TRUST BOARD IN PUBLIC AGENDA
10.00am – 12.30pm
Wednesday 26 March 2014
New Boardroom, Charing Cross Hospital,
Fulham Palace Road, London, W6 8RF

		Paper	Presenter	Timing
1	**General Business**			
1.1	Chairman's Opening Remarks	**Oral**	Chairman	10.00
1.2	Apologies	**Oral**	Chairman	
1.3	Board Members' Declarations of Interest and Conflicts of Interest	**1**	Chairman	
1.4	Minutes of the meeting held on 29 January 2014	**2**	Chairman	
1.5	Matters Arising and Action Log	**3**	Chairman	
1.6	Chairman's Report	**Oral**	Chairman	
1.7	Chief Executives' Report	**4**	Chief Executives	
2	**Quality and Safety**			
2.1	Director of Nursing's Report	**5**	Director of Nursing	10.10
2.2	Medical Director's Report	**6**	Medical Director	10.20
2.3	Quality Committee To note the report of the Quality Committee held on 6 March 2014	**7**	Prof Sir Anthony Newman Taylor	10.25
2.4	Infection Prevention and Control Report	**8**	Medical Director	10.30
2.5	Quality Accounts	**9**	Director of Governance & Assurance	10.40
2.6	Safeguarding of Children and Young People Annual Declaration 2013/14	**10**	Director of Nursing	10.50
3	**Performance**			
3.1	Integrated Performance Report and Scorecard Month	**11**	Chief Operating Officer	10.55
3.2	Dementia Audit	**12**	Chief Operating Officer	
3.3A	Finance Report – Month 11	**13**	Chief Financial Officer	11.05
3.3B	Finance & Investment Committee To receive a verbal update of the Finance & Investment Committee held on 20 March 2014	**Oral**	Sarika Patel	
3.4	Annual Plan 2014/15	**14**	Chief Financial Officer	11.15

3.5	Director of People and Organisation Development's Report	**15**	Director of People & Organisation Development	11.25
3.6	Remuneration and Appointments Committee To note the report of the Remuneration and Appointments Committee meeting held on 26 February 2014	**16**	Jeremy Isaacs	11.35
3.7	Risk Report	**17**	Director of Governance & Assurance	11.40
3.8	FT Consultation	**18**	Chief Financial Officer	11.50
3.9	Terms of Reference	**19**	Director of Governance & Assurance	12.00
3.10	Non-Executive Director's Indemnity	**20**	Director of Governance & Assurance	12.05
3.11	Audit, Risk and Governance Committee To note the report of the Audit, Risk & Governance Committee meeting held on 12 March 2014	**21**	Sir Gerald Acher	12.10
3.12	NHS Trust Development Authority Self-Certifications: • Compliance December • Board Statement December • Compliance January • Board Statement January	**22** **22A** **22B** **22C** **22D**	Chief Financial Officer	12.15
3.13	Foundation Trust Programme Board To note the report of the Foundation Trust Programme Board meeting held on 18 March 2014 To receive the minutes of the meeting held on 23 January 2014 and 18 February 2014	 **23** **24** **25**	Dr Rodney Eastwood	12.20
4	**Any Other Business**			
4.1	Any other business raised with the Chairman		Chairman	12.25
5	**Date of Next Meeting:**			
Trust Board Meeting in Public: Wednesday 28 May 2014, 10am – 12 noon, Clarence Wing Boardroom, St Mary's Hospital, Praed Street, London W2 1NY				
7	**Questions from the Public relating to Agenda Items**			
8	**Exclusion of the Press and the Public**			
'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1(2), Public Bodies (Admission to Meetings) Act l960.				

Imperial College Healthcare NHS
NHS Trust

Report Title: Declarations of Board Members' Interests

To be presented by: Cheryl Plumridge, Director of Governance & Assurance

Executive Summary: The Department of Health's "Code of Conduct and Accountability" requires that the Chairman and Board members should declare any conflict of interest that arises.

To comply with this requirement a note of all Declarations made by the Board will be taken to each Public Board meeting as a formal record and is attached as Appendix A.

A full register of all Declarations made by all staff, including the Board, will continue to be kept in accordance with the requirements of the Register of Interests Policy.

The relevant extract relating to Declarations of Interests from the Standing Orders is attached as Appendix B.

Action: For noting

Board Members' Register of Interests – January 2014 **Appendix A**

Sir Richard Sykes Chairman

- Chairman, Singapore Biomedical Sciences International Advisory Council since 2002
- Chairman, UK Stem Cell Foundation since 2004
- Member, Bristol Advisory Council since 2006
- President, Institute for Employment Studies since 2008
- Chairman, Careers Research Advisory Centre since 2008
- Non-Executive Chairman of NetScientific
- Non-Executive Director of ContraFect since 2012
- Chairman of Royal Institution of Great Britain
- Chancellor Brunel University

Sir Thomas Legg Senior Independent Director

- Imperial College Healthcare Trust Charity Trustee

Sir Gerald Acher Non-Executive Director

- Deputy Chairman of Camelot Group PLC
- Vice Chairman of Motability
- Trustee of Motability 10 Anniversary Trust
- Chairman Littlefox Communications Ltd

Dr Rodney Eastwood Non-Executive Director

- Visiting Fellow in the Faculty of Medicine of Imperial College
- Governor, Chelsea Academy [Secondary school]
- Consultant, Mazars
- Trustee of the London School of ESCP Europe (a pan-European Business School)
- Member of the Editorial Advisory Board of HE publication

Jeremy M Isaacs Non-Executive Director

- JRJ Group Limited – Director
- JRJ Jersey Limited - Director
- JRJ Investments Limited – Director
- JRJ Team General Partner Limited - Director
- JRJ Ventures LLP – Partner
- JRJ Partner 1 LP – Partner
- JRJ Partner 2 LP – Limited Partner
- JRJ Carry LP – Partner
- Food Freshness Technology Holdings Ltd – Director
- United Jewish Israel Appeal – Director
- Kytos Limited - Director
- Support Trustee Ltd – Director
- LSBI LLP - Member
- Marex Spectron Group Limited – Director/NED Chairman
- Member, Bridges Ventures Advisory Board (Privately owned Venture Capital Company with a social mission)
- Trustee, Noah's Ark Children's Hospice
- Trustee, The J Isaacs Charitable Trust

Professor Sir Anthony Newman-Taylor Non-Executive Director

- Chairman, Colt Foundation
- Trustee, Rayne Foundation
- Chairman, independent Medical Expert Group, Armed Forces Compensation Scheme, MoD
- Member, Bevan Commission, Advisory Group to Minister of Health, Wales
- Trustee, CORDA, Preventing Heart Disease and Stroke
- Rector's Envoy for Health, Imperial College
- Head of Research and Development, National Heart and Lung institute (NHLI)
- Member Advisory Board, Royal British Legion Centre for Blast Injury Studies (CBIS), Imperial College

Sarika Patel Non-Executive Director

- Board – Centrepoint
- Board – Royal Institution of Great Britain
- Partner – Zeus Capital
- Board – London General Surgery
- Board – 2020 Imaging Ltd

Dr Andreas Raffel Designate Non-Executive Director

- Executive Vice Chairman at Rothschild
- Member of council of Cranfield University
- Trustee of the charity Beyond Food Foundation
- Member of the International Advisory Board of Cranfield School of Management

Professor Nick Cheshire Chief Executive

- Hansen Medical: Scientific advisory board Member (Endovascular Robotics programme)
- Hansen Medical: Dept level research support.
- McKinsey Company. Member of Medical Directors Advisory Group
- Medtronic Inc: Scientific Advisory Board Member (Branch AAA stent programme), Institution level grant support. .
- Veryan Medical (IC spin out) Shareholder (0.5%)
- NICE: Member of TOPIC Selection Committee
- Cook (UK) Speakers Bureau
- Member, Organising Committee of the Multidisciplinary European Endovascular Therapies Conference (MEET) Rome, Italy
- Member, Scientific Advisory Committee of the Controversies and Updates in Vascular Surgery (CACVS) conference Paris France
- Organiser & speaker, Medtronic University course
- Gore Company - Consulting agreement for advanced endovascular therapies

Cook, Medtronic and Gore are endovascular equipment suppliers to the Trust
Hansen Medical manufactures the only commercially available endovascular robot and supplies hardware and disposable robotic equipment to the trust.

Bill Shields Chief Executive

- Honorary Colonel, 243 (Wessex) TA Field Hospital:
- Elected member of CIPFA council
- Chairman, CIPFA Audit Committee
- Board member, NHS Shared Business Services

Dr Chris Harrison Medical Director

- Non-Executive Director, CoFilmic Limited
- Director, RSChime Limited
- Vice Chair, London Clinical Senate Council

Steve McManus Chief Operating Officer

- Chair – National Neurosciences Managers Forum
- Chair of Governors – Tackley Primary School

Professor Janice Sigsworth Director of Nursing

- Honorary professional appointments at King's College London, Bucks New University and Middlesex University
- Trustee of the Foundation of Nursing Studies

Marcus Thorman Director of Finance

Nil

Extract from Standing Orders **Appendix B**

7.1.2 Interests which are relevant and material

(i) Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
d) A position of authority in a charity or voluntary organisation in the field of health and social care;
e) Any connection with a voluntary or other organisation contracting for NHS services;
f) Research funding/grants that may be received by an individual or their department;
g) Interests in pooled funds that are under separate management.
h) Funding received from a third party, excluding Imperial College London, for a staff member.

(ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 29 January 2014
Oak Suite,
W12 Conference Centre, Hammersmith Hospital,
London W12 0HS

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Present:	
Sir Richard Sykes	Chairman
Sir Thomas Legg	Deputy Chairman and Senior Independent Director
Sir Gerald Acher	Non-Executive Director
Dr Rodney Eastwood	Non-Executive Director
Jeremy Isaacs	Non-Executive Director
Prof Sir Anthony Newman-Taylor	Non-Executive Director
Sarika Patel	Non-Executive Director
Andreas Raffel	Non-Executive Director (Designate)
Prof Nick Cheshire	Chief Executive (until agenda item 4.2)
Bill Shields	Chief Executive
Marcus Thorman	Chief Financial Officer (from agenda item 4.4)
Dr Chris Harrison	Medical Director
Marcus Thorman	Chief Financial Officer
Prof Janice Sigsworth	Director of Nursing
In attendance:	
Ian Garlington	Director of Strategy
Prof Alison Holmes	Director of Infection Prevention and Control
Prof Dermot Kelleher	Principal of the Faculty of Medicine of Imperial College (until agenda item 4.2)
Jayne Mee	Director of People and Organisation Development
Cheryl Plumridge	Director of Governance and Assurance
Helen Potton	Interim Corporate Governance Manager
Nicola Grinstead	Director of Operational Performance
Katie Goodwin	Grant Thornton
Bill Upton	Grant Thornton
Jay Bevington	Deloitte
Priya Rathod	Interim Head of Quality Governance

1	**General Business**
1.1	**Chairman's Opening Remarks** The Chairman welcomed Board members, staff and members of the public to the meeting. He also welcomed colleagues from Grant Thornton and Deloitte who were observing the meeting.

1.2	**Apologies for Absence** Apologies had been received from Steve McManus, Chief Operating Officer and Marcus Thorman, Chief Financial Officer. Nicola Grinstead, Director of Operational Performance, was attending on Steve McManus' behalf.
1.3	**Board Members' Declarations of Interest and Conflicts of Interest** There were no additional conflicts of interests declared at the meeting.
1.4	**Minutes of the Meeting held on 27 November 2013** The minutes of the meeting held on 27 November were approved as a true record.
1.5	**Matters Arising and Action Log** The Board noted the updates to actions in the log. Cheryl Plumridge advised that item 4.2 was now completed following her email of 28 January 2014.
1.6	**Chairman's Report**
1.6.1	Sir Richard Sykes updated the Board on the recruitment for the Chief Executive. Following a process of long and short listing there were three candidates for the position and interviews would take place on Thursday 6 February 2014, following a number of meetings between members of the Board and the candidates.
1.6.2	He confirmed that as a result of work undertaken as part of the Foundation Trust application no formal record had been found confirming the appointment of Sir Thomas Legg as Deputy Chairman and Senior Independent Director. He confirmed this now and advised that on Sir Thomas Legg's retirement both roles would be undertaken by Sir Gerald Acher. He also noted that following the departure of Stephen Guile, Cheryl Plumridge would undertake the Trust Secretary role in addition to her other duties.
1.6.3	Finally, he referred the Board to the arrangements for the Board committees which would commence from the Trust Board meeting in March.
1.7	**Chief Executives' Report** The Board noted the Chief Executive's report which was presented by Prof Nick Cheshire and Bill Shields. In particular they referenced:
1.7.1	**Update on Trust Development Authority (TDA) Planning Guidance** Bill Shields welcomed the guidance which should allow for better alignment between the Trust and Commissioners. He noted that whilst this would initially involve more work as the Trust would be moving from a 1 year contract to include a 5 year planning horizon, which would not be familiar to the Commissioners, it should enable better clinical alignment. Prof Nick Cheshire noted that with QIPP and CQUIN they controlled the way that the Trust worked and resulted in Commissioners spending money on things that they did not necessarily want. By having the new model of working agreed this conflict would no longer be present, as all the issues would have been discussed and agreed previously.
1.7.2	**Talent Development - Engagement** Bill Shields noted that the first survey had achieved a 27% response rate and had identified that there was an issue around Junior Doctors and how the Trust engaged with them. The Trust only paid half their salary and there was some confusion as to who they considered their employer to be. Prof Nick Cheshire suggested that the correct message at induction was key and that it was important to make them feel like they were a member of the Trust. The Board acknowledged that there was further work to be done on this issue and that the Executive Team had already had detailed discussions on the issues, and that Jayne Mee would take this forward.

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1.7.3	**Leadership Development** Bill Shields advised the Board that the four new leadership programmes had been well received.
1.7.4	**Performance and Development Review** Bill Shields noted the new review process for Trust staff, which would be discussed in more detail later in the meeting.
1.7.5	**Performance** Bill Shields referred to two particular areas of performance: • There had been 10 cases of MRSA to date, and there was a detailed action plan in place which had been discussed at length with the TDA. • The Trust had achieved the 62 day target for Cancer and was on track to achieve the Quarter 4 target. Sir Richard Sykes asked for clarification as he had noted that in some reports it referred to achieving all 8 of the overall targets yet others suggested only 7. Dr Chris Harrison confirmed that it was the quarterly target that Monitor would asses meaning that the Trust might not achieve in a particular month, but could still achieve the quarterly target.
1.7.6	**Finance** Bill Shields noted that the Trust was currently on track to deliver the projected surplus and that detailed discussions had taken place at the Finance & Investment Committee on the CIP position.
1.7.7.1	**Foundation Trust Application** The Trust continued to work towards an authorisation date of January 2015. Although there had been some slippage on the programme all key deadlines had been met. The focus for an aspirant Foundation Trust was on being a well led organisation and a number of projects had been undertaken including the Board Governance Assurance Framework (BGAF) and the Quality Governance Framework (QGF) which the Board would be signing off at today's meeting.
1.7.7.2	Discussions had taken place with the TDA around the timing of the Chief Inspector of Hospital's (CIH) visit and they had agreed that it should take place after the implementation of Cerner which was currently scheduled for the Easter weekend.
1.7.7.3	Prof Janice Sigsworth suggested that it would be helpful to adopt a "war room" approach to the visit putting together a group of individuals who had experience in this area and to learn from those who had already had a CIH visit. The planning for this was being led by Cheryl Plumridge who advised the Board that steps were already underway to recruit an interim team to manage it. She noted that whilst she was currently facing some staffing challenges, this would not be allowed adversely to affect the visit. Sir Gerald Acher supported the decision to recruit a team to manage the work on an interim bias.
1.7.7.4	Prof Janice Sigsworth noted that the Trust was already used to accommodating inspectors, albeit not on the same scale.
1.7.8	**Board Preparation** Prof Nick Cheshire highlighted that this was currently underway and as part of that, the Board were being observed by both Grant Thornton and Deloittes.
1.7.9	**Integrated Business Plan (IBP)** Prof Nick Cheshire advised the Board that this was a very important document which was progressing well, despite a slightly difficult start, which had demonstrated the value in going through the detail. Bill Shields noted that there had been a good discussion at the Foundation Trust Programme Board (FTPB) which had identified that whilst it was a complex document, it did cover all key areas. Sir Richard Sykes supported this point.
1.7.10.1	**NWL Business** There had been a very productive meeting with the 5 GP Chairs, their Financial Officer and Daniel Elkeles. PwC had been commissioned to provide a report on clinical and site strategy which would include immediate next steps which

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	represented a significant step forward in terms of agreement.
1.7.10.2	Prof Sir Anthony Newman-Taylor asked about the future of Charing Cross. Prof Nick Cheshire advised that it was about providing integrated care that focused on keeping patients out of hospital to enable better healthcare to be provided at less cost. Sir Richard Sykes suggested that this would result in a complete purpose built, new build facility, which was a very exciting prospect and which would provide clear alignment to the Trust's vision.
1.7.11	**Clinical Research Network for North West London** Prof Nick Cheshire advised the Board that following the Trust's successful bid to host the new NIHR (NWL) Clinical Research Network (CRN), work had been undertaken on setting up new governance structures with two new senior appointments having been made.
1.7.12	**Divisional Research Structures** Leads had been identified for each division and further details would be brought to the Board in March.
1.7.13	**AHSC - Redesignation Update** Following the announcement of the redesignation of Imperial College AHSC, work had commenced on strengthening the new governance structures. Prof Nick Cheshire advised that the acceptance letter had focused on the informatics platform which was a significant opportunity for the Trust to develop further. Prof Dermott Kelleher suggested that a critical part of the AHSC was the relationship with Imperial College as a whole and not just with the Faculty of Medicine. Relationships would need to be developed with other faculties including Mathematics, Computer Engineering and Engineering which would give the Trust the opportunity to take the lead in this area. He noted that the Trust had already worked with the College on Cerner to good benefit. Jeremy Isaacs suggested that this was a very compelling argument.
2	**Quality and Safety**
2.1	**Director of Nursing's Report** Prof Janice Sigsworth presented her report, and in particular noted:
2.1.1.1	**Safe Nurse Staffing** Boards were required to sign off establishments for all clinical areas no later than June 2014 and the logistics of this would be slightly easier once e-rostering had been upgraded. She had received some early feedback from a Trust in Salford which showed that their establishment was 86% filled, however this was over 20/30 clinical areas. Imperial had 80/90 clinical areas and she was in the process of running some pilots to understand what the shortfall would look like. Sir Richard Sykes suggested that this was a difficult area as it was not about quantity, but about quality and having the right people. Prof Janice Sigsworth noted that whilst it was important to match equity to need, she suspected that clinical staff would say that quantity could dramatically affect quality, although they would want our people and not bank or agency staff.
2.1.1.2	Sarika Patel suggested that it would be important to find the money so would be essential to involve Divisional leads. Prof Janice Sigsworth advised the Board that, the following day, she was holding an event with senior staff to look at the guidance and the establishment required in detail.
2.1.1.3	Jayne Mee suggested that it was important to understand why staff left the Trust and to engage with our people better, providing good career pathways. Sir Richard Sykes agreed referencing the 10% staff turnover to which Prof Janice Sigsworth responded that it was important to understand why staff had left, as this would include staff that had left following an active management process, as the Trust would not tolerate poor practice. Jeremy Isaacs highlighted that it was important to understand what percentage had left the Trust without having been subject to the management process.
2.1.1.4	Sarika Patel noted the difficulties in recruiting with Jayne Mee advising that it underlined the need to develop a talent pool by over recruiting which the Trust

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	could appoint from rather than one division seeking to recruit one member of staff at a time. Bill Shields suggested that it was essential to get the phraseology correct as the Trust should only be recruiting to its establishment and it was agreed that a set establishment would be brought back to a future meeting. **Action: Director of Nursing**
2.1.2	**Patient Experience** Prof Janice Sigsworth noted the work that was being undertaken in this area. She advised the Board that despite the poor results, one of the Maternity Teams who worked with vulnerable pregnant woman had won a national award.
2.1.3	**Patient Story** The story highlighted that improvements were required in the operational process to ensure that patients were not spending unnecessary periods of time waiting.
2.1.4	**Healthcare Innovation Exchange (HELIX) Project** Prof Janice Sigsworth advised the Board that in early spring a pop up studio would be placed in Norfolk Place which would be an area to create innovative products and services. As a part of this project the team were already engaged in the PICU redevelopment and she believed that this was an excellent opportunity for the Trust.
2.1.5	**Central West London Healthwatch Visit** The relationship had been developed to enable them to act as a critical friend and was proving to be very supportive. In particular they had asked to be involved in the further development of the Trust's Membership Strategy and take an active part in the Council of Governors.
2.2	**Medical Director's Report** Dr Chris Harrison presented his report noting that quality dominated and highlighted in particular:
2.2.1	**Quality Strategy** Calendars and Postcards which described the quality goals had been distributed to all divisions. Sarika Patel commended the calendars.
2.2.2	**Safety & Effectiveness Board (S&EB)** The management of Serious Incidents (SI) was moving to the Medical Directorate and would be reported up through the S&EB. Dr Rodney Eastwood asked how much time would be spent on Effectiveness and Dr Chris Harrison advised that Safety and Effectiveness were for him different sides of the same issue, and what was important was that care provided made a difference. He said that this was well established within the Trust and believed that a balance would be found although was not yet sure what that would be. Sir Richard Sykes asked what the difference was between the S&EB and the Friday morning meetings. Dr Chris Harrison advised that the Friday meetings were real time live meetings of what needed to be done whereas the S&EB was a discussion around an aggregate of themes from the incidents.
2.2.3	**Neurosurgical Trauma Review** Sir Richard Sykes asked whether the Trust had a licence to land helicopters in Hyde Park and was advised that whilst it did, patients would often be taken to the Royal London as transition to the Trust, due to distance, caused a potential problem. He asked that the provision of a Helicopetr Landing Site (HLS) be considered further as part of the OBC for the clinical strategy and SaHF. **Action: Director of Strategy**
2.2.4.1	**Education** An external review of medical education had been conducted by Dr Fiona Moss and Sir Gerry asked if the Board could have a copy of the Report. **Action: Medical Director**
2.2.4.2	Prof Dermott Kelleher suggested that the AHSC had a substantial role to play

	as an interface with the University and this would be discussed at their away day, the outcome of which he would bring back to the Board. **Action: Principal of the Faculty of Medicine of Imperial College**
2.4.2.3	Jeremy Isaacs asked whether or not education had changed much over the last 15/20 years which could mean that there was a substantial opportunity to transform what the Trust did. Dr Chris Harrison suggested that there could be radical changes although believed that changes had already taken place. Prof Nick Cheshire noted that staff no longer worked very long hours which represented a significant culture shift and that there were lots of areas of good practice but admitted that it was still very hierarchical. He suggested that the future of Charing Cross could enable the Trust to do this in a different way enabling the effective delivery of quality healthcare.
2.3.1	**Infection Prevention and Control Report** Prof Alison Holmes presented her report noting that in November there were no Trust attributable cases for MRSA with the total standing at 10 for the year to date, with four cases having been reallocated to the Trust. The Trust carried out 2500 blood cultures each month which was a huge amount of work. Sir Richard Sykes suggested that in the recent cases it was difficult to see that anyone had done anything wrong which made it difficult to stop. Prof Janice Sigsworth asked if there was more that the Board could do to assist and stressed that she and Dr Chris Harrison would continue to reiterate the message. Prof Alison Holmes noted that devices were a critical risk and it was important that they were checked on every round of every shift. Prof Janice Sigsworth advised that the AN&TT training was due to be repeated.
2.3.2	*C-Dificile* continued to fall with the Trust standing at 67 cases against a target of 65.
2.3.3	There had been a small number of incidents over six wards of Norovirus but these had been dealt with efficiently and effectively working closely with bed management.
2.3.4	Two new groups had been established Surgical Site Infection (SSI) Prevention and Surveillance Group and the Vascular Access Group both led by senior clinicians.
2.3.5	The Trust had been successful in being shortlisted for four categories in a recent NIHR competition and had won all four, with one being shared with Kings College. Sir Richard Sykes noted that this had been led extremely well by Prof Alison Holmes and was very good for the Trust and colleagues.
	Performance
3.1.1	**Integrated Performance Report and Scorecard Month 9 2013/14** Nicola Grinstead presented the report on behalf of Steve McManus explaining that there were three key areas that she wanted to highlight to the Board:
3.1.2.1	**How the Scorecard worked and how feedback was captured?** The Scorecard was set around quality and the six themes plus people and finance. It consisted of a series of wheels which gave an 'at a glance' status, which could be tracked through to provide information on an individual indicator giving an opportunity to identify where a standard was leading or lagging, the former of which could be an early warning sign of a negative impact to future performance. Where an area had turned red there was a risk mitigation table to inform what action was being taken.
3.1.2.2	Currently the benchmarking data compared the Trust to itself and if it was aspiring to be the best, it would need an appropriate peer group to compare itself against. This was an area under further development.
3.1.3	**Overview of the narrative** The narrative paper reported the Trust performance data in accordance with Monitor's requirements and currently the Trust would be RAG rated amber. Where either an amber or red rating was indicated, text would be provided to understand issues. It would also highlight any changes to the regulatory

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	framework to enable performance to be tracked consistently.
3.1.4.1	**Highlights from December's performance included:** • The Quarter 3 target had been met; • Actions for winter resilience were on target with a review of performance over the previous 24 hours and a look ahead at the next 24 hours taking place. This was not just for A&E but had been linked to other services; • A&E 4 hour wait continued to be delivered; • Continued reduction in reported sickness absences.
3.1.4.2	Sir Gerald Acher commented that he had spent a day with the team and had been very impressed both with the winter preparedness and the availability of live data, but also that it had been treated as business as usual.
3.1.4.3	Sir Richard Sykes congratulated Nicola Grinstead on a very good, clear and helpful report.
3.1.4.4	Continued development would form part of the Delivering Operational Excellent Programme which would enable at first minimum standards to be met, but thereafter National and then International standards to be achieved.
3.1.4.5	Sir Richard Sykes expressed concern that theatre utilisation was currently only 36%. Nicola Grinstead advised that she had previous experience with this issue and that a key element was around bed capacity and patients not being sent down to theatre if a bed had not already been identified and allocated. The issue was one of confidence in the system and her experience was that by introducing performance league tables within the Trust this delivered significantly better utilisation.
3.1.4.6	Dr Rodney Eastwood highlighted that outpatients continued to be an issue for the Trust. He believed that it was not acceptable for the Trust simply to display a sign saying that clinics were running an hour late as this led to nursing staff receiving complaints and patients waiting longer for their appointment which would adversely affect the patient experience. Bill Shields noted that work had already been undertaken in this area with Serco, and the Trust was shortly to go through a tender exercise to provide support to resolve this type of issue.
3.1.4.7	Sarika Patel asked how the indicators had been chosen and was advised by Nicola Grinstead that initially those required for mandatory compliance for Monitor and CQC had been included together with the most important as identified working with the clinical directors but suggested that they were likely to change over time. Sarika Patel expressed surprise that only the FRR was considered to be important from a Finance perspective and queried why CIP was not included.
3.1.4.8	Nicola Grinstead advised that further work would be required and that, once completed, work would take place on a similar process for the Divisions.
3.1.4.9	Sarika Patel suggested that an overarching performance report similar to the Nursing Report might be helpful.
3.2	**Dementia Care Audit** One of the indicators for the national Dementia CQUIN goal related to supporting carers of people with dementia and the Trust had devised an audit questionnaire to be completed by carers. The audit was being piloted on 5 wards and had seen that 70% of carers had felt supported and knew where to get information from. However of the 30% that did not feel supported a common experience was that they had not had the opportunity to speak to a healthcare professional. Nicola Grinstead advised that work was being undertaken to develop a carer's pack and that an audit would take place in March on the effectiveness of these packs. Prof Janice Sigsworth noted that it was an excellent report and congratulated the team highlighting that following an unannounced CQC visit they had commended much of the work undertaken which was delivered with great care and compassion from all staff.
3.3	**Finance**

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3.3.1	**2013/14 Month 9 Report** Bill Shields presented the report in the absence of Marcus Thorman. He advised the Board that the Trust remained on track to deliver the planned surplus noting that there were some unusual characteristics to the asset impairment charge for the devaluation of buildings, which had been discussed at length at the Finance & Investment Committee (FIC). He suggested that it was too early to assess whether winter planning would have any impact but advised that investigations were ongoing on this issue however, this would not have an effect on delivering the overall forecasted position.
3.3.2	Sir Richard Sykes suggested that the position regarding CIP delivery was fragmented and that there was a significant issue highlighted within the Medicine Division and wanted to understand what the problem was, as he had expected, that following the reorganisation, things would improve. Bill Shields advised that the reorganisation had, in part, made the situation worse by putting together the old CPG1 with Renal services. He accepted though that other Divisions were coming forward with good examples of CIP plans but that this was not happening in Medicine, which needed to be addressed. Prof Nick Cheshire suggested that it was largely a clinical problem with a high emergency demand and low tariff although he accepted that there were some issues with length of stay. He noted that the Out of Hospital agenda would be key to dealing with this.
3.3.2	Sarika Patel suggested that it was not appropriate for this to rest with the Office of the Chief Executive and it should come from those who were tasked to deliver. She noted that 70% of CIPs had come from the corporate services divisions and believed that the Trust should now be in a position to identify what the problems were and how to deal with them. She explained that at the FIC meeting they had requested a report on the issues, to their next meeting.
3.4.1	**Emergency Planning Update** Nicola Grinstead presented the report noting that whilst not a new requirement responsibility had transferred for oversight to NHS England and local Clinical Commissioning Groups (CCGs). There were 115 measures of which 107 were RAG rated. The Trust had received 88 green and 19 amber ratings with no red ratings. She noted that the Trust was one of two highly performing Trusts with only one Trust providing greater assurance.
3.4.2	Areas of good practice had been shared amongst the Trusts with 14 of our areas having been shared.
3.5	**Director of People and Organisation Development's Report** Jayne Mee presented her report noting that some of the issues had already been covered earlier in the meeting but noted the following in particular:
3.5.1.1	**Performance and Development Review** This had been a significant piece of work with engagement from the Trades Union and around 100 of our staff in the design and development of the process, culminating in sign off by 40 of this group during a People and Organisation Development forum. The form was clear, with clear guidelines, and introduced new concepts including rating of staff. Everyone who had to undertake a review must complete the training, before they would be able access and undertake reviews and forms could be completed online.
3.5.1.2	The reviews represented a cultural change which had been started following the development of the leadership development programme with the second cohort having started. This was beginning to demonstrate that the Trust was really engaging with its staff.
3.5.1.3	Jeremy Isaacs stressed the importance of first class training of the people undertaking the reviews and suggested that this represented an inherent risk that would need to be well managed. Jayne Mee advised that she was in the process of setting up a calibration group who would assess the quality of reviews and the ratings given and feedback would be provided where it was

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	believed that the reviews were not consistent. Sir Thomas Legg suggested that it was important to adopt a consistent approach and that not everyone could be rated an A and that our staff would need considerable support to do this. Jeremy Isaacs referenced that white males would tend to be more generous to diverse groups as they were frightened that they would be challenged more, which resulted in the opposite of what the Trust was trying to achieve. Prof Sir Anthony Newman Taylor noted that it was often the case that underperforming staff received good appraisals as managers did not like having difficult conversations. Dr Rodney Eastwood asked if it included junior doctors and was advised by Dr Chris Harrison that their appraisals were conducted through shared services. Jayne Mee confirmed that she was aware of the challenges that the review presented but believed that it was important to move forward.
3.5.2	**Nursing and Midwifery Recruitment** Jayne Mee advised that the Trust had made, and had accepted, 639 offers of appointment between April – December 2013. The Trust had been out to India to recruit 37 ICU nurses who, under the terms of their visa, could only work for the Trust. Prof Janice Sigsworth explained that it was difficult to recruit nurses who were neither working at team leader level nor newly qualified and it was this middle level that the Trust was recruiting for. This was a wider London issue and also occurred in Neonatal and Paediatric ICU. This was a short term solution and the Trust was looking at a longer term solution to ensure that career progression was attractive, which was particularly important bearing in mind that the Trust was a significant trainer of nurses so needed to demonstrate good plans were in place to deliver starter jobs and support those staff into middle grade roles.
3.5.3	**Bank and Agency (Clinical)** Prior to 20 January 2014 the Trust had not paid bank workers in accordance with Agenda for Change which had resulted in our staff, when working on bank, working for other Trusts. This had now been changed so that they would earn the same as in their substantive role whilst working on bank. Prof Janice Sigsworth noted that this had been very well received by staff and that the fill rate for the first week had increased by 2%.
3.6	**Director of Governance and Assurance's Report** Cheryl Plumridge presented her Governance and Assurance Report highlighting the following:
3.6.1	**CQC** The Trust had had one whistleblowing incident reported which had been concluded to the satisfaction of the CQC. There had also been one unannounced themed visit to Dementia care at Charing Cross with informal feedback received being very positive.
3.6.2.1	**Serious Incidents** Cheryl Plumridge noted three key themes: • Maternity Service • Pressure Ulcer • Infection Prevention and Control and advised that appropriate actions were being undertaken stressing that the Trust was performing better than other Trusts.
3.6.2.2	When compared against wider NHS Acute Trust metrics, the Trust under reported incidents and it was hoped that the upgrade to Datix would enable more accurate reporting as would the introduction of an element of feedback on incidents which should demonstrate that the reporting of incidents made a difference. Dr Chris Harrison noted that it was important to publicise the changes to Datix which should see an increase of low or no harm incidents. Prof Nick Cheshire commented that historically the trust had reported lower numbers but with a higher element of no harm so that the current figures

	demonstrated that the Trust had made good progress.
3.6.3.1	**Complaints, Claims and Inquests** Cheryl Plumridge noted that all three areas had seen a significant increase in numbers compared to the previous month/year. There were three main reasons for this increase: 1. Mid Staffs and other similar reports; 2. A changing political and media profile; 3. A change to the legal environment around conditional fee arrangements which had seen a threefold increase. She advised that she was putting together an in-house legal team, with the first member of the team due to start in April which would manage the three areas and look to develop organisational learning. Andreas Raffel suggested it would be useful to see a comparison of expenditure of outside counsel as a result of the in house team.
3.6.3.2	Bill Shields noted that the methodology for calculating NHSLA premiums was changing and would no longer be based upon theTrust's NHSLA rating but would based upon the claim's history. As the Trust was currently level three but had a poor claim's history, this would result in an additional £3M to pay on the premium. He therefore stressed the importance of understanding the consequences of incidents or the premium would continue to rise.
3.7.1	**Corporate Risk Register (CRR)** Cheryl Plumridge presented the CRR a previous version of which had been discussed at a Board Seminar and which had been considered by the AR&GC and signed off by the Management Board. She was keen to get the Board's view on whether the document felt intuitively correct and whether the Board considered that the specific risks were well articulated and clear.
3.7.2.1	Sir Gerald Acher asked if she was experiencing sufficient traction from risk owners and she confirmed that this was starting to be demonstrated and was part of the learning and development point on clinical, reputational and corporate risk together with horizon scanning. He suggested that any risk that was getting worse was worrying, and referred to the Estate's risk. Prof Nick Cheshire confirmed that the estates plan would be going to the Management Board to understand the need and then consider finance.
3.7.2.2	Finally Sir Gerald Acher suggested that the Board had during their meeting identified a new risk which might merit inclusion onto the CRR namely the Fiona Moss training report implications **Action: Medical Director**
3.7.2.3	The Board agreed that it would receive the CRR at each of its public meetings. The Board approved the CRR.
3.8	**Board Assurance Framework (BAF)**
	The BAF was presented to the Board which had been developed further by risk owners following the Board development session in December 2013. The purpose of the BAF was to provide different levels of assurance linking risk to the Corporate Objectives. An updated version would be brought to the July Board. The Board approved the BAF. **Action: Director of Governance & Assurance**
3.9.1	**NHS Trust Development Authority Self-Certifications** Bill Shields presented the self-certifications which had replaced the previous SOM process.

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3.9.2	The Trust Board approved the following Self-certifications: • October Compliance • October Board Statement • November Compliance • November Board Statement
4	**Strategy**
4.1.1	**Immediate tasks/Key priorities** Bill Shields presented the update noting that following the departure of the CEO a plan of key priorities had been developed and presented by the joint Chief Executives.This report updated the Board on the delivery of that plan and they would continue to bring the update to the Board until the new CEO was in place.
4.1.2	He noted in particular that: • Winter planning was a number one priority for the Trust; • The implementation of Cerner was on track to deliver; • Site leadership and responsibility had been discussed at length and appropriate people had been identified to undertake the roles; • The development of the Clinical Strategy was on track with assistance with Oliver Wymann; • The FT process had been helpful to the political stakeholder process with a number of important meetings having taken place; • There was now a comprehensive report on data quality for baseline validation.
4.2.1	**2014/15 Integrated Planning Framework** The report set out a new approach to business planning demonstrating significant progress towards integrated planning within the Trust. This approach was consistent with TDA requirements and what Monitor would want the Trust to do.
4.2.2	The challenge was to have a comprehensive management process that enabled divisions to earn some autonomy with additional investment but where there were performance issues they received closer management.
4.2.3	The framework had been discussed in detail at the last FIC and comments fed into the version before the Board.
4.2.4	Insofar as this would impact on CIP delivery substantial support had been provided by Red Clover and the process allowed for the rewarding of divisions and corporate directorates for schemes where cost savings were delivered.
4.3	**Outcome of approval of Academic Health Science Centre (AHSC) accreditation by Department of Health (DoH)** This item was not discussed.
4.4	**Board Governance Assurance Framework (BGAF)** **Approval of Board Governance Memorandum** Cheryl Plumridge presented the BGAF which was split into five sections: four sections were self-assessments and the fifth was four case studies. The document had been discussed in detail at FTPB and approved with some minor amendments which had been undertaken. Dr Rodney Eastwood confirmed that he was very happy with the document. The Trust Board approved the BGM.
4.5	**Quality Governance Framework** **Approval of Board Governance Memorandum** **Self Assessment & Quality improvement plan** Dr Chris Harrison presented the three documents that had been discussed in detail and approved with some amendments by the FTPB. Dr Rodney Eastwood confirmed that he was very happy with the documents. The Trust Board approved the documents.

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5	**Papers for Information**
5.1	**Finance & Investment Committee** **Report of the meeting on 23 January 2014:** Sarika Patel noted that the detailed discussions around CIPs, that had taken place at the meeting, had already been discussed.
5.2	**Quality Committee** **Report of meeting held on 5 December 2013** Prof Sir Anthony Newman Taylor noted that key issues had already been discussed.
5.3	**Foundation Trust Programme Board** **Report of meetings on 17 December 2013 and 14 January 2014** Dr Rodney Eastwood noted that key issues had already been discussed.
5.4	**Audit, Risk and Governance Committee** **Report of meeting held on 11 December 2013:** Sir Gerald Acher highlighted the implementation of Cerner in April.
6	**Any other business** There was no other business.
7	**Date and time of next meeting:** **Trust Board Meeting in Public:** Wednesday 26 March 2013, 10am -12 noon, New Boardroom, Charing Cross Hospital, Fulham Palace Road, London W6 8RF
8	**Questions from the Public:** There were no questions from members of the public.
9	**Exclusion of the Press and the Public** The Board resolved that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act I960.

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ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
27 November 2013

Minute Number	Action	Responsible	Completion Date	March 2014 Update
4.2	**Non-Executive Directors' Operational Visits** Systematic organised visits, involving local staff, to be arranged.	Director of Governance & Assurance		**Completed.**
5.2	**FT Membership Strategy** The plan for building up the Membership and the creation and development of the Council of Governors to be brought forward via the FT Programme Board.	Director of Governance & Assurance	**18.2.14**	Membership recruitment campaign due to start at end of April. Report on the development of Council of Governors to be presented to the Foundation Trust Programme Board in April.
6	**Terms of Reference** A single document of Committee terms of reference to be provided.	Director of Governance & Assurance	**26.3.14**	**Completed.** Agenda Item.

ACTIONS FROM TRUST BOARD MEETING IN PUBLIC
29 January 2014

Minute Number	Action	Responsible	Completion Date	March 2014 Update
2.1.1.4	**Safe Nurse Staffing.** Details of the required establishment would be brought to a future meeting	Director of Nursing		**Completed.** Included in Director of Nursing's report.
2.2.3	**Neurosurgical Trauma Review.** The Provision of a Helicopter Landing Site be considered as part of the OBC for the clinical strategy.	Director of Strategy / Director of Estates		**Completed.** Consideration is being given to the possibility of a helicopter landing pad on the roof of the new building at St Mary's. St Mary's will soon be the only major trauma centre in London without an air ambulance landing area. It would be structurally almost impossible to retro-fit and raise significant planning issues if pursued in isolation from the main master plan, so the best time to secure the option for

				providing this facility is now. If designed into the building from the outset, it does not represent a major cost or logistical problem.
2.2.4.1	**Education.** A copy of the external review of medical education conducted by Dr Fiona Moss to be given to the Board.	Medical Director		**Completed.** A copy of the review was circulated to the Board after the January meeting
2.2.4.2	**AHSC.** An update on the discussion at their away day around the substantial role that the AHSC could play as an interface with the University would be brought back to the Board.	Principal of the Faculty of Medicine of Imperial College		Away day is on 25 March and an update will be brought back to the Board in May.
3.7.2.2	**CRR.** To consider whether there was a risk identified by the Fiona Moss training report which should be escalated to the CRR.	Medical Director		**Completed.** Chris Harrison has provided Cheryl Plumridge with a proposed entry for the Risk register**.**
3.8	**BAF.** An updated version would be brought to the July Board.	Director of Governance & Assurance	July TB	**Completed.** On forward plan for July TB and will be removed from action log.

Imperial College Healthcare NHS
NHS Trust

Chief Executive's Report

26th March 2014

1 TRUST BUSINESS

1.1 Update on FT Programme Plan

The Trust Board and the Foundation Trust Programme Board were both notified in February 2014 that the TDA expected there to be a delay to the timing of the Chief Inspector of Hospitals' (CIH) visit. It was originally thought that the CIH visit would take place between Mid-May and June, however following discussions with the Trust Development Agency, it was confirmed that the visit would not occur in Quarter 1 FY 2014/15.

In a letter to Sir Richard however, Sir Peter Carr (Chief Executive Officer of the TDA) stated that he is confident that the visit will take place in Quarter 2 FY14/15 – i.e. between July and September 2014. He also noted that there is a discussion taking place with Monitor which may see Monitor's Quality Governance (QGAF) work being undertaken in Q1 FY14/15, with a subsequent reduction in the time needed for Monitor's assessment of the Trust after the CIH visit. Nevertheless, it remains unlikely that the Trust will achieve Foundation Trust authorization by December 2014.

In early February 2014, Grant Thornton attended Trust Board, the Finance and Quality Committees and conducted interviews with the Board members for the Trust's BGAF/QGF process. The formal BGAF/QGF report prepared by Grant Thornton will be presented to Trust Board on 26th March.

KPMG commenced Stage 1 (formerly known as the Historical Due Diligence process) in late February 2014. This stage included interviews with Non- Executive Directors, Executive Directors and Divisional Directors as part of the preliminary review of our governance processes and financial reporting procedures. KPMG's report will also be presented to Trust Board on 26th March.

The Foundation Trust consultation closed on 10th February with the Trust receiving a total of 543 responses. The results have now been collated and analysed.

Lead Director – Marcus Thorman, Chief Financial Officer

2 PEOPLE AND ORGANISATIONAL DEVELOPMENT

2.1 Engagement Survey and NHS Staff Survey

In early March the Trust received the results of both the National NHS Staff Survey 2013, and our second local Engagement Survey. A more detailed presentation will be made at the Trust Board on March 26 2014

To further support our work on Engagement we plan to introduce an Exit questionnaire and an "On Boarding " questionnaire to help pin point any other issues for both new joiners and leavers which will help us improve the engagement of our people.

2.1.2 Friends and Family Question for Staff

From April 1 2014 it will be mandatory for all NHS Trusts to ask two survey questions to all staff;

-"How likely are you to recommend this organisation to friends and family if they needed care or treatment?"
-"How likely are you to recommend this organisation to friends and family as a place to work?"

The guidance allows us to ask this through our existing Engagement Survey and we will be ready to launch this in April. The requirement is to allow all our people to answer this at least once a year with a quarterly data collection by the Department of Health. The results from this will be measured as part of the overall Friends and Family Test CQUIN in 2014-5. There will be a requirement to publish the results of this question locally and nationally but detailed information on this element is not yet available.

2.1.3. NHS Change Day Briefing

Engaging our people is a key priority. NHS Change Day provided us with a key opportunity to do just this by empowering people to own, and be part of, the change that they want to see at Imperial.

On 3rd March 2014 we introduced NHS Change Day to Imperial College Healthcare NHS Trust. On all three main sites we had teams talking to our people and patients about NHS Change Day, demonstrating how one simple action or idea can make a difference and improve experiences of our colleagues, our patients and their carers. With large pledge trees in the Hospital entrances, and three walking pledge trees, our people were encouraged to complete and hang their pledges. It was positive to see so many engaged in this event and inspiring to read the range of pledges made.

2.1.4 Leadership Programmes

In April, our fifth new Leadership Programme "Headstart" will commence. This is aimed at our middle managers; ward managers, business managers, heads of department and newly appointed consultants. Our "Aspire" Programme will commence its third cohort in April and a fourth cohort in September. In total we now have 5 programmes running at every level of the organisation and by May we will have 8 cohorts running in parallel with 89 participants.

2.1.5 Performance and Development Review

This month the Trust launches the new Performance Development and Review process. A comprehensive training programme has been designed with external partners who are experts in this area, and all managers will be required to attend this training over the coming year, to obtain their Licence to practice.

2.2 EMPLOYEE RELATIONS

2.2.1 Make a Difference: recognising great work

The Trust will launch a new recognition scheme on 1 April to replace the existing "I recognise" and "Osc@rs" schemes. The scheme will be called "Make a Difference" to reflect the impact people who go the 'extra mile' have on the lives of patients and colleagues. The charity has generously agreed to fund the new scheme. "Make a Difference" will combine instant recognition thank you cards, bi monthly team and individual awards, and an annual award ceremony.

Instant recognition: Patients, family, colleagues, and managers can nominate people for instant recognition thank you cards for a range of positive behaviours, such outstanding commitment to meet someone's needs, and great work that exceeds expectations.

Divisional awards: Once every two months each division will select their best team and best individual. Divisions will also make an annual lifetime achievement award. Corporate directorates such as Estates and ICT will be treated as a single division.

Annual awards: An annual award ceremony will be held to celebrate the best team, individual, bank worker, and volunteer, and the lifetime achievement award. There will also be a Chairman's award which will go the team who have made the most outstanding contribution on a theme selected by the Chairman.

2.2.2 Pay progression

On 1 April new Trust rules on pay progression come into effect for people on Agenda for Change (AfC) contracts. For the first time, incremental pay increases will depend on satisfactory ratings at annual performance & development review (PDR); a satisfactory disciplinary record; and, in the case of managers, 100% completion of PDRs for their team members. This change represents a first move towards modernising our pay structures. In the coming year we will develop a new pay system for senior managers and a common incremental date will be implemented.

2.2.3 Dignity and Respect

The Trust has published a new Dignity and Respect Policy. The policy emphasises the types of positive behaviours we expect from our people and replaces the current Bullying and Harassment Policy. The Trust is currently reviewing its Equal Opportunities Policy: a new version is expected to be published in April.

2.3. RESOURCING

2.3.1 Senior Recruitment

The following have recently joined the Trust:
Karen North, Associate Director of HR Operations
Michelle Dixon, Director of Communications & External Relations

2.4. PEOPLE PLANNING &INFORMATION TEAM

2.4.1 Qlikview

The development of the new 'Your People' application within Qlikview has now moved to the user pilot stage. The Division of Investigative Sciences & Clinical Support and the Corporate Directorate of Estates & Facilities will be testing the new application. Managers will be able to access core details about their people including key people metric information such as PDR, sickness absence, and statutory training compliance.

2.4.2 Safe Staffing Levels

A new monthly report has been developed and piloted within the Division of Surgery, Cancer & Cardiovascular to support the Trust reporting requirements on safe staffing levels within our wards, inpatient, and outpatient areas. The report combines key people and establishment information, including vacancies, turnover and sickness, along with rostering data pertaining to shift requirements and cover as well as core harm-free care indicators and FFT ratings. This new report will be used by all Clinical Divisions for Month 11 reporting in March.

2.4.3 People Planning

Work to compile the 2-Year TDA workforce plan was completed during February through collaborative working with Finance, Divisional, and Corporate Directorate colleagues. Work also continues to create a people plan that supports the Trusts LTFM, OBC, and Clinical Strategy. The Trust continues to support the SaHF PMO and other SaHF working groups through attendance at workstream meetings and completion of specific data requests and analysis.

2.5. HEALTH & WELLBEING

2.5.1 Departure of Clinical Director

John Harrison, Clinical Director of Health and Wellbeing has resigned to take up the position of Chief Medical Officer for Devon and Cornwall Police, where he has decided to relocate with his wife. I have taken the opportunity to revise the structure given the exciting review of Occupational Health that we have completed (Appendix 1). The Trust intends to recruit an Associate Director of Health and Wellbeing who will lead and drive the service forward, and an OH Consultant 5 PAs per week who will be dedicated to the service.

2.5.2 Health and Wellbeing Strategy

The second meeting of the Trust Health and Wellbeing Committee met on 04 February 2014. A strategic approach to promoting health and wellbeing in the Trust has been agreed and the next step is to produce a Gant chart / time line for the programme in 2014 and subsequent years. The aim in 2014 is to build on existing initiatives, such as iMove, and to produce tangible examples of health and wellbeing initiatives to address the low scores achieved for health and wellbeing in the recent engagement survey.

2.5.3 Flu Vaccination

There has been a seismic shift in the expectations around healthcare worker flu vaccination. The Trust will be required to plan to achieve >75% of front line clinical staff and students in the 2014-15 flu season which is way above our achievement of 48%. This requirement is a challenge set to us by both the Secretary of State for Health in September 2013 but also from TDA. TDA have explicitly advised Steve McManus and Nicola Grinstead that the Trust is required to have a robust plan to achieve this target.

Lead Director – Jayne Mee, Director of People and Organisational Development

3. PERFORMANCE

3.1 Performance Summary

The Trust has sustained good performance in Quality Performance Indicators such as Mortality, Stroke Care and meeting the 95 per cent standards for VTE risk assessments. The Trust also continued to deliver the Referral to Treatment standards and continues to do so and each month in 2013/14 the Trust has met the Accident and Emergency 4 hour maximum waiting times standard. The Trust has implemented a range of initiatives to build capacity and resilience over the winter period to ensure that we continue to meet the 4 hour standard and that elective throughput is not affected by increased emergency demand.

In February zero cases of MRSA BSI occurred, however one case that was in arbitration from January 2014 has now been allocated to the Trust. The total number of ‘cases’ reported against the Trust is eleven year to date, four of the ten represent cases re-allocated to the Trust through the review process introduced this year.

The Trust had one mixed sex accommodation breach in February 2014. This was due to a delayed discharge resulting in a bed not being available for the patient within the six hour timeframe from an Intensive Care Unit step-down. A route cause analysis has been completed and lessons learnt will be cascaded throughout the organisation.

The Trust failed in January to meet the Cancer waiting times targets for 62 day first treatment standard with 21 patients having delayed treatment and also failed to meet the 62 day first treatment for screening

patients standard (cancer data is reported one month in arrears). Work continues with the Cancer Management team to track patient pathways to ensure that patients receive treatment within the target time. The Trust expects to achieve all 8 cancer standards from quarter 1 2014/15.

Lead Director – Steve McManus, Chief Operating Officer

4. FINANCE

The Trust has achieved a year to date surplus of £12.3m at the end of February 2014 (after adjusting for impairments and donated assets), an adverse variance against the plan of £1.2m. This is based on a deficit in month of £2.8m, which was adverse variance of £0.4m. CIPs are cumulatively behind plan by £3.3m. However, this has been offset by over-performance income on CCG and NHSE contracts. An impairment of assets of £117m for the devaluation of buildings has been included as a financing cost in the I&E Account.

The forecast outturn has been updated to reflect the Clinical Divisions' and Non Clinical Directorates' anticipated income and expenditure for the year. The Trust is still expecting to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets

Lead Director – Marcus Thorman, Chief Financial Officer

5. NWL BUSINESS

5.1 "Shaping a Healthier Future"

The Trust has been collaborating with its commissioners to clearly articulate the clinical design of the elements of Charing Cross Hospital, this is now encapsulated in:

- the ambulatory centre for surgery and medicine and
- complementary primary care and community services.

There has also been fine tuning on the clinical content of St Mary's and importantly, a clear vision for the future delivery of Private Patients. In the coming period, final discussion will be held to settle the expectations at Hammersmith Hospital

It is intended to have an outline business case broadly at a stage of 85% complete by the end of March. This will permit the NWL sector to evaluate the ICHT role in the wider NWL context, along with the other 26 business cases coming in from complementary organisations. It is the intention to bring the OBC to the Trust Board at its next public meeting in May 2014. This rescheduling from March 2014 has been a considered position agreed with our commissioners, to reflect the need to ensure total alignment of our respective thinking and positioning within the sector.

The Partnership Board for the future of the Central Middlesex Hospital, met recently and endorsed the Strategic Outline Case for the proposals to bring CMH back into financial balance; ICHT continues to be a contributor to that process with the creation of the orthopaedic centre proposed at the CMH. This case will be presented to the ICHT Board for it consideration and debate once released by the Partnership Board.

5.2 Whole Systems Integrated Care - Pioneer Status

During the preceding period the WSIC programme management team have held events to narrow down the 25 'expressions of interest' received from within the sector, to 11 viable early adopter programmes. ICHT is well represented in the plans and will work with partners across the sector to further develop outline plans between now and May 2014. An external review of the projects will follow before proceeding

to business case status by October 2014. Schemes include work with frail elderly with more than two co-morbidities, paediatrics and cancer.

There has also been activity within the seven day working initiative. NWL has been awarded 'early adopter status' by NHS England/NHS IQ, which means that NWL has a responsibility to progress seven day services at scale and pace, setting an example to other areas of the country; NHS IQ has set down six goals for early adopters to achieve within the next five years:

1. Be regarded as experts in delivering seven day services
2. Have demonstrated a range of approaches and models involving whole systems
3. Demonstrated scope to make rapid progress at scale and pace
4. Have overcome barriers to delivering coordinated care, testing radical options for delivering care differently
5. Have accelerated learning locally, regionally and nationally
6. Improved the robustness of the evidence base

Lead Director – Ian Garlington, Director of Strategy

6. RESEARCH

6.1 Clinical Research Network for North West London

For the 2014/15 financial year, the Trust will receive an allocation of £12.8m as host of the new NIHR North West London (NWL) Clinical Research Network (CRN). This allocation will be distributed to Trusts in NWL in order to grow the regional NIHR Portfolio of research studies, increase numbers of patients recruited into those studies, improve set-up times and delivery, and develop commercial clinical investment. The allocation also provides hosting and management costs for ICHNT, and for Clinical Specialty Leads.

The two senior posts of Clinical Director (Dr Robina Coker) and Chief Operating Officer (Joanne Holloway) have been recruited, and regular transition meetings are held via the Medical Directorate with the relevant Trust support departments. Detailed consideration is being given to the transition of existing CLRN workforce to a new structure, and relocation of staff to a new office space in Hammersmith Hospital. A new Executive Committee has been established and met for the first time on 21 February. The NWL CRN sits within the Medical Director's office and reports through there, with the CEO/Medical Director as Host Organization Accountable Officer.

Plans for ICHNT's distribution of its own delivery budget (i.e. internally by Division) will be ratified by the AHSC Research Committee in April.

Lead Director (ICHNT as Host Organization): CEO/Medical Director
Lead Director (ICHNT as Partner Organization): Director of Research, Imperial AHSC

6.2 NIHR Imperial Biomedical Research Centre (BRC)

As of 1 April 2014, two years of the current NIHR Imperial BRC programme will have passed, with three years remaining of the programme. It is essential to be able to demonstrate sufficient outcomes within this period and, as such, the next two years are crucial to delivery of BRC plans and to our re-application.

BRC Themes have all recently engaged in planning for 2014/15 and beyond, and to consider priorities. ICHNT has confirmed a budget envelope of £9.5m for BRC projects in 2014/15. On this basis, detailed plans were presented to the AHSC Research Committee on 11 March 2014, which enable the BRC to support existing Theme commitments, a number of new experimental medicine projects, collaborative work with other NIHR infrastructure, key core facilities such as the Tissue Bank and Imperial Clinical

Trials Unit, training schemes, and new resource for genomics sequencing, metabolic profiling, imaging, and biobanking.

A mid-term appraisal of BRC progress, by external reviewers, is planned for early autumn 2014 - this will inform both the remaining two and a half years of the programme, and our plans for re-application in 2016.

Lead Director – Professor Jonathan Weber, Director of Research

6.3 Divisional Research Structures

The post of Divisional Director of Research (DDoR) has been developed and a role description agreed. The role of the DDoR is to develop the quality and quantity of clinical research within each Division, in line with the over-arching strategic priorities set out by the AHSC Research Committee, and to ensure delivery of research against national and local performance benchmarks. In particular, DDoRs will be responsible for increasing awareness of, and improving performance against, NIHR metrics for initiating and delivering research.

A replacement Divisional Research Manager has been recruited (starting March 2014). Two Research Feasibility Officers have also been recruited (to start April / May 2014). An additional 8A Divisional Research Manager and the 8B Senior Research Manager post are to be recruited shortly.

Lead Directors: Professor Jonathan Weber, Director of Research
Shona Maxwell, Chief of Staff for the Office of the Medical Director

7. AHSC - REDESIGNATION UPDATE

The new designation period is to become live from 1st April 2014 for a period of five years.

7.1 AHSC Event 20th February 2014

The AHSC Directorate held an event at the Wolfson Centre, Hammersmith Campus, to showcase the AHSC's plans, achievements and on-going programmes to our stakeholders. In total 151 people attended and included a mixture of senior leaders from the AHSC and stakeholders from across both North West London and beyond. AHSC students, researchers and clinical academic leads also attended the event and showcased some of the AHSC's futuristic health innovations.

This was the first in a series and will be followed by further events for patients and the public later in the summer.

Lead Director – Professor David Taube, AHSC Director

8 COMMUNICATIONS

8.1 Stakeholder engagement

An important feature of the Trust's foundation trust application is listening to the views of our people, patients, the public and stakeholders. Stakeholder engagement activities during February/March 2014 have focused on the final stages and follow-up to the public consultation on the Trust's foundation trust application which closed on Monday 10 February.

Since the January Trust Board meeting, an open meeting was held with the 'tri borough' Healthwatch Central West London (30 January) and there was further attendance at the London Borough of Hounslow's health overview and scrutiny committee (4 February).

We are grateful to everyone who participated and let us have their views on the Trust's proposals for becoming a foundation trust including some 135 attendees at public/staff meetings and nearly 550 responses. We have been carefully reviewing and considering all the feedback that has been received. The findings and our recommended responses have been submitted to the Trust Board for its consideration and will be reflected in our final application for foundation trust status. A summary of the results of the consultation and our response is scheduled to be published in April.

Further contact meetings are due to take place in March with councillors representing residents in the boroughs of Hammersmith & Fulham, and Westminster.

8.2 Developing a communications strategy

Instinctif Partners (formerly College Hill) has been commissioned to undertake a small piece of perceptions research with key external stakeholders as a follow up to a larger piece of stakeholder research carried out in 2012. Brief 'stock takes' of four key communications functions – digital communications, media and stakeholder relations, marketing (public, patient and commissioner engagement) and internal communications (staff engagement) – have also been kicked off. The headline findings from all of these initiatives, and how they are helping to shape an emerging communications strategy, will be shared with the Trust board in April.

Lead Director – Michelle Dixon, Director of Communications

9 IMPERIAL COLLEGE HEALTHCARE CHARITY BUSINESS

9.1 Grants

The charity has approved grants totalling £240,220 to support socially excluded groups or individuals. There are three projects in which community organisations and charities will work alongside the Trust to improve the health of hard to reach communities in London. This is the first time that the charity has had such a programme. From 18 Expressions of Interest (the first stage of application), seven full applications were submitted to the tune of £744,149. The successful projects involve improving the skills of Trust staff to understand the needs of homeless patients, improving the levels of engagement of homeless persons with the Trust's services and addressing the needs of patients who have experienced female genital mutilation.

The next round of research fellowships opened on 17 March. In addition to the two usual clinical research fellowships awarded, funds will be available this time, to encourage nurses and allied health professionals in particular to apply.

9.2 Communications

The charity is working alongside the charity COSMIC (Children of St Mary's Intensive Care) on joint fundraising and communications messages to raise £900,000 towards the proposed redevelopment of the Paediatric Intensive Care Unit.

Following on from a survey in 2013, the current charity awareness survey will ascertain how much progress has been made in building its profile and understanding. In addition to this, the charity is increasing its visible presence across Trust sites with more poster and leaflet sites.

9.3 Fundraising

Key charity staff and trustees have now met all non-executive directors of the Trust to discuss how they can support the efforts of the charity in the delivery of its five year fundraising strategy.

As part of its Major Trauma Centre Appeal for £1m, the charity has secured funding from local councils in North West London for its Serious Youth Violence project. This project will provide youth workers in the major trauma centre at St Mary's to engage with young people who are being treated for serious injuries sustained through violence. Its intention is to support them in turning around their lives.

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public

For information

Report Title: Director of Nursing's Report
Report History: Regular report
To be presented by: Janice Sigsworth, Director of Nursing
Executive Summary: The attached paper is a consolidated report covering the following areas: • Quality and Safety • Patient Experience • Other updates for information
Key Issues for discussion: Please refer to the attached paper which summarises the key issues for discussion.
Legal implications or Review Needed: a. No
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: N/a
Recommendations and Actions Required: To note the updates for information

1. QUALITY AND SAFETY

1.1. Safe Nursing Staffing

The Trust Board received a detailed update on safe nurse staffing at its meeting on 29 January 2014, in light of the publication by the national quality board on staffing. The Trust is currently undertaking a number of actions to meet the expectations outlined in the document and these have been amalgamated into a work plan. Key actions include displaying nurse staffing levels in each ward area and introducing headboards above each bed which outline the named consultant and nurse for each patient. Examples of these boards can be seen below:

Nurse staffing levels board

I-Staff

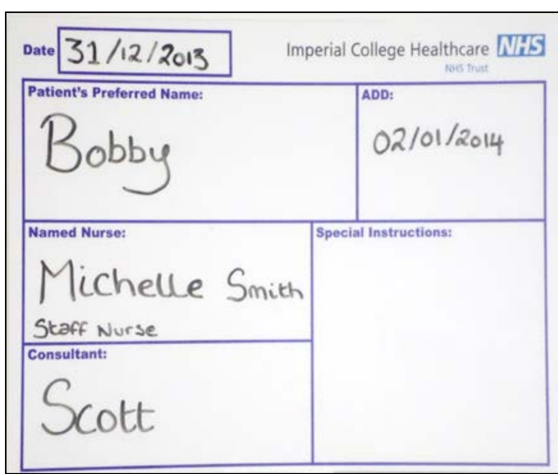
Imperial College Healthcare NHS

Date:

	Staff Required	On Duty
Day	6/2	6/2
Night	4/2	4/2

Required – Staffing levels that are required in line with number and dependency of patients in ward

Patient headboard



In addition, Imperial have been invited to assist in developing national technical guidance to supplement the safe nurse staffing publication. The technical guidance will provide clarity about what information should be published in monthly board reports on nurse staffing. It is anticipated that the guidance will be presented at a national workshop on 28 March 2014 hosted by NHS England & NHS Employers.

A paper summarising the Trust's nurse staffing establishments and its current position against the expectations, will be taken to Management Board (Quality), the Quality Committee and the Trust Board in the coming months, no later than June 2014.

1.2. Back to the Floor – Nights

The Back to the Floor Friday initiative, where senior nurses above sister level, return, in uniform, to clinical practice every Friday, has been extended to included evenings and nights. During January and February senior nurses have spent over 200 hours out in their clinical areas between the hours of 3pm and 06.00am. In some cases they have been accompanied by their heads of operational services.

This programme of activity has provided a valuable insight into out of hours care. In general the feedback has been very positive. Staff were welcoming and friendly and felt the visits to be very useful. Lights were off at reasonable times and noise levels were low. Both the divisions of surgery and medicine highlighted issues with drug cupboards not being locked. Going forward, work will be undertaken with staff out of hours to focus on the safe storage of medicines. The division of medicine also found a problem with the availability of out of hour's snacks for patients which they are working with ISS to resolve.

Divisions will continue to develop this programme of activity to include weekends and Bank holidays to provide themselves assurance that care is consistent across 24 hours

1.3. Nursing revalidation

The Nursing and Midwifery Council (NMC) has launched a 12 week statutory formal public consultation on revalidation and the Code, the document that sets out the expected standards of behaviour, ethics and professional expectations of registered nurses and midwives.
Revalidation is a process where registered nurses and midwives will demonstrate that they remain fit to practice and adhere to the professional standards set out in the NMC's Code. Nurses and midwives will be expected to revalidate every three years at the point of renewing their registration. The structure and the content of the code of professional conduct for nurses and midwives will be reviewed and the consultation will assess whether or not the Code should be used as the basis for the principles and assessment of revalidation. An internal consultation on the principles and methods of revalidation was launched by the deputy director of nursing in February. The first part of the consultation will complete at the end of March and the national consultation will conclude sometime in June.

1.4. Update on the Trust's quality impact assessments (QIA) for cost improvement programmes (CIP)

As part of the scheduled quarterly CIP QIA clinical review meetings, the Medical Director and Director of Nursing met with colleagues from all corporate areas and divisions in February and March. CIP Schemes for 2013/14 were discussed and there was no evidence of any adverse impact on quality for the schemes which have been implemented during the year. There was brief discussion about schemes for 2014/15 for which the QIAs were still being developed and these will be discussed in further detail with all areas before the end of March.

The Quality Committee will receive a detailed annual summary about QIAs for schemes in 2013/14 at its meeting in May and a summary will be presented to Trust Board.

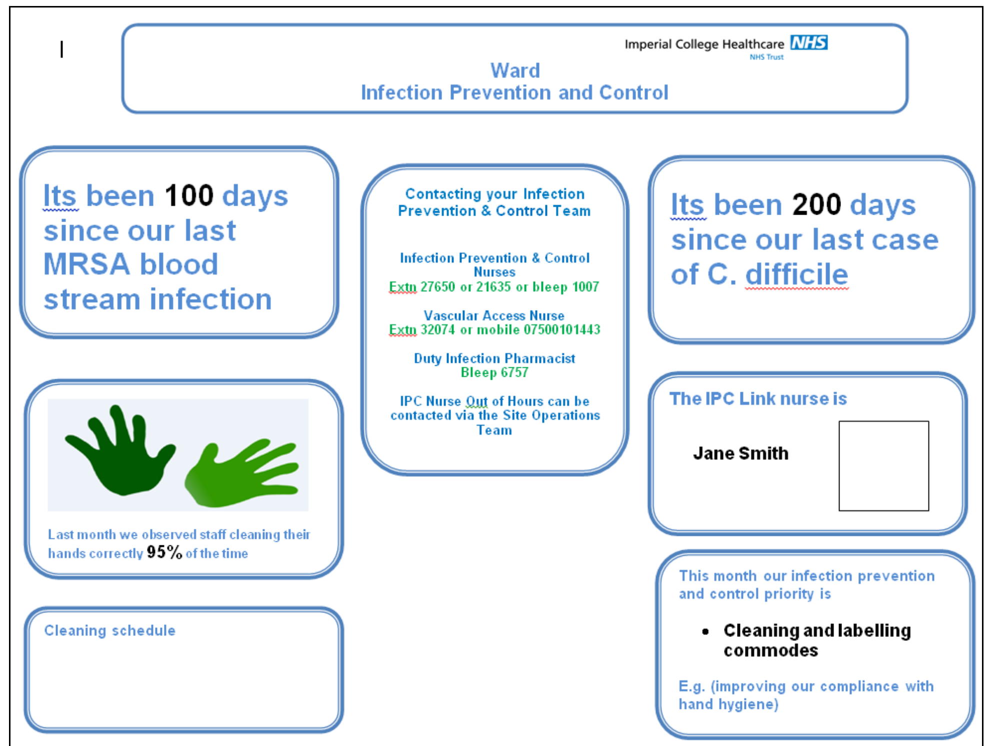
2. PATIENT EXPERIENCE

2.1. Cancer patient experience

An in-depth discussion on cancer patient experience took place at the Quality committee in February and Sir Anthony-Newman Taylor will report further on this within his update of the meeting. The 100 day event took place on 14th February 2014 and was successful with a large attendance. The next event will be on 27th June 2014.

2.2. Patient communication boards

Information boards have been implemented across clinical areas within the Trust to communicate with patients about infection prevention and control performance within ward areas. An example of the board can be found on the following page.



Going forward, further information to include; the number of days since the last pressure ulcer and fall, will also be included. The current patient experience information boards will also be revised to include friends and family performance.

2.3. Patient Story

Please refer to Appendix A for the patient story

3. EXTERNAL VISITS

3.1 Healthcare Assistants visit to Parliament

The Trust was invited to attend an event at Parliament on 28th January 2014 in recognition of the value and contribution of Health Care Assistants (HCAs) in the NHS. HCAs working within the Trust were nominated by their Divisions in acknowledgement of their contribution to their department. These were; Valerie McLennon, from the Stroke Unit at Charing Cross Hospital and Jodie Sudds from the Paediatric Outpatients Department, at the St. Mary's site. Joyce Williams – Senior Nurse, for Education Learning and Development from the Nursing Directorate was also present.

The attendees had the opportunity to engage with speakers; Health Secretary Jeremy Hunt, MP, Camilla Cavendish, journalist and author of The Cavendish Review – (the review into the role of Healthcare Support Workers in the NHS) and Peter Carter – Chief Executive & General Secretary of the Royal College of Nursing (RCN).

4. OTHER ITEMS FOR INFORMATION

4.1. Darzi fellowship 2014/15

The Trust has been awarded £30,000 to host a 'Darzi' fellow during 2014/15. The fellow will work on a project focusing on intentional regular nursing rounding to improve the uptake and patient experience.

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public

For information

Report Title: Medical Director's Office Report
Report History: Regular report
To be presented by: Professor Chris Harrison, Medical Director
Executive Summary: The attached paper is a consolidated report covering the following areas; 1. Safety & Effectiveness 2. Education
Key Issues for discussion: Please refer to the attached paper which summarises the key issues for discussion
Legal implications or Review Needed: a. No
Link to the Trust's Key Objectives: *Please identify which and how* 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients. 2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners. 3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves. 4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: NA
Recommendations and Actions Required: NA

1. Quality – Safety & Effectiveness

The corporate safety and effectiveness team have transferred to the management of the Office of the Medical Director from the Director of Governance and Assurance (February 2014). A full review of the resource, function and reporting is underway to ensure that the team are fully integrated with clear role definition.

1.1 Safety & Effectiveness Board

The Safety & Effectiveness Board continues to meet monthly to deliver 2 of the quality goals in the strategy. It is chaired by the Medical Director.

Actions and key work-streams include the following:

- Mortality alert investigation process now in place with monthly outcome reporting
- Mortality reporting and review improvement plan in development
- Upgraded incident reporting system due to go live in April 2014
- Safety and effectiveness reporting and processes review underway
- Safety improvement programme being developed which will be presented to Management Board in April 2014
- Serious incident policy and process under review
- Investment case for expansion of the clinical audit and effectiveness team submitted to the investment committee in March 2014

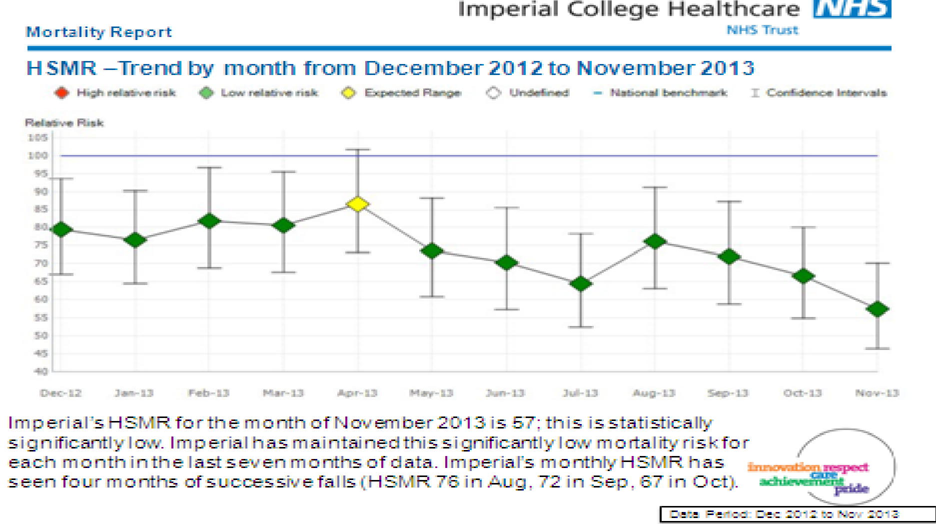
1.2 Mortality reporting

Mortality is one of the measures used to monitor how safe and effective the healthcare we deliver is.

The Trust's mortality report for month 8 is attached in **appendix A**. The report describes mortality using Dr Foster methodology which includes Hospital standardized mortality ratios (HSMR) and Summary hospital mortality indicators (SHMI). These measure mortality in hospital and post discharge and give an overall indication of how safe our care is.

In summary, both mortality rates remain consistently within the top ten best performing when compared nationally.

The Trust monthly HSMR is showing a downward trend with improvement between April to November 2013 when the lowest rate of the year was recorded (57) - see chart below.



The annual cumulative rate is currently recorded at 74.07. When the mortality is considered at Trust site level all sites have a lower than expected relative mortality risk.

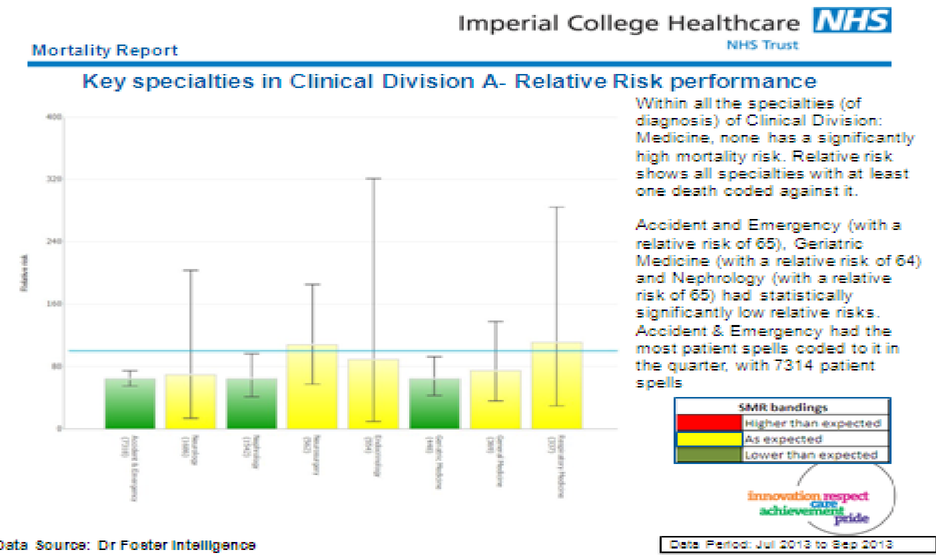
The latest SHMI rate covers Q1 2013/14 and is 74.1. The rate has improved from the previous quarter when it was 86.1.

In both data sets the national benchmark is set at 100 with lower figures indicating better performance.

Mortality reporting has now commenced at specialty level to provide the divisions with an overview of performance. This will supplement the alerting process already in place and will provide more detailed analysis than aggregate data can give. This will be undertaken on a quarterly basis.

Assurance will be provided to the Trust board by exception reporting from Quarter 1 in 2014/15.

An example of the specialty data is provided in the chart below. This is the high level Division of Medicine data. The data is compared to peers in the more detailed analysis.



A guide to mortality reporting has been developed to improve understanding and allow our teams to use the data in their local networks. The guide, which has been circulated widely, is now on the intranet (**appendix B**).

1.3 Medical Director's Incident Review Panel

The weekly incident review panel continues to review all moderate and above incidents that occur within the Trust. This allows the Medical Director to have real time oversight of issues as they arise.

Actions arising from these meetings since the last Trust Board include:

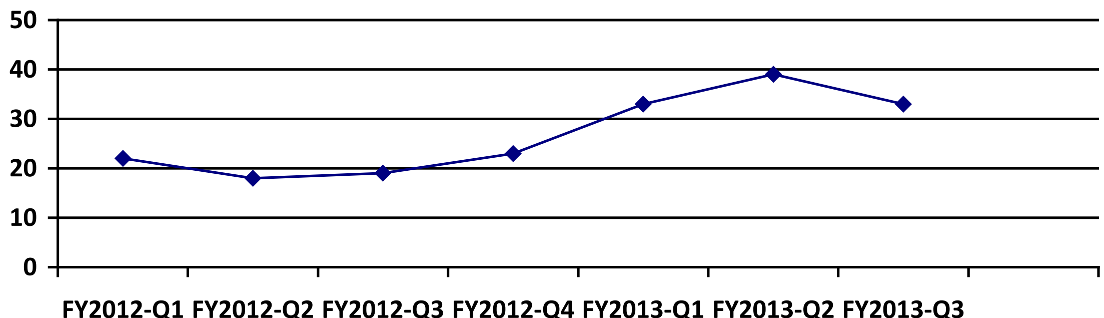
- Standardisation of the role of Operating Department Practitioners in medication administration implemented
- Look back exercise commenced to review accuracy of electronic discharge communications in a specific ward following identification of an error
- Review of availability of Gallium and the process for requesting investigation underway

Where a potential cluster of incidents at moderate or above level have occurred an internal review including benchmark comparison is undertaken. This is to ensure there are no concerns which require further intervention. No new reviews have been commissioned since the last board report.

1.4 Serious Incident Reporting

The rate of identification of externally reportable serious incidents increased after the Medical Director's incident review panel commenced in 2013/14. The table below shows the trend in reporting which is being monitored through the appropriate governance structure.

Number SI's by Quarter ICHT



SI data is not available nationally so benchmarking is not possible. Using National Reporting and Learning System to benchmark performance of incidents reported in the categories of “death” or “severe harm” places ICHT as either within or better than the peer group (per 100 bed days).

The top five themes from reported SIs in 2013/14 are:

- Pressure ulcers (Grade 3 and above)
- Maternity services
- Delayed diagnosis
- Unexpected death
- Sub-optimal care of the deteriorating patient

These five themes will be the key priority areas of our safety improvement programme for 2014/15. This will build on the work already underway e.g. the pressure ulcer improvement strategy which the Director of Nursing is implementing.

An action plan is implemented following each investigated serious incident. The following are recent examples of actions taken to prevent issues re-occurring and improve awareness:

- Escalation process for emergency theatre access modified, with escalation now direct to the consultant
- Step down process for Major Trauma Ward revised
- New process implemented for tracking direct access referrals to diagnostic services in primary care
- Seven registrar level doctors appointed into safety champion roles to support feedback to our junior doctors and engage them in improvement projects
- Monthly “lessons learned” forums for junior doctors now in place

The actions from our SI investigations will be audited as part of the clinical audit plan for 2014/15 to ensure compliance.

A never event related to the misplacement of a nasogastric tube has been reported in March 2014. The incident is being investigated however appropriate immediate action was taken, the patient has recovered and been discharged home.

2. Medical Education

An external review of medical education has been completed by Dr Fiona Moss, previous Director of Medical and Dental Education Commissioning for London. A detailed report will be submitted and an action plan implemented by the Medical Director. Work has already commenced to improve the experience of our trainees including:

- A bullying and undermining action project has been convened with support from Health Education England (Dr John Launer). Interventions undertaken include a statement of non-acceptance and commitment to take action from the Medical Director to trainees and consultants, a dignity at work trainee guide and a dedicated session at induction. Initial evaluation of this project is expected in March 2014 and results will be reported to the next board
- Trust-wide trainee forums with the Medical Director commenced in December 2013 with follow up actions with the Divisions
- A detailed educational transformation programme is being developed
- An engagement event is planned for April 2014 to ensure the vision for improvement is consulted on and our people can be involved
- A restructure of the team providing leadership and support to medical education will be undertaken during quarter one of 2014/15

The transformation programme will be presented to the Trust Board at a future meeting.

In January, the Trust was required to submit 2 action plans regarding education and training at ICHT. These action plans are now led from the Office of the Medical Director and are as follows:

2.1 GEMV Action Plan

The Governance and Education Monitoring visit to ICHT took place on 7th November 2013 and an action plan was submitted in February 2014.

Overall, feedback was mixed on all sites with variable performance in student surveys across specialties. Specific concerns were highlighted which were as follows:

- recognition of the time required for undergraduate teaching in job planning
- lack of engagement at CXH from consultants
- loss of teaching rooms
- placement of O&G students at QCCH
- dermatology teaching
- investment in teaching fellows

It was recognised that progress had been made in the following area:

- oncology teaching as evidenced by positive feedback

Actions are in place to address all areas of concern including:

- teaching fellow establishment increased to benchmark number and recruitment completed

- review of consultant teaching commitments and associated programmed activity time in job plans split by specialty is underway
- review of the roles needed and appropriate allocation of time needed to deliver the job description nearing completion
- educational income and activity analysis work has commenced
- cost collection exercise underway to clarify the time spent with trainees in direct clinical care commenced as part of national exercise teaching. This will help to determine the principles of how this should be set in job planning guidance.

2.2 GMC National Trainee Survey Update Request

Following the 2013 General Medical Council (GMC) National Trainee Survey, the Trust was required to submit an action plan detailing how we would investigate and improve any red outliers. An update on progress against these outliers was submitted in March 2014.

Areas of concern highlighted by the survey include:

- bullying and undermining of trainees
- access to daytime/supervised experience
- rotas and workload
- access to educational resources

Resulting actions include:

- increased teaching sessions and regular scheduled meetings with educational supervisors
- review of local induction
- review of workload in specific specialties

Imperial College Healthcare NHS
NHS Trust

Report Title: Quality Committee Chairman's Report

To be presented by: Prof Sir Anthony Newman Taylor, Chairman Quality Committee

1. Introduction

The Quality Committee met on 6 March 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

- Timetabled closure of Hammersmith EU and Central Middlesex which will be discussed at a future Trust Board meeting.
- The last 100 day event had been an inspiring event which showcased redesigned pathways having a positive improvement on patient experience. The next event was on 27 June and all NEDs were invited to attend and which would be an excellent opportunity for them to see the commitment, compassion and dedication of our staff.

3. Key risks discussed

The following Key risks were discussed:

- Agreement had been reached to replace the current cardiol/ICU 1 on site/2 on call overnight junior doctor system with one cardiac registrar supplemented by anaesthetic/interventionist junior cover on site.
- The impact of the divisional restructure was being worked through and this risk would be able to come off the register.
- The committee was advised that the issue of chiller units for MRI scanners had been dealt with on a short term basis but needed a permanent solution which was being sought.
- A new consultant had been recruited for the labour ward to meet the recommended benchmark for the number of births.
- Obstetric-trained anaesthetists would be on call to provide advice to non-obstetric trained anaesthetists.
- Renal transport had been stabilised and a fourth permanent post for a consultant surgeon was being developed.
- At the Hammersmith EU there had been a proactive approach to recruiting middle grade cover and plans to help cover overnight had been mitigated.

4. Key decisions taken

The following key decisions were made:

- The possibility of the TDA Director and Mike Anderson being invited to attend a

future Quality Committee meeting
- After discussion it was decided that the indicators for Quality Accounts would be presented for agreement at the Management Board.
- Consideration would be given to arranging a general patients group to be representatives on the new Quality Boards.

5. Agreed Key Actions

The committee agreed actions in relation to:
- The issue relating to the Ascribe prescribing and XP no longer being supported by Microsoft would be highlighted to the Audit, Risk & Governance Committee.
- A review of winter pressures would come to the June meeting.

6. Future Business

The Committee will be focusing on the following areas in the next three months:
- New infection risk from a multidrug–resistant infection
- Outline business case for a larger vascular access team
- A review of winter pressures organisational learning and early preparations for Q3/4 2014/15.
- A Deep dive would take place into elective surgery cancellations

7. Recommendation

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

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public
For information

Report Title: Infection Prevention Summary

Report History: Regular Trust Board Report

To be presented by: Professor Christopher Harrison

Executive Summary: This report includes the Trust's monthly mandatory reports of HCAI for January and February 2014, key activity and infection prevention and control issues.

Meticillin resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)
In January a Trust attributable case was reported from a patient who had undergone emergency trauma surgery. The source of this bacteraemia was the surgical wound following discharge from acute care. Actions included a review of the process for following up patients and their results in specialist outpatient dressing clinics.

There were no MRSA cases reported in February. This brings the total number of 'cases' reported against the Trust to eleven for the year to date, five of the eleven represent cases re-allocated to the Trust through the review process introduced this year.

C. difficile
For 2013/14, the annual ceiling for the Trust is 65 cases of C*. difficile* infection.
There were 4 Trust attributable cases in January.
There were no Trust attributable cases in February.
Year to date 51 Trust attributable cases have been reported to the PHE.

Carbapenemase producing gram negative organisms (CPGNB)
Guidance for acute Trusts on managing patients identified with these drug resistant organisms was issued by PHE in February 2013. The importance of this issue has been highlighted by both a patient safety alert issued to Trusts by NHS England and a letter to CEOs from PHE and Sir Bruce Keogh The emphasis is on risk assessment and isolation of patients repatriated to the Trust, transferred from abroad or from other healthcare centres. A draft plan for management of these organisms was reviewed with PHE colleagues including our local CCDC who visited the Trust in late February.

A detailed monthly Infection Prevention and Control report is attached as an appendix.

Key Issues for discussion:
- 'Trust attributed' MRSA BSI cases year to date
- C.*difficile* infections year to date, the reduction in rates and preventive actions taking place.
- Carbapenemase producing gram negative organisms (CPGNB)

Legal implications or Review Needed: N/A

Link to the Trust's Key Objectives:
1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.

3. With our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities the Trust serves.
4. With our partners in the Academic Health Science Centre (AHSC) and leveraging the wider catchment population afforded by the Academic Health Science Network (AHSN), innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: Management of risks described

Recommendations and Actions Required: Continued activity and vigilance, ensuring infection prevention is a core aspect of patient safety and quality of care

Imperial College Healthcare
NHS Trust

March 2014
(February 2014 data)

Key Indicators February 2014

		Trust		Divisions				
	Threshold	**Trust**		**1**	**2**	**3**	**4**	**PPs**
MRSA BSI (>48hrs)	0	0		0	0	0	0	0
MSSA BSI (>48hrs)	N/A	3		1	2	0	0	0
E.coli BSI (>48hrs)	N/A	10		4	5	1	0	0
C. difficile (>72hrs)	6	0		0	0	0	0	0

Year to Date 2013/14	YTD 2013/14				Divisions									
	Threshold		Cases											
	Year	**YTD**	**Trust**		**1**		**2**		**3**		**4**		**PPs**	
MRSA BSI (>48hrs)	0	0	11		5		6		0		0		0	
MSSA BSI (>48hrs)	N/A	N/A	33		11		17		5		0		0	
E.coli BSI (>48hrs)	N/A	N/A	66		21		31		12		0		2	
C. difficile (>72hrs)	65	60	51		30		20		0		0		1	

Key:
Division 1 = Medicine
Division 2 = Surgery, Cancer and Cardiovascular
Division 3 = Women's and Children's
Division 4 = Investigative sciences and clinical support
N/A = Not applicable

= Above threshold value
= Below threshold value
= Equal to threshold value

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

There is a national expectation of zero MRSA blood stream infections for all Trusts for 2013/14. In January there was one Trust attributable case and one non-trust attributable case reported. The source of this bacteraemia was the surgical wound following discharge from acute care. There were no MRSA blood stream infections reported in February.

Year to date the 'cases' reported against the Trust is 11. Five of these represent cases re-allocated to the Trust through the post infection review process (PIR) introduced this year.

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

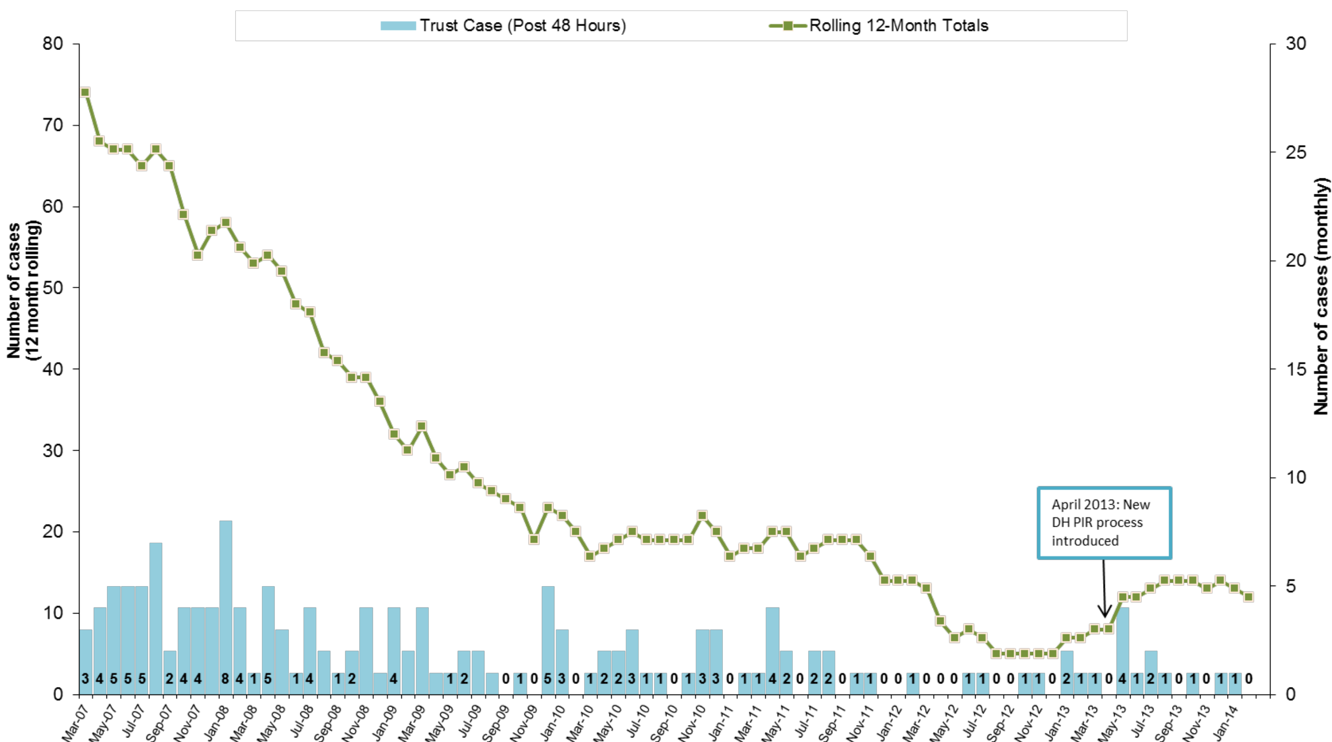
Actions from the cases detailed above:

Actions from the January Trust attributable case include a review of the process for following up patients and their results in specialist outpatient dressing clinics.

This now brings the total number of cases reported against the Trust to eleven for the year to date.

During 2013/14 the Infection Prevention and Control team have been working closely with the Trust Development Authority (TDA). This collaboration is important in ensuring that the TDA is assured that the Trust is undertaking all steps to minimise the risk of HCAIs to all our patients. In light of the Trusts position for MRSA blood stream infection, the TDA also requested an action plan based on local learning and detailed review of all the cases of MRSA BSIs. This was sent at the end of January 2014. The team have been working with Mr Victor Oladele, the Head of Infection Control for the TDA (London) and to date he has visited two of our main hospital sites.

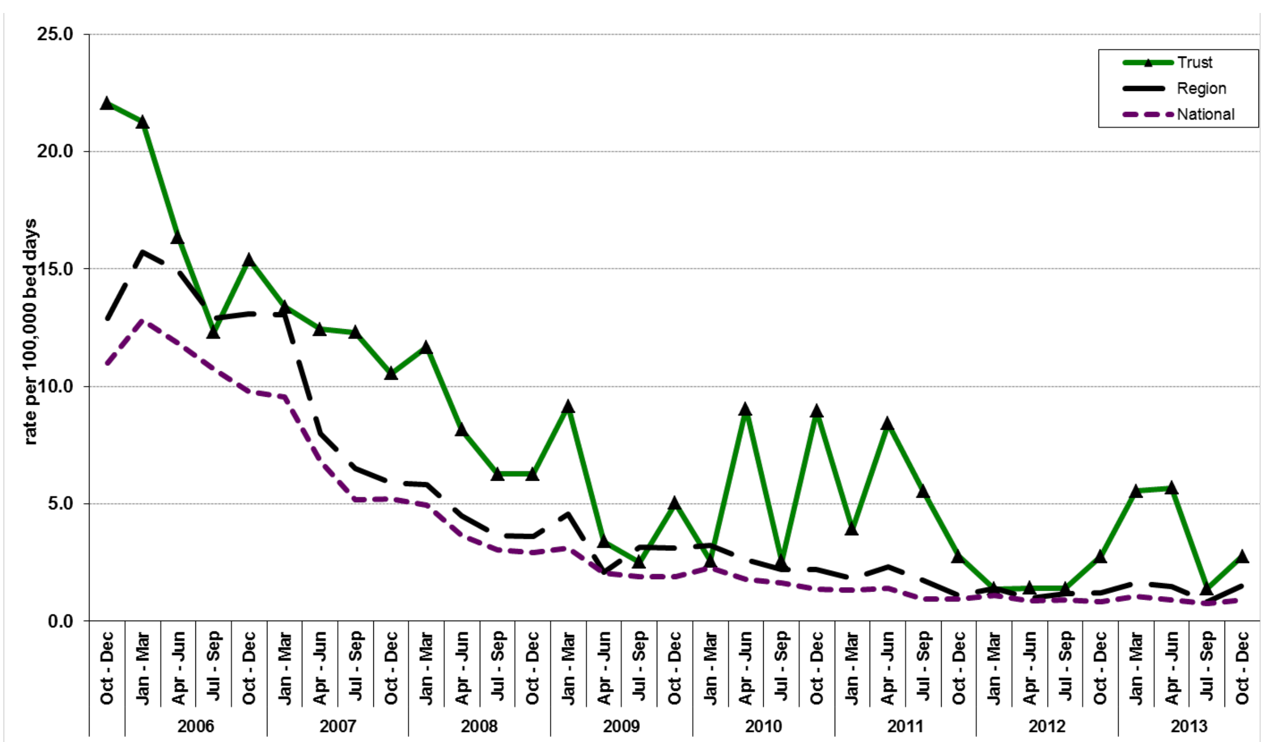
Figure 1: Rolling 12-month and monthly number of Trust attributed MRSA BSI cases



1.2 Benchmarking Trust-attributable MRSA BSI rates

Provisional data presented by Public Health England (PHE) in Figure 2 shows that the Trust had a quarterly Trust apportioned rate of 2.7 per 100,000 bed compared to a regional rate of 1.5 per 100,000 bed days and national rate of 0.9 per 100,000 bed days.

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



Source: PHE Trust reports March 2014

2. *C. difficile* infections

For 2013/14, the Department of Health annual ceiling for the Trust is 65 cases of *C. difficile* infection.
In January there were four Trust attributable cases out of 11 cases reported to PHE.
In February there were no Trust attributable cases out of eight reported to PHE.
Year to date 51 Trust attributable cases have been reported to the PHE.

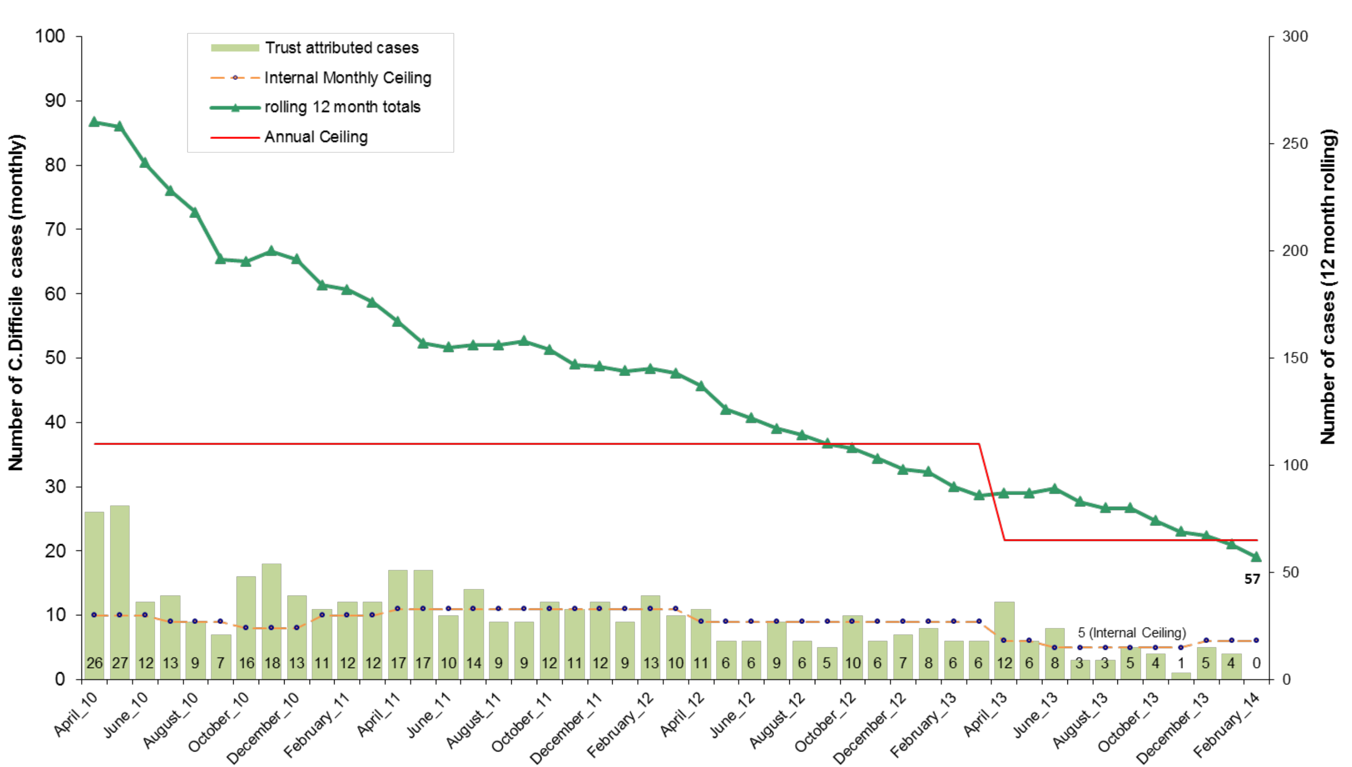
Of the four Trust-attributable cases in January, two occurred in patients aged over 65 with none of these patients being over 75. Isolation in an appropriate side room with en-suite facilities within two hours of diarrhoea commencing occurred in one of the January cases. In the three cases that were not isolated within two hours, one did not require isolation, one was not isolated within the time frame due to requiring level 2 care and the third was delayed due to availability of a side room. All four had unavoidable exposure to antibiotics and all of these were in line with policy or approved by infection clinical team.

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

A Trust taskforce meets weekly to address healthcare associated infections (HCAI) with specific reference to MRSA blood stream infection and *C. difficile*. A standard operating procedure has been written and disseminated which sets out the requirements for isolating patients with suspected or confirmed infectious diarrhoea within two hours of onset of diarrhoea. In addition to the detailed clinical review of each case, the time taken to isolate is being monitored. A monthly MDT review of all cases is undertaken in which risk factors for each case are collated and learning shared with primary care colleagues.

Findings of this ongoing review include: 83% (41/51) of our patients with *C. difficile* are aged over 65, 74% received a proton pump inhibitor (26% initiated in hospital),82% had exposure to antibiotics, most of which were within policy or according to infection specialist advice, 11/51 (21%) had had a hospital stay longer than one month at the time of the diagnosis of *C. difficile*, and of the 40 who had a length of stay shorter than one month, 22/40 (55%) had had an admission to the Trust within the previous three months. There is great diversity of ribotyping indicating minimal patient to patient transmission, in common with recent published literature. These findings are shared monthly with the Commissioning Quality Group. It has been requested that there be a nominated GP to work with the Trust regarding reducing unnecessary antibiotic and PPI exposure.

Figure 3: Trust- attributable *C.difficile* Infections and 12 month rolling totals, April 2010 - February 2014



2.2 Benchmarking Trust-attributable *C. difficile* rates

Provisional data presented by Public Health England in figure 4 shows a Trust quarterly rate of 13.8 per 100,000 bed days compared to a regional rate of 10.0 per 100,000 bed days and national rate of 11.6 per 100,000 bed days.

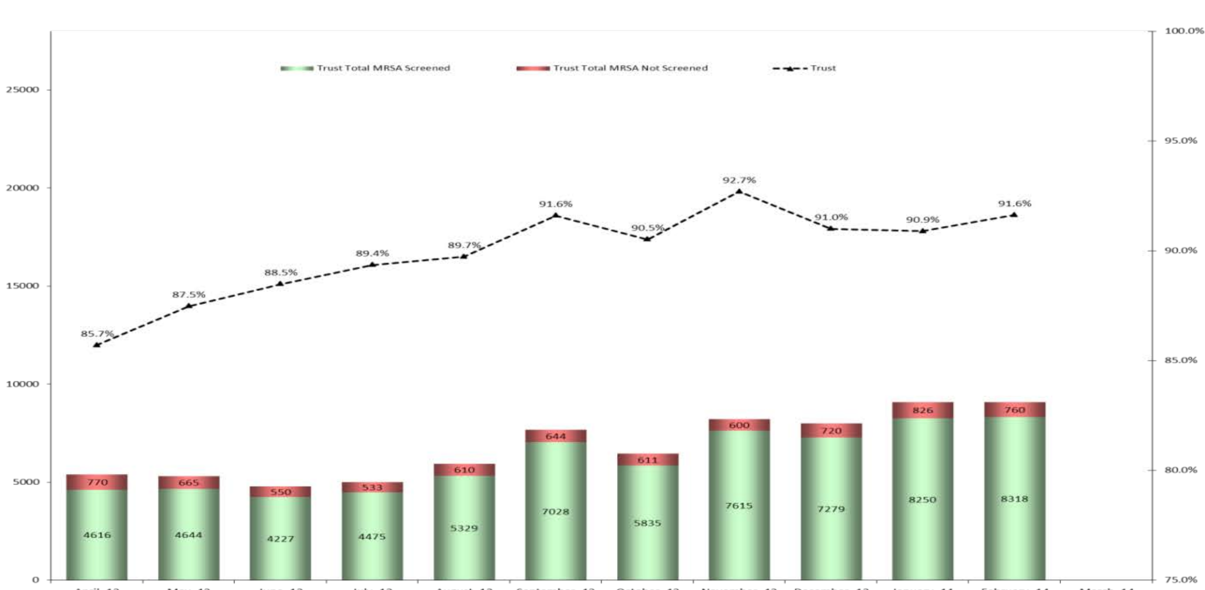
Figure 4: Trend in Trust-attributable CDI rate compared to national & regional rate (in 100,000 bed days)

Source: PHE Trust reports March 2014

3. MRSA Screening

The Trust remains compliant with the Department of Health population MRSA screening requirements. Analysis at an individual patient level identified 9078 patients admitted in February 2014 who required screening, of which 8318 (91.6 percent) were screened.

Figure 5: MRSA screening compliance rate from April 2013 to Feb 2014



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

There is no threshold for this indicator at present. In January 2014 there were three cases of MSSA BSI reported to Public Health England (PHE), of which none were Trust attributable (i.e. post 48 hours of admission), in February nine cases were reported of which three was Trust attributable.

In January, there were no cases of MSSA.

In February there were three cases, one related to a surgical site infection in a patient following recent cardiothoracic surgery, one in a patient with a complex skin and soft tissue infection in the foot which was vulnerable to infection because of peripheral vascular disease and diabetes, and one related to skin and soft tissue infection associated with an arterial catheter in an adult ICU.

Figure 6a: Monthly MSSA BSI cases

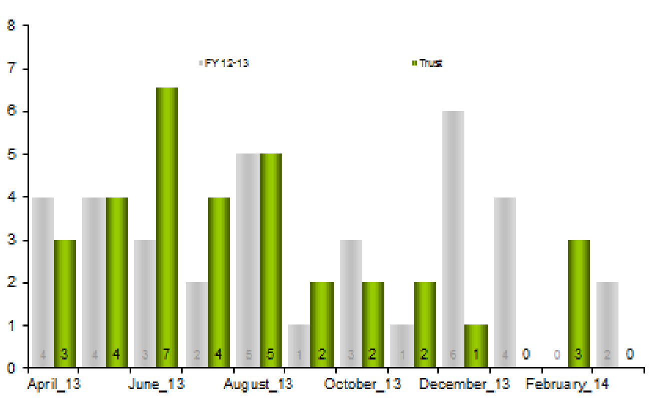
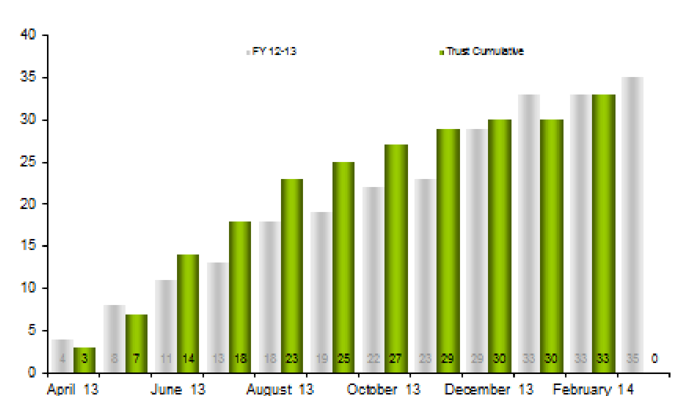


Figure 6b: Cumulative MSSA BSI cases



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

There is no threshold for this indicator at present. The steep rise in *E.coli* BSIs nationally is a cause of significant concern. In January 2014 there were 23 cases reported to the Public Health England (PHE), of which five were Trust attributable. In February, 32 cases were reported to the PHE including ten Trust attributable cases.

In January there were five cases, four of which were associated with urinary tract infections (one in a renal transplant patient and one in a patient with a renal calculus), and the remaining one related to an abdominal source of infection.

In February there were ten cases, three of which were related to urinary tract infections (one in a renal transplant patient, one urinary catheter associated). One of the patients from January relapsed with a repeat *E. coli* bacteraemia, which although in January was related to a UTI, in February this was now associated with an orthopaedic prosthesis which had been in place for years. Two patients had bacteraemia related to metastatic cancer affecting the biliary tract; one had a pneumonia following oesophagectomy, one had had an appendicectomy two days prior to bacteraemia, and one was septic following retention of products of conception post C. section. In one remaining case, the source was not clearly identified but was managed as a urinary source.

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

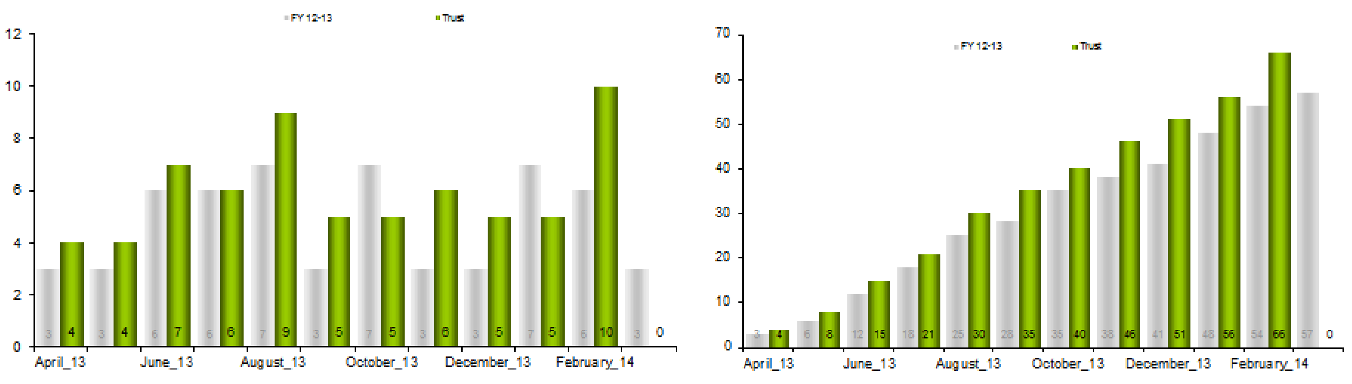
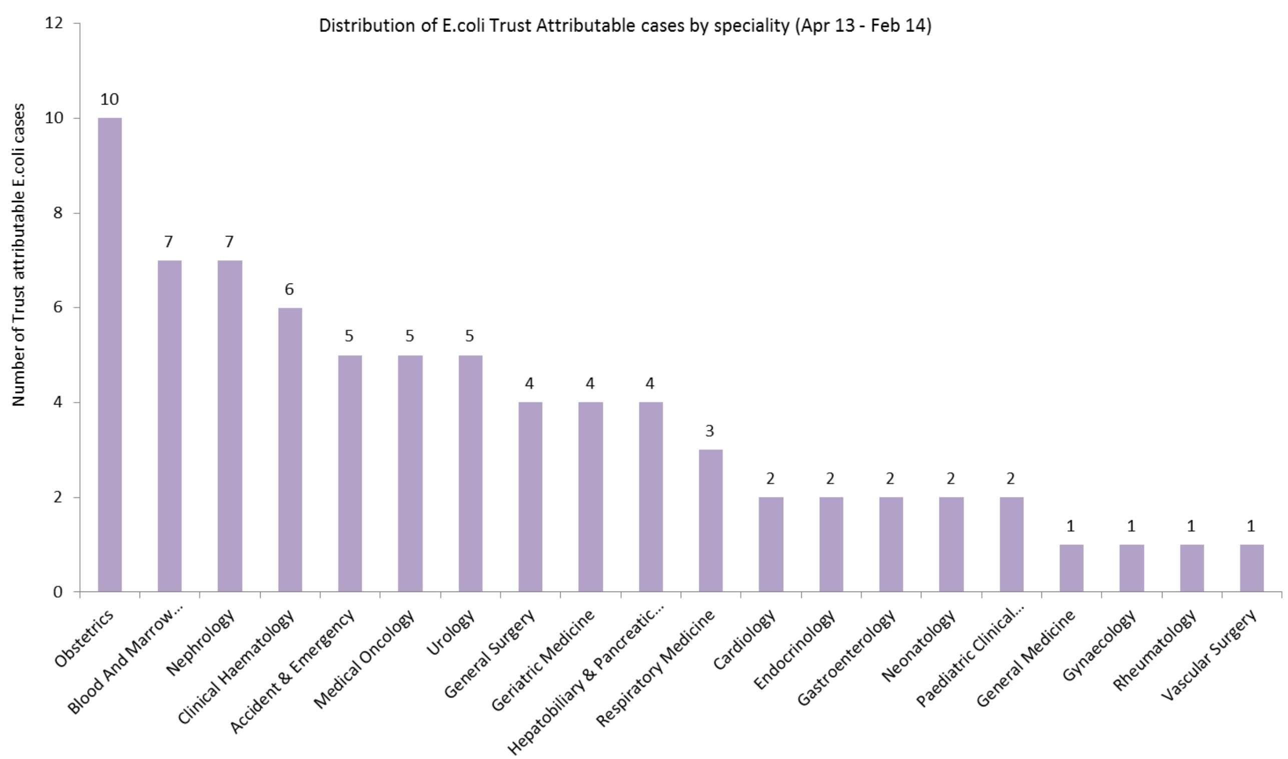


Figure 8a: Distribution of post 48 hour *E. coli* BSI cases by speciality



Antibiotic resistance in *E coli* bacteraemias for both hospital and community associated bacteraemias (pre and post 48 hours) is summarised in the figure below.

Figure 8b: *E.coli* BSI sensitivity analyses (April to October 2013)

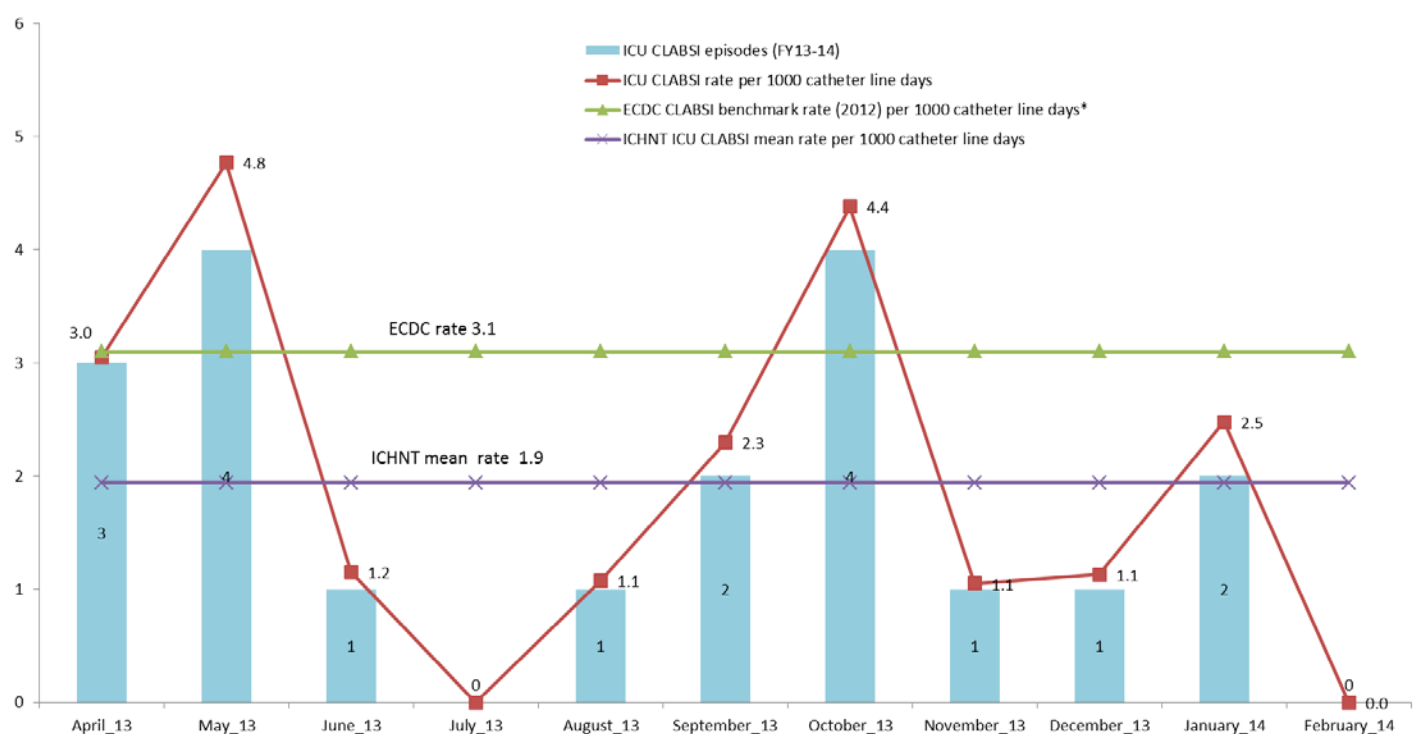
% E.coli BSI isolates resistant to antibiotics tested April- Oct 2013

The overall resistance rate to amoxicillin, co-amoxiclav, trimethoprim and ciprofloxacin were all greater than 30% indicating that as single agents these would not be effective empiric therapy for Gram negative sepsis. The aminoglycoside resistance rate is 11% for gentamicin and 0.5% for amikacin; these are currently included in the Trust adult treatment of infection policy for use as an additional agent in the empirical management of sepsis of unknown source, intra-abdominal or urinary sepsis, but are not mentioned in biliary tract sepsis in the policy. Carbapenem resistance in *E. coli* bacteraemias was low with only one meropenem resistant isolate found in this period. The rate of production extended spectrum beta lactamases (ESBL) was 11.5% reflecting that seen in *E. coli* urine isolates. Hospital acquired *E. coli* bacteraemias (post 48 hours) accounted for 22% of total *E. coli* bacteraemias but resistance rates were higher, in particular the cephalosporin resistance and co-amoxiclav resistance. In light of these data, the recommendations in the adult treatment of infection policy are being reviewed in particular for biliary sepsis. The aminoglycoside and carbapenem resistance rates are low in *E. coli* bacteraemias, but additional work is underway to confirm that these rates are similarly low in the other main causes of Gram negative bacteraemia, particularly hospital associated Klebsiella, Enterobacter, Citrobacter and pseudomonas infections.

6. Intensive Care Catheter Line Associated Bloodstream Infections (CLABSI)

The measurement of CLABSI in intensive care units is an important patient safety indicator. The current mean rate of CLABSI per 1000 catheter line days is 1.9, for the period April 13 to February 14. The CLABSI rate for February 2014 currently stands at zero, therefore below the Trust target of 1.4 per 1000 catheter line days, as achieved in the Michigan Keystone Project (*Bion J, et al. BMJ Qual Saf. 2013; 22: 110-123).* In addition it in our paediatric ICU ther hav been no CLABSI since August 2013 and in the neonatal ICUs the late onset sepsis in very low birth weight infants (<1500g) is 7.4% compared to a mean of 13.0% in the Vermont Oxford network and a UK mean of 21.9%.

Figure 9: Adult Intensive Care CLABSI rate per 1000 catheter line days, FY 13-14



**Source: ECDC Annual Epidemiological Surveillance Report 2012*

The rate takes into account CLABSI episodes in patients staying more than two days in ICU, as per the latest European Centre for Disease Control, Annual Epidemiological Surveillance report (2012).

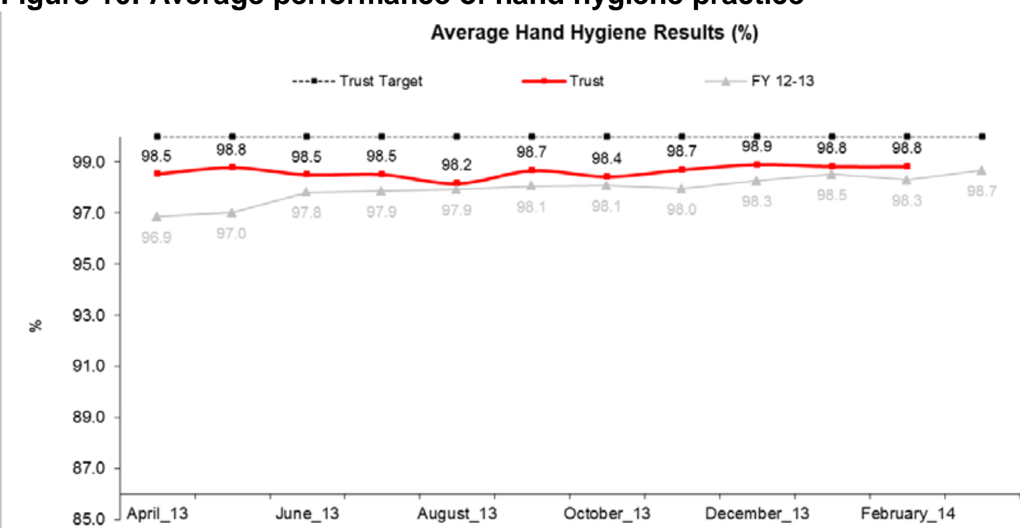
7. Hand hygiene compliance

In February 2014, 86.2% of clinical areas submitted a total of 5120 observations (as measured by the current Trust audit procedures based on a minimum of ten observations per ward, per week). Hand hygiene was 98.8%, and compliance with bare below elbows was 98.8%.

7.1 Hand hygiene compliance audit process

Hand hygiene is one of the most effective methods to prevent health care associated infections. Audits of hand hygiene compliance measured against the WHO 5 moments of hand hygiene are currently undertaken by each ward monthly and a more detailed and rigorous validation audit is undertaken by the infection prevention and control team.

Figure 10: Average performance of hand hygiene practice



8. ANTT

Since the introduction of the ANTT competency assessment framework in January 201, 9005 staff who have worked or are still working at Imperial have undertaken the assessment. The Trust continues a rolling programme of the aseptic non-touch technique (ANTT) competency assessment programme at Divisional level as part of the infection prevention and control plan and the two yearly reassessment programme for assessors commenced in December 2013. Completion of assessments was 91% in January 2014 and 75% in February 2014. This figure represents the large number of staff who have now reached their two yearly reassessment point and are currently undergoing reassessment for ANTT competency.
Junior doctors are now assessed for ANTT competency on the day of induction in a skills lab setting with these assessments now being undertaken using medical assessors from the Divisions.

9. Antibiotic stewardship

9.1 Point Prevalence Studies

Antibiotic stewardship is of fundamental importance to the Trust**.** The anti-infective point prevalence studies provide assurance to the Trust relating to antibiotic use and in particular the key Trust anti-infective prescribing indicators. Every quarter, the pharmacy department surveys all inpatients prescribed a systemic anti-infective for compliance against the three Trust anti-infective prescribing quality indicators, with a more detailed study undertaken annually. The results of the survey are disseminated via clinical and managerial structures with detailed suggested action plans where appropriate. Where a speciality fails to show improvement for two successive quarters, enhanced monitoring of anti-infective prescribing will be advised. In addition, the results of the key anti-infective prescribing indicators form part of Quality Accounts.

The three Trust anti-infective prescribing quality indicators are shown below and are set at 90% compliance:
Indicator 1: Percentage of anti-infectives in line with policy or approved by the infection team
Indicator 2: Percentage of anti-infectives with a documented indication in the medical notes or drug chart
Indicator 3: Percentage of anti-infectives with a documented stop or review date on the drug chart.

9.2 Overview of January 2014 results:

The average results for the Trust for January 2014 for the three Trust anti-infective prescribing quality indicators is 83%, which is an increase compared to the October 2013 results (average 78%). The results for each of the Trust quality indicators including additional patient safety indicators are detailed in Figure 11.

Figure 11: Trust anti-infective prescribing practice (2008-2014)

Figure 1: Trust Anti-infective Prescribing Practice 2008 to 2014

Date	Oct 08	Jun 09	Nov 09	May 10	Nov 10	May 11	Nov 11	Jun 12	Nov 12	Jun 13	Oct 13	Jan 14
No. of pts seen	1126	1221	1139	1181	1055	1090	1001	1051	1063	1071	1064	1050
Pts on anti-infective(s)	39.4%	39.8%	38.4%	40.8%	42.9%	39.8%	39.7%	40.2%	40.5%	42.5%	40.7%	41.4%
Anti-infectives prescribed IV	45%	52%	48%	55%	52%	53%	58%	50%	59%	51%	n/a	n/a
Total No. of doses prescribed	n/a	n/a	n/a	n/a	n/a	6229	5550	5202	4634	5691	n/a	n/a
Total No. of missed doses	n/a	n/a	n/a	n/a	n/a	173 (3%)	329 (6%)	80 (2%)	110 (2%)	53 (1%)	n/a	n/a
Total No. IV missed doses	n/a	n/a	n/a	n/a	n/a	47 (0.8%)	233 (4.2%)	28 (0.5%)	64 (1.4%)	14 (0.3%)	n/a	n/a

n/a – not assessed

9.3 Paediatric & Neonatal Antibiotic Stewardship

Antibiotic stewardship rounds within paediatrics continue to be undertaken and have been very well received and are providing to be a valuable education tool. Data is being collected on interventions and will be reported shortly. Neonatal antibiotic stewardship rounds are due to commence in March 2014.

The paediatric antibiotic app for smart phones is currently under development and is due in April/ May 2014. This app is based on the award winning Trust adult antibiotic app.

9.4 Fungal Stewardship

Darius Armstrong James (Consultant Infectious Diseases) and Mark Gilchrist (Consultant Pharmacist) have initiated a fungal stewardship round at the Hammersmith site aimed at promoting the prudent use of antifungals and using the round as a teaching and educational tool.

10. Other matters

10.1 Carbapenemase producing gram negative organisms (CPGNB)

The Trust has experienced ongoing instances of patients being identified with these drug resistant organisms on each of the three main sites.

A draft plan for management of these organisms was reviewed with PHE colleagues including our local CCDC who visited the Trust in late February; the plan will continue development via the HCAI taskforce. The importance of this issue has been highlighted by both a patient safety alert issued to Trusts by NHS England and a letter to CEOs from PHE and Sir Bruce Keogh (appendix A) requesting that the recommended practices are embedded in usual admission assessments and IPC practice across the Trust. The guidance for acute Trusts for managing patients identified with these drug resistant organisms was issued by PHE in Feb 2013 (to which Trust colleagues had contributed). In late 2013, additional supportive recommendations were issued in the form of a toolkit. The emphasis is on risk assessment of patients repatriated to the Trust, transferred from abroad or from other healthcare centres, isolation in single rooms with en suite facilities until screening results prove absence of carriage of or infection with such organisms.

10.2 Norovirus

In January and February 2014 the Trust experienced an increase in cases of norovirus with four wards being affected across two sites. Only patients were affected and the situation was recognised promptly and was managed by partially closing the affected patient areas in line with PHE guidance and Trust policy and infection prevention and control measures implemented rapidly to control and limit transmission. All patients were managed appropriately and symptoms resolved as expected. The outbreak was reported to PHE via the norovirus outbreaks in hospitals reporting scheme.

10.3 Surgical site infection (SSI) prevention and surveillance

The group continues to focus on the Trust wide programme for surgical site infection surveillance and are building on the work already in place across orthopaedics, cardiothoracic surgery and neurosurgery. The programme is going to be extended to upper and lower gastric surgery and obstetrics, specifically caesarean section. The group will be addressing clinical issues such as the MSSA blood stream infection related to SSI (detailed in section 4 above) and issues related to the recently published NICE guidelines on SSI's and are currently standardising preoperative practice (i.e. antimicrobial prophylaxis and surgical skin preparation).

10.4 Trust Development Authority (TDA) assessment and visits 2013/14

During 2013/14 the IP&C team have been working closely with the Trust Development Authority (TDA). This collaboration is important in ensuring that the TDA is assured that the Trust is undertaking all steps to minimise the risk HCAIs to all our patients. The team have been working with Mr Victor Oladele, the Head of infection control for the TDA (London) and to date he has visited two of our main hospital sites.
An in-depth inspection of the clinical areas and environment was performed, as well as meeting senior leaders from each clinical area and positive feedback was provided from these ward visits with assurance provided that staff were fully engaged with IP&C practice.

11. Applied Research, Innovation and Education.

The UKCRC Centre of Infection Prevention and Management (CIPM)

The Centre for Infection Prevention and Management continues to progress innovative technologies to support improvements in antimicrobial prescribing and infection prevention and control behaviours. Recently, the Centre completed the development of an antibiotic prescribing electronic game that will complement current Imperial College Healthcare Trust initiatives. The smartphone/tabled-based game focuses on 'good prescribing' practices described in national guidance such as 'Start Smart then Focus'. The game will be officially launched on 5th May 2014, in support of this year's WHO patient safety campaign

HPRU success and welcome meeting

Professor Alison Holmes, CIPM Co-Director, will direct a new Health Protection Research Unit in Healthcare Associated Infections (HCAI) and Antimicrobial Resistance (AMR). The Unit, one of 13 partnership grants across a number of priority areas, was one of four awarded to Imperial. The HCAI and AMR partnership consists of Imperial College London, Wellcome Sanger Institute, North West London Academic Health Science Network, and Cambridge Veterinary School. Alison will work alongside Mike Catchpole, from Public Health England to direct the Unit. Alison and Mike welcomed all those involved with the research at a welcome meeting which took place on 13 February at Queens Gate, South Kensington Campus. For more info
http://www3.imperial.ac.uk/newsandeventspggrp/imperialcollege/newssummary/news_20-12-2013-14-27-3

CIPM exhibit work at AHSC launch

Imperial College Academic Health Science Centre held a special event on Thursday 20th February at the Wolfson Education Centre to mark its recent award of AHSC status. Members of CIPM, including Shiranee Sriskandan, Luke Moore, Esmita Charani, Enrique Castro Sanchez and Monsey McLeod attended the event. The team from work-stream one were also able to demonstrate their 'mHealth for Antimicrobial Stewardship' work which includes a POCAST, IAPP and ENIAPP projects, as well as their work towards a prescribing game. For further
information, http://www1.imperial.ac.uk/departmentofmedicine/divisions/infectiousdiseases/cipm/news_and_media/ahsclaunch/

Appendix A: Letter to Trust CEOs: Addressing the infection risk from carbapenemase-producing Enterobacteriaceae and other carbapenem-resistant organisms

PHE Gateway number: 2013-499

To: Chief Executive Officer
CC: Director of Nursing
Medical Director
Health Protection and
Medical Directorate

Wellington House
133-155 Waterloo Road
London SE1 8UG
Email: hcai@phe.gov.uk
T +44 (0)20 7 811 7033
www.gov.uk/phe

27 February 2014

Dear Chief Executive Officer,

Re: Addressing the infection risk from carbapenemase-producing Enterobacteriaceae and other carbapenem-resistant organisms

We are taking the unusual step of writing directly to you to ask for your essential support and action to address the risk posed to trusts and other healthcare organisations by carbapenemase-producing Enterobacteriaceae and other carbapenem-resistant organisms. Carbapenemase-producing Enterobacteriaceae represent one of the most serious emerging infectious disease threats that we currently face, and the failure to control their spread now, while we still have the opportunity, could have substantial human health and financial consequences. Infections caused by these bacteria are extremely difficult to treat as they are resistant to carbapenems, which are considered 'last resort' antibiotics. Management of these infections is not only more difficult, affecting patient outcomes, but also significantly more costly for the healthcare system.

In order to minimise the wide spread of these multidrug-resistant infections across England we would be grateful if you could ensure, as a matter of highest priority and urgency, that the recently published national 'Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae1' is embedded into clinical practice within your Trust.

1 Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae available at:
http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317140378529

Additionally, to ensure that trusts are fully informed about the need to address this risk and to embed the toolkit, next week NHS England will be circulating a Stage 2 Patient Safety Alert entitled 'Addressing rising trends and outbreaks in carbapenemase-producing Enterobacteriaceae'. Further resources and information that will support you in addressing the issue in your Trust have also been included in the 'Key Information' appended to this letter.

These infections are already causing national concern due to the observed increasing trends in numbers of infections, outbreaks and clusters. Public Health England's (PHE) Antimicrobial Resistance and Healthcare Associated Infection Reference Unit has worked with carbapenemase-producing organisms since 2000 and is seeing year-on-year increases in these infections, currently confirming up to 25 positive samples per week that have been submitted by trust laboratories on a voluntary basis. PHE will continue to monitor the situation nationally and will make data on affected trusts available to professional colleagues and the public, including through publication, to support national efforts to address the public health threat.

It is important that we learn lessons from other countries that have been affected by these bacteria, e.g. Israel, Italy and Greece, and note in particular the difference in impact on patient safety and healthcare systems between addressing2 and failing to address3 the problem at an early stage.
Failure to act promptly has the potential to paralyse healthcare delivery (with resultant human and financial costs) as organisations struggle to control and reverse an escalating problem caused by a delayed response.

2 Containment of a country-wide outbreak of carbapenem-resistant Klebsiella pneumoniae in Israelihospitals via a nationally implemented intervention. Clin Infect Dis 2011 Apr 1;52(7):848-55 Schwaber MJ et al National Center for Infection Control, Israel Ministry of Health, Tel Aviv, Israel

3 An outbreak of infection due to beta-Lactamase Klebsiella pneumoniae Carbapenemase 2-producing K. pneumoniae in a Greek University Hospital: molecular characterization, epidemiology, and outcomes Souli M et al Clin Infect Dis. 2010 Feb 1;50(3):364-73

In the UK, we have a window of opportunity to prevent widespread problems caused by these organisms. Whilst we are seeing increasing numbers of carbapenemase-producing Enterobacteriaceae, we have not yet reached the escalated situation seen in other countries, although continuing significant levels in one part of North West England are having an impact on services. We are at a point in time when, if we act quickly and decisively, we can minimise the negative impact of these organisms.

We appreciate that application of the toolkit will be challenging in terms of both organisational capability and capacity, but unless each trust and healthcare organisation meets this challenge head on, the consequences of failing to act will be far greater.

We appreciate your support in this important matter and trust that collectively we will be able to address this issue in England.

Yours sincerely,

Dr Paul Cosford
Medical Director and
Director for Health Protection, PHE

Sir Bruce Keogh
Medical Director
NHS England

Key information:

Enterobacteriaceae
Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. However, these organisms are also some of the most common causes of urinary tract, intra-abdominal and bloodstream infections. They include species such as Escherichia coli, Klebsiella spp. and Enterobacter spp.

Acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae

The toolkit provides expert advice on the management of carbapenemase-producing Enterobacteriaceae, to prevent or reduce spread of these bacteria into (and within) health care settings, and between health and residential care settings. It provides practical advice for clinicians and staff at the frontline in acute care settings. The toolkit is intended to provide a framework to support local risk assessment, providing the minimum interventions required to safeguard patient safety and prevent an escalation of the problem. Some trusts that are already experiencing problems have applied even more stringent interventions. Every scenario will be different and trusts may wish to seek additional advice from their local PHE Centres and Regional Public Health Microbiologists.

Additional resources
You may also already be aware of the existing guidance for best practice on laboratory testing published by British Society for Antimicrobial Chemotherapy (BSAC)4 and a UK Standards for Microbiology Investigations document5, which provide further support to address this issue.

4 BSAC antibiotic susceptibility testing guidance http://bsac.org.uk/wp-content/uploads/2012/02/AST-testing-and-Reporting-guidance-v1-Final.pdf

5 Laboratory Detection and Reporting of Bacteria with Carbapenem-Hydrolysing ß-lactamases (Carbapenemases). http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317138520481

6 CDC Report: Antibiotic Resistance Threats in the United States, 2013: http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf

Additional information about the threat

A recent US report on antimicrobial resistance from the Centers for Disease Control and Prevention (CDC)6 acknowledged the significance of these infections and graded the organisms as “an urgent threat” - the highest level used to express a threat.

Imperial College Healthcare NHS
NHS Trust

Report Title: Quality Accounts Indicators 2014-15 and External Audit

To be presented by: Cheryl Plumridge, Director of Governance & Assurance

Executive Summary:

The Quality Accounts indicators have been developed following a process of engagement with stakeholders and staff. The indicators have been shared with the relevant Trust leads for agreement and have been presented to the Quality Committee and were agreed by the Management Board on 17th March 2014. These indicators will form the basis of next year's Quality Accounts, supported by key performance and quality information as prescribed by the Quality Accounts Toolkit and NHS England.

This paper outlines the Quality Indicators for the 2014/ 2015 Quality Accounts and confirms the quality indicators for data quality assurance purposes, as part of the external audit requirements, for the Quality Accounts.

Key Issues for discussion:

To note the Quality Accounts Indicators for 2014/15 (appendix 1) as agreed by the Management Board 17 March 2014.

To note the 2 data sets that will be subject to external scrutiny as part of the Quality Accounts process. These are: the FFT Patient question, and *clostridium difficile*, as presented to the Quality Committee and Management Board.

Legal implications or Review Needed: *delete as required*

a. Yes
b. **No**

Details of Legal Review, if needed:

Link to the Trust's Key Objectives: *please identify which and how*

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

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:

Recommendations and Actions Required:

For information: the indicators were approved at Management Board on Monday 17 March 2014.

Quality Account Indicators 2014-15 and External Audit

1. Introduction

Each year the Trust reviews and agrees their quality indicators for the next year's 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 indicators were presented to the Quality Committee on 6 March 2014 and were agreed by the Management Board on 17th March 2014. The Trust Board is asked to note, for information, the new Quality indicators (appendix 1). Those highlighted in red are new indicators/ measurements for 2014/15.

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.

2. National Requirements

2.1 New National Guidance

In January 2014, new guidance was published from NHS England confirming the core set of Quality indicators to be included in the 2013/14 Quality Accounts. 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 and the national average, and provide a supporting commentary which will explain variation from the national average and any steps taken or planned to improve quality.

3. Engagement Process

3.1 An engagement process ran between December 2013- February 2014 with internal and external stakeholder groups to discuss their views on what should be included in this year's 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
- Nurses
- HealthWatch
- Commissioners.

A total of 3 workshops were held alongside 7 local engagement meetings.

3.2 Key themes identified

In addition to the proposed indicators, stakeholders were keen to include:

- Analysis from SIs – the deteriorating patient
- Trust Never Events – WHO surgical checklist compliance

- Patient Experience – cancer survey improvements
- Cancer performance

We were also asked to include more information regarding complaints. We discussed this and agreed it could be included in the text of the document rather than as an indicator.

3.3 Improvements/ comments on the document

These were noted as:

- People liked the case study examples used in the report
- A live contents page was suggested taking the reader directly to the relevant section
- A short summary leaflet should be available outlining our performance and targets for the upcoming year

4. External Audit Requirements

The Quality Accounts will be subject to a formal external audit. One of the indicators is mandated: the FFT Patient question. The other indicator, clostridium difficile, was selected from:

- Patient safety incident reporting
- % of patients risk assessed for VTE
- Rate of Clostridium difficile

This was selected as infection prevention and control continues to be an important indicator of the quality of care delivered and although we have met this target this year, it continues to be a challenge for everyone.

5. New Quality Account Indicators 2014/15 as agreed by Management Board

Appendix One summarises all of the indicators to be included for 2014/15. Those highlighted in red are new for this year. We are awaiting notification of some of the targets for next year as evidenced in the appendix.

5.1 Patient Experience

- To roll out the FFT for all outpatient areas by October 2014
- To have zero tolerance for EMSA
- To implement the staff FFT in line with national guidance by June 2014
- To improve on the national patient Cancer Survey.
-

5.2 Clinical Effectiveness

- No changes

5.3 Patient Safety

- To have a zero tolerance for never Events.

6. Action

The Trust Board is asked to note, for information, the priority indicators for inclusion in the Quality Accounts for 2014/15, as presented to the Quality Committee and approved by the Management Board on the 17th March 2014.

The Trust Board is asked to note the quality indicators 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 2014, prior to submission for external audit, commissioners, Overview & Scrutiny Committees, NHS England and HealthWatch review.

Appendix 1

Quality Account Improvement Priorities 2014-15

<table>
<tr><th colspan="2">PATIENT SAFETY</th></tr>
<tr><td colspan="2">Quality Strategy Goal - Safety
Safety in clinical practice is our most significant goal; all patients will be as safe in our hospitals as they are in their own homes and outcomes will be as good as anywhere in the world. Our patient safety measures below reflect two of the key outcomes for this goal, as identified below.</td></tr>
<tr><th>Our quality priority</th><th>What will success look like</th></tr>
<tr><td>To achieve year on year reductions in inf[illegible] prevention and control. We ha[illegible]sen this priority to support our quality strategy goal.
*C.diff is a mandated indicator in the DH reporting arrangements for the Quality Accounts.</td><td>We will achieve the Clostridium.difficile (c.diff) Department of Health target of less than <u>xx</u> cases in the Trust during 2014/15.

We will aim to achieve the MRSA Blood stream infections (BSI's) national directive to have a zero tolerance for all healthcare associated MRSA Blood Stream infections (BSI's) across the NHS

We will be 90% compliant with the Trust anti-infective prescribing as measured by:
A reason for starting the antibiotic clearly documented within the patients' medical notes/drug chart
A stop/review date on the drug chart to optimise duration of therapy
Antibiotics are prescribed in line with the Trust antibiotic policy or approved by specialists from within our infection teams</td></tr>
<tr><td>To increase incident reporting rates and reduce their reported harm to meet NRLS peer target. We have chosen this priority to support our quality strategy goal.

*Patient Safety incident reporting is a mandated indicator in the DH reporting arrangement for the Quality Accounts.</td><td>We will meet the NRLS (National Reporting and Learning System) peer target for patient safety reporting rates per 100 admissions.

To be below the peer target for incidents graded as extreme (death).

To be below the peer target for incidents graded as major (severe).

To have a zero tolerance for Never Events.</td></tr>
</table>

To continuously improve HSMR and SHMI ratios and reduce variation across the week days. We have chosen this priority to support our quality strategy goal. **SHMI are a [illegible]lated indicator in the DH reporting arrangements for the Quality Accounts.*	We will be better than the national average for mortality rates as measured by SHMI **and HSMR.**
To ensure high performance against the Safety Thermometer. We will deliver 95% harm free care to our patients by reducing the number of falls, pressure ulcers and catheter related infections, as evidenced by the Safety Thermometer NHS Safety Thermometer allows frontline teams to measure how safe their services are and to deliver improvements locally.	Falls - to remain below the national average for falls with harm Pressure ulcers - to reduce the total number of all grades pressure ulcers .The current CQUIN target is a 50% reduction. Urinary catheter related infections - to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts
We want to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed.	We will achieve our CQUIN target of 90% compliance with the three key measures Element A: **F**ind; identify patients aged 75 and over and ask case-finding question Element B: **A**ssess and **I**nvestigate; Element C: **R**efer; ask GP to refer on for specialist memory service assessment

CLINICAL EFFECTIVENESS	
Quality Strategy Goal – Effectiveness. Our objective is that systems must match care to science, avoiding overuse of ineffective care and underuse of effective care. The Quality Accounts has two mandated indicators that measure clinical effectiveness indicators that we have included in this section.	
Our quality priority	**What will success look like**
To reduce the number of emergency readmissions to hospital within 28 days of discharge. **This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.*	*To reduce the number of readmissions to hospital within 28 days of discharge for patients under the age of 14 years as compared against the national average* *To reduce the number of readmissions to hospital within 28 days of discharge for patients 15 years and over as compared against the national average*
Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective and provide valuable information on the outcome of the surgery for our patients. To ensure the data is reflective of our patient groups, we need to increase our participation rates. **This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.*	To increase our participation rates to above 80% for all PROMs (groin hernia surgery; varicose vein surgery, hip replacement surgery and knee replacement surgery)

PATIENT EXPERIENCE	
Quality Strategy Goal - Patient Centredness Our goal is that our people will respect the individual patient and his/ her choices, culture and specific needs. For Imperial, a key component of this goal is to improve the reported experience of our patients when compared nationally.	
Our quality priority	**What will success look like**
We aim to provide the highest quality of healthcare. We will ask patients in adult inpatient and A&E departments: 'How likely are you to recommend our ward/A&E department to friends/family if they needed similar treatment or care?' We have chosen this priority to support one of our quality strategy goals. **This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.*	We will meet our CQUIN targets of: **Inpatient** Quarter 1= 25% response rate Quarter 4 = 30% response rate with month 12 (March 2015) having a 40% response rate **A&E** Quarter 1= 15% response rate Quarter 4 = 20% response rate In addition to monitoring our response rates, we will include feedback on our scores over the year.
We aim to provide the highest quality of healthcare. We will ask patients in our outpatients departments (OPD): 'How likely are you to recommend our OPD to friends/family if they needed similar treatment or care?' We have chosen this priority to support one of our quality strategy goals.	We will complete the implementation of the FFT question for all outpatient areas by October 2014.
To improve the reported experiences of our patients including responsiveness to the personal needs of our patients.	To improve on our 2013 scores in the National Patient Survey and **National Cancer Survey**.

We have chosen this priority to support one of our quality strategy goals. **This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.*	To improve on last year's score in relation to responsiveness to patient needs.
We recognise that by listening to our people (staff) and by improving our staff experience, we will make a positive difference to our patients' experience. We have chosen this priority to support one of our quality strategy goals. **This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.*	We will remain above average of 60% of staff who would recommend the trust to friends/ family needing care as measured through the annual National Staff survey and **we will implement the staff FFT test in line with national guidance by June 2014**.
We will nurse our patients in single sex accommodation as defined by the DH and our Trust policy.	**We will have a zero tolerance of breaches of mixed sex accommodation as defined by the Trust policy**

Imperial College Healthcare NHS
NHS Trust

Report Title: Safeguarding of Children and Young People: Annual Declaration 2013/14

To be presented by: Janice Sigsworth, Director of Nursing

Executive Summary:

Imperial College Healthcare NHS Trust is required to publish an annual declaration stating that the organisation is compliant against recommendations for children and young peoples' safeguarding as stipulated by David Nicholson's letter dated 16th July 2009. This paper details the draft declaration and confirms that there are structures, polices, processes and named individuals in place with defined responsibilities for children and young peoples' safeguarding within the Trust.

The attached document presents the declaration for 2013/2014. The number of staff trained will be updated at the end of March prior to publication to reflect performance of annual figures. The current performance of level 2 training (106%) reflects an over performance due to combined data sets that include staff who are required to be trained every 2 and 3 years. There are plans to split this data, which will provide a clearer summary of performance at that level.

A full report of the work undertaken by the children and young peoples' safeguarding team will be presented to the Quality Committee in July/August 2014.

The David Nicholson letter is attached can be found at the link below:

http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CDUQFjAB&url=http%3A%2F%2Fwww.nuh.nhs.uk%2Fhandlers%2Fdownloads.ashx%3Fid%3D14490&ei=QEcDU5_DOoOw7Aa52YDQCw&usg=AFQjCNECNtoUSk5ZKxQEE45jrckPse52Pw&bvm=bv.61535280,d.ZGU

Key Issues for discussion:
The declaration

Legal Implications or Review Needed : delete as required
No

Link to the Trust's Key Objectives: please identify which and how
1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients..

Recommendations and Actions Required:

The Board is asked to approve the declaration

1. Introduction

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

Imperial College Healthcare NHS Trust meets statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the Trust undergo a DBS 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 2013.

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 compromised. In addition, the Trust has a system in place for flagging children who are subject to a child protection plan from the four neighbouring boroughs.

All eligible staff undertakes 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 for the twelve month period ending 31st January 2014 is as follows against a target of 80%:

	Staff in Post	Staff requiring training per annum	Staff trained	% compliance
Level 1	1718	573	457	**80%**
Level 2	6562	2187	2315	**106%**
Level 3	1205	402	346	**86%**
Overall compliance	9485	3162	3118	**99%**

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 responsibilities 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 along with an administrator.

The team comprises:

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

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 Divisional Director of Midwifery and Nursing for the Women and Children's Division 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 via the Director of Nursing's Report taken to the Trust Board Meeting in September 2013. 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

Nick Cheshire
Bill Shields
Joint Chief Executive Officers

Imperial College Healthcare NHS
NHS Trust

Board Meeting
For information and discussion

Report Title: *Integrated Performance Scorecard Month 11 2013/14*

Report History: *Regular report presented to the Trust Board*

To be presented by: *Steve McManus, Chief Operating Officer*

Executive Summary:

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

The scorecard begins with an overview of the shadow Monitor performance framework and then the published indicators are subdivided into the six quality domains as well as People and Finance indicators.

The top 8 indicators for each domain have been specifically selected and agreed by the quality domain leads as those that the Board should be sighted on.

Foundation Trust governance risk rating (shadow): Amber
Rationale: Cancer 62 day standard has consecutively breached for three or more

In month 11 (end quarter 3), against the shadow Foundation Trust governance risk rating, the Trust is rated as Amber.

The Trust failed to meet the cancer 62 day standard to first treatment from urgent GP referral and the 31 day standard from diagnosis to treatment. However, the cancer standards are assessed quarterly and the Trust achieved 7 out of 8 standards for quarter 3. Cancer performance is reported one month in arrears so this represents the January position.

2013/14			Performance to date 13/14				Forecast		
Area	Indicator	Threshold	Q1	Q2	Q3	YTD	Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15
Finance	Capital Servicing Capacity		4	4	4		4		
	Liquidity Ratio		4	2	2		2		
	Continuity of Services Risk Rating		4	3	3		3		
Access	18 weeks referral to treatment - admitted	90%	92.50%	93.35%	93.18%	92.90%			
	18 weeks referral to treatment - non admitted	95%	96.85%	96.80%	95.88%	96.40%			
	18 weeks referral to treatment - incomplete pathway	92%	95.96%	95.96%	95.05%	95.60%			
	2 week wait from referral to date first seen all urgent referrals	93%	98.27%	98.37%	98.51%	98.07%			
	2 week wait from referral to date first seen breast cancer	93%	97.63%	97.60%	97.28%	97.37%			
	31 days standard from diagnosis to first treatment	96%	94.43%	96.89%	96.07%	95.95%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%	99.47%	100.00%	99.84%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.50%	98.73%	98.06%	98.21%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.07%	95.47%	95.42%	95.60%			
	62 day wait for first treatment from NHS Screening Services referral	90%	91.27%	95.57%	92.23%	92.61%			
	62 day wait for first treatment from urgent GP referral	85%	74.27%	74.00%	80.10%	76.46%			
	A&E maximum waiting times 4 hours	95%	96.24%	96.68%	95.97%	96.30%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	26	11	10	47			
	Governance Risk Rating		2	2	1	n/a	1	0	0

In future months, it is anticipated that a summary of the non-Foundation Trust compliance frameworks will also be included (NTDA/CQC).

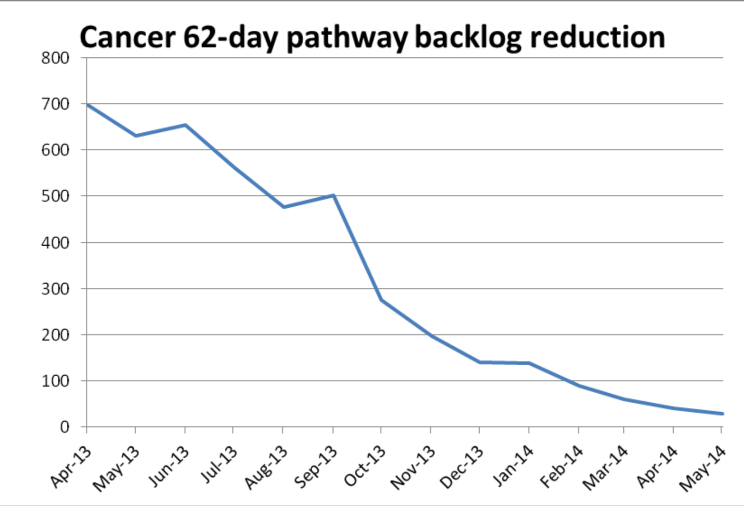
Key Issues for discussion:

Performance overview

A summary of the areas of key concern are provided by exception only.

Quality

- The Trust is now within trajectory for C.*difficile*. For 2013/14, the annual ceiling for the Trust is 65 cases of *C.difficile* infection. In February there were no Trust attributable cases.Year to date 51 Trust attributable cases have been reported to the PHE, the Trust remains on trajectory for year end.
- MRSA blood stream infections are not currently included within the Monitor governance rating score. However, any cases will continue to reported above the threshold (currently 0) to the Trust Board. In February no cases of MRSA BSI occurred, however one of the cases that was in arbitration from January 2014 has now been allocated to the Trust. The total number of 'cases' reported against the Trust is eleven year to date, four of the ten represent cases re-allocated to the Trust through the review process introduced this year.
- In January 2014 the Open Exeter published data indicated that the Trust failed 2 Cancer Waiting Time standards: 62-day 1st treatment (after GP referral) and 62-day 1st treatment (from NHS screening services).
- 62-day 1st treatment (after GP referral): 92 patients were treated within the month (75.5 after adjustments for shared pathways with other Trusts have been applied) and 21 patients breached (15.5 patients after adjustments for shared pathways). Performance was 79.5% against an 85% standard. Of the 21 breaches, 8 related to late transfers between Trusts (Inter-trust referral (ITR) sent after day 42), Work continues to reduce the backlog and we expect to achieve this standard from Q1 2014/15. See graph below for backlog reduction.
- 62-day 1st treatment (from NHS screening services): 29 patients were treated in the month (27 after adjustments for shared pathways with other Trusts have been applied) and 5 patients breached (3 patients after adjustments for shared pathways). Performance was 88.9% against a 90% standard. The Trust is in the process of contesting achievement of this standard in January. Two other Trusts uploaded shared breaches on the Open Exeter upload deadline which were not visible to us until after the frozen position was published. One breach did not take into account a waiting time adjustment and the other was a benign diagnosis. Without these breaches the Trust would have met the standard in January.
- The Trust had one mixed-sex accommodation breach in February 2014. This was due to a delayed discharge resulting in a bed not being available for the patient within the six hour timeframe from an Intensive Care Unit step-down. A route cause analysis has been completed and lessons learnt will be cascaded throughout the organisation.
- The Trust has consistently delivered the three agregate RTT standards since November 2012. Hoever, in recent months the Trust has seen an increase in patients waiting for treatment over 18 weeks. This increase has stabalised in February 2014. A remedial action plan is in place to ensure that this backlog is cleared to enable the Trust to deliver the three standards within each speciality as well as at Trust agregate level. The specialities included within the remedial action plan are Urology, General Surgery, Trauma & Orthopaedics and ENT. The Management Board will be increasing the oversight of the RTT backlog until this is reduced and sustained.



People

- The Trust vacancy rate increased from 11.63% to 12.03% in February due to an additional 70 new posts added to the establishment and despite an increase of 28 WTE in the numbers of people directly employed. Half of these new posts were nursing posts within our ward and inpatient areas to support safe staffing levels for our patients. A full review of vacant posts has just been completed within two of the Divisions with further review underway across the Trust to ensure that only those posts required for current service delivery are established and reported on.
- The Trust voluntary turnover rate continues to show a decreasing trend with the 12-month rolling figure, at the end of February at 10.15%. Working with an external provider, we are establishing a new exit survey process for our leavers as well as surveying our new joiners after their first 3 months to ask some questions about the first few weeks in the Trust. This insight will help us understand what really matters to our people during those early weeks and months. Our plan is to make on boarder and exit surveys another aspect of our engagement activity so that we can support the Divisions to improve our people's experience and help to reduce regretted turnover.
- Recorded sickness absence during February is showing an 8% increase on those seen in February 2013; reasons for this increased absence relate to musculoskeletal/back problems as well as anxiety and stress, cancer and pregnancy related illness. The 12-month rolling position for sickness absence is now at 3.43%; against the year-end target of 3.40%. This is significantly lower than the position seen in February 2013 when the 12-month rolling figure stood at 3.62%; a decrease of 5.2%.

- Consultant appraisal has dropped in month and will remain red in March – we have undertaken a complete review of the system and process for data collection for this. This has led to a drop in the appraisal compliance figure this month. Previous figures included only consultants using e-appraisal system which did not include consultants on ESR who have not yet got accounts set up on the using e-appraisal system.
- The new figure now provides the figure for all consultants due appraisals as per ESR, regardless of whether they are registered onto the e-appraisal system. An action plan is in place to ensure this is managed to target.

Finance

- In future months, any finance key areas of risk will be reported here

Regulatory reforms

Each month in this section, any future changes to standards or the way the Trust is assessed will be documented so that the Trust Board has early sight of these. These will remain within the report for two consecutive Trust Board meetings before they are removed from the report.

To support the achievement of RTT standards nationally, the NTDA on the 20th March gave the Trust notification that additional information will need to be submitted from 26th March on a weekly basis and includes information on our patient tracking lists. This will include information such as the number of patients that will breach 18 weeks in different brackets of time and the number of patients who breached 18 weeks in the last 7 days. Overall numbers and also numbers only for Trauma & Orthopaedics are required to be submitted.

Monitor revised its performance framework in August 2013 and published the Risk assessment framework http://www.monitor.gov.uk/sites/default/files/publications/RAF_Final_August2013_0.pdf

This framework differs from the previous Compliance Framework in that there are only three ratings assigned:

Rating	Description
Green	• No governance concern is evident
Amber*	• Potential materal causes for concern (requiring further informaiton or formal investigation) identified (see table for examples of governace concern) • * in the Risk assessment framework, there is no 'amber' category. If there are potental governance concerns, the 'green' rating would be replaced by a description of the issues and steps being taken to address these.
Red	• Red rating assigned if regulatory action taken

The following diagram illustrates what could give Monitor cause for governance concerns (presented by category). Information that comes to light from other areas of governance oversight may lead to overrides in the governance rating. These include corporate governance statements, the annual governance statement, forward plans and regular governance reviews.

Category	Metrics	Governance concern triggered by
CQC information	• CQC judgments	• CQC warning notice issued • Civil and/or criminal action initiated
Access and outcome metrics	For acute trusts, metrics including: • Referral to treatment within 18 weeks • A&E (4 hours) • Cancer waits (62 days) • C.difficile – national target	• Three consecutive quarters' breaches of a single metric *or* a service performance score of 4 or greater • Breaching pre-determined annual C.difficile threshold (either three-quarters' breach of the year-to-date threshold or breaching the full year threshold at any time in the year) • Breaching the A&E waiting times target in two quarters over any four-quarter period and in any additional quarter over the subsequent three quarters.
Third party reports	• Ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports, Health & Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges etc.	• Judgment based on the severity and frequency of reports

Quality governance indicators	• Patient metrics
	  • Patient satisfaction
	• Staff metrics
	  • High executive team turnover
	  • Satisfaction
	  • Sickness/absence rate
	  • Proportion temporary staff
	  • Staff turnover
		• Material reductions in satisfaction, or increases in sickness or turnover rates
		• Material increases in proportion of temporary staff
		• Cost reductions in excess of 5% in any given year

Financial risk	• Continuity of services risk rating	• Breaching any continuity of services licence condition as a result of governance • Inadequate planning processes

Scorecard update

In this section the Board will be notified or consulted of any proposed changes and amendments.

Summary pie charts

In March, the colour scheme has changed whereby any indicator with a data feed but no threshold is coloured blue. Any indicator without a data feed at this stage is coloured grey.

Leading/lagging indicators

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

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

QlikView roadmap

It is proposed that the Integrated Performance Scorecard is developed into a QlikView

application with an initial version to be presented to the Trust Board in August/September 2014. This will allow for the complex data feeds to be fully embedded into the scorecard and will allow full testing of the iPad friendly version of QlikView which is soon to be released. QlikView will allow Trust Board members to drill down into further detail into the indicators that are presented. This could be to divisional or speciality level.

Source framework

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

Future development

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

- Reducing the number of indicators where data is not yet available for the scorecard. This has improved since January and it is anticipated that all indicators will be populated by the next Trust Board meeting in May.
- Include further comparison data, when this becomes available to allow benchmarking to be made with other London Trusts, the Shelford Group and against the national average;
- All indicators having a forecast Red/Green for the coming three quarters.

Legal implications or Review Needed: *delete as required*

a.
b. **No**

Details of Legal Review, if needed:

Link to the Trust's Key Objectives:

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

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:

Recommendations and Actions Required:

The Board are asked to:

- Review the paper and scorecard
- Note key areas of risk and planned mitigations
- Discuss content/format of scorecard regarding any future amendments.

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public
For information

Report Title: Dementia Care & CQUIN – Supporting Carers
Report History: to be reported twice-yearly
To be presented by: Steve McManus, Chief Operating Officer
Executive Summary: There are four national Commissioning for Quality and Innovation (CQUIN) goals for 2013/14, including the national Dementia CQUIN goal. The dementia goal consists of three indicators, one of which requires the Trust to conduct a monthly audit of carers of people with Dementia to test if they feel supported. The CQUIN requirements also state that the findings from this audit are presented to the Trust board on a twice-yearly basis. This paper contains the details of the audit that Trust is undertaking as well as the findings so far.
Key Issues for discussion: The Board are asked to be sighted on the contents of this report.
Legal implications or Review Needed: a. No **Details of Legal Review, if needed:** n/a
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients. 2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: This paper provides the Board with an assurance that the Trust is compliant with the requirements of the national Dementia CQUIN goal.
Recommendations and Actions Required: 1. For the Board to note the contents and findings in the report 2. For the Board to agree that this report can be shared with commissioners

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

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

CQUIN Pre-qualification

In order to quality for Commissioning for Quality and Innovation (CQUIN) payments in 2013/14, ICHT had to satisfy at least 50% of national CQUIN pre-qualification criteria based on the six NHS *High Impact Innovations*. One of these criteria was ensuring 'carers of patients with dementia are sign-posted to relevant advice and that they receive the relevant information to help and support them'.

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

Supporting Carers of People with Dementia

There are four national CQUIN goals for 2013/14. The national Dementia CQUIN goal consists of 3 indicators, the details and requirements of these indicators are as follows:

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

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

Audit of Carers of Patients with Dementia

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

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

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

Initial findings

The monthly breakdown of responses is presented in the table below. 57% of surveys were completed by telephone, 26% were completed face-to-face and for the remaining 17% the carer completed the questionnaire alone.

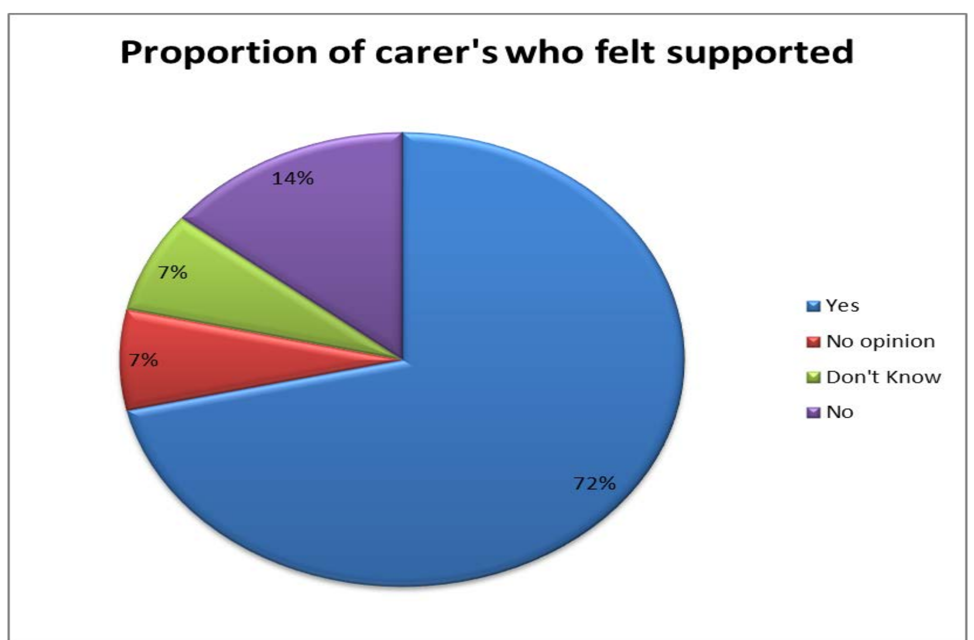
Year	Month	Total Responses
2013	October	9
	November	3
	December	11
2014	January	9
	February	6
	March (so far)	4
Grand Total		**42**

The key question in relation to the CQUIN indicator is question 2: *During the patient's admission in hospital, do you feel that you have been supported in relation to their existing diagnosis of dementia?* 72% of recipients said that yes, they felt supported. The responses to this question are presented in the graph below.

Of the 42 respondents, 26 reported that health professionals (HCP) spoke to them about the patient's diagnosis of dementia (*question 3*). Of those 26 respondents, 24 stated that they had received sufficient information.

64% of respondents stated they had received enough information in relation to how patients' physical health impacts on their dementia (*question 4*).

In terms of discharge planning and onward care, 64% (or 29 out of 42) of carers surveyed stated they were involved in this process and provided with information about services (*question 5*).



Of those carers who felt supported, 80% (or 24 out of 30 respondents) stated they had been spoken to by a health professional in relation to the patient's dementia, whereas of the 6 respondents who stated they did not feel supported, 2 (or one-third) had been spoken to by a health professional.

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

> "This is a very difficult time. It's hard to know what to think with all the decisions that need to be made"
>
> "Excellent care at hospital. I'm learning from the Nurses/Healthcare staff how to manage agitation in my relative with dementia by observing them"
>
> "Staff are very patient and try to keep her [the patient] calm"

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

Next steps

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

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

The Audit Questionnaire

Date:

Imperial College Healthcare NHS
NHS Trust

☐ **Phone** ☐ **Face-to-face** ☐ **Completed alone**

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

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

Carer questionnaire (please tick)

Q1. Would you be willing to complete this questionnaire?

☐Yes ☐No

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

☐ Yes ☐ No ☐ Don't know ☐ No opinion

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

☐Yes ☐No

If yes,

Do you feel that you received sufficient information?

☐ Yes ☐ No ☐ Don't know ☐ No opinion

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

☐ Yes ☐ No ☐ Don't know ☐ No opinion

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

☐ Yes ☐ No ☐ Don't know ☐ No opinion

Additional comments regarding the above questions and dementia care:

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

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FINANCE REPORT – FEBRUARY 2014

Report Title: Finance Performance Report

To be presented by: Marcus Thorman, Chief Financial Officer

Chief Financial Officer's message:
The Trust has achieved a year to date surplus of £12.3m at the end of February (after adjusting for impairments and donated assets), an **adverse** variance against the plan of £1.2m. This is based on a deficit in month of £2.8m, which was an **adverse** variance of £0.4m.

CIPs are behind plan by £3.3m. However, this has been offset by over-performance income on CCG contracts. It should not be expected that the over-performance on income will continue and therefore persistent improvement in delivery of the CIPs is required in order to achieve the financial plan target.

The Trust is still expecting to deliver the planned surplus of £15.1m after adjusting for impairments and donated assets.

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 ✓

FINANCE REPORT – FEBRUARY 2014

1 Introduction

1.1 This paper outlines the main drivers behind the Trust's reported financial position for the month ending 28th February 2014.

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

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 **deficit** of £2.8m, with a year to date surplus of £12.3m. This was an **adverse** variance of £0.4m in month.

2.2 **CCGs/NHS England Service Level Agreement (SLA) Income** – The CCG & NHS England SLA contract monitoring report for the month was calculated using the month 10 actual data and adjusted for the planned monthly profile within the SLA. A year end settlement has been agreed with the NWL CCGs which includes payment of over-performance of £23.4m and this is reflected in the year to date and forecast position.

2.3 **Expenditure** - Pay expenditure shows an **adverse** variance of £13.4m year to date as result of under-achievement of CIPs and a failure to reduce bank & agency costs. Non pay expenditure is showing an **adverse** variance year to date of £15.4m which is mainly due to the purchase and sale of drugs for £2.7m to Lloyds Pharmacy as part of them running the outpatient pharmacies. The sale of stock of £1.9m as part of CIP managed service initiative for the Catheter Labs and activity growth for excluded drugs and devices.

2.4 **Financing costs** - Impairment on buildings of £117,142k has been charged to the I&E Account this month following a comprehensive valuation review of the Trust's estate by an independent valuer.

3 Monthly Performance (Page 4)

3.1 Divisional financial performance has been assessed against the Financial Risk Rating. The metrics shown in the tables above reflect the five key themes and summarise performance against 25 detailed metrics. The FRR is supporting improvements in financial management and engagement within Clinical Divisions and plans are on track to expand the FRR to Directorates.

4 Cost Improvement Plan (Page 5)

4.1 The CIP plan for the year is £49.3m. Expected forecast outturn is £46.6m which is £2.7m behind plan.

4.2 Year to date delivery of CIP was £41.8m (a deficit of £3.3m against plan)

4.3 The Transformation Board is closely monitoring the position and significant work has taken place to ensure plans are robust in delivery of the 2013/14 target.

5 Statement of Financial Position (Balance Sheet - Page 6)

5.1 The overall movement in balances when compared to the previous month is a decrease of £2.9m and is predominately due to movements in cash and debtors.

6 Capital Expenditure (Page 7)

6.1 Expenditure in month was £3.2m (£18.2m year to date) which is £7.9m behind plan.

6.2 The variance is largely due to previously-reported changes in Endoscopy and Imaging.

6.3 The contingency of £2.5m has been utilised to purchase medical equipment to provide some headroom in next year's capital programme.

7 Cash (Page 8)

7.1 The cash profile has been set out as per the TDA plan. Cash is behind plan due to organisational changes in the NHS resulting in delay in payment of over-performance which has now been agreed as part of the year end contractual settlement with CCGs.

8 Monitor metrics – Financial Risk Rating (Page 9)

8.1 The presentation of the Financial Risk Rating has changed to a tabular format and includes the new Monitor Continuity of Service risk rating (CoSRR). All risk metrics are on track.

9 Conclusions & Recommendations

The Board is asked to note:

- The **deficit** of £2.8m for the month of February; the cumulative **surplus** of £12.3m, a cumulative **adverse** variance of £1.2m against the plan.
- Actual achievement of CIP schemes year to date was £41.8m which is behind plan by £3.3m. It is therefore recommended that discretionary expenditure and new projects are stopped until it is confirmed the Trust is back on track with delivery of the financial plan.
- Forecast outturn remains at a surplus of £15.1m.

Prepared by Mark Collis, Deputy Director of Finance & Marcus Thorman, Chief Financial Officer

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TRUST BOARD

Title: Annual and Medium Term Financial Plan 2014/15 to 2015/16

To be presented by: Marcus Thorman – Chief Financial Officer

Purpose of Paper: FOR INFORMATION AND APPROVAL

Executive Summary:

This paper summarises the draft annual and medium term plan submitted to the TDA on the 6th March and updated Long Term Financial Model (LTFM). The final plan submission is due on 4th April.

The LTFM is a work in progress and will require further development taking into account the impact of planned service developments, local planning and unquantified risks.

The objective of this report is to approve the financial plan for 2014/15 and appraise the board of the key risks on the final two year plan due to be submitted on 4th April to the TDA.

Key Issues for discussion:

The Trust Board is asked to review and discuss the annual and medium term plan (which is now reflected in the LTFM), and agree the key modelling assumptions used.

Trust Board
Annual and Medium Term Financial Plan

26th March 2014

1. Introduction

This paper summarises the draft Annual and Medium Term Financial Plan (MTFP), to be submitted to the TDA on the 4th April, and the updated Long Term Financial Model (LTFM). It focuses on the forecast financial position over the next two years from 2014/15 to 2015/16, including the key assumptions that impact upon the projected performance. The Finance and Investment Committee reviewed a draft version at their meeting of 20th March.

1.1. Developments

The MTFP and LTFM is a work in progress and will be further developed to incorporate the following:

- impact of enabling and transitional service reconfigurations to support the Shaping a Healthier Future (SaHF) programme as well as the Trust's own business case to support this and the redevelopment of the St Mary's Hospital site;
- North West London Pathology modernisation programme;
- Detailed impact of the implementation of the Cerner patient administration system (estimated costs currently included); and
- Detailed development of Private Patient services (high level income and cost increases currently included)

These developments will be reflected once the relevant business cases are available.

1.2. Modelling Updates

Since the last iteration of the LTFM/Initial Annual Plan was presented to the Trust Board and Finance & Investment Committee (FIC), the model has been updated to:

- update the actuals and forecast outturn as reported at February 2014;
- reflect the latest planning assumptions for 2014/15 onwards from NHSE / Monitor / TDA; and
- reflect the latest assumptions on cost pressures and cost improvement plan (CIP)

In addition to these developments, the MTFP will also need to be updated to:

- incorporate the impact of refined activity, capacity and forecasting assumptions from divisional planning and commissioner proposals;
- incorporate further local service developments included in the clinical strategy; and
- update the actual outturn at the end of 2013/14

Key inflation and efficiency assumptions remain unchanged from those presented in the LTFM and MTFP update at the last Finance and Investment Committee.

2. Summary of Forecast Outturn and Medium Term Financial Plan (MTFP)

A summary of the forecast financial performance for 2014/15 and 2015/16 as presented in the current LTFM and to be reported in the final financial plan to the TDA on 4th April 2014 is shown below.

Forecast Outturn and Medium Term Financial Plan against Financial Indicators

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
Net Surplus/(Deficit)	(102.7)	(144.7)	17.5
Net Surplus/Deficit before Impairments	14.5	9.9	17.5
Normalised Net Surplus / (deficit)	18.3	18.6	19.5
Cash balance	50.2	55.5	67.1
NRAF (Net Return After Financing)	2.1%	2.0%	4.3%
CIP plan	49.3	42.9	37.6
CIP achieved/forecast	46.7	42.9	37.6
CIP achieved/forecast (%)	94.7%	100.0%	100.0%
Recurrent CIP achieved	tbc		

3. Forecast Performance

3.1. Forecast Assumptions

A complete table of forecast assumptions is provided in Appendix A.

3.1.1.1 Income and Activity

Planning guidance issued by NHSE / Monitor / TDA include high level planning assumptions for inflation/deflation on NHS clinical income, pay and non-pay, with drugs specifically mentioned. These assumptions have been used and adjusted where appropriate.

Income and Activity Assumptions

	2014/15	2015/16
Income and Activity		
Volume assumptions		
Protected/Mandatory Revenue (SLA) - Growth	2.0%	2.0%
Protected/Mandatory Revenue (SLA) - Demographics	0.7%	0.7%
Protected/Mandatory Revenue (SLA) - Demand Mgmt	(3.0%)	(3.0%)
Private Patients Revenue	£3.7m	£7.3m
PP Cost Response	(£0.6m)	(£5.9m)
Other Revenue	0.0%	0.0%
Inflation assumptions		
Protected Revenue Income - Tariff	(1.2%)	(1.2%)
Protected Revenue Income - Non-tariff	(1.5%)	(1.5%)
Private Patients Revenue	2.7%	2.7%
Education & Training	0.0%	0.0%
Research & Development	0.0%	0.0%
Other Revenue	0.9%	1.0%

- Protected (NHS) income has been deflated in line with Monitor guidance for 2014/15 and 2015/16.
- Protected (NHS) activity assumes a net 0.3% reduction in years 2014/15 and 2015/16. The 0.3% net reduction is consistent with Commissioner proposals as part of the Shaping a Healthier Future (SaHF) Decision Making Business Case (DMBC).
- Private Patient revenue growth is from a mixture of price renegotiation and activity growth.
- Education and Training income is assumed to reduce by £2m per year due to MPET reductions.
- No inflation has been assumed for Education & Training or Research & Development income.

3.1.1.2 Commissioning Update and Impact on Assumptions

Contract negotiations with major commissioning bodies are progressing, with key highlights being:

- CWHHE and BEH CCG Collaborative
    - Proposed contract values agreed in principle
    - Detail on the underlying reporting of the contract, e.g. metrics, QIPP and growth, to be agreed
- NHS England
    - Agreed baseline and major pricing assumptions
    - Proposed service developments, payment of CQUIN on high cost drugs and devices and demand management schemes (QIPP) still under discussion

Given the current situations with the Trust's major commissioning bodies, there are only expected to be a small number of changes to financial modelling in the final financial plan, not incorporated in this report.

There remains a risk to the payment of the two tranches of Project Diamond funding, totalling £17.3m, in the 2014/15 plan. The Trust, along with other Project Diamond Trusts, is in on-going correspondence with both the Department of Health (DH) and NHS England (NHSE) on the future payment of these monies, received in previous years. An update on progress will be provided to the Trust Board in the first quarter of 2014/15.

3.1.2. Expenditure

The expenditure inflation assumptions used in the LTFM are provided below.

Expenditure Inflation Assumptions

	2014/15 %	2015/16 %
Expenditure		
Inflation assumptions		
Employee Benefit Expenses (includes AfC changes)	1.5%	2.2%
Drugs	2.1%	2.1%
Clinical Supplies & Services	2.1%	2.1%
PbR Excluded Drugs & Devices	7.2%	7.2%
Other Expenses	3.8%	2.1%
Capex inflation	3.8%	3.8%

- Pay inflation includes incremental drift and an estimate for increases in employer contributions to the NHS pension scheme in 2015/16 of 0.7%. Recently published guidance issued on 13th March 2014 has yet to be modelled, but the impact is expected to be a lower cost than that currently included.
- Non pay inflation is split by cost type and is based on combination of historic trends and national guidance.

3.1.3. Other

A breakdown of other key assumptions and standalone adjustments has been listed below. The additional expected impact of 'stranded' fixed costs from activity reductions that cannot be removed has been allowed for.

Other Assumptions

	2014/15	2015/16
Other assumptions		
Stranded cost impact of Demand Management	47.5%	47.6%
Cost impact of growth (% of income change)	70.0%	70.0%
CQUIN investment	(£4.0m)	(£2.0m)
Recurrent FT Costs	£0m	(£0.5m)
Dividend Payable	3.5%	3.5%
Redundancies (recurrent)	(£1.0m)	£0.0m
Project Diamond (recurrent)	(£0.5m)	£0.0m
Cerner disruption (non-recurrent)	(£6.0m)	£0.0m
CNST & Utilities	(£2.9m)	(£2.5m)

Key cost assumptions detailed above include £4m to cover the cost of investing in quality and other developments, badged as CQUIN investment above.

Currently the investment proposals presented during Divisional planning bilaterals present a risk and significant difference to the planning amount. The process for prioritising the proposed costs and investments, including discussions with commissioners on funding for national schemes (e.g. 7-day working), will continue through the Investment Committee and Executive Team.

3.2 Income and Expenditure

3.2.1 Detailed I&E Forecast 2013/14 to 2015/16

The forecast income and expenditure positions for 2014/15 and 2015/16 are shown below.

Income and Expenditure Forecast

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
Protected/Mandatory Revenue			
Elective	111.4	109.7	108.1
Non elective	158.6	156.2	153.9
Outpatient	88.6	87.3	86.0
A&E	20.1	19.8	19.5
Other clinical - Tariff	72.6	71.5	70.4
Other clinical - Non Tariff	242.1	257.1	271.1
Other block or Cost and Volume contract	40.4	39.7	38.9
Sub-Total	***733.7***	***741.3***	***747.9***
Non Protected/Non Mandatory Revenue			
Private patient revenue	34.1	38.8	47.6
Other non protected revenue	3.7	3.8	3.9
Sub-Total	***771.5***	***783.9***	***799.4***
Other revenue			
Education and Training	61.8	59.8	57.8
Research & Development	53.4	61.4	63.0
Other revenue	82.6	83.6	87.4
Sub-Total	***197.8***	***204.8***	***208.2***
Total revenue	**969.3**	**988.7**	**1,007.5**
Expenses			
Employee Benefit Expenses	(518.0)	(516.9)	(515.3)
Drug expenses	(48.0)	(49.5)	(50.4)
Clinical supplies and services expenses	(95.3)	(91.0)	(87.3)
PbR Excluded Drugs & Devices	(74.8)	(77.9)	(83.3)
Other expenses	(163.1)	(194.2)	(207.7)
Provision for bad debts	0.3	0.0	0.0
Total expenses	**(898.8)**	**(929.6)**	**(944.0)**
Surplus/(Deficit) from operations	***70.5***	***59.1***	***63.5***
Profit / loss on asset disposals	(0.0)	0.0	0.0
Fixed Asset impairments	(117.1)	(154.5)	0.0
Total Depreciation & Amortisation	(36.4)	(34.6)	(34.3)
Total interest receivable/ (payable)	0.2	0.2	0.2
Total interest payable on Loans and leases	(0.9)	(0.8)	(0.8)
PDC Dividend	(18.9)	(14.1)	(11.1)
Net Surplus/(Deficit)	**(102.7)**	**(144.7)**	**17.5**
EBITDA Margin	7.3%	6.0%	6.3%
Net surplus/(deficit) margin	(10.6%)	(14.6%)	1.7%
Movement in I&E Reserve			
Opening balance	(72.9)	(175.6)	(320.3)
Movement in Year	(102.7)	(144.7)	17.5
Closing balance	**(175.6)**	**(320.3)**	**(302.8)**

The Trust is forecasting that it will deliver a surplus of £9.9m (before impairments) in 2014/15, increasing to £17.5m by 2015/16.

When comparing the net surplus performance to current Trust (TDA) reporting, a technical adjustment for the impact of donated assets is added. This currently increases the planned surplus in 2014/15 to £11.2m, an adjustment of +£1.3m.

3.2.2 Normalised I&E Forecast 2013/14 to 2015/16

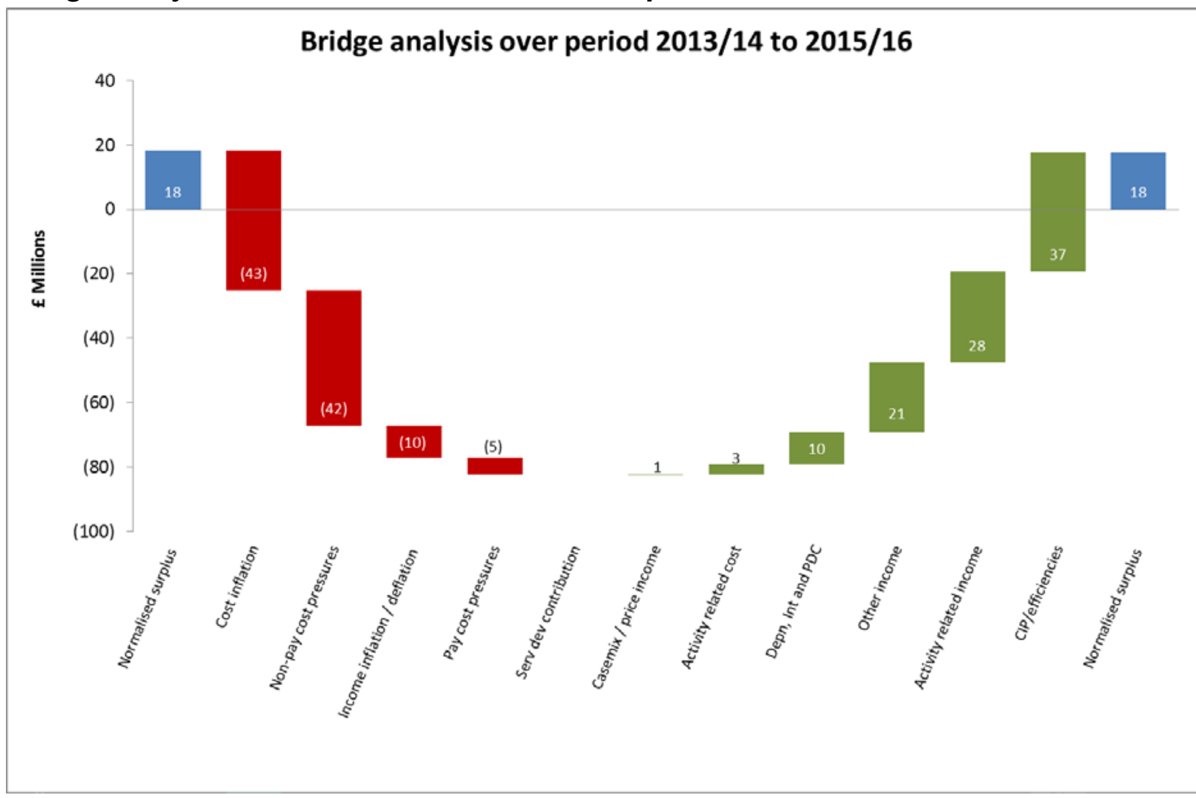
When the Trust's projected income and expenditure position is adjusted for all known significant, one-off/ non-recurrent and exceptional financial items, the normalised position moves to a surplus of £18.6m in 2014/15, increasing to £17.5m in 2015/16.

It is assumed that income from Project Diamond and MFF on R&D as well as on-going expenditure on Cerner is recurrent.

Normalised Income and Expenditure Forecast

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
Net Surplus/(deficit)	**(102.7)**	**(144.7)**	**17.5**
Less:			
Non Recurring Revenue and Income	(1.0)	0.0	0.0
Add:			
Non recurring expenses	5.6	8.7	0.0
Other:			
Profit/(loss) on asset disposals	0.0	0.0	0.0
Fixed Asset impairments	117.1	154.5	0.0
Normalised surplus /(deficit)	**18.3**	**18.6**	**17.5**
Add:			
Total Depreciation & Amortisation	36.4	34.6	34.3
Total interest receivable/ (payable)	(0.2)	(0.2)	(0.2)
Total interest payable on Loans and leases	0.9	0.8	0.8
PDC Dividend	18.9	14.1	11.1
Normalised EBITDA	**74.3**	**67.8**	**63.5**
EBITDA margin	*7.7%*	*6.9%*	*6.3%*

Bridge Analysis of Normalised Income and Expenditure Forecast



4. Service Developments

All investment decisions that have been approved through the Trust's Investment Committee to proceed beyond Outline Business Case (OBC) stage have been included.

As yet no major service developments have been modelled in the MTFP. These will be incorporated into the next iteration of the MTFP dependent on the completion and approval of the supporting business cases. The major developments to be included are the:

- impact of enabling and transitional service reconfigurations to support the Shaping a Healthier Future (SaHF) programme as well as the Trust's own business case to support this and the redevelopment of the St Mary's Hospital site;
- North West London Pathology modernisation programme

There is expected to be no impact of these service developments in 2014/15. Where significant, costs to support the development of respective business cases have not been included in the MTFP on the assumption that these would be funded externally by commissioners.

5. Cost Improvement Plans

5.1. Savings Target 2013/14 to 2018/19

In order to deliver the planned surpluses in future years, the Trust will need to deliver efficiency savings of 4.3% in 2014/15 and 3.8% in 2015/16 of income, as outlined below. This delivery target excludes the contribution/profit from Private Healthcare but includes contribution/profit assumed from other areas of income growth (e.g. NHS market share changes and service developments).

Cost Improvement Plans

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
Impact Nominal:			
Recurrent CIP's	45.8	42.6	38.3
Non-recurrent CIP's	0.9	0.9	0.3
Total CIP's (Nominal) p.a.	**46.7**	**43.5**	**38.5**
Recurrent CIPs' (Cum.)	**45.8**	**88.4**	**126.7**
Statistics (Nominal):			
CIP as a % of Income	*4.7%*	*4.3%*	*3.8%*
CIP as a % of Costs	*4.9%*	*4.5%*	*3.9%*
CIP as a % of Costs (Cum.)	*4.8%*	*9.1%*	*12.9%*
Impact Real:			
Total CIP's (R & NR) p.a	**46.7**	**42.9**	**37.6**
Recurrent CIPs (Cum.)	**45.8**	**87.9**	**125.2**

The current plan includes detailed schemes developed by the directorates. Further work on developing a robust plan to deliver CIPs over the planning horizon is on-going, with the outputs to be included in the next iteration of the MTFP.

5.2. Monitor Efficiency Requirement

In order to demonstrate compliance with the planning guidelines issued by Monitor, below is a breakdown of performance.

Monitor Efficiency Requirement

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
Efficiency requirement	**4.0%**	**4.0%**	**4.5%**
Indicative efficiency (from LTFM)	3.3%	2.9%	3.3%
Adjustments to exclude:			
Research & Development			
Education & Training		*0.2%*	*0.2%*
and Private Patients			
Adjusted indicative efficiency		**3.1%**	**3.5%**

The forecast efficiency modelled is below the aggregate levels identified in Monitor's planning guidance in year 2014/15 and 2015/16. This is despite all major cost categories being modelled consistently with the detailed guidance.

We have undertaken work to explain the deviation from the aggregate efficiency requirement and the assumptions of the cost structure of ICHT compared to that modelled by Monitor. This will be done by segmentally showing indicative efficiencies in key areas (e.g. NHS clinical activity, high cost drugs and devices, Education & Training, Research & Development and Private Patients).

The impact of reductions in dividend payments (PDC), and corresponding increase in offsetting costs, reduce the level of indicative efficiency, but do not overall effect the net surplus position.

6. Balance Sheet and Cash Flow 2013/14 to 2015/16

6.1. Balance Sheet

The Trust's projected closing balance sheet for the next two financial years is set out in the table below.

Balance Sheet Forecast

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
NON CURRENT ASSETS			
Property, Plant and Equipment and intangible assets, Net	596.9	400.2	395.9
Total Non Current Assets	**596.9**	**400.2**	**395.9**
CURRENT ASSETS			
Inventories	15.2	14.9	14.7
NHS Trade Receivables, Current	35.0	36.9	36.6
Non NHS Trade Receivables, Current	7.8	15.0	16.8
Other Receivables, Current	5.7	3.1	3.2
Prepayments, Current, non-PFI related	20.0	20.8	21.6
Cash and Cash Equivalents	50.2	55.5	67.1
Other Current Assets	**133.9**	**146.2**	**160.0**
Total Assets	**730.8**	**546.5**	**555.9**
CURRENT LIABILITIES			
Interest-Bearing Borrowings , Current (including accrued interest)	(2.7)	(2.0)	(1.5)
Deferred Income, Current	(25.0)	(26.0)	(27.0)
Provisions, Current	(33.3)	(11.7)	(19.0)
Trade payables, Current	(39.2)	(38.1)	(38.9)
Other payables, Current	(4.8)	(20.3)	(20.8)
Capital payables, Current	(2.5)	(1.7)	(2.8)
Accruals, Current	(38.8)	(34.3)	(29.6)
Total Current Liabilities	**(146.3)**	**(134.2)**	**(139.7)**
NET CURRENT ASSETS/(LIABILITIES)	**(12.4)**	**12.1**	**20.3**
NON-CURRENT LIABILITIES			
Interest-Bearing Borrowings, Non-Current	(20.7)	(18.7)	(17.1)
Provisions, Non-Current	0.0	(12.1)	0.0
Total Non-Current Liabilities	**(20.7)**	**(30.8)**	**(17.1)**
TOTAL ASSETS EMPLOYED	**563.7**	**381.5**	**399.0**
TAXPAYERS' EQUITY			
Public dividend capital	696.1	696.1	696.1
Retained Earnings (Accumulated Losses)	(175.6)	(320.3)	(302.8)
Revaluation reserve	43.2	5.7	5.7
Total Taxpayers Equity	**563.7**	**381.5**	**399.0**

Major changes in the balanced sheet are driven by:

- non-current assets reduction due to planned capital expenditure being lower than depreciation;

- reduction in land values and buildings at Charing Cross totalling £192m resulting in a reduction in revaluation reserve of £37.5m and an impairments, taken to I&E, of £154.5m;
- cash increases from operating surpluses; and
- payables and borrowings reduced as more timely payment to support discounts and loan repayments continues.

6.2. Cash Flow

The Trust's projected cash flow forecast for the next two financial years is set out in the table below.

Cash Flow Sheet Forecast

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
EBITDA	**70.5**	**59.1**	**63.5**
Non cash adjustments	(0.7)	0.0	0.0
Operating cash flows before movements in working capital	**69.8**	**59.1**	**63.5**
Movement Increase/(decrease) in working capital			
Inventories	2.5	0.3	0.1
NHS Trade Receivables, Current	(11.6)	(1.9)	0.4
NHS Trade Receivables, Non Current	0.0	0.0	0.0
Non NHS Trade Receivables, Current	6.5	(7.3)	(1.8)
Other Receivables, Current	0.3	2.6	(0.1)
Other Receivables, Non Current	0.0	0.0	0.0
Prepayments, Current	2.0	(0.8)	(0.8)
Deferred Income,Current	(0.4)	1.0	1.0
Provisions, Current	(4.3)	(21.6)	7.3
Trade Payables, Current	(5.2)	(1.1)	0.7
Other payables, Current	(4.2)	15.5	0.4
Accruals, Current	(4.3)	(4.5)	(4.7)
Increase/(decrease) in working capital	**(18.7)**	**(17.7)**	**2.6**
Increase/(decrease) in Non Current provisions	0.0	12.1	(12.1)
Net Cash inflow/(outflow) from operating activities	**51.0**	**53.5**	**54.0**
Cash flow from investing activities			
Capex spend	(33.5)	(30.8)	(28.8)
Net cash inflow/(outflow) from investing activities	**(33.5)**	**(30.8)**	**(28.8)**
CF before Financing	**17.5**	**22.7**	**25.2**
Cash flow from financing activities:	**(33.5)**	**(30.8)**	**(28.8)**
Dividends paid	(18.9)	(14.1)	(11.1)
Interest (paid) on loans and leases	(0.9)	(0.8)	(0.8)
Interest received on cash and cash equivalents	0.2	0.2	0.2
Drawdown of loans and leases	0.1	0.0	0.0
Repayment of loans and leases	(3.1)	(2.7)	(2.0)
Net cash (outflow)/inflow from financing	**(22.6)**	**(17.4)**	**(13.7)**
Net cash (outflow)/inflow	**(5.1)**	**5.3**	**11.5**
Opening cash balance	**55.3**	**50.2**	**55.5**
Net cash (outflow)/inflow before interest	(5.3)	5.0	11.3
Interest (paid)/received on cash balance	0.2	0.2	0.2
Closing cash balance	**50.2**	**55.5**	**67.1**

7. Capital Programme 2014/15 and 2015/16

An outline of the planned Trust's capital programme and sources of funds is outlined below. The major drivers of expenditure are asset replacement and renewal, including estate, medical equipment and CIT infrastructure.

As outlined before, the values included to date exclude any impact of site rationalisation or redevelopment to support the SaHF programme.

Capital Programme

Schemes	2014/15 Forecast £m	2015/16 Forecast £m
Maintenance - all sites	(6.6)	(5.5)
Imaging Improvements - Hammersmith Hospital	(1.9)	(8.5)
PICU St Mary's	(2.6)	(0.2)
Theatre Refurbishment Programme	(1.0)	(1.0)
Waste compound relocation (HH)	(0.5)	0.0
Endoscopy provision QEQM level 2 (SMH)	(0.3)	0.0
Private Patient Facility improvements	(1.1)	0.0
Other developments / future unidentified	(3.6)	(3.8)
Imaging Review - Equipment	(2.7)	(2.1)
Other Medical Equipment	(2.4)	(2.4)
ICT investment programme	(7.2)	(6.6)
Total	**(30.0)**	**(30.0)**

Capital Funding Sources

	2014/15 Forecast £m	2015/16 Forecast £m
Sources		
Loans & Leases	0.0	0.0
PDC Received	0.0	0.0
Forecast depreciation	34.6	34.3
Other cash movements	3.4	9.2
Loan & lease repayments	(2.7)	(2.0)
Total sources	**35.3**	**41.5**
Applications		
Maintenance Capex	(7.1)	(6.0)
Buildings & Dwellings and AUC	(10.6)	(7.6)
Equipment (Plant & Machinery)	(5.1)	(9.8)
Information Technology	(6.5)	(5.9)
Intangible /SW	(0.7)	(0.7)
Capex programme	**(30.0)**	**(30.0)**
Total Cash movement	**5.3**	**11.5**

8. Private Patient Income and Expenditure 2013/14 to 2015/16

The current draft plans for development and growth of Private Patient services are forecasted to impact as below.

Private Patient Income and Expenditure Forecast

	2013/14 Forecast £m	2014/15 Forecast £m	2015/16 Forecast £m
Income			
Private patient base revenues	34.1	37.8	45.1
Pricing increases (cum 2.7% p.a.)	0.0	1.0	2.5
Total private patient income	**34.1**	**38.8**	**47.6**
Direct Expenditure			
Contracted Pay	(9.4)	(9.9)	(11.6)
Agency Pay	(0.3)	(0.3)	(0.7)
Clinical Supplies and Services	(1.4)	(1.7)	(2.0)
Drugs	(1.4)	(1.4)	(1.7)
General Supplies and Services	(2.9)	(2.9)	(3.3)
Other	(1.2)	(1.2)	(1.4)
Total direct expenditure	**(16.6)**	**(17.4)**	**(20.7)**
Gross Contribution	**17.5**	**21.4**	**26.9**
Gross Contribution %	***51.4%***	***55.2%***	***56.6%***
Indirect Expenditure			
Contracted pay	(7.2)	(8.5)	(10.3)
Clinical and General Supplies and Services	(4.8)	(5.6)	(6.9)
Total indirect expenditure	**(12.0)**	**(14.1)**	**(17.1)**
Net Contribution	**5.5**	**7.3**	**9.8**
Net Contribution %	***16.2%***	***18.8%***	***20.6%***

Key assumptions to deliver the planned growth and contribution margins are:

- use of currently unused capacity;
- renegotiation of prices for self-pay, embassy and insured markets; and
- growth of profitable and core specialties

9. Risk Ratings 2013/14 to 2015/16

Since 1st October 2013, Monitor's Risk Assessment Framework has replaced the Compliance Framework and with it a movement in assessment from a Financial Risk Rating (FRR) to a Continuity of Services Risk Rating (CoSRR), with a focus away from generating surpluses to solely liquidity and capital servicing capacity.

9.1. Continuity of Services Risk Rating (CoSRR)

The liquidity measure is calculated in the same way as the liquidity ratio in previous FRRs, and as such produces the same number (measured in days) for each year of the plan. The risk ratings have different thresholds, have been adjusted downwards and also reflect the

revised scoring between 1 and 3. The impact of this can be seen in 2015/16 where a ratio of -1.1 days produces a risk rating of 1 out of 5 under the old measure (see the FRR section) but 3 out of 4 under the new CoSRR.

The Trust's forecast provides a CoSRR of 3 in 2014/15, increasing to 4 in later years. A minimum CoSRR of 3 is required at authorisation by Monitor.

CoSRR without Working Capital Facility

Continuity of Service Risk Rating (CoSRR)	Weight	2013/14	2014/15	2015/16
Liquidity		(19.1)	(10.7)	(1.1)
Liquidity Risk Rating	50.0%	1	2	3
Capital Servicing Capacity		3.11	3.71	4.58
Capital Servicing Capacity Risk Rating	50.0%	4	4	4
Overall CoSRR		**3**	**3**	**4**

The calculation of liquidity in the LTFM compares one year's expenditure with the previous year's balance sheet values, whereas the true calculation (and the one used for all current FTs) uses the in-year balance sheet figures. The effect of shifting the calculation to the in-year balance sheet amounts produces the following CoSRRs.

CoSRR without Working Capital Facility Adjusted to In-Year Balance Sheet

Continuity of Service Risk Rating (CoSRR)	Weight	2013/14	2014/15	2015/16
Liquidity		(11.1)	(1.1)	2.1
Liquidity Risk Rating	50.0%	2	3	4
Capital Servicing Capacity		3.11	3.71	4.58
Capital Servicing Capacity Risk Rating	50.0%	4	4	4
Overall CoSRR		**3**	**4**	**4**

Due to stable levels of operating expenditure each year, the effect of this change is to shift the liquidity values in days one year earlier (+/- 0.1 days). This now produces an overall CoSRR of 4 from 2014/15 and is a truer measure than in the LTFM.

9.2. Financial Risk Rating (FRR)

The previous FRR measures are still calculated in the TDA's planning template and are included below.

Financial Risk Rating

Key deliverables	2013/14 Data		2014/15 Data		2015/16 Data	
EBITDA (£m)	70.5		59.1		63.5	
Net surplus (£m)	(102.7)		(144.7)		17.5	
Cash at bank (£m)	50.2		55.5		67.1	
Metric and Rating						
EBITDA margin (%)	7.2%	3	6.0%	3	6.3%	3
EBITDA, % achieved	110.2%	5	110.2%	5	100.0%	5
NRAF (%)	2.1%	4	2.0%	4	4.3%	5
I&E surplus margin (%)	1.5%	3	1.0%	3	1.7%	3
Liquid ratio (days)	(19.1)	1	(10.7)	1	(1.1)	1
Overall rating	2		2		2	

It is important to note that the ratings calculated above have been assessed against numbers assuming no working capital facility is taken out by the Trust, something which many FTs used in order to achieve a minimum rating of 3 for the liquidity measure. Performance against other deliverables is a 3 or above in all areas.

10. Conclusion

The financial plan presented ensures the Trust delivers the required Continuity of Services Risk Rating (CoSRR) of 3 and a normalised surplus in line with previous years.

The plan provides a level of financial coverage for the impact of Cerner implementation, enables investment in quality in line with national expectations (0.4%) and capital in line with last financial year. Key cost increases of Cerner and CNST (£2.9m) have also been included, as well as inflationary pressures being modelled in line with guidance.

The work to date on the MTFP is consistent with the current LTFM and broadly consistent with the LTFM presented to Finance and Investment Committee previously.

The current plan includes the following outstanding risks:

- agreement of Service Level Agreements with commissioners in line with the income plan
- mismatch of cost increases and developments above levels planned
- growth in private patients income
- delivery of the cost improvement plan (CIP)
- non-payment of Project Diamond and Market Forces Factor (MFF) of Research & Development (R&D) monies, income assumed at £17.3m
- reduced Contracted Out Services VAT reclaim opportunities as the result of the proposed changing of HMRC rules, estimated at £6.1m with £4.6m not currently planned for

Appendix A
Key Modelling Values and Assumptions

Key Values and Assumptions	2014/15	2015/16	Comment
VOLUME ASSUMPTIONS			
Protected/Mandatory Revenue (SLA) - Growth	2.70%	2.70%	0.7% Demographics + 2% Growth
Protected/Mandatory Revenue (SLA) - Demand Management	(3.00%)	(3.00%)	(3%) Demand Management
Cost impact of growth (%of income change)	70%	70%	In line with SaHF - To refine using PLICS
Cost impact of Demand Management including sustainability adjustment	36.9%	48.3%	In line with SaHF but adjusted for stranded costs (sustainability adjustment)
Non Protected/Non Mandatory Revenue (Private Patients)	£3.7m	£7.3m	Confirmed with Private Patients Team
PP Cost Response	£0.6m	£5.9m	Direct costs confirmed with Private Patients Team Clinical support & indirect overheads added
R&D Income	£7.0m	£0.0m	LCRN hosting income
R&D Expenditure	(£7.0m)	£0.0m	LCRN hosting cost
Other Revenue	0.00%	0.00%	
RECURRING COSTS / INCOME LOSS			
Education & Training	(£2.0m)	(£2.0m)	MPET reduction capped at £2m per year
Recurrent FT Costs	£0.0m	(£0.5m)	
Redundancies	(£1.0m)	£0.0m	Based on existing spend. Agreed to include as recurrent
Project Diamond	(£0.5m)	£0.0m	
Cerner	(£6.0m)	£0.0m	Assumed disruption costs
CNST	(£2.9m)	(£2.5m)	
CQUIN investment	(£4.0m)	(£4.5m)	Costs of delivering CQUINs each year
Changes in VAT Reclaim - Admin	(£1.5m)	£0.0m	
Contract Management Risks	(£3.4m)	(£1.1m)	
NON RECURRING COSTS			
Cerner Implementation Costs	(£2.0m)	£0.0m	
Cerner Disruption	(£6.0m)	£0.0m	
FT Costs	(£0.7m)	£0.0m	
OTHER			
Dividend Payable	3.50%	3.50%	
Agenda for Change	0.00%	0.00%	Included in the inflation assumptions

Key Values and Assumptions	2014/15	2015/16	Comment
BALANCE SHEET			
Capital investment	£30.0m	£30.0m	
Working Capital Facility	£0.0m	£0.0m	
INFLATION ASSUMPTIONS - INCOME			
Protected Revenue Income	(1.20%)	(1.20%)	
Non Protected / Non Mandatory Clinical Income Inflation	2.70%	2.70%	
Education & Training	0.00%	0.00%	
Research & Development	0.00%	0.00%	
Other Revenue	0.93%	1.02%	
INFLATION ASSUMPTIONS - PAY			
Employee Benefit Expenses	1.50%	2.20%	
INFLATION ASSUMPTIONS - NON PAY			
Drugs	2.10%	2.10%	
Clinical Supplies & Services	2.10%	2.10%	
PbR Excluded Drugs & Devices	7.20%	7.20%	
Other Expenses	2.10%	2.10%	
Unitary Charge indexation	0.00%	0.00%	
Capex inflation	3.80%	3.80%	
COST IMPROVEMENT PLANS (CIPs)			
CIPs (real)	£42.9m	£37.6m	
CIPs (nominal)	£43.5m	£38.5m	
CIP target as % of cost	4.6%	4.0%	
CIP target as % of income	4.3%	3.7%	
SURPLUSES			
Surplus	(£144.7m)	£17.5m	
Surplus %	(14.63%)	1.74%	
Normalised surplus	£18.6m	£17.5m	
Normalised surplus %	1.9%	1.7%	

Report Title: Director of People & Organisation Development Report

To be presented by: *Jayne Mee*

Executive Summary: *This report updates on the People & Organisation Development strategy developments.*

Key Issues for discussion:
For information

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

Details of Legal Review, if needed
N/A

Link to the Trust's Key Objectives: *please identify which of the following key objectives this report supports or advances and how.*

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 the relevant key objective(s): *please identify the relevant risks and the assurance that the proposals provide*

Actions required: *please list recommendations/action required as a result of this report*

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

Imperial College Healthcare NHS
NHS Trust

1. TALENT DEVELOPMENT

1.1. Engagement Survey and NHS Staff Survey

In early March we received the results of both the National NHS Staff Survey 2013, and our second local Engagement Survey. A more detailed presentation will be made at the Trust Board on March 26 2014.

The Second Local Engagement Survey was carried out in January 2014, with 2000 being invited to take part via email. The overall results were very similar to Engagement Survey 1, with response rate at 26% (down 1% from survey 1) and the overall Engagement Score was 39% (compared to 42% in the first survey). This reflects the number of people who answered questions positively with 8, 9, or 10, out of 10). The key themes also remain very consistent with the lowest scoring questions again being:

-The senior leaders here empower and inspire me to deliver good performance
-In general my job is good for my health
-My organisation takes positive action on health and well being
-At work my opinions seem to count

The National NHS Survey was carried out across all Trusts across the UK between October and December. A much longer survey, this has been run since 2007, but for the first time this year we moved to an electronic survey. Our response rate this time was 49.4% (average for NHS Trusts). A different Engagement Indicator is used, and our score this year was 3.77, which is classed as "Above Average "compared with other Acute Trusts.

To further support our work on Engagement we plan to introduce an Exit questionnaire and an "On Boarding " questionnaire to help pin point any other issues for both new joiners and leavers which will help us improve the engagement of our people.

1.2. Friends and Family Question for Staff

From April 1 2014 it will be mandatory for all NHS Trusts to ask two survey questions to all staff;

-"How likely are you to recommend this organisation to friends and family if they needed care or treatment?"
-"How likely are you to recommend this organisation to friends and family as a place to work?"

The guidance allows us to ask this through our existing Engagement Survey and we will be ready to launch this in April. The requirement is to allow all our people to answer this at least once a year with a quarterly data collection by the Department of Health. The results from this will be measured as part of the overall Friends and Family Test CQUIN in 2014-5. There will be a

requirement to publish the results of this question locally and nationally but detailed information on this element is not yet available.

1.3. NHS Change Day Briefing

Engaging our people is a key priority. NHS Change Day provided us with a key opportunity to do just this by empowering people to own, and be part of, the change that they want to see at Imperial.

On 3rd March 2014 we introduced NHS Change Day to Imperial College Healthcare NHS Trust. On all three main sites we had teams talking to our people and patients about NHS Change Day, demonstrating how one simple action or idea can make a difference and improve experiences of our colleagues, our patients and their carers. With large pledge trees in the Hospital entrances, and three walking pledge trees, our people were encouraged to complete and hang their pledges. It was positive to see so many engaged in this event and inspiring to read the range of pledges made.

For those who were unable to join us on the 3rd March they were encouraged to pledge online through the NHS Change Day web page or through twitter and facebook. Across the Trust we have recorded just under 300 pledges of action. We have now collated all the pledges and will be following up with people every three months to see what impact their actions have had. We plan to share the good news stories throughout the year and prepare for an even bigger NHS Change Day event in 2015.

Background to NHS Change Day
NHS Change day is a social movement that started with a single tweet in 2012 and inspired more than 189,000 pledges of action from people to make a positive and sustainable different to the NHS. This level of activity and response led to the very first NHS Change Day in 2013. The initial goal was to mobilise 65,000 people – 1000 for each year the NHS has been established. In fact it generated 189,000.

NHS Change Day is now a national movement and has an annual event supported by an increasing number of NHS organisations across the UK.

1.4. Leadership Programmes

In April, our fifth new Leadership Programme "Headstart" will commence. This is aimed at our middle managers; ward managers, business managers, heads of department and newly appointed consultants. Our "Aspire" Programme will commence its third cohort in April and a fourth cohort in September. In total we now have 5 programmes running at every level of the organisation and by May we will have 8 cohorts running in parallel with 89 participants.

1.5 Performance and Development Review

In March we launch the new Performance Development and Review process. A comprehensive training programme has been designed with external partners who are experts in this area, and all managers will be required to attend this training over the coming year, to obtain their Licence to practice.

2. EMPLOYEE RELATIONS

2.1. *Make a Difference*: recognising great work

The Trust will launch a new recognition scheme on 1 April to replace the existing "I recognise" and "Osc@rs" schemes. The scheme will be called "Make a Difference" to reflect the impact people who go the 'extra mile' have on the lives of patients and colleagues. The charity has generously agreed to fund the new scheme. "Make a Difference" will combine instant recognition thank you cards, bi monthly team and individual awards, and an annual award ceremony.

Instant recognition: Patients, family, colleagues, and managers can nominate people for instant recognition thank you cards for a range of positive behaviours, such outstanding commitment to meet someone's needs, and great work that exceeds expectations.

Divisional awards: Once every two months each division will select their best team and best individual. Divisions will also make an annual lifetime achievement award. Corporate directorates such as Estates and ICT will be treated as a single division.

Annual awards: An annual award ceremony will be held to celebrate the best team, individual, bank worker, and volunteer, and the lifetime achievement award. There will also be a Chairman's award which will go the team who have made the most outstanding contribution on a theme selected by the Chairman.

2.2. Pay progression

On 1 April new Trust rules on pay progression come into effect for people on Agenda for Change (AfC) contracts. For the first time, incremental pay increases will depend on satisfactory ratings at annual performance & development review (PDR); a satisfactory disciplinary record; and, in the case of managers, 100% completion of PDRs for their team members. This change represents a first move towards modernising our pay structures. In the coming year we will develop a new pay system for senior managers and a common incremental date will be implemented.

2.3. Dignity and Respect

The Trust has published a new Dignity and Respect Policy. The policy emphasises the types of positive behaviours we expect from our people and replaces the current Bullying and Harassment Policy. The Trust is currently reviewing its Equal Opportunities Policy: a new version is expected to be published in April.

3. RESOURCING

3.1. Senior Recruitment

- The following have recently joined the Trust:
    - Karen North, Associate Director of HR Operations
    - Michelle Dixon, Director of Communications & External Relations

3.2. Nursing & Midwifery Recruitment

- The drive to reduce vacancies amongst Nursing & Midwifery posts in bands 2–6 continues. Between 1 April and 28 February of this year 566 nurses, nursing assistants and midwives in these bands have joined the Trust, of whom 46 started in February. In the period between April and February, 848 offers have been made and accepted
- 35 ICU nurses recruited from India in November 13 will join the Trust in 3 batches up to August; the first batch of 13 will start in April
- 20 Nurses were appointed for Medicine following a further successful open day in January
- The average number of nurses (all bands) recruited from outside the Trust per month between April 2013 and February 2014 was 61, compared to an average of 26 per month across the whole of 2012/13; an increase of more than 230% (12/13 total: 313; 13/14 total for 11 months to date: 675)

3.3. Candidates in the pipeline/current live vacancies

	WTEs	***WTEs***
	Nursing & Midwifery	*Non-Nursing*
Vacancies in progress	*237*	*80.4*
Candidates pending clearances	*140*	*92.7*
Candidates due to start	*69*	*28*

3.4. Temporary Staffing/E-Roster

- The number of shifts being requested has continued to increase month on month. January 14 was 17% higher than January 13. The opening of additional winter pressure beds and increased establishment has increased the demand for bank and agency
- Bank pay rates were increased for general nursing bands 2 – 6 and a new rate for ICU/PICU/NICU/CICU was also introduced which is comparable to the GOSH and GSTT rates. So far we have seen an increase in the actual numbers of shifts filled each week although this is against a background of increasing number of requests for shifts
- Recruitment to bank only nurses continues and January saw 21 workers and 81 substantive workings registered on the bank

3.5. Administrative & Clerical Agency

- With effect from 1 April 2014 the Trust will no longer be able to reclaim VAT on A&C bands 1 – 5. This will result in an increase in costs of approximately £1.8 million over a year. In view of the number of agency staff in Trust there continues to be a drive to reduce the numbers down and make substantive appointments
- Brook Street have been commissioned to find 250 workers to assist the Cerner Team as floor walkers. The first batch of 38 workers have commenced and are being trained

4. PEOPLE PLANNING & INFORMATION TEAM

4.1. Qlikview

The development of the new 'Your People' application within Qlikview has now moved to the user pilot stage. The Division of Investigative Sciences & Clinical Support and the Corporate Directorate of Estates & Facilities will be testing the new application. Managers will be able to access core details about their people including key people metric information such as PDR, sickness absence, and statutory training compliance.

4.2. Safe Staffing Levels

A new monthly report has been developed and piloted within the Division of Surgery, Cancer & Cardiovascular to support the Trust reporting requirements on safe staffing levels within our wards, inpatient, and outpatient areas. The report combines key people and establishment information, including vacancies, turnover and sickness, along with rostering data pertaining to shift requirements and cover as well as core harm-free care indicators and FFT ratings. This new report will be used by all Clinical Divisions for Month 11 reporting in March.

4.3. People Planning

Work to compile the 2-Year TDA workforce plan was completed during February through collaborative working with Finance, Divisional, and Corporate Directorate colleagues. Work also continues to create a people plan that supports the Trusts LTFM, OBC, and Clinical Strategy. We continue to support the SaHF PMO and other SaHF working groups through attendance at workstream meetings and completion of specific data requests and analysis.

5. HEALTH & WELLBEING

5.1. Departure of Clinical Director

John Harrison, Clinical Director of Health and Wellbeing has resigned to take up the position of Chief Medical Officer for Devon and Cornwall Police, where he has decided to relocate with his wife. I have taken the opportunity to revise the structure given the exciting review of Occupational Health that we have completed (Appendix 1). I intend to recruit an Associate Director of Health and Wellbeing who will lead and drive the service forward, and an OH Consultant 5 PAs per week who will be dedicated to the service.

5.2. Health and Wellbeing Strategy

The second meeting of the Trust Health and Wellbeing Committee met on 04 February 2014. A strategic approach to promoting health and wellbeing in the Trust has been agreed and the next step is to produce a Gant chart / time line for the programme in 2014 and subsequent years. The aim in 2014 is to build on existing initiatives, such as iMove, and to produce tangible examples of health and wellbeing initiatives to address the low scores achieved for health and wellbeing in the recent engagement survey.

There will be cross-linkage with other elements of the P and OD strategy. For example, there will be links to the reward and recognition element with nomination of people who exemplify behaviours underpinning the five principles of health and wellbeing;

- Good diet (Eat well)
- Physical Exercise (Be active)
- Continual learning (Develop yourself and others)
- Take notice (Put things right that are wrong)
- Give something (Make someone's life better)

A particular action that would send a powerful message to our people working on the St Mary's site would be recognition that there is currently a lack of good eating options in the Trust, following the removal of the restaurant. Current outlets are said to provide unhealthy food that does not taste good. There is an opportunity to address this when the contract for the food outlets comes up for renewal around May 2014.

There was also an agreement that we need to do much more to stop smoking on Trust premises. An implementation plan will be tabled at the next meeting of the committee, prior to going to Trust Management Board. The aim is to make Trust premises completely no smoking and to have zero tolerance of smoking, including patients. This will require appropriate support for patients, particularly in-patients, and the provision of nicotine replacement therapy supplemented by on-going smoking cessation support, where appropriate. We will also have to address concerns about how to challenge members of the public who do not comply with Trust policy.

5.3. Flu vaccination

There has been a seismic shift in the expectations around healthcare worker flu vaccination. We will be required to plan to achieve >75% of front line clinical staff and students in the 2014-15 flu season which is way above our achievement of 48%. This requirement is a challenge set to us by both the Secretary of State for Health in September 2013 but also from TDA. TDA have explicitly advised Steve McManus and Nicola Grinstead that we are required to have a robust plan to achieve this target.

Using figures from this year's programme, we have around 7700 staff and students who meet Department of Health definitions of front-line (or supporting front line) staff. 75% of these equates to nearly 5800 doses. In addition to these we will also have a proportion of non-front line staff who ask to be vaccinated. This was 220 or so this year but I think we should allow for 500 doses for this group as I believe any activity we run to increase uptake in our target staff groups will result in a higher uptake in non-target staff too.

We will be arranging a high level meeting in the next few weeks to make firm commitments and decisions about how the Trust will run the 2014-15 programme.

5.4. Heath Foundation Shared Purpose Programme

The Shared Purpose Programme, funded by the Health Foundation aims to develop a toolkit based on potential links between workforce predictors and clinical outcome data. The quantitative project is now at the data analysis phase using three-years of retrospective ICU data. A medical statistician, Dr Direk commenced in post on 03 March 2014 and will be working with Professor Scholtes from the University of Cambridge to statistically analyse the data. The qualitative project, that includes an interview study and systematic review, is on track. The interview study to understand staff perceptions of risk and safety in relation to staffing has progressed with the final interviews planned to complete the adult ICU study in March. The systematic review to understand links between staffing factors and clinical outcomes has commenced, a search strategy has been agreed and this is being signed off by the clinical collaborators on the project, before a title and abstract review is undertaken.

Imperial College Healthcare NHS
NHS Trust

Report Title: Remuneration & Appointments Committee Chairman's Report

To be presented by: Sir Richard Sykes, Chairman, Remuneration & Appointments Committee

1. Introduction

The Remuneration & Appointments Committee met on 26 February 2014. The main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The proposed remuneration package for the newly appointed Chief Executive, Dr Tracey Batten, was noted and formally approved. The acting Chief Executive, Bill Shields, briefed the committee on the annual Performance & Development reviews for the Director of Nursing and the Chief Operating Officer. The committee also discussed the arrangements for the return to the Trust of a member of staff who had been on secondment. The committee's Terms of Reference were reviewed and agreed and it was noted that formal meetings of the committee would be held in June and December each year.

3. Key risks discussed

There were no risks discussed.

4. Key decisions taken

Approved newly appointed Chief Executive's remuneration package.

5. Agreed Key Actions

Market review of remuneration of directors' pay to be undertaken.

6. Future Business

N/A

7. Recommendation

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

Report Title: Risk Report

To be presented by: Cheryl Plumridge, Director of Corporate Governance & Assurance

Executive Summary:
The Board received the Corporate Risk Register (CRR) at its meeting in January. Discussions at the Trust Board Seminar in February 2014 centred on how the CRR could be improved by recasting some of the risks to make them more strategic and all-encompassing, and by linking them to the Trust's strategic objectives.

An updated version of the original style CRR was taken by the Audit, Risk & Governance Committee at its meeting on 12 March 2014. There has been insufficient time between then and now to re-engineer the risk register in conjunction with the exec team members who will own those risks and for the CRR to be discussed and moderated by the executive team and the Management Board prior to it returning to the Trust Board. The aim is to complete this work and present it to the Trust Board meeting in May.

With this in mind, what is being presented to the Trust Board on this occasion is an updated version of the existing style of CRR (Appendix A) together with a note of those risks that have since been deleted from the CRR.

Legal Implications or Review Needed

a. Yes ☐
b. No √

Link to the Trust's Key Objectives:

1. Provide the highest quality of healthcare to the communities we serve improving patient safety and satisfaction

Purpose of Report

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

1. Executive Summary

1.1 Since the last Corporate Risk Register (CRR) was presented (Trust Board 29 Jan '14 and Audit, Risk & Governance Committee 12 March '14), two new risks have been added and six risks have been downgraded and removed from the CRR. Following this Trust Board meeting, the intention is to recast many of the risks currently on the CRR to ensure they are more reflective of the Trust's strategic objectives, and sufficiently broad to capture the totality of the potential risk e.g. the continued financial sustainability of the Trust would replace but still embrace the current more narrow focus on CIPs.

1.2 The CRR will also undergo a complete refresh to ensure we have captured emerging risks and which have been the focus of recent Board level discussion e.g. workforce issues. This new style CRR will need to be discussed both individually and collectively with the executive team, as well as at the Management Board and including moderation of risks. It will also be timely to take the new Chief Executive's view on how as a Trust we undertake risk management. The intention is to present a revised CRR at the Trust Board's meeting in May.

2. New Risks

Two new risks have been added to the CRR. The first of these provided by the Director of Nursing concerns the poor patient experience as reported in the national cancer survey 2014: the underlying causes and action in hand, together with good progress to date has already been discussed at the Quality Committee and the Audit, Risk & Governance Committee. The second risk, provided by the Medical Director, relates to the failure to achieve corporate objectives for medical education. Again, Board members will be familiar with the underlying reasons for this risk and the Fiona Moss report that has been circulated to Board members.

3. Downgraded Risks

3.1 A total of six risks have been downgraded and removed from the CRR. Some of these will remain on Divisional risk registers but scoring following mitigating actions that have already delivered means they are now lower level risks and do not warrant inclusion on the CRR. These are:

3.1.1 **Risk to patient safety in the EU at Hammersmith Hospital as a result of insufficient/adequate middle grade cover**.
This risk has been mitigated by the extension of the UCC operating hours, recruitment of middle grades and a locum consultant, and ongoing discussions over plans for change as part of SaHF.

3.1.2 **Lack of senior clinicians at Charing Cross to review emergency cases.**
This risk has been downgraded as a result of, inter alia, changes to junior doctors' rotas, job planning reviews of surgical consultants, cross cover on call

arrangements with Hammersmith, and changes to patient pathways including transfer to St Mary's.

3.1.3 **Failure to transfer patients between wards and hospitals in a safe and timely way appropriate to clinical need.**
Downgraded as a risk due to a number of actions being taken including ironing out of procedural flaws coupled with a newly revised Transfer Policy and closer working arrangements with DHL. Reduction in likelihood of risk materialising as referenced by reduced DATIX incident reports and complaints about transfer.

3.1.4 **Introduction of RIS/PACS.**
Controls are now in place with additional staff having been recruited and effective monitoring arrangements as evidenced by a much reduced backlog.

3.1.5 **Consultant presence on Delivery Suite below recommended benchmark.**
Additional recruitment of consultants has now ameliorated this risk.

3.1.6 **Non compliance with NHS England's requirement for neurosurgical services.**
Agreement to recruit to meet requirement and additional business cases submitted. Downgraded to a Divisional risk where progress on control actions will continue to be closely monitored.

4. Recommendation

The Trust Board is asked to note the Corporate Risk register and the actions that will be taken.

Imperial College Healthcare NHS
NHS Trust

Board Meeting In Public

For decision

Report Title: Consultation on foundation trust application
To be presented by: Marcus Thorman, Chief Financial Officer
Executive Summary: We see achieving foundation trust status as a means towards bringing our Trust closer to our patients, the people who work for us, our local communities and partner organisations. Becoming a foundation trust will demonstrate that our healthcare meets the highest standards of safety and quality and that the Trust is a well-organised and well-governed organisation. An important feature of the Trust's application for foundation trust status is listening to the views of our patients, the people who work for us, public and partner organisations. A consultation on the proposals for becoming a foundation trust was undertaken during the period Monday 11 November 2013 until Monday 10 February 2014. The Trust's proposals for becoming a foundation trust were set out in the consultation document 'Working in Partnership' which contained 13 specific questions. All the feedback received from the consultation has been analysed and reviewed. The Foundation Trust Programme Board considered the findings at their meeting on 18 March 2014. The findings are being submitted to the Trust Board for their consideration and response with a view to helping shape the final application for foundation trust status. A summary of the results of the consultation and the Trust's response will be made publicly available and are expected to be published in April.
Key Issues for discussion: These are set out in the attached paper structured according to the 13 consultation questions.
Legal implications or Review Needed: No **Details of Legal Review, if needed:** N/A
Link to the Trust's Key Objectives: The Trust's vision and objectives formed a central section of the consultation document and the subject of the first question for response. 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.

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

Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks:
The foundation trust application programme incorporates the management of risks featuring a risk register which is regularly reviewed and considered by the Foundation Trust Programme Board.

Recommendations and Actions Required:
The Foundation Trust Programme Board has considered the findings of the consultation and makes the following recommendations:

1.1 use the opportunity provided by the publication of the formal response to the consultation to provide further updated information on the development of its plans to implement its clinical strategy across the three main hospital sites.

2.1 proceed with the minimum age of 16 for membership.

2.2 review its methods for communication and engagement with younger patients particularly those under 16 years of age.

3.1 proceed with a single public constituency for Greater London covering the 32 London Boroughs and the City of London.

3.2 consider a geographical sub-division of the seats allocated to the public constituency on the council of governors (see Question 10)

4.1 proceed with three membership constituencies: public; patient; and, staff.

5.1 proceed with the patient constituency without any sub-divisions.

5.2 consider ‘ring-fencing’ the nominated partner seat for the voluntary organisation for a carer organisation on the council of governors (see Question 10)

6.1 proceed with the automatic enrolment of directly-employed staff as members of the foundation trust.

7.1 proceed with staff membership for any current employee of the Trust with a permanent, temporary or fixed-term contract for at least 12 months.

8.1 proceed with the sub-division of the staff constituency into two sections: clinical and non-clinical.

9.1 proceed with the three levels of membership as described in the consultation document: informed; involved; and active.

10.1 sub-divide the eight seats allocated to the public constituency so that five are elected

from members living in north west London (eight boroughs) and three are elected for the rest of Greater London (24 boroughs and the City of London) – (see Question 3)

10.2 increase by one the number of seats allocated to the patient constituency giving a total of nine seats for this constituency

10.3 increase by one the number of seats allocated to clinical commissioning groups giving a total of two seats for this constituency

10.4 increase (based on acceptance of recommendations above) by two seats the total number of seats on the council of governors giving a total of 33 seats for the council

10.5 specify that the seat/s allocated to clinical commissioning groups are specifically in relation to the eight CCGs in north West London and that the process for deciding how these seats are filled is their responsibility

10.6 specify that the two seats allocated to local authorities are specifically 'ring-fenced' to the two local authorities in which the Trust's three main hospital sites are geographically located – ie. London Borough of Hammersmith & Fulham and Westminster City Council respectively – and that the process for filling the one seat allocated to each local authority is their responsibility

10.7 specify that the one seat allocated to an independent medical charity is specifically 'ring-fenced' to the Association of Medical Research Charities and that the process for deciding how this seat is filled is their responsibility

10.8 specify that the one seat allocated to a voluntary organisation is specifically 'ring-fenced' to be filled by an organisation representing carers

11.1 proceed with 16 as the minimum age for governors, while specifying this relates to being 16 or over at the closing date for nominations to stand for election as a governor.

12.1 proceed with the proposed arrangements for elections.

13.1 proceed with the proposed plan for the board of directors as set out in the consultation document.

Imperial College Healthcare NHS
NHS Trust

Consultation on foundation trust application

Introduction

The formal consultation on the Trust's application to become a foundation trust ran from Monday 11 November 2013 until Monday 10 February 2014.

This paper is divided into 13 sections – one section for each of the 13 consultation questions.

Each consultation question section provides a summary of the answer choices provided by respondents who completed the online questionnaire and response form, displaying a bar chart and table containing a breakdown by percentage and actual numbers.

A summary analysis of the comments made to each question is then provided.

The final part of each section sets out the response and recommendation of the Foundation Trust Programme Board which considered the findings at their meeting on 18 March 2014.

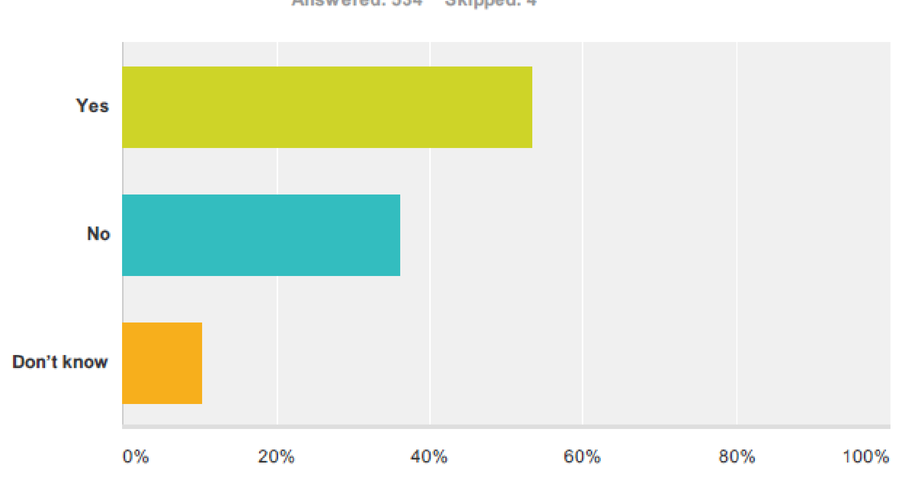
Consultation Responses (breakdown by method)
Online Questionnaires: 305
Response Forms: 231
Emails/Letters: 9
Total: 545

Substantive comments were provided by the three local authorities who submitted formal responses: Royal Borough of Kensington and Chelsea; London Borough of Hammersmith & Fulham; and, Westminster City Council.

Responses from other organisations were provided by email and letter: Healthwatch Central West London; Buckinghamshire New University; LB of Harrow; North West London Hospitals NHS Trust and Ealing Hospital NHS Trust; Macmillan Cancer Support; and NHS West London Clinical Commissioning Group.

Public Meetings (approximate attendees)
Kensington: 25
Hammersmith: 35
Paddington: 75
Total: 135

Q1: Do you agree with our vision and strategy for the future?



Answer Choices	Responses	
Yes	53.37%	285
No	36.14%	193
Don't know	10.49%	56
Total		534

Analysis of individual comments (total 313)
There were 117 generally favourable and supportive comments which featured the following words and phrases in a positive context: 'high quality/healthcare/education/research/AHSC/ innovations/patient care/patient experience/ staff/ partnership'.

The majority of negative comments (115) provided by respondents answering this question related to concerns over future changes to the emergency departments and other services at: 'closure/downgrade/300-800 beds reduced/land sales/save our hospitals' - at Charing Cross Hospital and Hammersmith Hospital.

This was also the case when attendees at the public meetings raised the issue of changes already consulted upon under the 'Shaping a healthier future' programme and subject to the Secretary of State for Health's announcement made on 30 October 2013.

5 of the 'no' respondents mentioned 'private control/privatisation' in their comments.
Of the respondents answering 'no' 32 answered Question 1 only (entering no responses for the subsequent questions 2-13).

Several comments, particularly in the written submissions from local authorities and during the public meetings, were based on requests for more detailed information about the Trust's clinical and site strategies and the business cases providing financial and development plans.

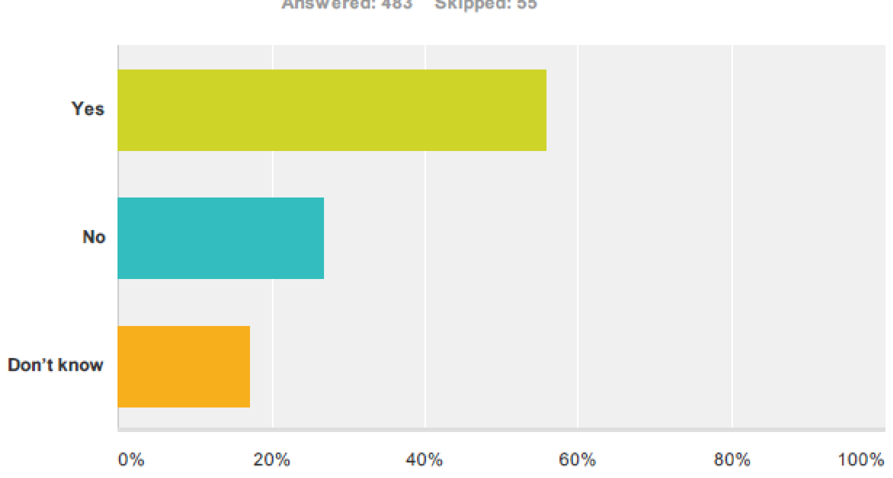
Some comments expressed a lack of understanding of how becoming a foundation trust would enable the Trust to achieve its strategic objectives and benefit patients.

During the presentation of the strategic objectives at the public meetings it was highlighted that objective four relating to the AHSC/AHSN benefits to patients was difficult to understand.

Response and Recommendations
The timing of the foundation trust consultation period meant it commenced shortly after the Secretary of State for Health's announcement of his decisions on the 'Shaping a healthier future' programme made on 30 October 2013. The Trust's emerging vision and strategy as set out in the consultation document therefore reflected the current state of development as at the end of October. In subsequent months further detailed work – for example on the Integrated Business Plan and draft Outline Business Case - has been undertaken on how the Trust intends to proceed in line with this strategic approach.

It is recommended that the Trust should:
1.1 use the opportunity provided by the publication of the formal response to the consultation to provide further updated information on the development of its plans to implement its clinical strategy across the three main hospital sites.

Q2: Do you agree that the minimum age for membership should be 16?



Answer Choices	Responses	
Yes	55.90%	270
No	26.92%	130
Don't know	17.18%	83
Total		483

Analysis of individual comments (total 220)
There were 69 comments from those respondents answering 'yes' to this question who used the following words and phrases in a favourable and supportive context: 'mature/understand/sensible/young person's point of view/informed/vision/involvement/ empowering'.

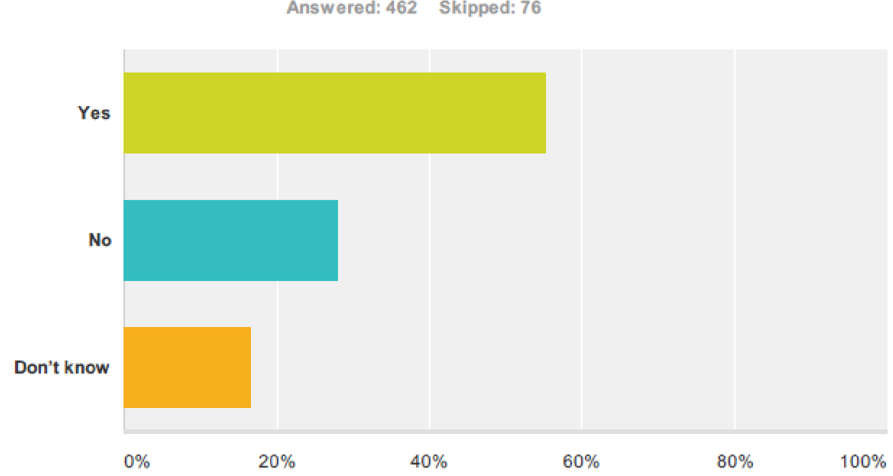
The majority of comments(87) provided by respondents answering 'no' to this question related to the view that at 16 years of age members would lack maturity and experience, suggesting minimum ages of 18 or 21 upward: 'too young/not old enough/not mature enough/ not enough life experience/should be voting age/should be 18/should be 21'.
5 comments specified that the minimum age should be 'under 16' or specified a minimum age of 14.

Similar themes run through the comments from the 'no' respondents on Q11 'Do you agree with the minimum age of governors being 16?'

Response and Recommendations
The responses and feedback to this question should be considered in conjunction with those made to Question 11 concerning the minimum age of governors. It is important that the Trust develops and maintains appropriate and effective channels of information and involvement for all its patients.

It is recommended that the Trust should:
2.1 proceed with the minimum age of 16 for membership.
2.2 review its methods for communication and engagement with younger patients particularly those under 16 years of age.

Q3: Do you agree that the public constituency should encompass the whole of Greater London?



Answer Choices	Responses	
Yes	55.41%	256
No	27.92%	129
Don't know	16.67%	77
Total		462

Analysis of individual comments (total 209)
There were 64 comments from those respondents answering 'yes' to this question who used the following words and phrases in a favourable and supportive context: 'specialist/tertiary/referrals/patients all over London/views of all/population of Greater London'.

The majority of comments (72) provided by respondents answering 'no' to this question related to the view that Greater London was too large an area and unrepresentative of the local public interested in the Trust and the geographical location of its hospitals: 'too big/too large/too wide/not familiar with geographical area/feeling of ownership/reflect the local catchment area/should be west-north west London'.

Similar themes concerning the public constituency run through the comments from the 'no' respondents on Q10 'Do you agree with the proposed size and composition of the council of governors?'

Response and Recommendations
The responses and feedback to this question should be considered in conjunction with those made to Question 10 concerning the size and composition of the council of governors.

While providing the same comprehensive range of healthcare services to the local population of nearly two million people resident in north west London, the Trust provided

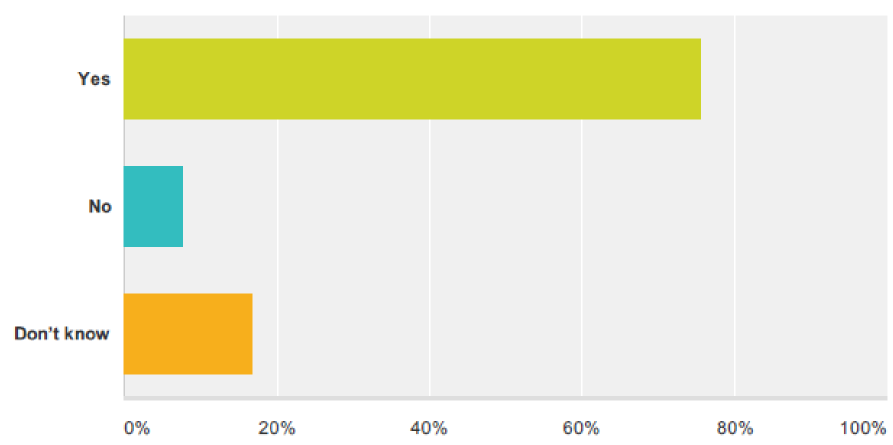
over 55 specialist services for patients from over 80 commissioners covering the rest of Greater London and nationwide in 2012-13.

The Trust believes that it would benefit from the involvement of members across the Greater London area who share an interest in our services.

It is recommended that the Trust should:
3.1 proceed with a single public constituency for Greater London covering the 32 London Boroughs and the City of London.

3.2 consider a geographical sub-division of the seats allocated to the public constituency on the council of governors (see Question 10)

Q4: Do you agree that we should have a public and a patient constituency?



Answer Choices	Responses	
Yes	75.56%	337
No	7.62%	34
Don't know	16.82%	75
Total		**446**

Analysis of individual comments (total 176)
The comments from those respondents answering 'yes' to this question used the following words and phrases in a favourable and supportive context: 'patients and the public: must be included as they are customers/should have a voice/must be included'.

The specific concern raised in this area was how the Trust would distinguish between the two constituencies – for example, a Healthwatch Central West London comment.

A specific question related to whether a patient member would transfer to the public constituency if they had received treatment over five years ago.

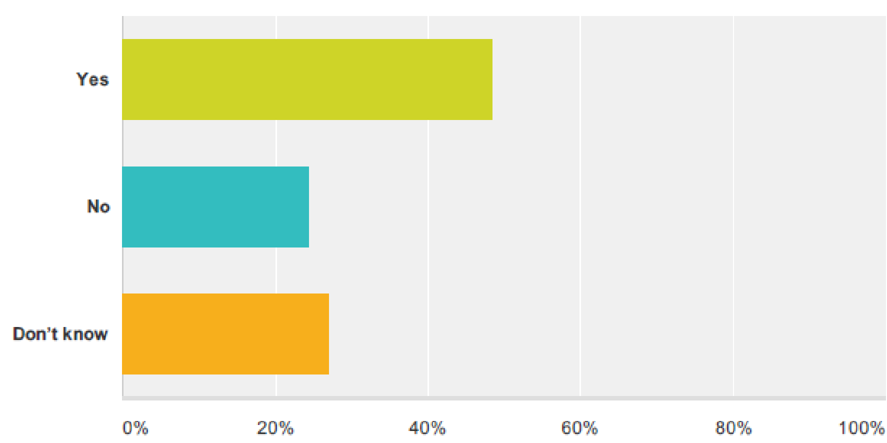
Response and Recommendations
Foundation trusts can choose if they wish to add a constituency for patients and we believe this would be a means of bringing the Trust closer to our patients ensuring that we are listening and responding to their views. Patients bring a different perspective than wider members of the public based on their direct experience of our care.

It would not be possible for the same individual to be a member in both the public constituency and the patient constituency at the same time. Once a member of the patient constituency became no longer eligible for membership after five years since their last episode of care, they would be offered membership of the public constituency based on meeting the required criteria.

It is recommended that the Trust should:
4.1 proceed with three membership constituencies: public; patient; and, staff.

Q5: Do you agree that the patient constituency should not be sub-divided to include carers?

Q5 Do you agree that the patient constituency should not be sub-divided to include carers? (Page 17)



Answer Choices	Responses	
Yes	48.51%	211
No	24.37%	106
Don't know	27.13%	118
Total		435

Analysis of individual comments (total 184)
This question received the lowest percentage of respondents answering ‘yes’.

The 55 comments from those respondents answering ‘yes’ to this question used the following words and phrases in a favourable and supportive context – ‘simplicity/too many sub divisions/unnecessary/can join public constituency’.

22 comments from ‘don’t know’ respondents used words/phrases such as – ‘uncertain/further information/specify carers/question confusing/badly worded question/not clear/do not understand question/not enough information/agnostic’.

The majority of comments (44) provided by respondents answering ‘no’ to this question related to the view that carers would provide a valuable viewpoint based on their experience using words/phrases such as – ‘understanding/voice/experience/different view’ – which was also a Macmillan Cancer Support comment.

Response and Recommendations
The Trust recognises the valuable role and contribution made by carers and the potential benefits from their involvement in our activities. However, the Trust feels that the sub-division of the patient constituency would increase the complexity of the governance arrangements.

An alternative method of ensuring carers’ involvement would be to encourage their membership of the public constituency and for the Trust to consider a ‘ring-fenced’

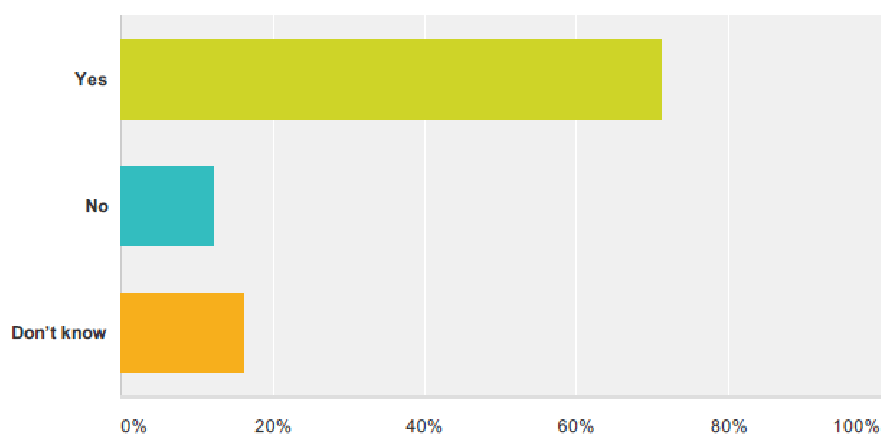
nominated partner as a voluntary organisation. See also Question 10 concerning the size and composition of the council of governors.

It is recommended that the Trust should:
5.1 proceed with the patient constituency without any sub-divisions.

5.2 consider ‘ring-fencing’ the nominated partner seat for the voluntary organisation for a carer organisation on the council of governors (see Question 10)

Q6: Do you agree that staff members should automatically become members of the Trust unless they choose to opt out?

Q6 Do you agree that staff members should automatically become members of the Trust unless they choose to opt out? (Page 17)



Answer Choices	Responses	
Yes	71.26%	310
No	12.41%	54
Don't know	16.32%	71
Total		**435**

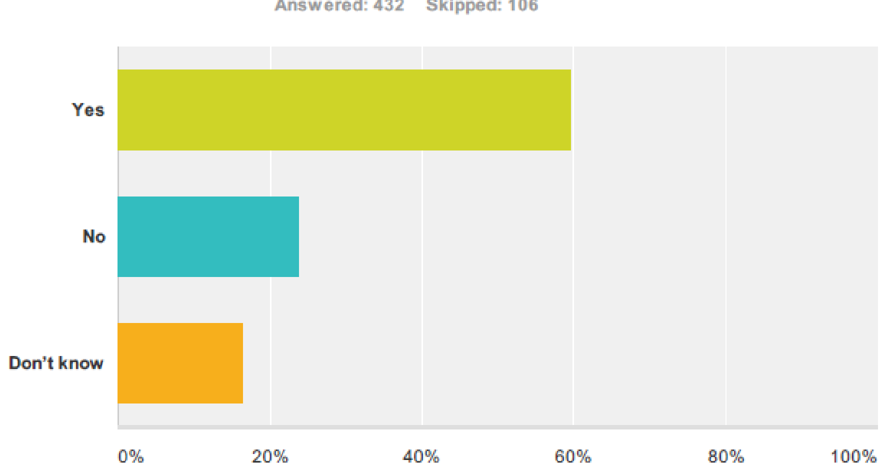
Analysis of individual comments (total 179)
The comments from those respondents answering 'yes' to this question used the following words and phrases in a favourable and supportive context – 'stakeholders/partners/commitment/accountability/active/ownership/loyalty/involved/have their say/staff satisfaction and patient experience/motivate/contributors/included'.

The specific concerns raised were about ensuring actively engaged staff as members and clearly stating they could opt out and how.

Response and Recommendations
While the Trust believes that this would be a means of bringing the Trust closer to our people ensuring that we are listening and responding to their views, we will consider appropriate methods for communicating the choice for individuals to opt out.

It is recommended that the Trust should:
6.1 proceed with the automatic enrolment of directly-employed staff as members of the foundation trust.

Q7: Do you agree that only staff directly employed by the Trust should be eligible for staff membership?



Answer Choices	Responses	
Yes	59.72%	258
No	23.84%	103
Don't know	16.44%	71
Total		432

Analysis of individual comments (total 172)

The comments from those respondents answering 'yes' to this question felt that permanent, directly employed staff should be eligible for membership and other types of staff could join the public constituency.

The comments from those respondents answering 'no' to this question mainly suggested that all staff including temporary, contract staff should be eligible for staff membership.

Response and Recommendations

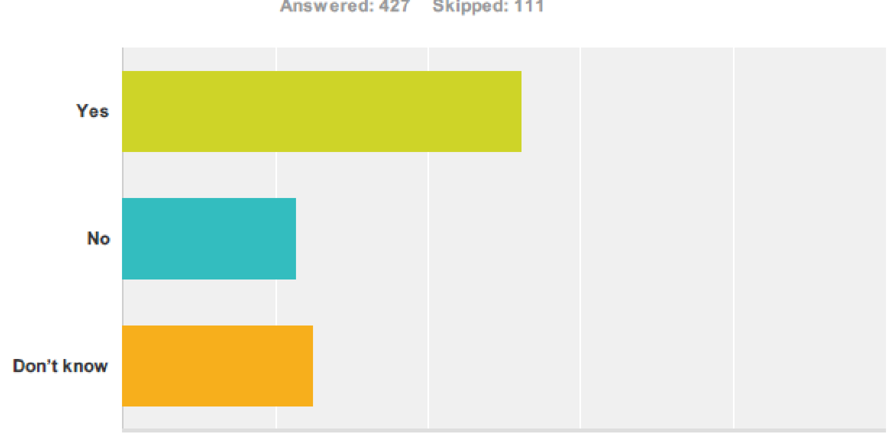
While the Trust recognises the contribution made by contractor and short-term temporary staff, it is felt that allowing their membership to the staff constituency would create a disproportionate administrative burden and increase the complexity of the governance arrangements.

However, as an alternative the Trust should encourage contractor and short-term temporary staff to become members of the public constituency provided they meet the required criteria.

It is recommended that the Trust should:

7.1 proceed with staff membership for any current employee of the Trust with a permanent, temporary or fixed-term contract for at least 12 months.

Q8: Do you agree that the staff constituency should be sub-divided as clinical and non-clinical?



Answer Choices	Responses	
Yes	52.22%	223
No	22.72%	97
Don't know	25.06%	107
Total		427

Analysis of individual comments (total 172)
The comments (66) from those respondents answering 'yes' to this question used the following words and phrases in a favourable and supportive context – 'broader base/different experiences/specific view/different but complementary'.

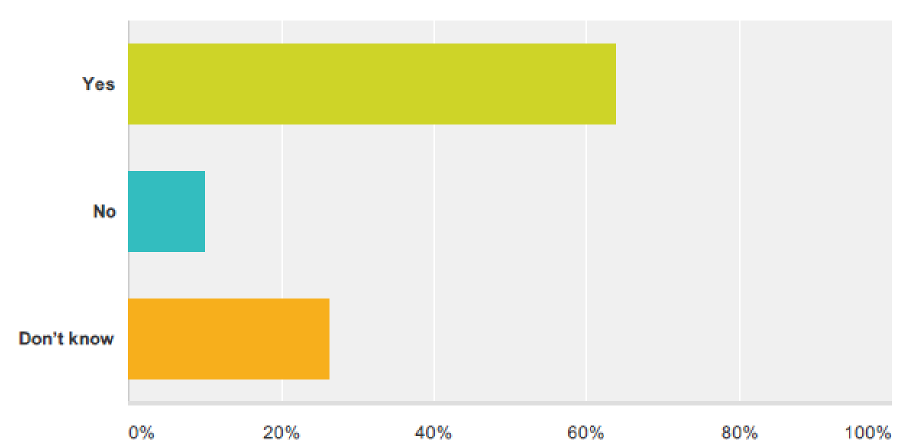
Comments (37) provided by respondents answering 'no' to this question related to the view that they did not understand the reason for a division, it was a waste and some thought it ran against effective team building across all Trust staff.

Response and Recommendations
The Trust values the engagement and involvement of all the people working for us in the development and delivery of our services. However, The Trust believes that input from the staff constituency should be representative of its average breakdown between clinical and non-clinical – in 2012-13 the total of some 9,500 employees was made up of approximately 7,500 clinical and 2,000 non-clinical.

It is recommended that the Trust should:
8.1 proceed with the sub-division of the staff constituency into two sections: clinical and non-clinical.

Q9: Do you agree with the proposed levels of engagement with our members as described?

Q9 Do you agree with the proposed levels of engagement with our members as described? (Page 17)



Answer Choices	Responses	
Yes	63.83%	270
No	9.93%	42
Don't know	26.24%	111
Total		423

Analysis of individual comments (total 141)

The comments from those respondents answering 'yes' to this question favoured the flexibility for engagement provided by the various levels of membership.

The main comment provided by respondents answering 'no' to this question related to the view that it would be unequal and a complicated and bureaucratic system of membership.

Response and Recommendations

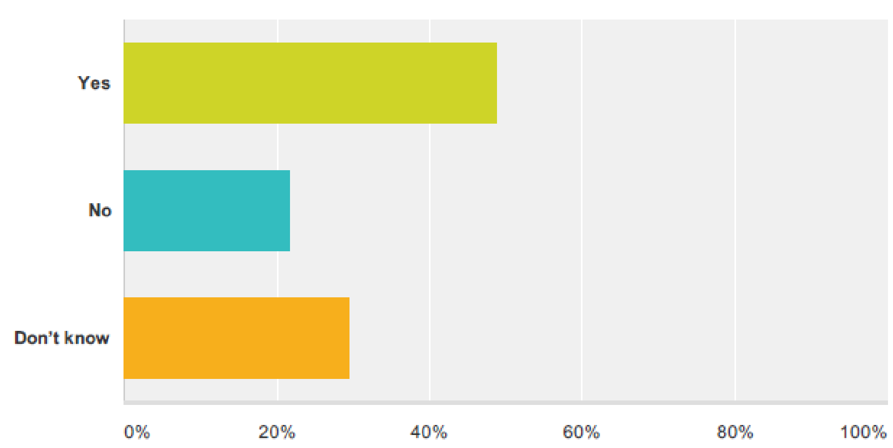
The Trust welcomes and values the engagement of each and every one of its members but recognises that individuals will wish to choose how often and to what extent they wish to be involved.

It is recommended that the Trust should:

9.1 proceed with the three levels of membership as described in the consultation document: informed; involved; and active.

Q10: Do you agree with the proposed size and composition of the council of governors?

Q10 Do you agree with the proposed size and composition of the council of governors? (Page 19)



Answer Choices	Responses	
Yes	48.80%	204
No	21.77%	91
Don't know	29.43%	123
Total		418

Analysis of individual comments (total 170)
This question received the highest percentage of respondents answering 'don't know'.

The comments (67) from those respondents answering 'yes' to this question used the following words and phrases in a favourable and supportive context – 'reasonable distribution/well represented/balanced/not unwieldy/right size/not too big/good balance/appropriate/good number/fair representation'.

The comments (49) questioning the size and composition of the council of governors included both that it was too big and that it was too small. Several comments related to the balance of representation for local authorities and commissioners: specific suggestions were made by the local authorities in Kensington and Chelsea, Hammersmith & Fulham, and Westminster. Several attendees at the public meetings also made similar comments.

It should be noted however, that one formal response was received (from NHS West London CCG) out of the eight clinical commissioning groups in North West London, suggesting increasing representation from the local CCGs.

Some comments said there should be more seats for non-clinical staff and additional seats for local authorities in Ealing and Hounslow.

Healthwatch Central West London suggested increasing the number of seats for local authorities and clinical commissioning groups. In addition, other specific comments focused

on a nominated partner seat for Healthwatch, which was a sentiment expressed in the responses from Buckinghamshire New University and Harrow Council.

Comments were made to limit the terms of governors' office to less than three terms. Other comments raised concerns about the council of governors lacking the necessary powers to hold the board of directors to account.

10.9 Response and Recommendations
It is important that the size and composition of the council of governors enables it to fulfill its role and responsibilities effectively. While increasing the number of seats in certain constituencies and for specific nominated partners may appear responsive to suggestions for increased representation, this needs to be weighed against the need to avoid a council which is too large, unwieldy and unable to function effectively.

As stated earlier (under Question 3), the Trust provides over 55 specialist services for both adults and children and we provided specialist care for patients from over 80 commissioners nationwide in 2012-13. While providing the same comprehensive range of healthcare services to the local population of nearly two million people resident in north west London, the Trust believes that it would benefit from the involvement of governors elected from across the Greater London area who share an interest in our services.

Being an academic health science centre brings significant benefits for our patients, staff, students and local population which we believe warrants allocating three seats for AHSC partners. For similar reasons, the Trust's close integration with Imperial College London means we wish to proceed with one allocated seat for this university.

The Trust is keen to ensure that governors with an active interest in its activities and affairs are able to contribute over a suitable length of time providing the opportunity to develop an individual governor's expertise and maintain appropriate continuity for the governance of the organization. We therefore intend to proceed with a maximum term of office up to nine years (also see Question 12).

The Trust is committed to providing a programme of ongoing development and support for all governors, both as individuals and as a group, to ensure they are able to effectively fulfill their important roles and responsibilities.

We see achieving foundation trust status as a means towards bringing the Trust closer to our patients and local communities, the people who work for us, and partner organisations including Healthwatch who work on behalf of patients and the public so that they have their say about the NHS. The Trust sees the continued development of a strong working relationship with Healthwatch Central West London as an important part of our approach to improving the experience of our patients and their carers while in contact with our services.

It is recommended that the Trust should:
10.1 sub-divide the eight seats allocated to the public constituency so that five are elected from members living in north west London (eight boroughs) and three are elected for the rest of Greater London (24 boroughs and the City of London) – (see Question 3)

10.2 increase by one the number of seats allocated to the patient constituency giving a total of nine seats for this constituency

10.3 increase by one the number of seats allocated to clinical commissioning groups giving a total of two seats for this constituency

10.4 increase (based on acceptance of recommendations above) by two seats the total number of seats on the council of governors giving a total of 33 seats for the council

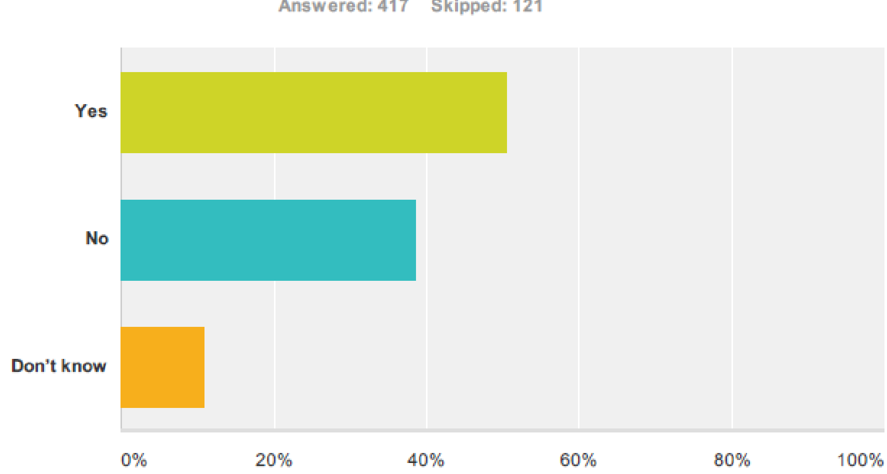
10.5 specify that the seat/s allocated to clinical commissioning groups are specifically in relation to the eight CCGs in north West London and that the process for deciding how these seats are filled is their responsibility

10.6 specify that the two seats allocated to local authorities are specifically 'ring-fenced' to the two local authorities in which the Trust's three main hospital sites are geographically located – ie. London Borough of Hammersmith & Fulham and Westminster City Council respectively – and that the process for filling the one seat allocated to each local authority is their responsibility

10.7 specify that the one seat allocated to an independent medical charity is specifically 'ring-fenced' to the Association of Medical Research Charities and that the process for deciding how this seat is filled is their responsibility

10.8 specify that the one seat allocated to a voluntary organisation is specifically 'ring-fenced' to be filled by an organisation representing carers

Q11: Do you agree with the minimum age of governors being 16?



Answer Choices	Responses	
Yes	50.60%	211
No	38.61%	161
Don't know	10.79%	45
Total		417

Analysis of individual comments (total 203)
This question received the highest percentage of respondents answering 'no'.

The majority of comments (108) provided by respondents answering 'no' to this question related to the view that at 16 years of age governors would lack maturity and experience, suggesting minimum ages ranging from a minimum of 18/21 and higher up to 30.

Similar themes run through the comments from the 'no' respondents on Q2 'Do you agree with the minimum age of governors being 16?'

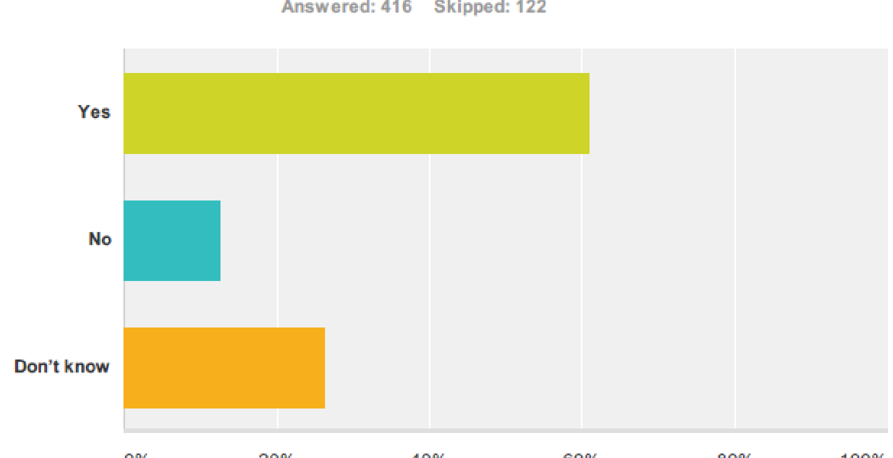
Response and Recommendations
The responses and feedback to this question should be considered in conjunction with those made to Question 2 concerning the minimum age of members.

It is a requirement of Monitor, the regulator of health services in England, that all governors of foundation trusts be aged 16 years or over.

The Trust understands the reasons for a significant number of respondents advocating a higher minimum age for governors. As stated above (see Question 10) however, the Trust is committed to providing a programme of ongoing development and support for all governors, both as individuals and as a group, to ensure they are able to effectively fulfill their important roles and responsibilities.

It is recommended that the Trust should:
11.1 proceed with 16 as the minimum age for governors, while specifying this relates to being 16 or over at the closing date for nominations to stand for election as a governor.

Q12: Do you agree with our proposed arrangements for elections?



Answer Choices	Responses	
Yes	61.06%	254
No	12.74%	53
Don't know	26.20%	109
Total		**416**

Analysis of individual comments (total 143)
The comments (95) from those respondents answering 'yes' to this question used the following words and phrases in a favourable and supportive context – 'reasonable/workable/open/fair'.

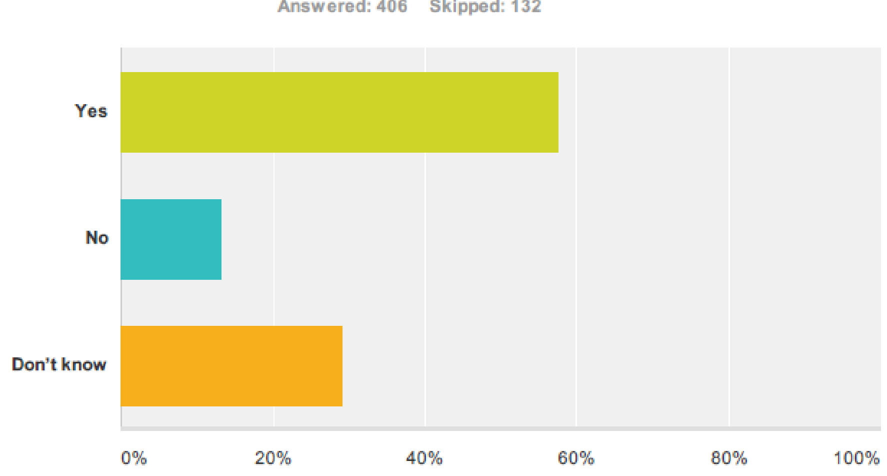
Comments (31) from respondents who said 'no' gave the view that nine years for maximum terms of office was too long and suggesting a voting system using proportional representation. Some questions were asked about which organisation would be the 'independent third party' organising elections.

Response and Recommendations
As stated above (see Question 4), it would not be possible for the same individual to be a member in both the public constituency and the patient constituency at the same time. As such, an individual member would vote in elections for governor candidates drawn from their own constituency using the 'first past the post system'.

As stated above (see Question 10), the Trust is keen to ensure that governors with an active interest in its activities and affairs are able to contribute over a suitable length of time providing the opportunity to develop an individual governor's expertise and maintain appropriate continuity for the governance of the organization. We therefore intend to proceed with a maximum term of office up to nine years.

It is recommended that the Trust should:
12.1 proceed with the proposed arrangements for elections.

Q13: Do you agree with our proposed plan for the board of directors?



Answer Choices	Responses	
Yes	57.64%	234
No	13.05%	53
Don't know	29.31%	119
Total		**406**

Analysis of individual comments (total 149)
The comments (71) from those respondents answering 'yes' to this question used the following words and phrases in a favourable and supportive context – 'appropriate/sounds right/standard practice/fairly standard/recognised structure/logical/well balanced'.
Several comments from respondents answering 'don't know' (23) asked for more detailed information on the composition of the board of directors and how non-executive directors would be appointed.

A specific suggestion was for Imperial College London to be allocated a non-executive director position on the board of directors, rather than holding a nominated partner seat on the council of governors – Westminster City Council comment.

Comments from respondents who answered 'no' (23) were largely based on overall opposition to the foundation trust application and service reconfiguration decisions under the 'Shaping a healthier future' programme.

Response and Recommendations
The detailed plan for the board of directors is currently being formulated as the draft constitution for the prospective foundation trust is given further consideration.

It is recommended that the Trust should:
13.1 proceed with the proposed plan for the board of directors as set out in the consultation document.

Imperial College Healthcare NHS
NHS Trust

Trust Board : 26 March 2014

Report Title: Terms of Reference
To be presented by: Cheryl Plumridge, Director of Governance & Assurance
Executive Summary: At the Trust Board meeting on 24 July 2013 the Trust Board approved a template Terms of Reference for all its Committees.
Legal implications or Review Needed: None. **Details of Legal Review, if needed:** None required
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
Recommendations and Actions Required: The Trust Board is asked to approve the Remuneration and Appointments Committee Terms of Reference and note the single set of Terms of Reference of its committees.

Terms of Reference

1 Introduction

1.1 At the Trust Board meeting on 24 July 2013 the Trust Board approved a template Terms of Reference (ToR) for all its Committees.

1.2 The Trust Board has received and approved all its committee's ToR except for the Remuneration and Appointments Committee as this committee meets on an infrequent basis. However the Committee met on 26 February 2014 and approved its ToR at that meeting and accordingly the ToR are attached for approval by the Trust Board.

1.3 In addition at its meeting on 27 November 2013 the Trust Board requested a single set of ToR which is now attached.

2 Recommendation

2.1 The Trust Board is asked to approve the Remuneration and Appointments Committee Terms of Reference.

2.2 The Trust board is asked to note the single set of Terms of Reference of its committees.

Imperial College Healthcare NHS
NHS Trust

Report Title: Non Executive Directors' Indemnity
To be presented by: Cheryl Plumridge, Director of Governance & Assurance
Executive Summary: As Non Executive Directors are not employed by the Trust Board they are not covered by the principle of vicarious liability for their decisions. To provide protection to them the Department of Health recommended that a form of indemnity be adopted by the Trust Board to provide them with such protection which will ultimately be covered by the NHS Litigation Authority's Liabilities to Third Parties Scheme.
Legal implications or Review Needed: Without the indemnity Non Executive Directors would be personally liable for their decisions and actions taken in good faith in the normal course of Board business. **Details of Legal Review, if needed:** None required
Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients.
Recommendations and Actions Required: The Trust Board is asked to adopt the indemnity on behalf of its Non Executive Directors.

Non Executive Directors' Indemnity

1 Introduction

1.1 HSC 1998/010 and HSC 1999/104 issued by the Department of Health provide guidance on the extent to which Non-Executive Directors of Trust Boards may be personally liable for their decisions and actions. The circulars are attached as Appendix A and B to this paper.

1.2 The circulars identified that whilst extremely rare it is possible for Non-Executive Directors to be personally liable for their decisions and actions but that this liability can be limited through an indemnity given by the Trust Board where the Non-Executive has acted in good faith and taken decisions in the normal course of Board business. It does not cover any personal criminal liability nor will it protect against reckless actions.

1.3. Having reviewed previous Board papers it does not appear that this indemnity has previously been given to the Trust's Non Executive Directors and therefore action is required to rectify the situation.

2 Indemnity

2.1 The circulars recommended that Trust Boards adopt an indemnity in the form of:

"A Chairman or Non-Executive member or Director who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her board function, save where the person has acted recklessly."

2.2 If adopted the indemnity is subsequently covered by insurance under the NHS Litigation Authority's Liabilities to Third Parties Scheme.

2.3 To minimise the risk, Non-Executive Directors should act only in accordance with the Board's Standing Orders and with the support of the Trust Board.

2.4 Whilst all members of the Trust Board are personally liable for their decisions and actions, Executive Directors do not require specific indemnity as they are direct employees of the Trust and as such the principle of vicarious liability applies in relation to their roles as Board members, ie the Trust is liable for the actions of its employees in the course of their employment.

3 Recommendation

3.1. The Trust Board is asked to adopt the above indemnity on behalf of its Non Executive Directors.

3.2 As the indemnity applies to all the Non Executive Directors an indemnity needs to be given to each individually, as the individual Non Executive Director will need to formally abstain from the decision making to grant them an indemnity as under the Standing Orders they are not able to participate in a decision that has a direct benefit to themselves.

Imperial College Healthcare NHS
NHS Trust

Report Title: Audit, Risk & Governance Committee Chairman's Report

To be presented by: Sir Gerald Acher, Chairman Audit, Risk & Governance Committee

1. Introduction

The Audit, Risk & Governance Committee met on Wednesday 12 March 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

- The committee were updated on the latest position of the Cerner implementation which continued to make good progress and was on track to go live on 22 April 2014. The Trust had progressed successfully through three Gateways and a Cutover Risk Mitigation Plan had been developed as a proactive approach to the management of risks. The Trust had now entered a phase of intense activity as the final countdown begins.
- The committee received a report on the results of two staff surveys that had taken place, one a local engagement survey and the other a NHS national survey and discussed the need for actions plans to move the scores forward.
- The committee received an update on the safeguarding adults' progress report and it was noted that key areas of strength were active engagement of clinical staff, good safeguarding adult alert reporting, active participation with Tri-borough arrangements together with an active Trust Adult Safeguarding Board.
- A report on Medical Education was presented to the committee which had suggested implementing a new model of shared leadership without a single Director of Education.
- The Elective Access Assurance Report was presented to the Committee. It was noted that details in the review had been discussed at Management Board and with colleagues at Deloitte and internal audit.
- The committee received a report from Deloitte's on External Audit Progress with a plan setting out a summary of the work performed.
- The committee was updated on the internal audit progress report. There had been thirteen additional audits where fieldwork had been completed and a draft report issued.
- The committee was updated on the counter fraud progress report with four counter fraud and bribery sessions being conducted since the last meeting.

3. Key risks discussed

The following risk related items were discussed:

- The implementation of Cerner.
- The Corporate Risk Register was discussed prior to it being discussed at the

Trust Board at the end of March, following which it would be revised and updated in line with recent discussions about over-arching areas of risk.

4. Key decisions taken

The following key decisions were made:

- Cerner continued to be an area for close scrutiny.
- The Committee wanted to be kept informed about progress on actions relating to the staff survey.
- The Internal Audit plan would be discussed in detail at the June meeting.

5. Agreed Key Actions

The committee requested future reports on:
- Post go live Cerner implementation.
- An update on the staff survey.
- An understanding of the failings that occurred in respect of the reporting break.

6. Future Business
- Issues with Pharmacy Ascribe and XP.
- Annual Governance Statement.
- Annual Accounts.

7. Recommendation

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

Imperial College Healthcare NHS
NHS Trust

Board Meeting in Public

For decision

Report Title: NHS Trust Development Authority Self-Certifications: for December 2013 and January 2014.

Report History: Regular

To be presented by: Marcus Thorman, Chief Financial Officer.

Executive Summary:

As part of the ongoing oversight by the NHS Trust Development Authority (TDA) and in preparation for the Trust's application for Foundation Status, the Trust is required to submit two self-certified declarations on a monthly basis. These self–certification declarations have replaced the Single Operating Model (SOM), which the Trust completed and submitted to NHS London, up until the end of 2012/13.

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

Under the new oversight model, all performance is reported one month in arrears, with the exception of cancer which is reported two months in arrears.
The Board is asked to approve the December 2013 and January 2014 submissions for ratification.

The December 2013 and January 2014 returns were approved by the Chief Financial Officer (CFO) prior to their submissions.

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

Key Issues for discussion:

- No changes to the compliance monitor returns since July;
- Please note as per previous months Q10 (related to performance) has been updated to reflect current status on MRSA, C. difficile and Cancer, as approved by Steve McManus.

Review Needed:

a. Yes √
b. No

Details of Legal Review, if needed:

Link to the Trust's Key Objectives: 1. To develop and provide the highest quality, patient focused and efficiently delivered services to all our patients. 2. To develop recognised programmes where the specialist services ICHT provides (defining services) are amongst the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners.
Assurance or management of risks associated with meeting the relevant key objective(s) or other identified risks: Continued registration of CQC, without having any conditions or non-compliant inspections recorded against the Trust. Monthly reporting of the Trust's performance and action plans being put into place to ensure improvement is measured and monitored by management, where targets are not being achieved.
Recommendations and Actions Required: a. For review and approval

Imperial College Healthcare NHS
NHS Trust

Report Title: Foundation Trust Programme Board - Committee Chairman's Report

To be presented by: Rodney Eastwood, Chairman Foundation Trust Programme Board Committee

1. Introduction

The Foundation Trust Programme Board met on 18th February 2014 and the main issues discussed at the meeting are set out below.

2. Significant issues of interest to the Board

The following issues of interest have been highlighted for the Trust Board:

Historic Due Diligence Process: KPMG commenced Stage 1 of the process in February 2014 and this stage includes interviews with Board members as part of the preliminary review of governance processes. KPMG's report will be reported to Trust Board on 28th March.

TDA Interviews: In February the TDA conducted one to one interviews with members of the Board as part of their assessment of whether the Trust is ready to be put forward to Monitor.

Chief Inspector of Hospitals (CIH) visit: This visit is no longer expected during Q1 which may impact on the project timetable, Board to Board normally takes place after this visit (to allow sufficient time for the Trust to address any issues that might arise out of the visit). The CIH visit is now expected in early Q2 FY14/15.

Consultation Update: the FT consultation closed on 10th February. In total, 543 responses were received and a detailed report analysing consultation responses will be presented at the March FT Programme Board. High level themes included:

- 53% of respondents agreed with the Trust vision and strategy whilst 36% disagreed, with the majority of comments relating to concerns over future changes to the emergency departments and other services at Charing Cross Hospital and Hammersmith Hospital arising out of SaHF.
- Issues of concern centred around the composition of our Public Constituency, the size and composition of the Council of Governors and the identity of the voluntary organisation to be included on the Council.

Membership Recruitment: the Trust currently has 3000 members and needs to ensure that it has 7000 prior to authorisation.

3. Key risks discussed

The following risks were discussed:

Risk ID 2: delivery of FRR3 or better – good progress has been made during bi-lateral meetings for next year's CIPs. The focus will shift in March on to plans for delivery of longer term CIPs

Risk ID 14: Change in Composition of Trust Board – The new Chief Executive takes up post on 7th April 2014. The risk on the register has been downgraded accordingly.

Risk ID 15: Achievement of Good or Outstanding assessment following Chief Inspector of Hospitals visit – the Trust has improved governance processes and is embedding good practice in advance of the visit.

4. Key decisions taken

The following key decisions were made:

Membership Recruitment: an external agency is to be engaged to undertake membership recruitment to deliver required target of at least 7000 members prior to planned authorisation in the autumn.

5. Agreed Key Actions

The Programme Board agreed actions in relation to:

The name of the Trust post Authorisation: written consent to be secured from Imperial College to ensure that the 'Imperial College' brand name can be used after authorisation.

Service Developments - Pathology: the need to secure a rolling brief on the North West London Pathology Programme was agreed to ensure the Trust reflects this in its plans.

6. Future Business

The Programme Board will focus on the following areas in the next three months:

- Outcomes from FT Consultation and consideration of any changes to the Foundation Trust Constitution.
- Outputs from the KPMG first stage review and any actions arising out of this
- IBP submission
- CIH visit preparations

7. Recommendation

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

Imperial College Healthcare NHS
NHS Trust

Minutes of the Foundation Trust Programme Board
Thursday 23rd January 2014.
09:30 – 11.30
Clarence Wing, Board Room. SMH.

ATTENDEES: Rodney Eastwood (RE) (Chair), Mark Brice (MB), Jayne Mee (JM), Cheryl Plumridge (CP), Tom Legg (TL), Ian Garlington (IG), Janice Sigsworth (JS), Bill Shields (BS), Marcus Thorman (MT), Steve McManus (SM), Chris Harrison (CH).

IN ATTENDANCE: Kartar Sandhu (KS), Mick Fisher (MF), Aisha Karefa-Smart (AKS), Alex Williams (AW), Helen Potton (HP), Shona Maxwell, (SM), Richard Sykes (RS).

DRAFT

1. **Apologies:** Nick Cheshire (NC), Anthony Newman Taylor (ANT).

2. **Minutes of Last meeting;**

   The minutes were accepted as a correct reflection of the meeting held on the 17th December 2013.

3. **Matters arising;**

   No matters arose that were not covered on agenda.
   Open actions:

i. The composition of the Council of Governor's Invitation to NHS England and the MRC were still outstanding.
   - **ANT** has written to AMRC inviting them to nominate a representative to the council of governors. There has been no feedback as of yet.
   - NHS England has nominated Alastair Whittington, NWL's lead for Specialist Commissioning as their representative.
   - **BS** gave the feedback form the tri-borough OSC and Westminster OSC
     - CCGS are concerned that their representation is not enough. They would like a 3rd nominee.
     - Greater London Constituency felt that ICHT isn't local enough.
     - The Local Authorities are concerned that their representation is not enough. They feel that two positions are not sufficient.
     - It was felt that four college positions were too many and that the college presence would be too strong.
   - The consultation period needs to finish before any changes can be made. **BS** noted that the Trust could increase the number of positions from 31 to 35, as long as any increase in non-elected positions was matched by an increase in elected positions.

ii. Further work needs to be done to deliver the five year CIP plan.
   - **MT** explained that this was on going work and it was on the afternoon's agenda of the Finance and Investment committee (F&IC). **RE** is attending the meeting, feedback of the discussions would be reported to the February FTPB.
     Action: **MT/RE** to report back to FTPB

iii. Appointment of Independent assessor for HDD delayed by Monitor. This will impact the programme timeline. Monitor need to be pressed for decision.
   - **MB** reported that KPMG have been chosen as the HDD1 auditors.
   - **MT** explained that KPMG were the only "big four" consultancy firm to not be conflicted. The start date will be 24th February. Action is now closed.

iv. Preparation of briefing pack.
AW to produce IBP /BGAF/QGF packs

v. **MT/RE** to consider a change to programme governance & structure to enable Executives and **RE** to be part of the FTPT meetings. This would facilitate more timely executive level decision making on key issues that do not necessarily require full FT Programme Board discussion e.g. approval of forecast planning assumptions, sign off of BGAF case studies.
- **MT** explained that Ad-hoc meetings will be held with appropriate members of the Executive team as required and any decisions requiring ratification will be brought to the FTPB.
  Action: Closed

vi. **MB** to confirm NEDs' involvement in CIH visit.
- **MB** explained that NEDs are usually involved at the end of the process and their involvement is related to quality related processes.
- Action: **MB** to check what happened at Bart's and report back to February FTPB.

vii. **CP** to confirm NEDs' involvement in CIH visit.
- **CP** was still seeking advice on this and asked for the action to remain on the log

viii. **MB** to confirm timeline of when Monitor will visit the Trust after CIH visit.
- **MB** advised that Monitor's Quality team will not be seconded into the TDA quality team. Monitor is currently running a pilot at two separate Trusts, however this will not impact ICHT as Monitor will not wait for the outcome of these pilots before assessing our application.
- **RS** asked if there was evidence that the TDA, CQC and Monitor were now more unified in their approach to the FT process.
- **MB** responded that there was not much evidence as yet, but it was coming to fruition.

4. Programme plan update:

A paper was presented to the December FTPB. Significant changes have been made to the paper which will be presented to the Trust Board on 29th January 2014 and any changes made at the Board will be reported to the February FTPB.

5. Board development update:

RS advised that Grant Thornton and Deloitte would be at the Trust Board meeting on the 29th January 2014. **CP** advised that Jay Bevington had offered to hold 1:1 Development Sessions starting on the 22nd of February, but at present it was not clear what would be covered. **JM** offered to find out what would be covered in the sessions.

6. Review and sign off of BGAF self-assessment

HP explained that BGAF is the method by which the Trust assesses itself against four areas.
These being:
- Board composition and commitment;
- Board evaluation, development and learning;
- Board insight and foresight;
- Board engagement and involvement.

The Trust needs to make sure that it is compliant in these areas. Any areas of noncompliance need to have an associated action plan to make them compliant. The BGAF will then be incorporated into the Board Governance Assurance Memorandum (BGAM). The BGAM went to Management Board on Monday 20th January.

- **RS** commented that the numbers being quoted in the documents were inconsistent across the IBP and BGAF.
- **RE** stated that the financial year 13/14 should be used as the baseline.
- **SM** noted that the running order of the document needs to be reworked as it does not flow.

DRAFT

- **RS** commented that **ANT** is an internationally recognised eminent physician and this needs to be rectified across all the documents.

The document was discussed in detail and recommended changes are to be made by **HP**
Action: **MF** to ensure data consistency across all the documents
Action: **HP** to make recommended changes and follow up on actions requiring feedback to the FTPB.

7. Review and sign off of QGF self-assessment

CH explained that section 5B covers the rescoring that the Trust has done. This paper will be going to the Board next week. Paper 5C is the Improvement plan and the scoring is highly subjective.

RS noted that "Medical Education" needs to be amended to "Medical Education and Training". Wording changes need to be implemented, changing "a satisfied workforce" to "a more engaged or rounded workforce" and "deliver 95% harm free care" to "deliver harm free care".

RS also noted that the risk management strategy doesn't make any reference to the Audit & Risk Committee and that there needs to be a post scheme implementation investigation for all major CIP's.

Action: **SM** to update the QGF document with recommendations by FTPB prior to paper being submitted to Trust Board.

8. IBP v0.6 (Review and chapter summaries)

IG advised that all members should now have received chapter summaries from version six of the IBP. Feedback has been received on the Trust Profile chapter summary and this will be incorporated into the document. The Board will need to be involved in the next iteration of IBP. The next iteration will be version seven and will need to be shorter, have consistent figures across the document and have commonality of language.
Action: **AW** to incorporate feedback on Trust Profile into IBP.

Service Developments: Pathology Summary
More information is needed on Pathology. There are a lot of unanswered questions. The numbers need to be refined and the impacts on the Trust need to be defined.
Action: John Wood to update the Board on the North West London Pathology Path.

Strategy Summary
RE noted that the enabling strategies section were not in enough depth.

Market Assessment
RS commented that there is no mention of specialist hospitals as our competitors where there should be.

Trust Profile
RS noted that there are six AHSC's not five and **MB** commented that the document needs to have a golden theme and that it all needs to hang together.
Action: **IG** and **AW** to review and update.

9. Revised Constitution draft

HP explained that this was the second time that the revised Constitution was coming to the Board and that the best way to proceed was to go through the track changes and look at the key issues.

i) College Appointed NED
The college would like the ability to appoint a NED. Cambridge NHS Trust was able to do this in a similar scenario and so there should be no reason why Monitor would not approve this.

RE noted that although governors normally appoint NED's this would be a way of ensuring that the Trust always has a NED appointed by the University. This would be a way to preserve the academic link with the university.

This recommendation was agreed.

DRAFT

ii) Appointment of NEDs

HP explained that the Governors have duties that are enshrined in legislation with regards to the Appointment of NED's.

RE noted that the constitution should allow for the appointment of two Nomination Committees, one for NEDs and one for Executive Directors. Both would normally be chaired by the Trust Chair and be composed of Governors who would have the ability to appoint others and advisors.

In the particular case of the appointment of the Trust Chair, the Nominations Committee should be chaired by the Trust Deputy Chair and be composed of Governors who would have the ability to appoint others and advisors. At least one member of this Committee should be appointed by the President of Imperial College.

The other Nominations Committee would be for the appointment of Executive Directors. This committee would be chaired by the Trust Chair, have NEDs as members and be able to appoint advisors. In the particular case of the appointment of the CEO, one member of the Nominations committee should be appointed by the President of Imperial College.

JM noted that in terms of remuneration and thinking about the executive directors, it makes sense to have separate committees.

iii) Significant Transactions

HP noted that the Board is keen to show that they are working with the Governors however understandably the Governors may not always appreciate the impact of particular issues to the same degree as the Board.

RS pointed out that the wording around this needed to be strengthened, as it may not be clear what is meant by "Significant Transactions". The line of communication between the Governors, Management Board and Trust Board need to be maintained.

RE commented that Option Three seems to be the best option as it is allows the Board to decide what is significant and allows for flexibility.

TL explained that there is no one ideal solution and that all reasonable power should be given to the Board, but in certain situations the Board may need advice on its own judgement. In these situations the Board can escalate to the Governors.

The Board recommended Option three.

iv) Removal of Governors

HP explained that is very difficult and challenging to remove Governors from their posts where their views were incompatible with the aims and objectives of the Trust.

RE commented that Governors cannot be NEDs and that they all have to sign a code of conduct that shows that they support the aims and objectives of the Trust.

v) Other

RE explained that the Trust would need a voluntary organisation represented on the Council of Governors and that maybe Imperial College Healthcare Charity could fill this role.

JS mentioned that Healthwatch may also be in a position to fill this role.

SM countered that a line of communication would need to be opened with Imperial College Healthcare Charity due to amount of money they raise for ICHT. Imperial College Healthcare Charity could be asked who they wanted to nominate into this role.
Action: **MB** to check what other Trusts do in similar situations.

HP explained that once all these amendments had been made, the constitution would come back to Foundation Trust Programme Board in May.

10. Consultation update:

MF gave a verbal update.

The Trust has had three public meetings with stakeholders and various campaigners. These meetings took place at Kensington, Hammersmith and Paddington and were attended by 25 people, 35 people and 75 people respectively. There have been a lot of adverse comments about the consultation document. 360 responses have been received to date.

MF explained that there was no specific consultation question asking whether stakeholders support the Trust's application to become a Foundation Trust; however the majority of respondents indicated that they were in agreement with the Trust's proposals. A significant number of respondents were using the Foundation Trust consultation as a means of expressing their disagreement with the service changes under the Shaping a healthier future programme.

BS commented that there had been a lot of questions around Shaping a Healthier Future and the futures of Charing Cross and the Western Eye Hospital.

There was an open meeting with CWL and Healthwatch and that there was an overall positive response. 10,000 outpatients have been written to and responses will be accepted after the 10th February close date.

11. Programme Risk Register

The Risk register was reviewed. No new risks were identified. The following risks need to be updated.

i. Risk number three:
- An Independent accountant had been appointed by monitor;
- The HDD process could commence on the 24th February 2014;
- The risk could be closed.

ii. Risk number six:
- Risk to be updated with latest information as consultation process continues.

iii. Risk number 14:
- **SR** advised that this risk would be resolved within the next month.

iv. Risk number 15:
- Risk to be updated with details of the unannounced visit by CQC (Care Quality Commission).
- The Trust received positive feedback.

12. Any Other Business

RE thanked **KS** for his contribution to the Foundation Trust Programme Team

13. Next Meeting

18th February 2014, 15:00– 17.00 Clarence Wing, Boardroom, SMH.

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Paper Number 24

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Imperial College Healthcare NHS
NHS Trust

Minutes of the Foundation Trust Programme Board
Tuesday 18th February 2014.
15:00 – 17.00
Clarence Wing, Board Room. SMH.

ATTENDEES: Rodney Eastwood (RE) (Chair), Jayne Mee (JM), Cheryl Plumridge (CP),Tom Legg (TL), Ian Garlington (IG), Bill Shields (BS), Marcus Thorman (MT), Chris Harrison (CH), Anthony Newman Taylor (ANT).

IN ATTENDANCE: Mick Fisher (MF), Aisha Karefa-Smart (AKS), Alex Williams (AW), Helen Potton (HP), Priya Rathod (PR), Nicola Grinstead (NG), Vicky Scott (VS).

1. Apologies: Nick Cheshire (NC), Steve McManus (SM), Janice Sigsworth (JS), John Underwood (JU).

2. Minutes of last meeting

The minutes were accepted as a correct reflection of the meeting held on the 18th January 2014.

3. Matters arising

Open actions;

I. The composition of the Council of Governors. Invitation to NHS England still outstanding.
- **ANT** spoke with the Association of Medical Research Charities (AMRC) CEO to discuss inviting the AMRC to represent Independent charities on the Trust's Council of Governors. She was happy to discuss internally and come back with a number of names.

II. Further work needs to be done to deliver five year CIP plan.
- **RE** attended the January Finance and Investment Committee (FIC). The discussion at FIC was wide ranging and covered CIPs and the LTFM. **RE** was content that all is in place for the Foundation Trust process.

III. The question of whether the Trust will need to obtain permission to use the Imperial College name when it becomes an FT was raised during the constitution discussion. SG to review Joint Working Agreement with College.
- **ANT** had a conversation with the Rector from Imperial College who said it was fine to use the College's registered name.
- Action: **ANT** to get written consent from Imperial College to use their name.

IV. **MB** to confirm NEDs' involvement in CIH visit.
- **VS** commented that NEDs were involved in the Bath CIH visit and were particularly involved in aspects around quality. There is no one size fits all policy.

V. **MB** to confirm timeline of when Monitor will visit the Trust after CIH visit.
- **RE** expressed concern and dismay that the CIH visit had not been scheduled in quarter one FY 2014/15. A delay of just one or two weeks could end up putting the FT programme back by more than a month. Further delay could be caused during the pre-election period.
- **VS** replied that it was disappointing and the TDA may have been wrong to have been so optimistic. The Director of Delivery and Development will be meeting with the CQC next

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week to discuss the rationale for the delay. The TDA will need to review the timetable but are keen for Imperial to progress as quickly as possible.
- **ANT** asked whether Mike Richards (the Chief Inspector of Hospitals) was fully aware of the implications of this decision.

VI. More information is needed on Pathology. There are a lot of unanswered questions. The numbers need to be refined and the impacts on the Trust need to be defined. John Wood to update the Board on the North West London Pathology Path.
- **IG** noted that the North West London Pathology Board met last week and John Wood will present a paper at the next Trust Board.
- **RE** commented that he did not feel that the Board had had sufficient exposure to the North West London Pathology Programme and asked whether a rolling brief could be commissioned.
- Action: **CP** to commission a rolling brief on the programme.

VII. **RE** explained that the Trust would need a voluntary organisation represented on the Council of Governors and that maybe Imperial College Healthcare Charity could fill this role. **MB** was asked to find out what other Trusts do in similar situations.
- **VS** looked at other Trusts which had been through the FT process and none of them seemed to have a voluntary representative on their council of governors. It is not common practice.
- **AW** commented although it may not be common practice, there are no rules to prevent it.
- **RE** noted that the Trust may have to change the composition of the Council of Governors depending on the feedback from the consultation.

4. Foundation Trust Programme plan update

MT explained that Grant Thornton attended Trust Board and the Finance and Quality Committees and have nearly completed all their interviews with the Non-executive and Executive Directors.

Discussions will take place around the themes from the interviews at Board Seminar next week and these themes will be developed with Jay Bevington from Deloitte.

The formal BGAF/QGF report will go to the March Trust Board.

5. HDD 1 Process

MT met with KPMG last week to discuss the process around stage one of the Foundation Trust Financial Assessment exercise.

Arthur Vaughan and Sarah Webster from KPMG will be on site from 24th February for three weeks and will be located at Salton House. Piers Ricketts and Richard Mills, also from KPMG, will be conducting all interviews with the Non-executive and Executive Directors on 27th and 28th February and 3rd and 7th March.

MT explained that there are three stages. Stage One centres around governance and involves a preliminary review and a Financial Reporting Procedures report. Stage Two is the Historical Due Diligence Report and Stage Three is the Financial Reporting Procedures Opinion.

MT advised that there is further work to do on the downsides and mitigations and that the LTFM and IBP are live documents that will change alongside the timeline as they can only be a maximum of three months out of date.

MT expressed concern that the regulators do not seem to have a joined up approach, and are not communicating with one another as they should. KPMG have been given incorrect dates by Monitor who expect the Trust to be authorised by October.

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KPMG have set a timetable that sees them come back to complete Stage Two in July. This gives a three month window for the Trust to rectify any issues that may come to light in the Stage One process and this window steers clear of year end process.

A kick off meeting will be held on 25th February with KPMG, **Sir Richard Sykes, NC, BS** and **MT** thus starting the Stage One process. KPMG are aiming for the report to be presented at Trust Board on 28th March.

RE asked whether there was anything that the Board needed to do in order to prepare for the interviews.

MT replied that the interviews would align closely with the BGAF/QGF interviews. Monitor are aware that the current process has a lot of duplication and so will be testing a new process in April that that aligns the BGAF, QGF and HDD exercises. However in order to keep the current FT authorisation timeline, the Trust decided to go ahead with the old process.

RE enquired whether the TDA would consider holding the Board to Board meeting in July, on the condition that the CIH visit was satisfactory, to ensure that the TDA process was not stopped because of the delay in the CIH visit.

VS commented that at present the plan was to have the Executive to Executive review prior to the CIH visit, however it would be very unlikely that there would be any movement around the Board to Board which would normally take place six to eight weeks after the CIH visit.

RE questioned whether the Trust could ask for an exception to be made, as the Trust was keen to have the CIH visit in Quarter one, 2014/15.

MT countered that it may be best for the Trust to wait for the outcome of the meeting between the Director of Delivery and Development. If the outcome of this was not satisfactory then maybe **BS** and **NC** could speak to David Flory. The concern being that if anything were to come out of the CIH visit, the Trust would not have any time to fix the issue and embed the new processes into everyday practice.

CH commented that he was fairly confident that the Trust would be prepared, as good practice and governance were being put in place. The Trust is now working on embedding these practices and that would take time.

BS noted that the Trust needs to achieve either a ‘Good’ or ‘Outstanding’ rating.

MT highlighted that the CIH visit was now a key risk and should be added to the Risk Register.

- Action: **AKS** to amend the risk register

CP advised that her team were currently going through the papers of Trusts that had previously had their CIH visit in order to try and prepare. The CIH review seems to be very wide ranging, looking at anything from Estates management and repairs to Trauma services or Data management and records.

PR explained that Bradford had recently had enforcement measures put in place regarding safe levels of nursing staff and consultant cover. Action plans were now in place and regular assurances had to be made to the CQC that the plans were being achieved.

BS commented that there are queries around what the true definition of safe staffing is as it can be interpreted differently by different inspectors. The Trust would need to be clear on the course of action if served an improvement notice.

6. Consultation update

MF reported that consultation closed on 10th February with the Trust receiving a total of 543 responses. Of these 543 responses, 305 were online, 231 were via post and 7 were emailed. These results have now been collated.

The first question: "Do you agree with our vision and strategy for the future?" garnered a fairly positive response with 53.28% of the respondents saying yes and 36.21% of the respondents saying no.

There was a general feeling that insufficient detail was provided around the proposed development of the Trust's sites. Local Authorities requested that the Trust provide more information around the Financial Planning and Estates proposals.

There have been no formal responses from the CCG's but responses were received from Kensington and Chelsea, Hammersmith and Fulham, Westminster and Healthwatch Central West London.

There will be a working group meeting on 19th February to start extracting the themes from the responses.

BS asked about the responses to question 3: "Do you agree that the public constituency should encompass the whole of Greater London?"

MF replied that Hammersmith and Fulham thought that the public constituency should be two thirds North West London and one third Greater London. Others thought it should only consist of the eight London Boroughs. There was some feeling that the public constituency would not be local enough.

RE noted that for the previous Foundation Trust consultation 590 responses had been received so the Trust received fewer responses this time around.

BS asked how the Trust would respond to the consultation and whether there were any concerns or issues to consider.

MF responded that there were three main points to cover;

- Public constituency- composition;
- Council of governors – size and composition;
- Whether the voluntary organisation should be Healthwatch.

The Trust would need to respond to each question in a report. This report would then go to FTPB in March and go to Trust Board a week later with recommendations.

RE noted that the Trust must respond to the consultation publicly and it was likely that the Trust would need to increase the size of the governing body from 31 members to 35 members.

BS commented that the Trust would either need to decrease the number of AHSC representatives or increase the overall amount of Governors.

RE countered that the Trust should be reluctant to lose AHSC representatives as the AHSC status was part of the Trusts' DNA.

ANT agreed with **RE** and advised that the Trust would want new AHSC members such as The Royal Marsden on the Governing Body so AHSC representatives should not be reduced.

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7. Programme Risk Register

The risk register was reviewed. New risks were identified and the following risks need to be updated.

I. Risk number two:
- There is no change to this risk; however there has been good progress on the bilaterals for CIPs next year. The Medicine CIP is very strong.
- **MT** commented that the 14/15 CIPs would be submitted to the TDA on 5th March. After that, focus would shift to the long term CIPs.
- **HP** noted that the completion date needed to be changed.

II. Risk number 14:
- The Chief Executive has now been appointed and will start on 7th April.
- This risk will stay on the register until the new Chief Executive starts, but the target score will be reduced to 6.

III. Risk number 15:
- **CP** noted that although this risk needs to remain on the register, the basis of the risk has now changed.

Action: **CP** to rewrite this risk.

8. Any Other Business

CP explained that prior to authorisation of the governors for shadow council in autumn, the Trust needs 7000 members. The Trust currently has 3000 members, but recruitment of these members is slow and if the Trust continues to recruit at the current rate the target of 7000 will not be achieved.

There are organisations who can recruit members for the Trust. They can be trained by the Trust and are paid by results, which will cost less than the current method being used.

HP noted that she had been provided with three references for one particular organisation and all were satisfactory.

The Board agreed this plan of action.

Action: **MT** to give quarterly updates on the Programme Budget.

9. Next Meeting

18th March 2014, 15:00 – 17:00 Clarence Wing, Boardroom, SMH.

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Public Trust Board Meeting on 26 March 2014

Supporting Documents

Agenda item no.	Title	Tab number
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2.2	Medical Director's Report. Appendix A: Mortality Report	2
	Medical Director's Report. Appendix B: Mortality Ratios	3
3.1	Trust Board Performance Report Month 11	4
3.3	Finance Report – Month 11	5
3.5	Director of People and Organisation Development's Report. Appendix A: Occupational Health Review	6
3.7	Corporate Risk Register	7
3.9	Terms of Reference	8
3.10	Non-Executive Director's Indemnity. Appendix A: HSC 1998/010	9
	Non-Executive Director's Indemnity. Appendix B: HSC 1999/104	10
3.12	NHS Trust Development Authority Self Certifications: Appendix A: December Compliance	11
	Appendix B: December Board Statement	12
	Appendix C: January Compliance	13
	Appendix D: January Board Statement	14

Patient Story

Trust Board Meeting
26th March 2014

Presented by Janice Sigsworth

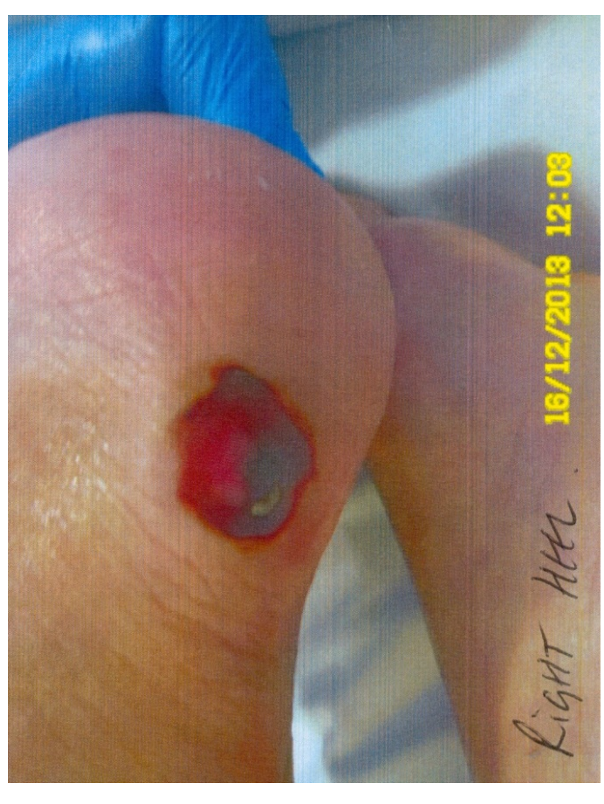
Background

- 70 year old gentleman with heart problems for valve surgery
- Re-admitted in September very unwell with shortness of breath due to fluid on the lungs
- The patient went to intensive care and then to a medical ward for on going care
- On arrival at the ward the patient had no pressure ulcers

- The patient was reviewed by the physiotherapists who implemented the use of splints to prevent contractures of the patient's legs

- A care plan was provided that recommended the splints were put on for 2 hours and taken off for 2 hours for periods of the day.
- A review of the notes found the splints were not always applied as per the care plan.
- After several weeks pressure damage was noted to both heels. Heel protectors were used when the splints were off and leg cushions overnight

- The physiotherapist documented a care plan to include heel protectors, re-positioning and splinting.
- Further episodes of the splints being applied for prolonged periods were noted
- 10 weeks after admission to the ward the tissue viability nurses were asked to review the patient and noted a grade 2 pressure ulcer to the left heel and to the right. A wound care plan was recommended by the tissue viability nurses and documented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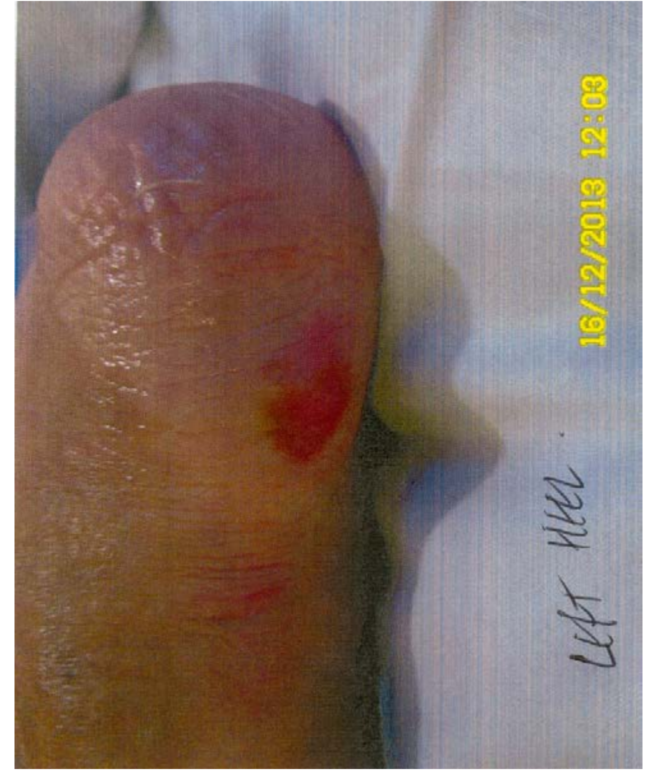
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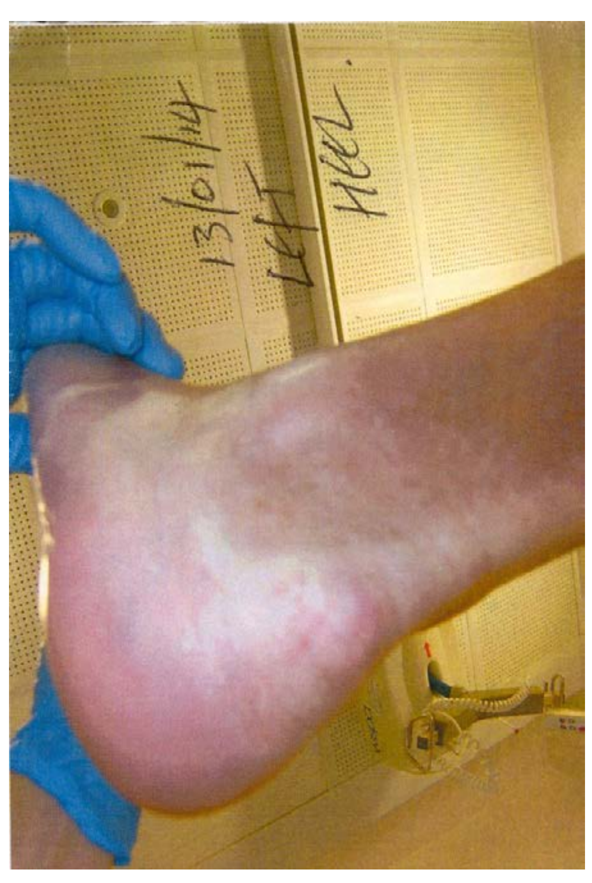
LEFT HEEL

- Use of the splints was discontinued and a wound care chart commenced
- After 3 weeks not using splints and providing wound care, the ulcers had heeled.
- Splints were re-introduced with careful application and the use of padding to prevent pressure.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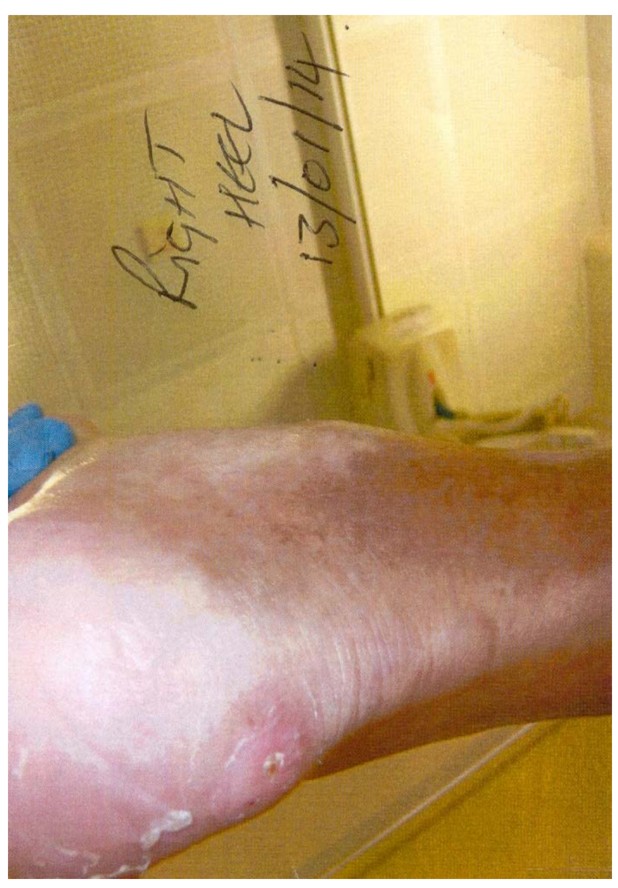
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Actions

- Implementation of zero tolerance to pressure ulcers across ICHT
- Nurse Director Chair of serious incident pressure ulcer panels
- Care plans for the use of specialist devices must be developed prior to their application. These should be signed off by the nurse in charge
- Interim guidance on the use of splints was issued to ward teams at Back to the floor Friday
- The pressure ulcer prevention policy is being revised to include this guidance
- Guidance on the use of padding inside splints was given to staff on the ward

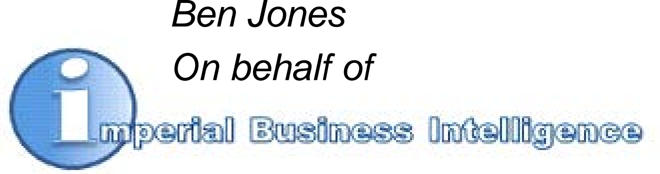
Imperial College Healthcare NHS
NHS Trust

Mortality Report (December 2012 to November 2013 data) QUALITY COMMITTEE

Report Date: February 2013

Ben Jones

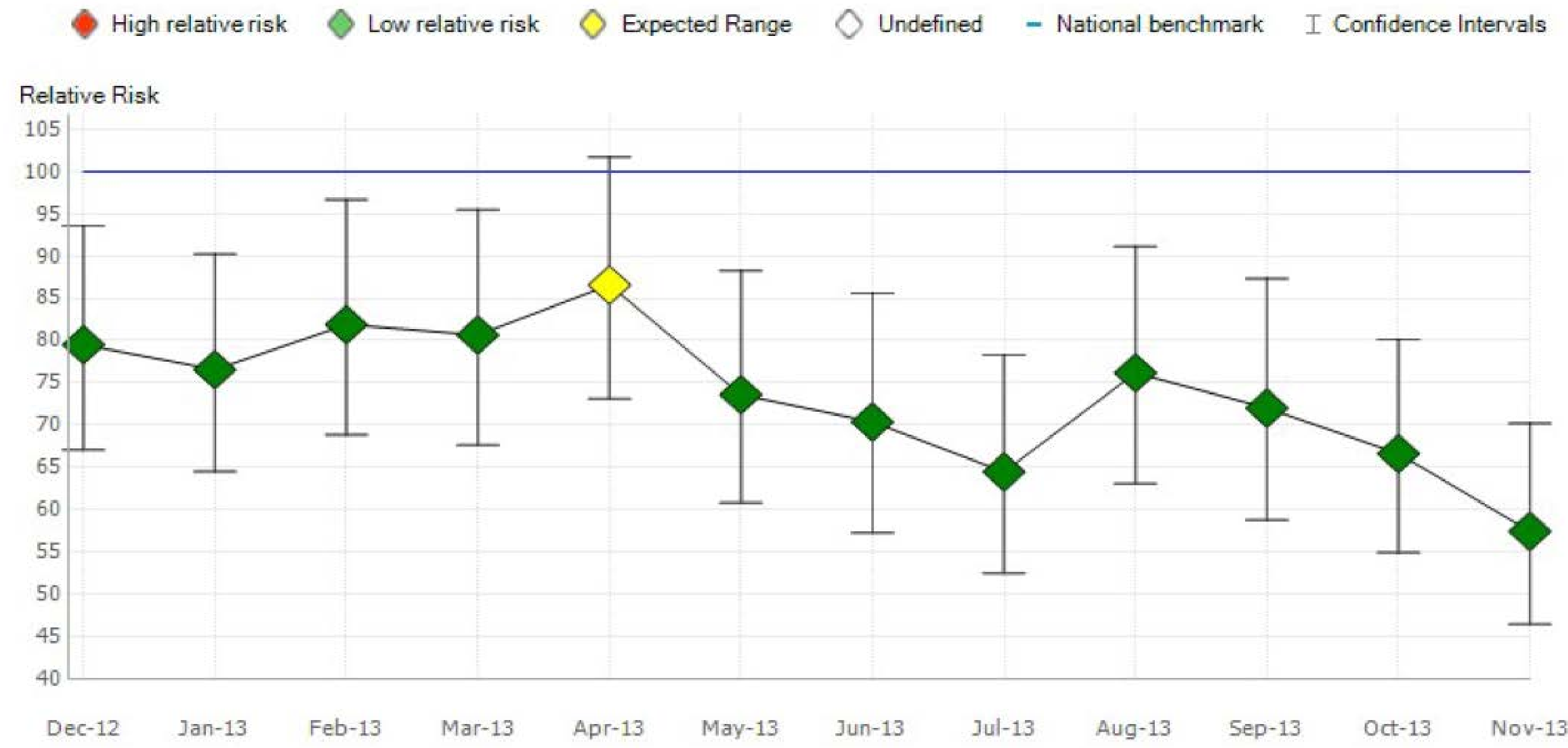
On behalf of



Imperial College Healthcare NHS
NHS Trust

Mortality Report

HSMR –Trend by month from December 2012 to November 2013



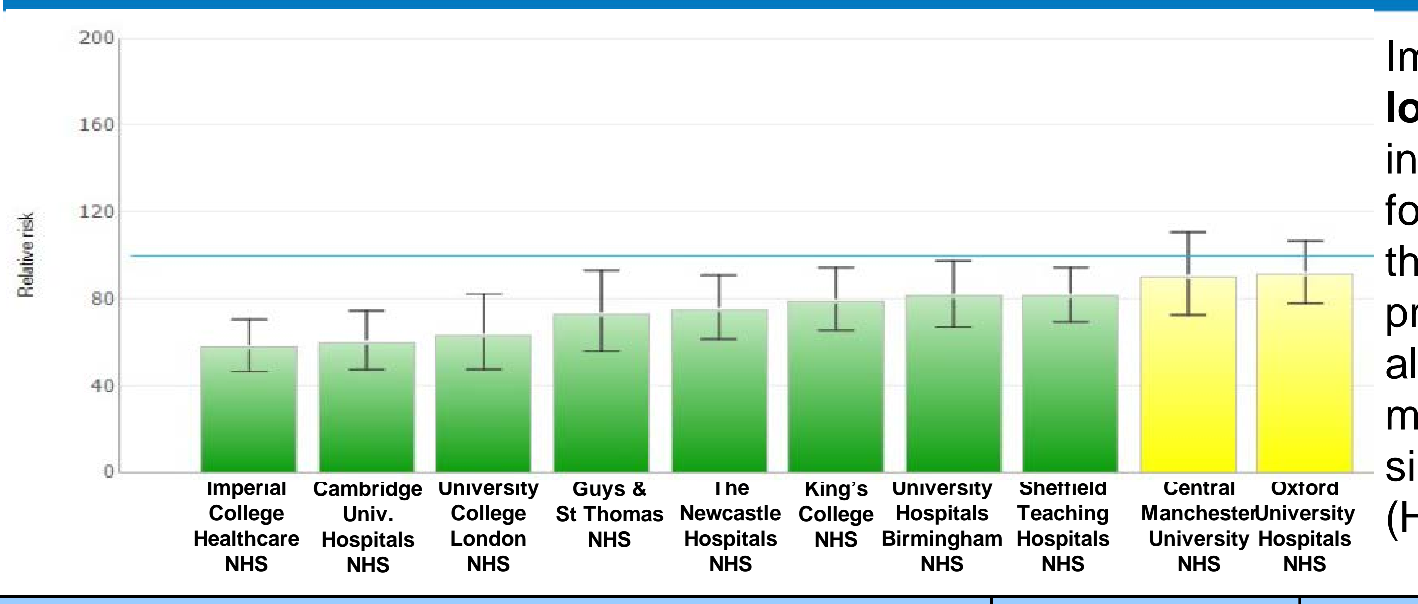
Imperial's HSMR for the month of November 2013 is 57; this is statistically significantly low. Imperial has maintained this significantly low mortality risk for each month in the last seven months of data. Imperial's monthly HSMR has seen four months of successive falls (HSMR 76 in Aug, 72 in Sep, 67 in Oct).

innovation respect care achievement pride

Data Period: Dec 2012 to Nov 2013

Imperial College Healthcare NHS
NHS Trust

HSMR –for Imperial and Rest of Shelford Group- for Nov 2013



Imperial has the **lowest** monthly HSMR in the Shelford Group- for the first time since this mortality reporting process began. This is also Imperial's lowest monthly HSMR value since March 2011 (HSMR of 52).

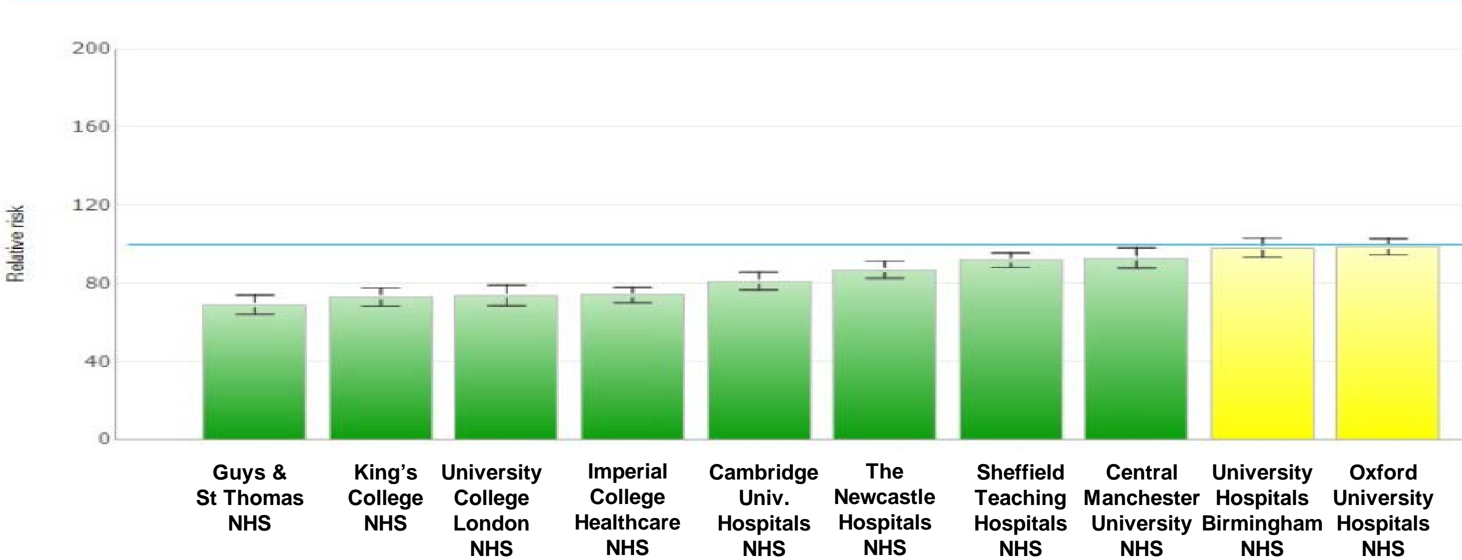
Peer (Shelford Group)	Spells	Relative Risk
ALL	42771	76.05
Imperial College Healthcare NHS Trust	4259	57.86
Cambridge University Hospitals NHS Foundation Trust	3929	60.18
University College London Hospitals NHS Foundation Trust	3689	63.36
Guy's and St Thomas' NHS Foundation Trust	2886	72.98
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	5319	75.28
King's College Hospital NHS Foundation Trust	3837	79.19
University Hospitals Birmingham NHS Foundation Trust	3151	81.41
Sheffield Teaching Hospitals NHS Foundation Trust	6745	81.48
Central Manchester University Hospitals NHS Foundation Trust	3523	90.37
Oxford University Hospitals NHS Trust	5433	91.69

SMR bandings	
(red)	Higher than expected
(yellow)	As expected
(green)	Lower than expected

Data Period: Nov 2013

Imperial College Healthcare NHS Trust

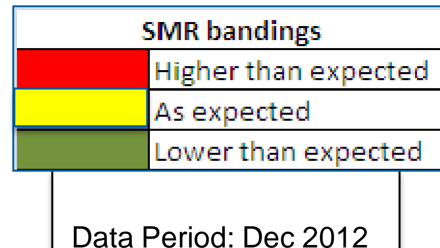
HSMR –for Imperial and Rest of Shelford Group for Dec 2012 to Nov 2013



Imperial HSMR value is now the 4th lowest value in the Shelford peer group over the last year of data. Imperial is also the 4th lowest HSMR nationally.

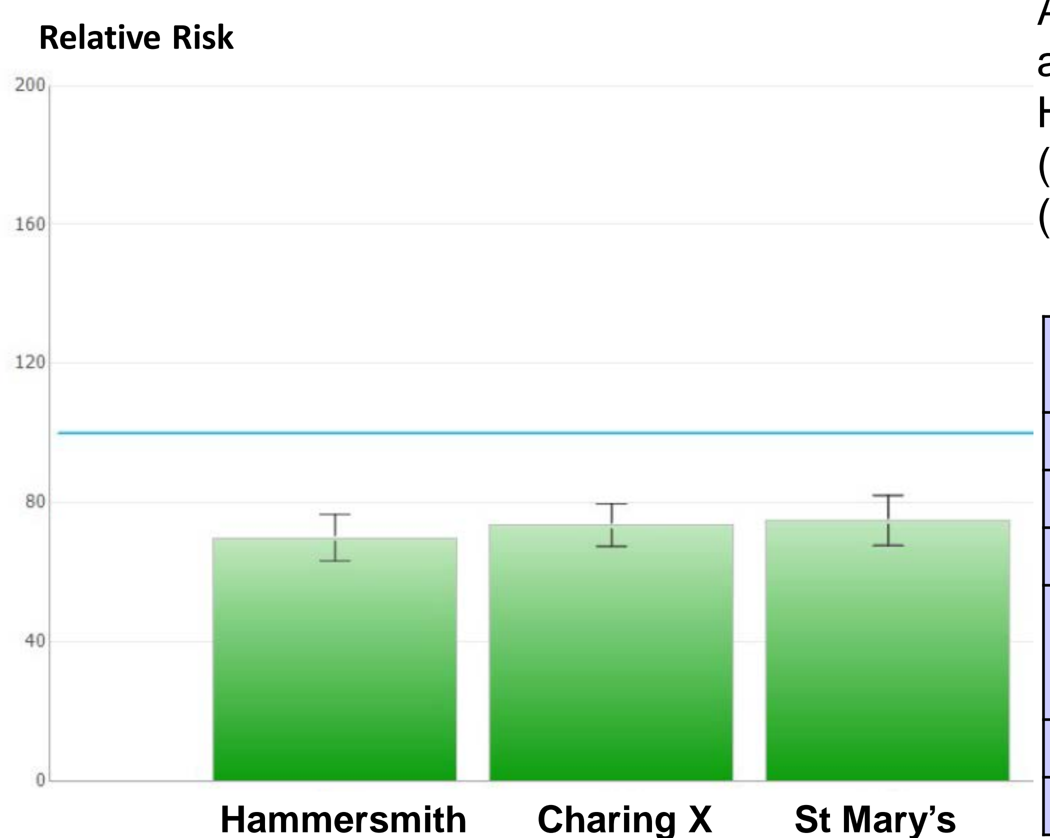
Imperial's HSMR value for the year (74) is lower than the peer group average of 86.

Peer (Shelford Group)	Spells	Relative Risk
ALL	489193	85.66
Guy's and St Thomas' NHS Foundation Trust	32030	69.1
King's College Hospital NHS Foundation Trust	30755	73.04
University College London Hospitals NHS Foundation Trust	43005	73.84
Imperial College Healthcare NHS Trust	49273	74.07
Cambridge University Hospitals NHS Foundation Trust	46642	81.15
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	64030	87.02
Sheffield Teaching Hospitals NHS Foundation Trust	81616	91.91
Central Manchester University Hospitals NHS Foundation Trust	41856	93.05
University Hospitals Birmingham NHS Foundation Trust	36843	98.29
Oxford University Hospitals NHS Trust	63143	98.83



Data Period: Dec 2012 to Nov 2013

HSMR –for Imperial at site level: year to November 2013 (site of diagnosis)



Across the past year of data, ALL sites have a lower than expected relative mortality risk. Hammersmith has both lowest HSMR (69.69) and lowest crude mortality rate (2.07% of all spells).

Activity summary

Provider	Ham Hosp	Charing X	St Mary's
Spells	20856	14441	13904
Observed	431	576	417
Expected	618.43	785.03	558.64
Observed-Expected (Variance)	-187.431	-209.031	-141.643
Crude Rate (%)	2.07	3.99	3
Rel Risk	69.69	73.37	74.65

Data Period: Dec 2012- Nov 2013

Data Source: Dr Foster Intelligence

SMR bandings	
(red)	Higher than expected
(yellow)	As expected
(green)	Lower than expected

SHMI –Trend from Q2 2010/11 to Q1 2013/14 (Financial Years)

SHMI trend for all activity across the last available 3 years of data

Relative Risk: 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10, 0

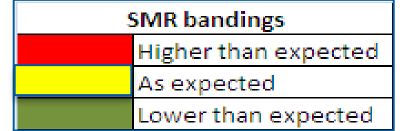
Crude mortality rate (%): 8, 7, 6, 5, 4, 3, 2, 1, 0

FY2010/11 Q2, FY2010/11 Q3, FY2010/11 Q4, FY2011/12 Q1, FY2011/12 Q2, FY2011/12 Q3, FY2011/12 Q4, FY2012/13 Q1, FY2012/13 Q2, FY2012/13 Q3, FY2012/13 Q4, FY2013/14 Q1

Financial Quarter

SHMI trend shows that all Imperial quarterly SHMI readings have been significantly lower than expected (green) for the last 3 years. By way of illustration, SHMI tends to follow crude mortality rate trend almost exactly. The latest SHMI for Imperial is **74.1** for Q1 Financial Year 2013 (Apr-Jun 13). This is a big fall from last quarter's figure of 86.1.

Data Period: July'10- Jun '13

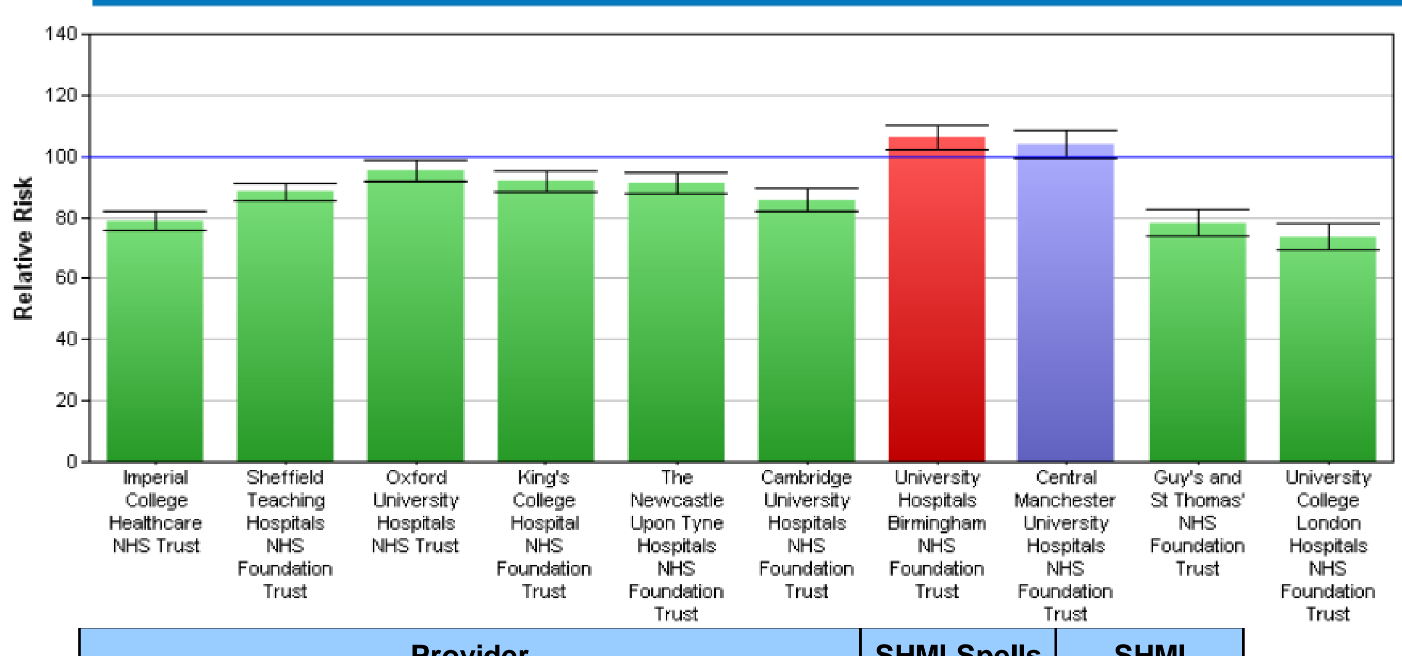


SMR bandings	
(red)	Higher than expected
(yellow)	As expected
(green)	Lower than expected

SHMI –for Imperial and rest of Shelford Group for year to June 2013

Imperial College Healthcare

NHS Trust



SHMI data is the latest made available by the Health & Social Care Information Centre (HSCIC).

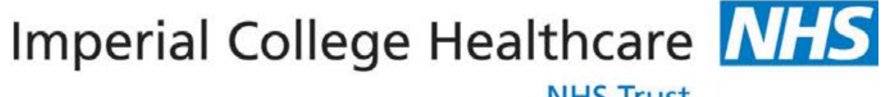
Imperial have the 3rd lowest SHMI in the Shelford Group, with a SHMI value of 78.8 for the period July '12 to June '13.

Provider	SHMI Spells	SHMI
University College London Hospitals NHS Foundation Trust	68179	73.51
Guy's and St Thomas' NHS Foundation Trust	84473	78.23
Imperial College Healthcare NHS Trust	101386	78.84
Cambridge University Hospitals NHS Foundation Trust	71017	85.6
Sheffield Teaching Hospitals NHS Foundation Trust	107529	88.34
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	105262	91.2
King's College Hospital NHS Foundation Trust	113656	91.79
Oxford University Hospitals NHS Trust	110281	95.33
Central Manchester University Hospitals NHS Foundation Trust	100669	103.9
University Hospitals Birmingham NHS Foundation Trust	58337	106.19

Data Source: Health & Social Care Information Centre (Dr Foster Intelligence)

SMR bandings	
	Higher than expected
	As expected
	Lower than expected

Data Period: July 2012 to June 2013



Mortality Report

SHMI for Imperial at site level: July 2012 to June 2013

Relative Risk
110
100
90
80
70
60
50
40
30
20
10
0
St Mary's Hospital (Hq)
Charing Cross Hospital
Hammersmith Hospital
Site

All Imperial sites have lower than expected SHMI ratios for the time period.

Charing Cross has the lowest SHMI value of 74.28.

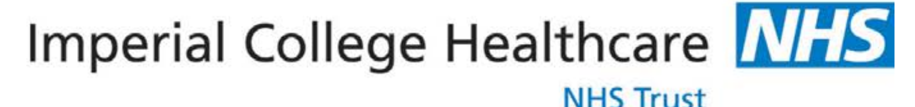
Site	St Mary's Hospital (Hq)	Charing Cross Hospital	Hammersmith Hospital
SHMI Spells	38173	31360	31357
Obs	676	952	674
Exp	842.36	1281.57	794.75
Obs-Exp (Variance)	-166.36	-329.57	-120.75
SHMI	80.25	74.28	84.81

SMR bandings	
	Higher than expected
	As expected
	Lower than expected

Data Period: July '12-June '13

innovation respect care achievement pride

Data Source: Information Centre (Dr Foster Intelligence analysis from Health & Social Care Information Centre)



November 2013: High Relative Risk and Negative CUSUM (Cumulative Sum) Alerts

• As part of quality governance the following alerts are raised each month as appropriate, as a basis for follow-up investigation with clinical involvement:

- Any high relative risk HSMR diagnosis groups/procedure groups, where results are statistically significantly higher than the benchmark figure using confidence intervals (CI)
- Any CUSUM negative alert diagnosis and procedure groups at 99% detection threshold.

The Mortality Audit Standard Operating Procedure outlines how these alerts fit into the Imperial College Healthcare NHS Trust mortality reporting strategy.

• For November 2013 the following diagnosis & procedure groups had a high relative risk. In brackets alongside each is the Clinical Division team it is proposed the alert is investigated by:

- **Diagnosis group(s)**
  - ***No** diagnosis group OR procedure group relative risk alerts for November 2013.*
- For November 2013 there were the following negative **CUSUM alerts** (at 99% detection threshold)
  - ***No** CUSUM alerts at diagnosis or procedure group level in November 2013.*

*** This is the first time in 2013 that Imperial have not had a diagnosis group, procedure group or CUSUM alert in a data month.**

innovation respect care achievement pride

Data Source: Dr Foster Intelligence

innovation respect
care
achievement
pride

Author: Louise Fleming, Programme Director for Safety & Effectiveness
Date: 30th January 2014
Review Date: 30th March 2014

Measuring Mortality

Measures of survival are an important measure of the quality of care provided by hospitals specifically safety and effectiveness. Measuring hospital performance is complex and mortality ratios should not be used in isolation, but rather considered with a basket of other indicators that give a well-rounded view of hospital quality.

The Hospital Standardised Mortality Ratio (HSMR) and The Standardised Hospital Mortality Ratio (SHMI) are the two measures of mortality used at ICHT. Both are calculated using different methodologies and cover different factors and patient groups. Their combined analysis allows for robust mortality monitoring and reporting.

Both methods enable comparisons in individual diagnoses and procedures over different time periods and are invaluable in explaining and exploring variations between trusts.

General differences between HSMR and SHMI

Indicator	HSMR	SHMI
Methodology derived by	Imperial College (Dr Foster Unit at Imperial College)	Health and Social Care Information Centre.
Published on NHS Choices	Yes	Yes
Frequency	Monthly	Quarterly
Timeliness	2-3 months after discharge	6 months
Coverage	In-hospital deaths 56 diagnosis groups that covers approximately 80% of deaths	In-hospital deaths up to 30 days post discharge All activity excluding still-births
Case mix adjustment	Adjustments made include: age, sex, method, source and month of admission, co-morbidities (using the Charlson score), diagnosis sub-group number of emergency admissions in previous 12 months, palliative care.	Adjustments made for diagnosis, age, sex, method of admission and co-morbidities (using the Charlson score.
Palliative care	Palliative care is adjusted for in the model	Not adjusted for palliative care
More information	http://www.drfosterhealth.co.uk/hospital-guide/methodology	http://www.hscic.gov.uk/SHMI

Mortality reporting at Imperial College Healthcare NHS Trust

HSMR and SHMI are reported regularly to the quality committee, management and trust boards. ICHT has one of the lowest mortality rates in the country. Below are examples of how ICHT performs.

HSMR –Trend by month from October 2012 to September 2013

Imperial's HSMR for the month of September 2013 is 72; this is statistically significantly low. Imperial has maintained this significantly low mortality risk for each month in the last five months of data.

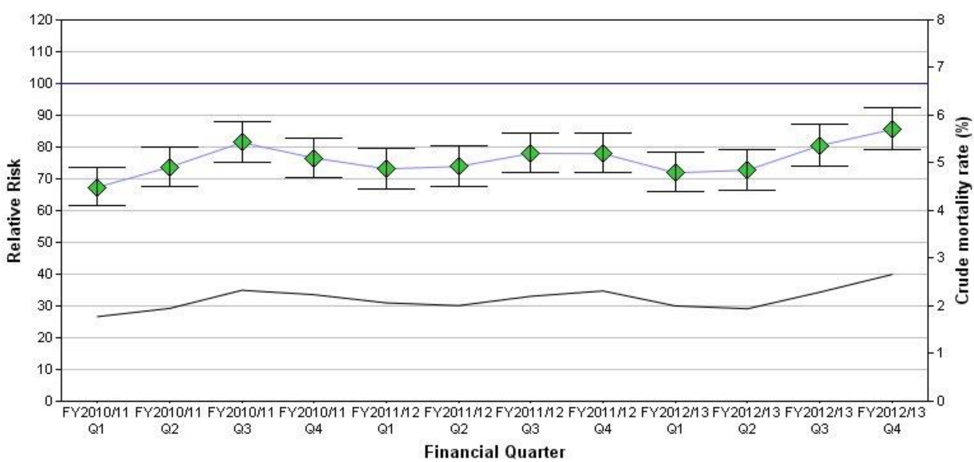
HSMR - ten non-specialist acute providers with the lowest HSMR values in England (All Admissions) in last available year of data

Peer (National)	RR
Guys and St Thomas NHS Foundation Trust	65.8
Kings College Hospital NHS Foundation Trust	69.5
University College London Hospitals NHS Foundation Trust	73
Royal Free London NHS Foundation Trust	74.7
Imperial College Healthcare NHS Trust	**75.5**
The Whittington Hospital NHS Trust	75.5
Ashford and St. Peters Hospitals NHS Foundation Trust	78
Salford Royal NHS Foundation Trust	78.5
Chelsea and Westminster Hospital NHS Foundation Trust	78.6
Airedale NHS Foundation Trust	79.2

This is the latest HSMR data available. HSMR data is more recent and published more regularly than SHMI data. Imperial are in the group of five hospitals with the lowest relative risk (although have exactly same relative risk as The Whittington).

Data Period: Oct '12 to Sep '13

SHMI –Trend from Q1 2011/12 to Q4 2012/13



SHMI trend shows that all Imperial quarterly SHMI readings have been significantly lower than expected for the last 3 years.

SHMI - ten non-specialist acute providers with the lowest SHMI values in England (All Admissions)

Provider	SHMI
The Whittington Hospital NHS Trust	65.23
University College London Hospitals NHS Foundation Trust	71.14
North Middlesex University Hospital NHS Trust	77.05
Imperial College Healthcare NHS Trust	77.78
Guy's and St Thomas' NHS Foundation Trust	77.91
Royal Free London NHS Foundation Trust	79.24
Barts Health NHS Trust	80.15
St George's Healthcare NHS Trust	81.34
North West London Hospitals NHS Trust	81.65
Chelsea and Westminster Hospital NHS Foundation Trust	81.81

Imperial has the 4th lowest SHMI ratio of all non-specialist providers in England.

In period Jan-Dec 2012, Imperial had 3rd lowest SHMI.

Data Period: April '12 – Mar '13

Data Source: Dr Foster Intelligence

Detailed HSMR data is reported monthly to the quality committee and management board and includes comparisons with peers, mortality by hospital site and mortality alerts which is where an increased number of patients die than is expected in a diagnosis or procedure group. These patients are then investigated within the relevant division.

The Care Quality Commission (CQC) has introduced a number of mortality measures into their new model for monitoring the NHS and includes for example, mortality by weekdays and weekends, mortality in specific diagnosis or procedure groups such as vascular conditions and procedures together with mortality in low-risk diagnosis groups. The Management Board will be regularly monitoring these and other measures to ensure we are keeping our patients safe.

For more information please contact the Quality Team at quality@imperial.nhs.uk

Trust Board Performance Report
Report Period Month 11
(to end February 2014)

Trust Board Wednesday 26th March 2014

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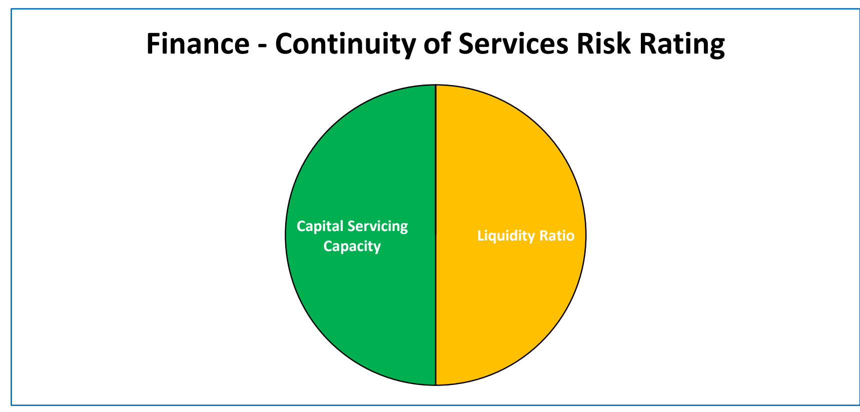
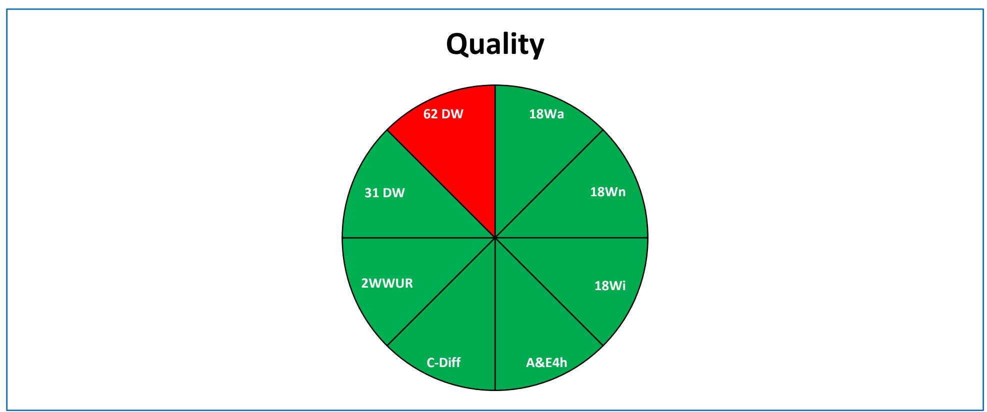
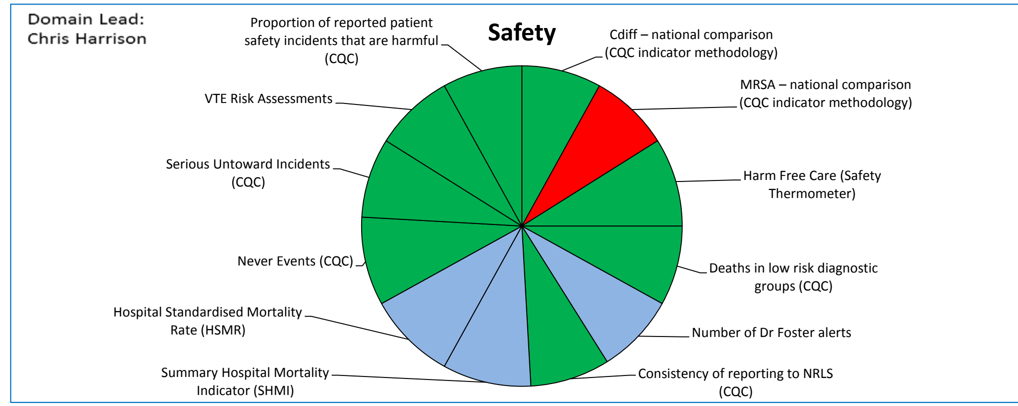
Shadow Foundation Trust Performance Framework

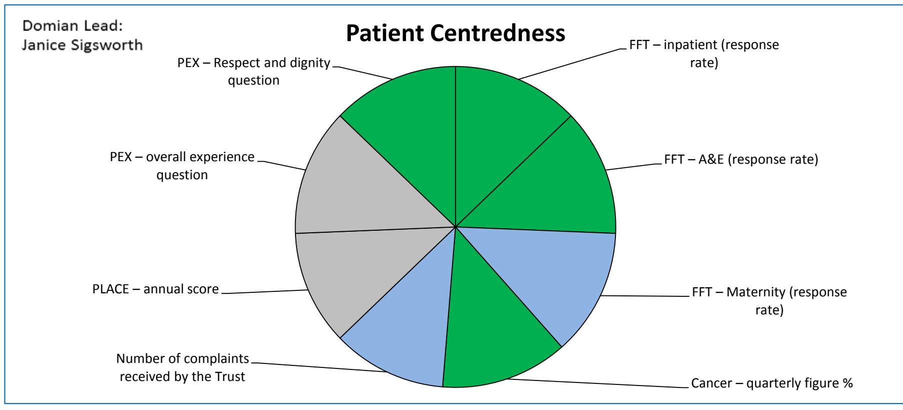


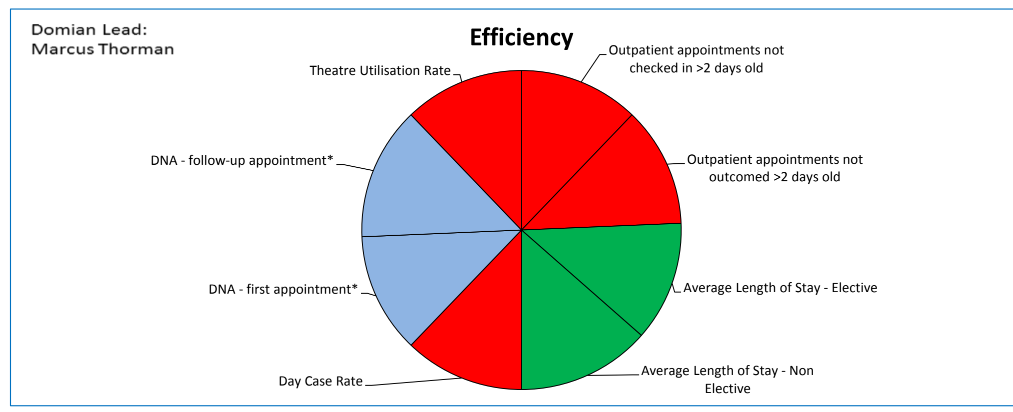


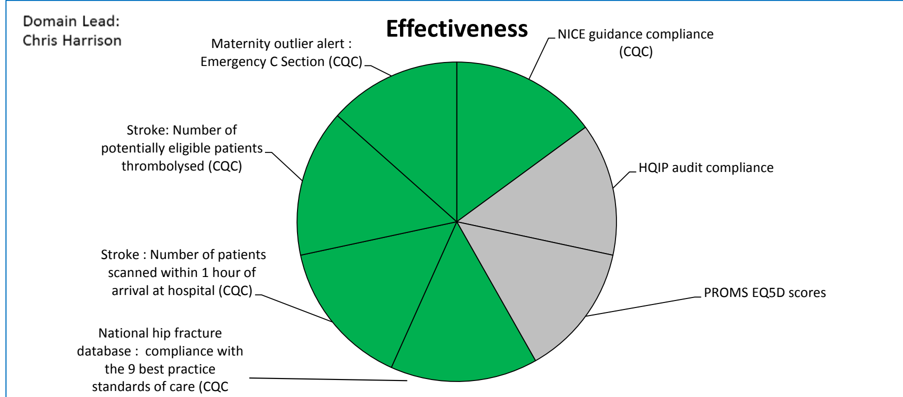
Monitor Risk Assessment Framework

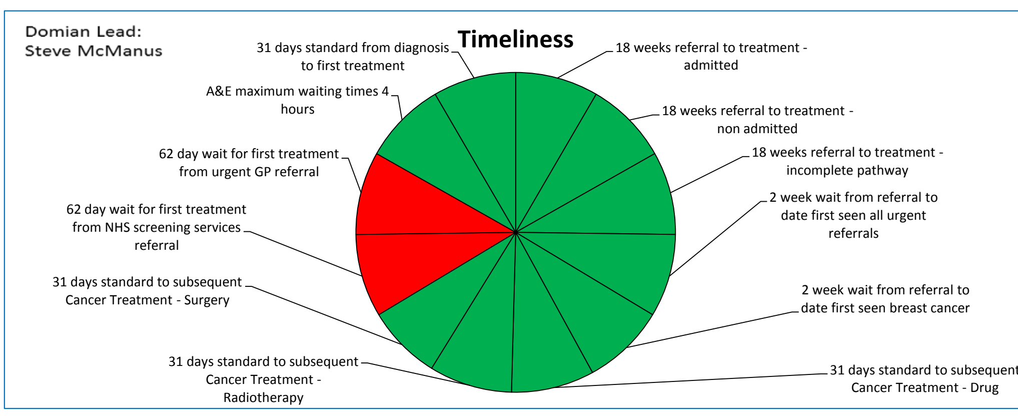
2013/14 Area	Indicator	Threshold	Performance to date 13/14 Q1	Q2	Q3	YTD	*Forecast* *Qtr 4 13/14*	*Qtr 1 14/15*	*Qtr 2 14/15*
Finance	Capital Servicing Capacity		4	4	4		4		
	Liquidity Ratio		4	2	2		2		
	Continuity of Services Risk Rating		4	3	3		3		
Access	18 weeks referral to treatment - admitted	90%	92.50%	93.35%	93.18%	92.90%			
	18 weeks referral to treatment - non admitted	95%	96.85%	96.80%	95.88%	96.40%			
	18 weeks referral to treatment - incomplete pathway	92%	95.96%	95.96%	95.05%	95.60%			
	2 week wait from referral to date first seen all urgent referrals	93%	98.27%	98.37%	98.51%	98.07%			
	2 week wait from referral to date first seen breast cancer	93%	97.63%	97.60%	97.28%	97.37%			
	31 days standard from diagnosis to first treatment	96%	94.43%	96.89%	96.07%	95.95%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%	99.47%	100.00%	99.84%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	97.50%	98.73%	98.06%	98.21%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.07%	95.47%	95.42%	95.60%			
	62 day wait for first treatment from NHS Screening Services referral	90%	91.27%	95.57%	92.23%	92.61%			
	62 day wait for first treatment from urgent GP referral	85%	74.27%	74.00%	80.10%	76.46%			
	A&E maximum waiting times 4 hours	95%	96.24%	96.68%	95.97%	96.30%			
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65	26	11	10	47			
	Governance Risk Rating		2	2	1	n/a	1	0	0

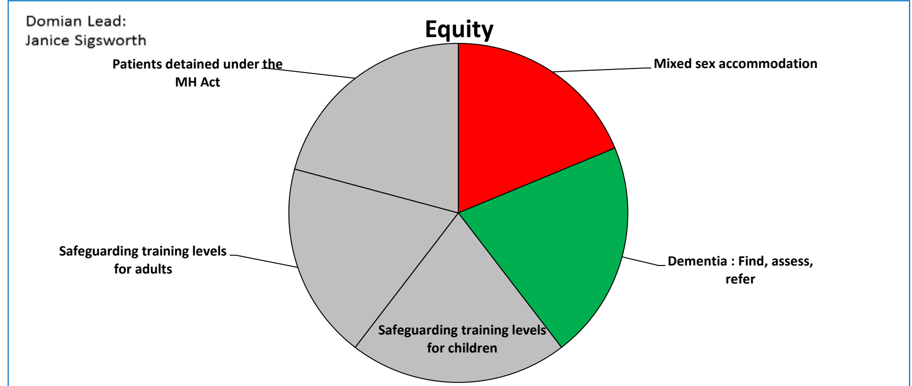

Domain Lead:
Chris Harrison
Safety
Proportion of reported patient safety incidents that are harmful (CQC)
Cdiff – national comparison (CQC indicator methodology)
MRSA – national comparison (CQC indicator methodology)
VTE Risk Assessments
Harm Free Care (Safety Thermometer)
Serious Untoward Incidents (CQC)
Never Events (CQC)
Deaths in low risk diagnostic groups (CQC)
Hospital Standardised Mortality Rate (HSMR)
Number of Dr Foster alerts
Summary Hospital Mortality Indicator (SHMI)
Consistency of reporting to NRLS (CQC)


Domain Lead:
Janice Sigsworth
Patient Centredness
PEX – Respect and dignity question
FFT – inpatient (response rate)
PEX – overall experience question
FFT – A&E (response rate)
PLACE – annual score
FFT – Maternity (response rate)
Number of complaints received by the Trust
Cancer – quarterly figure %


Domain Lead:
Marcus Thorman
Efficiency
Theatre Utilisation Rate
Outpatient appointments not checked in >2 days old
DNA - follow-up appointment*
Outpatient appointments not outcomed >2 days old
DNA - first appointment*
Average Length of Stay - Elective
Day Case Rate
Average Length of Stay - Non Elective


Domain Lead:
Chris Harrison
Effectiveness
Maternity outlier alert : Emergency C Section (CQC)
NICE guidance compliance (CQC)
Stroke: Number of potentially eligible patients thrombolysed (CQC)
HQIP audit compliance
Stroke : Number of patients scanned within 1 hour of arrival at hospital (CQC)
PROMS EQ5D scores
National hip fracture database : compliance with the 9 best practice standards of care (CQC


Domain Lead:
Steve McManus
Timeliness
31 days standard from diagnosis to first treatment
18 weeks referral to treatment - admitted
A&E maximum waiting times 4 hours
18 weeks referral to treatment - non admitted
62 day wait for first treatment from urgent GP referral
18 weeks referral to treatment - incomplete pathway
62 day wait for first treatment from NHS screening services referral
2 week wait from referral to date first seen all urgent referrals
31 days standard to subsequent Cancer Treatment - Surgery
2 week wait from referral to date first seen breast cancer
31 days standard to subsequent Cancer Treatment - Radiotherapy
31 days standard to subsequent Cancer Treatment - Drug

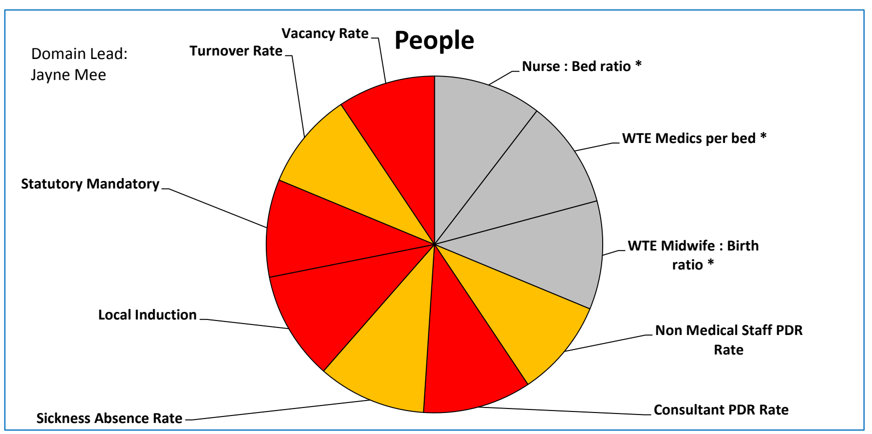

Domain Lead:
Janice Sigsworth
Equity
Patients detained under the MH Act
Mixed sex accommodation
Safeguarding training levels for adults
Dementia : Find, assess, refer
Safeguarding training levels for children

Financial Risk Rating

Metric	Weighting %	Metric Description	Actuals Q1	Actuals Q2	Actuals Q3	Forecast Q4
Achievement of Plan	10%	EBITDA achieved (% of Plan)	5	5	5	5
Underlying Performance	25%	EBITDA margin %	3	3	3	3
Financial Efficiency	40%	Net return after financing (%) I&E surplus margin net of dividends (%)	2	3	3	3
Liquidity	25%	Liquidity ratio (days)	4	3	3	3
Overall Financial Risk Rating			3	3	3	3

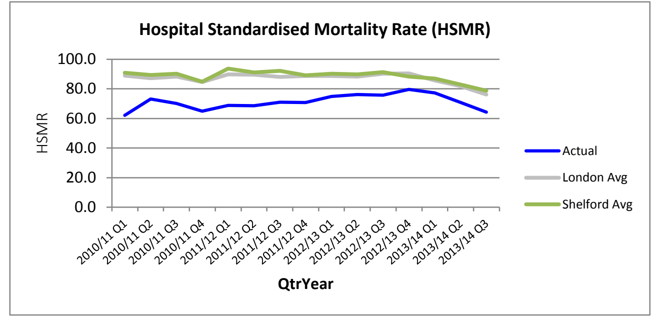
Continuity of Services Risk Rating

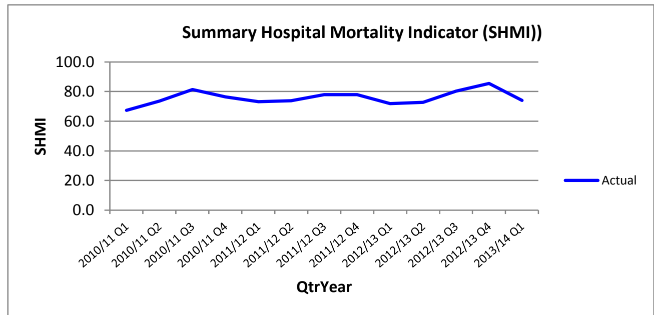
Metric	Weighting %	Metric Description	Actuals Q1	Actuals Q2	Actuals Q3	Forecast Q4
Liquidity Ratio	50%	Liquidity Ratio (days)	4	2	2	2
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	4	4	4	4
Continuity of Services Risk Rating			**4**	**3**	**3**	**3**

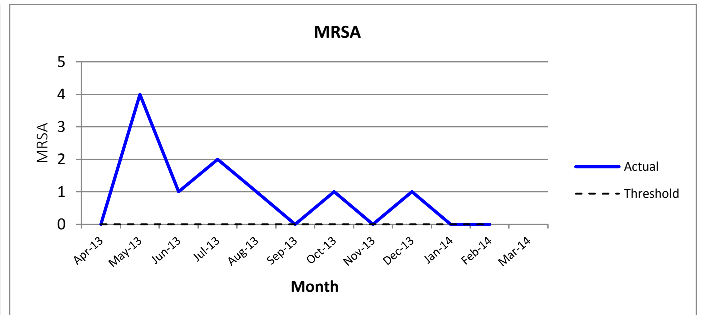


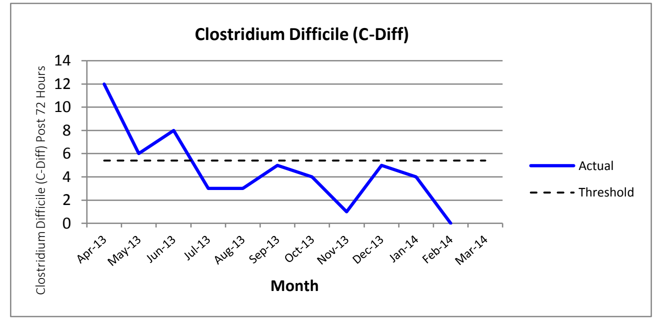
*Clarity as to how these indicators are measured and which domain they are included in is being proposed and will be refreshed in the next integrated performance scorecard.

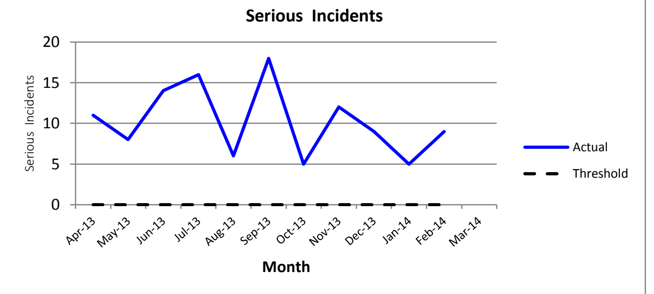
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2012/13 Feb	Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Mortality Indicators															
Hospital Standardised Mortality Rate (HSMR)	HSMR	-	Qtr	n/a	n/a	75.8	68.4	77.3	70.6	64.2	n/a				CQC
Summary Hospital Mortality Indicator (SHMI)	SHMI	-	Qtr	n/a	n/a	80.4	n/a	74.1	Not avail.	Not avail.	n/a				CQC
Infection Control															
MRSA	MRSA	-	Mth	0	1	2	0	5	3	2	10				TDA, CQC
MRSA (latest CQC report)	MRSA (CQC)	-	Qtr	0	Not avail.	Not avail.	-	-	-	-	-				TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours	C-Diff	-	Mth	5 per mth	6	23	0	26	11	10	51				Mon, TDA, CQC
Clostridium Difficile (latest CQC report)	C-Diff(CQC)	-	Qtr	0	Not avail.	Not avail.	-	-	-	-	-				Mon, TDA, CQC
Incidents															
Serious Incidents	SUI	-	Mth	*tbc*	6	14	9	33	40	26	113				TDA, CQC
Never Events	Nev	-	Mth	0	0	1	0	1	0	0	1				TDA, CQC

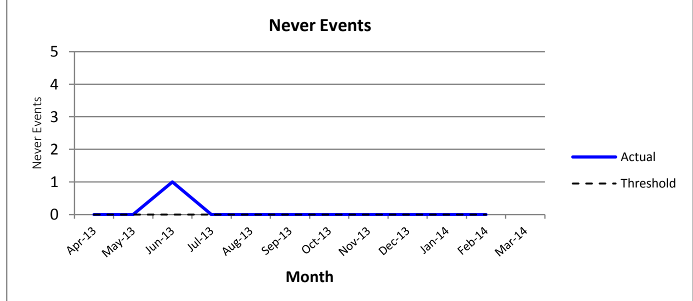






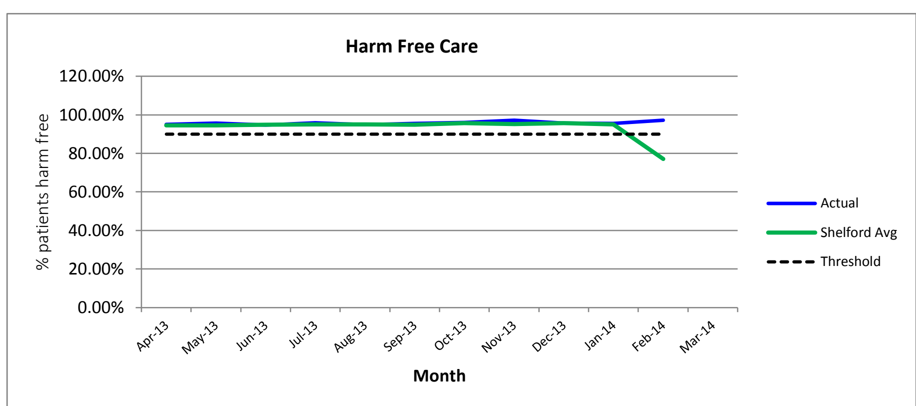


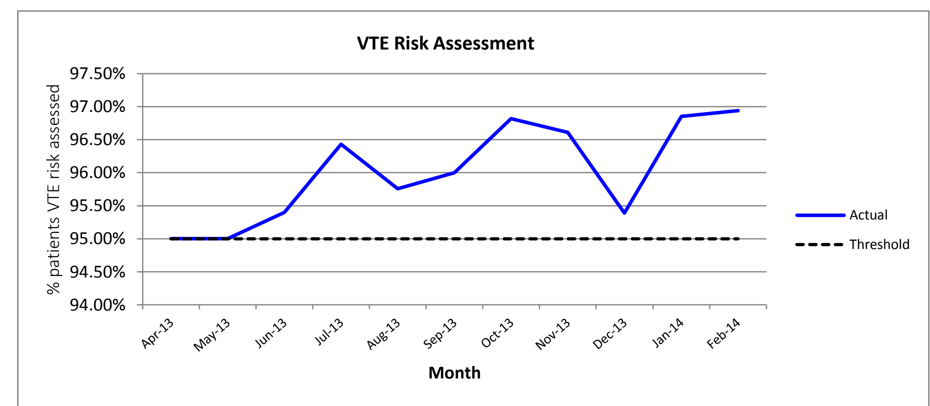


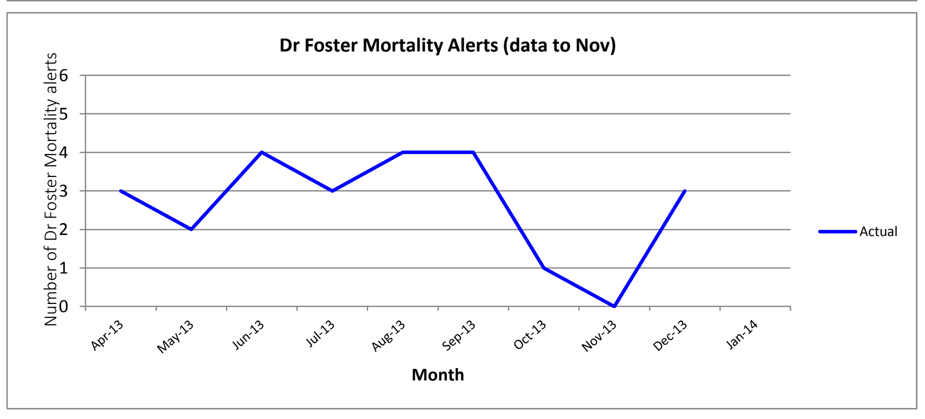


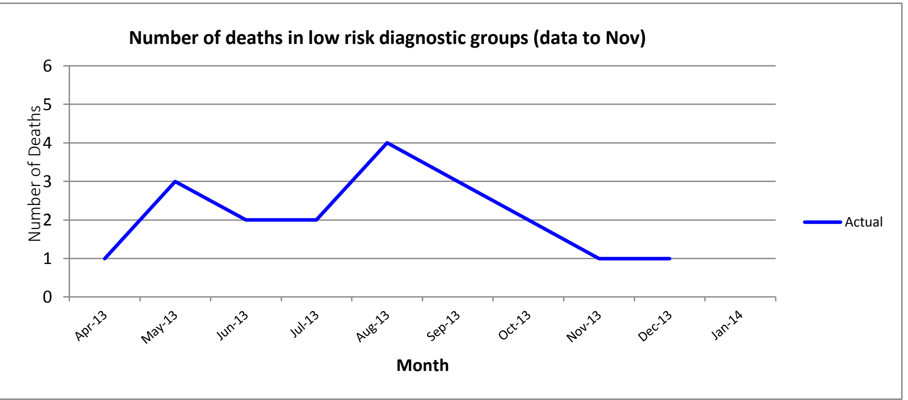
Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2012/13 Feb	Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Safety Thermometer															
Harm Free Care (Safety Thermometer)	HF	-	Mth	90%	95.0%	96.0%	97.25%	95.2%	95.4%	96.3%	95.8%				TDA, CQC
CQUIN - VTE															
CQUIN - VTE Risk Assessments	VTE	✓	Mth	95%	91.5%	91.1%	96.9%	95.1%	96.1%	96.3%	96.0%				CQC, Contractual
Dr Foster Alerts															
Number of Dr Foster mortality alerts	DrF	-	Mth	*tbc*	Not avail.	Not avail.	3	9	11	4	24				CQC
Deaths in low risk diagnostic groups															
Number of deaths in low risk diagnostic groups	DrFLR	-	Mth	n/a	Not avail.	Not avail.	1	6	9	4	19				CQC

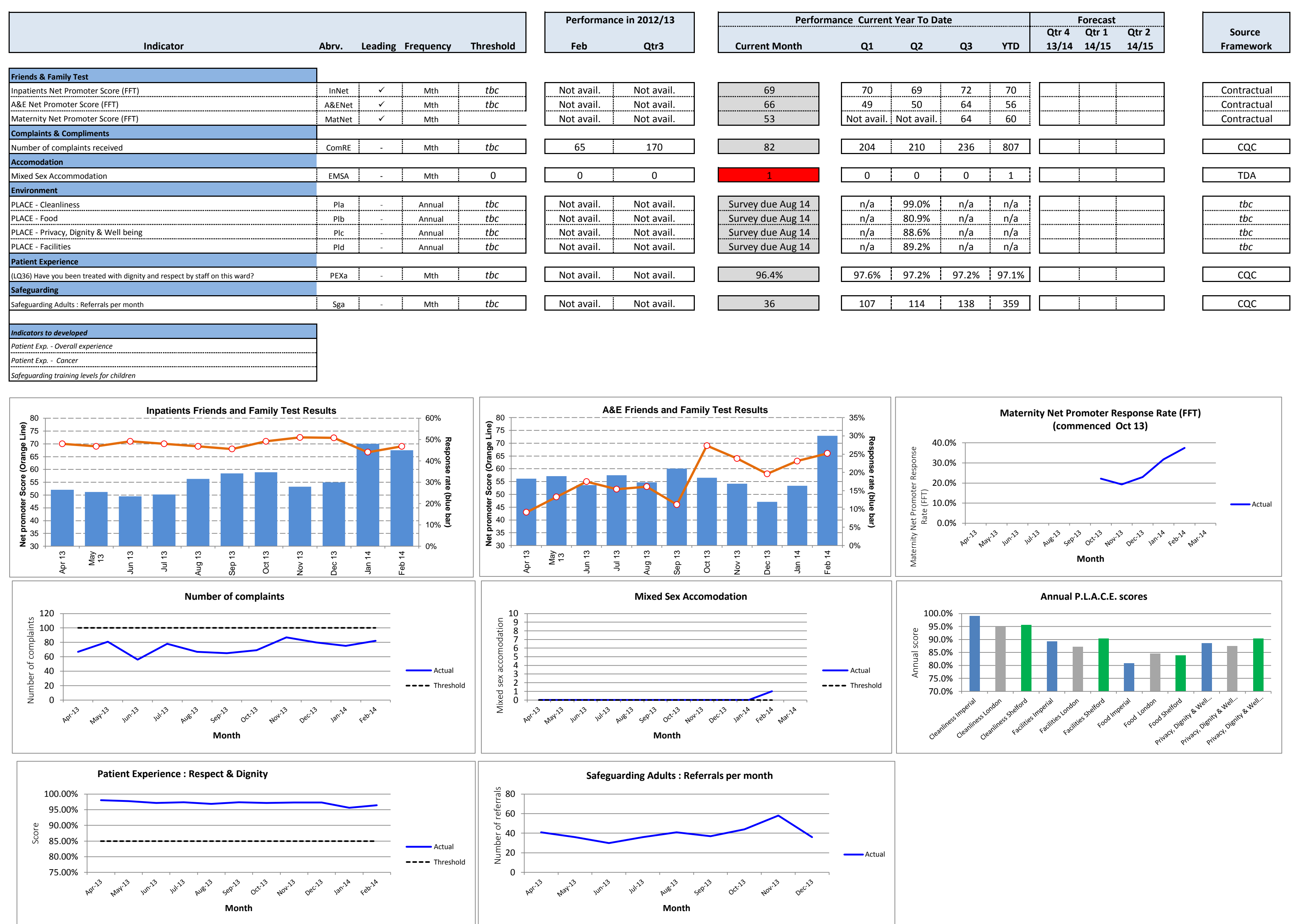
Indicators to developed
Proportion of reported harmful incidents
Consistency of reporting to NRLS











Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2012/13 Feb	Qtr3	Performance Current Year To Date Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Friends & Family Test															
Inpatients Net Promoter Score (FFT)	InNet	✓	Mth	tbc	Not avail.	Not avail.	69	70	69	72	70				Contractual
A&E Net Promoter Score (FFT)	A&ENet	✓	Mth	tbc	Not avail.	Not avail.	66	49	50	64	56				Contractual
Maternity Net Promoter Score (FFT)	MatNet	✓	Mth		Not avail.	Not avail.	53	Not avail.	Not avail.	64	60				Contractual
Complaints & Compliments															
Number of complaints received	ComRE	-	Mth	tbc	65	170	82	204	210	236	807				CQC
Accomodation															
Mixed Sex Accommodation	EMSA	-	Mth	0	0	0	1	0	0	0	1				TDA
Environment															
PLACE - Cleanliness	Pla	-	Annual	tbc	Not avail.	Not avail.	Survey due Aug 14	n/a	99.0%	n/a	n/a				tbc
PLACE - Food	Plb	-	Annual	tbc	Not avail.	Not avail.	Survey due Aug 14	n/a	80.9%	n/a	n/a				tbc
PLACE - Privacy, Dignity & Well being	Plc	-	Annual	tbc	Not avail.	Not avail.	Survey due Aug 14	n/a	88.6%	n/a	n/a				tbc
PLACE - Facilities	Pld	-	Annual	tbc	Not avail.	Not avail.	Survey due Aug 14	n/a	89.2%	n/a	n/a				tbc
Patient Experience															
(LQ36) Have you been treated with dignity and respect by staff on this ward?	PEXa	-	Mth	tbc	Not avail.	Not avail.	96.4%	97.6%	97.2%	97.2%	97.1%				CQC
Safeguarding															
Safeguarding Adults : Referrals per month	Sga	-	Mth	tbc	Not avail.	Not avail.	36	107	114	138	359				CQC

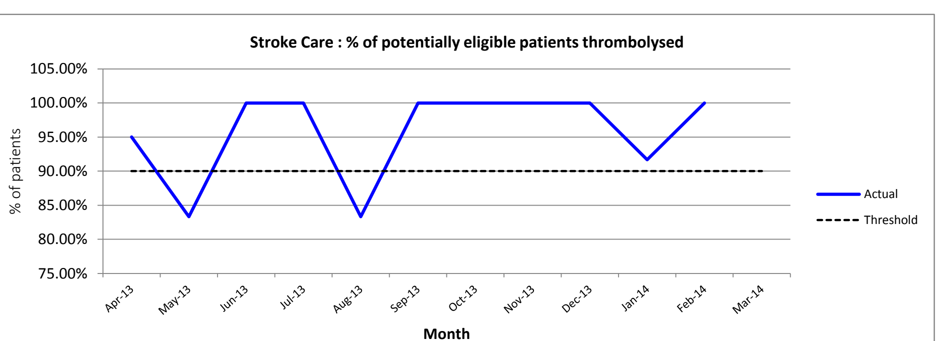
Indicators to developed
Patient Exp. - Overall experience
Patient Exp. - Cancer
Safeguarding training levels for children

Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2012/13 Feb	Performance in 2012/13 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Maternity Outlier Alerts															
Stroke Care : % of patients scanned within 1 hr of arrival at hospital	Str1	-	Mth	50%	100.0%	100.0%	100.00%	100%	100%	100%	100%				CQC
Stroke Care : % of potentially eligible patients thrombolysed	Str2	-	Mth	90%	100.0%	100.0%	100.00%	92%	94%	100%	95%				CQC

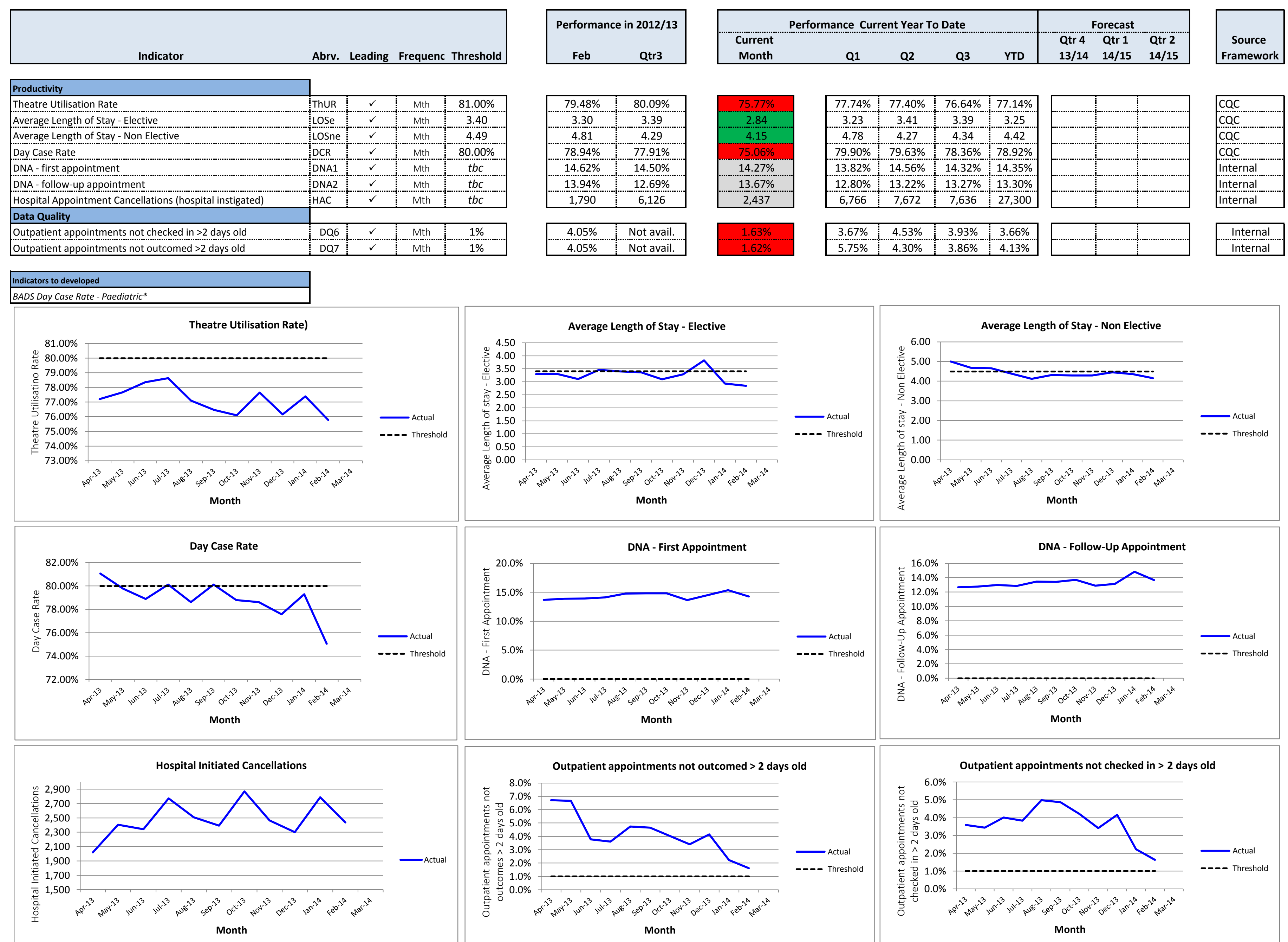
Indicators to developed
Nice Guidance Compliance
HQIP Audit Compliance
PROMS ESQD Scores
Maternity outlier alert : Emergency C section
National Hip Fracture Database : Compliance With 9 Best Practice Standards

Stroke Care : % of patients scanned within 1 hr of arrival at hospital

120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
% of patients
Apr-13 May-13 Jun-13 Jul-13 Aug-13 Sep-13 Oct-13 Nov-13 Dec-13 Jan-14 Feb-14 Mar-14
Month
Actual
Threshold



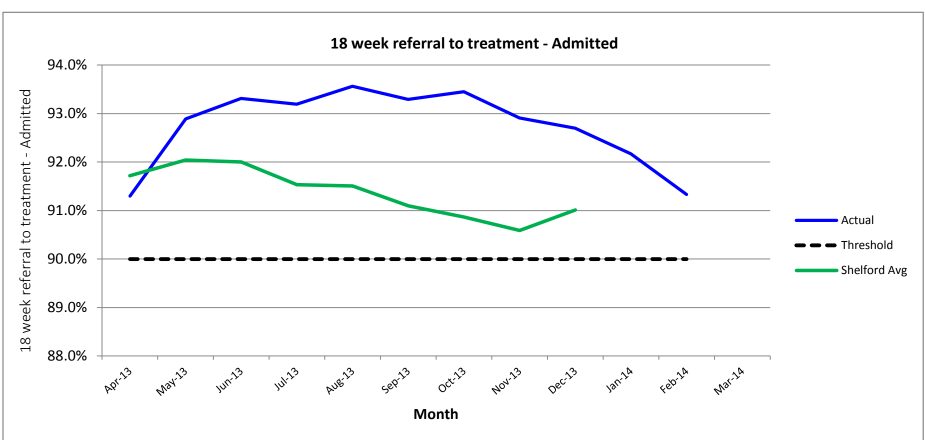
Quality Principles - Efficiency 4.1
Productivity

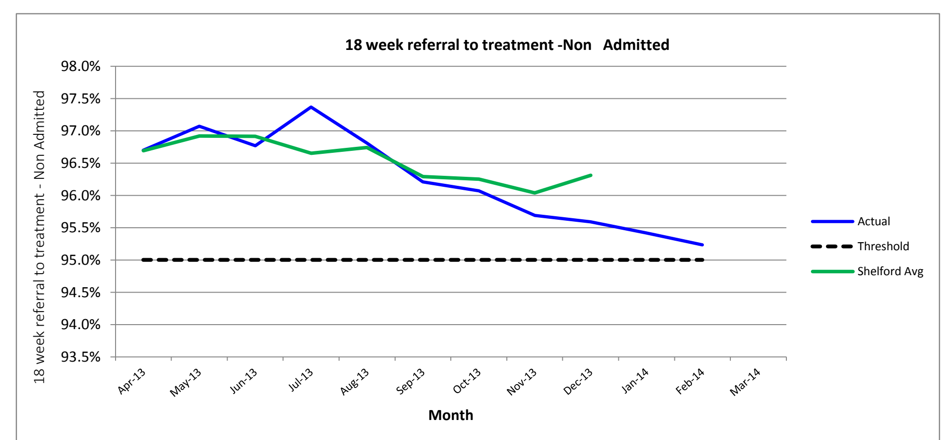


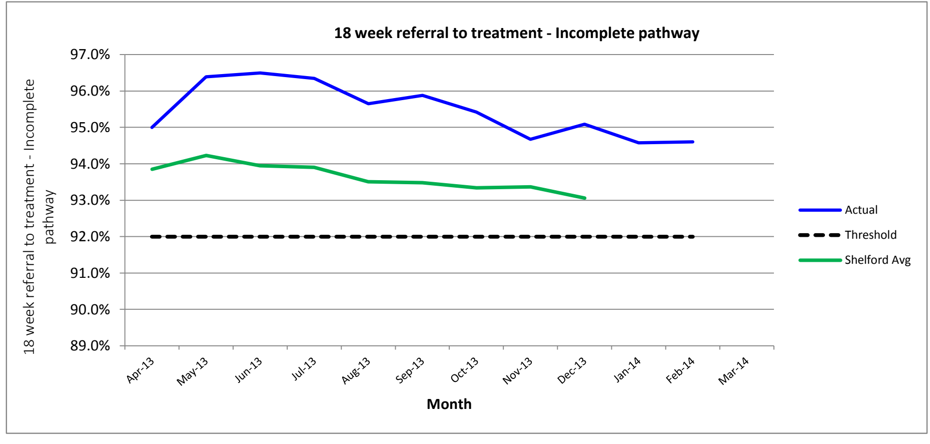
Indicator	Abrv.	Leading	Frequenc	Threshold	Performance in 2012/13 Feb	Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Qtr 1 14/15	Qtr 2 14/15	Source Framework
Productivity															
Theatre Utilisation Rate	ThUR	✓	Mth	81.00%	79.48%	80.09%	75.77%	77.74%	77.40%	76.64%	77.14%				CQC
Average Length of Stay - Elective	LOSe	✓	Mth	3.40	3.30	3.39	2.84	3.23	3.41	3.39	3.25				CQC
Average Length of Stay - Non Elective	LOSne	✓	Mth	4.49	4.81	4.29	4.15	4.78	4.27	4.34	4.42				CQC
Day Case Rate	DCR	✓	Mth	80.00%	78.94%	77.91%	75.06%	79.90%	79.63%	78.36%	78.92%				CQC
DNA - first appointment	DNA1	✓	Mth	*tbc*	14.62%	14.50%	14.27%	13.82%	14.56%	14.32%	14.35%				Internal
DNA - follow-up appointment	DNA2	✓	Mth	*tbc*	13.94%	12.69%	13.67%	12.80%	13.22%	13.27%	13.30%				Internal
Hospital Appointment Cancellations (hospital instigated)	HAC	✓	Mth	*tbc*	1,790	6,126	2,437	6,766	7,672	7,636	27,300				Internal
Data Quality															
Outpatient appointments not checked in >2 days old	DQ6	✓	Mth	1%	4.05%	Not avail.	1.63%	3.67%	4.53%	3.93%	3.66%				Internal
Outpatient appointments not outcomed >2 days old	DQ7	✓	Mth	1%	4.05%	Not avail.	1.62%	5.75%	4.30%	3.86%	4.13%				Internal

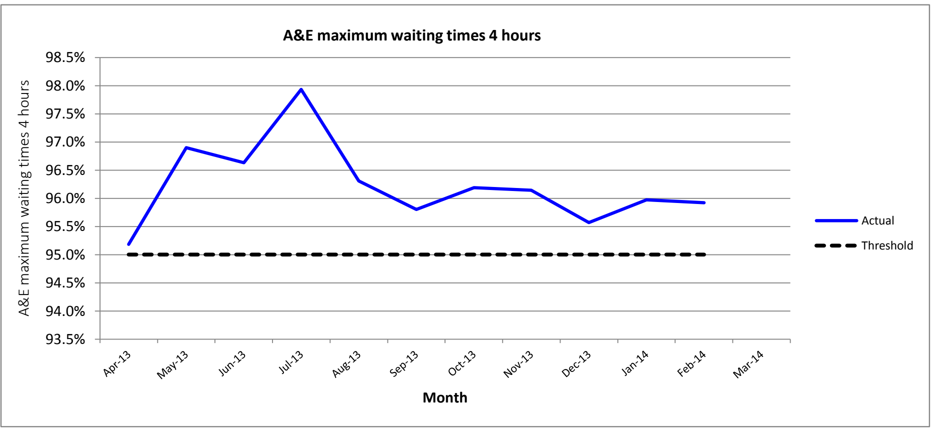
Indicators to developed
*BADS Day Case Rate - Paediatric**

Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2012/13 Feb	Performance in 2012/13 Qtr3	Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Elective Access															
18 weeks referral to treatment - admitted	18Wa	-	Mth	90%	91.4%	89.1%	91.3%	92.5%	93.3%	93.2%	92.7%				Mon, TDA, CQC
18 weeks referral to treatment - non admitted	18Wn	-	Mth	95%	96.4%	96.6%	95.2%	96.8%	96.8%	95.8%	96.3%				Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	18Wi	-	Mth	92%	94.6%	92.7%	94.6%	96.0%	96.0%	95.1%	95.5%				Mon, TDA, CQC
A&E Quality															
A&E maximum waiting times 4 hours	A&E4h	✓	Mth	95%	96.6%	96.9%	95.9%	96.2%	96.7%	96.0%	96.2%				Mon, TDA, CQC









Indicator	Abrv.	Leading	Frequency	Threshold	Performance in 2012/13 Feb	Performance in 2012/13 Qtr3	Current Month	Q1	Q2	Q3	YTD	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Cancer Access Waiting Times															
2 week wait from referral to date first seen all urgent referrals	2WW	✓	Qtr	93%	94.9%	93.5%	95.3%	98.3%	98.4%	98.5%	98.1%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer	2WW	✓	Qtr	93%	95.3%	92.6%	96.2%	97.6%	97.6%	97.3%	97.4%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment	31DW	-	Qtr	96%	96.3%	95.1%	97.3%	94.4%	96.9%	96.1%	95.9%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug	31DT	-	Qtr	98%	98.6%	99.4%	100.0%	100.0%	99.5%	100.0%	99.8%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy	31DT	-	Qtr	94%	96.9%	99.0%	99.2%	97.5%	98.7%	98.1%	98.2%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery	31DT	-	Qtr	94%	94.7%	97.8%	95.2%	96.1%	95.5%	95.4%	95.6%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral	62DW	-	Qtr	90%	90.9%	86.7%	88.9%	91.3%	95.6%	92.2%	92.6%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral	62DW	-	Qtr	85%	71.8%	78.7%	79.5%	74.3%	74.0%	80.1%	76.5%				Mon, TDA, CQC

2 week wait from referral to date first seen all urgent referrals

2 week wait from referral to date first seen Breast Cancer

31 days standard from diagnosis to first treatment

31 days standard to subsequent Cancer treatment - Drug

31 days standard to subsequent Cancer treatment - Radiotherapy

31 days standard to subsequent Cancer treatment - Surgery

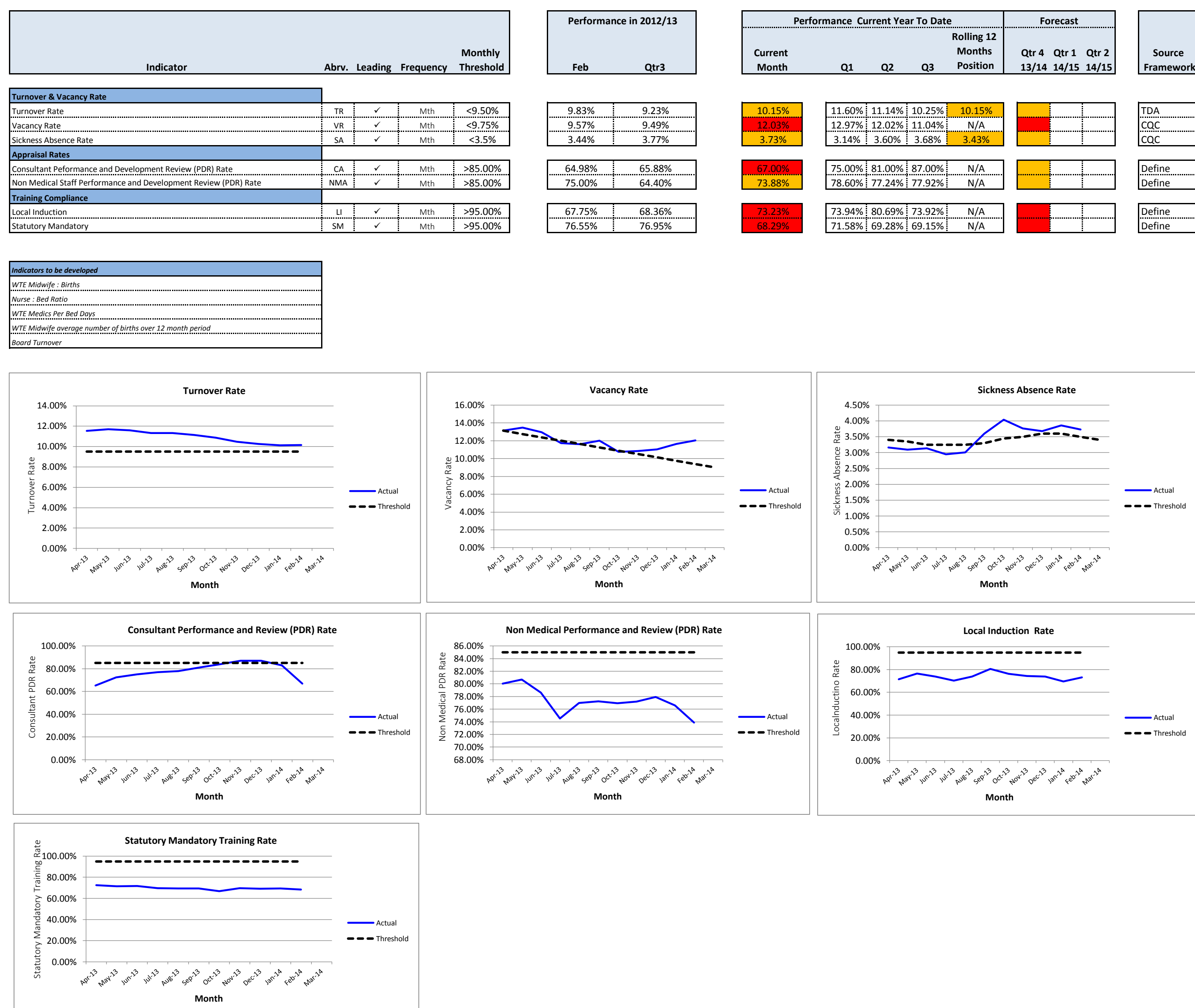
62 day wait for first treatment from NHS screening services referral

62 day wait for first treatment from urgent GP referral

(Legend for each chart: Actual, Threshold, London Avg, Shelford Avg; x-axis: Month, Apr-13 to Mar-14)

Quality Principles - People 6.1

Imperial College Healthcare NHS
NHS Trust



Indicator	Abrv.	Leading	Frequency	Monthly Threshold	Performance in 2012/13 Feb	Performance in 2012/13 Qtr3	Performance Current Year To Date: Current Month	Q1	Q2	Q3	Rolling 12 Months Position	Forecast Qtr 4 13/14	Forecast Qtr 1 14/15	Forecast Qtr 2 14/15	Source Framework
Turnover & Vacancy Rate															
Turnover Rate	TR	✓	Mth	<9.50%	9.83%	9.23%	10.15%	11.60%	11.14%	10.25%	10.15%				TDA
Vacancy Rate	VR	✓	Mth	<9.75%	9.57%	9.49%	12.03%	12.97%	12.02%	11.04%	N/A				CQC
Sickness Absence Rate	SA	✓	Mth	<3.5%	3.44%	3.77%	3.73%	3.14%	3.60%	3.68%	3.43%				CQC
Appraisal Rates															
Consultant Peformance and Development Review (PDR) Rate	CA	✓	Mth	>85.00%	64.98%	65.88%	67.00%	75.00%	81.00%	87.00%	N/A				Define
Non Medical Staff Performance and Development Review (PDR) Rate	NMA	✓	Mth	>85.00%	75.00%	64.40%	73.88%	78.60%	77.24%	77.92%	N/A				Define
Training Compliance															
Local Induction	LI	✓	Mth	>95.00%	67.75%	68.36%	73.23%	73.94%	80.69%	73.92%	N/A				Define
Statutory Mandatory	SM	✓	Mth	>95.00%	76.55%	76.95%	68.29%	71.58%	69.28%	69.15%	N/A				Define

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

POTENTIAL RISKS AND MITIGATING ACTIONS

Potential Risk	Threshold	Current Position	Main Controls	Mitigating Action	Target Date	Accountable Officer for Action
MRSA - 11 reported cases (year to date), failing the zero tolerance target, which could compromise patient safety and governance ratings	0	11	Infection Prevention & Control Policy Infection Prevention Training Clinical Rounds Incident Reporting Monitoring	Review of procedures and practice. Re-enforce patient safety practice and infection prevention and control on wards and clinical areas. Checking intravenous and devices daily and their removal as soon as no longer needed. Additional weekly MRSA screening on ward for high risk patients. Consider universal decolonisation outside intensive care. External experts to examine and report on safety systems for patients requiring intravenous lines and hand hygiene	Q4	AH
				Anticipated Effect On Control		
				These actions will help to avoid further cases and increase risk score, without these on-going interventions it could increase the likelihood breaching the Monitor 6 cases level.		
62 Day Wait for 1st Treatment	85%	79.5% in month ; 76.5% YTD	Elective Access Policy Cancer Standard Operating Procedures Cancer PTL meetings Elective Access Waiting List meeting Cancer MDT meetings	Twice weekly meetings with Chief Operating Officer and Cancer Management Team to track patients on active pathway to ensure they are treated within target time. Redesign of cancer pathways per tumour site which is focussing on speeding up the diagnostic part of the pathway.	Qtr4	SMcM
				Anticipated Effect On Control		
				These actions will help ensure patients are treated within target time and help minimise breaches.		

Contents

Finance Performance Report for the month ending 28th February 2014

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	R	R	Attached
4	Financial Risk Rating for Divisions & Corporate Services	A	A	Attached
5	Cost Improvement Plan	A	A	Attached
6	Statement of Financial Position (Balance Sheet)	G	G	Attached
7	Capital Expenditure Report	R	R	Attached
8	Cash Flow Report	G	A	Attached
9	Financial Risk Rating for Trust	G	G	Attached
10	SLA Activity & Income Performance	G	G	Attached

Variance: Favourable / (Adverse)

PAGE 1 - STATEMENT OF COMPREHENSIVE INCOME

	In Month			Year To Date (Cumulative)			Forecast Outturn		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Income									
Clinical	58,366	61,364	2,998	683,202	705,534	22,332	745,934	771,654	25,720
Research & Development & Education	9,562	10,571	1,009	105,182	107,688	2,506	114,743	117,461	2,718
Other	6,648	5,142	(1,506)	73,148	75,852	2,704	79,799	81,909	2,110
TOTAL INCOME	**74,576**	**77,077**	**2,501**	**861,532**	**889,074**	**27,542**	**940,476**	**971,024**	**30,548**
Expenditure									
Pay - In post	(38,697)	(39,339)	(642)	(424,859)	(431,859)	(7,000)	(462,891)	(469,093)	(6,202)
Pay - Bank	(1,719)	(2,370)	(651)	(19,077)	(20,639)	(1,562)	(20,798)	(22,617)	(1,819)
Pay - Agency	(1,881)	(2,698)	(817)	(20,951)	(25,761)	(4,810)	(23,743)	(28,139)	(4,396)
Drugs & Clinical Supplies	(17,762)	(20,351)	(2,589)	(196,926)	(216,715)	(19,789)	(214,761)	(236,348)	(21,587)
General Supplies	(2,963)	(3,018)	(55)	(32,583)	(34,853)	(2,270)	(35,551)	(37,996)	(2,445)
Other	(9,399)	(7,712)	1,687	(103,464)	(96,871)	6,593	(112,879)	(107,175)	5,704
TOTAL EXPENDITURE	**(72,421)**	**(75,488)**	**(3,067)**	**(797,860)**	**(826,698)**	**(28,838)**	**(870,622)**	**(901,367)**	**(30,745)**
EBITDA	**2,155**	**1,589**	**(566)**	**63,672**	**62,377**	**(1,295)**	**69,854**	**69,657**	**(197)**
Financing Costs	(4,612)	(4,455)	157	(50,740)	(168,021)	(117,281)	(55,371)	(172,324)	(116,953)
SURPLUS / (DEFICIT) including Impairment	**(2,457)**	**(2,866)**	**(409)**	**12,932**	**(105,645)**	**(118,577)**	**14,483**	**(102,667)**	**(117,150)**
Impairment of Assets & Donated Asset treatment	49	51	2	537	117,923	117,386	592	117,742	117,150
SURPLUS / (DEFICIT)	**(2,408)**	**(2,815)**	**(407)**	**13,469**	**12,278**	**(1,191)**	**15,075**	**15,075**	**(0)**

Surplus / (Deficit): The Trust delivered a deficit of £2,815k in month, which is adverse variance of £407k. The actual achievement of CIP YTD is £41,752k and this is behind plan by £3,265k.The forecast outturn reflects the Clinical Divisions' and Non Clinical Directorates' (NCD) anticipated income and expenditure for the year. The financing costs includes an impairment of assets of £117m for the devaluation of buildings.

I**ncome**: Clinical income is ahead of plan and is mainly associated with continuing over-performance on the CCGs & NHS England SLAs. Additional R&D income was released in month but is matched with expenditure.

Expenditure: Pay overall is broadly consistent with the previous period. **Non Pay** overall is lower than the previous month due to the one-off cost for the sale of stock and higher R&D spend in last month.

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	Forecast £000s	Variance £000s
Income from Clinical Activities									
Clinical Commissioning Groups	30,981	34,267	3,286	362,760	375,044	12,284	396,073	413,425	17,352
NHS England	22,147	22,116	(31)	259,242	269,134	9,892	283,046	292,748	9,702
Other NHS Organisations	1,368	934	(434)	16,001	14,095	(1,906)	17,469	14,438	(3,031)
Sub-Total NHS Income	**54,496**	**57,317**	**2,821**	**638,003**	**658,273**	**20,270**	**696,588**	**720,611**	**24,023**
Local Authority	746	707	(39)	8,729	9,459	730	9,529	9,750	221
Private Patients	2,576	2,861	285	30,044	31,338	1,294	32,801	34,282	1,481
Overseas Patients	142	182	40	1,666	2,176	510	1,820	2,350	530
NHS Injury Scheme	107	152	45	1,257	1,461	204	1,373	1,574	201
Non NHS Other	299	144	(155)	3,503	2,827	(676)	3,823	3,086	(737)
Total - Income from Clinical Activities	**58,366**	**61,364**	**2,998**	**683,202**	**705,534**	**22,332**	**745,934**	**771,654**	**25,720**
Other Operating Income									
Education, Research & Development	9,562	10,571	1,009	105,182	107,688	2,506	114,743	117,461	2,718
Non patient care activities	2,941	2,586	(355)	32,364	35,062	2,698	35,306	39,027	3,721
Income Generation	505	415	(90)	5,563	4,052	(1,511)	6,070	4,373	(1,697)
Other Income	3,202	2,142	(1,060)	35,221	36,738	1,517	38,423	38,509	86
Total - Other Operating Income	**16,210**	**15,714**	**(496)**	**178,330**	**183,540**	**5,210**	**194,542**	**199,370**	**4,828**
TOTAL INCOME	**74,576**	**77,077**	**2,501**	**861,532**	**889,074**	**27,542**	**940,476**	**971,024**	**30,548**

Income from Clinical Activities: The favourable in month variance is associated with the continuing over-performance of CCGs & NHS England SLA contracts. It is expected that the CCGs QIPP programmes will not deliver the anticipated reductions in admitted care and outpatient activity

Education, Research & Development income for the month is greater than planned and is matched by expenditure to ensure a net zero impact on the bottom-line.

Other Income: The adverse variance in month relates to changes in bad debt provisions following a review of outstanding debt in preparation of the Annual Accounts.

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	Forecast £000s	Variance £000s
Pay - In Post									
Medical Staff	(12,404)	(13,046)	(641)	(135,009)	(140,501)	(5,492)	(150,440)	(153,381)	(2,941)
Nursing & Midwifery	(11,888)	(12,188)	(300)	(130,701)	(134,509)	(3,808)	(144,068)	(147,092)	(3,024)
Scientific, Therapeutic & Technical staff	(5,534)	(5,502)	31	(60,800)	(61,416)	(616)	(66,586)	(67,008)	(423)
Healthcare assistants and other support staff	(2,054)	(2,285)	(231)	(22,686)	(24,727)	(2,042)	(24,633)	(26,985)	(2,351)
Directors and Senior Managers	(2,380)	(2,289)	91	(26,871)	(26,889)	(19)	(28,761)	(29,214)	(453)
Administration and Estates	(4,437)	(4,029)	408	(48,793)	(43,816)	4,977	(48,403)	(45,413)	2,990
Sub-total - Pay In post	**(38,697)**	**(39,339)**	**(642)**	**(424,859)**	**(431,859)**	**(7,000)**	**(462,891)**	**(469,093)**	**(6,202)**
Pay - Bank/Agency									
Medical Staff	(613)	(849)	(236)	(6,902)	(8,824)	(1,922)	(8,002)	(9,604)	(1,601)
Nursing & Midwifery	(1,247)	(2,085)	(838)	(13,728)	(15,754)	(2,025)	(14,693)	(17,415)	(2,722)
Scientific, Therapeutic & Technical staff	(366)	(255)	111	(4,164)	(5,390)	(1,226)	(4,565)	(5,822)	(1,258)
Healthcare assistants and other support staff	(280)	(539)	(259)	(3,085)	(4,201)	(1,116)	(3,992)	(4,603)	(611)
Directors and Senior Managers	(326)	(117)	209	(3,591)	(1,814)	1,777	(4,010)	(1,900)	2,110
Administration and Estates	(767)	(1,222)	(456)	(8,559)	(10,418)	(1,859)	(9,278)	(11,411)	(2,133)
Sub-total - Pay Bank/Agency	**(3,600)**	**(5,068)**	**(1,468)**	**(40,028)**	**(46,400)**	**(6,372)**	**(44,540)**	**(50,756)**	**(6,216)**
Non Pay									
Drugs	(7,778)	(8,667)	(890)	(88,931)	(97,563)	(8,632)	(99,268)	(106,401)	(7,133)
Supplies and Services - Clinical	(9,984)	(11,684)	(1,699)	(107,995)	(119,152)	(11,157)	(115,493)	(129,947)	(14,454)
Supplies and Services - General	(2,963)	(3,018)	(55)	(32,583)	(34,853)	(2,270)	(35,551)	(37,996)	(2,445)
Consultancy Services	(1,289)	(1,348)	(59)	(14,179)	(14,051)	128	(15,464)	(15,864)	(400)
Establishment	(618)	(521)	97	(6,813)	(6,962)	(149)	(7,435)	(7,566)	(131)
Transport	(824)	(1,032)	(208)	(9,064)	(10,551)	(1,487)	(9,892)	(11,538)	(1,646)
Premises	(3,351)	(2,810)	541	(36,862)	(35,188)	1,674	(40,219)	(38,587)	1,632
Other Non Pay	(3,317)	(2,001)	1,316	(36,546)	(30,119)	6,427	(39,869)	(33,621)	6,248
Sub-total - Non Pay	**(30,124)**	**(31,081)**	**(957)**	**(332,973)**	**(348,439)**	**(15,466)**	**(363,191)**	**(381,519)**	**(18,328)**
TOTAL EXPENDITURE	**(72,421)**	**(75,488)**	**(3,067)**	**(797,860)**	**(826,698)**	**(28,838)**	**(870,622)**	**(901,367)**	**(30,746)**
Financing Costs									
Interest Receivable	25	20	(5)	265	179	(86)	287	188	(99)
Receipt of Grants for Capital Acquisitions	67	58	(9)	739	506	(233)	798	798	0
Interest Payable	(72)	(61)	11	(789)	(786)	3	(859)	(856)	3
Other Gains & Losses	0	0	0	0	(18)	(18)	0	(18)	(18)
Impairment on Assets	0	0	0	0	(117,142)	(117,142)	0	(117,142)	(117,142)
Depreciation	(2,916)	(2,896)	20	(32,077)	(33,433)	(1,356)	(35,001)	(36,392)	(1,391)
Public Dividend Capital	(1,716)	(1,575)	141	(18,878)	(17,327)	1,551	(20,596)	(18,902)	1,694
TOTAL - FINANCING COSTS	**(4,612)**	**(4,455)**	**157**	**(50,740)**	**(168,021)**	**(117,281)**	**(55,371)**	**(172,324)**	**(116,953)**

Pay total spend in month is broadly consistent with the previous period. The increase in temporary staff costs when compared to last month is mainly associated with winter pressure initiatives.

Non Pay: Overall spend is down when compared to last month due to the sale of stock of £1.9m in January as part of a CIP project which is matched by income and spend on R&D projects being higher for last month. Also the Trust received a rates rebate of £0.5m this month.

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

PAGE 4 - Financial Risk Rating for Clinical & Non Clinical Divisions

Medicine

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	Green	Green	Green	Green	Green	Amber	Amber	Green	Amber	Amber	Green	
Cost Control	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Forecasting Accuracy	Red	Red	Red	Red	Red	Amber	Amber	Amber	Amber	Amber	Amber	
Financial Governance	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Working Capital & Equipment	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	

S&C

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	Green	Green	Green	Green	Green	Amber	Amber	Green	Amber	Amber	Green	
Cost Control	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Forecasting Accuracy	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Financial Governance	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Working Capital & Equipment	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	

DISCS

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	Green	Green	Green	Green	Green	Amber	Green	Amber	Amber	Amber	Green	
Cost Control	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Forecasting Accuracy	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Financial Governance	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Working Capital & Equipment	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	

W&C

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	Green	Green	Green	Green	Green	Amber	Amber	Green	Amber	Green	Amber	
Cost Control	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Forecasting Accuracy	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Red	Amber	Red	
Financial Governance	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Working Capital & Equipment	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	

Corporate

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *												
Cost Control	Red	Red	Red	Red	Red	Amber	Red	Red	Amber	Red	Red	
Forecasting Accuracy	Amber	Amber	Amber	Amber	Amber	Red	Red	Red	Amber	Red	Amber	
Financial Governance	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Working Capital & Equipment	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	

TRUST

Theme	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Financial Sustainability *	Green	Green	Green	Green	Green	Amber	Amber	Green	Amber	Amber	Amber	
Cost Control	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Forecasting Accuracy	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Financial Governance	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	
Working Capital & Equipment	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	Amber	

KPI PERFORMANCE COUNT

	Red	Amber	Green
Medicine	16%	60%	24%
S&C	12%	60%	28%
DISCS	20%	52%	28%
W&C	32%	56%	12%
Corporate	38%	52%	10%

* Financial sustainability always uses the income figures from the previous month, due to the reporting lag around income of 1 month.

To give a more transparent view of FRR performance, the table to the left summarises the proportion of KPIs scored Red, Amber or Green for each Division and Corporate.

Improvements in timing of income reporting and the rollout of a income reporting tool to Divisions will improve transparency and engagement in maximising income receivable.

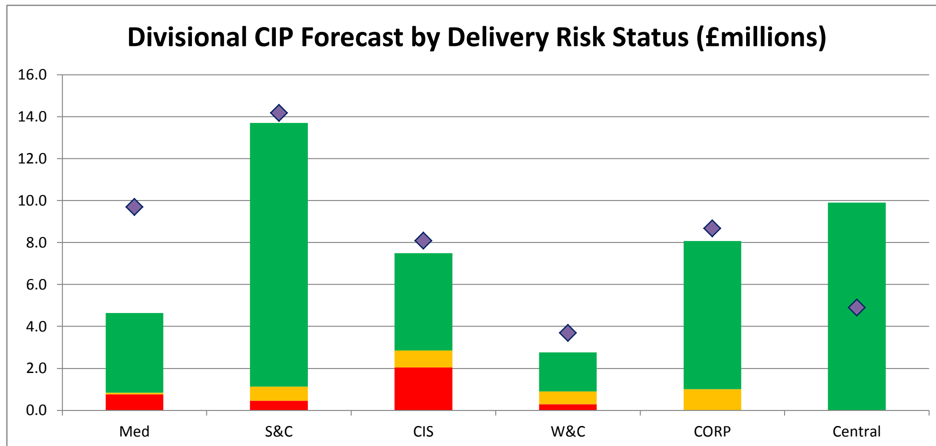
A Qlikview application to allow drilldown from Divisional level to Directorate, Speciality and Cost Centre is now live for th e Business Partners and Business Analysts to use with their Divisions and NCDs. This will allow detailed understanding of which areas are driving Divisional performance in relation to the

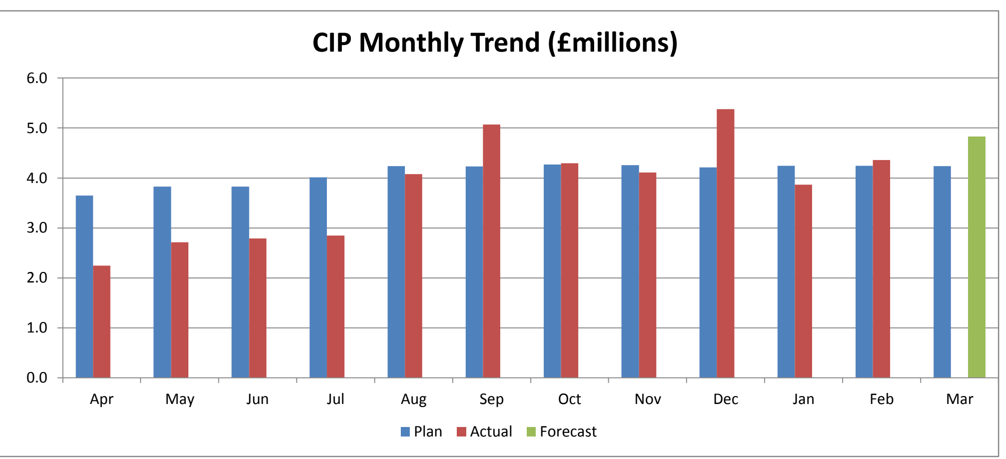
Financial Risk Rating (FRR) **Risk: A**

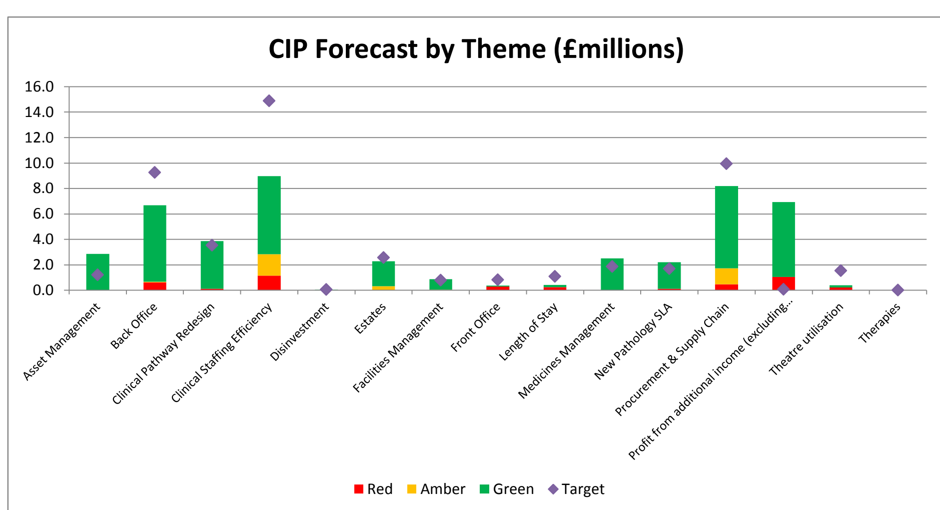
Appendix - Financial Risk Rating Detail

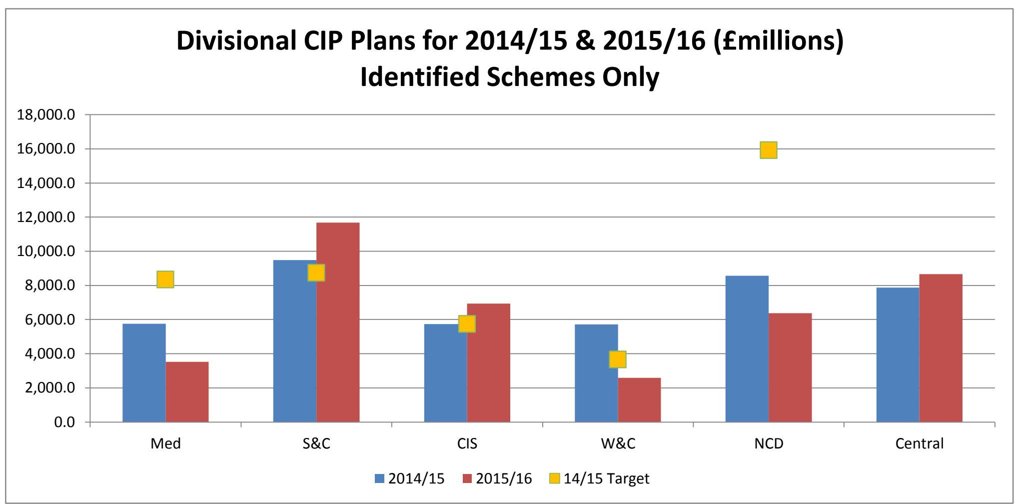
		Medicine	S&C	DISCS	W&C	Corporate
Financial Sustainability	Change in EBITDA Margin %					
	NHS Income Loss %					
	Income per Consultant Clinical PA (£)					
	NHS Clinical Income Trends					
Cost Control	YoY Change in Expenditure %					
	Premium Pay %					
	% of Total Hours related to Annual Leave, Sickness, Study & Other Leave					
	Establishment Accuracy					
	% Procurement Spend Covered by Catalogue					
	% of Procurement Spend Covered by Contract					
	Purchase Order Compliance					
Forecasting Accuracy	Monthly Forecasting Accuracy					
	Quarterly Forecasting Accuracy					
	Annual Planning Accuracy					
	Expense Type Forecasting Accuracy					
	Cost Centre Forecasting Accuracy					
Financial Governance	Planning Ownership					
	Planning Integration					
	Risk Management					
	Training					
	Attendance at Divisional Finance Review Meetings					
Working Capital & Equipment Assets	Stock Days					
	Creditor Payment Terms					
	Debtor Days					
	Unplanned Capital Equipment Purchases					

Financial Risk Rating Detail **Risk: A**









Key Issues:

- £41.8m savings delivered year to date (deficit of £3.3m against plan)
- £46.6m of savings forecast for current year (deficit of £2.7m against plan)
- The Trust has committed to the Trust Development Authority delivery of the full £49.3m plan. Current Divisional and Non-Clinical Directorate forecasts are £46.6m, leaving a gap of £2.7m to be mitigated.
- £43.1m of savings identified for 2014/15 by Divisions and Non-Clinical Directorates (6% of operating costs)
- £39.8m of savings identified for 2015/16 by Divisions and Non-Clinical Directorates (5.6% of operating costs)
- New system 'StratPro' for Quality & Efficiency Programme approved at January Transformation Board and rolled out within Divisions and NCDs for 14/15 , 15/16 and 16/17schemes to be entered by 14th March.

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

PAGE 6 - STATEMENT OF FINANCIAL POSITION

		Opening Balance £000s	Current Month Balance £000s	Previous Month Balance £000s	Monthly Movement £000s	Forecast Balance £000s
Non Current Assets	Property, Plant & Equipment	715,616	585,943	585,620	323	595,813
	Intangible Assets	1,681	1,318	1,347	(29)	1,225
Current Assets	Inventories (Stock)	17,652	14,872	15,155	(283)	15,152
	Trade & Other Receivables (Debtors)	65,462	109,176	129,132	(19,956)	68,462
	Cash	55,326	69,399	54,732	14,667	50,326
Current Liabilities	Trade & Other Payables (Creditors)	(127,930)	(149,092)	(151,349)	2,257	(110,311)
	Borrowings	(3,059)	(3,075)	(3,075)	0	(2,701)
	Provisions	(37,353)	(28,746)	(46,051)	17,305	(16,150)
Non Current Liabilities	Borrowings	(23,362)	(21,873)	(21,873)	0	(20,709)
	Provisions	0	(17,149)	0	(17,149)	(17,149)
	TOTAL ASSETS EMPLOYED	**664,033**	**560,773**	**563,638**	**(2,865)**	**563,958**

Ratio/Indicators	Risk Rating		
	Current Month	Previous Month	Forecast
Debtor Days	40	47	26
Trade Payable Days	55	60	46
Cash Liquidity Days	29	23	26

The decrease in debtors is predominantly due to:

- Receipt of £10.1m from Department of Health for MFF R&D 2013/14
- Decrease in prepayments of £4.4m, this includes ISS payment in advance of £2.4m, CNST of £1.1m and Ravenscourt Park of £378k
- Reduction in NHS accruals of £4.1m re phasing

The increase in creditors is predominantly due to:

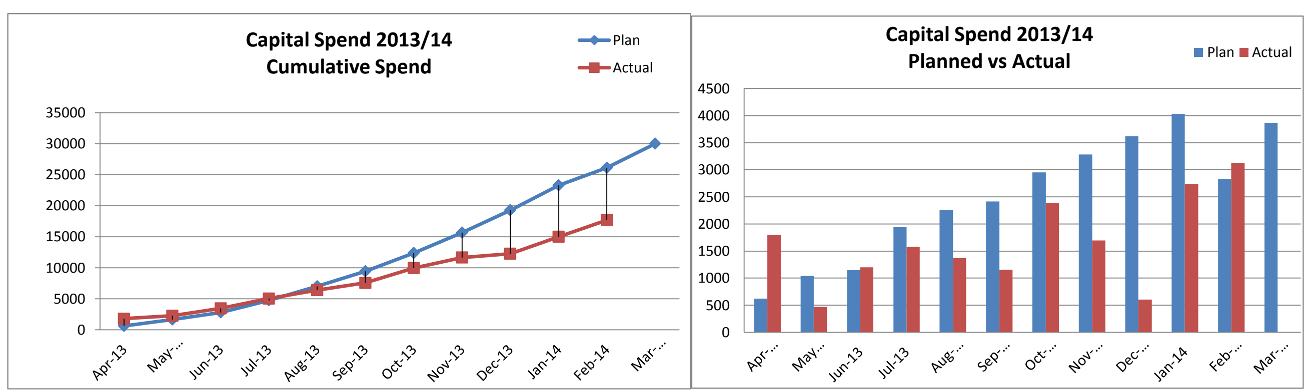
- Increase in PDC accrual of £1.6m
- Decrease in deferred income of £3.1m, this includes project diamond of £642k, R&D MFF of £842k and other R&D projects of £782k
- Decrease in trade creditors and accruals of £0.8m

The decrease in non-current provisions of £17,305k is predominantly due to the re-categorisation of £17,149k as non-current.

Statement of Financial Position (SOFP)	Risk:	G

PAGE 7 - CAPITAL EXPENDITURE

By Scheme	In Month Plan £000s	In Month Actual £000s	In Month Variance £000s	Year To Date (Cumulative) Plan £000s	Year To Date (Cumulative) Actual £000s	Year To Date (Cumulative) Variance £000s	Forecast Outturn Plan £000s	Forecast Outturn Actual £000s	Forecast Outturn Variance £000s
Imaging Improvements HH	424	0	424	1,669	137	1,532	2,093	156	1,937
ICT Investment Programme	600	760	(160)	3,900	4,151	(251)	4,500	6,000	(1,500)
Endoscopy QEQM	372	550	(178)	5,420	3,022	2,398	5,674	4,500	1,174
Cardiac Relocation (EP)	195	0	195	1,513	558	955	1,708	708	1,000
Medical Equipment	450	869	(419)	3,600	3,043	557	4,000	5,000	(1,000)
Capital Maintenance CXH	100	107	(7)	900	912	(12)	1,000	1,200	(200)
Capital Maintenance HH	170	245	(75)	1,040	928	112	1,200	1,700	(500)
Capital Maintenance SMH	100	107	(7)	900	432	468	1,000	900	100
Access Control Upgrade	150	0	150	750	0	750	900	0	900
CCTV Development	15	0	15	50	0	50	65	0	65
Imaging Review	100	0	100	2,900	0	2,900	3,000	750	2,250
Theatre Upgrade	0	292	(292)	900	356	544	900	600	300
Pathology Equipment	0	0	0	140	0	140	140	350	(210)
Minor Works	50	69	(19)	450	509	(59)	500	950	(450)
Bathroom Upgrade HH Private Patients	0	40	(40)	250	62	188	250	50	200
Bio-Resource Centre	0	9	(9)	350	684	(334)	350	696	(346)
Aggregate Site Developments	100	112	(12)	1,400	1,399	1	1,470	2,394	(924)
Contingency	0	0	0	0	0	0	1,250	0	1,250
Shaping a Healthier Future Site Development	0	23	(23)	0	1,024	(1,024)	0	1,400	(1,400)
Radiotherapy Improvements	0	3	(3)	0	888	(888)	0	890	(890)
SALIX	0	1	(1)	0	47	(47)	0	64	(64)
New Linear Accelerators	0	3	(3)	0	21	(21)	0	1,921	(1,921)
Outpatient self-check-in kiosks	0	0	0	0	0	0	0	771	(771)
Total Capital Expenditure	**2,826**	**3,190**	**(364)**	**26,132**	**18,176**	**7,956**	**30,000**	**31,000**	**(1,000)**
Donations	0	(58)	58	0	(506)	506	0	(798)	798
Disposal proceeds	0	0	0	0	(2)	0	0	(2)	2
Total Charge against Capital Resource Limit	**2,826**	**3,132**	**(306)**	**26,132**	**17,668**	**8,462**	**30,000**	**30,200**	**(200)**
Capital Resource Limit							**(30,000)**	**(30,264)**	**264**
Over/(Under)spend against CRL							**0**	**(64)**	**64**



As reported through the year, the programme has become back-ended as result of:
- slippage in some large projects such as HH imaging, where TDA approval is still awaited for the OBC
- reorganisation of CPGs into Divisions, meaning that decisions on medical equipment purchases were made late in the year when new incumbents had taken up post
- retaining of contingency until almost the end of the year

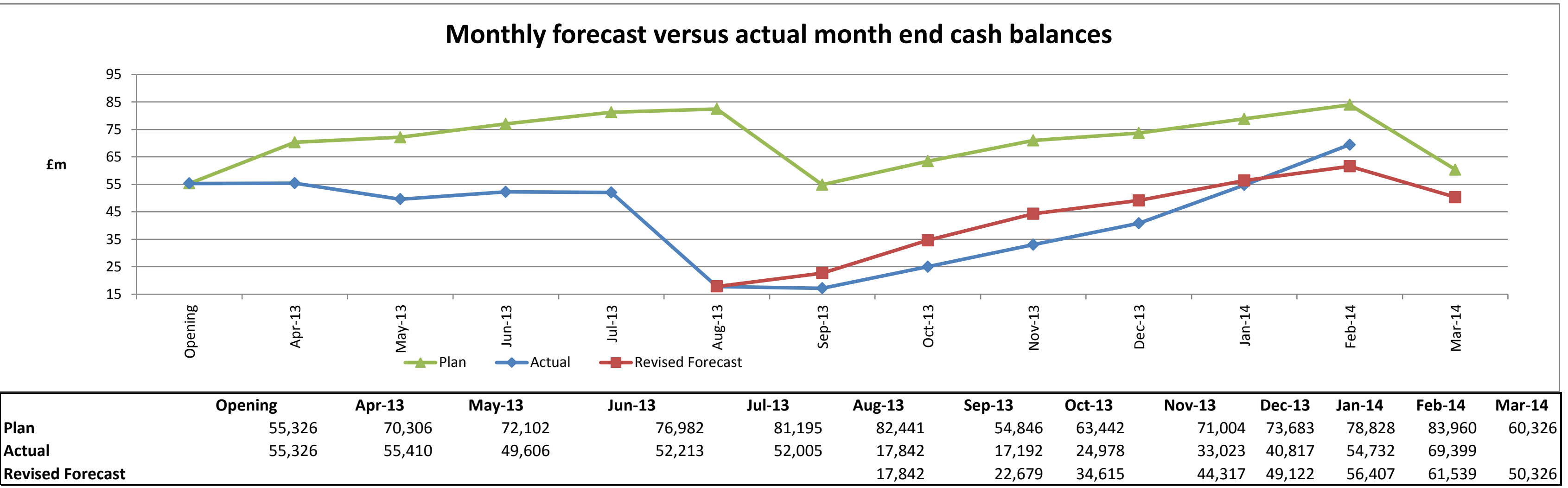
Efforts have been made to accelerate investments already approved to make use of headroom from slippage and unused contingency. This is primarily ICT hardware and medical equipment.

Securing delivery of more than £12m of investment in one month is not unprecedented in the Trust but does create some pressure. To provide confidence this is achievable, there were £15.2m of outstanding order balances in eFinancials, not all of which is due this year and will involve careful programme management to ensure CRL is maximised but not exceeded.

Next year to enable us to maximise investment in what should be that last year of CRL for the Trust we aim to over-programme by 10-20% to allow for a less frenetic year-end.

Statement of Financial Position (SOFP)	Risk:	R

PAGE 8 - CASH



	Opening	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Plan	55,326	70,306	72,102	76,982	81,195	82,441	54,846	63,442	71,004	73,683	78,828	83,960	60,326
Actual	55,326	55,410	49,606	52,213	52,005	17,842	17,192	24,978	33,023	40,817	54,732	69,399	
Revised Forecast						17,842	22,679	34,615	44,317	49,122	56,407	61,539	50,326

Aged Debtor Analysis

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total	Previous Month Total
NHS	£ 16,337,420	£ 14,311,896	£ 2,827,294	£ 15,045,589	£ 10,121,105	£ 166,662	**£ 58,809,965**	**£ 76,576,613**
Non-NHS	£ 5,778,508	£ 4,406,498	£ 176,557	£ 1,557,761	£ 591,455	£ 865,181	**£ 13,375,961**	**£ 12,032,533**
Overseas Visitors	£ 234,717	£ 229,847	£ 133,353	£ 385,218	£ 525,305	£ 2,362,073	**£ 3,870,513**	**£ 3,746,617**
Private Patients	£ 2,826,693	£ 1,034,373	£ 768,100	£ 1,370,257	£ 1,499,028	-£ 92,727	**£ 7,405,724**	**£ 7,383,724**
Total	**£ 25,177,337**	**£ 19,982,615**	**£ 3,905,304**	**£ 18,358,825**	**£ 12,736,893**	**£ 3,301,189**	**£ 83,462,163**	**£ 99,739,488**
% of Total Debt	**30.2%**	**23.9%**	**4.7%**	**22.0%**	**15.3%**	**4.0%**	**100.0%**	

Aged Creditor Analysis

Category	0 to 30 Days	31 to 60 days	61 to 90 days	91 days to 6 months	6 to 12 months	Over 1 Year	Grand Total	Previous Month Total
All AP Creditors	£ 7,655,069	£ 7,034	£ 37,139	£ 270,469	£ 9,007	£ 255,278	**£ 8,233,996**	**£ 11,774,905**
Total	**£ 7,655,069**	**£ 7,034**	**£ 37,139**	**£ 270,469**	**£ 9,007**	**£ 255,278**	**£ 8,233,996**	**£ 11,774,905**
% of Total Creditors	**93.0%**	**0.1%**	**0.5%**	**3.3%**	**0.1%**	**3.1%**	**100.0%**	

The level of NHS debtors has decreased in February in part due to payment received from the Department of Health for MFF R&D and NHS England for Project Diamond. However, there are still some delays in the payment of over performance invoices despite contracts now being agreed. The Trust has also received a number of payments in advance for March SLAs from Shared Services resulting in a reduction in the difference between plan and actual.

The cash forecast was revised in August to take into account delays in agreeing contracts with commissioners as well as the advance payment to ISS.

The variance from plan of £14m is made up of a shortfall in income of £2.2m and payments in advance of plan of £11.8m. The increase in payments is in part due to the Trust paying an additional £4.6m in advance to ISS for the 8 months to 31st May 2014. The original plan only had a six month payment in advance.

The main elements of the shortfall in income are:
- £3.9m Non Contract Activity (NCA) invoiced to CCGs, NHS England and NHS Commissioning Board for months 1-7 still outstanding. Invoices for month 7 were raised in Dec 2013.
- £(16.3)m received in advance from Shared Services for March SLAs for four NW London CCGs
- £12.4m being over performance for Q1 to 3 invoiced to CCGs
- £2.2m for NCAs invoiced to local authorities still outstanding

At the end of February the balance of cash invested in the National Loan Fund scheme totalled £58m. This amount was invested for 7 days at an average rate of 0.40%. Total accumulated interest receivable at 28 February 2014 was £179k.

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

Page 9 - FINANCIAL RISK RATINGS (FRR)

Financial Risk Rating

Metric	Weighting	Metric Description	April	May	June	July	August	Sept	Oct
Achievement of Plan	10%	EBITDA achieved (% of Plan)	5	5	5	4	4	5	5
Underlying Performance	25%	EBITDA margin %	3	3	3	3	3	3	3
Financial Efficiency	40%	Net return after financing (%) I&E surplus margin net of dividends (%)	2	2	2	2	3	3	3
Liquidity	25%	Liquidity ratio (days)	4	4	4	4	4	3	3
Overall Financial Risk Rating			2	3	3	3	3	3	3

Continuity of Service Risk Rating

Metric	Weighting	Metric Description	April	May	June	July	August	Sept	Oct
Liquidity Ratio	50%	Liquidity ratio (days)	4	4	4	4	4	2	2
Capital Servicing Capacity	50%	Capital Servicing Capacity (times)	3	4	4	4	4	4	4
Overall Continuity of Service Risk Rating			**4**	**4**	**4**	**4**	**4**	**3**	**3**

The presentation of the Financial Risk Rating (FRR) has changed to a tabular format and includes the new Monitor Continuity of Service (CoS) risk rating for comparison purposes.

All risk metrics are on track for February.

* The liquidity ratio for FRR is a proxy rating assuming a 30 day working capital facility available only to Foundation Trusts.

Financial Risk Ratings

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

Point of Delivery	Year to Date (Activity)			Year to Date (Income)			Forecast		
	Plan	Actual	Variance	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
Admitted Patient Care									
- Day Cases	60,949	63,618	2,669	53,074	53,728	654	57,947	58,721	774
- Regular Day Attenders	12,946	14,178	1,232	6,010	6,360	350	6,561	6,943	382
- Elective	19,235	18,204	(1,031)	66,423	63,367	(3,056)	72,522	69,184	(3,338)
- Non Elective	75,971	80,345	4,374	144,558	152,864	8,306	157,529	169,500	11,971
Accident & Emergency	155,372	154,550	(822)	18,485	18,482	(3)	20,182	20,197	15
Adult Critical Care	37,781	38,934	1,153	45,813	43,410	(2,403)	50,020	47,399	(2,621)
Outpatients - New	213,567	275,119	61,552	40,739	46,927	6,188	44,216	51,569	7,353
Outpatients - Follow-up	410,591	445,876	35,285	57,692	63,943	6,251	62,782	70,215	7,433
Ward Attenders	6,467	5,219	(1,248)	1,049	854	(195)	1,146	932	(214)
PbR Exclusions	906,915	1,473,276	566,361	160,016	172,219	12,203	174,684	188,415	13,731
Direct Access	2,010,201	2,024,953	14,752	13,877	14,825	948	15,151	16,195	1,044
CQUIN	0	0	0	14,726	15,838	1,112	16,078	17,293	1,215
Others	1,879,153	1,916,904	37,751	19,221	20,268	1,047	20,986	22,130	1,144
Commissioning Business Rules	(18,742)	(21,090)	(2,348)	(17,138)	(13,411)	3,727	(18,712)	(14,641)	4,071
SLA Income	5,770,406	6,490,086	719,680	624,545	659,674	35,129	681,092	724,052	42,960
Less Non English Organisations				(12,549)	(13,053)	(504)	(13,701)	(14,250)	(549)
TDA Over performance				13,523		(13,523)	15,598		(15,598)
HTLV					1,094	1,094		1,200	1,200
Non Patient Care CCG Income				2,317	2,131	(186)	2,500	848	(1,652)
Performance Bond				4,766	4,766	0	5,203	5,203	0
Adjustment to TDA Plan				5,401	3,661	(1,740)	5,896	3,558	(2,338)
TOTAL	**5,770,406**	**6,490,086**	**719,680**	**638,003**	**658,273**	**20,270**	**696,588**	**720,611**	**24,023**

Income by Sector	Year to Date (Income)			Forecast		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Forecast £000s	Variance £000s
North West - London	292,790	312,006	19,216	318,902	344,432	25,530
London - Others	37,858	37,250	(608)	41,311	40,680	(631)
Non London	18,434	17,907	(527)	20,125	19,550	(575)
NHS England	253,193	268,040	14,847	276,440	292,673	16,233
Foundation Trust	3,359	3,241	(118)	3,667	3,538	(129)
Non Contracted Activities	5,492	7,307	1,815	5,996	7,977	1,981
Out of Area Treatment	870	870	0	950	950	0
Other SLA			0			0
TDA Over performance	13,523		(13,523)	15,598		(15,598)
HTLV		1,094	1,094		1,200	1,200
Non Patient Care CCG Income	2,317	2,131	(186)	2,500	848	(1,652)
Performance Bond	4,766	4,766	0	5,203	5,203	0
Adjustment to TDA Plan	5,401	3,661	(1,740)	5,896	3,560	(2,336)
TOTAL	**638,003**	**658,273**	**20,270**	**696,588**	**720,611**	**24,023**

The report is an analysis of NHS SLA Income from clinical activities.
The Year to Date position is favourable variance against plan of £20.3m. The main reasons are :-
- Increase in Day case activity with the key over performing service line being Clinical Haematology £1.8m and Cardiology and Ophthalmology underperformance of (£0.6m) and (£0.5m) respectively.
- Elective activity is below plan by (£3.0m). The key under performing service lines are Trauma & Orthopaedics (£1.5m), Vascular Surgery (£0.6m) , Head & Neck Reconstruction (£0.6m), and others (£0.3m).
- Non Elective work is above plan by £8.8m with the key over performance on Accident and Emergency £3.4m, Paediatrics £1.5m, Major Trauma £1.3m, General Medicine £0.8, Urology £0.6m, Cardiology £0.5m, Thoracic Medicine £0.4 and Others £0.3m.
- Outpatient first appointments are above plan £6.1m reflecting the 13/14 change in the unbundled activity for imaging, cardiology and gynaecology.
- Outpatient follow up appointments have increased against plan by £6.2m. The main variances are Cardiology £1.0m, AMD One Stop £0.9m, Urology £0.6m and Ophthalmology £0.4m .
- Other key over performance relates to PbR Exclusions mainly with NHSE for drugs.

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

ICHT Occupational Health Review

Management Board

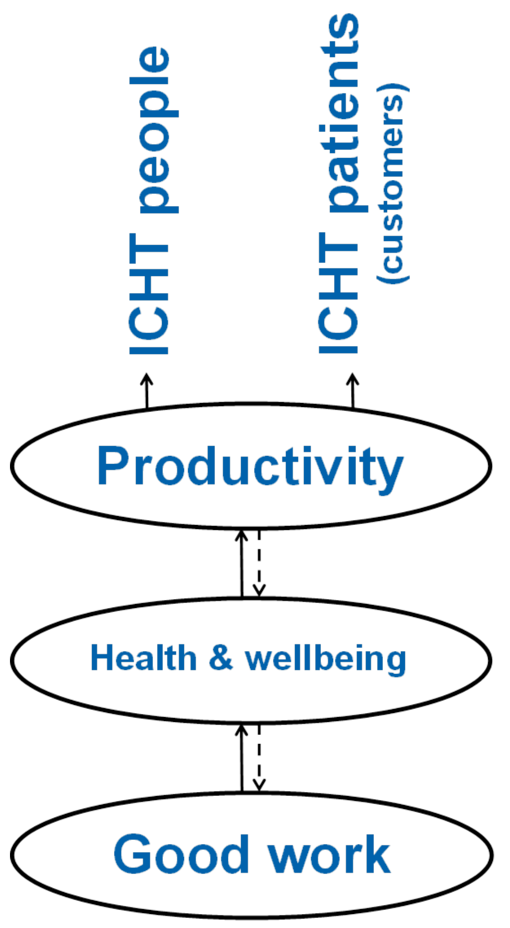
March 3rd 2014

Review premise

Work ability is a key health outcome.

"Good work is good for health, good for business and good for national prosperity"

The Council for Work and Health. *Planning the future: Delivering a vision of occupational health and its workforce for the UK for the next 5-20 years. 2013*



Review goal

Imperial Health at Work
Improving work with each conversation

- A **new vision for occupational health** to deliver good patient outcomes through the health and wellbeing of our people in the Trust
- A **new vision for the NHS** to develop a **health and wellbeing culture** that embraces **employment and work ability as key health outcomes**.

We will model a new way of offering healthcare to measurably improve health outcomes and patient satisfaction – **through *work health coaching***.

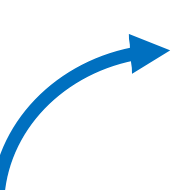
How it will work

FIT 3

- Health and wellbeing
- Health risk management
- Fast track referrals
- Work for health
- Patient OH interventions
- Research

FIT 2

- Duty nurse
- Duty doctor
- Health protection
- Rapid access assessment



FIT 1

- Website – knowledge content/ decision tree
- Call centre – advice

Imperial College Healthcare NHS
NHS Trust

Benefits

ICHT:

- People & patients – culture change
- Imperial reputation
- FT application and AHSC reaccreditation
- Stakeholder relationships
- Service development and income generation
- Strengthened market position

Wider:

- Patient care outcomes for NWL population
- UK/global productivity

4-year plan

1. March 2014
   - Move to two-site working (CXH & SMH) = £89k
2. Years 1/2: 2014-16
   - Phase 1 transformation (FIT 1, FIT 2, FIT3 in part) implemented
   - 2014/15 CIP = c.£40k saving
   - cost of change = c.£23.5k from business investment
   - staff costs – redundancy/redeployment
3. Year 3: 2016/17
   - Phase 2 transformation (FIT 3) fully operational
   - £178K surplus through business development
   - external service growing (7 contracts)
4. Year 4: 2017/18
   - wider impact across London and UK (15 contracts)

Making the change

Stakeholder engagement – ongoing

Develop services and people – Feb/June 14

Programme of research – June 2014

FIT 1/FIT 2 launched – June '14

FIT 3 launched – From June '14 (staged)

Culture transformation – Jan '15-Mar '18

Promoting *The Imperial Way* externally – Jan '16

- develop direct provision and franchise models to sell to NHS

ICHT success measures

Imperial Health at Work
Improving work with each conversation

1. Culture change (5-year research project)

2. ↑ staff health and wellbeing
   - ↑ physical activity
   - ↑ staff survey outcomes
   - ↑ discretionary effort

3. ↑ patient health and wellbeing
   - ↓ return to work time
   - ↓ adverse events/SUIs/accidents at work
   - ↓ mortality
   - ↑ patient satisfaction

4. ↑ organisational performance
   - ↓ staff sickness and associated temporary staffing costs
   - ↑ recruitment and retention
   - ↑ income generation from patient referrals

Corporate Risk Register as at 20 March 2014

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
7	Chief Operating Officer	Risk Assessment	June 2007	**Description**: **Failure to maintain operational performance** **Cause**: • Failure of national performance targets (ED, cancer, RTT) • Failure of locally negotiated performance targets (CQUIN) • Failure of accurate reporting and poor data due to implementation of Cerner • Unexpected large-scale events impacting negatively on business continuity **Effect**: • Reduced patient experience • Increased inefficiencies • Reduced staff morale **Impact**: • Failure to gain FT Status • Loss of reputation and reduced confidence from key stakeholders • Impact on finances due to reactive and inefficient ways of working and from contractual penalties • Negative impact on patient experience and safety • Failure to meet contractual requirements • Failure to meet regulatory standards	• Weekly elective waiting list review • Cancer patient targeted list review • Daily ED Performance Reports • Local level scorecards and monitoring forums • Agreed remedial action plan with commissioners for cancer and RTT • Tri-borough urgent care board to oversee improvements in ED performance and urgent care pathway. • Patient experience programme - Itrack • Formal review re ED performance via ECIST with improvement action plan • Increased investment in cancer MDT Coordinators • Investment into Somerset System (Cancer tracking tool • Business Continuity and Emergency Plans in place and tested regularly • Additional senior input into site operations • Introduction of Urgent Care Board And Weekly winter operational delivery group • Opening of the “winter office” to act as the interface with external agencies including data collation and submission. To be a point of contact for site issues • Funded opening of additional acute medical beds • Extended opening hours in UCC • Increased senior medical staff input into A&E • Additional trauma lists • Increased therapy support • Revised SitRep document implemented	• Adjust action in relevant action plan in line with the deteriorating performance		• 7 of the national cancer targets were met in August and September. • 3 RTT standards are at an aggregate level. • Number of treatment function codes (TFCs) achieving the standards continues to increase. In September the Trust achieved 54 out of 57 TFCs • Incomplete backlog has reduced to just over half a week’s worth of activity.	5	3	15	↓

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
10	Director of Infection Protection Control	R A	June 2007	**Description**: **Increased levels of HealthCare Acquired Infection (HCAI).** **Cause**: Failure to maintain good infection prevention and control processes including prudent anti-infective prescribing. **Effect**: • Failure to achieve DH thresholds for *C.diffcile* and MRSA BSI's • Closure of wards • Extended length of stay • Increased waiting lists • Increased morbidity • Litigation **Impact**: • Financial penalties for cases above the DH thresholds for *C.diffcile* and MRSA BSI's • Negative media coverage resulting in loss of reputation.	• Performance monitoring system including HCAI in Trust Board Performance Report and ward level reporting • Regular executive and operational walk arounds • Trust Infection Prevention Control Committee • Comprehensive Aseptic Non-Touch Technique Training programme including competency assessment • Programme of antibiotic prescribing, monitoring and improvement in place • *Smart then Focus* campaign for appropriate prescribing of antibiotics including regular review of patients taking antibiotics • Surveillance of emerging trends in other organisms, this is dependent on adequate IT systems. • All MRSA BSI's cases have root cause analysis undertaken • All *C.difficile* cases undergo an in-depth MDT clinical revie	• Weekly Trustwide HCAI taskforce to review actions that have and need to take place • Enhanced surveillance of HCAI's that have increased in incidence • With increased incidence across the organisation a review of the cases take place with the initiation of relevant policies and procedure such as outbreak management. • With an increased incidence related to a particular ward, there would be intense ward review to establish cause, a review of patient pathways to isolate source, followed by enhanced education and support, with close monitoring for impact and resolution.	Current	Between 01/04/13 – 28/02/14 the Trust had 11 'Trust attributable MRSA BSI's' allocated to it, the DH target is zero. The Trust reported 51 Trust attributable cases of C.*difficle,* this is within trajectory for the year. **Actions include:** • Any MRSA case is reviewed at the weekly Medical Directors meetings. • Trust wide action plans in response to increase incidence of C.*diffcile* in April and MRSA in May 2013 to ensure all learning from review of cases are implemented Trustwide. Actions are reviewed on a weekly basis in the Trustwide HCAI taskforce. • Enhanced vascular lines and device management, education and communications. Care of peripheral vascular devices policy reviewed and updated. • Appointment of a third Vascular access nurse • The Trusts Vascular access group has been redefined to form a Trust wide line safety group that will ensure senior clinician engagement and delivery of quality improvement initiatives. • Enhanced Hand hygiene and MRSA Screening programmes • Working with peers, CCG, TDA and PHE to ensure all appropriate processes are in place. • Extension of the IPC policy on multidrug resistant organisms to address the latest advice from PHE on isolation and screening of patients at risk of carbapenem resistant organisms • Revised C. *difficile* and D&V policies to ensure isolation of patients with diarrhoea within 2 hours of onset to reduce transmission risk. • Highlighting inadequate isolation facilities as a risk to managing infection (on IP&C RR). Enhanced surveillance for MSSA and E.*coli* bacteraemias and trend analysis of risk factors.	5	4	20	↔

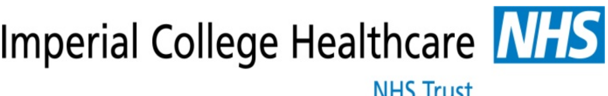
Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
43	Chief Information Officer	Local Risk Register	July 2011	**Description**: **Failure successfully to implement the new EPR system (Cerner)** **Cause**: • Insufficient organisational engagement • Supplier fails to deliver • Failure of programme deliverables **Effect**: • Patient administrative and clinical processes are disrupted • Adverse impact on data quality **Impact**: • Harm to patients • Inability to report on activity to commissioners • Negative media coverage resulting in loss of reputation	• Cerner Programme Board is in place with Chief Operating Officer as the Senior Responsible Owner for the Programme • Clearly defined criteria that have to be met before the system is taken into live operation • Internal and external audit of business readiness prior to commencing live operation	• Delay go live until the trust and the system are fully ready • Detailed plan to provide pre and post-go live support including a familiarisation and training programme for staff, floor walkers to help end users adapt to the new system etc • A set of Key Performance Indicators to track data quality and enable management action to address any emerging problems	April 2014	• Gateway criteria have been developed against the key milestones • First three gateways have been passed successfully and the trust is on track for go live on 22nd April 2014.	3	4	12	⇔
48	Chief Financial Officer	Risk Assessment	March 2012	**Description**: **Failure to deliver Cost Improvement Programmes (CIPs)** **Cause**: • Lack of properly defined, risk assessed, achievable CIPs • Poor management and reporting of CIPs **Effect**: Reduced financial capacity **Impact**: • Failure to gain FT Status • Adverse impact on the AHSC mission.	• Transformation and CIP Board • New structure in place • Senior Finance team in place • Robust CIP identification process in place • Enhanced controls in place for appointment of staff and ordering of goods and services	• CPDs/Divisions and non-clinical directorates have earned autonomy. If they do not deliver then this will be performance managed through an escalation mechanism similar to the turnaround process in 2012/13.	Monthly	Progress on delivery of the CIP programme is reviewed monthly at the performance review meetings and the Board and bi-monthly by the Finance and Investment Committee.	3	5	15	⇩

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
49	Chief Executives	Risk Assessment	February 2012	**Description**: **Inability to achieve Shaping a Healthier Future (SaHF) activity changes due to failure to deliver associated estate change.** **Cause**: • Lack of effective working relationships with commissioners • Lack of understanding and inability to influence the commissioning agenda **Effect**: • Loss of activity/revenue • Inability to fund estate changes **Impact**: • Reduced quality of patient care • Financial loss • Operational pressures •	• Collaboration and engagement with GPs and commissioners • Revised Trust demand and capacity planning • Trust developing its own business case reflecting the changes in SaHF on the estate • PwC have been commissioned to provide a report on clinical and site strategy to include immediate next steps. Report due end of February 2014. •	• Deliver additional CIPs to account for the reduction in activity. • Review demand and capacity and close surplus capacity.	Current	Chairman and Chief Executives met with the 6 CCG leads and Daniel Elkeles to discuss commissioning needs to enable a strategy report to be commissioned.	3	4	12	
55	Director of Estates & Facilities	Director of Estates & Facilities	Mar 11	**Description:** **Insufficient historic and current investment in the Estates leads to failures that prejudice Trust operations and increases clinical and other safety risks unacceptably.** **Cause** • Poor condition of much of the Estate • Large backlog of £146m (of which £3.9m is High Priority and a further £17m is Significant Priority) **Effect:** • Possible short-notice closure of facilities due to equipment failures • Hampered movement around the Trust for patients (e.g, lift unavailability) • Failure of building systems to support key clinical equipment (e.g. pathology, ICT, power) • Cosmetic work cancelled (e.g. redecorating, floor repairs • Inability to provide sufficient single rooms for HCAI patients. • Inability to keep up with repair requests and minor improvements for operational / clinical benefit **Impact:** • Potential adverse impact of HCAI • Possible unavailability of clinical facilities • Adverse impact on patient experience • Possible suspension of patient services • Increased waiting list time • Breach of H&S regulations • Risk of failure of CQC Inspection	• The condition survey is to be updated to scope the issues more accurately. • PLACE (Patient-Led Assessment of the Care Environment) is run by Estates and Facilities to identify priorities from a patient point of view. • Statutory and regulatory inspections are now in place to pick up major risks to continued safe operation of the hospitals • Planned preventative maintenance schedules are largely in place now to reduce the risk of key equipment failure • Reorganisation of Estates Maintenance team will provide more effective planning and prioritisation of resources. • In the long term, significant parts of the worst estate will be replaced by new buildings under site reconfigurations derived from SaHF proposals and Trust clinical strategy	• Repairs and reactive maintenance would need to increase. • Some clinical facilities may need to be closed at short notice either for extended periods to carry out repairs (e.g. as for CXH theatres in summer 2013) or permanently if repairs were judged not to be cost-effective. The longevity of buildings and sites will influence the approach to be taken.		• Revenue maintenance budget was increased by £2.4m per annum phase over 2012/13 and 2013/14. Further £2.4m revenue has been requested through 2014/15 business planning to improve repair performance comprehensiveness of PPMs and completion of remedial works arising from condition and patient surveys and from statutory/ regulatory inspections. • A new specialist maintenance management system went live (1 Nov 13) to enable better tracking of maintenance checks, fault reports and identification of trends over time that can better inform prioritisation of planned works / backlog investments. Data backup problems delayed full implementation and rectification work is being accelerated to reinstate lost data. We have also replaced paper-based systems with mobile phones to task tradesmen and record work without having to return to the workshops between jobs • Plans for updated backlog maintenance expenditure and backlog investment are being developed as part of the Trust capital planning process for 2014/15 and beyond, and include seeking a significant uplift from recent years. • Completion of work to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out. This is coupled to the PPM task above. However, the cost of remedial works may turn out to be significant in some cases and need specific additional funding. This work is on-going.	4	4	16	

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
58	Divisional Director for Women's and Children's	National recommendations	2/7/2013	**Description:** **PICU Risk to patient transmission of a multi-drug resistant infection between patients resulting in colonisation from VIM resistant Pseudomonas isolated on PICU which carries up to 75% mortality with bacteraemia** **Cause:** • Unit does not comply to Paediatric Intensive Care Society standards 2010 – Spaces between each bed are 50% less than required standards **Effect:** • Adverse impact on infection control and patient experience **Impact:** • Breach of national standards • Possible suspension of patient services • Possible harm to patients • Negative media coverage resulting in loss of reputation	• A review of storage has taken place and controls in place to prevent accumulation of stock/equipment to assist in maintaining a clear and clutter free environment for easier cleaning and maintenance • A weekly matron cleaning audit is in place in conjunction with the ISS supervisor. Scores and trends monitored via the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • Hand washing and bare below the elbows audits take place and are monitored by infection control and the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • All patients are screened on admission for VIM-P • All patients are screened weekly for VIM-P • Training and adherence to the Trust's prevention of infection policy is in place • Bacterial filters are used on ventilator circuits for intubated children • There is a close partnership with the Trust's infection control team. Infection scores and trends monitored via the Children's Directorate scorecard at the Children's Quality and Safety Committee meetings • Remedial estate works have been carried out to replace all sinks/taps on unit have been replaced to prevent splash back • A Business Case has been compiled regarding the relocation of PICU to a larger footprint	• There is a close partnership with the Trust's infection control team in identification of trends and themes regarding infection control issues. • Review the closure of beds to mitigate risks identified	Current	UPDATE 20/11/2013 all sinks and taps replaced to conform to modern standards, all water tests on sinks clear. UPDATE 03/12/2013 a full business case to relocate PICU to a larger footprint has been compiled UPDATE 14/03/12 Mitigating measures continue – Strict hygiene controls, screening all patients weekly and renewal of all the sinks in the unit have so far stemmed any further nosocomial transmission, still remains high risk due to condition of estate. Recent two cases of Pertussis and one of Influenza A on unit recently. The flu case led to patients needing oseltamivir prophylaxis and the pertussis has led to some staff requiring immunisation and take antibiotics.	4	4	16	⇔

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk (Impact / Effect / Cause)	Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score: Likelihood	Current Score: Consequence	Current Score: Risk Score	Trend / Movement
62	Division of Medicine	Risk Assessment	03/12/20 13	**Description:** **Insufficient Level 2 beds on the Hammersmith Hospital Site.** **Cause:** • No level 2 beds established on the Hammersmith Hospital Site. • B1 ward used to deliver some aspects of level 2 care **Effect:** • Unwell patients deemed not for ITU nursed in inappropriate care environment (for example B1 ward) • Patient care undertaken in either too complex or insufficiently complex environment **Impact:** • Possible harm to patients / detrimental impact on patient outcomes	• A Trust Critical Care group is in place to discuss these issues. • To develop a clear pathway for the management of patients who are too sick to be nursed on B1 Ward. • On-going review of B1 ward nursing cover. • Early involvement of ITU for patient review.	• To explore the establishment of a Medical High Dependency Unit on the Hammersmith Site.	Current	• Trust Critical Care group is in place • Review of B1 ward nursing cover on an ongoing basis. • Change in function of B1 and C8 to centralise sick medical patients will offer opportunity to review nursing profile.	4	4	16	⇔
64	Director of Nursing	National Survey	Feb 2014	**Description:** **Poor patient experience reported in the 2014 national cancer survey** **Cause**: • ICHT fails to make improvements in experience reported by cancer patients • Annual production of league table produced by Macmillan, the methodology of which puts ICHT at the bottom • Time lag between survey sample and report created limited window to deliver improvements **Effect**: • Negative experience reported by cancer patients • Poor rating in Macmillan performance league table **Impact**: • Damage to ICHT reputation as a leading cancer hospital • Adverse press coverage • Potential loss of income if GPs don't refer patients or patients choose not to come to ICHT	• Cancer patient experience action plans and specific work streams in place • Senior clinician leading improvement • Fortnghtly cancer patient experience steering group • Monthly cancer steering board • Monthly cancer senior leadership meeting • Continuous monitoring of patient feedback via iTrack • Quarterly bespoke surveys based on national survey questions	• Cancer patient experience steering group will develop detailed analysis and amend action plan when results are received • Communications plan in development to respond if results for national survey (due in Aug 14) have not improved	Between 3 – 12 months	• Significant work was undertaken prior to September 2013 (the beginning of the last sampling period) so the expectation is that some improvements will be realised. • Work continues with a new focus on key improvements in advance of the 14/15 sampling period • Since last national results, some small improvements in bespoke survey results have been seen	4	3	12	

Risk ID Number	Risk Owner	Risk Source	Date when risk first identified	Description of Risk			Key Controls	Contingency Plans	Proximity	Actions and Progress report	Current Score			Trend / Movement
				Impact	Effect	Cause					Likelihood	Consequence	Risk Score	
65	Medical Director		Feb 2014	**Description:** **Failure to achieve corporate objectives for medical education** **Cause**: • Failure to maintain medical education income • Reduction in medical student places or postgraduate placements commissioned by Imperial College or HE NWL • Failure to achieve high quality training as measured by college visits or GMC surveys • Failure to address allegations of bullying and undermining of medical staff **Effect**: Undermines mission of AHSC by failing to provide medical education integrated with research and service provision **Impact**: • Reduces quality of care provided by undermining teaching commitment • Compromises future re-designation of AHSC • Undermines financial assumptions in LTFM			• Responsibility transferred to medical directors office • Action plan to implement recommendation of Fiona Moss review of postgraduate education • Anti-bullying strategy and action plan implemented • Review and improvement in induction processes • Project to identify income streams and use of educational funds, including transparency of consultant job plans	Continue to monitor impact of changes and implement further corrective measures as needed Seek further advice and support as required			3	4	12	



Committee Terms of Reference
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2	Finance & Investment Committee
3	Foundation Trust Programme Board
4	Quality Committee
5	Remuneration & Appointments Committee

Imperial College Healthcare NHS
NHS Trust

Audit, Risk & Governance Committee
Terms of Reference

Role

The role of the Audit, Risk & Governance Committee is to provide the Trust Board with the assurance that an adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively.

Definitions

"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Audit, Risk & Governance Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of a minimum of three members. Only non-executive Directors shall be members of the Committee. Members may not appoint a deputy to represent them at a committee meeting. The Chairman of the Trust is not a member of the Committee.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent non-executive director. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of 75% scheduled meetings.

- 1.4.1 Internal and External Audit representatives will always attend meetings. The committee shall meet privately with the Internal and External Auditors at least once a year;
- 1.4.2 The Chief Executive will be invited to attend any meeting and should attend at least annually to discuss with the committee the process for assurance that supports the Annual Governance Statement.
- 1.4.3 The Chief Operating Officer, Chief Financial Officer, Director of Nursing and Medical Director will attend all meetings as requested in the capacity of being in attendance.

2 Secretary

2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be 2 members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Board of Directors unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

8.1 Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

8.2 In relation to the management of risk, the Committee will:

- 8.2.1 Review the process under which the trust sets its risk appetite;
- 8.2.2 Oversee and advise the Board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- 8.2.3 Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- 8.2.4 Refer to the quality committee any clinical risks that require further scrutiny by its membership;
- 8.2.5 Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- 8.2.6 Review the statements to be included in the Annual Report concerning risk Management;
- 8.2.7 Review the process and effectiveness of learning from incidents trustwide.

8.3 The Committee will monitor due diligence on any integration or partnership arrangements, reviewing the risk assessment and decision-making processes to ensure all control issues are addressed.

8.4 The Committee will seek assurance on behalf of the Board that the design and application of the control environment in core financial processes are fit for purpose

and reflect both public and commercial sector best practice.

8.5 In particular, the Committee will review the adequacy and effectiveness of:

8.5.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

8.5.2 an effective system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

8.5.3 the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

8.5.4 the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

8.5.5 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by NHS Protect

8.6 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.7 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

9 Internal Audit

9.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board of Directors. This will be achieved by:

9.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

9.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

9.1.3 consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

9.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

9.1.5 annual review of the effectiveness of Internal Audit.

10 External Audit

10.1 The Committee shall review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work. This will be achieved by:

10.1.1 appointment of the External Auditor, as far as the relevant rules and regulations permit;

10.1.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;

10.1.3 discussion with the External Auditors of their local evaluation of audit risks

and assessment of the Organisation and associated impact on the audit fee;

10.1.4 review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

11 Whistleblowing and counter fraud

11.1 The Audit Committee will review the adequacy of the trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern including patient care and safety and bullying.

11.2 In particular the committee will:

11.2.1 review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service;

11.2.2 approve and monitor progress against the operational counter fraud plan;

11.2.3 receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;

11.2.4 monitor progress on the implementation of recommendations in support of counter fraud;

11.2.5 receive the annual report of the local counter fraud specialist.

12 Other Assurance Functions

12.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

12.2 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (for example the NHS Litigation Authority), professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

12.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.

13 Management

13.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

13.2 They may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

14 Financial Reporting

14.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

14.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Board of Directors.

14.3 The Committee shall review the Annual Report and Financial Statements before recommending them to the Board of Directors, focusing particularly on:

•the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;

•changes in, and compliance with, accounting policies and practices;

•unadjusted mis-statements in the financial statements;
•major judgmental areas; and
•significant adjustments resulting from the audit.

15 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

15.1 The committee will review on behalf of the Board proposed changes to the Standing Orders and Standing Financial Instructions;

15.2 The committee will examine the circumstances of any departure from the requirements of Standing Orders, Standing Financial Instructions;

15.3 The committee will monitor the policy on standards of business conduct for members of staff with reference to the codes of conduct and accountability thereby providing assurance to the Board of probity in the conduct of business;

15.4 The committee will review proposed changes to the Scheme of Delegation before recommending to the Trust Board for approval;

15.5 The committee will review schedules of losses and compensations annually.

16 Reporting responsibilities

16.1 The committee will report to the Board of Directors on its proceedings after each meeting;

16.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed;

16.3 The committee will produce an annual report to the Board of Directors.

17 Other matters

The committee will:

17.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

17.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

17.3 give due consideration to laws and regulations;

17.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Board of Directors for approval, any changes it considers necessary.

18 Authority

18.1 The committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

18.1.1 to seek any information it requires from any employee of the trust in order to perform its duties;

18.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary;

18.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

19 Monitoring and Review:

19.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.

19.2 The secretary will assess agenda items to ensure they comply with the committee’s responsibilities.

19.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.

19.4 Terms of reference approved September 2013

19.5 To be reviewed dd/mm/yyyy

FINANCE AND INVESTMENT COMMITTEE (FIC)

Terms of Reference

Role

The role of the Finance and Investment Committee (FIC) is to undertake on behalf of the Trust Board thorough and objective reviews of financial policy and financial performance issues reviewing the risks to the financial position. In addition the FIC will advise the Trust Board on finance issues and investment strategy, including those relating to the Trust's estate.

The Committee will review the Trust's financial performance and identify the key issues and risks requiring discussion or decision by the Trust Board.

Definitions

"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Finance and Investment Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Trust Board. The committee shall be made up of six members. These are three non-executive members / Designate NED, the Chief Executive, Chief Financial Officer and the Chief Operating Officer.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent non-executive director. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the committee. Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of four scheduled meetings.

- Director of Operational Finance
- Director of Estates and Facilities
- Deputy Director of Finance (rotational basis)

2 Secretary

2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be three members, two of which are non-executive directors'/ Designate NED'. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of tow thirds of meetings. The Secretary of the committee

shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Trust Board unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

8.1 **Financial policy, management and reporting**

The Committee shall make recommendations to the Trust Board on financial policies, provide oversight of financial management and reporting with consideration to the overall financial performance of the Trust.

Specifically the committee shall:

- advise the Trust Board on financial policies;
- recommend to the Trust Board the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust Board;
- review the Annual Plan including the annual revenue and capital budget prior to submission to the Trust Board for approval;
- review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust Board;
- review compliance with the self-assessment quality checklist for the annual reference cost submission;
- review at the request of the Trust Board specific aspects of financial performance where the Board requires additional scrutiny and assurance;
- review the Trust's projected and actual cash and working capital;

- approve and keep under review, on behalf of the Trust Board, the Trust's investment and borrowing strategies and policies;
- ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control);
- review the financial risks.

8.2 **Investment policy management and reporting**
The Committee shall review and recommend to the Trust Board:

- the Trust's Investment Strategy and maintain oversight of the Trust's investments, including:
  - establish the overall methodology, processes and controls which govern the Trust's investments;
  - evaluate, scrutinise and monitor investments;
  - review the capital programme;
  - prepare post project evaluations for capital projects and for revenue projects which have a whole life contract value of £5 million and above. All projects will have a two stage review that will be presented to the FIC; immediately to assess project or contract completion and approximately 12 months later to review whether anticipated outcomes/savngs had been achieved.

- review and recommend to Trust Board the Trust's treasury management, working capital and estates strategies.
- within limits set out in the Standing Orders, Standing Financial Instructions and matters reserved to the Trust Board, the Committee shall approve, evaluate and scrutinise the financial and commercial validity of individual investment decisions, including the review of Outline and Final Business Cases. Business cases will usually be referred to the FIC following initial review by the Investment Management Committee, with input from the others as appropriate. The current delegated limit for the Trust is £5million.

9 Reporting responsibilities

9.1 The committee will report to the Trust Board on its proceedings after each meeting.

9.2 The committee shall make whatever recommendations to the Trust Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.3 The committee will produce an annual report to the Trust Board.

10 Other matters

The committee will:

10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

10.3 give due consideration to laws and regulations;

10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust Board for approval, any changes it considers necessary.

11 Authority

11.1 The committee is a non-executive committee of the Trust Board and has no powers, other than those specifically delegated in these Terms of Reference. The committee is authorised:

11.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties;

11.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary;

11.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.

12.2 The secretary will assess agenda items to ensure they comply with the committee’s responsibilities.

12.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.

12.4 Terms of reference approved: FIC 19 September 2013.

12.5 To be reviewed September 2014.

Imperial College Healthcare NHS
NHS Trust

FOUNDATION TRUST PROGRAMME BOARD (FTPB)

Terms of Reference

Role

The role of the Foundation Trust Programme Board is established as a time-limited sub-group of the Trust Board. It will exist until the date that the Trust is authorised as a Foundation Trust. At that time, a decision will be made as to whether the FTPB should continue for a limited period beyond the date of authorisation.

The role of the FTPB is to lead and monitor all aspects of the programme. The FTPB will provide leadership and direction to the programme, and assurance to the Trust Board in ensuring its success.

Definitions:

In these terms of reference:-

"the Trust" means Imperial College Healthcare NHS Trust;
'the Trust Board" means the Board of Directors of the Trust;
"the FTPB" means the Foundation Trust Programme Board;
"the Directors" means the Trust's Board of Directors;
"the programme" means Imperial's application and programme to achieve Foundation Trust status.

1 Membership:

1.1 The members of the FTPB shall be appointed by the Trust Board. The FTPB shall be made up of around 13 members, excluding commissioning representatives and external advisors. Members may appoint deputies to represent them at meetings on a one-off basis if approved by the chair

1.2 Only members of the FTPB have the right to attend and vote at its meetings. The FTPB may require other officers of the Trust and other Trust employees to attend all or any part of its meetings.

1.3 The chair of the FTPB shall be an independent Non-Executive Director. In the absence of the chair and/or his appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 The initial composition of the FTPB shall be:-

- Four Non-Executive Directors, (one of whom shall be Chair);
- Chief Executive Officer (Deputy Chair);
- Chief Financial Officer (Lead Director);
- Medical Director;
- Director of Nursing;
- Chief Operating Officer;

- Director of Strategy;
- Director of Governance & Assurance;
- Director of People & Organisational Development;
- Director of Communications;
- Trust Development Authority representative;
- Commissioning representative – TBA;
- Senior external advisors – TBA;

1.5 In addition to the Members the following are required to attend meetings of the FTPB:-
Head of Planning & Business Development;
Foundation Trust Programme Manager.
Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of two thirds of meetings.

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2 Secretary:

2.1 The Foundation Trust Programme Manager shall act as the secretary of the FTPB.

3 Quorum:

The FTPB's quorum shall be not less than one third of members present, including not less than two Non-Executive Directors and two Executive Directors. A duly convened meeting of the FTPB at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the full FTPB.

4 Frequency of meetings and attendance requirements:

4.1 The FTPB will meet on a monthly basis throughout the life of the application programme and dissolved once FT authorisation is achieved.

Extraordinary meetings can be convened by the chair if required to deal with particular items of business.

4.2 FTPB members should aim to attend all scheduled meetings but must attend a minimum of three-quarters of the meetings in a year. The FTPB's secretary shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings:

5.1 Meetings of the FTPB may be convened by the secretary at the request of any of its members or otherwise where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to all members, to any other person required to attend, and to all other Non-Executive Directors, no later than five working days, before the date of the meeting.

Supporting papers shall be sent to members and to other attendees as appropriate, at the same time.

6 Minutes of meetings:

6.1 The secretary shall minute the proceedings of all FTPB meetings, including the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

6.3 Minutes of FTPB meetings should be circulated promptly to all members and, once agreed, to all members of the Trust Board, except any such members who are debarred by a conflict of interest.

7 Annual General meeting:

7.1 The chair of the FTPB will normally attend the Trust's Annual General Meeting in order to respond to any questions on the FTPB's activities.

8 Duties:

8.1 The FTPB has the following key duties:-

- To provide leadership and direction to the FT Programme;
- To oversee the programme and ensure that appropriate plans are put in place to mitigate any potential deviations from it;
- To provide assurance to the Trust Board that the programme is progressing according to plan and to hold Directors to account for their contributing areas of responsibility;
- To provide effective scrutiny and approval of all programme deliverables prior to review and sign-off by the Trust Board;
- To issue the necessary directions, receive reports and seek positive assurances from directors and managers on the overall arrangements for the poroigramme and its supporting portfolio of change;
- To provide assurance and recommendations to Trust Board for sign-off of submission documents;
- To monitor programme progress and direct action where necessary;
- To ensure required resources are committed to the programme;
- To manage or resolve any conflicts or issues within the programme that have been escalated to it;
- To resolve strategic and directional issues that affect the programme, and which may need the input and agreement of senior stakeholders to ensure the progress of the programme;
- To define the acceptable levels of risk for the programme;
- To review and approve programme documentation and deliverables;
- To agree the key messages to stakeholders.

8.2 Under the guidance of the FTPB, a Foundation Trust Programme Team will lead the day-to-day execution of activities required for the application process. The team will escalate any matters arising to the FTPB for decision or action as required

9 Reporting responsibilities:

9.1 The FTPB will report bi-monthly to the Trust Board to update it on the progress of the programme, to provide assurance concerning the mitigation of any issues arising, and to request the Board's action as required by way of inclusion in the Chief Executives report.

9.2 The Chief Financial Officer will provide a monthly update on the programme to the Trust Management Board and weekly during peaks of activity within the programme (e.g. during external assessment phases). Additionally, FTPB members will work with the Trust Board as and when required for example during Board Development sessions.

9.3 The FTPB will receive a monthly update report from the chair of the Programme team updating him on progress against the programme plan and any significant issues for discussion or decision.

9.4 The FTPB shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

10 Other matters:

The FTPB will:

10.1 At least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust Board for approval, any changes it considers necessary.

11 Authority:

11.1 The FTPB is authorised by the Trust Board:-

- To seek any information it requires from any employee of the Trust in order to perform its duties;
- To obtain outside legal or other professional advice on any matter within its terms of reference through the Trust Secretary; and
- To call any employee to be consulted or questioned at a meeting of the FTPB as and when required.

The FTPB has no powers other than those specifically delegated in these terms of reference. The FTPB and Trust Board may identify from time to time, delegated authorities which would facilitate the FTPB to discharge its responsibilities. Any approved delegated authorities will be recorded in Trust Board minutes.

12 Monitoring and Review:

12.1 The Trust Board will monitor the effectiveness of the FTPB through receipt of its minutes and such written or oral reports as the chair of the Trust Board may require.

12.2 The FTPB's secretary will assess agenda items to ensure they comply with the needs of the programme and the Board's responsibilities.

12.3 The FTPB's secretary will also monitor the frequency of the FTPB's meetings and the attendance records to ensure that the minimum attendance figures are complied with. The attendance of members will be reported in the annual report.

12.4 Terms of reference approved: 20 September 2013 (FTPB)

12.5 To be reviewed:March 2014

Imperial College Healthcare NHS
NHS Trust

QUALITY COMMITTEE

Terms of Reference

Role

The role of the Quality Committee is to obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust. The committee will also obtain assurance that the quality strategy is being implemented and continuous improvement evidenced.

Quality encompasses the six principles for improvement set out by Donald Berwick: "care that is safe, effective, patient-centered, timely, efficient, and equitable", which in turn are the key elements of the quality strategy.

The committee will ensure that robust Clinical Governance structures, systems and processes including those for Clinical Risk Management and service user safety, are in place across all services and are line with national, regional and commissioning expectations.

The committee will refer appropriate issues to relevant committees including the operational and management boards.

Approval of required annual reports related to quality will be undertaken through this committee for example Quality Accounts, for recommendation for Trust Board approval where required.

Definitions
"the Trust" means Imperial College Healthcare NHS Trust
"the committee" means the Quality Committee
"the Directors" means the Trust's Board of Directors.

1 Membership

1.1 Members of the committee shall be appointed by the Board of Directors. The committee shall be made up of at least four members. Members may not appoint a deputy to represent them at a committee meeting. The Committee will comprise four Non-Executive Directors, the Medical Director, the Director of Nursing and Midwifery, the Chief Operating Officer, the Divisional Directors, the Director of Governance and Assurance and the Director of infection Prevention and Control.

1.2 Only members of the committee have the right to attend and vote at committee meetings. The committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of the committee will be an independent non-executive director. In the absence of the committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members there may be, from time to time, other persons who are required to attend meetings of the Quality committee: Those in attendance may appoint a deputy to attend on their behalf but should aim to attend a minimum of two thirds of scheduled meetings.

2 Secretary

2.1 The Trust Secretary or their nominee shall act as the secretary of the committee.

3 Quorum

3.1 The quorum necessary for the transaction of business shall be two including one Non Executive and one Executive Director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

4 Frequency of meetings and attendance requirements

4.1 The committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

4.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Secretary of the committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

5 Notice of meetings

5.1 Meetings of the committee may be called by the secretary of the committee at the request of any of its members or where necessary.

5.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to committee members and to other attendees as appropriate, at the same time.

6 Minutes of meetings

6.1 The secretary shall minute the proceedings of all meetings of the committee, including recording the names of those present and in attendance.

6.2 Members and those present should state any conflicts of interest and the Secretary should minute them accordingly.

6.3 Minutes of committee meetings should be circulated promptly to all members of the committee and, once agreed, to all members of the Board of Directors unless a conflict of interest exists.

7 Annual General meeting

7.1 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

8 Duties

The committee should carry out the following duties for the Trust:

8.1 Quality Governance

8.1.1 Obtain assurance that robust Quality Governance structures, systems,

and processes, including those for Clinical Risk Management and service user safety, are in place across all services, and developed in line with national, regional and commissioning expectations;

8.1.2 Approve and assure delivery of the integrated quality governance plan which includes actions related to; Mid Staffordshire NHS Foundation Trust Inquiry (2013), Clinical governance review (2012), Quality Governance Assurance Framework (2013) and QG15;

8.1.3 Obtain assurance that the Divisional Clinical Governance groups are effectively coordinating Clinical Governance activity within the Trust.

8.2 Patient Centeredness

8.2.1 Approve and assure delivery of the Trust's user involvement and patient experience annual plans/ strategy;

8.2.2 Obtain assurance that this is a key element of the work of Clinical Governance across the Trust.

8.3 Effectiveness (Monitoring and improving clinical performance)

8.3.1 Approve and assure delivery of the annual programme of Trust-wide clinical audits;

8.3.2 Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented;

8.3.3 Obtain assurance that NICE Guidelines and Technology Appraisals are implemented;

8.3.4 Obtain assurance that systems are robust for undertaking nationally mandated audits receiving summary results and monitoring the implementation of recommendations;

8.3.5 Oversee the Trust's work on Care Quality Commission's Improvement Reviews.

8.3.6 Report to the Audit, Risk and Governance Committee any ongoing concerns or risks being overseen by the Committee and to refer other matters to other committees as appropriate

8.4 Safety (Managing service user safety and clinical and other risks)

8.4.1 Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents, and taking action to reduce risks and improve clinical quality;

8.4.2 Receive and review reports on individual serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;

8.4.3 Obtain assurance that effective channels are in operation for communicating and managing issues of Clinical Governance to relevant managers, staff and external stakeholders;

8.4.4 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults;

8.4.5 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act.

8.5 Equity (Equality & Diversity)

8.5.1 Approve and monitor delivery of the Trust's equality delivery system so that essential

principles of equality are embedded into the culture, behaviour and decision making process of the organisation;

8.5.2 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

8.6 Efficiency and Timeliness

8.6.1 Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the CIP process;

8.6.2 Obtain assurance that patient access targets are being delivered.

8.7 NHSLA

8.7.1 To oversee the Trust's approach to the NHS Litigation Authority (NHSLA) Risk Management Standards assessment.

9 Reporting responsibilities

9.1 The committee will report to the Board of Directors on its proceedings after each meeting.

9.2 The committee shall make whatever recommendations to the Board of Directors it deems appropriate on any area within its remit where action or improvement is needed.

9.3 The committee will produce an annual report to the Board of Directors.

10 Other matters

The committee should:

10.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

10.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

10.3 give due consideration to laws and regulations;

10.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Board of Directors for approval, any changes it considers necessary.

11 Authority

11.1 The committee is a non-executive committee of the Board of Directors and has no powers, other than those specifically delegated in these Terms of Reference. The c committee is authorised:

11.1.1 to seek any information it requires from any employee of the trust in order to perform its duties

11.1.2 to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust Secretary

11.1.3 to call any employee to be questioned at a meeting of the committee as and when required.

12 Monitoring and Review:

12.1 The Board will monitor the effectiveness of the committee through receipt of the committee's minutes and such written or verbal reports that the chair of the committee might provide.

12.2 The secretary will assess agenda items to ensure they comply with the committee’s responsibilities.

12.3 The secretary will monitor the frequency of the committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the committee will be reported in the annual report.

12.4 Terms of reference approved by the Committee 11/9/2013

12.5 To be reviewed in March 2014.

REMUNERATION & APPOINTMENTS COMMITTEE Paper 6

TERMS OF REFERENCE

July 2013

1. Duties – General

1.1. To act on behalf of the Trust Board in determining the appointment, remuneration, terms of service and performance of the Executive Director members of the Trust Board (Executive Directors) listed in the Appendix.

1.2. To agree and oversee the process for appointing Non Executive, Executive Directors and direct reports to the CEO

1.3. To agree, on behalf of the Board of Directors, the remuneration and terms of service of the Executive Directors and note the remuneration of all other Directors..

1.4. To monitor the performance and the development of Executive Directors.

1.5. To ensure that effective plans are in place to provide continuity of leadership in the event of extended Executive Director absence or vacancy.

1.6. To approve any severance payments that are proposed for Executive Directors, for other very senior managers (VSMs) and others as maybe required by the DH.

2. Duties – Specific

Board Composition

Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.

1.1 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.

1.2 Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

1.3 Be responsible for identifying and nominating a candidate, for approval by the Board, to fill the position of Chief Executive.

Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall; use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

Appointment of Executive Directors

2.1. To nominate one or more members to be actively involved with the Chief Executive in the appointment of specific Executive Director posts, and in the design of the selection process on behalf of the committee.

2.2. To ensure that the selection process is based upon

- An agreed role and person specification.
- The use or other involvement of any third party recruitment professionals.
- An interview panel to include the Chief Executive, an agreed non-executive director or directors, an external assessor representing the SHA or its successor body and such other persons as may be agreed to be helpful.

2.3. To ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection.

2.4. To keep the Trust Board informed of the process, procedures and timetable to which it is working, as appropriate.

Remuneration of Executive Directors

2.5. To agree on behalf of the Trust Board the remuneration and terms of service of the Executive Directors. To ensure that the Executives are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant.

2.6. To agree and review annually a policy framework for the pay of VSMs not on national contracts, including Executive Directors.

2.7. To establish the parameters for the remuneration and terms of service for the appointment of Executive Directors, with delegated authority of the Chief Executive to agree starting salaries within the agreed parameters.

2.8. Responsibility for the determination of the salaries of VSMs other than Executive Directors is delegated to the Chief Executive or relevant Executive Director advised by the Director of People & OD and working within the agreed policy framework. The committee will review annually the earnings of the VSMs including senior clinicians and clinical managers.

2.9. To agree the Termination of Contract of Executive Directors and the payment of any redundancy or severance packages in line with prevailing DH or SHA guidance.

Performance and Succession Planning

2.10. To monitor and evaluate the performance both individually and collectively of the Executive Directors in the context of their responsibilities and objectives.

2.11. To ensure the capability of potential or nominated deputies for Senior Executive Directors to effectively deputise during periods of extended absence on the part of the Executive Directors.

2.12. To oversee an assessment of the capability and succession potential of the top 100-150 Trust leaders in order to identify any strategic gaps requiring appropriate intervention

3. Membership

3.1 The Committee will comprise the following who will be appointed by the Chair of the Trust Board:-

Members:

- The Chair of the Board of Directors
- Two Non–Executive Directors

Chairman:

- The Chair will be nominated by the Chairman of the Trust Board.

Attendees:

- Chief Executive and Director of People & OD

4. Quorum

4.1. A quorum shall be two members.

5. Expected Attendance

5.1. Members are expected to attend at least 75% of meetings.

6. Frequency of Meetings

6.1. The Committee will meet as required and at least twice a year.

6.2. The timetable of meetings will be agreed between the Chair of the Committee and the Secretary.

7. Authority

7.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee with relevant responsibility and knowledge of the matter and all employees are directed to cooperate with any request made by the Committee.

7.2. The Committee may commission such external professional advice or services as is deemed appropriate to enable it to fulfil its responsibilities.

7.3. In order to ensure the business of the committee is not unduly held up between meetings, the Chair. may take Chair's action between meetings. Any such decisions thus taken will be reported to the next meeting. This may include authorisation of contractual severance payments to staff other than Executive Directors as required by the DH. Where substantive or sensitive decisions are required outside of scheduled meetings then the Chair may convene an extraordinary meeting of the committee.

8. Reporting

8.1. The Committee shall produce an annual report of the Trust's remuneration policy and practices which will be part of the Trust's Annual Report.

9. Procedures

9.1. The Committee shall be supported administratively by the Director of People & OD, who will act as Secretary to the Committee, whose duties in this respect will include:

- The Agreement of agendas with Committee Chair and collation of papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on employment issues and procedures.

10. Review of Terms of Reference

10.1. At intervals of not more than two years the Committee shall make periodic reviews of its terms of reference, and on each such occasion shall report its conclusions to the Trust Board, submitting any proposed amendments to the Board for its approval.

11. Evaluation of Compliance with and the Effectiveness of the Committee

11.1. The Committee shall produce a bi-annual report for the Trust Board, including a review of compliance and effectiveness together with an action plan to address any issues.

Appendix

EXECUTIVE DIRECTORS

Posts
Chief Executive
Chief Finance Officer
Chief Operating Officer
Medical Director
Director of Nursing & Midwifery

Health Service Circular

Series number: **HSC 1998/010**
Issue date: **6 March 1998**
Review date: **5 March 1999**
Category: **General Management**
Status: **Action**
requires a specific action on the part of the recipient with a deadline where appropriate

PERSONAL LIABILITY OF NON-EXECUTIVE DIRECTORS OF NHS TRUSTS, NON EXECUTIVE MEMBERS OF HEALTH AUTHORITIES AND NON-EXECUTIVES OF SPECIAL HEALTH AUTHORITIES

For action by:
Health Authorities (England) - Chairmen and Non-executive Members
Health Authorities (England) - Chief Executives
NHS Trusts - Chairmen and Non-executive Directors
NHS Trusts - Chief Executives
SHA - Chairmen and Non-executives
SHA - Chief Executives

For information to:
Regional Chairmen
Health Authorities (England) - Directors of Finance
NHS Trusts (England) - Directors of Finance

Further details from: Dr Roger Moore,
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Room GW42,
Quarry House,
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Additional copies of this document can be obtained from:

Department of Health
PO Box 410
Wetherby
LS23 7LL
Fax 01937 845 381

It is also available on the Department of Health website at
http://www.open.gov.uk/doh/outlook.htm

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PERSONAL LIABILITY OF NON-EXECUTIVE DIRECTORS OF NHS TRUSTS, NON-EXECUTIVE MEMBERS OF HEALTH AUTHORITIES AND NON-EXECUTIVES OF SPECIAL HEALTH AUTHORITIES

Introduction

This HSC provides guidance on the extent to which non-executive directors of trusts and non-executive members of health authorities may be personally liable for their decisions and actions. It gives advice on the precautions which should be taken to minimise the risk of a legal action; recommends the form of indemnity which non-executives may be given by their trust or authority; and gives advice on insurance cover. Where this guidance refers to health authorities, this means SHAs and HAs unless specified. Where it refers to non-executives, this includes non-executive chairmen.

Summary

2. The threat of legal action against non-executives personally rather than the trust or health authority on which they serve is very small. Nevertheless, we believe that, other than in rare circumstances, non-executives are personally liable for their actions and decisions whether acting as individuals or as members of a board.

3. For the reassurance of non-executives, trusts and health authorities may provide them with an indemnity for decisions taken in the normal course of board business and in accordance with the correct procedures.

4. Trusts and health authorities are advised to issue suitable indemnities to their non-executive board members in accordance with the following text:

> A chairman or non-executive member or director who has acted honestly, reasonably, in good faith and without negligence will not have to meet out of his or her own resources any personal civil liability which is incurred in furtherance, or purported furtherance, of the execution of the NHS Acts.

The Legal Position

5. The Department has sought legal advice on three issues: a) the circumstances in which non-executive directors of trusts and non-executive members of health authorities may be personally liable for their decisions or actions; b) the circumstances in which these non-executives be exempted from liability; and c) the powers of trusts and health authorities to indemnify their non-executives.

6. It is evident from the advice which has been received that the law is unclear. There is very little judicial authority on which to rely because in most cases, legal actions have been brought against corporations rather than directors because the former, in general, have the greater assets. This means that the view of the law which follows below, whilst representing our best understanding of the position, may not be the view that a court at

some future date may take.

Extent of Liability

7. In most cases, non-executive directors of trusts and non-executive members of health authorities will probably be personally liable for their decisions or actions whether acting as an individual or as a member of a board. This applies for cases of tort (eg negligence, nuisance, defamation) as well as criminal offences. However it probably does not apply to contracts entered into by the trust or health authority unless the non-executives contract in their own names or on their own behalf.

Exemption from Liability

8. If a non-executive faces personal liability under paragraph 7 above, he or she may nevertheless under certain circumstances be exempted by virtue of Section 265 of the Public Health Act 1875 (as applied by Section 125 of the NHS Act 1977). Under these provisions, non-executives may be exempted from personal liability in libel proceedings and some other torts but probably not in criminal proceedings or proceedings for negligence or breach of contract.

Powers of Indemnity

9.1 Although a non-executive may be found to be personally liable as stated in paragraph 7 above, the trust or health authority has the power to provide an indemnity or reimbursement in appropriate cases. Such cases are likely to be those where the non-executive has acted in good faith for the purposes of executing the relevant NHS Act.

9.2 If a court finds that a non-executive was not acting in good faith, then it may also find that any money advanced to the non-executive for legal costs may be recoverable.

9.3 At present, these powers to indemnify and reimburse only apply to trusts, HAs and most, although not all, SHAs. The Department will be taking steps to ensure that these powers apply to all SHAs in the near future.

10. **Liability of Lay Members of Board Committees**

NHS boards may properly delegate their powers to take action or make decisions to independent people acting on their behalf. Examples are those committees which consider the discharge of patients under Section 23 of the Mental Health Act and committees which consider complaints under the new procedures. The independent members of such committees should be given the same indemnity as that given to non-executives.

11. **Secretary of State's Powers**

11.1 The Secretary of State, and therefore the Department of Health/NHS Executive, probably has the power (but would be under no obligation) to reimburse an HA or SHA which has properly indemnified or reimbursed a non-executive member under paragraph 9 above.

11.2 However, the Secretary of State, and therefore the Department of Health/NHS Executive, has no statutory power to indemnify or reimburse a trust which has in turn indemnified or reimbursed a non-executive director under paragraph 8 above.

11.3 Moreover, the Secretary of State, and therefore the Department of Health/NHS Executive, has no statutory power to directly indemnify or reimburse a non-executive director of a trust or a non-executive member of a health authority in respect of that director or member's personal liability.

12. Actions Required

12.1 Minimising the Risk

To minimise the risk of a personal liability action, non-executives should act only in accordance with the board's Standing Orders and with the support of the board. Wherever there is doubt about the propriety of a particular course of action, then legal advice should be sought.

12.2 Explicit Indemnity

Trusts and health authorities are recommended to issue suitable indemnities to their non-executive members or directors in accordance with the wording set out in paragraph 4 above.

12.3 Insurance

Trusts are free to take out commercial insurance to cover the costs of indemnifying their non-executives for personal liability or to carry the risk themselves (self-insurance) based on their assessment of which offers best value for money. However, the risks involved are normally very low and commercial insurance is likely to be an expensive option. Health authorities should abide by the principles set out in EL(90)195 that the public sector carries its own risks and should not take out insurance.

This circular has been issued by:

Colin L Reeves

Director of Finance and Performance

Health Service Circular

Series number: **HSC 1999/104**
Issue date: **21st April 1999**
Review date: **20th April 2000**
Category: **General Management**
Status: **Action**
sets out a specific action on the part of the recipient with a deadline where appropriate

Personal Liability of Non-Executives: Amendment of Indemnity

For action by:
Health Authorities (England) - Chairman and Non-Executive Directors
Health Authorities (England) - Chief Executives
NHS Trusts - Chairman and Non-Executive Directors
NHS Trusts - Chief Executives
SHAs - Chairmen and Non-Executives
SHAs - Chief Executives

For information to:
Regional Chairmen
Regional Directors
Regional Directors of Finance
NHS Trusts - Directors of Finance
Health Authorities - Directors of Finance

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It is also available on the Department of Health website at
http://tap.ccta.gov.uk/doh/coin4.nsf

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Personal Liability of Non-Executives: Amendment of Indemnity

Introduction

1. HSC 1998 (010) provided guidance on the extent to which non-executive directors of NHS Trusts and non-executive members of Health Authorities may be personally liable for their decisions and actions. The circular provided advice on the precautions which should be taken to minimise the risk of legal action and recommended the form of indemnity which non-executives may be given by their NHS Trust or Health Authority. The present circular extends the actions which the indemnity should cover. Where this guidance refers to Health Authorities, this means HAs and SHAs unless specified. Where it refers to non-executives, this includes non-executive chairmen.

Summary

2. The threat of legal action against non-executives personally rather than the NHS Trust or Health Authority on which they serve remains very small. Nevertheless, we believe that, other than in rare circumstances, non-executives are personally liable for their actions and decisions whether acting as individuals or as members of a board. For the reassurance of non-executives, NHS Trusts and Health Authorities may provide them with an indemnity for decisions taken in the normal course of board business and in accordance with the correct procedures.

3. The Treasury, acting on a recommendation from the Neill Committee on Standards in Public Life, has reviewed the terms of a standard indemnity which should be offered to board members. The indemnity goes further than that previously set out in HSC 98(010) and is intended to reflect the protection which would be offered under a commercial insurance policy. The cover excludes any personal criminal liability nor will it protect the reckless who have acted in bad faith.

Action

4. NHS Trusts and Health Authorities are advised to issue suitable indemnities to their non-executive board members in accordance with the following text:

A chairman or non-executive member or director who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution of his or her board function, save where the person has acted recklessly.

5. This indemnity may be extended to members of those committees which have delegated powers to make decisions or take actions on behalf of NHS boards. Examples are those committees which consider the discharge of patients under Section 23 of the Mental Health Act, the committees which consider complaints and Primary Care Groups.

Insurance

6. Some NHS Trusts may in the past have taken out commercial insurance against the risk of litigation against their non-executives (Health Authorities may not, of course, commercially insure for this or other purposes). Under the terms of HSC 1999(021) this option has no longer been available to NHS Trusts from 1 April 1999. However, the new Liabilities to Third Parties Scheme, set up under Section 21 of the NHS and Community Care Act 1990 and administered by the NHS Litigation Authority, will provide cover for this risk in terms identical to the wording in paragraph 4. All NHS Trusts are eligible to apply for membership of the new scheme. Further details are available from the scheme managers, Willis Corroon, on the following helpline number: 0845 - 6010193.

Executive Directors and Executive Members

7. HSC 1998(010) provoked questions about the position of executive directors of NHS Trusts and executive members of Health Authorities. Their position is markedly different from non-executives and so the indemnity does not extend to them. The reason for this is that the NHS Trust or Health Authority is always liable for the actions of its employees in the course of their employment. It would therefore be a matter for the NHS Trust or Health Authority whether it sought to recover from its employees the costs of loss or damage. Individual executives may however be prosecuted for criminal acts committed in the course of their employment such as breaches of the Health and Safety at Work Act 1974.

This circular has been issued by:

COLIN L REEVES
DIRECTOR OF FINANCE AND PERFORMANCE

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.

Monthly Data: December 2013 Submitted 29/01/2013.

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

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence:
The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

Condition	Compliance Yes/ No	Comment	Executive lead
1.**Condition G4** Fit and proper persons as Governors and Directors. (also applicable to those performing equivalent or similar functions)	Yes	None	Jayne Mee, Director of People and Organisational Development.
2. Condition G5 Having regard to monitor guidance.	Yes	None	Marcus Thorman. Director of Finance.
3. Condition G7 – Registration with the Care Quality Commission.	Yes	None	Cheryl Plumridge Director of Governance.
4. Condition G8 Patient eligibility and selection criteria.	Yes	None	Steve McManus, Chief Operating Officer.
5. Condition P1 Recording of information	Yes	None	Marcus Thorman, Director of Finance.

Condition	Compliance Yes/ No	Comment	Executive lead
6. Condition P2 Provision of information.	Yes	None	Marcus Thorman, Director of Finance.
7. Condition P3 Assurance report on submissions to Monitor.	Yes	None	Marcus Thorman, Director of Finance.
Condition	**Compliance Yes/ No**	**Comment**	**Executive lead**
8. Condition P4 Compliance with the National Tariff.	Yes	None	Marcus Thorman, Director of Finance.
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	None	Marcus Thorman, Director of Finance.
10. Condition C1 The right of patients to make choices.	Yes	None	Steve McManus, Chief Operating Officer.
11. Condition C2 Competition oversight.	Yes	None	Marcus Thorman, Director of Finance.
12. Condition IC1 Provision of integrated care.	Yes	None	Claire Braithwaite, Divisional Director of Operations.

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: December 2013, Submitted 29/01/2014.

CLINICAL QUALITY
FINANCE
GOVERNANCE
The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope

For CLINICAL QUALITY, that:	Compliance Yes/ No	Comment	Executive lead
1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes	None	Chris Harrison, Medical Director.
2. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes	None	Cheryl Plumridge, Director of Governance.
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	None	Chris Harrison, Medical director.

For Finance, that:	Compliance Yes/ No	Comment	
4. The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.	Yes	The Trust remains a going concern as defined by the most up to date accounting standards.	Marcus Thorman, Director of Finance.
For GOVERNANCE, that:	**Compliance Yes/ No**	**Comment**	
5. The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.	Yes	As part of the on-going FT application the Trust is to review its compliance with the NHS Constitution. This work to be integrated into the review of the outcome of the Francis recommendations, with the action plan monitored by the Quality Committee/Audit, Risk and Governance Committee.	Janice Sigsworth Director of Nursing.
6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.	Yes	The Trust has a Risk Management Strategy and a Corporate Risk Register. The CRR identifies the key risks to the organisation. The CRR accompanied the Annual Governance Statement.	Cheryl Plumridge, Director of Governance and Assurance.
7. The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.	Yes	The Annual Governance Statement identifies significant issues for the coming year. A revised Risk Management Strategy has been approved at the July Trust Board meeting.	Cheryl Plumridge, Director of Governance and Assurance.
8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted	Yes	All audit committee recommendations to the Board are implemented satisfactorily. ICHT's final 2013/14 Operating Plan was approved in May 2013	Cheryl Plumridge, Director of Governance and Assurance.

by the board are implemented satisfactorily.			
9. 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	The Annual Governance Statement identifies significant issues for the coming year.	Cheryl Plumridge, Director of Governance and Assurance.
10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.	Yes	C.difficile The Trust is now within trajectory for C.difficile. For 2013/14, the annual ceiling for the Trust is 65 cases of C. difficile infection. In December there were five Trust attributable cases. Year to date 47 Trust attributable cases have been reported to the PHE and the Trust remains on trajectory for year end. MRSA blood stream infections are not currently included within the Monitor governance rating score. However, any cases will continue to reported above the threshold (currently 0) to the Trust Board. In December, a Trust attributable case was reported from a patient who required treatment for lymphoedema secondary to amyloidosis. The source of this bacteraemia was phlebitis related to a peripheral vascular access device. Actions have included educating clinical staff on the requirements for peripheral vascular access device management. This brings the total number of ‘cases’ reported against the Trust to ten for the year to date,	

		four of the ten represent cases re-allocated to the Trust through the review process introduced earlier this year. Cancer In November 2013 the Trust failed 2 Cancer Waiting Time standards: 62-day 1st treatment (after GP referral) and 31-day subsequent surgery. 62-day 1st treatment (after GP referral): 80 patients were treated within the month and 22 patients breached (17 patients after adjustments for shared pathways with other Trusts have been applied). Performance was 78.8% against an 85% target. Of the 22 breaches, 6 related to late transfers between Trusts (Inter-hospital transfer (ITR) sent after day 42), We expect to achieve the standard in December 2013 but we will fail Q3 2013/14. 31-day subsequent surgery: 82 patients were treated in the month and 6 patients breached. Performance was 92.7% against a 94% target. We will pass this standard in December and achieve Q3.	
11. The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes	The Trust is compliant and will re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
12. 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	Yes	The Trust has a declaration of interest policy and maintains a register of interests in accordance with accepted NHS practice with an item on each Board agenda dealing with interests. A review of the committee structure has been carried	Cheryl Plumridge, Director of Governance and Assurance.

place to fill any vacancies.		out, and the recommended new committee structure was approved at the July Trust Board. A Board Development programme is being undertaken during the autumn as part of the FT application process.	
13. 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	A Board development programme is being undertaken during the autumn as part of the FT application process, which will further enhance the Trust Board's skills.	Jayne Mee, Director of People and Organisational Development.
14. The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.		A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan. A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.	Jayne Mee, Director of People and Organisational Development.

<u>**NHS TRUST DEVELOPMENT AUTHORITY**</u>
<u>**OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.**</u>
<u>**Monthly Data: December 2013 Submitted 29/01/2013.**</u>

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

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

Condition	Executive lead
Q1. Condition G4 Fit and proper persons as Governors and Directors. (Also applicable to those performing equivalent or similar functions). **ICT Response: Yes** **Comment: None**	Jayne Mee, Director of People and Organisational Development.
Q2. Condition G5 Having regard to monitor guidance. **ICT Response: Yes** **Comment: None**	Marcus Thorman. Director of Finance.
Q3. Condition G7 Registration with the Care Quality Commission. **ICT Response: Yes** **Comment: None**	Cheryl Plumridge Director of Governance.
Q4. Condition G8 Patient eligibility and selection criteria. **ICT Response: Yes** **Comment: None**	Steve McManus, Chief Operating Officer.
Q5. Condition P1 Recording of information. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q6. Condition P2 Provision of information. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q7. Condition P3 Assurance report on submissions to Monitor. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q8. Condition P4 Compliance with the National Tariff. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q9. Condition P5 Constructive engagement concerning local tariff modifications. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.
Q10. Condition C1 The right of patients to make choices. **ICT Response: Yes** **Comment: None**	Steve McManus, Chief Operating Officer.
Q11. Condition C2 Competition oversight. **ICT Response: Yes** **Comment: None**	Marcus Thorman, Director of Finance.

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Q12. Condition IC1 Provision of integrated care. **ICT Response: Yes** **Comment: None**	Steve McManus, Chief Operating Officer.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: January 2014, Submitted 28/02/2014.

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

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICT Response: Yes** **Comment: None**	Chris Harrison, Medical Director.
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance & Assurance.
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICT Response: Yes** **Comment: None**	Chris Harrison, Medical director.
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICT Response: Yes** **Comment:** The Trust remains a going concern as defined by the most up to date accounting standards.	Marcus Thorman, Director of Finance.
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICT Response: Yes** **Comment:** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation.	Cheryl Plumridge, Director of Governance and Assurance.
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.* **ICT Response: Yes** **Comment:** The Annual Governance Statement identifies significant issues for the coming year.	Cheryl Plumridge, Director of Governance and Assurance.
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.

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Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q10. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* **ICT Response: Yes** **Comment:** **MRSA BSI** In January 2 cases of MRSA BSI occurred, these have been initially highlighted as community acquired, however both cases are out to arbitration and we await final allocation. The total number of 'cases' reported against the Trust is ten year to date, four of the ten represent cases re-allocated to the Trust through the review process introduced this year. **C. difficile** For 2013/14, the annual ceiling for the Trust is 65 cases of C. difficile infection. In January there were four Trust attributable cases. Year to date 51 cases attributable to the Trust have been reported to PHE, the Trust remains on trajectory for year end. **Cancer** Any pathway that breaches this standard is personally reviewed by the Chief of Service to ensure that there was no harm to any patient due to any delays. The Trust has a robust process in place to track urgent suspected cancer referrals. Referrals are received to a central team and are immediately entered onto the tracking system, as are diagnosed patients not referred via the urgent two week referral route, to ensure that patients are seen within the two week, 31 day and 62 day standards. We now have a level of confidence regarding an underlying positive trend regarding the 62 day standard as we see our historic backlog reducing.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICT Response: Yes** **Comment:** The Trust is compliant and will re-submit the toolkit return on 31 March 2014.	Kevin Jarrold, Chief Information Officer.
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICT Response: Yes** **Comment: None**	Cheryl Plumridge, Director of Governance and Assurance.
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICT Response: Yes** **Comment:** A Board development programme is being undertaken as part of the FT application process, which will further enhance the Trust Board's skills.	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICT Response: Yes** **Comment:** A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan. A development plan is also currently being rolled out for the Senior Management team to help optimise the performance of the senior team over the coming year.	Jayne Mee, Director of People and Organisational Development.

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