration without conditions all 5 Trust sites or more than moderate concerns identified following an inspection visit. Failure to maintain appropriate standards in relation to CQC requirements	3	4	12	Leadership Walkabouts, Review of CQC Quality and Risk Profile (QRP) reports, Trust continuous monitoring process	Continue Leadership walkabouts across all sites and follow up actions arising, complete actions from QRP reports. Renal satellite units registered. Most recent Quality & Risk profile (dec) compliance risk 'low;. Positive feedback CXH inspection, End of year compliance declaration to Board March	DGCA (Director of Nursing pro tem)	nil	2	4	8	CRC Quality & Risk Profile remains low risk. At the Trust Board meeting on 30 January 2013 Ms Janice Sigsworth presented a report which confirmed that the CQC had now visited all of the Trust main sites and two renal satellite units. All of the sites inspected were found to be compliant with the Essential Standards of Quality and Safety, in line with the Trust's own compliance submission. There are no outstanding actions.	Jan-13	Mar-13
ER 44 BPObj:1,5	Financial, Operational/Performance Targets, Patient Safety, Reputational	Local Risk Register	Jul-11	Lack of uninterrupted power supply.Possible risk to patient safety if power supplies fail, patients also need to be moved at short notice if an ongoing loss of power.	3	4	12	Review of critical areas in progress. Estates response plans. Ensure life support medical equipment has self contained ups where required	Progress closely monitored and outcome of review expected by end of July with installations of UPS if needed. UPS PICU completed. Theatres 1-7 all groundwork finished . Further funding applied to complete this work. Winnicott, AB Theatres and other critical areas funding applied for. Emergency lighting upgraded. 2 Generator sets in place for Clarence,OPD, Jefferiss & Winston Churchill. Mobile Generator on hire sized to accommodate Mint Wing,Gynaecology, Lindo & Patterson loads pending permanent replacements	Director of Estates	TBC	2	4	8	Upgrade of electrical infrastructure at SMH commenced and scheduled for completion on 14/12/12. Works include upgrading and reinforcing supplies and capacity to site and installing new standby generator to serve Pattison, Lindo, Data Centre and Mint Wing areas etc. Recent projects in the Surgical Innovation Centre and Lindo Wing ensure compliance with IPS/UPS in operating theatres and critical care areas. Improvements to emergency lighting undertaken in Cambridge/Clarence Wing main fire escape routes in FY 11/12. HTM06 compliance reviews to be undertaken for and further works to be identified and programmed. Update required	Dec-12	Mar-13
ER 47 BPObj:1-5	Reputational, Financial , Operational/Performance, Strategic	Risk Assessment	Mar-12	CIPs 2012/13 not fully identified. Impact on financial position, FT authorisation and AHSC mission.	3	4	12	Revised reporting, PMO function transferred to CFO, investment in finance team	Regular progress reviews to continue as overseen by CIP Board	CFO	tbc	1	4	4	CIP Board oversee this and the total CIP for 2012/13 has been identified.	Dec-12	Mar-13
ER50	Financial, Operational/Performance Targets, Patient Safety, Reputational	Risk Assessment	Aug-12	Failure to learn from never events reLated to retained swabs and therefore not minimise repeat occurances	3	4	12	Swab Count Policy, training for nurses, increased vigilence, swab count bags	Audit, promotion of policy, signing up from surgeons to assurance process, training programme	TBC at next meeting	tbc	2	4	8	New Risk added from 15 August 2012 Governance Committee meeting. Updated guidance and actions for completion. Discussed at the Trust Board meeting on 30 January 2013.	Dec-12	Jan-13

Imperial College Healthcare NHS Trust
Extreme Risk Register
Risk Scoring Methodology

Consequences					
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Extreme**
Risk Score	**1**	**2**	**3**	**4**	**5**
Risk Rating	**5 (M)**	**10 (H)**	**15 (E)**	**20 (E)**	**25 (E)**
	4 (M)	**8 (H)**	**12 (H)**	**16 (E)**	**20 (E)**
	3 (L)	**6 (M)**	**9 (H)**	**12 (E)**	**15 (E)**
	2 (L)	**4 (L)**	**6 (M)**	**8 (H)**	**10 (E)**
	1 (L)	**2 (L)**	**3 (M)**	**4 (H)**	**5 (H)**

Table 1: Consequence Score					
	1	**2**	**3**	**4**	**5**
Descriptor	**Insignificant**	Minor	**Moderate**	**Major**	**Extreme**
Achievement of Objectives / External Standards	No effect	External standards being met. Minor impact on achieving objectives	Adverse effect on delivery of secondary objective	Major adverse effect on delivery of key objective. Affects Care Quality Commission rating.	Does not meet key objectives. Prevents achievement of a significant amount of external standards
Patient Harm	No obvious harm	Non permanent harm. Increased length of stay 1-7 days	Semi-permanent harm. Increased length of stay 8-15 days.	Major permanent harm. Increased length of stay >15 days or death. Significant claim	Multiple deaths.
Injury (not patient)	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	Lost time injury or RIDDOR /Agency reportable > 3 days absence	Fractures, amputation, extensive injury or long term incapacity/ RIDDOR reportable	Death or major permanent incapacity
Service / Business Interruption	Loss / interruption more than 1 hour	Loss / interruption more than 8 hours	Loss / interruption more than 1 day	Loss / interruption more than 1 week	Permanent loss of service or facility
Financial/ Litigation	local management tolerance level	Loss less than 0.25% of budgeted operating income	Loss less than 0.5% of budgeted operating income. Improvement notice	Loss less than 1% of budgeted operating income. Significant claim. Prosecution or Prohibition Notice	Loss more than 1% of budgeted operating income. Multiple claims.
Quality	Minor non-compliance with internal standards	Single failure to meet internal standards or follow protocol	Repeated failures to meet internal standards or follow protocols	Failure to meet national standards. Failure to comply with IR(ME)R	Gross failure to meet professional standards
Reputation	Rumours	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National Media less than 3 days. Major loss of confidence in organisation.	National media more than 3 days. MP Concern (Questions in House). Severe loss of public confidence.

Table 2- Likelihood score					
	1	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
	Less than 1%	1 – 5%	6 – 20%	21 – 50%	Greater than 50%
Probability	Will only occur in exceptional circumstance	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Imperial College Healthcare NHS
NHS Trust

BOARD ASSURANCE FRAMEWORK

Risk Assessment on Business Plan Objectives

2012-13

March 2013 Progress Report (previously reviewed at September 2012 Board)

References

Trust Business Plan (BP) Objectives

1. Provide highest quality of healthcare the communities we service
2. Provide world leading specialist care in our chosen fields
3. Conduct world class research and deliver the benefits of innovation to all our patients and populations
4. Attract and retain a high - calibre workforce offering excellence in education and professional development
5. Achieve outstanding results in all our activities

Department of Health AHSC Criteria

1. Excellence in Biomedical, Clinical and applied health research that is of international standing across a range of interests and of critical mass
2. Excellence in undergraduate and post graduate medical education and as appropriate other areas of healthcare and health science education
3. Excellence in patient care
4. Vision, ambition, partnership arrangements for delivering benefits in patient care with an emphasis on benefits for the local community
5. Sound financial performance

Care Quality Commission (CQC) Regulations

Key	**Requirement**
Outcome 1 *Regulation 17*	**Respecting and Involving Service Users**
Outcome 2 *Regulation 18*	**Consent to Care and Treatment**
Outcome 3 *Regulation 19*	**Fees**
Outcome 4 *Regulation 9*	**Care and Welfare**
Outcome 5 *Regulation 14*	**Nutritional Needs**
Outcome 6 *Regulation 24*	**Cooperating with other providers**
Outcome 7 *Regulation 11*	**Safeguarding**
Outcome 8 *Regulation 12*	**Cleanliness and Infection Control**
Outcome 9 *Regulation 13*	**Management of Medicines**
Outcome 10 *Regulation 15*	**Safety and Suitability of Premises**
Outcome 11 *Regulation 16*	**Safety, Availability and Suitability of Equipment**
Outcome 12, 13, 14 *Regulation 21, 22, 23*	**Suitability of Staffing**

Outcome 15, 16, 17, 18, 19, 20, 21 *Regulations 12, 10, 19, 18, 17, 20*	**Quality and Management**
Outcome 26 *Regulation 13*	**Financial Position**

OBJECTIVE ONE
Provide the highest quality of healthcare to the communities we serve

Responsible Executive Director: Chief Executive (CEO)

Reference	Risk Register Reference	CQC Reference
AHSC 1&3	Board Level risk register (ER) ER7, ER10, ER 11, ER9, ER 22, ER27, ER30, ER 31, ER 32, ER34, ER40, ER41, ER42, ER43, ER 44, ER45, ER47, ER48, ER49,	All outcomes

Key deliverables

1. Deliver healthcare that meets all national targets
2. Maintain regulatory compliance
3. Meet commissioning intentions
4. Develop ITC infrastructure to support high quality healthcare: preparatory and enabling plans
5. Business continuity and emergency preparedness plans

Principal Risks

1. Failure to meet performance and quality targets
2. Failure to minimise repeat adverse events with reputational consequences for example, Never Events
3. Patient experience is not maintained
4. Rates of Healthcare Acquired Infection do not decrease in-line with DH trajectory
5. Major incident, including the Olympics, compromises services provided,
6. Estate challenges quality of care that can be provided and impact service and targets
7. Ability to continuously comply with all regulatory requirements, including CQC
8. Maintaining standards of care during delivery of cost improvement plans (CIPs)
9. Data quality and accuracy is below acceptable standards

Risk Rating (Consequence X Likelihood from Trust Risk Matrix)
Pre –corrective action: **Likely * (4) x Major (4) =16** ***Risk level until national reporting of waiting times recommences**
Residual risk: Unlikely (2) x Major (4) = 8

Controls	Gaps in Controls	Actions	Lead & Completion Date
Performance reviews CIP Board Governance structures and information flows from CPG Boards, Management Board, Committees and Trust Board Risk and control framework Capacity meetings	1. Completion of work to strengthen data quality and re-commence national data submission 2. Local data quality measures for each Quality Accounts	Complete agreed improvement actions Quality Accounts	Director of Performance, June 2012 **Completed** Chief Operating

Leadership walkarounds and mock CQC inspections all sites Patient Experience Committee and associated feedback mechanisms, improvement actions Complaints, claims adverse events monitoring and improvement actions Olympics plan approved by NHS London Weekly, monthly, ward, CPG and Trust level HCAI data and monitoring against local and national targets ITC and Information Governance infrastructure Local risk register monitoring, including clinical and patient safety risks to Governance Committee Trust priority clinical audit programme Audit Committee review of clinical audit processes, activity and improvements Internal Audit work programme developed from key risks in assurance framework External Audit reviews notably: A&E data quality, MRSA data quality NHSLA action plan per standards Compliance with NICE and CAS, quarterly reports Patient representative on Quality and Safety Committee Service Level Agreement contract monitoring meetings Mental Health/Mental Capacity Group Safeguarding Boards	indicator 3. Awareness of CQC new approach to inspection 4. Further strengthening compliance related to Safeguarding Adults, Mental Capacity and Mental Health 5. Trustwide ANTT training 6. Agreed site partners emergency response plans 7. Sharing of learning/common themes from Performance Reviews/CIPs Board 8. Forum to focus on Safer Surgery	data quality framework Briefing to be included in CQC Quarterly report to Management Board and integrated into walkarounds Implement agreed actions Implement agreed actions Complete plans Complete plans Agenda item Management Board Establish Safer Hospital Board	Officer (COO), January 2013 **In progress** Director of Corporate affairs, May 2012: **COMPLETED** Medical Director July 2012: **In progress; training continues** Director of Nursing, March 2013: **TRAINING IN PROGRESS** Director of Nursing, March 2013 – **Handing over to COO (Sept 2013)** Chief Financial Officer (CFO) December 2012 Medical Director, December 2012

Assurances	Gaps in Assurances	Actions	Lead & Completion Date
Performance reports Quality Accounts progress reports External and Internal audit of Quality Accounts CQUIN progress against contract CQC Registration – 'without conditions' across all sites CQC Quality and Risk Profile – Trust rated as 'low compliance risk' NHSLA Risk Management Standards Level 3 in place NPSA twice yearly reports Hospital Standardised Mortality Data (HSMRS) within top performers Hand hygiene clinical audit data Results of Trust clinical audits including: Surgical site infection clinical audit data, accuracy of prescription chart clinical audit, consent audit results, documentation audit results Performance reports NHS London Patient Survey results Out Patient Survey results Staff survey results PET Tracker results and action plan Board level risk register shows Annual compliance declarations: CQC, Eliminating Mixed Sex Accommodation, Safeguarding Children and Young People, Equality Delivery Scheme	1. Revised performance scorecard 2. Audit schedule for NHSLA new clinical standards 3. Trustwide audits of WHO surgical checklist and Swab Count Policy	Launch revised performance scorecard Implement ward based regular audits with performance report to Management Board Agreed as Priority audits in Clinical Audit work programme	Director of Performance, May 2012:**COMPLETED** Director of Corporate Affairs, May 2012:**COMPLETED, Level 3 Assessment passed** Director of Corporate Affairs, June 2012:**COMPLETED added to schedule**

Progress Report
Q1 Noted completed actions for Controls 1 and 3 and continued work; and completed actions for Gaps 1, 2 and 3. NHSLA achieved 48/50 standards. Implementation work continues for retained swab issue – added to extreme risk register.

Q2
Q3
Q4

OBJECTIVE TWO
Provide world-leading specialist care in our chosen fields

Responsible Executive Director : (Chief Operating Officer)/Medical Director

Reference	Risk Register Reference	CQC Reference
AHSC 3	As Objective one plus ER30	All outcomes

Key deliverables
1. Cancer strategy, in relation to developing Crescent 2. Full implementation of the Surgical Innovation Centre 3. Development and implementation of innovative models of care for acute medical patients

Principal Risks
1. Failure to safeguard patient flows in specialist areas 2. Achieving critical mass for specialist services and impact of sector changes to patient flows 3. Tariff does not fully fund costs of specialist care 4. Not all specialist services achieve internationally recognised outcomes 5. Lack of support for longer term plans for selected specialist services

Risk Rating (Likelihood x Consequences from Trust Risk Matrix)
Pre – corrective action Score: Unlikely (3) x Major (4) = **12**
Residual risk Score: Unlikely (2) x Moderate (3) = 6

Controls	**Gaps in Controls**	**Action**	**Lead & Completion Date**
All controls identified in objective 1, in addition: Participation in clinical networks Quarterly Clinical Outcomes review Participation in national audit Collaborative working with Commissioners Clinical Standards Committee monitors outcomes, effectiveness and clinical audits at speciality level	1. Benchmarking data for all selected specialist services 2. Cancer survey results	To be reviewed by COO Complete improvement actions Developed and implemented Improvement action plan	COO, March 2013 **In Progress** CPGD 2 , March 2013 CPGD & Nursing Director

Assurances	**Gaps in Assurances**	**Actions**	**Lead &**

			Completion Date
Progress reports from London Cancer Alliance Reports of Clinical Standards Committee Plus all assurances identified in Objective 1	No gaps in assurance noted		

Progress Report
Q1 Latest Cancer survey results presented to September 2012 Trust Board meeting and– new actions to be developed.
Q2
Q3
Q4 Comprehensive Improvement Plan presented to February 2013 Board Seminar
OBJECTIVE THREE
Conduct world-class research and deliver the benefits of innovation to our patients and population

Responsible Executive : Director of Research

Reference	Risk Register Reference	CQC Reference
AHSC 1-5	Board Level Risk Register ER 22, ER30, ER31, ER40, ER41, ER43, ER47	N/app

Key Deliverables
1. Securing maximum scientific impact and patient benefit from NIHR funding streams 2. Development of improved financial systems for R&D management 3. Development of Academic Health Sciences Network and Partnership (AHSP) 4. Maintain regulatory compliance for R&D activities 5. Develop PPI and commercial strategies for R&D activities

Principal Risks
1. Failure to renew AHSC accreditation 2. Failure to develop AHSC partners 3. Lack of appropriate performance review framework 4. Unbalanced investment in R&D infrastructure vs. projects 5. Lack of engagement with PPI in R&D 6. Lower levels of income from commercial R&D studies 7. Small reduction in commercial clinical research due to economic climate 8. Patient numbers enrolled in clinical trials across all CPGs and research themes are insufficient 9. Failure to maximise innovation as a cost saving tool

Risk Rating (Likelihood X Consequences from Trust Risk Matrix)
Pre – corrective action Score: Likely (3) x Major (4) =**12**
Residual risk Score: Unlikely (2) x Major (4) = 8

Controls	Gaps in Controls	Action	Lead & Completion Date

AHSC Research Committee / quarterly reports to NIHR 'Building World Class Finance' initiative College-Trust Joint Research Office (JRO) service level agreement Research Office SOPs and on-going clinical trial monitoring programme	1. Effective link to job planning process	Develop R&D 'performance scorecard' & associated framework	Director of Research / Clinical Research Operations Manager, December 2012 In progress
	2. Improvements in data capture and reporting systems	Implement new clinical R&D database	JRO Operations Manager , December 2012 – In progress
	3. Innovation plans fully worked up in each CPG/Corporate Directorate	Review options	Director of Research/COO March 2013
	4. Relationship Agreement Trust/College	Complete College/Trust partnership agreement	CEO delegate December 2012
	5. Performance management framework to support effective delivery of BRC contract	Implement revised financial R&D management systems and controls	Director of Operational Finance, March 2013
		Allocate 2012/13 NIHR funding stream budgets and develop planning process for 2013/14 and beyond	Director of Research / Clinical Research Operations Manager, June 2012 **Completed**

Assurances	**Gaps in Assurances**	**Actions**	**Lead & Completion Date**
PPI support roles in Centre for	1. Audit programme to	Further	Director of

Patient Experience and BRC Office Regular reports from Joint Research Office Annual reports to NIHR Annual report to Governance Committee	fulfil research governance requirements	development of internal R&D quality assurance systems	Research / Head of Regulatory Compliance, March 2013

Progress Report
Q1 Approval received to implement new database. Delivery plans for NIHR drafted and working towards KPIs. Ongoing engagement with IA on R&D financial controls.
Q2
Q3
Q4

OBJECTIVE FOUR
Attract and retain a high-calibre workforce offering excellence in education and professional development

Responsible Executive Director: Director of People and Organisational Development/ Director of Education

Reference	**Risk Register Reference**	**CQC Reference**
AHSC	ER7, ER9, ER22, ER31,ER34, ER40, ER42, ER43, ER47	Outcomes 11, 12, 13, 14, 15,16 17, 20, 21

Key Deliverables

1. Develop and deliver on workforce plans
2. Reduce vacancy rates Trustwide to 7% (national average) and sickness absence rates to 3.4%
3. Maintain staff engagement scores within top 20% from National Staff Survey
4. Achieve KPIs related to appraisal rates and compliance with mandatory training
5. Actively manage the effective transition of Local Education Training Board (LETBs)

Principal Risks

1. Failure to attract and retain best staff
2. Management capacity during periods of challenge
3. Failure to sustain and improve staff engagement
4. Key vacancies remain unfilled, in particular specialist services
5. Educational programmes are not rated as excellent as per AHSC designation criteria
6. Failure to improve results of Junior Doctor survey
7. Staff morale affected by CI Moderate (3) Ps
8. Impact of formation of LETBs on Trust

Risk Rating (Likelihood x Consequences from Trust Risk Matrix)
Pre –corrective action Score: Likely (4) x Moderate (3) = **12**
Residual risk Score: Unlikely (2) x Moderate (3) = 6

Controls	**Gaps in Controls**	**Action**	**Lead &**

			Completion Date
Healthcare Education Board Staff Engagement Committee Patient Experience Committee, associated feedback mechanisms and improvement actions Corporate and local HR teams Director of Education and team, CPG Education leads, Director of Post Graduate Medicine, Director of Clinical Studies and Nursing Education team Improvement actions Junior Doctors Survey NHS London Learning and Development Agreement N W London Lead Provider Committee Staff survey action plans Mandatory training group Exit interviews Local risk register monitoring, including clinical and patient safety risks to Governance Committee includes staffing related risks NHSLA action plans per each HR related standard and audits Joint Negotiating and Consultative Partnership	1. Agreed governance structure of LETB	Develop governance framework	Director of Education, December 2012

Assurances	Gaps in Assurances	Actions	Lead & Completion Date
National staff survey results and action plan GMC trainee survey results Workforce data monitoring of reports and flagging system NHSLA Level 3 for Mandatory Training Allocation of educational funding process Workforce data reports and upwards trends for mandatory training and appraisal rates Managers workforce KPI reports and 'triggers' Governance Committee reports to Board and includes HR representatives, regular mandatory training reports,	1. Reporting arrangements of LETB in to Trust 2. Review need for a Trustwide monitoring process for reviewing staffing to budgeted clinical establishment	Developing reporting framework Develop monitoring framework	Director of Education, October 2012 Director of People and Organisational Development/ Director of Nursing, July 2012 **Completed**

fortnightly updates to Management Board Equality & Diversity Committee reports NHSLA standards audit results			

Progress Report
Q1 – LETB to operate in shadow form from October and officially from April 2013; LETB reported to May Trust Board and will report biannually.
Q2
Q3
Q4

OBJECTIVE FIVE
Achieve outstanding results in all our activities

Responsible Executive : CEO

Reference	Risk Register Reference	CQC Reference
AHSC 1-5	All risks on Board level risk register	All outcomes

Key Deliverables
As listed as for objectives 1-4, in addition: 1. Achievement of Financial Risk Rating of Level 3 (FRR based on Monitor rating) for each quarter of 12-13 2. Acute Trust Performance requirements met by quarter 3 3. FT preparatory plan 4. Established Board for FT

Principal Risks
As listed for objectives 1-4, in addition: • CIPs not achieved in full • FRR 3 not achieved • Liquidity risks • FT regime changes

Risk Rating (Likelihood x Consequences from Trust Risk Matrix)
Pre – corrective action Score: likely (4) x Extreme (5) = **20**
Residual risk Score: likely (4) x Moderate (3) = 12

Controls	Gaps in Controls	Action	Lead & Completion Date
As for all objectives 1-4, in addition: CIP framework, CIP Board Quality Impact Assessment on CIP schemes TFA	1. FT Preparatory plan	Develop plan	Director of Strategy , September 2012 – in progress
	2. CPG and Corporate Directorates capability and capacity to deliver CIPs	Support from Finance Directorate, Turnaround Director, continuous monitoring of CIP performance	CFO – in progress

Assurances	Gaps in Assurances	Actions	Lead & Completion Date
As for all objectives 1-4, in addition: Summary of CIP progress in Finance Reports	1. CPG/Corporate FRR	Develop approach	Director of Operational Finance, **Completed**

Progress Report
Q1 Note completed action Gaps 1.
Q2
Q3
Q4

Consequence Score (C) **TRUST RISK MATRIX**

Descriptor	1	2	3	4	5
	Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
Achievement of Objectives / External Standards	No effect	External standards being met. Minor impact on achieving objectives	Adverse effect on delivery of secondary objective	Major adverse effect on delivery of key objective. Affects Care Quality Commission rating.	Does not meet key objectives. Prevents achievement of a significant amount of external standards
Patient Harm	No obvious harm	Non permanent harm. Increased length of stay 1-7 days	Semi-permanent harm. Increased length of stay 8-15 days.	Major permanent harm. Increased length of stay >15 days or death. Significant claim	Multiple deaths.
Injury (not patient)	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	Lost time injury or RIDDOR /Agency reportable > 3 days absence	Fractures, amputation, extensive injury or long term incapacity/ RIDDOR reportable	Death or major permanent incapacity
Service / Business Interruption	Loss / interruption more than 1 hour	Loss / interruption more than 8 hours	Loss / interruption more than 1 day	Loss / interruption more than 1 week	Permanent loss of service or facility
Financial/ Litigation	local management tolerance level	Loss less than 0.25% of budgeted operating income	Loss less than 0.5% of budgeted operating income. Improvement notice	Loss less than 1% of budgeted operating income. Significant claim. Prosecution or Prohibition Notice	Loss more than 1% of budgeted operating income. Multiple claims.
Quality	Minor non-compliance with internal standards	Single failure to meet internal standards or follow protocol	Repeated failures to meet internal standards or follow protocols	Failure to meet national standards. Failure to comply with IR(ME)R	Gross failure to meet professional standards
Reputation	Rumours	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National Media less than 3 days. Major loss of confidence in organisation.	National media more than 3 days. MP Concern (Questions in House). Severe loss of public confidence.

Likelihood Score (L)

Descriptor	1	2	3	4	5
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
	Less than 1%	1 – 5%	6 – 20%	21 – 50%	Greater than 50%
Probability	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

R (Risk) = C (Consequence) x L (Likelihood)

Likelihood	Consequences				
	Insignificant	Minor	Moderate	Major	Extreme
	1	2	3	4	5
5 (almost certain)	5 (M)	10 (H)	15 (E)	20 (E)	25 (E)
4 (likely)	4 (M)	8 (H)	12 (H)	16 (E)	20 (E)
3 (possible)	3 (L)	6 (M)	9 (H)	12 (E)	15 (E)
2 (unlikely)	2 (L)	4 (L)	6 (M)	8 (H)	10 (E)
1 (rare)	1 (L)	2 (L)	3 (M)	4 (H)	5 (H)

Trust Board: 27 March 2013: Agenda Number: 4.2 Education directorate: action plan for addressing educational issues for doctors and medical students within ICHT

March 16th 2013 *Jeremy Levy, Director of Education*

Issue	Action	Owner	Dates
Lack of physical space for simulation based training	1. For skills and simulation based learning, agreement has been reached with Prof Hanna to use resources within the Paterson Building, however this remains insufficient for need across all specialties due to the high throughput of students currently, and limited rooms. 2. Needs analysis being undertaken currently by newly appointed simulation lead to determine detailed requirements for simulation space across all specialties and for multiprofessional training and training based on significant and serious incidents: current estimates indicate a significant shortfall. 3. We continue to use (and pay for) trainees to attend simulation sessions at Chelsea and Westminster and other Trusts and this will continue unless we can develop more space locally 4. It is unlikely Paterson can offer sufficient space to meet Trust needs and will require space for which significant funds were awarded by the Deanery in 2013, but at risk if not used.	Estates Dir Education and Simulation lead	Review July 2013
Lack of physical space for small group teaching and training, especially at St Mary's	1. Remains a significant problem. Teaching rooms have been removed by Trust for clinical service over last 3 years and not replaced. The Education team have not identified any new space for converting to seminar rooms despite further assessment in December 2012 and February 2013. Proposals to use Mint Wing and V+A ward have been shelved by Trust but no replacements identified. No space available for this within Paterson. Head of estates formally asked to identify space again in March 2013, following similar requests in 2011 and 2012. 2. Room identified within renal building at Hammersmith which could be more widely used for teaching but ongoing conversations with renal department preventing ease of access for teaching	Estates Dir Education with renal	Review again end March 2013

Postgraduate medical training: trainee feedback on quality of training	1. internal survey of all trainees completed in February 2013: many positive aspects reported, but concern over work intensity in some areas (52% reported workload heavy or very heavy), rota patterns, very poor IT infrastructure on wards (too few computers and unreliable, slow, too many systems and log-ins), significant burden of administrative duties including phlebotomy and high level of reported "undermining" by consultants and others. Summary results presented to MB and details from every department sent to CPG directors and CPG Heads of Education from DMEs for further dissemination to departments and actions. Medical Director asked to raise in monthly meeting with consultants. CPG directors need to solve workload issues and poor admin support for doctors including lack of phlebotomy. Dir of ICT made aware of ongoing feedback concerning doctors perception of poor IT. Directors of medical education meeting directly with education leads in all departments to ensure local actions in place to improve outcome 2. Detailed actions from every department from 2012 GMC national survey presented regularly to healthcare education board (HEB) and to management board and ongoing oversight by DMEs 3. restructuring of HEB to separate meetings for discussion and oversight of response to trainee survey to ensure more rigorous assessment of actions to be chaired by NED	CPG directors (most problems relate to service impact on training) and heads of education. Dir Education for confirmation of actions, support and facilitation in departments through DMEs; Med Director	Ongoing review by DMEs. Formal review with national GMC survey May 2013. New HEB oversight April 2013
Future reduction in number of doctors in postgraduate training in secondary care	1. This is a national agenda. 2. ICHT needs to ensure highest quality training to protect as much as possible from inevitable future reductions. See all above 3. Departments need to develop plans to manage patients with fewer doctors either by consultant expansion, role change (eg perioperative physicians/geriatricians) or expansion of specialist nurses or acute care teams	CPG directors Dir Ed as above	Ongoing
Quality of undergraduate teaching	1. Detailed feedback requested from ICL more frequently to come to Dir Education in addition to site based directors of clinical studies (DCS). Feedback was previously annual only. 2. Student feedback data to be presented to CPGs (directors and heads of education) regularly and actions logged: follow-up from DCS reported to HEB.	Dir Education, CPG Heads of education and DCSs	March 2013

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE GOVERNANCE COMMITTEE
Held on
Wednesday 13 February 2013
10.00 a.m. – 12.00 p.m.
Clarence Wing Boardroom, St Mary's Hospital, Paddington

Present:	Sir Thomas Legg (Chair)	Non Executive Director
	Prof Sir Anthony Newman-Taylor	Non Executive Director
	Prof Nick Cheshire	Medical Director
	Kevin Jarrold	Chief Information Officer
	Janice Sigsworth	Director of Nursing
In attendance:	Angela Ballard	Head of Nursing, CPG1 *(items 1-4)*
	Adam Bland	Emergency Planning Manager
	Sue Grange	Associate Director of HR Development (for items 5-9)
	Philip Lazenby	Internal Audit Manager, Parkhill
	Kathryn Hughes	Acting Head of Performance
	Prof Jeremy Levy	Director of Education
	Stephen Guile	Head of Corporate Services & Trust Secretary
	Meryln Marsden	Head of Site Operations & Emergency Planning *(for items 1-4)*
	Priya Rathod	Interim Head of Quality Governance
	Justin Vale	Director, CPG 2 *(for items 1-4.1)*
	Komal Whittaker-Axon	Head of Operations, Infection Prevention and Control

1	**Apologies for Absence** Apologies were received from Sir Gerald Acher; Dr Rodney Eastwood; Paul Grady; Mike Griffin; Prof Alison Holmes; Steve McManus and Bill Shields.
2	**Minutes of the Previous Meeting**
2.1	The minutes of the meeting held on 17 October 2012 were agreed as a true record
3	**Matters Arising / Action Monitoring**
3.1	**Junior Doctor Induction (Minute 6)** 17 October 2012: Minute 6 Mandatory Training: Sue Grange said she would review the actions concerning junior doctor induction with Jeremy levy and other colleagues to provide assurance for the 17 April Governance Committee meeting.

3.2	**Action Summaries** Future summaries of actions would include only those that were outstanding or had been completed since the last meeting.
4	**Local Risk Assessment and Management of Risks**
4.1	**CPG2**
4.1.1	Justin Vale presented CPG2 top ten risks. Those discussed included: • Cancer Services: six out of eight integral targets were now rated green and it was hoped to archive all 8 as green by 31 March. • Urology Cancer: the risk was now rated amber. • Major trauma: repatriation was still an issue. Rehabilitation services in North West London were relatively poor. • General Surgery, Charing Cross: Discussions were under way with Nick Cheshire on acute surgery cover. • Radiotherapy, Charing Cross and Hammersmith: Replacement options and costs for older machines are being considered. • Staffing for additional beds: permanent staff were being supplanted with temporary staff. • Nursing Vacancy Rate: Nursing establishment CPG2 had now been reviewed and this risk would be removed from the Register...
4.1.2	Sir Thomas Legg identified instances which needed a better description of Identified Risk, Existing Controls, Action to be Taken or Progress. Residual Risk Scores (i.e. after applying actions), that had changed from the report to the previous meeting, should be highlighted, especially if that had resulted in a 'traffic light' re-rating. The covering report provided an opportunity to highlight key changes in risks. Some entries on the risk registers appeared to be 'under-powered' -especially when compared with the more substantial oral updates given at the meeting. All CPG and Departmental Risk Leads are asked to review carefully their top-ten risk registers for report to the next meeting. **Action: CPG and Departmental Risk Leads**
4.1.3	There were no risks added to the Extreme Risk Register.
4.2	**Performance**
4.2.1	Kathryn Hughes presented the Performance Department top ten risks. She commented that where the numbers counted are low, small changes in numbers can have large percentage effects. There was discussion on: • Cancer: Patient Experience: Janice Sigsworth said that the Trust had ranked bottom in the 2011 National Patients Survey. Action had been taken to improve the patient pathway though this would take some time to come through. There would be an update report at the 27 February Board seminar. Janice Sigsworth said that action plans for elective surgery and IST (Intensive Support Team) cancer reviews should be noted in the Performance Risk Register. • National Referral Treatment Standards: Winter funding had helped reduce backlogs. • A&E Targets: the 95% target for type 1 was only just being achieved and might not be achieved at the year end. The Committee asked that CPG restructuring be added to the appropriate Risk Register under the Chief Operating Officer: **Action Katherine Hughes/ Steve McManus**
4.2.2	There were no risks added to the Extreme Risk Register.

4.3	**Education**
4.3.1	Jeremy Levy presented the Education Top Ten Risks. • Financial Risks due to reductions in funding: these were being discussed within the Trust. • Failure to make undergraduate and graduate education a priority: Sir Tom Legg asked whether this was properly identified as a risk. Sir Anthony Newman-Taylor said that there was an issue of ensuring that consultants gave sufficient time and priority to education of junior doctors. Consultants' job plans must include sufficient teaching sessions. There could be an effect upon the stats of the Academic Health Science Centre The Committee asked for an update on the plan of action...**Action: Jeremy Levy/CPG Directors** • Junior Doctor Induction: It was agreed that this should be added to the Education Risk register. Jeremy Levy would bring a report to the Management Board. **Action: Jeremy Levy**
4.3.2	There were no risks added to the Extreme Risk Register.
4.4	**Emergency Planning**
4.4.1	Meryln Marsden presented the Emergency Planning Top Ten Risks. The first five risks listed had remained almost the same. The second five risks related at least in part to the CERNER records systems upgrade. A risk had been added in relation to inadequate response from partners due to some vacancies in the national Commissioning Board. Risks included updating business continuity plans for CPGs. Bad weather planning included flood risk in relation to Charing Cross on which joint working with other authorities was taking place.
4.4.2	Two risks had been eliminated: Olympics Planning and Emergency Plans for the Fulham Gasworks-which had now closed.
4.4.3	There were no risks added to the Extreme Risk Register. The Olympis/Gasworks could be removed from the Register.
4.5	**CERNER**
4.5.1	Kevin Jarrold tabled a replacement summary of the CERNER Top Ten Risks. The three most significant risks were: • Data Migration Failure: 10 weeks were allowed for improvement in data quality prior to migration to CERNER. • Lack of organisation preparedness due to poor staff engagement and possible delay in implementation: • CERNER reporting systems may not be 'Fit for Purpose' given that the Trust is the pioneer. Regular systems of control are being implemented to deliver the project and to mitigate the risks.
4.5.2	The Committee noted the risks and controls and that regular reporting took place within the Trust.
5	**Clinical Governance Review**
5.1	Janice Sigsworth presented the report on the review commissioned by NHS NWL on behalf of NHS London. A letter from NHS London's Medical Director, signing off the process, had been presented to the Trust Board at its meeting on 30 January. The

	Committee noted the report and the action plan, which the Medical Director was updating with colleagues, particularly with the Chief Operating Officer. **Action: Chief Operating Officer/Medical Director**
5.2	Nick Cheshire said that the report had been very valuable. The recent accreditation of the Trust as NHSLA as Level 3, was also recognition of good polices and processes being in place. Commitment by Clinical Leadership was vital. The Quality and Safety Committee would monitor implementation.
5.3	Sir Thomas Legg underlined the importance of the review and the action plan that was being implemented. He said that he would write, as Governance Committee Chairman, to his fellow Non-Executive Directors to recommend they each read the report and action plan. **Action: Stephen Guile** *(to draft note for Sir Tom).* The Committee accepted the report.
6	**Savile Allegations**
6.1	Janice Sigsworth presented the report responding to the Department of Health's requirements. The Savile allegations underlined the need for visits to the Trust to be appropriately controlled and monitored. An update report would be brought to the Committee's next meeting, on 17 April.
6.2	The Committee noted the report.
7	**Education Update**
7.1	Jeremy Levy presented the report that had been considered at the Trust Board meeting on 30 January.
7.2	The Committee was concerned about the reporting of bullying by colleagues. Some of this may reflect expectations of levels of support from colleagues not being achieved. The Committee also asked whether there may be some over-use of trainees in excessive regular working rather than in training opportunities. Jeremy Levy would report to the Management Board. **Action: Jeremy Levy**
8	**Mandatory Training Report and Training Schedules**
8.1	Sue Grange presented the report. The follow matters were discussed: • mandatory training compliance rate at 77% had seemed to reach a plateau • non-medical induction had dipped to 57% • local induction for non-medical staff had improved from c20% a year before, to 69% • permanent medical induction was at 72% (Jeremy Levy reported there was some backlog in recording/reporting by consultants) • local induction of temporary staff was at 86%
8.2	Sue Grange reported that agreement between NHS bodies to accept a 'carry-over' of training from one employer to another will improve scores. In response to a question from Sir Thomas Legg, Sue Grange said that she would clarify who defines 'mandatory' training. The Committee noted the report and looked forward to improvements in training scores.
9	**Update on Statutory and mandatory training for staff**

9.1	Sue Grange presented the report. The report had been requested to provide information on non-standard NHS mandatory training by looking at other staff groups and disciplines to see what was required, professionally and otherwise.
9.2	The Committee welcomed the report and asked for quarterly exception reports on compliance.
10	**Estates Backlog and Priorities Report: Capital Investment Prioritisation**
	As there was no-one to present this report, the Committee decided to defer consideration until its next meeting on 17 April 2013.
11	**Sub-Committee reports by Exception**
11.1	**Quality and Safety Committee** • 4 February 2013 • 3 December 2012 • 5 November 2012 The reports were taken as read.
11.2	**Patient Experience Strategy implementation Group meeting on 28 November 2013** Janice Sigsworth highlighted actions being taken to improve cancer patient experience and to change culture and include patients and families more in all aspects of cancer care. .
11.3	**Equality and Diversity Committee meeting on 22 October 2012** The Governance Committee discussed the provision of spaces for religious activities. The Committee noted that the gymnasium at Charing Cross had been identified as a possible location for Muslim prayers. Philip Lazenby commented that, in his experience as a practising Muslim, the prayer facilities in the Trust were excellent and that other organisations designated gymnasia for prayers.
11.4	**Health, Safety, Fire and Security Committee on 28 November 2012** The report was taken as read
12	**Briefing on the Francis Report**
	Janice Sigsworth gave an oral update on the outcome of the Francis Committee's inquiry into failures of care at Mid Staffordshire Foundation Trust. In total there were some 290 recommendations, of which approximately 20% related to trusts such as Imperial. The remainder of the recommendations required responses from the DH and other bodies. There were many governance and assurance issues in the report, including teaching and training and scrutiny challenges. Sir Bruce Keogh was investigating some 14 trusts over high mortality rates. Imperial had relatively low mortality rates. The Prime Minister had announced the Friends and Family test and work was under way to implement this in the Trust. Imperial had a number of initiatives and activities under way, including: • The recent Clinical Governance Review-discussed earlier in the meeting • Publication of Nursing Staffing levels

	• Responsible Officers for Nursing and Midwifery • Named consultants and named nurses for care of the elderly • Reviews were under way against Monitor's Quality Governance Framework and Board Governance Assurance Framework, allied to work on the Trust's aspiration to achieve authorisation as a Foundation Trust during 2014. Sir Thomas Legg said that one key to learning the lessons of the Francis Report would be the Department of Health's attitude towards patient care and funding. Sir Anthony Newman-Taylor said that he had been disturbed by the failures in professional staff's care of patients and the indifference shown. It was vital that health providers listened to patients and families and responded appropriately. The Trust will respond to the Report and had accepted the recommendation at its seminar in February.
13	**Any Other Business** There was no other business
14	**Date and time of next meeting:** 10am-12 noon on Wednesday 17 April in the Clarence Wing boardroom, St Mary's Hospital, Paddington**.**

.

.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD: 27 March 2013 **Agenda Number: 5.4**

Report Title: Foundation Trust Programme Update

To be presented by: Rodney Eastwood, Chair of Foundation Trust Programme Board

In February, the Trust Board was notified of the formal authorisation received from the NHS Trust Development Authority (TDA) to proceed with the Trust's Foundation Trust (FT) application. This paper seeks to update the Board on progress in establishing a formal programme of work since that point.

Key actions for the Board's note have been:

- Establishment of a FT Programme Board, chaired by Rodney Eastwood, with Non-Executive, Executive Director and external membership, to direct the programme, make key decisions, provide scrutiny and challenge to all deliverables and provide assurance to the Board;
- Establishment of a FT Programme Team, led by the Head of Planning & Business Development, to plan and manage the day-to-day execution of the programme, underpinned by five key workstreams;
- Development of a high level programme plan and risk register, to now be refined through the development of more detailed work plans;
- Conduct of the Board Governance Assurance Framework baselining exercise, the findings of which will be presented for discussion at the April Trust Board seminar;
- Consideration of an approach to addressing the requirements of Monitor's Quality Governance Framework;
- Identification of the Trust's likely external support requirements through the lifecycle of the programme.

Priority actions of the FT Programme Board in the coming month will be:

- More detailed development of the programme plan and risk register, in discussion with work stream leads, the TDA and in light of the recommendations from the Francis Report;
- Development of a high level clinical strategy, for the Board's discussion at the April seminar, to be followed by the development of specialty level plans;
- Agreement of the FT programme budget as part of the 2013/14 financial planning round;
- Redraft the Tripartite Formal Agreement for agreement following the conclusion of the 2013/14 contracting round.

It is proposed that the Chair of the FT Programme Board now continue to update the Trust Board to provide assurance on the status of the programme on a monthly basis until authorisation, in addition to bringing key deliverables before the Board for approval as they are developed.

The Board is asked to:

- **Note** the progress report.

Legal Implications or Review Needed

a. Yes
b. No ✓

Details of Legal Review, if needed: n/a

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and

satisfaction
2. Provide world-leading specialist care in our chosen field
3. Conduct world-class research and deliver benefits of innovation to our patients and population
4. Attract and retain high caliber workforce, offering excellence in education and professional development
5. Achieve outstanding results in all our activities.

Purpose of Report

a. For decision and approval
b. For review/noting ✓

Foundation Trust Programme Update

1. Summary

The stated aim of the Department of Health remains to support all NHS Trusts in becoming Foundation Trusts (FT) by April 2014, with a few attaining authorisation beyond this date by exceptional agreement.

The Trust's extant Tripartite Formal Agreement (TFA), dated August 2012, sets out a trajectory culminating in FT authorisation in October 2015. This was based on the need for:

- Improved financial stability;
- Improved operational performance;
- Strengthened governance;
- Development of a coherent clinical strategy.

Based on the compelling evidence of the Trust's progress in these and other areas presented to NHS London and the Trust Development Agency (TDA) on 14 February 2013, the Trust received formal approval to proceed with its FT programme with a view to potential authorisation in August 2014.

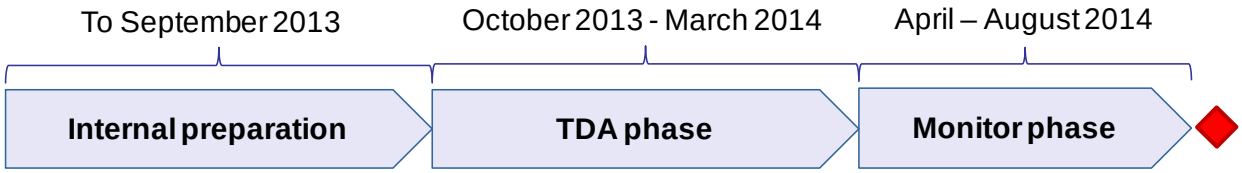
This paper sets out for the Board's information the indicative timescales that the FT programme will follow, the governance structure designed to oversee the programme and the immediate next steps that the programme team will need to follow.

The Board is asked to:

- **Note** the Trust's formal authorisation to proceed with its FT programme;
- **Note** the indicative timescales of the programme;
- **Appove** the draft Terms of Reference of the FT Programme Board.

2. Indicative programme timescales

NHS London and the TDA have agreed the principles underpinning the Trust's proposed FT programme timescaled as described in the diagram below.



- 2013/14 planning round
- Clinical strategy development
- Revise LTFM
- Draft IBP
- Board development
- Organisational development
- Revise membership strategy

- BGAF assessment
- QGF assessment
- Public consultation
- Finalise LTFM and IBP
- HDD1
- Ongoing Board and organisational development
- Membership recruitment

- HDD2
- Ongoing Board and organisational development
- Membership recruitment

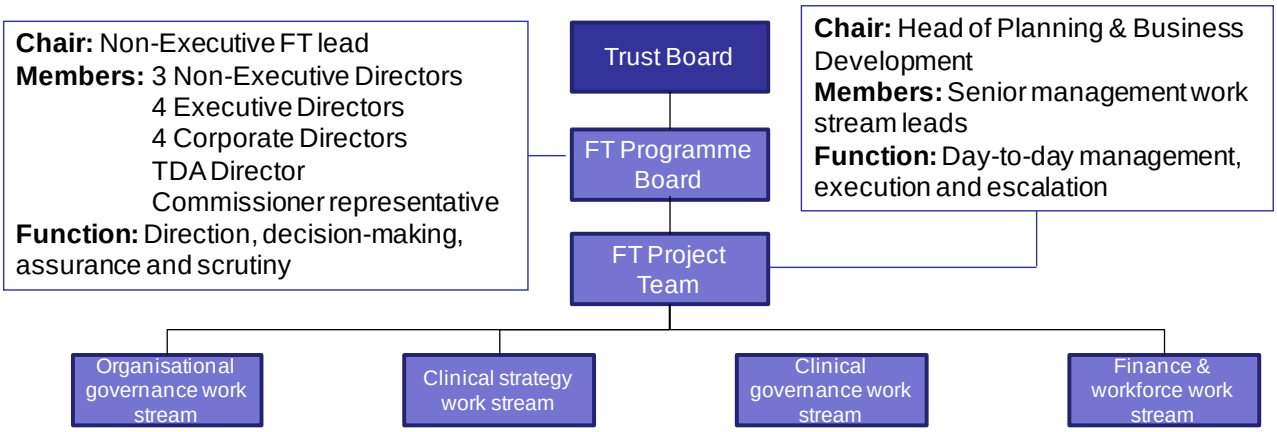
.It should be noted that:

- Timescales will need to be immediately revisited in light of the Francis Report recommendations;
- An additional six months will need to be factored in in the event that the proposed merger with West Middlesex University Hospitals NHS Trust goes ahead.

A detailed programme plan will be developed and presented to the Board in March.

3. Proposed governance structure

The governance structure illustrated below is proposed to oversee the programme.



It is proposed that a FT Programme Board be established to direct the programme, make key decisions, provide scrutiny and challenge to all deliverables and provide assurance to the Board. The first meeting of the FT Programme Board will be held on 21 February.

The draft Terms of Reference of the FT Programme Board can be found in Appendix 1 for the Board's approval.

4. Next steps

The FT Programme Board will be asked to commission the following immediate next steps:

- Develop a detailed programme plan;
- Agree work stream leads;
- Convene the Project Team and agree its high level work programme;
- Complete the Board Governance Assurance Framework baseline exercise, the findings of which will be reported to the Board in March;