Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC
27 May 2015
11.15 – 13.00
Oak Suite, W12 Conference Centre, Hammersmith Hospital, London W12 0HS

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Chairman	11.15	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 25 March 2015	Chairman		1
1.4	Record of items discussed at Part II board meetings 25 March, 8 April, 13 May	Chairman		2
1.5	Action Log	Chairman		3
1.6	Record of the use of the Trust seal	Trust company secretary		4
2	**Operational items**			
2.1	Patient Story	Director of nursing	11.25	5
2.2	Chief Executive's Report	Chief executive		6
2.3	Operational Report & Integrated Performance Scorecard	Chief operating officer (COO)		7
2.5	Finance report: Annual plan submission 2015/16; 14/15 out turn and April performance; quarterly QIA of cost improvement plans	Chief financial officer		8 (no paper 9)
3	**Items for decision or approval**			
3.1	Proposal for co-location of stroke services	COO/ Div director of medicine	11.55	10
3.2	Responsible Officer's Annual report – Revalidation & Appraisal	Medical director		11
3.3	NHS Trust Development Authority self-certifications • compliance & board statement	Trust company secretary		12
3.4	Safeguarding: Annual adult safeguarding report Annual safeguarding children declaration	Director of nursing		13
3.5	J Savile and the Kate Lampard Lessons learned report	Trust company secretary		14
4	**Items for discussion**			
4.1	Corporate risk register	Director of nursing	12.15	15
4.2	Board assurance framework	Trust company secretary		16
5	**Board committee reports**			
5.1	Audit, risk & governance committee report of the meeting held on 22 April and minutes of the meeting held on 11 March	Committee chair	12.30	17
5.2	Quality committee report of the meeting held on 13 May	Committee chair		18

5.3	Finance and investment committee report of the meeting held on 20 May	Committee chair		19
6	**Items for information**			
6.1	Ealing maternity transfer	Chief operating officer	12.35	20
6.2	Annual Caldicott report	Chief information officer		21
6.3	Annual Complaints report	Director of nursing		22
6.4	CQC update report	Director of nursing		23
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
			12.50	
9	**Date of next meeting**			
	29 July 2015, New Boardroom, Charing Cross Hospital			

Imperial College Healthcare NHS
NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

11.45am – 1.30pm
Wednesday 25 March 2015
Clarence Wing Boardroom, St Mary's Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerald Acher	Deputy Chairman
Dr Rodney Eastwood	Non-Executive Director
Jeremy Isaacs	Non-Executive Director
Sir Anthony Newman Taylor	Non-Executive Director
Sarika Patel	Non-Executive Director
Andreas Raffel	Non-Executive Director Designate
Dr Tracey Batten	Chief Executive Officer
Alan Goldsman	Interim Chief Financial Officer
Prof Chris Harrison	Medical Director
Steve McManus	Chief Operating Officer
Prof Janice Sigsworth	Director of Nursing
In attendance:	
Jan Aps	Trust Company Secretary (Minutes)
Michelle Dixon	Director of Communications
Ian Garlington	Director of Strategy and Redevelopment
Kevin Jarrold	Chief Information Officer
Jayne Mee	Director of People and Organisation

1	**General business**	**Action**
1.1	**Chairman's opening remarks and apologies for absence** The Chairman welcomed Board members, staff and members of the public to the meeting.	
1.2	**Board members' declarations of interest and conflicts of interest** There were no additional conflicts of interests declared at the meeting.	
1.3	**Minutes of the meeting held on 28 January 2015** The minutes were **agreed** as an accurate record.	
1.4	**Record of items discussed at Part II board meeting 28 January 2015** The Board noted the report.	
1.5	**Action log** The Board noted the updates to the action log.	
2	**Operational items**	
2.1	**Patient story** Prof Janice Sigsworth noted that the Trust Board had invited individual patient stories for a number of meetings, and it was appropriate to present to members one of the patient experience improvements being introduced, the *#hellomynameis* initiative. She introduced Di Dunn, who outlined that the Trust had been working on this initiative for nearly a year, the delay mainly caused by the need to amend the Uniform Policy. The initiative had been developed by a doctor who had found	

	herself as a cancer patient, and had identified shortcomings in the way in which clinical staff had both introduced themselves, and sought to check how she wished to be addressed. The *#hellomynameis* initiative was part of a wider SMILE campaign which is addressing a number of patient experience issues, and staff were undergoing comprehensive briefing and training, and new name badges were being introduced. In response to a number of questions from Non-Executive Directors, Ms Dunn confirmed that there was commitment to implement fully the SMILE programme, and to measure and evaluate the impact that it had on patient experience following completion in the autumn. The Board noted the work being undertaken on *#hellomynameis*.	
2.2	**Chief Executive's report** Dr Tracey Batten particularly highlighted the following items: • Ealing maternity services: further work would be undertaken by both Ealing CCG (on timing of transfer) and the Trust (on operational readiness). [Post meeting note: the Trust received a letter from Ealing CCG on 25 March confirming that further work needed to be done on operational readiness before a decision on the closure of Ealing maternity unity was made (likely to be at the meeting of its governing body in May. The Trust had been asked to provide further assurances in relation to operational readiness]. • Cerner implementation: feedback on the clinical documentation pilot had been very positive, and the Trust had returned to a data quality steady state without significant loss of income. • Nursing and midwifery revalidation: being introduced to demonstrate that staff possessed the appropriate competence to undertake their roles; lessons would be learned from the introduction of medical revalidation. • Community Independence Service (CIS): the Trust would act as lead provider from 1 April, the introduction of which would form the basis for future co-operation across the tri-borough areas. All chief executive officers were meeting as a partnership board. • Leadership forum: over 100 of the Trusts' senior clinicians and managers had contributed to a very positive day of engaging in shaping the Trust's plans, with a clear focus on patient experience and engaging with the health of the wider population. In response to a question from Sarika Patel, Dr Batten assured the Board that this was an integral part of the Trust's wider engagement approach, and agreed that Non-Executive Directors would be welcome to attend the events on rotation. • Imperial College: Prof Gavin Screaton had been appointed as the new Dean of the Faculty of Medicine and would become an attendee at the Trust Board meetings. The Board noted the report.	
2.3	**Operational report and Integrated Performance Scorecard** Steve McManus presented the operational report and integrated performance scorecard together, with Board discussion on the following items: • Scorecard refresh: a number of directors had offered valuable feedback on the development of a revised scorecard; the new scorecard would be presented at the May Trust Board. • Stroke indicators: performance had returned to 100% of potentially eligible patients thrombolysed within 45 minutes. • Theatres performance: there had been some improvements in theatre efficiency, and a detailed review would be presented to the Audit, Risk and Governance Committee. • A&E target: the Trust, with concerted effort from all staff, had achieved a 95%	

	week, but performance had slipped back slightly; continued attention was being paid to this area. • 18 week referral to treatment target: the backlog had been reduced to a total of 7,000 patients (end February), and was on target to further to reduce this to 5,000 patients (end March). • Cancer targets: the Trust achieved seven of the eight cancer targets in January, and whilst it was possible that the 62 day GP referral to treatment target would be missed again in February, actions in place were expected to ensure that all targets were achieved in March. The Board were please to note the continued attention to, and understanding of, the importance of continuing to deliver good performance to ensure patients are receiving the best possible care. • Carbapenemase Producing Organisms: it was understood that these were in situ in patients returning from overseas; Prof Harrison would obtain further feedback. • C difficile cases: Sarika Patel noted that the Trust had exceeded the annual threshold of 65 cases. Each case remained subject to forensic investigation, with only three cases identified as some form of non-adherence to agreed procedures. Breaching the threshold would not incur financial penalties in 2014/15. • Complaints / PALS: in response to a question from Dr Andreas Raffel, Prof Janice Signsworth noted that increased elective patient operation cancellations (mainly due to increased emergency patients) had led to increased patient complaints. With the reduction in cancellations, it was expected that there would be fewer complaints. • Outpatient indicators: the Board agreed that it was important in develop further indicators in this area. • Vacancy rates: recruitment amongst bands 2-6 was proving successful, with 500 staff in the pipeline, but those divisions experiencing particular problems in recruiting may take 3-6 months to have substantive staff levels at the preferred levels. Work continued with the Shelford Group to address hard to recruit areas. The board noted the report.	**CH** **SMcM**
2.4	**Finance Performance Report** Alan Goldsman particularly noted that whilst the Trust was expected to achieve a breakeven at year end, the reduction in Project Diamond income meant that the planned surplus would not be achieved. The key focus in the next week would be demonstrating delivering against the full-year position in relation to CQUIN payments and the performance bond. There had been a £1 million improvement in the February run rate compared with prior months, with income enhanced by winter pressures funding and elective waiting list reduction funding. Alan Goldsman would further develop the narrative report provided to the Board, including greater activity analysis. The Board noted the finance performance report.	
3	**Items for Decision**	
3.1	**NHS Trust Development Authority self-certifications** Alan Goldsman presented the self-certifications required as part of the TDA oversight. Retrospective approval was sought for December 2014, January 2015, and February 2015, and approval of the proposed submission for March 2015, noting that there had been no material changes during these months. Mr Goldsman also noted that an improved assurance process would be introduced	

	for approvals in 2015/16. The Board approved the self-certifications.	
3.2	**Elimination of mixed sex wards (EMSA) declaration** Steve McManus noted the real improvement in the elimination of mixed sex accommodated, highlighting that the 14 breaches reported related to three episodes where patients had been delayed in returning to a ward environment from intensive care. A full root-cause analysis was undertaken on each incident to minimise reoccurrence. Given the low rate of incidence the Trust was in a position to declare compliance. The Board approved the public declaration of compliance for 2014/15.	
4	**Items for Discussion**	
4.1	**Financial plan 2015/16** In reporting the current position, Mr Goldsman noted that the Trust Board would normally signoff the financial plan at its March meeting, but that delays in the tariff meant that the Board would be asked to sign off the plan in May. Good progress had been made on the efficiency programme and capital allocations, and also with negotiations with local commissioners, but significant work remained to be completed with NHS England in relation to the specialised services tariff. Risk associated with the position had been addressed and mitigated to ensure that the Trust was in a sustainable position entering the new financial year. Sarika Patel, in noting the difficult position that the Trust was in, considered that the executive team were handling it effectively. The Board noted the finance performance report.	
4.2	**Research Review for 2014** Prof Joanthan Weber, AHSC Director) presented a detailed research review report to the Trust Board, noting the particular contribution of Dr Paul Craven. He particularly highlighted: • the NIHR biomedical research centre (BRC), focused on translating research into patient benefits, noting the reshaping of themes which now aligned well with the Trust divisions. Examples of recent translational activity: epigenetic therapy for Friedrich's ataxia; I-knife surgical technology; and safer infertility treatment. The BRC had been awarded six new NIHR Infrastructure Awards in 2014. • the Genomics Medicine Centre, developed to deliver the Prime Minister's 100,000 genomes initiative. • the Patient Experience Research Centre (PERC), taking forward the greater involvement of patients in research. • the best ever results in Research Excellence Framework (REF), which would attract additional funding. • Priorities for 2015: new BRC structure and prepare for re-application in 2016; realise NHS transformation of genomics medicine; closer research collaboration; and building industry links. Non-Executive Directors raised a number of questions, to which Prof Weber responded: • Assessing strategic success (Jeremy Isaacs): performance metrics tended to focus on recruitment to trials and research funding volume (areas where the AHSC has good results). • Biggest challenge (Sir Gerald Acher): not having sufficient people, as the AHSC had become an exporter of expertise in recent years, although elements were now felt to be in place to help address this, and the leadership now needed to identify and recruit new expertise.	

	• AHSC interface at all levels of the Trust; introduction of a non-medical pre-PHD diploma would help with this, and there had been success in engaging Informatics in a similar scheme. The Board noted the annual research review.	
4.3	**CQC report** Prof Janice Sigsworth noted the work being undertaken to deliver the Trust-wide action plan in place to ensure compliance with CQC regulations, and reported that actions due in March had been completed. She outlined the Compliance and Improvement Framework being implemented designed to ensure achievement of a constant state of compliance and inspection readiness. From April 2015, the Trust would be require to display its CQC rating at the main entrance of each hospital site, at its head office, and on its website, and work was being taken to ensure implementation. An update would be provided to the Trust Board in the next CQC report. The Board noted the report.	**JS**
4.4	**Trust Engagement survey (no 6) and NHS annual staff survey** Jayne Mee was pleased to report that the response rate of the most recent engagement survey had been 55% (double that of October 2013), and had shown a 4% increase in the engagement score since survey 5. This would suggest that management efforts are starting to resonate with staff, although further improvement was sought. Feedback was provided to local managers, who were asked to take action in relation to 'one big thing' for their teams. The Trust had scored well on the CQUIN-related questions in the NHS survey, and the greatest improvements had been in areas of reporting incidents, communications, and equality and diversity. There were areas where improvement was seen by staff to be needed, including harassment and bullying and health and safety training (although the Trust could demonstrate 83% compliance with this). Ms Mee commented that whilst there was no room for complacency, the actions which had been taken appeared to be having an impact. The Board noted.	
5	**Board Committee Items**	
5.1	**Quality Committee** Professor Sir Anthony Newman Taylor particularly highlighted the increased level of incident reporting, and on-going low level of incidents causing harm, which was as the Trust would wish. He noted that the Committee had been pleased to see a considerable improvement in compliance with the WHO operating checklist. The Board noted the report of the meeting on 11 February and 4 March 2015.	
5.2	**Audit, Risk & Governance Committee** Sir Gerald Acher noted that the Committee was more confident that the risk register now reflected the risks to which the Trust was exposed and articulated the controls and mitigations in place to manage these. The Committee had noted that data quality issues with the Cerner system had been addressed and that data quality had returned to the pre-implementation levels. The Committee would continue to review the post-implementation achievement of planned savings. The appointment, by the Audit Commission, of BDO as the Trust's external auditors had been noted. Discussion continued as to whether the Trust was receiving good value for money from its internal auditors.	

	The Board noted the report of the meeting on 11 March 2015.	
5.3	**Finance & Investment Committee** Sarika Patel , in her verbal report, noted that the Committee had discussed the financial report, an outline of the private patient strategy to be considered by the Board at its seminar on 13 May, the proposed FT Treasury Policy (and asked for a brief current policy to be developed), and asked for a six-monthly review of the Sodexo contract at its next meeting. The Board noted the oral report of the meeting on 19 March 2015.	
6	**Items for information**	
6.1	**Annual update on implementing the recommendations from the Francis Inquiry (2013)** Prof Janice Sigsworth noted that the recommendations from the Francis Inquiry had been mainly subsumed in the wider quality improvement work streams, and would form part of the Quality Strategy; as such, the Executive Committee continue to monitor achievement of the recommendations. Prof Sigsworth reported that in relation to the 'freedom to speak up' initiative, the Guardian was Jayne Mee, the Nominated Director was Prof Sigsworth, and the nominated Non-Executive Director would be Prof Sir Anthony Newman Taylor. The Board noted the report.	
7	**Any other business**	
	There were no items of any other business.	
8	**Questions from the public relating to Agenda items** In response to a question from the public, Michelle Dixon confirmed that the Trust was still considering whether to attend the Commission of Inquiry into the Reconfiguration of Acute Services in North West London public hearing session in May. She noted that the Trust had, in attending the Overview & Scrutiny Committee meetings and other meetings, answered a wide range of questions in public on this subject. Dr Batten confirmed that the clinical strategy published on the website remained current, including the services outlined for the Charing Cross Hospital site.	
9	**Date and time of next meeting** The next meeting would be held on Wednesday 27 May 2015, Oak Suite, W12 Conference Centre, Hammersmith Hospital, W12 0HS.	

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	1.4
Title	Record of items discussed at the confidential Trust Board on 25 March and extraordinary Trust Boards on 8 April and 13 May 2015
Report for	Noting
Report Author	Jan Aps, Trust company secretary
Responsible Executive Director	Tracey Batten, Chief executive

Executive Summary:

Decisions taken during the confidential sessions of a trust board are reported (where appropriate) at the next trust board held in public. Those issues of note and decisions taken at the Trust board's confidential meeting held on 25 March and extraordinary Trust boards on 8 April and 13 May 2015 are outlined below:

- **Appointment of a substantive chief financial officer**: the Trust board noted the appointment of Mr Richard Alexander, who was currently the CFO at University College London Hospital FT, and recognised the effective and substantial contribution that Alan Goldsman had made since joining the Trust in an interim capacity in January 2015. Mr Alexander will be joining the Trust in August 2015.
- **24 hour MRI diagnostic cover at St Mary's Hospital**: the Board were pleased to hear that this would be in place by the end of 2015, and noted the mitigation arrangements in place in the interim.
- **St Mary's Hospital development**: the Trust board noted the report on the development plans and associated planning application and stakeholder and public engagement requirements.
- **Quality strategy and quality accounts**: the Board noted the progress made towards developing a revised quality strategy and the draft quality accounts.
- **Risk management**: the Board approved the corporate risk register and board assurance framework for presentation at the public board meeting in May.
- **Financial plan submission**: the Trust board approved the submission of the annual plan for 2015/16, noting that it was a deficit plan (£18.5m).

Recommendation to the Board:

The Trust Board is asked to note the report.

Imperial College Healthcare NHS
NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status	Update (where action not completed)
Carbapenemase Producing Organisms To provide further information on the origin of these organisms as presenting in patients	25 March 2015 2.3	Chris Harrison	Completed – this has been reported at quality committee	
Performance Scorecard: To develop further out-patient performance metrics	25 March 2015 2.3	Steve McManus		In development – updated scorecard for July Trust board meeting
Displaying Trust's CQC ratings To provide an update on the displaying of CQC ratings at each site	25 March 2015	Janice Sigsworth	Completed – included in the CQC update report (item 6.4)	
Integrated performance scorecard To review scorecard, including board members, and implement revised scorecard for May Trust Board	28 January 2015 2.3	Steve McManus		In development – updated scorecard for July Trust board meeting
Integrated performance scorecard To confirm the Troponin testing arrangements for male and female suspected heart attack patients	28 January 2015 2.3	Chris Harrison		Verbal update at meeting
Theatres efficiency To provide a presentation to AR&G Committee in July (update to Trust Board in AR&G report). on the actions to improve theatre efficiency	28 January 2015 2.3	Steve McManus		For July ARG and update to Trust board

Imperial College Healthcare NHS Trust

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible
July 2015	**On-line performance scorecard** Demonstration of the Qlik view scorecard (This would be presented as part of the presentation of the performance report)	26 November 2014 2.3	Steve McManus
July 2015	**Emergency preparedness, resilience and response (EPRR)** To present progress against action plan to address 'amber' ratings	28 January 2015 3.2	Steve McManus
September 2015	**Leadership development** Consideration to be given to implementing a Trust-based graduate training scheme	27 November 2013 3.4.2	Jayne Mee

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	1.6
Title	Record of the use of the Trust seal
Report for	Noting
Report Author	Tracy Walsh, Committee clerk
Responsible Executive Director	Tracey Batten, Chief executive

Executive summary:

The table on the following pages summarises the use of the Trust seal during 2014-15 under part IV of the Standing Orders.

Recommendation to the Trust board:

Board is asked to note the use of the Trust seal during 2014-15.

Trust strategic objectives supported by this paper:

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

Use of the Trust common seal 2014-15

This table is a record of the use of the Trust seal under part IV of the Standing Orders

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
109	ICH Charities	Deed of variation relating to a nursery at Holborn House, Du Cane Rd, W12 0TV	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	02/05/2014
110	EE Ltd & Hutchinson 3G UK Ltd	Deed of variation relating to roof of CHX	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	06/06/2014
111	Derwent Valley London Ltd and European Land & Property Ltd	Licence to underlet counterpart underlease	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	06/06/2014
112	Lauder and Rees Ltd	Lease for rooms in the West wing, ground floor, CHX	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	06/06/2014
113	Lauder and Rees Ltd	Lease of premises in the basement of the Western Ophthalmic Hospital	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	06/06/2014
114	Medical Research Council	Licence to carry out works at Linear Accelerator and Cyclotron Building, HH	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	13/06/2014
115	Medical Research Council	Conditional agreement for surrender of part at HH	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	13/06/2014
116	Medical Research Council	Transfer of part of registered title (TP1) at HH	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	13/06/2014
117	London Cancer Alliance	Provision of indemnity cover to the Royal Marsden for hosted services	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	18/06/2014

Seal number	Parties	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
118	Imperial College of Science, Technology and Medicine	Lease of the Royal Post Graduate Medical School, HH	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	03/07/2014
119	ME Construction Ltd	Construction contract for the Endoscopy Reprocessing unit in Clarence wing basement in support of new Endoscopy unit in QEQM	Dr Tracey Batten, Chief Executive Helen Potton, Interim Corporate Governance Manager	16/07/2014
120	Sodexo Ltd	NHS Terms and Conditions for the provision of services	Dr Tracey Batten, Chief Executive	24/10/2014
121	Trevor Alan Bennett and Kama Nain Ojha	Contract for the sale of Leasehold land with vacant possession at 5 Riverside, SW18 and transfer form TR1	Dr Tracey Batten, Chief Executive Helen Potton, Interim Trust Company Secretary	07/11/2014
122	Nadine Lanham and Jon Swinstead	Lease and sale of flat 6a and 6 Ravenscourt Square	Dr Tracey Batten, Chief Executive Helen Potton, Interim Trust Company Secretary	14/11/2014
123	Ravenscourt Square Management Co. Ltd	Agreement for the sale and transfer of the title of 6 Ravenscourt Square	Dr Tracey Batten, Chief Executive Helen Potton, Interim Trust Company Secretary	14/11/2014
124	ME Construction Ltd	Refurbishment of building 114 for the decant of ICCH clinical space at 59 North Wharf Rd to HH	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	12/12/2014
125	Royal Mail Group Ltd and Great Western Developments Ltd	Deed of novation relating to landowners agreement – future development proposals affecting former mail centre, The Mint, Outpatients, Jefferies & Winston Churchill wing of SMH	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	03/12/2014
126	Cerner Ltd	Call off agreement for the provision of a PAS/EPR solution Call off agreement for the provision of hosting services	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	08/12/2014
127	Trong Bau Hoang	Lease of shop unit 7 on concourse at CHX	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	12/12/2014
128	Dr P Kanagaratnam and Imperial Innovations	Deed of assignment	Steve McManus, acting Chief Executive Jan Aps, Trust Company Secretary	22/12/2014

Seal number	Parties	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
129	Dr L Brennan and Imperial Innovations	Deed of assignment	Steve McManus, acting Chief Executive Jan Aps, Trust Company Secretary	22/12/2014
130	Ravenscourt Square Management Co. Ltd and Sara Chuppora & Giulio Baratta	Lease and contract of sale relating to Flats 4 and 4a Ravenscourt Square, Hammersmith W6 0TW	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	21/01/2015
131	Sodexo Ltd	FM services to Imperial Private Health on all ICHT sites	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	02/02/2015
132	Airwave Solution Ltd	Deed of variation to their aerial lease dated 3/11/2010 at CHX	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	02/02/2015
133	Sodexo Ltd	Lease for retail premises at CHX and HH sites. Included licence agreement.	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	16/02/2015
134	Natwest Bank Plc	Lease for an ATM at Hammersmith Hospital	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	02/03/2015
135	Sodexo	Lease for retail premises – licence to alter only	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	19/03/2015
136	Patients know best	care information exchange	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	30/03/2015
137	Catalyst Housing, London NW NHS Trust, CNWL NHS Trust, NHS Property Services, Secretary of State	Deed of release of covenants and rights arising in relation to a nominations agreement	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	22/04/2015
138	Contract document superseded			
139	Sodexo	Final licence to alter, required as part of Sodexo contract (see 120, 131, 133, 135)	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	27/04/2015
140	Westminster City Council	Community Cardiology Service Contract.	Dr Tracey Batten, Chief Executive Jan Aps, Trust Company Secretary	14/05/2015

Imperial College Healthcare NHS Trust

Trust Board - Public

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

Executive Summary:

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

L is a patient with sickle cell disease. She will talk about her experience of using the Trust haematology services, in particular the Pain Day Unit which opened in 2013. She will be joined by clinical nurse specialist, Lydia Alexander.

Recommendation to the Board:

The Board is asked to note the patient story

Trust Strategic Objectives Supported by this Paper:

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

Imperial College Healthcare NHS
NHS Trust

Patient Story

Background

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

The perceived benefits of patient stories are:

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

L's story

Sickle cell anaemia is a serious inherited blood disorder where the red blood cells, which carry oxygen around the body, develop abnormally. The disorder mainly affects people of African, Caribbean, Middle Eastern, Eastern Mediterranean and Asian origin.

Normal red blood cells are flexible and disc-shaped, but in sickle cell anaemia they can become rigid and shaped like a crescent (or sickle). The abnormal cells are unable to move around as easily as normal shaped cells and can block blood vessels, resulting in tissue and organ damage and episodes of severe pain. These 'crises' can last from a few minutes to several months, although on average most last five to seven days and usually require admission to hospital.

ICHT trust provides a comprehensive haematology service across all sites with the main focus being Hammersmith Hospital. In 2013, the service opened the Pain Day Unit on the Hammersmith site, an innovative service where patients with pending or actual sickle cell crisis can be seen without an appointment for prompt intervention and treatment. This includes the provision of pain control and intravenous fluids by experts in the field.

This rapid specialist care, as opposed to the care patients might receive in an A&E department, helps to reduce complications and in many cases the need for a hospital admission. Indeed, arrangements have been made with the London Ambulance Service to take known sickle cell patients direct to the unit rather than A&Es.

L will talk about her experience of using the unit and how it has improved the quality of her care.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	2.2
Title	Chief Executive's Report
Report for	Noting
Report Author	Dr Tracey Batten, Chief Executive
Responsible Executive Director	Dr Tracey Batten, Chief Executive

Executive Summary:

This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust (ICHT).

Recommendation(s) to the Board/Committee:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Key Strategic Priorities

1. Financial performance and sustainability

For month one, the Trust is meeting its financial plan. There is limited activity, performance and income data at this early stage but it is notable that payroll expenditure is within budget. NHS contracts for 2015/16 are still to be finalised, but major points of principle and financial envelopes have been agreed with the Trusts major commissioners.

While the Trust improved its underlying financial position during 2014/15, it had an £8.0 million underlying deficit at the year-end. This was offset by income from some one-off land deals and, at the end of the year, a £24.4 million final settlement in relation to Project Diamond funding. The final year-end position was therefore a surplus of £15.4 million.

The Trust has committed to a payment by results contract with Clinical Commissioning Groups (CCGs) for 2015/16. As well as meeting new external cost pressures, it will be necessary to 'lock in' key investments made in 2014/15 (including the increase in our staff numbers), cover inflation and invest in essential developments. To help do this, £36.8 million has been identified in cost improvement programme (CIP) schemes, equivalent to 4.7 per cent of the Trust's core spend. Every division and corporate directorate is contributing to this CIP total, and the proportion is in line with that for other trusts. £47.0 million has been allocated for capital developments (using some of our cash reserves and with support from our charity) which will leave an £18.5 million shortfall for the year. A deficit plan has therefore been put forward to the NHS Trust Development Authority. This is a significant decision and not one taken lightly – it is more important than ever to achieve the financial plan in order to help the Trust get back to at least break-even next year and longer term, to be able to invest for the future.

To this end, the medical director and chief operating officer have been scoping a three-year integrated development programme to support quality improvement, clinical transformation and financial sustainability. The three key themes arising from this work include: site optimisation/service consolidation, pathway management and income/cost management.

Importantly, agreement has been reached for an independently chaired review of the specialist tariff for 2016/17 to ensure that it accurately reflects the costs of delivering high quality care.

2. Operational performance

Performance against the standard for 95 per cent of Emergency Department patients to be treated or admitted within four hours remained below target in April 2015. This is a key management and clinical priority to ensure we are able to meet the standard consistently. Whilst considerable improvement has been made over the past two months, the process improvements now need to be embedded.

In May, performance is reported for the cancer waiting time's standard in March. In March, the Trust achieved all of the eight cancer standards. The Trust recovered performance against the 62-day GP referral to first treatment standard. The performance recovery seen in March has continued into April and it is expected that the standard will be met in May. The Trust expects to achieve the standard for quarter one 2015/16.

It is expected that the Trust will return to achieving all the aggregate referral to treatment (RTT) standards within the second quarter of 2015/16. Considerable work was undertaken during the latter part of 2014/15 to reduce the number of patients on the Trust's waiting list for treatment. A range of initiatives are also being implemented including additional theatre lists and outpatient clinics to increase the throughput of patients treated from the waiting list, especially through the summer.

3. Cerner Implementation

Following the successful pilot of Cerner clinical documentation for doctors, nurses and therapists along with electronic prescribing, detailed discussions are now taking place with clinical teams on the plans to roll this out across the whole Trust by the end of this financial year. A trust-wide event scheduled for Thursday 4 June will review and sign off the plans. The aim is to roll out at St Mary's and the Western Eye first, to be followed by Hammersmith Hospital and Queen Charlotte's and Chelsea Hospital and then Charing Cross Hospital.

The move out of the BT data centre and into the Cerner data centre is scheduled for early September and is tracking to plan. Once the move has been completed, there will be a sequence of developments that will see the Trust move to a more up to date version of the Cerner code base, the implementation of the new version of the Cerner Patient Administration System that has been developed within the UK, and the roll out of bed side medical device integration which will allow the results of bedside observations from Cerner compatible devices to go directly into Cerner without the need for manual input.

4. Midwifery supervision

Midwifery regulation has been established since 1902 with minimal change since that time. It is regulated differently to the other health care professions because the Nursing and Midwifery Order 2001contains an additional set of powers for the Nursing and Midwifery Council (NMC) to set rules related to midwifery. These rules provide midwives with an extra layer of regulation known as 'statutory supervision'.

A report was commissioned following the Parliamentary and Health Service Ombudsman in England's investigations into three cases arising from failures in maternity care at Morecambe Bay NHS Foundation Trust along with a report *Midwifery supervision and regulation: recommendations for change* (Parliamentary and Health Service Ombudsman 2013). This report recommended that:

- midwifery supervision and regulation should be separate
- The NMC should be in direct control of regulatory activity. This means that the additional layer of regulation currently in place for midwives and the extended role for the NMC over statutory supervision should end.

The Trust is awaiting further guidance from NHS England/Department of Health on timescales

5. Inpatient survey results

The 2014 national inpatient survey results will be published towards the end of May. The results will be assessed and benchmarked with other Trusts both nationally and locally

once published. A summary report will be brought to the next Trust Board meeting.

6. Royal Birth

On Saturday 2 May the Duchess of Cambridge gave birth to a healthy baby girl, Princess Charlotte Elizabeth Diana, weighing 8lb 3oz at the Lindo Wing of St. Mary's Hospital. The logistics of ensuring that the St Mary's site was able to continue to function effectively for all out patients was managed through our Bronze, Silver, Gold command structure with close working with the police, London Ambulance Service, Westminster City Council. There were no incidents or issues during the day related to access to the St Mary's site. We had excellent support from our Volunteer team who provided invaluable way-finding throughout a busy period. At the end of the event the Trust received extremely positive feedback from the Met Police, Royal Household and the couple themselves for the manner in which the day was managed.

7. Engagement survey

The results of survey seven have just been released and are our best scores to date. We increased our response rate by a further 2 per cent taking this to 57 per cent. Our Engagement Index (our people voting 8, 9, or 10) has risen by 3 per cent taking us to an all-time high of 44 per cent. This is very encouraging and demonstrates how sustained focus on the engagement of our people is starting to really resonate. There's still much to be done on our journey, however this shows we are headed in the right direction. These results will be cascaded to teams over the coming weeks.

8. Make a difference awards

The first Make a Difference Annual Awards ceremony is due to take place on 25 June at the Hilton London Metropole, supported by Imperial College Healthcare Charity. The scheme, which recognises the achievements of our people who work at Imperial College Healthcare NHS Trust, continues to attract high participation rates into 2015/16. In 2014/15 it is estimated that our managers awarded 1,500 Instant Recognition awards of which 700 were confirmed to HR; there were 195 nominations for bi-monthly team and individual excellence awards for exceptional work; and high numbers of nominations were received for the chairman's award, the lifetime achievement awards and the bank and volunteer awards. All directors are invited to attend the evening.

9. Stakeholder Engagement

The usual level of activity in our external stakeholder contact programme has been reduced over recent weeks to take into account the requirements of the pre-election period in the run-up to the UK General Election held on 7 May.

Key Strategic Issues

1. General Election

The outcome of the General Election resulted in several changes across the 18 parliamentary constituencies in north west London. Labour made three gains – two from the Conservatives in Ealing constituencies and one from the Liberal Democrats in Brent – with six new MPs in all after other former MPs did not stand for re-election.

In terms of the Trust's local constituency MPs, Mark Field (Conservative) was re-elected for the Cities of London and Westminster (including St Mary's Hospital) while neighbouring MP Karen Buck (Labour) was re-elected in Westminster North. In Hammersmith (including Charing Cross and Hammersmith hospitals) Andy Slaughter (Labour) was re-elected while neighbouring MP Greg Hands (Conservative) was re-elected for Chelsea and Fulham. In Kensington, Victoria Borwick was elected for the Conservatives, succeeding former MP Sir Malcolm Rifkind who stood down shortly before the election.

In appointing his new Cabinet, the Prime Minister Rt Hon David Cameron MP confirmed Rt Hon Jeremy Hunt MP will remain as Secretary of State for Health. Local MP Rt Hon Greg Hands MP became Chief Secretary to the Treasury and will attend Cabinet.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	2.3
Title	Operational Report
Report for	Monitoring/Noting
Report Author	Nicola Grinstead, Interim Chief Operating Officer
Responsible Executive Director	Nicola Grinstead, Interim Chief Operating Officer

Executive Summary: This is a regular report to the Trust board and outlines the key operational headlines that relate to the reporting month of April 2015.

Recommendation to the Trust board: The Trust board is asked to note the contents of this report. Please note that the revised scorecard template will now be available for the July Trust board meeting.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

Title : Operational Report

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

Introduction: This report relates to activity within M1 (April) 2015/16.

A. Shadow Monitor compliance

Foundation Trust governance risk rating (shadow): Amber
Rationale: The Trust is expected to have under-delivered on the RTT standards, has under-delivered the 4 hour A&E waiting time standard and the 62 day cancer standard for quarter four.

B. Safety

Mortality Rates & Incidents

Mortality Rates:

The Trust's HSMR for Q3 2014-15 is 67.45, statistically significantly low. The rate for the last year of data (Jan-Dec 2014) is excellent when compared nationally, being the lowest in the Shelford Group And second lowest in our peer group of non-speciality acute providers across the last year of data.

There was one mortality alert for the December 2014 data relating to the diagnosis group 'other psychoses'. This will be investigated by the appropriate division and will be reported to ExCo in the Quality Report.

Serious Incidents (SIs) & Never Events:

7 SIs were reported in April 2015. No never events were reported in April.

Reporting Rate:

The Trust reporting rate for 2014/15 was 45.29 per 1000 bed days. The Trust reporting rate continues to exceed the peer reporting rate of 35.1.

The Trust reported a total of 12 (0.08 per cent) severe harm incidents and 27 (0.17 per cent) incidents causing death for the period 2014/15 compared with our NRLS peer group 0.4 per cent and 0.1 per cent respectively. (Using NRLS published data for April – September 2014. October 2014 – March 2015 NRLS data is published in Sept 2015).

Infection Prevention & Control

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

- Three cases of MRSA BSI occurred in April 2015 and are under investigation (One of these has been initially allocated to the Trust);

- The first (initially non-trust) case was in a patient who regularly attends the dialysis unit and the source of infection was thought to be the dialysis catheter;
- The second (initially trust) case was in a patient on a medical ward and the likely source of infection was skin contamination; &
- The third (initially non-trust) case was in a patient who attended our A&E but who had recently had orthopedic surgery at the Trust. This case is still under investigation.

Clostridium difficile infections:

- Eight cases of *C. difficile* were allocated to the Trust for April 2015;
- The annual objective for the Trust is 69 for 2015/16; &
- The provisional definition of a lapse in care associated with toxin positive *C. difficile* disease within ICHT is described as a) non-compliance to the ICHNT antibiotic policy or b) If the patient shared a ward with another patient who was symptomatic and later found to be *C. difficile* positive (with the same ribotype). After a review of Trust attributable *C. difficile* cases from FY 2014/15, eight cases have been agreed with the IPC lead for the CCG, there are two additional cases from March 2015 that we are awaiting ribotyping on.

Adult ICU CLABSI

- The 12 month rolling CLABSI rate for all three adult ICUs combined is 1.0 per 1000 catheter days, benchmarked against the ECDC (Annual epidemiological report, 2014) ICU CLABSI rate of 3.0 per 1000 catheter days; &
- There have been two episodes of CLABSI this calendar year (Jan- April 2015), a period which saw approximately 3610 catheter line days.

Surgical Site Infection (SSI)

Orthopaedics:

- The 12 month rolling Trust average SSI rate is 0.3 per cent for Knee replacement and 0 per cent for Hip replacement procedures (Apr 2014 – Mar 2015); &
- The latest quarter (Jan – Mar 2015) has seen zero SSIs identified in 83 knee replacement and 53 hip replacement procedures; the National average (PHE) SSI rate is 0.6 per cent for both procedures.

Cardiothoracic:

- The 12 month rolling Trust average SSI rate is 2.2 per cent for CABG and 0.4 per cent for non-CABG replacement procedures (Apr 2014 – Mar 2015). The latest quarter (Jan – Mar 2015) has seen three post-CABG SSIs, two superficial incisional, the third a deep incisional, of 122 CABG procedures; &
- This period has seen zero SSIs identified out of 48 non-CABG procedures, the National average (PHE) SSI rate is 4.5 per cent for CABG and 1.2 per cent for non-CABG.

Carbapenemase Producing Organisms:

- The total PHE reference lab confirmed CPO isolates for 2014/15 until the end of March 2015 is 56.These represent multiple different types of organisms;
- April 2015 has seen 9 PHE reference lab confirmed CPO isolates, 7 of which were identified as *Klebsiella pneumoniae* NDM;
- In line with the guidance issued by PHE and NHS England, an action plan is in place to ensure that the tool kit is embedded into practice; &

- We continue to send risk factor information relating to each (PHE reference lab confirmed) CPO case to Public Health England.

Carbapenemase Producing Enterobacteraciae Outbreak (*Klebsiella pneumoniae* NDM):

- As part of an ongoing investigation, liasion between IPC and PHE, into cases of *K pneumoniae* New-Delhi Metallo-beta-lactamase (NDM) organisms across the Hammersmith and St. Mary's sites, mainly affecting vascular and renal wards, we have identified 21 patients, spanning a 12 month period, with this organism and mechanism of resistance; &
- Investigations are underway regarding patient pathways within ICHNT and other hospitals, in collaboration with PHE.

C. Patient Centeredness

Friends and Family Test

In April, the Trust changed to a new real-time feedback system: meridian from Optimum Contact. This new system provides much greater flexibility in terms of collecting and reporting feedback. During the changeover period, the Trust ran both electronic and paper collections in order to ensure that we were able to maintain our FFT reporting. The real-time ward surveys were not undertaken in April and the surveys will be reviewed and rebuilt with a view to restarting these surveys in June or July.

It will be noted that, in line with NHS England guidance, the net promoter score is no longer reported. FFT scores are now presented as the percentage of those likely to recommend (extremely likely + likely responses) versus those unlikely to recommend (unlikely + extremely unlikely responses). Neutral responses are not considered except as part of the denominator (total responses).

As a result of the introduction of the system and a period where patients were using paper surveys whilst the feedback devices were updated, there was a fall in the inpatient response rate in April to 19.2 per cent (1600 responses). All ward based devices are now operational and this is expected to improve. The percentage of patients that would recommend the ward on which they were staying remains high.

There was a significant fall in the A&E response rate in April. This was in part for the same reasons as outlined for the inpatient areas, but in addition from April, there was a requirement to include urgent care centres in the responses. This has led to a large increase in the denominator used to calculate the response rate. Combined with the reduced volume of responses this has led to a low response rate. As mentioned above, all areas now have operational devices and the expectation is that this will improve from May onwards.

Now the technology is in place, the patient experience team is working with the divisions to promote the new system in order to drive up the response rates to previous levels. The new system also enables other routes for collection - for example, through a link on the Trust website, which will be developed over the coming months. The enhanced and real-time reporting that is now available will support divisions in monitoring feedback and learning from it. The divisions are committed to collecting it and using feedback from patients and this should now be much easier.

Complaints & PALS
Scorecard data for this indicator was not available at the time of compiling this report.

D. Effectiveness

No update for Month 1.

E. Efficiency

Performance against some of the key efficiency measures is reported in the Integrated Performance Scorecard. Both elective and non-elective length of stay has remained above threshold and higher than in 2014/15. Elective length of stay was 4.38 in April against a threshold of less than 3.5 days, continuing the upwards trend seen over the last year. The Information Team are aware of data quality issues relating to this indicator and are currently investigating the causes.

Non-elective stay was 4.70 in April against a threshold of less than 4.5 days. The post-operation length of stay has increased slightly month on month to 5.4 days, although has decreased each month over the previous quarter.

Although performance against the Day of Surgery Admission indicator has decreased in month, this is potentially the culmination of more accurate reporting for both surgery and admission dates and is therefore reflective of the Trust's true position.

Scorecard data for theatre utilisation data was not available at the time of compiling this report.

The Trust's Did Not Attend (DNA) rate has resumed its continued decreased for both first outpatient and follow up appointments after a slight increase in March 2015. This follows the resumption of the text messaging reminder service for patients at the end of September.

F. Timeliness

Accident and Emergency

Performance against the standard for 95 per cent of Emergency Department patients to be seen within four hours remained challenged in April 2015. There is considerable management focus on sustainably improving this performance.

Referral to treatment (RTT)

Submission of the Trust's data for April RTT performance will be delayed by six days until Tuesday, 26th May 2015, due to an issue with retrieving reports from Surginet.

The validation programme to improve data quality is still underway and the Trust continues to see a reduction in the backlog of patients waiting for treatment (exact number to be confirmed before Trust Board meeting).

There are a number of initiatives to reduce further the number of patients on the Trust waiting lists for treatment. These include:

- Clinical validation of referrals
    - Will support referral back to GP earlier for those patients who do not need hospital

treatment and support application of access policy for patients who DNA
- Additional outpatient activity
    - Will support earlier delivery of non-admitted standard
    - Will reduce time to first outpatient appointment to support shorter pathway time for admitted and non-admitted pathways
- Outsourcing of diagnostic work
    - Trust has capacity constraints in several diagnostic modalities
    - Reducing waiting times will support delivery of 6 week standard as well as reducing overall pathway times for RTT and cancer patients
- Additional inpatient activity
    - This will support clearance of a backlog of admitted activity in challenged specialties
- Outsourcing of inpatient activity
    - Additional capacity will be needed in the later part of the summer months as a proportion of the additional outpatient activity converts to admitted pathways
    - Starting planning for this extra volume of capacity now will allow for a structured approach to managing the flow of activity to alternative providers.

It is expected that the Trust will return to achieving all the RTT standards within the second quarter of 2015/16, however achievement may be earlier with the above initiatives.

Additional dedicated resource is now in place within the Performance Team to support two significant projects within the Trust related to Choose & Book and RTT capacity & demand.

Following the successful pilot of the Clinic Outcome Form in the ENT section of main St Mary's hospital outpatients building, this is now being extended to additional specialties in coordination with specialist RTT training for all staff involved. The aim of this project is to improve the data that is captured following a patient outpatient appointment and this will in turn have an impact on the quality of the data for patients waiting for treatment.

Cancer

In May, performance is reported for the cancer waiting times standard in March. In March, the Trust achieved all of the eight cancer standards.

The Trust recovered performance against the 62-day GP referral to first treatment standard. Having failed to meet the standard in January and February, the Trust was unable to meet the standard for Quarter 4 2014-15. The performance recovery seen in March has continued into April and it is expected that the standard will be met in May. The Trust expects to achieve the standard in Quarter 1 2015-16.

The Trust achieved the 6-day Screening standard for both the month and for Quarter 4 2014-15 after failing to meet the standard in Quarter 3 2014-15.

Diagnostic waiting times

Performance against the six week wait for diagnostic test standard in March remained challenged. This was as a result of a number of issues, with the most notable in Gynaecology regarding capacity issues due to sharing equipment amongst services.

There are a number of longer term capacity issues within imaging services and these are currently being addressed as part of the RTT recovery plan but will affect the six week

diagnostic standard over the next few months.

G. Equity

Scorecard data for the Trust's safeguarding training indicator was not available at the time of writing this report.

H. People

Mandatory Training

WIRED 2 was launched on 13 March 2015 to enhance our ability to report on topic level compliance rates for the Trust's ten core skills training topics. Compliance rates have improved significantly from 69 per cent in April 2014 to 80.49 per cent currently.
WIRED 2 allows individuals to review their individual compliance profile and directly access e-learning for 9 of the 10 core skills topics, which has already led to an increase in learning activity. WIRED 2 also provides summary compliance reports at departmental, specialty and divisional level. A number of training campaigns will launch over the next few months focusing on improving compliance rates for particular topics, including patient manual handling and clinical and high risk fire training.

A first set of Seminars for managers have been held across sites with over 40 managers attending, with more planned in May.

Health and Wellbeing

Fast tracking our people for consultant appointments (with ICHT specialists)

Nearly 90 per cent of the referrals to Occupational Health are for musculoskeletal and psychological/ psychiatric conditions, the remainder are respiratory, allergy and dermatological, cardiac and cancer conditions. Due to the nature of the cancer and cardiac conditions, patients are generally seen by specialists fairly quickly. Therefore we have focussed our initial fast track efforts on conditions which cause significant sickness absence.

During our communication with the relevant clinical leads, we have found great levels of engagement and they are encouraging us to refer cases and fast track our people. The departments we have been in contact with so far are Orthopaedics, Respiratory, Allergy, Neurology and Neurosurgery. The dermatology is only needed for work related skin conditions. Although we have fast track counselling/psychological therapy, we are exploring fast track for psychiatric cases. The cases we have referred have successfully been expedited and this has been supported by the Medical Director which is encouraging. We will continue our efforts in other specialities over the coming months.

Raising Concerns (Whistleblowing)

In April we began a campaign to raise awareness of the need to report concerns to support the launch of our new Raising Concerns (Whistleblowing) Policy. The policy is available on the source and communication has gone out via the Leadership Brief, In-Brief and direct emails to the Divisional Directors to cascade information. The Source pages have been updated and information will be incorporated into the workforce policy training sessions and Corporate Induction moving forward. The policy launch is also supported by a poster

campaign and a new raising concerns screen saver.

Workforce Equality: the NHS Equality Delivery System

In April a stakeholder group met to decide the two key areas for focus for workforce equality in 2015/16:

a) Access to non-core statutory training for nurses and midwives. Data on the protected characteristics of people accessing courses provided by universities has traditionally been poor. An analysis of data provided by the universities will be undertaken with a report back in the autumn.

b) Equal pay. The Trust will expand its range of equal pay reports to include awards of clinical excellence awards and agenda for change incremental pay progression.

The stakeholder group will meet again in October 2015 to review the information and determine further action as appropriate

E-Rostering

- SafeCare - Private Patients are live with inputting into Safecare. Women's & Children are in the implementation phase. Further work required to ensure Divisions are realising the benefits of the data available and use as part of day-to-day processes and supporting decisions making. The team are reviewing any opportunities to bid for funds to provide all wards with tablets so that they can easily review the data from Safecare; &
- The Executive Team would like the roll out of auto-rostering to be completed within a shorter timeframe to release the benefits as soon as possible. As a consequence we are looking to appoint a further person to the team for a period of 3 / 4 months to complete this project.

HEALTH AND SAFETY

Health and Safety Updates for Directorates

A number of health and safety initiatives/projects/toolkits have been developed by the health and safety team. Feedback from the March Health and Safety Committee intimated that not all divisional health and safety leads/coordinators felt they had been provided with enough information, understanding and appreciation of the new health and safety systems.

Health and Safety Head (Sanjay Dhir) & Managers (Paul Reilly & Damian London) have made contact with Divisional Leads and requested attendance at their Divisional Health and Safety Committee Meeting or set up subcommittee (whichever is sooner) to provide two-way information, updates and tutorials with respect to:

1. Updating DSC, First Aider & Fire Warden lists/gaps by department and location;
2. Reviewing and discussing division health and safety risk profile to ensure its agreement, accuracy and in line with division's scorecard;
3. Full overview and tutorial of Qlikview including installing software patches, compiling dashboards, filtering data, reviewing incidents and links with Datix;
4. Logging H&S incidents on Datix and the importance of accuracy and quality;
5. Navigating the H&S Intranet and understanding where/when information is stored, updated and controlled;
6. Update on the risk assessment process & forms, how to complete (paper or Assessnet);

7. Update on health and safety training courses available – including e-learning, stat – mand and classroom based;
8. Concept of health and safety inspection forms, frequency, completion and retention;
9. Update on health and safety audit programme – including new form, pilot project and programme role out; &
10. Assist and guidance in the completion of the Divisional Health and Safety Objectives Template.

Sessions have been completed for Investigative Sciences and Estates (as of 6 May), remaining divisions and corporate functions are scheduled with divisional/directorate leads within the next two weeks.

Chemical and Biological Agents Management & Control

Matthew Hall, our new Health and Safety Manager (BioScience), has started with the Trust and is undertaking a review of chemical and biological safety in order to ensure compliance with the control of substances hazardous to health (CoSHH) regulations. This review will extend to:

- CoSHH policy and assessments;
- Safe handling, storage and use of chemical and biological agents;
- Correct selection and use of personal protective equipment (PPE);
- Appropriate information, training, communication and awareness;
- Monitoring and measuring of safe practices and reporting of incidents; &
- Emergency arrangements – including spillages, fire safety, and first aid.

The review is not limited to laboratories as it will include maintenance, clinical and cleaning operations. Once the review is completed, an action plan will be developed and shared with managers and ExCo.

Matthew will also be the Trust health and safety lead for the Joint Clinical Research Committee and a meeting has been set up with Alison Holmes.

Health and Safety Benchmarking

Sanjay Dhir has contacted a number of Shelford NHS Trusts in order to establish health and safety benchmarking data. Data being analysed and benchmarked includes:

- First aid injuries;
- RIDDOR 7+ Day accidents;
- RIDDOR Major injuries;
- RIDDOR Dangerous Occurrences; &
- Patient on staff assaults.

In order to gauge a comparison, incident rates will be per 1000 employees (WTE).

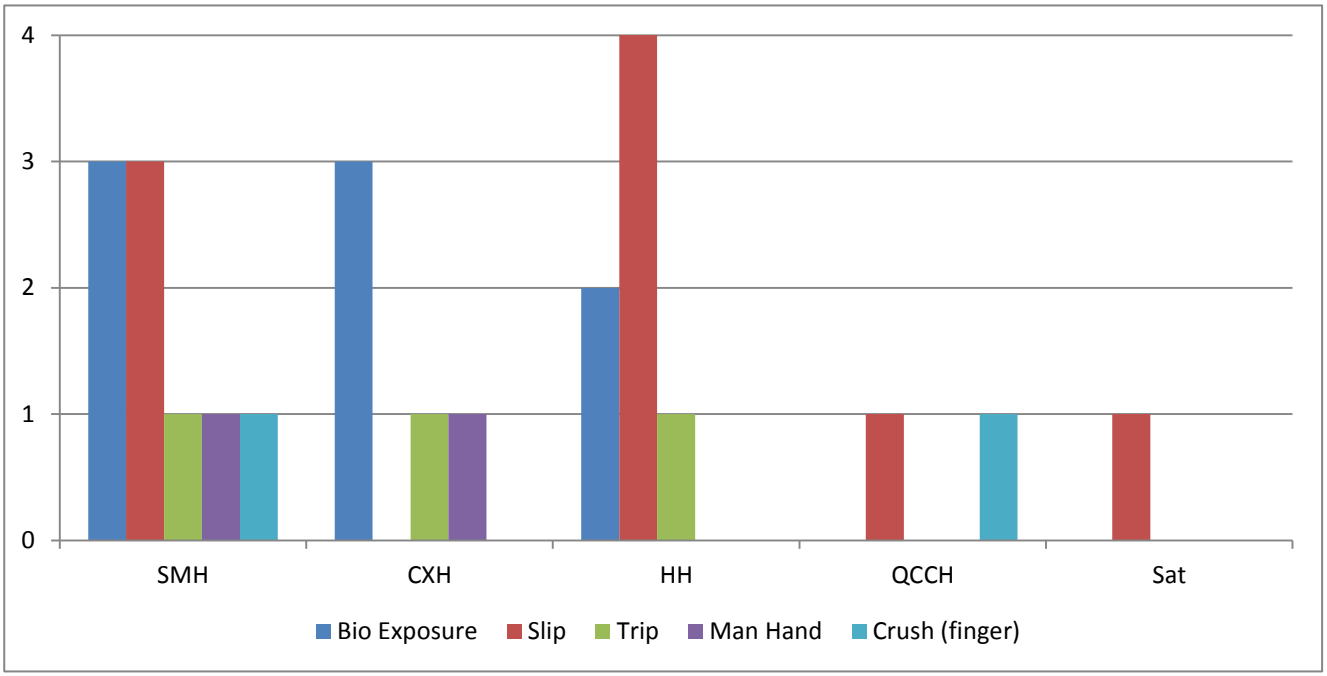
Accidents & Incidents

No RIDDOR reportable accidents during April 2015.

Total RIDDOR reportable accidents from April 2014 – Apr 2015 = 16

No RIDDOR Reportable Dangerous Occurrence during April

Total RIDDOR reportable dangerous occurrences from April 2014 – Apr 2015 = 8



The majority of RIDDOR accidents relate to slips, trips and falls followed by manual handling injuries. Health and safety has introduced a more robust monthly workplace inspection form whereby DSCs/Managers identify slip/trip hazards and controls. Health and safety is also working with Estates to look at reactive and preventative maintenance programmes to reduce the likelihood of slipping/tripping hazards. There is also an increase in Manual handling training [Level 2] to educate employees working in high risk areas on manual handling risks and risk reduction techniques. Further information on health and safety risks and risk management is contained within the department risk assessments and health and safety e-learning modules.

The RIDDOR dangerous occurrences relate to exposure of biological risks (e.g. HIV, Hep B/C). Education continues on hygiene, PPE provisions, supervision and monitoring.

Violence and aggression continues to be the biggest cause of workplace health and safety incidents. Staff are encouraged to report all incidents of violence and aggression in order for the Trust to monitor and evaluate trends and hot spots (which are currently emergency medicine and elderly care (32 per cent) followed by stroke and neuroscience (8 per cent)). The health and safety team are working with security, wards and A&E to develop and implement prevention, intervention and control strategies. This includes training and awareness, improved guidance and review of physical conditions.

Safe Nurse/Midwife Staffing

In April, the Trust reported the following for the average staffing fill rate:

- Above 90 per cent for registered nursing/midwifery and care staff during the day; &
- Above 95 per cent for registered nursing/midwifery and care staff during the night.

Please refer to Appendix 1 for ward level detail.

The month of April saw an improvement in performance, particularly regarding care staff. This is due to a reduction in vacancies and an increase in the bank fill rate. There were some ward areas where the fill rate was below 85 per cent for care staff. Key reasons for this are:

- Small numbers of unfilled shifts in some areas e.g. A6 CICU and Paterson ward which has shown a bigger impact on the overall fill rate for that area.
- An increase in the acuity of patients particularly on medical wards which has resulted in requesting additional staff for patients who require specialling. Where additional shifts have not been filled, this has impacted on the fill rates for these areas

On these occasions senior nurses have made decisions to mitigate any risk to patient safety by undertaking the following:

- The ward manager/sister working clinically within the numbers;
- Increasing the compliment of registered staff where there has been a reduced fill rate for care staff;
- Monitoring progress against recruitment and vacancy reduction plans;
- Reviewing staffing on a daily basis;
- Adjusting the occupancy to ensure patient needs are met by the staff that are available; &
- Redeploying staff from other areas, where possible.

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

I. Finance

Please see separate agenda item.

J. Education

In response to a number of concerns raised both internally and by our external stakeholders, two new processes for monitoring education quality have been established.

These comprise of a formal process for the management of education action plans and an annual series of specialty education reviews, which will include meetings with the trainees and students to triangulate metrics with real time feedback. This will allow the Medical Director to have continued oversight of postgraduate and undergraduate education at specialty level and to provide assurance to the executive committee and the board that areas of concern are being addressed, improvements monitored and any patient safety or service impact issues as a consequence of developments in education are dealt with.

This process will also be more pre-emptive, allowing problems to come to light earlier and ensuring actions are put in place to deal with any issues before they escalate.

K. Research

Local Clinical Research Network:

North West London LCRN and Imperial College NHS Trust have been confirmed as the first network/site to achieve 1st global patient in a commercial study in 2015/16 across the country.

NIHR Imperial Biomedical Research Centre (BRC): no update this month.

Recommendation to the Trust board: The Trust board is asked to note the contents of this report. Please note that the revised scorecard template will now be available for the July Trust board meeting.

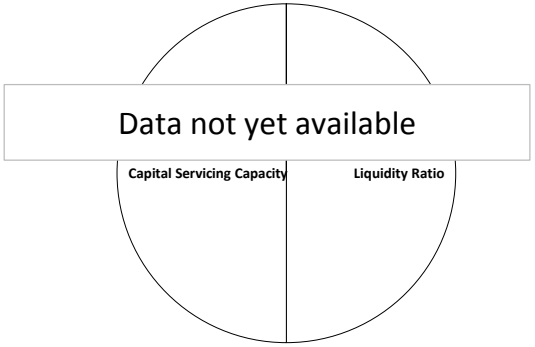
Trust Board Performance Report
Report Period Month 1 (to end April 2015)

Trust Board Wednesday 27th May 2015

Table of Contents

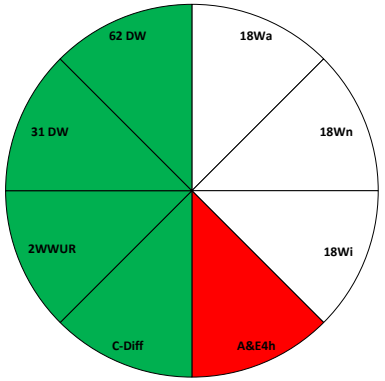
Imperial College Healthcare NHS Trust

Finance - Continuity of Services Risk Rating - Month 1 (April 2015)



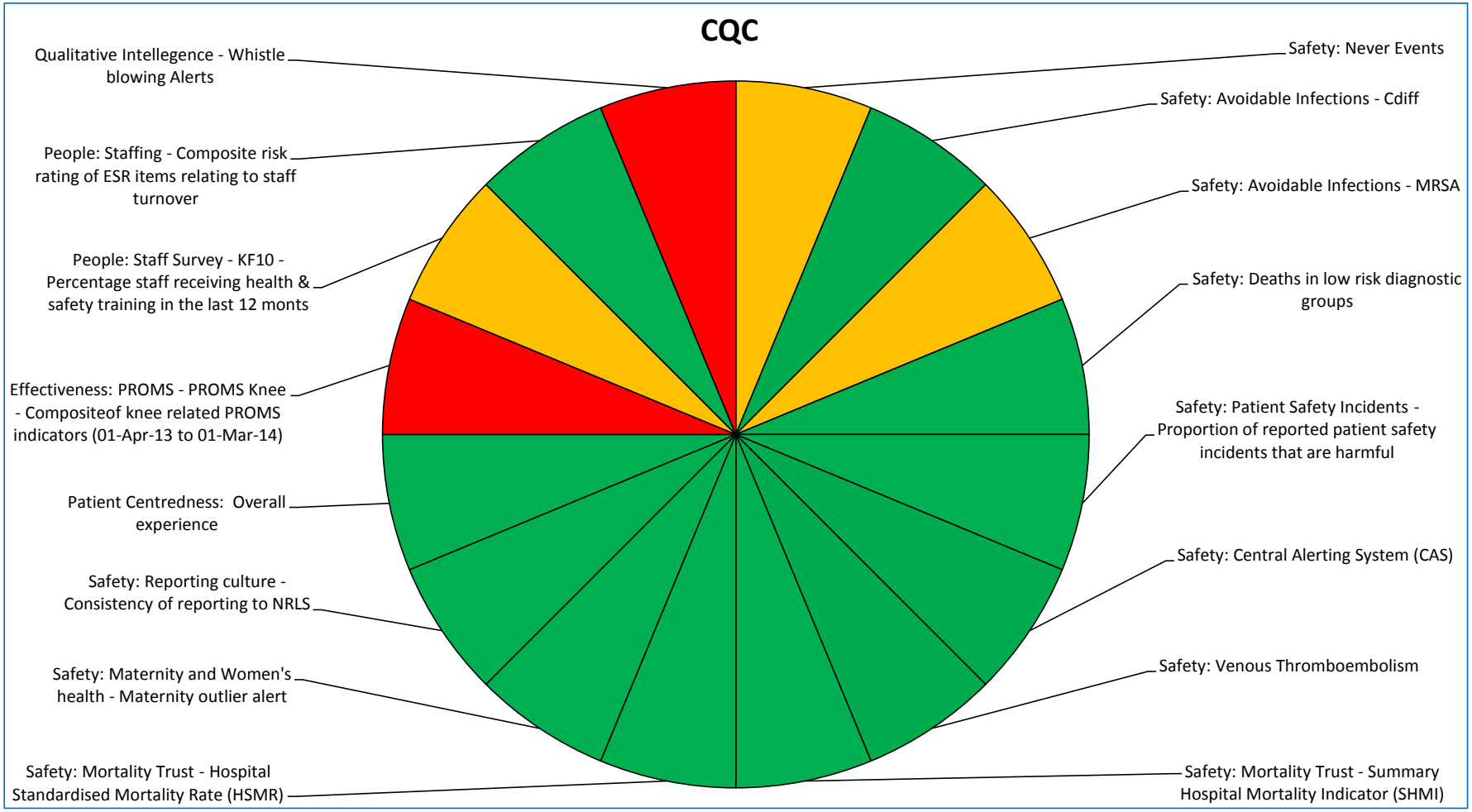
Quality - Month 1 (April 2015)

Cancer is reported one month in arrears

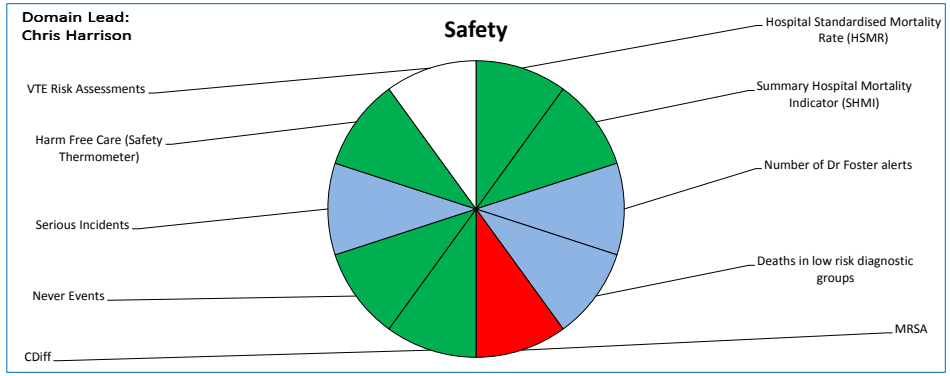


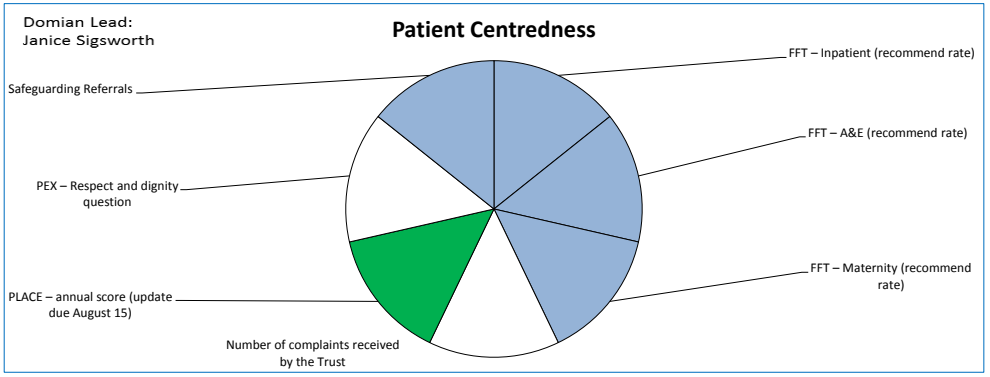
2014/2015			Actual	Forecast		
Area	Indicator	Threshold	Q4 14/15	Q1 15/16	Q2	Q3
Finance	Capital Servicing Capacity		Data not yet available			
	Liquidity Ratio					
	Continuity of Services Risk Rating					
Access	18 weeks referral to treatment - admitted	90%	82.31%	not avail		
	18 weeks referral to treatment - non admitted	95%	89.38%	not avail		
	18 weeks referral to treatment - incomplete pathway	92%	86.65%	not avail		
	2 week wait from referral to date first seen all urgent referrals	93%	93.90%			
	2 week wait from referral to date first seen breast cancer	93%	94.40%			
	31 days standard from diagnosis to first treatment	96%	96.70%			
	31 days standard to subsequent Cancer Treatment - Drug	98%	100.00%			
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94%	99.60%			
	31 days standard to subsequent Cancer Treatment - Surgery	94%	96.80%			
	62 day wait for first treatment from NHS Screening Services referral	90%	92.80%			
	62 day wait for first treatment from urgent GP referral	85%	79.10%			
	A&E maximum waiting times 4 hours	95%	91.90%	92.58%		
Outcomes	Clostridium Difficile (C-Diff) Post 72 Hours	65 p/a	18	8		
Governance Risk Rating						

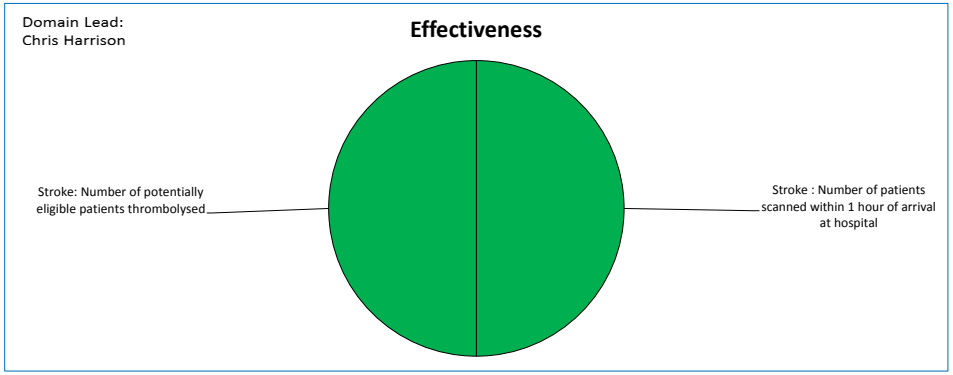
Care Quality Commission (CQC) Rating as at December 2014

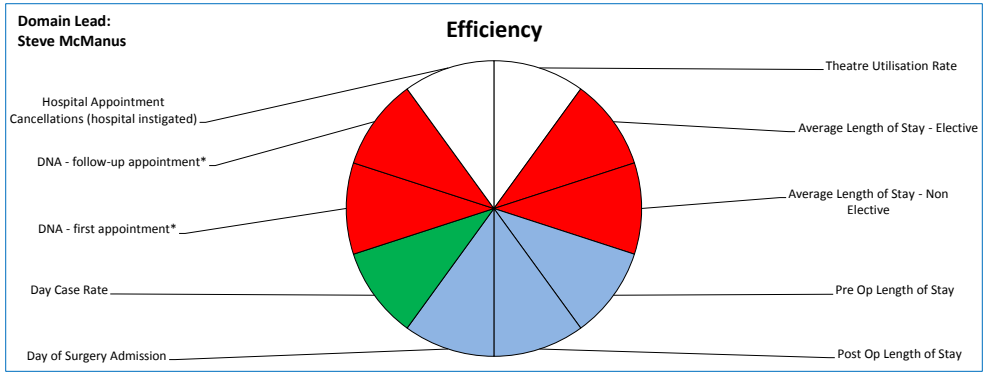


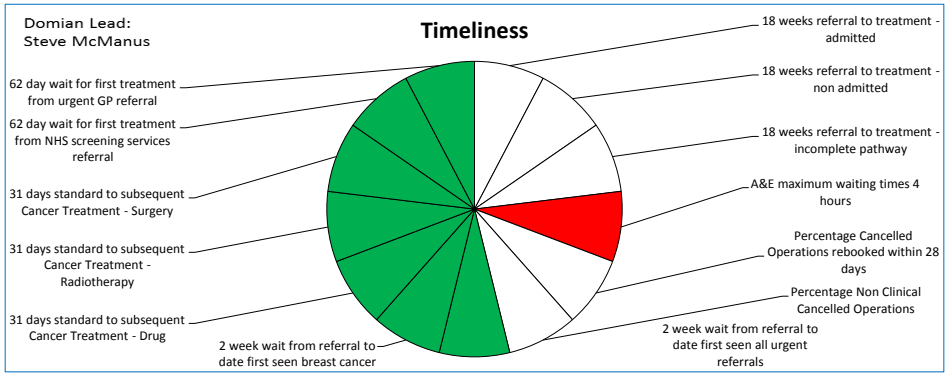
No evidence of Risk | Risk | Elevated Risk

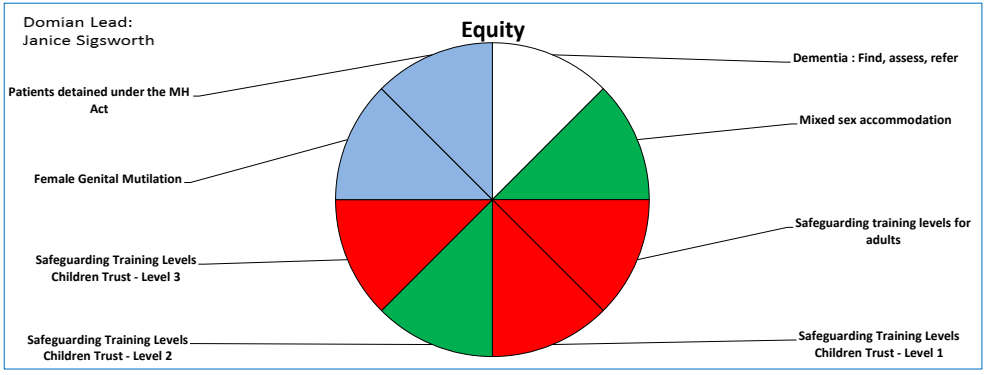












	Threshold met
	Threshold NOT met

	Have Data - NO Threshold
	Data not available

Indicator	Leading	Frequency	Threshold	Performance in 2014/15 Dec-14	Performance in 2014/15 Qtr 3 14/15	Current Month	Performance Current Year To Date Qtr 1 14/15	Qtr 2 14/15	Qtr 3 14/15	Qtr 4 14/15	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Mortality Indicators *															
Hospital Standardised Mortality Rate (HSMR)	-	Quarterly	n/a		66		71.0	80.8	66.4						CQC
Summary Hospital Mortality Indicator (SHMI)	-	Quarterly	n/a		0		67.2								CQC
Dr Foster Alerts *															
Number of Dr Foster mortality alerts	-	Monthly	n/a	1	2	1	3	4	2		9				CQC
Deaths in low risk diagnostic groups *															
Number of deaths in low risk diagnostic groups	-	Monthly	n/a	2	5	2	7	6	5		18				CQC

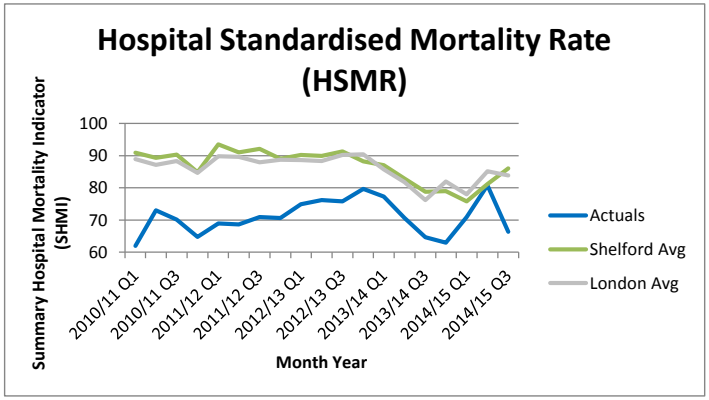
*** Dr Fosters data is 4 months in arrears**

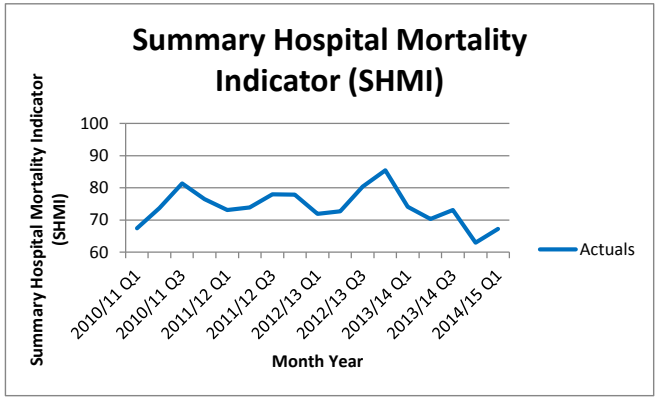
Relative risk refers to the ratio of observed deaths divided by the risk adjusted expected deaths in a given metric, multiplied by 100. On this basis, a figure of 100 represents the NHS England average for a metric. Anything lower than 100 means the relative risk is lower than expected.

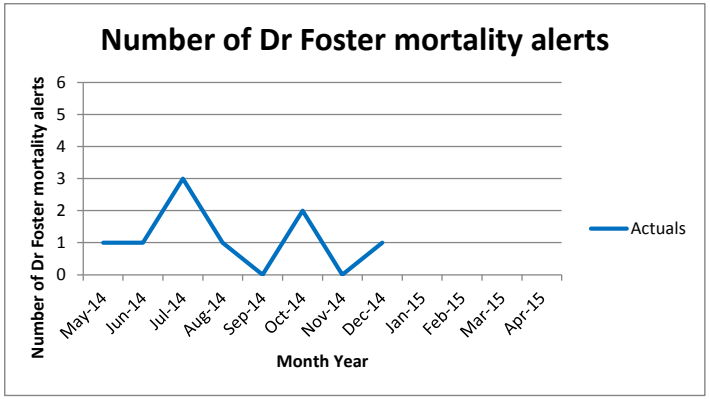
Deaths in low risk diagnosis group is the relative risk for the combined 200 diagnosis groups that have low mortality outcomes.

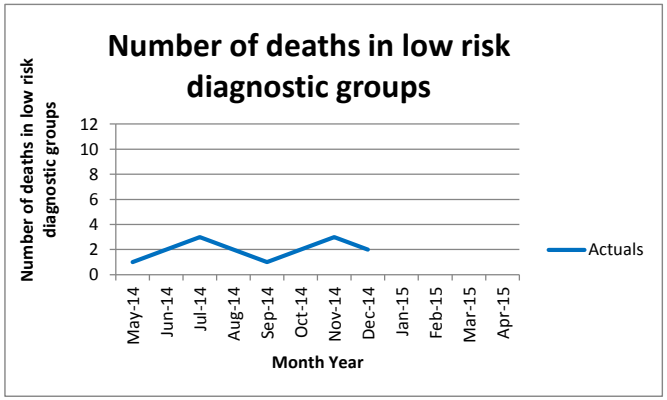
In Hospital Mortality - "various" conditions covers the combined mortality risk for similar diagnosis groups in a specialty (e.g. vascular, haematological). This metric has been developed to replicate the CQC composite mortality indicators wherever possible. This is based on the diagnosis of admission.

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



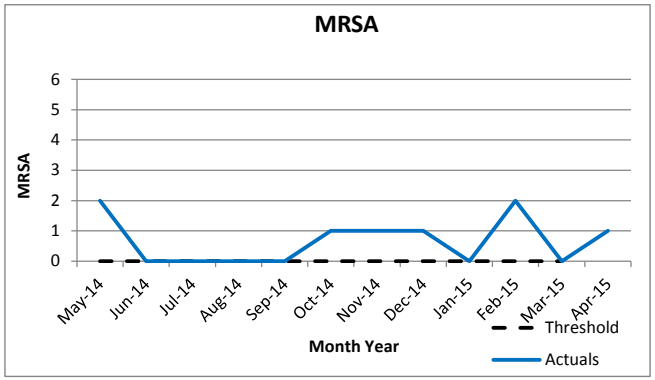


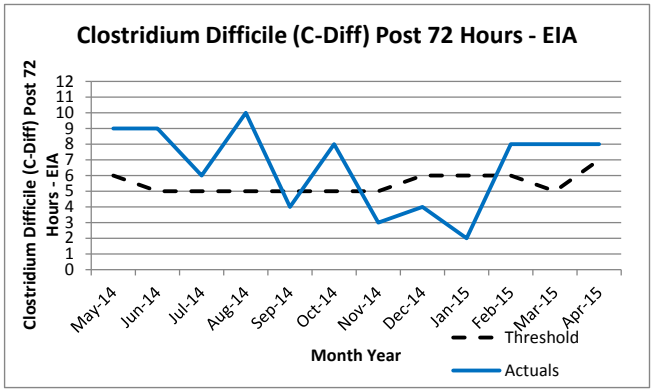


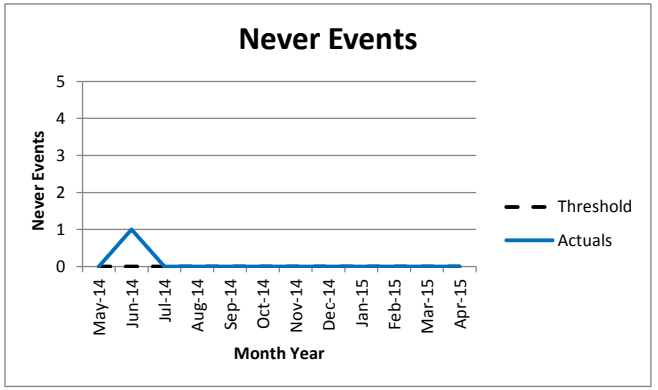


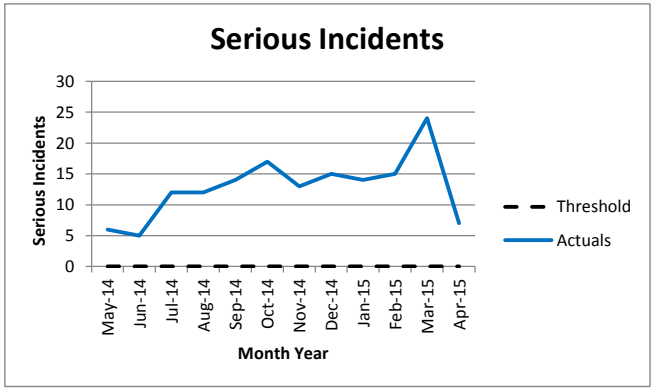
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Infection Control *															
MRSA	-	Monthly	0	1	3	1	1	0	0	0	1				Mon, TDA, CQC
Clostridium Difficile (C-Diff) Post 72 Hours - EIA	-	Monthly	<65 p/a	7	25	8	8	0	0	0	8				TDA, CQC
Incidents *															
Never Events	-	Monthly	0	1	2	0	0	0	0	0	0				Mon, TDA, CQC
Serious Incidents	-	Monthly	tbc	9	20	7	7	0	0	0	7				CQC
Safety Thermometer *															
Harm Free Care (Safety Thermometer)	-	Monthly	>90%	1	1	97.19%	1	0	0	0	1				Mon, TDA, CQC
VTE															
VTE Risk Assessments	-	Monthly	>95%	1	1	No Data	0	0	0	0	0				CQC

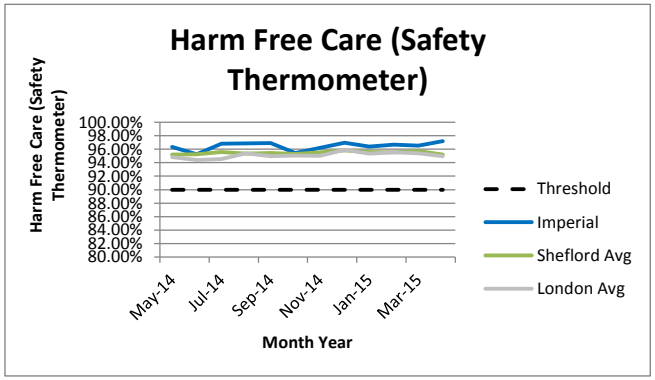
*** Includes Private Patients**

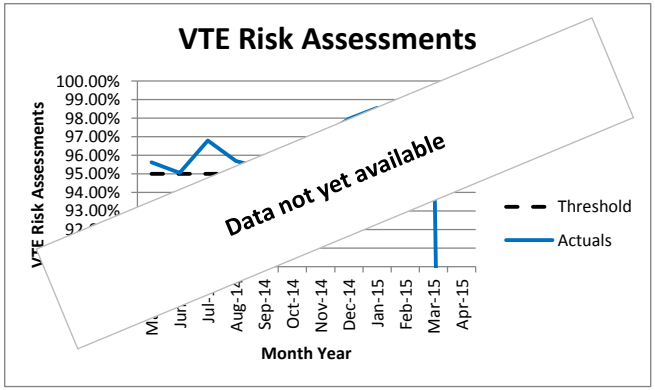




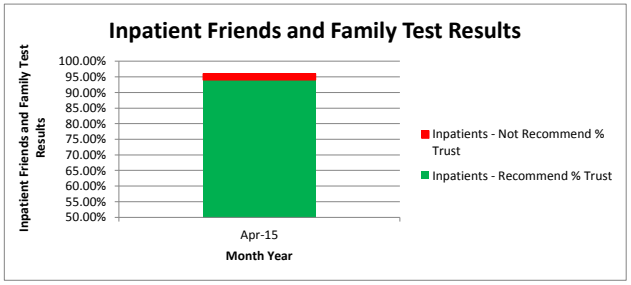


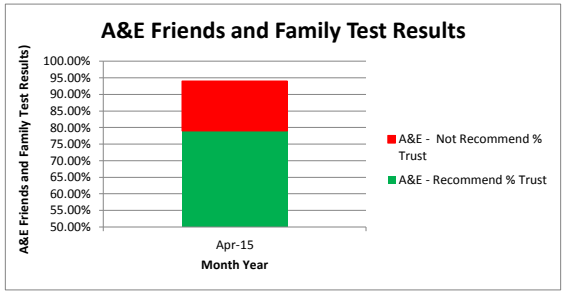


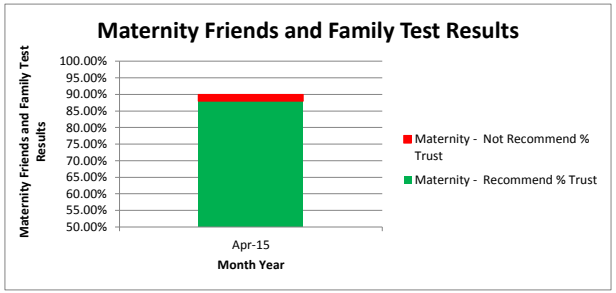


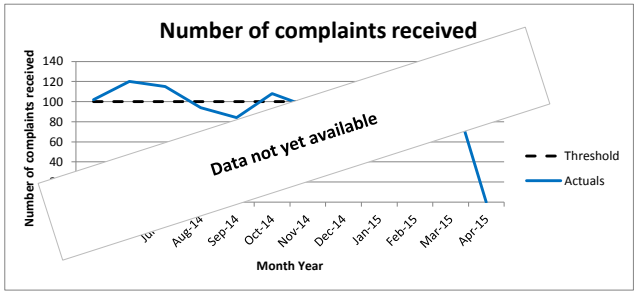


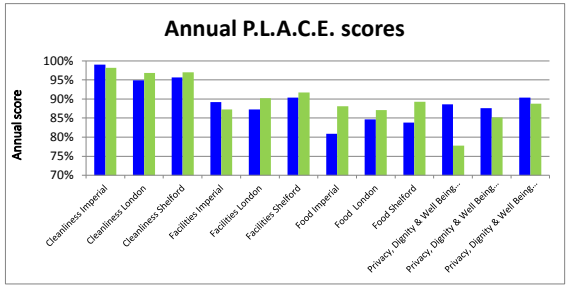
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Friends & Family Test															
Inpatients - Not Recommend %	-	Monthly	tbc	n/a	n/a	2.00%	2.00%	0.00%	0.00%	0.00%	2.00%				Contractual
Inpatients - Recommend %	-	Monthly	tbc	n/a	n/a	94.00%	94.00%	0.00%	0.00%	0.00%	94.00%				Contractual
A&E - Not Recommend %	-	Monthly	tbc	n/a	n/a	15.00%	15.00%	0.00%	0.00%	0.00%	15.00%				Contractual
A&E - Recommend %		Monthly	tbc	n/a	n/a	79.00%	79.00%	0.00%	0.00%	0.00%	79.00%				Contractual
Maternity - Not Recommend %		Monthly	tbc	n/a	n/a	2.00%	2.00%	0.00%	0.00%	0.00%	2.00%				Contractual
Maternity - Recommend %		Monthly	tbc	n/a	n/a	88.00%	88.00%	0.00%	0.00%	0.00%	88.00%				Contractual
Complaints & Compliments															
Number of complaints received	-	Monthly	< 100	92	314	No Data	0	0	0	0	0				Contractual
Environment															
PLACE - Cleanliness	-	Annual	> 95.00%	n/a	n/a	Due Aug-15	0	0	0	0	0				tbc
PLACE - Food	-	Annual	> 84.00%	n/a	n/a	Due Aug-15	0	0	0	0	0				tbc
PLACE - Privacy, Dignity & Well Being		Annual	> 82.00%	n/a	n/a	Due Aug-15	0.00%	0.00%	0.00%	0.00%	0.00%				tbc
PLACE - Facilities		Annual	> 83.00%	n/a	n/a	Due Aug-15	0.00%	0.00%	0.00%	0.00%	0.00%				tbc
Parient Experience															
(LQ36) Have you been treated with dignity and respect by staff on this ward?	-	Annual	> 85.00%	n/a	n/a	No Data	0	0	0	0	0				CQC
Safegurarding															
Safeguarding Adults : Referrals per month	-	Annual	n/a	n/a	n/a	32	32	0	0	0	32				CQC

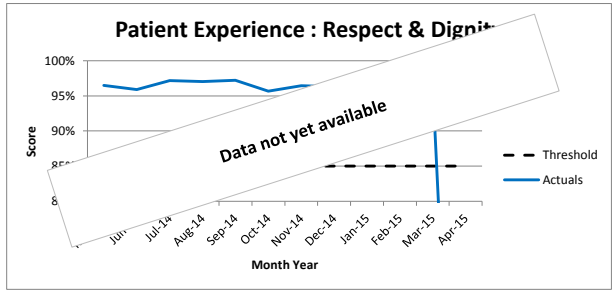


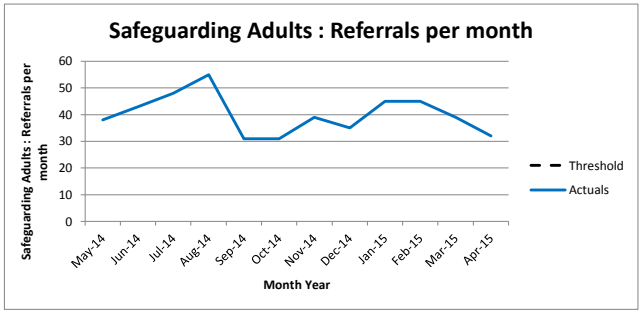




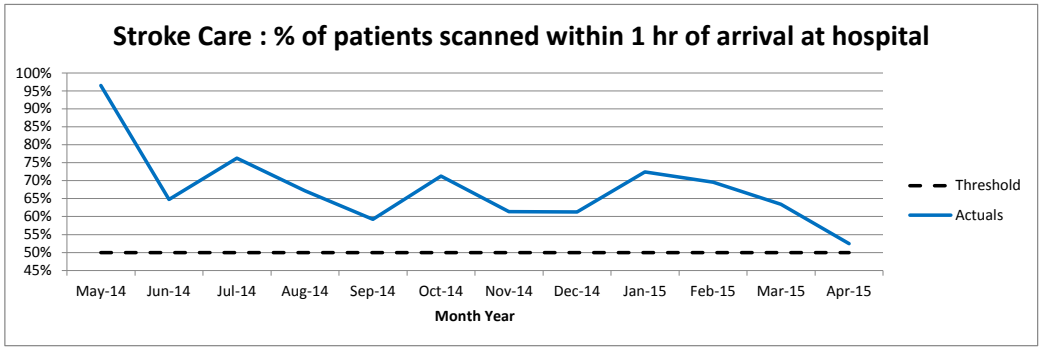


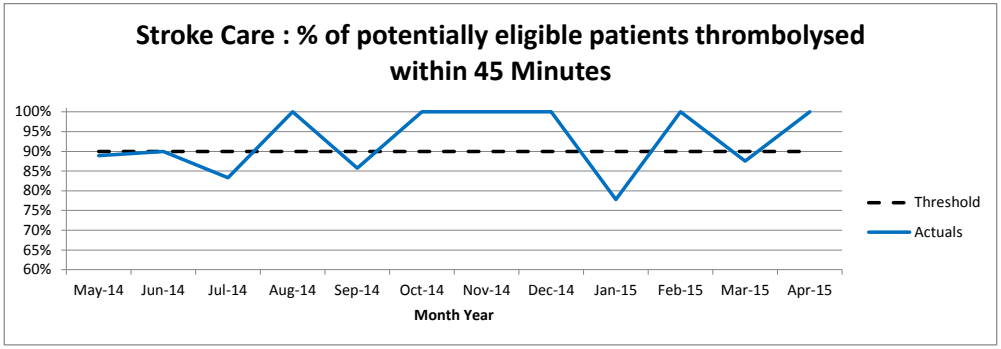




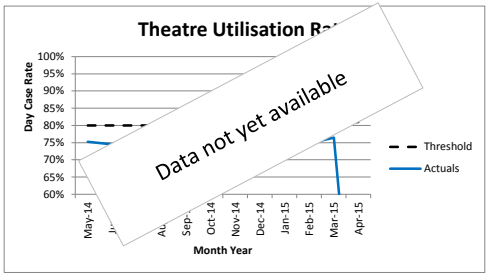


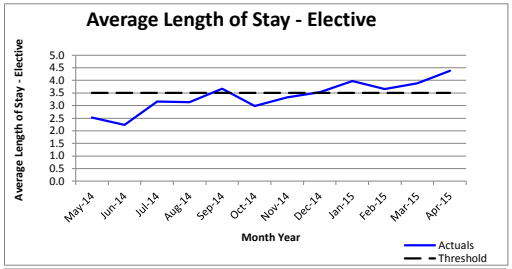
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Stroke Alerts															
Stroke Care : % of patients scanned within 1 hr of arrival at hospital		Monthly	> 50.00%	54.69%	72%	52.50%	52.50%	0.00%	0.00%	0.00%	52.50%				CQC
Stroke Care : % of potentially eligible patients thrombolysed within 45 Minutes		Monthly	> 90.00%	88.89%	89%	100.00%	100.00%	0.00%	0.00%	0.00%	100.00%				CQC

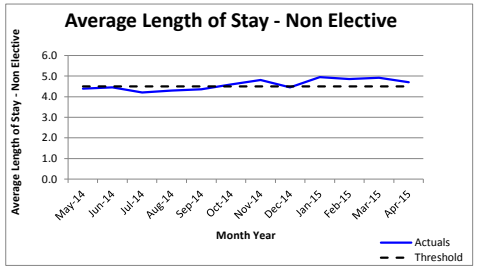


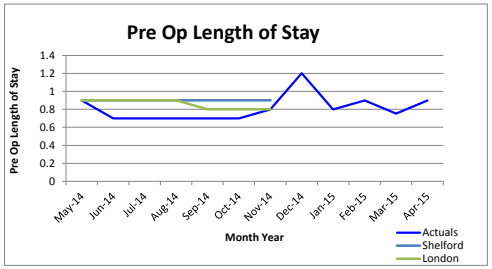


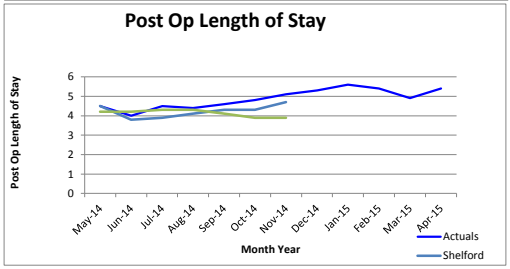
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Productivity															
Theatre Utilisation Rate	✓	Monthly	<3.5	2.52	2.62	No data	0.00	0.00	0.00	0.00	0.00%				CQC
Average Length of Stay - Elective	✓	Monthly	<3.5	2.52	2.62	4.38	4.38	0.00	0.00	0.00	4.38				CQC
Average Length of Stay - Non Elective	✓	Monthly	<4.5	4.39	4.35	4.70	4.70	0.00	0.00	0.00	4.70				CQC
Pre Op Length of Stay*	✓	Monthly	*tbc*	0.90	0.83	0.90%	90.00%	0.00%	0.00%	0.00%	90.00%				CQC
Post Op Length of Stay*	✓	Monthly	*tbc*	4.40	4.30	5.40%	5.40%	0.00%	0.00%	0.00%	5.40%				Internal
Day of Surgery Admission*	✓	Monthly	*tbc*	88.12%	88%	89.29%	89.29%	0.00%	0.00%	0.00%	89.29%				Internal
Day Case Rate	✓	Monthly	80.00%	78.13%	73%	81.73%	81.73%	0.00%	0.00%	0.00%	81.73%				CQC
DNA - first Appointment	✓	Monthly	12.30%	15.70%	18%	13.21%	13.21%	0.00%	0.00%	0.00%	13.21%				CQC
DNA - follow-up appointment	✓	Monthly	11.30%	15.10%	17%	12.32%	12.32%	0.00%	0.00%	0.00%	12.32%				CQC
Hospital Appointment Cancellations (hosptial instigated)	✓	Monthly	tbc	2529	3663	No Data	0.00	0.00%	0.00%	0.00%	0.00%				CQC

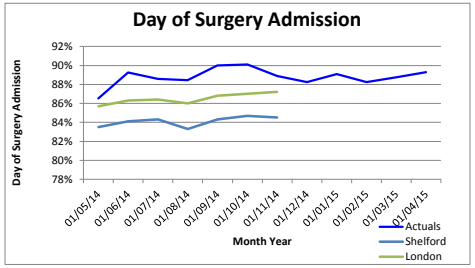


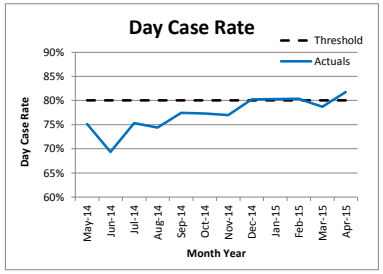


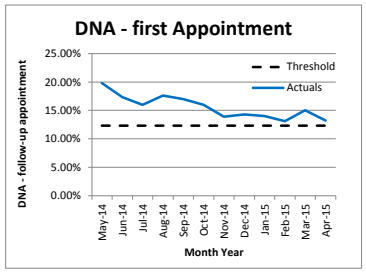


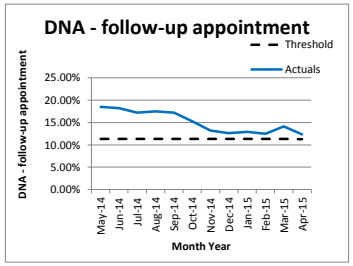


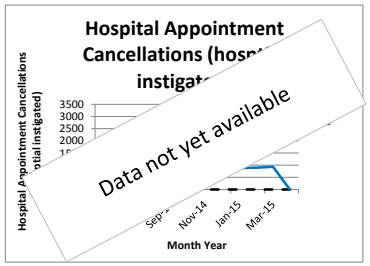




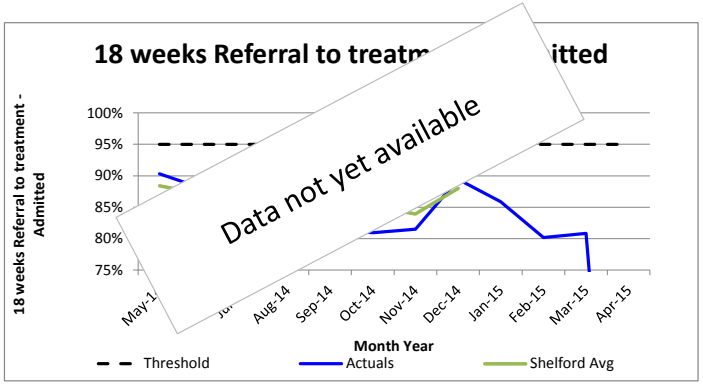


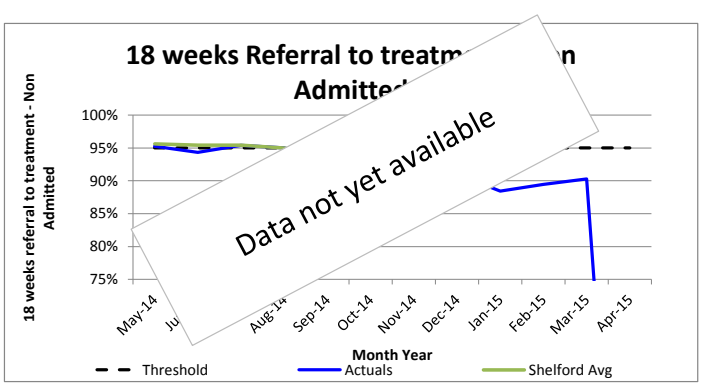


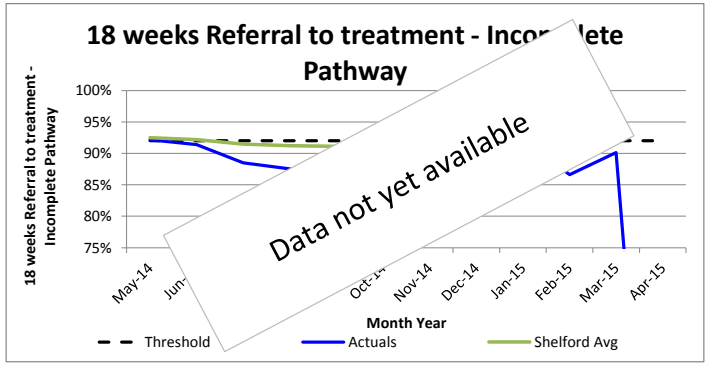


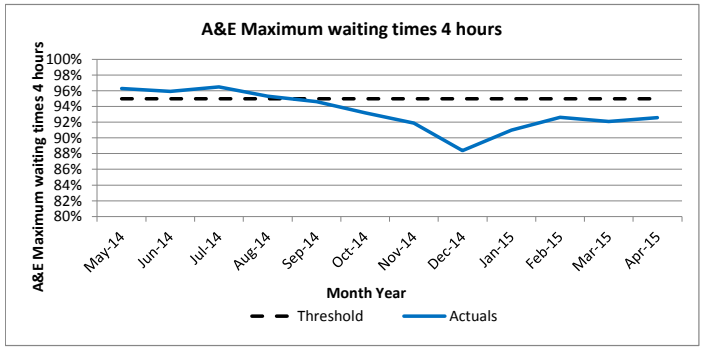


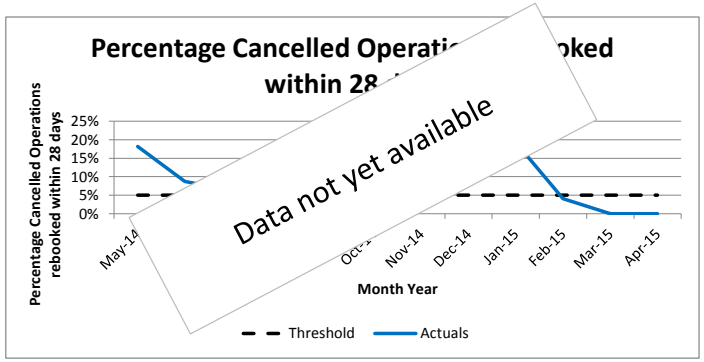
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Elective Access															
18 Weeks referral to treatment - admitted	-	Monthly	> 90.00%	88.3%	88.9%	No Data	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
18 weeks referral to treatment - non admitted	-	Monthly	> 95.00%	94.4%	94.7%	No Data	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
18 weeks referral to treatment - incomplete pathway	-	Monthly	< 92.00%	92.9%	92.2%	No Data	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
A&E Access															
A&E Maximum waiting times 4 hours	-	Monthly	> 95.00%	95.40%	95.87%	92.58%	92.58%	0.00%	0.00%	0.00%	92.58%				Mon, TDA, CQC
Other Access Measures															
Percentage Cancelled Operations rebooked within 28 days		Monthly	< 5.0%	9.3%	12.1%	No Data	0.0%	0.0%	0.0%	0.0%	0.0%				TDA, CQC
Percentage Non Clinical Cancelled Operations		Monthly	< 0.8%	0.8%	0.8%	No Data	0.0%	0.0%	0.0%	0.0%	0.0%				Define

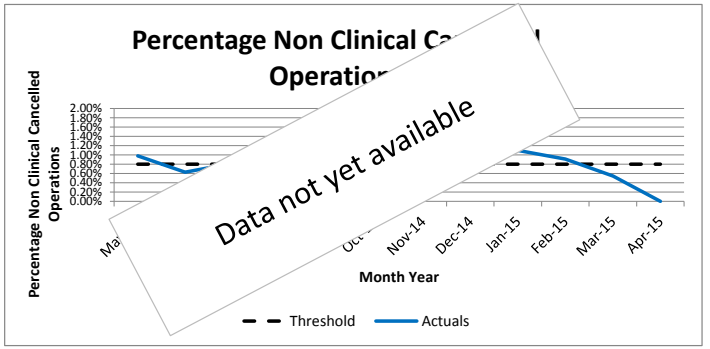






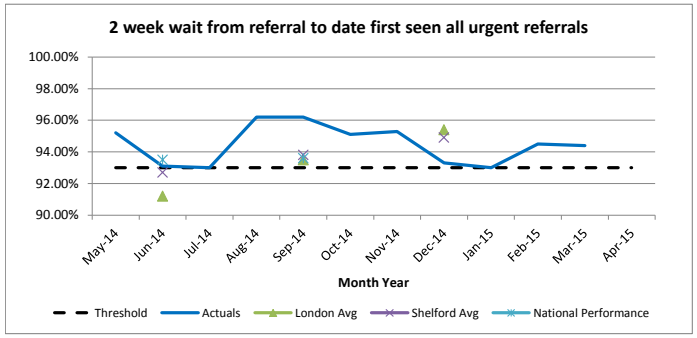


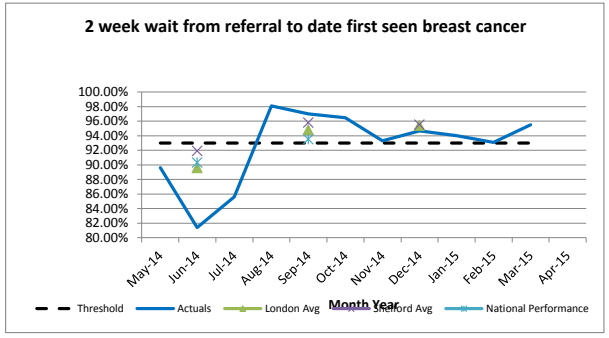


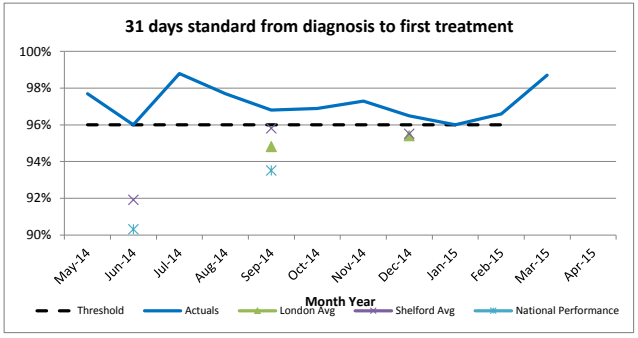


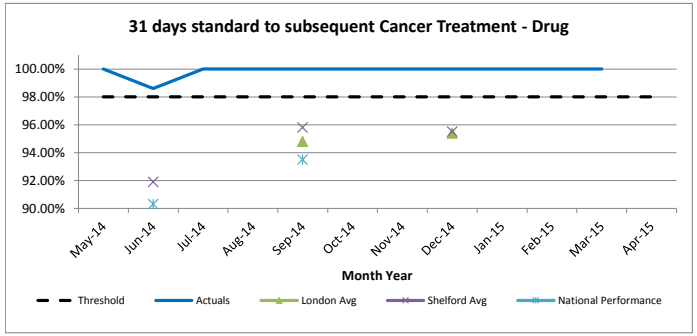
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
2 week wait from referral to date first seen all urgent referrals	-	Monthly	> 93.00%	93.10%	93.80%	94.40%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
2 week wait from referral to date first seen breast cancer		Monthly	> 93.00%	93.30%	88.10%	95.50%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
31 days standard from diagnosis to first treatment		Monthly	> 96.00%	98.30%	97.33%	98.70%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Drug		Monthly	> 98.00%	100.00%	99.53%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Radiotherapy		Monthly	> 94.00%	96.60%	97.87%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
31 days standard to subsequent Cancer Treatment - Surgery		Monthly	> 94.00%	98.00%	97.47%	94.80%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
62 day wait for first treatment from NHS screening services referral		Monthly	> 90.00%	94.30%	92.00%	90.60%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC
62 day wait for first treatment from urgent GP referral		Monthly	> 85.00%	89.00%	85.53%	87.80%	0.00%	0.00%	0.00%	0.00%	0.00%				Mon, TDA, CQC

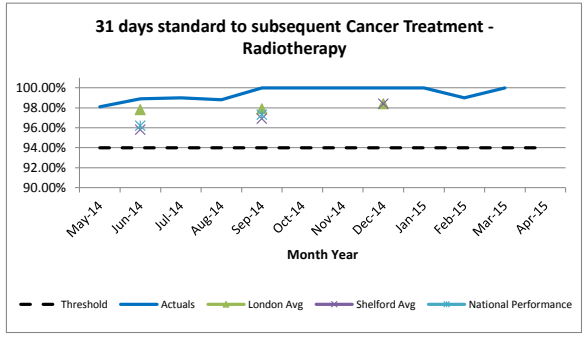
Cancer Access Waiting Times are a month in arrears

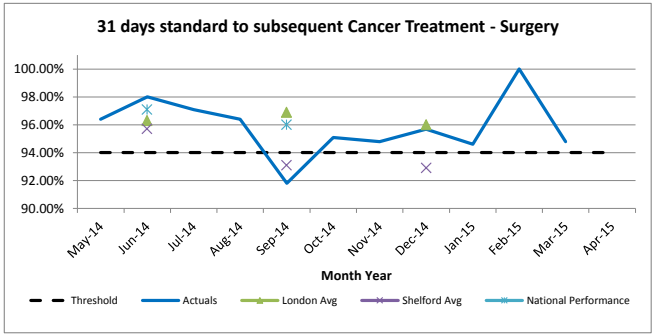


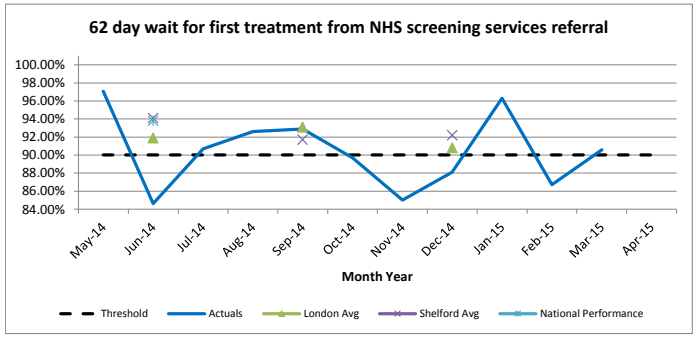


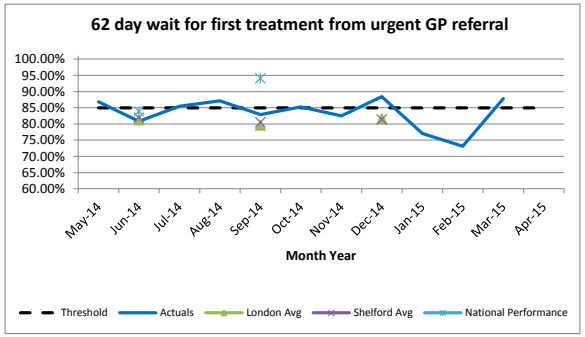




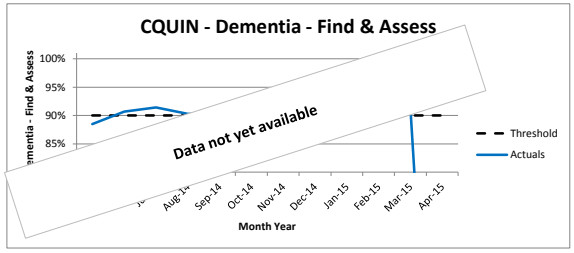


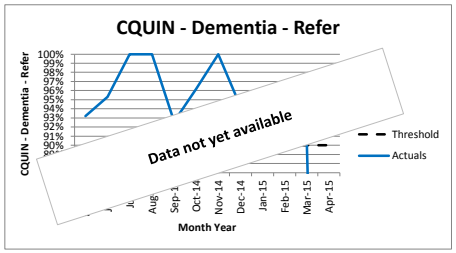


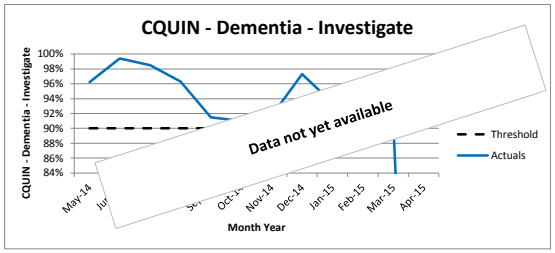


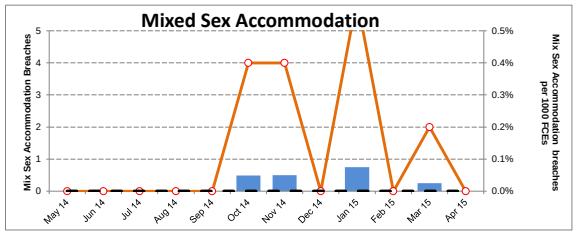


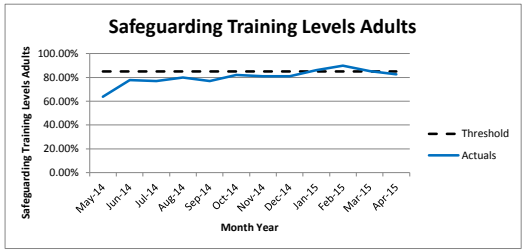
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
CQUIN - Dementia															
CQUIN - Dementia - Find & Assess	-	Monthly	> 90.00%	90.00%	89.73%	No Data	0.00%	0.00%	0.00%	0.00%	0.00%				Define
CQUIN - Dementia - Refer		Monthly	> 90.00%	96.40%	94.97%	No Data	0.00%	0.00%	0.00%	0.00%	0.00%				Define
CQUIN - Dementia - Investigate		Monthly	> 90.00%	99.30%	98.30%	No Data	0.00%	0.00%	0.00%	0.00%	0.00%				TDA, CQC
Accomodation															
Mixed Sex Accommodation		Monthly	0	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				TDA, CQC
Mixed Sex Accommodation Rate per 1000 FCEs		Monthly	0	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%				TDA, CQC
Safeguarding															
Safeguarding Training Levels Adults		Monthly	> 85.00%	0.00%	70.81%	82.66%	82.66%	0.00%	0.00%	0.00%	82.66%				Define
Safeguarding Training Levels Children Trust - Level 1		Monthly	> 80.00%	n/a	79.00%	77.87%	77.87%	0.00%	0.00%	0.00%	77.87%				Define
Safeguarding Training Levels Children Trust - Level 2		Monthly	> 80.00%	n/a	143.00%	84.05%	84.05%	0.00%	0.00%	0.00%	84.05%				Define
Safeguarding Training Levels Children Trust - Level 3		Monthly	> 80.00%	n/a	124.00%	73.28%	73.28%	0.00%	0.00%	0.00%	73.28%				Define
Mental Health Act Detentions															
Patients detained under the Mental Health Act		Monthly	tbc	n/a	5.5	8	8	0	0	0	8				TDA, CQC
Female Genital Mutilation Caseload															
Female Genital Mutilation Caseload		Monthly	tbc	n/a	n/a	n/a	0.00%	0.00%	0.00%	0.00%	0.00%				TDA, CQC

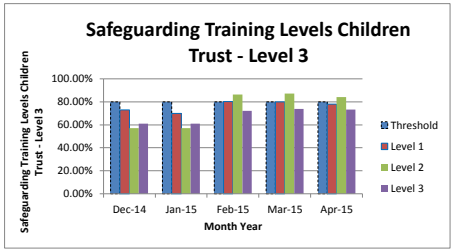


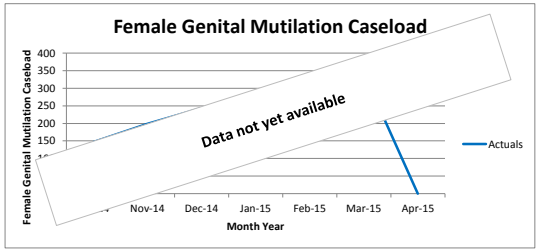


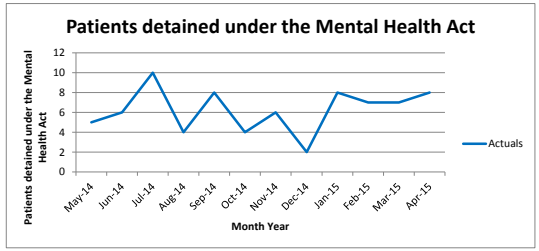




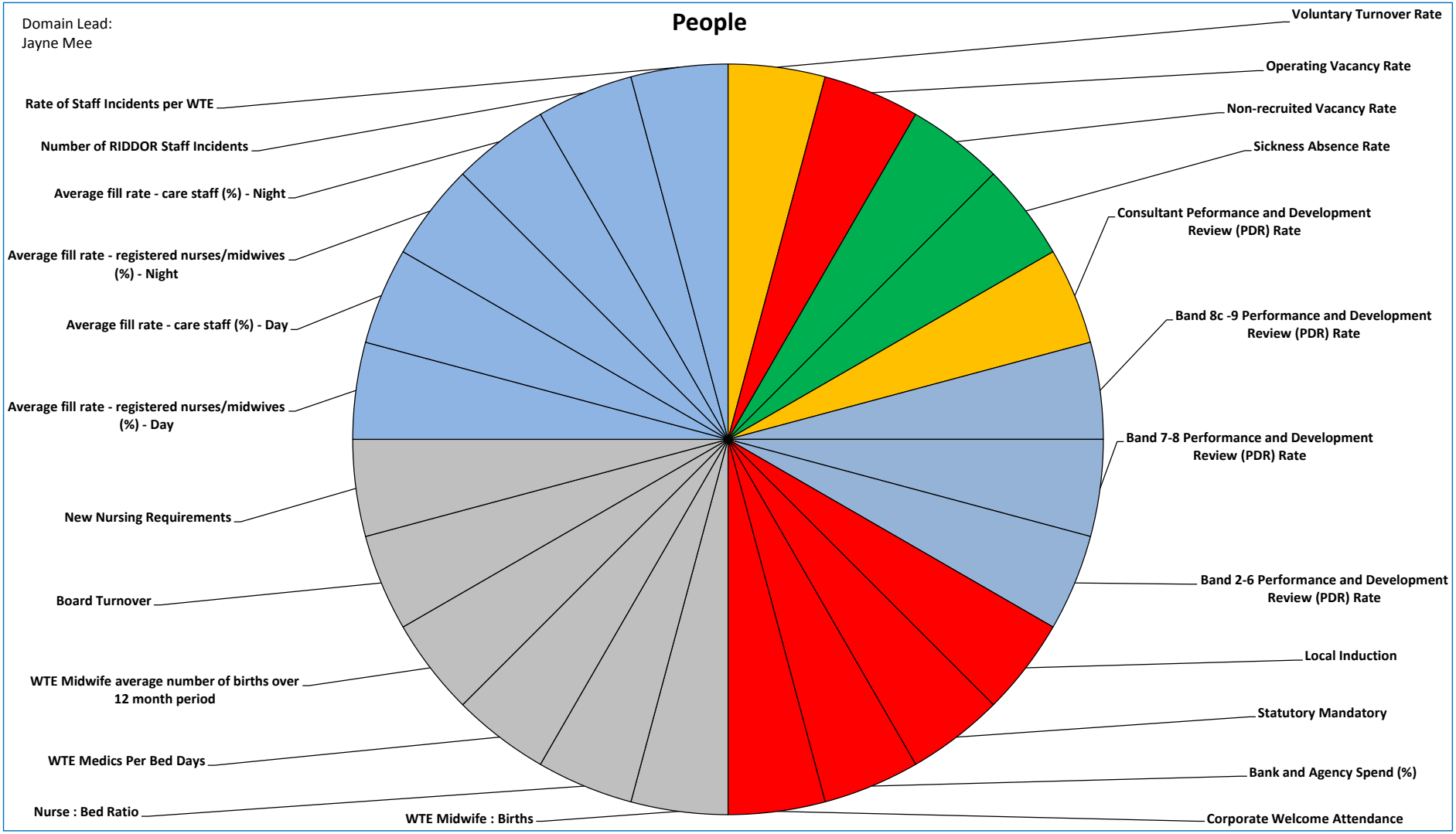








Domain Lead:
Jayne Mee



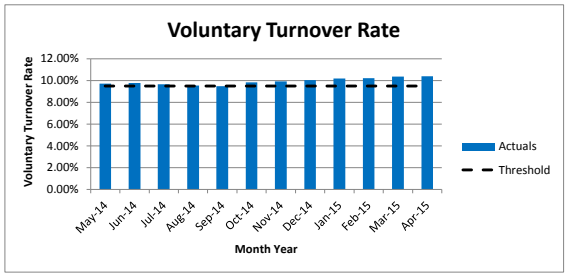
*Clarity as to how these indicators are measured and which domain they are included in is being proposed and will be refreshed in the next integrated performance scorecard.

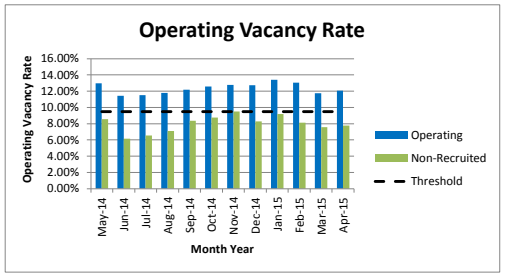
Current performance which meets or exceeds target

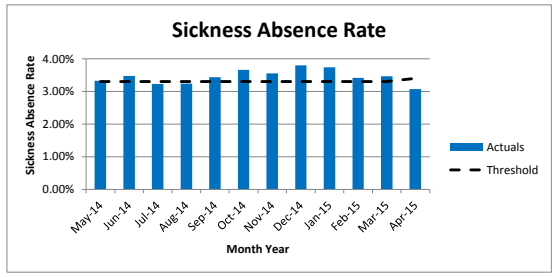
Current performance which is not meeting target but is within 10% of target

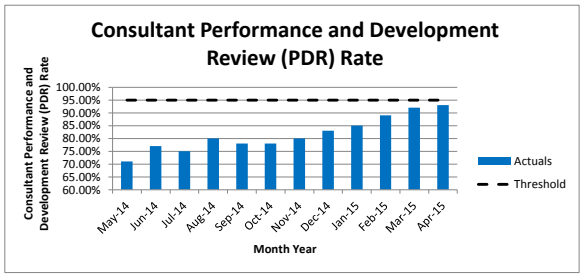
Current performance which is not meeting target within 10%

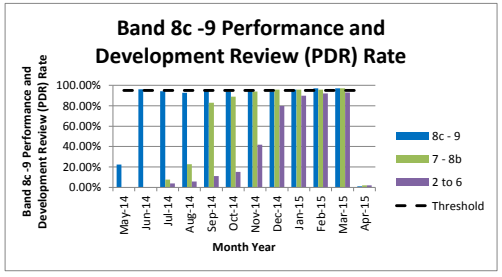
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Current Month	Performance Current Year To Date Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	Rolling 12 Months Position	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Turnover & Vacancy															
Voluntary Turnover Rate	-	Monthly	< 9.50%	9.86%	9.78%	10.40%	10.40%	0.00%	0.00%	0.00%	10.40%				TDA
Operating Vacancy Rate		Monthly	< 10.00%	13.10%	12.50%	12.05%	12.05%	0.00%	0.00%	0.00%					CQC
Non-recruited Vacancy Rate		Monthly	< 9.00%	8.61%	7.77%	7.79%	7.79%	0.00%	0.00%	0.00%					CQC
Sickness Absence Rate		Monthly	< 3.40%	3.24%	3.34%	3.07%	3.07%	0.00%	0.00%	0.00%	3.45%				CQC
Appraisal Rates															
Consultant Performance and Development Review (PDR) Rate	-	Monthly	> 95.00%	72.00%	73.33%	93.00%	93.00%	0.00%	0.00%	0.00%					Define
Band 8c -9 Performance and Development Review (PDR) Rate		Monthly	> 95.00%	12.00%	43.48%	1.00%	1.00%	0.00%	0.00%	0.00%					Define
Band 7-8 Performance and Development Review (PDR) Rate		Monthly	> 95.00%	n/a	n/a	2.00%	2.00%	0.00%	0.00%	0.00%					Define
Band 2-6 Performance and Development Review (PDR) Rate		Monthly	tbc	n/a	n/a	2.00%	2.00%	0.00%	0.00%	0.00%					Define
Training Compliance															
Local Induction		Monthly	tbc	75.84%	77.01%	83.00%	83.00%	0.00%	0.00%	0.00%					Define
Statutory Mandatory		Monthly	tbc	69.52%	69.20%	79.00%	79.00%	0.00%	0.00%	0.00%					Define
Bank & Agnecy Spend															
Bank Spend (%)		Monthly	tbc	5.88%	5.61%	5.17%	5.17%	0.00%	0.00%	0.00%	12.83%				Define
Agency Spend (%)		Monthly	tbc	8.12%	8.10%	7.66%	7.66%	0.00%	0.00%	0.00%					Define
Corporate															
Corporate Welcome Attendance		Monthly	tbc	0.00%	90.12%	87.00%	87.00%	0.00%	0.00%	0.00%					Define

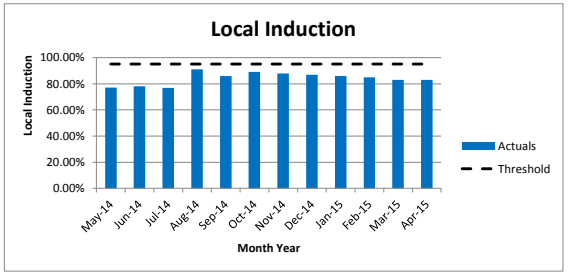


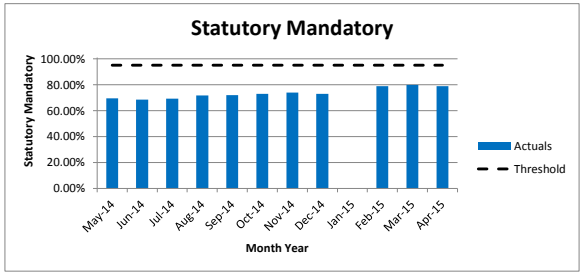


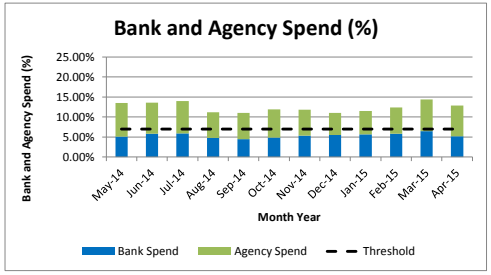


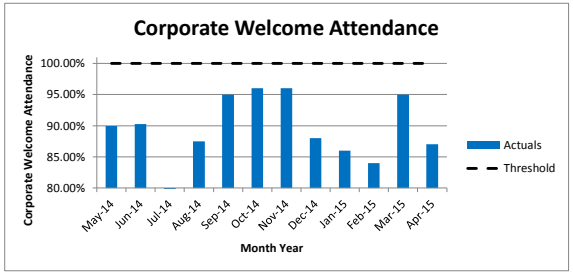




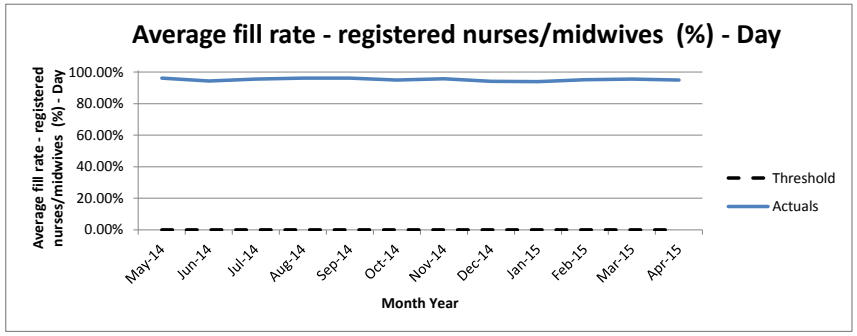


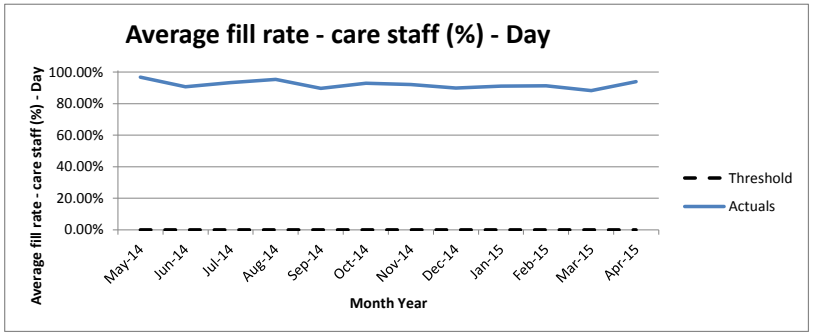


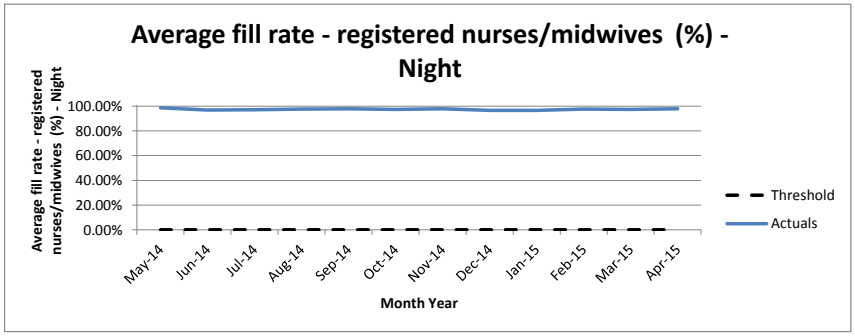


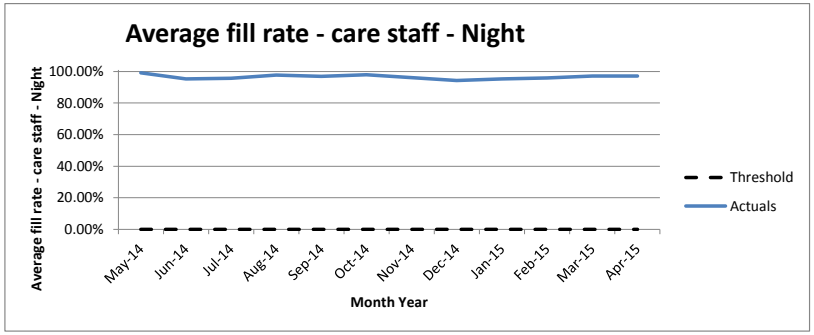


Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Year To Date: Current Month	Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Qtr 4 15/16	YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Staffing Nursing, midwifery and care staff															
Average fill rate - registered nurses/midwives (%) - Day	-	Monthly	tbc	n/a	95.30%	**95.00%**	**95.00%**	**0.00%**	**0.00%**	**0.00%**	**95.00%**				Contractual
Average fill rate - care staff (%) - Day		Monthly	tbc	n/a	93.80%	**94.00%**	**94.00%**	**0.00%**	**0.00%**	**0.00%**	**94.00%**				Contractual
Average fill rate - registered nurses/midwives (%) - Night		Monthly	tbc	n/a	97.75%	**98.00%**	**98.00%**	**0.00%**	**0.00%**	**0.00%**	**98.00%**				Contractual
Average fill rate - care staff - Night		Monthly	tbc	n/a	97.15%	**97.00%**	**97.00%**	**0.00%**	**0.00%**	**0.00%**	**97.00%**				Contractual

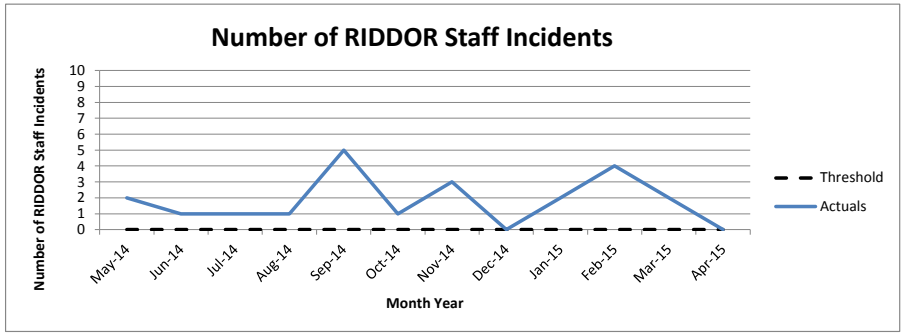


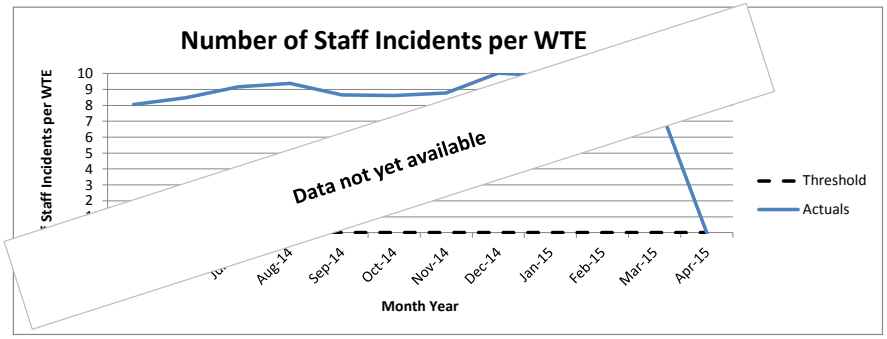






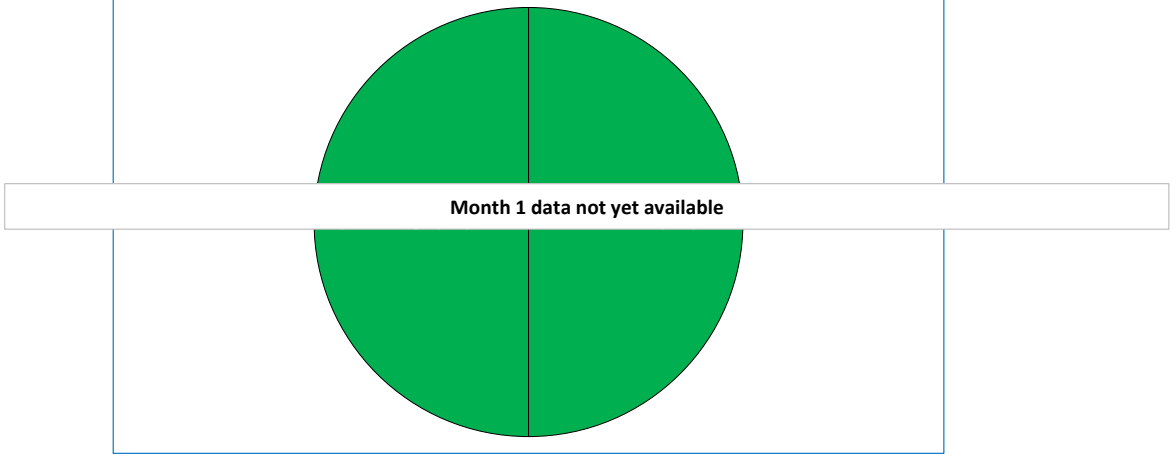
Indicator	Leading	Frequency	Threshold	2014/15 Apr-14	2014/15 Qtr 1 14/15	Performance Current Month	Performance Qtr 1 15/16	Performance Qtr 2 15/16	Performance Qtr 3 15/16	Performance Qtr 4 15/16	Performance YTD	Forecast Qtr 2 15/16	Forecast Qtr 3 15/16	Forecast Qtr 4 15/16	Source Framework
Health and Safety															
Number of RIDDOR Staff Incidents	-	Monthly	tbc	0	1	0	0	0	0	0	0				Internal
Number of Staff Incidents per WTE		Monthly	tbc	7	8	No data	0	0	0	0	0				Internal





Domain Lead:
Alan Goldsman

Finance - Continuity of Services Risk Rating

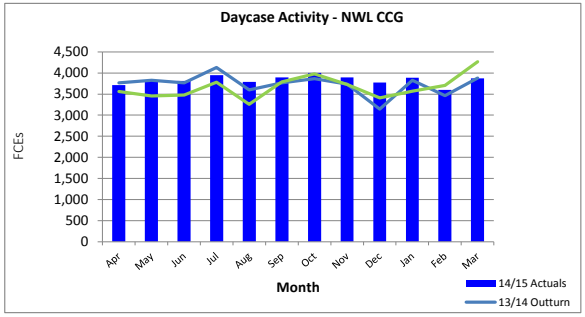


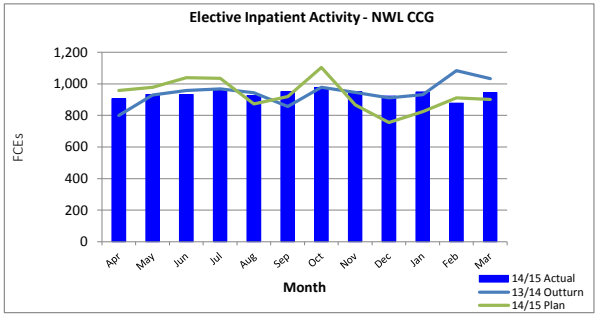
Imperial College Healthcare NHS Trust

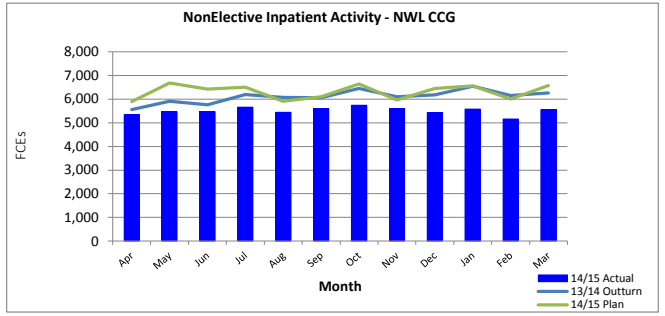
Indicator	Leading	Frequency	Weighting	Performanc	urrent Year To Date Q2	Q3	Q4	Forecast Qtr 4 14/15	Qtr 1 15/16	Qtr 2 15/16	Source Framework
Continuity of Service Risk Rating											
Liquidity Ratio		Monthl			3	3	3	3			
Capital Servicing Capacity		M			3	4	4	4			
Overall Continuity				4	3	4	4	4			

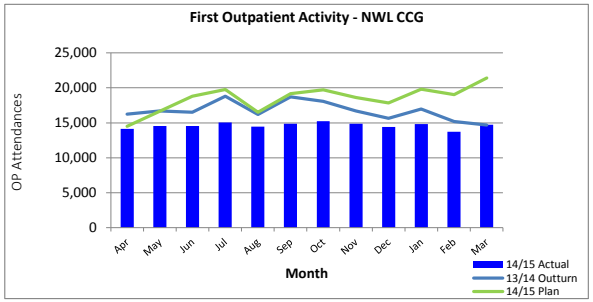
Month 1 data not yet available

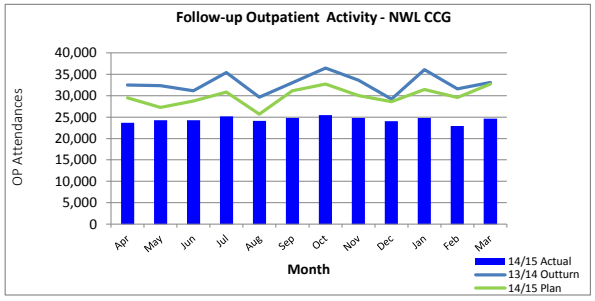
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Mar	Performance in 2013/14 Qtr4	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Daycases		Month	4,267	3,879	11,164	**3,869**	11,339	11,633	11,675	11,353	46,000				Contractual
Elective Inpatients		Month	902	1,033	3,048	**945**	2,771	2,843	2,853	2,774	11,241				Contractual
NonElective Inpatients		Month	6,564	6,264	18,963	**5,552**	16,272	16,695	16,754	16,292	66,014				Contractual
First Outpatient		Month	21,396	14,681	46,868	**14,749**	43,230	44,353	44,510	43,283	175,376				Contractual
Follow-up Outpatient		Month	32,743	33,092	100,800	**24,646**	72,238	74,114	74,378	72,326	293,056				Contractual
Adult Critical Care		Month	2,028	1,339	4,169	**1,599**	4,686	4,808	4,825	4,692	19,010				Contractual
A&E Attendances		Month	10,961	12,282	33,593	**11,886**	34,837	35,742	35,869	34,880	141,328				Contractual
Regular Day Attender		Month	70	263	736	**225**	659	676	679	660	2,675				Contractual

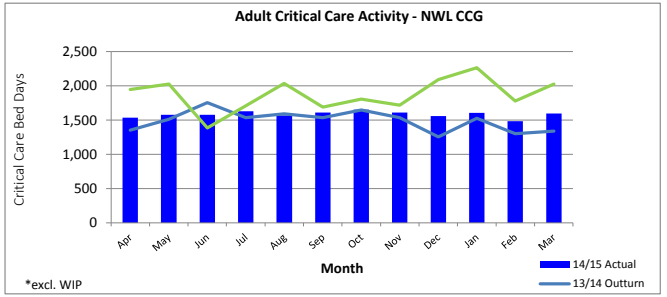


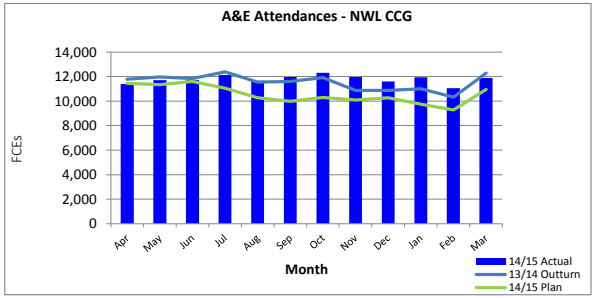


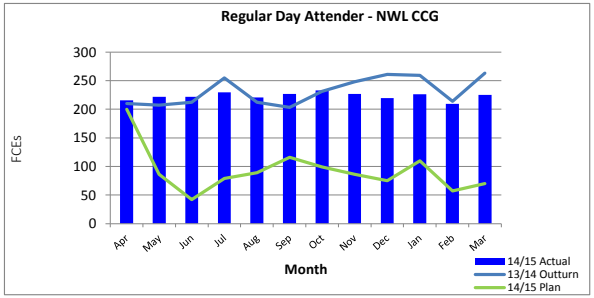






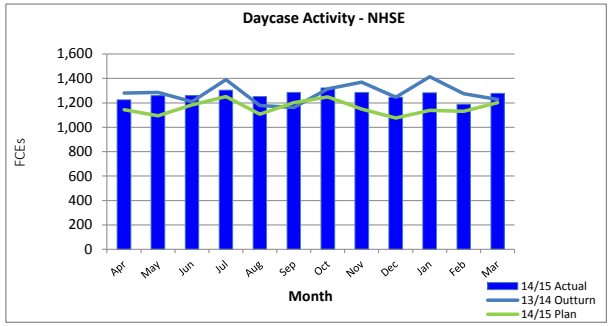


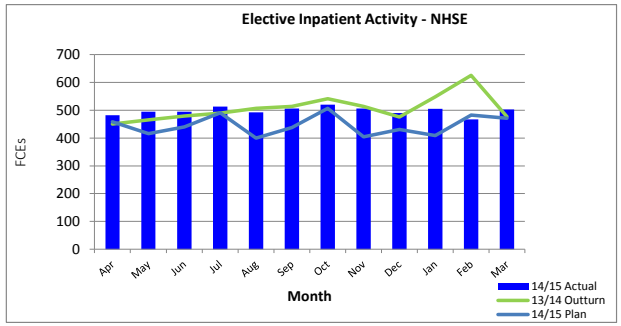


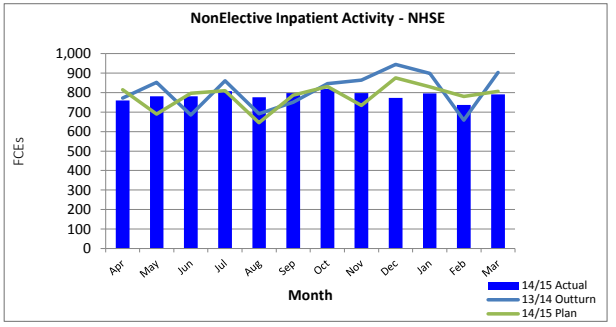


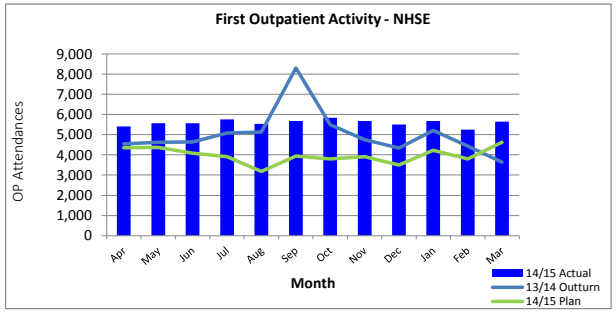
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are included in the "Other" tab. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently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

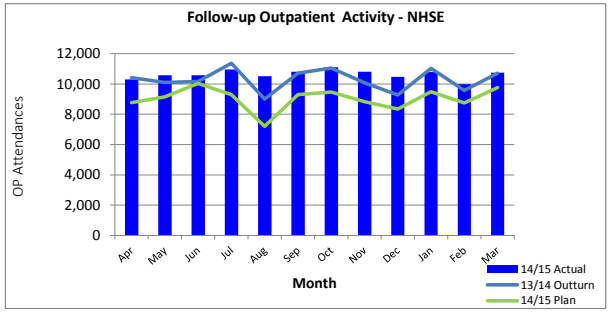
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Mar	Performance in 2013/14 Qtr4	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Daycase		Month	1,201	1,228	3,915	**1,277**	3,744	3,841	3,855	3,749	15,189				Contractual
Elective Inpatients		Month	471	476	1,649	**502**	1,471	1,510	1,515	1,473	5,970				Contractual
NonElective Inpatients		Month	807	904	2,461	**792**	2,321	2,381	2,389	2,323	9,414				Contractual
First Outpatient		Month	4,631	3,640	13,288	**5,645**	16,544	16,974	17,034	16,564	67,117				Contractual
Follow-up Outpatient		Month	9,769	10,714	31,317	**10,734**	31,463	32,280	32,395	31,501	127,638				Contractual
Adult Critical Care		Month	1,157	1,324	3,672	**1,393**	4,083	4,189	4,203	4,088	16,562				Contractual
A&E Attendances		Month	1	2	10	**2**	6	7	7	6	26				Contractual
Regular Day Attender		Month	1,122	909	2,800	**1,025**	3,004	3,082	3,093	3,007	12,185				Contractual

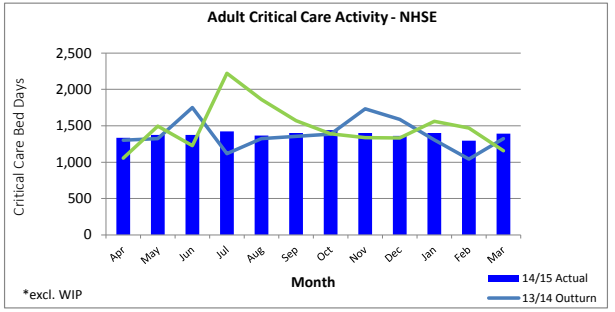


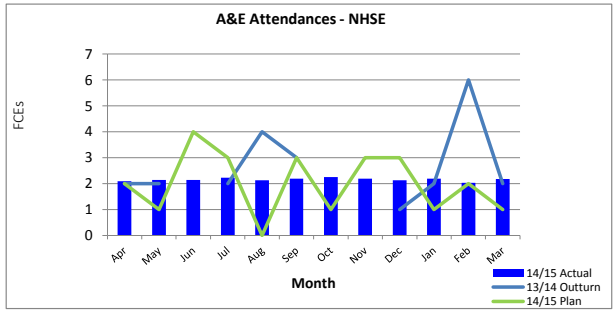


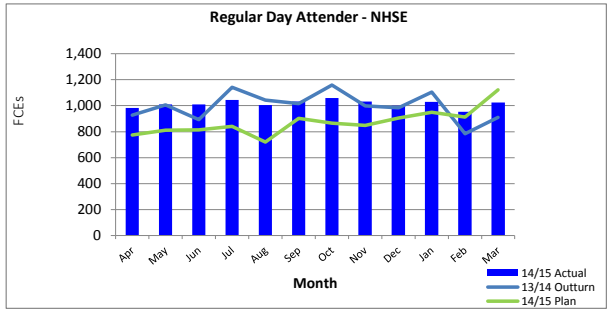






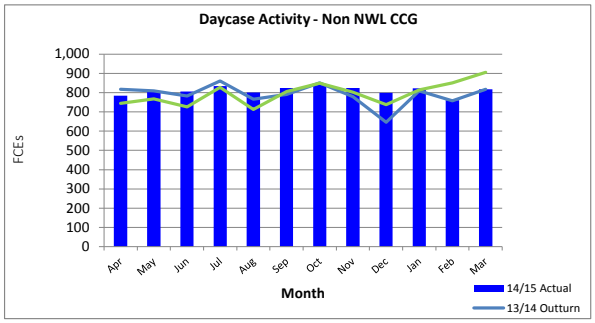


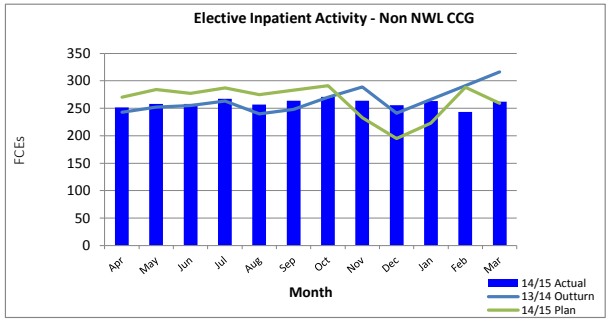


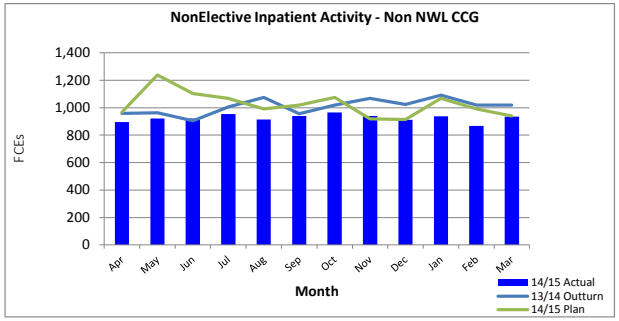


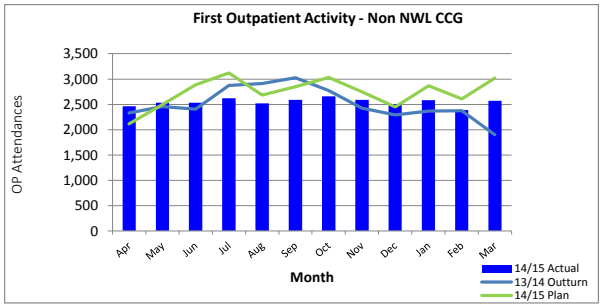
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are included in the "Other" tab. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently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

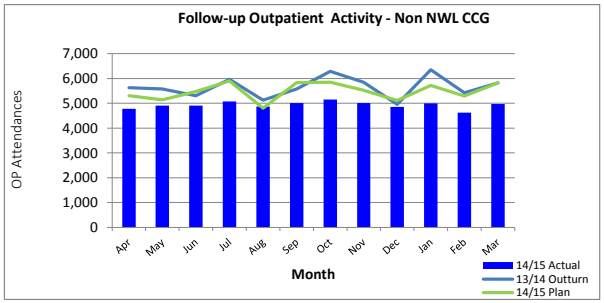
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Mar	Performance in 2013/14 Qtr4	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Daycase		Month	905	818	2,384	**818**	2,397	2,460	2,468	2,400	9,726				Contractual
Elective Inpatients		Month	259	316	873	**262**	768	788	791	769	3,115				Contractual
NonElective Inpatients		Month	940	1,018	3,130	**934**	2,738	2,809	2,819	2,741	11,107				Contractual
First Outpatient		Month	3,022	1,899	6,638	**2,569**	7,531	7,726	7,754	7,540	30,551				Contractual
Follow-up Outpatient		Month	5,825	5,828	17,600	**4,976**	14,586	14,965	15,018	14,604	59,172				Contractual
Adult Critical Care		Month	215	251	903	**345**	1,011	1,037	1,041	1,012	4,102				Contractual
Regular Day Attender		Month	24	56	156	**34**	100	103	103	100	405				Contractual

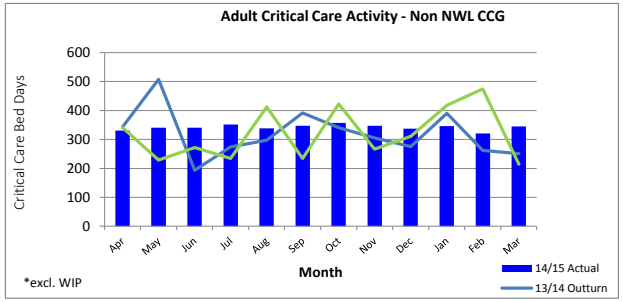


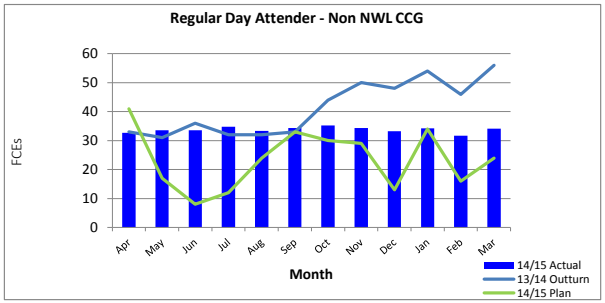






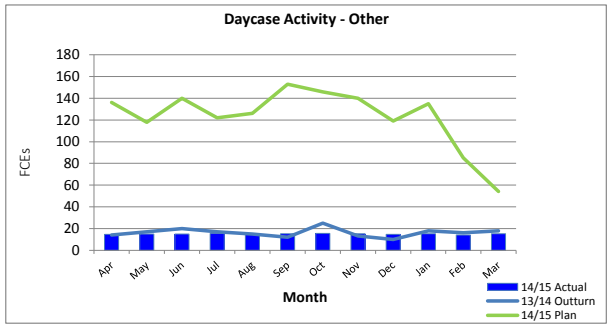


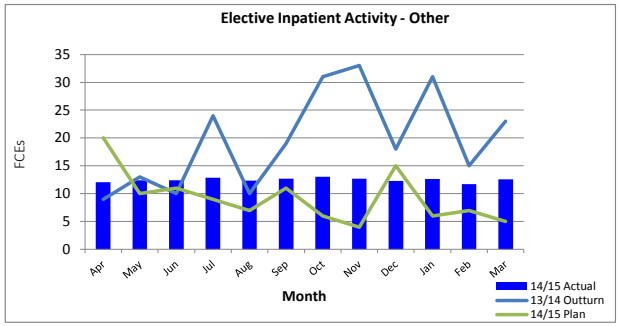


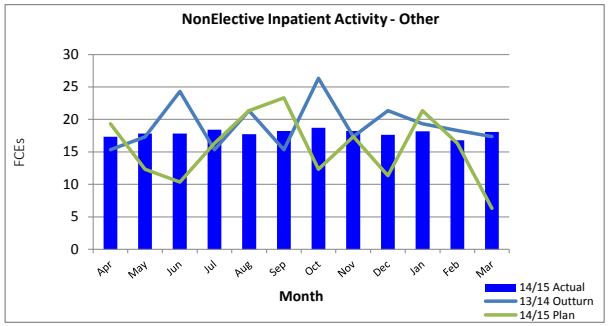


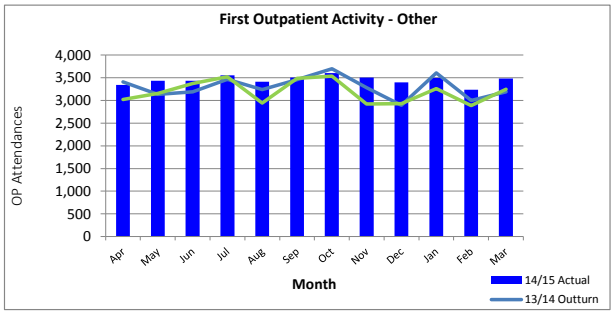
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are included in the "Other" tab. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently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

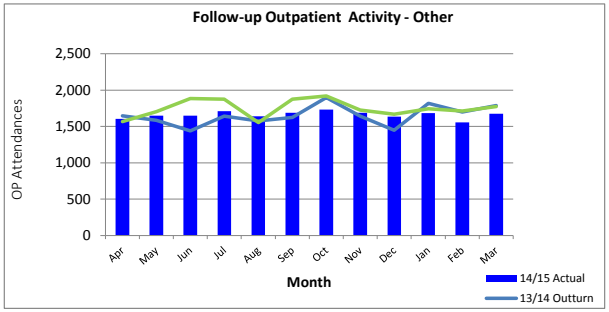
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Mar	Performance in 2013/14 Qtr4	Performance Current Year To Date Current Month	Q1	Q2	Q3	Q4	YTD	Forecast Qtr 4 14/15	Forecast Qtr 1 15/16	Forecast Qtr 2 15/16	Source Framework
Daycases		Month	54	18	52	**15**	44	45	46	44	180				Contractual
Elective Inpatients		Month	5	23	69	**13**	37	38	38	37	150				Contractual
NonElective Inpatients		Month	6	17	55	**18**	53	54	55	53	215				Contractual
First Outpatient		Month	3,247	3,189	9,790	**3,480**	10,199	10,464	10,501	10,211	41,375				Contractual
Follow-up Outpatient		Month	1,776	1,790	5,308	**1,675**	4,909	5,037	5,055	4,915	19,915				Contractual
Adult Critical Care		Month	6	12	34	**22**	65	66	67	65	263				Contractual
Regular Day Attender		Month	0	1	1	**0**	0	0	0	0	0				Contractual

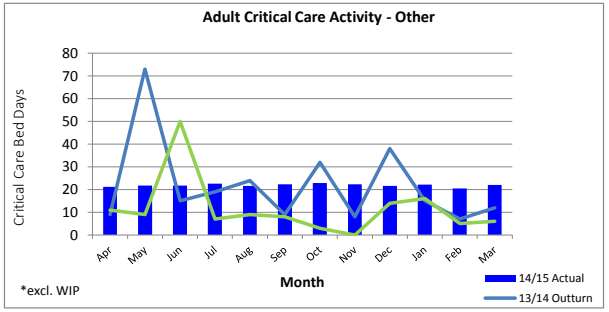


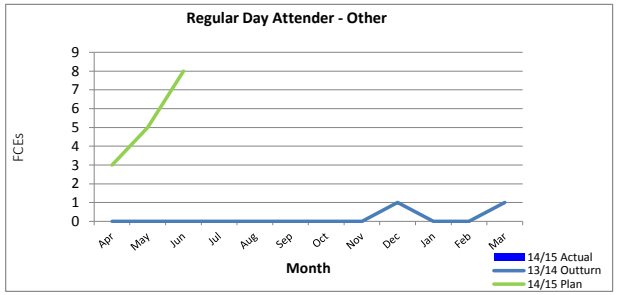




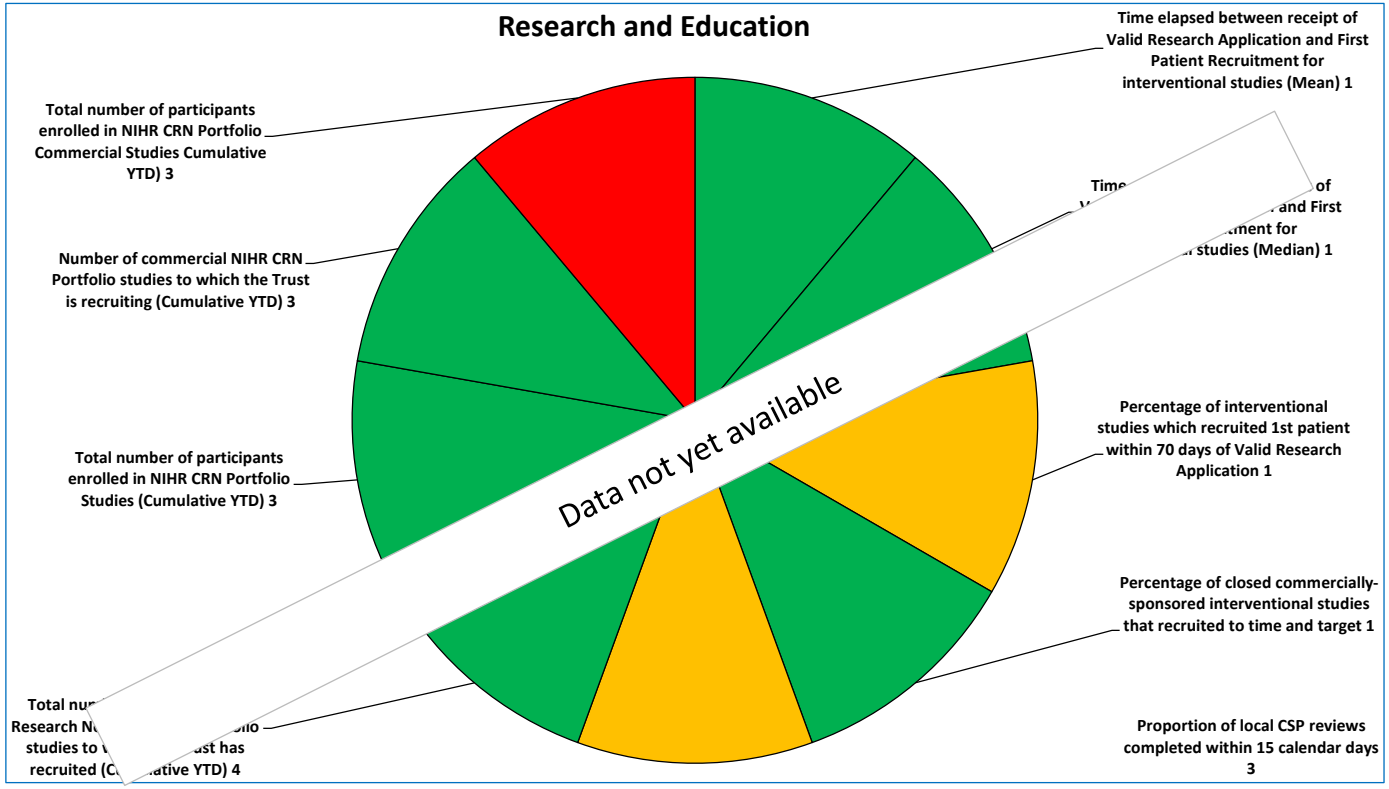






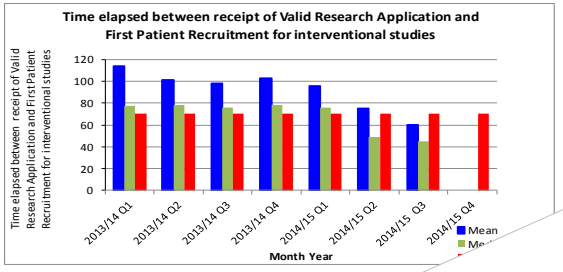


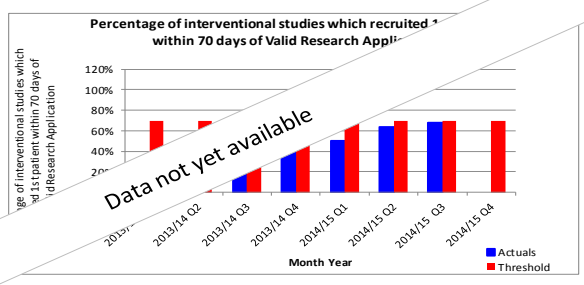
Please note : A small number of additional activity plans are in place for non-contracted activity, activity with devolved administrations, local authorites and overseas patients. These are shown here. A number of additional activitities (e.g. HASU bed days, Ward Attenders) are currently not shown.
.

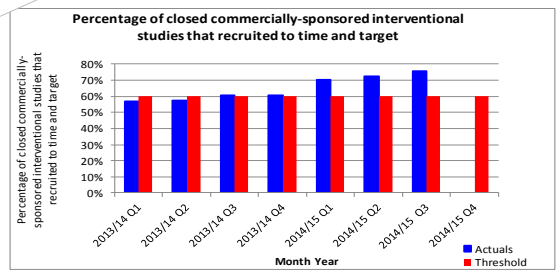

Research and Education
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (Mean) 1
Total number of participants enrolled in NIHR CRN Portfolio Commercial Studies Cumulative YTD) 3
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 1
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 1
Proportion of local CSP reviews completed within 15 calendar days 3
Data not yet available

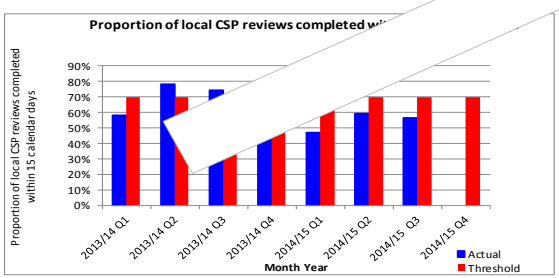
Indicator	Leading	Frequency	Threshold	Performance in 2013/14 Q3	Performance Current 2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	YTD	Forecast Qtr 1 15/16	Qtr 2 15/16	Qtr 3 15/16	Source Framework
Research & Development													
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Mean)** 1		Quarterly	<=70	98	95.7	76	60		231				Define
Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies **(Median)** 1		Quarterly	<=55	76	76.0	49	45		170				Define
Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application 2		Quarterly	>=70%	30%	50.6%	63.5%	67.5%		60.5%				Define
Percentage of closed commercially-sponsored interventional studies that recruited to time and target 1		Quarterly	>=60%	61%	70.4%	72.2%	75.5%		72.7%				Define
Proportion of local CSP reviews completed within 15 calendar days 3		Quarterly	>=70%	74%	47.1%	60.7%	56.5%		54.3%				Define
Total number of NIHR Clinical Research Network (CRN) Portfolio studies to which the Trust has recruited (Cumulative YTD) 4		Quarterly	>241	291	178	237	296		7				Define
Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD) 3		Quarterly	>6215	9211	2933	5929	8887						Define
Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting (Cumulative YTD) 3		Quarterly	>35	51	24	40	53						Define
Total number of participants enrolled in NIHR CRN Portfolio Commercial Studies Cumulative YTD) 3		Quarterly	>380	554	128	308	395.0						Define

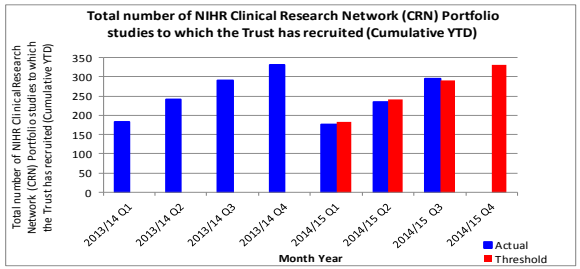
[1] Data source: ICHNT quarterly returns to NIHR CCF (Q3 data is provisional and subject to NIHR verification – Q3 return due to be submitted end of January 2015)
[2] Data source: Q2 14/15 Mean and median are verified and final figures from the NIHR CCF Q2 Report. Figure on percentage of studies that recruited in <70 days under KPI #2 is provisional and is being reviewed by NIHR
[3] Data source: NIHR Open Data Platform download for current YTD (13Jan2015)
[4] Data source: NIHR Open Data Platform www.odp.nihr.ac.uk/ Period analysed = Q1 (April to June); Q2 (April to September); Q3 (April to December) and Q4 (April to March) in each FY.

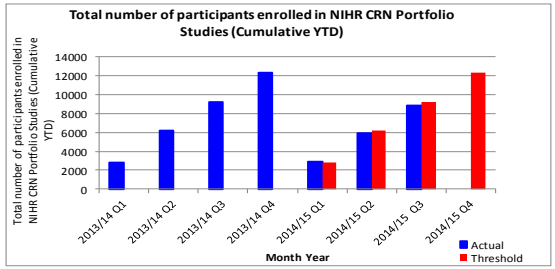


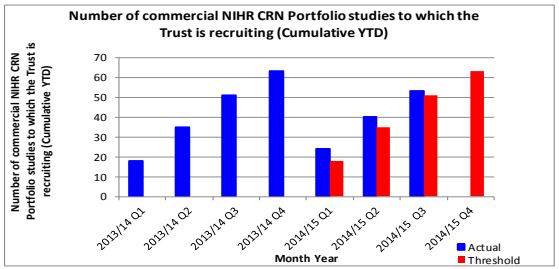


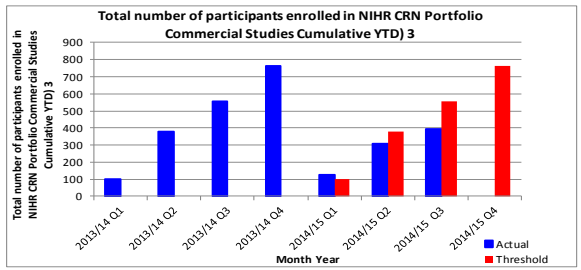












Domain	Sub-domain	Page number	Indicator title	Description	Rating
Summary	Finance	3	Capital Servicing Capacity	The Capital Servicing Capacity indicates the degree to which the organisation's generated income covers its financing obligations. A high rating indicates that the Trust has a low risk of defaulting.	Scored between 1-4: '4' – Low risk '3' – Emerging or residual financial '2' – Financial position may require '1' – as with '2' and may instigate
Summary	Finance	3	Liquidity ratio	The Liquidity ratio is based on a calculation of the Trust's available capital against outstanding debt. A high rating indicates that the Trust has a low risk of defaulting.	as with Capital Servicing Capacity
Summary	Access	3	18 weeks referral to treatment	Patients have a legal right to commence NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate to do so. The Trust's service-level waiting times can be compared to other Healthcare Providers across England.	Operational standards: Admitted ≥90% Non-admitted ≥95% Incomplete pathway ≥92%
Summary	Access	3	2 week wait from referral to date first seen all urgent referrals	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where cancer is suspected.	Operational standards: ≥93%
Summary	Access	3	2 week wait from referral to date first seen breast cancer	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where breast cancer is suspected.	Operational standard: ≥93%
Summary	Access	3	31 days standard from diagnosis to first treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat to the start of their treatment.	Operational standard: ≥96%
Summary	Access	3	31 days standard to subsequent cancer treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat to their subsequent treatment.	Operational standard: Drug-based ≥98% Radiotherapy ≥94% Surgery ≥94%
Summary	Access	3	62 day wait for first treatment from NHS Screening Services referral / GP referral	In cases where a patient has been referred for suspected cancer, and where cancer has subsequently been confirmed, patients have a right to commence NHS treatment within a maximum of 62 days from referral for suspected cancer.	Operational standard: NHS Screening Services ≥90% GP referral ≥85%
Summary	Access	3	A&E maximum waiting times 4 hours	Patients should be seen, treated, admitted, or discharged in under four hours of presenting at A&E. The national target is 95%.	Operational standard: ≥95%
Summary	Outcomes	3	Clostridium Difficile (C-Diff) Post 72 hours	Clostridium Difficile (C-Diff) is a type of infectious diarrhoea that can be difficult to treat due to antibiotic resistance. This rating indicates the number of cases of C-Diff infections within the Trust during the reporting period. A high number may be indicative of infection control issues, such as hand hygiene.	Threshold: 65 cases
Summary	Governance	3	CQC Judgements – warning notice issued, civil and / or criminal action initiated	In Foundation Trusts, Monitor can assign a red rating for governance concern based on CQC warning notices issued or Civil and/or criminal action initiated	n/a
Summary	Governance	3	Third party reports from e.g. GMC, Ombudsman, medical Royal Colleges etc – judgement based on severity and frequency of reports	In Foundation Trusts, Monitor can assign a red rating for governance concern based on ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports, Health & Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges etc. The judgement would be based on the severity and frequency of reports.	n/a
CQC	CQC	4	MRSA (latest CQC report)	This rating indicates the total number of incidences of MRSA within the Trust, as reported in the most recent CQC report.	Operational Standard: 0 incidences
CQC	CQC	4	Clostridium Difficile (latest CQC report)	This rating indicates the total number of incidences of C-Diff within the Trust, as reported in the most recent CQC report.	Operational Standard: 0 incidences

Quality	Safety	6	Hospital Standardised Mortality Rate (HSMR)	The HSMR is an indicator of healthcare quality that measures the number of deaths in the Trust, during the patients' stay at the Trust, and which is adjusted for a variety of factors (i.e. age, poverty, treatments offered). A score of 100 indicates that the number of deaths within the Trust is similar to what you would expect. A higher score means more deaths than expected, which may result from patient safety or clinical quality issues.	TBD
Quality	Safety	6	Summary Hospital Mortality Indicator	The SHMI is an indicator of healthcare quality that measures whether the number of deaths in the Trust, or within 30 days of the patient's discharge, is higher or lower than you would expect. A score of 100 indicates that the number of deaths within the Trust is similar to what you would expect. A higher score means more deaths than expected, which may result from patient safety or clinical quality issues.	TBD
Quality	Safety	6	Number of Dr Foster morality alerts	Dr Foster Mortality alerts are sent to the Chief Executive of the Trust when the HSMR has, on at least one occasion in the preceding three months, reached double the expected rate for a particular diagnosis or procedure. This rating indicates the total number of Mortality alerts that have been sent to the Chief Executive of the Trust and may require investigation of the safety and quality of clinical care provided.	TBD
Quality	Safety	6	Number of deaths in low risk diagnostic groups	This indicator aims to identify deaths that are likely to be attributable to health care errors by measuring deaths in patients admitted with, or for, a condition or procedure that has a low associated risk of death (i.e. headaches; tonsillectomy). This rating indicates the total number of deaths in low risk diagnostic groups during the reporting period.	TBD
Quality	Safety	7	MRSA	Methicillin-Resistant Staphyloccocus Aureus (MRSA) is a type of bacterial infection that is resistant to a number of widely used antibiotics. This rating indicates the total number of incidences of MRSA within the Trust during the reporting period.	Operational Standard: 0 incidences
Quality	Safety	7	Clostridium Difficile (C-Diff) Post 72 Hours	Clostridium Difficile (C-Diff) is a type of infectious diarrhoea that can be difficult to treat due to antibiotic resistance. This rating indicates the number of cases of C-Diff infections within the Trust during the reporting period. A high number may be indicative of infection control issues, such as hand hygiene.	Operational Standard: 66 incidences per annum
Quality	Safety	7	Never Events	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (i.e. wrong site surgery; wrong route administration of chemotherapy; retained instrument post-operation). The incidence of Never Events may indicate unsafe care. This rating indicates the number of Never Events that have occurred within the Trust during the reporting period.	Operational Standard: 0 incidences
Quality	Safety	7	Serious Untoward Incidents (SUI)	An SUI is a serious incident or event which led, or may have led, to the harm of patients or staff (i.e. Grade 3/4 pressure ulcer; data loss; HCAI outbreak; Never Events) This rating indicates the number of SUIs that have occurred within the Trust during the reporting period.	TBC
Quality	Safety	7	Harm Free Care (Safety Thermometer)	Delivering Harm Free Care is a core component of the care that we provided to our patients. Harm Free Care is care that is provided in the absence of the four common harms: Pressure Ulcers; Falls; Catheter Associated Urinary Tract Infections (CAUTIs); and Venous Thromboembolism (VTE). This rating indicates the percentage of patients that received Harm Free Care at the Trust. A decreasing trend may indicate issues with the quality and safety or care provided to patients.	Operational Standard: ≥90%
Quality	Safety	7	VTE Risk Assessments	A VTE (Venous Thromboembolism) is a blood clot that forms within a vein and is a serious, potentially fatal, medical condition. VTE Risk Assessments should be undertaken for every patient within 1 hour of admission. The rating indicates the percentage of patients that had a VTE risk assessment undertaken within 1 hour of admission.	Operational Standard: ≥95%
Quality	Patient Centredness	8	Inpatients Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's Inpatient services to their friends and family if they needed similar care or treatment. The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.	TBC
Quality	Patient Centredness	8	Inpatients Net Promoter Response Rate	It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas. The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.	Response rate: Total trust-level respondents, divided by total trust-level eligible patients
Quality	Patient Centredness	8	A&E Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's A&E services to their friends and family if they needed similar care or treatment. The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would.	TBC
Quality	Patient Centredness	8	A&E Net Promoter Response Rate	It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas. The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.	Response rate: Total trust-level respondents, divided by total trust-level eligible patients
Quality	Patient Centredness	8	Maternity Net Promoter Score (FFT)	This Friends and Family Test (FFT) asks patients whether they would recommend the Trust's Maternity services to their friends and family if they needed similar care or treatment. Women will be asked for their views on their maternity services at three touch points: antenatal care; birth and care on the postnatal ward; and postnatal community care.	TBC
Quality	Patient Centredness	8	Maternity Net Promoter Response Rate	The Net Promoter Score (NPS) ranges from -100 to 100. A score that is higher than 0 is generally 'good', whilst a score above 50 is considered 'excellent'. The score is calculated by deducting the proportion of respondents who would not recommend the Trust from the proportion of respondents who would. It is important to ensure a high Net Promoter Response Rate (NPRR). A low response rate may mean that the FFT data is not robust, whereas a high response rate is more likely to provide valuable data which can be analysed for potential service improvement ideas. The NPRR is the proportion of people that responded to the FFT of the total that were eligible to do so.	Response rate: Total trust-level respondents, divided by total trust-level eligible patients
Quality	Patient Centredness	8	Number of complaints received	When things do not go according to plan, a patient may decide to formally complain to the organisation. This will usually result in an investigation into the concerns raised and a formal response to the complainant. This rating indicates the total number of complaints received by the Trust within the reporting period. A high number of complaints, or an unexpected or prolonged rise in complaints, may warrant extra investigation into the matter.	
Quality	Patient Centredness	8	PLACE – Cleanliness; Facilities; Food; Privacy, Dignity, & Well being;	PLACE (Patient-led Assessments of the Care Environment) replaced the PEAT (Patient Environment Action Team) inspections in 2013. These are undertaken annual by teams, which include local people, to assess how the environment supports the patients' privacy and dignity, food, cleanliness, and general building maintenance. This rating indicates how the Trust fared for each of the separate areas (i.e. cleanliness, food). The higher the percentage, the better the score.	

Quality	Patient Centredness	8	(TC6) Involvement in care	"The most important goal of a modern health service is to achieve authentic patient participation. The lessons of the Francis inquiry into Stafford hospital are that the absence of patient participation is the root cause of poor care." - Tim Kelsey, Director, NHS-England. Engagement increases the likelihood of successful treatment, whilst also improving our patients' experience.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff have involved patients in the development of their treatment plans.	
Quality	Patient Centredness	8		Patients attending the Trust may require support in dealing with their worries and fears during their visit. Overcoming these obstacles is more likely to increase patient engagement with our services, whilst also improving their overall experience.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff provide sufficient support to patients to overcome their worries and fears.	
Quality	Patient Centredness	8	(LQ35a) Did you get enough help from staff to eat your meals?	Some people may require extra help to ensure that they receive adequate nutrition whilst in hospital. It is important that we identify these patients and support them appropriately, as eating and drinking well while in hospital can help our patients get better sooner and reduce the risk of complications.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff assisted our patients to eat their meals.	
Quality	Patient Centredness	8	(CLQ14) Do you think hospital staff did everything they could to help control your pain?	Good pain control can help to reduce risks and reduce the patient's length of stay in the hospital. If it is not well controlled, patients may, for example, not be able to breathe deeply or cough, increasing their risk of developing a chest infection; or they may not be able to walk or sit out in a chair, thereby increasing their risk of developing a deep vein thrombosis.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that our staff are suitably skilled to ensure that our patients were as comfortable, and pain free, as possible during their stay.	
Quality	Patient Centredness	8	(CLQ29) Did you have confidence and trust in the doctors treating you?	It is important that patients have confidence in our doctors, and that they feel that they can trust them. This provides an element of security for the patient and allows them to engage with the service, i.e. by making informed choices about their care.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that patients trust our doctors to treat them.	
Quality	Patient Centredness	8	(CLQ10) Did you have confidence and trust in the nurses treating you?	It is important that patients have confidence in our nurses, and that they feel that they can trust them. This provides an element of security for the patient and allows them to engage with the service, i.e. by making informed choices about their care.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that patients trust our nurses to treat them.	
Quality	Patient Centredness	8	(LQ36) Have you been treated with dignity and respect by staff on this ward?	It is important to ensure our patients are treated with dignity and respect, as evidence has shown a link between a failure to do so with a drop in both the patient experience and the quality of care that they experience.	
				This rating highlights the percentage of people that answered 'yes' to this question on the survey. The higher the score, the stronger the evidence that the organisation treats our patients with dignity and respect in a consistent manner.	
Quality	Patient Centredness	8	Safeguarding Adults : Referrals per month	The NHS has a key role to play in preventing all forms of harm, abuse and neglect, to our patients. Where abuse is suspected (whether physical, verbal, sexual, financial, or neglect), there is a duty to report this by raising a Safeguarding Alert. Safeguarding alerts generally regard external organisations (i.e. nursing homes; NHS providers).	
				This rating indicates the total number of safeguarding adults referrals were made in the previous month. A significant increase in the number of referrals may warrant further investigation and escalation to our commissioners, whilst a significant decrease may indicate underreporting of safeguarding concerns.	
Quality	Effectiveness	9	Stroke Care : % of patients scanned within 1 hr of arrival at hospital	Stroke is a preventable and treatable disease that affects approximately 110,000 people in England each year. A stroke occurs when the blood supply to part of the brain is cut off, which can be caused by a blockage within one of the vessels within the brain or a bleed in the brain. Early intervention is linked with better patient outcomes, including reduced morbidity and dependency.	Operational standard:
				This rating indicates the proportion of patients that had a brain scan within 1 hour of arrival at the hospital. A higher percentage means that we are ensuring that our patients are receiving the right diagnostic intervention at the right time.	≥50%
Quality	Effectiveness	9	Stroke Care : % of potentially eligible patients thrombolysed within 45 Minutes	Thrombolysis is the use of drugs to break up a blood clot. When given in a timely manner, this can significantly improve the outcome for patients, such as a decreased likelihood of complications.	Operational standard:
				This rating indicates the proportion of eligible patients that were treated with thrombolysing drugs within 45 minutes of arrival at the hospital.	≥80%

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

Quality	Timeliness	12	18 weeks referral to treatment	Patients have a legal right to commence NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate to do so. The Trust's service-level waiting times can be compared to other Healthcare Providers across England.	Operational standards: Admitted Non-admitted Incomplete pathway	 ≥90% ≥95% ≥92%
Quality	Timeliness	12	A&E maximum waiting times 4 hours	Patients should be seen, treated, admitted, or discharged in under four hours of presenting at A&E. The national target is 95%.	Operational standard: ≥95%	
Quality	Timeliness	12	Percentage Cancelled Operations rebooked within 28 days	Where a patient's surgery appointment has been cancelled by the hospital, they have a right to be provided a new appointment date that occurs within 28 days of the original operation. This rating indicates the percentage of cancelled operations that were rebooked to occur within 28 days of the original operation.	Operational standard: <5%	
Quality	Timeliness	12	Percentage Non Clinical Cancelled Operations	Surgical operations may be cancelled for both clinical and non-clinical reasons. The former relates to, for example, where a patient is too unwell to undergo surgery, thereas the latter might occur in instances whereby the theatre is required for an alternate emergency operation. Whilst some cancellations may be unavoidable, it is important to minimise these as it reduces the efficiency of Trust and may be distressing and inconvenient for patients. This rating provides a percentage of operations that were cancelled for non-clinical reasons.		
Quality	Timeliness	13	2 week wait from referral to date first seen all urgent referrals 2 week wait from referral to date first seen breast cancer	Patients have a right to be seen by a specialist within a maximum of 2 weeks from GP referral where cancer is suspected. These ratings indicate the percentage of patients that were seen within the 2 week target.	Operational standards: ≥93%	
Quality	Timeliness	13	31 days standard from diagnosis to first treatment 31 days standard to subsequent cancer treatment	In cases where cancer has been confirmed, patients should wait no more than 31 days from the decision to treat (either as initial or subsequent treatment) to the start of their treatment. This rating indicates the percentage of patients that were treated within 31 days of a cancer diagnosis, or within 31 days of deciding that subsequent treatment is required.	Drug-based Radiotherapy Surgery	≥98% ≥94% ≥94%
Quality	Timeliness	13	62 day wait for first treatment from NHS Screening Services referral / GP referral	In cases where a patient has been referred for suspected cancer, and where cancer has subsequently been confirmed, patients have a right to commence NHS treatment within a maximum of 62 days from referral for suspected cancer. This rating indicates the percentage of patients that were treated within 62 days of referral for suspected cancer.	NHS Screening Services GP referral	≥90% ≥85%
Quality	Equity	14	CQUIN – Dementia: Find & Assess; Investigate; & Refer	Dementia is a common condition that affects about 800,000 people in the UK. The risk of developing dementia increases as you get older, and usually occurs in people over the age of 65. Most types of dementia cannot be cured, but its progression can be slowed down it detected early. Therefore, it is important to assess patients at risk of developing patients for signs of dementia, as well as undertaking investigations and referring patients to memory specialists if appropriate. This indicator is a combination of three ratings. The first indicator highlights the percentage of eligible patients that were risk assessed. The second highlights the percentage of appropriate patients that underwent further investigation, with the third being the percentage of appropriate patients that were referred onto specialist services.	TBC	
Quality	Equity	14	Mixed Sex Accommodation	Being in mixed-sex hospital accommodation can be difficult for some patients for a variety of personal and cultural reasons. Therefore, all providers of NHS-funded care are expected to eliminate mixed-sex accommodation (except where it is in the overall best interest of the patient or reflects their personal choice). Hospitals can face a fine of up to £250 for breaching same-sex accommodation guidance. This rating highlights the total number of times that the same-sex accommodation guidance was breached during the reporting period.	TBC	
Quality	Equity	14	Safeguarding Training - Adults; Children (levels 1 - 3)	Everyone has a responsibility for safeguarding vulnerable people, whether children or adults. Safeguarding is the protection of our patients from maltreatment, such as neglect; emotional, physical, sexual, discriminatory, institutional or financial abuse. Our responsibilities include training our staff to ensure that they are competent to identify, and then act on, safeguarding concerns. This rating indicates the percentage of staff that have attended their Safeguarding training within the last 3 years.	TBC	
Quality	Equity	14	Female Genital Mutilation Caseload	The total number of patients identified as having FGM before the Reporting Period Start Date, who are actively being treated on the Trust active caseload	TBC	
Quality	Equity	14	Patients detained under the Mental Health Act	The number of patients detained under the Mental Health Act 1983 in month	TBC	

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

Finance	Finance	20	Liquidity ratio	The Liquidity ratio is based on a calculation of the Trust's available capital against outstanding debt. A high rating indicates that the Trust has a low risk of defaulting.	TBC
Finance	Finance	20	Capital Servicing Capacity	The Capital Servicing Capacity indicates the degree to which the organisation's generated income covers its financing obligations. A high rating indicates that the Trust has a low risk of defaulting.	TBC
Finance	Finance	21 - 24	Daycase	Daycases are elective surgeries that do not usually require a patient to be admitted to hospital (i.e. have an overnight stay). Elective surgeries are scheduled (i.e. a mastectomy or inguinal hernia repair). This rating denotes the total number of daycase surgeries that were undertaken during the reporting period.	TBC
Finance	Finance	21 - 24	Elective Inpatients	Elective inpatients includes all patients that were admitted to hospital (i.e. had an overnight stay) for a scheduled surgical procedure (i.e. a mastectomy or inguinal hernia repair). This rating denotes the total number of elective inpatients during the reporting period.	TBC
Finance	Finance	21 - 24	Non Elective Inpatients	Non-elective inpatients includes all patients that were admitted to hospital (i.e. had an overnight stay) for emergency medical intervention (i.e. an injury or illness that is actue and poses an immediate risk to a person's life or long term health). This rating denotes the total number of non-elective inpatients during the reporting period.	TBC
Finance	Finance	21 - 24	First Outpatient	First outpatient appointment are primarily for the patient to discuss their concerns with an appropriate clinician and to coordinate their future care plan with the clinician (including which diagnostic tests to undertake, or which medical intervention is required). This rating denotes the total number of first outpatient appointments that took place during the reporting period.	TBC
Finance	Finance	21 - 24	Follow-up Outpatient	Follow up outpatient appointment are primarily for the patient to discuss any new concerns with a clinician, to discuss any investigations that may have been undertaken, and, if appropriate, to agree an appropriate treatment plan. This rating denotes the total number of follow up outpatient appointments that took place during the reporting period.	TBC
Finance	Finance	21 - 24	Adult Critical Care	Adult critical care encompasses patients that require high dependency or intensive care following, for example, surgical interventions or serious illnesses or traumatic injuries. In the UK, it costs around £1,328 per bed, per day, for an adult intensive care unit. This rating denotes the total number of adult patients that required critical care during the reporting period.	TBC
Finance	Finance	21 - 24	A&E Attendances	There are over 21 million attendances at A&E (Accident & Emergency) departments in England each year. A&E departments assess and treat patients with serious injuries or illnesses (i.e. loss of consciousness; chest pain; severe bleeding that cannot be stopped). This rating denotes the total number of A&E attendances in the Trust during the reporting period.	TBC
Research & Education	Research & Education	26	Time elapsed between receipt of Valid Research Application and First Patient Recruitment for interventional studies (mean)	Research is a major priority at Imperial College Healthcare NHS Trust. Medical research is essential for developing new and improved medical treatments to improve the health of both adults and children. It is, therefore, important that research is undertaken in a timely manner after research applications have been approved. There are two ratings associated with this indicator - the mean and median. The mean provides the average length of time elapsed between receipt of a valid research application and the first patient recruitment, whilst the median provides the 'middle number' in a list of these times. The median indicator are used to ensure that anomalous results have not significantly affected the average (i.e. skewing it).	TBC
Research & Education	Research & Education	26	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	This indicator is identical to the above, although the rating indicates the percentage of studies which recruited their first patient within 70 days of a Valid research application.	TBC
Research & Education	Research & Education	26	Percentage of closed commercially-sponsored interventional studies that recruited to time and to target	Imperial College Healthcare NHS Trust works closely with commercial enterprises, such as pharmaceutical companies, in the undertaking of medical research to develop and improve new treatments. It is, therefore, important that research is undertaken in a timely manner after applications have been approved, in accordance with bespoke targets to the research item involved. This rating provides a percentage of commercially-sponsored interventional studies that recruited to time and to target.	TBC
Research & Education	Research & Education	26	Percentage of local R&D reviews for NIHR CRN Portfolio studies given within 30 days	Local R&D review is a measure of the time taken by the Trust to give approval for clinical research studies to take place at any of our sites. This is a legal requirement, which aims to ensure that all studies taking place at ICHT are appropriately resourced and meet our own standards and policies. However, it is also important to ensure this process is completed in a reasonable timescale, to allow study sponsors to set up studies as quickly as possible and for patients to enter these studies. The NIHR Clinical Research Network Portfolio is a major	TBC
Research & Education	Research & Education	26	Total number of NIHR Clinical Research Network (CRN) portfolio studies to which the	The NIHR Clinical Research Network Portfolio is an important subset of all the clinical research studies undertaken at ICHT, these having been reviewed nationally for scientific quality and applicability to the NHS. It is our strategic aim, and that of the NIHR, to grow the number of studies being carried out at ICHT year on year, enabling more of our patients to take part in research. This indicator aims to demonstrate that growth.	TBC
Research & Education	Research & Education	26	Total number of participants enrolled in NIHR CRN Portfolio Studies (Cumulative YTD)	The NIHR Clinical Research Network Portfolio is an important subset of all the clinical research studies undertaken at ICHT, these having been reviewed nationally for scientific quality and applicability to the NHS. It is our strategic aim, and that of the NIHR, to enable more of our patients to participate in research. This indicator aims to demonstrate that growth.	TBC
Research & Education	Research & Education	26	Number of commercial NIHR CRN Portfolio studies to which the Trust is recruiting	Commercially-sponsored / funded clinical research is an important part of our overall R&D strategy, and that of the NIHR. It is important for the UK to be competitive on the global stage in attracting commercial investment in clinical research. Growing the number of commercial studies at ICHT is an important indicator of our ability to do this.	TBC
Research & Education	Research & Education	26	Total number of participants enrolled in NIHR CRN Portfolio Studies	Commercially-sponsored / funded clinical research is an important part of our overall R&D strategy, and that of the NIHR. It is important for the UK to be competitive on the global stage in attracting commercial investment in clinical research. Enabling more of our patients to take part in commercially-sponsored studies at ICHT is an important indicator of our ability to do this.	TBC

Appendix 1

April 2015

Monthly planned Nursing/Midwife staffing hours versus Nursing/Midwife staffing hours actually worked

			Day						Night					
			Registered Nurses/Midwives			Care Staff			Registered Nurses/Midwives			Care Staff		
Division	Hospital Site Name	Ward Name	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled	Total Monthly Planned Staff Hours	Total Monthly Actual Staff Hours	% Filled
Medicine	Charing Cross Hospital - RYJ02	10 North Ward	1773.00	1713.00	96.62%	345.00	345.00	100.00%	885.50	862.50	97.40%	368.00	368.00	100.00%
Medicine	Charing Cross Hospital - RYJ02	11 South Ward	2733.50	2530.00	92.56%	460.00	409.00	88.91%	2242.50	2185.00	97.44%	483.00	471.50	97.62%
Medicine	Charing Cross Hospital - RYJ02	4 South Ward	1630.00	1478.00	90.67%	1058.00	1000.50	94.57%	1081.00	1035.00	95.74%	736.00	701.50	95.31%
Medicine	Charing Cross Hospital - RYJ02	5 South Ward	1790.00	1790.00	100.00%	0.00	0.00	100.00%	1713.50	1702.00	99.33%	46.00	46.00	100.00%
Medicine	Charing Cross Hospital - RYJ02	5 West Ward	2598.00	2572.00	99.00%	759.00	678.50	89.39%	2242.50	2196.50	97.95%	747.50	712.00	95.25%
Medicine	Charing Cross Hospital - RYJ02	8 South Ward	2093.50	1945.93	92.95%	1688.25	1634.25	96.80%	1297.83	1263.33	97.34%	1368.50	1368.50	100.00%
Medicine	Charing Cross Hospital - RYJ02	8 West Ward	1473.00	1424.00	96.67%	1407.50	1355.00	96.27%	1115.50	1115.50	100.00%	1053.50	1051.00	99.76%
Medicine	Charing Cross Hospital - RYJ02	9 North Ward	2616.00	2309.50	88.28%	1069.50	1033.00	96.59%	2070.00	2012.50	97.22%	619.50	619.50	100.00%
Medicine	Charing Cross Hospital - RYJ02	9 South Ward	2056.92	1919.09	93.30%	1023.50	943.00	92.13%	1274.00	1239.50	97.29%	1196.00	1196.00	100.00%
Medicine	Charing Cross Hospital - RYJ02	9 West Ward	1380.00	1366.00	98.99%	805.00	776.00	96.40%	690.00	690.00	100.00%	943.00	931.50	98.78%
Medicine	St Mary's Hospital (HQ) - RYJ01	Almroth Wright Ward	1810.50	1706.00	94.23%	733.75	699.25	95.30%	1380.00	1345.00	97.46%	414.00	391.00	94.44%
Medicine	St Mary's Hospital (HQ) - RYJ01	AMU	1379.00	1287.25	93.35%	586.00	514.50	87.80%	1085.00	1085.00	100.00%	471.50	448.50	95.12%
Medicine	Hammersmith Hospital - RYJ03	C8 Ward	1890.50	1775.75	93.93%	690.00	677.50	98.19%	1759.50	1679.00	95.42%	690.00	654.25	94.82%
Medicine	Hammersmith Hospital - RYJ03	Christopher Booth Ward	2048.25	1932.00	94.32%	864.00	773.50	89.53%	1058.00	1035.00	97.83%	517.50	517.50	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Douglas Ward SR	2087.50	1985.00	95.09%	0.00	0.00	100.00%	1846.00	1765.50	95.64%	11.50	11.50	100.00%
Medicine	Hammersmith Hospital - RYJ03	Dewardener Ward	1440.00	1385.50	96.22%	0.00	0.00	100.00%	1380.00	1322.50	95.83%	0.00	0.00	100.00%
Medicine	Hammersmith Hospital - RYJ03	Fraser Gamble Ward	1354.00	1314.50	97.08%	1158.50	1135.50	98.01%	1035.00	1012.00	97.78%	701.50	667.00	95.08%
Medicine	St Mary's Hospital (HQ) - RYJ01	Grafton Ward	1151.00	1106.00	96.09%	775.50	760.00	98.00%	1035.00	1012.00	97.78%	414.00	414.00	100.00%
Medicine	Hammersmith Hospital - RYJ03	Handfield Jones Ward	1398.50	1248.75	89.29%	806.00	755.76	93.77%	1035.00	1023.50	98.89%	460.00	458.00	99.57%
Medicine	Hammersmith Hospital - RYJ03	John Humphrey Ward	1390.00	1314.00	94.53%	841.50	720.00	85.56%	690.00	690.00	100.00%	805.00	805.00	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Joseph Toynbee Ward	1225.50	1194.00	97.43%	445.00	330.00	74.16%	1150.00	1058.00	92.00%	460.00	437.00	95.00%
Medicine	Hammersmith Hospital - RYJ03	Kerr Ward	1635.50	1514.00	92.57%	939.50	810.50	86.27%	1149.00	1126.00	98.00%	805.00	690.00	85.71%
Medicine	Charing Cross Hospital - RYJ02	Lady Skinner Ward	1162.50	1146.00	98.58%	347.50	347.50	100.00%	690.00	678.50	98.33%	759.00	759.00	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Manvers Ward	1460.50	1414.50	96.85%	759.00	724.50	95.45%	1472.00	1437.50	97.66%	770.50	747.50	97.01%
Medicine	Hammersmith Hospital - RYJ03	Peters Ward	1244.00	1135.00	91.24%	800.50	759.00	94.82%	690.00	675.50	97.90%	414.00	414.00	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Lewis Lloyd	1232.00	1174.50	95.33%	828.00	736.00	88.89%	746.25	734.75	98.46%	851.00	830.00	97.53%
Medicine	St Mary's Hospital (HQ) - RYJ01	Samuel Lane Ward	1501.00	1437.00	95.74%	770.50	736.00	95.52%	1092.50	1069.50	97.89%	655.50	655.50	100.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Thistlewaite Ward	1537.62	1505.12	97.89%	713.00	701.50	98.39%	1058.00	1058.00	100.00%	575.00	552.00	96.00%
Medicine	St Mary's Hospital (HQ) - RYJ01	Witherow Ward	1200.50	1128.00	93.96%	1007.58	858.08	85.16%	805.00	782.00	97.14%	1322.50	1299.50	98.26%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	10 South Ward	2235.00	2045.25	91.51%	752.00	736.50	97.94%	1391.50	1380.00	99.17%	34.50	34.50	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	6 North Ward	2172.50	2043.00	94.04%	713.25	610.50	85.59%	1092.50	1023.50	93.68%	770.50	747.50	97.01%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	6 South Ward	1403.00	1327.00	94.58%	717.00	687.50	95.89%	989.00	977.50	98.84%	195.50	161.00	82.35%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	7 North Ward	1927.50	1790.50	92.89%	713.00	701.25	98.35%	1380.00	1380.00	100.00%	725.00	712.50	98.28%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	7 South Ward	1958.50	1831.30	93.51%	832.00	729.50	87.68%	1012.00	988.83	97.71%	345.00	331.92	96.21%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A6 CICU	3331.50	3284.25	98.58%	375.50	281.00	74.83%	3016.00	3016.00	100.00%	207.00	115.00	55.56%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A7 Ward & CCU	2094.50	2019.00	96.40%	563.50	416.00	73.82%	1725.00	1669.25	96.77%	425.50	414.00	97.30%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A8 Ward	1678.42	1549.67	92.33%	716.00	692.00	96.65%	1184.50	1127.00	95.15%	92.00	80.50	87.50%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	A9 Ward	1380.00	1345.50	97.50%	391.00	391.00	100.00%	1035.00	1012.00	97.78%	345.00	345.00	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Albert Ward	1873.50	1699.00	90.69%	1035.00	1004.00	97.00%	1069.50	1023.50	95.70%	1035.00	1012.00	97.78%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Charles Pannett Ward	2478.00	2352.00	94.92%	777.50	701.50	90.23%	1897.50	1828.50	96.36%	759.00	759.00	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	D7 Ward	1382.00	1382.00	100.00%	264.00	260.58	98.70%	715.00	715.00	100.00%	275.00	275.00	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Dacie Ward	1669.00	1631.00	97.72%	328.50	279.50	85.08%	1034.00	1003.00	97.00%	132.00	132.00	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	Intensive Care CXH	5060.00	4858.25	96.01%	1280.20	1203.70	94.02%	5017.00	4870.25	97.07%	747.50	747.50	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Intensive care HH	4726.50	4677.50	98.96%	782.00	747.50	95.59%	4830.00	4798.95	99.36%	253.00	253.00	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Intensive Care SMH	5077.25	5020.43	98.88%	1299.50	1299.50	100.00%	5129.00	5098.50	99.41%	1035.00	1023.50	98.89%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Major Trauma Ward	1871.00	1816.00	97.06%	438.00	426.50	97.37%	1528.17	1505.17	98.50%	402.50	402.50	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Patterson Ward	1365.50	1307.00	95.72%	462.50	378.75	81.89%	690.00	690.00	100.00%	356.50	356.50	100.00%
Surgery and Cancer/Clinical Haem	Charing Cross Hospital - RYJ02	Riverside	2585.00	2330.00	90.14%	1441.50	1239.00	85.95%	1391.50	1311.00	94.21%	609.50	609.50	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Valentine Ellis Ward	2303.75	2257.25	97.98%	781.00	701.50	89.82%	1528.50	1436.50	93.98%	401.50	401.50	100.00%
Surgery and Cancer/Clinical Haem	Hammersmith Hospital - RYJ03	Weston Ward	1365.00	1348.00	98.75%	252.00	252.00	100.00%	979.00	936.00	95.61%	0.00	11.00	100.00%
Surgery and Cancer/Clinical Haem	St Mary's Hospital (HQ) - RYJ01	Zachary Cope Ward	2765.50	2687.50	97.18%	687.50	653.00	94.98%	2402.50	2379.50	99.04%	690.00	657.50	95.29%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Aleck Bourne 2 Ward	4421.75	4195.48	94.88%	1241.50	1017.50	81.96%	3795.00	3633.20	95.74%	1437.50	1310.08	91.14%
Women and Children's	Queen Charlotte's Hospital - RYJ04	Birth Centre QCCH	1040.00	1040.00	100.00%	149.50	149.50	100.00%	713.00	713.00	100.00%	299.00	299.00	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Birth Centre SMH	1035.00	1000.50	96.67%	11.50	11.50	100.00%	701.50	701.50	100.00%	333.50	333.50	100.00%
Women and Children's	Queen Charlotte's Hospital - RYJ04	Edith Dare Postnatal Ward	2173.75	2101.00	96.65%	1282.00	1190.00	92.82%	1770.00	1712.50	96.75%	690.00	678.50	98.33%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	GRAND UNION WARD	1816.00	1816.00	100.00%	0.00	0.00	100.00%	1736.50	1736.50	100.00%	0.00	0.00	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	GREAT WESTERN WD	2230.00	2197.00	98.52%	310.50	310.50	100.00%	1817.00	1815.00	99.89%	345.00	333.50	96.67%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	Lillian Holland Ward	1121.45	992.45	88.50%	561.00	561.00	100.00%	690.00	678.50	98.33%	322.00	321.00	99.69%
Women and Children's	Queen Charlotte's Hospital - RYJ04	Neo Natal	4202.01	3831.50	91.18%	185.00	185.00	100.00%	3828.80	3783.50	98.82%	80.50	80.50	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	NICU	2012.50	1931.50	95.98%	368.00	368.00	100.00%	2139.00	2070.00	96.77%	253.00	253.00	100.00%
Women and Children's	St Mary's Hospital (HQ) - RYJ01	PICU	3126.50	2878.50	92.07%	0.00	0.00	100.00%	3134.58	2883.58	91.99%	0.00	0.00	100.00%
Women and Children's	Queen Charlotte's Hospital - RYJ04	QCCH labour	4250.25	4190.51	98.59%	828.75	749.00	90.38%	3957.58	3867.50	97.72%	690.00	690.00	100.00%
Women and Children's	Hammersmith Hospital - RYJ03	Victor Bonney Ward	1797.50	1598.58	88.93%	540.50	501.92	92.86%	897.00	885.50	98.72%	299.00	287.50	96.15%

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	2.4
Title	Finance report: annual plan submission 2015/16, out turn and April performance and QIA of cost improvement
Report for	Noting
Report Author	Alan Goldsman, Chief financial officer
Responsible Executive Director	Alan Goldsman, Chief financial officer

Executive Summary

The Annual Plan was approved by the Board at its meeting on 13th May 2015 for submission to the NHS Trust Development Authority (TDA). The purpose of this paper is to provide a summary of the plan and Board discussion in the public domain at the earliest opportunity.

The paper also provides a brief update on the 2014/15 out turn and April 2015 performance.

Finally, it provides a summary of the quality impact assessments undertaken on the cost improvement plans across the Trust, which were discussed at the Quality Committee.

Recommendations to the Trust board

The Trust board is asked to note this paper.

Trust strategic objectives supported by this paper:

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

1) Summary of the Annual Plan 2015/16

The approved plan shows deficit of £18.5m: an improvement of £49m (6.2%). This is built up from an efficiency programme (£36.8m - 4.7%), improvements to contract and release of contingencies built into the original assumptions.

The plan differs from the draft plan submitted to TDA on 7th April, which showed a deficit of £15.5m; requiring efficiency savings of £52m – 6.6% of influenceable spend and considered to be the maximum realistically achievable.

The cash position shows that this deficit can be sustained for one year only with a closing cash balance of approximately £37m and Continuity of Service Risk Rating above 2 and close to 3 (of 4). A limited capital programme of £47m has been factored into these assumptions with contributions from both NHS and Charity sources.

2) Efficiency programme

The efficiency programme breaks down to each Division as follows:

- Medicine - £8.8m (4.5%) – meets target set
- Surgery - £9.8m (5%) – exceeds target by £1.3m
- Women and Children - £4.2m (4.5%) – meets target
- Investigative sciences - £3.5m (2.7%) - £2m short of target
- Private Care - £1.2m – meets target (mostly within divisions above)
- Corporate Services - £8.6m (6.1%) – exceeds target set by £2.3m

All of the efficiency schemes are registered on the Trusts 'StratPro' system with detailed project plans backing these up. Budget letters covering expenditure / staff / activity have been signed and committed to by all Directors and a performance management model is to be implemented for activity variation.

3) NHS Contracts

Contracts are not yet signed with NHS commissioners but, for the most part, contract heads of agreement are in place that support the assumptions contained in the plan.

3.1) CCGs

A cost and volume contract has been agreed with an additional funding of £2m to support the continuation of the clinical transformation office, and £2.7m for renal patient transport.

There is a significant QIPP (£14m) and discussions are outstanding for CQUIN and RTT activity.

3.2) NHS England

The NHS England remains a cost and volume contract with discussions on CQUIN also outstanding. The QIPP is £6.5m of which £3.5m is for 'patient access schemes' but not otherwise described.

4) Capital programme

The capital programme is funded as follows:

- Depreciation - £32m
- Charity - £6m
- Ealing services transfer - £1.7m (awaiting confirmation)
- Cash reserves – £7.3m

This funding provides for:

- Backlog maintenance - £14.2m - risks rated above 16
- ICT - £6.5m

- Equipment - £8.2m
- Charity schemes - £6m - Hammersmith (£1m); Patient Services Centre (£4m) PICU (£1m)
- Invest to save - £4m – Riverside Theatres (£3m); NWL Pathology (£1m)
- Contingency and roll over - £2.5m
- Master Planning and application SMH - £2.1m
- Other various - £3.5m – includes Ealing

The Trusts Finance and Investment Committee will function on this programme in detail at its July meeting.

5) Risk and mitigation

The Trust Board considered a range of risks to the plan and potential mitigation of these:

- The efficiency programme is challenging and therefore each scheme has developed mitigation strategies. The on-going work being developed by the Medical Director and Chief Operating Officer provides further opportunities to both add to the plan and re-shape a new programme going into 2016 / 17.
- Performance on challenging and high risk contract metrics carries both risk (of fines) and reward (payment for additional activity) – most notably for A&E and RTT. Close and frequent performance management remains in place.
- 'Getting to Good' under the CQC inspection regime is critical and investments have been made across the board in ensuring this can be achieved; including from Trust and CCGs funding for clinical transformation.
- An extremely tight capital programme delivers absolute minimum requirement. This contains some limited contingency for emergency requirements.
- The NHS Tariff for specialised services under the Default Tariff Rollover is acknowledged as not fit for purpose. Shelford and Diamond Trusts will be actively engaging with Monitor over the summer and the Trust will be taking an active role using its Patient Level Information and Costing data and other evidence to support this.

6) Out-turn and April performance

The plan has been assessed in the light of financial performance in 2014 / 15 and for April 2015 (month 1).

The year-end position shows a surplus of £15.4m, a favourable variance to plan of £4.2m. This includes Project Diamond income of £24.4m, without which a deficit position was likely. This underlying position has been factored into the planning assumptions and no further changes were required.

An early view of the position for April shows that the Trust was operating within its approved and funded staffing establishment. This was backed up by an analysis of the bank and agency staff booking systems. There was limited information on activity and performance but under reasonable assumptions it was concluded that the plan for 2015 / 16 was functioning properly in the first month.

7) Discussion

The Trust board considered that the plan was cohesive and provided a rationale as to the submission of a deficit budget. The following were the key points of discussion, in response to non-executive challenge:

- Opportunities would be explored for ensuring that cost-saving departments benefited directly from their achievements; this would require improvements in allocating savings to directorates
- It was acknowledged that the capital programme was very tight, but it was considered deliverable
- Focus on delivery of the plan was now essential; income was very dependent on delivery of planned activity

- The full-year effect of all schemes would be assessed, as this would provide the starting point for the CIP for 2016/17.

8) Conclusion

The scale of the task was not to be under-estimated and it was essential that sufficient resources were dedicated to delivery, and that sufficient and appropriate support was put in place. It was noted that the Trust needed to consider what it would do should the plan show early signs of not delivering. Given that the future years were planned around the need for transformation, it may be necessary to bring forward specific elements from the 2016/17 plan if other aspects of the earlier scheme do not result in the savings envisaged.

9) Quarterly update on the quality impact assessments (QIA) for Trust cost improvement programmes (CIP)

During March, the Medical Director and Director of Nursing met with all four divisions and corporate areas to review the QIAs for 2015/16 CIP schemes. Over 50 QIAs were discussed. Currently, there are no schemes that have a QIA risk score above 12, where risk has been identified, mitigating actions are in place. A summary outlining CIP schemes with a QIA risk score of 9 and above are outlined in below.

At the meetings no schemes were recommended for withdrawal based on an assessment of the QIA although a calibration of some of the risk scores was discussed where these were perceived to be either too high or too low.

The final 2015/16 budgets had not been signed off at the time of the meetings.

Of the 2015/16 schemes and QIAs discussed in March 2014, many of the proposed schemes were income generation. In essence they are about increasing activity within the same capacity and resources. Although no significant risk has been identified to date, these schemes will be closely monitored through the quarterly CIP QIA meetings.

It has been recognised that there are several ‘cross cutting’ schemes and in order to understand the organisation wide impact of these, QIAs are currently being developed through the QuEst team and will be reviewed in May 2015.

The next set of regular quarterly meetings will take place in June 2015.

The Director of Quality, Nursing and Patient Safety (Central, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs) wrote to the Medical Director in February and subsequently in March, requesting information about the Trust’s QIA process for CIPs, which has been responded to; the correspondence was made available to the Quality Committee.

Summary of 2015/16 CIP schemes with a QIA risk score of 9 and above

Division/Corporate Area	Scheme	QIA Risk Score	Net Financial Value (£’0000)
Investigative Sciences and Clinical Support	DISCS-1516-OUT-003 Synertec Printing Services (OPD letters)	9	20
	DISCS-1516-THE-009 Theatres rationalisation	9	200
Medicine	1415CORP001 Implement HARS reporting solution	9	25

Division/Corporate Area	Scheme	QIA Risk Score	Net Financial Value (£'0000)
	1516MEDD004 Development of a GUM EPR	9	-50
	SPM1516 – lung Market Share Increase in NWL Lung Cancer Provision	9	1000
Surgery	1516002 Plastic surgery PP income	9	244
	1415SGCN001 Depth of Coding - Upper GI	9	75
	1516POEM03 Review of existent SLAs	9	30
	1516poem11 Hips - Trauma standardisation prosthesis	9	31
	1516POEM12 knee trauma prosthesis standardisation	9	31
	1516POEM14 Limb Fitting Orthotics and Prosthetics	9	104
	1516POEM15 Spinal instrumentation standardisation	9	111
	CCH1516005 Blood product expenditure	12	200
	POEM1516001 audiology - high cost agency technical staff	9	7
Women's and Children's	1516WACD016 Private Midwifery Packages	9	359
	1516WACD003 Transforming Outpatients Gynaecology	9	66
	1516WACD005 Agreed market share increases	9	246

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.1
Title	Proposal for co-location of stroke services
Report for	Decision
Report Author	Prof. Tim Orchard, Divisional Director, Medicine
Responsible Executive Director	Steve McManus, Chief Operating Officer

Executive Summary

Currently, Imperial College Healthcare NHS Trust provides two stroke units – at Charing Cross Hospital in Hammersmith and St Mary's Hospital in Paddington - as well as a hyper acute stroke unit (HASU) at Charing Cross Hospital.

There is a strong clinical consensus within the Trust that providing our stroke services across two hospital sites is not sustainable in terms of quality or efficiency. We believe there are significant benefits in creating a fully integrated service on one site in terms of seven-day access to senior specialist clinicians, therapists and MRI scanning services.

The stroke unit at St Mary's Hospital, caring for around 180 patients per year, is based in the Grafton Ward which features old and outdated facilities. There is no prospect of significantly improving these facilities in advance of the planned major redevelopment of the St Mary's estate which is at least five years away. There is an opportunity to re-provide this service in larger, modern facilities at Charing Cross Hospital in the interim.

St Mary's Hospital is a major acute hospital for the region, with the designated major trauma centre for north west London. Given the important connections between Accident and Emergency (A&E), major trauma and the HASU, our longer term plan is for all stroke services to be co-located on a re-developed St Mary's site.

This proposal is about raising the overall quality of care available to stroke patients, their families and carers through the co-location of the Trust's stroke services on one site. The total number of inpatient beds and stroke service staff would remain unchanged.

The main reasons underlying the proposal to change our current stroke services are to:

- Provide the best outcomes and experience for patients, their families and carers
- Improve access to therapy services
- Provide 7-day, 24-hour consultant cover for all our patients, in line with best practice guidelines set out by the Royal College of Physicians
- Co-locate stroke and neurosurgical services
- Provide 24 hour availability of MRI scanning service
- Reduce the average length of stay for all stroke patients
- Have the best trained stroke specialist teams.

Imperial College Healthcare NHS
NHS Trust

Recommendation to the Board

The Board is asked to approve that engagement and communications on the proposed stroke service co-location proceeds followed by a further report for consideration by the Board on the outcomes of this process.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Proposal for co-location of stroke services

Purpose of the report

This proposal is about raising the overall quality of care available to stroke patients, their families and carers through the co-location of the Trust's stroke services on one site.

Currently, Imperial College Healthcare NHS Trust provides two stroke units – at Charing Cross Hospital in Hammersmith and St Mary's Hospital in Paddington - as well as a hyper acute stroke unit (HASU) at Charing Cross Hospital.

There is a growing clinical impetus for moving the St Mary's Hospital stroke unit to Charing Cross Hospital to enable us to create a fully integrated service on one site as soon as possible. This is supported by the clinical stroke lead clinician for London and the NHS.

The proposed move would be an interim measure for approximately five years until the stroke service could be permanently centralised in new facilities at St Mary's Hospital as set out in the Trust's clinical strategy published in July 2014 and as agreed as part of the London-wide improvement of stroke services agreed in 2008.

The Trust Board is asked to approve proceeding with a process of engagement on the proposal. Once timelines are agreed, the engagement with staff directly affected by the proposed change would run concurrently with the public engagement.

Background

In 2008, as part of the London-wide improvement of stroke services, the Trust successfully bid to run a HASU as well as two stroke units.

Subsequently, the HASU opened at Charing Cross Hospital in December 2009. The public consultation that informed the London stroke services improvement project showed a preference for co-locating HASUs on the same site as major trauma centres, as they need similar back-up and support. The longer term agreement was therefore to move the HASU to St Mary's Hospital, which runs the major trauma centre for north west London, as part of the future redevelopment of the St Mary's site.

Our two stroke units are based at Charing Cross Hospital, next to the HASU, and at St Mary's Hospital.

We provide outpatient follow-up services and TIA (transient ischaemic attack) investigation services at both Charing Cross and St Mary's hospitals.

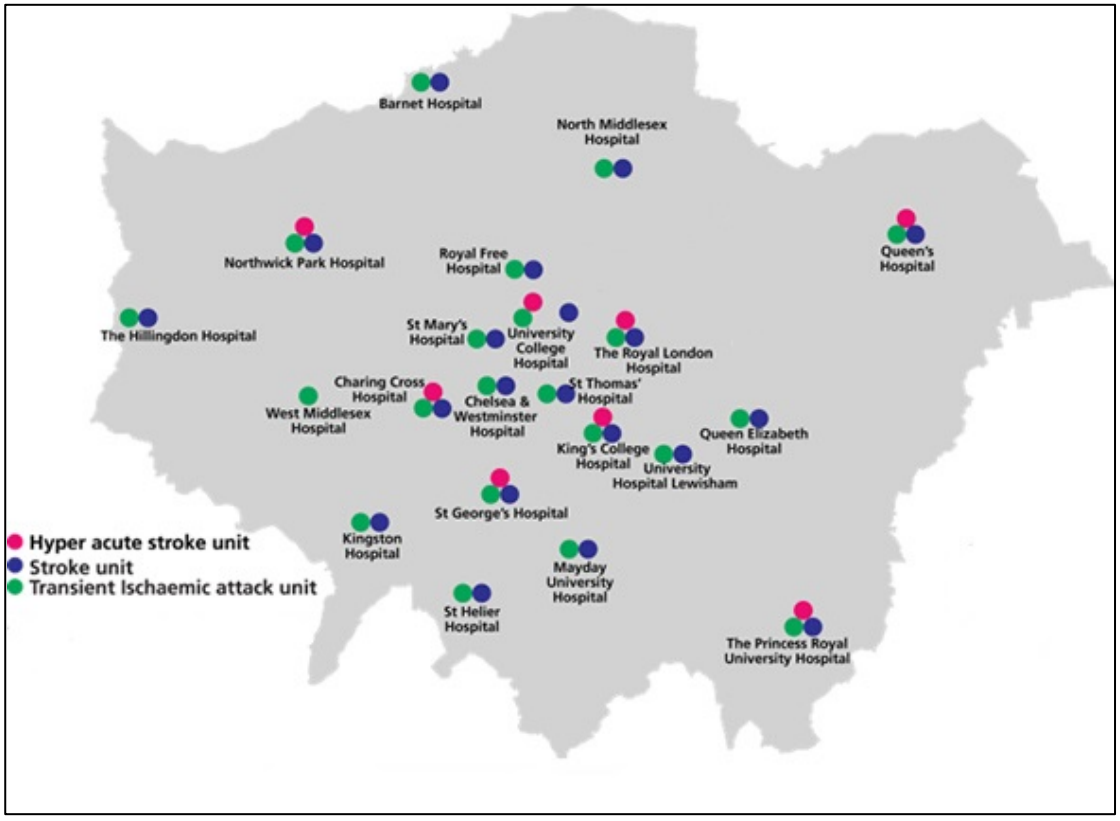
During the year 2014/15, we treated 1,745 patients in the HASU, 379 in the Charing Cross stroke unit and 186 in the St Mary's stroke unit.

Patient admissions 2014/15

Site	Stroke	TIA	Other
Charing Cross HASU	1111	162	472
Charing Cross Stroke Unit	343	7	26
St Mary's Stroke Unit	186	-	-

London Stroke Network

There are eight HASUs and 24 stroke units across London.



The case for change

There is a strong clinical consensus within the Trust that providing stroke services across two hospital sites is not sustainable in terms of quality or efficiency. The main benefit of the proposed co-location would be better patient outcomes and experience with improved continuity of care. The entire stroke specialist team would be on one site and would be better equipped to deliver the quality of service for all stroke patients within the recommendations of the Royal Colleges for working seven days per week.

The proposal is in line with the Trust's clinical strategy, approved by the Board in July 2014, which set out the case for co-locating stroke services. The strategy states:

"4.2.4 Stroke and neurosciences
There is strong clinical consensus that providing inpatient stroke and neurosciences services across three sites is not sustainable from a safety and quality perspective. There are critical clinical adjacencies with A&E, major trauma and the hyper acute stroke unit and so all stroke services plus a neurosurgical elective spinal service will be based alongside those services on the St Mary's major acute site. Remaining elective neurosciences

services will be based at Hammersmith Hospital alongside related specialties, particularly head and neck/base of skull surgery."

The main reasons underlying the proposal to change our current stroke services are to:

- **Provide the best outcomes and experience for patients, their families and carers.** The current stroke unit at St Mary's Hospital is based in old and outdated facilities. There is no prospect of significantly improving these facilities in advance of the planned major redevelopment of the St Mary's estate which is at least five years away. The current facilities are cramped, reducing privacy for patients, and do not include a day room where patients can spend time with visitors during their recovery period in hospital. There is an opportunity to re-provide this service in larger, modern facilities at Charing Cross Hospital in the interim.
- **Improve access to therapy services.** Having all specialist therapy staff on one site, with an expanded and improved gym, would enable us to provide high-quality, seven day services to all stroke patients. The more therapy stroke patients receive, the better their potential outcome.
- **Provide seven-day consultant review for all our patients, in line with best practice guidelines set out by the Royal College of Physicians.** As there is a much smaller service at St Mary's Hospital, there have not been enough patients to support the workload for a specialist consultant to be on duty for routine work at the weekends. Instead, there is daily consultant review from Monday to Friday only. Integrating the two stroke units and co-locating them with the HASU, would enable us to have seven day access to a stroke consultant on site for all stroke patients.
- **Co-location of stroke and neurosurgical services**
  Charing Cross Hospital has neuro-surgeons on-site and bringing together specialist services will mean better clinical outcomes and safer services for patients.
- **24-hour availability of MRI scanning service**
  Linked to the HASU and neuro-surgery services, Charing Cross has 24-hour availability of MRI scanning services. With a co-located stroke service at Charing Cross, all stroke patients would have access to 24-hour MRI if their condition should deteriorate.
- **Reduce the average length of stay for all stroke patients.** The average length of stay for a stroke patient at Charing Cross is 18 days compared with 26 days at St Mary's. This is partly linked to increased access to specialist consultants and other specialist clinicians and greater availability of therapy services.
- **Have the best trained stroke specialist teams.** By creating an integrated stroke service on one site, rather than being split over two sites, we would be able to deploy our doctors, nurses and therapists more effectively. This would improve rota cover, training opportunities, communication and shared learning.

Proposed service model for stroke care

The Trust wants to deliver the best outcomes and experience for all our stroke patients. We believe that the proposed changes would enable us to meet fully best practice standards seven days a week, enabling patients to have the fullest and speediest recovery possible.

Current stroke services at the Trust:

- Hyper acute stroke unit (HASU), with 20 beds at Charing Cross Hospital
- A stroke unit at Charing Cross Hospital with 20 beds, a gym, and day room
- A stroke unit at St Mary's Hospital with 14 beds and a small gym
- TIA (transient ischaemic attack) investigation services at Charing Cross and St Mary's hospitals
- Outpatient follow-up clinics at Charing Cross and St Mary's hospitals

Proposed stroke services at the Trust:

To support best practice, we propose moving the St Mary's Hospital stroke unit to Charing Cross Hospital to create a fully integrated service on one site. The service would be provided across one floor and would include:

- Hyper acute stroke unit (HASU), with 20 beds at Charing Cross Hospital
- A stroke unit at Charing Cross Hospital with 34 beds, an expanded gym, and day room
- TIA (transient ischaemic attack) investigation service at Charing Cross Hospital
- In addition, there would be outpatient follow-up clinics at Charing Cross and St Mary's hospitals

The total number of inpatient beds and stroke service staff would remain unchanged.

Benefits of the proposed co-location would be realised through:

- Better usage of beds allowing consistency of management, reduction in the average length of stay by avoiding internal waits for transfers, availability of senior therapy and nursing staff expertise.
- Better staff utilisation:
    - Consultants able to participate in combined clinics.
    - Additional flexibility to provide internal cover.
    - No requirement to maintain consultant cover on both sites.
    - More efficient use of therapy staff and strengthened cover with senior staff all on one site.
    - Ability to increase the critical mass of staff to cross cover sickness and annual leave.
    - Ability to increase the critical mass of patients in order to run efficient models of working such as group exercise classes and stroke education groups for patients.
- Management issues will be improved significantly with standardised operating procedures and consistency of pathways.
- Better informed staff who will be able to access teaching and departmental meetings on one site.
- More efficient stroke departmental management eg: audits, infection control issues and other trust procedures.
- Less duplication of meetings.
- More rapid referral of patients from HASU to the stroke unit.
- Improved TIA service running seven days a week with a simpler referral system for primary care physicians.

- Overall improved access to training, teaching and research. There are currently no training grade junior staff within the existing stroke service on the Charing Cross Hospital site where there is a wealth of clinical material available for teaching and training purposes.

There are also opportunities for efficiencies:

- Improved bed usage through reduced average length of stay
- Reduction in the use of bank and agency staff due to greater staffing resilience
- Improved efficiency due to reduction in transferring between sites
- Larger potential for research opportunities because of the larger cohort of patients available in one place
- The ward foot print would allow for future re–design for the rehabilitation pathway.

Public engagement

If given the go ahead by the Trust Board, we would proceed with a process of enagement on the proposal. The purpose of this engagement would be to give service users, partner organisations, other interested individuals and organisations, and the public the opportunity to:

- Understand how the Trust wants to improve the stroke service.
- Make any comments or raise any questions about the proposed change.

Once timelines are agreed, the consultation process with Trust staff directly affected by the proposal would run concurrently.

Trust staff engagement

There would be a robust plan for engaging with all staff directly involved in the proposed change along with a restructure consultation to further underpin the leadership of the services. It is planned to undertake this internal consultation concurrently and alongside the external process.

Access and travel issues

We appreciate the proposed changes may result in increased travelling times for some patients and visitors but we believe this would be more than offset by the improvements in outcomes and experience.

There would still be outpatient stroke services at both Charing Cross and St Mary's hospitals so there would be no travel impact for patients once they were discharged from hospital.

We recognise however, that this will form an important issue to be addressed during the engagement process.

Additional benefits for emergency services at St Mary's Hospital

The Trust has been working on how we can best develop our existing services and sites to meet changing health needs, both in the longer term as set out in our clinical strategy and

estates redevelopment plans, as well as in the short term over the next five years.

St Mary's Hospital is a major acute hospital for the region, with the designated major trauma centre for north west London. Given the important connections between A&E, major trauma and the HASU, our longer term plan is for all stroke services, plus a neurosurgical elective spinal service, to be co-located on a re-developed St Mary's site.

In the short term, however – at least over the next five years - we need to find solutions to the capacity pressures at St Mary's Hospital caused by our old and outdated estate. We will also be looking at how best to utilise each of our hospital sites through reviewing opportunities to consolidate or optimise clinical adjacencies.

Stakeholder engagement on the proposal

This proposal is supported by Professor Tony Rudd, the National Clinical Director for Stroke at NHS England, London Stroke Clinical Director and Stroke Programme Director, Royal College Physicians London. NHS England is the lead organisation for commissioning stroke services across London. We have begun close liaison with our local authority partners, clinical commissioning groups, patient groups and other key local stakeholders on this proposal.

Potential timescales

The proposal is for the co-location to take place during the second half of 2015 before the winter period, subject to the outcomes of the engagement process and further consideration of these by the Trust Board before reaching its decision.

Finance issues

While finance is not the primary reason for the proposed co-location there are opportunities for savings which arise from the efficiencies outlined above:

- Reduction in transfers of patients between sites.
- Reduced average length of stay for patients and improved bed usage.
- Avoiding use of agency staff.
- Larger cohort for research opportunities.
- Junior doctors' rotas being made more robust.

There would however, be a small, non-recurrent capital cost for refurbishing the area for the expanded stroke unit at Charing Cross Hospital.

Risks

Risk	Likelihood	Mitigation
Lack of wider staff support for the changes	Low	Clinical consensus on the need to co-locate services to improve quality and efficiency and full staff consultation on changes to roles and main place of work
Impact on junior grade doctors covering the medical acute rota at St Mary's Hospital	Low	This would be reviewed alongside a proposal for a new junior grade rota at Charing Cross Hospital. Furthermore, co-location of services would increase consultant presence on one site providing additional flexibility.
Access issues for some patients impacts negatively on patient experience	Medium	Ensure access/transport – and any other concerns – are fully covered and addressed as part of the public engagement.

References:

http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/London-Stroke-Strategy.pdf
https://www.rcplondon.ac.uk/sites/default/files/national-clinical-guidelines-for-stroke-fourth-edition.pdf

Recommendation to the Board

To approve that engagement and communications on the proposed stroke service co-location proceeds followed by a further report for consideration by the Board on the outcomes of this process.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.2
Title	Responsible Officer's Annual Report – Revalidation & Appraisal
Report for	Noting and approval
Report Author	Lauren Harding
Responsible Executive Director	Julian Redhead, Acting Medical Director

Executive Summary:

Revalidation via the General Medical Council (GMC) is a statutory requirement for all doctors registered with a license to practice.

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

The purpose of this report is to:

1. provide the Board with assurance of the Trust's compliance with the FQA standards to allow them to approve the Statement of Compliance (Appendix A) required to be submitted to NHS England;
2. inform the Board of changes to the way in which appraisal compliance is reported in the Trust Board scorecard;
3. request the Board to appoint Julian Redhead, Deputy Medical Director for Appraisal, Revalidation and Job Planning, as Responsible Officer for the Trust.

Recommendation(s) to the Board:

The Board is asked to:

- note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable the statement of compliance will be submitted to NHS England by 31st August 2015;
- note the change to appraisal compliance reporting in the Trust Board for 2015/16;
- approve the appointment of Julian Redhead as Responsible Officer.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Responsible Officer's Annual Report – Revalidation & Appraisal

Purpose of the report:
Revalidation via the General Medical Council (GMC) is a statutory requirement for all doctors registered with a license to practice.

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

The purpose of this report is to:

1. provide the Board with assurance of the Trust's compliance with the FQA standards to allow them to approve the Statement of Compliance (Appendix A) required to be submitted to NHS England;
2. inform the Board of changes to the way in which appraisal compliance is reported in the Trust Board scorecard;
3. request the Board to appoint Julian Redhead, Deputy Medical Director for Appraisal, Revalidation and Job Planning as Responsible Officer for the Trust.

1. Background

Revalidation via the General Medical Council (GMC) is the process by which doctors demonstrate that they are up to date and fit to practice. Medical Revalidation started on 3 December 2012 and was introduced in a phased manner with the majority of doctors will be revalidated by March 2016.

All doctors are legally required to revalidate every 5 years. Revalidation aims to give patients greater confidence that doctors are up to date in their practice. It also supports doctors in maintaining and developing their practice, by ensuring that they have the opportunity for regular reflection. Annual appraisal is the keystone of revalidation and is the means by which the designated body is required to assess and assure the fitness to practise of individual doctors against the core standards

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

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

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

The Trust's RO role was combined with the Medical Director role in May 2014, with Julian Redhead, Deputy Medical Director, acting as delegate. However with over 1000 medical staff, the requirement for the RO to deal with matters personally, and the detailed attention necessary for the role, this has proved impractical. Due to the demands of the role, there are an increasing number of trusts in which the roles of Medical Director and RO are separate. The board is therefore requested to approve that Dr Redhead takes on the role of RO in his capacity as Deputy Medical Director for Revalidation, Appraisal and Job Planning from May 2015 onwards, supervised and guided by the Medical Director as necessary. This will mean the trust has an RO with the necessary authority to act quickly if needed. Dr

Redhead is fully trained in the role and has been successful in setting up improved systems and processes for the successful revalidation and appraisal of our doctors.

2. External Monitoring & Assurance

NHS England monitors compliance with Responsible Officer Regulations via the Framework of Quality Assurance for Responsible Officers (FQA). As part of the FQA, NHS England requires designated bodies to adhere to a set of Core Standards (Appendix B). The Trust is required to submit the following as evidence of performance against these standards:

- the Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England, due by the end of May each year (see Appendix C and section 2.2);
- 'Information Template' (see Section 2.1, Statement 5, Figures 1 & 2) to NHS England, due one month following the end of each quarter;
- an Annual Report to the Trust Board on compliance with these standards (this report);
- the Annual Statement of Compliance (see Appendix A and section 2.1) made by the Trust's Executive Team to NHS England, due by 31 August each year;

2.1. Statement of Compliance

The following sections of this report will provide the Executive Team with the information on 2014/15 performance with annual appraisal and revalidation and seeks to provide the assurances required to enable the authorisation of the Annual Statement of Compliance to NHS England.

***STATEMENT 1* - A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer**

Imperial College Healthcare NHS Trust is a recognised designated body. The Trust's RO is Professor Chris Harrison, Medical Director who has received the appropriate RO training. The 'alternative Responsible Officer' is Dr Julian Redhead, Deputy Medical Director and Responsible Officer, who has also received appropriate RO training.

***STATEMENT 2* - An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained**

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

***STATEMENT 3* - There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners**

All appraisers are required to undertake appraiser training and then receive refresher training every 3 years. This is delivered by an external training provider, MIAD. The appraiser training curriculum includes information for appraisers on how to conduct and quality-assure appraisals.

As at 31st March 2015, the Trust has 204 named appraisers of which 140 have received training. Of the appraisers who are not trained, currently 13 are scheduled to receive training in May 2015 with more expected. A further 6 new appraisers will also be trained in May 2015.

Following the May training sessions, any appraisers who remains non-complaint will be contacted and informed that they will no longer be able to act as an appraiser. All Heads of Speciality have been made aware of the need to ensure adequate appraisers are trained within their speciality so that appraisal compliance is not compromised.

***STATEMENT 4* - Medical appraisers participate in on-going performance review and training /**

development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent)

- Appraiser forums are run every two months, rotating across sites, which allow appraisers the opportunity to share best practice, benchmark and develop.
- A sample of appraisal forms are reviewed each year and information on appraisal quality fed back to individual appraisers;
- A sample of appraisal portfolios is reviewed by the RO prior to making Revalidation recommendations and feedback is giving to appraisers regarding appraisal quality as appropriate;
- The RO commissioned an external audit from MIAD in December 2014 to review the quality of appraisals, as well as the Trust's internal quality assurance processes for appraisal and revalidation. The resulting report commended the Trust in a number of areas:

  "[The Trust] has done an excellent job and established a strong technical platform and early good practice……..The scale and complexity of the 900 doctors with a prescribed connection to imperial means that much of the work to date has rightly focussed on foundation elements…The longer term benefit of this should not be underestimated". MIAD, July 2014

  Recommendations from the report related to appraiser development, support and inclusion, reflection and communications.

***STATEMENT 5* - All licensed medical practitioners (with a prescribed connection to the designated body on the date of reporting) either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken**

As well as being a contractual requirement, annual appraisal for doctors is a requirement for GMC Revalidation. Compliance with annual appraisal for the 2014/15 annual period as required to be reported to NHS England in the FQA is shown in Figure 1. The quarterly performance is shown in Figure 2.

FQA appraisal compliance for 2014/15 has increased significantly in comparison with 2013/14 (+21%). This is a result of concerted efforts have been made by the Revalidation team to improve compliance rates during 2014/15. This has been supported by the publication of the Appraisal and Revalidation policy, including clear escalation processes for doctors who are non-compliant with annual appraisal, as well as the presentation of appraisal compliance rates at the monthly Divisional Performance Reviews.

A system for recording the reason for missed appraisals has been introduced in March 2015 and will be fully implemented in 2015/16.

Where doctors remain non-compliant with their annual appraisal without a valid reason this will be managed in accordance with the Appraisal and Revalidation policy and ultimately treated as a disciplinary matter. Doctors who are 'non-engaged' are reported to the GMC who take appropriate action to ensure compliance or de-registration. A non-engagement decision has been made on 2 doctors within the last year – both have since engaged with revalidation.

Imperial College Healthcare NHS Trust

FIGURE 1: Annual FQA Appraisal Compliance

Indicator		Year (2014/15)
1	**Name of designated body**	Imperial College Healthcare NHS Trust
2	Number of doctors with whom the designated body has a **prescribed connection**	941
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	781
3.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	648
3.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	133
	% Compliance	**82.9%**
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	1
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	132

FIGURE 2: Quarterly FQA Appraisal Compliance

Indicator		Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)	Q4 (1 Jan to 31 March)
1	**Name of designated body**	Imperial College Healthcare NHS Trust			
2	Number of doctors with whom the designated body has a **prescribed connection**	935	904	899	941
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	310	305	214	227
3.1	Number of those within ♯3 above who **held an appraisal meeting** in the reporting period	215	214	145	192
3.2	Number of those within ♯3 above who **did not hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	95	91	69	35
	% Compliance	**69.4%**	**70.2%**	**67.8%**	**84.6%**
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	0	1	0	0
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either not understood or accepted by the RO**	95	90	69	35

The annual and quarterly figures cannot be directly compared due to the following reasons:

- *doctors joining and leaving the Trust throughout the year;*
- *owing to the FQA definition of when an appraisal is due some doctors were due in both Q1 and Q4. This has been corrected for in the annual figures;*

- *non-compliant doctors are rolled over into subsequent quarters until they become compliant, resulting in doctors being counted more than once in the quarterly figures.*

***STATEMENT 6* - There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners (with a prescribed connection to the designated body on the date of reporting), which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal**

Performance is managed through the clinical divisions' local quality structures. Clinical outcome data, such as directorate specific mortality reports, are provided to Heads of Specialty and Chiefs of Service. Clinical Governance information is provided to doctors and the RO by the Safety and Effectiveness Team according to DOH, NHS England and NICE guidelines.

***STATEMENT 7* - There is a process established for responding to concerns about any licensed medical practitioners fitness to practise**

The Trust has a published Raising Concerns policy. There is an established process within the Trust for dealing with any concerns about doctors' fitness to practice; all concerns and investigations are logged electronically.

***STATEMENT 8* - There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work**

There is a procedure in place for obtaining and sharing information about doctors between our RO and those of other designated bodies, and with the GMC. The Trust uses the approved NHS Medical Practice Information Transfer form (MPIT) form to share this information.

***STATEMENT 9* - The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners (with a prescribed connection to the designated body on the date of reporting) have qualifications and experience appropriate to the work performed**

The Trust held NHSLA Level 3 which included assurances that it conducted appropriate pre-employment, registration and right to work checks. All appropriate pre and post-employment clearances are carried out by HR and the recruiting managers in line with NHS Employers guidance and Trust policy to ensure that all licensed medical practitioners have qualifications and experience appropriate to the work performed. Agency doctors are booked via agreed framework agencies who comply with NHS Employers guidance.

***STATEMENT 10* - A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations**

2014/15 Key Achievements:

- 21% increase in appraisal compliance;
- Consolidation of the Revalidation Support Team following the restructure of the Office of the Medical Director;
- Improved provision of resources / support for doctors including drop-in tutorials, regular appraisal forums, updated web pages and guides;
- Appraisal and Revalidation Policy published February 2015;
- Standard Operating Procedure for tracking and managing overdue appraisals with appropriate escalation pathways;
- An external quality assurance audit for completed medical appraisals;
- Positive feedback from NHS England 'Medical Revalidation Independent Verification' visit;
- Electronic collection of patient feedback has been piloted in gynaecology outpatients using

iTrack devices which are also used to collect responses to the Friends and Family Test (FFT);
- The appraisers forum has evolved and now regularly incudes guest speakers e.g. the account manager from Premier IT (host of the Imperial online appraisal system) check this;
- Medical personnel have appointed to a substantive admin post to enable the improvement of processes for honorary contracts. Further engagement work will be undertaken with medical personnel and workforce planning to improve data validation.

Several key challenges have been identified through the year, including:
- Doctors identified a need for increased support in the provision of appropriate evidence;
- Non-standard processes for collection of patient feedback across specialties;
- Significant data quality issues in ESR which compromises the cross-validation of doctors for whom the Trust should be responsible, this is a particular issue in relation to the processing of honorary (unpaid) contracts;
- A large increase in the number of doctors seeking to connect to the trust as their designated body;
- Requirement to improve the quality and quantity of the educational appraisal module.

The following action plan has been established to address the above issues and areas of non-compliance reported in the AOA:
- Ensure appraisers have recognised time in their job plans;
- Ensure that all appraisers are appropriately trained and that appraisers who are non-compliant with trainer are removed from the list of approved appraisers;
- Follow a collated action plan for recommendations from the NHS England Medical Revalidation Independent Verification visit and the external quality assurance review conducted by MIAD;
- A system for recording the reason for missed appraisals has been introduced in March 2015 and will be fully implemented in 2015/16;
- Electronic collection of patient feedback will be rolled out to the rest of the Trust once work has been completed to switch to the new software provider used for FFT which is being led by the Nursing Director's Office;
- Create an automated link between Datix and PReP to support doctors in collating clinical governance evidence.

2.2. Annual Organisational Audit

The Responsible Officer has confirmed that the Trust is compliant with all aspects of the AOA End of Year Questionnaire (see Appendix C), with the exception of:

- Section 2.2 "Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded"

A system for recording the reason for missed appraisals has been introduced in March 2015 and will be fully implemented in 2015/16.

3. Internal Performance Monitoring

Appliance compliance is reported monthly in the Trust Board Scorecard. The appraisal compliance measure reported in the Trust Board Scorecard differs from the definition of compliance required in the FQA submitted to NHS England quarterly, as described below:

- ***FQA:***
  - Includes all doctors who have a prescribed connection to the Trust
  - a doctor is considered as being compliant if they have completed an appraisal in the period which their appraisal is due which is defined as:

"*the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner";*

- non-compliant doctors are rolled over into subsequent quarters until they become compliant, resulting in doctors being counted more than once & therefore increasing the denominator;

- ***Trust Board scorecard:***
  - Includes consultants who have a prescribed connection to the Trust but does not include career grades;
  - a doctor is considered as being compliant if they have completed an appraisal in the previous 12 months at the time of reporting;
  - doctors are considered as having completed an appraisal if they have submitted the 'input form' on the ePortfolio system which is not the final stage in the appraisal process.

The monthly performance throughout 2014/15 is shown in Figure 3 for consultants, careers grades and the Trust overall. Only consultant appraisal compliance is currently reported in the Trust Board Scorecard.

FIGURE 3: Percentage of doctors who have completed an appraisal ('input form') in the last 12 months

	% Compliance											
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	Dec	**Jan**	**Feb**	**Mar**
Consultants	72%	74%	76%	74%	79%	77%	78%	79%	82%	85%	88%	91%
Career Grade	22%	24%	31%	34%	37%	46%	47%	48%	56%	51%	72%	80%
TOTAL	**60%**	**62%**	**67%**	**67%**	**70%**	**71%**	**72%**	**73%**	**77%**	**78%**	**86%**	**89%**

There has been a significant improvement in appraisal compliance reported to the board for consultants (+19% in 2014/15). Appraisal compliance is worse amongst career grade doctors in comparison to consultants although the gap has narrowed significantly in 2014/15. Targeted actions will be taken in 2015/16 to bring appraisal compliance for career grade doctors in line with consultants. It is expected that the appraisal compliance rate will continue to improve and that the Trust target of 95% for both consultants and career grades will be achieved during 2015/16.

In 2015/16 the Trust Board scorecard will now include:

- quarterly appraisal compliance as per the FQA definition prior to submission to NHS England;
- monthly appraisal compliance for both consultant and non-consultant doctors (excluding doctors in training) where an individual will be considered compliant if they have had an appraisal in the last 12 months;
- doctors will only be considered as having completed an appraisal if they have submitted the 'output form' on the ePortfolio system which is the final stage the appraisal process.

4. Recommendations

The Board is asked to:

- note this report and confirms that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable the statement of compliance will be submitted to NHS England by 31st August 2015;
- note the change to appraisal compliance reporting for 2015/16.
- note the appointment of Julian Redhead, Deputy Medical Director for Appraisal, Revalidation and Job Planning as Responsible Officer for the Trust.

Imperial College Healthcare NHS Trust

APPENDIX A

Designated Body Statement of Compliance

The executive management team of Imperial College Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in on-going performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

   Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

    Comments: Yes

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Imperial College Healthcare NHS Trust

APPENDIX B – Core Standards

1	The Designated Body and the Responsible Officer	Mandatory	Good Practice
1.1.1	The designated body has nominated or appointed a responsible officer in compliance with the Responsible Officer Regulations. The responsible officer is a licensed doctor who has been licensed continuously for the previous five years and continues to be licensed throughout the time they hold the role of responsible officer.	X	
1.1.2	The designated body has nominated or appointed an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection	X	
1.1.3	The responsible officer has sufficient time to carry out the role including the training, support and quality assurance requirements	X	
1.1.4	The designated body provides the responsible officer with sufficient funds, capacity and other resources to enable the responsible officer to carry out the responsibilities of the role.	X	
1.1.5	The responsible officer ensures an accurate record is maintained of all doctors with a prescribed connection to the designated body.	X	
1.1.6	The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer	X	
1.1.7	The responsible officer is actively involved in peer review and networking for the purposes of calibrating decision-making and organisational systems and processes	X	
1.1.8	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the *Responsible Officer Protocol*. Ideally at the beginning of the 3 month notice period.	X	
1.1.9	The responsible officer considers all relevant information from the doctor's full scope of work and through the complete revalidation cycle in making a recommendation about a doctor's fitness to practise.	X	
1.1.10	The responsible officer ensures that accurate records are kept of all relevant actions and decisions relating to the responsible officer role	X	
1.1.11	The responsible officer has mechanisms in place to assure the quality of the processes underpinning the Responsible Officer Regulations	X	
1.1.12	The responsible officer provides a report to the designated body's board (or an equivalent governance or executive group) and the higher level responsible officer, on compliance with the Responsible Officer Regulations and any other statutory requirements.	X	
1.1.13	The responsible officer provides the designated body's board (or an equivalent governance or executive group) with a development plan that addresses any identified weaknesses or gaps in compliance with the Responsible Officer regulations to agreed timelines.	X	

1.1.14	The responsible officer includes the report on compliance and resulting development plan in their own appraisal and revalidation portfolio.	X	
1.1.15	The responsible officer ensures that the designated body's medical revalidation policies and procedures comply with equality and diversity legislation.	X	
1.1.16	Where the responsible officer role is outsourced, the designated body must be satisfied that the service specification for the role (including responsible officer training, support and review) meets the required core standards.	X	
1.1.17	The responsible officer has completed a recognised training programme before making revalidation recommendations.	X	
1.1.18	The responsible officer attends three out of four regional networking events each year.	X	
2	**Appraisal**	**Mandatory**	**Good Practice**
2.1	**Policy, Leadership and Governance**		
2.1.1	The responsible officer ensures that a medical appraisal policy is in place which is ratified by the designated body's board (or an equivalent governance or executive group), with core content which is compliant with national guidance (GMC Guidance, Medical Appraisal Guide, Responsible Officer Guidance, etc.)	X	
2.1.2	The responsible officer ensures that every doctor participates in the annual medical appraisal process	X	
2.1.3	The responsible officer ensures that every doctor with a missed or incomplete medical appraisal have an explanation recorded	X	
2.1.4	The responsible officer ensures that appraisals will be undertaken according to professional standards (as laid out in *Providing a Professional Appraisal, RST*)	X	
2.1.5	The responsible officer ensures that there is a written protocol for the handling of information for appraisal and revalidation which complies with information governance, confidentiality and data protection requirements.	X	
2.1.6	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified	X	
2.1.7	The responsible officer ensures that there is a process for the allocation of appraisers and the scheduling of appraisals.	X	
2.1.8	The responsible officer ensures that no appraisals are carried out by an appraiser who is not trained to undertake the role.	X	
2.1.9	The responsible officer ensures that steps are taken to ensure the objectivity of the appraisal.	X	

2.1.10	The responsible officer ensures that the appraiser submits the completed appraisal outputs within 28 days of the appraisal meeting.	X	
2.1.11	The responsible officer ensures that there is a process for quality assuring the inputs and outputs of appraisal to ensure that they comply with GMC requirements and other national guidance.	X	
2.1.12	The responsible officer ensures that all doctors with whom the designated body has a prescribed connection are able to obtain structured feedback from patients and colleagues in compliance with GMC criteria	X	
2.1.13	Where some or all of the functions required for the medical appraisal system are commissioned externally (e.g. from an appraisal provider), the responsible officer must be satisfied that the service specification including appraiser training, support and review meets the required core standards.	X	
2.1.14	The responsible officer ensures that the designated body's medical appraisal policy is reviewed to ensure continued alignment with national guidance.	X	
2.1.15	The responsible officer ensures that a doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser	X	
2.1.16	The designated body has guidance on the expected time requirements to prepare for, undertake and complete documentation for appraisals (for both doctors and appraisers).	X	
2.1.17	The responsible officer ensures that there is a named clinical appraisal lead.	X	
2.2	**Capacity and Capability**		
2.2.1	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection	X	
2.2.2	The responsible officer ensures that medical appraisers are recruited and selected in accordance with national guidance (Quality Assurance of Medical Appraisers).	X	
2.2.3	The responsible officer ensures that medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals.	X	
2.1.4	The responsible officer ensures that all appraisers have access to medical appraisal leadership and support.	X	
2.2.5	The responsible officer ensures that there is a system in place to obtain feedback on the appraisal process from the doctors being appraised.	X	
2.2.6	The responsible officer ensures that medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers)	X	

2.2.7	The responsible officer ensures that there is a process for responding to concerns about appraisers and the appraisal process.	X	
2.2.8	The responsible officer ensures that the initial training programme is competency based and those who cannot demonstrate the competencies do not become/are not appointed as medical appraisers.		X
2.2.9	The responsible officer ensures that there is an initial review of performance for appraisers covering the first three appraisals followed by an initial review.		X
2.2.10	The responsible officer ensures that appraiser to doctor ratios lower than 1:20 and higher than 1:5 are recorded and justified.		X
2.2.11	The responsible officer ensures that there is a written role description, person specification and terms of engagement for medical appraisers		X
2.2.12	The responsible officer ensures that appraisers have access to regular appraiser assurance groups or networks, which will include agreement about expectations of attendance.	X	
2.3	**Appraisal standards for trainees**	**Mandatory**	**Good Practice**
2.3.1	**Policy, Leadership and Governance**		
2.3.1.1	The responsible officer ensures that medical appraisal and Educational Supervision policies are in place and ratified by the by the designated body's Board, with core content, which are compliant with standard national guidance. (GMC, MAG or equivalent)	X	
2.3.1.2	The responsible officer ensures that every doctor participates in the ARCP process and those with a missed or incomplete ARCP have an explanation recorded	X	
2.3.1.3	The responsible officer ensures that there is a process for the management of education in the LETB including ARCPs.	X	
2.3.1.4	The responsible officer ensures that there is a written protocol for the handling of information for ARCPs and revalidation which sets out information governance and data protection requirements.	X	
2.3.1.5	The responsible officer ensures that there is a process for quality assuring the inputs and outputs of appraisal and ARCPs to ensure that they comply with GMC requirements and other national guidance.	X	
2.3.1.6	The responsible officer ensures that a doctor should normally have no more than three consecutive appraisals with the same appraiser and must then have a period of at least three years before being appraised again by the same appraiser	X	
2.3.1.7	The designated body has guidelines on the expected time requirements to prepare for, undertake and complete paperwork for ARCP (both doctors and Educational Supervisor) and twice yearly exception and exit reports.	X	
2.3.1.8	The responsible officer ensures that each LEP has a Director of Medical Education or equivalent		X

2.3.2	**Capacity and Capability**		
2.3.2.1	The responsible officer ensures that each designated body has access to sufficient numbers of trained clinical and educational supervisors to carry out the regular educational supervisor reports and assessments for all trainee doctors with whom it has a prescribed connection.	X	
2.3.2.2	The responsible officer ensures that Educational Supervisors are selected and approved in accordance with national GMC guidance.	X	
2.3.2.3	The responsible officer ensures that Educational Supervisors are trained to approved GMC standards.	X	
2.3.2.4	The responsible officer ensures that Educational Supervisors educational training and development activities are part of CME.	X	
2.3.2.5	The responsible officer ensures that the ARCP decision making process has access to all the information needed to make a revalidation recommendation for the doctor at the final ARCP panel	X	
2.3.2.6	The responsible officer ensures that there is a process for responding to concerns about Educational Supervisors and the educational process.	X	
2.3.2.7	The responsible officer ensures that Educational Supervisors contribute to local educational arrangements including local faculty, ARCPs and recruitment meetings.	X	
3	**Monitoring Performance and Responding to Concerns**	**Mandatory**	**Good Practice**
3.1	**Policy, Leadership and Governance**		
3.1.1	The responsible officer ensures that there is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection.	X	
3.1.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group), with core content which is compliant with national guidance (Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice), and where necessary compliant with Maintaining High Professional Standards in the Modern NHS (Department of Health, 2003)	X	
3.1.3	The responsible officer ensures that there are formal procedures in place for colleagues to raise concerns.	X	
3.1.4	The responsible officer identifies any issues arising from routinely collected information (such as complaints, significant events and outlying clinical outcomes) and ensures that the designated body takes steps to address such issues.	X	
3.1.5	The responsible officer ensures that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.	X	
3.1.6	The responsible officer ensures there is a process established for initiating and managing investigations of capability, conduct, health and fitness to practise concerns which complies with national guidance (*How to conduct a local performance investigation*, NCAS)	X	

3.1.7	The responsible officer ensures that a doctor who is subject to investigation procedures is kept informed about progress, the doctor's comments are taken into account and appropriate support mechanisms are in place.	X	
3.1.8	The responsible officer ensures that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, HR and occupational health.	X	
3.1.9	The responsible officer ensures that there is a process in place for key items of information (such as complaints, significant events and outlying clinical outcomes) to be included in the doctor's appraisal portfolio and discussed at the appraisal meeting.	X	
3.1.10	The responsible officer ensures that any steps necessary to protect patients are taken.	X	
3.1.11	The responsible officer ensures that the locally agreed approach and actions are a proportionate response to a concern and take into account patient safety, the doctor's needs and the needs of the service or designated body.	X	
3.1.12	The responsible officer ensures that where issues have been identified, measures are initiated to address concerns which may include re-skilling, re-training, rehabilitation services, supervision, mentoring, coaching etc. in line with relevant national guidance	X	
3.1.13	The responsible officer ensures that where necessary a recommendation is made to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.	X	
3.1.14	The responsible officer ensures that where necessary measures are taken to address systemic issues within the designated body that may contribute to concerns identified.	X	
3.1.15	The responsible officer is proactive in sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.	X	
3.1.16	The responsible officer refers serious concerns about a doctor's fitness to practise to the GMC	X	
3.1.17	The responsible officer ensures that where a doctor is subject to conditions imposed by, or undertakings agreed with, the GMC, systems are in place to monitor compliance with these conditions or undertakings.	X	
3.1.18	The designated body's board (or an equivalent governance or executive group) makes provision for the cost and impact of investigating and responding to concerns about doctors' practice	X	
3.1.19	The responsible officer ensures that arrangements for the sharing of relevant information about a doctor's practice exist between all organisations in which a doctor works, which complies with information governance, confidentiality and data protection requirements	X	

3.1.20	Where some or all of the functions required for the responding to concerns system are commissioned externally (e.g. from a Professional Support Unit, etc.), the responsible officer must be satisfied that the service specification including case investigator and case manager training, support and review meets the required core standards.	X	
3.1.21	The responsible officer ensures that the Responding to Concerns policy and pathway are shared within the designated body and are publicly available.	X	
3.1.22	Systems are in place to monitor data about a doctor's practice on an on-going basis to enable the early identification of trends, and to respond appropriately when variation in individual performance is identified.		X
3.1.23	The responsible officer ensures that frameworks are in place to describe the process for categorising risk and thresholds for investigations.		X
3.1.24	The responsible officer ensures that individuals monitoring, supervising or supporting practitioners are appropriately qualified and indemnified		X
3.1.25	The responsible officer or appointed case manager takes the lead in drafting, implementing and monitoring action plans to address the identifiable needs.		X
3.1.26	The responsible officer ensures that appropriate arrangements are in place to support for the re-entry of appropriate practitioners to the designated body		X
3.1.27	The responsible officer compares patterns of handling and concerns through their responsible officer network.		X
3.1.28	The responsible officer co-ordinates a quality assurance look back process of cases.		X
3.1.29	The responsible officer ensures that there are mechanisms are in place to define the success criteria for interventions and processes and to demonstrate that the organisation learns from experience.		X
3.2	**Capacity and Capability**		
3.2.1	The responsible officer ensures that the designated body has access to sufficient numbers of trained case investigators and case managers, whether they are sourced internally or externally.	X	
3.2.2	The responsible officer ensures that case investigators and case managers are recruited and selected in accordance with national guidance (*Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice*, RST)	X	
3.2.3	The responsible officer ensures that case investigators and case managers have completed a suitable training programme, with essential core content (Ref RST training specification - including equality and diversity, information governance) before starting to perform investigations.	X	
3.2.4	The responsible officer ensures that individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (ref RST guidance)	X	

3.2.5	The responsible officer ensures that personnel involved in responding to concerns have sufficient time to undertake their responsibilities	X	
3.2.6	The responsible officer ensures that case investigators and case managers have a regular programme of updates and skills development.		X
3.2.7	The responsible officer ensures that case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance.		X
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.		X
4	**Recruitment and Engagement**	**Mandatory**	**Good Practice**
4.1	The responsible officer ensures that when entering into contracts of employment or contracts for the provision of services, the designated body has policies and procedures in place to ensure that:	X	
4.1.1	The doctor has qualifications and experience relevant to the work being performed	X	
4.1.2	Appropriate references are obtained and checked	X	
4.1.3	Any steps necessary to verify the identity of doctors are taken	X	
4.1.4	Doctors have sufficient knowledge of the English language for the work to be performed	X	
4.1.5	All pre-employment checks recommended In national guidance are performed (ref NHS Employers Guidance)	X	
4.1.6	Any other relevant information is obtained from the doctor, the previous responsible officer, the GMC or other sources to enable a judgement to be reached about the doctors suitability for the proposed role	X	

Imperial College Healthcare NHS Trust

APPENDIX C – Annual Organisational End of Year Questionnaire Return

Section 1: The Designated Body and the Responsible Officer

1.1 1.2 1.3	Organisation Contact Details Organisation type RO's higher level RO details
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.
1.5	Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?
1.6	In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.
1.7	The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.
1.8	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.
1.9	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.
1.10	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.
1.11	The governance systems (including clinical governance where appropriate) are subject to external or independent review.
1.12	The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment)

Section 2: Appraisal

2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2015 should be included. Where the answer is 'nil' please enter '0'.	Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	Consultants						
2.1.2	Staff grade, associate specialist, specialty doctor						
2.1.3	Doctors on Performers Lists						
2.1.4	Doctors with practising privileges						
2.1.5	Temporary or short-term contract holders						
2.1.6	Other doctors with a prescribed connection to this designated body						
2.1.7	TOTAL						

2.2	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded
2.3	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.
2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.
2.6	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.

Section 3: Monitoring Performance and Responding to Concerns

3.1	There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection.
3.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).
3.3	The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.
3.4	The designated body has arrangements in place to access sufficient trained case investigators and case managers.

Section 4: Recruitment and Engagement

4.1	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.3
Title	NHS Trust Development Authority Self-Certifications
Report for	Ratification & Approval
Report Author	Jan Aps, Trust company secretary
Responsible Executive Director	Tracey Batten, chief executive

Executive summary:

As part of the on-going oversight by the NHS Trust Development Authority (TDA) the Trust is required to submit self-certified declarations on a monthly basis.

A revised process has been introduced to strengthen the internal signoff and assurance process, and the executive committee.

The Trust board is asked to ratify the March 2015 submission and to approve the April 2015 submission; both submissions will be reviewed by the executive committee on 26 May 2015. There were only minor changes to the report from previous submissions.

Recommendation to the Board:

The Board is asked to approve the Trust Development Agency self-certifications.

Trust strategic objectives supported by this paper:

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

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: March 2015 Submitted 30/04/2015

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

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

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

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

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: March 2015, Submitted 30/04/2015

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

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICHT Response: Yes** **Explanation: Governance arrangements in place to assure quality of care with clear accountability and reporting.**	Chris Harrison, Medical Director
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICHT Response: The Board is satisfied that the Trust meets the CQC registration requirements and is registered with no conditions.** **Following the CQC inspection in September 2014, the Trust received a number of compliance actions. An action plan has been approved by the Trust Board and CQC to address these regulatory breaches. Furthermore, a new compliance and improvement framework outlining the Trust's approach to ensure on-going compliance has been approved by the Trust's Executive Committee.**	Janice Sigsworth, Director of Nursing
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICHT Response: Yes** **Explanation: Responsible officer in place with governance arrangements to provide assurance.**	Chris Harrison, Medical director
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICHT Response: Yes** **Explanation: The Trust remains a going concern as defined by the most up to date accounting standards.** **The Trust board considers annually the Going Concern of the Trust as per IAS 1. The accounts for 2013/14 were prepared on a 'Going Concern' basis with a paper reviewed by the May 2014 Trust Board that supported this conclusion.**	Alan Goldsman, Chief Financial Officer
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICHT Response: Yes** **Explanation: A detailed review of the NTDA Accountability Framework and the NHS Constitution was undertaken in February 2014, the outcome of which considered that the Trust was compliant with the NTDA accountability framework. A further review of both compliance with, and assurance mechanisms for, the Accountability Framework and constitution will be undertaken by the Trust during the Spring / summer of 2015.**	Jan Aps Trust company secretary
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICHT Response: Yes** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation. **Explanation: The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver.**	Janice Sigsworth Director of Nursing

Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.* **ICHT Response: Yes** **Explanation: The Annual Governance Statement identifies significant issues for the coming year. The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver. In addition the risk management framework includes a rigorous review of scoring and review of controls and mitigation.**	Janice Sigsworth Director of Nursing
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICHT Response: Yes** **Explanation: There are risk management processes in place and the management of strategic risks is currently undergoing review. Recommendations from the Audit, risk & governance committee are followed up on and the actions reported at each Committee.**	Alan Goldsman, Chief Financial Officer
Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICHT Response: Yes** **Explanation: The AGS for inclusion in the annual report for 2014/15 has been submitted (23 April 15) to the TDA and external auditors for review, and will be finalised as part of the annual report and accounts. It has been review by the executive committee and the audit committee.**	Jan Aps Trust company secretary
Q10. *The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* **Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):** • To date six cases of MRSA BSI have been allocated to the Trust (one case in April, two cases in May, one case in October, November and December). • In February two further cases of MRSA BSI occurred, these have initially been allocated to the Trust (post 48 hour specimens). PIRs for both cases are currently being undertaken within the division of medicine; the final allocation will be made once the PIRs are completed. **Clostridium difficile infections:** • Eight cases of C. difficile were allocated to the Trust for February 2015. • The annual objective for the Trust is 65 for 2014/15; at the end of February 2015 we reported 70 cases attributed to the Trust. • The provisional definition of a lapse in care associated with toxin positive C. difficile disease within ICHT is described as a) non-compliance to the ICHNT antibiotic policy or b) If the patient shared a ward with another patient who was symptomatic and later found to be C. difficile positive (with the same ribotype). A sample of Trust attributable C. difficile cases from Quarters one, two and three has been subject to a collaborative review with the CCG. • In Quarter one, two cases were felt to be due to a potential lapse in care (one due to non-compliance with antibiotic policy and one having had contact with another patient with C. difficile). In Quarter two there was one case felt to be due to a potential lapse in care (having had contact with another patient with C. difficile). There were no lapse of care cases identified in Q3. • The IP&C team monitor the time to isolation for all cases of C. difficile; during Q3, seven of the 15 cases were not isolated with the two hour time period. **Referral to treatment (RTT)** • Data for January RTT performance is due to be submitted on Wednesday 18th March. The Trust is expected to under deliver the RTT standards in both February and March 2015. This is a planned under delivery following agreement by the Trust Development Authority (TDA) to focus on data validation of patients still waiting for treatment, rather than data validation of those patients who have already had their treatment. • The Trust is on target with its trajectory to reduce the number of incomplete RTT pathways to 7,000 by the end of February (submitted on 18th March) and to 5,000 by the end of March (submitted on 17th April). • In addition to improvements to Cerner workflow and resolving technical issues affecting reporting, the Trust has invested in a team, through funding from the TDA, to support on-site training to staff to support them to use Cerner without inadvertently entering erroneous data.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.*	Kevin Jarrold, Chief Information Officer.

ICHT Response: Yes **Explanation: The Trust is compliant and submitted its most recent toolkit return on 31 March 2015, achieving a minimum level 2 assessment against all standards.**	
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICHT Response: Yes** **Explanation: Board members are reminded at each Trust board of the need to ensure that the register of interests is current; it is formally reviewed at every other Trust Board meeting. Arrangements for making declarations for all staff grade 8c and above are being reviewed (to strengthen assurance); a new process using the e-learning tool will ease management action and provide an audit tool for compliance. The Trust currently has one NED vacancy, and the Chief Financial Officer role is covered by an interim – a substantive replacement has been recruited and will commence in the summer.**	Jan Aps Trust company secretary
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICHT Response: Yes** **Explanation: A Board Development programme continues to run in 2015/16 on a bi-monthly basis.**	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response: Yes** **Explanation: A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan.** **Development sessions will continue in 2015/16.**	Jayne Mee, Director of People and Organisational Development.

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Compliance Monitor.
Monthly Data: April 2015 Submitted 29/05/2015

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

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

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

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

NHS TRUST DEVELOPMENT AUTHORITY
OVERSIGHT: Monthly self-certification requirements - Board Statements
Monthly Data: April 2015, Submitted 29/05/2015

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

For CLINICAL QUALITY, that:	Executive lead
Q1. *The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* **ICHT Response: Yes** **Explanation: Governance arrangements in place to assure quality of care with clear accountability and reporting.**	Chris Harrison, Medical Director
Q2. *The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.* **ICHT Response: The Board is satisfied that the Trust meets the CQC registration requirements and is registered with no conditions.** **Following the CQC inspection in September 2014, the Trust received a number of compliance actions. An action plan has been approved by the Trust Board and CQC to address these regulatory breaches. Furthermore, a new compliance and improvement framework outlining the Trust's approach to ensure on-going compliance has been approved by the Trusts' Executive Committee.**	Janice Sigsworth, Director of Nursing
Q3. *The Board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **ICHT Response: Yes** **Explanation: Responsible officer in place with governance arrangements to provide assurance.**	Chris Harrison, Medical director
For Finance, that:	
Q4. *The Board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.* **ICHT Response: Yes** **Explanation: The Trust remains a going concern as defined by the most up to date accounting standards.** **The Board considers annually the Going Concern of the Trust as per IAS 1. The accounts for 2013/14 were prepared on a 'Going Concern' basis with a paper reviewed by the May Trust Board that supported this conclusion.**	Alan Goldsman, Chief Financial Officer
For GOVERNANCE, that:	
Q5. *The Board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.* **ICHT Response: Yes** **Explanation: A detailed review of the NTDA Accountability Framework and the NHS Constitution was undertaken in February 2014, the outcome of which considered that the Trust was compliant with the NTDA accountability framework. A further review of both compliance with, and assurance mechanisms for, the Accountability Framework and constitution will be undertaken by the Trust during the Spring / summer.**	Jan Aps Trust company secretary
Q6. *All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.* **ICHT Response: Yes** The Trust has a Risk Management Strategy and a Corporate Risk Register (CRR). The CRR identifies the key risks to the organisation. **Explanation: The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver.**	Janice Sigsworth Director of Nursing
Q7. *The Board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed*	Janice Sigsworth Director of Nursing

appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance. **ICHT Response: Yes** **Explanation: The Annual Governance Statement identifies significant issues for the coming year. The Trust has a Risk Management Framework in place and risks identified as part of the FT process have been identified and documented with appropriate actions in place to deliver. In addition the risk management framework includes a rigorous review of scoring and review of controls and mitigation.**	
Q8. *The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.* **ICHT Response: Yes** **Explanation: There are risk management processes in place and the management of strategic risks is currently undergoing review. Recommendations from the Audit, Risk & Governance Committee are followed up on and the actions reported at each Audit, Risk & Governance Committee.**	Alan Goldsman, Chief Financial Officer
Q9. *An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk)* **ICHT Response: Yes** **Explanation: The AGS for inclusion in the annual report for 2014/15 has been finalised and signed as part of the annual report and accounts following review by TDA and external audit. Compliance with AGS will be monitored using the Trust's risk management and assurance frameworks**	Jan Aps Trust company secretary
Q10. *The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.* **Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI):** • To date six cases of MRSA BSI have been allocated to the Trust (one case in April, two cases in May, one case in October, November and December). • In February two further cases of MRSA BSI occurred, these have initially been allocated to the Trust (post 48 hour specimens). PIRs for both cases are currently being undertaken within the division of medicine; the final allocation will be made once the PIRs are completed. **Clostridium difficile infections:** • Eight cases of C. difficile were allocated to the Trust for February 2015. • The annual objective for the Trust is 65 for 2014/15; at the end of February 2015 we reported 70 cases attributed to the Trust. • The provisional definition of a lapse in care associated with toxin positive C. difficile disease within ICHT is described as a) non-compliance to the ICHNT antibiotic policy or b) If the patient shared a ward with another patient who was symptomatic and later found to be C. difficile positive (with the same ribotype). A sample of Trust attributable C. difficile cases from Quarters one, two and three has been subject to a collaborative review with the CCG. • In Quarter one, two cases were felt to be due to a potential lapse in care (one due to non-compliance with antibiotic policy and one having had contact with another patient with C. difficile). In Quarter two there was one case felt to be due to a potential lapse in care (having had contact with another patient with C. difficile). There were no lapse of care cases identified in Q3. • The IP&C team monitor the time to isolation for all cases of C. difficile; during Q3, seven of the 15 cases were not isolated with the two hour time period. **Referral to treatment (RTT)** • Data for January RTT performance is due to be submitted on Wednesday 18th March. The Trust is expected to under deliver the RTT standards in both February and March 2015. This is a planned under delivery following agreement by the Trust Development Authority (TDA) to focus on data validation of patients still waiting for treatment, rather than data validation of those patients who have already had their treatment. • The Trust is on target with its trajectory to reduce the number of incomplete RTT pathways to 7,000 by the end of February (submitted on 18th March) and to 5,000 by the end of March (submitted on 17th April). • In addition to improvements to Cerner workflow and resolving technical issues affecting reporting, the Trust has invested in a team, through funding from the TDA, to support on-site training to staff to support them to use Cerner without inadvertently entering erroneous data.	Steve McManus, Chief Operating Officer.
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICHT Response: Yes** **Explanation: The Trust is compliant and submitted its most recent toolkit return on 31 March 2015, achieving a**	Kevin Jarrold, Chief Information Officer.

minimum level 2 assessment against all standards.	
Q12. *The Board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.* **ICHT Response: Yes** **Explanation: Board members are reminded at each Trust board of the need to ensure that the register of interests is current; it is formally reviewed at every other Trust Board meeting. Arrangements for making declarations for all staff grade 8c and above are being reviewed (to strengthen assurance); a new process using the e-learning tool will ease management action and provide an audit tool for compliance. The Trust currently has one NED vacancy, and the Chief Financial Officer role is covered by an interim – a substantive replacement has been recruited and will commence in the summer.**	Jan Aps Trust company secretary
Q13. *The Board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICHT Response: Yes** **Explanation: A Board development programme continue to run in 2015/16 on a bi-monthly basis.**	Jayne Mee, Director of People and Organisational Development.
Q14. *The Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response: Yes** **Explanation: A high calibre senior management team is in place with the capacity, capability and experience to deliver the annual operating plan.** **Development sessions continue in 2015/16.**	Jayne Mee, Director of People and Organisational Development.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.4
Title	Adult Safeguarding Report 2014-2015
Report for	Noting
Report Author	Guy Young, Deputy Director of Patient Experience
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary:

This report summarises activities to support the adult safeguarding agenda at ICHT during the period April 2014 to March 2015.

The report provides a high level summary of structures and processes, activity and training.

Recommendation to the Board:

The Board is asked to note the contents of the report

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Adult Safeguarding Annual Report 2014/15

1 Introduction

Safeguarding adults is an important responsibility of the Trust. The primary objective of adult safeguarding activity is to prevent and reduce the risk of harm to patients at risk from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion.

In 2014/15 the Trust worked closely with Tri-Borough (Westminster, Hammersmith & Fulham and Kensington & Chelsea) partners to ensure consistent, effective and safe systems for protecting vulnerable adults.

2 Background

In 2014, the *No secrets* guidance for the protection of vulnerable adults from abuse and neglect, was replaced by the Care Act (DoH, 2014). This wide ranging piece of legislation outlines the way in which local authorities should provide support for adults in need of care and support. There is specific reference (chapter 14) to safeguarding arrangements and, whilst the guidance is aimed primarily at local authorities, collaborative working with partners such as the NHS, is critical to delivering appropriate safeguarding systems.

The guidance focuses on “adults at risk” (there is a move away from the term vulnerable adult) and the categories of abuse have been expanded to include domestic violence and modern slavery.

A key development in the safeguarding chapter is the notion of “making safeguarding personal”. In effect this means recognising that safeguarding arrangements are there to protect *individuals*. It can therefore be unhelpful to apply prescribed processes in all situations; every case should be looked at on an individual basis. For example, it may be that a family member is taking money from an elderly relative, but intervention that negatively affects the relationship between them may be more damaging to the older person than stopping the abuse.

The Trust has been working closely with colleagues in the local authority to ensure that the Care Act principles are properly applied.

3 Structures, Processes and Roles

The Director of Nursing provides the Executive Lead for Adult Safeguarding. The Deputy Director of Patient Experience has managerial responsibility for adult safeguarding.

The Deputy Director of Patient Experience chairs the Trust Adult Safeguarding Committee and represents ICHT on the Tri-borough Safeguarding Adults Executive Board (SAEB). They also provide quarterly update reports to the commissioners via the Clinical Quality Group.

Each division has a designated adult safeguarding lead (either the Divisional Director of Nursing or one of their deputies) who can be contacted for advice and support. Their information is available on the Trust intranet, The Source, which provides a number of resources to help staff with adult safeguarding issues - http://source/safeguardingadults

There are monthly conference calls between the Trust and Tri-Borough colleagues to track cases and validate outcomes for safeguarding alerts raised by the Trust.

During the year the Trust appointed one of the care of the elderly physicians to the role of the named doctor for adult safeguarding. This role provides advice, training for junior doctors and sits on the local safeguarding adults committee. This was a recommendation from an internal audit report in 2014.

4 Adult Safeguarding Activity

Work undertaken in the year focused on strengthening the process for raising and recording safeguarding concerns. Working with the local authorities, the Trust reviewed local polices and guidance to ensure that safeguarding alerts are raised in a timely and appropriate fashion.

During the year, 477 safeguarding alerts to the local authority were raised. This represents a 25% increase on 2013/14. This increase is most likely to be as a result of increased awareness arising from the focus on level 1 training. The majority of these alerts, as in previous years, were related to community acquired pressure ulcers, which acute trusts are required to report via the safeguarding route.

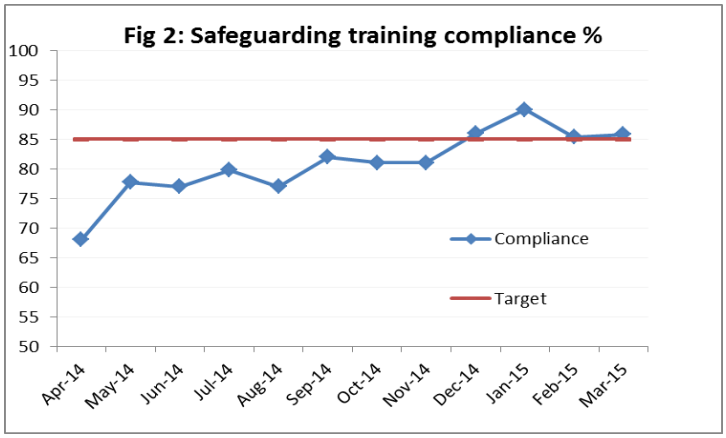
Few of the alerts raised required formal intervention by social services. Further work has been undertaken to ensure staff are raising concerns when appropriate.

5 Adult Safeguarding Training

The compliance with Level 1 safeguarding training was well below the required level at the beginning of 2014/15 and increasing this to 85% by the end of the year was the primary objective. This was achieved (fig 2) through delivering training in a range of ways, including ward based sessions and joint “loop days” where training was delivered alongside child safeguarding training.

Adult safeguarding training was the first speciality to go onto Wired 2, the new Trust mandatory training database. This has been a major step forward. Also, Wired 2 not only provides accurate and almost real-time data, but divisions can go down to individual records to see who in their teams is and is not compliant.

It was also noted in the CQC report that when asked, staff were able to provide information about safeguarding including what action they should take and who they would contact for advice.



6 Internal Audit Report

Published in December 2014, this report provided "reasonable" assurance about the trust safeguarding systems and processes. This was an improvement over the two previous years where only limited assurance was provided. The summary findings were:

- The level of reporting on Datix, the Trust incident reporting system, has significantly improved since the previous audit
- The level of awareness training has greatly improved from last year with 77% of all Trust staff having received the training
- The recording of safeguarding adult alerts in patients' health records is not adequate;
- The documentation of raised alerts was inconsistently applied making assessments of patients that have attended the Trust on multiple occasions hard to identify and therefore hard to refer to the correct agencies.
- The Safeguarding Adults policy does not indicate what level of training constitutes a minimum level of compliance.

Six recommendations were made and a plan to address these is in place and underway.

7 MCA and DoLS

There was a large amount of training in year in relation to the Mental Capacity Act (MCA). This is integral to training about consent, but also needs to be addressed separately in relation to the management of patients who lack capacity to make decisions. There was an increased focus in 2014/15 on Deprivation of Liberty Safeguards (DoLS) following a Supreme Court judgement. In a case brought against Cheshire West Council, the court found that P, a profoundly disabled man, was deprived of his liberty by virtue of the complete and effective control exercised over his life by those looking after him in a care home.

This has had a significant impact on all organisations that provide care, including acute trusts. The number of DoLS applications to the local authority has increased ten-fold, to the point where they are struggling to action them. ICHT has seen a similar rise.

This issue is under constant review as new information is emerging all the time. For acute trusts, for example, there are implications in relation to patients in intensive care, who as a result of sedation may be considered to be technically deprived of their liberty. This has been discussed at length at the trust Mental Health Act group and the local safeguarding committee. The trust lead for the MCA chairs the trust Mental Health Act group and has been involved in national discussions about this. It was agreed that a sensible and proportionate response is required from the Trust, being mindful of the issues raised as a result of P v Cheshire West. DoLS will remain a focus of work in the coming year.

8 Prevent

Prevent is a component of the Government's counter terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism. Focusing on radicalisation of at risk young people, the strategy sits under the safeguarding umbrella.

At ICHT, Prevent is managed by the trust Head of Security. The focus has been awareness raising through training. Given the volume of mandatory training, it has been difficult to secure good attendance at the training sessions and different approaches are being considered. A trust Prevent steering group has been established. New guidance and training resources are emerging from NHS England and the trust will take steps to implement these.

9 Plans for 2014/15

The priority areas for development during 2015 are:

- Maintaining 85% compliance rate for level 1 adult safeguarding training and the provision of a level 2 and 3 training strategy
- Reviewing trust systems and process to ensure that the changes arising from the Care Act, particularly "making safeguarding personal", are properly addressed
- Monitoring DoLS related activity and guidance to ensure that we are seeking appropriate authorisation for patients who lack capacity
- Delivering the Prevent agenda.

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.4
Title	Safeguarding Children and Young People Annual Report 2014-15
Report for	Monitoring and Noting
Report Author	Cressida Zielinski, Named Nurse Safeguarding Children and Young People; Lynda Hassell, Deputy Divisional Director of Nursing, Children and Safeguarding
Responsible Executive Director	Janice Sigsworth Director of Nursing

Executive Summary:

The 2013/14 Safeguarding Children and Young People Annual report was received at the Trust Board meeting in November 2014.

This paper presents the 2014/15 Safeguarding Children and Young People Annual report and the Annual Safeguarding Children Declaration. The declaration confirms that the Trust meets all the requirements set out in David Nicholson's letter of 16th July 2009 whereby Trusts are required to publish an annual declaration of compliance against the recommendations in the letter. The updated declaration for March 2015 is included in Appendix 1.

The annual report provides a progress update against the key priorities identified for 2014/15. It highlights significant achievements made in changing the reporting of safeguarding children training and documents the priorities for 2015/16. These include progressing new work streams set up to screen for and report incidences of Female Genital Mutilation (FGM) and to provide an associated counselling service for these women.

In addition, it highlights the Chief Inspector of Hospitals CQC inspection of the Trust between 2nd - 5th September 2014 which resulted in a positive report of the Safeguarding Children and Young People Services and no suggested actions for improvement.

Recommendation to the Board:

The Trust Board is asked to note the Annual Safeguarding Children Declaration, which has been ratified by the Executive Committee, and presented to the Quality Committee in May 2015 in preparation for publication on the ICHT website.

Trust Strategic Objectives Supported by this Paper:

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

SAFEGUARDING CHILDREN & YOUNG PEOPLE SERVICE ANNUAL REPORT 2014-2015

1. BACKGROUND

The Children Act 1989 HM Gov (1989), the Children Act 2004 HM Gov (2004) and the Government's Statutory Guidance contained within Section 11 of the Children Act 2004 specifies that the Trust Board has a legal responsibility to safeguard and promote the welfare of children and young people.

The Healthcare Commission's Child Safeguarding Review in February 2009 highlighted cause for concern in areas of England and Wales resulting in the Secretary of State requesting that the Care Quality Commission (CQC) undertake a review of arrangements across the NHS for safeguarding children and young people CQC (2009).

The Trust Board received David Nicholson's letter of the 16th July 2009 setting out the minimum requirements for Trust Boards to be assured that appropriate arrangements were in place for safeguarding children and young people and directing that a declaration should be placed on the website of each provider and commissioning Trust confirming that requirements were in place for safeguarding children and young people. A declaration was first placed on the Imperial College Healthcare NHS Trust (ICHT) website on 19th October 2009 and an updated declaration is placed on the website annually. The March 2015 declaration is included in Appendix 1.

2. CONTINUING IMPROVEMENTS TO THE SAFEGUARDING CHILDREN & YOUNG PEOPLE SERVICE FOR 2014- 2015

Sixteen priorities were identified for 2014-2015; progress against these is reported below:

2.1 To complete a review of the Safeguarding Children and Young People service

A comprehensive review of the Trust wide safeguarding children service was undertaken and completed by the Named Nurse. This was a significant piece of work which will underpin the development of the trust safeguarding children strategy and work plan for 2015/2016.

2.2 To develop and launch a Trust wide Safeguarding Children and Young People Operational Strategy

The Safeguarding Children Strategy will be developed as a key priority in 2015/16 by the named professionals, giving consideration to the findings and recommendations of the review of safeguarding children services.

2.3 To ensure the effective continuation of safeguarding procedures with Cerner CRS, in relation to the flagging of children with a child protection plan

A retrospective audit took place in November 2014 to ascertain whether lists of the names of children that are subject to child protection plans are uploaded on to the Cerner and Symphony systems and if the names of children who are removed

from child protection plans are removed from both Cerner and Symphony when notification is received from the local authority. The recommendations of the audit have been completed.

2.4 To continue to work with the Trust CERNER CRS team to support the implementation of the CQC recommendation that all health professionals ask patients whether they have children at home and assess that they are safe and being cared for

The team have continued to work with Cerner to support the CQC recommendation that all health professionals ask patients whether they have children at home and assess that they are safe and being cared for. An audit is planned in 2015/2016.

2.5 To review training requirements & strategy in light of new Intercollegiate document RCPCH 2014

The safeguarding children training policy and training requirements have been reviewed and updated in light of the new Intercollegiate document. Reporting methods have been amended to a new method of reporting safeguarding children training compliance, which measures the compliance of staff in post, rather than the training sessions delivered. The new reporting method commenced in January 2015.

Training compliance March 2015

- Level 1 80%,
- Level 2 87%
- Level 3 74%
- Trust overall 84%

2.6 To complete the qualitative audit of staff experience of the quality and efficiency of safeguarding children and young people's supervision in the Maternity Department

The audit of staff experience of the quality and efficiency of safeguarding children and young people's supervision in the Maternity Department was completed in August 2014. While many of the findings were positive, a series of recommendations were made and this will be re-audited in 6 months, as a key priority for 2015/16.

2.7 To develop a trust wide Domestic Violence Policy

The Domestic Violence Policy is to be a Trust wide safeguarding policy jointly developed and written by leads from adult and children's safeguarding and Standing Together as recommended in the review of safeguarding children. This will be a key priority for 2015/16.

2.8 To work together with partner agencies to develop cohesive policy and practice regarding Female Genital Mutilation (FGM)

The Trust wide FGM Policy is now complete and will be ratified at the Safeguarding Children and Young People Committee in May 2015.

The Trust participated in a three month pilot project with Children's Social Care at the St Mary's Hospital FGM Clinic which commenced in September 2014. A Social worker and health advocates worked in the St Mary's FGM clinic with the midwife

to provide a joint agency approach to risk assessment and the provision of education, guidance and support to women who have suffered FGM. Further funding has been obtained enabling this project to continue across both sites for a further 18 months. This will include specialist midwives, a Faith and Cultures social worker and advocates for the women. There will also be a psychologist and a worker to focus on communicating with the men within the family to increase awareness.

Funding was secured by our Tri Borough colleagues for an educational FGM training video to be designed and recorded. Members of safeguarding and midwifery teams have developed and recorded an educational video for Health Colleagues in North West London.

Data regarding FGM has been collected from midwifery services and reported to the Department of Health (DH). A Cerner form has been developed; from May 2015 the DH will be informed of all cases of FGM identified throughout the organisation. The Trust wide FGM data collection and reporting to the DH is to commence in May 2015.

2.9 The implementation of a Youth worker in A&E at St Mary's Hospital site for gangs/sexual exploitation

There is now a team of youth workers from the Red Thread Project working in St Mary's A&E. The Safeguarding Children Team are now working in partnership with the youth workers in A&E and on the major trauma unit. The youth workers are now participating in the trusts level 3 safeguarding children training.

2.10 Completion and implementation of the Trust policy in relation to the management of life threatening behaviour and refusal to consent by children and young people

The Policy was completed and ratified in July 2014.

2.11 To adapt the Standard Operating Procedure for the admission of 16 to 18 year olds, in order to incorporate placements of all children on adult wards Trust wide

The current Standard Operating Procedure for the admissions of all children on adult wards now requires amendment as the NSF standards ended in 2014. This will be a priority for 2015/16.

2.12 To develop a Trust policy on well-wishers delivering gifts to patients e.g. gifts to children at Christmas

Guidelines for visiting children's wards have been written which include ensuring that children are safeguarded while on the ward and guidance on the management of well-wishers delivering gifts to patients. These guidelines were approved at the March 2015 Children's Quality Committee. These guidelines have considered and incorporated lessons learnt from the Savile Inquiry findings.

2.13 Imperial College Healthcare NHS Trust and the Tri Borough Multi Agency Safeguarding Hub (MASH) to continue to develop partnership working and Information sharing pathways between MASH partners

The Caldicott Guardian signed the MASH Information Sharing Agreement in March 2015. The Trust continues to work in partnership with MASH and other agencies.

2.14 To achieve a successful CQC inspection of Safeguarding Children and Young People's Services

The Trust did not receive a CQC inspection of Safeguarding Children and Young Peoples Services. There was a CQC hospital inspection and safeguarding children services were included in the hospital inspection. No concerns were raised in relation to safeguarding children services in the Trust.

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

The Named Nurse provided a chronology for a serious case review.

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

The Trust continues to work in partnership with our Inner North West London Colleagues. Examples of this are ensuring continued attendance at Local Safeguarding Children Board meetings, through subgroup working, training and through joint project working.

3. GOVERNANCE ARRANGEMENTS FOR SAFEGUARDING CHILDREN & YOUNG PEOPLE (CYP)

3.1 Executive Leadership

The Intercollegiate Guidance RCPCH (2014) defines roles and responsibilities of named doctors, nurses and midwives. The document also specifies that named individuals and the nominated Trust Board representatives have a duty to monitor safeguarding throughout the organisation. In accordance with this, the Director of Nursing is the Trust Champion and Executive Lead for Safeguarding Children & Young People, and is a member of the ICHT Safeguarding Children and Young People Committee and the NSF for Children, Young People and Maternity Services Committee.

3.2 The ICHT Safeguarding Children and Young People Committee

The ICHT Safeguarding Children and Young People Committee was established in November 2009. The Terms of Reference were reviewed and amended in August 2014 and February 2015 and are included in Appendix 2.

As an over-arching committee it is responsible for providing strategic leadership to assure the integration of all aspects of policy and procedure in relation to the safeguarding of children and young people to ensure that ICHT provides safer, high quality care in the best environment.

The ICHT Safeguarding Children and Young People Committee reports to the Trust Board via the ICHT Quality Committee and the ICHT Executive Committee, see attached governance arrangements in Appendix 3.

3.3 Disclosure and debarring service checks (formerly Criminal Records Bureau Checks)

The Trust is currently operating in line with statutory requirements.

3.4 Implementing Safe Recruitment Practices

Ensuring that safer recruitment practice is embedded within the relevant areas has been identified as a key performance indicator and performance against this in 2014/15 was 100%.

4. DEVELOPING CAPACITY AND CAPABILITY FOR SAFEGUARDING CHILDREN & YOUNG PEOPLE

4.1 Named Individuals for Safeguarding Children &Young People

The Named individuals for Safeguarding Children & Young People, as detailed in Appendix 4, meet together with the specialist clinical leads, the Deputy Divisional Director of Nursing for Children and safeguarding, and the team administrator at a six weekly operational group meeting. This meeting is structured to provide close monitoring of required actions. A spreadsheet action tracker is updated each month to assure compliance and evidence against required actions.

4.2 Safeguarding Supervision for Staff involved with Children and Young People

In order for the Safeguarding of Children and Young People to continue to be of a high standard it is essential that all staff who have direct contact with children have appropriate safeguarding children supervision. The roles of key safeguarding children staff are demanding, stressful and can be distressing, therefore all staff involved in Safeguarding Children and Young People should have supervision according to their role, as set out in the Intercollegiate Document RCPCH (2014). This is also recommended by the CQC. The ICHT Safeguarding Children & Young People Supervision Policy sets out requirements for the relevant staff groups; this policy has been implemented and identified as a key performance indicator. Data analysis is reported quarterly to the Safeguarding Children & Young People Board.

5. POLICIES & PROCEDURES IN PLACE TO SAFEGUARD CHILDREN & YOUNG PEOPLE

Policy review and development continues to be a significant aspect of the Safeguarding Team's role. Safeguarding Children Policies are regularly reviewed to reflect national and local guidelines as summarised below:

6. AUDIT OF THE SAFEGUARDING CHILDREN & YOUNG PEOPLE SERVICE

An internal programme of continuing audit has been established. The Named Nurse and Named Midwife for Safeguarding CYP present a quarterly report to the Safeguarding Committee reflecting activity, compliance with established standards and identifying trends.

This data will also be utilised to populate the Inner North West London Commissioning cluster Acute Trust Monitoring Safeguarding Children Template. This data is also sent to the Commissioning Quality Group, and reported quarterly.

7. PARTNERSHIP WORKING TO PROMOTE SAFEGUARDING OF CHILDREN & YOUNG PEOPLE

7.1 Local Safeguarding Children's Boards

Safeguarding children requires comprehensive partnership working between the relevant statutory and non-statutory organisations, and other local agencies. To enable partnership working, each local authority is required under the Children's Act 2004 to establish a Local Safeguarding Children Board (LSCB). This is the principal mechanism for agreeing how relevant local organisations co-operate to safeguard children and ensure that this is done effectively.

The Trust attends the Tri Borough LSCB and relevant sub groups.

8. MONITORING OF SAFEGUARDING CHILDREN AND YOUNG PEOPLE AND QUALITY ASSURANCE MECHANISMS

As described in 3.2 above the ICHT Safeguarding Children and Young People Committee ensures that ICHT provides safer, high quality care in the best environment, by agreeing strategic priorities and objectives in line with national standards and accreditations, such as those set out by the CQC and by holding each Division to account for their implementation.

8.1 Serious Case Reviews and Individual Management Reviews

When a child dies or sustains a potentially life-threatening injury, and abuse or neglect is known or suspected to be a factor in the death or injury, LSCBs must undertake a serious case review (SCR). The purpose of SCRs is to find out what can be learned from the case about the way local professionals and organisations work together to safeguard children. As part of an SCR, the LSCB commissions an overview report and each relevant service should complete a separate management review or an individual management review (IMR).

ICHT is represented on Serious Case Review Panels as necessary and ensures Individual Management Reviews are thorough and extensive and that any learning and recommendations are thoroughly and effectively implemented. A Trust Consultant Paediatrician and Named Midwife for Safeguarding Children & Young People sit on the Child Death Overview Panel.

8.2 Assurance to our Commissioners

Reporting templates to provide assurance to our commissioners have been agreed at the ICHT Safeguarding Children and Young People Board of which the Designated Nurses for NHS Westminster and NHS Hammersmith and Fulham are members. Additionally NHS Westminster has included a safeguarding CQUIN relating to the flagging of children with safeguarding plans within the A&E departments. A report is presented to the Clinical Quality Group quarterly.

9. KEY PRIORITIES FOR THE NEXT YEAR

The following are the key priorities for the Safeguarding Children and Young People service for 2015/16:

9.1 To develop and launch a Trust wide Safeguarding Children and Young People Operational Strategy

9.2 To develop a Trust wide Domestic Violence Policy together with the Safeguarding Vulnerable Adults Team and Standing Together.

9.3 To complete a follow up qualitative audit of staff experience of the quality and efficiency of safeguarding children and young people supervision in the Maternity Department.

9.4 To adapt the Standard Operating Procedure for the admission of 16 to 18 year olds, in order to incorporate placements of all children on adult wards trust wide, taking into consideration that the NSF standards ended in 2014, it will therefore take into consideration the current relevant documents and standards guiding this practice.

9.5 To achieve trust wide agreement from the Divisional Directors to the recommendations from the Review of Safeguarding Children Service; to form part of the 2015/16 Business Planning process.

9.6 To develop the Trust's Liaison Health Visitor /Nurse team and service to include the Western Eye Hospital.

9.7 To review the Safeguarding Children Supervision policy and practice.

9.8 To develop more integrated working with the Trusts Vulnerable Adults Team.

9.9 To complete a Trust wide audit of adult areas to all health professionals ask patients whether they have children at home and assess that they are safe and being cared for.

9.10 To achieve 95% of staff completing the appropriate level of safeguarding children training.

9.11 To develop a Level 3 e- learning module to support the class room level 3 training.

9.12 To review the training matrix for staff who require safeguarding children training to clarify which level is required.

9.13 To complete action plans that may arise from the Serious Case Reviews and Domestic Homicide Reviews in progress.

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

10. FUTURE REPORTING

The intention is to report to the Board as follows:

A Safeguarding Children and Young People Annual Report in May 2015.

11. REFERENCES

HM Government 1989 *The Children Act*. London: HMSO
ttps://www.legislation.hmso.gov.uk/acts/acts1989/ukpga_19890041_en_1

HM Government 2004 *The Children Act:* London: HMSO
http://www.opsi.gov.uk/acts/acts2004/pdf/ukpga_20040031_en.pdf

HM Government 2007 The Children Act 2004 *Section 11: Statutory guidance on making arrangements to safeguard and promote the welfare of children* London: HMSO
http://www.dcsf.gov.uk/everychildmatters/_download/?id=1372

Care Quality Commission July 2009 *Safeguarding children: A review of arrangements in the NHS for safeguarding children*; London CQC
http://www.cqc.org.uk/_db/_documents/Safeguarding_children_review.pdf

HM Government 2013 Working *Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*. London: HMSO
http://publications.dcsf.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00305-2010

Royal College of Paediatrics and Child Health April 2014 *Safeguarding Children and Young People: Roles and Competences for Health Care Staff. Intercollegiate Document.* London: RCPCH

Appendix 1

Imperial College Healthcare NHS Trust

Safeguarding Children and Young People Declaration March 2015

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 children 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 Trust has a policy and 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 undertake relevant safeguarding children training and this is regularly reviewed to ensure that it is up to date. The Trust has a robust training policy in place with regard to delivering safeguarding children training.

The percentage of staff compliant with safeguarding children training for the twelve month period ending **31st March 2015** is as follows against a target of 80%:

	Staff in Post	Staff trained	% compliance
Level 1	1861	1487	**80%**
Level 2	5506	4804	**87%**
Level 3	1014	749	**74%**
Overall	8381	7040	**84%**

It is projected that the Trust will achieve 80% compliance for level 3 by the end of May 2015.

2. Named Professionals for Safeguarding Children and Young People

The Safeguarding Children and Young People 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 clinical nurse specialist, two lead/midwives covering maternity/neonates along with an administrator.

The team comprises:

Named Nurse	1 wte
Named Midwife	1 wte
Clinical Nurse Specialist	1 wte
Safeguarding Lead/ Midwife	2 wte
Named Doctor	0.4 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 Committee 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 last received by the Trust Board via the Director of Nursing's Report taken to the Trust Board Meeting in November 2014. The minutes of all public Trust Board meetings where safeguarding children has been discussed can be found at http://www.imperial.nhs.uk/aboutus/ourorganisation/boardmeetings/index.htm

Appendix 2

Imperial College Healthcare NHS
NHS Trust

Safeguarding Children and Young People Committee

TERMS OF REFERENCE

Terms of Reference

1.Constitution

1.1 The Trust Board hereby resolves to establish a Safeguarding Children and Young People's Committee, who holds only those executive powers as are delegated in the Terms of Reference.

1.2 The Safeguarding Children and Young People's Committee, provides the leadership and strategy which integrates all aspects of Safeguarding Children and Young People's policy and procedures to ensure that the Trust provides safer, high quality care in the best environment, manages the risks necessary to innovation in healthcare, uses accurate clinical information to bring about improved outcomes and the achievement of excellence in all regional and national Care Quality Commission (CQC) standards and accreditations.

1.3 The Trust Board has delegated the review of all aspects of the Safeguarding Children and Young People to the Safeguarding Children and Young People's Committee.

2. Membership

2.1 The Safeguarding Children and Young People's Committee will comprise of the following:-

- Divisional Director of Midwifery and Nursing, Women's and Children's Division (Chair)
- Deputy Divisional Director of Nursing Children's Services & Safeguarding
- Named Doctor Safeguarding Children and Young People, ICHT
- Designated Nurse for Safeguarding Children CWHH
- Named Nurse Safeguarding Children and Young People, ICHT
- Named Midwife Safeguarding Children and Young People, ICHT
- Safeguarding Lead, Vulnerable Adults, ICHT
- Divisional Directors of Nursing or delegated representatives
- Deputy Divisional Director of Midwifery
- Associate Head Of Nursing Private Health Care
- Senior/Lead Nurse Neonates
- Chief of Service, Children's Services
- Associate Director HR

Associate Members:-
- Designated Doctor, NHS Brent
- Designated Nurse, NHS Brent

2.2 A quorum shall consist of not less than eight members of the Safeguarding Children and Young People's Committee, one of which must be the chair or designated deputy.

3. Attendance

3.1 Members of the Safeguarding Children and Young People's Committee are expected to attend at a minimum three out of four meetings.

3.2 If Safeguarding Children and Young People's members are unable to attend a meeting they are requested to send a deputy.

4. Frequency of Meetings

4.1 The Safeguarding Children and Young People's Committee will meet quarterly in tandem with the National Service Framework for Children, Young People and Maternity Services Committee.

4.2 Extraordinary meetings may be called at the request of the Chairman of the Committee.

5. Authority

5.1 The Safeguarding Children and Young People's Committee, is authorised by the Trust 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 co-operate with any request made by the Safeguarding Children and Young People's Committee.

5.2 The Safeguarding Children and Young People's Committee, is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Evaluation of the Effectiveness of the Committee

6.1 The Safeguarding Children and Young People's Committee will prepare an annual report for presentation to the ICHT Executive Committee (Quality), Quality Committee and Trust Board.

6.2 The ICHT Executive Committee (Quality) is required to ratify the annual objectives.

7. Reporting

7.1 The minutes of Safeguarding Children and Young People's Committee meetings shall be formally recorded. . The Chair of the Safeguarding Children and Young People's Committee shall draw to the attention of the ICHT Executive Committee and the Trust Board any issues that require disclosure to the full Trust Board, or require executive action.

7.2 The Safeguarding Children and Young People's Committee will receive the following direct reports:-

- Divisional reports
- Local Safeguarding Committee Board Reports
- Reports from Named professionals for Safeguarding Children and Young People
- Safeguarding Children and Young People Action Group reports

8. Procedures

8.1 The Safeguarding Children and Young People's Committee, will complete an annual self–assessment exercise and where areas of need have been identified implements and monitors an action plan to address this issues

8.2 Any member of the committee can raise issues and concerns with the Chairman of the Safeguarding Children and Young People's Committee, where local resolution has not been taken forward in the spirit of Trust wide learning.

8.3 Any member of staff may raise an issue with the Chairman of the Safeguarding Children and Young People's Committee, by written submission. The Chairman shall decide whether or not the issue shall be included in the Chairman's business. The individual raising the issue may be invited to attend.

9. Review of Terms of Reference

9.1 The Safeguarding Children and Young People Committee shall review its terms of reference yearly and present these to the Board for approval.

Appendix 3

Governance Structure for Safeguarding Children and Young People

- The Director of Nursing is the Board Level Executive Director lead for Safeguarding – the designated 'Children's Champion' and the Deputy Director of Nursing is a member of the Local Children's Safeguarding Board.

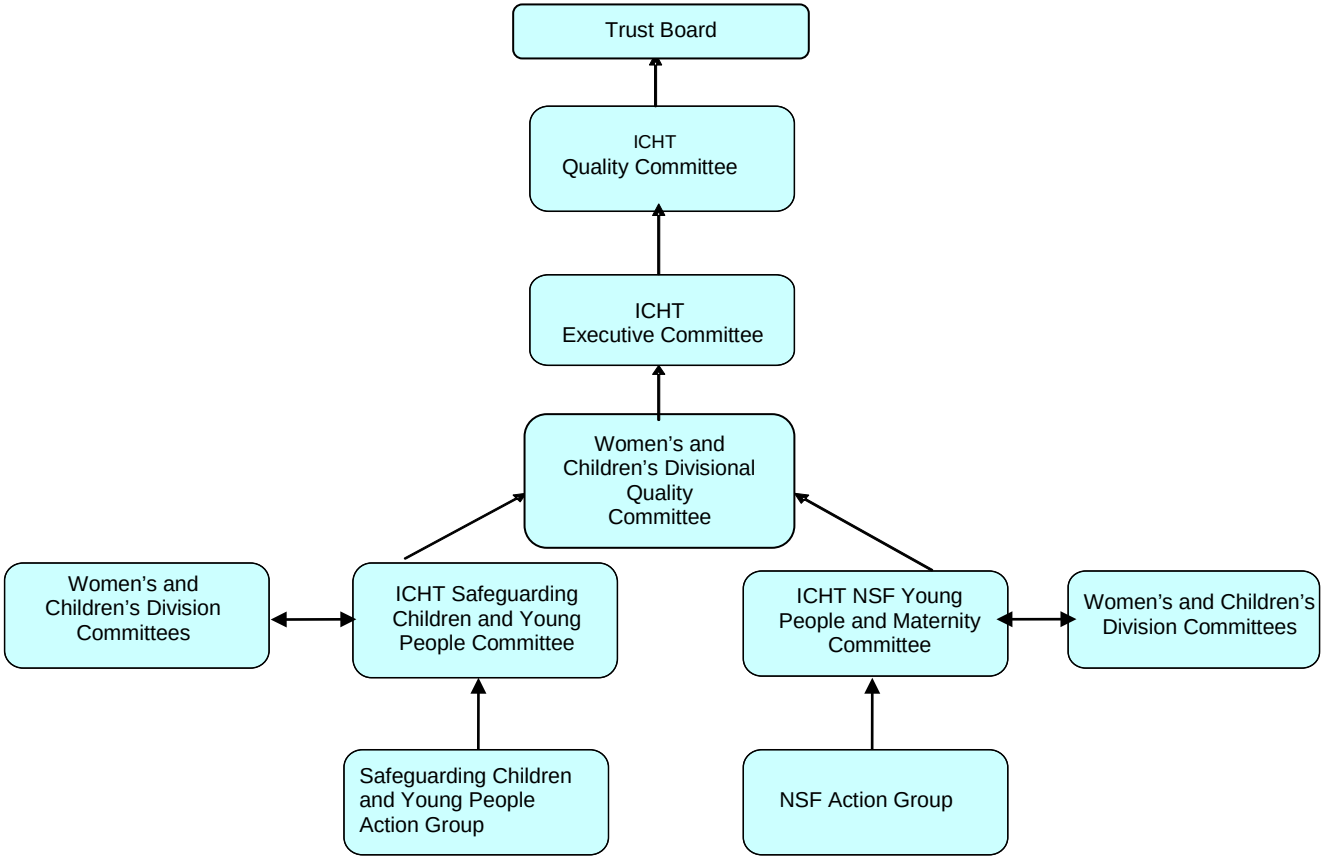
- The Director of Midwifery/Head of Nursing for the Women and Children's Division chairs the ICHT Safeguarding Children and Young People Committee, which leads and co-ordinates the management of safeguarding children and young people throughout the ICHT.

- The Deputy Divisional Director of Nursing for Children's Services chairs the ICHT Children, Young People and Maternity NSF Committee.

- Each Division is represented on the ICHT Safeguarding Children and Young People Committee, who will be responsible for reporting the compliance of their Division in meeting the CQC safeguarding standards.

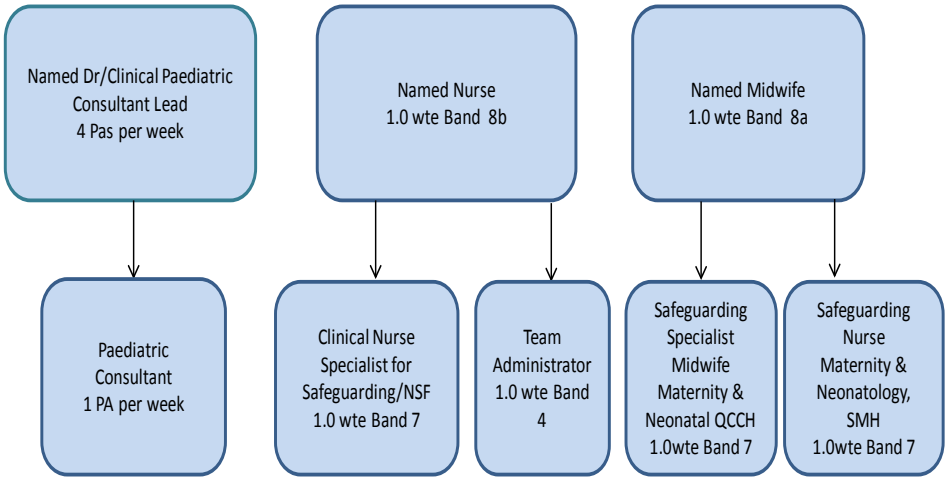
Please see diagram below

Reporting Structure for Safeguarding Children and Young People



Appendix 4

Safeguarding Children and Young People Team
March 2015



Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	3.5
Title	J Savile and the Kate Lampard Lessons learned report
Report for	Noting
Report Author	Jan Aps, Trust Company Secretary
Responsible Executive Director	Jan Aps, Trust Company Secretary

Executive Summary:

- A further report has been issued relating to the J Savile investigation, undertaken by Kate Lampard, making a series of recommendations to trusts. The TDA requires that each trust return their response to the recommendations on a template action plan. The approved submission is enclosed.

The Trust board is asked to:

- Note the publication of the Kate Lampard Lessons Learned Report, and the recommendations made for NHS trusts;
- Note that the required return has been reviewed and approved for submission by the executive committee, and reviewed by quality committee.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

NHS investigations into Jimmy Savile and the Kate Lampard Lessons Learnt Report

Members will recall that during late 2012 and early 2013, Management Board (now Executive Committee), Governance Committee (now Audit/Risk and Governance Committee) and the Trust Board received regular reports and updates on areas and systems being reviewed and actions taken to address issues identified in the initial Savile NHS investigations. This included confirmation to the NHS Commissioning Board in December 2012 and June 2013 that all procedures relating to the safeguarding of vulnerable people had been reviewed and were considered robust.

In March 2015 the TDA Chief Executive, David Flory, wrote to all trusts drawing their attention to the publication of an overarching Lessons Learned Report authored by Kate Lampard. The full recommendations are attached as appendix two.

The TDA require each trust to respond using the action plan provided. The proposed response is attached and has been reviewed and approved by Executive Committee.

The Director of Nursing presented a summary of the Trust's response to the TDA at the Integrated Delivery Meeting on Thursday 23 April. Further guidance is expected from the TDA in relation to three year DBS checking arrangements for staff and volunteers; at present the Trust complies with NHS Employer's guidance.

The Trust is required to ensure that the Board has sight of the full recommendations from the Lampard report.

The Trust board is asked to:

- Note the publication of the Kate Lampard Lessons Learned Report, and the recommendations made for NHS trusts;
- Note that the required return has been reviewed and approved for submission by the executive committee and reviewed by quality committee.

Imperial College Healthcare NHS Trust

Appendix one

REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

NAME OF TRUST:	Imperial College Healthcare NHS Trust

Recommendation	Issue identified or current position	Planned Action	Progress to date	Due for completion
I. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	The Trust VIP policy was reviewed in 2012/13 and considered appropriate for managing VIPs and other official visitors. It is now subject to further review.	Being reviewed as part of action outlined in XI below	Current policy under review. Meeting held with charity agreed to develop joint strategy, which will impact policy review.	June 2015
II. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and, • All voluntary services managers have development opportunities and are properly supported.	Arrangements were reviewed in 2014, following initial publication of the initial investigation reports. The arrangements are considered to be appropriately robust.	None beyond planned review		
III. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	Safeguarding training is provided to relevant staff and volunteered at least every three years.	None beyond planned review		
IV. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes	Safeguarding arrangements were comprehensively reviewed following the	None beyond planned review		

Imperial College Healthcare NHS Trust

NAME OF TRUST:	Imperial College Healthcare NHS Trust

Recommendation	Issue identified or current position	Planned Action	Progress to date	Due for completion
(including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. • to ensure that their arrangements are robust and operate as effectively as possible.	initial investigation reports and are subject to regular review.			
V. All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	The Trust complies with NHS Employer's guidance in undertaking checks on appointment and at significant change in role.	None beyond planned review, but understand this was raised at IDM meeting (27/4/15)		
VI. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	The Trust's public wifi provider is a member of the 'Friendly WiFi' Scheme. This ensures that the public WiFi provided has been checked and verified so that pornography and child abuse websites are blocked.	None		
VII. All NHS hospital trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	The Trust is assured as to the arrangements and checks in place in relation to agency workers, as the Trust uses framework agencies which are audited by the framework provider. A checklist is provided by the agency with the relevant data for each agency worker	None beyond planned review		

Imperial College Healthcare NHS Trust

NAME OF TRUST:	Imperial College Healthcare NHS Trust			
Recommendation	**Issue identified or current position**	**Planned Action**	**Progress to date**	**Due for completion**
	employed by the ICHT.			
VIII. NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	The centralised recruitment and HR service ensure that robust and consistent practices occur during the recruitment and on-boarding processes. The recruitment process is the responsibility of the Director of people and OD.	None beyond planned review		
IX. NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.	Opportunity to strengthen existing arrangements for handling VIP access to Trust facilities. Trust reputational risk issues partially addressed by Naming policy. There are risks associated with celebrity endorsements should negative public relations occur linked to that celebrity; the same applies to major donors. The Charity acknowledges both in its risk register.	Trust and the Charity are working on a joint communications strategy to deal with this potential issue. The Charity will undertake thorough cross-checks of donors and celebrities before confirming their involvement/support.		June 2015

I confirm that the Trust board has reviewed the full recommendations in Kate Lampard's lessons learnt report:

SIGNED: DATE:

Imperial College Healthcare NHS Trust

NAME OF TRUST:	Imperial College Healthcare NHS Trust			
Recommendation	**Issue identified or current position**	**Planned Action**	**Progress to date**	**Due for completion**
CE NAME: Dr Tracey Batten				

Return to Natalie Dixon, Senior Policy Advisor, NHS TDA – Natalie.Dixon7@nhs.net

Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

Independent report for the Secretary of State for Health

February 2015

Authors:
Kate Lampard
Ed Marsden

PLEASE NOTE - THIS IS AN EXTRACT, AND ONLY CONTAINS THE EXECUTIVE SUMMARY AND RECOMMENDATIONS

Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

Independent report for the Secretary of State for Health

February 2015

Authors:

Kate Lampard

Ed Marsden

4. Executive summary and recommendations

Executive summary

4.1 In October 2012 the Secretary of State for Health asked me to provide independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the department, and allegations that Savile committed sexual abuses on the hospitals' premises.

4.2 Following my appointment to that oversight role and in the wake of increasing concern about the nature and enormity of Savile's activities, the Secretary of State also asked me to identify the themes that would emerge from the investigations and to look at NHS-wide procedures in light of the investigations' findings and recommendations. Subsequently, I was also asked to include in my considerations the findings of internal investigations into further allegations of abuse by Savile at various other NHS hospital sites. Reports of the investigations by 28 NHS organisations into matters relating to Savile, together with my oversight and assurance report were published on 26 June 2014. Sixteen further investigation reports are being published on the same day as this report.

4.3 I have been supported in my work by Ed Marsden, managing partner of the consultants Verita. In this report we summarise the findings of the reports of NHS Savile investigations. We describe and consider the themes and issues that emerge from those findings and the further evidence we gathered. We identify lessons to be drawn by the NHS as a whole from the Savile affair and we make relevant recommendations.

4.4 Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissitic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today. These matters are considered in this report.

4.5 In light of other recent sex abuse scandals and allegations, the lessons learnt from the Savile case must form part of a wider public conversation about how all professionals and public bodies identify abuse and act to tackle it.

Methodology

4.6 During the course of our work we maintained close contact with the many NHS Savile investigation teams and with the NHS Savile legacy unit. We also had regular contact with MPS officers leading Operation Yewtree. This allowed us to identify issues and themes as they emerged during the investigation process. We have drawn on the evidence and findings contained in all the investigation reports.

4.7 Our own evidence gathering included:

- meetings and interviews with commentators, experts and practitioners;
- a review of relevant documents, articles, research literature and reports;
- a call for evidence from NHS staff;
- a programme of hospital visits; and
- two discussion events (one with historians, described below, and one with experts in sexual offending and safeguarding).

Historical background

4.8 The need to take account of the historical background to the events and issues arising in the Savile investigations prompted us to commission History and Policy[2] to put on a discussion event for the NHS investigation team leads and us. We wanted to gain evidence and understanding of the historical culture and circumstances that would have influenced Savile's behaviour and how others responded to him. We wanted also to gain insight into how the culture and circumstances in question have altered over time so that we could identify the lessons still relevant for today's NHS.

[2] History and Policy is a national network of academic historians.

Our findings

4.9 The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- security and access arrangements, including celebrity and VIP access;
- the role and management of volunteers;
- safeguarding;
- raising complaints and concerns (by staff and patients);
- fundraising and charity governance; and
- observance of due process and good governance.

Security and access arrangements

4.10 The investigation reports relating to Leeds General Infirmary, Stoke Mandeville, and Broadmoor, suggest that security at those hospitals has improved. This accords with what we learnt about how awareness of security and security arrangements elsewhere in the NHS have developed and improved in recent years, and particularly since the introduction in 2003 of a national strategy aimed at raising the standards and professionalism of security management in the NHS.

4.11 Hospitals should try to reduce opportunities for those without legitimate reasons from gaining access to wards and other clinical areas. Interviewees made plain to us however, that total restriction or control of public access across a whole hospital site is neither desirable nor achievable. Hospitals are public buildings and significant employers in their localities. The public regard their local hospital as their "facility" and they have many and varied reasons for wanting access to it.

4.12 The Leeds investigation report shows that Savile was an accepted presence at Leeds General Infirmary for over 50 years. He wandered freely about the hospital and had access to wards and clinical areas during the day and at night. The Stoke Mandeville

investigation report shows that the circumstances of Savile's access within that hospital were similar to those at Leeds General Infirmary.

4.13 In the case of most NHS hospitals, high-profile celebrity or VIP visitors are rare. Organisations told us this was why they had not thought to draw up formal policies for managing them. However, many organisations told us they hoped in future to increase their revenue from fundraising, which would entail developing associations with celebrities and VIPs. Regardless of whether they had a formal policy, most organisations told us that in practice all celebrity or VIP visitors were accompanied while on hospital premises.

4.14 The failure to draw up a policy for managing celebrity and VIP visits leaves hospital organisations vulnerable to mismanagement of approaches from celebrities and VIPs for such visits and of the visits themselves. Staff must be adequately supported to ensure that they feel able to keep relationships with VIPs and celebrities on an appropriate footing and to supervise and regulate their visits. To this end, they need clear and accepted policies and procedures.

Role and management of volunteers

4.15 Savile's relationships with Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals arose out of a number of volunteer roles: he helped with the hospital radio at Leeds General Infirmary, he was a volunteer porter at Leeds General Infirmary and Stoke Mandeville and he supervised entertainments at Broadmoor. In addition, Savile became well known for fundraising for these and other NHS organisations.

4.16 We examined whether NHS hospitals today have arrangements to ensure that volunteers are properly managed and operate within defined and acceptable parameters.

4.17 Our interviews with those involved in managing NHS hospital volunteer services not only made plain how the numbers of volunteers have increased in recent years but also how the profile of volunteers and the type of work they do have changed and expanded. Nearly all of the hospitals we had contact with told us they had plans to increase their volunteer numbers.

4.18 The scale of the volunteer presence and the extent and nature of the work they do means that the arrangements for managing volunteers, and the risks associated with their presence in hospitals, need to be robust and command public confidence.

4.19 Effective management of volunteers requires board level commitment and leadership. Organisations need to take a strategic approach to planning their volunteer schemes. Managing a scheme properly demands resources and has a cost.

4.20 The management arrangements for volunteer schemes in NHS hospitals vary widely in the commitment and resources devoted to them. Some hospitals we visited demonstrated that their volunteer schemes were overseen at board level, were subject to strategic planning processes and that their voluntary service managers had appropriate support. However we also encountered hospital voluntary services that did not appear to be strategically planned or led, and where the voluntary services manager worked in isolation with little or no connection to the wider management system of the hospital, and with little or no management or adminstrative support.

4.21 Hospitals told us that their recruitment processes for new volunteers included interviews and obtaining references, and in some cases occupational health checks. They also told us they undertook enhanced record checks via the Disclosure and Barring Service (DBS).

4.22 Hospitals told us that they gave new volunteers induction training. In most cases the induction training included safeguarding training but it was not always of high quality. The training volunteers receive needs to impart the values of the organisation as a whole, and the expectations and responsibilities of volunteers, including the part they play in safeguarding patients, visitors and colleagues.

4.23 There is also an issue with hospitals not requiring volunteers to have their training updated and refreshed. Volunteers should be given regular safeguarding training to ensure that they are equipped to identify safeguarding isuues and respond to them appropriately.

4.24 We were impressed by the extent of volunteer schemes in NHS hospitals and the many ways volunteer schemes in hospitals improve the patient experience as well as benefiting those who volunteer and the wider community. We share the view of many we

spoke to that volunteers in NHS hospitals are a force for good. We should not place unnecessary barriers in the way of well-intentioned people who wish to volunteer in hospitals. Nevertheless, having large numbers of volunteers working in hospital settings involves risks and the Savile case has clearly highlighted the need to ensure reasonable precautions to protect vulnerable people from those who might seek to do them harm under the guise of volunteering.

Safeguarding

4.25 Social attitudes and public policy in relation to the protection of children and young people have changed and developed significantly since the time that Savile first started volunteering in NHS hospitals. In keeping with these wider societal developments, awareness among NHS staff of the issue of safeguarding and of their obligations to protect patients, especially children and young people, from abuse, harm, and inappropriate behaviour has increased markedly in recent years. There is some concern however that while staff may be aware of the issues raised by recent scandals, they may not necessarily recognise the implications of these issues for themselves and their own organisations.

4.26 All the hospitals we visited, and most of those who responded to the call for evidence, told us that all their staff, both clinical and non-clinical, received mandatory induction training that included safeguarding, with higher levels of safeguarding training being mandatory for all clinical staff working with children and vulnerable adults. Nevertheless we received evidence that not all hospitals deliver safeguarding training of a high quality. We also learnt of hospitals that did not ensure that all staff updated their safeguarding training.

4.27 Our investigations showed that numbers of dedicated safeguarding staff varied widely in different NHS hospitals and in some cases staff resources were stretched. The numbers of staff in dedicated safeguarding roles is not the only key to effective safeguarding, but it is essential that all staff should be trained to identify safeguarding issues and should be able at all times to access specialist support and advice if necessary.

4.28 We considered what makes for an effective safeguarding system from the particular perspective of trying to prevent a recurrence of events similar to the Savile case. We identified the need for hospital leadership that promotes the right values:

boards and individual leaders of organisations must be clear about their intention to take safeguarding seriously and put in place mechanisisms that allow concerns to be raised and dealt with properly. Effective safeguarding requires organisations to encourage openness and listening when people, including children, raise concerns. It also requires senior staff to be approachable and well informed about what is happening in their organisations: we heard of good examples of senior managers spending time on wards and how this allowed them to pick up on issues of concern.

4.29 It is an essential part of an effective safeguarding system that safeguarding messages are reinforced through regular training and communication with staff. As part of this, organisations also need to demonstrate and give feedback to staff to show that they respond appropriately to specific safeguarding concerns.

Specific safeguarding issues

DBS checking

4.30 We looked at the current legislative framework governing record checks for those who work or volunteer in NHS hospitals.

4.31 The Discloure and Barring Service (DBS) maintains lists of people barred from engaging in "regulated activity". An organisation engaging staff and volunteers in "regulated activity" can access a barred list check by requiring those staff and volunteers to undertake an enhanced DBS check (previously known as a CRB check) together with a barred list check. It is unlawful for any employer to require an enhanced DBS check with barred list information for any position other than one that is "regulated activity" as defined by Safegauarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012).[3]

4.32 In the context of NHS hospital settings, what amounts to "regulated activity" in relation to adults differs significantly from that relating to children. With adults, only

[3] An organisation engaging staff and volunteers not in "regulated activity" can only require standard or enhanced DBS checks without a barred list check if those staff or volunteers are eligible for such checks because of their activities. This includes work or volunteering with vulnerable groups including children.

those staff or volunteers with direct hands-on or close contact with adult patients can be required to undergo a barring list check, and this applies whether they undertake the activity in question once or more frequently, and whether or not they are supervised in it. With respect to children, staff and volunteers with less intimate contact can be required to undergo a barring list check but checks can only be required where the activity in question is undertaken frequently and is unsupervised.

4.33 Most of those we interviewed who had experience of safeguarding issues told us of their concerns about the present limitations on barring list checks for staff and volunteers working in NHS hospital settings and elsewhere and the risks this poses. Many staff and volunteers in NHS hospitals who do not fall within the present definitions of "regulated activity" have legitimate reasons and opportunities for being in close proximity to adult and child patients and their visitors. The concerns are compounded by the fact that people in hospital are more vulnerable and likely to be at greater risk than others from the attentions of those inclined to commit sexual assault.

4.34 The barring lists clearly do not provide a comprehensive list of all those who might pose a threat of abusing people in hospital. Nevertheless we believe it would be proportionate and justified to require all those who work or volunteer in hospitals and have access to patients or their visitors to be subject to barring list checks.

4.35 Under the present DBS system, criminal record and barring list checks on staff and volunteers are required only when they are first engaged, with no requirement for retrospective or periodic checks. It is naïve to assume that a risk based approach, rather than mandatory periodic checks, offers greater assurance in relation to record checking. Large organisations are unlikely to have the resources or the opportunities to immediately identify each employee who might at a given time present a risk to others and whose records ought to be checked. We believe there should be DBS checks on NHS hospital staff and volunteers every three years.

NHS engagement with wider safeguarding systems

4.36 We interviewed a number of chairs of local safeguarding boards. They all raised concerns about how far NHS hospital trusts engaged with local safeguarding boards and local safeguarding arrangements.

4.37 A number of interviewees raised with us their concerns about how far NHS hospitals fulfilled their obligations to make referrals to the local authority desginated officer (LADO) and to the Disclosure and Barring Service (DBS) in respect of staff who had harmed or posed a risk of harm to children or adults vulnerable to abuse.

4.38 Local multi-agency working arrangements to protect children and vulnerable adults are compromised if NHS organisations do not share information about those who pose a threat. Equally, it undermines the barring system if NHS organisations do not refer to DBS persons who ought to be included on a barring list. We believe NHS organisations should be fully aware of their obligations in relation to these matters.

Internet and social media access

4.39 We learnt of incidents relating to the use of the internet and social media on hospital premises that raised safeguarding concerns. They caused us to question whether NHS hospitals had adequate arrangements in place to protect people in their care, particularly children and young people, from the risks posed by modern information technology.

4.40 The evidence we gathered shows that some NHS hospitals do not have a clear and consistent policy on managing internet and social media access by patients and visitors. Hospital organisations need such a policy, to protect people on their premises from the consequences of inappropriate use of information technology, the internet and social media. Without one, staff do not have the guidance and support they need to deal with difficult issues. They may also be exposed to pressure and complaints from patients and their families, some of whom may wish to use the internet and other technology in a way that could be offensive or harmful.

The management of human resources

4.41 Many people working on NHS premises, including many estates and security personnel, are employed by third-party contractors. A number of people with experience of safeguarding matters raised with us their concerns about whether contractors do in fact

follow appropriately rigorous recruitment and employment processes (including DBS checking). They also questioned whether contract and agency staff received appropriate training.

4.42 The Leeds investigation, and our own investigations, showed that in some hospitals responsibility for certain employment and human resources matters lies elsewhere than with the hospital's HR department. For instance, some contract staff are managed by facilities and estates departments. Recruitment, checking and training of staff including contract and agency staff should be managed professionally and consistently across a hospital trust. HR processes expected of third party contractors should be devised and compliance with them should be monitored by a hospital's professional HR managers. Overall responsibility for HR matters and board assurance in relation to HR matters should ultimately rest with a single executive director.

Raising complaints and concerns

4.43 The difficulties that Savile's victims had in reporting his abuse of them are evident in particular from the reports of the Leeds and Stoke Mandeville investigations.

4.44 Preventing abusive and inappropriate behaviour in hospital settings requires that victims, staff and others should feel able to make a complaint or raise their concerns and suspicions, and that those to whom they report those matters are sensitive to the possible implications of what is being reported to them and escalate matters to managers with authority to deal with them. We identified a number of specific matters, set out below, that we believe will encourage staff, patients and others to raise the alarm about sexual abuse and other inappropriate behaviours.

Policies and using the right terminology

4.45 Many people we interviewed told us that the term 'whistleblowing' to cover policies aimed at encouraging staff and others to speak out about matters of concern was unhelpful. They said the term implied a public challenge to an organisation and an assumption that the organisation or part of it would not respond positively to the matters being raised.

4.46 Most of the organisations we visited and many of those who responded to the call for evidence recognised the problem with using the term 'whistleblowing' and had changed the name of their policy to 'raising concerns policy' or were using the term 'raising concerns' in conjunction with 'whistleblowing'. All NHS organisations should ensure that the title and content of their policy make clear that it applies to raising all concerns, whether or not they amount to matters some might describe as 'whistleblowing'.

4.47 Staff should also be trained and encouraged to report any matters which indicate a risk of harm to others even if such matters appear to amount only to suspicion, innuendo or gossip.

A culture that supports and encourages people to make complaints and raise concerns

4.48 Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. People do not feel comfortable challenging those they see as in positions of authority and hierarchies within hospitals are a barrier to staff raising concerns. It is important in encouraging hospital staff to overcome or question the behaviour of others that managers are present within the hospital and approachable. Managers need to be trained to deal positively and appropriately when matters of concern are reported to them.

4.49 Another important element in encouraging and supporting staff and patients to raise concerns is for organisations to ensure that they feel protected from threats or other adverse consequences if they do so.

4.50 Many people we spoke to were certain that in relation to sexual harassment and sexually inappropriate behaviour in the workplace awareness and attitudes had improved markedly in recent times.

Providing opportunities for staff, patients and others to raise concerns

4.51 Most of the hospitals we visited demonstrated that they understood the need for flexibility in the way that staff and others can raise their concerns; that they needed to offer many and varied opportunities to ensure that they captured significant issues and concerns that posed a risk to their organisation, their patients and their staff. All organisations must continue to think imaginatively and share ideas about how they encourage feedback and the raising of concerns by staff and patients.

Mandatory reporting

4.52 Mandatory reporting of information and suspicions relating to abuse is an issue on which opinions differ and are deeply held. It would have significant implications for the way that professionals involved in safeguarding work. We do not think it is appropriate for us to come to conclusions on mandatory reporting purely in the context of the lessons to be drawn from one particular, historical, sex abuse scandal.

Fundraising and charity governance

4.53 The Savile case raises the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in fundraising for NHS organisations.

4.54 Most NHS hospitals have their own associated charities, which hold charitable funds for furthering the aims of the hospital. These are known as NHS charities. They are governed by the NHS Act 2006 as well as charity law. In most cases the hospital's board acts collectively as trustee of the charitable property given to it.

4.55 The question of the most appropriate governance structure for NHS charities has recently been the subject of a review by the Department of Health. As a result of the review the government will now permit all NHS charities to transfer their charitable funds to new, more independent charitable trusts regulated by the Charity Commission under charity law alone. However, NHS bodies will be able to continue to act as corporate

trustee of their charitable funds established and regulated under NHS legislation if they wish to do so.

4.56 Savile's charitable fundraising was undertaken via two charities, the Jimmy Savile Charitable Trust and the Jimmy Savile Stoke Mandeville Hospital Trust. These charities were separate from the NHS organisations to which they made charitable donations. Many individual charitable trusts, like those established by Savile, raise funds for NHS organisations but sit outside the governance arrangements of the NHS.

4.57 We considered how NHS hospitals and their associated NHS charities ensure that their fundraising is subject to good governance, and how they ensure appropriate management of their relationships with independent charitable trusts, such as those Savile established, and with individual donors and celebrities.

4.58 The first element of best practice in charitable fundraising is proper risk management to ensure not only the protection of charitable assets and funds raised but also the good name and reputation of the charity. In considering the risks to an NHS charity and the organisation it seeks to benefit, trustees and hospital managers must look at the hospital's and the charity's relationships with celebrities, major donors, commercial partners and other charitable organisations.

4.59 Most of the NHS organisations we had contact with did not have clear documented policies and risk assessment processes for managing these relationships and for protecting the organisation's brand and reputation. Some said they had no need of formal arrangements because of the limited nature of their fundraising activity. However we believe that staff with little or no experience of managing relationships with celebrities and major donors are at greatest risk of being "star struck" and of mishandling such relationships. They must be able to refer to guidance in a formal policy.

4.60 Nearly all the NHS organisations we spoke with said they would like to increase their income from charitable fundraising, especially given likely future pressure on budgets. In the event of increased charitable fundraising by NHS organisations, brand and reputation management and protection will become all the more pertinent.

4.61 Best practice also requires NHS charitable trusts to be managed and structured so that they act independently in the best interests of the charity and its purposes, with no

one trustee or group of trustees dominating decision making or acting other than in the interests of the charity. There needs to be a shared understanding between hospital management and the NHS charity of the service needs and priorities of the hospital. This demands good communication and constructive behaviours.

The observance of due process and good governance

4.62 Savile's involvement with Broadmoor and Stoke Mandeville hospitals was supported and facilitated by government ministers and senior civil servants. It is not within our terms of reference to investigate and pronounce on the weighty issue of when and on what terms it is ever justified for those at the heart of government to waive the machinery and procedures of good governance or invite outsiders including celebrities to engage in public service management. However, in the context of NHS hospitals, the Savile case vividly illustrates the dangers of allowing an individual celebrity to have unfettered access or involvement in management, and of not ensuring that good governance procedures are followed at all times and in all circumstances.

4.63 We make recommendations in this report aimed at dealing explicitly with some of the shortcomings in hospital governance processes at a local level that allowed the Savile scandal to occur. Ministers and officials have a responsibility to ensure that hospital managers are able to implement and adhere to these recommendations. They should not undermine the processes of good governance and local management.

Recommendations

Our recommendations for NHS hospital trusts are also addressed to Monitor and the Trust Development Authority under their duties to regulate NHS hospital trusts. Most of them are also addressed to:

- the Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of childen and adults.

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- they are fit for purpose;
- volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- all voluntary services managers have development opportunities and are properly supported.

R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

R5 All NHS hospital trusts should undertake regular reviews of:

- their safeguarding resources, structures and processes (including their training programmes); and
- the behaviours and responsiveness of management and staff in relation to safeguarding issues

to ensure that their arrangements are robust and operate as effectively as possible.

R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.

Imperial College Healthcare NHS
NHS Trust

Trust Board - Public

Agenda Item	4.1
Title	Corporate Risk Register
Report for	Noting
Report Author	Priya Rathod, Associate Director – Chief of Staff Claire Broster, Trust Risk / Projects Manager
Responsible Executive Director	Janice Sigsworth, Director of Nursing

Executive Summary

The Executive Committee reviewed and agreed the risk management policy in February 2015 which sets out how risks are identified, mitigated and managed from ward to board level. As part of the review it has been agreed by the Executive Committee, and based on good practice as outlined by Monitor and the NTDA, that the corporate risk register will be reviewed by the Trust Board every six months. Please refer to Appendix 1 for a copy of the Trust's risk register.

At present there are 16 corporate risks within the risk register of which 9 are identified as operational and 7 as strategic. The highest risks are scored as 20 and the lowest as 9. Two risks have been removed from the corporate risk register as they commercial in confidence.

The risks within the corporate risk register have been ordered under the following Trust objectives the risk relates to:

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

Key themes include:

- Workforce
- Operational performance
- Financial sustainability
- Clinical site strategy
- Regulation and compliance
- Delivery of care

The following risks are scored as 20 due to the likelihood of the risk occurring and the consequence the risk would have:

- **Failure to achieve financial sustainability**
  A range of controls and actions are in place to mitigate this risk. These include; active cash management and reports to the Finance and Investment Committee and Trust Board, Divisional performance meetings to review spend and income against budget and engagement with Monitor as part of the independent review of specialist tariff. Please refer to the 'finance report' agenda item for further information.

- **Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks**
  A number of actions have been undertake to mitigate this risk including; holding a risk analysis workshop and prioritising the action plan to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out as quickly as possible. The capital programme has been reviewed and decision making for investment has been based on robust risk assessments.

- **Mismatch in capacity and demand increasing risk of not achieving key operational performance standards (i.e. 95% ED target).**
  Resource has been introduced in A&E and a restructure of operations team has been undertaken resulting in a head of site operations and head of emergency pathways and major trauma to increase focus and improve performance. Please refer to the 'operational report' agenda item for further information.

The Corporate risk register is a live document and any changes agreed at the Trust Board will be made. It is likely that the following risks will be de-escalated as the Corporate risk register goes through its review and updating process:

- **Failure to achieve benchmark levels of workforce engagement**
- **Failure to deliver transformational integrated, personalised and systematised models of care to achieve long term sustainability.**

There is currently an emerging risk related to infection control on one the Trust's vascular wards. At present the risk is being managed and will be closely monitored. If the risk increases, this will be escalated onto the Corporate risk register.

The following governance process for risk management is in place:

- **Divisional risk register;** this is discussed at monthly divisional quality meetings, at the Quality Committee and at the Executive Committee each quarter.
- **Director risk register;** each Director has their own risk register which is discussed at the Executive Committee quarterly.
- **Corporate risk register:** This is discussed monthly at the Executive Committee, quarterly at the Audit, Risk and Governance Committee and six-monthly at the Trust Board.

Implementation of Datix

To support robust risk management, the Trust is currently implementing the Datix system. The implementation began in March 2015 with the division of women's and children's with all divisional and corporate directorate risks to be transferred onto the system by the end of June.

Imperial College Healthcare NHS
NHS Trust

Recommendations to the Board:

- Note the corporate risk register

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

Corporate Risk Register

Public Trust Board

May 2015

V.39

Key: Scoring

To calculate the risk placement on the matrix,
it is necessary to consider both the likelihood of the risk happening and the consequence of it happening as described below:

			Likelihood				
			Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Consequence	**Severity**		1	2	3	4	5
	Negligible	1	1	2	3	4	5
	Minor	2	2	4	6	8	10
	Moderate	3	3	6	9	12	15
	Major	4	4	8	12	16	20
	Catastrophic	5	5	10	15	20	25

Key:

Risk Source: The source of the risk / where or how the risk was identified, for example strategic planning

Initial Score: The score of the risk when first identified

Current Score: The current risk score including key controls to mitigate this risk

Trend / Movement: Arrow to show if the risk has increased ↑ decreased ↓ or remained the same ↔ within the last four weeks.

Target Score: Target of the risk once all future and current actions have been completed and implemented

Contingency Plans: Predefined action plans that would be initiated should the risk materialise

Corporate Risk Register Dash Board
Public Trust Board May 2015

Corporate Risk Register:			Lead Director	Initial score	Date risk Identified	≤6	8	10	12	15	16	≥20	Dates to achieve target risk
Strategic Risks													
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion													
68	Page 3	Insufficient support for key aspects of our clinical strategy from one or more key audiences / stakeholders.	Director of Communications	12	Apr-14		○		♦				Sep-15
48	Page 4	Failure to maintain financial sustainability	Chief Financial Officer	20	Mar-12			○				♦	Review June - 15
81	Page 5	Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target	Director of Nursing	16	Dec-14		○		♦				Dec-15
83	Page 6	Failure to meet required or recommended vacancy rates across all areas of the organisation	Director of People & OD	12	Jan-15		○		♦				Jul-16
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement													
67	Page 7	Failure to achieve benchmark levels of workforce engagement	Director of People & OD	9	Oct-13	○		♦					Oct-16
Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve.													
74	Page 8	Failure to complete and gain approval for the redevelopment business case	Director of Strategy and Redevelopment	12	Oct-14	○			♦				Sep-15
73	Page 9	Failure to deliver transformational integrated, personalised and systematised models of care to achieve long term sustainability, enhance acute services and support out of hospital care.	Medical Director	16	Oct-14	○		♦					Oct-15
Operational Risks													
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion													
79	Page 10	Mismatch in capacity and demand increasing risk of not achieving 95% A/E target	Chief Operating Officer	16	Nov-14		○					♦	Jul-16
55	Page 11	Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Strategy and Redevelopment	20	Mar-11					○		♦	Review June - 15
7	Page 12	Failure to maintain operational performance standards	Chief Operating Officer	15	Jun-07	○				♦			Dec-15
71	Page 13	Failure to deliver safe patient care / effectiveness of care (HCAI)	Medical Director	12	Oct-14		○		♦				Jun-16
85	Page 14	Failure to recruit to substantive nursing posts on some medical wards	Divisional Director	15	Jan-15	○				♦			Oct-15
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement													
72	Page 15	Failure to assess the risks to the health, safety, and wellbeing of employees, workers, students, and visitors	Director of People & OD	12	Oct-13	○			♦				Jan-16
65	Page 16	Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors	Medical Director	12	Feb-14		○				♦		Dec-15

Key:
♦ Diamond indicates current score;
◯ Circle indicates target risk score

Strategic Risks

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
68	Director of Communications	Strategic Planning / Strategic Risk	1	April 2014	**Insufficient support for key aspects of our clinical strategy from one or more key stakeholders.** **Cause:** • Case for change not sufficiently clear and/or compelling • Poor communications – channels, content and/or co-ordination • Lack of trust in our motives/ability • Unwillingness corporately to engage and respond to questions, concerns and ideas • Promotion by others of inaccurate information about our plans and services • Insufficient prioritisation/ownership across the organisation of the work required to manage and support the change **Effect:** • Failure /delays in achieving funding, planning permissions, other formal approvals • Failure/delays in implementing new clinical models and new ways of working • Plans do not sufficiently reflect patient/public/staff needs • Reduced confidence in our services/public concern about their services • Impact on staff morale **Impact:** • Potential to increase costs : Reactive & Inefficient ways of working • Potential to increase costs : Inflation of building work exclude running costs • Unable to deliver Trust strategic vision • Potential to incur penalties and/or fines: • Potential reputational impact with adverse revenue impact • Potential reputational impact with adverse revenue impact:	3 12	4	• Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluation • Active interim internal communications plan, including regular CE open sessions • Regular review by ExCo and updates to Board • Regular communications training for key staff • Communications leads assigned to each clinical division to improve identification and management of potential communications issues	3 12	4	Current	• Develop comprehensive corporate communications strategy (including project for development of overarching brand) – 15/16 Values, behaviours and promise project underway - recommendations to go to July 15 board meeting. Exploring how to progress brand aspects following this work, including link into external positioning. Restructure of communications directorate to address issues in strategic communications review part way through – completion early summer 2015. • Prioritise redevelopment of trust website and content Phase 1 completed (Sept 14 – Jan 15); procurement completed (April 2015) - delivery September 2015 • Develop external/internal communications and engagement strategy as a key strand of clinical transformation programme/estates redevelopment programme, working closely with commissioners/*Shaping a healthier future* team Target risk score date: September 2015	⇔	2 8	4	• Increase priority of stakeholder engagement activities

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
48	Chief Financial Officer	Risk Assessment / Operational Risk	1	March 2012	**Failure to maintain financial sustainability** **Cause:** • CCG reductions / changes in commissioned activity • Changes to specialist commissioning regime • Risk of failing to deliver a surplus with consequent effect on liquidity resulting in a failure to maintain a CoS risk rating of 3 • Non-delivery of expected efficiencies and cost improvement plans • Loss of DH/NHS England Project Diamond income and market forces factor in respect of additional specialist care and R&D costs • Adverse impact of tariff deflator greater than planned • Failure to maintain and / or increase private patient market share • Failure to secure funding for the redevelopment of our site **Effect:** • Could undermine Trust's critical mass to provide high end secondary and tertiary services with increased pressures on A&E, other services, etc and the potential to lose key services • Reputational risk - not engaging with wider healthcare community, inability to engage with Monitor pricing and external benchmarking exercises, in tariff setting and reviews. Inability to deliver a recurrent surplus to enable planned investments in estate and quality initiatives with consequent risk to service viability **Impacts:** • Potential to incur penalties and / or fines: Contractual, CQUIN. Enforcement notice • Potential loss of revenue: NHS income, research and education income, other income • Potential to increase costs: bank and agency, reactive and inefficient ways of working, increased length of stay • Reputational with adverse revenue impact: reduction in market share, service decommissioned, failure to gain FT status - impact on capital plan and strategy, compromise future re-designation of BRC and AHSC • Lack of resources to support strategic investment	4 x 5 20		• Contract Negotiating Team engages with Divisions via Service Agreement Steering Group and reports progress on contracts via ExCo to FIC • Feedback on consultation on national tariff. Active cash management and reports to FIC and Board. Monthly financial reporting and performance reviews. Divisional performance meetings to review spend and income against budget and progress in delivering savings. Regular meetings with Commissioners and TDA to review contract performance • QuEST governance structure, monthly financial reporting, weekly divisional performance meetings to review spend and income against budget and progress in delivering savings. Pro-actively work with the Shelford group and Project Diamond group to influence national tariff to guarantee adequate reimbursed for provision of complex activity. Ensure PLICS systems are materially accurate to reflect the costs of treating patients	4 x 5 20	Current	• Actions being managed through Corporate Risk register and through the Finance Department Risk Register • CE to attend the next meeting of the NIHR where this issue will be under discussion • CE & CFO attending discussions with NHSE on future Project Diamond Funding. • COO / MD Exec review work of more transformational design opportunities • Engagement with monitor as part of the independent review of specialist tariffs. Target risk score date: Review June 15	⇔	2 x 5 10		• Meetings with each Division now in place to ensure pay and non-pay controls in place and CIP delivery is back on track • Continued concentration on identifying new schemes and mitigate any slippage. • Focus on in-year run-rate control measures. • Develop a clinical transformation programme for 2016/17 and outer years during the first half of the current financial year, to enable further identified schemes to be pulled forward in mitigation should the need arise

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
81	Director of Nursing	Strategic Planning / Strategic risk	1	Dec 14	**Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target following the inspection in September 2014 (which means that ICHT would remain in breach of regulations as identified during the inspection):** **Cause**: • Systems not in place which enable the Trust to achieve regulatory compliance • Failure of staff to comply with practice governance (i.e. policies, procedures, guidelines, etc.) and the compliance and improvement framework (implementation of the framework is due to begin in April 2015) • Lack of resource within the nursing directorate to effectively manage on going compliance **Effect**: • Greater number of incidents of poor patient experience and potentially greater severity • Reduction in the quality and safety of patient care • Poor reputation • Potential for financial penalties • Potential for criminal prosecution • Potential restriction on individuals' ability to practice and / or of the Trust's services imposed by the CQC in response to on-going regulatory breaches **Impact**: • Potential loss of ability to practice or deliver a service at one or all sites. • Potential loss of revenue: NHS Income (as result of inability to deliver service from one or all sites) and reduced revenue from Imperial Private Healthcare as a result of poor reputation • Potential to increase costs :Reactive and inefficient ways of working.(arising from services being stopped on one or more sites) • Threaten FT application • Poor Monitor Governance Risk Rating • Potential to increase costs of Bank & Agency staff arising from inability to retain and recruited staff • Potential to incur penalties/fines imposed by the CQC • Potential to increase costs: i.e. claims and litigation impact on CNST payment	4 x 4 16		• Compliance and improvement framework introduced to manage compliance with regulatory requirements and drive related quality improvements being implemented from April 2015. This includes named executive leadership for the Trust's compliance with CQC regulations, including provision of assurance of regulatory compliance • Clinical leads have processes in place to collate compliance evidence on an on-going basis, which means concerns can be raised sooner rather than later. These will be reviewed as part of the framework development to ensure they are fit for purpose. This minimises the chance of poor patient care, harm and regulatory non-compliance • Each action in the current CQC inspection action plan has nominated executive and divisional leads for delivery • The CQC action plan will be monitored by the Executive Committee, with risks of non-completion raised by exception and actions agreed in response • CQC Intelligent Monitoring (six-monthly, July and December) is presented at the Executive Committee, Quality Committee and reported to the Trust Board • A Patient Safety and Service Quality report is presented quarterly to the Trust Board • A Corporate Secretary began in post in September 2014 with responsibility for delivering governance and assurance activities at the Trust (e.g. Head of Policy is currently undertaking a review of all Trust policies) • First progress report presented to ExCo in March 15	3 x 4 12		Current	• Education and training in relation to the framework delivered from February 2015 • Delivery of the current CQC inspection action plan is underway. A process for reporting progress towards delivery of the action plan was approved at the Executive Committee. • Discussion has taken place with Internal Audit and a 12 month plan developed and agreed to provide support with the delivery of the improvement framework (core service reviews / deep dives / staff focus groups). • Further deep dive of issues identified by CQC will be undertaken • Development of a communications plan • Ratification of compliance and improvement framework policy at Exco on 05/05 • Implementation of 12 month IA support plan • Development and implementation of ward accreditation pilot (July) **Target risk score date: December 15**	↓	2 x 4 8		• Prioritise and utilise internal expertise (external additional support may be required) and undertake site wide quality and safety reviews and assessment to identify key risks and provide a Trust action plan to mitigate any issues • Commission external review and support

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
83	Director of People & OD	Staff engagement surveys / Strategic Risk	1	Jan 15	**Failure to meet required or recommended vacancy rates across all areas of the organisation** **Cause:** • Mis-match of staff establishment requirements and / or rostering • National Shortage of clinical / non clinical • Conflicting operations priorities slowing down recruitment process. • Competition from neighbouring trusts attracting potential employees • Trust not employing 'the right people in the right posts', **Effect:** • Reduced staff morale /increased turnover /Increased rates of sick absence • Increased bank and agency usage • Poor patient experience • Poor organisational performance • Inability to recruit high quality candidates **Impact:** • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and Enforcement Notices	3 x 4 12		• Associate Director of HR Operations • Restructure and new admin support now in place to reduce the total time to hire. • Additional resource identified for E-Rostering implementation • Business case for midwifery recruitment agreed Sept 2014 and plan being implemented • Recruitment open days being held (nursing and midwifery) • All current vacancies for nursing in key areas advertised • Monthly strategic people planning meetings with divisions	3 x 4 12		Current	• Recruiting to 5% vacancy level for bands 2- 6 • Vacancy levels for bands 2 to 6 will be reviewed monthly at divisional performance reviews (on-going) • Attain bank fill of 90% by improving management of requests. • New e-rostering policy which includes key indicators has been developed and training rolling out • Monthly recruitment open days are on-going • Associate Director of HR Operations and Resourcing working with Business Partners to monitor vacancy levels. (Target risk score date: July 16)	⇔	2 x 4 8		• Continue to monitor impact of changes and implement further corrective measures as needed

Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
67	Director of People & OD	Staff engagement surveys / Strategic Risk	2	Oct 13	**Failure to achieve benchmark levels of workforce engagement** **Cause:** • Senior leaders fail to empower/inspire staff • Job not regarded as good for health • Organisation not seen to be taking positive action on health & wellbeing • Opinions thought not to count • Trust not employing 'the right people in the right posts', **Effect:** • Reduced staff morale/increased staff turnover/ Increased rates of sick absence / bank and agency usage • Lack of engagement • Poor patient experience /Poor organisational performance • Increased safety risk to patients • Inability to recruit high quality candidates • Staff sickness **Impact:** • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working	3 x 3 9		• Trust surveys (quarterly) covering all staff annually • NHS survey • Communications events – Open Forum, Talk to Mee, Divisional Forums (e.g. Tea with Tim (Prof Orchard) • Newsletters • Exit surveys • Joiners surveys • Engagement on Clinical Strategy • Source communications • Monitoring at Executive Committee • Monitoring at Quality Committee & Trust Board • Discussed at Divisional reviews • Consultant appointed in Occupational Medicine • Associate Director Health & Wellbeing appointed April 14 • Health and Wellbeing Strategy developed • People strategy • Make a Difference people recognition scheme • My Benefits launched Nov 14	3 x 3 9		On-going	• Trust quarterly surveys held and 6th survey showing improved engagement scores and increased response rates • Better than average staff engagement scores in national staff survey compared with other UK acute Trusts. • Specific action plans developed by Corporate & Divisional Directors now includes the "one big thing" for each division to work on. • People strategy 2015-2019 (which includes; Culture & Engagement, Organisation Development, Talent Development and Health & Wellbeing) has been refreshed • Director of People & OD attends Quality Committee • Standing item on Quality Committee • Board Seminar ran April 2015 (Target risk score date: October 16)	⇔	2 x 3 6		• Continue to monitor impact of changes and implement further corrective measures as needed

Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
74	Director of Strategy and Redevelopment	Risk Workshop / Strategic Risk	4	Oct 2014	**Failure to gain approval for the redevelopment business case resulting in continuing to deliver services from sub-optimal estates and clinical configuration.** **Cause**: • Case for change not sufficiently clear and/or compelling • Delays to obtaining planning permissions • Technical design and build issues lead to unanticipated challenges and project creep • Increase in costs beyond currently expected levels through indexation, due to delays in business case. • Inability to obtain sufficient and timely funding • Investment objectives / benefits unachievable • Inability to demonstrate management of key corporate risks facing the Trust • Insufficient organisational capacity and failure to deliver cultural change to achieve the Trust's vision • Failure to achieve support for key aspects of our clinical transformation, especially service reconfiguration and estate redevelopment from one or more key audiences / stakeholders **Effect**: • Poor organisational performance – inefficient pathway management • Poor reputation with regulatory bodies • Could affect the ability of services to achieve long term sustainability • Deteriorating and / or inadequate estate • Reduced staff morale **Impact**: • Potential loss of income • Potential to increase costs due to reactive and inefficient ways of working • Potential to increase costs due to (bank and Agency and recruitment and retention costs) • Potential reputational impact - Loss of market share • Potential to impact upon securing FT status	3 x 4 12		• Regular meetings with NHSE, TDA, CCG partners for early identification of potential issues/changes in requirements • Redevelopment programme board in place • Stakeholder engagement strategy to manage relationships with external partners • Active management of development market. • Reports to Trust Board and ExCo • Development of KPI dashboard • Regular CCG chairs meeting.	3 x 4 12		One to six months	• Draft Implementation Business Case complete and submitted to NHSE March 2015 • Communicated to NTDA by NWL PMO as 'Draft' March 2015 • Provisional approval date October 2015 • Appointment of Healthcare planning resource • Trusts Estates Strategy outlining contingence plans seen by ExCo April 2015, to Trust Board 2015. • Town planning activities funded within 2015/16 capital programme. • Active engagement with developers of adjoining sites. • Production of procurement vehicle paper for Trust Board July 2015. Target risk score date: October 2015	⇔	1 x 4 4		• Smaller capital solutions • Maintain flexibility to respond to any changes in demand as required • Identify and develop alternative options. • Development of a 'strategic Estates Partnership' to support site redevelopment programme

Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
73	Medical Director	Risk Workshop / Strategic Risk	4	October -14	**Failure to deliver transformational integrated, personalised and systematised models of care to achieve long term sustainability.** **Cause:** • Failure to set up an adequately resourced and skilled programme group • Lack of engagement with clinical and managerial staff • Lack of support from commissioning colleagues • Lack of engagement from external stakeholders • Unknown / changing economic landscape effecting health care needs **Effect:** • Failure to improve clinical care • Failure to improve patient experience • Failure to meet efficiency KPI • Failure to grasp opportunities in development of personalised medicine • Inability to support out of hospital care **Impact:** • Poor patient experience as not responding to changes in clinical practice and advances in clinical care. • Poor clinical care as not responding to changes in clinical practice and advances in clinical care. • Potential to incur contractual penalties (due to higher demand for trust services impacting upon waiting time) • Potential for loss of NHS income • Potential for increased costs as result of reactive and inefficient ways of working	4 x 4 16		• Set up of Clinical Transformation Programme office • Engagement of all staff through development of clinical strategy • Identification of key programmes utilising Darzi fellows. • Integrated care pilot status as part of whole system pioneer • Development of the CIS • Monthly integrated performance reporting at ExCo and Board level designed to identify any issues early • Links to quality strategy and CQC action plan	3 x 3 9		Current	• Clinical Transformation programme transferred to medical directors office • Development of strategy document for the programme. • Development of Clinical Strategy • Delivering the CQC action plan Target risk score date: September 2015	⇔	1 x 3 3		• Continuous review of progress and benchmarking with other comparable organisations.

Operational Risks

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
79	Chief Operating Officer	Divisional risk register/Operational risk	1	November -14	**Description:** **Mismatch in capacity and demand increasing risk of not achieving key operational performance standards (i.e. 95% ED target)** **Cause:** • Bed capacity at SMH site • Volatility of non-elective demand • Increased requirements for elective RTT activity • Late discharges / delayed review by speciality doctors • Potential Infection outbreak **Effect:** • Elective patients on the waiting list have to be cancelled. • Delayed step downs from critical care. • Transfer of patients between sites impacting on patient experience **Impacts:** • Poor quality of care • Reputational impact results in reduction in market share • Potential for loss of NHS income and contractual penalties. • Potential for increased costs as result of reactive and inefficient ways of working • Potential for increased lengths of stay • Inability to deliver RTT and access targets	4 x 4 16		• Elective Patients: Weekly clinical risk assessment of all patients on the waiting list to triage those most at risk. • All cancelled patients have been reviewed on an individual basis. • Non-elective patients: Decision to transfer patients to CXH made by an SpR or Cons. and only clinically appropriate cases are transferred. • Theatre utilisation mtgs • Review meetings for all inpatients with a length of stay longer than 10 days • Clear escalation plans • Daily circulation of Trust SITREP • 3x daily site calls to manage capacity • Participation in weekly sector operations executive • Development and implementation of site/clinical strategy • Discharge lounge opened • 12 more beds opened at STM • 5 more beds opened at CCx • Addition 6 mew A&E consultants appointed.	5 x 4 20		Current	• For Surgical Patients: Ensure daily sub-specialty Cons. ward rounds, and implementation of abscess pathway where patients are booked onto emergency list and sent home. • Re-location of current UCC location to SMH site releasing space in main ED (Feb 15) • Deployed Service Improvement team regarding emergency pathway across trust. • Working with CCG on DToC / repat reduction programme to release bed capacity. • Review capacity plan July 15 • Investigate alignment of capacity with likely seasonal demand for Q3/4 • Deliver breaking the cycle week and sustain improved performance. • April Update: restructure of Ops team including new Head of site operations, Head of emergency pathways and major trauma • New Head of service for emergency medicine • Increased escalation and visibility of DTOC within the sector • For the first quarter of 2015, the Trust worked to deliver an intensive review of emergency pathways and to identify key areas to improve efficiency, with the overall aim of improving patient experience and achievement of the four-hour emergency care standards. This review also included 'Breaking the cycle' (BTC) week in February, where additional focus and resourcing was placed on supporting the emergency pathways and implementing new ways of working. • on-going work to move discharges forward to before 12.00. • A report was presented to the executive committee, identifying where changes need to be made to achieve these targets. • Head of emergency pathways appointed • On-going operational monitoring. Target risk score date: July 16	⇔	2 x 4 8		• ED recovery plan • Additional elective activity focused on CXH / HH sites • Additional step down beds (18 CLCH) at CXH • Increased senior (executive) scrutiny of the emergency pathway and in patient discharge planning • Weekly review by CEO at ExCo • Weekly operational resilience meeting

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
55	Director of Strategy & Redevelopment	Strategic planning / Operational Risk	1	Mar 11	**Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks** **Cause:** • Historic under investment • Obsolescence of the estate • Availability of capital and revenue funding • Delay in approval of the medical equipment capital replacement programme • Inability to retain core competencies within the workforce • Delay in delivering NWL reconfiguration plans **Effect:** • Possible short-notice closure of facilities due to equipment failures and breakdowns (e.g. lift breakdowns, chiller plant failures) • Obsolete installations that do not meet current standards • Key medical equipment being off line • Inability to keep up with repair requests and minor improvements for operational / clinical benefit • Reduced staff morale leading to higher turnover and increased rates of sickness absence • Loss of reputation and reduced confidence from key stakeholders **Impact:** • Potential to incur penalties /fines: Enforcement Notices • Inability to effect changes to estate in order to achieve transformation of clinical services • Potential to increase costs: Reactive & inefficient ways of working • Potential reputational Impact: Loss of market share • Potential to increase costs: i.e. claims and litigation impact on CNST payment • Potential to increase costs: Bank & Agency staff	4 x5	20	• Statutory and regulatory inspections are now in place to pick up risks to continued safe operation of the Trust • The new PPM concept database is operational and generating planned work schedules • The ExCo approved Backlog maintenance programme is targeted to risks 16 or above and capital funding, and managed through risk assessment directed at addressing these high risk categories • 2015/16 capital programme £14 million allocated to deal with 16 and above risks. • Formal reviews of operational performance are conducted monthly both internally and with ops team to continually review performance • PLACE (Patient-Led Assessment of the Care Environment) is run by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works • Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services • Estates & Facilities H&S, Fire and Compliance committee has been established to monitor compliance • Quarterly reporting to ExCo • Monitoring of incidents	4 x 5	20	Current	• All policies and procedures have been reviewed, rewritten were necessary and approved in order to ensure statutory regulatory compliance • A risk analysis workshop has been held and the action plan prioritised to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out as quickly as possible within the constraints of available resources • The 2015/16 backlog maintenance capital programme is targeting the highest risk areas £14 million has been allocated. • Planned preventative maintenance scheduling is in place to reduce the risk of key equipment failures together with regular testing of equipment and systems. • Procurement options being tested to secure additional labour force to deliver planned activity. • A full condition survey has been commissioned and 6 facet survey commenced May 2015, to help identify and update the future investment priorities. Target risk score date: Review for July 15	⇔	3 x 5	15	• Plans for future years assume that NWL reconfiguration will provide the necessary funding for the long term solution which will address a large proportion of the backlog maintenance issues • If NWL reconfiguration funding is not approved then the Capital Programme will need to continue to increase, reflecting the degree of depreciation that is attributable to estates buildings and equipment and will continue to be targeted on the highest risks. • Assets register to be utilised to share in house equipment and rental of medical devices available if required • Capital plan to align to clinical strategy within financial abilities • Major incident plan / sector wide contingency plans • Business continuity plan • NHSLA insurance cover • Estates Strategy with contingency plans agreed.

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
7	Chief Operating Officer	Risk Assessment / Operational Risk	1	June 2007	**Failure to maintain operational performance *standards*** **Cause**: • Mismatch of accurate reporting and poor data due to implementation of new pt IT system • Delays to management of 18 week pathway due to embedding of new systems and processes • Unexpected large-scale events impacting negatively on business continuity • High bed occupancy rates • Mismatch of capacity and demand • Financial economic landscape challenges **Effect**: • Reduced patient experience / staff morale • Increased operational inefficiencies • Failure to meet contractual / regulatory requirements • Failure to achieve national and local performance targets (ED, cancer, RTT) • Potential for poor reputational damage • Loss of reputation and reduced confidence from key stakeholders • Delays to first outpatient appointments **Impact**: • Potential to increase costs: Reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and CQUIN Contractual penalties • Potential reputational Impact: Loss of market share	5 x 3 15		• Weekly elective waiting list review • Cancer patient targeted list review • Daily ED Performance Reports • Local level scorecards and monitoring forums • Tri-borough urgent care board to oversee improvements in ED performance and urgent care pathway • Patient experience programme - Itrack • Increased investment in cancer MDT Coordinators • Investment into Somerset System (Cancer tracking tool) • Business Continuity and Emergency Plans in place and tested regularly • Senior input into site operations • Clinical transformation plan includes Urgent Care Board and Weekly operational delivery group • Centralised site office / cancer committee ” 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 • Revised SitRep document implemented • Weekly Cerner review meeting • Daily circulation of Cerner data KPI information per review • 3 year MOU and funding agreement with Macmillan into cancer services • Ambulatory emergency capacity on 3 sites • Recruit additional 6 ED consultants to St Marys • Monthly RTT delivery plan for admission pathways • Clinical review of all out-patient waiting lists.	5 x 3 15		Current	• Remedial action plan for ED performance developed in response to sub 95% standard in September • April Update: restructure of Ops team including new Head of site operations, Head of emergency pathways and major trauma • New Head of service for emergency medicine • Increased escalation and visibility of DTOC within the sector • Discharge lounge opened • Implemented internal validation process for cancer pathways • On-going negotiations with commissionaires regarding demand management. • On-going work with DGH in relation to timeliness of cancer pathway referrals • Weekly GM meeting • Weekly operational resilience meeting • Cancer steering committee • Implemented internal validation process for cancer peer review • On-going validation of out-patient waiting list status (June 15) Target risk score date: July 15	⇔	3 x 2 6		• Adjust action in relevant action plan in line with the deteriorating performance • Agreed remedial action plan with commissioners for RTT and choose and book. • Formal review re ED performance via ECIST with improvement action plan • Additional trauma lists • Increased therapy support • Weekly operational resilience meeting

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
71	Medical Director	NHSLA / CQC / Operational Risk	1	October 2014	**Failure to deliver safety and effectiveness of care in respect to :** • **Incident reporting, including Serious Incidents and Never Events** • **HSMR, SHMI and mortality alerts** • **Infection Prevention & Control** • **CAS alerts** • **NICE guidance and standards** • **National audits** • **Clinical audit programmes** • **Quality assurance of data submissions** • **Clinical guidelines** **Cause:** • Appropriate governance process not in place • Visibility of current compliance not available or known • Insufficient resource in place to manage the process • Non-compliance with Trust policies and procedures • Continued change in HCAI landscape • Increasing incidence of antimicrobial resistance **Effect:** • Unable to demonstrate that practice is evidence based • Limited oversight of externally reported data • Inability to demonstrate any or adequate audit trail • Unable to benchmark care against peers • Increase in SIs and Never Events • Increased mortality rates • Increased potential for Healthcare Acquired Infection (HCAI) **Impact:** • Potential to incur penalties and/or fines: Contractual and Enforcement notices (Financial penalties resulting from non-compliance) • Limited understanding of performance benchmarks • Potential loss of reputation and reduction in market share as a result of Negative media coverage • Non-compliance with CQC regulation • Potential to increase costs: i.e. claims and litigation impact on CNST payment	3 x 4 12		• Associate Medical Directors for Safety & Effectiveness and Infection Prevention & Control appointed • Executive responsibility for clinical governance revised • Compliance and improvement monitoring governance process through the Executive Committee in place • Trustwide reports including performance data in place • Root cause analysis and learning from incidents • Weekly incident review meeting with Medical Director	3 x 4 12		current	• Review of all existing data and benchmark comparators underway • SI policy updated to streamline process • Being Open policy reviewed to include duty of candour, training undertaken within divisions, divisional duty of candour advisors in place • Business case for resource expansion approved – recruitment commenced. Full team anticipated to be in place by July 2015 • Quality Strategy being revised incorporating CQC Safe and Effective domain. Publication due end of June 2015– current progress: ➢ Feedback from engagement events collated for inclusion in the strategy ➢ Baseline data collection exercise completed to allow metrics and targets for all goals to be defined and aligned with Quality Accounts ➢ Implementation plan in development ➢ Editor commissioned to align the documents for the Quality Strategy, Quality Accounts and Annual Report. • Corporate clinical audit programme developed to enable directing of efforts to areas most in need of improvement. To be signed off at ExCo Quality in May. • Draft Quality Accounts submitted to ExCo 21/04/15 (Target risk score date: June 16)	⇔	2 x 4 8		• Process to be managed through the Medical Director's office with nominated clinical leads

Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
85	Divisional Director MD / Chief Operating Officer	Divisional Risk Register / Operational Risk	1	January 15	**Failure to recruit to substantive nursing posts on some medical wards.** **Cause:** • The increase in emergency activity has resulted in additional capacity which requires the recruitment of staff. • Additional beds opened • Lack of available / suitable specialist nursing staff **Effect:** Potential reduction in staff morale /increased staff turnover /Increased rates of sick absence • Increased bank and agency usage • Potential for poor patient experience • Inability to recruit high quality candidates • Potentially increased incidents **Impact:** • A potential impact on the delivery of care • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and Enforcement Notices	3 x 5 15		• Divisional performance review meetings monitoring vacancy rates • Bank and agency support available • Recruitment open days taking place with a rolling programme of recruitment. Review of trust recruitment processes to streamline process and ensure rapid turnaround of offer letters	3 x 5 15		Current	• Additional recruiting staff employed to speed up recruitment process and manage increased volume and work load. • Divisional recruitment and vacancy reduction trajectory to achieve less than 5% rate to be set. • Agreement to involvement in international recruitment • Continue with Divisional plan for reduction in vacancies through open days and over-recruitment. Target risk score date: October 2015	⇔	1 x 5 5		• Review of bed capacity • Escalation of staffing issues through divisional management structure and site team • Early identification of staffing issues with shifts put out to bank and agency,

Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
72	Director of People & OD	Strategic Planning / Operational risk	2	Oct 13	**Failure to implement, manage and maintain an effective health and safety management system including:** - **Appropriate health and safety policies, procedures and safe systems of work** - **Risk assessments and risk control measures** - **Information, instruction, training, support and supervision** - **Monitoring, measuring and auditing** - **Governance and assurance arrangements** **in order to protect the health, safety, and wellbeing of employees, contractors, students, patients and visitors whilst at or on behalf of the Trust.** **Cause:** • Lack of appropriate and effective H&S management structures • Lack of appropriate H&S information and guidance – including policies, procedures and safe system of work • Lack of induction, job specific and refresher training • Lack of management ownership and accountability • Poor employee engagement, awareness and culture • Lack of competent H&S advice and resources • Failure to report and investigate accidents/incidents/near misses **Effect:** • Increase in accidents, incidents and ill health • Damage to property and equipment • Impact on business continuity • Reduced morale, quality & productivity • Increased rates of sickness absence due to injuries and ill health • Poor patient experience • Poor reputation with regulatory bodies such as HSE and CQC **Impact:** • Potential to incur criminal penalties and/or fines: • Contractual and Enforcement Notices • Potential to increase costs: i.e. claims and litigation impact on CNST payment • Potential loss of revenue : NHS Income as a result of Increased incidents to staff and patients • Management time to investigate accidents/incidents and implement corrective/preventative action • Training & retraining costs • Reputational risks	3 x 4 12		• Appointment of Head of Health and Safety who starts 15 June 2015 • Strategic Health and Safety Committee (SHSC) in operation bi-monthly • Division/Corporate Functions Health and Safety Committees in operation • Trust wide health and safety action plan • Divisional health and safety action plans • Accident/incident reporting via DATIX • H&S risk assessments undertaken and recorded on assessnet • Health and Safety dashboards presented to SHSC and ExCo • Manual handling training • E-learning H&S module • Regular updates to ExCo and Quality Committee • Health and Safety gap analysis undertaken	3 x 4 12		Current	• New health and safety policies, procedures, forms, checklists that are fit for purpose • Revised H&S intranet site where information is easy to find and easy to use • Increase employee engagement via blended comms programmes e.g. electronic, mailshots, noticeboards and face to face • 3 x Health and Safety Managers recruited. • Health and safety training plan for all levels of management and staff now in place • Risk profiling exercise completed for Divisions/ Directorates • Increase complement and training of Department Safety Coordinators (DSCs), Fire Wardens and First Aiders ongoing • Quantitative health and safety audits for divisions, directorates, sites and service areas taking place (Target risk score date: Jan 16)	⇔	1 x 4 4		• Prioritise and utilise internal H&S expertise e.g.DSCs, Security, Trade Union Reps (external additional support may be required) • Monitor effectiveness of health and safety action plan

Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
65	Medical Director	Divisional risk register / Operational risk	2	Feb 2014	**Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors, resulting in suspension of training.** **Cause**: • Inadequate training and education programmes • Failure to address allegations of bullying and undermining • Poor engagement and supervision • Poor access to and transparency of educational resources • Failure to be able to deliver safe patient care due to reduced doctor cover as an immediate consequence of trainee reduction (training suspension) • Failure to ensure that trainee doctors are able to progress in their training programme **Effect**: • Failure to deliver high quality training • Reduction in student and training places commissioned by Imperial College or HE NWL • Damage to reputation as a world class medical education provider • Withdrawal/Suspension of ST1 Training • Gaps on ward cover and out of hours on call rota causing pressure on existing workforce • Risk of trainees being removed **Impact**: • Potential loss of revenue: Research and education income (Failure to maintain medical education income) • Undermines mission of AHSC by failing to provide medical education integrated with research and service provision • Reputational with adverse revenue impact: Compromises future re-designation of AHSC • Potential to increase costs: Bank & Agency staff as result of being unable to recruit and retain medical staff at all levels • Potential to increase costs: i.e. claims and litigation impact on CNST payment due to poorly trained staff and potential for harm. • Reputational with adverse revenue impact: Service decommissioned and withdrawal of medical student places • Possible increase of complaints / incidents due to lack of continuity of medical staff/gaps in rotas • Potential Cost implications of locum requirements, service pressures and impact of future removal of funding for training posts	3 x 4 12	• Education improvement Action plan in place • New management structure in place • Anti-bullying strategy implemented • Development of KPIs underway • Revised governance structure implemented • Proactive management of recruitment and rotas, with locums filling shifts and escalation process in place in neurosurgery • Safety panel monitoring incidents weekly – chaired by MD • Fortnightly immediate critical review taskforce established for neurosurgery, led by MD to ensure ongoing review of action plan and evaluation of risk assessment	4 x 4 16	On-going	• Recruitment to new management structure commenced – will complete in Q4 2014/15 • Trustwide education forums commenced • Transformation programme launched • Education strategy in development • Job plan review continues with education framework in development • Bullying and undermining project continues with further evaluation of experience underway • GMC annual survey for 2013/14 results show reduced number of “red flags” • Project to identify income streams and use of educational funds, including transparency of consultant job plans completed – awaiting finance approval re accrual of funds • GEMV visit - action plan in place, reviewed at ExCo 070415. Business cases submitted for additional teaching fellows and admin support – awaiting outcome. • Action plan in place to deal with concerns raised by HENWL with regard to ophthalmology taining at WEH – fortnightly meeting chaired by medical director to review progress established • Specialty Reviews to take place summer 2015 – ToR in development. (Target risk score date: December 2015)	⇔	2 x 4 8	• Increase scope of CIP programme due to loss of income

Acronyms

AHSC – Academic Health Science Centre

BRC – Biomedical Research Centre

CCG – Clinical Commissioning Group

CE – Chief Executive

CFO – Chief Financial Officer

CNST – Clinical Negligence Scheme for Trusts

COO – Chief Operating Officer

CQC – Care Quality Committee

CQUIN – Commissioning for Quality and Innovation

CXH – Charing Cross Hospital

ECIST – Emergency Care Intensive Support Team

ED – Emergency Department

ExCo – Executive Committee

FBC – Full Business Case

FIC – Finance Investment Centre

FT – Foundation Trust

HCAI – Healthcare Associated Infections

HSE – Health and Safety Executive

MD – Medical Director

NWL – North West London

PLACE – Patient Led Assessment of the Care Environment

PMO – Project Management Office

PPM – Planned Preventative Maintenance

R&D – Research and Development

RTT – Referral to Treatment

TDA – Trust Development Authority

UCC – Urgent Care Centre

Imperial College Healthcare NHS Trust

Trust Board - Public

Agenda Item	4.2
Title	Board assurance framework (BAF)
Report for	Noting
Report Author	Jan Aps, Trust Company Secretary
Responsible Executive Director	Tracey Batten, Chief executive

Executive Summary:

The board assurance framework seeks to provide

Board members reviewed the board assurance framework (BAF) in March; the attached version has been updated to reflect the current risk register.

The executive committee have developed a range of indicators, which will feed a RAG rating, to provide an 'at a glance' view of movement towards achievement (or otherwise) of the strategic objectives of the Trust. The indicators are listed in the attached, as are the data sources, and the way in which the RAG rating will be provided.

The Trust board is asked to:

- Note the board assurance framework, noting any areas that are considered not to appropriately reflect the current risk environment
- Note the key performance indicators and RAG rating which are being introduced
- Note that the framework will be subject to comprehensive review over the summer.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

Measuring Achievement of our Corporate Objectives 2015-16 - KPIs and Data Sets

Objective 1. To Achieve Excellent Patient Experience and Outcomes, Delivered Efficiently and with Compassion

Imperial College Healthcare NHS Trust

Driver	Weighting	Key Performance Indicator	Frequency	Current Performance	Period	Threshold	DataSource
1.1 Standards	1	1.1 CQC Overall Risk Score	Quarterly	64.37	Q1 14/15		CQC Intelligent Monitoring
1.2 Compassion	0.5x2	1.2.1 (LQ36) Have you been treated with dignity and respect by staff on this ward? (National Inpatient Survey)	Monthly	96.3%	M9 14/15	*>85%*	TB
		1.2.2 (Q35) Do you feel you got enough emotional support from hospital staff during your stay? (National Inpatient Survey)	Annually	6.75	M3 13/14 - M5 13/14		CQC Intelligent Monitoring
1.3 Experience	0.5x2	1.3.1 (Q67) "Overall I had ...(Good/Poor Experience) (National Inpatient Survey)	Annually		M3 13/14 - M5 13/14		CQC Intelligent Monitoring
		1.3.2 FTT recommend as place for treatment	Monthly				TB
1.4 Outcomes	1	1.4.1 HSMR	Quarterly				Dr Foster
BAF Ref .		1a, 1b, 1c					

Objective 2. To Educate and Engage Skilled and Diverse People Committed to Continual Learning and Improvement

Driver	Weighting	Key Performance Indicator	Frequency	Current Performance	Period	Threshold	DataSource
2.1 Equal opportunities	1	2.1.2 Equal opportunities to career progression (all staff) (National Staff Survey)	Annual				P&OD
2.2 Staff engagement	0.5 x 2	2.2.1 Overall Trust engagement score (National Staff survey)	Quarterly				P&OD
		2.2.2 Overall engagement score National Survey	Annual				P&OD
2.3 Satisfaction with training	1	2.3.1 Staff satisfaction with job-related training, learning, development in last 12 months (National Staff Survey)	Annual				P&OD
2.4 Talent management	1	2.4.1 Completed PDRs (Trust)	Quarterly				P&OD
BAF Ref .	2a, 2b,						

Objective 3. As an Academic Health Science Centre, generate world Leading Research that is translated raspidly into Exceptional Clinical Care

Driver	Weighting	Key Performance Indicator	Frequency	Current Performance	Period	Threshold	DataSource
3.1 Research income	1	3.1.1 Total research income	Quarterly				JRO
3.2 Research outputs	1	3.2.1 Total research volume	Quarterly				JRO
3.3 Patients in trials	1	3.3.1 Total number of patients recruited into clinical trials	Quarterly				JRO
3.4 Discovery IP	1	3.4.1 Total IP income Trust	Quarterly				Imperial Innovations
3.5 AHSC Plan	1	3.5.1 Implement the AHSC Strategy progress per plan	Quarterly				AHSC Directorate
BAF Ref .	3a, 3b						

4. To Pioneer Integrated Models of Care with our Partners to Improve the Health of the Communities we serve

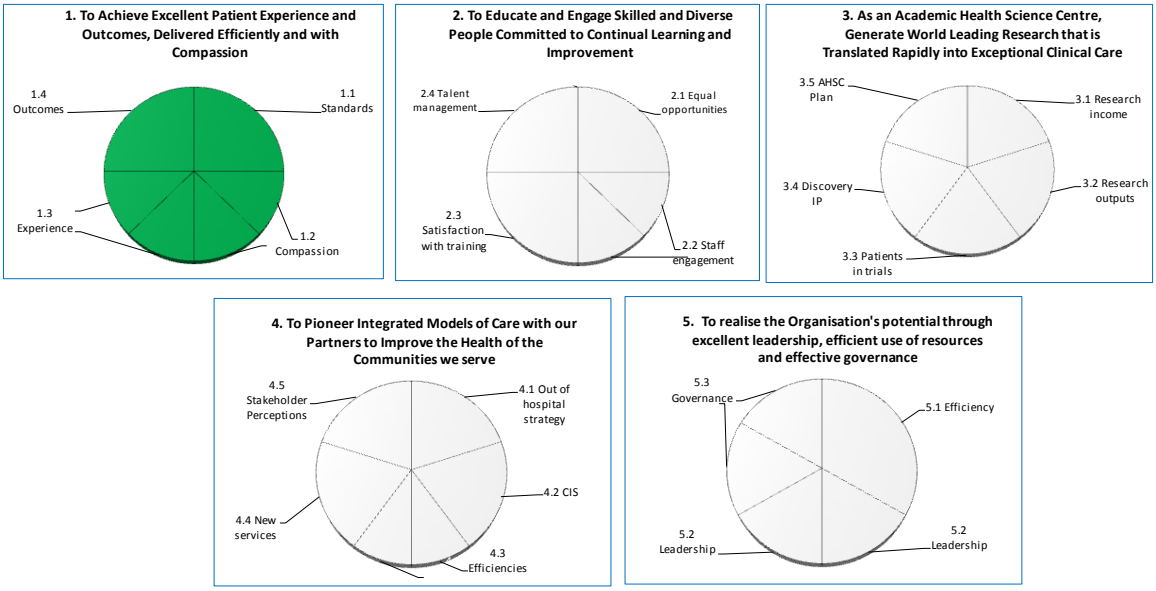
Driver	Weighting	Key Performance Indicator	Frequency	Current Performance	Period	Threshold	DataSource
4.1 Out of hospital strategy	1	4.1.1 Establish CIS as ACO by end of FY	Annual				CIS
4.2 CIS	1	4.2.1 Achieve CIS Contract standards	Annual				CIS
4.3 Efficiencies	0.5 x 2	4.3.1 Unscheduled care convergence rate %	Quarterly				Population Health, Med. Div.
		4.3.2 30 Day Readmissions	Quarterly				TB
4.4 New services	1	4.4.1 Sucessful community service bids (vs total community service bids submitted)	Quarterly				Business Planning
4.5 Stakeholder Perceptions	1	4.5.1 Year on Year improvement in stakeholder engagement survey (Trust)	Annual				
BAF Ref .	tbc						

5 To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

Driver	Weighting	Key Performance Indicator	Frequency	Current Performance	Period	Threshold	DataSource
5.1 Efficiency	1	5.1.1 EBITDA	Monthly				TB
5.2 Leadership	0.5 x 2	5.2.1 Board Leadership Trust Engagement Survey	Quarterly				TB
		5.2.2 Recommend Trust as a place to work	Anually				National Staff Survey
5.3 Governance	0.5 x 2	5.3.1 CQC Overall Score Min/Good rating	Annually				CQC
		5.3.2 Self Assessment against Monitor and TDA Quality Governance Frameworks (Well Led)	Annually				Trust company secretary
BAF Ref .	tbc						

Imperial College Healthcare NHS Trust

Presentational approach to the RAG rating of our strategic objectives



Imperial College Healthcare NHS Trust

Board Assurance Framework

May 2015
V.1

CORPORATE OBJECTIVE	**1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.**
Sub objective	**1a. To achieve excellent patient experience with compassion (Director of nursing)**

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	**KEY CONTROLS** What controls / systems do we have in place to assist in delivering this objective?	**GAPS IN CONTROL AND ACTIONS** Where we are failing to put controls / systems in place? What action needs to take place?	**SOURCES OF ASSURANCE** Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	**GAPS IN ASSURANCE AND ACTIONS** Where we are failing to gain evidence that our assurance systems are effective?
Internal • Ineffective patient systems and processes leading to delays, cancellations, waits etc. • Complex pathways of care including requirement for multi-site attendance (includes ageing estate) • Lack of patient facing customer care skills in some areas • Level of reported staff engagement • Lack of agreed overarching approach to delivering high quality patient **External** • Underdeveloped engagement systems with users and commissioners of services	**1. Plan** • Development of patient service centre • Clinical and estates strategies • Clinical transformation programme • Patient experience work plans (generic and cancer specific) • Staff engagement strategy & wellbeing programme **2. Resources** • Clinical transformation team • Patient experience team **3. Governance structure & reporting** • All programmes have designated executive lead • Programmes report up through Executive Committee plus Quality Committee and Board when appropriate	• Scope and develop a programme and agree time scale, approach and funding	**Internal** • Friends and family test data • Patient stories to the Trust Board / cancer 100 day events • Local real time surveys system • PALS and complaints analysis • Internal Audit programme **External** • National patient experience surveys • NHS Choices feedback • Feedback from commissioners, patient representative organisations (e.g. Healthwatch) and other stakeholders	None identified
Link to Corporate Risk Register	CRR:71 Failure to deliver safe patient care / effectiveness of care (HCAI) (current score 12)			

CORPORATE OBJECTIVE	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Sub objective	1b. To achieve excellent outcomes (Medical Director)

PRINCIPAL BARRIERS & RISKS What could prevent this Objective being achieved?	KEY CONTROLS What controls / systems do we have in place to assist in delivering this objective?	GAPS IN CONTROL AND ACTIONS Where we are failing to put controls / systems in place? What action needs to take place?	SOURCES OF ASSURANCE Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	GAPS IN ASSURANCE AND ACTIONS Where we are failing to gain evidence that our assurance systems are effective?
Internal • Lack of safety improvement programme to drive continuous improvement • Lack of appropriate data or ability to benchmark outcomes / effectiveness • Non-achievement of defined metrics e.g. quality account • Inadequate audit and effectiveness resource • Inadequate clinical and nursing staff levels • Failure to translate research into exceptional clinical care **External** • Conflicting priories for work streams caused by external priorities and pressures	**1. Plan** • Quality Strategy & Quality Accounts • Participate actively in 'Sign Up To Safety' campaign **2. Resources** • Associate Medical Director for Safety & Effectiveness in post • Business case for audit and effectiveness team approved **3. Governance structure & reporting** • Governance process including monitoring and assurance to Trust Board in place • Quality report and governance process now in place	• Align the revised quality strategy with the 5 CQC domains, and ensure alignment with the Quality Accounts, to develop a unified safety improvement plan to reduce avoidable harm across the Trust • Proposal for standardised quality improvement methodology • Develop and improve reporting systems • Continuous monitoring of actions to reduce levels of infection	**Internal** • Low HSMR and SHMI + • Infection Control Rates – • Local Audit programme plan – • VTE, Safety Thermometer, Harm Free Care + **External** • Low HSMR and SHMI + • Infection Control Rates – • National Audit –	• Internally agreed audit programme plan • Currently unable to effectively benchmark national and internal audit data or monitor actions arising from audit • Lack of clinical guideline management system

Link to Corporate Risk Register	CRR:55 Failure of critical equipment and facilities that prejudices trust operations and increases clinical and safety risks (current score 20) CRR:71 Failure to deliver safe patient care / effectiveness of care (HCAI) (current score 12) CRR:81 Failure to comply with statutory and regulatory duties and requirements, including CQC action plan (current score 12) CRR:83 Failure to meet recommended vacancy rates across all areas in the organisation (current score 12)

CORPORATE OBJECTIVE	To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
Sub objective	1c. To deliver outcomes that are efficient (Chief Operating Officer)

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	KEY CONTROLS What controls / systems do we have in place to assist in delivering this objective?	GAPS IN CONTROL AND ACTIONS Where we are failing to put controls / systems in place? What action needs to take place?	SOURCES OF ASSURANCE Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	GAPS IN ASSURANCE AND ACTIONS Where we are failing to gain evidence that our assurance systems are effective?
Internal • Mismatch of capacity and demand • Organisational ability to manage multiple large scale service change. **External** • Political appetite for system change • Impact of service changes in other parts of the sector	**1. Plan** • Performance management framework • Business Planning • External relationship management • Transformation programme • Winter operational plan • Changes to clinical pathways **2. Resources** • Performance team and head of performance • Additional Winter contingency funds • 18 beds opened on the vacated Marjorie Warren Ward at Charing Cross. • Increase to 7/7 discharge team support focussed on the EDs and key admitting areas; • Extending the emergency ambulatory provision at SMH/CXH to support timely patient flow through the EDs. **3. Governance structure & reporting** • Strategic investment group • Emergency performance and assurance monitored via Executive Committee • Weekly reviews	• Scoping additional bed capacity • Developing ambulatory models of care • CTP programme and quest team	**Internal** • Internal audit annual performance audit (N) • Monitoring and scorecard **External** • External Audit • External regulatory assessments	None identified
Link to Corporate Risk Register	CRR:48 Failure to maintain financial sustainability (current score 20) CRR:68 Insufficient support for key aspects of our clinical strategy (current score 12) CRR:79 Mismatch in capacity and demand, 95% ED target (current score 20) CRR:7 Failure to maintain operational performance (current score 15)			

CORPORATE OBJECTIVE	2. To educate and engage skilled and diverse people committed to continual learning and improvement
Sub objective	2a. To educate skilled and diverse people (Medical Director)

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	KEY CONTROLS What controls / systems do we have in place to assist in delivering this objective?	GAPS IN CONTROL AND ACTIONS Where we are failing to put controls / systems in place? What action needs to take place?	SOURCES OF ASSURANCE Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	GAPS IN ASSURANCE AND ACTIONS Where we are failing to gain evidence that our assurance systems are effective?
Internal • Failure to deliver high quality medical education • Risk to implementation of the nursing and midwifery education strategy relating to resources and financial limitations • Learning needs not identified or addressed during PDR or consultant appraisal process **External** • Reducing numbers of training placements leading to increased competition • NHS Graduate scheme has reduced numbers of graduates over the last five years.	**1. Plan** • Education transformation programme • Anti-bullying strategy and action plan implemented • New PDR process in place with training programmes for managers • Development and vocational succession planning apprentices and graduates **2. Resources** • New education management team **3. Governance structure & reporting** • New governance and reporting process for medical education being implemented, including scorecard reported through ExCo • Education reported to TB through operational report	• Education strategy to be developed • Anti-bullying strategy to be rolled out Trustwide, starting with specialties where red flags were identified by GMC NTS 2014 • Programme plan for Year of Education 2015 to lead culture change • Educational appraisal to be rolled out for educational supervisors as part of revalidation • GMC survey & SOLE action plans to be monitored at divisional level and through Education Report • Review of educational activity in consultant job plans • Potential graduate scheme bid submitted to charity for funding (Dec 14)	**Internal** • Internal trainee surveys - • Monitoring of KP's via education strategy • Statutory and mandatory training compliance monitoring • Staff retention and exit interview • Recruitment of student nurses and midwives into substantive posts **External** • GMC National Trainee Survey – • SOLE Feedback – • CQC compliance with regulation 23 – supporting workers	• Education KPIs to be identified
Link to Corporate Risk Register	CRR:65 Failure to achieve benchmark levels of medical education performance (current score 16) CRR:85 Failure to recruit to substantive posts on some medical wards (current score 15)			

CORPORATE OBJECTIVE	2. To educate and engage skilled and diverse people committed to continual learning and improvement
Sub objective	2b. To engage skilled and diverse people (Director of People & OD)

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	KEY CONTROLS What controls / systems do we have in place to assist in delivering this objective?	GAPS IN CONTROL AND ACTIONS Where we are failing to put controls / systems in place? What action needs to take place?	SOURCES OF ASSURANCE Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	GAPS IN ASSURANCE AND ACTIONS Where we are failing to gain evidence that our assurance systems are effective?
Internal • Hotspot areas of low engagement **External** • Competition from other London Trusts affecting our ability to attract skilled and diverse candidates into fill 'hard to fill' roles	**1. Plan** • People and OD Strategy reviewed for 15/16 to 18/19. • Engagement has been built into key policies and process • All management teams have local action plans monitored quarterly • Values and behaviours **2. Resources** • Director of People and OD • Each Operations Division has a dedicated HR Business Partner • Health and Wellbeing Programme for staff • **3. Governance structure & reporting** • Quality committee • ExCo • Trust Board via Operational report • Divisional quarterly meetings	• Careers micro site to be launched end Feb 15 • "CLOi " a cultural leadership index is being piloted in 6 areas.	**Internal** • Staff are actively engaged in change process, organisational and service developments on an on-going basis • Staff FFT • Quarterly staff engagement surveys • Staff exit survey **External** • ICHT in upper quartile of best companies to work for • Benchmarking with other NHS Trusts	None identified
Link to Corporate Risk Register	CRR:67 Failure to achieve benchmark levels of workforce engagement (current score 9) CRR: 72 Failure to implement, manage and maintain effective H&S systems (current score 12)			

CORPORATE OBJECTIVE	3. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
Sub objective	3a. Generate world leading research (Medical Director)

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	KEY CONTROLS What controls / systems do we have in place to assist in delivering this objective?	GAPS IN CONTROL AND ACTIONS Where we are failing to put controls / systems in place? What action needs to take place?	SOURCES OF ASSURANCE Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	GAPS IN ASSURANCE AND ACTIONS Where we are failing to gain evidence that our assurance systems are effective?
Internal • Failure to meet NIHR metrics • Lack of transparency in resource allocation to support clinical research **External** • External competition for securing tenders	**1. Plan** • AHSC Strategy • New processes set up with divisions to enable metrics to be improved **2. Resources** • Research facilities • Divisional Directors of Research • Divisional Research Managers • Imperial Clinical Phenome Centre • 7 Centres for Translational Medicine (CTMs) established **3. Governance structure & reporting** • Research reports to ExCo and TB through Operational Report • Medical Director Executive Lead for Research • Robust feasibility assessment for new studies in place in all divisions	• Trust Research Strategy in Development • Develop quarterly Research Report for ExCo – Quality	**Internal** • HTA inspection - ICHT found to be suitable in accordance with the requirements of the legislation + • Pilot of new procedures to meet metrics took place in Division of Surgery, Cancer & Cardiovascular + • Genomics Centre designation + **External** • Redesignation as AHSC and BRC + • Regulatory compliance with MHRA and HTA + • External mid-term inspection of BRC + • Genomics Centre designation +	• BRC Office: to carry out formal review / evaluation of the impact of the new processes
Link to Corporate Risk Register				

CORPORATE OBJECTIVE	3. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
Sub objective	3b. Transition into exceptional care (Medical Director)

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	KEY CONTROLS What controls / systems do we have in place to assist in delivering this objective?	GAPS IN CONTROL AND ACTIONS Where we are failing to put controls / systems in place? What action needs to take place?	SOURCES OF ASSURANCE Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	GAPS IN ASSURANCE AND ACTIONS Where we are failing to gain evidence that our assurance systems are effective?
Internal • Lack of transparency of potential translational research • Lack of resources to implement and monitor outcomes of translated research • Physical infrastructure and support **External** • Constraints with commissioning contracts • Patient & stakeholder engagement	**1. Plan** • AHSC Strategy • Clinical Strategy **2. Resources** • Divisional Directors of Research • Divisional Research Committees • BRC • Partner organisation with NIHR CLARCH **3. Governance structure & reporting** • Medical Director Executive Lead for Research • Research reported to ExCo and TB	• Trust research strategy in development	**Internal** • Translational research in the Trust has led to improvements in: Safer removal of liver tumours, Improving survival for chronic myeloid leukaemia, Preventing bowel cancer, Saving babies from brain damage + **External** • Redesignation as AHSC and BRC + • External mid-term inspection of BRC + • Designation as Genomics Medical Centre	• Unknown intelligence regarding numbers of models of care we were unable to roll out due to internal/external barriers
Link to Corporate Risk Register				

CORPORATE OBJECTIVE	4. To pioneer integrated models of care with our partners to improve the health of the communities we serve.
	(Director of Strategy and Redevelopment)

PRINCIPAL BARRIERS & RISKS What is currently getting in the way of achieving this objective	**KEY CONTROLS** What controls / systems do we have in place to assist in delivering this objective?	**GAPS IN CONTROL AND ACTIONS** Where we are failing to put controls / systems in place? What action needs to take place?	**SOURCES OF ASSURANCE** Where/How can we gain evidence that our control systems are effective and that our objectives are being delivered?	**GAPS IN ASSURANCE AND ACTIONS** Where we are failing to gain evidence that our assurance systems are effective?
Internal • Appetite for change • Inability to manage funding flows (national and local commissioning) • System capacity and capability to effect change **External** • The complex and changing NHS landscape environment mean providers in primary and secondary care and speciality social care place barriers to the integration of services around patient needs.	**1. Plan** • Clinical strategy – programme of service integration (established and planned) **2. Resources** • Health and wellbeing programme for staff **3. Governance structure & reporting** • Executive committee • Trust Board • CTP committee • External Planned / Urgent care programme boards • External tri-borough system restructure group • CGA	• Tender submitted for NHS Genomics Medicine Centre (for personal medicine)	**Internal** • Maintenance of current community based services and further extension including awarding of key tenders • Already run primary care based services in relation to UCC GP Services **External** • CIS Tender awarded to ICHT as Lead Health Provider across the Tri-borough. • Public health capability via AHSC with Imperial collage • Invested in Clinical Transformation in area of service integration	None identified
Link to Corporate Risk Register	CRR:68 Insufficient support for key aspects of our clinical strategy from one or more key audiences / stakeholders (current score 12) CRR:73 Failure to deliver transformational integrated, personalised and systematised models of care to achieve long term sustainability, enhance acute services and support out of hospital care (current score 9) CRR:74 Failure to achieve and gain approval for the FBC (current score 12)			

Imperial College Healthcare NHS Trust

Report to**:** **Trust Board**

Report from**:** **Audit, Risk & Governance Committee (22 April 2015)**

KEY ITEMS TO NOTE

Internal Audit and Counter Fraud Annual plans 2015/16
Alan Goldsman reported that the annual plans had been reviewed and approved by the Executive Committee and that key areas for 2015/16 would be the CQC action plan and data quality.

Annual governance statement – draft statement
Jan Aps reported that the statement included business planning, the BGAF and QGAF, raising concerns, leadership development and emergency preparedness.

Annual accounts – draft
Alan Goldsman reported that while a small surplus had been achieved for the 2014-15 year, expenditure had risen due to investments made to address the requirements of 'safe staffing' and improving the midwife ratios.

Quality Accounts – draft report
Prof Julian Redhead reported that the final version of the accounts would include cleanliness targets, how the Trust involves patients in their care, staff and patient safety, research and education and the WHO checklist.

Action requested by Trust Board

The Trust Board is requested to:

- Note the report

Report from: Sir Gerald Acher, Chairman, Audit, Risk & Governance Committee
Report author: Tracy Walsh, Committee Clerk
Next meeting: 27 May 2015

Imperial College Healthcare NHS Trust

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE
Wednesday 11 March 2015
10.00am – 12.30pm
Clarence Wing Boardroom
St Mary's Hospital

Present:	
Sir Gerald Acher (Chair)	Non-Executive Director
Prof Sir Anthony Newman Taylor	Non-Executive Director
Sarika Patel	Non-Executive Director
Dr Andreas Raffel	Non-Executive Director
In Attendance:	
Dr Tracey Batten	Chief Executive
Claire Broster	Risk/Projects Manager (Item 2.1 until the end of item 4.1)
Heather Bygrave	Partner, Deloitte
Alan Goldsman	Interim Chief Financial Officer
Chris Harrison	Medical Director
Julian Hunt	Deloitte (until the end of item 2.4)
Kevin Jarrold	Chief Information Officer
Diane Jones	Divisional Governance Lead for Women's & Children's (until the end of item 2.1)
Philip Lazenby	Director of Audit, TIAA
Steve McManus	Chief Operating Officer
Ann Mounsey	Chief Pharmacist (from item 2.1 until the end of item 2.4)
Chris O'Boyle	Director of Estates & Facilities (until the end of item 2.1)
Arti Patel	Senior Counter Fraud Specialist, TIAA
Ian Sharp	Executive Director, TIAA
Prof Janice Sigsworth	Director of Nursing
Tracy Walsh	Committee Clerk (minutes)

1	**GENERAL BUSINESS**	
1.1	**Chair's opening remarks and apologies for absence** The Chair welcomed everyone to the meeting. Apologies for absence were received from Jan Aps. The Chair requested that timings on the agenda be reviewed as he would always aim to finish the meeting by 12.30pm.	TW
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
1.3	**Minutes of the Committee's meeting on 10 December 2014** The minutes were approved as an accurate record.	
1.4	**Action log** The committee noted the updates to the action log.	
1.5	**Matters arising report** The committee noted the matters arising report.	
2	**GOVERNANCE & RISK BUSINESS**	
2.1	**Update on risk management** Prof Janice Sigsworth introduced the report noting that the Board Assurance Framework (BAF) would be submitted to the Trust Board in March and to the Audit, Risk and Governance Committee on a 6 monthly basis. It had been agreed that responsibility for the BAF would transfer to the Trust Company Secretary from April; the Committee advised that it needed to be ensured that the BAF did not	

	become too far removed from the operational aspects of the Trust. Sir Acher thanked Prof Janice Sigsworth and Claire Broster for their excellent work on the BAF. Risk owners had reviewed and revised scores accordingly with three risks being escalated from divisional director risk registers to the corporate risk register. The Committee reviewed in detail risks where the score had either increased or decreased: • Risk 55: Failure of critical equipment and facilities (increased) • Risk 79: Mismatch in capacity and demand increasing risk of not achieving 95% A&E target (increased) • Risk 48: Failure to maintain financial sustainability (increased) • Risk 82: Non-Executive Directors not informed of potential operational or reputation risks (decreased). Philip Lazenby reported that he had recently reviewed the risk register against that of other NHS Trusts and advised it was of a good standard. **Actions:** • Risk 55: Failure of critical equipment and facilities, the capital envelope would be provided to the next Audit, Risk and Governance Committee and Quality Committee meetings. • Steve McManus would advise the Trust Board at the meeting in March of the expected timetable for availability of 24 hour MRI at St Mary's Hospital. Diane Jones reported that the Gynaecology service had been the initial pilot area for implementing Datix for risk management and this had completed to schedule at the end of February. A full roll out to the divisions of women's and children's and medicine was expected by the end of April and the remaining divisions by the end of June. The Committee noted the update.	IG SMcM
2.2	**Elective Access assurance report update** Steve McManus advised that the update provided a brief summary of the actions that had been completed following the report in January 2014. There had been on-going data quality challenges since the implementation of Cerner in April 2014 which had impacted on the data reported for Referral to Treatment (RTT) pathways. This was due to data migration issues, technical issues with the reporting of the data from Cerner and staff entering data incorrectly. The issues were being addressed through validation, supporting and retraining staff and tracking through KPI's. The Elective Access assurance policy had been updated in August 2014 and was currently under review. The Committee noted the update.	
2.3	**Pharmacy Performance update** Ann Mounsey highlighted: • Two additional delivery rounds solely for discharging prescriptions had been added at Hammersmith Hospital • All sites had 5-6 delivery rounds a day • St Mary's was currently piloting the assignment of porters to an area rather than delivering by function • The appropriate staff on wards were able to use ward stock, rather than waiting for pharmacy, which had speeded up the discharge process • The average end to end discharge time over the last 7 months had consistently been 3hrs 15mins. • E-prescribing would to be piloted over the next 6 weeks The Committee noted the update.	
2.4	**Cerner post implementation review** Kevin Jarrold highlighted:	

	• Clinical documentation functionality had been successfully piloted in the outpatient and inpatient setting and a rollout across the Trust was being developed • Electronic prescribing in theatres had gone live at Hammersmith Hospital that week with St Mary's and Charing Cross Hospitals going live on subsequent weeks. Emergency department e-prescribing had gone live at all three sites the previous day • Plans were in place to move into the Cerner data centre in early September 2015 using a process tried and tested in other NHS Trusts • The accurate recording of the 18 week referral to treatment pathway would be addressed over the coming weeks • The predicted overspend was now below £0.4 million There had been challenges with the data quality which in some cases had been resolved by Cerner fixing bugs in the system or the retraining of staff; Mr Jarrold confirmed there were processes and procedures in place for staff to follow, including guidelines for coding. Julian Hunt noted that Deloitte considered that the Trust had a significant opportunity over the next 2-3 years for cost saving due to the implementation and Philip Lazenby reported that TIAA believed the tracking of data such as cancer waiting times would be simpler. As reported to Quality Committee on the 4 March, the Trust was reviewing a number of options with regard the Radiology Information System (RIS) and Picture Archive and Communication System (PACS). Depending on the final agreed option, the RIS/PACs system may need to be added to the Corporate Risk Register. The Committee noted the update.	TB/CB
3	**EXTERNAL AUDIT BUSINESS**	
3.1	**External Audit interim update report** Heather Bygrave reported that while the land valuation in relation to the hypothetical site had initially been a concern for Deloitte the valuer had changed their report, which Deloitte were still to receive, but they were confident that the methodology used and the land price were now realistic. Alan Goldsman advised the Trust was due to pay a dividend in the next couple of weeks and Ms Bygrave confirmed Deloitte did not believe there was a risk in doing so. Ms Bygrave noted that with regard Value for Money (VfM), Deloitte had reviewed the delay to the Foundation Trust application, CQC report, Cerner project, CIPs and project diamond and at the this point in time did not feel the need to draw the Committees attention to any particular risk, but it would be kept under review. Ms Bygrave reported that the Trust was not required to have an enhanced audit report this year and following a discussion with the Executive Directors the Committee agreed the Trust would not require an enhanced audit report. The Committee noted the report.	
3.2	**Appointment of External Auditor from 2015/16** Alan Goldsman tabled a letter to the Trust from BDO LLP; the external auditor appointed for a period of two years from 2015/16 by the Audit Commission. The letter included the proposed planning arrangements and fees for 2015/16. The Committee considered the letter and accepted the proposed fees. The Committee noted the paper.	
4	**INTERNAL AUDIT BUSINESS**	
4.1	**Internal audit and Counter fraud progress report** Ian Sharp highlighted: • That progress against the annual audit plan for 2014-15 should all complete in the current year apart from the ICT audit which would run into	

	the first week of April • Two areas had been assessed as limited assurance; temporary staffing and registration authority • That the indicative audit plan for 2015/16 was a result of meetings with executive leads and senior managers and had been mapped against the risk register. The final plan would be submitted to Executive Committee, and ratified by this Committee at its meeting in April. Mr Sharp confirmed that discussions that had taken place during the meeting e.g. datix, pharmacy times etc would be taken into consideration in the final plan. Philip Lazenby reported that following a review of the staff leavers and starters process TIAA had been satisfied with the level of controls in place. Mr Lazenby reported that the controls that had been put in place for temporary staffing in July had initially helped control, but that further issues identified that these were not sufficiently robust. The executive lead for temporary staffing was to be reviewed and agreed. The Committee asked that TIAA meet with executive leads to agree the management comments (as it felt that this was a role that should not be delegated within the Trust), and that the internal audit reports should be presented with the management comments, and the number of recommendations and actions not yet completed. Sir Gerald Acher asked that, should TIAA become aware of any urgent issues requiring attention that were not reflected in the risk register or discussed at the Committee meetings, he (as Committee chair) be informed immediately after Dr Batten had been made aware. Arti Patel provided an update on the fraud progress report highlighting: • Case PAA 5989 – a court date had been set for 11 May • Case PAA 6295 – there was no evidence to substantiate the allegation and the case would be closed Mr Jarrold reported that internal audit would review use and IT access cards. The Committee noted the report.	IS PL/TB PL
5	**FINANCIAL & OTHER BUSINESS**	
5.1	**Tender Waiver report** Any waivers over £100,000 would be listed in the report with a brief background summary. The Committee noted the tender waiver report.	AG
5.2	**Losses and Special Payments Register** Items over £50,000 to be included in the register with a brief summary of the final outcome. The Committee noted the losses and special payments register.	AG
5.3	**Committee work plan 2015-16** The Committee understood that the meeting in April would only consider the draft accounts and no other Committee business. The Trust Company Secretary would be asked to clarify and confirm to all members and attendees. The Committee noted the work plan.	JA
6	**ANY OTHER BUSINESS** There was no other business to consider.	
7	**DATE OF NEXT MEETING** Wednesday 22 April 2015, 10.00am – 12.30pm, Clarence Wing Boardroom, St Mary's Hospital.	

Imperial College Healthcare NHS Trust

Report to: **Trust Board**

Report from: **Quality Committee (13 May 2015)**

KEY ITEMS TO NOTE

Professor Jamil Mayet reported that there had been a CRE outbreak (K. pneumoniae NDM (New Delhi metallo-beta-lactamase) producing organism) on a renal ward. An existing Trust dialysis patient had returned from India carrying the infection which had spread to other patients. In line with the guidance issued by Public Health England (PHE) and NHS England, the screening toolkit was already in place, with targeted screening implemented for identified high risk patients. The Trust is working closely with PHE and continues to update the CCG and TDA on progress. A root cause investigation was being undertaken to ensure lessons were learned.

Quality report

Justin Vale highlighted:

- It was the Trust's fourth successive month of low relative mortality in HSMR (following the raised indicator in August)
- Serious Incidents (SIs) reporting had increased for the year
- The Friends and Family Test in February, 96% of our inpatients would recommend the Trust to their family or friends, as compared with 95% nationally

Quality Strategy 2015-18

Dr Julian Redhead reported that Commissioners were satisfied with the structure of the report which had been aligned to the five CQC domains (safe, effective, caring, responsive and well-led) and would be monitored through measurable KPIs. The final strategy with the improvement methodology would be provided to the Board meeting in July.

CQC update report

Professor Janice Sigsworth reported that the Trust continued to be registered at each site without any conditions. It had been agreed at the executive committee that quarterly reviews of activities with divisional directors would take place to ensure the Trust's CQC registration remained accurate and up to date. Internal audit had been requested to conduct a series of in-depth reviews, in line with the CQC format, for areas that were rated as 'good', the first of these had taken place on 6/7 May in critical care services. A detailed action plan for outpatient services would be provided to the Quality Committee meeting in July.

Annual Safeguarding reports inc Annual Safeguarding Children declaration

Prof Janice Sigsworth highlighted:

- Training rates in adults safeguarding had improved
- The internal audit report had provided 'reasonable' assurance about the trust safeguarding systems and processes
- A key priority for 2014/15 was to screen for and report incidences of female genital mutilation (FGM) and to provide an associated counselling service for these women.

Imperial College Healthcare NHS Trust

Action requested by Trust Board
The Trust Board is requested to: • Note the report

Report from: Prof Sir Anthony Newman Taylor, Chairman, Quality Committee
Report author: Tracy Walsh, Committee Clerk
Next meeting: 15 July 2015

Imperial College Healthcare NHS Trust

Report to: **Trust Board**

Report from: **Finance & Investment Committee (20 May 2015)**

KEY ITEMS TO NOTE

Finance report - out turn and April performance

The year-end position shows a surplus of £15.4m, a favourable variance to plan of £4.2m. This includes Project Diamond income of £24.4m, without which a deficit position was likely. This underlying position has been factored into the planning assumptions and no further changes were required.

An early view of the position for April shows that the Trust was operating within its approved and funded staffing establishment. This was backed up by an analysis of the bank and agency staff booking systems. There was limited information on activity and performance but under reasonable assumptions it was concluded that the plan for 2015 / 16 was functioning properly in the first month.

PICU full business case

Professor TG Teoh reported that costs had increased in part due to extensive ventilation work and strengthening the floor on the 7th floor of Queen Elizabeth Queen Mother building. Part of the gross capital requirement would be through charitable funding from Imperial College Healthcare Charity and COSMIC. The full business case met the TDA's requirements. The Committee recommended the full business case for Board approval.

Cost improvement plans update

Jon Schick reported that 209 CIPs had been identified for 2015-16 with a total value of £36.8m and highlighted some of the key efficiency programmes:

- A new e-rostering programme
- Reduction of readmissions being enabled by a new reporting tool developed by IT
- Medicines management.

Community ophthalmology tender

A verbal update would be provided at the Trust board meeting.

Action requested by Trust Board

The Trust Board is requested to:

Imperial College Healthcare NHS Trust

- Note the report

Report from: Sarika Patel, Chairman, Finance & Investment Committee
Report author: Tracy Walsh, Committee Clerk
Next meeting: 22 July 2015

Imperial College Healthcare NHS Trust

Trust board - public

29 April 2015

Agenda Item	6.1
Title	Ealing maternity transfer arrangements
Report for	Noting
Report Author	Jan Aps
Responsible Executive Director	Steve McManus

Executive Summary:

The report consists of the following:

- The letter sent to Clare Parker, SRO Shaping a Healthier Future, on 26 March 2015 detailing operational readiness of the Trust in preparation for the transfer of maternity services from Ealing Hospital;
- Presentation made to TDA / SaHF on 6 May detailing operational readiness;
- Letter to Dr Parmar, chair of Ealing CCG on 13 May confirming operational readiness;
- The letter from Clare Parker detailing the outcome of the decision of Ealing CCG Governing Body on 20 May 2015.

Recommendation:

The Trust board is asked to note the report, and confirm they are assured as to the Trust's operational readiness.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

Chief executive: Dr Tracey Batten
The Office of the Chief Executive
The Bays Building
South Wharf Road
London
W2 1NY

0203 312 5897
tracey.batten@imperial.nhs.uk
www.imperial.nhs.uk

Sent via Email

Clare Parker
Chief Officer CWHHE Clinical Commissioning Groups
North West London Collaboration of Clinical Commissioning Groups
15 Marylebone Road
London
NW1 5JD

26 March 2015

Dear Clare,

Subject: Action required by Imperial College Healthcare NHS Trust (ICHT) following the Ealing CGG Governing Body (Wednesday 18 March)

In response to your letter received on the 25th March 2015 on the above subject, I can confirm that preparation to enable the transition of maternity and neonatology, gynaecology, and paediatric activity from Ealing Hospital continues as previously assured.

In relation to the particular actions required in section one, I confirm the following:

Step	Timing	Actions taken or to be taken
1 – Note Ealing CCG GB decision	25 March – ICHT Board meeting in public	The Chief Executive report included the following statement "The Trust has confirmed its commitment to proceeding with the Ealing Maternity services transfer of 1000 births/101 neonates per annum; on the condition that this is supported by commissioners within a sustainable financial sum and long term contract arrangements. NHS England have now outlined their assurance process for stage one. This recommends that before Ealing CCG make a decision on the timing of the planned service transitions further assurance is sought on confirmation of staffing, estates work completion timelines, details of the maternity booking service and details of the gynaecology model of care at Ealing Hospital. It is anticipated that further work will need to take place on operational readiness before a decision on the timing for the transfer of maternity services is made." On receipt of your letter, the minutes contain a post-meeting note as follows "The Trust received a letter from Ealing CCG on 25 March confirming that further work

Step	Timing	Actions taken or to be taken
		needed to be done on operational readiness before a decision on the closure of Ealing maternity unity was made (likely to be at the meeting of its governing body in May). The Trust had been asked to provide further assurances in relation to operational readiness.
2 – Trusts confirm operational readiness in private	29 April – ICHT board seminar	A further report will be considered at the meeting as part of the Women's and Children's Divisional Review. The Chief Executive will write following the seminar.
3 –Trust letter of support		Template of letter awaited
4 – Trust Chief Executive to attend Ealing CCG Governing Body meeting		Invitation to Governing Body meeting awaited
5 – Trusts confirm operational readiness in public		A final version of the Trust Operational Readiness Report will be presented to the public Trust Board.

Section 2: While we await the final decision on the date for transition, we continue to work through our "operational readiness" plans. A short update has been incorporated in the table below to give some insight into ICHT "operational readiness" activities to ensure that both Ealing CCG and the wider NHS delivery system can have confidence that our organisation will be operationally ready for the transition.

Domain	Immediate requirements	Sitrep
1. Maternity workforce	Ensure that your maternity workforce recruitment plans are in place and that active steps are being taken to recruit to these positions Orientation and induction of maternity staff transferring from Ealing Hospital is being arranged and delivered	- Workforce Planning Group in place overseen by a senior HR lead - Recruitment plan and activity schedule in place -Welcome, orientation and induction plan in place. -Projected delivery date for an appropriate staff model including dependency on contingency workforce by 25th May 2015
2. Estates	The ICHT maternity estates work is on track to provide the required maternity physical capacity at Queen Charlotte's and Chelsea Hospital. ICHT is progressing plans to provide the required physical capacity to support the transition of paediatrics services from Ealing Hospital by summer 2016.	-Estates MDT in place overseen by an Estates Manager and Project Lead. -Estates plan and project schedule in place - Day treatment/assessment, SCBU, antenatal works progressing with a completion date of 29th May 2015 - Plans for theatre refurbishment on SMH to be tendered shortly - The estates team are looking at options to provide additional physical capacity for paediatrics A&E on SMH site by summer 2016
3. New maternity model of care	ICHT is working to implement the new maternity model of care,	-Operational and Quality MDT Group in place lead by a senior manager -Review of Quality requirements and

Domain	Immediate requirements	Sitrep
	and that appropriate actions are being taken for the use of new community facilities and clinical and operational pathways	clinical and operational pathways being under taken by midwifery, clinical and operational managers. -Community facilities currently being scoped -Community IT infrastructure is emerging as a risk as unlikely to be completed by 6th May, however mitigation and alternative plans are being developed. - Community/ Models of Care presently progressing to projected delivery date of 18th May 2015.
4. Internal staff communication	Appropriate internal communications plans are in place and on track to ensure that ICHT staff at all levels are fully aware of the trust plans for receiving maternity activity from Ealing Hospital	-Communications plan for internal communications has been developed in conjunction with communications team. -internal face to face briefings being developed for all levels of staff across the affected services - Email communications plan initiated
5. Trust Project Support	Project support requirements to deliver your operational plans have been confirmed and are in place	-Operational Project Manager is in post -Implementation management and appropriate governance structure is in place.

We will continue to work closely throughout the mobilisation phase with the CCG and SaHF colleagues and welcome the opportunity to share our progress. As we get closer to the transition date if you have any queries, please do contact me.

Yours sincerely

Dr. Tracey Batten
Chief Executive

cc: Steve McManus – Chief Operating Officer, Imperial College Healthcare NHS Trust
Alan Goldsman – Chief Financial Officer, Imperial College Healthcare NHS Trust
Prof TG Teoh – Divisional Director, Women's & Children's Services, ICHT

Shaping a healthier future

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

NHS TDA Quality Assurance Peer Review of Operational Readiness for NWL Maternity Services Transition

Shaping a healthier future

Imperial College Healthcare NHS
NHS Trust

1. Risks to quality and safety, risk identification and mitigation

Trust Risk Management Process

A governance framework has been put in place to ensure appropriate reporting, escalation and resolution of risks and issues, both internally and externally to the SaHF programme, including:

- Development of clear detailed project plan under the supervision of clinical and management team.
- A clear project governance structure with steering group chaired by Maternity Chief of Service with work streams for Workforce, Operations/Quality and Estates
- The creation of risk registers, a staff engagement process, and reporting mechanism to ExCo and Trust Board
- Weekly project report with identified progress, accomplishments, activities, risks and issues (with mitigation actions / owner and RAG rating)
- Regular reporting to SaHF Delivery Board.

Key Trust Risks for Transition of Maternity and Interrelated Services from Ealing Hospital

Risks (Red and Amber only)	Mitigation Actions	RAG
IT infrastructure for community clinics will not be available in time for Transition to occur. Midwives will have to use hand written notes increasing workload, requirement to return to base to document and chance of increase errors	Work with Ealing/NWL/SaHF to develop IT plans. Options appraisal being developed, plan to be agreed by 24/4. Funding agreed at Ex Co 8/4. Scoping week of 20/4.	12
ICHT currently has challenges with People Metrics and staff satisfaction. Risk is that these will be further challenged when Staff from Ealing Hospital are TUPE`d over.	Plans to mitigate risk have been developed in workforce work stream. OD role to be recruited to facilitate plans.	12
Financial risk due to ICHT not receiving the projected activity and associated income from planned Transition of activity, further risk if Trust was to lose part of the originally agreed boundaries	Negotiation with Commissioners regards first 2 years income and agreed boundaries	12
Absence of an ICHT SaHF Steering Group as part of the agreed governance reporting structure	Engagement with Senior Management to reinstate, engagement with external stakeholders	10
Delay in final decision SaHF regards transition till 20th May 2015	Recruitment has progressed at risk, plan to be operationally ready for transition at 28th May. Financial risks of delaying discussed with SaFH	9

- ICHT consider that all significant risks have been identified and have robust mitigation plans in place

CQC CIH Compliance /Quality Improvement Plans, Interdependencies & Mutual Aid

ICHT had its CQC full inspection in September 2014
Maternity and paediatrics obtained a rating of "Good" overall

Our ratings for St Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity & gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Queen Charlotte and Chelsea Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity & gynaecology	Good	Good	Good	Good	Good	Good
Neonatal services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Good

Actions to further improve was to increase staffing levels to a 1:30 ratio which is funded from April 2015 with staff in post by July 2015

Shaping a healthier future

Imperial College Healthcare NHS
NHS Trust

3. Receiver Unit Preparedness

Trust Workforce Planning

- Progress of midwifery recruitment to full establishment including BR+(1:30 ratio), Transition and vacancies at 20th April 2015.
  - Total of 28 WTE posts remain to recruit
  - 16 WTE posts potentially to be to be filled by students finishing in Sept 2015 if not recruited to full establishment earlier
  - Further interviews week commencing 20th April
  - Recruitment on going with rolling advertising and recruitment day planned in early May
- Full communication schedule arranged for existing and transitioning staff
- Induction program for transitioning staff has commenced.
- Recruitment for essential support and clinical staff has commenced at risk.
- Medical recruitment will result in increase in consultant presence on labour ward to 140 hours/week from current 98 hours.
- Staff not required to facilitate transition approved but on hold until Transition is confirmed.
- OD HR manager to be appointed to for 12 months to help manage organisational developmental needs.

Trust Physical Capacity and Equipment Planning

- Estates work continues on schedule at St Mary's and Queen Charlotte's, work essential to transition scheduled to be finished end of May 2015.
- Equipment requirements finalised; equipment being procured ready for commissioning of estates work.
- Pathology and waste collection arrangements for community clinics being finalised
- Funding for community IT agreed; developing implementation plans. Phased implementation across ICHT community midwifery service, with contingency in place for community services until fully implemented.
- ICHT requirements to deliver ante and post natal services in the community confirmed by Ealing community sites.
- Boundaries confirmed in Brent area, work progressing in this area.

Maternity Booking Service and Trust Communications Plans

- Capacity plans to increase activity for new bookings completed and in place
- Plans for full capacity transition on schedule for mid May 2015
- Developing booking templates for new community and hospital booking
- MBS contacting women currently booked for pregnancy at Ealing women to confirm their 2nd /3rd preference of hospitals to transfer their care to
- Implement the agreed SaHF booking priority criteria for the new Imperial community area.
- Booking office administration staff base increase
- Maternity helpline staff base increased to take calls from GPs and patients
- GP study day planned on 7th May 2015 to update them of services
- Internal Trust Communications plans have been developed and are being implemented through website, emails and direct face to face communication with staff

Trust Clinical Governance Arrangements

- Review of all polices, procedures and guidelines against new model of care.
- Clinical group currently reviewing key policies such as BBA, ambulance calls, safe guarding, DNA and escalation policies.
- Revising community and hospital pathways to reflect changes in activity and new models.
- Reviewing and updating patient information to reflect changes to services..
- Setting up clinically led internal process to receive transfer of high, medium, low risk and vulnerable women with appropriate handover
- Patient safety, risk management, quality improvement and patient information leads incorporated into new consultant posts
- New Risk Midwife posts part of business plan.

Shaping a healthier future

Imperial College Healthcare NHS
NHS Trust

4. Quality and Performance KPI Monitoring

Quality and Performance KPI Monitoring

- Finalising KPI suite for monitoring transition impact with SaHF team. Baseline data available. Monthly data monitoring will be implemented following transition.
- Baseline complaints and SI data available and will be monitored following transition
- HR OD lead to be appointed for 12 months to work to maintain and improve staff/ people metrics
- Regular staff briefing sessions occurring and regular staff surveys already taking place to monitor staff experience now and following transition
- Clinical metrics will continue to be internally monitored using the clinical dashboards and compared to the baseline, and will also be reported centrally to SaHF team and commissioners.
- Patient experience FFT data collected from all areas and reported internally and externally

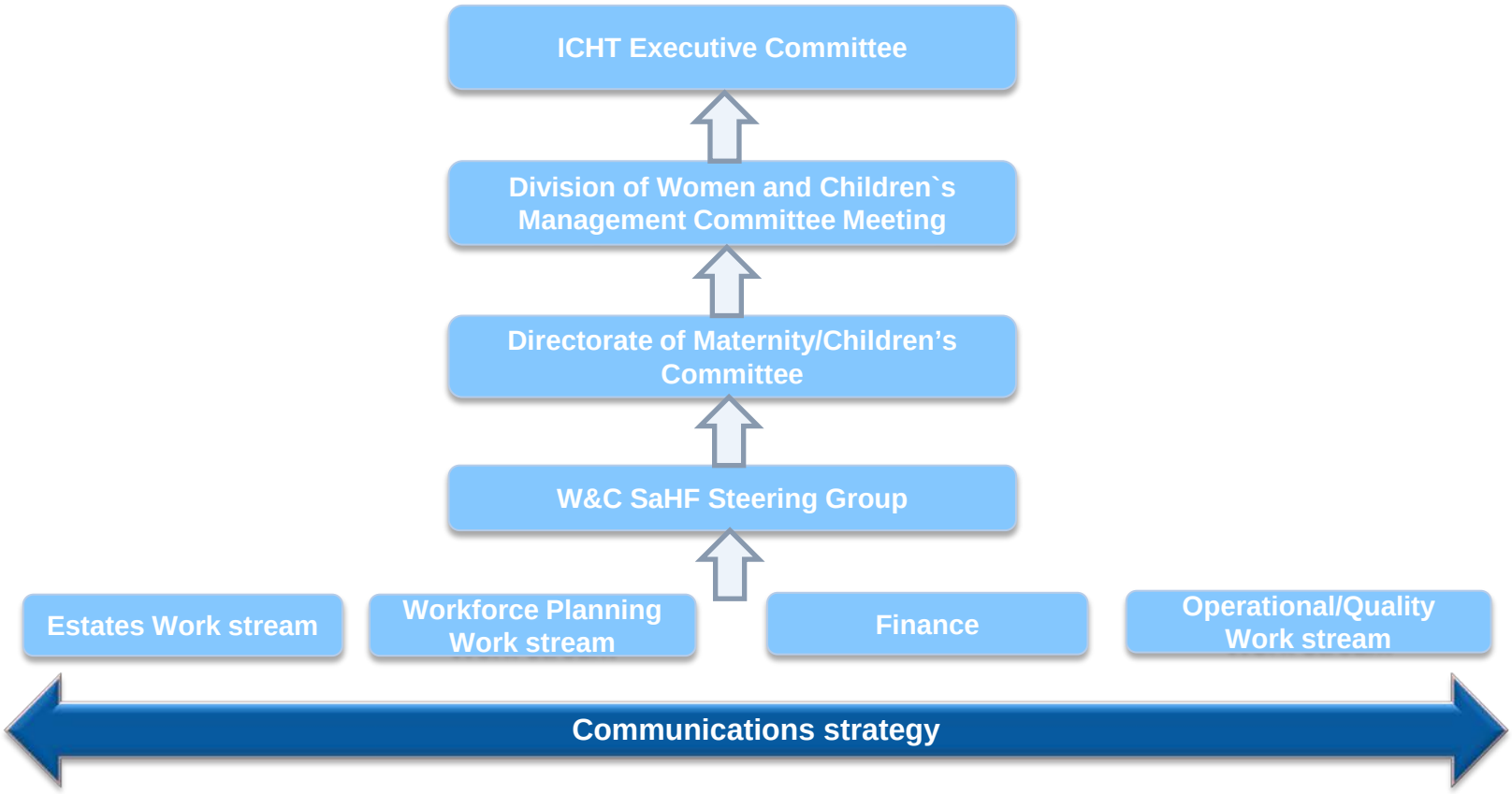
Shaping a healthier future

Imperial College Healthcare NHS
NHS Trust

6. Trust Executive Oversight

Executive and Board level Oversight

Summary of the arrangements for ensuring that the Trust executive and board have sight of quality assurance for the service transition.



Shaping a healthier future

Imperial College Healthcare NHS
NHS Trust

6. Other Emergent Issues of Risk to Quality

Other Emergent Issues of Risk to Quality

- ICHT consider that all issues have been addressed in the presentation

Chief executive: Dr Tracey Batten
The Office of the Chief Executive
The Bays Building
South Wharf Road
London
W2 1NY

0203 312 5897
tracey.batten@imperial.nhs.uk
www.imperial.nhs.uk

11th May 2015

Dr Mohini Parmar
Chair,
Ealing CCG

Dear Dr Parmar

Confirmation of operational readiness from Imperial College Healthcare NHS Trust (ICHT) board ahead of the forthcoming meeting of Ealing CGG Governing Body

I am writing to inform the Ealing CCG Governing Body that ICHT is operationally ready and fully supports the proposed transition of maternity services from Ealing Hospital on behalf of the Trust Board.

At its meeting on March 18th 2015, I note that Ealing CCG Governing Body confirmed that further work needed to be undertaken on operational readiness before a decision on timing of the closure of Ealing maternity unit is made. Following this meeting, we have continued to work with clinical and operational colleagues across North West London to ensure we are ready to proceed once your Governing Body's decision is made.

We have set out below the work undertaken since your last meeting to support your decision making process and confirm our operational readiness for transition.

Actions required to support operational readiness ahead of the next Ealing CCG GB meeting:

Domain	Progress made since last meeting
1 – Maternity workforce	All maternity workforce recruitment plans are in place and active steps are being taken to recruit to these positions. ICHT is committed to ensuring that the required workforce will be in place at the point of transition. Orientation and induction of maternity staff transferring from Ealing Hospital has begun on a contingency basis should your Governing Body take a decision to set a transition date.
2 – Estates	The ICHT maternity estates work is on track to provide the required maternity physical capacity. However,confirmation is yet to be received from the CCG's for the additional funding required to refurbish the maternity theatres at St Mary's Hospital. Urgent confirmation of this funding is required to undertake these works.
3 – New maternity model of care	ICHT is working to implement the new NWL maternity model of care, and appropriate actions are being taken for the use of new community facilities and clinical and operational pathways
4 – Internal staff communications	Appropriate internal communications plans are in place and on track to ensure that ICHT staff at all levels are fully aware of the trust plans for receiving maternity activity from Ealing Hospital.
5 – Trust Project Support	Project support requirements to deliver all operational plans have been confirmed and are in place.

Based on the progress we have made, the Trust Board members considered that the Ealing Maternity report provided assurance of operational readiness and that this would be ratified at the public board meeting on 27th May 2015. I can therefore confirm that this organisation is ready for the transition of maternity activity from Ealing Hospital.

We will continue to work with the *Shaping a Healthier Future* programme and the Maternity Project Delivery Board to ensure that all preparatory steps are in place for transition should your Governing Body elect to set a date for the proposed transition.

Should Ealing CCG Governing Body not be in a position to take a decision to set a date for this transition, I would request a meeting with you and other leaders from the North West London health economy so that we can define a rapid solution in light of the previous delays to this decision making process.

For maternity estates, completion of the theatre works is not contingent on receiving activity at this date and the Trust has contingency plans to bridge the short period over the summer.

In relation to the proposed transfer of Ealing paediatric emergency and inpatient activity in the summer of 2016, ICHT has been working hard to review options to provide this additional capacity. This has proven particularly difficult, especially given the increased demand on A&E and inpatient beds at St. Mary's Hospital since September 2014. ICHT does not believe it can absorb the additional paediatric A&E work and continue to improve A&E performance without creating additional paediatric inpatient and emergency capacity. Given the constraints of our site, solutions to build additional capacity are proving costly and inefficient to run on a recurrent basis (at a minimum this will require rebasing paediatric emergency work at the Trust). However there are options that are feasible to achieve by the proposed timeframe for paediatric transition of 30 June 2016.

We therefore would suggest that the best way to agree an option would be to co-produce this with the CCGs. Our lead for this piece of work is Ian Garlington. I would be grateful if you could advise me of your lead so that we can finalise the option selection by the end of June 2015 to ensure we can be operationally ready by 30 June 2016.

Yours sincerely

Dr Tracey Batten
Chief Executive
Imperial College Healthcare NHS Trust

CC: Alan Goldsman
Nicola Grinstead
Tg Teoh
Ian Garlington
Tim Orchard

North West London Collaboration of Clinical Commissioning Groups

15 Marylebone Road
London NW1 5JD

By Email

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

21st May 2015

Dear Tracey,

Update following the decision of Ealing CCG Governing Body on the transition of maternity and interdependent services from Ealing Hospital

I am writing to provide you with an update following yesterday's meeting of the Ealing CCG Governing Body. As you will be aware, the CCG Governing Body met on 20 May 2015, with the main item of business being a discussion on the proposed transition of maternity and interdependent services from Ealing Hospital.

Following careful deliberation of the materials provided and after discussions with a number of clinical experts from across North West London, the CCG Governing Body took the decision that a date should now be set for this service transition. The key dates for service changes are summarised in the table below.

Service Change	Transition Date
Defined range of maternity services	To be completed on 1 July 2015
Defined range of gynaecology services	To be completed by 1 July 2015
Defined range of paediatric services	To be completed on 30 June 2016

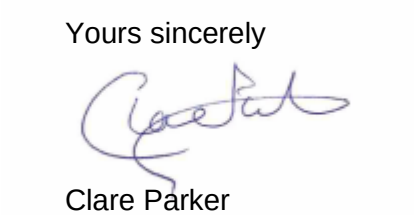
Further requirement of Imperial College Healthcare NHS Trust following the decision by Ealing CCG Governing Body

I would be grateful if, following the receipt of this letter, you could ensure that your Trust Board is fully briefed when it next meets. One of the important documents which the Governing Body considered was your letter regarding the operational readiness of your organisation and I would be grateful if you could ensure your Board has had the opportunity to review this content. Subsequently, there may be a request from NHS England and / or the Trust Development Authority to review a copy of the minutes which document this Board level discussion and I would be grateful if you could assist with this request should it arise.

Finally, I would like to take this opportunity to thank you for the commitment of your organisation and its leaders, both clinical and managerial, for all of the time and assistance which has been provided in planning for this change.

Kind regards

Yours sincerely



Clare Parker
SRO Shaping a Healthier Future
Chief Officer CWHHE Clinical Commissioning Groups

CC: Dr Mohini Parmar, Chair, Ealing CCG

Imperial College Healthcare NHS Trust

Trust board - public

27 May 2015

Agenda Item	6.2
Title	Caldicott Annual Report (2014 – 15)
Report for	Noting
Report Author	Dr Sanjay Gautama, Caldicott Guardian Philip Robinson, Information Governance Manager
Responsible Executive Director	Kevin Jarrold, Chief Information Officer

Executive Summary:

The Caldicott Annual Report (2014- 15) is an essential evidence requirement of the Department of Heath Information Governance Toolkit. It is being presented to ExCo to provide assurance the Trust is operating a robust Information Governance structure and is meeting its obligations as a responsible data controller as required by the Data Protection Act (1998) and related legislation.

Recommendation to the committee:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS
NHS Trust

CALDICOTT ANNUAL REPORT (2014 - 2015)

Overall Aim or Purpose

To ensure that the Trust can provide assurance that it is in compliance with Information Governance legislative requirements and NHS Information Governance standards. The annual report is an essential evidence requirement of the Department of Heath Information Governance Toolkit. It provides assurance to the ExCo that the Trust is operating a robust Information Governance structure and is meeting its obligations as a responsible data controller as required by the Data Protection Act (1998) and related legislation. The report is used by the Care Quality Commission (CQC) to evidence good practice. It can also be used as a reference document for independent reviews of Information Governance related incidents and is frequently used in external reviews of incidents and also used for tenders / pre qualification questionnaires. The report is structured to provide evidence of how the objectives from the Terms of Reference of the Caldicott Committee have been evidenced throughout the course of the year.

Caldicott Guardian Foreword

The Caldicott and Information Governance Team have maintained the satisfactory status of the Information Governance Toolkit Return for the past three years. This Level 2 IGTT status allows other organisations to have confidence that the Trust manages its patient and staff information in compliance with the standards set by the Information Commissioner's Office. The Trust is continuing to experience a number of Information Governance Incidents - some of the increase in the number of incidents recorded is due in part to improved reporting mechanisms within the Trust. The risk of further incidents needs to be mitigated through continuing staff education with the annual mandatory information governance training and enforcement of procedures mandated through policies. The Caldicott and Information Governance Team have continued to utilise the Landesk Call Management system to ensure accountability and transparency of the service resulting in over 1200 calls being closed in this financial year.

Key Concerns:

1. Case note tracking and loose filing

This continues to be an issue for the Trust, especially with respect to complex patient problems and cross site working. The realistic mitigation is the deployment of the electronic patient record across the Trust.

2. Agency staff access to Trust systems

As clinicians become increasingly dependant on electronic systems to access patient records and deliver care, secure and managed access for short term, short notice locums / agency staff will be significantly problematic. Global solutions revert to using bank staff with defined access rights.

Seven themes for 2015/16

1. AHSN Research Agenda

The IG and Caldicott Team have closely supported the Research Agenda leading to the signing of the NHIR-HIC information sharing agreement with (Oxford / Cambridge / UCLH and King's Health Partners). This is in addition to providing support for the five themes mandated in the agreement to ensure they met Caldicott and Information Governance Standards. The IG and Caldicott Team have also developed and

signed off an Information Sharing Agreement between Imperial College London and Imperial College Healthcare NHS Trust to ensure that there is an appropriate management arrangement to support the AHSN Research Agenda. The team will be working to reduce the SLA applicable for Information Governance Review from 30 working days to 15 working days.

2. Development of Interactive Online Information Governance App for Researchers

A business case has been developed for the implementation of an Online Interactive Information Governance App for Researchers. This will be provided from a HTML Internet site using a web form utility that supports LDAP allowing AD Accounts authentication supporting direct linkage to the Landesk call management system. The new app will make provision of Information Governance management information directly to researchers based at Imperial College London and other academic partners.

3. Care Information Exchange (CIE) / Whole Systems Integrated Care (WSIC)

The Caldicott Guardian will be co-chair of the North West London WSIC Governing Group and will support the convergence of information sharing agreements, consent arrangements and on-going management of the WSIC linked with the CIE powered by the Patient Knows Best utility. The implementation of patient knows best will be supported by an independent audit conducted by TiAA as part of the informatics audit programme. Imperial is a key component of the North West London Design Authority for IT, and is working towards a sector wide health and social care information sharing agreement supported by HSCIC and NHSE.

4. Update of IG Training – question stratification, malicious code / ransomware

There will be an update of the Trust's annual mandatory information governance provision. This will include updates to ensure optimal learning from recent incidents including maintenance of physical security, prevention of propagation of malicious code such as ransom-ware, secure disposal of confidential information and ensuring prevention of misuse of authorised access.

5. Community Services (Paediatric / Opthalmology /Urology / Dermatology /

Together with the Community Independence Service the Trust is moving to community provision in a number of clinical services. This will require detailed support from the Information Governance team to support the joint working arrangements from the provision of services in the community. An internal audit of remote access that will be used to support remote working is planned this year.

6. Mobile Apps

The IG and Caldicott Team working with HELIX Centre have defined a new process for the review of proposed mobile applications. The team will be supporting the review of the information governance related to mobile apps together with providing admin and organisational support to the new mobile apps committee.

7. Electronic patient record and Day One Readiness

The mitigation for issues related to case note tracking and loose filing will be dealt with by transitioning to the Cerner clinical documentation and electronic prescribing and administration modules. Clinical leadership and governance will be key in delivering a successful deployment. Access to patient records will be controlled by a security matrix linked to the user's smartcard managed by the Registration Authority and supported by the IG team. User's will need to be able to access all appropriate

Trust systems from their first day of employment. This will require input from HR, IT and IG teams to implement a robust Day One Readiness process.

Imperial College Healthcare NHS
NHS Trust

Review of Progress Against Objectives

<table>
<tr><th>Objective</th><th>How Addressed</th></tr>
<tr><td>Review of the mandatory Information Governance Toolkit (signed off by the Caldicott Guardian) / other mandatory returns relating to Information Security and Confidentiality. Review of associated Information Governance action plans together with any relevant independent audits relating to submission</td><td>
Information Governance Toolkit Return 2014
The toolkit is an online self assessment that is conducted by all NHS Trusts and other NHS bodies. It is submitted thrice yearly on 31st July, 31st October and the final submission was made on 31st March 2014. The assessment consists of 45 self assessment requirements. These requirements are divided into six initiatives;
<table>
<tr><th>Initiative</th></tr>
<tr><td>Information Governance Management (IGM)</td></tr>
<tr><td>Confidentiality and Data Protection Assurance (CDP)</td></tr>
<tr><td>Information Security Assurance (IS)</td></tr>
<tr><td>Clinical Information Assurance (CR)</td></tr>
<tr><td>Secondary Use Assurance (SU)</td></tr>
<tr><td>Corporate Information Assurance (CO)</td></tr>
</table>
Information Governance Toolkit Assessment
Each initiative is subject to review against a highly detailed written specification. The specification states what policies, procedures and review processes must be in place to provide evidence and assurance that the Trust is working in accordance with the requirement. Each requirement is assessed according a scale noted as 0,1,2,3 (where 0 equates to no activity and 3 equates to all evidential and assurance requirements are met.)

Satisfactory – is defined as a Trust which has returned level 2 or level 3 for <u>all</u> 45 requirements
Unsatisfactory – is defined as a Trust which has returned a Level 0 or Leve1 1 for <u>any</u> of the 45 requirements.

Independent Assurance
The final assessment must be subject to independent audit and the results of this assessment are published online and available to all. The Trust had a robust Computer Audit review conducted in October and in February. The final audit report gave ‘the Trust “Substantial Assurance” of the self assessment.
</td></tr>
</table>

Summary Table of Current IG Assessment

Initiative	Score	Total Possible	%	Grade
Information Governance Management	10	15	67%	Satisfactory
Confidentiality and Data Protection Assurance	16	24	67%	Satisfactory
Information Security Assurance	30	45	67%	Satisfactory
Clinical Information Assurance	10	15	67%	Satisfactory
Secondary Use Assurance	16	24	67%	Satisfactory
Corporate Information Assurance	6	9	67%	Satisfactory
Overall	88	132	67%	Satisfactory

The Trust has submitted an overall return of 67% (satisfactory). The satisfactory rating was achieved by ensuring the Trust was able to return a minimum level 2 assessment against all standards. The Information Governance Toolkit return was subject to a two stage independent audit conducted in October and in February. The final audit report gave the Trust "Substantial Assurance" of the self assessment. The Trust has maintained a satisfactory Information Governance toolkit return for the last three years.

Forward Plan for IG Toolkit Compliance

A new version of the Information Governance Toolkit v13 will be released by the Department of Health in June 2015. The IG Team will review the new version to ensure that any new or significantly ammended standards are understood, to allow planning of any innovations to meet the new standards. A detailed Information Governance toolkit return reviewed by our independent auditors will be undertaken in October 2015. An Information Governance Action Plan will be formulated that will ensure the Trust retains its "satisfactory" status. The interim IG audit return and IG Action Plan will be scrutinised by the Caldicott Committee.

Objective	How Addressed
Oversight of IG SIRI Incidents reviewing aggregate information about Level 0 and Level 1 incidents together with more detailed information about Level 2 incidents	Information Security Incidents are reported via the Trust's incident reporting system "DATIX". Information Governance incidents are also separately recorded in the Department of Health provided Serious Incidents Requiring Investigation (IG SIRI) database. They are classified into three incident categories: • Level 0 – Near miss • Level 1 – Locally reportable • Level 2 – Serious Incident requiring a report to the DH and Information Commissioners Office There were no Level 2 Information Governance Serious Incidents (SI) recorded in the financial year 2014 – 2015 Incidents are reported to the Caldicott Guardian at the weekly Caldicott Review meeting. They are also reported via the Caldicott Guardian Annual Report and the Caldicott Guardian Half Year Report to the Caldicott Committee. Incidents relating to ICT Security are discussed at the ICT Security Audit and Risk Committee (ICT-SARC) where they can be used to inform the ICT Risk Register and / or the Informatics Audit Programme managed by TIAA, the Trust's internal auditors. A summary of the 79 incidents that occurred during the 14/15 are set out below. **Cumulative Number of Reported IG SIRIS 01/04/14 – 31/03/15** / **Number** Level 0 IG SIRIS (Near Misses) – 24 Level 1 IG SIRIS (Internally Reported) – 55 Level 2 Serious Incidents (Reported to the DH and ICO) – 0 **Total** – **79** A table of the Level 1 internally reported IG SIRIs is provided in Appendix 1. **Double Reporting** All IG incidents get reported in two places. This is because the Trust is mandated to undertake *"Double Reporting"* of the same event via two separate and unrelated streams. The first being DATIX and the second being the online Dept of Health IG SIRI reporting system.

Sponsorship and review of Information Governance training initiatives and review training metrics to support staff compliance with Confidentiality and Information Security Standards.

Information Governance Mandatory Training

Target

The Trust achieved the Department of Health Target for Information Governance Training that is mandated via the Information Governance Standard 112. The training target is defined as;

- 95% of Trust staff must complete mandatory Information Governance training annually

The Trust worked with Imperial College London, and other academic institutions working in partnership with the Trust to ensure that all placement students had completed annual mandatory Information Governance Training prior to attending the Trust. Additional work was carried out with SODEXO and DHL to try and ensure completion of annual mandatory IG Training for all of their staff within the final year.

IG Training Action Plan

Achievement of this target is exceedingly difficult and requires persistent and robust management. The Trust engaged an additional temporary IG Training Officer to support robust communications both directly with Directors and Senior Managers and at staff level using the Trust intranet, email, screensaver, and briefing documents. Progress of the Trust was monitored and published on the IG Intranet site. The issue was raised with ExCo and achievement of the target was supported by the Chief Executive.

Summary of Mandatory IG Training Achievement

Total Number of staff that completed IG Training between 01/04/14 – 31/03/15 was 9307 (97%)

Summary Table of Mandatory IG Training Achievement

Division / Corporate Directorate	Staff Headcount	Staff IG Training completed	%
Medicine	2492	2361	95
Surg, Cancer & Cardiovascular	2541	2428	96
Investigative Sciences & C S	2036	2014	99
Women And Children	1198	1151	96
Estates Directorate	172	172	100
Private Patients Directorate	202	202	100
Human Resources	126	126	100
Finance Directorate	120	120	100
Other Corporate	404	395	98
Information & Comms Technology	319	319	100
Press & Communications	18	18	100
Trust Overall Compliance	9629	9307	97

	Forward Plan for IG Training A planned key development for IG Training is to support the Day 1 Readiness Challenge. This is a new approach to ensure that clinical staff are able to commence clinical duties on Day 1 having completed their IG Training obligation. To support this there is a plan to re-provide the IG Training modules on an external website accessible from anywhere and also available for access and use via mobile phone and tablet computers as well as from a conventional desktop environment. In addition, the question bank will be subject to an annual refresh and stratified questions.
Review of Implementations of Clinical Information Systems to ensure it is in accordance with Information Governance / Clinical Records Policies, procedures and standards. Including determination of the clinical, operational and corporate appropriateness of, and need for, applications already developed, or in the process of being developed for use within ICHT	**Whole Systems Integrated Care (WSIC)** The IG / Caldicott Team led the Trust in a series of detailed negotiations over the course of eight months regarding the WSIC information sharing agreement. At issue was the designation of the Information Sharing Agreement as a "legally binding contract" between data controllers in common. The Trust was able to negotiate a concession that the legally binding contract would apply between the data controllers in common and the data processor but not between the data controllers in common. This distinction was crucial to reducing the risk profile of the agreement for the Trust. **Care Information Exchange** The Caldicott and Information Governance Team produced an accession agreement for other health providers to join the Care Information Exchange (powered by Patient Knows Best). This accession document referenced an Information Sharing Agreement, Fair Processing and Consent information to support the Consent Engine, Data Flow Map, Template Privacy Impact Assessment **ICL / ICHT Information Sharing Agreement** An information sharing agreement between the Trust and its main academic partner Imperial College London was developed. The purpose of this agreement is to support joint working with Imperial College London whist protecting the information rights of our patients. The agreement sets out a process flow for the management of anonymised information requests from the college. It also requires that any personal identifiable information cannot be transferred to the College unless there is a justifiable legal basis for doing so for example with the informed, explicit and recorded consent of the data subjects. **NHIR- HIC** The Trust is participating in a collaborative research project involving five Academic Health Sciences Networks; Imperial, UCLH, Oxford, Cambridge, and Kings Health Partners. This required the signing of a five party complex Information Sharing Agreement. In addtion, the IG/ Caldicott Team reviewed data flow maps, information processing agreements relating to the proposed test data and the live data.

Review of clinical records risks and issues to ensure remedial action by the appropriate responsible management team.	The Caldicott Committee reviewed the following • Communications about the Subject Access Request Procedure • Management of medical report requests • Advice for staff on the management of police requests • Procedures for management and notification of unwarranted EPR Systems • Advice to consultants on retention preservation and destruction of health records • Advice about the management and notification of Junior Doctor Clinical Audit Exercises • Zero tolerance for abuse of health records staff by frustrated colleagues
Review of the role of the Caldicott Guardian, Caldicott Committee, Senior Information Risk Owner and to put forward suggestions for enhancements as appropriate	The Caldicott Committee reviewed the following structural elements: • Information Governance Management Structure • Information Governance Policy Structure • Caldicott Committee Terms of Reference The Caldicott Forward Plan was created by the Information Governance Team to ensure that all the required structural discussions were scheduled appropriately allowing for detailed scrutiny by the Caldicott Committee.
Review of Registration Authority (RA) compliance, communications to end users and any issues arising.	An Audit to assess whether the use and administration of access to systems under Registration Authority (RA) is carried out in accordance with policy, national guidance and best practice, so as to ensure the security of sensitive information and the accountability for transactions was carried out as part of the 2014/2015 Audit schedule with resulting actions to be completed by 30/09/2015. Information for users regarding changes to Registration Authority requirements and procedures have been posted on the Cerner @ Imperial website.
Review of Freedom of Information (FOI) compliance and any issues arising including audits and satisfaction surveys.	In the 2013/14 financial year the Trust saw a 53% rise in the number of FOI requests. In 2014/15 there was another significant rise in request numbers from 695 to 774 (an extra 79 requests). The average number of requests has risen from 58 a month to 64.5. Despite the extra strain this has placed on Trust resources we have maintained the same 97% completion rate as the previous financial year (for completion within the statutory 20 day limits).

<table>
<tr>
<td>Review of procedures to support confidentiality and security of Trust data and clinical records in relation to the requirements to carry out clinical research, national reporting initiatives, clinical audit, patient satisfaction surveys and any other operation that requires secondary use of personal identifiable information</td>
<td>The Information Governance Team utilised the Landesk Call Management system to manage a wide number of service requests.

Table of Calls Managed 01/04/2014 – 31/03/2015
<table>
<tr><th>Status of Calls</th><th>Number</th></tr>
<tr><td>Opened</td><td>1278</td></tr>
<tr><td>Closed</td><td>1257</td></tr>
<tr><td>Remaining Open</td><td>239</td></tr>
</table>

The average time to resolve each call was 20 days.</td>
</tr>
<tr>
<td>Review of metrics of patient subject access requests, statutory disclosures, public interest disclosures and issues arising from Information Governance related complaints including issues raised by the Office of the Information Commissioner.</td>
<td>The Health Records manager and team have taken forward adopting a one stop email address that contacts all records managers to begin the access process quickly and efficiently. Every member of the Health Records team across all sites will be trained in Access under the Data Protection Act and will be signed off when competent. The Health Records Management team continuously review processes to ensure best practice and process.

Number of Completed Subject Access Requests excluding X Rays
5376 subject access request from April 2014 – March 2015

The Trust was 100% compliant with the 40 working day deadline for validating and processing subject access requests.</td>
</tr>
</table>

To implement an application "warranty" process that supports appropriate scrutiny of apps with detailed reviews being recorded via the IG Call Management System and recommendations to adopt or rescind adoption being sent to the Change Advisory Board as appropriate.	The Caldicott Committee has reviewed the Mobile Apps Process flow chart and Information Governance Mobile Apps Form. There is a Mobile Apps Group Committee supported by the Information Governance team that is working in collaboration with the Helix Centre. The purpose of the Mobile Apps Committee is to review and advise upon new and proposed Apps. A new Apps intranet site has been developed in conjunction with the Communications Team.
To consider and approve any changes, updates or improvements to existing Imperial College Healthcare Trust adopted applications and to ensuring applications retain fidelity with trust image and policy recommendations.	The governance process for apps is overseen by this committee but the review of individual apps is delegated to the Mobile Apps Committee. Changes to other applications are managed through the change management procedure.

Responsibility for the review of Information Governance policies and any procedures, standards and processes mandated by the above policies. To ensure these policies are in accordance with national requirements and legislation.	The following policies were reviewed and ratified by the Caldicott Committee Avoid abbreviations and replace with the full names

Policy	Date
Terms of Reference of the Caldicott Committee	11/07/14
Information Governance Action Plan	11/07/14
Conditions of Use Statement	11/07/14
Policies tackling abuse against Health Records staff discussed	11/07/14
Policy review: *Imperial NHS Number Policy 2014 v2.*	26/09/14
Policy review: *Imperial College NHS Trust Operational Data Quality Policy 2014-15 v1.*	26/09/14
Policy review: *Health Records Tracking Policy Cerner v2.0.*	26/09/14
Policy review: *Procedure for the merging of case notes where duplicate registrations have been created v2.0*	26/09/14
Communications about the Data Protection Act Subject Access Request procedure	30/01/15
Terms of Reference - Data Standards Committee	30/01/15
Caldicott Function Plan	30/01/15
Staff Guidance on Confidentiality	30/01/15
Information Governance Policy and Strategy	30/01/15
Pseudonymisation Policy	30/01/15
Information Governance Structure	30/01/15
Information Governance Training Action Plan	30/01/15
Information Governance Communications Plan	30/01/15
Review updated Freedom of Information Policy	27/02/15
Health Records Audit Plan	27/02/15
Health Records Audit Report	27/02/15
Exemplar Fair Processing Notice	27/02/15
Information Governance Training Programme	27/02/15
Information Governance Training Needs Analysis	27/02/15
Health Records Policy	27/02/15
Health Records Subject Access Procedure	27/02/15
Health Records Tracking Policy	27/02/15

Conclusion

The report evidences the objectives set out in the Caldicott Committee Terms of Reference have been achieved. In addition, it should be noted there has been a huge effort across the organisation to ensure we achieved compliance with the annual mandatory information governance training target. The recent implementation of WIRED 2 allows better visibility of IG Training compliance for Trust staff. Unlike other statutory and mandatory training requiring updates every three years IG Training requires an annual update. Where possible, it would be useful for annual mandatory IG Training to be completed in the early part of the year instead of being left until the last quarter.

The Trust has met all of the key Information Governance standards and will be able to maintain connection to the NHS Connecting for Health infrastructure. This has been assured by an independent audit. The Caldicott Committee is continuing to scrutinise and support the Information Governance forward plan.

Imperial College Healthcare NHS
NHS Trust

Appendix 1: Detailed List of Information Governance Incidents

Date	IG SIRI Level	Breach Type	Summary of Incident
05/03/2015	1	Lost or stolen paperwork	Confidential papers in respect of a disciplinary meeting were left by accident by a member of the ERAS team in Tescos, Praed Street on their way home from the hearing on the 5th March 2015.
22/12/2014	1	Disclosed in Error	Two Screening client packets were found on the 1st floor corridor near the Riverside Wing on 22.12.2014, by a patient's relative.
04/12/2014	1	Unauthorised Access/Disclosure	A patient and his relatives complained that he waited in the Imaging Department for 30 minutes for a CT scan and during that time the patient notes were left on the bed.
18/11/2014	1	Disclosed in Error	A report outlining patient's functional ability and requirements for support was incorrectly faxed to Westminster social services whereas it should have been sent to Hammersmith and Fulham.
10/11/2014	1	Disclosed in Error	Patient attended A&E for advice/treatment. Discharge treatment/information belonging to another patient given on discharge.
29/10/2014	1	Disclosed in Error	Confidentiality breach. Two clients attended the Results clinic on 29/10/2015, when the client copy of the Results Clinic letter were sent out, each copy was placed in an envelope which was labelled with the other client's address.
15/10/2014	1	Lost or stolen paperwork	Patient Ward Handover found by a financial controller on the pavement at the back of Tesco's off South Wharf Road.
22/08/2014	1	Disclosed in Error	Patient Affairs Officer received a telephone call from a GP surgery, they had received a "notification of death" letter in May 2014 for a patient that was still alive. Surgery were advised to contact the Patient Affairs Manager with full details of circumstances. Patient Affairs manager advised of phone call. Patient Affairs manager received a telephone call from GP practice on 26/08/2014 - PA manager asked GP practice manager to forward an email and a scanned copy of the letter for investigation - GP surgery advised that incident would be investigated and response would follow.
22/08/2014	1	Unauthorised Access/Disclosure	A set of patient notes went missing for 50 minutes and were handed back in by an unknown lady.
20/08/2014	1	Disclosed in Error	Patient received another patient's GP letter
21/08/2014	1	Disclosed in Error	Two patient letters were placed in the wrong envelopes and therefore delivered to the wrong patients.
12/08/2014	1	Unauthorised Access/Disclosure	Bogus Nurse breached physical security to gain access to the Emergency Department (ED) of St Mary's Hospital Paddington.
11/08/2014	1	Disclosed in Error	Breach of confidentiality - Incorrect appointment letter sent to one of the patients containing

			details of another patient.

Date	IG SIRI Level	Breach Type	Summary of Incident
07/08/2014	1	Disclosed in Error	An Email was accidentally attached which contained a patients letter and some internal investigation into a complaint.
06/08/2014	1	Disclosed in Error	Patient was given details of a condition relating to an imaging investigation under the same name. It was later noticed that the imaging did not correspond to the patient in question.
01/08/2014	1	Other	Discharged patient stayed in a cubicle in A&E and was filming using google glasses. Patient stated he would put the video on youtube and left.
31/07/2014	1	Corruption or inability to recover electronic data	Record of procedure lost – Cerner difficulties mapping but resolved by IT
30/07/2014	1	Disclosed in Error	Clinic letter and outpatients appointment delivered to the incorrect address.
24/07/2014	1	Disclosed in Error	Email containing patient identifiable information sent to nhs.net email account.
23/07/2014	1	Disclosed in Error	Patient's x-ray/scan reports transmitted electronically to incorrect GP practice.
23/07/2014	1	Lost In Transit	External mail envelope received with patient notes. No message inside to explain. Notes were posted from St Mary's hospital site to secretarial team at Hammersmith Hospital.
22/07/2014	1	Other	Health records destroyed by consultant and thrown in normal waste bin instead of using confidential waste. Waste was picked up and placed in the correct bin by another member of staff.
18/07/2014	1	Disclosed in Error	Breach of confidentiality – The patient also received another patient's appointment letter in the same envelope as her own.
16/07/2014	1	Corruption or inability to recover electronic data	Planned treatment discussion between patient and doctor overheard.
04/07/2014	1	Corruption or inability to recover electronic data	Wrong patient's details included in discharge letter.
03/07/2014	1	Disclosed in Error	Incorrect information sent to patient.
02/07/2014	1	Disclosed in Error	Attachment listing a number of patients details sent to wrong email.
01/07/2014	1	Disclosed in Error	Handover sheet containing patient information accidentally given to patient with his discharge letters.
30/06/2014	1	Disclosed in Error	DNA letter sent to temp address on Cerner in error.
20/06/2014	1	Other	Two siblings. Only one set of notes available. Ward admin had been unable to pull notes for 1 sibling as it is a new patient. When checking the other siblings notes both children had been seen at the 1 clinic appointment and the doctor had just put a foot note on the other siblings letter- therefore put forward for challenge with no notes, no individual referral and no clinical letter. Now a patient has the clinical details of both siblings in one letter and one set of notes

Date	IG SIRI Level	Breach Type	Summary of Incident
17/06/2014	1	Other	Consultant left clinic and did not see patient, ripped up patient health records and put in waste bin.
20/06/2014	1	Disclosed in Error	Breach of confidentiality. Appraisal results for a member of staff e-mailed to HR Business Partner via 'reply'. Realised too late that the original e-mail had been distributed to other managers within the division and the results of this particular appraisal was therefore distributed to a wider circulation than intended.
16/06/2014	1	Unauthorised Access/Disclosure	Patient entered secure prep office and walked down into medical records seeking copies of her health records.
13/06/2014	1	Unauthorised Access/Disclosure	Huge section of one patient's medical records contains another patient's notes.
05/06/2014	1	Lost In Transit	Health Records clerk made a delivery of notes and did not notice that a file had fallen from the transporting trolley.
29/05/2014	1	Unauthorised Access/Disclosure	Caller pretending to be a member of staff phoned a junior doctor to obtain personal information. Caller became aggressive when the Junior Doctor correctly didn't disclose information.
28/05/2014	1	Lost or stolen paperwork	A Consultant received her payslip - it was opened and the content torn out.
27/05/2014	1	Unauthorised Access/Disclosure	Patient gained access to secure medical records preparation room for copies of medical records.
25/05/2014	1	Disclosed in Error	Patient was sent two letters. One with their correct information and the other of another patient's information
19/05/2014	1	Corruption or inability to recover electronic data	Maternity notes missing from patient's medical record.
16/05/2014	1	Disclosed in Error	Patient sent another patient's information.
15/05/2014	1	Unauthorised Access/Disclosure	Staff failed to check patient's GP details on request form and booked them in against their old GP practice.
09/05/2014	1	Disclosed in Error	A patient was sent a clinic letter which was also sent to a business address and a consultant at another hospital which did not relate to the patient. The letter contained patient identifiable information.
04/05/2014	1	Disclosed in Error	Patient referred from HH but sent to the Western Eye with another patient's records.
30/04/2014	1	Disclosed in Error	Patient results filed in another patient's records.
30/04/2014	1	Disclosed in Error	Information about one patient had printed out on the back of a letter to another patient.
28/04/2014	1	Other	Patient ID error during data entry. Screening client's appointment was cancelled in error. The client who asked for her appointment to be cancelled was not identified correctly during data entry on NBSS.

Date	IG SIRI Level	Breach Type	Summary of Incident
25/04/2014	1	Unauthorised Access/Disclosure	Folders containing patient data on the Trust wide shared drive.
22/04/2014	1	Corruption or inability to recover electronic data	Appointment recording documentation given to the wrong patient.
22/04/2014	1	Corruption or inability to recover electronic data	Main Cardiology & medical secretary doors damaged & broken into. ID badge and two dictaphones (no dictations logged) stolen.
17/04/2014	1	Lost or stolen hardware	Two towers and monitors scheduled to be used in the staff canteen went missing.
15/04/2014	1	Disclosed in Error	Wrong GP sent patient information.
08/04/2014	1	Disclosed in Error	Patient clinical summary letter addressed to incorrect healthcare professional which led to another Trust posting to a clerical worker who had left the Trust.
03/04/2014	1	Disclosed in Error	Failure to note relevant information in the patient's health record.
01/04/2014	1	Disclosed in Error	Patient letter sent to the wrong person in error.

Imperial College Healthcare NHS Trust

Trust Board - Public

27 May 2015

Agenda Item	6.3
Title	Annual Complaints Report 2014/15
Report for	Noting
Report Author	Guy Young, Deputy Director of Patient Experience
Responsible Executive Director	Janice Sigsworth, Director of Nursing
FOI Status	Report can be made public

Executive Summary:

This report provides a summary in relation to complaints received by the Trust during 2014/15 providing further breakdown and analysis. During 2015/16, further detailed analysis will be undertaken, improvements made and lessons learnt. These will be shared across the Trust.

Recommendation:

The Board is asked to note the report.

Trust strategic objectives supported by this paper:

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

ANNUAL COMPLAINTS REPORT 2014/15

1.0 Background

In June 2014, the executive oversight of the complaints function moved from the Director of Governance to the Director of Nursing. Managerial responsibility of the complaints function now sits with the Deputy Director of Patient Experience. This brings the complaints function and the PALS function under the same directorate which is believed to open up greater opportunities for managing and responding to people's concerns. Dr Rodney Eastwood provides non-executive oversight and support for complaints and PALS.

The numbers of complaints and performance in terms of response times are reported to the Board through the Trust scorecard. More recently, the Executive Committee have been receiving monthly complaints updates as part of the patient experience section of the Quality Report.

The latter part of 2014 saw a major national focus on NHS complaints handling with reports from the Patients Association (*Handling complaints with a human touch*), the Ombudsman and Healthwatch (*My expectations for raising complaints and concerns*) and the CQC (*Complaints matter*). These reports highlighted the need for NHS organisations to have a timely, responsive and humane approach to handling patients' complaints and concerns.

This led to an exploration of the current systems and processes at ICHT as currently the Trust sometimes struggles to provide timely responses that adequately address and resolve the complaints concerns. The Trust plans to move from an approach which currently focuses on investigation and written response to one which starts by asking "What can we do to help resolve your concerns?" Two papers outlining a proposal to centralise the complaints function to enable the shift in approach went to the Executive Committee during 2014/15. The proposal received broad support for implementation by the Executive Committee.

2.0 Numbers of Formal Complaints Received

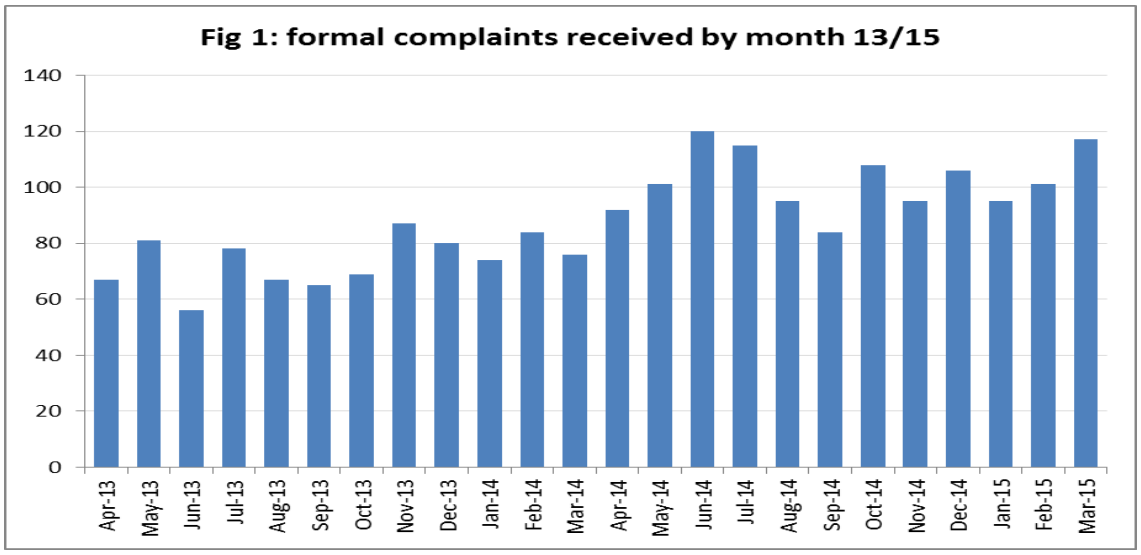
During 2014/15 the Trust received a total of 1242 complaints. This is shown in Fig 1, which covers two years for reference.

It can be seen that there has been a steady increase in the volume of complaints over the past two years, with it not being uncommon now to have over 100 each month. The noticeable peak in May, June and July was related to the Cerner implementation and the impact that this had on patients, particularly in relation to appointments, bookings and waiting times in outpatient clinics. However the underlying increase over the last 12 months is more difficult to analyse. There is undoubtedly a greater awareness in the general population of issues related to the NHS. Reports such as those highlighted above have raised the profile of the complaints and the NHS's handling of them. The increase is not confined to ICHT and complaints colleagues in the Shelford Group are reporting similar increases, although at the time of writing we do not have access to comparative figures for 2014/15.

There has been an increase in the complexity of complaints received. Whilst there remains a sizeable element of single issue complaints, there are others where the issues are multifactorial. This is particularly the case where there has been a bereavement and it is the relatives who are complaining. This highlights that we could improve how we manage dissatisfaction in relation to bereavement. More often than not, where there are concerns about the quality of care delivered it is the failure to adequately communicate, listen or apologise at the time that prompts the formal complaint.

The impact of the publication of the CQC report in December 2014 should also not be underestimated, particularly related to outpatient services where there has been an increase in the volume of complaints.

Finally, it should be considered that the quality of services has in fact deteriorated in some areas, for example in relation to waiting times. This is a national issue. It is no great surprise then that more people complain about these issues.



3.0 Breakdown of Complaints

The tables below show how the complaints are spread by category, service and division. These are drawn from the data collected in line with Department of Health guidance (KO41a – hospital and community health services complaints). The nature of this collection system is that each complaint can only be attributed to one category or service; the primary one. The data do not therefore provide a full picture as many feature multiple categories or services. This data collection is changing in 2014/15 so that multiple sources can be attributed to a single complaint. This will make analysis somewhat more complicated but potentially more useful. In order to manage this, changes to Datix are required and these are currently being tested with a view to going live in May. Data will be entered retrospectively to ensure a full year picture is available.

Table 1 shows the top 5 categories of complaints received in the year. These categories are nationally prescribed and are quite broad in nature. For example the *all aspects of clinical care* category can range from serious concerns about treatment, to privacy and dignity issues to the late administration of a medication. Communication is also a key factor in many complaints about care.

Table 1: Complaints categories 2014/15

Category	No	% of total
All aspects of clinical care	460	37
Appointments, delays & cancellations (IP & OP combined)	360	29
Communication/information	125	10
Attitude of staff	124	10
Admission, discharge and transfer	69	6
Total	1138	92

It can be seen that these five categories account for the bulk of complaints received. Appointments are a significant issue. The table above shows those patients who have felt it necessary to make a formal complaint.

Table 2 shows the breakdown by service area (top 4) and as alluded to earlier the largest proportion come from outpatient services. It is acknowledged that outpatient services have the highest number of patient contacts, so a higher number of complaints would be expected. However, in general complaints arising from outpatients should be fairly straightforward, related to appointments for example.

Table 2: Complaints by service area

Service area	No	% of total
Outpatients	684	55
Inpatients	366	29
A&E	115	9
Maternity	61	5
Total	1226	98

Table 3 shows complaints by division. Surgery has the most complaints although the complexity of the majority of these tends to be less than the other divisions. It should be noted that outpatient complaints tend to be allocated to the division responsible for the patient's care unless the complaint is specifically about the outpatient department environment or frontline staff. It should also be pointed out that the women and children's complaints are predominantly in relation to maternity, gynaecology and outpatient services; there are virtually no complaints about children's services.

Table 3: Complaints by division

Division	No	% of total
Surgery	547	44
Medicine	348	28
Women & children	186	15
IS & CS	82	7
Corporate	79	6
Total	1242	100

4.0 Ombudsman Cases

There has been an increase in the number of cases the Ombudsman has decided to investigate this year, 27 compared to 18 in 2013/14. Interestingly, 11 of these were from the last quarter of the year.

Recently, the Ombudsman's office seems more likely to investigate than not.

A feature this year has been the increase in cases where the Ombudsman has made a recommendation for a financial award to complainants. In year, awards in the region of £12,000 have been made. The highest of £4750 was awarded for loss of income resulting from a delay in performing an elective procedure, the lowest of £350 for distress caused by poor communication and a delayed complaint response.

5.0 Responsiveness

The Trust aims to provide complainants with a written response to their complaint within an agreed time frame. This time frame is nominally 25 working days, but it is important thing is to discuss this with the patient and agree at the outset when they can expect a response. Very complex complaints, for example those running alongside a serious incident case may require longer, whereas it would seem excessive for someone with a straightforward complaint to have to wait 5 weeks for a response.

ICHT has struggled to meet this requirement during the year. This is partly because of the increased volume of complaints, but mainly because the current systems and processes do not support timely resolution. The need to become more responsive is a key driver behind the proposed changes to the complaints function.

6.0. Learning and plans for 2015/16

The redesign and consolidation of the Trust's booking and appointment systems will help to reduce complaints related to outpatients and appointments. The continuing development of the patient services centre is expected to have a significant impact on this.

The work underway to review the Trust values and associated behaviours is expected to have an impact on complaints related to communication. This will also have a knock on effect on all categories of complaints because, as previously identified, communication is often an important theme running through them.

Finally, the redesign of the complaints handling process will improve the responsiveness to concerns raised. It is anticipated that if a proportion of straightforward concerns raised can be resolved promptly and effectively, they may not need to become a formal complaint.

Additional benchmarking information will be sought, alongside new targets for acknowledgement and responses to complaints. These will be reported through the quality strategy reporting and for the basis of the 2015/16 annual report.

Imperial College Healthcare NHS Trust

Trust board - public

27 May 2015

Agenda Item	6.4
Title	CQC Update Report
Report for	Noting
Report Author	Priya Rathod, Associate Director – Chief of Staff (Nursing Directorate)
Responsible Executive Director	Professor Janice Sigsworth Director of Nursing

Executive Summary:

The following report provides an update to the Trust Board in relation to; the Trust's Care Quality Commission (CQC) registration for quarter 4 (Q4) of 2014/15, the implementation of the compliance and improvement framework and the CQC action plan.

Recommendation:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

CQC Update Report

1 Purpose

The following report provides an update to the Trust Board in relation to; the Trust's Care Quality Commission (CQC) registration for quarter 4 (Q4) of 2014/15, the implementation of the compliance and improvement framework and the CQC action plan.

2 Quarter 4 (2014/15) update in relation to the Trust's CQC registration

2.1 Registration Status

- The Trust continues to be registered at each site without any conditions.
- It was agreed at the Executive Committee in February 2015 that a quarterly assessment of registered services would be undertaken by Divisional Directors in order to ensure that the Trust's CQC registration remains accurate and up to date.
- This has been undertaken for Q4, which has identified the need to make some changes to the Trust's registration in terms of amending our Statements of Purpose for our main sites. These changes have been submitted to the CQC.

2.2 Intelligent Monitoring

- On 19 December 2014 we received notification from the CQC that the Trust was an outlier for mortality rates for patients admitted with acute myocardial infarction. The initial response was submitted by the Trust on 23 January 2015 with a further response, detailing the outcome of an internal clinical review, submitted in April. The Trust is currently awaiting a response.
- The latest CQC Intelligent Monitoring report for the Trust will be published by the CQC on 29 May 2015.
- All risks are currently under review.

2.3 Notifications made to the CQC

- 2 notifications were made to the CQC in relation to the Mental Health Act 1983 in Q4
- 6 deprivation of liberty applications were made in Q4.
- In Q4 the Trust notified the CQC about five incidents as required under Regulation 4(5) of the Ionising Regulation (Medical Exposure) Regulations 2000.

2.4 Complaints to the CQC

- Four complaints were made to the CQC about the Trust in Q4 relating to the following services; maternity, renal, gender reassignment and trauma. All complaints were investigated by the Trust and a response provided to the CQC who have confirmed they are satisfied and closed all four complaints.
- The CQC did not receive any whistleblowing alerts about the Trust in Q4.

2.5 Inspections

- The Trust was not inspected by the CQC in Q4 of 2014/15.
- The Trust is not included the CQC inspection schedule for Q1 and Q2 of 2015/16.

2.6 New Requirement to Display our CQC Ratings

- In line with the new requirement to display CQC ratings, since 21st April the Trust has displayed posters at the main entrance to each hospital site (excluding Western Eye Hospital) and at its headquarters (The Bays). These ratings also published on the Trust's website.

Imperial College Healthcare NHS Trust

3 Compliance and Improvement Framework

- A trust-wide Compliance and Improvement Framework has been developed to ensure the Trust is compliant with CQC regulations and continuously reviewing and improving. A policy to underpin the delivery of the framework has been drafted and will be ratified by the Executive Committee in June.

- The framework comprises of the following components:

3.1 Director led compliance reviews

- A Director lead has been identified for each of the 13 CQC regulations who will lead a quarterly assurance process to understand if regulatory requirements are being met.
- The review for quarter 1 will be completed by the end of July.

3.2 Core service reviews

- Three core service reviews will be undertaken throughout 2015/16 for areas that were rated as 'inadequate' and 'requires improvement'.
- These reviews will be unannounced mock inspections based on CQC methodology and will be led in conjunction with internal audit.
- The first core service review will take place in June.
- These reviews will involve Healthwatch, the CCG and patients.

3.3 Deep dive reviews

- Internal audit will conduct a series of deep dive reviews for areas that were rated as 'good'.
- The first deep dive will take place at the end of May.

3.4 Ward accreditation programme

- A ward accreditation programme will be implemented across the Trust with a pilot commencing in July 2015. The programme is designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed.
- A Darzi Fellow is currently being appointed to assist in the delivery of the programme, which has been supported and part funded by Health Education North West London.

3.5 Support through Back to the Floor (Friday)

- The back to the floor programme will have an on-going focus on cleanliness for next 6-12 months.

4 Engagement with external stakeholders

- A range of external stakeholders have been invited to be a part of the Trust's core service review teams

5 CQC action plan

- All actions within the plan are largely on track. A summary of progress is outlined below.

CQC 'Must-do Compliance' Actions Overview	
Summary of actions	**No.**
Actions completed on time	21
Actions on track	21
Actions completed late	3
Actions off track	3
Actions not completed	4
Total	**52**

CQC 'Must-do' Actions Overview	
Summary of actions	**No.**
Actions completed on time	19
Actions on track	17
Actions completed late	0
Action off track	0
Actions not completed	1
Total	**37**

The exceptions relate to the following areas:

- Critical care and medical staffing cover out of hours.
  - A deep dive took place by internal audit in early May and the recommendations and associated actions will be monitored through the Executive Committee. A longer term plan for managing critical care across all sites will be presented to the Executive Committee in September.
- Outpatients
  - A number of work streams are in place to deliver a programme of improvement for outpatients. The project plan was presented to the Executive Committee on 19th May and progress will be overseen by the committee going forward. A presentation on progress will be provided to the Quality Committee in July.

Recommendation:

The Trust board is asked to note the report.