Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 29th January 2020, 11.30am to 1.30pm
New Boardroom, Charing Cross Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1130	**1.**	**Opening remarks**	Paula Vennells	Oral
	2.	**Apologies:**	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
1135	**4.**	**Minutes of the meeting held on 27th November 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 27th November 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
1140	**7.**	**Patient story review** *To note and discuss the report*	Janice Sigsworth	04
1150	**8.**	**Chief Executive Officer's report** *To note the report*	Tim Orchard	05
For decision				
	9.	**No items for approval**		
For discussion				
1205	**10.**	**Bi-monthly Integrated Quality and Performance report** *To receive the integrated quality and performance report for month 8*	Julian Redhead/ Claire Hook	06
1215	**11.**	**Finance report** *To receive an update for month 9, year to date and other financial matters*	Jazz Thind	07
1225	**12.**	**CQC update** *To receive an update on CQC related activity at and/or impacting the Trust*	Peter Jenkinson	08
1235	**13.**	**HMRC business risk review plus (BRR+)** *To note the report and strategy*	Jazz Thind	09
1245	**14.**	**Freedom to speak up 2020 plan** *To note the priorities for 2020, in order to deliver the FTSU vision*	Nick Ross	10
For noting				
1255	**15.**	**Learning from deaths report Q1 & Q2** *To note the progress and findings*	Julian Redhead	11
1300	**16.**	**Mid-year update on safe, sustainable and productive nursing and midwifery staffing** *To note the report and findings*	Janice Sigsworth	12

1305	**17.**	**Pathway to excellence** To note the overview of the programme and benefits for ICHT	Janice Sigsworth	13
1310	**18.**	**Trust Board Committees – summary reports** *To note the summary reports from the Trust Board Committees*		
	18.1.	Audit, Risk and Governance Committee, 4th December 2019	Gerald Acher	14a
	18.2.	Quality Committee, 15th January 2020	Andy Bush	14b
	18.3.	Finance, Investment and Operations Committee, 22nd January 2020	Andreas Raffel	14c
1315	**19.**	**Any other business**	Paula Vennells	Oral
	20.	**Questions from the public**	Paula Vennells	Oral
Close	**21.**	**Date of next meeting** Board Seminar: 25th and 25th February 2020 (venue tbc) Trust Board: 25th March 2020, W12 Hammersmith Hospital		

Updated: 23 January 2020

Reading room material for reference:

1.	**Annual end of life care report**

Imperial College Healthcare NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Wednesday 27 November 2019
11.00 –13.30hrs
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
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
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** Sir Gerry Acher welcomed everybody to the meeting.
2.	**Apologies** Apologies were received from Richard Alexander and Ben Maruthappu.
3.	**Declarations of interest** There were no declarations made at the meeting. The Board noted the declarations of interest.
4.	**Minutes of the meetings held on 25 September 2019** The minutes of the previous meeting, held on 25 September 2019, were confirmed as an accurate record. The Board approved the minutes from the previous meeting.
5.	**Record of private items discussed at Board**

	The Board noted a summary of confidential items discussed at the confidential board meetings held on 25 September 2019.
6.	**Action log and matters arising** The Trust board noted the action log and updates.
7.	**Patient story**
7.1	The Board welcomed Annabel Rule, Clinical Lead Therapist in Acute and Elderly Medicine at St Mary's Hospital and Charing Cross Hospital. Ms Rule told the Board of a patient, who shall be referred to as Ms A, who had a history of dementia and was admitted to the Trust in August, following a fall at home. The patient was found at home by their carer, having sustained head and scalp lacerations. 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.
7.2	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 person's 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.
7.3	Annabel Rule described how she worked with the multidisciplinary team, the patient, the patient's 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.
7.4	The Board reflected on 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; the Board welcomed this approach and noted that the story demonstrated the Trusts 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.
7.5	The Board thanked Miss Rule for sharing her experiences and noted the lessons learned. The Trust board noted the patient story.
8.	**Chief executive officer's report**
8.1	Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership.
8.2	Financial performance Prof Orchard highlighted that the Board had 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).
8.3	Transformation programme update Prof Orchard noted that transformation projects continue, with collaborative clinical transformation projects with Chelsea and Westminster at the fore, driven by weekly progress calls between the Strategy and Transformation teams at each site. Since the last update, Renal was moving forward well, with strong local engagement from the service. Trauma & Orthopaedics had been launched with a kick-off meeting, and was being scoped. The newly-established Transformation team was settling in, with a key member returning from maternity leave this week, who will be looking at Endoscopy. Additionally, the Director of Transformation would be leading the Business Planning cycle for 2020/21.

8.4	Patient focus Care Quality Commission (CQC) inspections Prof Orchard was pleased to confirm that since the last meeting, the CQC had published the final report from the CQC inspection of the GP service at Hammersmith Hospital, with the Trust receiving 'good' ratings in all domains of the inspection.
8.5	Non-emergency patient transport At the last meeting Prof Orchard 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, there had been a deterioration once again and Prof Orchard would therefore be meeting with the CEO of Falck UK again to escalate these issues.
8.6	New Urgent and Emergency Care (UEC) standards Prof Orchard reported that the Trust continued to participate in the national field test of the proposed new UEC standards that began in the spring. Reporting against the new standards would continue until March 2020 and, in view of this, there had been a review of the 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. The Trust's 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.
8.7	Emergency Preparedness, Resilience and Response At the public meeting in September the Board received an update in relation to the Emergency Preparedness, Resilience and Response (EPRR) plans. This included the annual self-assessment submission to NHS England. NHS England had 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. The Trust received no red or amber ratings and hence achieved full compliance against all 69 core standards.
8.8	EU Exit As the UK and the EU agreed an extension of the Article 50 period to 31st January 2020, the Trust did not trigger the 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 the Trust would continue to review the plans to ensure we are as ready as we can be when the UK leaves the EU.
8.9	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. Prof Orchard was 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.
8.10	Strategic development Prof Orchard highlighted 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.
8.11	People Prof Orchard noted the Active Bystander training programme was taking place which aims to empower staff across the Trust to challenge poor and negative behaviours.
8.12	Flu Campaign Prof Orchard reported that this year's flu campaign had followed the 'best practice checklist - Flu vaccination of healthcare workers' published by NHSE / NHS Improvement. Peer vaccinators and roaming vaccinators had been appointed and trained, supported by an extensive communications and influencing campaign.
8.13	Research and innovation AHSC redesignation The Trust was currently working with partners within the Academic Health Science Centre (AHSC) to pull together a submission for re-designation 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 Board agreed delegated authority for the Chief executive and Chair to approve the submission.
9.	**Strategic development – Implementation of a management system (The Imperial Way**
9.1	The Board received and noted the report. Claire Hook highlighted that the proposed approach to delivering the Trust's strategy in a standardised way, linking in with the Trust's values and behaviours. Board members discussed the programme and agreed whilst they all supported the proposal, that there needed to be a clear and practical way of delivering it, with it being collectively owned by the executive team. The Board approved the Imperial management system (working title 'the Imperial Way') and noted the process for agreeing priorities for 2020/21 and the process for delivery of the 2019/20 objectives. **Action:** An update outlining the delivery process and risks would be presented to a future board meeting.
10.	**Bi-monthly Integrated Quality and Performance report**
10.1	The Board received and noted the integrated quality and performance report. Prof Julian Redhead highlighted that the Trust remained one of the safest acute hospitals in the country and was pleased to note that the reporting rate had improved. Noting the increased number of extreme harm incidents that had been reported, Prof Redhead confirmed that these were all being investigated and were being closely monitored.
10.2	Prof Redhead noted that a never event had been reported in October, this had caused no harm to the patient but a root cause analysis investigation was being completed.
10.3	Responding to a query from Kay Boycott and Paula Vennells regarding maternity sepsis, Prof Andy Bush confirmed that this had been discussed at the Quality Committee and no lapses in care had been identified. Prof Redhead agreed to provide further assurance regarding this. The Board noted the report.

	Action: Prof Redhead would provide further assurance regarding maternity sepsis rates.
11. 11.1 11.2 11.3	**Finance report month 7:** The Board received the finance report for month 7 noting that the Trust had 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 was planning to deliver a £11.1m surplus. The Trust was £3.8m better than plan in month and for the 7 months year to date before PSF and MRET. The Trust had received additional income in month for estates works. The Trust operational teams had completed a forecast that was £6m worse than plan. This had improved significantly over the past 3 months as additional benefits have been identified and delivered. The Trust expected to meet the control total for the financial year. The Board noted the report.
12. 12.1 12.2 12.3	**CQC update** The Board received the report and noted that since the previous meeting the CQC had asked the Trust to investigate one complaint. Some whistleblowings had been made to the CQC which all specifically related to safe medical and nurse staffing out of hours at Charing Cross Hospital; the CQC had not asked the Trust to take any action in relation to these; however, the Trust's internal response was noted by the Board. 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. Board members noted that the CQC was planning to introduce new core services relating to cancer, beginning in 2020/21. The frameworks for these inspections were currently in development, which the Trust was contributing to. No inspections had been carried out since the previous CQC update to the Board; there was no intelligence about which services the CQC may inspect at the Trust in the current financial year. The Board noted the update.
13. 13.1 13.2 13.3 13.4	**Corporate Risk Register and Board Assurance Framework** The Board received the report and noted that the Board had 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 had been undertaken; the outcomes of the review and any further changes had been reviewed by the Executive Committee and by the Audit, Risk and Governance Committee. The Board Assurance Framework had also been redeveloped, to align it to the Trust's strategic objectives and to incorporate the new approach to assurance, as agreed by the Audit, Risk and Governance Committee. The new format and process had been presented to the Audit, Risk and Governance Committee in October 2019 and to the Executive Finance Committee in November 2019. There were 25 corporate risks within the risk register; including 3 risks that were commercial in confidence or had other confidential information and were therefore not included in the report. The highest risks were scored as 20 and the lowest had been scored as 8. Key themes included:

13.5	• 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).
13.6	Noting the changes to the Board Assurance Framework, Peter Goldsbrough asked whether the amount of time it would take to track assurance had been considered. Peter Jenkinson reflected that it shouldn't take up much more time than it currently did but agreed to discuss this at the following Audit, Risk & Governance Committee and feedback. The Board noted the report. **Action:** To discuss the time and resource required for the Board Assurance Framework at the next meeting of the Audit, Risk & Governance Committee
14.	**Infection, Prevention and Control and Antimicrobial Stewardship Quarterly Report**
14.1	The Board received and noted the report. Prof Julian Redhead highlighted that there had been 28 Trust-attributed *C. difficile* cases during Q2, against a ceiling of 16 cases. Although this rise has prompted further investigations, there had been no lapses in care identified this quarter and none for 2019/20 so far. Board members were pleased to note that there had been no cases of Trust-attributed MRSA BSI during Q2 from 8007 blood cultures tested and the Trust was 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.
14.2	Dr Andreas Raffel raised concern at the rate of surgical site infection (SSI) following coronary artery bypass graft (CABG) cardiothoracic surgery which was 10.9% (8 superficial incisional SSIs in 73 procedures), and above the national average of 3.8%; Prof Redhead confirmed that SSI prevention measures had been reinforced and an action plan was being developed in a Task and Finish group chaired by a cardiothoracic surgeon to address this. A further update on this would be included in the next quarterly report to the Board. The Board noted the report.
15.	**Research and Development Quarterly Report**
15.1	Dr Bob Klaber presented the research and development quarterly report highlighting recent activity and progress with respect to various research initiatives within the Imperial Academic Health Science Centre.
15.2	Responding to a query from Nick Ross regarding surgical trials, Prof Katie Urch confirmed that surgical trial recruitment had decreased since the previous year but added that Imperial was still one of the biggest recruiters of surgical trials. Board members noted that they hoped performance in surgical trials would increase going forward and an update would be presented to the Board in March 2020. The Board noted the Quarter 2 2019/20 Research & Development report.
16.	**General Medical Council National Training Survey - results**
16.1	The Board received and considered the GMC national training survey results and Prof Julian Redhead highlighted the overall improving position 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.

16.2	Prof Redhead noted that action plans were 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.
16.3	In relation to the trainee survey, the Trust was required to submit action plans to Health Education England (HEE) for training programmes where there were: • 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
16.4	Prof Redhead confirmed that the Trust had submitted action plans to HEE for the five programmes which met these criteria on 6 September 2019. The Board noted the overall improvement in the 2019 GMC NTS results and the actions currently underway, or already completed in response to the results.
17. 17.1	**Quality Impact Assessments for Cost Improvement Programme (2019/20)** Prof Julian Redhead confirmed that there was a well-established process for the quality impact assessments of cost improvement programme projects. The Board noted the report.
18. 18.1	**2018/19 Annual Report of the Trust Safeguarding Committee** The Board received and noted the annual report from the Trusts Safeguarding Committee noting the increasing activity and that the service had successfully introduced a seven day service in 2018/19. The Board noted the report.
19 19.1	**Trust Board Committees – Terms of Reference** The Board approved the Terms of Reference from the following Committees: • Audit, Risk & Governance Committee • Quality Committee • Finance, Investment & Operations Committee • Remuneration and Appointments Committee The Board approved the terms of reference.
20. 20.1	**Trust Board Committee summary reports** The Board received and noted summary reports from the following Board committee meetings: • Audit, Risk & Governance Committee meeting held on 2 October 2019 • Quality Committee meeting held on 13 November 2019 • Finance, Investment and Operations Committee meeting held on 20 November 2019 • Remuneration and Appointments Committee meeting held on 30 October 2019 The Trust board noted the reports.
21. 21.1	**Any other business** No other business was discussed.
22. 22.1	**Questions from the public** Many Sodexo employees from St Mary's Hospital attended the public board meeting and were invited to ask questions. They raised concerns about their terms and conditions of

22.2 22.3	employment, including their level of pay. They asked the board why they were not on the NHS agenda for change terms and conditions. Prof Orchard reflected that the Trust was not where it wanted to be in terms of the terms and conditions for outsourced staff but were committed to improving this for all staff working at Imperial and confirmed that the Trust had given the London Living Wage from 1 November to all of the Sodexo staff. The following actions were agreed as part of this discussion: • Weekly updates would continue to be shared by Kevin Croft with the union regarding discussions with Sodexo management. • Prof Tim Orchard would confirm a timescale regarding the review into terms and conditions of Sodexo staff by the 3 December 2019. The Board noted the actions agreed.
23.	**Date of next meeting** Wednesday 29 January 2020 10.00 – 11.00, W12 Conference Centre, Hammersmith Hospital.

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meetings held on 27th November and 11th December 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 January 2020	**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.

November 2019

The Board received a report from the Chief Executive, including an update regarding the Sodexo industrial action; and performance against the new UEC standards.

The Board considered and approved the Strategic Imaging Asset Management Strategic Outline Case relating to aged imaging assets which will also help meet the increasing demand on the imaging service. Progress and consideration of the aspects of the Outline Business Case will be discussed by the Finance, Investment & Operations Committee and the Trust board in approximately six months.

The Board received an update on the procurement process in respect of Soft FM services. The Board agreed to terminate the process without making an award, in accordance with Standing Orders, and to consider the options available for the provision of Soft FM services.

December 2019

The Board met in seminar mode on 11 December 2019 at which they received an update from Sir David Sloman regarding perspectives from NHS London. Other subjects covered during the day included developing integrated care and partnerships in North West London.

Recommendations:

The Trust board is asked to note this report.

Trust strategic goals supported by this paper:

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 27 November 2019

Updated: 22 January 2020

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	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. January 2020 update: Nicola Horlick will not be resuming her role as Non-executive Director role at the Trust and recruitment will be underway to fill the vacancy.	Paula Vennells/Peter Jenkinson	January 2020 Close at meeting
2.	27 November 2019 10.3	Bi-Monthly Integrated Quality and Performance Report	Responding to a query from Kay Boycott and Paula Vennells regarding maternity sepsis, Prof Andy Bush confirmed that this had been discussed at the Quality Committee and no lapses in care had been identified. Prof Redhead would provide further assurance regarding maternity sepsis rates. January 2020 update: The sepsis rates were October 1%, November 1.3% and December 1% against the target of 1.5%. Therefore assurance provided that there is no issue of concern.	Prof Redhead	January 2020 Close at meeting
3.	27 November 2019 22.3	Questions from the public	The following actions were agreed as part of this discussion relating to the terms and conditions of Sodexo staff: ▪ Weekly updates would continue to be shared by Kevin Croft with the union regarding discussions with Sodexo management. ▪ Prof Tim Orchard would confirm a timescale regarding the review into terms and conditions of Sodexo staff by the 3 December 2019. January 2020 update: These actions have been completed.	Prof Orchard/Kevin Croft	January 2020 Close at meeting
4.	27 November 2019 9	Strategic development – Implementation of a management system (The Imperial Way	Claire Hook highlighted that the proposed approach to delivering the Trusts strategy in a standardised way, linking in with the Trusts values and behaviours. Board members discussed the programme and agreed whilst they all supported the proposal, that there needed to be a clear and practical way of delivering it, with it being collectively owned by the executive team. The Board approved the Imperial management system (working title 'the Imperial Way') and noted the process for agreeing priorities for 2020/21 and the process for delivery of the 2019/20 objectives. An update outlining the delivery process and risks would be presented to a future board meeting.	Prof Orchard/Claire Hook	March 2020

5.	27 November 2019 13.6	Board Assurance Framework	Noting the changes to the Board Assurance Framework, Peter Goldsbrough asked whether the amount of time it would take to track assurance had been considered. Peter Jenkinson reflected that it shouldn't take up much more time that it currently did but agreed to discuss this at the following Audit, Risk & Governance Committee and feedback. Discuss the time and resource required for the Board Assurance Framework at the Audit, Risk & Governance Committee on 4 March 2020, and feed back to board members at the Trust Board on 25 March 2020. January 2020 update: on the agenda for the March Audit, Risk & Governance Committee.	Peter Jenkinson	March 2020

Items closed at the November 2019 meeting

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	Closed
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	Closed
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	Closed
	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	Closed
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	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 review	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29th January 2020	**Item 7, report no. 04**
Responsible Executive Director: Janice Sigsworth	**Author:** Steph Harrison-White Guy Young

Summary:

Patient stories have been presented at the public Trust Board since September 2014. They complement information that the Board receives such as the NHS Friends and Family Test and the summary of formal complaints and Patient Advice and Liaison concerns.

Since a review of the approach in 2016, 20 patient stories have been presented to the Board. This paper reviews the approach and summarises the themes arising from these stories.

Patient stories provide a valuable perspective for the Board. Previously the Board has noted that the *in person* stories have been particularly welcomed. That said, since the last review there have been a number of stories presented in other ways that seem to have been equally valuable.

Recommendations:
The Board is asked to confirm whether it would like patient stories to continue and, if so, that the current mixed method approach remains the one of choice

This report has been discussed at: N/A

Quality impact:
Understanding the experience of patients supports the business of the Board. There is no detrimental impact on quality as a result of this 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:
There are no risks associated with this paper.

Workforce impact (including training and education implications):
There is no workforce impact associate with this paper

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

How have patients, the public and/or the community been involved in this project and what changes were made as a result? Yes

What impact will this have on the wider health economy, patients and the public?
Better understanding of the experience of patients should lead to improvements in the quality of care.

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 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?
  - Patient stories to the board are a powerful way of hearing the voice of users of trust services
- What (if anything) do you want senior managers to do?
  - If they identify any stories that they think could be presented to the board to get in contact with the patient experience team.
- Contact details or email address of lead and/or web links for further information
  - stephanie.harrison-white@nhs.net
- Should senior managers share this information with their own teams? ☒ Yes ☐ No

Imperial College Healthcare NHS Trust

Patient story review

1. Executive Summary

1.1. Patient stories have been presented at the public Trust Board since September 2014. They complement information that the Board receives such as the NHS Friends and Family Test and the summary of formal complaints and Patient Advice and Liaison concerns.

1.2. In May 2016, a review paper was taken to the Board, summarising the stories to date and highlighting key learning.

1.3. Since that last review, 20 patient stories have been presented to the Board. This paper reviews the approach and summarises the themes arising from these stories.

2. Purpose

2.1. The purpose of this report is to give an overview of the themes arising from stories that the Board has heard and to confirm that the process is still of value.

3. Background

3.1. Patient stories are seen as a powerful method of bringing the experience of patients to the Board. The purpose of this is to try to frame patient experience as an integral component of quality alongside clinical effectiveness and safety.

3.2. The Board had its first 'in-person' patient story in March 2014. This was well received and, following a review of other organisations approaches, the Director of Nursing presented a paper to the Board in July 2014 outlining various approaches to patient stories, which the board approved.

3.3. These approaches include:

- Patients attending the Board in person to tell their story
- Video or audio presentations of patients telling their stories
- Divisional, clinical or patient experience staff telling a story on the patient's behalf
- An executive director, usually the Director of Nursing, telling the story about a patient's experience

3.4. The Board agreed, following the review presented in May 2016, that this combination of methods had worked well and added value to the information presented to the Board. It was agreed that this approach would continue. It was noted that the *in person* stories were felt to be particularly valuable.

3.5. Since 2016, 20 patient stories have been told at the Board; 14 of these have been presented in person by the patient or their carer; three as videos and three by a staff member sharing a patient story.

3.6. The approach has continued to be successful, but it is timely to ensure that the Board are still content with this approach.

3.7. It is worth noting that having patients tell their own stories at the board is the less prevalent approach amongst other trusts, with most relying on the alternative methods outlined above. To enable people to tell their stories as effectively as possible the Trust patient experience team provides support and coaching to them before the Board meeting, as well as supporting them during and after it.

4. Review of stories

4.1. In bringing stories to the Board the aim is to provide a balanced picture of the experience of patients and their relatives. This means that the Board gets to hear about outstanding and innovative practice but also about when things did not happen as they should have done, and what and how improvements are to be made.

4.2. A number of themes emerged:

- Managing transitions for patients is important, whether from child to adult services or from high dependency areas to a general ward environment. Both can cause anxiety but managed properly will result in a positive experience.
- Patients with learning disabilities can be disadvantaged in terms of their experience of services. Stories heard almost two years apart at the Board demonstrated how the Trust had made important strides forward in terms of awareness and being able to make reasonable adjustments for this group of patients.
- Delays and cancellations of appointments and procedures can cause high levels of frustration and anxiety for patients. Managing these situations promptly after the event can reduce some of the associated problems, but reducing delays and cancellations is an important issue for the Trust to address.
- Expert clinical care is important to patients and the stories received at the Board would suggest that this is the norm in the organisation. There were stories where this expert care was praised extremely highly and it was a major influence on the positive experience. However, this in itself was not always enough if there were problems with other parts of the care journey, for example properly planning and managing discharge from hospital.
- Running through all the stories is the theme of kindness. More often than not patients said that they had been treated with kindness and that this had been very important to them. Phrases such as “small act of kindness”, “the human touch” and “going the extra mile” were used when people were telling their stories. Conversely, those who reported a negative experience talked about a lack of kindness or thoughtfulness. This theme in particular is seen in many other forms of feedback such as NHS choices, compliments and complaints.

5. Actions arising from stories

5.1. Stories help to provide assurance to the board that the quality of care is generally high and consistent with the trust values. There were of course situations where the experience fell below the standards expected and the Board needs to see that things have changed as a result.

5.2. Below is a summary of some of the actions and outcomes resulting from patient stories:

- The development of the trust Gender Recognition Policy. The patient who shared their story about being a transgender patient was involved in this work.
- The development of transition services for young people became a focus of the young people's Big Room.
- The development of the patient pathway for day case surgery and supporting the case to make improvements to facilities in the area.
- The production of a deaf awareness training video and introduction of blue wrist bands to alert staff that a patient has hearing difficulties. Again, the patient who shared their story was involved in these two initiatives.
- The Trust's Eat, Drink, Move and Sleep initiative, now being implemented across 18 wards, was directly influenced by one of the stories; particularly the move and sleep components.
- A story about end of life care has influenced the agenda of the End of Life Big Room, indeed it was the first patient story to be shared here.

6. Summary and Next Steps

6.1. Patient stories provide a valuable perspective for the Board. Previously the Board has noted that the *in person* stories have been particularly welcomed. That said, since the last review there have been a number of stories presented in other ways that seem to have been equally valuable.

6.2. The Board is asked to confirm whether it would like patient stories to continue and, if so, that the current mixed method approach remains the one of choice.

Authors: Steph Harrison-White
Guy Young

Date Jan 2020

NHS
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: 29th January 2020	**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) Operational performance
2) Financial performance
3) Transformation programme update
4) Patient focus
5) Strategic development
6) People
7) Research and innovation
8) Stakeholder engagement
9) Other items to note

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. Operational Performance

As part of our winter plan, we have started to deploy "command centre" technology in the site operations offices. The command centre uses wall-mounted screens that display dashboards with real-time information about ambulance arrivals and handover times, waiting times in our emergency departments, available bed capacity and predicted discharges. This is a first step in a wider programme to digitalise site operations, but is already supporting pre-emptive decision making. We are now in the most operationally challenging part of the year and, as anticipated, there has been increased pressure on the non-elective pathway both at our Trust and across north-west London. Attendances to our emergency departments increased by 11% in November 2019 compared with October 2019, and by a further 5% in December 2019 compared with November 2019.

Despite being busier than ever – with an 8.5 per cent increase in type 1 A&E attendances in December 2019 when compared to December 2018 – staff have been working very hard to ensure patients are treated as quickly and as safely as possible.

2. Financial performance

Year to date the Trust is on plan with a deficit of £6.8m before PSF. The Trust is over plan on activity mainly in emergency work with additional costs of delivery. Activity is above plan with both with North West London local commissioners and specialist commissioning with NHS England. The additional activity represents a cost pressure to commissioners and the Trust is working closely with commissioners to agree appropriate payment for the activity delivered.

At month 9 the Trust is forecasting to be £4.5m worse than plan a £3m improvement from month 8. The forecast gap to the control total has improved significantly over the year but with significant non-recurrent benefits. Unless operational teams are able to close the £4.5m gap to the control total the total amount of non-recurrent support required will equate to £26m. Though this helps the Trust position in year it increases the efficiencies required in the next financial year. To mitigate the effect in next year the Trust is focusing on reducing the run rate of spend, especially temporary staffing spend.

The finance report to the Board provides detail of the trust's financial position for the nine months year to date (April - December 2019).

3. Transformation update

We have a deployment working group established, and through the Business Planning process, being run by Transformation, we will have a filtered list of the 'Focused Improvements', programmes and projects that will become our agreed deliverables in 20/21, and therefore the content for the Imperial Way architecture". The deployment working group will present an outline implementation and resource plan to the Executive Digital, Strategy and Transformation Committee for approval in February.

Our business planning for the next financial year aims to connect our Trust strategy and objectives to directorate level plans and priorities, with the aim of supporting the delivery of our vision for 'better health for life'. Each directorate has prepared and presented a business plan to an executive committee, with a greater emphasis on objectives and prioritisation. All directorate presentations will be complete by Monday 27 January and during February the executive team will prioritise and confirm resource plans for key projects and programmes.

4. Patient focus

Developing aligned clinical services with Chelsea and Westminster

The Trust continues to collaborate with Chelsea and Westminster NHS Foundation Trust on developing aligned clinical services, on a service by service approach. Together we are working on developing unified pathways and processes, improving quality and cost-effectiveness by reducing unnecessary variation. We currently have three projects ongoing in HIV inpatient services, dermatology and

ophthalmology, and will use the learning from that experience to design a systematic approach to planning further projects.

Developing a joint children's service with Chelsea and Westminster
The children's services teams at both trusts have been working together and with Imperial College to explore how best to run, organise and develop care for children and young people in north west London.

The vision is to create joint care pathways that make best use of our collective strengths and assets, organised around the needs of our patients and their families. We want to look at how we improve child health across our population and move towards 'life course' pathways rather than one-off interventions.

The joint service will make better use of data to understand need, be more proactive about interventions and have a much bigger focus on translational research, building a particular expertise in treating and preventing conditions common in childhood, such as allergy, asthma, infectious diseases and mental health problems. This will include working in partnership with local communities and with colleagues in primary care and local mental health and community services.

The focus for 2020/21 will be supporting the integrated care 'test-bed' being developed with Hammersmith & Fulham Partnership Primary Care Network. We are beginning to put in place the management and governance structure to create a formal 'West London children's alliance'. This will include a single 'managing director' reporting to both Trust chief executives and a joint clinical leadership team. Imperial College are seeking a new paediatric clinical chair. We are also widening out involvement and engagement to more staff, patients and partners.

End of Life care – annual report
Dr Katherine Buxton & Guy Young have produced a first annual report of the End of Life Steering Group for the Trust. The report, included in the Reading Room for this meeting and available on request, provides a summary of the achievements over last year (1st April 2018 to 31st March 2019) to raise the profile of End of Life care across the organisation.

The end of life care team at Imperial is a strategic team leading on the planning and implementation of innovative service improvements and the co-ordination and delivery of education. There is a close relationship with the specialist palliative care team who are the providers of direct clinical care for those with complex needs and support the ward teams with the non-complex care where they feel they need additional support.

The annual report for 2019/20 will be presented to the Board in May 2020.

5. <u>Strategic development</u>

Piloting new integrated approaches with PCNs
We have been co-designing a 'test bed' with one of our system's primary care networks (PCNs) - the Hammersmith & Fulham Partnership. A 'super-practice' with a registered list of 67,000. The purpose of this new approach is to:

- improve experience and clinical outcomes for patients
- improve staff experience, retention and recruitment
- reduce per capita spend compared with peer PCNs
- improve and expand research and training opportunities
- develop and evaluate a model that is scalable for integrated working across the system.

We're aiming to integrate the work of hospital, primary care and community clinicians, in partnership with patients and other local organisations, focusing on the development of:

- 'compassionate communities' – 'de-medicalising' care for people by connecting them to assets in their community
- better management of long term conditions, building on the work of connecting care for children/adults

- better management of complexity, for example for frail, older patients or people with multiple long-term conditions – building on the expertise developed through our Charing Cross frailty team and working alongside community and mental health partners in multi-disciplinary teams
- 'smarter working' – reducing non-value adding administrative tasks through the development of a population-based administrative function based in the PCN.

This will require a change to our contracting arrangements and to the sharing of risks and opportunities arising from new ways of working. We are working with Imperial Health Charity and an organisation called 'Social Finance' as delivery partners, who will contribute expertise, some external rigour and additional project funding. If successful, we would look to expand the programme to other partner PCNs.

This is an essential part of our organisational strategy that will help to shape our future working relationship with primary care colleagues and seek to reduce growth in acute activity and spend.

Redevelopment
Our redevelopment programme continues to progress. We are exploring funding approaches including a developer opportunity linked to the wider regeneration of the Paddington area. We are working closely with a range of partners, especially Imperial Health Charity, Imperial College and local authorities to progress the planning.

In the next phase we will:
- develop our overall 'offer' – clinical, research and education, anchor institute – to ground the St Mary's redevelopment plans – and use the St Mary's redevelopment to support an organisation-wide move to new ways of working.
- develop an outline business case for St Mary's redevelopment as first step in securing approvals from NHS England/Improvement and Treasury – for submission late spring
- develop and secure funding approach - ongoing
- expand engagement and involvement with all our stakeholders – ongoing

Bob Klaber and Deirdra Orteu are currently leading a virtual weekly 'clinical thinking' group with a wide range of staff, GPs, lay partners and health planners to share and test ideas to feed into initial assumptions and plans. A series of meetings and workshops are also planned with key partner organisations and wider staff, patient and public events and activities are planned for later this spring.

Matthew Tulley starts as the Trust's new director of development on 3 February. Matthew joins our executive management team at an important time for the Trust's redevelopment ambitions. Matthew will lead on our strategic redevelopment vision and how we translate that vision into detailed plans. He will be working closely with our staff, patients, partners and local communities to achieve this vision.

6. People

Hotel services
At the end of November, we committed to review a range of options to further improve the working lives of our hotel services staff, including bringing in NHS Agenda for Change terms and conditions. We have been involving our trade union partners in this review.

It quickly became clear that the review would lead to changes to terms and conditions for hotel services staff. We therefore, in December, terminated the procurement process that was underway to re-tender the hotel services contract. The current contract, with Sodexo, is due to end on 31 March 2020. A decision on how we will provide hotel services from 1 April 2020 will be made by the end of the month.

Tackling violence and agression
Since December the following actions have been taken to help us tackle increased incidences of violence and aggression:
- all ten of our additional security officers have now begun work at St Mary's
- as part of our enhanced lockdown procedures, additional CCTV has now been installed in QEQM
- from Friday 24 January we are expanding our pilot introducing body-worn cameras for clinical staff

- we've made good progress to complete small works highlighted as a security risk by staff – for example putting in additional swipe access to the ambulance entry point for A&E at St Mary's

Pathway to excellence programme
I'm pleased to announce that we've been selected as one of 14 Trusts in England to participate in the programme, which aims to create a positive practice environment for nurses and midwives. More details on this programme is being presented to the Board at this meeting.

International year of the nurse and midwife
This year, to mark the 200th birthday of Florence Nightingale, the World Health Organization has declared this the first international year of the nurse and midwife. We are developing a programme to mark the contribution of our nurses and midwives throughout 2020.

Flu Campaign
This year's flu campaign commenced the end of September and has been running throughout the winter. We continue to use peer vaccinators and roaming vaccinators, supported by an extensive communications and influencing campaign. To date over 62 per cent of staff have been vaccinated. Further actions continue to increase uptake of the vaccination include following up at ward / departmental level by the executive team.

Best ever response in this year's staff survey
Over 5,000 staff completed a staff survey, helping to achieve an 11 per cent improvement in our survey response rate over the past two years. The results will be published in February and will be presented at the next Board meeting.

New staff side chair and thanks to Lorry Phelan
Donato Tallo has been appointed as staff side chair, ensuring that we work closely with unions representing staff to ensure that any staff issues are addressed swiftly. Many thanks to Lorry Phelan for all her hard work in this role.

7. Research and innovation

Research
Professor Christoph Lees (Trust lead for perinatal medicine and Professor of Obstetrics at Imperial College London) has been successful in winning a £2.4m NIHR grant for a large multicentre clinical trial in perinatal medicine.

Strategic planning work is underway in preparation for our re-application to be a Biomedical Research Centre (BRC) which is expected to open as an application process later in 2020

We are working in partnership with Imperial Health Charity who have just launched a new grants scheme, Innovate at Imperial, which aims to provide opportunities for Trust staff to explore novel and innovative ways of improving health and social care, hospital processes, patient safety and/or patient care.

AHSC redesignation
We are currently working with our partners within the Academic Health Science Centre (AHSC) to prepare our application for redesignation of the AHSC. The bid was submitted to NIHR-NHSE/I at the beginning of December, with interviews of shortlisted applicants planned for 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.

8. Stakeholder engagement

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

- Strategic Lay Forum: 4 December
- Healthwatch Central West London: 9 December
- NW London CCGs Chairs and Managing Directors: 19 December
- Hammersmith& Fulham Save our NHS: 19 December
- Michelle Donelan MP, Minister for Children and Families, Project SEARCH visit to Charing Cross Hospital: 16 January
- Karen Buck MP for Westminster North and Andy Slaughter MP for Hammersmith: 21 January

9. Other items to note

On 16 January we welcomed Michelle Donelan MP, Minister for Children and Families, to visit the Project SEARCH supported internship at Charing Cross Hospital.

Project SEARCH is a programme where employers provide supported placements to young people with learning disabilities, which can lead to full time work. The Minister was able to hear first-hand from young people about their personal experience of their supported internships. She also met with representatives of the partnership organisations who work with the Trust to deliver this best practice programme.

The programme offers 12 interns a year-long placement in which they undertake 10 to 12 week placements around our hospitals. The onsite Project SEARCH team have worked closely with Trust managers and staff who have provided valuable placements and experiences to the interns which has enabled them to gain the confidence and the skills they require to help them find paid employment.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Bi-monthly integrated quality and performance report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: Wednesday 29 January 2020	**Item 10, report no. 06**
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 8 (November 2019).

Contents:

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

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

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

Executive Quality Committee
Board Quality Committee
Executive Finance Committee
Finance, Investment and Operations 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 service deliverables. 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 November 2019 (month 8).

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 November 2019 (month 8) integrated performance scorecard are provided below. Updates for latest data are given where appropriate.

Quality

2.1. The incident reporting rate for November 2019 was above target and the overall number of incidents reported has continued to improve.

2.2. There has been an increase in the number of 'moderate harm' incidents reported which may be attributed to our drive to encourage staff to report recognised complications as moderate harm. However we expect to be within target on the percentage of moderate harm incidents by March 2020. We remain on track to meet our target of major harm incidents by March 2020. Since April 2019, 12 extreme harm incidents have been reported and is likely to remain higher than last year.

2.3. A Never Event has been declared in January under the category 'misplaced naso or oro-gastric tube'. An investigation has commenced; initial review has highlighted human error where the incorrect chest x-ray was reviewed when the position was checked.

2.4. In November 2019,

- There have been 70 cases of hospital-associated C. difficile so far this financial year, which is above our trajectory of 37. Only one case has been related to a lapse in care, due to cross transmission. Eighteen of the 70 cases are community onset-hospital associated cases.
- There have been 54 cases of *E.coli* BSI attributed to the Trust so far this financial year, compared to 68 the same time in 2018/19.
- There were no Trust-attributable cases of MRSA BSI reported in November 2019 and the figure remains at three cases so far this financial year, compared to three in total in 2018/19.

- There were no cases of CPE BSI reported in November 2019 and the figure remains at six cases so far this financial year, compared to six the same time in 2018/19.

2.5. The percentage uptake of flu vaccination for frontline healthcare workers was 56% at end November 2019 compared to 45% in November 2018.

2.6. In November 2019, 90.5% of patients received antibiotics within 1 hour of their confirmed sepsis diagnosis, above our 90% target. There has been substantial press interest in the Trust digital sepsis alert following a research publication that reported improved outcomes following its introduction in 2016.[1] Work to implement the sepsis alert in paediatrics and maternity services will commence January 2020.

2.7. 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 request. A full review of the approach has been completed and we expect that changes being introduced over quarter 4 will lower the time taken to complete an SJR.

2.8. The latest reported Hospital standardised mortality ratio (HSMR) score ratio was 72.0 (August 2019) which remains statistically low. The Trust was the lowest of acute non-specialist providers for the Standardised hospital mortality indicator (SMHI) score.

2.9. Our vacancy rates have continued to reduce. At the end of November 2019, the overall vacancy rate was 9.7% against the 10% target.

Operational performance

2.10. As previously reported, a progress report from the NHS Medical Director was published in October 2019 on the review of NHS Access Standards. A final report with recommendations is expected March 2020.

2.11. For urgent and emergency care, testing of the proposed new standards has continued. As one of the 14 hospital trusts taking part in the national pilot, we will not be required to report performance against the four-hour standard for the remainder of the financial year.

2.12. In November 2019, four patients had been waiting for more than 52 weeks for treatment. The overall size of the referral to treatment waiting list size appears stable and is meeting the trajectory.

2.13. The Trust did not meet the diagnostic performance standard in November 2019. The performance was 1.15% of patients who had waited over six weeks for their diagnostic test, against the target of 1%. The main issue has been increased GP referrals for ultrasound (imaging) including within the Head & Neck pathway. Capacity constraints for acute echocardiography also impacted on the November diagnostics waiting times. The Trust has established a plan including additional capacity to ensure a return to performance.

[1] Imperial College London 'Digital sepsis monitoring system helps save lives and improves care'. 20 November 2019

Imperial College Healthcare NHS Trust

3. Additional information

3.1. Exception slides for month 8 are provided for information in appendix 1 and cover the following scorecard metrics:

- Incident reporting rate
- Patient safety incidents
- Never Events
- Compliance with duty of candour
- MRSA BSI and C.difficile
- Safeguarding in children training
- Cleanliness audit scores
- Reactive maintenance
- National clinical audits
- Mortality reviews (including SJR compliance)
- Mixed sex accommodation
- Patient transport FFT
- Patient transport collection times
- RTT patients waiting < 18 weeks
- RTT patients waiting > 52 weeks
- Theatre utilisation
- Cancer waiting times
- A&E patients waiting > 12 hours from decision to admit
- Ambulance handovers (30 minute delays)
- Extended length of stay
- Diagnostic waiting times
- Data quality error rate - RTT

4. Recommendation

The Board is asked to note the contents of the integrated performance report for month 8.

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Nov-18	Latest reported performance: May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
FYTD = Financial Year to Date											
Safe											
Patient safety - incident reporting											
Serious incidents	-	Nov-19		13	33	12	44	22	14	25	**22**
Incidents - moderate harm (FYTD)	<1.68%	Nov-19		1.30%	1.85%	1.58%	1.44%	1.39%	1.43%	1.57%	**1.69%**
Incidents - severe/major harm (FYTD)	<0.23%	Nov-19		0.04%	0.00%	0.00%	0.02%	0.01%	0.01%	0.01%	**0.02%**
Incidents - extreme harm/death (FYTD)	<0.09%	Nov-19		0.04%	0.11%	0.11%	0.11%	0.11%	0.10%	0.10%	**0.10%**
Incident reporting rate (per 1,000 beds)	>=50.38	Nov-19		44.70	46.56	53.75	56.75	47.96	51.19	57.88	**57.10**
Never events	0	Nov-19		1	0	0	0	0	0	0	**2**
PSAs open and overdue (FYTD)	0	Nov-19		-	0	0	0	0	0	0	**0**
Incidents with DoC completed	100%	Oct-19		-	90.8%	93.6%	94.2%	95.8%	96.1%	96.9%	**94.9%**
Infection prevention and control											
Trust-attributed MRSA BSI (FYTD)	0	Nov-19		3	2	3	3	3	3	3	**3**
Trust-attributed C. difficile (FYTD)	77	Nov-19	48	-	14	25	37	47	53	63	**70**
Trust-attributed C. difficile (lapses in care) (FYTD)	0	Nov-19		-	0	0	0	0	0	1	**1**
E. coli BSI (FYTD)	75	Nov-19	57	63	14	19	27	30	35	45	**54**
CPE BSI (FYTD)	0	Nov-19		6	0	2	3	6	6	6	**6**
VTE											
VTE risk assessment	>=95%	Nov-19		95.3%	93.8%	93.6%	97.3%	97.4%	98.5%	97.9%	**97.6%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year Nov-18	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Latest reported performance Nov-19
FYTD = Financial Year to Date											
Safe											
Flu											
Flu vaccination for frontline healthcare workers	>=75%	Nov-19		45.2%	-	-	-	-	-	**34.0%**	**55.8%**
Sepsis											
Sepsis - Antibiotics	>=90%	Nov-19		93.2%	92.3%	90.4%	89.9%	89.3%	90.9%	88.4%	**90.5%**
Maternity standards											
Puerperal sepsis	<=1.5%	Nov-19		1.1%	1.6%	1.0%	1.1%	1.3%	0.9%	1.1%	**1.0%**
Safe staffing											
Safe staffing - registered nurses	>=90%	Nov-19		97.5%	98.0%	97.7%	97.3%	97.1%	97.2%	97.0%	**97.0%**
Safe staffing - care staff	>=85%	Nov-19		96.2%	96.4%	96.1%	96.9%	96.6%	96.3%	96.3%	**95.4%**
Workforce and people											
Core skills training	>=90%	Nov-19		90.2%	91.8%	91.9%	92.5%	93.5%	93.8%	93.8%	**94.3%**
Safeguarding children training (level 3)	>=90%	Nov-19		77.2%	-	89.4%	88.5%	87.0%	86.0%	85.0%	**85.0%**
Vacancy rate - Trust	<10%	Nov-19		12.7%	11.7%	11.7%	12.0%	11.7%	11.1%	10.3%	**9.7%**
Estates and Facilities											
Cleanliness audit scores (very high risk)	>=98%	Nov-19		90.0%	87.0%	88.0%	95.0%	92.0%	88.5%	92.1%	**90.2%**
Cleanliness audit scores (high risk)	>=95%	Nov-19		93.0%	90.0%	95.0%	96.0%	80.0%	93.1%	91.1%	**94.1%**
Reactive maintenance	>=70%	Nov-19		34.9%	-	31.0%	61.6%	61.4%	67.0%	57.0%	**65.0%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year Nov-18	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Latest reported performance Nov-19
FYTD = Financial Year to Date											
Effective											
Mortality indicators											
HSMR: Trust ranking	top 5 lowest risk	Aug-19		5th Lowest	4th Lowest	2nd Lowest	9th Lowest	5th Lowest	Lowest	5th Lowest	**9th Lowest**
HSMR ratio	<100	Aug-19		54.0	57.0	64.0	72.0	56.0	60.0	55.0	**72.0**
SHMI: Trust ranking	top 5 lowest risk	Jun-19		4th Lowest	2nd Lowest	2nd Lowest	Lowest	Lowest	Lowest	Lowest	**Lowest**
SHMI ratio		Jun-19		69.1	68.1	71.9	70.46	70.69	70.32	70.34	**69.67**
Mortality reviews (at 09/12/2019)											
Total number of deaths	-	Oct-19		162	175	138	128	119	160	162	**138**
Number of avoidable deaths (Score 1-3) (FYTD)	0	Oct-19		6	2	2	3	3	3	3	**3**
SJRs not completed within 30 days (FYTD)	0%	Oct-19		-	58.4%	61.0%	63.0%	63.1%	62.6%	60.9%	**60.4%**
Readmissions (unplanned)											
under 15 yr olds	<9.33%	May-19		3.9%	5.0%	5.3%	4.5%	4.1%	4.4%	4.6%	**5.1%**
over 15 yr olds	<8.09%	May-19		6.7%	6.9%	7.5%	6.5%	6.9%	7.1%	8.1%	**7.1%**
National Clinical Audits											
Participation in relevant NCAs (FYTD)	100%	Aug-19		86.7%	87.2%	87.2%	100.0%	100.0%	100.0%	100.0%	**100.0%**
High risk/significant risk audits with action plan (FYTD)	100%	Aug-19		100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	**100.0%**
Review process not completed within 90 days	0	Aug-19		5	12	12	1	7	11	18	**19**
Clinical trials				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	**Qtr 2 19/20**
Recruitment of 1st patient within 70 days	>=90%	Qtr 2 19/20		53.3%	67.6%	85.1%	95.7%	93.9%	96.0%	96.3%	**100.0%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator	Overall target	Latest Period	Trajectory	Same period last year: Nov-18	Latest reported performance: May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
FYTD = Financial Year to Date											
Caring											
Friends and Family											
A&E - % recommended	>=94%	Nov-19		96.8%	92.8%	93.1%	92.5%	93.5%	94.4%	94.4%	**92.3%**
A&E - % response rate	>=15%	Nov-19		15.9%	14.9%	17.1%	14.6%	17.3%	16.1%	20.0%	**18.6%**
Inpatients - % recommended	>=94%	Nov-19		97.7%	97.1%	97.2%	97.2%	97.3%	97.3%	96.9%	**97.8%**
Outpatients - % recommended	>=94%	Nov-19		92.5%	94.1%	94.1%	94.5%	94.0%	93.9%	94.08%	**94.1%**
Maternity - % recommended	>=94%	Nov-19		94.7%	94.0%	94.7%	92.5%	93.4%	95.2%	94.7%	**91.4%**
Patient Transport - % recommended	>=90%	Nov-19		88.4%	94.3%	75.0%	50.0%	48.3%	44.4%	49.5%	**68.2%**
Mixed sex accommodation											
Mixed-sex accommodation breaches	0	Nov-19		64	35	48	41	15	28	45	**42**
Well led											
Workforce and people											
Voluntary staff turnover rate (12m rolling)	<12%	Nov-19		11.9%	11.6%	11.3%	11.8%	11.7%	11.8%	11.8%	**11.8%**
Sickness absence rate (12m rolling)	<=3%	Nov-19		3.13%	3.17%	3.19%	3.20%	3.18%	3.18%	3.24%	**3.26%**
Doctor appraisal rate	>=95%	Nov-19		90.1%	92.3%	92.7%	93.0%	93.4%	94.0%	94.8%	**95.1%**
Consultant job planning completion rate	>=95%	Nov-19		99.5%	78.2%	80.9%	91.3%	91.6%	91.6%	91.6%	**91.6%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

Indicator		Overall target	Latest Period	Trajectory	Same period last year Nov-18	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Latest reported performance Nov-19
FYTD = Financial Year to Date												
Responsive	Data reliability rating											
Referral to treatment (elective care)												
RTT patients waiting < 18 weeks	6%	>=92%	Nov-19	83.7%	83.8%	86.1%	85.2%	84.6%	82.8%	83.6%	81.8%	**81.4%**
RTT waiting list size		63,099	Nov-19	63,100	66,953	63,097	63,088	63,098	62,918	62,664	60,992	**63,036**
Long waiters												
RTT patients waiting > 52 weeks	5%	0	Nov-19		10	0	1	0	2	3	2	**4**
Cancer waiting times												
Two Week Wait	5%	>=93%	Nov-19		94.9%	92.5%	91.0%	85.8%	82.9%	84.5%	89.1%	**91.7%**
62 Day Screening Standard		>=90%	Nov-19		79.2%	82.2%	80.8%	73.9%	77.3%	92.0%	81.5%	**82.0%**
62 Day Wait (start of treatment)		>=85%	Nov-19	85.2%	86.8%	91.5%	86.7%	87.3%	86.9%	86.3%	83.7%	**87.4%**
Theatre utilisation												
Theatre touchtime utilisation		>=85%	Nov-19	83.2%	79.3%	80.5%	81.7%	80.4%	82.4%	82.2%	79.5%	**78.1%**
Critical care												
Critical care patients admitted within 4 hours		100%	Nov-19		92.6%	98.1%	97.7%	95.0%	94.4%	94.6%	96.4%	**93.6%**
Urgent & Emergency Care (UEC)												
A&E patients waiting > 12 hours from DTA	1%	0	Nov-19		4	7	22	17	8	7	8	**5**
A&E ambulance handover delays 30 minutes		100%	Nov-19	100%	92.0%	89.0%	90.0%	90.6%	90.6%	91.4%	92.7%	**92.7%**
Length of stay												
Patients with LoS >= 21 days	3%	tbc	Nov-19		-	235	234	218	212	212	208	**206**
Discharges before noon		>=33%	Nov-19		16.0%	15.8%	14.9%	16.0%	16.3%	16.1%	16.0%	**16.2%**
Diagnostics												
Diagnostic test waits > 6 weeks	0.4%	<1%	Nov-19		0.47%	0.901%	0.75%	0.90%	1.04%	0.50%	0.69%	**1.15%**

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: Nov-18	Latest reported performance: May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
FYTD = Financial Year to Date											
Responsive											
Outpatients											
DNA	<10%	Nov-19		**10.5%**	10.3%	10.4%	10.7%	11.1%	10.8%	10.7%	**10.1%**
HICs (Appt moved to a later date)	<7%	Nov-19	7.2%	**6.2%**	7.5%	7.2%	7.2%	7.9%	7.4%	7.3%	**6.3%**
Complaints management											
Complaints - formal	<90	Nov-19		**91**	104	96	136	87	98	100	**83**
Complaints – average days to respond	40 days	Nov-19		**26.5**	29.8	34.0	32.4	32.7	36.3	35.7	**33.3**
Complaints - patient satisfaction with handling	>=70%	Nov-19		-	84.0%	82.0%	81.0%	85.0%	82.0%	82.0%	**72.0%**
Patient transport											
All Journeys: Collection Time (60 Mins)	>97%	Nov-19		**93.0%**	93.3%	51.5%	86.4%	77.6%	68.7%	86.2%	**74.7%**
Data quality											
Data Quality Maturity Index	>98%	Mar-19	95%	-	95.0%	95.2%	95.1%	96.7%	96.8%	96.7%	**96.4%**

Imperial College Healthcare NHS Trust

Integrated Quality and Performance Scorecard

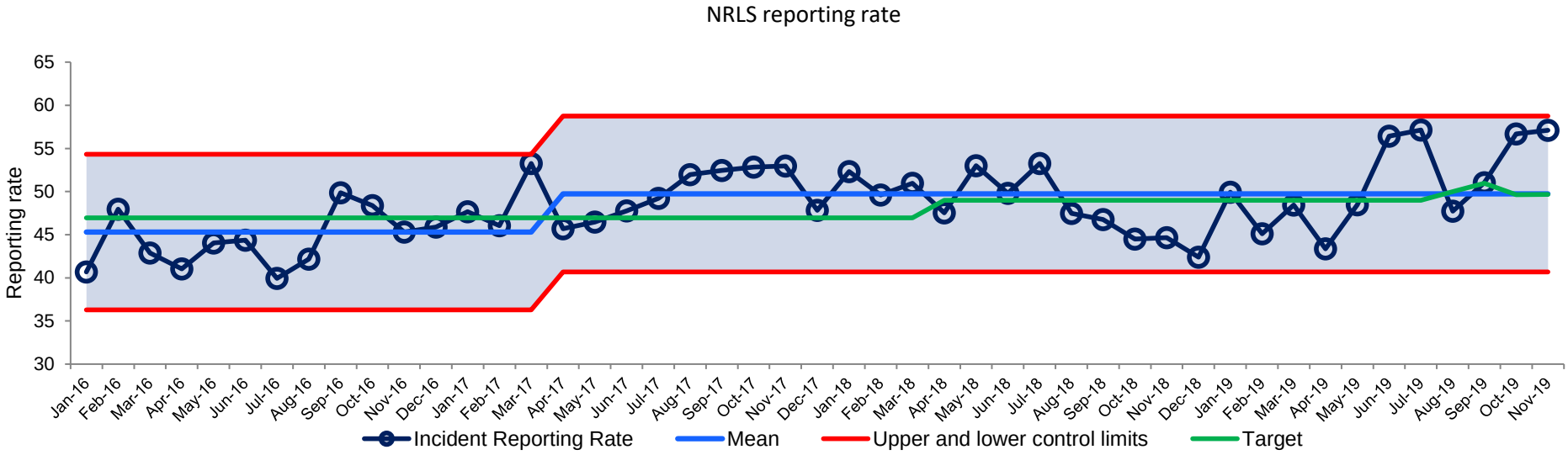
Indicator	Overall target	Latest Period	Trajectory	Same period last year: Nov-18	Latest reported performance: May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
FYTD = Financial Year to Date											
Use Of Resources											
Finance KPIs											
Monthly finance score (1-4)	-	Nov-19		3	3	3	3	3	3	3	**3**
In month Position	-	Nov-19		**-0.44**	0.25	0.92	0.00	0.12	-0.05	3.80	**-1.60**
YTD Position £m	-	Nov-19		**6.04**	4.58	5.50	7.07	7.85	7.08	6.84	**4.24**
Annual forecast variance to plan	-	Nov-19		**-3.86**	-	-12.58	-18.11	-11.34	-9.14	-5.02	**-6.51**
Agency staffing	-	Nov-19		4.3%	3.4%	3.1%	3.2%	3.1%	2.9%	2.8%	**2.8%**
CIP (FYTD)	-	Nov-19		73.6%	66.5%	65.7%	64.6%	66.0%	74.1%	73.5%	**74.8%**

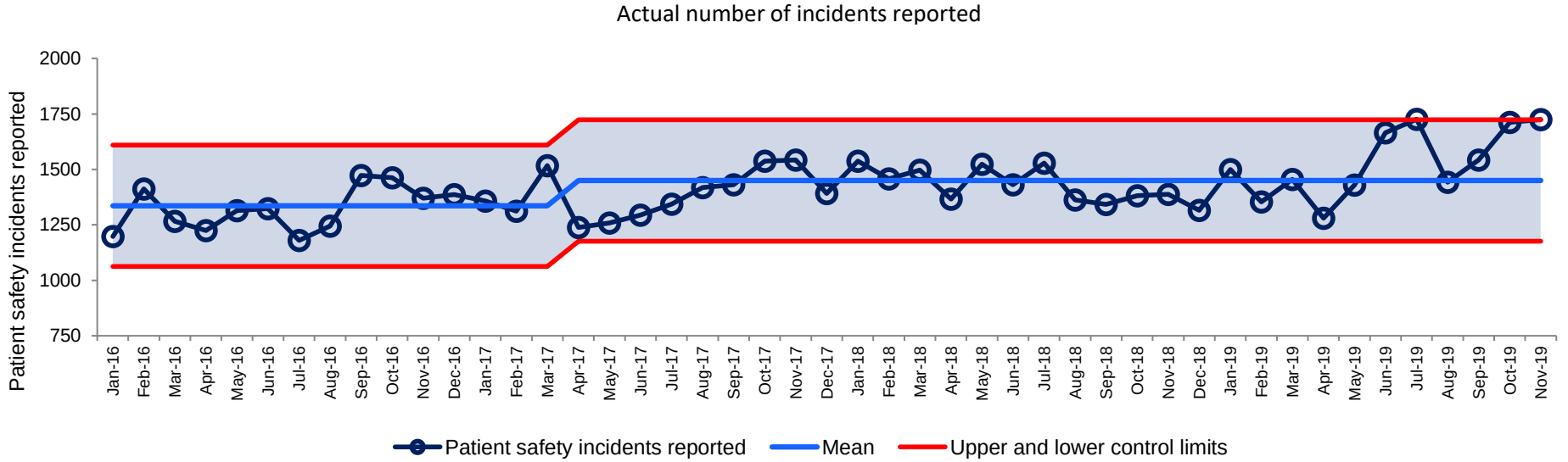
Additional slides by exception for month 8 (all sections)

Domain	Report
Safe	Incident reporting rate
	Patient safety incidents
	Never Events
	Compliance with duty of candour
	MRSA BSI and *C.difficile*
	Safeguarding in children training
	Cleanliness audit scores
	Reactive maintenance
Effective	National clinical audits
	Mortality reviews (including SJR compliance)
Caring	Mixed sex accommodation
	Patient transport FFT
Responsive	Patient transport collection times
	RTT patients waiting < 18 weeks
	RTT patients waiting > 52 weeks
	Theatre utilisation
	Cancer waiting times
	A&E patients waiting > 12 hours from decision to admit
	Ambulance handovers (30 minute delays)
	Extended length of stay
	Diagnostic waiting times
	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)	56.67 – Oct 2019 57.10 – Nov 2019	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance





Safe – Patient safety incident reporting

Latest performance

Our reporting rate for November 2019 is 57.10 against the target of 50.38. The overall number of incidents reported has improved over the previous two months (1,712 – October, 1,725 - November). Both the incident reporting rate and the overall number of incidents have been increasing over the past three months. The number of incidents reported over the previous two months is above the Upper Control Limit, which shows that a new trend may be emerging.

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 met 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. • The higher number in November is mostly driven by transport incidents, which accounted for 202 incidents. • Overall, transport accounted for 11.8% of all incidents, with 202 reported in November 2019. The average number of transport incidents reported per month since we switched to the new contract is 115, compared to 28 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 (572 between June and November 2019 compared to 147 in the preceding 12 months). • SCCS and WCCS reported more incidents in October and November than previous months and more than their yearly average. Overall, 15 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. • Following an improvement during October MIC reported less incidents in November (442) than in previous months, the months total is the lowest since May 2019, this number also includes 35 transport incidents reported by the renal directorate. • NWLP has increased the numbers of incidents during October and November following a notable decrease during September.

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	Five areas identified with the SCC division participated 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 involved the teams designing small tests of change to address some of these barriers. Small but statistically significant improvements have been seen on the wards which have started their tests of change. An evaluation of the pilot was presented at sub group in November with a number of recommendations made, which will be taken forward during Q4.
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 recently established Safety Improvement Group. 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. We are working with the communications team to develop and deliver a 12-month communication strategy which will incorporate a focus on the cultural aspects of incident reporting.
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. Work to reduce and rationalise categories, sub-categories and location codes has commenced and it is anticipated that this work will be completed by the end of 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.

Safe – Patient safety incident reporting

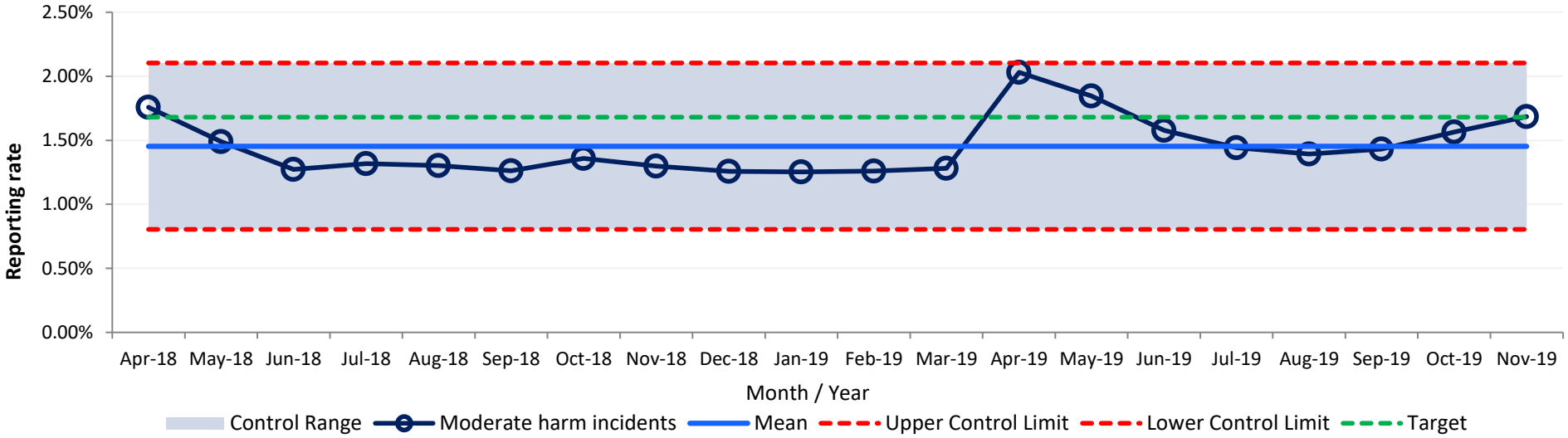
Improvement plans and actions	Lead	Timescale	Progress update
To continue to encourage staff to report incidents (including recognised complications). We need further analysis of the moderate harm incidents	Head of Quality Compliance and Assurance	End of Q4	We will undertake a deep dive of all moderate harm incidents reported since June 2019 and identify where the incident reported is a recognised complication. Going forward we will provide data on recognised complications reported as moderate harm
The final attributable harm should be reviewed and appropriately adjusted following completion of the investigation.	Head of Quality Compliance and Assurance	End of Q4	Divisions to ensure the final harm category is updated following investigation. Divisions to ensure all incidents downgraded at the incident panel are appropriately actioned on datix. We will undertake six monthly audits of all incidents graded as moderate harm and above to ensure the final attributable harm is correct when the investigation is completed – the first audit will be completed in January 2020.
To ensure the target set for 2020/21 fits with our ambition to increase incident reporting.	Chief of staff	End of Q4	As part of the consultation for the quality account metrics and as part of the 4 trust wide improvement priorities we will review whether an absolute number is the right target for measuring patient harm.

Safe – Patient safety incident reporting

Improvement plans and actions	Lead	Timescale	Progress update
Extreme harm incidents must be investigated in a timely manner.	Head of Quality Compliance and Assurance	End of Q4	Divisions to review extreme harm incidents and produce a report within 72 hours of the incident being reported. When a serious incident/level one is declared this should be completed rapidly to ensure the level of harm is understood
On completion of the investigation, the harm must be reviewed and appropriately amended.	Head of Quality Compliance and Assurance	End of Q4	The final attributable harm will be discussed at the SI/level one panel and if the harm is downgraded this should be reflected on Datix. We will undertake six monthly audits of all incidents graded as moderate harm and above to ensure the final attributable harm is correct when the investigation is completed – the first audit will be completed in January 2020.

Safe – Moderate Harm

Indicator	Target	Latest data	Executive lead	Report author(s)
To reduce the number of incidents causing moderate harm	Fewer incidents than last year (217) and below national average (1.68%)	39 (1.57%) – Oct 19 42 (1.69%) – Nov 19	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

In month performance is above the target of having less than 1.68% of our incidents being graded as 'moderate harm' as of November 2019 (1.69%). We were previously above target in April and May 2019 (2.03% and 1.85% respectively).

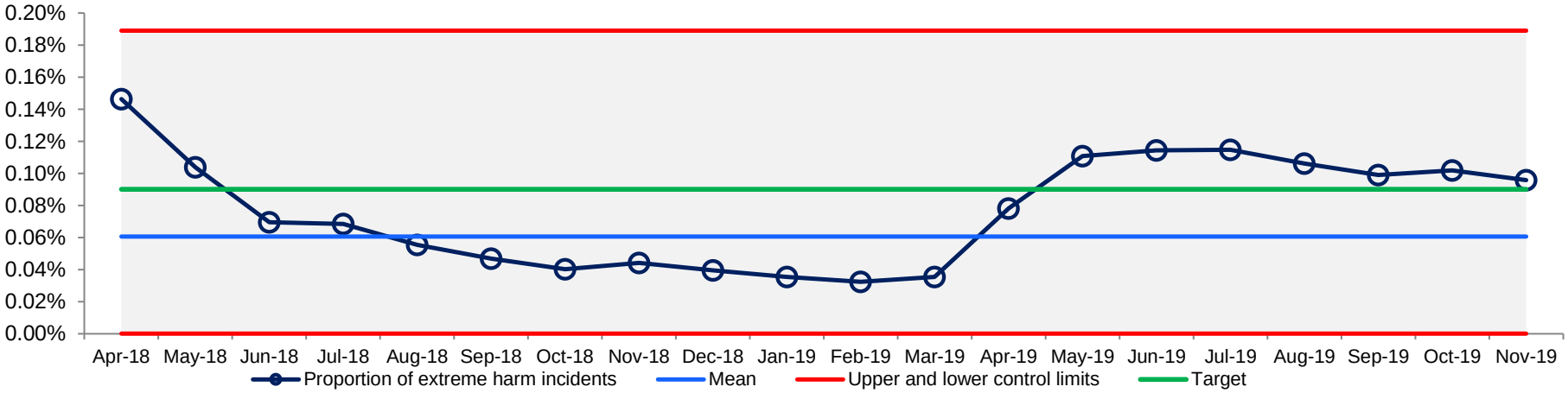
We have also reported 211 moderate harm incidents from April to November whereas in the previous financial year, we reported 217 for the whole 12 months. We are currently expected to report more moderate harm incidents than last year; exceeding our target for this indicator. This is a consequence of encouraging staff to report recognised complications as moderate harm incidents in line with national best practice. This target should be reconsidered for 2020/21 and the percentage in our harm profile used as the measure of harm reduction.

Return to target / trajectory

We expect to be within target on the percentage of moderate harm incidents by year end.
We do not expect to report less absolute numbers of moderate harm incidents than last year.

Safe – Extreme Harm

Indicator	Target	Latest data	Executive lead	Report author(s)
To reduce the number of incidents causing extreme harm	Fewer incidents than last year (6) and below national average (0.09)	2 (0.10%)– Oct 19 1 (0.10%)– Nov 19	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

We are currently above the target of having less than 0.09% of our incidents being graded as ‘extreme harm’. The last time we achieved this target was in April 2019 (0.08%).

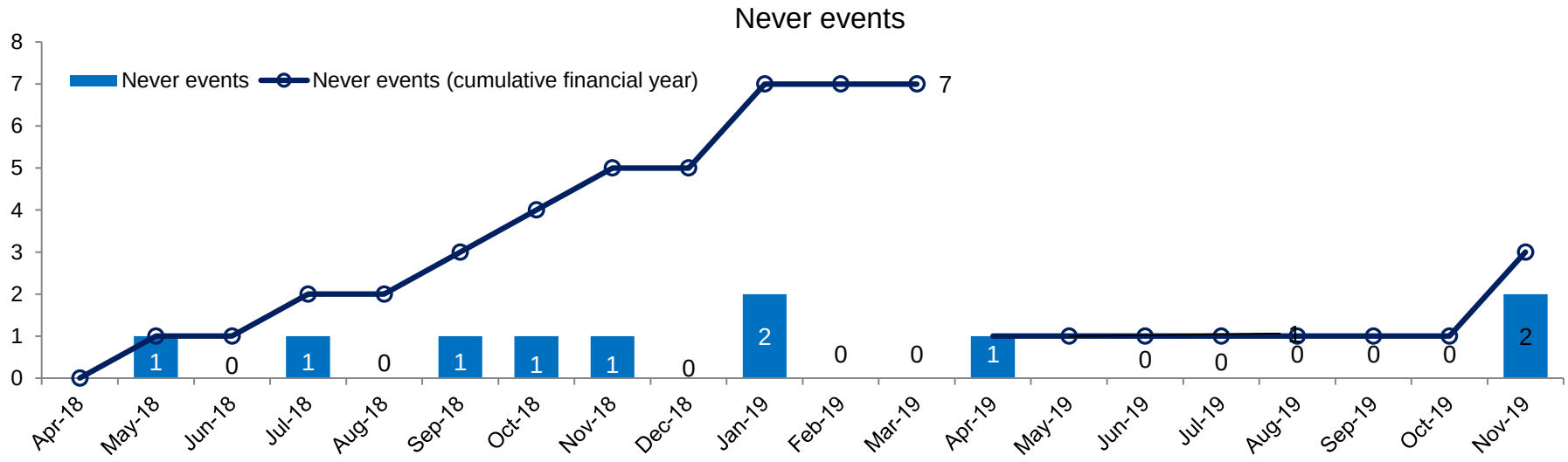
We have also reported 12 extreme harm incidents from April to November whereas in the previous financial year, we reported 6 for the whole 12 months. We have not met the target of extreme harm incidents accounting for less than 0.09% of all our incidents for seven months running. We have previously reported that we expected to return to trajectory and meet the target of extreme harm incidents accounting for less than 0.09% of incidents. However, our denominator has now increased significantly and our overall percentage rate of extreme harm incidents has not lowered accordingly. While it is still possible that we will meet our target our overall number of extreme harm incidents is likely to remain higher than last year.

Return to target / trajectory

We remain within the upper control limit for this indicator. The definition of this indicator will be reviewed in 2020/21 and we will consider if a whole number/comparison to national average remains appropriate.

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 Never Events	0	2 – Nov 2019	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

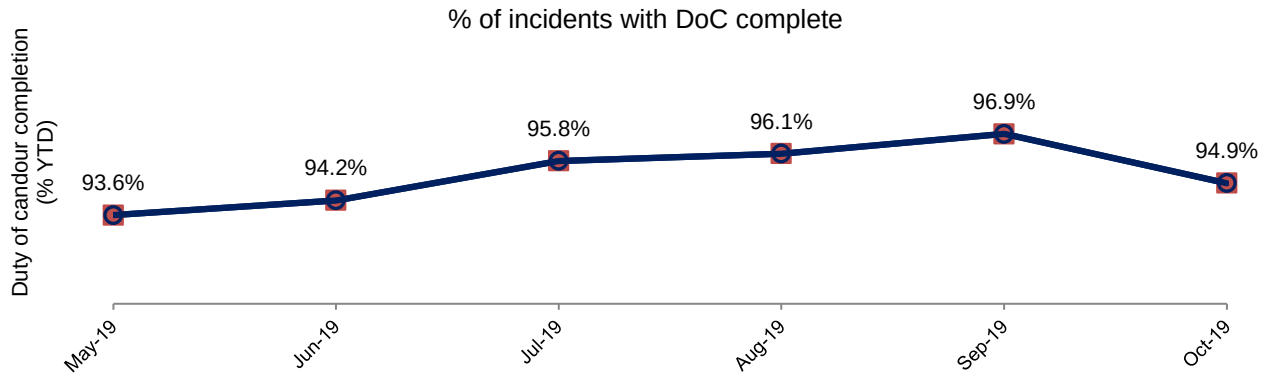
The graph above shows our performance in the 2018-19 and the 2019-20 financial years. From April 19 to October 19, we had 0- Never Events, which was an improvement compared to the period from April 18 to October 18. However in November 19 we reported 2 Never Events which fell under the criteria of *Wrong Site Surgery* and *Retained Foreign Body.*

Return to target / trajectory

We have a Trust-wide programme in place in response to the never events declared in 2018/19. The Helping our Teams to Transform (HOTT) programme continues to be rolled out across the Trust and a detailed report on the 'Never Event Action Plan', presented to ExQu in January 2020 details the actions taken regarding never events.

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%	94.9 – October 2019	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 94.9% of the incidents 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 has been improving but we have unfortunately decreased our compliance in October 2019. 16 incidents (4 SIs, 3 Level 1s and 9 moderate and above incidents) reported between April and October 2019 have not had DoC completed. This is not an improvement compared to last month's position when there were 9 overdue.

Return to target / trajectory

Performance is variable despite improvement plans in place. We will only meet our 100% target. If the actions outlined on the following slide are successful, if we implement the divisional escalation process 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 has been developed for the clinical governanve 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 in December
90% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisional Directors	March 2018 – overdue	Trust-wide compliance is 92.1%. Compliance is over 90% for all divisions except SCCS 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 has been undertaken by the clinical audit team, the results are being analysed and will be circulated in January prior to the Quality and Safety sub group.

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

Safe – MRSA BSI and *C.difficile*

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure we have no preventable MRSA BSIs and no cases of *C. difficile* attributed to lapses in care	0 0	MRSA BSI: 0 – Oct 2019 0 – Nov 2019 MRSA BSI YTD: 3 *C.difficile* lapse in care: 1 – Oct 2019 0 – Nov 2019 *C.difficile* lapse in care YTD: 1	Julian Redhead, Medical Director	Jon Otter, General Manager IPC

Latest performance	One case of *C. difficile* infection was attributed to a lapse in care as a result of patient-to-patient transmission.
Return to target / trajectory	Target for MRSA is zero, therefore no return to target this FY 19/20. Target for *C. difficile* lapse in care is zero, therefore no return to target this FY 19/20.

Key issues	**MRSA:** N/A. ***C. difficile*:** in October 2019 we identified one lapse in care out of 10 cases of hospital onset-hospital associated (HO-HA) *C. difficile* infection. This relates to cross-transmission (defined as shared ward time and same isolates confirmed by ribotyping) between two patients on a medical ward. This is the first lapse in care identified this financial year and a root cause analysis has been completed as required.

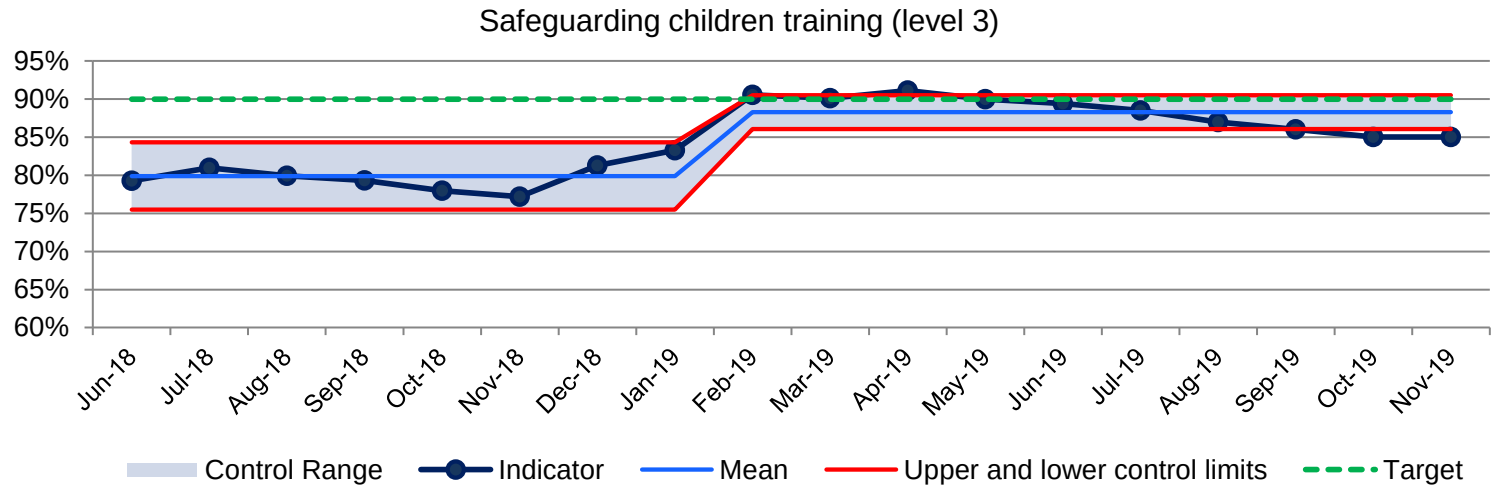
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
On-going review of potential themes arising from lapses in care related to *C. difficile.*	Eimear Brannigan, Deputy DIPC	On-going	We have identified our first *C.difficile* case resulting from a lapse in care this financial year. We continue to work with clinical divisions in reviewing each case and identifying opportunities for preventative action.

Risk

Is it on the (divisional / corporate) risk register? YES (Divisional risk ID 2066 Poor practice related to vascular access, Divisional risk ID 2570 Low level of hand hygiene and inappropriate use of gloves, Divisional risk ID 2059 inappropriate use of antibiotics, and Divisional risk ID 2364 fragile supply chain of antibiotics).

Safe – Safeguarding in children training (level 3)

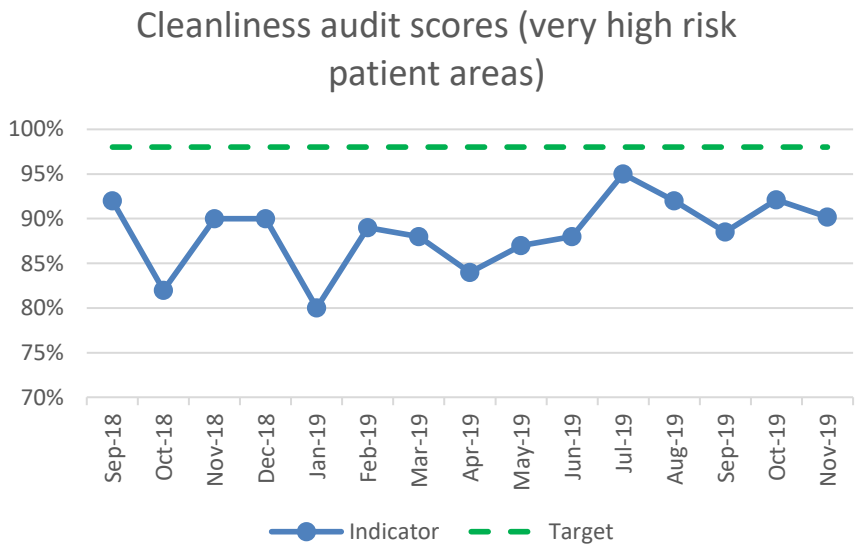
Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90% or greater	November 2019 compliance was 85%	Janice Sigsworth (Director of Nursing)	Guy Young (Head of Patient Experience)

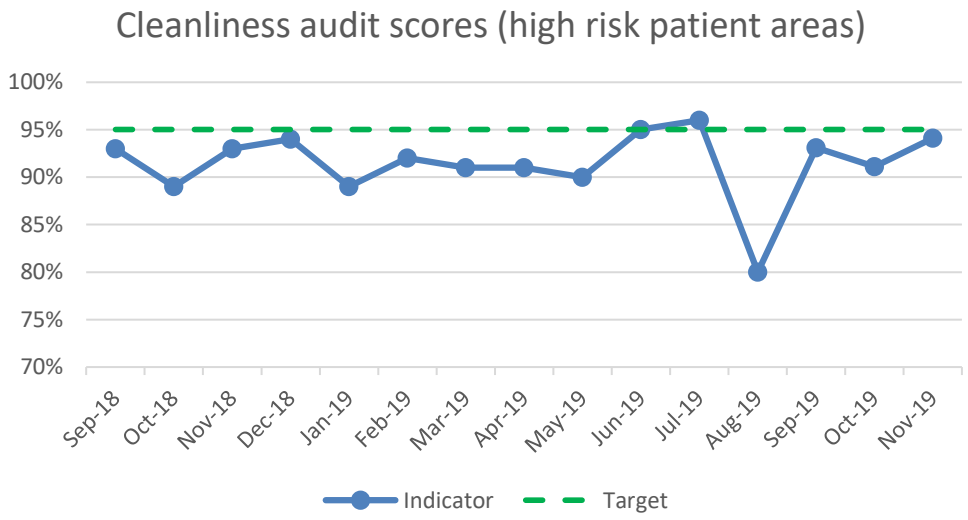


Issues and root cause	▪ The percentage of eligible staff compliant with level 3 safeguarding children training dropped to 85% in November. ▪ There has been an overall improvement in compliance of 4% to 89% in December. We are on track to meet the 90% target by end of financial year. ▪ The primary issue appears to be new starters as opposed to existing staff whose compliance is expiring.
Key updates	Level 3 children's safeguarding training is a classroom based half day of training. Staff are expected to book onto via their *Learn* account. ➢ Training capacity – training slots scheduled for all non-compliant staff – to remain available until end April 2020 ➢ Reminders to staff and their managers who are non-compliant - ongoing ➢ Learn compliance reports to all directorate and divisional managers who develop local plans to achieve the target - ongoing

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)	November 2019 compliance was 90% (very high risk) and 94% (high risk)	Janice Sigsworth (Director of Nursing)	Hugh Gosling

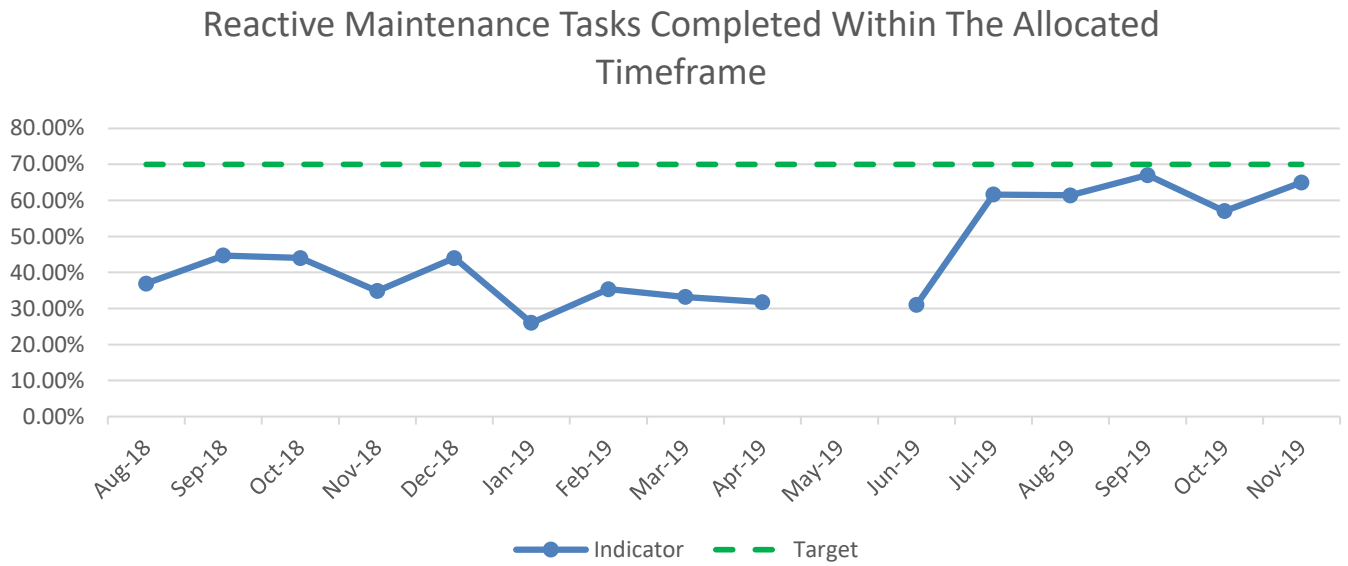




Issues and root cause	The main issue is inconsistent cleaning provision across the trust estate a combination of domestic services, training, equipment and access. Regular cleaning audits are performed as part of a scheduled regime of cleaning and auditing of standards.
Key updates	➢ Close monitoring of the cleaning service continues to be undertaken and issues escalated to the contractor, via weekly monitoring meetings, improvement remains localised, this process will continue to the end of the current contract on 31st March 2020. ➢ 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. In November ➢ Very High Risk: There were 5 audits within 2% of achieving a pass and if those 5 audits had met the target the audit score would have been 95.7 %. ➢ High Risk: There were 7 audits that were within 2% of achieving a pass and if those 7 audits had met the target the audit score would have been 96.3%.

Safe – Reactive maintenance

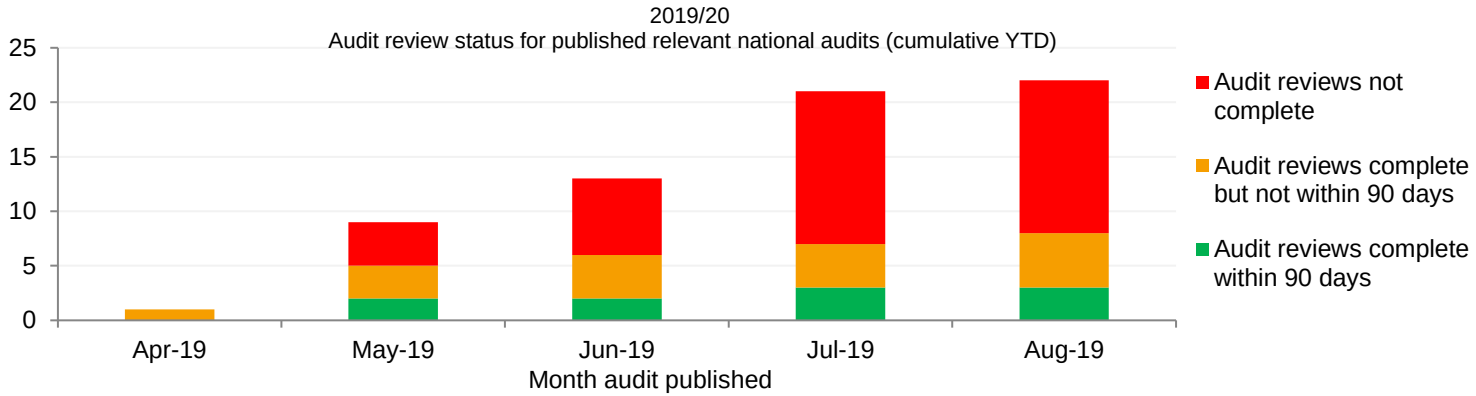
Indicator	Target	Latest data	Executive lead	Report author(s)
Reactive maintenance	70% or greater	November 2019 compliance was 65%	Janice Sigsworth (Director of Nursing)	Andrew Murray (Head of Facilities)



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. ➢ Meetings are held twice a month and a plan to achieve the target is being develop for approval during February 2020. Achieving the target and beyond is challenging and requires greater partnership working between the Trust and contractor to achieve required increase in performance.

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	100% participation 19 – YTD (5 complete but not within 90 days, 14 outstanding)	Julian Redhead, Medical Director	Louise Knight, 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. 22 national audit reports have been published so far this financial year, all of which were relevant to the Trust. Our participation rate for national clinical audits published is currently 100% (22 / 22 audits). *The participation rate has changed since previous exception slides as it has been agreed to remove BAUS from the scorecard. 5 BAUS audits have been published since April 2019. Assurance for BAUS is provided by the division through an alternative arrangement agreed at Executive Quality Committee; there are a number of reports that remain outstanding and these will be followed up with the specialty for submission to ExQu in February 2020. Divisional reviews were completed within 90 days for 3 of the national audits, published this year. Reviews were completed for 5 of them outside of the 90 day deadline. There has been 1 audit (National Clinical Audit of Specialist Rehabilitation following Major Injury) identified as Significant Risk so far, which will be reviewed at the Quality and Safety Sub-group in January 2020, for analysis of the results and action plan and will be monitored through the divisional governance process. Of the 14 that are outstanding, 11 reports are outstanding and overdue; 5 of these reports are from MIC and 6 from SCC.
Return to target / trajectory	Progress is tracked weekly at the MD incident panel and monthly at CAEG. The overdue National Diabetes Audits will be raised with the MIC division as part of the response to the GIRFT report.

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, 14% of reviews were completed within 90 days, compared to 65% at the end of 2018/19. The 11 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.

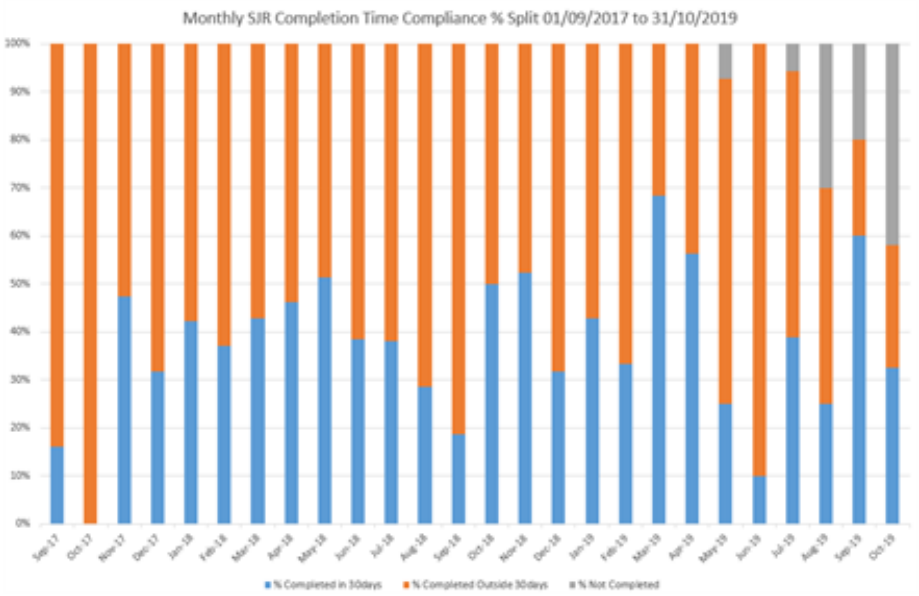
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Overdue audits escalated at the weekly Friday MD panel for review.	Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings. Escalation in place for a number of outstanding audits with dates of completion agreed for all.
National Clinical Audit of Specialist Rehabilitation following Major Injury	Davina Richardson	Jan - 20	Report will be escalated to Sub Group for analysis of the action plan and it will be monitored through the divisional governance process.
All audits not completed within the 90-day timeframe will be directly escalated to the relevant Divisional Director and Clinical Director	Clinical Auditor	Week commencing 13 January 2020	New action
A monthly update on clinical audits will be presented to the Quality and Safety Sub-Group until such a time as performance improves in order to provide additional oversight	Improvement Programme Manager	January 2020	New action

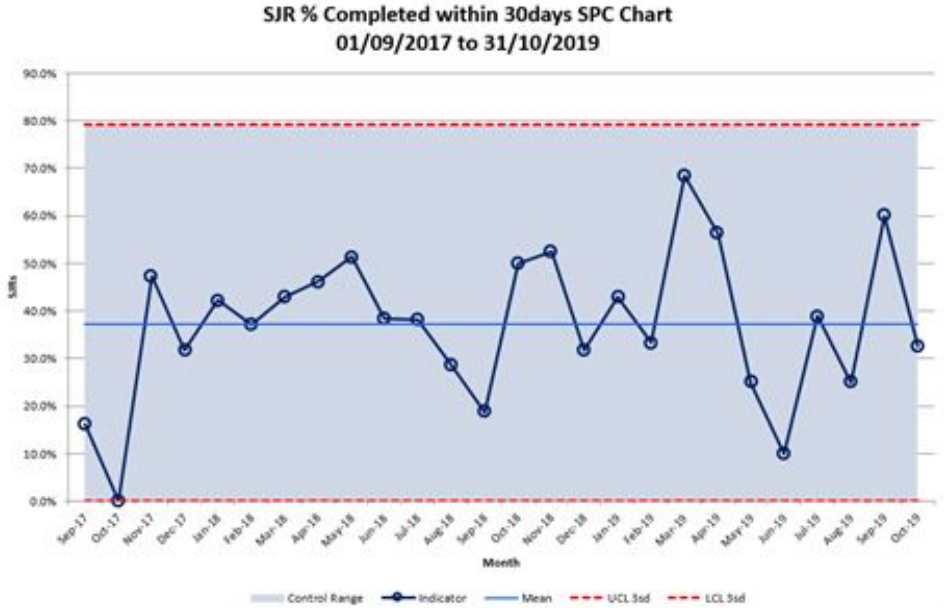
Risk

- 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: 60.4% YTD Outstanding cases October: 25 outstanding cases Avoidable deaths: 0 (YTD)	Julian Redhead, Medical Director	Ian Bateman, General Manager, MDO





Latest performance	• The graphs above shows the percentage of SJRs completed by month within 30-days. In addition it shows the extent to which SJRs have been completed within 30-days or outside of this target. • 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 60.4% not completed within the timeframe. The YTD performance has been decreasing since August 2019. There are currently 25 SJRs not completed in October 2019. • YTD, 3 avoidable deaths were identified via SJR. Two have since been downgraded following the decision MD decision making panel and one remains under investigation. **We have not retrospectively changed the IQPR scorecard.**
Return to target / trajectory	We are continuing to recruit additional SJR reviewers in order to deliver more capacity and expect to have additional trained reviewers in place by March 2020. A full review of our approach and methodology to undertaking mortality reviews has been completed and we have revised our scoring system to be in line with the recommended Royal College Physicians (London) methodology. In support of this all outstanding SJRs as at 25 November 2019 have been reallocated. We are also reviewing our inclusion criteria for SJRs to ensure that we are utilising our resources in this areas to the greatest affect.

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 60.4% 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.

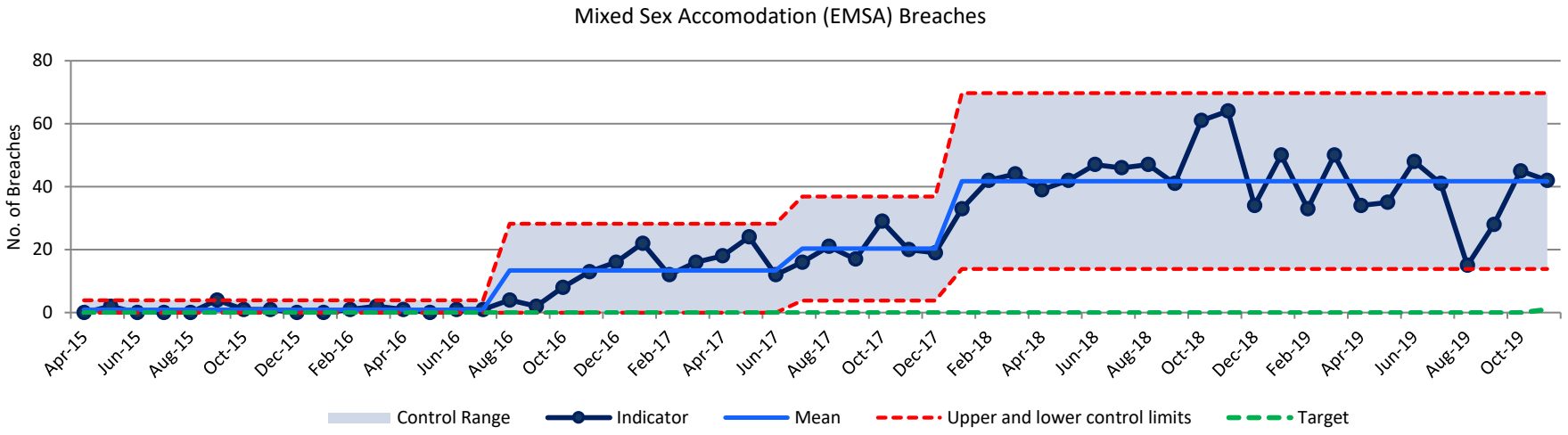
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	General Manager, MDO	March 2020	To increase capacity, recruitment of additional structured judgment reviewers is underway. 3 additional senior nurses were recruited and trained in July. 25 expressions of interest have been received from consultants we have now contacted the consultants to invite them to an information session in January 2020. In addition to this the RCP have agreed to run a bespoke training session for SJR reviewers, this will be organised for March 2020. Ensuring that we use the RCP methodology correctly is likely to support us in reducing the time taken to complete the SJR.
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	The quarterly decision making group took place on 8 November. The final decisions made at this meeting have been reported in the learning from deaths paper presented to the January 2020 ExQu. Changes to our process whereby the SI will decide on avoidability means that the SJR and SI are now completely aligned.
Undertake review of the mortality processes	General Manager, MDO	March 2020	We have now revised our approach and methodology to undertake mortality reviews in line with the recommended Royal College Physicians (London) methodology, meaning that the SJR does not comment on avoidability, and rather triggers the SI process for deaths where care was poor or very poor. The learning from deaths policy has been reviewed and changes are being made to align this with the medical examiner service and revised processes. This will lower the time to complete a SJR to 10 days, and will be implemented by the end of Q4 2019/20. We are also reviewing our inclusion criteria for SJRs to ensure we utilise resource associated with these reviews to its greatest possible affect.

Risk

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

Caring - Eliminating Mixed Sex Accommodation (EMSA)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have zero mixed-sex accommodation breaches	0	42 breaches (November 2019)	Janice Sigsworth	Felicity Bevan



Latest performance	The national standard is to eliminate all mixed sex breaches for Level 1/0 patients. Inability to care for patients in a same sex environment can have a detrimental effect on patient experience. The Trust reported 42 mixed-sex accommodation (MSA) breaches in November 2019, which arose exclusively in the ICU's (Intensive Care Units), with patients awaiting discharge to a ward area. Intensive care units do not provide care for level 1/0 patients. The breaches occur once patients are declared ready for step down to ward areas and they are waiting for a suitable bed in the most appropriate area. Increase in breaches often occur inline with increase occupancy through out the Trust which may impact on flow.
National Guidance Update	An amendment to national guidance on mixed sex patients has been released for critical care. The update provides clarification on the point at which a mixed sex breach should be recorded for patients that are ready for discharge. For patients within Critical Care, either level 2 or 3 care, a breach occurs from when a patient is declared ready for transfer. Once a patient is declared as ready for step down, there is a 4 hour period in which the patient must be transferred from the unit. Any delays in this transfer result in a delayed discharge and a potential breach in mixed sex accommodation. **There is no change to reporting for Critical Care breaches, current reporting metrics are in line with the update to national guidance.**

Caring - Eliminating Mixed Sex Accommodation (EMSA)

Issues and root causes	Breaches at Imperial are incurred by patients awaiting discharge from the ICUs to ward areas. Downstream flow is the main obstacle. Imperial appear an outlier for reported MSA breaches in London. Most other London hospitals report discharge delays from ICU but report fewer or no MSA breaches. The reason for this is unclear, as the two indicators are seemingly contradictory. The root cause of MSA breaches in ICU is delayed discharge of patients within the national 4 hour target once they have been identified as fit for discharge. Breach rates have increased since July 18 due to the critical care co-location (movement of previous L2 beds in ward areas to ICU), which resulted in 1) increased discharges from ICU and 2) the vast majority of patients leaving the department requiring discharge to a level 1 bed. As this cohort of patient were previously being discharged to a L2 bed they were not included in this reporting criteria. Furthermore the previous HDU areas did not report MSA data, this is now being captured in the ICU reports. There are clinical risks associated with moving ICU patients to create single sex bays or to vacate side rooms (whereby they would not be reported as a breach). Bed moves increase the risk of cross contamination of infection and pose risk to unwell patients. There is no evidence locally (from patient feedback) that being in MSA after being declared fit for discharge has an adverse effect on patient experience. The preferred option for elimination of MSA in ICU would be to reduce discharge delays as this has benefits beyond resolving the immediate MSA concern. It is recognised however that this is dependent on downstream bed availability and bed allocation prioritisation. The delayed discharges from the ICUs will form part of the on-going Trust capacity and flow work. Within ICU, we also recognise that improvements also need to be made to reduce the time from bed identification to actual discharge as this also impacts on the breach data. Assurance work has been completed in service, following release of the national guidance. Confirming that reporting is accurate and inline with national guidance. Commissioner review of other Trusts reporting methodologies, to ensure these are inline with national guidance is still awaited.

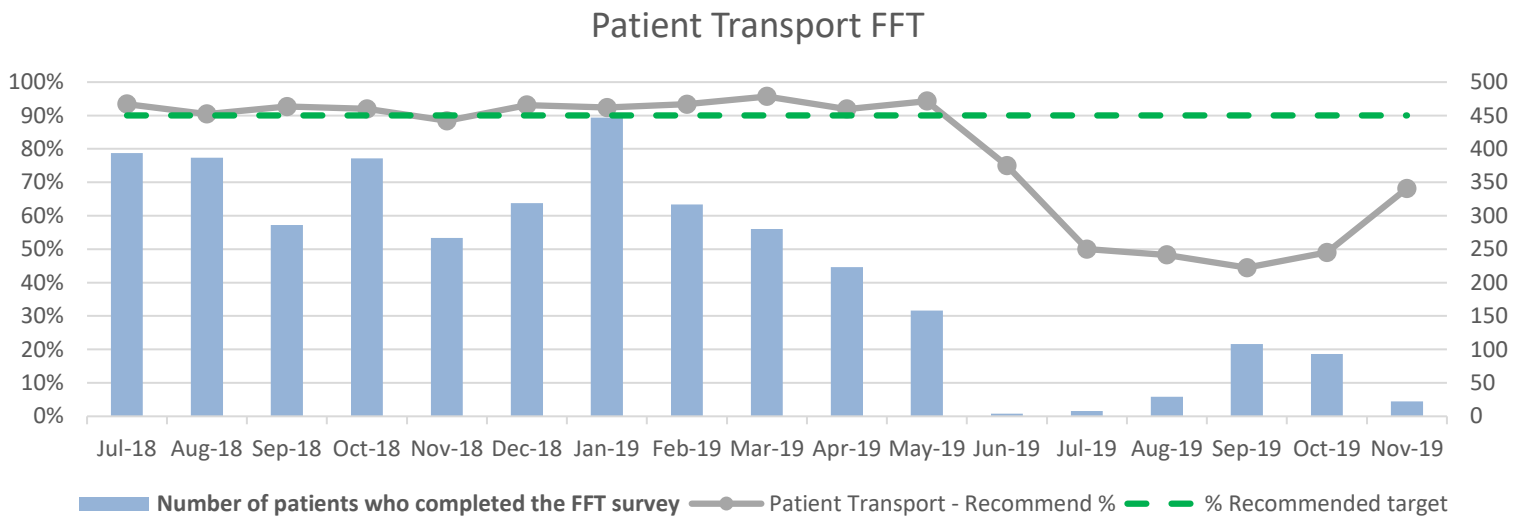
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Data analysis of delayed discharges from Critical Care	Maie Templeton Pavee Jeyaratnam	M9 exception reporting	• Additional data to be included for reporting including: total number of discharges, Trust level occupancy figures, delayed discharges summary.
In conjunction with the Hospital Directors, discussions to be held to review the prioritisation of discharges from ICU	Felicity Bevan; Simon Ashworth	Action in place, work ongoing to maintain focus	• Attendance at Trust Care Journey Capacity Collaboration (CJCC) meeting, to raise profile and areas of delayed discharges from ICU • Delayed discharges and MSA breaches focused on in site management meetings. • Patients placed as soon as an appropriate bed is available.
Provide information to patients on mixed sex accommodation within ICU, and assess impact on patients through feedback	Melanie Denison	Action in place, work ongoing to maintain focus	• A question has been added into the Critical existing patient experience survey to assess the impact on patients that are a MSA breach in ICU. • Literature developed for patients providing information for patients on MSA in ICU. • Feedback from patients suggest no negative impact from mixed sex accommodation.

Risk register

This risk is on the directorate risk register (ID 2457).

Caring – Patient Transport Friends and Family Test - % Recommended

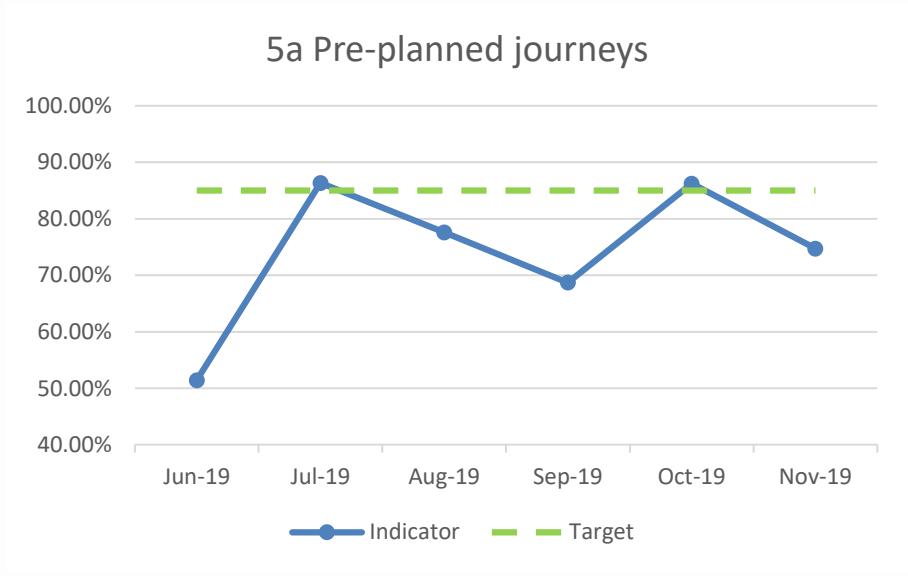
Indicator	Target	Latest data	Executive lead	Report author(s)
Patient Transport - % patients likely to recommend	90% or more	Currently FFT survey numbers are too small to report % recommended in a meaningful way	Janice Sigsworth (Director of Nursing)	Guy Young (Head of Patient Experience)

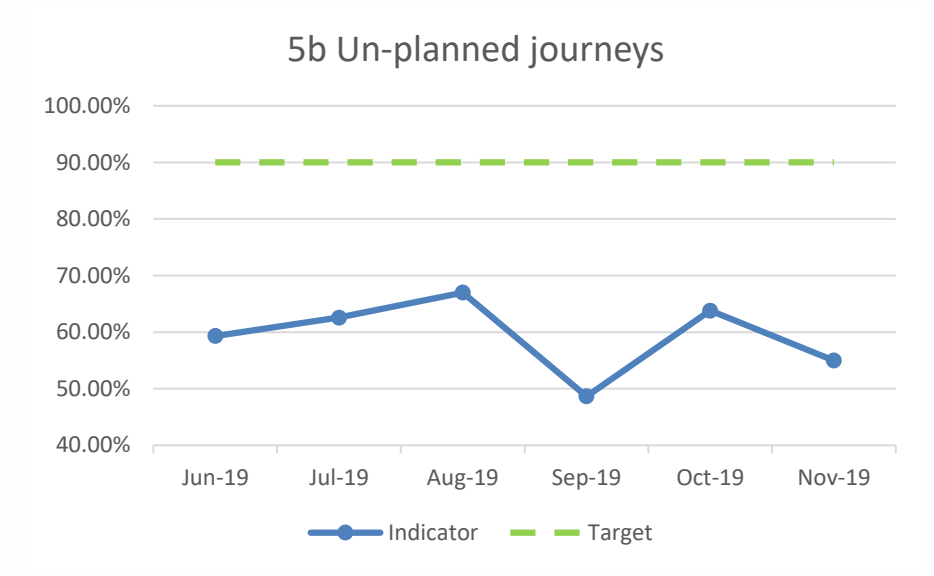


Issues and root cause	The patient transport FFT response rate is currently very low. In November only 22 patients completed the survey which means that the results cannot be extrapolated or considered reliable. Significant Patient Transport contract performance issues have existed since the service transferred to Falck in June 2019.
Key updates	➢ Improvements in delivery and collection times, and a reduction in incidents and complaints have been the primary focus of the management team during this period. ➢ Improvement plans for the last quarter of the 2019/20 financial year will include increasing the response rate for FFT surveys to enable greater insight and continuous improvements plans to be developed jointly with the contractor. The few surveys that are being completed are currently mainly paper based.

Responsive – Patient Transport Collection Times

Indicator	Target	Latest data	Executive lead	Report author(s)
5a Generally pre-planned Patients collected within 60 minutes of booked ready	Contractual minimum standard 85%	November 2019 74.71%	Janice Sigsworth (Director of Nursing)	Hugh Gostling (Director of Estates & Facilities)
5b Generally un-planned Patients collected within 90 minutes of booked ready	Contractual minimum standard 90%	November 2019 54.98%	Janice Sigsworth (Director of Nursing)	Hugh Gostling (Director of Estates & Facilities)

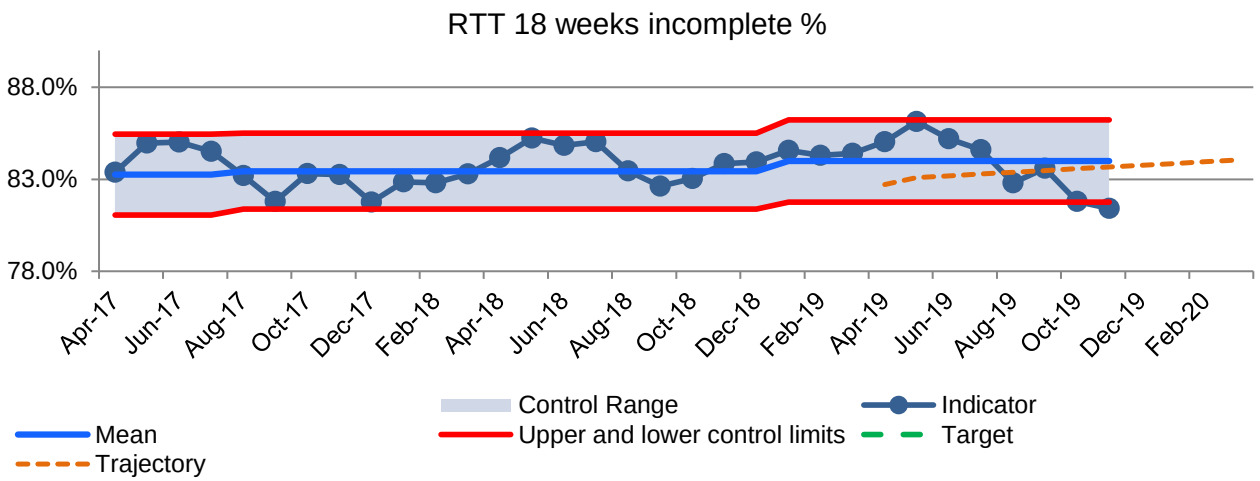




Issues and root cause	New contract as 1st June 2019 – issues include: The amount of new staff employed, and the training and job familiarisation required to achieve efficient operating model. High level of staff churn and vacancies particularly in September 19. The dispatch ICT system not efficiently utilising vehicle and staff resource leading to lack of flexibility in the service.
Key updates	➢ CEO to CEO face to face meetings - undertaken. ➢ Patient Safety / Performance Breach Notice issued by the Trust December 19. - Remedy plan sets out steps to improve performance and reduce patient safety incidents. Plan outlines improvements over February and March 2020. Improvements monitored on a weekly basis. ➢ Contractor has now confirmed all staffing vacancies have been filled.

Responsive – Referral to Treatment: 18 weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT patients waiting less than 18 weeks	83.7% in November 2019	81.4% in November 2019	Dr Catherine (Katie) Urch	Toyin Lawoyin, Performance Support Business Partner



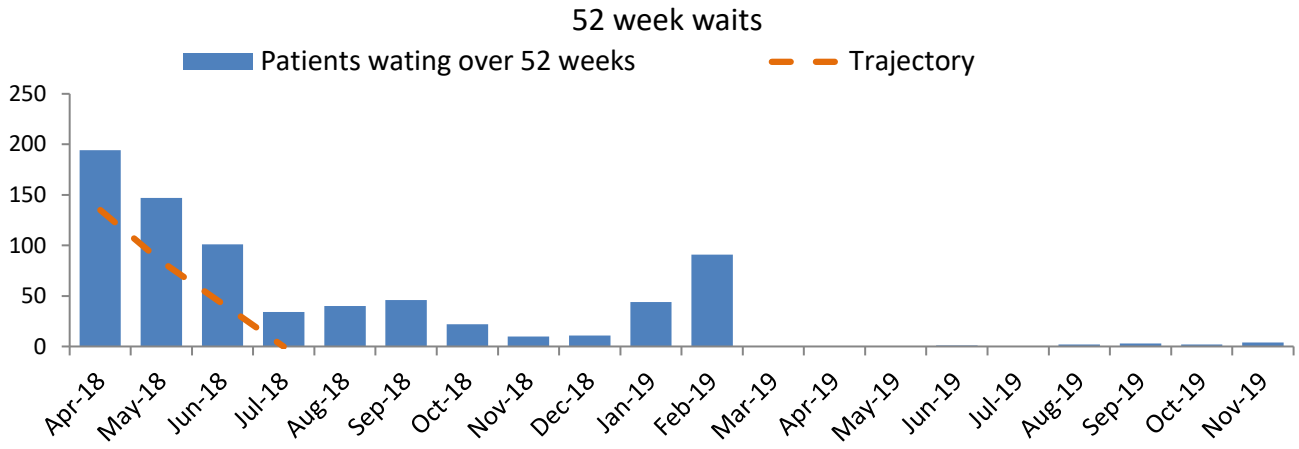
Latest performance

- 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 81.4%, below the trajectory of 83.7%.

Issues and root causes	➢ There was a partial RTT submission in October due planned to Cerner reporting down time. A number of additions and treatments during the downtime (25th Oct – 6th Nov) were not captured in the PTL until reporting resumed to business as usual in the second week of November. ➢ The overall data quality of the PTL is constantly improving through targeted validation implemented alongside Qubit phase 2. This has resulted in a reduction in denominator which has impacted the performance percentage reported for November month end.
Key updates and improvement actions	➢ Validation deep dive to assure current approach is providing the best gains to reporting both waiting list size and % performance – on track to deliver end January 2020. ➢ A validation oversight group was commissioned in late September 19, with the remit to agree validation priorities, monitor improvements and facilitate a weekly tracking and targeted approach. This is due for publication end January. The work will be lead by the newly appointed Validation Optimisation Lead. The intention of this role is to develop an Operational Framework through which the validation teams can more easily target and manage the monthly validation cycle, leading to improved performance (both RTT % and PTL size) and more accurate PTLs. ➢ The increased SRO lead oversight on patients over 38 weeks continues.

Responsive – Referral to Treatment 52 week waits

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT patients waiting > 52 weeks	0	4 (November 2019)	Dr Catherine (Katie) Urch	Jan Palmer



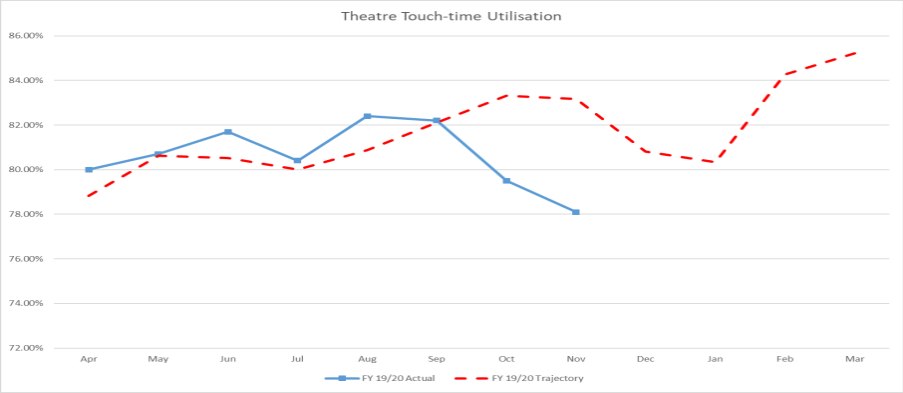
Latest performance

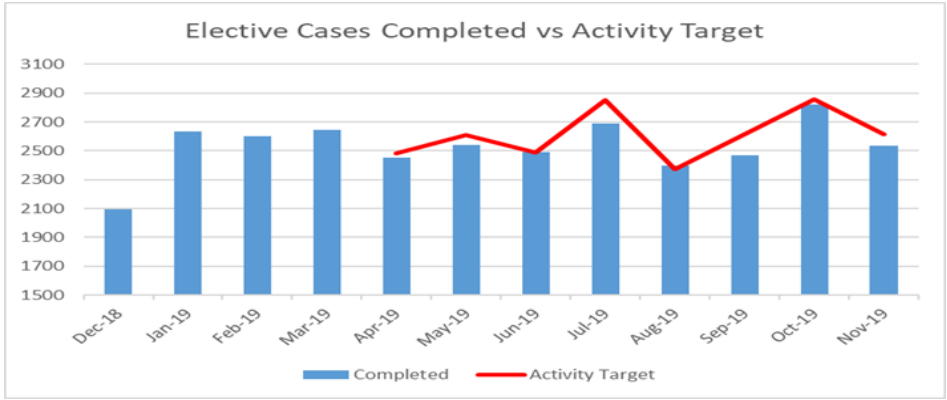
- At end November, four patients were reported as waiting more than 52 weeks for treatment.

Issues and root causes	One 52 week breach was as a result of an administrative error and incorrect interpretation of RTT rules earlier in the patient pathway, one was a patient that was unfit for surgery on the day, and two pathways were identified through the September RTT Clock Stop Audit as incorrect clock stops. All four patients have now received their treatment.
Key updates and improvement actions	• 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 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

Responsive – Theatre touchtime utilisation

Indicator	Target	Latest data	Executive lead	Report author(s)
Theatre touchtime utilisation	83.3% at October 2019	78.1% at November 2019	Dr Catherine (Katie) Urch	David Woollcombe-Gosson (Programme manager surgical productivity)





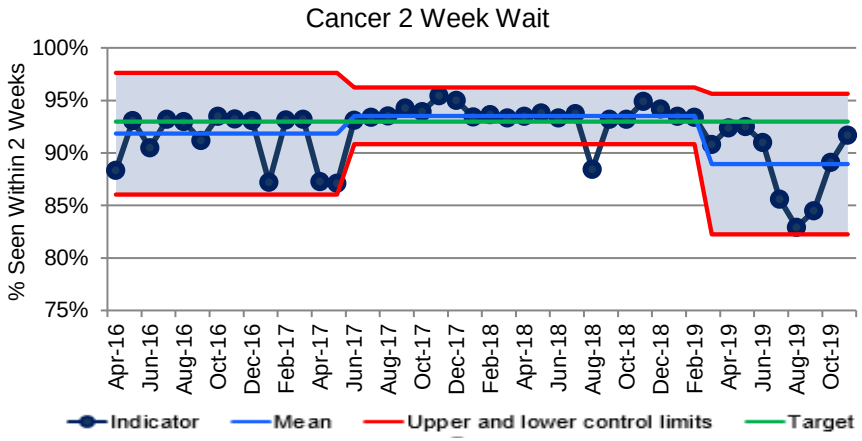
Issues and root causes	• Touchtime utilisation in November was 5.2% below trajectory. Elective cases completed were 2534. This represented 97% of the theatre elective activity plan of 2613, and 80.7% of the theoretical opportunity. Contributing factors were a relative high on-the-day cancellation rate (11.3%) and a slight fall off in scheduling to 90.9% of capacity.
Actions since last update	• Review of Cerner procedure catalogue (ongoing). • Initial review of Cerner surgical Order Entry Form (OEF) with Chelsea & Westminster. • Initiated benchmarking of day surgery data vs British Association of Day Surgery procedures dataset. • DSU improvement options developed and reviewed by Care Advantage project board. • HPB Prehab/rehab and Enhanced Recovery working groups established and baseline data collection commenced.
Key updates and improvement actions	• Review & refresh of POA improvement implementation plan (31/12/19) – on track. • Develop targeted action plans to improve day surgery rates where appropriate (31/1/20) – on track. • Ratify DSU improvement plan (31/1/20) – risk of minor delay due to change of key staff in January. • Scope and develop programme plan for surgical prehabilitation & Enhanced Recovery (29/2/20) – not yet started. • Close out Care Advantage project in DSU, SIC and Hammersmith theatres (29/2/20) – on track. • Data review and action plan to improve pre-operative lengths of stay where appropriate (29/2/20) – not yet started. • Theatre schedule review and develop options across all sites (31/3/20) – not yet started. • Update Cerner procedure catalogue (1/4/20) – on track, subject to confirmation of Cerner freeze/update plan. • Redesign of Cerner surgical Order Entry Form (OEF)(1/4/20) on track, subject to confirmation of Cerner freeze/update plan and Chel West sign-off.

Responsive – Cancer standards (1 of 2)

Indicator	Latest data	Executive lead	Report author(s)
In November 2019 the Trust delivered six of the eight national cancer standards.	See below	Dr Catherine (Katie) Urch	Gareth Gwynn

Latest submitted performance

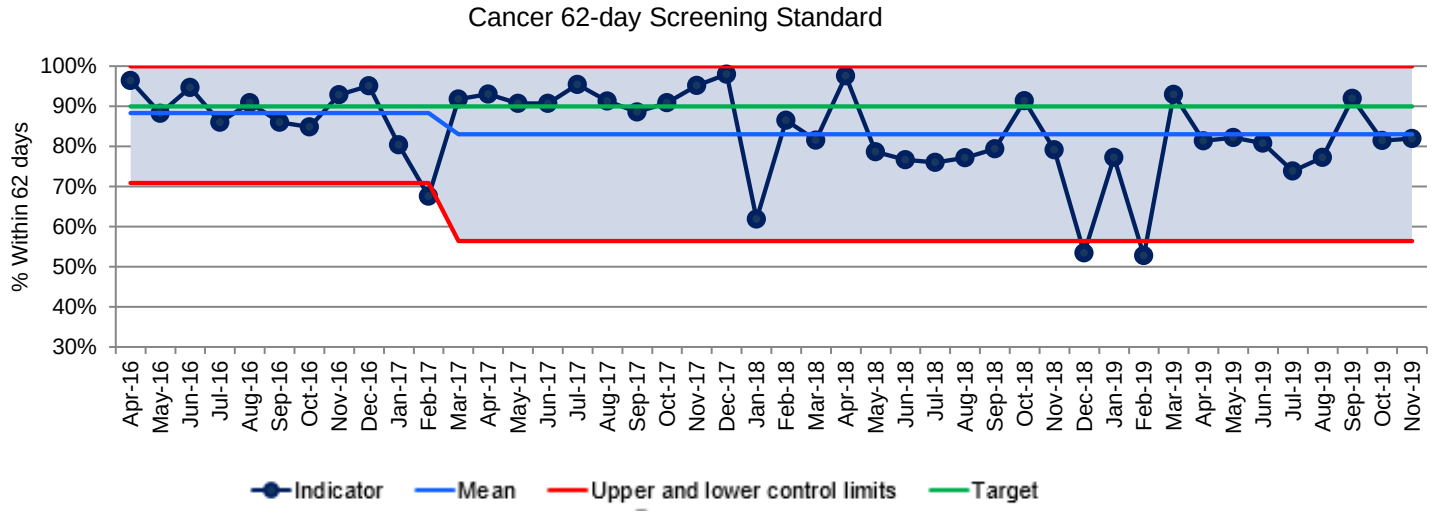
Standard	Target	Sep-19	Oct-19	Nov-19
Cancer Two Week Wait	93%	84.5%	89.1%	91.7%
Breast Symptom Two Week Wait	93%	94.9%	95.0%	94.7%
31 Day First Treatment (Tumour)	96%	97.1%	96.5%	96.4%
31 Day Subsequent Treatment - Drug Treatments	98%	98.8%	100.0%	100.0%
31 Day Subsequent Treatment - Radiotherapy	94%	100.0%	95.7%	97.5%
31 Day Subsequent Treatment - Surgery	94%	98.5%	96.7%	94.5%
Cancer Plan 62 Day Standard (Tumour) with reallocation	85%	86.3%	83.7%	87.4%
CRS 62 Day SCREENING with reallocation	90%	92.0%	81.5%	82.0%



2WW Narrative

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 and improvement actions	• The 2WW standard recovery trajectory is being established. Key updates are as follows: ○ Colorectal service - a new consultant appointment in August 2019 has supported increased capacity and improved tumour-level performance over October and November. Staff recruitment to support the straight to test diagnostic pathway was completed in November. All patients will be managed through the STT pathway from January 2020. To support this, the endoscopy service has undertaken a demand and capacity exercise and has created protected lists for cancer referrals, beginning in January 2020. Performance is expected to be compliant from February. ○ 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. The service has introduced dermatoscopy assessment for 2WW referrals patients. Capacity for this will increase from 135 patients per month in December 2019 to 269 per month in March 2020. Following successful consultant appointment, face to face capacity will increase from 208 patients per month in December 2019 to 370 in March 2020. The service will be compliant with the 2WW standard from April 2020, but improvements in tumour-level performance in Q4 will support the Trust position. ○ Aggregate Trust 2WW performance is expected to be compliant with the 2WW standard from February 2020.

Responsive – Cancer standards (2 of 2)

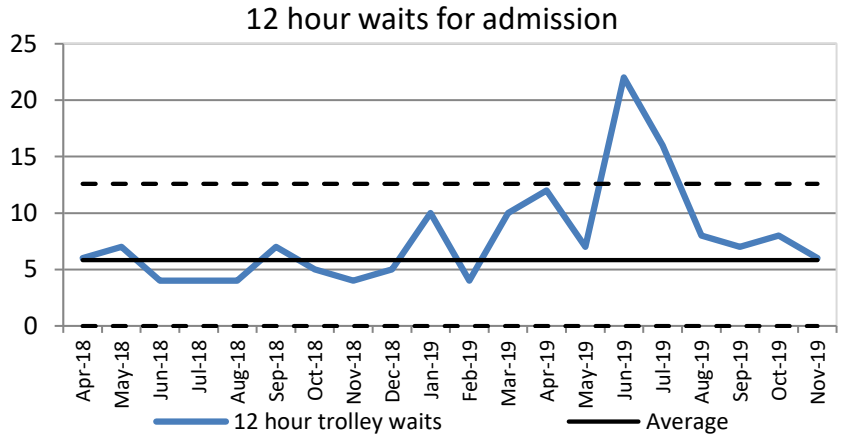


62-Day Screening Narrative

Issues and root cause	• National breast screening service guidelines do not align with national Cancer Waiting Times guidelines. Breast screening pathways and processes have not, therefore, been designed to meet CWT. More breast cancers are now diagnosed through screening referral than through symptomatic referral.
Key updates and improvement actions	• An RM Partners working group has been established to review the delivery of the breast screening pathway. The terms of reference for the group are being defined by the clinical leads; • A pathway mapping session with the breast screening service has identified a number of waiting times improvement opportunities through alignment of diagnostic requesting processes with Cerner, increasing patient communication to address non-attendance, reducing the number of MDT discussions before treatment and moving patients into the breast cancer MDT earlier in the pathway; • Delivery dates are being agreed with the service, but the above must be completed in Q4 in preparation for the changes to the CWT standards expected in Q1 2020/21 when the screening standard will be merged with the 62-day and consultant upgrade standards. The service began fortnightly delivery meetings in December 2019.

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

Indicator	Target	Latest data	Executive lead	Report author(s)
No. of waits for admission over 12 hours from decision to admit (DTA)	0 breaches	6 breaches – Nov 2019	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



Latest performance

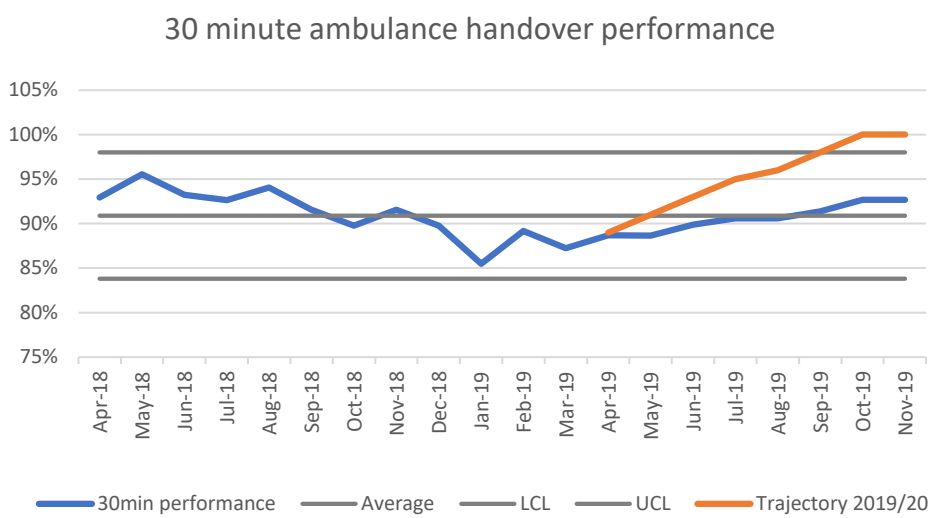
- There were 6 confirmed twelve hour breaches of wait from DTA to admission in November 2019 compared with 8 in October 2019.
- All were mental health delays, (5 occurred at SMH and 1 at CXH).
- These patients spent an average of 29 hours in the department, with an average of 19 hours from DTA to admission.
- Referral number remained consistent at CXH (avg. 5.6/day) and reduce slightly at SMH (avg.5.9/day).
- The no. of pts on mental health pathways spending a total of 12 hours in ED (new UEC standard) was 54 in November 2019, 4 less than Oct-19 (58).

Issues and root causes	Mental Health issues • Lack of available mental health beds. • Delays with out of hours HTT (Home Treatment Team) and AMHP (Approved Mental Health Professional) at SMH.

Key Improvement Actions	External actions
	• Simplifying the Mental Health Compact to avoid debate over detail
	• Recruitment to the first responder service and patient flow social workers
	• Sanctuary pilot at St Charles continuing until January (small numbers of referrals excepted from ICHT)
	Internal actions
	• Courtyard Development at CXH – on track for delivery in march 2020
	• Security risk assessment for MH at SMH ED – on track for delivery in February 2020
	• Big Room for continuous improvement - on track for delivery in January 2020 these actions include;
	  • Focus on homelessness at SMH by developing links with Street Link and other partners
	  • Collaboration with West London SPA to divert patients form UCC
	  • Embed PET calls
	• BI team linking with MH to share data on new UEC standards, information currently distributed through CJ&CC papers
	• ICHT and MH trusts meeting regularly at DDO level to share plans and ideas

Responsive – Ambulance Handovers

Indicator	Target	Latest data	Executive lead	Report author(s)
No ambulance handover delays >30 minutes	100% <30 minutes	Nov 2019 92.7% < 30 minutes	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



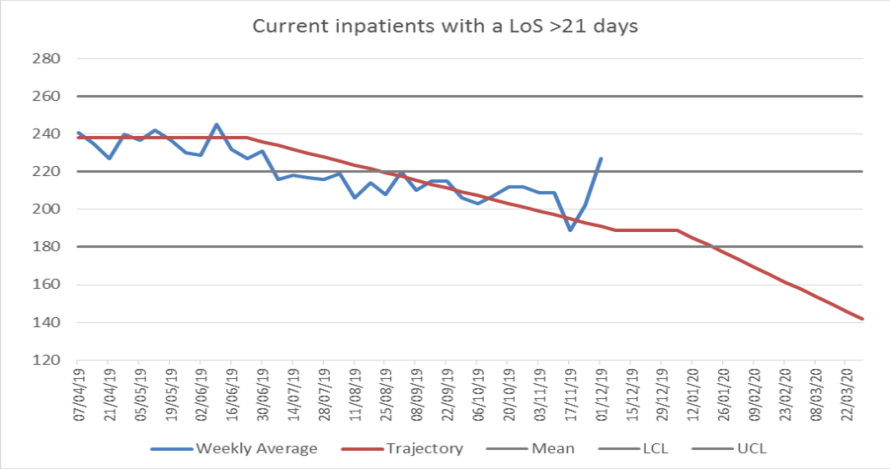
Latest performance

- Performance against the 30 minute handover standard overall remained static for the Trust at 92.7% in November 2019. This is 7.3% below the trajectory.
- Performance at CXH rose to 97.3% in November 2019 and was the highest performing hospital against this metric in NWL sector for the month. Performance against the 15 minute standard also increased to 52%.
- SMH performance decreased by 0.5% from 90.1% to 89.6%. Within NWL sector SMH ranked fifth out of seven.

Issues and root causes	• Capacity in the system including availability of cubicles in ED • Influx of arrivals in a short period of time • Acuity/complexity of arrivals, and linked with this at SMH number of RNA spaces (2 trolleys and seats) • Occasionally nurse can be tied up moving and handing over a patient into the main department, no porter resource here
Key Improvement Actions	• Launch of live ambulance dashboard (QlikSense App) - live trial to begin 16/12 • Trial of new approach to porter resource in RNA at SMH – not yet started • CXH involvement in the London-wide Exemplar programme - ongoing • Continued meetings and liaison with local LAS operational leads on issues – ongoing • Analysis of data where handover overridden but subsequent pin entered that extends the handover time – analysis of one week's data in December completed • Audit to validate 30 minute handover breaches for one month to understand opportunity for validation and amendment of conveyance times - completed

Responsive – Long Length of Stay

Indicator	Ambition	Latest data	Executive lead	Report author(s)
Reducing long length of stays (LoS) for inpatients	<=142 occupied beds by March 2020, November trajectory <=194	Avg. occupied beds 206 – November 2019	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



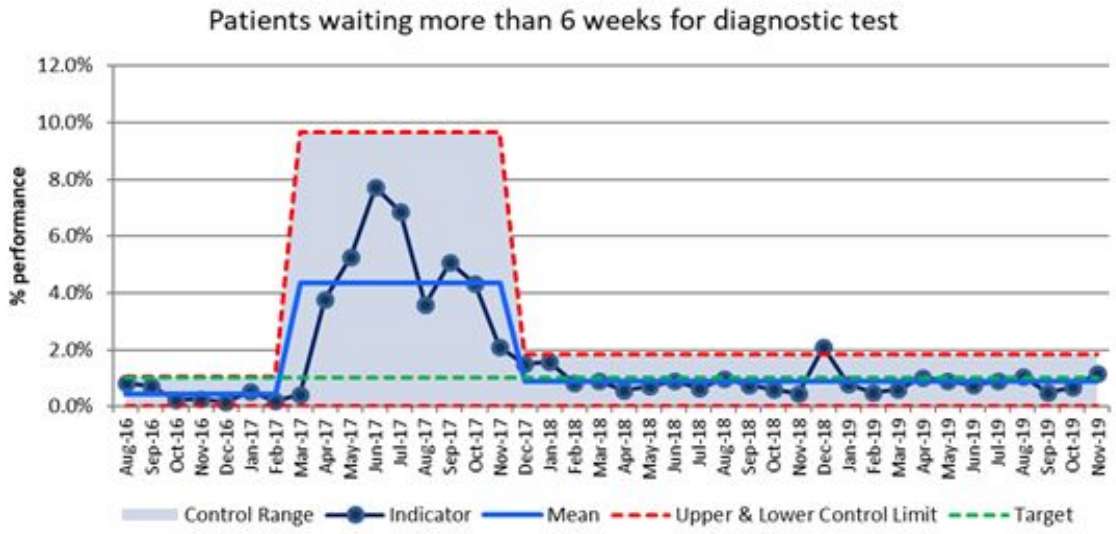
Latest performance

- In November 2019 there was an average of 206 occupied beds with patients with a length of stay greater than 21 days. This is 12 higher than the expected trajectory average for the month. This equates to 21% of occupied beds (excl. paediatrics / maternity) and represents an 13.5% reduction on baseline.
- The graph shows progression against the weekly trajectory with data up until the week ending Sunday 1 December. In November as a whole the progression has slowed to c.10 beds over the trajectory figure for the month.
- Data to the 15th Dec shows there was a peak in the avg. occupied beds.

Issues and root causes	• Increased proportion of unwell patients • Inconsistent use of R2G/board rounds and LLOS review meetings • Inconsistent application of patient choice policy • Reduced capacity in community bedded facilities creating discharge blockages including closure of 8 beds at Garside • Re-organisation of NWL Continuing Healthcare teams causing delays to fast track nursing home placements
Key Improvement Actions	• Proactive distribution of LLOS data to specialties/directorates that are challenging the trajectory – commenced Dec 19 • Consistent LLOS review meetings including; a) clinical leadership and challenge, b) a home first attitude and c) closing the loop on actions – ongoing • Full implementation of the choice policy including; a) continuing rollout of training, and b) confidence/usage of policy – by 31 Jan • Board round audit in January to baseline effective use of board rounds and Red 2 Green methodology including; a) guideline, b) escalation process, c) embedding into the ward culture, and d) developing AMD role at site level – by 28 Feb • Extended LoS Task force in place with associated improvement plan

Responsive – Diagnostic Waits – over 6 weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
Diagnostic waits over 6-weeks	<1%	1.15% (Nov-19)	Tg Teoh	Bec DuBock (Performance Support Business Partner)



Latest performance

The overall diagnostic 6-week wait (DM01) standard was 1.15% in November-19 above the target of 1%. Compared to the previous month, this is a 0.46% increase in performance.

Modalities over 1% in November:

- **Imaging** – 1.4%
- **Cardiology** – 1.4% (Echo), 5.3% (EP – small denominator)

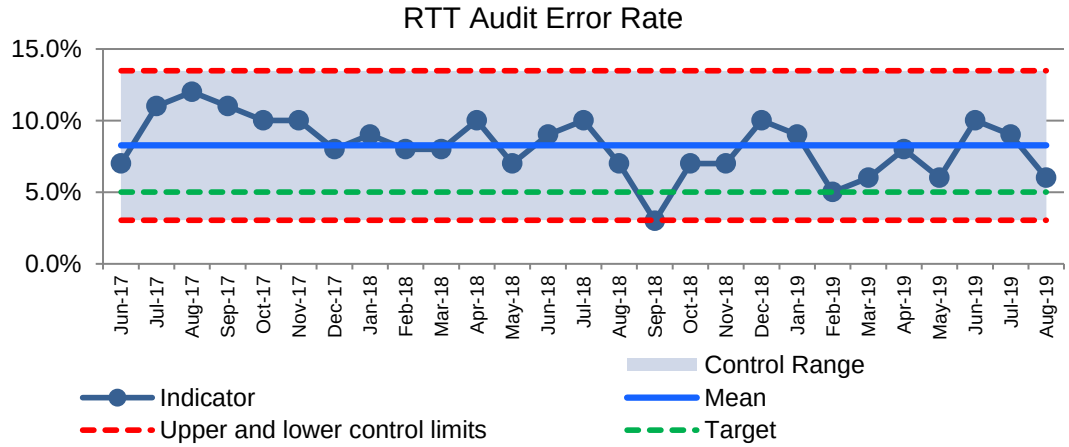
Issues and root cause	**Imaging**: Increased demand on the Head & Neck pathway, which has limited capacity and has seen an increase in the breach rate; this is in part due to the changes to the Consultant Pension which means additional capacity had not been available. This issue has been addressed by the Trust and additional lists are now being made available in January/February however, the Trusts pool of Head & Neck specialists is small which may limit the additional capacity. Other London Trusts are paying significantly more per hour for locum rates and this is also affecting our cover uptake rate. The December performance is reporting above the 1% tolerance due to the continued ultrasound demand. Additional slots are being opened in January to reduced the risk to the performance; this is being monitored closely within the Division and weekly updates will be requested to track the possible breach rate. The increase in the imaging demand remains an on-going risk to the Trusts performance. **Cardiology**: Capacity constraints impacted on delivery in month for acute echocardiography.

Responsive – Diagnostic Waits – over 6 weeks

Key updates and improvement actions	**Imaging:** The service is exploring outsourcing ultrasound with the initial meeting planned for the 10/01/2020; scans would be outsourced at the same tariff to be cost neutral. The bank rate for sonographers remains under discussion - further assessment of the impact of uplifting the agency rate/current costs of delivery and likelihood of uptake of additional lists has been requested & is due for completion the w/c 13th January – est. delivery/implementation of new rate by the end of January. Other key updates include: • Meeting with commissioners to jointly review increases in demand in imaging – 17 January 2020 • Local capacity plan and trajectory being modelled to include all imagining and mitigation for MRI replacements - MRI replacement on track to commence March 2020 • Performance Support Team to hold weekly check point calls with all services to support mitigation of breaches in other areas – on track to commence February 2020. • Work underway by BI Team to move imaging dataset (SOLITON) into the Trust data warehouse to improve oversight and our ability to forecast performance in-month – in progress but delivery date is TBC with BI Team. • In house training programme for head & neck sonographers to increase capacity within service - underway **Cardiology:** Additional Saturday clinics – operational Recruitment of an additional nurse to support on-going improvements – in progress. In the community, administrative issues / changes at remote sites led to incorrect rebookings or appointments booked over the 6-weeks; training has been provided and on-going support is in place. Both areas anticipate performance to be within tolerance by the end of January 2020.

Responsive – RTT Audit Error Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT Audit Error Rate	5%	6% (August 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 August 2019 was 6%. This equates to a total of 59 incorrect clock stops found through audit for the submission month of August 2019.

Issues and root cause	• Root cause analysis has shown themes consistent with those reported over the last two month, the most frequently used RTT code when applying incorrect clock stops remains code 32 – clinician/hospital initiated active monitoring and the key action associated with incorrect clock stops continues to be check out from outpatient clinics.
Key updates and improvement actions	• The Trust error rate has reduced by 3% when compared to the previous month and two out of the three divisions (SCC and WCCs) have reported error rates of 5%, achieving the target threshold. • The error rate for long waiting patients (at 38 weeks and above) has also reduced when compared to last month and is now reported at 5%. • 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. To date 1,400 staff have been trained. It has been recognised that delivering a full classroom training programme to staff has become challenging and there has been a need to condense training into more achievable options utilising digital and targeted DQI training more frequently. • The RTT audit error rate is still expected to return to best practice 5% error rate in November 2019, with a dependence on multiple transitional work streams in the Surgery division including (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 December 2019	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 29th January 2020	**Item 11, report no. 07**
Responsible Executive Director: Jazz Thind, 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 nine months to the 31st December 2019.

Income and expenditure key highlights:

- actual year to date deficit of £14.45m (on plan)
- additional income associated with over performance in activity, mainly in relation to emergency work, is offset by the additional costs of delivery
- in-month forecast improved by £3m bringing the overall gap to the control total to £4.5m - mainly driven by an improvement in the SCC forecast, after a worsening in their position at month 8
- the Trust continues to forecast to meet the control total

Closing the financial gap to control total is likely to continue to require further non-recurrent actions/mitigations (one-offs) to be taken, resulting in a significant pressure being carried forward into 20/21.

The forecast position assumes / requires:

- All divisions to achieve their current forecast outturn position
- Continued concerted effort to reduce pay exit run rate
- NHS income over performance disputes to be settled with NWL and NHSE
- Further spend against contingency is not required over winter
- Unless operational teams are able to close the £4.5m gap to the control total the total amount of non-recurrent support required will equate to £26m

Key Risks or areas of concern impacting delivery of control total:

- NHS Commissioners continue to challenge charges for over- performance and not agreeing to settle the full amount. Any future increase in NHS clinical activity not in the forecast, is also unlikely to be funded
- Review of capital spend results in a greater than planned increase in the 'capital to revenue transfer' value
- North West London Pathology costs may cause a pressure but is being reviewed regularly

Capital resource limit:

Capital expenditure is £1.7m behind plan but forecast to catch up in order that the Trust meets its capital resource limit of £50m.

Recommendations:
The Committee is asked to note this paper

This report has been discussed at: N/A

Quality impact:
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 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

- *Should senior managers share this information with their own teams? Yes*

FINANCE REPORT – 9 MONTHS ENDED 31st December 2019

1. Introduction

This report provides a brief summary of the Trust's financial results for the 9 months ended 31st December 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). Taking this funding into account means that Trust will deliver and report a £11.1m surplus position.

The table below sets out the performance to 31st December 2019. The Trust reported a 'on plan' position year to date before PSF and MRET. Although the latest re-forecast still results in the Trust being £4.5m worse than plan, this is a significant improvement against the previous position reflecting the additional benefits that have been identified and delivered.

The Trust continues to:

- rely on significant levels of non-recurrent benefits to deliver the control total and these will need to be identified recurrently as additional efficiencies for 2020/21
- focus attention on delivering recurrent reductions in the pay run rate, espeically in temporary staffing spend
- negotiate with both NHSE and North West London CCGs with regards to clsooing down disputes associated with over-performance challenges

The Trust remains committed to meeting 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	92.91	95.58	2.67	863.80	884.09	20.29
MRET Income	0.85	0.85	-	7.67	7.67	-
Pay	(54.55)	(55.65)	(1.11)	(486.72)	(498.32)	(11.61)
Non Pay	(37.29)	(41.00)	(3.71)	(360.06)	(367.64)	(7.58)
Internal Recharges	0.00	0.00	(0.00)	0.00	0.00	(0.00)
Reserves	(1.69)	(1.73)	(0.04)	3.46	2.28	(1.17)
EBITDA	**0.24**	**(1.96)**	**(2.20)**	**28.15**	**28.08**	**(0.07)**
Financing Costs	(3.56)	(4.02)	(0.45)	(32.86)	(33.94)	(1.08)
SURPLUS / (DEFICIT) inc. donated asset treatment	**(3.32)**	**(5.97)**	**(2.65)**	**(4.71)**	**(5.86)**	**(1.15)**
Donated Asset Treatment	(0.32)	0.14	0.46	(2.10)	(0.91)	1.19
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT) < PSF	**(3.64)**	**(5.83)**	**(2.19)**	**(6.81)**	**(6.77)**	**0.04**
PSF Income	1.68	1.68	-	10.95	11.91	0.97
CONTROL TOTAL	**(1.96)**	**(4.15)**	**(2.19)**	**4.13**	**5.14**	**1.01**

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 positive positon of £0.97m relates to retrospective adjustment in relation to 2018/19. This funding is 'cash only' and does not support the delivery of the Surplus/(deficit) of the Trust.

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.

This year's contract with NWL commissioners includes 1% cap with over performance above this level attracting payment at a marginal rate of 70%. On the basis of current activity the marginal rate for the trust equates to c55% of income and this been reflected in the divisional positions.

Payment for over-performance is not guaranteed and must be agreed across the sector, the Trust is working with commissioners to sign off the payment due and should the Trust be not paid in line with expectations; this would directly impact the financial performance for the year and potentially the delivery of the underlying position (surplus/(deficit) before PSF).

Divisions	Year To Date Activity			Year to Date Income (£m)		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	734,337	667,596	(66,740)	216.87	226.18	9.31
Division of Surgery, Cancer & Cardiov.	574,261	601,616	27,354	271.85	266.45	(5.40)
Division of Women, Children & Clin. Support	322,368	333,994	11,627	117.49	118.46	0.97
Clinical Income	**1,630,966**	**1,603,207**	(27,759)	**606.21**	**611.09**	**4.88**
Central Income				90.81	99.19	8.38
Pathology	1,660,635	1,865,522	204,887	8.54	9.03	0.49
Clinical Commissioning Income	**3,291,601**	**3,468,729**	**177,128**	**705.56**	**719.32**	**13.76**

- Medicine and Integrated Care (MIC) is over performing on acute non-elective activity across all sites
- Surgery, Cancer and Cardiovascular (SCC) is below plan year to date with the reduction in cardiac activity being reviewed by the directorate with clinical haematology low in non-elective
- Women, Children and Clinical Support (WCCS) is ahead of plan year to date with additional activity over plan in paediatric care and women's care and maternity behind plan due to fewer 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 £2.7m higher in 19/20 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	24.93	26.21	1.28	229.36	238.77	9.41
	Expenditure	(18.09)	(20.07)	(1.98)	(167.63)	(180.04)	(12.40)
	Internal Recharges	(1.05)	(1.08)	(0.03)	(9.47)	(9.45)	0.02
	Total	5.78	5.06	(0.72)	52.26	49.28	(2.98)
Surgery, Cancer and Cardiovascular	Income	29.17	29.27	0.09	275.72	270.33	(5.39)
	Expenditure	(25.60)	(25.41)	0.19	(231.39)	(230.75)	0.64
	Internal Recharges	1.48	1.12	(0.37)	13.35	13.14	(0.21)
	Total	5.06	4.98	(0.08)	57.68	52.72	(4.96)
Women, Children & Clinical Support	Income	13.89	13.11	(0.78)	122.21	121.86	(0.35)
	Expenditure	(14.11)	(14.14)	(0.03)	(124.17)	(125.13)	(0.96)
	Internal Recharges	2.03	1.81	(0.22)	17.25	17.07	(0.18)
	Total	1.81	0.79	(1.02)	15.29	13.80	(1.49)
Imperial Private Healthcare	Expenditure	2.45	1.97	(0.48)	20.58	21.28	0.70
	Internal Recharges	(2.46)	(1.85)	0.61	(21.14)	(20.76)	0.37
	Total	(0.01)	0.13	0.13	(0.56)	0.51	1.07
Total Clinical Division		**12.65**	**10.95**	**(1.69)**	**124.67**	**116.31**	**(8.36)**

MIC is £3.0m worse than plan year to date mainly due to delays in the efficiency programme. There is significant income over performance within the division on emergency work with additional costs to deliver the activity.

SCC is £5.0m worse than plan year to date. The division is behind plan on income, mainly in elective work and has not been able to reduce costs to compensate. The division is working on a set of recovery actions to reduce the adverse position in the remainder of the year.

WCCS is £1.5m worse than plan year to date. The division is under plan on income relating to non NHS imaging and pharmacy activity. There are overspends for unidentified CIP and additional costs for repair work in imaging.

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 £11.5m worse than plan year to date on where plans for CIPs have not yet been identified. The Trust has focused on pay savings in year, and the Project Management Office has been working with operational teams to identify recurrent pay savings and support the delivery of schemes.

4. Cash

The cash balance at the end of December was £33.7m an increase of £7m since the start of the year, driven mainly by the receipt of PSF payments, including those related to 2018/19. In month 9 there was decrease in cash of £22.2m, the main drivers being the settlement of significant outstanding creditor payments and delays in receipt of income. The Trust must maintain a cash buffer balance of £3m to meet its obligations in relation to loan conditions.

5. Capital

To date the Trust has expended £34.1m of capital against a plan of £35.9m, the under spend is due to the phasing of specific projects. Where these changes in timing have resulted in projects moving into next financial year alternative schemes from the capital pipeline have been agreed to be brought forward to ensure that the Capital Resource Limit of £50m is met.

6. Conclusion

The Trust is reporting a ‘on plan’ positon year to date and remains committed to meeting the control total. The Trust must identify and deliver recurrent efficiencies to ensure future financial sustainably and deliver the financial trajectory issued by NHSI for 20/21.

7. Recommendation

The Trust Board is asked to note the report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CQC Update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29 January 2020	**Item 12, report no. 08**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance	**Author:** Kara Firth, Head of Regulation
Summary: This paper presents the latest update on CQC activities at and impacting on the Trust, covering December 2019 and January 2020.	
Recommendations: To note the update.	
This report has been discussed at: Executive (quality) committee on 05/11/2019 and 03/12/2019; Trust quality committee on 15/01/2020.	
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: This paper relates to **Risk 81 on the 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 No impact on any specific protected characteristic.	
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: 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

CQC Update

1. Purpose

1.1. This report presents the CQC report to the board, covering December 2019 and January 2020.

2. Concerns, Complaints and Whistleblowings Raised with the CQC

2.1. The board will recall that in October 2019, the CQC contacted the Trust in relation to a collection of whistleblowings made to them that all related to safe medical and nurse staffing out of hours at Charing Cross Hospital.

- The board will also recall that in its response to the CQC, the Trust provided initial data and information, and set out a series of activities that will be undertaken during November and December 2019 to investigate the matter.
- The Trust will provide a further response to the CQC by the end of January 2020, including updates on progress and outcomes of action taken.
  - This response is being coordinated by the Director of People & organisational development and overseen by the CEO.

2.2. Since the previous update the CQC asked the Trust to investigate its process for one complaint, where the person said they had complained to the Trust but had not received a response. This complaint has now been investigated and a response issued to the complainant.

3. Death Reviews

3.1. As part of the CQC's routine oversight of learning from deaths, the Trust was asked to provide further information in relation to three deaths. The CQC was satisfied with the information provided and did not require any further action to be taken at this time.

4. CQC Insight

4.1. There were no changes in performance against Trust-level indicators within CQC Insight between October and November 2019.

4.2. Changes in performance against Trust-level indicators in the CQC Insight report for December 2019, compared to November, were:

- The Trust's ratio of senior staff nurses to staff nurses decreased. Previously we were performing better than other trusts on this measure; we are now performing about the same as other trusts.
- The Trust's performance in relation to potential under-reporting of patient safety incidents resulting in death or severe harm, has decreased and we are now again performing worse than other trusts on this measure.
- Turnover rates for two staff groups have increased, reducing the Trust's performance on this measure:
  - Medical and dental staff. Previously we were performing better than other trusts on this measure; we are now performing **about the same as other trusts.**

- For other clinical staff, we are now performing **worse than other trusts** on this measure.

5. National Reviews and Surveys

5.1. The CQC published the outcomes of its 2018 Children's and young people survey in November 2019.

- The Trust's response to this survey is managed by the division of Women, Children and Clinical Support; the division will present the survey outcomes and its response via its normal communication routes.

6. Engagement

6.1. The CQC requested a face-to-face engagement meeting between one of its specialist pharmacy inspectors and the Trust's Chief Pharmacist, which took place on 16 December 2019.

- The Chief Pharmacist indicated that the meeting was positive, with a focus on what works well at the Trust and improvement activities relating to medicines management during the past year.
- Details of action taken since previous inspections were provided where issues with medicines management had been raised.

6.2. The next regular 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.

6.3. The first face to face engagement meeting for the next financial year, scheduled for April 2020, will include the leads for the Western Eye Hospital.

- The meeting will take place on site and will include a tour of the premises.
- On the same day, the CQC will also hold a focus group for Western Eye Hospital staff.

7. Preparations for Upcoming CQC Inspections

Internal Q2 PIR update

7.1. An internal update of the CQC PIR, using quarter 2 (Q2) data and information, is expected to be completed in mid to late January 2020.

7.2. The committee is aware that self-assessments of each core service, at each site, against the CQC's standards must be submitted as part of actual PIRs.

- The committee is also aware that self-assessments were undertaken between April and October 2019 as part of the inspection preparation programme under the Improving Care Programme Group (ICPG).
- A meeting will be held in January 2020 to sign off the self-assessed ratings, as is done with actual PIRs. The meeting will include the CEO, Director of corporate governance, Director of Nursing, Medical Director and divisional leads.

7.3. The Q2 PIR update, and in particular the self-assessments, is being used to plan mock inspections as described in the next section.

Mock inspection programme

7.4. A programme of mock CQC inspections is being organised, to take place during February and March 2020, which follow the CQC's inspection format as closely as possible.
- Each review will be led by a divisional director of nursing (DDN) with the exception of WEH, which is being led by the Chief of Staff for the Medical Director's office.
- Requests have now been issued for internal and external reviewers.
  - Specialists will be identified for each review as is the case for actual inspections: pharmacists, mental health, safeguarding, governance, infection control and patient experience
- Interviews will be arranged with key staff and focus groups for staff will be held.
- No reports will be issued following these reviews but feedback will be provided to areas visited each day and summaries of findings for services at each site will be provided at the end of each review to divisional leads. Local responses to review findings will be overseen by the ICPG.

8. Next steps

8.1. Finalise the Q2 PIR update.

8.2. Continue preparing for the programme of mock inspections.

8.3. Prepare for the January engagement meeting with the CQC.

9. Recommendations to the board

9.1. To note the updates.

Author: Kara Firth, Head of Regulation
23 January 2020

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: HMRC business risk review plus (BRR+)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 29th January 2020	**Item 13, report no. 09**
Responsible Executive Director: Jazz Thind - Chief Finance Officer	**Author:** Adedoyin Ogunbiyi Associate Director of Finance

Summary:

HMRC are due to visit the Trust in February 2020 in order to carry out a review of the Trust's arrangements for managing and disclosing its compliance with UK tax regime.

HMRC's review will use their new risk-based approach business risk review plus (BBR+) approach and this is broadly expected to cover organisational approaches and behaviour across three distinct areas:

- systems and delivery;
- internal governance; and
- approach to tax compliance

The outcome of the review will result with the Trust being classified against one of four ratings:

- low;
- moderate;
- moderate-high; and
- high

Given this is a new approach and the Trust is one of the first NHS entities to be subject to this, it is difficult to be certain as to how the organisation will be assessed. However the Trust's annual VAT reviews, internal audit's work on key financial systems and other specific audits (e.g. IR35) and adoption of nationally mandated systems such as the staff payroll system; should provide a level of assurance with regards to our internal approach to tax matters.

To additionally prepare for the visit the Trust is reviewing the available guidance and engaging with its advisors to identify what resources are available to aid readiness. As part of this preparatory exercise, and in order to strengthen the assurances Trust is able to give, a tax strategy and tax policy have been prepared for Board authorisation. These documents between them codify the Trust's longstanding arrangements to its tax arrangements which can briefly summarised as being transparent and taking a low risk approach, balancing the dual responsibility to comply with tax legislation and guidance and to ensure maximum value-for-money for the taxpayer and service users.

Work continues in other areas of the review to assess the Trust's ability to respond to potential lines of enquiry which may be pursued by HMRC.

Recommendations:
The Board is requested to note this report and adopt the tax strategy and note the tax policy.

This report has been discussed at:
Executive Committee, 28th January 2020

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☒ No

If yes, when……

Quality impact: N/A.

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: N/A.

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:
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?.....

HMRC business risk review plus (BRR+)

1. Background

1.1 HMRC's business risk review (BRR) regime applies to approximately 2,000 of the largest organisations subject to UK tax law.

1.2 Following the introduction of the corporate criminal offences (CCO) of failing to prevent tax evasion as part of the Criminal Finances Act 2017 the BRR was subject to a consultation in autumn 2017 with a pilot of the proposed model in autumn 2018. The new model, BBR+, has been enhanced in response to feedback during the consultation and pilot and it is now being rolled out by HMRC.

1.3 BRR+ rates organisations based on their behaviour and strategy in relation to tax which in turn determines HMRC's approach to review and assessment of each organisation. Under BRR+ organisations will be classified against one of four ratings – low, moderate, moderate-high, and high (see appendix 1).

1.4 The results of the BRR+ inform HMRC's overall approach to an organisation and the focus of any future risk assessment activity with an at least annual review for organisations not assessed as low risk. For low risk customers BRR+ will, in general, be carried out on a three year cycle.

1.5 The BRR+ will form an assessment based on the following criteria:

- Considering the organisation's context, the sectoral landscape and the environment in which the organisation operates, and the potential of these factors to impact the organisation's inherent level of tax compliance risk;
- Assessing whether the organisation's approach to systems and processes, internal governance and approach to tax compliance increase or decrease the level of inherent risk of non-compliance; and,
- For each applicable tax regime, considering the effect of the organisation's strategy and behaviour i.e. the organisation's relationship with HMRC.

1.6 Based on the output of this work, HMRC will consider the overall risk rating of the organisation which will then be discussed and agreed with the organisation. Based on this any action plans required to reduce the level of risk will be put in place.

2. Next steps

2.1 The Trust is scheduled for a BRR+ visit with HMRC in February 2020.

2.2 As BRR+ is a new, risk based approach, and the Trust are one of the first NHS organisation's to go through this process, there is limited intelligence available about how the Trust will be assessed against the lines of enquiry within the regime however the Board should note that the organisation can take assurance from the following work carried out to-date:

- Annual assurance reviews by the Trust's first- and second-line VAT advisors CRS and Liaison;
- Internal audit's review of employment status (IR35) – currently on-going;
- Internal audit work incorporating key financial systems; and
- Use of the national payroll system, ESR.

2.3 In advance of the BRR+ meeting with HMRC the Trust is engaging with existing suppliers and tax specialists to determine what resources exist to specifically help the Trust prepare for the visit and assess its state of preparedness.

2.4 As a result of this research and emerging measures that would assist the Trust in demonstrating it is approach to tax, management has formally codifies its tax strategy (appendix 2) and tax policy (appendix 3).

2.5 The tax strategy documents the organisation's existing approach to tax which recognises that the Trust has a dual responsibility to comply with tax legislation and guidance and to ensure maximum value-for-money for the taxpayer and service users. To this end the Trust is committed to arranging its tax affairs in a transparent, efficient and low risk manner and seeks to comply with the rules in good faith and in the manner with which tax law intends.

2.6 The tax policy provides operational clarity as to how the strategy will be transacted.

3. Conclusion

3.1 The Board is asked to adopt the tax strategy and note the tax policy.

Appendix 1: HMRC BRR+ classification guidance

Rating 1 (Low)	Rating 2 (Moderate)	Rating 3 (Moderate to High)	Rating 4 (High)
All customers will be able to say the following: I maintain an open and transparent relationship with HMRC. I have systems and processes which deliver timely and accurate returns, declarations, payments and claims. I have sufficiently skilled and experienced resources in my tax teams. I only require HMRC assistance on the most complex issues and clearances; I routinely review my tax systems and declarations and, if I identify any errors, I notify HMRC at the earliest opportunity and take appropriate steps to remedy the situation. I have a clear tax strategy which is applied in practice to try and ensure the right tax is paid at the right time. I provide a complete worldwide group structure, if requested to do so by HMRC. I am not involved in tax planning other than that which supports genuine commercial activity and fully disclose the facts to HMRC where there is any uncertainty or disagreement. I am not directly involved with illicit trades and am active in mitigating illicit trades within my supply chain.	*Customers will be able to say one of the following:* I want to get to low-risk and am working towards getting there. There are some aspects of my systems, tax governance or my approach to tax compliance which need to be addressed, but once these are resolved, I would expect to become low risk. I am not particularly concerned about being low-risk and recognise that there are aspects of my systems, my tax governance or my approach to tax compliance which may well prevent me getting there. I am, however, keen to maintain a collaborative, open and transparent working relationship with HMRC and, other than the occasional tax dispute where HMRC and I might disagree about the appropriate tax treatment, I am striving to get all my taxes right.	*Customers will be able to say one or more of the following:* I am sometimes non-cooperative in my approach to tax compliance and/or fail to engage openly and constructively with HMRC, which means I cannot always be relied on to get my taxes right. My systems and processes are not sufficiently robust that I can always be expected to get my taxes right and the amounts of tax potentially at risk are material and significant. I seldom engage in tax avoidance schemes or boundary pushing as a leader, but I regularly position myself as a follower to try and secure tax advantages. I am not directly involved in illicit trades but I am not averse to profiting from them and take little active interest in mitigating illicit trades within my supply chain.	*Customers will be able to say one or more of the following:* I am in the High-Risk Corporates Programme. My non-cooperative approach to tax compliance and/or unwillingness to engage openly and constructively with HMRC means I cannot be relied on to get my taxes right and the amounts of tax potentially at risk are material and significant. My structures and/or systems and processes are so labyrinthine or weak that I cannot be expected to get my taxes right and the amounts of tax potentially at risk are material and significant. My tax strategy makes me an outlier in terms of my approach to tax compliance. I am persistent in using creative tax planning and/or tax avoidance schemes; I regularly push boundaries to try and secure tax advantages. I am directly involved in illicit trades.

Appendix 2: Tax Strategy

1. Introduction

1.1 This document sets out Trust's strategy to organising its tax affairs and management of tax risk.

1.2 This document is published for our Trust for the year ended 31 March 2020, pursuant to Paragraph 16(2) Schedule 16, Finance Act 2016, and is intended to comply with all other obligations within Schedule 16 Finance Act 2016.

2. Approach to tax management

2.1 The Trust is committed to arranging its tax affairs in a transparent, efficient and low risk manner.

2.2 As an entity subject to UK tax law and funded by the UK taxpayer, the Trust has a dual responsibility to comply with tax legislation and guidance and to ensure maximum value-for-money for the taxpayer and service users.

2.3 The Trust's tax strategy seeks to maintain the Trust's reputation as a fair contributor to the UK economic community, applying tax rules in good faith and in the spirit in which they are intended.

2.4 Where appropriate the Trust will structure itself to optimise tax reducing arrangements permitted within the UK tax code doing so in an open and transparent manner aligned to the spirit of tax legislation and guidance. Where necessary, the Trust will take expert advice about the intention and suitability of any proposed arrangements where, to do so, would help the Trust demonstrate its commitment to transparent, efficient and low-risk tax arrangements.

2.5 Where there is doubt about the suitability of a transaction the Trust considers a number of principles before undertaking any transaction which at a minimum will consider:

- Tax advisor's opinion
- Reputational impact
- Financial impact
- Cash impact

3. Governance arrangements

3.1 The Trust's governance arrangements in relation to taxation are intended to ensure robust processes are in place at all levels to manage accurate, timely reporting and to identify, assess, mitigate and monitor risks.

3.2 The Board is ultimately responsible for oversight, tax governance and ensuring that there is an appropriate framework in place in relation to tax and associated risks across the Trust. Detailed scrutiny is to be provided by any committee delegated by the Board. It is expected that this delegated authority will primarily be addressed by the Audit and Risk Governance Committee.

3.3 The Chief Financial Officer is responsible for ensuring that the Trust's approach to tax is clearly communicated and understood. As the senior responsible officer for tax matters, the CFO is responsible for ensuring that there are appropriate and effective controls and processes that are maintained and improved as necessary to ensure compliance tax matters. The CFO is responsible for ensuring that the Board are formally notified of any relevant tax matters in accordance with a defined reporting timetable.

3.4 The Trust is accountable to HMRC and reports to HMRC as required. The Trust is committed to maintaining an open book approach in its relation with HMRC embracing full disclosure and cooperation.

4. Acceptable levels of risk

4.1 In accordance with its robust tax governance and tax risk management approach, the Trust has a low tolerance of tax risk and actively seeks external professional tax advice when required.

4.2 Taxation risks are assessed on the basis of their likelihood of occurrence and their potential financial and non-financial impact in line with the Trust's risk management framework.

4.3 The Trust seeks to fully comply with its all obligations under current legislation, including the Finance Act 2016 and the Criminal Finance Act 2017.

4.4 The low risk environment is maintained by:

- ensuring that there are appropriately qualified and experienced employees within the finance function;
- putting processes and procedures in place that mitigate risk; and
- using external advisors for advice and review.

Appendix 3: Tax Policy

1. Introduction

1.1 This policy is aligned with the Trust's tax strategy and is intended to provide all staff which guidance about how to approach operational issues which relate to the Trust's tax affairs.

2. Purpose

2.1 The Trust is committed to conducting its tax affairs consistent with the following principles:

- Trust seeks to fully comply with its all obligations under current legislation, including the Finance Act 2016 and Criminal Finances Act 2017;
- Ensure that the tax strategy is at all times consistent with the Trust's overall strategic plan, its approach to risk and its values;
- Comply fully with relevant laws, rules, regulations, statutory reporting and disclosure requirements wherever it operates;
- Apply professional diligence and care in the proactive management of risks associated with tax matters, and ensure that governance and assurance procedures are appropriate;
- Foster constructive, professional and transparent relationships with tax authorities, based on principles of integrity and collaboration;
- Ensure that financial affairs are arranged tax efficiently to enable relevant available reliefs, exemptions and incentives, when practical and economical to do so, in order to minimise unnecessary tax exposure in the conduct of its activities, but will not use them for purposes which are knowingly contradictory to the intent of and the spirit of the legislation;
- Trust will not enter into transactions that have a main purpose of gaining a tax advantage or intentionally make interpretations of tax law that are opposed to what is generally accepted to be the original intention or spirit of the legislation; and
- In circumstances where the correct amount of tax amount may not be clearly defined, or where an alternative interpretation or application of tax law might result in different tax outcomes, the risk will be assessed in a controlled manner, applying best judgement to determine the appropriate course of action. This will usually involve seeking advice from external professional advisers in support of our decision-making process.

3. Roles and responsibilities

3.1 The Trust Board delegates the responsibility for managing the Trust's financial activities to the Chief Financial Officer including all areas of taxation.

3.2 The Chief Financial Officer (CFO) has overall responsibility for ensuring compliance with the tax statutes and regulations. The CFO has delegated to the Deputy CFO to oversee this and nominated the Associate Director of Finance (Financial Services) to manage this process.

3.3 The Associate Director of Finance (Financial Services) has day-to day responsibility for managing the tax affairs of the Trust and acts as the main co-ordinator of Trust's internal and external tax advisors.

3.4 The Associate Director of Finance (Financial Services) ensures that:

- the Financial Controller, Head of Financial Accounts and Technical Accountants advise directorates and departments across the Trust to provide advice and guidance as necessary and in a timely manner to ensure compliance;
- the finance function is appropriately qualified, experienced and resourced to meet the organisation's obligations with regards to tax and tax disclosures;
- resources are committed to ongoing continuing professional development and are members of appropriate professional associations;
- appropriate training is undertaken to ensure the finance function remain up-to-date with changes in tax legislation and best practice; and

- the Trust seeks professional advice from suitably qualified external advisors where the tax treatment of specific transactions or other matters is uncertain or requires external consideration and confirmation.

3.5 All employees have a duty to assist the Trust in complying with tax laws and regulations. Any employees acting on behalf of the Trust will notify and/or seek advice from the Financial Controller when fulfilling tasks which may have tax implications.

3.6 This policy applies to all individuals of all levels at the Trust, whether permanent, fixed term, or temporary. It is the responsibility of all of the above to report any concerns they may have concerning tax, any associated risks and issues.

4. Systems and Internal Control

4.1 The Trust adopts standardised internal control systems and procedures across its financial activities, including tax compliance matters.

4.2 Internal control procedures and processes within the Trust's finance function will ensure that information and documents underlying tax returns and submissions are accurate and complete.

4.3 Tax returns and submissions are subject to appropriate levels of internal review prior to their submission. This process is led by the Financial Controller.

4.4 Procedures and controls across the Trust, including those specifically related to tax, are subject to periodic internal audit review, as well as statutory external audit. Management are accountable to the Audit, Risk and Governance Committee with regards to timely and effective resolution of all audit recommendations.

4.5 All tax returns, reports and submissions are signed-off by the Financial Controller after initial review by the Head of Financial Accounts and preparation by the Technical Accountants.

4.6 The Financial Controller manages all communications with HMRC on tax matters

4.7 Significant issues are to be escalated to the Deputy CFO by the Associate Director of Finance (Financial Services). The Deputy CFO will recommend to the CFO when to seek guidance and direction from the Board or Audit, Risk and Governance Committee.

4.8 Tax risks are to be recorded on the Trust risk register and notified to the Director of Corporate Governance.

5. Relationships with tax authorities

5.1 The Trust seeks to have a transparent and constructive relationship with tax authorities wherever it operates around the world.

5.2 All dealings with tax authorities and other regulatory bodies will be conducted professionally, transparently, collaboratively and in a timely manner to ensure that the Trust is able to meet all its statutory and legislative tax requirements.

5.3 In this context the Trust commits to:

- make fair, accurate and timely disclosures as soon as reasonably practical after they are identified;
- minimise the risk of future challenge to any tax positions taken and gain certainty in the Trust's tax affairs by proactively entering into dialogue in real time with regard to issues where the correct treatment is uncertain;
- communicate with relevant authorities in respect of developments which may be subject to interpretation in respect of relevant tax law and guidance; and
- engage with consultations regarding tax developments as appropriate.

6. Monitoring arrangements

6.1 The Trust's compliance with this policy will be periodically assessed by the appointed internal auditor.

6.2 The Audit, Risk and Governance (ARG) Committee will receive progress report on the assessment and on-going review of tax risks in the Trust. The Audit Committee can question and ask further explanation in relation to any aspect of the work done on the managing the Trust's tax risks. The ARG also receives and reviews the reports of the work undertaken by internal audit with respect tax risks review/assessments.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Freedom to Speak Up (FTSU) – 2020 plan	☐ Approval ☒ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 15 January 2020	**Item 14, report no. 10**
Responsible Executive Directors: Nick Ross, Non-executive director Peter Jenkinson, Director of Corporate Governance	**Authors:** Nat Johnson, FTSU Guardian

Summary:

Background

Freedom to Speak Up (FTSU) was established as a national initiative on the recommendation of Sir Robert Francis, whose review highlighted the need for creating a Freedom To Speak Up Guardian at every Trust to support staff in raising concerns. Trusts were tasked to develop a more open and supportive culture that encourages staff to speak up about any issues of patient care, quality or safety. The FTSU Guardian process is subject to CQC review, and so must not merely be effective but seen to be effective.

The key principles behind the FTSU are to:

- promote a culture in the NHS where staff feel safe and encouraged to speak up
- make sure all concerns are heard, investigated properly and the right support is on hand for staff
- protect vulnerable groups, such as student nurses and medical trainees, from intimidation
- prevent discrimination against people who have been brave enough to speak up and help them get back into work

The Freedom To Speak Up (FTSU) service offers advice and support for people wishing to raise concerns. This may be in a confidential or anonymous way, if desired. The service covers all sites and roles in ICHT teams (including domestic, admin and clerical, student, volunteer etc).

Current position

When the FTSU service was first established, the Trust decided to seek part-time volunteers from front-line services rather than professionalise the role, so that the Guardians were staff representatives rather than an arm of management. The principle worked well, with enthusiastic volunteers from each site and including a range of jobs including technical, nursing and consultant. However, it proved difficult for all but the most senior to get time off for the role.

Following the completion of a self-assessment of compliance with FTSU best practice in September 2018, the Trust Board agreed a vision for speaking up and an approach to ensure more robust arrangements, including changes to the service model to enable the FTSU guardians to carry out the full range of the role, according to best practice. The self-assessment also identified the need for increased awareness across the organisation regarding the role of guardians and the support available to staff.

The Trust therefore revised its FTSU strategy, including some changes in structure and resources to enable the delivery of the strategy. The strategic aims included:

- create a culture where all staff feel safe to raise concerns
- enable our leaders to be responsive to concerns and act on these promptly
- celebrate concerns raised and share the learning to improve patient safety

The Trust has made progress in delivering these strategic aims. We have:

- changed the management structure and increased the time allocated to Guardians and the appointment of a 0.5 wte lead Freedom To Speak Up Guardian. All the Guardians now have direct access to the Director of Corporate Governance and to the Chief Executive, and the Trust's approach to the Guardians is now part of the CQC inspection. We have maintained the model of having part-time volunteer Guardians rather than a single full-time Guardian, since that keeps the Guardians closer to the operational staff and provides an good spread of locations, experience and seniority.
- developed links with the People & OD and Medical Directors directorates seeking to ensure collaboration and joint learning from concerns being raised across different mechanisms, and to embed the FTSU service with other existing programmes and initiatives.
- completed specific awareness raising initiatives, including various roadshows as part of the FTSU month in October 2019.

Activity continues to increase. In 2018/19 Guardians managed 48 referrals. During quarters one and two of 2019/20 (October data), 37 concerns were raised with Guardians.

Some key challenges remain to be addressed through the implementation of the strategy and plan, and through linking the FTSU service with other Trust initiatives and collaborating with other directorates, including:

- achieving bandwidth in the Trust to raise awareness.
- linking the work of the Guardians with the culture and values programme to support the continuing work to address issues of bullying and support for staff from management.
- continuing to strengthen existing processes so staff have confidence in those processes and therefore don't feel the need to raise their concerns with the Guardians.
- continuing to support staff who do speak up, and supporting the Guardians in this – under national FTSU guidelines Guardians are effectively conduits for concerns being raised, yet in our experience they sometimes need to provide positive reassurance and support. Support to those who raise concerns is critical, while ensuring this does not conflict with trades union roles and that Guardians can remain impartial.
- strengthening data collection and reporting so key themes can be identified and actioned.

Plan for 2020

The FTSU Guardians, Executive Lead and NED Lead have met to agree the strategy and priorities for 2020 to continue to deliver the strategic aims. A FTSU strategy has been drafted which focuses on the Trust value of *Kindness*. This sets out how the FTSU team aim to raise awareness and effectiveness of the service.

The strategy focuses on:

- ensuring adequate resource for the service to cope with increasing demand, including recruitment of a Guardian based in Charing Cross Hospital and to establish a network of FTSU ambassadors.
- raising awareness of the service by embedding the FTSU service within other existing trust initiatives such as the culture and values work and patient safety programme, as well as other awareness activities.
- continued collaboration with People & OD and the Medical Director's office, to ensure an effective link between the various services. A review of the ICHT Raising Concerns

(Whistleblowing) Policy is in its early stages, which will include guidance from the National Guardians Office.

Projects for 2020 include beginning the use of an in-house tool for collating figures/ themes/ progress of ongoing cases (which is secure and confidential), a rolling programme of information stands across sites, feedback from those who have used the service with specific attention to perceived detriment from speaking up, visiting other Trusts to learn from their best practice, review of other Trusts' resources, attendance at ambassadors/ champions training and working on the priorities from the new drafted strategy.

Recommendations:
The Board is asked to note the priorities for 2020, in order to deliver the FTSU vision.

This report has been discussed at (delete/tick as relevant):
This report will be discussed at the Executive People & OD Committee on 14 January 2019. An update from those discussions will be provided to the Committee on 15 January.

Quality impact:
The report applies to all CQC domains: Safe, Caring, Responsive, Effective and Well-Led.

Financial impact:N/A

Risk impact and Board Assurance Framework (BAF) reference:
The proposed actions to develop the FTSU service contribute towards the control of risks around staff engagement and patient safety.

Workforce impact (including training and education implications):
The purpose of the FTSU vision and strategy is to provide greater support to staff by providing a mechanism to raise concerns and to ensure that any member of staff who raises concerns does not suffer detriment.

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

Has an Equality Impact Assessment been carried out?
☒ Yes ☐ No ☒ Not applicable
The proposals in this strategy do not affect any particular protected characteristic.

Paper 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):
Please use the detail outlined in the Executive Summary.

Freedom to Speak Up
Guardian

Freedom To Speak Up - our 2020 vision

> "*The NHS is blessed with staff who want to do the best for their patients. They want to be able to raise their concerns, free of fear that they may be badly treated when they do so, and confident that effective action will be taken. Everyone in the NHS needs to support staff so they have the courage to do the right thing when they have concerns about patient safety. We need to get away from a culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement. If these things are achieved, the NHS will be a better place to work. Above all, it will be a safer place for patients."*

Background and purpose

Following a number of high-profile failures across the NHS to respond effectively to concerns being raised, a 'Freedom To Speak Up' review was led by Sir Robert Francis. The review highlighted the need for creating a Freedom To Speak Up Guardian at every Trust to support staff in raising concerns. Trusts were tasked to develop a more open and supportive culture that encourages staff to speak up about any issues of patient care, quality or safety.

The purpose of the Principles and Actions from the report were designed to:
• promote a culture in the NHS where staff feel safe and encouraged to speak up
• make sure all concerns are heard, investigated properly and the right support is on hand for staff
• protect vulnerable groups, such as student nurses and medical trainees, from intimidation
• prevent discrimination against people who have been brave enough to speak up and help them get back into work.

10 principles of the role

Published by The National Guardian's Office, Annual Report 2017

Aim

The aim of this strategy is to ensure the Trust actively encourages raising concerns, supports staff when they have a concern they wish to raise, makes speaking up business as usual, promotes effective avenues to raise concerns, and ensure no-one suffers a detriment as a result of doing so. The Trust will provide a service which follows advice from the National Guardian's Office and fully satisfies a CQC Well-Led inspection.

The Trust Freedom To Speak Up service will lead, encourage and support this by actively promoting the Trust value of **kindness** in everything we do.

> *We are considerate and thoughtful so everyone feels valued, respected and included*
> *Kind – a value of Imperial College Healthcare NHS Trust*

Our vision

To create an open and transparent culture throughout the Trust to ensure all our people feel safe and confident to speak up knowing their concerns will be treated with kindness and they will not suffer a detriment for doing so.

Our strategy to deliver

The Trust will take the following actions in 2020 to deliver this vision:

- Recruit a Guardian based on the Charing Cross Hospital site to ensure a balanced representation which allows our people to have convenient access to a Guardian
- Raise awareness with an annual programme of promotion including
    - celebration of existing Trust, National and International events
    - monthly roadshows and walkabouts across the hospital's sites
    - attendance at a wide range of meetings across the Trust
    - targeted awareness sessions for students, volunteers, junior doctors and contracted services
    - target other groups of our people who may be more vulnerable to Speaking Up by working with our staff networks
    - distribution of a range of information/awareness materials across our services
- Engage with the Trust communications team to raise awareness using existing channels within the Trust. This output will be frequent and diverse to reach all our people
- Engage with HR to share information on services where there are concerns then target visits to engage with staff

- Accurately record all cases of concerns being raised to a Guardian, with a system for reporting action, feedback and results in a timely manner. We will use this to identify themes
- Engage with the Values and Behaviours workstreams promoting our service and mutual aims
- Identify confidential, comfortable spaces to meet our people on each main hospital site
- Review existing Speaking Up pathways then publish information for our people on the range of options available to them
- Create a network of champions/ advocates including a diverse range of people, roles and grades to promote the work of Speaking Up
- Review instances where staff perceive a detriment due to Speaking Up. Share these with the Director of Corporate Governance on a quarterly basis to review themes and discuss justice
- Provide appropriate support, training, resources and protected time for our Guardians
- Continue frequent, open communications with the Director of Corporate Governance and Non-Executive Director with responsibility for Speaking Up to review the service and escalate cases of concern.

Reporting and monitoring

We will review anonymised data from those using the service and widely share this, including to the National Guardian's Office. We will benchmark ourselves against other Trusts. We will look at reporting systems the Trust currently uses such as the annual staff survey and friends and family tests. We will internally report on qualitative data, feeding into existing reporting systems. We will review themes quarterly, reporting to the Director of Corporate Governance and Non-Executive Director with responsibility for Speaking Up. These findings will inform our priority aims.

We believe this will allow the delivery of a first-class service, based on kindness, which will improve the working life of staff and the safety of our patients.

> *"Failure to speak up can cost lives."*
> *Sir Robert Francis*

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Learning from Deaths Quarterly report: Q1 & 2 2019/20	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29 January 2020	**Item 15, report no. 11**
Responsible Executive Director: Professor Julian Redhead Medical Director	**Author:** Ian Bateman General Manager, Office of the Medical Director

Summary:

This paper was reviewed at Trust Quality Committee on 15th January 2020 and provides an update to the Board on the Trust's Learning from Deaths (LfD) programme including changes made during this reporting period.

The paper outlines activity undertaken as part of the mandated programme; it further provides information regarding our mortality rate and mortality surveillance activity as a Trust.

This paper sets out the further developments to our learning from deaths processes and our plans to further align our processes as part of the implementation of the medical examiner service. Further, the paper outlines our current performance and activity with regard to mortality and mortality surveillance.

The Trust has a comprehensive learning from deaths process in place, however as we continually strive to improve our processes and our ability to learn from deaths that occur at our hospitals, it is appropriate that we review our processes and make changes and improvements. This paper outlines recent changes that we have made to our learning from deaths processes, and outlines our plans for the future.

The Trust is required to report avoidable deaths on a regular basis to the Trust Board and NHS England and this paper outlines the findings that will be reported in relation to Q1-2 2019/20.

We have put processes in place to ensure that in the future deaths will not be reported as avoidable until senior decision makers have reviewed them.

Recommendations:
The Trust Board is asked to:

- note progress with implementing the actions and recommendations to improve our learning from deaths processes
- note the findings from our mortality surveillance programme in relation to Q1 and 2 2019/20.

This report has been discussed at: NA

Quality impact:
This process supports improved learning from deaths that occur in the Trust, therefore supporting the safe, effective and well-led quality domains.

Financial impact: NA

Risk impact and Board Assurance Framework (BAF) reference: There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the divisional risk register (no. 2439).
Workforce impact (including training and education implications): NA
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? NA
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
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

Imperial College Healthcare NHS Trust

Learning from Deaths Quarterly report: Q1 & 2 2019/20

1. Executive Summary

1.1. This paper was reviewed at Trust Quality Committee on 15th January 2020 and provides an update to the Board on the Trust's Learning from Deaths (LfD) programme including changes made during this reporting period.

1.2. The paper outlines activity undertaken as part of the mandated programme with an updated dashboard as Appendix D; it further provides information regarding our mortality rate and mortality surveillance activity as a Trust.

2. Background

2.1. In March 2017, the National Quality Board published a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care. This included a number of standards and deadlines and gave guidance on the review process and the need to use structured judgment review (SJR) in selected deaths.

2.2. Although we already had an established mortality review process and associated policy, it was necessary to review these in line with new national requirements. We have put in place reporting structures, processes and timelines to ensure we are compliant with all requirements.

2.3. This paper sets out the further developments to our learning from deaths processes and our plans to further align our processes as part of the implementation of the medical examiner service.

3. Mortality data

3.1. The Trust has had a significantly low relative mortality risk when assessed via the Hospital Standardised Mortality Ratio (HSMR) across the last twelve consecutive months and is in a group of two hospitals with the lowest relative risk values for the last year of data - see Appendix A. We have recently seem some variation in our in-month HSMR ranking however, our number of deaths remains consistent. We are reviewing our data with support from the Dr Foster analytics service.

3.2. The Standardised Hospital Mortality Index (SHMI) trend is shown in Appendix A. SHMI tends to follow crude mortality rate trend almost exactly. Our SHMI trend shows that our quarterly readings have been significantly lower than expected for the last three reported financial years. We have the lowest SHMI ratio of all non-specialist providers in England for July 2018 to June 2019.

3.3. Both HSMR and SHMI show our rate of mortality to be significantly, and consistently, lower than that, which is expected for a Trust of our size.

3.4. The Trust receives mortality alerts via the Dr Foster analytics services. These alerts relate to cases where death(s) have occurred that require further investigation, either because there is a possible trend/pattern, or the death(s) is an outlier compared to other organisations. No clinical concerns have been found following review of any alerts received by the Trust.

Imperial College Healthcare NHS Trust

4. Changes to our learning from deaths process

4.1. In order to identify 'avoidable deaths' we have been using Structured Judgement Review (SJR) as our mortality review methodology since 2017. This method was originally proposed by The Royal College of Physicians (RCP) and rated avoidability using a six point scoring tool. This was then used to report to the Trust board and NHSE.

4.2. We have now reviewed the approach taken by other organisations, as well as the RCP revised methodology, and made changes to the SJR process, from 2 December.

4.3. The SJR will now rate care using a five-point Likert scale (1: Very Poor Care – 5: Excellent Care) and where issues are identified the Serious incident (SI) process will then be triggered. This root cause analysis (more in-depth investigation) will then make a decision on the avoidability of the death.

4.4. Making this change ensures that we do not continue a situation whereby an SI and SJR have conflicting findings with regard to the avoidability of a death. SI investigations that are triggered by SJRs are required to make an explicit judgement regarding the avoidability of a death to allow us to continue to report these to the Trust Board and NHS England.

4.5. Appropriate changes are being made to the metrics measured in the Trust Integrated Quality and Performance Report (IQPR) that relate to mortality.

4.6. An additional review panel has been introduced, chaired by the Medical Director and with all Divisional Directors in attendance to review deaths that may be avoidable.

5. Summary of learning from deaths data – Q1 and Q2 2019/20

5.1. There have been 883 deaths in Q1 and Q2 2019/20. A local level 1 review has been completed for 770 deaths. An SJR has been requested for 107 of these deaths (12%); of which 95 have been completed.

5.2. In Q1 and Q2 2019/20 three deaths were identified as being avoidable via the SJR process, these deaths have been reported via the Integrated Quality and Performance Report (IQPR) in Q1 & Q2. Two of these deaths have now been investigated via the SI framework, and discussed at the decision making group where they were categorised as unavoidable. One case remains under investigation. These cases are detailed in Appendix C, highlighted in red. Given that, these cases were not reported to NHS England in the previous update we have removed them as avoidable deaths in the Q1 and Q2 2019/20 NHS England return which is available at Appendix D to this paper.

6. Triggers for SJR review

6.1. The graphs in Appendix D show the triggers for an SJR by type, and the percentage of triggers based on the overall number. It is important to note that some cases have more than one trigger, thus the overall number of triggers (n=125) is higher than the overall number of SJRs completed (n=95).

6.2. The highest number of triggers are from cases that relate to vulnerable groups, where the referral for an SJR is automatic, this was a trigger in 46 (36.8%) SJRs. A review of the outcomes of these cases will be presented to Quality Committee in Q1 2020/21.

6.3. The triggers for SJRs in Q1 and Q2 2019/20 are in line with previous reports.

6.4. We are currently reviewing the triggers for SJRs to ensure that they align to the medical examiner service, and our quality improvement priorities. Any changes to our triggers will not come in to affect until Q1 2020/21 and will be reported to BQC in Q4 2019/20.

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7. Conclusion and Next Steps

7.1. The Trust has a comprehensive learning from deaths process in place, however as we continually strive to improve our processes and our ability to learn from deaths that occur at our hospitals, it is appropriate that we review our processes and make changes and improvements. This paper outlines recent changes that we have made to our learning from deaths processes, and outlines our plans for the future.

7.2. The Trust is required to report avoidable deaths on a regular basis to the Trust Board and NHS England and this paper outlines the findings that will be reported in relation to Q1-2 2019/20.

7.3. We have put processes in place to ensure that in the future deaths will not be reported as avoidable until senior decision makers have reviewed them.

8. Recommendations

8.1. The committee is asked to note progress with implementing the actions and recommendations to improve our learning from deaths processes.

8.2. The committee is asked to note the findings from our mortality surveillance programme in relation to Q1 and 2 2019/20. These findings are being presented to the committee for noting ahead of submission to NHS England.

Ian Bateman, General Manager - Office of the Medical Director

8 January 2020

Appendices:

Appendix A - Dr Foster Mortality Data – HSMR and SHMI
Appendix B - Learning from Deaths Data – Q1 and Q2 2019/20
Appendix C - Triggers for SJR – Q1 and Q2 2019/20
Appendix D - Q1 & Q2 NHSE Learning from Deaths Dashboard

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APPENDIX A – DR FOSTER MORTALITY DATA – HSMR AND SHMI

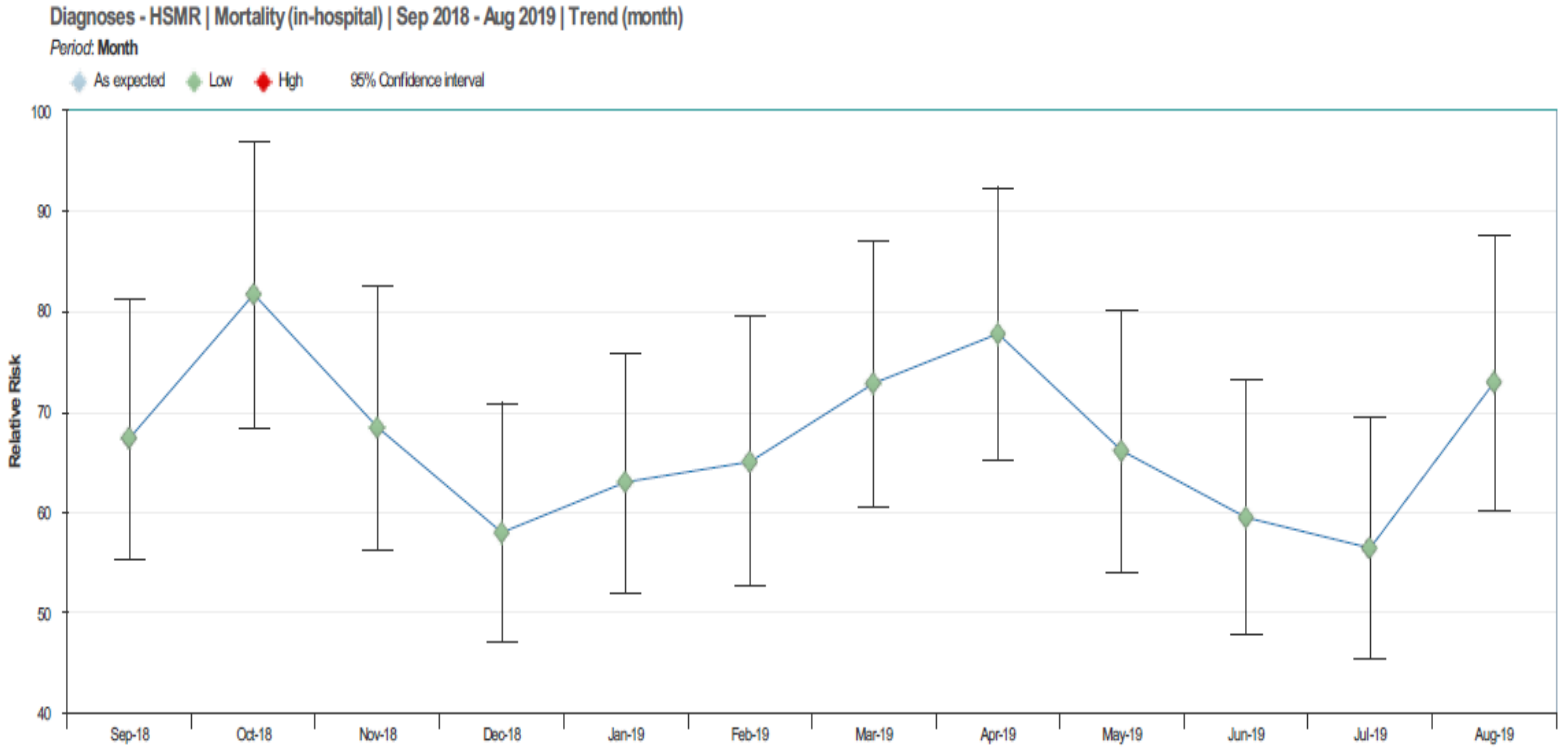

Figure 1 – HSMR trend by month from March 2018 to August 2019

Imperial College Healthcare NHS Trust

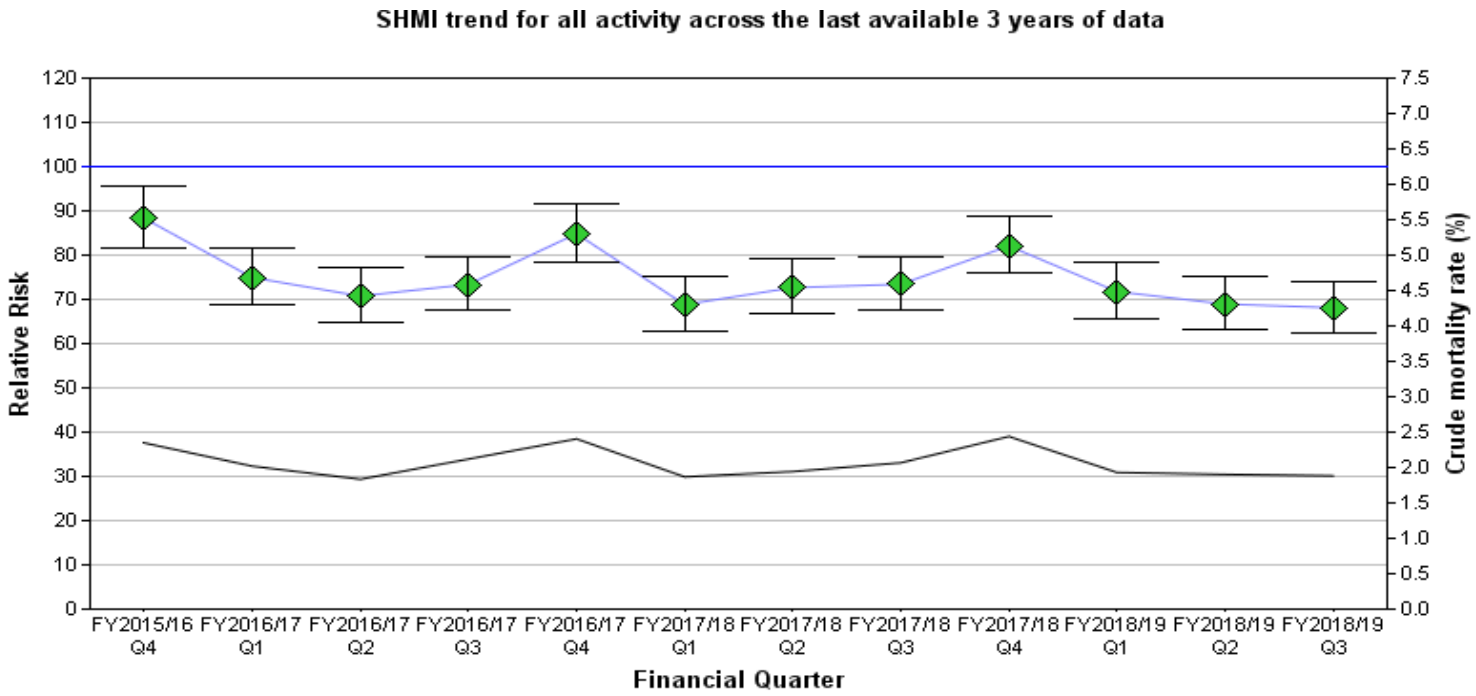

Figure 2 – SHMI trend from Q4 2015/16 to Q3 2018/19

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APPENDIX B – LEARNING FROM DEATHS DATA Q1 AND Q2 2019/20

Trust Total	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
Total Deaths	175	138	128	119	160	162							**883**
No. Level 1 Reviews Completed	166	134	120	109	128	133							**770**
% Level 1 Reviews Completed	94.9%	97.1%	93.8%	91.6%	80.0%	82.1%							**87.2%**
No. of SJRs Requested	16	28	20	18	20	5							**107**
No. of SJRs Completed	16	26	20	17	14	4							**95**
% SJRs Completed	100.0%	92.9%	100.0%	94.4%	70.0%	80.0%							**89%**
No. of Avoidable Deaths reported via SJR (Score 1-3)	2	0	1	0	0	0							**3**
No. of Avoidable Deaths confirmed via senior decision maker review	**0**	**0**	**0**	**0**	**0**	**0**							**0**

Imperial College Healthcare NHS Trust

APPENDIX C – TRIGGERS FOR SJR – Q1 AND Q2 2019/20

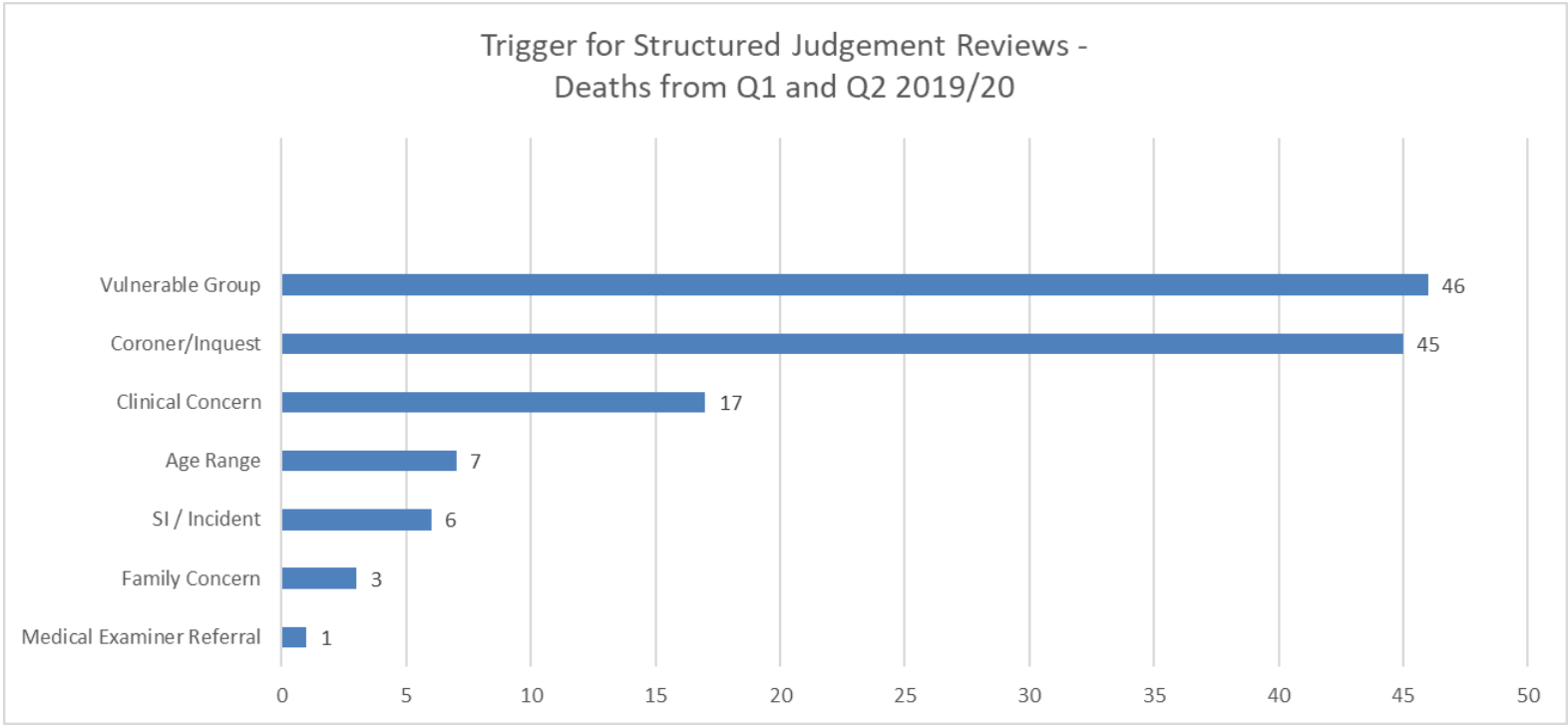


Figure 3 – SJR triggers by number Q1 – 2 2019/20

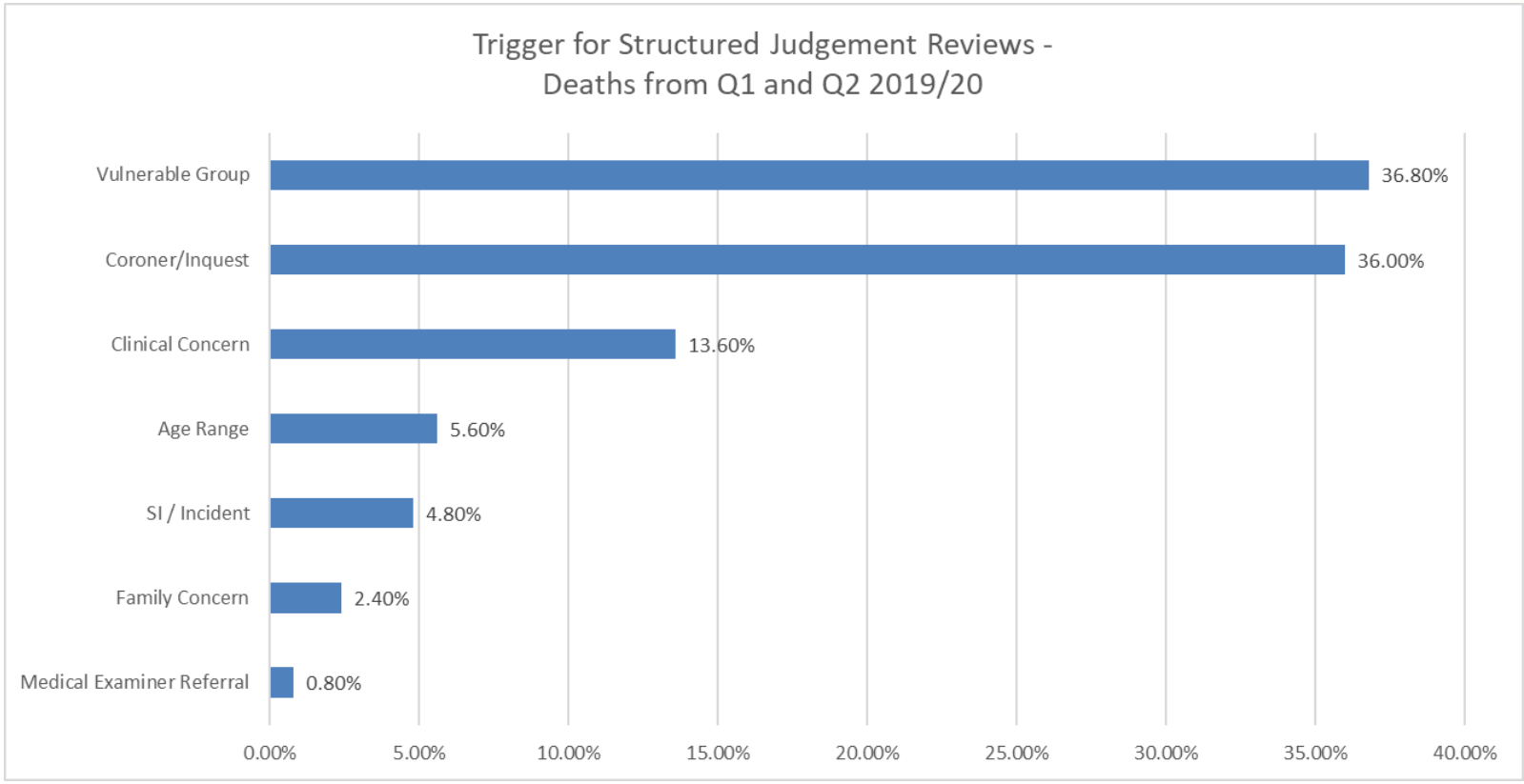


Figure 4 – SJR triggers by percentage Q1 – 2 2019/20

Imperial College Healthcare NHS Trust

APPENDIX D - Q1 & Q2 NHSE LEARNING FROM DEATHS DASHBOARD

Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - September 2019-20

Department of Health

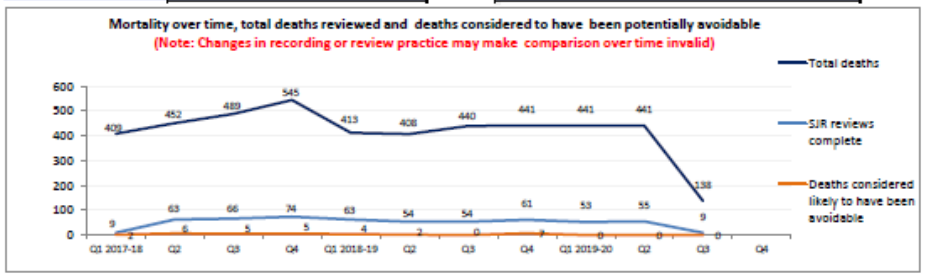
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
162	160	21	20	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
441	441	55	53	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
882	1702	108	232	0	13

Time Series: Start date 2017-18 Q1 — End date 2019-20 Q3



Total Deaths Reviewed by RCP Methodology Score

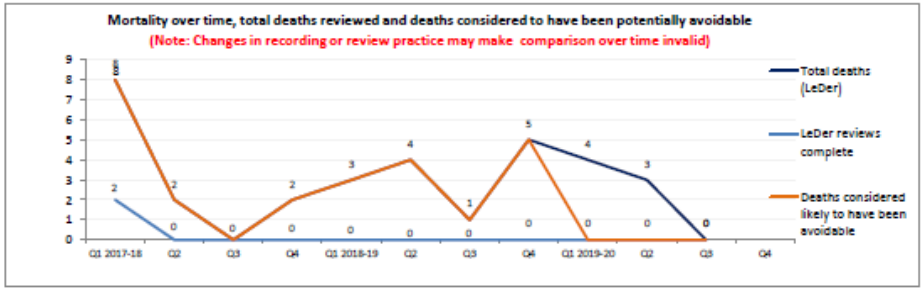
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	6.3%	This Month	15	93.8%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	3	7.3%	This Quarter (QTD)	3	7.3%	This Quarter (QTD)	35	85.4%
This Year (FYTD)	0	0.0%	This Year (FYTD)	0	0.0%	This Year (FYTD)	1	1.1%	This Year (FYTD)	7	7.5%	This Year (FYTD)	14	15.1%	This Year (FYTD)	71	76.3%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
0	13	0	0	0	13

Time Series: Start date 2017-18 Q1 — End date 2019-20 Q3



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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Mid-year update on safe, sustainable and productive nursing and midwifery staffing	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29 January 2020	**Item 16, report no. 12**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Sinead O'Neill, Senior Nurse Regulation & Revalidation

Summary:
This report provides a summary of the Trust's work to deliver safe and sustainable nursing & midwifery (N&M) care.

The future supply of the nursing and midwifery workforce is a well-documented challenge for many NHS Trusts in England. Since May 2018, the Imperial 'strategic supply of nursing' business case outlined the number of key initiatives that are being undertaken in light of the national nursing staffing landscape.

The Trust has developed a set of schemes to help mitigate the impact of the skills shortages. This includes a range of actions to grow and develop its nursing workforce, including the introduction of the nursing associate role, apprenticeships in nursing and overseas recruitment.

It is recommended that twice a year establishment reviews are undertaken and reported to the Trust Board. A mid-year establishment review was undertaken in November 2019. Overall, there has been an actual increase of 40.29 Whole Time Equivalents (WTE) in the nursing and midwifery establishment when compared with the data from the previous establishment review undertaken in March 2019.

Recommendations:
The Trust Board is asked to note the report and the findings from the mid-year establishment review.

This report has been discussed at:
Quality Committee, 15th January 2020

Quality impact:
Ensuring that the right nursing and care staff are place to respond to patient's needs positively impacts the 'Safe', 'Caring' and 'Well-led' CQC domains.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
- Has no financial impact OR Has been reviewed and signed off by (insert name of finance business partner or similar) AND

Risk impact and Board Assurance Framework (BAF) reference:
Corporate risks:

2944 - Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas
Workforce impact (including training and education implications): The aim is to ensure optimum N&M staffing levels, the ways in which this is being done is discussed in the report
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
How have patients, the public and/or the community been involved in this project and what changes were made as a result? N/A
What impact will this have on the wider health economy, patients and the public? Ensuring optimum safe staffing levels will have a direct effect on the quality of patient care.
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 the details can be shared, please provide the following in one to two line bullet points: ▪ What should senior managers know? A number of sustainable, productive and safe nursing and midwifery staffing initiatives are underway at the Trust. A mid-year establishment review of nursing and midwifery has taken place. ▪ What (if anything) do you want senior managers to do? For noting only ▪ Contact details or email address of lead and/or web links for further information (maximum one bullet point) – sinead.o'neill1@nhs.net

Mid-year update on safe, sustainable and productive nursing and midwifery staffing

1. Purpose

This report provides a summary of the Trust's work to deliver safe and sustainable nursing and midwifery (N&M) care.

2. National and Local Context

England continues to experience a national shortage of nurses, being almost 44,000 in the first quarter of 2019/20. This is equivalent to 12% of the N&M workforce; similar to ICHT which has a N&M vacancy of 13%. The future supply of the N&M workforce is a well-documented challenge for many NHS Trusts at this time.

To help fill these vacancies the Trust has embarked on a number of actions. These include apprenticeship opportunities, overseas recruitment, staff retention, providing more training placements and the development of the nursing associate role. A 'strategic supply of nursing' business case was approved in May 2018, which outlines a set of schemes to help mitigate the impact of the anticipated nursing shortages.

The government has recently announced a return of the £5000 p.a. bursary to support people doing nurse training; this will commence from the next academic year.

3. Apprenticeships and New Roles

The Trust currently has 28 of its own staff on a Registered Nurse Degree Apprenticeship programme with a further 20 of its healthcare support workers, who have expressed interest in this programme, to commence later in 2020.

The Nursing Associate is a registered role regulated by the Nursing and Midwifery Council (NMC). At the Trust, there are currently 12 qualified Nursing Associates in post with a further 19 on the apprenticeship programme for Nursing Associates.

Both of Registered Nurse Degree and the Nursing Associate apprenticeship programmes of training are very popular in the organisation, allowing the opportunity to retain staff locally.

4. Overseas Recruitment

The Trust has been successfully recruiting overseas. The aim is to recruit 390 international nurses between 2018 –2023. To date 116 nurses have been recruited since 2018. A further trip to the Philippines took place in December 2019, where 139 offers of employment were made. The next overseas recruitment campaign is due to take place in February 2020.

5. Retention

In addition to the 'strategic supply of nursing' action plan, there has been a focus on retaining more of nurses, with a particular emphasis on supporting students nurses to transition into staff nurses jobs Continuous professional practice development (CPPD) monies have been

allocated to support educational requirements and to develop N&M leadership programmes such as the *Springboard* programme.

These initiatives have resulted in 85% of student nurses on placement at ICHT being recruited into substantive registered nurse positions. 90% of N&M staff who attended the *Springboard* leadership programme remained in the trust for at least a year following its completion.

6. Review of Trust's Safe Staffing Approach

Having been made aware by the Care Quality Commission (CQC) of whistleblowing concerns relating to safe staffing levels, the Trust has commissioned internal auditors to review the safe staffing process within the inpatient areas. This is due for completion within the coming weeks. We have also undertaken a number of other actions, for example Freedom to Speak Up Guardian sessions, senior nurse out of hours walkabouts and a review of how we report actual versus planned staffing requirements. We are working to implement a red flag system whose definition will be based on staff's perceptions of safe N&M staffing.

As part of reviewing the safe staffing approaches, the inpatient ward areas are undertaking a roster review to ensure they are accurate and are able to meet the necessary safe staffing numbers.

A monthly safe staffing meeting is held and chaired by the Director of Nursing and the Trust continues to publish the monthly staffing levels per ward.

7. Mid-year N&M Establishment Review

The Trust undertakes an annual and mid-year nursing and midwifery establishment review, to provide assurance both internally and externally that ward staffing is safe and that staff are able to provide appropriate levels of care to our patients. The mid-year nursing and midwifery establishment review follows the annual review which was undertaken in March 2019. The mid-year review was undertaken in November 2019 using workforce data from September 2019. The results of this are shown in table 1below.

Overall, there has been an actual increase of 40.29 whole time equivalents (WTE) in the nursing and midwifery establishment when compared with the establishment review undertaken in March 2019. In the Division of Surgery, Cancer and Cardiovascular Science, Operating Department Practitioner (OPD) posts were recoded and removed from the nursing establishment and moved into the Allied Healthcare Professional (AHP). This equated to a decrease of 57.40 WTE of non-nursing posts, with an actual decrease of 13.68 of nursing posts within this same division, hence the two figures displayed for this division within table 1 below.

An overall breakdown of the data by division and the ratio for registered (RN) and unregistered care staff (CS) can also be found within table 1. NHS England does not provide a recommended ratio of RN to CS, but the ICHT overall levels of 78% to 22% are in keeping with Shelford group trusts. The Royal College of Nursing did a limited study of smaller trusts and found a ratio of around 65% to 35%. This is the lowest ratio that ICHT would accept and if wards predict that this might happen they must submit a formal request to make such an exception.

An annual establishment review will take place in March 2020 aligned to business planning and the outputs reported to the Trust Board in July 2020.

8. Recommendations

The Board is asked to note the work the Trust is undertaking to deliver safe and sustainable N&M care and the latest mid-year review results.

Table 1: Summary of mid-year establishment review

Clincial Division	Total registered nurse and unregistered care staff WTE March 2019	Total registered nurse and unregistered care staff WTE September 2019	WTE Change to establishment September 2019 to March 2019	September 2019 Registered nurse (RN) to unregistered care staff (CS) ratio	
				RN	CS
Women's children's and clinical support	889.07	894.81	5.74	77%	23%
Surgery, Cancer and Cardiovascular sciences	1,620.51	1,549.43	(-71.08) Actual -13.68	82%	18%
Medicine and Integrated care	1,671.40	1,718.03	46.63	73%	27%
Imperial Private Healthcare	196.78	198.38	1.6	79%	21%
Nursing & Midwifery total	4,377.76	4,360.65	(-17.11) Actual + 40.29	78%	22%

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Pathway to Excellence ®	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 29th January 2020	**Item 17, report no. 13**
Responsible Executive Director: Professor Janice Sigsworth Director of Nursing	**Author:** Michael Underwood Pathway to Excellence ® Facilitator Lead

Summary:
Imperial College Healthcare Trust has been selected as one of fourteen Trusts (England) to participate in the Pathway to Excellence® programme, which is a programme to promote nursing & midwifery (N&M's) excellence seeking to create a positive practice environment for N&M's staff that improves satisfaction and retention.

The programme is closely aligned to the Trust's values and behaviours and will support the establishment of a leadership model that focuses on continuous improvement.

This paper provides detail of the programme structure and benefits to ICHT.

Recommendations:
The Board is asked to note the overview of the 'Pathway to Excellence ®' programme and the benefits for ICHT.

This report has been discussed at:
Executive Quality Committee

Quality impact:
This paper supports the CQC domains of safe, caring, responsive, effective and well-led.

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

- The Trust has agreed to match the funding being provided by NHSE (£100K / 2 years);
- In addition, there is likely to be cost for material and conference attendance of a further £50K (support for this from Health Education England).

Risk impact and Board Assurance Framework (BAF) reference:
A risk register is in development.

Workforce impact (including training and education implications):

- Improvement in nurse satisfaction
- Retaining choice nursing staff & leaders
- Improved inter-professional teamwork
- Championing high-quality nursing practice
- Supporting business growth

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
How have patients, the public and/or the community been involved in this project and what changes were made as a result? National Project
What impact will this have on the wider health economy, patients and the public? Evidence from Pathway to Excellence ® organisations suggests that care quality indicators improve.
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?..... Should senior managers share this information with their own teams? ☒ Yes ☐ No

Pathway to Excellence ®

1. Executive Summary

1.1. Imperial College Healthcare Trust (ICHT) has been selected as one of fourteen Trusts (England) to participate in the Pathway to Excellence® programme. A programme to promote nursing & midwifery (N&M's) excellence, seeking to create a positive practice environment for N&M's staff to improve satisfaction and retention. The programme is closely aligned to the Trust's values and behaviours and will support the establishment of a leadership model that focuses on continuous improvement.

1.2. Globally, organisations who have achieved accreditation report the following benefits:

- Improvement in N&M's satisfaction
- Retaining choice N&M's staff and leaders
- Improved inter-professional teamwork
- Championing high-quality N&M's practice
- Supporting business growth
- Improved patient care and experience outcome

2. Purpose

2.1. The purpose of this paper is to provide the Trust Board with an overview of the 'Pathway to Excellence ®' programme and the benefits for ICHT.

3. Background

3.1. Pathway to Excellence ® is an N&M's excellence framework that aims to create a positive practice environment for N&M staff. Evidence suggests that when an organisation achieves accreditation there are visible improvements in N&M's satisfaction and retention as well as other quality indicators.

3.2. Northampton General Hospital (NGH) achieved Pathway to Excellence® accreditation in 2016. NGH have seen many of the described benefits since achieving accreditation. Nottingham University Hospital (NUH) are currently applying for Magnet ® accreditation – an accreditation that has components as well as standards. https://www.nursingworld.org/organizational-programs/magnet/magnet-model/

4. Pathway to Excellence ® Standards

4.1. The programme involves a self-assessment against a set of standards, gap analysis and a development plan. To achieve successful accreditation, organisations must meet six Pathway Practice Standards essential to an ideal N&M's practice environment. These are:

- **Shared Decision Making** – The organisation has an established shared governance structure as the foundation for involving direct care N&M's in decision-making. This means launching councils across the organisation that involve staff at all levels and enables them to have the opportunity to contribute to decisions making.

- **Leadership** – Leadership fosters the foundation of collaboration among staff and supports a shared governance environment. This means a review leadership training at all levels to demonstrate a commitment to preparing all staff to be leaders. Through the gap analysis and through work already underway areas for improvement will be easily identifiable.

- **Quality** – Organisation-wide quality initiatives are evidence-based, focused on improving patient outcomes, developed through inter-professional collaboration, and implemented based on internal and external benchmarking.

- **Safety** – The organisation protects the safety and well-being of N&M's, staff, and patients through safety policies and processes. This means ensuring all N&M's staff have the opportunity to speak up if the safety or well-being of N&M's is compromised. Shared decision-making councils will help to ensure policies and procedures meet staff needs.

- **Well-being** – Staff have the opportunity to develop a balance between work and personal life. Achievements for community service, patient advocacy, and contributions to improving population health are encouraged, supported and recognised by the organisation. This means ensuring staff are able to contribute to the development of the well-being strategy, though the council structure. The great work already undertaken in the areas described will be recognised and supported.

- **Professional Development** – The organisation recognises the importance of staff orientation, collaboration, and professional development in the delivery of safe and effective patient care. Embarking on this pathway coincides with the announcement of additional funds for education for nursing and midwifery. Through the council process, we will ensure that the monies are distributed in a way, which supports N&M's and is transparent and fair.

More details can be found at **Appendix 1**.

Some of the requirements and evidence required to meet the standards are already in place and include:

- Ward accreditation programme (WAP);
- The Black, Asian and Minority Ethnic (BAME) and Lesbian, Gay, Bisexual and Transgender (LGBT) networks are well developed and provide great examples of collective leadership;

- The N&M's Professional Practice Committee provides a forum for direct care nurses to influence strategic decision-making and participate in professional discussions;
- Divisions run back to the floor Thursday programmes which exemplify the principle of shared governance and collective leadership;
- The 'Making a Difference' award scheme provides an opportunity to reward and recognise N&M's. Other Trusts who have undergone this process have award events at regular intervals where the success of N&M's is celebrated. Other examples include an N&M's of the Year award and 'tea with the director' opportunities.
- The N&M's Springboard leadership programme, the preceptorship programme and the success ICHT student nurse recruitment programme are also good examples of how recognising and supporting our N&M's workforce.

We are currently developing a plan with timed milestones to deliver Pathway to Excellence ®. We are likely to submit our application in late 2020 / early 2021.

5. Key Points

5.1. Imperial College Healthcare NHS Trust is the largest Trust (England) to be enrolled into the Pathway to Excellence ® programe. Other London Trust's include Homerton University Hospital & Moorfield's Eye Hospital. ICHT is working collaboratively with NGH and NUH throughout the programme to ensure effective communication and relevant lessons learnt.

Michael Underwood
Pathway to Excellence ® Facilitator Lead
January 2020

Appendix 1: Shared Decision Making information sheet

Shared Decision Making at Imperial
Pathway to Excellence®

Janice Sigsworth, Chief Nurse

Imperial College Healthcare Trust has been selected as one of fourteen Trusts (England) to participate in the Pathway to Excellence® that promotes nursing and midwifery excellence. The programme seeks to create a positive practice environment where nurses and midwives excel and satisfaction and retention are improved. Through this programme, we want to improve the work environment, raise staff morale, and give nurses a stronger voice through culture change and transformation.

To achieve the Pathway award we have to provide evidence that demonstrates how we meet six practice standards essential to an ideal nursing practice environment:

- Leadership
- Shared decision-making
- Quality
- Safety
- Well-being
- Professional development

As a key part of this programme, we want our key front line nursing and midwifery employees working together in shared decision-making councils to discuss opportunities for process and quality improvement in patient care and staff well-being. Through these councils, we can develop ways to improve continually. You or your colleagues (including Health Care support workers) can chair councils. We will provide training and support to get things going and ensure your councils run effectively.

We have appointed a senior nurse to lead this programme: **Michael Underwood**

If you would like to get involved or want more information, please email him at michael.underwood@nhs.net

The pathway is a two-year programme. Before we apply, we need to assess where we are using a gap analysis tool and then set up a programme of work address those gaps. We will also get our shared decision-making programme going. We aim to complete the online application next August when this work is completed and we are confident that we can meet the practice standards at the end two years.

The programme is American in origin but several European hospitals have achieved the standard and received the recognition award. Northampton General is the first UK Trust to be Pathway to Excellence® accredited. As part of their Pathway to Excellence®, they have developed a Nursing Strategy that reflects the key principles and empowers teams of front line staff to take responsibility and accountability for shaping change. Do visit their website to see more about this.

There are some good videos on line, which tell you more about the programme:

https://youtu.be/Qf-6T5JcPG8

https://www.youtube.com/watch?time_continue=24&v=Qf-6T5JcPG8&feature=emb_logo

In order to measure whether we have achieved the standards, all of nursing and midwifery workforce are surveyed at the end of two years. A 60% response rate is required and 75% of these are required to respond positively to say they have felt the culture change the programme is designed to deliver – no tick box exercise!

The programme is an important part of our National Chief Nurse's (Ruth May) vision for enabling nursing and midwifery excellence and giving us a powerful voice in shaping our services.

The current climate for nursing in particular is very challenging. As nurses and midwives we are the largest workforce and key to keeping the hospitals running and our patients safe and well cared for.

Our own chief nurse, Janice Sigsworth, is committed to delivering this programme and giving you the opportunity to be heard and to be part of decision making at all levels.

Look out for lots more information and opportunities to get involved – this will be exciting!

Feel the force!

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee **–** report from meeting on 4 December 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 January 2020	**Item 18.1, report no. 14a**
Responsible Non-Executive Director: Sir Gerald Acher, Deputy Chair	**Author:** Jessica Hargreaves, Deputy Trust Secretary

Summary:

The Audit, Risk and Governance Committee met on 4 December 2019. Key items to note from that meeting include:

External Audit
The Committee received and noted the external audit plan for 2019/20 and noted the significant audit risks related to the financial statements which were consistent with the risks identified in the previous year.

Internal audit progress report
Committee members noted the internal audit progress report and were pleased to note that the Trust was in a really good place to deliver the 2019/20 audit plan. The Committee noted the outcome of the North West London Pathology and Non-emergency patient transport audits and the action plans and next steps.

Local Counter Fraud Service (LCFS)
The Committee received the counter fraud update noting the proactive work taking place. In terms of reactive work, eight fraud referrals were carried forward from 2018/19, of which seven had been closed in the period to December 2019. Thirteen new referrals were received to date from the Trust and outside sources nine of these had been closed in the period to December 2019. Committee members also received the national fraud initiative (NFI) update and noted that the 2018/19 NFI exercise had identified 823 high priority matches for the Trust from a total of 6,612 potential matches. 487 matches had been investigated and cleared to date and a further 114 matches were under active investigation. No fraud had yet been confirmed although six potential errors were being evaluated.

Corporate risk register, key risks and board assurance framework
The Committee noted the corporate risk register, key risks and board assurance framework. It was highlighted that with launch of the 'Imperial Way' the board assurance framework had been re-aligned to the 3 year strategic objectives and had also been aligned to a responsible Board Committee that would review the relevant risks twice per year prior to the full document being presented to the Audit, Risk & Governance Committee and the Trust Board.

Raising concerns update
Committee members received the raising concerns update and noted that in the period under review, there had been no new disclosures logged. Since the work to increase the profile of the freedom to speak up guardians (FTSU) the cases raised to the employee relations team had slowly reduced. This, along with cases being raised directly to CQC which were reported separately, was likely to explain the reduction in cases being reported to the employee relations team. The Committee noted

that the FTSU guardians were required to report their case information to the national guardian's office and as part of moving the service into the Chief Executive's Office, consideration would be given to reporting concerns raised through different routes into a central point with consolidated reporting.

Capacity management
The Committee noted the updates to the actions from the internal audit into capacity management and were pleased to note that all actions had been completed.

HMRC business risk review
Committee members noted that HMRC would be visiting the Trust in February 2020 to carry out a review of the Trust's arrangements for managing and disclosing its compliance with UK tax regime. The review would be undertaken using HMRC's new risk-based approach risk review plus (BBR+) approach and is broadly expected to cover organisational approaches and behaviour across three distinct areas; systems and delivery; internal governance; and approach to tax compliance. The outcome of the review would mean that the Trust would be classified against one of four ratings: low, moderate, moderate-high and high. Committee members reflected that as one of the first NHS entities to be subject to this assessment, it was difficult to be certain how the organisation would be assessed but Committee members sought assurance from the Trusts internal processes from annual VAT reviews, internal audit work on key financial systems and other specific audits such as IR35 as well as the adoption of the nationally mandated systems such as the staff payroll system. It was agreed that a further update on preparation for this visit would be presented to the Trust board in January 2020.

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.

The Committee will next meet on Wednesday 4 March 2020.

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 15 January 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 January 2020	**Item 18.2, report no. 14b**
Responsible Non-Executive Director: Professor Andy Bush, Non-Executive Director (Committee Chair)	**Author:** Amrit Panesar, Corporate Governance Assistant

Summary:

The Quality Committee met on 15 January 2020. 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 data from October showed that 90.5% of patients received antibiotics within 1 hour of confirmed sepsis, above the 90% target. Last month, the Trust reported the highest number of hospital acquired pressure ulcers in 12 months. Committee members discussed the increased number of pressure ulcers reported and the Director of Nursing confirmed that a deep dive investigation would be undertaken and findings would be reported back to the Committee in March 2020.

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.

Incident Monitoring Report
Committee members were pleased to note continuing improvement in the number of incidents reported which was a positive reflection of the recent work to encourage all divisions to report incidents. The overall harm profile remained good, with some of the lowest mortality rates in the country. There were still overdue Serious Incident (SI) investigations, it was anticipated that the new process that had been introduced would help address 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 a never event had recently been reported, emphasising the need for the HOTT programme to continue and be supported.

Implementation of the Medical Examiner Service
The Committee received an update on the implementation of the Medical Examiner Service and noted that the Trust had made very good and significant progress with this programme of work, and was on track to have an operational service in place by April 2020. The Committee noted that the avowed external aim of the process was to prevent another Shipman, but that without overall figures, merely reviewing isolated deaths would be highly unlikely to achieve this

Flu update
Committee members received an assurance report on progress with the Trust's 2019/20 flu campaign and noted the actions taken to maximise the uptake of the vaccine and the decision to extend the campaign until January 2020. The Committee welcomed the progress made by the Trust since the last meeting, noting that 62% of frontline staff had received the vaccination, and our figures were our best ever.

Learning from Deaths Quarterly Report
The Committee received an update on the progress since the last report to the Committee. The Committee noted the key points regarding progress made with implementing actions to improve the learning from deaths process, and noted the findings from the mortality surveillance programme in relation to Q1&2 2019/20.

CQC Update
The Committee received an update on CQC activity noting that the CQC had asked the Trust to investigate one complaint. The Trust's investigation did not substantiate the complaint; the response to the complainant had been issued and shared with the CQC. Committee members noted that a programme of mock CQC inspections was being organised to take place during February and March 2020.

Pathway to Excellence Progress report
The Committee received an update on the Pathway to Excellence Progress report noting the new appointment of a facilitator for this programme. The programme had been launched by the Director of Nursing at the Nursing and Midwifery conference and received positive feedback from attendees. Committee members noted that good progress has been made in building resource to support the Trust's successful accreditation.

Improvement Team Update
The Committee noted the report which provided an update on progress being made against the key priorities of the core programme of the Improvement Team. The Committee noted that the team had developed a dosing model called the Improvement Competency model, to provide a structured framework that sought to ensure all colleagues in the organisation had access to the right improvement education for the knowledge, skills and behaviours they need to be successful in their role. The Committee highlighted the importance of translating the excellent processes into tangible benefits that would be obvious to patients.

Freedom to Speak up 2020 Plan
The Committee received the Freedom to speak up (FTSU) 2020 plan and noted the key priorities for 2020, in order to deliver the freedom to speak up vision. The Committee noted and welcomed the progress made in delivering the strategy, including some changes in structure and resources to enable the delivery of the strategy, but noted ongoing challenges including increasing awareness across the Trust, the need to develop the skills of middle management and the need to clarify the role of Guardians in ongoing cases. The Committee proposed that we should monitor the success of our FTSU processes against the number of external anonymous complaints, both in our own and other Trusts

Mid-year update on safe, sustainable and Productive Nursing and Midwifery Staffing
The Committee received the Mid-year update on safe, sustainable and productive nursing and midwifery staffing and noted the findings from the review.

Overview of 2020 International year of the Nurse and Midwife
The Committee noted the overview of the 2020 International Year of the Nurse and Midwife. The Director of Nursing highlighted that individual Trusts were encouraged to undertake activities that celebrate 2020 and presented the draft programme of possible events at the Trust.

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 22 January 2020	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 29 January 2020	**Item number 18.3 , report no. 14c**
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 22 January 2020. Key items to note from that meeting include:

Financial performance including CIP performance and recovery plan
Committee members noted the finance report for month 9, with the Trust being on plan year to date using nonrecurrent measures. The focus in quarter 4 would be to reach the outturn position and divisions continued to work hard to close their CIP gaps. Challenging discussions regarding overperformance income with the CCGs and NHSE, continued. It was agreed that sector collaboration for discussions around increased demand (overperformance) with the CCGs going forward, would be helpful and was necessary in terms of agreeing a realistic , deliverable plan for the Trust.

Capital programme review
Committee members noted progress with the capital programme and were pleased to note that the Trust was on plan to deliver the plan by year end.

2020/21 IPH business plan update
The Committee noted the business plan update for Imperial Private Healthcare and were pleased to note that engagement with IPH across the Trust had greatly improved and there continued to be work to ensure that staff across the organisation were aware of the benefits from private care, particularly that revenue from private care went back into the Trust. Key risks to the delivery of the plan were around the capacity for increased demand as well as the continuing estates issues. A further update on the longer term strategy for IPH would be presented to the Committee in March 2020.

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.

North West London Pathology (NWLP) financial performance
Committee members reviewed the financial performance of NWLP for month 8, noting that the service expected to have delivered the transformation plan by the summer 2020. Committee members were pleased to note the positive feedback regarding the new governance structure, noting that the increased support had seen improved communication and better visibility across the management teams.

Update on transformation plan including specialty review programme update

The Committee noted the progress against the transformation plan and the speciality review programme, particularly the key milestones refresh. It was agreed that the Committee would receive further detail on how the transformation programme would contribute to the CIP plan for next year.

Business planning process
The Committee noted that the business planning process continued and feedback on the new process used this year had been very positive. Next steps would include prioritising programmes whilst focusing on CIPs. Committee members discussed the importance of putting forward realistic recovery plans with the sector in terms of continued increased demand on services; work on a 5 year plan was in progress using sector based activity assumptions.

Responsiveness scorecard
The Committee reviewed the responsiveness section of the performance scorecard. It was agreed to review the scorecard/operational information which should be provided to FIOC to align with the Terms of Reference.

Recommendations:
To note this summary.