Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 27th November 2019, 11am to 1.30pm
Oak Room, W12 Conference Suite, Hammersmith Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Paula Vennells	Oral
	2.	**Apologies:** Ben Maruthappu, Richard Alexander	Paula Vennells	Oral
	3.	**Declarations of interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting*	Paula Vennells	Oral
1105	**4.**	**Minutes of the meeting held on 25th September 2019** *To approve the minutes from the last meeting*	Paula Vennells	01
	5.	**Record of items discussed in Part II of Board meeting held on 25th September 2019** *To note the report*	Paula Vennells	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Paula Vennells	03
1110	**7.**	**Patient story** *To note the story*	Prof. Sigsworth	04
1125	**8.**	**Chief Executive Officer's report** *To note the report*	Prof. Orchard	05
For decision				
1140	**9.**	**Strategic development – Implementation of a management system (working title 'the Imperial Way')** *To approve the Imperial management system and note progress for agreeing priorities for 2020/21; and delivery of the 2019/20 objectives*	Claire Hook	06
For discussion				
1155	**10.**	**Bi-monthly Integrated Quality and Performance report** *To receive the integrated quality and performance report for month 6*	Prof. Redhead/ Claire Hook	07
1210	**11.**	**Finance report** *To receive an update for month 7, year to date and other financial matters*	Janice Stephens	08
1225	**12.**	**CQC update** *To receive an update on CQC related activity at and/or impacting the Trust*	Peter Jenkinson	09
1230	**13.**	**Corporate Risk Register (CRR) and Board Assurance Framework (BAF)** *To discuss and note the updated CRR and BAF*	Peter Jenkinson	10
For noting				
1240	**14.**	**Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report**	Alison Holmes	11

		To note the quarter 2 report		
1245	**15.**	**Research and Development Quarterly Report** *To note the quarter 2 report*	Bob Klaber	12
1250	**16.**	**General Medical Council National Training Survey – results** *To note the results of the 2019 survey and the action underway or completed*	Prof. Redhead	13
1255	**17.**	**Quality Impact Assessments for Cost Improvement Programme (2019/20)** *To note the summary of the QIA process and the Cost Improvement Programme for 2019/20*	Jeremy Butler	14
1300	**18.**	**2018/19 Annual Report of The Trust Safeguarding Committee** *To note the systems and processes in place at ICHT to ensure that it fulfils its responsibilities in relation to safeguarding people in its care; and note the summary of safeguarding activity during the year and priorities*	Prof. Sigsworth	15
1305	**19.**	**Trust Board committees – Terms of References** *To approve the updated Board Committee Terms of References*	Peter Jenkinson	15
	19.1.	Audit, Risk and Governance Committee	Sir Gerald Acher	16a
	19.2.	Quality Committee	Prof. Bush	16b
	19.3.	Finance, Investment and Operations Committee	Dr Andreas Raffel	16c
	19.4.	Remuneration and Appointments Committee	Peter Goldsbrough	16d
1310	**20.**	**Trust Board Committees – summary reports** *To note the summary reports from the Trust Board Committees*		
	20.1.	Audit, Risk and Governance Committee, 2nd October 2019	Sir Gerald Acher	17a
	20.2.	Quality Committee, 13th November 2019	Prof. Bush	17b
	20.3.	Finance, Investment and Operations Committee, 20th November 2019	Dr Andreas Raffel	17c
	20.4.	Remuneration and Appointments Committee, 30th October 2019	Peter Goldsbrough	17d
1320	**21.**	**Any other business**	Paula Vennells	Oral
1325	**22.**	**Questions from the public**	Paula Vennells	Oral
1330 Close	**23.**	**Date of next meeting** Board Seminar: 11th December 2019, Hilton Paddington Trust Board: 29th January 2020, 10am, Charing Cross Hospital		

Updated: 21 November 2019

Reading room material for reference:

1.	**The Imperial Way Model (full version)**

Imperial College Healthcare NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Wednesday 25 September 2019
11.00 – 11.30hrs
W12 Conference Centre, Hammersmith Hospital

Present:	
Paula Vennells	Chair
Sir Gerry Acher	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Kay Boycott	Non-executive director
Prof Andy Bush	Non-executive director
Prof Tim Orchard	Chief executive officer
Prof Julian Redhead	Medical director
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Dr Frances Bowen	Divisional director, MIC
Jeremy Butler	Director of transformation
Kevin Croft	Director of people & OD
Michelle Dixon	Director of communications
Claire Hook	Director of operational performance
Hugh Gostling	Director of estates and facilities
Kevin Jarrold	Chief information officer
Peter Jenkinson	Director of corporate governance
Ben Maruthappu	Associate non-executive director
Nick Ross	Designate non-executive director
Prof TG Teoh	Divisional director of operations, WCCS
Dr Katie Urch	Divisional director of operations, SCCS
Prof Jonathan Weber	Dean of the Faculty of Medicine, Imperial College

1.	**Chairman's opening remarks, apologies and declarations of interests** Ms Vennells welcomed board members and attendees to the meeting. Ms Vennells welcomed new members of the Board – Kay Boycott, Non-executive director, and Ben Maruthappu, Associate non-executive director – and reported that Nicola Horlick had also been appointed as Non-executive director but had deferred taking up the appointment due to her being selected as a parliamentary candidate in the next general election. This appointment would therefore be reviewed following the outcome of the general election. Ms Vennells reflected on a successful Annual General Meeting held on 11 September and thanked members of the Board, public and staff for their support.
2.	**Apologies** No apologies were received.
3.	**Declarations of interest** There were no declarations made at the meeting.

4.	**Minutes of the meetings held on 24 July 2019** The minutes of the previous meeting, held on 24 July 2019, were confirmed as an accurate record.
5.	**Record of private items discussed at Board** The Board noted a summary of confidential items discussed at the confidential board meetings held on 24 July 2019.
6.	**Action log and matters arising** The Trust board noted the action log.
7.	**Patient story**
7.1	The Board welcomed Mr Elroy Edwards, who presented a summary of his experience as a patient at Hammersmith Hospital undergoing an open cholecystectomy. He commended the post-surgery care and thanked all staff involved in his care, but also noted issues in his outpatient experience, including incorrect appointments leading to delays. The Board also noted the lessons learned from Mr Edwards' experience included the need to ensure we give consistent clear information to patients using the same terminology to avoid any misinterpretations and unnecessary anxiety.
7.2	The Board thanked Mr Edwards for sharing his experiences and noted the lessons learned. The Trust board noted the report.
8.	**Chief executive officer's report**
8.1	Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership.
8.2	*Financial update – North West London sector* Prof Orchard reported on the Trust's current financial performance and the performance of the North West London sector (STP). He reported that the Trust's forecast had improved, but that a significant risk remained regarding achieving the control total. It was noted that any use of non-recurrent savings to achieve the target this year would increase the challenge faced in the next year. Prof Orchard highlighted the update on the development and implementation of the Trust's transformation plan, including clinical collaboration with Chelsea & Westminster NHS Foundation Trust and internal operational efficiency.
8.3	*Quality* Prof Orchard reported the publication of final reports following CQC's inspection of the trust-run GP service at Hammersmith Hospital, highlighting that the service was rated as 'good' in all domains.
8.4	Prof Orchard provided an update on the implementation of the non-emergency patient transport contract, reporting that improvements had been made in the performance of FALCK but that the improvement had been slower than hoped. The issues continued to be escalated with FALCK senior management and further improvement was expected by December.
8.5	*Operational performance* The Board noted that the pilot of new Urgent and Emergency Care (UEC) standards had been extended until the end of the financial year. These new standards, including the total amount of time patients spent in A&E, would be used to drive pathway improvements.
8.6	Prof Orchard reported that NHS Improvement had confirmed at the last Provider Oversight Meeting that they would be reviewing the Trust's regulatory segmentation and

	undertakings, to reflect the progress made by the Trust. Formal confirmation of the outcome of this review was awaited.
	People
8.7	Prof Orchard also updated the Board on various staff related issues, including the launch of a reverse mentoring scheme for the executive team, the plan for the Great Place To Work (GPTW) week running from 30th September to 4th October that would see the launch of several initiatives, including values workshops, and the launch of a revised approach to the Make a Difference awards. He also reported the launch of a development programme for General Managers.
8.8	The Board also noted the structured approach adopted for this year's Flu Campaign, including the use of peer vaccinators and influential colleagues to strengthen the communication, and noted progress to date. The Board discussed the contractual and behavioural drivers to improve take-up of the vaccination and noted the adoption of contractual requirement for new starters. It was agreed that the contractual requirement for existing staff would be reviewed. **Action: Kevin Croft**
	The Trust board noted the report.
9.	**Board level governance – amendments to current arrangements**
9.1	The Board considered proposed amendments in Board governance arrangements, including amendments to terms of reference for Board committees following review by respective committees, amendments in non-executive membership of Board committees and a proposed approach for Board seminars.
9.2	The Board noted the deferment to Nicola Horlick taking up her appointment as non-executive director due to her being selected as a parliamentary candidate in the next general election, and agreed that this would be reviewed again in three months. **Action: Paula Vennells**
9.3	The Board discussed the format and approach for Board seminars and agreed the outline schedule and extended time for these sessions. It was agreed that the dates for these sessions would be circulated as soon as possible. **Action: Peter Jenkinson**
	The Trust board agreed the changes to Board level governance, including the amended terms of reference for Board committees.
10.	**2018/19 Annual workforce equality and diversity report**
10.1	The Board welcomed Gemma Glanville to the meeting.
10.2	The Board considered the draft annual report, including the Trust's compliance with the Public Sector Equality duties under the Equality Act 2010, and also the current performance data and plans for the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES) and our Gender Pay Gap Report. The Board noted the summary of the discussion at executive and the Quality Committee, noting in particular the challenge regarding whether enough was being done to understand the causes of deteriorating performance such as the likelihood of BME staff being appointed from shortlisting and being the subject of formal disciplinary procedures, and whether the Trust was doing enough to address the gender pay gap, especially in relation to the proportion of female senior managers and the success of part-time female doctors in applying for Clinical Excellence Awards. The Board noted that it had been agreed that additional actions would be considered in refreshing the 2019 equalities programme and in preparation for 2020 business planning.

10.3	The Board also noted anecdotal evidence that BAME doctors were more likely to be referred to the General Medical Council and noted the importance of recognising language and cultural differences. The Board acknowledged the importance of the Trust's culture and the need for the culture to change to accommodate new entrants rather than expecting new entrants to adapt to the existing culture.
10.4	The Trust board noted the report and approved the publication of the annual report.
11.	**Integrated Quality and Performance Report (month 4 2019/20)**
11.1	The Board received the Integrated quality and performance report for July (month 4), noting exceptions as presented:
	Quality
11.2	The Board noted that the Trust's incident reporting rate had been above target for two months following ten months of underperformance. All three clinical divisions were reporting higher numbers of incidents. The Trust's harm profile was good and the Trust remained one of best in the country for mortality rates. The Board received an update on the ongoing process to strengthen governance arrangements for the management of serious incidents, including the establishment of a central investigation team to ensure sufficient resource and time for the investigation of incidents.
11.3	The Board noted an increase in the number of serious incidents being reported, due to breaches in the time taken to care for patients with mental health issues in A&E. Mrs Hook reported on action being taken nationally and locally to address this issue, including commitments to changes in service and commissioning arrangements that should have a positive impact.
11.4	The Board noted that no further never events had been reported year to date and noted that the HOTT programme continued. Prof Redhead updated on the training programme and noted opportunities to extend the training from those involved in invasive procedures to include other surgical procedures.
11.5	The Board noted current infection rates and an update on antibiotic stewardship, noting 37 cases of *C. difficile* year to date, which was above our trajectory of 27. It was noted that none of these cases had been related to lapses in care.
11.6	The Board received an update on operational performance, noting the extension of field-testing of the proposed new urgent and emergency care standards to include 'mean time to initial assessment', as well as the 'average time spent in A&E', which had commenced in May. It was noted that performance data on the A&E four hour standard would not be published during the pilot period.
11.7	The Board noted that the Trust continued to report that no patients had been waiting for more than 52 weeks for treatment. The overall size of the referral to treatment waiting list size was being maintained and met the trajectory, as did the aggregate performance of the standard to treat patients within 18 weeks of their referral. The Board also noted that the Trust delivered six of the eight national cancer standards in July; the two areas performing below the standard (cancer 2 week waits and the 62 day screening standard) were being reviewed by the service and an improvement trajectory was being developed.
11.8	The Board noted a significant increase in the numbers of formal complaints, primarily linked to the introduction of the new non-emergency patient transport service as reported in the Chief executive's report. The Trust board noted the report.

12.	**Financial performance report**
12.1	The Board received and noted the financial performance report for month 5, noting that the Trust remained on track against the plan in month and year to date; however significant risks remained in the sector financial position and the potential impact on payments for activity over the agreed contract, and in the divisional delivery of CIPs.
12.2	The Board noted the report from the Chair of the Finance, Investment and Operations Committee, and discussed the sector-wide trend in activity, the financial impact and the ongoing initiatives in demand management. The Board noted the risk arising from the financial position of the sector, and noted the assumed payment for activity as per the contract but the potential need for the Trust to make provision for non-payment of over-activity by the Sector. It was agreed that this risk would be reviewed following publication of month 6 data. **Action: Richard Alexander** The Trust board noted the report.
13.	**CQC update report**
13.1	The Board received and noted the update report, including the outcome of a follow up inspection carried out in August 2019, to check compliance against the Improvement Notice served to the Trust following the CQC inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations (IRMER) in the Imaging department at St Mary's Hospital in June 2019. It was noted that the Trust had been deemed compliant with the requirements of the regulation against which the Notice had been set, and no further action would be taken.
13.2	The Board also noted that the Trust had received its draft inspection report following the CQC inspection of its GP practice in July. It was noted that the final report would be published on the CQC's website in due course, but that the draft findings were very positive. The Trust board noted the report.
14.	**Board member visit programme – update**
14.1	The Board received and noted the report on the first twelve months of the Board member visit programme, established with the principal aim of providing board members with an opportunity to meet front line staff, to learn about the services they provide and to engage with them in understanding what matters to them and how they can continually improve their services. The Board noted that around 60 different areas of the Trust had been visited and that the response to the visit programme had been generally positive, particularly from staff who appreciated the time taken by members of the Board to visit and engage with them to understand what it's like to work in some of the Trust's departments / wards.
14.2	The Board noted and agreed the strengthening of the feedback process, noting that the board member conducting the visit should feedback to the local management and the divisional management team, whose responsibility it was to then consider any recommendations and report back on action taken. The Board noted that a look back on feedback provided from visits conducted in the last six months had been published separately.
14.3	The Board agreed the continuation with the programme, with revised process, and that a new programme would be circulated. **Action: Peter Jenkinson** The Trust board noted the report.

15.	**Patient and public involvement – annual report**
15.1	The Board welcomed Trish Longdon, Chair of the Strategic Lay Forum, to the meeting.
15.2	The Board received the annual review of patient and public involvement (PPI), including progress against the Trust's PPI strategy and priorities for 2019/20. The Board noted and welcomed the Strategic Lay Forum's involvement in a number of projects across the Trust, including the 'care journey and capacity' project which involved looking at how patients move through the hospitals from A&E through to discharge, and highlighted the role of the Forum members in developing the Trust's organisational strategy in partnership with the Trust.
15.3	The Board also noted the award of the first Michael Morton patient and public involvement award as part of the Trust's Make a Difference' annual awards, noting the winner and shortlisted projects outlined in the report as examples of staff and patients working together. The Board welcomed this new award as one of five awards presented annually as a fitting way to remember Mr Morton, the first chair of the strategic lay forum who passed away in November 2018. The Board acknowledged Mr Morton's dedication to patient and public involvement and his instrumental role in establishing the strategic lay forum.
15.4	Ms Longdon outlined the Forum's priorities and focus, including the involvement in strategic programmes such as the estates redevelopment programme, and the development of an organisation culture in which patients were put first and in which patients were empowered to manage their care.
15.5	The Board thanked Ms Longdon and the strategic lay forum members for their time and commitment in developing the relationship between trust and forum, acknowledging the importance of the Trust's partnership with the forum and the demonstrable progress made in developing that partnership. The Board also thanked all patients who were involved with the trust in improving services and noted, for example, the positive impact of having patient involvement in estates projects. The Trust board noted the report.
16.	**Emergency preparedness, resilience and response**
16.1	The Board received and considered an update on the Trust's Emergency preparedness, resilience and response (EPRR) planning, including an update and assurance in relation to the Trust's EPRR arrangements and plans. The Board noted updates on current threat level, EPRR exercises and training and the NHS England Assurance rating and action plan.
16.2	The Board noted the number of business continuity incidents that had been managed successfully by the management team, with lessons learnt from each one and collectively.
16.3	The Board also discussed the risk of cyber-attacks and the preparation and prevention of such attacks. Mr Jarrold reported that table-top exercises had been completed with the EPRR team; he noted the risk of ensuring the aged network infrastructure remained robust but opined that the Trust was well placed given the financial constraints in the capital programme. The Board noted that quarterly updates on cyber-security were presented to the Audit, Risk and Governance Committee, acknowledged as being exemplar by Trust auditors, over 90% of staff were compliant with information governance training and the Board received annual training in cyber security. It was agreed that further discussion and training would be part of a future Board seminar. **Action: Peter Jenkinson / Kevin Jarrold**

17.	**Infection prevention and control – quarterly report**
17.1	The Board welcomed Prof Alison Holmes, Director of Infection prevention and control, to the meeting.
17.2	The Board received and noted the Infection Prevention and Control (IPC), and Antimicrobial Stewardship quarterly report for quarter 1 of 2019/20. The Board noted that the rate of C Difficile infection was above trajectory, but no lapses in care had been identified, suggesting that these cases are not due to cross-transmission or poor antibiotic practices. The Board also noted that three cases of Trust-attributed MRSA BSI had been reported during the quarter from 8004 blood cultures tested. Poor documentation of vascular access devices had been identified in two of the three cases; this had been highlighted to the teams involved and shared more widely via the Line Safety Management Group.
17.3	The Board noted an overall 3% reduction on total consumption of antibiotics in 2018/19, exceeding the 1% externally-set reduction target of the 2018/19 'Reducing the impact of serious infection' CQUIN. There had also been an improvement in the compliance levels in the most recent hand hygiene audits; this had been a focus of the world patient safety day held on 17 September across the Shelford Group hospital trusts.
17.4	The Board noted that the Trust's work on reducing sepsis was being shared with clinical networks, including GPs, and had attracted BRC funding, with publication to follow. The Board noted the summary of the applied research and welcomed the influence the Trust had in national projects. The Trust board noted the report.
18.	**Research and development – quarterly report**
18.1	The Board received and noted the quarterly report, including a summary of recent progress with respect to various clinical research initiatives within the Imperial Academic Health Science Centre (AHSC). The Board noted progress against plan to increase the number of commercial clinical trials at ICHT, details of recent performance in initiating clinical trials and translational research highlights and outputs from the Imperial BRC. The Board welcomed the joint work being done with Imperial College and Imperial College Health Partners, and the positive impact it was having with successful bids for clinical trials and a growth in commercial trials. Prof Weber highlighted the establishment of a digital innovation hub, created to take advantage of and exploit the integrated data available. The Board discussed the research strategy and noted examples of where academic, research and clinical teams were integrated and where the academic agenda was embedded within the service.
19.	**Trust Board Committee summary reports**
19.1	The Board received and noted summary reports from the following Board committee meetings: • Quality Committee meeting held on 11 September 2019 • Finance, Investment and Operations Committee meeting held on 18 September 2019 The Trust board noted the report.
20.	**Any other business**
21.1	No other business was discussed.

	The Board noted the planned memorial event for Sir William Stanley Peart, to be held on 11 April 2020 at the Royal Society.
21.	**Questions from the public**
21.1	Victoria Craven reflected on various aspects of patient safety, including incident reporting and follow up and the world patient safety day, and then asked about the level of antibiotics used in the production of patient meals and whether the Trust had included any commitment to reduce use of antibiotics in supplier contracts. Prof Sigsworth agreed to confirm and report back to Ms Craven.
21.2	A lay member reflected on his experience of supporting the strategic lay forum and reflected on the success of the AGM, but stressed the need for the Trust to invest some of its surplus in disabled access. Ms Vennells confirmed the Board's commitment to ensuring access to all patients and explained the financial constraints within the NHS, including the constraints in spending any surplus made at the end of year.
22.	**Date of next meeting** Wednesday 27 November 2019 10.00 – 11.00, W12 Conference Centre, Hammersmith Hospital.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meetings held on 25th September and 30th October 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27th November 2019	**Item 5, report no. 02**
Responsible Executive Director: Professor Tim Orchard, chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance

Summary:

Decisions taken, and key briefings, during the confidential sessions of a Trust board are reported (where appropriate) at the next Trust board meeting held in public. Items that are commercially sensitive are not published.

September 2019

The Board received a report from the Chief Executive, including an update on the pilot of emergency care standards.

The Board received a report on a major incident at Charing Cross Hospital, involving power outage to two wards due to water damage. It considered the Trust's business continuity and resilience of its power supply, noting the challenges in providing modern standard resilience systems in aged estate.

The Board also noted an interim change in the governance arrangements for North West London Pathology (NWLP), in response to the findings from an external review commissioned by three owner trusts in response to concerns about the current performance of the entity and delays in achieving the transformation required to ensure the joint ventures viability. It was noted that the report confirmed that the current senior management team were the right team, but there were weaknesses in the governance arrangements of the entity.

In response, the owners had agreed the need to suspend the independent Pathology Board and for the Trust to provide more direct support to the NWLP executive team on behalf of the owners. It was noted that the owners remained committed to the joint venture and its future viability, and the Board noted the strategic importance of NWLP in terms of research and development.

October 2019

The Board met in seminar mode on 30th October, with the session devoted to the redevelopment of Trust estate. No decisions are made in seminar mode.

Recommendations:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 25 September 2019

Updated: 20 November 2019

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 September 2019 12.2	Financial performance report	The Board noted the report from the Chair of the Finance, Investment and Operations Committee, and discussed the sector-wide trend in activity, the financial impact and the ongoing initiatives in demand management. The Board noted the risk arising from the financial position of the sector, and noted the assumed payment for activity as per the contract but the potential need for the Trust to make provision for non-payment of over-activity by the Sector. It was agreed that this risk would be reviewed following publication of month 6 data. November 2019 update: The Trust continues to engage and work with commissioners to manage the risk and impact of over-activity versus the contract, and to ensure payment in line with expected income.	Janice Stephens	November 2019
2.	25 September 2019 8.8	Flu campaign (arising from CEO report discussion)	The Board also noted the structured approach adopted for this year's Flu Campaign, including the use of peer vaccinators and influential colleagues to strengthen the communication, and noted progress to date. The Board discussed the contractual and behavioural drivers to improve take-up of the vaccination and noted the adoption of contractual requirement for new starters. It was agreed that the contractual requirement for existing staff would be reviewed. November 2019 update: The adoption of contractual requirements has been included in contracts for new employees. Imposing new terms and conditions on existing staff is not feasible in the short-term and would potentially undermine the positive engagement that exists for this year's campaign.	Kevin Croft	Close
3.	25 September 2019 9.3	Board level governance	The Board discussed the format and approach for Board seminars and agreed the outline schedule and extended time for these sessions. It was agreed that the dates for these sessions would be circulated as soon as possible. November 2019 update: Dates circulated and calendar invites sent.	Peter Jenkinson	Close
4.	25 September 2019 14.3	Board member visit programme	The Board agreed the continuation with the programme, with revised process, and that a new programme would be circulated. November 2019 update: New Board member visit programme has been circulated.	Peter Jenkinson	Close

5.	25 September 2019 16.3	Annual training in cyber security arising from EPRR discussion)	The Board also discussed the risk of cyber-attacks and the preparation and prevention of such attacks. Mr Jarrold reported that table-top exercises had been completed with the EPRR team; he noted the risk of ensuring the aged network infrastructure remained robust but opined that the Trust was well placed given the financial constraints in the capital programme. The Board noted that quarterly updates on cyber-security were presented to the Audit, Risk and Governance Committee, acknowledged as being exemplar by Trust auditors, over 90% of staff were compliant with information governance training and the Board received annual training in cyber security. It was agreed that further discussion and training would be part of a future Board seminar. November 2019 update: Added to Board Seminar Forward Planner (scheduled for February 2020, to be confirmed).	Peter Jenkinson/Kevin Jarrold	Close
6.	25 September 2019 9.2	Board level governance	The Board noted the deferment to Nicola Horlick taking up her appointment as non-executive director due to her being selected as a parliamentary candidate in the next general election, and agreed that this would be reviewed again in three months.	Paula Vennells	January 2020

Items closed at the September 2019 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	24 July 2019 10.2	Trust Strategy	The Board welcomed the progress made in developing the integrated strategy and the process undertaken, in particular the involvement of the Strategic Lay Forum, and agreed the need to distil the new objectives into fewer key priorities. The Board also noted that the executive were developing a governance framework for the development and delivery of the revised strategy, to be completed in September 2019. It was noted that this governance framework would include an approach to communications to ensure dissemination of a consistent message and would also include an approach to reinforce the Trust's values and behaviours. It was agreed that this would be shared with the Board at its next meeting. September 2019 update: The original timescales for the project have been extended due to the need to ensure appropriate input from the executive team, and a proposal will be shared with the Board in time for the seminar in October. Close	Tim Orchard / Claire Hook	Closed
2.	24 July 2019 21.3	Questions from the public / non-emergency patient transport issues	A member of public referenced the non-emergency patient transport issues reported by the Chief executive and reported examples of the impact on dialysis patients. Prof Orchard summarised the actions being taken to improve the responsiveness of the service and confirmed that improvements were being seen. He confirmed that lessons would be learnt from this issue for future implementations. It was agreed that a deep dive review of the issues and lessons learnt would be presented at the October meeting of the Audit, Risk and Governance (ARG) Committee. September 2019 update: An update will be provided to the October ARG Committee and review in December 2019. Added to the ARG forward planner. Close	Prof Sigsworth / Hugh Gostling	Closed

After the closed items have been to the proceeding meeting, then log these will be logged on a 'closed items' file on the shared drive.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 November 2019	**Item 7, report no. 04**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Steph Harrison-White, Head of Patient Experience and Improvement

Summary:

A member of staff will present this month's patient story. The patient has dementia and was admitted to our Trust in August, following a fall at home. The patient, who shall be referred to as Ms A, was found at home by their carer, having sustained head and scalp lacerations.

Annabel Rule, lead occupational therapist, will explain how important it is for frail patients to remain on their existing plan of care whenever possible, and the potential impact if they deviate from this.

This story demonstrates our core values in practice, with collaborative working and expert knowledge coming together to enable a frail vulnerable patient to be discharged home and prevent a prolonged admission.

Recommendations:

The Board is asked to note the issues raised.

This report has been discussed at:

None

Quality impact:

Being kind, expert practitioners who work in collaboration to deliver person centred care can facilitate patients receiving 'the right care and support, in the right place, at the right time'.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:

1) Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:

Not applicable

Workforce impact (including training and education implications):

Not applicable

Has an Equality Impact Assessment been carried out or have protected groups been considered?

☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☐ No

What impact will this have on the wider health economy, patients and the public?

☐ Yes ☐ No ☒ Not applicable

If yes, briefly outline. ☐ Yes ☐ No
……

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

If the details can be shared, please provide the following in one to two line bullet points:

- What should senior managers know?
- Teams that have the Trust values at the core of all they do will improve patient experience.
- Discharge planning must be coordinated by the multidisciplinary team, working in the patient's best interests.

- What (if anything) do you want senior managers to do?
  Promote the key messages of this story

- Contact details or email address of lead and/or web links for further
- Stephanie.harrison-white@nhs.net

- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why? To reinforce the importance living the Trust values and behaviours

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

A member of staff will present this month's patient story. The patient has dementia and was admitted to our Trust in August, following a fall at home. The patient, who shall be referred to as Ms A, was found at home by their carer, having sustained head and scalp lacerations.

Annabel Rule, lead occupational therapist, will explain how important it is for frail patients to remain on their existing plan of care whenever possible, and the potential impact if they deviate from this.

This story highlights the importance of coordinated, expert care working in close collaboration with the multidisciplinary team and families/ friends/ carers. Using expert skills and knowledge, decisions can be made in a person's best interests that can expedite a discharge and support a person to return to their on-going plan of care.

2. Purpose

The use of patient stories at board and committee level is seen as positive way of reducing the "ward to board" gap, by regularly connecting the organisation's core business with its most senior leaders.

The perceived benefits of patient stories are:

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

3. Background

The British Geriatric Society (BGS)(2014) published best practice guidance for the care of older people living with frailty and according to this guidance, Frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body's physical and psychological reserves. The degree of frailty of an individual is not static; it naturally varies over time.

Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event that challenges their health (e.g. infection, new medication, fall, constipation or urine retention).

Early warning signs that someone has Frailty include falls; immobility; delirium; incontinence and susceptibility to side effects of medication.

According to the BGS, the gold standard for the management of frailty involves a holistic, interdisciplinary assessment. The result of this holistic review should be a

personalised Care and Support Plan (CSP) focusing on the individual's needs and goals. According to the BGS, CSP's can reduce hospital admissions and improve outcomes.

At the Trust, our Frailty team provides care through a number of pathways including the Older persons Rapid Access Clinic and through our older patients inpatient wards. Our multidisciplinary team form a central part of the Frailty work.

This patient story will describe how the input from a specialist occupational therapist facilitated a personalised discharge plan that prevented an extended length of stay and enabled a patient to continue with their previously agreed CSP.

4. Summary/Key points

Ms A was admitted to one of our hospitals following a suspected fall at home. She had sustained laceration injuries to her head and scalp. Ms A had a history of dementia. After an initial assessment and investigations, Ms A was transferred to the care of the frailty team due to her underlying frail condition and potential need for ongoing support in a residential home setting.

A detailed assessment and history was undertaken by the occupational therapy lead. This assessment identified that a prolonged hospital admission would not be in this persons best interests and in fact, as highlighted by the BGS above, it would be in their best interests to be discharged home to continue with their existing care plan.

Annabel Rule (lead occupational therapist) will describe how she worked with the multidisciplinary team, the patient; the patients support network and the community team to facilitate a discharge home. Ms A was able to go home after 3 days rather than face a potential prolonged length of stay and move to a residential home.

5. Conclusion and Next Steps

This story demonstrates our core values in practice with *collaborative* working and *expert* knowledge coming together to enable a frail vulnerable patient to be discharged home and prevent a prolonged admission. Ms Rule demonstrated *kindness* in ensuring she kept the patient's best interests at heart and listened to and respected her wishes.

One of our key objectives we *aspire* to is 'to enable more patients to get the right care and support, in the right place, at the right time'. This story demonstrates that this is possible and as highlighted here, we were able to facilitate Ms A returning to her established person centred plan of care in her home, as this was the 'right place' for her at this time.

Ms A's story has been shared within the division to highlight the importance of the Frailty pathway and provide an example of best practice.

Author: Steph Harrison-White
Date: November 2019

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27th November 2019	**Item 8, report no. 05**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

Summary:

This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust. It will cover:

1) Financial performance
2) Transformation programme update
3) Patient focus
4) Operational performance
5) Strategic development
6) People
7) Stakeholder engagement
8) Celebrating achievements

Recommendations:
The Trust board is asked to note this report.

This report has been discussed at: N/A

Quality impact: N/A

Financial impact:
The financial impact of this proposal as presented in the paper enclosed: N/A

Risk impact and Board Assurance Framework (BAF) reference:

Workforce impact (including training and education implications): N/A

What impact will this have on the wider health economy, patients and the public? N/A

Has an Equality Impact Assessment been carried out?
☐ Yes ☒ No ☐ Not applicable
If yes, are there any further actions required? ☐ Yes ☐ No

Paper respects the rights, values and commitments within the NHS Constitution.
☒ Yes ☐ No

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Chief Executive's Report to Trust Board

1. Financial performance

The Board has agreed the control total of a £16.0m deficit before Provider Sustainability funding (PSF) and Marginal Rate Emergency Threshold Funding (MRET). The finance report to the Board provides detail of the trust's financial position for the seven months year to date (April - October 2019).

Year to date the trust is over plan on activity, mainly on emergency work and has incurred additional costs to deliver this activity. The trust's activity is above plan for both local Clinical Commissioning Groups (CCGs) and specialist commissioning with NHS England. This activity represents a cost pressure to commissioners and should they be unable to pay for the additional activity it would put a significant pressure on the trust's ability to meet the control total. The Trust is working closely with commissioners to understand the full year activity and how best to meet demand over winter.

At month 7 the trust is forecasting to be £6m worse than plan, an improvement of £4m from the last month. The forecast gap to the control total has improved by £13m over the past 3 months as efficiencies have been identified and implemented. If this improvement continues the trust would expect to meet the control total for the year. The forecast position includes a number of non-recurrent benefits which will increase the efficiencies required for the next financial year. The trust is therefore focusing on improving the run rate, especially on temporary staffing spend, to start the year in a sustainable position.

2. Transformation programme update

Our programme of transformation projects continue, driven by weekly progress calls between the Strategy and Transformation teams at each site. Since the last update, Renal is moving forward well, with strong local engagement from the service. Trauma & Orthopaedics has been launched with a kick-off meeting, and is being scoped. The newly-established Transformation team is settling in, with a key member returning from maternity leave this week, who will be looking at Endoscopy. Additionally, the Director of Transformation is supporting the Business Planning cycle this year, as SRO.

3. Patient focus

Care Quality Commission (CQC) inspections
Since the last meeting, the CQC have published the final report from the CQC inspection of the GP service at Hammersmith Hospital, and I'm pleased to confirm that the Trust received 'good' ratings in all domains of the inspection.

Further details on CQC related activity and inspections are included in the report being presented to the Board.

Non-emergency patient transport
At the last meeting I reported on the implementation of the new non-emergency transport contract and the issues arising from the change in provider to Falck, leading to delays in transport for a number of patients. Having seen recent improvements in performance we have seen a deterioration once again. I am therefore meeting with the CEO of Falck UK again to escalate these issues.

4. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance as at September 2019 (month 6).

New Urgent and Emergency Care (UEC) standards
We continue to participate in the national field test of the proposed new UEC standards that began in the spring. Reporting against the new standards will continue until March 2020 and, in view of this, we have reviewed our performance management and monitoring arrangements for winter, focusing on reducing the mean time patients spend in our Emergency Departments and the number of waits in

excess of 12 hours from arrival. To minimise delays, whilst still always providing prompt and expert care, we are now concentrating on meeting the following standards:

- All patients booking in to the emergency department have an initial assessment within 15 minutes
- All patients have their clinical assessment by an emergency department practitioner within 60 minutes
- All patients have a management plan within 2 hours 30 minutes
- All patients referred from the emergency department to a speciality will be reviewed by a senior doctor and have a plan documented in their clinical notes within 60 minutes of referral (30 minutes for critical care patients)
- Patients will be discharged from inpatient wards before 12.00 when appropriate
- All wards have a daily board round using the SAFER tool and using the Red2Green methodology
- Weekly MDT long stay meetings take place to review all patients in hospital over 21 days to avoid delays in getting patients home

Our operational performance reports and escalation processes have been updated to support delivery of these standards. Although there are some challenges associated with the proposed new UEC standards, our experience during the field testing so far suggests that they represent an opportunity to improve patient experience by encouraging improvements across the whole pathway.

Emergency Preparedness, Resilience and Response

At the public meeting in September the Board received an update in relation to our Emergency Preparedness, Resilience and Response (EPRR) plans. This included our annual self-assessment submission to NHS England. I am pleased to confirm that, following a planned review meeting on 9th October, NHS England has now completed its assurance process and have assessed Imperial College Healthcare NHS Trust as fully compliant. The overall level of compliance is based on the total percentage of amber and red ratings against 69 core standards. We received no red or amber ratings and hence achieved full compliance against all 69 core standards.

EU Exit

As the UK and the EU agreed an extension of the Article 50 period to 31st January 2020, we did not trigger our EU Exit plans on 31st October 2019. The nature of the extension is that if the Withdrawal Agreement is ratified by both the UK and European Parliaments, the UK will leave with a deal. If ratification has not happened by 31st January 2020 the legal default is that the UK will leave the EU without a deal. This means that preparations for a no deal outcome must continue, adjusted to the new timescales. During the period of the extension we will continue to review our plans to ensure we are as ready as we can be when the UK leaves the EU. National reporting via the daily sitrep has been paused for the time being and will recommence as the next no deal date approaches.

Trust undertakings

As reported at the last meeting of the Trust Board, the Trust's regulatory segmentation (rating) and the undertakings have been reviewed by NHS Improvement and other regulatory partners to reflect the progress made by the Trust. I'm delighted to report that as an outcome of that review, NHS Improvement has confirmed that they have removed or discontinued all undertakings and amended the regulatory segmentation for the Trust.

5. Strategic development

New support for Charing Cross Hospital following improvements to acute medical care pathway

Charing Cross Hospital has been named as one of five hospitals involved in a new London-wide programme aimed at reducing patient stays in hospital. NHS's Acute Medical Pathway Programme (AMPP) is a new project led by NHS England aimed at improving access to community services and reducing the number of people staying in hospital for 1-7 days.

This follows a series of improvements we've already made to our acute medical care pathway as patients move from the emergency department to other parts of the hospital. Successes include a £7.2 million expansion of our A&E department. We've also increased the number of beds at our acute assessment unit (AAU) by 13 to 24, creating a total of 59 acute medical beds at Charing Cross.

The £7.2 million refurbishment and expansion of Charing Cross Hospital's A&E department will provide much needed capacity as we prepare to head into winter. The improvements to the ED will combat overcrowding and long waits at times of peak demand, providing more space for patients to be assessed and treated. They include:

- three more cubicles for patients with serious illness or injuries (from 12 to 15) and three additional resuscitation bays (from 5 to 8)
- more space for patients to be assessed and treated including two additional urgent care centre rooms(from 7 to 9)
- two new dedicated rooms for patients with mental health conditions providing them with a calm, quiet and safe space away from the busy ED environment
- an expanded 'ambulatory emergency care' unit with additional treatment areas, consulting rooms and more staff, allowing patients with a wide-range of urgent health problems get the treatment they need without being admitted to a ward or having an overnight stay
- a new common entrance and waiting area for all patients who walk-in, allowing a better patient experience and more joint working across the urgent care centre, ambulatory emergency care unit and emergency department.
- The refurbished ED sits alongside a number of measures the Trust has introduced to help respond to increasing demand and continue to provide the best possible care for our patients. This will be especially important over the upcoming winter period.

6. People

Active Bystander programme

The Active Bystander training programme aims to empower staff across the Trust to challenge poor and negative behaviours. We know that the way we behave has the biggest impact on our colleague's experience at work and our new Trust-wide behavioural framework sets out the behaviours we expect to see from each other through living our values.

We are therefore launching this high impact one-hour workshop to skill up members of staff with a number of techniques to challenge our "don't want to see" behaviours and help us create a culture where we live our "love to see" behaviours more of the time.

We ran a pilot workshop in August 2019 with overwhelmingly positive feedback and it was clear that the session made the participants feel more capable and willing to challenge negative behaviours. We're running sessions throughout November and December at Hammersmith, Charing Cross and St Mary's.

Flu Campaign

This year's flu campaign commenced the end of September. The campaign has followed the 'best practice checklist - Flu vaccination of healthcare workers' published by NHSE / NHS Improvement, and we have completed a self-assessment against this best practice (attached at Appendix 1).

We now have peer vaccinators and roaming vaccinators appointed and trained, supported by an extensive communications and influencing campaign. To date a total of 5,186 staff have been vaccinated, but a further update on progress will be given at the meeting. Further actions to increase uptake of the vaccination include following up at ward / departmental level by the executive team.

London Living Wage and facilities staff

The Trust specified an increase to the London Living Wage as the minimum pay level as part of a planned retendering of our facilities management contract, due to begin in April 2020. Since we

announced this intention in April this year, we have been exploring the possibility of moving to the new pay level within our existing contract with Sodexo so that the pay increase could be achieved sooner.

On 6 November, following a review of our mid-year financial position, the Trust was able to make a formal offer with Sodexo to staff and trade unions to bring forward our planned move to the London Living Wage to 1 November 2019. This means all facilities staff, currently employed by Sodexo, have had a pay increase to £10.55 per hour. Staff will see this pay increase in their pay packets by the end of the month at the latest and it will be backdated to 1 November. We are also working with UNISON and other partners to determine how a move to the London Living Wage as the minimum pay rate can best be achieved for staff employed through other external contracts.

Meanwhile, we are expecting industrial action by some Sodexo staff at St Mary's over pay and conditions that began on 29 October to continue. In a widely shared statement, chief executive Professor Tim Orchard has made clear: "We greatly value the work of facilities staff and the contribution they make to providing a safe and healthy environment for patients, visitors and colleagues. I am very clear that all of the staff who work in our hospitals – including through contracts with specialist companies like Sodexo – should be part of one team. The high quality care we provide to our patients is the result of collaboration between many different people and every role is important."

We have also made it absolutely clear that all staff who work at our hospitals are welcome to use the facilities we provide for staff. There is a dedicated changing area for porters at St Mary's that has been found to be in an inadequate state of repair and we are in the process of securing a better facility on the site. We have committed to act immediately if a Sodexo member of staff feels they are being prevented from using rest facilities. Sodexo staff have shared reports of a number of cases of unresolved unfair treatment relating to sick leave and other aspects of their employment which our director of people and organisational development and our director of nursing are following up urgently with Sodexo."

7. Research and innovation

Digital sepsis alert

A digital sepsis alert system and multidisciplinary care plan introduced at the Trust was associated with lower odds of death, shorter hospital stays and increased odds of receiving timely antibiotics in a study led by researchers at Imperial College, London.

The study was published in the Journal of the American Medical Informatics Association on 20 November and is the first evaluation of a digital sepsis alert system in a British hospital trust and the largest undertaken anywhere to date.

Sepsis, also known as blood poisoning, is life threatening and accounts for an estimated 46,000 deaths in the UK each year. If diagnosed early it can be treated effectively with antibiotics but the difficulty lies in spotting sepsis before it develops, as symptoms are similar to other illnesses such as flu.

The system monitors a range of changes in patients such as temperature, heart rate and glucose levels and alerts doctors and nurses if they fall outside safe parameters so they can investigate further. Clinicians are notified of patients who have triggered the alert either through a pop-up warning on the Cerner electronic health records system and/or on a dashboard, which highlights any patient with an active alert when they open a patient's record.

In addition to the alert, introduced in 2016, the Trust designed a multidisciplinary care plan which is launched in the electronic patient record system when a clinician confirms a diagnosis of sepsis. This prompts the clinical team to determine the best options from a range of treatments, such as fluids, oxygen, diagnostic tests and early antibiotics, and ensure they are given to patients within one hour – in line with national targets.

AHSC redesignation

We are currently working with our partners within the Academic Health Science Centre (AHSC) to pull together a submission for redesignation of the AHSC. This is due to be submitted to NIHR-NHSE/I at the beginning of December, with interviews of shortlisted applicants to be held at the end of February 2020. The aim of the newly designated AHSCs is to harness the strategic alignment of NHS organisations and their university partners to improve health and care through increased translation of discoveries from early scientific research into benefits to patients.

The criteria for redesignation of the AHSC partnerships stipulates that they will be nested within, and work with, the local Academic Health Science Network (AHSN). They will also work with other NIHR-NHSE/I AHSCs, AHSNs, NIHR infrastructure and the wider innovation landscape to help deliver the commitments in the NHS Long Term Plan, the Life Science Industrial Strategy and the goals of the expanded Accelerated Access Collaborative (AAC), and to facilitate the acceleration of improvements to healthcare for both their local population and the national population through these collaborations.

Our submission will describe how Imperial College AHSC brings together all the research intensive hospitals in west London with Imperial College London and the Institute of Cancer Research. Its aim is to add value through multidisciplinary collaboration in research, education and clinical delivery and ensure that discovery research and other innovations benefit patients and the population more broadly. In the submission we describe how we will focus on common diseases - cancer, cardiovascular, respiratory and brain disease, metabolic conditions and infections/antimicrobial resistance, with three main goals:

- To prevent disease through health interventions, and where this is not possible;
- To detect disease earlier through better diagnostics and new bio-markers, and where this is not sufficient;
- To improve on current therapies through innovative drugs, advanced therapeutics, devices and digital technologies.

8. Stakeholder engagement

Below is a summary of significant meetings and communications with key stakeholders since the last meeting:

- Rt Matt Hancock MP, Secretary of State for Health and Social Care, Hammersmith Hospital visit: 18 September
- Cllr Jonathan Glanz, Westminster City Council: 26 September
- Healthwatch Central West London: 8 October
- Cllr Robert Freeman, Royal Borough of Kensington and Chelsea: 10 October
- Strategic Lay Forum: 16 October
- Andy Slaughter MP for Hammersmith, Charing Cross Hospital visit: 18 October
- Cllr Stephen Cowan and Cllr Ben Coleman, London Borough of Hammersmith & Fulham: 25 October
- Hammersmith& Fulham Save our NHS: 28 October
- Karen Buck MP for Westminster North, Rt Hon Mark Field MP for Cities of London & Westminster, and Andy Slaughter MP for Hammersmith: 29 October
- Cllr Heather Acton, Westminster City Council: 29 October
- Cllr Jonathan Glanz, Westminster City Council: 14 November

Appendix 2 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	Committed leadership Trust Self- (number in brackets relates to references listed below the table) assessment	Trust Self Assessment (RAG)	Gaps and Action Plan
A1	Board worker record commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated, and for any healthcare who decides on the balance of evidence and personal circumstances against the vaccine should anonymously mark their reason for doing so.	G	Evidenced in September 2019 Quality Committee report
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	G	Done
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	G	Evidenced in March 2019 Quality Committee report
A4	Agree on a board champion for flu campaign	G	Director of People and Organisational Development
A5	All board members receive flu vaccination and publicise this	G	1. Covered via social media, the communications team are supplied with photos as vaccinations are undertaken - photos for all board members have not yet been received 2. Review gaps and agree a vaccination timetable
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	G	1- The Flu Delivery team comprises representatives from across the Trust 2- Discussed with Trust Trades Union Lead and, consequently, invitations have been extended to a number of Trades Union representatives to participate in all Flu Delivery team meetings.
A7	Flu team to meet regularly from September 2019	G	Meets weekly
B	**Communications plan**		
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	G	1- The flu programme is supported by the senior clinical teams. ✓ 2- Discussions are currently being undertaken with Trade Union representatives, with the aim to either attend the weekly Flu leads meeting or to agree communication and engagement with the campaign moving forward.
B2	Drop in clinics and mobile vaccination schedule to be published and electronically, on social media and on paper	G	1- Drop in clinics have been instigated ✓ - Details on the intranet and social media @imperialpeople 2- Additional dates, times and locations need to be included on the intranet
B3	Board and senior managers having their vaccinations to be publicised	G	1. Covered via social media, the communications team are supplied with photos as vaccinations are undertaken - photos for all board and senior managers have not yet been received This process also includes NEDs 2. Review gaps and agree a vaccination timetable
B4	Flu vaccination programme and access to vaccination on induction programme	G	Vaccinators attend all Trust induction sessions
B5	Programme to be publicised on screensavers, posters and social media	G	This campaign is very well publicised
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	G	Weekly feedback reported in Executive reports
C	**Flexible accessibility**		

C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	G	1- Peers have been identified and trained to provide vaccination✓ - Leads also receive an updated report listing those who have successfully completed training 2- Flu Leads to confirm vaccinators have protected time to undertake vaccinations
C2	Schedule for easy access drop in clinics agreed	G	1- OH drop in clinics dates and times on the intranet✓ 2- local drop in clinics are communicated locally by ward managers and Flu leads - details of communication to be confirmed from the flu leads
C3	Schedule for 24 hour mobile vaccinations to be agreed	G	Flu vaccinations can be available at any time of the day on any day of the week, subject to a Peer Vaccinator being available. Alternatively, for example staff can have a vaccination at shift handover in the morning, which will capture those completing a night shift.
D	**Incentives**		
D1	Board to agree on incentives and how to publicise this	G	Incentives have been agreed and detailed in reports to the Trust
D2	Success to be celebrated weekly	G	This celebration occurs across the Trust in team meetings at all levels

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Strategic development – Implementation of a management system (working title 'the Imperial Way')	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27th November 2019	**Item 09, report no. 06**
Responsible Executive Director: Bob Klaber, Director of Strategy, Research & Innovation Claire Hook, Director of Operational Performance	**Authors:** Bob Klaber, Director of Strategy, Research & Innovation Claire Hook, Director of Operational Performance Peter Jenkinson, Director of Corporate Governance
Summary: The purpose of this paper is to describe the Imperial management system (working title 'the Imperial Way'), the associated implementation plan and to explain how it will be used to set priorities for 2020/21. The paper also provides an update on progress delivering our 2019/20 objectives.	
Recommendations: The Trust Board is invited to: ▪ Approve the Imperial management system (working title 'the Imperial Way'); ▪ Note the process for agreeing priorities for 2020/21; and ▪ Note progress with delivery of the 2019/20 objectives.	
This report has been discussed at: Executive Operational Performance Committee If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☐ No ☒ Not applicable	
Quality impact: This paper relates to the CQC domains of safe, responsive, effective, caring and well-led.	
Financial impact: The financial impact of this proposal as presented in the paper enclosed: has no financial impact.	
Risk impact and Board Assurance Framework (BAF) reference: N/A	
Workforce impact (including training and education implications): Training will be required to develop capability to use the Imperial Way. This will be considered in the design of the implementation plan.	
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable	
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No	
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do	
Update for the leadership briefing and communication and consultation issues (including	

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patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

If the details can be shared, please provide the following in one to two line bullet points:

- What should senior managers know?
  The Imperial management system (working title 'the Imperial Way'), is a high level framework that sets out how we will operate as an organisation. Its purpose is to:

  - Ensure our strategic goals drive progress and action at every level;
  - Enable individuals and teams to link the work they are doing to our strategic goals;
  - Tie the work at the front line to senior management decision making (and vice versa);
  - Embed a common improvement method that becomes business as usual;
  - Give front line teams the skills, clear permission and confidence to try new things knowing that they have the backing of their managers to do so; and
  - Underpin our work with metrics that look across all domains of quality and help us understand how we are doing at all levels in the organisation.

  The implementation of the Imperial Way will require detailed design, planning, and engagement with staff at all levels of the organisation. We have established a programme group to manage the staged implementation of this approach.

- What (if anything) do you want senior managers to do?
  Engage with the design process as per the implementation plan

- Contact details or email address of lead and/or web links for further information:
  Claire Hook, Director of Operational Performance (claire.hook@nhs.net)

- Should senior managers share this information with their own teams? ☒ Yes ☐ No

Imperial College Healthcare NHS Trust

Strategic development – Implementation of a management system (the 'Imperial Way')

1. Introduction

1.1. The purpose of this paper is to describe the Imperial management system (working title 'the Imperial Way'), the associated implementation plan and to explain how it will be used to set priorities for 2020/21. The paper also provides an update on progress delivering our 2019/20 objectives.

2. Background

2.1. In March 2019, the Board agreed a new strategy, building on work and thinking over the previous four years to set a clearer and more cohesive direction for our organisation. The next iteration of the strategy was approved by the Board in July 2019, setting out eight objectives for the organisation to deliver by April 2023. At that time it was recognised that the next step would be to design a mechanism to plan and monitor progress against these objectives.

2.2. The Imperial Way has been developed to do this. Intelligence to inform the design has been drawn from interviews with key stakeholders, feedback obtained during the development of our strategic goals and objectives and learning from other organisations (including East London NHS Foundation Trust, Health Improvement Scotland, Surrey & Sussex Healthcare Trust, Brighton & Sussex University Hospitals NHS Trust, Royal United Hospitals Bath).

2.3. It is proposed that the Imperial Way will be used in our upcoming business planning and to set and support the delivery of priorities for 2020/21. Existing mechanisms will be used to manage delivery of objectives for 2019/20.

3. The Imperial Way

3.1. The Imperial Way is a high level framework that sets out how we will operate as an organisation. Its purpose is to:

- Ensure our strategic goals drive progress and action at every level;
- Enable individuals and teams to link the work they are doing to our strategic goals;
- Tie the work at the front line to senior management decision making (and vice versa);
- Embed a common improvement method that becomes business as usual;
- Give front line teams the skills, clear permission and confidence to try new things knowing that they have the backing of their managers to do so; and
- Underpin our work with metrics that look across all domains of quality and help us understand how we are doing at all levels in the organisation.

3.2. The Imperial Way is made up of three components that, together, will ensure delivery of our strategic goals and objectives. These are annual objective setting, business planning and the delivery system. Underpinning the approach are the Trust's governance framework, which provides assurance that policy, risk and reporting processes are adhered to, and the values and behaviours framework. The Imperial Way framework is summarised in Figure 1 and the full framework is available in the Diligent reading room.

Imperial College Healthcare NHS Trust

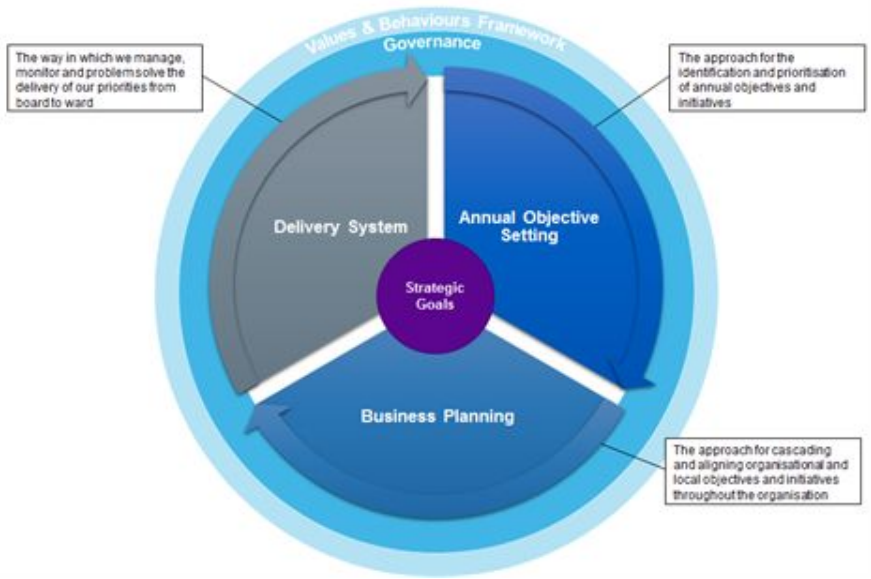


Figure 1: The Imperial Way

4. High-Level Design and Roadmap Plan

4.1. The implementation of the Imperial Way will require detailed design, planning, and engagement with staff at all levels of the organisation. We are confident that we have many components of our prospective system in place already. However, we recognise that (a) a stronger focus on prioritisation – linked to our strategic goals (b) the implementation of a standard framework and way of working that cascades throughout the organisation, and (c) an improved approach to data visualisation of priority measures at a local team level are the three key steps to successful delivery.

4.2. We have established a programme group to manage the staged implementation of this approach. Experience from other organisations suggests that full implementation, where the system becomes “the way we do things around here”, can take up to three years.

4.3. Figure 2 is a high level plan that sets out the actions we will take between now and the end of this financial year to prepare for full implementation. The Project Initiation Document for the Imperial Way was presented to the Finance, Investment and Operations Committee in November 2019.

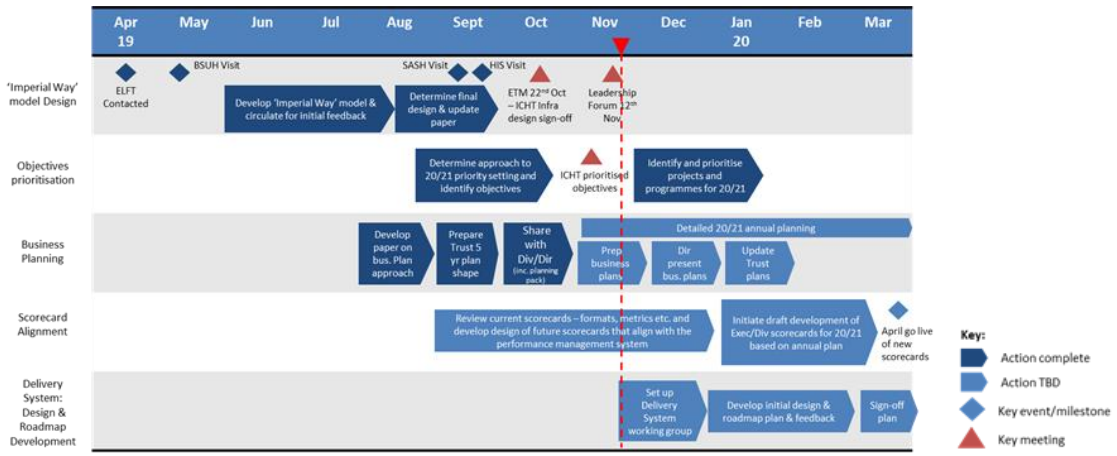


Figure 2: High level implementation plan for 2019/20

Imperial College Healthcare NHS Trust

5. Setting priorities for 2020/21

5.1. Within the Imperial Way, we have developed an approach to categorise initiatives into Focused Improvements, Trust Projects and Trust Programmes, as shown in Figure 3.

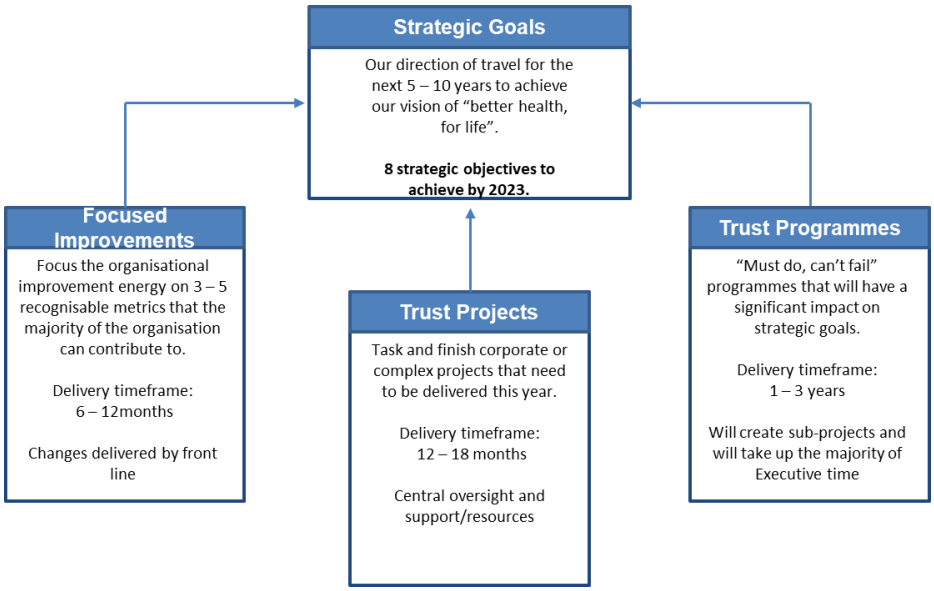


Figure 3: Categorisation of priorities to drive our strategic goals

5.2. Following the work of the task and finish group in designing the high level architecture of the Imperial Way, and wider discussions within an Executive Transformation workshop, we are finalising plans to prioritise 4 'focused improvements' at all levels of the Trust over the next 12 months. This improvement work will utilise our well established improvement methodology, will be supported by a strong approach to data visualisation and will use improvement 'huddles' at all levels of the Trust. The focused improvements we have selected cover all domains of quality, and will help us move towards our strategic goals. They are:

- To improve incident reporting
- To improve patient experience through increasing the Friends and Family Test response rate, and implementing the successful pilot of NLP analysis of free text comments trust wide
- To improve the safety and financial sustainability of staffing (e.g. through specific improvement work on agency, bank & medical staffing)
- To improve the number of staff who feel they have the skills and support to make improvements

5.3. We will ensure these focused improvements each have clear metrics that are used within huddles to measure and then drive improvements. The huddles will also provide a supportive mechanism to enable locally designed and driven improvements to be made.

5.4. A prioritised list of Trust Projects and Trust Programmes will result from a logical and analytical prioritisation process, which will be led by the executive directors involved in the development of the Imperial Way. A list of initiatives will be gathered from numerous sources including executive and corporate strategies, executive committee papers and outputs of the redesigned Division and Directorate business planning process (led by Jeremy Butler, Director of Transformation). These initiatives will be prioritised with a wider team of executives using a prioritisation filter to ensure Trust Projects and Programmes for 2020/21 are aligned to our

strategic goals and objectives. This process will be completed by the end of January 2020. The prioritisation filter is included at Appendix 1.

6. Progress with objectives for 2019/20

6.1 The Board approved eight objectives for 2019/20 at its meeting in March 2019. Attached at Appendix 2 is a summary of progress against these objectives, for the Board to note. This update reflects on key achievements of the past six months, including:

Quality

- Latest CQC inspection: six 'good' and two 'outstanding' ratings
- Lowest mortality ratio in NHS over last year of data
- Improvements in hand hygiene, mortality for patients with sepsis, our response to deteriorating patients

Operational

- A&E access challenging but top 5 in London; piloting new national standards
- Meeting performance trajectory for 18 week referral to treatment
- Regularly achieving cancer wait standards

Culture and people

- New behaviours framework and 'living our values' workshop
- Over 65 lay partners involved in Trust projects and programmes
- Growing networks for women, LGBTQ and BAME staff
- Reduction in formal disciplinary cases

Service and estate improvement

- £7.5m expansion of Charing Cross A&E
- £10m expansion of St Mary's PICU (with charities support)
- West London children's initiative/ cardio-respiratory proposals
- £2m impact maintenance fund and soon-to-launch staff space fund

Finance and efficiency

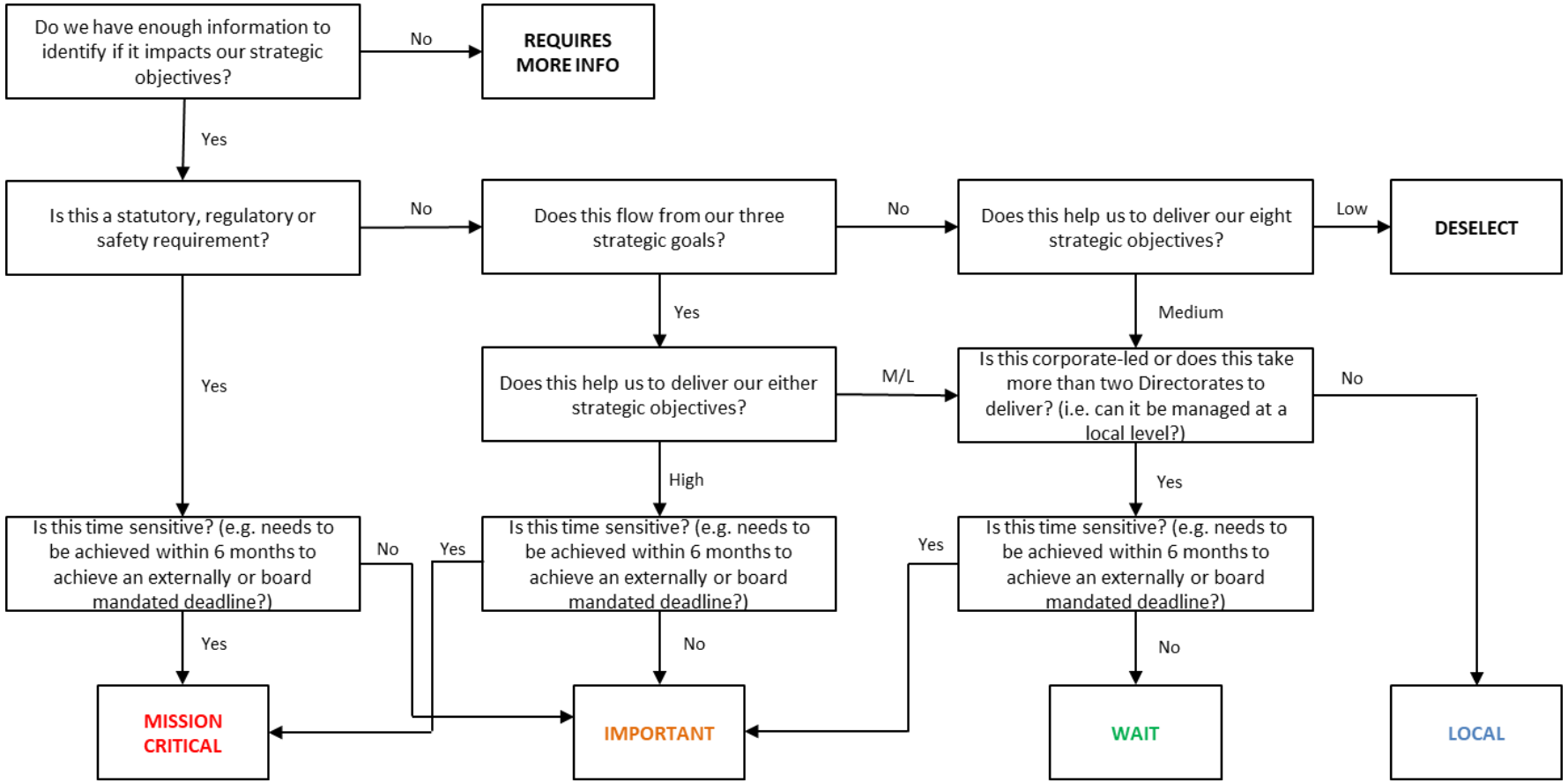
- On track to meet our plan for 2019/20
- Assessed as 'good' by NHSI for use of resources
- Continuing to reduce underlying deficit

7. Recommendations

7.1. The Trust Board is invited to:

- Approve the Imperial Way;
- Note the process for agreeing priorities for 2020/21; and
- Note progress with delivery of the 2019/20 objectives.

Appendix 1: Prioritisation filter



Appendix 2: 2019/20 Corporate objectives – six month update

2019/20 objective	Progress update
1 To enable more patients to get the **right care and support, in the right place, at the right time** – focusing this year on improvements in **operational processes** and **use of data**	***Operational performance (month 6 data)*** • *RTT*: Three patients reported as waiting more than 52 weeks for treatment. The RTT waiting list size was maintained and met the trajectory. The performance of the standard to treat patients within 18 weeks of their referral was 83.6% and met the trajectory of 83.4%. • *New UEC standards*: Field-testing the proposed new UEC standard standards to continue to end of year. The overall average time in department in September 2019 was 184 mins. Working with BI to include the new metrics within the operational scorecard – from November. • *Diagnostics*: 0.5% of patients had been waiting over 6 weeks for a diagnostic test, which met 1% target. • *Cancer*: In August 2019, the Trust delivered six of the eight national cancer standards; the two areas performing below the standard were cancer 2 week waits and the 62 day screening standard. • *Cancelled operations*: Quarter 2 submission is 23 October. Elective cancellation rate for same day of surgery has remained stable and below national average (227 cancellations of all elective activity equating to 0.7%). The improvement in 28-day rebooking performance has been sustained and the breach rate was 10% (22 patient breaches) which met the trajectory of 13% for the quarter. • *Complaints:* The number of complaints for September was above the threshold (due to non-emergency patient transport issues); expected to reduce as patient transport improves. ***Regulatory compliance*** NHS Improvement confirmed in November 2019 that the Trust's segmentation has been amended and the undertakings removed or discontinued. ***Keeping care flowing collaborative*** A range of projects to ensure patients are able to move through our care pathways as quickly and smoothly as possible – focusing on improving real-time operational data, emergency department pathways, ward-level processes and discharge from hospital. • Care Journey and Capacity Collaborative September 2019 Report:

	<table><tr><th>Measure</th><th>Sept 2019 (Aug 2019)</th><th>Measure</th><th>Sept 2019 (Aug 2019)</th></tr><tr><td>4-hour standard (%)</td><td>87.5% (86.4%)</td><td>12 hour DTA to admission (no. of breaches)</td><td>7 (9)</td></tr><tr><td>Average time in department (mins)</td><td>184 (180)</td><td>Total time in department >12 hours (no.)</td><td>179 (217)</td></tr><tr><td>Average time in department - Admitted (mins)</td><td>306 (314)</td><td>Total time in department >12 hours – Admitted (no.)</td><td>79 (81)</td></tr><tr><td>Average time in department - Non-Admitted (mins)</td><td>186 (184)</td><td>Total time in department >12 hours – Non-admitted (no.)</td><td>100 (136)</td></tr><tr><td>Time to Initial Assessment (mins)</td><td>10 (10)</td><td>Number of mental health pathway patients (no.)</td><td>338</td></tr><tr><td>Time to referral for psych assessment (mins)</td><td>98 (84)</td><td>Time to psych assessment (mins)</td><td>139 (156)</td></tr><tr><td>>30min ambulance handovers</td><td>91.4% (90.6%)</td><td>Patients with >21days LoS (avg. of month)</td><td>212 (212)</td></tr></table> • *Long stay patients* - Data for the beginning of October is showing an average of 205 occupied beds versus baseline of 238 occupied beds and reduction from September (212). ***The care environment*** *Wayfinding / signage*: wayfinding project established to test and develop a future wayfinding strategy for the Trust – this includes signage, naming conventions, environmental changes, guidelines and processes to ensure accuracy, consistency and maintenance in the future. • Interim signage project to address pressing signage issues as an interim measure until the new wayfinding strategy is fully implemented. • Funding for the next stage of the wayfinding project and a further phase of the interim signage project has now been agreed for 2019/20. • These projects will build on the previous work with a view that we would be in a position to start full implementation of the wayfinding strategy from 2020/21.
2 To expand and connect developments that enable **better integration of care** – focusing this year on establishing strong **partnerships** and **involvement,** new **care models** and **systems to support collaboration**	***New care models*** Key developments include new approaches to outpatient services, the development of the West London Children's initiative, working up plans for new adult respiratory pathways and facilities within our 'healthier hearts and lungs' proposal, and collaborations such as RM cancer partners, a sector-wide imaging network and Hammersmith and Fulham Integrated Care Partnership. • The West London Children's initiative, which builds on the proposals described in our 'Healthier Hearts

	and Lungs' submission to NHS England, continues to develop in collaboration with colleagues in ChelWest and Imperial College. The aim is to develop an approach that will in effect be an integrated care system for the children and young people of inner NWL ***Collaboration with Chelsea & Westminster*** MOU signed with ChelWest and joint executive group established to drive joint initiatives. Collaborative initiatives currently focus on clinical services (ophthalmology, dermatology, HIV). Initial discussion with Board re further collaboration and governance roadmap, and Chairs / CEO meeting established to take forward. ***Primary care partnerships*** Prototyping new ways of working with local primary care networks, building on learning to date from our connecting care programmes and co-designing patient-focused collaborations with GPs and other partners. • Developed outline proposals of a mechanism through we will prototype partnership working with local primary care networks (PCNs) • Commenced co-design workshops with partners in primary care to develop these new ways of working ***Patient and public involvement*** Further expansion and support for our lay partner programme, a new focus on learning from complaints and patient feedback, actions to embed involvement in day-to-day activities and processes and improving evaluation of impact.
3 To **reduce unwarranted variations** in care pathways – focusing this year on projects supported by the **Imperial flow coaching academy** and guided by external benchmarking on quality and efficiencies.	***Safety improvement*** Includes nine improvement work streams, focusing on use of real-time data to drive improvements, to tackle sepsis and deteriorating patients for example, and behaviour change, to improve compliance with surgical checklists and hand hygiene for example. Good progress is being made in these 9 safety improvement streams which address the key risks from our most frequently reported SIs, for example: • Overall compliance with hand hygiene increased from 56% in May 2018 to 63% in September 2019, with improvements in focus wards from 36% in February to 63% in September and evidence of sustained change in previous focus wards. • Reduction in incidents where misinterpretation of fetal monitoring is a factor following roll-out of digital monitoring, real time "fresh eyes" auditing and staff training. • To support never event reduction by focusing on team working, observation of practice and feedback, we have developed our HOTT programme with 728 staff participating so far. We have reported 2 never events (April & November) so far this year compared with 6 in 2018/19. • Now meeting our target to ensure at least 90% of patients receive antibiotics within 1 hour of sepsis

	diagnosis with an electronic alert in place and a MDT approach to management. • We have reduced falls with harm by 25% with an increase in the completion of falls assessments in 5 high risk wards. Adoption of the change ideas is now being coordinated through a new falls steering group. • Following roll out of NEWS2 we have reduced the number of moderate and severe harm failure to detect a deteriorating patient incidents, seen a 38% decrease in out of ICU cardiac arrests and increased the number of incidents reported overall. To improve how we report, respond to and learn from patient safety incidents we are: • Completing a diagnostic cycle with 5 wards to better understand the barriers; • Planning a communication and engagement programme to commence in January; • Starting a trail of a simplified reporting app in January; • Trialling after action reviews/conversation cafes to better support staff; • Restructuring our investigation resource with a new model and team in place by December; This work is making progress with small but statistically significant increases in the number of incidents reported in the focus wards. To ensure we learn from deaths that happen in our hospitals we are implementing the mandated medical examiner model by April 2020. This will require a fundamental change in how we review care, engage with bereaved families and determine cause of death. A project plan is being delivered, led by the Medical Director. ***Planned care improvement*** A range of initiatives to improve our management of waiting lists and to reduce waiting times, leading to sustained improvement in operational performance as summarised above (RTT performance, waiting list size and A&E waiting times, reduced cancelled operations and reduced number of long-stay patients). Examples of initiatives include: • Outpatients improvement programme ***Flow Coaching Academy (FCA) Imperial*** Cohort of 15 pathways (9 internal, 6 external) were launched in April 2019, on top of 12 established ‘big rooms’. New Big Rooms implemented by the end of October and will be expected to start reporting their progress at the end of the calendar year. As the number of Big Rooms expand at the Trust we are looking to develop a cadre of staff who are able to fill vacancies and support Big Rooms in both an ad hoc and on-going basis. These staff will be trained to coach existing Flow Coaching Big Rooms (particularly to replace non-pathway coaches who leave the Trust) or coach time-bound Big Rooms (such as the Values & Behaviours Big Room and Strategy Big Room)

4 To develop **strategic solutions to key challenges** – focusing this year on staff **recruitment and retention**, reducing our underlying **financial deficit** and **estates redevelopment**	***Specialty review programme*** Priority developments across all services to help ensure alignment with our organisational strategy. • Four collaborative ventures with Chelsea & Westminster are under way; Dermatology, Ophthalmology, HIV and, through the Brompton work, Paediatrics. • Internal projects launched include 'Same Day Emergency Care', Renal, and T&O. ***Strategic workforce programme*** Work streams include developing new roles, apprenticeships, overseas recruitment and improving career development opportunities. Workforce strategy programmes include: • **Nursing & midwifery** – the group has focused on the key themes of recruitment and retention of the Trusts nursing and midwifery workforce, meeting monthly with Executive, Divisional and POD leaders. Key achievements this year are; o Automatic student offer: this year the number of student offers has increased, with the number of accepted offers at an all-time high (87.1%) o International nurses: successful appointment of over 200 international nurses with more than half already joined and the remainder in post between now and March 2020. Further international campaigns planned for December 19, February 2020 & May 2020 o Analysis of leaver's data and new N&M leavers survey: leavers data from ESR is analysed on a monthly basis and a new leaver's survey for N&M staff was introduced in June 2019. o Analysis of joiners data and new joiners survey: a new joiners survey for N&M has been piloted and joiners data is analysed on a monthly basis o Careers clinic and internal transfer scheme: 48 careers coaches have been trained to date with quarterly careers clinics taking place across the main sites. A "register your interest" has been set up for both the careers clinics and internal transfer schemes with a matching panel being held in late November o Vacancies and pipeline: detailed analysis on a quarterly basis of vacancies and pipeline candidates across the Trust at divisional and banding level with focused action on identified 'hotspot' areas • **Management & admin** – the group has focused on the development and support for staff within these groups. Key achievements this year are; o Development of new bespoke leadership programme for general managers o Further development of bespoke programme for new Consultants, "Frontier" which is now mandatory for all new consultants o Commissioning of a third cohort of AHSC leadership programme for senior leaders o Design complete of a bespoke programme or Admin and Clerical staff, to include digital content, better career support and development interventions for 2020 • **AHP/HCS/Pharmacists; –** this multi-disciplinary group meets monthly and is focused on the

	professional development, retention and attraction of staff within these groups. Key achievements to date are; ○ Creation of a priority based workforce development plan for scientists, therapists, technicians and pharmacists aligned with the core themes of the POD Strategy – being taken forward for implementation ○ Professional leads incorporated into the Specialty Review Programme to ensure these key workforce groups are represented, involved and contributing to the success and outcomes of the SRP ○ Collective forum for identifying common issues and problems for joined-up resolution • **Medical** – the Medical Staffing Improvement Programme Board meet monthly with representation from the central teams who have responsibility for areas supporting the medical workforce. A two weekly call has been set up to take forward workstreams and any ad hoc issues that arise outside of the monthly meeting. ○ Significant work has been undertaken to review all junior doctor rotas, ensuring that they meet the new safety rules introduced as part of the new contract refresh and that the resource has been rostered to cover required activity. The implementation timeline released by NHS Employers is being followed in terms of introducing the required changes. Whilst full analysis has been carried out on rotas in T&O and ITU a schedule is being developed for full analysis of all rotas. ○ The Doctors Bank was agreed, with a steering group meeting weekly to review progress and undertake the pre-implementation work required in advance of roll out in the first area from December. Implementation of the Doctors Bank will drive full utilisation of Healthroster for doctors, and allow a full view of the junior doctors staffing position. ○ The first official announcement of the 2020/21 Job Planning round was sent out in the RO newsletter in mid-August, with follow ups sent out to consultants in advance of the round opening on 1st October. Changes have been made to SARD to automate some features, which will make updating job plans easier, and dates have been circulated for targeted support. ***Estates and facilities programme*** *Facilities contract:* Re-tendering of catering, cleaning and portering contract nearing completion. *Hybrid theatre:* Works to build a new £1.865 million hybrid theatre at St Mary's Hospital have begun this month and run until March 2020. *Developing our strategic imaging assets programme:* Strategic Imaging Asset Management (SIAM) Strategic Outline Case (SOC) approved and OBC being developed. *Redevelopment of Trust sites*: programme established with appropriate governance for the redevelopment of STM, CXH and HH, with initial focus on STM. Options for redevelopment.and procurement process being

	progressed. Redevelopment director appointed and further programme resource / support to be confirmed. Awaiting confirmation of HIP2 funding to support development of OBC etc. ***Financial sustainability*** Focus on recurrent CIPs this year to enable us to reduce the underlying deficit and achieve financial targets in 2020/21 and beyond. To improve the delivery of sustainable CIPs the Trust is focusing on reducing pay costs, with reviews being undertaken on ways to reduce agency and other temporary staffing spend. Plans go through a full quality assessment to ensure that there is no effect on patient safety. Progress being made in financial performance has been recognised by NHSI through removal of financial sustainability undertakings.
5 To strengthen the **connections between our service developments and our research** – focusing this year on **data and digital** initiatives and expanding **translational opportunities.**	***Research*** Key developments include widening access to research opportunities and the development of Imperial Health Knowledge Bank – a register of patients who want to support and/or be more involved in research We have also worked to strengthen our relationships with the new NIHR Applied Research Collaborative (ARC). This research programme, which launched in October 2019, will support us to develop evaluation programmes of our integrated care work and also on innovation, improving health inequalities and our plans to develop as an anchor institution. We are also making progress in working with Imperial College to develop an aligned strategy around patient data and research. ***Digital connectors*** The programme includes the expansion of the care information exchange, providing patients and clinicians in north west London with secure online access to health records and two-way communications, further development of WSIC (Whole Systems Integrated Care) integrated dataset and dashboards for use in improving population health, and working with Chelsea and Westminster to roll out our Cerner electronic patient record system across their hospitals. • Working in partnership with ChelWest on successful rollout of Cerner at ChelWest November 2019 – West Middx to follow in 2020 • Care Information Exchange (CIE) – 36,665 patients registered – examples of CIE being used include monitoring patients post discharge in Vascular to encourage better self-care and care in the community to reduce the risk of infection
6 To achieve a measurable improvement in our **organisational culture -** focusing this year on **improvements in leadership, fairness and collaboration.**	***Leading change through vision, values and behaviours*** Embedding our new behaviours framework, focusing on feedback, appraisals, leadership, management and behaviours training and measuring impact. • Behaviour framework launched • Values workshops run as part of GPTW week – September 2019

	Equality, diversity and inclusion A renewed focus on ensuring our leadership and management development, HR processes and talent management actively promote diversity and fairness; our first priority is to implement the NHS workforce race equality standard across the organisation: • Reverse mentoring programme established for executive team • Equality, Diversity and Inclusion (EDI) Committee now chaired by the Chief Executive, overseeing the programme of work agreed by Trust Board ***Workplace wellbeing and collaboration*** A programme to create better working and social spaces and other opportunities to facilitate connections, support and learning. • Charity funding obtained to roll out Mental Health awareness training for managers and to pilot fast track access to physiotherapy for staff, both launching in January • New Active Bystander training to promote improved relationships, reduce negative behaviours at work, 250 trained to date with capacity for 500 more Oct - Dec 2019 • Development of the Values workshops and recruitment of Values Ambassadors to promote values and behaviours at local level; 17 ambassadors trained and 63 more booked in for training between November and January • Ongoing development of Schwartz round to provide emotional support and debrief for staff ***Imperial Way*** The final version of the Imperial Way – the framework and approach for the development and delivery of Trust strategy and priorities – will be presented at Trust Board in November. This will provide the framework and approach for 2020/21 business planning, setting objectives and prioritisation.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Month 6 integrated quality and performance report (Board version)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: Wednesday 27 November 2019	**Item 10, report no. 07**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development) Claire Hook (Director of Operational Performance)	**Author:** Submitted by Performance Support Team

Summary:

This is the Board version of the integrated quality and performance report for data published at month 6 (September 2019).

The report is presented as follows:

- Summary report of key headlines
- Indicator scorecard
- Appendix 1: Additional slides by exception (for information)

Recommendations:
The Board is asked to note the contents of this report.

This September 2019 performance scorecard and reports have been discussed at:

Executive Operational Performance Committee
Executive Quality Committee
Board Quality Committee
Executive Finance Committee

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☐ No ☒ Not applicable

Quality impact:
The delivery of the full integrated quality and performance report will support the Trust to more effectively monitor delivery against internal and external targets and quality standards. All CQC domains are impacted by the paper.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:

Has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:

- 2472: Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards
- 2477: Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues
- 2480: Patient safety risk due to inconsistent provision of cleaning services across the Trust
- 2485: Failure of estates critical equipment and facilities
- 2487: Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)
- 2942: Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines
- 2937: Failure to consistently achieve timely elective (RTT) care
- 2938: Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards
- 2943: Failure to maintain non elective flow
- 2944: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas
- 2946: Failure to provide timely access to critical care services
- 1660: Risk of poor waiting list data quality

Workforce impact (including training and education implications):
None

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☐ No

What impact will this have on the wider health economy, patients and the public?
Comprehensive performance and quality reporting is essential to ensure standards are met which benefits patients. The report is aligned with CQC domains to ensure the Trust has visibility of its compliance with NHS wide standards.

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:
Retain as appropriate:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?.....

Imperial College Healthcare NHS Trust

Integrated quality and performance report

1. Introduction

1.1. The Board are asked to consider the integrated quality and performance report and the key headlines relating to performance as at September 2019 (month 6).

1.2. The indicator scorecard and this summary report highlights where performance is above target, or within tolerance, and where performance did not meet the agreed target / threshold.

2. Key headlines

The key highlights from the September 2019 (month 6) integrated performance scorecard are provided below. Updates for October 2019 performance data are given where appropriate.

Quality

2.1. The incident reporting rate for September 2019 was above target with the overall number of incidents reported increasing to 1,604 from 1,445 in the previous month. Our incident reporting rate is still variable and the new safety improvement group is taking forward a longer-term campaign to support sustainable improvement. This will focus on the links between incident reporting and safety behaviours.

2.2. Overall our harm profile is good and the Trust has some of the lowest mortality rates in the country. The percentage of moderate and above incidents we have reported so far this year is below national average (1.69% compared to 2.12%). However we have seen an increase in the number of extreme incidents we are reporting in comparison to last year. Currently, based on our average incident reporting rate, we should meet the target to be below national average moderate and above incidents for by March 2020. This is being closely monitored and exception slides will be provided in the next report if the position changes.

2.3. Duty of candour compliance continues to improve and is currently at 96%.

2.4. In September 2019,

- There have been 53 cases of hospital-associated *C. difficile* so far this year, which is above our trajectory of 37. None of these cases have been related to lapses in care suggesting that they were not related directly to cross-transmission or poor antibiotic stewardship.

- There were eight cases of *E.coli* BSI attributed to the Trust in August and September 2019, and a total of 35 cases so far. We are currently on track to meet our internal reduction target of 10%.

- There were no Trust-attributable cases of MRSA BSI reported in September 2019 and the figure remains at three cases reported so far this financial year, compared to three in total in 2018/19.

- There were no cases of CPE BSI reported in September 2019, however three were reported in August 2019. There have been six cases reported so far this year, compared to five this time last year.

2.5. Issues with reporting data for antibiotic administration for patients diagnosed with sepsis have been resolved. In September 2019, 90.8% of patients received antibiotics within 1 hour of their confirmed sepsis diagnosis, just above our 90% target.

2.6. Structured judgement reviews (SJRs) are undertaken for all relevant deaths in line with national requirements and Trust policy. We continue to have an issue with meeting our performance target for completing SJRs within 30 days of the date of request. A full review of our approach and methodology has been completed and changes planned to support improvement. Three deaths have been confirmed as 'avoidable' this financial year following completion of the SJR. These incidents were reviewed at the first learning from deaths outcome review group on 8 November as the findings of the initial investigations into the incidents differ from the SJRs. The final decision will be reported to the board in the next learning from deaths report in January 2020.

2.7. The consultant job planning cycle for 2019/20 has concluded with overall compliance of 95.3%, above our 95% target.

2.8. Our doctor appraisal rate is currently at 94% against our 95% target. This is the highest level of compliance reported since April 2016.

2.9. Our vacancy rates have continued to reduce and we are on track to meet our targets. At the end of October 2019, the Trust vacancy rate was 10.29% against the 10% target (improvement of 1.35% from July 2019). The overall nursing and midwifery vacancy rate was 13.34% against the 13% target (improvement of 2.5% from July 2019).

2.10. The Trust reported 28 mixed-sex accommodation (MSA) breaches in September 2019. The breaches are incurred by patients awaiting step down from critical care to ward areas whose discharge is delayed by more than the national 4-hour target, once they have been identified as fit for discharge. The number of MSA breaches has reduced in recent months (42 breaches were reported the same month last year). The Trust is reviewing publication of new national guidance (with effect from 1 January 2020) to understand if breaches within critical care will continue to be reported in the standard.

Operational performance

2.11. On 31 October, the NHS Medical Director published a progress report setting out how each of the proposed new NHS Access Standards (UEC, elective, cancer and mental health) is being tested and the early learning[1]. Based on initial data and feedback, the progress report highlights benefits for patients in the wider package of measures that are being tested within urgent and emergency care services. The report states that it is too early to draw firm conclusions and NHS England and NHS Improvement will continue their qualitative and quantitative evaluation. A final report with recommendations is expected March 2020.

[1] Clinically-led Review of NHS Access Standards. Progress Report from Professor Stephen Powis, NHS National Medical Director. 31 October 2019.

Imperial College Healthcare NHS Trust

2.12. As one of the 14 trusts taking part in the testing of the proposed new UEC standards, we will not be required to report performance against the four-hour standard for the remainder of the financial year. We will however continue to submit data about our performance for the proposed new UEC standards including the 'average time spent in A&E' and also test different aspects of the critical time standards.

2.13. In September 2019, three patients had been waiting for more than 52 weeks for treatment. The overall size of the referral to treatment waiting list size was maintained and met the trajectory, as did the aggregate performance of the standard to treat patients within 18 weeks of their referral.

2.14. Theatre utilisation is 81.1% year to date which is above our trajectory and is +1.7% on the same period last year. There was a slight dip in performance in early part of quarter two, which was exacerbated by a challenging period of anaesthetist capacity over the summer, but even with this we remained above trajectory throughout.

2.15. In September 2019, the Trust delivered seven of the eight national cancer standards. The cancer 2 week waits performed below standard and is being reviewed by the service and the trajectory is being developed.

3. Additional information

3.1. Exception slides for month 6 are provided for information in appendix 1 and cover the following scorecard metrics:

- Incident reporting rate
- Patient safety incidents
- Compliance with duty of candour
- CPE
- Vacancy rates
- Safeguarding in children training
- Cleanliness audit scores
- Reactive maintenance
- National clinical audits
- Mortality reviews
- Doctor appraisal rate
- Patient transport FFT
- RTT patients waiting > 52 weeks
- Cancer 2 week waits
- A&E patients waiting > 12 hours from decision to admit
- Ambulance handovers (30 minute delays)
- Outpatient DNA
- Data quality error rate – RTT

4. Recommendation

The Board is asked to note the contents of the integrated performance report for month 6.

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year Sep-18	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Latest reported performance Sep-19
FYTD = Financial Year to Date											
Safe											
Patient safety - incident reporting											
Serious incidents	-	Sep-19		**17**	17	12	33	12	44	23	**14**
Incidents - moderate harm (FYTD)	<1.68%	Sep-19		**1.26%**	1.29%	2.16%	1.92%	1.64%	1.49%	1.42%	**1.44%**
Incidents - severe/major harm (FYTD)	<0.23%	Sep-19		**0.05%**	0.04%	0.00%	0.00%	0.00%	0.02%	0.01%	**0.01%**
Incidents - extreme harm/death (FYTD)	<0.09%	Sep-19		**0.05%**	0.04%	0.08%	0.11%	0.12%	0.12%	0.11%	**0.10%**
Incident reporting rate (per 1,000 beds)	>=50.38	Sep-19		**46.75**	48.46	41.70	46.56	53.75	56.75	47.96	**51.19**
Never events	0	Sep-19		**1**	0	1	0	0	0	0	**0**
PSAs open and overdue (FYTD)	0	Sep-19		**-**	-	0	0	0	0	0	**0**
Incidents with DoC completed	100%	Aug-19		**-**	-	93.9%	90.8%	93.6%	94.2%	95.8%	**96.1%**
Infection prevention and control											
Trust-attributed MRSA BSI (FYTD)	0	Sep-19		**2**	3	0	2	3	3	3	**3**
Trust-attributed C. difficile (FYTD)	77	Sep-19	37	**-**	-	5	14	25	37	47	**53**
Trust-attributed C. difficile (lapses in care) (FYTD)	0	Sep-19		**-**	-	0	0	0	0	0	**0**
E. coli BSI (FYTD)	75	Sep-19	44	**49**	83	8	14	19	27	30	**35**
CPE BSI (FYTD)	0	Sep-19		**5**	7	0	0	2	3	6	**6**
VTE											
VTE risk assessment	>=95%	Sep-19		**96.3%**	93.8%	93.8%	93.8%	93.6%	97.3%	97.4%	**98.5%**
Sepsis											
Sepsis - Antibiotics	>=90%	Sep-19		**-**	93.8%	93.5%	92.3%	90.3%	89.9%	89.3%	**90.8%**
Maternity standards											
Puerperal sepsis	<=1.5%	Sep-19		**1.0%**	0.3%	0.7%	1.6%	1.0%	1.1%	1.3%	**2.3%**
Safe staffing											
Safe staffing - registered nurses	>=90%	Sep-19		**95.6%**	96.9%	97.8%	98.0%	97.7%	97.3%	97.1%	**97.2%**
Safe staffing - care staff	>=85%	Sep-19		**96.3%**	95.3%	97.0%	96.4%	96.1%	96.9%	96.6%	**96.3%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year Sep-18	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Latest reported performance Sep-19
FYTD = Financial Year to Date											
Safe											
Workforce and people											
Core skills training	>=90%	Sep-19		**89.5%**	92.1%	91.9%	91.8%	91.9%	92.5%	93.5%	**93.8%**
Safeguarding children training (level 3)	>=90%	Sep-19		**79.3%**	90.1%	91.1%	-	89.4%	88.5%	87.0%	**86.0%**
Vacancy rate - Trust	<10%	Sep-19		**13.3%**	13.5%	11.4%	11.7%	11.7%	12.0%	11.7%	**11.1%**
Estates and Facilities											
Cleanliness audit scores (very high risk)	>=98%	Sep-19		**92.0%**	88.0%	84.0%	87.0%	88.0%	95.0%	92.0%	**88.5%**
Cleanliness audit scores (high risk)	>=95%	Sep-19		**93.0%**	91.0%	91.0%	90.0%	95.0%	96.0%	80.0%	**93.1%**
Reactive maintenance	>=70%	Sep-19		**44.7%**	33.2%	31.8%	-	31.0%	61.6%	61.4%	**67.0%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year Sep-18	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Latest reported performance Sep-19
FYTD = Financial Year to Date											
Effective											
Mortality indicators											
HSMR: Trust ranking	top 5 lowest risk	Jun-19		**4th lowest**	3rd lowest	3rd lowest	4th lowest	2nd lowest	9th lowest	5th lowest	**Lowest**
HSMR ratio	top 5 lowest risk	Jun-19		**55.0**	53.0	59.0	57.0	64.0	72.0	56.0	**60.0**
SHMI: Trust ranking	top 5 lowest risk	Apr-19		-	4th lowest (last quarterly figure, now monthly)		2nd lowest	2nd lowest	Lowest	Lowest	**Lowest**
SHMI ratio	top 5 lowest risk	Apr-19		-	66.84		68.11	71.93	70.46	70.69	**70.32**
Mortality reviews (at 07/10/2019)											
Total number of deaths	-	Aug-19		**118**	124	164	175	139	128	119	**160**
Number of avoidable deaths (Score 1-3) (FYTD)	0	Aug-19		**6**	10	13	2	2	3	3	**3**
SJRs not completed within 30 days (FYTD)	0%	Aug-19		-	-	58.6%	58.4%	61.0%	63.0%	63.1%	**62.6%**
Readmissions (unplanned)											
under 15 yr olds	<9.33%	Mar-19		**5.0%**	5.3%	4.7%	5.0%	5.3%	4.5%	4.1%	**4.4%**
over 15 yr olds	<8.09%	Mar-19		**6.5%**	7.1%	7.1%	6.9%	7.5%	6.5%	6.9%	**7.1%**
National Clinical Audits											
Participation in relevant NCAs (FYTD)	100%	Jun-19		**100.0%**	84.4%	86.5%	87.2%	87.2%	100.0%	100.0%	**86.7%**
High risk/significant risk audits with action plan (FYTD)	100%	Jun-19		**100%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**
Review process not completed within 90 days	0	Jun-19		**3**	8	11	12	12	1	7	**11**
Clinical trials				**Qtr 2 17/18**	Qtr 3 17/18	Qtr 4 17/18	Qtr 1 18/19	Qtr 2 18/19	Qtr 3 18/19	Qtr 4 18/19	**Qtr 1 19/20**
Recruitment of 1st patient within 70 days	>=90%	Qtr 1 19/20		**53.3%**	53.3%	67.6%	85.1%	95.7%	93.9%	96.0%	**96.3%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year Sep-18	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Latest reported performance Sep-19
FYTD = Financial Year to Date											
Caring											
Friends and Family											
A&E - % recommended	>=94%	Sep-19		93.9%	93.6%	93.3%	92.8%	93.1%	92.5%	93.5%	94.4%
A&E - % response rate	>=15%	Sep-19		10.8%	18.1%	19.5%	14.9%	17.1%	14.6%	17.3%	16.1%
Inpatients - % recommended	>=94%	Sep-19		97.2%	97.7%	97.2%	97.1%	97.2%	97.2%	97.3%	97.3%
Outpatients - % recommended	>=94%	Sep-19		92.1%	94.2%	94.2%	94.1%	94.1%	94.5%	93.99%	93.9%
Maternity - % recommended	>=94%	Sep-19		93.1%	92.9%	91.2%	94.0%	94.7%	92.5%	93.4%	95.2%
Patient Transport - % recommended	>=90%	Sep-19		92.7%	95.7%	91.9%	94.3%	75.0%	50.0%	48.3%	44.4%
Mixed sex accommodation											
Mixed-sex accommodation breaches	0	Sep-19		41	50	34	35	48	41	15	28
Well led											
Workforce and people											
Voluntary staff turnover rate (12m rolling)	<12%	Sep-19		11.5%	11.3%	11.3%	11.6%	11.3%	11.8%	11.7%	11.8%
Sickness absence rate (12m rolling)	<=3%	Sep-19		3.06%	3.13%	3.15%	3.17%	3.19%	3.20%	3.18%	3.18%
Doctor appraisal rate	>=95%	Sep-19		87.5%	93.0%	93.6%	92.3%	92.7%	93.0%	93.4%	94.0%
Consultant job planning completion rate	>=95%	Sep-19		99.5%	-	-	78.2%	80.9%	91.3%	91.6%	95.3%

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator		Overall target	Latest Period	Trajectory	Same period last year Sep-18	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Latest reported performance Sep-19
FYTD = Financial Year to Date												
Responsive	Data reliability rating											
Referral to treatment (elective care)												
RTT patients waiting > 18 weeks	10%	>=92%	Sep-19	83.5%	**82.6%**	84.4%	85.0%	86.1%	85.2%	84.6%	82.8%	**83.6%**
RTT waiting list size		63,099	Sep-19	63,100	**64,305**	61,371	62,546	63,097	63,088	63,098	62,918	**62,664**
Long waiters												
RTT patients waiting > 52 weeks	12%	0	Sep-19		**46**	0	0	0	1	0	2	**3**
Cancer waiting times												
Two Week Wait		>=93%	Aug-19		**-**	93.4%	90.8%	92.4%	92.5%	91.0%	85.8%	**82.9%**
62 Day Screening Standard	1%	>=90%	Aug-19		**-**	52.8%	93.0%	81.4%	82.2%	80.8%	73.9%	**77.3%**
62 Day Wait (start of treatment)		>=85%	Aug-19	85.0%	**85.4%**	86.2%	86.8%	88.2%	91.5%	86.7%	87.3%	**86.9%**
Theatre utilisation												
Theatre touchtime utilisation		>=85%	Sep-19	82.1%	**80.6%**	78.6%	80.0%	80.5%	81.7%	80.4%	82.4%	**82.2%**
Critical care												
Critical care patients admitted within 4 hours		100%	Sep-19		**92.7%**	95.8%	92.2%	98.1%	97.7%	95.0%	94.4%	**94.6%**
Urgent and emergency care												
A&E patients waiting > 12 hours from DTA	5%	0	Sep-19		**7**	10	12	7	22	17	8	**7**
A&E ambulance handover delays 30 minutes		100%	Sep-19	98%	**92.0%**	87.0%	89.0%	89.0%	90.0%	90.6%	90.6%	**91.4%**
Length of stay												
Patients with LoS >= 21 days	3%	tbc	Sep-19		**-**	233	236	235	234	218	212	**212**
Discharges before noon		>=33%	Sep-19		**12.8%**	14.5%	16.1%	15.8%	14.9%	16.0%	16.3%	**16.1%**
Diagnostics												
Diagnostic test waits > 6 weeks	0.4%	<1%	Sep-19		**0.75%**	0.61%	0.998%	0.90%	0.75%	0.90%	1.04%	**0.50%**

Key to data reliability scores:

Data reliability scores are currently provided for the above RTT, Cancer, Emergency care, Diagnostics and Long stay patient datasets

Above 5% error rate to inform a Red data quality rating.

5% error rate or below to inform a Green data quality rating.

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

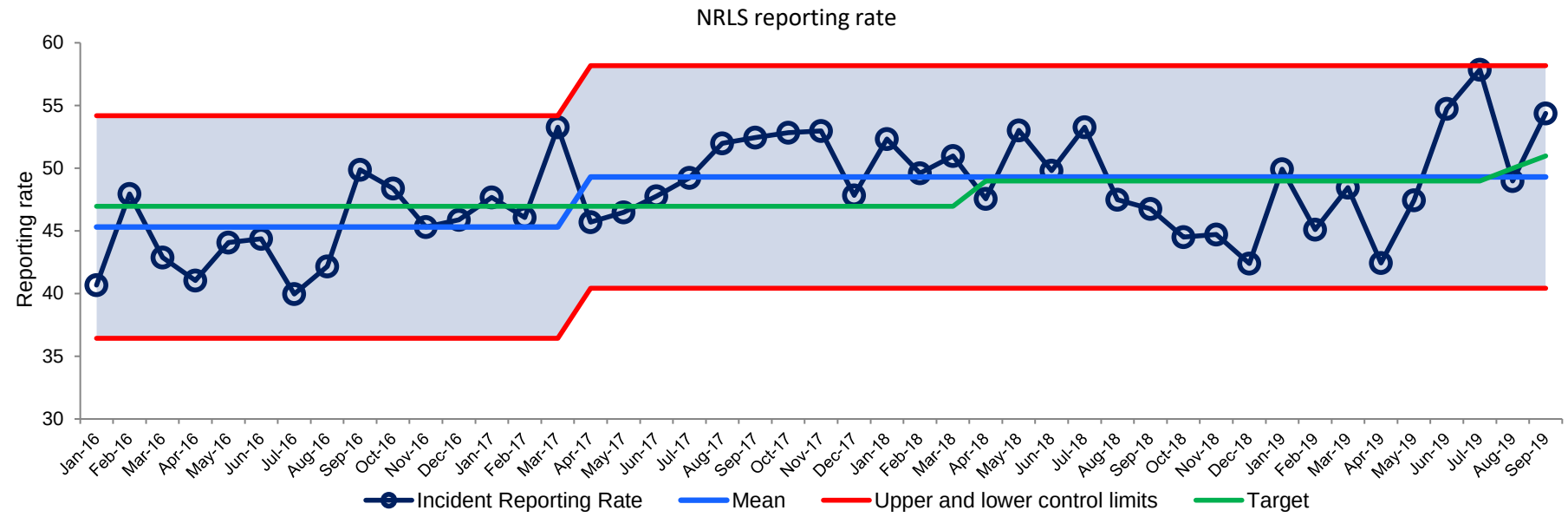
Indicator	Overall target	Latest Period	Trajectory	Same period last year Sep-18	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Latest reported performance Sep-19
FYTD = Financial Year to Date											
Responsive											
Outpatients											
DNA	<10%	Sep-19		**10.8%**	10.2%	10.5%	10.3%	10.4%	10.7%	11.1%	**10.8%**
HICs (Appt moved to a later date)	<7%	Sep-19	7.5%	**7.1%**	7.2%	7.6%	7.5%	7.2%	7.2%	7.9%	**7.4%**
Complaints management											
Complaints - formal	<90	Sep-19		**65**	88	88	104	96	136	87	**98**
Complaints – average days to respond	40 days	Sep-19		**31.1**	27.9	29.0	29.8	34.0	32.4	32.7	**36.3**
Complaints - patient satisfaction with handling	>=70%	Sep-19		**-**	84.0%	86.0%	84.0%	82.0%	81.0%	85.0%	**82.0%**
Patient transport											
All Journeys: Collection Time (60 Mins)	>97%	Sep-19		**94.7%**	94.1%	93.6%	93.3%	51.5%	86.4%	77.6%	**68.7%**
Data quality											
Data Quality Maturity Index	>98%	Jun-19	95%	**97.1%**	96.7%	96.8%	96.7%	96.4%	99.3%	99.4%	**99.3%**
Use Of Resources											
Finance KPIs											
Monthly finance score (1-4)	-	Sep-19		**3**	3	3	3	3	3	3	**3**
In month Position	-	Sep-19		**3.21**	0.32	-0.59	0.25	0.92	0.00	0.12	**-0.05**
YTD Position £m	-	Sep-19		**2.04**	10.68	0.00	4.58	5.50	7.07	7.85	**7.08**
Annual forecast variance to plan	-	Sep-19		**-6.13**	0.32	-	-	-12.58	-18.11	-11.34	**-9.14**
Agency staffing	-	Sep-19		**4.1%**	4.1%	3.5%	3.4%	3.1%	3.2%	3.1%	**2.9%**
CIP (FYTD)	-	Sep-19		**75.8%**	76.4%	74.5%	66.5%	65.7%	64.6%	66.0%	**74.1%**

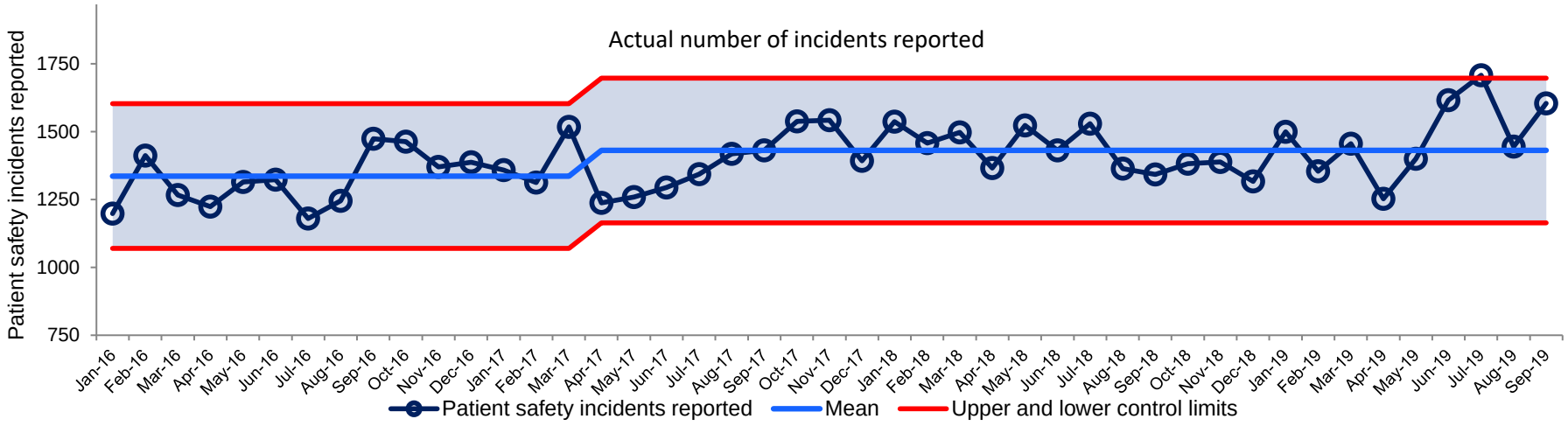
Additional slides by exception for month 6

Domain	Report
Safe	Incident reporting rate
Safe	Patient safety incidents
Safe	Compliance with duty of candour
Safe	CPE
Safe	Vacancy rates
Safe	Safeguarding in children training
Safe	Cleanliness audit scores
Safe	Reactive maintenance
Effective	National clinical audits
Effective	Mortality reviews
Well led	Doctor appraisal rate
Caring	Patient transport FFT
Responsive	RTT patients waiting > 52 weeks
Responsive	Cancer 2 week waits
Responsive	A&E patients waiting > 12 hours from decision to admit
Responsive	Ambulance handovers (30 minute delays)
Responsive	Outpatient DNA
Responsive	Data quality error rate - RTT

Safe – Patient safety incident reporting

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain our incident reporting numbers and be within the top quartile of trusts	In top quartile (50.38)	48.97 – Aug 2019 54.36 – Sep 2019	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance





Safe – Patient safety incident reporting

Latest performance

Our reporting rate for September 2019 is 54.36 against the target of 50.38. The overall number of incidents reported has improved since last month, with 1,604 reported compared to 1,445. Our incident reporting rate is still variable and our year to date rate is only just over the top quartile target.

Return to target / trajectory

We are currently above target, however our incident reporting rate fluctuates each month with a lack of evidence of sustained improvement. National comparison data is published six months in arears which means that if the national reporting rate continues to increase we may fall below our target when the data is refreshed. A longer-term campaign focusing on the links between incident reporting and safety behaviours will be required to support sustainable improvement across the organisation. This is being taken forward by the new safety improvement group which will meet for the first time on 28th November 2019.

Key issues	• Historically, we have been in the top quartile for incident reporting rates published by the National Reporting and Learning Service (NRLS), however our reporting rate fell below target between August 2018 and May 2019. Since then it has been variable. • All three clinical divisions reported more incidents in September than last month and more than their yearly average. Overall, 19 directorates reported more incidents than average, with 9 reporting fewer. However, the number of incidents fluctuate from month-to-month for each directorate, with no sustained improvements. • The increase in MIC can be partly attributed to greater numbers of transport incidents affecting the renal directorate, with 20 reported for September. Overall, transport accounted for 4% of all incidents, with 64 reported in September 2019. The average number of transport incidents reported per month since we switched to the new contract is 156, compared to 51 in the preceding 12 months, with there being a significant increase in the number of incidents reported because the vehicle didn't arrive or was late (311 between June and September 2019 compared to 147 in the preceding 12 months). • The number of incidents fell in NWL Pathology to 44 compared to their average of 65.

Safe – Patient safety incident reporting

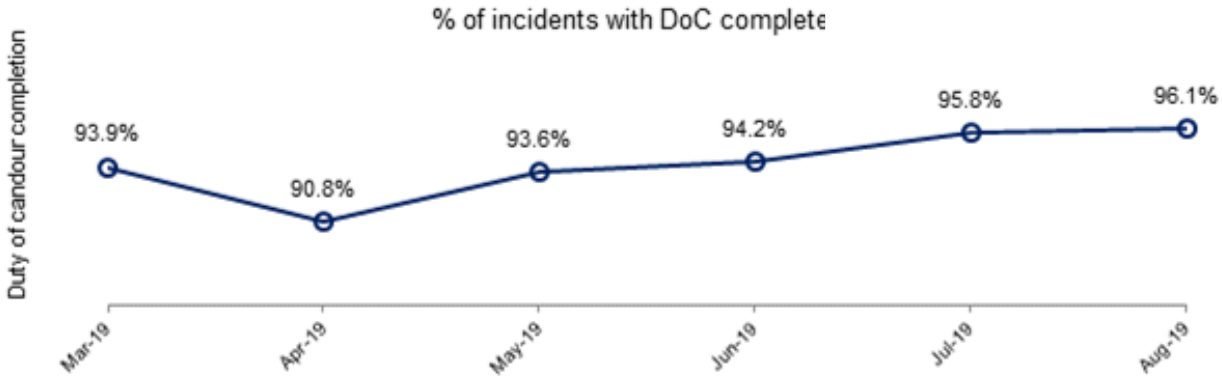
Improvement plans and actions	Lead	Timescale	Progress update
Undertake 90 day improvement cycles with lower reporting wards in SCCS	Deputy DDN Improvement Manager for Safety	On-going	5 areas identified with the SCC division are participating in the pilot. The work began in July with a diagnostic phase to understand the enablers and barriers to incident reporting in clinical areas. The next phase is involving the teams in designing small tests of change to address some of these barriers. Small but statistically significant improvements are being seen on the wards which have started their tests of change. Regular updates on progress are being provided to the quality and safety sub-group.
Address the cultural issues affecting incident reporting raised by staff	Improvement programme manager – safety	March 2020	Actions related to improving the culture of incident reporting across the organisation will be taken forward by the safety improvement group, which will meet for the first time on 28th November. This will require a trust wide focus linked to our values and behaviours work to encourage staff to speak up when things go wrong and celebrate when we do things well. A more long-term awareness campaign is being designed with the communications team which will start in November 2019.
Review the functionality of Datix as staff continue to raise this as a barrier to reporting	Head of Quality Compliance and Assurance	March 2020	A monthly Datix User Group has been established to review the functionality of the system. The first meeting took place on 22nd October. The group has identified a number of actions which will be undertaken over the next few meetings, including rebuilding the incident categories and sub-categories function and the streamlining of location codes across the Trust (we currently have over 500). This work will be completed by Q4. Work is also being undertaken nationally to implement a new safety learning system in place of the NRLS, which will simplify the process. We are awaiting a date for when this will launch and we will look to re-tender our reporting system once it is clear what the national direction is.
Review the training available with a view to training team members in identification and reporting	Head of Quality Compliance and Assurance	March 2020	Corporate welcome and junior doctor sessions have been refreshed to encourage staff to report. Review of the education and training around incident reporting is underway and the approach will be standardised for all departments. The aim is to develop an eLearning module.

Risk

- Is it on the (divisional / corporate) risk register? No

Safe – Compliance with duty of candour

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	Total: 96.1%	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

Data is reported one month in arrears. The graph above shows that 96.1% of the incidents occurring in the past 12 months have had DoC completed. We have amended the way we present the data so that it reflects in month performance and so allow us to track improvements. Data is only available from March 2019 using this methodology. The graph demonstrates that compliance is improving. Work has been undertaken to review compliance for historic incidents and as of the end of September 2019, there are no incidents which occurred before April 2019 which have DoC incomplete. 11 incidents (3 SIs, 2 Level 1s and 6 moderate and above incidents) reported between April and August 2019 have not had DoC completed. This is an improvement compared to last month's position when there were 14 overdue.

Return to target / trajectory

We continue to make improvements with DoC compliance, however we are not meeting our 100% target. If the actions outlined on the following slide are successful, we should meet the target by year end.

Safe – Compliance with duty of candour

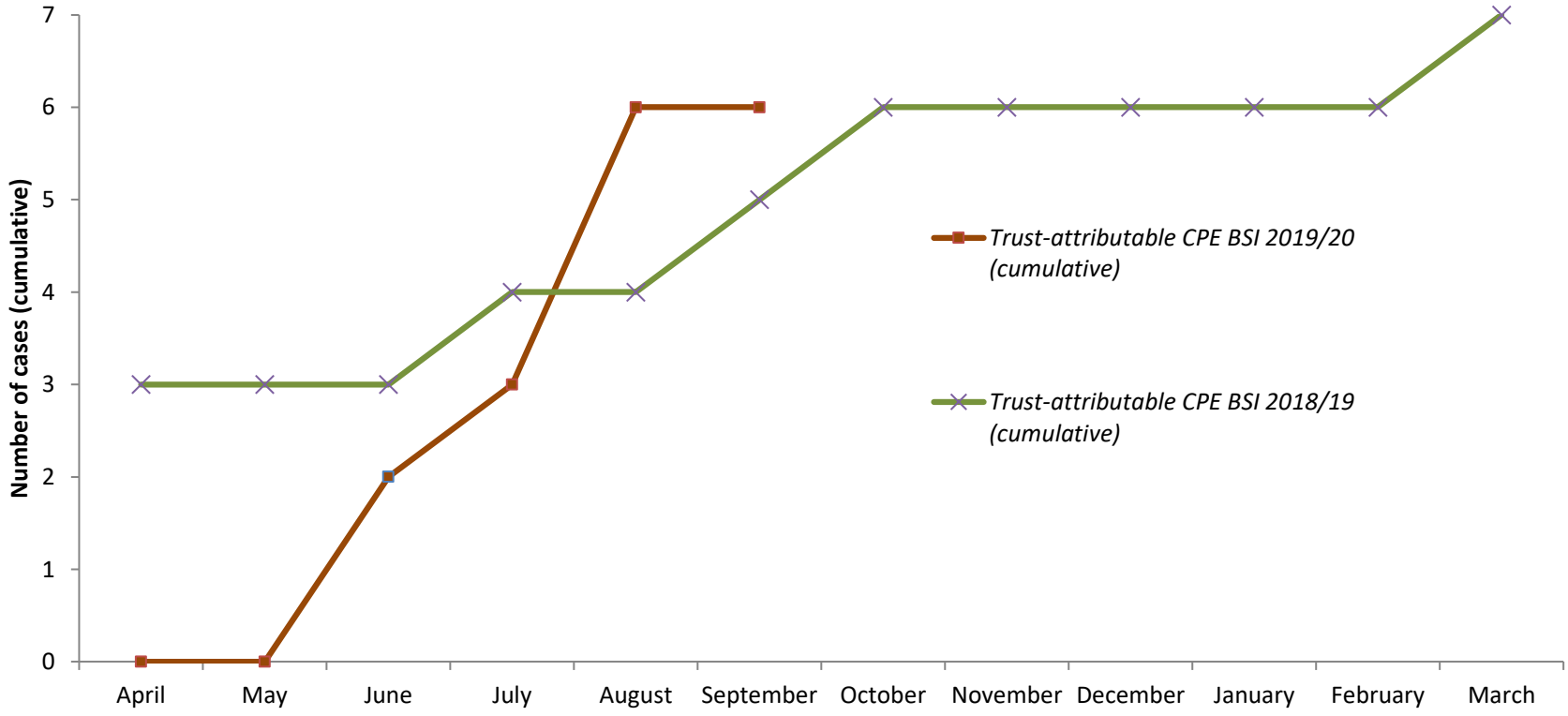
Issues and root causes	Although improvements have been made, such as ensuring all DoC letters are logged on Datix once completed, issues remain around completion of both parts of the DoC process (Part 1 – the initial conversation, and part 2 – the follow up letter) by the consultant responsible for the patient's care.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Ensure all pertinent information is available for the clinician completing the DoC letter	Head of quality compliance and assurance	December 2019	A SOP will be developed for the administration team outlining all the information needed to be sent to the clinicians to support them in completing the letter.
Standardise the escalation process when DoC not completed across all divisions	Chief of staff, MD office	December 2019	Review of escalation processes across divisions commenced.
90% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisional Directors	March 2018 – overdue	Trustwide compliance is 92.3%. Compliance is over 90% for all divisions except MIC and IPH where it is just below target. Non-compliant staff are being managed through standard divisional processes.
Annual audit of DoC to be undertaken	Improvement Manager - Safety	December 2019	An audit of the DoC process and the quality/standard of DoC letters is currently being undertaken by the clinical audit team. This will be completed by the end of November.

Risk
• Is it on the (divisional / corporate) risk register? YES (Risk ID 2054 Compliance with duty of candour legislation)

Safe - CPE

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have no healthcare-associated BSIs caused by CPE	0	3 – Aug 2019 0 – Sept 2019 YTD = 6	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	There were three CPE BSI cases in August and none in September 2019. There have been a total of 6 cases so far in 2019/20 compared to 5 this time during 2018/19.
Return to target / trajectory	Target for CPE BSI is zero, therefore no return to target for 2019/20.

Safe - CPE

Key issues	There have been six CPE BSI cases so far this year, three of which were in August 2019 and none in September. Each case undergoes clinical review to optimise management from the infection multidisciplinary team. Themes are collated at quarterly intervals to identify learning and opportunities for preventive action.

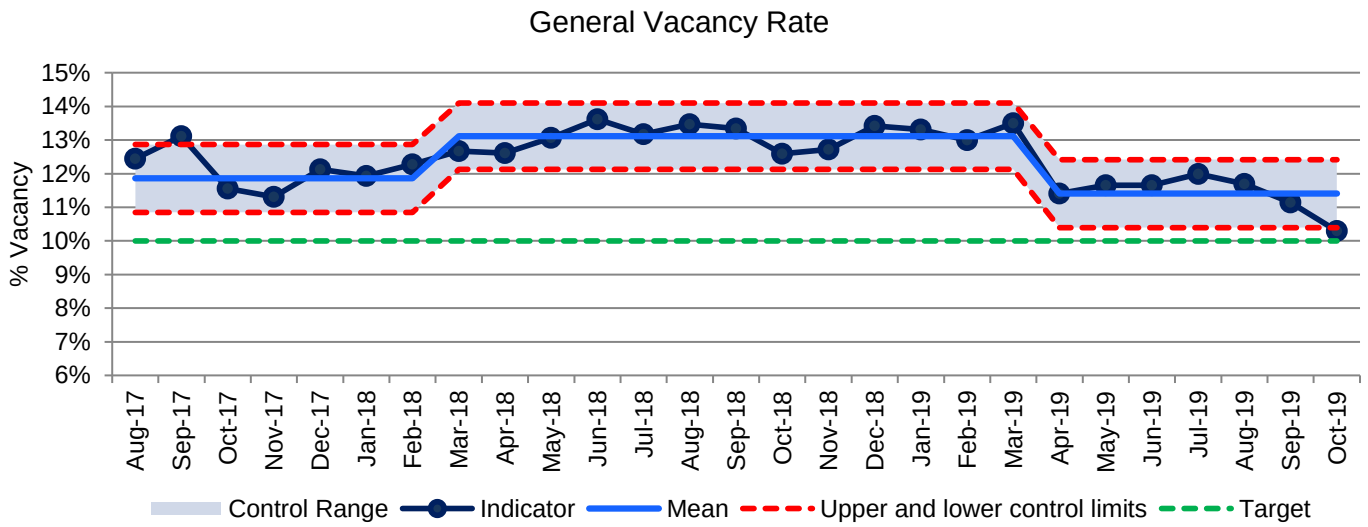
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Case review of BSIs to identify learning	Eimear Brannigan, Deputy DIPC	On-going action	The case reviews indicate limited opportunity for prevention in these cases other than prevention of CPE acquisition, by a focus on reducing carbapenem use and improving IPC practice especially hand hygiene.
Develop and launch Cerner CPE screening tool to promote and support implementation of CPE screening.	Jon Otter, General Manager, IPC	Dec 2019	An agreement has been reached between us and Chelsea and Westminster Hospital NHS Trust to use the same tool for both organisations. A timeline for implementation is being developed.

Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2487 - Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae)

Safe – Vacancy rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less	10% target for overall Trust vacancies	All Trust was 10.29% in October 2019	Kevin Croft, Director of People and Organisational Development	Dawn Sullivan, Deputy Director of People and Organisational Development



Latest performance	• At the end of October the overall Trust vacancy rate was 10.29% reflective of 1,150 WTE vacancies; 260 WTE non-clinical roles and 890 WTE clinical roles • The number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 10,035 WTE; an increase of 232 WTE from those employed in August 2019 • For all nursing & midwifery roles, the vacancy rate was 13.34% (700 WTE vacancies)
Return to target / trajectory	• Based on current forecasts we expect to hit a vacancy rate of 13% for nursing and midwifery roles and 10% for overall trust vacancies by November 2019 as we are marginally above them at the moment however the pipeline data which projects this position could be negatively impacted if establishments are increased to manage winter.

Safe – Vacancy rates

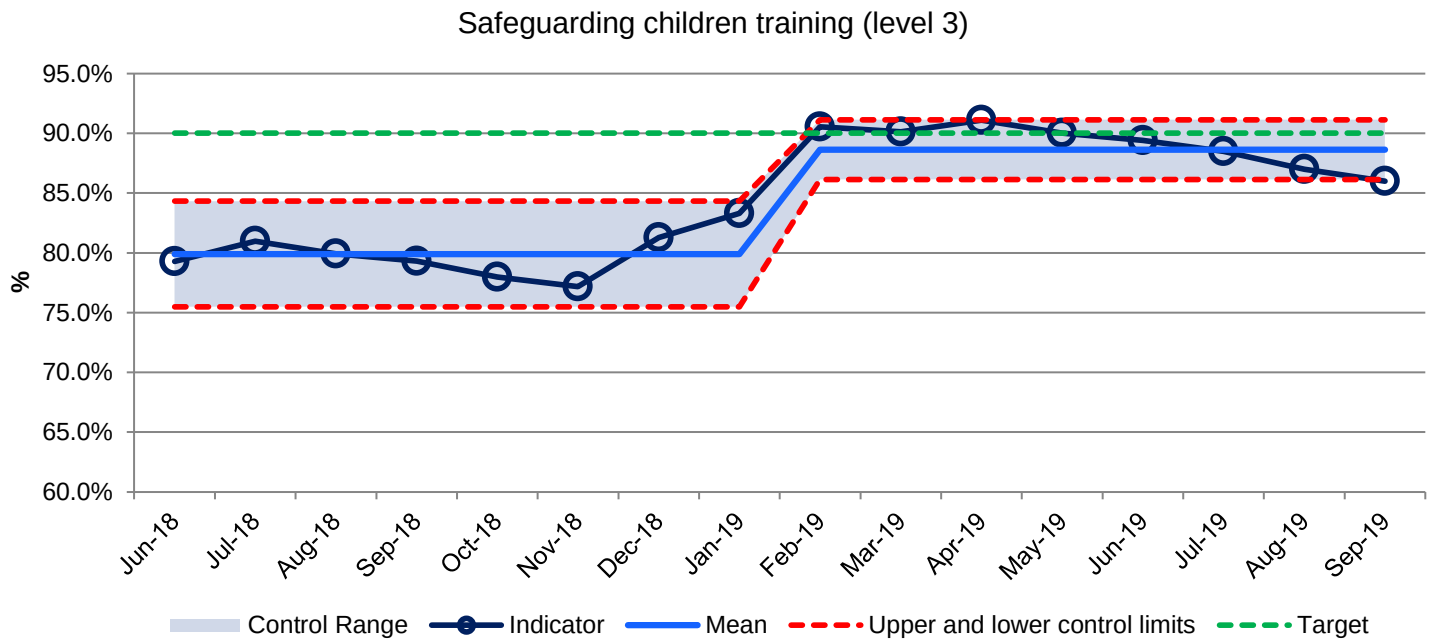
Issues and root causes	• In 2017 more nurses left the profession than joined. Imperial has an overall nursing and midwifery vacancy rate of 13.34% - a reduction of 2.5% from July 2019. There are a wide range of recruitment initiatives in place however, with a growing workforce demand, these maintain our position rather than reduce the vacancy rate significantly • There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff very difficult: the removal of the bursary, contractual changes with trainee doctors, the pressure of work and the reduction in CPD funding • The London recruitment market is very difficult with a large number of employers in close proximity and a number of staff are leaving to re-locate due to the high cost of living and lack of affordable housing. • We have only recently seen the benefits of our increased international recruitment strategy but this will have more of an impact in the later part of 19/20 and 20/21.

Improvement plans and actions	Lead	Times cales	Progress update
To develop an accurate picture of current staffing levels, hotspot areas for vacancies and turnover and develop strategies to manage these	Pen Parker/ Dawn Sullivan/ Divisional Directors of People	31 Oct 2019	• A comprehensive workforce report & plan reviewed by executive bi-monthly • Divisional Directors of Nursing have identified top hotspot areas for vacancy and turnover across the Trust that required additional support and targeted interventions • Leavers data from ESR is analysed on a monthly basis. In addition, a new leavers survey for N&M staff was introduced in June 2019 • A joiners survey for N&M has been piloted and joiners data is analysed on a monthly basis
Enhancing the offer for staff at different career stages	Dawn Sullivan	30 Sept 2019	• To promote flexible working, all advertised roles, encourage candidates to discuss their flexible working requirements at the interview • Self-rostering is being piloted in Imperial Private Health (to improve retention and staff engagement)
To create and promote opportunities for staff to ensure they are aware of what is available. Ensure staff receive careers support through the careers clinic or other channels	Dawn Sullivan	31 March 2020	• A pool of careers coaches identified and trained to provide careers coaching. 38 N&M staff have been trained to become career coaches to date. The quarterly careers clinics have been taking place across the main sites • The internal transfer scheme for band 5 N&M has been refreshed where a “register your interest” form and panels to manage transfers will be managed bi-monthly
To maximize recruitment and develop a 3-5 year workforce plan to make the supply of N&M staff more sustainable	Dawn Sullivan/ Sue Burgis	31 March 2020	• A review of the annual N&M recruitment strategy has been completed • Introduced an automatic offer to our student nurses. The acceptance rate is 88% • An International Recruitment campaign has resulted in 118 International nurses starting with the Trust. Currently we have 135 nurses in the pipeline and 180 will have joined by March 2020. • Bespoke recruitment campaigns in hard to recruit areas (e.g. Trauma, Critical Care, Haematology, Cardiac and Specialist Surgery)

Risk register
Corporate risk register id 2944: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas.

Safe – Safeguarding in children training (level 3)

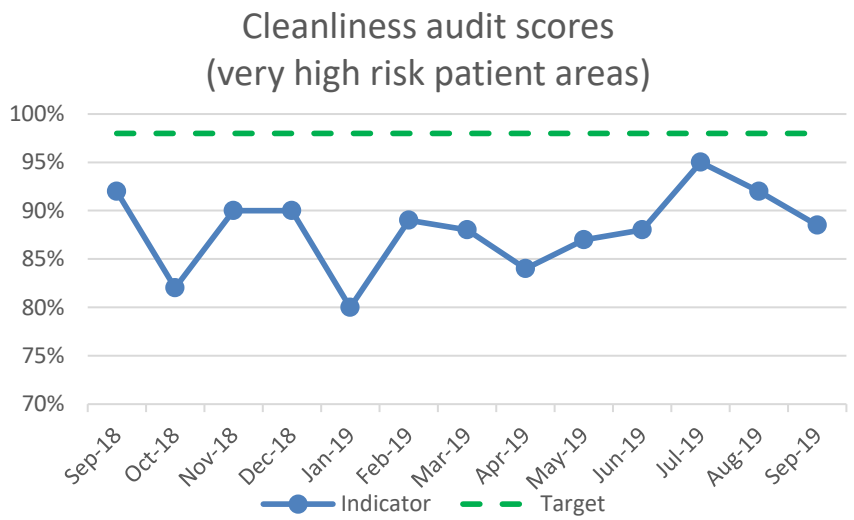
Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90% or greater	September 2019 compliance was 86%	Janice Sigsworth (Director of Nursing)	Guy Young (Head of Patient Experience)

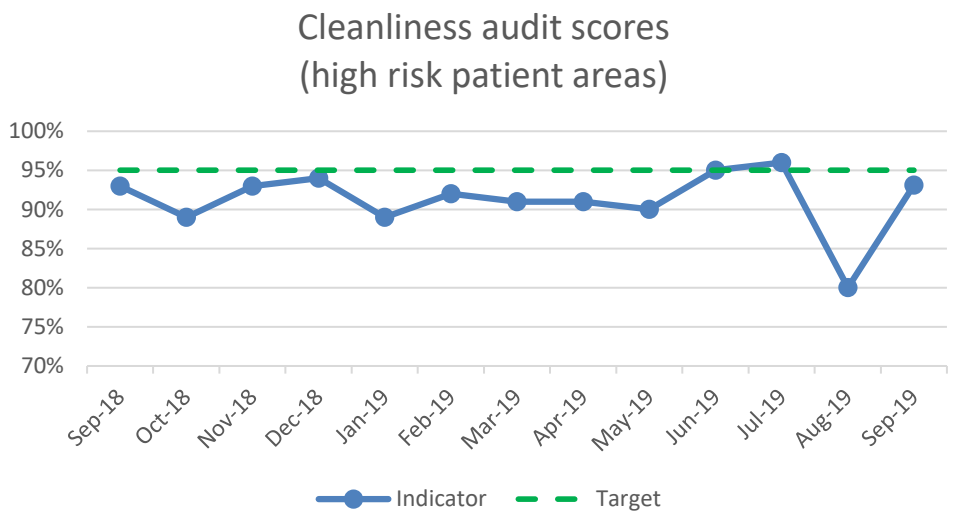


Issues and root cause	The percentage of eligible staff compliant with level 3 safeguarding children training has dropped to 86% which is below our 90% target. This appears to be related to new starters waiting who are yet to complete their level 3 training.
Key updates	Training sessions have been scheduled every week up to the Christmas holiday period and clinical divisions have been instructed to ensure eligible staff attend.

Safe – Cleanliness audit scores

Indicator	Target	Latest data	Executive lead	Report author(s)
Cleanliness audit scores	98% or greater (very high risk); 95% (high risk)	September 2019 compliance was 88.5% (very high risk) and 93.1% (high risk)	Janice Sigsworth (Director of Nursing)	Hugh Gosling

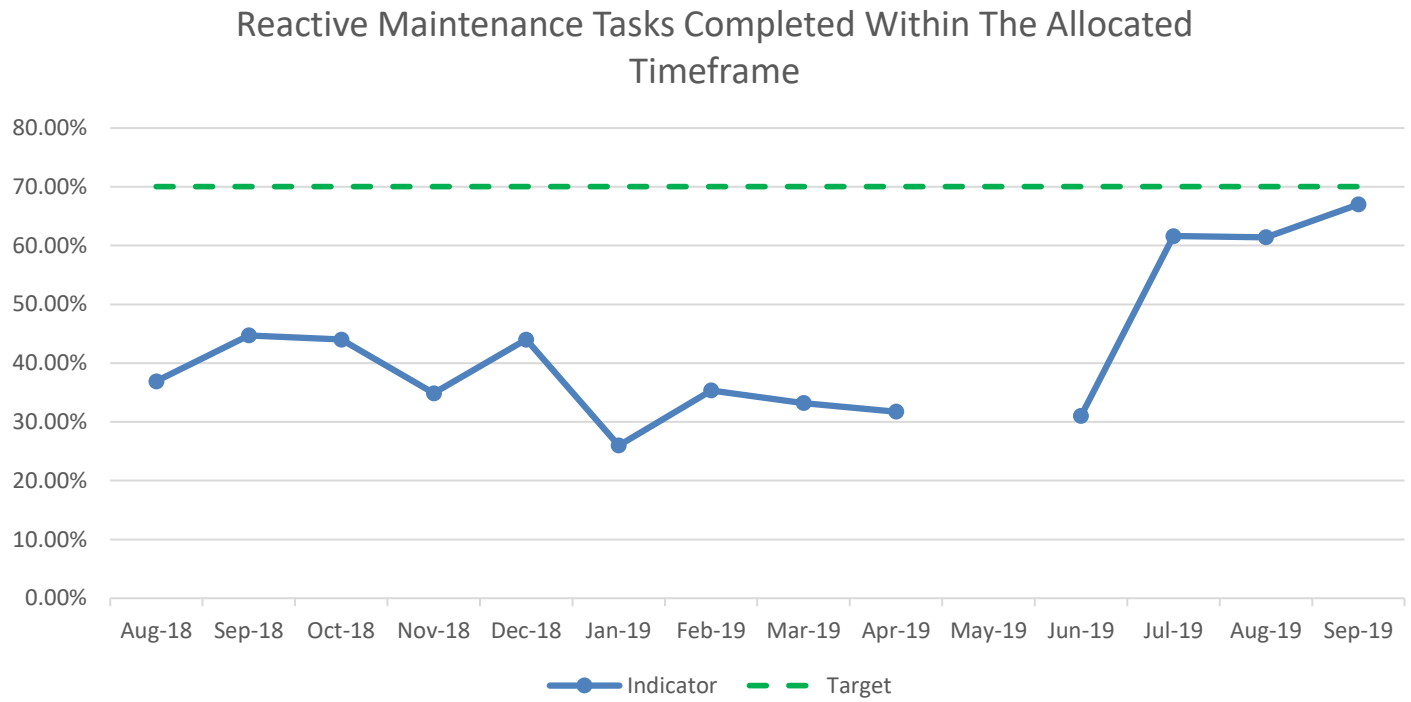




Issues and root cause	The main issue is inconsistent cleaning provision across the trust estate a combination of domestic services, training, equipment and access. Regular cleaning audits are performed as part of a scheduled regime of cleaning and auditing of standards. For the September audits of high risk areas the following is noted: Very High Risk: There was 1 audit within 2% of achieving a pass and if that 1 audit had met the target then cleanliness audit score would have been 934 % in September; High Risk: There were 14 audits that were within 2% of achieving a pass and if these 14 audits had met the target then cleanliness audit score would have been 95% in September.
Key updates	➢ Close monitoring of the cleaning service continues to be undertaken and issues escalated to the contractor. ➢ Cleaning is closely monitored through the corporate risk register *ID 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust.* ➢ Risk reduction plan for higher risk areas with low cleaning scores being developed.

Safe – Reactive maintenance

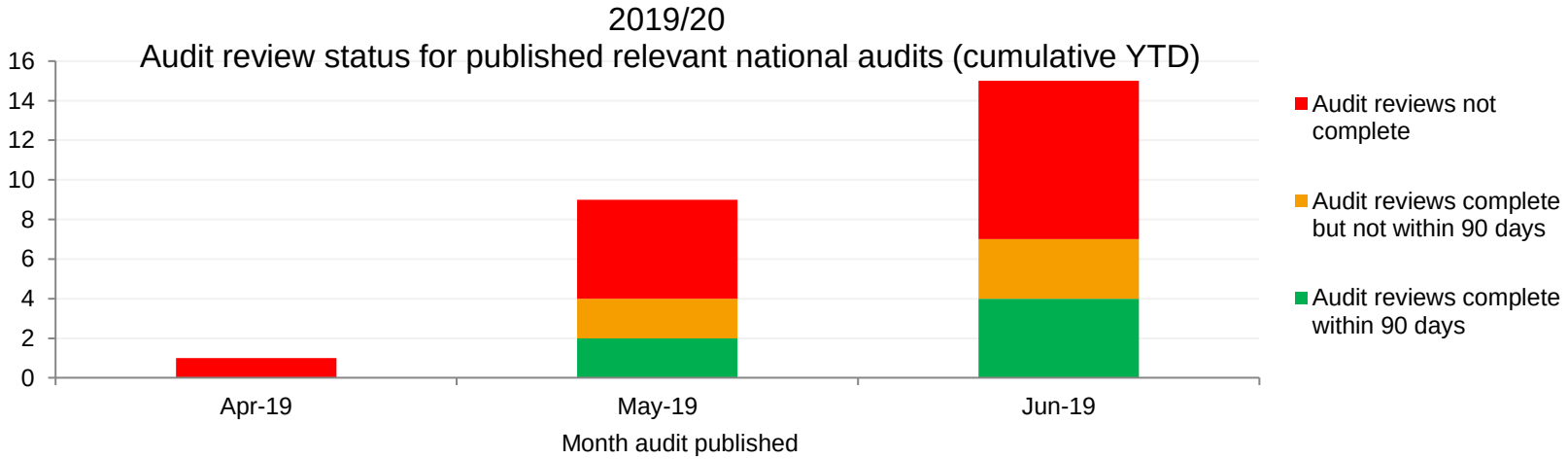
Indicator	Target	Latest data	Executive lead	Report author(s)
Reactive maintenance	70% or greater	September 2019 compliance was 67%	Janice Sigsworth (Director of Nursing)	Andrew Murray (Head of Facilities)



Issues and root cause	• High volumes of work over and above expected base level. • Issue identified with duplicate reporting and resolution of this is part of the work streams within the estates improvement group meetings.
Key updates	Performance continues to improve and is being closely monitored through the estates improvement meetings which includes divisional representation.

Effective – National clinical audit

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits Number of audits that have not completed the review process within 90 days	87% – YTD 11 – YTD (3 complete but not within 90 days, 8 outstanding)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor



Latest performance	Data is reported on a monthly basis, but the data presented here is three months in arrears to allow time to go through the Trust internal review process. Fifteen national audit reports have been published so far this year, all of which were relevant to the Trust. Our participation rate for national clinical audits published is currently 87% (13 / 15 audits). This is because, as previously agreed at executive quality committee in July, we did not participate in two of the audits which are run by the British Associate of Urological Surgeons (BAUS). Assurance on outcomes was due to be reviewed through a separate report to the clinical audit and effectiveness group (CAEG) in October using CRAB data, however this was not available at the meeting. This has been escalated to the divisional director and will be discussed at the next CAEG meeting, with an update on progress provided to quality and safety sub-group. Divisional reviews were completed within 90 days for 4 of these audits. Reviews were completed for 3 of them outside of the 90 day deadline. Eight reports are outstanding and overdue. Five of these reports are from MIC, and three from SCC. There have been no audits identified as significant risk so far.
Return to target / trajectory	Progress is tracked weekly at the MD incident panel.

Effective – National clinical audit

Issues and root causes	There are issues with the timely review and risk assessment of audit reports by divisions within the internally set target of 90 days. So far this year, 31% of reviews were completed within 90 days, compared to 65% in 2018/19. The 8 outstanding and overdue reviews have been escalated to the divisions through the clinical audit and effectiveness group and the medical director's incident review panel. These are expected to be completed by the end of Q3.

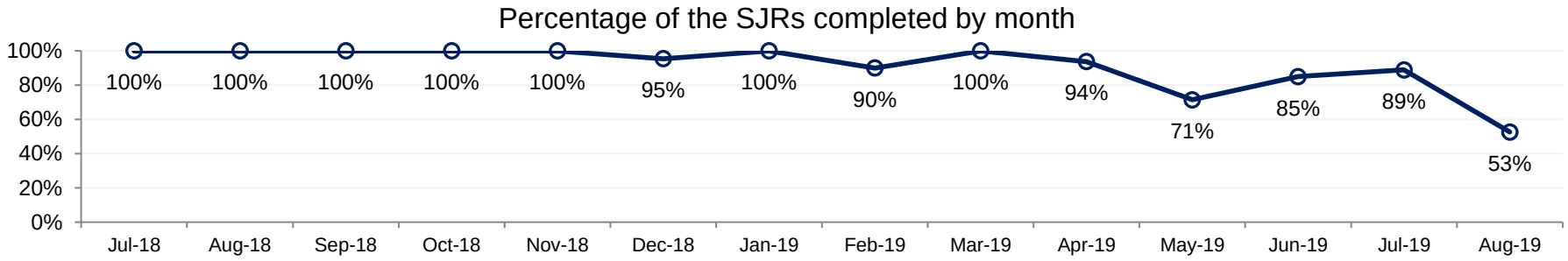
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Overdue audits escalated at the weekly Friday MD panel for review.	Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings. Escalation in place for a number of outstanding audits with dates of completion agreed for all.

Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2136) Failure to deliver the Trust's requirements as part of the national clinical audit programme)

Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJRs not complete within 30 days of request: 62.6% YTD Outstanding cases 2018: 3 2019: 23 outstanding cases Avoidable deaths: 3 (YTD)	Julian Redhead, Medical Director	Trish Bourke, Mortality Audit Manager



Latest performance	• The graph above shows the percentage of SJRs completed by month. • We continue to have an issue with meeting our performance target for the completion of SJRs within 30 days of request; our YTD performance is 62.6% not completed within the timeframe which is similar to last month's performance. There are a total of 3 SJRs that remain outstanding from 2018/19, and 23 SJRs outstanding from April-August 2019. • Since the last report, two deaths have been confirmed as 'avoidable' following completion of the SJR and review at the mortality review group. These incidents were reviewed at the first learning from deaths outcome review group on 8th November as the findings of the initial investigations into the incidents differ from the SJRs. The final decision will be reported to the board in the next learning from deaths report in January 2020.
Return to target / trajectory	We are continuing to recruit additional SJR reviewers in order to deliver more capacity. SJRs are being reassigned where there is a delay in order to deliver timely outcomes. A full review of our approach and methodology to undertaking mortality reviews has been completed and we intend to revise our scoring system to be in line with the recommended Royal College Physicians (London) methodology. In support of this all outstanding SJRs will be completed, or reassigned, by 25 November 2019. The learning from deaths policy will be reviewed by the end of Q4 to ensure it aligns with the medical examiner service and revised processes. This will lower the time to complete a SJR to 10 days.

Effective – Mortality reviews

Issues and root causes	We continue to have an issue with meeting our performance target for the completion of SJRs within 30 days of request, with 62.6% not completed within the timeframe YTD. This is due to the allocated reviewer not completing it within the allotted timeframe, usually because of capacity issues.

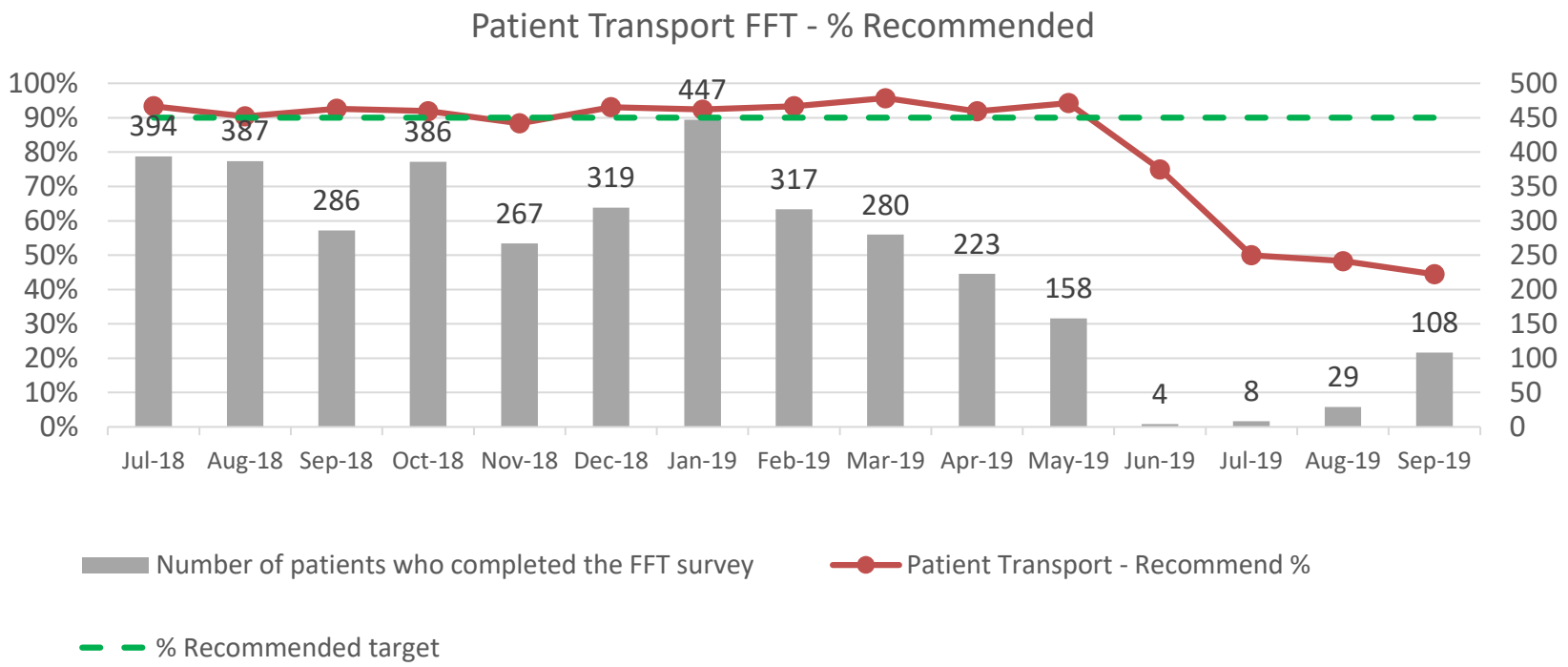
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	Mortality Auditor	June 2019	To increase capacity, recruitment of additional structured judgment reviewers is underway. 3 additional senior nurses were recruited and trained in July. 25 expressions of interest have been received from consultants and next steps are being confirmed. Overdue cases are also escalated to the divisions and reviewer reallocated to where necessary.
Strengthen and formalise the process for triangulating data from cases that have both SJRs and SI investigations undertaken, this includes the recording and accessibility of the data generated.	Head of Quality Compliance & Assurance	Complete	Changes were made in April 2019 to ensure that these two investigatory processes, whilst independent of one another, are appropriately linked. These include presentation of all SJRs with a score of 1-3 at the MD panel, and a new quarterly decision making group, the first meeting of which took place on 8th November. The final decision will be made at this meeting and reported in the next learning from deaths paper to ExQu, quality committee and Trust board.
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Auditor	Complete	Completed for all avoidable deaths reported as at March 2019. Themes and learning from all cases deemed avoidable are now outlined in the regular learning from deaths report.
Undertake review of the mortality processes	General Manager, MDO	December 2019	A full review of our approach and methodology to undertaking mortality reviews has been completed and we intend to revise our scoring system to be in line with the recommended Royal College Physicians (London) methodology. The learning from deaths policy will be reviewed by the end of Q4 to ensure it aligns with the medical examiner service and revised processes. This will lower the time to complete a SJR to 10 days.

Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2439 Learning from Deaths)

Caring – Patient Transport Friends and Family Test - % Recommended

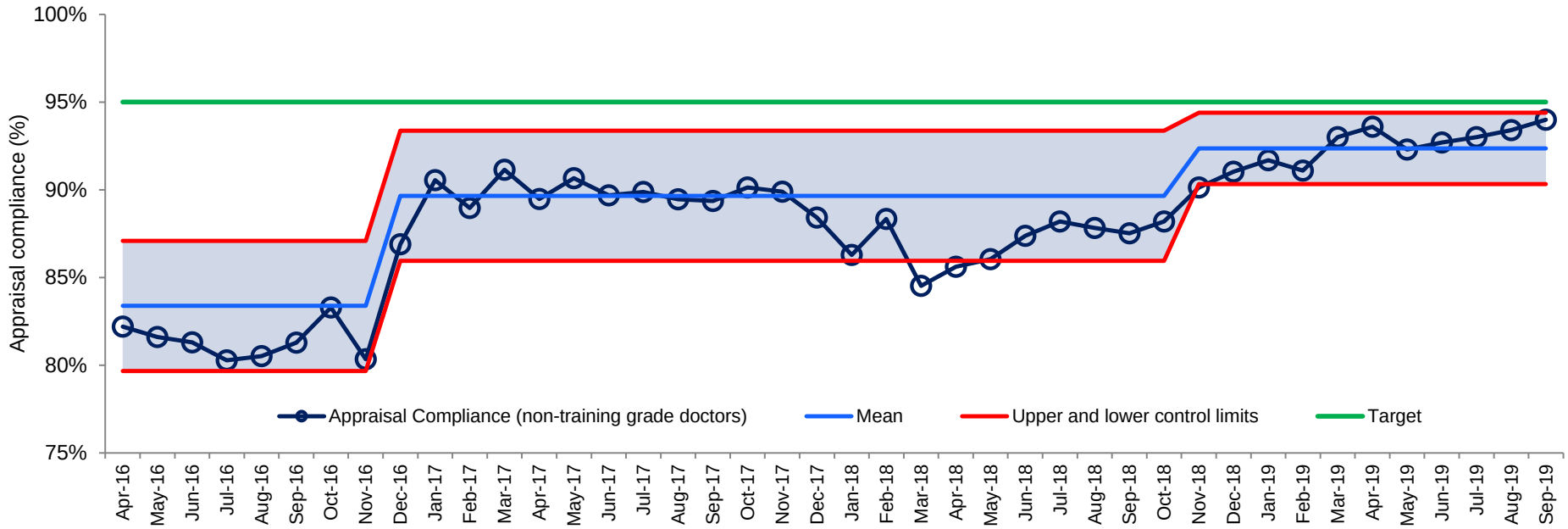
Indicator	Target	Latest data	Executive lead	Report author(s)
Patient Transport - % patients likely to recommend	90% or more	September 2019 compliance was 67%	Janice Sigsworth (Director of Nursing)	Guy Young (Head of Patient Experience)



Issues and root cause	The limited feedback suggests that delays are the main issue. It is important to know that the patient transport FFT response rate is currently very low (less than 0.5%) and the results cannot be extrapolated or considered reliable.
Key updates	There continues to be a focus on improving the patient experience since the introduction of the new contract. The situation is improving and the number of transport complaints is falling, but work is continuing.

Well led – Doctor Appraisal Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	94% - September 2019	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance	Overall compliance has increased from 93.4% in August to 94% in September. This is the highest level of compliance reported since April 2016. The total number of appraisals overdue by more than six months is currently 7, compared to 16 last month and 42 this time last year.
Return to target / trajectory	The target date for achieving the 95% compliance rate was September 2018. This has been added to the risk register as we have not met our internal compliance target. An improvement plan has been developed and is being implemented.

Well led – Doctor Appraisal Rate

Issues and root causes	The appraisal rate for non-training grade doctors has improved but remains below our target of 95%. Reports are circulated to clinical directors and heads of specialty to review which doctors are not compliant with appraisal. All overdue doctors have been written to, and there are plans in place to support individuals that need help to complete their appraisal. The professional development team have developed a more robust tracker which records the actions that have been taken and which level of escalation the overdue consultants are at. Appraisals that are more than six months overdue have been escalated to the Medical Director and the doctors concerned have been advised that failure to engage will result in a referral to the GMC.

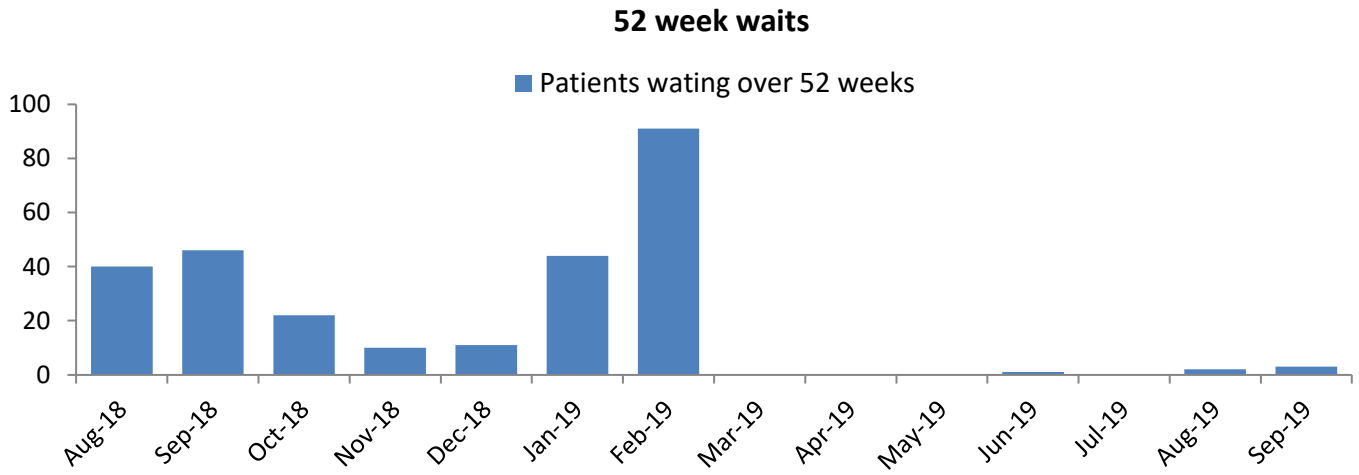
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
External appraiser training	General Manager	October 2019	Four training days have now been completed over the last six months, providing both new and refresher training for over 100 appraisers.
Tackling appraisals that are more than six months overdue	General Manager	December 2019	There are escalation plans in place for all doctors more than six months overdue. This has led to a significant reduction in the total number of six month overdue appraisals
Improved processes within the Professional Development team for managing the Trust's prescribed connections, leading to more accurate data and reporting	General Manager	December 2019	Exploring installing a live link between the appraisal system (PREP) and GMC connect

Risk

- Is it on the (divisional / corporate) risk register? Yes (Risk ID 2810 - Doctors' Appraisal Rates)

Responsive – Referral to Treatment 52 week waits

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT patients waiting > 52 weeks	0	3 (September 2019)	Dr Catherine (Katie) Urch	Jan Palmer



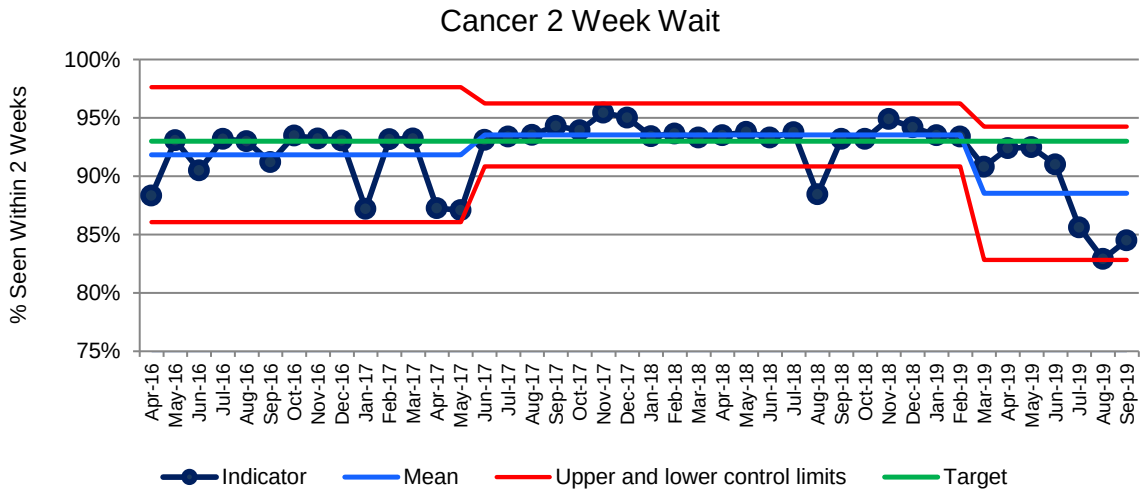
Latest performance

- At end September 2019, three patients were reported as waiting more than 52 weeks for treatment.

Issues and root causes	All three reported breaches were the result of admin errors applying incorrect clock stops being applied at earlier stages in the patient's treatment journey (1 Trauma and Orthopaedic pathway, 1 Plastics pathway and 1 Gynaecology pathway) . All three patients have now received their treatment. Two breaches were pop-ons (a pop-on is defined as a pathway not on the previous month's submission) and the third was identified as an incorrect clock stop in the July RTT Clock Stop Audit and therefore the pathway was re-opened resulting in a breach..
Key updates	• There is on-going review and monitoring of the Trust's long wait position and weekly SRO oversight meetings to support with moving patients through pathways with less delay. • All patients waiting over 44 weeks are reviewed for clinical harm in line with the agreed validation process. The clinical harm review of the August 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

Responsive – Cancer standards

Indicator	Target	Latest data	Executive lead	Report author(s)
In September 2019 the Trust delivered six of the eight national cancer standards.	2WW – 93% target	2WW – 84.5% (September 2019)	Dr Catherine (Katie) Urch	Gareth Gwynn



Latest performance

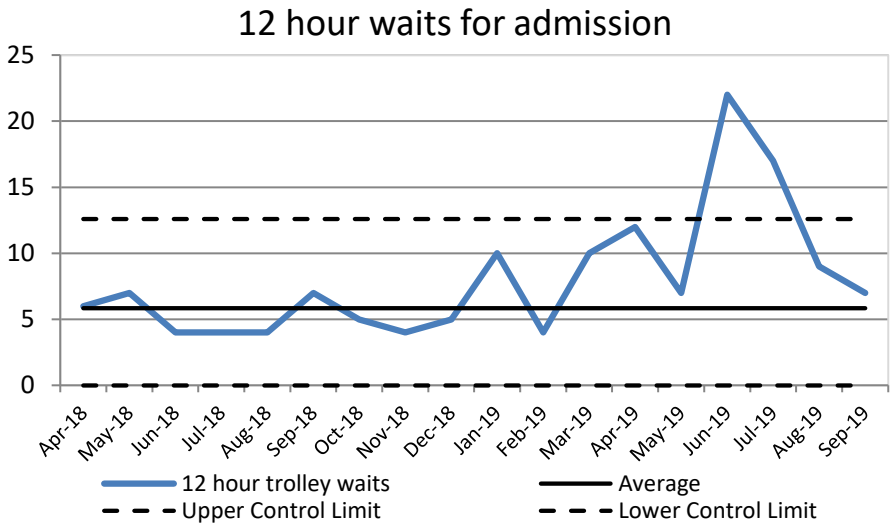
- In September 2019 the Trust delivered seven of the eight national cancer standards.
- The Trust recovered performance against the 62-day screening standard and underperformed against the 2 week wait standard.

Issues and root cause	• Colorectal 2WW capacity impacted by significant increases in demand (35% since 17/18) and delays in delivering the straight to test model to move patients into endoscopy or CTC rather than outpatient appointments following nurse-led triage. • Skin 2WW capacity has also been impacted by significant increases in demand (25% since 17/18) and challenges in securing non-locum supported first appointment clinics.

Key updates	• The 2WW standard recovery trajectory is being established. Key updates are as follows:
	  ○ Colorectal service - recruitment of new nurses to implement the straight to test model. A new consultant appointment in August 2019 has also increased baseline outpatient capacity.
	  ○ Skin service - continues to work with substantive and locum staff to deliver as much capacity as possible. Training commenced with existing CNS staff to allow nurse-led assessment of patients and biopsy to improve available capacity.
	  ○ A non-doctor-led model (ANP or medical photographer) for assessment and biopsy of all skin 2WW referrals has been proposed which mirrors the CWH diagnostic pathway. The business case is under development and is required to map and deliver a recovery trajectory. The Trust is working with Chelsea and Westminster Hospital to share pathway management initiatives and explore the feasibility of triage of 2WW referrals. Pilot Telederm (medical photography) clinics started October 2019.

Responsive – A&E patients waiting more than 12 hours from decision to admit

Indicator	Target	Latest data	Executive lead	Report author(s)
Number of waits for admission over 12 hours from decision to admit (DTA)	0 breaches	7 breaches – Sept 2019	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



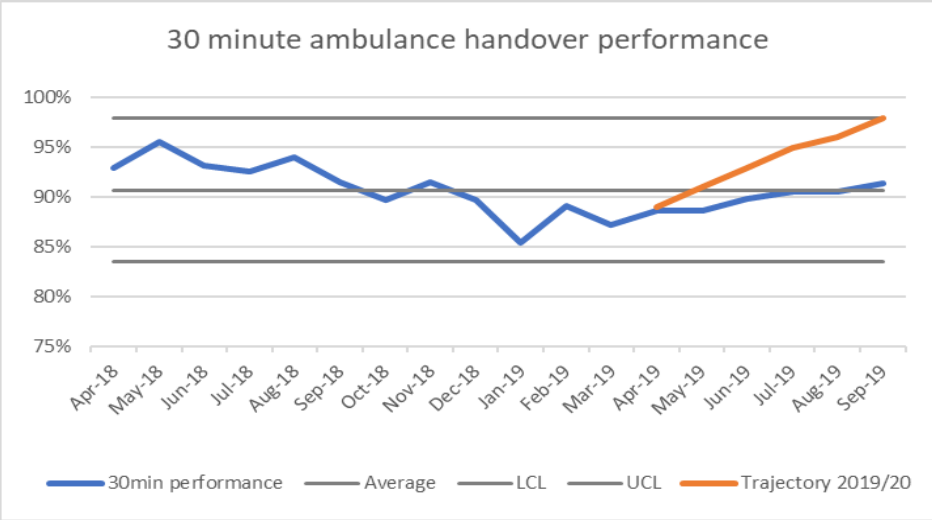
Latest performance

- The number of confirmed twelve hour breaches of wait from DTA to admission fell to 7 in September 2019 compared with 9 in August 2019.
- All breaches were delays in admission to mental health provider beds and occurred at SMH.
- These patients spent an average of 25 hours in the department, with an average of 18 hours from decision to admit (DTA) to admission. These figures are lower than has been seen in previous months.

Issues and root causes	• Lack of available mental health beds • Delays with provision of out of hours HTT (Home Treatment Team) and AMHP (approved mental health professional) resource at SMH • Referrals to Mental Health are increasing, however not to the same rate as 12 hour DTA to admission breaches. • There are more in area breaches currently than out of area.
Key updates	Update from partners at the October A&E Delivery Board included; ➢ 21 first responders and 3 social workers now in place to support improved gatekeeping and access to the Mental Health sanctuary (assessment lounge) at The Gordon Hospital. ➢ There was agreement for improved joined up working on Urgent and Emergency Care standards for mental health patients so that data can be captured in a more useful way for the system. ➢ Results of recent audit of mental health pathways carried out by the national emergency care intensive support team to be shared. ➢ Training day for staff planned for 29/11.

Responsive – Ambulance Handovers

Indicator	Target	Latest data	Executive lead	Report author(s)
Ambulance handover delays	September 2019 98%	September 2019 91.4%	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



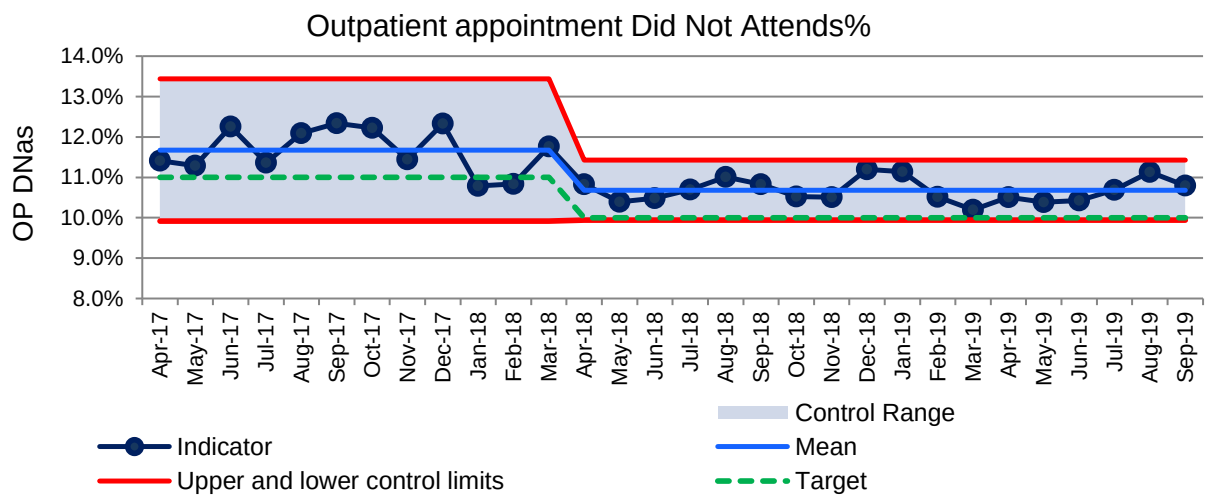
Latest performance

- Performance against the 30 minute handover standard increased to 91.4% in September 2019 compared to 90.6% in August. This is 6.6% below the trajectory.
- Performance at CXH rose by 1.4% from 92.4% in August 2019 to 93.8% in September 2019.
- SMH performance increased 0.5% from 89.3% to 89.8%. This is the fourth consecutive month with an improvement.
- From October 2019 the target is 100%.

Issues and root causes	• Impact on CXH department logistics and capacity during refurbishment • High volumes of ambulance arrivals within a short period at the SMH site.
Key updates	➢ CXH improvement timescales linked to new build opening. The department is already seeing improvements in weekly data direct from LAS. ➢ Dedicated receptionist at CXH commenced. ➢ Rapid Assessment space is now open. ➢ 30 minute handover breach number to be added to the internal daily sitrep and discussed daily at the site meeting. ➢ Exemplar programme to start October 2019. *This is an initiative led through NHSE to share learning to improve handover times across 'exemplar' sites. Further updates to be provided as the programme becomes clearer.* ➢ Winter meetings with local LAS operational leads established from 17 October 2019.

Responsive – Outpatient DNA

Indicator	Target	Latest data	Executive lead	Report author(s)
The percentage of booked outpatient appointments (including diagnostics) where the patient did not attend	10%	10.8% (Sept 2019)	Tg Teoh	Danya Cohen (General Manager) Bec DuBock (Performance Support Business Partner)



Latest performance

The DNA performance was 10.8% in September 2019, above the target of 10.5%. Compared to the previous month this is a 0.3% decrease (August 2019 reported 11.1% and to performance in September-18 10.9%).

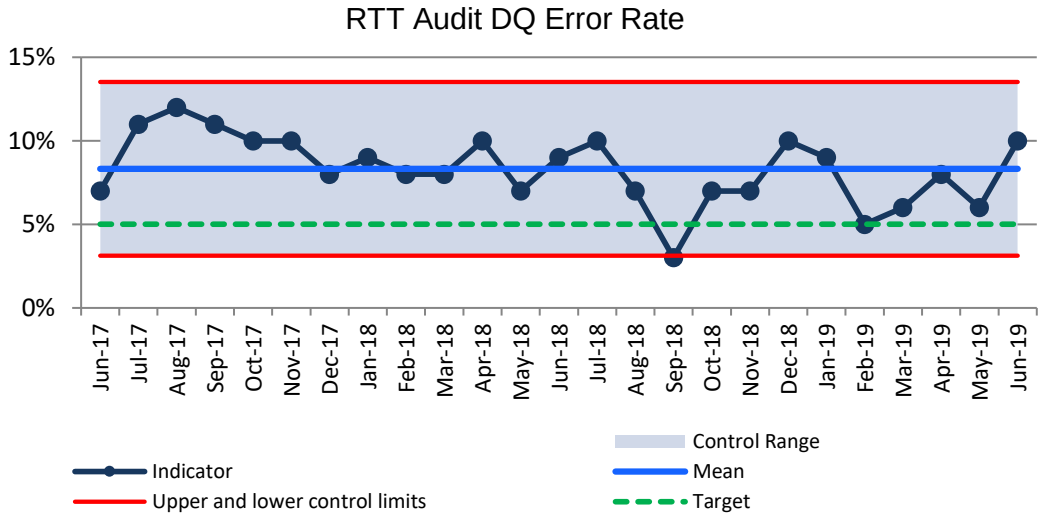
By Division the performance is:

- SCC: 10.8%
- MIC: 12.4%
- WCCS: 8.4%

Issues and root cause	• The reasons for patients not attending appointments are multifactorial. There has been renewed efforts by the clinical divisions to audit their DNA rates to understand specific factors that are contributing to higher non-attendance rates in certain specialities.
Key updates	➢ Additional work to ensure all areas are utilising text messaging. ➢ Improvement work with cardiology underway in the Patient Services Centre to coordinate the booking of diagnostic test and outpatient appointments to reduce calls to patients. This is so that patients only receive one call for the linked diagnostic and outpatient appointment. ➢ Mid-year deep dive completed in October 2019 highlighted 12 of the 17 actions have been completed to support the improvement to the DNA rate. The on-going improvement work for the Care Information Exchange awareness will also support the patient in their awareness and management of upcoming appointments. It is hoped this will reduce the DNA rates as well.

Responsive – RTT Audit Error Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT Audit Error Rate	5%	10% (June 2019)	Dr Catherine (Katie) Urch; Claire Hook.	Caroline O'Dea (Business Partner, Performance Support Team)



Latest performance

- The Trust latest RTT Audit error rate reported for June 2019 was 10%. This equates to a total of 99 incorrect clock stops found through audit for the submission month of June 2019.
- SPC analysis of the last 2 years RTT audit results shows the process is within control limits, however there has been no consistent trend seen yet to evidence a significant improvement to RTT data quality.

Issues and root cause	• Root cause analyses have shown an increase in the number incorrect clock stops applied at outpatient check out, reporting 64% in June compared with 28% in May. • A new issue was identified through the RTT audit process for data reported in June whereby an incorrect stop was being added at pre-assessment clinics in two services. The Elective Care Training team provided a rapid response to train highlighted staff within the department to ensure the codes are used correctly going forward.
Key updates	• All 3 divisions have reported increased RTT audit error rates for June 2019 since the previous month. • The Elective Care Training Team continues to provide both speciality-specific and rapid response training aligned to the results of the RTT audit and monthly data quality performance. • It was originally anticipated that the RTT audit would return to the best practice 5% error rate in September 2019. However this is now expected November 2019. This is due to multiple transitional work streams in the Surgery division that are planned to deliver throughout September – November. These include (i) replacing agency validation teams with substantive pathway co-ordination teams; (ii) Qubit Phase 3 roll-out including management reporting tools which will facilitate smart validation to maximise benefits; and (iii) roll-out of the elective care training rapid response and learning cycle.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Finance Report for October 2019	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27th November 2019	**Item 11, report no. 08**
Responsible Executive Director: Richard Alexander, Chief Financial Officer	**Author:** Janice Stephens, Deputy Chief Finance Officer Michelle Openibo, Associate Director: Business Partnering

Summary:

This paper provides the Board with an update on the financial position for the Trust for the seven months until the end of October 2019.

At the end of October the Trust is £3.8m better than the plan year to date due to additional non-recurrent income received.

The Trust is behind plan with cost improvement programmes and further work is being undertaken to ensure that the full year control total of £16.0m deficit is met.

Capital is behind plan year to date but forecast to catch up in order that the Trust meets its capital resource limit.

Recommendations:
The Committee is asked to note this paper

This report has been discussed at:
N/A

Quality impact:
N/A
This paper relates the CQC domain well-led.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
This report relates to risk ID:2473 on the trust risk register - Failure to maintain financial sustainability

Workforce impact (including training and education implications):
N/A

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☒ No

What impact will this have on the wider health economy, patients and the public? ☐ Yes ☐ No ☒ Not applicable
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic objectives supported by this paper: Retain as appropriate: ▪ To develop a sustainable portfolio of outstanding services
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No ▪ Should senior managers share this information with their own teams? Yes

FINANCE REPORT – 7 MONTHS ENDED 30th October 2019

1. Introduction

This report provides a brief summary of the Trust's financial results for the 7 months ended 30th October 2019

2. Financial Performance

The Trust has set a plan to meet the control total of £16.0m deficit before Provider Sustainability Funding (PSF) and Marginal Rate Emergency Threshold Funding (MRET). After these top-ups the Trust is planning to deliver a £11.1m surplus.

The Trust is £3.8m better than plan in month and for the 7 months year to date before PSF and MRET. The Trust has received additional income in month for estates works. The Trust operational teams have completed a forecast that is £6m worse than plan. This has improved significantly over the past 3 months as additional benefits have been identified and delivered. The Trust expects to meet the control total for the financial year.

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	103.00	107.81	4.82	675.31	691.04	15.72
Pay	(54.38)	(55.77)	(1.39)	(378.18)	(386.42)	(8.25)
Non Pay	(41.55)	(42.35)	(0.80)	(284.78)	(287.33)	(2.55)
Internal Recharges	0.00	0.00	(0.00)	0.00	0.00	(0.00)
Reserves	1.68	2.84	1.16	5.18	4.19	(0.99)
EBITDA	8.75	12.54	3.79	17.54	21.47	3.93
Financing Costs	(3.56)	(3.87)	(0.31)	(25.74)	(26.17)	(0.43)
SURPLUS / (DEFICIT) inc. donated asset treatment	5.19	8.67	3.48	(8.19)	(4.70)	3.50
Donated Asset Treatment	(0.32)	(0.00)	0.32	(1.46)	(1.12)	0.33
Impairment of Assets	-	-	-	-	-	-
CONTROL TOTAL	4.87	8.66	3.80	(9.65)	(5.82)	3.83
PSF Income	1.68	1.68	(0.00)	7.58	8.55	0.97
MRET Income	0.85	0.85	-	5.97	5.97	-
SURPLUS / (DEFICIT) after PSF/MRET Income	**7.40**	**11.20**	**3.80**	**3.90**	**8.70**	**4.80**

2.1 Provider Sustainability Funding

PSF is assessed on a quarterly basis on achievement of the control total. Based on the current position the Trust is assuming 100% achievement of 2019/20 PSF. The Trust has received an additional £0.97m of PSF relating to 2018/19. This funding cannot be used to help meet the control total.

2.2 NHS Activity and Income

The summary table shows the position by division. The Trust is over plan on income year to date for both local and specialist commissioners. In this year's contract with NWL commissioners, the Trust has a cap of 1% before over performance is paid after which we are paid marginal rate of 70%. Based on current activity the marginal rate for the trust is c55% of income. This is what has been shown in the divisional position. Payment for over-performance is not guaranteed and must be agreed across the sector.

Divisions	Year To Date Activity			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	575,402	521,686	(53,716)	168.91	175.89	6.98
Division of Surgery, Cancer & Cardiov.	451,584	469,544	17,960	212.51	208.60	(3.91)
Div of Women Children & Support Servs	1,557,918	1,718,411	160,493	97.13	98.87	1.74
Central Income	(319)	21,751	22,070	71.65	77.93	6.28
Clinical Commissioning Income	**2,584,586**	**2,731,393**	**146,807**	**550.20**	**561.29**	**11.09**

Medicine and Integrated Care (MIC) is over performing on acute non-elective activity across all sites. Surgery, Cancer and Cardiovascular (SCC) is below plan on elective activity, especially in cardiac and clinical haematology. Women, Children and Clinical Support (WCCS) is ahead of plan year to date with additional activity over plan in paediatric care offset by reduced births.

2.3 Private Patient Income

Private income is ahead of plan year to date and in month. There has been significant growth in private income across the Trust in year and income is forecast to be £3m higher this year than in 2018/19. The clinical teams and Imperial Private Health team have been working to identify further growth plans for private activity in future years.

2.4 Clinical Divisions

The financial position by clinical division is set out in the table below.

		In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	26.91	28.46	1.54	178.62	185.58	6.97
	Expenditure	(18.14)	(19.97)	(1.83)	(131.45)	(139.39)	(7.94)
	Internal Recharges	(1.05)	(1.13)	(0.08)	(7.36)	(7.31)	0.05
		7.72	7.36	(0.36)	39.80	38.89	(0.92)
Surgery, Cancer and Cardiovascular	Income	33.13	32.46	(0.67)	215.48	211.76	(3.72)
	Expenditure	(25.66)	(25.86)	(0.21)	(180.22)	(179.37)	0.85
	Internal Recharges	1.48	1.28	(0.20)	10.38	10.48	0.10
		8.95	7.88	(1.07)	45.64	42.87	(2.77)
Women, Children & Clinical Support	Income	15.78	15.50	(0.28)	102.29	103.12	0.83
	Expenditure	(17.86)	(17.79)	0.07	(125.16)	(126.88)	(1.73)
	Internal Recharges	2.05	2.07	0.02	13.33	13.17	(0.16)
		(0.04)	(0.22)	(0.18)	(9.53)	(10.58)	(1.05)
Imperial Private Healthcare	Income & Expenditure	2.47	2.78	0.31	15.80	16.37	0.56
	Internal Recharges	(2.48)	(2.23)	0.25	(16.35)	(16.34)	0.01
		(0.01)	0.56	0.56	(0.55)	0.02	0.57
Total Clinical Division		**16.62**	**15.57**	**(1.05)**	**75.36**	**71.20**	**(4.17)**

MIC is £0.9m worse than plan year to date. The division is significantly over plan on income from non-elective activity with additional costs to deliver the income. The cost of meeting the additional demand has put strain on the division's ability to meet efficiencies. The unmet CIP and the additional activity costs are causing the division to be over plan on expenditure.

SCC is £2.8m worse than plan year to date. The division is behind plan on income due to elective underperformance. The division is over plan on private income, which is shown in internal recharges. The division has not been able to reduce costs to match the underperformance on income.

WCCS is £1.1m worse than plan year to date. The division is over plan on income but has not been able to achieve its savings plan causing an overall adverse position.

Imperial Private Health (IPH) is favourable to plan, overall income is ahead of plan with marginal cost increases.

3. Efficiency programme

The Trust has set a Cost Improvement Plan (CIP) of £57m to meet the deficit plan for the year. The Trust is £6.5m worse than plan year to date on where plans for CIPs have not yet been identified.

To deliver sustainable cost improvements the Trust has decided to focus on pay efficiencies in year, especially on reducing temporary staffing costs. The Project Management Office is working with clinical and corporate teams to identify improvements to meet the underlying plan. All schemes go through a quality assessment to ensure that there is no effect on patient care.

4. Cash

Cash balances have increased by £29.5m year-to-date and stand at £56.3m at the end of October. The key driver in the increase is receipt of PSF for 2018/19. The Trust is forecasting to reduce the cash balance as the year continues, with additional spend on capital expected in line with the capital forecast.

5. Capital

The Trust's capital programme is focused on tackling the significant challenges arising from the age and condition of the estate whilst continuing to invest in equipment and ICT required to deliver effective services.

The Trust has spent £24.4m of capital against a plan of £25.6m, this underspend has been due to the phasing of specific projects and the spend is expected to meet the plan by the end of the financial year.

6. Conclusion

The Trust is on plan year to date and is expected to meet the control total. The Trust must identify and deliver recurrent efficiencies to ensure that the plan for next year is achievable.

7. Recommendation

The Trust Board is asked to note the report.

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TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: CQC Update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 November 2019	**Item 12, report no. 09**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Author:** Kara Firth, Head of Regulation

Summary of key points:

- Since the previous update:
  - The CQC has asked the Trust to investigate one complaint.
  - Some whistleblowings have been made to the CQC which all specifically relate to safe medical and nurse staffing out of hours at Charing Cross Hospital.
    - The CQC has not asked the Trust to take any action in relation to these; however, the Trust's internal response is included in this update.
- Following inspection of the Trust's GP practice in July 2019, the reports have now been published on the CQC's website.
- The CQC held an engagement meeting with the leads and representatives for the Trust's cancer services, as well as its regular engagement meeting for the Trust overall, on 3 October 2019.
- The CQC is planning to introduce new core services relating to cancer, beginning in 2020/21. The frameworks for these inspections are currently in development, which the Trust is contributing to.
- No inspections have been carried out since the previous CQC update to the board; there is still no intelligence about which services they CQC may inspect at the Trust in the current financial year.

Recommendations: To note the updates.

This report has been discussed at: Executive (quality) committee on 05/11/2019 and Trust quality committee on 13/11/2019.

Quality impact: This paper applies to all five CQC domains.

Financial impact: This paper has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
Risk 81 (corporate risk register): *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*

Workforce impact (including training and education implications): None

Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable

What impact will this have on the wider health economy, patients and the public? As declared in the Trust's strategic goals below.

The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No

CQC Update

1. Purpose

1.1. This paper presents the regular CQC report to the board, covering September and October 2019.

2. CQC Registration Fees

2.1. The CQC has announced that there will be no changes to its registration fees for 2020/21.

3. Inspections

3.1. Following an inspection of the GP practice carried out on 8 and 9 July 2019, the inspection reports were published 11 October 2019.

- The summary report and evidence table can be accessed by clicking on the link for each site where the practice is located (Charing Cross Hospital and Hammersmith Hospital).
  - Click on either the 'all reports' tab or on one of the practice's population groups (listed on the right hand side).

3.2. No inspections were carried out at the Trust since the previous update.

4. Concerns, Complaints and Whistleblowing Raised with the CQC

4.1. Since the previous update the CQC asked the Trust to investigate one complaint, which related to a complainant being dissatisfied with the Trust's response to their complaint.

- The CQC was satisfied with the Trust's handling of the original complaint and consider the matter closed.

4.2. On 16 October 2019, the CQC contacted the Trust in relation to a collection of whistleblowings made to them which all related to safe medical and nurse staffing out of hours at Charing Cross Hospital.

- No details were shared with the Trust in terms of areas or what was meant by unsafe staffing; it was therefore agreed with the CQC that a broad investigation would be undertaken which included vacancy and fill rates, presence of senior staff on shifts, wards which senior staff have concerns about, and any concerns raised internally by junior staff.
- In its response to the CQC, the Trust provided initial data and information, and set out a series of activities which will be undertaken during November and December 2019 to investigate the matter.
  - A review of medical staffing rotas by the divisional directors and the Trust's People & Organisational Development team.
  - 'Snapshot audits' of clinical during nights and weekends by senior nurses and the Trust's site team.
  - A deep dive of incidents in areas with the highest number of incidents (this review has yet to be commissioned; the lead is not yet known).
  - The Trust will provide a full response to the CQC in January 2020.

5. CQC Engagement

5.1. The latest face to face quarterly CQC engagement meeting took place on 3 October 2019.

- The first part of the meeting was held with leads and other representatives from the Trust's cancer services.
  - The CQC considered the meeting to be largely positive and indicated they have no concerns in relation to cancer services at this time.
- The CQC has been considering introducing a new core service relating to cancer; this work has progressed and the CQC indicated that it is now expected there will be four core services relating to cancer:
  - Radiotherapy, which is likely to be a core service at the Trust
  - Chemotherapy, which is likely to be a core service at the Trust
  - Haematology, which is likely to be a core service at the Trust
  - Adult solid tumour, which the CQC is not certain at this time, will be a core service at the Trust
- Once the new core services are finalised, the areas of services they cover within the Trust will be removed from the core services where they currently sit, i.e. radiotherapy will be removed from Outpatients, chemotherapy and haematology will be removed from Medical care.
- The inspection frameworks for the new core services are currently in development, with an expectation that they will begin to be used in acute trusts in 2020/21.
  - The Trust lead for corporate cancer offered to engage with external colleagues to arrange an event for reviewing the draft framework and providing feedback to the CQC, to help ensure the framework is fit for purpose in assessing cancer services within acute trusts.
  - The CQC has welcomed this offer and has indicated that its leads for this work will participate in any such event.

5.2. The second part of the engagement meeting was for Trust-level matters; there is nothing of note to report in relation to this.

5.3. In line with normal practice, Trust responses to matters raised by the CQC in the engagement meetings were submitted after the meetings, along with additional information the Trust wished to share with the CQC.

- On this occasion, a significant amount of data and information about cancer services at the Trust was shared with the CQC.

6. CQC Insight

6.1. Changes to Trust-level indicators in the September and October 2019 CQC Insight reports compared to previous reports were as follows:

- Performance in relation to one measure has declined: we are now performing **worse than other trusts** when compared nationally for 'stability of other clinical staff'
- Following de-escalation of one never event (i.e. it is now considered a serious incident rather than a never event) we are now performing the **same as other**

trusts when compared nationally (previously we were performing worse than other trusts on this measure).

- We have improved on the following measures and are now performing **better than other trusts** when compared nationally for:
  - Sick days for non-clinical staff
  - Turnover rate for medical and dental staff.
- The only change to a Trust-level indicator in the CQC Insight report for October 2019 was that the Trust's performance has improved in relation to potential under-reporting of patient safety incidents resulting in death or severe harm. The committee will recall that between June and September 2019 (inclusive) the Trust was performing worse than other trusts on this measure; however, the Trust is now performing about the **same as other trusts** for this indicator.

7. Preparations for Possible CQC Inspections in 2019/20

7.1. The Improving Care Programme Group (ICPG) continues to oversee preparations for possible CQC inspections.

- ICPG previously took place on a weekly basis.
- During October it was agreed that ICPG would move to every other week, alternating with a more operational meeting between the Director of corporate governance and the divisional directors of nursing.

7.2. A programme of mock CQC inspections to take place during 2019/20 is currently in development; it is anticipated that these will be scheduled for late January and February 2020.

7.3. The second internal CQC PIR refresh, using quarter 2 (Q2) data and information, has now commenced and is expected to be completed in December 2019.

- This PIR refresh will be used to plan the mock inspections (section 7.2).

8. Next steps

8.1. Continue with the current PIR refresh, based on Q2 data and information.

8.2. Continue to prepare for possible CQC inspections during 2019/20.

8.3. The next face-to-face CQC engagement meeting is scheduled to take place on 29 January 2020.

- The Trust's leads for the Surgery core service will meet with the CQC, followed by the normal Trust level engagement meeting.

9. Recommendations for the board

9.1. To note the updates.

Author: Kara Firth, Head of Regulation
27 November 2019

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Corporate Risk Register & Board Assurance Framework	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27 November 2019	**Item 13, report no. 10**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Authors:** Valentina Cappo, Corporate Risk/ Project Manager and Stephanie Goddard, Corporate Governance Manager

Summary:
The Trust Board reviewed the corporate risk register and the Board Assurance Framework at its meeting in March 2019.

Since then, a deep dive review of all corporate risks has been undertaken; the outcomes of this and any further changes are reflected in this paper and have been reviewed by the Executive Committee and by the Audit, Risk and Governance Committee.

The Board Assurance Framework has also been redeveloped, to align it to the Trust's strategic objectives and to incorporate the new approach to assurance, as agreed by Audit, Risk and Governance Committee. The new format and process was presented to the Audit, Risk and Governance Committee in October 2019 and to the Executive Finance Committee in November 2019.

PART 1: Corporate Risk Register

There are 25 corporate risks within the risk register; these include 3 risks that are commercial in confidence or have other confidential information and are therefore not included in this report. The highest risks are scored as 20 and the lowest is scored as 8.

Key themes include:

- Operational performance
- Financial sustainability
- Estates critical equipment and facilities
- Workforce
- Delivery of care (including regulation and compliance, medicines management and safety)
- ICT infrastructure (including cyber security, data quality, infrastructure, Information Governance and security).

Frequency of reporting to the Trust board
The Trust board is the accountable body for risk management at the Trust. The Board delegates authority to the Audit, Governance and Risk Committee to ensure that a robust system of internal control is in place, including risk management. The corporate risk register is therefore presented at each Audit, Governance and Risk Committee meeting and will be reviewed in detail there.

Changes to the Corporate Risk Register
The report includes a summary of changes made to the Corporate Risk Register over the last period. Changes to risks are agreed by the Executive Committee and reported to the Audit, Governance and Risk Committee.

Imperial College Healthcare NHS Trust

PART 2: Board Assurance Framework

This report provides an overview and progress update on the processes and reporting structure for the Board Assurance Framework (BAF), to align the BAF to strategic objectives, to strengthen the approach to assessment of assurances and to align the BAF with Board committees.

Next steps

- The corporate risk register and Board Assurance Framework will be presented to the Audit, Risk and Governance Committee on 4 December 2019.
- The Corporate Risk Register will be presented to the Executive Finance Committee on 19 December 2019 and monthly thereafter.

Recommendations:
The Committee is asked to note the updated corporate risk register and the Board Assurance Framework.

This report has been discussed at:
The Executive Finance Committee (Executive risk committee) and Audit, Risk and Governance Committee meetings between April and November 2019.

Quality impact:
The corporate risks are reviewed by the Executive Committee regularly to consider any impact on quality and associated mitigation.
The report applies to all CQC domains: Safe, Caring, Responsive, Effective and Well-Led.

Financial impact:
Where relevant, the financial impact of the risks presented is captured within the detail of each risk within the corporate risk register.

Risk impact and Board Assurance Framework (BAF) reference:
Evidence of assurance to the effectiveness of controls for risks included onto the Corporate Risk Register is reflected on the Board Assurance Framework.

Workforce impact (including training and education implications): N/A

What impact will this have on the wider health economy, patients and the public?
Individual risks have different impact on the above topics, as reflected within each risk description.

Has an Equality Impact Assessment been carried out?
☐ Yes ☐ No ☒ Not applicable

Paper respects the rights, values and commitments within the NHS Constitution.
☒ Yes ☐ No

Trust strategic objectives supported by this paper:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do.

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Please use the detail outlined in the Executive Summary.

Imperial College Healthcare NHS Trust

PART 1: Corporate Risk Register

1. Background

The Trust Board last reviewed the Corporate Risk Register at its meeting on 24 March 2019. The Board will recall that at that time a deep dive review of the register had been undertaken and it was agreed that a similar review would be undertaken every six months. To this end, a deep dive review of corporate risks took place between August and September 2019 and the outcome is reflected in this paper, together with any further change made between September and November 2019.

As part of the review, for each risk it was considered whether the current risk description is reflective of the actual risk and whether the current and target risk scores and the target risk score date are still appropriate.

1.1 Risk Management Governance

The following risk management governance process is in place within the Trust:

- **Directorate risk registers**; these are in place for all clinical directorates and are discussed and approved at directorate Quality and Safety Committee meetings or equivalent; risks that cannot be managed locally are escalated to the divisional risk register.
- **Divisional risk registers;** these are discussed and approved at the designated forums with responsibility for risk within all clinical and corporate divisions. In the clinical divisions these are the divisional Quality and Safety Committees.
- Key quality divisional risks are escalated to the Executive Quality Committee each month.
- All key divisional risks are presented to the Executive Finance Committee monthly and relevant themes are escalated to the Audit, Risk and Governance Committee at each meeting.
- **Corporate risk register:** This is discussed and approved monthly at the Executive Finance Committee and is presented to the Audit, Risk and Governance Committee at each meeting, and to the Trust Board every six months.

2. Frequency of reporting to the Trust board

The Trust board is the accountable body for risk management at the Trust. The Board delegates authority to the Audit, Governance and Risk Committee to ensure that a robust system of internal control, including risk management, is in place. The corporate risk register is therefore presented at each Audit, Governance and Risk Committee meeting and will be reviewed in detail there. This report provides a summary of the changes discussed and agreed by Audit, Governance and Risk Committee.

3. Changes to the Corporate Risk Register

The following changes have been made to the corporate risk register and approved by the Executive Committee since it was last presented to the board in March 2019.

The following risks have been <u>disaggregated</u>:

- **Risk 2476 -** *Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust;*
  This risk has been closed and the following risk has been escalated onto the Corporate Risk Register in its place:
  - Risk 2946 – *Failure to provide timely access to critical care services***.** The current risk score is 16 (C4 x L4).
- **Risk 2473** - *Failure to meet control total and deliver the financial recovery plan* has been closed and the following risks have been escalated in its place:
  - Risk 3015 - *Failure to meet control total*. The current risk score is 15 (C5 x L3).

- Risk 3014 - *Failure to deliver financial recovery*. The current risk score is 20 (C5 x L4).

The following risks have been de-escalated from the Corporate Risk Register or closed:

- **Risk 2475** – *Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results.*
- **Risk 2697** – *Impact of Paddington Square development on Trust services at St. Mary's Hospital*
- **Risk 2677** – *Risk of failure of Network Core devices as they reach End of Life*

The following risks have been escalated onto the Corporate Risk Register:

- **Risk 2976** – *Effect of knives and rising violence on the Trust.* The current risk score is 15 (C5 x L3)
- **Risk 3057** - *Restrictions and limited availability of capital funding negatively impact Trust's ability to mitigate significant risks and achieve key objectives.* The current risk score is 16 (C4 x L4)
- **Risk 2383** – *Failure to identify poor compliance with legislative and regulatory requirements, including required accreditations.* The current risk score is 8 (C4 x L2)
- **Risk 3038** – *Failure to provide timely transportation for non-emergency patients*. The current risk score is 15 (C3 x L5).

The following risks have been reviewed and their description has changed:

- **Risk 1660** – *Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality.* The risk description has changed to: *Risk of poor waiting list data quality resulting in inaccurate data records, which can lead to delays in patient treatment, inaccurate data sets being published externally and therefore breach of contractual and regulatory requirements and loss of Trust reputation*. The risk score has changed from 16 (C4 x L4) to 12 (C3 x L4).
- **Risk 2944** – *Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas.* The risk description has changed to: *Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas and bands (particularly at Band 5) across the Trust and in areas where there is a national shortage of nurses*.
- **Risk 2613** – *Compliance with General Data Protection Regulation (GDPR).* The risk description has changed to: *Risk of failure to Uphold Rights and Freedoms of Data Subjects (GDPR).* The risk score has changed from 16 (C4 x L4) to 15 (C5 x L3).
- **Risk 2943 –** *Failure to meet ED trajectories.* The risk description has changed to: *Failure to manage non elective flow could lead to failure to meet urgent and emergency care performance standards*. The risk score has changed from 20 (C4 x L5) to 16 (C4 x L4).

The score of the following risks has reduced:

- ***Risk*** – *Commercial in confidence*. The risk score has reduced from 20 (C4 x L5) to 16 (C4 x L4).

The score of the following risk has increased:

- **Risk 2477 -** *Risk to patient experience and care due to delay for mental health patients in the ED*. The risk score has increased from 16 (C4 x L4) to 20 (C4 x L5).

The target risk score dates for a number of risks have been revised.

4. Recommendations

The Board is asked to note the latest version of the Corporate Risk Register, attached at Appendix 1, and to note the summary of changes agreed by the executive team and Audit, Risk and Governance Committee.

Imperial College Healthcare NHS Trust

PART 2: Board Assurance Framework

1. Background

The purpose of the Board Assurance Framework (BAF) is to enable the Board and its committees to ensure that it receives appropriate assurance that all key risks to the achievement of strategic objectives are being effectively managed and to commission additional assurance where it identifies any gaps. This process enables the Board to have confidence in its self-assessment of compliance with regulatory standards and in the year-end reporting.

2. The Board Assurance Framework Process

The Compliance Unit has previously provided updates for each risk based on knowledge from information presented and discussed at Executive and Board Committees. The BAF process has now been reviewed to make it a more 'live' document, involving the Directors providing accurate and up-to-date reviews twice a year, and the categorisation of assurances so the Board can assess the strength of the assurance being provided.

With the launch of the 'Imperial Way' the BAF has been re-aligned to the 3 year strategic objectives. If there are any changes to the objectives during the set 3 years, the Compliance Unit will ensure these changes are reflected within the BAF. The Compliance Unit have met with members of the executive team to initiate a risk assessment of the strategic objectives and seek updates of assurance for each of the current areas of risk. As the Trust proceeds through business planning for 2020/21, these risk assessments will be reviewed again and will be developed further.

In conjunction with the BAF being aligned to the strategic objectives and each risk being updated by the relevant director, the BAF has also been aligned to a responsible Board Committee that will review the relevant risks twice per year prior to the full document being presented to the Audit, Risk & Governance Committee and the Trust Board.

The Board Committees will review the relevant risks ensuring that sufficient assurances received for risks and ensure that the agendas and forward plan for Board committees are driven by the strategic objectives and the management of associated risks. If the Trust Committees feel there is not enough assurance they can request additional assurances or for an action plan to be developed to maintain a high level of assurance.

The schedule of review by Board committees and Trust Board is outlined below. The Trust Board will review the BAF twice a year, following review by Board committees.

Board Assurance Framework - Schedule of Review 2020 — **Appendix 3**

		BAF Presented to:					
	Request to Directors for Updates to the Board Assurance Framework	Executive (Finance) Committee	Audit, Risk & Governance Committee	Finance, Investment & Operations Committee	Quality Committee	Redevelopment Committee	Trust Board
January 2020							
February 2020	24.02.2020 to 06.03.2020						
March 2020		17.03.2020 To Note: BAF in Full					
April 2020			22.04.2020 To Note: BAF in Full; To Discuss: Areas of Concern Specific to this Committee			15.04.2020 To Discuss: Areas of Concern Specific to this Committee	
May 2020				13.05.2020 To Discuss: Areas of Concern Specific to this Committee	06.05.2020 To Discuss: Areas of Concern Specific to this Committee		25.05.2020 To Note: BAF in Full
June 2020							
July 2020							
August 2020	24.08.2020 to 04.09.2020						
September 2020		15.09.2020 To Note: BAF in Full					
October 2020			07.10.2020 To Note: BAF in Full; To Discuss: Areas of Concern Specific to this Committee				
November 2020				18.11.2020 To Discuss: Areas of Concern Specific to this Committee	11.11.2020 To Discuss: Areas of Concern Specific to this Committee	18.11.2020 To Discuss: Areas of Concern Specific to this Committee	25.11.2020 To Note: BAF in Full
December 2020							

Imperial College Healthcare NHS Trust

3. Recommendations

The committee is asked to note the latest version of the BAF, attached at Appendix 2, and to note the changes to the process and the schedule of updates and reviews that will be put in place for future updates.

APPENDIX 1

Corporate Risk Register
Trust Board Committee
November 2019

Scoring Matrix

To calculate the risk score it is necessary to consider both how severe would be the consequences and the likelihood of these occurring, as described below:

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

Key:

Initial Score: The score of the risk when first identified

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

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

Corporate Risk Profile

Risks scored 15:

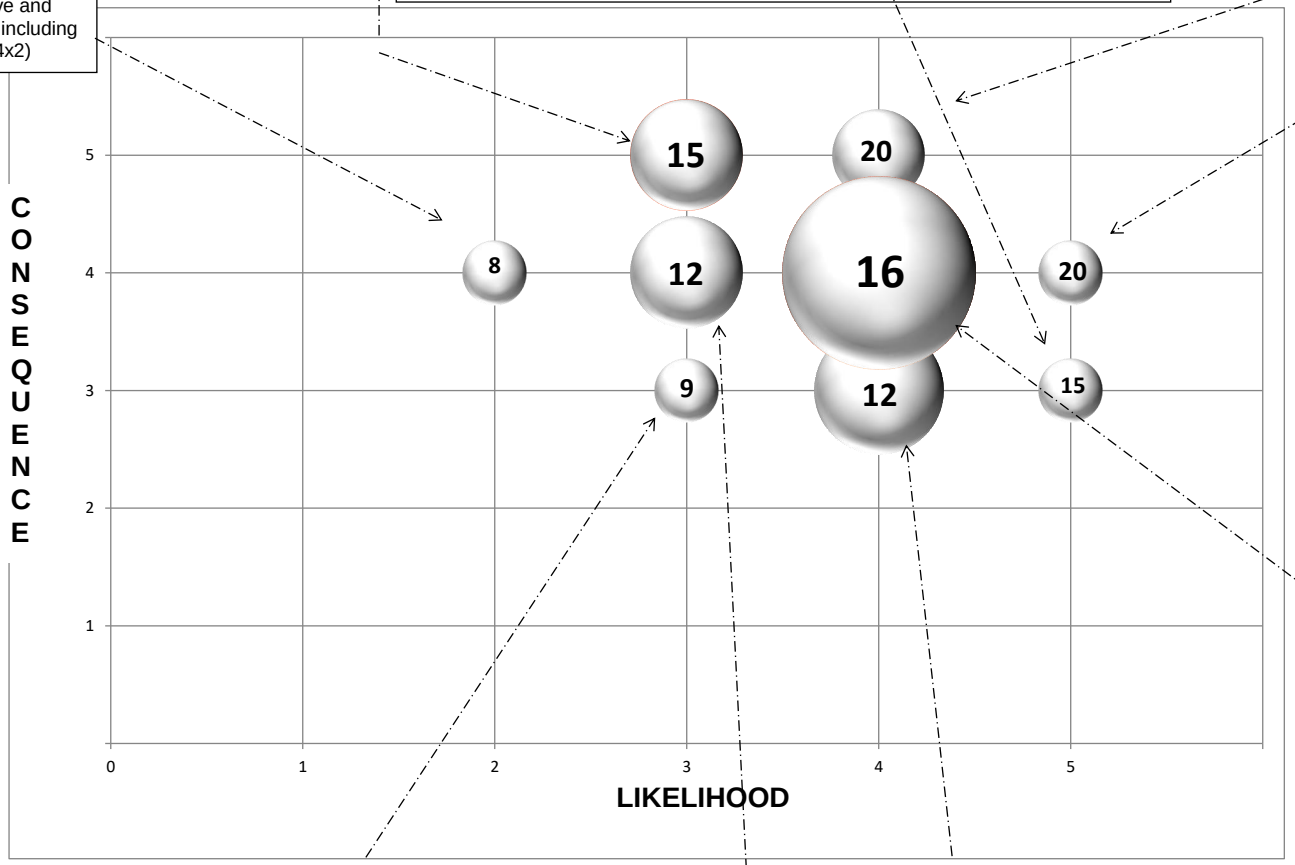
1. *NEW* 2976 Effect of knives and rising violence on the Trust (5 x 3)
2. 2613 Risk of failure to Uphold Rights and Freedoms of Data Subjects (GDPR) (5x3)
3. *NEW* 3015 Failure to meet control total (5x3)
4. *NEW* Risk commercial in confidence (3x5)

Risk scored 8:

1. 2383 Failure to identify poor compliance with legislative and regulatory requirements, including required accreditations (4x2)

Risks scored 20:

1. 2485 Failure of estates critical equipment and facilities (5x4)
2. *NEW* 3014 Failure to deliver financial recovery (5x4)
3. 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (4x5)



Risks scored 16:

1. 2482 Risk of Cyber Security threats (4x4)
2. *NEW* 2946 Failure to provide timely access to critical care services (4x4)
3. 2498 Failure to gain funding and approvals from key stakeholders for the redevelopment programme (4x4)
4. 2942 Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines (4x4)
5. 2911 Risk confidential (4 x 4)
6. 2937 Failure to consistently achieve timely elective (RTT) care (4 x 4)
7. 2943 Failure to manage non-elective flow (4x4)
8. 2902 Risk confidential (4x4)
9. *NEW* 3057 Restrictions and Limited availability of capital funding negatively impact Trust's ability to mitigate significant risks (4 x 4)

Risk scored 9:

1. 2538 Risk of medication safety being adversely affected by poor adherence to medication safety policies (3x3)

Risks scored 12:

1. 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust (3x4)
2. 2944 Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas (3 x 4)
3. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (3 x 4)
4. 1660 Risk poor waiting list data quality (3x4)
5. 2922 Unmanaged Shared Email Boxes - Risk to delay patient treatment (4x3)
6. 2938 Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards (4 x 3)
7. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards (4x3)

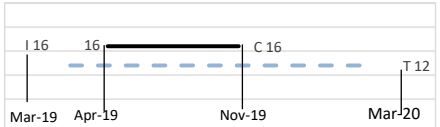
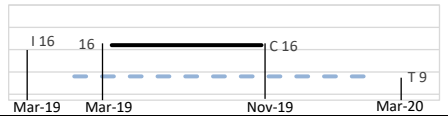
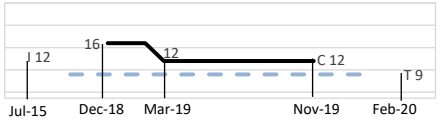
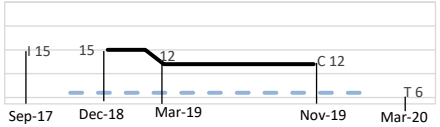
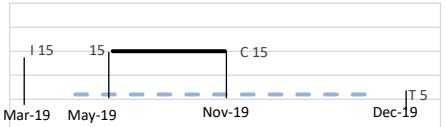
May-19

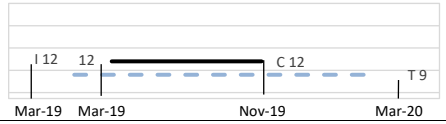
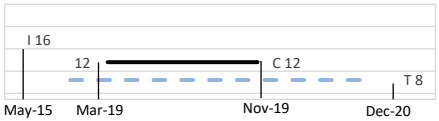
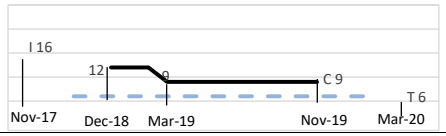
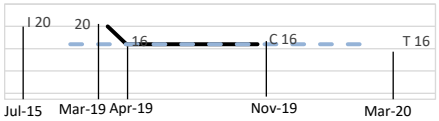
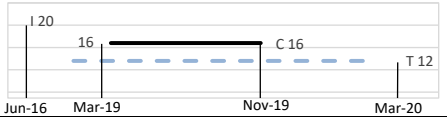
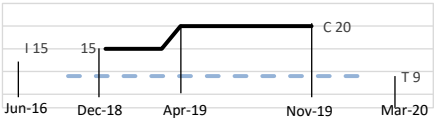
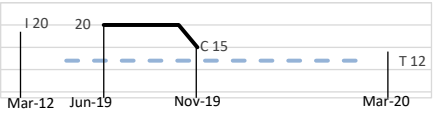
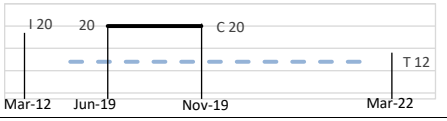
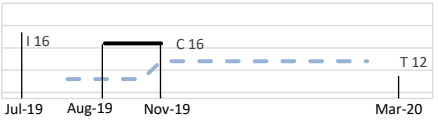
Corporate Risk Register Dash Board

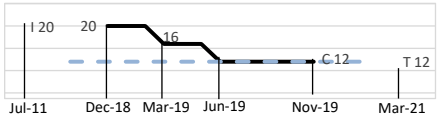
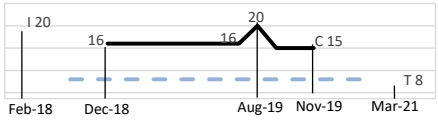
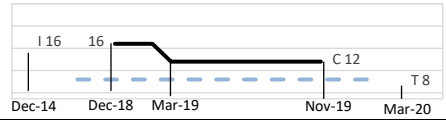
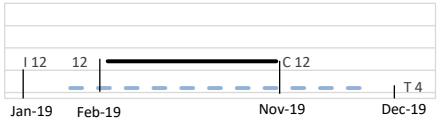
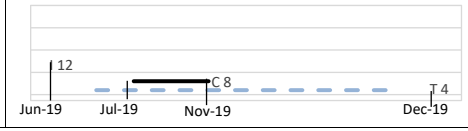
Key:	
♦	Initial Risk Score
▲	Target Risk Score
-------	Benchmark target risk score
IRS	Initial Risk Score
CRS	Current Risk Score
TRS	Target Risk Score

Risk appetite		
Avoid/ Minimal (ALARP - As little as reasonably possible)	**Low**	Strives to avoid risk and uncertainty and works to minimize unavoidable risk. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	**Medium**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Open		Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek/ Mature	**High**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in accepting or setting high levels of risk because controls, forward scanning and responsiveness systems are robust.

Risk Response:	
Treat	The risk is being managed and the mitigation plan is being implemented
Tolerate	Accept that all possible mitigations have been implemented from the Trust and the risk has to be tolerated until further mitigations that are dependent on external stakeholders are implemented
Transfer	The risk can be transferred to a third party (e.g. insurance)
Terminate	The risk is too severe and the Executive has decided to terminate the activity that is causing it

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 5	2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing		IRS 20 / CRS 20 / TRS 15 TRSD initially agreed: Oct-17	Medium	Tolerate
Page 6	2946	Safe Effective	*NEW* Failure to provide timely access to critical care services	Divisional Director of SCC		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Mar-20	Low	Treat
Page 7	2942	Safe	Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines	Medical Director		IRS 16 / CRS 16 / TRS 9 TRSD initially agreed: Mar-20	Low	Treat
Page 8	2487	Safe	Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Apr-18	Low	Treat
Page 9	2480	Safe Responsive	There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust	Director of Nursing		IRS 15 / CRS 12 / TRS 6 TRSD initially agreed: Dec-17	Low	Treat
Page 10	2976	Safe	*NEW* Effect of knives and rising violence at the Trust	Director of Operational Performance		IRS 15 / CRS 15 / TRS 5 TRSD initially agreed: Aug-19	Low	Treat

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 11	2944	Safe	Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas	Director of People & OD		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Mar-18	Low	Treat
Page 12	2938	Responsive	Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards	Divisional Director of WCCS		IRS 16 / CRS 12 / TRS 8 TRSD initially agreed: Dec-20	Low	Treat
Page 13	2538	Safe	Risk of medication safety being adversely affected by poor adherence to medication safety policies	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS		IRS 16 / CRS 9 / TRS 6 TRSD initially agreed: May-18	Low	Treat
Page 14	2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Mar-18	Low	Treat
Page 15	2943	Responsive	Failure to manage non elective flow	Divisional Director of MIC		IRS 20 / CRS 16 / TRS 16 TRSD initially agreed: Mar-20	Medium	Treat
Page 16	2937	Responsive	Failure to consistently achieve timely elective (RTT) care	Divisional Director of SCC		IRS 20 / CRS 16 / TRS 12 TRSD initially agreed: Mar-20	Medium	Treat
Page 17	2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC		IRS 15 / CRS 20 / TRS 9 TRSD initially agreed: Dec-17	Low	Treat
Page 18	3015	Well Led	*NEW* Failure to meet control total	Chief Financial Officer		IRS 20 / CRS 20 / TRS 12 TRSD initially agreed: Mar-20	Low	Treat
Page 19	3014	Well Led	*NEW* Failure to deliver financial recovery	Chief Financial Officer		IRS 20 / CRS 20 / TRS 12 TRSD initially agreed: Mar-22	Medium	Treat
Page 20	3057	Well Led	*NEW* Restrictions and Limited availability of capital funding negatively impact Trust's ability to mitigate significant risks	Chief Financial Officer		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Mar-20	Low	Treat

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 21	1660	Well Led	Risk of poor waiting list data quality	Director of Operational Performance		IRS 20 / CRS 12 / TRS 6 TRSD initially agreed: Mar-18	Medium	Treat
Page 22	2613	Well Led	Compliance with General Data Protection Regulation (GDPR)	Chief Information Officer		IRS 20 / CRS 16 / TRS 8 TRSD initially agreed: Mar-21	Low	Treat
Page 23	2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive Officer		IRS 12 / CRS 16 / TRS 8 TRSD initially agreed: Dec-20	Medium	Treat
Page 24	2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Corporate Governance		IRS 16 / CRS 12 / TRS 8 TRSD initially agreed: Apr-18	Medium	Treat
Page 25	2922	Well Led	Risk of delay in patient treatment due to unmanaged shared email boxes	Chief Information Officer		IRS 12 / CRS 12 / TRS 4 TRSD initially agreed: Apr-19	Low	Treat
Page 26	2383	Well Led	Failure to identify poor compliance with legislative and regulatory requirements	Director of Corporate Governance		IRS 12 / CRS 8 / TRS 4 TRSD initially agreed: Dec-19	Low	Treat

ID: 2485 **Title: Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks **Cause:** • Historic under investment • Obsolescence of the estate • Availability of capital and revenue funding • Inability to retain core competencies within the workforce • Delay in delivering NWL reconfiguration plans. **Effect:** • Possible short-notice closure of facilities due to critical equipment failures and breakdowns (e.g. lift breakdowns, chillers and plant failures, infrastructure and effect on environment) resulting in loss of capacity • Obsolete infrastructure, plant and equipment installations that do not meet current standards • Inability to keep up with repair requests and minor improvements for operational / clinical benefit • Reduced staff morale leading to higher turnover and increased rates of sickness absence • Loss of reputation and reduced confidence from key stakeholders • Increased waiting times for patients • Increase length of stay for patients • Breaching waiting targets and diagnostic targets	**20**	**20**	**15**		**Director of Nursing**	Estates and Facilities Compliance Committee Minutes, which are reported to ExQual Delivery of the Capital Backlog Maintenance Programme over the next 7 years. This is monitored by the Capital Expenditure Assurance Group, who report to the Capital Steerin

Current Risk Controls

• Implementation of new Hard Facilities Management (Hard FM) Managed Service solution through specialist maintenance provider CBRE Ltd from 1/4/16 for 5 years to provide improved compliance and responsive reactive repair maintenance service.
• Retention of Senior Estates Management team structure to deliver 'informed client role' to ensure effective and compliant delivery of contract against specification and performance standards.
• Statutory and regulatory inspections have been re-scheduled to ensure compliance with statutory and mandatory undertakings and to minimise impact on front line service
• All planned (PPM) and reactive (repair) maintenance works managed through computer aided maintenance management system (CAMMS) to provide improved programming and management reporting.
• Current backlog maintenance capital funding for 2019/20 is £19.4m.
• Formal reviews of Hard FM operational performance are conducted continually review performance against contract.
• PLACE (Patient-Led Assessment of the Care Environment) lead by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works.
• Monthly Estates & Facilities Quality Committee for closer collaborative working with front line services and appropriate reporting to monitor/improve performance.
• Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services
• Estates & Facilities H&S, Fire and Compliance committee has been established to formally report and monitor statutory/mandatory compliance.
• Estates and facilities issues discussed three times a day on site calls so ensure timely resolution of any issues identified.

Mitigation Plan

Action:
Establish Estate Improvement Plan to make recommendation options to get better reactive maintenance times. EIP to include: • Process review; • Workforce review; • Bi-monthly backlog review and prioritisation. *Due Date:* 28/10/19
Update on action:
The Estates Improvement group is progressing with works, reviewing:
CBRE and Estates Operational process, to ensure PPMs are being scheduled and completed in a timely manner;
The process for submitting reactive jobs;
The Emandate process for small works;
The process for authorisation of small works;
The communication of the different stages the Emandate work flow.
Further works will continue with the group.

Contingency Plans

• Capital plan to align to clinical strategy within financial abilities
• Major incident plan / sector wide contingency plans
• Development and implementation of integrated business continuity plan
• NHSLA insurance cover
• Estates Strategy with contingency plans (Board approved).
• Mitigation of 'single points of failure' and improved infrastructure resilience providing improved business continuity planning.
• Trust is reviewing options to utilise potential land receipts to use to re-invest in modernising the estate in addition to the Capital Programme will need to continue to increase, reflecting the degree of depreciation that is attributable to estates buildings and equipment and will continue to be targeted on the highest risks.

Key Summary Updates & Challenges

Continued monitoring of Trust equipment. PPM programmes in place. Hard FM staff now working with PDA systems.

ID: 2946 ***NEW*** **Title: Failure to provide timely access to critical care services**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to provide timely access to critical care services with regard to; access to critical care beds within 4 hours, provision of timely rehabilitation and follow up post Critical Care admission, provision of 24/7 access to consistent outreach and follow up services.	**16**	**16**	**12**	*NEW*	**Divisional Director of SCC**	• Time to admission to critical care • Delayed discharges from ICU's • MSA breaches • Non clinical transfers • Elective cancellations review

Cause:
- Challenges in ability to discharge level 1 patients from ICU's to level 0/1 beds due to high hospital bed occupancy
- Insufficient specialist clinical staff, medical and nursing
- Poorly benchmark against GPICs recommendations for therapy and pharmacy staff
- Surges in demand, major incident, flu pandemic etc
- Ward vacancy rates and training needs requirements impacting on the number of Tracheostomy step-down beds
- Infection control management of highly resistant organisms requiring isolation
- No formal resourcing for rehabilitation or follow up care
- Outreach service 7/7 from 8-8pm, relying on out of hours support by site nurse practitioner team
- HH critical care units not fully optimised and coordinated against GPICS standards

Effect:
- Mixed Sex Accomodation (MSA) breaches
- Elective cancellations
- Emergency access compromised
- Non clinical transfers
- Extended length of stay in ICU and with overall hospital admission
- Potential Clinical harm
- Reduced service of early goal directed rehabilitation needs assessment
- Site nurse practitioner service not being able to cover outreach service if other site pressures occur

Current Risk Controls

- Co-location of services has been completed at SMH and CXH, where Level 2 patients are now cared for in a dedicated critical care area.
- A Critical Care Steering group has been established to provide dedicated governance and oversight to address non-compliance for HH.
- Critical Care outreach provision is available 24/7 - to support any outlying critical care patients.
- Escalation SOP for Critical Care in place, which details plans for increased demand within ITU on each site, including staff arrangements.
- Critical care SOP

Contingency Plans

- Escalation SOP
- Use of whole ICU critical care bed base and staffing across sites
- Full Capacity Protocol -Escalation to Critcon 4 for regional support

Mitigation Plan

Action:
Address flow into level 1/0 beds and transfer processes with QI programme and framework *Due Date:* 09/12/19
Update on action:
Mapping in progress against GPICS 2 and via the on-going audits of patients admission and discharge into critical care. Critical care are also a key stakeholder in the Trusts Transfer working group

Action:
Complete staffing establishment review of SMH and CX. HH review of staffing requirements and oversight through HH Critical Care Steering Group *Due Date:* 10/12/19
Update on action:
Establishment reviews will form part of the options paper going to the executive in December 2019

Action:
Conduct GPICS benchmarking exercise for therapies and pharmacy workforce *Due Date:* 02/12/19
Update on action:
Mapping exercise progressing with Therapies in relation to GPICS 2

Action:
Ensure assessment and review current service against escalation SOP, major incident and mass casualty plan *Due Date:* 31/12/19
Update on action:
SOP remains in development

Action:
Formal review and scope of outreach service, rehabilitation and follow up care requirements via Critical care delivery group *Due Date:* 31/12/19
Update on action:
Work continues on this issue via the critical care steering group at HH

Action:
Review HH critical care steering group governance structure and agree future strategy plan *Due Date:* 31/03/20
Update on action:
HH critical care steering group continue to meet fortnightly

Action:
Review tracheostomy provision on ward areas *Due Date:* 02/12/19
Update on action:
No further update awaiting SOP for ratification

Key Summary Updates & Challenges

The HH critical care steering group has agreed on the shortlisted options for submission in a business case that addresses non-compliance in critical care on the HH site. The timeline for submission for executive review is December 2019

ID: 2942 **Title: Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines **Cause:** • Non-compliance with surgical WHO checklist • Lack of Local Safety Standards for Invasive Procedures (LocSSIPs) • Trust policies too complex and difficult to put into practice • Ineffective team working and leadership leading to human error • Staff inadequately trained • Inadequate staffing levels • Interruptions to procedures leading to human error • Inadequate or faulty equipment **Effect:** • Increase in SIs and Never Events • Risk of increased level of harm • Reduced patient confidence • Reputational damage • Increased staff stress & reduced morale	**16**	**16**	**9**	⇔	**Medical Director**	Incidents, SIs and Never Events Trustwide safer surgery audit Training compliance

Current Risk Controls

• Trustwide action plan in place in response to never events
• Weekly updates on progress with the action plan provided to the executive committee
• Bi-weekly invasive procedure task and finish group in place, chaired by the medical director with representation from all divisions
• Divisional invasive procedure task and finish groups established
• Safer surgery safety stream in place, led by the Trust Lead Surgeon
• Programme manager from the office of the medical director in place to support implementation
• Policies and guidelines to support safe invasive procedures in place
• Invasive procedure e-learning module part of core clinical skills training
• Trustwide safer surgery audit included in annual audit plan focused on simulation, coaching, human factors and support
• HOTT programme in progress focused on simulation, coaching, human factors and support.

Mitigation Plan

Action:
Develop and deliver trustwide action plan in response to recent invasive procedure never *Due Date:* 31/03/20
Update on action:
Progress with individual actions is outlined separately. 27 actions have been closed with the remaining 12 being monitored through the invasive procedure task and finish group. Monthly updates are being provided to the executive quality committee.

Action:
Undertake engagement with clinical workforce in response to never events *Due Date:* 08/08/19
Update on action:
Communication and engagement will continue as the work progresses so that staff remain informed of the actions we are taking and the part they play in them.

Action:
Develop simulation training and coaching programme to be delivered to all invasive procedure staff *Due Date:* 31/03/20
Update on action:
Phase one of the HOTT programme, which included the five original specialties where never events had occurred was completed on 15 May 2019. Phase two of the programme was a three month pilot of the wider programme to understand cost, resource and other implications to the services (June – Sept 2019). As of 23 October, a total of 728 staff have participated in one of the three HOTT training streams (218 in coaching and training, 88 in human factors train the trainer sessions and 422 in SIM and debriefing sessions). This has increased from 676 last month. An evaluation of the resource required to deliver the HOTT programme on a cyclical basis has been completed. This is now being reviewed with the divisions. Now that we understand the denominator numbers and the logistics of delivery, we are revising our plans and estimated timescales.

Action:
Review all Trust policies and guidelines relating to invasive procedures to ensure they are in line with national guidance and are audited *Due Date:* 31/12/19
Update on action:
We have completed our review of the policies relating to invasive procedures.
All completed LocSSIPs have now been published on the intranet. A safety alert has been published to inform staff. Divisions are ensuring this information is appropriately cascaded and paper copies of the LocSSIPs provided for use. The majority of the LocSSIPs are now complete however there are two which are still being developed by the divisions (breast and lumbar puncture). These will be reviewed and ratified at the next invasive procedures meeting. A rolling audit plan for the LocSSIPs is being developed by the Trust clinical audit team in conjunction with the divisions through CAEG, to provide assurance that they are being used in practice.

Action:
Undertake actions to improve, monitor and provide assurance around compliance with key safety checks *Due Date:* 31/03/20
Update on action:
Outstanding actions include:
• Audit of stop before you block, the count policy and the WHO safer surgery checklist have been completed. Results have been shared with the divisions ahead of review at the next invasive procedures group on 13 November. The divisions are developing actions in response which will be reported to the next CAEG meeting. The findings and actions will be provided to the committee through this report in December. Actions will be linked to the HOTT programme, with the next phase of the programme starting in the specialties where the audit identified issues.
• A review of surgical never events by NHSI recommend that each patient has a treatment plan in place, which includes the procedure, the site, the side and direction of surgery. This work is on-going, with the focus being on ensuring procedures are ordered correctly. An audit of laterality of hip and knee replacements has been conducted in orthopaedics, which has confirmed that procedures are being correctly ordered. Audits are now being undertaken in other areas e.g. ENT, vascular. The results will be shared with the task and finish group once available. Work to rationalise the list of procedures available on Cerner is on-going.

Action:
Ensure 100% compliance for all doctors with the invasive procedure electronic training module *Due Date:* 31/12/19
Update on action:
There are currently 2 staff members from the original list who the divisions have confirmed still need to complete the invasive procedures training, one from IPH, who has had their contract suspended and is currently being removed from ESR and one from SCC who is on long-term sick leave with no current date of return. Once this staff member has completed their training, this action can be closed and this can go back to being monitored through the standard processes the divisions have for managing core skills training, with regular review of the data at the invasive procedure group.

Contingency Plans

Process to be managed through the Medical Director's office with nominated clinical leads

Key Summary Updates & Challenges

The trust wide action plan in response to the seven invasive procedure never events continues to be delivered. The action plan is progressing well, however the risk score will only be reduced when the HOTT programme has commenced in all specialties and we have seen a sustained reduction in events

ID: 2487 **Title: Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae)**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust. **Cause:** • CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, environmental hygiene, and optimised use of antibiotics. • Easy transmission from patient to patient will occur, if correct IPC procedures are not followed. • With increased cases of CPE presenting to the Trust there is a risk for potential transmission and in particular in the renal, vascular and haematology cohorts with frequent admissions and outpatient appointments. • Current isolation capacity (sideroom capacity) insufficient to implement the PHE toolkit recommendations. • Recent changes in the spectrum of CPE producing organisms with increasing identification of CPE in Citrobacter and Enterobacter species resulting in increased pressure on isolation facilities and infection teams to trace potential transmission • Location of services across the Trust for diagnostics and treatment, resulting in a frequent need for cross-site transfer. • Estates not ideal for IPC practice, compounded by backlog maintenance issues. **Effect:** • Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotic choices for treatment and ultimately worse patient outcomes. • Increased demand for isolation facilities, potentially exceeding available capacity more frequently, and risking the spread of other organisms between patients. • This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage. • Increased movement of patients and possible transmission during these movements for diagnostics and treatments. • Increased risk of further transmission due to estates issues, particularly in toilets and bathrooms.	**12**	**12**	**9**		**Medical Director**	• High level of compliance with CPE admission screening(>90%) • No increase in CPE BSIs • Reduction in the use of carbapeneme antibiotics where there is no indication • 6 monthly antibiotic point prevalence audit to monitor correct antibiotic use. • Automated room decontamination available on site for CPE • Daily sit-rep available to know where current inpatients are situated • Validation of current screening approach performed • Reduction in outbreak frequency.

Current Risk Controls	Mitigation Plan
• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship. • The Trust has a CPE Policy in place, and has patient and staff information available on the trust intranet. • Flagging system on CERNER for identifying known carriers is in place. • Serious Incident investigation following transmission events and ward closures resulting in increased emphasis on hand hygiene, environmental improvements and cleaning. • CPE management is discussed weekly at the HCAI Taskforce meeting • CPE action plan has been revised in light of recent increases in CPE. • CPE screening data now available at ward level through the IPC scorecard and is included in the harm free care reports. • Regional and national involvement in CPE prevention and policy development	**Action:** Development of an in-house HPV decontamination service *Due Date:* 30/09/19 **Update on action:** This has been funded – sitting with facilities **Action:** Implementation of a CPE screening tool through Cerner *Due Date:* 29/11/19 **Update on action:** Timeline has now been agreed for systematic screening. **Action:** Explore funding options for in-house sequencing of CPE *Due Date:* 30/09/19 **Update on action:** Alternative funding options have been explored - there are no available alternatives at this point. This action is now completed. **Action:** The evaluation of the current Trust CPE screening approach will commence mid-July and has a duration of 10 weeks *Due Date:* 29/11/19 **Update on action:** Analysis of data has been completed; preliminary data will be shared in the December risk register update.

Contingency Plans	Key Summary Updates & Challenges
• The Trust has in place a local contingency plan to implement ward-level cohorting in the renal speciality. • Seek guidance and support from NHSE and PHE.	Formal proposal for CPE screening tool was agreed and implemented, and is systematically recording screening data. The point prevalence survey of all inpatients for CPE carriage has been completed and preliminary results collated and analysed. We will be in a position to share preliminary data at the end of November.

ID: 2480 **Title: There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust **Cause:** • Domestic services; effectiveness of training, staff competency and provision of necessary equipment and materials • Failure to follow infection control practices as part of cleaning duties • Equipment cleaning: frequency and effectiveness • Access; ability to clean inhibited by activity due to operational issues or inappropriate storage **Effect:** Increased risk of infection, risk of reduced CQC score, risk of reduced patient satisfaction. Ultimately, this might result in the following impacts: • Potential infection control issues and response to outbreak • Potential for CQC related penalties due to a failure identified by inspection. • Potential for penalties/ fines or enforcement notice. • Impact on reputation through Friends and Family Test (FFT) responses, NHS Choices feedback, other satisfaction surveys and Patient-Led Assessments of the Care Environment (PLACE) scores	**15**	**12**	**6**		**Director of Nursing**	Planned and unannounced Audit results against the National Cleaning Standards. Estates and Facilities Quality Committee. Monitoring of overall action plan. Infection Prevention Control team observation audits.

Current Risk Controls	Mitigation Plan
• Contract with external provider to provide cleaning services in line with National Specification for Cleanliness in the NHS • Trust Cleaning Policy detailing responsibilities, methods and materials with reference to detailed procedures for specific tasks. • Comprehensive training schedule and modules provided by domestic services contractor. • Scheduled regime of cleaning and auditing of standards conducted and reported on a weekly basis. Timetables are in place for cleaning within departments. Regular cleaning audits are performed with oversight from area clinical manager. • Advising on specific / specialist cleaning requirements. Educating staff about the importance of following the correct processes for decontamination and cleaning. • Escalation of issues by users to cleaning provider and Facilities team. • Monthly contract review meetings between Facilities and contractor to monitor, review and agree any necessary actions related to quality and performance against contract. • Monthly report provided by contractor detailing results of cleaning audits including if audits are conducted in partnership with clinical staff. • Cleaning outcomes will be regularly monitored and reviewed to ensure the appropriate cleaning services are provided to each clinical activity. • Bi-monthly quality meetings between service providers and cross section of multi-disciplinary Trust staff • Additional senior cleaning resource from contractor in place since September 2017. • New Contract Manager commenced on site 5th February 2018 • Invoking contractual clauses to remedy failures	**Action:** Develop and deliver risk reduction plan for higher risk areas which continue seeing low cleaning performance *Due Date:* 31/12/19 **Update on action:** In progress.

Contingency Plans	Key Summary Updates & Challenges
• Invoke the terms and clauses of the Hotel Service Contract to impose escalations, rectifications and as appropriate breach of contract leading to possible termination of contract as follows: • Without prejudice to any other right or remedy it might have, including escalation and rectification, the Trust may terminate the Agreement by written notice to the Supplier with immediate effect, for example for material breaches not capable of remedy or where they have not been remedied with the specified number of days in the notice provided to the Supplier.	Continued monitoring and daily auditing of cleaning.

ID: 2976 ***NEW*** **Title: Effect of knives and rising violence on the Trust**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Increased risk of violence and aggression to patients and staff in the ED, Trauma pathway and ITU corresponding to the rise in knife and gang associated violence. **Cause:** • Patients and members of the public carrying knives on hospital premises on more than one occasion this year • Members of rivals gangs admitted to Trauma and ITU units sharing details of patients whereabouts via families and social media • Families and friends trying to access main theatres during operations • Families and friends with restricted access to the wards share details with other members of the public through social media • Inadequate and poorly functioning access controls and cctv cameras • Insufficient security presence, particularly out of hours **Effect:** • Verbal and physical assault to staff • Failure to safeguard at risk patients and other patients within relevant areas • Injury to patients • Increased stress for staff which could result in high sickness and turnover • Reputational damage to the Trust	**15**	**15**	**5**	*NEW*	**Director of Operational Performance**	• Number of reported incidents • Staff satisfaction surveys • Staff exit interviews

Current Risk Controls

• Restricted visitor access no password issued, NOK only i.e. parents but no additional family members
• Close work with trust safeguarding team and Red Thread Charity
• CCTV and access control
• Ability to fast bleep Security
• Dedicated ward security officer located with patient
• Conflict avoidance & self defence training
• Ward lock down

Mitigation Plan

Action:
Review and upgrade current CCTV and access control systems *Due Date:* 31/01/20
Update on action:
Current CCTV repairs are taking place via Security information manager and Estates. Additional CCTV works will be installed as part of the new lock down plan that will identify areas of concern and risk. Challenges waiting for authorisation of capital funding to implement the new lock down plan.

Action:
Increase training for security officers to include specific training on how to deal with increased violence and weapons *Due Date:* 31/01/20
Update on action:
The training started on the 23/10/2019 with an additional session completed on the 04/11/2019. Additional training sessions are planned until the end of January 2020. Challenges: There are 52 Security staff employed and they all work rotating shift patterns that include annual leave, this does slow the process on completing the training. There will an additional 10 officers that will be required to complete the Training during early 2020.

Action:
Trial extra security arrangements for high risk areas *Due Date:* 30/07/19
Update on action:
Action complete. The pilot programme is ongoing, including 8 additional security officers. Pilot evaluated and recommendations have been accepted by the Executive Operations Committee in October to recruit additional officers and to install additional CCTV and access control.

Action:
Agree a protocol for security response when patients in high risk situations are admitted *Due Date:* 24/09/19
Update on action:
Action complete and protocol implemented as part of business procedures.

Action:
Present evaluation of pilot and recommended next steps to Executive Committee *Due Date:* 22/10/19
Update on action:
Paper submitted and agreed at the Executive Operations Committee in October – this includes the enhanced staffing and capital requirements.

Contingency Plans

Request police intervention
Lockdown affected areas
Extra advice and support to staff
Additional security staff located on the ward patient allocated

Key Summary Updates & Challenges

Paper has been agreed at the Executive Operational Performance Committee and this secures the additional security officers and capital costs to update CCTV and access control across the QEQM - this will also include the Emergency department.

A process is now in place where patients deemed as high risk are identified and managed according to the renewed protocol.

A group has been set up on the SMH site to agree how we manage this patient group going forward and to ensure the recommendations on the security paper are taken forward.

ID: 2944 **Title: Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas across the Trust and areas where there is a national shortage of nurses. **Cause:** • National shortage of nursing staff in some disciplines, including: Acute and Specialist Medicine, Neuroscience and Stroke, Clinical Haematology, Trauma, Gynaecology & Reproductive Medicine and Imaging • High turnover of staff • Areas expanding their services when there is limited supply. **Effect:** • Reduced staff morale /increased turnover /Increased rates of sick absence • Inadequate skill mix on wards • Poor patient experience • Potentially increased incidents.	12	12	9	⇔	Director of P&OD	Workforce Establishment & Vacancy Indicators (QlikView) People KPI (QlikView)

Current Risk Controls

• Revised recruitment and retention plan for 2019/2020 developed to reduce the turnover for all nursing and midwifery staff. The plan was approved in July 2019 and delivery is in progress.
• Nursing and Midwifery Workforce Strategy Meeting was established, chaired by the Director of People & Organisation Development and/or Director of Nursing reviews progress of plan on a monthly basis.
• Careers clinic and internal transfers are in place to support action plan as well as a range of retention initiatives to reduce turnover. Additional resource has been recruited to support the action plan
• Student and newly qualified attraction strategy is in place which includes students' automatic offers and working in partnership with the Nursing Directorate to engage this group before and after they qualify
• Leavers data is analysed on a monthly basis as part of 2019/2020 action plan
• Monthly meetings in place with Divisions to review vacancy rate, recruitment activity and impact of this
• Proactive attraction and recruitment plan in place to attract passive and active candidates
• A new Applicant Tracking System will be in place by December 2019
• Four Resourcing Business Partners have been added to the team act as account managers for Divisions, run centralised campaigns, manage campaigns for hard to recruit areas and manage international recruitment
• All current vacancies for hard to recruit roles advertised through rolling adverts
• Safe staffing on wards monitored through monthly fill rate reports for nursing by division.
• Monthly exception reports produced for Divisional Quality and Safety Committee
• Procedures implemented to manage establishment, staffing, sickness & turnover information
• Business case was signed off to increase supply which includes: international recruitment, Nursing Associates, Graduate Nurse Apprenticeships and addition Practice Educators to support newly qualified staff.

Mitigation Plan

Action:
Delivery of Recruitment and Retention Action Plan *Due Date:* 31/03/20
Update on action:
The R&R action plan is currently in place and in delivery is in progress. It consists of 5 workstreams:
-Managing trends and hotspots
-Enhancing the offer for staff at different career stages
-Providing career opportunities
-Supply and stability of nurses
-Engagement, leadership & management
- Bespoke recruitment campaigns in hard to recruit areas
- International recruitment of nurses: On the 6th December 2019 2 interview panels will be travelling to the Philippines to recruit to Band 5 nursing roles within MIC and IPH. Following the December trip there are 2 further trips scheduled for February 2020 & May 2020

Action:
Delivery of proactive recruitment and attraction plan *Due Date:* 31/03/20
Update on action:
The R&R action plan is currently in place and in delivery is in progress. It consists of 5 workstreams:
-Managing trends and hotspots
-Enhancing the offer for staff at different career stages
-Providing career opportunities
-Supply and stability of nurses
-Engagement, leadership & management.

Action:
Implement a new Applicant Tracking System *Due Date:* 30/12/19
Update on action:
RECRUIT is currently in build phase:
- Authorisation process: This process has now been designed and built. Next steps would be to agree how to brief and engage staff on the process
- Job descriptions, adverts and multiple application routes: job adverts have been redesigned, job description templates have been created for different staff groups with consistent top and tail messages. The system will enable dual application routes (option to apply via an application form or via CV submission)
- Channels to market: job adverts will be advertised through appropriate free channels (Idibu). There will also be options to use paid for advertising channels which will need to be agreed and paid for by the hiring manager
- Comms and engagement activities are underway (including, briefings at Divisional Management Committees)

Action:
Divisional Recruitment and Retention plans to be developed to manage turnover, expanding services and hard to recruit areas *Due Date:* 31/10/19
Update on action:
Leavers data from ESR is analysed on a monthly basis and discussed at the N&M Workforce Strategy meeting. The leavers data will be discussed at the November N&M Workforce Strategy meeting. The DDNs and DDPs will also present strategies and plans for addressing recruitment and retention hotspots.

Action:
Delivery of Strategic Supply of Nursing Business *Due Date:* 31/03/20
Update on action:

Contingency Plans

Reduction in activity

Key Summary Updates & Challenges

The vacancy rate for all N&M for September was 14.8%. Key highlights:

- International nurses: There are currently 113 IELTs & OET passers within the pipeline scheduled to commence within the Trust between December 2019 & July 2020. Each month a cohort of 16 nurses commence with the total number of international nurses joining the Trust as of November being 116 since the campaign commenced in September 2018. The Trust also has a healthy pipeline of 105 non IELTs or OET passers who are in the process of preparing to sit their OET or IELTs in the coming months. On the 6th December 2019 2 interview panels will be travelling to the Philippines to recruit to Band 5 nursing roles within MIC and IPH. Following the December trip there are 2 further trips scheduled for February 2020 & May 2020

- Analysis of leavers data and new N&M leavers survey: Leavers data from ESR is analysed on a monthly basis. A new leavers survey for N&M staff was introduced in June 2019. The number of leavers has remained consistent YTD.

- Analysis of joiners data and new joiners survey: a new joiners survey for N&M has been piloted and joiners data is analysed on a monthly basis

- Careers clinic and internal transfer scheme: the careers clinics and internal transfer schemes have been refreshed. For both schemes a "register your interest" form has been introduced. To date 10 people have registered their interest for the internal transfer scheme. A matching panel will be held in late November.

ID: 2938 **Title: Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of delayed diagnosis and treatment leading to poor clinical outcomes and failure to maintain key operational performance standards relating to the Diagnostic target (DM01) **Cause:** • Mismatch of accurate reporting and poor data quality due to implementation and embedding of new systems and processes • Mismatch of capacity and demand • Financial challenges and subsequent limited capability to increase capacity • Imaging capacity being lost due to equipment failure • User related data entry issues • Cerner system issues - pooled referrals ; cancellations on Cerner not being communicated to downstream systems • Lack of sufficient BI, Cerner/Cerner change and data warehouse resource which can compromise reporting • Lack of sufficient BI resource to manage emerging and backlog issues rapidly • Increase in demand in Imaging • Recruitment issues in certain areas • Inconsistencies between the DM01, inpatient waiting list and Cerner front end • Increased risk of human and technical errors due to the number of required manual processes associated to the DM01 PTL when both processing the data and validating. **Effect:** • Increased risk of clinical harm to patients who remain on waiting lists for a long time • Reduced quality of patient experience / staff morale • Increased operational inefficiencies • Failure to meet contractual / regulatory / performance requirements and trajectories • Loss of reputation and reduced confidence from key stakeholders • Increased cost pressures through funding of improvement programmes.	**16**	**12**	**8**	⇔	**Divisional Director of WCCS**	• Delivery of the performance trajectory agreed with Commissioners • Local level scorecards • Clinical harm review (MD Office) • Where there are challenged diagnostic services action plans are agreed and implemented. This is being monitored by GM's and BI services. • Data quality audit (consistently reported < 5%)

Current Risk Controls

• Extended operational hours
• Imaging Reporting - Additional radiologist sessions to report on images and reduce turnaround time
• Data quality monitoring
• Development and implementation of site/clinical strategy
• Prioritising of urgent inpatient and cancer 2WW patients.
• Outsourcing of MRIs to Alliance and the Steiner unit
• Weekly RTT Planning meetings held cross site for improved work flow co-ordination, service escalations, potential breach alerts and validation, resolution of in week challenges and sign off for 6 week and beyond capacity planning and review
• Increased work of pathway reviews being undertaken through modality meetings led by Heads of Service.
• Endoscopy – Additional capacity in place to reduce backlog
• IT team have escalation process in place with Cerner through weekly meetings for managing system issues.
• Diagnostic performance metrics presented at the Performance Frameworks meetings.
• Performance Support team are providing weekly and monthly (manual) quality assurance.
• Cardiac have implemented additional capacity for stress echo clinics.

Mitigation Plan

Action:
Develop a business case for additional equipment to deliver increased capacity for MRI and PET CT *Due Date:* 31/03/20
Update on action:
In progress. Due in Q4 2019/20.

Action:
Review ultrasound capacity with a view to expand establishment to deliver increased capacity *Due Date:* 31/08/19
Update on action:
Action complete.

Action:
Performance support team to complete an options appraisal looking at internal and external reporting and validation solutions. *Due Date:* 31/10/19
Update on action:
In progress. Due for presentation to the Executive Operational Performance Committee in October 2019.

Contingency Plans

• Mitigation plans in development with local services.
• Clinical harm review.
• Additional resource (sonographer) has been employed within Imaging to minimise risk.

Key Summary Updates & Challenges

We have seen an improvement re the diagnostic wait target between the months of August & September. The position in August was 1.04% and this has improved to 0.50% in September. An options paper was presented to the Execs aiming to find a solution to the multiple technical issues and risks associated with the DM01 reporting structure. Confirmation of the agreed option and costs are to be confirmed.

ID: 2538 **Title: Risk of medication safety being negatively affected due to poor adherence to medication safety policies**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of medication safety being negatively affected due to poor adherence to medication safety policies, particularly with regard to: • Effectiveness of medication storage • Security of medicines • Risk of expired medications in clinical areas. **Cause:** • Limited storage facilities, particularly IV fluids • Failure to monitor temperature of storage areas and fridges and document remedial actions • Inability to maintain required room temperature in some areas due to lack of temperature control / air conditioning. • Lack of secured access in some areas and response time from estates to redress • Failure to effectively check expiry dates of medicines • Failure to segregate and maintain personal control of CD keys. **Effect:** • Loss of medication • Tampering with medication by unauthorised people • Drugs may not be effective if stored incorrectly or expired • Failure to comply to statutory/ mandatory regulations related to medicines.	**16**	**9**	**6**	⇔	**Divisional Directors**	Storage audits Temperature audits Six-monthly drug stock security audit undertaken Compliance to medicines management training module on Wired Monthly medicines matters audits - Synbiotix

Current Risk Controls	Mitigation Plan
• Policy for Security, Safe Storage and Transport of Medicines includes a section on the safe storage of medicines • Annual bedside locker audit undertaken • Induction training • Medicines management mandatory training module • Pharmacy assistant checks stock cupboard for medicines expiry dates on a monthly basis • Application of a green expiry sticker if expiry is due in less than 6 months • Six-monthly control drug audits • Six-monthly safety and security audits • Monthly audits via Synbiotix for CD, Fridge and Security • Medicines Matter programme to raise awareness • Updated Do-designed materials to make following policy simpler for users. • Monthly Medicines management committee to oversee compliance	**Action:** Delivery of the Medicine Management Improvement Plan *Due Date:* 30/05/19 **Update on action:** The Medicines matters 2 products have now been released across all sites of the Trust. The medicines management improvement plan was reviewed at the May meeting of the medicines management (12/05/2019) improvement group and agreed to have been completed.
Contingency Plans	**Key Summary Updates & Challenges**
• Areas found to be significantly out of temperature range - consider relocation of Medicines,Increase stock rotation to reduce impact to individual medicine lines through prolonged exposure • Security issues; prioritise with estates for action • Increase monitoring in areas where expired medications are found.	The risk score was downgraded to a 9 in March and the group felt this was still the most appropriate risk level. There are still significant challenges with the estate related to management of ambient room temperatures and ability of the estates team to rectify these in a timely manner. The most recent CQC reports were favourable with respect to medicines management and this reflects well on the work to date. However the group felt that a longer period / further CQC cycle would be beneficial prior to consideration of downgrading the risk further. Risk score retained at 9, target date adjusted to allow for a further CQC inspection cycle prior to review.

ID: 2482 **Title: Risk of a cyber security incident caused by threats leading to compromised confidentiality, integrity or availability of data**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk to Data: A cyber security incident can result in data being stolen, destroyed, altered or ransomed. Risk to Infrastructure: A cyber security incident can result in all or part of Trust ICT infrastructure being disabled, or destroyed. There would be a prolonged period of recovery.	16	16	12	⇔	Chief Information Officer	• DSP Toolkit Return (Independently audited) • Monthly Cyber Security Dashboard (reviewed by DSPC) • Annual Penetration Test (Top 3 risks and associated action plans to be presented the Board) • Annual Informatics Audit Plan (reviewed by DSPC) • Completeness of DSP Training (~96%). • NHS Digital Advanced Threat Protection (ATP) enrolment.

Cause:
In order to function, the Trust needs to maintain an ICT environment connected to the internet and other networks. This exposes the Trust to a constant flow of infection and attack.

Effect:
• Data:
o Stolen; reputational damage, breach of obligations as regards data security, fines, notification to the victim (s), compensation and legal claims.
o Destroyed; almost all patient data is being created and stored digitally including medications, observations and treatment decisions.. It is possible for hackers to destroy not only online data but all backups.
o Altered; connected medical devices are vulnerable to external hacking. Staff with access to data are the most likely insider threat. Maliciously altering data can affect both corporate and clinical systems and can result in either patient data or corporate data being changed.
o Ransomed; the data doesn't leave the Trust infrastructure but is unable to be accessed until a ransom is paid. Even if a ransom is paid, there is no guarantee that the encryption key will be handed over and access to the data restored.
• Infrastructure
o Disabled; there would be a prolonged period of downtime while networks, servers and storage were restored to service. An outage is likely to be anywhere between a week to a month.
o Destroyed; there would be up to 6 months downtime, several million pounds of expenditure to replace equipment and restore services.

Current Risk Controls

Technical Controls:
• The Trust tries to maintain the lowest possible attack profile to reduce exposure to malware and hacking. Access to social networking, webmail, tor browsers and other high risk sites are all blocked.
• The Trust maintains firewalls and a documented change control process to block threats.
• The Trust maintained Servers and Desktops are installed with antivirus software.
• Trust uses a secure web gateway to detect and prevent any malicious network activity from coming into or leaving the network.
• The Trust has invested in a backup and restore system that, to date, has been able to restore files compromised by ransomware with minimal data loss.
• There is a monthly cyber security dashboard reviewed at the Data Security and Protection Committee (DSPC) to track threat activity and effectiveness of response.
• The Trust has a Cyber Incident Response Plan and an ICT Disaster Recovery Plan to ensure that ICT staff can effectively contain and respond to cyber threats. This procedure is reviewed and updated annually to ensure that the documented processes are current and aligned to industry best practices.
• The Trust works in accordance with the DSP Toolkit requirements, such as performing an annual penetration test on the Trust critical assets.
• The Trust has an ICT Security team consisting of two members of staff.
• The Trust has procured multiple security solutions which are being implemented.

Mitigation Plan

Action:
Process Controls: Continual deployment of critical and security patches to Servers and Desktops in accordance with ITIL standards *Due Date:* 31/03/20
Update on action:
Windows Server patching remains at a good level.
Windows Desktop patching has improved and is at a good level.

Action:
Security Software Investment: Multi Layered Security Software currently in the process of being implemented *Due Date:* 31/12/19
Update on action:
Added extra security controls such us USB port blocking on Windows 10 to prevent data leakage and malware infection via USB ports.

Action:
Completion of Annual Mandatory DSP Training Target (> 95%) *Due Date:* 31/03/20
Update on action:
Action complete.

Action:
To achieve Cyber Essentials Plus accreditation *Due Date:* 30/06/21
Update on action:
The Trust is working with third parties regarding NHS D CSSM offerings.

Contingency Plans

• In the event of an incident, hire external specialists to resolve security threat and restore service as soon as possible
• Downtime procedures
• Trust Cyber Security Incident Plan

Key Summary Updates & Challenges

The ICT Security Team has revamped the Cyber Security Dashboard to include more relevant metrics.

The ICT Security Team is continuing to remediate issues highlighted in the 2019 2020 on-site assessment.

ID: 2943 **Title: Failure to manage non elective flow**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk to A&E performance caused by the failure to manage non-elective flow meaning that the Trust fails to meet the new urgent and emergency care performance standards being piloted in 2019. **Cause:** • Inadequate ED estate to meet demand • Insufficient bed capacity across sites • Impact of winter bed pressures **Effect:** • Increased risk of clinical harm to patients waiting for a long time • Reduced quality of patient experience • Reduced staff morale • Provider Sustainability funding being withheld • Loss of reputation and reduced confidence from key stakeholders	20	16	16		**Divisional Director of MIC**	• ED Performance Reports • Outcome of external review of ED performance with emergency care intensive support team (ECIST) • Clinical harm review (MD Office and division)

Current Risk Controls

New performance targets being piloted in 2019.
• Improving 4 Hour Performance Working Group
• Full capacity protocol
• Support from 2020 Delivery and SAFER flow bundle
• Improving Care Journey and Capacity Collaborative
• Urgent and Emergency Performance and Accountability Framework
• A&E Operational Group established to identify areas of focus for improvement
• A&E Operational Group established to identify areas of focus for improvement
• Assessment of Imperial College Healthcare Partners (ICHP) report to confirm next steps with the development of a specification for a digital tool that will deliver against its operational and strategic objectives, with regards to Red2Green, capacity management and flow.
• Extended operational hours for ambulatory emergency care services at St Mary's and Charing Cross
• Roll out of long stay review meetings across all sites to expedite decision making
• SOP for boarding piloted since January 2019
• Extra beds in place at SMH and CXH since January 2019

Mitigation Plan

Action:
Redevelopment of CXH Emergency Department *Due Date:* 30/09/19
Update on action:
Action complete. Department refurbished and now open.

Action:
Embed flow coordinators at CXH *Due Date:* 31/01/20
Update on action:
Potholders appointed and starting w/c 18/11/19. One applicant pulled out so being re-advertised. Action date postponed to end of January 2020.

Action:
Publish ambulance handovers protocols *Due Date:* 31/10/19
Update on action:
Action complete. CXH part of ambulance handover exemplar programme with NHS England. Regular meetings with London Ambulance Service (LAS) to work on improving 15 and 30 minute handover.

Action:
Pilot trial for improved streaming with Vocare *Due Date:* 31/01/20
Update on action:

Action:
Roll out Trustwide plan to focus on reducing the number of long stay patients *Due Date:* 31/03/20
Update on action:

Action:
Same Day Emergency Care programme roll out with potential impacts in 2020/21 *Due Date:* 31/03/20
Update on action:

Action:
Focus for winter in Time from referral to review and patients over 12 hours in the ED department *Due Date:* 31/03/20
Update on action:
Ongoing review.

Contingency Plans

• Continued drive of above controls and standards

Key Summary Updates & Challenges

Refurbished and extended department open at Charing Cross Hospital and supporting winter flow.

ID: 2937 **Title: Failure to consistently achieve timely elective(RTT) care**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to achieve the maximum waiting times of 18 weeks from GP referral to treatment as set out in the NHS Operating Guidance 2019/20, including zero > 52 week waits and maintenance of the size and volume of the RTT PTL (waiting list). **Cause:** • Ineffective RTT Patient Tracker Management (Waiting List), insufficient capacity accross pathways and increasing demand. • Cancellations of elective care patients during emergency care surge and/or delays in discharges. • Incomplete suite of visible waiting lists i.e. follow-up waiting list. • Business continuity impacted by the quality and resilience of the estates and availability of equipment. • Data quality issues driven by both front end user error, extraction and reporting. • Theatre capacity not fully utilised.	20	16	12	⇔	Divisional Director of SCC	• Clinical harm review • Datix Reporting • RTT performance reports and governance structures including specialty level compliance with 0 >52 weeks waits and RTT PTL size • RTT Clock Stop Audit • Delivery of the 19/20 performance trajectory agreed with commissioners/NHSI • Theatre utilisation • Cancellations(including QMCO) • CQC Ratings for Responsive • Monthly integrated performance scorecard • Surgical Productivity Programme PIs.

Effect:
• Clinical harm to patients, poor experience of care and unacceptable delays for patients.
• Deterioration in ICHT's regulatory compliance rating.
• Poor experience for the multidisciplinary teams and referrers.
• Enforcement of contractual financial penalties and loss of income.
• Diversion of care to other NHS and private providers.
• Impact to organisational reputation and partnerships including the NWL STP.
• ICHT's performance against the 18 week standard could deteriorate if non payment for clinical activity 1% above contract and 70% marginal rate thereafter is not affordable

Current Risk Controls

• ICHT Access Policy
• ICHT Clinical Harm Standard Operating Procedure
• RTT Improvement Programme Governance and oversight by Executive Operational Committee(bi-monthly report) – trustwide elective performance framework, validation systems and MDT education.
• Monthly Elective RTT Care Steering Groups including NHSE/I and NWL CCG commissioners
• Trust Data Quality Framework including RTT Clock Stop Audits and NHSI RTT DQ
• Elective Assurance Review Action Plan(MBI)
• Fortnightly CEO RTT meetings
• Data Quality Steering Group providing digital enhancement and action where needed
• Surgical Productivity Programme
• ICHT Performance & Accountability Framework
• RTT Induction Training published on ICHT Digital Learning Management System.

Mitigation Plan

Action:
Design develop and embed an Elective Care Performance Framework *Due Date:* 29/03/19
Update on action:
Complete, with further enhancements of specialty level PTL meetings under way. Review and evaluation of specialty level PTL meetings to be completed by 31 August 2019 with a review of the Elective Care Framework and results scheduled for completion by 31 December 2019.

Action:
Design and deliver relevant training packages using classroom and digital platforms *Due Date:* 30/09/19
Update on action:
The Digital Learning Management System(LEARN) is now live. RTT Induction Training for all staff groups went live on 3 July 2019. Story boards and Phase 1 Modules published.
Planning for full Implementation of Service Specific Classroom training is underway. Project timescales being reviewed owing to learning from early roll outs.

Action:
Enhance management of RTT PTL through the review and restructure of the validation team to provide greater resilience and consistency around RTT PTL management and move towards prospective tracking *Due Date:* 30/09/19
Update on action:
Due to interdependency on enhancement of the RTT validation tool and expected recruitment timelines to achieve the ICHT Target RTT/CWT Model, the completion date is likely to be 30 September 2019; however this remains under review and mitigation. The ICHT executive group and executive team meeting has authorised the implementation of the proposed model. Recruitment has commenced with intensive support and oversight by People & Organisational Development.

Action:
Enhance RTT Validation tool (Qubit), to deliver further efficiency and data quality benefits for RTT management *Due Date:* 01/07/19
Update on action:
Phase 2 was launched on 10 July 2019 with a period of training and embedding. This included the introduction of auto validation. Phase 3 testing and implementation date to be finalised at the next Qubit Project Board.

Action:
Develop a follow-up waiting list *Due Date:* 31/12/19
Update on action:
Technical data extraction and reporting under design. This will be followed by extensive validation and data clean up in advance of clinical operational implementation. This action is being reviewed with the suite of actions around ICHT's waiting lists.

Action:
Deliver IST and Elective Care Assurance Report action plans *Due Date:* 31/12/19
Update on action:
This remains on track and reported through bi monthly reports to the Executive Operational Committee.

Contingency Plans

• Stand up ad hoc clinical capacity
• Stand up ad hoc/responsive data clean up and validation catch up
• Diversion/outsourcing to third party providers
• Escalation to Divisional Directors of MIC/SCCD/WCCS and Director of Operational Performance
• Enactment of "special measures"/SRO meetings providing intensive support to mitigate long waiting time.

Key Summary Updates & Challenges

In September 2019 ICHT continues to deliver good performance against RTT measures. RTT size @ 62527 against at trajectory of 63100. Incomplete performance increased to 83.60% against a plan of 83.40%. The Trust reported three 52 week breaches.

ID: 2477 **Title: Risk to patient experience and care due to delay for mental health patients in the ED**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues as a result of increasing volume of attendances and significant delays for those patients requiring admission to a mental health bed **Cause:** • Lack of mental health bed capacity • Delayed access to mental health input for patients in the department (for example the Home Treatment Team) **Effect:** • Extended stay for patients in a sub-optimal care environment for mental health patients (the Emergency Department)	**15**	**20**	**12**		**Divisional Director of MIC**	• Number of mental health breaches • Number of incidents

Current Risk Controls

• Reporting of all 12 hour trolley wait breaches as Serious Incidents.
• Escalation framework agreed with commissioners.
• Meetings held with the mental health trusts to raise concerns.
• Increased engagement from mental health Trust and CAMHS service in Serious Incident investigation process.
• Regular meetings with CNWL and ongoing engagement with mental health trusts and ICHT with regards to pathways and management of patient group.
• Escalation to the A&E Delivery Board.
• Escalation at Provider Oversight Meetings with NHS Improvement.
• Escalation of delays in real time to both the relevant mental health trust and commissioners.
• Augmenting the nursing establishment in the emergency departments with registered mental health nurses.
• Increased security presence in the emergency department at SMH.
• The establishment of a dedicated consultant lead for mental health in both emergency departments.
Ongoing discussions with the commissioners regarding liaison psychiatry role
• Conference call established for paediatric MH patients likely to require admission.
• There has been an increase in the RMN presence at SMH to 24/7
• Safety stream established reviewing mental health care within the Emergency Departments.
• Mental Health Big Room in progress.
• Mental Health compact being rolled out across London.
• ED Delivery board in place.
• Increased Approved Mental Health Professionals in Westminster
• Westminster recently increased Approved Mental Health Professionals

Mitigation Plan

Action:
Continue work with Commissioners and Central & North West London NHS Foundation Trust (CNW) and monitor effectiveness of the implementation of CNWL action plan, which includes:
• Development of 24/7 assessment lounge at the Gordon to admit people not likely to require a bed. This provision is for up to 3 patients and is for KCW patients only.
• Encouraged to transfer patients requiring a bed earlier even if current occupant has yet to vacate the bed.
• Appointment of Head of Urgent Care role in CNWL to support location of beds.
• Westminster recently increased Approved Mental Health Professionals, although acknowledges there is more to do.
• CNWL investigating potential to support provision of bank registered mental health nurses to ED. *Due Date:* 31/01/20

Update on action:
• 21 first responders and 3 social workers now in place to support improved gatekeeping and access to the MH sanctuary (assessment lounge) at the Gordon.
• Opening of the MH Sanctuary at the Gordon since 1st October.
• Agreement for joined up working on UEC standards for mental health patients to see how to report the data in a useful way for the system.
• NHSE audit of mental health pathways to be shared.
• Training day for staff planned for 29/11.

Contingency Plans

Management within department with existing controls, ongoing investigation of serious incidents for 12 hour trolley wait incidents.

Key Summary Updates & Challenges

Further breaches declared for October, Serious Incidents continue to be investigated jointly with CNWL and WLMH. Latest batch of 9 reports for panel 11th November 2019.

The numbers of patients attending the ED departments on mental health pathways increased slightly from an average of 12 patients per day (total 381 patients) in August 2019 to an average of 15 patients per day (total 435 patients) in September 2019. At CXH the average daily attendances increased slightly to 6 (compared to 5 in August), and at SMH there was an increase from an average of 7 patients per day in August to an average of 9 in September. 51% of these attendances breached the 4-hour standard (an average of 2 per day ay CXH and 5 per day at SMH); with 7 breaching the 12-hour wait from DTA to admission.

The main factors effecting placement of patients on mental health pathways continues to be availability of inpatient mental health beds and provision of HTT and AMHP services particularly out of hours. Efforts made to create additional assessment capacity in the mental health trusts may correlate with the reduction of breaches but the impact of delays in assessment under HTT or AHMP remain. A significant impact remains on acute resources including insufficient appropriate nursing support for mental health patients (RMN), the cost of temporary staffing at short notice and delays bed allocation contributing to overcrowding in ED.

ID: 3015 **** NEW**** **Title: Failure to meet control total**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to meet control total **Cause:** • NWL CCGs affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Structural deficit due to deterioration of estates. - Additional costs of operating across three sites & with outdated estate and aged equipment • Capacity limitations constrain activity growth, especially in private patients • Annual reductions in Education and Training funding • Correction of historic usage of R&D funding for clinical subsidy • Reliance on temporary / Agency staff at greater cost • Limited ability to use non-recurrent financial gains to deliver Control Total targets • Inability to identify and deliver cost improvement programmes at a local level **Effect:** • Reputational damage • Failure to qualify for sustainability funding of £17m plus potential for bonus funding. In turn this would impact cash flow and ability to repay working capital loan. • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Impacts ability to run and invest in services - Dependence upon external initiatives and funding for required capital investments	**20**	**15**	**12**	**NEW**	**Chief Finance Officer**	Trust met its control total in 2018/19 receiving £14m bonus funding on top of planning PSF. The 2019/20 submitted plan shows the Trust accepting its 19/20 control total of £16m deficit before funding, thereby qualifying for £10m of central 'MRET' funding and £17m of 'PSF' on delivery of the control total. Divisions working with transformation to team to close unidentified CIP gap. Focus on pay run rates Ability to use additional non-recurrent measures (some level of risk with this)

Current Risk Controls

• Bi-weekly FASRG meetings with divisions and senior finance teams (CEO and CFO attend at least monthly)
• Additional Executive review for any division forecasting to miss budget
• Monthly financial reporting, cash and performance reviews reported to ExFin, bi-monthly to FIC and Trust board
• Oversight with Regulator via Provider Oversight Meeting (POM)

Mitigation Plan

Action:
Focus on Pay cost reduction & transparency - reduce the establishment to remove unfilled vacancies. Ensure consistency between detailed workforce plan including temporary workforce, detailed budgets and CIPs *Due Date:* 30/11/19
Update on action:
Finance working with Transformation and POD

Action:
Divisions to close plan gap by identifying CIPs and undergo review *Due Date:* 30/11/19
Update on action:
Divisions not yet closed CIP gap. Focussed sessions held with CEO in September.

Contingency Plans

Identify additional, probably non-recurrent, measures.

Key Summary Updates & Challenges

Full year gap to delivering plan has reduced to £10m as at mth 6. The current risk of not meeting the control total has therefore also been reduced, accordingly.

ID: 3014 ***NEW*** **Title: Failure to deliver financial recovery**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to deliver financial recovery and get to break even income and expenditure position by 2021/22 **Cause:** • Reduction in Market Forces Factor (MFF) funding • Underfunding of complex specialist treatment • NWL CCG affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Structural deficit due to estates - Additional costs of operating across three sites & with outdated estate and aged equipment • Capacity limitations constrain activity growth, especially in private patients • Annual reductions in Education and Training funding • Correction of historic usage of R&D funding for clinical subsidy • Use of temporary staff at higher cost • Continuing dependence upon significant non-recurrent financial gains to deliver Control Total targets & receipt of STF funding masks underlying deficit • Inability to identify and deliver cost improvement programmes at a local level • Transformation programme unable to deliver significant financial savings **Effect:** • Failure to deliver a financial surplus • Failure to receive provider sustainability funding and equivalent bonus funding • Inability to generate required additional Capital funding • Reputational risk of being in deficit • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Dependence upon DH revolving working capital facility • Impacts ability to run and invest in services - Dependence upon external initiatives and funding for required capital investments	**20**	**20**	**15**	*NEW*	**Chief Finance Officer**	Trust met its control total in 2018/19 receiving £14m bonus funding on top of planning PSF. The 2019/20 submitted plan shows the Trust accepting its 19/20 control total of £16m deficit before funding, thereby qualifying for £10m of central 'MRET' funding and £17m of 'PSF' on delivery of the control total. This would leave a surplus position of £11m. Cash balance never less than £3m – monitored monthly and reported to Exec and Board. Internal forecast outturn (monthly refreshed).

Current Risk Controls	Mitigation Plan
• Bi-weekly FASRG meetings with divisions and senior finance teams (CEO and CFO attend at least monthly) • Monthly financial reporting, cash and performance reviews reported to ExFin, bi-monthly to FIC and Trust board • Oversight with Regulator via Provider Oversight Meeting (POM) • Causes of the Deficit work incorporated into financial recovery plans and business planning processes • CEO & CFO engagement with Provider Network, AUKUH, Shelford etc, to lobby on system issues pressures including Tariff and Diamond – reports to FIC and Trust board • The Improvement Team and all major change programmes report to monthly Executive Digital & Transformation Committee (ExDST)and then to FIC • Speciality Review Program (SRP) started Apr 2017 reviewed all 31 specialities for sustainability (financial and clinical). SRP phase 2 now merged into Transformation and Recovery Plans reporting to SRP, SROs and ExDST • Full engagement in health economy wide initiatives, e.g. seek to maximise Trust gain and mitigate risks from broader initiatives • CEO member of STP Provider Board addressing STP financial challenge. • Financial recovery plan.	**Action:** Update the accepted 4 year financial recovery plan for new NHS planning and tariff assumptions and extend to 5 years per NHS planning guidelines. *Due Date:* 30/11/19 **Update on action:** Long term plan using sector assumptions and the financial improvement trajectory from NHSI was submitted on 1st November. **Action:** Focus on Pay cost reduction & transparency through monitoring of run rates - includes focus on unrequired and unfilled vacancies, and use of agency. *Due Date:* 30/11/19 **Update on action:** Pay run rates adopted as key performance measure and incorporated into reporting. **Action:** Reviews of divisional and directorate recovery plans *Due Date:* 30/11/19 **Update on action:** Regular targeted support sessions through new FASRG meetings for directorate teams whose budgets are off plan, with divisional leadership, to plan and monitor actions to get back on track. **Action:** Fortnightly meeting of STP CFOs to facilitate sector-level change and sharing of gains, and ongoing involvement in STP efficiency initiatives. *Due Date:* 30/11/19 **Update on action:** CFO team have: proposed business rules to remove the financial barriers to joint working; set-up team focusing on sector-wide analytics to support sector wide decision-making; aligned provider contracts.

Contingency Plans	Key Summary Updates & Challenges
Revolving working capital facility provides cash support cover of up to £26m (£16m has been drawn down YTD) – with the ability to extend the limit up to £65m. (However, note that these national arrangements are interim while a permanent process is being agreed between DH and NHSI)	Long term strategic plan submitted inline with NHSI's financial improvement trajectories.

ID: 3057 ***NEW*** **Title: Restrictions and Limited availability of capital funding negatively impact Trust's ability to mitigate significant risks**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Restrictions and limited availability of capital funding negatively impacts Trust's ability to mitigate significant risks and achieve key objectives. **Cause:** As a Non-foundation trust, ICHT is tied to a depreciation based Capital resource limit (CRL) and has very limited freedom to raise capital finance or reinvest its own cash in capital. In addition, the age of the Trust infrastructure means that the CRL is too low to properly address replacement and infrastructure requirements, in particular Backlog maintenance. For 2019/20 the NHS national Capital envelope was oversubscribed and as a result NHSI/E required Trusts to reconsider their capital programmes for 2019/20, consider deferring expenditure which is not deemed to be essential or already contractually committed into future years, and resubmit plans accordingly. ICHT reduced its plan by 20% in line with guidance, by taking out an emergency capital loan which is not expected to be granted. However, the revised Trust plan still includes the reinvestment of some surplus cash subject to NHSI approval. **Effect:** • Inability to fully mitigate a number of risks on the corporate and divisional risk registers, with a direct impact on: o Trust estates and redevelopment [corporate risk no. 2485] o ICT infrastructure and cyber security [corporate risk nos. 2677, 2681, 2680, 2482] o Imaging equipment and efficiency of imaging services o Imperial Private Healthcare development. • Impact on staff who will be required to work in suboptimal conditions • Poor Patient experience • Reputational damage • Increased costs for reactive estate and equipment maintenance • Potential loss of NHS and private income • Inability to fund service improvements and transformational programmes • Potential fines if unable to prevent cyber-attack.	**16**	**16**	**8**	*NEW*	**Chief finance Officer**	Meeting Capital resource limit year to date On track with 8 year Backlog maintenance plan.

Current Risk Controls

• Capital plan allocations prioritised via a structured process including consultation of the corporate and divisional risk registers
• Operational management of capital programme through the Capital Expenditure Assurance Group ('CEAG')
• Oversight of capital programme and plans through Capital Steering Group ('CSG')
• Trust financial delegations and Executive approval of capital programme and individual business cases
• Close working with Imperial charities to optimise use of charitable funds in capital programme
• NWL sector forums
• Ongoing representation too, and communication with, external stakeholders (inc. NHSI, DH, Treasury) to ensure Trust's capital challenge is understood.

Mitigation Plan

Action:
Submit and follow up application to use own cash to extend Trust Capital resource limit *Due Date:* 31/07/19
Update on action:
Application approved. NHSI still to formally update capital resource limits through monthly finance reporting.

Action:
Submit emergency capital loan request *Due Date:* 31/05/19
Update on action:
Action closed. Request submitted; based on communication with NHSI we will not be receiving the loan this year.

Contingency Plans

• Ability to flex capital plan to meet emerging priorities where necessary
• Use of alternative financing approaches to projects where viable e.g. revenue based Managed equipment services
• Give consideration to overshooting trust Capital resource limit if required to mitigate significant safety or quality concerns.

Key Summary Updates & Challenges

There has been some relaxing of the NHS capital challenge - the signals from the centre are that we won't receive an Emergency loan but will receive permission to use our own cash to increase our CRL, in line with the revised capital plan (totalling £55m). We are working with NHSI to confirm this.

ID: 1660 **Title: Risk of poor waiting list data quality**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of poor waiting list data quality resulting in inaccurate data records which can lead to delays in patient treatment, inaccurate data sets being published externally and therefore breach of contractual and regulatory requirements and loss of Trust reputation **Cause:** • Inaccurate,incomplete or delayed data entry of outcomes post clinical attendance • Inconsistent use of waiting list and non-chronological booking • Failure to comply with standard workflows and/or operating procedures • Varied level of understanding of waiting list management across the organisation • Incorrect design/build of system, workflows reports • Staff are not trained adequately **Effect:** • Possible delay to treatment of patients, e.g. high number of "pop on" to the RTT PTL over 18 weeks • Possible failure of governance • Inefficient working, e.g. high levels of validations • Loss of Trust reputation • Possible financial penalty for Trust or loss of income • Breach of contractual and regulatory requirements.	**20**	**12**	**6**	↓	**Director of Operational Performance**	• Data quality audit results, currently showing an improved accuracy rate in LOS, Cancer and Diagnostics all below the NHS I recommended 5% error rate • Trust Performance and Accountability framework • Elective care performance framework KPI's • Reduction in pop on numbers • Stability in waiting list numbers.

Current Risk Controls

• The Trust developed a data quality framework in 2017
• A monthly progress update is provided to ExOP
• 20 key data quality indicators have been prioritised for 2019/20, 10 of which relate to waiting list data quality
• The wider framework includes 165 data quality indicators (DQIs) across 32 datasets and includes in its scope the optimisation of the 10 systems used to collect them and the data processing involved.
• A key component of the data quality framework is a quality assurance and audit process to inform training, learning and development. The Performance Support Team carries out routine audits of RTT, Length of Stay (LoS), A&E, Diagnostics (DM01) and Cancer Waiting Time data. Results of these audits are reported via the Data Quality Steering Group and ExOp
• Diagnostic Reporting working group is implementing an agreed action plan to improve completeness and quality of data reported via the DM01
• Implementation of MBI Elective Assurance review recommendations.

Mitigation Plan

Action:
Power Insight Electronic Data WareHouse (PIEDW) replacement *Due Date:* 31/03/20
Update on action:

Action:
RTT removals report to be built in qubit to provide real time capture of incorrect clock stops *Due Date:* 12/02/20
Update on action:
Qubit are running a removal report in November as part of the assurance checks post of Cerner downtime. This demo report will be reviewed to agree development plan for BAU report

Action:
Agree purchasing requirements and timelines for extending current contract with Qubit to provide a validation tool for diagnostic reporting *Due Date:* 10/12/19
Update on action:

Action:
Agree a project plan and timelines for BI review of the current DM01 script, ensuring that the capture of currently unreported Cerner queues is prioritised. Plan to be presented at ExOP *Due Date:* 02/12/19
Update on action:

Action:
Pilot a audit for ambulance handover and agree next steps *Due Date:* 26/11/19
Update on action:
Pilot audit completed, further audit using Trust and LAS data sets required

Action:
Transfer of Cymbio data quality indicators to data warehouse and Qliksense in line with decommissioning of cymbio *Due Date:* 01/04/20
Update on action:

Action:
Development of routine operational monitoring and governance process for activity and income priority indicators *Due Date:* 01/04/20
Update on action:

Contingency Plans

Report as incident
Urgent review of data sets and external submission requirements
Engage with commissioners and governing bodies to jointly consider Impact i.e. delayed/partial submission for some data sets
Implement a clinical harm review process
Ensure learning is fed back via Elective Care training team.

Key Summary Updates & Challenges

Recent improvements have been seen in the data quality for diagnostic reporting and the Data Quality Maturity Index, both are reported within the Trust Integrated Quality and Performance repot. Error rates for A&E, Diagnostics and Cancer waiting times remain on or below the 5% threshold advised by NHS I. The Error rate for RTT remains a challenge reporting above the threshold, themes and user level information is shared with the elective care training team as part of the learning cycle approach. A dashboard for activity and income priority indicators has been developed and will be reported to ExOp on a monthly basis alongside waiting times indicators. A process for review operational input and governance monitoring is being designed.

ID: 2613 **Title: Risk of failure to Uphold Rights and Freedoms of Data Subjects (GDPR)**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of financial and reputational damage to the Trust resulting from failure to fully comply to the General Data Protection Regulation (GDPR), which became effective in May 2018. The GDPR is a Directive for the European Union that is enacted in UK legislation under the Data Protection Act 2018.	25	15	10		Chief information Officer	Data Security and Protection Toolkit Independent Audit of the DSP Toolkit CE+ Implementation Programme.

Cause:
The Trust is required to demonstrate how it
o Upholds the rights of patients and staff as data subjects, including provision of appropriate privacy notice information, upholding rights of access,
o Provides demonstrable legal basis for the processing of data
o Mitigates risk of data breaches caused by failure of technical security or failure of management procedure or misuse of authorised access
o Maps data flows to and from third parties that have been privacy risk assessed and the liabilities allocated appropriately through appropriate information sharing agreements / contracts
o Undertakes robust privacy risk assessment and the reporting of high residual risk processing to the ICO
o Provides demonstrable legal compliance through accurate, complete, valid and timely records of processing
o Establishes a robust Data Protection framework

Effect:
• Identified breaches can be fined to up to 4% of global turnover
• Reputational Damage possibly leading to brand toxicity
• Loss of research funding and potential losses of inward investment
• Loss of confidence in the senior management of the Trust

Mitigation Plan

Action:
Trust Privacy Programme (TPP) to deliver compliance to GDPR *Due Date:* 31/03/21
Update on action:
The Trust Privacy Programme achieved a first milestone by providing a "satisfactory" DSP toolkit return on 31/03/2019.
The Trust also achieved a DSP Training Target outcome of 96%
The Trust approach is to be compliant with GDPR by 31/03/2021

Action:
Implementation of ONE TRUST Data Protection Management Console *Due Date:* 31/10/19
Update on action:
Phased implementation. Records of Processing and Vendor Management, as well as several assessments, have been implemented. Further implementation to be undertaken.

Action:
DSP Toollkit Return "Satisfactory" and Independently Audited by 31/03/2020 *Due Date:* 31/03/20
Update on action:
First gap analysis and action plan undertaken

Current Risk Controls

Data Protection Management Console Provided in ONETRUST to store records of processing and support SAR Management
DSP Structure
Trust Privacy Programme
Policies Procedures Protocols
DSP Training
Records of Processing.

Contingency Plans

• Report breaches to the ICO
• Report non compliance to Information Sharing Partners in NW London and elsewhere
• Escalation of non compliances and attendant risks to the Trust board.

Key Summary Updates & Challenges

DSP Toolkit Baseline Submission subjected to internal review and submitted with no new issues identified - final DSP return will be pursued for 31/03/2020. 95% DSP Training compliance in support of DSP Toolkit has been achieved for 2019/20 period.

ID: 2498 **Title: Failure to gain funding and approvals from key stakeholders for the redevelopment programme**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to gain funding and approvals from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration, including Paediatric Intensive Care Unit (PICU) and Western Eye Hospital (WEH)	12	16	8	⇔	Chief Executive Officer	• Programme governance • Reports to Trust Board and ExCo, Redevelopment Committee

Cause:
• Case for change not sufficiently clear and/or compelling therefore insufficient support for key aspects of our clinical strategy from stakeholders.
• Delays to obtaining planning permissions
• Technical design and build issues lead to unanticipated challenges and project creep
• Increase in costs beyond currently expected levels through indexation, due to delays in business case.
• Insufficient organisational capacity to capitalise on strategic and commercial opportunities.
• Failure to achieve support for key aspects of our clinical transformation, especially service reconfiguration and estate redevelopment from one or more key audiences / stakeholders
• Lack of internal resources allocated to deliver the programme
• Backlog maintenance costs increase

Effect:
• Poor organisational performance – inefficient pathway management
• Poor reputation with regulatory bodies
• Failure/delays in implementing new clinical models and new ways of working
• Deteriorating and / or inadequate estate
• Failure of critical equipment and facilities that prejudices trust operations
• Reduced staff morale and staff engagement
• Reduced confidence in our services/public concern about their services
• Difficulty in programming interim capital projects
• Project cannot proceed.
• Patients continue to be seen in poor accommodation,
• Poor staff morale and increased turnover
• Increase in project costs
• Planning application may lapse.

Current Risk Controls

• Regular meetings with NHS England, NHS Improvement, CCG partners for early identification of potential issues/changes in requirements
• Reports to Trust Board and ExCo
• Regular meetings with Council planners and Greater London Authority (GLA)
• Active management of backlog maintenance.
• Active ways of engaging clinicians through models of care work
• Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluation
• Active internal communications plan, including CEO open sessions
• Internal and external resource and expertise in place.

Mitigation Plan

Action:
Review all redevelopment options for the Trust *Due Date:* 13/12/19
Update on action:
Trust exploring options

Action:
Agree scope of works sufficient to protect existing planning approval leading to certificate of lawfulness. *Due Date:* 04/01/20
Update on action:

Action:
Notices to be formulated and served on the residents of Westcliffe Apartments by August 2019 to prevent acquisition of rights of light over the Trust. *Due Date:* 31/08/19
Update on action:
Light Obstruction Notices have been registered with Westminster County Council

Action:
Development of contingency plan in the event of failure to gain funding and approvals for redevelopment programme. *Due Date:* 31/12/19
Update on action:
Action postponed to end of December 2019

Contingency Plans

Implementation of Contingency Plan from late April 2019.

Key Summary Updates & Challenges

External adviser have been appointed to undertake a strategic review of options.

ID: 2472 **Title: Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the Trust by the CQC. **Cause:** • Lack of robust systems and processes which enable the trust to achieve regulatory compliance and to drive improvement to address previous inspection findings / resolve internally identified problems • Failure of staff to adhere to trust and local area policies, procedures, guidelines, etc. • Lack of resource to support business as usual and improvement activities **Effect:** • Reduction in the quality and safety of patient care: o Greater number of incidents relating to patient safety, and of potentially greater severity o Increase in poor patient experiences and complaints • Regulatory intervention due to regulatory breaches being identified • Reputational damage.	**16**	**12**	**8**	⇔	**Director of Corporate Governance**	CQC inspections outcome and reports, including positive CQC core service inspection report from 2018/19, GP practice inspection report and Trust level Well-Led inspection report 2018/19. CQC Insight report and benchmarking data contained within it Performance on key quality indicators outlined in the Trust's quality report/Trust scorecard Outcomes from internal reviews and audits Outcomes from external reviews, e.g. inspections by other regulators, accreditation bodies, professional bodies and peer reviews Patient feedback. e.g. FFT result, local and national surveys Staff engagement survey results (local and national)

Mitigation Plan

Action:
Deliver a peer review programme for services which could possibly be inspected in the current year *Due Date:* 31/01/20
Update on action:
Programme being planned.

Current Risk Controls

• The trust has a dedicated Head of Regulation with a significant background in healthcare regulation, including experience with CQC inspections and the CQC's current regulatory approach
• A framework for managing CQC compliance has been in place at the trust since April 2015 which includes core improvement workstreams and robust assurance mechanisms. The framework is aligned with the CQC's inspection methodology for NHS acute trusts and is adapted when the CQC make changes to their regulatory approach.
• Centralised oversight of compliance by the Improving Care Programme Group
• Support to areas for business as usual, improvement activities and management of CQC inspections from the Trust's CQC team
• Governance via divisional governance processes, the Improving Care Programme Group, the Executive (Quality) Committee and Quality Committee, and the Trust board
• Other trusts that have improved their CQC ratings have been engaged to share learning

Contingency Plans

• Commission external review and support, including other trusts, NHS Improvement, etc.
• Work with commissioners where demand is outstripping capacity.

Key Summary Updates & Challenges

Activities to prepare for possible upcoming CQC inspections as previously described continue as planned; there are no further updates to this risk for this month.

ID: 2922 **Title: Risk of delay to patient care caused by Un-monitored shared mailboxes leading to patient harm**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk that "unknown" unmanaged shared email accounts are active and published to patients. This risk was identified when the Western Eye Hospital management team discovered an email account published to patients with over 3000 unread emails. **Cause:** • Current process to request generic email accounts does not include failsafe to ensure that relevant email accounts are managed by requestors for the lifecycle • Failure of people to highlight/ re-allocate relevant email accounts when generic email account handler is changing role/ leaving the Trust **Effect:** Risk to delay of patient care.	12	12	4	⇔	**Chief Information Officer**	•Number of unmanned email addressed identified. Process for validation agreed Notification to divisional DDOs completed All 2200 email address have been sent an email requesting a 5 working day response with key information Clarification of mailbox owner

Current Risk Controls

• Starters and leavers process and policy denotes managerial responsibility to notify ICT
• Revised responsibilities for shared mailbox owners included in the revised and agreed Information Security Policy (Ratified at March 19 ExOP)
• New process agreed to request shared mailboxes and implement automated process for ongoing failsafe
• Process agreed to monitor, alert and escalate non-active shared mailboxes with Divisional Directors of Operations.
• Governance process for setting up new shared email accounts designed and implemented.

Mitigation Plan

Action:
Where a mailbox is identified by ICT as not being monitored, the relevant department or division will carry out a complete a review of all emails and take whatever action is needed *Due Date:* 29/11/19
Update on action:
Responses from the DDO's are being received and actioned. An audit of mailboxes where no response has been received will now be carried out

Action:
All shared email accounts should have assigned owner(s) *Due Date:* 31/12/19
Update on action:
All owners are being asked to retrospectively complete the new shared mailbox governance process. Any shared mail boxes where a response hasn't been received has been escalated to the divisions.

Action:
ICT should remind all shared email account owners of the process for decommissioning a shared email account *Due Date:* 31/12/19
Update on action:
Shared Mailbox section of updated Information Security Policy has been sent to all Shared mailbox owners
All Shared mailbox owners are being contacted to verify that the mailboxes are being monitored and have 3 named owners
Responses from communications to Shared mailbox owners actioned as appropriate.

Contingency Plans

Full audit of shared mailboxes, activity and owners in progress
New process to request shared mailboxes required
New process to monitor, alert and escalate non-active shared mailboxes to be implemented.
Responsibilities of shared mailbox owners clarified

Key Summary Updates & Challenges

One more round of communications has been planned and mailbox owners further contacted. Any mailboxes still not owned/monitored will be put through a closure process. Governance for closure process being worked up at present.

ID: 2383 ***NEW*** **Title: Failure to identify poor compliance with legislative and regulatory requirements**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to identify poor compliance with legislative and regulatory requirements, and to accreditations that are required to maintain relevant clinical services. **Cause:** • Trust devolved management structure • Some external visits rely on Trust self-assessments and might respond to false assurance • Inadequate governance procedures in place to identify, monitor and remedy all legislative and regulator requirements across the Trust **Effect:** • Patients and staff safety jeopardised • Executive Committee unaware of regulator failings • Insufficient action taken to address regulator shortcomings • CQC enforcement notice • Regulatory interventions • Reputational damage	**12**	**8**	**4**	*NEW*	**Director of Corporate Governance**	• Strengthen reporting between management committees • Quality and Safety sub-committee allows oversight to many division and specialist committees • BAF now contains comprehensive review of committee and reporting structure.

Current Risk Controls

• Governance arrangements in place with named leads to identify, address and remedy regulator requirements, including:
  o H&S legislation
  o Fire safety legislation
  o IRMER (Ionising Radiation) & other radiation based requirements
  o Pathology - UKAS (exCPA)accreditation, including ISO1518912012
  o Pharmacy regulations, specially manufacturing
  o Hygiene Act
• Managing external visits policy in place which sets out requirements re reporting external regulatory visits
• Performance reviews with divisions.

Mitigation Plan

Action:
Establish a central compliance unit that will oversee all external visits and regulatory compliance. *Due Date:* 31/07/19
Update on action:
[29/07/2019 10:05:26 Valentina Cappo] Action complete. Compliance unit established and paper outlining relevant priorities presented to ExOp on 23 July 2019.

Action:
Identify all regulatory and statutory standards for the Trust and map with relevant governance arrangements to ensure appropriate assurance mechanisms are in place *Due Date:* 31/10/19
Update on action:
This action has been postponed due to the project proving to be more complex than expected. A paper summarising the findings of this review will be presented to the Executive Quality Committee on 3 December 2019.

Action:
Agree assurance mechanism for monitoring compliance to regulatory requirements (e.g. via ICPG) *Due Date:* 31/12/19
Update on action:
Following presentation of the review of regulatory compliance at the Executive Quality Committee in December, an assurance framework will be agreed.

Contingency Plans

Manage reputational impact through communications

Key Summary Updates & Challenges

The action plan is in progress. A list of all regulations applying to the Trust and relevant processes to assure compliance has been developed and will be circulated to the Executive Quality Committee on 3 December 2019.

Board Assurance Framework

Appendix 2

Imperial College Healthcare NHS Trust

BAF Reference	Area of Risk	1st Line Assurance (Directorate / Divisional Level Committees and Reports)	2nd Line Assurance (Executive Committee, Trust Committee and Board Reporting)	3rd Line Assurance (National, Independent (i.e. Internal Audit) and External Body Reporting)	Summary Update (Identify issues arising from assurance received / gaps in assurance)	Assurance Rating (Level of Confidence of Assurance Received)	Reporting Committee	Accountable Executive Director	Risk Appetite	Risk Register References (Rating (LxC) and Reference)	CQC Domain
Objective 1 - Integrating Patient Feedback into Care Ensure all of the care and support each of our patients receives is shaped by actively asking and understanding what matters to them, and measuring outcomes against agreed goals.											
OBJ1-01	Failures of quality governance may allow poorer standards of care and may lead to non-compliance with statutory / contractual obligations.	Governance arrangements reviewed and reported by the Divisional Directors of Nursing; Integrated Quality & Performance Report covering all quality governance issues and performance.	Quality Committee reports bi-monthly; Updates provided to the Trust Board as and when required via an exception report from the Quality Committee.	Internal Audit; CQC Inspections; Commissioner Quality Group Oversight.	CQC Well-Led Inspection took place in April 2019 with an outcome of a 'Good' rating. Internal Audit review of Board and Executive Level Governance in March 2019, found no significant risks. Introduction of directorate governance reviews piloted in October 2019. Management of external visits reviewed and process re-launched in November 2019. Regulatory compliance monitored. **Corporate Risk Register Update - October 2019:** Deep dive review of CQC compliance completed in September 2019. Preparations for CQC inspections continued as planned. **Action Plan to Address Gaps in Assurance:**	**Medium**	Quality Committee	Medical Director Director of Corporate Governance	Medium	12 CRR: 2472	Effective / Safe
Objective 2 - New Care Models Establish formal partnerships with our primary care networks and other neighbouring providers to enable at least half of our care to be provided through 'place-based' health approaches and new models of care.											
OBJ2-01	Failure to deliver the clinical strategy programme to enhance acute services and support out of hospital care	Governance arrangements across STP with H&FGPF and within the Trust.	Audit, Risk & Governance reporting annually; Trust Board Seminars on Integrated Care Developments and the Clinical Strategy.	NHS Improvement and Commissioners Oversight; STP Programme Board and Oversight Group.	Board seminar programme including external stakeholders, including sessions on clinical strategy and enabling strategic plans. Extensive external engagement with clinical strategy and redevelopment programme (September / October 2019. **Action Plan to Address Gaps in Assurance:**	**Medium**	Audit, Risk & Governance Committee	Director of Strategy, Innovation & Research	Medium		Effective
OBJ2-02	Failure to secure redevelopment support and approval from STP, NHSI etc., failure to secure redevelopment funding and failure to secure support for moving services. Failure to secure effective ChelWest collaboration and partnership.	Project Board oversight.	Executive Committee and Redevelopment Programme Board monthly reporting; Trust Board updates as and when required via Redevelopment Programme Board exception report.	NHS Improvement, STP and NHS England programme oversight.	Board seminar on 30.10.2019 to develop forward programme. Engagement with stakeholders, NHSE/I, MP's, Local Authority and patient representatives. **Action Plan to Address Gaps in Assurance:**	**Medium**	Redevelopment Programme Board	Director of Redevelopment	Medium	16 CRR: 2498	Safe / Well-Led
Objective 3 - Pathway Redesign Re-design at least 50 care pathways, derived from out specialty review programme and making appropriate use of our flow coaching programme, to make them as user-friendly and digitally enabled as possible; five of the highest impact pathways to receive additional support to transform at scale.											
OBJ3-01	Failure to deliver the transformation programme required to achieve long term efficiencies and financial sustainability	Director of Transformation reports.	Executive Committee (DST & Finance), Finance, Investment & Operations Committee and Trust Board bi-monthly reports.	External Audit; NHS Improvement Oversight.	FIOC ToR strengthened to include transformation updates and oversight. Bi-Weekly FASRG meetings with Divisions and Senior Finance Teams with the CEO and CFO attending at one a month. Monthly financial reporting, cash and performance reviews reported to ExFin, FI&OC and Trust Board. **Action Plan to Address Gaps in Assurance:**	**Medium**	Finance, Investment & Operations Committee	Director of Transformation	Medium	20 CRR: 3014	Effective / Well-Led
OBJ3-02	*Failure to use benchmarking information available to improve quality and effectiveness of services from, for example, GIRFT, specialty review programmes, SSQD, NICE and Clinical Audits*				*Regular reviews of findings from GIRFT developing action plans against recommendations. Changes to care pathways based on national guidance.* **Action Plan to Address Gaps in Assurance:**	**Medium**	*Quality Committee*				

BAF Reference	Area of Risk	1st Line Assurance (Directorate / Divisional Level Committees and Reports)	2nd Line Assurance (Executive Committee, Trust Committee and Board Reporting)	3rd Line Assurance (National, Independent (i.e. Internal Audit) and External Body Reporting)	Summary Update (Identify issues arising from assurance received / gaps in assurance)	Assurance Rating (Level of Confidence of Assurance Received)	Reporting Committee	Accountable Executive Director	Risk Appetite	Risk Register References (Rating (LxC) and Reference)	CQC Domain
Objective 4 - Staff Engagement in Improving, Learning and Research Ensure every member of staff is able to participate in improvement, learning, teaching, transformation or research.											
OBJ4-01	Failure of systems and processes (including training of staff) may under-identify safeguarding issues and/or may lead to a failure to respond appropriately	Incidents investigated and resolved at Directorate and Divisional level; Serious Case Review Outcomes.	Executive (Quality) Committee reports monthly; Trust Quality Committee reports bi-monthly; Safeguarding Executive (Quality) Committee reports 6-monthly; Update on Safeguarding to the Trust Board every six months.	OFSTED Inspections and Reports.	Safeguarding training compliance (ICPG November 2019) - >90% compliance apart from safeguarding children level 3 (89%). Internal audit review of safeguarding due to be completed December 2019. **Action Plan to Address Gaps in Assurance:**	**Medium**	Quality Committee	Director of Nursing	Medium		Effective / Safe / Well-Led
OBJ4-02	*Potential for insufficient resource (time and people) to deliver the required capacity and capability for improvement methodology at scale and pace across the organisation (to deliver the dosing model)*				*Role of the improvement team is to provide education and training to support capacity and capability, potential resourcing implications under new management system. Management system will direct the priorities which may lead to current priorities being reviewed and stopped.* **Action Plan to Address Gaps in Assurance:**	**Low**	Quality Committee				
Objective 5 - Improve Patient Engagement Establish a systematic, evidence-based approach to building two-way relationships with as many patients and local people as possible, offering a range of engagement and involvement opportunities.											
OBJ5-01	*Failure to involve patients, public and local community in transformation or redevelopment plans and decisions and the Trust organisational strategy*	*Strategic lay forum, includes 14 lay partners, meets bi-monthly*	*Executive (Transformation) Committee reports quarterly;* *Trust Board reports annually;* *Redevelopment Programme Board*	*NHS Improvement and Commissioners Oversight*	*Redevelopment public engagement to start in Q4 2019. Issues are speed of the project, planning deadlines and managing messages across various stakeholders. The strategic lay forum input into plans at each meeting, the chair and deputy chair of the strategic lay forum attend the leadership forum, the chair of the strategic lay forum sits on the redevelopment board, two lay partner network events have been held in April and Sept, a third for late Nov, to discuss the organisational strategy and redevelopment with the Trust lay partner community, lay partners attend the strategy big room, 69 lay partner roles across 21 Trust projects, quarterly meetings held with Health watch (an operational meeting chaired by patient experience and a strategic one between Trust and Health watch CEOs), bi-monthly members update following each public board sent to key stakeholders* ***Action Plan to Address Gaps in Assurance:***	***Medium***	*Redevelopment Programme Board*	*Director of Communications*	*Medium*	*Comms RR: 2508*	*Effective / Responsive / Well-Led*
OBJ5-02	*Failure to establish a systematic membership offer to routinely communicate and engage patients and the local community. Failure to capture relevant contact information and preferences to tailor engagement opportunities and understand our audiences and communities*	*Directorate of communications*	*Strategic lay forum, includes 14 lay partners, meetings bi-monthly*	*Executive (Transformation) Committee reports as required;* *Joint Executive Committee*	*Creating a co-ordinated offer that considers the engagement needs of the College, BRC, Trust and other partners that is positioned and made easy to understand from the users point of view. Will involve liaising with partners, agreeing shared goals and collaborating on working processes. Funding of the membership offer and associated resource TBC. Joint paper from the College and Trust was present at the October JEG.* ***Action Plan to Address Gaps in Assurance:***	***Medium***	*Quality Committee*	*Director of Communications*	*High*		*Effective / Responsive / Well-Led*
OBJ5-03	*Failure to respond to user insight and shape services after capturing patient and community preferences regarding their care*	*Transformation Board*	*Executive (Transformation) Committee*	*Trust Board;* *CQC inspections*	*Quality improvement agenda, Flow Coaching Academy, HOTT programme* ***Action Plan to Address Gaps in Assurance:***	***Medium***	*Quality Committee*	*Director of Strategy, Innovation & Research*	*Medium*		*Effective / Responsive / Safe / Well-Led*
Objective 6 - Tackling Population Inequality Define and establish a method to measuring inequalities and have started to show the impact of specific interventions.											
OBJ6-01	*Failure to measure population inequalities and shape services to address them*				***Action Plan to Address Gaps in Assurance:***		*Finance, Investment & Operations Committee*				

BAF Reference	Area of Risk	1st Line Assurance (Directorate / Divisional Level Committees and Reports)	2nd Line Assurance (Executive Committee, Trust Committee and Board Reporting)	3rd Line Assurance (National, Independent (i.e. Internal Audit) and External Body Reporting)	Summary Update (Identify issues arising from assurance received / gaps in assurance)	Assurance Rating (Level of Confidence of Assurance Received)	Reporting Committee	Accountable Executive Director	Risk Appetite	Risk Register References (Rating (LxC) and Reference)	CQC Domain
Objective 7 - Improve Safety Embed a systematic approach to identifying safety priorities, test improvements and scale and sustain what works; including making further improvements to reducing falls, safer surgery and hand hygiene and to how we respond to deteriorating patients and investigate incidents.											
OBJ7-01	Risk of spread of infection.	Trust Infection Prevention and Control Committee; Divisional quality and safety committees.	Quarterly update to ExQual, Quality Committee and Trust Board	CQC Inspections; National reporting on infection rates	Weekly meetings between Facilities, Estates and IPC to discuss progress on improving cleaning. Hand hygiene improvement programme continues to be developed and rolled out to more clinical areas. High levels of compliance with CPE screening >90%. Proposal for CPE screening tool agreed and implemented. Negative pressure rooms at CXH are currently out of service with remedial plans in place. A SSI and Epidemiology team has been established and recruitment into posts is underway. There have been 53 cases of hospital-associated C. Difficile so far this year, which is above our trajectory of 37. None of these cases have been related to lapses in care suggesting that they were not related directly to cross-transmission or poor antibiotic stewardship. There were eight cases of E.coli BSI attributed to the Trust in August and September 2019, and a total of 35 cases so far. We are currently on track to meet our internal reduction target of 10%. There were no Trust-attributable cases of MRSA BSI reported in September 2019 and the figure remains at three cases reported so far this financial year, compared to three in total in 2018/19. There were no cases of CPE BSI reported in September 2019, however three were reported in August 2019. There have been six cases reported so far this year, compared to five this time last year. **Corporate Risk Register Update - October 2019:** CPE Screening Tool to be implemented alongside evaluation of the CPE screening tool. **Action Plan to Address Gaps in Assurance:**	**Medium**	Quality Committee	Medical Director	Low	16 (L4 x C4) CRR: 2487	Safe
OBJ7-02	Failure to ensure that required fire prevention and management systems are in place, including effective evacuation systems.	Incidents reported on Datix are investigated and resolved at Directorate and Divisional Level and reported to the Quality Committee every other month; Fire Safety reports submitted to the Executive Committee every 6 months.	Updates provided to the Trust Board as and when required via an exception report from the Quality Committee; Fire Safety Committee reporting into the Strategic Health & Safety Committee	London Fire Brigade Review and Oversight.	Latest report to Strategic Health & Safety Committee (September 2019): Fire risk assessments 100% at QCCH and Western Eye, but only 48% at CXH - 71% overall. Fire training at 88% (vs. target of 85%). Fire Safety Assurance Report presented to Executive (Operational Performance) Committee on 22.10.2019 outlined that the Trust remains compliant with Fire Safety (FS) Legislation. The London Fire Brigade is currently content with the evidence provided to demonstrate commitment to the backlog maintenance programme, training of fire wardens and evacuation systems. A meeting with the London Fire Brigade that is due to take place this year has not happened due to the retirement of the LFB Health & NHS appointed individual. **Action Plan to Address Gaps in Assurance:**	**High**	Quality Committee	Director of Operational Performance	Low	16 (L4 x C4) FEN RR: 2183 8 (L2 x C4) OP RR: 1689	Safe
OBJ7-03	Failure to provide safe equipment impacts patient and staff safety. Equipment failure reduces ability to achieve operational targets.	Capital Steering Group oversee prioritisation of critical equipment spend; Medical devices management group report quarterly to the Executive Committee.	Incidents investigated and resolved at Directorate and Divisional level and reported to the Quality Committee every other month; Trust board as and when required via an exception report from the quality committee.	Internal Audit; IR(ME)R oversight.	Medical devices report to ICPG - November 2019. Medical devices maintenance compliance meeting targets for high, medium and low risk devices. Internal audit review of medical devices - to report to ARG December 2019. Bi-monthly meetings of the Medical Devices Committee, which reports into Executive (Quality) Committee. **Action Plan to Address Gaps in Assurance:**	**High**	Quality Committee	Director of Estates & Facilities Divisional Director Medicine & Integrated Care Divisional Director Surgery Cancer & Cardiovascular Divisional Director Women's, Children's & Clinical Support	Medium	9 (L3 x C3) FEN RR: 2539 6 (L2 x C3) E&F RR: 1737	Responsive / Safe / Well-Led
OBJ7-04	Failure to maintain high quality patient care and experience in ED due to extended delays experienced by mental health patients awaiting transfer	Incidents investigated and resolved at Directorate and Divisional level; Core Service Reviews conducted as and when required.	Quality Committee reports bi-monthly; Emergency Department updates Executive (Quality) Committee reports monthly.	CQC Inspections.	SI report to Board highlighting number of incidents relating to patients requiring mental health care. CEO updates to board re changes to MH commissioning - the MH Compact. **Corporate Risk Register Update - October 2019:** Mental health breaches have been escalated to commissioners and collaborative work has been undertaken with Central & North West London NHS FT. Actions are being put into place to ease the situation including the development of a 24/7 assessment lounge, appointment of a Head of Urgent Care role within CNWL to support the location of beds. **Action Plan to Address Gaps in Assurance:**	**Medium**	Quality Committee	Divisional Director Medicine & Integrated Care	Low	20 CRR: 2477	Safe
OBJ7-05	Failure to adhere to medication safety policies, failure to adopt best practice may lead to sub-optimal treatment and failure of controlled medicines usage may lead to unnecessary costs.	Incidents reported on Datix are investigated and resolved at Directorate and Divisional level; Medication Safety reports.	Executive (Quality) Committee reports monthly; Trust Quality Committee reports bi-monthly; Updates to Trust Board as and when required via exception report from Quality Committee.	CQC Inspections; MHRA Annual Submissions and Reviews.	CQC inspection reports from 2018/2019 - published July 2019. Pharmacy and medicines management internal audit review - in progress. Medicines management one of 4 key work streams in QI. **Corporate Risk Register Update - October 2019:** Most recent CQC reports were favourable with respect to medicines management and this reflects well on the work to date. **Action Plan to Address Gaps in Assurance:**	**High**	Quality Committee	Medical Director	Medium	12 CRR: 2538	Safe

BAF Reference	Area of Risk	1st Line Assurance (Directorate / Divisional Level Committees and Reports)	2nd Line Assurance (Executive Committee, Trust Committee and Board Reporting)	3rd Line Assurance (National, Independent (i.e. Internal Audit) and External Body Reporting)	Summary Update (Identify issues arising from assurance received / gaps in assurance)	Assurance Rating (Level of Confidence of Assurance Received)	Reporting Committee	Accountable Executive Director	Risk Appetite	Risk Register References (Rating (LxC) and Reference)	CQC Domain
OBJ7-06	Failure to provide safe estate impacts patient and staff safety, failure to provide an appropriate environment (including cleaning impacting patient experience and outcomes and failure to manage property portfolio impacts on financial position.	Incidents investigated and resolved at Directorate and Divisional level; Hard FM Procedures in place for responding to priority issues; Capital Programme reports.	Executive (Quality) Committee and Trust Quality Committee incident reports bi-monthly; Trust Board reports as and when required via an exception report from the Redevelopment Committee.	External Review of Backlog Maintenance; NHS Improvement Oversight.	Trust estate and infrastructure is a risk and has seen recent failures, reflected in serious incidents. Redevelopment programme in place to oversee redevelopment of Trust sites. **Corporate Risk Register Update - October 2019:** Continued monitoring of Trust Infrastructure and equipment, PPM maintenance programme on system through which closer monitoring of PPM schedules are available to be reviewed. Contingency plans of Capitals, Major Incident and Integrated Business Continuity Plans and NHSLA Insurance cover. Also including the right to invoke the terms and clauses of the Hotel Services Contract to impose escalations, rectifications and any breaches of contract. **Action Plan to Address Gaps in Assurance:**	**Low**	Quality Committee	Director of Estates & Facilities	Medium	20 CRR: 2485 12 CRR: 2480	Responsive / Safe / Well-Led
OBJ7-07	Failure to ensure appropriate arrangements in place to protect staff and failure to ensure that staff are immunised fully against biological agents to which they may be exposed.	Incidents investigated and resolved at Directorate and Divisional level.	Executive (Quality) Committee and Trust Quality Committee incident reports bi-monthly; Trust Board reports as and when required via an exception report from the Quality Committee.	Internal Audit; CQC Inspections; HSE Inspections.	Quality Committee November 2019 Update: 5 weeks into the campaign: 4,277 people have been vaccinated. This breaks down as 2,442 frontline healthcare workers, 780 non-healthcare workers and 1,055 nondirectly employed workers (e.g. students, contractors, volunteers). A cleanse of the non-directly employed workers is currently being undertaken as this may contain frontline workers where there has been no electronic match between the name entered into the flu database and the Trust's electronic staff record system. NHSe/ NHS Improvement (NHSi) has asked the Trust to complete its best practice management checklist for healthcare worker vaccination and, subsequently, publish a self-assessment against these measures in the Trust board papers before the end of December 2019. The Trust is undertaking all the actions recommended on the checklist which will be presented at the November Trust Board. **Action Plan to Address Gaps in Assurance:**	**Low**	Quality Committee	Director of People & Organisation Development	Low	9 (L3 x C3) P&OD RR: 2024	Caring / Responsive / Safe / Well-Led
OBJ7-08	Failure to adequately train staff poses risk to quality of patient care and failure to achieve benchmark levels of medical education performance.	Online monitoring tool for all staff.	Executive (Quality) Committee reports monthly; Trust Quality Committee reports bi-monthly; Trust Board seminars on educational activities annually.	Internal Audit; Various Royal College and GMC Inspections.	Compliance with training monitored monthly using LEARN. Non-compliant staff are escalated via line managers and divisional structures. Policies and guidelines to support safe invasive procedures in place. Invasive procedure e-learning module part of core clinical skills training. HOTT programme in progress focused on simulation, coaching, human factors and support. **Action Plan to Address Gaps in Assurance:**	**Medium**	Quality Committee	Medical Director Director of Nursing	Low		Caring / Effective
OBJ7-09	*Failure to prevent never events.*	*Invasive Procedure Task and Finish Group*			*Trust-wide action plan developed including a number of actions to improve, monitor and provide assurance around compliance and key safety checks such as the 'Five Steps to Safer Surgery', the 'Count' and 'Stop Before You Block'. There is also a review of all Trust policies and processes related to invasive procedure. The implementation of the HOTT programme. Action plans will be monitored by the Invasive Procedures Task and Finish Group.* ***Action Plan to Address Gaps in Assurance:***	***Medium***	*Quality Committee*				
OBJ7-10	*Failure to prevent avoidable harm in hospital.*				*Workstream in place to cover: safer medicines management, reduction in harm from falls, pressure ulcer reduction, responding to deteriorating patients and sepsis and safer surgery work streams.* ***Action Plan to Address Gaps in Assurance:***	***Medium***	*Quality Committee*				
Objective 8 - Improve Translation of Research Into Patient Care In collaboration with partners, especially Imperial College, improve the speed and scale of the translation of biomedical and data science research into better patient care, and the adoption and spread of innovative ideas, technologies and ways of working.											
OBJ8-01	Failure to secure development of NIHR BRC, failure to ensure research embedded in divisions and failure to develop AHSC to full potential and successful redesignation	Divisional research reports.	Executive (Quality) Committee and Trust Quality Committee 6-monthly research reports.	National Research Bodies Oversight.	ICHT research committee established. BRC research director appointed and office resourced. Monthly teleconferences between BRC Director, ICHT CEO and Dean of FoM. **Action Plan to Address Gaps in Assurance:**	**Medium**	Quality Committee	Medical Director	High	12 (L3 x C4) MDO RR: 2620	Safe / Well-Led
Operational & Financial Performance											
OFP-01	Poor systems and processes lead to financial loss through fraud	Cases raised and cases pursued reported to the Audit, Risk and Governance Committee Quarterly.	Report to the Trust Board as and when required via the Audit, Risk and Governance Committee.	Local Counter Fraud Specialist (LCFS) report to each ARG meeting	Latest LCFS report presented at July ARG meeting. Revised fraud standards reflected in risk management processes - risk is now embedded in existing risk registers. **Action Plan to Address Gaps in Assurance:**	**High**	Audit, Risk & Governance Committee	Chief Financial Officer	Low	9 (L3 x C3) F RR: 1045	Well-Led
OFP-02	Failure to secure contracts with commissioners on sound contractual terms, impacts on the financial security of the Trust and may adversely affect quality of service.	Clear processes in place within the Service Development and Commissioner Relations Team.	Executive (Finance) Committee, Finance, Investment & Operations Committee and Trust Board bi-monthly contract position reports.	NHS Improvement Oversight.	Internal audit / external audit opinion (May 2019). Bi-Weekly FASRG meetings with Divisions and Senior Finance Teams with the CEO and CFO attending at one a month. Monthly financial reporting, cash and performance reviews reported to ExFin, FI&OC and Trust Board. **Action Plan to Address Gaps in Assurance:**	**High**	Finance, Investment & Operations Committee	Chief Financial Officer	Medium	20 CRR: 3015	Responsive / Well-Led

BAF Reference	Area of Risk	1st Line Assurance (Directorate / Divisional Level Committees and Reports)	2nd Line Assurance (Executive Committee, Trust Committee and Board Reporting)	3rd Line Assurance (National, Independent (i.e. Internal Audit) and External Body Reporting)	Summary Update (Identify issues arising from assurance received / gaps in assurance)	Assurance Rating (Level of Confidence of Assurance Received)	Reporting Committee	Accountable Executive Director	Risk Appetite	Risk Register References (Rating (LxC) and Reference)	CQC Domain
OFP-03	Failure to deliver against NHSI targets, in particular ED performance & emergency flow, RTT & elective performance and data quality.	IQPR; Divisional oversight meetings; Review of services every other month.	Executive (Quality) Committee reporting monthly; Trust Quality Committee reporting bi-monthly; Operations performance report to Trust Board bi-monthly.	NHS Improvement and Commissioners Oversight; Monthly provider oversight meetings.	November 2019 Update: NHSI have removed or discontinued the Trust undertakings and upgraded Trust segmentation. Update of performance as per latest performance scorecard: - 3 patients waiting > 52 Weeks; - RTT waiting list size maintained and met trajectory; - RTT 18 week trajectory met; and - Diagnostics - target met. **Corporate Risk Register Update - October 2019:** Flow coordinators recruited at Charing Cross with an expected start date of November 2019. Expected improvement in flow once posts in place. ICHT has delivered good performance across two of the RTT measures, with the 2019/2020 trajectory agreed within the operational plan. **Action Plan to Address Gaps in Assurance:**	High	Quality Committee	Director of Operational Performance Divisional Director Medicine & Integrated Care Divisional Director Surgery Cancer & Cardiovascular Divisional Director Women's, Children's & Clinical Support	Medium	20 CRR: 2943 16 CRR: 2937	Responsive
OFP-04	Failures of financial control risk leads to unanticipated budget overspends	Finance team controls over month and year end; Monthly reports to Divisions and Directorates.	Executive Committee and Audit, Risk and Governance Committee reports annually; Audit included as part of the Annual Accounts presented to the Trust Board annually.	Internal Audit; External Audit.	Internal audit / external audit opinion (May 2019). **Action Plan to Address Gaps in Assurance:**	High	Audit, Risk & Governance Committee	Chief Financial Officer	Medium		Well-Led
OFP-05	Failure to deliver financial plan.	Divisional financial reporting; Scrutiny of Trust Financial position every other month.	Monthly reporting to the Executive (Finance) Committee and the Finance, Investment and Operations Committee; Executive Committee monitor delivery of achievements against performance; Financial report presented to the Trust Board every other month.	External Audit; NHS Improvement Oversight.	As at Month 5 of the 2019 / 2020 financial year, there is a £12m forecast gap to plan. This is an improvement on previous months and Divisions are working hard to close gaps. 3% reduction in pay run rate is being monitored to drive lower cost base. Bi-Weekly FASRG meetings with Divisions and Senior Finance Teams with the CEO and CFO attending at one a month. Monthly financial reporting, cash and performance reviews reported to ExFin, FI&OC and Trust Board. **Action Plan to Address Gaps in Assurance:**	High	Finance, Investment & Operations Committee	Chief Financial Officer	Medium	20 CRR: 3014	Effective / Well-Led
OFP-06	Inability to recruit and retain appropriately skilled staff poses risk to quality of patient care; Inability to deliver a workforce that enables the required changes for the clinical model.	Vacancy rates and time to recruit figures; Efficiency and effectiveness of the recruitment process; Safer staffing levels published monthly.	Executive (Quality) Committee reporting monthly; Trust Quality Committee reporting bi-monthly; Updates provided to the trust board as and when required via an exception report from the quality committee.	Internal Audit; NHS Improvement Oversight; Commissioners Quality Group Oversight.	**Corporate Risk Register Update - October 2019:** Vacancy rate for all Nursing & Midwifery for August 2918 was 15.45%. A comprehensive workforce report and plan will be reviewed by executives on a bi-monthly basis with leavers data from ESR analysed monthly. To promote flexible working, all advertised roles will encourage candidates to discuss their flexible working requirements at interview. A pool of career coaches have been identified and trained to provide careers coaching to nursing staff with quarterly career clinics taking place across the main sites. **Action Plan to Address Gaps in Assurance:**	Medium	Quality Committee	Director of People & Organisation Development	Low	12 CRR: 2944	Caring / Safe / Well-Led
OFP-07	Breaches to data security and protection may result in failure to comply with Global Data Protection Regulations (GDPR) and could incur financial penalties.	Process in place for reporting breaches and actions in place to minimise the impact of data security breaches reported to the Audit, Risk and Governance Committee quarterly.	Annual Information Governance Data Security & Protection Toolkit returns reported to ARG; Annual Governance Statement performance and serious breaches exception report to Trust Board annually.	Internal Audit; NHSIC Oversight; External Audit.	Quarterly review of GDPR actions by the Audit, Risk & Governance Committee. Information Governance mandatory training at 90% in October 2019. Internal Audit review of Data, Security and Protection Toolkit to commence. **Action Plan to Address Gaps in Assurance:**	High	Audit, Risk & Governance Committee	Chief Information Officer	Low		Well-Led
OFP-08	*Risk of cyber security attack is increased due to old and unsupported hardware and software.*	*Process in place for reporting breaches and actions in place to minimise the impact of cyber crime reported to the Audit, Risk and Governance Committee quarterly;* *Cyber Security dashboard;* *Senior Leadership monitoring.*	*Updates to ARG quarterly.*	*Internal Audit;* *Monitoring against the Network & Information Standards (NIS).*	*Cyber security discussed monthly via a dashboard at the Data Security and Protection Committee and a Cyber Security Incident Plan is in place. Internal Audit review of Data, Security and Protection Toolkit to commence.* ***Corporate Risk Register Update - October 2019:*** *NHS England have announced a potential cyber security funding opportunity to which the Trust has expressed an interests.* ***Action Plan to Address Gaps in Assurance:***	*High*	*Audit, Risk & Governance Committee*	*Chief Information Officer*	*Low*	*16* *CRR: 2482*	*Well-Led*

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TRUST BOARD – PUBLIC
REPORT SUMMARY

Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q2 2019/20	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27th November 2019	**Item 14, report no. 11**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Jon Otter, General Manager, IPC Professor Alison Holmes, Director, IPC Dr Eimear Brannigan, Deputy Director, IPC

Summary:

- There have been 28 Trust-attributed *C. difficile* cases during Q2, against a ceiling of 16 cases. Although this rise has prompted further investigations, there have been no lapses in care identified this quarter and none for 2019/20 so far.
- There were no cases of Trust-attributed MRSA BSI during Q2 from 8007 blood cultures tested.
- We are on target to achieve a 10% year-on-year reduction in Trust-attributed *E. coli* BSIs, with 16 cases during Q2 against a ceiling of 21.
- The rate of surgical site infection (SSI) following coronary artery bypass graft (CABG) cardiothoracic surgery is 10.9% (8 superficial incisional SSIs in 73 procedures), which is above the national average of 3.8%; SSI prevention measures have been reinforced and an action plan is being developed in a Task and Finish group chaired by a cardiothoracic surgeon to address this.
- We remain above the 90% target for all quality indicators in the bi-annual point prevalence survey of antimicrobial prescribing.
- There has been a sustained reduction in carbapenem consumption in Q2 2019/20 reversing the upward trend reported in Q4 2018/19.
- A new Antibiotic Stewardship Cerner Dashboard has been launched in Cerner, enabling a more targeted approach to antibiotic reviews and will now be embedded in antibiotic stewardship activities.
- We are making good progress towards increasing are use of more narrow spectrum antimicrobials from the World Health Organisation “access group” classification. In Q2, 45% of the Trust overall antimicrobial use came from this group specifically in the use of oral rather than intravenous agents.
- During Q1, several clusters and outbreaks were identified and managed, including a CPE outbreak on a renal ward, a CPE outbreak on a paediatric haematology ward, and *E. coli* colonisation in the neonatal ICU at SMH. The CPE outbreaks have prompted two SI investigations.
- The second cohort of hand hygiene improvement focus wards have completed their 12 week improvement cycle; the bi-annual hand hygiene audits results (from September 2019) show that all phase II wards have improved compliance, with mean compliance increasing from 38% to 64%.

This report was discussed at executive quality committee and board quality committee in November 2019, where performance was noted.

Recommendations:
The Board is asked to note the report.

This report has been discussed at:
Executive quality committee; Quality committee

Quality impact:
IPC and careful management of antimicrobials are critical to the quality of care received by patients at ICHT, crossing all CQC domains. This report provides assurance that IPC within the Trust is being addressed in line with the ‘Health and Social Care Act 2008: code of practice on the prevention and control of infections’ and related guidance.

Financial impact: No direct financial impact.
Risk impact and Board Assurance Framework (BAF) reference: This report includes a summary update of the IPC risk register.
Workforce impact (including training and education implications): None
Has an Equality Impact Assessment been carried out? ☐ Yes ☐ No ☒ Not applicable
Trust strategic objectives supported by this paper: ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

1 Healthcare-associated infection surveillance and mandatory reporting

- There have been 28 hospital-associated *Clostridium difficile* cases during Q2 (17 Hospital Onset, Healthcare-Associated, HOHAs and 11 Community-Onset, Healthcare-Associated, COHAs), against a ceiling of 16 HOHA and COHA cases combined (Appendix Table 1; Figure 1). Hospital-associated *C. difficile* cases were detected in 1.7% of 1689 stool specimens tested during Q2. This means that there have been 53 cases of hospital-associated *C. difficile* against a ceiling of 37 for the first half of 2019/20. None of these *C.difficile* cases were identified as having a lapse in care due to cross-transmission or antibiotic choices, compared with eight with during the first half of 2018/19. Our rate of hospital-associated (HOHA and COHA) *C. difficile* cases ranks 10th and therefore highest amongst the Shelford group, compared to a rank of 3rd in 2018/19. The rate of specimens tested for *C. difficile* in the other trusts is unknown, but remains broadly constant here.
- We adhere to a comprehensive set of measures to optimise antibiotic usage thereby minimising the risk of *C. difficile* infections developing and reducing transmission. This includes multidisciplinary clinical review of all cases, and rapid feedback of lapses in care to prompt ward-level learning, and *C. difficile* prevention ward rounds. The additional investigations outlined below are ongoing in response to the overall elevated rate of *C. difficile* in the first half of 2019/20:
  - The procurement process for HPV has stalled; we have sought a timeline from procurement as to when the technology will be available to be used for terminal disinfection following the discharge of patients with *C. difficile* infection.
  - Since the COHA cases represent most of the increase above the ceiling, the clinical reviews of these cases from the first half of 2019/20 is being scrutinised to identify any potential trends. Initial investigations suggest no linkage in pathway for these patients, with diverse genetic types of the bacteria involved.
  - We are investigating trends in the prescribing of antibiotics that are known to increase *C. difficile* infection.
- There were no cases of Trust-attributed methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI) during Q2 from 8007 blood cultures tested. Compliance with MRSA admission screening was on target at 90% for Q2: 7059 of the 7840 patients identified as requiring MRSA screening were screened. The process for evaluating MRSA admission screening is being reviewed to identify clinical areas that could improve their compliance.
- There have been eight cases of Trust-attributed methicillin-susceptible *S. aureus* (MSSA) BSI during Q2, compared with seven during Q2 2018/19. There is no national threshold. Four of the eight cases were associated with a vascular access device (two cases were central line associated and two cases were arterial line associated). Each case is reviewed by a multidisciplinary group (including the clinical team), and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases. This has prompted teaching on the wards in relevant areas around line care, recording keeping and contacting the vascular access team for support. There has been no evidence of clustering by ward or Division.
- The reviews of MSSA and MRSA BSI cases during Q1 and Q2 identified issues related to the management of vascular access devices. In response to these findings, a Patient Safety Alert was sent out to all clinical staff to promote best-practice in the management of vascular access devices.
- The number of Gram-negative *E. coli*, *Pseudomonas aeruginosa*, and *Klebsiella pneumoniae* BSI cases during Q2 2019/20. There have been four CPE BSI in Q2, compared with a total of seven cases during 2018/19. The source of all Gram-negative BSIs is reviewed by a multidisciplinary team to identify learning. Urinary and gastrointestinal sources for *E. coli* BSI predominated during Q2. Addressing the various sources of *E. coli* BSI, especially urinary sources and surgical site sources, is a focus of a multidisciplinary (MDT) group working around reducing Gram-negative BSI.
- The Trust is on target to meet its 10% year-on-year reduction in *E. coli* BSIs (an internal performance metric), with 16 cases in Q2 against a ceiling of 21 (Appendix Figure 2). The rate of E. coli BSI ranks second lowest in the Shelford group.
- Key developments and accomplishments towards supporting the government's ambition to halve healthcare-associated Gram-negative BSI by 2021 during Q2 2019/20 include:
  - Contribute to the inaugural Gram-negative BSI reduction group hosted by the North West London Collaboration of CCGs (NWL CCGs), in October 2019; a follow up meeting is scheduled during November 2019.

- MDT group meetings continue to review *E. coli* BSIs. Members of the CCG are attending to promote collaborative working across acute and non-acute care.
- Initial internal meeting with key stakeholders (including the Medical Director, IPC, Deputy Chief Nurse, Procurement Nurse, and quality improvement experts) to review the current infrastructure and resourcing for the management of urinary catheters and patient hydration.
- Working with the *E. coli Cancer Collaborative* (a partnership of several NHS Trusts that include Cancer services) to review cases of *E. coli* BSI in cancer patients and share learning across the Collaborative.
- Development of a driver diagram to streamline planning activities around preventing GNBSI.

- Plans for Q3 include:
- Continue to support NWL CCGs in developing plans to reduce Gram-negative BSI.
- Developing a series of interventions to improve urinary catheter management in order to prevent *E. coli* BSIs secondary to urinary catheter-associated UTI.
- Planning of interventions aimed at preventing *E. coli* BSIs in specialist high-risk patient groups (haematology, renal, NICU and post-surgical wards).

- The rate of catheter line-associated BSI (CLABSI) remains below benchmark rates in adult ICU, paediatric ICU, and in very-low birthweight babies in the neonatal ICU. The rate of 'contaminants'[1] also remains below the benchmark rate.
- Rates of surgical site infection (SSI) remain below national benchmark rates following the selected elective orthopaedic procedures included in the mandatory national surveillance scheme (Appendix Section 6.2). Rates of SSI following CABG and non-CABG procedures remains consistently above the national average over the past 12 months, and is rising. A letter has been received from PHE flagging the high rate of SSI for the April – June 2019 quarter; a response to this letter will be sent in Q3. The cardiothoracic team have convened a bi-weekly Task and Finish group chaired by a cardiothoracic surgeon and including key stakeholders in order to urgently develop an action plan to reduce the risk of SSI following cardiothoracic procedures. This action plan will be monitored through the *Surgical Infection Group.*
- A business case to enhance SSI surveillance and prevention activities in the Trust has been approved. The recruitment process is in progress for the new SSI surveillance and prevention team. It is anticipated that posts will be filled during Q3.
- The national *Getting It Right First Time (GIRFT)* prospective audit of SSI between May and October 2019 is in progress in in Vascular and Cardiothoracic surgical categories. Final results will be available during Q3, and will be presented to the *Surgical Infection Group*. General surgery had planned to participate in the GIRFT SSI audit, but have not yet been able to provide data.
- The number of carbapenemase-producing Enterobacteriaceae (CPE) identified each month has plateaued at between 50 and 80 each month. More than 95% of these samples are from screening specimens rather than from clinical specimens. The number of screens taken for CPE each month has also plateaued over the previous 18 months.
- Overall compliance with CPE admission screening was 83%, and >90% in the four specialties performing universal admission screening. CPE admission screening compliance is included by ward in the monthly *Harm Free Care* report. This provides a mechanism to prompt targeted improvement at ward level to address areas of low compliance.
- The CPE Action Plan was originally launched in December 2017, and is now a rolling action plan, monitored by the quality and safety sub-group. One action remains outstanding currently:
  - A Cerner tool to offer decision support to frontline staff and to track and report on CPE admission screening compliance, including patients who declined to be screened. We have reached an agreement with Chelsea and Westminster Hospital NHS Trust to use the same tool. We are currently waiting for the date that this change will be implemented in Cerner. Communications will then be planned to brief clinical staff.
  - A Trust-wide point prevalence screen of all inpatients to understand the CPE carriage rate across our inpatient population and inform our screening strategy, as recommended in the PHE guidance of 2013, was completed in September 2019. The results will be shared following completion of analysis during Q3.

[1] Bacteria identified in blood cultures that are associated with patients' skin and considered not to be representing infection. Benchmark for contaminated blood cultures set based on published literature, which suggests a rate of 3%: Self et al. *Acad Emerg Med* 2013; 20:89-97.

2 Antibiotic stewardship

- The biannual antibiotic point prevalence study (PPS) examines key antibiotic prescribing and safety indicators was conducted in August 2019.
  - Approximately 41% of inpatients were scheduled to receive an antibiotic. 92% were prescribed according to policy or on the advice of infection teams. 94% of antibiotic prescriptions had a documented review within 72 hours of initial prescribing and treatment duration was in line with policy or approved by the Microbiology/ID team in 94% of cases. The Trust has a suggested compliance of 90% for these indicators.
- There has been a reduction in total antimicrobial consumption during Q2 2019/20, in line with the trend seen over the past 5 years, following the winter months (Appendix Figure 3). We continue to prescribe fewer antimicrobials than four years ago.
  - Carbapenem-reduction initiatives that were introduced in Q1 have continued to curb usage and consumption has been successfully maintained in Q2.
  - A rise in piperacillin/Tazobactam use during Q2 2019/20 can be attributed to a reintroduction of the drug within Critical Care as authorised by Antibiotic Review Group. Usage will be monitored closely in Q3.
  - Compared with our Shelford peers, ICHT ranks 3rd best for Piperacillin/ Tazobactam but ranks 8th for carbapenem usage.
  - There has been a continual increase in the percentage of antibiotics from within the Access Group[2] since its launch through to Q2, reaching 45.2%; this metric will continue to be monitored throughout 2019/20.
- A new Antibiotic Stewardship Cerner Dashboard has been launched in Cerner. This system has allowed for a more targeted approach to antibiotic reviews and will be embedded in further antibiotic stewardship activities in Q3 2019/20.
- We continue to experience the impact of national antimicrobial shortages for a number of agents; this challenge is identified on the risk register. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis. There is no evidence of patient harm as a result of these shortages.
- We are participating in the *NHSE Anti-fungal CQUIN* with 0.4 WTE 8a pharmacy support. This work is part of the wider *Medicines Optimisation CQUIN*.
- We are participating in the *Antimicrobial Resistance 2019/20 CQUIN* where part 1 aims to improve the management of lower urinary tract infections (UTI) in the elderly and part 2 looks at appropriate use of antibiotic surgical prophylaxis in colorectal surgery. A 1.0 WTE band 7 pharmacist is now in post to support this.
- Work to improve the identification and management of sepsis continues through the Sepsis Big Room. The clinical workflow to respond to the electronic sepsis alert was revised including a change to wording during Q2, which has resulted in reduced time to diagnosis and less variability in clinician response. A paper summarising improved clinical outcomes associated with the introduction of the sepsis alert in Cerner (including a rise in the identification of sepsis, a fall in mortality and length of stay related to sepsis) has been accepted for publication.

3 Hand hygiene and Aseptic Non-Touch Technique (ANTT) competency assessment

- The Trust has a requirement that ANTT competency assessment is undertaken and documented for all clinical staff. Currently the compliance rate is 80.2%, below our 90% target. Plans are in place to improve compliance along with other core clinical skills, including the new model for Divisionally-led ANTT assessment for new doctors on arrival, which was launched in Q4 2018/19.
- A new approach to hand hygiene compliance auditing to improve the quality of data in order to guide improvement commenced during 2018. A multidisciplinary Hand Hygiene Improvement Group meets monthly to lead the hand hygiene improvement work.
- A bi-annual hand hygiene compliance audit for September 2019 has been completed.
  - Overall compliance has increased from 56% of 3560 observations in the May 2018 audits to 63% of 2,856 observations in the September 2019.

[2] The AWaRe index categorises antibiotics into three groups: Access antibiotics are those that should be available to treat a wide range of infections; the Watch group are antibiotics recommended for a small number of infections; and the Reserve group should be considered last resort options.

- Hand hygiene compliance trends for the Phase II focus wards have shown an increase in compliance since the February 2019 audits. Overall compliance has increased from 38% in February 2019 to 64% in September 2019.
- The improvements that were attributed to the Phase 1 improvement cycle in November 2018 have been sustained overall, with compliance at 69% in September 2019, compared with 64% in November 2018.

- Two alternative non-observational methods to measure hand hygiene compliance are being trialled by the Hand Hygiene Improvement Group (ask patients for their perspective on hand hygiene during their stay, and automated measurement of hand hygiene product consumption).
- Phase III focus wards (identified for intensive support in developing local improvement plans) are being selected for Q3.
- The first round of new hand hygiene awareness posters (based on song lyrics) have been ordered. The impact will be evaluated to inform the decision of whether to invest in a quarterly update of the campaign over the next 12 months.
- The therapists team were given a Make A Difference award to celebrate the sustained improvement in hand hygiene compliance amongst therapists.
- A QI sprint was held in September 2019 to focus on improving hand hygiene in public areas. Improvement interventions will be piloted during Q3 and Q4.

4 Clinical activity, incidents, and lookback investigations during Q2

- During Q2 two separate clusters of CPE were identified on a renal ward in August 2019 at HH, each affecting four patients. One patient had an infection and was treated, the remaining cases were colonisations. These were indistinguishable by typing and transmission was therefore suspected. A full investigation into IPC practice, cleaning, and the environment was undertaken. This was reported as a serious incident (2019/20276) which is under investigation.
- Nine babies have been identified with an ESBL *E. coli* on the neonatal unit in September 2019. These all represent colonisation and include several sets of multiple births and three singletons. An investigation is being undertaken and focuses on hand hygiene, IPC practice, and decontamination of the environment and equipment.
- Six patients were identified with CPE on a paediatric haematology ward at SMH in August 2019. All were identified by screening and represent colonisation. In addition one child subsequently developed a BSI with the organism, possibly associated with a femoral central venous catheter (CVC). The device was removed and the patient was treated but remains an in-patient due to their underlying condition. These isolates were indistinguishable by typing and transmission was therefore suspected. A full investigation into IPC practice, cleaning, and the environment was undertaken. Cleaning concerns were highlighted and rectified and the outbreak was declared over in September 2019. This was reported as a serious incident (2019/1924) which is under investigation.
- In Q2, a total of 19 communicable disease ‘‘look back’ investigations were undertaken related to potential exposures to chickenpox, shingles, measles, pertussis and invasive group A streptococcal infection. This has reduced slightly from 24 during Q1.

5 Compliance, policies, and risks

- Issues with cleaning standards continue to be identified. Facilities have reviewed cleaning policies and processes in conjunction with the Divisions and IPC in order to improve. A new cleaning contract is in the process of tendering.
- We have two tiers of annual core skills IPC training: compliance with Level 1 is 93% and 91% for Level 2.
- There have been no new IPC risks identified.
- The existing risk related to negative pressure isolation rooms at the Charing Cross site has been updated to include a lack of functional negative pressure isolation rooms at Level 1, and in the Emergency Department at CXH.
- The water hygiene management risk has been updated to reflect ongoing challenges with water hygiene management.

6 Other

- Members of the IPC team have produced 11 peer-reviewed publications relating to applied research in HCAI and AMR during Q2

7 Appendix

7.1 *Healthcare-associated infection surveillance and mandatory reporting*

	Apr-19		May-19		Jun-19		Jul-19		Aug-19		Sep-19		Oct-19		Nov-19		Dec-19		Jan-20		Feb-20		Mar-20		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	YTD (ceiling)
Trust MRSA BSI	0	0	2	0	1	0	0	0	0	0	0	0													3	0
Hospital onset- Hospital associated (HOHA)	3	-	7	-	10	-	6	-	6	-	5	-													37	-
Community onset-Hospital associated (COHA)	2	-	2	-	1	-	6	-	4	-	1	-													16	-
Total Hospital associated C.difficile cases (HOHA + COHA)	5	8	9	7	11	6	12	6	10	5	6	5													53	37
Trust *E.coli* BSI	8	-	6	-	5	-	8	-	3		5														35	-
Trust MSSA BSI	2	-	1	-	1	-	5	-	2		1														12	-
Trust CPE BSI	0	-	0	-	2	-	1	-	3		0														6	-
Trust Pseud BSI	2	-	4	-	2	-	5	-	4		2														19	-
Trust Kleb BSI	2	-	3	-	6	-	3	-	10		5														29	-

'Trust' refers to cases that are identified after two days of hospitalisation and so are defined epidemiologically as "hospital-acquired". A further delineation is made for C.difficile whereby non-Trust toxin (EIA)-positive cases where the patient has had a previous hospitalisation within 4 weeks are classified as 'Community Onset-Hospital Associated (COHA), distinguishing it from 'Hospital Onset-Hospital Associated' (HOHA) cases. National thresholds are set for MRSA BSI and C. difficile infection.

Table 1: HCAI mandatory reporting summary.

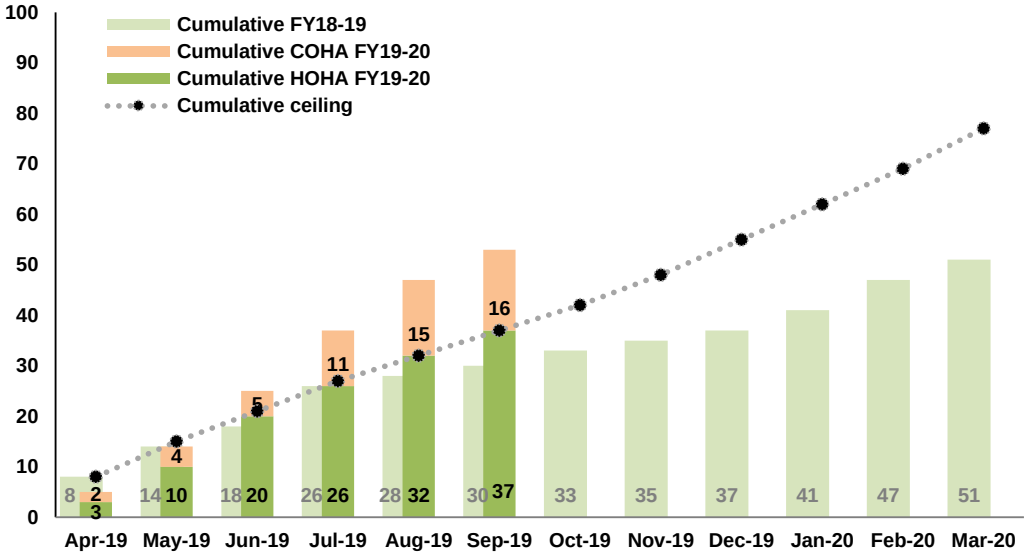

Figure 1: Cumulative monthly hospital-associated C. difficile cases in Q1-Q2, 2019/20 (dark green bars = HOHA, orange bars = COHA) compared with Trust-associated C. difficile cases 2018/19 (light green bars); COHA was not measured in 2018/19 or previous financial years, as per PHE's surveillance definitions.

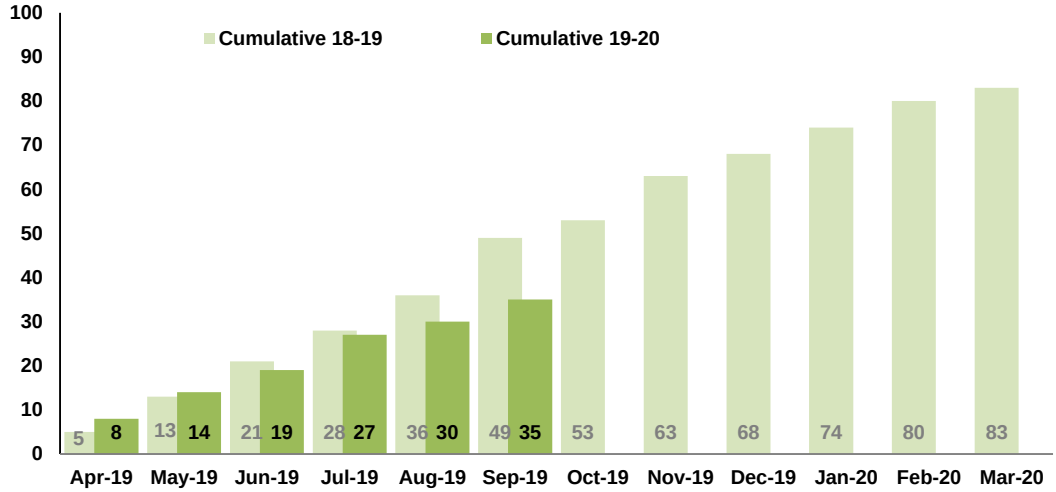

Figure 2: Cumulative monthly 2019/20 Trust-attributed E. coli BSI (dark green bars) compared to 2018/19 (light green bars).

7.2 *Surgical site infection*

7.2.1 Orthopaedics

The latest quarter (Apr-Jun 19 finalised data) has seen:

- Knee procedures: 0 SSI in 103 procedures; 12-month average is 0.2% (1 SSI in 385 operations); national average is 0.6%.
- Hip procedures: 0 SSI in 60 procedures; 12-month average is 0% (0 SSI in 281 operations), national average is 0.6%.

7.2.2 Cardiothoracic

The latest quarter (Apr-Jun 19 finalised data) has seen:

- CABG: 8 SSI (10.9%) of 73 procedures; 12-month average is 6.7% (19 SSI in 283 procedures); national average is 3.8%. All eight were superficial incisional SSIs.
- Non-CABG: 2 SSI (4.4%) of 45 procedures; 12-month average is 3.1% (5 SSI in 162 procedures); national average is 1.3%.

7.3 *Antimicrobial stewardship*

7.3.1 Antimicrobial consumption

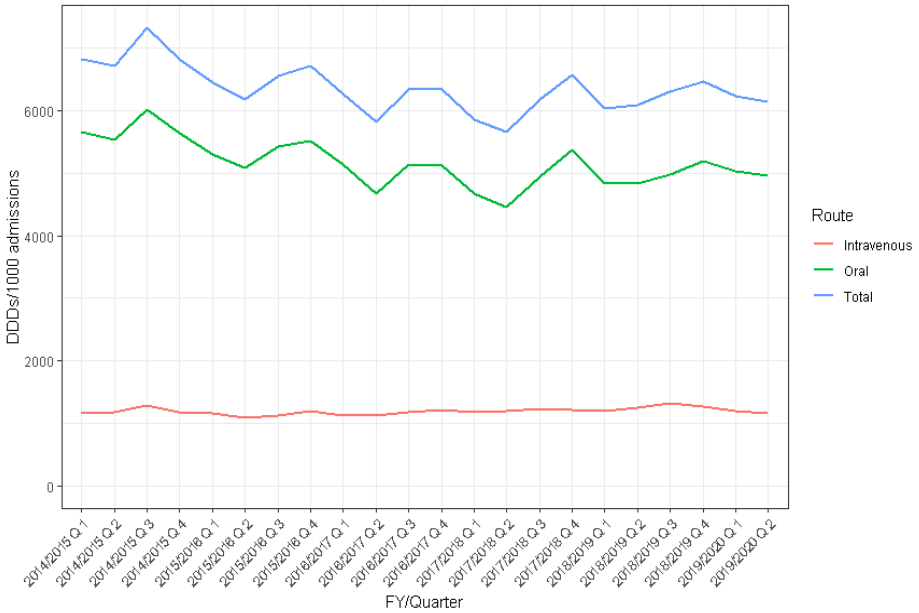

Figure 3: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Research and development quarterly report (Q2 2019/20)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 November 2019	**Item 15, report no. 12**
Responsible Executive Director: Bob Klaber, Director of strategy, research and innovation	**Author:** Paul Craven, Head of Research Operations Mark Thursz, Director of Research

Summary:

This quarterly scheduled report presents a summary of recent progress with respect to various clinical research initiatives within the Imperial Academic Health Science Centre (AHSC). It covers:

A) Progress against plan to increase the number of commercial clinical trials at ICHT;
B) Clinical Trials Reporting (EU Clinical Trials Tracker)
C) Details of recent performance in initiating clinical trials;
D) Translational research highlights and outputs from the Imperial BRC.

This report has previously been reviewed and noted by the executive digital, strategy and transformation committee in October 2019 and the quality committee in November 2019.

Recommendations:

The Committee is asked to note the Q2 2019/20 R&D report.

This report has been discussed at:

Executive digital, strategy and transformation committee
Quality committee

Quality impact:

The benefits of an active clinical research environment for NHS Trusts are well documented. ICHT currently benefits from a number of important NIHR infrastructure awards which form the basis of our joint clinical research strategy with Imperial College London Faculty of Medicine. The quality and scale of biomedical and clinical research carried out across the Imperial Academic Health Sciences Centre (AHSC) will impact patient care in the future in terms of innovative treatments, diagnostics and devices. Research activity includes many specific examples of patient benefit. Patient and public involvement in research is enabled through the Imperial Patient Experience Research Centre (PERC).

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:

1) Has no financial impact

Overall research income to ICHT is valued at ~£48m per annum. Delivery of high quality clinical research (experimental and applied) for the benefit of patients is essential to future revenue streams, to the reputation of the AHSC, and to the continuation of a culture of innovation and continuous improvement.

Imperial College Healthcare NHS Trust

Risk impact and Board Assurance Framework (BAF) reference: There are no specific risks attached to this report. The general risks associated with research are financial and reputational. Competition for research funds is extremely high and Imperial must continue to demonstrate a high level of high-quality research outputs and activity, as well as value for money.
Workforce impact (including training and education implications): Not applicable in this report.
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
What impact will this have on the wider health economy, patients and the public? Clinical and biomedical research, when validated, is adopted and embedded into the healthcare system, enabling better diagnostics and treatments, as well as informing preventative measures and taking advantage of 'big data' to develop improved service pathways.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No ▪ Senior managers should note in particular those successful examples of translational research, moving from the laboratory into the clinic, and share any appropriate examples with their own teams. ▪ Further info here: https://imperialbrc.nihr.ac.uk/

Imperial College Healthcare NHS Trust

Research and development quarterly report (Q2 2019/20)

1. Executive Summary

1.1. Imperial College Healthcare NHS Trust (ICHT) works in close partnership with Imperial College London, through the Faculty of Medicine, to initiate and delivery clinical and biomedical research across many specialties. The R&D Directorate produces a quarterly update on R&D activity and performance within ICHT, as well as highlighting key examples of translation – where new science has led (or is leading) directly to patient benefit.

2. Purpose

2.1. The purpose of this paper is to present the committee with a quarterly update on recent activity and progress with respect to various research initiatives within the Imperial Academic Health Science Centre (AHSC).

3. Commercial trials growth

3.1. In 2018/19, the executive committee approved a specific plan to double existing activity (and associated revenue) from commercially-sponsored trials within 4 years.

3.2. Recent performance indicators (as of end of September 2019) in relation to ICHT commercial clinical trial activity, are provided below.

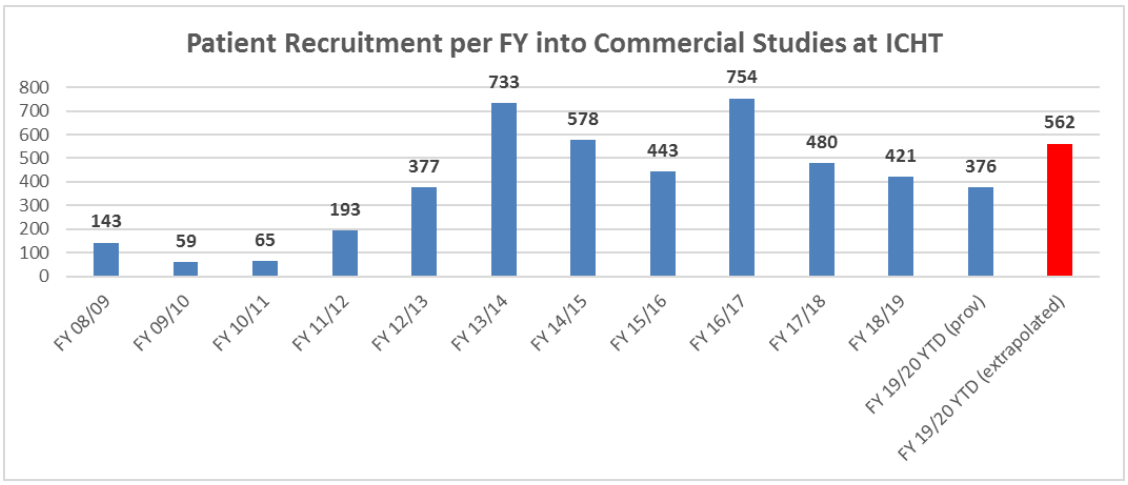

Figure 1. Patient recruitment numbers into ICHT-hosted commercial trials per FY (data source: NIHR ODP as of 30 September 2019; Generations-1 screening study not included).

3.3. In terms of numbers of patients recruited into these studies, there were 421 in total in the 2018/19 FY (Apr to Mar; not including Generations-1 study). As of the end of September 2019, we have already seen 376 NIHR Portfolio commercial recruits (190 of these as a result of another specific Novartis dementia study, Generations-2, which has since been suspended);

3.4. Extrapolating linearly provides a forecast number of NIHR Portfolio recruits into ICHT commercial studies of 562 (including Generations-2 but not Generations-1). This would be slightly ahead of target in terms of the business case put forward for year 1 of the plan (10% increase on baseline of 466 = 513);

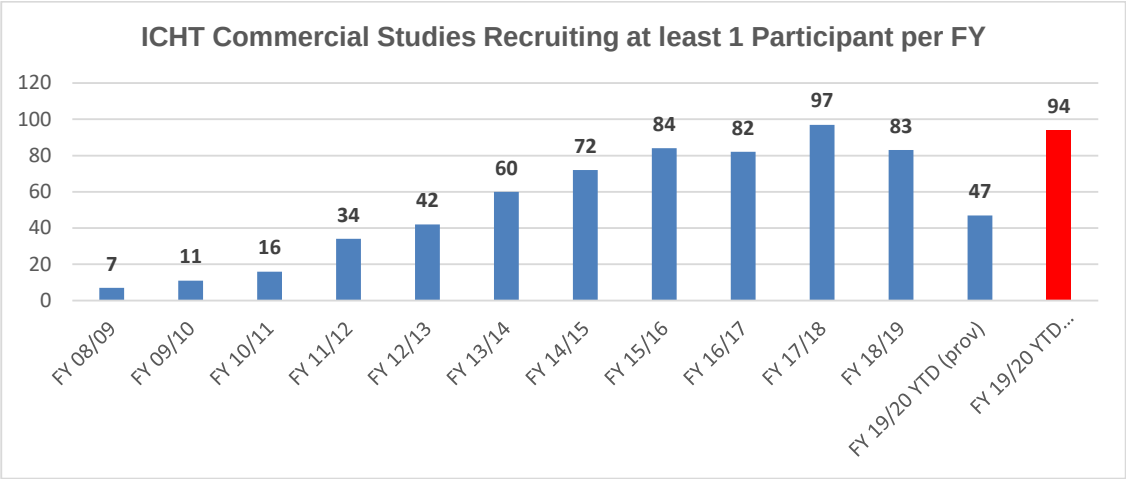

Figure 2. No. of ICHT-hosted commercial trials recruiting >1 patient per FY (data source: NIHR ODP as of 30 September 2019).

3.5. Between April 2019 and end of September 2019, a total of 46 new commercial study records have been created in the ICHT trials management system (DOCUMAS). This compares to 58 in the same period the previous year;

3.6. On the NIHR Portfolio, 82 commercial studies recruited at least 1 patient in the 16/17 FY. In 17/18 the figure increased to 97. In 18/19 this dropped back to 83. In 19/20 YTD (6 months), 47 commercial studies have recruited at least 1 participant. Linear extrapolation of this yields a forecast figure of 94 studies to recruit at least 1 participant in the current financial year.

3.7. Although total income YTD is slightly behind last year (£2.08m against £2.48m), the cumulative overheads retained as of M05 (£374k) is the highest since these reports were first generated.

3.8. In summary, the above activity data would suggest that we may well exceed last year's performance for commercial study recruitment and overhead reimbursement, even though the number of new commercial studies opened in the year may be lower. However, due to 'lag' in the various data reporting systems (internal and national) we will still need several more months' data to be more confident in our forecasts, and to understand to what degree the large Generations dementia studies are 'skewing' activity data.

3.9. We also need to ensure that the number of studies increases sustainably year on year. This will take a little longer to demonstrate, to smooth out any statistical anomalies, as a result of the additional financial investment made towards the end of the 18/19 FY and the beginning of the 19/20 FY.

3.10. In recent months we have agreed an active working relationship and framework agreement with Merck, and we are developing a "preferred partnership" agreement with Novartis. Parexel, the global Clinical Research Organisation (CRO), have also approached us with a view to further studies.

4. Clinical trials reporting (EU trials tracker)

4.1. In order to improve transparency, and responding to recent recommendations from the House of Commons Science and Technology Committee ("Research integrity: clinical trials transparency"), the Health Research Authority (HRA) has asked all UK sponsors of clinical trials to ensure that their results are registered and made public, within appropriate timelines, on the industry-standard online trials register known as the EU Clinical Trials Database. Compliance against this is now being assessed by the HRA and, in line with all other sponsors, ICHT has been asked what steps are being taken to ensure that the appropriate trial results are posted.

4.2. According to data published on EU Trials Tracker for the Trust, at the current time, 4 out of 6 due trials (i.e. completed more than 12 months ago) have not yet reported their results and we have written to the respective Chief Investigators to ask them to do so.

4.3. Of the other ongoing trials led by ICHT, all are either not yet due (n=8) or have reported early (n=1). There are 2 more trials with inconsistent data which may or may not have reported (according to this database). We are also clarifying these with the respective investigators (although these are from some time ago).

4.4. We aim to review the EU Trials Tracker database on a regular basis (quarterly via this report) – through our Joint Research Office – and also present this information to the ICHT Research Committee (which reports into our Executive Committee). These quarterly reports will highlight non-compliance as well as progress in completing any outstanding entries.

5. Performance in initiating and delivering clinical trials

Initiation

5.1. Our performance for initiating interventional clinical trials (70-day target) remains above 95%. The confirmed figure for Q1 2019/20 is 96.0%. However, the 70-day "percentage compliance" metric is no longer used or published by NIHR. For the overall initiation metric ICHT is performing well against its peer organisations in League 1 (7th-9th). It is doing very in terms of the time taken to recruit the first patients into studies (DSC to FPR), but there is some room for improvement in terms of the time taken to set up and open sites (DSS to DSC). To address this, the Joint Research Office are working on new ways to review, escalate and prioritise studies which are experiencing delays at any point in the study set-up process.

Delivery

5.2. For delivery of commercially-sponsored interventional studies to time and target, 55.4% of ICHT-hosted trials met their recruitment targets on time. ICHT was the 5th best performing NHS Trust in League 1. ICHT submitted the 5th highest number of such trials in League 1 (n=58).

6. Translational research highlights from the Imperial BRC

6.1. ***Dormant cancer cells evade hormone therapy***

Breast cancer medicines may force some cancer cells into 'sleeper mode', allowing them to potentially come back to life years after initial treatment. The Imperial research team, who studied a group of breast cancer drugs called hormone treatments, say their research opens avenues for finding ways of keeping the cancer cells dormant for longer, or even potentially finding a way of awakening the cells so they can then be killed by the treatment. Dr Luca Magnani, lead author of the study from Imperial's Department of Surgery and Cancer and NIHR Imperial BRC Cancer Theme, said: "For a long time scientists have debated whether hormone therapies – which are a very effective treatment and save millions of lives – work by killing breast cancer cells or whether the drugs flip them into a dormant 'sleeper' state.

In the study, published in Nature Communications and funded by Cancer Research UK and the NIHR Imperial BRC, the team studied around 50,000 human breast cancer single cells in the lab, and found that treating them with hormone treatment exposed a small proportion of them as being in a dormant state. The team say the 'sleeper cells' may also provide clues as to why some breast cancer cells become resistant to treatment, causing a patient's drugs to stop working, and their cancer to return.

Single-cell transcriptomics reveals multi-step adaptations to endocrine therapy

Nature Communications

6.2. ***First vaccine for chlamydia shows promise in early trials***

The first ever early clinical trial for a vaccine for genital chlamydia has shown it to be safe and effective at provoking an immune response.

The latest findings, from a randomised controlled trial of 35 healthy women led by Imperial College London and the Statens Serum Institut in Copenhagen, demonstrate promising early signs of what could be an effective vaccine against chlamydia. The infection is the most common bacterial sexually transmitted infection (STI) worldwide and it can lead to infertility.

The full findings are published in the journal The Lancet Infectious Diseases. The group is now planning phase 2 trials.

Safety and immunogenicity of the chlamydia vaccine candidate CTH522 adjuvanted with CAF01 liposomes or aluminium hydroxide: a first-in-human, randomised, double-blind, placebo-controlled, phase 1 trial

The Lancet Infectious Diseases

6.3. ***White matter affects how people respond to brain stimulation therapy***

Tiny changes in the microscopic structure of the human brain may affect how patients respond to an emerging therapy for neurological problems. The technique, called non-invasive electrical brain stimulation, involves applying an electrical current to the surface of a patient's head to stimulate brain cells, altering the patient's brain activity. It is being trialled for a range of neurological problems including recovery from stroke, traumatic brain injury, dementia, and depression, but research to date has found the effects to be inconsistent. Now, a team led by researchers from the NIHR Imperial BRC has shed more light on why these inconsistencies occur and may provide physical evidence for why some patients respond better than others – because of the fine structure of their brain tissue. The new research suggests it may be possible to target the therapy to patients most likely to benefit.

In the study, researchers looked at 24 healthy patients and 35 patients recruited predominantly from St Mary's Hospital, recovering from a moderate or severe traumatic brain injury (TBI). Participants performed a task inside an MRI scanner while receiving small amounts of electrical current through electrodes on the surface of the scalp or a placebo. They were unable to tell whether they were receiving brain stimulation or not. They found that healthy participants who received brain stimulation performed better in the task than when they did not receive the treatment. For patients with TBI, task performance in response to stimulation varied widely.

Traumatic axonal injury influences the cognitive effect of non-invasive brain stimulation

Brain

7. Recommendations

7.1. The Committee is asked to note the Q2 2019/20 R&D report.

Author Paul Craven, Head of Research Operations
Mark Thursz, Director of Research

Date 15 November 2019

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: 2019 General Medical Council National Training Survey – result analysis and management plan	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 November 2019	**Item 16, report no. 13**
Responsible Executive Director: Julian Redhead, medical director	**Author:** Danielle Bennett, head of operational management - medical education Ruth Brown, associate medical director – education

Summary:
The results of the 2019 General Medical Council (GMC) National Training Survey (NTS) were published on 8 July 2019. Our results show an improvement overall compared to last year with a 4% reduction in red outliers by programme group, by site in the trainee survey, and a 54% reduction in red outliers by programme in the trainer survey.

Action plans are being developed in response to all red flags following deep dive meetings with the trainees and local faculty group meetings to review the results and understand the underlying causes.

In relation to the trainee survey, we are required to submit action plans to Health Education England (HEE) for training programmes where there are:

- four or more red outliers at site level, and or,
- red outliers for overall satisfaction, clinical supervision, clinical supervision out-of-hours and educational supervision

We submitted action plans to HEE for the five programmes which met these criteria on 6 September 2019.

This paper has been previously reviewed by the Executive Operational Performance Committee and the Quality Committee where the results and the actions being taken in response were noted.

Recommendations:
The Board is asked to note the overall improvement in the 2019 GMC NTS results and the actions currently underway, or already completed in response to the results.

This report has been discussed at:
Medical Education Committee
Executive Operational Performance Committee
Quality Committee

Quality impact:
Delivery of the actions will further improve junior doctor and medical student experience and engagement, ensuring they are equipped to deliver high quality patient-centred care within a safe and supportive environment.

Financial impact:
This paper has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:

The actions described in this paper provide mitigation for the risk of failing to provide adequate and appropriate training for junior doctors and medical students.
Workforce impact (including training and education implications): As above
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
What impact will this have on the wider health economy, patients and the public? See quality impact above.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

Imperial College Healthcare NHS Trust

2019 General Medical Council National Training Survey

1. Executive Summary

1.1 The results of the 2019 General Medical Council (GMC) National Training Survey (NTS) were published on 8 July 2019. Our results show an improvement overall compared to last year with a 4% reduction in red outliers by programme group, by site in the trainee survey, and a 54% reduction in red outliers by programme in the trainer survey.

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- red outliers for overall satisfaction, clinical supervision, clinical supervision out-of-hours and educational supervision

We submitted action plans to HEE for the five programmes which met these criteria on 6 September 2019.

2. Purpose

2.1 The purpose of this paper is to inform the board of the results of the 2019 GMC NTS. This paper has been previously reviewed by the Executive Operational Performance Committee and Quality Committee where the results and the actions being taken in response were noted.

3. Background

3.1 The GMC NTS, which is formed of two parts a survey for trainees and a survey for trainers, is conducted on an annual basis. Every postgraduate medical trainee in a GMC approved training post and every approved trainer in the UK are invited to complete the survey. In 2019, the national response rate was 99**%** and 44.8**%** for the trainee and trainer survey respectively. The response rate for the Trust was 99% and 36% respectively.

3.2 The results are analysed by training programme (specialty by grade of trainee e.g. foundation, core and higher specialty training and specialty) and post specialty (all grades in a department together). In addition to this, the analysis is conducted at trust and site level. Guidance on interpreting the results can be found at Appendix A.

3.3 The GMC has issued an initial findings report of the national results in which they note:

> "Trainees continue to highly rate the quality of their clinical supervision, experience, and the teaching they receive. And nine in ten trainers told us they enjoy their role. There are also some positive signs that fewer trainees are working beyond their rostered hours. However system pressures continue to affect training environments."

4. 2019 GMC National Training Survey Results

4.1 Our results have improved compared to last year, with 23% more green outliers and a 5% reduction in red outliers if compared by programme group by Trust, with some specialties demonstrating significant improvements. It should be noted that the number of red outliers at a site level are higher, but these have not extrapolated up in to Trust-wide outliers.

Tables showing the results by programme, site and domain can be found at Appendix B and C; points to note include:

- While 13 programmes have removed their red outliers completely and three programmes have reduced theirs, a further three programmes (Haematology, Medicine F2 and Surgery F2) have increased their red outliers this year when comparing the results by programme and site.
- There are 10 site-specific programmes with two or more red outliers, and 16 with one. Overall, the total number of red outliers has increased to 51 from 47 at a site level. This suggests that there are site-specific challenges in these training programmes, especially where the red outlier has not been generated at a Trust/programme level also.
- There are 33 site-specific programmes that have generated green outliers. Eighteen programmes have two or more.
- Forty-six programmes have pink outliers. Seven programmes (Core surgery, Clinical Oncology, Core Anaesthetics, Gastroenterology, Neurosurgery, Sports and Exercise and Trauma & Orthopaedics) have four or more.
- It is of note that gastroenterology has 6 pink outliers, suggesting that there are potential issues here that require proactive management.
- In 2018, there were 45 programmes with pink flags, and 11 programmes with four or more. Overall, the total number of pink flags has significantly decreased from 132 to 46.

4.2 The results of the trainer survey show five programmes received red outliers, down from eight in 2018; and 11 green outliers, up from six in 2018.

In ten specialties, insufficient numbers of trainers responded to analyse the results, and in four others less than 25% of trainers responded. In some cases specialties where there was low trainer engagement with the survey correlate with specialties where there was a deterioration in the results reported by trainees, such as Haematology and Gastroenterology.

Full results are shown in table 4 in appendix C.

5. Trust response to 2019 GMC National Training Survey results

5.1 In order to understand the results, including the reasons for poor feedback from the trainees and the possible barriers to improvement from the trainers, the following have been undertaken:

- **Deep dives with trainees** – medical education managers met with trainees in all specialties. Their anonymised feedback was then shared with the Unit Training Lead (UTL), Divisional Director of Medical Education (DDME) and Head of Specialty to support action planning.

- **UTL workshop** – this took place in July, with 30 UTLs in attendance, to discuss results, share good practice and approaches to improvement.

- **Local Faculty Groups (LFGs)** – specialities have held LFGs with trainees to discuss the results. Where possible, these were completed before 1 August for those specialties where trainees were rotating to other posts/organisations so that feedback could be obtained directly from the trainees who responded to the survey. LFGs will continue quarterly, chaired by the UTL.

5.2 Local action plans for site specific red flags are being developed through the LFGs. The divisional directors of medical education are supporting unit training leads to triangulate the results with other sources of information e.g. exception reports and HEE local surveys. These action plans are due to be reviewed by the divisions in December 2019. They will

be monitored through the divisional committees, with reporting on progress to the Medical Education Committee (MEC).

5.3 Where specialties have significantly improved or retained positive results, actions taken have included the following:

- Job plan reviews for consultants to ensure time for training and appropriate EPA allocation
- Review of trainee rotas to ensure optimum exposure to theatre time (craft specialties)
- Review of rotas and rota gaps to ensure appropriate medical staffing to allow learning
- Regular meetings with trainees to share ideas, changes being planned and to invite contributions from them
- Regular meetings between the specialty trainee reps and UTLs to capture feedback prior to the local faculty group
- Improvements to local induction content to support orientation and welcome new doctors

5.4 We are required to submit action plans to Health Education England (HEE) for training programmes where there are:

- four or more red outliers at site level, and or,
- red outliers for overall satisfaction, clinical supervision, clinical supervision out-of-hours and educational supervision

5.5 We submitted action plans to HEE for the five programmes which met these criteria (haematology, intensive care medicine, acute internal medicine, GP obstetrics and gynaecology, Foundation (surgery F2, emergency medicine F2 and medicine F2) on 6 September.

5.6 The actions remain open, with a progress update due to be submitted to HEE in December 2019. The action plans are being monitored by the MEC, with reporting to the Trust Education Committee (TEC), and escalation to the Medical Director as necessary. Progress will be included in the bi-annual TEC report to the Executive People and Organisational Development Committee.

6. Recommendations

6.1 It is recommended that the board:

- Note the overall improvement in the 2019 GMC National Training Survey results
- Note the actions currently underway, or already completed in response to the results.

Danielle Bennett, Head of Medical Education
Dr Ruth Brown, Associate Medical Director – Education

9 October 2019

Appendix A NTS Guidance for interpreting the results
Appendix B NTS Results 2019_Analysis by programme by site
Appendix C NTS Results 2019_Analysis Trainer by specialty

Imperial College Healthcare NHS Trust

Appendix A: interpreting the results

The trainee survey contains 91 generic questions, across 18 domains. Questions regarding facilities and resources for rest and study are new in 2019.

The trainer survey contains 75 questions, across four themes: learning environment and culture; educational governance and leadership; supporting educators and developing and implementing education. Questions regarding less than full time working and additional roles and responsibilities are new this year.

The trainee survey allocates a numerical score for each domain, derived from the responses made in the survey by trainees in a particular programme at the Trust (foundation, specialty core, or specialty higher). This numerical score is then compared to the national mean response for trainees in that programme. Scores for individual training programmes are then compared to the national mean and outliers are allocated accordingly based on standard deviation from the mean:

Red	Red outlier – score in bottom quartile of benchmark group, and confidence interval does not overlap with that of the benchmark mean
Pink	Score in bottom quartile, but confidence interval overlaps with that of the benchmark mean
Light green	Score in top quartile, but confidence interval overlaps with that of the benchmark mean
Dark green	Green outlier – score in top quartile of benchmark group, and confidence interval does not overlap with that of the benchmark mean

Imperial College Healthcare NHS Trust

Appendix B Results by domain

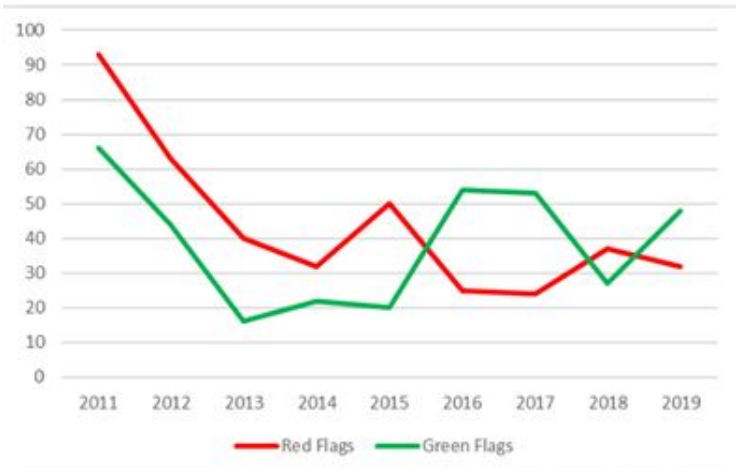
Table 1 shows that the decrease in red outliers is across two of 18 domains and the increase in green outliers across 11 out of 18 domains.

Table 1: Overview of results by domain

Domain	2018	2019	Trend	2018	2019	Trend
Overall Satisfaction	1.00	2.00	↑	1.00	1.00	↔
Clinical Supervision	1.00	0.00	↓	0	1.00	↑
Clinical Supervision out of hours	1.00	0.00	↓	1.00	3.00	↑
Reporting systems	0.00	0.00	↔	1.00	3.00	↑
Work Load	4.00	2.00	↓	6.00	4.00	↓
Teamwork	3.00	1.00	↓	1.00	1.00	↔
Handover	1.00	1.00	↔	3.00	4.00	↑
Supportive environment	5.00	2.00	↓	2.00	4.00	↑
Induction	2.00	3.00	↑	1.00	4.00	↑
Adequate Experience	2.00	2.00	↔	1.00	0	↓
Curriculum Coverage	3.00	5.00	↑	0	0	↔
Educational Governance	2.00	3.00	↑	2.00	4.00	↑
Educational Supervision	1.00	4.00	↑	1.00	0	↓
Feedback	1.00	1.00	↔	0	0	↔
Local Teaching	3.00	1.00	↓	4.00	8.00	↑
Regional Teaching	4.00	2.00	↓	1.00	2.00	↑
Study Leave	1.00	2.00	↑	0	1.00	↑
Rota Design	2.00	1.00	↓	2.00	8.00	↑
Total	37	32		27	48	

Table 2 shows the total number of red and green outliers by year since 2011, indicating a deterioration in results in 2018, a slight improvement when comparing red outliers in 2019 and a significant improvement when comparing green flags.

Table 2: Trend analysis by domain 2011-2019



	2011	2012	2013	2014	2015	2016	2017	2018	2019
Red Flags	93	63	40	32	50	25	24	37	32
Green Flags	66	44	16	22	20	54	53	27	48

Imperial College Healthcare NHS Trust

Appendix C: results by Programme and Site

Table 3: Trainee results by Programme and Site

		2018		2019		
Programme Group	Site	Red flags	Green flags	Red	Green	Trend
ACCS	Charing Cross Hospital - RYJ02	0	0	0	0	↔
ACCS	St Mary's Hospital (HQ) - RYJ01	0	1	0	1	↔
Anaesthetics	Charing Cross Hospital - RYJ02	1	0	2	2	↔
Anaesthetics	Hammersmith Hospital - RYJ03	0	0	0	0	↔
Anaesthetics	Queen Charlotte's Hospital - RYJ04	0	4	0	0	↓
Anaesthetics	St Mary's Hospital (HQ) - RYJ01	0	1	0	0	↓
CMT	Charing Cross Hospital - RYJ02	0	0	1	1	↑
CMT	Hammersmith Hospital - RYJ03	2	0	0	1	↑
CMT	St Mary's Hospital (HQ) - RYJ01	0	1	0	0	↓
CST	Charing Cross Hospital - RYJ02	0	1	0	0	↓
CST	St Mary's Hospital (HQ) - RYJ01	0	1	0	1	↔
Cardio-thoracic surgery	Hammersmith Hospital - RYJ03	n/a	n/a	0	3	↑
Cardiology	Hammersmith Hospital - RYJ03	1	0	0	2	↑
Cardiology	St Mary's Hospital (HQ) - RYJ01	2	0	1	0	↓
Clinical oncology	Charing Cross Hospital - RYJ02	1	0	0	1	↑
Clinical oncology	Hammersmith Hospital - RYJ03	n/a	n/a	2	0	↑
Clinical radiology	Hammersmith Hospital - RYJ03	1	0	0	1	↑
Clinical radiology	St Mary's Hospital (HQ) - RYJ01	5	0	0	1	↑
Combined Infection Training	Hammersmith Hospital - RYJ03	n/a	n/a	0	1	↑
Core Anaesthetics	Charing Cross Hospital - RYJ02	2	0	1	0	↓
Core Anaesthetics	St Mary's Hospital (HQ) - RYJ01	0	1	1	0	↑
Emergency Medicine F2	Charing Cross Hospital - RYJ02	0	2	2	0	↑
Emergency Medicine F2	St Mary's Hospital (HQ) - RYJ01	1	2	1	1	↓
Emergency medicine	Charing Cross Hospital - RYJ02	0	6	0	0	↓
Endocrinology and diabetes mellitus	Charing Cross Hospital - RYJ02	0	2	0	0	↓
Endocrinology and diabetes mellitus	Hammersmith Hospital - RYJ03	1	0	0	1	↑
GP Prog - Medicine	Charing Cross Hospital - RYJ02	0	1	1	0	↑
GP Prog - Medicine	St Mary's Hospital (HQ) - RYJ01	0	1	0	1	↔
GP Prog - Paediatrics and Child Health	St Mary's Hospital (HQ) - RYJ01	0	7	0	5	↓
Gastroenterology	Charing Cross Hospital - RYJ02	2	0	0	2	↑
Gastroenterology	Hammersmith Hospital - RYJ03	0	0	3	0	↑
Gastroenterology	St Mary's Hospital (HQ) - RYJ01	0	1	3	0	↑
General surgery	Charing Cross Hospital - RYJ02	0	2	1	0	↑
General surgery	Hammersmith Hospital - RYJ03	0	2	0	2	↔
General surgery	St Mary's Hospital (HQ) - RYJ01	1	0	0	0	↓
Genito-urinary medicine	St Mary's Hospital (HQ) - RYJ01	0	2	0	7	↑
Geriatric medicine	St Mary's Hospital (HQ) - RYJ01	0	0	0	5	↑
Haematology	Hammersmith Hospital - RYJ03	5	0	10	0	↑
Intensive care medicine	Charing Cross Hospital - RYJ02	n/a	n/a	1	0	↑
Medical oncology	Charing Cross Hospital - RYJ02	0	1	1	0	↑
Medicine F2	Charing Cross Hospital - RYJ02	2	0	0	0	↓
Medicine F2	Hammersmith Hospital - RYJ03	1	0	5	0	↑
Medicine F2	St Mary's Hospital (HQ) - RYJ01	0	1	0	0	↓
Neurology	Charing Cross Hospital - RYJ02	0	1	0	0	↓
Neurology	St Mary's Hospital (HQ) - RYJ01	0	0	1	0	↑
Neurosurgery	Charing Cross Hospital - RYJ02	0	0	1	0	↑
Obstetrics and gynaecology	Queen Charlotte's Hospital - RYJ04	1	1	0	2	↑
Obstetrics and gynaecology	St Mary's Hospital (HQ) - RYJ01	2	0	0	0	↓
Ophthalmology	Charing Cross Hospital - RYJ02	0	1	0	4	↑
Ophthalmology	Western Eye Hospital - RYJ07	0	3	0	2	↓
Otolaryngology	Charing Cross Hospital - RYJ02	0	0	0	3	↑
Otolaryngology	St Mary's Hospital (HQ) - RYJ01	1	1	n/a	n/a	↔
Paediatrics	Hammersmith Hospital - RYJ03	1	1	1	1	↔
Paediatrics	St Mary's Hospital (HQ) - RYJ01	0	3	0	3	↔
Paediatrics and Child Health F1	St Mary's Hospital (HQ) - RYJ01	0	4	0	4	↔
Plastic surgery	Charing Cross Hospital - RYJ02	0	0	0	4	↑
Renal medicine	Hammersmith Hospital - RYJ03	0	0	0	1	↑
Respiratory medicine	Charing Cross Hospital - RYJ02	n/a	n/a	2	0	↑
Respiratory medicine	St Mary's Hospital (HQ) - RYJ01	0	2	1	2	↑
Sport and Exercise Medicine	Charing Cross Hospital - RYJ02	2	1	1	2	↑
Surgery F2	Charing Cross Hospital - RYJ02	0	4	1	0	↑
Surgery F2	St Mary's Hospital (HQ) - RYJ01	1	0	3	0	↑
Trauma and orthopaedic surgery	Charing Cross Hospital - RYJ02	1	0	0	1	↑
Trauma and orthopaedic surgery	St Mary's Hospital (HQ) - RYJ01	0	0	3	0	↑
Urology	Charing Cross Hospital - RYJ02	1	1	1	3	↑
Vascular surgery	St Mary's Hospital (HQ) - RYJ01	3	0	0	0	↓
Totals		**47**	**72**	**51**	**72**	

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Table 4: Trainer results by Programme

		2019			2018	
Trainer Specialty	Response Rate	Green Flags	Red Flags	Response Rate	Red flags	Green flags
Acute Internal Medicine	100%	n/a	n/a	n/a	n/a	n/a
Anaesthetics	43%	0	0	29%	0	0
Audio vestibular medicine	100%	n/a	n/a	n/a	n/a	n/a
Cardio-thoracic surgery	60%	1	0	75%	3	0
Cardiology	13%	n/a	n/a	20%	1	0
Clinical oncology	28%	0	0	19%	1	0
Clinical radiology	30%	0	0	29%	0	0
Dermatology	43%	0	0	75%	1	0
Emergency medicine	48%	3	0	55%	1	4
Endocrinology and diabetes mel	11%	n/a	n/a	21%	0	0
Gastroenterology	19%	1	1	32%	1	0
General (internal) medicine	33%	n/a	n/a	n/a	n/a	n/a
General surgery	42%	0	0	23%	0	0
Genito-urinary medicine	40%	4	0	n/a	n/a	n/a
Geriatric medicine	31%	0	0	29%	0	0
Haematology	16%	0	5	6%	n/a	n/a
Histopathology	32%	0	0	25%	0	0
Infectious diseases	67%	0	0	57%	0	0
Intensive care medicine	41%	3	0	32%	1	1
Medical Virology	100%	n/a	n/a	n/a	n/a	n/a
Medical microbiology	100%	n/a	n/a	n/a	n/a	n/a
Medical microbiology and virolo	50%	n/a	n/a	60%	0	1
Medical oncology	50%	n/a	n/a	n/a	n/a	n/a
Neurosurgery	22%	n/a	n/a	25%	n/a	n/a
Nuclear medicine	100%	n/a	n/a	n/a	n/a	n/a
Obstetrics and gynaecology	38%	1	0	32%	0	0
Ophthalmology	61%	5	0	47%	0	6
Otolaryngology	43%	0	1	50%	0	0
Paediatric surgery	67%	n/a	n/a	n/a	n/a	n/a
Paediatrics	39%	1	0	36%	0	3
Palliative medicine	50%	n/a	n/a	50%	n/a	n/a
Pharmaceutical medicine	100%	n/a	n/a	n/a	n/a	n/a
Plastic surgery	44%	0	0	43%	1	0
Renal medicine	47%	1	1	41%	0	0
Respiratory medicine	61%	0	1	41%	0	0
Rheumatology	25%	n/a	n/a	n/a	n/a	n/a
Trauma and orthopaedic surgery	20%	2	0	n/a	n/a	n/a
Urology	44%	7	0	57%	0	10
Vascular surgery	11%	n/a	n/a	n/a	n/a	n/a

ALL PROGRAMMES	2018	2019
Total programmes	29	39
Total red flags	10	9
Total green flags	26	29
Total programmes with red flags	8	5
Percentage programmes with red flags	28%	13%
Total programmes with green flags	7	11
Percentage programmes with green flags	27%	28%

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CIP QIA - Update on the Quality Impact Assessments for Cost Improvement Programme (2019/20)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 27 November 2019	**Item 17, report no. 14**
Responsible Executive Director: Janice Sigsworth, Director of Nursing Julian Redhead, Medical Director	**Author:** Naomi Sloan, PMO Lead

Summary:

The Trust has a comprehensive Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) process in place to understand the risk/s to quality (aligned to the five CQC domains) as a result of introducing a cost improvement programme.

The Quality Impact Assessment (QIA) is an essential part of ensuring the quality of services remains or improves when implementing cost savings (cost improvement plans), changing staffing models, altering clinical areas in terms of use or location, closing down services or establishing new services. The agreement for any of these changes can only be sanctioned once the QIA has been approved.

Once a CIP scheme has been identified and then worked up into a plan the scheme is reviewed and authorised to go ahead using the project management gateway process. Schemes are only accepted for approval into implement if a QIA has been signed off by the clinical divisional process. Once this process has been completed schemes are reviewed by the Chief Nurse and Medical Director.

The Trust has 265 CIP schemes in implementation in FY 19/20 of which 4 are on hold. Those on hold require rework to the scheme or will not proceed because the Quality risks are too high.

The next routine quarterly meetings with divisions are scheduled to take place during quarter three 2019/20 where the focus will be to review the QIAs for new schemes that have been identified part way through the year.

Recommendations:
The Committee is asked to note the paper and acknowledge that the QIA process is an iterative process done throughout the year as new schemes continue to be identified.

This report has been discussed at: N/A

Quality impact:
The CIP QIA process ensures that any adverse impact on quality and patients (taking into account all five CQC domains) is mitigated.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:

This paper relates to the following corporate risks**: 2473 and 2472**

Workforce impact (including training and education implications): N/a

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☒ Yes ☐ No ☐ Not applicable

If yes, are further actions required? ☐ Yes ☒ No

What impact will this have on the wider health economy, patients and the public?
As outlined above under 'quality impact'.

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?.....

If the details can be shared, please provide the following in one to two line bullet points:
- What should senior managers know?
  - All CIPs are subject to review and must follow the QIA process
- What (if anything) do you want senior managers to do?
  - Undertake the QIA process
- Contact details or email address of lead and/or web links for further
  - Imperial.pso@nhs.net
- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why?
  - Teams should be completing the QIAs for the CIPS schemes they are responsible for

CIP QIA - Update on the Quality Impact Assessments for Cost Improvement Programmes (2019/20)

1. Purpose

The following report provides a summary of the QIA process and the Cost Improvement Programme (2019/20).

2. Background

The Trust has a comprehensive Cost improvement Programme (CIP) Quality Impact Assessment (QIA) process in place to understand the risk/s to quality (aligned to the five CQC domains) as a result of introducing a cost improvement programme. The trust reviews all CIP QIAs within the divisions and closely monitors all CIPS with a risk rated 6 and above. As part of this process, the Medical Director and Director of Nursing periodically meet with divisions to review the QIAs presented. In terms of assurance about the robustness of the process, the Committee will recall that in July 2019 the CQC rated the trust Good in the domain of well led. It was noted on page 11 of the Use of Resources Assessment Report (July 2019) that the Trusts approach to CIP planning is an area of outstanding practice; *The trust has undertaken a comprehensive and consistent approach to quality improvement through the Speciality Review Programme (SRP). This programme has brought together costing data, Patient Level Information and Costing System (PLICS data), income expertise, 'Get It Right First Time' (GIRFT) reviews and Model Hospital data to work with each specialty to create plans to optimise performance. This has meant that there has been a systematic approach to Cost Improvement Programmes (CIPs), job planning, rostering and a number of other operational areas. In turn, this approach resulted in improvements in operational performance, efficiency and underlying financial performance.*

3. Review of QIA for CIP schemes FY19/20

The Trust has 265 recurrent CIP schemes across the three clinical divisions, these include a variety of income, productivity, pay and non-pay schemes. The majority of schemes have been approved and are in the process of being delivered and monitored in line with the QIA policy including monitoring any mitigations identified. The Trust continues to have four CIP schemes in work in progress and once these are developed fully they will progress toward implementation and the QIA will be reviewed in line with the Trust QIA process. Four schemes remain on hold, these require further mitigations to be put in place before the QIA can be signed off and the scheme can proceed.

		QIA Approval Process			
Clinical Division	CIP Schemes #	QIA Approved	QIA Submitted	On Hold	CIP in working progress
SCC	140	140			
MIC	91	85	1	2	3
WCCs	34	31		2	1

4. Next steps

- The next routine quarterly meetings with divisions are scheduled to take place during quarter three 2019/20 to review the CIP schemes.
- The next routine meeting will also review the Trusts QIA policy as part of the Trusts policy review in February 2020.
- The Trust will start its annual post-implementation evaluation (PIE) based on;
    - A mixture of scheme categories e.g. pay, non-pay, productivity and income
    - A mixture of QIA risk scores (high, medium and low)
    - Discussions from previous CIP QIA review meetings where a scheme/s has been identified to be reviewed at a later date.
- An update on the outcomes of these meetings will be presented to the Board in March 2020.

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: 2018/19 Annual Report of The Trust Safeguarding Committee	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 November 2019	**Item 18, report no. 15**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Guy Young, Nicci Wotton

Summary:
This report outlines the systems and processes in place at Imperial College Healthcare NHS Trust (ICHT) to ensure that it fulfils its responsibilities in relation to safeguarding people in its care. It also provides a summary of safeguarding activity during the year and describes current priorities.

Recommendations:
The Board is asked to note the report.

This report has been discussed at:
- Trust Safeguarding Committee, 15 October 2019
- Executive Quality Committee, 5 November 2019
- Quality Committee, 13 November 2019

Quality impact:
Safeguarding adults, children and young people is part of the Safe domain.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
- There is no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
Failure to provide effective safeguarding services to our patients would present a risk. At his time this risk is scored as 8 on the corporate nursing divisional risk register.

Workforce impact (including training and education implications): None specific.

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

What impact will this have on the wider health economy, patients and the public?

The report content respects the rights, values and commitments within the NHS Constitution
☒ Yes ☐ No

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
No

Imperial College Healthcare NHS Trust

2018/19 Annual report from the Trust Safeguarding Committee

1. Introduction

The Trust has a responsibility to safeguard children, young people (C&YP) and adults in its care. This requirement is laid out in legislation including The Children Act (1989), the Children Act 2 (2004) and The Care Act (2014).

This responsibility is also made clear in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.

This report outlines the systems and processes in place at Imperial College Healthcare NHS Trust (ICHT) to ensure that it fulfils its responsibilities. It also provides a summary of safeguarding activity during the year and describes current priorities.

The CQC inspected maternity, children and young people, neonatal and critical care core services in February 2019. In their summary of findings from the report of these inspections, they stated: "*Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.*"

2. Trust governance arrangements for safeguarding

2.1 Executive leadership

The Intercollegiate Guidance (Royal College of Paediatrics and Child Health, 2018) continues to define roles and responsibilities of named doctors, nurses and midwives. The document also specifies that named individuals and the nominated Trust Board representatives have a duty to monitor safeguarding throughout the organisation.

In accordance with this, the Director of Nursing is the Trust Executive Lead for Safeguarding. The Deputy Director – Patient Experience is the managerial lead and chairs the ICHT Safeguarding Committee.

2.2 The safeguarding team

The team is based in the corporate nursing division and consists of:

- a consultant nurse (also the named nurse)
- a named doctor for children (4 programmed activities)
- a named midwife
- four C&YP clinical nurse specialists

- two safeguarding midwives
- a safeguarding adult clinical nurse specialist
- an identified doctor for adult safeguarding (1 programmed activity)
- two administrators
- a charity funded Independent Domestic Violence Advisor (IDVA)

The three named professionals are mandated positions within NHS organisations and all had people in post during 2018/19.

2.3 The ICHT Safeguarding Committee

The committee oversees the provision of safeguarding services across the trust and seeks assurance that these services are in place and effective. The committee is chaired by the Deputy Director of Patient Experience and membership includes all trust named professionals, designated professionals from the CCG, local authority safeguarding representatives and senior nurses from the clinical divisions. The committee focuses on assurance and key decision-making.

The committee met four times during 2018/19 and was quorate on each occasion with good attendance from the named professionals.

2.4 Policy framework

Practice during the year was supported by a comprehensive suite of policies and procedures designed to help safeguard C&YP and adults:

- Safeguarding children and young people operational policy (2016)
- Safeguarding adults policy and procedure (2017)
- Domestic abuse operational policy (2018)
- Learning disabilities and autism policy and procedure (2017)
- Policy for the management of children who are not brought to outpatient appointments (2017)
- Female genital mutilation policy (2016)
- Standard operating procedure; admission of adolescents to [adult] inpatient wards (2017)
- Chaperone Policy (2018)
- Restrictive Physical Intervention and Therapeutic Holding Guideline for Children and Young People (2018)
- Restraint (adults) procedural guidance (2018)

- Deprivation of Liberty Safeguards policy and procedure (2016)
- Patients Detained Under the Mental Health Act Policy (2017)

2.5 Training

ICHT has a requirement to provide training at different levels for safeguarding children and adults. This has been done in line with national intercollegiate guidance, ensuring that staff get the level of training most appropriate to their role. Training is delivered through a combination of e-learning and face-to-face sessions. A significant focus in year was achieving the required compliance with level 3 C&YP training. The training compliance levels at March 2019 were as follows:

- Safeguarding children level 1 93%
- Safeguarding children level 2 89%
- Safeguarding children level 3 90%
- Safeguarding adults level 1 94%
- Safeguarding adults level 2 94%
- Prevent basic + workshop 94%
- Board level training Delivered June 2018

Domestic abuse, child sexual exploitation and modern slavery are included in the training above. All members of the safeguarding team have additional training and clinical supervision commensurate with their role.

2.6 Safer recruitment

NHS trusts are required to ensure that staff are recruited using *safer recruitment practice* in accordance with NHS Employers' guidance. ICHT complies with this by carrying out either enhanced or standard DBS (Disclosure & Barring Service) checks on new employees as well as rigorous checking of identity and referencing. Compliance with this standard is monitored by the people & organisational development division.

2.7 Child Protection – Information Sharing project (CP-IS)

CP-IS, introduced by NHS Digital, helps health professionals and social care to work together to share information when children or pregnant women attend an unscheduled healthcare setting. CP-IS was in use in the trust during the year for patients attending the emergency departments, urgent care centres, the children's' ambulatory unit, maternity triage and the labour ward.

Staff have had to use a two-step approach for activating CP-IS but work was commenced in year to have the system integrated with Cerner which would make it easier for staff to use.

3. Safeguarding activity and practice

3.1 Referrals

An increase in the volume of referrals to both the safeguarding team and the local authority safeguarding teams was seen in 2017/8 and this trend continued in 2018/19. Total referrals across C&YP, maternity and adults was up on the previous year by around 20%; in excess of 6000 (see table below).

Referrals to safeguarding team 2018/19	**Q1**	**Q2**	**Q3**	**Q4**
Children	893	807	945	1021
Maternity	426	431	586	543
Adult	110	99	101	149
Total	1429	1337	1632	1713

The main safeguarding themes seen during the year were children and families who fail to engage with health and social care organisations, assaults against children, serious youth violence (gangs), mental illness in families, domestic abuse, self-neglect in older people and families already known to children's social care.

The increase in numbers is in part due to the increased incidence of the themes above. However, there is also greater awareness within the trust about safeguarding issues because of training and information provided by the safeguarding team meaning that staff are more likely to report things. Whilst this is positive, the team's resources have been stretched and therefore this has been identified as a risk. Actions such as working in different ways, supporting clinical staff to handle low risk cases and the use of temporary bank staffing have mitigated this risk, but it will remain under close review.

3.2 Model of working

One of the different ways of working was to introduce a seven-day safeguarding service, which was successfully implemented in 2018/19. This has been helpful in spreading the work over the week, for example by avoiding the high volume of work associated with

sorting out weekend referrals on a Monday. It has also been invaluable in supporting the organisation during events such as the Notting Hill Carnival. Another initiative is that all members of the team, irrespective of their speciality will provide advice and support whatever the case. This is unusual in the safeguarding field, but has proved to be effective and popular with staff in the trust.

Safeguarding nurses and midwives give specialist advice and support, particularly in complex cases. They provide liaison with community and local authority teams and provide teaching and clinical supervision to trust staff. They aim to empower staff to acknowledge the context within which safeguarding is set, to have professional curiosity, to be able to think the unthinkable, and to hear the voice of the child or adult.

The team had to attend a wide range of meetings from case conference and strategy meetings about individual patients to representing the trust at external safeguarding board and board subcommittee meetings. The appointment of an independent domestic violence advisor (IDVA) has helped considerably as the volume of multi-agency meetings about domestic abuse have increased.

Serious youth violence (gangs) and knife crime, which are national issues, were an increasing issue in year. Whilst this clearly represents a risk to young people in our care, we also saw an increase in year of aggression towards staff either deliberately or inadvertently because of gang related disputes coming into the hospital space. The safeguarding team promote a zero tolerance to violence from these young people to the staff whilst maintaining the safeguarding processes. They have devised a serious youth checklist for staff and completed health promotion activities, such as first aid talks for the young people experiencing exploitation and violence.

4. Summary and priorities for 2019/20

The trust safeguarding committee, based on evidence and reports received during 2018/19, is assured that the trust had the infrastructure and appropriate systems in order to provide a safe and effective safeguarding service.

The committee has no significant areas of concern that it wishes to advise the trust about, but expects further work to undertaken in 2019/20 that will aim to address ongoing and developing issues including:

- The increasing volume of safeguarding activity will be monitored and the safeguarding team will review ways of working and resources to ensure the service is provided and the safeguarding staff are supported.
- The increase in domestic abuse concerns will be monitored as will the effectiveness of the charity funded IDVA. Work will be undertaken to review additional funding routes to enable the continuation of this role beyond the current 2-year charity funding and to increase the number of IDVA posts within the trust.
- The provision of safeguarding training in the trust will be reviewed in line with the most recent intercollegiate guidance
- The safeguarding team will ensure that it contributes to the work related to serious youth violence both external to the trust and more locally in terms of keeping staff, patients and visitors safe.
- Planning will commence and be well underway by the end of the year for the introduction of the Liberty Protection Safeguards, which are due to replace the Deprivation of Liberty Safeguards in October 2020.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Trust Board Committee Terms of Reference	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 30th January 2019	**Item 19, report no. 16**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Author:** Peter Jenkinson, Director of Corporate Governance

Summary:
It is good practise to review the Committee Terms of Reference on an annual basis to ensure that they are fit for purpose and reflect any changes made to the Committee in-year.

The following Board Committees reviewed their Terms of Reference during September to November 2019:

- Audit, Risk & Governance Committee
- Finance, Investment and Operations Committee
- Quality Committee
- Remuneration and Appointments Committee

Recommendations:
The Board Committee Terms of Reference are attached for Trust Board approval.

This report has been discussed at:
- Audit, Risk & Governance Committee, 2nd October 2019
- Finance, Investment and Operations Committee, 18th September 2019
- Quality Committee, 13th November 2019
- Remuneration and Appointments Committee, 30th October 2019

Quality impact:
Regular review of terms of references support good assurance and oversight arrangements.

Financial impact:
No impact

Risk impact and Board Assurance Framework (BAF) reference:
Good governance supports the reduction of risk to the Trust overall.

Workforce impact (including training and education implications): N/A

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable

If yes, are further actions required? ☐ Yes ☐ No

What impact will this have on the wider health economy, patients and the public?

☐ Yes ☐ No ☒ Not applicable If yes, briefly outline. ☐ Yes ☐ No ……
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do ▪
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Not relevant.

Imperial College Healthcare NHS Trust

AUDIT, RISK & GOVERNANCE COMMITTEE

TERMS OF REFERENCE

Role

To provide the Trust board with the assurance that an adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively. The Committee will operate in two parts, Part I: Audit, and Part II: Risk and Governance.

1 Membership and quorum

1.1 Members of the Committee shall be appointed by the Chairman on behalf of Trust board.

Part I - Audit

1.1.1. The Committee shall be made up of a minimum of three members. Only non-executive directors shall be members of the Committee.

1.1.2. The chief financial officer, director of nursing and medical director will attend all meetings

1.1.3. The chief executive will be invited to attend any meeting and should attend at least annually to discuss with the Committee the process for assurance that supports the annual governance statement.

Part II – Risk & Governance

1.2.1 The Committee shall be made up of a minimum of three non-executive directors, chief finance officer, director of nursing, and medical director.

1.2.2 Members may not appoint a deputy to represent them at a Committee meeting. The Chairman of the Trust is not a member of the Committee.

1.2.3 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.2.4 The chair of both parts the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.2.5 The quorum for the meeting will be two non-executive director members for Part I and Part II and the addition of two executive directors for Part II; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

1.2.6 Internal and External Audit representatives will always attend both parts of the meeting. The Committee shall meet privately with the Internal and External Auditors at least once a year.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The secretary of the Committee shall maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary will attend each meeting and they or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers shall be forwarded to each member of the Committee, any other persons required to attend and all other non- executive directors, no later than five working days before the date of the meeting.

3.4 The secretary will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

3.5 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

3.6 Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust board unless a conflict of interest exists.

4 Duties

4.1 The Committee (across Part I and Part II) should carry out the following duties for the Trust:

4.2 Governance, Risk Management and Internal Control

4.2.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In relation to the management of risk, the Committee will:

- Review the process under which the trust sets its risk appetite;
- Oversee and advise the Trust board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- Refer to the Quality Committee any clinical risks that require further scrutiny by its membership;
- Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- Review the statements to be included in the Annual Report concerning risk management;
- Review the governance arrangements in place to ensure effectiveness of learning from incidents trust-wide is achieved.

4.2.2 The Committee will seek assurance that the monitoring of due diligence on any integration or partnership arrangement is appropriate.
arrangements, reviewing the risk assessment and decision-making processes to ensure all control issues are addressed.

4.2.3 The Committee will seek assurance on behalf of the Trust board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice.

4.2.4 In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;
- an effective system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
- the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant reglatory, legal and code of conduct requirements;

- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by NHS Protect.

4.2.6 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.2.7 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.3 Internal Audit

4.3.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board of Directors. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of Internal Audit.

4.4 External Audit

4.4.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- appointment of the External Auditor, as far as the relevant rules and regulations permit;
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Organisation and associated impact on the audit fee;
- review all External Audit reports (together with the appropriateness of management responses), including agreement of the annual audit letter before submission to the Trust board.

4.4.2 The Committee will review any proposal considered for commissioning work outside the annual audit plan (in its role as the Audit Panel) prior to approval.

4.5 Auditor Panel

4.5.1 NHS trusts are required to appoint their own external auditors and directly manage the resulting contract and the relationship; trusts are required to have an auditor panel to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them;

4.5.2 In accordance with The Local Audit and Accountability Act 2014, and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015, the Trust has nominated the Committee (Part I) as the Auditor Panel for the Trust;

4.5.3 The Auditor Panel will advise the Trust board on the selection and appointment of the external auditor;

4.5.4 The Trust board must consult and take account of the Auditor Panel's advice on the selection and appointment of the Trust board on the appointment of external auditors, and publish a notice on the website within 28 days of appointing the auditor providing details of appointment, and noting auditor panel advice;

4.5.5 The Auditor panel must advise on the Trust's policy on use of auditors for the provision of non-audit services;

4.5.6 Auditor panel business must be identified clearly and separately on the agenda.

4.6 Whistleblowing and counter fraud

4.6.1 The Audit, Risk and Governance Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern including patient care and safety and bullying (including the Freedom to Speak up Guardian).

4.6.2 In particular the Committee will:

- review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service;
- approve and monitor progress against the operational counter fraud plan;
- receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;
- monitor progress on the implementation of recommendations in support of counter fraud;
- receive the annual report of the local counter fraud specialist.

4.7 Other Assurance Functions

4.7.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

4.7.2 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (for example the NHS Litigation Authority), professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

4.7.3 In addition, the Committee will be cognisant of the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

4.8 Management

4.8.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.8.2 They may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

4.9 Financial Reporting

4.9.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

4.9.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Trust Board.

4.9.3 The Committee shall review the Annual Report and Financial Statements before recommending them to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas; and
- significant adjustments resulting from the audit.

4.10 Standing Orders and Standing Financial Instructions

4.10.1 The Committee will review on behalf of the Trust board any proposed changes to the Standing Orders and Standing Financial Instructions;

4.10.2 The Committee will examine the circumstances of any departure from the requirements of Standing Orders and Standing Financial Instructions;

4.10.3 The Committee will monitor the Declarations of Interest & Hospitality policy with reference to the codes of conduct and accountability thereby providing assurance to the Board of probity in the conduct of business;

4.10.4 The Committee will review schedules of losses and compensations annually.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting;
5.2 Minutes of Part I will be reported to the public Trust board; minutes of Part II shall be reported to the private Trust board, with a report of proceeding to Part II;
5.3 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

6 Other matters

6.1 The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- give due consideration to laws and regulations;
- at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary; and.
- The chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

7 Authority

7.1 The Committee is a Committee of the Trust board, and has no powers, other than those specifically delegated in these Terms of Reference. The Committee is authorised to:

- seek any information it requires from, or the attendance of, any employee of the Trust in order to perform its duties
- obtain outside legal or other professional advice on any matter within its terms of reference via the trust company secretary.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.
8.2 The Secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

Reviewed: September 2019

Imperial College Healthcare NHS Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

Role

To obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust. The committee will also obtain assurance that the quality strategy is being implemented and that continuous improvement is evidenced; To ensure that robust clinical governance structures, systems and processes (including those for clinical risk management and service user safety) are in place across all services and are line with national, regional and commissioning requirements; Onward referral of appropriate issues to relevant committees (including the operational and management committees) for further review or action; and review and approval (or recommendation for approval by the Trust board) of required quality-related annual reports (for example the Quality Account).

1 Membership and quorum

1.1 The Committee chair (an independent non-executive director) and Committee members will be appointed by the Trust Chair. The Committee will comprise three non-executive directors, the medical director, the director of nursing, the chief executive, the divisional directors, and the director of infection prevention and control.

1.2 Only members of the Committee have the right to attend and vote at meetings; officers of the Trust and other individuals may be required to attend all or any part of Committee meetings. Non-executive directors are invited to attend any board committee they wish and will notify the secretary of the committee when they have a specific meeting that they would like to attend.

1.3 In the absence of the Committee chair, members present will agree that one among them will chair the meeting.

1.4 The meeting quorum is two, of which one is a non-executive director; the meeting will be considered competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

2 Frequency of meetings and attendance requirements

2.1 The committee will normally meet bi-monthly; the Committee chair has the power to increase the frequency to monthly if considered necessary.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their deputy shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

3.5 Minutes of Committee meetings should be circulated to all members of the committee and, once approved, to all members of the Trust board (unless a conflict of interest exists).

4 Duties - The committee should carry out the following duties for the Trust:

4.1 Safety

4.1.1 Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents, and taking action to reduce risks and improve clinical quality;

4.1.2 Receive and review reports on individual serious adverse incidents; individual 'never' events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;

4.1.3 Obtain assurance that robust safeguarding structures, systems and processes are in place to safeguard children and young people and vulnerable adults;

4.1.4 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act;

4.1.5 Obtain assurance that the Trust has appropriate arrangement in place to remain compliant with all aspects of Health and Safety legislation.

4.2 Effective

4.2.1 Approve and assure delivery of the annual programme of Trust-wide clinical audits;

4.2.2 Obtain assurance that NICE Guidelines and Technology Appraisals are implemented;

4.2.3 Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations;

4.2.5 Oversee the Trust's work on Care Quality Commission's improvement reviews.

4.2.4 Report to the audit, risk and governance committee any ongoing concerns or risks being overseen by the Committee, and to refer other matters to other committees as appropriate.

4.3 Well-led

4.3.1 Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services, and developed in line with national, regional and commissioning requirements;

4.3.2 Approve and monitor delivery of the Trust's equality delivery system so that essential principles of equality are embedded into the culture, behaviour and decision making process of the organisation;

4.3.3 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

4.3.4 Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the cost improvement process (CIP);

4.3.5 Approve and assure delivery of all quality governance plans including CQC inspection action plans, and quality improvement methodology;

4.3.6 Obtain assurance that the divisional quality groups are effectively coordinating quality and clinical governance activity within the Trust;

4.3.7 Ensure that board assurance framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

4.4 Caring

4.4.1 Approve and assure delivery of the Trust's patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are keys element of the work of quality and clinical governance teams across the Trust;

4.4.3 Receive assurance that appropriate safeguarding arrangements are in place and effectively monitored;

4.4.4 The chairman of the committee shall be the Trust's Duty of Candour champion.

4.5 Responsive

4.5.1 Obtain assurance that patient access targets are being delivered;

4.5.2 Obtain assurance that effective channels are in operation for communicating and managing issues of clinical governance to relevant managers, staff and external stakeholders;

4.5.3 Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The chair of the Committee will normally attend the annual general meeting prepared to respond to any questions on the committee's activities.

6 Other matters

6.1 The Committee will:

- Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- Give due consideration to legislation and regulations;
- Review both its effectiveness and terms of reference on an annual basis, and recommend to the Trust board for approval, any changes it considers necessary.

7 Authority

7.1 The Committee is a Committee of the Trust board and has no powers other than those specifically delegated by the schedule of reserved and delegated powers, as described in these terms of reference. The Committee is authorised:

7.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to a meeting of the committee as and when required.

7.1.2 to obtain outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary.

8 Monitoring and review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide;

8.2 The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Reviewed: November 2019

Imperial College Healthcare NHS Trust

FINANCE, INVESTMENT AND OPERATIONS COMMITTEE
TERMS OF REFERENCE

Role

The purpose of the Finance, Investment & Operations Committee is to provide oversight, on behalf of the Trust Board, and seek assurance that efficient and effective budget and financial management arrangements are in place for the Trust. It will undertake, on behalf of the Trust board, thorough and objective reviews of financial policy and financial performance issues, reviewing the risks to the financial position, advising the Trust board on finance issues and investment strategy, including those relating to the Trust's estate.

The Committee will also be sighted on operational performance and planning, focusing specifically on ensuring there is alignment between financial plans and priorities for operational delivery.

It will have oversight of the development and implementation of the Trust's Transformation programme, including monitoring the progress in delivering the key projects that support the achievement of financial and operational performance.

1 Membership and quorum

1.1 Members of the Committee shall be appointed by the Chairman, on behalf of the Trust board. The committee shall be made up of five members;
- three non-executive directors
- Chief executive
- Chief financial officer

1.2 Only members of the Committee have the right to attend and vote at Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of the Committee's meetings.

1.3 The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members, the Deputy Chief Financial Officers (two posts) and divisional directors are expected to attend Committee meetings; others may be invited on an as needs basis.

1.5 The meeting quorum is three members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their nominee shall act as the secretary of the Committee.
3.2 Meetings of the committee may be called by the secretary of the Committee at the request of any of its members or where necessary.
3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers, shall be forwarded to each member of the committee, and any other person required to attend, no later than five days before the date of the meeting.
3.4 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present, and any conflicts of interest.
3.5 Minutes of committee meetings should be circulated to all members of the Committee, and once approved, minutes are reported to the private Trust board.

4 Duties

4.1 The Committee should carry out the following duties for the Trust:

- advise the Trust board on financial policies;
- recommend to the Trust board, the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust board;
- review the Annual Plan including the annual revenue and capital budget prior to submission to the Trust board for approval;
- review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust board;
- review compliance with the self-assessment quality checklist for the annual reference cost submission;
- review, at the request of the Trust board, specific aspects of financial performance where the Trust board requires additional scrutiny and assurance;
- review the Trust's projected and actual cash and working capital;
- approve and keep under review, on behalf of the Trust board, the Trust's investment and borrowing strategies and policies;
- ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control); and
- review the financial risks;
- establish the overall methodology, processes and controls which govern the Trust's investments;
- evaluate, scrutinise and monitor investments, including regular review of the capital programme;
- review post project evaluations for capital projects (above £5million) and for revenue projects (above £9 million per annum). All projects will have a two stage review that will be presented to the FIC; shortly after implementation to assess project or contract completion, and approximately 12 months later to review whether anticipated outcomes/savings had been achieved;
- review, and recommend to Trust board, the Trust's treasury management, working capital and estates strategies;
- evaluate and scrutinise the financial and commercial validity of individual investment decisions over £5m recommended for approval by the executive committee, including the review of outline and final business cases, and service development tenders, for onward

recommendation for approval by the Trust board. The current delegated limit for the Trust is £15 million;

- bi-annually review business cases approved by the executive committee of a value between £2m and £5m.

- review operational planning for the Trust, including activity and capacity planning and winter planning, identifying the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning;

- Review performance against such plans and identify the key issues and risks requiring discussion or decision by the Trust board where these issues and risks impact on financial performance and planning;

- review the Transformation programme and receive progress reports on key projects within that programme.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

6 Other matters

6.1 The committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;
- give due consideration to laws and regulations;
- at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

7 Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties;
- to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary;
- to call any employee to a meeting of the committee as and when required.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the committee through receipt of a written report following each meeting and the Committee's minutes.

8.2 The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

Reviewed: October 2019

Imperial College Healthcare NHS Trust

REMUNERATION & APPOINTMENTS COMMITTEE

TERMS OF REFERENCE

Role

To act on behalf of the Trust board in:

- [duplicates what is listed below]
- Agreeing and overseeing the process for appointing executive directors and other direct reports to the chief executive as listed in the Appendix 1;
- Agreeing the remuneration and terms of service of executive directors and all other director level reports to the chief executive officer, and noting the remuneration of all other very senior managers (VSM);
- Monitoring the performance and the development of executive directors;
- Ensuring that Equality and Diversity has appropriate priority in leadership development and succession;
- Review, and recommend approval to the Chairman where appropriate, requests by executive directors to act as non-executive directors in other organisations or in similar roles;
- Ensuring that effective plans are in place to provide continuity of leadership in the event of extended executive director absence or vacancy;
- Approving any severance payments that are proposed for executive directors, for direct reports to the chief executive officer, and any other very senior managers and others as may be required by NHS Improvement and the Department of Health.

1. Membership and quorum

1.1. Members of the committee shall be appointed by the Chair of the Trust board. The committee shall be made up of three members:
- The Chair of the Trust board
- Two non–executive directors.

1.2. Only members of the Committee have the right to vote at the Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of its meetings.

1.3. The chair of the Committee will be a non-executive director, appointed by the Chair of the Trust board.

1.4 In addition to the Members, the following are required to attend all meetings of the Committee:
- Chief executive
- Director of people & OD
- Trust company secretary.

They will, however, be excluded from Committee discussions in relation to them.

1,5 A quorum necessary for the transaction of business shall be two members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

2. Frequency of meetings and attendance requirements

2.1 The committee will meet as required and at least twice a year. The timetable of meetings will be agreed between the Chair of the Committee and the Director of people & OD.

2.2 Members are expected to attend at least 75 per cent of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3. Executive lead and meeting administration

3.1 The director of people and OD shall support the Committee in advising the Committee on employment issues and procedures, and shall agree agendas and papers with the committee Chair.

3.2 The Committee shall be supported administratively by the Trust company secretary, who will distribute papers, take the minutes and keep a record of matters arising and issues to be carried forward.

4. **Duties -** The Committee shall carry out the following duties for the Trust:

4.1 Trust board composition

- regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust board and make recommendations to the Trust board with regard to any changes.
- give full consideration to and make plans for succession planning for the chief executive officer and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
- be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- be responsible for identifying and nominating a candidate, for approval by the Trust board, to fill the position of chief executive officer.
- before an appointment is made evaluate the balance of skills, knowledge and experience on the Trust board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

4.2 Appointment of executive directors

- nominate one or more members to be actively involved with the chief executive officer in the appointment of executive director and executive team member posts, and in the design of the selection process on behalf of the Committee.
- ensure that the selection process is based on: an agreed role and person specification; the use or other involvement of any third party recruitment professionals; an interview panel to include the chief executive officer, an agreed non-executive director or directors, an external assessor representing NHS Improvement/DH or successor bodies and such other persons as may be agreed to be helpful.
- ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection. This will include ensuring compliance with fit and proper person regulations (FPP).
- keep the Trust board informed of the process, procedures and timetable to which it is working, as appropriate.

4.3 Remuneration of executive directors

- agree on behalf of the Trust board the remuneration and terms of service of the Executive directors and that the executive directors are fairly rewarded for their contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant. Approve the remuneration policy for executive directors and executive team members, including approving the performance criteria for bonuses where appropriate and agreed. For the Chief executive, the Committee will advise the Chair regarding the framework for bonuses, in accordance with contract of employment.
- agree and review annually a policy framework for the pay of very senior managers (VSM) not on national contracts, including executive directors. Determination of the salaries of very senior managers, other than executive directors, is delegated to the chief executive officer or relevant executive director, advised by the director of people & OD and working within the agreed policy framework. The committee will review annually the earnings of such managers including senior clinicians and clinical managers.

- establish the parameters for the remuneration and terms of service for the appointment of executive directors, with delegated authority of the chief executive officer to agree starting salaries within the agreed parameters.
- agree the termination of contract of executive directors and the payment of any redundancy or severance packages in line with prevailing national guidance.

4.4 Performance and Succession Planning

- monitor the performance both individually and collectively of the executive directors in the context of their responsibilities and objectives, inputting into the annual review of performance by the Chief executive and receiving a summary of the final outcomes of the appraisal.
- ensure the capability of potential or nominated deputies for executive directors to effectively deputise during periods of extended absence on the part of the Executive directors.
- oversee an assessment of the capability and succession potential of the Trust leaders in order to identify any strategic gaps requiring appropriate intervention and to receive assurance regarding the succession plans for directors and talent management; including assurance regarding equality in the succession planning.

5. Reporting responsibilities

5.1 The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.2 The Committee shall oversee the production of an annual report of the Trust's remuneration policy and practices which will be part of the Trust's Annual Report.

6. Other matters

6.1 The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members
- give due consideration to laws and the regulatory framework within which the Trust operates;
- at least once every two years review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

7. Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised to:

- seek any information it requires from any employee of the Trust in order to perform its duties;
- obtain outside legal or other professional advice on any matter within its terms of reference via the director of people and OD;
- call any employee to be questioned at a meeting of the Committee as and when required.

7.2 In order to ensure the business of the Committee is not unduly held up between meetings, the Chair may take Chair's action between meetings. Any such decisions thus taken will be reported to the next meeting. This may include authorisation of contractual severance payments to staff other than Executive Directors as required by NHS Improvement or the Department of Health. Where substantive or sensitive decisions are required outside of scheduled meetings then the Chair may convene an extraordinary meeting of the Committee.

Reviewed: October 2019

Appendix 1

Posts for which the Committee has responsibility

EXECUTIVE DIRECTORS
Chief executive
Chief finance officer
Medical director
Director of nursing
OTHER DIRECTOR LEVEL DIRECT REPORTS TO CHIEF EXECUTIVE
Divisional directors
Director of people & organisation development
Chief information officer
Director of communications
Director of redevelopment
Director, Imperial Private Healthcare
Director of transformation
Director of operational performance
Director of strategy, research and innovation
Director of Corporate governance & trust secretary

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee **–** report from meeting on 2 October 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27 November 2019	**Item 19.1, report no. 16a**
Responsible Non-Executive Director: Sir Gerald Acher, Deputy Chair	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Audit, Risk and Governance Committee met on 2 October 2019. Key items to note from that meeting include:

External Audit
The Committee received the sector update noting the new IFRS 16 guidance from the department of health; Committee members noted the changes and the next steps that had been recommended by the external auditors. Committee members noted as part of the sector update that the government had proposed mandatory Taskforce on Climate-related Financial Disclosure (TCFD) from 2022 and agreed that climate change and sustainability were increasingly important areas to be mindful of; it was agreed that the executive team would consider where the responsibilities were for leading on these within the Trust. Committee members noted that the final audit plan would be presented to the Committee in December 2019.

Internal audit progress report
The Committee received the internal audit progress report, noting that the 2018/19 work had completed including the IT disaster recovery review. Work against the 2019/20 plan was on track. Committee members discussed the lessons learned around data quality and reflected that improving data quality is a journey for any Trust and whilst there were no issues found in the sample test, which was positive, there was still learning to be shared. The Committee reflected that there was a significant level of focus on data quality at the Trust and felt that they could be much more confident in the quality of data now, acknowledging that the next step was focusing on the system being able to pull data together, getting it right first time and that this would enable the Trust to manage its risks better. It was noted that the Trust had a data quality steering group with finance indicators now in place; the Trust now needed to focus on both clinical data and finance in parallel.

The Committee noted the outcome of the IT disaster recovery review and the action plan and next steps.

The Committee also noted the finalised 2018/19 internal audit annual report.

Local Counter Fraud Service (LCFS)
The Committee received the counter fraud update noting that the proactive work was on plan. There had been a significant change in the fraud risk assessment which had been made in line with the Trust's risk management approach. In terms of reactive counter fraud work, a number of referrals had been closed and this work continued. Committee members noted that the Trust was making progress

against the national fraud initiative and was on track to meet the trajectory to complete high risk matches by March 2020.

Update on Better Payment Practice Code performance
The Committee noted the report on the Trusts BPPC performance which was going in the right direction.

Corporate risk register, key risks and board assurance framework
The Committee noted the corporate risk register, key risks and board assurance framework.

Data quality report and RTT update
Committee members received the data quality report and were pleased to note that there had been a focus on waiting time data quality over the previous 6 months and that there had been positive progress against the metrics in place. The Trusts current position in terms of RTT performance was also reviewed, including progress against the actions from the Elective Assurance Review conducted by MBI in 2018/19.

EU exit plans
The Committee received the EU exit plans update and noted that all NHS organisations had been requested to undertake local EU exit readiness planning, local risk assessments and to plan for wider potential impacts including winter pressures with the new date to leave of 31 October 2019. Committee members felt confident that the appropriate plans were in place and confirmed that these plans were being overseen by the EU exit working group. Committee members noted the risk associated with significant disruption to the continued provision of service in the event of a 'no deal' Brexit which had been upgraded from 8 to 12 as the likelihood had changed from being 'unlikely' to 'likely'. Next steps included communications with staff to ensure that everyone was aware of the steps in place; Committee members confirmed that EU staff were incredibly welcome at the Trust, and hoped that they would continue to work here, adding that it was important that they were supported throughout this time.

Tender waiver & Losses and special payments reports
The Committee received and noted a summary of the number of tender waivers since April 2019 and the controls in place.

Quality account 2019/20 proposed changes to format

The Committee agreed to and welcomed the proposed changes to the Quality Account in 2019/20 which sought to reduce the amount of repetition and duplication of work between the annual report and the quality account, and within the quality account document itself, helping to make it more readable and accessible.

The Committee will next meet on Wednesday 4 December 2019.

Recommendations: The Trust Board are requested to note this report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from Quality Committee – report from meeting held on 13 November 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27 November 2019	**Item 20.2, report no. 17b**
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Quality Committee met on 13 November 2019. Key items to note from that meeting include:

Integrated Quality and Performance Report
The Committee reviewed the quality aspects of the performance report and were pleased to note that compliance with the duty of candour requirements was improving. Committee members discussed the vacancy rate which looked to be improving (acknowledging that nursing vacancies continued to be of concern) and noted that work to retain staff continued, with a focus on offering students jobs which had proven to be successful.

Key Divisional Quality Risks
The Divisional Directors and Corporate Directors provided an update on their key divisional risks which remained largely the same as the previous meeting. Key themes included issues relating to the estate and the non-emergency patient transport service. Committee members noted the risks and the actions being taken to mitigate these.

CQC Update
The Committee received an update on CQC activity noting that the CQC had not asked the Trust to investigate any concerns or complaints, nor had any whistleblowing's been made to the CQC about the Trust, since the previous update. Committee members noted that following the inspection of the Trust's GP practice in July 2019, the reports had now been published on the CQC's website.

Incident Monitoring Report
The Committee considered the regular incident monitoring report, noting that incident reporting had increased which was a positive reflection of the recent work to encourage reporting across all divisions. The overall harm profile of the Trust remained good, with some of the lowest mortality rates in the country and the percentage of moderate and above incidents reported so far this year being below the national average. Noting that there were still overdue Serious Incident (SI) investigations, it was confirmed that a new process was being introduced which would allow increased communication with patients and their families in regards to ongoing investigations and timelines associated with this, acknowledging that some SI's were very complex and took longer than the 60 day target completion dates. The Committee would continue to monitor this.

Never events action plan update
The committee reviewed progress with the never events action plan and committee members strongly supported the Helping Our Teams Transform (HOTT) programme. The committee noted that another never event has been reported, emphasising the need for the HOTT program to be supported

Infection prevention and control quarterly report

Committee members received the quarterly infection prevention and control report and noted that 28 cases of Trust attributed C. difficile cases had been reported in quarter 2; this was an increase on previous quarters which had been investigated and the Committee were pleased to note that there had been no lapses in care identified in 2019/20 so far. Performance against the infection control metrics was noted and Committee members noted that surgical site infection (SSI) performance following coronary artery bypass graft cardiothoracic surgery had risen above the national average. This was being very closely monitored and an action plan was being developed in a task and finish group chaired by a cardiothoracic surgeon to address this. Committee members were pleased to note that the second round of hand hygiene improvement focus wards had completed their 12 week improvement cycle and the bi-annual hand hygiene audit results demonstrated an improved compliance, with mean compliance increasing from 38% to 64%.

Health and safety report
The Committee noted the work taking place to address the continuing risk relating to violence and aggression with a real focus on supporting frontline staff.

Flu update
Committee members were concerned to note that progress with the flu campaign was not progressing as quickly as they would like to have seen, despite it being a strong campaign; the non-executives urged the executive team to continue their significant focus on increasing the level of uptake of the vaccine, particularly amongst frontline staff.

Seven day services update
The Committee received the bi-annual update on the latest position against the four priority national seven day hospital services standards noting that the Trust continued to meet three out of the four standards, with a continued improvement noted against standard 2 (the percentage of patients reviewed by an appropriate consultant within 14 hours of admission). Committee members noted that though the Trust continues to fall below the target of this standard, the way that the Trust organise specialist services provides assurance that the medical model offered provides appropriate expertise should patients require it. The Trust is clear that the forecasted recurrent cost of delivering such rotas (circa £2m) would not have a significant enough impact on improving quality of care to justify this spend to specifically achieve this standard; this approach has previously been well understood by our Clinical Commissioning Groups and NHS Improvement.
The Committee approved the submission of the report to NHSI, on behalf of the Trust board.

2018/19 Annual report from the Trust Safeguarding Committee
Committee members received the annual report from the Trusts' Safeguarding Committee and noted the increased volume of safeguarding activity and were pleased to note the successful introduction of a seven day service.

Quality account progress report
The Committee noted the progress against the quality account improvement priorities noting that each priority had defined work plans that were progressing and being reported on regularly to the executive committee.

Research report
The Committee noted the research report.

Quality Committee Terms of Reference annual review
The Committee approved the terms of reference.

Recommendations:
Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from the Finance, Investment and Operations Committee meeting held on 20 November 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27 November 2019	**Item 20.3, report no. 17c**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Finance Investment & Operations Committee met on 20 November 2019. Key items to note from that meeting include:

Financial performance including CIP performance and recovery plan
Committee members noted the month 7 finance report and current position noting that there had been a £4m improvement since month 6 due to additional non-recurrent income received. This meant that the Trust was on plan to achieve the year end control total however the Committee noted the impact that significant non-recurrent measures this year would have the following year. The Committee discussed the recovery plans within each division with a focus on delivering recurrent improvements in pay run rates and recurrent CIPs which will enable them to enter 2020/21 with a more sustainable underlying position.

Capital programme review
The Committee noted that a mid-year review of the capital programme had been completed and against the original plan was slightly behind year to date which, members were assured, was due to phasing of projects. The Trust was slightly ahead in spend on the backlog maintenance in year. Committee members were pleased to note that the Trust was on course to deliver the capital plan for the year.

Annual Imperial Private Healthcare (IPH) performance and strategy review
The Committee received the annual IPH performance and strategy review noting that despite a challenging London private patients market, and with more competition around, IPH was currently ahead of both plan and prior year and was forecasting to continue that trend for year end. Committee members were pleased to note that IPH had made good progress by working more closely with the Divisions and Consultant body. The Committee will receive further detail, including – inter alia - more information on customer strategy and financial targets in the January FIOC meeting.

Summary of business cases approved by the executive from 1 April 2019
Committee members reviewed the business cases that had been approved by the Executive.

Strategic imaging asset management (SIAM) strategic outline case (SOC)
Committee members were pleased to recommend approval to the board to move to the development of the outline business case phase of the strategic imaging asset management project noting the benefits which would include working more closely with the NWL sector and being considered one of the most innovative Trusts in the country in terms of cutting edge imaging services. Members also highlighted the need to procure/hire the requisite expertise to design and manage such a complex programme.

Update on transformation plan including specialty review programme update
The Committee noted the progress against the transformation plan and the speciality review programme and were pleased to note that there had been good engagement from the divisions with the focus on improving quality, patient care and efficiencies.

Business planning process
The Committee noted that the business planning process for next year was underway and were pleased to note that finance were working closely with the divisions to ensure that finances and operations were closely aligned.

Winter capacity plan update
The Committee discussed the winter plan for 2019/20 which is informed by previous learning and a bed modelling process, noting the actions the Trust will take to ensure that our services remain resilient to seasonal pressures. The aim of the plan is to maintain patient safety whilst optimising performance against the national access standards. Committee members noted the eight work streams that the plan is based around: triggers and escalation, pathway optimisation, predicting peak pressure, digital site operations, maintaining safe staffing, flu vaccination, EU exit and Christmas and the New Year. It was agreed that a post winter review would be presented back to the Committee in May next year.

The Committee will next meet on 22 January 2020.

Recommendations:
To note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Remuneration and Appointments Committee – report from meeting on 30th October 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27th November 2019	**Item 19.4, report no. 16d**
Responsible Non-Executive Director: Peter Goldsbrough, Chair of Remuneration Committee	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:
The Remuneration and Appointments Committee met on 30th October 2019. Key points to note include:

Committee terms of reference
The Committee reviewed its terms of reference and the forward planner, focusing on the remit of the Committee and the associated agenda items during the year to ensure the Committee fulfils this remit. The Committee also agreed a schedule of meetings for 2020/21.

NHS Pension update
The Committee considered an update on the issues relating to tax on NHS Pension Benefits and how the changes to the annual and lifetime allowances affects staff in the NHS Pension scheme. The Committee considered an update on the impact on operational services and action being taken at a national level and options for the Trust response, and agreed a recommendation to take no local action until the national picture was clearer but noted that the current Trust continued to raise awareness among staff, and doctors in particular.

Senior management appointments
The Committee considered the process for the appointment of an interim and substantive Chief financial officer to replace Richard Alexander following his resignation. The Committee also noted the appointment of Matthew Tully as Director of Redevelopment, due to start in early 2020.

Recommendations:
The Trust Board is asked to note the report.