Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC

27 September 2017

11.30– 13.00

		Presenter	Timing	
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Chairman	11.30	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 26 July 2017	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 26 July 17	Chairman		2
1.5	Action Log and matters arising	Chairman		3
1.6	Board committee terms of reference annual review	Trust company secretary		4
1.7	2017/18 Board committee meeting schedule	Trust company secretary		5
2	**Operational items**			
2.1	Patient story	Director of nursing	11:40	6
2.2	Chief Executive Officer's report	Chief executive		7
2.3	Integrated performance report	Safe/effective: Medical director Caring: Director of nursing Well-led: Director of P&OD Responsive: DD Medicine & Int care DD surgery, cancer & CV DD Women's, chil'n & CS		8
2.4	Month 5 Finance report	Chief finance officer		9
3	**Items for decision or approval**			
3.1	Nursing and Midwifery annual establishment review and safe staffing update 2017/18	Director of nursing	12:20	10
3.2	Annual workforce equality report 2016/17	Director of people & organisational development		11
3.3	Hammersmith & Fulham Integrated Care Partnership	Integrated care programme director		12
4	**Items for discussion**			
4.1	CQC update	Director of nursing	12:40	13
5	**Items for information**			
5.1	Board assurance framework	Trust company secretary	12:45	14
5.2	Postgraduate Medical Education: Report on the results of the General Medical Council National Training Survey 2017	Medical director		15
6	**Board committee reports**			
6.1	Finance and investment committee	Committee chair	12:50	16
6.2	Redevelopment committee	Committee chair		17
6.3	Quality Committee	Committee chair		18
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
9	**Date of next meeting**			
	Public Trust board: Wednesday 29 November 2017, Oak Suite, W12, Hammersmith Hospital			

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 26 July 2017
11.15 – 13.00
New Boardroom, Charing Cross Hospital

Present:	
Sir Gerry Acher	Deputy chairman
Sarika Patel	Non-executive director
Peter Goldsbrough	Non-executive director
Prof Andy Bush	Non-executive director
Victoria Russell	Non-executive director
Nick Ross	Designate non-executive director
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Dr Julian Redhead	Medical director
Prof Janice Sigsworth	Director of nursing
Prof Tim Orchard	Divisional director, medicine & integrated care
In attendance:	
Ian Dalton CBE	Designate chief executive
Michelle Dixon	Director of communications
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Martina Dineen	Director of operations, surgery, cancer & CV
Patricia Reyes	Director of operations, women's, children's & clinical support
Jan Aps	Trust company secretary (minutes)
Prof Jonathan Weber	Director of research (item 4.7)
Dr Paul Craven	Head of clinical research operations (item 4.7)
Steph Harrison White	Head of patient experience (item 2.1)

1	**Administrative Matters**	**Action**
1.1	**Chairman's opening remarks and apologies** Sir Gerry Acher welcomed all members and attendees to the meeting, and noted apologies from Sir Richard Sykes, Dr Andreas Raffel, Prof TG Teoh and Dr Katie Urch. In noting that it was Dr Tracey Batten's last Trust board meeting, he extended warmest thanks from the Trust board as to the positive commitment, contribution and impact that she had made during her time leading the Trust particularly in relation to values and openness. On behalf of all patients and staff, he offered his gratitude for her massive contribution to the Trust. In wishing her every success and happiness in her future endeavours, he hoped that she would take happy memories from her time at Imperial. Sir Gerry Acher also welcomed Ian Dalton, as incoming chief executive, to his first meeting, noting that he would commence as the Accountable Officer on 31 July. He noted that the robust handover between the two chief executives had been very positive.	
1.2	**Board member's declarations of interests** There were no additional declarations of interest made at the meeting.	
1.3	**Minutes of the meeting held on 24 May 2017** The minutes were accepted as an accurate record of the meeting.	

1.4	**Record of items discussed at Part II of board meeting held on 24 May 2017** The Trust board noted the report.	
1.5	**Action Log and matters arising** The Trust board noted the updates provided.	
2	**Operational items**	
2.1	**Patient story** Prof Janice Sigsworth introduced Mr C, who had been referred to the Trust with a cancer diagnosis following a routine endoscopy at Hillingdon Hospital. Mr C reflected that hearing the word 'cancer' directed at oneself was devastating and that the most difficult element had been dealing with his family's distress. The PREPARE team, and particularly Venetia Wynterbourne had offered amazing support to him and his family, and had completely transformed his experience of preparing for his operation and understanding what would happen. He did feel that the change in the level of interaction between staff and himself once he had moved from high dependency to the main ward was difficult, but noted that the information 'app' provided did help. The dietetics support to manage the changes required was fabulous, but even so, after three months he did feel very low, and at this point the PREPARE team helped again. He had recently been able to climb Mount Snowden; a real achievement. Sir Gerry Acher thanked Mr C for sharing his experience and was glad that such a difficult time had been made more bearable. The Trust board noted that the PREPARE programme was being introduced for Hepatobiliary and pancreatic (HPB) and ENT major surgery. Responding to Dr Batten's request for any learning the Trust should take on board, Mr C reflected that the real preparation for patients was about being mentally prepared; he considered that the 'pre-op' preparation was good but there was room for improving the support for 'post-op' patients, and suggested the introduction of patient peer mentors for cancer patients. The Trust would give this further consideration. The Trust board noted the patient story.	
2.2	**Chief Executive's report** Dr Tracey Batten particularly noted the following items: • The response to the 'Hospital' television documentary had been overwhelmingly positive; staff's compassion and care had shone through, and staff had reflected that it made them proud to work at the Trust. The Trust had targeted recruitment campaigns to align with the programme. • The fire safety improvement plan had been reviewed following the Grenfell Tower fire; there was a comprehensive plan in place which had been signed off by the London Fire Brigade in 2016. • The Trust had commenced 'soft market testing' in relation to the development of the St Mary's site; this consisted of asking a series of developers how they viewed the Trust's initial plans and asking what options they considered there to be in developing the site. Westminster City Council's planning committee would review the plans for the outpatient services' building in September. The Trust remained supportive of the Paddington quarter development, approved by Westminster City Council in December 2016, but the concerns raised by the Trust, London Ambulance Service and other health organisations, had not been taken effectively into consideration; even following multiple meetings with Westminster City Council, the GLA and TFL, these parties remained confident that the plan was safe, and the s106 agreement was likely to be signed in the near future. The Secretary of State for Local Government and Communities had also chosen not to require further scrutiny of the plans. The Trust board noted the report.	
2.3	**Integrated performance report** SAFE / EFFECTIVE: Dr Julian Redhead reported that overall, the Trust continued to	

	provide safe services. He reported that, unfortunately, a never event has occurred (previously reported to members) whereby an inappropriate attachment had been made to an epidural; fortunately, no harm had come to the patient, and investigations continued. Responding to questions from members, Dr Redhead reported that, whilst 'unique connector' kits did exist, these were not nationally recognised as best practice. Reminding members that it had been predicted following a change in reporting methodology, he noted the fall in reported VTE compliance, but reflected that it had not fallen as far as expected, and that with a more accurate position, action could now be taken to improve. A reported reduction in performance in signing up to clinical trials had also resulted from a change in reporting methodology, but further focus would be given to ensuring that contract were progressed in a timely manner. Responding to a query from Peter Goldsbrough, Dr Redhead confirmed that the two instances of major harm incidents (one a major trauma patient, one a cardiac arrest patient) were being reviewed to identify any potential issues and for learning for the future. CARING: Prof Janice Sigsworth noted that staff fill rates remained a challenge, but that work continued on the broader recruitment and retention fronts. She noted that mixed sex breaches had occurred within the intensive care unit at Charing Cross, where, if a patient was well enough to return to a ward but no bed was yet available, this was considered a breach given that the patient remained in a mixed sex environment; this would be the subject of further review by the executive. Reactive maintenance performance remained poorer than desired, but following a review and amendments to the contract, this was expected to improve in the autumn. Work continued, both with the patient transport fleet and the wards, to bring supply and demand closer together; the contract was being retendered and further flexibility was being built in. Nick Ross commented that the Trust should be proud to have achieved such high patient satisfaction as reflected in the friends and family test (FFT) results. [Post meeting note: the Trust had received a letter from the Secretary of State for Health congratulating the Trust on its FFT satisfaction rates]. WELL-LED: David Wells reported the vacancy rate, but mainly reflected an increase in headcount; the recruitment and retention team were focused on continuous improvement in this area, although it was recognised that the availability of nurses was becoming a growing issue for the NHS as a whole. Responding to a query from Peter Goldsbrough, David Wells commented that there were eight workstreams of activity focused on improving recruitment and retention. Prof Sigsworth also noted that gaps were filled as much as possible by bank staff with robust systems in e-roster to ensure safe and appropriate cover, and where gaps occurred at short notice, these were reviewed each morning and at the site meetings, and could be covered with flex between wards. In extremis, beds would be closed; at all times staff cover would ensure patient safety. RESPONSIVE: Prof Tim Orchard reported that in June 90 per cent of patients had been seen and treated within the four hour A&E target, with a further slight improvement in July to date. He noted that the trajectory agreed with commissioners and NHS Improvement was predicated on both a one per cent growth rate and Vocare delivering the KPIs agreed with the CCG as part of their recovery plan, neither of which were being delivered (growth remained at 8 per cent and breaches continued to be caused by UCC delays). The revised targets required patient streaming and 90 per cent achievement for Q1, 90.2 per cent for Q2 and Q3, and Q4 performance of 95 per cent in March 2018. NHS Improvement has confirmed that they are assured as to our processes and are keeping performance under constant review; Prof Orchard expressed particular concerns about performance over the winter period at Charing Cross, but noted that refurbishment of additional space vacated by the CCG had been agreed which would help improve patient and staff experience in the longer term. The emergency pathway group were developing a dashboard to demonstrate improvement in performance at each stage of the pathway. Responding to a query from Sarika Patel, Prof Orchard reported that	

	financial penalties were not directly attached to the trajectory, and that there was an appeal mechanism which had successfully been used in 2016/17. Prof Orchard also reported on the diagnostic endoscopy booking issues which had emerged recently, and which had meant that some patients had, unfortunately, waited an extended time for their endoscopies. It had been identified that a change in process had meant that some patients who had not made direct contact the department to arrange appointments had not had appointments arranged. The process had been changed to ensure this was no longer the case, and patients still requiring endoscopies were being contacted and would have been given a date for their procedure by the end of August. All cases were being reviewed to ensure patients had not come to harm from the delay. Prof Orchard would confirm to the Trust board when the proposed single list management system had been implemented. Martina Dinneen reported that greater progress had been made on reducing patient waits for elective procedures than had been planned (the wait of 1,000 patients had been reduced), but that the team strove to both maintain this performance and further reduce patient waits, and achieve the trajectory. Appropriate clinical review of all patients experiencing long waits (over 52 weeks) continued. Responding to a query from Peter Goldsbrough, Martina Dinneen considered that the improvements being introduced in Cerner patient tracking would help the Trust move to a position where it consistently understood where patients were experiencing extended waits. She noted, responding to a query from Sarika Patel, that performance should further improve as the longer term pathway changes took effect. Patricia Reyes reported that, unfortunately, an issue with patient tracking, identified in local record audits, has meant that a number of patients had been waiting longer than planned for imaging diagnostic tests; this was being addressed as a matter of urgency. Responding to a question from Sarika Patel, Patricia Reyes said that she would ensure further review of the increasing number of outpatients' appointments being cancelled by the Trust with less than six weeks' notice. The Trust board noted the integrated performance report.	**TO**
2.4	**Month 3 Finance report** Richard Alexander introduced the financial position for the first three months of the financial year to the end of June 2017, and was pleased to report that, overall, the Trust was on plan both year-to-date and in-month. The Trust had a cash balance of £21m and was not expecting to need to draw down cash from the agreed working capital facility during 2017/18. Whilst capital spend was behind plan at month 3, it was expected to be on target for the end of the financial year. The need to return the Trust to financial sustainability was recognised, and continued to be the subject of detailed discussion and planning at executive committees and private Trust board. The Trust board noted the report.	
3	**Items for decision or approval**	
3.1	**Complaints annual report** Prof Janice Sigsworth introduced the report which reviewed the activity, focus and improvements of the complaints service in 2016/17, noting that the year had seen full embedding of the complaints management process which had resulted in maintenance of good and responsive performance. She highlighted that the focus had been on establishing a structured way of learning from complaints and improving the quality of care as a result; a number of improvements delivered thus far were detailed in the report. The report also detailed the activities of the Patient Advice and Liaison Service (PALS), which worked ever closer with the complaints team. The Trust board noted the report and extended congratulations for the continuing improvement evident in the handling of patients' concerns.	

4	**Items for discussion**	
4.1	**Care Quality Commission (CQC) update** Prof Janice Sigsworth introduced the report which outlined the CQC's new approach for regulating NHS acute trusts, and confirmed that the Trust's inspection framework was currently being updated in light of the changes. There would be one inspection of the well led domain and a minimum of one core service each year, along with the requirement to provide an annual comprehensive information return (Provider information return - PIR), and annual self-assessment of all core services. The Trust had received the PIR on 14 July; it would be submitted on 4 August, and the self-assessment submitted a week later. The Trust board welcomed the peer challenge approach being used in relation to the self-assessment. The Trust board agreed that an extra-ordinary Quality Committee would be convened to review the self-assessments before submission. Prof Tim Orchard commented that all divisions had been self-assessing their services since 2016. Prof Janice Sigsworth noted that, as part of simplifying regulatory approaches, NHS Improvement (NHSI) had worked closely with the CQC to bring together their respective approaches, resulting in a fully joint 'well-led framework' (June 2017) structured around eight key lines of enquiry. The final version of the Framework would be presented to the Trust board in September 2017, and a plan for the inspection of the well-led inspection domain be presented at the Board seminar in October. The Trust board noted the paper, and noted that further information on the inspection frameworks would be made available in the Autumn.	JA JSi JSi
4.2	**CQC inspection report on Trust Outpatient and diagnostic services** Patricia Reyes outlined the report findings of the CQC inspection of outpatients and diagnostic imaging that took place in November 2016, being pleased to report an improvement in all scores, from 'Inadequate' to 'Good' at St Mary's and Hammersmith hospitals and from 'Inadequate' to 'Requires improvement' at Charing Cross. The Charing Cross rating reflected issues in radiotherapy which had previously been identified by the Trust and were being addressed by 'in your shoes' and 'values' workshops and a clear improvement could be seen in the department. The Trust board noted the report and welcomed the comprehensive improvement reflected in the inspection report.	
4.3	**Responsible officer's annual report** Dr Julian Redhead, in introducing the paper, noted that revalidation via the General Medical Council (GMC) was a statutory requirement for all doctors registered with a licence to practice. This report was the annual report on compliance with Framework of Quality Assurance (FQA) standards, which set out the obligation on the part of designated bodies to provide support to the responsible officer. Dr Julian Redhead confirmed that the Trust was compliant with all ten standards. The Trust board noted the report and confirmed that it was satisfied that "the organisation, as a designated body, was in compliance with the FQA regulations", and approved the submission of the statement of compliance to be submitted to NHS England by 29 September 2017.	
4.4	**Corporate risk register** Prof Janice Sigsworth introduced the bi-annual Trust board review of the Corporate Risk Register, noting the changes approved by the Executive Committee and presented to the Audit, Risk and Governance Committee. Key themes on the register included: workforce; operational performance; financial sustainability; clinical site strategy; regulation and compliance; delivery of care; and cyber security. Two risks had been de-escalated (Failure to provide safe Emergency Surgery at Charing Cross and Failure to ensure staff are immunised fully against those biological agents to which they are most likely to be exposed whilst at work) and one	

	new risk has been escalated (Risk to patient experience and quality of care in the emergency departments caused by the significant delays experienced by patients presenting with mental health issues). Following the Westminster terrorist attack in March, the London Bridge terrorist attack and the Grenfell Tower fire earlier in June, a number of risks associated to fire safety, security and major incidents management were being reviewed for possible inclusion; a verbal update would be provided to the Trust board once considered. The Trust board noted the report, and welcomed the robust oversight provided at both executive and audit risk and governance committees.	
4.5	**Children & young people safeguarding report** Prof Janice Sigsworth introduced the report, noting that the in-year restructure had been positive, and that, whilst it had been a busy year for the team with another increase in referrals, improvements could clearly be seen, with significant policy developments and initiatives delivered and the safeguarding systems and processes continued to be strengthened. The Trust board noted the report and considered that it provided appropriate assurance as to the children and young people safeguarding arrangements in place in the Trust.	
4.6	**Annual adults safeguarding report** Prof Janice Sigsworth introduced the report, which described adult safeguarding systems, processes and activity during 2016/17; she noted that it was the first since having brought together the management of all areas of safeguarding under one management team. Evidence suggested the systems in place continued to improve year-on-year, and that patients at risk of abuse or neglect were protected from harm. Governance structures and a policy framework were well established. Whilst recognising that enabling staff release for training continued to be difficult, she welcomed the increased staff awareness of the risks and how these should be dealt with. The Trust board noted the report and considered that it provided appropriate assurance as to the adult safeguarding arrangements in place in the Trust.	
4.7	**Research report** The report, prepared and presented by Prof Jonathan Weber and Dr Paul Craven, provided a summary of recent progress with respect to the various clinical research initiatives on-going within the Imperial Academic Health Science Centre (AHSC). It covered the new NIHR Imperial Biomedical Research Centre (BRC), activity on the NWL Clinical Research Network portfolio, commercially-sponsored research, and other relevant research-related news. Prof Weber highlighted that, whilst research accounted for approximately 4.5 per cent of turnover, it had a far greater relative impact; income came from a wide range of sources including the National Institute for Health Research and commercial sources. Clinical trial income had doubled from a low base, and plans were to double it again over the next four years. This would require greater engagement in trials by the consultant body, which needed to be driven by the divisional research leads with oversight from the AHSC. Prof Weber highlighted a couple of examples of current research: coffee drinking leading to a reduced risk of dying from stroke and heart disease; inferring phenotype from genotype for cardiovascular disease; and experimental drug to alleviate symptoms of the menopause. Responding to a query from Sarika Patel, Prof Orchard agreed that clinicians needed to focus time to increasing research income, and ensure that such research was delivering results for the Trust; the focus on job planning would support this. The Trust board acknowledged that it was important to ensure that clinicians were incentivised to attract research income; this would be subject to further discussion at	

	the Intellectual Property Committee. The Trust board noted the report and thanked Prof Weber and his team, and welcomed the continued and growing areas of research activity.	
4.8	**Engagement survey results** David Wells introduced the paper which summarised the initial results of the latest Local Engagement Survey 'Our Voice Our Trust' which was held across the Trust in late Spring 2017, and also outlined the next steps in developing action plans to address any areas of concern. The headlines showed that the overall Engagement score improved slightly between 2016 and 2017, to 80 per cent, with 86 per cent of staff recommending the Trust as a place for care or treatment and 72 per cent recommending it as a place to work; these were the best results achieved over the three years that the questions had been asked. The results would be distributed to all managers, who would be encouraged to develop action plans to address any issues raised, by early September. Further analysis would also be carried out to understand, and develop broader improvement plans in areas of concern identified, including bullying and harassment, and health and wellbeing. The Trust board welcomed the continued improvement in positive responses, and sought a further update on actions to address areas of concern at an appropriate time.	
4.9	**Annual freedom of information report** Michelle Dixon introduced the report which showed that the Trust had received 21 per cent more freedom of information requests in 2016/17 (821 received) than 2015/16 (681 received), with a particular peak in February 2017 when 94 requests were received in one month. The Trust achieved about 90 per cent compliance with the Act's target of responding within 20 working days, and, where not possible, kept in close contact with the requesters as to the reasons for delay. There has been only one request for an internal review in 2016/17, and no complaints had been made to the Information Commissioner's Office. The Trust board noted the report.	
5	**For information**	
5.1	**Quality account 2016/17** The quality account reported on progress against the three-year quality strategy and confirmed the priority programmes and targets for the following year. It was an annual report to the public from the Trust outlining the quality of services delivered. NHS England had stated that the documents 'primary purpose was to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer, and to explain their progress to the public' – the Trust has sought to deliver on this ambition. This report presented the final published version of the quality account for 2016/17 for information; it had been published on NHS Choices and the Trust website since 30 June 2017 in line with requirements. The Trust board noted the final published version of the quality account.	
5.2	**National Cancer Patient Experience survey results** The results of the 2016 National Cancer Patient Experience Survey (NCPES) were released on 21 July 2017. The results indicate small changes to individual questions but the majority of these were not considered to be statistically significant. A more detailed update would be provided to the Trust board in September. The Trust board noted the verbal update and that a further report would be presented in September.	**JSi**

5.3	**STP Joint health & social care transformation group** The Trust board noted the STP meeting summary.	
5.4	**Key legislation for board members** The Trust board noted the revised document which highlighted for board members the key legislation of which they should be aware.	
6.1-6.4	**Board committee reports** The Trust board noted the reports from the following committees: • Finance and investment committee • Redevelopment committee • Audit, risk & governance committee and audit minutes • Remuneration committee.	
7	**Any other business**	
	There was no other business.	
8	**Questions from the public relating to agenda items**	
	• A member of the Charing Cross hospital save our hospitals support group reported a particularly good patient experience at St Mary's; she then extended thanks to Dr Tracey Batten, recognising the positive influence that Dr Batten had made. She also noted that the television documentary 'Hospital' had provided a useful insight and helped improve patient engagement. However, she felt that the letters to and forth the Borough of Hammersmith and Fulham about the future of Charing Cross had undermined public confidence. Michelle Dixon clarified that the Trust had no political intent in the writing of the letter to the Councillor Cowen; the initial letter had been written before the announcement of the election, and the Trust's intent was only to clarify the facts as to plans for Charing Cross Hospital. The most recent letter was attached to the chief executive's briefing. • Another member of the group extended a particular thank you to the staff on the frontline, but considered that more nurses were required across the Trust. She also reflected that four years on from the Shaping a Healthier Future proposals, the attendances and admissions at Charing Cross Hospital were still very high; Dr Batten referred back to the letter to Councillor Cowan attached to the chief executive's report, which provided full coverage of these issues. • Richard Alexander confirmed that funding for the two LINACs was conditional on the Trust agreeing the Control Total with NHS Improvement by 31 August 2017. • It was agreed that the Quarterly research report would be added to the publications scheme on the website.	**JA**
	Date of next meeting	
	Public Trust board: Wednesday 27 September 2017, Clarence Wing Boardroom, SMH	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Record of items discussed at the confidential Trust board meetings on 26 July and 23 August 2017

Executive summary:

Decisions taken, and key briefings, during the confidential sessions of a Trust board are reported (where appropriate) at the next Trust board held in public.

Issues of note and decisions taken at the Trust board's confidential meetings held on 26 July 2017:

Ratification of the appointment of the chief executive officer
The Trust board welcomed and ratified the appointment of Ian Dalton CBE as the Trust's chief executive officer, and noted that he would take over the role of accountable officer on 31 July 2017.

Fire safety assurance report
The Trust board noted the contents of the report and considered that it provided an adequate level of assurance as to the Trust's fire safety arrangements.

Financial update

The Trust board discussed the financial position at month 3, and supported the proposed approach in relation to moving towards longer term financial sustainability and noted that more detailed proposals would be presented at the September private meeting. Noting the potential financial implications should the Trust not be in a position to sign up to the revised control total by 31 August, the Trust board agreed that an extra-ordinary meeting would be arranged in August to discuss further.

Sustainability and transformation partnerships (STPs)

The Trust board noted that in a recent rating of Partnerships by NHS England the NW London Partnership had been rated as category two – advanced, across the measure used.

Issues of note and decisions taken at the Trust board's confidential meeting held on 23 August 2017:

Accounts and annual report 2016/17
Taking into account the best interests of the Trust, its patients and its staff, the Trust board approved the revised control total.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Jan Aps, Trust company secretary	Ian Dalton CBE, Chief executive officer

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status update

MATTERS ARISING

Minute Number	Action /issue	Responsible	September 2017 Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Annual review of board committees' terms of reference

Executive summary:

It is good practise to review the terms of reference on an annual basis to ensure that they are fit for purpose and reflect any changes made to the committee in-year.

No major changes are proposed to the terms of reference; however, the format has been amended and some language updated. Reference has been made to the board assurance framework where appropriate, and the addition of 'oversight of fit and proper person's compliance' to the Remuneration Committee.

Quality impact:

Regular review of terms of reference support good assurance and oversight arrangements.

Financial impact:

No impact

Risk impact:

Good governance supports the reduction of risk to the Trust overall.

Recommendations to the Trust board:

The Trust board is asked to review and:

- Approve the terms of reference for Quality, Finance and Investment and Redevelopment Committees
- Noting any changes made by the Remuneration Committee, approve the Committee's terms of reference
- Noting there may be further minor change at the Committee on 4 October, approve in principle the Audit, Risk and Governance Committee's terms of reference
- Note that the terms of reference to be approved within the Hammersmith and Fulham integrated care partnership agreement will be reformatted (for the Trust's use) as per the other committee terms of reference.
-

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Jan Aps, Trust company secretary	Ian Dalton, CBE Chief executive	21 September 2017

Imperial College Healthcare NHS Trust

AUDIT, RISK & GOVERNANCE COMMITTEE

Terms of Reference

Role

- to provide the Trust board with the assurance that an adequate processes of corporate governance, risk management, audit and internal control are in place and working effectively.
-
- The Committee will operate in two parts, Part I: Audit, and Part II: Risk and Governance.

1 Membership and quorum

1.1 Members of the Committee shall be appointed by the Chairman on behalf of Trust board.

Part I - audit:

1.1.1. The Committee shall be made up of a minimum of three members. Only non-executive directors shall be members of the Committee.

1.1.2. The chief financial officer, director of nursing and medical director will attend all meetings

1.1.3. The chief executive will be invited to attend any meeting and should attend at least annually to discuss with the Committee the process for assurance that supports the annual governance statement.

Part II – risk & governance:

1.1.4. The Committee shall be made up of a minimum of three non-executive directors, chief finance officer, director of nursing, and medical director.

1.2. Members may not appoint a deputy to represent them at a Committee meeting. The Chairman of the Trust is not a member of the Committee.

1.2 Only members of the Committee have the right to attend and vote at Committee meetings. The Committee may require other officers of the Trust and other individuals to attend all or any part of its meetings.

1.3 The chair of both parts the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

3.1 The meeting will be two non-executive director members for Part I and Part II and the addition of two executive directors for Part II; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

1.4 Internal and External Audit representatives will always attend both parts of the meeting. The Committee shall meet privately with the Internal and External Auditors at least once a year.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet at least four times a year at appropriate times in the reporting cycle and otherwise as required;

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The secretary of the Committee shall maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary will attend each meeting and they or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary of the Committee at the

request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers shall be forwarded to each member of the Committee, any other persons required to attend and all other non- executive directors, no later than five working days before the date of the meeting.

3.4 The secretary will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

3.5 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

3.6 Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust board unless a conflict of interest exists.

4 Duties

The Committee (across Part I and Part II) should carry out the following duties for the Trust:

4.1 Governance, Risk Management and Internal Control

4.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In relation to the management of risk, the Committee will:

- Review the process under which the trust sets its risk appetite;
- Oversee and advise the Trust board on the current risk exposures of the Trust, and the effectiveness of the Trust's risk management systems;
- Keep under review the effectiveness of the Trust's risk management and risk assessment processes ensuring the use of both qualitative and quantitative measures in assessment;
- Refer to the Quality Committee any clinical risks that require further scrutiny by its membership;
- Review the effectiveness and timeliness of actions to mitigate critical risks including receiving exception reports on overdue actions;
- Review the statements to be included in the Annual Report concerning risk management;
- Review the process and effectiveness of learning from incidents trust-wide.

4.1.2 The Committee will monitor due diligence on any integration or partnership arrangements, reviewing the risk assessment and decision-making processes to ensure all control issues are addressed.

4.1.3 The Committee will seek assurance on behalf of the Trust board that the design and application of the control environment in core financial processes are fit for purpose and reflect both public and commercial sector best practice.

4.1.4 In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with CQC Standards), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;
- an effective system of management of performance and finance across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;
- the Board Assurance Framework and the underlying integrated assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant reglatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State directions and as required by NHS Protect.

4.1.6 In carrying out this work the Committee will primarily utilise the work of Internal Audit,

External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.1.7 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2 Internal Audit

4.2.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Chief Executive and Board of Directors. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of Internal Audit.

4.3 External Audit

4.3.1 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- appointment of the External Auditor, as far as the relevant rules and regulations permit;
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Organisation and associated impact on the audit fee;
- review all External Audit reports (together with the appropriateness of management responses), including agreement of the annual audit letter before submission to the Trust board.

4.3.2 The Committee will review any proposal considered for commissioning work outside the annual audit plan (in its role as the Audit Panel) prior to approval.

4.4 Auditor Panel

4.4.1 NHS trusts are required to appoint their own external auditors and directly manage the resulting contract and the relationship; trusts are required to have an auditor panel to advise on the selection, appointment and removal of external auditors and on maintaining an independent relationship with them;

11.2 In accordance with The Local Audit and Accountability Act 2014, and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015, the Trust has nominated the Committee (Part I) as the Auditor Panel for the Trust;

11.3 The Auditor Panel will advise the Trust board on the selection and appointment of the external auditor;

11.4 The Trust board must consult and take account of the Auditor Panel's advice on the selection and appointment of the Trust board on the appointment of external auditors, and publish a notice on the website within 28 days of appointing the auditor providing details of appointment, and noting auditor panel advice;

11.5 The Auditor panel must advise on the Trust's policy on use of auditors for the provision of non-audit services;

11.6 Auditor panel business must be identified clearly and separately on the agenda.

4.5 Whistleblowing and counter fraud

4.5.1 The Audit, Risk and Governance Committee will review the adequacy of the Trust's arrangements by which staff may, in confidence raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern including patient care and safety and bullying (including the Freedom to Speak up Guardian).

4.5.2 In particular the Committee will:

- review the adequacy of the policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service;
- approve and monitor progress against the operational counter fraud plan;
- receive regular reports and ensure appropriate action in significant matters of fraudulent conduct and financial irregularity;
- monitor progress on the implementation of recommendations in support of counter fraud;
- receive the annual report of the local counter fraud specialist.

4.6 Other Assurance Functions

4.6.1 The shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

4.6.2 These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (for example the NHS Litigation Authority), professional bodies with responsibility for the performance of staff or functions (for example Royal Colleges and accreditation bodies).

4.6.3 In addition, the Committee will be cognisant of the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

4.7 Management

4.7.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

4.7.2 They may also request specific reports from individual functions within the organisation (eg clinical audit) as they may be appropriate to the overall arrangements.

4.8 Financial Reporting

4.8.1 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

4.8.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness, integrity and accuracy of the information provided to the Trust Board.

4.8.3 The Committee shall review the Annual Report and Financial Statements before recommending them to the Trust Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- major judgmental areas; and
- significant adjustments resulting from the audit.

4.9 Standing Orders and Standing Financial Instructions

4.9.1 The Committee will review on behalf of the Board proposed changes to the Standing Orders and Standing Financial Instructions;

4.9.2 The Committee will examine the circumstances of any departure from the requirements of Standing Orders, Standing Financial Instructions;

4.9.3 The Committee will monitor the Declarations of Interest & Hospitality policy with reference to the codes of conduct and accountability thereby providing assurance to the

Board of probity in the conduct of business;

4.9.4 The Committee will review schedules of losses and compensations annually.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting;

5.2 Minutes of Part I will be reported to the public Trust board; minutes of Part II shall be reported to the private Trust board;

5.3 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

6 Other matters

The Committee will:

6.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

6.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

6.3 give due consideration to laws and regulations;

6.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

6.5 The chair of the Committee will normally attend the Annual General Meeting prepared to respond to any questions on the Committee's activities.

7 Authority

7.1 The Committee is a Committee of the Trust board, and has no powers, other than those specifically delegated in these Terms of Reference. The Committee is authorised to:

- seek any information it requires from, or the attendance of, any employee of the Trust in order to perform its duties
- obtain outside legal or other professional advice on any matter within its terms of reference via the trust company secretary.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the Chair of the Committee might provide.

8.2 The Secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

Imperial College Healthcare NHS Trust

FINANCE AND INVESTMENT COMMITTEE (FIC)

Terms of Reference

Role

- to undertake on behalf of the Trust board thorough and objective reviews of financial policy and financial performance issues, reviewing the risks to the financial position;
- to review the Trust's financial performance and identify the key issues and risks requiring discussion or decision by the Trust board.
- to review the Trust's financial strategy, business plans and budgets, and advise the Trust board on their acceptance of such;
- t o advise the Trust board on finance issues and investment strategy, including those relating to the Trust's estate;

1 Membership and quorum

1.1 Members of the committee shall be appointed by the Chairman, on behalf of the Trust board. The committee shall be made up of five members; three non-executive directors, the chief executive, and chief financial officer.

1.2 Only members of the Committee have the right to attend and vote at Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of the Committee's meetings.

1.3 The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members, the Deputy CFOs (two posts) and divisional directors are expected to attend Committee meetings; others may be invited on an as needs basis.

1.5 The meeting quorum is three members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in, or exercisable by, the Committee.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet six times a year at appropriate times in the reporting cycle and otherwise as required.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers, shall be forwarded to each member of the committee, and any other person required to attend, no later than five days before the date of the meeting.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present, and any conflicts of interest.

3.5 Minutes of committee meetings should be circulated to all members of the Committee, and once approved, minutes are reported to the private Trust board.

4 Duties

The committee should carry out the following duties for the Trust:

- advise the Trust board on financial policies;
- recommend to the Trust board, the Trust's medium and long term financial strategy (capital and revenue) including the underlying assumptions and methodology used, ahead of review and approval by the Trust board;
- review the Annual Plan including the annual revenue and capital budget prior to submission to the Trust board for approval;
- review the Trust's financial performance and forecasts (including performance against Cost Improvement Programmes) and identify the key issues and risks requiring discussion or decision by the Trust board;
- review compliance with the self-assessment quality checklist for the annual reference cost submission;
- review, at the request of the Trust board, specific aspects of financial performance where the Trust board requires additional scrutiny and assurance;
- review the Trust's projected and actual cash and working capital;
- approve and keep under review, on behalf of the Trust board, the Trust's investment and borrowing strategies and policies;
- ensure the Trust operates a comprehensive budgetary control and reporting framework (but acknowledging that the Audit, Risk & Governance committee is responsible for systems of financial control); and
- review the financial risks;
- establish the overall methodology, processes and controls which govern the Trust's investments;
- evaluate, scrutinise and monitor investments, including regular review of the capital programme;
- review post project evaluations for capital projects (above £5million) and for revenue projects (above £9 million per annum). All projects will have a two stage review that will be presented to the FIC; shortly after implementation to assess project or contract completion, and approximately 12 months later to review whether anticipated outcomes/savings had been achieved;
- review, and recommend to Trust board, the Trust's treasury management, working capital and estates strategies;
- evaluate and scrutinise the financial and commercial validity of individual investment decisions over £5m recommended for approval by the executive committee, including the review of outline and final business cases, and service development tenders, for onward recommendation for approval by the Trust board. The current delegated limit for the Trust is £15 million;
- bi-annually review business cases approved by the executive committee of a value between £2m and £5m.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee will make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The chair of the committee will normally attend the Annual General Meeting prepared to respond to any questions on the committee's activities.

6 Other matters

The committee will:

6.1 have access to sufficient resources in order to carry out its duties, including access

to the Trust secretariat for assistance as required;

6.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

6.3 give due consideration to laws and regulations;

6.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

7 Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties;
- to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary;
- to call any employee to be questioned at a meeting of the committee as and when required.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the committee through receipt of a written report following each meeting and the committee's minutes.

8.2 The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

QUALITY COMMITTEE

Terms of Reference

Role

- To obtain assurance that high quality care is being delivered across Imperial College Healthcare NHS Trust. The committee will also obtain assurance that the quality strategy is being implemented and that continuous improvement is evidenced;
- To ensure that robust clinical governance structures, systems and processes (including those for clinical risk management and service user safety) are in place across all services and are line with national, regional and commissioning requirements;
- Onward referral of appropriate issues to relevant committees (including the operational and management committees) for further review or action;
- Review and approval (or recommendation for approval by the Trust board) of required quality-related annual reports (for example the Quality Account).

1 Membership and quorum

1.1 The Committee chair (an independent non-executive director) and Committee members will be appointed by the Trust Chair. Members may not appoint a deputy to represent them regularly at meetings. The Committee will comprise three non-executive directors, the medical director, the director of nursing, the divisional directors, and the director of infection prevention and control.

1.2 Only members of the Committee have the right to attend and vote at meetings; officers of the Trust and other individuals may be required to attend all or any part of Committee meetings.

1.3 In the absence of the Committee chair, members present will agree that one among them will chair the meeting.

1.4 The meeting quorum is two, of which one is a non-executive director; the meeting will be considered competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

2 Frequency of meetings and attendance requirements

2.1 The committee will normally meet bi-monthly; the Committee chair has the power to increase the frequency to monthly if considered necessary.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of scheduled meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their deputy shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda and supporting papers, will be forwarded to each member of the Committee and any other person required to attend no later than five working days before the date of the meeting.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including noting any conflicts of interest.

3.5 Minutes of Committee meetings should be circulated to all members of the committee and, once approved, to all members of the Trust board (unless a conflict of interest exists).

4 Duties

The committee should carry out the following duties for the Trust:

4.1 Safety

4.1.1 Obtain assurance that the Trust has effective mechanisms for managing clinical risk, including clinical risk associated with clinical trials and improving service user safety, learning from incidents, and taking action to reduce risks and improve clinical quality;

4.1.2 Receive and review reports on individual serious adverse incidents; individual 'never'events; coroners' post-mortem reports; medico-legal cases and trend analysis of clinical incidents and be assured that actions are being taken to address issues and share learning;

4.1.3 Obtain assurance that robust safeguarding structures, systems and processes are inplace to safeguard children and young people and vulnerable adults;

4.1.4 Obtain assurance that the Trust is compliant with the Mental Health Act and its associated Code of Practice and the Mental Capacity Act;

4.1.5 Obtain assurance that the Trust has appropriate arrangement in place to remain compliant with all aspects of Health and Safety legislation.

4.2 Effective

4.2.1 Approve and assure delivery of the annual programme of Trust-wide clinical audits;

4.2.2 Obtain assurance that NICE Guidelines and Technology Appraisals are implemented;

4.2.3 Obtain assurance that there are robust systems for undertaking nationally mandated audits, receive summary results and monitor the implementation of recommendations;

4.2.5 Oversee the Trust's work on Care Quality Commission's improvement reviews.

4.2.4 Report to the audit, risk and governance committee any ongoing concerns or risks being overseen by the Committee, and to refer other matters to other committees as appropriate.

4.3 Well-led

4.3.1 Obtain assurance that robust quality governance structures, systems, and processes, including those for clinical risk management and service user safety, are in place across all services, and developed in line with national, regional and commissioning requirements;

4.3.2 Approve and monitor delivery of the Trust's equality delivery system so that essential principles of equality are embedded into the culture, behaviour and decision making process of the organisation;

4.3.3 Receive assurance that clinicians, managers and staff promote and advance equality and diversity, whilst working closely with patients, the public, local communities, voluntary organisations, staff and staff side organisations.

4.3.4 Obtain assurance that efficiency programmes are not having a detrimental effect on quality through the cost improvement process (CIP);

4.3.5 Approve and assure delivery of all quality governance plans including CQC inspection action plans, and quality improvement methodology;

4.3.6 Obtain assurance that the divisional quality groups are effectively coordinating quality and clinical governance activity within the Trust;

4.3.7 Ensure that board assurance framework reflects the assurances for which the committee has oversight, and that risks highlighted are appropriately reflected on the risk registers.

4.4 Caring

4.4.1 Approve and assure delivery of the Trust's patient and public engagement plans, and the patient experience plans/strategy, and obtain assurance that these plans are keys element of the work of quality and clinical governance teams across the Trust;

4.4.3 Receive assurance that appropriate safeguarding arrangements are in place and effectively monitored;

4.4.4 The chairman of the committee shall be the Trust's Duty of Candour champion.

4.5 Responsive

4.5.1 Obtain assurance that patient access targets are being delivered;

4.5.2 Obtain assurance that effective channels are in operation for communicating and managing issues of clinical governance to relevant managers, staff and external stakeholders;

4.5.3 Obtain assurance that clinical recommendations resulting from complaints including those investigated by the Parliamentary and Health Service Ombudsman have been implemented.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee wiall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The chair of the Committee will normally attend the annual general meeting prepared to respond to any questions on the committee's activities

6 Other matters

The Committee will:

6.1 Have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

6.2 Be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

6.3 Give due consideration to legislation and regulations;

6.4 Review both its effectiveness and terms of reference on an annual basis, and recommend to the Trust board for approval, any changes it considers necessary.

7 Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated by the schedule of reserved and delegated powers, as described in these terms of reference. The committee is authorised:

7.1.1 to seek any information it requires from any employee of the Trust in order to perform its duties, and to call any employee to be questioned at a meeting of the committee as and when required.

7.1.2 to obtain outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary.

8 Monitoring and review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and any further written or verbal reports that the chair of the Committee might provide;

8.2 The secretary will review all agenda items to ensure they align with the Committee's responsibilities.

Imperial College Healthcare NHS Trust

REDEVELOPMENT COMMITTEE

Terms of reference

Role

- to undertake, on behalf of the Trust board, thorough and objective reviews of the redevelopment transformation programme, including performance issues and financial issues, and to review investment requirements and risks associated with the overall redevelopment transformation programme
- to identify the key issues and risks requiring discussion or decision by the Trust board and advise accordingly.

1 Membership and quorum

1.1 Members of the Committee will be appointed by the Chairman, on behalf of the Trust board. The Committee shall be made up of three non-executive directors, the chief executive officer, the chief financial officer, and the Medical Director.

1.2 Only members of the Committee have the right to attend and vote at Committee meetings.

1.3 The chair of the Committee will be an independent non-executive director. In the absence of the Committee chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.4 In addition to the Members the following are required to attend meetings of the Committee: the chief executive, Imperial Health Charity, director of planning & redevelopment, and the deputy medical director. The Committee may require other directors or officers of the Trust to attend Committee meetings.

3.1 The meeting quorum is four members, of which two are non-executive directors; the meeting will then be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

2 Frequency of meetings and attendance requirements

2.1 The Committee will normally meet monthly at appropriate times in the reporting cycle and otherwise as required.

2.2 Committee members should aim to attend all scheduled meetings but must attend a minimum of two thirds of meetings. The secretary of the Committee shall maintain a register of attendance which will normally be published in the Trust's annual report.

3 Meeting administration

3.1 The Trust company secretary or their nominee shall act as the secretary of the Committee.

3.2 Meetings of the Committee may be called by the secretary of the Committee at the request of any of its members or where necessary.

3.3 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend and all other non-executive directors, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

3.4 The secretary shall minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance.

3.5 Members and those present should state any conflicts of interest and the secretary should minute them accordingly.

3.6 Minutes of Committee meetings should be circulated promptly to all members of the Committee and, once agreed, to all members of the Trust board unless a conflict of interest exists.

4 Duties

The Committee should carry out the following duties for the Trust:

4.1 Redevelopment programme assurance

The Committee shall make recommendations to the Trust board on the redevelopment transformation programme, performance issues, financial issues, including investment and risks associated with the overall redevelopment programme. Specifically the Committee will:

- review the redevelopment programme and identify key issues with progress and assess the impact on the trust business that requires discussion or decision by the Trust board;
- review partnership arrangements between trust and key stakeholders and advise the trust board of impact and issues that require discussion or decision by the Trust board;
- review the quality of the healthcare facilities being developed to ensure trust transformational objectives are being met and advise the Trust board of issues that require discussion or decision by the Trust board;
- review the redevelopment programme risk register and identify the key issues and risks requiring discussion or decision by the Trust board;
- ensure the redevelopment programme operates a comprehensive budgetary control.

4.2 Redevelopment programme management and reporting

The Committee shall review and recommend to the Trust board:

- the Trust's investment strategy in so far as this is relevant to the redevelopment of the Trust sites, including:
- establish the overall methodology, processes and controls which govern the approach to site redevelopment;
- evaluate, scrutinise and monitor investment relating to site redevelopment; prepare post project evaluations for capital projects and for revenue projects related to redevelopment which have a whole life contract value of £5 million and above;
- review and recommend to Trust board the Trust's estate strategies;
- within limits set out in the standing orders, standing financial instructions, scheme of delegation and matters reserved to the Trust board, the Committee shall approve, evaluate and scrutinise the financial and commercial validity of relevant individual investment decisions, including the review of outline and final business cases. The current delegated capital limit for the Trust is £15million.

5 Reporting responsibilities

5.1 The Committee will report to the Trust board on its proceedings after each meeting.

5.2 The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.3 The Committee will produce an annual report to the Trust board.

6 Other matters

The Committee will:

6.1 have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;

6.2 be provided with appropriate and timely training, both in the form of an induction programme for new members and on an ongoing basis for all members;

6.3 give due consideration to laws and regulations;

6.4 at least once a year, review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for

approval, any changes it considers necessary.

6.5 The chair of the Committee will normally attend the annual general meeting prepared to respond to any questions on the Committee's activities.

7 Authority

7.1 The Committee is a Committee of the Trust board and has no powers other than those specifically delegated in these terms of reference. The Committee is authorised:

- to seek any information it requires from any employee of the Trust in order to perform its duties;
- to obtain, outside legal or other professional advice on any matter within its terms of reference via the Trust company secretary;
- to call any employee to be questioned at a meeting of the Committee as and when required.

8 Monitoring and Review

8.1 The Trust board will monitor the effectiveness of the Committee through receipt of the Committee's minutes and such written or verbal reports that the chair of the Committee might provide.

8.2 The secretary will assess agenda items to ensure they comply with the Committee's responsibilities.

8.3 The secretary will monitor the frequency of the Committee meetings and the attendance records to ensure minimum attendance figures are complied with. The attendance of members of the Committee will be reported in the annual report.

Imperial College Healthcare NHS
NHS Trust

REMUNERATION & APPOINTMENTS COMMITTEE

Terms of Reference

Role

To act on behalf of the Trust board in:

- determining the appointment, remuneration, terms of service and performance of the executive director members of the Trust board (executive directors) as listed in the Appendix;
- Agreeing and overseeing the process for appointing non-executive and executive directors and other direct reports to the chief executive as listed in the Appendix;
- Agreeing the remuneration and terms of service of executive directors and all other director level reports to the chief executive officer, and noting the remuneration of all other very senior managers (VSM);
- Monitoring the performance and the development of executive directors;
- Ensuring that effective plans are in place to provide continuity of leadership in the event of extended executive director absence or vacancy;
- Approving any severance payments that are proposed for executive directors, for direct reports to the chief executive officer, and any other very senior managers and others as may be required by NHS Improvement and the Department of Health.

1. Membership and quorum

1.1. Members of the committee shall be appointed by the Chair of the Trust board. The committee shall be made up of three members:
- The Chair of the Trust board
- Two non–executive directors.

1.2. Only members of the Committee have the right to vote at the Committee meetings; other officers of the Trust and other individuals may be required to attend all or any part of its meetings.

1.3. The chair of the Committee will be an independent non-executive director, and appointed by the Chair of the Trust board.

1.4. In addition to the Members, the following are required to attend all meetings of the Committee:
- Chief executive
- Director of people & OD
- Trust company secretary.

1.5. A quorum necessary for the transaction of business shall be two members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

2. Frequency of meetings and attendance requirements

2.1. The committee will meet as required and at least twice a year. The timetable of meetings will be agreed between the Chair of the Committee and the Director of people & OD.

2.2. Members are expected to attend at least 75 per cent of meetings. The Committee secretary will maintain a register of attendance which will be published in the Trust's annual report.

3. Executive lead and meeting administration

3.1. The director of people and OD shall support the Committee in advising the Committee on employment issues and procedures, and shall agree agendas and papers with the committee Chair.

3.2. The Committee shall be supported administratively by the Trust company secretary, who will distribute papers, take the minutes and keep a record of matters arising and issues to be carried forward.

4. Duties

The Committee shall carry out the following duties for the Trust:

4.1. Trust board composition

- regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust board and make recommendations to the Trust board with regard to any changes.
- give full consideration to and make plans for succession planning for the chief executive officer and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
- be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- be responsible for identifying and nominating a candidate, for approval by the Trust board, to fill the position of chief executive officer.
- before an appointment is made evaluate the balance of skills, knowledge and experience on the Trust board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

4.2 Appointment of executive directors

- nominate one or more members to be actively involved with the chief executive officer in the appointment of specific executive director posts, and in the design of the selection process on behalf of the Committee.
- ensure that the selection process is based on: an agreed role and person specification; the use or other involvement of any third party recruitment professionals; an interview panel to include the chief executive officer, an agreed non-executive director or directors, an external assessor representing NHS Improvement/DH or successor bodies and such other persons as may be agreed to be helpful.
- ensure that posts are openly advertised and that the appointment procedure at all times complies with the Trust's policies, standards and general procedures on recruitment and selection. This will include ensuring compliance with fit and proper person regulations (FPP).
- keep the Trust board informed of the process, procedures and timetable to which it is working, as appropriate.

4.3 Remuneration of executive directors

- agree on behalf of the Trust board the remuneration and terms of service of the Executive directors and that the executive directors are fairly rewarded for their

contribution to the Trust, having proper regard to its circumstances and performance, and to the provision of any national arrangements or directives for such staff where relevant.

- agree and review annually a policy framework for the pay of very senior managers (VSM) not on national contracts, including executive directors.
- establish the parameters for the remuneration and terms of service for the appointment of executive directors, with delegated authority of the chief executive officer to agree starting salaries within the agreed parameters.
- determine the salaries of very senior managers other than executive directors is delegated to the chief executive officer or relevant executive director advised by the director of people & OD and working within the agreed policy framework. The committee will review annually the earnings of such managers including senior clinicians and clinical managers.
- agree the termination of contract of executive directors and the payment of any redundancy or severance packages in line with prevailing national guidance.

4.4 Performance and Succession Planning

- monitor and evaluate the performance both individually and collectively of the executive directors in the context of their responsibilities and objectives.
- ensure the capability of potential or nominated deputies for executive directors to effectively deputise during periods of extended absence on the part of the Executive directors.
- oversee an assessment of the capability and succession potential of the top 100 - 150 Trust leaders in order to identify any strategic gaps requiring appropriate intervention.

4.5 Employee engagement

- to monitor the annual results of the employee engagement surveys and provide oversight of the Trust action plan for continuous improvement.
- to provide oversight of the Trust's action plan to improve staff retention.

5. Reporting responsibilities

5.1. The Committee shall make whatever recommendations to the Trust board it deems appropriate on any area within its remit where action or improvement is needed.

5.2. The Committee shall oversee the production of an annual report of the Trust's remuneration policy and practices which will be part of the Trust's Annual Report.

6. Other matters

The Committee will:

- have access to sufficient resources in order to carry out its duties, including access to the Trust secretariat for assistance as required;
- he provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members
- give due consideration to laws and the regulatory framework within which the Trust operates;
- at least once every two years review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend to the Trust board for approval, any changes it considers necessary.

7. Authority

7.1 The Committee is a committee of the Trust board and has no powers other than those specifically delegated in these Terms of Reference. The Committee is authorised to:

- seek any information it requires from any employee of the Trust in order to perform its duties;
- obtain outside legal or other professional advice on any matter within its terms of reference via the director of people and OD;
- call any employee to be questioned at a meeting of the Committee as and when required.

7.2 In order to ensure the business of the Committee is not unduly held up between meetings, the Chair may take Chair's action between meetings. Any such decisions thus taken will be reported to the next meeting. This may include authorisation of contractual severance payments to staff other than Executive Directors as required by NHS Improvement or the Department of Health. Where substantive or sensitive decisions are required outside of scheduled meetings then the Chair may convene an extraordinary meeting of the Committee.

Appendix

Posts for which the Committee has responsibility

EXECUTIVE DIRECTORS
Chief executive
Chief finance officer
Medical director
Director of nursing
Transformation director (once post and title confirmed)
OTHER DIRECTOR LEVEL DIRECT REPORTS TO CHIEF EXECUTIVE
Divisional directors
Director of people & organisation development
Chief information officer
Director of communications
Director of redevelopment
Director, Imperial Private Healthcare

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Schedule of Trust board, seminar and board committee meetings 2017/18 (financial year)

Executive summary:

The proposed framework for Trust board and its Committees remains similar to 2016/17. All regular meetings continue to be held on a Wednesday (although this may not always be possible for short-notice ad hoc meetings).

Where possible, we have sought to shifts dates within the month to avoid the most likely half-term or Easter weeks.

Quality impact:

No direct quality impact.

Financial impact:

No direct financial impact.

Risk impact:

Agreeing the meeting schedule reduces the risk of non-attendance, and therefore risk of reduced oversight and assurance.

Recommendation to the Trust board:

The Trust board is asked to:

- consider the meetings schedule outlined;
- agree the dates for Trust board, and board committees as proposed

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Jan Aps, Trust company secretary	Ian Dalton, Chief executive officer	21 September 2017

Quality Redev
F+I AR+G

2018

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1 Su	1 Tu	1 Fr	1 Su	1 We	1 Sa	1 Mo	1 Th	1 Sa
2 Mo Easter Monday	2 We	2 Sa	2 Mo	2 Th	2 Su	2 Tu	2 Fr	2 Su
3 Tu	3 Th	3 Su	3 Tu	3 Fr	3 Mo	3 We AUDIT,R,G	3 Sa	3 Mo
4 We	4 Fr	4 Mo	4 We AUDIT,R,G	4 Sa	4 Tu	4 Th	4 Su	4 Tu
5 Th	5 Sa	5 Tu	5 Th	5 Su	5 We	5 Fr	5 Mo	5 We AUDIT,R,G
6 Fr	6 Su	6 We	6 Fr	6 Mo	6 Th	6 Sa	6 Tu	6 Th
7 Sa	7 Mo Early May Bank Hol.	7 Th	7 Sa	7 Tu	7 Fr	7 Su	7 We	7 Fr
8 Su	8 Tu	8 Fr	8 Su	8 We	8 Sa	8 Mo	8 Th	8 Sa
9 Mo	9 We QUALITY	9 Sa	9 Mo	9 Th	9 Su	9 Tu	9 Fr	9 Su
10 Tu	10 Th	10 Su	10 Tu	10 Fr	10 Mo	10 We	10 Sa	10 Mo
11 We	11 Fr	11 Mo	11 We QUALITY	11 Sa	11 Tu	11 Th	11 Su	11 Tu
12 Th	12 Sa	12 Tu	12 Th	12 Su	12 We QUALITY AGM	12 Fr	12 Mo	12 We SEMINAR
13 Fr	13 Su	13 We	13 Fr	13 Mo	13 Th	13 Sa	13 Tu	13 Th
14 Sa	14 Mo	14 Th	14 Sa	14 Tu	14 Fr	14 Su	14 We QUALITY	14 Fr
15 Su	15 Tu	15 Fr	15 Su	15 We	15 Sa	15 Mo	15 Th	15 Sa
16 Mo	16 We FINANCE REDEVELT	16 Sa	16 Mo	16 Th	16 Su	16 Tu	16 Fr	16 Su
17 Tu	17 Th	17 Su	17 Tu	17 Fr	17 Mo	17 We	17 Sa	17 Mo
18 We	18 Fr	18 Mo	18 We FINANCE REDEVELT	18 Sa	18 Tu	18 Th	18 Su	18 Tu
19 Th	19 Sa	19 Tu	19 Th	19 Su	19 We FINANCE REDEVELT	19 Fr	19 Mo	19 We
20 Fr	20 Su	20 We	20 Fr	20 Mo	20 Th	20 Sa	20 Tu	20 Th
21 Sa	21 Mo	21 Th	21 Sa	21 Tu	21 Fr	21 Su	21 We FINANCE REDEVELT	21 Fr
22 Su	22 Tu	22 Fr	22 Su	22 We	22 Sa	22 Mo	22 Th	22 Sa
23 Mo ? ARG accounts	23 We TRUST BOARD	23 Sa	23 Mo	23 Th	23 Su	23 Tu	23 Fr	23 Su
24 Tu	24 Th	24 Su	24 Tu	24 Fr	24 Mo	24 We	24 Sa	24 Mo
25 We SEMINAR	25 Fr	25 Mo	25 We TRUST BOARD	25 Sa	25 Tu	25 Th	25 Su	25 Tu Christmas Day
26 Th	26 Sa	26 Tu	26 Th	26 Su	26 We TRUST BOARD	26 Fr	26 Mo	26 We Boxing Day
27 Fr	27 Su	27 We SEMINAR	27 Fr	27 Mo August Bank Hol.	27 Th	27 Sa	27 Tu	27 Th
28 Sa	28 Mo Spring Bank Hol.	28 Th	28 Sa	28 Tu	28 Fr	28 Su	28 We TRUST BOARD	28 Fr
29 Su	29 Tu	29 Fr	29 Su	29 We	29 Sa	29 Mo	29 Th	29 Sa
30 Mo	30 We ? TELECON ARG IBD ACCOUNTS	30 Sa	30 Mo	30 Th	30 Su	30 Tu	30 Fr	30 Su
	31 Th		31 Tu	31 Fr		31 We SEMINAR		31 Mo

2019

Jan	Feb	Mar	Apr
1 Tu New Year's Day	1 Fr	1 Fr	1 Mo
2 We	2 Sa	2 Sa	2 Tu
3 Th	3 Su	3 Su	3 We
4 Fr	4 Mo	4 Mo	4 Th
5 Sa	5 Tu	5 Tu	5 Fr
6 Su	6 We	6 We AUDIT,R,G	6 Sa
7 Mo	7 Th	7 Th	7 Su
8 Tu	8 Fr	8 Fr	8 Mo
9 We	9 Sa	9 Sa	9 Tu
10 Th	10 Su	10 Su	10 We QUALITY
11 Fr	11 Mo	11 Mo	11 Th
12 Sa	12 Tu	12 Tu	12 Fr
13 Su	13 We	13 We QUALITY	13 Sa
14 Mo	14 Th	14 Th	14 Su
15 Tu	15 Fr	15 Fr	15 Mo
16 We QUALITY	16 Sa	16 Sa	16 Tu
17 Th	17 Su	17 Su	17 We FINANCE REDEVELT
18 Fr	18 Mo	18 Mo	18 Th
19 Sa	19 Tu	19 Tu	19 Fr Good Friday
20 Su	20 We	20 We FINANCE REDEVELT	20 Sa
21 Mo	21 Th	21 Th	21 Su
22 Tu	22 Fr	22 Fr	22 Mo Easter Monday
23 We FINANCE REDEVELT	23 Sa	23 Sa	23 Tu
24 Th	24 Su	24 Su	24 We
25 Fr	25 Mo	25 Mo	25 Th
26 Sa	26 Tu	26 Tu	26 Fr
27 Su	27 We SEMINAR	27 We TRUST BOARD	27 Sa
28 Mo	28 Th	28 Th	28 Su
29 Tu		29 Fr	29 Mo
30 We TRUST BOARD		30 Sa	30 Tu
31 Th		31 Su	MAY I Wed SEMINAR

NO MTG TO AVOID EASTER

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Patient Story

Executive summary:

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

This month's patient story highlights how it is possible to deliver care that is *kind* and caring, treating a patient with respect; however without *expert* knowledge this can result in a positive patient experience becoming a negative one.

This patient story is based on the real experience of a transgender patient who did not wish to attend in person and wished to remain anonymous. The head of patient experience will share their story, describing the impact that misgendering a person can have.

Quality impact:

The board will hear how it is not only staff's behaviour and verbal communications that impact on our patients but also what we record may result in a negative patient experience. This activity is relevant to the safe and caring CQC domains.

Financial impact:

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

Risk impact:

None

Recommendation(s) to the Committee:

The Committee is asked to note this paper and the patient story

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Guy Young Stephanie Harrison-White	Janice Sigsworth	15 September 2017

Patient Story

1. Background

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

The perceived benefits of patient stories are:

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

The Board has previously approved the patient and public involvement strategy, a key part of which is engagement with users of our services and increasing the number of patients who are actively involved.

2. Susan's story

Transgender people represent a marginalized group who continue to experience considerable difficulty in obtaining 'culturally competent health care' despite the introduction of discriminatory legislation (Equality Act 2010) and recommendations by professional organisations, including the General Medical Council (GMC 2016) (Redfern & Sinclair 2014).

A person whose gender identity is different from the biological sex that was assigned at birth, has the right to be recognised as the gender which they are permanently living as under the Equality Act (2010). This includes changing their gender and name on documents such as passports; driver's license or the majority of documents including their health records, they do not require a gender recognition certificate for these purposes.

The Trust is currently commissioned to provide male to female gender reassignment surgery, we are the primary NHS Trust to provide this service. We recognise however that our patients do not always have a positive experience and that one contributing factor is staff knowledge.

Susan (patient name changed to protect anonymity) shared her experience with the head of patient experience but did not want to share her story in public. Transgender people are often exposed to 'transphobia' (Women and Equalities Committee 2016) that can include for example discrimination and hostile portrayal in the media. It is this fear of 'transphobia' and stigmatisation that can further isolate people and consequently further marginalise them. The essence but not the detail of Susan's story will be shared on her behalf as it is only through raising awareness and challenging practice that we can learn and improve our services.

Susan attended one of our departments earlier in the year. She described how she felt she was treated kindly by staff who showed her great compassion and treated her with respect. On discharge she was presented with a copy of her GP letter. On reading the letter, Susan noted that she had been 'misgendered' through an inappropriate use of pro-nouns. Susan was understandably upset and confused by this. She described feeling 'humiliated,

embarrassed and sad'. She left the hospital in tears.

3. Lessons learnt

We know from complaints we have received and from Susan's experience that whilst our staff may have positive interactions with transgender patients, some of our staff do not have the expert knowledge to support them in accurately recording trans patient's gender and that this causes unnecessary distress for people.

This has highlighted that we need to review our staff training with regards to Equality and Diversity and that we needed to develop relevant policies to support and promote best practice.

In a recent paper presented to the Executive Quality Committee, it was agreed that under the Equality Delivery System (EDS2), we will focus on the following objective over the next year:

Goal 2: Improved patient access and experience

- Outcome 2.3 Patients and carers report positive experiences of the NHS, were they are listened to and respected and their privacy and dignity is prioritised

We will focus on the protected characteristic referred to as gender reassignment under the Equality Act (2010).

We have begun work on this objective with the publication of the Gender Recognition Policy (2017) that was co-designed with clinicians and service users. A current review of the EDS training is underway in consultation with a service user. Bespoke training is being developed to deliver to local departments, in addition to the Statutory mandatory EDS training.

We have learnt that behaviours need to be supported by knowledge to ensure that our patients receive the positive experience we would want everyone to experience.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	**27 September 2017**

Chief Executive Officer's Report

Executive summary:

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

Key strategic priorities:

1) Financial performance
2) Financial improvement programme
3) Operational performance
4) Stakeholder engagement
5) Update on major building improvements

Key strategic issues:

6) Estates problems
7) Cancer patient experience survey results
8) Flu immunisation campaign
9) 'Great place to work' week

Quality impact:

N/A

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.
As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.
To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Ian Dalton, Chief Executive Officer	Ian Dalton, Chief Executive Officer	21 September 2017

Chief Executive Officer's report

Key Strategic Priorities

1. Financial performance

During September the Trust agreed a revised control total with NHSI, a planned deficit of £25.15 million, which is £15.85m better than the previous planned deficit outturn of £41m. While the stretch on the clinical divisions remains the same, the Trust has agreed with the regulator a number of additional, mainly non-recurrent, areas of movement. This still leaves the Trust with a significant recurrent problem, but agreeing to the control total gives the Trust access to £20.65m of Sustainability and Transformation funding (STF). The Trust will obtain this funding if it achieves the financial control total and the agreed trajectories for the accident and emergency department four hour waits and primary care streaming. It also provides continued support for the Global Digital Excellence programme, and funding for two diagnostic scanners. Importantly, it gives the Trust the opportunity to focus on fundamental transformation of its services in order to deal with its recurrent deficit over the next few years and to return to balance.

In August 2017, the Trust reported an in-month deficit, before STF of £1.0m which was on plan for the month. Year to date (i.e. the 5 months up to the end of August 2017), the Trust reported a deficit of £18.7m which is also on plan. After STF the Trust had a surplus in month of £2.2m and a deficit year to date of £15.5m.

2. Financial improvement programme

The Trust has set a £54.4m cost improvement programme (CIP) in 2017/18 as part of its overall financial plan; this is in line with the value achieved in 2016/17 of £53.8m.

The year to date plan is £17.8m, there has been achievement of £12.7m, giving a £5.1m underperformance. This underperformance is due to a combination of slippage against planned schemes and yet to be identified plans. Divisions meet weekly with the Programme Support Office and Trust management team to review progress on identification and achievement of CIPs. The rest of the year remains a challenging stretch, but one which the Trust continues to believe will be achieved.

The specialty review programme is continuing across the Trust. This is a clinically-led approach to supporting clinical specialties to develop sustainable plans, including clinical, workforce and financial data.

3. Operational Performance

Cancer 62 day waits: In September 2017, performance is reported for the Cancer waiting times for July 2017. The Trust delivered performance of 86.7% against the 62-day standard for July which is above the national standard of 85% and ahead of trajectory (85.6%).

Accident and Emergency: Performance against the four-hour access standard for patients attending Accident and Emergency was 88.8% in August 2017 which did not meet the performance trajectory target for the month. The key issues remain as follows:

- Difficulties with transfer of patients from the Vocare Urgent Care Centre to the emergency department;
- Increased demand and acuity;
- High levels of bed occupancy;

- High numbers of bed days lost through delayed transfers of care from the hospital;
- Delays for mental health beds; &
- On-going estate issues.

A four-hour performance steering group has been established to oversee a programme of improvements across six work streams. The group is chaired by the divisional director for medicine and integrated care and includes the chief executive officer. Each work stream is led in partnership by a senior clinician and a senior manager.

Referral to treatment (RTT): At the end of August 2017, 83.2% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92%. This was below of the trajectory target of 84.3%.

At the end of August 2017 there were 301 patients who had waited over 52 weeks for their treatment since referral from their GP. Our August performance reflects the additional impact of data issues identified with our waiting list. The validation of all patients is due to completed by the September 2017 submission and trajectory re-modelling is being developed.

We are disappointed to be in a position where we are reporting the identification of further patients who have experienced long waits for their treatment, and extend our apologies to patients affected. Not only are we focusing on improving our processes to ensure that such errors do not occur in the future, we are also ensuring that the treatment for these patients is expedited. The priority for all long waiters is to agree a date for treatment for each patient as soon as possible. Each patient is subject to a clinical review to make sure that their care plan is appropriate in view of the time they have waited for treatment.

The Trust continues the work on its waiting list improvement programme (WLIP) and action plan to address RTT challenges and return to delivering the RTT standard sustainably. The programme has been restructured into three key work streams which respond to the original data clean up recommendations, as recommended by NHS Improvement's intensive support team. These are: RTT recovery and sustainability, elective care operating framework and digital optimisation. The programme is also being delivered through four supporting workstreams: performance support, clinical harm review processes, outsourcing and elective care pathway transformation.

The programme continues to be overseen by a Waiting List Improvement Programme Steering Group, with external representation from Commissioners and NHS Improvement. The Trust has also introduced the Trust's quality improvement team as additional support to the programme.

Diagnostic waiting times: The latest reported performance is for July 2017 where 6.9% of patients were waiting over six weeks against a tolerance of 1%. The deterioration in performance resulted from a deep dive into local data records which identified a recent issue with patient tracking and the recording of offer dates for some endoscopy patients. Recent operational performance suggests that the Trust is driving back towards our target of 1% and should achieve this over the next few months.

The Trust has continued to hold a weekly steering group which is carrying out a full assessment. Steps are being taken to ensure a rapid improvement of performance and weekly progress updates are being made to NHS Improvement and Commissioners.

4. Stakeholder engagement

The Trust's strategic lay forum met on 9 August for the latest of its bi-monthly meetings.

On 12 September, we attended Hammersmith & Fulham Council's health scrutiny committee to discuss adult inpatient discharge covering the Trust's performance and plans for improvement in partnership with stakeholders.

Just under 100 people attended our 2017 Annual General Meeting held on 13 September at St Paul's Church in Hammersmith.

5. Update on major building improvements

Refurbishment of Main Outpatients: Work continues to refurbish the outpatient departments at both Charing Cross and Hammersmith hospitals; phase one of four is near completion for the outpatients refurbishment at Charing Cross with a planned overall completion date of March 2018.

Work to the main outpatients department at Hammersmith Hospital is complete with minor snagging and furniture installations to complete. Renal outpatient refurbishment will be completed end of October 2017. The whole refurbishment programme for outpatients has been funded by Imperial Health Charity.

St Mary's Hospital emergency department and paediatric emergency department refurbishment: Works are now complete on the emergency department improvements the remodelling of the resuscitation and paediatric areas. The whole refurbishment programme for St Mary's Hospital A&E department has been funded by Imperial Health Charity.

Paediatric intensive care unit (PICU) at St Mary's Hospital: Works continue to support the expansion of, and improvements to PICU. Phase one is underway to prepare new space in Cambridge Wing to allow relocation of the paediatric research unit which, in turn, will allow expansion space for PICU in the QEQM building. The redeveloped unit will have 15 beds, almost doubling the current number, plus new equipment, a dedicated parents' room and a private room. This project is divided into three phases with a final completion date scheduled for January 2019. The project is funded through both Trust capital and Imperial Health Charity funding.

Reorganisation of critical care to create co-located high dependency unit (HDU) provision- St Mary's Hospital: Works are due to commence shortly of phase 1 of the scheme with works to HDU and Zachary Cope ward within the Queen Elizabeth Queen Mother building (QEQM).

Some other capital projects currently in feasibility or out to Tender include:

- Refurbishment of 7 North Ward at Charing Cross Hospital- out to tender. Planned works this financial year.
- Imaging machines replacement programme – all sites. Out to tender, Phase 1 planned for this financial year.
- Haematology works in Mint Wing St Mary's- As part of the North West London Pathology programme a new fit out of the 2nd floor mint wing is proposed to site the new Haematology lab.
- Emergency Department re-configuration at Charing Cross hospital to expand the resuscitation and majors areas. A feasibility study is being undertaken; it is hoped that work could commence in the new year.

6. Estate problems

There have been a series of significant estate failures on the St Mary's site over the summer, requiring temporary closure of facilities and urgent repairs. With growing concern about the building most severely impacted – the 147-year-old Cambridge wing– we commissioned a structural survey that identified a number of issues that have required further building

work. As well as disruption and inconvenience for patients and staff, the problems have resulted in a current loss of 30 inpatient beds and unbudgeted repair or remediation costs of around £1 million.

The estate failures, impacts and repairs are as follows:

- In May, part of the ceiling fell down in one section of Thistlethwayte ward in the Cambridge wing. The whole ward section has been closed to allow for repair works, resulting in the loss of 20 beds until the end of December 2017. (We are also using the opportunity of the urgent repairs to bring forward a planned ward upgrade, to include new, en-suite bathrooms where possible.)
- In June, there was a flood in the basement of the Paterson Centre, causing an electrical outage for the whole building and parts of Mint wing. The Paterson Centre, housing the surgical innovation unit, was closed for 14 days to enable repairs. The flood also meant a small number of operations had to be cancelled.
- In June, a small hole appeared in an area of flooring on the first floor of Cambridge wing. An immediate investigation indicated structural problems. The area was made safe with structural support scaffolding and remediation works are now underway. This has required the temporary closure of the nearby birth centre until mid-November, though we continue to offer midwife-led care at either the labour ward at St Mary's or at the birth centre at Queen Charlotte's and Chelsea Hospital.
- In August, there was a flood in the Jefferiss wing, which closed the department for the morning though no services or patient appointments were affected.
- A structural survey of the whole of the Cambridge wing, undertaken during August and September, assured us of the safety of the majority of the building but identified a further, potential issue in Grafton ward. Remediation works are due to be completed by the end of December, with a loss of ten beds until that date.

The Trust has one of the largest backlog building maintenance programmes in the NHS. With a third of its buildings over a hundred years old, St Mary's has the largest proportion of maintenance issues but all five of our hospital estates have significant problems. Even before the unexpected costs incurred by the problems at St Mary's over the summer, we were spending £16 million this year to address our most pressing estate issues across our sites. This is in addition to investment in building improvements – developments worth £18 million commenced or were completed last year across our sites, largely supported by Imperial Health Charity; more are planned for this year.

We continue to work on a long-term, sustainable solution through a major redevelopment of our sites. Our planning application for a first phase of a redevelopment of the St Mary's site is due to be considered by Westminster City Council on 26 September 2017.

In the short-term, we are also working on extended contingency plans to manage the additional pressure that the current bed losses will cause as we approach winter. As of 21 September, we have had to trigger black (the highest level) capacity escalation measures 21 times since 1 April; in all but one of these cases, this was for the St Mary's site only, reflecting the impact of the unplanned reduction in beds.

7. Cancer patient experience survey results

The 2016 National Cancer Patient Experience Survey (NCPES) results were published in July 2017. The results did not show the notable level of improvement of the previous year's survey, which is somewhat disappointing, but it is felt that the on-going cancer patient experience improvement work, notably phase two of the programme with Macmillan, remains the right way to get sustained improvement. It is important to note that phase two had not commenced at the time the patients responding to the 2016 survey were receiving treatment

here (those discharged between 01 April 2016 and 30 June 2016).

A more detailed review of the survey results has been undertaken and an action plan addressing key issues arising from the survey is being finalised. This will be shared with the Trust board in November.

8. Flu campaign 2017

This year's staff flu vaccination programme has got off to a good start with an overachievement of our first target for the recruitment of 'peer vaccinators'.

The Trust has had a low uptake of the flu vaccine amongst staff in recent years. This year's vaccination programme, led by the improvement team in partnership with occupational health, communications and others, has been carefully planned to ensure much greater, and earlier, take up – at least 70 per cent of frontline staff to be vaccinated between 25 September and 30 November 2017. This will be especially important given the expectation, following on from the Southern hemisphere's experience during their winter, that there will be a high level of infection this year.

The central plan is being supported by divisional flu plans to help ensure coverage of all wards and services. Implementation of the plans commenced on 16 August with the following highlights so far:

- We have trained 138 peer vaccinators to date; a further 21 will be trained by 22 September 2017. Our aim has been to recruit at least 140 peer vaccinators who will be able to recruit colleagues locally.
- In addition, three roaming vaccinators have been recruited who will be focused solely on vaccinating staff in preparation for winter.
- A measurement plan and database has been developed which the improvement team will administer. This will ensure that vaccination rates are recorded in real-time with monitoring and sharing across all divisions, directorates and wards and at weekly flu huddles. This continuous learning will allow the reallocation of resources, adaptations to the implementation approach and targeted support with divisions to provide focus on those areas most in need.
- A staff communications campaign is underway, focusing on a 'get winter ready' message that will also be central to a wider winter preparedness action programme that will roll out from late September. The campaign also features mythbusters, peer support and promoting vaccination successes across different teams.
- A logistics plan for receiving and distributing the vaccine has been developed with pharmacy.
- Divisions have nominated flu leads who are joining weekly flu huddles – with leaders from across the organisation supporting the campaign.

9. Great place to work week (Monday 25 September to Sunday 1 October)

As part of our staff retention strategy, we have created our first 'Great place to work week' to raise awareness of the wide range of opportunities available to our staff and to celebrate their achievements. There is a packed programme of roadshows, talks, workshops, taster sessions and other activities across all of our sites – and lots of ways for staff to get involved.

The week's programme is structured around our offer to staff - from working with amazing people in a huge variety of roles, pushing the boundaries of what's possible, to making the most of a vast range of learning and development options, being part of a community that values wellbeing and reward and recognition.

The week also incorporates our regular charity week (run by Imperial Health Charity) and health and wellbeing week, coinciding with Healthy London Partnership's healthy living week.

Imperial College Healthcare NHS Trust

Report to:	Date
Trust board - public	**27 September 2017**

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of August 2017 (month 5).

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Terence Lacey (Performance Support Business Partner) Julie O'Dea (Head of Performance Support)	Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Catherine Urch (Divisional Director) Tim Orchard (Divisional Director) Tg Teoh (Divisional Director)

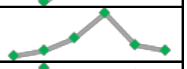
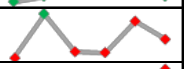
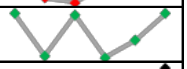
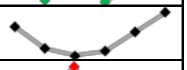
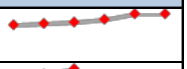
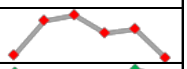
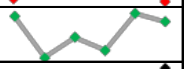
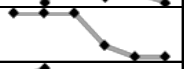
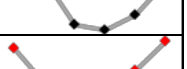
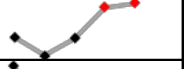
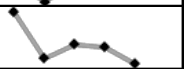
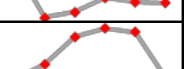
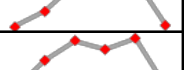
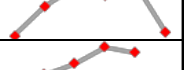
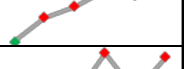
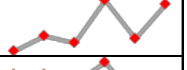
Contents

1. Scorecard

ICHT Integrated Performance Scorecard - 2017/18

Month 5 Report

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Aug-17	-	**27**	
Incidents causing severe harm (number)	Julian Redhead	Aug-17	-	**1**	
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Aug-17	-	**0.08%**	
Incidents causing extreme harm (number)	Julian Redhead	Aug-17	-	**2**	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Aug-17	-	**0.08%**	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Aug-17	44.0	**50.0**	
Never events (number)	Julian Redhead	Aug-17	0	**0**	
MRSA (number)	Julian Redhead	Aug-17	0	**0**	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Aug-17	62	**21**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Aug-17	95.0%	**91.9%**	
CAS alerts outstanding (number)	Janice Sigsworth	Aug-17	0	**2**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Aug-17	-	**3**	
Staffing fill rates (%)	Janice Sigsworth	Aug-17	tbc	**96.0%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Aug-17	2.8%	**2.5%**	
Core Skills Rate - excluding Doctors in Training (%)	David Wells	Aug-17	90.0%	**84.4%**	
Core Skills Rate - Doctors in Training only (%)	David Wells	Aug-17	90.0%	**66.9%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Aug-17	tbc	**80.2%**	
Core Clinical Skills (including Doctors in Training) (%)	David Wells	Aug-17	tbc	**53.2%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Aug-17	0	**5**	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Apr-17	100	**55.0**	
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Qtr 4 16/17	90.0%	**48.8%**	
Unplanned readmission rates (28 days) over 15s (%)	Tim Orchard	Jan-17	-	**6.52%**	
Unplanned readmission rates (28 days) under 15s (%)	Tg Teoh	Jan-17	-	**5.13%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days) (number)	Tg Teoh	Aug-17	-	**1571**	
Outpatient appointments checked-in AND not checked-out (number)	Tg Teoh	Aug-17	-	**2187**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Aug-17	95.0%	**96.9%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Aug-17	85.0%	**94.6%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Aug-17	95.0%	**93.5%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Aug-17	94.0%	**91.5%**	
Complaints: Total number received from our patients	Janice Sigsworth	Aug-17	100	**90**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Aug-17	-	**82.4%**	
Mixed-Sex Accommodation (EMSA) breaches	Janice Sigsworth	Aug-17	0	**21**	
Well Led					
Vacancy rate (%)	David Wells	Aug-17	10.0%	**12.4%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Aug-17	10.0%	**10.2%**	
Sickness absence (%)	David Wells	Aug-17	3.1%	**2.7%**	
Personal development reviews (%)	David Wells	Jul-17	95.0%	**88.5%**	
Consultant Appraisal Rate (%)	Julian Redhead	Aug-17	95.0%	**89.5%**	
Education open actions (number)	Julian Redhead	Aug-17	-	**2**	
Reactive maintenance performance (% tasks completed within agreed response time)	Janice Sigsworth	Aug-17	98%	**38.1%**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	Aug-17	92.0%	**83.2%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	Aug-17	-	**10569**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	Aug-17	0	**301**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	Jul-17	85.0%	**86.7%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Jul-17	0.8%	**1.1%**	
28 day rebooking breaches (% of cancellations)	Catherine Urch	Jul-17	8.0%	**8.4%**	
Theatre utilisation (%)	Catherine Urch	Aug-17	85.0%	**75.5%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Aug-17	95.0%	**73.9%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Aug-17	95.0%	**88.8%**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Jul-17	1.0%	**6.9%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Aug-17	11.0%	**12.3%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Aug-17	7.5%	**7.6%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Aug-17	95.0%	**85.0%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Twenty seven serious incidents (SIs) were reported in August 2017. These are currently under investigation.

Of the 27, 20 were declared in the Division of Medicine and Integrated Care, 14 of which relate to treatment delay (availability of mental health beds) at St Mary's Hospital. A number of actions have been taken in previous months including strengthening of the escalation processes with our mental health providers. A working group has been established between the Trust and Central and North West London Foundation Trust to review and address operational processes and agree routes for data sharing; including outputs from SI investigations and Root Cause Analysis. An escalation process is in place which the Trust is following.

The peaks in monthly SIs correlate with the months where treatment delay (availability of mental health beds) have been reported. There were no common themes for the remaining 13 cases.

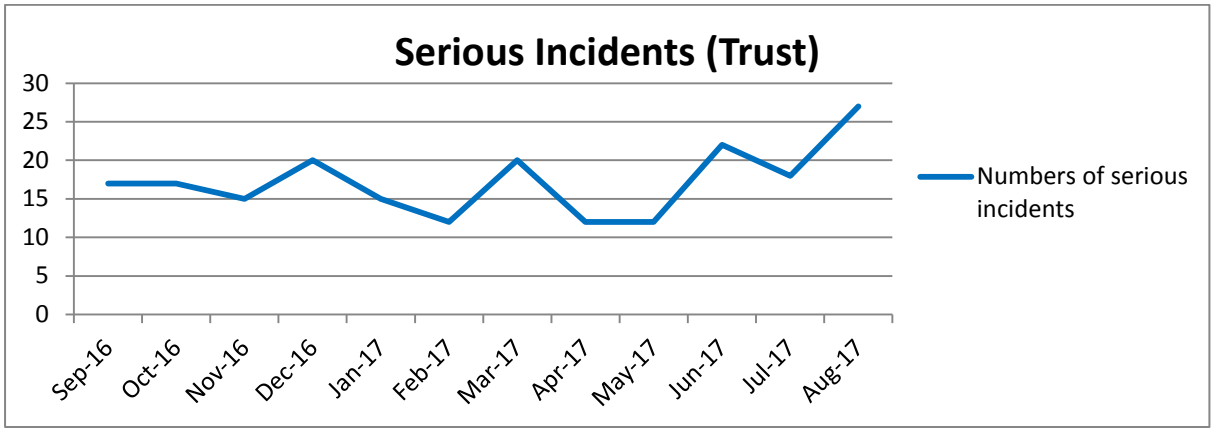


Chart 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period August 2016 – July 2017

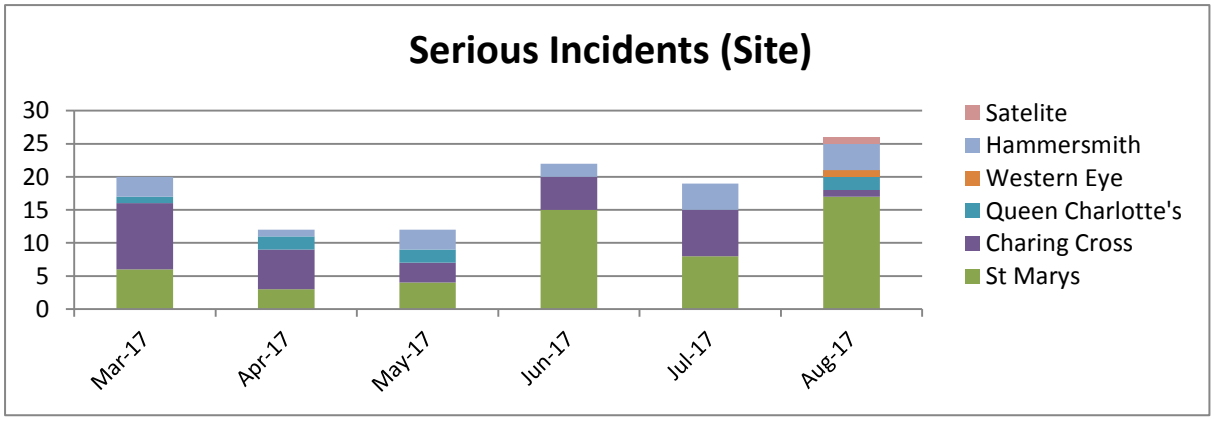


Chart 2 - Number of Serious Incidents (SIs) (Site level) by month for the period March 2017 – August 2017

2.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported one severe/major harm incident and two extreme harm/death incidents in August 2017. The one severe/major harm incident is being investigated as an SI. One of the two extreme harm/death incidents is being investigated as an SI and the other is an internal investigation.

One incident reported in July 2017 was also upgraded to major/severe harm in August and is being investigated.

There have been five severe and five extreme harm incidents reported so far this year. This is below average when compared to data published by the National Reporting and Learning System (NRLS) in April 2017.

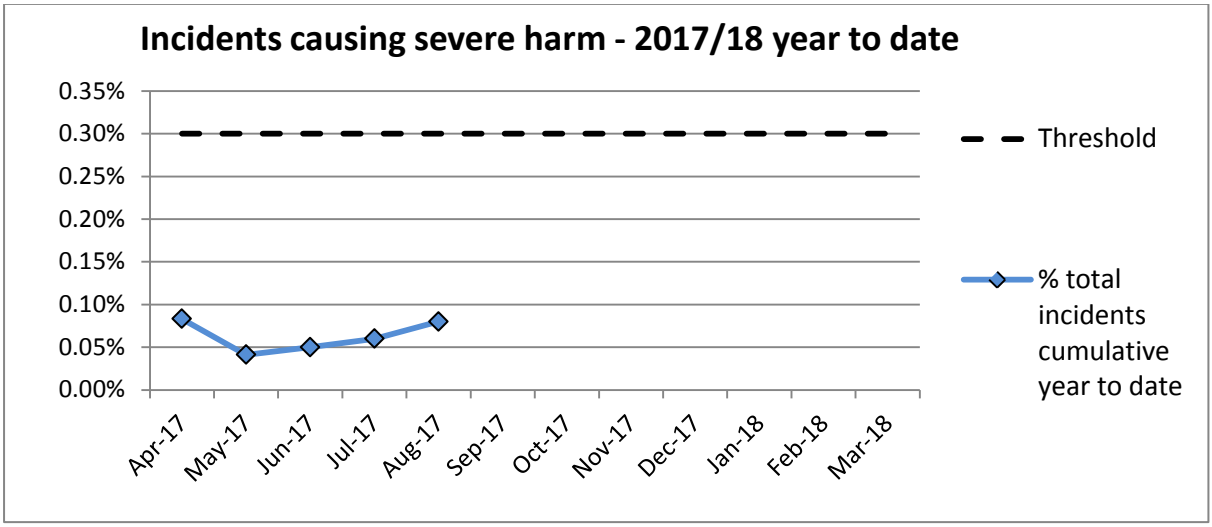


Figure 3 – Incidents causing severe harm by month from the period April 2017 – August 2017 (% of total patient safety incidents YTD)

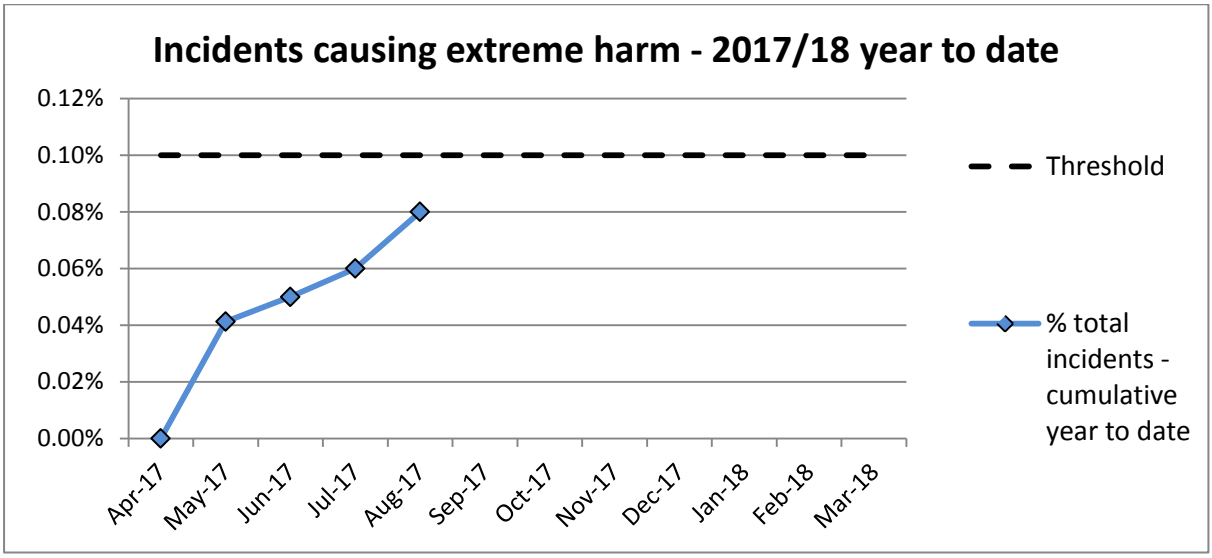


Chart 4 – Incidents causing extreme harm by month from the period April 2017 – August 2017 (% of total patient safety incidents YTD)

Patient safety incident reporting rate

The Trust's patient safety incident reporting rate for August 2017 is 50 per 1000 bed days. This means that the organisation has met its target to be within the highest 25 per cent of reporters nationally. Through the safety culture programme we are committed to continuing to encourage and support increased reporting. A communications campaign across the Trust has now been fully implemented and bespoke trigger lists for reporting are currently being trialled on wards with historically low levels of reporting.

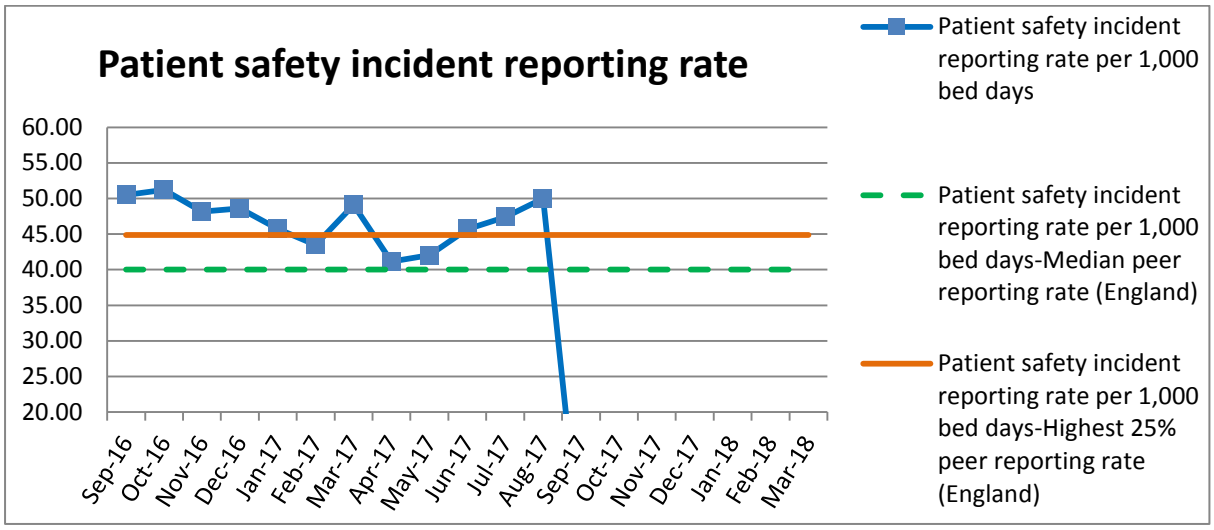


Chart 5 – Trust incident reporting rate by month for the period August 2016 – August 2017

(1) Median reporting rate for Acute non specialist organisations

(2) Highest 25% of incident reporters among all Acute non specialist organisations

2.1.3 Never Events

Following the Never Event that occurred in July 2017, the Trust is working on a transition plan to safely introduce a standardised product that will prevent epidural lines from being connected to the inappropriate route access. An implementation plan is currently being developed and is due for presentation at the executive quality committee at the beginning of October 2017.

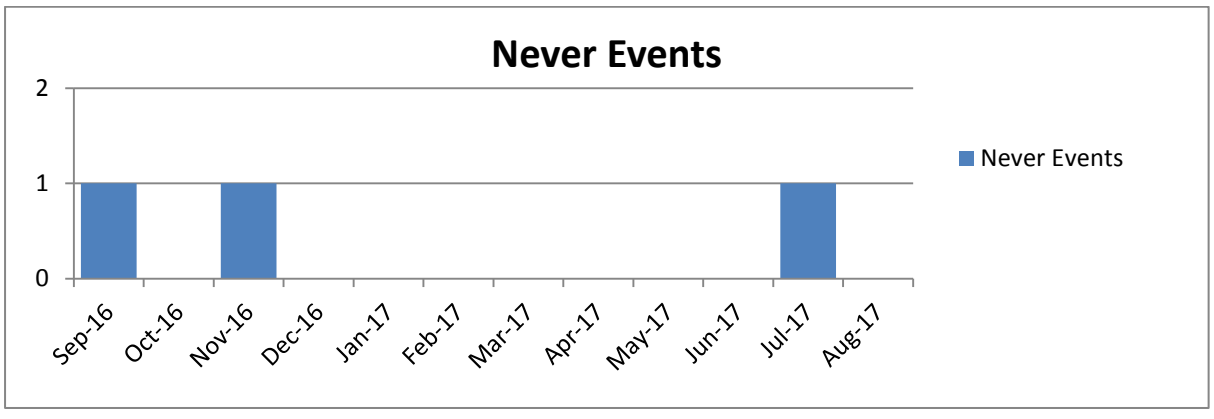


Chart 6 – Trust Never Events by month for the period September 2016 – August 2017

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

There were no cases of MRSA BSI identified at the Trust in August 2017. One case of MRSA BSI has been allocated to the Trust so far in 2017/18; this occurred in April 2017.

2.1.5 Safe: *Clostridium difficile*

Two cases of *Clostridium difficile* were allocated to the Trust for August 2017, which is below trajectory. One of these has been identified as a lapse in care, due to a transmission event on John Humphrey ward. Ward-level investigation is underway. This is the first *Clostridium difficile* lapse in care to occur so far in 2017/18.

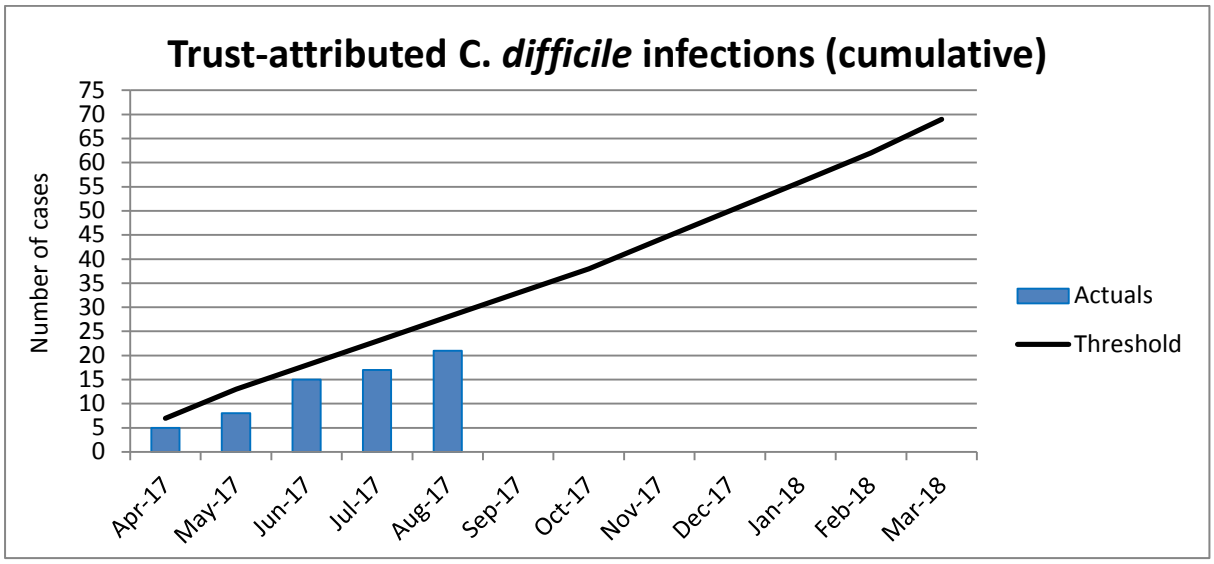


Chart 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – August 2017

2.1.6 Safe: Venous thromboembolism (VTE) risk assessment

The Trust has moved to assessment for VTE at drug prescription on admission rather than at discharge. This went live in Cerner at the end of March 2017 however there were issues with the reporting script which meant we were unable to accurately reflect admission assessment for April and May; the data included for these two months therefore shows data on discharge. The reporting script has now been amended and performance, although improving, is below target at 91.9 per cent at end of August.

The divisions have identified key areas where the 95 per cent target is not being met and submitted initial action plans to the quality sub-group in August. A Key area of focus for improvement in achieving the 95 per cent assessment rate is maternity, the Division of Women's and Children and Clinical Support have put an action plan in place to drive up and monitor improvements in compliance, a weekly progress update is provided to the Medical Directors office.

Weekly reports provided to the Divisions show performance is improving during September. A Trust wide action plan is in place reporting to Executive Quality Committee through the Trust's Quality Report.

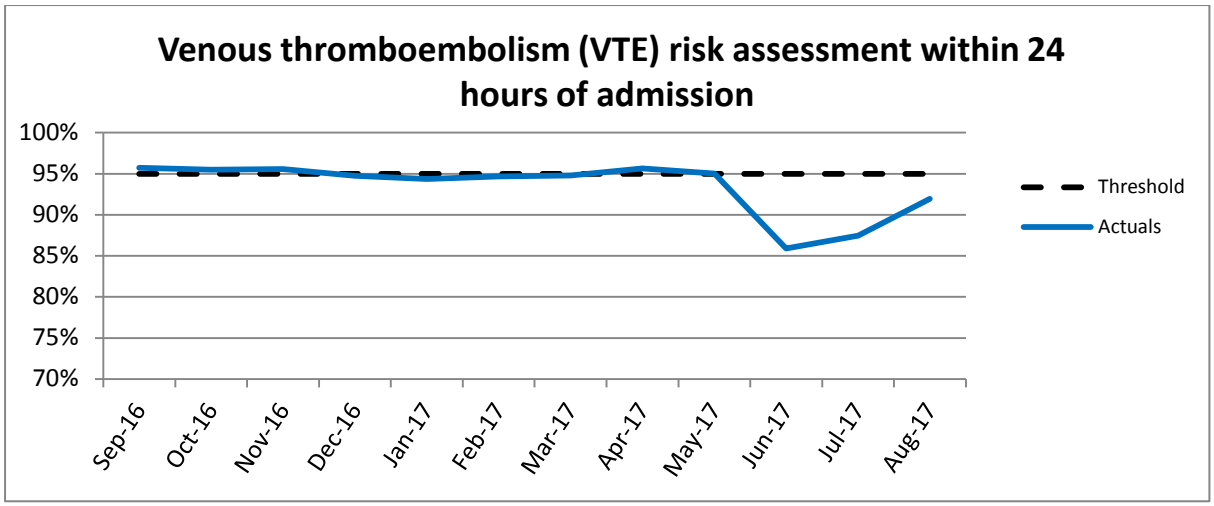


Chart 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period September 2016 – August 2017

2.1.7 Safe: CAS alerts outstanding

The Department of Health Central Alerting System (CAS) is a system for issuing patient safety alerts, public health messages and other safety critical information and guidance to the NHS and others. At end August 2017 two CAS alerts were outstanding. These are being reviewed by the leads so that actions can be put in place.

2.1.8 Safe: Avoidable pressure ulcers

There were three Trust acquired avoidable category 3 pressure ulcers for the month of August 2017. The Trust continues to strive to prevent all avoidable pressure ulcers.

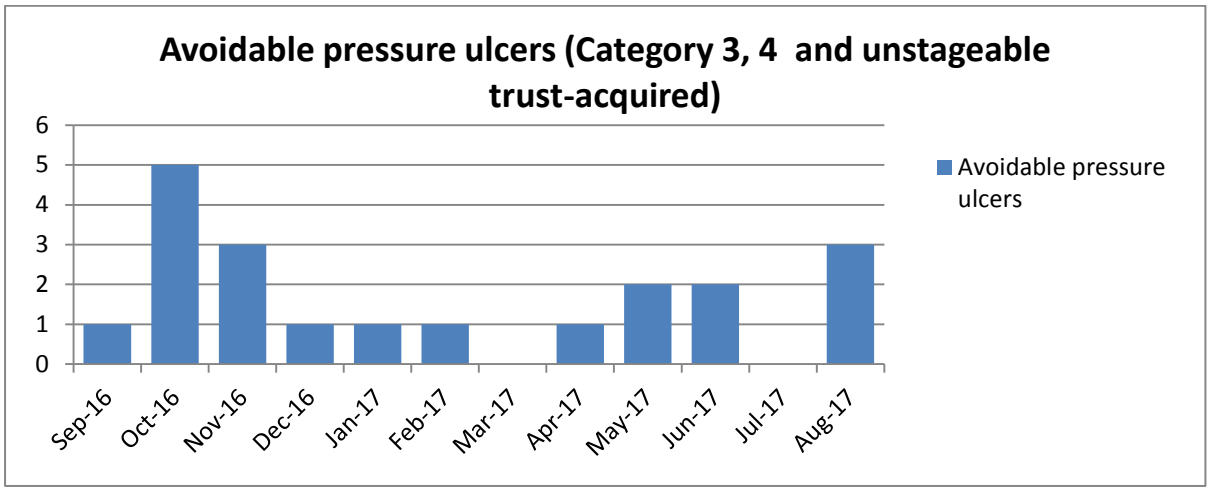


Chart 9 – Number of category 3 and category 4 (including unstageable) Trust-acquired pressure ulcers by month for the period September 2016 – August 2017

2.1.9 Safe: Safe staffing levels for registered nurses, midwives and care staff

In August 2017 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff.

The percentage of shifts meeting planned safe staffing levels by hospital site are as follows:

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	94.11%	93.35%	96.24%	97.66%
Hammersmith	96.37%	93.29%	97.60%	97.31%
Queen Charlotte's	97.27%	92.61%	97.44%	95.48%
St. Mary's	97.30%	92.14%	97.60%	95.65%

In order to maintain standards of care the Trust's Divisional Directors of Nursing and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways:

- Using the workforce flexibly across floors and clinical areas and in some circumstances between the three hospital sites.
- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

In addition, the Divisional Directors of Nursing regularly review staffing when, or if there is a shift in local quality metrics, including patient feedback.

In order to respond to the continued challenge of filling shifts for health care staff from the nurse bank, plans are being established to improve the uptake of these shifts to reduce future staffing gaps.

There is also renewed focus on recruitment and retention of staff across bands 2-6 and a strategic reponse to the challenges has been developed .

The Nursing Associate pilot commenced in April 2017 and 21 new trainees were employed across our partner organisations, 13 of which are based at Imperial.

The development of the apprentice nurse pathway in the coming months will also offer an opportuntiy to bolster up the workforce whilst new recruits train towards registration over a four year period, whilst being employed as apprentices. The clinical Divisons will consider increasing numbers of trainees in the coming months.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in August 2017 were safe and appropriate for the clinical case mix.

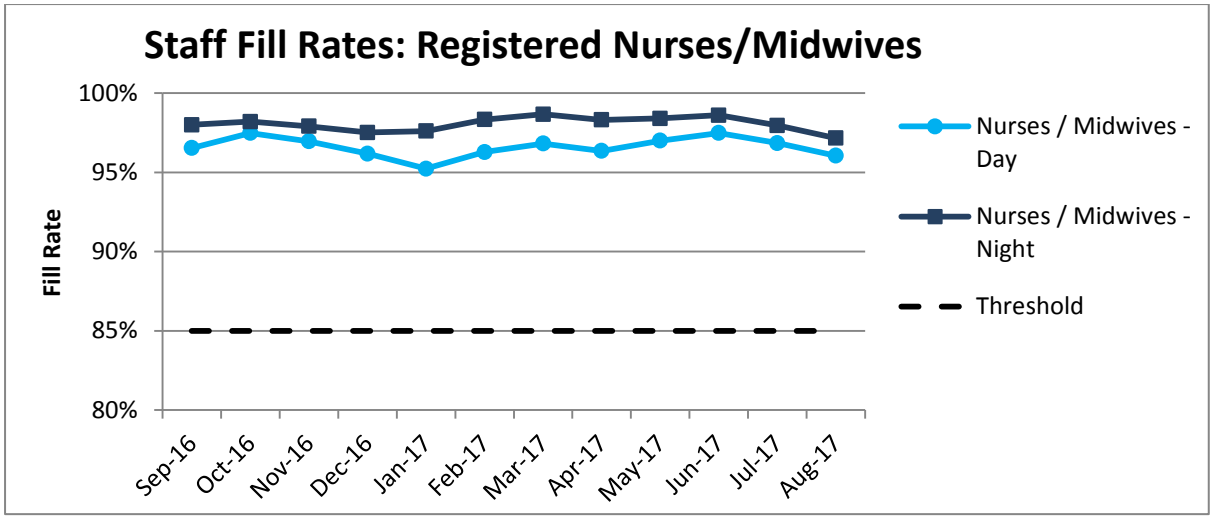


Chart 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period September 2016 – August 2017

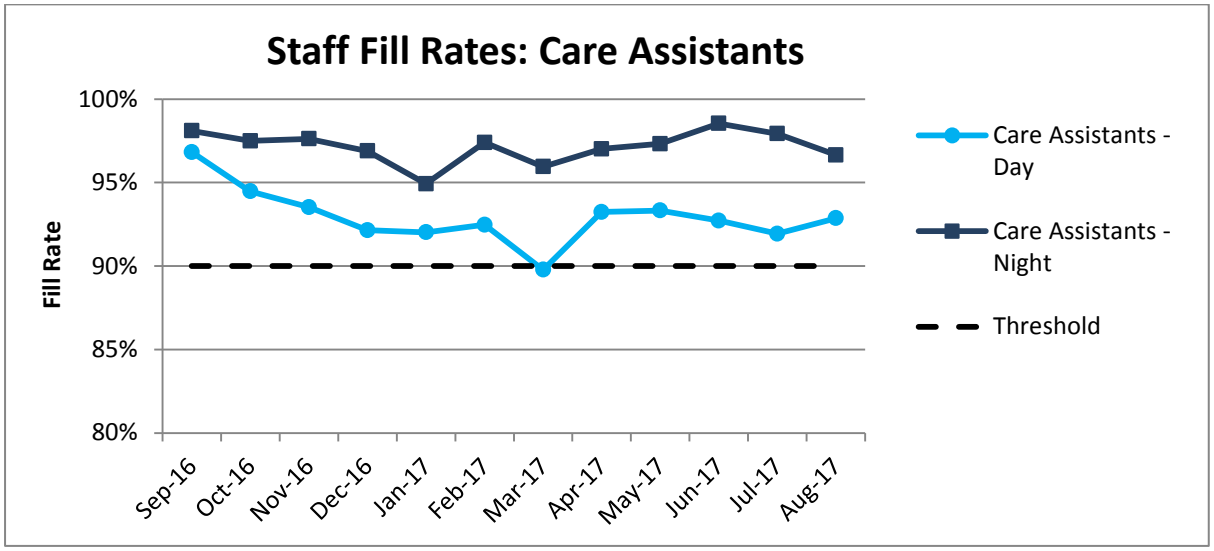


Chart 11 - Monthly staff fill rates (Care Assistants) by month for the period September 2016 – August 2017

2.1.10 Safe: Postpartum haemorrhage

In August 2.5 per cent of women who gave birth at the Trust had a postpartum haemorrhage (PPH), involving an estimated blood loss of 1500ml or more within 24 hours of the birth of the baby. This met the Trust target of 2.8 per cent or less.

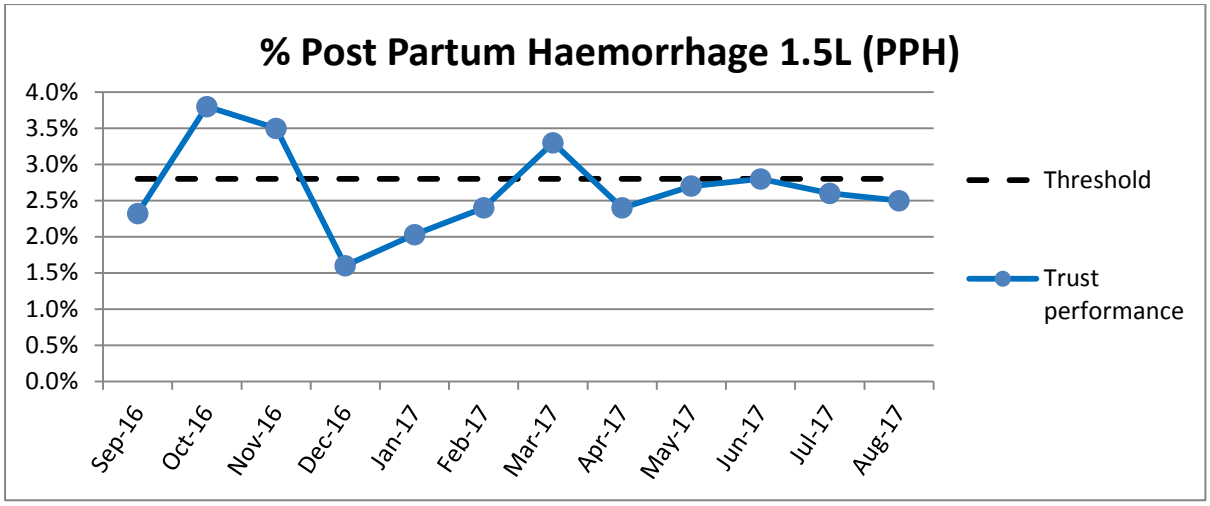


Chart 12 – Postpartum haemorrhage (PPH) for the period September 2016 – August 2017

2.1.11 Safe: Core skills training

At the end of August, the Core skills compliance rate for doctors in training was 66.9 per cent and for all other staff it was 84.4 per cent

Additionally, core clinical topics are a requirement for staff working in clinical, medical and scientific/technical patient-facing roles. At the end of July, the compliance rate for doctors in training was 53.2 per cent and for all other staff it was 80.2 per cent.

- Compliance is being driven via normal management channels as well proactive chasing of poor performing teams and departments to achieve the target of 90 per cent.
- The compliance rate for the August intake of Juniors Doctors for core skills training has improved by over 14 per cent on last years' intake due to a more robust approach during their induction.

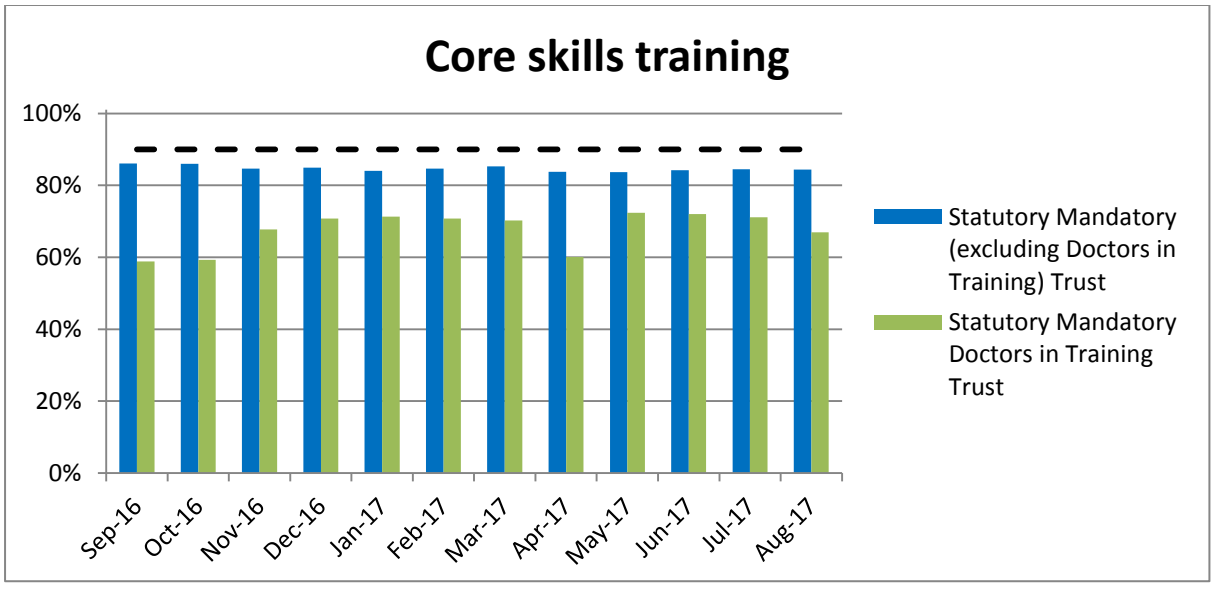


Chart 13 - Statutory and mandatory training for the period September 2016 – August 2017

2.1.12 Safe: Work-related reportable accidents and incidents

There were six RIDDOR-reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in August 2017

The first incident involved a member of staff striking their head on pipes protruding from a low ceiling. This resulted in a sickness absence of over 7 days.

The second incident involved a member of staff receiving a needle-stick injury from a sharp contaminated with a blood-borne virus. The incident was reportable to the Health and Safety Executive as a Dangerous Occurrence (release or escape of a biological agent).

- The third incident involved a member of staff falling down stairs, fracturing their ankle. The incident was reportable to the HSE as a 'specified injury'.
- The fourth incident involved a member of staff fracturing a rib during an awkward movement. This resulted in a sickness absence of over 7 days.
- The fifth incident involved a member of staff being struck by a door, sustaining a shoulder injury. This resulted in a sickness absence of over 7 days.
- The sixth incident involved a member of staff sitting on a chair which broke, striking their back and elbow. This resulted in a sickness absence of over 7 days.

In the 12 months to 31 August 2017, there have been 40 RIDDOR reportable incidents of which 14 were slips, trips and falls. The Trust Health and Safety service continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

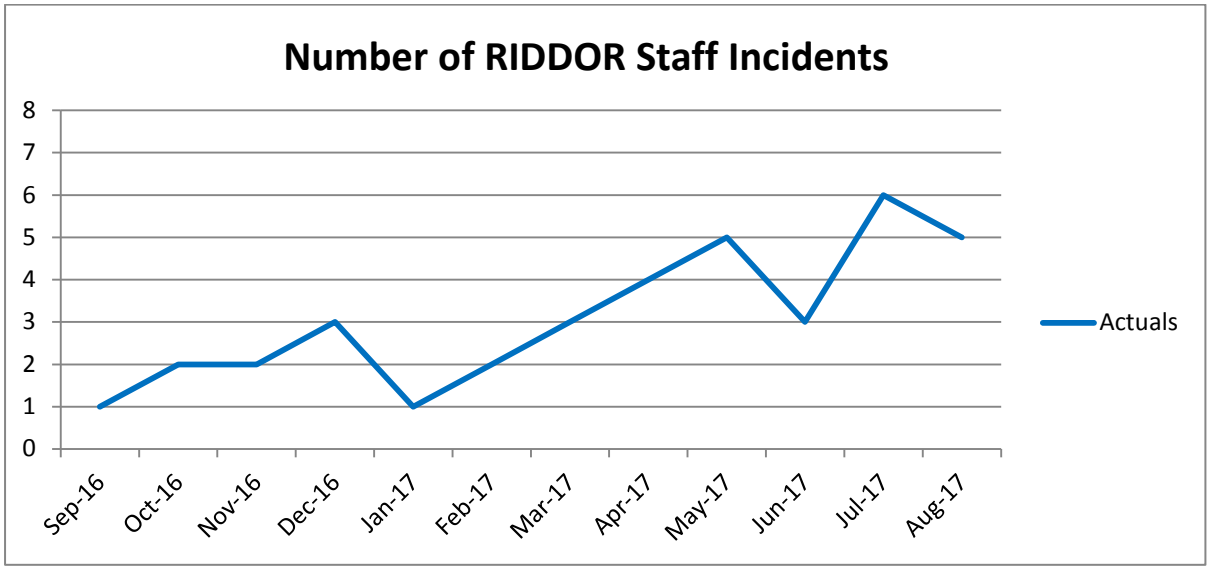


Chart 14 – RIDDOR Staff Incidents for the period September 2016 – August 2017

2.2 Effective

2.2.1 Effective: National Clinical Audits

Each month throughout 2017/18 we will report the number of audits which have been published, and the number of improvement plans which have been developed by the services in response to recommendations and areas for improvement. The improvement plans will be reviewed at the divisional quality and safety committees and at the Clinical Audit & Effectiveness Group meeting and summarised in the quarterly report to executive quality committee.

There have been 13 reports published so far in 2017/18. Twelve of these are currently under review by the divisions. One, the national perinatal mortality surveillance report MBRRACE UK, has already been reviewed with substantial assurance confirmed by the division and action plans already in place. The report showed that the Trust's perinatal mortality rates were lower than those seen across similar Trusts.

2.2.2 Effective: Mortality data

The Trust target for mortality rates in 2017/18 is to be in the top five lowest-risk acute non-specialist trusts as measured by the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI).

The most recent HSMR is 55 (April 2017). Over the last 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust has the fourth lowest SHMI of all non-specialist providers in England for Q4 2016/17 – Q3 2016/17.

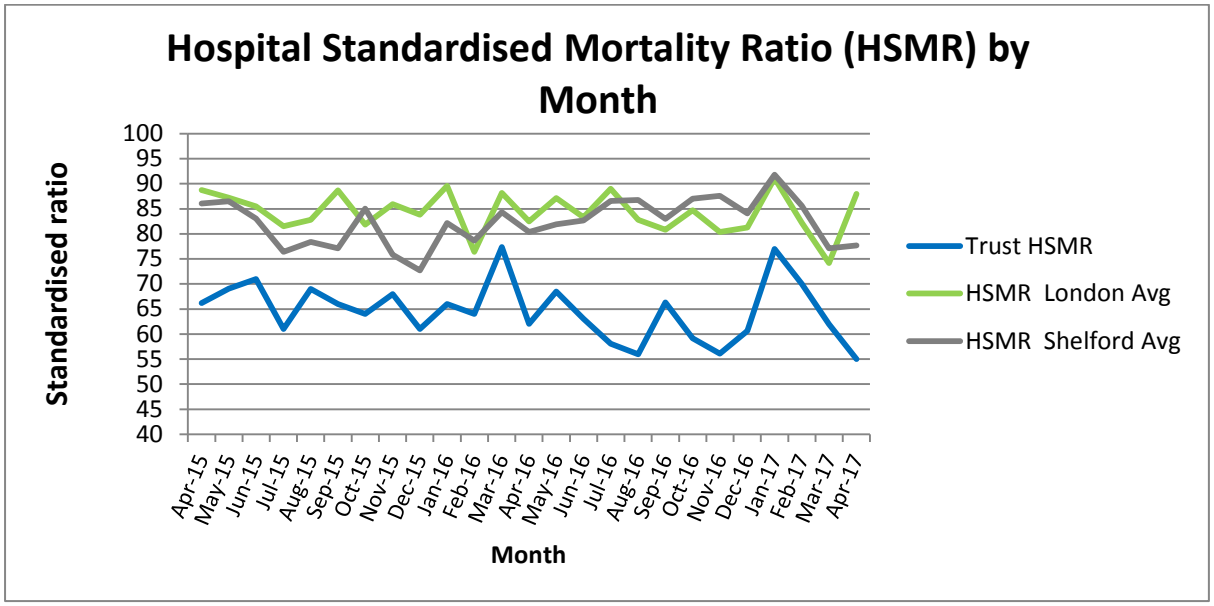


Chart 15 - Hospital Standardised Mortality Ratios for the period April 2015 – April 2017

2.2.3 Effective: Mortality reviews completed

This data are reported quarterly, with the next update due in November 2017. Since the online mortality review system went live in February 2016, 12 avoidable deaths have been confirmed. These have all been investigated either as serious incidents or internal investigations, with learning and actions shared through the mortality review group.

An action plan is in place to ensure that the Trust meets the requirements of the national Framework on Identifying, Reporting, Investigating and Learning from Deaths in Care by Q3 2017/18 (published by the National Quality Board, March 2017). This is on track to be delivered in time, with a new Learning from Deaths policy due to be published and implemented by the end of September 2017.

2.2.4 Effective: Recruitment of patients into interventional studies

Performance data for Q4 2016/17 has recently been validated by the National Institute for Health Research (NIHR) at 48.6 per cent. Almost all Trusts took a significant down-turn in performance in Q4 2016/17 and although we did not achieve our target of 90 per cent of clinical trials recruiting their first patient within 70 days of a valid research application we did perform above the national average of 46 per cent.

The down-turn in performance across Trusts is the result of the introduction of a new trial approval process in 2016, via the Health Research Authority. This has meant that the 'clock start' for trials is now more tightly defined and study contract negotiations cannot begin prior to this 'clock start'. Many research-active Trusts have found it difficult to adapt to this change in terms of the metrics as negotiating contracts (finances, indemnity, patient safety, liability, respective responsibilities) is challenging to complete within 40 calendar days. We have plans in place to speed up contract negotiations internally through more joined up processes, clearer escalation points and standard terms to enable more studies to be initiated within the 70 days (including contract negotiation). Performance for Q1 2017/18 is 48.8 per cent. We expect the trajectory to improve from Q2 onwards.

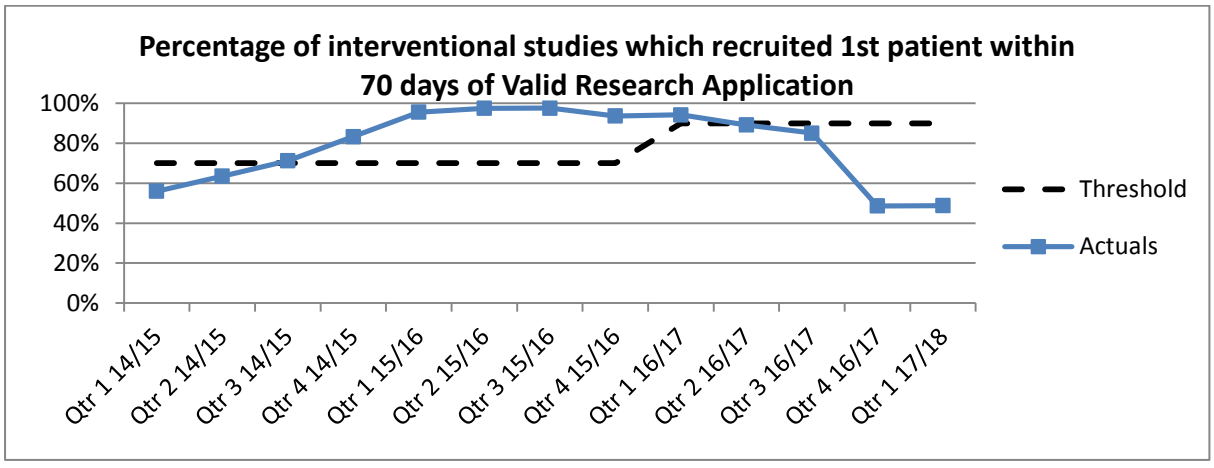


Chart 16 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q1 2017/18

2.2.5 Effective: Readmission rates

For February 2017 (the latest month reported), the Trust readmission rates continued to be lower in both age groups than the Shelford and National rates for both age groups (0-15 years and ages 16 plus).

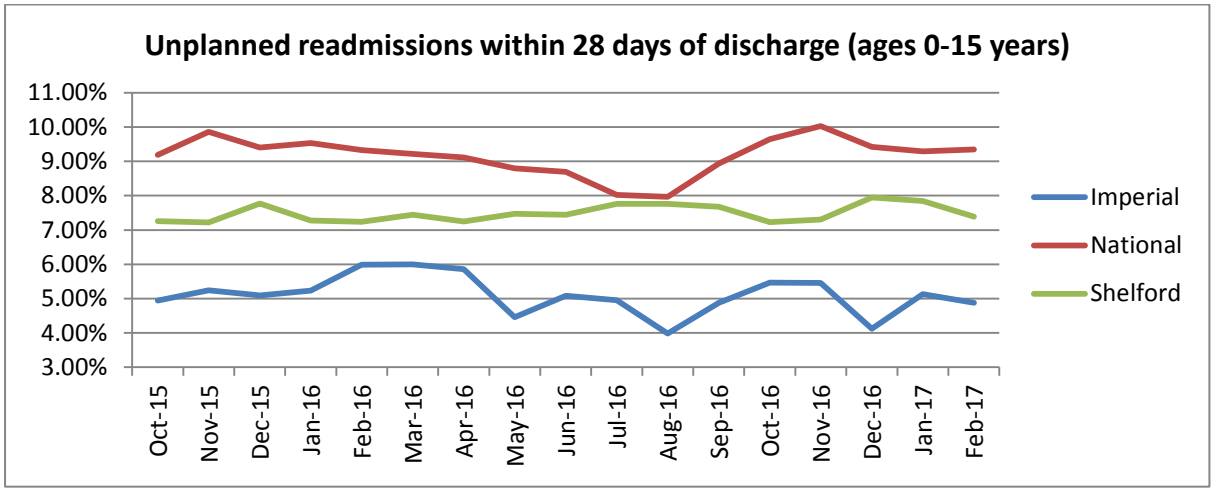


Chart 17 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – February 2017

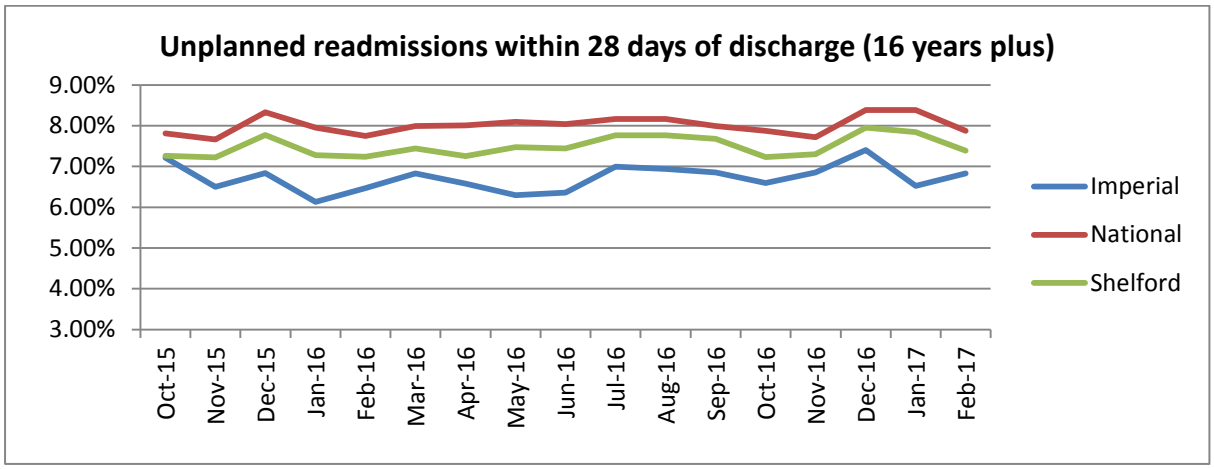


Chart 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – February 2017

2.2.6 Effective: Outpatient appointments checked in and checked out

The rate of reduction has slowed and escalation processes to clear appointments from the booking systems are being stepped up. The amount of outstanding appointments is expected to continue to reduce during September and onwards.

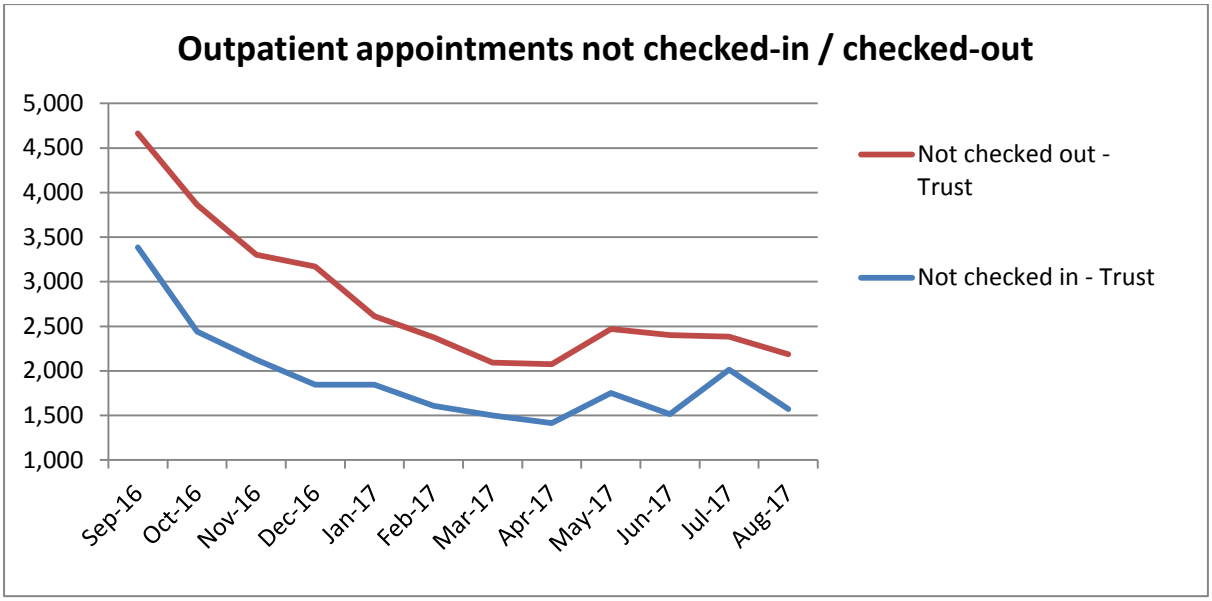


Chart 19 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days)/ checked-in and not checked-out for the period September 2016 – August 2017

2.3 Caring

2.3.1 Caring: Friends and Family Test

Generally the likelihood to recommend score remains high across the board. The outpatient FFT willingness to recommend has increased to 91.5 per cent, which is the highest since the online survey was introduced. The A&E response rate also increased in month, but remains below target and there are actions in place to get it to 20 per cent by the end of the calendar year.

Service	Metric Name	Jun-17	Jul-17	Aug-17
Inpatients	Response Rate (target 30%)	35%	35%	**33%**
	Recommend %	98%	97%	**97%**
	Not Recommend %	1%	1%	**1%**
A&E	Response Rate (target 20%)	12%	11%	**13%**
	Recommend %	99%	95%	**95%**
	Not Recommend %	0.40%	3.10%	**3.09%**
Maternity	Response Rate (target 15%)	29%	30%	**26%**
	Recommend %	93%	95%	**94%**
	Not Recommend %	3%	3%	**3%**
Outpatients	Response Rate (target 6%)	9%	9%	**10%**
	Recommend %	90%	90%	**91%**
	Not Recommend %	5%	5%	**4%**

Friends and Family test results

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

Performance has been affected over the recent period due to number of major incidents which had an impact of vehicular logistics. The Trust service provider has also been participating in the 'Improving patient flow' initiative to improve discharge planning processes. Generally the response times have improved.

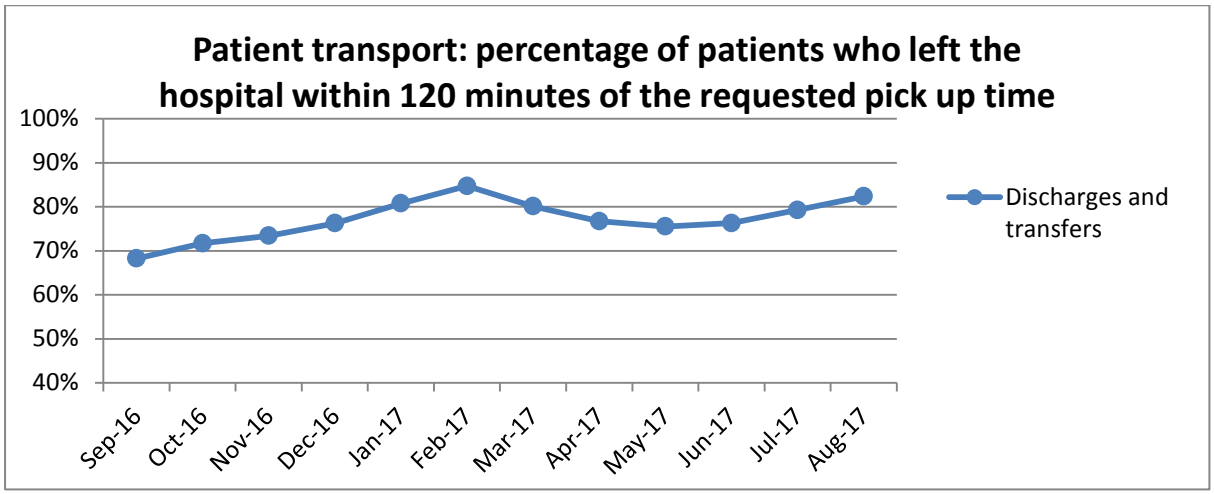


Chart 20 - Percentage of patients who left the hospital as part of the patient transport scheme within 120 minutes of their requested pick up time between September 2016 and August 2017

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 21 mixed-sex accommodation (MSA) breaches for August 2017. All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed.

For critical care (level 2 and 3) mixing is acceptable as it is recognised nursing acuity requires gender mixing, however it is not acceptable when a patient in the critical care units no longer requires level 3 or 2 care, but cannot be placed in an appropriate level one ward bed.

The increase in breaches since October 2016 has been mainly attributable to breaches occurring within ITU at Charing Cross. The Division of Surgery and Cancer continue to undertake a deep dive into the situation at Charing Cross to understand root causes and an action plan is being put in place to address the recommendations.

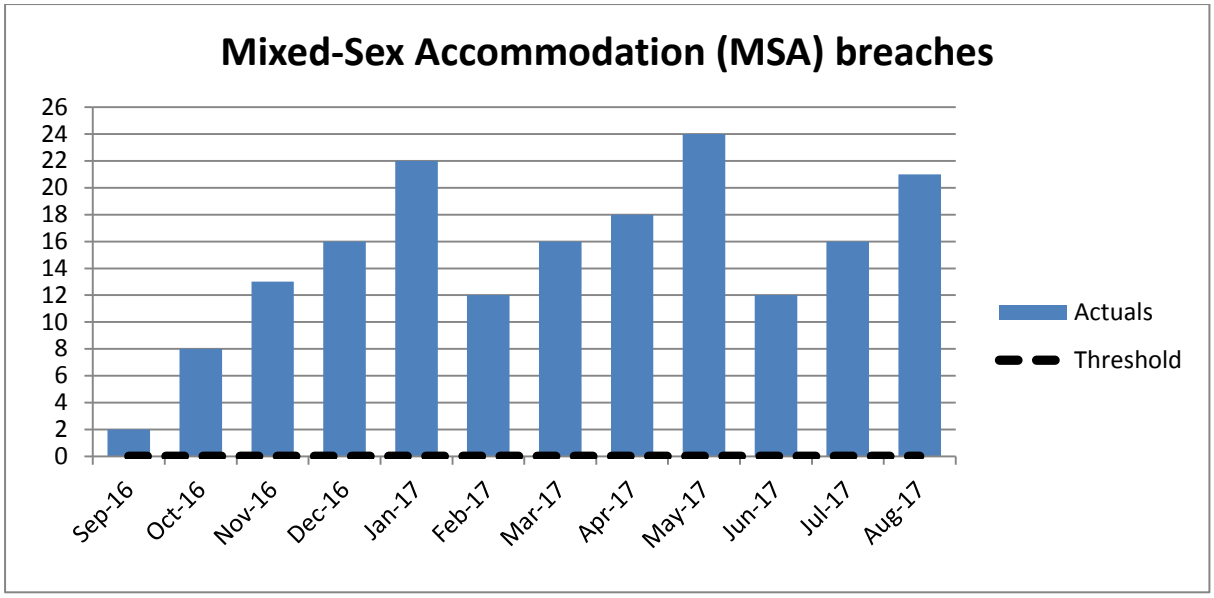


Chart 21 – Number of mixed-sex accommodation breaches reported for the period August 2016 – July 2017

2.3.4 Caring: Complaints

The volume of formal complaints was up from the previous month, but at 90 this is still below the threshold and consistent with the continuing year-on-year downward trend. All complaints were acknowledged within three days and 99% were responded to within the timeframe agreed with the complainant.

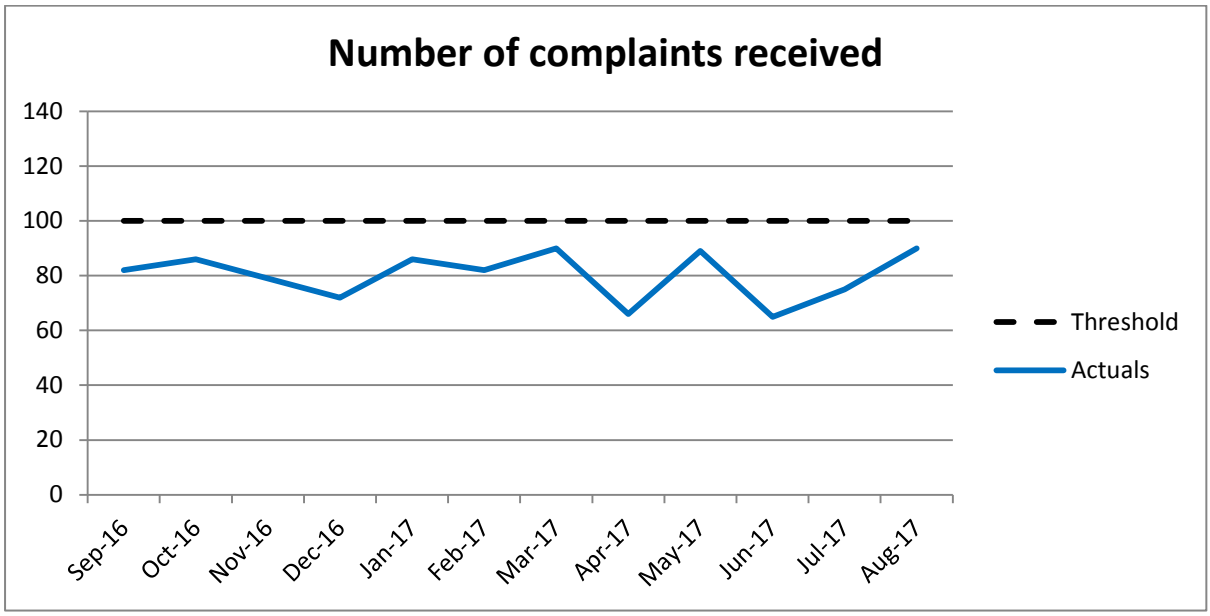


Chart 22 – Number of complaints received for the period September 2016 – August 2017

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

At the end of August 2017, the Trust directly employed 9,110 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions. The contractual vacancy rate for all roles was 12.4 per cent against the target of 10 per cent; continuing to compare favourably to the average vacancy rate of 13.2 per cent across all London Trusts.

During the month there were a total of 488 WTE joiners and 410 WTE leavers across all staffing groups and the Trusts voluntary turnover rate (rolling 12 month position) stands at 10.20 per cent.

Actions being taken to support reduction in vacancies across the Trust include:

- Bespoke campaigns and advertising is underway for a variety of specialities e.g. Radiography and Imaging and Critical Care

- A variety of channels are being used to attract and recruit people including, Open Days, Fairs (we are attending the RCN fair in Islington and the Nursing Times in Birmingham), social media, print advertising and direct sourcing. We are also putting a Preferred Supplier List in place which will support the hard to recruit areas.

- The Careers website content will be redrafted during September/October. The main recruitment look and feel is now live and further marketing materials are being developed to support the development of the brand. All hard to recruit areas adverts are being refreshed to ensure a more compelling and consistent look and feel in the marketplace and will go live in September.

- As part of our retention campaign an internal campaign commenced in July with an extended version of the Pulse. The 'Our Working Lives' pages on the Source are being revised to better articulate our Employee Value Proposition to staff and a ‘Great Place to Work’ Road-show is being planned for September

All Nursing & Midwifery Roles

At end of August 2017, the contractual vacancy rate for all of the Trusts Nursing & Midwifery ward roles was 15.8 per cent with 789 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate stands at 17.4 per cent and we continue to work with other London Acute Teaching Trusts to benchmark and share information to support a reduction in these vacancies.

Actions being taken to support reduction in our Nursing and Midwifery vacancies include:

- A project group is up and running to address Band 2-6 ward based recruitment & retention

- The Recruitment Team have planned three main nursing campaigns for early summer, the autumn and in early 2018

- An automatic conditional offer letter was sent out to all of our student nurses who graduated in August. We have 102 students joining us between September and November. A letter has been sent to all of those who finish in February/March. There is a 'Student Attraction Strategy' which will build on this activity year on year and work towards making us an employer of choice for students

- Open Days and social media campaigns re planned for Haematology, Theatres, ITU, Specialist Surgery, Children's Services, Imaging, Haemodialysis, Specialist Medicine and Stroke and Neurology. Options are being discussed for the Charing Cross hotspots.

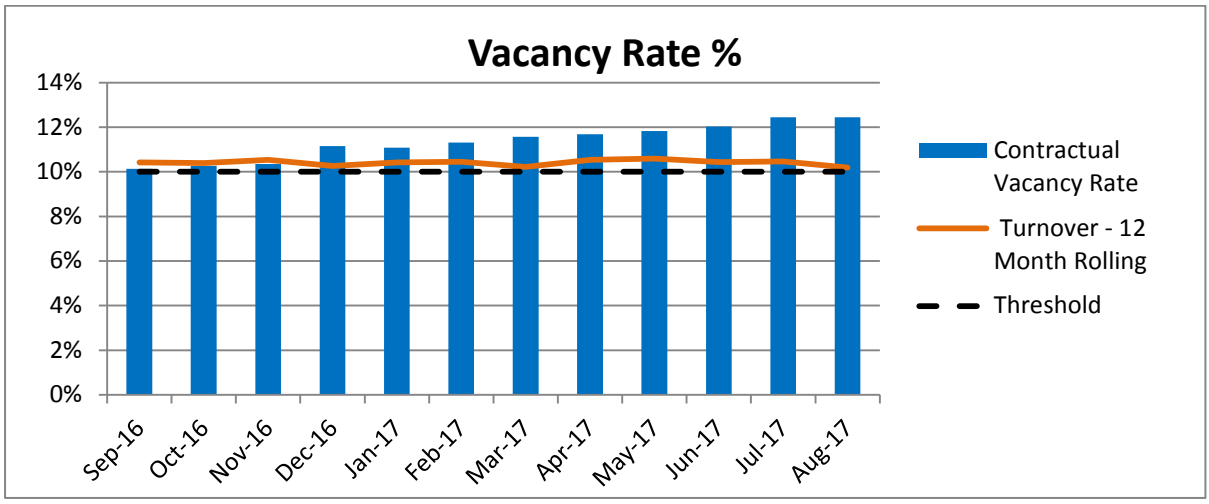


Chart 23 - Vacancy rates for the period September 2016 – August 2017

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in August was 2.75 per cent, maintaining the Trusts rolling 12 month sickness position at 2.90 per cent against the year-end target of 3.10 per cent or lower.

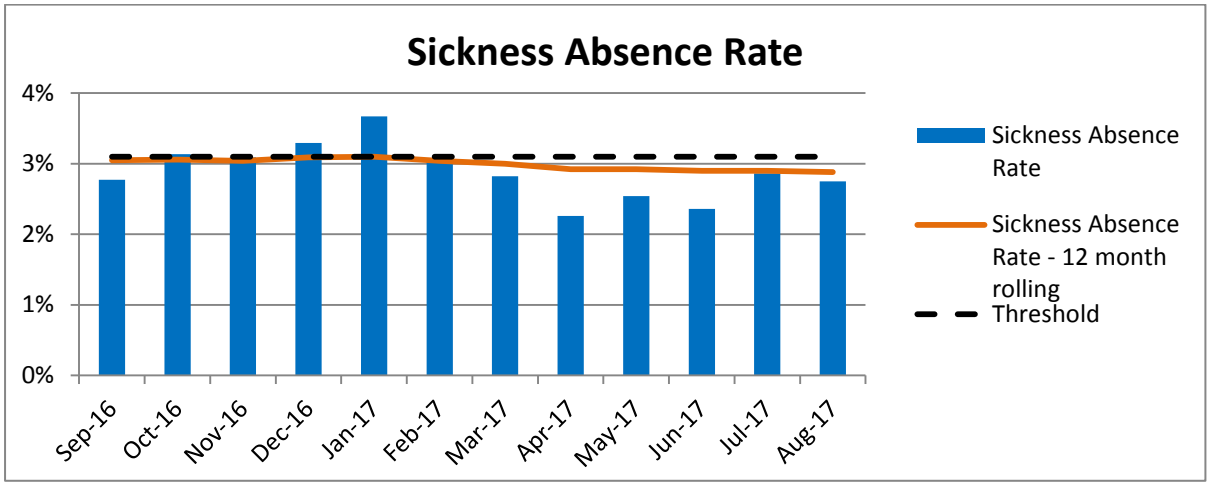


Chart 24 - Sickness absence rates for the period September 2016 – August 2017

2.4.3 Well-Led: Performance development reviews

The PDR cycle for 2017/18 began on 1 April 2017 and closed on the 31 July 2017 with 88.5 per cent of staff having completed a PDR with their line manager.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates remained at 89 per cent. This is just below the national average of 90.1 per cent for designated bodies within the same sector according to the Medical Revalidation Annual Organisational Audit Comparator Report, published in July 2017. Actions being taken to increase compliance include:

- The Deputy Responsible Officer is managing, with the Divisional Directors, the doctors that have not done their appraisals as per the Trust policy.
- Continuing to promote the Professional Development monthly drop-in sessions to provide one to one assistance for doctors with all aspects of their professional development.
- "Appraiser refresher training", which concludes in September and reiterates to the Appraisers the importance of ensuring a doctor is on track for the appraisal cycle, and where the doctors can seek further support.
- Appointment of two new Appraisal Leads and redefinition of their role.
- Reviewing the automated messages from the appraisal system to see if they need to be more explicit on the implications of an overdue appraisal.

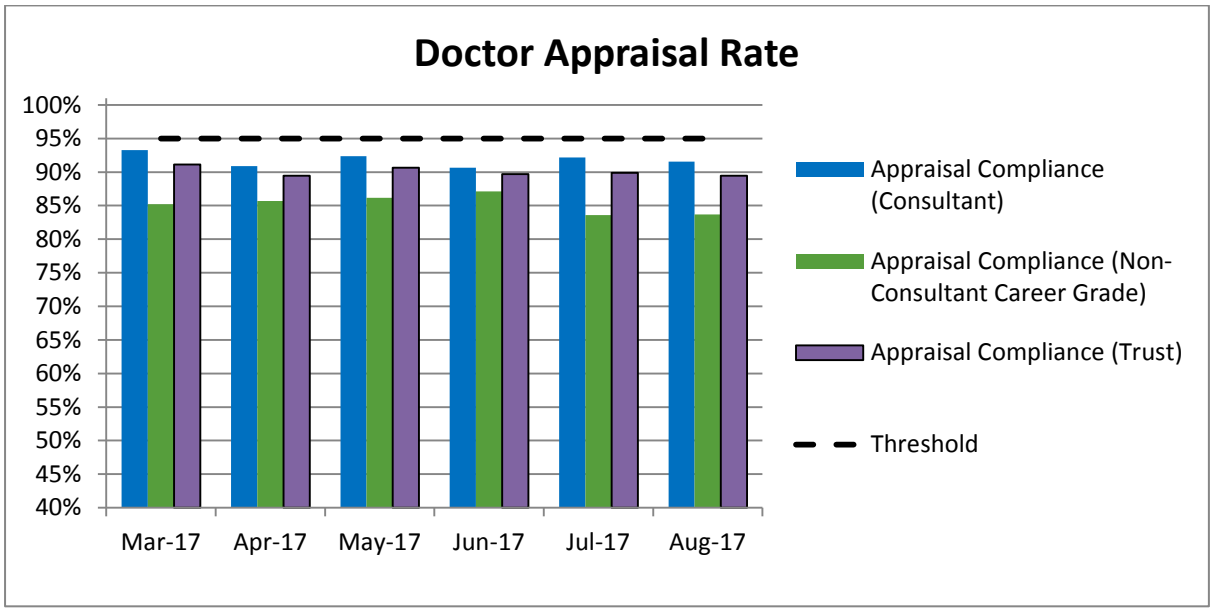


Chart 25 - Doctor Appraisal Rates for the period March 2017 to August 2017

2.4.5 Well-Led: General Medical Council - National Training Survey Actions

Health Education England quality visit

Two actions remain open from the quality visit and are being monitored through the local faculty group meetings (LFGs).

2016/17 General Medical Council National Training Survey

The results of the General Medical Council's National Training Survey 2017 were published in July. The 2016 survey demonstrated significant improvements on previous results. The 2017 results indicate that we have maintained our performance overall, with some specialties demonstrating significant improvements, while others either remain challenged or have seen a deterioration in performance. On-going internal monitoring is being undertaken for specialities of concern through education specialty reviews.

Health Education England (HEE) have specified 10 programmes which require actions in response to red flags; an action plan consisting of 12 actions has therefore been developed in response and will be submitted to HEE in September 2017. Progress with completion of these actions will be monitored through the medical education committee and be reported in this report.

In addition to the external action plan, we are developing an internal action plan for other red outliers which will be monitored internally through local faculty groups and education specialty reviews. Progress will be summarised in the quarterly reports to the executive quality committee.

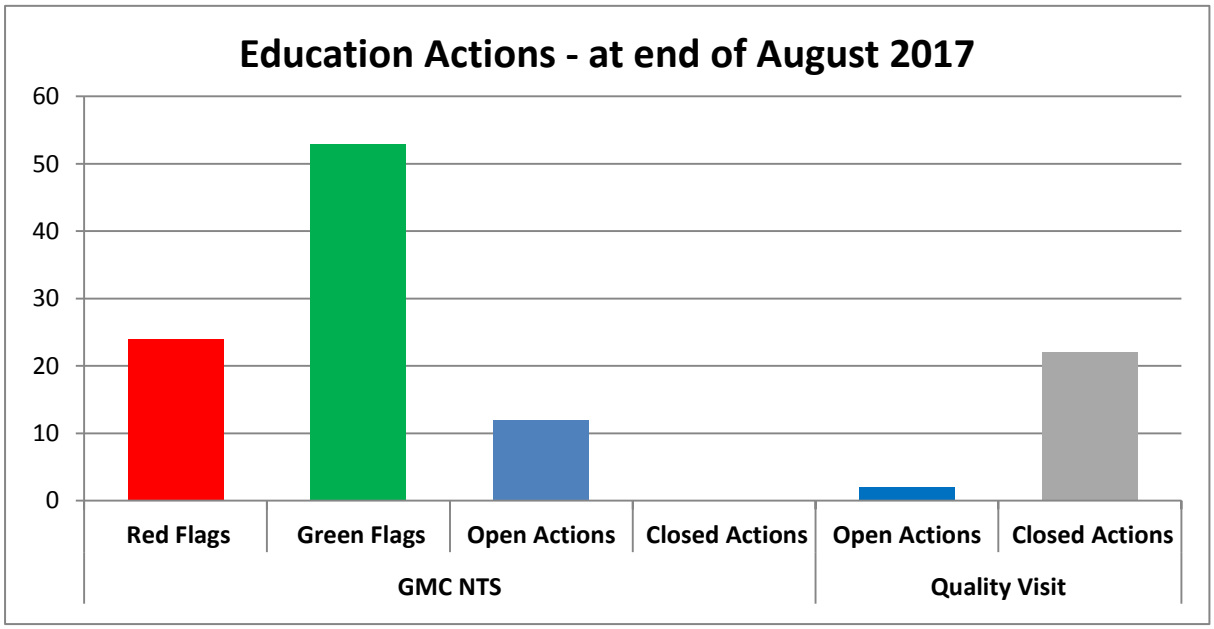


Chart 26 – General Medical Council - National Training Survey action tracker, updated at end August 2017

2.4.6 Well Led: Estates – reactive (repair) maintenance tasks completed on time

The performance for completion on time of reported repair tasks is at present at about 40 per cent (completed on time). The maintenance contractor CBRE has instigated changes to their site based management team to help address completion times.

Delivery continues to be challenging with an aging estate. Due to age and technology change spare parts are often not available or not readily available which can result in delays.

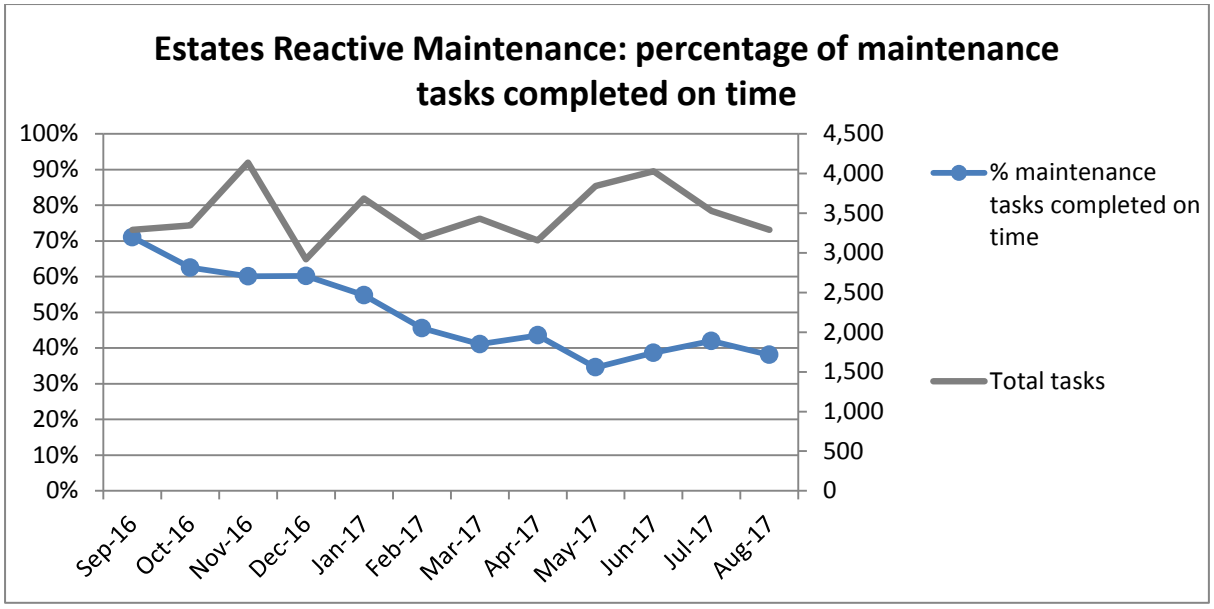


Chart 27 – Estates: percentage of maintenance tasks completed on time for the period September 2016 – August 2017

2.5 Responsive

2.5.3 Responsive: Consultant-led Referral to Treatment waiting times

At end August 83.2 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent. This was below of the trajectory target of 84.3 per cent. The backlog of patients waiting over 18 weeks was 10,569 patients.

Inpatient waiting list data clean up

A large scale data clean-up of the Trust inpatient waiting list was completed January 2017. The impact was a large number of patients were identified whom we had not been tracking consistently in specific specialities because RTT rules were applied incorrectly at an earlier stage of the patient's treatment pathway.

A change in the leadership of the Trust Waiting List Improvement Programme (WLIP) in April 2017 led to a stocktake of the programme aims and progress. This included an assessment of the waiting list which has identified a further cohort of patient records requiring validation.

In total at the end of August 2017 there were 301 patients who had waited over 52 weeks for their treatment since referral from their GP. Our August performance reflects the additional impact of data issues. Immediate actions have been taken to ensure all outstanding patient pathways are reviewed by the services and where appropriate reinstated onto the waiting list. The validation of all patients is due to be completed for the September submission and trajectory modelling is being finalised.

The priority for all long waiters is to agree a date for treatment for each patient as soon as possible. Each patient is subject to a clinical review to make sure that their care plan is appropriate in view of the time they have waited for treatment.

Revised programme structure

The programme has been restructured into three key work streams which respond to the original data clean up recommendations as recommended by NHS Improvement's Intensive Support Team. These are: RTT Recovery and Sustainability; establishment of Elective Care Operating Framework and Digital Optimisation. The programme is also managed through four supporting workstreams: Performance Support, Clinical Harm Review Processes, Outsourcing and Elective Care Pathway Transformation.

The programme continues to be overseen by a Waiting List Improvement Programme Steering Group, with external representation from Commissioners and NHS Improvement. The Trust has also introduced the Quality Improvement Team as additional support to the programme.

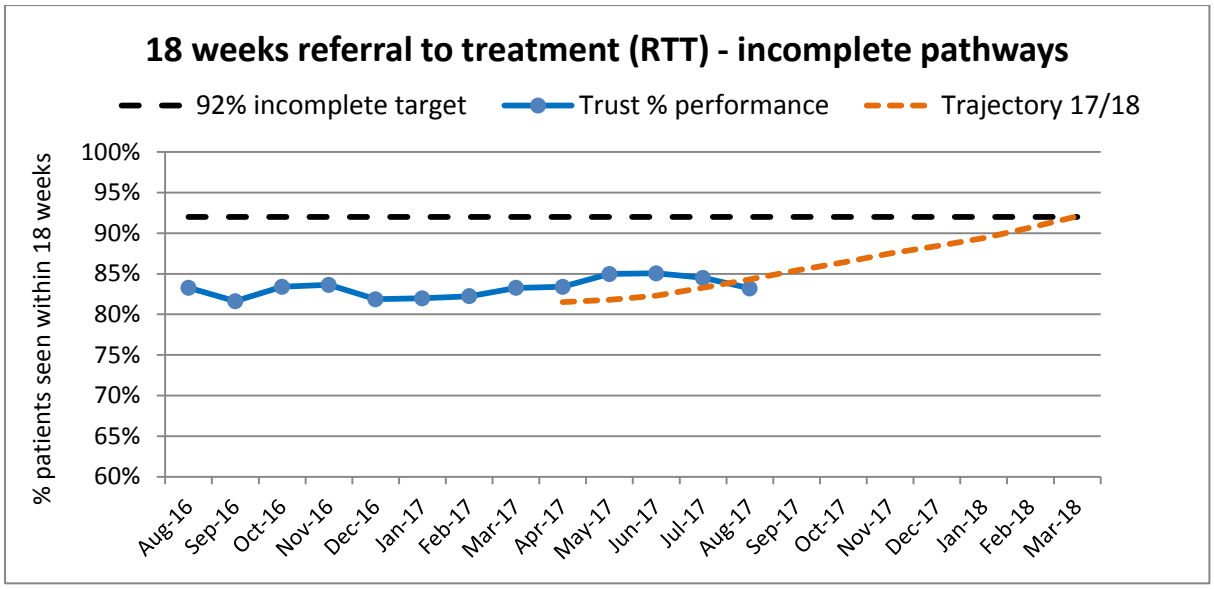


Chart 28 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period August 2016 – August 2017

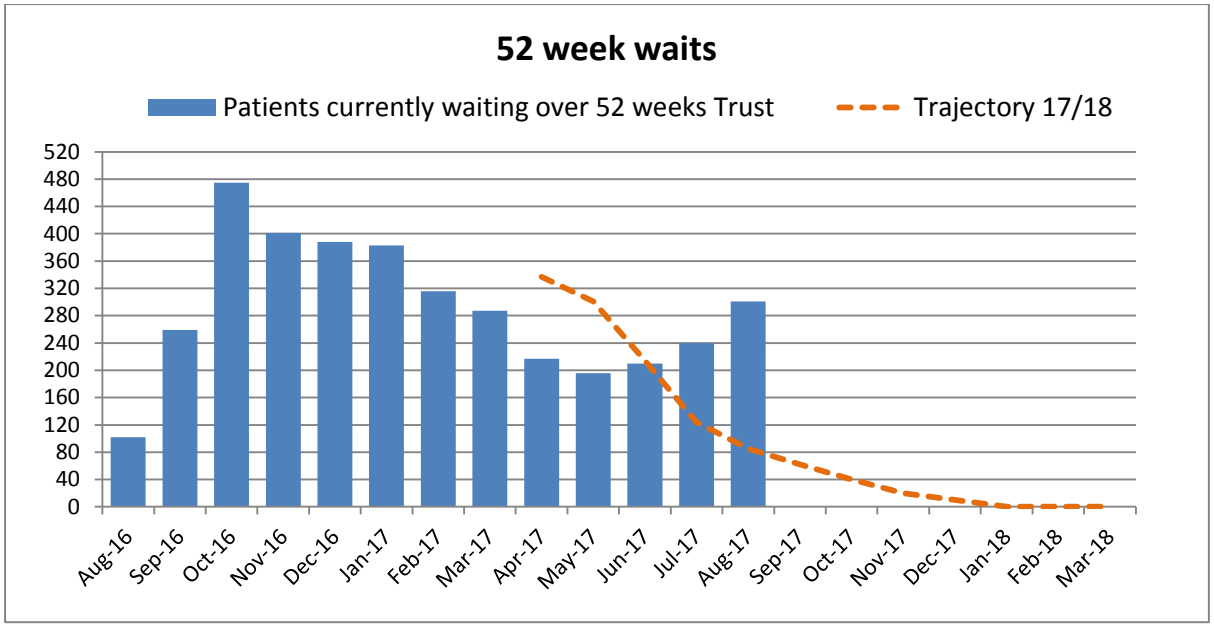


Chart 29 - Number of patients waiting over 52 weeks for the period August 2016 – August 2017

2.5.4 Responsive: Cancer 62 day waits

In September 2017, performance is reported for the Cancer waiting times for July 2017. The Trust delivered performance of 86.7 per cent against the 62-day standard for June which is above target of 85 per cent.

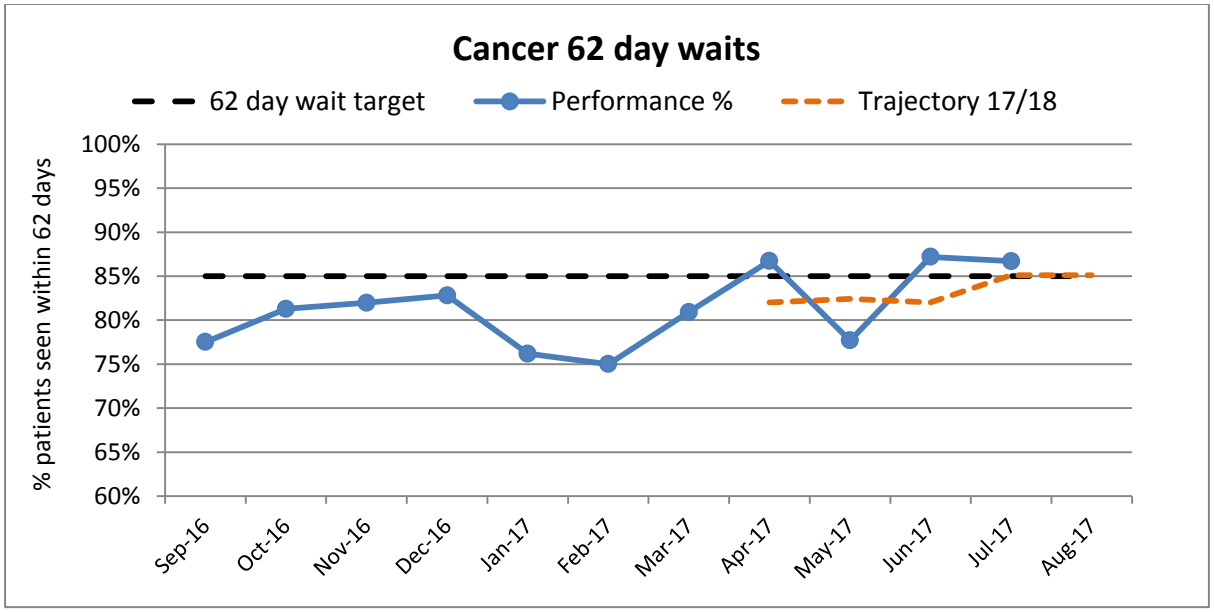


Chart 30 – Cancer 62 day GP referral to treatment performance for the period September 2016 – July 2017

2.5.5 Responsive: Theatre utilisation

The Trust overall theatre utilisation performance was 76 per cent in August 2017 (no change from July 2017). The key issues are as follows:

- High levels of preventable on the day cancellations, e.g. admin errors, pre-

assessment processes, DNA's

- Scheduling processes
- Capacity issues often leading to late starts and/or cancellations on the day

Performance is being reviewed monthly with the specialities at the Trust's Theatre Efficiency Group, which is chaired by the General Manager for Theatres & Anaesthesia. Each specialty has an improvement action plan and is monitored against an improvement trajectory, with the overall aim of reaching the Trust's theatre utilisation target of 85 per cent as quickly as possible.

The Trust is taking the following steps to improve overall theatre performance:

- Supporting the NHS Improvement national review of theatre efficiency led by Four Eyes with the aim of improving key operational processes;
- Undertaking deep dive analysis and agreeing further interventions with specialties that are currently off-trajectory; &
- Strengthening scheduling processes e.g. introduction of casemix templates at surgeon level and improving the consistency of 7 Day and 48 hour reminder calls to patients for their operations.

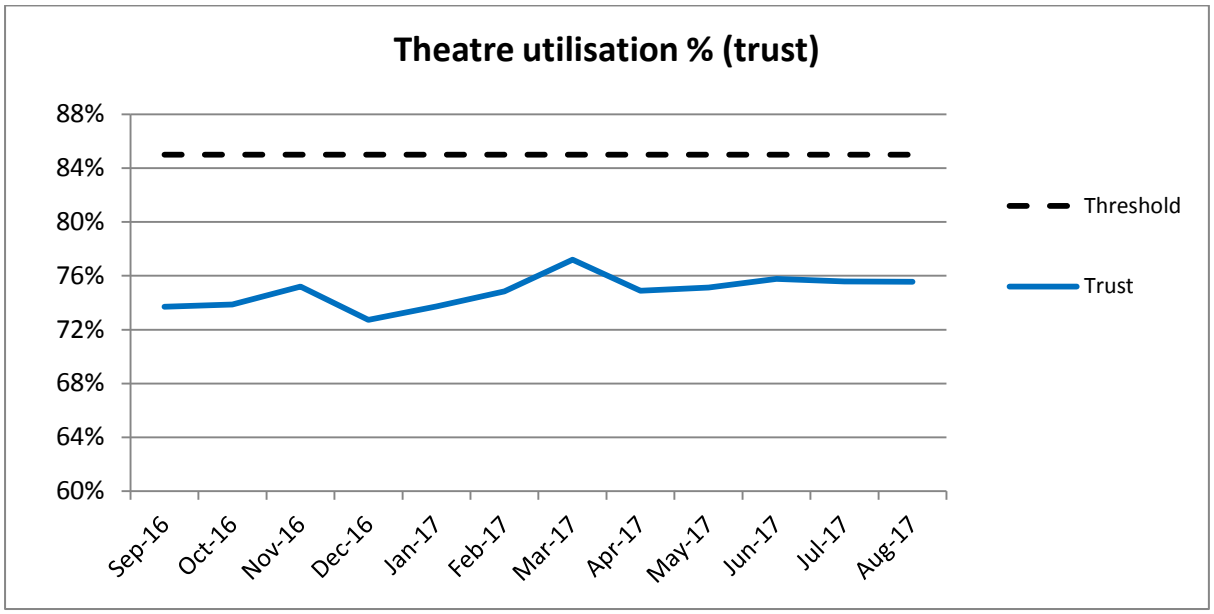


Chart 31 – Theatre utilisation average % (Trust) for the period September 2016 – August 2017

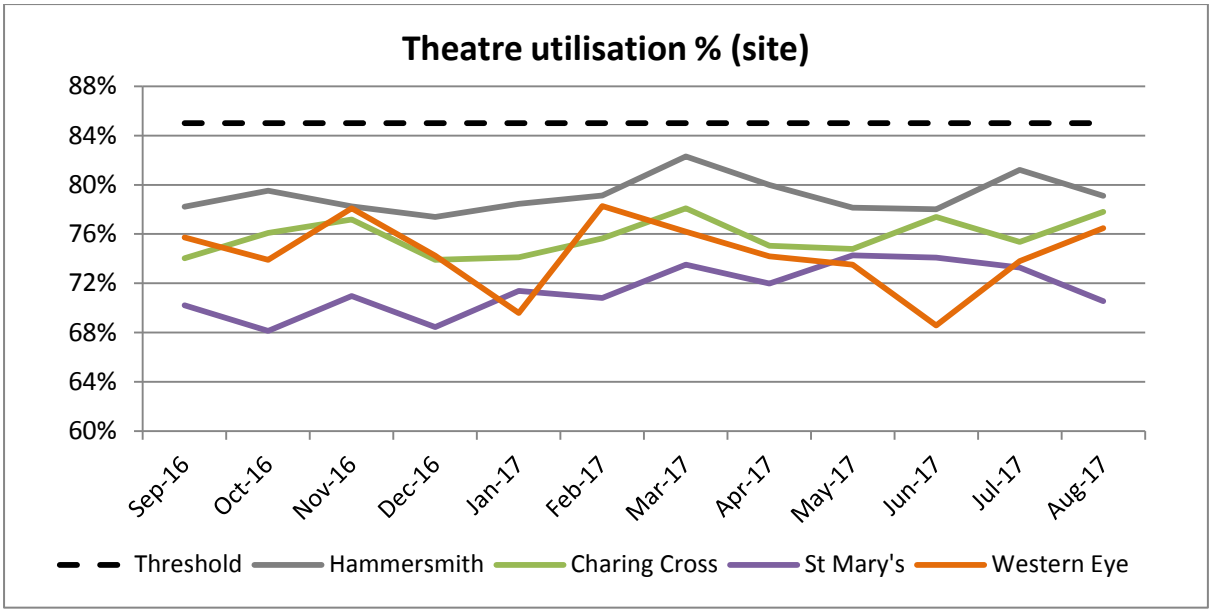


Chart 32 – Theatre utilisation average % (site level) for the period September 2016 – August 2017

2.5.6 Responsive: Cancelled operations and 28-Day rebookings

The cancelled operations rate has increased and the Trust is cancelling approximately 25-30 operations each week on the day for non-clinical reasons. The 28-day rebooking breach rate is currently around 10% (the national average is 8 per cent). A working group, as part of the elective care delivery forum, is reviewing the end to end reporting of cancellations across the Trust and root causes to mitigate 28-day breaches and enable improvements in performance.

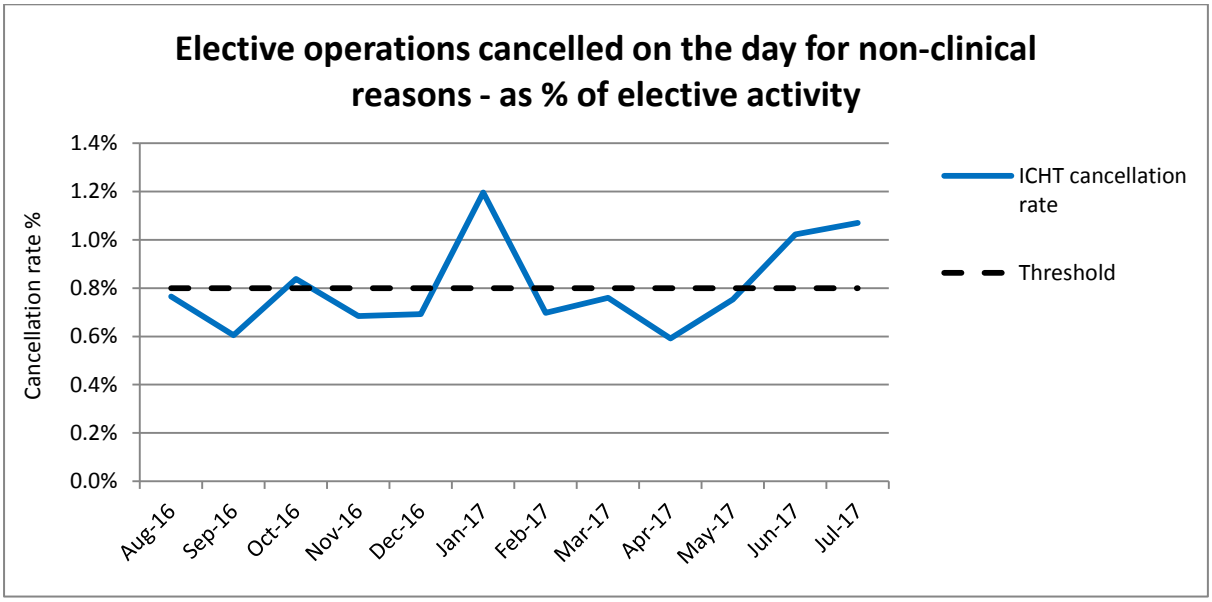


Chart 33 - Elective operations cancelled on the day for non-clinical reasons - as % of elective activity by month for the period August 2016 – July 2017 (August performance subject to further validation)

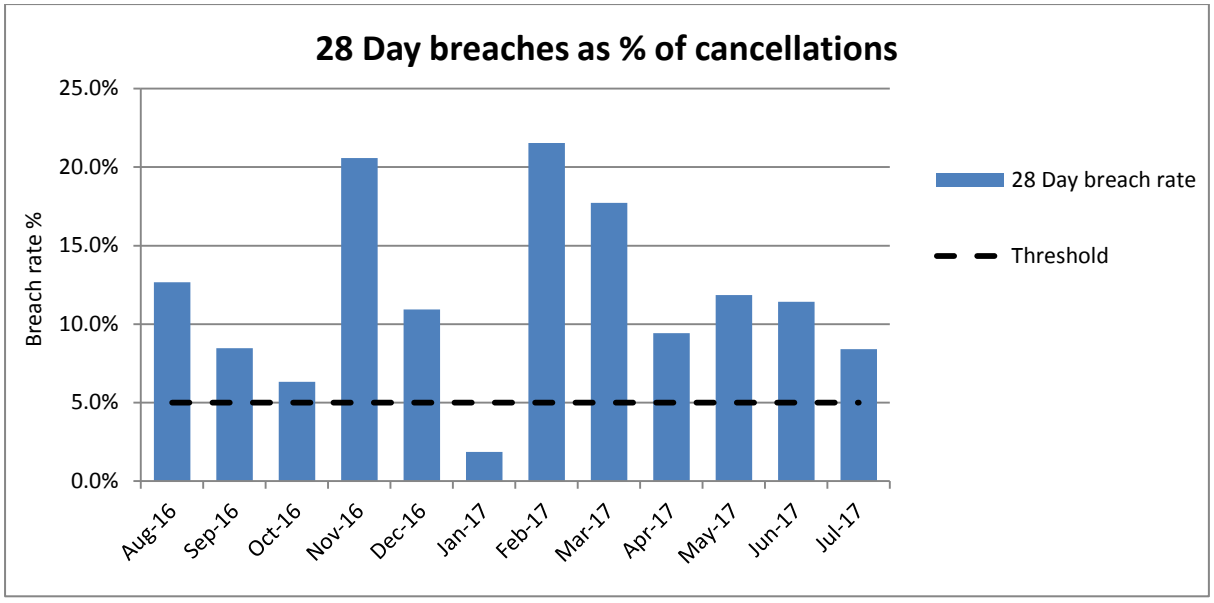


Chart 34 - Elective operations cancelled on the day for non-clinical reasons - as % of elective activity by month for the period August 2016 – July 2017

2.5.7 Responsive: Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 88.8 per cent in August 2017 against the 90.2 per cent target for the month. The key issues remain as follows:

- Difficulties with transfer of patients from the Vocare UCC to the Emergency Department;
- Increased demand and acuity;
- High levels of bed occupancy;
- High numbers of bed days lost through delayed transfers of care from the hospital; & delays for mental health beds; &
- On-going estate issues.

The Trust has launched a programme of developments, focussing on the following six work streams:

1. Streaming and admission avoidance strategies
2. Effective emergency department operations and avoiding non admitted breaches
3. Efficient specialist decisions and pathways
4. Managing beds effectively
5. Improving ward processes
6. Effective discharge processes

A four-hour Performance Steering Group has been established to oversee the activities within the six work streams. The group is chaired by the Divisional Director

of the Medicine and Integrated Care and attended by the Chief Executive Officer. Each work stream is led in partnership by a senior clinician and a senior manager.

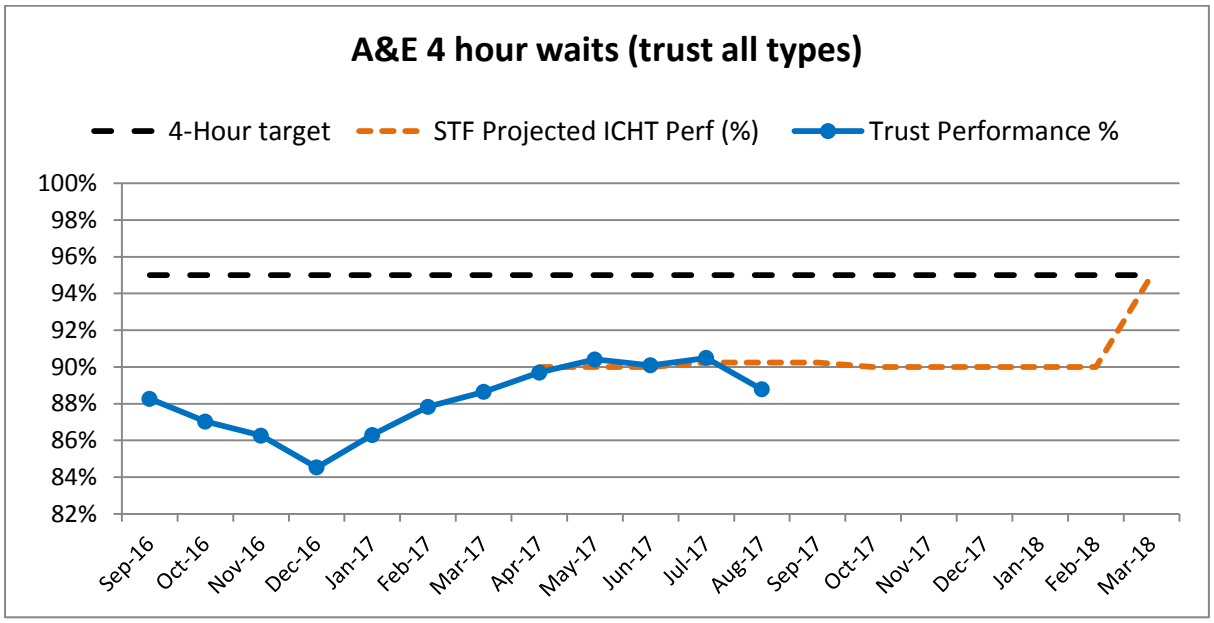


Chart 35 – A&E Maximum waiting times 4 hours (Trust All Types) for the period September 2016 – August 2017

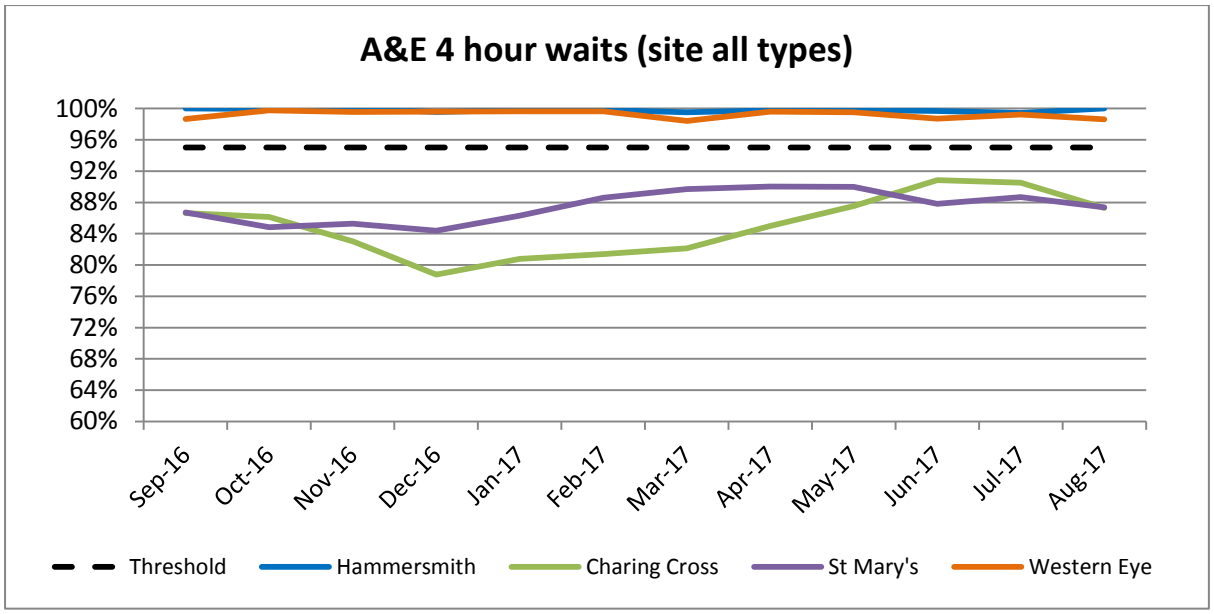


Chart 36 – A&E Maximum waiting times (Site All Types) 4 hours for the period September 2016 – August 2017

2.5.8 Responsive: Diagnostic waiting times

The latest reported performance is July 2017. In July, 6.9 per cent of patients were waiting over six weeks against a tolerance of 1 per cent. The deterioration in performance resulted from a deep dive into local data records, this identified an issue with patient tracking and the recording of offer dates for some patients. The Trust continues to hold a weekly steering group which is carrying out a full

assessment. Steps are being taken to ensure the improvement of performance and weekly progress updates are being made to NHS Improvement and Commissioners.

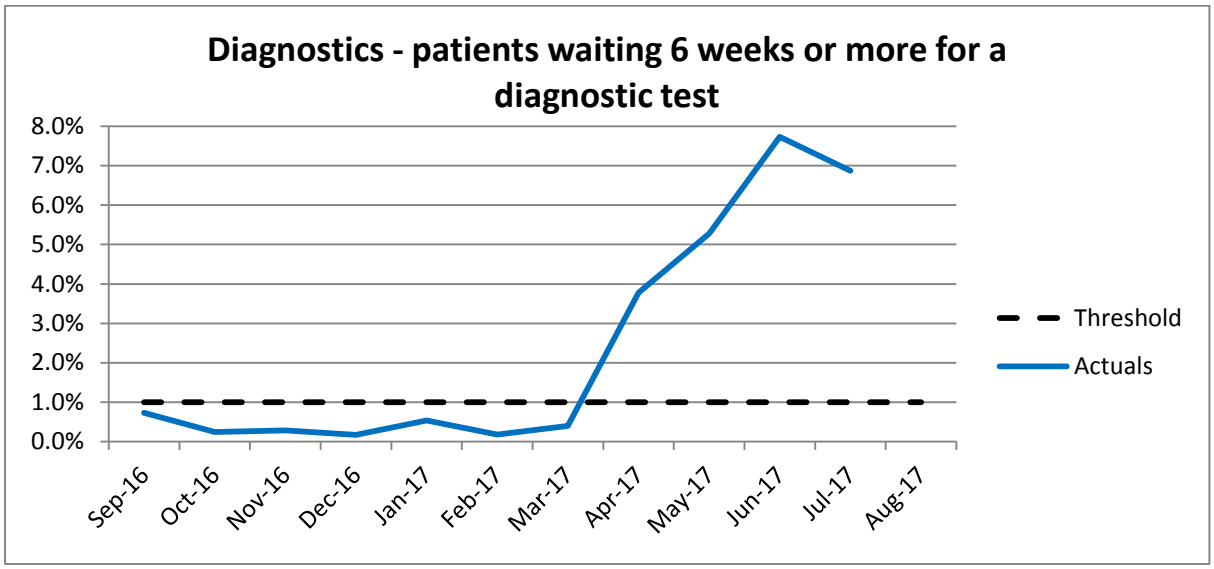


Chart 37 – Diagnostic waiting times for the period September 2016 – July 2017

2.5.9 Responsive: Outpatient DNA

The overall DNA rate (first and follow up) was 12.2 per cent in August. The detailed review of outpatient DNA rates in parallel with hospital- and patient-initiated cancellations is continuing. Specialty reports will allow managers and clinicians to explore their appointment data in greater detail and consider steps that can be taken to further improve attendance.

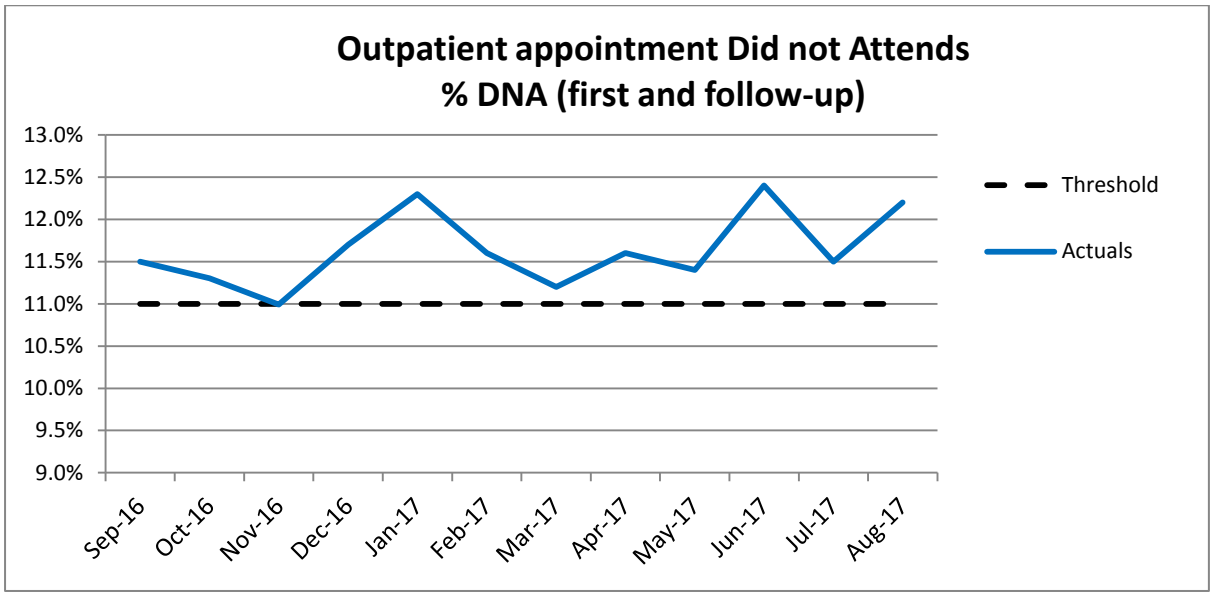


Chart 38 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period September 2016 – August 2017

2.5.10 Responsive: Outpatient appointments cancelled by the Trust

In August, 7.6 per cent of outpatient appointments were cancelled by the hospital with less than 6 weeks' notice and performance remains above the agreed threshold of 7.5 per cent.

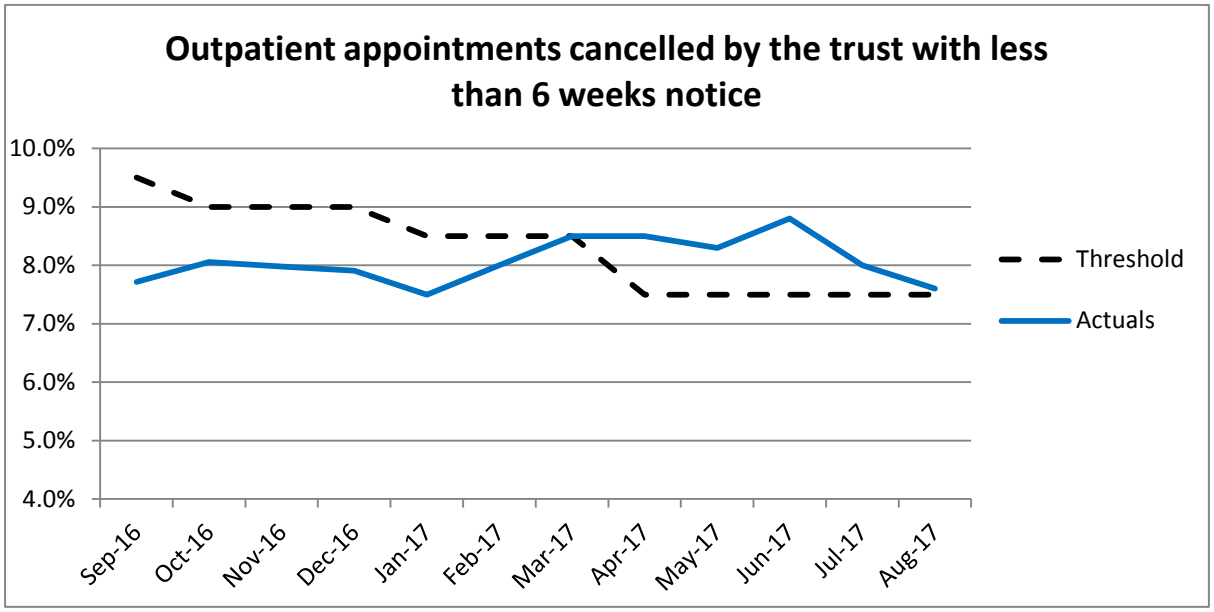


Chart 39 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period September 2016 – August 2017

2.5.11 Responsive: Outpatient appointments made within 5 days of receipt

In August, 85.0 per cent of routine appointments were made within 5 days. Work continues to establish new ways of working to increase responsiveness including improved tracking through the Patient Service Centre.

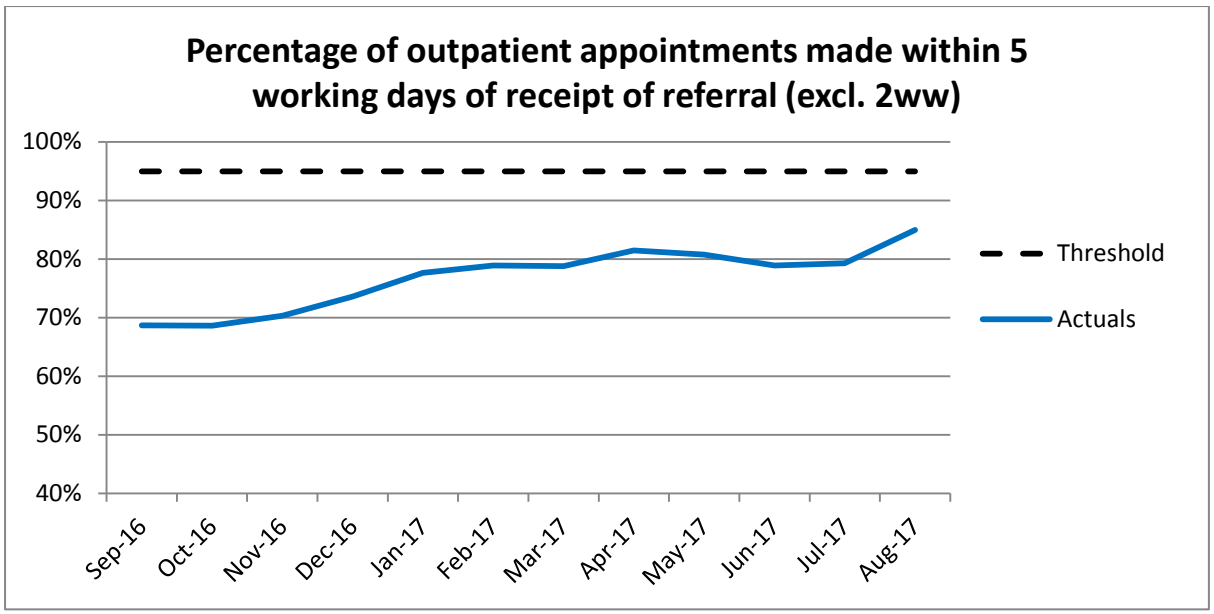


Chart 40 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period September 2016 – August 2017

3. Finance

Please refer to the Monthly Finance Report to Trust Board for the Trust's finance performance.

Appendix 1 Safe staffing levels below target by ward (additional detail)

The fill rate was below 85 per cent for care staff and 90 per cent for registered staff in the following wards:

- C8 Cardiology had a day fill rate of 82.71 per cent for care staff. This equated to 5 shifts unfilled for enhanced care. These shifts were safely covered by the ward. The overall day fill date was 90.34 per cent.
- Major Trauma Ward SMH had a day fill rate of 84.70 per cent for registered nurse staff. This equated to 8 shifts unfilled due to vacancies. These shifts were safely covered by cross cover from Intensive Care SMH and cohorting of patients. The overall day fill rate was 88.84 per cent.
- CXH 9 South ASU had a day fill rate of 89.03 per cent for registered nurse staff. This equated to 17 shifts unfilled due to vacancies. These shifts were safely covered by cross cover of registered nurse staff from 9 North. The overall day fill rate was 92.22 per cent.
- CXH AAU had a day fill rate of 84.94 per cent for registered nurse staff. This equated to 15 shifts unfilled due to sickness absence and vacancies. These shifts were safely covered by the Ward Manager, the AMU Matron and the Older Patients Assessment and Liaison Nurse. The overall day fill rate was 88.86 per cent.
- CXH AMU had a day fill rate of 84.49 per cent for care staff. This equated to 16 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager, and Matron and redeployment of care staff. The overall day fill rate was 92.34 per cent.
- DAAU AMU had a day fill rate of 89.59 per cent for registered nurse. This equated to 21 shifts unfilled, 14 of which were due to an extra registered nurse added to the establishment to improve patient flow and the remaining due to sickness absence. These shifts were safely covered by the Matron and redeployment of staff. There was a day fill rate of 77.73 per cent for care staff. This equated to 9 shifts unfilled for enhanced care. These shifts were safely covered by redeployment of care staff across the first floor. The overall day fill rate was 87.21 per cent.
- John Humphrey had a day fill rate of 81.59 per cent for care staff. This equated to 22 shifts unfilled due to transferring patients across site for medical tests and vacancies. These shifts were safely covered by bank and cross cover by the ward. The overall day fill rate was 90.81 per cent.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Finance Report for 2017/18 for the five months to August

Executive summary:

During September the Trust agreed a revised control total with NHSI, and this report presents the position against the new plan.

This paper presents the financial position for the first five months of the year to the end of August 2017.

Overall, The Trust is on plan year to date and in month.

Capital spend is behind plan year to date by £6.1m, although this relates largely to phasing of spend and the Trust expects to live within the capital resourcing limit.

There was £33m in the bank at the end of August. The Trust is not anticipating drawing down any additional working capital

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:

Risks are highlighted in the summary pages

Recommendation(s) to the Committee:

The Board is asked to *note the paper, including the risks and recommended actions*

Trust strategic objectives supported by this paper:

Retain as appropriate:
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Paul Doyle, Deputy CFO Janice Stephens, Deputy CFO Michelle Openibo, Associate Director: Business Partnering	Richard Alexander, CFO	20 September 2017

FINANCE REPORT – 5 MONTHS ENDED 31 AUGUST 2017

1. Introduction

This report provides a brief summary of the Trust's financial results for the 5 months ended 31st August.

2. Control Total

In September the Trust agreed a control total with NHS Improvement. Our plan before Sustainability and Transformation Funding (STF) is now a deficit outturn of £25.15m, an improvement of £15.85m on the previously agreed plan for the year. This improvement will be delivered through largely non-recurrent means. As the Trust has now agreed to the control total it has access to STF for Q2-Q4 of £20.65m. The achievement of STF is based 70% on financial performance and 30% operational. In 2017/18 the operational element will be received if the Trust can achieve the trajectories on A&E 4 hour waits and primary care streaming targets.

3. Financial Performance

The Trust met its financial plan in month and year to date.

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	94.56	90.94	(3.62)	443.21	444.00	0.79
Pay	(48.56)	(49.01)	(0.45)	(244.31)	(243.12)	1.18
Non Pay	(38.54)	(39.14)	(0.60)	(191.00)	(194.65)	(3.65)
Reserves	(4.36)	0.15	4.51	(6.00)	(6.00)	-
EBITDA	3.09	2.93	(0.16)	1.91	0.23	(1.67)
Financing Costs	(3.61)	(2.83)	0.79	(18.07)	(16.33)	1.74
SURPLUS / (DEFICIT) including donated asset treatment	(0.52)	0.10	0.62	(16.17)	(16.10)	0.07
Donated Asset treatment	(0.51)	(1.13)	(0.62)	(2.55)	(2.62)	(0.07)
Impairment of Assets	-		-	-		-
SURPLUS / (DEFICIT)	(1.03)	(1.03)	0.00	(18.72)	(18.72)	0.00
STF Income	3.24	3.24	-	3.24	3.24	-
SURPLUS / (DEFICIT) after STF income	2.21	2.21	0.00	(15.48)	(15.48)	0.00

In month income shows below plan due to reflecting the changes made to the plan for the new control total. Year to date the Trust is ahead of plan on activity based clinical commissioning income by £3.0m. The Trust is underperforming on income relating to pass through drugs and devices by £2.2m and this is offset in non-pay. Other income is also underperforming as private patients income is below plan. Pay costs are favourable year to date. There are underspends in pay in clinical areas where growth schemes have not yet started. Agency spend is below plan and the NHS Improvement agency cap.

Non Pay expenditure is adverse to plan year to date. There is overspending on contracted out services where savings were phased too early in the year. There are also overspends on outsourced services to other organisations to meet the elective access targets. Within the expenditure position there are some adverse variances caused by unidentified cost improvement programmes (CIPs). The PSO and operational teams are working to identify schemes to meet the Trust's plan.

3.1. NHS Activity and Income

The summary table shows the position by division.

Divisions	Year To Date Activity			Year To Date £m		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine and Integrated care (MIC)	356,415	366,247	9,832	106.49	107.20	0.72
Division of Surgery, Cancer and Cardiovascular (SCC)	289,236	289,343	107	124.88	129.28	4.40
Division of Women, Children and Clinical Support (WCCS)	1,087,325	1,091,136	3,811	65.84	63.60	(2.24)
Central Income			-	55.63	53.53	(2.10)
Clinical Commissioning Income	1,732,976	1,746,726	13,750	352.84	353.61	0.77

Within clinical divisions there is over performance on clinical activity year to date. The adverse variance within central is mainly due to pass through drugs and devices income which is £2.2m under plan year to date. When setting the revised plan the Trust has assumed that 75% of the commissioner demand management schemes will not deliver, which is in line with 2016/17 achievement. As the Trust's income plan does not align to the commissioner plan the current position will represent over performance to the commissioners. The Trust has agreed a 70% marginal rate on over performance with North West London CCGs and this has been factored into the year to date income.

MIC over performance is mainly relating to non-elective income, there has been growth in attendances above the amount agreed with commissioners. Renal income is below plan; there was an increase in activity expected in year which has not taken place. Within SCC there is over performance in clinical haematology which has seen an increase in day case work and in bone marrow transplants. There has also been an increase in activity for radiotherapy. WCCS is underperforming, with reduced activity in maternity services. The Division is working on improving patient access to services to try and mitigate this position.

3.2. Private Care Income

In month private income is above plan, though it remains below plan year to date. Additional capacity has been made available in Charing Cross hospital and this site has seen a substantial increase in activity in month. Year to date there are two main issues drive the adverse variance. There has been a reduction in the activity seen within clinical haematology paediatric care where cases are no longer being sent to the Trust and there has also been a delay in the planned growth of some services. The Private Patients Division is working with Clinical Divisions to agree additional growth schemes where appropriate for 2017/18 to offset the underperformance.

3.3. Clinical Divisions

The devolved financial position for clinical divisions is set out in the table below. Clinical Divisions are adverse to plan in month and year to date.

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	22.35	23.12	0.77	113.85	114.25	0.41
Expenditure	(17.66)	(18.75)	(1.09)	(88.48)	(90.33)	(1.85)
Medicine and Integrated Care	4.69	4.37	(0.32)	25.37	23.93	(1.45)
Income	25.61	27.85	2.24	126.97	132.03	5.07
Expenditure	(22.35)	(23.11)	(0.76)	(111.67)	(114.38)	(2.71)
Surgery, Cancer and Cardiovascular	3.26	4.75	1.49	15.30	17.66	2.36
Income	14.61	12.60	(2.01)	75.41	70.17	(5.24)
Expenditure	(16.35)	(16.52)	(0.17)	(82.74)	(81.35)	1.39
Women, Children & Clinical Support	(1.74)	(3.92)	(2.17)	(7.33)	(11.17)	(3.85)
Imperial Private Healthcare	0.73	1.10	0.37	5.91	6.09	0.17
Total Clinical Division	6.94	6.30	(0.64)	39.26	36.50	(2.77)

MIC is showing an adverse variance to plan year to date. Income is over plan and the Division have incurred costs to meet this activity. There is also an adverse position in the renal Directorate due to income under performance. The position in SCC is primarily due to over performance in income, there have been additional costs to cover this with spend on clinical supplies and also on costs for outsourced services. The WCCS adverse variance to plan is mainly due to income. Pathology is within WCCS and is £1.1m adverse to plan year to date. There has been a reduction in income for tests provided to other organisations, and the Division is reviewing this variance to ensure all income for the Trust has been received. Within the rest of the WCCS position the adverse variances are caused by underperformance on maternity NHS income and private paediatric and gynaecology income. For Imperial Private Health there has been over performance on income with associated costs of delivery.

4. Efficiency programme

The Trust has set a £54.4m CIP in 2017/18 as part of its overall financial plan; this is in line with the value achieved in 2016/17 of £53.8m.

The year to date plan is £17.8m there has been achievement of £12.7m giving a £5.1m underperformance year to date. This underperformance is due to a combination of slippage against planned schemes and yet to be identified plans. The key areas of underperformance are on income generation schemes not yet fully implemented. The divisions continue to work hard in identifying and delivering these further efficiencies, supported by an internally established PSO. There are other opportunities being developed and there are also mitigations being forecast against this position.

5. Cash

The Trust closed month 5 with a cash position of £32.9m. It is currently anticipated that the Trust will not require further draw down of working capital. The closing cash balance for the year is forecast to be £26.7m, an improvement of £20.0m following revised assumptions in the plan.

6. Capital

In-month capital expenditure, including donated assets was £1.7m against a planned spend of £3.4m. Cumulatively the gross spend is £5.7m against a plan of £11.8m. The current underspend reflects that the fact that a number of schemes are in development and work-up phase with business cases and tenders being developed. The run rate of capital spend is increasing and it is expected that these schemes will catch-up and deliver the plan of £54m gross spend and the Capital resource limit without donations of £46m.

7. Conclusion

The Trust is on plan in month and year to date.

Clinical Divisions are currently £2.8m adverse. Divisions are working with the PSO to identify efficiency opportunities to help mitigate their position.

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 5 months to 31st August 2017

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical (Excl Private Patients)	79.2	75.5	(3.7)	364.1	362.2	(2.0)
Private Patients	3.8	4.1	0.3	21.3	20.0	(1.3)
Research, Development and Education	8.4	8.7	0.3	41.6	41.6	0.0
Other	3.2	2.6	(0.5)	16.3	20.2	4.0
TOTAL INCOME	94.6	90.9	(3.6)	443.2	444.0	0.8
Pay - in post	(45.8)	(44.4)	1.4	(230.4)	(219.3)	11.1
Pay - Bank	0.0	(2.6)	(2.6)	(0.0)	(12.6)	(12.6)
Pay - Agency	(2.8)	(2.0)	0.8	(13.9)	(11.2)	2.7
Drugs and Clinical Supplies	(20.6)	(21.8)	(1.2)	(102.8)	(101.6)	1.2
General Supplies	(2.8)	(3.0)	(0.2)	(13.8)	(15.0)	(1.2)
Other	(15.2)	(14.3)	0.9	(74.3)	(78.0)	(3.7)
TOTAL EXPENDITURE	(87.1)	(88.2)	(1.1)	(435.3)	(437.8)	(2.5)
Reserves	(4.4)	0.1	4.5	(6.0)	(6.0)	0.0
Earning Before Interest, Tax Depreciation & Amortisation	3.1	2.9	(0.2)	1.9	0.2	(1.7)
Financing Costs	(3.6)	(2.8)	0.8	(18.1)	(16.3)	1.7
SURPLUS/(DEFICIT) including financing costs	(0.5)	0.1	0.6	(16.2)	(16.1)	0.1
Donated Asset treatment	(0.5)	(1.1)	(0.6)	(2.6)	(2.6)	(0.1)
SURPLUS/(DEFICIT) including donated asset treatment	(1.0)	(1.0)	0.0	(18.7)	(18.7)	0.0
Impairment of assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS/(DEFICT) before STF	(1.0)	(1.0)	0.0	(18.7)	(18.7)	0.0
STF	3.2	3.2	0.0	3.2	3.2	0.0
SURPLUS/(DEFICT)	2.2	2.2	0.0	(15.5)	(15.5)	0.0

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Nursing and Midwifery Annual Establishment Review and Safe Staffing Update 2017/18

Executive summary:

The divisional management teams have undertaken a detailed and comprehensive annual review of Nursing and Midwifery (N&M) establishments using the embedded approach. The review has been a fundamental part of the divisional business planning and budget setting.

This is the fourth year that this annual process has been adopted within the Trust and it follows that which is advised in key national guidance issued by the National Institute for Health and Care Excellence (2014) and the National Quality Board (2013) and 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (July 2016).

This paper will provide the Trust Board with:

- An overview of the establishment review process adopted by the Trust to provide assurance that ward N&M establishments are safe and that the N&M workforce is theoretically adequate in terms of number and skill mix to provide safe clinical care.
- The high level establishment changes by division.
- An overview of the work on-going nationally and locally to deliver safe, sustainable and productive N&M staffing and the way in which the Trust has engaged with this work.

This paper has been reviewed and is supported by the Executive Quality Committee.

Quality impact:

This paper describes the Trust's approach to securing safe, sustainable and productive N&M staffing due to high vacancies in some clinical areas which contributes to the conditions required to deliver the best possible clinical care to patients and their families and carers.

Financial impact:

This has been considered at divisional level and incorporated into business planning.

Risk impact:

This paper presents no quality risk. The Trust has identified a risk regarding safe N&M staffing due to high vacancies in some clinical areas, which is reviewed monthly by the Divisional Directors of Nursing (DDNs) and for which there are controls and mitigating actions in place, one of which is the annual and mid-year establishment review cycle.

Recommendations to the Committee:

The Board is asked to:

1. Note that the 2017/18 annual establishment review of N&M staffing has been completed in line with Trust policy and that it has been aligned with business planning for the year ahead.

2. Note the establishment changes prompted by the annual review.
3. Note the national and local work to deliver safe, sustainable and productive staffing.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Mark Baker, Senior Nurse (Workforce, Revalidation and Regulation) Senga Steel, Deputy Director of Nursing	Janice Sigsworth Director of Nursing	20 September 2017

Nursing and Midwifery (N&M) Annual Establishments Review and Safe Staffing Update

1. The Trust's N&M Annual Establishment Review Process

The 2017/18 N&M annual establishment review has followed the process set out in the Trust's *Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments* with the division of Medicine adopting a more detailed approach developed over the last two years. It is the fourth year that this annual process has been adopted within the Trust and it follows that which is advised in key national guidance issued by the National Institute for Health and Care Excellence (NICE, 2014) and the National Quality Board (NQB, 2013, 2016).

Staffing data has been extracted from the Trust's Safe Care module in the Healthcare e-Rostering system and in addition, the following have been used to provide a rounded view of staffing and skill mix needs:

- Changes in the environment of care (e.g. the ward design or layout),
- Patient characteristics (e.g. changes in the case mix or specialty),
- Professional judgement of the N&M leadership team leading the review and those working in the local area (e.g. the Sister or Matron),
- Data from the Trust's Harm Free Care reports and other quality reports.

The Trust's *Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments* lists the following principles and these have been taken account of within the annual review:

- Staying above a 65% : 35% ratio (registered nurse: unregistered care staff) unless DDN approved.
- Not going above a 1:8 ratio in adult inpatient (registered nurse : patient) during the day.
- Optimising the visibility and supervisory status of the Ward Manager/Matron so that s/he can lead the clinical nursing/midwifery team in delivering the best possible care.

The annual establishment review primarily focuses on inpatient areas including theatres and private patients.

2. The Outcome of the annual 2017/18 Establishment Review

The establishment reviews were undertaken by the DDNs between March 2016 and November 2016 in partnership with Divisional Director/ Divisional Director of Operations and have been aligned to the budget setting process and business planning cycle. They were then finalised during May 2017 as part of budget setting and signed off by the Director of Nursing in June and July 2017. A summary of the review findings and a more detailed overview are appended (Appendix 1). There have been a number of clinical services, bed base and acuity shifts during the past year across almost all departments and these have been considered by the DDNs as part of the annual review.

Since completing the annual reviews, each of the DDNs have met individually with the Director of Nursing to discuss their approach, the findings, the assurances that they have taken with regard to clinical quality and patient outcomes and the level of engagement and involvement they have had with their staff during the process. They have also confirmed that any change in the establishments is reflected in the divisional baseline budgets.

Additional assurance is provided from the discussions the Director of Nursing has with front line nurses, midwives and care assistants during the Back to the Floor visits to clinical areas. As part of the establishment review cycle she also meets with a group of matrons and sisters

from each division to discuss the staffing and skill mix arrangements in their areas and to determine the level of engagement they have with the establishment review process. This data is triangulated during the Director of Nursing discussions with each of the DDNs.

2.1 The Division of Medicine and Integrated Care (M&IC)

The review was undertaken by the DDN of Medicine and Integrated Care. Over the past two years, the Division of Medicine has piloted a more detailed methodology by using several months of data extracted from e-roster and the 'safe care' module, alongside other metrics. This work will be shared and adopted Trust wide next year.

Overall there is a decrease of 52.32 WTE from 1184.42 to 1132.10 WTE (Table 1), with the majority of the WTE decrease related to the August 2016 closure of wards C8 and B1 that were transferred out of the division at the Hammersmith Hospital site into the Division of Surgery, Cancer and Cardiovascular Services.

The nursing establishments across the division remain relatively unchanged. Changes made relate to ward / speciality moves and an increased acuity or dependency in a number of areas, such as Assessment ward at St Mary's Hospital and 11 South at Charing Cross Hospital. These changes have prompted an in year review of staffing and skill mix and has seen a funded increase in their respective establishments.

Table 1: Division of Medicine and Integrated Care

Establishment Required after Review March 2016	Establishment Required after Review November 2016	Difference
1184.42 WTE	1132.10 WTE	Decrease of 52.32 WTE

The changes have already been approved by the division's management board and are included in the 2017/18 budget.

2.2 The Division of Surgery, Cancer and Cardiovascular Services (SCCV)

The DDN undertook the clean sheet review for the clinical areas based on the agreed methods. Overall there is an increase of 57.92 WTE from 974.25 to 1032.17 WTE (Table 2).

The divisional staffing model has seen an increased shift in establishment as a result of new services and increased bed capacity within the division. This includes the opening of Renal & Haematology Triage Unit (RHTU) at Hammersmith in August 2016, C8 Ward opening August 2016, an increase of 5 beds on Fraser Gamble Ward, an increase of 10 level 2 beds in Charing Cross ICU, and a number of other areas had slight increases in establishment due to increased activity and dependency of patients.

All service changes (e.g. commencement of new services, increased bed capacity) were funded and establishments adjusted.

Table 2: Division of Surgery, Cancer and Cardiovascular Services

Establishment Required after Review March 2016	Establishment Required after Review November 2016	Difference
974.25	1032.17	Increase of 57.92 WTE

Surgery Theatres

There was an increase in activity across 3 of the 4 sites and with the opening of Riverside theatres. A 1.35 WTE increase in staffing was agreed to ensure full theatre utilisation (Table 3).

Table 3: Surgery Theatres

Establishment Required after Review March 2016	Establishment Required after Review November 2016	Difference
411.99	413.34	Increase of 1.35 WTE

2.3 The Division of Women's, Children's and Clinical Support (WC&CS)

The previous year's extensive review conducted by the Women's and Children's DDN provided a clear and accurate starting point of this review for Women's and Children's. The March 2016 starting point for Clinical Support was complex due to a number of changes to establishments in year and due to the transition to Women's, Children's and Clinical Support resulting in a difference of 2.7 WTE more than was originally in the baseline (123.89 WTE vs 121.19 WTE).

The Women's and Children's establishment has remained constant, with a slight 0.11 WTE reduction from 555.64 to 555.53 WTE. Clinical Support had an increase in WTE by 20, made up of a 5 WTE increase in Interventional Radiology and 15 WTE increase in OPD, which is inclusive of receptionist and phlebotomy staff.

Overall, the division had an increased establishment of 19.89 WTE (Table 4).

There remain challenges in recruiting to services across the division, predominantly Neonatal ICUs and Children's Haematology. There is an on-going recruitment and retention plan, in conjunction with HR and business partners, to address vacancies in these areas.

In maternity, the birth rate is slightly lower than planned. The future establishment in this area is currently under review utilising Birth Rate Plus data to provide assurance of safe staffing. 15 posts continue to be held in a management cost centre in anticipation of potential activity changes in order to be able to respond to demand quickly.

Table 4: Division of Women's and Children's and Clinical Support

	Establishment Required after Review March 2016	Establishment Required after Review November 2016	Difference
W&C	555.64	555.53	Decrease 0.11 WTE
Clinical Support	123.89	143.89	Increase 20 WTE
Total	679.53	699.42	Overall increase of 19.89 WTE

2.4 The Division of Private Healthcare

The clean sheet review was undertaken by the DDN for Imperial Private Healthcare (IPH).

IPH establishment review was undertaken by reviewing the current and planned future activity. Overall, there is a slight increase of 0.76 WTE from 183.24 to 184.0 WTE (Table 5).

Of note, Lindo Maternity had a small increase in activity, with 922 births, an additional 29 births up from last year. Notwithstanding this, the N&M staffing establishments remain stable.

Posts have been transferred between sites to balance staff numbers with activity and to standardise staffing rosters on all sites.

Within the private patient clinical areas the working establishments were found to be adequate for the level of activity required. Assurance was taken from the DDN for IPH that this is sufficient to enable a safe level of N&M staffing and this is checked weekly.

Table 5: Division of Private Healthcare

Establishment Required after Review March 2016	Establishment Required after Review November 2016	Difference
183.24	184.0	Slight increase of 0.76 WTE

The DDNs have individually confirmed to the Director of Nursing that the establishment requirements are being met for the clinical areas reviewed.

3. Safe Sustainable and Productive Nursing and Midwifery Staffing

There is much work taking place nationally to achieve and maintain safe, sustainable and productive N&M staffing with all of the arm's length bodies, including regulators, commissioners, professional bodies and providers, working together to optimise alignment of challenging and very complex work streams.

3.1 Nursing Associate role and Graduate Apprenticeships in Nursing

The introduction of a new regulated role into the Nursing profession, the 'Nursing Associate' will help to ensure that the future staffing pool of nurses will offer greater flexibility and fill the skills gap between heath care support workers and registered staff. The trust is a 'fast follower' implementer for the new role and currently 20 Nursing Associate trainees are working across the acute and community setting in partnership with Central London Community Healthcare NHS Trust, Hammersmith and Fulham West London Clinical Commissioning Group partners, Central and North West London NHS Foundation Trust and Buckinghamshire New University. The 2 year training programme will enable the Nursing Associates to work in both community and acute settings within a regulated role at band 4 once qualified under the direction of a registered nurse.

Nationally, the apprenticeship programme for undergraduate nurse training is being developed and this will allow provider organisations to support staff to learn and acquire full registration over a period of four years whilst being employed in health care support roles. Apprenticeship Nursing schemes are being planned to begin in September 2017 but curriculum development and logistical issues may not be complete until the spring of 2018.

The Trust is also part of the national trailblazer group leading the development of the

Advanced Clinical Practitioner (ACP) standard and assessment criteria to allow NHS organisations to train a range of clinical staff (many of whom are nurses) in an apprenticeship model to acquire advanced practice skills and capability. Developing a greater pool of ACPs will enable nursing staff to respond to the greater clinical complexity of our patients and fill the skills gap presented by any loss of junior or middle grade medical staff in the future. Developing greater autonomy and clinical capability in our workforce will remain a strategic focus for workforce, education and training agendas in the near future for the Trust to ensure the delivery of high quality and safe staffing models.

3.2 The Workforce Efficiency Network Programme

The Department of Health (DH) established a Workforce Efficiency Network, led by Lord Carter, to examine how best to get the most out of the existing workforce. In joining this programme the Trust has been able to not only learn from colleagues elsewhere but share our work on key staffing issues, such as the enhanced care of patients with increased care requirements (e.g. mental health needs or at risk of harm from falls). Our progress on 'specialling' (enhanced care) led by the Division of Medicine, has been picked up and used as an exemplar of not only securing efficiencies, but in delivering a better service for patients and also for members of staff.

3.3 Good Practice Guidance (rostering, enhanced care etc.)

In June 2016 The Workforce Efficiency Network issued good practice guides on matters such as rostering and the Trust has adopted this guidance. Rostering practices and their key performance indicators are monitored at divisional level.

3.4 The introduction of Care Hours Per Patient Day (CHPPD) measures

The DH noted that one of the challenges to eliminating unwarranted variation in nursing and care staff deployment across the NHS was the absence of a single means of recording and reporting it. As a result of the different ways of recording this data, no consistent way of interpreting productivity and efficiency was available nor comparable between organisations.

To provide a single consistent way of recording and reporting deployment of nursing staff working on inpatient wards/units the DH developed and tested the Care Hours Per Patient Day (CHPPD) measure. CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight).

As part of the safer staffing metrics the reporting of CHPPD through UNIFY (the DH's online data collection tool) became mandatory in June 2016 and the Trust continues to comply with this requirement. The CHPPD measure on its own is not particularly informative metric, however, when combined with other quality data and nurse sensitive indicators it could provide valuable information over time. The Trust will continue to work closely with DH and the evolution of the CHPPD metric to be used meaningfully for N&M service delivery.

3.5 New Expectations from the National Quality Board

As a follow up to the 'right staff, right skills, right time and right place' guidance issued in 2013, the National Quality Board (NQB) issued its updated guidance in July 2016. Work has been undertaken in order to develop the Trust's approach to utilising quality and staffing data to support staff in providing high quality consistent care.

The policy on safe staffing has been refreshed and was ratified by Exco and included in the November 2016 N&M Establishments Review and Safe Staffing Update report. An internal benchmarking exercise was undertaken in May 2017 mapping Trust process and policy

against the NQB guidance with findings indicated the Trust was compliant with the updated guidance. There is an opportunity for the Trust to consider how N&M staffing decisions are made in the context of the wider registered multi-professional team in inpatient adult wards, specifically in relation to areas where allied health professionals form part of the staffing establishment of inpatient areas. This will be considered in further annual establishment N&M staffing reviews.

3.6 Non-inpatient areas

Work has also been on-going during 2017 to explore sustainable and safe staffing models for outpatient areas in the Trust reviewing the skill mix of current establishments, clinical activity, patient experience and the safety criteria for those areas that can be met through the remodelling of staffing provision that respond more sensitively to patients' needs. Nationally there are no established models for safe staffing in the outpatient setting and it is expected that the project, being led by one our senior nurses, will be an exemplar to others.

3.7 Nurse in Charge Standard

A standard has been developed collaboratively with our N&M staff that sets out the minimum expectations of the role of the Nurse in Charge of a shift to support a consistent approach to nurse leadership and management of the ward that includes consideration of safe staffing and how safe staffing is achieved and maintained. The standard has been further developed to include a competency assessment to support staff development in this area and worked into the Trust's newly developed development and leadership programme for nurses and midwives called Springboard.

4. Conclusion

The Trust's N&M annual establishment review has been completed in line with existing national and local policy and the Trust's policy. It has informed business planning. The Director of Nursing has taken assurance from each DDN that their N&M workforce is sufficient to provide appropriate care and safe staffing levels for N&M is maintained through meeting the requirements of actual verses planned staffing recommendations.

Each division has signed off the establishment plans through its own management approval processes.

Appendix 1 - Ward level Establishment review - March to November 2016

Division	Date of clean sheet review	Tools/standards used	Clean sheet establishment in March 2016 (WTE)*	Clean sheet Establishment in November 2016 (WTE)	Gap (+/-) between est review in March 2016 and after review in November 2016	Skill mix (WTE) in March 2016		Skill mix ratio in March 2016		Skill mix (WTE) in November 2016		Skill mix ratio in November 2016	
						RN	HCA	RN	HCA	RN	HCA	RN	HCA
Surgery & Cancer	May-17	•AUKUH/SNCT •British Association of Critical Care Nurses standards for nurse staffing in critical care	974.25	1032.17	57.92	829.47	144.78	85%	15%	867.36	164.81	84%	16%
Surgery Theatres	May-17	Association for Peri-Operative Pratice	411.99	413.34	1.35	340.81	71.18	83%	17%	337.83	74.51	82%	18%
Medicine	May-17	AUKUH/SNCT	1184.42	1132.10	-52.32	887.19	297.23	75%	25%	829.80	302.30	73%	27%
Private patients	May-17	AUKUH/SNCT	183.24	184.00	0.76	148.63	34.61	81%	19%	164.00	20.00	89%	11%
Women's and Children's*	May-17	• AUKUH/SNCT •Paediatric Intensive Care Society 2010 standards •British Association of Perinatal Medicine staffing standards •Birth-Rate Plus	555.64	555.53	-0.11	463.47	92.17	83%	17%	454.88	100.65	82%	18%
Clinical Support	May-17		123.89	143.89	20.00	60.32	60.87	50%	50%	71.00	72.89	50%	50%
TOTAL			3433.43	3461.03	27.60	2729.89	700.84			2724.87	735.16		

* excludes private pts

DIVISION OF PRIVATE PATIENTS: Establishment review - March to November 2016

Inpatient Ward / Department	Site	Number of Beds	Nurse Grade	ESTABLISHMENT MARCH 2016	Skill mix WTE MARCH 2016		Skill mix ratio MARCH 2016		Establishment NOVEMBER 2016	Skill mix WTE NOVEMBER 2016		Skill mix ratio NOVEMBER 2016	
					RN	HCA	RN	HCA		RN	HCA	RN	HCA
Lindo General	SMH		Band 8a	1.00	1.00								
			Band 7	1.00	1.00					1.00			
			Band 6	6.00	6.00					8.00			
			Band 5	11.00	11.00					21.50			
			Band 3	5.00		5.00					4.50		
				24.00	**19.00**	**5.00**	79%	21%	**35.00**	**30.50**	**4.50**	87%	13%
Lindo General Level 3	SMH		Band 6										
			Band 5										
Lindo Day Unit Level 1	SMH		Band 5	4.00	4.00								
				4.00	**4.00**		100%	0%	**0.00**	**0.00**	**0.00**	0%	0%
Lindo OPD	SMH		Band 7										
			Band 6	3.72	3.72								
			Band 5	2.00		2.00							
			Band 3										
				5.72	**3.72**	**2.00**	65%	35%	**0.00**	**0.00**	**0.00**	0%	0%
Lindo Theatres	SMH		Band 7	1.00	1.00					**1.00**			
			Band 6	12.00	12.00					**13.00**			
			Band 5	4.00	4.00					**4.00**			
			Band 3	2.00		2.00					**2.00**		
				19.00	**17.00**	**2.00**	89%	11%	**20.00**	**18.00**	**2.00**	90%	10%
Lindo Maternity Level 3 and 4 and ANC	SMH		Band 8a	1.00	1.00					**1.00**			
			Band 7	12.41	12.41					**13.00**			
			Band 6	10.29	10.29					**19.00**			
			Band 4	7.91	7.91	12.61				**5.00**			
			Band 3	12.61						**13.00**			
				44.22	**31.61**	**12.61**	71%	40%	**51.00**	**51.00**	**0.00**	100%	0%
15 North	CXH		Band 8a	1.00	1.00					**1.00**			
			Band 7	3.00	3.00					**3.00**			

			Band 6	7.50	7.50					**13.00**			
			Band 5	21.50	21.50					**14.00**			
			Band 3	6.00		6.00					**9.00**		
				39.00	**33.00**	**6.00**	85%	15%	**40.00**	**31.00**	**9.00**	78%	23%
15 South	CXH		Band 6	1.00	1.00								
			Band 5	4.50	4.50								
			Band 3	2.00		2.00							
				7.50	**5.50**	**2.00**	73%	27%	**0.00**	**0.00**	**0.00**	0%	0%
Chemo Day Unit	CXH		Band 6	2.50	2.50								
				2.50	**2.50**		100%		**0.00**	**0.00**	**0.00**	0%	0%
				1.50	1.50								
OPD	CXH		Band 5	**1.50**	**1.50**		100%						
				1.00	1.00				**0.00**	**0.00**	**0.00**	0%	0%
Robert & Lisa Sainsbury Wing Level 4	HH		Band 8a	2.00	2.00					**1.00**			
			Band 7	7.20	7.20					**2.00**			
			Band 6	14.10	14.10					**13.00**			
			Band 5	2.50		2.50				**17.50**			
			Band 3								**4.50**		
				26.80	**24.30**	**2.50**	91%	10%	**38.00**	**33.50**	**4.50**	88%	12%
				1.00	1.00								
Robert & Lisa Sainsbury Wing Level 3	HH		Band 6	4.00	4.00								
			Band 5	1.00		1.00							
			Band 3	**6.00**	**5.00**	**1.00**	83%	17%	**0.00**	**0.00**	**0.00**	0%	0%
Robert & Lisa Sainsbury Wing OPD	HH		Band 5	1.50	1.50	1.50							
				3.00	**1.50**	**1.50**	50%	50%	**0.00**	**0.00**	**0.00**	0%	0%
				183.24	**148.63**	**34.61**	**81%**	**19%**	**184.00**	**164.00**	**20.00**	**89%**	**11%**

DIVISION OF MEDICINE AND INTEGRATED CARE: Establishment review - March to November 2016

Inpatient Ward / Department	Site	Number of beds	Nurse grade	Establishment after review in March 2016	Establishment after review in NOVEMBER 2016	Skill Mix WTE March 2016		Skill mix WTE Nov 2016		Skill Mix Ratio March 2016		Skill mix Ratio Nov 2016	
						RN	HCA	RN	HCA	RN	HCA	RN	HCA
A&E (AE120)	CXH	NA		**68.48**	**76.31**					84%	16%	**83%**	**17%**
			8a			1.00		1.00					
			7			9.00		8.00					
			6			18.00		19.68					
			5			29.64		34.79					
			3				6.00		8.00				
			2				4.84		4.84				
A&E Adult (CAS 04)	SMH	NA		**97.68**	**74.67**					90%	10%	**88%**	**12%**
			8a			1.00		1.00					
			7			11.10		10.58					
			6			31.38		22.36					
			5			44.20		31.93					
			3				10.00		5.00				
			2						3.80				
A&E Paeds (CAS07)	SMH				**29.40**							**79%**	**21%**
			8a					1.00					
			7					1.00					
			6					10.00					
			5					11.20					
			3						1.00				
			2						5.20				
A&E ward	CXH	10 bed + 8 trollies		**27.00**	**27.00**					70%	30%	**70%**	**30%**
			7			1.00		1.00					
			6			3.00		3.00					
			5			15.00		15.00					
			3				4.00		4.00				
			2				4.00		4.00				
UCC CXH & HH (PFH02)	CXH	NA			**23.33**							**83%**	**17%**
			8a					1.00					
			7					18.33					
			3						4.00				
DAAU	SMH	5 level 2 + 5 isolation		**26.86**	**26.86**					100%	0%	**100%**	**0%**
			7			1.00		1.00					
			6			5.17		5.17					
			5			20.69		20.69					
CDU	SMH	12		**18.25**	**19.11**					57%	43%	**59%**	**41%**
			7			1.00		1.00					
			6			1.74		2.59					
			5			7.75		7.76					
			2				7.76		7.76				
Joseph Toynbee	SMH	16		**21.80**	**26.87**					76%	24%	**61%**	**39%**

			7			1.00		1.00					
			6			5.17		5.17					
			5			10.35		10.35					
			2				5.28		10.35				
AMU	SMH	10+8 trollies		**26.86**	**26.14**					81%	19%	**80%**	**20%**
			7			1.00		1.00					
			6			5.17		5.17					
			5			15.52		14.80					
			2				5.17		5.17				
5 South ward	CXH	9 level 2		**27.40**	**0.00**					100%	0%		
			7			1.00							
CLOSED			6			10.56							
			5			15.84							
8 West ward	CXH	22		**32.50**	**32.50**					63%	37%	**63%**	**37%**
			7			1.00		1.00					
			6			3.00		3.00					
			5			16.50		16.50					
			2				12.00		12.00				
AAU	CXH	13		**0.00**	**21.69**							**76%**	**24%**
			7					1.00					
			6					5.17					
			5					10.35					
			3						5.17				
MWW AMU with level 2	CXH	40		**64.33**	**74.90**					85%	15%	**70%**	**30%**
			8a			1.00		1.00					
			7			1.00		2.00					
			6			17.76		17.76					
			5			34.96		31.64					
			2				9.61		22.50				
4 South	CXH	21		**27.50**	**27.98**					71%	29%	**71%**	**29%**
			7			1.00		1.00					
			6			4.00		5.00					
			5			14.50		14.00					
			2				8.00		7.98				
9 North	CXH	20 HASU + 3 ASU beds (previously 20 HASU beds only)		**47.85**	**47.85**					82%	18%	**82%**	**18%**
			8a			1.00		1.00					
			6			10.61		10.61					
			5			27.42		27.42					
			2				8.82		8.82				
8 South	CXH	25		**35.85**	**35.85**					64%	36%	**64%**	**36%**
			8a			1.00		1.00					
			6			4.00		4.00					
			5			17.85		17.85					
			3				5.00		13.00				
			2				8.00						
9 South ASU (previously 9 west ASU)	CXH	22 (previously 20 beds)		**32.61**	**32.61**					66%	34%	**66%**	**34%**
			7			1.00		1.00					
			6			5.90		5.90					
			5			14.73		14.73					
			3										
			2				10.98		10.98				

Appendix 1 - Ward level Establishment review - March to November 2016

9 West Neuro Rehab (previously 9 south CXH neuro rehab)	CXH	15/16 inpatient beds + 3/4 SNROS beds		**30.70**	**30.70**					58%	42%	**58%**	**42%**
			7			1.00		1.00					
			6			5.50		5.50					
			5			11.20		11.20					
			2				13.00		13.00				
Lady skinner ward, now on 5W	HH	15		**22.00**	**21.86**					68%	32%	**69%**	**31%**
			7			1.00		1.00					
			6			2.00		2.00					
			5			12.00		12.00					
			2				7.00		6.86				
Ward B1 Spam/Smac	HH			**18.82**	**0.00**					49%	51%		
			8a			1.00							
			7			3.00							
			6			5.22							
			5				7.00						
			2				2.60						
Fraser Gamble ward	HH	29		**30.00**	**0.00**					65%	35%		
			8a			1.00							
			6			4.00							
			5			14.50							
			3				3.00						
			2				7.50						
John Humphrey	HH	21		**27.26**	**27.26**					63%	37%		
			7			1.00		**1.00**					
			6			3.00		**3.00**					
			5			13.26		**13.26**					
			2				10.00		**10.00**				
Christopher Booth	HH	28		**33.00**	**38.03**					73%	27%		
			7			1.00		**1.00**					
			6			5.00		**5.00**					
			5			18.00		**20.63**					
			2				9.00		**11.40**				
Manvers ward	SMH	26		**33.00**	**33.00**					82%	18%	**82%**	**18%**
			8A			1.00		1.00					
			6			7.00		7.00					
			5			16.00		16.00					
			3			3.00		3.00					
			2				6.00		6.00				
Samuel Lane ward	SMH	24		**26.88**	**26.88**					71%	29%	**71%**	**29%**
			8A			1.00		1.00					
			6			2.59		2.59					
			5			15.53		15.53					
			3										
			2				7.76		7.76				
Thistlewaite ward	SMH	20		**26.87**	**29.46**					71%	29%	**65%**	**35%**
			7			1.00		1.00					
			6			2.59		2.59					
			5			15.52		15.52					
			2				7.76		10.35				
Grafton ward	**SMH**	**12**		**24.80**	**0.00**					**57%**	**43%**		

CLOSED			8a			1.00							
			6			3.00							
			5			10.24							
			3				2.00						
			2				8.56						
Witherow ward	SMH	12		24.29	24.29					57%	43%	57%	43%
			8a			1.00		1.00					
			6			2.59		2.59					
			5			10.35		10.35					
			2				10.35		10.35				
Lewis Lloyd ward	SMH	14		24.80	24.29					57%	43%	57%	43%
			7			1.00		1.00					
			6			3.00		2.59					
			5			10.24		10.35					
			2				10.56		10.35				
Almorth wright / Rodney Porter ward	SMH	15+8		33.69	37.21					73%	27%	65%	35%
			8A			1.00		1.00					
			6			6.00		5.17					
			5			17.52		18.11					
			3										
			2				9.17		12.93				
C8 ward	HH	15-20		35.33	0.00					78%	22%		
			7			1.00							
			6			6.00							
			5			20.53							
			2				7.80						
10 North ward Neurology & PIU	CXH	15 inpatient +7 PIU		27.45	27.45					82%	18%	82%	18%
			8a			1.00		1.00					
			6			5.88		5.88					
			5			15.67		15.67					
			3										
			2				4.90		4.90				
11 South Neurosurgery	CXH	25		37.06	41.65					85%	15%	82%	18%
(excludes. pathway co-ordinator)			7			1.00		1.00					
			6			4.88		5.88					
			5			25.47		27.47					
			3										
			2				5.71		7.30				
PIU Renal Unit	HH	18		8.20	8.20					76%	24%	76%	24%
			7			1.00		1.00					
			6			3.00		3.00					
			5			2.20		2.20					
			3				1.00		1.00				
			2				1.00		1.00				
Handfield Jones ward	HH	21		27.00	26.63					70%	30%	70%	30%
			8a			1.00		1.00					
			6			4.00		3.92					
			5			14.00		13.71					
			2				8.00		8.00				
Peters ward	HH	16		27.00	21.47					70%	30%	64%	
			8a			1.00		1.00					
			6			4.00		2.92					

			5			14.00		9.72					
			2				8.00		7.83				
De Wardner ward	HH	12		**22.00**	**22.55**					95%	5%	**96%**	**4%**
		Level 1&2	7			1.00		0.98					
			6			10.00		9.80					
			5			10.00		10.79					
			2				1.00		0.98				
Kerr ward	HH	22		**27.00**	**26.45**					0.70	0.30	**70%**	**30%**
			7			1.00		0.98					
			6			4.00		3.92					
			5			14.00		13.71					
			2				8.00		7.84				
8 North	CXH	22		**29.50**	**29.50**					64%	36%	**64%**	**36%**
			8a			1.00		1.00					
			6			3.00		3.00					
			5			15.00		15.00					
			2				10.50		10.50				
7 West	CXH			**32.80**	**32.15**					68%	32%	**68%**	**32%**
			7			1.00		1.00					
			6			4.00		2.92					
			5			17.20		17.85					
			3				7.00						
			2				3.60		10.38				
				1184.42	**1132.10**	**887.19**	**297.23**	**829.80**	**302.30**	**75%**	**25%**	**73%**	**27%**

DIVISION OF WOMENS AND CHILDRENS: Establishment review - March to November 2016

Code	Speciality	Inpatient Ward / Department	Site	Number of beds	Nurse grade	Establishment required after review in MARCH 2016	Skill mix WTE March 2016		Skill mix ratio MARCH 2016		Establishment required after review in NOVEMBER 2016	Skill mix WTE November 2016		Skill mix ratio November 2016	
							RN	HCA	RN	HCA		RN	HCA	RN	HCA
58900	Gynaecology	Victor Bonney Ward	HH	20	Band7	1					1				
					Band 6	2.94					2.94				
					Band 5	16.63					16.63				
					Band 3	1					1				
					Band 2	6.37					6.57				
						27.94	**20.57**	**7.37**	**67%**	**26%**	**28.14**	**20.57**	**7.57**	**73%**	**27%**
GYN02	Gynaecology	Lillian Holland Ward	SMH	13	Band 7	1.00					1.00				
					Band 6	2.94					2.94				
					Band 5	10.57					10.57				
					Band 3	0.98					0.98				
					Band 2	5.87					6.00				
						21.36	**14.51**	**6.85**	**67%**	**32%**	**21.49**	**14.51**	**6.98**	**68%**	**32%**
46500	Neonates	QCCH Neonates	QCCH	24	Band 7	6.00					6.00				
					Band 6	47.01					47.00				
					Band 5	5.58					5.58				
					Band 4	5.49					5.49				
						64.08	**58.59**	**5.49**	**94%**	**9%**	**64.07**	**58.58**	**5.49**	**91%**	**9%**
NEO09	Neonates	Winnicott Baby Unit	SMH	22	Band 7	5.00					5.00				
					Band 6	18.06					19.00				
					Band 5	18.37					17.53				
					Band 4	5.2					7.39				
						46.63	**41.43**	**5.2**	**94%**	**11%**	**48.92**	**41.53**	**7.39**	**85%**	**15%**
54700	Maternity	QCCH Maternity Inpatient	QCCH		Band 7	24					24				
					Band 6	92.13					95.13				
					Band 5										
					Band 3	21.27					21.27				
					Band 2	12.55					12.55				
						149.95	**116.13**	**33.82**	**61%**	**23%**	**152.95**	**119.13**	**33.82**	**78%**	**22%**

Appendix 1 - Ward level Establishment review - March to November 2016

MAT10	Maternity	SMH Maternity / Inpatient	SMH		Band 7	14					14				
					Band 6	68.64					65.64				
					Band 5										
					Band 3	26.07					26.07				
					Band 2	1					1				
						109.71	**82.64**	**27.07**	**61%**	**25%**	**106.71**	**79.64**	**27.07**	**75%**	**25%**
56300	Maternity	Stanley Clayton Private Patients	QCCH	7	Band 7	2					2				
					Band 6	3.96					3.96				
					Band 3	3.96					3.96				
					Band 2	2					2				
						11.92	**5.96**	**5.96**	**55%**	**50%**	**11.92**	**5.96**	**5.96**	**50%**	**50%**
62200	Paediatrics	Ambulatory Paeds	HH		Band 7	0.5					0.5				
					Band 6	4					4				
					Band 5	1					1				
					Band 3	1					1				
					Band 2										
						6.5	**5.5**	**1**	**85%**	**15%**	**6.5**	**5.5**	**1**	**85%**	**15%**
PAE01	Paediatrics	Westway +Haem day unit	SMH		Band 7	2					2				
PAE01	Paediatrics	PHDU	SMH		Band 6	2					2				
					Band 5	2.4					2.4				
					Band 3	1					1				
						7.4	**6.4**	**1**	**61%**	**14%**	**7.40**	**6.40**	**1.00**	**86%**	**14%**
PAE02	Paediatrics	Grand Union	SMH	14	Band 7	1					1				
					Band 6	5.85					5.85				
					Band 5	23.88					24.08				
						30.73	**30.73**	**0**	**106%**	**0%**	**30.93**	**30.93**	**0**	**100%**	**0%**
PAE03	Paediatrics	Great Western/PSSU Staff	SMH	20	Band 8a	1					1				
					Band 7	1					1				
					Band 6	11.24					11.24				
					Band 5	23.84					23.84				
					Band 3	6.37					6.37				
						43.45	**37.08**	**6.37**	**102%**	**15%**	**43.45**	**37.08**	**6.37**	**85%**	**15%**
PAE07	Paediatrics	Paediatrics ICU	SMH	8	Band 8a	1					1				
					Band 7	5.38					6				
					Band 6	23.44					23.73				
					Band 5	16.22					16.22				
						46.04	**46.04**	**0**	**90%**	**0%**	**46.95**	**46.95**	**0.00**	**100%**	**0%**

MAT04	Maternity	SMH Community / Outpatient	SMH		Band 7	3.2					3.2				
					Band 6	30.3					30.3				
					Band 2	0					0				
					Band 3	13.2					13.2				
						46.7	**33.5**	**13.2**	**70%**	**28%**	**46.70**	**33.50**	**13.20**	**72%**	**28%**
47100	Maternity	Caseload Midwives	HH		Band 7	8					8				
					Band 6	6					6				
					Band 8a										
						14	**14**	**0**	**111%**	**0%**	**14.00**	**14.00**	**0.00**		
55500	Maternity	QCCH Community / Outpatient	QCCH		Band 7	8.66					8.66				
					Band 6	47.82					47.82				
					Band 3	15.3					15.3				
					Band 2	0					0				
						71.78	**56.48**	**15.3**	**102%**	**21%**	**71.78**	**56.48**	**15.30**	**79%**	**21%**
MAT09	Maternity	Management Cost Centre				**15.75**	**15.75**				**15.75**	**15.75**			

Including private pts	**713.94**	**585.31**	**128.63**	**82%**	**18%**	**717.66**	**586.51**	**131.15**	**82%**	**18%**

Excluding private pts	**555.64**	**463.47**	**92.17**	**83%**	**17%**	**555.53**	**454.88**	**100.65**	**82%**	**18%**

DIVISION OF WOMENS, CHILDRENS AND CLINICAL SUPPORT : Establishment review - March to November 2016

Code	Inpatient Ward / Department	Site	Number of theatres	Nurse grade	ESTABLISHMENT March 2016	Skill mix WTE		Skill mix ratio		Establishment Required post review November 2016	Skill Mix post review		Skill Mix Ratio	
						RN	HCA	RN	HCA		RN	HCA	RN	HCA
63000	Radiology Nursing	ALL								WCCS	WCCS	WCCS	WCCS	WCCS
			7	Band 8a	1	1				1				
				Band 7	4.6	4.6				5				
				Band 6	9	9				13				
				Band 5	14	14				15				
				Band 3	2		2			2				
				Band 2	3.43		3.43			4.57				
	Radiology Nursing				34.03	28.6	5.43			40.57	34.00	6.57	84%	16%
	OPD	SMH/SCH								WCCS	WCCS	WCCS	WCCS	WCCS
					1	1								
				Band 7	1	1				1				
				Band 6	1	1				2				
				Band 5	8	8				10				
				Band 3	16.75		16.75			22.75				
				Band 2	6.57		6.57			5.57				
	OPD	SMH/SCH			34.32	11	23.32			41.32	13.00	28.32	31%	69%
	OPD	HH/CXH								WCCS	WCCS	WCCS	WCCS	WCCS
				Band 8a	2	2				1				
										2				
				Band 6	5	5				5				
				Band 5	13.72	13.72				16				
				Band 3	28.12		28.12			34				
				Band 2	4		4			4				
					52.84	20.72	32.12			62	24.00	38.00	40%	60%
					123.89	**60.32**	**60.87**	**50%**	**50%**	**143.89**	**71.00**	**72.89**	**50%**	**50%**

DIVISION OF SURGERY: Establishment review - March to November 2016

Inpatient Ward / Department	Site	Number of beds	Nurse grade	Clean sheet establishment after review in March 2016	after review in NOVEMBER 2016	Skill Mix WTE March 2016		Skill mix WTE Nov 2016		Skill Mix Ratio March 2016		Skill mix Ratio Nov 2016	
						RN	HCA	RN	HCA	RN	HCA	RN	HCA
6 South ward	CXH	25		**34.25**	**30.95**					**73%**	**27%**	**73%**	**27%**
			7			3.00		1.00					
			6			9.00		9.00					
			5			13.00		12.70					
			3				3.00		3.00				
			2				6.25		5.25				
6 North ward	CXH	26		**31.50**	**35.65**					76%	24%	**69%**	**31%**
			8a					1.00					
			7			1.00							
			6			5.00		4.92					
			5			18.00		18.63					
			3				2.00		1.96				
			2				5.50		9.14				
7 North ward - Gi	CXH	26		**35.75**	**39.61**					81%	19%	**72%**	**28%**
			8A			1.00		1.00					
			6			4.00		4.00					
			5			24.00		23.61					
			3				1.00		1.00				
			2				5.75		10.00				
Riverside ward	CXH	26 + 18 trollies		**44.30**	**35.38**					71%	29%	**77%**	**23%**
		26	7			1.00		1.00					
			6			5.00		4.88					
			5			25.50		21.50					
			3				3.00		1.00				
			2				9.80		7.00				
Alex Cross Eye ward	WEH	4		**16.50**	**17.86**					75%	25%	**69%**	**31%**
			6			1.00		**1.00**					
			5			11.00		**11.36**					
			2				4.50		**5.50**				
A6 ward - CITU	HH	16		**59.47**	**58.78**					98%	2%	**98%**	**2%**

			8A			1.00		1.00					
			7			6.00		6.00					
			6			22.30		21.30					
			5			29.17		29.48					
			2				1.00		1.00				
Zachary Cope ward	SMH	22 inc. 5 HDU beds		**47.20**	**47.28**					80%	20%	**80%**	**20%**
		22	8A			1.00		1.00					
			6			12.65		12.65					
			5			24.14		24.22					
			3				3.53		3.53				
			2				5.88		5.88				
HH CCL & Day-Ward Nurse Staff	HH	12		**41.93**	**25.01**					81%	19%	**92%**	**8%**
			8A					1.00					
			7			1.00		1.00					
			6			16.60		11.48					
			5			16.53		9.53					
			3				4.00		2.00				
			2				3.80						
Weston ward	HH	15		**22.80**	**22.80**					91%	9%	**91%**	**9%**
Cost centre: 67800			7			0.80		0.80					
			6			8.00		8.00					
			5			12.00		12.00					
			3										
			2				2.00		2.00				
D7 - Clinical Haem ward	**HH**	**16**											
Ward was relocated to Fraser Gamble Ward - Jan 2016.													
Not currently occupied by a clinical service													
Dacie ward	HH	14		**24.00**	**24.00**					92%	8%	**92%**	**8%**
Cost centre: 71500			7			1.00		1.00					
			6			8.00		9.00					
			5			13.00		12.00					
			3				2.00		2.00				
11 North and 11 West ICU	CXH	24		**89.95**	**114.59**					99%	1%	**96%**	**4%**
			8A			1.00		1.00					
			7			9.69		6.74					
			6			36.60		40.55					
			5			41.66		61.30					
			3				1.00		3.00				
			2				0.00		2.00				

10 South ward	CXH	23		**31.00**	**32.66**					81%	19%	**76%**	**24%**
			8A			1.00		1.00					
			6			6.00		5.88					
			5			18.00		18.02					
			3				4.00		4.00				
			2				2.00		3.76				
Western Eye A&E/OPD/DSU													
A7 ward	HH	27		**35.77**	**39.77**					83%	17%	**88%**	**12%**
			8A			1.00		1.00					
			7					1.00					
			6			6.67		6.59					
			5			22.10		26.26					
			3				4.00		2.92				
			2				2.00		2.00				
A8 ward	HH	20		**31.93**	**34.23**					84%	16%	**85%**	**15%**
			8A			1.00		1.00					
			6			3.00		5.00					
			5			22.93		23.23					
			3				2.00		2.00				
			2				3.00		3.00				
A9 ward	HH	20		**24.27**	**24.27**					77%	23%	**77%**	**23%**
			7			1.00		1.00					
			6			4.61		4.61					
			5			13.00		13.00					
			3				1.74		1.74				
			2				3.92		3.92				
Major Trauma ward	SMH	16		**30.00**	**31.18**					80%	20%	**71%**	**29%**
			8A			1.00		1.00					
			6			7.48		6.00					
			5			15.52		15.18					
			3				3.00		1.00				
			2				3.00		8.00				
Valentine Ellis ward	SMH	24		**28.22**	**31.00**					77%	23%	**77%**	**23%**
			8A			1.00		1.00					

			6			5.00		5.00					
			5			15.61		18.00					
			3				1.00		2.00				
			2				5.61		5.00				
Charles Pannett ward	SMH	25		**42.11**	**44.00**					77%	23%	**77%**	**23%**
			8A			1.00		1.00					
			6			9.61		11.00					
			5			22.00		22.00					
			3				3.00		3.00				
			2				6.50		7.00				
Paterson ward	SMH	14		**24.00**	**26.00**					75%	25%	**69%**	**31%**
			8A			1.00							
			7			1.00		1.00					
			6			3.00		4.00					
			5			13.00		13.00					
			3				1.00		2.00				
			2				5.00		6.00				
Albert ward	SMH	28		**35.59**	**40.05**					66%	34%	**61%**	**39%**
			7			1.00		1.00					
			6			4.00		5.00					
			5			18.59		18.59					
			3				1.00		0.96				
			2				11.00		14.50				
AICU	SMH	16		**98.05**	**94.55**					97%	3%	**97%**	**3%**
			8A			1.00		1.00					
			7			10.21		6.01					
			6			34.84		33.52					
			5			49.00		51.08					
			2				3.00		2.94				
GICU	HH	12		**80.29**	**77.59**					96%	4%	**96%**	**4%**
			8A			1.00		1.00					
			7			6.98		6.43					
			6			24.83		24.64					
			5			44.48		42.58					
			3				3.00		2.94				
7 South	CXH	25		**31.81**	**24.45**					75%	25%	**80%**	**20%**
			8A			1.00		1.00					
			6			5.00		4.00					
			5			17.81		14.45					
			3				6.00						
			2				2.00		5.00				
Fraser Gamble	HH	21		**23.00**	**29.00**					83%	17%	**83%**	**17%**
			7			1.00		1.00					
Cost centre: 71400 Relocated from			6			6.00		7.00					

Ward D7 Jan 2016 with 16 funded Clinical Haematology beds			5			12.00		16.00					
			2				4.00		5.00				
Renal & Haematology Triage Unit (RHTU)	HH	8		**10.56**	**10.56**					100%	0%	**100%**	**0%**
Cost centre: 71700. Opened 03/08/16 to provide emergency clinical pathway for renal and		**Trolleys**											
			6			5.00		5.00					
			5			5.56		5.56					
C8 ward	HH				**19.63**					0%	0%	**74%**	**26%**
			7					1.00					
			6					5.75					
			5					7.73					
			2						5.15				
Heart Attack Centre	HH				**21.32**					0%	0%	**73%**	**27%**
			6					3.72					
			5					11.88					
			3						2.00				
			2						3.72				
Totals				**974.25**	**1032.17**	**829.47**	**144.78**	**867.36**	**164.81**	**85%**	**15%**	**84%**	**16%**

DIVISION OF SURGERY - THEATRES: Establishment review - March to November 2016

Code	Inpatient Ward / Department	Site	Number of theatres	Nurse grade	Establishment required after review in March 2016	Skill mix WTE March 2016		Skill mix Ratio March 2016		Establishment required after review in NOVEMBER 2016	Skill mix WTE NOVEMBER 2016		Skill mix Ratio NOVEMBER 2016	
						RN	HCA	RN	HCA		RN	HCA	RN	HCA
TH110	Theatres Main CXH	CXH	14		**147.43**	**122**	**25.43**	**83%**	**17%**	**151.43**	**122**	**29.43**	**81%**	**19%**
				Band 8a		1					1			
				Band 7		10					10			
				Band 6		46					46			
				Band 5		65					65			
				Band 3			8					7		
				Band 2			17.43					22.43		
71800	Theatres Main HH	HH	8		**91.13**	**71.83**	**19.30**	**79%**	**21%**	**88.48**	**69.85**	**18.63**	**79%**	**21%**
				Band 8a		1					1			
				Band 7		8					8			
				Band 6		25.13					25.13			
				Band 5		37.7					35.72			
				Band 3			2					2		
				Band 2			17.3					16.63		
THE01	Main Theatre SMH	SMH	16		**173.43**	**146.98**	**26.45**	**85%**	**15%**	**173.43**	**145.98**	**26.45**	**85%**	**15%**
	8B										**1**			
				Band 8a		1					1			
				Band 7		11					10			
				Band 6		68.62					68.62			
				Band 5		66.36					66.36			
				Band 3			11.45					11.45		
				Band 2			15					15		
					411.99	**340.81**	**71.18**	**83%**	**17%**	**413.34**	**337.83**	**74.51**	**82%**	**18%**

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Annual Workforce Equality Report 2016-17

Executive summary:

This paper provides an overview of key workforce equality metrics for the year 2016-17. The annual workforce equality report and the Workforce Race Equality Standard (WRES) report, appended to this paper, will be posted on the Trust website in order to meet our statutory duty under the Equality Act and the mandate in the NHS standard contract. The information within the reports is used to monitor progress and to inform future actions to promote equality and combat bias.

Quality impact:

Aligns to the CQC well-led domain.

From April 2016, progress on the Workforce Race Equality Standard is being considered as part of the 'well led' key question for CQC's inspections.

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust board is asked to approve the report for publication on the Trust website.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.

Author	Responsible executive director	Date submitted
Daisy Tsai, HR Manager	David Wells, Director of P&OD	15 September 2017

Annual Workforce Equality Report 2016-17

Introduction:
The annual workforce equality report and WRES report provide an overview of key workforce equality metrics for the year 2016-17. The reports identify a number of current and future initiatives aimed at promoting workforce equality.

- **Workforce Composition**
  Ethnicity - the trust's workforce is drawn from a wide variety of ethnic backgrounds. 52% of staff who have disclosed their ethnicity are from Black and Minority Ethnic (BME) backgrounds and 48% are white. This was the same last year.

  Age - 80% of our staff are aged 25 to 54. There have been no significant changes in regards to age since 2010/11.

  Gender - The workforce split in regards to gender has remained unchanged in the last 5 years: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations. Figures published by NHS Employers in 2017 show that 77% of NHS workforce are women and 23% are men.

- **Trust Board Composition**
  The trust Board of Directors comprises 13 people (as of 31st March 2017). White people account for 84.6% of Board Directors compared to 48% of the workforce as a whole. In regards to gender, 69.2% of the Board are men and 30.8% are women compared to the overall trust composition of 29% male and 71% female.

- **Data Quality**
  Workforce information on disability, sexual orientation and religion has improved since last year. The trust now holds demographic information on 62% (up from 56% in 2015/16) of all staff disability status and 67% (up from 60% in 2015/16) on sexual orientation and religion. The quality of data for new starters has dropped in 2016/17 compared to the previous year. This now stands at 87-88% for all three protected characteristics.

- **Recruitment**
  66% of applicants throughout 2016/17 were from BME groups and 30% were white. This was comparable to those who were shortlisted: 67% were from BME backgrounds and 30% were white. White people were however more likely to be successful at interview than people from BME backgrounds.

- **Access to training**
  The analysis is based on vocational courses and discretionary HR programmes, a total of 24 different courses running throughout 2016/17. It does not include mandatory training as this is non-discretionary. Access to these courses was broadly in line with the workforce composition, with women and people from BME backgrounds slightly more likely to access the training.

- **Performance ratings**
  A disproportionate number of poor performance ratings were awarded to people from BME backgrounds (71%) compared to 52% of the workforce. When the data is cut by grade and professional group, there is a disproportionately high number of band 2 to band 4 admin and clerical and unqualified nursing staff receiving poor performance ratings. D or E ratings have been awarded to less than 1% of our workforce.

- **Promotions and Leavers**
  White British staff were more likely to leave than other ethnic groups, accounting for 36% of leavers in 2016/17. When the data is split by gender, women are more likely to leave than men. The proportion of promotions is largely in line with trust population when split by ethnicity. Women were marginally more likely to be promoted than men.

- **Application of workforce procedures**
  In 2016/17, there were 89 formal disciplinary cases, 36% involved white people and 57.3% involved BME people, with a disproportionately high involvement from people from black ethnicity (accounting for 34.8%, compared to its workforce 16.2%). Similar patterns exist in other organisations. When the data is cut by occupational groups, 50.6% of disciplinary hearings involved qualified nurses when they account for 33% of the Trust population. This was particularly the case for BME qualified nurses who account for 69% of disciplinary meetings involving qualified nurses whereas they account for 57.3% of the occupational group. Other factors influencing involvement in formal workforce procedures are seniority and gender.

- **NHS National Survey questions mandated by the WRES**
  The outcome of 4 of the Trust NHS National Survey questions below are mandated in the WRES:

  2 indicators are about staff's experience in harassment, bullying or abuse from the public or staff. On average 32% of people participating in the Survey reported such experience. There was not much difference in BME or white people's experience.

  BME people reported more negatively than white people on equal opportunities for career progression or promotion within the Trust.

  BME people were more likely to report experiencing discrimination at work from colleagues in the past 12 months compared to white people (19% vs. 7%).

- **Current and future initiatives to mitigate disproportionality include:**

Action 1 - Improve workforce representation of BME people on Band 7 and above		
1.1	Introduce values-based interviews, which includes new guidance on recruitment and selection and highlight the minefield of potential bias. Recruitment and selection training will be adapted to include the new guidance	Resourcing
1.2	Review the language used on job adverts so it is more inclusive and target diverse groups	Resourcing
1.3	Monitor and report on the breakdown of talent management based on E&D criteria	Talent
1.4	Review all leadership programme and ensure that they promote a culture of inclusions and raising awareness of Diversity issues	Talent

1.5	Refresh skills and awareness of Diversity and Inclusion issues and unconscious bias across all our professional P & OD staff to ensure we are offering the best practice and consistent advice and support	Talent

Action 2 - Improve disproportionate representation of BME people receiving D or E rating (PDR)		
2.1	The PDR training content will be reviewed to raise awareness of unconscious bias and best practice at PDR	Talent

Action 3 - Mitigate disproportionate representation of BME people entering formal workforce procedures		
3.1	Review the reasons that people are facing formal procedures to establish whether further training and support can be offered to prevent staff from entering into formal procedures	Employee Relations
3.2	Review the training provided for managing workforce procedures to include a focus on potential bias	Employee Relations

Action 4 - Actions will be developed to address the concerns about harassment and bullying reflected in the 2016-2017 NHS staff survey.		
4.1	A review of the national local survey results will take place with a targeted action plan aimed at prevention of harassment and bullying across the organisation	Wellbeing

Imperial College Healthcare NHS
NHS Trust

Annual Workforce Equality and Diversity Report 2016/2017

(Incorporating Workforce Race Equality Standard)

Sebastiano Rossitto and Daisy Tsai

Directorate of People and Organisational Development

Sep 2017

1. Introduction

This report is published to help Imperial College Healthcare NHS Trust meet the public sector equality duty, as outlined in the Equality Act 2010. In addition, this report provides information required by the Workforce Race Equality Standard that is mandated in the NHS standard contract.

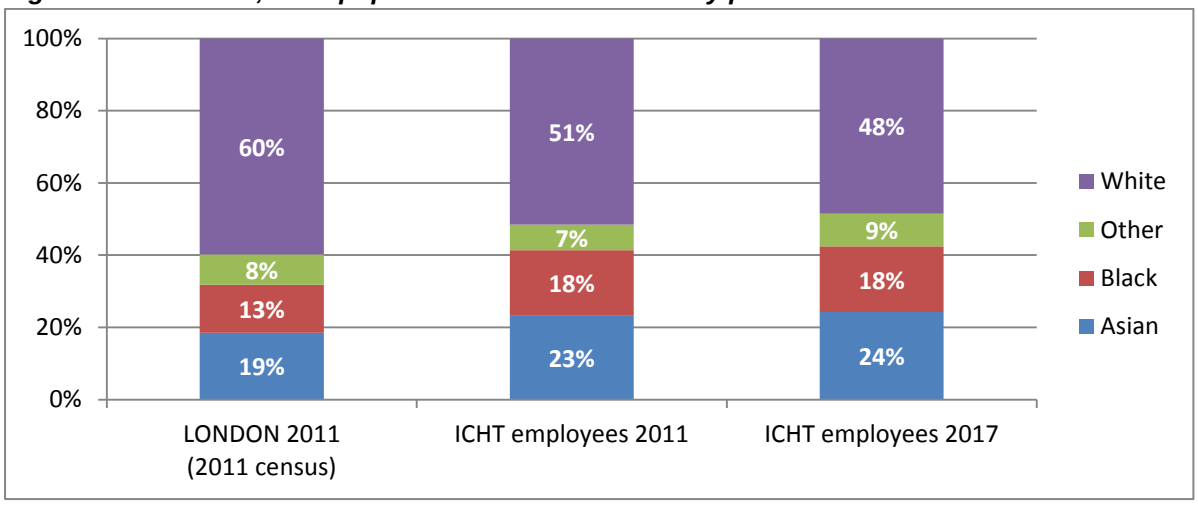
An action plan to mitigate any disproportionality can be found in section 10.

2. Workforce Composition

2.1 Ethnicity

The percentage of staff employed by the Trust from Black and Minority Ethnic (BME) backgrounds accounts for 52% of those who disclose their ethnicity. White people make up 48% of the workforce. The proportion of people from white backgrounds has decreased from 51% in 2011. In comparison, 40% of the London population is of BME backgrounds and 60% is white.

Fig. 1 London, local population and Trust ethnicity profile



Note: for the purpose of this Figure, data of “unknown” and “not stated” ethnicity is excluded.

When the workforce ethnicity data is split by clinical and non-clinical staff, it is largely comparable within bands. The majority of people in junior roles are from BME backgrounds. This changes with seniority as the majority of people in bands 7 and above are from white backgrounds. Similarly, there are more doctors, including consultants from white backgrounds than BME backgrounds.

The Trust offers programmes to support career management, including development of our staff and better systems for internal transfers. The Trust will also support positive action where possible, such as Ready Now external BAME (Black, Asian and minority ethnic) programmes. The impact of this will continue to be reviewed to see how this can support ethnic distribution within bands that is more representative of our workforce.

Tab 1 Ethnicity profile – percentage of staff in each of the AfC bands, medical grades and Very Senior Managers (VSM) – March 2017

	Clinical				Non-clinical			
Row Labels	BME	Unknown	White	Count	BME	Unknown	White	Count
BAND 1	0%	0%	0%	0	100%	0%	0%	2
BAND 2	68%	8%	25%	665	65%	5%	30%	219
BAND 3	62%	6%	32%	495	61%	4%	35%	674
BAND 4	49%	7%	44%	153	48%	6%	46%	375
BAND 5	59%	6%	36%	1676	50%	5%	45%	309
BAND 6	57%	4%	38%	1734	46%	3%	51%	250
BAND 7	38%	5%	57%	1084	41%	3%	55%	150
BAND 8A	28%	6%	66%	324	34%	10%	56%	110
BAND 8B	22%	6%	72%	109	28%	3%	70%	112
BAND 8C	10%	5%	86%	42	15%	7%	78%	54
BAND 8D	6%	0%	94%	17	22%	3%	75%	36
BAND 9	13%	0%	88%	8	10%	5%	85%	20
CONSULTANT	30%	8%	62%	683	0%	0%	0%	0
Doctor (Career Grade)	34%	7%	59%	61	0%	0%	0%	0
Doctor (Training Grade)	32%	21%	46%	1098	0%	0%	0%	0
Spot Salary[1]	38%	15%	46%	13	17%	33%	50%	6
VSM	0%	0%	100%	2	10%	5%	86%	21
Total Count				8164				2338

2.2 Workforce Composition: Age

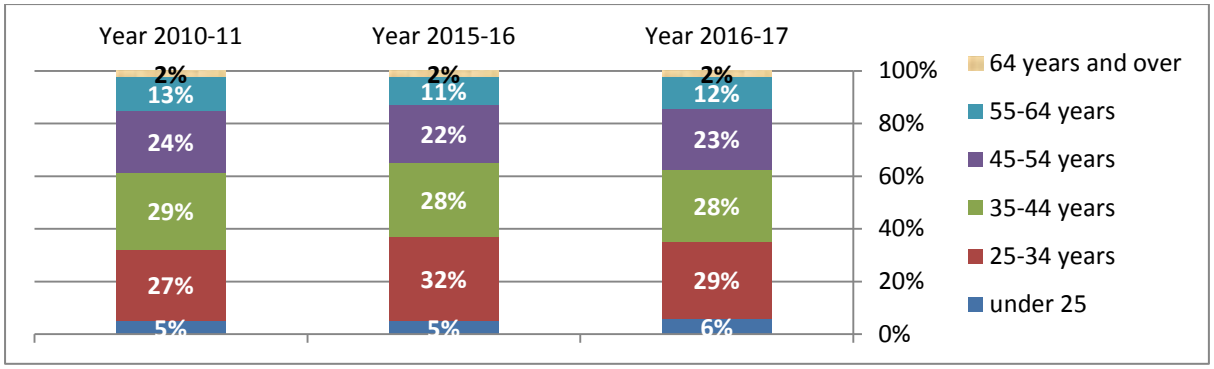
There have been no significant changes in the workforce composition in regards to age since 2010/11. The majority of our staff, 80%, are aged 25 to 54.

The most noticeable variation can be seen amongst people aged between 25 to 34. Currently, 29% of our staff are within this age group compared to 32% in 2015/16 and 27% in 2010/11.

The Trust seeks to increase its attractiveness to people of all age groups through a range of measures including the widespread provision of work experience opportunities and apprenticeships and the promotion of flexible working.

Fig 2 Trust age profile - March 2017

[1] See Appendix 3 Glossary of Terms used in this report

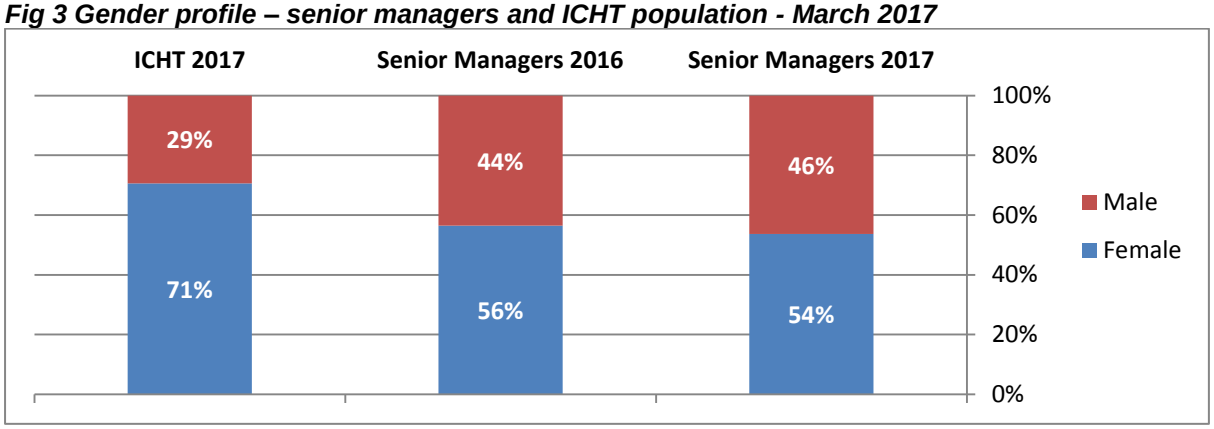


2.3 Workforce Composition: Gender

The workforce split in regards to gender has remained unchanged in the last 6 years: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations, reflecting the gender split of people entering healthcare professions. Figures published by NHS Employers in 2017 show that 77% of NHS workforce are women and 23% are men.

The proportion of male employees continues to increase in more senior roles. The figure below shows that 46% of people employed as senior managers are men and 54% are women. This is a slight increase from 44% in year 2015/16 and a continuous trend from 2014/15 when 34% of senior managers were men and 66% were women.

Fig 3 Gender profile – senior managers and ICHT population - March 2017

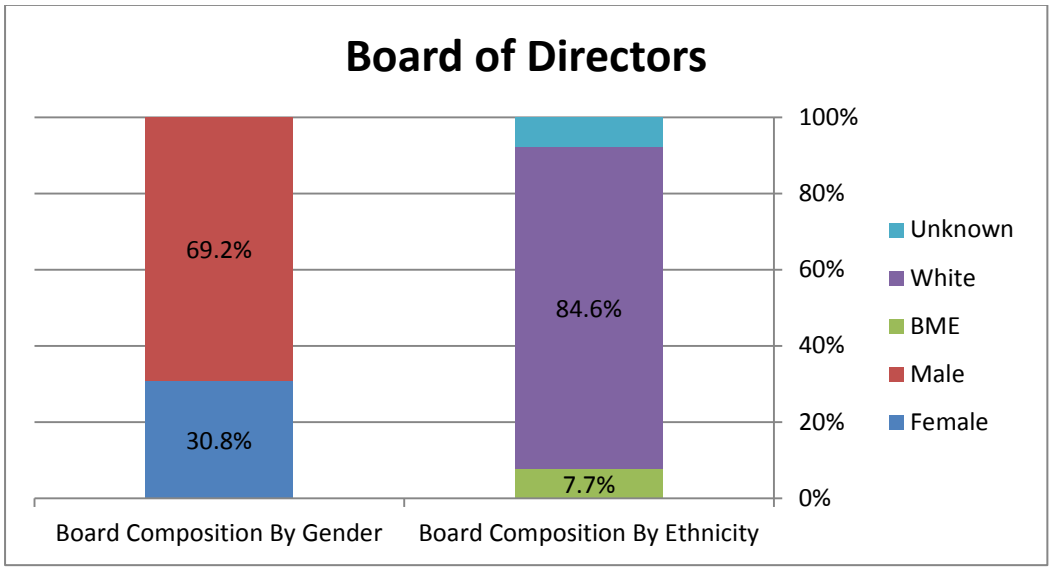


2.4 Trust Board of Directors Composition: gender and ethnicity

The Board of Directors comprises 13 people. White people accounting for 84.6% of Board Directors compared to 48% of the workforce as a whole. 69.2% are men and 30.8% are women compared to the overall Trust composition of 29% male and 71% female. While the majority of the board directors remain male, it has seen an increase in female representation compared to 25% in 2015/16.

This continues to be an important area of review for the Trust. We have included the equality and diversity policies as part of the criteria when selecting the talent sourcing providers for board executive recruitment and will continue to do so to ensure that they are fair, equitable and transparent.

Fig 4 Trust Board composition by gender and ethnicity 2017



2.5 Data quality for disability, sexual orientation and religion – 2016/17

Workforce information on disability, sexual orientation and religion has improved year on year. The Trust now holds demographic information on 62% (up from 56% in 2015/16) of all staff disability status and 67% (up from 60% in 2015/16) on sexual orientation and religion.

The quality of data for new starters has dropped in 2016/17 compared to the previous year. This now stands at 87-88% for all three protected characteristics.

The data capture is 100% for new starters whose applications are recorded via the Trac recruitment system. Trac system has now been rolled out to all staff groups so the data return next year will be complete, although people may still choose not to declare their personal information.

Tab 2 Disability, sexual orientation and religion records for all staff including new staff

Protected Characteristic	Recorded demographic for all staff in 2013/14	Recorded demographic for NEW staff in 2013/14	Recorded demographic for all staff in 2014/15	Recorded demographic for NEW staff in 2014/15	Recorded demographic for all staff in 2015/16	Recorded demographic for NEW staff in 2015/16	Recorded demographic for all staff in 2016/17	Recorded demographic for NEW staff in 2016/17
Disability	40%	95%	47%	89%	56%	92%	62%	87%
Sexual Orientation	46%	96%	54%	88%	60%	90%	67%	88%
Religion	46%	96%	54%	88%	60%	90%	67%	88%

3. Recruitment

The Trust monitors the progress of applicants through the selection process by protected characteristic. A summary of the monitoring information is shown in tables 3-10 (see Appendix 1 for tables 5-10).

3.1 Recruitment by ethnicity

66% of applicants throughout 2016/17 were from BME groups while 58% of those appointed were from BME groups. In comparison, 30% of applicants described their ethnic origin as white and 34% of those appointed were from white background. Please see Appendix 1 for more details.

3.2 Relative likelihood of being appointed from shortlisting

Tab 3 Likelihood of being appointed from shortlisting by ethnicity – 2016/17

Descriptor	White	BME	Unknown
Number of shortlisted applicants	2962	6629	320
Number appointed	630	1088	155
Relative likelihood	0.2127	0.1641	0.4844

The likelihood of white applicants being appointed from shortlisting is 0.2127 and 0.1641 for applicants from BME groups. The relative likelihood of white applicants being appointed from shortlisting compared to applicants from BME groups is roughly 1.30 times greater; this is an improvement from last year when the relative likelihood was 1.42 times greater.

Recruitment analysis by gender shows that conversion rate for female applicants' remains slightly higher than for male applicants. There is however a small change of roughly 0.6% in favour of male applicants compared to last year.

Tab 4 Recruitment analysis by gender 2016-17

Gender	Applicants	Shortlisted	Appointed
Male	32.38%	28.57%	26.43%
Female	67.02%	70.80%	73.36%
Not stated	0.60%	0.63%	0.21%

Analysis of conversion rates by transgender, age, sexual orientation, religion and disability remain broadly in line with the ratio of applicants and those shortlisted. Please see Appendix 1 for more details.

Diversity training is mandatory for everyone working at the Trust. In addition recruitment training is provided for managers.

4. Access to non-mandatory training 2016/17

An analysis of access to training which is centrally recorded in HR has been undertaken. This includes vocational courses and discretionary HR programmes, a total of 24 different courses running throughout the year. It does not include mandatory training as this is non-discretionary. Due to the limitations of the current training record system, it is not possible to analyse all training activity across the Trust.

Access to courses which have been analysed shows that access is broadly in line with the workforce composition. The main outliers which are statistically significant are that:-

When the data is cut by gender, women are more likely to access training than men within the organisation: women accessing training is 10% higher than the Trust workforce composition. This is a slight increase from last year when it was 7% higher.

Access to training for people from different age groups shows that 5% more people in the 25-34 age group accessed courses. This may reflect the fact that this age group are more likely to be seeking development in the early part of their career

Key recommendations for next year will be to seek investment in an integrated learning management system which will facilitate easier reporting for a greater range of training

This data does not include Core Skills training (formerly Statutory and Mandatory) as this is required by all staff regardless of age, gender or ethnicity.

Tab 11 Access to training by gender, ethnicity and age 2017[2]

GENDER	Workforce	People accessed training
Female	72%	82%
Male	28%	18%
ETHNICITY	**Workforce**	**People accessed training**
White	45%	44%
BME	48%	52%
Unknown	7%	4%
AGE	**Workforce**	**People accessed training**
Under 25 Years	6%	4%
25-34 Years	30%	35%
35-44 Years	27%	24%
45-54 Years	23%	24%
55-64 Years	12%	11%
64 Years and Over	2%	1%

4.1 Relative likelihood of accessing non-mandatory training

The likelihood of BME people accessing non mandatory training and CPD was 0.1541 and for white people it was 0.1356. The relative likelihood of BME people accessing non mandatory training and CPD was 1.1364 times greater than white staff. This is a slight increase from the previous year when the relative likelihood of accessing training and CPD was greater for BME people than White people by 1.1144 times.

[2] Data is gathered from 24 different courses running throughout the year.

Tab 12 Access to non-mandatory training and CPD by ethnicity

Descriptor	Number of Staff in Workforce	Staff accessing non mandatory training and CPD	Likelihood of accessing non mandatory training and CPD
White	4874	661	0.1356
BME	5218	804	0.1541

5. People awarded D or E rating on Performance and Development Review (PDR)

PDR ratings have pay implications for people on Agenda for Change contracts because incremental pay increases are awarded to people who are given A, B or C ratings. Fifty people (0.5% of the Trust population) were awarded D or E rating on PDR in 2016/17, compared to ninety four people (0.9% of the Trust population) in 2015/16. D or E ratings indicate that performance is unsatisfactory and trigger formal performance management process in line with the Trust poor performance management policy.

Figure 5 shows the data on people who were awarded a D or E rating on PDR by gender and ethnicity. When cut by gender, the likelihood of male employees being awarded D or E rating are higher than their female colleagues when compared to the overall workforce composition. When cut by ethnicity, people from BME backgrounds were more likely to be awarded a D or E rating. 71% of D and E ratings were awarded to BME staff. The disproportionality has increased since last year when BME people accounted for 66% of those who received a D or an E rating.

When the data on those who received D and E ratings is cut by grade and professional group, there is a disproportionately high number of band 2 to band 4 admin and clerical and unqualified nursing staff. Grade and professional group may be contributory factors for the high proportion of BME staff amongst those who received low performance ratings but even when these factors are taken into account, ethnicity may be a factor.

The Trust has entered into the fourth year of conducting PDRs in line with this process. This is an important area of review to ensure that it is designed and followed robustly and is not open to bias.

Fig 5 People awarded D or E rating on PDR by gender and ethnicity 2016-17

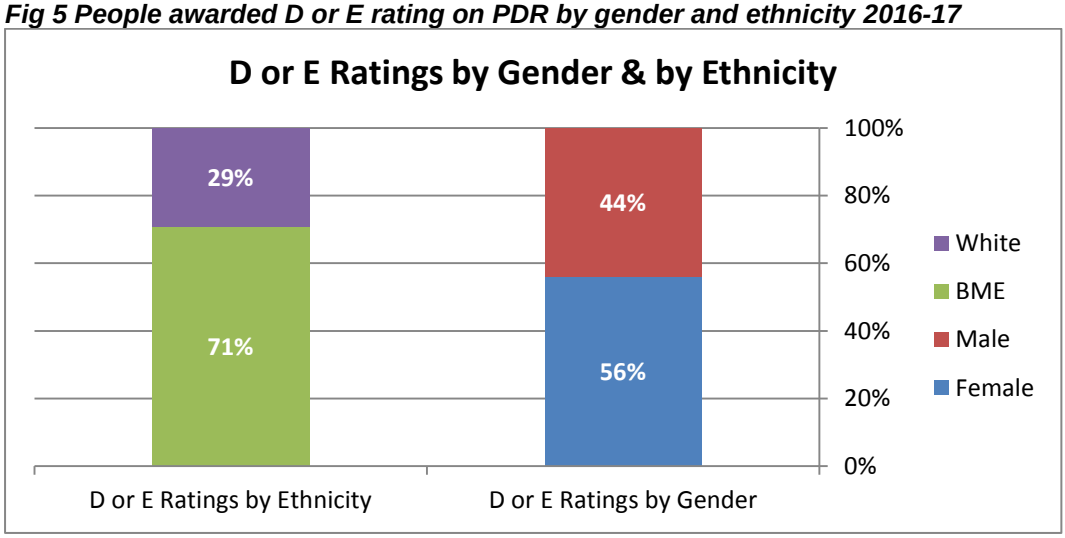


Fig 6 People awarded D or E rating on PDR by band 2016-17

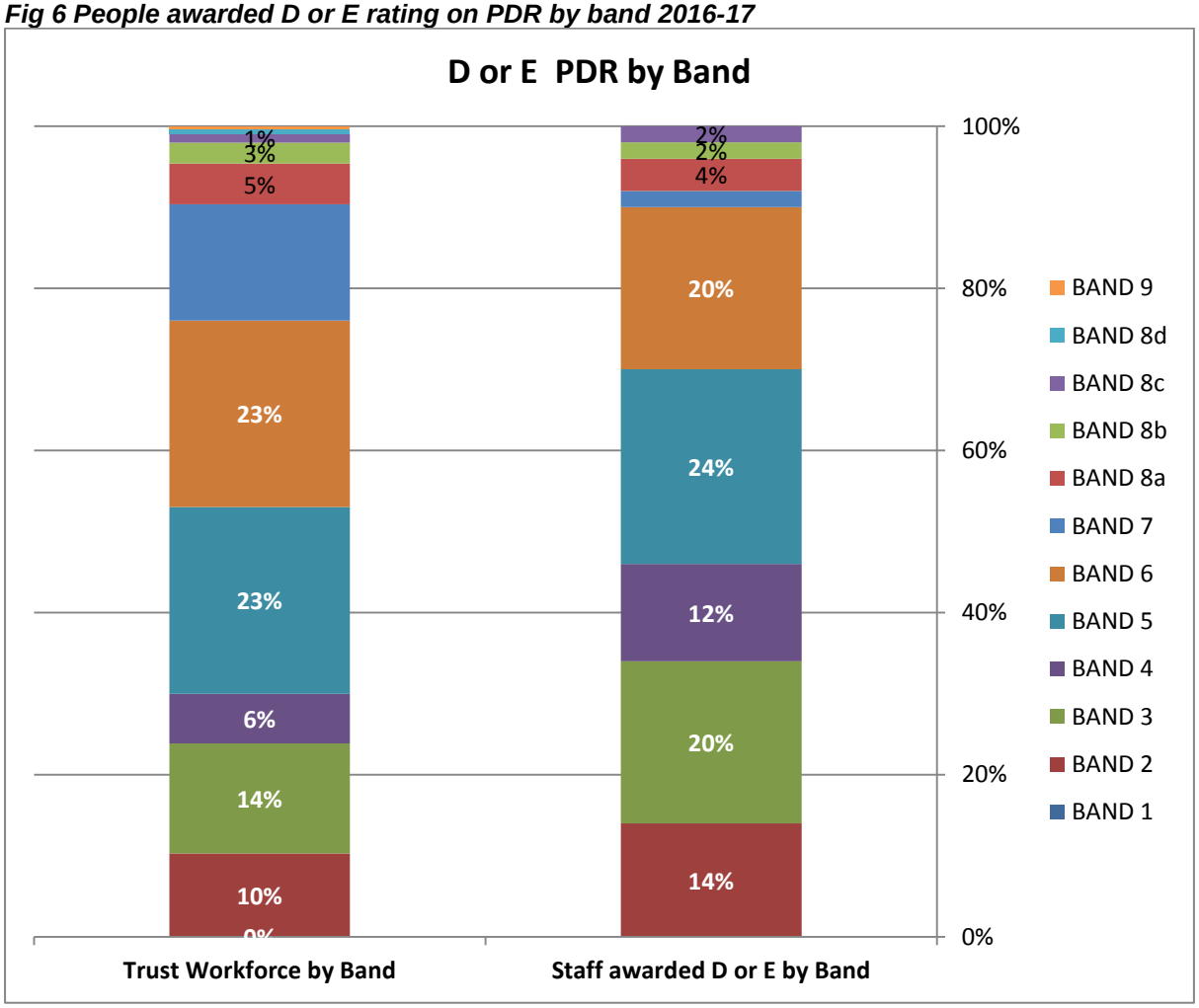
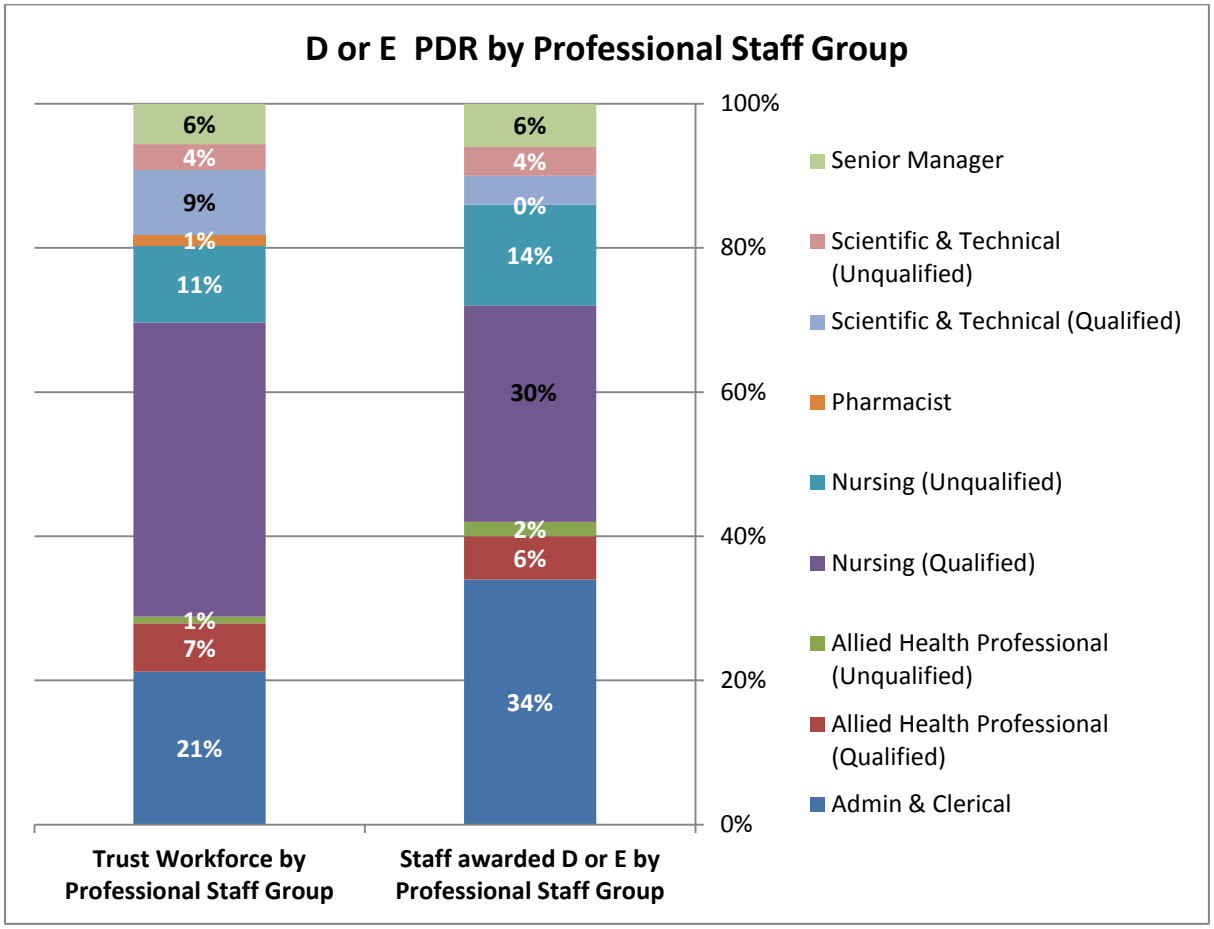


Fig 7 People awarded D or E rating on PDR by professional group 2016-17



6. Promotions and leavers

White British staff are more likely to leave than other ethnic groups, accounting for 36% of leavers in 2016/17. When the data is split by gender, men are marginally more likely to leave than women – men accounted for 32% of leavers compared to 29% the workforce. This is a significant change from last year when 25% of leavers were men.

People from white backgrounds accounted for 49% of promotions and BME people for 49%. This is comparable to the Trust population where BME people account for 52% and white people account for 48% of the workforce. When promotions are cut by gender, women are more likely to be promoted than men.

Fig 8 Promotions and leavers by ethnicity 2016-17

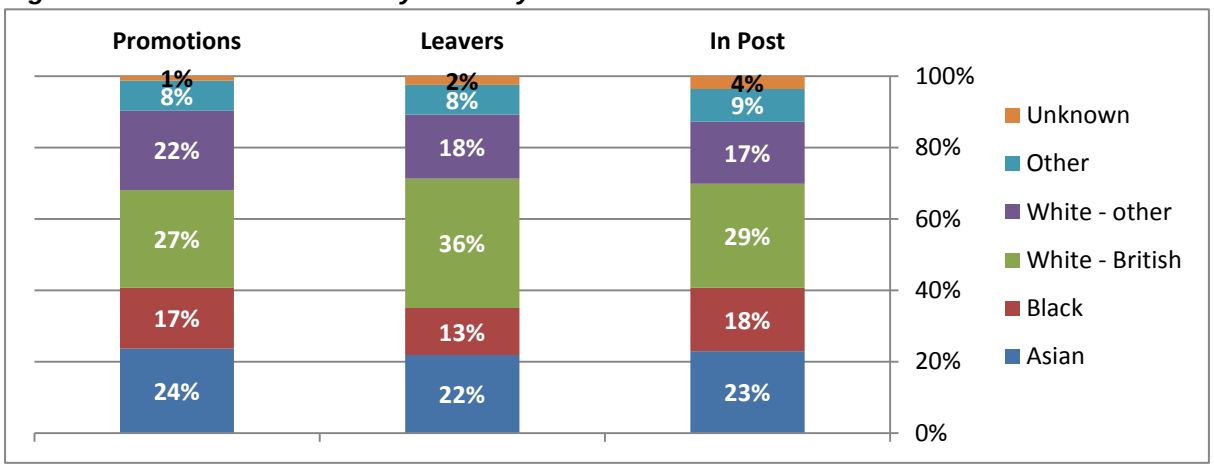
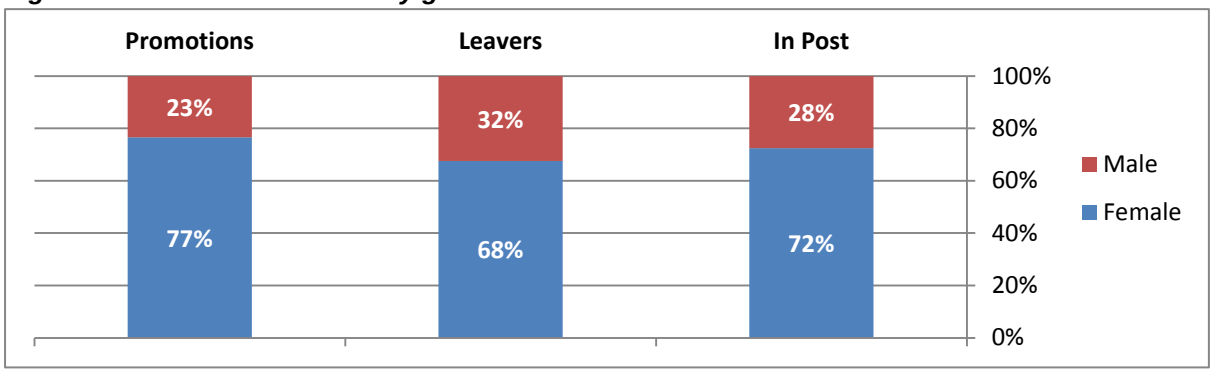


Fig 9 Promotions and leavers by gender 2016-17



7. Application of formal workforce procedures 2016/17

The Trust monitors the formal application of workforce procedures by ethnicity, gender and age. In 2016/2017, there were 342 formal meetings in total.

7.1 Ethnicity

In 2016/17, there were 89 formal disciplinary cases, twelve (13.5%) involved Asian, thirty-one (34.8%) involved black people and thirty-two (36%) involved white people. Compared to 2015/2016, there was a drop in the involvement of BME employees in disciplinary cases from 69% in 2015/2016 to 57% in 2016/2017. This appears to be mainly due to a drop in the involvement of Asian employees in disciplinary cases (from 32% of cases in 2015/2016 to 13.5% in 2016/2017). There is still a disproportionate involvement of black employees in formal disciplinary cases as they accounted for 34.8% of disciplinary hearings and made up 16.2% of the workforce in 2016/2017 in comparison to 28% of disciplinary cases in 2015/2016 where black people constituted 17% of workforce. There is a rise in the involvement of white people in formal disciplinary cases (from 19% of cases in 2015/2016 to 36% in 2016/2017).

In 2016/17, there were 22 formal performance management cases. Table 13 shows that black people, who made up 16.2% of the workforce, accounted for 40.9% of performance meetings. This is an increase of 9% in comparison to 2015/2016.

In 2016/2017, there were 213 formal sickness absence cases, both long term and short term, of which 42.3% involved white people.

There were also 18 formal grievance hearings, of which 3 (16.7%) involved white people and 14 (77.8%) involved BME people.

Tab 13 Formal hearings by ethnicity 2016-17

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Ethnicity	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Asian	21.7%	12	13.5%	5	22.7%	40	18.8%	4	22.2%
Black	16.2%	31	34.8%	9	40.9%	45	21.1%	7	38.9%
White	43.3%	32	36%	7	31.8%	90	42.3%	3	16.7%
Other	7.6%	8	9%	1	4.5%	23	10.8%	3	16.7%
Unknown	11.1%	6	6.7%	0	0%	15	7%	1	5.6%
Total	100%	89	100%	22	100%	213	100%	18	100%

Table 14 below suggests that both grade and ethnicity are factors influencing participation in formal workforce procedures. Junior people from all ethnic groups are more likely to be involved in formal procedures than senior people. In 2016/17, band 2-5 employees whose ethnicity is known accounted for 44% of the total workforce and 68% of formal workforce procedures. Amongst them, band 3 and band 5 employees accounted for the majority of the cases. Comparing participation in all formal procedures among white and BME people in bands 2-5, it appears to be relatively proportionate when compared to respective workforce population, with white people being slightly more likely to participate in formal procedures. However, there is a relatively higher proportion of BME employees participating in formal procedures in bands 6 and above, including medical and dental employees in comparison to white people.

Tab 14 Formal hearings by ethnicity and band 2016-17

Band	No of meetings involving white people	% of meetings involving white people	% of white people by band in workforce	No of meetings involving BME people	% of meetings involving BME people	% of BME people by band in workforce
2	14	4.4%	2.4%	31	9.7%	6.1%
3	29	9.1%	4.1%	36	11.3%	7.4%
4	14	4.4%	2.5%	16	5.0%	2.6%
5	30	9.4%	7.7%	46	14.4%	11.8%
6	24	7.5%	8.1%	40	12.5%	11.4%
7	14	4.4%	7.2%	14	4.4%	4.9%
8 and above	5	1.6%	6%	4	1.3%	2.1%
Medical & Dental	2	0.6%	9.9%	1	0.3%	5.9%

Total	132	41.3%	47.9%	188	58.8%	52.2%

Note: for the purpose of this table, "unknown" ethnic status were excluded.

When analysing the data by occupational groups, it shows that both occupational group and ethnicity are factors influencing participation in formal workforce procedures. For some occupational groups, there were not sufficient numbers to draw meaningful conclusions, however for the other occupational groups, the following conclusions could be drawn. Please also see Appendix 2 for tables with detailed figures.

Qualified nurses and admin & clerical employees are more likely to be involved in formal performance and disciplinary meetings than other occupational groups, whereas admin & clerical employees and qualified scientific & technical staff are more likely to be involved in formal grievance meetings than other occupational groups.

The disproportionate involvement from admin & clerical staff is particularly the case for BME admin & clerical employees in formal performance and grievance procedures. Nevertheless, white admin & clerical employees were more heavily involved in formal disciplinary procedures. Please see table 16 and 18 (Appendix 2)

Qualified nurses are also disproportionately involved in formal disciplinary meetings as 50.6% of disciplinary hearings involved qualified nurses when they account for 33% of the Trust population. This was particularly the case for BME qualified nurses who account for 69% of disciplinary meetings involving qualified nurses whereas they only accounted for 57.3% of the occupational group (table 17, Appendix 2). The involvement of qualified nurses in formal performance meetings (31.8%) was in line with the Trust's qualified nursing population (33%) (table 15, Appendix 2). The involvement of both white and BME qualified nurses in formal performance meetings was also broadly in line with the Trust's qualified nursing population (table 16, Appendix 2).

Finally, qualified scientific & technical employees were disproportionately involved in grievance meetings as 29.4% of formal grievance meetings involved qualified scientific & technical staff when they only accounted for 7% of the Trust's workforce population. The qualified scientific & technical employees involving in formal grievance procedures were all of BME origin (table 15, Appendix 2).

The Trust continues to deliver training sessions year on year to ensure that managers are appropriately trained in fair application of workforce policies, including disciplinary, poor performance and dignity and respect policies.

7.2 Relative likelihood of entering into formal disciplinary procedure

Table 15 shows that the likelihood of BME people entering the formal disciplinary procedure over the two year rolling period from April 2015 to March 2017 was 0.0102 and for white people it was 0.0048. Therefore the relative likelihood of BME staff entering the formal disciplinary procedure, compared to white people was 2.125 times greater.

Tab 19 Likelihood of entering the formal disciplinary hearing by ethnicity – two year average 2015-17

Descriptor	Average number of staff in	Annual average of number	Relative likelihood of

	workforce (2015-17)	of formal disciplinary meetings (2015-17)	entering formal disciplinary meetings
White	**4772**	**23**	**0.0048**
BME	**5094**	**52**	**0.0102**

7.3 Gender

Comparing the figures against the Trust population, table 16 shows that men are more likely than women to be subject to disciplinary and performance management. This differs from 2015/2016 when women were more likely than men to be subject to performance management. Women are more likely than men to be involved in other workforce procedures, including sickness and grievance. We have observed this trend over the recent years.

Tab 20 Formal hearings by gender 2016-17

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Gender	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Female	71%	55	61.8%	13	59.1%	169	79.3%	15	83.3%
Male	29%	34	38.2%	9	40.9%	44	20.7%	3	16.7%
Total	100%	89	100%	22	100%	213	100%	18	100%

7.4 Age

Table 17 demonstrates that the 35-44 age group had the highest participation rates for disciplinary and sickness formal procedures, it is also the second largest age population amongst the Trust workforce. The 45-54 age group were the most likely to raise grievances and be subject to formal performance management procedures. This differs from 2015/2016 when the 25-34 age group had the highest participation rates for disciplinary and performance management procedures, and the 55-64 age group were the most likely to raise grievances. With regards to formal sickness procedures in 2015/2016 the 25-34 and the 35-44 age groups had the highest participation rates.

Tab 21 Formal hearings by age 2016-17

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Age group	% of Trust population	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Under 25	6%	4	4.5%	1	4.5%	6	2.8%	1	5.6%
25-34	29%	19	21.3%	5	22.7%	53	24.9%	0	0
35-44	28%	26	29.2%	5	22.7%	63	29.6%	6	33.3%
45-54	23%	21	23.6%	6	27.2%	55	25.8%	8	44.4%

55-64	12%	18	20.2%	4	18.2%	30	14.1%	3	16.7%
65 and over	2%	1	1.12%	1	4.5%	6	2.8%	0	0
Total	100%	89	100%	22	100%	213	100%	18	100%

8. Staff experience: 2016 NHS Staff Survey Results

The Trust monitors staff experience by protected characteristics through the annual NHS Staff Survey. The 2016 staff survey results revealed some differences in experience when analysed by disability status, ethnicity, age and gender.

The full results of the 2016 staff survey can be found at http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/

8.1 Gender

There are few significant differences in experience by gender. Overall men respond less positively to some questions relating to personal development, working patterns as well as job satisfaction and their contribution to patient care and experience.

Women, on the other hand, were more likely to report experiencing harassment, bullying or abuse, feeling work-related stress and feel pressurised to attend work when unwell than men. Nevertheless, women respond more positively about organisation and management interest in and action on health and wellbeing.

Women are overall more engaged than men with engagement scores of 3.87 and 3.72, respectively.

8.2 Disability

People with disabilities and those who do not report to have a disability provide similar answers to the majority of the king findings. Where the responses differ significantly, they are typically less favourable for disabled people.

Disabled people provide less favourable responses to questions relating to equality and diversity, as well as health and well-being. For example disabled people were more likely than non-disabled people to report work related stress in the last 12 months (41% compared to 34%). Disabled people are also more likely to report feeling less satisfied with the quality of work and care they are able to deliver.

The engagement score, is higher for non-disabled people (3.82) than disabled people (3.77).

8.3 Age

People of all age groups report similar experiences on the majority of the key findings. The area where responses differ most significantly relates to violence, harassment and bullying.

The age group 41-50 were more likely to report experiencing physical violence and harassment, bullying or abuse in last 12 months. People above age 51 had higher percentage of reporting most recent experience of violence.

The most engaged staff group when split by age are people aged 31-40 and 51 and over, with a drop in engagement for age group 41-50. Overall the age groups engagement curve shows a dip when people are halfway into their career life at age between 41-50.

8.4 Ethnicity

When the data is split by ethnicity, the biggest variation is on questions relating to equality and diversity, appraisals and support for development, job satisfaction as well as satisfaction with quality of work and patient care. BME people were more likely to report experiencing discrimination at work (19% BME, 7% white) and felt less positive about the organisation's equal opportunities for career progression (74% BME, 87% white people). The likelihood of BME people reporting *most recent* experience of violence and harassment, bullying or abuse are higher than white people.

However, BME people report more positively than white people on quality appraisals and support for personal development. They are also more likely to feel motivated at work, satisfied with resourcing and support and more likely to recommend the organisation as a place to work or receive treatment.

Overall, BME staff shows a higher engagement level than white staff. The scores are 3.87 and 3.78 respectively.

8.5 NHS National Survey questions mandated by the WRES.

Under the Workforce Race Equality Standard the Trust is required to publish the responses cut by ethnicity to the following NHS staff survey results:

Tab 18: Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

White	*BME*
33%	31%

Tab 19: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

White	*BME*
32%	32%

Tab 20: Percentage of staff who believe that trust provides equal opportunities for career progression or promotion.

White	*BME*
87%	74%

Tab 21: In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

White	*BME*
7%	19%

9. Progress on actions agreed last year

A number of actions were agreed by managers and staff side colleagues following the analysis of the data contained in last year`s report. Actions and the progress relating to them are noted below:

1. *An internal transfer's scheme for nurses and midwifes will be introduced. Access to this will be monitored and ethnic breakdown will be reviewed*

As the program has so far been available only to nurses, it is understandable why there is a female bias to the numbers presented. Among the 15 participants and excluding the one with unknown ethnicity, 7 were from BME backgrounds and 7 were white. The number of staff transferred so far does not provide a sufficient number to draw meaningful conclusions regarding this data.

Gender	% of Trust population	No of participants	% of participants
Male	29%	2	13%
Female	71%	13	87%
Total	100%	15	100%

2. *Band 5 rotation scheme will be offered and access to this monitored and reviewed*

The scheme has been implemented.

3. *Band 6 development programme will be offered and access to this will be monitored and reviewed*

Several Band 6 development programmes continue to run across the Trust. In addition, a new leadership programme for Band 5 and 6 has been launched in the summer 2017 and access to the programme will be monitored.

4. *Capacity of Trust leadership courses will be increased and access to these reviewed by ethnicity*

The Trust increased the capacity where the capacity meets demand.

5. *Review of the apprentice scheme to ensure that it is promoted and accessible to our local population*

This has been in progress and on-going. Around 50% of our current apprentices have been recruited from west and north west London and we are now developing strong relationships with Job Centre Plus in west London

6. *We will continue to monitor interview panel membership to check that at least one panel member has been trained in recruitment and selection*

Over all just over 31% of interviews had one member of the panel who had attending recruitment training at the Trust. It should be noted that we do not hold data regarding the training managers have obtained elsewhere. It is therefore possible that this number is under reported for managers who have been trained to conduct interviews.

7. *The recruitment and selection training content will be reviewed to raise awareness of unconscious bias and best practice at interview*

The training content was revised in 2016.

8. *The Employee Relations team will continue to train managers in fair and equitable application of workforce policies*

In 2016 / 2017 188 managers were trained in fair and equitable application of the main workforce policies and procedures (disciplinary, sickness, poor performance, whistleblowing and dignity and respect). In addition, ad hoc training sessions were held and 78 managers were trained in sickness absence management and 15 in managing poor performance. Ad hoc training sessions in Dignity and Respect were held and 102 managers and employees were trained.

Moreover, ad hoc training on how to appropriately and fairly manage special leave was provided in Division of Medicine and Integrated Care where they identified an issue and in 2016/2017 28 people were trained.

9. *Managers will be reminded to ensure to provide a good on-boarding and induction experience for all new starters by email when appointment is confirmed to them by the resourcing team.*

Action completed.

10. *We will report on access to courses offered by universities when this is available for review*

This action will roll over to the following year.

11. *Additional support will be offered to managers to help them understand the results of the engagement survey and design appropriate action*

Following the engagement survey, 'In Our Shoes' was rolled out to help managers consider how they can help their staff to experience better days at work. These are listening workshops driven by individual department managers and supported by In Our Shoes facilitators. In Our Shoes used the It's Up To Me, Not Down To Them method, which encourages individual responsibility of all employees to help their colleagues to have a good day at work. There are just under 1000 staff who have participated in the workshops. The work has also been featured in a NHS Employers case study.

12. *We will review access to Trust coaching and mentoring registers to establish whether positive action to ensure that this is accessed by BME people is required*

This is currently under review.

13. *We will train more managers in addressing bullying and harassment*

In 2016 / 2017 we trained 188 managers in how to address bullying and harassment concerns and additionally, we held ad hoc training sessions in Dignity and Respect and trained 102 managers and employees.

14. *We will review the equality and diversity policies of search teams we engage with for the purpose of Board level candidate searches*

This is something we include as part of the criteria to select an agency for senior posts.

In addition, the Trust uses the NHS Equality Delivery System 2 (EDS2) framework to fulfil its public sector equality duty to promote equality. In 2016/17 the Trust's EDS2 workforce focus was on flexible working opportunities being equitably available to people. Please visit the Trust website for more information on equality and diversity:

https://www.imperial.nhs.uk/about-us/who-we-are/publications

10. Annual Workforce report Action Plan for 2017/18

		Owner
ACTION 1	**Improve workforce representation of BME people on Band 7 and above**	
1.1	Introduce values-based interviews, which includes new guidance on recruitment and selection and highlight the minefield of potential bias. Recruitment and selection training will be adapted to include the new guidance	Resourcing
1.2	Review the language used on job adverts so it is more inclusive and target diverse groups	Resourcing
1.3	Monitor and report on the demographic breakdown of people on the talent plan	Talent
1.4	Review all leadership programme and ensure that they promote a culture of inclusions and raising awareness of diversity issues	Talent
1.5	Refresh skills and awareness of Diversity and Inclusion issues and unconscious bias across all our professional P & OD staff to ensure we are offering the best practice and consistent advice and support	Talent
ACTION 2	**Improve disproportionate representation of BME people receiving D or E rating (PDR)**	
2.1	The PDR training content will be reviewed to raise awareness of unconscious bias and best practice at PDR	Talent
ACTION 3	**Mitigate disproportionate representation of BME people entering formal workforce procedures**	
3.1	Review the reasons that people are facing formal procedures to establish whether further training and support can be offered to prevent staff from entering into formal procedures	
3.2	Review the training provided for managing workforce procedures to include a focus on potential bias	
ACTION 4	**Actions will be developed to address the concerns about harassment and bullying reflected in the 2016-2017 NHS staff survey.**	
4.1	A review of the national local survey results will take place with a targeted action plan aimed at prevention of harassment and bullying across the organisation	

Appendix 1 Recruitment data 2016-17

Tab 5 Recruitment analysis by ethnicity

Ethnic Origin	Applicants	Shortlisted	Appointed
WHITE - British	15.20%	15.92%	18.31%
WHITE - Irish	1.09%	1.72%	2.94%
Any other white background	13.52%	12.25%	12.39%
ASIAN or ASIAN BRITISH - Indian	10.74%	10.17%	7.85%
ASIAN or ASIAN BRITISH - Pakistani	4.45%	3.36%	1.71%
ASIAN or ASIAN BRITISH - Bangladeshi	4.58%	3.11%	2.14%
Any other Asian background	7.29%	9.41%	6.94%
BLACK or BLACK BRITISH - Caribbean	6.78%	6.57%	9.29%
BLACK or BLACK BRITISH - African	18.36%	18.56%	16.28%
Any other black background	4.07%	5.14%	4.27%
MIXED - White & Black Caribbean	1.24%	1.25%	0.64%
MIXED - White & Black African	1.01%	1.06%	0.59%
MIXED - White & Asian	0.72%	0.85%	0.75%
any other mixed background	1.53%	1.44%	1.12%
Chinese	0.71%	0.80%	0.91%
Any other ethnic group	4.81%	5.18%	5.61%
Not stated	3.92%	3.23%	8.28%

Tab 6 Recruitment analysis by transgender 2016-17

Transgender	Applicants	Shortlisted	Appointed
No	18.57%	19.44%	29.31%
Yes	0.09%	0.09%	0.11%
Not stated	81.34%	80.47%	70.58%

Tab 7 Recruitment analysis by age 2016-17

Age	Applicants	Shortlisted	Appointed
Under 20	1.07%	0.68%	0.59%
20 - 24	16.92%	13.87%	15.86%
25 - 29	25.64%	24.27%	27.07%
30 - 34	17.22%	16.92%	18.47%
35 - 39	11.69%	12.35%	12.55%
40 - 44	9.38%	10.83%	8.38%
45 - 49	7.79%	9.26%	7.15%
50 - 54	6.27%	7.17%	5.66%
55 - 59	2.86%	3.32%	3.31%
60 - 64	1.02%	1.16%	0.69%
65+	0.11%	0.14%	0.27%
Not stated	0.03%	0.03%	0.00%

Tab 8 Recruitment analysis by disability 2016-17

Disability	Applicants	Shortlisted	Appointed
No	94.64%	94.74%	89.80%
Yes	3.74%	3.84%	2.88%
Not stated	1.61%	1.41%	7.31%

Tab 9 Recruitment analysis by religion 2016-17

Religion	Applicants	Shortlisted	Appointed
Atheism	6.81%	7.43%	11.80%
Buddhism	1.11%	1.00%	1.12%
Christianity	49.29%	53.56%	46.45%
Hinduism	7.39%	6.35%	6.25%
Islam	17.53%	14.64%	10.89%
Jainism	0.18%	0.17%	0.11%
Judaism	0.27%	0.24%	0.32%
Sikhism	1.63%	1.62%	1.07%
Other	5.17%	5.01%	5.45%
I do not wish to disclose my religion/belief	10.63%	9.98%	16.55%

Tab 10 Recruitment analysis by sexual orientation 2016-17

Gender	Applicants	Shortlisted	Appointed
Bisexual	0.94%	0.79%	1.07%
Gay	1.37%	1.40%	1.71%
Heterosexual	87.96%	88.34%	79.55%
Lesbian	0.25%	0.30%	2.72%
Not stated	9.48%	9.17%	14.95%

Appendix 2 Application of formal workforce procedures by occupational group 2016/17

Tab 15 Formal meetings by occupational group 2016/17

		Performance		Disciplinary		Grievance	
	% of Trust Population	**No of mtgs**	**% of mtgs**	**No of mtgs**	**% of mtgs**	**No of mtgs**	**% of mtgs**
Admin & Clerical	17%	6	27.3%	20	23%	5	29.4%
Allied Health Professional (Qualified)	5%	3	13.6%	2	2.3%	1	5.9%
Allied Health Professional (Unqualified)	1%	-	-	-	-	-	-
Doctor (Consultant)	9%	-	-	-	-	-	-
Doctor (Training Grade)	10%	-	-	1	1.1%	-	-
Nursing (Qualified)	33%	7	31.8%	44	50.6%	4	23.5%
Nursing (Unqualified)	9%	2	9.1%	11	12.6%	2	11.8%
Pharmacist	1%	-	-	-	-	-	-
Scientific & Technical (Qualified)	7%	3	13.6%	3	3.4%	5	29.4%
Scientific & Technical (Unqualified)	3%	-	-	4	4.6%	-	-
Senior Manager	5%	1	4.5%	2	2.3%	-	-
TOTAL	100%	22	100%	87	100%	17	100%

Note: for the purpose of this table, 3 meetings involving employees of other occupational groups were excluded.

Tab 16 Formal performance meetings by ethnicity and occupational group 2016/17

Occupational Group	No of performance meetings involving white people	% of performance meetings involving white people	% of white people by occupational group in workforce	No of performance meetings involving BME people	% of performance meetings involving BME people	% of BME people by occupational groups in workforce
Admin & Clerical	2	33.3%	42.5%	4	66.7%	57.5%
Allied Health Professionals (Qualified)	1	33.3%	68.5%	2	66.7%	31.5%
Nursing (Qualified)	3	42.9%	42.7%	4	57.1%	57.3%
Nursing (Unqualified)	-	-	29.7%	2	100%	70.3%
Scientific & Technical (Qualified)	1	33.3%	49%	2	66.7%	51%
Senior Manager	-	-	68.6%	1	100%	31.4%

Tab 17 Formal disciplinary meetings by ethnicity and occupational group 2016/17

Occupational Group	No of disciplinary meetings involving white people	% of disciplinary meetings involving white people	% of white people by occupational group in workforce	No of disciplinary meetings involving BME people	% of disciplinary meetings involving BME people	% of BME people by occupational groups in workforce
Admin & Clerical	10	55.6%	42.5%	8	44.4%	57.5%
Allied Health Professionals (Qualified)	1	50%	68.5%	1	50%	31.5%
Nursing (Qualified)	13	31%	42.7%	29	69%	57.3%
Nursing (Unqualified)	3	30%	29.7%	7	70%	70.3%
Scientific & Technical (Qualified)	1	33.3%	49%	2	66.7%	51%
Scientific & Technical (Unqualified)	2	50%	49%	2	50%	51%
Senior Manager	1	50%	68.6%	1	50%	31.4%

Note: for the purpose of this table, 6 meetings involving employees of 'unknown' ethnic origin were excluded and 2 meetings involving employees of other occupational groups were excluded.

Tab 18 Formal grievance meetings by ethnicity and occupational group 2016/17

Occupational Group	No of grievance meetings involving white people	% of grievance meetings involving white people	% of white people by occupational group in workforce	No of grievance meetings involving BME people	% of grievance meetings involving BME people	% of BME people by occupational groups in workforce
Admin & Clerical	1	20%	42.5%	4	80%	57.5%
Allied Health Professionals (Qualified)	-	-	68.5%	1	100%	31.5%
Nursing (Qualified)	2	50%	42.7%	2	50%	57.3%
Nursing (Unqualified)	-	-	29.7%	2	100%	70.3%
Scientific & Technical (Qualified)	-	-	49%	4	100%	51%

Note: for the purpose of this table, 1 meeting involving an employee of 'unknown' ethnic origin was excluded and 1 meeting1 involving an employee of another occupational group was excluded.

Appendix 3 GLOSSARY OF TERMS USED IN THIS REPORT

Not stated	Answer to the question about demographic status was not provided
I do not wish to disclose	Person chose not to disclose demographic status
Unknown	A combination of Not stated and Unrecorded
Senior Managers	This includes people in bands 8-9, very senior managers and senior medical staff
Spot salaries	People who came to the Trust through TUPE and are not on NHS payscale
PDR	Performance and Development Review
New Starters	People who began working for the Trust between April 2016 and March 2017
Non-clinical support	Admin & Clerical, Estates and senior managers
Clinical support	Unqualified, Nurses, Scientific and Technical (S&T) and Allied Health Professionals (AHP)
Scientific & Technical	Qualified Scientific & Technical and pharmacists
BME	Black & Minority Ethnic
White	A combination of White British and White Other
Promotions	People who have an upward change of band/grade during the reporting year and are still employed at the end of the reporting year.

Appendix 4 Cross-referencing the Workforce Race Equality Standard requirements with the Annual Workforce Equality and Diversity Report

	Indicator **For each of these nine workforce indicators, data is compared for white and BME staff**	Section of the report
1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce (split by clinical and non-clinical staff).	2.1
2	Relative likelihood of staff being appointed from shortlisting across all posts.	3.2
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (a two year rolling average of the current year and the previous year).	7.2
4	Relative likelihood of staff accessing non-mandatory training and CPD.	4.1
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	8.5
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	8.5
7	Percentage of staff who believe that trust provides equal opportunities for career progression or promotion.	8.5
8	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.	8.5
9	Percentage of difference between the organisations' Board membership and its overall workforce (split by voting membership and executive membership)	2.4

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**27 September 2017**

Hammersmith and Fulham Integrated Care Partnership Agreement

Executive summary:

As previous briefed to board members in June 2017, the Hammersmith & Fulham Integrated Care Partnership is seeking to sign a Partnership Agreement. The Partnership Agreement has been co-designed by the Company Secretaries of the provider partners, with legal input from Capsticks and recommended for approval by the Executive Transformation Committee.

The corporate governance proposal will see the introduction of 'committees in common', whereby the Integrated Care Partnership Board will become a formal committee of each partner's sovereign Board.

This paper is the Partnership Agreement and corporate governance proposal for review by the Trust Board. The Board is being asked to sign the Partnership Agreement and approve the introduction of 'committees in common'.

Quality impact:

The development of the Integrated Care Partnership will have a positive impact on both patient care and patient experience.

Financial impact:

No direct impact.

Risk impact:

The most relevant risk to the long-term governance of the H&F Integrated Care Partnership programme is summarised below:

Risk	Mitigations
Failure of partners to agree contract terms between themselves or with commissioners	• Formal Partnership Agreement between providers as a first step towards an alliance contract • Prioritisation of OD work to engender trust between partners; participation in accelerated support programme offered by ICHP together with commissioners • Using learning from pioneer and vanguard sites (e.g. Cambridge & Peterborough contract collapse).

The proposed Partnership Agreement should help mitigate this risk.

Recommendation to the Trust board:

The Trust board is asked to sign the Partnership Agreement and approve the corporate governance proposal for 'committees in common'.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.
To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Jessica Nyman Accountable Care Partnership Programme Manager	Professor Tim Orchard Divisional Director, Medicine & Integrated Care	19 September 2017

Dated 2017

Partnership Agreement

Hammersmith & Fulham Integrated Care Partnership

Table of contents

Clause heading and number Page number

THIS PARTNERSHIP AGREEMENT is made the ..... day of 2017

BETWEEN: The Parties listed in Schedule 2 (Parties)

INTRODUCTION:

(A) The Parties will work in common in accordance with this Partnership Agreement to decide the specific arrangements for the provision by the Parties of the Integrated Care Partnership and what each Party shall do to ensure the delivery of the desired Integrated Care Partnership Outcomes; once agreed this will be documented in an Integrated Services Schedule.

(B) The Parties recognise that over the term of this Partnership Agreement there may be changes in the way that individual Parties provide the Integrated Care Partnership Services and how responsibilities are allocated between them. This Partnership Agreement aims to foster integration of the Integrated Care Partnership Services delivery via a committee in common structure.

(C) The aim of this Partnership Agreement is to facilitate that the development of the Integrated Care Partnership Services by the Parties to be delivered in a seamless and patient focussed manner.

(D) The Parties acknowledge that each Commissioning Contract will detail the payments due from any CCG to the Parties individually.

(E) In consideration of the above, the Parties have agreed to enter into this Partnership Agreement to set out how they will work together to facilitate the integrated provision of the Integrated Care Partnership Services in order to deliver its outcomes.

1. DEFINITIONS AND INTERPRETATION

1.1 The provisions of this Partnership Agreement shall be interpreted in accordance with Schedule 1 (Definitions and Interpretation).

2. PRE COMPLETION

2.1 Each Party acknowledges and confirms that as at the date of this Partnership Agreement it has obtained all necessary authorisations to enter into this Partnership Agreement.

2.2 The Parties have agreed the terms of reference of:

2.2.1 the Integrated Care Partnership Board, acting as a committee in common for all parties, as set out in Part 1 of Schedule 4 (Integrated Care Partnership Board – Terms of Reference) (the "**Integrated Care Partnership Board TORs**"); and

2.2.2 the Integrated Care Partnership Management Group, as set out in Part 2 of Schedule 4, (Integrated Care Partnership Management Group– Terms of Reference) (the "**Integrated Care Partnership Management Group TORs**").

2.3 The Parties will agree the format of an Integrated Services Schedule – this will be added to the Partnership Agreement when completed and approved by the Integrated Care Partnership Board.

3. PRINCIPLES

Partnership Principles

3.1 The Parties acknowledge and confirm that this Partnership Agreement is not intended to create binding obligations compelling any Party to act otherwise than as such Party determines in its sole discretion.

3.2 Subject to Clause 3.1, the Parties agree to work together at all times in accordance with the Partnership Principles to collectively achieve the Integrated Care Partnership Outcomes.

3.3 The Parties acknowledge and confirm that:

3.3.1 each Party shall be solely responsible for delivering its obligations strictly in accordance with its own Commissioning Contracts;

3.3.2 each Party shall be responsible for delivering such obligations as are identified as being its responsibility in the Integrated Services Schedule (once confirmed by the Integrated Care Partnership Board); and

3.3.3 nothing in this Partnership Agreement shall be interpreted as an assumption by any Party of obligations or liabilities arising under the other Parties' Commissioning Contracts, the Integrated Services Schedule or otherwise (unless expressly agreed to the contrary in writing).

3.4 The Parties also recognise that engagement and consultation duties, relating to any changes in clinical services, rest largely with the commissioners who will lead on such changes.

Commissioning Principles

3.5 Whilst acknowledging (i) the sovereign nature of each Party; (ii) the application of competition law (as relevant); and (iii) any applicable procurement obligations, the Parties consider that patient benefits and national policy stemming from the Five Year Forward View and the GP Forward View will be optimised by commissioning services from the Integrated Care Partnership where possible..

3.6 In due course (and forming part of the usual contracting round in the NHS), the Parties intend that the relevant CCGs will hold contracts with the Parties which will contain the Integrated Care Partnership Outcomes that are to be achieved collectively by the Parties.

3.7 The Parties will seek to agree that Commissioning Contracts relevant to Clause 3.6 above:

3.7.1 are agreed in a manner consistent with this Partnership Agreement; and

3.7.2 recognise the collective interdependencies with respect to the performance or non-performance of the Integrated Care Partnership Outcomes.

3.8 The Parties acknowledge that each Commissioning Contract details the payments due directly from any CCG to the Parties individually.

3.9 In order to discharge its payment obligations under each of the Commissioning Contracts, the relevant CCG shall be responsible for making payments to each of the Parties in accordance with the relevant Commissioning Contract.

4. INTEGRATED CARE PARTNERSHIP GOVERNANCE

Integrated Care Partnership Board

4.1 The Parties have established the Integrated Care Partnership Board, which acts as a committee in common of the Parties. The common governance arrangements for the committee in common are outlined in Schedule 6. Where any decision is outwith the delegated authority of the Integrated Care Partnership Board, each of the Party's board or governing body (as applicable) will be required to approve such decision, and report this to the Integrated Care Partnership Board prior to implementation. For the avoidance of doubt, nothing in this Partnership Agreement shall create a joint committee of the Parties.

4.2 The Parties have each agreed that the Integrated Care Partnership Board TORs shall apply in respect of the Integrated Care Partnership Board.

Integrated Care Partnership Management Group

4.3 The Parties have established the Integrated Care Partnership Management Group.

4.4 The Integrated Care Partnership Management Group TORs shall apply in respect of the Integrated Care Partnership Management Group although each Party acknowledges and confirms that such Integrated Care Partnership Management Group TORs are not intended to be contractually enforceable between the Parties but rather to indicate intended behaviours and processes of the Parties.

Admitting new members to the Integrated Care Partnership

4.5 Where a Party or Parties wish to admit a new member to be a provider under this Partnership Agreement, such a proposal shall be considered at the next Integrated Care Partnership Board meeting.

4.6 The relevant Party or Parties that wish to admit a new member shall serve a written notice on the Integrated Care Partnership Board setting out the details of:

4.6.1 the proposed new member (where known);

4.6.2 reasons and rationale for the proposed admission of a new member; and

4.6.3 the likely impact on the Integrated Care Partnership.

4.7 Following receipt of the notice referred to in Clause 4.6, the Integrated Care Partnership Board shall then consider the proposal and decide what actions (if any) need to be taken, in terms of varying this Partnership Agreement, for example.

5. INTEGRATED PROVISION OF THE SERVICES

5.1 All Parties intend for the services which fall within the remit of the Integrated Care Partnership to be provided in an integrated and patient-centred way by the Parties.

5.2 Subject to the provisions of each relevant Commissioning Contract, the Parties shall determine between themselves how they shall collaborate to achieve the Integrated Care Partnership Outcomes, and shall record the manner of their collaboration in the Integrated Services Schedule (once approved).

5.3 In accordance with Clause 11, the Integrated Services Schedule (once approved) may be varied by signed written agreement of the Parties and the Parties agree to work on the basis that the latest agreed Integrated Services Schedule (once approved) indicates how the Parties intend to work collectively.

6. GOVERNANCE

6.1 The Parties are individual organisations and each has their own individual corporate and clinical governance arrangements. The Parties shall comply with their own policies and procedures in the provision of the Integrated Care Partnership Services.

6.2 Nothing in this Partnership Agreement shall absolve any of the Parties from their obligations under each Commissioning Contract.

6.3 Without prejudice to the generality of Clause 6.2, where there are any Patient Safety Incidents or Information Governance Breaches relating to the Integrated Care Partnership Services, the Parties shall ensure that they each comply with their Commissioning Contract(s) and work collectively and share all relevant information to that Patient Safety Incident or Information Governance Breach (or other similar issue) for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

7. TRANSPARENCY AND INFORMATION SHARING

Transparency

7.1 The Parties shall seek to operate in an open and transparent manner with each other for the purposes of this Partnership Agreement, save for ensuring compliance with competition law requirements.

7.2 The Parties will provide to each other all information that is reasonably required in order to achieve the Integrated Care Partnership Outcomes and to design and implement changes to the ways in which the Integrated Care Partnership Services are delivered (and from where the Integrated Care Partnership Services are delivered).

7.3 The Parties have obligations to comply with competition laws and each acknowledges that it will comply with those obligations. The Parties will therefore ensure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law.

7.4 The Parties shall ensure that the Integrated Care Partnership Board establishes appropriate ethical walls between and within the Parties so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Parties who need to see it for the purposes of this Partnership Agreement and for no other purpose whatsoever.

Patient information sharing

7.5 The Parties acknowledge their respective obligations arising under the 1998 Act and under the common law duty of confidentiality and shall assist each other as necessary to enable each other to comply with these obligations.

7.6 Each Party shall procure that certain patient data for which it is Data Controller shall be made available to other Parties in accordance with the information sharing arrangements set out in Schedule 5 (Information Sharing Arrangements).

7.7 Each Party shall ensure that it does not share any patient identifiable data under this Partnership Agreement otherwise than in accordance with the arrangements set out in Schedule 5 (Information Sharing Arrangement).

7.8 Each Party agrees and understands that it retains responsibility for data for which it is Data Controller.

8. INTELLECTUAL PROPERTY RIGHTS

Pre-existing IPR

8.1 Nothing in this Partnership Agreement or any activity undertaken that is contemplated by this Partnership Agreement shall affect the ownership by any Party of any Intellectual Property Rights held immediately prior to this Partnership Agreement coming into effect ("**Pre–existing IPR**").

8.2 Each Party (the "**Granting Party**") shall grant to the other Party a revocable, royalty free, non-exclusive licence to use its Pre-Existing IPR for as long as the Granting Party remains a Party under this Partnership Agreement solely to the extent that this is necessary for the carrying out of the obligations in this Partnership Agreement and for the collective delivery of the Integrated Care Partnership Outcomes and the Integrated Care Partnership by the other Parties.

IPR created in the course of the integrated working

8.3 Subject to Clause 8.2, any Intellectual Property Rights created individually by a Party or jointly by more than one of the Parties in the course of the activities contemplated by this Partnership Agreement during the term of this Partnership Agreement ("**Shared Intellectual Property Rights**") shall be jointly owned by the Parties (as at the date of creation of the relevant Intellectual Property Rights) unless otherwise agreed by the Integrated Care Partnership Board.

8.4 The Parties shall:

8.4.1 subject to Clause 8.4.3, not enter into any licence or other contract exploiting or disposing of the Shared Intellectual Property Rights without the agreement of all of the Parties;

8.4.2 share any receipts produced by such exploitation with the Parties from time to time in the same proportions as may be agreed by the Parties; and

8.4.3 grant to each of the Parties at the time of creation of the relevant Shared Intellectual Property Rights a non-exclusive, perpetual, non-terminable, royalty free, licence to use the Shared Intellectual Property Rights for the purposes of providing NHS services.

9. CONFIDENTIALITY AND ANNOUNCEMENTS

Confidentiality

9.1 Each Party agrees:

9.1.1 to use a disclosing Party's Confidential Information only in connection with the receiving Party's performance of this Partnership Agreement, particularly in relation to commercially sensitive information;

9.1.2 not to disclose a disclosing Party's Confidential Information to any third party or to use it to the detriment of the disclosing Party;

9.1.3 to maintain the confidentiality of a disclosing Party's Confidential Information; and

9.1.4 to return it immediately on receipt of written demand from the disclosing Party.

9.2 The obligations in Clause 9.1 will not apply to any Confidential Information which:

9.2.1 the receiving Party is required to disclose to comply with law, or is required to disclose by any court or other authority of competent jurisdiction or any governmental or other regulatory authority;

9.2.2 is in or comes into the public domain other than by breach of this Partnership Agreement;

9.2.3 the receiving Party can show by its records was in its possession before it received it from the disclosing Party; or

9.2.4 the receiving Party can prove it obtained or was able to obtain from a source other than the disclosing Party without breaching any obligation of confidence.

9.3 The Parties acknowledge that the some of the Parties are subject to the provisions of the Freedom of Information Act 2000 ("**FOIA**") and will facilitate such Parties' compliance with their information disclosure requirements and FOIA in connection with this Partnership Agreement.

Announcements

9.4 No Party shall make any public announcement about the matters set out in this Partnership Agreement without the written agreement (which will be accepted by email correspondence) of all of the Parties.

Branding

9.5 As soon as reasonably practicable after the date of this Partnership Agreement, the Parties shall agree on the branding to be used by the Integrated Care Partnership, as set out in Schedule 4.

Indemnity Arrangements

9.6 Each Party agrees to ensure that it shall, at all times, have in place adequate Indemnity Arrangements (as defined in the NHS England standard contract General Conditions) for the purposes of its own service delivery that it is providing at any relevant time, and shall provide details of the same to the other Parties upon reasonable written request.

10. EXIT PLAN

10.1 The Parties shall produce and maintain an exit plan ("**Exit Plan**") setting out:

10.1.1 the likely impact on the Integrated Care Partnership should a Party's involvement in this Partnership Agreement be terminated;

10.1.2 the steps that the remaining Parties shall take in respect of any equipment, IT systems or premises that has been jointly used by the Parties for the purposes of providing the Integrated Care Partnership;

10.1.3 the steps that the remaining Parties must take to mitigate any detrimental impact upon patients receiving the Integrated Care Partnership Services

should a Party's involvement in this Partnership Agreement be terminated, including transitional governance arrangements; and

10.1.4 the steps that the Parties must take in relation to the following matters:

(a) any third party contracts entered into by the Parties specifically in connection with the Integrated Care Partnership; and

(b) staff employed or engaged by the Parties strictly in connection with the Integrated Care Partnership.

10.2 The Exit Plan shall be reviewed periodically by the Integrated Care Partnership Board and any changes must be agreed by the Parties.

10.3 Upon the termination of a Party's involvement in this Partnership Agreement, such Party and each remaining Party shall comply with their respective obligations under the Exit Plan.

11. VARIATION

11.1 A variation to this Partnership Agreement shall only be effective if it is in writing and signed by all of the Parties.

SCHEDULE 1 - Definitions and Interpretation

1.1 In this Partnership Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

1998 Act	means the Data Protection Act 1998;
Integrated Care Partnership	means the collective of the Parties;
Integrated Care Partnership Board	the Hammersmith and Fulham Health and Care Partnership (HFHCP) Integrated Care Partnership Board established in accordance with the provisions of Clause xx (Integrated Care Partnership Governance) and subject to the Integrated Care Partnership Board TORs;
Integrated Care Partnership Board TORs	has the meaning set out in Clause 2.2.1;
Integrated Care Partnership Management Group	means the Integrated Care Partnership Management Group established in accordance with the provisions of Schedule 7 (Integrated Care Partnership Governance) and subject to the Integrated Care Partnership Management Group TORs;
Integrated Care Partnership Outcomes	the outcomes specified in each of the specifications of the contracts;
Integrated Care Partnership Services	the services described in the Commissioning Contracts and referenced as the Integrated Care Partnership services as well as the services detailed in the Integrated Services Schedule (once agreed) as amended from time to time;
Commissioning Contract	means a contract for the provision of services entered into by a Party with a NHS Clinical Commissioning Group Party;
Competition Sensitive Information	means such information (not being in the public domain, generic or sufficiently aggregated) that, if shared between some or all of the Parties might constitute a breach of an of the Parties' competition law obligations;
Confidential Information	means all information which is confidential or otherwise not publically available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Partnership Agreement;
Data Controller	has the meaning set out in the 1998 Act;
Exit Plan	has the meaning set out in Clause 10;
Integrated Services Schedule	a schedule developed by the Parties setting out the specific arrangements between them as to which Party provides which aspect of the Integrated Care Partnership Services which is incorporated, as amended from time to time, into this Partnership Agreement once agreed.

Intellectual Property Rights	inventions, copyright, patents, database right, trademarks, designs and confidential know-how and any similar rights anywhere in the world whether registered or not, including applications and the right to apply for any such rights;
Month	means a calendar month and "Monthly" shall be interpreted accordingly;
Party	has the meaning set out in Schedule 2 (Parties);
Patient Safety Incident	has the meaning set out in the NHS Standard Contract as amended from time to time;
Partnership Agreement	means this agreement including its Schedules;
Partnership Principles	means the principles set out in Schedule 4 (Partnership Principles);
Party and **Parties**	has the meaning set out in Schedule 2 (Parties);

1.2 A reference to any Party shall include that Party's successors and permitted assigns.

1.3 A reference to a statute or statutory provision is a reference to it as amended, extended or re-enacted from time to time.

1.4 A reference to a statute or statutory provision shall include all subordinate legislation made from time to time under that statute or statutory provision.

1.5 References to Clauses and Schedules are to the Clauses and Schedules of this Partnership Agreement.

1.6 Any words following the terms **including**, **include**, **in particular**, **for example** or any similar expression shall be construed as illustrative and shall not limit the sense of the words, description, definition, phrase or term preceding those terms.

SCHEDULE 2 - Parties

#	Party	Signed for and on behalf of the Party
1	**Chelsea and Westminster Hospital NHS Foundation Trust**	
2	**Central London Community Healthcare NHS Trust**	
3	**H&F GP Federation**	
4	**Imperial College Healthcare NHS Trust**	
5	**West London Mental Health NHS Trust**	

Parties 1 to 5 are collectively "**the Parties**".

SCHEDULE 3 (1) – Integrated Care Partnership Board Terms of Reference

HAMMERSMITH & FULHAM HEALTH & CARE PARTNERS

Integrated Care Partnership BOARD

TERMS OF REFERENCE

Role

The role of the Integrated Care Partnership Board is to ensure the engagement, alignment and shared decision making of all participant organisations in the Integrated Care Partnership and to oversee the programme of work to deliver the Integrated Care Partnership, as set out in the Memorandum of Understanding ("**MOU**") in place between Imperial College Healthcare NHS Trust ("**ICHT**"), Chelsea & Westminster Hospitals NHS Foundation Trust ("**C&W**"),the Hammersmith & Fulham GP Federation ("**HFGPFED**") and West London Mental Health NHS Trust ("**WLMHT**") signed on 28 June 2016 and which Central London Community Healthcare NHS Trust did not sign at the time but which it wishes to implement in accordance with the terms of this Partnership Agreement.

1. Membership

1.1. The Integrated Care Partnership Board will be made up of sovereign board committees or executives delegated from each Party - membership of which is to consist of Chief Executive, one senior clinical lead and one Programme Director:

1.2. The Integrated Care Partnership Board may request attendance of other officers from partner organisations and/or other individuals to attend all or any part of its meetings as the agenda requires.

1.3. Two lay members will be standing attendees of the Integrated Care Partnership Board to ensure a patient-centric approach is adopted by the Integrated Care Partnership and to hold providers to account for their commitment to co-design but shall have no voting rights.

1.4. The Clinical Chair of the HFGPFED will act as chair for administrative and meeting management purposes at Board meetings and shall nominate a Chief Executive colleague of one of the Parties to deputise in his absence.

2. Secretary

2.1. ICHT's Integrated Care Programme Director will coordinate the overall common administrative arrangement for the Integrated Care Partnership Board. Member organisations will rotate administration and minuting of the meetings.

3. Quorum

3.1. Given the Integrated Care Partnership Board's status as a committee in common, no formal quorum is necessary for the transaction of business. However, to ensure appropriate engagement and validity of decision making each member organisation is intended to be represented. The quorum of each member's individual committee will be decided by that organisation.

4. Frequency of meetings and attendance requirements

4.1. The Integrated Care Partnership Board will meet monthly;

4.2. Members should aim to attend all scheduled meetings.

5. Duties

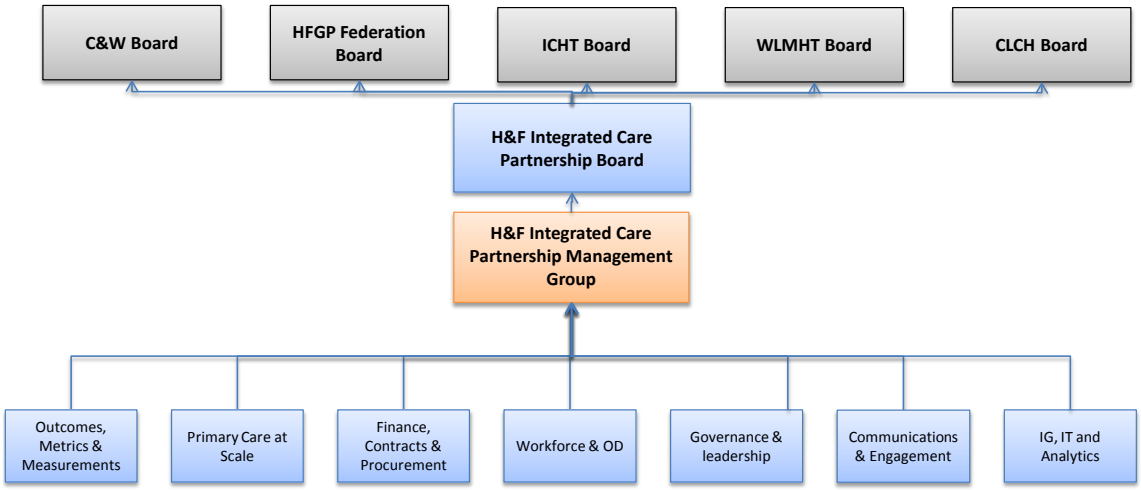
Whilst fully acknowledging (i) the committee in common structure, (ii) that the Integrated Care Partnership Board is not a joint contractual decision making forum; (iii) the sovereignty and ultimate accountability of each Party; and (iv) each Party's obligations in relation to competition and procurement law, the Integrated Care Partnership Board is intended to carry out the following duties for the Parties:

5.1. obtain assurance that high quality care is being delivered across Integrated Care Partnership Services;
5.2. scrutinise and approve proposals from the Management Group (described in the governance structure below) for wider dissemination and/or cascading through member organisations;
5.3. make decisions about joint investments;
5.4. obtain assurance that robust governance structures, systems and processes (including those for clinical risk management and service user safety) are in place across all member organisations;
5.5. agree key messages to be communicated to shared stakeholders e.g. commissioners, other providers, staff, the public, local politicians;
5.6. consider how the Integrated Care Partnership responds to any relevant tender processes for service in Hammersmith and Fulham, and beyond;
5.7. share member organisations' key strategic intentions that may impact on Integrated Care Partnership development or delivery of other initiatives relating to the Whole Systems/Integrated Care agenda;
5.8. facilitate appropriate sharing of data between member organisations;
5.9. provide a forum for broader strategic discussion; and
5.10. enable onward referral of appropriate issues to partner organisations' relevant committees (including the operational and management committees) for further review or action.

6. Reporting responsibilities

6.1. The Integrated Care Partnership Board will report into the Board of each of the partner organisations, and provide reports to relevant executive committees as appropriate.
6.2. It will receive reports from the Management Group, focusing on technical and enabling aspects and co-design of care pathways.

Proposed Programme Governance Structure



Key deliverables:
- Financial analysis tool and indicative scenario based risks & opportunities
- Draft Partnership Agreement
- A detailed work plan for progressing the ACP against all areas of competency framework

Resource:
- **Key support:** Programme Manager
- **Specialist knowledge:** BAU within corporate directorates
- **Identified resource gap:** Support for financial work stream

Key deliverables:
- Key opportunities for quality and efficiency improvement identified
- Work plan for integrated pathway development

Resource:
- **Key support:** Programme Manager
- **Specialist knowledge:** Clinical & operational leads
- **Identified resource gap:** Flexible back-fill resource for clinical input

7. Monitoring and Review:

7.1. Terms of reference approved October 2016

7.2. Reviewed and amended September 2017

SCHEDULE 3 (2) – Integrated Care Partnership Management Group Terms of Reference

HAMMERSMITH AND FULHAM HEALTH & CARE PARTNERSHIP

Integrated Care Partnership MANAGEMENT GROUP

TERMS OF REFERENCE

Role

The role of the Integrated Care Partnership Management Group is to oversee the development of technical capabilities within the Integrated Care Partnership that will enable the delivery of the new care models designed within the new care model steering groups. This will require working in a matrix structure working with the clinical model driving the operating model. This will include capabilities in:

- Governance (both clinical and corporate)
- Technology and information governance
- People and culture
- Finance & contracts
- Outcomes and metrics
- Communications and engagement

1. Membership

1.1. The Integrated Care Partnership Management Group will be made up of Directors or Deputies from each Party with expertise in technical work areas stated above and also a citizen representative.

1.2. The Integrated Care Partnership Management Group may request other officers from local provider organisations and/or other individuals to attend all or any part of its meetings as the agenda requires.

1.3. The Chief Executive from the Hammersmith & Fulham GP Federation ("**HFGPFED**") will chair Integrated Care Partnership Management Group meetings and the agenda will be set by programme leads across the partnership.

2. Secretary

2.1. The jointly appointed Integrated Care Partnership Programme Manager will act as the secretary to the Integrated Care Partnership Management Group.

3. Quorum

3.1. The quorum necessary for the transaction of business shall be one Director level member from each Party.

4. Frequency of meetings and attendance requirements

4.1. The Integrated Care Partnership Management Group will meet every month.

4.2. Members should aim to attend all scheduled meetings but where this is not possible are asked to nominate an appropriate deputy.

5. Objectives

5.1. The Integrated Care Partnership Management Group will adopt the principles of co-design laid out in the MOU between Imperial College Healthcare NHS Trust ("**ICHT**"), Chelsea & Westminster Hospitals NHS Foundation Trust ("**C&W**"), West London Mental Health NHS Trust ("**WLMHT**"), and HFGPFED. Objectives will be reviewed in real time as commissioning intentions are communicated to providers. Current objectives of the Integrated Care Partnership Management Group are to:

5.1.1. Ensure commitment to working together for the improvement of health and wellbeing for the population of Hammersmith and Fulham, including embedded engagement with service users and the voluntary sector, and to extracting maximum value from public spend on health;

5.1.2. Drive cultural change towards the management of population health and wellbeing;

5.1.3. Ensure open and regular communication, early raising of risks and issues and a shared commitment to their resolution wherever possible;

5.1.4. Ensure transparent sharing of data, where this does not represent a commercial conflict.

5.2. The Integrated Care Partnership Management Group has been delegated the following objectives from the Integrated Care Partnership Board:

5.2.1. To direct and oversee the work of the care model project groups and technical enabler working groups to ensure joined up matrix working;

5.2.2. To provide advice to the Integrated Care Partnership Board as requested, for example in terms of options appraisals to support their decision making;

5.2.3. To ensure that processes put in place enable the partnership to operate effectively;

5.2.4. To ensure organisational readiness for the transition to accountable care in North West London, which could include use of capitated budgets, alliance or joint venture arrangements and outcomes based contracting;

5.2.5. To undertake analysis and identify opportunities to realise benefits from partnership working;

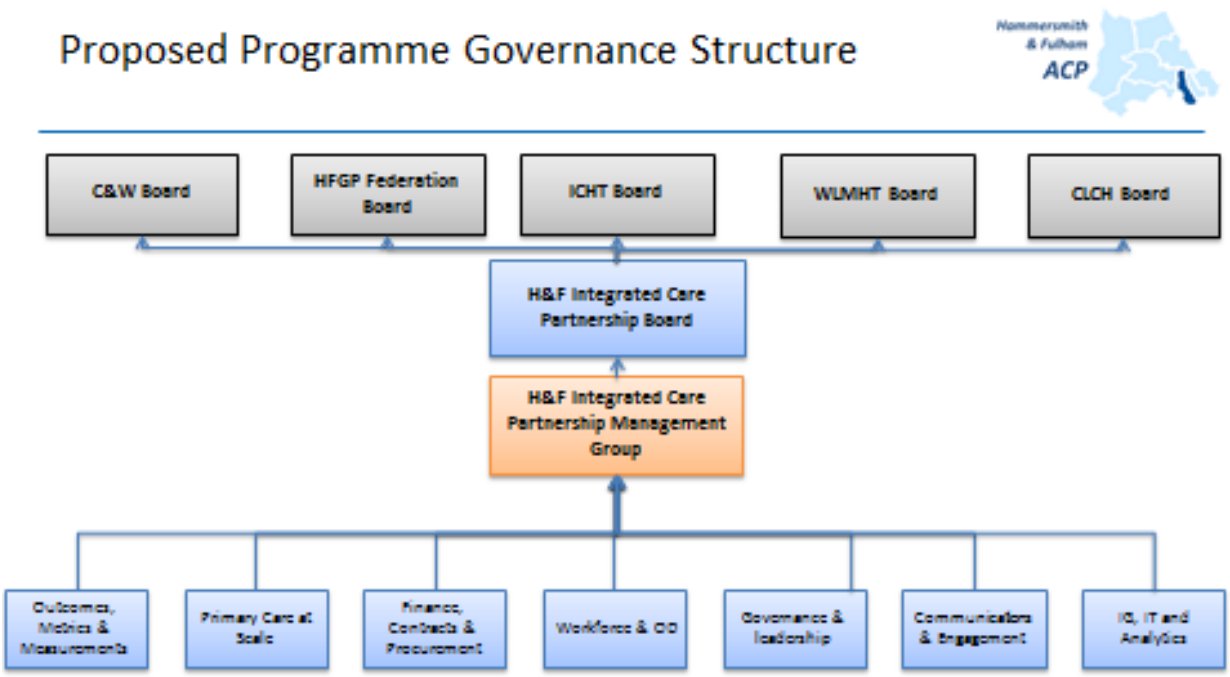
5.2.6. To ensure that appropriate financial and risk management controls are in place to manage services under the remit of the partnership and to manage project work within the partnership;

5.2.7. To support compilation and assess business cases for the partnership, reporting into the Integrated Care Partnership Board for a final decision; and

5.2.8. To protect the duty of confidentiality and commercial sensitivity for sovereign bodies & patients.

6. Reporting responsibilities

6.1. The Integrated Care Partnership Management Group will report into the Integrated Care Partnership Board. It will receive reports from task and finish groups which it will use to deliver specific piece of work as required to meet the objectives of the group.



7 Monitoring and Review:

7.1 Terms of reference – initial approval: March 2017

7.2 Reviewed, and amended: July 2017

SCHEDULE 4 - Partnership Principles

[The Partners agree to adopt the following principles (the "**Partnership Principles**"):

A core group of health and care organisations working in Hammersmith and Fulham have come together to work in partnership with local patients and residents to develop a radically better way of providing care.

There is a growing consensus that we need to change from being reactive and crisis-driven to being proactive, health and well-being focused. Patients need to feel that their care is joined-up, consistent and high quality, regardless of the provider.

- Our care will be integrated and seamless with the whole of health and care system **working as one partnership organisation** across a population
- Savings will be **reinvested** in services where they are most needed
- Focus on **preventing a more serious intervention later and hospital admission**
- **Pooled budgets** and **shared benefits/risks** is a fundamental change and ensures everyone is working together
- **The partnership is driven by the needs of patients and local people** – not commissioners or providers
- **We will make care simpler**

To be practical and flexible, **we want to start small** (43,000 population across three merged GP practices) and open up to whole borough, and potentially beyond

Branding

Until such a time that a definitive name and logo has been approved, the Integrated Care Partnership will use the NHS logo followed by a list of all partners.

SCHEDULE 5 - Information Sharing Arrangements

All Parties are signed up to the NWL Information Sharing Protocol (see Appendix 1 to this Schedule). For the initial Integrated Care Partnership Services, each Party will use its own systems for reporting operational activity. Initially, staff requiring access to these systems will have contracts with the respective Parties. The GP Federation does not have access to patient identifiable information.

The NWL Care Information Exchange (CIE) pilot will confirm the information sharing requirements for the strategic solution and it is envisaged that the GP Federation (EMIS Web) ISA will form the basis for this development.

Parties have SIRO and Caldicott Guardians and the Parties will address incidents together, but carry their own risks. Each Party will be responsible for reporting incidents, as appropriate, through the IG Toolkit incident reporting tool and will keep other Parties informed of on-going investigations and outcomes.

The Partner Organisations recognise that where Personal Confidential Data is shared because it is necessary for Direct Care, the patient's consent may usually be implied, providing a legal basis for such sharing as set out in the North West London Information Sharing Protocol.

Appendix 1 to Schedule 5

NWL Information Sharing Protocol

NORTH WEST LONDON

INFORMATION SHARING PROTOCOL

(F) **The purpose of this Protocol is to facilitate the secure sharing of information amongst key public sector, private and voluntary organisations in North West London Clinical Commissioning Groups to support the provision of effective and efficient health and social care services to the populations of the local area.**

(G) **This Protocol sets out general principles, standards and governance agreed between the identified Partner Organisations to provide a secure framework for the sharing of information between the Partner Organisations within which they can all operate.**

(H) **By signing this document, each Partner Organisation undertakes to implement and adhere to the principles, standards and governance set out in this Protocol, reassuring the other Partner Organisations that patient information will be used and managed only in agreed and appropriate ways.**

(I) **This Protocol will be underpinned by service specific Information Sharing Agreements between the Partner Organisations that are designed to meet the specific requirements for the sharing of specific information for specific purposes using specific systems.**

(J) **This Protocol will be extended to include other organisations working in partnership to deliver services in North West London. Organisations that enter an approved specific Information Sharing Agreement will automatically become a Partner Organisation and a signatory to this Protocol.**

12. PARTIES TO THIS PROTOCOL

We the undersigned agree that each organisation that we represent will adopt and adhere to the principles, standards and governance set out in this Protocol, and are prepared to sign Information Sharing Agreements for the sharing of specific information for specific purposes, using specific systems:

(Please see next page and the list of Partner Organisations in Appendix 2)

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Responsible Manager	

Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	

Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

Agency Name	
Address	
Contact Details	
Authorised Signatory-	

This page must be completed by the Caldicott Guardian:

Organisation Name	
Address	
Contact Details	

Organisation Name	
Address	
Contact Details	
Authorised Signatory- Caldicott Guardian for	

Each of the above listed organisations shall be a **Partner** and together they shall be the **Partner Organisations**.

13. OVERARCHING PRINCIPLES

13.1 The Partner Organisations recognise that many services cannot be effectively delivered without the exchange of Personal Confidential Data across key public sector, private and voluntary organisations. This Protocol sets out the principles by which the Partner Organisations agree to exchange information, in a manner which is compliant with their legal responsibilities. The Partner Organisations will ensure the accurate, timely, secure and confidential sharing of information where such information sharing is essential for the provision of health and social care to the local population in North West London.

13.2 Each Partner Organisation is responsible for ensuring that robust technical and organisational measures and information governance arrangements are in place to protect the security and integrity of information to ensure a trusted sharing environment.

13.3 Information shared pursuant to this Protocol may not be shared with any other organisation not a signatory to this Protocol without the prior consent of the relevant Partner Organisation and/or patient/client.

13.4 The Partner Organisations recognise that there must be a legal basis for any sharing of Personal Confidential Data.

13.5 The Partner Organisations recognise that where Personal Confidential Data is shared because it is necessary for Direct Care, the patient's consent may usually be implied, providing a legal basis for such sharing.

13.6 The specific purpose for use and sharing information will be defined in the Information Sharing Agreements, however the following principles should form the basis of such Information Sharing Agreements relevant to its type:

13.6.1 Provided any disclosure is in accordance with this Protocol, Partner Organisations should share Personal Confidential Data when it is needed for the safe and effective care of an individual.

13.6.2 Where Personal Confidential Data is shared for Indirect Care, consent may not be implied. The Partner Organisations agree to anonymise such data before sharing where possible. Any Personal Confidential Data should only be shared for Indirect Care if:

(a) the Data Subject has given consent;

(b) the data sharing is required by law;

(c) the recipient has approval to receive it under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 (otherwise known as Section 251 support).

13.7 The Partner Organisations agree to respect an individual's right to object to the sharing of Personal Confidential Data about them.

14. KEY LEGISLATION AND GUIDANCE

14.1 The Partner Organisations are subject to a variety of legal obligations, and statutory and other guidance in relation to the sharing and disclosure of information, including (without limitation):

14.1.1 Data Protection Act 1998

14.1.2 Human Rights Act 1998

14.1.3 Common Law Duty of Confidence

14.1.4 Caldicott Principles

14.1.5 ICO Data Sharing Code of Practice

14.1.6 Confidentiality: NHS Code of Practice

14.1.7 HSCIC: A guide to confidentiality in health and social care

14.1.8 NHS England Information Governance and Risk Stratification: Advice and Options for CCGs and GPs

14.1.9 Department of Health: Information Security: NHS Code of Practice

This is not an exhaustive list and other legislation applies in specific circumstances.

14.2 Each Partner Organisation must have documented policies and procedures to ensure compliance with the national requirements for data protection, information security and confidentiality and committed to ensuring that any information is shared in accordance with its legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

As part of each Information Sharing Agreement each Partner Organisation shall specify how it meets its legal obligations and the legal basis under which information can be shared.

15. INFORMATION GOVERNANCE REQUIREMENTS

15.1 Subject to clause 4.3, each Partner Organisation is required to comply with the then current NHS Information Governance Toolkit as appropriate to its organisation type and adhere to robust information governance management and accountability arrangements, including effective security event reporting and management.

15.2 Subject to clause 4.3, each Partner Organisation must comply with the IGT assessment, reporting and audit requirements relevant to its organisation type. Each Partner Organisation will provide evidence of compliance to the Governing Group or the other Partner Organisations on written request.

15.3 Any Partner Organisation which is a non-NHS organisation and unable to comply with the IGT must obtain prior written approval from the Governing Group to adopt an alternative, but equivalent standard to the IGT for NHS organisations. For the avoidance of doubt, the Governing Group reserves the right to reject/amend any proposed standard at its sole discretion.

15.4 Each Partner Organisation must ensure and maintain its registration with the Information Commissioner under the Data Protection Act 1998.

15.5 In the event of a Security Incident, the responsible Partner Organisation should immediately inform the Governing Group and all other affected Partner Organisations (usually the disclosing Partner Organisation(s)) with as many details as known at that time and regularly update the relevant Partner Organisations and Governing Group thereafter, including any subsequent investigation report or remedial actions. Any affected Partner Organisation will then pass on the information in accordance with incident reporting procedures within their own organisation if appropriate.

15.6 If any Partner Organisation cannot or may not be able to comply with the requirements in this Clause, the partner should inform the Governing Group

immediately. The Governing Group will undertake an urgent review and has the discretion to authorise derogation from or amendment to the requirements of this clause, on such terms as the Governing Group considers to be appropriate, as long as the derogation or amendment is lawful.

16. PERSONAL CONFIDENTIAL DATA: COMMUNICATION AND CONSENT

Communication

16.1 Each Partner Organisation must:

16.1.1 Effectively inform patients about the ways the information they have provided may be used, who it may be shared with, what will be shared and for what purpose;

16.1.2 effectively inform patients that they have the right to opt out of sharing their information or select/restrict which elements of their information may or may not be shared and that any consent can be changed in the future;

16.1.3 effectively inform patients of the implications for the provision of care or treatment, such as the potential risks involved if their full record is not made available to health professionals involved in their Direct Care; and

16.1.4 ensure fair processing notices are always in place.

16.2 Any Partner Organisation which does not have the ability to mark part of a record as private, must notify the Governing Group and inform the patient that they must decide whether all or none of their record should be shared.

16.3 Each Partner Organisation must ensure that technical and organisational measures are in place to obtain and record consent from patients and allow patients to select which elements of their information may not be shared. These measures must also allow for the patient to withdraw consent and include a process for ceasing processing of such information immediately and give notice to affected Partner Organisations.

16.4 Each Partner Organisation should employ a variety of channels to communicate with its patients regarding information sharing, such as information leaflets, posters, at the point of care, during the patient registration process or when referring into other services.

Consent

16.5 Patient consent must be obtained in line with NHS guidance then in force. Consent can be Explicit Consent or Implied Consent. Each Partner Organisation recognises that different consent arrangements are needed in respect of sharing information for Direct Care and Indirect Care purposes.

16.6 Obtaining Explicit Consent for information sharing is best practice and ideally should be obtained when the patient first accesses the service.

16.7 Partner Organisations must make arrangements for the systematic obtaining of consent.

16.8 Consent must be informed. Each Partner Organisation must ensure that the patient has the capacity to give consent and if not, follow the relevant guidance to obtain the appropriate consent.

16.9 Each Partner Organisation must ensure that technical and organisational measures are in place to obtain and record consent from patients and allow patients to select which elements of their information may not be shared. These measures must also

allow for the patient to withdraw consent and include a process for ceasing processing of such information immediately and give notice to affected Partner Organisations.

16.10 Each Partner Organisation will, as a matter of good practice, seek fresh consent if there are significant changes in the circumstances of the individual or the work being undertaken with them.

16.11 Each Partner Organisation must ensure that where required, consent is recorded and a full audit trail retained of who obtained consent.

16.12 Partner Organisations have authority to seek consent only on behalf of their own organisation.

17. DECIDING WHETHER TO SHARE PERSONAL CONFIDENTIAL DATA

17.1 Partner Organisations will follow the decision tree at Appendix 4, adapted from the guidance given by the HSCIC in its *Guide to confidentiality in health and social care*.

17.2 Information relating to a deceased person is not subject to the Data Protection Act 1998, however careful consideration should be given and further advice sought before any such information is released. Duties of confidence still apply.

17.3 If a Partner Organisation decides not to disclose some or all of the Personal Confidential Data, the requesting Partner Organisation must be informed why in so far is as permitted by law. For example, if the Partner Organisation is relying on an exemption or on the inability to obtain consent from the patient.

18. SYSTEM SUPPLIER STANDARDS

18.1 Each system operated by any Partner Organisation for sharing clinical information should have NHS Interoperability Toolkit accreditation, thus assuring its system specifications and standards meet the agreed interoperability standards for the NHS. Partner Organisations that operate such systems will provide evidence of compliance to the Governing Group or other Partner Organisations on written request.

18.2 Any proposed non-compliance must be explained, documented and agreed in advance by the Governing Group.

18.3 If any Partner Organisation cannot or may not be able to comply with the requirements in this Clause, the partner should inform the Governing Group immediately. The Governing Group will undertake a review and may in its discretion authorise derogation from the above requirements subject to such conditions as it deems appropriate.

18.4 All partner organisations' systems under this Protocol must have user authentication mechanisms to ensure that all instances of access are auditable against an individual, including the following information:

18.4.1 Job role and name of staff member accessing the system;

18.4.2 Organisation name;

18.4.3 What actions were performed; and

18.4.4 The date and time the information was viewed.

18.5 The systems and technical measures used by each Partner Organisation for the sharing of Direct Care and Indirect Care must be specified in any Information Sharing Agreement.

19. KEY CONTACTS

19.1 Each Partner Organisation will nominate a person as a key contact to deal with queries and requests for information under this Protocol. This person shall also represent the Partner Organisation in the Governing Group. It is advisable that such appointed contact shall usually be the Partner's Caldicott Guardian or data protection officer or equivalent.

19.2 A Partner Organisation may change its appointed contact at any time on written notice to all Partner Organisations.

19.3 The key contact for each Partner Organisation will ensure dissemination of this Protocol in line with each Partner Organisation's internal arrangements for the distribution of policies, procedures and guidelines and monitor the implementation and compliance of this Protocol within their own Partner Organisation.

20. GOVERNING GROUP

20.1 The purpose of the Governing Group is to oversee, support and maintain the secure sharing of information under this Protocol.

20.2 Each Partner Organisation will have a representative on the Governing Group which in accordance with clause 8 will be each Partner Organisation's key contact under this Protocol.

20.3 Patient representation on the Governing Group will be nominated by Partner Organisations

20.4 The Governing Group will meet at least annually.

20.5 The Governing Group shall have the following powers and responsibilities:

20.5.1 to approve ISAs and additional Partner Organisations to this agreement;

20.5.2 to administer membership of this Protocol

20.5.3 to determine whether a Partner Organisation should cease to be a party to this Protocol for a specific period of time or permanently for non-compliance;

20.5.4 to determine whether a Partner Organisation may derogate from or amend any requirement under this Protocol;

20.5.5 to maintain an information conduit between the Partner Organisations;

20.5.6 to maintain a channel of liaison with pan-London personal information sharing initiatives and relevant NHS and local authority national initiatives;

20.5.7 to investigate breaches of the Protocol and require Partner Organisations to take remedial actions;

20.5.8 to monitor each Partner Organisation's compliance with this Protocol or any ISA The Governing Group may request evidence of compliance with this Protocol on written request to any Partner Organisation;

20.5.9 to approve common patient communication materials; and

20.5.10 to develop, review and maintain the Protocol to ensure that it reflects any legal and statutory obligations and any other related best practice guidance in relation to information governance.

20.6 The Governance Group may regulate its own procedure subject to the provisions of this Information Sharing Protocol.

20.7 It is noted that there may be specific information sharing protocols already in place between some Partner Organisations, which must be taken into consideration.

20.8 In accordance with clause 8, any Partner Organisation wishing to amend the details of its representative must notify, in writing, the Governing Group, providing details of the newly appointed representative as soon as is practicably possible.

21. DATA RETENTION STANDARDS

21.1 Each Partner Organisation must have a written policy for the retention and disposal of information in accordance with NHS Best Practice guidance.

21.2 No Partner Organisation should retain information for longer than is necessary to achieve the objectives for which the information was obtained.

22. ASSURANCE

22.1 Each Partner Organisation must, so far as possible, ensure the accuracy of the information (correct, complete and up-to-date) which it is sharing under this Protocol and must have in place appropriate systems to update any information if subsequently discovered to be inaccurate.

22.2 If a Partner Organisation is aware of a material inaccuracy or omission in information that it shares under an Information Sharing Agreement, the Partner Organisation must inform the recipient of that inaccuracy or omission.

22.3 Where possible, the NHS number must be used as the unique patient identifier and systems used by the Partner Organisations should connect to the Connecting for Health Personal Demographic Service to ensure the NHS numbers are accurate and demographic data synchronised.

23. STAFF

23.1 Each Partner Organisation is responsible for ensuring that access to shared information is documented and restricted to those staff who have a legitimate and appropriately approved reason to access it and those staff who are properly trained to discharge any relevant obligations in accordance with this Protocol.

23.2 Each Partner Organisation shall provide staff with training on the principles and legal requirements for information sharing and the appropriate tools to enable them to comply with the obligations under this Protocol.

23.3 Each Partner Organisation shall ensure that shared information can only be accessed via username and password.

23.4 Each Partner Organisation shall make it a condition of employment that all employees, agents or contractors will abide by the rules and policies of that Partner Organisation in relation to information governance. This condition should be written into employment and other contracts and each Partner Organisation shall make staff aware that any failure to comply with the requirements outlined in this Protocol is likely to be subject to disciplinary action.

24. SUBJECT ACCESS AND COMPLAINTS

24.1 Each Partner Organisation is responsible for putting into place effective procedures to address complaints about data sharing and subject access requests relating directly

to this Protocol. Information about these procedures should be made available to patients.

24.2 Each Partner Organisation must have a designated Data Protection Officer or Information Governance Manager who is responsible for subject access requests and complaints.

24.3 Subject access requests from third parties for data available to organisations under this Protocol are to be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

24.4 Any complaints about data sharing relating directly to this Protocol should be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

25. FREEDOM OF INFORMATION

25.1 The Partner Organisations recognise that public bodies are subject to the requirements of the Freedom of Information Act 2000 ("**FOIA**") and the Environmental Information Regulations ("**EIR**"). Any such requests relating to information governed by this Protocol should be directed promptly to the Data Protection Officer or Information Governance Manager of the relevant Partner Organisation.

25.2 The Partner Organisations shall notify the Governing Group of any such request and assist and co-operate with the Governing Group to enable compliance with any obligations under the FOIA and the EIR.

26. AUDIT

26.1 Each Partner Organisation accepts responsibility for independently or jointly auditing its own compliance with this Protocol and any Information Sharing Agreements in which it is involved on a regular basis (at least annually).

26.2 Each Partner Organisation is required to keep and maintain records of all requests for information sharing received and track the flow of Personal Confidential Data.

26.3 This Protocol will be formally reviewed annually by the Governing Group, unless in the Governing Body's opinion new or revised legislation or national guidance necessitates an earlier review.

26.4 Following each review the Governing Group will confirm whether this Protocol remains fit for purpose, or whether to recommend amendments to the Partner Organisations.

APPENDIX 4 - GLOSSARY

In this Protocol unless the context otherwise requires the following words and expressions shall have the following meanings:

"Anonymised Data"	means data in a form where the identity of the individual cannot be recognised i.e. when: • Reference to any data item that could lead to an individual being identified has been removed; • The data cannot be combined with any data sources held by a Partner with access to it to produce personal identifiable data;
"Data Controller"	A company, organisation or person who decides what data is collected, the purposes for which it is used and how that data is handled;
"Direct Care"	means clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals (all activities that directly contribute to the diagnosis, care and treatment of an individual);
"Explicit Consent"	means articulated patient agreement which gives a clear and voluntary indication of preference or choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear, and in relation to data sharing, the consent covers the specific details of processing; the data to be processed; and the purpose for processing;
"Implied Consent"	means patient agreement that has been signalled by behaviour of an informed patient;
"Indirect Care"	means activities that contribute to the overall provision of services to a population as a whole or a group of patients with a particular condition, but which fall outside the scope of direct care. It covers health services management, preventative medicine, and medical research;
"Information Sharing Agreement(s)"	means the agreement to be entered into between Partner Organisations prior to sharing information that is designed to meet the specific requirements for the sharing of specific information for specific purposes using specific systems and based on the attached template in Appendix 3;
"NHS Information Governance Toolkit" "IGT"	means the set of information governance requirements produced by the Department of Health and now hosted by the Health and Social Care Information Centre. It is a tool with which health and social care organisations can assess their compliance with current legislation and national guidance;
"Partner" **"Partner Organisations"**	means the organisation(s) party to this Protocol, or automatically added as a signatory to this Protocol by way of entering an approved specific Information Sharing Agreement;
"Personal	means personal information about identified or identifiable

Confidential Data"	individuals, which should be kept private or secret. For the purposes of this Protocol 'personal' includes the definition of 'Personal Data', but it is adapted to include dead as well as living people. 'Confidential' includes both information 'given in confidence' and 'that which is owed a duty of confidence' and is adapted to include 'Sensitive Personal Data' as defined in this Protocol;
"Personal Data"	has the meaning given to it in the Data Protection Act 1998, namely: data which relate to a living individual who can be identified: (a) from those data; or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the Data Controller, and includes any expression of opinion about the individual and any indication of the intentions of the Data Controller or any other person in respect of the individual. Typical examples of this type of data could include a Name, Address, Full Postcode, Date-of-Birth, Email Address, and Telephone Number or a photograph or CCTV image. A unique number such as an employee number or NHS number could be considered as personal data if the organisation holds the identifying data relating to the unique identifier;
"Security Incident"	means an actual, suspected or threatened unauthorised exposure, access, disclosure, use, communication, deletion, revision, encryption, reproduction or transmission of any component of Personal Data and/or Sensitive Personal Data or unauthorised access or attempted access to any Personal Data and/or Sensitive Personal Data;
"Sensitive Personal Data"	means Personal Data consisting of information as to - (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or other beliefs of a similar nature, (d) whether he is a member of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings,

APPENDIX 5 - RESPONSIBILITIES OF PARTNER ORGANISATIONS

Partner Organisation	Responsibility
Federation of Brent, Harrow and Hillingdon CCGs	Governing Group (Informatics Sub-Committee)
NHS Brent Clinical Commissioning Group	Host of Protocol
NHS Harrow Clinical Commissioning Group	Host of Protocol
NHS Hillingdon Clinical Commissioning Group	Host of Protocol

The following pages set out the Partner Organisations for each borough.

Hillingdon Partner Organisations:

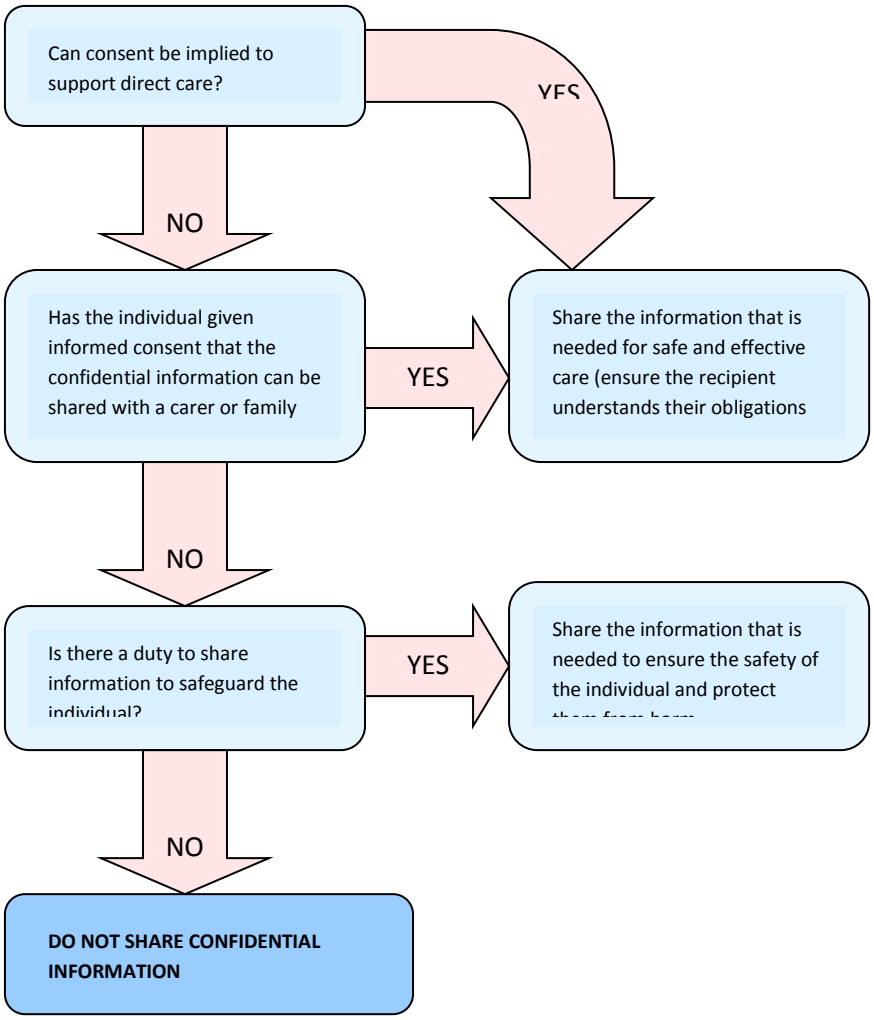
Partner Organisation	Responsibility
GP Practices within NHS Hillingdon CCG	Primary Healthcare provision – direct care
Hillingdon Hospitals NHS Foundation Trust	Secondary Healthcare provision – direct care
Central and North West London NHS Foundation Trust	Community and mental healthcare provision – direct care
London Borough of Hillingdon	Social Services – direct care Telecare services – direct care
Greenbrook Healthcare Ltd – Urgent Care Centre at Hillingdon Hospital	Urgent care services – direct care
Harmoni Ltd – Out of Hours and 111 services	OOH and 111 services – direct care
Imperial College Healthcare NHS Trust – including West London Breast Screening	Secondary Healthcare provision – direct care and screening services
North West London Hospitals NHS Trust (Northwick Park Hospital) – colorectal screening, cervical cytology screening	Secondary Healthcare provision – direct care and screening services
Ealing Hospital NHS Trust	Secondary Healthcare provision – direct care
Royal Brompton and Harefield NHS Foundation Trust (Harefield Hospital)	Secondary Healthcare provision – direct care
West Hertfordshire Hospitals NHS Trust (Watford General Hospital)	Secondary Healthcare provision – direct care
Heatherwood and Wexham Park Hospital NHS Foundation Trust	Secondary Healthcare provision – direct care
West Middlesex University Hospital NHS Trust	Secondary Healthcare provision – direct care
London Ambulance Service	Emergency care services – direct care
North West London Commissioning Support Unit	Clinical Quality and Patient Safety – clinical audit and/or investigation; recording, monitoring and analysing serious incidents; supporting the CCG in its statutory responsibilities for clinical quality and patient safety in all elements of the

	commissioning cycle
Age UK - Hillingdon	Support services as per agreed care pathways – direct care
Royal Marsden – Host of the Co-ordinate My Care (CMC) Programme	Host of shared electronic healthcare record created with patient consent
Healthcare Gateway Ltd - Medical Interoperability Gateway	Host of Information Technology solution that enables the sharing of electronic patient records

APPENDIX 3 - Information Sharing Agreement Template

[see separate document]

APPENDIX 4 - Deciding whether to share Patient Confidential Information



Appendix 2 to Schedule 5

GP Federation (EMIS Web) ISA

To be provided

SCHEDULE 6 - Governance Arrangements for Committees in Common

The Parties agree to establish an Integrated Care Partnership Board to implement the Integrated Care Partnership. The Integrated Care Partnership Board will not operate as a statutory committee or a committee with delegated decision making. The Integrated Care Partnership Board will be comprised of a committee of three representatives from each Party.

As at the date of entering into this Partnership Agreement, the Parties' representatives on the Integrated Care Partnership Board are as follows:

Chief Executive, one senior clinical lead and one Programme Director from each partner, as well as two lay members who will be standing attendees of the Integrated Care Partnership Board to ensure a patient-centric approach is adopted by the Integrated Care Partnership and to hold providers to account for their commitment to co-design but shall have no voting rights.

In addition, the Integrated Care Partnership Board may invite such persons as it thinks fit to attend the Integrated Care Partnership Board meetings from time to time.

The Integrated Care Partnership Board shall send monthly progress updates to the Parties.

The Integrated Care Partnership Board shall not have any authority to make binding decisions on behalf of the Parties.

H&F ACP Partnership Agreement

Trust Boards

September – October 2017

Who we are

The Hammersmith & Fulham Health and Care Partnership consists of:

- Hammersmith & Fulham GP Federation (all 29 GP practices in the borough)
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- West London Mental Health NHS Trust
- Central London Community Healthcare NHS Trust
- Lay representatives

Other strategic partners are:

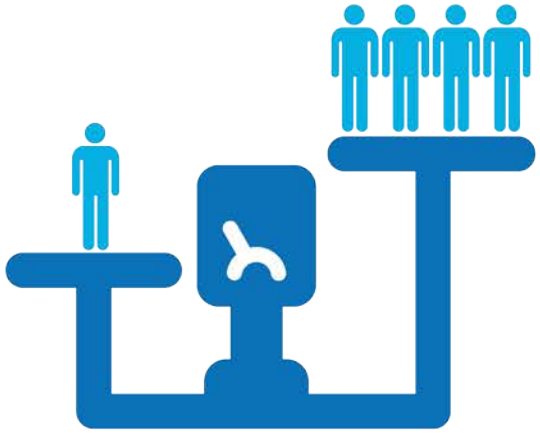
- London Borough Hammersmith & Fulham
- Hammersmith & Fulham CCG
- The Community and Voluntary Sector

Why we're doing it

Health and wellbeing

in people living with one or more **long term condition**

in people with **advanced dementia** or **Alzheimer's**



One in five children aged 4-5 are **overweight**

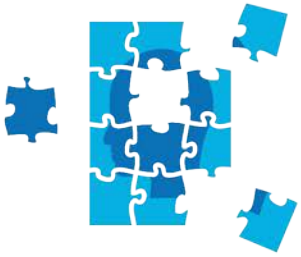
Why we're doing it

Care and quality

A third of patients in our acute hospitals could be better cared for in the community or at home

Four in five of us would **prefer to die at home** but only one in five are able to do so

Waiting times for many outpatient services and operations are **increasing**

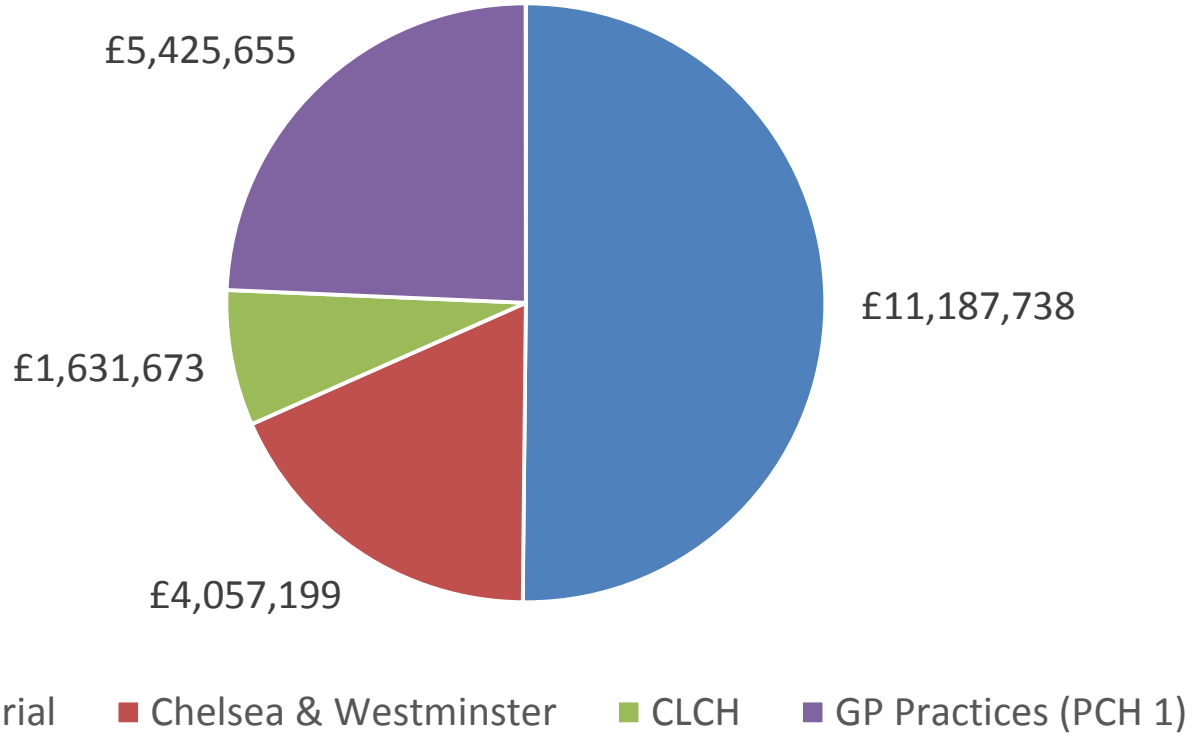


Care is often **fragmented**

ACP development plans

1. September - October 2017: sign Partnership Agreement as interim step in formalised corporate governance
2. October 2017-March 2018: co-produce a small number of integrated pathways + detailed implementation planning
3. March 2018: sign alliance contract for the first Primary Care Home, whose 43,000 patients account for approximately:
    - 400 A&E attendances per month
    - 2,500 outpatient appointments per month
    - 930 bed days per month
4. April 2018: go live with small scale ACP for 43,000 H&F residents from the first Primary Care Home to test scalable ACP operating model on a low risk scale
5. April 2019: go live with ACP across Hammersmith and Fulham

Income in first Primary Care Home for all partners

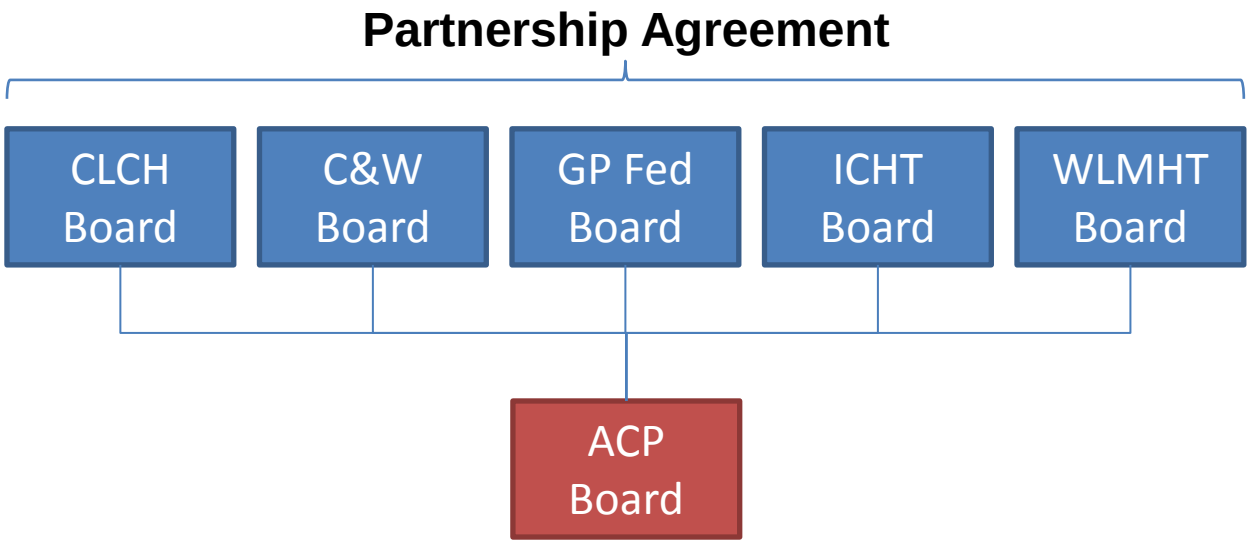


Caveats:

- Some patients opted out – data does not cover full registered list
- Data up to Month 11 for 2016/17
- Child data and cost data potentially incomplete
- All data still being validated for ACP purposes

Source: WSIC dashboards

Corporate governance proposal



"Committee in common"

Key features:

- Not legally binding
- Maximum flexibility for evolving partnership
- Speed of implementation
- Potential to establish contractual or organisational joint venture in the future
- Precedents amongst NWL CCGs and NHS Improvement

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

CQC Update

Executive summary:

The following report provides an update to the Trust Board on:

CQC inspections of medical care and maternity (March 2017)

- The Board will recall that the CQC carried out unannounced inspections of Medical care at St Mary's, Charing Cross and Hammersmith Hospitals, and Maternity at St Mary's Hospital, in March 2017.
- The Trust received the draft inspection reports in early September 2017 and is currently undertaking the factual accuracy checking process.

Annual routine Provider Information Request (PIR)

- The Trust is required to submit an annual routine PIR to the CQC. The PIR consists of a wealth of data related to performance against the CQC's five domains. It also includes a self-assessment component, whereby Trusts must submit a self-evaluation of their performance against the CQC's five domains across each core service by hospital site and for the organisation as a whole.
- The Trust received notification to complete its annual PIR on 14 July 2017 and this was submitted to the CQC by 11 August 2017 (the deadline date) following a robust sign off process.
- Within two months of the Trust submitting its PIR to the CQC, the CQC will hold a planning meeting and agree what will be inspected at the Trust during the current financial year. The inspections for the Trust will include, at a minimum:
    - An inspection of the well-led domain at Trust level
    - An inspection of at least one core service.

Assessments of well-led at the Trust

As part of simplifying regulatory approaches, NHS Improvement (NHSI) and CQC has worked closely together to review how they both assess organisations for being 'well-led'.

- Whilst NHSI and the CQC are separate organisations with different statutory functions, and the methodologies for undertaking their respective reviews, assessments and inspections are different, they have jointly agreed a set of revised key lines of enquiry (KLOEs) for 'well-led' which they will both use when undertaking assessments of Trusts.
- The CQC will undertake an annual inspection of the well-led domain at Trust level (review of the governance and decision-making processes among senior managers, and the board) using the jointly agreed KLOEs.
- It is likely that the Trust will have its CQC well-led inspection by the end of December 2017.
- NHSI has amended their 'well led' framework which now includes a component whereby Trusts should undertake a developmental review of how well-led they are, using the jointly agreed KLOEs.
- NHSI have also introduced a 'use of resources' assessment and the Trust is currently awaiting confirmation as to when this will take place.

The Trust's 2017/18 *CQC Registration and Inspection Framework*

As part of the routine annual review process, the Trust's 2017/18 *CQC Registration and Inspection*

Framework has been revised. Key highlights of this year's framework include:

- Presentation of self-assessments against the CQC domains by core service and by site, three times each year to the Executive (Quality) Committee and the Quality Committee
- Monthly reporting of outcomes of continuous performance monitoring carried out by the CQC, called CQC Insight, when it commences (the start date has not yet been identified).

Next steps

- The Trust will continue to improve compliance with the CQC's well-led domain in conjunction with the support currently being provided by the Head of Quality Governance from NHSI.
- Undertake inspection and assessment preparation for the NHSI use of resources assessment and the CQC well led inspection, both of which are expected to take place during quarter 3.
- A well-led inspection preparation session will take place at the October 2017 board seminar
- An update on progress will be presented to the Board in November 2017.

Quality impact:

The report applies to all five CQC domains.

Financial impact:

This paper has no financial impact at present.

Risk impact:

This paper relates to the following risks on the corporate risk register:

- **Risk 81:** *Failure to comply with statutory and regulatory duties and requirements, including failure to deliver the CQC action plan on target*

Recommendation(s) to the board:

To note the paper.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion

Authors	Responsible executive director	Date submitted
Priya Rathod, Deputy Director of Quality Governance Kara Firth, Regulation Manager	Janice Sigsworth, Director of Nursing	20 September 2017

CQC Update

1. Purpose

The following report provides an update to the Trust Board on:

- The CQC inspections related to medical care and maternity (March 2017).
- The annual routine Provider Information Request (PIR).
- Assessments of 'well-led' at the Trust and NHSI use of resources.
- The Trust's 2017/18 *CQC Registration and Inspection Framework.*

2. CQC inspections of medical care and maternity (March 2017)

- The Board will recall that the CQC carried out unannounced inspections of Medical care at St Mary's, Charing Cross and Hammersmith Hospitals, and Maternity at St Mary's Hospital, in March 2017.
- The Trust received the draft inspection reports in early September 2017 and is currently undertaking the factual accuracy checking process.

3. Annual routine Provider Information Request (PIR)

- The Board will recall there is now an annual PIR return that the Trust is required to submit to the CQC. The PIR has two parts:

    - A substantial Trust-level request which asks about performance against the CQC's five domains, with a focus on changes and improvements since the previous CQC inspection. This part of the request will inform the Trust-level inspection of well-led.
    - The Trust-level PIR includes a self-assessment component, whereby Trusts must submit a self-evaluation of their performance against the CQC's five domains across each core service by hospital site. They are also required to complete a self-assessment for the organisation as a whole.
    - A smaller sector-specific request which includes focused questions that are particularly relevant to acute Trusts (and which differ from those for mental health Trusts, for example), and for which CQC-accessible national data sets are not available.

- The Trust received notification to complete its annual PIR on 14 July 2017 and this was submitted to the CQC by 11 August 2017 (the deadline date) following a robust sign off process.
- Within two months of the Trust submitting its PIR to the CQC, the CQC will hold a planning meeting and agree what will be inspected at the Trust during the current financial year. As the Trust received its notice in July 2017, it is likely that the Trust's planning meeting will take place by the end of September 2017.
- The inspections for the Trust will include, at a minimum:
    - An inspection of the well-led domain at Trust level.
    - An inspection of at least one core service.

4. Assessments of 'well led' at the Trust

- Previously, Monitor and CQC both assessed Trusts on leadership/being 'well led' using different key lines of enquiry and approaches to do this.
- As part of simplifying regulatory approaches, NHS Improvement (NHSI) and CQC has worked closely together to review these approaches and this has resulted in:

- A shared set key lines of enquiry (KLOEs) for well-led that will be used by both the CQC and NHSI when undertaking their assessments/inspections.
- The introduction of a CQC inspection of the well-led domain at Trust level (review of the governance and decision-making processes among senior managers, and the board).
- Changes to the NHSI well-led framework which include revised guidance for Trusts in carrying out developmental reviews of their leadership and governance, based on the revised shared set of KLOEs. This is in addition to the CQC annual well-led assessment.
- The Introduction of 'use of resources' assessments for Trusts.

4.1. CQC Inspections of its Well-led Domain

- The CQC has indicated that once the annual routine PIR is sent to a Trust, the inspection of its well-led domain will take place within six months.
- As the Trust received its PIR in July 2017, the Trust is expected to have its first CQC inspection of the well-led domain by the end of December 2017.
- The Head of Quality Governance from NHSI will be working with the Trust for approximately six weeks, from mid-August to the end of September 2017, to identify areas for improvement, share good practice and share learning from other Trusts' experience with the CQC's new inspections of the well-led domain.
- A work plan is being developed and progress against this will be overseen by the Executive Quality Committee.
- In line with business as usual and with support from NHS Improvement, the Trust will continue to improve its compliance with the CQC's well-led domain.

4.2 NHS Improvement Developmental Reviews and Assessments of Use of Resources

- In June 2017, NHSI published new guidance for developmental reviews to review the effectiveness of their leadership and governance (previously recommended only for Foundation Trusts).
  - These reviews focus on how well Trusts integrate quality, operational and financial governance.
  - The aim of these reviews is to support improvement.
  - These reviews are considered good practice, but are not currently required. In July 2017, NHSI wrote to all Trusts encouraging them to have an external party carry out these reviews and that they should be undertaken at least every three years.
    - Trusts that do not undertake these types of reviews must be able to demonstrate to NHSI how assurance is gained about the effectiveness of their leadership and governance.
      - Due to the CQC inspection activity and NHSI assessment of use of resources expected for the Trust during the current year (see last bullet in this section), the executive team recommend that a developmental review be timetabled after the use of resources (NHSI) and well-led assessment (CQC) that is due to be undertaken in 2017/18.
      - The benefit of developmental reviews for the Trust can be re-evaluated for 2018/19.
- From September 2017, NHSI will carry out use of resources assessments. The methodology for undertaking these assessments was published in August 2017, which will review:
  - How well Trusts are meeting financial controls.
  - How financially sustainable Trusts are.
  - How efficiently Trusts use their resources.
  - How Trusts mitigate the impact of financial management, including, making financial efficiencies, on the quality of care.

- The Trust is currently awaiting confirmation as to when this assessment will take place.

- The Trust's Chief Financial Officer will lead the use of resources assessments.

4.3 Summary of approaches

- It is important to note that NHSI and the CQC are separate organisations with different statutory functions, and the methodologies for undertaking their respective reviews, assessments and inspections are different.
- Whilst the same well-led KLOEs will be used by NHSI and CQC, both organisations will continue to assess Trusts separately for well-led using their existing approaches i.e. CQC through inspection and NHSI through development reviews/use of resources assessments (see next section).
- The Trust will be awarded a CQC rating for its well-led domain and a separate NHSI rating for its use of resources.
- In future, the CQC and NHSI will agree an approach to combing their respective ratings; a consultation relating to this is expected to launch in autumn 2017.
- It is recognised that there is overlap between the CQC and NHSI's approaches and to this end the table presented in **Appendix 1** sets out the different approaches which will be used for CQC inspections of its Well-led domain at Trust level, NHSI developmental reviews and NSHI assessments of the Trust's use of resources. These assessments will need to be resourced and add another priority to the corporate and clinical teams during the winter period.

5. The Trust's 2017/18 *CQC Registration and Inspection Framework*

- As part of the routine annual review process, the Trust's 2017/18 *CQC Registration and Inspection Framework* has been revised. Key highlights of this year's framework include:
    - Presentation of self-assessments against the CQC domains by core service and by site, three times each year to the Executive (Quality) Committee and the Quality Committee by Divisional Directors.
    - A self-assessment tool and a reporting template have been developed and are accessible to staff via the Source.
    - The establishment of a forum ahead of each self-assessment presentation to support areas to review evidence and decide on ratings.
    - Monthly reporting of outcomes of continuous performance monitoring carried out by the CQC, called CQC Insight, when it commences (the start date has not yet been identified).
- The framework has been presented to the Executive Quality Committee and Quality Committee in September 2017.

6. Next steps

- The Trust will continue to improve compliance with the CQC's well-led domain in conjunction with the support currently being provided by the Head of Quality Governance from NHSI.
- Undertake inspection and assessment preparation for the NHSI use of resources assessment and the CQC well led inspection, both of which are expected to take place during quarter 3.
- A well-led inspection preparation session will take place at the October 2017 board seminar
- An update on progress will be presented to the Board in November 2017.

.

7. Recommendations to the Board:

- To note the paper.

Appendix 1: Differences between the Well-led Activities of the CQC and NHS Improvement

	CQC Inspection of its Well-led Domain at Trust Level	NHSI Developmental Review of Leadership and Governance*	NHSI Assessment of the Trust's Use of Resources*
Required?	Yes	No	Yes
Timing	Once each financial year	Recommended at least once every three years	Not yet determined but expected to be once each financial year
Announced?	Yes - with up to 12 weeks' notice	N/A	Not known
Team	Small team of senior inspectors and specialist advisors with board / executive level experience	• Recommended that this be commissioned to an external party • External party to be determined by the Trust	Small team of senior NHSI assessors
Site visit?	Yes – two days	As determined by the Trust	Yes – one day
Methodology	• Follows the CQC's key lines of enquiry for its well-led domain • Evidence will be gathered from: o Interviews with board members, executive and senior staff o Other staff views gathered via focus groups o Trust-level strategies, policies, procedures and guidelines o Trust-level data o Risk management o Information from external partners (commissioners, other health providers with whom the Trust works, NHS Improvement, Healthwatch, etc.)	• Based on the CQC's key lines of enquiry for its well-led domain • Includes a self-review by the Trust board • Following review by an external party, recommendations are made and actions to take in response should be agreed by the Trust board • The Trust should write to NHS Improvement when the review has been completed, about concerns raised / areas for improvement and any areas of good practice identified	• Based on five themes: o Use of resources to provide **clinical services** that operate as productively as possible to maximise patient benefit o Use of **workforce** o Use of **clinical support services** Management of **corporate services, procurement, estates and facilities** o Management of **financial** resources • Evidence will be gathered from: o Intelligence held by NHSI based on its routine interactions with the Trust o The Finance and use of resources metrics in NHSI's Single Oversight Framework o Productivity metrics o Qualitative assessment of context, performance and improvement activities
Outcome	Inspection report published on the CQC's website	Report of a format determined by the Trust	Assessment report published on the CQC's website
Rating	Yes • Separate from NHSI's rating for how the trust uses resources • Based on characteristics for the well-led domain key lines of enquiry • Published on the CQC's website	No – unless requested by the Trust that a predictive rating be provided	Yes • Separate from the CQC's rating of its well-led domain • Based on NHSI's ratings characteristics • Published on the CQC's website

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Board assurance framework

Executive summary:

Assurance goes to the heart of the work of any NHS Trust board. The Trust risk management policy and procedures provide the executive team with a robust framework by which they ensure that risk is successfully controlled and mitigated. Assurance is then the bedrock of evidence that gives confidence to the Trust board that risk is being effectively managed, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed. The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

The framework was last reported to the Trust board in March 2017, and a number of amendments have been made.

Generally –

- all corporate risk register references have been reviewed and updated; all new corporate risks have been considered. Risks on the register rated 'red' are not automatically rated as 'high' in terms of assurance risk, as the measure is focused on the understanding, reporting and assurance mechanisms in place rather than the absolute nature of the risk.
- new areas of activity:
    - Transformation programme – this is suggest for inclusion given that such importance is being given to its delivery;
    - Major incidents – following increased non-executive focus on this area (and inclusion in the corporate risk register), this is proposed for inclusion.
- the framework also includes:
    - the Trust's corporate committee structure, which continues to be reviewed and updated as new information is provided.
    - The most recent executive assurance statements to the Trust board; these are designed to provide assurance to the Trust that areas covered by the NHSI 'licence' requirements are appropriated managed and reviewed.

The Trust's board assurance statement has been subject to internal audit in recent months and a rating of 'substantial assurance' was received.

Quality impact:

Ensuring that we seek to continuing improve various areas of our corporate governance will demonstrate that the Trust strives to be a well-led organisation.

Financial impact:

The framework has no direct financial impact.

Risk impact:

Each of the work streams within corporate governance are regularly reviewed for risk impact, and risk register entries developed, including controls and mitigations as appropriate.

Recommendation to the Trust board:

The Trust board is asked to:

• review the proposed additional areas of potential risk (transformation / major incident) and agree (or otherwise) their inclusion, the proposed rating, and assurance sources; • Note the 'substantial' assurance rating recently received on the board assurance framework internal audit.
Trust strategic objectives supported by this paper:
To realise the organisation's potential through excellent leadership, efficient use of resources, and effective governance.

Author	Responsible executive director
Jan Aps, Trust company secretary	Ian Dalton, Chief executive

Board Assurance Framework

Revised Sept 2017 (v2.6 - working document)

New objectives being developed - will amend next version

Corporate objectives

1. To achieve excellent patient experience and outcomes delivered with care and compassion
2. To educate and engage skilled and diverse people committed to continual learning and improvement
3. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care
4. To pioneer integrated models of care with our partners to improve the health of the communities we serve
5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

CQC domain	Areas of activity	Corporate objective	Lead	Area of risk	Corporate risk register reference	Sources of Assurance			Principal Assurance Committee(s)	Timetable of assurance reporting	Board reporting		Risk classification (see guidance)	
						1st line Reporting	2nd line Internal assurance	3rd line External assurance			What	When	Inherent assurance risk	Residual assurance risk
Safe	**Patient safety: Infection control**	1	DIPC	Risk of spread of CPE	88	Reports on outbreaks reports against key metrics	Quarterly report to quality committee	CQC inspection	Quality Committee	Quarterly	Quality committee report to the board	Bi-monthly	High	Medium
Safe	**Patient safety: Medicine management**	1 5	Medical director / chief pharmacist	Failure to: - adopt best practice may lead to sub-optimal treatment - controlled medicines usage may lead to unnecessary costs - controlled drugs may lead to improper use / theft of medicines	Held on relevant dept RR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	MRHA annual submission and review CQC inspection	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	Medium	Medium
Safe	**Patient safety: Staff: Fire**	1	Director of estates & facilities	Failure to ensure that required fire prevention and management systems are in place, including effective evacuation systems	Held on relevant dept RR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	Review and on-going oversight by London Fire Brigade	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	High	Low
Safe Effective	**Patient safety: Critical care**	1	Divisions directors, DDC & MIC	Failure to achieve specific standards and specifications in delivering critical care standards	91	Reporting to executive committee of issues and potential resolution. Any patient risk issues would be covered in Quality report	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly.	CQC inspections	Quality Committtee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	High	Medium
Safe Effective	**Patient safety: Clinical governance**	1 5	Medical director	Failures of quality governance may allow poorer standards of care and may lead to non-compliance with statutory /contractual obligations	81 /71	Divisional governance leads review directorate and divisional arrangements	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly. Internal audit	Commissioner Quality Group have oversight CQC inspections	Quality Committee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low
Safe Effective	**Patient care**	1	Medical dir / dir of nursing/ divisional directors	Failure to safe and effective care affects CQC rating / incurs penalties/ impacts support for Trust strategic plans	81	Incidents raised on Datix Complaints Whistleblowing Service line self-assessments	Board member visits Core service reviews Deep dive reviews Internal audit support to core service reviews	CQC inspections PLACE audits	Quality Committee Ad-hoc risk reports are reported to the ARG Comm)	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium
Safe	**Patient safety: Mental health**	1	Divisional director, MIC	Failure to maintain high quality patient care and experience in ED due to extended delays experieinced by mental health patients awaiting transfer	94	Incidents raised on Datix Regularly reported at executive committee	Core service reviews	CQC inspections	Quality Committee	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium
Safe Effective Well-led	**Patient safety: Safeguarding**	1	Director of nursing	Failure of systems and processes (including training of staff) may under-identify safeguarding issues and/or may lead to a failure to respond appropriately	71	Incidents raised on Datix	Six monthly report to the executive committee	Serious case review outcomes Ofsted reports	Quality Committee	Six-monthly report	Update on safeguarding cases and position	Six-monthly	Medium	Low
Safe Caring Well-led	**Staff: recruitment and retention**	1 2	Dir P&OD	Inability to recruit and retain appropriately skilled staff poses risk to quality of patient care Inability to deliver a workforce that enables the required changes for the clinical model	93	Vacancy rates Time to recruit	Executive committee monitoring programme looks at the efficiency and effectiveness of the recruitment process Internal audit	Safe staffing reported to Commissioners and NHSI at Commissioners Quality Group	Quality Committee receives report on safer staffing and by exception on other risks associated with shortage of appropriate staff Also ARG	Bi-monthly	Safer staffing figures published monthly Update by exception through the quality committee report	Bi-monthly	High	Medium
Safe Caring Well-led	**ICT: Data quality**	1 2 5	CIO, CFO, Divisional directors, Dir P&OD	Poor quality of patient information may undermine patient care Poor data quality of Trust information may undermine strategic and contractual decisions	Held of relevant dept RR	Standardised business and reporting rules that are aligned to national policy with standard definitions and robust change control processes	Snap-shot audits via carried out at team and individual level Monthly audit of backing data at patient level and cross checking against clinical systems Programme of internal audit DQ Steering Group reporting to Exec	The external auditors provide a limited audit of information reported as part of their work on annual report and accounts	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Quarterly	High	Medium
Safe Responsive Well-led	**Patient safety: Availability of necessary equipment**	1	Dir of estates & facilities Divisional directors	Failure to provide safe equipment impacts patient and staff safety Equipment failure reduces ability to achieve operational targets	55	Incidents raised on Datix	Capital steering group oversees prioritisation of critical equipment spend Medical devices management group & quarterly report to ExQual Internal audit	Oversight of IRMER Regulations	Quality committee Finance & investment committee	Bi-monthly	Update by exception through the committee reports	Bi-monthly	High	Medium
Safe Responsive Well-led	**Patient safety: Staff safety: Management of estates**	1 5	Director of estates & facilities	Failure to: - provide safe estate impacts patient and staff safety - provide an appropriate environment impacting patient experience and outcomes - manage property portfolio impacts on financial position	55	Incidents raised on Datix Trust's outsourced hard FM have clear procedures for responding to priorities issues	Capital programme reports to executive committee External review of backlog maintenance identified £1.3bn of which £130m of high risk; programme in place to continually monitor priorities as issues are addressed	NHSI aware of external review outcome, and Trust's approach to managing the risk	Finance and investment committee	Bi-monthly capital report toF&I Comm	Update by exception through the report of the F&I Comm, the report of the Redevelopment Comm Specific report on Backlog maintenance	Bi-monthly	High	High

Safe Well-led	**Patient & staff experience:** **Site redevelopment**	4 1 5 2 3	Dir of redevelopment	Failure to: - secure redevelopment approval - secure redevelopment funding - secure support for moving services (Impact on equipment replacement)	74	Project board oversight and reporting	Reporting to executive committee and board redevelopment committee and commercila sub-group	Approval and programme oversight by NHS Improvement / CCG / NHS England	Redevelopment Committee	Monthly	Update by exception through the redevelopment committee report	Bi-monthly	High	Medium
Safe Responsive Well-led Caring	**Staff:** **Health & safety**	5	Dir P&OD	Failure to ensure: - appropriate arrangements in place to protect staff - that staff are immunised fully against biological agents to which they may be exposed	92 /72	Incidents raised on Datix Incidents reported by Occ Health	Bimonthly report to the executive committee	HSE inspections CQC inspections Internal audits	Quality committee	Bi monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low
Safe Well-led	**Research**	3	Medical director	Failure to: - secure development of NIHR BRC - ensure research embedded in divisions - to develop AHSC to potential	Held on medical director's risk register	Research lead in each division reporting through management reporting structure	Research and AHSC reports to executive committee	National research oversight bodies	Quality committee	Six monthly research report	Overview of AHSC and other research activity	Annual Six monthly	Medium	Low
Effective	**Patient pathway:** **Development of ACP arrangements & other STP arrangements**	4,1	Chief executive	Failure to deliver the clinical strategy programme to enhance acute services and support out of hospital care and the STP	Held on MIC division risk register	Clear governance arrangements across STP, with H&FGPF, and within Trust	Regular reports to Executive Committee	NHSI have oversight of the STP plans, and engaged in development of ACP arrangements	Audit, risk & governance committee	Propose an annual review of governance arrangements	Annual seminar on integrated care developments; regular updates in CE report	Annual Bi-monthly	Medium	Low
Effective Caring	**Staff:** **Education and training (including mandatory training)**	2,3	Medical director / Dir POD / Dir of nursing	Failure to: - adequately train staff poses risk to quality of patient care - achieve benchmark levels of medical education performance	65 POD RR	On-line register for all staff	Monthly reporting to the executive committee Internal audits of the systems and processes	Various Royal College and and GMC inspections and visits	Quality committee	Annual report of validation; performance report	Annual seminar on educational activities; mandatory elements in performance report; revalidation report	Annual Bi-monthly	Medium	Medium
Effective Well-led	**Finance:** **Short-term financial performance**	5	Chief financial officer	Failure to deliver financial plan	48	Divisional reporting Review financial review meetings for each division	The F&I scrutinise the financial position of the Trust The Exec Comm monitor delivery of achievement against savings plans, and performance against NHSI targets	External audit review during annual accounts preparation NHSI oversight, particularly in relation to control total and the STF	Finance and investment committee	Bi-monthly	Monthly finance report circulated Full reporting every other month in Finance report F&I Committee reports	Monthly Bimonthly	High	Medium
Effective Well -led	**Finance:** **Long term sustainability**	5	Chief executive	Failure to deliver the transformation programme required to achieve long term efficiencies and financial sustainability	48	??	Regular reports to Executive Committee and Trust board		Finance and investment committee	Bi-monthly	??Transformation programme report	Bi-monthly	High	High
Responsive	**Operational performance**	5 1	Divisional directors	Failure to deliver: - against NHSI targets (particular ED performance & emergency flow & RTT & elective performance)	7	Divisional review / ICT reporting Senior level committees in place addressing ED / emergency flow, RTT/elective activity, and outpatient improvement	Executive committee reviews performance each month, including reports from committees	NHSI and commissioners - monthly reporting	Executive committee	Bi-monthly	Operations performance report reported to Trust board	Monthly	High	High
Responsive Well-led	**Patient and staff experience:** **major incidents**	1 2 5	Chief executive	Excess organisational pressure associated with major malicious attack leads to: undue pressure on staff; reduction in patient experience; reduced bed capacity	95	Silver and gold command oversight; Hot and cold debrief ; site team meetings and escalation arrangements. Schwartz Rounds.	Lessons learned reports are presented to the Executive committee, and are reflected in the business continuity plans; internal audit	Business continuity plan submitted to NHSE;	Audit, Risk & Governance committee	Following major incidents	Exception reporting as required	Following major incidents	High	Medium
Well-led	**Finance:** **Financial control**	5	Chief financial officer	Failures of financial control risk leads to unanticipated budget overspends	48	Standing financial instructions; scheme of delegated authorities; discretionary spend controls	SFIs; SoDFA reviewed annually at executive and relevant board committee Internal audit opinion	External audit opinion CQUIN achievement	Audit, Risk & Governance Committee	Quarterly, and annual	Audit opinions reported as part of the annual accounts	Annual April/May	High	Medium
Well-led	**Counter fraud**	5	Chief financial officer	Poor systems and processes lead to financial loss	48	Cases raised Cases pursued	Internal audit	LCFS reports National benchmarking Home Office feedback	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Bimonthly	Medium	Low
Well-led	**ICT:** **Programmes & systems**	5 1	Chief information officer	Failure to: - optimise use of GDE award - maintain control may lead to overspend on major investments - potential distraction of shared ICO	ICT risk register	Clear governance arrangements within ICT and between Imperial and C&W to ensure planned progress achieved, and manage risk of 'shared ICO'	Dedicated Executive Digital Strategy Comm monitors delivery against key ICT projects, and ensure engagement Business cases and post-implementat'n reports are presented to the F&I Committee	NHS England - Global Digital Excellence oversight	Finance and investment committee / ARG Committee	Bi-monthly	Reports of the F&I Committee to each Trust board	Bi-monthly	Medium	Low
Well-led	**ICT:** **Information security and cyber crime**	5	Chief information officer / SIRO	Breaches indicate a detriment to patients or staff. Serious breaches may incur financial penalties Ransomware challenges	90	Process in place for reporting breaches Clear awareness and actions in place to minimise the impact of cyber crime	Annual report on performance in the Annual governance statement Exception reports on serious breaches IG annual return Internal audit	DH Information Governance return NHSIC have overview of all cyber crime issues	Audit, risk & governance committee	Quarterly	Annual performance in the Annual governance statement Exception reports on serious breaches IG annual return	Annual	High	Medium
Well-led Responsive	**Finance:** **Commissioning environment**	5	Chief financial officer	Failure to secure contracts impacts on the financial security of the Trust and may adversely affect quality of service	48	Clear direction and guidance in place within commissioning team	Executive and F&I Comm receive regular updates on contract position Review as part of the Business Planning process	Monthly NHSI oversight, and review of contracts agreed with Commissioners	Finance and investment committee	Bi-monthly	Exception reporting through Committee report Considered as part of	Bi-monthly Annual	High	Low

Executive governance statements for Trust board – September 2017

SAFE	Executive lead
Q1. *The Trust board can be satisfied that, to the best of the Executive's knowledge, the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* *(This takes account of NHSI's oversight model, CQC information and its own data on serious incidence and patterns of complaints)* **Director response:** Yes **Explanation, where response is No:**	Dr Julian Redhead, Medical director Prof Tim Orchard, Dr Katie Urch, Prof TG Teoh Divisional directors
Q2. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.* **Director response:** Yes **Explanation, where response is No:**	Janice Sigsworth, Director of nursing Prof Tim Orchard, Dr Katie Urch, Prof TG Teoh Divisional directors
Q3. *The Trust board can be satisfied that processes and procedures are in place to ensure all clinical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **Director response:** Yes **Explanation, where response is No:**	Dr Julian Redhead, Medical director Prof Janice Sigsworth, Director of nursing
EFFECTIVE	**Executive lead**
Q4. *The trust board can be satisfied that appropriate clinical audit arrangements are in place to ensure effective care and treatment is received in line with legislation, standards, evidence based guidance and service change.* **Director response:** Yes **Explanation, where response is No:**	Dr Julian Redhead, Medical director
CARING	**Executive lead**
Q5. *The trust board can be satisfied that the trust takes appropriate measures to engage patient and public involvement in the development of services and in shaping patient care.* **Director response:** Yes **Explanation, where response is No:**	Michelle Dixon, Director of Communications
Q6. *The trust board can be satisfied that patients are treated with kindness, dignity, respect and compassion.* **Director response:** Yes **Explanation, where response is No:**	Prof Janice Sigsworth, Director of nursing
RESPONSIVE	**Executive lead**
Q7. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with all existing operational targets and a commitment to comply with all known targets going forward.* **ICHT Response:** No **Explanation, where the response is No:** Emergency department: The Trust is currently not achieving the national standard to see, treat and discharge 95 per cent of patients that present to an urgent or emergency care setting within four hours. The key drivers of this underperformance are rising demand, particularly from ambulance arrivals, high levels of inpatient bed occupancy and underperformance of the outsourced urgent care centre on the St Mary's site. In response to these pressures we have developed an on-going programme of developments to improve the whole urgent and emergency care pathway. The priority of this plan is to reduce waits, improve flow and capacity and manage additional demand. The plan is supported by a trajectory for improvement, agreed with our commissioners and approved by NHSI, that will bring performance to 95 per cent by the end of March 2018. Progress with delivering the action plan and monitoring performance against the improvement trajectory is undertaken through the four hour performance working group. This meeting is chaired by the divisional director for medicine and integrated care and reported to the executive committee. Referral to treatment: The Trust brought in external expertise to support it in addressing a number of underlying issues identified in waiting list management early in 2016; the data validation team had picked up inconsistencies in how waiting list processes were being managed, there were some continuing data quality issues highlighted on risk registers, and not enough outpatient and elective treatment were being planned to ensure there was capacity to meet demand. With the support of local commissioners, the Trust invited a national team to review our information systems and processes, data validation and rules application in	Prof Tim Orchard, Dr Katie Urch, Prof TG Teoh Divisional directors

relation to the 18 weeks referral to treatment standard. In response to the report, the Trust established a waiting list improvement programme to develop and implement an action plan to: • support the office of the medical director in embedding processes to assure patient safety • put in place and maintain best practice waiting list management processes • complete work to ensure a fully comprehensive and accurate understanding of all of our waiting lists • improve our systems and processes to ensure good data quality at point of entry • achieve the national waiting list standard sustainably. The programme is driven by a dedicated waiting list improvement team supported by an external waiting list expert and incorporates a number of work streams: establishing comprehensive and accurate data quality; focus on treating patients waiting over 52 weeks; improving responsiveness, including through increased capacity both within the Trust and with the support of independent sector providers; improving waiting list management processes and data quality practice; and governance and monitoring. A revised trajectory was agreed with the Trust's commissioners and approved by NHS Improvement which saw the Trust achieving the RTT target by March 2018. Unfortunately, a large number of further cases have now been identified; work is in hand to ensure that the issues are addressed in a sustainable way. Cancer: The Trust has consistently met four of the eight cancer targets, but performance against the two week GP referral to first outpatient for both 'all urgent referrals' and 'breast symptoms' has been less consistent. Improved clinic planning is expected to improve this position. The Trust continues to address the late referrals of patients on shared pathways from other NW London sites, recently exacerbated by internal pathway delays, which makes achieving the 62 day urgent GP referral to treatment target a particular challenge. The Trust is continuing to work with linked hospitals and CCGs to improve shared patient pathways to recover performance. The very low numbers of patients on the 62 day urgent GP referral to treatment from screening means that a single patient delay can adversely impact achievement of this target; it is rare that any breaches of the screening standard is Trust attributable. Endoscopy: The Endoscopy Service identified an issue in May 2017 with the tracking of patients waiting for their diagnostic procedures which has resulted in an increased number of reported 6 week breaches on the Trust's monthly diagnostics waiting times submission (DM01). The issue with tracking has now been resolved and additional capacity sourced to accommodate long wait patients and patients added back to the waiting list following a manual validation process. It is anticipated that performance will recover to meet the 6 week standard for diagnostic tests by the end of September 2017.	
WELL-LED:	
Q8. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with all existing financial targets and a commitment to comply with all known targets going forward.* **ICHT Response:** Yes **Explanation, where the response is No:**	Richard Alexander, Chief financial officer
Q9. *The Board can be satisfied that they will be proactively, reliably & independently advised as to the going concern status of the Trust and the issues impacting that status, as defined by the most up to date accounting standards in force from time to time and financial best practice.* **ICHT Response:** Yes **Explanation, where response is No:**	Richard Alexander, Chief financial officer
Q10. *An Annual Governance Statement is in place, and the Trust board can be satisfied that the Trust is compliant with the risk management and assurance framework requirements that support the Statement and that significant issues are included within the Board Assurance Framework.* **ICHT Response:** Yes **Explanation, where the response is No:**	Jan Aps Trust company secretary Prof Janice Sigsworth, Director of nursing
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICHT Response:** Yes **Explanation, where the response is No:**	Kevin Jarrold Chief information officer
Q12. *The Trust board will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled appropriately, and that plans exist to fill any vacancies as required.* **ICHT Response:** Yes **Explanation, where response is No:**	Jan Aps Trust company secretary
Q13. *Fit and proper persons: The Board can be satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and*	David Wells Director of people and organisational

capability. **ICHT Response:** Yes **Explanation, where the response is No:**	development
Q14. *The Board can be satisfied that: the management team has the capacity, capability and experience necessary to deliver the Trust objectives; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response:** Yes **Explanation, where the response is no:**	David Wells Director of people and organisational development
Q15. *The Trust board can be satisfied that the Trust seeks to remain at all times compliant with the NHSI Single Oversight Framework and shows regard to the NHS Constitution at all times. All current key risks to compliance have been identified and addressed – or there are appropriate action plans.* **ICHT Response:** Yes **Explanation, where the response is No:**	Ian Dalton, Chief executive officer

Committee reporting structure: management and assurance

Committee / Group	First Stage Reporting	Management Reporting to Executive Committee (Operations / Quality / Transformation / Digital Strategy / Redevelopment)	Accountable Executive Director	Assurance Reporting to Trust Board or Committee (Most by Exception Only)
Activity & Income Data Quality Group	Data Quality Steering Group	Executive Digital Strategy Committee	Chief Information Officer	Audit, Risk & Governance Committee
AHSC Research Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Caldicott & Health Records Committee	Data Quality Steering Group	Executive Digital Strategy Committee	Chief information Officer	Audit, Risk & Governance Committee
Cancer Board	-	Executive Quality Committee	Medical Director	Trust Board
Change Advisory Board	ICT Security Audit & Risk Committee, then Caldicott & Health Records Committee	Executive Digital Strategy Committee	Chief Information Officer	Audit, Risk & Governance Committee
Clinical Academic Research Committee	Trust Education Committee	Executive Quality Committee	Medical Director	-
Clinical Ethics Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Clinical Strategy Implementation Programme (CSIP) Group	-	Executive Transformation Committee	Medical Director	Trust Board
Clinical Systems Sub-Group	Data Quality Steering Group	Executive Digital Strategy Committee	Chief Information Officer	Audit, Risk & Governance Committee
Corporate Functions Health & Safety Committee	Strategic Health & Safety Committee	Executive Quality Committee	Director of People & Organisation Development	Quality Committee
Data Standards Committee	Data Quality Steering Group	Executive Digital Strategy Committee	Chief Information Officer	Audit, Risk & Governance Committee
Decision Support Panel	-	Executive Operational Performance Committee	Chief Financial Officer	Finance & Investment Committee
Decontamination Steering Group	Trust Infection Prevention Control Committee	Executive Quality Committee	Medical Director	Audit, Risk & Governance Committee
Digital Strategy Steering Committee	-	Executive Digital Strategy Committee	Chief Information Officer	Audit, Risk & Governance Committee
Divisional Health & Safety Committee(s)	Strategic Health & Safety Committee	Executive Quality Committee	Divisional Directors	Quality Committee
Divisional Quality & Safety Committee(s) (each of 27 directorates has a Q&SC reporting to both Div. S&QC & Management Committee - full list held in division)	Trust Safety & Effectiveness Committee	Executive Quality Committee	Divisional Directors	Quality Committee
Drugs & Therapeutics Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Elective Access Waiting List Group	-	Executive Operational Performance Committee	Divisional Director, Surgery, Cancer & Cardiovascular	Audit, Risk & Governance Committee
Emergency Planning Committee	Strategic Health & Safety Committee	Executive Quality Committee	Director of Nursing	Trust Board
End of Life Committee	Quality & Safety Sub-Group	Executive Quality Committee	Director of Nursing	Quality Committee
Estates & Facilities Quality Committee	Quality & Safety Sub-Group	Executive Quality Committee	Director of Nursing	Quality Committee
Estates Health & Safety Committee	Strategic Health & Safety Committee	Executive Quality Committee	Director of Nursing	Quality Committee
Finance & Sustainability Review Groups	-	Executive Operations Committee	Chief Financial Officer	Finance & Investment Committee
Fire Safety Committee	Strategic Health & Safety Committee	Executive Quality Committee	Director of Nursing	Quality Committee
Genomic Medicine Centre	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Imperial College Joint Safety Group	Strategic Health & Safety Committee	Executive Quality Committee	Director of People & Organisation Development	Quality Committee
Imperial Private Healthcare Management Committee	-	Executive Quality Committee	Director of Imperial Private Healthcare	Trust Board
Imperial Private Healthcare Medical Advisory Committee	Imperial Private Healthcare Management Committee	Executive Quality Committee / Executive Operational Performance Committee	Director of Imperial Private Healthcare	Trust Board
Imperial Private Healthcare Quality Committee	Imperial Private Healthcare Management Committee	Executive Quality Committee	Director of Imperial Private Healthcare	Trust Board
Intellectual Property Committee	Sub Transformation Committee	Executive Transformation Committee	Medical Director	Trust Board
Ionising Radiation Committee	Strategic Health & Safety Committee	Executive Quality Committee	Divisional Director, Women's, Children's & Clinical Support	Quality Committee
Joint Clinical Research Health & Safety Committee	Strategic Health & Safety Committee	Executive Quality Committee	Medical Director	Quality Committee
Joint Executive Group	Strategic Partnership Board	Executive Quality Committee	Chief Executive	Trust Board
Joint Trades Union Safety Committee	Strategic Health & Safety Committee	Executive Quality Committee	Director of Nursing	Quality Committee
London Cancer Research Network	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Local Negotiating Committee	BMA	-	Medical Director	Quality Committee
Medical Devices Management Group	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Medications Safety Review Group	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Medicines Optimisation Committee	Quality & Safety Sub-Group	Executive Quality Committee	Divisional Director, Women's, Children's & Clinical Support	Quality Committee
Mental Health Act & Mental Capacity Act Group	Trust Safeguarding Committee	Executive Quality Committee	Director of Nursing	Quality Committee
Mobile Apps Committee	Caldicott & Health Records Committee	Executive Digital Strategy Committee	Chief Information Officer	Audit, Risk & Governance Committee
New Drugs Panel (NDP)	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
New Interventional Procedures Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Non-Medical Prescribing Group	Quality & Safety Sub-Group	Executive Quality Committee	Director of Nursing	Quality Committee
Nursing & Midwifery Evidence Based Practice Group	Professional Practice Committee	N/A (Advisory)	Director of Nursing	N/A
Nursing & Midwifery Learning & Development Group	Nursing & Midwifery Education Committee, then Trust Education Committee	Executive Quality Committee	Director of Nursing	Quality Committee
Nursing & Midwifery Research Committee	Professional Practice Committee	N/A (Advisory)	Director of Nursing	N/A
Nutrition Steering Group	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
North West London Pathology Board	-	Executive Committee	-	Trust Board
North West London Pathology Host Committee	-	Executive Operational Performance Committee	Trust Company Secretary	Audit, Risk & Governance Committee
North West London Pathology Joint Governance Group	-	Executive Operational Performance Committee	Divisional Director, Women's, Children's & Clinical Support	Trust Board
Organ Donation Committee & Tissue Guardian	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Partnership Committee	-	Executive Operational Performance Committee	Director of People & Organisation Development	Trust Board
Point of Care Testing (POCT) Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Resuscitation Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Redevelopment Committee	-	Executive Committee	Director of Redevelopment	Trust Board
Security Committee	Strategic Health & Safety Committee	Executive Quality Committee	Director of People & Organisation Development	Quality Committee
Service Agreement Steering Group	-	Executive Operational Performance Committee	Divisional Directors	Audit, Risk & Governance Committee
Trust Capital Steering Group	-	Executive Operational Performance Committee	Chief Financial Officer	Finance & Investment Committee
Trust Infection Prevention & Control Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Trust Medical Advisory Committee	-	-	Medical Director	Trust Board
Trust Radiation Safety Committee	Strategic Health & Safety Committee	Executive Quality Committee	Divisional Director, Women's, Children's & Clinical Support	Quality Committee
Trust Safeguarding Committee	Quality & Safety Sub-Group	Executive Quality Committee	Director of Nursing	Quality Committee
Trust Safety & Effective Committee	Quality & Safety Sub-Group	Executive Quality Committee	Medical Director	Quality Committee
Trust STP Forum	Sub Transformation Committee	Executive Transformation Committee	Chief Financial Officer	Trust Board

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	27 September 2017

Postgraduate Medical Education: Report on the results of the General Medical Council National Training Survey 2017

Executive summary:

The results of the General Medical Council's National Training Survey 2017 were published on 4th July 2017. The 2016 survey demonstrated significant improvements on previous results. The 2017 results indicate that we have maintained our performance overall, with 24 red flags compared to 25 in 2016 and 53 green flags compared to 54 in 2016 across our training programmes.

The key points to note are:

- Loss of red flags from 6 programmes;
- Significant improvement in Histopathology (6-0 red);
- Significant increase in green flags for Anaesthetics F2 (1-9 green) and GP Paediatrics and Child Health (2-6 green);
- Ophthalmology, Paediatrics and Child health F1 and HIV/GUM maintained green flags;
- Maintained our performance as measured against Shelford group with the least overall number of red flags, and second largest number of green flags;
- No bullying and undermining concerns reported in year;
- Reduction in safety concerns raised by trainees from 5 to 3.

This has been brought about by the following actions:

- Strengthening education governance
  - Embedding Local faculty groups
  - Faculty development programme for unit training leads and educational supervisors
  - Appointment of senior specialty trainees
- Support through education specialty reviews for challenged specialities;
- Clear guidance on the EPAs required for education in team job plans.

There are several specialties of concern which are undergoing on-going internal monitoring through education specialty reviews. This includes ITU at Charing Cross, which is under GMC enhanced monitoring and has seen a deterioration in the survey results. Monthly meetings are occurring, with plans in progress, including a new rota. The next meeting will take place before the action plan submission is due in September.

Over the next 12 months, the work of the postgraduate team will be focused on consolidating the results by:

- Evaluating and sharing of good practice from areas with green flags;
- Focused service reviews with challenged specialties;
- Embedding time for education in job plans and making it sustainable;
- Further development of faculty development programme;
- Ensuring administrative support for LFGs is provided to retain the engagement with trainees;
- Work with P&OD to develop the multi-professional workforce as well as

implementation of the integrated education strategy.

Quality impact:

Improving junior doctor and medical student experience and engagement, and ensuring they are equipped to deliver high quality patient-centred care within a safe and supportive environment, will support all 5 domains of the quality strategy.

Financial impact:

This paper has no financial impact.

Risk impact:

The risk to the trust of failing to achieve benchmark levels of medical education performance or provide adequate and appropriate training for junior doctors is reflected in our corporate risk register.

Recommendation(s) to the Committee:

The Committee is asked to note the contents of the report

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Ruth Brown, Associate Medical Director for Education	Julian Redhead, Medical Director	22 September 2017

Report on the results of the GMC National Training Survey 2017

1. Purpose of the Paper

The purpose of this paper is to update the committee on the results of the General Medical Council's National Trainee survey 2017.

2. Background

The national training survey is conducted annually by the General Medical Council (GMC). There are two parts to the survey; a survey for trainees which monitors the quality of medical education and training and a survey for trainers to ensure they are well supported.

The trainee survey is comprised of a set of generic questions which explore trainees' perceptions of their training. The questions focus on the domains of the General Medical Council standards for education and training. There are also specialty specific questions set by Royal Colleges and Faculties to explore specialty curricula issues. There are 49 generic questions which are grouped into the 17 domains of the GMC standards document. Any question may be used in one or more domains. Most domains have 4-5 questions and the responses are a range of options, for example from poor to excellent, which are then given a numerical value. Responses are compared to the mean response for all Trusts in England and an outlier is determined by the cohort response at the Trust compared to the mean of the national response. Red flags are significantly worse response scores than the national mean, green flags are significantly better.

The responses can be analysed by programme (generally a single specialty at core or higher level of training) or specialty (all grades working in a specialty regardless of training programme).

The trainer survey tests trainers' perception on the quality and effectiveness of medical training and how well they are supported in their role within the local education provider.

Response rates in London were among the highest in the country this year at >99% of trainees and 54% of trainers.

3. Introduction

Our results in the 2016 GMC NTS demonstrated significant improvements with a doubling of green flags and a 50% reduction in the number of red flags per programme. This was the result of an education transformation programme launched in 2015 and which continued into the following year, with the following key developments made in 2016/17:

- Strengthening education governance
    - Embedding Local faculty groups; every specialty now has a fully functioning LFG which meets quarterly as a minimum requirement.
    - Faculty development programme for unit training leads and educational supervisors.
    - Appointment of senior specialty trainees.
- Support through education specialty reviews for challenged specialities.
- Clear guidance on the EPAs required for education in team job plans, which is currently being implemented.

The 2017 national training survey results were published in early July. Overall they show that we have maintained our performance compared to last year, with some specialties demonstrating significant improvements, while others either remain challenged or have seen a deterioration in performance. The results by programme, specialty and domain are summarised below. Also included is a summary of the results of the trainer survey.

In response to the results, we are required to submit a formal action plan to HEE in

September 2017 for red flags in 10 programmes. In addition, we will be developing an action plan for flags in other outliers, which will be monitored internally. Education specialty reviews will continue for specialties where there are particular concerns. Progress will be reported to ExQu through the regular quarterly updates.

3.1 Results by programme

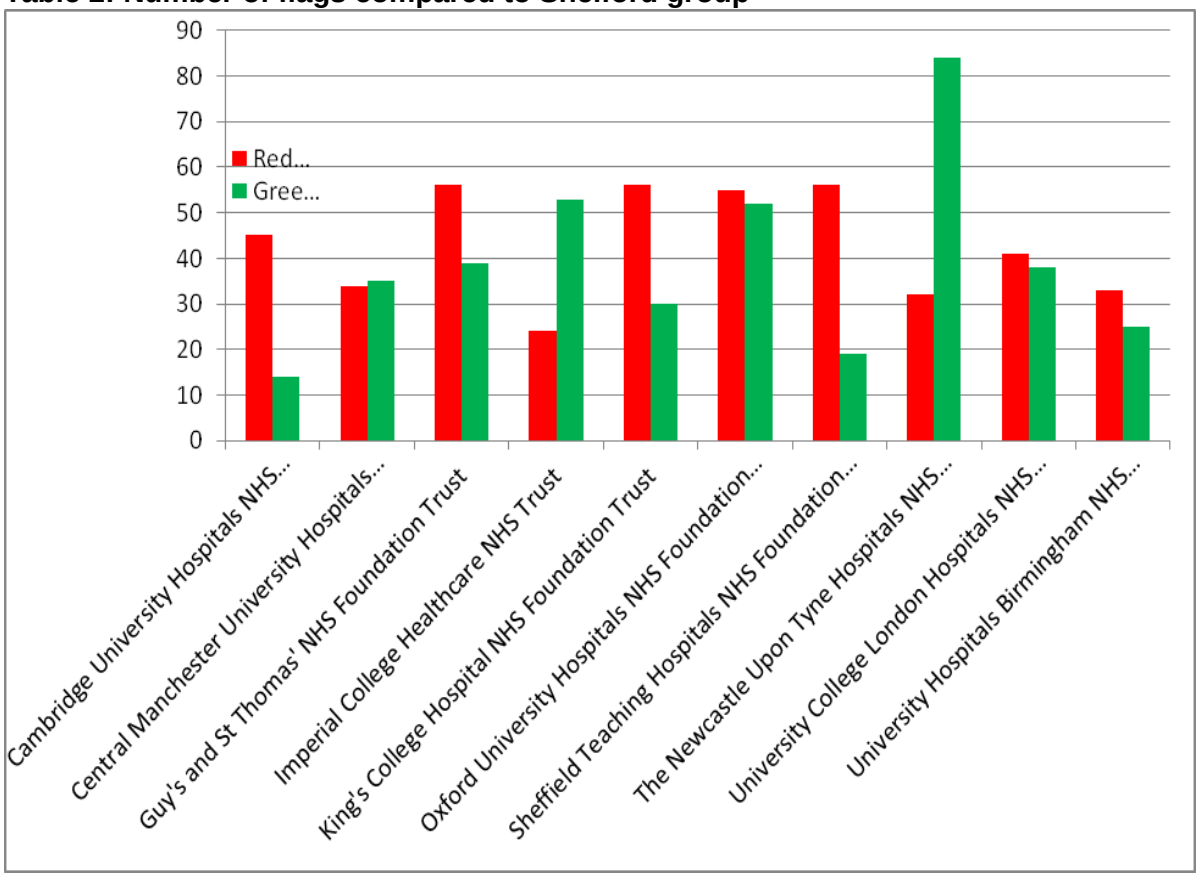
The 2017 results by programme indicate that we have maintained our performance overall, with 24 red flags compared to 25 in 2016 and 53 green flags compared to 54 in 2016 across our training programmes. See table 1 below.

Table 1: Year on Year comparison – red and green flags per programme

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

We have also maintained our performance in comparison with the Shelford Group (see table 2 below), reporting the smallest number of red flags and the second largest number of green flags.

Table 2: Number of flags compared to Shelford group



Programmes which have made significant improvements include:

- Anaesthetics F2 – increase in green flags from 1 to 9
- Chemical Pathology – 2 green flags compared to 0 last year
- GP Prog – Paediatrics and child health – increase in green flags from 2 to 6
- GP Prog – Surgery – loss of 2 red flags
- Geriatric medicine – 3 green flags acquired
- Histopathology – loss of all 6 red flags

- Medical Oncology – loss of 4 red flags

Programmes which have maintained red flags include:
- Clinical radiology – maintained 2 red flags in 2017
- GP Prog – O&G – reduction in red flags from 5 to 2, and loss of a green flag
- Plastic surgery – maintained 1 red flag

Programmes which have acquired new red flags include:
- Cardiology – 3 red flags compared to 0 last year
- Clinical oncology – 1 red flag compared to 0 last year
- Dermatology – 4 red flags compared to 0 last year and a decrease in green flags from 2 to 1
- Endocrinology and diabetes – 1 red flag acquired and the loss of 1 green flag
- GP Prog – Medicine – 2 red flags acquired and the loss of 1 green flag
- Haematology – 4 red flags compared to 1 last year
- Medicine F2 – 2 red flags compared to 1 last year
- Neurosurgery – 1 red flag compared to 0 last year

Analysis of programmes by site reveals an additional three programmes with significant numbers of red flags: ACCS at CXH, Haematology at HH, and Endocrinology and Diabetes at SMH. Otherwise programme flags do not appear to be focused on one site rather than another.

3.2 Results by specialty

Overall, our results by specialty have improved this year with an increase in green flags from 40 to 48 and a decrease in red flags from 20 to 14.

Specialties which have made significant improvements include:
- Chemical pathology – 2 green flags compared to 0 last year
- Hepatology - 2 green flags compared to 0 last year
- Neonatology – loss of all 6 red flags
- Intensive care medicine – loss of 1 red flag and 1 green flag gained
- Paediatric emergency medicine – loss of 2 red flags and 1 green flag gained
- Paediatrics – increase in green flags from 3 to 5
- Vascular surgery – loss of 1 red flag and 1 green flag gained

Specialties which have maintained red flags include:
- Haematology – 1 red flag maintained
- Medical oncology – 2 red flags maintained

Specialties which have acquired new red flags include:
- Cardiology – 3 red flags compared to 0 last year
- Clinical oncology – 1 red flag compared to 0 last year
- Clinical radiology – 2 red flags compared to 0 last year
- Dermatology – 2 red flags compared to 0 last year, and the loss of 2 green flags
- Endocrinology and diabetes – 1 red flag compared to 0 last year
- Medical microbiology – 1 red flag compared to 0 last year
- Neurosurgery – 1 red flag obtained however there has also been an increase in green flags from 0 to 3.

By site, the specialty specific flags show additional specialties with red flags and the site specific nature of some of those flags, particularly intensive care medicine at CXH and endocrinology and diabetes at SMH.

3.3 Results by domain

Three additional domains were included in this year's survey: teamwork, educational governance and curriculum coverage. One domain, access to educational resources, was removed.

Green and red flags per domain are shown in table 3 below.

Table 3: Green and red flags per domain

	2016 Green	2017 Green	2016 Red	2017 Red
Overall Satisfaction	1	2	3	3
Clinical Supervision	4	3	5	2
Clinical Supervision out of hours	1	5	0	0
Reporting systems	6	3	1	0
Work Load	6	5	3	3
Teamwork	New in 2017	3	New in 2017	1
Handover	6	4	2	0
Supportive environment	4	4	0	2
Induction	4	5	0	2
Adequate Experience	0	1	1	1
Curriculum Coverage	New in 2017	0	New in 2017	1
Educational Governance	New in 2017	4	New in 2017	1
Educational Supervision	0	2	1	1
Feedback	3	2	2	2
Access to educational resources	7	N/A	1	N/A
Local Teaching	7	3	1	0
Regional Teaching	6	6	1	4
Study Leave	1	1	0	1

For most domains, performance is similar over both years. Analysis for domains where there have been significant changes is below. The new red flags are in specialties which had no flags last year but which are under significant pressure. The local faculty groups will be exploring the reasons for any lost green flags.

Handover and induction

Following the work in 2015/16 on induction and handover, we retain green flags in both these areas. However, we have acquired two red flags for induction. The induction questions relate to the preparation for the post not the main trust induction. The LFGs in these programmes will be focusing on exploring the needs of the trainees and improving the induction information provided.

Supportive environment

We have continued to work with specialties on developing the positive culture within the training environment. We have maintained four green flags; however have acquired 2 red flags in cardiology and dermatology for this domain. The red flags correlate with red flags for overall satisfaction. We will work with the senior trainees in these two specialties to explore how the environment can be improved.

Regional teaching

We have received 4 red flags for regional teaching. Whilst we know that in some cases this is related to pan London operational issues as well as the closure of the lead provider

function (all London trusts have red flags in these specialties) we are also aware of problems with approval for study leave and releasing trainees for mandatory training. We are working with the rota coordinators and HR to ensure the processes for enabling mandatory training are consistent and fair across all specialties and will report on this in our next quarterly update.

3.4 Patient Safety and Bullying and Undermining Concerns

Whilst the survey is open, any patient safety or bullying or undermining concerns raised by the trainees when completing the survey are sent directly to the Trust for immediate investigation and action. This year, there were no bullying and undermining concerns raised. There was one immediate safety concern, compared to two in 2016, which has been investigated. This was related to haematology staffing levels and is reflected in the red flags gained in that programme. Actions have been developed by the division, including changes to the rota and recruitment plans. These were sent to HEE in May; a response is awaited.

4. GMC NTS Results 2017 - Trainers

The standards for education and training includes a domain for supporting educators, the Trainers survey monitors this domain. Results for the trainers survey were also published in July. Previously the results were circulated a few months after the trainee survey for information. This year they have been sent to us at the same time as the trainee survey for us to reflect on and use in our action planning. This year, we are not required to provide action plans in response to the results; however this will be a requirement in future.

This year's survey included six new domains; Overall satisfaction, workload, educational governance, curriculum coverage, rota design and resource for trainers. The organisational culture domain was removed. Results show 11 red flags (compared with 7 in 2016) and 30 green (compared with 13 in 2016). Most red flags are in workload (3), time for training (2) and resources for trainers (2).

It should be noted that the red flags for the trainer's survey coincide with the red flags for trainees in the majority of specialties.

5. Specialties where there are concerns

There are a number of specialties which have previously been identified as of particular concern, either because of previous survey results or concerns raised at quality visits. These specialties have been undergoing ongoing monitoring through the education specialty review process, which will continue throughout 2017/18 to ensure improvements are sustained.

In addition, a number of specialties have been added to the list due to concerns raised by the results of this year's survey. Monthly internal monitoring will commence for these specialties in September.

Action Plan	Specialty	Issue	Actions and progress report
GMC Enhanced monitoring	Neurosurgery	Poor access to training and failure to provide curriculum coverage. Temporary removal of core trainees and subsequent replacement	Ongoing monitoring for sustainability.
GMC Enhanced monitoring	Ophthalmology	Poor environment for training, failure to cover curriculum, failure to	Ongoing monitoring for sustainability.

		provide supervision. Temporary removal of trainees and subsequent replacement	
GMC Enhanced monitoring/HEE Quality Review/2017 NTS survey	Critical Care (CXH)	Triple (or more) red outliers by post specialty in a number of domains particularly supervision, support and curriculum coverage	HEE have met with the trainees and an action plan is in place. Under monthly internal monitoring through education specialty reviews in response to HEE concerns. Plans are in progress including a new rota; the next meeting is taking place before the action plan submission.
HEE Quality Review 2015	Histopathology	Triple (or more) red outliers by post specialty (2013-16) Key issues identified; autopsy experience and lack of BMS support for cutup.	HEE have met with the trainees and trainers and an action plan in place. Under monthly internal monitoring through education specialty reviews in response to HEE concerns. 2017 NTS results did not produce any further red flags.
NTS 2016/7	Medical Oncology	Triple (or more) red outliers by post specialty Key issues related to: overall satisfaction (trainer engagement with training) and adequate experience	HEE have met with the trainees and trainers which resulted in no additional actions for the specialty. Following triple flags being triggered in 2017 NTS monthly internal monitoring will resume.
NTS 2016/7	Haematology	Triple (or more) red outliers by post specialty Key issues related to: overall satisfaction, workload, regional teaching and feedback	HEE have requested to meet with the trainees in August 2017. To undergo monthly internal monitoring.
NTS 2016/7	Cardiology	Triple (or more) red outliers by post specialty Key issues related to: overall satisfaction, team work, supportive	To undergo monthly internal monitoring.

		environment	
HEE Quality Review 2015/ NTS 2016/7	GP Programme O&G	Double red outliers by post specialty Key issue related to clinical supervision	To undergo quarterly internal monitoring.
NTS 2016/7	Endocrinology & Diabetes – SMH	Multiple outliers by post specialty	To undergo monthly internal monitoring.
NTS 2016/7	Clinical radiology	Multiple outliers by post specialty	To undergo monthly internal monitoring.
NTS 2016/7	ACCS CXH	Multiple outliers by post specialty	To undergo monthly internal monitoring.

6. Requirements for programme specific action planning

We are required to provide an action plan for red flags in 10 programmes (aggregated across the Trust) to the GMC and HEE (Appendix 1 – HEE Action Planning Requirements), selected for the following reasons:

- Three of more flags in a programme;
- A red flag for one or more of clinical supervision, clinical supervision (out of hours), educational supervision and overall satisfaction;
- A programme where there has been recurrent red flags for three or more years.

The first submission of the action plan is due in September 2017. It will set out how we have investigated the red flags and the actions planned to improve. Once that is approved by HEE, we will be required to provide further quarterly submissions until the actions are deemed closed.

In addition to the external action plan, we are developing an internal action plan for other red outliers which will be monitored internally through local faculty groups and education specialty reviews. Progress will be summarised in the quarterly reports to ExQu.

7. Improvement plans for 2017/18

In addition to the programme/specialty specific actions, the medical education team will also be undertaking a number of improvement projects to improve the quality of education overall. These include:

<u>Supporting educators</u>

We are continuing to work with the revalidation team to ensure time for training is included in job plans, highlighting the income associated with trainee placement fees and ensuring it is recognised within the directorate budget. This information will support the discussion with Clinical directors for the requirement for educational time in job plans.

We have planned further development of the faculty development programmes for supervisors including a bi-annual faculty network conference.

We are planning a programme of development for the senior specialty trainees including educational competences and leadership.

We have implemented a network programme for SAS doctors to allow them to develop their supervisory skills as well as leadership and career development.

Educational governance and leadership
Continuation of education specialty reviews with focussed support for specialties where there are multiple red flags or continued enhanced monitoring in place.

Workload
Working closely with the departments and HR to monitor the impact of rota gaps on the training experience and workload, and exploring workforce development options to resolve the workforce shortfall. We are developing medical recruitment and retention case studies to share across the specialties as well as working with the Deputy Director of Nursing to develop a shared vision of advance clinical practice within the multiprofessional team.

Supporting learners
We have developed the senior specialty trainee cohort to support the engagement and work with the junior trainees in creating a positive environment.

Study leave
We will commence a workstream with HR and the rota coordinators to standardise and ensure parity across the Trust in relation to access to study leave time. This is an essential part of the new contract and will ensure compliance. This work will also prepare the Trust for the anticipated national centralisation of study leave planned by HEE for February 2018

Exception reporting
We have worked closely with HR to implement the new junior doctor contract. The completion of roll out in August/October 2017 will effectively see all trainees on the new contract and able to exception report. We will work with the Guardian of Safe Working to follow up and monitor exception reports, both educational (no formal educational exception reports to date) and hours where the breach of hours may indicate excess intensity or demand affecting training.

Management of LP Transition

A separate paper is included on the transition of Lead Provider to HEE. We continue to monitor the risks associated with this, and are working with HEE to outline next steps to ensure the impact is minimised.

Appendix 1: HEE Action planning requirements

Training Programme	Site	Indicator(s)	Outlier Colour	Year Identified
Three or more red outliers - programme wide action plan required				
Dermatology	**Trust Wide**	Overall Satisfaction	RED	2017
		Supportive environment	RED	
		Induction	RED	
		Educational Governance	RED	
		+2 Pinks	PINK	
Haematology	**Trust Wide**	Overall Satisfaction	RED	2017
		Work Load	RED	2017
		Feedback	RED	2017
		Regional Teaching	RED	2015, 2016, 2017
		+2 Pinks	PINK	2017
Cardiology	**Trust Wide**	Overall Satisfaction	RED	2017
		Teamwork	RED	
		Supportive environment	RED	
		+1 Pink	PINK	
Red outliers in key indicators - indicator specific action plan required				
GP Prog - Obstetrics and Gynaecology	**Trust Wide**	Clinical Supervision	RED	2016, 2017
GP Prog - Medicine	**Trust Wide**	Educational Supervision	RED	2017
Clinical radiology	**Trust Wide**	Clinical Supervision	RED	2016, 2017
Triple (or more) Red outliers by post specialty - indicator specific action plan required				
Medical oncology	**Trust Wide**	Overall Satisfaction	RED	2015, 2016, 2017
Medical oncology	**Charing Cross Hospital**	Adequate Experience	RED	2015, 2016, 2017
Intensive care medicine	**Charing Cross Hospital**	Overall Satisfaction	RED	2012, 2013, 2014 2015, 2016, 2017
Intensive care medicine	**Charing Cross Hospital**	Work Load	RED	2014, 2015, 2016, 2017
Anaesthetics	**Hammersmith Hospital**	Local Teaching	RED	2014, 2015, 2016, 2017
Cardiology	**Hammersmith Hospital**	Overall Satisfaction	RED	2015, 2016, 2017
Cardiology	**Hammersmith Hospital**	Supportive environment	RED	2015, 2016, 2017

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (20 September 2017)**

KEY ITEMS TO NOTE

The Committee:

- Noted that overall the Trust was on plan in-month and year to date. There was some concern that the paper suggested that the risk to the year-end forecast appeared to have increased, but further information provided verbally at the meeting reassured the Committee that the Trust continued to consider the year-end position realistic.

- Discussed at some length work in progress towards development of a strategy for the Trust's long-term clinical and financial sustainability. The Committee was broadly supportive the paper, recognising that there was further work required to achieve a programme of activities to progress. This would be the subject of further discussion at the Trust board private meeting.

- Welcomed the further progress on specialty-level reviews, particularly the level of clinical engagement and opportunities identified, and considered how these would most effectively align with the broader transformation programme.

- Received an annual review of the performance and strategy for Imperial Private Healthcare (IPH), the contribution from which supported the Trust's NHS activity. Despite reduction in some areas of activity, the private patients' business had experienced a successful early part to the year, with good performance in month 5. The team continued to work constructively with divisional colleagues to ensure mutual support in accessing theatre and diagnostic capacity, and providing capacity during times of particularly high patient activity in the main hospital wards.

- Supported the submission of a PET CT tender for NHS England commissioned diagnostic services across south-west and north-west London, as part of an RM Partners consortium bid.

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jan Aps, Trust company secretary
Next meeting: 22 November 2017

Imperial College Healthcare NHS Trust

Report to:	**Trust board**
Report from:	**Redevelopment committee report (20 September 2017)**

KEY ITEMS TO NOTE

Phase one St Mary's redevelopment planning application: It was confirmed that the Trust's application would be heard at 26 September meeting of Westminster City Council planning committee.

Paddington Cube safety concerns over 'blue light' access to St Mary's Hospital: It was confirmed that the s106 agreement in relation to the Paddington quarter development had been signed. The Trust was seeking legal advice and considering its position.

St Mary's Hospital redevelopment programme: The results of the soft market testing had been received; there had been a diverse range of interested parties and feedback had been positive in reassuring the Trust that there was definite commercial interest in developing the site.

RECOMMENDATION:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Report from: Sir Richard Sykes, Chairman
Report author: Jan Aps, Trust company secretary
Next meeting: 25 October 2017

Imperial College Healthcare NHS
NHS Trust

Report to**: Trust board**

Report from: **Quality Committee (13 September 2017)**

KEY ITEMS TO NOTE

Divisional director's risk register update: The Committee reviewed the divisional risks:
Winter planning –the Committee noted that a comprehensive winter plan was being developed with involvement of the A&E delivery board and community partners.
Estates: the Committee noted the continuing risks relating to the infrastructure of the Trust; the divisions continued to work closely with the estates team to mitigate the impact of these risks.
RTT – The Committee noted with concern the deteriorating RTT performance position; but recognised the work in place to both clinically review all patients affected as quickly as possible and to ensure that such errors did not occur in the future were noted.

Serious Incident (SI) monitoring report: The Committee noted that the Trust remained in a high reporter / low resultant harm position in relation to serious incidents, which was felt to be an indicator of a positive reporting culture. The most frequently causes of reported serious incidents related to pressure ulcers, slips, trips and falls, and mental health 12 hour breaches in the emergency department. It was noted that a number of safety work streams were in place, with each work stream reporting through the quality and safety sub-committee. The quality improvement project to review the SI process continued with the first phase of delivery taking place between September and October 2017.

Infection Prevention & Control (IPC) report: The Committee were pleased to note that the number of C.difficile cases attributable to the Trust for quarter 1 was below the threshold trajectory and that there had been no lapses in care related to C.difficile in the quarter. Shortages of key antibiotics continued to challenge the antimicrobial stewardship programme, but it was noted that antibiotic usage was its lowest for five years.

Health and safety report: The Committee noted that violence and aggression remained a risk to staff, particularly in high risk areas such as the emergency department; the security committee continued to manage and mitigate this risk. The Committee were pleased to note the reduction in slips, trips and falls following the programme of work that had been undertaken with Sodexo. It was noted that the Health and Safety Executive (HSE) had recently visited the clinical research facility; the outcome of this visit would be reported to the Committee once the HSE report had been received.

Flu plan: The Committee were pleased to note the flu plan and comprehensive implementation plan that was being led by the Trust's improvement team and occupational health team.

Friends and Family Test (FFT): The Committee expressed concern at the low number of responses to the friends and family test at St Mary's Hospital emergency department. It was agreed that an action plan to improve this would be developed in order to collect important feedback from patients and their families.

Patient Led Assessment of the Care Environment (PLACE) Report : The Committee noted that the Trust's results had improved overall from the previous year. Whilst estates issues continued, which had impacted scores, the Committee noted the continuing works to address the issues and mitigate the risks. The Committee were pleased to note the encouraging report and highlighted the significant improvements made at the Western Eye Hospital by the new leadership team in place.

Imperial College Healthcare NHS
NHS Trust

GMC National training survey 2017 results: The Committee noted the actions in place to address the areas of concern and were pleased to note the improvements from the previous year, particularly that there had been no reports of bullying or harassment.

RECOMMENDATION:
The Trust board is requested to:

- Note the report

Report from: Sir Gerry Acher, Acting chairman, Quality Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: 15 November 2017