

# TRUST BOARD MEETING

# Thursday, 27<sup>th</sup> June 2013

# Trust Boardroom, 1st Floor, West Rotunda, Sterling Way

Item			Action	Lead
ADMINISTRA	ATIVE ITEMS			
1	Welcome to the Public			J Carrier
2	Apologies for Absence			J Carrier
3	Declaration of interests			J Carrier
4	Minutes of last meeting - 25 <sup>th</sup> April 2013	Α	For approval	J Carrier
5	Matters Arising	В	For approval	
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CHAIRMAN	AND CHIEF EXECUTIVE REPORTS			
6	Chairman's Report	C	For discussion	J Carrier
7	Chief Executive's Report	D	For discussion	J Lowe
QUALITY AN	D SAFETY			
8.1	Annual Serious incident report	E	For assurance	P Reeves
8.2	Board members' walkabouts Feedback	F	For assurance	P Reeves
8.3	Quality Accounts	G	For approval	S Okolo
8.4	Patient Experience Survey and Action plan	Н	For assurance	P Reeves
STRATEGY A	ND GOVERNANCE			
9	TDA Self certification return		For monitoring	J Lowe
10	London Cancer Memorandum of Agreement	J	For approval	J Lowe
11	Annual Report and Accounts	K	For approval	M Armstrong
12	Financial Resilience Review	L	For agreement	M Armstrong
<b>OPERATION</b>	AL			
13	Integrated Performance report	М	For monitoring	M Armstrong
13	integrated refrontiance report	IVI	and assurance	WI ATTIISTIONS
			and assurance	
MAY BOARI	COMMITTEE MINUTES AND CHAIR ASSURANCE REP	PORTS		
14	Finance and Investment Committee	N	For assurance	J Simons
15	Workforce Development and Education Committee	0	For assurance	D Price
16	Patient Safety and Quality Committee		For assurance	L Cantor
17	Foundation Trust Project Board		For assurance	L Cantor
18	Audit Committee	Q R	For assurance	C Dugmore
_3				
OTHERS				
19	Questions from the Public			J Carrier
20	Any Other Business			J Carrier
20	Any Other business			J Carrier

End of the public session of the Board meeting

Date and Time of the Next Trust Board Meeting – 30<sup>th</sup> July at 10.30, Trust Boardroom



#### **MINUTES**

A public meeting of the North Middlesex University Hospital NHS Trust was held on **Thursday 25<sup>th</sup> April 2013** Trust Board Room, 1<sup>st</sup> Floor, West Rotunda, North Middlesex University Hospital NHS Trust.

**Present:** Lynne Cantor Acting Chair

**Executive Directors:** Martin Armstrong Finance Director

Julie Lowe Chief Executive

Lance McCarthy Deputy Chief Executive
Theresa Murphy Director of Nursing
Stanley Okolo Medical Director

**Non-Executive Directors:** 

Catherine Dugmore Non-Executive Director
Sally Field Non-Executive Director
John Simons Non-Executive Director
David Price Non-Executive Director

Other Directors: Mark Morgan Interim Director of Operations

Rachel Patterson, Director of People and Organisational Development

Kevin Howell Environmental Director

In Attendance: Julie Kerr Executive Assistant to CEO & Chair

Kyn Ailzewood Head of Delivery & Development. NTDA

Alastair Finney Portfolio Director NTDA

**TB 13/183 WELCOME** 

The Chairman welcomed members of the public to the Trust Board meeting.

TB 13/184 APOLOGIES FOR ABSENCE

No apologies were received.

TB 13/185 DECLARATION OF ANY CONFLICTS OF INTEREST

There were no declarations of any conflicts of interest in respect of items to be addressed

on the agenda.

TB 13/186 MINUTES OF THE MEETING HELD ON THURSDAY 28<sup>TH</sup> MARCH 2013

The Minutes of the meeting held on Thursday  $28^{\text{TH}}$  March 2013 were agreed as a correct record

with the following amendments -:

• Page 5 point 10 second bullet point should read a *review* not a revision.

TB 13/187 MATTERS ARISING REPORT

Updates on the Matters Arising report were recorded and noted.

TB 13/188 CHAIRMAN'S REPORT

Lynne Cantor, Acting Chair reported that she did not have any further update on the appointment

of the Chair.

#### TB 13/189 CHIEF EXECUTIVE'S REPORT

#### 7.0 Chief Executives Report

The Chief Executive reported that the David Donegan had been appointed following interviews on Monday 15<sup>th</sup> May 2013. David will be joining the Trust at the end of June. David is currently working at Barts Health NHS Trust. Prior to that role David worked as Chief Operating Officer at East of England Ambulance and also working for NHS London.

Members were also informed of the appointment of the Director of Nursing, Paul Reeves following following interviews held on the 8<sup>th</sup> of May. Paul Reeves was currently working at Mid Essex Hospital Services Trust as Chief Nurse. Paul has worked in the NHS since 1980 and has several senior appointments at UCLH and Ealing NHS Trusts.

The Chief Executive welcomed Molly Clark to the Trust and to the Trust Board meeting. Molly Clark is the newly appointed Board Secretary. Ms Clark will be joining the Trust on Monday 13<sup>th</sup> May 2013.

The Chief Executive reported that the Secretary of state wrote to Chairs on 26<sup>th</sup> March re: the governments response to the Francis Enquiry. Trusts were asked to for on internal events to listen to staff report. The internal report will go to the next PSQ meeting then presented at the July 2013 Trust Board.

### Action: Internal Events report to be presented at July Trust Board Meeting, CEO

The Chief Executive reported that a revised NHS constitution was published on 26th March in light of the Francis report. The revised document included improving areas such as patient involvement, feedback and dignity, and bringing it in line with the new health and care system. The changes followed a consultation on HS proposals.

The Chief Executive reported that NHS England had published an 11 point Business Plan for 2013/14 – 2015/16 called Putting Patients First, which explains how they will deliver their mandate for the Government and ensure that best possible outcomes for patients is delivered. This will inform the Trusts clinical strategy and aspects of the Integrated Business Plan to ensure that the Trust services are outcome focused and meet the commissioner's requirements.

The Chief Executive stated that the TDA had published their accountability framework which detailed how they will work with NHS Trusts. This had been circulated separately to Trust Board members.

The result of the 2012 survey were published on 16<sup>th</sup> April. The Chief Executive reported that whilst the Trust had made some progr3ess in a number of areas, quality of patient experience remained an area of concern. Quality is something of a concern the Trust is working with the Royal Free Hospital sharing best practice. The survey data will be discussed at the May Patient, Safety and Quality sub committee and will be the subject of a full report at the June Trust Board meeting.

#### Action: Patient Experience, June 2013 Trust Board meeting, Director of Nurse

#### 7.1 Single Operating Model (SOM) Self-Certification Return

The Chief Executive presented the Trust Board with the February 2013, Single Operating Model (SOM) self-certification return.

There are two material changes from the January return:

- the Governance Risk Rating moved back to Green from Amber / Green as a result of achieving the 95% arrival to treatment time target in A&E in February
- the TFA progress section has been updated to reflect some risks to delivery of 3 of the milestones (external review of the BGAF and MQGF, commencement of HDD1 and submission of key draft documents to TDA) as a result of the lack of a substantive Chair for the Trust and delays in the Trust being assigned an external reviewer to undertake the HDD1 in line with the agreed timescales.

John Simons, Non Executive Director asked if the Liquidity injection for 2013/2014 had been confirmed. The Finance Director responded that the Trust was currently still awaiting confirmation of the amount of money, which we are to receive from NTDA.

Sally Field, Non Executive Director requested clarification on why there was a variation between information that went to the Patient Safety Quality (PSQ) Committee and the Board in relation to the WHO theatre checklist. Information received at the PSQ stated that the Trust was 70% compliant on the C section WHO theatre checklist and on the Trusts WHO Trust wide compliance for [SOM] it stated that the Trust's compliance level was 100%.

Julie Lowe confirmed that this matter would be investigated, with feedback to the Board in June through the Director of Nursing.

Action: Director of Nursing to present a variance analysis in relation to the WHO theatre checklist at the June 2013 Trust Board meeting

Julie Lowe explained that due to the timing of the return for the SOM report the February return was being presented to the Trust Board.

Catherine Dugmore asked what would happen if the SOM figures were submitted and then the Trust later realised that the figures were incorrect. Julie Lowe explained that this would then be updated and corrected on the following months SOM report.

Members *approved* the SOM return.

#### TB 13/190 QUALITY AND SAFETY

#### 8.1 Serious Incidents (closed and lessons learned)

The Director of Nursing reported that the presented paper outlined the serious incidents that were closed by the Trust during the March 2013.

There were 2 serious incidents closed. The Nurse Director summarised the incident of a patient that was admitted to A&E with a head injury and drunk during peek hours of the day. The patient was found in the department unconscious and required admission to another hospital where the patient later died. The Nurse Director summarised the contributory factors.

David Price asked if A& E was fully staffed at the time that the patient presented. The Nurse Director reported that the department was fully staffed.

The Medical Director summarised key recommendations and immediate actions that had taken place within the A&E department.

A discussion then took place about staffing in the department at peek and handover hours of the day in A&E.

The Nurse Director summarised the second incident of a term baby that was born with an undiagnosed diaphragmatic hernia. A baby was admitted to the neonatal unit and then transferred to a tertiary unit for further management. The Medical Director summarised the contributory factors of the incident, actions and recommendations.

Members *noted* the report.

#### 8.2 Trust Board Members' Walkabouts Feedback

The Director of Nursing summarised the following Trust Board walkabout as follows-:

- Lynne Cantor and Rachel Patterson visited rainbow ward
- Julie Lowe, CEO visited Care of the Elderly ward and A & E
- Ann Clwyd (MP) Cardiff visited the Surgical wards. Ann Clywd and her team have been commissioned by the Prime Minister to look at complaints process in Acute Trusts.

Non Executive and Executive Directors were scheduling some time to catch up on any visits that had been missed during the month.

Members *noted* the report.

#### TB 13/191 STRATEGY AND GOVERNANCE

#### 9 Foundation Trust Progress Update

The Deputy Chief Executive reported that the Trust remained broadly on plan against the FT Project Plan. The Deputy Chief Executive summarised the following elements -:

- The Membership Strategy and Trust's Service Development Priorities were approved by the Trust Board on 28 March
- The TDA conducted 1:1 interviews with Board members last week (16 / 17 April) as part of the early phase of the application process, the output of which will be fed in to the Board Development Programme, and the TDA were in attendance at the April Board meeting as part of their observation process.
- The revised Trust Risk Management Strategy was on the agenda for approval as well as the draft BGAF and MQGF self-assessments

The Trust was still waiting to be assigned (by Monitor) an external reviewer to undertake the Historic Due Diligence (HDD) 1. This needed to start in mid-May to ensure there is sufficient time for it to be completed and any relevant action plan devised and implemented in advance of the Trust Board sign-off of the draft Integrated Business Plan (IBP) on 27 June. The TDA are currently working with Monitor to confirm the timeframe and the implications on the overall impact on the Trust's Project Plan.

The Deputy Chief Executive reported that the Trust is still awaiting confirmation of the appointment of a substantive appointment of a Chair before committing to dates for the external reviews of the Board Governance Assurance Framework (BGAF) and Monitor Quality Governance Framework (MQGF).

The Deputy Chief Executive summarised two of the top 4 risks to achieving FT authorization-:

- Membership Strategy Risk that a lack of members and engaged governors would inhibit the Trust from achieving to achieve FT authorization.
- Board Capability There is a risk that the Board capability is insufficient to get through the FT application process.

- There is a risk that the trust fails to deliver against the agreed application timetable.
- FT Financial Risk Rating. Service Level Agreements (SLAs) with our commissioners for 2013/14 are still be agreed and signed and at the time of writing this paper there remains a material gap between parties.

John Simons asked if there was sufficient time in the program to deliver. The Deputy Chief Executive confirmed a project plan has been developed for theft project and the time previously allocated for the May would now be used for a board development day.

A discussion took place about planning time, input and focus. The Chief Executive reported that planning, monitoring and governance will all be discussed in detail at the Foundation Trust Steering group and the Foundation Trust Project Group.

Members *noted* the report.

#### 10 Board Governance Memorandum

The Deputy Chief Executive presented the trust Board members with the Board Governance Memorandum (BGM) self assessment for the Trust. The Deputy Chief Executive reported that the self assessment was planned to be presented to the Board for this month for formal sign off, however the external review and the self assessment itself need to be undertaken within 12 months of an aspirant FT's application to Monitor.

The Deputy Chief Executive summarised the scoring criteria that was detailed on page 49.

The Deputy Chief Executive reported that action plans had been developed to address the weaknesses identified as part of the self-assessment and were now in the process of being implemented. The commencement of the revised Board Development Programme had been realigned to address most of the areas identified in the BGM, which will play a major part in the Trust strengthening its governance.

The output from the external assessment of the BGAF and the output from the TDA's 1:1 interviews with Board members and Board observation would also be included in the local action plans and where relevant in to the Board Development Programme.

The Deputy Chief Executive reported that the RAG ratings of 5 criteria have changed, 2 have improved and 3 worsened.

The Board were informed that Trust was now in the process of scoping a Board Development Programme. A 3<sup>rd</sup> party company would be identified to provide support for this with an agreed start date of 30 May.

Catherine Dugmore, Non Executive asked how the progression of the BGAF would be monitored. The Deputy Chief Executive explained that the BGAF would be monitored through the Foundation Trust Project Board.

Members *noted* content of the self assessment, and the updates to it since the February Trust Board.

#### 12 Risk Management Strategy

The Deputy Chief Executive presented the Trust Board with an updated risk management strategy for approval.

The Deputy Chief Executive summarised 7 changes / updates made from the approved version from August 2011 they were as follows -:

- Expansion of the introduction to link the strategy to the Francis reports and the Trust's FT application
- Addition of Risk Support Officer Duties in section 3
- Redefinition of 'Risk' in section 4 to bring it in line with ISO 31000 (2009) Risk
   Management Standard
- Expansion of section 6.2 to explicitly state the BAF review process and the recent changes made to the BAF from 15+ rated risks to principal risks related to the achievement of the Trust's corporate objectives.
- Clarification in section 6.3 of how CBUs manage risk, following suggestions from our NHSLA Level 3 assessment in November 2012
- Expansion of section 6.4 in light of the Mid Staffordshire NHS FT Public Inquiry
- Creation of section 6.12 to address risks created by CIP / QIPP plans

The Deputy Chief Executive reported that the Audit Committee will be the relevant assurance committee for corporate risk management, to focus on, on its behalf.

Catherine Dugmore, Non Executive Director asked if there was a process for this strategy to go through other Trust Board committees. The Deputy Chief Executive confirmed he would make relevant changes to ensure that the correct linkage and integration is embedded into the process.

The Chief Executive said that the document is still work in progress and will need to be updated again to include objectives and to incorporate consistencies with Monitor requirements and chapter 7 (Risk Management) of the Integrated Business plan. Members were informed the document would then go back to the audit committee before being presented back to the Trust Board in October 2013

Action: Revised Risk Management strategy to be presented to the Trust Board in October

Sally Field, Non Executive Director observed that there was a lot of work to be undertaken and enquired whether its achievement was feasible. The Deputy Chief Executive confirmed there was a plan for each action.

Members approved the Risk Management Strategy, subject to further amendment and update in October

### 13 Staff Survey Results 2013

The Director of People and Organisational Development presented Trust Board members with a paper that summarised a brief overview of the National Staff Survey Results 2012. The paper highlighted results from areas of particular importance, indicating the areas where the Trust had made improvements and those where the results had worsened from the 2011 Staff Survey.

The report provided comparator data for similar types of London Trusts in key result areas and identifies the approach the Trust is taking to address the areas where scores were poor.

The Director of People and Organisational Development summarised the following key themes -:

Equality and Discrimination

- Violence and Aggression
- Hand Washing material
- Hours worked
- Staff Engagement

The Director of People and Organisational Development summarised the following areas as where the Trust made improvement

- Structured Appraisals
- Job relevant training
- Patient Focus

David Price, Non Executive Director reported that following the Workforce meeting it was agreed that an action plan would be developed for the Staff Survey Results 2013 accompanied by KPIs for the June Workforce meeting.

Lynne Cantor, Chair asked the Director of People and Organisational Development if The Trust had looked at any other Trusts whose Staff Survey Results had improved. The Director of People and Organisational Development confirmed Royal Free and UCLH are using NMUH were using the same company.

The Chief Executive added that a holistic approach for NMUH would be undertaken through a review of values and behaviours and a report will be presented to the Trust Board.

Action: Values and Behaviours to be presented to the Trust Board.

David Price, Non Executive Director, said that UCLP have done a study on workforce looking at diverse areas including culture and behaviours. The Chief Executive said that report should go to the Workforce Committee.

Action: UCLP report on culture and behaviours to be presented to the Workforce Committee

Members *noted* the report.

#### 14. Board Committee Changes

The Deputy Chief Executive presented the Trust Board with the proposed changes to the Trust Board Committees. The proposed changes have been developed with reference to the FTN's 2011 publication; "The Foundations of Good Governance; A Compendium of Best Practice", and with reference to structures adopted by local FTs. They have been discussed widely during April between Board members.

The Deputy Chief Executive proposed that the formal Board Committees remain as they are in name and existence with the exceptions that -:

- Strategy and Planning Committee (S&PC) ceases to exist
- Audit, Assurance and Governance Committee (AAGC) is renamed the Audit Committee
- Finance and Contracts Committee is renamed the Finance and investment Committee

The Audit Committee's functions and responsibilities will remain as they are currently, with primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and financial assurance. As this is currently in line with recommended best practice and the AAGC performs the role of a recognised Audit Committee it is felt that the addition of "Assurance and Governance" to the title is unnecessary and so removed.

It is proposed that the Finance and Contracts Committee remains as it is currently with the addition of the responsibility for reviewing all business cases and investments of material value (>£0.5m), a role currently performed by S&PC. In recognition of this and the potential requirement

for more investment opportunities and decisions in the future post FT authorisation, the Committee is renamed the Finance and Investment Committee.

The Deputy Chief Executive proposed the reduction of the number of EDs as members at most committees to 2, will ensure appropriate representation and free up ED time to manage the hospital, implement the Clinical Strategy and ensure a smooth path to FT authorisation. The proposed ED membership was presented to the Trust Board.

In addition to ED time, it was also proposed that Non-Executive Director (NED) time is freed up through reduced time in formal Board Committees. Reducing NED membership of each Committee from 3 to 2 (with the exceptions of the Audit and Remuneration Committees) will ensure increased time is available for NEDs to undertake other activities within the Trust and similarly support the drive towards FT authorisation. The exact detail of this requires further discussion and approval with the new substantive Chair. The NED Committee membership was outlined.

The Deputy Chief Executive reported that the Chair and CEO effectively 'float' between the committees, attending those that they choose to or where there are particular issues that necessitate their specific attendance.

The Deputy Chief Executive concluded by summarising the following -:

- The Board and its formal Committees will become less operationally focussed, leaving the operational oversight of the Trust to the EMB, which in return will report formally to the Trust Board
- As a result more time will be available in the Board Committees to focus on assurance and close some of the current gaps
- Many of the structural issues and gaps identified in the BGAF and MQGF self-assessments will be addressed
- Both Executive Director and Non-Executive Director time will be freed up, spending less time in formal Committee meetings with resultant benefits to the day to day management of the Trust, the implementation of the BEH Clinical Strategy and the FT application
- The split of formal Committee meeting functions will be more equitably spread across the NEDs

Catherine Dugmore, Non Executive Director said that it is important that if membership is only 2 Executive Directors at any meeting that Executive Directors ensure that if they are not available to attend a meeting that they arrange appropriate cover. This will ensure that meetings are appropriately covered and quorate.

Catherine Dugmore also stated that because of the nature of papers that are presented to the Audit Committee that sometimes Executive Directors and Non Executives may be called to attend a meeting to respond to a particular item on the agenda.

Catherine Dugmore asked in terms of Finance and Investment, what meeting involves clinical representation. Mark Morgan Interim Operations Director reported that the Transformation and QUIPP meeting that is chaired by Julie Lowe, CEO includes Clinical involvement and engagement.

The Medical Director reported that the overall sign off of QUIPP is solely the responsibility of the Medical Director and the Nurse Director.

The Deputy Chief Executive reported that in light of the recommendations and changes to the Trust Board Committees membership the Terms of Reference for all the committees will need to be updated and presented to Trust Board for approval.

Action: TOR's for Trust Board Committees to be presented to Trust Board, June 2013 – Lance McCarthy.

The Trust Board approved the proposed changes to the Trust Board Committees.

#### TB 13/192 OPERATIONAL

#### 15. Finance and Activity Report

The Finance Director provided Trust Board members with a summary of performance against key following -:

- The Trust reports delivery against its key statutory duties for 2012/13.
- At Month 12 the Trust reports a cumulative retained surplus of £1,848k
- The Trust confirms achievement of both External Financing Limit and Capital Resource Limit targets.
- The Trust submitted its pre audit annual accounts to the Department of Health on the 19<sup>th</sup> April 2013. The external audit of these accounts will commence in early May 2013.
- March Pay budgets report an over spend in month, with a year to date overspend of £1,825k the is a reflection of the challenges in managing bed capacity and winter pressures during the second half of the year.
- Non pay budgets report a year to date over spend of £2.8m, with overspends against drugs and medical & surgical consumables being partially offset by slippage against excluded drug expenditure.
- The Trust financial position reflects the proportionate impact of winter pressure funding made available to assist NHS providers during Q4.
- Shortfall against some CBU QIPP plans.
- Over performance against non NCL patient care SLA's remained at Month 12.
- BEH capital expenditure has increased significantly in recent months.
- Trust cash balance at 31st March 2013 £8.6m

In terms of the activity position the following was summarised -:

- Elective activity levels increased marginally during March, the Trust continues to run a significant number of additional elective theatre sessions to address RTT pressures in surgical specialties.
- Emergency activity levels remained high in March consistent with a winter profile.
- Combined A&E & UCC activity increased during March, though was broadly consistent with the activity profile and volume for the corresponding period in the previous year.

Sally Field, Non Executive Director asked about the Length of Stay activity and whether the Trust have met the target. The Chief Executive responding by saying the Trust has a Length of Stay project shows a reduction. Members were informed the Trust is in the process of working on rolling this model out.

Members *noted* the report.

#### 16. Access / Operation Performance Report

The Interim Operations Director presented Trust Board members with a summary of performance against key national waiting time targets.

The Interim Operations Director reported that all national patient access targets for month 12 showed strong performance. Year to date performance has also been strong. The March A&E performance Deteriorated and the Trust failed 'type 1' performance.

Performance against A&E type 1 target of 95% of patients being seen in 4 hours was not achieved in M12 (94.1.% type 1, 96% all types%). The Trust achieved the year end Type 1 target (95.4%) and the Q4 all types, which was key in retaining the winter pressures funding. The deterioration in performance has been noted in the entire hospital sector in London.

The Trust have invited the NHS Emergency Care Intensive Support Team (ECIST) to the Trust run a series of event to agree recovery actions for Emergency Care at the Trust. The Emergency care Standards Board CCGS and CSU will be joining the meetings to look at recovery plans.

Referral to Treatment (RTT) figures continue to achieve national standards, although there has been a slight drop in performance partially due to a greater focus on emergency admissions in the past month.

A discussion then took place about the following:

- Emergency pathways
- Deep Dive Review
- A & E performance at other Trusts in comparison to NMUH position
- Assurance and governance that plans will assist capacity

Members *noted* the report.

#### 17. Workforce Report

The Director of People and Organisational Development reported that March saw a reduction in the sickness absence rate of 1.1% taking the rate to 3.2%. The Return to Work completion rate had also reduced from 78.6% to 68.3%.

The vacancy rate for March increased from 4.4% to 4.5%, however within nursing the rate reduced by 0.2%.

The Trust had failed to maintain its achievement of the target of an 80% appraisal rate for the year by 1% and ends the year with an appraisal rate of 79%.

The Trust's compulsory training compliance rate has reduced to 69%, which is a reduction of 1% from month 11.

The Medical Director reported that the Workforce committee had spend some time looking at the detail of the vacancy rate and the temporary staffing figures and there were a few anomalies as some of the figures did not correlate as temporary staffing figures.

The Chief Executive reported temporary staffing is currently being monitored on a weekly basis.

Members *noted* the report.

#### 18. Environmental Services Report

The Environmental Services Director summarised the following -:

- All demolition and surveying works was now complete.
- Women's & Children's Unit Excavation of foundations and breaking down of piles is complete. Foundations are being poured by concrete pump with the last pour programmed for 10th April to ensure all foundations are complete prior to Yorkon commencing on 15th April.
- Infrastructure The attenuation tank for the Women's & Children's Unit has been installed and back filled, and the commencement of the north car park area has

started early to provide temporary site parking and retained estate tower storage area.

- Cardiology The clinical area was handed over and the Trust is open for clinics. The
  administration areas have been completed, with only the remaining windows to
  install and surrounds to be completed and decorated. All other windows have
  been installed. Ceiling and floor coverings are in progress. The remaining areas
  are due to be completed on 15<sup>th</sup> April.
- Asbestos removal of spandrel panels and façade cleaning works are under notice to commence late April 2013. The Trust is currently undertaking asbestos clearance works on T7, T8 and T1 floors which are due for possession later in April 2013.
- Legionella a number of failures were recorded in the retained estate during March – all outlets have been cleaned, chlorinated and resampled and we are currently awaiting results.
- Pseudomonas Aeruginosa no Pseudomonas failures were recorded during the month of March.

Members *noted* the report.

#### 19. Performance against Trust Objectives 2012/13

The Deputy Chief Executive presented the Trust Board with a table that summarised the key deliverable performance against the 3 overarching corporate objectives in Q4 in comparison to Q3. The objectives that had not been achieved within the expected timeframe were discussed.

The Deputy Chief Executive summarised the deteriorating performance for specific key deliverables.

Members *noted* the report.

### 20. Trust Objectives 2013/2014

The Deputy Chief Executive presented Trust Board members with the Trusts Objectives 2013/2014. The paper outlined the proposed 5 corporate objectives for 2013/14 which will be implemented over the next 5 years in line with the LTFM.

The Deputy Chief Executive reported that the objectives are in line with the strategy, vision and service development priorities of the Trust as discussed as part of the Trust's IBP and build upon the 3 high level corporate objectives we have used for the last 2 years.

The Deputy Chief Executive summarised the changes to the objective for 2013/14 onwards and the corporate objective 1: The achievement of excellent clinical outcomes.

Action: CQC compliances should be added and risk rating for Finance -- Lance McCarthy

Members *noted* the report.

### 21. Integrated Performance Report

The Chief Executive reported that the Integrated Performance Report was presented to the Trust Board for information. The report summarised the Trusts Month 12 position against key national and local performance targets and other milestones as set out in the NHS Performance Framework and Trust Annual Plan 2012-13.

Members *noted* the report.

#### TB 13/193 MARCH BOARD COMMITTEE MINUTES AND CHAIR REPORTS

- 22 Finance and Contracts Committee
- 22. Workforce Development and Education Committee
- 23. Patient Safety and Quality Committee
- 24. Foundation Trust Project Board
- 25. Audit Committee
- 26. BEH Strategy meeting

The minutes of all the above meetings were approved by the respective committees and chairs.

Members *noted* the minutes of the meetings.

#### TB 13/194 USE OF THE TRUST SEAL

The Trust seal was not used in March 2013.

#### TB 13/195 QUESTIONS FROM THE PUBLIC

- 1) Donald Smith asked if a May Board meeting is not going to take place will monthly management reports still be prepared. The Chief Executive responded by stating yes monthly reports will still be prepared.
- 2) Donald Smith presented Theresa Murphy with a bouquet of flowers, as a token of thanks for her hard work and commitment to patients at NMUH.
- 3) Kay Winn-Cannan, asked if the Trust had a policy or any procedure around dealing with drunk patients.

Action: Theresa Murphy, Nurse Director to send Kay Winn-Cannon a written response to the question.

4) Kay Winn-Cannan, asked if there was a policy for Dementia patients and time to treat.

Action: Theresa Murphy, Nurse Director to send Kay Winn-Cannon a written response to the question.

### TB 13/196 ANY OTHER BUSINESS

- 1) The Trust Board formally delegated the authority to review and approve the Trust accounts for 2012/2013 to the audit committee which will meet on the 4<sup>th</sup> June 2013 to discharge this responsibility.
- 2) Julie Lowe, Chief Executive thanked Theresa Murphy, Nurse Director for all her hard work and commitment to North Middlesex University Hospital and wished her all the very best for the future.

#### TB 13/197 DATE OF NEXT MEETING

The next public meeting of the Trust Board would be held on *Thursday 27<sup>th</sup> June 2013 at 10:30am* in the Trust Board Room, 1<sup>st</sup> Floor, West Rotunda, North Middlesex University Hospital.

Lynne Cantor			
Chair			

# NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST TRUST BOARD. PART I REPORT ON MATTERS ARISING

# Matters Arising including items from the meeting held on Thursday 25<sup>th</sup> April 2013

Item No.	Minute Ref. No	Issue/Action	Lead Director	Outcome	Completion Date
1.	TB 12/163	The Environmental Director to provide the Trust Board with a food comparison for England rather than just London	Environm ental Director	Deferred to July meeting	June 2013
2.	TB 12/179	Patient Safety and Quality :Director of Nursing to present a paper to the Trust Board June 2013 meeting on complaints and clinical standards.	Director of Nursing	On Board agenda	June 2013
3.	TB 13/189	Chief Executives Report: Internal events report to be presented to the July Trust Board.	Chief Executive		July 2013
4	TB/13/189	Chief Executives Report: Director of Nursing to present a variance analysis in relation to the WHO theatre checklist at the June 2013 Trust Board meeting	Director of Nursing		
5.	TB 13/189	Chief Executives Report: Patient Experience Report to be presented to the Trust Boards next meeting	Director of Nursing		June 2013
6	TB 13/190	Strategy and Governance: Risk Management Strategy to be re-submitted to the Board in October	Deputy Chief Executive		October 2013
5.	TB 13/191 point 13	Strategy and Governance: Values and Behaviours to be presented to the next Trust Board Meeting	Director of People & Organisat ional Developm ent		June 2013
6.	TB 13/191 point 14	Strategy and Governance: Terms of Reference for Trust Board Committees	Deputy Chief Executive		June 2013
8.	TB 13/191	Strategy and Governance :UCLP report on culture and behaviours to be presented to the Workforce Committee	Director of People & Organisat ional Developm ent		June 2013
9.	TB 13/192 point 20	Operational: CQC compliances to be added to the risk rating for Finance	Deputy Chief Executive		June 2013

Trust Board				
MEETING DATE: 27	7 June 2013			
TITLE: Ch	nairman's repor	rt		
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AGENDA ITEM: 6		PAPER: C		
EXECUTIVE SUMMARY	•			
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This provides the Board	d with an overvi	view of key activities that have been undertaken by the Board		
		on the 4 <sup>th</sup> of June, as well as some of the future priorities for		
the Board in the near fu	uture			
The Board is asked to re	eceive the June	e Chairman's report		
ACTION REQUESTED OF THE MEETING:				
For comment	For agreement For ratification			
For discussion	x For resolution			
LINK TO:				
CORPORATE OBJECTIVE	ES:	Directly impacts on them		
CQC OUTCOMES:		Outcome 16 – Monitoring the quality of service provision		
IMPACT ASSESSMENTS / IMPLICATIONS ON:				
PATIENT SAFETY AND QUALITY EQUALITY				
RISK (BAF / risk register)				
FINANCES / RESOURCES:				
THIS PAPER HAS BEEN PREVIOUSLY n/a				
CONSIDERED BY:				
AUTHOR AND TITLE: John Carrier, Board Chairman				

### Chairman's report – June 2013

I am very pleased to have been appointed as Trust Chairman of North Middlesex University Hospital Trust. Over the next two years, I look forward to learning as much as possible about the Trust as we progress towards Foundation Trust (FT) status.

My areas of priority as Chairman are to ensure the Board has processes in place to monitor the quality of services provided, the level of efficiency with which the Trust uses public resources, and to ensure that the Trust provides equitable access to all services and tackles health inequalities. Since arriving on the 4<sup>th</sup> of June I have had the pleasure of being taken around the hospital to aid my understanding of the services and also to meet the staff.

To date I have visited the maternity, paediatric and Accident and Emergency services, and hope to visit all the services on site within the next few months. During my visit I was struck by the busy thoroughfare at the front of the hospital reception area and was able to have some informative and engaging conversations with members of the public and staff about their experience of the hospital and its services. I got a favourable impression that our services were highly valued, whilst at the same time noting that there is always room for improvement.

I have also met senior executives and non-executives as a group.

We will all be aware that the Trust is undergoing significant change with the implementation of the BEH Clinical strategy and the drive towards the attainment of FT status. Ahead of us there is the important challenge for the Board to balance its 'business as usual' with these changes. It is important that we do not lose sight of the need to make the transfer of the BEH services to the North Middlesex as seamless as possible whilst at the same time maintaining the quality of care to our patients.

As Chair of the Board I am conscious of the need to create an atmosphere in which all associated with the hospital have confidence that we can proceed to the 'challenge' phase which takes place as a Board to Board meeting with Monitor.

The Board's confidence will be assisted by its reliance upon the systems in place to substantiate the delivery of our Quality Account priorities and key metrics . Whilst not having been directly involved in the discussions leading up to the development of the 2013/14 priorities, I am confident they represent feasible and important goals that the Trust will aim to achieve. I look forward to receiving assurances on their delivery through the Patient Safety and Quality Committee. I understand the delivery of the priorities is incorporated into day to day work of the Executives.

To assist the Trust's progress towards FT status, the Board will hold 3 away days which are aimed at enhancing the awareness of challenges and risks. These away days will be facilitated by an independent external expert. At the same time as we progress towards FT status, we should not lose sight of the primary role of the Board, to oversee and assure the provision of high quality services to the population of Enfield and Haringey.

Of course, achieving the aspirations of the Board are highly dependent upon our staff, who are conscious of their own professional standards, as in the midst of change they continue to treat patients on a daily basis. The Board takes assurance from this professionalism through the work of the Workforce Committee and standing reports from the Director of Workforce

We are an organisation generating an annual income of £180m. These are public funds we are charged with spending wisely and with this in mind, we are able to subscribe fully to the founding principles of the NHS, that services should be universally available, of high quality and accessible for all

I am keen to ensure the Board discharges its statutory duty of ensuring that the local population receives safe services of a high standard of quality during this time.

With this in mind, and with the assistance of the Board and the advice of the Chief Executive it is necessary at this time to review some of the current processes of the Trust Board and its Committees. The Board will also take assurance from its Committees which are delegated to

undertake key functions, one of which includes overseeing the attainment of FT status, through the FT Project Board.

Over the next few months we can expect the appointment of an independent assessor by the TDA to undertake a 'historical due diligence, Board and Quality governance assessment exercise of our preparedness for FT status. This will be an important aid of our understanding of the appropriate next steps. The output of the due diligence exercise may inform the structure of the annual Board cycle, which is being developed through our governance arrangements.

John Carrier Board Chairman 27<sup>th</sup> June 2013



	Trust Board				
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MEETING DATE: Thursday 27 <sup>th</sup> Ju	une 2013				
Chief Franchisch	V- Down and				
TITLE: Chief Executive	s Report				
AGENDA ITEM: 7	PAPER: C				
AGENDA ITEIVI. /	FAFEN. C				
EXECUTIVE SUMMARY:	EXECUTIVE SUMMARY:				
This paper summarises key issues	from the Chief Executive over the last month				
The Board is asked to note the rep	oort.				
ACTION REQUESTED OF THE MEE	TING:				
For information x	For assurance				
For comment	For ratification				
For discussion x	For discussion x For resolution				
LINK TO:					
CORPORATE OBJECTIVES:	Relevant to all				
CQC OUTCOMES:	Relevant to all				
neievant to an					
IMPACT ASSESSMENTS / IMPLICATIONS ON:					
PATIENT SAFETY AND QUALITY	None				
EQUALITY	None				
RISK (BAF / risk register)	None				
FINANCES / RESOURCES:	None				
THIS PAPER HAS BEEN	N/A				
PREVIOUSLY CONSIDERED BY:					
AUTHOR AND TITLE: Julie Low	e, Chief Executive				

# Trust Board Thursday 27<sup>th</sup> June 2013 Chief Executive's Report

#### 1. UCLP Update

Board members will be aware that membership of UCLP is key to our relationships with partner organisations and enables us to be involved in the work of an Academic Health Science Network (AHSN). I am delighted that UCLP has been formally designated as an AHSN by the Department of Health and a copy of the designation letter is attached as *Appendix 1*.

I am attaching for reference UCLP's year end performance report, which forms *Appendix 2* of this report. This details the tremendous range of work that UCLP is undertaking. Of particular note for North Mid is reduction in patients suffering a cardiac arrest in hospital as a result of the deteriorating patient collaborative, and the commencement of the specialist services programme which is looking at specialist cardiac and cancer provision including the development of a single provider in radiotherapy (across a range of sites).

For Board members' information the UCLP Business Plan Executive summary is also attached as *Appendix 3*. Broadly this details the continuation of UCLP's work, highlighting six corporate development priorities for 2013.

#### 2. BEH update

The clinical work streams continue to meet to progress the plans for implementation of the strategy.

During May and June additional asbestos was identified and has needed removal from the Tower Building. This is always a risk when working on this type of building. This has caused some pressure on the building programme, but contingency planning has been undertaken to ensure that the strategy can commence in November.

Bookings continue to be received in Maternity directly from GPs and also from Chase Farm hospital direct when they receive bookings from women within the revised boundaries. The number of bookings are monitored weekly and are broadly on track with the expected referral levels. The new Women's and Children's building is on track to be handed over to the Trust in November.

Members of the clinical assurance team for the programme came to visit and meet key individuals within the Trust during June ahead of the clinical cabinet and presentation by the joint paediatric team. The clinical assurance team came together in May and are commissioned by the 3 CCGs to provide external assurance on the capacity and safety of the health economy to implement as planned in November 13. They have started to collect evidence for their key lines of enquiry which will be used in their report to the CCGs in September 13.

The Trust Board will be requested to provide assurance in September that it is ready to safely implement the strategy ahead of the 3 CCGs reaching their decision regarding the timing of the implementation. Operational teams have drafted plans to demonstrate that

the proposed workforce will be able to deliver to the forecast activity levels as well as contingency plans for scenarios such as difficulties with recruitment.

### 3. Foundation Trust update

Good progress towards Foundation Trust status continues to be made.

The overall timeline to authorisation is currently being revised to take into account the changes to the application process outlined in the recently published Accountability Framework from the National Trust Development Authority (NTDA). The revised timeline is due to be signed off with the NTDA by the end of this week.

An external assessor (PwC) has been assigned to the Trust by Monitor to undertake Historic Due Diligence (HDD) 1. This is expected to start in mid-September.

We have appointed KPMG to undertake the external assessments for the Board Governance Assurance Framework and Quality Governance Assurance Framework. These are both planned to start in early August.

Membership Engagement Services, a subsidiary of Electoral Reform Services, have been appointed to support the Trust with recruiting public and patient members. Using face to face discussions in both the community and on site, and taking advantage of events like the AGM and public consultation events, recruitment will begin in earnest at the end of the summer.

Finally, good progress continues to be made with the development of the detail in the Integrated Business Plan, the supporting strategies and the Long Term Financial Model. Submission in draft form of all these to the NTDA will be made prior to Christmas.

Julie Lowe
Chief Executive

Rachel Cashman NHS England Richmond House 79 Whitehall London SW1A 2NS 27.05.2013

Dear Rachel,

#### Re: Draft AHSN licence

Thank you very much for sharing the draft licence, and for again confirming that its development is an iterative co-design process in line with the ethos of AHSNs at inception.UCLPartners and the Eastern AHSN have decided to do a joint response because we have common perspectives, close working relationships and shared experiences of working together to support the development of our AHSNs across Essex, Herts and Beds, and were both involved in the original proposals to development a national framework of AHSNs.We welcome the work that has gone in to developing the document since you invited comment on the first draft of the AHSN licence. Whilst some of our concerns have been addressed we believe that significant issues still remain and that there is scope for further improvement. Our shared aim is to arrive at a licence that will allow the NHS and the UK life sciences industries to derive the maximum benefit from the AHSNs, a radical and important element of the new health and care landscape.

We describe the issues in more detail below but strongly feel that the best way forward is to develop a small writing group to work with you to produce the licence as a co-operative exercise. As you know, this approach added significantly to the section on AHSNs in Innovation, Health and Wealth.

In discussion with our own teams (including our Chairs) and with colleagues in other AHSNs, the following four principal themes are emerging as essential to be addressed in the co-design of the licence. In addition, comments against each of the proposed objectives in the draft licence are summarised in Appendix 1.

1. Partnership approach of AHSNs. In a number of cases, the draft licence appears to assume that AHSNs will direct rather than facilitate action by individual partners. However, the approach of AHSNs is one of partnership working: partners working together, with patients and for patients. The diffusion model is horizontal and bottom-up, rooted in peer-to-peer alignment and patient pull. It is not one of top down compliance. AHSNs do not, and should not, have the levers of power required to command compliance which furthermore would undermine other statutory and commissioning arrangements. Mandating national NHS initiatives through the AHSN will damage local partnership working, disengage both NHS and non NHS partners within AHSNs, and thereby reduce the effectiveness of AHSNs. The draft licence needs further work to reflect this, moving away from a culture of command-control to a largely non-hierarchical structure of peer challenge and support. We believe this to be a defining characteristic of AHSNs.

(We note that eight of the AHSNs have received a licence with immediate effect and that the remaining seven have restrictions. Those AHSNs with restrictions have been instructed to seek the help of one of three management consultancies. We are uncertain of the expertise or the experience and track record of the management consultancies in this area. We suggest that a complementary approach would be for

an AHSN seen as requiring further development to link with one of the currently stronger AHSNs, thus providing support and challenge, better value for money, as well as providing an excellent opportunity to contribute to building a strong network of the 15 AHSNs).

2. Local AHSN Prospectuses. There is disconnect between the current national licence and the locally-developed AHSN business plans. Positioning 'Local Area priorities' as one of 25 objectives (and virtually the last) risks disengaging the patients and staff across multiple organisations who gave their time and energy, working together, to co-create a compelling local vision and priorities. As such, AHSN partnerships may be damaged, along with the reputation of NHSE, whose commitment is to enable greater local autonomy. There should be an explicit recognition of the importance of each submitted prospectus and achievement of the proposals developed by the local patients, populations and organisations as the core priority of the licence.

Furthermore AHSNs, particularly in the context of significantly reduced AHSN funding, will not have capacity to deliver the full range of national policy initiatives across their entire population. The proposal to co-develop objectives and metrics with individual AHSNs is well received. This needs to be based on a discussion about local priorities, as well as resources, starting point, challenges and capacity, and overall deliverability within the available financial envelope.

The 15 prospectuses show the AHSNs to be significantly different in terms of their cultures, existing partnerships and relative priorities across bioscience industries and biomedical research, each with their own strengths and opportunities. One pragmatic way to reflect these differences is to construct a licence in two parts:a licence of 'core' functions, common to all, and a further element of the licence that translates the individual prospectuses into clear deliverables in terms of innovations relevant to the particular health system (see below).

- 3. Health and wealth outcomes measures. Measuring outcomes rather than process measures is well articulated at the beginning of the draft licence. However, this philosophy is lost later where there is no mention of any outcomes which are meaningful to the population AHSNs serve. Insteada set of process control mechanisms are detailed. This risks creating a culture of micro-management and control, positioning AHSNs as a vehicle for delivering national programmes rather than a mechanism to enable partners to focus on local health needs and improving health and wealth outcomes. We feel that a new Post Francis approach, characterised by a culture of local empowerment, is needed to create pull for translating innovation into practice. This issue could be addressed by setting a smaller number of strategic objectives focussed on health and wealth outcomes, and for each AHSN to work with their members (including patients) to co-develop measures so those participating in, delivering and paying for services "own" the measures. A better approach may be a common framework (like that for FTs) supported by fewer measures and then more bespoke discussions with each AHSN as to its own priorities and delivery timetable.
  - 4.**Funding allocation**. Innovation, Health and Wealth suggested that the AHSNs might expect to receive a budget of £2 million per one million population for each of the five years of the licence. In our view, the current proposal to allocate funding to each AHSN, irrespective of the size of the population (range of 2 7m –a 3.5 fold difference) or the content of the local AHSN Prospectuses is problematic and runs directly contrary to the Mandate to reduce health inequalities. While there will be some costs that occur

irrespective of population size, for the most part this is untrue. The success of an AHSN is dependent on building relationships and partnerships, which increase disproportionately with scale -more people and communities, more organisations (e.g., CCGs, primary, community and acute providers, councils, HWB, etc.) and larger geography (e.g., more travel)<sup>1</sup>. This has been our experience over the last four years with our own partnership growth to encompass much wider geographies and populations than our AHSCs designated in 2009. The current funding allocationwill result in patients living within larger AHSN populations and geographies being offered much less opportunity to benefit from this new initiative than those living within smaller AHSNs, which is counter to NHS values to provide equal opportunity to all patients. The funding formula used for year one enhances this variance per head of population further from 3.5 fold to in excess of fivefold from the most well supported AHSN on health care and economic growth per head to the least supported. These variances are unrelated to deprivation or demonstrable additional need. We would suggest this approach is reconsidered so as to comply with the NHS Mandate and reverts to a population base approach.

The funding allocation is reduced nationally from £150m to £55m. This requires new ways of working, including minimising unproductive bureaucracy, developing effective partnerships between AHSNs and a culture of simplification to focus relentlessly on the deliverables. We welcome this and believe that the best AHSNs are poised to deliver large-scale sustainable change by adopting this approach. By contrast, the draft licence still includes too many objectives, some additional to those originally indicated (e.g. NHS Centre for Frugal Innovation, not referred to in previous documents or in IHW) and an onerous level of accountability and reporting against process, measures which will consume, possibly without any clear benefits, much of the limited resources.

The above comments are written in the spirit of a trying to achieve a licence that will allow the benefit of the ASHN concept to be realised over the next five years. We believe that our assessment reflects views that are broadly shared across most of the AHSNs, who are committed to working with you to co-produce a document that will provide a framework to deliver the maximum health improvement and economic growth across the whole country within the much reduced funding envelope. We are keen to discuss the best way forward and to contribute to this important project.

Yours

David Fish

Managing Director

UCLPartners

Robert Winter

Managing Director

Eastern Academic Health Science Network

<sup>&</sup>lt;sup>1</sup> The number of relationships for a facilitating partnership to support increases in relation to the square of the number of partners using the formula:  $(n^2-n)/2$  i.e. for 5 partners there are 10 relationships, for 10 partners there are 45 etc.

#### Appendix 1: Commentary on the draft licence Agreement between AHSNs and NHS England

Five additional comments to those detailed in the covering letter are detailed below. These general observations are followed by commentary against each of the proposed 25 objectives.

#### 1. One size fits all

The current (incorrect) assumption appears to be that for all AHSNs:

- The costs of delivery for all of the themes are the same.
- The order of priorities are similar and will be best delivered through the same set of processes and enablers.
- The relationships and accountabilities between all partners (and thereby overall governance structures) are the same.

#### 2. Licence v contract

The language and also order of priorities seems to indicate, rightly or wrongly, AHSNs are being seen to an extent as tools of NHS England rather than as independent partners trusted and contracted to design and deliver a set of desired outcomes – this is perhaps most stark within the paragraph re AHSN delivery monitoring (page 15) which reflects a rather draconian top-down performance management approach. Many AHSN are expected to be, or to become independent legal entities operating as an interface with industry in a way that is familiar to Industry and Industry understands. This positioning runs counter to developing that culture.

It may, on reflection, have been more useful to position the licence and its tone more akin to a contract between AHSNs and NHS England as partners (with a limited set of contracts or SLAs which will inevitably evolve over time and designed to deliver an agreed set of behaviours and outcomes). This is a shift from the current feel in which the licence implies AHSNs report to NHS England, which is acting as both the issuer of the licence and also its regulator, rather than as a separate contractor. In our view the current approach risks losing many of the benefits we have seen already through partnership.

#### 3. Cost v benefit

There appear to be too many objectives and metrics (even before the local priorities are added though these should be the core priorities in a devolved system) – the cost of collection of information and reporting by individual AHSNs may in some cases take up a significant part of the resource before the needs of local populations are even touched.

#### 4. Wealth creation v IP protection

The provisions in relation to wealth creation and new technologies may be overly simplistic in the face of IP and other confidentiality complexities. Whilst openness and pace of diffusion is clearly an objective, so the individual partner incentives and protections for value creation will also need to be recognised. It is unclear how this important element will in reality work.

### 5. Gaps in emphasis

Apart from the focus on local empowerment and partnership working the licence does not make sufficient emphasis on the core partnership with academia within AHSNs. In addition there are step change opportunities to support increased participation in research which NIHR are facilitating through the new co-

terminus arrangements for CRNs and CLAHRC, and new forms of relationship with education and training boards to enable delivery of AHSN objectives. The current approach risks disengaging HEIs.

### **AHSN Priorities and Objectives**

Set out below are some more detailed comments regarding the scope of the proposed five year licence (and individual one-year contracts)

#### Theme A: spread of innovation at pace and scale

Comment: AHSNs will support NHS England to implement national policy programmes (e.g. High Impact Innovations, commitment to implement NICE approved technologies). However, it is essential to recognise that the approach of AHSNs is one of partnership working and horizontal diffusion, not compliance. Furthermore, AHSNs do not have the levers of power required to mandate compliance. Mandating national initiatives through the AHSN will damage partnership working and thereby reduce the effectiveness of AHSNs. AHSNs will not have capacity to deliver the full range of national policy initiatives across their entire population; each AHSN will need to select those initiatives which most strongly align with the health needs of their local population, and where their members seek support for implementation. The approach will be targeted and balanced with local need. It is essential to focus on outcome measures, rather than, for example, the number of patients receiving the innovation. Measuring outcomes ensures a focus on accurate diagnosis, treatment pathways, adherence support etc. rather than simply uptake. Given the "start-up" nature of AHSNs, the need to have "space" for local engagement and priorities agreed through the prospectus approach, the desire to create a Network of Networks and the reduced funding we would strongly recommend a focus during the early years of the licence on no more than one or at most two High Impact Innovations. More is not practical and will fail in other than a tick box target driven mentality.

- **1. Adoption of high-impact innovations (HIIs)**: current focus is (incorrectly) on collection of data and information (and explanations), rather than outcomes.
- 2. NICE Guidelines and Technology Appraisals: current focus is (incorrectly) on collection of data and information (and explanations), rather than outcomes. As it stands each AHSN board will need to address the issue of clinical liability. For example, if a patient does not receive care in compliance with NICE guidance (be that in a partner acute trusts or primary care practice) and suffers harm will NHSLA or the patient be able to seek redress from the legal entity AHSN —be that hosted in an NHS Trust or a separate company? It would be helpful for the licence to address this directly, for example by making it clear that clinical liability remains with each partner organisation. Note that UCLPartners has considered this issue carefully since our designation in 2009 and opted so far for additional private insurance given the ambiguity. The licence is a good opportunity to resolve this and reduce costs for all AHSNs who may otherwise duplicate partner NHSLA payments.
- **3. Best practice and innovation**: this seems a fairly broad requirement ('levels of variation.. must be reduced') but is really in the first instant about collating and reporting. Greater detail of what is required is needed.
- **4. NHS Outcomes Framework**: in its current form the obligation is 'to align with and contribute to' it will be important to ensure that any contract does not start attaching more detailed outcome related performance to this. This objective also presupposes that the obligations in the Outcomes Framework are all relevant to the all AHSNs' objectives.
- **5. Three Million Lives Programme**: this is supported and for negotiation with each AHSN.
- **6. Specialised Commissioning Innovation Fund:** this is supported.

- **7. Horizon Scanning**: this is broadly supported but currently vague. It will need to take account of the cost of collating information and deal with any commercial confidentiality / IP issues where these exist (i.e.: innovation / invention where IP belongs to individual partners, other third parties, is subject to NDAs etc.).
- **8. Procurement performance benchmarking:** AHSNs may or may not have a role in helping to encourage collation of this information. However, it is absolutely not appropriate for an AHSN as part of this licence to undertake an annual bench-marking exercise, ensuring compliance with coding and the payment code (the latter is often a cashflow issue in individual entities), agree to a savings target and SME contracts. The obligations relating to procurement are unexpected. There are a number of initiatives relating to improving procurement across the NHS. While the AHSNs would look to ensure that new technologies or solutions are adopted using appropriate procurement methodologies, this should not be extended such that AHSNs become accountable for the standards of all procurement by NHS Trusts.

#### Theme B: economic growth and wealth creation

**Comment**: some of the objectives of this theme appear to sensibly combine a partnership, reporting and outcomes approach. However it is unclear as to whether they are the right ones in each case and whether even if undertaken this will really result in economic growth / wealth creation. Given the relative lack of experience the NHS has in this area, any licence will need to reflect an evolutionary approach and also balance the difficulties of confidentiality with a desire to be open and to share innovation as early as possible for the benefit of patients. The outline proposals seem to duck this latter issue.

- **9. Industry investment**: if mixed funding is agreed in principle then this approach seems sensible if 20% is the right level to aim for the detail will be relevant.
- **10. Small Business Research Initiative**: this is supported.
- **11. Commercialisation**: this sounds like a reporting procedure and not unreasonable (subject to any NDA considerations regarding IP etc.) but attribution will be difficult between what would have happened without AHSNs by individual partners and what is attributable to AHSNs as most of the income will sit with partners.
- **12. Work with Healthcare UK:** the principle sounds fine but the calculation of the value of international business engagement and then targets may be more of a challenge as presumably this will be dependent on collaboration with other partners/ AHSNs / NHS and others. For example an AHSN may play a very small/no role in enabling a partner to set up an overseas health care facility, or a major role but it is important we focus on the overall outcomes for UKPLC not partitioning/target management.

### Theme C: inclusivity and partnership

**Comment:** this theme seems to correctly recognise the value of developing partnerships (within and across AHSNs) although, almost inevitably, struggles to assign qualitative measures of their value and also the outcomes. It recognises but does not reflect that in reality this will be undertaken differently depending on the local set-up and nature of the partners (HEIs, providers etc.).

- 13. Network of Networks: collaboration through the Network of Networks and with other organisations is expected and supported. This however, must be balanced against a focus on developing and sustaining relationships for local delivery which will inevitably be the priority for start-up organisations, followed by relationships with adjacent AHSN given the importance of good cross boundary working. The Network of Networks will need the right people attending, with the right Terms of Reference and an agreed investment/ management and joint communications approach (e.g.: to support website development) that the AHSNs own and fund i.e. that they perceive the value of doing so, for it to work.
- **14. Partnering with Academic Institutions and AHSCs**: Academic institutions are at the heart of AHSNs which are much more than a partnership of healthcare providers. Partnership with AHSC is supported.

- **15. Partnering with NHS Improving Quality**: the obligation should be to work with NHS IQ to help develop and shape programmes and, where contributing to the aims and consistent with the role of AHSNs, support their delivery. It is not the case that a single model of change, driven centrally, is the best way in which to facilitate transformation through innovation.
- **16. Partnering with CLRNs**: we support working with NIHR functions to enable research –CRNs and CLAHRCs –this is an area for greater emphasis given the opportunities and work of NIHR to ensure coterminosity.
- 17. Local Enterprise Partnership Engagement: this engagement will presumably vary in each region (and in some regions there will be over-lapping or more than one LEP). As drafted the obligation is not really defined and the metric could if taken at face value be a full-time responsibility of a senior individual/team. In addition, it is not clear that it makes sense for each AHSN to engage directly with national and Government departments (maybe this needs to fall within the remit of the Network of Networks to co-ordinate)
- **18. Joint working with industry**: the objective is supported. The metric is too broad and ill-defined at present. The concept of a stakeholder survey is a good one and this may be the sensible metric for a range of these partnership objectives.
- **19. Contribution to Healthcare Innovation Expo:** The value and benefits of this conference should be evaluated annually to ensure that this is the most effective use of resources.

#### Theme D: unmet need assessment

- **20. Unmet need assessment**: this is a core function of commissioning and/or public health, of which AHSNs will want to input but not duplicate. It is important to clarify the role of AHSNs in this. There will be a focus on variation in quality of care or access that would be addressed in ensuring consistent application of best practice.
- 21. NHS Challenge Prizes: this is supported,
- **22. Innovation Fellows**: this is supported.
- **23. NHS Centre for Frugal Innovation**: this is an unanticipated objective. It is not yet possible to comment as further information is required on the vision, form and function of this centre.

### **Theme E: Local Area Priorities**

Comment: it is perhaps interesting that this theme is placed last and remains to be completed by Regional and Area teams despite the fact that the core strengths of AHSNs is harnessing the power of partnership and focusing on local priorities to improve local delivery and outcomes. Presumably this will be the focus of one-year contracts.

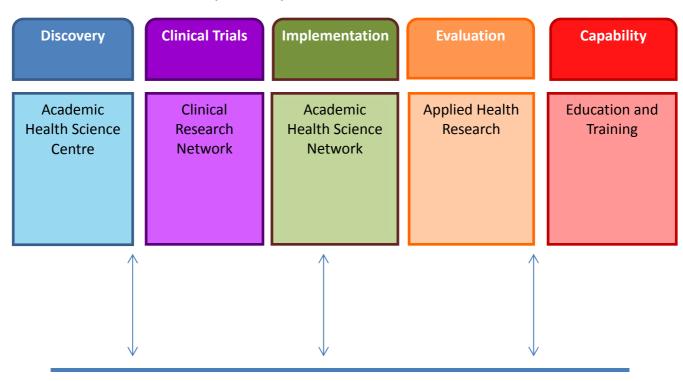
- 24. Local Area Priorities: a focus on local priorities would be very welcome. However, it is lost as 24 of 25 objectives. Furthermore the local priorities of the AHSNs (rather than the Local Area Priorities with which AHSN will work in partnership some covering or partially overlapping more than one Local Area) should be defined in the licence of each AHSN and be a theme that runs throughout their individually agreed objectives against each theme (e.g., HIIs, local partnerships etc.). Indicating that local priorities will be completed by the Local Regional and Area Teams (of NHS England) runs counter to the suggestion of patient pull or working in partnership.
- **25. Equality and diversity**: reducing health inequalities is core to the NHS. It should be centre stage in any agreement and run through everything we do –including the funding arrangements for AHSNs.

## 1. Introduction

The Board agreed In January that UCLPartners would provide a common enabling/integrating function across the partnership for health improvement and wealth creation for UKPLC through the delivery of a series of programmes that bring together the various functions created by the National Commissioning Board (NCB), National Institute of Health Research (NIHR) and Health Education England (HEE) to create more efficient alignment of resources:

- Discovery through to "first in man" (AHSC)
- Participation in clinical trials (CRN)
- Implementation innovation into practice (AHSN)
- Evaluation Applied Health Research (Health Improvement Science (HIS) and Collaboration for Leadership in Applied Health Research and Care (CLAHRC))
- Education and training (working with the Local Educational Training Boards (LETBs))

# Clinical and academic pathways and levers



Trusts Relationships Alignment Outcomes

This is in contrast to other regions where the various functions have been separated out, and report separately to the national oversight body.

Our intent is to secure a number of income streams to provide partners with at least £5 income for every £1 invested. We have previously agreed at the Board that 70% of the founding partner contributions will be allocated to the AHSC. Other funding principles including AHSN income will be no more than 49% of total income; the CRN and CLAHRC will be funded by NIHR and hosted by an NHS partner; and Education will be funded principally by the LETBs.

When partners request a specific activity to be delivered (e.g. major unfunded projects such as A&E optimisation), additional partners' contributions will be secured.

# 2. Board Reports

## 2.1 Discovery through to "first in man" report (AHSC)

The DOH published the process for AHSC reaccreditation on April 12<sup>th</sup>. The call specified that the defined role of the newly designated AHSCs will be to increase strategic alignment of NHS providers and their university partner. Their focus is on world class research, health education and patient care, in order to improve health and healthcare delivery, including through increased translation of discoveries from basic science into benefits for patients. AHSCs will be able to realise their potential as drivers of economic growth through research partnerships with commercial life science organisations. The criteria for designation go well beyond the implied focus on discovery through to first in man –linking strongly with implementation, education and clinical quality (more akin to Johns Hopkins model). The published criteria for AHSCs characteristics will include:

- strategic alignment of NHS provider and university objectives;
- the highest volume, critical mass and world-class excellence in basic medical research (much of this determined by DoH commissioned metrics);
- the ability to translate findings from basic research into excellent translational, clinical and applied research across a range of interests;
- ability to translate scientific advances into patient benefit, in order to improve patient care and healthcare delivery;
- excellence in patient care;
- excellence in health education;
- strong partnership governance;
- strong clinical informatics platform to underpin the delivery of AHSC objectives;
- strong track record of, and capacity for, productive research collaborations with the life sciences industry and contribution to economic growth;
- strong patient and public involvement and engagement.

The PQQ also includes traditional NHS metrics such as the annual in-patient survey, mortality data, Dr Foster etc, as well as financial stability.

Prof Sir John Tooke is leading preparation of our bid for re-designation on behalf of the Partnership.

## 2.1.1 UCLP: Academic Health Science Centre

UCLP was accredited as one of the UK's five AHSCs in 2009 and has evolved as a large, inclusive partnership, noted for its impact on service reconfiguration and for a number of programmatic project successes. It has created a template for a national system of Academic Health Science Networks designed to facilitate the diffusion of innovation and contribute to economic growth as well as population health gain. UCLP's standing as the model for AHSNs is a considerable achievement but carries with it, as AHSC reaccreditation approaches, the risk that it will detract from our success as a Centre.

This is particularly relevant given the international nature of the panel likely to be judging the reaccreditation process as they are more familiar with the American Academic Medical Centre model involving tight links and often unitary governance between elite hospitals and universities. The challenge then for UCLP in the run up to AHSC reaccreditation is to redefine our AHSC component, to provide evidence that our interpretation is the most successful, and in particular to demonstrate that our large and diffuse partnership has achieved more than the sum of its parts both in terms of conventional academic metrics and high impact 'stories'.

### 2.1.2 UCLP emergent thinking on the role of an AHSC

The goals of an AHSC in many ways are identical to those of an AHSN: harnessing academia to translate discovery into population health gain. The objectives of the two can be broadly distinguished according to the AHSN's primary focus on research 'delivery', alongside the AHSC's focus on discovery and generation of research 'evidence and engagement'. There is no doubt that the Biomedical Research Centres (BRC) and Biomedical Research Units (BRU) – which occupy a critical part of the innovation value chain (experimental medicine, involving proof of concept in human subjects) – are a key driver of AHSC activity. But a contemporary AHSC must be much more than that, if it is to attend to the evolving nature of health challenges.

As Dzau has pointed out<sup>1</sup>, demographic shifts, the rise of chronic disease, the role of health related behaviour, and the increasing role of the physical sciences and data synthesis demand many more constructive links with multi-faculty universities if the full potential of the academic health alliance is to be realised. In this regard UCLP's wider academic partnership and excellence in other faculties (for example in Economics, Law, Computing, Maths and Physical Science) offer a considerable advantage over other Centres that involve a more limited and conventional array of disciplinary excellence.

Another key role of a contemporary AHSC is to play a much more deliberate role in the generation of new therapies and diagnostics. It is widely recognised that the old Pharma model of drug development is no longer fit for purpose. Pharma (and MedTech) are now looking to partner with academia to draw on its expertise in understanding the nature of disease and the identification of therapeutic targets. Responding fully to these new opportunities not only supports the primary mission of the AHSC/N but will also appeal to national judges of our performance, given the

<sup>&</sup>lt;sup>1</sup> Victor J Dzau, D Clay Ackerly, Pamela Sutton-Wallace, Michael H Merson, R Sanders Williams, K Ranga Krishnan, Robert C Taber, Robert M Califf (2010), *The role of academic health science systems in the transformation of medicine*, The Lancet, vol 375, pp 949-953

primacy given to initiatives that stimulate economic growth, including retention of the pharmaceutical industry in the UK.

#### 2.1.3 What we said we would do

Our original application for an AHSC describes not only a number of objectives that still remain pertinent today, but also a range of structures that were more relevant to the limited range of the original partnership.

The clinical academic programmes have pursued specific project based objectives but a coherent approach to driving forward the translational pathway, particularly the first 'Gap' (discovery to proof of concept), and mustering the full research strength of the partnership requires a different focus and drive.

In terms of partnerships as well as pathways of care and quality (value), we can evidence a strong performance, which underpins our AHSN status, although outcome measurement (apart from in cardiovascular) and quality accounts are very much a work in progress. We expect that in our fifth year we will publish our performance against international benchmarks.

In the education field our position as a leading provider of PGMET in London and the strength of our emerging LETB evidences real progress. The fact that we involve two strong medical schools is a special feature but again we will need to evidence the added value. Our capacity to provide integrated clinical academic training is probably unrivalled.

It is sobering to review the one, three and five year objectives we set ourselves. Only now are we gripping the integration of research governance and integration of Clinical Trial Networks (CRN) / Clinical Trial Units (CTU) (year one objectives). We also promised to co-locate cardiovascular scientists and clinicians in a 'new build' in 3 to 5 years, an aim that is tantalisingly close to being realised. However, the application process makes it clear that this is a new challenge not a judgement on our past performance.

2.1.4 Our strengths in population health, applied health research and mental health have burgeoned. Very constructive joint working to develop our CLAHRC bid augurs well for added value in this area, which a successful bid would endorse. Moves are being made to strengthen and unify industry links not only through our partnership but across London.

#### What we have done

The following is a limited illustrative list of relevant achievements, and evidences significant achievements upon which to build:

- Medical Research Council (MRC) CHAPTER award: Designated as one of only four e-health/informatics centres for the UK, involving UCL, QMUL and LSHTM, providing inter alia a critical part of the architecture necessary to execute the government's 100,000 genome initiative.
- UCL's new Faculty of Population Health Sciences, bringing together arguably the largest grouping in these disciplines in the UK.
- UCL's and LSHTM's designation as part of the National School of Public Health Research.

- Growing links with LSHTM with joint activity in health economics, genetic epidemiology and pathogen research.
- Promotion of Pan-London Improvement Science.
- Development of a joint QMUL / UCL competitive bid for a BHF (British Heart Foundation) Cardiovascular Research Centre of Excellence.
- Imminent integration of the MRC CTU into UCL, creating the largest collection of clinical trials methodological expertise in the UK.
- Formation of a joint Institute with Oxford (Centre for Advancement of Sustainable Medical Innovation) to promote a new holistic approach to drug and device development, drawing on the whole range of academic expertise. Advisory Board Chaired by David Cooksey, with Sally Davies and senior FDA representatives as members.
- Renewal of all UCL and QMUL BRCs/BRUs with funding enhancement for Moorfields and a new dementia BRU.
- £20m award from the Wolfson Foundation to establish an experimental neurology centre.
- Major growth in proof of concept funding including lead winner of MRCs 'confidence in concept' fund.
- QMUL's prime site link with Quintiles.
- UCL's 5 year agreement with Eisai regarding co-development of new neurological therapies.
- Imminent contact with Stevenage Bioscience Catalyst to establish project presence in the incubator adjacent to GSK.
- Host of 2 of only 10 worldwide Drug Partnership Units with GSK.
- Formation of Imanova, joint company with Kings College London (KCL), Imperial College (IC) and MRC to use PET to develop new diagnostic ligands in conjunction with both industry and academia.
- Lead sponsor of rare diseases initiative across the GMEC partnership.
- Formation of a cardiovascular devices innovation initiative as part of the Yale / UCL Collaborative.

# 2.1.5 What must we do to prepare for reaccreditation and prepare a distinctive vision of an AHSC and its achievements?

- Board level agreement on what constitutes a distinctive vision and its promulgation.
- Governance and oversight: Formation of a core group to oversee the process of reaccreditation.
- Research Sub Board to adopt a systematic approach to overcome barriers to translation (Gaps 1 to 3).
- Secure critical objectives: Review plans made at inception and identify critical objectives requiring imminent delivery e.g. achieving a single cardiovascular centre and harmonising R&D approval.
- Identification of areas of best practice across the partnership e.g. translational research offices, academic careers office – to reveal opportunities for short term gains in other partners, working to a common purpose
- Resolve further the academic strategies for cancer and cardiovascular demonstrating the added value for early phase work as well as the evident clinical quality and teaching gains.
- Communications: Development of a comprehensive communications strategy to evidence our AHSC achievement and our distinctive vision in advance of the

reaccreditation process. This should identify existing and emerging exemplar initiatives to frame the narrative of the AHSC reaccreditation application and demonstrate a commitment to the wider UK life sciences and wealth generation strategies, raise our global competitiveness in Intellectual Property (IP), and highlight translational successes gained through partnership working and industry engagement.

 Core metrics: Rapid development of core metrics to evidence both growth in academic activity and industrial engagement but also the added value derived from the wider partnership. Metrics should underpin UCLP's core messages as well as provide examples to demonstrate an accessible and delivery-focussed narrative for UCLP.

A working group to include the five BRC and BRU leaders and the Programme Director of Immunology and Transplantation has been established to foster increased collaboration and support the AHSC bid. There will need to be strong involvement of the Founding Partners – both HEI leaders and Trust CEOs throughout the development of these proposals and at the designation interview.

It is crucial that we use this process to bind all of the existing founding partners (which are themselves "Academic Medical Centres" in the sense of this application) together through the single bid, and support each other, showing true added value at every step. They will need to understand how our relatively large AHSC partnership works and delivers much more than the sum of its parts. We will also need to consider our relationship with LSHTM carefully: Professor Tooke will give a verbal update on this to the Board.

The UCLP board will be provided with an update of the progress for the re-bid for accreditation on July 23<sup>rd</sup>.

**Risk to UCLPartners:** Failure to maintain accreditation would significantly undermine the company's reputation and damage the reputation of the founding partners. AHSC status recognises the strengths of the UK's most prestigious academic clusters which support the recruitment of academics with global reputations for excellence encouraging them to work with us. It also supports grant income applications.

Risk mitigation: partnership working and swift establishment of governance to ensure co-development of optimal bid

#### 2.2 Participation in clinical trials report (CRN)

**Harmonisation**: The NE & NCL CRN has made substantial progress as a national pilot site for Harmonisation of Permissions for commercial trials across all North East London (NEL) and North Central London (NCL) providers, with Prof Nick Lemoine leading on these changes on behalf of UCLP. The work on single permission for any given study rather than sequential negotiation and approval with each provider separately is already providing peer pressure and competitive advantage. The UCLP Trials Harmonisation Programme has made effective progress to achieving the target of granting permissions within 30 days.

Progress by Permission Site to date 30 Day Metric (SSI Validation to NHS Permission):

- Barts Health Permissions Centre (PC) Total: Mean 16, Median 10, Range 0-67
- Barts Health PC Corrected for Status Change Requests metric clock stopped for issues outside of permission centre control – responses from regulatory authorities: Mean 9, Median 6, Range 0-32
- UCLH PC Total: Mean 34, Median 34, Range 3-65
- UCLH PC Corrected for Status Change Requests: Mean 10, Median 10.5, Range 1-22

The pilot has unearthed a number of issues which are being addressed:

- Costing acceptability to Industry partners due to application of inner London Market Forces Factor (MFF) to all sites could lead to loss of business: Permission centres are now able to negotiate costs within the parameters of inner and outer London MFF;
- Capacity of Pharmacists to deliver commercial clinical trials within timelines:
   Review of WTE Pharmacist availability, training to increase number of trained clinical trial Pharmacists;
- Industry partners not responding to queries and entering projects too early in their development. Potential to cause breaches of turnaround metric: Communications and presentations to Industry partners explaining how to use harmonisation effectively. Working with NIHR Industry team to re-frame how Industry prioritise studies by asking when they need permission to be in place and working back from that date.

Clinical Research Network (CRN): Progress on harmonisation has underpinned the designation of UCLP as the national pilot site for rationalisation of CRNs from April 2014 (from >100 to 15, broadly 1 per AHSN). UCLP needs to select a single host for a single CRN to serve UCLP from April 2014. The DOH/NIHR criteria dictate that Barts Health and UCLH are the only viable potential NHS hosts.

The UCLP Executive agreed that only one bid would be submitted from the partnership. A single CRN, including the various current topic-specific networks, for each AHSN geography to maximise trials performance makes a great deal of sense for delivery and will produce some administrative savings (of the order of about £1-£1.5m p.a). Most of the budget goes on direct support staff for trials. The real gains will be in more efficient studies, better recruitment and therefore more trials being done across the partnership (competitive advantage for UKPLC).

A set of key principles have been prepared to inform the approach

- If we do go to a more "centralist" model of approvals through one hub, the NHS host Trust should not dictate the location of the administrative staff; they should be allocated across the system to optimise delivery. Relationships and engagement will be key, and with whatever structure we have for themes, we will need support for engagement in all 4 major geographic sectors of UCLP (possibly as deputies to the medical director) it is about themes, and with geography, wide local engagement. To make this work, engagement and relationships will be everyone's relentless responsibility.
- The degree to which physical centralisation of such staff is required is uncertain - we may continue with a matrix model of site working as we do now with the 4 thematic permission centres, which have much improved the way we work and are starting to show better results for commercial trials.
   Whatever the degree of centralisation for NIHR portfolio studies there will

- need to be continued arrangements for the significant numbers of non NIHR portfolio studies which are often managed in combination with NIHR studies rather than separately.
- With the existing local Trust management of non-commercial NIHR portfolio studies NIHR has local redress for noncompliance. With the more centralised system that redress would need to move appropriately i.e. to the accountable officer/host for the CRN.
- Across the whole partnership (including Essex & Hertfordshire (E&H)) at least 200 staff will be affected in some significant way though we can and should keep the disruption down by only moving employees when essential. This also spreads the risks if in the future the funding is withdrawn –otherwise the host carries a major redundancy liability if the system changes in the future or trials work declines. Whatever the hosting arrangements and the chosen model, an inclusive, constructive entity with transparency of funding flows and a positive staff team culture is key to success, and this all takes time and effort to build.
- The CRN budget has to pay the reconfiguration costs including any redundancies. There will probably be a handful (5-10) less managerial posts than people applying (but the exact number needs to be clarified) hence the administrative saving.
- All leadership appointments need to be independently evidenced either through NIHR or UCLP support for the HR processes. Rebecca Graham (UCLP Director of HR) can provide HR support from UCLP for the key appointments unless dictated otherwise to be NIHR itself. There will be new leadership roles. It will add to trust and legitimacy in the partnership amongst the clinical academics to engage beyond one Trust HR appointment process alone. Usually these need to be skilled-based only but there may be some ring-fencing to the composition of senior teams to ensure stakeholder buy-in across the whole geography.
- An independent finance officer should "oversee/audit" any transactional changes to assure fairness to all the partners. Janet Pressland (UCLP Finance Director) can do this. There is significant disentangling and reallocation of budgets to support clinical trials. This should not disadvantage any Trust and the additional £3m this year will make the process easier. Some Trust posts will no longer be supporting clinical trials (which have finished) and some posts will be supporting clinical trials but will not yet be funded through the CRN. This will need tracking and resolving. The total budget across all of UCLP will be circa £25m.
- CRN payments and Trust liquidity: the host trust should not gain by slowness to release cash to partner trusts. This applies especially to funds flowing to Essex and Herts partners who currently receive payments from E&H CRN monies held locally. The host applicant will need to set out the processes before the application is submitted so they get partnership-wide support. Some Trusts have expressed concern that they would lose out on the additional liquidity as NIHR have previously paid the host Trust upfront either quarterly or annually, especially in Essex where the E&H money is currently held locally. It is likely NIHR will pay in arrears in the future reversing this issue.
- If the rules for Support cost for research (SCR) funding change such that CRN
  hosting attracts SCR funding in the future (it does not currently) there would
  need to be an agreement in advance that any such gain would be distributed
  to partners based on the trials activity rather than to the simple NHS host
  Trust. There will probably continue to be a small management reimbursement
  for host HR and finance support but no significant overheads as host.

Specifically funds flow to all partners according to activity costs with an 8% overhead currently. This may increase to 10% for the transition year to ease the challenges. It is the same rate for host and non-host partners. The cost reimbursements for staff will go out to whichever Trusts have the staff working in them so this is not a factor. Currently hosting a CRN does not attract NIHR SCR payments to the host but the rules could change creating an unfair windfall gain for the host based on other partners' activity.

The advice of the current Central and East London CRN Chair (David Sloman), endorsed by the CEOs of Barts Health and UCLH, is that for our partnership, and to build trust, we should ensure a balance of board roles i.e. that the Chair and Medical Director are from different components/geographies of the partnership, and probably that the MD and COO likewise do not have hold primary contracts with the same organisation.

The CEO of the host organisation will be accountable both to the peers in the AHSN and to NIHR. There is concern that having the Medical Director from the same geography will create too much imbalance and it would be better for stakeholder engagement if these two leadership posts are from different partners and different sectors/geographies. The split of an independent chair from the "accountable" host Trust CEO has not worked optimally for us to date. Whatever arrangement we agree needs to encourage partnership and satisfy effective balance and challenge. It is clear that the Medical Director will need to hold a proper contract with the host Trust for the CRN function irrespective of his/her substantive employer.

UCLH and Barts Health based bids would be equally strong. However, given that the existing CRN is hosted at Barts Health and is leading the major current change programme for trials approval and support as a national pilot the success of which will be crucial for our AHSC bid, it is recommended that we continue with BH as the CRN host.

**Risk to UCLPartners:** Aligning clinical research networks across the system will be a real test of partnership and the CEOs of BH and UCLH will need to build Trust across their organisations and the whole partnership Failure to deliver in a collaborative way will damage the culture of UCLP and our reputation at NIHR.

Risk Mitigation: partners to support the designation processes, and founding partners commit to the underlying principles described above.

## 2.3 Innovation into practice report (AHSN)

We submitted our AHSN prospectus in November 2012, and were the first applicant to be interviewed (3<sup>rd</sup> December 2012). All prospective AHSNs nationally have now been interviewed by the designation panel. NHS in England are currently reviewing the designations, funding and licence arrangements – the expected launch of the programme of 15 AHSNs nationally is May 2013 with up to three tiers of approval.

AHSNs will be required to have a strong focus on delivery of innovation into practice to support UKPLC (wealth, jobs) as well as more effective healthcare delivery, through enabling implementation of NICE guidance and other nationally agreed high impact innovations across whole partnerships, and working closely with related CRNs to improve delivery of clinical trials and global market share of biomedical investment.

Creating wealth is a greater cultural challenge than improving health and a framework has been developed to further define the concept of wealth creation:

#### **Wealth Creation**

We aim to support UK wealth creation through specific industry collaborations, creating new jobs, bringing economic investment into the UK and return on that investment for exportable solutions. Wealth creation is also realised by releasing savings through improvements in productivity, increasing adoption of innovations (e.g. NICE), helping support growth in life sciences and indirectly, by improving the health of our population, to increase work-force productivity.

#### **Examples Outcomes** Quintiles Industry investment (£ income **Collaborations GSK** for Fragility invested by industry to support with industry AHSN programmes) (reducing secondary Research income (£) Increase in participation in fractures for pts with osteoporosis) research (%) Seminars to build Patient benefit specific to relationships---projects ---(Essex) Sales (£) generated from MedTech **Exportable** commercialisation of AHSN IT platform solutions supported/developed Innovation technologies and services capacity Reducing Improved workforce **Economic** absenteeism in productivity productivity schools Boost growth in life Supporting science industry (link to adoption of NICE) innovation e.g. NICE techs

A cross cutting approach has been established to create "exportable solutions". At least two new businesses will be created over the course of the 5 year licence to create and commercialise innovation, initially in Medical Technology and Informatics.

The principle behind these businesses is to seek investment from a commercial partner and from an independent investor to multiply investment from AHSN funds by at least 3 times. The new companies will combine the commercial capabilities of the commercial partner with UCLPs ability to create collaborations within the health system to improve health and create wealth. UCLP will invest in these businesses during the term of the AHSN licence with a target for the businesses to be self-standing by the end of the 5 year licence.

For Medical Technology, UCLPartners (UCLP) and PA Consulting Group (PA) have developed a draft business plan to establish a new company to translate innovation into practice in order to improve health and create wealth. The company will put patient interests ahead of commercial interest and at same time draw on models of best practice and novel methods to deliver innovation to patients more effectively and in a financially sustainable way. The proposal is to set up a new legal entity jointly owned by UCLP, PA and other financial and/or industry investors. The core services delivered will lead to the creation of a number of project assets which will be part owned by the entrepreneurs, the company and financial/industrial investors. A full business proposal will be brought to the Board for consideration on 26<sup>th</sup> October.

For Informatics, UCLP has selected and is currently in discussion with two companies Arihidia and Concentra to select the best partner. The target is to develop a novel business model by 2013/14 year end with a view to a full business plan coming to the Board before the financial year end 2014.

**AHSN Progress Report**: We have secured £500k from NHS London to support mobilisation of our plans. Working at a system level UCLP has already supported our partners to deliver health outcomes which are meaningful to patients:

- "Year in the Life" COPD initiative, now run across 188 primary care practices and trusts in Outer North East London (ONEL). It involved linking education to regular data-feeds of comparative performance on dimensions of quality spanning diagnosis to admission, derived from NICE quality standards for COPD and PDSA change cycles. At the start of the work, variation across GP practices was 5-10 fold or more on most metrics. Quality of care increased 20% or more across all key dimensions of COPD care. The most marked increase was in the number of patients with a self-management plan, which has tripled. Total costs initially rose due to increased diagnosis (increasing patient numbers), and then fell due to reduced admissions (around 80% of total cost of COPD care is in hospital-based care). Overall, total monthly cost per practice of COPD care was £750/month lower at year's end.
- Deteriorating Patient collaborative was formed in 2011 to deliver an improvement-centred, measurement-focused, collaborative learning approach. Its aim is reducing avoidable cardiac arrests by 50% from 2011 baseline (an important aim for reducing mortality and linked to the organisations' Summary Hospital level Mortality Indicator (SHMI) / Hospital Standardised Mortality Rates (HSMR) performance). Active participation now extends beyond the original 6 NCL trusts UCLP-wide to 15 acute trusts spanning Anglia Ruskin Health Partnership (AHRP) / Essex, Luton & Dunstable, West Herts and NEL. Of the original 6 trusts, 4 achieved reductions in arrests of at least 45% by Q1 2013.

We set out our first 100 days deliverables in the Prospectus, progress is reported below:

Goal	Initiative	Status	Comments
Local Initiatives	Earlier diagnosis of	AMBER	Trust started to collect data in January. 220
	cancer, working in		patients have been identified. The number
	partnership with		of patients identified has been lower than
	primary care and		expected due to lack of Trusts engagement
	public health: release		and the lack of systems to extract the data.
	of novel whole		Patients will be well characterised within
	pathway audit for		100 days but there remains a risk that

Goal	Initiative	Status	Comments
	patients presenting to A&E with cancer		primary education will be delivered late.  We have 11 secondary care sites live on this audit since November 2012, and at the end of March reported initial findings on 220 patients to our partner trusts, the Department of Health (who part-funded the study), 10 of our local GPs and 4 CCG representatives. We are looking at increasing recruitment through roll-out of our informatics phase of the study in April, and patient interviews begin in May 2013 (up to 40 to take place in total). A learning and sharing event for secondary care, primary care and patients will be held on 30 May 2013.
	UCLP Deteriorating Patient initiative: saving and improving lives through collaboration across trusts and reliable delivery of care	GREEN	<ul> <li>Deteriorating patient is now active in all 15 acute trusts across UCLP toward the aim of 50% reduction in cardiac arrests vs baseline through collaboration and systematic application of improvement. The clinical fellow focusing on Essex (Dr Charlotte Hopkins) is now in post, with initial focus on Basildon. On 16 April hosted an Experience Day at BMJ/IHI International Forum in Quality &amp; Safety attracting over 60 participants from Europe and beyond.</li> <li>Extending focus to include Treatment Escalation/Thresholds: highlights include-successful application for Darzi fellow (hosted by Camden CCG) to lead work, linked to frailty pathway (with successful Darzi fellow application, hosted by BHRUT). The group is currently mapping the pathway, developing measures and scoping possible interventions</li> <li>The UCLP Deteriorating Patient was presented at AHSN Masterclass on innovation diffusion at the Healthcare Innovation Expo 13-14 March and was well received.</li> </ul>
Increasing the participation in research	A UCLP Research Office is opened  The Quintiles Queen Mary Prime Site has expanded to reach across the Academic Health Science Network	GREEN	The Harmonisation project is on track to deliver its objectives. The CRN project timelines and size of the change management task mean this objectives needs to be revised.  The QM Quintiles Prime site contract has been varied to provide preferential access to global studies to all UCLP Trusts. Quintiles are investing in building capability at Royal Free, Moorfields and Barking.
Compliance with NICE Technology Appraisals	Bone health closer- to-home service for	GREEN	<ul> <li>Collaboration agreed with Amgen.</li> <li>Chris Gallagher (our Chemo Chair) has persuaded Barts Health to finance the use</li> </ul>

Goal	Initiative	Status	Comments
	people with cancer being evaluated		of denosumab for breast patients (TA265) as of now, CCGs are aware. Trust guidelines written and only frontline staff training outstanding, and roll out expected over the next month. We have scoped usage across the rest of London Cancer, but are working on agreement with CCGs (via the CSU initially) to progress on other sites. Aim to take forward UCLH in May 2013.
	New anticoagulation service for patients being tested	GREEN	Atrial Fibrillation / Anticoagulation: UCLP has been selected as the national pilot for a Nice Implementation Collaboration to establish a population scale implementation program for adoption of a novel anticoagulant for stroke prevention in AF patients. We have secured £590,000 from Camden CCG to support a local project to detect and treat AF in Camden.
	2000 staff trained in dementia care and Shared Decision Making framework developed for memory clinics	GREEN	<ul> <li>1000 staff members trained across the partnership have been trained in NICE Dementia Quality Standards and are on course for 2000 by end of July.</li> <li>Shared Decision making in dementia: Held our launch education event with 57 attendees and agreed to measure the implementation of SDM in patients with a new diagnosis of dementia in memory clinics. Design event takes place end of April to review first set of data.</li> <li>Behaviour change course launched with 26 funded delegates from across the partnership, including acute, mental health, public health and commissioners. Good feedback on first 2 weeks.</li> <li>GP Mental Health Leadership in commissioning course completed. This course will now be franchised across UK to meet requests for the course nationally. Funding secured to continue to support development of GP MH commissioning leads in London, with possibility of extending this to MH SCN.</li> </ul>
Wealth creation – commercialisation of specific products/services in partnership with industry	A globally competitive centre for cardiovascular research and clinical services is agreed	AMBER	<ul> <li>Service reconfiguration proposed for public consultation (see separate section). BHF Research Excellence Award: we have received notification that the bid was unsuccessful. We need to develop and describe the academic strategy to align with the AHSC process and planned service reconfiguration as a matter of urgency</li> <li>Root cause analysis of CVD events – £525,000 in total has been confirmed from Camden CCG and the steering group met 5th April. Second wave sites have been identified (Enfield and Southend) and we are working with the CCGs to identify management capacity required and funding.</li> </ul>

Goal	Initiative	Status	Comments
			<ul> <li>A further £350,000 in this year has been secured to complete the analysis in the Olympic Boroughs.</li> <li>Heart Failure: an agreement in principle has been reached to treat UCLPartners as a preferred recruitment site for Novartis clinical trails for Seralaxin. UCLP will work with Novartis to shape the implementation of a phase III study</li> </ul>
	3 Million Lives Pathfinder Project at UCLPartners has enabled the delivery of novel ambulatory blood pressure monitoring to serve a community	AMBER	Alignment with Camden CCG has taken longer than anticipated.
	A UCLPartners MedTech Accelerator is launched	GREEN	See wealth creation section 3

#### **Risk to UCLPartners:**

- High expectations for delivery with reduced funding (initial indication circa £1m/million population, i.e. probably 50% less than original assumption). It is important that as much of the funding as possible is applied to frontline delivery
- Ensuring we continue to work as an agile/creative horizontal enabler for patient and population gain, embedded within partner organisation and with a small central team, and avoid NHS culture for central control/over-administration

Mitigation: Hire high quality core team and focus on enabling our partners work.

#### 2.4 Applied Health Research Report

**CLAHRC:** UCLP is sponsoring a bid for NIHR funding which comes with designation as Collaboration for Leadership in Applied Health Research and Care. It will be hosted by Barts Health on behalf of the partnership. The combination of applied health researchers across the partnership reflects one of the strongest groupings in Europe, and we expect them to submit a forefront bid. There has been good engagement across the NHS partners and the bid has been supported by 29 letters of support from partners so far.

If successful the funding would be circa £2m p.a. from 1<sup>st</sup> January 2014 and would enable both local evaluation and wider learning from our experience.

A proposal to improve health outcomes through education and research for the population in the Olympic boroughs and to diffuse best practice developed across

London and the UK is also being prepared.

**Risk to UCLPartners**: Failure to win CLAHRC bid. *Mitigation*: develop complementary approach to strengthen applied health research through Health Improvement Science and the Sir Ludwig Guttmanm Health & Wellbeing Academic Centre.

**Sir Ludwig Guttmann Health & Wellbeing Academic Centre:** As members of the Strategic Partnership Board, UCLP was asked by the former NHS North East London and the City to develop an academic proposal for a centre based at the Sir Ludwig Guttmann Health & Wellbeing site ("The Centre").

UCLP has engaged with universities and NHS providers to review potential opportunities for the Centre that will contribute to the health improvement of the Newham population, assist in driving innovation in local service delivery, and contribute to the health legacy of the 2012 Olympic and Paralympic Games for East London.

The vision is to develop a centre for applied health research and education focussed on meeting the needs of the local population of the Growth (former Olympic host) Boroughs, as part of the Olympic legacy. At the core of the centre will be community engagement and knowledge sharing where the community can engage with researchers, health professionals and educators in an informal environment to encourage cross-directional exchange of ideas and knowledge, which will provide the driver for further innovative projects led by the Centre.

The Centre will address the needs of the whole population and apply learning from exercise and sports medicine to improve health with a particular focus on those with disabilities and particular needs. It will take a locally owned, population based approach to research and education, aligning these with innovations in service delivery to address the needs of the people in the immediate area.

Over a period of 5 years, the Centre will develop to become a distinct site of excellence for population research testing and for evaluating new ways to deliver health provision. £1million has been secured by UCLP on behalf of our partners to cover the costs of establishing the centre.

#### 2.5 Education and Training Report

UCLP is supported by two LETBs - one for North East and North Central London, and one for Essex, Herts and Beds partners via the East of England. Both have strong and effective Boards.

There are already strong collaborations across the two AHSC and AHSN functions supporting partners, and the strengthening biomedical corridor between London and Cambridge. We will need to ensure similarly strong collaboration/alignment between the two LETBs.

For inner London there will be specific challenges relating to tariff changes for education affecting NHS partners, and in the medium term inevitable pressure to reduce the scale/ number of HEIs providing health education in London.

**Risk to UCLPartners**: For inner London there will be specific challenges relating to tariff changes for education affecting NHS partners, while creating new models of

training required for the future.

Mitigation: LETB MD to work with Trust CEs to mitigate the impact as much as possible

#### 2.6 Integrated Programme Report – Highlights for the board

Five integrated programmes have been identified to connect research, education, wealth creation, informatics and implementation of clinical innovations: Cancer, Cardiovascular Disease, Mental Health, Life-Course (maternal, child and teenage health) and Co-Morbidities. These integrated programmes create and support collaborative projects with members of the partnership. Each programme will include all 5 levers outlined in section 1.

The Cancer, Cardiovascular Disease and Mental Health Integrated Programme strategies have been reviewed and endorsed by the UCLP Executive. The infrastructure to deliver the Cancer Programme was established during 2011. The infrastructure to support Mental Health and CVD will be completed by June 2013. The Life Course Programme and Co-morbidities Programme strategies will be discussed at the Executive in September and progress reported to the Board in January 2014.

Cross cutting programmes are being developed for Quality and Value, Innovation, Research, Education and Informatics.

#### **Cancer Programme Report:**

• The London Cancer integrated system has, through extensive engagement and inspiring clinical leadership, built consensus across partners and commissioners agreeing that centralisation is absolutely necessary for an effective strategy for highly specialist cancer services and to optimise functional outcomes for patients. The cancer care, which is split into five pathways (in addition to changes in urological cancer already recommended), will be designated to preferred centres by the London Cancer Board by July 2013. Current status is detailed in Appendix 1.

#### Cardiovascular (CV) Programme Report:

 Heart Centre of excellence: An agreement in principle has been reached to relocate the UCLH Heart Hospital to Barts to create a world class centre of excellence. Clinical Academics have developed outline proposals to enhance academic and health outcomes for each specialist CV area. A Programme Board is being established to lead implementation (see above).

#### **Integrated Delivery of Specialist Services Programme Report:**

 The Chief Executives of the Trusts most impacted by specialist service reconfiguration have elected to create a Programme Board, chaired by the London Regional Director of NHS England. This Board would oversee coordination of the transactions necessary for the delivery of both the specialist cardiac centre and designated cancer specialist centres, including development

of a single provider in radiotherapy. It will report monthly to the UCLPartners Executive. The Board would include the specialist commissioners and the most affected Trusts (RFH, UCLH, BH, NMUH and BHRT).

NHS England has agreed one joint consultation process for cancer and cardiac.
 A letter indicating this should be received later this week. If required, any consultation or engagement exercise will begin on or around 02/9/2013 (Appendix 1 provides a detailed update to the Board on Cancer Service Detailed Reconfiguration).

#### 2.7 2012-13 Financial Update - Janet Pressland, Finance Director

The 2012-13 financial year end process is underway with draft accounts expected to be completed by the end of April, for submission to auditors in May, and approval by the Board in July 2013.

It is anticipated that the final accounts will show achievement of UCLP's key financial target to break-even. There will be, however, significant deferred income due to UCLP being successful in a number of funding bids before the year end. These include:

- Sir Ludwig Guttmann Health & Wellbeing Centre infra-structure proposal -£1m
- Cardiovascular provision roll out in the Olympic boroughs £500k
- London Cancer commissioner support for 2013-14 £560k
- Mental Health primary care network development programme £183k
- Reduction of emergency admissions at Whittington Health grant £150k
- Enabling of AHSN grant £500k

As a consequence of some of these being paid already, our cash position at year end was equally healthy with a cash position of £3,591k

Appendix 1

#### **Cancer Service Detailed Reconfiguration Update to the Board**

*Urological Cancer Surgery:* The first of *London Cancer's* formal recommendations on the consolidation of specialist cancer surgery related to a single centre designation for bladder and prostate cancer at UCLH and renal cancer at RFL has been submitted to the commissioners. They will review the recommendation, along with feedback from the engagement, with a view to making a decision in the week commencing 6<sup>th</sup> May 2013.

*Gynaecology & Hepato-Pancreatic Biliary Cancer*. These specialist services have already centralised to two sites and further physical centralisation is not seen as helpful for patient care/access.

Head and Neck Cancer (excluding Thyroid): The service specification has been completed and will be circulated with a request for expressions of interest from partners in April 2013.

There are strong recommendations for necessary co-locations, and we anticipate that there may be only one expression of interest received for the single specialist surgical centre.

Haemopoietic Progenitor cell Transplant (Bone Marrow Transplantation): The London model of care is clear on a maximum of 2 adult BMT units instead of the current 3; London Cancer supports this recommendation, especially in the context of decreasing numbers at one site. An open event to discuss the model of care for the future is being held on 23<sup>rd</sup> April 2013.

*Brain/CNS Cancer*: For Brain and CNS tumours, a maximum of four centres providing neuro-oncology surgery for London is proposed. This equates to one centre serving the population of *London Cancer*, with BHRUT continuing to provide the regional specialist centre for Essex. The Pathway Board is developing their specification for the whole pathway, including the specialist centre, for the end of May 2013.

Oesophageal-Gastric Cancer: There is much clinical and organisational concern expressed in this pathway about proposals to consolidate surgical services. There is a call for expressions of interest by May 2013.

*Thoracic Surgery:* This specialty carries a risk that the recommendation might not be fully resolved by September 2013 in time for the critical path for public engagement/consultation.

Radiotherapy: London Cancer has proposed a new approach to the way radiotherapy is delivered across the NC and NE London to improve access to advanced therapy and ensure sustainability.

Tumour Type	Approximate Patient Numbers (% of total)	Current Providers	London Cancer recommended number of sites	Timeline for development of clinical model (specification)	Timeline for agreed site	
Oesophago- Gastric	150 20%	3 BH (RLH) BHRUT(QH) UCLH (UCH)	1 or 2	Early April 2013	Jun-13	
Head & Neck (excludes thyroid)	250 Dependent on model	3 BCFH(CFH) BH(RLH) UCLH(UCH)	1	Completed. For expressions of interest April 2013	Jun-13	
Brain & Central Nervous System	625 79%	3 BHRUT(QH) UCLH(NHNN) BH(RL)	2 1 for London 1 for Essex	May-13	Jun-13 (Inner London site)	
Lung Cancer (thoracic surgery)	195 (<20%)	2 UCLH(UCH) BH	1	End May 13	Jun/Jul 13*	
Haemopoietic Progenitor cell Transplant	340	3 RFH BH UCLH(UCH)	2	End May 13	Jun-13	
Gynaecological Cancers	The London Cancer Board has accepted the clinical recommendations of the Pathway Directors in these two tumour types (HPB and Gynaecology) that the					
maximum improvement for patient outcomes and experience is through building a single service delivered across two sites surgery.						
Cancer						
Colorectal Cancer	In Breast and Colorectal cancer there may be future consideration of the patient benefit to sub-specialise for some specific sub-groups or parts of the pathway, to be determined by the Pathway Boards.					
Breast Cancer						

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#### The Purpose Is:

To improve health and create wealth creation for the UK through excellence in research, translating innovation into practice and education.

#### The Partnership Approach:

UCLP works with patient groups, universities, NHS Trusts, community care organisations, commissioners, government and industry. The company's role is not to mandate change or to "own" solutions ourselves. Rather, to work with partners to co-create, test and implement solutions, ultimately embedding these solutions into practice.

#### **Our Partners And Geographic Strategy:**

Our Partners include Universities, health providers, commissioners and local authorities in North Central, London, North East London, Hertfordshire and Essex. The company seeks industry and the third sector collaboration.

The prime focus is to support the partners to meet the needs of a diverse population and geography. This often involves working with University and NHS staff to co-create, test and evaluate new ways of working, considering from the outset how to enable adoption and adaption across the partnership. Anglia Ruskin Health Partnership supports the focus by defining local population needs in Essex, contributing to the broader partnership by identifying best practice across the broader partnership and infusing it throughout the wider partnership.

UCLP also imports and exports innovation identifying best practice nationally and internationally. The company develops strategic alliances with global centres of excellence, UK AHSC partners, our neighbouring AHSNs and though a national network of AHSNs and with neighbouring CLAHRCs.

#### **Five Levers:**

UCLP translates cutting edge research and innovation into measurable health gain for patients and populations by integrating five "levers":

Discovery through to "first in man" research (AHSC)

Clinical trials (CRN)

Innovation into practice (AHSN)

Improvement Science and robust academic health economic evaluation (Health Improvement Science (HIS) & Collaborations for Leadership in Applied Health Research and Care (CLAHRC))

Education and training (working with the LETBs)

The levers deliver specific outcomes which, when aligned effectively, translate innovation into health and wealth outcomes for patients:

Increase research collaboration (AHSC)

Increase participation in clinical trials (CRN)

Increase access to proven service innovations and technologies (AHSN)

Increase knowledge of how to deliver innovation and measure innovation in practice (HIS & CLAHRC)

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Increase workforce knowledge and capability to deliver innovations (LETB)

# UCLP Corporate Development 2013 Priorities (for reporting and tracking at Executive and Board)

Secure AHSC reaccreditation to strengthen ability to further enhance discovery and research capabilities

Create a single CRN with the highest national performance. This will increase research participation and provide our patients access to new technologies that improve clinical standards of practice

Generate >£5M per annum as a tier one provider designated to drive innovation into practice to improve health and create wealth

Win CLAHRC bid to create the knowledge to diffuse innovation locally, nationally and internationally

Deliver innovation in the delivery of education to train the work force to improve health outcomes

Deliver Cancer and CVD Specialist Service reconfiguration and support service development activities in Hertfordshire and Essex to improve patient outcomes and experience

# Partnership and Programme Enablers (for reporting and tracking at Executive and to inform the Board)

Five enablers have been agreed:

Research
Education
Quality Improvement and evaluation
Informatics
Innovation implementation capability

#### 3 Year Partnership Enablers - Outcomes And One Year Delivery Examples

In the full business plan each enabler has identified three priorities and for each priority a measurable outcome has been defined.

In this executive summary for the Board, one example is provided for each enabler and integrated programme.

Research three year outcome

Health – HEI and BRC/U cluster can each demonstrate globally competitive research outcomes and jointly the cluster have evaluated and implemented best methodology to close gaps 1 and 2, CLAHRC has published at least 5 major studies to diffuse best practice

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Wealth - NIHR minimum performance standards have been achieved which will result in a 50% increase in patients recruited to commercial studies across the AHSN geography

#### Research one year delivery

Health – Demonstrable increase in research outcomes delivered, evidenced through grant income from UCLPartners sponsorship and at least one major research strategic alliance formed

Wealth - NIHR targets met and Harmonisation Project fully evaluated with industry engagement plan in progress. Consent to take part in research achieved

#### Education three year outcome

Health - Trainees and senior clinicians report progressive improvement in quality and satisfaction measures for post graduate education

Wealth - Education programmes are fully aligned to speed up adoption and diffusion of innovations identified within the integrated programmes

#### Education one year delivery

Health - Infrastructure in place to deliver MDECs stages 1-3, all professional development programmes reviewed and new programme ready for initiation 2014/15. First wave of trainees completed multi-professional training programmes

Wealth - Education strategy agreed and implemented to underpin educational activity as an enabler across programmes and across professional groups

#### Informatics three year outcome

Health – Support CHAPTER to develop a global centre of excellence for academic research capability so that UCLP is recognised as the preferred EU centre for informatics research collaboration, create a shared IT platform to enable data sharing between clinicians, researchers and commissioners

Wealth – Develop a self-sustaining UCLP- sponsored company to develop and market plug-ins to the shared platform to enable service improvements

#### Informatics one year delivery

Health - CHAPTER has secured MRC funding to build an academic centre of excellence for informatics research, System wide platform established to enable data sharing in at least one area

Wealth – A business plan created to establish a new company to support informatics innovation

Quality and Value Improvement 3 year outcome

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Health - Value scorecards developed for key pathways and 5 integrated programmes across the health system with improvement trajectory and major variation reduction demonstrated. Pragmatic evaluation of this and other initiatives

Wealth – At least 3 mutually beneficial partnerships with industry, linking cost and quality improvement (facilitated by UCLP, establishing a reputation as a 'beacon' health economy for value improvement)

Quality and Value Improvement one year delivery

Health – By extending Deteriorating Patient across the whole partnership (including Essex) at least 2 trusts beyond NCL achieve 40% reduction in cardiac arrests; value scorecards developed for frail patients; Medical Directors and Chief Nurses' networks strengthened, and delivering practical response to Francis Report with UCLP-wide agenda

Wealth – At least one mutually beneficial partnership with industry driving quality improvement across a whole-pathway

Three year Innovation capability outcome

Health - Self-funded innovation and medical technology incubator units recognised internationally as the centre of excellence to (i) deliver innovation into practice; a not for profit, self-funded innovation unit providing services across the partnership and (ii) connect med- tech entrepreneurs to clinical, academic and business partners

Wealth - Set up two companies (i) to incubate new medical technologies and (ii) to provide innovation capability / capacity into programmes and to the wider UCLPartners' membership

Innovation capability one year delivery

Heath – build capability across the partnership to deliver innovation into practice

Wealth – finalise the business plan for a new medical technology company, secure two investment partners and deliver pilot projects in orthopaedics and cardiovascular, create a communication/social networking platform and support a student initiated conference. Work closely to complement existing capability in Anglia Ruskin MedTech Campus.

#### **Programme Portfolio**

UCLP provides operational support for" programmes "of work selected by the Executive and led by senior Clinical Academic Leaders appointed to lead across the partnership.

Based upon ability to compete with global centres of research excellence, six programmes were established in 2009 (focussed AHSC objectives):

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Neuroscience
Eyes and Vision
Immunology
Infection
ENT
Liver and Digestive Health
Maternal Health

These programmes will conclude when AHSC reaccreditation takes place early in 2014, and a new programme focus will be defined within our reaccreditation strategy.

Five integrated programmes were selected to combine the AHSN and AHSC work in 2012. A process of consultation and broad stakeholder engagement identified five areas where members of the partnership felt there was most potential to improve health and wealth:

Cancer (start 2010 - TBA)
Cardiovascular (start Q4 2013 - end Q 4 2017)
Mental health (start Q1 2014 - end Q1 2017)
Child and teenage (start Q2 2014 - end Q2 2017)
Co- morbidities (start Q2 2014 - end Q2 2017)

Subject to a successful bid, the CLAHRC will focus on 5 themes from January 2015 which align with three integrated programmes and build applied research capability across the system:

- 1. Mental Health
- 2. Child & Adolescent Health
- 3. Systems and Models for Health (recognising the need for NHS systems to take a 'whole person based care' perspective aligned with Co-morbidities theme)
- 4. Methodological Questions
- 5. Behaviour Change in (i) patients /public; health care professionals (ii) organisations (iii) environments/structures (response to the Francis Report)

#### 3 Year Programme Outcomes And One Year Delivery

In preparation for our AHSC reaccreditation bid a new set of strategic priorities are being developed and will be reported to the Board later this year.

Each integrated programme has identified three priorities and for each priority a measurable outcome has been defined. One health and wealth example is provided for each integrated programme.

Cancer 3 year outcome

Health - Improve 1-year survival to equal the best performing regions in England, improve patient experience measured by PROMs and PREMS

Wealth - Increase the number of industry supported cancer trials in the NIHR portfolio by 20% by 2016/7

Cancer one year delivery

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Health - Pathways of care redesigned for all specialist and common cancers in NE and NC London, plans co-created by Essex stakeholders to improve cancer services by the end of October, emergency presentation audit completed to inform 2014 priorities

Wealth – Expand number of industry partners for commerciality sponsored studies

#### Cardiovascular 3 year outcome

Health - Identify and tackle 25% or more CV risk factors which will reduce major CV events, reduce CV mortality from cardiac surgery to compare with the top 10 international centres, increase patients in trials

Wealth - Establish a culture of early collaboration with BioTech companies and develop at least 3 new Med Tech devices auctioned to companies with global marketing capabilities

#### Cardiovascular one year delivery

Health - Root cause analysis data collection is being completed across London and Essex sites and ready for interpretation, AF project designed with industry partner and under way, public engagement aiming to be completed by December 2013 to create a single heart centre in North Central and North East London and business plan signed off by Barts Health Board and UCLP Executive

Wealth - Informatics platform developed to support a 3 million lives initiative and two pilot projects identified to be incubated through a new Med Tech incubator

#### Mental Health 3 year outcome

Health – 30% increase in dementia diagnosis rates, improvement rates in Child & Adolescent Mental Health patients will be proportionally greater by 30%, increase the number of people with identified and successfully managed cardiovascular risk factors with severe mental illness by 10% through better integration of physical health and mental health care

Wealth – Over 100 people with mental health conditions will return to work, with a published evaluation of this intervention

#### Mental Health one year delivery

Health – Establish sub-working group of dementia network with an agreed plan for delivery of improved dementia diagnosis rates involving both acute and primary care, completion of phase one of ERIC-D pilot (tackling cardiovascular risk in depressed patients through interventions in primary care), Newham employment pilot underway

Wealth - Identify one industrial collaboration to create an informatics enabler to deliver the defined health outcomes, Newham pilot underway with manual complete

#### Co-morbidities 3 year outcome

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Health - Increase percentage of patients with LTCs/multiple morbidity with a goal orientated care plan by 50%, 95% of patients dying in place of preference, increase proportion of patients capable of self-management by 10%

Wealth - At least three mutually beneficial partnerships with industry supporting new models of care that demonstrate benefits to patients per pound spent

#### Co-morbidities one year delivery

Health – 80% of patients dying in place of preference, Increase percentage of patients with a coordinate my care plan by 50%, Care plans for patients with multiple morbidities designed and tested, value scorecards developed and measured for frail patients, tariff research completed and written up for publication

Wealth – Industry collaboration with GSK for fragility to reduce prevalence of secondary fractures

#### Child and teenage three year outcome

Health - Reduce attendance at A&E of children with chronic conditions by 10% across the AHSN and increase <19 year old participation in applied health and medical research by 25%

Wealth - reduce school absenteeism and thereby life chances from children with chronic diseases by 15%, increase meaningful work experience in children (14-18 years) by 10%

#### Child and teenage health one year delivery

Health – establish primary and secondary schools network; establish networks across UCLP to improve management of asthma, diabetes and epilepsy; establish UCLP health visitor programme across London, Herts and Essex to improve infant mortality and life chances

Wealth – set up work experience scheme with major industry to improve UCAS applications and work opportunities for children 16-19 years

An audit of delivery from the original 6 AHSC programmes vs. the AHSC objectives will be completed by end May and reported to the Research sub-board and Programme sub-board. The plan to focus activity in the last 6-9 months prior to AHSC accreditation will be reported to the Executive.

#### **Key Strategic Risks**

**Failure to maintain and grow the culture of collaboration**; partners prioritise institutional priorities over system level priorities and see greater benefit in focussing on institutional priorities over system level patient priorities with a result that senior leaders do not support their staff to devote resources and time to working at a

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system level. UCLP staff have become focused on UCLP priorities rather than patient and partners priorities.

Risk Mitigation – Ask for support from members of the Executive to lead the culture of collaboration and partnership. Focus UCLP resources and mind-set on in areas which deliver enhanced outcomes for the population we serve and support partners to deliver their strategic priorities.

Service reconfiguration work damages trust between partners and UCLP. The Cancer and CVD specialist centre reconfiguration has significant potential to create tension between institutional priorities and system/patient priorities. This tension could undermine partnership working between the major London teaching hospitals who set the tone for collaboration across the partnership.

Risk mitigation - UCLP MD to chair a programme board to oversee change and enable the Executive to focus on the central purpose of the AHSC and AHSN.

**Delivery capacity:** The company has set a very ambitious programme of work and there could be a disconnect between the ambitions of the company and the capacity of a young company to deliver those ambitions.

Risk mitigation - strengthen capability by hiring outstanding operational managers to support clinical academic leaders and ask the Executive to help both focus the operational plan and deploy the brightest and best staff in their institutions to lead system level delivery.

AHSN Income levels and restrictions within the licence which do not align with UCLP values - UCLP submitted a bid for AHSN status with a projected cost of £12m. The Department of Health has still not formally announced the outcome of the AHSN bidding process, but income predicted to be £11m now likely to be <£5m.

Risk mitigation is to focus the ambition of the programmes and seek alternative income streams, particularly from commercial partners where we can both enable them to achieve their commercial objectives and help patients.

Loss of AHSC accreditation Failure to maintain accreditation would significantly undermine the company's reputation and damage the reputation of the founding partners. AHSC status recognises the strengths of the UK's most prestigious academic clusters which support the recruitment of academics with global reputations for excellence to work with us and supports grant income applications.

Risk Mitigation: Deploy operational resources and engage with partners to build the strongest bid strategy.

**Risk to UCLPartners:** Aligning clinical research networks across the system will be a real test of partnership and the CEOs of BH and UCLH will need to build trust across their organisations and the whole partnership. Failure to deliver in a collaborative way will damage the culture of UCLP and our reputation at NIHR.

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Risk Mitigation: UCLH and BH CEOs agree who will host.

**Education:** Senior leadership roles within UCLP have been appointed by the London LETB and "seconded to UCLP" with line management to the LETB. This creates a conflict of interest between provider and commissioner. There is also operational complexity in engaging with the East of England LETB to ensure alignment and engagement around education in Essex and Hertfordshire. For inner London there will be specific challenges relating to tariff changes for education affecting NHS partners, while creating new models of training required for the future.

Risk mitigation includes hiring an Education Operations Director and empowering the director to lead for UCLP across the whole AHSN geography. LETB MD to work with Trust CEOs to mitigate the impact.

**Failure to create wealth:** The NHS has a poor track record and UCLP will need to demonstrate its capacity to add value across its whole spectrum of activities. There is a risk that wealth creation will lose ground against well embedded bias from leaders with deeply embedded values who find the concept of wealth creation alien or do not have the capabilities to deliver.

Risk mitigation: ask the Board and Executive to champion wealth creation, appoint a Board member with commercial capabilities, explicit embedding of wealth creation objectives into business plans and supporting the personal development plans of UCLP operations directors to build commercial capabilities. Leverage existing wealth creation initiatives such as the Anglia Ruskin MedTech campus.

Changing priorities of member organisations. The health system is under increasing operational pressure, and there is still uncertainty as to how the reformed NHS will work in England. It may be that the priorities of individual members change in order to best meet the needs of patients, and that UCLP has not planned to support these new priorities.

Risk mitigation: A flexible strategy and business plan, subject to regular review. Partners may be asked to make additional contributions to enable UCLP to respond to specific needs identified e.g. task and finish priorities like A&E.

Note: This risk will be reviewed and prioritised by the Risk and Audit Committee.

#### 10. Income And Resource Deployment

The Board will be provided will a detailed budget when the AHSN budget has been allocated. There is no clarity on the AHSN budget, current working assumption is £5 million. We are expecting confirmation of the allocation in May.

The following key principles will be applied:

Partners contributions provide the "foundation" income, these contributions play an important role to focus delivery on meeting the needs of each partner (new partners

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each pay £50K and have a seat at the Executive, Founding Partners pay £100K and also have a seat at the Board).

The Board has previously agreed that 70% of the founding partner contributions (£500K) should support AHSC delivery.

The balance of the Partners contributions (£750K) will support system enablers to benefit their organisations (e.g. project management to developed shared informatics platform, quality scorecards).

UCLP will secure at least £5 for every £1 invested by partners from alternative funding streams and we will deploy alternative income streams to deliver outcomes defined by the investor.

AHSN income will be deployed to meet the expectations of the licence (e.g. Implementation of NICE guidelines, implementation of High Impact Initiatives, wealth creation projects across the AHSN geography and in line with population).

Income from local commissioners and industry partners will be applied to specific projects with defined outcomes (e.g. Atrial Fibrillation and Root Cause Analysis Projects).

Income from national commissioners will be deployed to deliver strategic projects where UCLP might act as a test bed and platform for national diffusion (e.g. Mental Health Informatics).

The CLAHRC will attract £1-2 million recurrent funding from 2014 onwards which is not included in the 2013/2014 plan as funding will be hosted with one of the partners. The same principle will apply for the CRN. UCLP will play a role to ensure funds are fairly allocated across the partnership.

Education budget is funded by the LETB.

The draft AHSN license stipulates 20% income should come from industry. Negotiation is underway to secure this income and will be supplementary.



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MEETING DATE:	Thursday 27 <sup>th</sup> June 2013	2
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TITLE:	Serious Incident Annua	l Report
AGENDA ITEM:	8.1	PAPER:
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		analysis investigations and details the lessons is implementing to minimise the risk of similar
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For information	X	For assurance x
For comment		For ratification
For discussion	X	For resolution
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Additional informa	ation:	
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RISK IMPLICATION	NS (BAF / risk register):	
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#### Serious Incident Annual Report April 2012 – March 2013.

#### 1. Introduction

- 1.1 Serious Incidents in healthcare are uncommon. But when they occur the National Health Service (NHS) has a responsibility to ensure there are systems in place for safeguarding people, property, NHS resources and reputation. This includes responsibility to learn from these incidents to minimise the risk of them happening again.
- 1.2 In order to provide national consistency in the definition of a serious incident and clear roles, responsibilities and timescales for completing serious incident investigations, the National Patient Safety Agency (NPSA) launched the first release of a National Framework for Reporting and Learning from Serious Incidents Requiring Investigation in March 2010.
- 1.3 NHS London adopted this framework in full and they expected all organisations to adhere to the guidance contained within the framework. North Middlesex University Hospital NHS Trust adopted this guidance to formulate its policy and during 2012/13 has worked within this framework.
- 1.4 All serious incidents are reported on STEIS and NHS London and our commissioners had access to this system to see serious incidents that we had reported. During 2012/13 NHS London had responsibility for the closure of serious incidents. This role has transferred to North and East London Commissioning Support Unit (NELCSU) on 1<sup>st</sup> April 2013, who will close serious incidents on behalf of Haringey CCG. Therefore some of the incidents that occurred during 2012/13 will be closed by NELCSU

#### 2. Definition of a serious incident

- 2.1 Serious Incidents are:
  - Unexpected or avoidable death or severe harm of one or more patients, staff or members of the public
  - A never event all never events are defined as a serious incident although not all ever events necessarily result in severe harm or death
  - A scenario that prevents or threatens to prevent an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population
  - Allegations, or incidents of physical abuse, sexual assault or abuse
  - Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation
- 2.2 NHS London also had specific criteria which they expected to be reported as a serious incident and investigated in accordance with the framework. These included:
  - Delay if ambulance handover in an Emergency Department of one hour or more
  - Maternal death
  - Intra partum death (during labour)
  - Unexpected neonatal death
  - Unexpected admission to Neonatal Intensive Care Unit of a term baby
  - Maternal unplanned admission to ITU
  - Suspension of maternity services

#### 3. Annual Serious Incident Activity

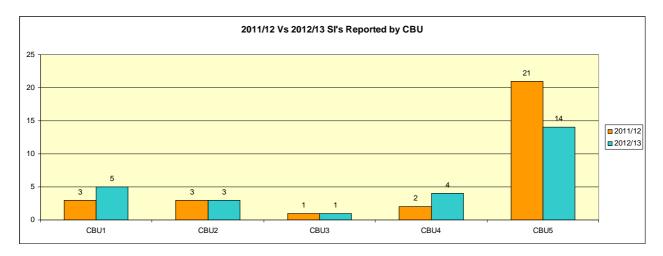
3.1 During 2012/13 North Middlesex University Hospital NHS Trust reported 27 serious incidents which occurred within the Trust and 47 community acquired pressure ulcers. In 2011/12 we reported 30 Serious Incidents.

This represents less than 1% of all incidents that are reported within the Trust

#### 3.2 Serious Incident analysis

The table below gives a breakdown of Serious Incidents by Clinical Business Unit (CBU) and a comparison to 2011/12. This shows that CBU 1 and CBU 4 had more incidents than in 2011/12 – 2 more incidents each, whereas CBU 5 had a reduction of 7 incidents. The reason that CBU 5 is an outlier is due to the fact that we are asked to report specific maternity type incidents as listed above. This anomaly occurs in all London Trusts that have a maternity department

		SI's by CBU 2011/12 Vs 2012/13					
Year	CBU1	CBU2	CBU3	CBU4	CBU5	<b>Grand Total</b>	
2011/12	3	3	1	2	21	30	
2012/13	5	3	1	4	14	27	



The table below gives a breakdown within each of the CBU's of where the incidents were attributed to for both 2011/12 and 2012/13

	CBU and Department	2011/12	2012/13
CBU	Dept	Total	
CBU1	A&E	3	4
	Radiology	0	1
	AMU	1	2
CBU2	Charles Coward	1	1
	Med 1	1	
CBU3	Stroke	1	0
	Pharmacy	0	1
	Colorectal	1	0
CBU4	Ophthalmology	0	1
	Orthopaedics	1	1
	Operating Department	0	2
CRUE	Maternity	20	13
CBU5	Paediatrics	1	0
	Gynaecology	0	1
Grand			
Total		30	27

Appendix 1 gives a breakdown of the specific type of serious incidents that were reported in 2012/13 by each CBU.

#### 3.3 Community Acquired Pressure Ulcers

In 2012/13 the Trust was asked to report community acquired pressure ulcers. These incidents do not "belong" to the Trust but it is a way of identifying harm that patients are experiencing in the community.

In 2012/13 we reported 47 community acquired pressure ulcers. These are patients who are admitted with a grade 3 or 4 pressure ulcer or grade 3 or 4 ulcer which develops within 72 hours of admission. These pressure ulcers are picked up by the nursing staff undertaking a risk assessment of the patient on admission. The Trust is responsible for reporting the community acquired pressure ulcer on STEIS and informing PCT who is responsible for the patient's care. The PCT then had to take ownership of the pressure ulcer and it would be closed against the Trust.

Of the community acquired pressure ulcers 30 of the patients were resident in Enfield, 14 were resident in Haringey, 2 were resident in Waltham Forest and 1 was resident in West Essex.

#### 3.4 Child Protection

Serious Case Reviews (SCR's) of children are discussed at the relevant borough safeguarding boards and also discussed at the Trust's Local Safeguarding Committee. These will only be declared a serious incident if there has been some failing in the care that has been provided by the Trust. During 2012/13 there were no child protection issues that required being declared as a serious incident.

#### Rule 43's from Inquests

3.5 During the 2012/13 year the trust was not issued with any Rule 43 judgements by the Coroner. In addition there are currently no rule 43s outstanding from prior years.

#### 4. Themes arising from Serious Incident Investigations

4.1 All serious incidents undergo a root cause analysis investigation. The purpose of this investigation is to ascertain what the care and service delivery problems, contributory factors and root causes of the incident were. The process is not to apportion blame to individuals, unless they have undertaken a deliberate act.

When investigating an incident often other issues are identified and these become lessons learned and recommendations come from the care and service delivery problems and contributory factors.

The types of incidents reported in 2012/13 in comparison to 2011/12 were very different so it is difficult to draw conclusions of any themes that are emerging.

- 4.2 CBU1 had a delay of handover of ambulances for more than an hour on one occasion in both 2011/12 and 2012/13. There was an increase in unexpected deaths from 1 in 2011/12 to 2 in 2012/13. The reasons for the unexpected deaths is not comparable as in 2011/12 the patient was, treated appropriately and sent home and then re-presented less than 24 hours later with a bowel obstructions. The x-rays confirmed that this was not present before. In 2012/13 the unexpected deaths were due to non compliance of the STEMI pathway and a patient deteriorating rapidly.
- 4.3 CBU 2 had 3 serious incidents in both 2011/12 and 2012/13. In 2011/12 they had 2 incidents of patients who died following a fall. There was no recurrence of this type of incident in 2012/13 which showed that the learning put into place appears to be correct. In 2012/13 there was a blood transfusion incident and an incident concerning a heparin and insulin pump.

- 4.4 In 2011/12 CBU reported a MRSA bacteraemia on a death certificate. In 2012/13 there were no incidence of a patient having MRSA on their death certificate. This is due to the increased vigilance of the infection control team and the teaching that they have undertaken concerning MRSA bacteraemia. In 2012/13 the incident in CBU 3 related to the pharmacy department.
- 4.5 All of CBU4's incidents in 2012/13 centred around the operating department. There was an incident of a guide plate being left in situ and an incorrect cataract lens being placed in a patient. The third incident concerned a piece of equipment which had not been sterilised properly. There is a new Theatre Manager in post who has been addressing the issues. In 2011/12 the incidents concerned an undiagnosed cancer and a patient who had a fatal pulmonary embolism following a lower limb plaster.
- 4.6 Due to the specific nature of the types of incidents that have to be reported as serious incidents in maternity there is more of a comparison in 2012/13 to 2011/12.

In 2011/12 and 2012/13 there were 2 maternal deaths in each year. The 2012/13 one was a patient who actually died from a sickle cell crisis but had a baby 6 months previously and the other was a patient who developed HELLP syndrome and multi organ failure immediately after giving birth. There were 2 unplanned hysterectomies in both years and these were due to women continuing to bleed following delivery and are undertaken as a life saving measure. Maternal unplanned admissions to ITU reduced from 6 to 3. This shows that some of the measures of recognising unwell patients that had been put in place were being implemented.

The main concern was that there were 2 retained swabs, one in gynaecology and one in maternity that occurred. This was followed a retained swab in 2011/12 so the actions were reviewed and a much more robust action plan was put in place with implementation of name bands and stickers. These actions have been audited and amendments made to the stickers and a re-audit has occurred. These audits have been presented to the Maternity Board.

Of the serious incidents that were reported and investigated during 2012/13 the following themes emerged:

#### 4.7 Documentation

Poor documentation is a theme that has emerged in many of the serious incident reports. This includes:

- Medical records not being dated, timed or signed
- Ineligible writing which makes it difficult to understand what has occurred and what the plan of care is
- Notes written in retrospect but not stating the time that events took place
- Medical records not written in as staff busy caring for the patient
- Not recording correctly where medication has been stored
- Information written in different places
- Not recording observations

#### 4.8 Escalation of unwell patients

- Not recognising the signs of an unwell patient
- Not undertaking observations when required to understand if a patient is deteriorating
- Observations being undertaken by Health Care Support Workers and them not understanding the significance of them

#### 4.9 Failure to follow protocol or guidance

- Not undertaking fetal monitor in line with the guideline
- Unclear when to refer a patient for a CT scan
- Referral to Maternity Day Unit
- Not booking patients in line with the antenatal guidelines
- Guideline unclear as to which level of doctor should be contacted
- Head injury guidelines out of date and not being followed

#### 4.10 Communication

- Ensuring that there is clear communication with patients about risks and documenting all discussion with patients in the medical records
- Not handing over clear instructions
- Staff not reading written instructions
- More than one version of a protocol on the intranet
- Not booking appointments for the times that they are required, this includes radiology appointments

#### 5. Learning Outcomes from Serious Incident Investigations

- 5.1 During 2012/13 the Trust continued to improve the quality of its serious incident reports, this has included appointing a clinical lead for incidents. We are also now including audits of the actions in the action plans. This is to ascertain if the action that we have suggested is the correct action and also to be able to monitor that the actions are completed.
- 5.2 Below is listed the learning that has come from the serious incidents and initiatives that have been introduced to minimise the risk of the incidents occurring in the future:
  - Introduction of using pink operation notes for women who are required to go back to theatre following a delivery
  - Introduction of different coloured name bands for patients who have vaginal packs in situ
  - Introduction of a "sticker" in the medical records of patients who have vaginal packs which are completed when pack put in place and also when removed. Following an audit this was then improved
  - Competency testing for all Health Care Support Workers across the Trust in undertaking observations
  - Information for all qualified staff on the role of the Health Care Support Worker
  - Ensure that all IV lines are labelled correctly with date and time
  - Continued to roll out the use of SBAR communication technique
  - Changed the appointment system in the Maternity Day Unit so that staff are aware of patients who require an appointment and can then follow them up if they do not arrive
  - There has been a piece of work to ensure that only the latest version of guidelines, protocols and polices are available to staff on the intranet
  - Revised the policy for decontaminating flexible scopes in theatres
  - Guidelines have been updated and audited
  - Hourly rounding in the Accident & Emergency department to check on all patients

#### 6. Next Steps

- As from the beginning of May the Director of Nursing on a daily basis is reviewing all incidents that have occurred and asking for 24 hour reports on incidents that may come under the category of Serious Incidents. These reports are being evaluated and decisions made in a timely manner and investigators are then appointed to undertake the investigation.
- 6.2 The Trust is also looking at the implementation of a Serious Incident panel for the signing off of incidents prior to them being sent to North & East London CSU.
- 6.3 Being Open and sharing incident reports with patients and their families is a crucial step that needs further development. This fits with the Francis report and the Trust needs to ensure that we are implementing the Duty of Candour in all cases.
- 6.4 Linking learning outcomes to audit needs development as well. The Trust is now auditing all action plans but this needs to feed into the Trust's audit programme to ensure that we continue to learn from incidents and that the lessons are totally embedded in all that we do.

#### 7. Conclusion

- 7.1 By understanding that a serious incident has occurred, reporting and investigating it leads the Trust to being a safer place for patients. Continuous learning is important in moving forward to ensure that we provide the best possible care and that patients feel safe at North Middlesex University Hospital NHS Trust.
- 7.2 By continuing to learn and ensure that the actions we have put in place are implemented and audited will continue to give the Trust, Commissioners and our patients reassurance that we are a safe and open organisation.

#### 8. Recommendation

The Board is asked to note and receive the 2012/13 Annual serious incident report.

Paul Reeves
Director of Nursing
June 2013

### Appendix 1

The table below gives a more detailed description of each of the serious incidents that were reported in 2012/13.

	2012/13 SI's With Descriptions	
CBU	Description	Total
	Delay if ambulance handover in an Emergency Department of one hour or more	1
	Red flag markers in one of the antenatal ultrasonographers which potentially led to incorrect scan measurements being given to women	1
CBU1	Unexpected death of a patient due to the STEMI pathway not being followed	1
	Unexpected death of a patient who was not attended to for several hours	1
	Unexplained child death of a child who had been seen within the previous 24 hours	1
CBU1 Total		5
CBU2	Hospital acquired grade 3 pressure ulcer Incorrect blood given to a patient Unexpected death of a patient following confusion	1 1
CBU2	with their heparin infusion	1
Total		3
CBU3	Not following the correct procedure in dispensing a Controlled Drug and giving it to the patient.	1
CBU3 Total		1
	A retained guide plate following shoulder surgery – this is a Never Event	1
CBU4	Diabetic retinal screening patients were sent the incorrect letters following testing.	1
	Dirty and incorrect instrument given to another department which was then used on a patient	1
	Incorrect cataract lens placed in a patient which had to be removed and the correct lens replaced	1
CBU4 Total		4
	Maternal Death	2
	A retained vaginal pack following surgery – this is a Never Event	1
	Maternal unplanned admission to ITU	3
CBU5	Retained swab which constituted a Never Event	1
	Unexpected admission to Neonatal Intensive Care Unit of a term baby	4
	Unexpected neonatal death	1
	Unplanned hysterectomy following caesarean section	2
CBU5		14
Total Grand		14
Total		27



Trust Board							
MEETING DATE:	Thursday 27 <sup>th</sup> Jur	ne 2013					
WILLTING DATE.	ELING DATE. Thursday 27 June 2013						
TITLE:	Board Members'	walkabouts					
AGENDA ITEM:	8.2		PAPER: F				
<b>EXECUTIVE SUMM</b>	1ARY:						
This report is a su	mmary of observ	ations and fi	ndings from Bo	ard members' walkabouts in			
the last month.							
1		rom walkabo	uts conducted	by the Chief Executive and			
the Director of Peo	•						
	•	•		proposal due to be			
considered at the	•	•		, .			
		eive assuranc	e from this rep	ort as part of the quality			
monitoring proces	sses.						
ACTION REQUEST	ED OF THE MEET	ING:		<u></u>			
For information		Fo	r assurance	X			
For comment		Fo	r ratification				
For discussion		Fo	r resolution				
LINK TO:							
CORPORATE OBJE	CTIVES:	Relevant to all					
CQC OUTCOMES:		CQC outcon	ne				
IMPACT ASSESSMENTS / IMPLICATIONS ON:							
PATIENT SAFETY AND QUALITY None							
RISK (BAF / risk register)  None  None							
FINANCES / RESOURCES: None							
THARCES / RESOURCES.							
THIS PAPER HAS B	BEEN						
	PREVIOUSLY CONSIDERED BY:						
<b>AUTHOR AND TITI</b>	LE: Paul Reeves	s, Director of I	Nursing	AUTHOR AND TITLE: Paul Reeves, Director of Nursing			

#### 1. Introduction

This paper provides the Board with a written report of Board walkabouts which have previously been verbally submitted to the Board.

#### 2. Julie Lowe, Chief Executive walkabouts- May and June

I have continued my programme of visits to clinical areas with the focus now on some of the smaller and more specialist areas. Since the last Board meeting I have completed the following visits:

Rainbow ward (child protection weekly meeting)
Anticoagulation clinic
Fracture clinic
Site management team

In the clinics I spent time sitting in on consultations which also provided an opportunity to talk to patients. I was very impressed by the way that staff treated each patient as an individual and worked hard to make sure that patients understood their condition and the options for treatment. Generally the patients were very positive about their experiences, although there remain issues about overcrowding in the anticoagulation clinic. We have now chosen the anticoagulation clinic to be the focus of some of the quality improvement work we are undertaking with the McKinsey Hospital Institute to try to improve the service that we offer.

#### 3. Rachel Patterson and Lynn Cantor walkabouts - May 2013

We visited the S3 ward on the 16<sup>th</sup> of May 2013.

The ward was very tidy, clean and calm. All areas seen were occupied however the various multi disciplinary staff present appeared to be managing the demands well. The nurse in charge reported that they had had a very busy day previously and that staffing levels can be problematic, particularly when staff go off sick at short notice.

We had discussions with three patients although two of the patients had limited English which made the discussion more limited. All three reported a good experience, with one gentleman who had been on the ward for 15 days reporting very positively about his experience, commending the staff, environment and food

#### 4. Recommendation:

The Board is asked to note and receive assurance from this report as part of the quality monitoring processes.

June 2013



Trust Board						
MEETING DATE:	Thursday 27 <sup>th</sup> June 2013					
TITLE:	2012/13 Quality	2012/13 Quality Accounts				
AGENDA ITEM:	8.3	PAPER: G				
EXECUTIVE SUMN	/IARY:					
compliance with the accounts have been the NHS Quality Accounds Department The draft 2012/13 review and consult Safety and Quality Council The attached quality through the Patient The Board will also priorities at its next Following this sessi Accounts will be suffer to the app Choices website on The Board is asked to	The Trust Board is responsible for the accuracy and completeness of the Quality Account and for compliance with the Quality Accounts regulations and guidance. The attached draft Quality accounts have been prepared in accordance with the Department of Health's Toolkit Guidance and the NHS Quality Account Regulations (published February 2010 and 2011), supplemented by additional Department of Health guidance published by letter in 2013.  The draft 2012/13 Quality Accounts are now submitted to the Board following external audit review and consultation with stakeholders. Stakeholder feedback was discussed at the Patient Safety and Quality Committee meeting of the 25 <sup>th</sup> of June 2013.  The attached quality accounts also incorporates the 2013/14 priorities, which will be monitored through the Patient Safety and Quality Committee.  The Board will also discuss the metrics and assurances to aid the monitoring of the 2013/14 priorities at its next Board development sessions.  Following this session, a detailed timeline of key activities and assurances to support the Quality Accounts will be submitted to the Committee in August.  Further to the approval of the Quality Accounts the final version will be published on the NHS Choices website on the 30 <sup>th</sup> of June.					
ACTION REQUEST	ED OF THE MEET	TING:				
For information		For assurance				
For comment		For ratification X				
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CORPORATE OBJECTIVES:		Relevant to all				
CQC OUTCOMES:		Relevant to all				
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IMPACT ASSESSME	IMPACT ASSESSMENTS / IMPLICATIONS ON:					
PATIENT SAFETY AND QUALITY		None				
EQUALITY		None				
RISK (BAF / risk register)		None				
FINANCES / RESOURCES:		None				
THIS PAPER HAS E		N/A				
	PREVIOUSLY CONSIDERED BY:					
AUTHOR AND TITLE: Stanley Okolo, Medical Director						



	Trust Board				
BAFFTING DATE Thursday	7 <sup>th</sup> 1 2012				
MEETING DATE: Thursday 2	27 <sup>th</sup> June 2013				
TITLE: April and N	Лау NTDA return				
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AGENDA ITEM: 9	PAPER: J				
EXECUTIVE SUMMARY: Following the introduction of the TDA Accountability framework, aspirant NHS Trusts subject to the TDA oversight model are now required to provide self certification assurance to the TDA on a monthly basis through a Board statement and Monitor licensing conditions return.					
ACTION REQUESTED OF THE	MEETING:				
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PATIENT SAFETY AND QUALI					
EQUALITY RISK (BAF / risk register)	None				
FINANCES / RESOURCES:	<u> </u>				
THANCES / RESOURCES:	None				
THIS PAPER HAS BEEN					
PREVIOUSLY CONSIDERED BY:					
AUTHOR AND TITLE: Paul Reeves, Director of Nursing					

#### Governance and monitoring of the return

The Foundation Steering Group agreed a process of monitoring each element of the returns with effect from June 2013. The work of the Group is supported by a monthly operational process where the Board Secretary receives evidence to substantiate the entries submitted on each monthly return with effect from July. Executive leads have been identified for each element of the return, and they will provide evidence to the Board Secretary a week prior to the meeting of the Steering Group in order to enable the evidence to be reviewed and formally agreed at the Steering Group, before being reported to the FT project Board retrospectively. The nature of the evidence required and ongoing assurance will be agreed by the Deputy CEO. The Board Chairman reviews the content of the return and approves its content prior to the submission to the NTDA.

#### **April and May submissions**

There are three options of compliance status when submitting the return, which range from 'compliant', 'risk of non compliance' and 'non compliant'

To date the Trust has declared compliance with all aspects of both returns with the exception of the following:

#### Monitor's Licensing Requirement:

Requirement P4: Compliance with the national tariff, certification

This is due to the fact that the Trust is in a block contract till the end of the 2013/14 financial period

#### **Board Statements**

Certification requirement 10: The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model

This has been certified as a' risk of non compliance' due to the current Trust performance on the A & E target. Details on mitigation plans are incorporated within the Integrated Performance report.

Certification requirement 11: The Trust has achieved a minimum of level 2 performance against the requirements of the Information Governance Toolkit

The Trust was compliant with all of the 2012/13 Information Governance Toolkit elements with the exception of information governance training, which achieved 50% compliance.

This therefore resulted in the Trust's overall compliance defaulting to 'not satisfactory level'. Plans are in place to achieve a month on month improvement on training compliance through the implementation of a detailed project plan, which is being monitored by the FT Steering Group and the Information Governance Committee.

#### **Recommendations:**

The Board is asked to:

Note the proposed monitoring and assurance arrangements to support the TDA return

Note and retrospectively approve the TDA returns for April and May 2013

Julie Lowe Chief Executive June 2013



# Board Statements submitted to the TDA

April

# NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

Dala Provided by, Molly Clark
Email Address: molly.clark@nmh.nhs.uk
Telephone: 02088873315 (ext: )
Date Provided: 17/05/2013

Reporting Timeframe: April [2013/14]

Reporting Times	rame: Aprii [2013/1	4]
For CLINICAL QUA	LITY, that	
Care Quality Comm	ission information, its ow s, and will keep in place,	ts knowledge and using its own processes and having had regard to the TDA's oversight model (supported by in information on serious incidents, patterns of complaints, and including any further metrics it chooses to effective arrangements for the purpose of monitoring and continually improving the quality of healthcare
Clinical Quality     Compliance     Yes	Clinical Quality     Timescale	1. Clinical Quality Response
For CLINICAL QUA	LITY, that	
2. The board is satis	sfied that plans in place a	are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.
2. Clinical Quality Compliance Yes	2. Clinical Quality Timescale	2. Clinical Quality Response
For CLINICAL QUA	LITY, that	
relevant registration	and revalidation require	
Clinical Quality     Compliance     Yes	3. Clinical Quality Timescale	3. Clinical Quality Response
For FINANCE, that 4. The board is satisto time.	sfied that the trust shall a	at all times remain a going concern, as defined by the most up to date accounting standards in force from time
4. Clinical Quality Compliance Yes	4. Clinical Quality Timescale	4. Clinical Quality Response
For GOVERNANCE	, that	
5. The board will en all times.	sure that the trust remain	ns at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at
5. Governance Compliance Yes	5. Governance Timescale	5. Governance Response
For GOVERNANCE	, that	
		e NTDA's Accountability Framework have been identified (raised either internally or by external audit and re are appropriate action plans in place to address the issues in a timely manner.
6. Governance	6. Governance	6. Governance Response

6. Governance	6. Governance	6. Governance Response
Compliance	Timescale	
Yes		

#### For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. Governance Compliance Yes	7. Governance Timescale	7. Governance Response

#### For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. Governance	8. Governance	8. Governance Response
Compliance	Timescale	
•	Timescale	
Yes		

### For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

Compliance Timescale	
Yes	

### For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

9. Governance Compliance Yes	9. Governance Timescale	9. Governance Response
For GOVERNANCE	E, that	
	atisfied that plans in place a to comply with all known ta	are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; argets going forward.
10. Governance Compliance Risk	10. Governance Timescale 30/06/2013	10. Governance Response The Trust is currently implementing plans to mitigate the risk around achieving the A & E 4 hour target in quarter 1, reference NTDA letter dated the 16th of May 2013, around conditions of sign off of 2013/14 Trust Operating plan.
For GOVERNANCE	Ē, that	
11. The trust has ac	chieved a minimum of Leve	el 2 performance against the requirements of the Information Governance Toolkit.
11. Governance ComplianceNo	11. Governance Timescale31/03/2014	11. Governance ResponseIn 2012/13, the Trust has achieved compliance with all of the information governance requirements, with the exception of the information governance toolkit training. A robust action plan has now been put in place which is monitored monthly, and the Trust will revert to a full compliance position by the end of the 2013/14 period.
For GOVERNANCE	=, that	<u>I</u>
		all times operate effectively. This includes maintaining its register of interests, ensuring that there are no rectors; and that all board positions are filled, or plans are in place to fill any vacancies.
12. Governance Compliance Yes	12. Governance Timescale	12. Governance Response
For GOVERNANCE	E, that	1
13. The board is sa functions effectively	tisfied that all executive an /, including setting strategy	nd non-executive directors have the appropriate qualifications, experience and skills to discharge their y, monitoring and managing performance and risks, and ensuring management capacity and capability.
13. Governance Compliance Yes	13. Governance Timescale	13. Governance Response
For GOVERNANCE	Ē, that	
		ent team has the capacity, capability and experience necessary to deliver the annual operating plan; and the o deliver the annual operating plan.
14. Governance Compliance Yes	14. Governance Timescale	14. Governance Response
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Business Intelligence		End of Data for:
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NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

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G4 Fit	Condition G4 Fit and proper persons	Condition G4 Fit and proper persons as Governors and Directors - Comments.		
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	Timeframe.			
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G5 –	2. Condition G5 –	2. Condition G5 – Having regard to monitor Guidance - Comments.		
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G7 –	3. Condition G7 –	3. Condition G7 – Registration with the Care Quality Commission.		
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nditi	on G8 - Patie	nt eligibility and selection criteria.		
G8 –	4. Condition G8 –	4. Condition G8 – Patient eligibility and selection criteria - Comments.		
ility 1	Patient eligibility and selection criteria -			
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onditi	on P1 – Reco	rding of information.		
P1 –	5. Condition P1 –	5. Condition P1 – Recording of information Comments.		
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onditi	on P2 – Provis	sion of information.		
P2 –	6. Condition P2 –	6. Condition P2 – Provision of information - Comments.		
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nditi	on P3 – Assur	ance report on submissions to Monitor.		
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7011				

ded: 17/05/2013 Timeframe: April [2013/14]

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onditi	on P5 – Const	tructive engagement concerning local tariff modifications.
P5 –	9. Condition P5 – Constructive	Condition P5 – Constructive engagement concerning local tariff modifications - Comments.
ocal	engagement concerning local tariff	
ations e.	modifications - Timescale.	
onditi	on C1 – The ri	ight of patients to make choices.
i C1 –	10. Condition C1 –	10. Condition C1 – The right of patients to make choices - Comments.
ake	The right of patients to make choices -	To solidition of the light of patients to make one cool
	Timescale.	
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maiti	on C2 – Comp	petition oversight.
C2 –	11. Condition C2 – Competition	11. Condition C2 – Competition oversight - Comments.
	oversight - Timescale.	
onditi	on IC1 – Provi	ision of integrated care.
IC1 –	12. Condition IC1 –	12. Condition IC1 – Provision of integrated care Comments.
re -	Provision of integrated care Timescale.	
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Iligence		End of Data for:
MEDI	NORT	TH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

### NHS TRUST DEVELOPMENT AUTHORITY

**CONTACT INFORMATION:** 

**NHS TRUSTS:** 



OVERSIGHT: Monthly self-certification requirements - Compliance Monitor Monthly Data.

Enter Your Name:				
Enter Your Email Address				
Full Telephone Number:		Tel Extension:		
SELF-CERTIFIC	ATION DETA	ILS:		
Select Your Trust:				
Submission Date:		Reportir	ng Year:	
Select the Month	April	May	June	
	July	August	September	
	October	November	December	
	January	February	March	

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:** Comment where non-compliant or at risk of non-compliance 1. Condition G4 Fit and proper persons as Governors and Directors. 2. Condition G5 Having regard to monitor

Timescale for compliance:

#### 3. Condition G7

Registration with the Care Quality Commission.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

4. Condition G8

Patient eligibility and selection criteria.

Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

<b>5. Condition P1</b> Recording of information.		
	Timescale for compliance:	
<b>6. Condition P2</b> Provision of information.		
	Timescale for compliance:	
7. Condition P3 Assurance report on submissions to Monitor.		
	Timescale for compliance:	
8. Condition P4 Compliance with the National Tariff.		
	Timescale for compliance:	
	Comment where non- at risk of non-complia	
9. Condition P5 Constructive engagement concerning local tariff modifications.		
	Timescale for compliance:	

Comment where non-compliant or at risk of non-compliance

<b>10. Condition C1</b> The right of patients to make choices.		
	Timescale for compliance:	
<b>11. Condition C2</b> Competition oversight.		
	Timescale for compliance:	
<b>12. Condition IC1</b> Provision of integrated care.		
	Timescale for compliance:	

### NHS TRUST DEVELOPMENT AUTHORITY



OVERSIGHT: Monthly self-certification requirements - Board Statements Monthly Data.

CONTACT INFORMATION:				
•••				
Enter Your Name:				
Enter Your Email Address				
Full Telephone Number:			Tel Extension:	
SELF-CERTIFIC	ATION DETA	ILS:		
Select Your Trust:				
Submission Date:		Reportir	g Year:	
Select the Month	April	May	June	
	July	August	September	
	October	November	December	
	January	February	March	



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.

#### **BOARD STATEMENTS:**



#### For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

#### 1. CLINICAL QUALITY

Indicate compliance

Timescale for compliance:

RESPONSE:

Comment where noncompliant or at risk of noncompliance



#### For CLINICAL QUALITY, that

**BOARD STATEMENTS:** 

•••

Commission's registration req	plans in place are sufficient to ensure ongoing compliance with the Care Quality juirements.
2. CLINICAL QUALITY Indicate compliance.	
Timescale for compliance:	
RESPONSE:	
Comment where non- compliant or at risk of non- compliance	
BOARD STATEMEN	NTS:
For CLINICAL QUALITY, th	at
3. The board is satisfied that care on behalf of the trust ha	processes and procedures are in place to ensure all medical practitioners providing ve met the relevant registration and revalidation requirements.
3. CLINICAL QUALITY Indicate compliance.	
Timescale for compliance:	
RESPONSE:	
Comment where non- compliant or at risk of non- compliance	

#### For FINANCE, that

4. The board is satisfied that t date accounting standards in f		nain a going concern, as	defined by the most up to
4. FINANCE Indicate compliance.			
Timescale for compliance:			
RESPONSE:			
Comment where non- compliant or at risk of non- compliance			
BOARD STATEMEN	ITS:		
For GOVERNANCE, that			
5. The board will ensure that t and shows regard to the NHS	the trust remains at all times Constitution at all times.	compliant with the NTD	A accountability framework
5. GOVERNANCE Indicate compliance.			
Timescale for compliance:			
RESPONSE:			
Comment where non- compliant or at risk of non- compliance			



6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE Indicate compliance.	
Timescale for compliance:	
RESPONSE:	
Comment where non- compliant or at risk of non-	

#### **BOARD STATEMENTS:**



#### For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

# 7. GOVERNANCE Indicate compliance. Timescale for compliance: RESPONSE: Comment where non-



8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.
8. GOVERNANCE Indicate compliance.
Timescale for compliance:
RESPONSE:
Comment where non- compliant or at risk of non- compliance
BOARD STATEMENTS:
For GOVERNANCE, that
9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).
9. GOVERNANCE Indicate compliance.
Timescale for compliance:

RESPONSE

Comment where noncompliant or at risk of noncompliance



targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.
10. GOVERNANCE Indicate compliance.
Timescale for compliance:
RESPONSE:
Comment where non-compliant or at risk of non-compliance
BOARD STATEMENTS:

#### For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit

#### 11. GOVERNANCE

Indicate compliance

Timescale for compliance:

#### RESPONSE:

Comment where noncompliant or at risk of noncompliance



12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE Indicate compliance.	
Timescale for compliance:	
RESPONSE:	
Comment where non- compliant or at risk of non-	

#### **BOARD STATEMENTS:**



#### For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

## 13. GOVERNANCE Indicate compliance. Timescale for compliance: RESPONSE: Comment where non-



14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE Indicate compliance.	
Timescale for compliance:	
RESPONSE:	

Comment where noncompliant or at risk of noncompliance



Trust Board				
MEETING DATE:	Thursday 27 <sup>th</sup> Jui	ne 2013		
TITLE:	ondon Cancer N	Memorandum Agreement		
		T		
AGENDA ITEM: 1	10	PAPER: J		
EVECUENCE CURARA				
Partners, with the ui	ists of a group nited aim of im I North East Lon nent is the Men	of providers, working in partnership with the UCL aproving outcomes and experiences for cancer patients and west Essex.  In a morandum of agreement covering the period of April in:		
<ul> <li>Accountability to commissioners for meeting national and local quality standards</li> <li>Operational day to day management of cancer care, including the implementation of recommendations from the London Cancer Pathway Boards</li> <li>Regulatory compliance.</li> </ul> The Trust Board is required to approve the MOA, which will be signed by the Chief Executive on behalf of the organisation.				
ACTION REQUESTED	OF THE MEET	ING:		
For information		For assurance		
For comment		For ratification X		
For discussion		For resolution		
LINK TO:				
CORPORATE OBJECTIVES: Releva		Relevant to all		
CQC OUTCOMES:		Relevant to all		
IMPACT ASSESSMENT	S / IMPLICATIO	NS ON:		
PATIENT SAFETY AN	D QUALITY	The implementation of the London Cancer Priorities will improve clinical outcomes and experience for cancer patients		
EQUALITY		None		
RISK (BAF / risk regi	ster)	None		
FINANCES / RESOUR	RCES:	None		
THIS PAPER HAS BEI	EN			
PREVIOUSLY CONSII	DERED BY:			
AUTHOR AND TITLE: Julie Lowe, Chief Executive.				



#### **Integrated Cancer System - London Cancer**

Memorandum of Agreement: April 2013-March 2014

#### Introduction

This document updates and replaces *London Cancer's* previous Memorandum of Agreement, which covered the period from April 2012 to March 2013.

It restates the previous commitment of each of the signatories and *London Cancer* to deliver better cancer related outcomes and experience for our patients and local communities by working in partnership.

This Memorandum of Agreement incorporates the significant progress made together since July 2011 to develop effective governance and reporting frameworks, and the work undertaken since *London Cancer* was officially established in April 2012 to build a platform from which to deliver our collective vision.

To this end, the signatories are now agreeing to enter into this updated Memorandum of Agreement, which runs from April 2013 to March 2014. This Memorandum of Agreement may be superseded during this timeframe if more detailed proposals are approved and agreed to be implemented.

#### **London Cancer**

London Cancer is an Integrated Cancer System for North Central and North East London and West Essex. It brings together providers from across the health community, academia and the voluntary sector to drive step change improvements in outcomes and experience for the cancer patients and populations we serve. Together the following provider organisations working with UCLPartners have to date led the co-creation of London Cancer:

•Barnet and Chase Farm Hospitals NHS Trust •Barts Health NHS Trust •Barking, Havering and Redbridge University Hospitals NHS Trust •Great Ormond Street Hospital for Children NHS Foundation Trust •Homerton University Hospital NHS Foundation Trust •Moorfields Eye Hospital NHS Foundation Trust •North Middlesex University Hospital NHS Trust •Princess Alexandra Hospital NHS Trust •Royal Free London NHS Foundation Trust •Royal National Orthopaedic Hospital NHS Trust •University College London Hospitals NHS Foundation Trust •Whittington Health

London Cancer is committed to working with its partners across the health community, academia and the voluntary sector in North Central and North East London and West Essex to deliver, by 2015, the following priority measures:

- Improved one year survival for patients within London Cancer\*\*;
- Improvement in patients self-reported experience of the care they receive; and

• Increased participation in clinical trials to 33% of all patients.

#### Accountability, reporting and governance

London Cancer will continue to focus on transformation which can only be achieved through partnership, not on the business-as-usual improvements which will be driven by individual providers. This focus will enable London Cancer to drive change with its partners at pace and scale. To ensure there is clarity for stakeholders and that we avoid duplication of effort, we will continue to clarify carefully responsibilities.

All parts of the system will be responsible for driving forward leadership skills and behaviours that deliver an integrated partnership around patients and local populations. Furthermore, all parts of the system will work together to align objectives and priorities within the wider climate of multiple and sometimes competing pressures.

Working with the signatories below, *London Cancer* has developed core governance processes, which were approved in principle by the signatories to the original Memorandum of Agreement. These were set out in proposals from the *London Cancer* governance working group dated 17 October 2011.

At the centre of these proposals is the appointment of an independent skills-based Board to lead *London Cancer*. This Board met for the first time in February 2012 and, meets on a monthly basis.

From April 2013 through to March 2014 processes for agreeing and implementing responsibilities, reporting and governance processes and procedures will continue to be developed and reported along the lines of those already agreed in principle. These proposals will be consulted on and, in due course, be submitted for approval by the Trust Boards which are signatories to the Memorandum of Agreement.

The current structures within *London Cancer* and its key external relationships are set out at Appendix 1.

#### London Cancer Board

The membership of the *London Cancer* Board will continue to be agreed by Trust Chief Executives who are members of the UCLP Executive Group. The primary purpose of the *London Cancer* Board is to provide skills-based leadership for *London Cancer* that is independent of the provider and other institutions. The full terms of reference are detailed in Appendix 2.

London Cancer's Board will work closely with a range of stakeholders including in particular the signatories below and the Joint Development Group. This latter group is the forum for discussions between London Cancer and the commissioners for our system. It is chaired by the Chief Executive of the North East London Cluster on behalf of North East and North Central London's commissioners, and will continue through the NHS North and East London Commissioning Support Unit. The stated purposes of this group are to:

<sup>\*\*</sup> used as a proxy measure for patients being diagnosed earlier in the course of their cancer

- Ensure that there is a common understanding and agreement across providers and commissioners regarding the priority changes in cancer care;
- Agree London Cancer's Service Plan to implement the agreed Model of Care<sup>1</sup> for Cancer in London; and
- Identify those service changes that require action by providers and commissioners and then to agree respective actions.

It is recognised by the signatories to this document that the Joint Development Group has an important role to play in ensuring that system level commissioning objectives and requirements are taken into account and, as appropriate, incorporated within the overall plans and objectives of *London Cancer*.

#### **Cancer Pathway Boards**

Cancer pathway boards are in place for each major cancer type, with a competitively appointed senior clinical leader. The boards have representation from all relevant providers, users, primary care and public health. They have taken over the responsibilities of the previous network site-specific groups of NCL and NEL Cancer Networks but with additional executive responsibility as below. Cancer pathway boards are accountable to the *London Cancer* Board and:

- Lead the co-design, implementation and management of adherence to integrated care pathways, including implementation of Model of Care recommendations appropriate to the pathway;
- Offer pathway-specific advice to commissioners;
- Build relations across the pathway, including public health and public/ patient engagement;
- Identify best practice and support its roll out; and
- Undertake governance roles for partners around peer review and Multidisciplinary Teams (MDTs).

**Provider Trusts**, which are signatories to the Memorandum of Agreement, will continue inter alia to be:

- Accountable to commissioners for meeting national and local quality standards at local sites e.g., waiting times, patient-experience, complaints, incidents, and peer review including MDTs;
- Responsible for day-to-day operational management of cancer care, including supporting implementation of relevant recommendations emanating from *London Cancer* Pathway Boards, and responsible financial management of cancer services;
- Responsible for contract negotiation and review with commissioners;

<sup>&</sup>lt;sup>1</sup> Commissioning Support for London, A Model of Care for Cancer Services, 2010

- Responsible for comprehensive, accurate capture of a common data set (including staging) and feeding this to a system-wide database for provision to Thames Cancer Registry, national audits, etc.; and
- Responsible for regulatory compliance.

#### **Members and Stakeholders Council**

A combined UCLPartners and NCEL Local Education and Training Board (LETB) members and stakeholders council will be the forum where *London Cancer* will present to our population. This will operate on the principles of openness and transparency. As a minimum, *London Cancer* will ensure compliance with the requirements within the Health and Social Care Act 2012 around patient involvement and public accountability.

#### Mutual responsibilities

Each of the signatories below recognises:

- The obligations that each provider organisation, UCLPartners and *London Cancer*, and their Boards have to patients, regulators, commissioners, governors, members and staff;
- The objectives of London Cancer (as set out in this Memorandum of Agreement);
- The crucial and central interests of patients; and
- The interests of commissioners.

Each of the signatories to the Memorandum of Agreement also recognises that to deliver the objectives of *London Cancer* will require co-operation and collaboration between providers and other partners across the pathway.

This will necessitate different ways of working and will be in the form of:

- Sharing reliable, complete and timely information with Cancer Pathway Boards and the London Cancer Board;
- Engaging fully and co-operating with other parts of the pathway;
- Investing in appropriate equipment;
- Engaging in MDTs in the right manner;
- Co-operating and collaborating in key clinical appointments; and
- Reduced waiting times, improving the quality of patient experience and delivering superior outcomes.

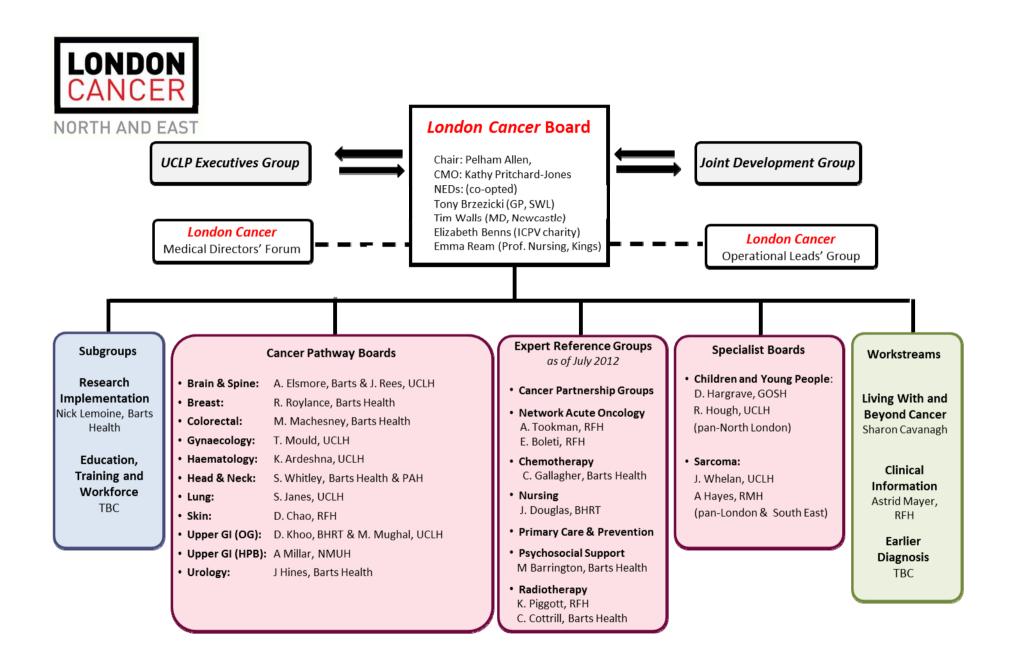
It is accepted that where these behaviours can't be evidenced, the capacity and capability of a signatory to the Memorandum of Agreement to contribute effectively to the delivery of the objectives of *London Cancer* may be in doubt.

In such circumstances, and where the clinically evidence based shortfall is not satisfactorily rectified, it is recognised that the *London Cancer* Board may recommend sanction. Following discussion with commissioners, this may result in a decision to decommission services or the removal of a provider from *London Cancer*.

London Cancer further agrees to:

- Keep information which is shared with it confidential as appropriate;
- Report to each of the organisations impacted at the earliest opportunity any matter which may risk an organisation and its reputation;
- To act only on clinical evidence, and only then once a full impact analysis has been undertaken and shared;
- Seek to consult and include wider representation wherever possible; and
- To act in a manner independent of all organisations within *London Cancer*.

Tim Peachey, Interim CEO BARNET AND CHASE FARM HOSPITALS NHS TRUST	Julie Lowe, CEO  NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
Signature	Signature
Peter Morris, CEO BARTS HEALTH NHS TRUST	Yi Mien Koh, CEO WHITTINGTON HEALTH
Signature	Signature
Averil Dongworth, CEO	Melanie Walker, CEO
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	PRINCESS ALEXANDRA HOSPITAL NHS TRUST Signature
Signature	0.9.000
Jan Filochowski, CEO	David Sloman, CEO
GREAT ORMOND STREET HOSPITAL FOR	ROYAL FREE LONDON NHS FOUNDATION TRUST
CHILDREN NHS FOUNDATION TRUST Signature	Signature
Signature	
Tracey Fletcher, CEO	Rob Hurd, CEO
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
Signature	Signature
John Pelly, CEO	Sir Robert Naylor, CEO
MOORFIELDS EYE HOSPITAL NHS FOUNDATION	UNIVERSITY COLLEGE HOSPITALS NHS
TRUST	FOUNDATION TRUST
Signature	Signature
David Fish, MD	Kathy Pritchard-Jones, CMO
UCLPARTNERS Signature	LONDON CANCER Signature
	1 5





#### Appendix 2: London Cancer Board: Terms of Reference

London Cancer is an Integrated Cancer System for North Central & North East London and West Essex. It brings together providers from across the health community, academia and the voluntary sector to drive step change improvements in outcomes and experience for the cancer patients and populations we serve.

Together the following provider organisations working with UCLPartners have to date led the cocreation of *London Cancer*:

•Barnet and Chase Farm Hospitals NHS Trust •Barts and the London NHS Trust •Barking, Havering and Redbridge University Hospitals NHS Trust •Great Ormond Street Hospital for Children NHS Trust •Homerton University Hospital NHS Foundation Trust •Moorfields Eye Hospital NHS Foundation Trust •Newham University Hospital NHS Trust •North Middlesex University Hospital NHS Trust •Princess Alexandra Hospital NHS Trust •Royal Free Hampstead NHS Trust •Royal National Orthopaedic Hospital NHS Trust •University College London Hospitals NHS Foundation Trust •Whipps Cross University Hospital NHS Trust •Whittington Health

Note: subsequent to the approval of the Terms of Reference on 28 February 2012, the following events have occurred:

- With effect from 1 March 2012, Great Ormond Street Hospital for Children NHS Trust has been awarded foundation trust status and is now Great Ormond Street Hospital for Children NHS Foundation Trust;
- With effect from 1 April 2012, Royal Free Hampstead NHS Trust has been awarded foundation trust status and is now Royal Free Hampstead NHS Foundation Trust; and
- With effect from 1 April 2012, Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust merged to form Barts Health NHS Trust.

#### London Cancer - mission and aims:

London Cancer's mission is to improve survival from cancer and experience of care for its patients and local communities. We aim to achieve this by leading a radical redesign of how cancer services are delivered across a population of nearly 4 million people in North Central and North East London and West Essex. This will be driven by all provider Trusts in London Cancer taking collective responsibility for the quality and outcomes of integrated care pathways, working in partnership with patients, primary care, commissioners, public health and the voluntary sector. Our ambition is to create a new model of cancer care for the NHS that empowers patients, facilitates equitable access to best practice and innovation and increases value for the health economy. We aim to support our staff to be leaders in cancer care – locally, nationally and globally. Ultimately, London Cancer aims to create a "virtual comprehensive cancer centre" serving the whole population of North Central and North East London, that comprises all of its partner organisations and is recognised globally for the excellence of its patient care and outcomes, education, training and research.

As partners we have developed *London Cancer* through engagement efforts reaching over 1000 staff, patients, carers, primary care and the voluntary sector, with the vision to:

- Be patient-focused through listening, communication, involvement, information, education, choice, and personalisation. Patient need and the patient journey will be the organising framework for care
- Optimise care along a co-ordinated pathway through earlier diagnosis, excellent treatment for all, local treatment where appropriate, compassionate aftercare and empowering/supporting patient self-management
- Embed research for personalised care, equitable access to trials, the discovery of new treatments and evaluating new ways of working together with patients
- *Increase value* through superior outcomes for patients per pound invested; continual improvement over time against our previous performance

The current priority measures are, by 2015, to:

- 1. Improve one year survival for patients within London Cancer\*\*,
- 2. Improve patients self-reported experience of the care they receive
- 3. Increase participation in clinical trials to 33% of all patients.

#### **London Cancer Board - purpose:**

The primary purpose of the London Cancer Board is to provide skills-based leadership for *London Cancer* that is independent of the partner institutions, to ensure the successful delivery of *London Cancer's* mission and goals, including:

- Setting and directing London Cancer's overall strategy
- Driving innovation, change and shaping new models of cancer care
- Securing behaviours and commitment from partners and participants along cancer pathways which are consistent with the overall goals of London Cancer
- Agreeing national and international benchmarks against which to measure and promote improved performance and changed models of cancer care
- Making evidence-based, clinically led and deliverable recommendations to commissioners of cancer care across North Central and North East London
- Influencing and informing the development of national strategies for value based healthcare in the NHS
- Horizon scanning to provide advance notice of new and emerging cancer technologies and practices that might require evaluation, consideration of clinical and cost impacts, or modification of clinical guidance prior to launch in the NHS

<sup>\*\*</sup> used as a proxy measure for patients being diagnosed earlier in the course of their cancer

The *London Cancer* Board will work with Cancer Pathway Boards, subgroups and work-streams, to ensure that on an ongoing and continuous basis, *London Cancer* takes steps to drive improvements and new models in cancer care for patients and its population.

#### Key responsibilities:

- To set, update and direct delivery of the overall strategy for *London Cancer* (including consideration and challenge of Pathway Board, key subgroup and work-stream plans)
- To prioritise consideration of potential cancer pathway changes taking into account and balancing:
  - likely impact on outcomes, patient experience and meaningful patient voice within the relevant cancer pathway
  - overall impact of change within and beyond cancer services
  - healthcare value, reflecting both cost and quality
  - potential resulting impact for treatments and commissioning of services other than cancer (e.g.: funding, location and sustainability of other services and organisations, use of healthcare resources, impact on ancillary services, equipment and other operating capacity)
- To consider and challenge recommendations from Cancer Pathway Boards and subgroups or work-streams (including evidence, impacts and mitigations)
- To make specific recommendations on behalf of *London Cancer* to commissioners for potential changes to cancer services and pathways
- To hold providers of cancer care accountable on an ongoing basis for their behaviours and commitment to the delivery of the overall goals of *London Cancer*
- To maintain an ongoing focus on the needs of local cancer patients and the population, ensuring London Cancer is constantly innovating and embedding its work in evidence to improve outcomes for patients and healthcare value
- To report recommendations and progress to UCLP Executive Group
- To review on a periodic basis a defined set of pathway metrics / outcome measures and agree any remedial steps as required (including the potential for exclusion of a partner from London Cancer)
- To require and review bench-marking (national and international) of evidence to demonstrate progress against agreed goals and the effectiveness or otherwise of changed models of cancer care
- To review, oversee the consultation on and update outcome focused compliance measures for cancer services
- To work in partnership with commissioners to develop and agree effective incentives (including to ensure GP engagement) designed to promote and support improvements in cancer services
- To oversee London Cancer's influencing and communication strategy (including publication of information and data) including, but not limited to, the development of national strategies for value based healthcare in the NHS

- Horizon scanning to provide advance notice of selected new and emerging technologies and practices that might require evaluation, consideration of clinical and cost impacts, or modification of clinical guidance prior to launch in the NHS
- To ensure effective engagement with and involvement of stakeholders on an ongoing basis
- To approve appointments of Cancer Pathway Directors
- To receive notification of membership of Cancer Pathway Boards to ensure proper representation
- To consider on an ad hoc basis solutions to specific and significant cancer-related challenges
- To ensure that momentum is maintained in the pace of work of *London Cancer*, and ensure that good and proper process does not delay progress in achieving the desired outcomes

#### Membership (and skills):

- The Board will include an independent Non-executive Chair
- The Chief Medical Officer, which will be an executive role, will be on the Board
- The Board will in addition have 6 independent Non-executive Directors, who will with the Chair and the Chief Medical Officer bring together the following skills and knowledge:
  - Cancer pathways and quality outcomes
  - Leadership of service transformation
  - Workforce development across partners
  - Strategy and financial governance
  - Clinical expertise in cancer
  - Patient and population focus
  - Public health priorities for cancer
  - Commissioning and value based healthcare
  - Primary care

#### Authority:

- To make recommendations and then agree with commissioners the appropriate incentives and any sanctions necessary to drive the prioritised recommendations from Cancer Pathway Boards on behalf of *London Cancer*
- To report recommendations to UCLP Executive Group
- To receive recommendations from Cancer Pathway Boards, subgroups and work-streams
- To commission further review, analysis or information gathering as necessary to support recommendations
- To recommend appointments to London Cancer Board (subject to the approval of UCLP Executive Group)
- To approve:
  - Changes in cancer metrics and outcome measures at the system level
  - Publications and other public announcements on behalf of London Cancer

• Appointment of Cancer Pathway Directors

#### Appointments to London Cancer Board:

- Initial appointments to be made by UCLP Executive Group
- Subsequent appointments to be made by London Cancer Board and approved by UCLP Executive Group

#### Support:

- Board support / administration through a London Cancer Board Secretary
- Communications support
- Cancer Pathway Boards
- Subgroups and work-streams

#### Meeting frequency:

Monthly



Trust Board					
		11431 00	uru		
MEETING DATE:	Thursday 27 <sup>th</sup> Ju	ne 2013			
	·				
TITLE:	2012/13 Annual	Report			
		·			
AGENDA ITEM:	11		PAPER:	K	
<b>EXECUTIVE SUMN</b>	ΛARY:				
These documents a	•	Trust to fulfil	its statutory re	eporting du	ities and are
presented to the Bo					AL.
				nittee on th	ne 4 <sup>th</sup> of June, the final
2012/13 Annual rep	•				
Key aspects of the a NHS Finance Manua		ae tne statuto	ry component	s as set out	in Chapter 2 of the
The Annual report h		l to audit and s	uhmitted as a	final version	on Further changes
would need consult			abilittea as a	illiai veisic	on. Further changes
The Board is asked t			eport.		
			-1		
<b>ACTION REQUEST</b>	ED OF THE MEET	ING:			
For information		Fo	r assurance		
For comment		Fo	r ratification		X
For discussion	х	Fo	r resolution		
LINK TO:					
CORPORATE OBJE	CTIVES:	Relevant to			
CQC OUTCOMES:		Relevant to	all		
Г					
IMPACT ASSESSME	-				
PATIENT SAFETY	AND QUALITY	None			
EQUALITY		None			
RISK (BAF / risk re		None			
FINANCES / RESO	URCES:	None			
		A 121 C			
THIS PAPER HAS E		Audit Comm	ittee		
PREVIOUSLY CON	SIDERED BY:				
AUTHOR AND TITLE: Martin Armstrong Director of Finance					
<b>AUTHOR AND TIT</b>	LE: Martin Arı	mstrong Direct	or of Finance		



## NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

ANNUAL REPORT 2012/13

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#### Welcome to our review of 2012/13

We are delighted to be introducing the Trust's annual report, which will be the first for both of us as Acting Chair and Chief Executive.

During 2012/13 we saw the beginning of the final stage of a major programme of investment in both clinical staffing and new facilities at the hospital as part of the Barnet, Enfield and Haringey Clinical Strategy. This will mean better local hospital healthcare provision for you, your families and friends with all of our new facilities scheduled to be open by November 2013. We have received £80 million worth of capital investment from HM Treasury enabling us to fully refurbish the existing Tower Block and build a brand new Women's and Children's Centre providing care in state of the art facilities. New services are being developed to improve the amount of choice we offer local families, including a midwife-led birth centre for women with low-risk pregnancies. Once completed, 80% of our clinical services will be housed in buildings less than three years old.

In November 2012 we also received the approval to apply for Foundation Trust (FT) status as a stand alone organisation. Becoming an FT will provide us with greater freedom to choose how we invest in clinical services and enable us to work more closely with local people to develop health services that meet their needs. We aim to achieve this status in 2015 and actively welcome local people to become part of our membership and potentially have a more formal role over time in the hospital as a governor. If you would be interested in standing for election as one of the Trust's first governors, we would be delighted to talk to you about the role and the governor election process, please contact the Communications department.

While these investments and strategic developments help to secure our long-term future, we continue to provide excellent standards of care to our patients. 2012/13 was again a year of significant achievement. With a continued focus on hospital acquired infections, we had only one MRSA Bacteraemia all year and significantly reduced the number of Clostridium Difficile infections. We continued to improve our Hospital Standardised Mortality Rate (HSMR) and maintained it at a level significantly under the expected rate and we met all the national performance and access standards, ensuring reasonable waits in A&E and for timely diagnosis and treatment of cancer. Maternity performance remained strong, with the midwifery team receiving the Royal College of Midwives Team of the Year Award and during 2012/13 we also had two unannounced inspections by the independent regulator, the Care Quality Commission (CQC), both of which were successful and demonstrated that we are providing a high quality service meeting the CQC's stringent essential standards of care.

The last year has also seen the publication of the second report and recommendations from Robert Francis QC in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. We are absolutely committed to provide excellent high quality care with compassion at North Middlesex, and this is reflected in our strategic priorities for 2013/14. Further information is in this report and in our published Quality Accounts for 12/13.

Lynne Cantor Acting Chair

Julie Lowe
Chief Executive

#### ANNUAL REPORT

#### SECTION ONE WHO WE ARE AND WHAT WE DO

This introductory section of the annual report provides an overview of what the Trust does, how it is organised, and our vision for how we wish to work. North Middlesex University Hospital NHS Trust is a medium sized acute hospital, located in Edmonton, on the Enfield / Haringey border. We provide high quality services across a full range of secondary care services and some specialist tertiary services that reflect the needs of the local population to approximately 280,000 people locally on behalf of our commissioners.

We provide services in collaboration with a range of partners, including local GPs, The Royal Free Hospital Hampstead, University College London Hospital and Great Ormond Street Hospital for Children and are a founder member of UCL Partners Academic Health Science Network, a system designed to improve health in North Central and North East London through the translation of research into clinical services. We also work closely with a range of Universities to provide medical and nursing undergraduate and post-graduate training and education.

We have a turnover of £180m and are a major local employer with 2,321 staff, the profile of which reflects the diversity of the community we serve. Our main commissioners are Haringey and Enfield Clinical Commissioning Groups (CCGs), formerly known as Primary Care Trusts (PCTs) until the end of March 2013.

#### **Our Vision**

The vision for the Trust, our high level purpose, for the next 10 years is:

To become the healthcare provider of choice for the diverse population we serve in North London and beyond, recognised for excellent emergency, acute, maternity and ambulatory care, delivered by excellent and compassionate staff.

To measure progress against the attainment of the vision the Trust has agreed five Strategic Objectives for the next 5 years:

- The provision of excellent clinical outcomes
- Ensuring positive experiences for patients, GPs and all stakeholders
- To be an employer of choice with a workforce that is excellent and compassionate, acting as ambassadors for the Trust
- Provide services that are value for money for the taxpayer
- Maximise the efficient use of the site through closer working with other organisations and fostering education, teaching and research

#### **Our Services**

We provide the following services to our local population:

- 24 Hour Accident and Emergency services
- A comprehensive range of diagnostic and outpatient department services
- Emergency medicine and elderly medicine;
- Emergency and elective surgical specialties;
- Intensive care, high dependency care and coronary care;
- Maternity and Obstetrics
- Specialist services (including Oncology, Haematology, HIV/AIDS, Diabetes, Renal and Cardiology)
- Children's Services: Paediatric inpatients and outpatients, paediatric A&E and neonatal

Our services are delivered through five Clinical Business Units (CBUs), a devolved management structure with an emphasis on the involvement of clinical professionals in the day-to-day running of the Trust. Each CBU is lead by a Clinical Director working in partnership with a General Manager and Matron and supported by a range of Clinical Leads and finance, information and human resource specialists.

#### **The Trust Board**

#### **Executive Directors**

Executive Directors are voting members of the Trust Board with executive responsibilities, and are part of the Executive Team which is accountable to the Chief Executive. There are five executive directors in our Trust and these are:

- Julie Lowe Chief Executive
- Lance McCarthy Deputy Chief Executive
- Martin Armstrong Director of Finance and Performance
- Professor Stanley Okolo Medical Director
- Theresa Murphy Director of Nursing

The Trust also has operating directors without voting responsibilities, and these are:

- Mark Morgan Interim Director of Operations
- Rachel Patterson Director of Workforce and Organisational Development
- Kevin Howell Director of Environment

During the period of 2012/13 the following people also held Executive or Operating Director posts:

- Claire Panniker Chief Executive until September 2012
- Lee McPhail Director of Operations until February 2013

#### **Non Executive Directors**

Non–executive members of the Board are directors without executive responsibilities, which enables them to hold the Executive Directors to account and scrutinise the way we provide services and spend money. Non–executive Directors are typically appointed because they have the skills and experience to provide an enhanced layer of leadership and to help ensure the Trust is governed properly. They work part time, at a rate of two and a half days a month, although their time input is generally greater.

We have 6 non executive directors on our Board and in 2012/13 they were:

- Lynne Cantor Acting Chair \*
- Sally Field
- John Simons \*\*
- Catherine Dugmore \*\*\*
- David Price
- David Hooper\*

- \*\* John Simons joined the Trust Board in June 2012
- \*\*\*Catherine Dugmore joined the Trust Board in September 2012.

During the period of 2012/13 the following person also held a Non-Executive Director post:

David Snowdon – until June 2012

If you wish to contact any of the Board members please contact the Board secretary on 0208 887 3315. You can read more about our board members online at: <a href="http://nmh-intranet/Page/View/3">http://nmh-intranet/Page/View/3</a>

<sup>\*</sup>David Hooper stepped down as Board Chairman in January 2013 and took leave until March 2013. This role was undertaken by Lynne Cantor, Deputy Chair, from February until the end of the financial year.

#### SECTION 2 OUR PERFORMANCE

This section provides an overview of how we performed in the 2012/13 period.

#### Implementing improvements in the quality of care

Our main aim is to achieve excellence in the delivery of care for our patients and to enhance user experience and engagement. The successful delivery of this aim relies on strong governance processes and systems which enable us to deliver consistently high performance.

Patients and carers receive information on the quality of care and services via the Trust's Quality Account. Quality is defined as safe, effective, personalised care and is now at the heart of the NHS. Quality Accounts help demonstrate NHS commitment to quality, with providers reporting on the quality of their services, covering safety, outcomes and patient experience. Similar to financial accounts, Quality Accounts bring together all information on a provider's quality measures, such as Care Quality Commission survey data, with additional information to meet local needs and answer local questions on quality and improvement. They aim to help promote a focus by providers on quality improvement, and give patients information to support informed choice.

We produce a set of quality accounts every year, and the 2012/13 report will be published on the 30<sup>th</sup> of June 2013, following consultation with our stakeholders. To access the detailed account report, please access the link to our website: <a href="https://www.northmid.nhs.uk">www.northmid.nhs.uk</a>

#### **Essential Standards of Quality and Safety**

The Care Quality Commission is the regulator of health and adult social care in England, and undertakes inspections as part of its role to ensure that the care our patients receive meets the quality thresholds set out in the Essential Standards of Quality and Safety. The CQC's registration and monitoring regime is focussed on outcomes rather than systems and processes, with the inspections and compliance assessments focussed on the views and experiences of patients, carers and service users at its centre.

We are registered without conditions and have no outstanding compliance actions. Over the past year the Trust has maintained and further evolved robust processes for the self- assessment and assurance of compliance with the Essential Standards of Quality and Safety. Further work is planned for the 2013/14 period to enhance the assurance and monitoring systems we have in place.

The CQC inspected the hospital over a period of 2 days in December 2013 and focussed on 8 outcomes. The inspection was a mixture of observations of clinical care and interviews with patients. The outcome of the inspection was positive and we were given a clean bill of health. To download the full inspection report, please access this link on the CQC website:

http://www.cqc.org.uk/sites/default/files/media/reports/RAP North Middlesex University Hospital N HS Trust RAPNM North Middlesex University Hospital NHS Trust 20130115.pdf

#### The Hygiene Code

We are required to put robust measures in place to enable compliance with the Hygiene code. The Hygiene Code is focussed on ensuring we comply with various elements of the Health and Social Care Act in relation to the prevention and control of infections.

The Trust has arrangements in place to maintain compliance with the Hygiene Code on an ongoing basis. Further information is incorporated in this section of our annual report about the Trust's performance on Health Care Acquired infections (HCAIs) which show that the trust met or achieved below the set targets for MRSA and C-Diff during the financial period. Our Nursing Director is also the Trust Director of

Infection Prevention and Control (DIPC), providing regular assurance to the Board on compliance with the Hygiene Code. The Infection Prevention and Control Committee meet bimonthly, chaired by the Director of Infection Prevention and Control — DIPC. The Committee monitors Infection Prevention Control work plan and HCAIs.)

All employees of NMUH have a responsibility to comply with Infection Prevention and Control practices and procedures.

#### **Sustainability**

At North Middlesex University Hospital we define sustainability as bringing together factors that influence environmental conditions. This includes developing strategies that reduce carbon emissions, recycling waste, improving fuel use and the plant that consumes it as well as highlighting these proposals to staff and those who provide services be it under contract or as a supplier. We are required to comply with the Climate Change Act requirements to reduce our carbon emissions as part of a mandatory target which we have to meet by 2014/15.

We are currently updating our Carbon Management plan to enable us to meet the mandatory target. Key benefits of meeting this target (through the implementation of the plan) are:

- Financial savings
- Reductions in waste
- Easier access to services for patients and visitors
- Better staff working conditions
- A better local employer
- A better local contributor to the economy

Estates rationalisation and procurement are crucial drivers to carbon management implementation. Key to this efficiency is our supply chain and activities that require transport and the essential ordering processes. By moving to more efficient, low carbon and sustainable processes the hospital will become less reliant on excess deliveries and less exposed to higher and more volatile energy prices in the future.

We work with our staff to implement other aspects of sustainability. Staff are encouraged to take part in behaviour change programmes, encouraging low carbon travel, and develop the use of ICT connectivity leading to paperless environments.

Our efforts to date include:

- Ongoing development of a Carbon Management Plan for the Estate, to cover all direct emissions from combustion, electrical consumption, and all other indirect emissions.
- Forensic Utility bill audits, with any savings ring-fenced for use in future carbon reduction & energy saving projects
- Implementation of STOR Project (Short Term Operating Reserve), whereby we plan to offer the use of our generators to provide electricity to the grid in times of peak demand
- Reduction of backlog maintenance throughout the site to improve the efficiency of the building fabric and plant
- We will maximise the efficiency of our new Build Construction Projects (for example: Barnet Enfield and Haringey) through the use of Combined Heat & Power boilers, photovoltaic cells and improved building construction technology If we set out our ambition to play a leading and innovative role in ensuring the shift to a low carbon society the outcome will be a major achievement in meeting the Climate Change Act target to cut carbon emissions by at least 80% by 2050, with a minimum reduction of 26% by 2020.

#### Performance against national targets for 2012/13

The end of the financial year 2012/13 marks a record breaking year for care at the North Middlesex. The year-end Trust Board performance reports, detailing national and local clinical targets, show that:

- Nearly 96% of patients were seen and treated in A&E within four hours
- 98% of patients with suspected cancer were seen by a specialist for tests that are available to patients within 2 weeks.
- Over 98% of all patients were seen on the 18 week pathway from GP to hospital care as an inpatient or outpatient
- 100% of smear tests were reviewed with the results sent back to GPs within 12 days
- We had a third fewer cases of Clostridium Difficile than expected
- We had only one case of MRSA bacteraemia all year against a projection of three MRSA bacteraemias.
- 100% of suitable inpatients were treated in single sex accommodation
- All maternity targets were met including making sure women book their antenatal appointments in the first 13 weeks of pregnancy, having 97% of women breastfeeding and reducing the number of expectant mothers smoking during pregnancy to 4%.
- Our HSMR was 87 and SHMI was 81

This has all been achieved with a £1.8 million surplus.

Key National Access and Quality Targets							
Indicator	Target 12-13	Performance 12-13	Status				
Type 1 (A&E) - Under 4 Hrs %	>95.0%	95.4%					
18RTT – incomplete	>92.0%	98.3%					
18RTT – Admitted	>90.0%	98.1%					
18RTT - Non-Admitted	>95.0%	98.1%					
Cancer 2 Wk - Suspected Cancer	>93.0%	98.0%					
Cancer 2 Wk - Breast Symptomatic	>93.0%	96.4%					
Cancer 31 Day - All Cancers	>96.0%	99.2%					
Cancer 31 Day – Drug	>94.0%	100%					
Cancer 31 Day – Radiotherapy	100%	100%					
Cancer 31 Day – Surgery	>94.0%	100%					
Cancer 62 Day - All Cancers	>85.0%	92.1%					
Cancer 62 Day - Hospital specialist	>85.0%	100%					
Cancer 62 Day – Screening	>90.0%	98.9%					
Diagnostics Wait Times	0.0%	0.0%					
Maternity Booking within 13 Weeks with Refs received <13W	>90.0%	94.0%					
C.difficile (Aged 2+)- Hospital Acquired	<32	22					
MRSA incidences - Hospital Acquired	<3	1					
Mortality (HSMR) - Rolling 12 mths*	<100	87.1					
Mortality (SHMI) - Rolling 12 mths* (Qtr)	<100	81.3					

#### Infection Control

The Trust had good performance in 2012/13 compared to previous years with only 1 case of MRSA for the entire financial year and 22 cases of C. Difficile. The Trust continues to strive to improve and recognises that performance could still be better relative to other Trusts. For example: Data for 2011/12 shows that the Trust had 25.6 cases of C. Difficile per 100,000 bed days compared to a national average of 21.8 per 100,000 bed days for patients aged 2 years old or over.

#### **Access to Services**

The Trust delivered on all key national access standards during 2012/13. All cancer standards continue to be delivered at, or well above, expected levels every month.

The Trust recognises that whilst A&E standards have been delivered, performance was not as strong in the final few months of 2012/13.

In terms of 18-week referral to treatment (RTT) performance, the Trust was named as top performing London Trust and 7th best performing Trust in the country in the DH Quarter 2 performance report. The Trust remains above the target threshold for all RTT standards, however, a downward trend was seen in incomplete performance during the final quarter of the year. The Trust is carrying out a patient pathway improvement programme to reduce waiting times (for example first outpatient appointment and diagnostics) that is intended to ensure continued achievement of 18 week RTT performance.

The Trust is working in collaboration with other health and social care providers and local commissioners in support of schemes that seek to avoid unnecessary:

- attendances at A&E and the Urgent Care Centre;
- referrals to the hospital and
- admissions into the hospital

through the provision of care outside of hospital or through the Trust's ambulatory care service.

#### Performance against Corporate objectives for 2012/13

In 2012/13 we again provided good quality clinical care to our patients and met the majority of our corporate objectives. At the start of the year, the Trust Board agreed 3 overarching strategic objectives; Quality, Business and People. Within each of these objectives we agreed priority areas for focus. Every quarter, performance against the priority areas and their associated key deliverables was formally reviewed by the relevant Sub-Committees of the Board and the Trust Board itself. For further information please review our Corporate objectives overview report via this link:

http://www.northmid.nhs.uk/assets/Trust%20Board%20Meeting%2025th%20April%202013.pdf

#### Key service and specialty highlights of quality improvement in 2012/13

As well as 2012/13 being a successful year in terms of performance against our corporate objectives and for improvements in quality outcomes for patients, a number of other developments and improvements have been made that underpin quality for our patients and show a commitment to continually improving the environment and the offerings that we make to our patients.

### Developments to cancer services

During 2012/13 we launched an acute oncology service to help ensure we provide the highest quality emergency care to patients with cancer or suspected cancer. This is a dedicated service provided by a Consultant and Clinical Nurse Specialist on a 24/7 basis.

We also approved a business case for investment of £2.1m in a new Linear Accelerator to replace an older machine and ensure the latest techniques in radiotherapy provision can be made at North Middlesex. The enabling works to accommodate the new

machine are well underway and the equipment is due to be fully commissioned and operational by the summer 2013. This is in addition to investment in August 2012 of £175k for state of the art equipment specifically designed to treat patients with skin cancer. This will improve the recovery rates of patients and provide them with a better experience while undergoing treatment through administering low energy X-rays to the areas of the skin showing signs of cancer.

2013/14 will see the development of a brand new cancer support information centre in the main hospital, coordinated by a dedicated Patient Information Manager who has a background in cancer care. Working in partnership with Macmillan, the centre will provide immediate resources to patients and families with a diagnosis of cancer, freeing up the time of our clinical staff to dedicate to providing excellent care. The centre will open in autumn 2013.

#### Non-invasive treatment for faecal incontinence

In 2012 we launched a tibial nerve stimulation service for patients suffering from faecal incontinence. This follows on from our very successful tibial nerve service for patients with urinary incontinence, which has now exceeded 4,000 treatments, making us one of the largest providers of this treatment in the UK. It is estimated that at least 4% of the national population suffer from faecal incontinence with conventional treatments including undertaking major surgical procedures. Tibial nerve stimulation, which takes just 30 minutes to administer per session, targets the tibial nerve in the ankle using a tiny needle, which modifies nerve impulses reducing faecal incontinence. The treatment is safe, NICE approved and cost-effective.

#### Investing in acute medicine

Acute medicine is now recognised as a specialty in its own right and has a specific training programme to prepare Consultants for this role. We invested in this specialty in 2012/13 with two new Acute Medicine Consultants joining the Trust. The team manages patients in the Acute Medical Unit and also oversees patients in our Ambulatory Care Unit which provides treatment for those who need care but not in a

hospital bed. This is one of a number of initiatives aimed at supporting the effective flow of patients through the hospital from A&E to home. It will be built upon in 2013/14, working with local GPs and community services to develop pathways that make it easier for patients to receive the assessment and treatment they need, without necessarily coming to A&E or being admitted to hospital.

#### Improvements to outpatient services

Most of our patients access our services via our outpatient services. This year we have invested in these services to improve the day to day running of the department making sure that patients and GPs have better experiences. A text reminder service is now provided to patients which we hope will reduce our 'did not attend' (DNA) rate and ensure that all outpatient clinics are seeing as many patients as possible, reducing waiting times. All patient appointment letters are also being reviewed to make sure that they are standardised and provide patients with easy, uncomplicated information about their hospital appointment. Following a successful pilot scheme, in 2013/14, clinical staff will also be able to process appointment results and hospital appointment requests electronically, reducing paperwork and ensuring all clinical information about a patient is held on one computer system.

### Tailored care and support for dementia

We also focussed in 2012/13 on the treatment of dementia patients, and supporting their carers, in order to meet their unique needs while in hospital. Improvements have included:

- the appointment of a Consultant clinical lead for dementia
- a carer's passport, formally recognising carers' roles and providing additional support while their loved one is in hospital
- the 'ten things to know about me' document highlighting triggers to ward staff that could upset dementia inpatients
- colour-coding medicine for the elderly ward bays to help with orientation and
- training for all staff, not just clinical, to recognise dementia symptoms

Building on these developments and continually improving services for our dementia sufferers is a key drive in 2013/14.

#### Maternity service award

Our maternity service was announced as the National Team of the Year for 2012/13, presented at the Royal College of Midwives' annual award ceremony. The maternity team's application focused on engaging the hearts and minds of staff and patients in order to provide a better working life and the best experience possible to mothers at every stage of pregnancy and birth. This engagement drive included:

- Involving all members of the team in developing a service vision that provides the best possible care for mothers
- Reinforcing good practice and behaviour of staff through an internal awards programme
- Innovative initiatives based on women's feedback including the 'mothers for mothers' scheme that involves women volunteers providing informal advice to new mothers about breastfeeding and other common practical issues
- The introduction of daily CARE rounds by midwives that ask women what they would score their care out of ten and whether they would recommend the service to a friend.

### New state of the art unit for HIV patients

A brand new environment in which to provide diagnosis, treatment and support to people with HIV officially opened to patients in February 2013. The unit, formerly known as T1 Coleridge Unit, has moved buildings and been renamed the Alexander Pringle Centre, a name chosen by staff and patients. Dr Alexander Pringle, was a Consultant Physician at North Middlesex for 20 years until 1997. He pioneered the development of many clinical services at the Trust including intensive care and renal medicine and had the foresight in the 1990s to realise that we would need a strong HIV service. The unit has grown from 160 patients in 1997 to more than 1,200 patients in 2012.

#### Better support for patients after a stroke

We have recruited voluntary stroke survivors to provide experience, advice and support to current patients on our Acute Stroke Unit. We believe this brand new initiative will help patients understand what it's like to live with and survive stroke, improving their experience in hospital and their outcomes when they get

home. These befrienders help patients with a range of activities which will improve their overall communication and reduce social isolation, including:

- reading a newspaper / magazine with or to them
- supporting them to complete wordsearches / crosswords
- playing games such as cards or Connect 4
- practising speech therapy exercises as advised

Each befriender keeps a record of visits and activities in a record book and can raise any issues about patients to the clinical team who will action them.

## Investment in spiritual services

A new spiritual resource for staff, patients and visitors opened on the lower ground floor of the main hospital in February 2013, providing a calming environment for prayer and reflection. The Chapel is complemented by a new multi faith room in the Pymmes courtyard, which includes a carpet with individual prayer spaces pointing to Mecca. We believe that these new facilities will help improve the patient experience by providing staff, patients and loved ones with emotional and spiritual support while in hospital.

### Community involvement

Our corporate nursing team has this year worked hard to provide public health advice and information to local communities. Our local population has over 140 different languages spoken and it is really important that we reach out to all community groups in order to give them specific advice about public health and healthcare provision available to them at the hospital. Attending community events can help reduce or remove barriers that can either prevent access to health services or make access more difficult or affect the quality of people's experiences. 2012/13 has seen attendance at a large range of community events including:

- Enfield multiagency carers event
- Deaf community event
- Polish community event
- Albanian 'shepresa' event
- Turkish Cypriot community open day

We have also held community specific events at the hospital for a range of communities

including the Turkish, Somalia, Kurdish and Albanian people. This year has also seen improvements to the experience of inpatients with support from the 'Kissing it Better' registered charity who aim to enhance healthcare through simple initiatives that will brighten up the day for those staying in hospital such as poetry and drama events.

#### Snapshot of our achievements in 2012/13 by month

2012/13 was a very successful year for the Trust. Below is a summary of the key achievements and headline service developments by month of the year. Further detailed information on performance against operational, national access, quality and finance targets are is available later in this report.

#### April 2012

- We started providing `cancer information prescriptions' to patients, a two year national programme
  to give those diagnosed with cancer the right information at the right time to help them understand
  their disease and the treatments being offered
- A review of the fast-track surgical abscess pathway indicated it has reduced patients' length of stay in hospital by 22%

#### May 2012

- The gynaecology department were commended at the Department of Health's Enhanced Recovery after Surgery Summit for reducing the length of stay in hospital after a vaginal hysterectomy operation to less than 24 hours
- Recently retired midwife Kate Anolou became Mayor of Enfield

#### June 2012

- We started the provision of the diabetic retinal screening service programme to the whole of North Central London (Barnet, Enfield, Haringey, Camden and Islington)
- The Department of Health released £8.5million to enable us to start the early building works to help with the implementation of the Barnet, Enfield and Haringey Clinical Strategy

#### July 2012

- 1 July marked a whole year of the Trust being hospital acquired MRSA bacteraemia free
- £175,000 was invested in state of the art x-ray equipment to help treat skin cancer

#### August 2012

- Building on the success of the tibial nerve stimulation service for urinary incontinence, a new, non-invasive treatment for faecal incontinence was launched
- Two new acute consultant physicians started working for the Trust, heralding the start of a different model of senior doctor cover for acute medicine

## September 2012

- The Trust was formally accepted on to the Foundation Trust (FT) pipeline to submit a stand alone FT application
- Our 2012 staff award winners were announced at the Annual General Meeting

#### October 2012

• We launched the Patient Charter spelling out the level of service and standard of care every patient can expect at North Middlesex

#### November 2012

- We achieved NHS Litigation Authority (NHSLA) level 3 one of only 31 acute Trusts in the country to reach the highest level, an indication of strong patient safety measures and governance at the Trust
- Suitable patients are receiving care in single sex accommodation, the North Mid achieving a 100% record since Department of Health monthly reviews began two years ago

#### December 2012

- We had a two-day unannounced Care Quality Commission inspection with very positive feedback and confirmation that we were compliant with all eight standards that were assessed
- The stroke team received formal feedback from the North Central London Cardiovascular and Stroke Network that they met the relevant standards of quality, performance and staffing ratios for patients

#### January 2013

- The midwifery team were chosen as the Royal College of Midwives' Team of the Year for 2013
- £85 million funding to invest in North Middlesex buildings, clinical staffing and new services was approved

#### February 2013

- A new multi faith room and chapel opened thanks to significant Trust and voluntary donations
- A new HIV Unit, the Alexander Pringle Centre, opened to treat patients in a state of the art environment meeting their unique needs while maintaining their privacy and dignity

#### March 2013

- The North Middlesex launched a scheme of stroke befrienders stroke survivors who would provide advice and practical support to patients suffering from the aftermath of stroke on a voluntary basis
- The North Middlesex's maternity service, featured in a new BBC Three series, launches a 'footy-natal' class aimed at educating fathers to be

# SECTION 3 OUR STAFF

At North Middlesex University Hospital NHS Trust we believe our 2,321 staff are our most valued asset.

The data in the tables below details the demographic make up of our staff, split by age group, profession and ethnicity.

## **Staff by Age Group**

Employee /	Age
Group	Headcount
16 – 20	6
21 – 25	125
26 – 30	288
31 – 35	317
36 – 40	331
41 – 45	315
46 – 50	296
51 - 55	258
56 - 60	234
61 - 65	118
66 - 70	23
71 & above	10
Grand Total	2,321

## **Staff by Profession**

Staff Group	Headcount
Nursing and Midwifery (Registered)	756
Administrative and Clerical	475
Medical and Dental	381
Healthcare Scientists	136
Allied Health Professionals	132
Estates and Ancillary	36
Other Clinical	339
Other Professional, Scientific and Technical	58
Students	8
Grand Total	2,321

## **Staff by ethnicity**

Ethnic Origin Group	Headcount
White British	612
Black or Black British	591
Asian or Asian British	500
White Other	252
Mixed	50
Any Other Ethnic Group	155
Not Stated	161
Grand Total	2,321

### **Sickness Absence**

Our sickness absence target rate for 2012/13 was 3%, and overall we achieved a rate of 3.9% across the year, a decrease of 0.18% compared with 2011/12. During 2012/13 we have established a Health and Wellbeing Group which aims to identify and improve the ways in which we support our staff when they are unwell, and that promotes ways in which we can help staff maintain their health. We remain committed to supporting our staff when they are unwell and continue to put measures in place to help them return to work.

#### Staff survey results

National staff survey results for the 2012/13 period were issued in March this year. The surveys are completed by a sample of staff who are selected at random and asked to complete a series of key questions ranging from personal development and experience of working in NHS Trusts.

The Trust maintained its response rate of 51% of staff replying. The results had not improved as much as we would have liked, however, our staff survey results did indicate that there are some key areas of improvement, and these relate to staff feeling they received more structured appraisals, and job relevant training.

We are progressing further work to tackle staff concerns raised in the survey about violence and aggression, equality and diversity. We have put measures in place such as additional lighting and CCTV cameras to make our hospital environment a safer place for our staff to work in. The Health and Well-Being Group was formed in January to analyse themes and trends arising from incidents related to violence and aggression. Breakaway/ conflict resolution training will continue to be provided to relevant staff.

As demonstrated by the demographic data above, the Trust has a diverse workforce, and the Trust takes its responsibilities under the Equality Act (2010) seriously. The survey results indicate we need to focus our efforts more on enhancing arrangements for putting in place equitable access to career progression and promotion opportunities.

#### Staff award winners 2012/13

Throughout the year, we run a series of staff awards for individuals and teams. Patients, members of the public and staff are all able to nominate an individual and a team of the month for awards. The winners of the annual team and employee of the year awards are drawn from the monthly winners and announced at the Trust's Annual General Meeting. In addition there are also further annual awards presented for specific achievements over the year.

Passion, commitment and innovative patient care were in full force as our annual award winners were acknowledged at the Annual General Meeting in September 2012. The five awards, presented to the winners by members of the Trust Board, spanned very important areas of focus for the North Middlesex including patient safety, innovation and creativity and outstanding contribution to clinical care. The winners in each of the categories were:

#### **Annual Award for Innovation and Creativity**

Winner – Dr Achim Schwenk, Consultant in HIV/AIDS Highly commended – 'Mothers for Mothers' volunteer scheme

#### **Annual Award for Outstanding Contribution to Clinical Care**

Winner – Dr Mary Brennan, Consultant in Palliative Care

Highly commended - Dorrett Wright, Clinical Nurse Specialist in pain management

## **Annual Award for Patient Safety**

Winner, Dr Janine Wright, Consultant Gastroenterologist Highly commended - Fola Babasola, Theatres Nurse

#### **Team of the Year**

Winner – George Marsh Centre Team Highly commended – Patient Systems Coordination Team

## **Employee of the Year**

Winner – Zoila Sanchez, Practice Development Nurse for Surgery Highly commended – Maria Taylor, Oncology Dietician

Patients and members of the public are encouraged to nominate staff for awards – please visit <a href="https://www.northmid.nhs.uk">www.northmid.nhs.uk</a> for a copy of the application form.

## SECTION 4 OUR GOVERNANCE

In this section we outline how the Trust uses its Committees and formal groups to monitor how the Trust is being run, together with the risks associated with the running of services.

The Trust Board is legally accountable for the delivery of services and our Annual Governance Statement, signed by the Chief Executive, gives a comprehensive overview of our governance arrangements and how we discharged our statutory duty to maintain a sound system of internal control.

### **Governance Structure and Board Committees**

The Trust Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Trust Board and the organisation

The general duties and responsibilities of the Trust Board are:

- To work in partnership with patients, carers, local health organisations, local government authorities
  and others to provide safe, accessible, effective and well governed services that meet the needs of
  patients, carers and the Trust's local population.
- To ensure that the Trust meets its obligations to the population it serves, its stakeholders including
  its staff in a way that is wholly consistent with public sector values, including the Nolan Principles of
  Public Life.
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

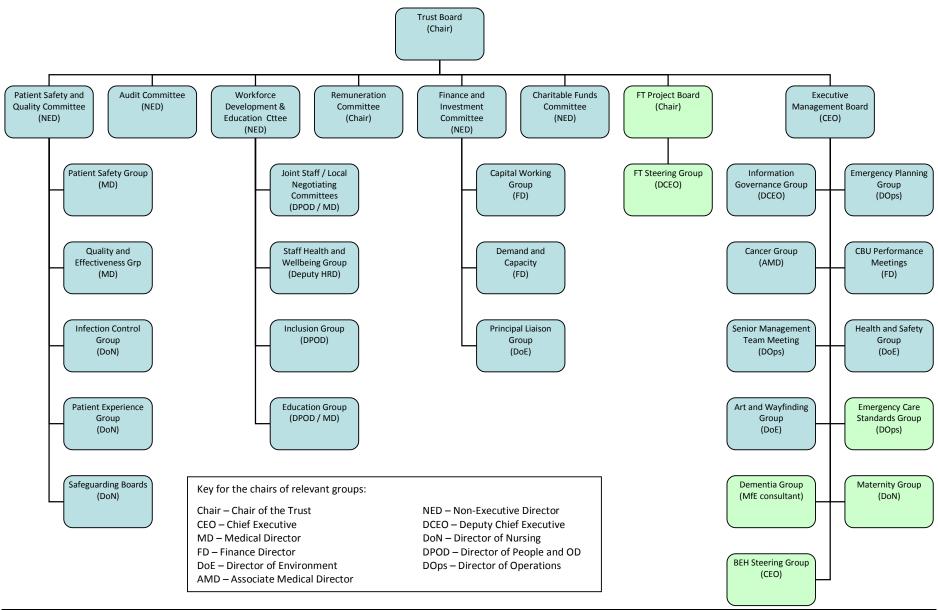
The Trust has an obligation under the Code of Conduct and Accountability for NHS Boards to compile and maintain a register of the interests of directors, which might influence their role. The register is available to the public, in accordance with the Freedom of Information Act, through written application to the Trust's Chief Executive. The Trust is also required to publish in the Annual Report the directorships of any member of the Board in companies that are likely to, or seek to, conduct business with the NHS.

In order to achieve these objectives the Trust Board meets, in public, each month. The Trust Board meetings are chaired by the Trust Chair, a Non-executive Director. The table below demonstrates the attendance each voting member of the Trust Board at the Trust Board meetings during 2012/13.

		Month										
Name	Apr	May	June	July	Sep	Oct	Nov	Dec	Jan 2013	Feb	Mar	Total
<b>Executive Directors</b>												
Julie Lowe	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Yes	Yes	2/2
Lance McCarthy	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10/11
Theresa Murphy	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	9/11
Stanley Okolo	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	10/11
Martin Armstrong	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	11/11
Clare Panniker	Yes	No	Yes	No	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2/4
Non-Executive Direct	Non-Executive Directors											
David Hooper	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n/a	n/a	9/9
Lynne Cantor	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	9/11
Sally Field	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	9/11

David Price	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	8/11
John Simons	n/a	n/a	Yes	9/9								
Catherine Dugmore	n/a	n/a	n/a	n/a	Yes	No	Yes	Yes	Yes	Yes	No	5/7
David Snowdon	Yes	Yes	Yes	n/a	3/3							

The Trust's governance structure is also outlined overleaf.



#### **Board Committees**

#### **Executive Management Board**

The Executive Management Board is responsible for the day-to-day operational management of the Trust and the delivery of the strategic objectives agreed by the Trust Board. The Executive Management Board also ensures that correct clinical and managerial expertise is brought to bear on developing policies and processes to ensure all parts of the Trust are engaged with the Trust's corporate agenda.

The Executive Management Board does not have any Non-Executive Director members. It is chaired by the Chief Executive and is attended by the other Executive Directors as well as the Clinical Business Unit Management teams.

## **Patient Safety and Quality Committee**

The Patient Safety and Quality Committee obtains assurance on behalf of the Trust Board that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

The Patient Safety and Quality Committee also:

- Promotes safety and excellence in patient care
- Identifies, prioritises and manages risk arising from clinical care
- Ensures the effective and efficient use of resources through evidence based clinical practice.

The Patient Safety and Quality Committee meets each month, with the exception of August. The Committee has 2 Non-executive Director members, however all Non-Executive Directors are welcome to attend Patient Safety and Quality Committee meetings.

Throughout 2012/13 the Patient Safety and Quality Committee was chaired by Lynne Cantor who attended all 11 Patient Safety and Quality Committee meetings. John Simmons is the second Non-Executive Director member of the Committee and he attended 10 out of 11 Patient Safety and Quality Committee meetings during 2012/13. There were at least 2 Non-executive Directors present at all 11 Patient Safety and Quality Committee meetings during 2012/13.

#### **Audit, Assurance and Governance Committee**

The Audit, Assurance and Governance Committee provides the Trust Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities.

In addition, the Audit, Assurance and Governance Committee:

- Provides assurance of independence for external and internal audit
- Ensures that appropriate standards are set and compliance with them is monitored in non-financial, non-clinical areas that fall within the remit of the Audit, Assurance and Governance Committee
- Monitor corporate governance (e.g. compliance with the code of conduct, standing orders, standing financial instructions and maintenance of a register of interests).

The Audit, Assurance and Governance Committee met 7 times during 2012/13. Attendance of 2 Non-Executive Directors is required in order for the Audit, Assurance and Governance Committee to be quorate. Following her appointment in September 2012, the Audit, Assurance and Governance Committee was chaired by Catherine Dugmore who has attended three of the four Audit, Assurance and Governance Committee meetings since her appointment. Sally Field, Senior Independent Director and Vice Chair is the deputy chair of the Audit, Assurance and Governance Committee and she attended all 7

Audit, Assurance and Governance Committee Meetings during 2012/13. All 7 Audit, Assurance and Governance Committee meetings were attended by at least 2 Non-executive Directors.

#### **Workforce Development and Education Committee**

The Workforce Development and Education Committee obtains assurance on behalf of the Trust Board that high standards of workforce development and education are provided to members of staff by the Trust. The Workforce Development and Education Committee also:

- Ensures the Trust has an up to date Workforce Strategy, incorporating all aspects of education, development and research
- Assures the Trust Board that all indicators of a well managed workforce are regularly reviewed
- Make recommendations to the Trust Board on specific initiatives and business cases in support of the delivery of the Workforce Strategy

The Workforce Development and Education Committee meets six times a year and has three Non-executive Director members and is quorate when chaired by a Non-Executive Director and 5 Executive Directors or managers are present. The Workforce Development and Education Committee was chaired by Professor David Price throughout 2012/13, who attended all six Workforce Development and Education Committee meetings.

#### **Finance and Investment Committee**

The Finance and Investment Committee, was previously titled as the Finance and Contracts Committee during 2012/13. This committee enables the Trust Board to obtain assurance on all matters relating to the finance, investment and contracting agendas of the Trust. This committee also ensures that the financial and contract planning, monitoring and reporting undertaken by the Trust us accurate, timely and robust.

The Committee meets each month. It is chaired by a Non-executive Director and requires the attendance of two non-executive directors and two executive directors in order to be quorate. The committee has been chaired by John Simmons since his appointment in June 2012, and he has attended all 10 committee meetings since his appointment. Catherine Dugmore is the other Non-executive Director member of the committee, and she has attended 6 out of 7 possible committee meetings since her appointment in August 2012. The committee is also attended by Lance McCarthy, Deputy Chief Executive, who attended all 12 meetings during 2012/13 and Martin Armstrong, Finance Director, who attended 11 of the 12 committee meetings. All meetings held during 2012/13 were quorate.

#### **Remuneration Committee**

This Committee consists of all the non- executive Directors of the Trust. The Committee meets at least annually and on an ad hoc basis as required. During 2012/13 the Committee met 3 times. More detail is included in Section 6 – Managing Finances.

#### **Annual Governance Statement 2012/13**

#### 1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of North Middlesex University Hospital NHS Trust's (the Trust) policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible, as set out in the Accountable Officer Memorandum.

It is my responsibility to provide leadership to the Trust and to ensure that the Trust provides safe, effective, high quality and patient centered care that is Value for Money.

As Chief Executive, I report to the Trust Chairman and work within a performance management framework established by NHS London and NHS North Central London. The Trust works in partnership with other local health and social care organisations in the North Central London sector and I have close working relationships with the local Primary Care Trusts, Boroughs, Local Authorities and acute NHS Trusts. The Trust has a strong relationship with Middlesex and City Universities and University College London and I and members of the Trust's Executive Team attend local Health Overview and Scrutiny Committee meetings to account for the performance of the Trust to the local community.

## 2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure, to achieve policies, aims and objectives. It can therefore, provide only reasonable and not absolute assurance of effectiveness.

The system of internal control is a continuous process designed to:

- identify and prioritise the risks to achievement of the Trust's policies, aims and objectives;
- evaluate the likelihood of those risks being realised, the impact should they be realised and to manage these risks efficiently, effectively and economically.

The system of internal control has been in place at the Trust for the year ended 31 March 2013 and is intended to remain so up to the date of approval of the Annual Report and Accounts. The Board Assurance Framework has been regularly reviewed and updated through the year.

## 3. The governance framework of the organisation

The Board has had 10 committees in 2012/13, 9 of which were chaired by non-executive directors. The Hospital Development and Environment Committee was disbanded in July 2012 and the Strategy and Planning Committee created from this date. The FT Project Board was created from 21.3.13. They have delegated authority from the Board and are aimed at covering all key areas of control and risk. They include:

- Audit, Assurance & Governance Committee (chaired by Sally Field, NED and Senior Independent Director, until September 2012 and Catherine Dugmore, NED, since November 2012)
- Patient Safety & Quality Committee (chaired by Lynne Cantor, NED)
- Finance and Contracts Committee (chaired by David Hooper, Chairman, until May 2012 and John Simons, NED, since June 2012)
- Workforce and Organisational Development Committee (chaired by David Price, NED)

- Hospital Development and Environment Committee until July 2012 (chaired by David Hooper, Chairman) – the committee was disbanded on 11 July 2012.
- Strategy and Planning Committee (chaired by Sally Field, NED, from October 2012) the Committee
  was a new committee set up from 9 October 2012.
- Charitable Funds Management Committee (chaired by Sally Field, NED, until December 2012 and Catherine Dugmore, NED, since 20 December 2012)
- Remuneration Committee (chaired by Sally Field, NED)
- FT Project Board (chaired by Lynne Cantor, NED, in her role as Acting Chair, from 21.3.13)

In addition there is an Executive Management Board, the most senior Executive meeting in the Trust, chaired by me as the Chief Executive.

Attendance at Trust Board and each of the committees is monitored as part of their annual assessment of effectiveness Trust Board and each of the committees are regularly attended by all relevant directors. Board attendance was 89% during the course of the 2012/13 financial year.

Scrutiny by the Non-Executive Directors provides assurance of internal control and probity. The role of the Non Executive chair and input at each of these committees represents an important and key element of the overall governance framework of the Trust.

The Audit, Assurance & Governance Committee oversees the performance of the Trust's risk management system and receives regular updates from each of the other Board Committees. Key risks are highlighted to and reviewed by the Trust Board as part of its regular monitoring of performance and the Board reviews reports from each of its committees to ensure that an integrated approach to governance and risk management is applied.

The Board agreed 3 overarching corporate objectives in April 2011 to provide clear direction for the organisation for 3 years. These, supported by 12 specific objectives, remained the same throughout 2012/13:

- Quality To provide excellence in treatment and care that is safe and patient-centred
- Business To ensure the Trust is a well-governed, financially viable business that adapts to the dynamic healthcare environment
- People To develop the leadership, potential and commitment of our people

Progress against the delivery of the corporate objectives, is monitored regularly at the Board committees through the achievement of the 12 specific objectives and 54 key deliverables that underpin them. The Board reviews progress formally through a quarterly report. Trust Board and Board committee member attendance is available to see in the Annual Report.

To demonstrate the successful operation of the Trust regular reports on all aspects of performance are provided to NHS London and our main commissioner (NHS North Central London (NCL)) in line with required reporting timescales. Annually, the Trust formally agrees an activity and finance contract and then holds monthly performance reviews and clinical quality meetings with NCL. Annually the Trust also submits a balanced financial plan to NHS London including Quality, Innovation, Productivity and Prevention (QIPP) programme details, progress against which are reported on monthly both to the Board and NHS London.

I also have close working relationships with partner organisations, including the local Primary Care Trusts, Boroughs, Local Authorities and University College London Partners (UCLP), and the Chief Executives of local NHS Trusts, including Barnet and Chase Farm Hospital NHS Trust. The Trust plays an

active role in the development of the Barnet, Enfield and Haringey Clinical Strategy and engages with local stakeholders through its Patients and Public Involvement Forum and LINks.

During 2012/13 there has been a Board development programme in place aimed at understanding the current effectiveness of the Board and its members and developing individuals and the team to increase effectiveness over time. As part of this a series of workshops have also been held to support the development of the Integrated Business Plan for FT application. The programme will be ongoing through 2013/14, updated slightly and linked to the best practice identified in the DH Board Governance Assurance Framework, including compliance with the Corporate Code of Governance. In addition, all Board committees have undertaken an annual review of their effectiveness during the year.

The Trust has in place arrangement for the discharge of its statutory functions, these are reviewed and validated through audit review and testing.

#### 4. **Risk Assessment**

Risk is assessed across the organization in line with the process outlined in the Corporate Risk Management Strategy. Risk is measured by multiplying the likelihood of the risk occurring and the impact of that risk event should it occur. The Trust uses a variety of safety, quality, financial and compliance metrics to accurately assess the extent of risk. This ensures that risks are assessed uniformly and consistently across the Trust and at different points in time during the financial year.

Following the agreement of the Trust Board's Corporate Objectives for the financial year, the Head of Risk Management and Executive Directors assess the risks to the achievement of the corporate objectives. These risks, the controls in place to mitigate them and assurances of their efficacy are incorporated in the Board Assurance Framework in order to ensure that the management of those risks is subject to regular and rigorous scrutiny by the Trust Board. Internal Audit have reviewed the risk assessment process and the operation of the Board Assurance Framework throughout 2012/13 and has reported an opinion of Substantial Assurance. In addition, the Trust also passed its NHSLA Level 3 assessment in November 2012. These reviews provide me, as Accountable Officer, with assurance that the system of internal control across the trust, operates effectively.

#### 5. **Risk and Control Framework**

The Trust has a Risk Management Strategy, approved by the Audit, Assurance & Governance Committee and endorsed by the Board, that sets out the accountability structure for the management of risks within the Trust. I have overall responsibility for risk management with day to day responsibility being delegated to the Deputy Chief Executive. I am supported in this by the executive directors through the delegation of responsibility for operational performance and risk management. Relevant Executive Directors take responsibility for specific risk areas as outlined below:

Patient Safety **Medical Director**  Patient Experience **Director of Nursing**  Clinical Outcomes **Medical Director**  Audit and Clinical Effectiveness Medical Director Finance Director of Finance Information Governance **Deputy Chief Executive** 

 Health and Safety Director of Environment

 Workforce Director of People and Organisational Development The performance of each executive director, and the services they lead, is monitored through the internal performance management systems and also by the Trust Board through the committee structure, and individual objective and performance review.

The Risk Management Strategy covers all aspects of the Trust's business including clinical, operational, financial, safety, reputational and environmental risks. All policies and procedures in relation to Risk Management are reviewed and approved by the Trust Board via the Committee structure. The Trust Board's Assurance Committees are structured to ensure they are chaired by non-executive directors and non-executive director scrutiny is appropriately focused and robust.

Training is available to all staff in risk management to ensure they have the necessary skills and knowledge to identify and manage risk within their work environment. Staff induction includes sections on risk management, incident reporting, infection control, health and safety and manual handling and annual compulsory training on these, and other issues, is provided appropriate to the roles.

The Trust's Risk Management Strategy describes the responsibilities and processes for identification, evaluation and control of risk within the Trust. It is reviewed annually. The Board has overall responsibility but it delegates the work to the Audit, Assurance & Governance Committee, which is chaired by a non-executive Director.

All identified and assessed risks are recorded on the Trust's Risk Register and are reviewed and updated regularly. Risks are identified from a range of sources including the Assurance Framework, risk profiling activities, incident reporting, claims / litigation, complaints received, internal management reviews and reports from external organisations. Staff are actively encouraged to highlight risks and the actions necessary to mitigate them. These are then reported back through local management meetings, and the Clinical Business Units (CBUs) and other key parts of the Trust develop their own risk registers which feed in to the corporate risk register.

Local risk registers are reviewed monthly, a process that is monitored through monthly performance meetings. The Assurance Committees routinely review risks of 15 and above to assess mitigation plans and actions.

Each objective within the Assurance Framework is allocated to the relevant executive director, who has the responsibility to link any risk to the delivery of the objective to gaps in assurance or control. The executive lead for each objective also has the responsibility to report to the Board through the Committee structure the actions necessary to address the risk. Risk managers proactively set up risk identification and review meetings with Executive Directors to maintain the effectiveness of the risk register. The relevant sections of the Assurance Framework are reviewed at the relevant Assurance Committees regularly and the Audit, Assurance & Governance Committee takes the lead in scrutinising progress against the Assurance Framework in its entirety. The Assurance Framework is reviewed quarterly at the Trust Board.

The Trust is fully compliant with Care Quality Commission (CQC) essential standards of quality and safety. Compliance is monitored on regularly through a process of peer reviews with a management and an Executive Director lead for each of the outcomes.

The Board is aware of the importance of maintaining high standards of information governance and ensuring the security of personally identifiable information. The Board has appointed the Deputy Chief Executive as the Senior Information Risk Officer (SIRO) who chairs the Information Governance Committee, supported by an Information Governance Manager. This Committee reports to Audit, Assurance & Governance Committee and has undertaken a self-assessment in respect of the Information Governance Toolkit v.10 which has highlighted that good practices are in operation in the majority of areas. The Trust declared compliance with all of the information governance toolkit

provisions with the exception of the information governance training. This resulted in an overall declaration of 'Level One '/Not satisfactory' rating. An information governance action plan is in place to address these gaps, which is monitored monthly and reported to the Information Governance Committee .

An information risk register is in place to capture and monitor the implementation of action plans associated with information risks. This is monitored actively by the Information Governance Committee, which is chaired by the SIRO. In making an assessment of the adequacy of internal controls relating to information risks , I have taken into account written advice from the SIRO on the content of this disclosure.

The Trust has arrangements in place for effective working with its partner organisations, principally its main commissioners, and continues to play an active role in the development of the Barnet, Enfield and Haringey Clinical Strategy, with construction works for the new building having started on site in the winter.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with including an Equality Impact Assessment accompanying all new Trust policies.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

#### 6. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers within the organisation who have responsibility for the development and maintenance of the system of the internal control framework.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Their opinion for the year ended 31 March 2013 is one of significant assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My view is also informed by the following:

 Strong and effective scrutiny and challenge from non-executive directors within committees and at the Trust Board

- Internal Audit review of the Assurance Framework, which was undertaken in February and March 2013 with an opinion of substantial assurance given
- Internal audit reports provided by Parkhill
- External audit reports provided by Grant Thornton
- NHSLA acute services accreditation Level 3 (November 2012)
- CNST Level 2 accreditation (December 2011)
- Achievement of the NHS London Standards for Stroke Care in August 2012
- CQC registration without compliance conditions
- CQC unannounced general visit (12.12.12 and 13.12.12) visiting A&E, PALS, 2 surgical wards, 2 older people wards, ambulatory care unit, acute stroke unit and theatres compliance with all 8 standards assessed 2, 4, 6, 9, 13, 16, 17 and 21
- Cancer Peer Review
- NHS London Emergency Planning Assurance process
- Value for Money assessments undertaken by external audit; in particular the standard on Internal Control
- Local Authority Overview and Scrutiny Committee reviews and comments
- Royal College Reviews
- Clinical Pathology Accreditation

The Board Committee structure and the Committee's performance over 2012/13 also inform my view:

The Board has reviewed the Assurance Framework, received regular reports from all its Committees and received monthly reports on patient safety and quality, financial performance and performance against activity, workforce, environmental and national targets.

The Audit, Assurance & Governance Committee oversees the performance of the Trust's risk management system and has received regular updates from each of the other Board Committees. It approved the internal audit workplan and has reviewed internal and external audit reports and monitored and scrutinised progress against the Corporate Objectives through the Assurance Framework. Areas highlighted within the Assurance Framework during the year have been:

- Improvement required in the Trust's ability to receive comprehensive and timely patient feedback and to influence the patient experience. A programme to improve patient experience at the Trust is in place.
- An emphasis on actions and systems to ensure that patient safety continues to remain a key focus
  for the Trust, with particular focus upon 'never events' and the reduced prevalence of pressure
  sores and falls. In addition the assurance framework has monitored delivery against key deliverables
  in respect of safeguarding compliance.
- The need to maintain focus on financial performance, notably the delivery of the large QIPP programme.
- Management of operational and strategic risk associated with the implementation of the Barnet, Enfield & Haringey clinical strategy. Throughout the year, the Trust has continued to work closely with partners associated with the strategy to plan for its implementation with Full Business Case approval received by DH and HM Treasury in January 2013.
- The need to continue with the implementation of the action plan in order to ensure the Trust meets NHS London's Quality and Safety Programme Acute Quality Standards for acute medicine and surgery, maternity and acute paediatrics. The Trust continues to implement its action plan to meet these standards as part of the implementation of the Barnet, Enfield and Haringey Clinical Strategy.

The Patient Safety & Quality Committee has monitored and reviewed the Trust's risk management processes with a primary focus on the safety and quality of care received by our patients. It has received regular reports from the Patient Safety Board and monitored the implementation of the Trust's Patient Safety and Patient Experience Strategies.

The Finance and Contracts Committee monitors the Trust's financial performance, including the delivery of the QIPP Programme, ensuring that financial performance is delivered without impacting adversely on patient safety.

The Trust has performed well in the year ended 31<sup>st</sup> March 2013 against the national performance indicators and national priorities. The Trust exceeded the national 95% 4-hour A&E target (96.2%) and performance against infection control targets for MRSA Bacteraemias (1 in total for the year) and C Difficile (22 in total) were within agreed targets. All cancer access targets were achieved and our HSMR continues to fall (87.1 for the rolling 12 months to March 2013).

After 2 days of review in November 2012 the Trust passed its NHSLA Level 3 assessment. This is a national risk management process with Trusts assessed against 50 standards across 5 domains that reflect issues that generally arise in clinical and non clinical negligence claims. Level 3 is the highest level attainable and checks that all our policies and procedures are being complied with and we have evidence of auditing ourselves against them and plans in place for addressing any weaknesses or issues that arise from the audits. It strongly supports our strategic objective to provide excellence in treatment and care that is safe and patient-centred.

The work undertaken in 2011/12 in conjunction with the national 18 week Intensive Support Team and the successful implementation of the associated action plan has been evident throughout 2012/13 with performance consistently above the national standards and comparable to some of the best in the country throughout the year.

During 2012/13 there were 58 Serious Incidents (SIs) reported by the Trust. Twenty nine of the SIs were in relation to patients being admitted with either grade 3 or grade 4 pressure ulcers. All SIs across the Trust are investigated using root cause analysis giving recommendations and learning for the organisation which is then disseminated to relevant CBUs and departments. An action plan is developed as part of all investigations, progress against which is monitored at both the Patient Safety and Quality Committee and the Executive Management Board and all investigations are signed off by an Executive Director. An SI update report including progress against outstanding actions plans and a summary of the most recent opened and closed SIs goes to the Board every month. There is also a regular process of benchmarking ourselves against other Trusts' levels and severities of SIs, including the use of analysis from NHS London - The Trust is not an outlier.

The 2012 Dr Foster Hospital Guide was published on 3 December 2012. Against the 4 hospital mortality measures used by Dr Foster, the Trust scored better than expected against 1 (SHMI) and as expected against the other 3 (HSMR, deaths in low risk conditions and deaths after surgery). The Guide did however highlight the outpatient DNA rate of 15.6% at the Trust to be a material outlier when compared to other Trusts nationally, which is being addressed through some ongoing transformation improvement work in conjunction with KPMG as part of the NHS London Productivity Improvement Programme.

The Trust commissions Internal Audit to support the assurance of the management of risks contained in the Board Assurance Framework. During 2012/13 Internal Audit reported three Limited Opinions. These concerned Internal Audit reviews of Clinical Audit, Medical Records and the management of complaints and incidents. In all cases the Trust has agreed action plans to improve the level of assurance and the implementation of these action plans is monitored at the Audit, Assurance and Governance Committee.

The Trust has compiled a Quality Account to provide assurance to its patients, the public and the Trust's commissioners with assurance of the standard and quality of care it has provided to patients during 2012/13. The Quality Account will be reviewed by the Trust's Commissioners who will provide an accompanying commentary reporting their opinion of the quality of services provided by the Trust. The Quality Account will also be externally audited and the External Auditor's opinion will be included with the Quality Account when published. Internal processes are in place to validate the content of the Quality Account, which includes ongoing collective review of key aspects of the account indicators both internally and also within the governance structure of the Trust.

The Trust had a Counter Fraud service provided by Parkhill that regularly reports progress on training, prevention, proactive reviews and investigations to the Audit, Assurance & Governance Committee. Over the course of the year some recommendations have been made and implemented to improve underlying systems in place to deter fraud from occurring at the Trust.

In recognition of the additional planning required for the 2012 Olympics, a task and finish Olympic sub-group to the Emergency Planning committee was set up, chaired by the Director of Operations and assurance provided to the NHS London Emergency Planning Team. An action plan is in place to close the gaps and will be monitored by the EP Committee.

#### 7. Financial Control

For the year ended 31<sup>st</sup> March 2013 the Trust reported an audited retained surplus of £1.8m, this builds upon strong financial improvement during the six preceding years.

## 8. Conclusion

Based on this review it is my view that, with the exception of the internal control issues I have outlined in this statement, North Middlesex University Hospital NHS Trust has a generally sound system of internal controls that support the achievement of the Trust's policies, aims and objectives and that the reported control issues are currently being addressed. The Trust Board remains committed to continue to strive to effect ongoing improvement.

I have been advised on the implications of the result of my review of the effectiveness of internal control by the Audit, Assurance & Governance Committee.

Signed	Julie Lowe, Chief Executive Officer
Date	

## SECTION 5 OUR FUTURE

This section covers our plans for the future and our priorities for the year ahead. We have a clear set of objectives and a set of strategies that are central to what we do, such as the Integrated Business Plan and Clinical strategies, which are currently being updated.

We are also applying to become a Foundation Trust and we firmly believe that the freedoms this will bring will enable us to offer the very best services for the local population that we serve.

2013/14 is a key and exciting year in the development of and the future of North Middlesex. Our strategic priorities for the next 5 years are outlined below together with some specific priorities for the year ahead. Within this two major strategic developments will be at the fore; the implementation of the BEH Clinical Strategy in conjunction with our partners and colleagues across the local health economy, and the ongoing development of our stand-alone Foundation Trust application.

#### **Barnet Enfield and Haringey Clinical Strategy**

HM Treasury approval of the Full Business Case for £80m of investment, with previous approval from NHS London and the Department of Health, is the final approval hurdle required to implement local hospital changes across Barnet, Enfield and Haringey by November 2013. The investment will provide:

- a new Stroke and HIV Unit
- a refurbished Oncology Ward
- the refurbishment of four floors of the Tower Block for 22-bedded inpatient wards on each
- a new HIV Outpatient department and
- the creation of a new Women's and Children's Centre.

The new Women's and Children's Centre will include two operating theatres, consultant and midwifery-led birthing units, an expanded Neonatal Intensive Care Unit/Special Care Baby Unit and outpatients facilities all in one building, dramatically improving the environment for expectant mothers.

#### **Attaining Foundation Trust status**

We are aiming to become a Foundation Trust during 2014/15. Gaining this status will give staff, patients and members of the local community a greater say in how the hospital is run. This closer involvement will bring lasting improvements to patient services and better health for communities. Being a Foundation Trust will also give us greater independence and financial freedoms to more easily facilitate our local priorities and shape services to the needs of local communities.

A formal FT governance structure has been put in place in 2012/13 and work on building a membership reflective of our patient base, with the subsequent recruitment of governors, will take place in early 2013/14. A detailed project plan is currently being updated to be aligned fully with the new Trust Development Authority Accountability Framework and will be available on our website once completed.

#### Our strategic priorities for 2013/14

As part of the development of our Integrated Business Plan (IBP) for our FT application, a review of and agreement of the Trust's strategy and vision has been undertaken and consulted upon within the Trust. It is imperative to have corporate objectives that support and underpin the Trust's strategy, vision and service development priorities so they too have been reviewed. The Trust Board felt that whilst the 3 corporate objectives remained reasonably well aligned with the Trust's strategy and vision, the 12 specific objectives were much less well aligned and very short-term focussed. It was also felt that having

15 objectives (3 corporate and 12 specific) supported by more than 60 key deliverables was too complicated for successful dissemination and use through the organisation.

Consequently, to support the Trust's Vision to "become the healthcare provider of choice for the diverse population we serve in North London and beyond, recognised for excellent emergency, acute, maternity and ambulatory care, delivered by excellent and compassionate staff" the Trust Board has agreed to have 5 Strategic Objectives for the next 5 years:

- The achievement of excellent clinical outcomes
- Ensuring **positive experiences** for patients, GPs and all stakeholders
- To be an **employer of choice** with a workforce that is excellent and compassionate, acting as ambassadors for the Trust
- Provide services that are **value for money** for the taxpayer
- Maximise the efficient **use of the site** through closer working with other organisations and fostering education, teaching and research

These objectives are supported by 60 key deliverables specific to 2013/14, progress against which will be tracked, monitored and reported on quarterly to the Trust Board and relevant Board committees.

#### Using the Francis Report to provide first rate care

Our objectives are well aligned to the areas of priority outlined in the Francis report and its associated recommendations.

As a Trust, from the Board to the ward, we are committed to being open and honest with our staff, patients and stakeholders about the quality and safety of our services which we believe will rightly instil confidence about the local NHS with the communities we serve.

North Middlesex University Hospital NHS Trust has in place an action plan specifically tailored to respond to the recommendations of the initial Francis Report and the publication in February 2013, Robert Francis QC's Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Progress against the Francis Action Plan has been monitored at the Trust Board. This plan has been discussed with stakeholders and has taken on board staff feedback at a range of targeted clinical workshops with frontline clinical staff chaired by the Director of Nursing and Chief Executive. Workshop attendance has included medical, surgical and nursing staff. The plan itself will continue to be updated following staff feedback.

By committing to this action plan, and subjecting performance and delivery to formal Non-executive Director led scrutiny, the North Middlesex Hospital NHS Trust Board ensures that as an organisation, we learn from the events that took place at Mid Staffordshire NHS Foundation Trust and prevent such events from being repeated.

The executive lead focused on delivering the Mid Staffordshire Action Plan is the Trust's Director of Nursing and Midwifery.

More widely, all staff members have been briefed about the outcome of the public inquiry and our updated action plan. Further briefings to specific staff groups and the wider staff based are being scheduled as we look to address the recommendations in full over the coming months. We want to hear their views and ideas about ensuring care and compassion remain at the core of service provision. We will continue to strengthen our existing approaches to ensuring that staff and patients views are listened to and inform the Trust's views on the quality of its services. We already conduct monthly Trust Board

walkabouts where an Executive and Non-Executive Director visit clinical services and talk to staff and patients about their experiences. The outcomes of these walkabouts are formally reported each month at the public part of the Trust Board meeting. We have carried out a series of 'back to the floor' sessions in 2012/13, where senior managers shadow services and departments to get a sense of staff experience and the challenges they face, which has led to meaningful operational changes to improve experience in these areas.

We have a strong relationship with our Patient Representative Forum who has direct access to Trust meetings, committees and senior staff in order to ensure that the patient voice remains a key focus in the Trust Board's decision making. We hold, and will continue to hold, throughout 2013/14, monthly patient story sessions at the Patient Safety and Quality Committee. These sessions provide an opportunity for our patients, their families and carers to attend the Trust's Patient Safety and Quality Committee and talk about and share their experiences and how they felt they were cared for at North Middlesex Hospital.

The Executive Directors have written to all staff to remind them of their responsibility to raise concerns and provide staff with the assurance that their concerns will be listened to and acted upon. There exists a formal process by which staff can raise concerns safely and without fear of reprisal and this has been repeatedly reiterated to staff in an effort to increase awareness of it. Following an internal review of compromise agreements over the past two years, the Trust is in a position to confirm that there are no gagging clauses in existence. This matter was discussed at the March Board meeting and a statement of compliance is on the Trust website to that effect.

We are taking the recommendations made by Robert Francis QC very seriously, including how we will continue to work with staff, patients and the wider community in order to deliver excellent care to the communities we serve and how we will react promptly in response to any concerns raised.

## ANNUAL ACCOUNTS

## SECTION 6 OUR FINANCES

This section provides information pertaining to how the Trust is funded and how we manage our finances. There is detailed information about how much funding we receive and where it comes from, as well as how we spend it on providing services. We have a duty to disclose the remuneration of our most senior staff, and our associated governance arrangements, this information is incorporated within the remuneration report. You can also learn about our financial targets that were set for 2012/13 and whether we have met them.

#### **Statement of Accountable Officer's responsibilities**

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place;
- and annual statutory accounts are prepared in a format directed by the Secretary of State with the
  approval of the Treasury to give a true and fair view of the state of affairs as at the end of the
  financial year and the income and expenditure, recognised gains and losses and cash flows for the
  year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as the Accountable Officer.

Julie Lowe Chief Executive

### Financial performance for 2012/13

For the year ending  $31^{st}$  March 2013 the Trust met all of its key operational financial targets and reported a retained surplus of £1.8m, after a technical adjustment of £480k relating to fixed asset impairments.

The technical impairment adjustment referred to above relates to the loss in value of the Trust's buildings following a revaluation undertaken during 2012/13 and reflects changes of use as a result of the continued extensive development of the site over the course of the year. This adjustment does not impact on the Trust's breakeven duty, whereby it is required to breakeven on its income and expenditure 'taking one year with another' (meaning that expenditure must not exceed income over three years).

The reported NHS financial performance of the Trust is a surplus of £1.8m, the movement between the deficit reported in the accounts and this retained surplus of £1.8m is shown in the table below:

	£m
Retained surplus (excluding impairment)	1.848
Impairment	(0.480)
Surplus reported in the accounts	1.368
Impairment	0.480
Donated asset adjustment	0.125
Adjusted retained surplus	1.973

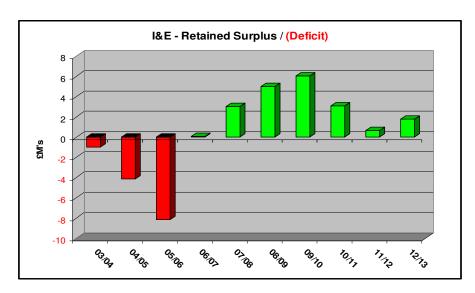
The Trusts net operating costs are chiefly incurred through the delivery of patient treatment activity within the framework of annual service level agreements with local CCGs, formerly Primary Care Trusts (principally Enfield PCT and Haringey PCT), which are financed from resources voted annually by Parliament. The Trust largely finances its capital expenditure from budgets generated internally, although during 2012/13 has received significant central capital funding to progress interim works associated with the implementation of the Barnet, Enfield and Haringey clinical strategy.

The Trust has delivered significant efficiencies during the course of 2012/13 (£8.1m). There were no new significant income generation activities during the year and additional unplanned income was primarily related to over performance against contracts with PCTs.

The Trust opened a (Public Funded Initiative) PFI hospital development in June 2010. It is important to reiterate that, in line with International Financial Reporting Standards (IFRS) and relevant accounting guidelines, the buildings are treated as Trust assets and are reflected as such within the Trust accounts.

The following graph illustrates how the financial performance of the Trust has changed over the last ten years.

The graph clearly illustrates that over the last seven years there has been a significant improvement in financial performance; moving the Trust from a position where it overspent by £8.1million in 2005/06 to that of subsequently reporting a consistent retained surplus. This sustained improvement is a result of the hard work of staff across the whole organisation in working to support the achievement of financial targets within a challenging economic environment.



In addition to the breakeven duty the other key annual financial targets that the Trust is measured against are;

- 1. To manage cash flows within the limits set by the Department of Health (the External Financing Limit EFL). This determines how much more (or less) cash can be spent by the Trust compared to that which is generated from its operations. The Trust is required to maintain net external financing within its approved EFL.
- 2. To achieve a 3.5% return on assets (the cost of capital absorption duty), in other words the total dividends paid on public dividend capital (PDC) must be 3.5% of the average net relevant assets (within a tolerance of 0.5%)
  - a. `To limit capital expenditure within the limit set by the Department of Health (the Capital Resource Limit CRL). The CRL determines the amount which can be spent by the Trust each year on capital purchases. It measures capital expenditure on an accruals basis (rather than cash outflow on capital) and must not be exceeded.
- 3. To pay 95% of undisputed invoices within 30 days of receipt of the invoice or goods, whichever is later (the Better Payment Practice Code).

Performance against these targets for the last five years is shown in the following table.

		<u> </u>			
Target	08/09	09/10	10/11	11/12	12/13
External Financing Limit	Met	Met	Met	Met	Met
Cost of capital absorption duty	Met	Met	Met	Met	Met
Capital Resourcing Limit	Undershoot	Undershoot	Undershoot	Undershoot	Undershoot
Better payment practice code	56%	65%	80%	52%	73%

As NHS trusts are allowed to undershoot the Capital Resources Limit the Trust can report it has met all of its financial targets with the exception of the Better Payment Practice Code (BPPC).

Whilst performance has improved significantly during 2012/13 it is recognised that the Trust has not achieved required levels of BPPC performance over the year. This can have an impact on the Trust's reputation and damage relations with suppliers, and that the Trust will work during 2013/14 to further improve payment practice in line with the standards set by the BPPC code.

During 2012/13 the Trust undertook a significant capital expenditure programme totalling almost £21.5m. The largest element of this spend was associated with construction costs related to the implementation of the Barnet, Enfield and Haringey clinical strategy. These capital works have been specifically funded by approved Public Dividend Capital; released by the Department of Health. The other features of the 2012/13 capital programme included investment to purchase medical equipment, the development of the Trust's Information Management and Technology (IM&T) infrastructure and also support for planned backlog maintenance

#### **Ongoing Financial Issues**

In the coming year the Trust will again look to continue to build upon the sustained financial performance reported over recent years. 2013/14 is again likely to represent a challenging year for North Middlesex reflecting the impact of both constrained national and local funding settlements. In response the Trust has set efficiency targets for the new year that will again require careful and robust management.

The Trust will continue to work with local commissioners to ensure that the Barnet, Enfield and Haringey clinical strategy is safely and effectively implemented to agreed timescales. This will again involve the commitment of significant approved capital resources as well as the recruitment of additional staffing resource in order to provide the extended services at the hospital that the strategy envisages. The Trust financial plan and its supporting Service Level Agreements with commissioners for 2013/14 have been prepared and agreed on his basis.

In addition the Trust will work closely with National Trust Development Authority (NTDA) and local commissioners and stakeholders during 2013/14 in order to move forward with the Trusts Foundation Trust application within the timescale agreed with the NTDA.

The Finance Department continue to provide valuable support in the delivery of Trust objectives and as such I would again like to extend my thanks to them for their active contribution this year.

The Trust Board continues to outline a robust and achievable plan to deliver agreed financial objectives and to ensure that the Trust has a stable and secure financial future moving forward. This will be delivered through the ongoing dedication and commitment of the Trust's staff.

#### **Overall Financial Arrangements**

The Trust operates within the regulatory framework determined by the Department of Health. Risk management is monitored through the Trust's Board Assurance Framework and risk register, as described in the Annual Governance Statement. Directors are members or attendees of the Trust Board and the Chief Executive, as accountable officer, has put in place systems that provide information and assurance for the Trust Board, including a significant internal audit programme which reports to the Trust's Audit Committee.

In addition, as confirmed via the annual letter of representation to the Trust's external auditors, there is no relevant audit information of which the Trust's auditors are unaware. This letter is signed by the Chief Executive, the Director of Finance and the non-executive Chair of the Audit Committee and has been agreed with other Board members.

The full Annual Governance Statement and the letter of representation relating to 2012/13 can be obtained from the Director of Finance, North Middlesex University Hospital NHS Trust, Sterling Way, Edmonton, London. N18 1QX.

## **Financial Statements**

The following section details the financial statements of the Trust for 2012/13, together with comparable data from the previous financial year. If you have any questions on the information provided please write to Director of Finance,.

The Trust's appointed external Auditors are Grant Thornton, total external audit fees for the 2012/13 year were £106k.

A complete set of the accounts can be obtained from the Trust's website or by contacting the Trust at the following address: Director of Finance, North Middlesex University Hospital NHS Trust, Sterling Way, Edmonton, London. N18 1QX

## **Summary financial statements**

## Statement of comprehensive income for the year ended 31 March 2013

	2012/13	2011/12
	£000	£000
Revenue from patient care activities	169,929	169,850
Other operating revenue	14,062	11,433
Impairment	(480)	(16,159)
Operating expenses	(176,204)	(175,111)
Operating surplus / (deficit)	7,307	(9,987)
Investment revenue	20	16
Other gains and (losses)	(16)	402
Finance costs	(5,551)	(5,680)
Surplus / (deficit) for the financial year	1,760	(15,249)
Public dividend capital dividends payable	(392)	(389)
Retained surplus / (deficit) for the year	1,368	(15,638)

## Other comprehensive income

Gains in revaluations	400	0
Total comprehensive income for the year	1,768	(15,638)

## **Reported NHS financial performance position**

Retained (deficit) for the year	1,368	(15,638)
Adjustment re donated asset	125	88
IFRIC 12 adjustment inc impairments	(1,829)	13,521
Impairments exc IFRIC 12 inc in expenses	2,309	2,698
Reported NHS financial performance position	1,973	669

All income and expenditure is derived from operating expenses

## Statement of financial position as at 31 March 2013

	31 March	31 March		
	2013	2012		
	£000	£000		
Non current assets				
Property, plant and equipment	178,208	163,902		
Intangible assets	1,619	1,758		
Total non current assets	179,827	165,660		
Current assets				
Inventories	3,355	3,083		
Trade & other receivables	9,199	12,080		
Cash and cash equivalents	8,569	3,446		
Total current assets	21,123	18,609		
Total assets	200,950	184,269		
Current liabilities				
Trade and other payables	(22,825)	(16,902)		
Other liabilities	(3)	(3)		
Borrowings	(6,350)	(7,455)		
Provisions	(400)	(770)		
Total current liabilities	(29,578)	(25,130)		
Total assets less current liabilities	171,372	159,139		
Non current liabilities				
Borrowings	(144,024)	(148,568)		
Provisions	(872)	(619)		
Total assets employed	26,476 9,952			
Financed by taypayard assists				
Financed by taxpayers' equity Public dividend capital	73,847 59,091			
Retained earnings	(79,578)	(81,419)		
Revaluation reserve	32,207	32,280		
inevaluation reserve	32,207	32,200		
Total taxpayers' equity	26,476	9,952		

These accounts were approved by the Board on 4 June and signed on its behalf by Julie Lowe, Chief Executive Officer.

## Statement of cashflows for the year ended 31 March 2013

	2012/13	2011/12
	£000	£000
Operating activities		
Net cash inflow/ (outflow) from operating activities	12,993	5,313
Cookflows from investing activities		
Cashflows from investing activities	20	4.5
Interest received	20	15
Payments for property, plant and equipment	(16,620)	(6,221)
Proceeds from disposal of plant, property and equipment	3	3,256
Payments for intangible assets	(382)	(403)
Net cash inflow / (outflow) from investing activities	(16,979)	(3,353)
Net seek inflow / (swifflow) hefere financing	(2.096)	1.000
Net cash inflow / (outflow) before financing	(3,986)	1,960
Cashflows from financing activities		
Public dividend capital received	14,756	6,963
Public dividend capital repaid	0	(3,800)
Loans received from the DH	1,900	5,050
Loans repaid to the DH	(2,985)	(6,380)
Capital element of finance leases and PFI	(4,562)	(4,804)
Net cash inflow / (outflow) from financing	9,109	(2,971)
		, ,
Net increase / (decrease) in cash and cash equivalents	5,123	(1,011)
Cash, cash equivalents and bank overdrafts at the beginning	3,446	4,457
of the financial year		
Cash, cash equivalents and bank overdrafts at the end of	8,569	3,446
the financial year		

## **Capital Cost Duty**

The Trust absorbed Capital Costs within its price charged to commissioners at the rate of 3.5% (2011/12 -3.5%)

## **External financing**

The Trust is given an external financing limit which it is permitted to undershoot

	2012/13	2011/12
	£000	£000
External financing limit	18,505	2,497
Cash flow financing	3,986	(1,960)
External financing requirement	3,986	(1,960)
Undershoot / (overshoot)	14,519	4,457

## **Better Payment Practice Code – measure of compliance**

	2012/13 Number	2012/13 £000
	Number	1000
Total non NHS trade invoices paid in year	34,443	83,867
Total non NHS trade invoices paid within target	25,021	63,355
Percentage of non NHS trade invoices paid within target	73%	76%
Total NHS trade invoices paid in year	2,605	11,362
Total NHS trade invoices paid within target	1,219	4,933
Percentage of NHS trade invoices paid within target	47%	43%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

## Staff sickness absence

	2012/13	2011/12
	Number	Number
Days lost	18,331	17,984
Total staff years	2,157	2,200
Average working days lost	8.5	8.17

The data set used to calculate staff sickness absence is based on the period January to December 2012, as an acceptable proxy for the financial year.

#### **Remuneration Committee**

The Remuneration Committee is a formally appointed Board of the Trust Committee. Its terms of reference comply with the Secretary of State's Code of Conduct and Accountability for NHS Board. The membership of the Remuneration Committee for the period April 2012 to March 2013 comprised all Non Executive Directors of the Trust. The Committee met 3 times in the financial period of 2012/13.

Remuneration of senior managers and assessment of performance

In determining the pay and conditions of employment for senior managers, the Committee takes account of national pay awards given to the Pay and Non-Pay Review staff groups.

All Executive and Non-Executive Directors are subject to individual performance review. This involves the setting and agreeing of objectives for a 12-month period running from 1st April to the following 31st March. The Executive Directors are assessed by the Chief Executive, the Chairman undertakes the performance review of the Chief Executive and Non-Executive Directors

#### Salary and pension entitlements for senior managers

The definition of a Senior Manager for disclosure purposes is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body'. This means those who influence the decisions of the entity as a whole rather than the decision of individual directorates or departments. The Chief Executive has confirmed that, for 2012/13, the definition applies only to those listed in the table of salaries and allowances overleaf.

# Remuneration Report Salaries and allowances of senior managers

Title	Name	2012-13				2011-12		
		Date Left Where applicable	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Bonus Payments (bands of £5,000)
	Non-Executive Directors							
Chairman	David Hooper*	31/03/13	20-25	0	0	20-25	0	0
Interim Chair	Lynne Cantor*		5-10	0	0	5-10	0	0
	Catherine Dugmore* (commenced Sept 12)		0-5	0	0	0	0	0
	Sally Field*		5-10	0	0	5-10	0	0
	David Price*		5-10	0	0	0 - 5	0	0
	John Simons* (commenced June 12)		5-10	0	0	0	0	0
	David Snowdon*	28/06/12	0 - 5	0	0	0 - 5	0	0
	Executive Directors							
Chief Executive	Julie Lowe (commenced 04/02/13)		25 - 30	0	0	0	0	0
Chief Executive	Clare Panniker	14/09/12	65 - 70	0	0	145-150	0	0
Deputy Chief Executive	Lance McCarthy		115 - 120	0	0	95 - 100	0	0
Finance Director	Martin Armstrong		105 - 110	0	0	105-110	0	0
Director of Nursing	Theresa Murphy		85 - 90	0	0	85-90	0	0
Medical Director	Stanley Okolo		105 - 110	45 - 50	35 - 40	105-110	45-50	35-40
Director of Human Resources	Rachel Patterson		85 - 90	0	0	10 - 15	0	0
Director of Environment	Kevin Howell		90 - 95	0	0	90-95	0	0
Director of Operations	Lee McPhail	01/02/13	75 - 80	0	0	90-95	0	0
Director of Operations – interim	Mark Morgan (commenced 14/01/13)		40 - 45	0	0	0	0	0

<sup>\*</sup> Member of the Remuneration Committee

### **Pay Multiples**

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The figure for the highest paid director is taken as the remuneration paid wholly for the duties as a director.

The remuneration of the highest paid director in the North Middlesex University Hospital NHS Trust in the financial year 2012-13 was £119.2k (2011-12, £147.5k). This was 3.7 times (2011-12, 4.6) the median remuneration of the workforce, which was £31.8k (2011-12, £31.8k). The median remuneration excludes any bank and agency staff paid by the Trust.

In 2012-13, 1 (2011-12, 1) employees received remuneration in excess of the highest paid director. Remuneration ranged from £17.6k to £190.9k (2011-12, £17.3k - £190.9k).

Total remuneration includes salary, non consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The remuneration of the highest paid director has fallen in the year due to the departure of the Chief Executive and the interim arrangements in place prior to the appointment of the new Chief Executive; this has resulted in a reduction of the ratio of the highest paid director to the median remuneration of the workforce. Whilst there was a pay freeze in the year, lower paid staff (with an annual salary of up to £21k) received a pay award of £250 and other eligible staff received an annual increment

#### **Pension Benefits**

Name	Real increase	Lump sum at	Total accrued	Lump sum at	Cash	Cash	Real increase	Employers
	in pension at	aged 60 related	pension at age	aged 60 related	Equivalent	Equivalent	(decrease) in	contribution
	age 60 (bands	to real increase	60, 31 March	to accrued	Transfer Value	Transfer Value	Cash Equivalent	to stakeholder
	of £2,500)	in pension	2013 (bands of	pension at 31	at 31 March	at 31 March	Transfer Value	pension
		(bands of	£5,000)	March 2013	2013	2012		
		£2,500)		(bands of £5,000)				
	£000			£000			£000	
		£000						£000
			£000		£000	£000		
Executive Directors								
Julie Lowe	0 – 2.5	0 – 2.5	30 - 35	100 - 105	486	464	22	0
Clare Panniker	2.5 – 5.0	7.5 – 10.0	45 – 50	135 - 140	735	672	63	0
Lance McCarthy	2.5 – 5.0	7.5 – 10.0	25 - 30	80 - 85	387	334	53	0
Martin Armstrong	0 – 2.5	0 – 2.5	20 - 25	60 - 65	282	264	18	0
Theresa Murphy	0 – (2.5)	0 – (2.5)	25 - 30	75 - 80	420	411	9	0
Stanley Okolo	0 – 2.5	5.0 – 7.5	40 - 45	120 - 125	873	807	66	0
Rachel Patterson	2.5 – 5.0	10.0 – 12.5	15 - 20	55 - 60	274	218	56	0
Kevin Howell	(2.5) - (5.0)	(7.5) - (10.0)	25 - 30	85 - 90	517	554	(37)	0
Lee McPhail	0 – (2.5)	0 – (2.5)	5 - 10	20 - 25	91	97	(6)	0

There are no entries in respect of pensions for Non-Executive members as they do not receive pensionable remuneration.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase / (Decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The factors used in the table above are 5.2% for 2012-13 and 3.1% for 2011-12.

The Government Actuaries Department (GAD) factors for the calculation of Cash Equivalent Transfer Values (CETV) assume benefits are in line with CPI rather than RPI, which was used previously.

### Reporting of other compensation schemes – exit packages

NHS body	North Middlesex Universit	y Hospital Trust		
A	b	С	d	е
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost)	Number of departures included in <i>b</i> and <i>c</i> where special payments have been made (special payment element (totalled))
Less than £10,000	2	0	2 (£12,107)	0
£10,001 - £25,000	2	0	2 (£33, 736)	0
£25,001 - £50,000	2	0	2(£61,797)	0
£50,001 - £100,000	1	0	1(£51,926)	0
£100,001 - £150,000	0	0		0
£150,001 - £200,000	0	0		
More than £200,000	0	0		
Total number of exit packages by type (total cost)	7 (£159,566)	0		
			Total number (and cost) of exit packages	Total number of special payments (an total cost of special payment element)
			7 (£159,566)	0

### **Off Payroll Engagements**

### For off payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

	No.
No. in place on 31 January 2012	8
Of which:	
No. that have since come onto the Trust's payroll	0
Of which:	
No. that have since been re-negotiated / re-engaged to include contractual clauses allowing the Trust to seek assurance as to	0
their tax obligations.	
No. that have come to an end	4
Total	4

The Trust has worked with contractors who are not on the payroll to establish employment status and ensure that tax obligations are met. This work is ongoing for the 4 engagements above that have not yet been renegotiated.

### For all new off payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months

	No.
No. of new engagements	2
Of which:	
No. of new engagements which include contractual clauses	
giving the department the right to request assurance in	0
relation to income tax and national insurance obligations	
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated	2
Total	0

#### **Independent Auditor's Report**

## INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

We have examined the summary financial statement for the year ended 31 March 2013 which comprises statement of comprehensive income, statement of financial position, statement of cashflows and capital cost duty, external financing, better payment practice code, staff sickness absence and remuneration report.

This report is made solely to the Board of Directors of North Middlesex University Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

### Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

#### **Opinion**

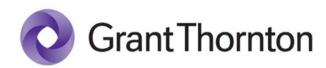
In our opinion the summary financial statement is consistent with the statutory financial statements of the North Middlesex University Hospital NHS Trust for the year ended 31 March 2013.

Grant Thornton UK LLP Grant Thornton House Melton Street Euston Square London NW1 2EP

5 June 2013



Т	RUST BOARD - AGENI	DA ITEM SUMMARY			
AGENDA ITEM NUMBER:	12				
SUBJECT:	Financial Resilienc	ce Review			
MEETING DATE:	27th June 2013				
SUMMARY:  As part of the statutory external audit, Grant Thornton undertake a review to determine if the Trust has proper arrangements in place for securing financial resilience. In so doing they considered whether the Trust has robust financial systems and processes in place to manage its financial risks and opportunities, and to secure a stable financial position that enables it to continue to operate for the foreseeable future. The report and its recommendations are attached for the Trust Board to discuss and comment. Grant Thornton will attend the July seminar meeting to discuss the report further.					
BOARD ASSURANCE FRAMEWORK	REFERENCE NUMBER	R: BUS 1			
Financial Issues:√	Legal Issues:	Equality Issues:			
ACTION REQUIRED:	1				
For information/note		For agreement			
For comment X		For ratification			
For discussion X		For Trust Board resolution			
THIS DOCUMENT HAS BEEN VIA/R	EQUESTED BY:				
Trust Board	X	Workforce and OD Committee			
Hospital Management Board		Patient Safety and Quality Committee			
Finance and Investment Committee	Finance and Investment Committee X Foundation Trust Project Board				
Audit Committee		Hospital Development Project Board			
FOLLOWING BOARD ACTION THIS	FOLLOWING BOARD ACTION THIS DOCUMENT WILL BE COMMUNICATED VIA:				
EXECUTIVE LEAD: Finance Directo	r				



# Review of the Trust's Arrangements for Securing Financial Resilience for North Middlesex University Hospital NHS Trust

### Year ended 31 March 2013

27 June 2013

#### **Phil Westerman**

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Manager

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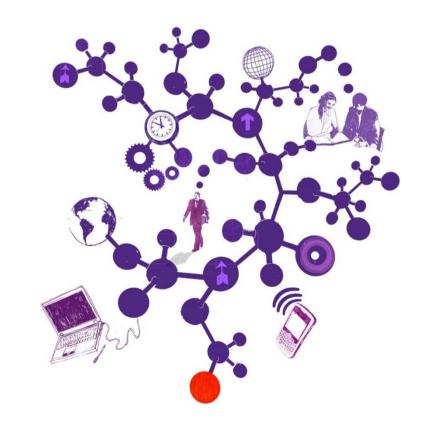
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#### **Chris Moule**

Manager

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The contents of this report relate only to the matters which have come to our attention,
which we believe need to be reported to you as part of our audit process. It is not a
comprehensive record of all the relevant matters, which may be subject to change, and in
particular we cannot be held responsible to you for reporting all of the risks which may
affect the Trust or any weaknesses in your internal controls. This report has been prepared
solely for your benefit and should not be quoted in whole or in part without our prior
written consent. We do not accept any responsibility for any loss occasioned to any third
party acting, or refraining from acting on the basis of the content of this report, as this
report was not prepared for, nor intended for, any other purpose.

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- 2 Key Indicators
- 3 Strategic Financial Planning
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- **5 Financial Control**

### **Our approach**

### **Value for Money Conclusion**

Our work supporting our Value for Money (VfM) conclusion, as part of the statutory external audit, includes a review to determine if the Trust has proper arrangements in place for securing financial resilience.

In so doing we have considered whether the Trust has robust financial systems and processes in place to manage its financial risks and opportunities, and to secure a stable financial position that enables it to continue to operate for the foreseeable future. We have carried out our work in discussion and agreement with officers and completed it in such a way as to minimise disruption to them.

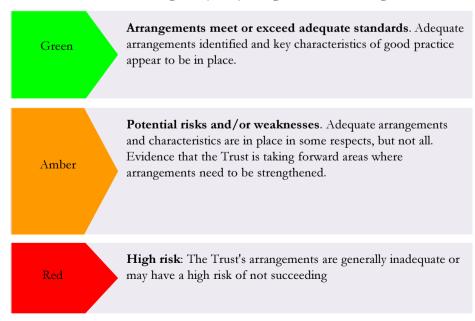
The definition of foreseeable future for the purposes of this financial resilience review is 12 months from the date of this report.

We have reviewed the financial resilience of the Trust by looking at:

- Key indicators of financial performance;
- Its approach to strategic financial planning;
- Its approach to financial governance; and
- Its approach to financial control.

Further detail on each of these areas is provided in the sections of the report that follow. Our overall conclusion is that the Trust has adequate arrangements in place for securing financial resilience.

We have used a red/amber/green (RAG) rating with the following definitions.



#### **National and Local Context**

#### **National Context**

The 2010 Spending Review set the Coalition Government's financial settlement for the next four years. Although this settlement set out that expenditure will be protected in real terms the NHS still has to make significant savings of in the region of £20 billion in order to manage rising demand as a result of demography and new technologies.

2012/13 is the second year that NHS trusts have had to deliver efficiency savings and will continue for the foreseeable future. Delivering these efficiency savings and maintaining financial resilience becomes increasingly difficult, even for top performing trusts, as opportunities to improve efficiency becomes more difficult to identify and trusts are also focused on the transition to Foundation Trust status.

Whilst facing these financial constraints NHS trusts have to also address a number of other challenges:

- developing relationships with their new commissioners as PCTs are abolished and Clinical Commissioning Groups established; and
- responding to the publication of the Francis report on Mid Staffordshire NHS Foundation Trust and ensuring that patient safety and care remain a priority.

#### **Local Context**

The Trust is one of those affected by the long-running Barney Enfield Haringey (BEH) strategy process, but that has now been determined, with implementation expected as of November 2013. The delays to this process have adversely affected the Trust, as it is not viable in its current form, and needs the contribution from the new arrangements to increase the surplus levels and to eradicate the poor liquidity that has affected it over the past few years.

The Trust is programmed to achieve Foundation Trust status in 2014, but the recent new assessment framework announced by the TDA may well delay that by 6 months.

The Trust has completed all its contracts for 2013-14, with, unusually, most income being subject to a block arrangement – though the Trust has stated that it will no longer accept block agreements after this year.

There has been considerable movement at Board level during 2012-13.

There are no matters significantly affecting the VfM conclusion individually or in aggregate.

## **Overview of Arrangements**

Risk area	Summary observations	High level risk assessment
	<ul> <li>The Trust met all its financial duties, slightly exceeding the planned surplus but needing extra winter funding</li> </ul>	
	<ul> <li>The CIP target was met but only with the help of non-recurrent savings identified during the year, following slippage in the original programme which lacked headroom</li> </ul>	
Key Indicators of Performance	<ul> <li>Liquidity remained poor, also continuing to affect the Trust's PSPP performance, which was always below target: both issues will only be resolved permanently by the extra contribution expected from the implementation of the BEH strategy; in the meantime there is an extra £8m of support agreed for 2013-14</li> </ul>	Amber
	<ul> <li>Board turnover was high during the year, with the absence of a substantive Chair having the most ongoing effect. A new Chair takes up post In June 2013.</li> </ul>	
	<ul> <li>The MTFS focuses on the benefits of the BEH implementation, which all parties expect to improve contribution and thus surplus levels and liquidity</li> </ul>	
	<ul> <li>The LTFM and IBP now need refreshing: this is taking place in anticipation of the HDD1 stage of the FT process expected in July 2013</li> </ul>	
Strategic Financial Planning	<ul> <li>The planning assumptions for 2013-14 are in line with industry expectations, and the relevant risks have been identified</li> </ul>	Amber
	<ul> <li>The CIP programme for 2013-14 is fully complete and worked up, but once again it contains no headroom, and only 35% of the programme value is made up of green RAG-rated schemes: it is inevitable that slippage will occur, once again requiring the Trust to seek mitigating part-year schemes.</li> </ul>	

### **Overview of Arrangements**

Risk area Summary observations		High level risk assessment
	<ul> <li>The Board clearly understands the financial environment, despite the degree of change during the year</li> </ul>	
	<ul> <li>The Board engages in debate, and provides adequate challenge</li> </ul>	
Financial Governance	<ul> <li>Risk management is well-controlled, though the Board will need to get assurance that the recent changes to the BAF have been effective</li> </ul>	
Financial Governance	<ul> <li>CIPs reporting has been further improved during the year</li> </ul>	0
	<ul> <li>Budget and outturn reporting have also improved further</li> </ul>	Green
	<ul> <li>However we and the Trust have independently concluded that the format of Board reporting lacks adequate exposition on the options appraisal involved in reaching the recommended decision.</li> </ul>	
	<ul> <li>The budget setting and monitoring process has further improved during the year, with proven effectiveness</li> </ul>	
	<ul> <li>The CIP programme creation process, while improved, still lacks the crucial element of headroom</li> </ul>	
Financial Control	<ul> <li>Fortunately the Trust recognises that achievement of the CIP target will be crucial for 2013-14 and has</li> </ul>	
	continued to improve the CIP management and monitoring processes: CIP management would be easier if headroom were built into the programme in the first place	Amber
	<ul> <li>The Finance directorate has been strengthened and the Trust has asked GT to carry out a "fitness for purpose" review in the summer.</li> </ul>	

### **Next Steps**

Area of review	Key points for consideration	Responsibility	Timescale	Management response
Key Indicators of Performance	The Trust needs to pay close attention to its workforce indicators for 2013-14 given the drift in 2012-13, especially on temporary staff as staffing levels will need to be carefully managed for the BEH strategy implementation	Director of Finance	Immediate	Detailed analysis of workforce indicators and costs are provided to the Finance Committee, Executive Management Board and Trust Board on a monthly basis. In addition workforce and associated financial issues are reviewed routinely at CBU monthly performance meetings with the Trust Executive. In addition the Trust now has in place a weekly feed of all temporary staffing shifts that are worked within the organisation that are required to be reviewed and justified by CBU management teams. This is accessible to all relevant staff via Qlikview reporting.
Strategic Financial Planning	The CIP/QIPP programme for 2013-14 should have headroom built into it as soon as possible, to help ensure that the target value will be achieved	Director of Finance	Immediate	The Trust has in place monthly QIPP review meetings led by the Trust Executive with CBU management teams. The Trust seeks to minimise and eliminate slippage through robust and responsive project management. The Trust recognises the need to generate alternative and substitute QIPP schemes should these be required and has instituted a number of plan B cases and reviews that can/will be activated to cover slippage. The Trust considers this to be an active and responsive approach to QIPP delivery and would express caution in respect of the identification of arbitrary headroom targets that are without substance

### **Next Steps**

Area of review	Key points for consideration	Responsibility	Timescale	Management response
Strategic Financial Planning (continued)	Mitigations for the amber and red RAG-rated schemes in the 2013-14 CIP/QIPP programme should be sought as soon as possible	Director of Finance	Immediate	The Trust continues to work on mitigations and actions that will reduce delivery risk associated with schemes currently rated as Amber or Red, although clearly the removal of all risk is unlikely, hence the plan to develop plan B schemes should the requirement arise
Financial Governance	The Board Secretary's current review of the content of Board reports should ensure that reports adequately discuss which options were considered, and which were rejected and why, in coming to any officer recommendations	Director of Finance	Q2 completion and action	Accepted
Financial Control	As per key point under <i>Strategic Financial Planning</i> re CIP headroom	Director of Finance	Immediate	As above

### 2 Key Indicators

- 3 Strategic Financial Planning
- **4 Financial Governance**
- **5 Financial Control**

This section of the report includes analysis of key indicators of financial performance, benchmarked where this data is available. These indicators include

- performance against statutory financial targets
- Monitor Financial Risk Rating
- public sector payment policy (PSPP)
- details on payroll costs including level of spend on agency workers
- sickness absence
- turnover of staff
- turnover of board members

## **Overview of performance**

Area of focus	Summary observations	Assessment
Performance against statutory financial targets	<ul> <li>All externally-set financial targets were met in 2012-13</li> <li>Income &amp; Expenditure (I&amp;E) returned a pre-impairment surplus of £1.85m – exceeding the target of £1.7m. However EBITDA (earnings before interest, tax depreciation and amortization) undershot by £0.7m, as a result of over-target Income being offset by an overshoot on both Pay &amp; Non-pay: the surplus was achieved as a result of a much lower than planned Public Dividend Capital Dividend payment, though even if the Dividend had been at the planned level the Trust would have remained in surplus</li> </ul>	
	• the Trust received extra winter funding support of just over £1m after achieving agreed performance trajectories	
	<ul> <li>the Trust met its External Financing Limit cash level requirement with an undershoot of £14.5m</li> <li>the capital spend in the year was £21.5m against a revised Cash Resource Limit of £26.4m. The original budget was revised down from £49.1m in line with the delayed approval and implementation of the BEH strategy; in a similar way the Trust only drew down £14.8m of the planned PDC of £21.4m.</li> </ul>	
	• The original approved Cost Improvement Programme (CIP) schemes were valued at a total of £8.1m but only realised £7.3m, a slippage of 10%, which affected the calculations for the 2012-13 budget. This is the inevitable consequence of again not including headroom in the original programme. Fortunately the Trust was able to identify alternative schemes during the year and the £8.1m target was reached, though this required non-recurrent savings worth £0.4m or 5% of the total target. This ability to deliver alternatives reflects an improvement on the 2011-12 performance in-year	Amber
	• Liquidity remained poor during the year, despite the closing cash balance of £8.6m being considerably higher than the forecast level of £0.7m., which would have been the minimum required to meet the EFL. This reflects the delay in the implementation of the BEH strategy, which will be required in order for liquidity to improve, but that will only be achieved in 2014-15 – the planned year-end balance for 2013-14 is £3.6m, with the help of approved liquidity funding support of £8.0m due in September 2013. The Trust did not receive any liquidity funding support during 2012-13 and none was planned. The Trust had negative net current assets at the end of 2012-13 and the budget for 2013-14 shows that this will remain the case.	

## **Overview of performance**

Area of focus	Summary observa	tions					Assessment
Monitor Financial Risk	<ul> <li>The Trust achieved its planned FRR of 2 – driven by the cap generated by the continuing low Liquidity score</li> <li>The EBITDA margin was below plan but the I&amp;E surplus margin exceeded the planned level</li> </ul>						
Rating	Category		ers 2012-13 Plan	2012-13 Actual	2011-12 Actual	•	
	EBITDA v plan	95.4%	5	4	4		
	EBITDA Margi	n 8.2%	3	3	3		
	Surplus to Incor	ne 1%	2	3	2	Overall FRR: 2 against plan of 2	
	Net return after	financing 1.3%	3	3	2		
	Liquidity	<10day	s 1	1	1		Amber
	£8.0m support f of a poor Debt S	• The Trust will not achieve the minimum requirement for FT status in 2013-14 on the basis of its budget plans, despite the £8.0m support funding, as the Liquidity component will still be 1 and there will be an on-going breach of the PBC as a result of a poor Debt Service Cover ratio: either of these outcomes will enforce an overall cap at a level 2, even though the remaining components justify a level of at least 3					
	~	*	,	J.		elivers the expected level of contribution, the e the FRR at an FT-acceptable level of 3.	
Public sector payment policy	The Trust's perf the gradually imp		luring the yea	r, with the fig	ures back to 2	2010-11 levels in 3 out of 4 cases. This reflects	
(Better Payments	The target was however not met in any category.						
Practice Code)		By number By	value [2011-1.	2 figures in brac	kets]		Analogu
	Non-NHS	73% [52%] 76%	[64%]				Amber
	NHS	47% [37%] 43%	[41%]				

## **Overview of performance**

Area of focus	Summary observations	Assessment
Key workforce indicators	• The total paybill was £109.3m, which was £1.8m over budget: the over spend chiefly relates to nursing and medical pay, winter pressures and unachieved savings. Of the total spend, agency/bank spend was £9.2m, which at 8.4% is well above the target for the year of 5% and double the actual rate for 2011-12	
	• Sickness absence ran at 3.9% for the year, above the target of 3% but below the 2011-12 level of 4.1%	
	• The target vacancy rate was 5%, which was exceeded in 6 of the 12 months	
	• Turnover of Board members was high: the Chief Executive moved on to another Trust, the Chair resigned, and new Directors of Operations and Nursing are being recruited. Also two NEDS left & were replaced. The Trust remains without a Chair but the post will be filled in June:. Given this amount of movement, we interviewed the Interim Chair, the new Chief Executive, the Deputy Chief Executive, the Chair of the Audit Assurance and Governance Committee and the Chair of the Finance Committee, the latter being the new NEDS: our interviews suggest that the changes have not destabilised the Trust and that the new post holders have a good grasp of the financial and risk environment and of the Trust – see also Financial Governance	Amber
	• The Board & Finance Committee both continue to receive comprehensive but intelligible statistics on a monthly basis. The Board has 7 staffing KPIs in its dashboard: of these 3 were adverse to target, including sickness absence as above.	

2 Key Indicators

## 3 Strategic Financial Planning

**4 Financial Governance** 

**5 Financial Control** 

### Key characteristics of good strategic financial planning

In conducting our review of strategic financial planning we have assessed the Trust's performance against the following indicators:

- Focus on achievement of Trust objectives should be evident through the financial planning process. The MTFS should focus resources on priorities
- The MTFS should include outcome measures, and evidence of scenario planning and resource planning. The financial implication of demographic trends over the longer term should have been considered
- Annual financial plans should follow the longer term financial strategy
- CIP/QIPP should be developed alongside the MTFS and annual budget. There should be an effective approach for developing CIP/QIPP projects which considers how robust and realistic they are
- There should be regular review of the MTFS and the assumptions made within it. The Trust should respond to changing circumstances
- The Trust should be managing its financial risks, including the financial positions of its providers and the impact of TCS
- The MTFS should be linked to and consistent with other key strategies, including workforce
- KPIs can be derived for future periods from the information included within the MTFS

### **Medium Term Financial Strategy**

Area of focus	Summary observations	Assessment
Focus of the MTFS	• The LTFM and IBP have not been updated since the last iteration of mid-way through 2011-12 (they are being refreshed now in advance of the next stage of the FT process in July) but interviews with Board members demonstrate that the thrust of the MTFS remains the same – ie that the Trust is not viable as it stands but that there is a widely-held expectation within the local health economy that the implementation of the BEH strategy later in 2013-14 will quickly result in a much improved bottom line and improved liquidity, enabling the Trust to eliminate the current caps on its Monitor FRR caused by low liquidity and a PBC breach, and to achieve an acceptable FRR of 3 during 2014-15, rising to level 4 in 2015-16	
	<ul> <li>This is reflected within the budget for 2013-14, given that BEH implementation is now expected in November 2013. The Trust is required to make a 1% surplus. On its planned income of £198m this would mean a £2m surplus, but the Trust is actually forecasting an underlying surplus of £2.5m, and with agreed in-year funding of £8.0m an overall surplus of £10.5m. The Trust plans to meet all external financial limits</li> <li>The Trust has clearly continued to work closely with its commissioners – including CCGs – and other partners.</li> </ul>	Green

### **Medium Term Financial Strategy**

Area of focus	Summary observations	Assessment
Adequacy of planning assumptions (excluding CIP)	<ul> <li>The Trust has reflected generally accepted assumptions in the LTFM and in its budget for 2013-14:</li> <li>contracts have been agreed, so the income assumptions are soundly based, though the agreement was only achieved very late and at one point the CIP target to balance any gap was as high as £16.6m, as the parties to the main contract discussed whether a block or PbR-based approach was appropriate and at what value</li> <li>in the event, a block contract was agreed with the main NCL Commissioners, all other contracts including specialist commissioning being on PbR. The Trust is aware that if the activity forecasts on which the BEH implementation is based prove to be invalid it is protected if there is an under-run but is exposed if there is excess activity: the Board believes that on balance the block agreement is advantageous − but it has advised commissioners that it will not accept a block contract for 2014-15. The BEH contribution in 2013-14 is expected to be £1.7m</li> <li>the Trust is not relying on income-generating activities in the CIP/QIPP programme − there are none</li> <li>inflation assumptions are compatible with current industry expectations, &amp; reflect local commissioner assumptions</li> <li>the overwhelming majority of the capital programme is associated with the BEH implementation and will be funded by agreed PDC. The Trust will fund £1m of backlog maintenance</li> <li>liquidity remains an issue pre-BEH implementation, and the Trust has agreed liquidity support of £8m due in September 2013. Month-end cash balances are not expected to fall below £1m, with a year-end forecast of £3.6m, so this support is essential.</li> </ul>	Amber

### **Medium Term Financial Strategy**

Area of focus	Summary observations	Assessment
Adequacy of planning assumptions	• The CIP requirement to balance the 2013-14 budget will be £8.4m – or 4.3% of forecast income. This is broadly similar to the 2012-13 requirement, which was eventually achieved but only with the help of extra in-year schemes, some non-recurrent, because the 2012-13 plan lacked headroom: this had a £1.7m impact on the budget for 2013-14	
(continued – CIP only)	• There is no headroom in the programme for 2013-14, and in our view this represents a major risk to the budget: the Trust acknowledges that achieving the required CIP level is a crucial part of hitting its 2013-14 targets. The Trust continues to rely on being able to generate extra schemes mid-year in the event of any slippage and there is no guarantee that this will be the case. Most Trusts are now building headroom into their CIP plans in order to increase resilience	Red
	• The programme for 2013-14 is fully-worked through, and all schemes are supported by PIDs and are all allocated and identified, but only 35% of the programme is currently green RAG-rated – 39% is amber, and 26% is red. This increases the risk as things stand that the programme value will not be delivered, and the Trust needs to work hard to mitigate the risks and to improve the RAG-ratings.	
Links to the Annual Plan	• The LTFM is currently being refreshed and this will include rolling the base year forward and adjusting 2013-14 to be in line with the agreed budget.	
		Green
Review processes	• The LTFM and IBP are being refreshed in readiness for the next stage of the FT process which will be HDD1, probably due in July, although the TDA's recent announcement about its new authorisation framework may delay this, and will certainly delay final authorisation	
	• FT has continued to take a lower priority than getting the BEH implementation agreed and properly planned, but as this is the main component in getting the Trust ready for FT status, and any application would not be successful without it, this is understandable. The Trust has an FT Board chaired by the Chief Executive which is moving the application forward.	Green

### **Medium Term Financial Strategy**

Area of focus	Summary observations	Assessment
Responsiveness of the Plan	• The Board was taken through several iterations of the budget for 2013-14 as the contracts negotiations proceeded, considering various options and strategies depending upon the status applying at the time	
	The Board has identified a variety of risks:	
	<ul> <li>that CBUs and Corporate Budget holders are unable to deliver the target QIPP requirement – see above for our views on this risk</li> </ul>	
	• that underlying financial performance and budget management is not controlled – the Trust has a good record on this	
	<ul> <li>the Trust does not achieve the planned surplus – impacting on its financial rating and FT application</li> </ul>	Green
	• the Trust proves unable to manage activity and demand within the SLA block framework – but the Trust is confident that this is less likely	
	<ul> <li>failure to work with CCGs to enact local health economy QIPP plans.</li> </ul>	
	<ul> <li>The downside LTFM is being refreshed as part of the current re-visiting of the FT documentation.</li> </ul>	
Links to other plans	• The LTFM and budget for 2013-14 appear to be reflected in the workforce and estates strategies.	
		Green

- 1 Executive Summary
- 2 Key Indicators
- 3 Strategic Financial Planning
- 4 Financial Governance

### Key characteristics of effective financial governance

- There should be a clear understanding of the Trust's financial environment:
  - Regular reporting to Non-Executive Directors (NEDs) and Executive Directors.
  - Actions have been taken to address key risk areas.
  - Directors and managers understand the financial implications of current and alternative policies, programmes and activities
- There should be engagement with stakeholders including budget consultations.
- There should be effective working relationships with key providers.
- There should be comprehensive policies and procedures in place for NEDs, Executive Directors and budget holders which clearly outline responsibilities.
- There should only be a limited number of internal and external audit recommendations that are overdue for implementation.
- The Board and relevant Committees should regularly review their performance and be subject to appropriate levels of scrutiny.
- There are effective recovery plans in place (if required).
- The Board should have the capacity and capability required to perform its role effectively

## **Understanding and engagement**

Area of focus	Summary observations	Assessment
Understanding the Financial Environment	<ul> <li>Financial instructions &amp; standing orders cover financial management responsibilities</li> <li>The Board delegates financial decision-making to the Finance committee. The Board receives its financial information as part of its monthly KPIs dashboard, plus via the Finance Committee minutes, while the Finance Committee receives monthly reports from the Director of Finance – see under <i>Budget Reporting</i> below for the content</li> <li>The Board and Finance Committee proved capable of managing the finances of the Trust during 2012-13, dealing effectively</li> </ul>	
	with the fluctuations in I&E and the slippage on the CIP programme  Given the high turnover of Board members in 2012-13, we interviewed the Interim Chair, the Chief Executive, the Deputy Chief Executive, the Chair of the Audit Assurance and Governance Committee and the Chair of the Finance Committee – all except the Interim Chair being new to the Trust. We are satisfied that these individuals are financially aware, bringing with them new ideas, and are generally satisfied with the financial information that they are receiving – but see Budget Reporting below. However they were not satisfied with the Trust's induction process, and the new Board Secretary will be considering revisions to this during 2013-14	Green
	• The Board is very aware of the importance of adequate clinical involvement, and has been keen to get the right replacements for the departing Medical and Nursing Directors: the Interim Chair and Chief Executive are confident that the appointees will add to the Trust and will represent clinicians effectively, as their predecessors did.	
Director & NED Engagement	• There is clear evidence from our attendance at Audit Assurance and Governance Committee that there is robust challenge and involvement	
	<ul> <li>Our interviews with Board members suggest that they all understand the importance of engagement and see it from their colleagues</li> </ul>	
	• The documentation of the 2013-14 budget process shows that there is involvement from CBU level and that the negotiations were well-thought through and soundly based.	Green

## Key cost categories, risk management and CIPs reporting

Area of focus	Summary observations	Assessment
Overview for controls over key	• The Trust's costs mainly relate to pay, drugs and the revenue costs of the PFI. These elements are reported on a monthly basis cumulatively and by CBU	
cost categories	<ul> <li>Budget holders are part of the budget setting process and therefore are aware of the need to control key costs</li> </ul>	00000
	• See also Budget Reporting below.	Green
Risk	There are no known legal proceedings outstanding	
management	• The Board has three main sources of information on the Trust's risk management:	
reporting	• those risks covered by the monthly BAF report: for the content and structure of the BAF see <i>Board Assurance Framework</i> in the <i>Financial Control</i> section	
	<ul> <li>annual assurance about the Trust's management of other risks from the Audit Assurance and Governance Committee,</li> <li>which receives reports about how the BAF should be updated and tests its assurance with other Board committees</li> </ul>	
	<ul> <li>any in-year reports on the Risk Management Strategy: this has recently been updated.</li> </ul>	
	• An issue is the recent change to the process following Internal Audit recommendations that the BAF should only contain those risks that are relevant to the Trust's objectives. We are in agreement with this change, as it focuses the Board's attention on the risks that are relevant, but it means that there are several major risks that it no longer receives regular reports on, and so places greater emphasis on the work of the other Committees and especially the Audit Assurance and Governance Committee. However the Trusts' existing committee reporting processes should ensure that any major issues get escalated upwards.	Green
CIPs reporting	• The way that the creation, delivery & monitoring of the CIPs programme are reported remains largely unchanged from the process in use during 2011-12, with the Board receiving RAG-rated year to date information by CBU and workstream, and the Finance Committee dealing with the creation of the programme, and receiving monitoring reports	
	• The Finance Committee monitoring report has been upgraded to identify extra schemes being developed in-year by CBU	Green
	• For the <u>processes</u> of creation, delivery & monitoring of the CIPs programme, see under the <i>Financial Control</i> section.	

## **Budget reporting**

Area of focus	Summary observations	Assessment
Budget reporting revenue and capital	<ul> <li>The Board receives a succinct but informative package of information each month in its KPI Benchmarking Pack:</li> <li>4 RAG-rated KPIs covering variance on overall I&amp;E, Pay, Non-pay and Income in-month and year to date compared with the target, showing the current rating and the direction of travel in the month</li> <li>summary &amp; detailed [RAG-rated] statements of Comprehensive income</li> <li>RAG-rated SLA income by POD and Commissioner</li> <li>Balance Sheet and rolling 12-month cashflow.</li> <li>The Finance Committee receives a much more detailed but well-presented monthly report from the DoF and an Excel package of annexes, of which the following elements are the most important:</li> <li>issues affecting the current &amp; forecast outturn positions</li> <li>forecast year-end outcome – much upgraded from last year</li> <li>current I&amp;E position by category &amp; CBU, both RAG-rated against target: last year's recommendation about a rolling 12-month forecast has not been accepted, though the Chair of the Committee states that this is an upgrade that he is thinking about</li> <li>year-on-year comparisons of expenditure to date</li> <li>income position to date RAG-rated against target</li> <li>current &amp; 12-month rolling cashflow: last year's recommendation about a rolling 13-week forecast has not been implemented, but the DoF notes that the Finance team has started weekly meetings which provides an effective additional process</li> <li>Balance sheet current but not at year end</li> <li>a discussion of the main financial risks especially those affecting year-end outturn</li> <li>capital expenditure to date.</li> </ul>	Green
	• There is no evidence of the data having to be changed or re-presented in subsequent reports.	

### Other Board Reporting, IA Recommendations and Board self-assessment

Area of focus	Summary observations	Assessment
Adequacy of other Board/ Committee reporting	<ul> <li>The Board receives a wide variety of non-financial information in its monthly KPI dashboard report, generally RAG-rated and showing performance against targets</li> <li>Our reviews of minutes suggests that there is robust discussion</li> <li>However our review of various reports suggests that further progress could be made in how well they set out: <ul> <li>the options that have been considered</li> <li>why a particular recommendation is made</li> <li>why the other options were rejected.</li> </ul> </li> <li>This is not regularly covered at the moment, and therefore reliance is placed upon Board members seeking this information via discussion, which takes time and may not be robust enough</li> <li>Our interviews of various Board members confirm that this aspect of the current reporting is seen as a weakness, and the new Board Secretary is already undertaking a review.</li> </ul>	Amber
Internal Audit Recom- mendations	The process of monitoring recommendations is unchanged from last year.	Green
Board and Committee self- assessment	• The Trust has a requirement for Committee self-assessment built in to its Governance & Assurance Framework, and utilises the framework set out in the Department of Health NHS Audit Committee Handbook. We have seen the outcome of this year's review of the Audit Assurance & Governance Committee, which has been presented to the Committee by the DoF seeking follow-up action.	Green

- 1 Executive Summary
- 2 Key Indicators
- 3 Strategic Financial Planning
- **4 Financial Governance**

### Key characteristics of effective financial control

### Budget setting and budget monitoring

- Budgets should be robust and prepared in a timely fashion.
- Budgets should be monitored at appropriate officer, committee and Board levels, and officers should be held accountable for budgetary performance.
- Financial forecasting should be well-developed and forecasts should be subject to regular review.

### Savings Plans

• There should be robust process for the management and monitoring of CIP/QIPP and ensuring that planned savings are being delivered.

### Finance Department

• The capacity and capability of the Finance Department should be fit for purpose.

### Financial Systems

- Key financial systems should have received satisfactory reports from internal and external audit
- Financial systems should be adequate for future needs

#### **Internal Control**

- There should be an effective internal audit which has the proper profile within the organisation. Agreed Internal audit recommendations should be routinely implemented in a timely manner
- There should be an Assurance Framework in place which is used effectively by the Trust
- Business risks should be managed and controlled
- The Statement of Internal Control should give a true reflection of the organisation.

## **Budget setting and monitoring**

Area of focus	Summary observations	Assessment
Budget setting and monitoring - revenue and	• The Budget for 2013-14 started in November 2012 and went though a sequence of processes within a framework designed to ensure:	
capital	<ul> <li>central influence over the basics such as adjustments related to inflation and recurrent/non-recurrent items – but validated by CBU Management teams</li> </ul>	
	<ul> <li>CBU influence over clinical strategies in service developments and the SLA negotiations</li> </ul>	
	clinically-driven CIP schemes	
	<ul> <li>good awareness of commissioner intentions and rationale</li> </ul>	
	• strong basis for SLA negotiations.	
	• The process for monitoring has improved in 2012-13 with the introduction of a requirement that CBUs that are red RAG-rated over a successive 3-month period are subject to a more intensive monitoring and investigation regime over a 2-month period, and conversely high-performing CBUs can have access to a range of incentive schemes	
	• That the monitoring is effective is shown by the fact that the Trust was able to manage the inevitable in-year issues successfully in 2012-13 and delivered a surplus slightly above target	Green
	<ul> <li>The Capital budget is subject to monthly monitoring by the Finance Committee</li> </ul>	
	<ul> <li>The cash management process is a critical one for the Trust given its poor liquidity position, and is subject to weekly monitoring by the Finance team</li> </ul>	
	<ul> <li>The budgeting process remains rooted in Service Line Reporting., and steps are now being taken to move into Service Line Management</li> </ul>	
	• Internal Audit gave the budget creation and monitoring process a Substantial Assurance rating at the end of 2012	
	• The budget is not subject to re-forecast once it is agreed.	

# Financial Control

# **Performance against CIP programme**

Area of focus	Summary observations	Assessment				
Performance against CIP programme	• The process for creating the CIP programme remains much as it was for 2011-12 and therefore has the same strengths and weaknesses, though there is now a NED-led requirement in place that all schemes must be fully identified and allocated, which is an improvement, and the KPMG training initiative should be better equipping clinical leads, service managers and CBU top teams with the skills needed to deliver change:					
	• projects are identified by CBUs (or the relevant central department) but within the overall framework set by the Service Transformation Team in consultation with the CBUs, whereby they must be produced in a "one organisation" environment, all supported by the Service Transformation Unit (the re-badged PMO)					
	<ul> <li>all schemes have to be evidenced – using SLR/Qlikview/Albatross data – with fully-completed PIDs</li> </ul>					
	<ul> <li>all schemes are externally benchmarked and tested against the 3-year plans and the LTFM</li> <li>no schemes can be non-recurrent.</li> </ul>					
	• There is however no headroom in the 2013-14 plan – this is a recurrent feature of CIP planning within the Trust and has the inevitable consequence that when slippage occurs replacement schemes have to be found: in 2012-13 this led to reliance upon non-recurrent schemes for 5% of the programme value. The Trust has not implemented our recommendations to introduce headroom	Red				
	• The schemes are RAG-rated: however only 35% of the 2013-14 programme is currently rated green, which presents a further risk of non-delivery which may require extra schemes to be identified later					
	• Given the Trust's recent history of not delivering the required CIP target and only delivering the 2012-13 programme by non-recurrent means, and also given that the Trust has acknowledged that it will be crucial to achieve the 2013-14 plan, it has taken action to further improve the CIP management processes:					
	<ul> <li>staffing the PMO team with new permanent staff with project management experience</li> </ul>					
	<ul> <li>rebranding the PMO as the Transformation Unit</li> </ul>					
	<ul> <li>increasing the monitoring regime on two of the CBUs given their particularly poor CIP delivery history.</li> </ul>					

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# Financial Control

# Performance against CIP programme (cont), financial systems, Finance Department and audit arrangements

Area of focus	Summary observations	Assessment
Performance against CIP programme (continued)	<ul> <li>The process in place to monitor in-year progress against plan remain largely as last year, but with two improvements:</li> <li>an increase in the monitoring regime on two of the CBUs given their particularly poor CIP delivery history</li> <li>a new proforma for Finance Committee that records by CBU any replacement schemes – a response to a recommendation in last year's FR report.</li> </ul>	Red
Key financial accounting systems	<ul> <li>Internal Audit has given all systems reviewed over the last year Substantial Assurance ratings</li> <li>There is no evidence that the systems are unreliable or inaccurate</li> <li>Service Line Reporting has now been fully implemented, and the Trust is moving forward with Service Line Management.</li> </ul>	Green
Finance Department resourcing	<ul> <li>The Board members we interviewed were very complimentary about the skills/capability of the Finance Department, especially of the DoF</li> <li>The DoF has recruited and additional Finance Manager and LTFM support staffing resources</li> <li>The Trust remains aware that further changes may be needed in readiness for FT status and has asked Grant Thornton to carry out a Fitness for Purpose review in the summer of 2013.</li> </ul>	Green
Internal audit arrangements including compliance with NHS Internal Audit Standards	<ul> <li>The Internal Audit Plan for 2013-14 was refreshed in March this year and is clearly risk-based, with a comprehensive initial review of the population</li> <li>Internal Audit is complying with current NHS IA Standards</li> <li>The Trust has now moved to RSM Tenon.</li> </ul>	Green
External audit arrangements	<ul> <li>We are proposing an unqualified audit opinion and an unqualified VfM conclusion</li> <li>We made 10 recommendations in last year's FR report: the Dof has provided us with an update on the latest position. Other than as noted elsewhere in this report, all have been actioned or an alternative approach has been substituted.</li> </ul>	Green

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# Financial Control

# **Board Assurance Framework**

Area of focus	Summary observations	Assessment						
Board Assurance Framework	• The Board Assurance Framework was further refined in January 2013 to take account of recommendations made by ourselves and Internal Audit, the publication of the Foundation Trust Network's "The foundations of good governance, a compendium of best practice" including a model Board Assurance Framework, and comments by NEDs at the corporate risk management training session during the September Board seminar							
	The changes made include:							
	• only including risks to the achievement of the corporate objectives, irrespective of their current rating: while we agree with							
	this change, it does mean that major risks that do not relate to the corporate objectives are left to individual Board Committees to consider as part of their own risk considerations – see the Financial Governance section	Green						
	• the introduction of a "heat map" which shows the direction of travel and also addresses our previous comments about including raw risk, mitigated risk and current risk scores							
	• re-introducing RAG-rating, in line with last year's recommendation							
	• categorising the source of assurance as either from management, Internal Audit or External Audit.							
	• These changes return the BAF to a best-practice status in terms of layout.							

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TRUST BOARD AGENDA ITEM							
MEETING DATE: 27 <sup>th</sup> June 2013							
MEETING DATE. 27 June 2013							
TITLE: Month 2 – Integrated Per	formance Report						
-	-						
AGENDA ITEM: 13	PAPER:						
·	sition against key national and local performance HS Performance Framework and Trust Annual Plan						
ACTION REQUESTED OF THE MEETING:							
For information X	For agreement						
For comment	For ratification						
For discussion X	For resolution						
Additional information:							
LINK TO RELEVANT CORPORATE OBJECTIVES:	Quality 1 4 Pusiness 1 E Poonlo 2						
LINK TO RELEVANT CORPORATE OBJECTIVES.	Quality 1–4, Business 1 – 5, People 2						
CQC OUTCOMES SUPPORTED BY THIS PAPER:	Outcomes: 4, 7, 8, 10, 13, 16, 25, 26						
RISK IMPLICATIONS (BAF / risk register):	1731, 1734, 1748, 1749, 1372, 1576, 1577, 1753. 1542, 1543, 1714, 1706, 1672, 1737						
FINANCIAL / RESOURCE IMPLICATIONS:	The paper provides analysis and commentary of the Trust financial position at Month 2						
THIS PAPER HAS BEEN PREVIOUSLY CONSIDERED BY:	None						
AUTHOR AND TITLE: Martin Armstrong, I	Director of Finance & Performance						



#### TRUST INTEGRATED PERFORMANCE REPORT - MAY 2013

#### **Executive Summary**

The report provides Board members with an overview of key performance issues highlighted within the May (Month 2) Integrated Performance Report.

The report narrative is focused around a summary dashboard schedule provided within the annexes to this report. The summary dashboard is supported by detailed schedules, which provide additional levels of analysis. These are referenced within each of the performance headings highlighted below.

#### **KEY PERFORMANCE THEMES FOR CONSIDERATION**

- During Month 2 the Trust did not achieve the 4hr A&E patient access target.
- The Trust continues to experience significant challenges in managing both A&E and general emergency access capacity. This has manifested in performance challenges within workforce, finance and mixed sex indicators.
- The Trust has reported 2 MRSA incidences in the year to date, both sample contaminants.
- The Trust reported 12 Serious Incidences in May, 18 in the year to date.
- The response rate for the Friends of Family test within A&E remains extremely low.
- The Trust continues to performance well against national elective and cancer patient access targets. Although some residual pressure continues to emerge as a consequence of emergency access challenges.
- Trust financial performance is on plan at Month 2, with significant overspends relating to the cost of unplanned emergency capacity being balanced against SLA income over performance.
- The Trust has seen a significant reduction in the delivery of mandatory training during April and May.

# ACCESS STANDARDS PERFORMANCE (ACC 1 – 4)

# **DIRECTOR OF OPERATIONS**

- Whilst Trust performance against the national 4 hr A&E access target improved in May compared with the previous month, it remained below the 95% all types target. The Trust will not achieve this target for the first quarter of 2013/14.
- The Trust has worked with local commissioners to agree a recovery trajectory in respect of A&E performance and is implementing the supporting action plan.
- RTT the overall number of patients on the waiting list remains high, pressures on capacity continue to be managed, although increased numbers of elective cancellations to support emergency bed pressure has added additional risk.
- RTT the volume of patients on incomplete pathways continued to rise. This was partly due to elective cancellations caused by a shortage of beds resulting from A&E demand pressures.
- All National cancer standards were achieved again in April and compliance is expected in May (the final validated position of these measures is always one month in arrears of the IPR reporting regime).
- Maternity Bookings within 13 weeks for maternity patients in May were above target for those referrals received inside the required deadline.

Against the Trust CBU Performance Framework which tracks Business Unit delivery against key indicators across 5 domains, 2 of the CBU's current rate 'RED' – CBU's 1 & 3. All CBU's rate 'RED' against workforce indicators.

# **CONTROL OF INFECTION (HCAI 1)**

#### **DIRECTOR OF NURSING**

- MRSA Following the review of cases with HPA over the past month, there are two
  incidences of Hospital acquired MRSA infections declared in April, both resulting from
  sample contaminants. These nevertheless count against the Trusts target. The national
  MRSA t target for 2013/14 is zero tolerance. Full RCA reports have been undertaken for
  both cases/
- There were no reported MRSA cases in May
- MRSA screening showed at 99% this month.
- The number of Hospital acquired C. difficile infections in May was 2 this maintained compliance with the Trusts' agreed year to date trajectory (4) at month 2.
- Training on blood Cultures in place for key staff.
- Hand Hygiene audits for May continued to show almost full compliance (98%)
- ANTT (aseptic non touch technique) training plans continue across the Trust to ensure all clinical areas have high levels of staff competency.

# PATIENT EXPERIENCE (PAT 1 & PAT 2)

# **DIRECTOR OF NURSING**

- Friends and Family test. The Trust is required to target coverage of 15% of inpatients and A&E attenders in this new measure of patient experience. Inpatient response rates have been above this level in April and May. In contrast A&E response rates have been extremely poor. A responding action plan is being implemented by CBU 1.
- The Trust showed improvement against most of the PET tracker targets in May.
- The 'Overall rating of care' target remained red status this month.
- The Hospital food rating slipped to amber status in May (green last month).
- Paediatric OPD the indicator on staff not adequately listening to patients and carers improved from red to amber in May but still remained below the required threshold.
- The total number of patients completing the PET tracker this month continued to drop – low response rates have shown to be a significant factor impacting negatively on performance.

# CLINICAL SAFETY (KPI 1& KPI 2)

### MEDICAL DIRECTOR

- Mortality Both HSMR and SHMI indicators remain within required parameters.
- No breaches of Mixed Sex accommodation were declared in May. However, recent severe pressures in A&E have impacted on bed capacity to such an extent that ongoing cohorting of patients by sex has been difficult to fully maintain, specifically in relation to showering arrangements. The Trust expects to report Mixed Sex Breaches in June.
- There were 12 reported SI's in May (2 in Maternity)
- There were no reported never events this month (target is zero tolerance).
- Patient falls (although lower than April) continued to be higher than expected this
  may partly reflect improved reporting. A detailed review of patient falls by each clinical
  area and CBU is in place and all reported incidences are clinically reviewed.
- There was one grade 4 Hospital acquired pressure ulcer in May. A supporting Root Cause Analysis is being undertaken.

## FINANCE (FIN 1-3)

#### **DIRECTOR OF FINANCE**

- At Month 2 the Trust reports an I&E actual surplus of £468k, this is £175k favourable to the planned position.
- The Trust continues to report a significant variance against staffing budgets, which are cumulatively overspent by £380k at Month 2. This has been driven by the cost of additional unplanned and unfunded capacity opened to support current A&E and bed pressures. It is supplemented by the impact of significant overspends against medical staffing costs within CBU 4 (Surgical Specialties)
- The volume and value of temporary staffing expenditure employed by the Trust continues to remain a significant concern. In May this amounted to £1.1m in the Month, this represented 11% of the total Trust pay bill.
- The expenditure overspend has been compensated by significant over performance against SLA income budgets, principally in relation to activity against specialist commissioning and non NCL CCG contracts
- The Trust has continued to incur and commit significant levels of capital expenditure in relation to the BEH build programme. The Trust continues to draw down approved Public Dividend Capital funding from the Department of Health to finance the programme.
- At the 31<sup>st</sup> May 2013 the Trust cash balance was £7.5m

# PATIENT CARE ACTIVITY (ACT 1-3)

#### **DIRECTOR OF FINANCE**

- Levels of Emergency Department activity (A&E and UCC) remained broadly static in May compared with the previous month. In comparison with 12/13, ED activity in the opening two months of 13/14 is 2.5% higher than in the corresponding period of the previous year. This equates to 627 patients over the two month period or 10 attendances per day.
- Emergency admission levels increased in May. In total Non Elective activity is 159 spells higher than over the same period of 12/13.
- Elective activity is above plan in the first two months of the year. The Trust continues to run some additional surgical waiting list sessions in order to support the overall RTT position. This is likely to continue due to the impact of cancellations resulting from continuing bed pressures.

# WORKFORCE (WORK 1-3)

# **DIRECTOR OF HR**

- Sickness absence rates across the Trust increased marginally during May to 3.3%, a rate of 3.7% across the year to date. This remains at significant variance to the Trust target of 3%.
- Sickness absence continues to be defined by specific and significant hot spot areas. Rates of nursing staffing sickness absence average around 5%.
- The Trust vacancy rate is at 7.2% for May, this is chiefly a product in delays in recruitment to additional midwifery posts that were approved as part of the 2013/14 budget.
- The level of temporary staffing, both in absolute terms and as a proportion of the pay bill continues to remain high reflecting the impact of additional unplanned bed capacity.
- The rolling measure of appraisal and PDP completion has fallen to 69% in May.
- The rate of compulsory training completion remains at 60% in M2, this is behind target.

## QIPP PROGRAMME (IMP 1)

## **DEPUTY CHIEF EXECUTIVE**

- The Total Trust QIPP programme for 2013/14 requires the identification and delivery of savings totalling £8.4m, this equates to 4.3% of Trust turnover.
- As at 31<sup>st</sup> May 2013 the Trust reported delivery of savings totalling £756k against a YTD target of £785k. As such the Trust QIPP plan remains broadly on track.
- Analysis of specific QIPP work streams reveals a range of QIPP performance delivery. As
  such to ensure that sufficient headroom exists within the overall QIPP programme to
  absorb and replace slippage the Trust Executive has met with CBU management teams to
  agree a range of supplementary schemes and actions to support ongoing delivery.

#### **ENVIRONMENTAL SERVICES (ENV1 – ENV3)**

#### **DIRECTOR OF ENVIRONMENT**

# **Contract Service Activity**

- Domestic Services Infection cleans have decreased in May and there was an increase in periodic work.
- Portering There has been a decrease in routine Portering requests. However there was an increase of 10% in urgent calls.
- Security There were an additional 180 hours in May all due to patient supervision in various areas.

#### **Estates & Utilities**

- Utilities Gas consumption has decreased significantly due to the warmer weather.
- Helpdesk Calls There has been a decrease of over 200 calls to 821 in May.
- 100% of planned preventative maintenance was completed.

#### **Facilities**

- Catering There has been an increase in day cases and snack bags in May due to additional demand in A&E and AMU. There has also been an increase in patient meals due to a 31 day month.
- Laundry There has been a decrease in usage due to the warmer weather.
- Waste Landfill and recycling figures remain consistent with previous months.
- Patient Transport On line bookings are now at 81%. There were delays in transport during the last week of May as the demand was higher due to additional Radiotherapy patients.

A summary of key performance risks arising from the Month 2 IPR report are presented over the page in **Appendix A.** 

## **Summary**

The Committee is asked to note the performance issues flagged within the May (Month 2) Integrated Performance Report.

Martin Armstrong

Director of Finance & Performance

June 2013

# **APPENDIX A**

# Key Performace & Compliance Risks at Month 2

Domain	Performance Risk	Risk RAG	Action	Lead Exec	Timeline
National targets	4hr A&E Access Target		Local Heath Economy Action plan agreed with NHS Engalnd. NMUH specific actions identified. Performance recovery and delivery in Q2	Dir Ops	Q2
National targets	2 MRSA Cases in April		RCA on cases to be undertaken, with asscoiated action, learning and monitoring plan to follow	Dir Nursing	July
National targets	Mixed Sex Accomodation		Director of Nursing and Environment to review configuration of bedded areas to ensure compliance	Dir Nursing & Dir of Environ	July
Finance	Staffing budget overspends resulting from unplanned capacity provision		Development of action plan to reduce unfunded bed capacity and costs over the summer months - linked into A&E recovery plan	Dir Ops & Finance	Q2
Clinical Saftey	Grade 4 hospital aquired pressure ulcer during May		RCA on cases to be undertaken, with asscoiated action, learning and monitoring plan to follow	Dir Nursing	July
Patient Expeirence	Low response rate to Frriends & Family Test witin A&E Department		CBU 1 management team and A&E Department have instigated an action plan to improve rersponse collection.	Dir Ops	July
Workforce	Below target compulsory training rates		Director of HR to lead the development and implementation of a recovery plan	Dir HR	July



May - Month 2 - 2013 / 14

Integrated Performance Report					
KPI 1	Main trust performance dashboard				

# North Middlesex University Hospital NHS

# Trust Board Dashboard Indicators - KPI 1 May - Month 2 - 2013/14

	Elective Access Standards						
Ref	Indicator	Target 13-14	Target Ytd	Actual Month	Actual Ytd	Move	Status
1.1	18RTT - 52 Week waits	0	0	0	0	•	
1.2	18RTT - incomplete	92%	92%	94%	94%	•	
1.3	18RTT - Admitted	90%	90%	94%	94%	•	
1.4	18RTT - Non-Admitted	95%	95%	98%	98%	•	
1.5	Cancer 2 Wk - Suspected Cancer	93%	93%	95%	98%	•	
1.6	Cancer 2 Wk - Breast Symptomatic	93%	93%	94%	98%	•	
1.7	Cancer 31 Day - All Cancers	96%	96%	100%	100%	•	
1.8	Cancer 31 Day - Drug	94%	94%	100%	100%	•	
1.9	Cancer 31 Day - Radiotherapy	100%	100%	100%	100%	•	
1.10	Cancer 31 Day - Surgery	94%	94%	100%	100%	•	
1.11	Cancer 62 Day - All Cancers	85%	85%	tbc	95%	•	
1.12	Cancer 62 Day - Hospital specialist	85%	85%	100%	100%	•	
1.13	Cancer 62 Day - Screening	90%	90%	100%	98%	<b>A</b>	
1.14	Diagnostics Wait Times	0%	0%	0%	0%	•	
1.15	Ops not rebooked within 28 days	0	0	0	0	•	
1.16	Cancelled Ops - On Day Non Clinical %	0.8%	0.8%	0.2%	0.4%	_	
1.17	Maternity Booking within 13 Weeks with Refs	90%	90%	95%	95%	<b>•</b>	

1.17	Maternity Booking within 13 Weeks with Refs received <13W	90%	90%	95%	95%	•			
	Emergency Acc	ess Sta							
Ref	Indicator	Target 13-14	Target Ytd	Actual Month	Actual Ytd	Move	Status		
1.18	Type 1 (A&E) - Under 4 Hrs %	95%	95%	94.4%	94.0%	_			
1.19	A&E - Left department without being seen	5%	5%	3%	3%	•			
1.20	A&E - Median Wait Time (mins)	159	159	156	161	_			
1.21	A&E - Time to initial assessment - 95th centile (mins)	15	15	8	11	<b>A</b>			
1.22	A&E - Time to treatment - median (mins)	60	60	75	80	_			
1.23	A&E - Total time in A&E - 95th centile (mins)	240	240	315	337	_			
1.24	A&E - Unplanned re-attendance within 7 days	5.0%	5.0%	0.8%	0.9%	_			
1.25	60min Ambulance Breaches	0	0	0	0	•			
1.26	15min Ambulance Handovers %	100%	100%	77%	77%	<u> </u>			
1.27	A&E 12-hr Trolley Waits	0	0	0	0	•			

	Safety & Outcomes								
Ref	Indicator	Target 13-14	Target Ytd	Actual Month	Actual Ytd	Move	Status		
4.1	All Reported Sis	38	6	12	18	•			
4.2	Maternity SIs	21	4	2	2	•			
4.3	Mortality (HSMR) - Rolling 12 mths*	100	100	82.0	82.0	<u> </u>			
4.4	Mortality (SHMI) - Rolling 12 mths* (Qtr)	100	100	80.1	80.1	<u> </u>			
4.5	Never Events - Composite	0	0	0	0	•			
4.6	Patient Falls	562	94	44	101	<b>A</b>			
4.7	Risk Register (Items Overdue)	51	51	51	51	<u> </u>			
4.8	VTE Risk Assessment	95%	95%	95%	96%	•			
4.9	Maternity 1:1 Care	90%	90%	95%	92%	<u> </u>			
4.10	C.difficile (Aged 2+)- Hospital Acquired	16	4	2	4	•			
4.11	MRSA incidences - Hospital Acquired	0	0	0	2	_			
4.12	MRSA Screening - Elective & Non Elective Patients	100%	100%	99%	98%	_			
4.13	Grade 3 & 4 Pressure Ulcers- Hospital Acquired.	9	1.5	1	1	<b>V</b>			
4.14	Trust Hand Hygiene Policy	95%	95%	98%	98%	•			
4.15	Maternity - Breastfeeding Rate %	95%	95%	96%	96%	<u> </u>			
4.16	Maternity - Smoking Mothers %	5%	5%	3.0%	4.0%	<u> </u>			
4.17	Mixed Sex Breaches	0	0	0	0	•			
4.18	Electronic Discharge Summary	75%	75%	63%	62%	<b>A</b>			

	Patient Experience							
Ref	Indicator	Target 13-14	Target Ytd	Actual Month	Actual Ytd	Move	Status	
5.1	Hospital Food Rating	69%	69%	67%	68%	•		
5.2	Pain Managed Well	88%	88%	92%	92%	•		
5.3	Involved in Decisions	79%	79%	91%	91%	<b>A</b>		
5.4	Were you (not) bothered by noise at night by Hospital Staff	86%	86%	95%	93%	4		
5.5	Talk to Hospital Staff Worries/Concerns	70%	70%	82%	82%	•		
5.6	Overall Care Rating	86%	86%	81%	80%	<u> </u>		
5.7	Were you given enough privacy when discussing your condition or treatment?	88%	88%	96%	95%	<u> </u>		
5.8	Were you informed about the side effects of medication ?	66%	66%	85%	83%	<u> </u>		
5.9	Who to contact if you were worried about your condition when you leave the hospital ?	87%	87%	94%	94%	•		
5.10	Did you feel that staff listened to your concerns? - OP PAEDS	79%	79%	77%	76%	_		
5.11	Did you feel that staff listened to your concerns? - T2 Rainbow (Paeds)	79%	79%	85%	85%	•		
5.12	Overall are you satisfied with the service of nurses? - Gynae clinic	82%	82%	89%	85%	<b>A</b>		
5.13	Friends & Family Score - Inpatients	TBC	TBC	52%	52%	_		
5.14	Friends & Family Score - A&E	твс	ТВС	6%	6%	•		
5.15	Friends & Family Coverage - Inpatients	15%	15%	19%	19%	•		
5.16	Friends & Family Coverage - A&E	15%	15%	4%	4%	▼		
5.17	Number of Respondents (IP PET)	12,000	2,000	627	1,256	•		

	Workforce & Training								
Ref	Indicator	Target 13-14	Target Ytd	Actual Month	Actual Ytd	Move	Status		
3.1	Appraisal & PDP - Rolling 12 mths %	90%	80%	69%	69%	•			
3.2	Compulsory Training - YTD%	90%	80%	60%	60%	•			
3.3	Safeguarding Children Level 1,2 & 3 Training	90%	80%	79%	79%	•			
3.4	Return to Work Interviews %	90%	80%	90%	90%	<b>A</b>			
3.5	Workforce - Sickness/Absence - Monthly	3.0%	3.0%	3.3%	3.7%	•			
3.6	Temp Staffing Expenditure %	5.0%	5.0%	11.2%	10.8%	•			
3.7	Adult Safeguarding Training	90%	80%	59%	59%	•			
3.8	Infection Control Training	90%	80%	42%	42%	•			
3.9	Vacancy Rate	5.0%	5.0%	7.2%	7.6%	<u> </u>			
3.10	Consultant Job Planning	твс	твс	TBC	твс				

	Finance, Activity & Transformation							
Ref	Indicator	Target	Target	Actual	Actual	Move	Status	
Rei	mucator	13-14	Ytd	Month	Ytd	IVIOVE	Status	
2.1	QIPP Targets Achieved	8,430	785	443	638	<b>A</b>		
2.2	Variance from I&E Plan	0	0	145	175	_		
2.3	Variance from Pay budgets	0	0	-255	-380	•		
2.4	Variance from Non Pay Budgets	0	0	-68	36	•		
2.5	Variance from Income Budgets	0	0	467	517	_		
2.6	A&E & UCC Activity Combined	160,663	21,817	13,145	26,096	_		
2.7	Elective & Daycase Activity	18,810	3,657	1,744	3,426	_		
2.8	Non Elective Activity	24,369	2,929	2,031	4,022	_		
2.9	First Out-patient Activity	59,917	11,649	4,992	10,146	•		
2.10	Follow-up Out-patient Activity	118,051	22,951	10,703	21,488	•		
2.11	Outpatient Procedures	25,944	5,044	2,458	4,849	_		
2.12	Critical Care Bed Day Actvity (Adult & Paeds)	12,446	1,867	1,180	2,277	•		
2.13	Elective Surgical DC Rate %	85%	85%	93%	93%	•		
2.14	IP Non Elective Ave Spell Los	4.0	4.0	4.2	4.5	<u> </u>		
2.15	Opd DNA Rate %	10%	10%	15.1%	15.2%	<u> </u>		
2.16	Opd New to Foll Up Ratio	2.0	2.0	2.4	2.4	•		
2.17	Theatre Utilisation	80%	70%	66%	66%	•		
2.18	Theatre Productivity - Cases Per Hour	0.8	0.7	0.62	0.62	•		



TRUST BOARD AGENDA ITEM SUMMARY				
AGENDA ITEM NUMBER:		14, Paper N		
SUBJECT:		Report from the Finance & I	nvestment Committee – April and May	
MEETING DATE:		27th June 2013		
SUMMARY: This paper updates the Trust Board on the actions of the Finance & Contracts Committee, at its April and May 2013 meetings. This report also updates the Board on progress in meeting the Finance Committee Work Plan (on target), and other key issues that need to be brought to the Board's attention.				
BOARD ASSURANCE FRAMEWORK REFERENCE NUMBER: BUS 1				
Financial Issues: Yes	L	egal Issues:	Equality Issues:	
ACTION REQUIRED:				
For information/note	Χ		For assurance x	
For comment			For ratification	
For discussion			For Trust Board resolution	
THIS DOCUMENT HAS BEEN VIA/REQUESTED BY:				
Trust Board		X	Workforce and OD Committee	
Hospital Management Board	t	Patier	nt Safety and Quality Committee	
Finance and Investments Committee Foundation Trust Project Board				
Audit Committee				
FOLLOWING BOARD ACTION THIS DOCUMENT WILL BE COMMUNICATED VIA:				
EXECUTIVE LEAD: Finance Director				

# North Middlesex University Hospital NHS Trust Trust Board, 25th June 2013

# **Report from the Finance & Contracts Committee**

#### Introduction

This paper provides a summary of the work undertaken by the Finance & Investments Committee for review by the Trust Board.

This report also highlights other significant financial issues that the Board need to be aware of, and provides an update on progress against the Finance Committee Annual Plan.

# Finance Committee Agenda, 23rd April 2013

The agenda for the meeting included the following issues;

- The Director of Finance presented the Month 12 Finance & Efficiency report. He confirmed that the Trust had submitted its pre audit accounts to the Department of Health on the 19<sup>th</sup> April 2013 in line with the national submission timetable. In addition he confirmed that the Trust had reported delivery of all of its key statutory duties and the delivery of its agreed I&E control total. The Director of Finance confirmed to the committee the timetable for the finalisation of the annual accounts process. The Committee reviewed and commented upon the detail of the Month 12 finance report, discussing at length the cost and impact of additional winter capacity that had been enabled by the Trust in Q4 funded through Department of Health monies and emphasising the importance of the de-escalation of this capacity during Q1 given that it is not funded on an ongoing basis.
- The Director of Finance presented a draft budget position for 2013/14 to the Committee. The assumptions and risks that underpin the plan were reviewed and considered at length by the Committee. Particular consideration was given to the current status of 13/14 SLA discussions with local CCG's. Given that the SLA position with commissioners was unlikely to be confirmed prior to the April meeting of the Trust Board, it was recommended that both the Finance Committee and the Trust Board approve the draft budget as a provisional financial plan for 13/14 to be amended and reapproved at the point of SLA confirmation in May 2013. The FCC duly approved the provisional 13/14 budget plan
- The Committee reviewed the Assurance Framework and risk register pertaining to relevant business objectives.
- The Deputy Director of Finance gave a presentation to the Committee that outlined
  a project to develop and implement an iSLR financial reporting framework. The
  presentation outlined some of the key principles and benefits that would be
  delivered by the project and also the key challenges. The Committee discussed the
  timeline and resourcing of the project and asked that it received an update in
  September 2013.

- The Committee received an update on key contractual matters and developments over the last quarter.
- In addition the Committee received a paper confirming financial returns made by the Trust to the Department of Health and NHS London over the last quarter

# Finance Committee Agenda, 28th May 2013

The agenda for the meeting included the following issues;

- The Director of Finance presented a revised Terms of Reference document for the Committee that reflected best practice. The Committee reviewed the document, noted the additional scope and remit in respect of Investment review and approved the Terms of Reference.
- Following the finalisation of 2013/14 SLA's with local commissioners. The Committee
  was presented was a final annual budget plan. The Director of Finance outlined the
  key elements of the plan, and the Committee discussed the opportunities presented
  by a block contract form and also risks and pressures that may need to be managed
  in year as a consequence. The Committee approved the plan and commended it to
  the June Trust Board for final ratification.
- The Director of Finance presented the Month 1 Finance & Efficiency reports. The Committee discussed the continuing impact and pressure presented to the Trust through additional unplanned capacity that was in place in an attempt to manage A&E and associated bed pressures. The Committee expressed concern in respect of slippage reported against the Month 1 QIPP plan. It was agreed that the report to the June 2013 Committee would detail steps that have been taken to recover this position.
- The Committee discussed at length potential options for post project review of schemes / initiatives undertaken by the Trust that fell within the remit of the Committee. The Director of Finance agreed to consider how this might be achieved.
- The Committee reviewed and considered outputs of the latest self assessment exercise that had been undertaken by members.
- The Committee reviewed the Assurance Framework and risk register pertaining to relevant business objectives.
- The Committee received an update on the activities of the Demand & Capacity Group over the last quarter.

#### Other issues of note

There are no other issues of note.

# Progress against the Annual Plan for the Finance Committee

The Committee agreed the annual planner for 2013/14.

# **Attendance at the Committee**

The April and May meetings of the Committee were quorate.

John Simons Non Executive Director June 2013

TRUST BOARD					
MEETING DATE:	27 June 2013				
TITLE:	Workforce Development	Workforce Development and Education Committee Report			
AGENDA ITEM:	15	PAPER: O			
AGENDA ITEM.	15	PAPER. U			
EXECUTIVE SUMMA	ARY:				
This paper provides a summary of agenda items discussed, assurance provided to the Committee and actions agreed at the Workforce Development and Education Committee meeting held on 25 April 2013.					
ACTION REQUESTE	D OF THE MEETING:				
For information	X	For assurance X			
For comment		For ratification			
For discussion		For resolution			
Additional information:					
LINK TO RELEVANT	CORPORATE OBJECTIVES:	People Objectives			
CQC OUTCOMES SI	UPPORTED BY THIS PAPER:	- Outcome 13, 14, 15			
RISK IMPLICATION	S (BAF / risk register):	None			
FINANCIAL / RESOURCE IMPLICATIONS:		Impact on pay budgets, reliance on temporary staff, investment in development, well being of staff			
THIS PAPER HAS BE CONSIDERED BY:	EEN PREVIOUSLY	None			
AUTHOR AND TITLE: Rachel Patterson, Director of People and Organisational Development					

#### **North Middlesex University Hospital NHS Trust**

#### **Workforce Development and Education Committee Report**

#### 1.0 Introduction

This paper provides an overview of key agenda items discussed, assurance provided to the Committee and actions agreed at the Workforce Development and Education Committee which took place on 25 April 2013.

#### 2.0 Key issues, actions and assurance

- Workforce Strategy some minor revisions to the workforce strategy were presented,
  the most significant of which was to include reference to the impact of the outcomes of
  the Francis Report on the workforce. The Committee received a progress report against
  achievement of the objectives contained within the strategy. Whilst the Committee was
  assured objectives had been met to a degree a further piece of work was requested to
  ensure clear outcomes measures were included to enable easier tracking of
  achievement for future reporting periods.
- Draft Organisational Development Strategy a first draft of an Organisational Development Strategy was presented and discussed. The committee proposed suggestions for additions such as an Executive Summary and provided feedback on content. These changes have been incorporated although it remains in draft form while further consultation takes place with the Joint Staff Committee ahead of Trust Board approval.
- Parkhill Audit Follow Up the Committee was presented with an updated action plan
  following the Limited Assurance provided by Parkhill last year after an audit covering
  sickness absence and appraisal processes. The progress against the actions indicated a
  number of the original issues have been rectified, however there are still some actions
  that need to take place to confirm the level of assurance required.
- Risk Register and Board Assurance Framework the highest workforce related risks remain high levels of sickness and having the capacity to release staff to complete compulsory training. The Committee was assured that proactive plans were in place to manage sickness and ensure compulsory training compliance was increased.
- Agenda for Change Terms and Conditions Changes the Committee was presented with a brief paper outlining the approach to implementation of the changes to AfC Terms and Conditions which had previously been agreed at the Joint Staff Committee in March.

#### 3.0 Conclusion and Recommendations

This paper is for information and assurance. The Trust Board is asked to note the contents.

David Price Non Executive Director 20 June 2013



TRUST BOARD					
	2711 1 2012				
MEETING DATE:	27th June 2013				
TITLE:	Patient Safety & Quality Committee Report				
		t dama, and the part of the pa			
AGENDA ITEM:	16	PAPER: P			
EXECUTIVE SUMMA	ARY:				
ACTION REQUESTE	D OF THE MEETING	G:			
For information					
For comment	For agreement For ratification				
For discussion	x	For resolution			
Tor discussion	_ ^ _	Tor resolution			
LINK TO:					
CORPORATE OBJEC	CTIVES:	Provide excellence in treatment and care that is safe and			
		patient centred [MD and DON]			
IMPACT ASSESSMENTS / IMPLICATIONS ON:					
PATIENT SAFETY A	ND QUALITY				
EQUALITY					
RISK (BAF / risk reg					
FINANCES / RESOU	IRCES:				
THE DARED HAS DE	FEN DDEVIOUSLY				
THIS PAPER HAS BEEN PREVIOUSLY					
CONSIDERED BY:					
AUTHOR AND TITL	E. Daul Poor	ros Director of Nursing			
AUTHOR AND TITLE: Paul Reeves, Director of Nursing					

#### **North Middlesex University Hospital NHS Trust**

#### Patient Safety and Quality Committee Trust Board report July 2013

#### **Executive summary**

Ms Lynne Cantor chaired the PSQ committee held on 28<sup>th</sup> May 2013, and welcomed Ms Hilary Shanahan, Interim Director of Nursing to the committee. Ms Cantor reviewed the annual planner and It was agreed that the annual GMC National Trainee Survey should be added to the Annual Planner 2013/14.

#### <u>Francis Report – Government Response and Action Plan</u>

Ms Cantor requested a response to the Government response to the Francis Report 'Patients First and Foremost' published on 26 March 2013. It was agreed that the Director of Nursing & Midwifery should provide a paper responding to the Government Response to the Francis Report – 'Patients First and Foremost' at the June PSQ Committee.

Action: Director of Nursing & Midwifery to provide a paper responding to the Government Response to the Francis Report – 'Patients First and Foremost'

#### **Patient stories**

Two representatives from the Haringey Advisory Group on Alcohol (HAGA) presented a brief introduction to the UK Polish community and hospital attendance trends by the Haringey Polish population. They highlighted data over the previous 3 years which indicated that there had been 502 Polish community A&E attendances, of which 88 were frequent attenders. The Polish Complex Needs Alcohol Worker outlined two examples from her current caseload of 21 clients who have been getting support from HAGA.

Ms Godun explained that she was frequently called to translate for other Polish patients who were not her clients and highlighted the key challenges for her clients:

- lack of understanding about the British healthcare system which is different to the one in Poland
- the language barrier and lack of translation services in hospital and Haringey GP surgeries
- a major problem for Polish homeless patients is that they are unable to register with a GP in Haringey unless they have ID and proof of residence and when A&E staff refer them back to their GP this contributes to a cycle of frequent attendances at A&E.

Ms Cantor asked if there was anything the Trust could do to improve this situation. Ms Godun emphasised the need for translation facilities for her clients at the Trust.

Members thanked the HAGA representatives for a very useful presentation.

# **CBU** presentation

The presentation highlighted some of the key challenges within CBU 2. The non-executive Directors asked for assurance in relation to medication administration omission errors. It was agreed that the Head of Pharmacy and Medicines Management should provide an overview report on medication administration related incidents to PSQ Committee in July 2013

# Action: Head of Pharmacy and Medicines Management to present an overview report on medication administration related incidents to PSQ Committee in July 2013

The Matron for CBU 2 highlighted an increase in use of bank and agency staff due to difficulties in recruiting to permanent staff vacancies on the Acute Medical Unit. The key reasons cited were unfilled vacancies due to difficulties in recruiting, high sickness absence levels and 5 staff being on maternity leave. She reported that staffing gaps on the ward equated to 12 qualified staff and 7 HCSW's which were being filled by bank and agency staff. The Matron for CBU 2 confirmed that a substantive Ward Manager had been appointed in March 2013 with a start date to be agreed and that approval had now been secured to recruit to vacant posts, rather than utilising bank and agency staff, and that a further 5 permanent staff had been recruited recently. She confirmed that recruitment to nursing posts remains a significant challenge on the AMU and that an interim action plan had been agreed with support from the Director of Nursing.

A discussion followed on maternity leave cover arrangements. Lynne Cantor, Chair, enquired whether there was a strategy across the Trust for maternity leave cover and the Medical Director confirmed that a review was currently being progressed by the Workforce Committee. It was agreed that the Medical Director would request a report from the workforce Committee on plans for maternity leave cover.

Action: Medical Director to request a report from the Workforce Committee on plans for maternity leave cover arrangements

#### **Serious Incidents and Never events**

The Head of Patient Safety and Quality presented an update on 3 new SI s reported in April 2013. The chair and the committee sought re-assurance that lessons had been learned from incidents, particularly those relating to clear escalation processes in the Accident and Emergency Department.

# **Infection Control update**

The Interim Director of Nursing and Midwifery gave a verbal update on Infection Control and confirmed that the Trust had two attributable cases of *Clostridium difficile* infection and two cases where MRSA was identified in blood cultures. Post infection review raised the possibility that both the latter may have been contaminants; a process by which the Trust can assure itself that individuals taking blood for culture are competent to do so is being developed. The chair and the committee sought assurance that immediate actions had been taken to ensure that there is no reoccurrence and requested an update at the next meeting. It was agreed that the Consultant Nurse Infection Control Prevention and Control should provide update on aseptic non-touch technique training in Infection Control Report at the June PSQ Committee.

Action: Consultant Nurse Infection Control Prevention and Control to provide update on aseptic non-touch technique training in Infection Control Report

# **Quality Performance Report**

The Interim Director of Operations informed the Committee that there had been a possible breach of 'Mixed-Sex Accommodation' in the Ambulatory Care Unit. Appropriate remedial action had been taken.

# **Adult Safeguarding Annual Report**

Highlights from the Safeguarding Adult Annual Report for 2012/13 were presented to the Committee. Specific risks identified included Safeguarding Adults level 2 training and ongoing provision of a Learning Disability Liaison Nurse post.

Ms Cantor sought clarification on how the Winterbourne View Hospital Action Plan was being followed up. The Senior Project Manager confirmed that outstanding actions required were being monitored by the Trust Safeguarding Adults Board and that a Trust wide Adult Restraint Policy had been approved by the Executive Management Board.

Ms Cantor also requested assurance that actions were being taken forward in relation to clear referral pathways for victims of Domestic Abuse. It was confirmed that the Safeguarding Adults Strategy and Action Plan had been updated to reflect the actions required and that this was being submitted to the Safeguarding Adults Board for ratification. The Trust website had also been updated with a new section on Domestic Abuse which signposts victims to relevant support agencies.

Lynne Cantor Non executive Director June 2013



	Trust Board				
MEETING DATE: 27 June 2013					
WIEETING DATE: 27 June 2013					
TITLE: FT Project Board	undata				
TITEL.	upuate				
AGENDA ITEM: 17	PAPER: Q				
NOLITO III	17.11.21.11				
SUMMARY:					
Attached are the minutes of the April FT Project Board meeting. The minutes of the May meeting will be signed off at the next FT Project Board on 28 June.					
Key items discussed and agreed at the meeting were: - Clinical Strategy and Service Development Priorities - Membership numbers					
- Risk register related to achieving F	T status				
An update on the progress towards FT since this meeting is included in the CEO report on the Trust Board agenda.					
The Board is asked to note the minutes of the FT Project Board meeting on 18 April 2013.					
ACTION DECLIFICATED OF THE MEETING					
ACTION REQUESTED OF THE MEETING	j: 				
For information x	For agreement				
For comment	For ratification				
For discussion	For resolution				
LINK TO:	Attainment of FT status will through the actions required				
CORPORATE OBJECTIVES:	Attainment of FT status will, through the actions required to achieve this, support all 5 of the Trust's corporate				
	objectives				
CQC OUTCOMES:	Attainment of FT status supports and underpins a number				
ede do redivies.	of CQC outcomes				
	1. 1.4. 1.4. 1.4. 1.4. 1.4. 1.4. 1.4. 1				
IMPACT ASSESSMENTS / IMPLICATIONS ON:					
PATIENT SAFETY AND QUALITY	None				
EQUALITY	None				
RISK (BAF / risk register)	Non-achievement of FT status is a significant risk to the				
	organisation's future				
FINANCES / RESOURCES:	None				
THIS PAPER HAS BEEN PREVIOUSLY	N/A				
CONSIDERED BY:					

Lance McCarthy, Deputy Chief Executive

AUTHOR AND TITLE:



# Foundation Trust Project Board Thursday 18<sup>th</sup> April 2013 3pm - 4:30pm

**Present:** Lynne Cantor Acting Chair

Julie Lowe Chief Executive

Lance McCarthy Deputy Chief Executive

Kyn Aizlewood Head of Delivery and Development, NE & NC London, TDA

Catherine Dugmore Non Executive Director
Sally Field Non Executive Director
Martin Armstrong Director of Finance

David Maloney Chief Finance Officer, Haringey CCG

In Attendance: Julie Kerr Executive Assistant

Walter Johnson TDA

## FTPB 13/12 APOLOGIES FOR ABSENCE

Apologies were received from Liz Wise, Alpesh Patel, Helen Pelendrides, Sarah Price and Stanley Okolo.

#### FTPB 13/13 DECLARATION OF INTERESTS

There were no declarations of interest.

## FTPB 13/14 MINUTES FROM THE LAST MEETING – 21 MARCH 2013

The minutes were agreed as a correct record.

#### FTPB 13/15 MATTERS ARISING

**Action**: FTPG 13/03 - Lance McCarthy, Deputy Chief Executive reported that the Board Secretary starts at NMUH on 13 May 2013. It has been decided to wait until she starts work to plan what additional support and resourcing, if any, is required for the FT office.

**Action:** FTPG 13/05 - Kyn Aizlewood said that the lack of a substantive chair would have an impact on the FT application process (eg: BGAF). The TDA are currently in talks about a substantive Chair for NMUH and the TDA are working to resolve this within a few weeks to minimise any impact on the FT application process.

#### FTPB 13/16 PROJECT PLAN UPDATE:

Lance McCarthy, Deputy Chief Executive presented the FT project Board with the FT Project Plan progress made against the relevant actions. Concerns were highlighted in yellow.

The Deputy Chief Executive reported that the TDA had interviewed most Board members this week and attending the Trust Board meeting on Thursday 25 April 2013 as part of their observation and baseline assessment of the Board.

The Trust Board approved the Clinical Strategy and Service Development priorities and the Membership Strategy on Thursday 28 March 2013.

The Deputy Chief Executive reported that there are two main areas that are of concern to the current critical paths of the plan -:

- HDD1 assessor appointment, delay due to Monitor / TDA process for selection. The Trust is likely to miss the date of 1st July submission date. This is due to a Monitor process issue.
- BGAF and MQGF external assessment delayed by lack of a substantive Chair. The Deputy
  Chief Executive reported that the Trust had decided to commission KPMG to undertake the
  external assessments but have not yet set a date for the reviews, waiting until a substantive
  Chair is in post.

A discussion then took place about CCG involvement and engagement in the Project Board and the critical timeline for commissioners, particularly in terms of the sign off of the IBP.

#### **Actions:**

Outline the commissioners' critical path for the application (LMcC)

Outline the critical path for the whole FT application (LMcC)

Move the next FT Project Board meeting to ensure CCG representation (LMcC)

#### FTPB 13/17 CLINICAL STRATEGY AND SERVICE DEVELOPMENT PRIORITIES

The Deputy Chief Executive highlighted the Clinical Strategy for the Trust for the next 5 - 10 years by way of the 4 high level Service Development Priorities (SDPs) that underpin the IBP.

In the autumn of 2012, the Trust Board agreed the Trust's Strategic Vision for the next 10 years to be, "To become the healthcare provider of choice for the diverse population we serve in North London and beyond, recognised for excellent emergency, acute, maternity and ambulatory care, delivered by excellent and compassionate staff".

To enable the development of the Trust's SDPs there has been a range of activities undertaken across the Trust since the autumn including:

- Consultation and discussion on the Trust's Vision and Strategy with clinical and non-clinical leaders in the Trust
- Detailed market analysis and assessment
- Completion of SWOT and PEST analyses and discussion and amendment of these at Trust Board and CBU levels
- Development of specialty specific strategies for the next 5 years
- Series of Executive Director and CBU workshops to pull all the above detail together
- Links to the Joint QIPP discussions with key local commissioners
- Discussions with Chairs and Chief Officers for Enfield and Haringey CCGs

The 4 SDPs are all aligned with the needs of our local population. The detail behind some of the local specialty developments that will underpin the Trust's SDPs was presented to the Trust Board in the Board seminar session on 28 March.

Presentations to the Executive Management Board about the 4 SDPs were attached. The 4 SDPs to underpin the Trust's IBP are:

- Urgent care provision
- Partnership working with primary and community services
- Partnership working with tertiary providers
- Expansion of service to the East and North

The Deputy Chief Executive also summarised the supporting strategies required to ensure successful implementation of the SDPs.

David Maloney, Chief Finance Officer, Haringey CCG, invited NMUH to attend a CCG Finance and Performance Committee Meeting to discuss in detail the papers presented. Mr Maloney also agreed to send the GP Collaborative meeting dates to Lance McCarthy, Deputy Chief Executive.

Critical path commissioner timelines were discussed – sign off of draft IBP from Enfield and Haringey CCGs required at FT Project Board meeting on 20 June 2013. Kyn Aizlewood, TDA confirmed they would require a letters from commissioners expressing an understanding and support of the process. Martin, Armstrong, asked if the TDA would expect the Trust to have other CCG support at this stage given Enfield and Haringey represent >90% of GP referred activity to NMUH.

#### **Actions:**

Dates of Haringey GP Collaborative meetings to be sent to Lance McCarthy (David Maloney)
Presentation to Haringey Finance and Performance Meeting in May (LMcC)
Check CCG sign off requirements (Kyn Aizlewood)

# FTPB 13/18 RISK REGISTER

The Deputy Chief Executive summarised the current FT risk register. Changes from last months report were highlighted in red text/yellow boxes on the report. The register will be updated on a monthly basis to reflect any changes as the Trust moves through the application process.

The Project Board discussed the risk register and the scoring. Sally Field, Non Executive Director, asked about the recruitment of the Membership Manager and the Communication Manager. The Deputy Chief Executive reported that the Head of Communications has been appointed, start date to be confirmed, and will recruit to the membership manager once in post. Sally Field also requested that the initial and the current risk ratings are presented on subsequent versions of the risk register.

The Deputy Chief Executive summarised the following key risks:

- Lack of a substantive Chair of the Trust and the impact on the FT application timeline
- SLAs unsigned for 2013/2014 and material gap between parties
- Gaps in controls: Monitor/TDA process means an assessor for HDD1 looks likely not to be identified in time to allow completion of HDD1 in line with the timetable

#### **Actions:**

Initial and current risk ratings to be included on future registers (LMcC)

# FTPB 13/19 MEMBERSHIP NUMBERS

The Deputy Chief Executive presented a methodology for determining possible membership numbers. In the absence of a clear methodology or formula for determining the number of members an FT ought to aspire to, a benchmarking paper was presented.

The Deputy Chief Executive reported that the document had been shared with the TDA and their comments and thoughts were summarised and included.

It was agreed to aim for the numbers outlined in the paper – just under 4,000 public and patient members on an opt-in scheme and 90% of staff members on an opt-out scheme with a plan to increase public and patient member numbers by 5% pa, in line with the benchmarked Trusts. It was also agreed to use a 3<sup>rd</sup> party to support the membership drive.

Kyn Aizlewood, TDA highlighted the need for the Trust to be pragmatic in terms of recruitment numbers and to recognise the difficultly in recruiting a representative membership from the local population.

#### **Actions:**

Develop membership plan and tender specification for external support (LMcC – end of May) Update Membership Strategy to reflect 5% pa uplift to member numbers (LMcC)

# FTPB 13/20 ANY OTHER BUSINESS

There was no further business.

# FTPB 13/11 DATE AND TIME OF THE NEXT MEETING

The date and time of the next meeting was discussed and agreed to be held on 13<sup>th</sup> May at 3pm – 4:30pm in the Trust Board, West Rotunda.



TRUST BOARD - AGENDA ITEM SUMMARY				
AGENDA ITEM NUMBER:	18			
CURIFOR	Description A	Processing and the second seco		
SUBJECT:	Report from the Au	idit Committee		
MEETING DATE:	27th June 2013			
SUMMARY: This paper updates the Trust Board on the actions of the Audit Committee at its meeting in April, May and June 2013. The Board is asked to note and seek assurance from the activities of the Audit Committee				
BOARD ASSURANCE FRAMEWORK REFERENCE NUMBER: 7				
Financial Issues: YES	Legal Issues: YES	Equality Issues:		
		1 ' '		
ACTION REQUIRED:				
For information/note	(	For assurance X		
For comment		For ratification		
For discussion		For Trust Board resolution		
THIS DOCUMENT HAS BEEN VIA/	REQUESTED BY:			
Trust Board	X	Workforce and OD Committee		
Hospital Management Board		Patient Safety and Quality Committee		
Finance and Investment Committ	ee	Foundation Trust Project Board		
Audit Committee				
FOLLOWING BOARD ACTION THIS DOCUMENT WILL BE COMMUNICATED VIA:				
Trust Board				
<u> </u>				
EXECUTIVE LEAD: Finance Director				

# North Middlesex University Hospital NHS Trust Trust Board, 27th June 2013

# **Report from the Audit Committee**

#### Introduction

This paper provides a summary of the work undertaken by the Audit Committee at its last meeting on the 30th May 2013 for review by the Trust Board.

This report also highlights other significant issues that the Board need to be aware of, and provides an update on progress against the Audit Committee Annual Plan.

# Audit Committee Agenda, 23rd April 2013

Items discussed as the meeting included;

- The Committee reviewed progress against the Audit Committee work plan for 13/14.
- The Committee reviewed a report from Parkhill that included a Final Head of Internal Opinion for 2012/13. This included amendments and corrections to the draft version presented at the March meeting of the Committee. The report also provided an update in respect of the small number of remaining audit reports that required close down from the 2012/13 plan.
- The Director of Finance provided an update in respect of the process to tender Internal Audit services. He confirmed that an evaluation panel had met in March as part of this process and that a recommendation had been made and accepted by the Director of Finance. The Trust was presently still in a formal contract standstill stage and as such would confirm details of the selected contractor shortly and would work to ensure that transition arrangements are in place
- The Committee review the draft Internal Audit Plan for 2013/14. This had been proposed by Parkhill at the March Committee meeting and subsequently reviewed and amended by the Trust Executive to reflect views on organisational risk and priority. The Committee agreed that the revised draft would be discussed with the new internal audit provider when confirmed.
- The Committee reviewed the latest version of the Board Assurance Framework. It discussed at length the relationship of the Committee to other Board sub Committee's and how it should discharge this duty effectively. It was agreed that the issue would benefit from further discussion outside of the Committee.
- The Deputy Director of Finance provided the Committee with an update in respect
  of progress against the final accounts timetable. She confirmed that the Trust had
  submitted its draft accounts by the required national deadline and that the external
  audit review would commence in early May. The Committee agreed that an informal
  accounts review workshop for NED's would be helpful.

The Committee received and commented upon a draft version of the Trust Annual Governance Statement. It was acknowledged that a final version would be presented for consideration and approval at the May meeting of the Committee

# Audit Committee Agenda, 30th May 2013

Items discussed as the meeting included;

- The Committee reviewed progress against the Audit Committee work plan for 13/14.
- The Director of Finance presented an update in respect of progress against the annual financial accounts process. He confirmed that the external audit review process was nearing completion, and that informal feed back from Grant Thornton indicated that an unqualified audit opinion would be issued. The Director of Finance outlined arrangements for the formal approval of the accounts by the Committee at its meeting on the 4<sup>th</sup> June 2013. He then presented a detailed review of the Trust accounts for 2012/13. The Committee discussed aspects of the accounts in detail and agreed that the provision of an additional and specific accounts review workshop for NEDs during May had proved helpful.
- The Deputy Chief Executive presented a draft of the Annual Governance statement of 2012/13. The Committee reviewed the document and asked that it be passed to both internal and external audit for review and comment with a further version for final approval to the April Audit Committee.
- Assurance reports from Patient Safety and Quality, Finance & Investments, Foundation Trust, EMB and Workforce were received, discussed and noted. Specific recommendations for additional assurance or information were made to lead Executives for a number of these Committees.
- The Committee welcomed RSM Tenon to the meeting as the Trusts new internal audit and local counter fraud service provider. The Committee discussed and agreed the approach to confirming an internal audit programme that could be initiated pending formal agreement of the annual plan at the next meeting of the Committee. The Committee received final audit reports from the outgoing provider – Parkhill.
- The Director of Finance presented a revised Terms of Reference document for the Committee that reflected best practice. The Committee reviewed and approved the Terms of Reference. In addition the Committee reviewed the latest version of the Trust BAF.
- For Information Reports were presented to the Committee in respect of losses and special payments, and also bad debts and write offs actioned in the last quarter. The Deputy of Finance confirmed that this information matched that contained within the Trust annual accounts.
- The Deputy Chief Executive provided an update in respect of ongoing work to ensure that Trust policies remain up to date.

#### Audit Committee Agenda, 4th June 2013

Items discussed as the meeting included;

- The Director of Finance presented an overview of the session. This outlined that the key purpose of the meeting was to formally receive and review the Trust accounts for the 2012/13 financial year; to receive and acknowledge the audit report presented by the Trust's external auditors and exercising the authority delegated to it by the Trust Board at its April Meeting authorise the signature of the Trust Accounts for submission to the Department of Health.
- The Director of Finance provided an overview of the Trust accounts for the year ending 31<sup>st</sup> March 2013. These had been previously review in detail by the Audit Committee at its May 2013 meeting. The Director of Finance highlighted that the accounts reported full delivery of all of the Trusts key statutory financial targets for 2012/13 and that no material changes had resulted to the accounts compared with the pre audit version submitted during April 2013. As such he commended the accounts to the Committee for approval.
- The Grant Thornton Partner presented the Auditors Report to those charged with governance (ISA260). This confirmed the approach and testing that the year end accounts audit had encompassed, and ultimately presented an unqualified opinion of the annual accounts.
- The Committee reviewed and approved both the Letter of Representation and also the final version of the Trust Annual Governance Statement. The latter document having been reviewed, approved and amended following the May Audit Committee and also comments from both External and Internal Audit.
- The Committee reviewed the latest draft of the Trust annual report. Grant Thornton
  confirmed that the financial statements and information contained within the document
  matched the Trust annual accounts. It was recognised by the Committee that any
  further minor change to the document prior to publication would require formal
  approval by Grant Thornton. The Committee recommended that in future a more robust
  approach be taken to the completion of the document given its importance as a public
  document.
- The Committee reviewed the latest version of the Trusts Quality Accounts for 2012/13. The Deputy Chief Executive identified significant changes to the document vs. the previous draft. He highlighted that the document would be circulated to key stakeholders to gather appropriate feedback, before final sign off at the June meetings of the Patient, Safety & Quality Committee and the Trust Board and required formal submission to the Department of Health on the 30<sup>th</sup> June 2013.
- The Audit Committee exercised its delegated authority to approve the signature of the Trust financial accounts for 2012/13.

# **Progress against the Annual Plan for the Audit Committee**

The Audit & Assurance Committee continues to meet the deadlines set within the Annual Plan.

# **Attendance at the Committee**

The May meeting of the Committee was quorate.

Catherine Dugmore
Non Executive Director
June 2013