Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC

26 July 2017

11.15 – 13.00

New boardroom, Charing Cross Hospital

Agenda Number		Presenter	Timing	Paper
1	**Administrative Matters**			
1.1	Chairman's opening remarks & apologies	Chairman	11.15	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 24 May 2017	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 24 May 2017	Chairman		2
1.5	Action Log and matters arising	Chairman		3
2	**Operational items**			
2.1	Patient story	Director of nursing	11.20	4
2.2	Chief Executive's report	Chief executive		5
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		6
2.4	Month 3 Finance report	Chief finance officer		7
3	**Items for decision or approval**			
3.1	Complaints annual report	Director of nursing	11.55	8
4	**Items for discussion**			
4.1	CQC update	Director of nursing	12.00	9
4.2	CQC outpatient and diagnostic services inspection report	Director of nursing		10
4.3	Responsible officer's annual report	Medical director		11
4.4	Corporate risk register	Director of nursing		12
4.5	Children's safeguarding annual report	Director of nursing		13
4.6	Adult safeguarding annual report	Director of nursing		14
4.7	Research quarterly report	Medical director		15
4.8	Engagement survey results	Director of P&OD		16
4.9	Freedom of information (FOI) report	Director of communications		17
5	**Items for information**			
5.1	Quality account 2016/17	Medical director	12.45	18
5.2	National Cancer Patient Experience survey results	Director of nursing		verbal
5.3	STP Health & Social Care Transformation Group	Chief executive		19
5.4	Key legislation for board members	Trust company secretary		20
6	**Board committee reports**			
6.1	Finance and investment committee	Committee chair	12.50	21
6.2	Redevelopment committee	Committee chair		22
6.3	Audit committee minutes and Audit, risk & governance committee report	Committee chair		23
6.4	Remuneration committee	Committee chair		24
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
			12.55	
9	**Date of next meeting**			
	Public Trust board: Wednesday 27 September 2017, Clarence Wing Boardroom, SMH			

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 24 May 2017
11.15 – 13.00
Oak Suite, W12, Hammersmith Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerry Acher	Deputy Chairman
Dr Rodney Eastwood	Non-executive director
Dr Andreas Raffel	Non-executive director
Sarika Patel	Non-executive director
Peter Goldsbrough	Non-executive director
Victoria Russell	Non-executive director
Nick Ross	Non-executive director
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
Dr Julian Redhead	Medical director
In attendance:	
Prof Tim Orchard	Divisional director, medicine and integrated care
Michelle Dixon	Director of communication
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Jan Aps	Trust company secretary (minutes and items 1.6 and 3.1)
Prof Jonathan Weber	AHSC director (item 4.4)
Michael Morton	Chair of strategic lay forum (item 4.1)

1	**Administrative Matters**	**Action**
1.1	**Chairman's opening remarks and apologies** The Chairman welcomed members, attendees and members of staff and the public to the meeting. Apologies had been received from Prof Andy Bush, Prof TG Teoh, Dr Katie Urch, and Prof Gavin Screaton. The Chairman noted that it was Dr Rodney Eastwood's last Trust board meeting as a non-executive director, and extended both his personal thanks and the Trust board's thanks for his many years of commitment and support of the Trust, both in its current and previous guises.	
1.2	**Board member's declarations of interests** There were not additional declarations of interest made at the meeting.	
1.3	**Minutes of the meeting held on 29 March 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 29 March 2017** The Trust board noted the report.	
1.5	**Action Log and matters arising** The Trust board noted the updates provided.	
1.6	**Use of the Trust seal**	

	The Trust board noted the use of the Trust seal on the listed documents between April 2016 and March 2017.	
2	**Operational items**	
2.1	**Patient Story** Prof Janice Sigsworth introduced Mr E. Mr E outlined his experience of developing type 1 diabetes in his youth which brought to an end his football career, and his understandable poor compliance with his care regime due to anger at his situation, which brought on complications in the shape of kidney disease twenty years later. From April 2014 he had been required to undertake dialysis three times a week; his first experiences had been difficult, in a very busy clinic at Hammersmith, and had brought on feelings of panic. On being able to move to the clinic at St Charles' Hospital, his experience had improved. Following kidney and pancreas transplantation six months later, he was first cared for on the high dependency unit on Derwardner ward, where he had found the 'care humbling and the nurses frighteningly good'. On being transferred to Peters ward as his recovery continued, he observed that it felt more stretched, and the nurses very busy, which impacted the care. Following discharge, he initially attended Monday clinics, which were particularly busy, but had been able to transfer to the Wednesday clinic which he found to be quieter; he was pleased to see the planned improvements to the environment. Whilst recognising the financial pressures that the NHS was under, he asked that consideration be given to the increasing the staffing levels in Peters ward. Responding to a query from Nick Ross, Mr E commented that all staff had received his thanks personally. Dr Tracey Batten thanked Mr E for coming to the Trust board to share his heart-wrenching experiences. Dr Rodney Eastwood commented that patients' initial experience of dialysis and similar treatments was often distressing, partly due to poor explanation of the equipment and the way in which alarms often sounded which created anxiety if not first explained. The Trust board noted the patient story.	
2.2	**Chief Executive's report** Dr Tracey Batten particularly highlighted the cyber-attack experienced by the NHS on Friday 12 May, and confirmed that the Trust had remained free from virus infection, thanks to the comprehensive efforts of the information team, led by Kevin Jarrold, and contribution from the site director's teams. There had been an operational impact in that the Trust had dealt with a number of major trauma patients that would normally have been taken to Barts Health NHS Trust; again, staff dealt with this very effectively. The Trust board noted the report.	
2.3	**Integrated performance report** SAFE/ EFFECTIVE: Dr Julian Redhead was pleased to report that the Trust had last had a never event in November 2016, and continued to have high reporting of incidents with a low incidence of harm. CARING: Janice Sigsworth reported that the number and severity of pressure ulcers had reduced, thanks to significant focus by clinical teams. Ensuring availability of sufficient and appropriate staffing remained a challenge, but one on which attention remained focused by both operational and human resources teams, with the recent commencement of a nursing associate programme pilot. WELL-LED: David Wells confirmed that the work on recruitment and retention in areas of vacancy gaps continued and was expected to show an impact shortly. He also noted that the performance development review appeared low, as the process for 2017/18 had only commenced in April. Recognising the high number of RIDDOR accidents reported, he reflected that on initial review it appeared to be catching up on unreported incidents over a period of time, but he would confirm this was the case. RESPONSIVE: Dr Julian Redhead reported that, whilst ensuring that patients were treated in a timely manner remained challenging and that the Trust was not achieving	DW

	the referral to treatment target, the number of patients waiting over 52 weeks was falling as planned. He confirmed that no patient had suffered significant harm from their extended wait for treatment, although recognising the delay itself was often of some harm to patients. Cancer performance remained strong overall, and the Trust was working with partners to ensure improvement across the sector. Responding to a query from Sarika Patel, he recognised that the total number of patients who had waited over 52 weeks had been higher than initially identified (increasing as more specialties had been reviewed), but confirmed that there would be no long wait patients by the end of the calendar year. Prof Tim Orchard reported that there was a clear national focus on emergency department performance in 2017/18; with 89.7% of patients having been and treated in April 2017, the Trust was on target to achieve 90% by September 2017. The plans had been reviewed by NHS Improvement and NHS England, and considered that they effectively mitigated the increased activity expected, which was likely to be significantly above the 1% which the CCG had planned. Prof Orchard replied to Dr Eastwood's question by confirming that there had been a delay to the refurbishment at St Mary's (air handling issues) but that it was likely the department would commence using the facility given that the air handling, whilst not at optimum level (until August), was better than had previously been the situation. Work was also underway to plan an expansion of the emergency department at Charing Cross Hospital, using space previously leased to the CCG. Responding to a query from Sir Gerry Acher, Prof Orchard outlined the six streams of activity being addressed to achieve the planned trajectory, including the work in partnership with other organisations, led by the A&E delivery board. Noting Dr Andreas Raffel's question as to how the Trust was supporting work which would reduce inappropriate attendance at the emergency department, Prof Orchard reflected that the Trust's focus was to ensure the effective 'streaming' of patients as they arrived, and to encourage CCGs to take action in primary care. He also noted that the Trust's emergency departments did not particularly experience this phenomenon; the key issue was the increasing number of sick patients requiring short stay hospital care, whom it was then difficult to discharge in a timely but safe manner. Dr Batten commented that the STP was taking a pan-organisation approach to these issues, and the Trust was a key part of the discussions. The Trust board noted that Dr Julian Redhead had been appointed as the co-chair to the Clinical board for the STP. Dr Julian Redhead noted that there had been a specific issue identified in diagnostic endoscopy, where, due to a change in administrative process at the start of the calendar year, approximately 300 patients had experienced extended waits for their procedures. A full investigation was in progress, and, thus far, no patient had been found to have come to harm as a result of the delay. Responding to a query from Dr Andreas Raffel relating the continuing issues in estates response times, Prof Sigsworth confirmed that following further discussions with the contractor and review of the contract, it was expected that response time would improve, although this may take between three and six months. The Trust board noted the integrated performance report.	
2.4	**Month 12 2016/17 Finance report and update on plan for 2017/18** Richard Alexander reported that, subject to final external audit, the Trust had delivered £54m of efficiencies, slightly over-achieved its year-end forecast, and met the control total set by NHS Improvement. In looking forward to 2017/18, however, he reported that the Trust had submitted a £41m deficit plan to NHS Improvement; this did not meet the control total set, which would mean that the Trust would not receive additional sustainability and transformation funding (STF) which had been made available in 2016/17. Responding to a query from Sir Gerry Acher, Richard Alexander commented that it had yet to be confirmed whether the Trust would receive the identified funding for two LINACs.	

	The Trust board noted the paper, including the risks and proposed actions.	
3	**Items for decision or approval**	
3.1	**NHSI Self-certification requirements** Jan Aps introduced the paper, noting that NHS Improvement had introduced a requirement for NHS Trusts to complete self-certification statements in a similar manner as previously only required by foundation trusts (FT). The statements were linked to the FT licence conditions which could not be directly read across to NHS trust legislation, but acted under the powers whereby the Secretary of State had issued directions to NHS Improvement to ensure similar oversight of NHS trusts as in place for FTs. The Trust board: • Confirmed that the Trust had well-established and effective processes and systems to identify risks and guard against their occurrences in 2016/17, and that these were still in place and that their implementation and effectiveness was regularly reviewed on an ongoing basis (condition C6); • Confirmed that the Trust applied those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS (as listed in condition FT4), other than, in recognising the deficit budget position for 2017/18, it could not confirm (a) 'compliance with the Licensee's duty to operate efficiency, economically and effectively'; • Agreed that sufficient assurance had been provided to the Trust board during 2016/17 (and continued to be provided) to enable the Trust board to confirm that the statements provided were considered to be an accurate reflection of the Trust's position; • Agreed to the publication of the statements FT4 and C6 being published within the Trust's publication scheme on the Website.	
4	**Items for discussion**	
4.1	**Patient and public engagement** Michelle Dixon introduced Michael Morton as the Chair of the strategic lay forum, noting that the report formed the annual review of the Trust's progress with the patient and public engagement strategy. She commented that much had been achieved, including the involvement of 14 new lay partners, an encouraging growth in lay partner engagement with specific projects, and an open day in October 2016; however, much was left to do, for which a 2017/18 action plan had been developed. Michael Morton fully endorsed the paper, and welcomed the genuine focus on working in partnership with patients and the public to improve services. He recognised that he sought to make the forum more diverse in its representatives, but thanked the existing lay representatives for their willingness to engage and support the work of the forum. In discussion, Sarika Patel cautioned against the use of the acronym 'PPI' given its broader use in financial services, and asked when key performance indicators could be introduced; Michelle Dixon responded that the Trust was working with Imperial College to develop these. Responding to a question from Dr Batten, she outlined that the key priority for 2017/18 would be the embedding of lay partners in co-production in all key areas of strategic change, and the mapping of all project groups and where lay partners are and are not involved. Reflecting on a query from Peter Goldsborough, Michael Morton confirmed that he saw the strategy as a key part of moving to a patient-centred approach to service development. The Chairman expressed the Trust board's thanks to Michael Morton and the strategic lay forum. The Trust board noted the progress against the strategy and endorsed the priorities for 2017/18.	

4.2	**CQC quarter 4 update** Prof Janice Sigsworth introduced the report, noting that the Trust continued to await the final CQC report for the outpatient and diagnostic services inspection in November 2016, and also the report following the inspection of medical services across the Trust and maternity services at St Mary's Hospital undertaken in February 2017. Prof Sigsworth also reported that the Trust would receive a 'well-led' assessment, which was likely to be co-terminus with the use of resources assessment which would be undertaken by NHS Improvement. She noted that, other than the annual 'well-led' assessment, all future inspections would be unannounced; full details of the revised arrangements were awaited. The Trust board noted the report.	
4.3	**Emergency planning, risk and resilience (EPRR)** Prof Janice Sigsworth reported that the Trust had, that morning, received notice that the threat level had increased to 'critical' (meaning a terrorist attack was imminent); the Trust was reviewing all arrangements, stocks, and staffing, to ensure a state of heightened readiness. In introducing the report, Prof Sigsworth, highlighted: • The successful response and activation of a number of the emergency plans in response to a number of incidents, and the debrief and learning from such incidents; • The continuing EPRR simulation exercises and training; • That action plans were in place to address the three amber measures (out of a total of 51) following the annual NHS England assurance review; • The Trust's response to the Westminster incident on 22 March 2017. Responding to a query from the Chairman, Prof Sigsworth outlined the way intensive care resources could be expanded, if required, in response to a major incident with the shifting of resources between sites, and use of recovery and high dependency areas; she noted that the Trust was considering the purchase of additional ventilation units. In answer to Sir Gerry Acher's enquiry, she reflected that St Mary's Hospital, as a major trauma unit, felt on perpetual standby and readiness for handling incidents. The Trust board noted the updates, and confirmed that it provided sufficient assurance as to the Trust's emergency planning, risk and resilience preparedness.	
4.4	**Academic health science centre (AHSC) update report** Prof Jonathan Weber introduced the report and presentation, noting that since the previous report, The Royal Brompton and The Royal Marsden NHS FTs had joined the AHSC, which provided a real opportunity to broaden research opportunities in the future focusing on a joint vision of 'preventing disease, earlier diagnosis of disease, and better treatments for disease'. Within the broader AHSC, the close relationship between the Trust and Imperial College remained. Prof Weber outlined the progress being made in terms of use of informatics to enable greater use (with appropriate information governance and ethics controls) of patient data, initially in relation to five disease groups. The Trust board noted that the AHSC was also focusing on increasing the availability of, and engagement in, research training opportunities for non-medical clinical staff to pursue higher degrees. Responding to a query from Peter Goldsbrough, Prof Weber commented that the most advanced research use of informatics was in acute coronary syndrome, where the work was now being clinically led, with clinical trainees, comfortable with 'coding', enabling effective use of the data sets. Responding to Nick Ross's comments on the inherent tension between patient privacy and best use of patient data, Prof Weber confirmed that patient consent was key to any use of data, and that anonomised data was appropriately used. Noting the shared Cerner platform between the Trust and Chelsea & Westminster Hospital NHS FT (C&W), the Chairman asked if C&W were	

	involved. Kevin Jarrold noted that C&W had yet to make significant progress towards electronic patient records, but would become more closely engaged in the programme once this was embedded. The Trust board extended thanks to Prof Weber, and noted the informative report.	
5	**Items for information**	
5.1	**Summary of STP Joint health and care transformation group** The Trust board noted the STP meeting summary.	
5.2	**Cost improvement programme Quality impact assessments (QIA)** Prof Janice Sigsworth introduced the quarterly review of the CIP QIA process, which ensured that the impact on the quality of care resulting from CIPs was fully considered before schemes were implemented, noting that, following review of the policy, the QIA process for low risk schemes had been simplified. The Trust board noted the report, and took assurance that the Trust had a robust policy and process in place to minimise the risk to, and impact on, patient care of any cost improvement proposals.	
5.3	**Delivering our promise: Better health for life** Michelle Dixon introduced the refresh of the 'better health for life' poster, which illustrated the connections between the Trust's values, strategies, key initiatives and 'promise', encompassing key elements of the 2017/19 business plan. The Trust board noted the refresh.	
6.1 – 6.4	**Board committee reports** The Trust board noted the reports from the following committees: • Finance and investment committee • Redevelopment committee • Quality committee • Audit, risk & governance committee (and audit minutes).	
6.5	**Remuneration committee** The Trust board noted the report from Sarika Patel as committee chair and ratified the appointment of Dr Katie Urch as divisional director for surgery, cancer and CV.	
7	**Any other business**	
	There was no other business.	
8	**Questions from the Public relating to agenda items** Responding to a question from a member of the public in relation to longer term plans for the A&E department at Charing Cross Hospital, Dr Batten confirmed that the SaHF plans remained, but confirmed that the NWL sustainability and transformation plan (STP) had clearly caveated that plan by stating that the health economy would require assurance that sufficient capacity existed in the community before enacting any changes. Whilst next steps may depend on the outcome of the election, it was likely that post-2021 STP plans would start to be developed after the mid-point of the existing STP.	
9	**Date of next meeting**	
	Public Trust board, Wednesday 26 July 2017, New Boardroom, Charing Cross Hospital	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Record of items discussed at the confidential Trust board meetings on 24 and 31 May 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 24 May 2017:

Global digital exemplar business case
The Trust board approved the plans for the global digital initiative as outlined in the business case, focused on enabling the Trust to move forward more quickly with the implementation of its digital strategy.

Business plan, control total and capped expenditure process
The Trust board heard that a capped expenditure process had been introduced by NHS Improvement, such that where individual organisations could not achieve their control total, the STP would need to consider alternative approaches to ensuring that the control total was achieved at STP level. The Trust board considered further cost saving options prepared by the executive team.

Quality account
The Trust board approved the content of the quality account for 2016/17, confirming that, to the best of their knowledge the Trust had complied with the requirements in preparing the document; and authorised the signing of the document by the chairman and chief executive.

Annual accounts preparation, and Annual report and governance statement

The Trust board noted that preparation of the accounts was progressing well, and that the auditor had confirmed that there had been no material corrections to the financial statements. They also noted that the report and statement were almost complete, and had been reviewed by the auditors.

Issues of note and decisions taken at the Trust board's confidential meetings held on 31 May 2017:

Accounts and annual report 2016/17
The Trust board approved the annual accounts for submission, and approved the annual report, including the governance statement, for submission.

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	Tracey Batten, Chief executive

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status update
RIDDOR incidents: to review and report whether the apparent increase in incidents resulted from 'catch up' or genuine increase	May 2017 2.3	David Wells	The number reported has increased, however, this is likely to be due to better identification and reporting of RIDDOR. The statistics are 2014/15 = 30 (of which there were 7 dangerous occurrences, 13 Slips trips and falls) 2015/16 =32 (6 DOs, 12 ST&F) 2016/17 = 44 (16 DOs and 17 ST&F) 2017/18 = 14 (8 DOs and 2 ST&F). This is after the first 3 months, suggesting a pro rata end of year figure of about 56 In particular, more sharps dangerous occurrences were reported last year, compared to previous years, due to greater awareness of the need to RIDDOR report such incidents. Slightly fewer sharps incidents are expected this year, as more control is secured over this risk. However a significant increase is expected in the number of dangerous occurrence incidents involving '(accidental) exposure to hazardous substances' reported, due to better identification of these incidents. Slips trips and falls are expected to reduce as the incidence of overly wet floors reduces

MATTERS ARISING

Minute Number	Action /issue	Responsible	July 2017 Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Imperial College Healthcare NHS Trust

Report due	Report subject	Meeting at which item requested	Responsible

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 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 aspire to deliver excellent innovative care led by experts working in collaboration across teams and with the patient and the positive impact this can have on a patient and their family.

Mr R will tell his story about his experience when he was treated for oesophageal cancer requiring major surgery and how the PREPARE programme supported him through this challenging period of his life.

Quality impact:

The board will hear how staff adopting innovative approaches to care results in improved patient care and outcomes 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
Stephanie Harrison-White Guy Young	Janice Sigsworth	13 July 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. There is an expectation from both commissioners and the Trust Development Authority that ICHT will use this approach.

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. Introduction to PREPARE

As part of the north west London specialist oesophago-gastric cancer service, we provide centralised expertise in the diagnosis and treatment of oesophageal-gastric cancer, including a full range of diagnostic tests, scans and examinations for patients suspected of oesophageal or gastric cancers.

Diagnosed patients are fully supported by our specialist oesophago-gastric cancer multidisciplinary team (MDT), consisting of oncologists, surgeons, nurse specialists and other professionals who meet every week to discuss new and recurrent cases of oesophago-gastric cancer.

Patients who are having oesophago-gastric surgery are recommended to take part in the PREPARE for surgery programme. This program offers a personalized programme of support throughout the peri-operative period focusing on physical, psychological and emotional well-being and providing coaching and tailored support in the areas of:

- physical fitness
- respiratory exercises
- healthy eating
- psychological wellbeing
- medication
- smoking and alcohol
- enhanced recovery after treatment

Last year the Board heard from Venetia Wynter-Blyth (upper GI clinical nurse specialist) about the PREPARE programme. The programme, funded by Imperial Health Charity has proved to be so successful that it was recognised through the RCNi Innovation Award and Venetia received the Nurse of the Year 2016 by the Royal College of Nursing (RCN). PREPARE has since been awarded the BMJ Surgical Team of the Year award, BMJ award

for Patient Partnership and the NIHR CLAHRC Brian Turley award for patient and Public Involvement 2017.

3. Mr R's story

Mr R is a London business owner, a husband and father who was diagnosed with oesophageal cancer just over a year ago. He will describe the devastating impact this diagnosis had upon him and his family and how overwhelming the diagnosis and the information he was given felt at the time.

Participating in the PREPARE programme helped him to focus and feel reassured and supported, bringing 'order and calm' to his life and enabling him to set goals and take 'one step at a time'. He will describe how he felt the teams were working together with him and that he felt 'people knew about' him and he wasn't 'forgotten'.

Mr R will describe how the PREPARE programme works and the value of the interactive app referred to as their 'constant companion', in keeping patients 'on track'. Although the focus of the programme is on the pre-operative period, Mr R explains how key members of the PREPARE team continued to support him, helping him through a difficult emotional journey following the surgery.

Today Mr R is recovering well, stating he feels healthier and more positive now than he did before he was diagnosed with cancer. He attributes this to the impact of the PREPARE programme, helping him to develop and sustain the positive changes he has made.

He has recently climbed Snowden alongside members of the PREPARE programme to help raise money to support the ongoing work of this team.

4. Lessons learnt

Patients benefit greatly from having access to intensive positive programmes of support pre-operatively and this can result in improved outcomes and quality of life post operatively, as demonstrated by Mr R.

The PREPARE programme brings together a team of people working *collaboratively* with each other and the patient. The programmes *aspirations* have been translated into practice providing patients with access to *expert* knowledge and care, delivered by a team who demonstrate *kindness* towards patients and their families.

It is recognised that other patients would benefit from this programme and therefore it is the *aspiration* of the team to extend this work across other cancer groups and clinical specialities.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	26 July 2017

Chief Executive'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
6) Patient letters disruption
7) Hospital documentary series
8) Fire safety

Key strategic issues:

1) St Mary's Hospital redevelopment plans
2) Paddington Quarter development and proposed new access road update

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 efficiently and with 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
Tracey Batten	Tracey Batten, Chief Executive	18 May 2017

Chief Executive's report

Key Strategic Priorities

1. Financial performance

For the 2017/18 financial year the Trust has a planned outturn of a £41m deficit. This is in line with the £41m deficit outturn, before sustainability and transformation funding, in 2016/17. The deficit planned currently leaves a £23.4m gap to the 'control total' set for the Trust by NHS Improvement meaning that we are not eligible for STF funding this year. The Trust is working in collaboration with partners across the North West London Sustainability and Transformation Plan footprint to develop options to close the sector's control total gap.

In June 2017, the Trust reported an in-month deficit of £4.1million which was on plan for the month. Year to date (i.e. the 3 months up to the end of June 2017) the Trust reported a deficit of £15.0m which is on plan. The Trust has not completed a detailed forecast for the year but is expecting to achieve the £41m deficit plan

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.

Against this plan we currently have £10.4m yet to be identified. The divisions continue to work hard in identifying and delivering further efficiencies, supported by an internally established Programme Support Office. There are other opportunities being developed and there are also mitigations being forecast against this position.

In addition the Trust is working with various information sets, including the 'Model Hospital' data from Lord Carter's review of hospital efficiency and GIRFT 'Get It Right First Time' to help identify cost and quality improvements and reduce unnecessary variation in the way we do things. We continue to work alongside our STP colleagues and wider partners to plan effectively and share best practice.

Further opportunities to improve our financial sustainability will be identified as part of our new specialty review programme – a clinically-led approach to supporting all of our clinical specialties to develop unified and sustainable clinical, workforce and financial plans.

3. Operational Performance

Cancer 62 day waits: In May 2017 the Trust underperformed against the 62-day urgent GP referral to treatment for all cancers. The performance was 77.7 per cent (compared with April 2017 of 86.1 per cent) which did not meet the trajectory target of 85.0 per cent or more. Performance continues to be impacted by late referrals and patients being referred with incomplete diagnostics from other trusts which is subject to an intensive piece of work in North West London to jointly resolve these issues.

Accident and Emergency: Performance against the four-hour access standard for patients attending Accident and Emergency was 90.4 per cent in June 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 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.

A four-hour performance steering group has been established to oversee a 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. Each work stream is led in partnership by a senior clinician and a senior manager.

Referral to treatment (RTT):

The latest reported performance is for the end of May where 85.0 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 an improvement on the position reported in April of 83.4 per cent and achieved the trajectory target of 81.8 per cent.

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 WLIP also oversees the management of the clinical review process which provides assurance that patients who wait over 52 weeks are not coming to harm. Significant progress is being made on all of the aspects of the programme, including the data clean-up of the waiting lists, the roll out of a new clinical outcome form across the Trust, the establishment of right first time processes, additional clinical activity and theatre capacity and performance recovery trajectories. The project continues into 2017/18.

Elective capacity modelling has now been completed and actions are underway to support improvements. Additional capacity is also being delivered for outpatients and work is on-going to quantify the capacity and demand gap to inform future planning.

The Trust reported 196 patients waiting over 52 weeks at the end of May; this was an improvement on April reported position of 217 patients. 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.

Diagnostic waiting times:
In June 2017, 7.73 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 which identified a recent issue with patient tracking and the recording of offer dates for some endoscopy patients.

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

We have continued our regular stakeholder engagement programme. I met with Olivia Clymer the recently appointed chief executive of Healthwatch Central West London on 19 June. We held a meeting with representatives of Save our Hospitals on 26 June. On 6 July, I met Cllr Heather Acton, Westminster City Council's Cabinet Member for Adult Social Services and Public Health, with Dr Neville Purssell, chair of NHS Central London Clinical Commissioning Group.

On 13 June we attended Hammersmith & Fulham Council's health scrutiny committee to discuss our annual Quality Account 2016/17.

In addition, we published the Trust's three, bi-monthly electronic newsletters for stakeholders, GPs and Trust members.

Jointly with Clare Parker of the North West London Collaboration of Clinical Commissioning Groups, I have responded to a letter from Cllr Stephen Cowan, chair of the London Borough of Hammersmith and Fulham. This correspondence relates to a complaint we made in March that the Council's distribution of materials about the future of Charing Cross Hospital is causing significant, unnecessary distress to patients and staff. Our joint letter sets out a summary of the key decisions relating to Charing Cross since 2012 as well as the latest position. We make clear that we need to create a shared understanding of the huge challenges we are facing in the NHS and social care if we are to address them effectively and that we wish to work with all of our local authorities as key partners in this endeavour. (The full response is attached – appendix 1.) We are developing an engagement plan to roll out from this autumn to inform the development of all of our services and sites over the coming years which we hope will facilitate more constructive and positive discussion with all of our stakeholders and partners.

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 has commenced for the outpatients refurbishment at Charing Cross with a planned completion date of March 2018.

Work continues on the refurbishment of the main and renal outpatients at Hammersmith Hospital. The main outpatients work is scheduled to complete this month with the renal outpatients refurbishment to commence this month and complete in September 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: As part of the emergency department improvements the remodelling of the resuscitation and paediatric areas has reached its final phase of works. These include creating a new clinical decision unit within the paediatric emergency department, refurbishment and expansion of resuscitation from four to six bays, and creating a new combined assessment space for ambulance and self-presenting patients. Works are scheduled in four phases and, phase three, new reception and waiting area has recently been completed and phase four which will be the new clinical decision unit will be complete late August 2017.

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 December 2018.

The project is funded through both Trust capital and Imperial Health Charity funding.

Backlog works including lift replacements across Charing Cross and St Mary's hospitals: As part of the continued works under back log maintenance, there is a major lift replacement programme currently underway on the seven main lifts in the St Mary's QEQM building, and the seven main tower lifts at Charing Cross Hospital.

The replacement programme will continue throughout 2017/18 and is due to complete in May 2018.

Replacement of catheter labs A & B at Hammersmith Hospital: As part of the managed service contract the Trust has with Medtronic, two new labs are planned for refurbishment and replacement equipment. This project is currently in design and works are scheduled to be completed late summer 2017.

New Replacement MRI at Hammersmith Hospital: A new MRI will be installed at Hammersmith to replace the existing MRI in A block. Works are planned to start at the end of August 2017 with completion by February 2018. The scheme has been fully funded through the Trust's capital programme.

Some other capital projects currently in feasibility include:

- Refurbishment of 7 North Ward at Charing Cross Hospital
- Imaging machines replacement programme – all sites
- Reorganisation of critical care to create co-located HDU provision- St Mary's Hospital.

6. Patient letter disruption

Over a four-week period in late May and early June there was some disruption to the production of patient letters due to a computer error. This will have impacted appointment letters for outpatient clinics and hospital admissions. A detailed root cause analysis is being carried out and we are putting in place measures to ensure this does not happen again.

We have reviewed the impact on patients and, of 4,354 patients who should have been sent a letter but who were not, 83% still attended their appointment, having been notified through telephone calls and voice and text reminders. However, others did miss appointments and had delays to their care. We contacted patients to explain and to re-book appointments, urgently where necessary. We are undertaking a clinical review of the missed appointments; so far we have not found any incident of harm to patients as a result of the delay to their attendance.

7. *Hospital* documentary series

Series 2 of *Hospital* aired from 20 June to 11 July 2017 at 9pm (or 9.30pm) on BBC2:

- Episode one focused on the Trust's response to the Westminster Bridge terrorist attack.
- Episode two looked at treatment options for patients with cancer across our NHS services, self-pay and insurance-funded private care.
- Episode three explored how acute hospitals work with mental health and social care partners in often complex and challenging circumstances to provide support to those in crisis.
- Episode four explored how cardiology, cardiothoracic surgery and neurosurgery are developing new models of care and pushing the boundaries of what's possible technologically, while also making efficiency savings across the board.

To launch the series we led a press screening and Q&A of the first episode, hosted by the controller of BBC2. A range of positive coverage about the series was generated across local, regional, national and international press.

For each episode, we developed an integrated communications approach spanning internal communications, media, stakeholder relations, social media and digital. Content shared included a mix of blog posts, frequently asked questions, videos, staff profiles, live tweeting and Facebook posts, all of which are available on the Trust website: https://www.imperial.nhs.uk/about-us/bbctwohospital

We also produced content for a special recruitment campaign to coincide with the series, using a refreshed design and consistent messaging and linking to a new careers area on our main website that we brought back in-house from a separate microsite in time for the series kick-off. Imperial Health Charity ran its own website and social media campaigns in co-ordination with the Trust.

We are working on a full evaluation of the impact of both series of *Hospital*. Early data from series 2 includes:

Viewing figures

Episode	Average live viewers	Share of total TV live viewing
1	2.2 million	12%
2	1.6 million	9%
3	1.2 million	7%
4	1.4 million	7%

We are still waiting for consolidated viewing figures that include people watching via iPlayer.

Digital content on our website

During the four week run, we saw over an 80 per cent increase in weekly unique visitors to the Trust website compared with the weekly average for 2016, up from an average of 20,900 to 37,900. During the four-week run, the careers section of the website had an almost 40 per cent increase in weekly page views compared with the weekly average for May 2017, from 3,370 to 4,700 (the careers content was on a separate microsite before that so is not directly comparable).

The top three most-read blogs linked to the series are currently:

- Working in the midst of a major incident: first-hand experience from A&E by Dr Ali Sanders
- Why A&E is struggling to be a ‘place of safety’ for mental health patients in crisis by Claire Braithwaite
- Behind the statistics: why we need a cultural change in our approach to dementia care by Dr Colin Mitchell.

Social media

We have seen over a 700 per cent increase in weekly twitter impressions (the number of times tweets from the Trust's corporate account were viewed) when comparing weekly impressions across the four-week run with weekly impressions across June 2016. This is up from 15,800 impressions to 130,200 impressions.

Our most popular tweets included (all over 10,000 impressions):

- Meet Natalie Marroney, major trauma and acute neurorehabilitation therapy team lead #hospital #imperialpeople
- Read more about #dementia in Dr Colin Mitchell's blog post #hospital
- Learn more about the iKnife, a surgical tool used during Ben's operation as part of a clinical trial #hospital

We have seen over a 130 per cent increase in weekly facebook impressions (the number of times posts on the Trust's corporate account were viewed) when comparing weekly impressions across the four-week run with weekly impressions across June 2016. This is up from 49,500 impressions to 117,200 impressions.

8. Fire safety

The Trust has an extensive fire safety improvement plan. This is incorporated in to a memorandum of understanding with the London Fire Brigade, which was signed in August 2016.

The improvement plan runs over six years and has prioritised actions to be delivered year on year.

Following the Grenfell Tower fire, the Trust has reviewed the nature of all cladding on buildings across the Trust sites. On first review, the Trust has no Grenfell Tower-like cladding ,It does have a small amount of cladding on some buildings though not on the tower blocks at Charing Cross or St Mary's.

The Trust is reviewing the improvement plan and priorities as well as increasing fire safety and evacuation training with live exercises at Charing Cross and St Mary's planned for September and October this year.

Key Strategic Issues

1. St Mary's Hospital redevelopment plans

In July, property developers were invited to participate in a 'soft market testing' process as an early step in the full redevelopment of the St Mary's Hospital site in Paddington as well as the Western Eye Hospital and the adjacent former Samaritan Free Hospital site in nearby Marylebone.

We are undertaking this informal engagement exercise with developers to test our current approach, set out in a high level, indicative 'masterplan'.

This follows on from phase one plans to develop a new outpatient building on the eastern edge of the St Mary's site, a planning application for which is being considered by Westminster City Council following extensive engagement and consultation with staff, patients, local communities and stakeholders. We currently anticipate a decision on this application at the September meeting of Westminster City Council planning committee. The consultation materials also included the current, indicative masterplan.

The wider redevelopment is intended to provide much needed new, high-quality hospital facilities on the St Mary's site, with complementary commercial and residential 'mixed use' developments to help fund the programme. We will be looking to use land that is surplus to our own needs to help fund the costs of the redevelopment, in full or in part.

We have always been clear that our intention is to at least maintain the current capacity of the hospital in new facilities. Services from the Western Eye Hospital are intended to be moved to new facilities on the St Mary's site. This will require fewer but larger hospital buildings, across a smaller footprint.

We are working in close partnership with Imperial Health Charity who own parts of the St Mary's and Western Eye/Samaritan estate, and with Imperial College London who own their own faculty of medicine building within the boundaries of the St Mary's site. Our regulators, NHS Improvement, are also supportive of our approach.

2. Paddington Quarter development and proposed new access road update

In December 2016, Westminster City Council's Planning Application Committee gave its approval, with conditions, to development proposals for the Paddington Quarter at 31 London Street, the former Royal Mail sorting office adjacent to St Mary's Hospital. The proposals were put forward by Great Western Developments Ltd and its development partner Sellar Property Group.

As updated previously, while the Trust is very supportive of the regeneration of the Paddington area, we and a number of London-wide NHS organisations have serious safety concerns about plans for a new access road to St Mary's Hospital as part of the development. The new road, as currently designed, will cause delays in access to and from the hospital, including for 'blue light' ambulances.

Together with the London Ambulance Service, we have raised concerns at every stage of the planning process – with the developers, Westminster City Council, the Mayor of London and the Secretary of State for Communities and Local Government. Leaders of the London region of NHS England and NHS Improvement have also raised their concerns directly with the Council and the Mayor.

The very last stage of the planning process – the finalisation of a section 106 agreement between Westminster City Council, Transport for London, Network Rail and the developers – is now approaching signature and our concerns remain unresolved.

On 16 June 2017, London Ambulance Service chief executive, Garrett Emmerson, and I sent a letter to Charlie Parker, chief executive of Westminster City Council, following a final meeting about the new access road which took place on 23 May 2017. The letter stated (full letter attached – appendix 2):
"Whilst our serious concerns have been explained in meetings and through correspondence, it has become clear over the course of these engagements, that these concerns are not shared. It is our understanding that Westminster City Council, the GLA and Transport for London believe that the Paddington Quarter proposals provide a safe access route into St Mary's Hospital, and so will not impact on the operational running of the hospital and the ability of the London Ambulance Service to provide an emergency ambulance service to this emergency department, major trauma centre and also at times of major incidents. The Trust and LAS therefore find themselves in a frustrating and challenging position, but feel that given our full concerns have been made clear to all parties, we are left with no other choice than to conclude our current discussions."

Appendix 1

Imperial College Healthcare NHS
NHS Trust

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Councillor Cowan
Hammersmith & Fulham Council
Town Hall, King Street
Hammersmith
London W6 9JU

18th July 2017

Dear Councillor Cowan

Thank you for your letter of 12 June 2017 responding to the complaint we raised with you in March. Your response, and subsequent mailings to local residents, continue to provide an extremely partial account of the facts about the future of Charing Cross Hospital. Our only motivation in challenging your approach is to end the unnecessary distress this is causing to our staff, patients and local communities, especially at a time when our health services are under particular pressure.

Through our regular meetings with your councillors and officers and frequent attendance at the Council's health overview and scrutiny committee, we believe we have set out the facts clearly:

In 2012, we published plans for a reconfiguration of health services across North West London to respond to rapidly changing health and care needs. We undertook a full public consultation which set out plans for a more integrated approach to care, with the consolidation of specialist services onto fewer sites, where this would improve quality and efficiency, and the expansion of care for routine and on-going conditions, especially in the community, to improve access. Charing Cross was envisaged as a 'local hospital' within this network of services, building on its role as a growing hub for integrated care offered in partnership between hospital specialists, local GPs and community providers.

After the consultation, the Joint Committee of Primary Care Trusts (JCPCT) met to make their decisions. One of those decisions related to an alternative proposal that we had developed for the Charing Cross Hospital site in response to feedback from the public consultation. This proposal, which saw a wider range of services on the Charing Cross site, was recommended by the JCPCT in early 2013.

The decisions of the JCPCT were then referred to the Secretary of State who asked the Independent Reconfiguration Panel (IRP) to look at the proposals. On the advice of the IRP, in October 2013, the Secretary of State supported the proposals in full, adding that Charing Cross Hospital should continue to offer an A&E service, even if it was a different shape or size to that currently offered. He also made clear that there would need to be further engagement to develop detailed proposals for Charing Cross.

Our subsequent work to engage patients and the public in the development of detailed plans for Charing Cross was paused as increasing demand for acute hospital services highlighted the need to focus first on the development of new models of care to help people stay healthy and avoid unnecessary and lengthy inpatient admissions. Our approach of actively ***not*** progressing plans to reduce acute capacity at Charing Cross unless and until we could achieve a reduction in acute demand was formalised in the North West London Sustainability and Transformation Plan published in 2016. The plan made a firm commitment that Charing Cross will continue to provide its current A&E and wider services for ***at least*** the lifetime of the plan, which runs until April 2021. We also made the commitment to

work jointly with staff, communities and councils on the design and implementation of new models of care.

Our commitment to Charing Cross is demonstrated further in the £8m we invested last year - to refurbish urgent and emergency care wards, theatres, outpatient clinics and lifts and to create a patient service centre and the main new facility for North West London Pathology. And in the further, significant investments we are planning for this year.

You have consistently failed to acknowledge any changes in our approach to Charing Cross since the original public consultation on proposed service changes for North West London. This is demonstrated most clearly by your latest mailing to local residents which included a copy of outline service proposals published five years ago.

In response to your detailed questions about how and why we shared our complaint to you in March, we felt we had no choice but to make it public. This was entirely a decision of the Trust and CCG leadership. Unfortunately, we do not have the resources to send materials directly to every house in the borough. We published our letter to you on our websites on 28th March 2017, the day after it had been sent to you and with full disclosure of our approach, to help allay unnecessary public concern. Unsurprisingly, there has been follow up media interest in our exchanges which our communications teams have responded to, as appropriate.

Concern about changes to local health services is entirely valid and understandable. Far from wishing to prevent debate, we encourage and welcome open discussion, especially with patients and the public. We have to create a shared understanding of the huge challenges we are facing in the NHS – and social care - if we are to address them effectively. We very much wish to work with all of our local authorities as key partners in this endeavour but it is only possible if the considered and honest opinions of our organisations, including those of our senior clinicians, are not actively misrepresented.

Yours sincerely,

Dr Tracey Batten
Chief Executive
Imperial College Healthcare NHS Trust

Clare Parker
Chief Officer – CWHHE
SRO – Shaping a Healthier Future

Appendix 2

London Ambulance Service NHS
NHS Trust

Chief executive: Garrett Emmerson
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

020 7783 2040

garrett.emmerson@lond-amb.nhs.uk

Imperial College Healthcare NHS
NHS Trust

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

0203 312 5897

tracey.batten@imperial.nhs.uk

16 June 2017

Mr Charlie Parker
Chief Executive
Westminster City Hall
64 Victoria Street
London SW1E 6QP

Dear Charlie

RE: 31 LONDON STREET, LONDON, W2 1DJ (WESTMINSTER CITY COUNCIL PLANNING REFERENCE 16/09050/FULL)

We refer to our meeting on 23rd May where we discussed the serious concerns of Imperial College Healthcare (the Trust) and London Ambulance Service (LAS) about the Paddington Quarter scheme and the revised access arrangements into St Mary's Hospital. As we explained during our meeting, and through previous engagements, the Trust and LAS have serious concerns about the ability of St Mary's Hospital to operate a busy emergency department and one of London's four major trauma centres due to the impact the revised access arrangements will have on the safe operation of the hospital and on patient safety. You will also be aware of the meetings which have been held with the Greater London Authority (GLA) and Transport for London (TfL) on this critical issue.

Whilst our serious concerns have been explained in meetings and through correspondence, it has become clear over the course of these engagements, that these concerns are not shared. It is our understanding that Westminster City Council, the GLA and TfL believe that the Paddington Quarter proposals provide a safe access route into St Mary's Hospital, and so will not impact on the operational running of the hospital and the ability of the London Ambulance Service to provide an emergency ambulance service to this emergency department, major trauma centre and also at times of major incidents.

The Trust and LAS therefore find themselves in a frustrating and challenging position, but feel that given our full concerns have been made clear to all parties, we are left with no other choice than to conclude our current discussions.

We are yet to receive a draft copy of the Paddington Quarter Section 106 agreement to comment on prior to it being signed, and would be grateful if you could forward this by return. Could you also keep us updated as to the timing of the execution of the agreement.

Yours sincerely

Dr Tracey Batten
Chief Executive
Imperial College Healthcare NHS Trust

Garrett Emmerson
Chief Executive
London Ambulance Service

Copy to: Steve Russell, Executive Regional Managing Director (London), NHS Improvement
Anne Rainsbury, Regional Director (London), NHS England

Imperial College Healthcare NHS Trust

Report to:	Date
Trust board - public	**26 July 2017**

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of June 2017 (month 3).

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)

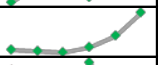
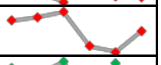
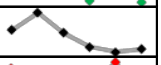
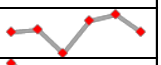
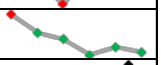
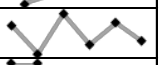
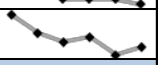
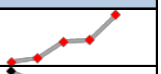
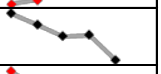
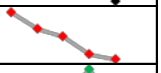
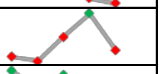
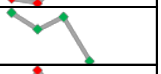
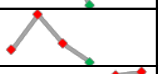
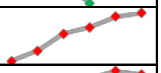
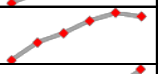
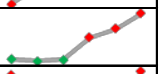
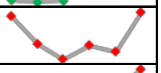
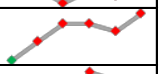
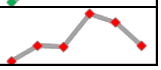
Contents

1. Scorecard

ICHT Integrated Performance Scorecard - 2017/18

Month 3 Report

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Jun-17	-	**22**	
Incidents causing severe harm (number)	Julian Redhead	Jun-17	-	**2**	
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Jun-17	-	**0.08%**	
Incidents causing extreme harm (number)	Julian Redhead	Jun-17	-	**2**	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Jun-17	-	**0.08%**	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Jun-17	44.0	**45.7**	
Never events (number)	Julian Redhead	Jun-17	0	**0**	
MRSA (number)	Julian Redhead	Jun-17	0	**0**	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Jun-17	62	**15**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Jun-17	95.0%	**85.90%**	
CAS alerts outstanding (number)	Janice Sigsworth	Jun-17	0	**0**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Jun-17	-	**3**	
Staffing fill rates (%)	Janice Sigsworth	Jun-17	tbc	**97.3%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Jun-17	2.8%	**2.8%**	
Core Skills Rate - excluding Doctors in Training (%)	David Wells	Jun-17	90.0%	**84.2%**	
Core Skills Rate - Doctors in Training only (%)	David Wells	Jun-17	90.0%	**72.1%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Jun-17	tbc	**52.9%**	
Core Clinical Skills (including Doctors in Training) (%)	David Wells	Jun-17	tbc	**78.4%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Jun-17	0	**2**	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Feb-17	100	**70.0**	
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Qtr 4 16/17	90.0%	**73.1%**	
Unplanned readmission rates (28 days) for over 15s (%)	Tim Orchard	Dec-16	-	**7.40%**	
Unplanned readmission rates (28 days) for under 15s (%)	Tg Teoh	Dec-16	-	**4.12%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days) (number)	Tg Teoh	Jun-17	-	**1513**	
Outpatient appointments checked-in AND not checked-out (number)	Tg Teoh	Jun-17	-	**2402**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Jun-17	95.0%	**98.0%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Jun-17	85.0%	**99.2%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Jun-17	95.0%	**92.7%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Jun-17	94.0%	**90.1%**	
Complaints: Total number received from our patients	Janice Sigsworth	Jun-17	100	**65**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Jun-17	-	**76.3%**	
Mixed-Sex Accommodation (EMSA) breaches	Janice Sigsworth	Jun-17	0	**12**	
Well Led					
Vacancy rate (%)	David Wells	Jun-17	10.0%	**12.0%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Jun-17	10.0%	**10.4%**	
Sickness absence (%)	David Wells	Jun-17	3.1%	**2.4%**	
Personal development reviews (%)	David Wells	Jun-17	95.0%	**43.3%**	
Consultant Appraisal Rate (%)	Julian Redhead	Jun-17	95.0%	**89.7%**	
Education open actions (number)	Julian Redhead	Jun-17	-	**3**	
Reactive maintenance performance (% tasks completed within agreed response time)	Janice Sigsworth	Jun-17	98%	**38.7%**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	May-17	92.0%	**85.0%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	May-17	-	**9552**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	May-17	0	**196**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	May-17	85.0%	**77.7%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Mar-17	0.8%	**0.7%**	
28 day rebooking breaches (% of cancellations)	Catherine Urch	Mar-17	5.0%	**10.4%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Jun-17	95.0%	**78.8%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Jun-17	95.0%	**90.1%**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Jun-17	1.0%	**7.7%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Jun-17	11.0%	**12.4%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Jun-17	7.5%	**8.8%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Jun-17	95.0%	**78.9%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Twenty two serious incidents were reported in June 2017. These are currently under investigation. In the period of July 2016 to June 2017 a total of 191 SIs were reported compared to 146 in 2015/16. The increase reflects the Trust's commitment to improving the culture of safety through encouraging transparent identification of issues to enhance the opportunities for learning in a supportive just environment. The increases are understood and when our harm profile is considered there is no cause for concern. Safety improvement programmes are in place to support reducing recurrence for the categories that have been reported most.

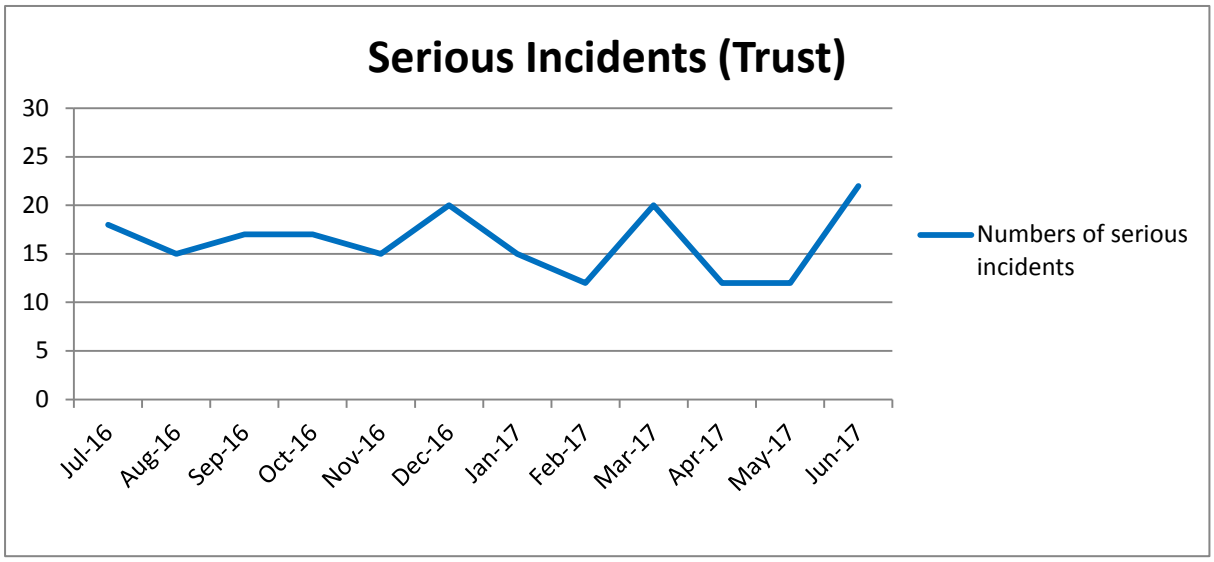


Figure 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period July 2016 – June 2017

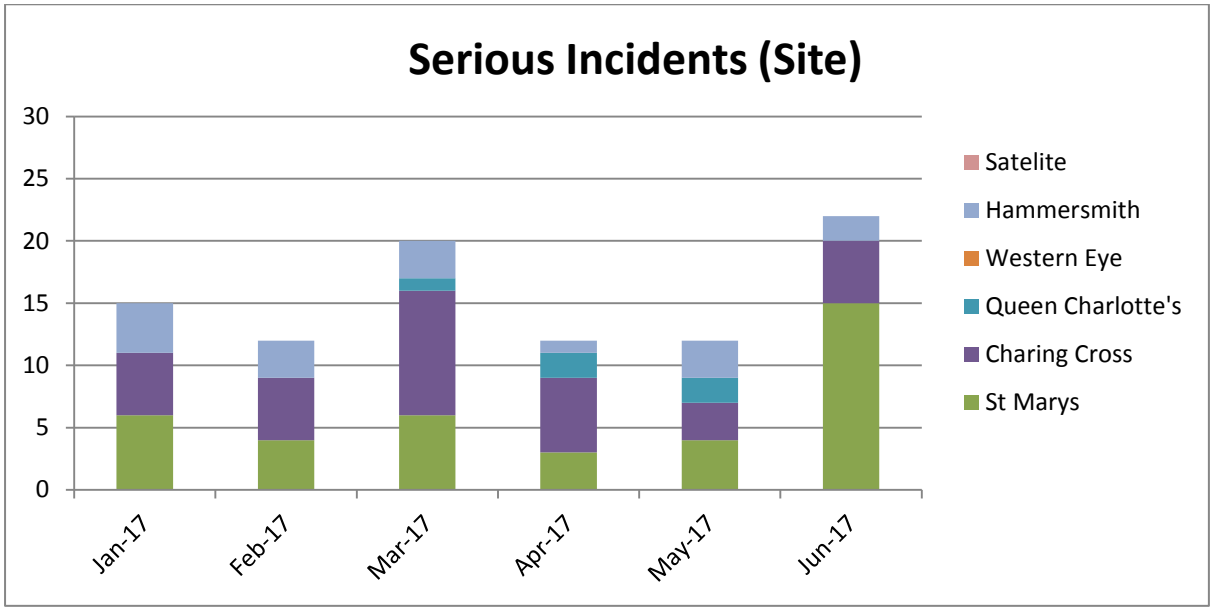


Figure 2 - Number of Serious Incidents (SIs) (Site level) by month for the period January 2016 – June 2017

2.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported two major/severe harm incidents and two extreme harm/death incidents in June 2017. This is below average when compared to data published by the National Reporting and Learning System (NRLS) in April 2017.

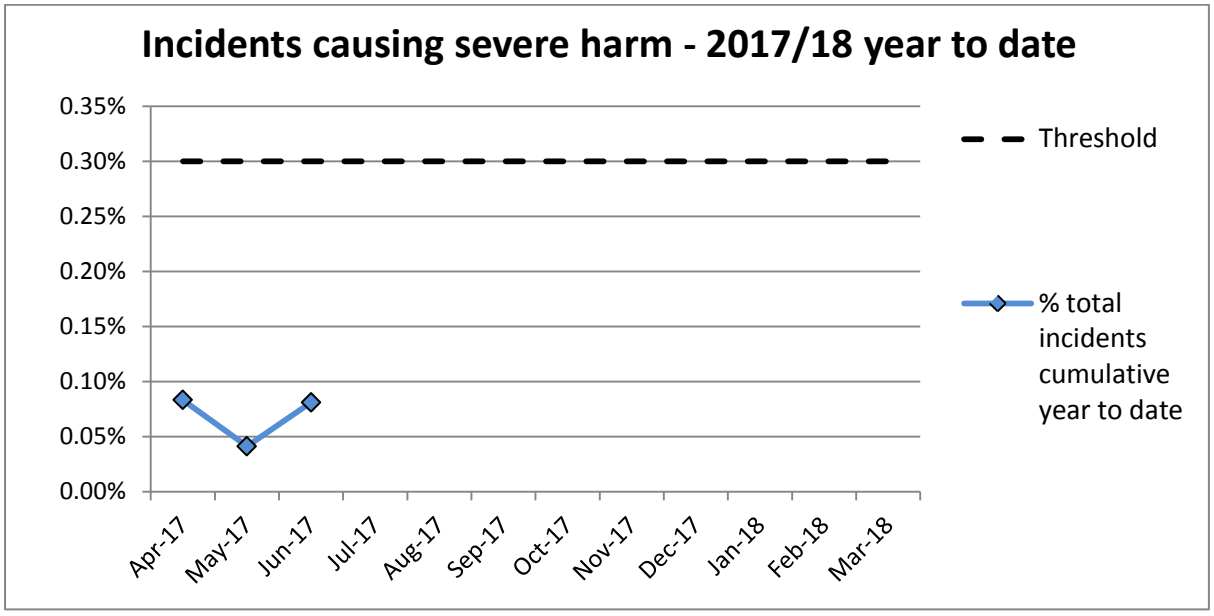


Figure 3 – Incidents causing severe harm by month from the period April 2017 – March 2018 (% of total patient safety incidents YTD)

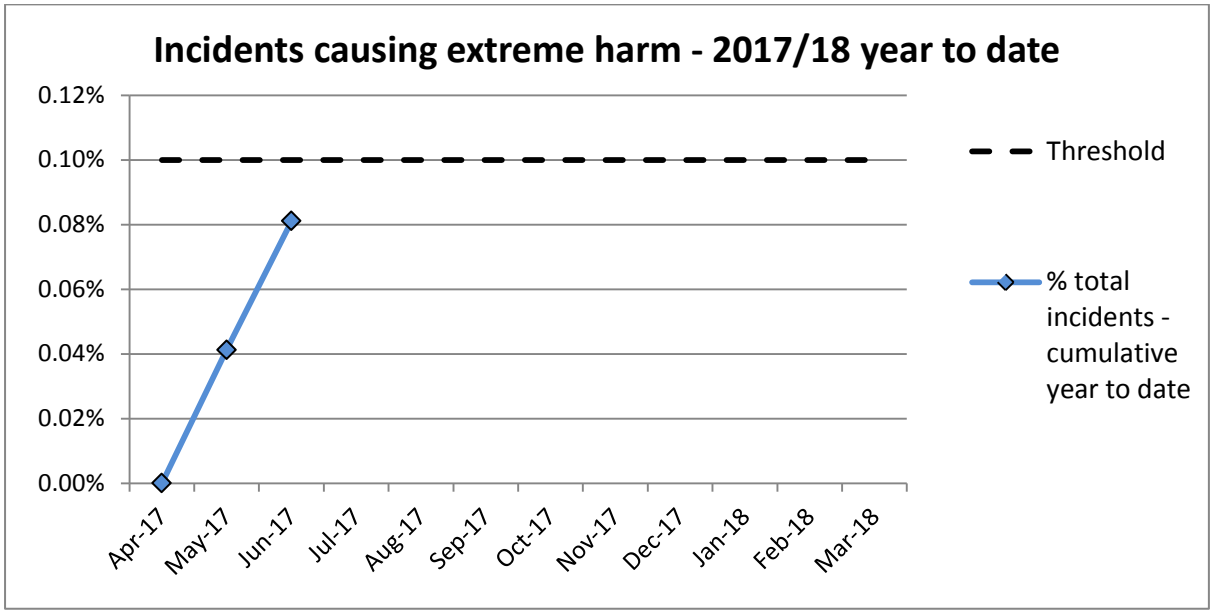


Figure 4 – Incidents causing extreme harm by month from the period April 2017 – March 2018 (% of total patient safety incidents YTD)

Patient safety incident reporting rate

The Trust's patient safety incident reporting rate for June 2017 is 45.69. This places the organisation just above the highest 25 per cent of reporters nationally.

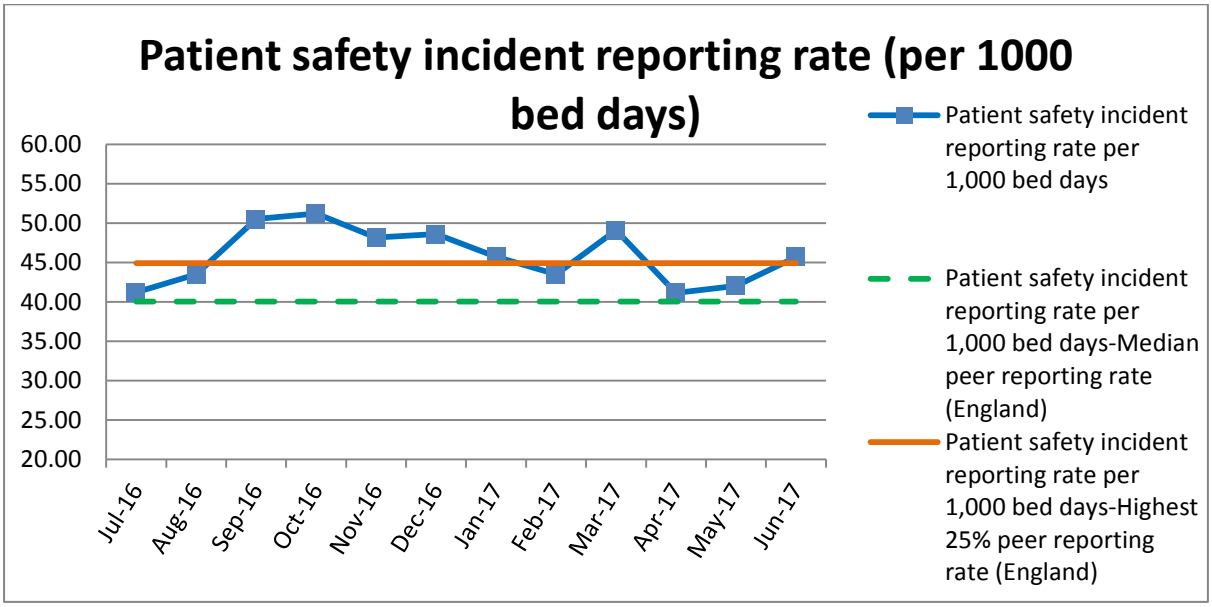


Figure 5 – Trust incident reporting rate by month for the period July 2016 – June 2017

(1) Median reporting rate for Acute non specialist organisations (NRLS 01/10/2015 to 01/03/2016)

(2) Highest 25% of incident reporters among all Acute non specialist organisations (NRLS 01/04/2015 to 30/09/2015)

Never Events

No never events were reported in June 2017. The last never event reported by the Trust was in November 2016

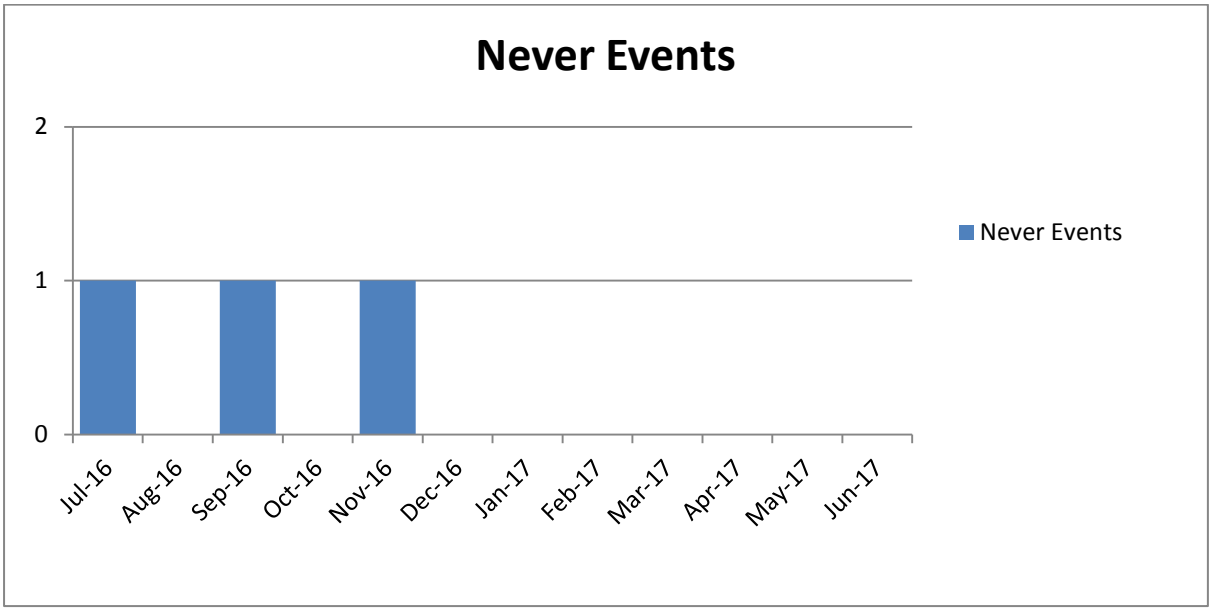


Figure 6 – Trust Never Events by month for the period July 2016 – June 2017

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

There were no cases of MRSA BSI identified at the Trust in June 2017, however one case originally assigned as non-Trust in April 2017 has been reassigned to the Trust. This patient had an infected vascular graft and had a previous prolonged admission at the Trust. The investigation identified some learning around MRSA screening and suppression therapy but this did not contribute to the patient developing a BSI.

2.1.4 Safe: *Clostridium difficile*

Seven cases of *Clostridium difficile* were allocated to the Trust for June 2017. None of these have been identified as a lapse in care. Each case is reviewed by a multi-disciplinary team to examine whether any lapses in care occurred.

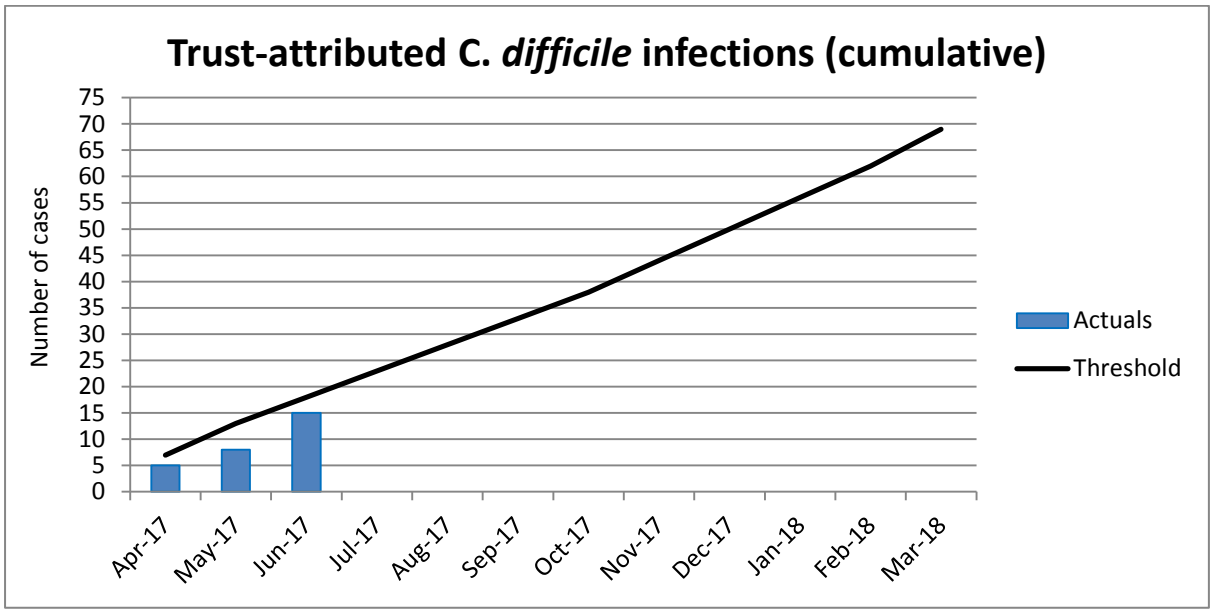


Figure 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – March 2018

2.1.5 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 March 2017. 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; assessment data for June 2017 is 85.9%. Weekly reports showing actual performance on admission are being provided to the divisions; the latest reports for July show improvements, with performance around 90%. The divisions are developing trajectories for areas which are not meeting the target.

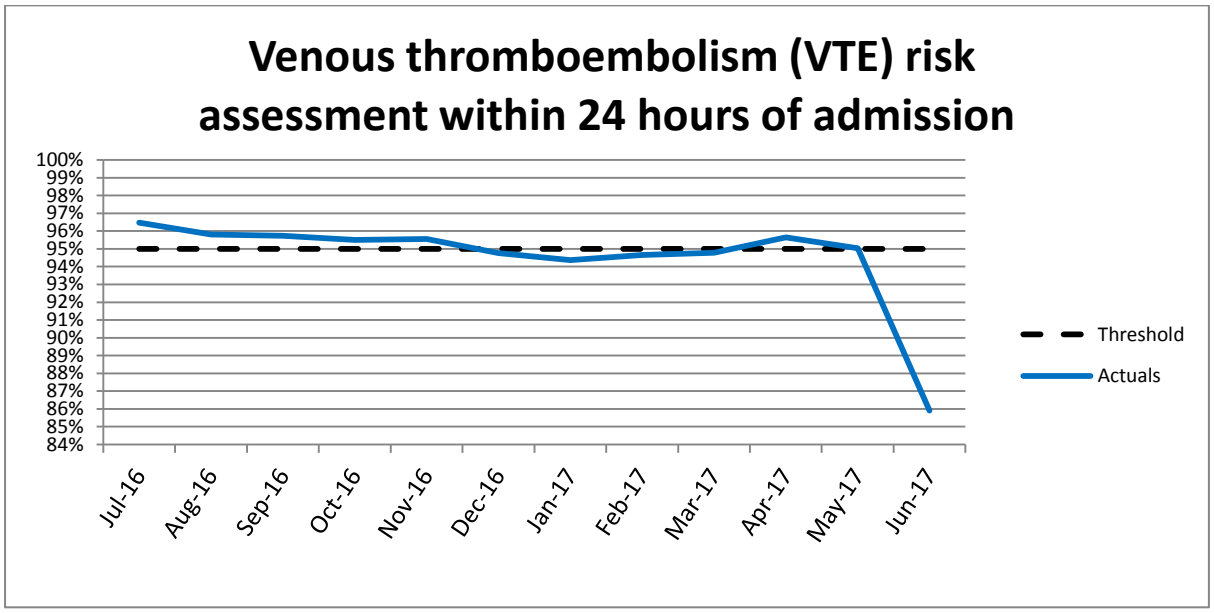


Figure 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period July 2016 – June 2017

2.1.6 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 June 2017 there were no overdue CAS alerts.

2.1.7 Safe: Avoidable pressure ulcers

There were three confirmed avoidable pressure ulcers (unstageable) reported in June 2017. The new pressure ulcer policy went live in April 2017 and this has been supported by a Trust wide study day for Tissue Viability Champions in June detailing the changes within the new policy.

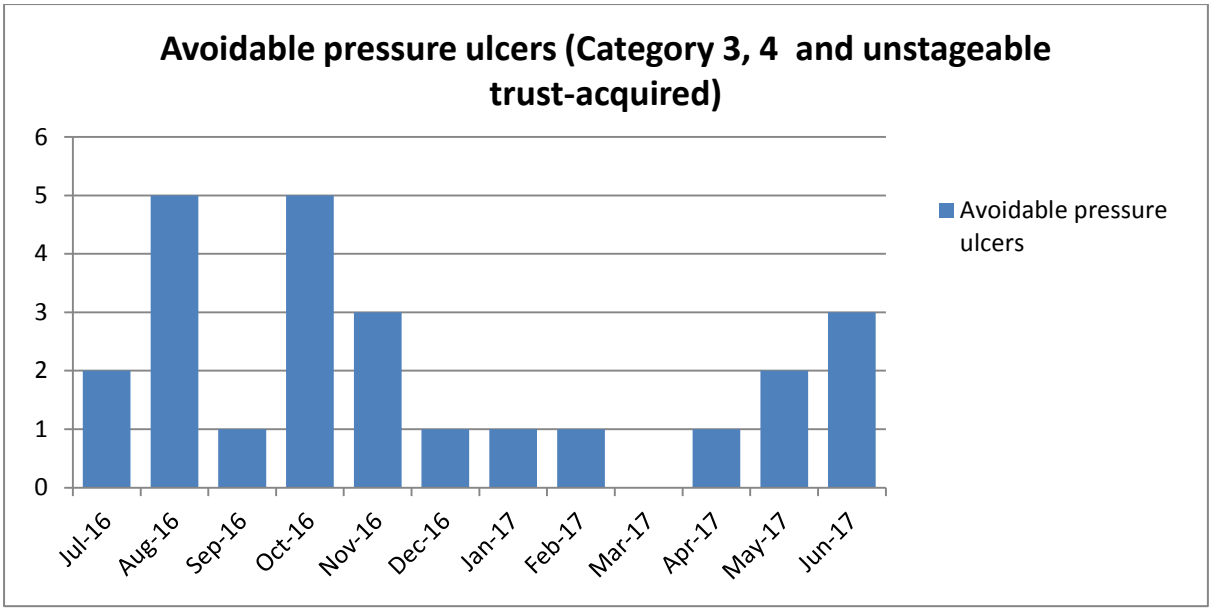


Figure 9 – Number of category 3 and category 4 (including unstageable) trust-acquired pressure ulcers by month for the period July 2016 – June 2017

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

In May 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	**96.83%**	**92.72%**	**98.33%**	**98.50%**
Hammersmith	**97.71%**	**90.17%**	**99.21%**	**98.92%**
Queen Charlotte's	**98.07%**	**93.85%**	**97.94%**	**98.01%**
St. Mary's	**97.79%**	**93.78%**	**98.68%**	**98.53%**

See appendix 1 for ward level narrative detail of the fill rate below threshold.

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 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 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 May 2017 were safe and appropriate for the clinical case mix.

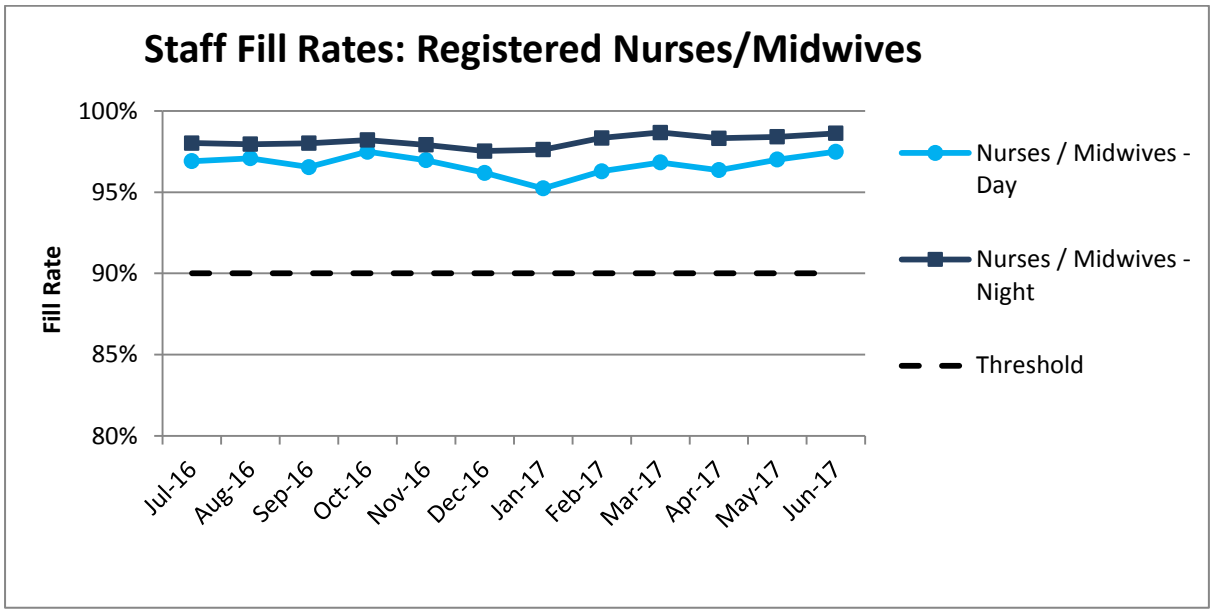


Figure 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period July 2016 – June 2017

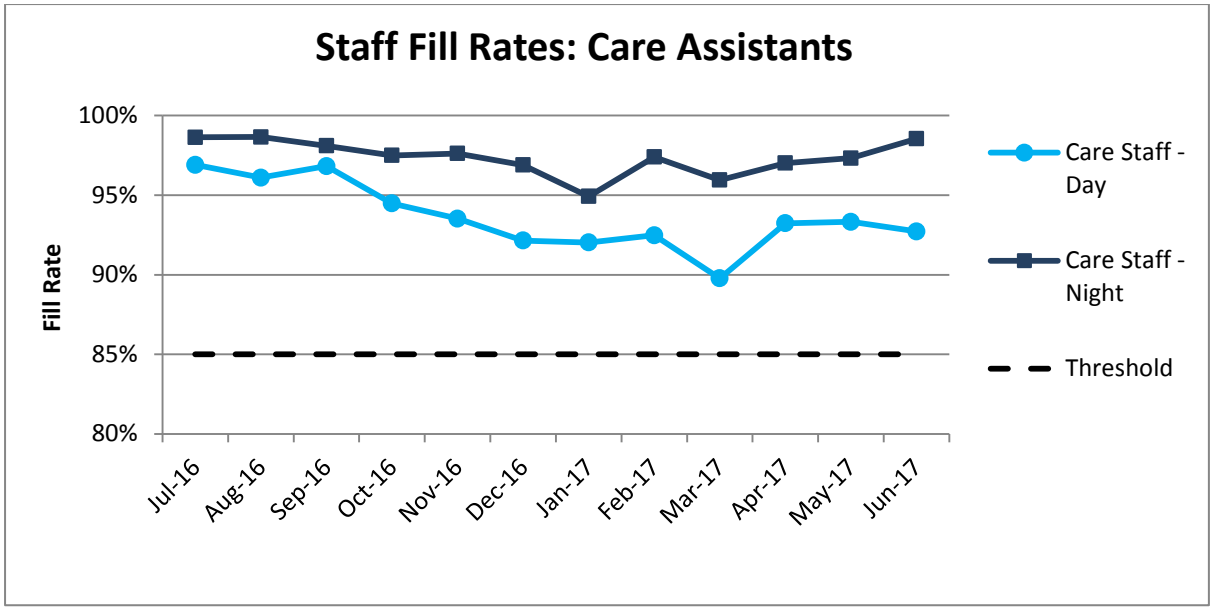


Figure 11 - Monthly staff fill rates (Care Assistants) by month for the period July 2016 – June 2017

2.1.9 Safe: Postpartum haemorrhage

In June 2.8 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.

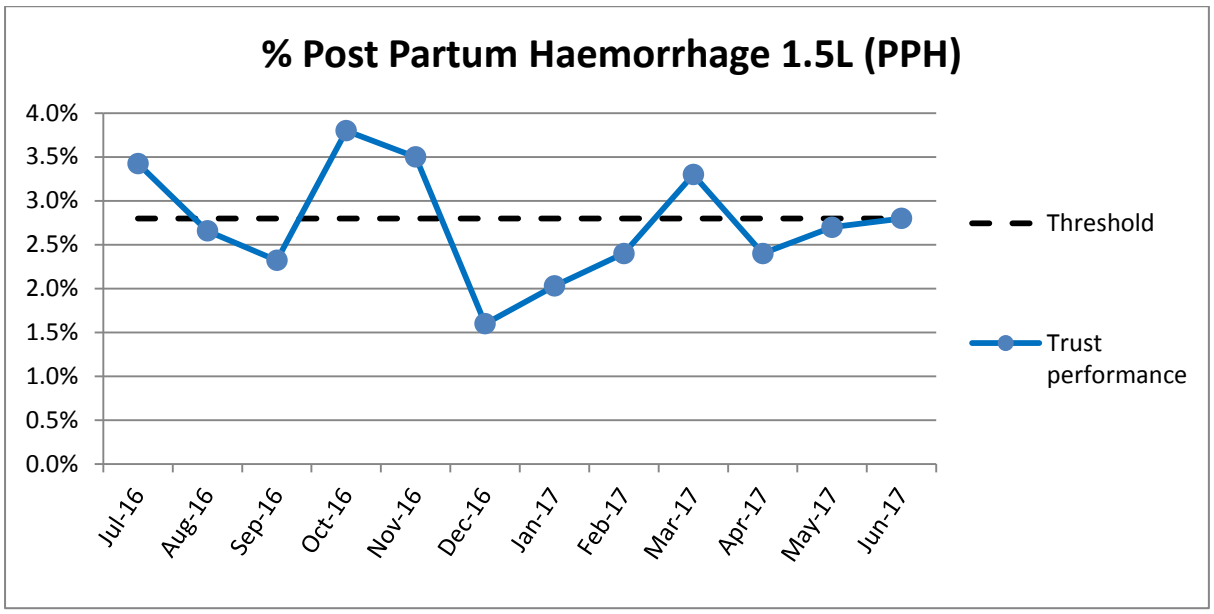


Figure 12 – Postpartum haemorrhage (PPH) for the period July 2016 – June 2017

2.1.10 Safe: Core skills training

Core skills

At the end of May, the compliance rate for doctors in training was 72.34 per cent and for all other staff, 83.72 per cent.

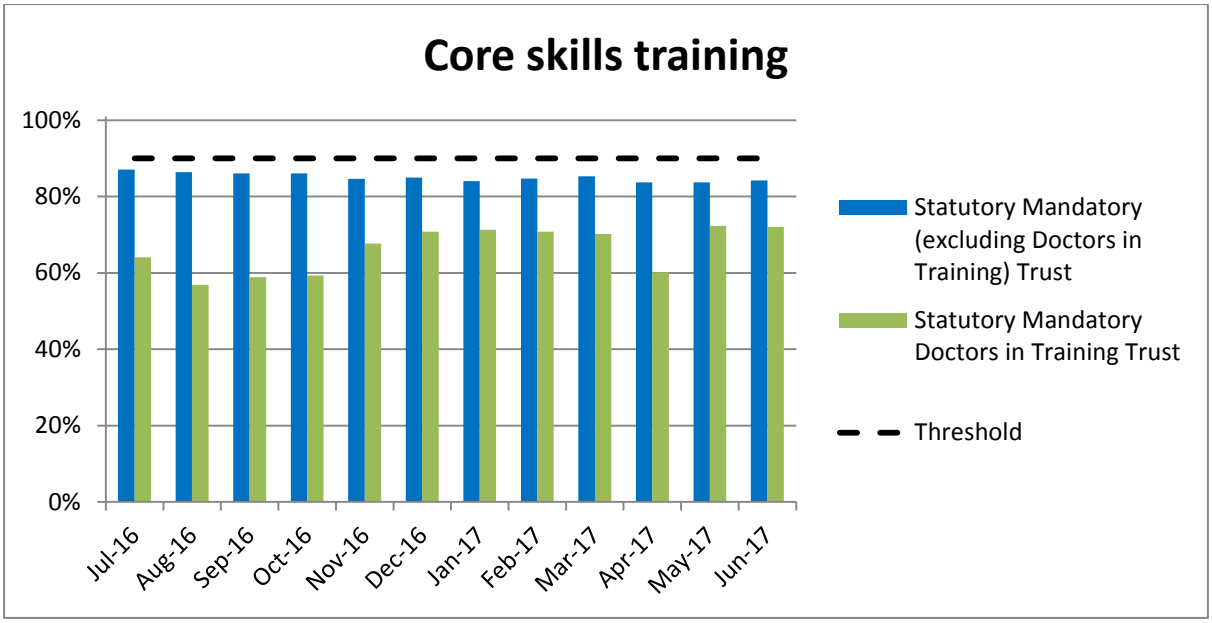


Figure 13 - Statutory and mandatory training for the period July 2016 – June 2017

Core clinical skills

A new indicator on core clinical skills training has been introduced and will be reported monthly from Month 4 onwards.

2.1.11 Safe: Work-related reportable accidents and incidents

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

- The first incident involved a member of staff being exposed to fumes from a nearby chimney, experiencing major respiratory problems and being taken to A&E. This resulted in a sickness absence of over 7 days.
- The second incident involved a member of staff who received a needle stick injury from a sharp contaminated with a blood borne virus. The incident was reportable to the HSE as a Dangerous Occurrence (release or escape of a biological agent).
- The third incident involved a member of staff sustaining injuries to her ankle and back whilst trying to calm and restrain a patient. This resulted in a sickness absence of over 7 days.

In the 12 months to 31st May 2017, there have been 37 RIDDOR reportable incidents of which 13 were slips, trips and falls. The 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.

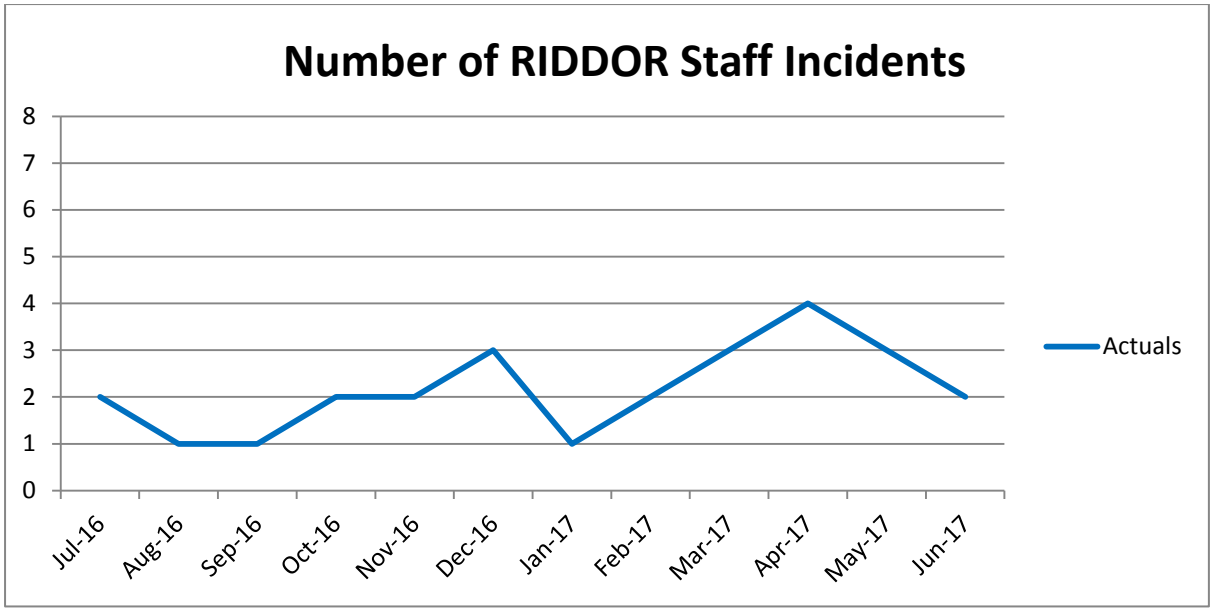


Figure 14 – RIDDOR Staff Incidents for the period July 2016 – June 2017

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. A quarterly report summarising these plans will be provided to the executive quality committee.

The national perinatal mortality surveillance report MBRRACE UK was published in June 2017. This is currently being reviewed by the service; however initial review shows 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 70 (February 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 July 2015 to June 2016.

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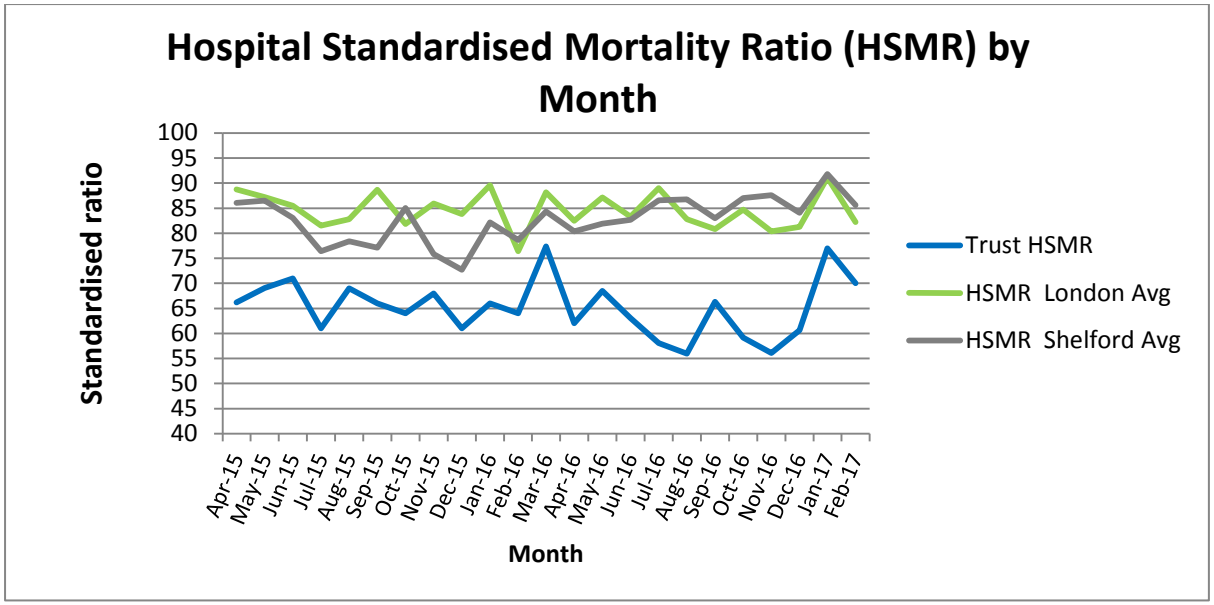


Figure 15 - Hospital Standardised Mortality Ratios for the period April 2015 – February 2017

2.2.3 Effective: Mortality reviews completed

This data is reported quarterly, with the next update due in August 2017. Since the online mortality review system went live in February 2016, seven avoidable deaths have been confirmed. These have all been investigated as serious incidents.

2.2.4 Effective: Recruitment of patients into interventional studies

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 in the last three quarters of 2016/17, with performance reducing to 73.1 per cent in quarter four. Data will be available for quarter one 2017/18 in August 2017.

The most recent result reflects the impact of the full implementation of the new Health Research Authority (HRA) approvals process. The main reason for longer approval times in the new system is that the full duration of contract negotiation must now be included within the strictly-defined study initiation window of 70 days. The contracts team only receives legal agreements for review on the date when the HRA clock starts; no initial review or assessment can take place prior to that date (which was the practice previously). Average approval times have increased nationally as well as locally in the last two quarters, according to the NIHR reports, and as shown by the national average figure of 72.5 per cent. The Trust is reviewing processes for contractual review and negotiation, to identify ways of shortening these approval times and coming back within our target metric of 90 per cent. It should be noted also that there is an inherent lag involved in the clinical trials set-up and reporting process.

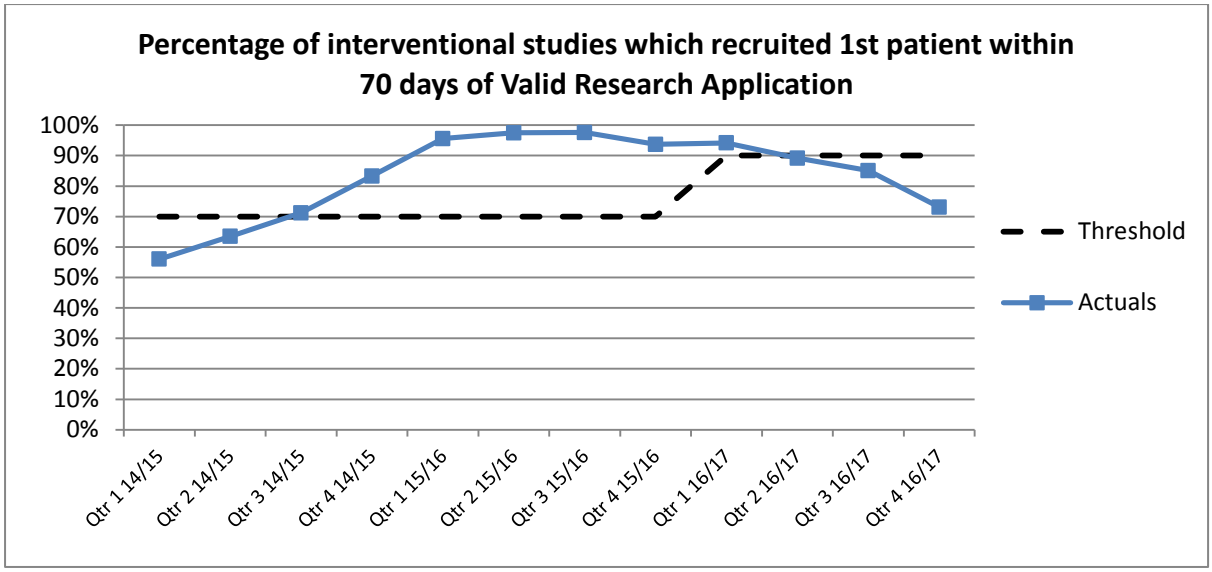


Figure 16 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q4 2016/17

2.2.5 Effective: Readmission rates

For December 2016 (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).

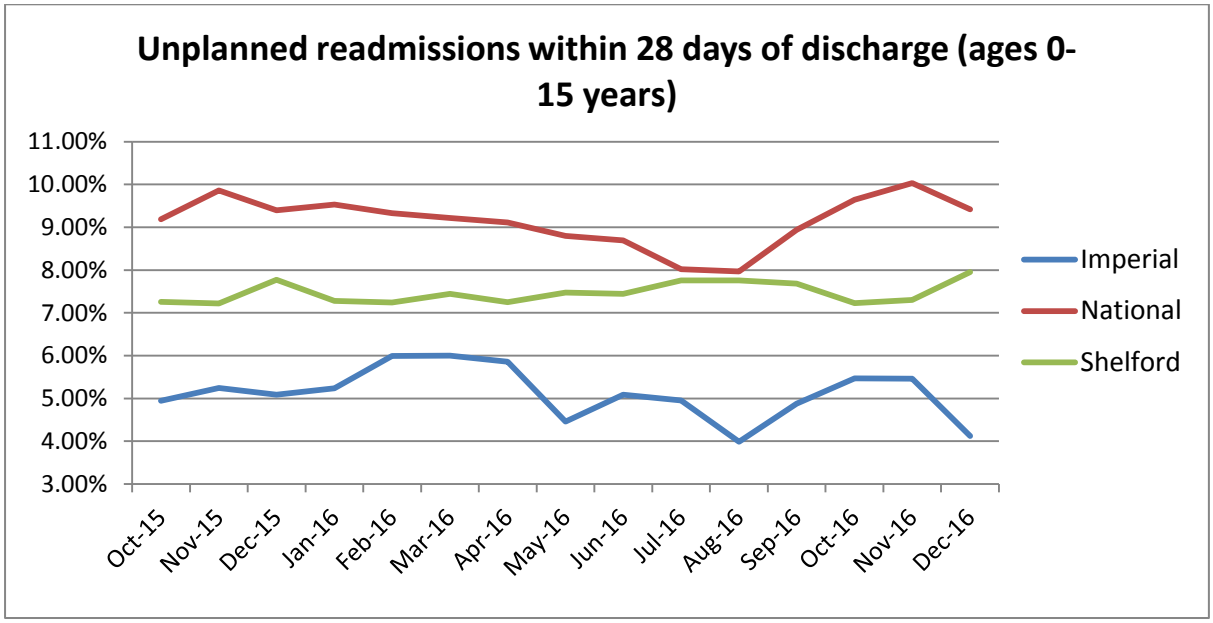


Figure 17 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – December 2016

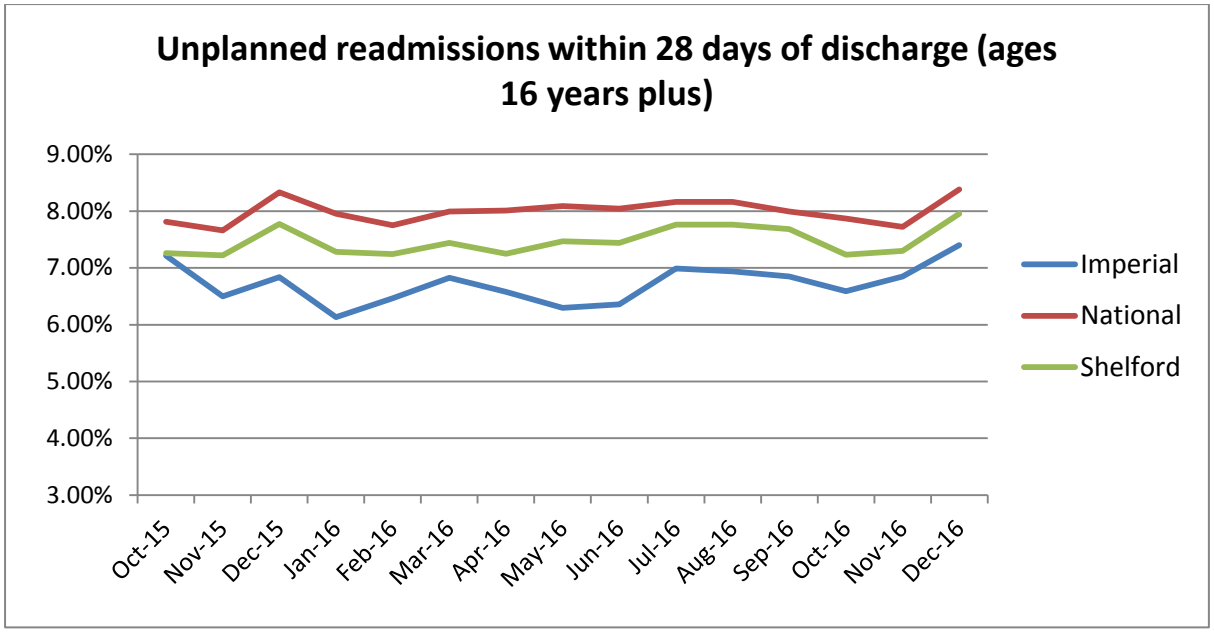


Figure 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – December 2016

2.2.6 Effective: Outpatient appointments checked in and checked out

When patients attend for their outpatient appointment they should be checked-in on the Trust system (CERNER) and then checked-out after their appointment so that it is clear what is going to happen next. The escalation processes to clear appointments on the system in a timely manner continue to be implemented.

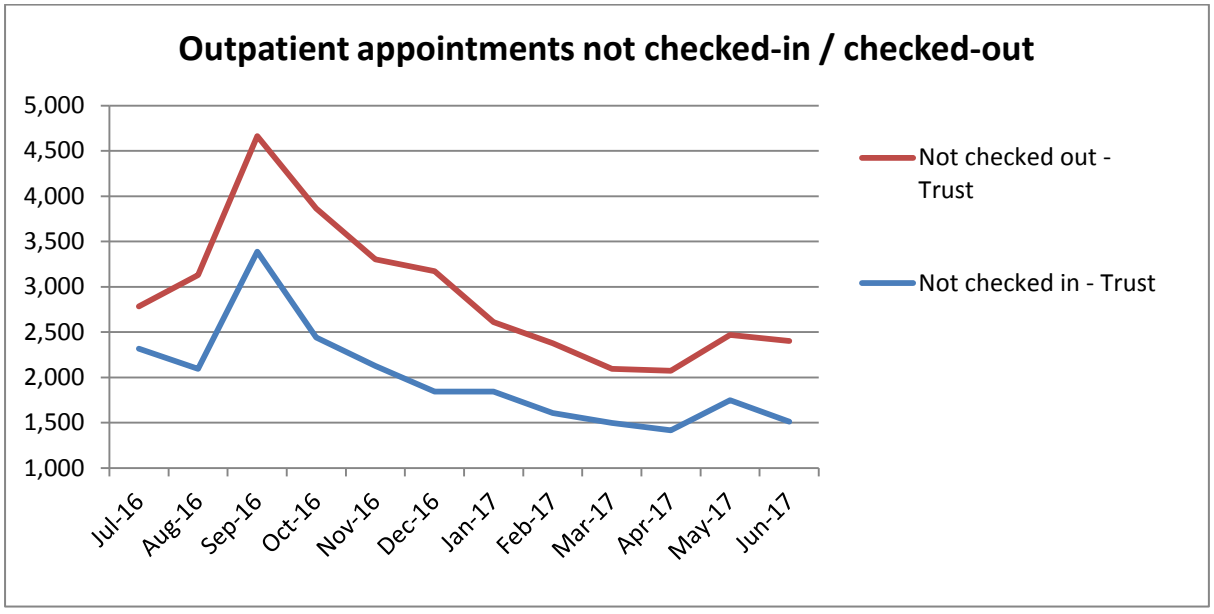


Figure 19 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days)/ checked-in and not checked-out for the period July 2016 – June 2017

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 has the lowest willingness to recommend but this is still at 90%. The "unlikely to recommend" responses from outpatient services almost exclusively relate to waiting (either in clinic or for an appointment).

The A&E response rate remains below target although is up marginally since last month. The issue continues to centre on St Mary's A&E, although in month there were falls in response rates across all trust emergency departments.

Service	Metric Name	Apr-17	May-17	June-17
Inpatients	Response Rate (target 30%)	30%	32%	**35%**
	Recommend %	*96%*	*97%*	**98%**
	Not Recommend %	*1%*	*1%*	**1%**
A&E	Response Rate (target 20%)	16%	15%	**12%**
	Recommend %	*95%*	*96%*	**99%**
	Not Recommend %	*3%*	*3%*	**0.4%**
Maternity	Response Rate (target 15%)	28%	30%	**29%**
	Recommend %	*95%*	*93%*	**93%**
	Not Recommend %	*1%*	*2%*	**3%**
Outpatients	Response Rate (target 6%)	10%	8%	**9%**
	Recommend %	*89%*	*89%*	**90%**
	Not Recommend %	*5%*	*6%*	**5%**

Friends and Family test results

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

Due to technical issues the most recently reported performance for patient transport is March 2017. The Trust is working with the service provider to re-establish monthly reporting for this indicator.

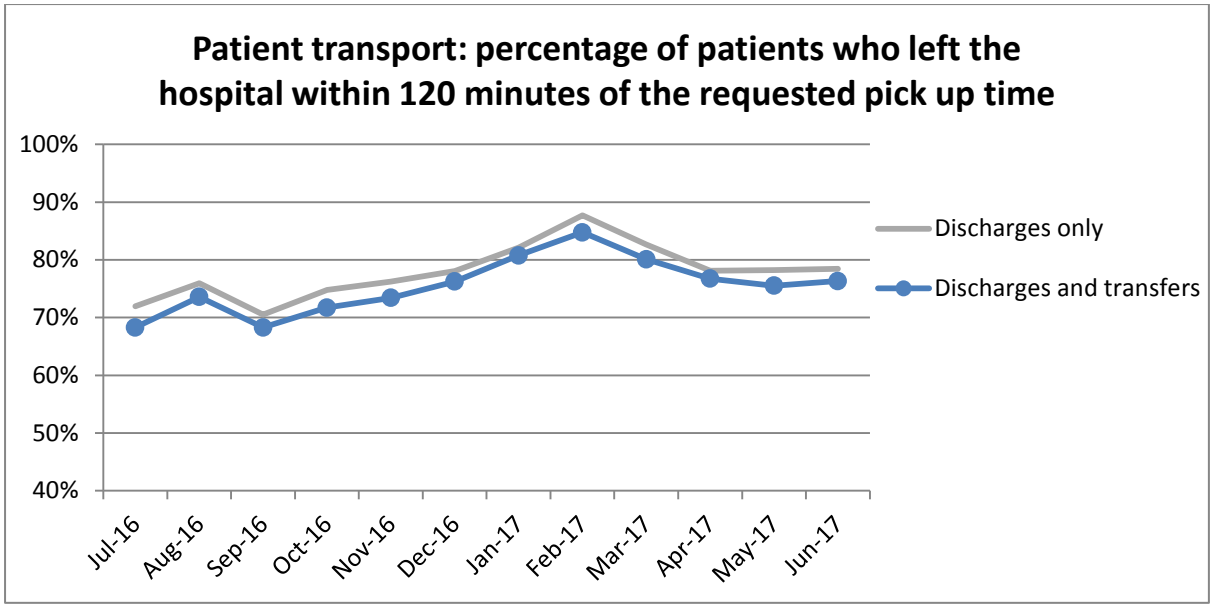


Figure 20 - Percentage of patients who left the hospital as part of the patient transport scheme within 120 minutes of their requested pick up time between July 2016 and June 2017

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 12 mixed-sex accommodation (MSA) breaches for the month of June 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 are undertaking a deep dive into the situation at Charing Cross to understand the root causes and an action plan is being put in place to address any recommendations.

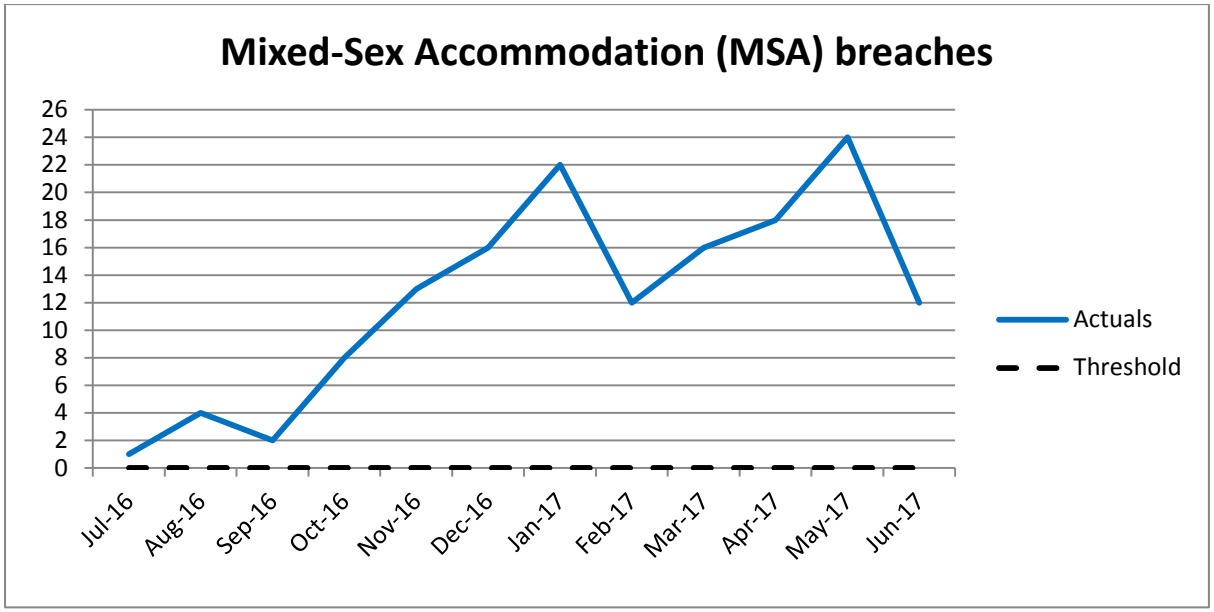


Figure 21 – Number of mixed-sex accommodation breaches reported for the period July 2016 – June 2017

2.3.4 Caring: Complaints

The volume of formal complaints fell by a third in June. There is no single category or division that accounts for this.

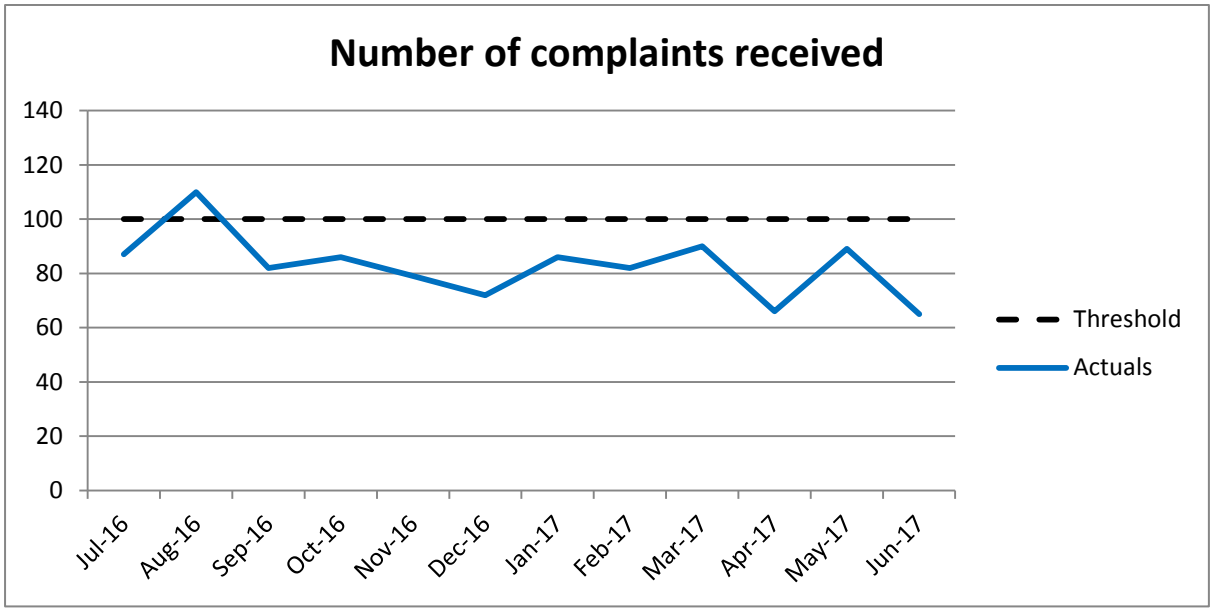


Figure 22 – Number of complaints received for the period July 2016 – June 2017

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

At the end of June 2017, the Trust directly employed 9,035 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions. The contractual vacancy rate for all roles was 12.03 per cent against the target of 10 per cent; continuing to compare favourably to the average vacancy rate of 14.0 per cent across all London Trusts.

During the month there were a total of 143 WTE joiners and 97 WTE leavers across all staffing groups and the Trusts voluntary turnover rate (rolling 12 month position) stands at 10.43 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

- A variety of channels are being used to attract and recruit people including, Open Days, Fairs, social media, print advertising and recruitment databases for direct sourcing

- An assessment and selection tool is now live to ensure consistent decision-making to support retention and engagement

-The medical recruitment process is under review and all roles are being managed through Trac - full functionality will be available by the end of August

- The Careers website content will be redrafted during July. The main recruitment look and feel has been agreed. An internal campaign will commence in July and will involve an article in Pulse, revamping of the 'Our Working Lives' pages on the Source pages and a Road-show in September. Marketing materials and adverts refreshed for all hard to recruit areas

- A planned recruitment campaign is being developed to run along the next Hospital series to commence late June/July involving an RCN advert, programmatic campaign and twitter social media

All Nursing & Midwifery Roles

At end of June 2017, the contractual vacancy rate for all of the Trusts Nursing & Midwifery ward roles was 14.92 per cent with 739 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate stands at 16.82 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 are planning 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 graduate in August. Student Open Day is being planned for end of July, a video is being created to promote the offer at Imperial and ambassadors are being sourced to help attract more students

- An Open Day for Oncology is planned for July and for the Western Eye for June

- The volume assessment centres have been revised to make these more efficient, effective and to realise a better candidate experience and conversion

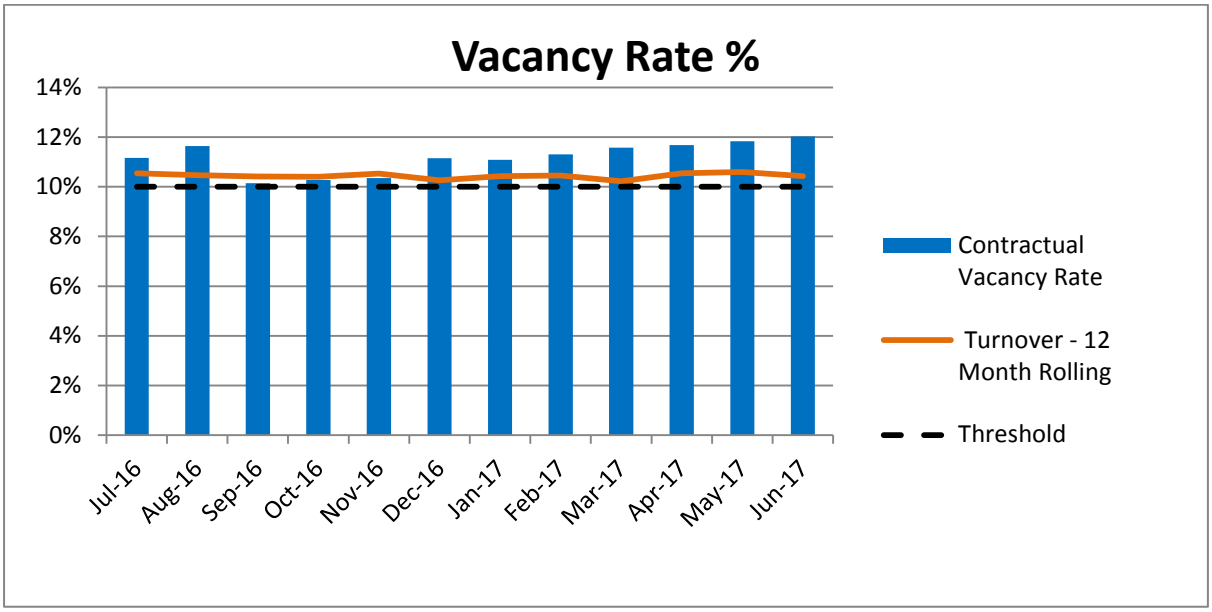


Figure 23 - Vacancy rates for the period June 2016 – July 2017

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in June was 2.36 per cent bringing the Trusts rolling 12 month sickness position to 2.90 per cent against the year-end target of 3.10 per cent or lower.

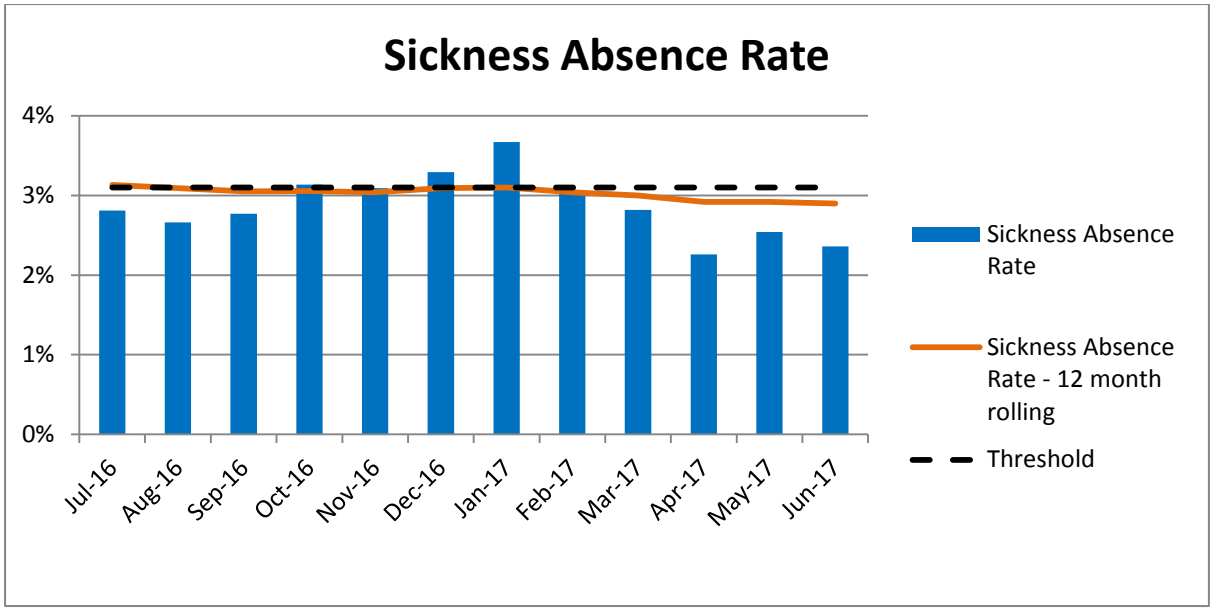


Figure 24 - Sickness absence rates for the period July 2016 – June 2017

2.4.3 Well-Led: Core skills training

Core skills

At the end of June, the compliance rate for doctors in training was 72.05 per cent and for all other staff, 84.18 per cent.

Core Clinical Skills

At the end of June, the compliance rate for doctors in training was 52.58 per cent and for all other staff, 78.40 per cent.

- Overall Core 10 compliance and Core Clinical is being pushed via normal management channels as well proactive chasing of poor performing teams and departments working with SMEs to achieve the target of 90 per cent
- Juniors Doctors compliance will be pushed via the new intake of Junior Doctors in August 2017, through encouraging junior doctors to bring their training records from previous Trusts, offering incentives to complete training before they come and piloting pre assessments to enable fast completion on arrival

2.4.4 Well-Led: Performance development reviews

The new PDR cycle began on 1st April 2017 with all PDR's to be completed by the end of July 2017; compliance for Clinical and Corporate Divisions was 43.31 per cent at the end of June.

2.4.5 Well-Led: Health and Safety incidents

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

- The first incident involved a member of staff being assaulted and sustaining injuries (including being bitten). 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 HSE as a Dangerous Occurrence (release or escape of a biological agent).

- The third incident involved a member of staff being exposed to ammonia from a fridge leak and experiencing breathing difficulties. The incident was reportable to the HSE as a Dangerous Occurrence (hazardous escapes of substances).

In the 12 months to 30th June 2017, there have been 36 RIDDOR reportable incidents of which 12 were slips, trips and falls. The 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.

2.4.6 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates have fallen slightly this month to 89.76 per cent from 90.66 per cent in May. We remain above the national average of 86.6 per cent.

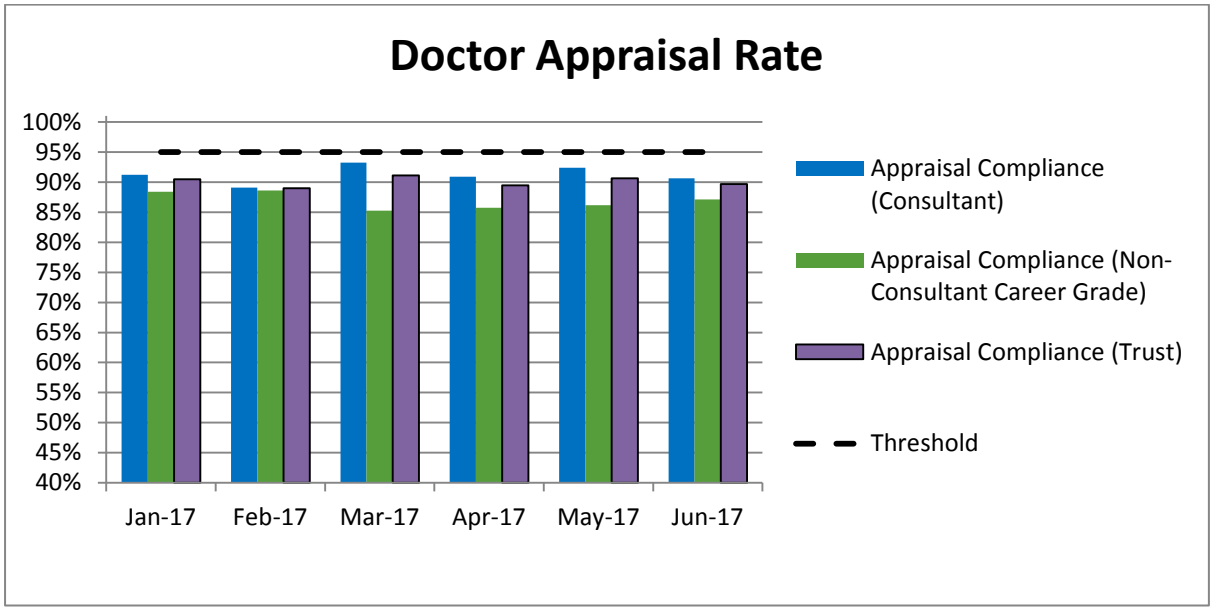


Figure 25 - Doctor Appraisal Rates for the period January 2017 to June 2018

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

<u>Health Education England quality visit</u>

Three actions from the quality visit were closed in June 2017. Three remain open and are being monitored through the local faculty group meetings (LFGs).

2015/16 General Medical Council National Training Survey

All outstanding actions on the 2016 National Training Survey action plan were closed in May.

2016/17 General Medical Council National Training Survey

The 2017 National Training Survey results were published in July. The results are currently being analysed, however initial review shows that the Trust's performance is similar to last year, with 24 red flags (where we are shown to be a significant national outlier) compared to 25 in 2016, and 53 green flags compared to 54 last year. Improvement plans are currently being developed, with the first Trust action plan due for submission to Health Education England in September 2017

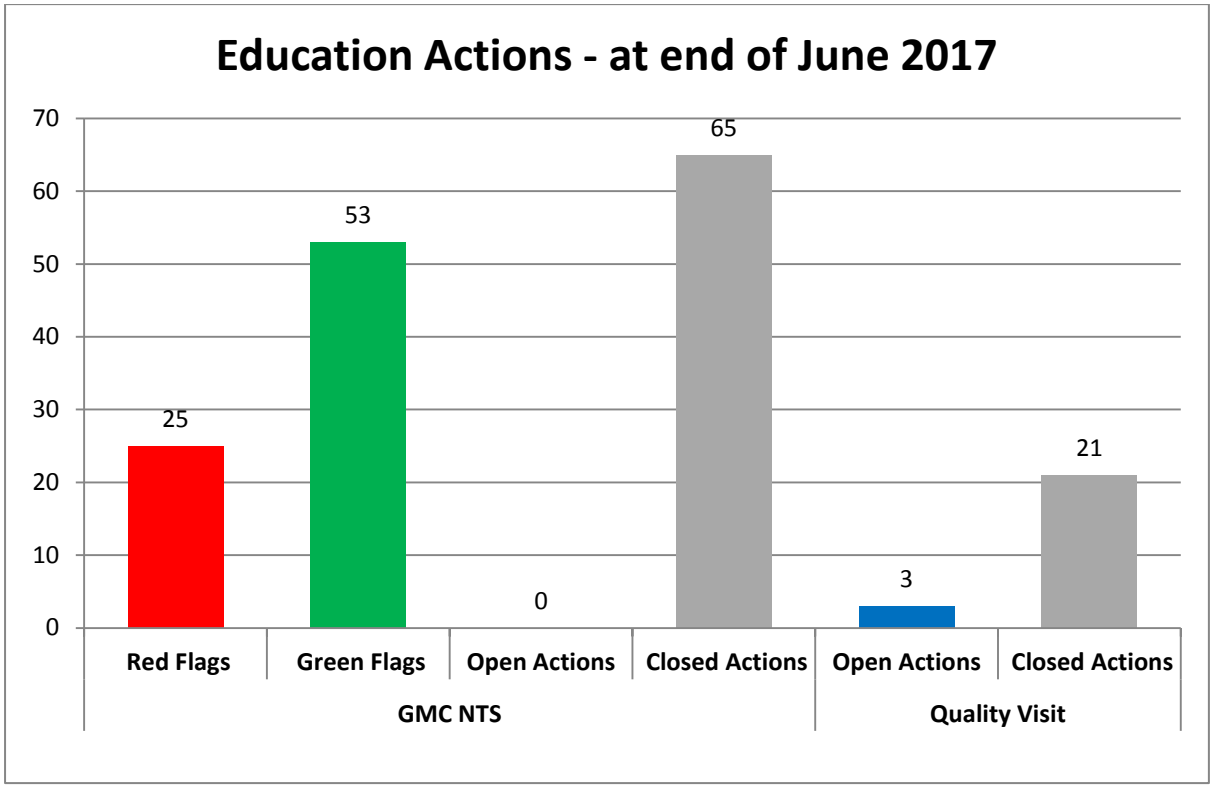


Figure 26 – General Medical Council - National Training Survey action tracker, updated at end June 2017

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

The percentage of estates reactive (repair) maintenance tasks completed on time fell in May. There were higher than expected number of tasks received for May. As part of the cyber-attack response in May, our supplier was unable to remotely access the Trust network for a period of one week. This caused delays in receiving and updating records on their helpdesk system and affected operational performance. The figures are being reviewed as part of the detailed HardFM contract review.

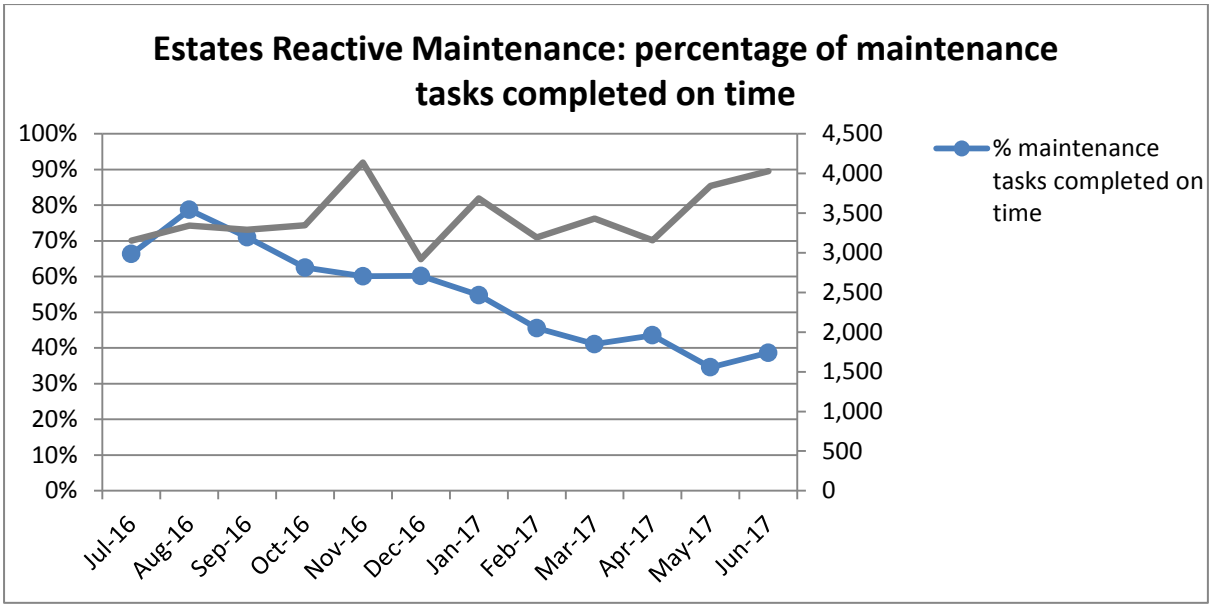


Figure 27 – Estates: percentage of maintenance tasks completed on time for the period July 2016 – June 2017

2.5 Responsive

2.5.3 Responsive: Consultant-led Referral to Treatment waiting times

The latest reported performance is for the end of May where 85.0 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 an improvement on the position reported in April of 83.4 per cent and achieved the trajectory target of 81.8 per cent.

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 WLIP also oversees the management of the clinical review process which provides assurance that patients who wait over 52 weeks are not coming to harm.

Significant progress is being made on all of the aspects of the programme, including the data clean-up of the waiting lists, the roll out of a new Clinical Outcome form across the Trust, the establishment of right first time processes, additional clinical activity and theatre capacity and performance recovery trajectories. The project continues into 2017/18.

Elective capacity modelling has now been completed and actions are underway to support improvements. Additional capacity is also being delivered for outpatients and work is on-going to quantify the capacity and demand gap to inform future planning.

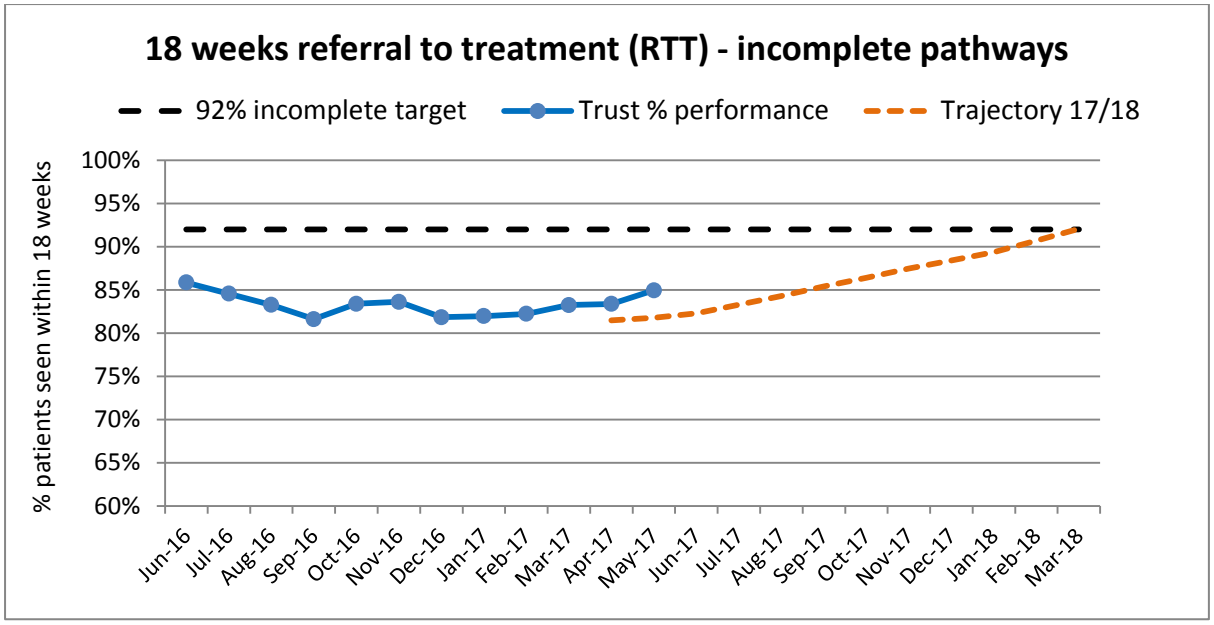


Figure 28 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period June 2016 – May 2017

52 weeks

The on-going data clean-up of the inpatient and outpatient waiting lists has resulted in a large number of patients whom we had not been tracking consistently in specific specialities. This is because RTT rules were applied incorrectly at an earlier stage of the patient's treatment pathway.

The Trust reported 196 patients waiting over 52 weeks at the end of May; this was an improvement on April reported position of 217 patients. 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.

Reducing the number of patients waiting over 52 weeks is a priority work stream for the programme over the coming months, and work is currently on going to support the directorates in their efforts to rapidly improve this position.

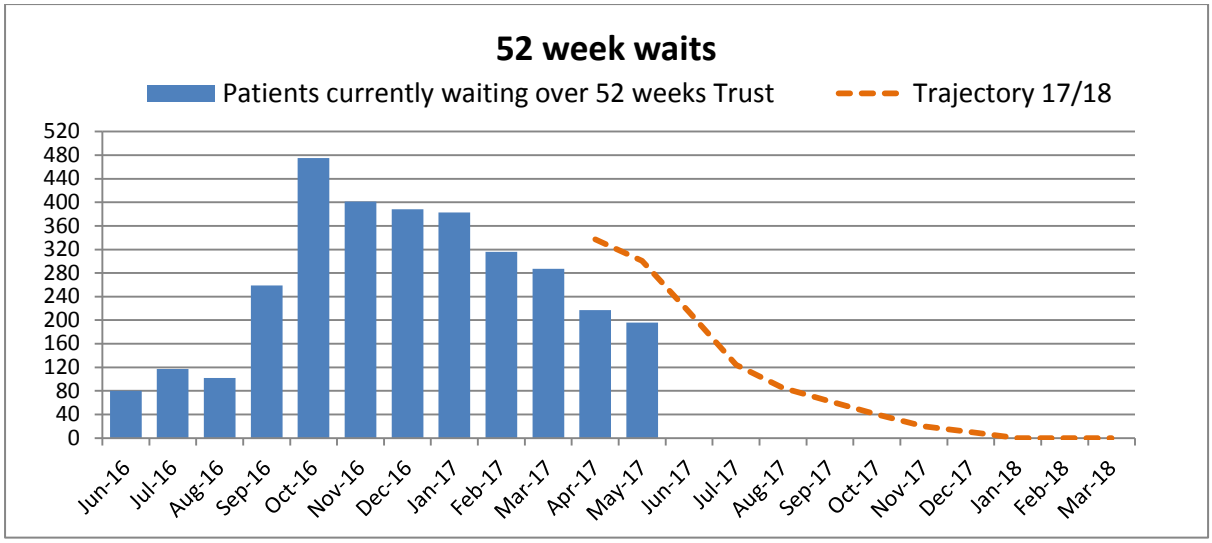


Figure 29 - Number of patients waiting over 52 weeks split by gender pathways and non-gender pathways, for the period June 2016 – May 2017

2.5.4 Responsive: Cancer 62 day waits

The trust underperformed against the 62 day standard for two key reasons. There were 8 internal prostate pathway breaches.

While this had a negative impact in May, it was a positive step in recovering the persistent problems on that pathway, reducing the prostate treatment backlog. There have been no prostate breaches in June.

There were also 15 shared pathway breaches (7.5 reported breaches). These were referred from a number of different trusts, across different treatment pathways, but the majority came from the LNWH gynae service. LNWH have been asked by the CCG to resubmit their performance trajectory and provide ICHT with a more accurate forecast of future likely shared breaches to allow us to assess any likely impact on our future performance, but they have not yet produced this. ICHT have offered the LNWH exec team support with producing their forecast, but this has not been taken up. ICHT have also offered to take a significant number of gynae referrals at the point of GP referral to support LNWH in recovering their position, but LNWH are yet to accept the offer.

The Trust has received £207k to provide additional MRI capacity to facilitate same-day scanning, reporting any biopsy. 18 patients per week will follow this pathway from July. Early pilot results show an average referral to treatment wait of 27 days, brought down from above 62 days under the old pathway. The money will also be used to reduce CTC reporting time to support delivery of the colorectal STT pathway.

This investment is separate to the RAPID transformation fund bid, which is expected to be agreed at the July RPM exec group meeting.

The 62 day standard has been delivered for June. This is will be the second month in Q1 that has been delivered in target and is above trajectory.

Both the 2WW and breast symptomatic standards were not delivered in May. This was because the breast capacity problems in April could not be contained to that month and a significant number of patients were seen beyond day 14 in May. The capacity problems have now been resolved in breast, and the booking profile across the majority of services has been brought down to be able to offer patients a first appointment by day 10. The standards are both expected to be delivered in June after validation.

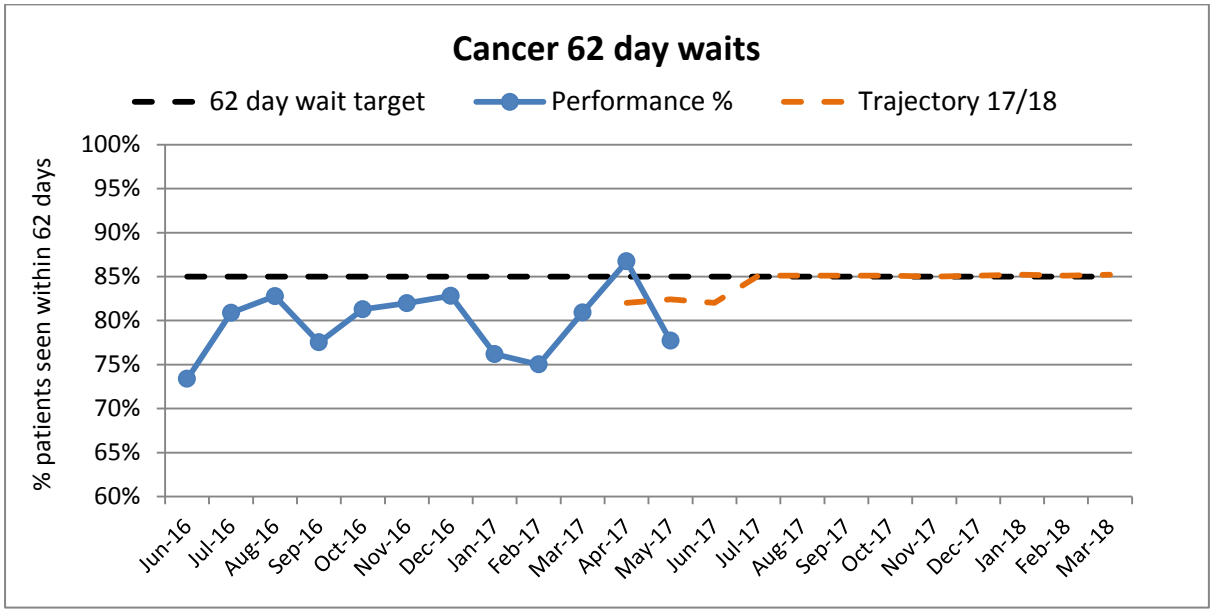


Figure 30 – Cancer 62 day GP referral to treatment performance for the period June 2016 – May 2017

2.5.5 Responsive: Cancelled operations

The cancelled operations performance for Quarter 1 (April to June) will be submitted on Thursday 27 July and a full update will be provided in the month 4 report. A review of the reporting and rebooking arrangements for cancellations is continuing across the Trust.

2.5.6 Responsive: Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 90.4 per cent in June 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 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.

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.

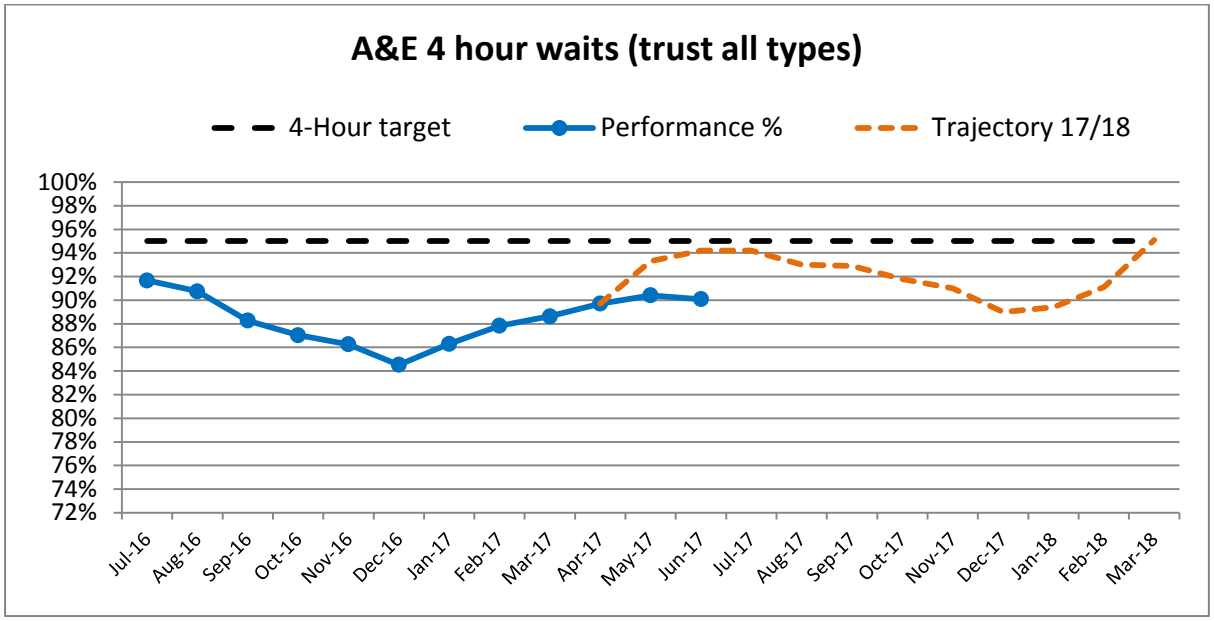


Figure 31 – A&E Maximum waiting times 4 hours (Trust All Types) for the period July 2016 – June 2017

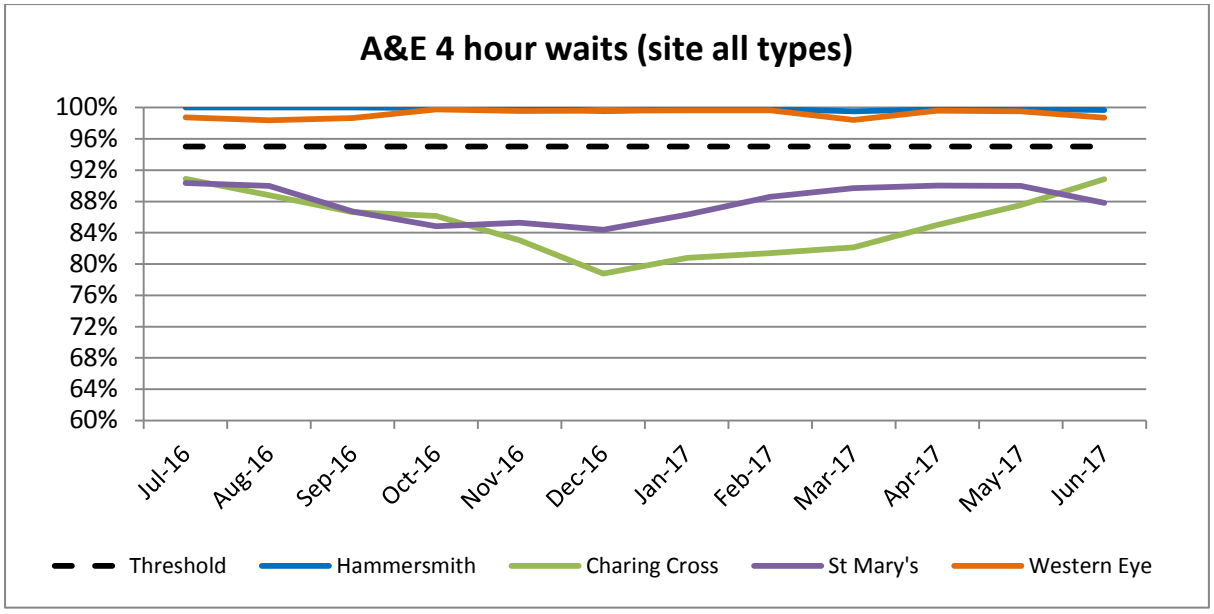


Figure 32 – A&E Maximum waiting times (Site All Types) 4 hours for the period July 2016 – June 2017

2.5.7 Responsive: Diagnostics

In June 2017, 7.73 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 has continues 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.

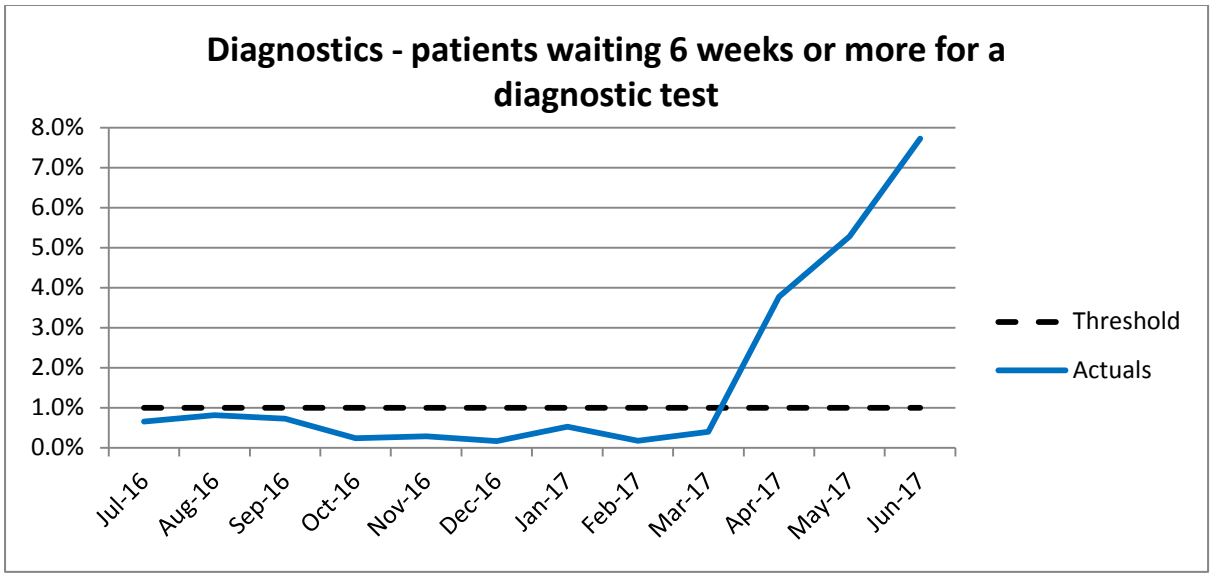


Figure 33 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period July 2016 – June 2017

2.5.8 Responsive: Outpatient DNA

The overall DNA rate (first and follow up) was 12.4 per cent in June. 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.

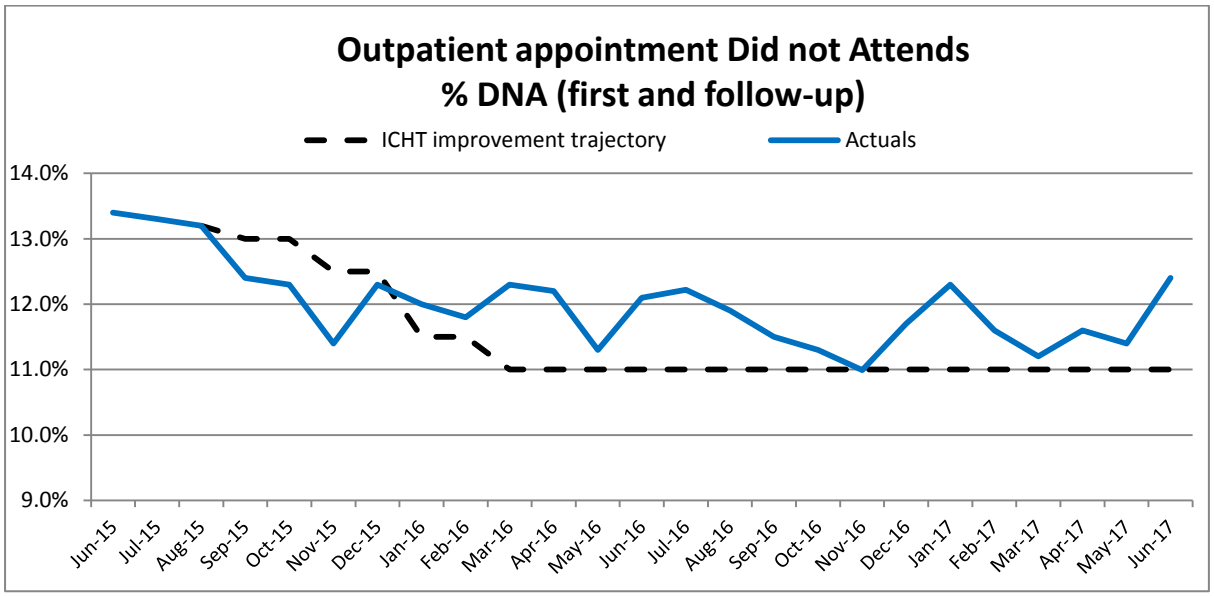


Figure 34 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period June 2015 – June 2017

2.5.9 Responsive: Outpatient appointments cancelled by the Trust

In June, 8.8 per cent of outpatient appointments were cancelled by the hospital with less than 6 weeks' notice. As noted above a detailed review of appointments data is being conducted to identify underlying trends and improvement actions.

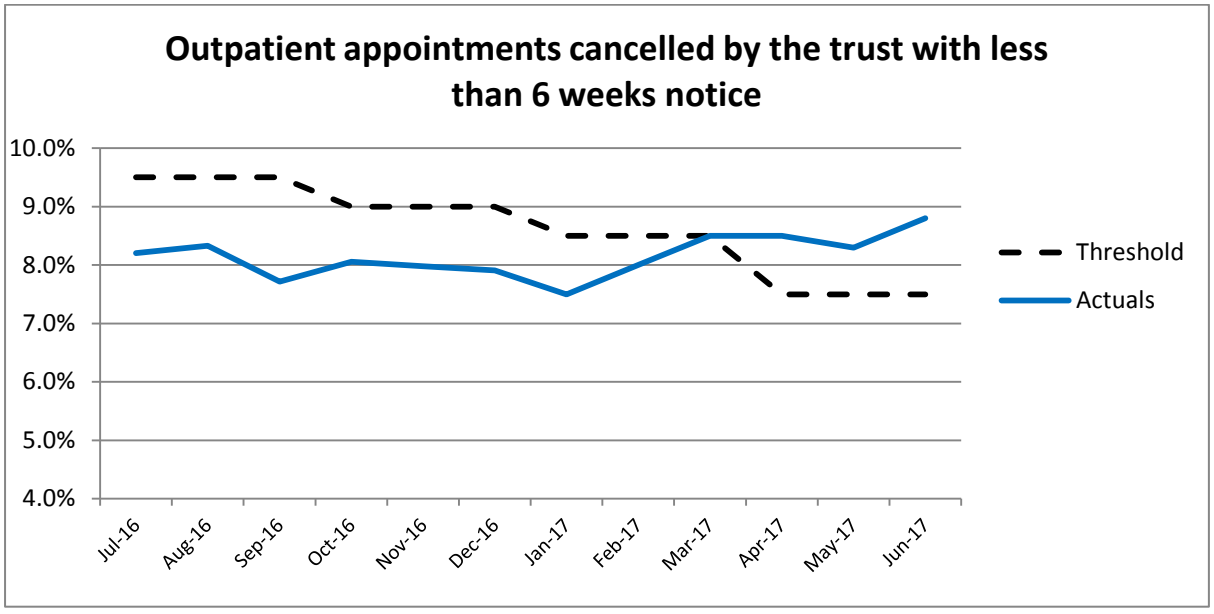


Figure 35 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period July 2016 – June 2017

2.5.10 Responsive: Outpatient appointments made within 5 days of receipt

In June, 79.0 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.

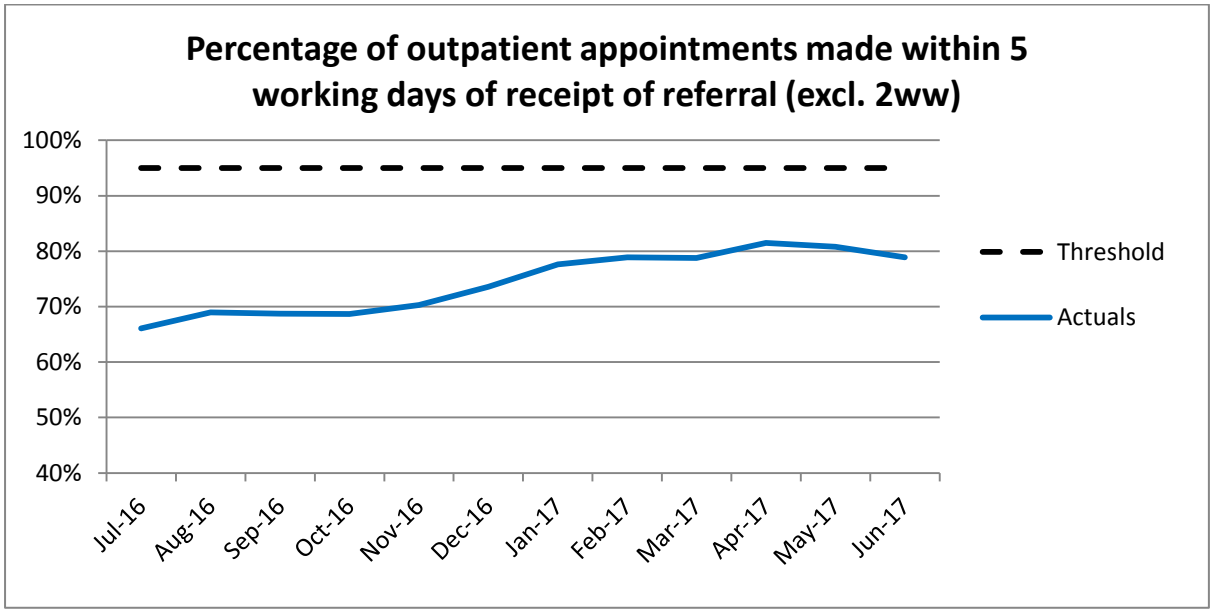


Figure 36 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period July 2016 – June 2017

3. Finance

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

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Finance Report for 2017/18 for the three months to June

Executive summary:

This paper presents the financial position for the first three months of the financial year to the end of June 2017.

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

The Trust has a cash balance of £21m and does not expect to draw down cash from the agreed working capital facility in year.

Capital spend is behind plan but expected to be on target for the end of the financial year.

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 July2017

FINANCE REPORT – 3 MONTHS ENDED 30 JUNE 2017

1. Introduction

This report provides a brief summary of the Trust's financial results for the 3 months ended 30th June 2017.

2. Financial Performance

The Trust has set a deficit plan of £41m, this does not meet the control total set by NHS Improvement meaning that we are not eligible for STF funding. The deficit planned leaves a £23.4m gap to the 'control total' set for the Trust by NHS Improvement.

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	87.55	89.41	1.86	259.02	263.41	4.39
Pay	(49.49)	(48.59)	0.90	(147.24)	(145.06)	2.18
Non Pay	(37.56)	(39.73)	(2.17)	(112.37)	(116.86)	(4.48)
Reserves	(0.47)	(1.42)	(0.95)	(2.02)	(5.22)	(3.21)
EBITDA	0.03	(0.34)	(0.37)	(2.61)	(3.73)	(1.12)
Financing Costs	(3.61)	(3.16)	0.45	(10.84)	(9.98)	0.86
SURPLUS / (DEFICIT) including donated asset treatment	(3.59)	(3.50)	0.09	(13.45)	(13.72)	(0.26)
Donated Asset treatment	(0.51)	(0.59)	(0.08)	(1.53)	(1.26)	0.26
Impairment of Assets	-		-	-		-
SURPLUS / (DEFICIT)	(4.10)	(4.09)	0.00	(14.98)	(14.98)	0.00
STF Income	-	-	-	-	-	-
SURPLUS / (DEFICIT) after STF income	(4.10)	(4.09)	0.00	(14.98)	(14.98)	0.00

Income is ahead of plan mainly due to NHS clinical activity income. When setting the plan the Trust budgeted for a reduction in income as commissioner demand management schemes reduced activity coming to the Trust. Delays in implementing these schemes may be causing the over performance on income year to date. The Trust also planned to remove the costs to deliver this activity, as this has not happened there is an overspend showing in expenditure. Pay costs are otherwise favourable to plan, within pay the use of agency staff is below plan and the NHS Improvement agency cap. Non pay expenditure is adverse to plan; these are at least partially driven by a shortfall on identifying and delivering cost improvement programmes (CIPs). Divisions are working with the programme support office (PSO) to identify schemes to meet the full plan for the year.

2.1 NHS Activity and Income

The summary table shows the position by division.

Divisions	Year To Date Activity			Year to Date Income £m		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine and Integrated care (MIC)	200,940	201,128	188	63.75	63.57	(0.18)
Division of Surgery, Cancer and Cardiovascular (SCC)	156,134	156,208	74	73.68	76.06	2.38
Division of Women, Children and Clinical Support (WCCS)	634,917	631,377	(3,540)	39.57	38.59	(0.98)
Central Income			-	28.30	30.13	1.83
Clinical Commissioning Income	991,990	988,713	(3,277)	205.29	208.35	3.06

Clinical activity is driving higher income than planned year to date, within clinical divisions there is £1.2m of over performance. In MIC there is over performance on non-elective income, the plan for non-elective growth was significantly reduced to reflect planned demand reduction schemes which are proving difficult to deliver. There is some underperformance in critical care; this is offset with over performance in SCC so the overall Trust critical care position is broadly on plan. Within SCC there is over performance in non-electives in trauma and oncology. WCCS is underperforming, there is reduced activity in paediatric services and maternity has seen a reduction in high value cases.

2.2 Private Care Income

Total private care income is below plan in month and year to date although that element delivered in dedicated facilities by Imperial Private Healthcare has exceeded plan . There has been a reduction in the activity seen within Paediatric care in particular. The Private Patients Division is working with Clinical Divisions to agree additional growth schemes where appropriate for 2017/18 to offset the underperformance.

2.3 Clinical Divisions

The devolved financial position for clinical divisions is set out in the table below.

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	22.98	24.12	1.14	68.20	67.73	(0.47)
Expenditure	(17.56)	(18.01)	(0.46)	(52.75)	(53.72)	(0.97)
Medicine and Integrated Care	5.42	6.10	0.68	15.45	14.00	(1.45)
Income	26.11	28.15	2.04	74.92	78.12	3.20
Expenditure	(21.89)	(23.71)	(1.82)	(66.69)	(68.03)	(1.34)
Surgery, Cancer and Cardiovascular	4.22	4.44	0.22	8.23	10.09	1.86
Income	15.41	15.38	(0.02)	45.03	43.40	(1.62)
Expenditure	(16.86)	(16.23)	0.62	(49.47)	(48.73)	0.74
Women, Children & Clinical Support	(1.45)	(0.85)	0.60	(4.44)	(5.32)	(0.88)
Imperial Private Healthcare	1.24	1.21	(0.03)	3.56	3.55	(0.01)
Total Clinical Division	9.43	10.91	1.48	22.79	22.32	(0.48)

Year to date Clinical Divisions are £0.5m adverse to plan. MIC are underperforming on income, mainly due to the effect of critical care offset with non-elective over performance. Expenditure is overspent where unidentified CIPs are not yet delivering savings. Within SCC expenditure is overspent reflecting the costs to deliver the additional activity. Within WCCS the adverse position is mainly due to a shortfall in income with both NHS and private income behind plan year to date. This is partially offset by underspends in pay, especially within Children's. For Imperial Private Health there has been over performance on income, especially at Charing Cross. However delays to expenditure CIPs caused overspending on pay bringing the overall position back to plan.

3. 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 but of course each year it gets harder to find new savings.

The year to date plan is £10.9m there has been achievement of £7.7m giving a £3.2m underperformance year to date. This underperformance is due to a combination of slippage in 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.

4. Cash

The Trust closed month 3 with a cash position of £21m. It is currently anticipated that the Trust will not require further draw down of working capital. There is close monitoring of cash in the Trust and active management of debtors to ensure maintenance of an appropriate cash position.

5. Capital

In-month capital expenditure, including donated assets was £2.6m against a planned spend of £3.0m. Cumulatively the gross spend is £4.4m against a plan of £8.3m. The current underspend reflects that the fact that a number of schemes are in developmental 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.

6. Conclusion

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

The size of NHS income over performance is a risk to the Trust's financial position as it may cause an affordability issue for commissioners. The finance team is working closely with commissioners to understand the key drivers of any income over performance.

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 3 months to 30th June 2017

	In Month			Year To Date (Cumulative)		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Income						
Clinical (excl Private Patients)	71.7	73.3	1.6	210.9	213.6	2.7
Private Patients	4.3	4.0	(0.3)	12.8	11.7	(1.1)
Research & Development & Education	8.3	8.2	(0.1)	24.9	24.3	(0.6)
Other	3.3	4.0	0.6	10.4	13.8	3.4
TOTAL INCOME	**87.6**	**89.4**	**1.9**	**259.0**	**263.4**	**4.4**
Expenditure						
Pay - In post	(46.3)	(42.4)	3.9	(138.0)	(127.0)	11.0
Pay - Bank	(0.3)	(3.7)	(3.3)	(0.9)	(11.2)	(10.3)
Pay - Agency	(2.8)	(2.5)	0.3	(8.3)	(6.8)	1.5
Drugs & Clinical Supplies	(20.1)	(20.3)	(0.3)	(60.0)	(61.4)	(1.4)
General Supplies	(2.8)	(3.1)	(0.4)	(8.3)	(9.0)	(0.7)
Other	(14.7)	(16.3)	(1.5)	(44.1)	(46.5)	(2.4)
TOTAL EXPENDITURE	**(87.1)**	**(88.3)**	**(1.3)**	**(259.6)**	**(261.9)**	**(2.3)**
Reserves	(0.5)	(1.4)	(1.0)	(2.0)	(5.2)	(3.2)
Earnings Before Interest, Tax, Depreciation & Amortisation	**0.0**	**(0.3)**	**(0.4)**	**(2.6)**	**(3.7)**	**(1.1)**
Financing Costs	(3.6)	(3.2)	0.5	(10.8)	(10.0)	0.9
SURPLUS / (DEFICIT) including financing costs	**(3.6)**	**(3.5)**	**0.1**	**(13.4)**	**(13.7)**	**(0.3)**
Donated Asset treatment	(0.5)	(0.6)	(0.1)	(1.5)	(1.3)	0.3
SURPLUS / (DEFICIT) including donated asset treatment	**(4.1)**	**(4.1)**	**0.0**	**(15.0)**	**(15.0)**	**0.0**
Impairment of Assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	**(4.1)**	**(4.1)**	**0.0**	**(15.0)**	**(15.0)**	**0.0**
STF	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	**(4.1)**	**(4.1)**	**0.0**	**(15.0)**	**(15.0)**	**0.0**

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

2016/17 Trust complaints service annual report

Executive summary:

This report reviews the activity, focus and improvements of the complaints service in 2016/17. This year has seen full embedding of the complaints management process which has meant that good performance in terms of responsiveness has been maintained.

Importantly, this year's focus has been on establishing a structured way of learning from complaints and improving quality as a result. This has delivered a number of improvements which are explored further in the report.

Because of the ever closer working between the complaints team and the Patient Advice and Liaison Service (PALS), there is a section in this paper on PALS activity.

Quality impact:

When people raise concerns about their care or that of their relatives, prompt resolution of those concerns is critical to maintaining a quality experience.

Complaints management is relevant to some extent to all the CQC domains, but particularly caring and responsive. An effective system that is able to demonstrate learning from complaints is evidence of a well led organisation.

Financial impact:

The proposed approach for 2017/18 will have no associated additional cost. Effective complaints handling has the potential to deliver small cost savings as a result of not needing to make financial remedy to complainants.

Risk impact:

Whilst things will not always go to plan, failing to deal with such situations sensitively and effectively can exacerbate the poor experience and damage the reputation of the organisation.

Recommendation(s) to the Committee:

The Board is asked to note the report.

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
Keith Ingram Daniel Marshall Guy Young	Janice Sigsworth	17 July 2017

2016/17 Trust complaints service annual report

1.0 Introduction

Last year saw the Patient Advice & Liaison Service (PALS) and Complaints Teams embed the changes made following the centralisation of the complaints function. These changes have transformed the quality of the service and the teams were therefore delighted that this was recognised in July 2016 when they were awarded Team of the Year at the Trust annual awards.

In November 2016 when audited the complaints process received the highest (substantial) level of assurance.

The headline performance figures for last year are:

- 1032 formal complaints received and 2589 PALS cases resolved.
- 99% of complaints were responded to within their agreed deadlines. Only 5 cases breached their agreed deadlines for the whole year.
- 99.8% of acknowledgment letters were sent within 3 working days.
- The average number of days to respond to complaints hit an all-time low, 27 days, which is well below the local target of 40 days.
- The number of complaints referred to the Parliamentary & Health Service Ombudsman (PHSO) fell to 17, from 19 cases in the year previously. The PHSO investigated 22 cases (12 not upheld, 8 partly upheld and 2 upheld).
- The proportion of reopened complaints continues to fall from 14% in 2015/16 to 10% in 2016/17
- Various members of the complaints team continue to be nominated by directorates for Make a Difference instant recognition awards.

Engagement between the Central Complaints Team, PALS and the divisions has been strengthened and there is now an established complaints presence at divisional monthly and quarterly governance meetings. This is supported by regular reports provided by the Complaints & Service Improvement Manager. A weekly tracker continues to be sent out to key staff. Last year the weekly report was improved by including compliments, to help balance feedback.

A system for ensuring that actions arising from complaint investigations are captured, and monitored, is now in place and the first significant service improvement resulting from trends in formal complaints was approved by the Trust Board in February 2017 and is now nearing completion (please see section 8).

When looked at in relation to other comparable trusts, ICHT has performed particularly well in terms of meeting response targets and in the number of PHSO cases relative to our overall case load. There is however, more work to be done to reduce our reinvestigation rate and we have therefore set ourselves an objective of reducing this to 5% by the end of 2017/18.

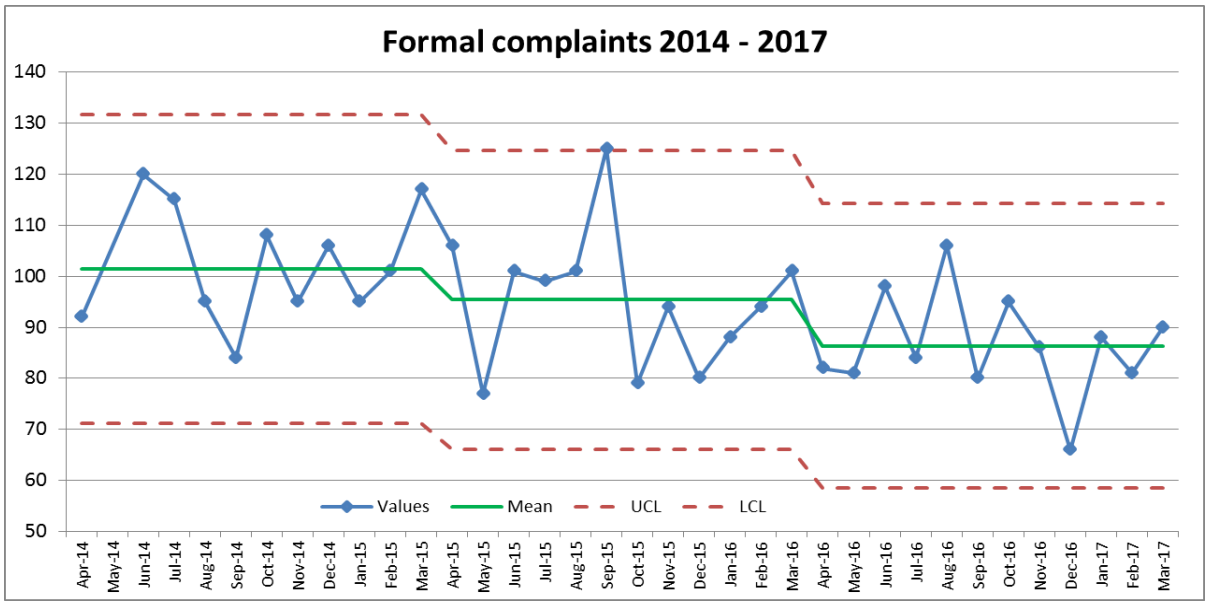
2.0 Numbers of Formal Complaints Received

Last year the Trust received a total of 1032 formal complaints. Following the pattern established in the previous year the volume of complaints fell by 10%, from 1145. This year's reduction in the number of formal complaints was particularly pleasing because of the concurrent increase in the Trust's activity. This reduction reflects not only our efforts to learn from our mistakes, but more importantly the Trust's significant investment in improving the

patient experience and other initiatives. The PALS has also contributed to this achievement by swiftly resolving many concerns so that they do not become formal complaints.

The graph below shows the trend in the number of formal complaints raised over the last three financial years. This graph demonstrates a slow but steady year-on-year fall in the volume of complaints received by the trust.

Graph 1: Numbers of formal complaints received for the last three years

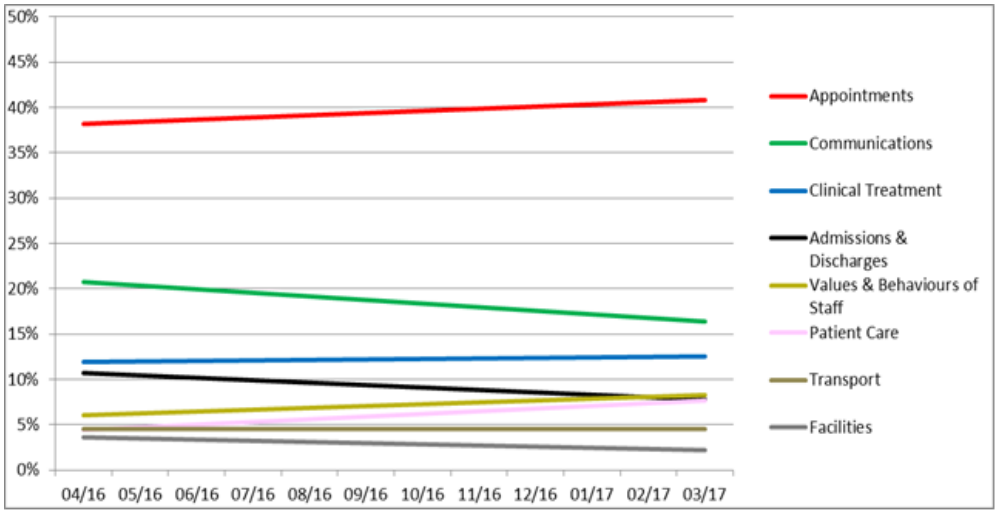


3.0 Complaints cases

Overall trends including PALS concerns

Graph two demonstrates general trends and covers both PALS and Formal Complaints themes raised as a proportion of the overall caseload for that month.

Graph 2: Trends in PALS and complaints themes last year



Since 1 April 2016 we have been reporting using standardised categories, set by NHS Digital. Table 1 highlights the top 5 categories of formal complaints received in the year in comparison with the previous year.

Table 1: Formal complaints by category

Category	2016/17	% of total	2015/16	% of total
Clinical treatment/patient care	475	46%	489	43%
Appointments	185	18%	240	21%
Communications	114	11%	117	10%
Values and Behaviours (Staff)	108	10.5%	142	12%
Admissions & Discharges	83	8%	44	4%
TOTAL	**965**	**93.5%**	**1032**	**90%**

Table 2 provides a breakdown by service area. We see the highest number of complaints from Outpatients due to their high activity; however, their complaints have decreased by around 25% over the year. A&E, another area that has seen an increase in activity, has also seen the volume of complaints fall significantly.

Table 2: Complaints by service area

Service area	2016/17	% of total	2015/16	% of total
Outpatients	470	46%	630	55%
Inpatients	412	40%	305	27%
A&E	77	7%	130	11%
Maternity	73	7%	53	5%
Total	**1032**	**100%**	**1118**	**98%**

Table 3 shows the number of complaints received by division. Due to the changing responsibilities for our divisions we have looked at the specialties that have attracted the most complaints in Table 4.

Table 3: Complaints by division

Division	2016/17	% of total	2015/16	% of total
Medicine & Integrated Care	389	38%	356	31%
Surgery, Cancer & Cardiovascular	314	30%	423	37%
Women's, Children's & Clinical Support*	192	19%	163	21.5%
Corporate (including IPH)	137	13%	118	10.5%
Total	**1032**	100%	**1145**	**100%**

Table 4: Complaints by specialty

Division	2016/17	2015/16	% change year on year
Emergency Medicine	72	94	-31%
Orthopaedics	71	51	+39%
Maternity	70	79	-11%
Imperial Private Healthcare	62	28	+221%
Transport	49	80	-61%

Orthopaedics and Imperial Private Healthcare (IPH) saw an increase in the number of formal complaints. The Orthopaedics specialty has had a challenging year in terms of meeting demand for its services. Waiting times and cancellation were issues of concern for our patients. The service implemented an improvement plan in place to address these issues by increasing capacity and recruiting more clinicians. Therefore we anticipate that complaints for this area will decline during 2017/18.

IPH is another area which has experienced an increase in complaints during the year. A review of these cases demonstrated a need to do more to ensure that these complaints are identified and resolved at an earlier stage during the patient's stay.

The outcome of any given complaint investigation is that the complaint can be "not upheld", "partly upheld" or "upheld". For those cases which are partly upheld or upheld, actions and learning are extracted and recorded on complaints change register for follow-up. Table 5 shows the outcomes of the 1080 complaints investigations completed in 2016/17. Approximately half of all complaints investigated were not upheld.

Table 5: Outcome by division

	Upheld	Partly upheld	Not upheld	Total
Medicine and Integrated Care	77	57	206	340
Surgery, Cancer and Cardiovascular	131	102	164	397
Women's, Children's and Clinical Support	50	66	82	198
Corporate (Inc. IPH)	48	38	59	145
Total	**306**	**263**	**511**	**1080**
Percentage	**28%**	**24.5%**	**47.5%**	

4.0 The year ahead for the Central Complaints Team

Our focus next year will be on further improving the quality of our responses by clearly explaining what occurred when things go wrong. We will be more empathetic and manage our complaint investigations in a prompt and effective manner; complainants should not have to wait any longer than is necessary to receive the outcome of the investigation or, where possible, to have their concerns resolved.

Additionally, the Central Complaints Team will also continue to improve the service it provides by reviewing the feedback obtained from our online complaints questionnaire.

5.0 PALS cases

The PALS team resolved 2859 informal concerns and enquiries last year. Table 6 displays a breakdown of the cases received by Division.

Table 6: PALS cases by Division

Division	2016/17	% of total	2015/16	% of total
Medicine & Integrated Care	885	31%	1008	27%
Surgery, Cancer & Cardiovascular	1140	40%	1634	43%
Women's, Children's & Clinical Support	327	11%	658	17%
Corporate	507	18%	473	13%
Total	**2859**	**100%**	**3773**	**100%**

The evidence suggests that there is a general downward trend as has been seen in formal complaints. PALS continue to deal with a greater proportion of cases for Surgery, Cancer & Cardiovascular than the complaints team. Many of these cases relate to delays and cancellations in surgery appointments, issues which are particularly amenable to quick resolution. The proportion of PALS cases regarding corporate issues has increased; this was predominantly related to patient transport issues, particularly in relation to access to the service following a drive to implement the eligibility criteria.

Table 7 shows the breakdown of PALS cases by specialty (for those specialties receiving more than 100 concerns in the year).

Table 7: PALS cases by specialty

Speciality	Number of cases received	% of all PALS cases
Orthopaedics	302	11%
Neurosurgery	207	7%
Neurology	188	7%
Ophthalmology	156	5%
Transport	132	5%
Ear, Nose & Throat	123	4%
General Surgery	118	4%

Table 8 shows a breakdown of PALS cases by category (top 5 categories only)

Table 8: PALS cases by category

Subject	2016/17	% of total	2015/16	% of total
Appointments	1082	38%	1017	27%
Communications	486	17%	957	25%
Admissions & Discharges	231	8%	111	3%
Clinical Treatment	183	6%	395	10%
Values & Behaviours (Staff)	122	4%	254	7%
TOTAL	**2104**	**74%**	**2734**	**72%**

The above table reflects the Trust's capacity issues. The main issues PALS dealt with last year were about appointments (primarily delays, cancellations and clinic waiting times) and problems relating to communication. These accounted for 55% of all the cases that PALS handled as opposed to 29% for formal complaints. This demonstrates the effectiveness of PALS in ensuring that simple queries about appointments are not allowed to escalate unnecessarily.

6.0 The year ahead for PALS

Next year we will shift PALS from a primarily reactive service model to more of a proactive service model. We would like PALS to be on the wards as well as in the office to ensure that every opportunity is taken to resolve concerns in house and at source. To help achieve this, a number of actions are planned. Firstly, PALS Officers are to be provided with uniforms to ensure they are more easily recognisable across our sites. In addition, PALS Officers will be allocated their own wards, or service areas, ensuring that they can develop their knowledge of particular patient areas and be seen as the 'go to' person for their area with the ability to provide immediate support.

To help them with this work the PALS Manager is developing PALS volunteers. This will help to ensure that PALS is highly visible and that they provide additional support and assistance to our PALS Officers so that we are able to resolve more concerns in house.

The Trust has recognised that it is important to resolve concerns before patients are discharged. A review of our PHSO cases reveals that our most difficult cases to resolve occur when a patient takes their concerns home with them before raising them. Therefore, PALS, and the formal complaints teams, are developing a Clinical Mediator role, which when implemented will provide another method of resolution for cases when immediate clinical input would be helpful. It is hoped that the Trust will make available a clinician from a related specialty to provide additional clinical overview, support and reassurance.

7.0 PHSO Cases

Table 9 provides a breakdown of all the PHSO decisions last year. The PHSO reviewed 22 cases, which amounts to 2.1% of the Trust's annual caseload.

Last year we strengthened the governance concerning the management of PHSO cases and how we share learning following a PHSO review. We now have a structured approach to ensure we report and share learning with our divisional triumvirates.

Table 9: Decisions the PHSO made last year by division

Division	Upheld	Partly Upheld	Not Upheld
Medicine & Integrated Care	2	1	2
Surgery, Cancer & Cardiovascular	0	4	9
Women's, Children's & Clinical Support	0	3	1
TOTAL	2 (9%)	8 (36%)	12(55%)

Financial remedy

The Trust made monetary payments totaling £11,696 last year to help remedy complaints where a service failure occurred. We are also required to put a complainant back to the same financial position they would have been in had the problem not occurred. Of the total amount, £3250 (27%) was paid as a result of specific recommendations from the PHSO (for comparison, in 2015/16 year the PHSO awarded £2,444.60). The remaining amount was paid pro-actively by the Complaints Team. This proactive approach prevents cases unnecessarily escalating to the PHSO, which incurs even a greater cost to the Trust not only in terms of a financial remedy but staff time.

8.0 Learning and Service Improvements following a formal complaint investigation

The Complaints & Service Improvement Manager works with the wider complaints team to ensure that learning and actions are recorded on a change register when complaints are closed. The register is reviewed on a monthly basis and any outstanding actions are reviewed and flagged with the Divisional Governance Lead on a quarterly basis, at their Divisional Quality and Safety Committee meeting, until they are completed.

Examples of improvements made in response to complaints include:

- a protocol for clinicians to better manage neurosurgical patients with serious conditions developing non-neurosurgical problems, especially when they manifest after discharge
- ward staff and junior medical staff received further training about safe urethral

catheterisation and removal
- production of a new gender recognition policy
- a new protocol was implemented to stagger the arrival times of ENT elective surgery patients

In addition to the above actions, on a quarterly basis, the Complaints & Service Improvement Manager produces the Complaint & PALS Service Improvement report. This provides a regular update on numbers, themes and learning from formal complaints and PALS feedback. Learning and actions are also presented in a "You Said, We Did" section as well as a list of actions already undertaken. This is presented at the divisional Quality & Safety Committee meetings so that staff are able to see how we have learned and improved as a consequence of a complaint investigation.

The Complaints and Service Improvement Manager works with the divisions (with the assistance of their governance leads) to proactively monitor trends in complaints and identify emerging themes.

9.0 Conclusion

The trust is seeing a gradual year-on-year reduction in the number of complaints and PALS concerns. This is likely to be in large part due to the wide range of quality improvement programmes and initiatives that the organisation is undertaking. Also, it is believed the proactive and timely approach to dealing with people's concerns so that they can be addressed before needing to progress to a formal complaint is beginning to show benefits.

2015/16 was focused on embedding a revised formal complaints process in order to address some real concerns about the trust performance in relation to response times. The primary task during 2016/17 was to embed a structured approach to learning from complaints, which has shown some clear benefits. In the coming year the focus will be developing the PALS component of the service to a more proactive one; dealing with issues long before people feel the need to raise a concern formally.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

CQC Update

Executive summary:

The following report provides an update to the Trust board on the CQC's new approach for regulating NHS acute trusts:

- The CQC published its new regulatory approach for NHS acute trusts on 12 June 2017.
- A number of changes have been outlined regarding the management of; inspections, intelligence the CQC hold of Trusts and relationships with the Trust. Change to the core services and key lines of enquiry have also been made.
- The Trust's inspection framework is currently being updated in light of the new CQC approach.
- The corporate nursing team will present a final version of the Trust's 2017/18 *CQC Registration and Inspection Framework* to the Board in September 2017.
- The corporate nursing team will draft a plan to prepare for the trust-level inspection of the well-led inspection domain and share this at the Board seminar in October.

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*

(This risk is currently being updated in light of the new CQC regulatory approach)

Recommendation(s) to the Trust board:

The Trust board is asked to note the paper.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion

Authors	Responsible executive director	Date submitted
Priya Rathod, Deputy Director of Quality Governance Kara Firth, Regulation Manager	Janice Sigsworth, Director of Nursing	19 July 2017

CQC Update

1. Purpose

The following report provides an update to the Trust Board on the CQC's new approach for regulating NHS acute trusts which was published in June 2017.

2. The CQC's new approach for regulating NHS acute trusts

2.1. Key changes to inspections

- The key changes to the approach are as follows:
  - Each trust is expected to have **at least one inspection per year**
  - This will include, at a minimum:
    - An assessment of the **well-led domain at Trust level .**
    - This inspection will be announced; however, the CQC has not published a notice period so it is not yet known how far in advance the Trust will be notified when this inspection will take place.
  - A **full inspection across all five domains of at least one core service**.
    - Inspections of core services will be unannounced; the Trust will not receive notification that they are taking place.
- Each trust will have its first trust-level well-led inspection by the end of 2018/19 (i.e. March 2019).
- The inspection will draw on a range of evidence applicable at trust level, including; interviews with board members and senior staff, focus groups, analysis of data, review of strategic and trust-level policy documents, and information from external partners such as commissioners, other health providers with whom the Trust works, NHS Improvement, Healthwatch, etc.
- Areas of focus for the well-led inspection will include:
  - Improvements and changes since any previous inspection
  - Trusts' ability to plan, deliver and optimise their digital systems
  - How trusts respond to the outcomes of the NHS staff survey
  - Whether trusts have developed models of care in response to the changing needs of their patient populations.
  - Whether trusts' values are reflected in the behaviour of senior leaders and staff.
  - The engagement of senior and executive leaders, and trust boards, with staff.
  - Whether there is a culture of sharing information within the trust, with other care providers, etc.
  - Whether there is a culture of raising concerns, learning from errors and being transparent with patients and families.
  - False assurance resulting from inadequate data and information being provided to senior and executive leaders, and trust boards, and failure to recognise or act on this.
  - Lack of challenge from / action taken by senior and executive leaders, and trust boards when the safety and quality of care within services is not meeting standards and expectations.
  - Regarding non-executive directors, their expertise, objectivity, and constructive challenge to trusts.
  - Whether concern about a trust's reputation leads senior and executive leaders, and trust boards to be reluctant to be open about issues and concerns.
  - Whether senior and executive leaders, and trust boards encourage feedback and are open to change, or are insular and resistant to the views of others.

2.1.1. Alignment between CQC's and NHS Improvement's approach to 'well-led'.

- As part of simplifying regulatory approaches, NHS Improvement (NHSI) have 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.

- There is strong alignment between the NHSI published 'well led framework' and the regulatory approach the CQC uses to assess the well-led domain.
- To this end, the corporate nursing team will work closely with the Trust company secretary to ensure there is a joint internal approach for managing the 'well-led framework' requirements as well as what is required for a CQC well-led inspection.

2.1.2. Feedback from another trust's well-led inspection

- The Divisional Director of Nursing for Medicine and Integrated Care is a specialist advisor for the CQC and participated in the first of these new 'well led' inspections in June 2017. They have indicated that key some of the key areas of focus during the inspection were:
- Sustainability of and confidence in leadership at trust board level
- Emergency planning
- Culture
- Equality, diversity and inclusion.
- The corporate nursing team have also liaised with the Trust that was inspected so that any learning can be shared.

2.1.3. Trust inspection preparation for 'well led'

A draft inspection preparation plan for the well-led inspection will be prepared by the corporate nursing team and proposed in September 2017, after which preparations will commence. Following this, a detailed discussion of preparations will take place at the Trust board seminar on 25 October 2017.

2.2. Key changes to CQC intelligence of the Trust - CQC Insight

Although the CQC has previously carried out monitoring of trusts to inform inspection scheduling and planning (referred to as 'intelligent monitoring'), a more robust approach called 'CQC Insight' is being introduced which includes data and information provided by trusts.

2.2.1. Provider Information Request (PIR)

- There is now an annual Provider Information Request (PIR) return that the Trust will be required to submit. It will include submitting a range of data and documents to the CQC reflecting recent / current performance in key areas. 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.
    - 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.
- Data and information about trusts will be monitored over time to identify changes and trends in performance, and will be compared to similar services (i.e. benchmarking).
- CQC Insight reports will be accessible on the CQC's website; the reports will not be in the public domain, each trust will be provided with access rights to log on and see its reports.
- The CQC will also share the reports with trusts' key partners including NHS England, NHS Improvement, clinical commissioning groups and Healthwatch.
- The Trust received its formal PIR request on 14th July 2017 and has three weeks to submit it to the CQC.

- The corporate nursing team are coordinating the PIR working with divisional and corporate colleagues and a standard operating procedure has been developed to manage the process.

2.3. Key changes to relationship management

In addition to the regular, informal meetings held between trusts and their CQC relationship managers, formal face to face meetings will now take place approximately every three months, which senior trust managers, executives and non-executive directors may be asked to attend if there is a particular area of expertise they wish to discuss. For example, the chair of the Quality Committee or the Director of People and Organisational Development.

2.4. Key changes to Core Services and key lines of enquiry (KLOE)

- Some changes have been made to what the CQC considers to be 'core services' for NHS acute trusts.
- The pathways in some previous core services have been separated.
- 'Additional services' have been introduced which are not considered 'core' for acute trusts, but may be inspected where they represent a significant proportion of a particular trust's activity.
- We do not yet know whether the CQC will consider that the Trust delivers any additional services; this will only be identified when the CQC arrive to inspect a service.
- The revised core services and example additional services are outlined overleaf:

CORE SERVICE	EXAMPLES OF ADDITIONAL SERVICES
Urgent and emergency services	Gynaecology
Medical care, including older peoples' care	Diagnostic imaging
Surgery	Rehabilitation
Critical care	Spinal injuries
Maternity (previously Maternity and gynaecology)	Neonatal services* (previously a core service)
Services for children and young people	
End of life care	
Outpatients (previously Outpatients and diagnostic imaging)	

- Some KLOEs have been moved among the five domains, the wording for some has been amended to be more explicit, and some new KLOEs have been introduced.
- KLOEs for the well-led domain have been agreed jointly between the CQC and NHS Improvement (NHSI); both organisations will use these KLOEs for the purposes of their individual remits. During 2017/18, NHSI will be introducing assessments of how trusts use resources (similar but separate to Monitor's Single Oversight Framework). NHSI will carry out these assessments, which are wholly separate from CQC inspections.

3. Updating the Trust's 2017/18 *CQC Registration and Inspection Framework*

- The Trust's inspection framework is currently being updated in light of the new CQC approach. The following changes have been agreed by the Executive Qulaity Committee:
  - Divisionally-led self-assessments against the CQC domains.
  - Identification of core service leads to support self-assessments against the CQC domains and to lead CQC inspections of core services for the Trust.
  - It was proposed that leads be directorate triumvirates (clinical lead, lead nurse and general manager), with general managers acting as inspection leads in practice.
  - Introduction of a 'CQC readiness' forum for core service leads, led by the CQC team in the corporate nursing directorate.

- A quarterly assurance update from divisions on the 'CQC readiness' for services in their areas.
- The corporate nursing directorate will manage the new trust-level inspections of the well-led domain.

4. Next Steps

- The corporate nursing team will make changes to the Trust's *CQC Registration and Inspection Framework* in line with the CQC's new approach; during July 2017 the team will consult with divisions about the framework for 2017/18.
- The corporate nursing team will present a final version of the Trust's 2017/18 *CQC Registration and Inspection Framework* to the Board in September 2017.
- The corporate nursing team will draft a plan to prepare for the trust-level inspection of the well-led inspection domain and share this at the Board seminar in October.

5. Recommendations to the Board:

- To note the paper.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

CQC Outpatients and diagnostic imaging inspection report

Executive summary:

The following report provides an update to the Trust Board on the CQC inspection of Outpatients and diagnostic imaging that took place in November 2016.

- The Trust's core service of Outpatients and diagnostic imaging was inspected by the CQC in November 2016 at St Mary's, Charing Cross and Hammersmith hospitals.
- The service was previously rated overall as 'Inadequate'. Significant improvement was identified at all three sites with ratings as follows:
  - St. Mary's Hospital: Good
  - Hammersmith Hospital: Good
  - Charing Cross Hospital: Requires improvement
- A range of actions and improvements are underway in response to the findings.

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*

(This risk is currently being updated in light of the new CQC regulatory approach)

Recommendation(s) to the board:

To received the CQC inspection reports.

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	19 July 2017

CQC Outpatients and diagnostic imaging inspection report

1. Purpose

The following report provides an update to the Trust board on the CQC inspection of Outpatients and diagnostic imaging that took place in November 2016.

2. CQC inspections of the Trust

2.1. Outpatients and Diagnostic Imaging

- The Trust's core service of Outpatients and diagnostic imaging was inspected by the CQC in November 2016 at St Mary's, Charing Cross and Hammersmith hospitals.
- Main and devolved outpatient areas, imaging services and Imperial Private Healthcare were visited.
- Inspection reports were published on the CQC's website on 31 May 2017
- The service was previously rated overall as 'Inadequate'. Significant improvement was identified at all three sites with ratings as follows:

St Mary's and Hammersmith hospitals						
Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**		**Overall**
Good	CQC does not rate for this service	**Good**	**Requires improvement**	**Good**		**Good**

Charing Cross Hospital						
Safe	**Effective**	**Caring**	**Responsive**	**Well-Led**		**Overall**
Requires improvement	CQC does not rate for this service	**Good**	**Requires improvement**	**Requires improvement**		**Requires improvement**

- Key issues resulting in the 'Requires improvement' ratings were:
  - Safe domain at Charing Cross:
    - Low rates of completion of statutory and mandatory training among all staff groups in both outpatients and diagnostic imaging
    - Concerns about safe staffing in Radiology due vacancies, and about the on-call procedure out of hours, in particular in relation to training for staff involved
    - Two examples of unsafe storage of medicines and equipment in Radiology
  - 'Well-led domain at Charing Cross:
    - Lack of visibility of senior manager and the executive team
    - Lack of awareness among staff of the Trust's vision and values
    - Leadership and a blame culture in the Radiotherapy service
  - Responsive domain at all three sites:
    - Not meeting RTT targets for both 2-week waits and routine referrals
    - Long waiting times for patients to be seen after they had arrived in some areas
    - Poor signage
- The CQC did not set any compliance actions or must-do actions for the Trust to take as a result of the inspection; only should-do actions were set.

- Since the inspection a number of improvements have already been made or are underway:
  - Completion of the Patient Service Centre at Charing Cross Hospital
  - Implementation of the Waiting List Improvement Programme for accurate tracking of patient pathways for RTT
  - Further investment in digital optimisation to expand digital communications with GPs and patients
  - Development of a business case for the Way Finding Programme
  - Launch of the Outpatients Experience Lab Project, a multidisciplinary co-design project for driving improvements
  - The first phase of outpatient refurbishment on the Hammersmith site is scheduled for completion in July 2017.
- The division will manage and monitor actions related to the inspection and will report on progress to the Executive Quality Committee in line with the existing CQC governance and reporting framework.

2.2. Maternity at St Mary's Hospital, and Medical care at St Mary's, Charing Cross and Hammersmith hospitals

- Following unannounced inspections at the Trust which took place in March 2017, the Trust is expected to receive its draft reports from these inspections between July and September 2017.

3. CQC inspection of Vocare - Urgent Care Centre (UCC) at St.Mary's Hospital

- On 13 July 2017, the CQC inspected the UCC at St. Mary's Hospital.
- This was not an inspection of the Trust as the service is run by Vocare, although the CQC did talk to some Trust staff on the day.
- The inspection report will be published in accordance with the CQC's timeframe which at present is 65 working days (from inspection).

Imperial College Healthcare NHS Trust

Outpatients and diagnostic imaging at St Mary's Hospital

Quality Report

St Mary's Hospital
Praed Street
London
W2 1NY
Tel: 020 3312 6666
Website: https://www.imperial.nhs.uk/our-locations/st-marys-hospital

Date of inspection visit: 22-24 November 2016
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

St Mary's Hospital is an acute general teaching hospital located in hospital in Paddington, London. The hospital was founded in 1845 and has been operated by Imperial College Healthcare NHS Trust since 2008. The trust's central outpatient departments were located at St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital which were overseen by a single leadership team (Lead Nurse, Clinical Director and General Manager), with dedicated clinical and administrative leadership teams based on each site.

Our last comprehensive inspection of the trust was undertaken in September 2014 when we rated the outpatients and diagnostic imaging service at St Mary's Hospital as inadequate. The purpose of this focused follow-up inspection was to inspect core services that had previously been rated as inadequate.

During this inspection we found the service had improved. We rated the outpatients and diagnostic imaging service at St Mary's Hospital as good overall.

Our key findings were as follows:

- Staff felt there was a positive incident reporting culture that promoted honesty within a 'no blame' culture. Staff at all levels told us they felt supported when they submitted incident reports and felt the level of feedback was appropriate.
- All areas met or exceeded the trust's 90% compliance target with hand hygiene and 'bare below the elbow' policies.
- Staff followed appropriate medicine management procedures that reduced the risk of incorrect doses and administration. Medicines were stored according to manufacturer instructions and mistakes were acted upon to reduce the risk they could happen again.
- The number of patients seen in outpatients with temporary notes as a result of their case records being unavailable was better than the national benchmark maximum of 4% of patients.
- Safeguarding processes were well established and staff demonstrated appropriate knowledge of them. All staff had access to trust safeguarding policies. Clinical staff in sexual health and HIV services had a higher level of safeguarding training that enabled them to safely care for vulnerable and at-risk patients, including those complex needs and challenging social circumstances.
- Processes were in place to ensure children and young people seen outside of paediatric services were cared for using appropriate safeguarding policies. Staff used monthly multidisciplinary safeguarding meetings to review such instances.
- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process as part of a robust risk management process.
- Consultant and nursing cover was generally adequate to meet demand. Where staff sickness might impact the ability to run a clinic, specialist registrars were able to provide some cover. Staffing levels were determined by the length of clinics and number of patients and according to consultant job plans.
- Staff in each service provided care and treatment that was benchmarked against the guidance of national bodies of practice, including the Medicines and Healthcare Products Regulatory Agency, National Institute of Health and Care Excellence, the Faculty of Sexual and Reproductive Health and the British HIV Association.
- Between January 2016 and December 2016, the hospital met the two week wait target for cancer referrals in every month.
- Waiting times in diagnostic imaging were better than the national target of six weeks for the five core diagnostic services between April 2016 and December 2016.
- Dedicated radiation protection advisers and radiation protection supervisors were in post and provided oversight for diagnostic imaging services to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011 safety guidance.

Summary of findings

- Staff spoke positively about the annual appraisal and professional development record process and said they had been able to secure training and development activities as a result.
- There was evidence of multidisciplinary working, including with safeguarding and infection control teams and between specialties. Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging that enabled clinicians to support each other and strategise complex cases.
- Staff treated patients with kindness and a friendly manner during all of our observations, including in clinical and non-clinical settings.
- Reception staff demonstrated understanding and patience when dealing with anxious or flustered patients and we saw reception staff in the Jefferiss Wing treat people who were waiting outside with particular compassion while they waited.
- Patients consistently told us they felt welcomed and valued in the service and they found staff attitudes to be memorable because of their warmth and positivity.
- When clinics were delayed or disrupted staff maintained communication with patients every 30 minutes and offered them water and advice about the delay and options for rebooking. .
- The volunteer service had started a pilot programme in main outpatients to scope the potential benefits and impact on patient experience of having a team based there permanently.
- An outpatient improvement programme was in place to reduce waiting times and delays to clinics. A new standard operating procedure enabled senior staff in main outpatients to escalate to the management team if a doctor was late for a clinic that resulted in delays to patients. We saw this worked well during our observations.
- In November 2016, main outpatients had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target.
- A new complaints and concerns policy enabled complaints to be recorded, investigated and resolved within the trust's 40 day maximum target. The new system also enabled services to identify trends in complaints to drive improvements.
- A new general manager and seniornursein main outpatients had conducted a significant nursing and leadership review of the service and restructured it to deliver results in the outpatient improvement programme.
- All of the staff we spoke with were positive about the overall vision and future strategy for the trust. Most staff also felt empowered to promote positive change and provide suggestions for improvement in their own local services.
- Clinical governance structures helped staff to manage risks to services and involved an appropriate range of staff in most cases. Risk registers were updated regularly and staff with appropriate experience and knowledge managed these.
- The majority of staff we spoke with felt positively about the leadership in their service and described a work culture that facilitated development and innovation. This was particularly the case in cardiac, sexual health and HIV services.
- Feedback from patient engagement was used to improve services, particularly with regards to staff communication in main outpatients and the role of trust volunteers.
- Individual services engaged with their staff teams to improve working conditions and deliver better patient services. This included through consultation on working patterns and the implementation of a working group in diagnostic imaging to identify solutions to some of the challenges the team faced.
- Staff felt recognised and rewarded for their work through trust and local initiatives and spoke positively of opportunities to work with colleagues in other areas to gain a better understanding of how they worked.

We saw several areas of outstanding practice including:

- The senior team in the Jefferiss Wing, including sexual health and HIV services, demonstrated a sustained track record of building staff skill mix and service sustainability through promoting specialist training, practice education and rewarding performance.This resulted in positive impact on the local population because it meant people who were vulnerable or at-risk received timely support and treatment.

Summary of findings

- The outpatient improvement programme had begun to deliver results in a relatively short space of time and the process, involving staff consultation and a restructured leadership and governance team, meant clinic delays had been reduced and communication with patients improved.

However, there were also some areas of practice where the trust needs to make improvements:

- The hospital should ensure all staff working in clinical areas have appropriate fire safety training and an understanding of local evacuation procedures.
- The hospital should ensure incidents are fully investigated within a reasonable timescale in such a way that allows trends to be identified so as to ensure the service remains safe.
- The hospital should ensure contractors providing services are able to respond within a reasonable time to complaints made by patients against the trust in cases that involved both providers.
- The hospital should ensure doctors in training have up to date mandatory training in all required areas.
- The hospital should ensure pre-qualification allied health professionals have up to date mandatory training in all areas.
- The hospital should ensure each radiology practitioner has a documented local induction for checked competency in working under IR(ME)R guidelines.

Professor Sir Mike Richards
Chief Inspector of Hospitals

St Mary's Hospital

Detailed findings

Services we looked at
Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Outpatients and diagnostic imaging at St Mary's Hospital

Outpatients and diagnostic imaging services at St Mary's Hospital consists of a main outpatients department that includes six clinical treatment and assessment areas with 36 consulting rooms over three floors. Outpatient clinics are offered in 12 specialties: dermatology, hepatology, respiratory medicine, ear, nose and throat, rheumatology, neurology, gastroenterology, vascular surgery, allergy, cardiology, clinical haematology, neurosurgery, bariatrics, physiotherapy, general medicine, elderly medicine and stroke.

The main outpatient building includes a phlebotomy clinic, a private pharmacy and a volunteer-led coffee shop.

A range of outpatient day case specialties are provided in multiple areas across the hospital site, including a chest clinic, fracture clinic, dermatology day treatment unit, diabetes and endocrine clinic and electrophysiology.

Diagnostic imaging services offer a range of diagnostic and interventional procedures to support all aspects of clinical management. This includes angiography, computed tomography (CT), interventional procedures, IVU, fluoroscopy, MRI, Nuclear Medicine, plain films (walk-in service with GP referral, no appointment necessary)and ultrasound. There are six ultrasound rooms with a seventh dedicated to recurrent miscarriages and a dedicated paediatric waiting area. Five MRI scanners are available in four locations. Three plain film radiographic rooms are available and the service offers single-photon emission computed tomography (SPECT) and dual-energy x-ray absorptiometry (DXA) to measure bone mineral density. One gamma camera is available. Resources also include an acute imaging centre with three-bay recovery area and anaesthetic capability and a fully equipped CT scanning unit.

The Jefferiss Wing offers dedicated Sexual Health, HIV and HTLV services on an outpatient basis. The Wharfside clinic is a dedicated HIV outpatient and day case unit with negative pressure facilities enabling respiratory isolation and delivery of nebulised pentamidine and other therapies.

Our inspection team

Our inspection team was led by:

Inspection Manager: Michelle Gibney, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultant physician, consultant cardiologist, consultant pathologist, superintendent radiographers, diagnostic radiographer, nurse matron, nurse outpatients manager, senior nurse manager, pharmacist and an Expert by Experience

Detailed findings

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out this inspection as part of our routine focused inspection programme. We carried out an announced inspection visit on 22, 23 and 24 November 2016.

Before visiting, we reviewed a range of information we held about the hospital.

During the inspection we talked with a range of staff throughout the outpatient and diagnostic imaging department, including senior managers, clinicians, nurses, healthcare assistants, administrative staff and volunteers.

We also spoke with patients and relatives of those who used the outpatient and diagnostic imaging services at St Mary's Hospital.

Facts and data about Outpatients and diagnostic imaging at St Mary's Hospital

There were 554,321 outpatient appointments across St Mary's Hospital between April 2015 to March 2016.

Between January 2016 and December 2016 64,000 outpatient appointments took place at the main/central outpatient department. This accounts for 38% of all outpatient appointments in the trust. The most common outpatient speciality was dermatology.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

Outpatients and diagnostic imaging services at St Mary's Hospital consists of a main outpatients department that includes six clinical treatment and assessment areas with 36 consulting rooms over three floors. Outpatient clinics are offered in 12 specialties: dermatology, hepatology, respiratory medicine, ear, nose and throat, rheumatology, neurology, gastroenterology, vascular surgery, allergy, cardiology, clinical haematology, neurosurgery, bariatrics, physiotherapy, general medicine, elderly medicine and stroke.

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The Jefferiss Wing offers dedicated Sexual Health, HIV and HTLV services on an outpatient basis. The Wharfside clinic is a dedicated HIV outpatient and day case unit with negative pressure facilities enabling respiratory isolation and delivery of nebulised pentamidine and other therapies.

We last inspected this service in November 2014 and rated it to be inadequate. This reflected delays of up to six weeks in sending out appointment letters following a GP referral and a failure to consistently meet demand. We found doctors often turned up late to clinics and there was little structure in place to monitor performance.

As part of this inspection we observed care and treatment and interviewed staff in main outpatients, the Jefferiss Wing, all areas of diagnostic imaging and seven specialist outpatient or day case units. To arrive at our ratings we spoke with 20 clinicians, 14 nurses, nine nursing and healthcare assistants, seven administrative staff, eighteen

Outpatients and diagnostic imaging

staff at senior or management level, two volunteers, nine patients and six relatives. We looked at the records of 29 patients across services and took into account 61 other individual items of evidence.

Summary of findings

We rated this service as good overall because:

- Staff felt there was a positive incident reporting culture that promoted honesty within a 'no blame' culture. Staff at all levels told us they felt supported when they submitted incident reports and felt the level of feedback was appropriate.
- All areas met or exceeded the trust's 90% compliance target with hand hygiene and 'bare below the elbow' policies.
- Staff followed appropriate medicine management procedures that reduced the risk of incorrect doses and administration. Medicines were stored according to manufacturer instructions and mistakes were acted upon to reduce the risk they could happen again.
- The number of patients seen in outpatients with temporary notes as a result of their case records being unavailable was better than the national benchmark maximum of 4% of patients.
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- Processes were in place to ensure children and young people seen outside of paediatric services were cared for using appropriate safeguarding policies. Staff used monthly multidisciplinary safeguarding meetings to review such instances.
- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process as part of a robust risk management process.
- Consultant and nursing cover was generally adequate to meet demand. Where staff sickness might impact the ability to run a clinic, specialist

Outpatients and diagnostic imaging

registrars were able to provide some cover. Staffing levels were determined by the length of clinics and number of patients and according to consultant job plans.

- Staff in each service provided care and treatment that was benchmarked against the guidance of national bodies of practice, including the Medicines and Healthcare Products Regulatory Agency, National Institute of Health and Care Excellence, the Faculty of Sexual and Reproductive Health and the British HIV Association.
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- Waiting times in diagnostic imaging were better than the national target of six weeks for the five core diagnostic services between April 2016 and December 2016.
- Dedicated radiation protection advisers and radiation protection supervisors were in post and provided oversight for diagnostic imaging services to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011 safety guidance.
- Staff spoke positively about the annual appraisal and professional development record process and said they had been able to secure training and development activities as a result.
- There was evidence of multidisciplinary working, including with safeguarding and infection control teams and between specialties. Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging that enabled clinicians to support each other and strategise complex cases.
- Staff treated patients with kindness and a friendly manner during all of our observations, including in clinical and non-clinical settings.
- Reception staff demonstrated understanding and patience when dealing with anxious or flustered patients and we saw reception staff in the Jefferiss Wing treat people who were waiting outside with particular compassion while they waited.
- Patients consistently told us they felt welcomed and valued in the service and they found staff attitudes to be memorable because of their warmth and positivity.
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- The volunteer service had started a pilot programme in main outpatients to scope the potential benefits and impact on patient experience of having a team based there permanently.
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- In November 2016, main outpatients had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target.
- A new complaints and concerns policy enabled complaints to be recorded, investigated and resolved within the trust's 40 day maximum target. The new system also enabled services to identify trends in complaints to drive improvements.
- A new general manager and senior nurse in main outpatients had conducted a significant nursing and leadership review of the service and restructured it to deliver results in the outpatient improvement programme.
- All of the staff we spoke with were positive about the overall vision and future strategy for the trust. Most staff also felt empowered to promote positive change and provide suggestions for improvement in their own local services.
- Clinical governance structures helped staff to manage risks to services and involved an appropriate range of staff in most cases. Risk registers were updated regularly and staff with appropriate experience and knowledge managed these.

Outpatients and diagnostic imaging

- The majority of staff we spoke with felt positively about the leadership in their service and described a work culture that facilitated development and innovation. This was particularly the case in cardiac, sexual health and HIV services.
- Feedback from patient engagement was used to improve services, particularly with regards to staff communication in main outpatients and the role of trust volunteers.
- Individual services engaged with their staff teams to improve working conditions and deliver better patient services. This included through consultation on working patterns and the implementation of a working group in diagnostic imaging to identify solutions to some of the challenges the team faced.
- Staff felt recognised and rewarded for their work through trust and local initiatives and spoke positively of opportunities to work with colleagues in other areas to gain a better understanding of how they worked.

However, we also found:

- Fire risk assessments had highlighted a significant number of failings in fire safety and breaches of regulatory compliance. This meant buildings, treatment and waiting environments were not safe for patients, staff and visitors.
- There was not always evidence that showed trends in incidents were identified or acted upon in a timely manner.
- Mandatory training completion rates were variable across staff groups and subjects. In diagnostic imagining, doctors in training and pre-qualification allied health professionals (AHPs) did not meet the trust's minimum 90% compliance target in any subject area. Doctors in training in diagnostic imaging did not meet the trust's target training rate in any of the mandatory training topics and only 52% of this team had up to date resuscitation training to the required level.
- There was a significant lack of up to date training evidence for allied health professionals who worked in diagnostic imaging.
- Local audits in January 2016 identified a lack of space for waiting patients in the urology-gynaecology and fracture clinics as an area for improvement but no action had been taken to date to improve this.
- Although induction processes for diagnostic imaging staff were robust and designed to test competency, there was room for improvement in the documentation of inductions.
- Not all staff in diagnostic imaging had nationally recognised intravenous cannulation training, which they routinely needed in the course of their work. Senior staff were in the process of resolving this by trying to source appropriate training within their budget.
- The Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- Waiting times in clinic for some services differed significantly between sites in the trust. This included ultrasound where the average wait for an appointment at St Mary's Hospital was 30 days from referral. This is within the national target of six weeks.
- There was limited space in many of the specialist clinical areas that impacted patient comfort and safety whilst waiting for appointments. This included overcrowded waiting areas such as in the diabetes

Outpatients and diagnostic imaging

and endocrine unit and ear, nose and throat (ENT) clinic. A trust action plan to identify better use of space in ENT had not been updated since February 2016.

- Navigation between services was problematic due to a lack of or confusing signage. Staff provided maps for patients and volunteers worked in some areas to help guide patients but staff in areas such as electrophysiology reported on-going concerns about this.
- Some patient waiting areas were cramped and not large enough to meet demand.
- There were limited resources to support patients with a learning disability and not all staff knew who to contact for support.
- Although clinical governance meetings in diagnostic imaging were well attended and led to demonstrable outcomes, there was a lack of representation from some specialties.
- Some staff said there was a lack of development opportunities, leadership support and innovation in their area of work.
- The senior team recognised staffing shortages in diagnostic imaging placed additional pressure on staff. However it was not clear that recruitment and training plans were understood by existing staff or that they had confidence in this process. This impacted their morale and exacerbated concerns around what they perceived to be inconsistent pay and conditions in some areas.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff felt there was a positive incident reporting culture that promoted honesty within a 'no blame' culture. Staff at all levels told us they felt supported when they submitted incident reports and felt the level of feedback was appropriate.
- All areas met or exceeded the trust's 90% compliance target with hand hygiene and 'bare below the elbow' policies.
- Infection control rooms were available for patients who presented with an infectious condition and processes were in place to contain the risk.
- Staff followed appropriate medicine management procedures that reduced the risk of incorrect doses and administration. Medicines were stored according to manufacturer instructions and mistakes were acted upon to reduce the risk they could happen again.
- The number of patients seen in outpatients with temporary notes as a result of their case records being unavailable was better than the national benchmark maximum of 4% of patients.
- Safeguarding processes were well established and staff demonstrated appropriate knowledge of them. All staff had access to trust safeguarding policies. Clinical staff in sexual health and HIV services had a higher level of safeguarding training that enabled them to safely care for vulnerable and at-risk patients, including those complex needs and challenging social circumstances.
- Processes were in place to ensure children and young people seen outside of paediatric services were cared for using appropriate safeguarding policies. Staff used monthly multidisciplinary safeguarding meetings to review such instances.

Outpatients and diagnostic imaging

- Staff in diagnostic imaging used the World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process as part of a robust risk management process.
- Consultant and nursing cover was generally adequate to meet demand. Where staff sickness might impact the ability to run a clinic, specialist registrars were able to provide some cover. Staffing levels were determined by the length of clinics and number of patients and according to consultant job plans.

However, we also found:

- There was not always evidence that showed trends in incidents were identified or acted upon in a timely manner. For example, incidents had been reported in diagnostic imaging that included delays in conducting emergency scans and patient dissatisfaction with a third party provider used to increase capacity in the magnetic resonance imaging (MRI) service. However, incident records did not indicate the causes of the incidents had been identified or appropriate action taken to prevent them happening again.
- Mandatory training completion rates were variable across staff groups and subjects. In diagnostic imagining, doctors in training and pre-qualification allied health professionals (AHPs) did not meet the trust's minimum 90% compliance target in any subject area. Doctors in training in diagnostic imaging did not meet the trust's target training rate in any of the mandatory training topics and only 52% of this team had up to date resuscitation training to the required level. There was a significant lack of up to date training evidence for allied health professionals who worked in diagnostic imaging.
- There was room for improvement in evacuation and fire safety processes and training in most areas. This included low levels of mandatory fire training amongst doctors in training and pre-qualification AHPs and a lack of safe evacuation routes for patients in wheelchairs or beds from the upper floors of the main outpatient building and the Jefferiss Wing.

Incidents

- Between August 2015 and August 2016, staff in diagnostic imaging services reported 299 incidents. One incident resulted in major harm and involved the trauma imaging unit and a delay of 47 hours in conducting abdominal x-rays for a patient admitted through the emergency department. The clinical service manager had reported that immediate action had been taken to ensure urgent scans could be provided immediately as a result. This incident was reported in September 2015 but had not been closed by November 2016. We were told that the delay in closing the incident was caused by actions required of another division. Three incidents resulted in moderate harm, including one incident of a delay in emergency scanning, a delay in processing the patient's diagnostic tests and a procedure undertaken in an unsafe environment. Immediate action was taken in each case to ensure the patient received appropriate care and staff initiated multidisciplinary contact to investigate the causes of each incident.
- Between July 2015 and July 2016, staff in outpatient services reported 72 incidents, all of which resulted in low or no harm. Fifteen incidents were reported due to patient notes or referral letters being unavailable to medical staff. This was a key focus of the trust's outpatient improvement programme and action had been taken since the incidents were reported.
- Staff had varying experiences of the incident reporting process, including learning. For example, radiation safety meetings were used to review incidents in diagnostic imagining but the meetings did not have permanent representation from radiology managers or medical physics experts. This was because the meetings were part of a more generic divisional safety meeting, which reduced the influence of operational level staff. Staff received feedback from the meetings via e-mail and team meetings and said they felt the level of feedback was appropriate. Key points from incident investigations were also displayed on each computer as a screensaver.
- Staff told us they felt able to submit incidents reports as part of a 'no blame' culture that enabled investigations to be transparent and involve everyone involved. A doctor told us they felt the senior team investigated incidents fairly and as a result staff were happy to be involved.
- The nurse manager and senior nurse in sexual health and HIV reviewed incident reports on a weekly basis and

assigned a member of staff with appropriate experience and knowledge to investigate each one. This service demonstrated responsiveness to learning from incidents. For example, electronic test ordering had been introduced following previous labelling errors and missing samples. Staff in this service had undertaken sharps injury training as a result of an incident, which also resulted in new needles being introduced with a safety lock.

- Between October 2015 and October 2016 outpatient services reported one serious incident. This occurred in April 2016 when 150 patient outcome forms dated from February 2016 were found without follow-up action. This meant the patients involved had not received follow-up care or appointments.

Cleanliness, infection control and hygiene

- Staff in each area carried out monthly hand hygiene and 'bare below the elbow' audits. Between April 2016 and July 2016, all areas of outpatients, diagnostic imaging and sexual health achieved or exceeded the trust 90% target for compliance.
- Amongst outpatient nurses, 89% had up to date training in infection control and 85% of healthcare assistants were up to date. In diagnostic imaging, only scientific and technical staff met the trust's minimum requirement of 90% compliance with up to date infection control training. This included pre-qualification allied health professionals, amongst whom only 43% had up to date training. The consultant group in diagnostic imagining had 85% compliance and doctors in training had 75%.
- Antibacterial hand gel was readily available in all OPD areas, including in treatment rooms and at the entrances and exits to waiting areas. Signs encouraged patients and visitors to use the gel and we saw staff use it routinely. All of the patients we spoke with said they noticed staff wash their hands before examining them and said they felt hygiene standards were high.
- Staff used green 'I'm clean' stickers to indicate when an item of equipment had been cleaned, disinfected and was ready for use. We saw consistent use of this process.
- Infection control and traceability processes in ear, nose and throat (ENT) were robust and included a two-hour decontamination turnaround time for nasendoscopes.
- Antibacterial wipes were available in paediatric outpatients and notices invited parents to use them before and after their child played with toys. A daily cleaning schedule for toys was on display and staff had completed this consistently.
- A protocol was in place in paediatric outpatients to reduce the risk of infection if a child attended with chicken pox or measles in the active stage. This included contact with the trust infection control lead and contact with each patient who had attended that session.
- Weekly nurse-led cleaning checks took place in the Jefferiss Wing, including workarounds with the cleaning contractor manager.
- Angiography x-ray, the ENT clinic and general x-ray participated in the patient-led assessments of the care environment (PLACE) national scoring system. This system benchmarks environmental condition and cleanliness as assessed by patients. The latest 2016 scores indicated both x-ray areas scored 100% for cleanliness and an average of 90% for condition and appearance. The ENT clinic scored 92% for cleanliness and 72% for condition and appearance.

Environment and equipment

- Personal protective equipment was available in all areas and we saw staff consistently and safely use this.
- The trust was registered with the Health and Safety Executive for ionising radiation and was compliant with safety requirements following the most recent inspection.
- Diagnostic imaging services had a confinement room available for patients who presented with a high level of infection risk.
- Waste management was in accordance with national guidance in all areas, including in the separation and secure storage and disposal of hazardous waste.
- The service level agreement between the estates team and clinical departments was for an assessment of a problem to take place within 48 hours of a logged call. Staff told us this was rarely adhered to and that multiple calls were usually needed to have an estates issue

resolved. Staff in the Jefferiss Wing had established a new escalation process whereby if a reported estates problem had not been attended to after three days; they could speak with an estates manager directly. Senior staff told us the lack of estates oversight had presented significant challenges. For example, a broken door to a liquid nitrogen storage area had taken 18 months to resolve and staff said the tracing of faults was not consistent as they were often reported as resolved when they were not. The estates function had been restructured with the head of nursing lead it, which was intended to deliver improvements.

- A central reporting area was available in diagnostic imaging, including a 'hot reporting area' with soundproofed doors for urgent and confidential discussions. This included capability for cross-site conferencing between clinicians.
- A negative pressure isolation room was available in the Wharfside clinic and could be used for nebulised therapies.
- The road outside of the Jefferiss Wing presented a risk to patient, visitor and staff safety. The unit exited directly onto a through public road that had limited clearance. During our inspection we observed a near miss when a person in a mobility scooter narrowly missed being hit by a car. There were limited warning signs or direction signs posted in the area. This was highlighted on the hospital risk register but no resolution had been found.
- Designated staff were responsible for safety checks on the equipment in their respective areas. For example, a senior nurse in the dermatology day treatment unit completed a safety check of ultraviolet UVB and UVA+B machines every morning using St John's Phototherapy Guidelines.
- Clinical space in specialist areas was clean, tidy, well equipped and fit for purpose. This included three echocardiogram rooms, an exercise room and two EG rooms in the cardiac diagnostics department and eight consulting rooms in the chest clinic. However, staff in every area described one of their key challenges as a lack of space for storage and patients who were waiting. For example, the waiting area in the cardiac diagnostics department was small and cramped and had no toilet facilities. Seating in the diabetes and endocrine unit was very limited and staff told us when four clinics were run concurrently on a Monday morning, some patients had to stand while waiting. This was further exacerbated when patients in wheelchairs or on stretchers were waiting.

Medicines

- Medicines were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Contrast media was stored in a locked room with restricted access.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2-8°C. We saw evidence of a 'Back to the floor Friday' audit which had recently been introduced by the trust, partly to ensure effective medicines management. This had been completed on a weekly basis for most clinics, although in clinic E this was missing for two weeks.
- Medicines used for resuscitation and other medical emergencies, including anaphylaxis, were available and tamperproof. However, we spoke to a member of staff who said they were not always accessible for immediate use, as the resuscitation trolley was situated in clinic D on the second floor of the outpatients building. This trolley served all three floors, which meant there was a risk that it would take a length of time to serve patients on the ground floor should it be required. We saw evidence of daily checks to ensure the appropriate medicines were stocked and had not expired.
- Appropriate arrangements for the supply of medicines were in place. A private pharmacy contractor served all outpatient prescriptions on the ground floor. They were open between 9am and 6.30pm Monday to Friday, and between 9am and 1.30pm on Saturday and Sunday. The latest figures available showed that more than 75% of prescriptions were dispensed within 15 minutes, and more than 99% within 30 minutes. We saw that prescriptions were prescribed to patients electronically and also via paper based prescriptions. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Staff had access to the trust pharmacy department for medicines information advice and medicines supply.

There was a pharmacy top-up service for stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.

- Medicines errors and safety incidents were reported quarterly to the Medicines Safety Committee. These were reviewed and information to staff was communicated via a variety of channels such as newsletters, emails and face-to face monthly clinical governance meetings if required.
- The nurse in charge completed a daily compliance checklist for medicines management to ensure storage and administration was compliant with trust policy. A medicines safety review group supported this process and provided additional medicines management training to help improve safety. New guidance had been issued to staff in ear, nose and throat clinics so they could administer topical medicines safely and appropriately.
- Staff gave printed instructions to patients in the use of contrast media and potential side effects.
- Nurses in sexual health and HIV services issued emergency contraception using patient group directions, which were monitored and updated regularly.
- There are three dedicated pharmacists aligned to the directorate who attended nurse and governance meetings, provided one-to-one staff support and maintained patient group directions in sexual health services.
- Appropriate action had been taken following a prescribing error in the Wharfside clinic. In this instance, a vaccine had been prescribed but another type was administered. In response, a mobile computer was provided that meant staff could take it with them into treatment bays and complete documentation alongside administering drugs or vaccines.

Records

- Outpatient services were transitioning from paper records to electronic records. The latest available data from July 2016 indicated an average of 2% of patients were seen in clinics with temporary records as a result of case notes being unavailable. This was better than the national benchmark maximum of 4%. Where clinical records were unavailable, a decision was made by the lead doctor for the clinic on a case-by-case basis.
- We looked at 29 patient records across the areas we inspected. All of the records were signed by a named clinician who was readily identifiable and entries were legible.
- Electronic patient records (EPR) have been introduced in the HIV outpatient service in November 2015 and in the asymptomatic patient pathway in sexual health in 2016. EPR is planned for all other clinics and pathways during 2017/18”
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Safeguarding

- In diagnostic imaging, the qualified allied health professional (AHP), scientific and technical and consultant staff groups met or exceeded the minimum trust requirement that 90% of staff had up to date safeguarding adults training. All other staff groups did not, including pre-qualification AHPs, whose compliance was 43%. In this division safeguarding children training was also variable. Consultants, scientific and technical staff and senior managers achieved the trust’s target but other groups did not. Training rates in outpatients were generally better, where all staff groups met or exceeded the 90% target for adult safeguarding and child safeguarding level one. Administration staff exceeded the target for child safeguarding level two and 78% of nurses and 88% of healthcare assistants had completed this.
- A paediatric safeguarding protocol was in place in main outpatients in the event a clinician booked a child or young person into an adult clinic for medical reasons. For example, a private waiting room was arranged and a children’s nurse could be present if needed. All staff had child safeguarding training.
- Staff in the Jefferiss Wing prioritised young people if they attended a walk-in session and ensured they were offered an appropriate waiting area. In this, unit, 97% of clinical staff had up to date training in safeguarding adults and children to a minimum of level two.
- We spoke with staff about safeguarding in each area or department we visited. In all cases both clinical and

non-clinical staff demonstrated appropriate knowledge and understanding. An alert on electronic records systems highlighted to staff if a patient was known to have a safeguarding issue. This system worked well in sexual health services and paediatric outpatients, both of which regularly cared for vulnerable or at-risk patients.

- Staff only administered contrast media in radiology if at least two members of staff were present.
- All clinical staff in sexual health and HIV services had level three adult and child safeguarding training and non-clinical staff had basic safeguarding training. Safeguarding training for clinical staff was specialised and enabled them to care for patients with specific risks, such as those at risk of Hepatitis B, men who have sex with men and sex-drug users.
- The specialist sexual health information and protection (SHIP) team in the Jefferiss Wing met weekly with child protection teams for young people seen in the service and used a specialist pathway to care for young patients who presented with needs relating to drug or alcohol use and self-harm. This team had working links with community youth offending teams and community adolescent mental health services to provide integrated safeguarding support.
- Monthly meetings took place trust-wide with safeguarding and service leads in each area.
- One safeguarding incident had been reported in outpatients between July 2015 and July 2016. This involved a nursing home sending an incorrect patient for an appointment. Staff in outpatients took the appropriate action at the time and there was no harm as a result.

Mandatory training

- All staff were required to complete a mandatory training programme that included safeguarding, basic life support and resuscitation, infection control and moving and handling. Staff in all areas told us they were given time during working hours to complete mandatory training updates.
- Amongst diagnostic imaging staff, 84% were fully up to date with mandatory training and in outpatients, 93% were up to date. The trust's target for mandatory training was 90% and four of the 10 staff groups in both divisions met or exceeded this, including administration staff and healthcare assistants in outpatients and consultants and scientific and technical staff in diagnostic imaging. Pre-qualification AHPs had 55% average compliance and administration staff in diagnostic imaging had 77% average compliance.
- Doctors in training in diagnostic imaging did not meet the trust's target training rate in any of the mandatory training topics. Overall this group had an average 71% compliance, which included 37% in fire safety, 52% in resuscitation level two and 55% in information and governance. Of the seven staff groups in this division, only consultants and scientific and technical staff, who represented 31% of total staff, met or exceeded the 90% training target.
- Overall in the Jefferiss Wing, 91% of staff had up to date mandatory training. This included 89% compliance amongst sexual health nurses, 100% compliance amongst HIV management staff, 92% amongst non-clinical staff, 85% of HIV nursing staff and 89% of doctors.

Assessing and responding to patient risk

- An imaging trauma service was available and staffed to provide emergency scans within 30 minutes of a request being made, although previous incidents indicated this target was not always achieved.
- Reception staff shifts in diagnostic imaging did not always match the running times of clinics. This meant clinical staff also performed reception duties at times, which they felt was unsafe. From the minutes of team meetings we saw the senior team were aware of this issue and were undertaking a staff consultation to address it by proposing revised working hours. In the meantime, reception desks could be staff outside of core working hours only if individuals accepted overtime.
- Staff in radiology used a three-point identity check for each patient before conducting a procedure that involved radiation exposure. This team also used a World Health Organisation (WHO) surgical safety checklist for radiological interventions and the Society of Radiographer's 'pause and check' process. The risk management steering group audited use of the WHO checklist. The latest available data, for May 2016 and June 2016, indicated 98% compliance. In addition,

two-person checks always took place before intravenous contrast media was administered. This meant staff ensured the correct patient was given the correct procedure every time.

- Staff in radiology routinely performed pregnancy checks and discussed recent sexual history with patients before completing a scan. If the results were inconclusive, they delayed the scan to protect the patient from potential harm.
- Staff in main outpatients followed an established policy in the event of a patient emergency that required the resuscitation team. This included outpatient staff waiting at the entrance to the unit to quickly direct the resuscitation team to the location of the patient. This had been tested in simulated exercises and as part of a live emergency.
- Treatment rooms were fitted with call bells, which staff could use to summon help in an emergency.
- Resuscitation equipment, including equipment for children, was available in all areas and staff consistently documented daily safety checks. In the main outpatients building, the resuscitation trolley was located on the second floor, with an emergency grab bag on the first floor. The trolley could only be safely moved between floors by use of a lift but staff did not have a manual override key for this, which meant they could not use the lift as a priority. We spoke with the general manager about this who said a second emergency grab bag would shortly be provided for the ground floor and the resuscitation team had approved this system.
- Evacuation procedures in the Jefferiss Wing did not meet the needs of all patients and staff. For example, a lift was available but this was a small passenger lift that could not fit patients who were cared for on a trolley or bed in the Wharfside clinic. A mobile 'medevac' chair had been provided to help staff evacuate people from the first floor but none of the staff we spoke with had been trained in its use. Staff said the risk of not being able to move patients on beds or stretchers to the ground floor was mitigated because this clinic was staffed by very experienced clinicians.
- All staff in the trust were required to undertake resuscitation level one training and some staff additionally required level two training as well as appropriate updates. In diagnostic imaging, 74% of staff were up to date with their required level of training. This included 95% of consultants, 52% of doctors in training and 43% of pre-qualification AHPs. In outpatients, 84% of nurses and healthcare assistants had up to date training to the appropriate level. In the Jefferiss Wing, 89% of all staff had up to date resuscitation training.

Nursing staffing

- The trust had established the need for eight whole time equivalent (WTE) nurses in main outpatients to run this service safely and as planned. In October 2016, there were two WTE vacancies.
- As at August 2015 and July 2016, the trust reported a vacancy rate of 13.6% in Outpatients; the vacancy rates ranged from 0% to 26.1% across reporting units.
- Nurse and healthcare assistant staffing levels per shift in main outpatients were established in advance based on the number of clinics running and the number of patients booked in.
- Specialist services planned staffing based on patient demand and the length of clinics running. For example, a senior sister, two nurses, three healthcare assistants and a plaster technician worked in the fracture clinic and ensured shifts were covered appropriately between them.
- Healthcare assistants worked across all outpatient clinics and had appropriate training for this. This meant the team could be deployed to the area that most needed support to meet patient needs. This was a recent initiative implemented as a result of patient feedback and ensured there was a staff presence at all times.
- Paediatric outpatients was staffed predominantly by healthcare assistants, with two registered children's nurses. A nurse manager led the unit and was based between two sites.
- Morning briefings were used to discuss complaints, feedback and incidents in main outpatients and paediatric outpatients. We attended one briefing in main outpatients and noted it was thorough, with all staff booked for the morning in attendance across multiple roles. The meeting was motivational and included a thorough discussion of the plans for the day and any concerns from the previous day.

Outpatients and diagnostic imaging

- Three ultrasound assistants supported the service in dedicated roles. For example, one assistant worked with a radiologist, one assistant worked with the clinician undertaking musculoskeletal injections and one assistant acted as a point of contact for patients.
- Two senior nurses, advanced nurse practitioners, staff nurses and nursing assistants led care in sexual health services. Following a skill mix review, all band seven nurses in sexual health and HIV services became nurse practitioners as a part of a new staff structure. In addition, all nursing assistants were trained as phlebotomists to help free up nurses to care for patients with more complex needs.
- Student nurses worked under direct supervision and were able to observe clinics and practice basic procedures. For example, a student nurse in the Wharfside clinic learned how to assist with a lumbar puncture and assisted with intramusculoskeletal injections.
- A team of four advanced nurse practitioners, three band six nurses and two band five nurses led the HIV service in the Wharfside clinic, with support from healthcare assistants. Individual shifts were staffed by an establishment of two nurses and one healthcare assistant.
- Community respiratory nurse specialists provided care and treatment in the chest clinic.
- Four nurse practitioner prescribers led the SHIP team and also provided a rotational training post for staff nurses from sexual health and HIV services.
- As at August 2015 and July 2016, the trust reported a vacancy rate of 13.6% in Outpatients trustwide; the vacancy rates ranged from 0% to 26.1% across reporting units.
- As at August 2015 and July 2016, the trust reported a turnover rate of 6.6% in Outpatients and 16.8% in Diagnostic Imaging; Turnover was greater among unqualified nursing staff in Diagnostic Imaging rather than qualified staff trustwide.
- As at August 2015 and July 2016, the trust reported a sickness rate of 4.7% in Outpatients and 2% in Diagnostic Imaging trustwide.
- Individual specialties were staffed according to consultant job plans and the number of patients seen per clinic. Each service had at least one dedicated consultant and a specialist registrar. For example, a consultant and a specialist registrar led the ENT service Monday to Friday and two specialist registrars and a middle career doctor led the gynaecology outpatient service.
- To address shortfalls in staffing in diagnostic imaging, a long-term action plan was in place. This aimed to develop existing staff into senior posts, extend recruitment to higher-level posts across a wider area of London and to begin international recruitment. The ratio of permanent sonographers to agency sonographers was 60:40 due to ongoing staff shortages. In radiology, staff told us clinics often ran with fewer staff rather than being cancelled, which they said was a safety concern.

  The radiology service had a 13% vacancy rate, which would be reduced when six newly-recruited staff came into post.
- A radiologist was always present in the trauma unit.
- Two cardio-radiologists were available in the acute imaging centre.
- The chest clinic was staffed by pulmonary function physiologists, respiratory specialists and respiratory consultants.
- A consultant and two physiologists led the electrophysiology department.

  A clinical director, two heads of specialty and a team of 14 consultants led care and treatment in sexual health and HIV services. There was one HIV consultant vacancy. There was always a supervising consultant or registrar who provided support on complex cases to other clinical staff including GP specialist training doctors. Usually this supervising senior doctor was supernumerary. Each consultant was paired with a nursing assistant per shift, which the nurse in charge allocated based on the nursing assistant's experience and skill base.
- Consultants in diagnostic imaging did not work to a shift-based system. Instead they used an individual job

Medical staffing

plan in each specialty to structure clinic times and availability. Specialist registrars were assigned to each radiology sub-specialty and were rotated between these every four months.

- The vacancy rates for imaging staff trust wide were as follows: Imaging – All Areas (All Medical and Dental) 19.7%, consultant 6.8% and doctor (training grade) 30%.

Major incident awareness and training

- Major incident contingency plans were in place in all areas but had not been practised in simulation or rehearsal scenarios.
- Fire risk assessments had been carried out in 2016 and identified a total of 103 regulatory fire safety breaches, including 40 breaches that represented an immediate risk to the people in the buildings as well as to the infrastructure. A fire risk advisor (FRA) conducted an assessment of all three clinical floors of the main outpatients building as well as the basement in October 2016. The risk assessments found 61 areas of non-compliance with the Regulatory Reform (Fire Safety) Order 2005. Of which, 22 were considered to be of an immediate risk to the safety of people and/or the building and required immediate rectification. This included not enough fire extinguishers on the first floor, two obstructed emergency escape routes on the ground floor and faulty automatic fire doors throughout the building. An FRA conducted a fire risk assessment in the Jefferiss Wing in November 2016 and found 23 areas of non-compliance, including 10 that presented an immediate risk. This included missing ceiling tiles that meant fire could spread quickly, poor maintenance of firefighting equipment and blocked escape routes. This report identified significant safety concerns in this building and recommended that fire action plans be completely overhauled. A similar risk assessment in the diagnostic imaging unit situated in the basement of the main hospital found 19 areas of non-compliance, including eight that represented an immediate risk. This included fire-fighting equipment that was inaccessible, faulty equipment and an electrical fuse box that was damaged and open to the public.
- After our inspection we asked the trust for an update on the areas of non-compliance in fire safety. In response to the findings, the trust had entered into a six year improvement plan with the local fire authority and as of January 2017 23% of the recommendations had been addressed. Seventy percent of the remaining requirements improvements were due to be implemented by July 2017 and 7% did not have a planned completion date. Some urgent requirements had not been addressed quickly. This included no planned date for the installation of a suitable fire detection system and a delay of at least five months in acquiring additional fire extinguishers and evacuation signage.
- Each clinical area had a designated fire warden who would be responsible in the event of an evacuation. The fire warden for the shift was highlighted in daily briefings and the nurse in charge made sure any agency or locum staff were aware of this. However, staff demonstrated inconsistent knowledge of local fire procedures and none of the staff we spoke with had taken part in evacuation exercises. Fire training records indicated wide variance in completion rates despite it being part of mandatory training. For example, only 38% of doctors in training in diagnostic imagining and only 58% of administration staff in the same department had completed fire safety relevant to high-risk clinical areas. Although 100% of outpatient nurses had completed fire safety awareness training, only 67% had up to date training in fire safety for clinical areas. Other than administration staff and allied health professionals in diagnostic imaging, all staff groups in the directorates exceeded the 90% minimum target for fire awareness training. However, with the exception of scientific and technical staff in diagnostic imaging, no staff group met the 90% completion target for clinical fire safety in high-risk areas. In October 2016 an FRA documented a requirement that department leads ensure there are enough trained fire wardens for each area on shift and that staff must ensure they enrol on refresher training. In December 2016 an FRA made an immediate requirement that diagnostic imaging services on the basement level of the main hospital introduce enough fire marshals to be able to safely complete an evacuation. The requirements had not been implemented at the time of our inspection.
- Specialist staff demonstrated a proactive approach to working with emergency planning staff to address

specific threats. For example, a HIV specialist nurse from the Wharfside Clinic worked with emergency planning and infection control staff to plan for infectious disease treatment provision in the event of an Ebola outbreak.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate the effective domain because we are not confident we can collect enough evidence to make a judgement. However, we found the following areas of good practice:

- Staff in each service provided care and treatment that was benchmarked against the guidance of national bodies of practice, including the Medicines and Healthcare Products Regulatory Agency, National Institute of Health and Care Excellence, the Faculty of Sexual and Reproductive Health and the British HIV Association.
- Dedicated radiation protection advisers and radiation protection supervisors were in post and provided oversight for diagnostic imaging services to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011 safety guidance.
- Nurses, nursing assistants and healthcare assistants had opportunities to develop audits, particularly in sexual health services. This included completion of Public Health England audits to benchmark the standard of swab samples for certain infections.
- Improvements had been made in main outpatients that enabled patients to schedule a follow-up appointment before they left the department. In addition, clinicians recorded appointment outcomes no later than the following day to ensure accuracy and timeliness.
- Test results in sexual health and HIV services were provided within 72 hours by an on-site laboratory.
- Nurses, nursing assistants and healthcare assistants undertook a period of induction and supernumerary practice before being tested on their practical competencies to work alone.
- Staff in sexual health and HIV services were supported to undertake a range of specialist training, including accreditation from the British Association for Sexual Health and HIV STI Foundation Competencies, access to an academic development pathway and support to complete accredited diplomas and Masters programmes of study.
- Staff spoke positively about the annual appraisal and professional development record process and said they had been able to secure training and development activities as a result.
- There was evidence of multidisciplinary working, including with safeguarding and infection control teams and between specialties. Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging that enabled clinicians to support each other and strategise complex cases.
- Staff in the adolescent HIV transition clinic worked as a multidisciplinary team to support patients moving between young people and adult services.

However:

- Local audits in January 2016 identified a lack of space for waiting patients in the urology-gynaecology and fracture clinics as an area for improvement but no action had been taken to date to improve this.
- Although induction processes for diagnostic imaging staff were robust and designed to test competency, there was room for improvement in the documentation of inductions.

Evidence-based care and treatment

- Diagnostic imaging services complied with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2006 and the IR(ME) Amendment Regulations 2011. This included availability of three radiation protection advisers in the trust and three radiation protection supervisors at this site and well defined referrer, operator and practitioner roles and responsibilities.
- The trust was licensed by the Administration of Radioactive Substances Advisory Committee to provide radioactive medicinal products by certified staff.

Outpatients and diagnostic imaging

- Staff in diagnostic imaging used the National Diagnostic Reference Levels (NDRLs) in line with IR(ME)R guidance for computed tomography (CT) scans, general radiography and fluoroscopy.
- Care, treatment and staff training in sexual health services was delivered according to national best practice guidance issues by the Faculty of Sexual and Reproductive Health (FSRH) and the British Association of Sexual Health and HIV (BASHH). Staff in HIV services followed national (BHIVA) guidance.
- The head of specialty for genitourinary medicine prepared guidelines for BASHH and staff told us she was proactive in sharing this with the whole team, which contributed to on-going updates of expertise.
- Nursing assistants (NA) in sexual health and HIV services were supported to develop their skills and experience by leading or supporting local audits. For example, one NA worked with a nurse to audit the quality of swab samples submitted to the laboratory for gonorrhoea testing in line with Public Health England guidance. Nurses were also involved in auditing the care of patients who had experienced sexual assault and were designing an audit protocol to assess the effectiveness of a new hepatitis pathway. Nurses involved in audits were given two presentation slots per year in divisional meetings to present their work.
- An outpatient audit in January 2016 identified a lack of space and overbooked clinics in the urology-gynaecology clinic and a lack of clinical space in the fracture clinic as risks to the services. Although a review of capacity had been undertaken, there was no mitigating action taken.
- Pathology services utilised an annual audit plan for infection immunity that included two audits at St Mary's Hospital to benchmark services against national standards. One audit was ongoing in respiratory medicine to test the efficacy of new testing equipment for tuberculosis and another audit was to assess diagnostic compliance of syphilis testing with national guidelines.

Equipment

- Ultrasound equipment was ageing and staff told us this meant it produced substandard image quality. This was noted on the service risk register in addition to the risk of chiller units failing. The trust was in the process of moving maintenance to a managed equipment service that would ensure more timely replacement.
- The imaging trauma unit was equipped with two scanners for the emergency department and could provide urgent ultrasounds, plain film, MRIs, CTs and x-rays. This unit was also able to see outpatients out of hours who required acute imaging.

Patient outcomes

- Staff used a trust IR(ME)R policy to ensure patient referrals for radiation treatment met established safety and medical criteria.
- The trust did not participate in the Imaging Services Accreditation Scheme and included this in a developmental strategy.
- Improvements had been made in how patients seen in main outpatients were followed-up. A new leadership team and strategy had implemented a standard operating procedure that meant patients could book a follow-up appointment before they left the department. In addition, staff recorded the final outcome of each appointment no later than the day after the appointment. This ensured notes were timely and accurate.
- Clinical nurse specialists across the trust used treatment pathways to ensure patients were seen at the most appropriate place. For example, if head or neck cancer was diagnosed at St Mary's Hospital, staff would refer the patient for treatment to another of the trust's sites.
- Staff in nuclear medicine rotated between three sites to take advantage of their experience during a period of staffing shortages and used common treatment protocols to ensure continuity of care.
- An electrocardiogram (ECG) technician was available in the cardiology clinic at all times and ensured each new patient received appropriate tests as well as their medical consultation.
- Test results in sexual health and HIV services were provided within 72 hours of testing by an on-site

laboratory and were sent to the requesting clinician. Junior doctors had access to all test results and reviewed these as they arrived, with rapid escalation to a consultant if needed.

- Between April 2015 and March 2016, the ratio of follow up appointments to new appointment was lower than the national average, at an average of 2.3:1 compared with the national average of around 4:1.
- Between January 2016 and December 2016, 74% of patients with suspected cancer had an appointment scheduled within two days of receipt of the referral. This was lower than the hospital's 98% target. However, in this period the hospital met the two week wait target for cancer review appointments in every month, with an average wait of 1.5 weeks.
- The hospital monitored waiting times in diagnostic imaging against the national diagnostic target of six weeks. Between April 2016 and December 2016, waiting times in for the five core diagnostics offered were significantly better than the target in every week, with an overall average wait of 2.9 weeks.

Competent staff

- Main outpatients did not have a dedicated education and learning post but the senior sister and charge nurse organised mentorships and specialist training, including in dermatology and diabetes. This enabled staff to move between clinics in line with the needs of the service.
- New nurses, healthcare assistants and NAs undertook a period of induction and supernumerary practice before working alone. In sexual health, the NA supernumerary period lasted two weeks during which time they were 'buddied' with an experienced member of staff and given time to complete study modules.
- Staff in diagnostic imaging underwent a local induction in addition to the trust induction that included IR(ME)R practitioner induction for plain film. However, this was not documented in any local procedures or policies and so could not always be evidenced. Senior staff practitioners acting under IR(ME)R regulations vetted scans and used quality assurance checks to make sure they were carried out appropriately. Local induction for CT scans was comprehensive and included the trauma unit, with a requirement that a senior member of the team observe staff to establish their competency.
- All staff in the fracture clinic had undergone an appraisal in the 12 months prior to our inspection.
- We looked at a sample of seven anonymised appraisals for clinical and non-clinical staff. In each case staff were given the opportunity to identify their positive achievements in the previous year and work with their line manager to establish what they planned for the next 12 months. Each appraisal included evidence of professional development, including through leadership courses, specialist training and successful completion of clinical competency checks. The appraisal structure provided a supportive framework staff could use to progress their career and ensure their clinical practice met trust and national standards.
- Staff in sexual health and HIV services had access to an academic development pathway. The senior team used this to encourage staff to continue their education and seek professional development in the service.
- Radiology services had introduced a picture archiving and communication system (PACS).
  A radiographer manager working in the department had been involved in the development and rollout of the system, which helped ensure staff competencies developed alongside this.
- Not all staff in radiology had intravenous cannulation training and service managers were sourcing less costly training courses to improve this. Intravenous cannulation training was mandatory for all senior radiographic staff, although all staff had been trained internally, at the time of the inspection some staff were on the waiting list to be attend the external course to achieve a national certification.
- Junior staff in diagnostic imaging told us they were supported by the CT lead to rotate through different areas in the department, which they felt enhanced their competency and skills development.
- Nurse practitioners in sexual health and HIV services were trained in motivational interviewing for harm reduction. This meant they could effectively communicate with a diverse range of people about sensitive or safety critical subjects, such as sexual risk and drug use. This unit demonstrated a sustained and consistent approach to ensuring staff were highly skilled. For instance, NAs and nurses were trained in the aseptic non-touch technique, administering Hepatitis B

vaccinations, microscopy and conducting intimate exams. Staff also completed partner notification workshops and British Association for Sexual Health and HIV (BASHH) training in caring for asymptomatic patients. The service provided training accreditation for all clinical staff from the BASHH STI Foundation Competencies (STIFF). All staff at band seven and above were accredited to the advanced STIFF level and all other clinical staff were accredited to STIFF level one.

- All band six nurses in sexual health and HIV had completed or were working towards a diploma from the FSRH in subdermal implants and band seven nurses were working towards a diploma in coil fitting. All staff in the SHIP team had completed training in sexual health advising.
- FSRH diplomas and BASHH accreditation was available to F2-grade doctors and a specialist trainee pathway was offered to registrars.
- Champions in domestic violence had been trained in sexual health and HIV services and were able to provide structured advice to any member of staff, including in urgent situations. The champions were supported by the SHIP team who could provide additional expertise and guidance.
- All staff in sexual health and HIV services were invited to submit an abstract to the annual BASHH conference. If this was accepted, the senior team supported their attendance as a development opportunity and they presented their experience back to the team.
- Qualified nurses in sexual health and HIV services had the opportunity to rotate between the two clinical areas after six months of experience. This enabled them to develop new skills, such as in cryotherapy and partner notification.
- Advanced nurse practitioners led staff training and skill development in the Wharfside clinic and a nurse consultant education lead fulfilled this role for sexual health services. Nurses in the Wharfside clinic undertook specialist training every two months, such as in caring for patients with complex comorbidities, including HIV and Hepatitis C.
- Staff completed an annual appraisal or professional development review (PDR) with support from their line manager. All of the staff we spoke with were positive about this process and said it helped them to benchmark their practice and performance against the needs of their patients and expectations of their respective department. Appraisal rates were generally high. In the Jefferiss Wing, 100% of staff had a PDR update in the previous year.
- A specialist cardiac physiologist in the cardiac diagnostics department attended monthly medical devices meetings to ensure the service was up to date with the latest equipment usage advice.

Multidisciplinary working

- Outpatient services worked together to meet the needs of patients, including unplanned needs. This included audiology support for all clinics and speech and language therapists working in consultant-led ear, nose and throat clinics.
- Weekly and fortnightly cross-site multidisciplinary meetings took place in diagnostic imaging in a dedicated room with capacity for 100 people and videoconferencing capability.
- Internal multidisciplinary working between diagnostic imaging staff ensured patients received treatment in the most appropriate location. For example, patients who were prescribed beta blockers had their moves minimised and scans in the hospital conducted in the area nearest to them.
- Staff in the adolescent HIV transition clinic worked as a multidisciplinary team to support patients moving between young people and adult services. For example, this process was led by a paediatric HIV consultant, an adult HIV consultant and an advanced nurse practitioner. A paediatric nurse could also support this process if necessary.
- Sexual health and HIV services had embedded links with a broad multidisciplinary team of specialties. This included a psychosexual consultant, psychiatric liaison nurse, accident and emergency department liaison, HIV dietician, smoking cessation nurse and a neurology consultant to support patients with HIV and dementia. The service demonstrated a track record of positive patient outcomes as a result of multidisciplinary working. For example, by working with geriatricians,

dementia specialist nurses and staff in accident and emergency (A&E), the service achieved a community placement for a patient living with HIV and dementia who attended A&E unnecessarily on a frequent basis.

- A professor in HIV ran a joint specialist clinic with a consultant neurologist for patients with neurocognitive impairment and other complex neurological conditions. A specialist eye clinic for HIV patients was also available every week.
- Weekly multidisciplinary lung cancer meetings were held with a consultant chest physician, respiratory physiologists and other clinicians from the chest unit. This unit ran as a multidisciplinary service. We spoke with a community respiratory nurse specialist who said they received "excellent" support from consultants and the lung function team.
- Cardiologists and echocardiogram physiologists attended weekly multidisciplinary meetings in the cardiac diagnostics department.
- Sexual health services had established agreements with the emergency gynaecology service to undertake urgent pelvic ultrasounds when needed. Staff could also refer patients for rapid testicular ultrasounds.

Seven-day services

- The trust planned to introduce bookable seven-day access to outpatient diagnostic imaging services in early 2017.
- At the time of our inspection, trauma imaging services were available 24-hours, seven days a week.
- A specialist registrar and interventional radiologists were available on-call 24-hours, seven days a week and consultants had remote access to the PACS.
- Individual specialties determined their own level of out of hours cover for emergencies. For example, a cardiologist and HIV consultant were always available on call.

A**ccess to information**

- As part of the outpatient improvement programme, a strategy had been implemented to improve the availability of case notes and reduce the risk patients would arrive for an appointment and the doctor did not have their records. The strategy included digitising existing health records and the use of an electronic system for new patients. This would also reduce the reliance on temporary paper records. In October 2016 the trust was digitising records at a rate of 80,000 per month.
- All of the staff we spoke with told us there had been a sustained improvement in the quality, availability and tracking of patient notes in the previous year.
- Patient records for sexual health and HIV services were stored on-site in the Jefferiss Wing. Administration staff ensured clinicians had ready access to these, including for pre-booked appointments.
- Patients told us they had noticed an improvement in communication between the hospital and their GP. This included more detailed information sent to them and GPs better informed of what had happened in the hospital. The diagnostic imaging risk register included a risk that GPs would not receive imaging results because the IT system used by the trust was incompatible with the GP records system. To address this, the IT department monitored results transmissions daily and the imaging department sent failed transmissions by fax instead.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguard**
- Staff demonstrated knowledge of the Mental Capacity Act (2005) at levels appropriate to their job role and responsibilities. Protocols were in place to support staff when they had concerns about a person's capacity to consent to treatment and staff showed us how they could access these.
- An appropriate clinician had documented consent in all of the records we looked at.
- Consent processes in diagnostic imaging were robust and ensured patient consent was documented by the referring clinician and by the radiographer before a procedure was carried out.
- Nurses in sexual health and HIV services were trained to complete initial mental capacity assessments and advanced nurse practitioners and doctors were able to complete full assessments under the MCA.

Outpatients and diagnostic imaging

- All clinical staff in sexual health and HIV services who could see patients independently had completed training in the Fraser guidelines and Gillick competencies. In these services 80% of clinical staff had up to date training in mental capacity.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness and a friendly manner during all of our observations, including in clinical and non-clinical settings.
- Reception staff demonstrated understanding and patience when dealing with anxious or flustered patients and we saw reception staff in the Jefferiss Wing treat people who were waiting outside with particular compassion while they waited.
- Patients consistently told us they felt welcomed and valued in the service and they found staff attitudes to be memorable because of their warmth and positivity.
- When clinics were delayed or disrupted staff maintained communication with patients every 30 minutes and offered them water and advice about the delay and options for rebooking.

Compassionate care

- We observed interactions between reception staff and patients on 17 occasions in 11 different areas. In every case the receptionist greeted the patient politely and with a friendly manner. Where patients had difficulty communicating, either because of a language barrier or a speech issue, receptionists were patient and kind.
- We observed a healthcare assistant in the fracture clinic speak gently and reassuringly with a patient who was confused and asking for analgesia. They made sure the patient was calm and orientated before seeking help from a nurse.
- Staff in the Jefferiss Wing treated patients with respect and kindness. For example, we saw a doctor gently and discreetly wake a patient up who had fallen asleep in the waiting room, offering them reassurance and humour afterwards. During another observation we saw a doctor recognised a waiting patient and greeted them with a manner that demonstrably pleased the individual.
- Patients told us staff were kind and friendly towards them. One patient in main outpatients said, “The care couldn’t be better.” One patient in the dermatology clinic said, “Everyone here is really nice, they always are” and one patient in the diabetic clinic described the consultant care and approach of the healthcare assistants as “first class.”
- Results from the patient survey in the Jefferiss Wing were consistently positive. Between November 2015 and December 2016 88% of patients said they would recommend the Wharfside clinic, 94% of patients would recommend the walk-in clinic and 98% of patients would recommend the sexual health service.

Understanding and involvement of patients and those close to them

- When a large queue formed for access to the sexual health drop-in clinic, we saw a receptionist spoke with patients one by one and gave them a registration form as well as information about the waiting time. Where someone had anxiety about the length of the wait or process, the member of staff offered calm reassurance as well as information about when the clinic usually had quieter periods.
- Patients we spoke with said they felt services tried to accommodate their needs. For example, one patient who was due to have a biopsy asked staff if they could move the appointment to later in the day, when a relative would be available to accompany them. They said this was changed without a problem. Another patient said staff were helpful and accommodating when they had asked to make changes.
- Patients told us they felt involved in their care and treatment. One patient said, “The doctor always shares his treatment plan with me.”
- A new standard operating procedure in main outpatients meant staff were more actively involved in communication with patients during periods of delay or disruption. In such circumstances staff provided an update to patients every 30 minutes.

Outpatients and diagnostic imaging

- Nurses and healthcare assistants in main outpatients demonstrated an understanding of patient frustration and helped to improve their experience. For example, we observed staff routinely apologise to patients and explain what had caused the delay. Staff also offered patients a glass of water.

Emotional support

- Chaplaincy, emotional support and counselling services were available to patients in the hospital and these services were signposted in waiting areas.
- Staff routinely provided printed and/or electronic information to patients with more information about their condition.
- Staff in the Wharfside clinic along with the specialist sexual health information and protection team were trained to provide emotional support to patients to help them adjust to an HIV diagnosis.
- The hospital had established provision to support patients who experience domestic violence to access crisis and mental health services.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- Waiting times in clinic for some services differed significantly between sites in the trust. This included ultrasound where the average wait for an appointment at St Mary's Hospital was 30 days from referral. This is within the national target of six weeks.
- There was limited space in many of the specialist clinical areas that impacted patient comfort and safety whilst waiting for appointments. This included overcrowded waiting areas such as in the diabetes and endocrine unit and ear, nose and throat (ENT) clinic. A trust action plan to identify better use of space in ENT had not been updated since February 2016.
- Navigation between services was problematic due to a lack of or confusing signage. Staff provided maps for patients and volunteers worked in some areas to help guide patients but staff in areas such as electrophysiology reported on-going concerns about this.
- Some patient waiting areas were cramped and not large enough to meet demand.
- There were limited resources to support patients with a learning disability and not all staff knew who to contact for support.

However:

- A wide range of services were available in response to the needs of the local population, including audiology support, specialist orthopaedic clinics, facilities for forensic examination of young people and rapid-result laboratory facilities in sexual health and HIV services. The chest clinic offered five core areas of treatment and four specialist consultant-led clinics.
- Sexual health and HIV services offered nine specialist clinics and a sexual health information and protection team (SHIP) provided targeted clinical care and treatment for vulnerable and at-risk patients.
- The volunteer service had started a pilot programme in main outpatients to scope the potential benefits and impact on patient experience of having a team based there permanently.
- An outpatient improvement programme was in place to reduce waiting times and delays to clinics. This information was monitored and between June 2016 and November 2016, an average of 73% of doctors were on

time for clinics and 24% of doctors were up to 30 minutes late. The improvement plan had led to a number of actions to reduce wasted appointments by patients who did not attend, including a restructured appointment communication process.

- A new standard operating procedure enabled senior staff in main outpatients to escalate to the management team if a doctor was late for a clinic that resulted in delays to patients. We saw this worked well during our observations.
- Staff audited clinic delays through a new electronic appointments system. This was in the implementation phase but all of the clinics that used it were able to submit data so staff could identify when delays occurred and why.
- In November 2016, main outpatients had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target.
- A range of access pathways for sexual health and HIV services meant patients were quickly directed to the most appropriate service and clinician. A pilot was underway to establish the usefulness of offering pre bookable appointments for asymptomatic patients 48 hours in advance.
- A new complaints and concerns policy enabled complaints to be recorded, investigated and resolved within the trust's 40 day maximum target. The new system also enabled services to identify trends in complaints to drive improvements.

Service planning and delivery to meet the needs of local people

- A dedicated audiology clinic provided service to ear, nose and throat (ENT) patients during new and review appointments. The service also provided direct access clinics for age-related hearing loss.
- A fracture clinic operated daily Monday to Friday and specialised orthopaedic clinics were available.
- The Jefferiss Wing had an on-site laboratory that provided immediate medical support to staff taking tests in sexual health and HIV services.
- A specific room to care for young people who needed forensic examination was available in paediatric outpatients.
- Although imaging staff were rotated between sites to reduce the impact of short staffing, waiting times different significantly. For example, the standard wait for an ultrasound at St Mary's Hospital was 30 days but the wait for the same procedure at Hammersmith Hospital was only 10 days.
- Navigation at the St Mary's site could be problematic due to service areas located in multiple areas with considerable distances between them. For example, although a phlebotomy unit was located in main outpatients; all other areas for tests such as x-rays and lung function were located elsewhere. This could not be fully mitigated until a new department was built, which was planned for 2020. As an interim measure, staff had replaced signage around outpatients and in the main hospital building and had produced easy-read and colour-coded maps to help people navigate. A pilot scheme had enabled volunteers to be based in the department and this team were also able to help patients navigate the site, including escorting them if needed. Staff in the electrophysiology department told us patients often arrived confused or anxious because it was so difficult to find. Staff told us they had not been able to secure improvements to signage in the building despite escalating the issue.
- Staff in main outpatients, sexual health and HIV services could deliver the flu vaccine at the time of a routine or walk-in appointment.
- Sexual health and HIV services offered nine specialist clinics, including sexual health for young people, a sexual function clinic, an emergency HIV clinic, gender-specific clinics and a sex worker support service.
- The sexual health information and protection (SHIP) team was formed to provide a dedicated service for those most at risk of sexually transmitted infections including vulnerable patients. A team of experienced nurse practitioners led this team and could provide microscopy, differential diagnosis, health promotion and treatment for sexually transmitted infections. This meant patients had one point of contact and did not need to see multiple clinicians, which could increase stress and anxiety. In addition the SHIP team provided care for patients who experienced domestic and sexual

violence and for all patients with complex sociosexual and/or safeguarding needs. Sub-specialty services included vulval dermatology, biopsies and chronic pelvic pain.

- The SHIP team participated in a healthy school relationship education network that enabled them to provide sex education and advice to young people.
- A dedicated adolescent HIV transition clinic was led by an advanced nurse practitioner and consultant. This service helped support young people in moving between young people's services and adult services for treatment management.
- The chest clinic offered capillary and arterial blood gas testing, pulmonary function tests (PFTs), follow-ups to patients who had been treated with continuous positive airway pressure and long term oxygen therapy for patients with chronic obstructive pulmonary disease. Consultant-led clinics were also available for tuberculosis, lung cancer, asthma and bronchitis.
- A team of 150 volunteers provided welcome and meet and greet services across the trust and had started a trial in main outpatients to identify if the team could have a positive impact on patient experience. As part of the trial the team wore new uniforms that were designed to make them easily identifiable by patients.
- Specialist outreach workers from non-profit agencies held sessions in sexual health and HIV services to provide additional capacity for harm and risk reduction with specific patient groups.

A**ccess and flow**

- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks. The trust are showing a downward trend which is in line with the trend in the England average which is also getting worse.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services was worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks. The England average is only just below the target, but this trust's performance is noticeably worse than the target and has the trend is getting worse.
- The trust was performing slightly worse than the 93% operational standard for cancer waiting times: people being seen within two weeks of an urgent GP referral. Performance rose in Q2 2016/17 to 92.4% which was still below the England average of 94.2%.
- The trust was performing better than the 96% operational standard for cancer waiting times: patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). Performance remained steady in Q2 2016/17 at 96.7% which was just below the England average of 97.6%.
- The trust was performing worse than the 85% operational standard for cancer waiting times: patients receiving their first treatment within 62 days of an urgent GP referral. Performance fell over two of the last three quarters but recovered in Q2 2016/17 to 80.1% which was still below the England average of 82.3%.
- Between August 2015 and July 2016 the percentage of patients waiting more than six weeks to see a clinician was lower than the England average.
- Staff monitored the punctuality of doctors in outpatient clinics as part of an overall improvement strategy to reduce waiting times and delays. Between June 2016 and November 2016, an average of 73% of doctors were on time for clinics, 24% of doctors were up to 30 minutes late and 3% were over 30 minutes late.
- Between April 2015 and March 2016 the 'did not attend' (DNA) rate for outpatients was between 8% and 10%, which was higher than the national average rate of 7%. This aspect of access and flow was a key focus of the trust's outpatient improvement programme. As a strategy to reduce the DNA rate, the trust introduced tracking of appointment letters from print to dispatch, introduced a voice reminder service as well as text, voicemail and e-mail options and improved the clarity of information sent out in letters. This reduced the trust-wide figure of outpatient DNAs from 17% in September 2014 to 11.3% in October 2016.
- Between December 2015 and December 2016, outpatient services cancelled 5856 appointments due to

administrative errors, patient error in booking or clinic cancellations within six weeks of the appointment. This equated to 7.9% of appointments, which was better than the maximum appointment cancellation target of 8.5%.

- Routine magnetic resonance imaging (MRI) scans were available from 8am to 8pm Monday to Friday and from 9am to 5pm on Saturdays. Emergency MRIs were available in the imaging trauma unit 24-hours, seven days a week.
- A new senior nursing team in main outpatients implemented changes in flow management and introduced a new standard operating procedure (SOP) to reduce delays and improve the service. For example, if a doctor was not present 15 minutes later than the planned start time of a clinic, the senior sister would escalate this to a manager. Staff told us this meant punctuality had improved and doctors routinely told the nurse in charge when they had arrived. We saw the escalation process worked well in practice. For example we saw a consultant had not arrived in the vascular clinic 15 minutes after its start time. The specialist registrar escalated this and obtained a second registrar to assist with consultations and the senior sister escalated it to the senior medical team, who found the consultant was in theatres. The senior sister spoke with waiting patients to explain the situation. It was not clear why there had not been communication between departments in advance to prevent the situation.
- As part of the new SOP, a clinic monitoring form was introduced as an auditable tool to help staff monitor where delays most often occurred. Staff running each clinic added feedback to the forms so that the senior team could establish how best to improve waiting times. The outpatient senior sister met with clinical leads to discuss tracked performance of each clinic, which was organised responsively depending on the performance of the clinic. For example, meeting with the hepatology lead took place every six weeks and with the neurology team every month.
- We looked at 12 completed clinic monitoring forms and noted they did not include the time patients were actually seen. We spoke with the general manager and senior sister about this. Patients who used the self-check-in system were called to their appointment room through the electronic system, which recorded the time they were seen. This system was in the implementation stage and 50% of clinics used it, which meant the time difference between the booked appointments and being seen was available for these patients.
- At the time of our inspection the trust was reporting 44% patients waiting over 30 minutes to see a clinician (this is the proportion of clinics which overrun by more than 30 minutes, so the trust has assumed the worst case scenario and that all patients are impacted by the delay).
- Between February 2016 and December 2016, 61% of patients were seen on time and 29% were seen within 20 minutes of their booked time. Once the electronic system was fully functional in all clinics, waiting times would be audited fully. The senior sister identified clinics with good levels of compliance with the new process during daily briefings. In one briefing we observed the neurology clinic had achieved 98% compliance on the previous day.
- Cardiology clinic bookings did not include pre-booked tests, which staff said meant they often ran late. For example, new patients always underwent an electrocardiogram (ECG) and echocardiogram (ECHO), which meant they then had to return to the doctor to be reviewed. This was mitigated to some extent by having a dedicated ECG technician in the clinic at all times it was open. On one day of our inspection the average delay was 45 minutes for this reason. Staff in this clinic told us this was a common occurrence as up to 18 new patients per day were seen.
- ENT services were available Monday to Friday with an emergency referral service available on a Wednesday afternoon.
- Waiting times to have a hearing aid fitted in the audiology department depended on the type of equipment needed. For example, an open fit model could be inserted one week after an initial assessment but moulded fit models could take up to five weeks.
- Patients gave us varying feedback of their experiences of waiting times. Six patients told us they had noticed a reduction in late clinics in the previous year and said they rarely waited more than 20 minutes past their appointment time. Another patient said there were often lengthy waits in phlebotomy and appointments in

the vascular clinic were often changed by the service several times. We spoke with nurses about this who told us delays in the phlebotomy unit were common but phlebotomy staff would advise people when their quieter times were so they had the option of coming back then. In addition, the haematology service provided staff to help in phlebotomy for two sessions each week.

- A new centralised booking system had been implemented to make appointment management more responsive to patient need. Individual outpatient specialties could decide if they wanted patients to book follow-up appointments through central booking or on-site at the time of their appointment.
- Staff identified cardiology, rheumatology and neurology as the clinics that most often ran late. This was because appointment slots were for 10 minutes but some patients needed up to 30 minutes. We spoke with the senior sister and two consultants about this who told us the templates for each clinic, which was used to structure appointment length, were under review by each specialty to identify how they could be more flexible or allocate extra time for each patient. This had resulted in early improvements, such as the removal of the ability to double-book appointments and a new template for the hepatology clinic that would allow staff to more accurately record waiting, treatment and departure times. This clinic had also introduced longer appointment times as a trial to reduce delays.
- If a patient did not attend for an urgent cancer referral, they were always offered a new appointment within two weeks.
- The Jefferiss Wing offered a range of clinics and access times that had been developed to meet the needs of patients. This included a rapid 'check and go' service for sexual health from 9am to 6.30pm Monday to Thursday and 9am to 4pm on Fridays. Early clinics were offered two days per week and sexual health checks and testing services were available five days a week. In response to patient feedback, the sexual health service had introduced a new asymptomatic care pathway that included pre bookable appointments online. The appointments were released 48 hours in advance and gave patients a time slot to attend that meant they could better plan their time in the clinic. Staff aimed towards a one hour assessment and treatment target for patients who were asymptomatic and attended the walk-in clinic. In October 2016 76% of patients were seen within this target. The HIV service operated an emergency clinic for patients who had run out of medication or who had symptoms that needed urgent attention.
- Treatment pathways in the sexual health unit were divided into symptomatic and asymptomatic streams, which helped staff to see patients more efficiently by using the most appropriate staff. For example, symptomatic patients would be seen by a nurse and doctor and asymptomatic patients would be seen by staff trained in contraception and sexual health testing.
- A policy was in place in the Jefferiss Wing for times of exceptional demand on the walk-in service. The nurse in charge would triage patients in the waiting areas to prioritise those with the highest level of need. The nurse in charge would then meet with the consultant in charge to expedite patient pathways and in exceptional circumstances allocate slots for patients to return the next day.
- The chest clinic was equipped to offer respiratory consultant review and pulmonary function tests, led by specialist physiologists. Emergency PFTs and appointments for cases of suspected TB were available within two weeks of referral and in this clinic we saw low waiting times with few delays.
- The booking and appointment system in the dermatology day treatment unit meant there were no delays. This system included separate appointments for each patient symptom or complaint and one hour review slots for new patients. Routine referrals were given an appointment in four to six weeks and urgent referrals were seen in two to four weeks. This information was provided by senior staff in the department although no audit data were available.
- Routine ECHO appointments in the cardiac diagnostics department were available with two to six weeks' notice. Urgent ECHO appointments were available for same-day referral.
- Staff in the diabetes and endocrine unit were able to facilitate urgent appointments for patients who turned up without an appointment if clinically appropriate. Routine referrals in this clinic were seen within 13 weeks and doctors operated extra clinics if waiting lists were

about to exceed this. Referrals to the weekly lipid clinic were also seen within 13 weeks. One patient we spoke with during the inspection said service in the clinic was variable. For example, they had visited in June 2016 and experienced a delay of 94 minutes with no information about the delay on the information board. Staff told us this was a rare occurrence and would only occur if a member of staff was off sick or if an emergency meant they needed to see patients urgently.

- Referrals to the electrophysiology department were seen within three weeks and the administrator told us they could accommodate urgent requests. This service had a track record of meeting the five week target for time from referral to appointment.
- Main outpatients monitored the turnaround time of referrals received with appointments. In November 2016, the department had achieved a turnaround time of 10 days for 95% of referrals, which was the trust target. In addition the department completed a consultation with a specialist organisation that helped to redesign printing and posting systems to ensure patients received letters in a timely manner. This involved a review of the patient database against Royal Mail records and digitisation of the letter dispatch process. An e-mail service was implemented in September 2016 and patients were routinely offered this.
- During our inspection we reviewed clinic waiting times in main outpatients at three points in time. This included a total of 19 clinics and 24 doctors. Overall 13 clinics were on time. Delays were found on two occasions in the ENT clinic and the vascular clinic. Most delays were less than 30 minutes, with the exception of cardiology where one doctor was running 55 minutes late. Where clinics were running late staff had written up to date information on a display board, apologised to patients and explained the situation.
- At the time of our inspection the trust was reporting that less than 2% of patients were being seen in Outpatients without the full medical record being available.

Meeting people's individual needs

- Waiting times were displayed on boards in each clinic area and staff updated these whenever there was a change, or at hourly intervals. In addition staff in each clinic carried an egg timer with them to remind them to update patients every 30 minutes during a delay. Staff advised patients of the waiting times on arrival in main outpatients and in sexual health walk-in services they were given an estimate of visit time.
- Separate waiting areas for men and women were provided in the sexual health unit and each had gender and condition-specific printed information available for patients. In addition, staff had created an electronic access option as an alternative to printed information from a sexual health charity. For example, QR codes linked to specific subjects were on display in waiting areas and patients could use their smartphone to access the information.
- Self-check-in machines were available in main outpatients and the Wharfside clinic and included instructions in 23 different languages the trust had identified as spoken locally. Managers monitored the most used languages and ensured they were prominently displayed on the welcome screen for easy access. The machines directed patients to the appropriate waiting areas and signage in the building matched the exact words used in on-screen information. Receptionists were available to provide one-to-one check-in and directions at all times when the department was open and a pilot volunteer scheme in main outpatients meant at busy times volunteers could also help direct patients.
- Reception areas were fitted with hearing loops, which were advertised to patients and visitors.
- Waiting areas in the main outpatients department had a range of seating available, including with and without arms and bariatric chairs.
- Signs in main outpatients advertised an e-mail appointment service to patients who wanted it.
- The audiology department had limited access space and we saw it became overcrowded due to having only two testing booths.
- Information on display in paediatric outpatients included a television screen that encouraged patients and parents to let staff know how they preferred to be addressed. Information for young people on the dates of various religious festivals was also on display, such as Diwali and Christmas.

Outpatients and diagnostic imaging

- Waiting areas had television screens that displayed information on the services provided, key members of staff and contact information, including social media.
- Staff in paediatric outpatients were not informed in advance if a patient had a learning disability but were able to adapt the service as they became accustomed to the individual's needs. For example, they could arrange appointments in the first or last slots of the day to avoid the anxiety arriving into a busy waiting room could cause.
- All departments had access to telephone or in-person interpreters.
- Most patient waiting areas were equipped with wi-fi.
- Posters were on display to advise patients that private areas were available if they wanted to speak with staff.
- Appointment reminders from main outpatients were sent out by text, e-mail or letter according to each patient's preference.
- Specialist sexual health clinics had adapted to the needs of individual people. For example a sexual function clinic included psychologist input and offered a consultant led sexual dysfunction service.
- A specialist trainee led the HIV emergency clinic under direct consultant supervision patients had direct line access to them and were able to attend the clinic at short notice. This member of staff also provided on-call advice to staff in the accident and emergency department.
- There were limited resources for patients with a learning disability and not all staff we spoke with knew if the trust had a learning disability lead. In sexual health, staff said they would refer to the SHIP team, who we confirmed were resourced to support patients with a learning disability.
- A psychosexual consultant was available in the Jefferiss Wing and a psychiatric liaison nurse ran three clinics per week and supported patients with issues such as alcohol dependency and depression.
- Although space was very limited in most areas for patients, the Coulter Suite, which provided dynamic endocrine testing, was spacious and comfortable with large chairs for patients whilst they underwent blood and endocrine tests.

Learning from complaints and concerns

- The trust responded to complaints based on the risk grade of the complaint. Low risk was 25 working days, medium risk was 45 days and high risk was 65 days, the trust allowed themselves one extension per complaint. All complaints were read by the associate director of complaints for the trust. Sign off on a complaint depended on the risk grade, low grade complaints were signed off by a complaints officer, medium risk were signed off by the associate director and high risk ones by the chief executive.
- In the reporting period between August 2015 and July 2016 there were 53 formal complaints about Outpatients services at this trust. The trust took an average of 32 days to investigate and close complaints; this is in line with their complaints policy, which states that the trust has a target to resolve each complaint within an average of 40 working days.
- A new complaints and concerns policy had been established following the centralisation of the complaints process, which included responsibility for complaints moved to the corporate nursing directorate. The complaints and service improvement manager implemented a 'change register' to identify and monitor all of the changes made as a result of complaints. This process helped to identify how divisional services were improving as a result of patient complaints.
- Between October 2015 and August 2016, outpatient services received six formal complaints and diagnostic imagining received 20 formal complaints. Five of the outpatient complaints and three imaging complaints related to poor communication about clinic running times or clinic delays. In each case, staff had recorded an apology to the patient as well as corrective action taken. For example, when a patient had been incorrectly booked into a clinic, the team responsible had been given additional training. The new centralised booking system would also prevent future recurrences. All of the complaints looked at this in this period had been resolved within the 40 day target established by the trust. However, there were not procedures in place to ensure third party contractors who provided services on behalf of the directorate were equipped to resolve complaints. For example, a mobile MRI scanner was available on site and was used to increase capacity. This was provided by an external agency. When a patient

submitted a formal complaint about this, the complaint coordinator was not able to obtain a timely response from the operator. The recorded complaint outcome stated that staff would continue to "chase up" the company responsible. One outpatient complaint related to the attitude of an agency nurse but there was no documented follow-up to this.

- Between January 2016 and November 2016, Jefferiss Wing services received four formal complaints. Three complaints related to patient experience in the walk-in clinic, including two complaints about delays to results. One complaint related to a reaction a patient experienced during a clinical trial. In each case the general manager contacted the patient and there was evidence they were kept up to date during the investigation. Changes were put in place as a result of complaints, including more detailed training for doctors with regards to information governance and training for reception staff to ensure they proactively offered patients a range of contact methods.
- 'Let us know' leaflets were widely available which detailed different methods of providing feedback. This was also a resource to signpost patients and visitors to appropriate bodies such as for complaints advocacy, Action against Medical Accidents and the Parliamentary and Health Service Ombudsman.
- All staff were able to handle verbal concerns or complaints in the first instance and each department had a clear escalation policy so that an appropriate senior person was made aware of the situation. Staff also referred patients to the patient advice and liaison service (PALS) if they wanted their complaint to be investigated by staff not directly involved in the department. Outpatient departments let the PALS team know when clinics were running late and what the reason was so they could be better prepared to discuss concerns with patients.
- Staff working in the trust's improvement project took a lead in resolving patient complaints at the local level. A doctor told us this worked well because those in the improvement project were very interested in dealing with problems and were able to get to the bottom of issues quickly.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- A new general manager and senior sister in main outpatients had conducted a significant nursing and leadership review of the service and restructured it to deliver results in the outpatient improvement programme. This was a collaborative project with a proactive programme manager that resulted in new operating practises to reduce clinic delays, improve patient outcomes and ensure the staff team was sustainable.
- All of the staff we spoke with were positive about the overall vision and future strategy for the trust. Most staff also felt empowered to promote positive change and provide suggestions for improvement in their own local services.
- Staff in diagnostic imaging, sexual health and HIV were research active and sought out projects that would help them develop their services.
- Clinical governance structures helped staff to manage risks to services and involved an appropriate range of staff in most cases. Risk registers were updated regularly and staff with appropriate experience and knowledge managed these.
- All services demonstrated high standards of information governance and patient confidentiality.
- The majority of staff we spoke with felt positively about the leadership in their service and described a work culture that facilitated development and innovation. This was particularly the case in cardiac, sexual health and HIV services.
- Feedback from patient engagement was used to improve services, particularly with regards to staff communication in main outpatients and the role of trust volunteers.
- Individual services engaged with their staff teams to improve working conditions and deliver better patient

services. This included through consultation on working patterns and the implementation of a working group in diagnostic imaging to identify solutions to some of the challenges the team faced.

- Staff felt recognised and rewarded for their work through trust and local initiatives and spoke positively of opportunities to work with colleagues in other areas to gain a better understanding of how they worked.
- A therapies quality and safety committee maintained oversight of clinical governance in individual specialist therapies clinics to ensure incidents and complaints were monitored and ensure clinical practice met trust and national guidance.

However:

- Although clinical governance meetings in diagnostic imaging were well attended and led to demonstrable outcomes, there was a lack of representation from some specialties.
- Some staff said there was a lack of development opportunities, leadership support and innovation in their area of work.
- The senior team recognised staffing shortages in diagnostic imaging placed additional pressure on staff. However it was not clear that recruitment and training plans were understood by existing staff or that they had confidence in this process. This impacted their morale and exacerbated concerns around what they perceived to be inconsistent pay and conditions in some areas.

Leadership of service

- The main outpatient service and diagnostic imaging had been restructured at a divisional level and had moved from the division of investigative sciences and clinical support services to the division of women's, children and clinical support. New leadership posts were also created, including a senior sister. Most of the staff we spoke with were positive about this change and the impact it had on patient experience and safety. One member of staff said they felt the changes had placed staff under high levels of stress, which had resulted in sickness and staff leaving.
- The senior sister in main outpatients had implemented a daily morning briefing to improve staff cohesion and morale in addition to the efficient running of the service. We attended one briefing, which included staff at all levels, including service and general managers. The meeting had a motivational tone and the nurse in charge asked each person how they were feeling and if there was anything everyone else needed to be aware of that meant they would benefit from extra help and support. Staff achievements were acknowledged, such as a healthcare assistant who had received positive feedback from a patient the previous day.
- Staff in diagnostic imaging spoke positively about their relationship with the clinical service manager and general manager and said they were both fair and approachable.
- There were clear lines of leadership support for staff at all levels and every individual we spoke with knew who to contact if they needed help or support. Staff in sexual health and HIV services spoke positively about the leadership team and said every member of the team was approachable and open to talking with them.
- Staff described varying experiences of the trust executive team. For example, staff in diagnostic imaging said the chief nurse and chief executive often came to the department and spoke with staff whereas some staff in the Jefferiss Wing said they had not met any members of the team.

Vision and strategy for this service

- The overarching plan for outpatients and diagnostic imaging services was to successfully move all services into a new purpose-built estate due to be completed in 2020. All of the staff few spoke with across departments and grades spoke positively about this. One person in sexual health services said, "I think the vision for redevelopment is very clear and detailed. We've all been involved in it and I think it's a very exciting goal for us."
- An outpatient improvement plan, launched in spring 2015, laid out five key areas of improvement including responsiveness to customer care, communication with patients and GPs and digitising outpatient services.
- Staff in diagnostic imaging were research active and proactively participated in studies that could improve patient treatment and outcomes. In 2015/16, three research projects were active that covered four clinical

specialties. Staff in the acute imaging centre planned to take part in research to introduce focused ultrasound treatment for brain tumours following successful trials in outside of the UK.

- Sexual health and HIV staff were in a retendering process with local commissioners. As part of this they planned to complete the pilot of pre-bookable asymptomatic pathway appointments and develop a self-swabbing service to increase efficiency for walk-in patients. Services also planned to introduce more technology to aid efficient communication with patients, such as software that would allow patients to access test results online. In addition a 'click' clinic has been established. This allowed HIV positive patients who were stable on medication to be seen in the clinic every six months for routine blood tests and see their consultant annually. Software planned for this service would allow patients to manage this themselves online. The service had also entered into a pilot scheme with a non-profit sexual health agency to offer home testing for HIV.
- The volunteering team had recently transferred from being operated and funded directly by the trust to a charity. As part of this the head of volunteering had drafted a new strategy that identified the numbers of volunteers needed, how the roles would be developed and how they would impact the quality of patient experience. The trust improvement team supported the development of volunteering services, which included planning for more robust recruitment, selection and training processes.

Governance, risk management and quality measurement

- HIV, sexual health and infectious disease services were a directorate within the medicine division led by a clinical director, lead nurse and general manager. Staff said the general manager and whole leadership team were visible, accessible and attended clinical meetings. Staff in this directorate used a series of four monthly meetings to ensure clinical governance was robust and the service was robustly managed. This included a genitourinary medicine meeting, a directorate meeting, a nurse meeting and a service development meeting.
- Outpatients and diagnostic imagining services were distinct directorates within the women's, children's and clinical support division. A divisional director had oversight of all clinical services within the directorates and was supported by a divisional director of operations, an outpatient improvement programme manager, a head of nursing and a divisional director of nursing and midwifery. The outpatient services directorate was led by a clinical director, senior nurse and general manager. The diagnostic imaging directorate was led by a general manager, lead radiographer, clinical director and senior nurse.
- A multidisciplinary radiation safety committee managed the investigation of safety issues and incidents in diagnostic imaging through monthly risk meetings. Senior managers and clinicians attended the meetings and radiation protection supervisors and medical physics experts were invited although their attendance was not mandatory.
- There was a lack of consistency in staff governance in diagnostic imaging. For example, there were strict limits to the number of radiographers and ultrasound staff who could be off at one time but this did not apply to radiologists, which could cause blocked lists. In addition, trust medical exposures and radiation protection meetings took place monthly but did not include radiographer representation.
- The radiology clinical service manager invited new staff to a 'welcome interview' following successful recruitment. This helped them get to know the department and ask any questions before they started their substantive post. We received positive feedback about this process.
- Services monitored risks with the use of risk registers. This was a tool used to assign ownership of risks to a named senior person who could then document progress towards resolving or mitigating the problem. The directorate committee initially reviewed entries on the risk register and once signed off these were sent to the divisional committee and then to the trust executive team.
- The risk register for diagnostic imaging included 38 items, 12 of which were classified as major risks. The age of equipment was a significant risk in diagnostic imaging and was listed on the appropriate risk register. Staff had submitted a business case for the replacement

of the gamma camera and were awaiting the outcome of this. Other major risks included inappropriate nurse skill mix, which led to an increase in sickness and turnover and lack of space in waiting areas.

- Staff in main outpatients attended a fortnightly meeting to discuss clinic operation, including trends in patients who missed appointments. We observed a meeting and found it well attended by a range of staff. The meeting was used to discuss incidents, complaints and updates to individual clinics. Staff also had the opportunity to give feedback and provide follow-up information from the last meeting.
- Risks associated with confidentiality were well managed. In all areas we saw patient notes were stored in locked cabinets or supervised by staff at all times. Information governance was part of the trust mandatory training programme and all of the staff we spoke with demonstrated this in practice, such as locking computers and removing IT access cards when they were not in use. All staff in outpatients, 93% of consultants in diagnostic imaging and scientific and technical staff had up to date information governance training. In diagnostic imaging, doctors in training (55% compliance), AHPs (73% compliance) and administration staff (79% compliance) did not meet the trust 90% target for up to date training in information governance.
- The risk register for main outpatients including eight items. The item with greatest severity involved the risk of overbooking appointments, resulting in cancellations and subsequent clinical risk. The new standard operating procedure for booking had begun to resolve the issue of overbooking, which now only took place with authority from a consultant under clinical need. This system also contributed to reducing clinic delays. In addition, a clinical reference group had been established to monitor progress. Other risks included patient notes being unavailable for clinics and delays of up to 3 hours in admitting patients to inpatient areas. Risks were clearly documented and evidenced and an assigned senior member of staff updated each risk monthly with mitigating actions and progress towards a firm resolution. There was appropriate input of clinical, non-clinical and managerial staff for each area of risk.
- Clinical governance and leadership in main outpatients had been restructured since summer 2015 and gave outpatients a dedicated leadership structure. This included the appointment of a senior nurse with a change management background to provide 50% clinical leadership and 50% management function. This member of staff worked with the general manager and service support manager to improve the operation of the unit, including working relationships, implementing a performance framework and improving patient experience. Managers involved in this told us the trust recognised outpatients as an area of priority and a steering group, formed of multiple business areas, was driving forward positive change.
- A therapies quality and safety committee, led by a therapies executive lead, maintained clinical governance for day case and outpatient specialist therapies including the hand therapy clinic and lipid clinic. The committee held a monthly clinical governance meeting, which was attended by a representative of each specialist service and grade of staff. This ensured each clinical service adhered to a structured risk management process regardless of how often it operated or how many patients it saw.

Culture within the service

- We spoke with seven staff from the imaging department representing five different grades across clinical and non-clinical services. All staff told us they felt the department was a supportive place to work, with opportunities for development and leadership that valued them. For example, staff in radiology told us they appreciated the opportunity to work under supervision in the trauma unit when they were relatively junior as a strategy to increase confidence and skills. One member of staff said, “There is never a day that I am overwhelmed or under challenged.”
- Staff we spoke with in other areas felt differently. For example, staff in audiology said they enjoyed working there but there was a lack of support for development. This included multiple cancellations of planned facilities work and a reliance on equipment manufacturers to fund conference attendances when the trust would not do so. One member of staff in paediatric outpatients told us they felt unsupported by the senior team and that they felt they could raise issues but this was not

followed up with action or change. All of the staff we spoke with in the chest clinic told us their working culture was supportive, positive and pragmatic to deal with challenges such as a lack of space.

- Staff told us when their circumstances changed or they were not able to fulfil their contracted role, the leadership team worked with them to find an appropriate alternative. This included support to move between clinical and non-clinical roles and the training needed to complete this effectively.
- Some staff felt they were not always spoken to with respect. For example, one member of staff said a consultant had shouted at them when they asked for some clarification about a follow-up plan for a patient who had not understood them. They said although working relationships were mostly positive, there was room for improvement in how staff with different roles spoke to each other.
- Senior staff in each department were clear about their responsibilities under the duty of candour. In diagnostic imaging, the site leads were responsible for ensuring this was followed. In outpatient areas the senior nurse or doctor responsible for the clinic would ensure they met the requirements.
- Diagnostic imaging site leads and radiology managers felt practice at the trust was not up to date and did not reflect comparable trusts in London. They felt this was a driving factor in the relatively high turnover of staff and difficulty in recruiting as it also meant there was limited scope for staff, particularly radiographers, to develop into advanced practice. Some staff also felt a lack of support from the clinical director and senior radiology team meant the situation had not changed. Staff in other areas were more positive about the future of their service. For example, one member of staff from nuclear medicine said equipment had slowly started to be replaced and a five year plan as to direct this was being put in place. The trust had identified room for improvement in some of the areas of concern raised by staff and planned to introduce new roles according to the North West London radiography careers framework, including reporting radiographers, trainee, sonographers and clinical nurse specialists for neuroradiology.
- Seven radiology staff we spoke with said they felt they had the opportunity to take part in innovative practice and their worked was varied, particularly with the opportunity to work in neuro-radiology, paediatrics and trauma.
- All of the staff we spoke with in sexual health and HIV services spoke positively about working relationships and culture. For example, a nursing assistant described “brilliant” relationships between the nursing team and doctors. They said, “All of the doctors are very approachable, very easy to speak to. They’ll step up and do examinations if no nurses are available.” A senior nurse said they appreciated the visibility of the leadership team. They said, “When we ask for training we get it and when we need something for our own wellbeing we get that too.”
- Non-clinical staff spoke positively of working relationships and culture. For example, a patient scheduler for the cardiac service said the support they received from the diagnostics support manager was of a high standard and a receptionist in the chest clinic described working relationships as “excellent.”
- Staff reported a working environment free from bullying and harassment in every area we visited, with the exception of one report in diagnostic imagining. Managers told us they were confident teams were stable and any minor concerns were handled appropriately. All staff also had knowledge of an employee relations advisory service, which gave them access to independent advice if they needed it.

Public engagement

- Reception staff and volunteers provided one-to-one education sessions to patients in the use of self check-in machines who otherwise felt anxious using them alone.
- As a strategy to increase patient feedback, staff in sexual health and HIV services had linked a patient survey with a QR code and text service. This enabled patients to use the QR scanner on their smartphone during the clinic visit to download the survey from a code on their registration form and submit it electronically. Patients who registered for the text message contact and results service received a survey link this way one week after their appointment. This helped staff to gain a clearer understanding of the individual experience as it had given them time to reflect.

Outpatients and diagnostic imaging

- As part of improvements to access and flow in main outpatients, the senior sister had spoken with patients and asked them what they would like to see changed in the department. Patients said they wanted a more 'personal touch' from staff and a more visual presence when waiting. Staff presented the findings in a poster to the trust executive team and implemented the changes as part of the wider improvement plan.
- New uniforms worn by volunteers had resulted from patient and visitor feedback that identified there was a lack of visibility of the team.

Staff engagement

- Senior staff in diagnostic imaging had consulted staff on using a shift rotation system between the three trust sites to reduce the impact of short staffing. Although staff told us they felt this was a positive approach, they said it was often difficult to reach the clinical director and they did not see him regularly.
- The radiology service operated staff partnership working groups with staff group representatives. This provided staff with a forum to discuss their work and to raise concerns and frustrations. The most common issues raised related to the age of equipment and the condition of the estate.
- The senior leadership team presented 'Make a difference' certificates to staff in recognition of good work. Staff demonstrated knowledge of this scheme and spoke positively about it. Staff in sexual health and HIV told us they felt the awards were motivational and generated a feeling of pride when anyone in their team achieved an award. Most recently a nursing assistant had been awarded this following positive feedback from a patient.
- Administration staff had raised concerns about the design and layout of the reception area in acute imaging. In response the area had been redesigned so they could see all waiting patients and panic alarms were installed with a direct link to the security team.
- Exit interviews with staff leaving diagnostic imaging services highlighted a trend that new people were recruited who did not expect to have to work weekends. To address this new contracts were offered that clearly outlined working hours and patterns to help people plan their work life balance more readily.
- As part of the changes implemented to working practices in main outpatients, the senior sister had met with each consultant to ask what they wanted to see in their clinics and how they could best be supported by the nursing team. Medical staff gave positive feedback about this process and it said it had led to collaborative changes. A consultant on shift patterns with nurses and HCAs had also taken place. As a result, some staff were trialling longer shifts over four days per week, instead of shorter shifts over five days. This was a voluntary trial and staff we spoke with told us the consultation process had been inclusive and made them feel valued.
- Results from the most recent staff survey showed 90% of staff in sexual health and HIV services would recommend it as a place to work and the team reported 86% job satisfaction. In outpatients, 93% of staff said they felt engaged by the trust, reported good job satisfaction and would recommend the hospital as a place to work.
- This team had participated in an 'In your shoes' programme that offered individuals the chance to work alongside colleagues to help understand each other's role. In addition, band six nurses met weekly to discuss their needs and support each other with any concerns or challenges.

Innovation, improvement and sustainability

- Staff in diagnostic imaging highlighted highly skilled imaging assistants and experienced reception staff as valuable assets to the department but raised concerns the roles were not sustainable because of disparities and inequalities in pay and skill base. As the department had on-going short staffing, the individuals we spoke with worried this could be worsened without recognition of the work their teams did. The trust had implemented a retention premium to help retain staff in the areas under most pressure.
- The radiology service predicted an increase in demand of 9.3% in the following year and was operating with 460 hours of overtime per week due to staff shortage. To ensure the service remained sustainable, a recruitment plan for 50 new staff over a two year period had been implemented.
- Staff in several different areas spoke to us about the development opportunities available within their role as a strategy to encourage building skills and their value to

patients and the trust. For example, band five staff in radiology told us they were happy to be supported to develop as individual practitioners and two band seven staff had been supported to undertake radiographer reporting training.

- Staff in sexual health and HIV services were prepared for local changes to referral protocols in order to maintain access for patients and protect the sustainability of the service. For example, referrals to specialist services were being transitioned to GPs. In response staff conducted outreach and education sessions with local GPs to ensure they were able to provide appropriate referrals.
- The nurse consultant education lead and other staff in sexual health and HIV services offered external training courses as a way to raise funds to send their own staff on specialist training and to conferences. The departmental approach to providing staff with highly specialised on-going training, including national accreditation and a diploma, also contributed to the sustainability of the service and staff retention.
- All band seven staff in sexual health and HIV had completed or were currently completing a Masters programme of study and the senior team supported them to complete their research in the department. Nurse research training was also available and nurses who had completed this took part in research projects as medication administrators. New band six nurses had to be prescribers as part of the service plan to ensure it remained sustainable.
- The sexual health information and protection (SHIP) team had been recognised with a national award for their work with patients who were victims of domestic violence.

Outstanding practice and areas for improvement

Outstanding practice

- The senior team in the Jefferiss Wing, including sexual health and HIV services, demonstrated a sustained track record of building staff skill mix and service sustainability through promoting specialist training, practice education and rewarding performance. A skill mix review had restructured the operation of sexual health services, which included each consultant working with a nursing assistant so that nurses could see patients independently. The training and competence profile of this team was evidence of proactive service led by a coherent team of highly skilled practitioners. This resulted in positive impact on the local population because it meant people who were vulnerable or at-risk received timely support and treatment. This included people who experienced substance addiction and domestic violence as well as sex workers and young people under court of protection orders.
- The outpatient improvement programme had begun to deliver results in a relatively short space of time and the process, involving staff consultation and a restructured leadership and governance team, meant clinic delays had been reduced and communication with patients improved. A dedication to utilising technology meant patients had the choice to be contacted by text message, e-mail or letter and these systems were tracked to ensure they were sent accurately. The improvement programme had included patient consultation and feedback was used to inform staff training as part of broader changes to the service.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

The hospital should ensure all staff working in clinical areas have appropriate fire safety training and an understanding of local evacuation procedures.

The hospital should ensure incidents are fully investigated within a reasonable timescale in such a way that allows trends to be identified so as to ensure the service remains safe.

The hospital should ensure contractors providing services are able to respond within a reasonable time to complaints made by patients against the trust in cases that involved both providers.

The hospital should ensure doctors in training have up to date mandatory training in all required areas.

The hospital should ensure pre-qualification allied health professionals have up to date mandatory training in all areas.

The hospital should ensure each radiology practitioner has a documented local induction for checked competency in working under IR(ME)R guidelines.

Imperial College Healthcare NHS Trust

Charing Cross Hospital

Quality Report

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Website: www.imperial.nhs.uk/our-locations/charing-cross-hospital

Date of inspection visit: 22nd - 24th November 2016
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

Charing Cross Hospital is an acute general teaching hospital located in Hammersmith, London. The present hospital was opened in 1973, it is part of Imperial College Healthcare NHS Trust. The trust's central outpatient departments were located at St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital which were overseen by a single leadership team (Lead Nurse, Clinical Director and General Manager), with dedicated clinical and administrative leadership teams based on each site.

Our last comprehensive inspection of the trust was undertaken in September 2014 when we rated the outpatients and diagnostic imaging service at Charing Cross Hospital as inadequate. The purpose of this focused follow-up inspection was to inspect core services that had previously been rated as inadequate.

During this inspection we found the service had improved. We rated the outpatients and diagnostic imaging service at Charing Cross Hospital as requires improvement overall.

Our key findings were as follows:

- The majority of non-managerial staff we spoke with were unsure regarding the duty of candour until prompted.
- We found nuclear medicine fridges containing radioisotopes for use in scans were not monitored consistently.
- The majority of radiotherapy staff members we spoke with raised concerns regarding the safety of the radiotherapy on-call service.
- The trust did not meet its diagnostic report turnaround time target of all diagnostic imaging being reported on within two weeks.
- We observed that there was poor signposting throughout the hospital both outside and inside.
- The outpatient and radiology waiting areas had a lack of drinking water facilities, the majority of patients we spoke with told us they could not find where to access drinking water.
- The trust consistently did not meet national targets for a variety of performance indicators.
- The majority of patients we spoke with in the outpatient and radiology departments commented negatively in regards to waiting times
- The majority of staff we spoke with felt that that senior management focussed on other trust sites more than Charing Cross.
- All non-managerial staff we spoke with across the whole hospital said that the executive team was not visible enough at Charing Cross.
- We found the leadership within the radiotherapy department required improvement.
- The majority of radiotherapy staff we spoke with told us that they did not feel supported by the managerial team.
- The majority of staff we spoke with could not tell us the hospital's vision or values.
- We were told of by staff of a blame culture in radiotherapy with friction between the different radiographer staffing groups.
- The majority of non-managerial nursing staff told us they felt tired and overworked.

However we also found some areas of good practice:

- The outpatient department consistently met its compliance target for hand hygiene and 'bare below the elbow'. The department also scored 100% for cleanliness in the patient-led assessments of the care environment (PLACE) audits for 2016.
- We observed that there were a sufficient number of doctors to run the scheduled outpatient clinics and the clinics were consultant led.
- Care and treatment within all areas we visited was delivered in line with evidence-based practice.
- Friends and family score for October 2016 demonstrated 88% and 97% of outpatient and radiology patients would recommend the service.

Summary of findings

- Patient comments regarding their care and treatment were positive regarding the outpatients, radiotherapy and imaging departments.
- A trust wide outpatient improvement plan which laid out five key areas of improvement was being implemented.

There were areas of poor practice where the trust needs to make improvements. Importantly, the trust should:

- Address the safety concerns of staff in regards to the weekend on-call radiotherapy service.
- Ensure the safe and consistent monitoring of fridges containing radioisotopes.
- Quicken the process of hiring new outpatient nursing staff, in order to provide adequate cover for staff absences.
- Ensure all staff understand the concept and utilisation of the duty of candour.
- All staff remain compliant with mandatory training and safeguarding training.
- Ensure there is adequate qualified radiologist cover for the out-of hours interventional radiology service.
- Ensure there is sufficient drinking water available to patients waiting to be seen.
- Address all concerns of staff bullying and harassment issues.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Outpatients and Diagnostic Imaging at Charing Cross Hospital

Detailed findings

Services we looked at
Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Outpatients and Diagnostic Imaging at Charing Cross Hospital

St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital each has a 'main outpatients' department which are overseen by a single leadership team (Lead Nurse, Clinical Director and General Manager), with dedicated clinical and administrative leadership teams based on each site.

The main outpatient department at Charing Cross Hospital is located on the first floor of the tower block and has 32 consulting rooms. Specialty services include plastic surgery, endocrinology, gastroenterology, dermatology, neurology, podiatry and diabetes. There is a phlebotomy service located in the department.

There were 425,848 outpatient appointments at Charing Cross Hospital in the period of April 2015 to March 2016.

In the period of August 2015 to July 2016, there were approximately 143,000 attendances in the main outpatient department at Charing Cross Hospital across all specialties.

Imperial college NHS Trust imaging departments offers a comprehensive range of diagnostics to support all aspects of clinical management, including ultrasound, MRI, CT, plain film X-Ray and Nuclear Medicine. Patient pathways for diagnostic imaging includes direct access, outpatients, A&E, inpatients, and inter-trust transfers from tertiary referrers, particularly linked to the Trust's specialist services. Over 418,000 diagnostic imaging examinations were undertaken by the Trust during 2015/16.

At Charing Cross Hospital the outpatient and radiology departments had undergone some divisional changes and were placed under the women's, children's and clinical support directorate at the time of the inspection. The outpatient department also received a managerial restructure with a new senior sister managing the department reporting into the lead outpatient nurse who overlooked all trust outpatient departments.

The radiotherapy and medical physics department offered a range of radiotherapy treatment including stereotactic ablative radiosurgery, deep breath hold gating techniques and volumetric arc therapy amongst others. The department consisted of a pre-treatment team utilising CT localisation, a medical physics and planning team, a treatment team utilising two radiosurgery capable linear accelerators and two older model linear accelerators and a radiotherapy patient review team. The department operated a satellite centre at the Hammersmith Hospital, consisting of a superficial treatment unit for skin lesions and two older model linear accelerators; however patients were not routinely seen there unless it was for skin treatment or if a linear accelerator was out of service in the main department.

We last inspected this service in November 2014 and rated it to be inadequate overall. This reflected delays of up to six weeks in sending out appointment letters following a GP referral and a failure to consistently meet demand. We found doctors often turned up late to clinics and there was little structure in place to monitor performance.

As part of this inspection we observed care and treatment and interviewed staff in main outpatients, the radiology department, pathology and radiotherapy department. To assist in the inspection we held a drop in session on the first inspection day to which all staff were welcome and

Detailed findings

we held interviews senior staff members of the outpatient, radiology and radiotherapy departments. We spoke with a total of 91 staff members across all grades including but not exclusively medical staff, nurses, radiographers, healthcare assistants, administrative staff and managerial staff. We also spoke to 30 patients and reviewed 20 sets of patient case notes across all areas we visited.

Our inspection team

Our inspection team was led by:

Inspection Manager: Michelle Gibney, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultant physician, consultant cardiologist, consultant pathologist, superintendent radiographers, diagnostic radiographer, nurse matron, nurse outpatients manager, senior nurse manager, pharmacist and an Expert by Experience

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out this inspection as part of our routine focused inspection programme. We carried out an announced inspection on 22, 23 and 24 November 2016.

Before visiting, we reviewed a range of information we held about the hospital.

During the inspection we talked with a range of staff throughout the outpatient and diagnostic imaging department, including senior managers, clinicians, nurses, healthcare assistants, administrative staff and volunteers.

We also spoke with patients and relatives of those who used the outpatient and diagnostic imaging services at Charing Cross Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

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Outpatients and diagnostic imaging

first inspection day to which all staff were welcome and we held interviews with senior staff members of the outpatient, radiology and radiotherapy departments. We spoke with a total of 91 staff members across all grades including but not exclusively medical staff, nurses, radiographers, healthcare assistants, administrative staff and managerial staff. We also spoke to 30 patients and reviewed 20 sets of patient case notes across all areas we visited.

Summary of findings

We rated this service as requires improvement because:

- The majority of non-managerial staff we spoke with were unsure regarding the duty of candour until prompted.
- We found nuclear medicine fridges containing radioisotopes for use in scans were not monitored consistently.
- The majority of radiotherapy staff members we spoke with raised concerns regarding the safety of the radiotherapy on-call service.
- The trust did not meet its diagnostic report turnaround time target of all diagnostic imaging being reported on within two weeks.
- We observed that there was poor signposting throughout the hospital both outside and inside.
- The outpatient and radiology waiting areas had a lack of drinking water facilities, the majority of patients we spoke with told us they could not find where to access drinking water.
- The trust consistently did not meet national targets for a variety of performance indicators.
- The majority of patients we spoke with in the outpatient and radiology departments commented negatively in regards to waiting times
- The majority of staff we spoke with felt that that senior management focussed on other trust sites more than Charing Cross.
- All non-managerial staff we spoke with across the whole hospital said that the executive team was not visible enough at Charing Cross.
- We found the leadership within the radiotherapy department required improvement.
- The majority of radiotherapy staff we spoke with told us that they did not feel supported by the managerial team.
- The majority of staff we spoke with could not tell us the hospital's vision or values.
- We were told of by staff of a blame culture in radiotherapy with friction between the different radiographer staffing groups.
- The majority of non-managerial nursing staff told us they felt tired and overworked.

However:

Outpatients and diagnostic imaging

- The outpatient department consistently met its compliance target for hand hygiene and 'bare below the elbow'. The department also scored 100% for cleanliness in the patient-led assessments of the care environment (PLACE) audits for 2016.
- We observed that there were a sufficient number of doctors to run the scheduled outpatient clinics and the clinics were consultant led.
- Care and treatment within all areas we visited was delivered in line with evidence-based practice.
- Friends and family score for October 2016 demonstrated 88% and 97% of outpatient and radiology patients would recommend the service.
- Patient comments regarding their care and treatment were positive regarding the outpatients, radiotherapy and imaging departments.
- A trust wide outpatient improvement plan which laid out five key areas of improvement was being implemented.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- The majority of non-managerial staff we spoke with were unsure regarding the duty of candour until prompted. Nursing and radiology staff told us that they were unaware of any formal training or policy provided by the trust.
- During the inspection we observed an incident where the laser room was left in a state of disorganisation, the machine was unattended with the keys left in and a staff members security badge on the floor.
- We found nuclear medicine fridges containing radioisotopes for use in scans were not monitored consistently.
- The outpatient management, nursing staff, radiology administrative staff and medical physics staff did not meet the hospital target of 90% for either or both safeguarding adult or children training.
- Senior outpatient staff told us that staffing at the hospital outpatient department was adequate for the service; however there were not enough staff to cover for staff sickness or annual leave.
- Staff members raised concerns regarding the imaging out of hours service as the on-call consultant was usually based in the Hammersmith site and had to be called over to Charing Cross when needed, this meant that in times of emergency there was a lack of qualified staff.
- Staff members raised concerns regarding the safety of the radiotherapy on-call service citing that a large portion of staff were unsure of how to carry out on-call procedures, staff members said help was not provided and the training was insufficient. Managers and senior staff told us that before undertaking on-call duties all members of staff are trained and signed off as competent for both the treatment competencies and the on-call competencies.

However:

Outpatients and diagnostic imaging

- The outpatient department consistently met its compliance target for hand hygiene and 'bare below the elbow'. The department also scored 100% for cleanliness in the patient-led assessments of the care environment (PLACE) audits for 2016.
- We observed that there were sufficient a number of doctors to run the scheduled outpatient clinics and the clinics were consultant led.
- There were business continuity and major incident plans to ensure that essential services were not disrupted as a result of emergencies and when internal incidents were declared.
- Incidents were discussed at monthly divisional governance meetings and information and lessons learnt were disseminated to staff via departmental staff meetings.

Incidents

- Between September 2015 and August 2016 the hospital reported one serious incident which was classified as a never events for outpatients. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents in outpatients and diagnostic imaging which met the reporting criteria set by NHS England between September 2015 and August 2016. One of each of the following occurred: diagnostic incident including delay (including failure to act on test results),surgical/invasive procedure and treatment delay. There were a total of 43 incidents reported in the hospital's outpatients department during the period of July 2015 to July 2016 with 30 of those incidents resulting in no harm, seven near misses and six low harm.
- There were 14 trust wide radiation incidents reported under the Ionising Radiation (medical Exposure) Regulations (IR(ME)R) in the period of July 2015 to July 2016.
- Incidents were reported using an electronic reporting system. Staff we spoke with could describe how to report incidents and reported receiving feedback at monthly team meetings however there was inconsistency with incident reporting in the radiotherapy department.
- The radiotherapy department used an internal reporting form which all staff below band eight had to use and forward to the superintendent radiographers who would in turn reported the relevant incidents on the electronic reporting system, we were told by the service manager this was because of the use of specialised coding of radiotherapy incidents.
- There were seven reportable radiotherapy incidents that occurred in the period of December 2015 to November 2016. Five of the incidents related to imaging, one incident related to a treatment error and one incident was regarding dose calculation. In the same period there were 42 minor radiation incidents and 28 near misses.
- Incidents were discussed at monthly divisional governance meetings and information and lessons learnt were disseminated to staff via departmental staff meetings. Outpatient nursing staff and radiology staff could describe examples of incidents which had occurred in their departments and across the hospital.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The majority of non-managerial staff we spoke with were unsure regarding the duty of candour, however upon prompting they were able to describe its principles and situations in which it might be used. Nursing and radiology staff told us that they were unaware of any formal training or policy provided by the trust. Staff in all areas told us that they believed it was the consultant's responsibility to inform the patient of any mistreatment or clinical error; however they were unaware of any formal process adopted by the trust.

Cleanliness, infection control and hygiene

- The staff we observed in the outpatients, radiology and radiotherapy department complied with the trust policies and guidance on the use of personal protective equipment (PPE) and were seen adhering to 'bare below the elbow' guidance.

Outpatients and diagnostic imaging

- All areas we visited were visibly clean and tidy. Completed cleaning checklists were observed in outpatients, radiology and radiotherapy.
- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of this being used across the departments we visited.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled.
- There were sufficient hand washing facilities and hand gels available in all areas we observed.
- Hand hygiene results were recorded monthly. Data from the women's, children's and clinical support division demonstrated 99.7% compliance in June 2016 and 99.8% in July 2016. The trust had a compliance target of 90%. We observed hand hygiene audit results in the radiology department and the data demonstrated 100% compliance in October 2016.
- The department also monitored bare below the elbows compliance rates. Data from the women's, children's and clinical support directorate demonstrated compliance results of 99.2% in June 2016 and 99.5% in July 2016. The trust had a compliance target of above 90%.
- The outpatients department scored 100% for cleanliness and 97% for appearance in the patient-led assessments of the care environment (PLACE) audits for 2016.

Environment and equipment

- All departments we visited were adequate for their purpose and well maintained. Patient waiting areas were clean and all clinical areas seen were visibly clean and tidy.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Portable appliance testing (PAT) for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and warning lights were in place outside the laser treatment room.
- During the inspection we observed an incident where the laser room was left in a state of disorganisation, we observed that the door to the treatment room was left unlocked, lenses were left out of containers, eye drops were left on the floor along with a doctors identification card and the laser machine was left unattended with the keys still in place. When brought to the attention of the nurse in charge, we were told that this was not common practice and the staff member whose identification card was found will be managed appropriately in line with trust policies.
- Clear signage and safety warning lights were in place in the radiology and radiotherapy departments to warn people about potential radiation exposure.
- Monthly quality assurance logs were observed for the X-ray units, MRI and CT scanners for the period of September 2016 to November 2016. We were assured that procedures were in place for the safety testing of all diagnostic imaging machines on a daily, monthly and annual basis.
- Daily quality assurance logs were observed for the radiotherapy linear accelerators for the period of September 2016 to November 2016. We were shown documentation and were assured that there were procedures regarding monthly and annual safety testing.
- Evidence was provided to show that an equipment replacement programme existed with all imaging and other equipment tracked and recorded in a database.
- All clinical staff we observed in the radiology departments had valid in-date radiation monitoring badges.
- Personal protective equipment was available in all clinical areas we observed.
- Emergency resuscitation equipment was in place in all areas of the outpatients, imaging and radiotherapy departments and followed national resuscitation council guidelines. Trolleys we reviewed were checked on a daily and weekly schedule and had their seals intact; trolleys that were asked to be opened had all the required equipment and medication valid in-date.

Medicines

- We found that medicines in the outpatients department were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad.
- All outpatient medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures

were within the recommended range of 2 - 8°C. We saw evidence that room temperatures were taken and below the recommended 25°C. These meant medicines were stored in a safe manner. In the treatment room we found completed weekly checklists for medicines (which had recently been introduced by the trust) which ensured effective medicines management.

- We found nuclear medicine fridges containing radioisotopes for use in scans were not monitored consistently. We reviewed log books for fridge temperatures for the period of September 2016 to November 2016 and we found that records were not completed for the majority of October and the first ten days in November. Nuclear medicine staff told us that the fridges should be monitored daily, but could not reassure us that they were. Local leads explained they could only remind staff to monitor the fridges.
- Staff had access to the trust pharmacy department for medicines information advice and medicines supply for unlicensed medicines. There was a pharmacy top-up service for stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- We found that medicines used for resuscitation and other medical emergencies (for example anaphylaxis) were readily available, accessible for immediate use and tamperproof. We saw evidence of weekly checks to ensure the appropriate medicines were stocked and had not expired.
- Arrangements for the supply of medicines were good. A private pharmacy contractor served all outpatient prescriptions on the ground floor. They were open between 09:00-18:30 Monday to Friday, and 09:00-13:30 on Saturday and Sunday. The latest figures provided showed that more than 75% of prescriptions were dispensed within 15 minutes, and more than 99% within 30 minutes. We saw that prescriptions were prescribed to patients electronically via Cerner® (The IT system at the trust), and also via paper based prescriptions. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. We saw evidence of allergies documented at the point of prescribing.
- Medicines errors and safety incidents were reported quarterly to the Medicines Safety Committee. These were reviewed and information to staff was communicated via a variety of channels such as newsletters, emails and face-to face monthly clinical governance meetings if required. We saw evidence of learning from incidents. For example, single dose containers of medicines were now in use within the ENT and eye clinic and Eye clinic instead of multi-dose vials, which reduced the risk of cross-contamination.

Records

- The hospital used an electronic patient record (EPR) as part of a hybrid paper light system. The paper record is provided by the health record team at the request of a clinic or department, if original records are unavailable temporary records are created, a log of the number of temporary records is kept. All existing paper records were in process to being uploaded onto the EPR. Senior managers described this to be a transition period before the trust uses a paperless system.
- Data provided to us showed that an audit was carried out over a 40 week period from November 2015 to August 2016 monitoring the use of temporary records in the outpatient departments across the trust. Charing Cross Hospital used the highest number of temporary records with a total of 3349 and also had the highest average use of temporary records per week. The data provided did show that the average use of temporary records was consistently declining over the audit period.
- We were shown data regarding a spot audit undertaken to monitor the use of temporary records in the hospital outpatient department in a week in August 2016. The data showed that out of the 20 clinics held that week only three breached the national target of 4% of original records being unavailable. The ENT clinic had the highest breach of 5%, the fracture and respiratory clinics had a breach of 4.5% each.
- Consultants and other doctors we spoke with told us that the EPR was not meeting their needs and that it was not suitable for use. An issue in particular was around the uploading of medical letters or previous paper notes onto the new system, the doctors we spoke with said this was too cumbersome and had an excessively complicated method. The hospital has an EPR helpdesk in place which all staff we spoke with acknowledged using.
- We reviewed a total of 20 patient records selected from the outpatients, radiology and radiotherapy departments. All contained the relevant patient details

required for identification, details of past medical history, allergies, infection control, medicines and discharge planning. Evidence of consent was also observed as appropriate.

- The radiotherapy department had a procedure to check all patient records on a weekly basis, this was done to ensure that the correct treatment dose of recorded, that treatment was delivered accurately, treatment x-ray images taken were verified correctly and any notes from other team members were not missed.
- Records could be viewed off site in any trust hospital due to the EPR. Service managers told us that in cases where physical records need to be moved off site for continuity of patient care then copies are made and the notes were tracked.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely in all departments we visited.

Safeguarding

- Safeguarding policies and procedures were in place. These were available electronically for staff to refer to. All staff we spoke with in all departments said that safeguarding concerns were rare, but they were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- The outpatient qualified nursing staff did not meet the hospital target of 90% for safeguarding adults level two.
- The radiology administrative staff did not meet the hospital target for safeguarding adults and children both level one.
- The medical physics staff did not meet the hospital target for any safeguarding adult or children training. Completion rates for 'safeguarding children level 2' in specific were below 50%. The radiotherapy department did not see any children at the time of the inspection and did not have any future plans to do so, service managers told us that they were re-evaluating the need for children safeguarding training.

Mandatory training

- All staff we spoke with confirmed that mandatory training was easily accessible and was available via the intranet or bookable through live sessions. Training included; infection prevention and control, medicines management, safeguarding adults and children, equality and diversity, information governance, health and safety, fire awareness, resuscitation level two, manual handling and lastly conflict resolution. The trust target for mandatory training was 90%.
- In the radiotherapy department the administrative staff met the target for all mandatory training courses. The qualified allied health professionals met the target for all courses except 'fire safety' and 'resus level 2'. Medical physics staff did not meet the target for any course.
- In the radiology department the administrative staff did not meet the target for 'infection prevention and control', 'information governance' and 'resus level 1'. The qualified allied health professionals met the target for all courses except 'moving and handling level 2' and 'resus level 2'.
- In the outpatients department the administrative staff met the target for all mandatory training courses except 'resus level 1'. The qualified and unqualified nursing staff did not meet the trust target for 'equality and diversity', 'fire safety', 'infection prevention and control' and 'resus level 2'.
- We did not find evidence that there was formal MRI specific cardiac arrest training; this was confirmed by radiology staff we spoke with.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure or laser treatments took place.
- The six point identification check was used in radiology and radiotherapy as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000). In addition we saw staff check patients against their scanning area and also asked patients what procedure they were there for.
- Staff told us they checked female patient's pregnancy status in the radiology department before initialising any imaging procedure. In the radiotherapy department they checked pregnancy status before the planning CT scan and once before the start of the treatment regime.
- The radiology department used a patient safety questionnaire for MRI in order to ascertain if the patient had any metal objects inside their body, the radiographers would then assess whether it was safe for the patient to have the scan. The department also evaluated patients prior to administration of contrast media to check if the patient suffered from any allergies or conditions which put them at risk ofa reaction..

Outpatients and diagnostic imaging

- Radiation protection supervisors were appointed for both the radiology and radiotherapy departments. Further support was noted in the respective department's local rules.
- Staff were able to describe the procedure of what to do if a patient was suspected of suffering from a cardiac arrest or anaphylaxis. All staff we spoke with knew the hospital internal crash team number.
- WHO safer surgical checklists were in use before any interventional radiology procedures.

Nursing and allied health professional staffing

- Outpatient staffing data submitted by the trust was presented for staff across the central outpatient departments of the trust; the data provided was for the period of August 2015 to July 2016. The latest staffing figures showed that there were 25 qualified nurses in the trust outpatient departments this included 16 band five nurses, five band six nurses, three band seven nurses and one band eight nurse. The data also showed that there were 45 unqualified nursing staff which included five band two staff and 40 band three staff.
- The hospital provided data for October 2016 which showed that there were 12.50 whole time equivalent nursing staff in the Charing Cross outpatient department.
- Senior managers told us that there was not currently an approved acuity tool to measure staffing levels in the outpatient setting and therefore the staffing levels were managed by staff rota system and local managers.
- Senior outpatient staff told us that staffing at the hospital outpatient department was adequate for the service; however there were not enough staff to cover for staff sickness or annual leave. The senior staff did tell us that additional staff could be borrowed from the trusts other outpatients departments if needed.
- Other members of staff raised concerns with us over the staffing levels for ENT outpatients and ophthalmology outpatients, we were told that there were the minimal number of staff to run the clinics properly and this meant staff had to skip lunch breaks and were not always able to take annual leave resulting in work related stress leave.
- At the time of the inspection there were four agency staff members being used, with three being unqualified nursing staff and one being qualified nursing staff. The department was also using two unqualified nursing bank staff members. Senior staff told us that this was due short term staff sickness.
- Senior outpatient staff told us that there were eight qualified nursing positions spread throughout the trust outpatient departments that were in process of being recruited.
- Imaging staffing data submitted by the trust was presented for staff across the whole trust and not broken down by hospital; the data provided was for the period of August 2015 to July 2016. The latest staffing figures showed that there were 59.5 WTE qualified staff in the trust imaging departments. The data also showed that there were 11 unqualified staff which were all band two staff.
- Data provided to us showed that the radiotherapy department consisted of 56 radiographers, two assistant practitioners, 11 medical physics staff, eight technical support staff and six administrative staff. The department also hosted long term students completing their university degree in radiotherapy. At the time of the inspection there was one radiographer vacancy and one technical support vacancy in the department.
- As at August 2015 and July 2016, the trust reported a vacancy rate of 13.6% in Outpatients; the vacancy rates ranged from 0% to 26.1% across reporting units.
- As at August 2015 and July 2016, the trust reported a turnover rate of 6.6% in Outpatients and 16.8% in Diagnostic Imaging; Turnover was greater among unqualified nursing staff in Diagnostic Imaging rather than qualified staff trust wide.
- As at August 2015 and July 2016, the trust reported a sickness rate of 4.7% in Outpatients and 2% in Diagnostic Imaging trust wide.

Medical staffing

- We observed that there were a sufficient number of doctors to run the scheduled outpatient clinics and the clinics were consultant led.
- Trust policy stated medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner.
- Incidents of short notice cancellations or clinics starting 30 minutes or later than schedules were always

investigated by the lead outpatient nurse and be escalated to the directorate quality and safety meetings. Repeat issues could be escalated further to the clinical director of outpatients.

- The trust provided data on medical staffing for all the trust imaging departments, according to the data provided the trust had 55 consultants and 49 training grade doctors in July 2016. Vacancy rates provided to us for the period of August 2015 to July 2016 were 7% for consultants and 30% for training grade doctors.
- Imaging out of hours requests were covered by the on-call registrars and on-call interventional radiologists providing 24 hour cover. Consultants had remote access for reporting via PACS. The Imaging department did not operate a shift system for its medical staff. Consultant allocations were based according to their job-plans whilst registrars were allocated based on their rotation to a given subspecialty. Registrars are rotated approximately every four months into the different sub-specialities of radiology across the three sites.

Out of hours service

- In the imaging department on-call interventional radiologists covered both the Charing Cross and Hammersmith sites, staff members raised concerns regarding this practice as the on-call consultant was usually based in the Hammersmith site and had to be called over to Charing Cross when needed. Staff members raising this concern felt that this meant in times of emergency there was a lack of qualified staff.
- The radiotherapy department had 56 whole-time equivalent radiographers this included subdivisions including, treatment, pre-treatment, review, superintendents and the service manager. Treatment radiographers were responsible for providing a weekend on-call service primarily used to treat emergency spinal cord compression cases.
- The majority of the 24 members of staff we spoke with in the radiotherapy department raised concerns around on-call working. The on-call service was provided by band five to band seven staff, the main concerns being the skill mix of staff and a number of staff being unsure of what to do during the on-call service.
- Radiotherapy staff also raised concerns regarding on-call training which they felt was insufficient. Staff said that they were not allowed to ask for assistance during on-call service because 'otherwise they would not learn', some radiographers told us they 'lived in fear of working at the weekends'. 12 out of the 14 staff raising concerns said they did not feel safe conducting the on-call service. Although no incident relating to the safety of the on-call service was reported in the last 12 months.

Major incident awareness and training

- There were business continuity plans to ensure that essential services were not disrupted as a result of emergencies and when internal incidents were declared. It was informed by national guidance such as the NHS Commissioning Board's 'command and control' and 'business continuity management framework'.
- The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as winter pressures, fire safety, loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We currently do not rate this domain, however the following are areas of good practice and areas of improvement we found:

- Care and treatment within all areas we visited was delivered in line with evidence-based practice.
- Evidence was provided to demonstrate that the radiology department actively participated in multi-centre research studies.
- In October 2016 the radiotherapy department actively participated in 18 national clinical trials; the department had implemented a robust tracking system to monitor the progress of participation.
- All areas we visited had appointed suitably qualified members of staff and any staff members without formal qualifications were appropriately supervised when undertaking clinical responsibilities.
- We saw evidence of positive multidisciplinary (MDT) working in all departments we visited.

However;

- Data provided showed that the trust did not meet its diagnostic report turnaround time target of 100% of all diagnostic imaging being reported on within two weeks, achieving an average of 92%.
- Trust data showed that in July 2016, 80% of letter to GP's were issued within 10 working days.

Evidence-based care and treatment

- Care and treatment within all areas we visited was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE) and the relevant royal colleges.
- Professional guidelines were discussed in the monthly quality and safety meetings which were attended by service managers, matrons and consultants. NICE guidelines information is discussed and disseminated to the relevant service leads that then discuss and implement the relevant guidelines within their own departments.
- Audits of compliance with IR(ME)R 2000 were completed. We saw evidence that there were annual radiation safety audits conducted by the medical physics expert in both the radiology and radiotherapy departments and that the relevant findings were action planned appropriately.
- In the interventional radiology department, we observed the World Health Organisation (WHO) checklist for interventions was routinely completed.
- Radiology dose reference level audit results were available for staff to read, where levels were raised the imaging machines manufacturers were contacted and the machines were recalibrated.
- There were radiation protection supervisors appointed for both the radiology and radiotherapy departments.
- Evidence was provided to demonstrate that the radiology department actively participated in multi-centre research studies taking both a lead and sub-site role. These research trials are undertaken in conjunction with the trust affiliated university.
- The nuclear medicine department has participated in the DaTSCAN Audit 2015 conducted by the British Nuclear Medicine Society. We were shown a valid certificate of participation.
- The radiotherapy department participated in 13 national audits including the stereotactic radiosurgery end to end audit, national lung cancer audit, left breast heart sparing audit and the electron audit 2016.
- We saw evidence to show that in October 2016 the radiotherapy department actively participated in 18 national clinical trials; the department had implemented a robust tracking system to monitor the progress of participation.
- The outpatient managers told us that alongside hospital key point indicator monitoring, local departmental audits identified areas of improvement and action plans were implemented accordingly. An example of this was shown to us where the outpatient nurses had implemented a new method of informing patients of waiting time delays for clinics.

Pain relief

- We observed prescription pads were available in outpatient clinics and we saw prescriptions for pain relief were recorded in patients' notes.
- Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures.
- Patients requiring pain relief in the radiotherapy department were seen by the review radiographers who would then refer onwards to the on-call oncology registrar.

Nutrition

- The hospital provided water fountains for patients' use in the outpatients and radiology department, the radiotherapy department also offered patients free tea and coffee. There was a shop, hospital café and numerous external company eateries where people could purchase drinks, snacks, and meals.

Patient outcomes

- The radiotherapy department were accredited by Caspe Healthcare Knowledge Systems (CHKS) for ISO 9001:2008 quality management system.
- The pathology department had achieved Clinical pathology accreditation and was in process to finalising their ISO 15189 accreditation.
- Between April 2015 and March 2016 the follow-up to new rates for Charing Cross hospital was lower than the England average.

Outpatients and diagnostic imaging

- Data provided by the radiotherapy department showed that the average time taken for a radiotherapy treatment plan from the localisation scan to being treatment ready ranged from 8.5 to 11 days, this increased to 11.6 to 16 days for more complex treatments. Palliative treatment plans had an average of 2.6 days.
- The trust provided data regarding its imaging turnaround times as a collective of all of its imaging departments; we did not receive this information broken down to hospital level. The trust target was to report 100% of all routine examinations within two weeks; all targets were approved by the medical director. Data provided for the period of November 2015 to October 2016 showed that the trust did not meet its target as an average of 92% of all outpatient diagnostic examinations were reported within two weeks. The lowest performing areas were CT and MRI with only 84% and 88% respectively, being reported on within two weeks. The highest performing areas trust wide were DEXA and ultrasound scan reporting having 100% of examinations reported within the target.
- Data for the period of August 2016 to October 2016 broken down to a monthly level did show improvement in meeting the target. In August an average of 88% of all outpatient diagnostic examinations were reported within the target; this lowered to 86% in September, but improved to 96% in October 2016.

Competent staff

- All areas we visited had appointed suitably qualified members of staff and any staff members without formal qualifications were appropriately supervised when undertaking clinical responsibilities.
- Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals.
- Hospital data showed that for the period of April 2016 and September 2016 showed that only 13% to 51% of staff in all the outpatient and radiology departments had completed their appraisals. The data did show that all administrative staff in the outpatient department had completed their appraisals. We were provided with further information to show that this rate had improved to 91% by November 2016.
- Data provided by the radiotherapy department showed that 96% of radiographers had completed their appraisals; all other staffing groups had 100% completion.
- The trust provided data regarding revalidation of doctors working in the trust imaging departments. The data showed 16 doctors in diagnostic imaging had recommendations for revalidations submitted. 14 were positive recommendations, and 2 were deferrals to due to insufficient evidence to support a recommendation to revalidate.
- Allied health professional staff we spoke with confirmed they were supported to undertake continual professional development (CPD) and were given opportunities to develop their skills and knowledge through training relevant to their role. This included completing competency frameworks for areas of development and they were also supported to undertake specialist courses.
- Evidence was provided to show all staff in the outpatients, radiology and radiotherapy departments had CPD and competency records for their specific role.
- Outpatient nursing staff we spoke with told us that there was not enough time given to complete training or courses for CPD, some nursing staff told us that due to working pressures and funding cuts that CPD courses were very rare.
- The radiology department provided evidence to show that the majority of their radiographer staff had post graduate qualifications including master degrees and post graduate diplomas.
- The outpatient department had nine members of staff with qualifications in post graduate specialist courses.
- In the radiotherapy department staff members with master degrees included one technical staff, five radiographers and all physicists. One medical physics staff member also held a PhD.
- Managers told us they had procedures in place for the induction of new staff and all staff, including bank staff completed hospital and departmental induction before commencing their role. We saw evidence that attendance at these induction sessions.
- Ophthalmology outpatient department was working towards training HCA's to complete competencies resulting in a more active role in the preparation of

clinics, by setting up trollies and also assisting consultants during appointments. Consultants must approve the competencies and have taken a supportive stance as this has helped free up qualified nursing time.

Multidisciplinary working

- We saw evidence of positive multidisciplinary (MDT) working in all departments we visited.
- Nursing staff and healthcare assistants we spoke with in outpatients told us the teamwork and multidisciplinary working was effective and professional.
- We were shown evidence of regular consultant led multidisciplinary team (MDT) meetings that were held to discuss patients based on their treatment area. We were told by service managers that nursing staff, allied health professionals and managers were encouraged to attend. The majority of nursing and allied health professional staff we spoke with were aware of relevant MDT meetings regarding their specialities; however we were told that they did not have the time to attend these meetings on a regular basis.
- Cross-site MDT working occurred in all outpatient services, in which the team from the Charing Cross site shared learning and assisted in the development of services at the other trust sites. Clinical nurse specialists and senior staff were routinely expected to work in all trust sites.
- We observed good MDT working in the radiotherapy department amongst differing professional groups such as Medical physics staff and consultants, however the working relations between internal department subdivisions such as treatment radiographers and review radiographers could be improved.
- We saw evidence of good multidisciplinary team meetings (MDT). MDT meeting minutes highlighted that meetings were attended by the full range of professionals and information and action points from these meetings were circulated to all staff in the department.

Seven-day services

- Seven day a week outpatient services were not provided. The outpatient service was provided Monday to Friday 8.30am to 5.30pm, extended clinics would occasionally run until 6.30pm. A weekend service was not available.
- The radiology service was available Monday to Sunday 8.30am to 5.00pm on weekdays and 9.00am to 4.00pm on weekends, with extended slots until 8.00pm however this was offered to staff as voluntary overtime.
- The radiology department provided 24 hours seven day a week on-call services.
- The radiotherapy department did not provide a seven day a week service. The department offered a Monday to Friday 8.00am to 8.00pm service and a weekend on-call service.
- Outpatient pharmacy was available Monday to Friday 9.00am to 6.30pm, there was a weekend service available 10.00am to 2.00pm.

Access to information

- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet.
- The radiology department used a nationally recognised system to report and store patient images. The system was used across the hospital and allowed trust and regional access to images.
- The average time taken to send a letter to the GP following an outpatient consultation in July was 7.8 days. The trust reported that in July 2016, 80% of the letters stored and emailed to GPs via the clinical document library (CDL) were issued within 10 working days – over 26,500 letters. This leaves approximately 6,500 letters being sent outside of the window.
- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the EPR.
- The outpatients department used both paper and electronic patients' records. All the clinicians we spoke with said they had easy access to electronic records system.
- We were told by managers that the hospital was working towards full digitisation of patient paper records to ensure consistent availability across departments and reduction in incidents where records were unavailable, misplaced, or damaged.
- All areas we visited had waiting areas with ample patient information leaflets about treatments and information specific to different conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients and diagnostic imaging

- Staff we spoke with were aware of the Mental Capacity Act 2008 (MCA) and Deprivation of Liberty Safeguards (DoLS) and its implications for their practice.
- We observed verbal consent being taken in the radiology department, before radiotherapy treatment and an outpatient clinic. We saw that there was a policy and protocols in place for obtaining consent before medical treatment was given.
- The majority of staff we spoke with told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any procedure. Patients we spoke with confirmed they were given enough time and received the relevant written and verbal information to make informed consent.
- Consent forms for patients lacking capacity were available in outpatients, diagnostic imaging and radiotherapy departments.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- Friends and family score for October 2016 demonstrated 88% and 97% of outpatient and radiology patients would recommend the service.
- Patient comments regarding their care and treatment were positive regarding the outpatients, radiotherapy and imaging departments.
- Outpatient, radiotherapy and diagnostic services were delivered by caring, committed and compassionate staff. We observed staff interaction with patients and found them to be polite, friendly and helpful.
- The radiotherapy department held open evenings these sessions allowed the patients and their relatives to have a tour of the facilities and ask any questions they may have.

Compassionate care

- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, asking them if they needed help and pointing people in the right direction.
- Patients' privacy was respected and they were addressed and treated respectfully by all staff. Staff were observed to knock on consulting room doors before entering. Consulting rooms had a curtained area for patients to be examined and change clothing if required.
- The environment and the consulting rooms in all departments we visited allowed for confidential conversations.
- All departments we visited had a chaperone service available to all patients, however there were very limited signs advertising this service.
- We spoke with a total of 30 patients regarding their care and treatment at the outpatient, radiology or radiotherapy departments. We were consistently given positive accounts of their experiences with staff and their clinical care. They told us they felt like the staff cared about them and respected their individual needs.
- Friends and family score for October 2016 demonstrated 88% and 97% of outpatient and radiology patients would recommend the service, however the response rates for the friends and family test were ranging from 8% to 10%.

Understanding and involvement of patients and those close to them

- We saw staff spent time with patients, explaining care pathways and treatment plans. All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- Patients and relatives who spoke with us in the outpatient clinics reported feeling involved and understood why they were attending the department, the types of investigations they were having, the expected frequency of attendance, they felt they were given enough time to make decisions and understood what other options were available.
- Patients attending for any outpatient's services including diagnostic imaging were encouraged to fill in the outpatient questionnaire.
- The radiotherapy department held open evenings for patients that have been or may be referred for

radiotherapy, these sessions allowed the patients and their relatives to have a tour of the facilities and ask any questions they may have. These sessions were run on an unpaid voluntary basis by staff.

Emotional support

- Nursing and allied health professional staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.
- Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.
- Nursing and radiotherapy staff told us that patients and their relatives could be referred to psychological and counselling services if needed.
- Radiotherapy patients had access to review radiographers who would hold weekly clinics and give the patient an opportunity to voice their concerns, worries and fears about their treatment or disease.
- A clinical nurse specialist for a number of outpatient specialities led the patient care pathway; one of their duties was to provide advanced emotional support to those patients.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

- We observed that there was poor signposting throughout the hospital both outside and inside.
- The outpatient and radiology waiting areas had a lack of drinking water facilities, the majority of patients we spoke with told us they did not know where to access drinking water.
- The trust only met its target for booking turnaround times in four out of the 12 month audit period.
- The trust did not meet the national standard for referral to treatment times for incomplete pathways between March 2016 and July 2016.
- The trust is performing slightly worse than the national target for people being seen within two weeks of an urgent GP referral.
- The trust is performing worse than the national target for patients receiving their first treatment within 62 days of an urgent GP referral.
- During the inspection we consistently observed patients waiting for 30 minutes or longer for both outpatient clinics and diagnostic imaging.
- The majority of patients we spoke with in the outpatient and radiology departments commented negatively in regards to waiting times.

However:

- The outpatient department held a dementia drop-in session every week to allow staff, patients, relative and carers to speak about any concerns or ask questions to a dementia nurse. This session was viewed very positively by all outpatient staff we spoke with.
- The outpatient department implemented a text, email and voice reminder system, patients we spoke with said they found it helpful.
- In the period of August 2015 and July 2016 the trust met the national standard for diagnostic imaging waiting times (that is less than 1% of patients waiting more than six weeks), with the exception of December 2015 and April 2016.
- The trust is performing better than the national target for patients waiting less than 31 days before receiving their first treatment following a diagnosis.

Service planning and delivery to meet the needs of local people

- We observed that there was poor signposting throughout the hospital . The majority of patients we spoke with said that they found the signposting and departmental layouts confusing.
- Patients told us they received instructions over the telephone when booking the appointments for outpatient or diagnostic appointments. We were told by staff that imaging appointments were followed up written information by post.
- Radiotherapy patients received detailed verbal and written instructions for preparation before their first treatment appointment, they also received a printed schedule of all their treatment appointments, and this was confirmed by all radiotherapy patients we spoke with.

Outpatients and diagnostic imaging

- All waiting areas seen within the hospital were clean, however waiting rooms in outpatients and radiology did not contain adequate seating, we observed a number of patients waiting for appointments without a seat on numerous occasions.
- The outpatient and radiology waiting areas had drinking water facilities that were not readily visible, the majority of patients we spoke with told us they could not find where to access drinking water. Waiting areas were however located near external company eateries and shops where patients could purchase food and beverages.
- In the radiology department there were two cubicles stocked with hospital gowns for the patients to change before their procedure, however there were no lockers for patients to store their belongings in general x-ray and ultrasound. Lockers were provided in CT and MRI.
- The outpatient department implemented a text, email and voice reminder system. Patients receive a voice message reminder seven days before their appointment and a text message two days before their appointment. Patients were able to choose to receive their appointment letters by post or email.

Access and flow

- The hospital provided data regarding the percentage of appointments booked by GP's through the electronic booking system without trust intervention. In April 2015 only 63% of bookings were completed without trust intervention. Trust intervention occurs when the appointment is unable to be booked due to capacity issues, the trust then contacts the patient directly to arrange an appointment. In October 2016 this figure had improved to 90% of bookings completed without intervention.
- The trust target for booking turnaround times was for 95% of bookings to be completed within ten working days of receiving the referral. Information provided to us showed that the trust did not consistently meet its target for the audit period only achieving the target in four out of the 12 month audit period.
- The outpatient department introduced self-check in kiosks this allowed a smoother and quicker flow of patients through the department.
- The trust did not meet the national standard of 92% for referral to treatment times for incomplete pathways between March 2016 and July 2016. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.
- The hospital also provided outpatient waiting times that were monitored for the period of February 2016 to December 2016, this audit was conducted on a total of 274,770 patients which was half of all outpatients seen in the period. The results showed that 61% of patients were seen on or before their appointment time, 29% were seen within 20 minutes, 5% within 40 minutes, 3% within 60 minutes and 2% after 60 minutes.
- The trust provided data to evidence the monitoring of late start clinics in October 2016 a total of 301 clinics were monitored,. of those clinics 86% started on time
- Between the period of August 2015 and July 2016 the trust met the national standard for diagnostic imaging waiting times (that is less than 1% of patients waiting more than six weeks), with the exception of December 2015 and April 2016. The percentage of diagnostic waiting times over six weeks was consistently lower than the England average during that period.
- The trust is performing slightly worse than the 93% national target for people being seen within two weeks of an urgent GP referral. Performance rose in quarter two of 2016/17 to 92.4% which was slightly below the England average of 94.2%.
- The trust is performing better than the 96% national target for patients waiting less than 31 days before receiving their first treatment following a diagnosis. Performance remained steady in quarter two of 2016/17 at 96.7% which was just below the England average of 97.6%.
- The trust is performing worse than the 85% national target for patients receiving their first treatment within 62 days of an urgent GP referral. Performance fell over 2 of the last 3 quarters but recovered in quarter two of 2016/17 to 80.1% which was still below the England average of 82.3%.
- During the inspection we consistently observed patients waiting for 30 minutes or longer for both outpatient clinics and diagnostic imaging; however we did also observe staff notifying and apologising the patients that were delayed.
- 18 out of 19 patients we spoke with that attended an appointment in the outpatient department commented negatively in regards to waiting to receive their

appointment, one patient said "I have been waiting months for this appointment and I don't think I should of waited that long". 14 out of 19 patients commented negatively on the waiting times in the departments, with patients saying "Yesterday I waited several hours and other elderly people were also waiting and it wasn't good for them" and "I came in at 11.45am and left at 6pm".

Meeting people's individual needs

- Reasonable adjustments were made so that patients with disability could access and use the outpatient and diagnostic services. Clinic and reception areas were wheelchair accessible, reception desks had sections that were at wheelchair height and there were toilet facilities for patients with disabilities.
- All outpatient nursing staff we spoke with were clear on their roles and responsibilities in regards to dementia patients, staff told us the provisions they would make for patients living with learning difficulties or dementia such as allowing them to be seen first and giving these patients a quiet clinic room to wait in if needed.
- Radiology and radiotherapy staff told us that patients living with dementia or learning difficulties were rare for their departments. The majority of staff we spoke with could not provide examples of any provisions they would make, however some radiographers did say that patients living with learning difficulties or dementia could be given an adjusted time slot for quieter parts of the day or they could be put forward in the queue.
- The outpatient department held a dementia drop-in session every Monday between 2.00pm -4.30pm to allow staff, patients, relative and carers to speak about any concerns or ask questions to a dementia nurse. This session was viewed very positively by all outpatient staff we spoke with.
- There were sufficient provisions to provide support to bariatric patients or those with mobility issues.
- Outpatient nursing staff told us that in order to reduce stress to patients with a learning disability or those living with dementia their carers were allowed to assist if patient consent was given.
- The trust had a chaperone policy in place and all staff we spoke with confirmed this, however we did not see any clear signs advertising this service to patients. The majority of patients we spoke with said that they felt comfortable in asking for a chaperone if they required one.
- Within the outpatient and diagnostic imaging department's main waiting areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. The information we observed was in English and a selection of major languages, outpatient staff told us that other languages could be sourced if needed. Staff told us that all information is available in any print size, language, braille and audio loops.
- An interpretation and translation service was available to patients via an external company. The patient's lingual needs would be considered at the time of appointment booking and an interpreter was booked via an electronic form by booking staff.
- A telephone language line was also available in all languages, however the majority of staff we spoke with during the inspection were unaware of how to access and use this service.
- The hospital had multi-faith chaplaincy team with a mixture of employed and trained volunteers. There were multi-faith quiet rooms, a Muslim prayer room with ablution area, and a Christian chapel available to all hospital staff, visitors and patients.
- Patients were able to book appointments through the 'choose and book' system for the outpatients department. In the radiotherapy department the treatment appointments were given to the patient for the entirety of the treatment regime, however patients were told that appointments could be negotiated for different times if they required.

Learning from complaints and concerns

- The trust responded to complaints based on the risk grade of the complaint. Low risk was 25 working days, medium risk was 45 days and high risk was 65 days, the trust allowed themselves one extension per complaint. All complaints were read by the associate director of complaints for the trust. Sign off on a complaint depended on the risk grade, low grade complaints were signed off by a complaints officer, medium risk were signed off by the associate director and high risk ones by the chief executive.
- In the reporting period between August 2015 and July 2016 there were 53 formal complaints about outpatients services at this trust. The trust took an average of 32

days to investigate and close complaints; this is in line with their complaints policy, which states that the trust has a target to resolve each complaint within 40 working days.

- In July 2016 the trust logged a total of 106 complaints both formal and through PALS as being outpatient related. 14 of the complaints were formal and 92 were made through PALS. The major causes of complaints were; being booked into the wrong clinic, not being given a follow-up appointment, not receiving a cancellation notice, being cancelled multiple times with one occasion being on the day and the length of time waiting for their first appointment.
- All staff we spoke with were aware of the local complaints procedure, and were confident in dealing with complaints if they arose. Staff told us that they first handled the complaint locally and referred to their line mangers if required and then managers would refer to the complaints procedure if the issue was not resolved.
- Information was displayed in outpatient areas informing people how they could complain or provide feedback on the service.
- The trust had systems and processes in place to learn from complaints and concerns and we saw evidence from weekly business unit governance meetings, departmental meetings, safety and quality meetings that this was a standing agenda .

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The majority of staff we spoke with in the hospital could not identify any other executive team member other than the CEO.
- We found leadership within the radiotherapy department required improvement as the majority of radiotherapy staff we spoke with told us that they did not feel supported by the managerial team.
- We were told by a number of staff of a blame culture in the radiotherapy department.
- The majority of staff we spoke within the hospital could not tell us the hospital's vision or values.
- The majority of non-managerial nursing staff told us they felt tired and overworked.

However:

- We found the outpatient department to have a clear vision and strategy for service and staff development.
- A trust wide outpatient improvement plan which laid out five key areas of improvement was being implemented.
- There was defined governance and reporting system within the hospital.

Leadership of service

- The main outpatient service had been restructured at a divisional level and had moved from the division of investigative sciences and clinical support services into the division of women's, children's and clinical support. The outpatient department had received new leadership in February 2016 with the induction of a new senior sister leading the Charing Cross Hospital outpatient department and a new outpatient lead nurse overseeing operations at all three trust sites.
- The outpatient department consisted of qualified and unqualified nursing staff who reported to the new senior sister who in turn reported to the outpatient lead nurse. The outpatient lead nurse line managed all senior sisters from all trust outpatient departments and reported directly to the divisional director of nursing.
- All outpatient staff we spoke with viewed the new outpatient lead and senior sisters favourably and they told us that the changes in the department were positive.
- The radiology department was also placed in the division of women's, children's and clinical support and was structured with senior radiographers leading in different areas in the department, reporting to the radiology service manager who in turn reported to the imaging general manager.
- The radiotherapy department was placed in the surgery, cancer and cardiovascular division. The department consisted of radiotherapy and medical physics, with radiographer staff supervised by superintendent radiographers who reported to the radiotherapy service manager and in medical physics the physicist and dosimetrist staff reported directly to the head of medical physics. The radiotherapy service manager and head of medical physics both reported to the cancer and haematology manager.

Outpatients and diagnostic imaging

- We found the leadership within the radiotherapy department required improvement as the majority of staff we spoke said that they were told they could not raise issues or concerns to do with the managerial team as they would not receive support..
- Radiotherapy staff felt the managerial team was not visible enough. Staff did not feel confident in the managerial teams ability to address issues regarding staff conflict.
- All non-managerial staff we spoke with across the whole hospital said that the executive team was not visible enough at Charing Cross. Outpatient staff told us that senior managers occasionally did walk around and conduct spot audits, but radiology and radiotherapy staff could not recall the last occasion of when executive staff visited their departments.

Vision and strategy for this service

- The majority of staff we spoke with could not tell us the hospital's vision or values. A large portion of staff we spoke with including medical staff, nursing staff, allied health staff and administrative staff told us they felt the hospital 'had no vision and this affected the individual departments', there were a number of staff that were concerned the hospital would be closed and felt senior trust management did not know what to do about the hospital.
- We found the outpatient department to have a clear local vision and strategy for service and staff development. The outpatient leads explained that due to the restructure of the outpatient departments across the trust, the new leads will be focussing in consolidating their roles and implementing improvement plans. In the short term the department was focussed in completing the refurbishment programme and analysing their recently implemented performance metrics as per the trusts outpatient improvement plan. The outpatient leads explained that the medium term goals included hiring additional nursing staff across all the trusts outpatient departments and providing additional training to the outpatient care assistants which would allow them to take on some extra responsibility reducing stress on qualified staff.
- A trust wide outpatient improvement plan, launched in spring 2015, laid out five key areas of improvement including responsiveness to customer care, communication with patients and GPs and digitising outpatient services.
- The radiology department was following the trust wide imaging directorate strategy originally initiated in 2014 as part of a five year improvement plan. Management and medical staff were aware of a five year plan of improvement; however radiographer staff, administrative staff and nursing staff told us they felt the department lacked any vision or strategy. The department was working towards hiring more radiographer staff and the imaging strategy also set out goals to increase capacity, replace aging equipment, improve report turnaround times and increase staff retention rates.
- The radiotherapy department had outlined service development and future planning as the main objective for the future. In the short term the department was seeking to replace the treatment machines with more advanced versions capable of radiosurgery. In the medium term the department was to expand the use of advanced treatment techniques.

Governance, risk management and quality measurement

- There was defined governance and reporting system within the hospital. Senior staff told us that quality measurement was carried out via a department to board framework. The system allowed for summaries and themes on incidents, complaints, compliments and key performance data to be produced and shared with staff for learning.
- We saw evidence of regular departmental governance and risks meetings consisting of senior staff and managers. Issues such as risk assessments, audits and service performance were discussed at these meetings.
- We saw evidence that there were regular departmental team meetings in the all visited departments consisting.. Monthly departmental meeting minutes had a standard agenda which included incident learning, performance and improvements.
- Separate radiation safety committee meetings were held monthly to ensure that clinical radiation procedures and supporting activities in the radiotherapy and radiology department were undertaken in compliance with radiation legislation.

Outpatients and diagnostic imaging

- Each department had their own risk register which fed into the main hospital risk register. We looked at risk registers in each department and saw that these were updated and reviewed every two weeks.
- Senior outpatient staff told us that the five main risks for the department were clinic cancellations, clinic late starts, failure to deliver the improvement plan, cold rooms in the ENT and ophthalmology outpatients and staffing. We did see evidence to show that these risks were being addressed at the time of the inspection.
- The radiotherapy risk register contained the general hospital related risks and three specific radiotherapy related risks which were identified as; two older treatment machines that were at the end of their life span and needing to be replaced, the shortage of medical physics staff especially engineering staff and the regular breaking down of the treatment machines due to their age. We did see evidence to show that these risks were being addressed at the time of inspection.
- The age of equipment was a significant risk in diagnostic imaging department and was listed on the risk register. Staff had submitted a business case for the replacement of the equipment and were awaiting the outcome of this.
- The trust had initiated and completed audits and improvement plans to address the concerns raised from the previous inspection. We were shown examples of new key performance indicators that were being monitored and evidence to show improvement had been achieved.
- Staff told us that a 'task and finish' group was organised in August 2016 to address the areas of improvement identified during the previous inspection. They told us that the service was required to measure specific performance indicators and they had weekly meetings regarding progress, staff said they felt overworked during the previous three months.

Culture within the service

- We found the care and service delivered in the outpatients, radiotherapy and imaging departments showed a compassionate and multidisciplinary team approach to patient care.
- Outpatient staff told us that the hospital was 'friendly' and that there was good team working within the outpatient department. All outpatient staff we spoke with held positive views regarding the new management structure and staff.
- Outpatient nursing staff told us that they felt valued by the outpatient leads, but felt that staff care from the trust and hospital was declining. Due to staffing issues nursing staff felt overworked and stressed many staff members complained that they had to take shorter breaks, skip lunch and postpone annual leave so the service could cope.
- We noted a culture of adaptable working in all departments we visited. Staff would routinely rotate across different areas to develop new skills and be flexible in their approach.
- During our inspection we noted all staff being positive and caring towards patients who used the service. We also observed that staff in the outpatient and radiology departments had a caring and respectful nature towards each other and their immediate teams.
- Radiology staff told us that they have seen a lot of improvement in working practice and culture within the hospital.
- Non-clinical staff told us that they felt included and part of the wider hospital team. Administrative staff told us that the majority of medical and nursing staff are courteous and polite. They felt that there was a drive for improvement in the hospital.
- The majority of all staff we spoke with told us that bullying and harassment issues were on the decline and 'not as bad as before', however they also said that incidents were still known to occur.
- We were told of a blame culture and allegations of bullying in radiotherapy with friction between the different radiographer staffing groups which included pre-treatment, treatment and review radiographers. Junior staff members told us they felt they were targeted negatively within the department and were not adequately supported by senior staff members in a constructive manner.
- We were told by 20 out of 24 radiotherapy staff that we spoke with that there were frequent staff clashes within the radiotherapy department with instances cultural and religious discrimination, bullying, and a culture of favouritism. All staff we spoke with said that team working could be improved. We were told by a patient regarding one instance where they witnessed a senior member of staff shouting at a junior member of staff in the corridor, the patient felt 'uncomfortable' and 'very sorry' for the staff member.

Outpatients and diagnostic imaging

- We found there was a lack of clear understanding of roles and responsibilities regarding the different radiographer staffing groups within the radiotherapy department, however there was good team working with clinical oncologists, medical physics and nursing..
- The majority of radiotherapy staff we spoke with told us that they did not feel supported by the managerial team. All staff we spoke with told us that at times the departmental culture could become 'toxic'.
- The radiotherapy managerial team confirmed that they were aware of culture issues within the department, but that the culture was generally open and friendly. The managers said there were cases of bullying and harassment that were being looked at the time of the inspection. They reassured us that appropriate action would be undertaken to resolve the departmental culture and that senior staff would be enrolled in to appropriate leadership courses.

Public and staff engagement

- The trust started a five year plan in November 2015 to incorporate members of the public into various trust level committees and forums in order to engage with public opinion when undertaking strategic decisions.
- The views of patients were sought within outpatients, radiotherapy and diagnostic imaging departments; patients were given a departmental specific feedback questionnaire and encouraged to complete it, however staff told us that response rates were low.
- We were provided with evidence to show that patient opinion was sought and acknowledged in regards to the outpatient department refurbishment.
- The radiotherapy department held open evening sessions for patients being referred to the service in order to help educate them and their families regarding the treatment and their disease. These sessions allowed patients to address their worries and concerns.
- All staff we spoke with told us they could approach and talk to the CEO.
- Service managers told us that the CEO held monthly 'open door' sessions that all staff were encouraged to attend.
- All non-managerial staff we spoke with in the hospital told us that they were aware of an annual staff survey but were not actively encouraged to participate. They felt that the choice was theirs to participate and the majority of them admitted to not participating citing work pressures and lack of time.
- We were provided results from the 2016 staff survey for all areas we visited. The results were displayed per question asked on the survey and results could only be shown if a survey minimum of at least five individuals answered the particular question. We were not provided with the number of participating staff per survey result.
- The outpatient results showed that 77% of staff were 'satisfied with their job', 91% of staff 'understood the vision of the hospital', 57% of staff agreed that 'senior leaders were approachable and visible' and that 60% felt 'valued'.
- The radiology results showed that 80% of staff were 'satisfied with their job', 60% of staff 'would recommend the hospital as a place of work', 40% of staff 'connected to the hospital vision', 60% agreed that their 'line manager treated all staff fairly', 20% of staff agreed that 'senior leaders were approachable and visible', 40% staff said they 'looked forward to going to work' and that 80% felt 'valued'.
- The radiotherapy results showed that 77% of staff were 'satisfied with their job', 54% of staff 'would recommend the hospital as a place of work', 38% of staff felt 'senior leaders communicated well with the hospital', 54% of staff agreed that 'staff are often rude or unkind to each other' and that 62% felt 'valued'.
- We were shown evidence of an action plan to address and help improve the results of the staff surveys for both the outpatient and radiology departments.

Innovation, improvement and sustainability

- We were provided with evidence to show that a sustainable strategy was developed and improvement plans enacted in the outpatient department to address the concerns from the previous inspection.
- The radiology and radiotherapy departments participated in a number of on-going clinical trials and research; this was done in conjunction with the trusts affiliated university.
- The majority of staff we spoke with told us that the hospital did encourage them to participate in research and innovation.

Outstanding practice and areas for improvement

Outstanding practice

- The outpatient improvement programme had begun to deliver results in a relatively short space of time and the process, involving staff consultation and a restructured leadership and governance team, meant clinic delays had been reduced and communication with patients improved. A dedication to utilising technology meant patients had the choice to be contacted by text message, e-mail or letter and these systems were tracked to ensure they were sent accurately. The improvement programme had included patient consultation and feedback was used to inform staff training as part of broader changes to the service.

Areas for improvement

Action the hospital SHOULD take to improve

- Address the safety concerns of staff in regards to the weekend on-call radiotherapy service.
- Ensure the safe and consistent monitoring of fridges containing radioisotopes.
- Quicken the process of hiring new outpatient nursing staff, in order to provide adequate cover for staff absences.
- Ensure all staff understand the concept and utilisation of the duty of candour.
- All staff remain compliant with mandatory training and safeguarding training.
- Ensure there is adequate qualified radiologist cover for the out-of hours interventional radiology service.
- Ensure there is sufficient drinking water available to patients waiting to be seen.
- Address all concerns of staff bullying and harassment issues.

Imperial College Healthcare NHS Trust

Outpatients and diagnostic imaging at Hammersmith Hospital

Quality Report

Du Cane Road
Shepherd's Bush
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Tel: 020 3313 1000
Website: https://www.imperial.nhs.uk/our-locations/hammersmith-hospital

Date of inspection visit: 22, 23 and 24 November 2016.
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Hammersmith Hospital is an acute teaching hospital located in East Acton, London. the hospital was founded in 1912 and is currently a part of Imperial College Healthcare NHS Trust. The trust's central outpatient departments were located at St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital which were overseen by a single leadership team (Lead Nurse, Clinical Director and General Manager), with dedicated clinical and administrative leadership teams based on each site.

Our last comprehensive inspection of the trust was undertaken in September 2014 when we rated the outpatients and diagnostic imaging service at Hammersmith Hospital as inadequate. The purpose of this focused follow-up inspection was to inspect core services that had previously been rated as inadequate.

During this inspection we found the service had improved. We rated the outpatients and diagnostic imaging service at Hammersmith Hospital as good overall.

Our key findings were as follows:

- Outpatient staff learned from incidents by monitoring and discussing them at departmental meetings. The senior sister sent a newsletter staff in the department which included information about the results of incident investigations and the key learning points.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended IR(ME)R trust policy, and how to access it.
- The trust's Executive Quality Committee monitored the number of IR(ME)R incidents. Incidents were investigated and actions were put in place to reduce similar incidents occurring in future.
- 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Clinical areas in the outpatient department were clean and tidy and staff told us they were responsible for ensuring clinic rooms were cleaned daily. Managers had been unhappy with the cleanliness of the department and had put a cleaning programme in place.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- We found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Medicines were stored in a safe manner.
- At our inspection in September 2014 we found records were not always available in clinic when patients attended for their appointment. At this inspection we found the trust were moving towards an electronic system for all patient records and the retrieval of paper records had improved.
- Arrangements were in place to safeguard patients from abuse.
- Nursing and medical staff accessed advice from the medial assessment unit. Patients were admitted if their condition required the level of care which could only be provided on a ward.
- The diagnostic imaging service used diagnostic reference levels (DRL's) as an aid to
- optimising patients exposure to radiation. The levels of radiation for procedures were on display.
- Managers were auditing incidents where the diagnostic reference levels were exceeded.
- Staff in diagnostic imaging were aware of NICE guidelines and evidence based guidelines were in place.
- The diagnostic imaging department were working towards achieving the Royal College of Radiologist Imaging Accreditation scheme.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.

Summary of findings

- At our previous inspection we found clinics often started late but the trust were not monitoring this. At this inspection we found the trust had started to monitor when clinics started and how long patients were waiting.
- Staff had developed a process for updating patients every thirty minutes if a clinic was running late and patients appreciated being kept informed.
- A strategy had been developed for diagnostic imaging setting out a five year plan which included amongst other things, a plan to extend the service during weekdays and introduce weekend working.
- The outpatient improvement programme was having an impact on bringing about change.
- An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.

We saw areas of outstanding practice including:

- The trust was transforming outpatient service across the trust through the outpatient improvement programme. A Patient Service Centre was being set up as the first point of contact for patients and plans had been developed for improvements to clinic environments, improving the quality and content of patient communication, increasing the availability of patient notes and monitoring clinic start and finish times.

However, there were also some areas of practice where the trust needs to make improvements:

- The trust should improve performance against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and the 62-day GP referral to first treatment standard.
- The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The trust should improve performance agains treferral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The diagnostic imaging service should ensure they comply with updated guidance; for example, the Royal College of Radiographers guidance on x-raying patients with longstanding lower back pain.
- The trust should reduce waiting times for patients in outpatient clinics.
- The trust should reduce the number ofoverbooked or cancelled clinics.
- The trust should ensure the temperature of the outpatients clinic department is a comfortable temperature for patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Hammersmith Hospital

Detailed findings

Services we looked at
Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Outpatients and diagnostic imaging at Hammersmith Hospital

The main outpatients department of Hammersmith Hospital is located on the ground floor with four clinic areas and 35 consulting rooms. The general outpatients department saw about 260,000 patients per annum.

There were 262,152 outpatient appointments at Hammersmith Hospital between April 2015 to March 2016.

Outpatient services includes all areas where patients are referred for investigations and diagnosis or for follow up care. Some patients are listed for admission following their visit to outpatients or they may attend on a regular basis for treatment of monitoring over time.

The general outpatients department includes a range of specialist medical teams such as oncology, cardiology, respiratory medicine, endocrinology, gastroenterology, neurology and diabetes. A phlebotomy service for taking blood samples was provided within the department.

A pharmacy was located at the entrance to the outpatient department where patients could take their prescriptions and collect their medicines.

The diagnostic imaging department was located on the first floor above the main outpatient department. The service included CT scanning, interventional radiography, ultrasound and magnetic resonance imaging (MRI). One MRI scanner was located in a portable extension which could be relocated on the site or transferred to another location if required.

The nuclear medicine service was not operating when we inspected. A new facility was planned to accommodate this.

We inspected the outpatient and diagnostic imaging departments over three days.

We spoke with 19 patients and three family members or carers. In addition, we spoke with 22 members of staff including managers, doctors, nurses, medical secretaries, administrators and receptionists.

We observed care being provided and looked at 18 care records in the outpatient department and diagnostic imaging.

We also reviewed performance information about the hospital.

The main outpatient department had two reception and waiting areas for four outpatient clinical areas each of which had 8 clinical consulting rooms.

The section of the OP area where dermatology clinics take place includes two minor procedures rooms, one of which is also used for laser treatment.

There were 262,152 outpatient attendances at the Hammersmith hospital between April 2015 and March 2016. The largest number of patients were in dermatology which saw nearly 14,000 patients. The smallest number of patients were in diabetes.

There were 80,148 attendances in diagnostic imaging.

Detailed findings

Our inspection team

Our inspection team was led by:

Inspection Manager: Michelle Gibney, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultant physician, consultant cardiologist, consultant pathologist, superintendent radiographers, diagnostic radiographer, nurse matron, nurse outpatients manager, senior nurse manager, pharmacist and an Expert by Experience

How we carried out this inspection

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out this inspection as part of our routine focused inspection programme. We carried out an announced inspection on 22, 23 and 24 November 2016.

Before visiting, we reviewed a range of information we held about the hospital.

During the inspection we talked with a range of staff throughout the outpatient and diagnostic imaging department, including senior managers, clinicians, nurses, healthcare assistants, administrative staff and volunteers.

We also spoke with patients and relatives of those who used the outpatient and diagnostic imaging services at Hammersmith Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

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The nuclear medicine service was not operating when we inspected. A new facility was planned to accommodate this.

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We spoke with 19 patients and three family members or carers. In addition, we spoke with 22 members of staff including managers, doctors, nurses, medical secretaries, administrators and receptionists.

We observed care being provided and looked at 18 care records in the outpatient department and diagnostic imaging.

We also reviewed performance information about the hospital.

The main outpatient department had two reception and waiting areas for four outpatient clinical areas each of which had 8 clinical consulting rooms.

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There were 80,148 attendances in diagnostic imaging.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as good because:

- Outpatient staff learned from incidents by monitoring and discussing them at departmental meetings. The senior sister sent a newsletter staff in the department which included information about the results of incident investigations and the key learning points.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended IR(ME)R trust policy, and how to access it.
- The trust's Executive Quality Committee monitored the number of IR(ME)R incidents. Incidents were investigated and actions were put in place to reduce similar incidents occurring in future.
- 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Clinical areas in the outpatient department were clean and tidy and staff told us they were responsible for ensuring clinic rooms were cleaned daily. Managers had been unhappy with the cleanliness of the department and had put a cleaning programme in place.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- We found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Medicines were stored in a safe manner.
- At our inspection in September 2014 we found records were not always available in clinic when patients attended for their appointment. At this inspection we found the trust were moving towards an electronic system for all patient records and the retrieval of paper records had improved.
- Arrangements were in place to safeguard patients from abuse.
- Nursing and medical staff accessed advice from the medial assessment unit. Patients were admitted if their condition required the level of care which could only be provided on a ward.
- The diagnostic imaging service used diagnostic reference levels (DRL's) as an aid to
- optimising patients exposure to radiation. The levels of radiation for procedures were on display.
- Managers were auditing incidents where the diagnostic reference levels were exceeded.
- Staff in diagnostic imaging were aware of NICE guidelines and evidence based guidelines were in place.
- The diagnostic imaging department were working towards achieving the Royal College of Radiologist Imaging Accreditation scheme.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.
- At our previous inspection we found clinics often started late but the trust were not monitoring this. At this inspection we found the trust had started to monitor when clinics started and how long patients were waiting.
- Staff had developed a process for updating patients every thirty minutes if a clinic was running late and patients appreciated being kept informed.
- A strategy had been developed for diagnostic imaging setting out a five year plan which included amongst other things, a plan to extend the service during weekdays and introduce weekend working.
- The outpatient improvement programme was having an impact on bringing about change.
- An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.

However

- The Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.

Outpatients and diagnostic imaging

- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- Patient experience was mixed but many patients told us they had waited for a long time in clinic to be seen.
- Some patients also told us their appointments had been cancelled and re-arranged several times or they had arrived for their appointment to find the clinic had been cancelled.
- An outpatient improvement programme had been developed which had resulted in a number of improvements but many of the objectives had still to be achieved.
- At our previous inspection we found that governance and leadership was shared between the main outpatient department and clinical directorates with no clear leadership structure At this inspection we found management was still shared between managers in the main outpatient department and the specialties and divisions which contributed to a lack of clarity about responsibilities for making improvements. Staff involved with the outpatient improvement programme spoke positively about the changes and new systems being introduced but said not all staff working in specialties were using the systems.
- Waiting times for patients in clinic were still a problem with clinics being overbooked or cancelled.
- Several patients told us they had attended clinic in the summer months and found the temperature in the outpatient clinics uncomfortable. Temperatures sometimes reached 30 degrees. The risk to patients had been identified and funds identified to make improvement but were not yet in place. There were interim solutions in place, including fans and mobile air conditioning units. The outpatient clinic environment had been identified as the service's greatest risk to patient safety and welfare.
- There were four vacancies amongst radiography staff. Managers told us recruitment was difficult and they had been using locums to cover the vacancies.
- Diagnostic imaging were not always following new guidance for example the Royal College of Radiologists guidance on x-raying patients with long standing lower back pain.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Outpatient staff learned from incidents by discussing them at departmental meetings. The senior sister sent a newsletter staff in the department which included information about the results of incident investigations and the key learning points.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended. 'IR(ME)R trust policy, and how to access it.
- The trust's Executive Quality Committee monitored the number of IR(ME)R incidents. Incidents were investigated and actions were put in place to reduce similar incidents occurring in future.
- 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Clinical areas in the outpatient department were visibly clean and tidy and staff told us the clinic rooms were cleaned daily. Managers had been unhappy with the cleanliness of the department and had put a cleaning programme in place.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- At our previous inspection we were concerned about the management and storage of medicines. At this inspection we found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad. Medicines were stored in a safe manner.
- At our inspection in September 2014 we found records were not always available in clinic when patients attended for their appointment. At this inspection we found the trust were moving towards an electronic system for all patient records and the retrieval of paper records had improved.
- Arrangements were in place to safeguard patients from abuse
- Nursing and medical staff accessed advice from the medial assessment unit. Patients were admitted if their condition required the level of care which could only be provided on a ward.

Incidents

- Staff in diagnostic imaging were aware of a never event involving the incorrect siting of a naso gastric tube which had occurred some time ago but there were no recent never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The minutes of the Central Outpatient Directorate Quality and Safety Committee showed that work was being undertaken on the investigation and closure of incidents within 20 working days. There were concerns about the relatively low number of incidents reported for outpatient services. As a result the incident reporting rates from other services were to be circulated and staff were to be encouraged to report incidents.
- Staff in outpatients told us they had all been trained to record incidents on the trust's incident reporting system. Outpatient care assistants told us they preferred to report anything to the registered nurses who would complete the incident report. When we asked if all staff were encouraged to report incidents the senior sister told us they were. Outpatient care assistants were encouraged to report incidents themselves if they felt happy to complete the reports.
- We saw an analysis of incidents in diagnostic imaging for the period January to August 2106. There were 76 incidents reported in total. 60 incidents resulted in no patient harm, 11 resulted in low harm and one resulted in moderate harm. There were four near misses reported. The largest number of incidents related to problems administering contrast media. Six incidents related to incorrect information about a patient's GP or other administrative information which resulted in reporting delays.

Outpatients and diagnostic imaging

- The minutes of outpatient departmental meetings showed incidents were discussed for example when a patient collapsed and when a patient lost the prescription they had been given in clinic.
- There were 18 patient related incidents reported for the outpatient service for the period January-August 2016. 11 incidents were clinics which were overbooked and three related to delays in patient transport taking patients home at the end of the clinic. None of the incidents reported resulted in harm to patients.
- The senior sister in the outpatient department sent a newsletter to all staff in the department which included information about the results of incident investigations and the key learning points.
- The minutes of outpatient departmental meetings showed that incidents were discussed. For example, overrun clinics or patients who became unwell.
- Staff we spoke with were aware of the: 'Ionising Radiation Protection - Dealing with Medical Exposures to Ionising Radiation Greater than Intended IR(ME)R trust policy, and how to access it. Senior staff were aware of their responsibilities to report radiological incidents involving unnecessary exposure of radiation to patients to the Care Quality Commission (CQC).
- The trust reported 14 Imaging related IR(ME) R incidents for all sites including the Hammersmith site between April 2015 and March 2016. These were made up of incorrect exams or protocols being used resulting in patients having repeat examinations and unnecessary exposure to radiation. In the main the exposures were small and resulted in no harm to the patient. IR(ME)R related incidents were reportable if the patient received 1.5 times more than the intended radiation dose or above (CT, Interventional radiology procedures) and 20 times more than the intended radiation dose for general x-ray procedures.
- We saw the Executive Quality Committee monitored the number of incidents and discussed how the number of ionising radiation incidents could be reduced.
- Staff within the diagnostic imaging department were able to describe examples of learning from incidents for example when an incorrect dose of radiation was given. Managers had reviewed the methodology and re-designed the process to reduce the risk of similar incidents occurring again.
- The diagnostic imaging service risk committee reviewed processes for requesting investigations to improve quality and safety.
- The results of a staff opinion survey carried out by the trust showed 83% of staff working in outpatients felt encouraged to report errors and near misses.
- Staff in diagnostic imaging and the outpatient department were aware of the duty of candour requirements and the importance of making patients aware an error had occurred.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

Cleanliness, infection control and hygiene

- Clinical areas in the outpatient department were visibly clean and tidy and staff told us the clinic rooms were cleaned daily.
- We observed checklists and 'clean' stickers had been completed to indicate when areas had been cleaned. Patients' toilets and waiting areas were clean and cleaning schedules had been completed to show the tasks undertaken. Outpatient care assistants were allocated responsibility daily for checking the cleanliness of treatment rooms at the beginning of each day and at the end of each clinic.
- We saw the list of scheduled cleaning tasks for the outpatient clinics. Staff within the outpatient department were allocated tasks to complete from the checklist. Staff had signed the sheets once they had completed their allocated checks. We saw records of similar checks carried out on the resuscitation trolley and drugs cupboards. Records of the checks were completed daily and weekly and showed these had been fully completed. The cleaning checklists included records of the rooms staff had cleaned.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients. Weekly hand hygiene audits were undertaken by the senior sister. When non-compliance with hand hygiene protocols were found, feedback was provided to the individual staff members.

Outpatients and diagnostic imaging

- We found all the curtains for drawing around patients in the treatment rooms were disposable and dated to indicate when they needed to be replaced. None of the curtains we saw were overdue for replacement.
- When inspected the x-ray rooms in the diagnostic imaging department, these appeared clean but we saw cleaning records had not been completed for two weeks.
- Hand hygiene audits were carried out in diagnostic imaging.
- Infection control monitoring was carried out by each clinical division. This included hand hygiene and compliance with the trust's bare below the elbow policy. Audits of the outpatient department were included in the figures for the women and children's division. These showed levels of compliance of 99% for bare below the elbows and 99% compliance with the trust's hand hygiene policies.
- Link nurses were responsible for infection control and the senior sister in the outpatient department carried out a weekly audit. The results were posted on a noticeboard in the department. The figures displayed showed 96% compliance with the cleaning audits carried out.
- Clinic rooms in the outpatient department where an MRSA patient was seen were not used again until the room had been deep cleaned. The senior sister told us they were responsible for ensuring the department was clean and they checked cleanliness daily. 'I am clean stickers' were attached to items of equipment dated on the day of our inspection. This meant staff knew the equipment was clean and ready or use.
- There were records of daily checks carried out on the resuscitation trolley equipment. These showed checks had been completed daily.
- Staff told us they could contact the cleaning department who would attend to clean up spillages.
- We observed staff washing their hands and they followed the trust's bare below the elbow policy. Staff were also used the sanitising hand gels.
- Personal protective equipment such as disposable gloves and aprons were readily available and we saw staff used these when caring for patients.

Environment and equipment

- The section of the outpatient department where dermatology clinics were held included two minor procedure rooms, one of which was used for laser treatment. The rooms had simple air conditioning without filtration so anything other than a simple surgical procedure was carried out in a suitable surgical area. There was a plan to use a different outpatient room with appropriate air filtration in place for more extensive outpatient procedures. The trust's risk register highlighted that there were specialised procedures being carried out in the environment for some group of patients treatment without sufficient preventative measures in place. We saw the trust had put a number of measures in place to reduce the risks to patients. These included appointing an external specialist company to provide the service with laser protection advice, ensure adequate numbers of staff had received laser safety training and there was a member of staff within the local nursing team was identified as a lead for laser safety.
- The risk register also highlighted problems with excessive heat and the lack of ventilation in the outpatient clinic with temperatures reaching 30 and sometimes 35 degrees. Several patients we spoke with told us they had attended in the summer months and found the temperature uncomfortable particularly when they waited a long time before being seen. We saw the trust had identified funds to improve the ventilation and the general environment in the outpatient clinics but the work had not taken place when we inspected.
- Equipment used to examine or treat patients was used only once and then discarded. A proctoscope was cleaned in the clinic using a local decontamination process. A risk assessment had been carried out to highlight any risks associated with the cleaning process and actions had been taken to minimise them.
- Waste was appropriately segregated and needles were disposed of in sharps disposal bins units which were signed, dated and were not overfilled.
- All the rooms in the diagnostic imaging department where imaging equipment was located had secure, controlled access. Staff accessed rooms using a code entered on to a key pad on the door.
- There were warning signs informing staff and patients not to enter rooms when x-rays and other diagnostic test were underway. These were illuminated when the room was in use so that staff and patients knew not to enter.
- Personal protective equipment (PPE) lead aprons, were available to staff for use to protect them from ionising radiation exposure.

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- There was a large room where mothers could change their babies' nappies.
- Toilets were accessible for patients in a wheelchair.
- The diagnostic imaging department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Local radiation protection rules were available for staff to refer to. It was the responsibility of the radiation protection supervisor (RPS) to supervise work and observe practices to ensure compliance. The service was complying with the regulations.

Medicines

- We found that medicines at the location were stored securely and appropriately. Keys to medicines cupboards and treatment rooms were held by appropriate staff. There was restricted access to rooms where medicines were kept via an electronic keypad.
- All medicines cupboards and fridges inspected were clean and tidy, and fridge temperatures were within the recommended range of 2-8°C. We saw evidence that room temperatures were taken and below the recommended 25°C. This meant medicines were stored in a safe manner. In the treatment room we found completed weekly checklists for medicines (which had recently been introduced by the trust) which ensured effective medicines management.
- Staff had access to the trust pharmacy department for medicines information advice and medicines supply for unlicensed medicines. There was a pharmacy top-up service for stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- We found that medicines used for resuscitation and other medical emergencies (for example anaphylaxis) were readily available, accessible for immediate use and tamperproof. We saw evidence of weekly checks to ensure the appropriate medicines were stocked and had not expired.
- Arrangements for the supply of medicines were good. A private pharmacy contractor served all outpatient prescriptions on the ground floor. They were open between 09:00-18:30 Monday to Friday, and 09:00-13:30 on Saturday and Sunday. The latest figures provided showed that more than 75% of prescriptions were dispensed within 15 minutes, and more than 99% within 30 minutes. We saw that prescriptions were prescribed to patients electronically via Cerner® (The IT system at the trust), and also via paper based prescriptions. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Medicines errors and safety incidents were reported quarterly to the Medicines Safety Committee. These were reviewed and information to staff was communicated via a variety of channels such as newsletters, emails and face-to face monthly clinical governance meetings if required. We saw evidence that clinical staff had recently participated in a learning event for the administration of Sandostatin®(a medicine used in oncology) by subcutaneous injection. This demonstrated that staff had learnt from a training requirement to administer medicines safely to patients.

Records

- Outpatient care assistants(OCAs)were responsible for ensuring records were available, complete and up to date. OCAs updated electronic and paper records with height, weight and blood test results prior to patients being seen by medical staff.
- Diagnostic imaging staff told us about the 'pause and check' system used in the department and we observed this being used This was a clinical imaging examination IR(ME)R checklist for ensuring the correct procedures were always performed. Staff checked the patient identification details were correct, that the test was justified, the anatomical area, the system and equipment settings were all correct and that the radiation dose was recorded. We checked 10 patient records and found these had all been fully completed.
- We reviewed eight sets of records in the outpatient department and found these contained correspondence from GPs and relevant clinical histories. All the notes were clearly written, signed and dated by the clinician who had included their contact details. There were clear instructions for staff on how staff should complete patient records.
- We spoke to one member of staff who was allocated to records management who recorded when the patient arrived and confirmed the records were available for the doctor to collect when they saw the patient. The system recorded when the patient was seen by the doctor
- The trust used a clinical information system for recording patient information. This was used in addition to patients' paper records and was still being implemented across the trust.

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- The trust's risk register highlighted the risk of missing records. An audit was carried out which found between 1.5% - 2.2% temporary notes in use compared with a national threshold of 4% for the period April- August 2016. A separate audit was undertaken to review availability of clinical document on the electronic system for example referral letters. This showed on in sixty records had items of information which were missing. The outpatient service audited the completeness and availability of records regularly and planned to improve this as part of the outpatient improvement plan.
- The diagnostic imaging service used an electronic patient information system (RIS). Information could be shared with the other hospitals in the trust (St Mary's and Charing Cross). This meant cross site reporting could also be carried out. Cross site reporting was carried out at week-ends and out of hours.
- Patient information in radiology was stored electronically. We reviewed 10 patient records and found radiology staff had carried out safety checks, for example checking the correct information had been included on the referral and checks on women of child bearing age who may have been pregnant.
- We observed staff using smart cards when they were accessing patient information on the computer. They removed these when they left the reception area.

Safeguarding

- Arrangements were in place to safeguard patients from abuse. The trust's procedures were based on relevant legislation and local requirements. Staff we spoke with understood their responsibilities and adhered to safeguarding policies and procedures.
- The trusts clinical information system contained a safeguarding alert for children and adults when there were any safeguarding concerns.
- Staff were able to access the trust's safeguarding policy, copies were available in the outpatient department and radiology.
- Diagnostic imaging staff were aware of the trust's safeguarding policy and who they should contact if they had any concerns. Staff had level two training for safeguarding adults. The department did not provide a service for children. Prevent training had been provided for staff by the safeguarding team.
- MCA and DoLS training was included in level 2 safeguarding adults training.

Assessing and responding to patient risk

- The diagnostic imaging department had a protocol in place which staff followed if they found something unexpected or if a patient's condition deteriorated. Staff informed the patient's GP and the patient would be referred to accident and emergency or a multi disciplinary team within the hospital for assessment.
- Patients who became unwell in the department were admitted to a ward or were referred to the appropriate medical team if attending as an outpatient. Staff were required to complete a transfer form for handover.
- A room was allocated in the outpatient department for any patients who became unwell. The rooms used contained a couch and oxygen.
- The risk of IR(ME)R incidents occurring was reviewed regularly by the diagnostic imaging Risk Management Steering Group meeting and scored according to the number of incidents reported. AIR(ME)R incidents were also reported to the Radiation Protection Advisor who assessed the radiation dose the patient had received.
- There were clear protocols which staff in radiology and the outpatient department followed which included using the National Early Warning Score (NEWS) system to assess what interventions were required.
- Nursing and medical staff accessed advice from the on call medical registrar. Patients were admitted if their condition required the level of care which could only be provided on a ward.
- There were signs on display throughout the radiology department informing patients and staff when machines were working and where there was a risk of radiation exposure.
- There were notices in different languages in the department highlighting the risk of radiological tests for women who might be pregnant and staff asked patients if they might be pregnant before carrying out the investigation.
- The World Health Organisation (WHO) surgical checklist was being used in the radiology department as a safety check for all procedures that took place in the department. Compliance with the WHO checklist was audited. We saw the results of the audit were reported to the Imaging Risk Management Steering Group which showed 100% compliance at Hammersmith hospital.
- Diagnostic reference levels were audited by the radiological protection advisor.

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- The hospital used a vacuum system for transporting samples to the pathology laboratory and we observed samples which carried a high risk of a transmittable disease were clearly labelled.

Nursing staffing

- Nurse staffing in the outpatient department comprised 15 outpatient care assistant posts and 8.4 professionally registered nurses. There was one vacant OCA post and one phlebotomy vacancy. An outpatient department assistant had recently been appointed and was due to take up post shortly. The other posts were full however two trained staff were on maternity leave. Vacant posts were covered by bank staff, employed by the trust, with experience of working in an outpatient department. There were no agency nurses used at the service.
- The senior outpatient nursing staff completed a weekly spread sheet with information about clinic cancellations as a basis to plan the outpatient nurse staffing requirements over the week.
- Nursing staff told us the staffing establishment had improved with the appointment of additional senior nursing staff. Support for staff for example with access to education had improved, together with improvements to environment has improved. Staff told us they were supported to maintain their competencies and access to mandatory training had improved.
- The outpatient department senior sister planned staffing levels to ensure sufficient numbers of staff were available to support the clinics. Staffing was planned according to the number of clinics, the number of appointments offered and in consultation with medical staff. When we spoke to the senior sister they told us they did not use a staffing acuity tool. They said there was no recognised best practice national acuity tool for safe staffing within outpatient areas. Safe staffing within the outpatient department was reviewed on a day by day basis by the clinical teams and any concerns were escalated to the senior nurses for resolution.
- The trust was beginning to monitor safe staffing in outpatient areas using the trusts e-roster system and was part of a national NHS improvement project to develop a model for safe staffing within outpatient areas.
- A skill mix review had been carried out which had resulted in the creation of additional outpatient department assistant posts. The senior sister had also developed a weekly clinic plan which showed each day's activities and which staff were allocated to clinics and tasks. Staff were familiar with the plan and with the clinic pathways used by each specialty to describe which tests and investigations or other tasks were required for each consultant and clinic.
- As at August 2015 and July 2016, the trust reported a vacancy rate of 13.6% in Outpatients; the vacancy rates ranged from 0% to 26.1% across reporting units trustwide.
- As at August 2015 and July 2016, the trust reported a turnover rate of 6.6% in Outpatients and 16.8% in Diagnostic Imaging. Turnover was greater among unqualified nursing staff in Diagnostic Imaging rather than qualified staff trustwide.
- As at August 2015 and July 2016, the trust reported a sickness rate of 4.7% in Outpatients and 2% in Diagnostic Imaging trustwide.

Medical staffing

- The clinical directorates were responsible for providing medical cover for clinics. The directorates identified the grade and number of medical staff required based on the number of patients who needed to be seen.
- Locum medical staff were used to provide cover on occasions, but the senior sister told us medical teams were relying less frequently on locums and providing cover within their own teams. Consultants supported by junior medical staff led most clinics.

Radiology staffing

- There were four vacancies amongst radiography staff. Managers told us recruitment was difficult. The service used agency staff to cover vacancies. Managers tried to use the same agencies and agency staff who were familiar with the department. The department was not supporting radiographers in training because of the staffing levels. The service had recently recruited to two of the four vacant posts. The new staff were due to start work at the service in January 2017. Managers told us agency staff were monitored for four weeks. There were two radiographers on duty out of hours and a duty radiographer.
- The imaging service did not operate a shift system for medical staff. Medical staff supported an agreed number of clinical sessions for an agreed range of subspecialties or specialisms. Junior medical staff were allocated according to subspecialties such as neurology or

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gastroenterology depending on where they had reached in their training. Registrars were rotated approximately every 4 months into the different sub-specialities of radiology across the trust's three hospital sites.
- The vacancy rates for imaging staff trust wide were as follows: Imaging – All Areas (All Medical and Dental) 19.7%, consultant 6.8% and doctor (training grade) 30%.

Major incident awareness and training

- There were plans for dealing with major disruptions to outpatient services which meant patients could continue to be seen in the event of a major service breakdown.
- Staff were aware of the trust's major incident policy and training records showed staff had received training for major incidents

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate the effective domain because we are not confident we can collect enough evidence to make a judgement. However, we found the following areas of good practice:

- The diagnostic imaging service used diagnostic reference levels (DRL's) as an aid to optimising patients exposure to radiation. The levels of radiation for procedures were on display.
- Managers were auditing incidents where the diagnostic reference levels were exceeded.
- Staff in diagnostic imaging were aware of NICE guidelines and evidence based guidelines were in place.
- The diagnostic imaging department were working towards achieving the Royal College of Radiographers Imaging Accreditation scheme.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.

However:

- Diagnostic imaging were not always following new guidance for example the Royal College of Radiographers guidance on x-raying patients with long standing lower back pain.

Evidence-based care and treatment

- Managers in the diagnostic imaging service told us they were working on achieving the Royal College of Radiographers Imaging Services Accreditation Scheme (ISAS) This is a patient focused scheme aimed at services improving the service provided to patients. The Department Of Health recommended that all radiology departments achieve accreditation. However, when we spoke with staff in the department they were unaware of the ISAS or ISO 9001 standards or the work that was underway to meet these standards.
- The diagnostic imaging service had adopted the use of diagnostic reference levels (DRL's) as an aid to optimising patients exposure to radiation. The levels of radiation for procedures undertaken in the department were on display.
- An audit of IR(ME)R incidents was carried out in February 2016. The audit found that most of the incidents were the result of human error. Root cause analysis had been carried out to identify the causes and these found a range of factors which had contributed to the errors. These included for example pressure of increased workload in terms of volume of examinations to be booked, insufficient time taken when booking and lack of attention to detail, requesting errors by referrers not picked up by imaging staff when protocolling or booking examinations. A range of actions were agreed to address the factors contributing to the errors including feedback being given to referrers who had made errors. The service had set a target of reducing reportable IR(ME)R incidents by 25% by March 2017.
- When we asked managers about the process for implementing national guidelines we found they were not familiar with the NICE image reporting guidelines. However, they were aware of recent NICE guidance on CT dosage and siting of naso gastric tubes. We also found the service was still carrying out x-rays on patients' spines for long standing back pain despite current guidance from the Royal College of Radiographers suggesting this was no longer considered appropriate practice.
- A policy had been developed for checking the correct siting of naso gastric tubes in response to NICE

guidelines. The policy required the siting of naso gastric tubes to be checked the radiology service. These were checked by radiology and the ward were informed if it was safe to use. However, no records were kept to indicate that the service had informed the ward.

- There were outpatient clinic guidelines and protocols for all staff to reference.
- We observed radiographers checking previous images and justifying the investigations, recording the information on the radiology information system (RIS) system. We reviewed 15 x–ray requests and found all were justifiable, according to Royal College guidelines.
- We reviewed the trusts records of IRMER regulations for staff. The versions we reviewed in the department were out of date and the procedure for inappropriate exposure of radiation to a patient documents did not provide guidance about the level of investigation required for example root cause analysis. When we asked managers about this they told us the documents were available via the trusts intranet.
- The diagnostic imaging department kept a list of non medical referrers. Incident reports were submitted if any inappropriate referrals were received.
- Staff in the outpatient department used pathways which were based on national guidance. For example smoking cessation was discussed with patients attending the cardiology clinic.

Pain relief

- The department did not keep pain relief medicines in the department. If a patient required pain relief medical staff provided a prescription and the medicine was dispensed by the pharmacy which was located just outside the outpatient department. Some patients told us they were unhappy because they had to wait for up to an hour for their medicine to be dispensed.
- Some patients were aware of the pain service run by the trust, base at Charing Cross hospital. They said they were told they could be referred to the pain service but there were long waits.

Nutrition and Hydration

- Nutrition and hydration needs were not routinely assessed as part of the outpatient process.
- The outpatient department's risk register highlighted the risk of patients receiving inadequate nutrition and hydration because of delays in clinic and patient transport and the lack of access to food and drink. The risk register highlighted that some patients were still waiting in clinic at eight pm in the evening.
- Water dispensers were available in waiting areas. Our inspection took place during warm weather. Some patients and carers had been waiting for over an hour to be seen but staff did not offer people drinks.
- The senior sister told us they offered patients a drink if they waited for a long time in clinic and they could order a meal from the catering department. However, one disabled patient we spoke withy told us they had spent eight hours at the hospital in outpatients and the patient transport lounge and never been asked if they would like a drink or something to eat. They were disabled and when they returned home they were unable to prepare any food.
- When we visited the patients transport lounge we saw there was a water dispenser and we observed staff offering patients warm drinks.

Patient outcomes

- There was a tracking system in place for patients who left the outpatient department without making a follow up appointment or for further investigations as requested by medical staff.
- The care and treatment provided was evidence based care and followed National Institute for Health and Care Excellence (NICE) guidelines where relevant. . For example smoking cessation was discussed with patients attending the cardiology clinic.
- Several patients we spoke with told us they had been referred to the hospital for specialist treatment which was not available locally.

Competent staff

- Diagnostic imaging staff told us they had appraisals annually. New staff were given a mentor and support when they started. They kept a training record as part of their induction.
- The senior sister kept records of the mandatory training staff completed. They told us staff had completed 98% of the trust's mandatory training requirements.
- Outpatient department assistants rotated between carrying out clinical duties, working on the reception desk and as a floor walker greeting patients when they arrived in the department. We spoke to three staff about this and they told us their knowledge of the

appointment system and clinic booking rules helped them answer patients' questions. Three patients we spoke with told us they appreciated being greeted by staff who were able to answer their questions and direct them to where they needed to be.

- Staff told us they had records of the training they received which described the level of competency they had achieved. Staff told us they had mentors who provided professional supervision. They said they met with their supervisor approximately every six months to discuss their clinical skills and development needs
- We saw examples of the competency booklets which were based on national guidance for outpatient care assistants.
- Staff told us they were supported and encouraged to develop. They said they were supported by their assigned mentors and the clinical nurse manager.
- Staff in diagnostic imaging told us if they were required to carry out a new role or procedure they received the appropriate training. There was an education team to support professional development and training.
- The results of a staff opinion survey carried out by the trust showed only 50% of diagnostic imaging staff reported that they were given regular helpful feedback by their line manager. 76% of staff working in outpatients said they had received feedback through appraisal.
- There was a poster on display showing local rules but staff we spoke with were unaware of these and what they meant.
- Laser competencies for practising clinicians were signed off every year and recorded in a log book within a laser procedures file which we looked at in the laser treatment room. The file also included local rules and a clinical check list that is completed by a clinician before every procedure.
- The dermatology clinical nurse specialist (CNS) had completed a dermoscopy course which meant they were competent to carry out mole mapping.
- Staff met daily before the clinics started and were allocated their roles for the day.
- Mandatory and statutory training figures provided by the trust showed that 97.3% clinical staff and admin staff in radiology had completed infection control training. 92.8% of MRI staff and 90.0% of managers had completed the training. 97.4% of clinical staff and admin staff, 100% of MRI staff and 90% of managers had completed safeguarding adults training. 97.4% of clinical and admin staff, 92.8% of MRI staff and 90% of managers had completed safeguarding children training. 97.4% clinical and admin staff, 100% of MRI staff and 100% managers had completed equality and diversity training. 96.5% of clinical and admin staff, 100% of MRI staff and 90% of managers had completed information governance training. 96.5% of clinical and admin staff, 100% of MRI staff and 90% of managers had completed health and safety training. 92% of clinical and admin staff, 92.8% of MRI staff and 90% of managers had completed equality and diversity training. There were similar high levels of training compliance with fire safety, moving and handling and conflict resolution.

Multidisciplinary working

- Staff briefings were held every morning to plan the day's work.
- Senior outpatient nurses met every two weeks across the Trust to discuss trust wide issues which affected outpatients. Monthly outpatient department meetings were held to discuss performance and service development.
- Staff told us there were good working relationships between medical and nursing staff. Nursing staff contacted medical staff if they were more than 10 minutes late for clinic. They described how interactions were improving which meant clinic staff could keep patients informed about any delays. Nursing staff described how the use of a new electronic system meant they could track when patients arrived and were seen and medical staff were able to check if patients had arrived and check their results before calling them in for their consultation.
- Patient seen in clinic who required inpatient treatment were referred to a specialty specific multidisciplinary care team who planned the treatment required.
- Clinical nurse specialists provided nurse led clinics for example in diabetes and dermatology.

Seven-day services

- The renal clinic operated seven days a week and patients could drop in for treatment f they had concerns or noticed a change in their condition.
- Clinics in the main outpatient department were provided Monday to Friday between 9am and 5pm.

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There were no early morning or late evening clinics for people who worked during the day. Incident reports showed clinics ran over with the last patients seen after the clinics usual closing time.

- Staff told us plans were being developed to extend access to outpatient services but these were not yet in place.
- Consultant radiologists had remote access for reporting via PACS Web which could be accessed any time. The diagnostic imaging service operated between Monday and Friday from 8:30am to 5pm, with extended lists for MRI until 8pm Monday to Friday, and 8am to 5pm on Saturdays. CT also operated extended days once or twice a week.

Access to information

- All staff working in the department had access to the electronic patient record system. We saw staff had their own cards for accessing the electronic records system which we saw they removed when they left the room. The system identified which member of staff entered the information into the patient's record. There were also paper records for patients which the trust was planning to withdraw once all patient's had an electronic record.
- Patients were provided with information about their condition. For example we saw a range of leaflets for dermatology patients.
- We saw copies of letters to the patient and their GP following their outpatient consultation.
- Outpatient referral to treatment (RTT) times were the responsibility of business managers in individual departments.
- All referrals apart from choose and book were uploaded to the booking system and triaged by consultant medical staff.
- Clinic templates were set by consultant medical staff.
- Reports from diagnostic imaging showing evidence of incidental findings were faxed to GPs to avoid any delays in diagnosis and treatment. All other reports were transmitted electronically to the GP practices.
- When we reviewed patients' gastroenterology records we saw letters which had been dictated by medical staff immediately after the clinics in August 2016 but there were delays in the letters being typed. One letter had been typed 37 days after the clinic. The shortest period between a letter being dictated and typed was 15 days. This meant there were delays in communicating with patients and GPs about the care provided. Following our inspection, the trust told us that in November 2016 the maximum time between a clinic taking place and the letter being produced in gastroenterology was 19 days. The trust was making progress in reducing the time it took to type up clinic visits.
- The time taken to send letters to GPs was being monitored as part of the outpatient improvement programme. The average time taken to send a letter to the GP following an outpatient consultation in July 2016 was 7.8 days. As part of the improvement programme letters were being emailed to GPs via the clinical document library (CDL). In July 2016 80% were issued within 10 working days.
- The trust used a system for medical staff to record patient information but not all clinicians were using this.
- Staff checked to ensure patients had returned their follow up cards to reception and any follow up action was recorded by the doctor.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed eight patients' paper records and found these contained patients agreement to investigations and treatment.
- However, staff within the diagnostic imaging department were not familiar with the requirements of the Mental Capacity Act (2005). They were unsure who might carry out a mental capacity assessment or about making and recording best interest decisions if a patient did not have the mental capacity to consent to treatment.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- An outpatient care assistant greeted patients when they arrived, provided reassurance and guided patients to their clinics.
- The majority of patients told us staff were kind and helpful.

Outpatients and diagnostic imaging

- Staff in outpatients told us they had received customer relations training which they had found helpful in responding to patients' needs.
- Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains and around the examination couch and patients were covered up whilst sensitive or intimate examinations took place.

However:

- Staff did not always notice when patients were feeling unwell and ensure they were seen quickly.

Compassionate care

- An outpatient care assistant greeted patients as they arrived and directed people to the appropriate clinic or waiting area. Outpatient assistants took it in turn to carry out the 'floor walking' role. We observed several members of staff carry out this role during our inspection and observed they were all warm and friendly towards patients.
- We observed one patient who was unwell. They told us they had been waiting for forty minutes to be seen. They said they had recently been discharged from another hospital and described how unwell they were feeling. We asked if staff had checked how they were feeling as they looked so unwell. They said no one had spoken to them since they arrived. We made the nurse in charge aware that the patient was feeling unwell and asked if they could check they were well enough to continue waiting to be seen.
- Patients told us staff were, "Friendly and understanding." One patient told us, "I had a heart attack a year ago and the information given on my treatment had been faultless.
- A patient told us, "Staff gave me privacy when examining me." Another patient told us, "If I need help I ask. I am happy to ask because I know staff will help me. I need to use the disabled toilet and staff are always happy to help."
- Healthcare assistants told us they had received customer relations training. We observed they were confident when communicating with patients and approachable. We saw several patients approach the outpatient assistants for information and directions.
- The majority of patients we spoke with told us staff in the outpatient department were caring and friendly.
- Two patients we spoke with in diagnostic imaging were positive about the service saying it was a good service and staff were kind and explained things clearly.
- Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains and around the examination couch and patients were covered up whilst sensitive or intimate examinations took place.

Understanding and involvement of patients and those close to them

- Patients attending the diagnostic imaging department were offered chaperones for examinations.
- One patient told us, "The staff listen and are informative and kind." My doctor supported me to come off my medicine." Another patient told us," I feel staff are keeping me informed about my treatment. The doctors have discussed the options and all aspects of my treatment."
- The diagnostic imaging department had a dementia ambassador who ensured staff knew how to support patients with dementia. Staff were also aware of the needs of patients with a learning disability and used their communication passports to understand the persons needs and concerns.
- One patient who had been waiting over fifty minutes to be seen told us they were happy to wait because the doctor took time to explain everything to them and they were able to ask questions about their condition and what they might expect to happen. They said the hospital had offered to send appointments by email but they preferred to receive a letter.
- We observed a patient who was attending with a relative. The patient had a condition which meant they could become unsettled. Nursing staff observed the patient becoming unsettled and showed them and their relative to a quiet room in the department.
- Other patients we spoke with told us medical and nursing staff explained their care and they were offered choices and options about the timing of their treatment. Patients and relatives told us they felt able to ask questions and medical staff provided them with the information they needed to address any concerns.

Emotional support

- Staff told us chaperones were always available. The use of chaperones was not audited but 'the doctors recorded the use of chaperones in the medical notes'.

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- We observed patients using the phlebotomy service to have their bloods taken. There were four cubicles each had curtains which were drawn around the patient during the procedure to maintain their dignity. Staff treated patients with respect introducing themselves and putting them at ease.
- Several patients were accompanied by relatives or carers and we saw they accompanied the patient during the consultation. One patient told us it meant a lot that their partner could attend to support them because they were often frightened or worried about their condition.
- Nurses were available to provide emotional support for patients who had received bad news within the rheumatology, renal, diabetic, endocrine and respiratory clinics.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as required improvement because:

- The Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- Patient experience was mixed but many told us they had waited for a long time in clinic to be seen.
- Patients also told us their appointments had been cancelled and re-arranged several times or they had arrived for their appointment to find the clinic had been cancelled.

However:

- At our previous inspection we found clinics often started late but the trust were not monitoring this. At this inspection we found the trust had started to monitor when clinics started and how long patients were waiting.
- Staff had developed a process for updating patients every thirty minutes if a clinic was running late and patients appreciated being kept informed.

Service planning and delivery to meet the needs of local people

- Staff told us there had been a significant increase in the number of patients attending outpatient clinics. Staff told us work had been taking place to improve waiting times for initial assessment and reduce waiting times in clinic.
- The trust worked with local clinical commissioning groups to plan capacity and demand requirements as part of the local sustainability plan.
- The trust was involved in collaborations across north west London health and social care, including development of sustainability and transformation plan, expanded academic health sciences centre and new integrated health programme.
- Two patients we spoke with in diagnostic imaging told us they were concerned about car parking. They were waiting to be seen and worried their car park tickets had expired. They said it was stressful worrying about car parking.
- The July 2016 performance report showed the Trust underperformed against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and underperformed against the 62-day GP referral to first treatment standard.

Access and flow

- Specialist nurses provided a 'walk in' clinic for patients on a Monday for patients where there was a suspicion of skin cancer. Patients were referred to the service by their GP and were often seen on the following Monday.
- A patient told us their appointment had been cancelled and re-booked twice because they required a CT scan before seeing the consultant again. They said they contacted the consultant's secretary because they did not understand why their appointments were cancelled, they had not understood they needed a CT scan. The consultant organised the scan and they were seen by

the consultant the following day. They were frustrated when their appointments were cancelled but pleased the problem had been sorted out and they saw the consultant so quickly.

- Another patient told us they had been waiting for an hour and 10 minutes. They said they attended clinic regularly and had always waited at least an hour to be seen.
- Another patient said they had once attended for their appointment and found the clinic was cancelled. They had travelled a long way and staff arranged for them to be seen. They said they accepted things went wrong: they were glad to be seen by medical staff.
- We spoke with 11 patients and asked them how long they had been waiting in clinic to be seen. The clinic was running thirty minutes late. Staff updated the whiteboard at the front of the clinic to display how late the clinic was running. Two patients had waited less than ten minutes, most waited 30 minutes, one waited for 45 minutes. Patients told us they appreciated being kept informed about delays.
- The trust had implemented a system which monitored when patients arrived and when they were seen. Patients checked in in by confirming their arrival on a computer screen located in the entrance to the department. Medical staff could see the patient had arrived and could call the patient into the clinic room using their computer. This enabled the service to monitor waiting times. However, not all medical staff were using the system and not all patients were checking in.
- Patients took a completed outcome form to the reception desk following their consultation. The doctor or nurse recorded when the patient required to be seen again and reception staff offered patients their appointment before they left clinic.
- The clinic fitted one patient into clinic from a ward because staff had concerns about their condition and knew medical staff from that specialty were in clinic.
- One patient we spoke with told us they had a number of very significant medical problems. They were attending the dermatology clinic with their partner. They had been discharged from another hospital in the trust and missed an appointment a few weeks later because they did not receive their appointment letter. They had not realised they had missed their appointment until they received a further appointment informing them about the missed appointment offering the appointment that day. They said apart from the administrative issues they were very happy with the medical care they had received.
- Outpatient department assistants carrying out the 'floor walker' role made sure patients knew where to go. They greeted and directed patients to the electronic check in or answered patients questions.
- We observed staff update a whiteboard showing if the clinics were running late. Staff also verbally informed patients in the waiting area how long they were likely to wait. We saw staff do this on several occasions during our inspection. This meant patients were kept informed about delays. Staff also apologised for the delay.
- Staff told us delays in waiting times to be seen in clinic were caused by complex patients needing longer than their allocated time; or overbooking the clinic by the clinician. Problems with waiting times in dermatology which had been addressed through additional ad hoc clinics and in endocrinology by bringing in additional medical staff.
- Nursing staff in the outpatient department had introduced a new system to inform patients about delays while waiting to be seen. Staff told us the longest delays could be up to two hours, in some specialist clinics. However, there have not been any complaints about waiting times since staff had started updating patients about delays.
- The matron told us they had recently introduced a process for doctors who had not arrived in clinic within 10 minutes of their first patient appointment. Staff contacted the doctor by telephone by senior nursing staff. Any further delay was escalated to a more senior level. An audit of clinic start times reported to the outpatient quality and safety committee found 33% of clinics started 10 minutes late with 6 clinics running 2.5 hours late.
- At our previous inspection we found clinics often started late but the trust were not monitoring this. As part of the trust's outpatient improvement programme a pilot audit to record doctor arrival times was undertaken in June 2016. The results for July 2016 showed 73% of doctors arrived on time to start their clinic and another 10% arrived within 10 minutes. 5% arrived 30 minutes after the clinic was due to start. The trust were monitoring when clinics started.
- There was a phlebotomy clinic with four cubicles next to general outpatient department. The phlebotomy clinic

started at 0800 to allow patients to have a blood test before the clinic began and the maximum wait was 20 minutes on the day we inspected. The phlebotomy clinic saw between 180 and 200 patients a day. Patients we spoke with told us they found the phlebotomy service very efficient.

- Consultant medical staff told us the imaging department provided an excellent service for urgent CT and PET CT scans.
- Staff told us last minute cancellations were rare and usually due to sickness. They said it was not always possible to inform them about clinic appointments that were cancelled at short notice
- The outpatient department operated a six week rule which meant no clinic should be cancelled with less than six weeks notice. The trust monitored this as part of their performance monitoring process. The performance report for July 2016 showed the number of hospital initiated cancellations was 8.1% compared with the trust's standard of 10%. This represented a reduction on previous months. 32% of the appointments cancelled were attributed to clinics being cancelled or the number of appointments reduced. Following our inspection the trust supplied us with additional information indicating the proportion of hospital initiated cancellations had reduced to 7.5%.
- During the period April 2015 to April 2016 the follow-up to new rate for Hammersmith Hospital was higher than the England average. Hammersmith Hospital is a specialist centre which meant many patients were referred for treatment from other hospitals resulting in higher rates of follow up attendances.
- Between April 2015 and March 2016 the 'did not attend rate' for the Hammersmith Hospital was higher than the England average. The performance report for July 2016 showed 12.1% patients did not attend for new or follow up appointments compared with the trust's target of 10.0%.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for non-admitted pathways for outpatient services was worse than the England average. The latest figures for July 2016 showed 85.4% of patients were treated within 18 weeks.
- Between August 2015 and July 2016 the trust's referral to treatment time (RTT) for incomplete pathways for outpatient services has been worse than the England overall performance and worse than the operational standard of 92%. The latest figures for July 2016 showed 84.6% of this group of patients were treated within 18 weeks.
- The England average was only just below the target, but this trust's performance is noticeably worse than the target and has the trend is getting worse.
- The trust was performing slightly worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral. Performance rose in Q2 2016/17 to 92.4% which was still below the England average of 94.2%.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). Performance remained steady in Q2 2016/17 at 96.7% which was just below the England average of 97.6%.
- The trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. Performance fell over 2 of the last 3 quarters but recovered in Q2 2016/17 to 80.1% still below the England average of 82.3%.
- The diagnostic imaging service sometimes outsourced image reporting when they had a backlog. There were no reporting radiographers.
- Information provided by the trust showed that between March and August 2016 patients waited between 16 and 25 weeks for an MRI appointment, 10-14 weeks for an ultrasound and 19-25 weeks for CT.

Meeting people's individual needs.

- We spoke with one patient who told us they had been attending the hospital for several years and received a diagnosis in December 2015 for a life limiting condition They said the consultant gave them the diagnosis but did not explain how this would affect them. The consultant gave them a leaflet developed by a charity and told them this included all the information they needed about their condition. They said they were told they would be referred to see a consultant who specialised in their condition and could ask any questions then. They received an appointment for February 2017. They felt this was too long to wait to find out how they would be affected by the condition.

Outpatients and diagnostic imaging

- Information leaflets in diagnostic imaging were available in several different languages and easy to read versions for people with a visual impairment. The service had access to interpreters if required, which could be booked in advance.
- We saw a complaints leaflet written in an easy to read format for patient with a learning disability. The leaflet described how patients could access advocacy advice and help if they were unhappy with their care.
- Staff told us patients who became unwell while waiting to be seen were brought to the attention of medical staff.
- Staff in the outpatient department told us they had all completed mandatory training in dementia. They said the department had a few patients with dementia every week and they felt able to provide appropriate support for patients who needed it.
- Paediatric referrals were all screened and referred on to paediatric clinics where appropriate. Very few young people were seen in the general outpatient department.
- There was a drop in service in the dermatology clinic every Monday. A specialist nurse would see patients referred by their GP because of unusual pigmentation or a suspicious mole.
- There were chairs in the clinic waiting areas for bariatric patients.
- When we reviewed patients' records we saw one patient had not attended their scheduled clinic appointment. The doctor had written to the GP and the patient requesting they re-arrange their appointment because they were concerned the patient's symptoms might suggest a potentially serious condition.
- We spoke with eight patients waiting in clinic to be seen. One patient told us things were improving. They said they attended approximately every three months and sometimes waited up to an hour to be seen but on the last few occasions they had attended the waiting time had improved. They said they thought nurses announcing how long patients had to wait was a good idea.
- Diagnostic imaging staff told us if a patient did not attend for an urgent appointment they would contact the referring doctor by phone or write to the referring doctor if the missed appointment was for a routine investigation. They described how text messaging was introduced which had resulted in the DNA rate reducing. They said patient had sometimes not attended because they had not received a letter but the text messaging meant patients were informed,
- The check in kiosks provided an extensive choice of languages. Interpreters were available either through a telephone link or by a translator by appointment.

Learning from complaints and concerns

- The trust responded to complaints based on the risk grade of the complaint. Low risk was 25 working days, medium risk was 45 days and high risk was 65 days, the trust allowed themselves one extension per complaint. All complaints were read by the associate director of complaints for the trust. Sign off on a complaint depended on the risk grade, low grade complaints were signed off by a complaints officer, medium risk were signed off by the associate director and high risk ones by the chief executive.
- In the reporting period between August 2015 and July 2016 there were 53 formal complaints about Outpatients services at this trust. The trust took an average of 32 days to investigate and close complaints; this is in line with their complaints policy, which states that the trust has a target to resolve each complaint within an average of 40 working days.
- Staff informed patients about waiting times in clinic in response to complaints they had received.
- Staff in diagnostic imaging told us they reviewed the complaints they received monthly. They told us patients raised concerns about dignity during examinations, the gowns patients were provided with, car parking and signage.
- Key themes were extracted from complaints about outpatient services to inform service improvement plans. The outpatient improvement programme identified that 106 complaints were received by July 2016 were relating to outpatients. 14 of the complaints were formal, the remaining 92 were made through PALS
- The problems included patients booked into the wrong clinic, not being given a follow up appointment not receiving cancellation letters, being cancelled multiple times including one occasion of on the day and the length of time waiting for a first appointment.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Good

We rated well-led as good because:

- A strategy had been developed for diagnostic imaging setting out a five year plan which included amongst other things, a plan to extend the service during weekdays and introduce weekend working.
- The outpatient improvement programme was beginning to have traction and bring about change. Staff involved with the outpatient improvement programme spoke positively about the changes
- An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.
- Staff described the culture within the service as open and transparent. Staff were able to raise concerns and felt listened to. Staff felt local leaders were visible and approachable.

However

- We found that governance and leadership was still shared between managers in the main outpatient department and within the different specialties and divisions. Staff told us that this could sometimes delay new systems from the development plan being implemented.
- Waiting times for patients in clinic were still a problem with some clinics being overbooked or cancelled.
- The results of the trust's staff opinion survey showed only 36% of diagnostic imaging staff felt connected to the vision of the Trust.
- Only 32% of staff in diagnostic imaging felt that poor behaviour and performance was addressed effectively.

Vision and strategy for this service

- A strategy for diagnostic imaging was developed in September 2014 which included a five year plan to extend the service during weekdays and introduce weekend working, achieve ISAS accreditation within 3 years, participate in benchmarking, achieve and sustain <15 days waiting time target for all imaging examinations for outpatient and GP referrals.
- An outpatient improvement programme had been developed to address concerns identified in the 2014 CQC inspection and improve the quality of service provided for patients. The programme update of August 2016 showed there were 14 projects underway including reducing the rate of patients who do not attend their outpatient appointment; address problems with the administration of appointments which was leading to unnecessary delays and inconvenience to patients
- Staff received a newsletter from the divisional director containing information and updates about the trusts outpatient improvement programme.
- The results of the staff opinion survey showed 91% of outpatient staff felt they understood the trust's vision. 74% of staff reported they felt connected to the trust's vision. 79% of staff said the executive team provided clear direction about the trust's priorities. However, results demonstrated only 36% of diagnostic imaging staff felt connected to the vision of the Trust.

Governance, risk management and quality measurement

- There were meetings every Friday where outpatient staff met with operations staff and development managers from the clinical divisions to discuss the organisation and performance of the outpatient clinics.
- The outpatient department maintained a risk register. The highest risks related to the temperature within the outpatient department which reached 30-35 degrees. We saw the risks were reviewed by the central outpatient directorate quality and safety committee. The committee raised the risk score to 16 due to the increased likelihood of the risk occurring over the summer months.
- An outpatient improvement plan had been developed which addressed many of the issues identified in the outpatient departments at the previous inspection in September 2014.
- A Risk Management Steering Group reviewed risks in diagnostic imaging. The minutes of the meetings showed infection control, incidents and risks within the imaging department were some of the topics discussed.
- An integrated performance report provided managers with monthly information on a range of quality measures for outpatients and diagnostic imaging. These included incidents, mandatory training, national clinical audits, referral to treatment times, cancelled clinics and reporting times for diagnostics. The performance report

charted improvements and reductions in performance. The information was discussed by local management teams, directorate, divisional and executive management teams.

- The Executive Quality Committee monitored the number of IR(ME)R incidents and discussed how the number of incidents could be reduced. The committee had commissioned an audit of the trust's management of ionising radiation. The risk of IR(ME)R incidents occurring was reviewed regularly at the departmental Risk Management Steering Group meeting and rescored appropriately in accordance with the number of reported incidents. All IR(ME)R incidents were also reported to the Radiation Protection Advisor who assesses the radiation dose to the patient. The service had set a target of reducing reportable IR(ME)R incidents by 25% by March 2017.

Leadership of service

- The outpatient service was overseen by a leadership team of three managers – the Senior Nurse, Clinical Director and General Manager. The team was supported by clinical and administrative staff. The team had been strengthened since our previous inspection and there was more of an emphasis on local site management.
- The outpatient and imaging departments were managed within the division of women and childrens' and clinical support services.
- However, governance and leadership was still shared between managers in the main outpatient department, different specialties and divisions. Staff were working more closely together on improvements but the structures were still relatively new and some posts had still to be appointed to. Some staff described their frustration in moving the outpatient improvement programme forward. They told us they felt the change and new systems being introduced were all positive but not all staff working in specialties were using the systems. An outpatient service level agreement had been developed which set out how the central outpatient service and specialist teams would work together to meet the targets in a new performance framework.
- The minutes of departmental staff meetings showed incidents and risks were discussed. We saw for example delays in clinics, heat in the department and other environmental issues had been discussed.
- Sisters from the three outpatient departments in the trust met weekly to share information and share good practice.
- Senior sisters met managers monthly to discuss the management of outpatient departments in all three hospitals. Information from these discussions was shared with staff in the outpatient department through the newsletter produced by the senior sister.
- A service support manager provided operational management support to the department dealing with complaints and IT issues.
- Staff told us a lot of effort was being invested in improving clinics with the longest waiting times and the most overbooked. Staff told us improvements were being made but there was still a lot of work required for example to review the clinic booking templates with each specialty.
- Some managers in the diagnostic imaging service were not aware of the IR(ME)R annual report
- Staff within the outpatient department spoke positively about their local leadership and told us they felt that valued.

Culture within the service

- Staff told us they were able to raise concerns and discuss issues openly within the department.
- One member of staff who had worked at the service for several years told us team working within the department had improved over the last year.
- The results of the trust's staff opinion survey showed 96% of staff were of the view that their immediate team worked well together. However, only 32% of staff in diagnostic imaging felt that poor behaviour and performance was addressed effectively. 63% of staff in outpatients felt poor performance and behaviour was effectively addressed. 94% of staff indicated their working environment was friendly and welcoming and 56% of staff, feel a sense of personal achievement in their work. However, 38% felt they were put under pressure to work outside their working hours
- 98% of staff working in outpatients felt they understood what behaviour and performance was expected at work. 98% of staff working in outpatients felt they were clear about their objectives and responsibilities.
- Staff in the outpatient department told us there was a strong team feeling it almost felt like a 'family' atmosphere.

Outpatients and diagnostic imaging

Public engagement

- Patient and GP representatives had been recruited to participate in the outpatient improvement programme.
- There was a noticeboard at the entrance to the department with photographs and names of the senior staff working in the department.
- Clinic appointment letters were changed recently to be more patient friendly' as a result of feedback from patients.

Staff engagement

- A clinical reference group provided advice and feedback on the outpatient service improvement plans.
- A staff recognition scheme was in place for staff. Staff were nominated for the award by their colleagues.
- Diagnostic imaging staff told us good practice was recognised through the 'Instant Recognition Awards' Staff received a card and a badge. Three groups of staff within the department had been recognised including the secretarial team.
- As a result of the staff opinion survey the diagnostic imaging service planned to complete and implement a workforce strategy in partnership with staff carry on with work to reduce vacancy rates and improve retention, consult with staff incorporate overtime hours into contracts for new staff.
- The staff opinion survey results for the outpatient department showed that 77% of staff would recommend working in the trust. The staff opinion survey results included staff working in all three outpatient departments. Separate results for Hammersmith hospital were not available. 77% of staff were satisfied with their job overall. 79% of staff would recommend the service as a place to receive care or treatment.
- 81% of staff working in outpatients felt they were able to contribute to innovation within their team or department 64% of outpatient staff felt they were empowered to make change happen in their area of work.

Innovation, improvement and sustainability.

- An outpatient improvement programme was in place. The programme was accountable to the trust's Executive Transformation Committee. The programme included contributing to the development of the trust wide Patient Service Centre as the first point of contact for patients, transforming the clinic environment, improving the quality and content of patient communication, increasing the availability of patient notes (paper and electronic, monitoring clinic start and end times.
- The outpatient team had won a 'Collaborating with our patient's award' for introducing the 30 minute updates for patients waiting to be seen in clinic. The number of complaints about waiting times had reduced since the updates had been introduced.
- The trust had developed and were implementing a digital strategy, including roll out of electronic patient records and electronic prescribing plus new website and Care Information Exchange pilots.
- The trust was developing a patient service centre to provide a single point of access for patients and referrers. The outpatient improvement team were incorporating outpatient appointment processes into the service centre. The centre was due to open in December 2016.
- An outpatient 'service level agreement' was being developed for specialist teams and agreed new performance framework. This included improved monitoring of booking processes, clear accountabilities and tracking of performance against trust targets.
- Staff told us they had participated a customer service training programme for outpatient teams.
- There were monthly team meetings in diagnostic imaging where incidents, staff and other organisational issues were discussed. Three members of the haematology department were engaged in a quality improvement team. The team holds regular monthly meetings where complaints and incidents are all reviewed and signed off by a lead clinician.

Outstanding practice and areas for improvement

Outstanding practice

The trust was transforming outpatient service across the trust through the outpatient improvement programme. A Patient Service Centre was being set up as the first point of contact for patients and plans had been developed for improvements to clinic environments, improving the quality and content of patient communication, increasing the availability of patient notes and monitoring clinic start and finish times.

Areas for improvement

Action the hospital SHOULD take to improve

- The trust should improve performance against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and the 62-day GP referral to first treatment standard.
- The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services.
- The diagnostic imaging service should ensure they comply with updated guidance; for example, the Royal College of Radiographers guidance on x-raying patients with longstanding lower back pain.
- The trust should reduce waiting times for patients in outpatient clinics.
- The trust should reduce the number of overbooked or cancelled clinics.
- The trust should ensure the temperature of the outpatients clinic department is a comfortable temperature for patients.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Draft Responsible Officer's Annual Report – Revalidation & Appraisal

Executive summary:

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

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

This report is the annual report on compliance with FQA standards, which is being presented for review at Trust Board, following presentation at executive quality committee in June 2017.

Quality impact:

This paper supports the 'well-led' domain by supporting a culture of learning and innovation amongst doctors through regular reflection and continued professional development.

Financial impact:

This paper has no financial impact.

Risk impact:

The risks associated with this paper are referenced in the risk register, and are managed through regular team meetings. Key risks will be escalated to the Responsible Officer where appropriate.

Recommendation(s) to the Committee:

The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to NHS England by 29 September 2017.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Victoria Ward, Professional Development Manager Justin Vale, Deputy Medical Director	Julian Redhead, Medical Director	19 July 2017

Responsible Officer's Annual Report – Revalidation & Appraisal

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

The expectation of regulators[1] is that the boards of designated bodies monitor the organisation's progress in implementing the Responsible Officer Regulations. This report provides an update on the Trust's implementation of and compliance with these regulations.

The purpose of this report is:

- To provide the Trust Board with a draft Annual Report on compliance with FQA standards;
- To provide the Board with assurance of the Trust's compliance with the FQA standards to allow them to approve the Statement of Compliance (Appendix A) required to be submitted to NHS England.

1. Background

Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field and able to provide a good level of care. Medical Revalidation started on 3 December 2012 and comprises a five year cycle; therefore, it is expected that the majority of doctors will be revalidated by December 2017.

The aim of revalidation is to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Licensed doctors have to revalidate every five years, by having an annual appraisal based on the GMC core guidance for doctors, *Good medical practice*.

Most licensed doctors have a prescribed connection with one organisation that provides them with an annual appraisal, and helps them with revalidation. This organisation is referred to as a 'designated body'.

All designated bodies must have an appointed Responsible Officer (RO) who submits revalidation recommendations to the GMC for all doctors with a prescribed connection to the organisation. The Trust's RO is the medical director.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[2] and it is expected that executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can in-

[1] General Medical Council, Care Quality Commission, Monitor and the NHS Trust Development Authority

[2] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

form the appraisal and revalidation process for their doctors; and

- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Revalidation recommendations for doctors in training are dealt with by Health Education England.

2. External Monitoring & Assurance

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

- the Annual Statement of Compliance (see Appendix A and section 2.2) made by the Trust Board to NHS England, due by 29th September 2017;
- the Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England, which was submitted on 31st May 2017 (see Appendix B);
- an Annual Report to the Trust Board on compliance with these standards (this report).

2.1. Statement of Compliance

The Responsible Officer Regulations set out the obligation on the part of designated bodies to provide support to the responsible officer. In demonstrating this support, the chief executive is asked to sign a statement of compliance with the Responsible Officer Regulations. This statement is due to be submitted to NHS England by 29th September 2017.

The completed statement can be found in Appendix A. We are compliant with all ten standards, as set out below.

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

Imperial College Healthcare NHS Trust is a recognised designated body. The Trust's RO is Professor Julian Redhead, Medical Director who has received the appropriate RO training. The 'Alternative Responsible Officer' is Professor Justin Vale, Deputy Medical Director, who has also had the appropriate RO training, in line with the core standards framework.

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

The Professional Development Team (formally the Revalidation Team) is part of the Office of the Medical Director and reports to the Alternative Responsible Officer. The Professional Development Team maintains and verifies an accurate record of all doctors with a prescribed connection to ICHT using the GMC Connect database.

STATEMENT 3 **- There are sufficient numbers of trained appraisers to carry out annual**

medical appraisals for all licensed medical practitioners;

As of 31 March 2017, the Trust had 211 trained appraisers, which is a ratio of appraisers to appraisees of 1**:**5.5, which complies with the NHS England recommendations[3]. This is a slight increase from the previous year when the ratio was 1:5.3. Departments which have less than the recommended amount of appraisers, or who have a high turnover of staff or a number of appraisers who are inactive, are offered the opportunity to have more appraisers trained to make up any shortfall. All Heads of Speciality are aware of the need to ensure they have adequate numbers of trained appraisers within their speciality.

All appraisers are required to undertake appraiser training and then receive refresher training every 3 years. This was formally delivered by an external training provider, MIAD, but is now being delivered internally. The internal appraiser training curriculum has been validated with NHS England and complies with their guidance 'Training Specification for Medical Appraisers in England'.

Each year the professional development team contact the clinical directors with the breakdown of how many appraisers they have in their area and the frequency of which they are appraising. They then advise whether more appraisers are needed, or if some who are not appraising would like to give up their role so that another doctor can be trained. From this, the team deliver as many sessions as required to have all nominated appraisers trained. This year only one training session for 20 appraisers was required.

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

- Appraiser forums are run on a monthly basis, rotating across sites, which allow appraisers the opportunity to network, share best practice and development opportunities and benchmark performance. This allows for peer review and calibration of professional judgements and is a requirement of the core standards framework.

- A questionnaire was sent to all the appraisers to establish if there was any further training or development requirements. Consequently refresher training has been developed and will be implemented in July 2017. The training meets the standards of the 'Training Specification for Medical Appraisers' produced by NHS England, by including the recommended focus on understanding the nature and purpose of medical appraisal for revalidation, which include; making judgements about when to postpone an appraisal, ensuring that the portfolio and discussion cover the full scope of the doctor's work, reviewing the portfolio of supporting information against GMC guidance, and the sign-off process and the outputs of medical appraisal. As part of the training, the appraisers will receive feedback from their current appraisees. Appraiser refresher training is a mandatory activity for all appraisers.
- Further to the external audit conducted in 2014 by Miad, and the Independent Verification Visit in 2015 from the GMC, we are currently in discussion with Bart's Health NHS Trust, to implement cross organisational auditing on the quality of completed appraisals.

***STATEMENT 5* - All licensed medical practitioners[5] either have an annual appraisal in**

[3] Core Standard 2.4.1
[4] http://www.england.nhs.uk/revalidation/ro/app-syst/

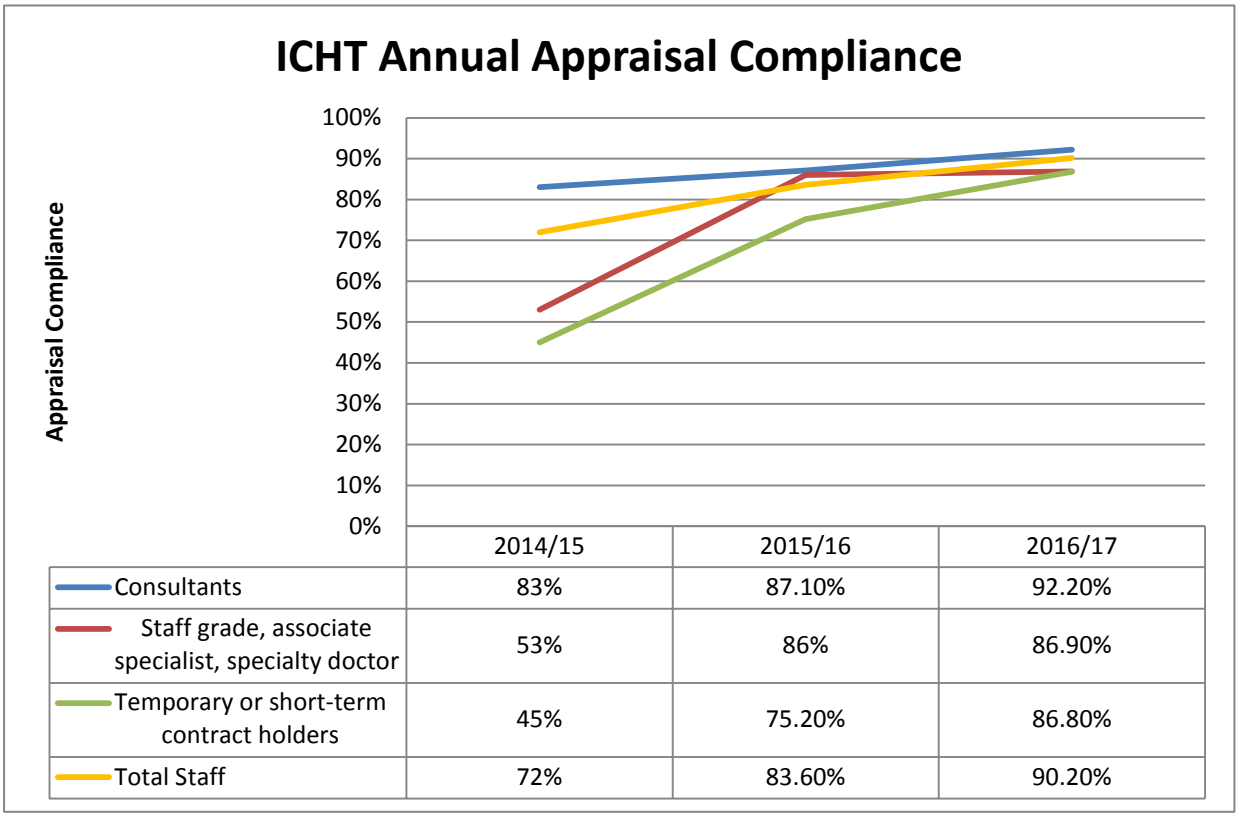
keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

As well as being a contractual requirement, annual appraisal for doctors is a requirement for GMC revalidation. Compliance with annual appraisal for 2016/17 was submitted to NHS England on 31st May and can be found in appendix B.

Of 1131 doctors, 1020 (90%) completed their appraisal in 2016/17, which is above the national average of 86.6%. Of the outstanding 111 appraisals, 17 of these missed appraisals were pre-approved. 94 were unapproved. Reasons for an unapproved overdue appraisal vary, but include unexpected long-term absences such as sick leave, or delays in obtaining sufficient supporting information for appraisal. The Trust has a clear process for dealing with unapproved missed appraisals. Initially, the professional development team follow up with the doctor in question and record the reason on an internal tracker. The doctor is then required to complete an appraisal postponement form, which allows for any mitigating circumstances to be taken into consideration, and a clear escalation process for where there are no mitigating circumstances.

FQA appraisal compliance for 2016/17 has increased from 2015/16 (+6.6%) (see table A). Appraisal statistics for each department are available to managers through the Qlikview system.

Table A: Annual Appraisal Compliance



	2014/15	2015/16	2016/17
Consultants	83%	87.10%	92.20%
Staff grade, associate specialist, specialty doctor	53%	86%	86.90%
Temporary or short-term contract holders	45%	75.20%	86.80%
Total Staff	72%	83.60%	90.20%

An annual audit of all missed appraisals was introduced in March 2016 and will be repeated by the end of the second quarter 2017/18.

***STATEMENT 6* - There are effective systems in place for monitoring the conduct and**

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

performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

Conduct and performance of licensed medical practitioners is managed by the division within which the doctor is based, through the speciality and directorate structure, with a process of escalation to the medical director/P&OD department if necessary and appropriate. Data on training, clinical outcomes (e.g. through clinical audit and mortality review), SIs and incidents, and complaints are routinely reviewed and monitored through the specialty, directorate and divisional quality and safety committees with exception reporting to the Trust quality and safety sub-group.

All appraisers are made aware through training of the information required to be reviewed at appraisal by the Trust, GMC and Royal College, and where the information can be obtained. This includes: internal training records for all core skills modules (available from WIRED); details of SIs, incidents and complaints that the doctor has been involved in (available from Datix); a mechanism for collecting patient feedback via an online questionnaire (SARD); and a mechanism for collecting colleague feedback through the PREP system.

For clinical outcomes data, Medical Royal Colleges and Faculties are responsible for setting the standards of care within their specialty, and for providing specialty advice and guidance on the supporting information required of doctors to demonstrate that professional standards have been met in line with the GMC requirements**.** This includes a review of Clinical Outcomes as part of their Quality Improvement Activity. The Royal College guidance is available on the internet, The Source, and included in the internal appraiser training programme.

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

The Trust has a published 'Handling Concerns about Doctors and Dentists' Conduct, Performance and Health' policy which outlines an established process within the Trust for dealing with any concerns about a doctor's fitness to practise, including those raised through appraisal, revalidation or job planning.

When concerns are raised by external bodies, e.g. GMC, or another healthcare organisation, the case is investigated by the RO, who will review all data available internally related to the doctor's conduct and performance, and respond as appropriate.

Concerns raised by patients are investigated through the Trust's complaints process.

***STATEMENT 8* - There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works[6];**

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

[6] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

information from other organisations where a doctor clinically practices during their revalidation period in line with the NHS Revalidation Support Team document (now NHS England) 'Information Management for Medical Revalidation in England'.

***STATEMENT 9* - The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[7] have qualifications and experience appropriate to the work performed;**

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

***STATEMENT 10* - A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance;**

Key achievements in 2016/17 include:

- Continued increase in overall appraisal compliance by 6.6%;
  - 0.9% increase in non-consultant appraisal compliance
  - 5.1% increase in consultant appraisal compliance
  - 11.6 % increase in temporary or short-term contract holders' appraisal compliance
- Continued provision of regular support for doctors across a variety of mediums
  - Monthly whole day drop-in session rotating across the Trust sites
  - Publication of the Responsible Officer's newsletter
  - One to one support four months prior to a revalidation date
  - Up to date pages on the Trust intranet site
- Quality Assurance of appraisal and revalidation process and procedures
  - Quality Assurance activity planned for 2017 with Bart's Health NHS Trust
  - Improved Educational Appraisal process in PReP

Key challenges that have been identified through the year include:

- Data quality issues in ESR.
- Honorary contracts process - accuracy of central electronic repository of honorary contracts which makes information sharing difficult, and on occasions it is difficult to ascertain whether a doctor does or does not hold an honorary contract.
- Whilst the service provided by Premier IT has shown some improvement, it still requires further development. We face continued problems with the Educational module, and the user interface is poorly received amongst the medical body.

The following actions are being taken to address the above issues and areas of non-compliance reported in the AOA:

- The professional development team do not have access to change data within ESR, but there is an initiative for the data to be corrected and during the recent job planning exercise, the professional development team and HR have worked together to capture errors and inconsistencies which need correction.

- The honorary contract process takes place within medical personnel, and changes to the current procedures are occurring.
- The contract with Premier IT will require renewal next year and we will look at alternatives to the system before we commence a tendering process. In the meantime we are working with PReP to explore the possibility of changing the front-end of the system to ensure it is intuitive to use.

2.2 Annual Organisational Audit

The annual audit provides assurance to patients, the public, the service and the profession that the systems and processes underpinning revalidation are in place and are working effectively. The Responsible Officer has confirmed that the Trust is compliant with all aspects of the AOA End of Year Questionnaire. This was submitted on 31st May and the final report is attached as appendix B.

2.3 Quality Assurance

Governance Arrangements

Progress is monitored through the Professional Development Team, with monthly reports provided to the executive quality committee and board quality committee (a sub-committee of the Trust Board) through the quality report. It is also reported monthly through the Trust Board scorecard.

The Professional Development team maintains an accurate list of doctors with a prescribed connection to ICHT, by cross referencing this against the organisational systems in addition to verifying information directly with the doctor. Where possible, doctors who are leaving the Trust are given advice at the end of their prescribed connection as to the next steps in their revalidation.

Further to the external audit conducted in 2014 by Miad, and the Independent Verification Visit in 2015 from the GMC, we are currently in discussion with Bart's Health NHS Trust, to implement cross organisational auditing on the quality of completed appraisals.

The GMC have informed us that we will next be due an Independent Verification Visit in 2020.

Policy and Guidance

The Appraisal Policy is currently under review. It is due to be published in February 2018.

Access, security and confidentiality

Information is stored either in a secure area on the Trust network electronic drives, or on the appraisal system PReP. PReP has been approved by the Caldicott Guardian and is due to be reviewed again on 11th August 2017, in line with local processes. Premier IT, the owners of PReP, take reasonable steps to protect any information a doctor submits via the System, in accordance with the Data Protection Act 1998. The Data Protection Act governs the collection, retention, and transmission of information held about living individuals and the rights of those individuals to see information concerning them. The Act also requires the use of appropriate security measures for the protection of personal data. Any information management breaches are escalated to the Professional Development team.

All information is handled in line with the document, 'Information Management for Medical Revalidation in England' produced by the NHS England team.

2.4 Quality Review Visit

Higher Level Responsible Officer (HLRO) Quality Review Visit

The NHS England London Revalidation Team visited Imperial College Healthcare NHS Trust, in December 2014 for a HLRO quality review visit. As well as highlighting good practice, the revalidation team also offered some recommendations outlined in a report received at the time. There are two outstanding actions:

- The development of an internal electronic patient feedback system in line with the Patient Experience team to provide a more efficient and cost-effective method to obtain patient feedback. This will be in place by April 2018;
- The recommendation to appoint a SAS (Specialty and Associate Specialist) lead doctor role is under review by the RO.

The London Revalidation Team confirmed in June that they will be conducting HLRO quality visits to all designated bodies over the coming year, with the Trust visit taking place in January 2018. Preparations are currently being made for this visit.

Recommendations

The Board is asked to:

- Note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable the statement of compliance to be submitted to NHS England by 29 September 2017.

APPENDIX A

Designated Body Statement of Compliance

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

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

   Comments: Yes

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

   Comments: Yes

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

   Comments: Yes

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

   Comments: Yes

5. All licensed medical practitioners[8] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

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

   Comments: Yes

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

   Comments: Yes

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible of-

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

ficer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Yes

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

Comments: Yes

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

Comments: Yes

Signed on behalf of the designated body

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

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

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

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

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust Board - Public	26 July 2017

Corporate Risk Register

Executive summary:

The Trust Board reviewed the Corporate Risk Register at its meeting in January 2017 as part of the agreed bi-annual process. A number of changes have been made to the Corporate Risk Register since the last update to the Trust Board, which have been approved by the Executive Committee and presented to the Audit, Risk and Governance Committee. Please refer to **Appendix 1** for a copy of the Trust's Corporate Risk Register.

At present, there are 16 corporate risks within the risk register, of which 10 are identified as operational risks and 6 as strategic. The highest risks are scored as 20 and the lowest is scored as 9.

Key themes include:

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

The following changes to the Corporate Risk Register have been made since the last review by the Trust Board in January 2017:

- Two risks have been de-escalated from the Corporate Risk Register:
  - *Risk 75 - Failure to provide safe Emergency Surgery at Charing Cross* and
  - *Risk 92 - Failure to ensure staff are immunised fully against those biological agents to which they are most likely to be exposed whilst at work*
- One new risk has been escalated to the Corporate Risk Register:
  - *Risk 94 - 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*
- The risk score for *Risk 93 - Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all N&M staff* has increased
- The risk scores for the following risks have decreased:
  - *Risk 81 – Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*
  - *Risk 67 - Failure to achieve benchmark levels of workforce engagement* and
  - *Risk 72 - Failure to implement, manage and maintain an effective health and*

safety management system.

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 are being reviewed.

There will be further discussion of the Corporate Risk Register at the Executive Committee on 25 July 2017. A verbal update will be given at the Board meeting on the outcome of that discussion.

Quality impact:

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

Financial impact:

Some of the risks outlined in Appendix 1 will have a financial impact and this is considered as part of existing work streams in relation to the risks.

Risk impact:

The impacts of each risk are captured within Appendix 1.

Recommendation(s) to the board:

- Note the changes to the corporate risk register
- Note the corporate risk register

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Valentina Cappo, Corporate Risk/ Project Manager	Janice Sigsworth, Director of Nursing	18 July 2017

Corporate Risk Register

1. Purpose

The following report provides an update on the Corporate Risk Register, including a summary of key changes since it was reviewed by the Trust Board in January 2017.

2. Background

The Trust Board reviewed the Corporate Risk Register at its meeting on 25 January 2017 as part of the agreed bi-annual process. The following governance process for risk management is in place within the Trust:

- **Directorate risk registers**; these are discussed and approved at directorate quality and safety meetings or equivalent; risks that cannot be managed locally are escalated to the divisional risk registers.
- **Divisional risk registers;** these are discussed and approved at the designated forums with responsibility for risk; in the clinical divisions these are the divisional Quality and Safety Committee.
  Key divisional risks are escalated to the Executive Quality Committee monthly by the attending directors and relevant updates are brought to the Quality Committee at every meeting.
  Key divisional risks from all divisions are presented to the Executive Committee quarterly.
- **Corporate risk register:** This is discussed and approved monthly at the Executive Committee, and is presented quarterly at the Audit, Risk and Governance Committee and six-monthly at the Trust Board.

3. Changes to the Corporate Risk Register

A number of changes have been made to the Corporate Risk Register since the last update to the Trust Board, which have been approved by the Executive Committee and are summarised below.
Please refer to **Appendix 1** for a copy of the Trust's Corporate Risk Register.

3.1 Risks de-escalated from the Corporate Risk Register

- ***Risk 75*** *Failure to provide safe Emergency Surgery at Charing Cross*
- A further two clinical positions have been recruited into, so the risk has been downgraded to a likelihood of 2, bringing the score to its target of 8 (L2 x C4).
- At the Executive Committee in February 2017 it was agreed that this risk be de-escalated from the Corporate Risk Register.

- ***Risk 92*** *- Failure to ensure staff are immunised fully against those biological agents to which they are most likely to be exposed whilst at work*
- There is now greater risk awareness amongst staff and, also, more effective mitigation arrangements in place.
- The likelihood of this risk materialising has reduced from possible (L=3) to unlikely (L=2) and the risk achieved its target score of 4 in March 2017.
- At the Executive Committee in March 2017 it was agreed that the risk could be de-escalated from the Corporate Risk Register to the People & Organisation Development (P&OD) Divisional Risk Register.

3.2 New risks escalated onto the Corporate Risk Register since January 2017

One new risk has been escalated to the Corporate Risk Register as follows:

- ***Risk 94*** *- 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 a change to legislation designating emergency departments as safe places to accommodate those in crisis, the number of patients attending the emergency departments at St Mary's Hospital (SMH) and Charing Cross Hospital (CXH) with a mental health related complaint has increased.
- At the Executive Committee on 25 April 2017 it was agreed that this risk be escalated to the Corporate Risk Register.
- This risk was presented to the Executive Committee on 24 May 2017, and again to the Executive Committee on 27 June 2017 to agree details and scoring.
- The Executive Committee has approved the risk with a score of 15.

3.3 Changes to risk score

The score for the following risks has increased:

- ***Risk 93*** *- Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing and Midwifery (N&M) staff*
- The risk score has been increased from 12 (L3 x C4) to 16 (L4 x C4) as we have not seen a reduction in vacancies.
- The way of measuring performance has been reviewed with a target of 12% vacancies across all nursing and midwifery posts; this will allow benchmarking ICHT performance against neighbouring organisations, both for internal use and when information is submitted externally.
- The overall N&M vacancy rate within the past few months has remained around 14%, with a rate of 14.6% in May; this compares well against an average 19% vacancy rate across London.
- Band 2-6 ward based N&M vacancy rate has been around 19%, and was 16.6% in May.

The score for the following risks has been reduced:

- ***Risk 81*** *– Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*
- Following publication of the CQC reports of the inspection of Outpatients and Diagnostic Imaging Services that took place in November 2016, the risk score has been reduced from 12 (L3 x C4) to 8 (L2 x C4) in May 2017.
- The likelihood of this risk materialising has been reduced due to the positive outcome of the inspection.

- ***Risk 67*** *- Failure to achieve benchmark levels of workforce engagement*
- The risk score has reduced from 12 (L4 x C3) to 9 (L3 x C3) due to the following:
- The latest Local Engagement Survey results have shown an overall increase in the engagement score from 77% in 2016 to 80% in 2017.
- The results from the 2016 National NHS Staff Survey also demonstrated an increase in the Trust's score.

- ***Risk 72*** *Failure to implement, manage and maintain an effective health and safety management system.*
- The risk score has been reduced from 12 (L3 x C4) to 9 (L3 x C3) to reflect more robust health and safety processes in place.
- This was evidenced by the findings of the Health & Safety Executive (HSE) inspections in November 2016, and also by the nature of the health and safety matters being reported upwards from the divisions and directorates.

4. Outcome of discussion at the Executive Committee on 25 July 2017

Due to the timing of the Trust Board meeting, there will be further discussion of the Corporate Risk Register at the Executive Committee on 25 July 2017, where it is likely that the following change will be agreed. The changes have subsequently been provisionally included in Appendix 1, as follows:

- ***Risk 81*** *– Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*
- On the 12 June 2017 the CQC published a new regulatory framework for NHS acute trusts, which includes the 'well led' inspection and the annual provider information return.
- Due to limited information and given this is entirely a new approach, the likelihood of this risk materialising has increased.
- It is likely that the risk score will go up from 8 (L2xC4) to 12 (L3xC4).

- ***Risk 73*** *Failure to deliver the Clinical Strategy Implementation programme (CSIP) to achieve long term sustainability, enhance acute services and support out of hospital care.*
- The Clinical Strategy Implementation Programme is now complete following discussions and the decision at the Executive Transformation Committee.
- All Phase 1 projects are complete with residual actions transferred to the relevant Divisions. Governance of Phase 2 Projects has transferred to "Emergency. Department (ED) Improving 4 hour performance Working Group", chaired by the Divisional Director for Medicine and Integrated Care.
- A proposal to close the risk was presented to the Executive Committee on 25 July 2017.

- ***Risk 87*** *Failure to comply with the statutory and regulatory duties and requirements, including failure to deliver OPD improvement plan*
- On 31 May 2017 the CQC published the reports of the inspection of the Outpatient and Diagnostic Imaging services that was held in November 2016.
- The CQC has acknowledged a significant improvement in outpatient services across the Trust's sites.
- It is likely that the risk score is reduced from 16 (L4xC4) to 12 (L3xC4).

A verbal update will be given at the Board meeting on the outcome of the discussion from the Executive Committee which took place on 25 July 2017.

5. Next steps

- The Corporate Risk Register will continue to be discussed at the Executive Committee each month and at the Audit, Risk and Governance Committee at each meeting.

6. Recommendations to the Board:

- Note the changes to the Corporate Risk Register,
- Note the Corporate Risk Register.

7. Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.
- To educate and engage skilled and diverse people committed to continual learning and improvement.

Imperial College Healthcare NHS Trust

Corporate Risk Register

Trust Board Committee

July 2017

V.70

Key: Scoring

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

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

Key:

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

Initial Score: The score of the risk when first identified

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

Trend / Movement: Arrow to show if the risk has increased ⇧ decreased ⇩ or remained the same ⇔ within the last four weeks.

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

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

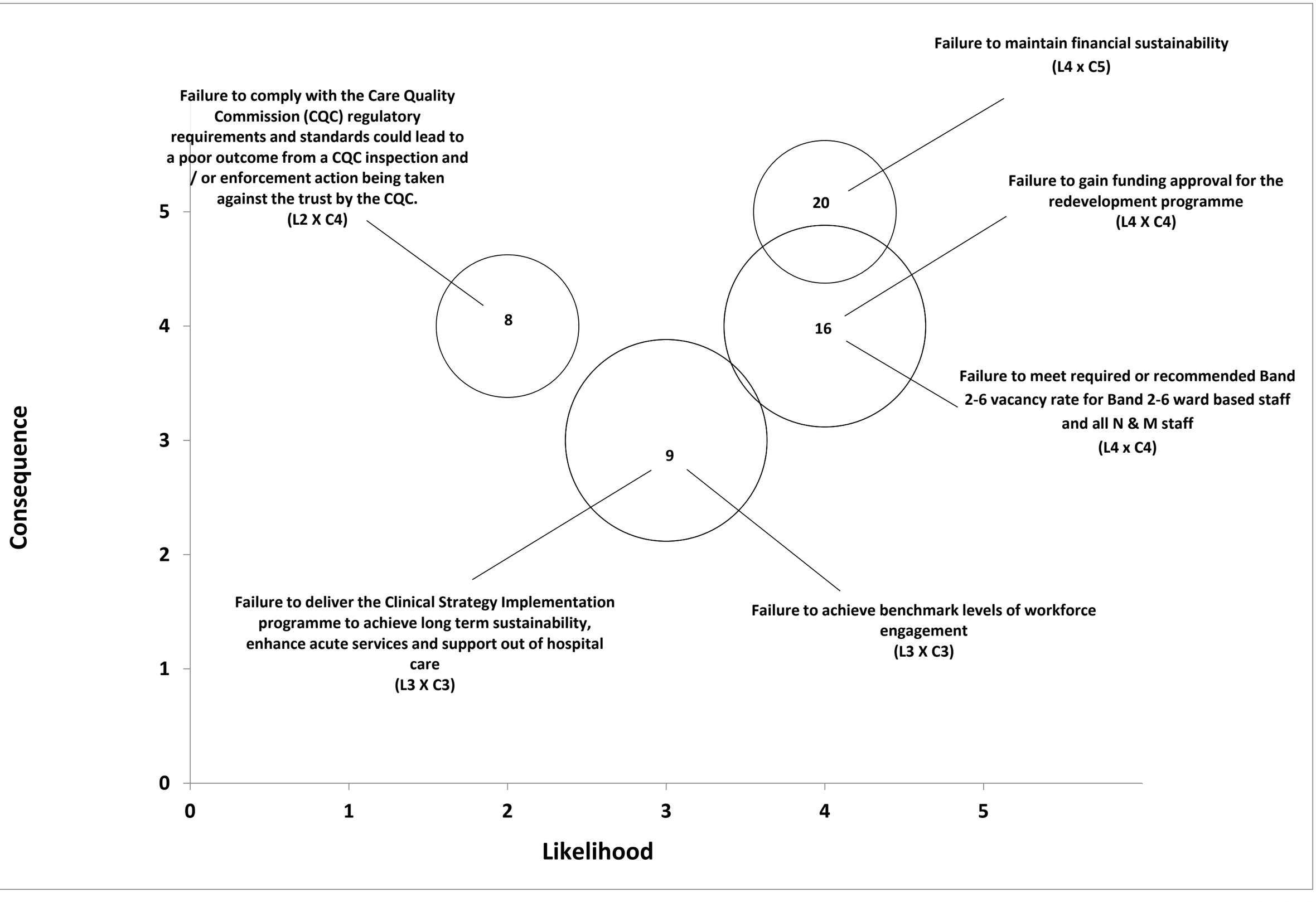
Corporate Risk Register Dash Board – Trust Board, July 2017

Corporate Risk Register			Lead Director	Initial Score	Date risk identified	≤6	8	9	10	12	15	16	≥20	Date to achieve target risk score
STRATEGIC RISKS														
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion														
81	Page 5	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.	Director of Nursing	16	Dec-14		○ ♦ ←			—				*Review Sep-17*
93	Page 6	Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff	Director of People & OD	12	Nov-16		○			→		♦		Mar-18
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement														
67	Page 7	Failure to achieve benchmark levels of workforce engagement	Director of People & OD	9	Oct-13	○		♦ ←		—				Aug-17
Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve														
74	Page 8	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive	12	Oct-14		○					♦		Dec-20
73	Page 9	Failure to deliver the Clinical Strategy Implementation programme to achieve long term sustainability, enhance acute services and support out of hospital care	Medical Director	16	Oct-14	○		♦						Oct-17
Trust Objective 5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance														
48	Page 10	Failure to maintain financial sustainability	Chief Financial Officer	20	Mar-12						○		♦	*Review Aug-17*
OPERATIONAL RISKS														
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion														
55	Page 11	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks *(Amalgamated with previous risk no. 89)*	Director of Nursing	20	Mar-11						○		♦	Mar-18
88	Page12	Risk of Spread of CPE (Carbapenemase Enterobacteriaceae)	Medical Director	12	Jul-15		○					♦		Oct-17
71	Page 13	Failure to deliver safe and effective care	Medical Director	12	Oct-14		○			♦				Dec-17
87	Page 14	Failure to comply with the statutory and regulatory duties and requirements, including failure to deliver outpatient improvement plan	Divisional Director of WCCS	12	Jul-15		○					♦		*Review Aug-17*
7	Page 15	Failure to maintain key operational performance standards	A&E: Divisional Director of MIC RTT: Divisional Director of SCC Diagnostics: Divisional Director of WCCS	15	Jun-07					○			♦	Mar-18
91	Page 16	Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust	Divisional Director of SCCs	16	Jun-16	○						♦		Jan-18
94	Page 17	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues as a result of increasing volume of attendances and significant delays for those patients requiring admission to a mental health bed	Divisional Director of MIC	15	Jun-16		○				♦			Dec-17
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement														
65	Page 18	Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors	Medical Director	12	Feb-14		○			♦				Sep-17
72	Page 19	Failure to implement, manage and maintain an effective health and safety management system	Director of People & OD	12	Oct-13	○		♦ ←						Oct-17
Trust Objective 5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance														
90	Page 20	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer	16	Jul-15							○ ♦		*Review Sep-17*

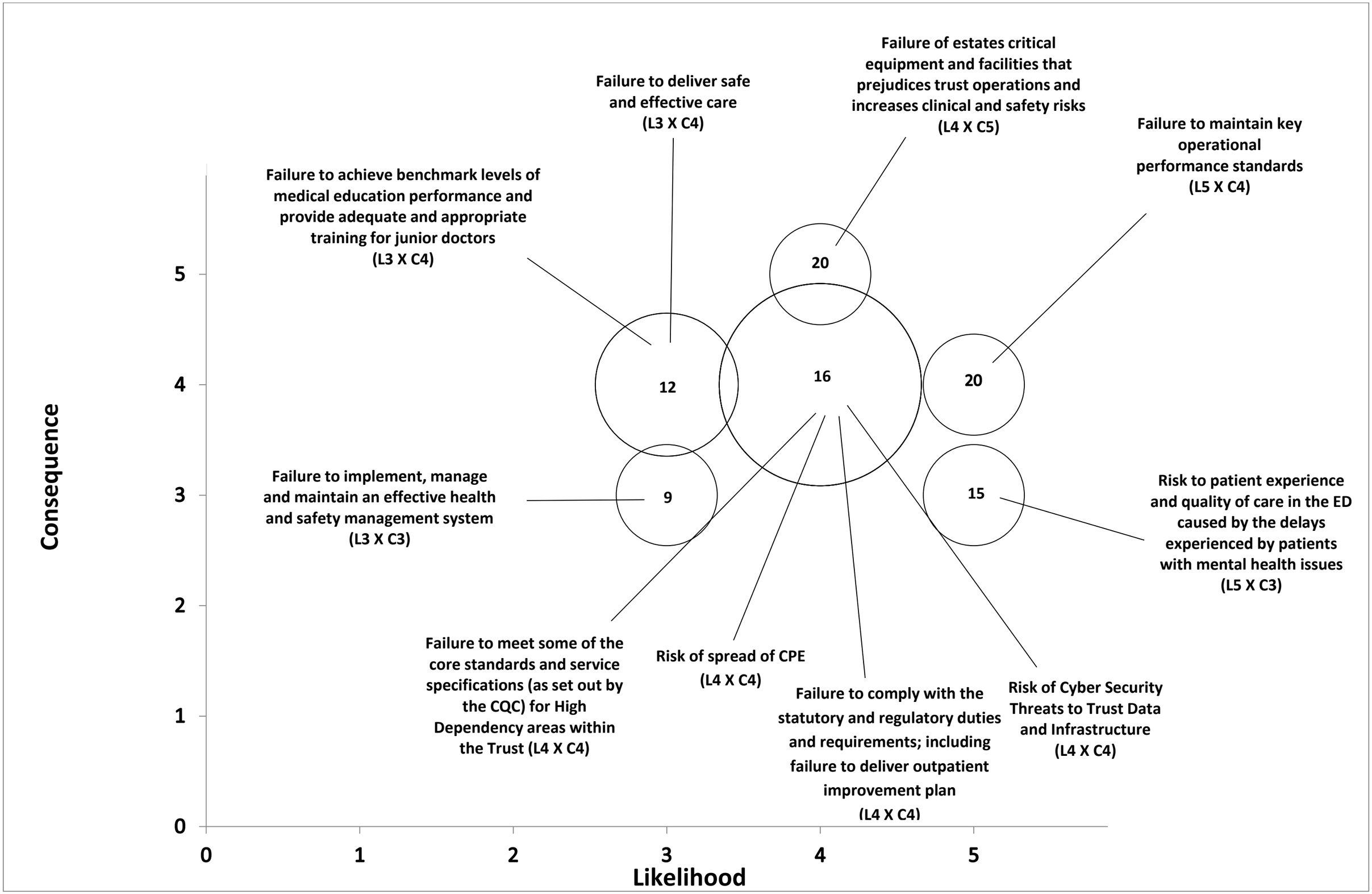
Key:

→ Arrow indicates movement since last report
♦ Diamond indicates current score
O Circle indicates target risk score
* Star indicates new risk since last report

Trust Risk Profile – Strategic Risks



Trust Risk Profile – Operational Risks



Strategic Risks

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Impact / Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
81 / Datix 1599	Director of Nursing	Strategic Planning / Strategic risk	1	Dec 14	**Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.** **Cause**: • Lack of organisational understanding and experience of the 2017/18 CQC regulatory approach which includes the 'well led' inspection and the annual provider information return. • Lack of robust systems and processes which enable the trust to achieve regulatory compliance and to drive improvement • Failure of staff to adhere to trust and local area policies, procedures, guidelines, etc. • Failure of staff to: o Seek and take account of regulatory advice o Participate in the trust's Improvement and Assurance Framework, and ensure action is taken in response to recommendations resulting from framework activities o Participate in the trust's Improvement and Assurance Framework • Lack of resource to support work and improvements relating to identified non-compliances and failures to deliver improvements **Effect**: • Reduction in the quality and safety of patient care: o Greater number of incidents relating to patient safety, and of potentially greater severity o Increase in poor patient experiences and complaints • Breach of regulatory requirements and failure to achieve regulatory standards **Impact**: • Potential for criminal prosecution • Potential restriction on individuals' ability to practice and / or restriction / closure of trust services • Poor reputation • Potential for financial impact: o Penalties imposed by the CQC o Reactive and inefficient ways of working o Increased use of bank and agency staff due to inability to recruit and retain staff o Increased claims and litigation, including increased CNST payment • Potential loss of revenue: o NHS income ▪ Inability to deliver services ▪ Termination of contracts by commissioners o Reduced business for Imperial Private Healthcare	3 x 4 16		• The trust has a dedicated Regulation Manager with a significant healthcare regulation background, including experience with inspections and policy development in the CQC's current regulatory approach • An Improvement and Assurance Framework was implemented at the trust during 2015/16 (currently under review). The framework is modelled on the CQC's inspection methodology for NHS acute trusts and is adapted when the CQC make changes to their regulatory approach. o Activities carried out under the framework include: ➢ Quarterly service checks to ensure the trust's CQC registration is kept up to date ➢ Divisional self-assessments against the CQC's five domains of care, which include a 'confirm and challenge' exercise to provide assurance about the validity and robustness of self-assessment outcomes ➢ Service and themed quality reviews using the CQC's inspection methodology ➢ Ward accreditation programme for inpatient areas and main outpatient services ➢ Management of CQC inspections, including responding to CQC inspection findings o Delivery of the framework and the outcomes of framework activities are reported to the Executive (Quality) Committee and Quality Committee, and the Trust board. • Departments, directorates, corporate areas and divisions undertake local monitoring activities and report the outcomes through local governance processes and as appropriate (may be a summary, may be by exception) to the Trust's Executive (Quality) Committee and Quality Committee, and the Trust board. • Incidents and complaints are monitored and reported as part of divisional and the Trust's Quality Reports o Issues with lack of resource can be addressed and escalated via local processes and via the Executive Committee.	2 x 4 8		Current	• The Trust's *CQC Registration and Inspection Framework* is being amended in response to the June 2017 publication of the CQC's new approach for managing NHS acute trusts: o The Trust's framework is expected to be finalised in August 2017 o Procedures and guidance are being developed to support areas during what will now be unannounced inspections of core services o There will be centralised management of a new annual trust-level inspection of the well-led domain. An inspection preparation plan is being developed for the first of these and is expected to commence in September 2017. o A procedure for preparing the Trust's new annual Provider Information Return (PIR) is being developed o Tools and templates are being prepared to support areas to carry out self-assessments against the CQC's standards, and for divisions to report 'CQC readiness' of their areas to the Executive (Quality) Committee • Following CQC inspections of three of the Trust's core services during 2016/17: o Significant improvements were identified in main outpatients with improved ratings at all sites ▪ No major concerns were identified for devolved outpatients areas or diagnostic imaging at St Mary's and Hammersmith hospitals ▪ Concerns were raised in relation to diagnostic imaging and the Radiotherapy service at Charing Cross Hospital; actions to improve have been completed or are underway o Inspection reports for Maternity at St Mary's Hospital and Medical care at St Mary's, Charing Cross and Hammersmith are expected between July and September 2017 • CQC inspections of DHL (Feb 2017) and the UCC run by Vocare (July 2017) have been undertaken and the reports are yet to be published. Whilst not inspections of the Trust, there may be implications for the Trust if any concerns are raised given DHL is sub-contracted by the Trust and Vocare operates on Trust owned premises. . Routine administration to keep the Trust's CQC registration accurate and up to date is managed in line with the Trust's *CQC Registration and Inspection Framework.* **Target risk score date: *Review September 2017*** ⇩		2 x 4 8	• Prioritise the use of internal expertise and act on their recommendations based on quality and safety information about the trust • Benchmark the trust's approach and performance against similar trusts • New trust organisational structure from April 2016 will support improved accountability at executive and senior level • Commission external review and support as needed

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Impact / Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
Risk 93/ Datix 2293	Director of People & OD	KPIs / Strategic Risk	1	Nov 16	**Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all N&M staff** **Cause:** • National shortage of N&M in some disciplines • Conflicting operational priorities slowing down recruitment process. • Competition from neighbouring Trusts attracting potential employees • High turnover especially for Band 2 & 6 & N&M staff • High turnover of Band 5& 6 N&M staff within two years of joining • Tier 2 visa requirements • The increase in emergency activity has resulted in additional capacity which requires the recruitment of staff. • Additional beds opened • Planning for additional posts is reactive compared to planning for additional beds **Effect:** • Reduced staff morale /increased turnover /Increased rates of sick absence – vicious circle • Increased bank and agency usage • Poor patient experience • Poor organisational performance • Inability to recruit high quality candidates • Potentially increased incidents **Impact:** • Potential to increase costs: Bank & Agency • Potential reputational with adverse revenue impact: reduction in market share • Potential to increase costs: reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and Enforcement Notices	3	4 12	• Restructured recruitment teams in place to reduce the total time to hire. Additional checks being monitored daily to increase the pace & quality of activity. Three Resourcing Business Partners have been added to the team act as account managers for Divisions, run centralised campaigns and also manage campaigns for hard to recruit areas. • Monthly meetings in place with Divisions to review vacancy rate, recruitment activity and impact of this • Recruitment and attraction strategy and plan in place which focuses on Divisional (rolling adverts and bespoke strategies) and across Trust activity (Student Nurse campaign and Open Days), as well as broadening channels used to increase the pipeline • All current vacancies for nursing in key areas advertised • Safe staffing on wards monitored through monthly fill rate reports for nursing by division. • Bank and agency support available • Monthly exception reports now produced for Divisional Quality and Safety Committee • A new revised retention plan is being developed to reduce the turnover for all N&M staff and for Band 2-6 ward based staff • Associate Director of HR Operations and Resourcing working with Business Partners to monitor vacancy levels. • Resourcing & Retention Task and Finish Group established, chaired by the Director of People & Organisation Development. Ward by ward focus and action plan to fill vacancies.	4	4 16	Current	• Recruiting to 12% or less vacancy level for all N&M staff. • Strategic People Planning meetings have been redesigned and have been re-launched. • On-going activity across the Trust and Divisions on HCA rolling adverts, across Trust monthly Open Days, Fairs, Capital Nurse Programme and Student Nurses scheme. • Attain bank fill of 90% by improving management of requests. • Increased use of social media and broadening of channels to increase the profile of the Trust and attract more candidates. • Revised Student Nurse recruitment is in place which has improved conversion rate to 60%. • Diagnostics exercise being developed to better target the retention strategy. New retention strategy in place since February 2017. • Recruitment and Retention Programme have been commenced to respond to challenging turnover and recruitment issues. • Way of measuring performance has been reviewed with a target to 12% vacancies across all nursing and midwifery; this will allow benchmarking ICHT performance against neighbouring organisations, both for internal use and when information is submitted externally. • The overall N&M vacancy rate at the end of May was 14.6%. This compares well against an average 19% vacancy rate across London. • Band 2-6 ward based N&M vacancy rate was 16.6% in May – this figure is hard to track against other trusts as they do not track the vacancy rate for this population. • Turnover rate for the Band 2-6 ward based N&M staff also affects achievement and sustainability of the 12% N&M vacancy rate target. The Recruitment and Retention Programme aim is to address turnover by March 2018. **Target risk score date: March 2018**	⇧	2 x 4 8	• Continue to monitor impact of changes and implement further corrective measures as needed • Use of Bank & Agency staff • Reduction in activity • Escalation of staffing issues through divisional management structure and site team • Early identification of staffing issues with shifts put out to bank and agency. • Reed introducing a “refer a friend” scheme to attract more bank workers.

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Impact / Cause / Effect)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
67/ Datix 1601	Director of People & OD	Staff engagement surveys / Strategic Risk	2	Oct 13	**Failure to achieve benchmark levels of workforce engagement** **Cause:** • Senior leaders fail to empower/ inspire staff • Job not regarded as good for health • Organisation not seen to be taking positive action on health & wellbeing • Opinions thought not to count • Managers not undertaking PDR's • Trust not employing 'the right people in the right posts', **Effect:** • Reduced staff morale/increased staff turnover/ Increased rates of sick absence / bank and agency usage • Lack of engagement • Poor patient experience /Poor organisational performance • Increased safety risk to patients • Inability to recruit high quality candidates • Staff sickness **Impact:** • Potential to increase costs: Bank & Agency • Potential Reputational with adverse revenue impact : reduction in market share • Potential to increase costs :Reactive & Inefficient ways of working	3	3 x 3 9	• NHS survey • Communications events – Open Forum, Divisional Forums Newsletters • Source communications • Monitoring at Executive Committee • Monitoring at Quality Committee & Trust Board • Discussed at Divisional reviews • Director of P&OD attends Quality Committee • Health and Wellbeing Strategy developed • People strategy • Make a Difference people recognition scheme • Monitoring of any 'hot spot' lack of engagement areas • 'In our Shoes' workshops to discuss staff engagement at ward or departmental level	3	3 x 3 9	Current	• In 2015 the National Staff Survey showed a deterioration on our Engagement score and a drop in our rankings when compared to other Acute Trusts from "Above Average" to Bottom 20%. • In response we took a number of key actions to address this:- • A New annual Trust Engagement Survey was introduced and run in August 2016. This has a new methodology and a new baseline Total Engagement score of 77%. Response rate was strong with 3224 responses. • The Standard FT questions in the new Survey showed improvement in the scores as follows: o 83% of respondents would recommend this Trust as a place for care or treatment (77% in our last Engagement Survey) o 65% of respondents would recommend this Trust as a place to work (60% in our last Engagement survey) • The results have now been made available to all managers down to Ward/Department level and Action plans have been returned to the People & Organisation Development team, who are designing a "You Said, We Did" video to capture the activities being undertaken within the action plans. Video will be used to promote the engagement programme and working to a completion of May 2017. A number of tools have been made available to managers to help them implement action including a "Managers guide", "In Your Shoes" workshops, and QI support. • As a result in the 2016 National Staff Survey our score increased to 3.8, the highest score to date in this survey and out ranking has changed from "Bottom 20%" to "Average" when compared to all acute Trusts. • The report of the latest Local Engagement Survey "Our Voice our Trust", which was run across the Trust between 2 May and 30 June 2017, have shown an overall increase in the engagement score from 77% in 2016 to 80% in 2017. **Target risk score date: August 2017**	⇩	2	3 x 2 6	• Continue to monitor impact of changes and implement further corrective measures as needed • Any identified hot spots to be directly addressed with tailored action plan

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk	Initial Score		Key Controls	Current Score		Proximity	Actions and Progress report	Trend / Movement	Target Score		Contingency Plans
					Impact / Cause / Effect / Impact	Likelihood	Consequence		Likelihood	Consequence				Likelihood	Consequence	
74 / Datix 1602	Chief Executive Officer	Risk Workshop / Strategic Risk	4	Oct 2014	**Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration, including PICU and WEH** **Cause**: • Case for change not sufficiently clear and/or compelling therefore insufficient support for key aspects of our clinical strategy from stakeholders. • Delays to obtaining planning permissions • Technical design and build issues lead to unanticipated challenges and project creep • Increase in costs beyond currently expected levels through indexation, due to delays in business case. • Inability to obtain sufficient and timely funding • Insufficient organisational capacity to capitalise on strategic and commercial opportunities. • Failure to achieve support for key aspects of our clinical transformation, especially service reconfiguration and estate redevelopment from one or more key audiences / stakeholders • Lack of internal resources allocated to deliver the programme • Backlog maintenance costs increase **Effect**: • Poor organisational performance – inefficient pathway management • Poor reputation with regulatory bodies • Failure/delays in implementing new clinical models and new ways of working • Deteriorating and / or inadequate estate • Failure of critical equipment and facilities that prejudices trust operations • Reduced staff morale and staff engagement • Reduced confidence in our services/public concern about their services • Difficulty in programming interim capital projects **Impact**: • Reduction in patient experience and satisfaction • Poor staff experience and increased staff turnover • Potential increase in clinical incidents • Potential increase in staff health and safety incidents • Potential loss of income • Potential reputational impact with stakeholders - Loss of market share • Poor patient experience	3 x 4 12		• Regular meetings with NHSE, NHSI, CCG partners for early identification of potential issues/changes in requirements • Reports to Trust Board and ExCo • Regular meetings with Council planners and GLA • Active management of backlog maintenance. • Active ways of engaging clinicians through models of care work • Active stakeholder engagement plan, including regular meetings and tailored newsletters/evaluation • Active internal communications plan, including CEO open sessions • Internal and external resource and expertise in place.	4 x 4 16		One to six months	• Option 4c is trust preferred option within financial constraints • Meetings with NHSE/NHSI, STP and SAHF team on-going. • Implementation Business Case will be split into two (Inner and Outer schemes in North West London). Strategic outline case (SOC) 2 currently on hold • Strategic estates advisor work on-going • Active engagement with developers of adjoining sites on-going • Internal and external stakeholder engagement strategy to manage relationships. • Approval given to explore the phase one of the redevelopment of St Mary's Hospital, working with Imperial College Healthcare Charity and SOC approved by NHSI and the Department of Health. • Planning application for phase one of the SMH redevelopment submitted to WCC. • Space utilisation panel established. This will review and prioritise uses of space across the trust. • Decant plans being developed. • Phase One Project Board established. • Staff consultation commenced July 2016. • Next steps to review option 4c to ascertain what is feasible within current funding levels. • Public exhibition held 8-10th September 2016. • Work on Phase one outline business case has commenced. • Approval has been given by the redevelopment committee and NHSI to prepare a strategic outline case for the St Mary's Hospital redevelopment plan. This will include a soft market testing exercise with commerical developers. The aim of this is to determine developer interest. **Target risk score date: December 2020**	⇔	2 x 4 8		• Develop site based redevelopment solutions • Maintain flexibility to respond to any changes in demand as required • Identify and develop alternative options • Increase priority of stakeholder engagement activities

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
73 / Datix 1510	Medical Director	Risk Workshop / Strategic Risk	4	October -14	**Failure to deliver the Clinical Strategy Implementation programme (CSIP) to achieve long term sustainability, enhance acute services and support out of hospital care.** **Cause:** • Failure to set up an adequately resourced and skilled programme group • Lack of engagement with clinical and managerial staff • Lack of support from commissioning colleagues • Lack of engagement from external stakeholders • Unknown / changing economic landscape affecting health care needs • Modelling assumptions for services are based on incorrect or inappropriate data • Clinical leads do not have capacity to deliver workstreams • External stakeholders and public consultations do not support the proposed changes • Lack of finance and information capacity **Effect:** • Capacity at SMH remains constrained • Clinical services are not configured appropriately to optimise the space available in the new hospital building at SMH • Unable to move to a 24/7 model of care • Unable to deliver highest possible quality of care • Failure to improve patient experience • Failure to meet efficiency KPI • Failure to grasp opportunities in development of personalised medicine • Inability to support out of hospital care **Impact:** • Poor patient experience and clinical care as not responding to changes in clinical practice and advances in clinical care • Potential to incur contractual penalties (due to higher demand for trust services impacting upon waiting time) • Potential for loss of NHS income • Potential for increased costs as result of reactive and inefficient ways of working • Failure to meet Trust strategic objectives • Failure to maintain high calibre employees • Potential to incur penalties and/or fines: Contractual and Enforcement notices (Financial penalties resulting from non-compliance) • Loss of reputation with commissioners and public • Financial loss due to amendments to build of new hospital at SMH	4	4 x 4 16	• Deputy Medical Director responsible for management of project • Clinical strategy in place • Estates strategy in place • Initial programme plan approved including phase one workstreams • Governance structure defined • Links with Estates Redevelopment Programme established – Deputy Medical Director is clinical lead • Initial scoping work completed • Links to quality strategy and CQC action plan • Clinical leads appointed for each workstream • Executive Transformation Committee established • Working groups established for each workstream	3	3 x 3 9	Current	**Phase 1** • Acute Medicine removed from HH on 03/08. • Phase 1 of new Chest Pain pathway commenced implementation on 03/08. • Ambulatory Emergency Care (AEC) programme complete. • Vascular Surgery Options Appraisal completed and presented to Executive Committee. Two Business Cases to be developed (by Divisions of Surgery, cancer and Cardiovascular and Womens, Childrens and Clinical Support) and presented to the Executive Transformation Committee in September 2017. **Phase 2** • Phase 2 of the Clinical Strategy Implementation Programme approved by ExTra 09/02/15. • CSIP team merged with QI and Safety Culture Teams to form Improvement Team, based in the Office of the Medical Director. Outstanding work is currently in transition to the divisions, or being reviewed as part of the prioritisation of the current improvement team workload. • Ongoing programmes: **i. Improving ward flow (Governance transferred to "ED Improving 4 hour Performance Working Group")** • Diagnostic phase complete • Clinical Leads appointed Oct 2016 • Pilot phase commenced: Workshops delivered across 3 sites. PDSAs and driver diagrams developed. • 4 workstreams identified (Board Round, Pharmacy/Dr interface, Patient Empowerment, and Discharge Lounge usage) Social Worker involvement being covered by another workstream led by Rebecca Campbell. • EDC/Pharmacy work underway on Manvers/Thistle, SMH & 7S CXH • Board Round/handover on 11south and 7W CXH, and Manvers SMH • Outcomes to be shared and rolled out to other wards from summer 2017 (priority ward to be ID'd by divisions) • New Governance structure designed to support reporting to 4hr perf. Goes live w/c 17th July. • Reporting to national "8 High Impact Change" programme scoped with leads of 2x 4hr workstreams (Discharge and Flow) and appear to be covered. **ii. Older person with frailty (Governance transferred to "ED Improving 4 hour Performance Working Group")** • Core group well established and lay members approached • Monthly meetings of Sub groups on CHX and SMH-over 55 MDT members led by clinical leads • Diagnostic phase in progress with current state mapping • Pilot projects identified (e.g. SMH QEQM 1st floor frailty pilot) • Data dashboards in development • HENWL funding secured for Frailty boot camp • Sustainability of workforce model will be reviewed following completion of 1st Floor pilot end of July. (Review to be shared in Sep). Clinical Strategy Implementation Programme now complete following discussions and decision at the Executive Transformation Committee. All Phase 1 projects complete with residual actions transferred to the relevant Divisions. Governance of Phase 2 Projects transferred to "ED Improving 4 hour performance Working Group" chaired by Divisional Director for Medicine and Integrated Care. Risk can therefore be closed. **Target risk score date: October 2017**	⇔	1 x 3 3	• Process to be managed through the Medical Director's office with nominated clinical leads

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Impact / Cause / Effect / Impact)	Initial Score: Likelihood	Initial Score: Consequen	Key Controls	Current Score: Likelihood	Current Score: Consequen	Proximity	Actions and Progress report	Trend / Movement	Target Score: Likelihood	Target Score: Consequen	Contingency Plans
48 / Datix 1597	Chief Financial Officer	Risk Assessment / Operational Risk	1	March 2012	**Failure to maintain financial sustainability** **Cause:** • Poor RTT performance could lead to excessive fines at a level significantly exceeding Trust budget from 17/18 • Loss of DH/NHS England (Diamond) income for complex specialist treatments • CCG affordability pressures combined with historic planning gap leading to increase in level of challenges and lack of recurrent reinvestment. Huge challenge for 17/18 • Historic dependence on non-recurrent funding sources masked underlying financial picture • Failure to increase private patient income as planned • Annual reductions in Education and Training funding • Correction of historic usage of R&D funding for clinical subsidy • Additional costs of operating across three sites & with outdated estate and aged equipment • Slower-delivery of Clinical Strategy Implementation Plan • Agency costs (at premium rates) incurred to cover substantive roles • Investments in Acute medical model • Investment in implementation costs of Cerner including data validation • NWL Pathology project represents a significant investment in a complex project **Effect:** • Failure to secure the full £24m of Sustainability and Transformation funding • Failure to deliver a financial surplus • Reputational risk of being in significant deficit and failure to commit to 17/18 Control Total • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures • Dependence upon DH revolving working capital facility • Dependence upon SaHF for site redevelopment project costs & Charity for major capital investments **Impact:** • Delays/cancellation of planned investments including projects for improved financial sustainability, estate and quality initiatives with risk to service viability • Previous guidelines now mandatory as linked to cash support • Enforced, rapid 10% cut on corporate functions has increased the risk of reduced control and service • Potential conflict between delivering operational targets and hitting financial goal, greater focus on financial priorities by all staff • Reduced capacity to engage with wider healthcare community & issues • Redesign/exit unsustainable service impacts: potential loss of revenue, including NHS income, research and education income, other income	4 x 5 20		• PWC engaged to carry out Causes of the Deficit work • Weekly CEO meeting with RTT turnaround team. Close monitoring with commissioners and regulators • CEO & CFO engagement with Provider Network, AUKUH, Shelford etc, to lobby on system issues pressures including Tariff and Diamond – reports to FIC and Trust board • Affordability gaps with commissioners minimised in 16/17; divisions fully engaged with Contracting process , senior engagement with STP demand reduction programme • Active cash management and reports to FIC and Board. • Monthly financial reporting and performance reviews reported up to FIC and Trust board • CIP, CSIP, QI and all major change programmes report to monthly Executive Transformation Committee and then to FIC • Performance oversight by NHSI • Cash controls: o Stock control – minimizing working capital tied up in stock o Cash monitoring – tracking forecast daily cashflows to identify risk points o Debt collection – maximizing cash collection from debtors o Creditor management • CEO led joint planning meeting with Charity • Full engagement in SaHF programme seek to maximise Trust gain and mitigate risks from broader initiatives • CEO leads for providers in the regional planning process (STP) • NWL Pathology joint Operations service now in place from April 2017. Three separate Executive leads for ICHT as Host, Owner & Customer	4 x 5 20	Current	**Working capital**: • Agreement of revolving working capital facility up to £65m from the Department of Health • Implementation of 13 week cash flow management model from April 2016 and weekly cash committee to review working capital position • Effective management of all working capital arrangements, improvement in effectiveness of forecasting and further action to recover income and manage accounts payable **I&E:** • Engagement with NHS Improvement's 'Financial Improvement' programme (FIP2) • Cost management teams of 3 (known as Cost Control Trios) for each directorate (Pilot began in April 2016, full implementation with advice / assistance from FIP partner) – progress reviewed weekly as part of FIP • Discussions with commissioners re their financial support • Speciality reviews started in April 2017 designed to identify key further opportunities towards sustainability of all service lines – sustainable operating model being developed to deliver reviews of all service lines by the end of next financial year, with sustainability and transformation plans for each service submitted to FIC **Long term:** Trust wide engagement in SAHF & STP programme (including consideration of long term financial modelling, sustainability and site strategy) A review of the target risk score date will be done in August 2017 after Quarter 1 financial position has been analysed. **Target risk score date:** ***Review in August 2017***	⇔	3 x 5 15		• Revolving working capital facility provides cash support cover of up to £26m (£16m has been drawn down YTD) – with the ability to extend the limit up to £65m. (However, note that these national arrangements are interim while a permanent process is being agreed between DH and NHSI)

Operational Risks

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk (Cause / Effect / Impact)	Initial Score (Likelihood / Consequence)	Key Controls	Current Score (Likelihood / Consequence)	Proximity	Actions and Progress report	Trend /Movement	Target Score (Likelihood / Consequence)	Contingency Plans
55 / Datix 1607 (merged with risk 89 1608)	Director of Nursing	Strategic planning / Operational Risk	1	Mar 11	**Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks** **Cause:** • Historic under investment • Obsolescence of the estate • Availability of capital and revenue funding • Inability to retain core competencies within the workforce • Delay in delivering NWL reconfiguration plans **Effect:** • Possible short-notice closure of facilities due to critical equipment failures and breakdowns (e.g. lift breakdowns, chillers and plant failures, infrastructure and effect on environment) resulting in loss of capacity • Obsolete infrastructure, plant and equipment installations that do not meet current standards • Inability to keep up with repair requests and minor improvements for operational / clinical benefit • Reduced staff morale leading to higher turnover and increased rates of sickness absence • Loss of reputation and reduced confidence from key stakeholders • Increased waiting times for patients • Increase length of stay for patients • Breaching waiting targets and diagnostic targets **Impact:** • Potential to incur penalties /fines: Enforcement Notices • Inability to effect changes to estate in order to achieve transformation of clinical services • Potential to increase costs: Reactive & inefficient ways of working • Potential reputational Impact: Loss of market share • Potential to increase costs: i.e. claims and litigation impact on CNST payment • Potential to increase costs: Bank & Agency staff	4 x5 20	• Implementation of new Hard Facilities Management (Hard FM) Managed Service solution through specialist maintenance provider CBRE Ltd from 1/4/16 to provide improved compliance and responsive reactive repair maintenance service. • Retention of Senior Estates Management team structure to deliver 'informed client role' to ensure effective and compliant delivery of contract against specification and performance standards. • Statutory and regulatory inspections have been re-scheduled to ensure compliance with statutory and mandatory undertakings and to minimise impact on front line service • All planned (PPM) and reactive (repair) maintenance works managed through computer aided maintenance management system (CAMMS) to provide improved programming and management reporting. • ExCo updated on 10/10/15 of current Trust Backlog Maintenance Liability of £1.3b (total project investment costs) and request for £131m Capital Backlog Maintenance funding over the period 2016/2021 to mitigate high and significant risk items. • Successful delivery of 2015/16 Capital Backlog Maintenance programme to mitigate Risks ≥ 16 Investment programme funding of £14m subsequently reduced mid-year to £11.5mand programme re-profiled accordingly. Risk prioritised Projects to the value of £11m delivered. • The 2016/ 17 Capital Backlog Maintenance programme of £10.42m Capital Backlog Maintenance, plus £0.8m contingency has been allocated to target the highest risk areas focusing on addressing single points of failure, emergency plant, equipment and infrastructure upgrades. • £1.1m additional Capital funding allocated to upgrade HH electrical Infrastructure to support known increase in supply capacity requirements. • Formal reviews of Hard FM operational performance are conducted continually review performance against contract. • PLACE (Patient-Led Assessment of the Care Environment) lead by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works. • Monthly Estates & Facilities Quality Committee for closer collaborative working with front line services and appropriate reporting to monitor/improve performance. • Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services • Estates & Facilities H&S, Fire and Compliance committee has been established to formally report and monitor statutory/mandatory compliance. • Quarterly reporting	4 x 5 20	Current	• Hard FM managed Service contract commenced in April 2016 with CBRE as service delivery partners. CBRE have now completed their Asset verification and condition surveys. It is now clear that the asset schedule issued as part of the contract procurement process is now disputed by CBRE and it will be necessary for the Trust to enter into a reconciliation exercise as a contract variation is now more likely to be required to align any significant differences with the latest survey and as such the contract may increase. A 3 month transition period was agreed to allow the contact to 'bed in'. KPI performance has been monitored during this period but KPI penalties have not been implemented prior to 30/6/16. This transition period has been extended due to delays in CBRE being able to fully implement their IT solution. The IT connectivity issue has been resolved and the Trust met with CBRE in February to review the KPI system. This work is ongoing as part of the resolution meetings referenced above. • An enhanced Planned Preventative Maintenance (PPM) programme is in place to reduce the risk of key equipment failures together with regular testing of equipment and systems. This is not yet achieved due to the issues with the CBRE contract. • All departmental Health and Safety Policies and Procedures have been reviewed following organisational change. All policies are being updated to reflect new ICHT organisation restructure • Formal safe systems of work duty holder appointment letters have been updated and re-issued to reflect ICHT organisation restructure. • Risk review workshops scheduled to update departmental risk registers and the action plans prioritised to ensure that all statutory, regulatory and preventative checks and maintenance are identified, programmed and carried out as quickly as possible within the constraints of available resources • A full Estate code 6 Facet Estate code condition survey was completed in early November 2015. Orders have been issued for a 20% update of the survey in accordance with Estate code guidance. The updated survey data identifies and prioritises future capital investment priorities. This document is continually updated to reflect investment and mitigation of backlog risk. • Review of 6 facet Condition Survey undertaken, including re-profiling and verification of data that has provided a 5, 10 and 15 year capital backlog funding look ahead to support the Trusts redevelopment programme. • 2016/17 Prioritised Capital Backlog Maintenance programme agreed to the value of £10.42m plus £0.8m for contingency sum for emergency plant, equipment and infrastructure upgrades. Agreed as follows - £1.1m HH power upgrade. The investment level for 2017/18 is 16.2 m, which has been approved as part of business planning. • Carrying out further 'what/If' reviews of Capital Backlog Maintenance Programme to reflect potential changes in Estates over the period 16/17 to 25/26. • Completion of detailed Business Continuity Plan in conjunction with Emergency Planning Team. Completed August 2016 • The Trust Board have been updated on the 6 Facet Survey and approved an eight year programme of investment. • The risk score will continue at the present level for the next year and will then be reviewed again. **Target risk score date: March 2018**	⇔	3 x 5 15	• Capital plan to align to clinical strategy within financial abilities • Major incident plan / sector wide contingency plans • Development and implementation of integrated business continuity plan • NHSLA insurance cover • Estates Strategy with contingency plans agreed. • Mitigation of 'single points of failure' and improved infrastructure resilience providing improved business continuity planning. • The Trust have implemented year 2 of the investment plan and £16.2m has been allocated for 2017/18. • The Trust has experienced two recent events Cambridge Wing floor collapse and Paterson Wing electrical failure. These are events which are examples of the events as described in point 1 as to the effects in the description of the risk. Once the repairs are undertaken the extent and impact of these events will be re-assessed.

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88 / Datix 1644	Medical Director	Incidents /Operational risk	1	July -15	**Risk of spread of CPE (Carbapenemase Producing Enterobacteriaceae)** **The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust.** **Cause:** • CPE will spread if it is not controlled through appropriate antibiotic stewardship infection prevention and control interventions, chiefly screening and isolation, hand hygiene, and environmental hygiene. • Easy transmission from patient to patient if correct IPC procedures are not followed. • With increased cases of CPE there is a risk in all areas for potential transmission • Current isolation capacity insufficient to implement the DH PHE toolkit recommendations. **Effect:** • Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotics choices for treatment and ultimately worse outcomes. • Increased demand for isolation facilities, potentially beyond available capacity. • Resource impact. • This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage. **Impacts:** • Increase costs - Reactive / inefficient working, • Penalties / fines - Enforcement notice.	3 x 4 12		• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship. • The Trust has a CPE Policy in place, and has patient and staff information available on the Source. • Flagging system on CERNER for identifying known carriers is in place. • Serious Incident investigation following transmission events and ward closures resulting in increased emphasis on hand hygiene, environmental improvements and cleaning. • CPE management is discussed weekly at the HCAI Taskforce meeting. • CPE action plan monitored monthly through Quality & Safety sub-group with exception reporting to ExQu	4 x 4 16		Current	• To plan for cohorting on a bay or ward basis. Cohorting plan has been agreed with the Divisions. • The surgical division is in the process of reviewing semi-permanent isolation pods to increase isolation capacity. • Work to consider the provision of an in-house environmental decontamination solution is on-going. In the short-term, an agreement has been put in place with the current provider to reduce cost and improve response times. Quality & Safety sub-group approved proposal to provide an on-site HPV service to support prevention of infections such as CPE and C. diff. Business case being progressed. • The Trust now reviews each new case of CPE individually as part of the Department of Health's ERS requirements. • Several new smaller CPE outbreaks have been identified and controlled. • Escalation of outstanding estates work - meeting has taken place with Estates, IPC and the Director of Nursing to establish timelines and resolution of outstanding issues. • Despite steady improvement, compliance with CPE admission screening remains low and requires further improvement, which is holding up the delivery of the CPE action plan. Screening data now available at ward level through the IPC scorecard and have been included in the HFC reports since January. Provision of patient level data is currently under review. Issues identified at sub-group by the divisions as barriers to screening are currently under review by IPC for discussion at sub-group in July. Once a solution has been reached, divisions will develop improvement plans for areas of low compliance which will be monitored through the sub-group. • A working group (including Estates, ward-level / divisional staff, site managers, and IPC) has been unable to find a way to convert the Weston ward shower walls to Whiterock due to continued high capacity. The risk of delaying cancer treatment outweighs the risk from the environment. As a result, Weston has implemented chlorine disinfection, and the environment will be reviewed again in light of this to ensure that all other risk mitigating measures are in place. • The target risk score date has changed to October 2017. **Target risk score date: October 2017**	⇔	2 x 4 8		• The Trust has in place a local contingency plan to implement ward-level cohorting in the renal speciality. • Pods may provide additional single room capcity suitable for isolating patients with CPE in some areas. • Seek guidance and support from NHSE and PHE. • Plans to add CERNER prompt for CPE on screening.

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71 / Datix 1609	Medical Director	NHSLA / CQC / Operational Risk	1	October 2014	**Failure to deliver safe and effective care in respect of:** • **Incident reporting and Serious Incidents.** • **Never Events** • **HSMR, SHMI and mortality alerts** • **Infection Prevention & Control** • **CAS alerts** • **NICE guidance and standards** • **National audits** • **Clinical audit programmes** • **Quality assurance of data submissions** • **Clinical guidelines** **Cause:** • Appropriate governance process not in place • Visibility of current compliance not available or known • Insufficient resource in place to manage the process • Non-compliance with Trust policies and procedures • Non-compliant with surgical WHO checklist • Continued change in HCAI landscape • Increasing incidence of antimicrobial resistance **Effect:** • Unable to demonstrate that practice is evidence based • Limited oversight of externally reported data • Inability to demonstrate any or adequate audit trail • Unable to benchmark care against peers • Increase in SIs and Never Events • Increased mortality rates • Increased potential for Healthcare Acquired Infection (HCAI) **Impact:** • Increased harm to patients • Potential to incur penalties and/or fines: Contractual and Enforcement notices (Financial penalties resulting from non-compliance) • Limited understanding of performance benchmarks • Potential loss of reputation and reduction in market share as a result of Negative media coverage • Non-compliance with CQC regulation • Potential to increase costs: i.e. claims and litigation impact on CNST payment	3 x 4 12	• Associate Medical Directors for Safety & Effectiveness and Infection Prevention & Control in post • Executive responsibility for clinical governance revised • A new centralised safety and effectiveness structure was implemented in September 2016 to ensure streamlined management and governance • Compliance and improvement monitoring governance process through the Executive Quality Committee (ExQu) in place • Trustwide reports including performance data in place • Root cause analysis and learning from incidents • Weekly incident review meeting with Medical Director • Quality Accounts published in June 2017 – aligned with Quality Strategy • Quarterly IPC report to ExQu and Quality Committee in place • Quality Strategy published and QI programme in place • Trust Quality & Safety Sub-group established in June 2016, reporting to ExQu • Action plans for areas of key risk in place and monitored through sub-group.	3 x 4 12	current	• Duty of Candour - A look back exercise to review all letters sent to patients/carers following an SI has been completed for all SIs reported April 2016 – Jan 2017, with letters sent where there is no evidence of notification. Risk assessment completed and approved for SIs reported 2015/16 with letters due to be sent where appropriate by the end of July 2017. A Duty of Candour training package is now in place on Moodle. All consultants and band 7 and above nurses must complete the training. Compliance will be monitored at the weekly incident panel from August 2017 with communications to improve uptake as required. • DoC compliance as evidenced on Datix is improving for SIs, with compliance of 76% for all SIs reported between February and April 2017. Compliance for incidents graded moderate and above is now being monitored through the weekly incident panel. • Four never events occurred between March and November 2016. A safer surgery task and finish group and action plan is in place – the ToR and work plan for this group will be refreshed during June 2017. • A process for the management of high risk SIs, inquests and claims has been implemented, which is reported monthly. • Safety culture programme project plan established – it has been informed by intelligence gathered through research and experience from organisations at national and international level, incident themes and learning, safety culture workshops, staff surveys and work conducted with staff in theatres through the safer surgery work. Current work includes a programme to improve incident reporting, and nine safety priority areas called 'safety streams' which have associated action plans. • Actions in place to improve the assessment and management processes for VTE through the Thrombosis Committee and VTE Working group. VTE RCA SOP has been developed and agreed with divisions. The deputy medical director has developed a detailed action plan, which is being monitored via the Q&S subgroup. • Strategies for ANTT and hand hygiene improvement approved by Quality & Safety Sub-Group in February 2017. Implementation commenced in March 2017 with a training programme for staff. The new hand hygiene audit process went live in April 2017. • Quality improvement project is in progress to review the SI process overall. This includes co-design events to redefine the SI processes at ICHT with involvement from patients, external experts, clinical directors, senior nurses, divisional management teams and any corporate teams involved in the process. The first full day event will take place 24/07/17. • A bespoke program of training and education for lead investigators and key stakeholders identified by the divisions will be delivered as part of this improvement work, to be delivered in Q3 17/18. • An overall Trust and division specific action plan are currently being finalised in response to an internal and external review of a SI where the family raised serious concerns. The outcome from the co-design workshop in July will contribute to this. Both action plans will be reported to executive and quality committees in September 2017. **Target risk score date: December 2017**	⇔	2 x 4 8	• Process to be managed through the Medical Director's office with nominated clinical leads

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87 / Datix 1780	Divisional Director of Women's, Children & Clinical Support	CQC inspection /Operational risk	1	July -15	**Failure to comply with the statutory and regulatory duties and requirements, including failure to deliver OPD improvement plan** **Cause:** • Lack of robust processes • Failure of staff to comply with Trust policies, processes and standards • Lack of visible leadership • Lack of robust key performance indicators • Impact from transition to Cerner • Multi management facets • Lack of clarity and consistency between centralised and decentralised OPD departments **Effect:** • Poor patient experience • Poor reputation of OPD services • Potential negative reputational impact • Potential failure to meet key Trust access targets • Potential to remain rated as inadequate by the CQC **Impacts:** • Increase costs - Reactive / inefficient working, • Penalties / fines - Enforcement notice	3 x 4 12	• Service Level Agreement • Outpatient improvement steering group • Monthly progress reports to Executive Quality Committee • OPD scorecard with key improvement trajectories Leadership walkrounds • Weekly patients referral triage management • Referral tracking indicators for OPD booking office • Local audits of clinic start and stop times and availability of patient records	4 x 4 16	Current	The Care Quality Commission (CQC) has acknowledged an improvement in outpatient services at Charing Cross, Hammersmith and St Mary's hospitals. On the 31st May the CQC published new ratings for outpatient services based on its inspection in November 2016. The ratings are up two levels to 'good' overall at St Mary's and Hammersmith hospitals, and up one level to 'requires improvement' at Charing Cross. There were no compliance or 'must do' actions. The CQC highlighted a number of areas for further improvement, especially in terms of waiting times across sites and, specifically at Charing Cross, to ensure a clearer vision and a more inclusive and positive organisational culture for staff. There were a number of 'should do' actions at all sites. These are **St Mary's Hospital** The hospital should ensure all staff working in clinical areas have appropriate fire safety training and an understanding of local evacuation procedures The hospital should ensure incidents are fully investigated within a reasonable timescale in such a way that allows trends to be identified so as to ensure the service remains safe The hospital should ensure contractors providing services are able to respond within a reasonable time to complaints made by patients against the trust in cases that involved both providers The hospital should ensure doctors in training have up to date mandatory training in all required areas **Charing Cross Hospital** Quicken the process of hiring new outpatient nursing staff, in order to provide adequate cover for staff absences Ensure all staff understand the concept and utilisation of the duty of candour All staff remain compliant with mandatory training and safeguarding training Ensure there is sufficient drinking water available to patients waiting to be seen Address all concerns of staff bullying and harassment issues **Hammersmith Hospital** The trust should improve performance against the two week wait (2WW) GP referral to first outpatient appointment standard for cancer and the 62-day GP referral to first treatment standard The trust should improve performance against referral to treatment time (RTT) for non-admitted pathways for outpatient services The trust should reduce waiting times for patients in outpatient clinics The trust should reduce the number of overbooked or cancelled clinics The trust should ensure the temperature of the outpatients clinic department is a comfortable temperature for patients Because of this a reduction in the current risk score from 16 to 12 is recommended. **Target risk score date: *review in August* 2017**	⇔	2 x 4 8	• May have to invest in additional resources including senior nurse and general manager leadership overseeing the outpatient clinics at each site • May have to reduce activity

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7/ Datix 1610	Divisional Director of MIC, SCC & WCCS	Risk Assessment / Operational Risk	1	June 2007	**Failure to maintain key operational performance standards including – Emergency Department (ED) target, Cancer waiting target, Diagnostic target and RTT target** **Cause**: • Mismatch of accurate reporting and poor data quality due to implementation and embedding of new systems and processes. • Mismatch of capacity and demand • Financial challenges • Bed capacity across sites • Volatility of non-elective demand • Increased requirements for elective RTT activity • Late discharges / delayed review by speciality doctors • Potential infection outbreak • Loss of capacity being lost due to equipment failure • Transfer of SMH UCC service to an external provider **Effect**: • Reduced patient experience / staff morale • Increased operational inefficiencies • Failure to meet contractual / regulatory / performance requirements • Loss of reputation and reduced confidence from key stakeholders • Delays to accessing services • Elective patients on the waiting list have to be cancelled. • Delayed step downs from critical care. • Transfer of patients between sites impacting on patient experience **Impact**: • Poor quality of care • Potential increased costs: Reactive & Inefficient ways of working • Potential to incur penalties and/or fines • Potential reputational Impact: Loss of market share • Potential for increased lengths of stay • Potential lack of continuity of service, reputation, retention of staff, accountability and governance caused by the transfer of SMH UCC	5 x 3 15	**ED** • Daily ED Performance Reports • Agreed performance trajectory with Commissioners and NHS England and an action plan to underpin the delivery of the trajectory. • Escalation to mental health providers • Agreement of full capacity protocol and implementation (from October 2016) • Extending operational hours for ambulatory emergency care services at St Mary's and Charing Cross (from 22nd October) • Escalation of ongoing issues with Vocare service to commissioners. • AAU/ MMU operational at CXH. **RTT** • Jul 2016-Apr2017: Monthly WLIP Steering Groups including IST NHSE and NWL CCG commissioners. Weekly WLIP management meetings and RTT meetings with General Managers to help ensure progress against actions and trajectories. Weekly meetings with CEO **Cancer waiting times** • 3 year MOU and funding agreement with Macmillan into cancer services • Increased investment in cancer MDT Coordinators • Investment into Somerset System (Cancer tracking tool **Diagnostic waiting times** • Additional radiologist sessions to report on images and reduce turnaround time • Local level scorecards and monitoring forums • Senior input into site operations • Information peer review • Clear escalation plans • Participation in weekly sector operations executive • Development and implementation of site/clinical strategy • Additional ad hoc sessions based on voluntary overtime • Prioritising of urgent inpatient and cancer 2WW patients. • Fortnightly Task and Finish Group to support improved recruitment • New RIS PACS system in place • Outsourcing of MRI scans as appropriate	5 x 4 20	Current	**ED** • Weekly performance review meeting with CEO and other divisions. • Fortnightly meetings with commissioners established • Redevelopment of SMH Emergency Department (to be completed in Q1 2017/18) • Formal review of ED performance via ECIST completed • Potential redevelopment of ED, CXH commencing Q2/3 17/18 • Bed base expansion at SMH, Q2/3 17/18 • NHS improvement have stated Trust needs to deliver 90% milestones for ED performance in plan and 95% by the end of the year, • Full capacity protocol being refreshed in advance of winter. **RTT** The waiting list improvement programme risk register was reviewed in May 2017; the risks primarily relate to one of five aspects of the programme (demand and capacity; data quality, finance, performance and governance). Below is a summary of mitigations to the risks. • Governance and support to theatre productivity work streams will be strengthen to support achieving internal activity assumptions; this will include NHSI RTT Theatre Productivity Programme (Four Eyes) and NWL theatre improvement programme for elective orthopaedic care. • Scopes of clinical criteria, procedures and patient cohorts for referral to outsourcing are being reviewed to prevent the risk of not increasing the volume of patients outsourced to achieve target. • IST modelling shows a sustainable capacity gap of 333 outpatient appointments per week, with a backlog of c.14,000 to clear; specialties are considering options to work differently, or address gaps. Plans to be updated in specialty action plans. • Procurement of validation tool to address reliance on validation to deliver RTT. Clinical outcome form roll out and training. Development of business as usual. • WLIP governance structure remains in place to mitigate assumptions as per trajectories • Data clean-up programme under regular review with IST and being proactively managed to mitigate the risk of additional RTT errors. • Monthly clinical harm review process agreed and is ongoing to identify if any long waiting patients are at risk of harm • Costs included in ICHT 17/18 financial plan to mitigate cost pressure to ICHT. Key deliverables agreed to return to business as usual. • Trajectories in place to deliver performance. Regular reporting structure with key stakeholders ongoing to mitigate potential for reputational damage due to RTT and 52 week wait performance. **Cancer waiting times** 1. Implemented internal validation process for cancer peer review 2. Implemented internal validation process for cancer pathways 3. On-going work with DGH in relation to timeliness of cancer pathway referrals **Diagnostic waiting times** • Outsourcing of MRI scans through Alliance and the Steiner unit • Recruitment continues to secure posts that would allow extended hours to be delivered within core hours to further support ED/Cancer/and RTT targets. • Average MRI waits are within 5 weeks for most areas and CT within 6 weeks. **July 17** • Breach validation work for June is still in process. • Weekly RTT meetings are in place for updates from modalities regarding wait times challenges, potential breaches and actions to be taken • The average waiting times for modalities, except MRI, has decreased. With the exception of MRI and DEXA, we remain within the 6 week target. The average waiting time for Cardiac CT and MRI has reduced to 45 and 34 days respectively whilst US MSK has increased to 57 days. • Continued capacity challenges are being addressed with the review of referral pathway, increased vetting, additional lists and options for outsourcing • Portering delays remain a concern and staff continue to record incidents as they arise on Datix. The; Portering Focus Group meeting to explore the efficiencies of the service, identify the problem areas and potential improvements continues on a fortnightly basis. The benefits of these meetings are yet to be realised and has been escalated at Divisional Quality & Safety Committee. • The reporting turnaround times and trajectories have also been escalated and it the appointment of Heads of Specialities will focus on this as an immediate priority for allocations, publishing performance and also outsourcing options. **Target risk score date: March 2018**	⇔	3 x 4 12	• Agreed remedial action plan with commissioners for RTT and choose and book. • ED recovery plan • Additional elective activity focused on CXH / HH sites • Increased senior (executive) scrutiny of the emergency pathway and in patient discharge planning • Validation of closed pathways on-going. Patients to be contacted as appropriate.

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					Impact / Cause / Effect / Impact	Likelihood / Consequence		Likelihood / Consequence				Likelihood / Consequence	
91/Datix 2023	Jamil Mayet, Divisional Director of SCC / Tim Orchard, Divisional Director of MIC	Incident reporting	1	3/6/2016	**Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust.** **Cause:** • Poor Environment • Poor equipment • Insufficient trained staff in Critical Care • Lack of Staffing on the St Mary's Hospital Medical HDU • Lack of Level 2 beds at Hammersmith Hospital • Current level of medical cover does not meet standard for critical care • Absent of Critical Care outreach team on the Hammersmith site • Lack of medical cover on the medical high dependency unit at SMH and CXH, which does not meet the standard for Critical Care **Effect:** • Delivery of care provided to patients • Patients being nursed in inappropriate areas (C8 ward) due to lack of level 2 beds • Inability to meet critical care standards on medical HDU with consequent impacts on patient safety. • Inability to open additional capacity on demand and potentially impacts on staff activity and morale and patient safety. **Impact:** • Potential to increase costs: staff • Potential to increase costs: Reactive & Inefficient ways of working • Potential to incur penalties and/or fines: Contractual and Enforcement Notices	4x4 16	• Review of the HDU's against the standards completed and paper written and reviewed at EX QU • Meeting completed with Medical Director to agree immediate actions and review risk, date for further meeting agreed. • Review of all incidents and SI's by critical care and two independent consultants • Cover arrangements under review with Chiefs of service in relation to cover being provided out of hours SOPs to be produced for each unit, links with medical firms strengthened by surgical HDUs • Options papers to Critical Care Committee 9/6/16 to review long term options • Patients are managed within existing medicine areas on the Hammersmith Site. C8 ward is operating as a level 1 area with monitored beds. • Escalation of staffing issues within agreed framework. Early requests for bank shift and agency where required. Requests for cross coverage from other clinical areas. • Current mitigations continue to be ICU support and use of Outreach. Outreach hours have been extended on CXH site and a proposal is in preparation to extend this to weekends and to HH.	4x4 16	Current	• SI and incident review completed. Three serious incidents reported all independently reviewed. At the review it was noted that whilst there was learning there was not felt to be failure to rescue. Two of the cases were infection control related • SOP in development • Site strategy plans are under development through the Trust critical care group with a Trustwide approach to the provision of level 2 and 3 beds. • Ongoing recruitment efforts to fill vacant posts on ward. • Out of hours SOP in development for each unit, and the cover arrangements for the HDUs are being reviewed by the Chiefs of Service • Outcome of Critical Care Group / Site Strategy Plans is for Critical Care to take over management of HDUs Trustwide. Further plans ongoing. Target Q2 2017 remains. **June 2017** • On-going project work to reconfigure on SMH site - expected implementation date October 2017 depending on estates work and staffing • Medicine developing business case for acute respiratory units and NIV capacity following review of level 2 activity winter 16-17 showed that current plans/current capacity likely to be insufficient to cater for all level 2 patients at times of peak activity. Acute respiratory unit at SMH likely to be on Manvers who currently provide this service but in a less formal way. Marjory Warren at CXH identified as ARU. **July 2017** • Project Manager in post • Project board convened & workstreams established • Clinical model agreed by all relevant clinicians **Target risk score date: January 2018**	⇔	3x2 6	• Continue to work towards an integrated model and utilisation of current services provided by the Site team and outreach.

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94/ Datix 1992	Divisional Director of MIC	Serious Incidents / Operational Risk	1	June 2016	***NEW* There is a risk to patient experience and quality of care in the Emergency Departments caused by the delays experienced by patients presenting with mental health issues as a result of increasing volume of attendances and delays for those patients requiring admission to a mental health bed.** **Cause**: • Lack of mental health bed capacity • Delayed access to mental health input for patients in the department (for example the Home Treatment Team) **Effect**: • Extended stay for patients in a sub-optimal care environment for mental health patients (the Emergency Department) **Impact**: • Impact on patients who are experiencing a crisis yet have to wait an extended period for admission to an appropriate bed. • Extended transfers for patients to distant appropriate beds • Risk of self-discharge or absconding patients.	5 x 3 15		• Reporting of all 12 hour trolley wait breaches as Serious Incidents. • Agreeing and piloting a new escalation framework with commissioners. • Meetings with the mental health trusts to raise concerns. • Increased engagement from mental health Trust and CAMHS service in Serious Incident investigation process. • Regular meetings with CNWL and ongoing engagement with mental health trusts and ICHT with regards to pathways and management of patient group. • Escalation to the A&E Delivery Board. • Escalation at Provider Oversight Meetings with NHS Improvement. • Escalation of delays in real time to both the relevant mental health trust and commissioners. • Augmenting the nursing establishment in the emergency departments with registered mental health nurses. • Increasing the security presence in the emergency department at SMH. • The establishment of a dedicated consultant lead for mental health in both emergency departments.	5 x 3 15	Current	• To have further discussion with commissioners about the future configuration of the liaison psychiatry service as the current offering does not meet the standards of a "Core 24" service • To Review the pathway for inpatient admission at SMH • To Request a formal update on the work of the Tri-borough Liaison Psychiatry Transformation Working Group • To Re-escalate concerns about provision for CAHMS to the Chief Officer for Central London, West London, Hammersmith & Fulham, Hounslow and Ealing CCGs. • A total of 9 incidents were reported in May and 3 in June **Target risk score date: December 2017**	*NEW*	3 x 3 9		Management within department with existing controls, ongoing investigation of serious incidents for 12 hour trolley wait incidents.

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

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					Impact / Cause / Effect / Impact	Likelihood	Consequenc		Likelihood	Consequenc				Likelihood	Consequenc	
65 / Datix 1613	Medical Director	Divisional risk register / Operational risk	2	Feb 2014	**Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors, resulting in suspension of training.** **Cause**: • Inadequate training and education programmes • Inconsistent engagement of supervisors and provision of supervision • lack of transparency of educational resources • Regional service reconfiguration that impacts training opportunities • Failure to introduce supervision time in consultant job plans **Effect**: • Failure to provide high quality learning and training environments • Failure to deliver high quality training • Reduction in student and training places commissioned by Imperial College or HEE • Damage to reputation as a world class medical education provider • Risk of trainees being removed **Impact**: • Potential loss of revenue: Research and education income (Failure to maintain medical education income) • Undermines mission of AHSC by failing to provide medical education integrated with research and service provision • Reputational with adverse revenue impact: Compromises future re-designation of AHSC • Potential to increase costs: Bank & Agency staff as result of being unable to recruit and retain medical staff at all levels • Potential to increase costs: i.e. claims and litigation impact on CNST payment due to poorly trained staff and potential for harm. • Reputational with adverse revenue impact: Service decommissioned and withdrawal of medical student places • Possible increase of complaints / incidents due to lack of continuity of medical staff/gaps in rotas Potential Cost implications of locum requirements, service pressures and impact of future removal of funding for training posts	3 x 4 12		• Education transformation programme launched • New management structure in place • Anti-bullying strategy implemented • Revised governance structure implemented • Safety panel monitoring incidents weekly – chaired by MD • National trainer census complete – meets required standards for supervisors • Formal process for the management of education action plans in place • Trust Education Committee established • Annual programme of specialty reviews chaired by the medical director established • Annual trainee 'deep dive' programme in place • Exception reporting process implemented for new junior doctor contract • Task and finish group for recruitment and retention of non-training grades established to mitigate rota gaps	3 x 4 12		On-going	**Protecting EPA in job plans:** GMC census returned with over 500 accredited trainers. Inability to quantify time in job plans for education due to lack of completion of job plan returns – job planning still underway in the divisions. Job planning exercise underway, the professional development team are working with the departments to ensure job plans are ratified to be signed off by July. **Undergraduate Teaching:** The undergraduate medical school visit occurred in November 2016. The final report and action plan was issued by the school in July. Report. The Trust response is being developed, due for submission in mid-August. A new process for identifying recurrent issues from SOLE feedback has been implemented with action plans where appropriate. National changes to the undergraduate medical licensing exam and curriculum are anticipated and likely to impact the delivery of teaching to medical students, the number of students the Trust receives and the subsequent income. The Trust is engaged with the College and will be represented on all workstreams for curriculum review **Action Plans:** The 2016 National Training Survey action plan has been closed. Three open actions remain from the Quality visit (Nov-15); all other actions were closed in May, with the impact monitored through the local faculty group meetings (LFGs). Four patient safety comments were received as part of the 2017 NTS; action plans have been submitted to HEE. Full survey results were published 4th July 2017 and are currently being analysed. Initial review shows that the results are largely similar to last year. A full action plan is being developed in response. **Day One Ready Induction:** Review of content for core skills training being undertaken by P&OD, supported by education. Plan to ensure trainees complete their training prior to starting in the Trust. Plans to ensure day one readiness for CERNER dependent on ICT resource and currently not confirmed. Day one ready steering group in place and preparation for the August induction has commenced. There are concerns with the quality of the rotational information received from HEE which is having a significant impact on our ability to adequately prepare our rotas and predict our vacancy rates with certainty. Internally, a validation exercise with all education leads to confirm their rotational information is underway. **Quality governance:** Training reinstated in Ophthalmology and Neurosurgery. Specialty reviews complete in specialties which have significant numbers of red flags, enhanced monitoring by the GMC already in place, or where SOLE (Student On-Line Evaluation) reports do not meet the required 0.5 score. Monthly specialty review meetings in place for Histopathology and Medical oncology. HEE Risk Review for Medical Oncology in January produced no further actions. Histopathology Risk Review Meeting in February resulted in a combined NWL pathology action plan, progress for which will be monitored via the monthly education specialty review. A Critical care trainee focus group in March resulted in an action plan; progress for which will be monitored via a monthly education specialty review. Review of quality assurance process underwater to align and incorporate the domains of the HEE Quality Framework. **Target risk score date: September 2017**	⇔	2 x 4 8		• Increase scope of CIP programme due to loss of income

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk Impact / Cause / Effect / Impact	Initial Score Likelihood	Initial Score Consequence	Key Controls	Current Score Likelihood	Current Score Consequence	Proximity	Actions and Progress report	Trend /Movement	Target Score Likelihood	Target Score Consequence	Contingency Plans
72/ Datix 1614	Director of People & OD	Strategic Planning / Operational risk	2	Oct 13	**Failure to implement, manage and maintain an effective health and safety management system including:** - **Appropriate health and safety policies, procedures and safe systems of work** - **Risk assessments and risk control measures** - **Information, instruction, training, support and supervision** - **Monitoring, measuring and auditing** - **Governance and assurance arrangements** **In order to protect the health, safety, and wellbeing of employees, contractors, students, patients and visitors whilst at or on behalf of the Trust.** **Cause:** • Lack of appropriate and effective H&S management structures • Lack of appropriate H&S information and guidance – including policies, procedures and safe system of work • Lack of induction, job specific and refresher training • Lack of management ownership and accountability • Poor employee engagement, awareness and culture • Lack of competent H&S advice and resources • Failure to report and investigate accidents/incidents/near misses **Effect:** • Increase in accidents, incidents and ill health • Damage to property and equipment • Impact on business continuity • Reduced morale, quality & productivity • Increased rates of sickness absence due to injuries and ill health • Poor patient experience • Poor reputation with regulatory bodies such as HSE and CQC **Impact:** • Potential to incur criminal penalties and/or fines: • Contractual and Enforcement Notices • Potential to increase costs: i.e. claims and litigation impact on CNST payment • Potential loss of revenue : NHS Income as a result of Increased incidents to staff and patients • Management time to investigate accidents/incidents and implement corrective/preventative action • Training & retraining costs • Reputational risks	3 x 4 12		• Fully staffed Health and Safety Service • Strategic Health and Safety Committee • Division/Corporate Functions Health and Safety Committees/ Quality and Safety Committees • Divisional Health and Safety Leads • Departmental Safety Coordinators • Accident/incident reporting via DATIX • H&S risk assessments undertaken and recorded on Assessnet • Trust and Divisional Health and Safety dashboards • Health and safety training, including Health and Safety e-learning, Manual handling training, Fire Safety training • Periodic updates to Executive (Quality) Committee and Quality Committee • Readily accessible H&S information e.g. webpages on Source • Health and safety policy, supported by Division local procedures	3 x 3 9		Current	• Risk reduction plans have been formulated, and are in the process of being implemented, for the current 4 highest causes of injury to staff: 'Violence and Aggression', 'Sharps', 'Slips, trips and falls' and manual handling • Introduction of Workplace review/inspection regime commenced in November 2015. Once introduced fully, a performance standard is likely to be set in relation to a minimum number of workplaces being reviewed each quarter e.g. 80% • Increased complement and training of Departmental Safety Coordinator required • Work closer with both external partners (such as Imperial College) and internal partners (such as Estates and Facilities and Occupational Health) to ensure any work affecting the health and safety of those who might be affected by the Trust undertaking is joined up, effective and efficient **July 2017** • New Slips, Trips and Falls reduction plan to be produced to take into account recent (Nov 16) Sodexo/ HSL review findings • Contractor Management Task and Finish Group operational (from March 2017). Appendices to Trust Contractor Management (health and safety aspects) being produced • Continued focussed work required to introduce workplace inspection regime, which has proved more difficult than anticipated to introduce. Web-based product purchased (EQMS by Qualsys) for carrying out workplace inspections. To be trialled by October 2017 • Patient Manual Handling risk reduction proposal being implemented from May 2017. First stage is to ensure there are sufficient working patient mobile hoists available. • Different method of measuring Departmental Safety Coordinator coverage has been introduced (from April 2017). **Target risk score date: October 2017**	⇩	1 x 4 4		• Prioritise and utilise internal H&S expertise e.g. DSCs, Security, Trade Union Reps (external additional support may be required) • Monitor effectiveness of health and safety action plans

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

Risk ID Number	Risk Owner	Risk Source / Type	BAF Ref.	Date when risk first identified	Description of Risk: Impact / Cause / Effect / Impact	Initial Score: Likelihood	Initial Score: Consequence	Key Controls	Current Score: Likelihood	Current Score: Consequence	Proximity	Actions and Progress report	Trend /Movement	Target Score: Likelihood	Target Score: Consequence	Contingency Plans
90/Datix 1978	Chief Information Officer	Information and Communications Technology Risk	1	July 15	**Cyber Security Threats to Trust Data and Infrastructure** Risk to Data; A cyber security incident can result in data being stolen, destroyed, altered or ransomed. Risk to Infrastructure: A cyber security incident can result in all or part of Trust ICT infrastructure being disabled, or destroyed. There would be a prolonged period of recover. **Causes:** In order to function, the Trust needs to maintain an IT environment connected to the internet. This exposes the Trust to a constant flow of infection and attack. **Effect:** • **Data:** o **Stolen;** reputational damage, breach of obligations as regards data security, fines, notification to the victim (s), compensation and legal claims. o **Destroyed;** almost all patient data is being created and stored digitally including medications, observations and treatment decisions.. It is possible for hackers to destroy not only online data but all backups. o **Altered;** connected medical devices are vulnerable to external hacking. Staff with access to data are the most likely insider threat. Maliciously altering data can affect both corporate and clinical systems and can result in either patient data or corporate data being changed. o **Ransomed;** the data doesn't leave the Trust infrastructure but is unable to be accessed until a ransom is paid. Even if a ransom is paid, there is no guarantee that the encryption key will be handed over and access to the data restored. • **Infrastructure** o **Disabled;** there would be a prolonged period of downtime while networks, servers and storage were disinfected and restored to service. Outage is likely to be anywhere between a week to a month. o **Destroyed;** There would be up to 6 months down time, several million pounds of expenditure to replace equipment and restore services. **Impact:** • Patient care and safety • Reputational damage • Contractual and Enforcement Notices , compensation claims • There would be a prolonged period of operation using downtime procedures which would severally impact capacity, revenue and costs	4	4	**Technical Controls** • The Trust tries to maintain the lowest possible attack profile to reduce exposure to malware and hacking. Access to social networking, Skype, webmail, tor browsers and other high risk sites are all blocked. • The Trust maintains firewalls and a documented change control process to block threats. • The Trust maintained Servers and Desktops are installed with anti - virus software. • Trust has contracted with iBoss for software to detect and mitigate any threats discovered inside the firewalls. • The Trust has invested in a backup and restore system that, to date, has been able to restore files compromised by ransomware with minimal data loss. There are about 3 – 4 incidents a month. • There is a monthly cyber security dashboard reviewed at ICT Security and Risk Committee (SARC) to track threat activity and effectiveness of response. • The Trust has an Anti-Malware Procedure to ensure that ICT engineers can efficiently contain, and resolve cyber threats. This procedure is reviewed and updated annually to ensure that the documented processes are current and aligned to industry best practices. • The Trust have contracted a 3rd party supplier to provide Security as a Service. This enables ICT to tap into specialist resources for support and assistance. In addition, PEN testing and Security Risk assessments are conducted annually to ensure that the Trust addresses and resolves these security gaps	4	4	Current	**Staff Education and Awareness of Cyber Risks:** Imperial have signed up with NHS Digital to be an early adopter of the KNOWLEDGE learning material to raise staff awareness of cyber security issues and safe practice. The course material will be incorporated into the mandatory IG training program in 2017/18. UPDATE: NHS Digital responded mid-June to inform Imperial that the solution will be available in mid-July. **Cerner 7 24 PCs:** A pilot project funded from 2016/17 capital has configured a new Cerner 7 24 PC which is more resilient to Cyber threat. Funding request to deploy this new configuration are in 2017/18 Capital Plans**.** UPDATE: ICT submitted a proposal for security funding to strengthen our cyber security position. The Cerner 724 PCs is included in this proposal **ICT Technical Security Manager recruitment**: The recruitment process is now complete. The successful candidate has been appointed, and has also accepted the post. The Technical Security Manger started on the 2nd of May 2017. **Process Controls** The Trust Emergency Planning Department are working on plans for business continuity in the event of Cyber Security incident. Advice from the Cabinet Office to all Boards is to plan on the basis of 'it is not if, but when'. • ICT continues to deploy critical and security patches to Servers and Desktops. However, this is impacting the Operational Teams productivity levels also dealing with daily tasks and BAU calls. **Target risk score** The target risk score is reflective of the continually changing nature of the external threat and evidence of recent attacks on other NHS organisations. The controls in place are appropriate and up to date, but because it is not possible to be one step ahead of all cyber threats this will continue to be a high risk. **Target risk score date:** ***Review September 2017 following Cerner 7 24 PC configuration.***	⇔	4	4	• In the event of an incident, hire external specialists to resolve security threat and restore service as soon as possible • Downtime procedures • Trust Cyber Security Incident Plan

Acronyms

AHSC – Academic Health Science Centre

BRC – Biomedical Research Centre

CCG – Clinical Commissioning Group

CE – Chief Executive

CFO – Chief Financial Officer

CNST – Clinical Negligence Scheme for Trusts

COO – Chief Operating Officer

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation

CXH – Charing Cross Hospital

ECIST – Emergency Care Intensive Support Team

ED – Emergency Department

ExCo – Executive Committee

ExQu – Executive (Quality) Committee

FBC – Full Business Case

FIC – Finance Investment Centre

FT – Foundation Trust

HCAI – Healthcare Associated Infections

HSE – Health and Safety Executive

MD – Medical Director

NWL – North West London

PLACE – Patient Led Assessment of the Care Environment

PMO – Project Management Office

PPM – Planned Preventative Maintenance

R&D – Research and Development

RTT – Referral to Treatment

TDA – Trust Development Authority

UCC – Urgent Care Centre

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board -public	**26 July 2017**

Safeguarding children and young people annual report 2016/17

Executive summary:

The annual report for safeguarding children and young people (C&YP) is presented for noting. It has been a busy year for the C&YP team with another increase in referrals. The team underwent a restructure during the year and moved into the corporate nursing division.

Significant policy developments and initiatives have been delivered and the safeguarding systems and processes continue to be strengthened.

Quality impact:

Provision of effective systems for safeguarding children and young people is essential to deliver high quality care. The primary relevant CQC domain is "safe".

Financial impact:

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

Risk impact:

Failure to provide effective safeguarding systems presents a risk to children and young people and can adversely affect the CQC safe domain.

Recommendation(s) to the Committee:

The Board is asked to note the report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Nicci Wotton, Nurse Consultant Guy Young	Janice Sigsworth	17 July 2017

Safeguarding children and young people annual report 2016/17

1. Introduction

The Children Act (1989), the Children Act 2 (2004) and the Government's Statutory Guidance contained within Section 11 of the Children Act (2004) specifies that Trust boards has a legal responsibility to safeguard and promote the welfare of children and young people (C&YP).

This report outlines the systems and processes in place at Imperial College Healthcare NHS Trust (ICHT) to ensure that it fulfils that responsibility. A declaration outlining this is available on the trust website in line with NHS England requirements.

The report provides an update on progress against 2016/17 key priorities and outlines the key priorities for the current year.

2. Trust governance arrangements for safeguarding C&YP

2.1 Executive leadership

The Intercollegiate Guidance (Royal College of Paediatrics and Child Health, 2014) defines roles and responsibilities of named doctors, nurses and midwives. The document also specifies that named individuals and the nominated Trust Board representatives have a duty to monitor safeguarding throughout the organisation. In accordance with this, the Director of Nursing is the Trust Executive Lead for Safeguarding C&YP. The Deputy Director – Patient Experience is the managerial lead and chairs of the ICHT Safeguarding C&YP Committee.

2.2 The C&YP safeguarding team

The team underwent a restructure in 2016 and now sits within the corporate nursing division rather than the women's, children's and clinical support division. This was in part due to the recognition that safeguarding C&YP cuts across all areas of the Trust not just the paediatric areas and also to achieve better alignment with the adult safeguarding agenda, which had been based in corporate nursing for some time.

The team is made up of:

- a named doctor (for 4 programmed activities)
- a consultant nurse (named nurse)
- two clinical nurse specialists (one of whom is designated lead CNS)
- two liaison nurses (based primarily in the two A&E departments)
- a named midwife and two safeguarding midwives
- two administrators

Safeguarding supervision is important for the team to maintain resilience as well as ensuring that actions are taken with the child's best interests. It is also mandatory for all level 3 trained staff. The Trust has a policy related to the provision of supervision.

2.3 The ICHT Safeguarding C&YP Committee

The ICHT Safeguarding Children and Young People Committee is held quarterly and reports to the Trust Board via the Executive Quality Committee. This committee consists

representatives from all clinical divisions as well as external partners, commissioners and designated professionals. This committee is responsible for overseeing the trust safeguarding arrangements, monitoring data and performance and reviewing and approving safeguarding related policies.

2.4 Policy framework

ICHT has a comprehensive suite of policies and procedures designed to safeguard C&YP. Those updated or created in 2016/17 include:

- Safeguarding children and young people operational policy (2016)
- Domestic abuse operational policy (2017)
- Policy for the management of children who are not brought to outpatient appointments (2017)
- Female genital mutilation policy (2016)
- Standard operating procedure; admission of adolescents to [adult] inpatient wards (2017)

2.5 Training

ICHT has a requirement to provide training at different levels from level 1 (all staff) up to level 4 (named professionals and CYP safeguarding specialists). Levels 1 and 2 are delivered as e-learning modules, level 3 in face-to-face workshops and level 4 through specialist sessions or tri-borough organised events.

The CYP safeguarding team has made significant efforts in this year to ensure all staff are trained to the required level. Apart from level 4, where compliance was 100%, the Trust aspires to achieve the required compliance level of 90%, with the figures being between 80% - 85% throughout the year. Training compliance continues to be a key priority for the coming year.

2.6 Safer recruitment

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

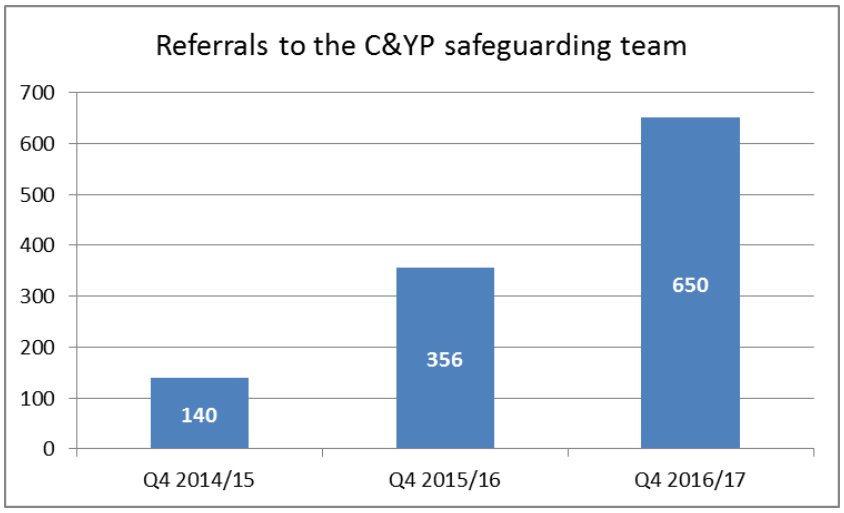
2.7 TIAA audit

An audit was conducted by TIAA and published in November 2016. The audit looked at the Trust policy, documents on the intranet and supervision arrangements. The audit provided *reasonable assurance* that the policy and systems were robust. Recommendations made have been implemented; including some policy revision and a complete overhaul of the intranet safeguarding pages. The audit commented that there had been significant improvement from the previous audit in 2015.

3. Safeguarding activity

The C&YP and maternity safeguarding services dealt with significant numbers of safeguarding issues during the year. There has been a year on year increase in the volume of referrals to the C&YP. Figure 1 shows for comparison the increase in quarter 4 numbers over the last 3 years.

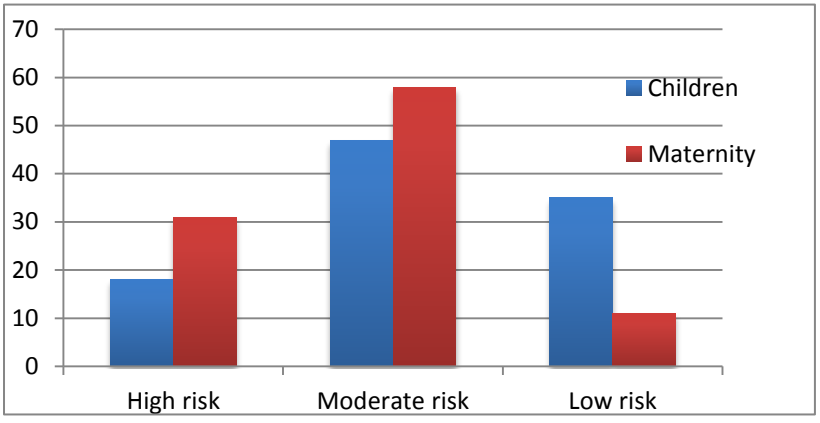
Figure 1: Number of safeguarding referrals made to C&YP safeguarding team



The team refer to 37 different children's social care (CSC) teams and maternity to over 30. The reasons for referral are varied with domestic abuse being high for both areas. Mental health issues and a history of social care involvement are also common reasons. Other issues seen are sexual exploitation and chronic sexual abuse, stabbings and gunshot incidents, self-harming behaviour, non-attendance at outpatient appointments, fabricated induced illness and neglect.

The increase appears to be primarily because the profile of safeguarding has risen across the Trust due to the visibility of the safeguarding teams and the increase of training. Maternity safeguarding is facing more demands due to identification of increasing homelessness without recourse to public funds. Partners with significant criminal histories are also presenting challenges for the teams. The majority of the cases are deemed moderate to high-risk levels (figure 2).

Figure 2: Percentage of safeguarding referrals by risk category



The teams oversee and advise clinical staff regarding these patients and will often facilitate referrals to external agencies that can support them, for example Redthread (gangs/youth violence), Child and Adolescent Mental Health Services (CAMHS) and domestic abuse services etc. The teams will also attend a variety of meetings e.g. strategy meetings, discharge planning etc. In addition they provide training, safeguarding supervision, advice and debriefing to staff and meet with children and parents/carers if applicable. They are the advocates for the child and unborn and strive

to allow the voice of the child to be heard. The C&YP nurse consultant also sits on the tri-borough local safeguarding children's board.

4. Notable practice and initiatives

During the year there have been a number of developments worth highlighting:

- **HEAD assessment** a tool that enables the voice of the child to be heard, used for 13-18 year olds.
- **Modern Slavery Wheel** a tool that enables staff to acknowledge and assess victims of modern slavery whilst pregnant and gives a clear pathway to follow if it is identified. This was noted as innovative practice and supported by NHS England
- **"Was Not Brought" policy** ensures that clinical and administrative staff understand that children are not brought in to outpatients rather than having not attended an appointment.
- **A fabricated or induced illness (FII) case** that was very challenging for staff and resulted in a prosecution of the parents primarily because of the tenacity of the ICHT safeguarding team.

5. Update on key priorities for 2016/17

The following table summarises progress against key priorities for the year.

Priority	Progress
To develop a Cerner safeguarding folder in conjunction with a visible safeguarding alert so that all notes regarding safeguarding can be recorded and visible across the Trust	Completed
To develop and launch a trust wide safeguarding children and young people operational strategy.	Completed
To work in conjunction with multi agency colleagues to launch the nationwide initiative - The Child Protection Information System (CP-IS)	ICHT preparations complete. Awaiting local authority to go live
To complete a team review and business planning process following the restructure	Completed
To review processes around timely discharge of high risk midwifery safeguarding cases in conjunction with the multi-agency teams.	Ongoing
To audit pre/post bespoke teaching on the completion of interagency referrals by clinicians.	Completed
To launch the trust wide female genital mutilation (FGM) policy and recruit a specialist FGM lead to support with training for staff around FGM policy and processes within the Trust.	Completed
To continue to work with North West London colleagues to ensure a joined-up response with partner agencies through care and referral pathways for treatment and recovery services for children who have been sexually exploited.	Ongoing – with active input to relevant agencies and panels
To complete action plans which may arise from the Serious Case Reviews and Domestic Homicide Reviews currently in progress.	Plans completed for published cases
To launch a Safeguarding Children and Young People's Action Group across sites. This will ensure that the Safeguarding Agenda is discussed on a regular basis on the three main sites.	Commenced in Q3
To ensure recommendations from the MBRACE-UK Dec. 2015 report (Mothers and Babies: reducing risk through audits and confidential enquiries across the UK) have been incorporated into Safeguarding Practice and ensure joint working with the Safeguarding Adults Team to ensure this is achieved.	Completed
To implement the practice of health professionals asking patients whether they have children at home and assess they are being cared for.	In development with Cerner

6. Key priorities for 2017/18

These will include the priorities that have not been completed for 2016/17. In addition the team will:

- Increase support for staff dealing with domestic abuse cases
- Devise a standard operating procedure for staff dealing with mental health cases in maternity in line with MBRACE report.
- Create of safeguarding Cerner pages/forms to aid assessments of children and aid data collection for a scorecard
- Develop a clear process regarding liaison of non-safeguarding cases to Health Visitors and School Nurses.
- Develop an inpatient process for dealing with high risk cases such as stabbings and shootings
- Achieve target levels of training and safeguarding supervision
- Strengthen mental health services for children in and out of hours across all sites
- Completion of section 11 review (an external review of all C&YP services)

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**26 July 2017**

Adult safeguarding annual report 2016/17

Executive summary:

This report describes adult safeguarding systems, processes and activity during 2016/17.

Evidence suggests the systems in place continue to improve year-on-year and that patients at risk of abuse are neglect are protected from harm. Governance structures and a policy framework are well established. Training in relation to the Mental Capacity Act and Prevent have improved during the year, but there is still work to be done to achieve the required compliance levels for level 1 and 2 training.

The number of concerns raised has fallen in year, but this is felt to be related to the fact that the quality of referrals has improved because of the training and support provided.

Quality impact:

Provision of effective systems for safeguarding adults is essential to deliver high quality care. The primary relevant CQC domain is “safe”.

Financial impact:

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

Risk impact:

Failure to provide effective safeguarding systems presents a risk to vulnerable adults and can adversely affect the CQC safe domain.

Recommendation(s) to the Committee:

The Board is asked to note the report

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	Janice Sigsworth	17July 2017

Adult Safeguarding Annual Report 2016/17

1. Introduction

Safeguarding adults is an important responsibility of the Trust. The primary objective of adult safeguarding activity is to prevent harm to patients at risk from abuse or neglect, whilst supporting individuals in maintaining control over their lives and in making informed choices about their care and safety.

In 2016/17 the Trust continued to work closely with Tri-Borough partners to ensure consistent, effective and safe systems for protecting vulnerable adults.

2. Background

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

The Trust has developed systems, processes and a policy framework to ensure that the Care Act principles are properly applied.

3. Trust governance arrangements for safeguarding adults

The Director of Nursing provides executive leadership for adult safeguarding. The Deputy Director of Patient Experience has managerial responsibility for adult safeguarding. The Deputy Director of Patient Experience chairs the Trust Adult Safeguarding Committee and represents ICHT on the Tri-borough Safeguarding Adults Executive Board (SAEB). They also provide quarterly adult safeguarding update reports to the commissioners via the Clinical Quality Group.

There is a named doctor for adult safeguarding and an adult safeguarding nurse specialist. Each clinical division has a designated adult safeguarding lead (either the Divisional Director of Nursing or one of their deputies). A Trust inclusion and vulnerability officer provides support for patients with learning disability.

The Trust adult safeguarding committee consists of all the adult safeguarding leads as identified above as well as representatives from tri-borough social services, Trust child and maternity safeguarding services, the Trust security team and safeguarding representatives from the CCG.

All safeguarding concerns are recorded on the Trust incident reporting system (Datix) where they can be categorised and themed in a number of ways. Any incident categorised as adult safeguarding is automatically forwarded to the nurse specialist and the relevant divisional safeguarding lead for review.

The Trust has a number of policy and procedural documents to support the safeguarding of adults. During the year the following were developed or updated:

- Safeguarding adults policy and procedure (2016)
- Domestic abuse operational policy (2017)
- Learning disability and autism policy and procedure (2017)

The adult safeguarding intranet page has undergone a major revamp to make key information and guidance more accessible. It can now be accessed with a single click form the Source homepage.

The CQC report from the outpatient and diagnostic imaging inspection, published in March 2017, noted that safeguarding systems were good and that all staff spoken to knew who to contact if they had concerns.

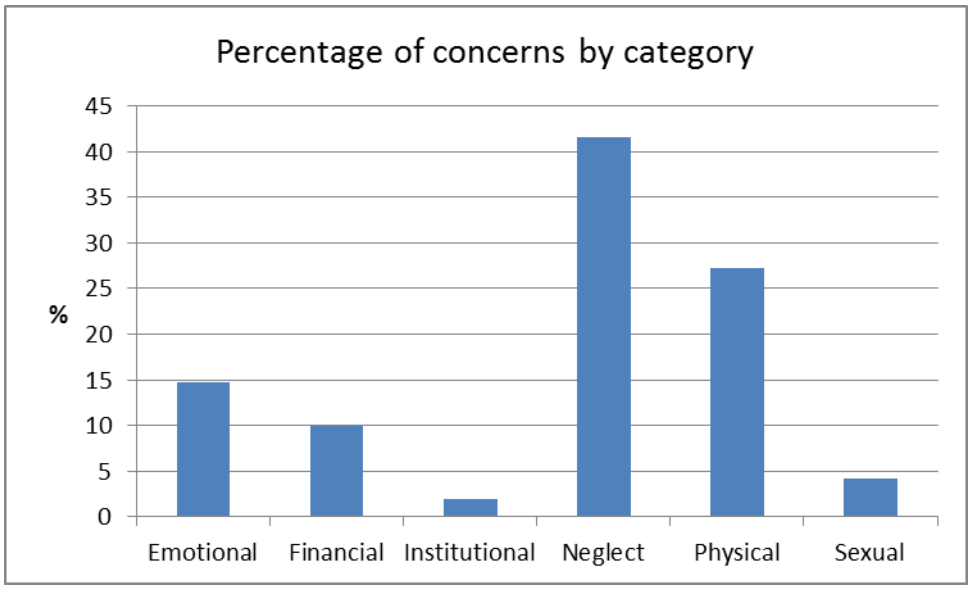
4. Adult Safeguarding Activity

During the year there was a focus on improving the quality of referrals both to the Trust safeguarding service and subsequently to the local authority safeguarding team. A new form on which to raise concerns to the local authority was jointly designed and implemented; this aimed to ensure all the necessary information was captured and that referrals were appropriate.

There is a responsibility on staff raising safeguarding concerns to ensure that those concerns are clearly articulated and supported. There was a good improvement in the quality of information in referrals during 2016/17. A knock on effect was that there was a fall in the numbers of concerns raised during the year compared with 2015/16; 273 compared with 452. Of the 273 concerns raised within the Trust just over 80% were referred onwards to the local authority safeguarding team.

The reduction in reported safeguarding concerns is primarily accounted for by only raising safeguarding concerns about community acquired pressure ulcers where there was clear evidence of neglect. In previous years all were reported irrespective of whether there were actual safeguarding concerns. Also, because of the appointment of the adult safeguarding CNS, a lot of potential safeguarding issues can be talked through and managed without needing to proceed to raising a formal concern.

The types of abuse reported in the 273 concerns is shown below:



Consistent with previous years, neglect accounts for the highest percentage and generally relates to patients arriving at the emergency department in a poor state of care. Most often these patients were admitted from their own homes or were homeless, but there are also occasions where patients came in from care homes.

The percentage of physical abuse cases increased in the year and this is related to an increasing number of referrals about domestic abuse. It is thought that this is related to increased training and awareness raising about this issue.

During the year a *safeguarding & alerts* folder was set up in Cerner, meaning that all safeguarding related records and documentation are now kept in a dedicated place in the patient's electronic record. This makes accessing key information much easier and quicker. This works alongside a new alert system in Cerner which will flag active safeguarding concerns when the patient's record is opened.

5. Adult Safeguarding Training

The trust provides 3 levels of adult safeguarding training:

- Level 1 – all staff, delivered by an e-learning module
- Level 2 – clinical staff, delivered by an e-learning module
- Level 3 – staff with specific adult safeguarding responsibilities, delivered through a variety of methods such as attendance at seminars and SAEB events.

Compliance with level 1 (c. 81%) and level 2 (c. 87%) whilst reasonable still falls short of the 90% target. Improving compliance with core skills training remains a focus for the trust.

6. MCA and DoLS

Mental Capacity Act (MCA) online training is undertaken by all clinical staff in addition to the level 2 safeguarding training described above. The named doctor for safeguarding offers face-to-face training for doctors. A new *consent for patients who might lack capacity* e-learning module was introduced within the year. This contains a very useful introduction to the mental capacity act and its application in practice. To date 4000 clinical staff have completed this module.

In January 2017 the Court of Appeal made a ruling (Ferreira) that "in general" there can be no deprivation of liberty under human rights in cases where a person is receiving life-saving medical treatment. This has had an impact on critical care units where previously there had been some grey areas about when a Deprivation of Liberty Safeguards (DoLS) application should be made. As a result there has been a reduction in the volume of DoLS applications from the trust critical care units.

In 2016/17 the Trust made 94 DoLS applications in total, an increase from the previous year (81) and the year before that (28). Given that the number of applications from critical care fell to virtually zero in Q4, this suggests that there is increasing awareness of when DoLS should be used. Most applications are related to patients suffering from dementia or following a stroke. A handful relate to patients with traumatic brain injury or learning disabilities.

During the year the Law Commission published its report into the DoLS framework. In essence it states that the current approach is not fit for purpose and recommended an entirely new model. However this will take some time to find its way into legislation so for the time being DoLS will continue as it is. The Trust DoLS policy is being revised to take account of the Ferreira judgement.

7. Prevent

Prevent is a component of the Government's counter terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism. Focusing on radicalisation of at risk individuals, the strategy sits under the safeguarding umbrella. This means the Trust executive and management leads are the same for Prevent as for safeguarding.

The focus in 2016/17 was to increase the level of Prevent training compliance, particularly in relation to the face-to-face Workshop to Raise Awareness of Prevent (WRAP). There were significant improvements in year with a total of 6380 (71.5%) staff being compliant with basic prevent awareness training (e-learning) and 1900 (42.5%) having undertaken WRAP. Both these figures meet the required trajectory for this training.

Despite the extensive training provided and the heightened awareness as the result of terrorist incidents in Europe, the actual volume of Prevent concerns raised in the Trust is small. In 2016/17 4 concerns were raised to the Trust Prevent lead, of these all 4 were referred to the police for further investigation. This is felt to be more of a reflection of the fact that not many prevent issues are coming to the fore rather than staff not recognising them.

8. Update on key priorities for 2016/17

The following table provides as progress update of the identified priorities for the year.

Priority	Progress
Achieving the required training compliance for Prevent training and delivery of WRAP sessions	This was achieved for the year but the threshold rises in 17/18
Strengthening links between adult and child safeguarding, with a view to centralising functions into a corporate safeguarding team	Much stronger links in place with joint meetings, potentially combining functions in 17/18
Improving the application of the MCA across the Trust and addressing any actions arising from the Law Commission review of DoLS	In progress and awaiting Government response to Law Commission review.
Developing a robust adult safeguarding dataset and implementing the recommendations arising from the 15/16 internal audit report of data quality.	Completed

9. Summary and priorities for 2017/18

Progress on embedding adult safeguarding practice has continued and the evidence suggests that the systems and processes are more robust than a year ago.

In the coming year the first three priorities from the table above will carried over as they still require more work. In addition it is planned that:

- A more streamlined approach to raising concerns with local authorities will be implemented, utilising email and electronic referrals
- A more focused review of the safeguarding dataset will be undertaken to better understand themes and learning so that the adult safeguarding resource is used effectively and the most at risk patients are protected.

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Research: Quarterly Report

Executive summary:

This report presents a summary of recent progress with respect to the various clinical research initiatives ongoing within the Imperial Academic Health Science Centre (AHSC). It covers the new NIHR Imperial Biomedical Research Centre (BRC), activity on the NWL Clinical Research Network portfolio, commercially-sponsored research, and any other relevant research-related news.

Quality impact:

The quality and scale of biomedical and clinical research carried out across the Imperial AHSC will impact patient care in the future in terms of innovative treatments, diagnostics and devices. Research activity includes many specific examples of patient benefit. Patient and public involvement in research is enabled through the Imperial Patient Experience Research Centre (PERC), and a strategy exists to involve and engage patients and the public in the research we do.

Financial impact:

This paper has no financial impact. However, overall research income to ICHT is valued at ~£40m per annum. Delivery of high quality clinical research (experimental and applied) for the benefit of patients is essential to future revenue streams, to the reputation of the AHSC, and to the continuation of a culture of innovation and continuous improvement.

Risk impact:

The risks associated with research are financial and reputational. Competition for research funds is extremely high and Imperial must continue to demonstrate a high level of high-quality research outputs and activity, as well as value for money.

Recommendation(s) to the Committee:

The Board is asked to note the recent developments in clinical research.

Trust strategic objectives supported by this paper:

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.

Author	Responsible executive director	Date submitted
Paul A Craven, Head of Clinical Research Operations	Dr Julian Redhead, Medical Director	19 July 2017

RESEARCH: QUARTERLY REPORT: June 2017

Purpose of the Report:

The purpose of this report is to provide an update on recent progress with respect to the various sources of funding for clinical R&D, and an indication of forthcoming priorities and actions in 2017-2018.

1) NIHR Imperial Biomedical Research Centre (BRC): 2017-22

The NIHR Imperial BRC was awarded £90,008,747 over the 5 years from 1 April 2017 to 31 March 2022. The BRC contract was finalised and fully executed in June. An additional £100k has been awarded in year 1 to be ring-fenced in support of the NIHR Bioresource initiative.

BRC project spend per annum has been agreed between the College and ICHT and a new system of regular, scheduled payments to the College to reimburse BRC costs will replace the current burdensome process of quarterly invoicing per project. Profiling payments in this way will alleviate a significant administrative burden in both organisations, ensure accurate and predictable cash forecasting for ICHT, and provide flexibility to the research teams to deliver their projects in an appropriate timescale.

There are 8 Research Themes within the BRC, each with a devolved budget and focusing on a number of projects/programmes. Relevant points to note for each are as follows:

Brain Sciences (Professor Paul Matthews):

- The Theme was awarded UK Dementia Research Institute status in April 2017 (worth > £20m over 5 years). This highly prestigious multidisciplinary award was granted in recognition of the strengths of dementia research at Imperial and our supporting infrastructure;
- Prof David Nutt's novel astroglial PET activation marker was selected for evaluation by Dementias Platform UK through its Experimental Medicine Pilot Programme, receiving more than £600K of "in kind" funding for imaging evaluations from GSK;
- The ICHT Memory Unit (Dr R Perry; Dr S Molloy; Dr P Malhotra) in Charing Cross is currently running several important trials in Alzheimer's and Parkinson's Disease on behalf of pharmaceutical sponsors, including TauRx Therapeutics Ltd, BIOGEN and Roche).

Cancer (Professor Charles Coombes)

- A combined NIHR / Cancer Research UK Experimental Cancer Research Centre (ECMC) and Imperial CRUK Centre has been awarded to A Darzi, M Seckl and E Aboagye (worth £7.2m over the next 5 years) which will develop novel imaging, biomarker and therapeutic approaches that will aid cancer diagnosis and deliver personalised treatment, for example, in understanding and overcoming drug resistance in breast and ovarian cancers;
- Prof W Atkin and colleagues published a paper in the Lancet in April 2017 showing that a one-off bowel screening test reduces the risk of developing bowel cancer by more than one third and could save thousands of lives;
- Prof Iain McNeish from the Beatson Institute, Univ of Glasgow, has been appointed to the Chair of Oncology, with a particular interest in ovarian cancer research; he will commence in the autumn;
- A CRUK Major Cancer centre application is in late stage development, jointly with the Institute of Cancer Research.

Cardiovascular (Professor Sian Harding)

- In May 2017, Prof D O'Regan and Prof S Cook published work from the "Digital Heart Project" demonstrating that machine-learning can predict the risk of death in people with serious heart disease faster and more accurately than current methods, using virtual models of the heart combined with real MRI scans of patients with pulmonary hypertension;
- The Acute Coronary Syndrome (ACS) theme of the NIHR Health Informatics Collaborative (NHIC) is preparing its first publication for submission. Using routinely-collected electronic clinical information from more than 250,000 patients in 4 NHS Trusts, standardised and anonymised, this project provides a very large pool of data to help our understanding of the factors that are important in the outcome of patients with acute coronary syndromes.

Gut Health (Professor Elaine Holmes)

- In March 2017, Professor Holmes and colleagues published work in Lancet Diabetes describing the development of a '5-minute test' which measures the various biological markers (metabolites) in urine created by the breakdown of different foods. Although the work is at an early stage, the team hope that with future development the test will be able to track patients' diets. It could also be used in weight loss programmes to monitor food intake;
- In collaboration with the Infection & AMR Theme, Prof J Marchesi has begun a BRC-funded project entitled "Faecal microbiota transplantation as a novel tool to decolonise Multi-Antibiotic Resistant infections of the gut". Faecal microbiota transplantation (FMT) is the transfer of faecal material containing bacteria and natural anti-bacterials from a healthy individual into a recipient patient.

Immunology (Professor Marina Botto)

- Systemic Lupus Erythematosus (SLE), vasculitis, renal transplantation, glomerular and chronic kidney disease (CKD) are important health problems with major unmet need. The effective management of these diseases requires an innovative approach to both clinical service and research activity. Three large clinical services within ICHT are embedded within this Theme: the Imperial Lupus Centre, the Imperial Vasculitis Centre and the West London Renal and Transplant Centre;
- These innovative integrated clinical services and related extensive expertise in these diseases enables the Theme to identify and focus on the key clinical needs;
- To realise the potential of the large numbers of patients attending these clinics, the NWL Clinical Research Network has recently invested more support into the delivery of renal and renal-related studies at ICHT, through its strategic workforce.

Infection & AMR (Professor Peter Openshaw)

- Investigators from the Theme, including R Shattock, S Fidler, J Gilmour, and P McKay, published the results of a phase I healthy volunteer study, as part of an ongoing programme of research to develop an effective vaccine for HIV. 12 volunteers were recruited and the study was carried out at the NIHR/Wellcome Trust Clinical Research Facility.
- Respiratory syncytial virus (RSV) bronchiolitis of infancy is a major global cause of morbidity and mortality. Nasal samples are used for clinical viral diagnostics as well as for research measurements of viral load and the immune response. The standard method for diagnosis of RSV infection uses nasopharyngeal aspiration (NPA) to obtain samples, but this is an invasive and unpleasant procedure for babies and children, making it difficult to repeat sampling. Nasosorption (NS) is a non-invasive alternative method to sample nasal mucosal lining fluid. An exploratory study by Hansel, Nadel, Openshaw and others – published in the Journal of Infectious Diseases in March 2017– found NS to be a useful sampling method for viral diagnostics, measurement of RSV load, and assessment of mucosal cytokine levels in babies hospitalized with bronchiolitis. Nasosorption was well

tolerated by babies, parents, and nursing staff in this study.

- The Theme will fund a new high priority project with Prof A Holmes on personalising antimicrobial dosing. Working within a multi-disciplinary collaboration (medicine, electronic engineering, bioengineering, chemistry, microbiology) this project will investigate a novel method of precision antimicrobial delivery using a closed-loop control system integrating a sub-dermal interstitial antimicrobial sensor. This allows for the continuous assessment of antimicrobial levels in real-time, to guide a closed-loop controller, which optimises the delivery of antimicrobials through direct communication and adjustment of an infusion pump. It is hypothesised from pre-clinical work that this will provide individualised dosing, significantly reducing the numbers of patients receiving sub-optimal antimicrobial doses currently in clinical practice;

Metabolic Medicine (Professor Steve Bloom)

- In May, W Dhillo, S Bloom, C Jayasena and colleagues published a Lancet paper showing that women suffering frequent hot flushes during the menopause could cut the number of flushes by almost three-quarters, by using a new drug compound re-purposed from the AstraZeneca compound library which targets receptors in the brain. The team hopes that this successful early-stage, collaborative study (carried out in the NIHR/Wellcome Imperial Clinical Research Facility and with joint funding from the BRC, MRC and AstraZeneca) could provide hope for women who are affected by flushes and for whom hormone replacement therapy (HRT) is either unsuitable or not preferred by the patient due to safety concerns.

Surgery & Technology (Professor Ara Darzi)

- In May, Normahani, Kwasnicki, Bicknell, Gibbs, Riga, Darzi and colleagues published the outcome of a BRC-funded randomised controlled trial into the efficacy of wearable sensors in peripheral vascular disease. The outcome of this study of patients at ICHT demonstrated the significant, sustained benefit of wearable activity monitor (WAM) technologies for patients with intermittent claudication (a condition in which cramping pain in the leg is induced by exercise, typically caused by obstruction of the arteries). This potentially resource-sparing intervention is likely to provide a valuable adjunct or alternative to supervised exercise programmes.
- The iKnife continued its validation in clinical trials, and in May, a team of investigators from ICHT, the College, and Waters Corporation published an article demonstrating that the device is capable of accurately separating breast tissue types by interpretation of the cellular chemical constituents. Patients undergoing breast surgery for benign and malignant disease were recruited. The iKnife method has been optimised and further work will focus on determining the accuracy of the tool for intraoperative classification of resection margins.
- The Theme has been particularly successful in the previous quarter, bringing in significant amounts of external research funding including;
    - **NIHR Imperial Patient Safety Translational Research Centre** (PSTRC); (£7.3m; 2017-22); the PSTRC is an NIHR infrastructure award to the ICHT/College partnership, which aims to advance the scientific understanding of patient safety, address safety challenges as healthcare evolves, and further international research collaborations. Its work will cover: safer systems across the continuum of care, partnering with patients for safer care, avoiding deterioration and delays in the care of patients with complex needs, enhancing the safety of medication and technology, improving diagnostic accuracy and decision-making, and ensuring value for money in patient safety;
- Also in progress are the applications for;
    - **NIHR Imperial MedTech & In Vitro Diagnostic Cooperative** (MIC); previously known as the Diagnostic Evidence Collaborative, this is NIHR infrastructure

funding which supports the design and validation of new diagnostic tests – especially Point of Care Tests (POCTs). This is achieved by developing research methods that help to expedite the process of evidence generation and by collaborating with clinicians to identify unmet needs for diagnostics. The MIC will work with diagnostic test developers to explore the utility of specific tests within the NHS settings. By facilitating the adoption of new, improved tests into clinical practice the MIC aims to improve the quality of patient care within the NHS. NB. The formal outcome of this competition is embargoed until a formal announcement is made by DH.

- Cancer Research UK 'Super Centre' (see Cancer Theme).

Cross-Cutting Themes

There are 5 Cross-Cutting Themes within the BRC, providing core platforms and technologies: Genetics & Genomics (Professor Jorge Ferrer), Imaging (Professor Eric Aboagye), Informatics & Biobanking (Professor Paul Elliott) and Molecular Phenomics (Professor Jeremy Nicholson), and Core Costs (Professor Jonathan Weber). Together with the Data Science Institute, ICHT Research Informatics and Computational Medicine, these form ITMAT – the BRC's Institute for Translational Medicine and Therapeutics.

- 45 new funding proposals have recently been received from across the Faculty of Medicine and ICHT, following calls through ITMAT. These aims to support new innovative translational experimental medicine with a clear clinical unmet need, and to develop our capacity in terms of younger investigators;
- A BRC initiative to support the recruitment of a new cadre of Clinical Senior Lecturers has already funded new posts in haematology and paediatric infection. Others are planned, with potential appointments discussed via the bilateral AHSC;
- Following interviews in June, an appointment has been made to the new Lead Research Nurse position in ICHT (funded by the BRC). The post-holder, Professor Mary Wells (currently at the University of Stirling) will support capacity and capability building of the research contribution of nurses and midwives, and provide professional support for all our research nurses and clinical trials practitioners.

2) Research Training

- Our flagship Chain-Florey Fellowship and Lectureship schemes have been funded for a further 5 years;
  - The Fellowships are for medical graduates pursuing a career as an academic clinician. Emphasis is placed on the development of researchers who are equally strong in both clinical research and basic science, and successful applicants are expected to carry out their research in one of the basic science groups within the MRC London Institute of Medical Sciences (LMS) at Imperial College (led by Professor Amanda Fisher);
  - In addition, 2-year Chain-Florey Clinical Lectureships are available for clinician scientists who hold a PhD or post-doc fellowship in basic science;
  - Finally, in a new scheme for 2017/18, Chain-Florey Foundation Year 2 (FY2) training allows clinical trainees in their second foundation year – who have completed their PhD and have a strong publication record – to undertake four months of research in an LMS laboratory. The scheme provides salary funding and consumables during their research stay, which is designed to support future applications for Academic Clinical Fellowships.
- As well as being an NIHR Research Professor, Professor Waljit Dhillo is now National Training Lead for NIHR infrastructure, overseeing and integrating doctoral training in 40 UK centres (>400 PhD students in programme across 20 BRCs) and providing leadership for the 47 local training leads;

- WT clinical training scheme, new AHSC CRFs supported by charitable donation; role of CATO; Waljit Dhillo now national lead for NIHR training; non-medical research training opportunities;
- Imperial has been awarded a 5-year Wellcome Trust Clinical PhD programme, making it one of only seven to have successfully obtained funding. The **Imperial Immunity, Inflammation, Infection and Informatics (4i) Clinician Scientist Programme** (Prof G Screaton / Prof M Pickering) will award 4 fellowships per year over a period of five years. The scheme is supported by the Imperial Clinical Academic Training Office (CATO) and the NIHR Imperial BRC which will provide funding for additional fellowships. The first cohort will be recruited this winter, to start in autumn 2017;
- Also support by CATO, and funded by a private donor, the **Imperial College Clinician-Investigator Scholarship programme (ICCIS)** has been established for 2017 to support doctors demonstrating exceptional clinical academic merit and potential, who wish to undertake research training within the Imperial AHSC. Candidates will have access to high quality supervision and will gain knowledge and analytical skills though exposure to Imperial research. They will be fully qualified medical doctors in training in the UK and at Core Training level or above, in any specialty. The scholarship provides a salary stipend for the duration of the programme, full fees and, bench fees of ~£15K per year;
- The joint NIHR Imperial BRC / Imperial Health Charity fellowships scheme provides 'first-step funding' for health professionals looking to begin their academic career. The scheme is supported and administered by CATO. The key aim of the programme is to allow non-medics to undertake 12 months of out-of-programme research to develop their research skills and produce the necessary data to springboard onto successful funding bids for further study. Applicants are asked to identify an important research question that will make an impact on patient care within the Trust, surrounding communities and the wider NHS. The 2017/18 jointly-funded fellowships have been awarded recently as follows;
    - Gemma Clunie (Speech and Language Therapist); £50,000 ("*Developing the design of a study that will investigate voice and swallowing outcomes in patients with airway narrowing*")
    - Tim Hoogenboom (Sonographer); £44,995 ("*Multi-Feature Ultrasound for the Assessment and Clinical Management of Chronic Liver Disease and HCC*")
    - Venetia Wynter-Blyth (Nurse Consultant) £43,231 ("*Exploring the factors that influence adherence to surgical prehabilitation programmes: An exploratory study*")
- An equivalent fellowship scheme at post-doctoral level will open later this year, again through CATO.

3) NWL Clinical Research Network 2017/18

NWL CRN received a 5% uplift overall in its allocation for 17/18 (to just over £14m). As a partner organisation, ICHT has been allocated a total of £4.2m of Activity Based Funding (ABF) for 2017/18 from the NWL Clinical Research Network. This funding has been disbursed to Divisions and to essential clinical services to support delivery of non-commercial studies. Allocations are based on retrospective recruitment activity over the past 2 years (with activity weighted for study complexity).

According to NWL CRN data, as of 23 June 2017, ICHT had recruited 2,086 patients to date in the 17/18 financial year, across 186 individual studies. ICHT is 4th nationally at this point of the year, in terms of numbers of unweighted participants recruited to portfolio studies (Figure 1 below). The NWL CRN has made additional strategic workforce investments in ICHT specialties in the previous quarter, including renal and ophthalmology.

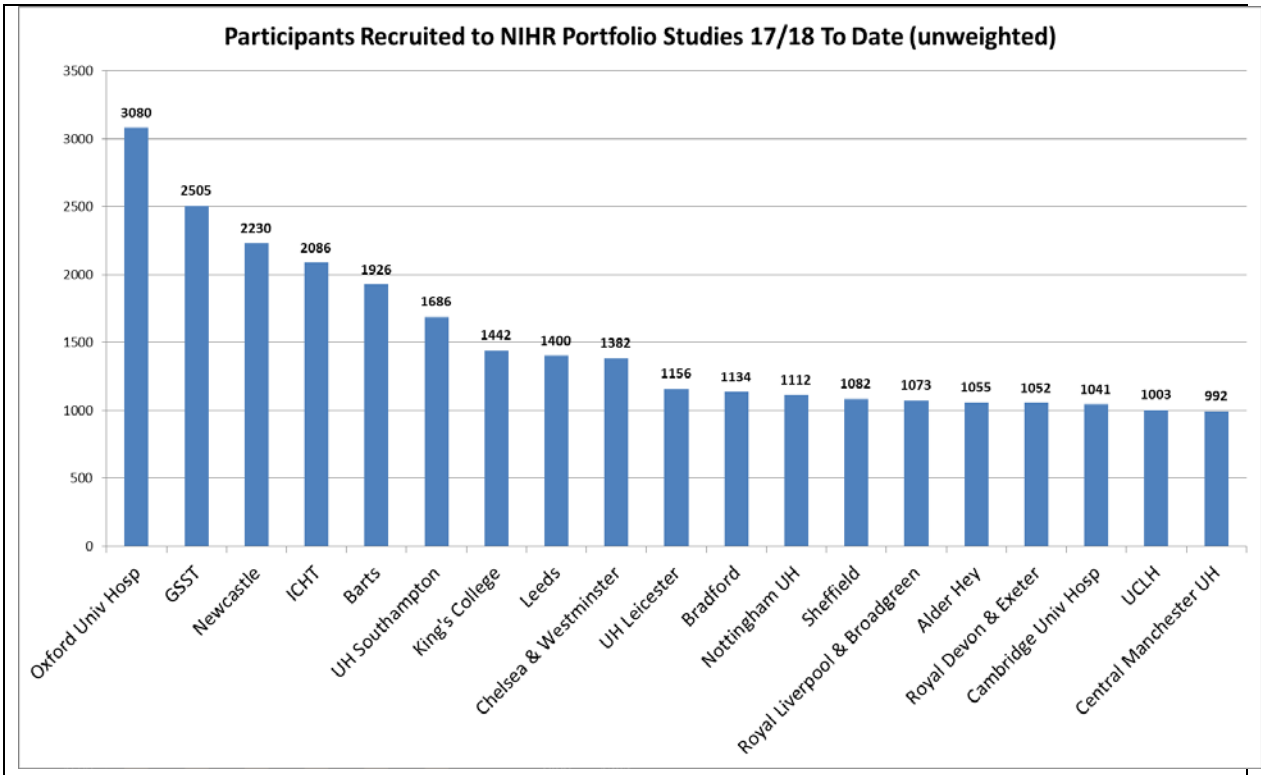


Figure 1. Participant recruitment to NIHR portfolio studies to date 17/18 (by NHS Trust).

4) Commercial Clinical Research

Approximately 80-100 new commercially-sponsored clinical trials are hosted by ICHT each year, from a variety of external companies (pharma, biotech, medtech, CROs). This is a competitive global market and commercial trials generate revenue for ICHT.

For these trials (generally later phase), the sponsoring company assumes the legal and financial management responsibilities under the Research Governance Framework and, as such, also takes on risks relating to study design, patient safety, IMP preparation, etc. The Sponsor usually has rights to any intellectual property that emerges.

ICHT acts as a host site – providing access to / consent / recruitment of eligible patients within its own clinical space, and carrying out the relevant procedures as specified in the protocol (e.g. blood tests, scans, IMP administration).

Figure 2 shows the number of new commercially-sponsored studies registered at ICHT per year since 2014. Already, halfway through the current calendar year, 70 such studies have registered at ICHT and have either started, are in set-up or are being assessed for feasibility.

Work is underway to identify opportunities for growing commercial trial activity, working with the Divisions and Principal Investigators to ensure appropriate systems and incentives are in place, and to develop frameworks for re-investing revenue to deliver additional capacity in R&D. With the input of the ICHT Quality Improvement Team and the NWL CRN, we are also developing new procedures to speed up the time taken to initiate clinical studies and to ensure studies deliver “to time and target”.

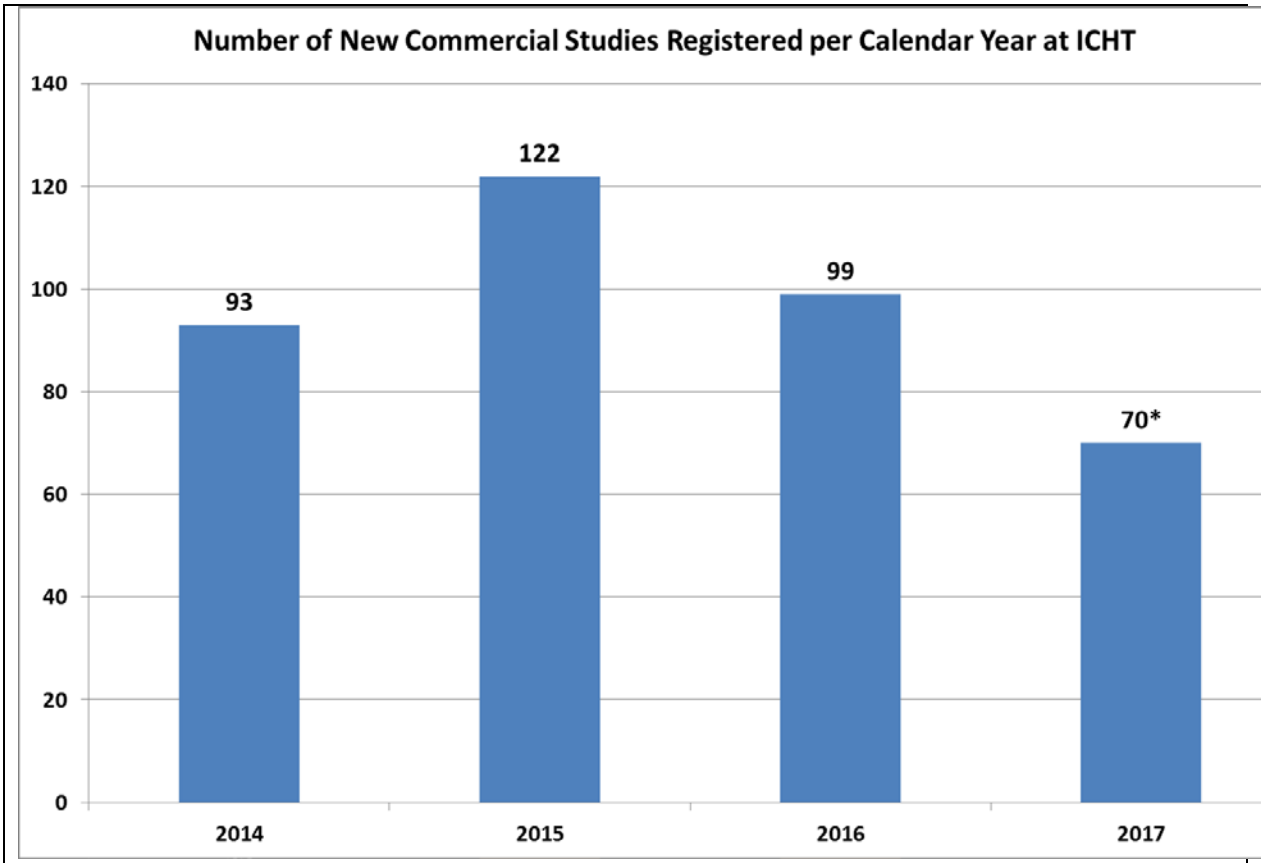


Figure 2. Number of new commercially-sponsored studies registered on ICHT study management system (as of 23/6/17).

5) Additional Points to Note

- The inaugural meeting of the new ICHT Research Committee was held on 12 June 2017, with healthy attendance from ICHT Divisions, BRC Themes and supporting services. This initial meeting provided a review of the history of R&D finance, of research governance within the Imperial AHSC, and of the BRC structure. Future meetings (to be held quarterly) will receive progress reports from the BRC Themes, performance and financial reports.
- The role of Director of the NIHR Imperial BRC / ICHT Research Director has been advertised; applications are being shortlisted. Interviews will take place on 11th August 2017.
- The 11th annual competition for NIHR Senior Investigators has opened. Senior Investigators include some of the country's foremost researchers, who make an outstanding contribution to clinical and applied health and social care research. Leading researchers funded by the NIHR and who are employed by ICHT or Imperial College may apply, depending on individual criteria. These awards bring significant revenue to ICHT in the form of Research Capability Funding (RCF) and applications will be coordinated through the BRC/Clinical Research Operations office.
- A joint response from ICHT and the College was submitted in respect of the recent consultation from NIHR/DH entitled "Health Futures: 20 year forward view". The response – which consisted of responses to 5 separate questions – can be found in Annex A.

Annex A NHIR Health Futures: 20 year forward view (consultation response)

1) **In relation to your area of interest (discipline or geography), what differences do you foresee in the state of health and provision of healthcare in England in 20-30 years' time? In your answer, please consider if/how these changes might affect some populations (within England) differently to others, i.e. socioeconomic, ethnic groups and/or geographic group**s.

This response draws on contributions from across the NIHR Imperial Biomedical Research Centre (within Imperial College Healthcare NHS Trust and the Faculty of Medicine at Imperial College London) spanning multiple clinical disciplines, services and scientific fields. We see the following to be key potential areas of development in health and provision of care, many of which are already shaping strategic choices within a number of political, health service and clinical academia developments, and within our own BRC. In brief, we consider headlines to be:

- Over the coming 20-30 years there will be progressive development in the health sector to understand and respond to the disease burden, treatment, wellbeing (including social, emotional, and mental health) and cost impacts (on the health service, the economy and on individuals) of an ageing population living longer lives, with an increasing proportion of those lives affected by complex multiple comorbidities.
- Development will involve increasing focus on;
    - prevention strategies for both communicable and non-communicable disease, working hand in hand with a push towards earlier and more accurate diagnoses;
    - a drive, for those who do need treatment, towards delivery of more personalized care, coupled with effective monitoring and management of conditions over a long period, at home or in a community setting, facilitated increasingly through use of remote devices.
- Success in the above areas will depend on, and by driven by, data and effective interpretation of that data. This will coincide with a seismic increase in the range, complexity and potential sources of health, lifestyle and environmental data which can/could be generated, stored and accessed through technological advance – leading on to a (pressing) need for refinement of approach and core skills development in data integration, visualization, interpretation, interoperability, governance and patient engagement/education.
- There will be a shift in health sector roles, education and CPD to develop and equip the existing and future workforce to engage with the data issues outlined above, as well as navigate the increasing complexity of care settings and pathways, understand and support effective risk management, manage remote patient relationships, and deliver effective multi-professional practice across sectoral / geographical distances.

The level of success of the organizational, local and national responses to the above challenges will not only shape the quality of health provision within England, but will also shape the environment for UK health research for the period and beyond. An effectively resourced and integrated health and social care strategy will both benefit from, and feed into, high quality innovation and research within the UK. Conversely, fragmentation of planning and service provision in the face of complexity and financial pressure would adversely impact the ability of the UK medical research environment to remain world-leading.

2) **What do you think will be the key drivers of the changes you have described?**

<u>Cost</u>

- Health costs have capacity to increase exponentially;
- Disease monitoring, prevention, stratification and early diagnosis can contribute to reducing the cost of care, and so will be increasingly attractive to policy-makers;

- Focus will shift to local care delivery though it will be essential this change is performed in parallel with access to specialist care where needed (eg in relation to rare disease, or key groups such as children).

Climate Change

- There will be a need to monitor and respond to emerging impacts on health as climate change manifests during the period;
- Vector-borne and parasitic disease may increase in line with disease spread associated with global warming, leading to increased incidence of existing and emergent forms of such disease in the UK.

Anti-microbial resistance (AMR)

- AMR will disrupt established forms of 'routine' care – affecting service design, treatment choice and research focus;
- Increased need for speed in diagnostic and decision-making aids for treatments;
- The speed at which micro-organisms are capable of evolving resistance is likely to exceed our ability to create new classes of chemical agents to address them – thus new paradigms for engagement with infection threats will be required.

Migration

- Migration may alter the profile of disease prevalence and disease risk/susceptibility within specific local UK cities and regions;
- Responsiveness to these alterations and strategies to address difficulties of access and communication will need to be factored into public health surveillance and service planning.

Political Shift

- Political drivers for change are also likely to include, for the early part of the period, the changes to the UK environment brought about by Brexit, with a potential impact on UK capabilities in;
    - health surveillance;
    - recruitment;
    - regulatory environments;
    - International research collaborations.

Scientific advance and multi-disciplinarity

- Population measures will address key factors in ill-health (obesity, alcohol, tobacco, air pollution);
- Effective Precision Medicine will be delivered through integration across genomics, phenomics, imaging and health informatics. It will require a culture of holistic scientific management. This is one of the key foci for the present NIHR Imperial BRC, in particular exemplified by the establishment of the Institute for Translational Medicine and Therapeutics (ITMAT);
- New cost effective strategies will derive from multi-disciplinarity, allowing deployment of environmental understanding, new technologies and materials, statistical evaluation and epidemiological analysis;
- There will be significant growth in telemedicine, remote monitoring, minimally invasive technologies. These will be key drivers in delivering a shift in location of care and an important tool in the fight against AMR;
- Risks associated with these developments include:

- Technology-related health inequalities (eg. accessing services without smart devices; regional access difficulties to major scientific health infrastructure (necessarily located within a limited number of UK institutions);
- Increased technology will entail capital and maintenance costs;
- There will be constantly developing information governance (IG) requirements and an increasing threat of 'cyber attacks' will bring a new cost burden to protect patients.

3) In your view, what will be the major trends in health and healthcare in England over the next 20-30 years? (Going beyond your immediate area and expertise).

- New care complexities will arise from longer living and disease survival (eg. damage from chemotherapy in the cancer survivor population). As previously terminal diseases become long-term manageable conditions (eg. HIV) these will add to the portfolio of shifting complexities of comorbidity. An increase in dementia prevalence with an ageing population will stretch care systems - requiring a radical shift towards developments in early detection, linked treatments and prevention strategies through lifestyle management. While these concerns will manifest among older patients, strategies to mitigate their long term cost and impact will need to focus equally strongly on the link between early-life events and subsequent adult morbidity and mortality and on earlier recognition of environmental risk factors and genetically and epigenetically determined conditions to reduce their later impact;
- There will be a growing responsibility (shared across health and, critically, other key service and political sectors) to recognize and tackle a complex set of economic, social and environmental factors which risk, without intelligent monitoring and responsive intervention, a potential increase in health inequalities across regional, racial, technological, cultural and economic boundaries. Exemplars of areas for concern include fears that under-resourcing and/or service fragmentation could lead to particularly adverse impacts and poorer health outcomes in vulnerable groups such as immigrant populations and in areas of health provision associated with social stigma (eg sexual health – such as HIV where late presentation is a poor prognostic factor);
- This shared responsibility will need to be recognised and monitored through clear allocation of accountability across policy, commissioning and care delivery sectors. Extending health and social care planning networks across larger populations and integrating interactions between these networks will become more important to maintaining balance of investment in, and access to, care;
- There will be a higher prevalence of mental health problems, which will affect management of all healthcare needs. In addition, there will need to be similarly focussed attention on effective investment in strategic service/support for individuals suffering from brain development disorders such as autism. Ensuring equal and effective access to care for these groups as part of the wider population will need to be monitored and proactively managed;
- The increasing personalisation of healthcare will have major impacts on how the healthcare profession engages with the public as 'future patients', with significant focus on the practical and ethical implications of patient empowerment and associated patient responsibility. Patient-centric demand/scientific capabilities will outstrip capacity and debate will increase on 'rationing' and/or alternative funding models/charging for care – these debates will create differences over prioritisation strategies for palliative care , life-prolonging v curative treatment, affordability of 'quality of life' interventions (eg cataracts, orthopaedics), and cost-effectiveness;
- The interface between the health service and industry will continue to develop, with private service providers, SMEs and consumer technology developers playing an increasingly important role in the healthcare landscape. There will be a continuing interest in the use of economic instruments as a lever for policy.

4) Are there any commonly discussed issues related to the future of health and healthcare in England which you believe to be overstated? If so, why do you believe them to be overstated?

- The speed of change - the health system is still largely faced with much the same burdens as we were a decade ago. Major diseases today will continue to be major diseases in the future, though they will increase in volume and patterns of disease will alter;
- The extent to which e-services can replace face-to-face contact – e-service developments will be an important in managing cost and maintaining quality of care, but cannot replace direct contact. Patients with health concerns will always need access to one to one interventions to support complex clinical management and behavioural risk reduction, despite increasing technological advances. At the other end of the spectrum patients requiring care will still require hospitalisation in many cases, though perhaps for different interventions and timeframes than is currently the case;
- Healthcare needs for immigrant populations - while important to address to enable effective service delivery to relevant populations, such needs will have a smaller proportional impact on costs and delivery of services than is sometimes represented;
- The extent to which the genomics revolution can deliver a sea-change in care by itself. Such a change will;
    - require major skills development programme to enable effective interpretation of genetic data to deliver clinical action;
    - require delivery of skilled genetic counsellors to translate data derived into patient care.

  Integration of genomics alongside other key areas of development (such as metabonomics, epigenetics, immunology) will be key to maximising the opportunity for generating translatable, scalable personalised health improvements from across any or all these areas of scientific advance.
- The ability of performance measures to inform decision making and respond to need – aspects of healthcare assessment (outcomes measures) and research processes (trial methodologies, quantitative measures of research quality) which may be too restrictive in scope to support changes in practice and behaviours required to tackle key challenges.

5) Are there any issues that are underrepresented in the debates around the future of health and healthcare in England? If so, please describe them and explain why you think they merit greater attention.

Under-representation in public and PPI debates:

- Lack of public awareness of the impact of local authority funding strategies on health outcomes, and of the importance of integrated planning between health and local government planning;
- Developing approaches for discussions around end of life care which formalise the patient's wishes in a more structured and legally acceptable way;
- Discussions around vaccine hesitancy.

Under-representation in policy and commissioning debates:

- Research foci;
    - Early life development- The first 3 years of life have a huge influence on disease risks in later life, for all killer diseases. So optimised study (which

involves metabolic, immunologic and microbiome development) and management of early life (including prenatal) care to maximise childhood and adult health will be critical in long term disease prevention strategies;

- Insufficient focus on a number of areas in policy, research and service development, e.g. renal, hepatic, respiratory, rheumatological, endocrine, inflammatory bowel disease, microbiome and to some extent cardiovascular disease;
- The role of social disadvantage in chronic disease. This is well known to be separate from lifestyle in general, but continues to be treated as it were a simple matter of improving diet/exercise/smoking;
- The future role and proper assessment of technologies and artificial intelligence in the provision of healthcare.

- Service development;
  - The realities for the health service of keeping pace with wider technology developments beyond the immediate control of the sector;
  - The influence of lobbyists on health and the need for training for policy and law makers on evidence based policymaking and statistics (training and re-accreditation);
  - The important value of behavioural insights in policy development, and development of patient pathways;
  - The importance of research being focused on areas of greatest cost effectiveness;
  - Differences in healthcare needs and best delivery models for different populations-e.g., urban/rural.
- Research delivery and impact;
  - The barriers to research (time, cost and regulatory hurdles) and associated impact on research opportunity;
  - Improving translation of research, patient involvement and uptake of innovation - need more nationally funded centres which are focused on translating research in practice (such as the NIHR Patient Safety and Translational Research Centre) - see also work done at Institute of Global Health Innovation, Imperial College London (Harris MJ, Bhatti Y, Prime M, del Castillo J, Parston G, Darzi Aet al., 2016, Global Diffusion of Healthcare Innovation: Making the Connections. Report for the World Innovation Summit for Health, World Innovation Summit for Health 2016, Publisher: World Innovation Summit for Health).

<u>Under-representation in professional/sectoral development:</u>

- Reducing interest and support for clinical translational research careers - these posts will be critical to delivering evidence-based solutions to the challenges outlined in previous questions;
- Ensuring clinical trial evidence is applied effectively in the appropriate patients in a personalised approach rather than non-selective application of evidence;
- Potential partnership models between industry providers of treatments or diagnostics and the NHS.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Engagement Survey Results

Executive summary:

This paper summarises the initial results of the latest Local Engagement Survey **"Our Voice Our Trust**" which was run across the trust between May 2 and June 30 2017. It will also outline the next steps in the process of reviewing these results across the Trust and devising action plans. This is the second Local Engagement survey run in this format and therefore can provide us with comparative data over time.

The headlines of the results show that

- the overall Engagement score increased from 77% in 2016 to 80% in 2017
- the FFT recommend as a place for care or treatment improved from 83% to 86%
- the FFT recommend as a place to work improved from 65% to 72%

The FFT scores were our highest performance to date in the last 3 years

The majority of our Divisions show an increase in Engagement, most notably in WCCS (76% to 82%) and SCCS (76% to 80%). Within Job role/profession, there has been a 6% increase (79% to 85%) in Nursing (Qualified) and 11% increase amongst Consultants (69% to 80%).

An analysis of the highest and lowest performing questions shows a very consistent result to last year; the lowest performing questions remain the same as last year but have all improved by a minimum of 3%:-
-Senior leaders are genuinely interested in staff opinions and ideas (52% to 57%)
-Senior leaders communicate well with the rest of the organisation (50 to 57%)
-Senior leaders and visible and approachable (49% to 56%)
-I generally have enough time to complete all of my work (51% to 54%)
-Poor behaviour and performance is addressed effectively in this organisation (43% to 48%)

The paper provides a range of additional breakdown information on the survey results. The results are being distributed and disseminated to all managers during July/early August and managers will be encouraged to develop action plans to address issues raised by September 8th 2017. Managers have access to an on line dashboard to analyse their own data, both statistic and verbal commentary to help them understand their results.

In addition, further analysis is being carried out to understand the feedback in areas of concern identified in previous surveys including Bullying and Harassment, Health and Well Being during July/August.

The next National NHS Survey will be carried out in September –December 2017 and plans are in place to communicate initial results and actions being taken in time for the next National Survey in order to maximise the response and results to that.

Quality impact:

There is growing research identifying a link between staff engagement/staff well-being, and patient well-being, hospital acquired infections, mistakes, outcomes, mortality rates and patient experience. The Staff Engagement Strategy links to aspects of CQC domains, but in particular to Well-led.

Financial impact:

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

1) Has no financial impact

Risk impact:

There are a number of risks associated with low staff engagement. Low staff engagement correlates strongly with retention and the associated vacancy rates. The paper details the mitigating actions being taken which include:-

-measuring staff engagement down to ward level

-providing tools for managers to improve staff engagement

-leadership development for all managers which includes behavioural strategies to drive engagement

Recommendation(s) to the Trust board:

The board is asked to NOTE

1. The Engagement Survey results
2. The plans for driving action plans and change as a result of the feedback

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director	Date submitted
Sue Grange, Associate Director of P & OD	David Wells, Director of P & OD	20 July 2017

Imperial College Healthcare NHS
NHS Trust

OUR VOICE
OUR TRUST

2017

Our staff survey

Using insights to drive improvement

Headline Report

17 July 2017

Why are we focusing on engagement?

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Staff engagement is defined as "*a set of positive attitudes and behaviours enabling high job performance of a kind which are in tune with the organisation's mission*," (Storey, 2008)[1].

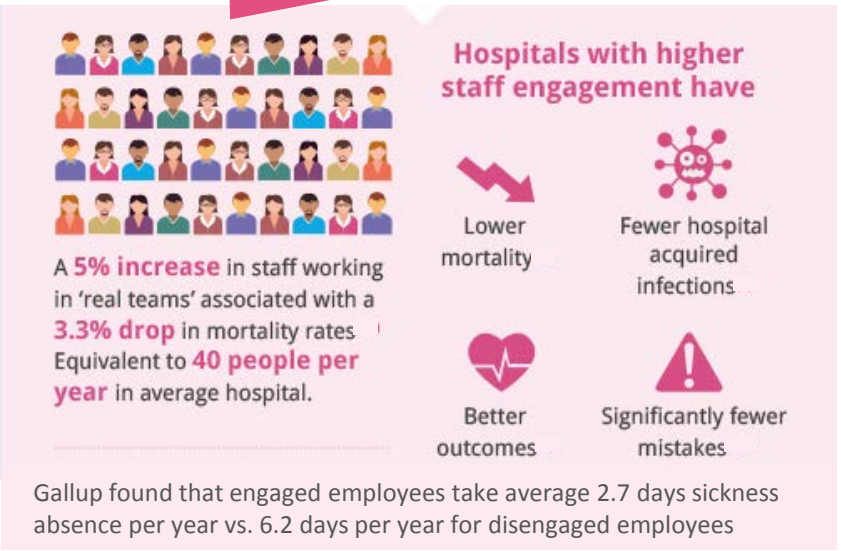
Why would we be concerned with this?

Because "*…there is a clear relationship between the wellbeing of staff and patients' wellbeing*" according to a major Kings Fund study in 2012[2].

Additional evidence shows that hospitals with higher levels of staff engagement have:

- Fewer hospital acquired infections [3]
- Significantly fewer mistakes [4]
- Better outcomes [5]
- Lower mortality rates [6]
- A better patient experience [7]

"There is a clear relationship between the wellbeing of staff and patients' wellbeing." *Kings Fund 2012*



Gallup found that engaged employees take average 2.7 days sickness absence per year vs. 6.2 days per year for disengaged employees

Sources

Boorman NHS Health and Well-being: final report. London: Department of Health, 2009

Dawson JF, West MA, Admasachew L, Topakas A, NHS Staff Management and Health Service Quality; *London, Department of Health*, 2011

Boorman NHS Health and Well-being: final report. *London: Department of Health*, 2009 and *The Kings Fund* 2012

Prins JT et al, Burnout and engagement among resident doctors in the Netherlands: a national study'. *Medical Education*, 2010

West M., Creating a culture of high-quality care in health services, *Global Economics and Management Review*, 2013

Harter, JK et al (2006) Q12 Meta-analysis Gallup

Introduction to this report

During May and June 2017, 2,802 people responded to our "Our Voice 2017" annual staff survey. This report summarises the results of this survey It outlines:

- Why staff engagement is important.
- Overall engagement and 'Friends and Family Test' (FFT) scores from the survey.
- Our key strengths and overall opportunities for improvement.
- The factors that influence engagement and how respondents scored them.
- Recommendations to improve response scores in key factors influencing engagement.

Managers will have access to an on-line dashboard from W/C July 24th to see their own team's scores and compare these to the overall organisation.

As last year we expect every manager to discuss results with their teams and we have developed a support toolkit including advice on interpreting results and team discussion guides.

How to read the results: Results are presented as bar graphs as shown below. The % represents a 'favorability rating' which is equal to the percentage of respondents who 'strongly agree' and 'agree with the statement/ question.

Green = Strongly Agree/ Agree
Yellow = Neither Agree nor Disagree/ Neutral
Red = Strongly Disagree/ Disagree

NB. For negatively worded questions where 'strongly agree' is a poor answer these scales have been reversed. **Green is always good.**

NEW to 2017

This % to the right of the breakdown bars shows favorability rating for 2016 survey. Green means this year's score is better. Red means this year is worse.

‘Our Voice’ survey response rates

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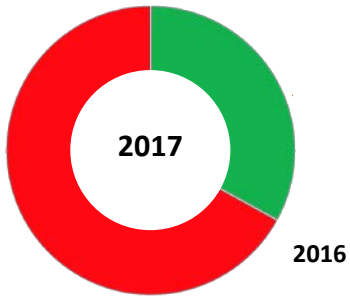
Methodology

‘Our Voice’ survey was open from 3 May to 30 June 2017 (8 weeks). An electronic link was sent to all staff with a live email account. Reminders were sent on a weekly basis. A generic link was available on the Source or via a QR code to maximise opportunities to complete the survey.

Response rates

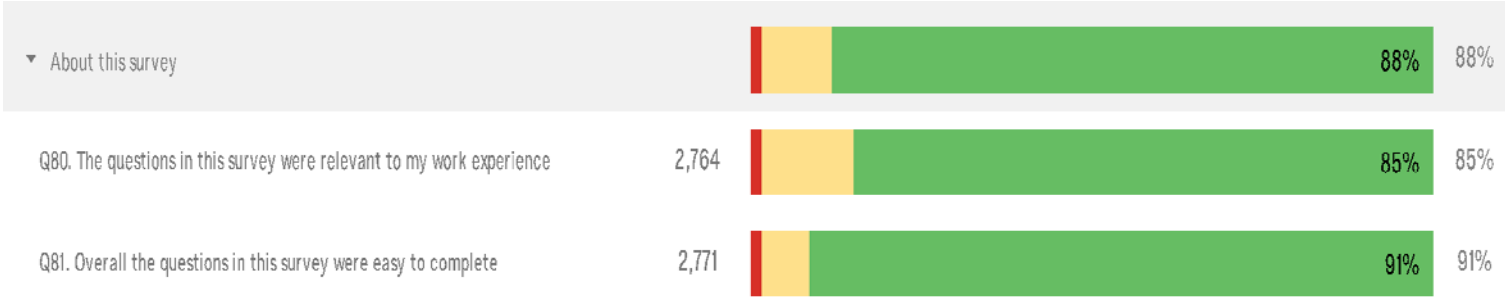
A total of 2,802 responses were received, (**33%**). This is slightly lower than last year’s survey for which the response rate was 38%



2017 responses – 2,802
2016 responses – 3,224

Feedback on the survey itself

Just as effective as last year



Overall engagement

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Overall engagement ('favorability') score is 80 up from 77 last year.

This is our overall outcome measure. It allows us to track engagement levels over time. It is calculated from a combination of three factors:

- *Advocacy*: How likely people are to recommend Imperial College Healthcare NHS Trust to friends and family as a **place to work** – Q3
- *Motivation*: How motivated to give their best effort at work people self-report feeling– Q53
- *Satisfaction*: Overall how satisfied people say they are with their job – Q76

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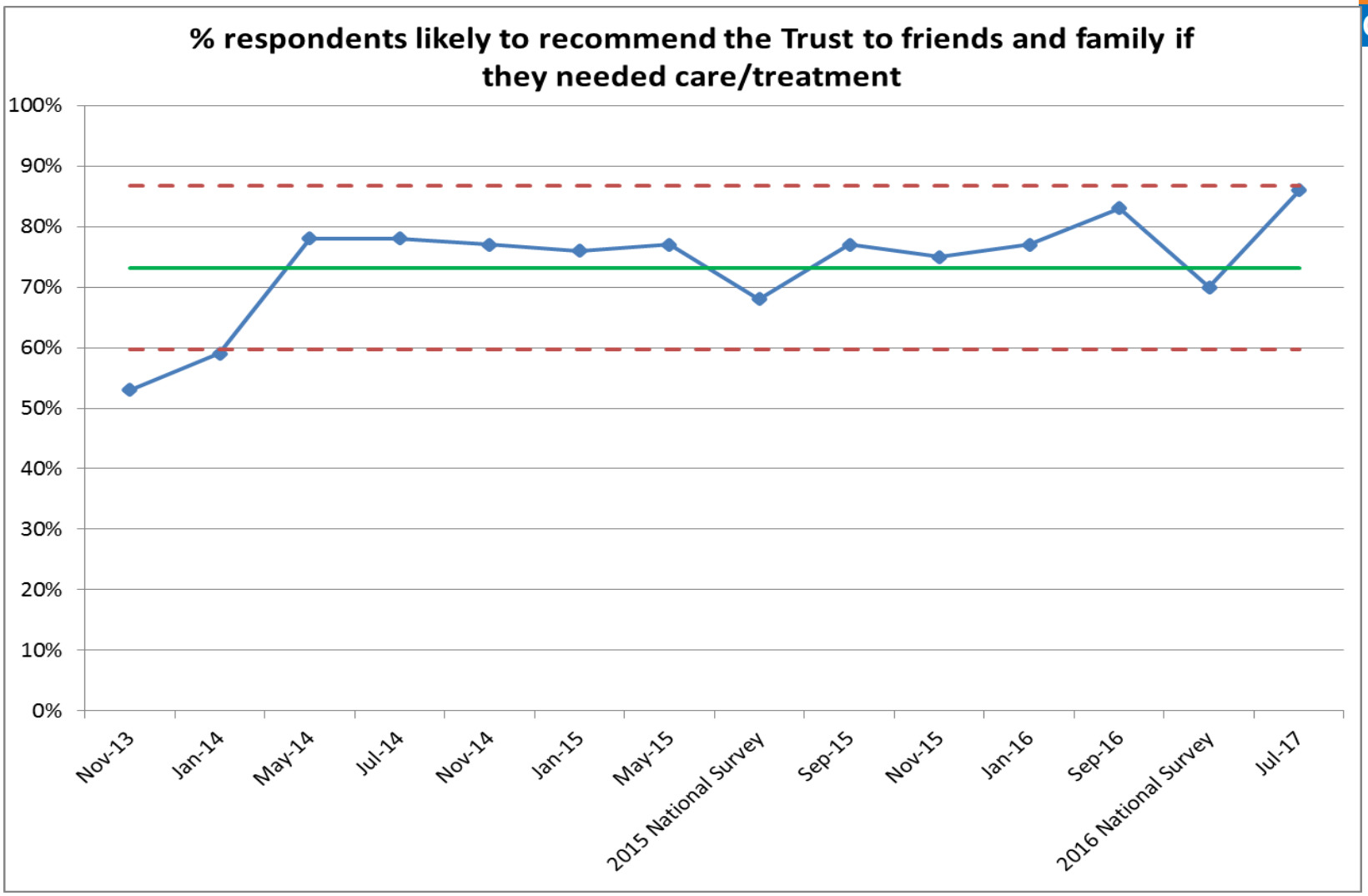
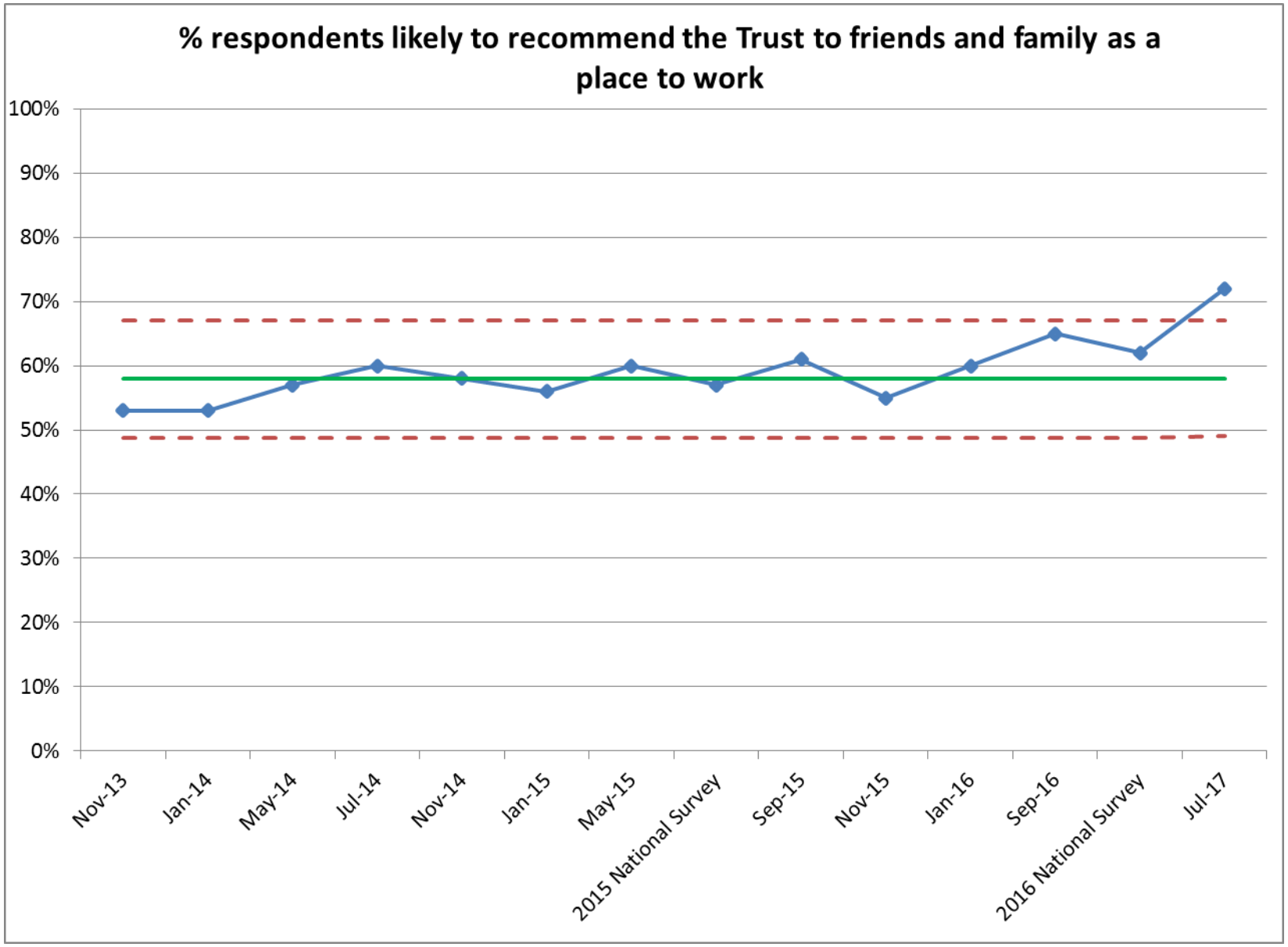


86%

Average % Upper/Lower control limits



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72%

Average % Upper/Lower control limits

Overall message is one of improvement

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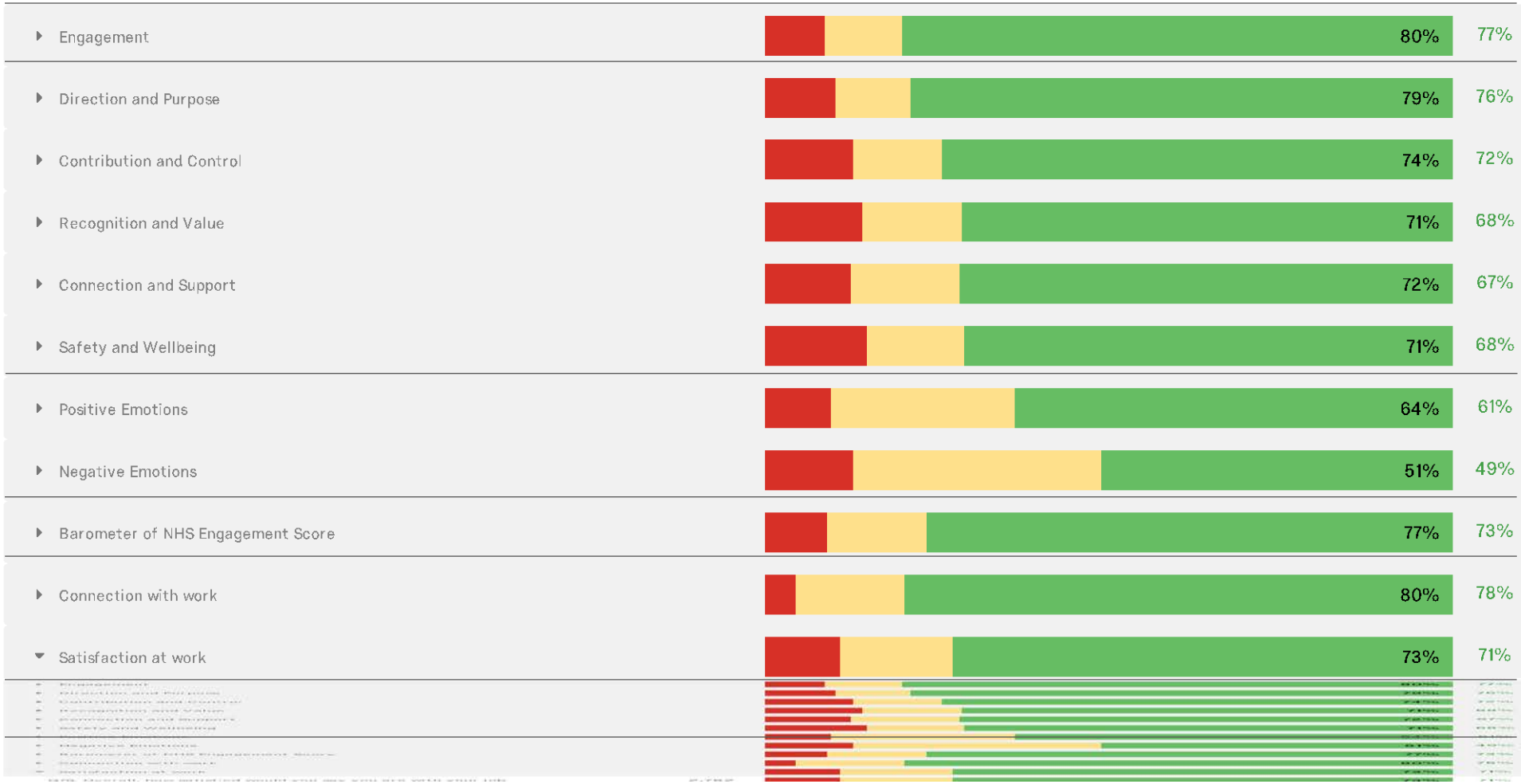
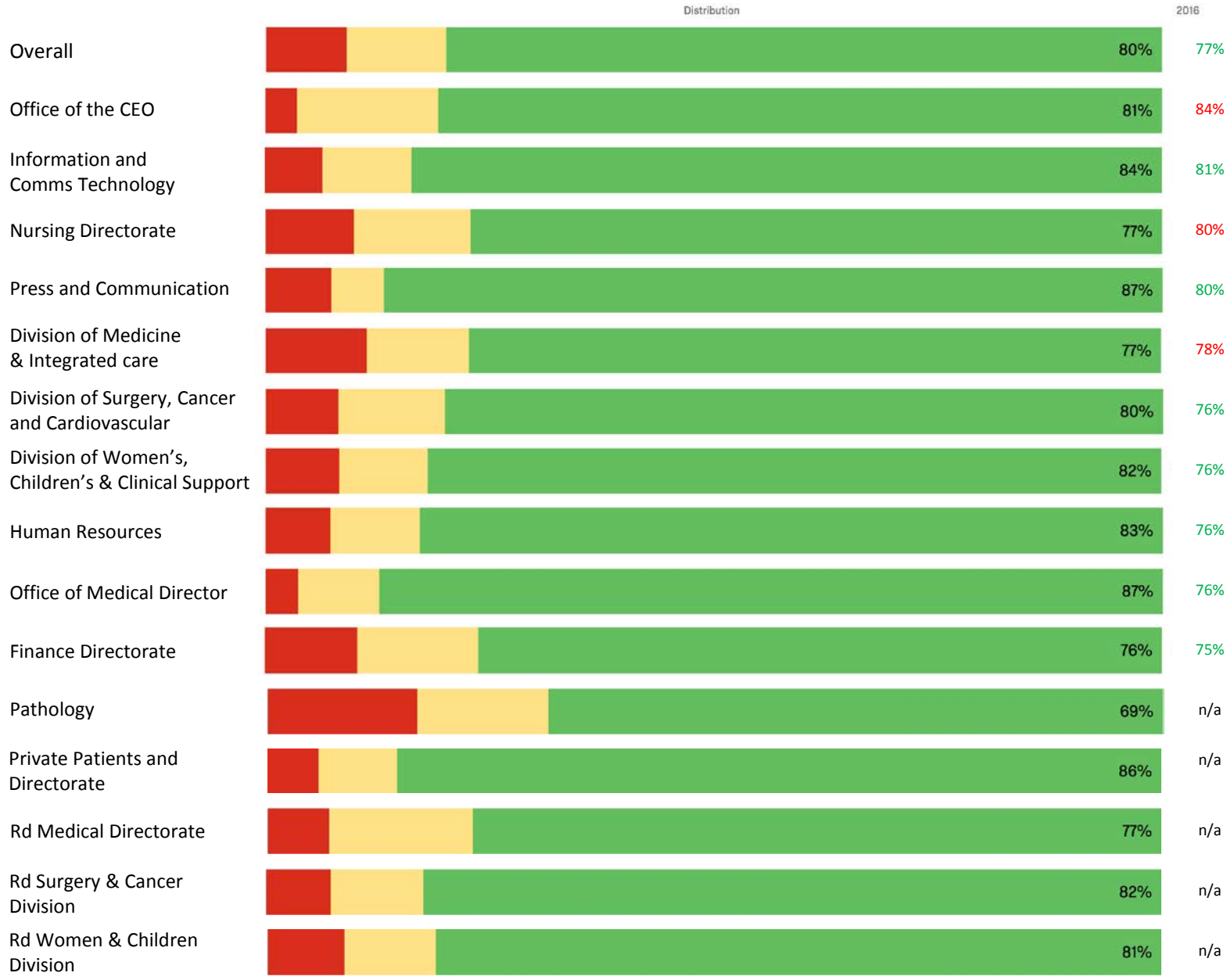
OUR TRUST

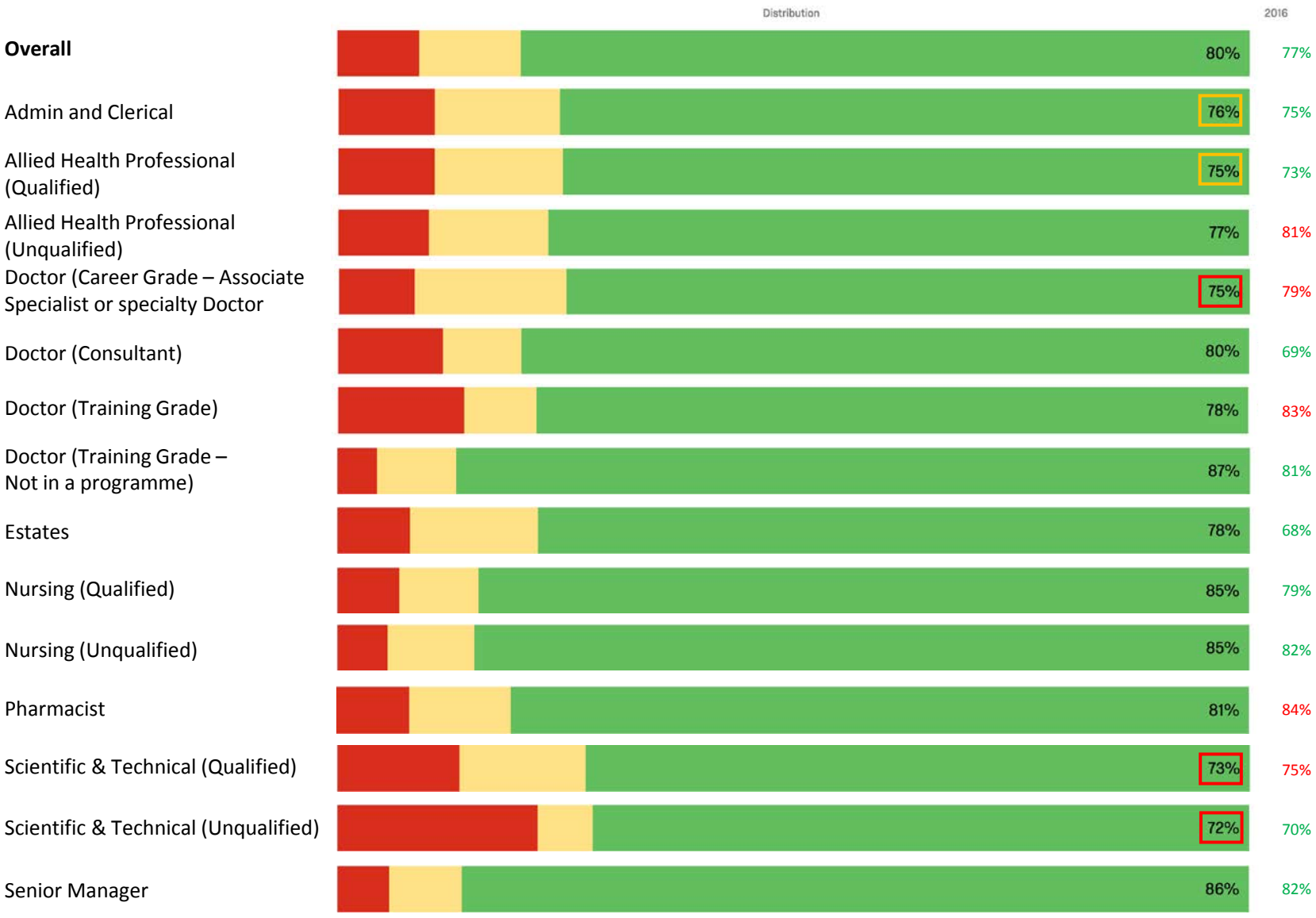
This shows the rolled up averages for each of the main sections in the survey.
Shows improvement in all areas of staff engagement and experience.



Engagement by division



Engagement by job role or profession



Highs and lows

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These are the questions about the drivers of engagement – people's experience at work – which display the highest and lowest scores across the survey. This provides one view of priorities for improvement.

Ranked by 'favorability %' ie % agree + % strongly agree (for negatively worded questions eg bullying % disagree + strongly disagree)

Key drivers: where to act first

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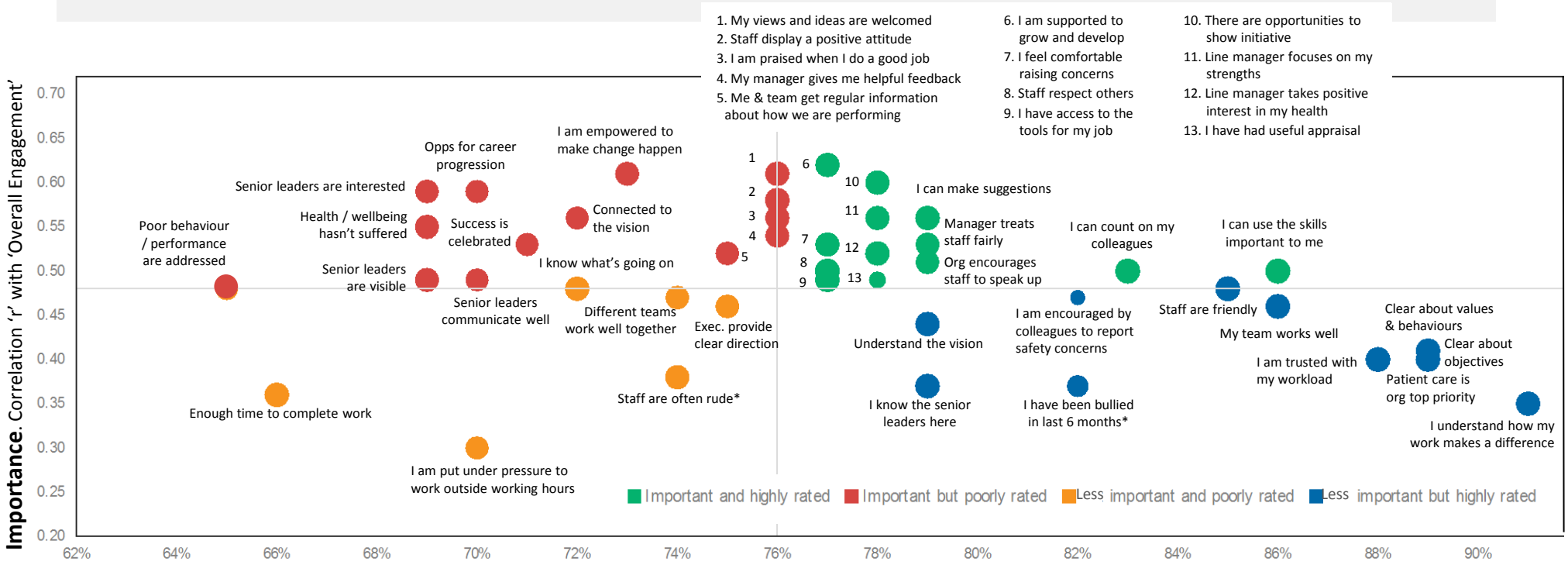
- This is a more insightful way to identify priorities for improvement. The Y-axis shows strength of correlation with overall engagement score. This is a measure of **importance**. Acting on questions with high correlation is likely to have more impact on engagement.
- The X-axis shows **performance** of that question in the survey. Mapped with mean score as a %, which is different to the favorability %
- ACT FIRST on the red dots. These are highly correlated with engagement, and have the most room for improvement



Performance. Mean score out of 5, expressed as a percentage. NB this is different to 'favorability' % in green on breakdown bars.

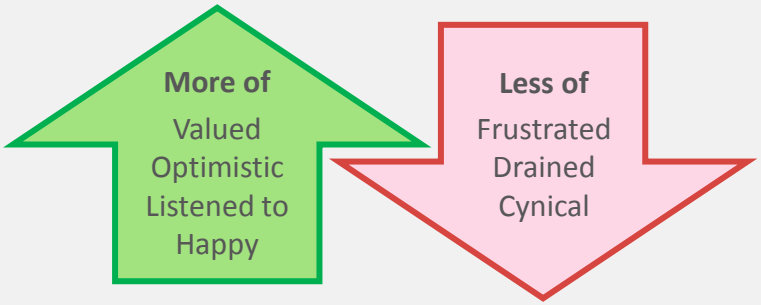
Worse scores → **Better scores**

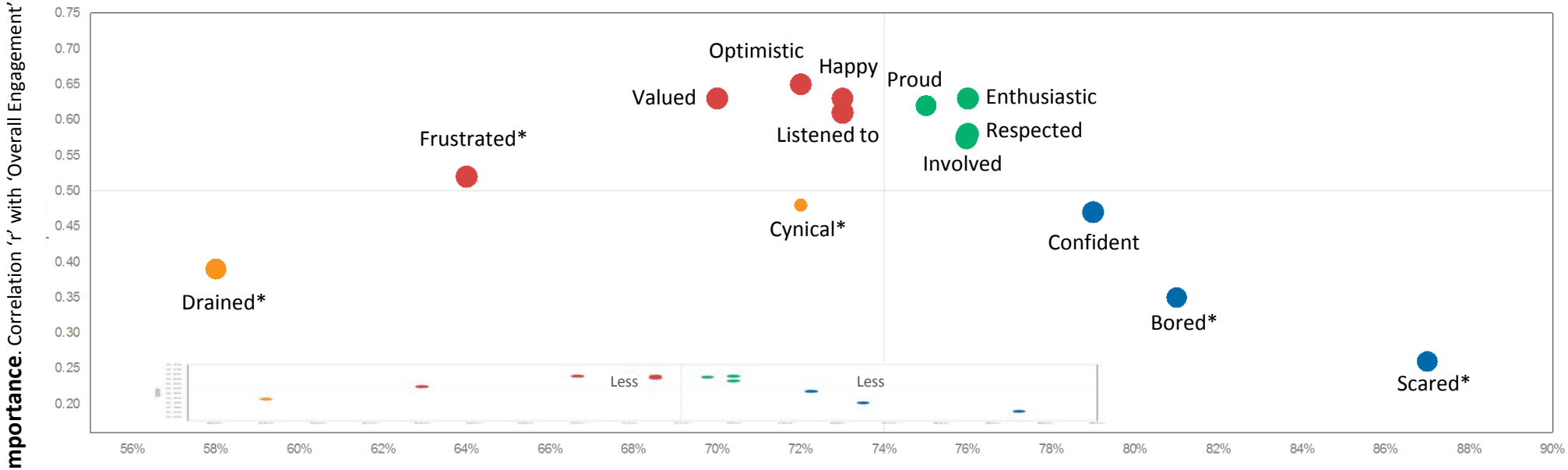
* NB negative questions eg bullying, scores are reversed. Scores to RIGHT is good, scores to the LEFT are bad.

Emotions. Where to act first.

- Similar chart – for staff emotions shows correlation with overall engagement score. This is a measure of **importance**. Acting on these will impact most quickly on engagement
- Vs. **performance** of that emotion in the survey – ie how regularly people feel it. Negative emotions are reversed. We want to see all emotions negative or positive to the right hand slide
- <u>We can act on staff emotions separately to other drivers. ACT FIRST</u> on the red dots. Highly correlated, most room to improve.

Key emotions to target





Performance. Mean score out of 5, expressed as a percentage. NB this is different to 'favorability' % in green on breakdown bars.

Worse scores → **Better scores**

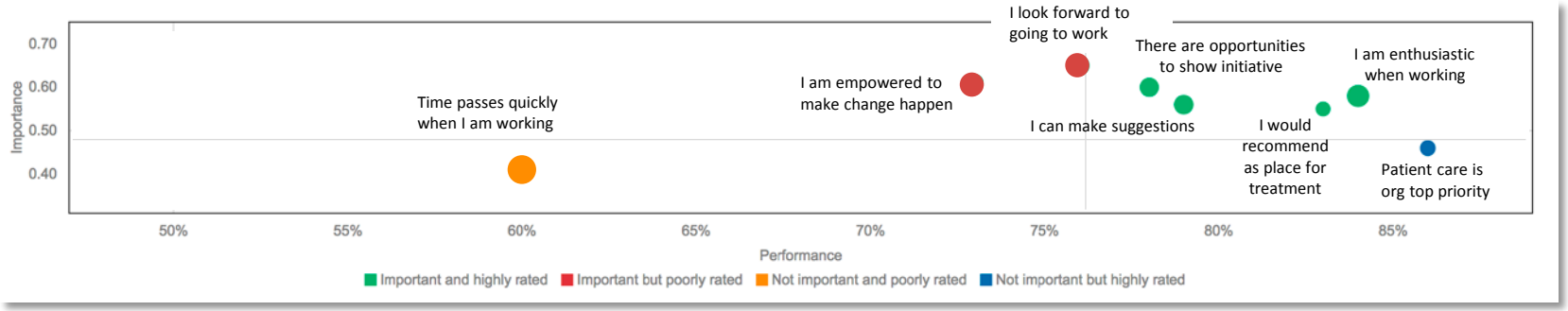
*NB negative emotions, scores reversed, as we want fewer of those. So for positive and negative emotions the RIGHT is good, scores to the LEFT are bad.

How does our engagement score compare?

Our engagement score uniquely calculates engagement based on the three conditions described previously. The Annual NHS Staff Survey uses 9 questions (below) to calculate staff engagement. The weightings applied to each question are not available to individual Trusts so direct comparison is problematic. Our performance across the 9 questions is shown below.

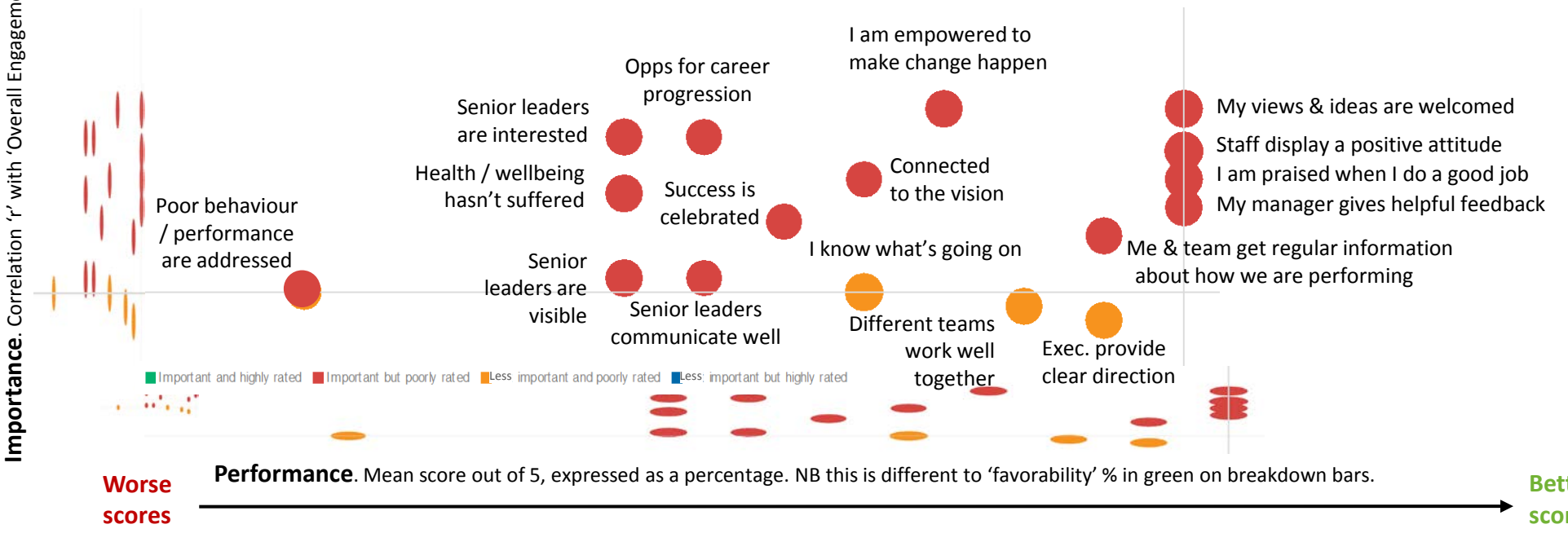
The recommendation from 2016 results was to focus on enabling people to make local change happen – this question has improved in 2017.

Barometer of NHS Engagement Score		77%	73%
Q11. Care of patients / service users is my organisation's top priority	2,760	86%	82%
Q22. I am able to make suggestions to improve the work of my team / department.	2,771	79%	76%
Q20. There are frequent opportunities for me to show initiative in my role	2,770	76%	73%
Q21. I am empowered to make change happen in my area of work	2,763	65%	60%
Q59. I look forward to going to work	2,773	64%	61%
Q60. I am enthusiastic when I am working	2,782	81%	82%
Q61. Time passes quickly when I am working	2,777	80%	79%
Q1. I would recommend my organisation as a place to receive care or treatment 5 is '...	2,756	86%	83%
Q3. I would recommend my organisation as a place to work 5 is 'extremely likely...	2,756	72%	65%

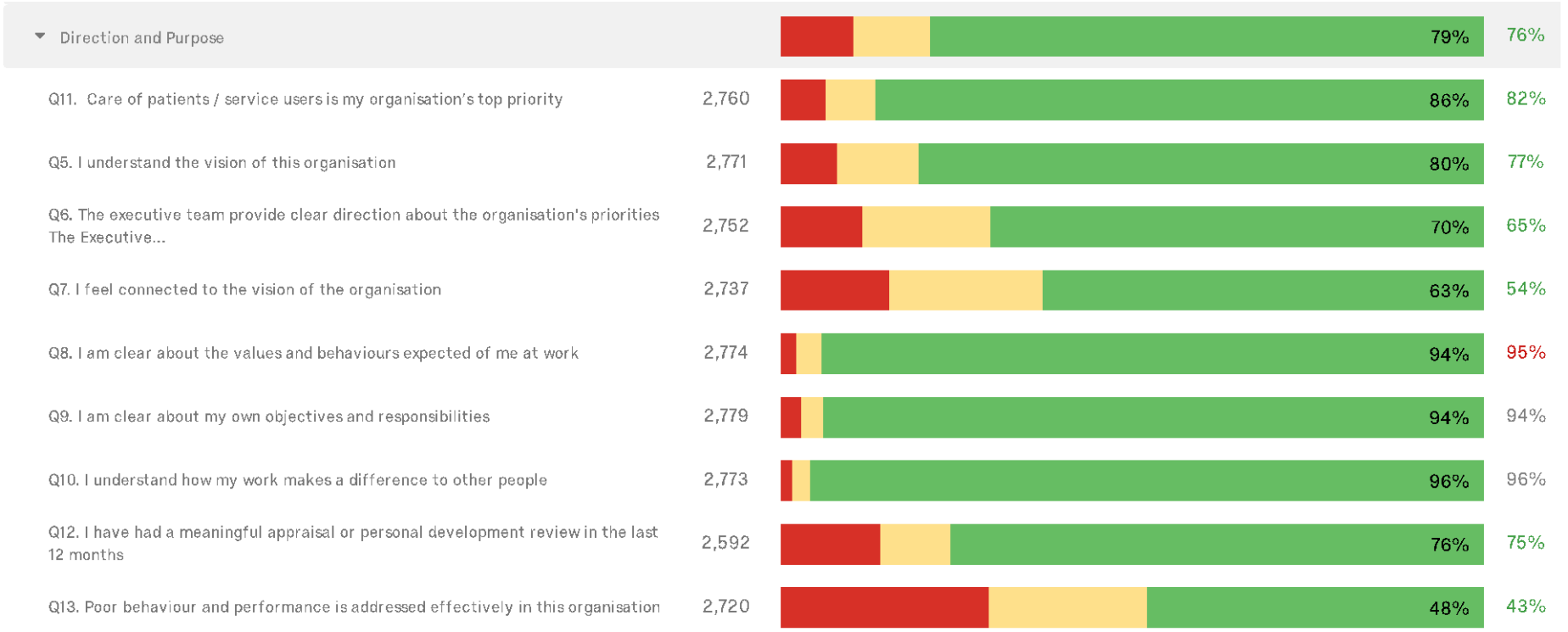


Emerging themes

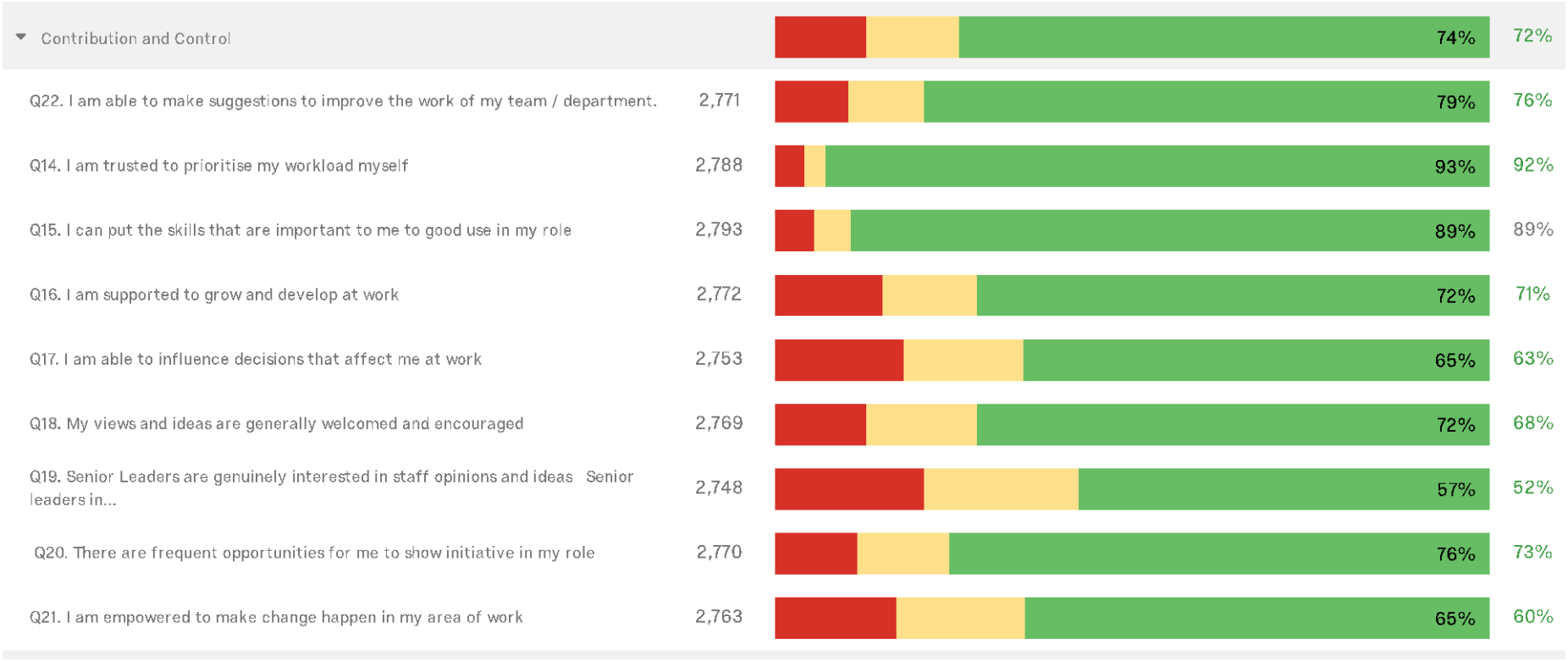
- **Senior leaders**: could be more visible, communication, clearer direction and vision and interested in views of staff
- **Managers**: give more regular helpful feedback ant personal and team performance, celebrate success and give praise
- **Poor behaviour** – leaders address it, make it easier for managers and staff to discuss poor behaviour / performance
- **Positivity**, positive attitudes, celebrate successes, appreciation
- Staff **heath and wellbeing**
- **Involved**, empowered to make change happen, ideas welcomed



Trust-level drivers scorecards: Direction and Purpose (1)



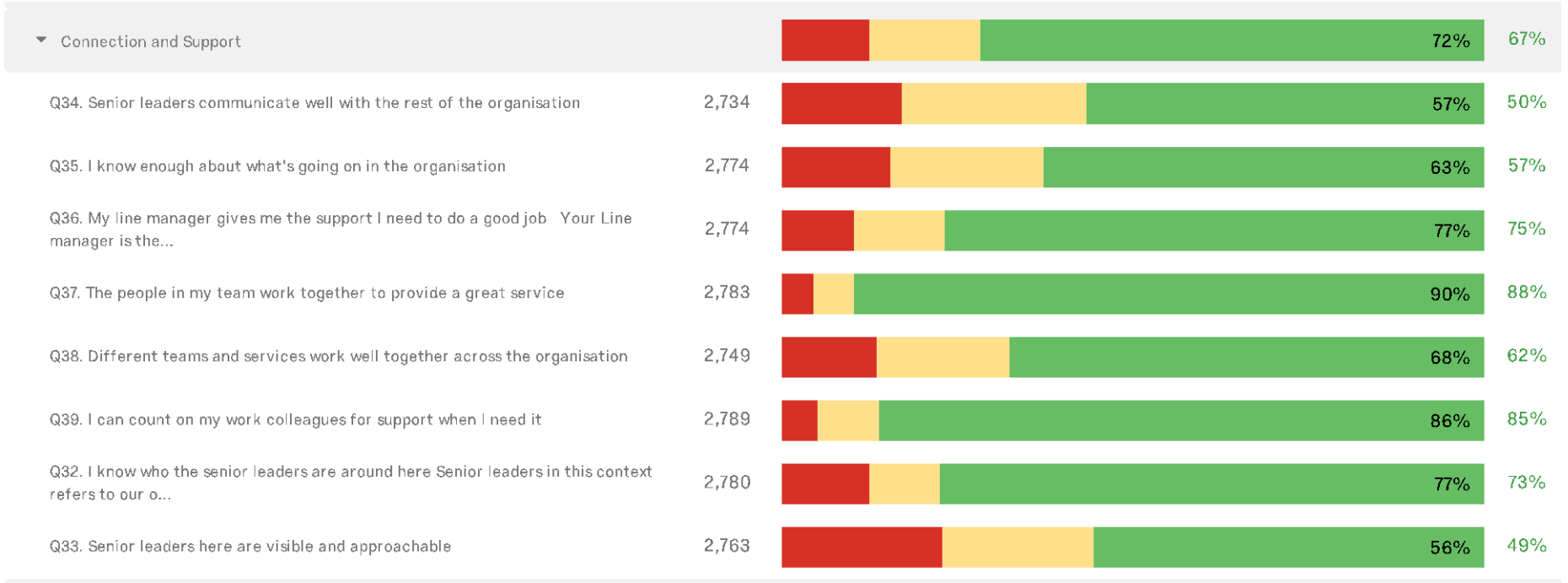
Trust-level drivers scorecards: Contribution and Control (2)



Trust-level drivers scorecards: Recognition and Value (3)

Recognition and Value		71%	68%
Q28. Me and my team get regular information about how we are performing	2,749	69%	65%
Q23. Staff here are generally friendly and welcoming	2,790	89%	89%
Q24. Staff respect each other whoever they are and whatever their role	2,787	74%	71%
Q25. My line manager focuses on my strengths and helps me to develop Your Line manager is ...	2,766	73%	72%
Q26. My line manager gives me regular, helpful feedback on my work	2,758	69%	66%
Q27. My line manager treats all their staff fairly	2,757	76%	73%
Q29. I am praised and recognised when I do a good job	2,771	70%	66%
Q30. Successes and small wins are celebrated in this organisation	2,735	61%	56%
Q31. There are opportunities for career progression at work	2,736	60%	57%

Trust-level drivers scorecards: Connection and Support (4)



Trust-level drivers scorecards: Safety and Well Being (5)

Next Steps

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Key Action	Date	Lead
Distribute headline results pack to all Division and Directorate mangers	20th July	P & OD (Sue Grange/Nathaniel Johnston)
Switch on access to dashboard reporting tool for managers Distribute Managers guide an supporting tools	W/C 24th July	P & OD (Sue Grange/Nathaniel Johnston)
Communicate results to teams, review and analyse local results, devise action plans and communicate action being planned or taken	July - Sept	All managers
Deadline for first draft of Directorate and Divisional action plans	8 Sept	All Managers
Anticipated go live for 2017 National NHS Staff Survey	W/C 18 Sept	P & OD (Sue Grange/Nathaniel Johnston)

Tools and Resources to Support Engagement Action Planning

1

Managers Guide to Understanding your results

Will be sent to all managers with headline results pack 20 July

2

Results Dashboard: explore and analyse your own results and verbal comments At ward/dept./directorate/divisional level through online dashboard

Access Passwords to be sent to all managers with high enough response rate W/C 24th July

3

In our Shoes Workshops: run a listening workshop with teams -10 -100 people to enable meaningful co-design of action plans. Flexible design from1-3 hours

Contact nathaniel.johnston1@nhs.net or your HRBP for further information

4

NEW "Engage Toolkit": Use toolkit for ideas on how to improve engagement in your team

Copies to be distributed with headline results or contact nathaniel.johnston1@nhs.net or your HRBP for hard copies (

NEW "Engage Workshop" : 3 Hour workshop to support managers in the Trust to think creatively and innovatively about how they engage their staff

Dates now available to book onto workshop YODEL

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Freedom of Information (FOI) report

Executive summary:

This paper provides a summary of the Trust's compliance with the Freedom of Information Act 2000 during the financial year 2016/17.

As a public authority, the Trust is legally bound to respond to requests for information under the Act, and must aim to do so within twenty working days. This report details the numbers of requests received by the Trust in 2016/17, and our compliance with the twenty working day deadline to respond to requests.

Quality impact:

Compliance with the Freedom of Information Act 2000 allows the Trust to share information and knowledge, openly and honestly in line with our collaborative values.

Financial impact:

The paper has no financial impact.

Risk impact:

The Trust is under a legal obligation to respond to all requests made under the Freedom of Information Act 2000. Poor performance puts the Trust at risk of reputational damage. Continued poor performance can result in the Information Commissioner's Office (ICO) issuing an enforcement notice against the Trust should it repeatedly fail to comply with its obligations under the Act.

Recommendation(s) to the Committee:

To note the paper

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
Barney Langrish, Freedom of Information manager	Michelle Dixon, director of communications	20 July 2017

Freedom of Information (FOI) report 2016/17

Month	Number of FOI requests received	Number of FOI requests processed within the 20 day deadline	Number of FOI requests processed outside the 20 day deadline	% compliance with 20 day deadline
April 2016	61	56	5	90

May 2016	55	48	7	87
June 2016	66	55	11	83
July 2016	73	65	8	89
August 2016	65	60	5	92
September 2016	66	59	7	89
October 2016	70	61	9	87
November 2016	70	60	10	86
December 2016	46	40	6	87
January 2017	78	67	11	86
February 2017	94	80	14	85
March 2017	77	71	6	92
Total	821	722	99	88

The Trust saw a significant increase in the receipt of requests in 2016/17 (821 received) when compared to 2015/16 (681 received). An additional 140 requests were received, representing an increase of nearly 21%. In particular, 94 requests were received in February 2017, which constitutes the highest volume of requests ever received by the Trust in a month, and a 64% increase on the same month in 2016 (57 received).

Of the 821 requests received, 88% were responded to within the 20 working days specified by the Act. This is a decrease from 91% in 2015/16; however, an additional 101 requests were responded to within the time limit due to the increase in requests received.

Specific areas of interest covered by requests received in 2016/17 have been: spend on agency staff; overseas patients; the junior doctors' contract; and cyber-attacks.

The majority of requests received by the Trust are from the media and commercial parties.

One request for an internal review was received in 2016/17. Internal reviews can be requested by an applicant where they believe the Trust has not responded appropriately to their request. This internal review related to a request regarding details of cyber-attacks at the Trust and how we prevent and respond to these. Our initial response exempted all the requested information under section 31(1)(a) (the prevention or detection of crime) due to the risk of exposing the Trust to attacks by revealing the defences in place. On review it was found that releasing the number of attempted attacks would not prejudice this, but that the exemption was correctly applied to the rest of the information.

No complaints were made to the ICO relating to FOI in 2016/17.

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board	26 July 2017

Final Quality Account 2016/17

Executive summary:

The Trust's quality strategy 2015-18 is being delivered through the achievement of our quality goals which are supported by specific annual targets and a number of improvement programmes. These are set out in our strategy under the five quality domains (safe, effective, caring, responsive and well-led). From 2015 to 2018, our annual quality account reports on progress against the three-year strategy and confirms the priority programmes and targets for the following year.

Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. According to NHS England, their primary purpose is 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 quality account was developed using the Department of Health Quality Account toolkit and complies with the mandatory requirements, in the following structure:

- Part 1: statement from the Chief Executive
- Part 2: priorities for improvement in 2017/18 and mandatory statements relating to quality
- Part 3: review of our quality performance in 2016/17 and statements from stakeholders

This report presents the final published version of the quality account for 2016/17 for information. Following an extensive consultation process with internal and external stakeholders, the final draft document was reviewed and approved at Board in May 2017 where authority for final sign off was delegated to the chief executive and chairman. The draft was then professionally designed to incorporate pictures and graphics. The final document was published on NHS Choices and the Trust website on 30 June 2017 in line with requirements.

Quality impact:

The trust's quality strategy is the plan through which we focus on the quality of clinical care, ensuring that quality is central to all that we do and that we are focused on continuous improvement at all levels of the organisation.

The strategy is designed to deliver improvements in all five quality domains, ensuring our services are safe, effective, caring, responsive and well-led.

Financial impact:

This paper has no financial impact.

Risk impact:

There are numerous risks associated with delivery of the quality strategy goals, programmes and targets, which are described in the trust's corporate risk register. The annual quality

account provides assurance to internal and external stakeholders that plans to improve quality in the Trust are robust.
Recommendation(s) to the Board:
The Board is asked to note the final published version of the quality account for 2016/17.
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. 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.

Author	Responsible executive director	Date submitted
Clementine Burbidge, Quality Strategy Implementation Manager	Julian Redhead, Medical Director	19 July 2017

Quality Account

2016/17

Imperial College Healthcare NHS
NHS Trust

Contents

Glossary

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page 90.

Alternative formats

This document is also available in other languages, large print and audio format on request. Please contact the communications directorate on 020 3313 3005 for further details.

Este documento encontra-se também disponivel noutros idiomas, em tipo de imprensa grande e em formatoáudio, a pedido.

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Este documento también está disponible y puede solicitarse en otros idiomas, en letra grande y formato de audio.

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Statement from the Chief Executive

We at Imperial College Healthcare NHS Trust are committed to helping the people we serve to live their lives to the fullest. We aim to do this by providing high quality care, whenever and however we are needed, and by working in partnership, supporting our patients to take an active role in their own health and wellbeing.

I am very proud of our Trust and optimistic for its future – though the whole NHS is in challenging times, we have so much to draw on in terms of the expertise, kindness and commitment of our staff. The amazing response we had to Hospital, the BBC2 documentary series about our organisation, provided tangible evidence of this, if it were needed.

Despite increasing financial and capacity pressures on our services, and on the NHS as a whole, we have seen some significant improvements this year. Building on our transformation programme launched in 2015/16, and supported by a re-organisation of our management structures at the beginning of this year, our staff have delivered real achievements in maintaining excellent clinical outcomes while reducing avoidable harm to patients, focusing on how we learn from mistakes and improve patient experience. I am particularly proud that we have delivered these improvements in the context of the significant challenges we have faced throughout the year to meet key national access standards and tackle long-standing pressures around demand, capacity and patient flow. Although we still have a lot more work to do, I am confident that we are starting to improve how we manage these pressures, whilst ensuring we continue to provide the best possible care to all our patients.

Most encouragingly of all, our staff are increasingly positive about working here. Our results in both our internal and the national staff engagement surveys have improved hugely and reflect our changing organisational culture; empowering staff to continuously improve the service they provide and working with our patients and communities to ensure that we are among the best healthcare providers in the country – safe, effective, caring, well led, and responsive to our patients' needs.

Our plans for 2017/18

Over the coming year, it's important that we address the immediate challenges we face but we also need to continue with the more strategic changes that will allow us to meet future health needs. We will focus on delivering the last year of our quality strategy to ensure sustainable and continuous improvement across our services, supporting the North West London Sustainability and Transformation Plan by ensuring we provide safe, high quality, sustainable acute services, while working with our partners to deliver better care across our communities.

With our staff, stakeholders and the public, we will also draw up our plans for the next three years, creating our third quality strategy which we will publish in spring 2018. This will build on the successes of our current strategy, while focusing on areas where further work is needed.

Acknowledgements

I hope that this quality account paints a clear picture of our commitment to continuous improvement, and of how important the safety and experience of our patients are to us all at Imperial College Healthcare NHS Trust.

We would like to thank everyone who helped us compile this document, including members of the public, Healthwatch, local authorities and commissioner colleagues.

Much of the work that is described in this document could not have been done without the generosity of our charity, so I would like to extend my thanks for all their support.

Finally, I would like to thank all our staff who work tirelessly every day to better the lives of patients and the community we serve.

Dr Tracey Batten
Chief executive, Imperial College Healthcare NHS Trust
20 June 2017

About this report

Quality accounts were introduced in 2009 to make healthcare organisations more accountable when it comes to quality of care. They are designed to report on how we have performed against the targets we set for ourselves last year, and to share our targets for next year.

There are a number of inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

We have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of the data reported, but we recognise that it is nonetheless subject to the inherent limitations noted above. We are working to improve data quality across the organisation, as described on page 39. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page 90.

If you have any questions, would like to provide feedback on this report, or to be involved in producing it next year, please email quality@imperial.nhs.uk.

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare quality accounts for each financial year. The Department of Health has issued guidance on the form and content of annual quality accounts, which incorporates the legal requirements in the Health Act 2009 and National Health Service (Quality Accounts) Regulations 2010 (as amended).

In preparing the quality account, directors are required to take steps to satisfy themselves that:

1 the quality account has been prepared in accordance with Department of Health guidance and National Health Service (Quality Accounts) Regulations 2010 (as amended) and presents a balanced picture of our performance over the period covered.

2 the content of the quality account is not inconsistent with internal and external sources of information including:

- Trust board minutes and papers for the period April 2016 to May 2017
- papers relating to Quality reported to the Trust board over the period April 2016 to May 2017
- feedback from local Clinical Commissioning Groups
- feedback from local scrutineers, including Healthwatch and local authority overview and scrutiny committees
- the Head of Internal Audit's Annual Opinion April 2017
- the national inpatient survey 2016
- the national staff survey 2016
- the General Medical Council's National Training Survey 2016
- mortality rates provided by external agencies (NHS Digital and Dr Foster).

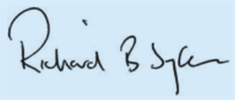
3 There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and those controls are subject to review to confirm they are working effectively in practice.

4 The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The directors have reviewed the quality account at executive quality committee in May 2017 and confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account. The quality account was reviewed at our Trust board meeting held on 24th May 2017, where the authority of signing the final document was delegated to the chief executive and chair.

By order of the Trust board

Chief Executive



Chairman
20 June 2017

About our Trust

This part of the report provides some background to our organisation and the people we care for. It describes our governance framework and structures, our values and behaviours, vision and objectives and some of the key strategies which are driving improvement in all areas across the organisation.

Imperial College Healthcare NHS Trust provides acute and specialist health care in north west London for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with nearly 11,000 staff.

We provide care from five hospitals on four sites as well as a range of community facilities across the region. Our five hospitals are Charing Cross Hospital, Hammersmith Hospital, Queen Charlotte's & Chelsea Hospital, St Mary's Hospital and Western Eye Hospital.

Our Trust in numbers

Our services

over **one million** outpatient contacts

210,000 inpatient contacts

288,500 A&E attendees

10,500 babies born

99,000 operations – day

109,000 operations – inpatient

Our staff

11,000 staff, including

2,500 Doctors

4,500 Nurses & midwives

650 Allied health professionals

1,000 Scientists & technicians

125 Pharmacists

810 Undergraduate doctors in training*

500 Nurses in education, pre-registration

* Health Education England

Our vision and objectives

Our vision is to be a world leader in transforming health through innovation in patient care, education and research.

To enable us to achieve this, our strategic objectives are:

- to achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- to educate and engage skilled and diverse people committed to continual learning and improvement.
- as an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care.
- to pioneer integrated models of care with our partners to improve the health of the communities we serve.
- to realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

For an assessment of performance against our strategic objectives in 2016/17, please see our annual report which will be published on our website in July 2017.

For 2017/18, we have developed a set of corporate objectives which will be the focus of our work over the coming year. They are:

- **Improving the way we run our hospitals and services.** We will create care pathways with processes, ways of working and facilities that consistently achieve the best possible outcomes and experiences for our patients and their families, making the most of digital and other new technologies.
- **Making our care safer.** We will build a culture where all our staff feel safety is key, are able to 'speak up' and understand their responsibilities, and where patients also feel confident to raise safety concerns and believe they will be addressed.
- **Developing more patient centred approaches to care.** We will work in partnership with our patients and partner organisations to create sustainable service and organisational models that help our population stay as healthy as possible and ensure access to the most appropriate care when it is needed.
- **Making the Trust a great place to work.** We will create a shared sense of belonging across our organisation, with staff feeling supported, valued and fulfilled, and a compelling 'offer' in terms of reward and recognition, wellbeing and development.
- **Building sustainability.** We will develop an organisational culture, care models and service portfolio that enable us to move from a deficit to a surplus budget, allowing us to make greater investment in maintenance, improvement and innovation.

The objectives reflect our commitment to improve the quality of care, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce as efficiently as possible.

Our ethos and values

To help everyone to be as healthy as they can be, we want to look out for the people we serve as well as to look after them.

We look after people by providing care, whenever and however we are needed, listening and responding to individual needs. We look out for people by being their partner at every stage of their life, supporting them to take an active role in their own health and wellbeing.

We are one team, working as part of the wider health and care community. We are committed to continuous improvement, sharing our knowledge and learning from others. We draw strength from the breadth and depth of our diversity, and build on our rich heritage of discovery.

By doing all this, we ensure our care is not only clinically outstanding but also as kind and thoughtful as possible. And we are able to play our full part in helping people live their lives to the fullest. Our promise is better health, for life.

Our values are:

- **Kind** – we are considerate and thoughtful, so you feel respected and included.
- **Expert** – we draw on our diverse skills, knowledge and experience, so we provide the best possible care.
- **Collaborative** – we actively seek others' views and ideas, so we achieve more together.
- **Aspirational** – we are receptive and responsive to new thinking, so we never stop learning, discovering and improving.

About our Trust

Our Governance framework and structures

Management structure

A new organisational structure was put in place in July 2016 to devolve more authority to clinical staff providing care to patients.

Services are now organised into one of 24 clinical directorates, each with its own 'triumvirate' of lead doctor, lead nurse and lead manager, with dedicated support from finance, human resources and information and communications technology.

The clinical directorates are organised into three clinical divisions, each led by a practising clinician, they are:

- medicine and integrated care;
- surgery, cardiovascular and cancer;
- women's, children's and clinical support.

The three divisional directors are now part of the executive management team and report directly to the chief executive.

The new structure also reduced the number of layers of management, to no more than five between the chief executive and frontline staff, to speed up decision-making and help the quick escalation of issues.

Imperial Private Healthcare is our private care division, offering a range of services across all of our sites. Income from our private care is invested back into supporting our NHS services.

The clinical divisions are supported by six corporate divisions:

- office of the medical director (including quality, education and research);
- nursing director's office (including patient experience, estates and quality compliance);
- finance;
- people and organisational development;
- information and communications technology;
- communications.

Governance Framework

We regularly review information and feedback about our services and activities at all levels across the organisation. This helps us ensure we are on track to meet our targets and objectives and to deliver our strategic plans, as well as to help us spot and address problems as soon as they arise.

We also contribute to a range of national monitoring programmes, which allows our performance to be benchmarked against that of similar NHS trusts.

Every month, our executive management team reviews a comprehensive set of performance indicators – our 'scorecard'.

A scorecard with a core set of indicators is also reviewed by the Trust board at its public meeting. For each indicator, we look at how we are performing against national standards and/or our own targets that flow from our various strategies.

On our website, we publish an easy-to-understand monthly performance summary taken from the scorecard as well as the full scorecard that goes to each public board meeting.

There are five board committees overseeing specific aspects of our work:

- quality;
- finance and investment;
- audit, risk and governance;
- remuneration and appointments;
- redevelopment.

Below the board committees is the executive committee which meets on a weekly basis.

We also triangulate key quality measures, including Friends and Family test results, complaints, infection rates and patient safety incidents, at ward level through monthly 'harm free care reports' which allow wards to review their key data in one place and develop coordinated plans for improvement.

Our key strategies

Quality strategy

Our Quality Strategy 2015-2018[1] sets out our definition of quality under the domains of safe, caring, effective, responsive and well-led, and describes our vision and direction, ensuring quality is our number-one priority. Our annual quality account reports on progress with delivery of the strategy and confirms the priorities for the following year.

Our quality strategy will come to an end in March 2018. From summer 2017 we will start the consultation process to develop our new quality strategy, which will build on the progress we have made over the last three years.

Patient and public involvement strategy

Last year, we developed a strategic approach to increasing and improving patient and public involvement in the delivery and development of care and services across our organisation. This is led by our director of communications.

At the heart of the strategy[2] is the commitment to ensure patients and the public are able to help shape and input to every aspect of the Trust's work. During the year, significant progress was made on establishing new ways for patients and the public to get involved. This includes:

- establishing a strategic lay forum – made up of patients, carers and local residents;
- recruiting, training and supporting an additional 22 lay partners to oversee Trust programmes and service developments as equal members of the team;
- creating a patient communications group to help ensure our materials are clear and effective.

People & organisational development (P&OD) strategy

Published in 2016, this strategy is designed to support the changing needs of the organisation, developing skills and capabilities amongst our staff. It encompasses plans to enhance patient and staff experience by focusing on attraction, onboarding, retention, development and continuously improving engagement of the workforce. The executive lead is our director of people and organisational development.

Clinical Strategy

Led by our medical director, our clinical strategy[3] sets out how we will develop, organise and connect our services and specialties to meet changing health needs. We are working to:

- Offer routine services locally where possible;
- Centralise specialist services where it will improve clinical outcomes and safety;
- Join up services more effectively, linking with other health and social care providers;
- Personalise care and treatment around individual needs and preferences.

In 2017 we will be refreshing our clinical strategy with a view to publishing it in 2018.

Estates strategy and redevelopment programme

We have one of the largest backlog maintenance liabilities of all trusts, mostly due to the age of estate. We therefore have some instances where equipment is now obsolete and this means that on occasion parts have to be specifically manufactured to support this obsolete equipment – this can lead to prolonged downtime, adversely affecting patient experience, service provision, and, at times, create a risk to patient safety.

Our Estates Strategy[4] for 2016 to 2026 provides an integrated approach to the estate and supports our ambition to consolidate our place as the secondary care provider of choice within north west London. It is aligned to the strategies and needs of the wider community identified through the Sustainability and Transformation Plan. The aim of the strategy is to ensure that the Trust provides safe, secure, high-quality healthcare buildings capable of supporting current and future service needs.

Whilst the strategy is being progressed, the Trust Board has agreed increased funding to support a number of major projects, service developments and medical equipment replacement. For further information, please see our annual report.

Digital strategy

Our digital strategy is led by our chief information officer and spans five years from 2015 to 2020. The strategy is supported by our business intelligence unit, who provide data and analytics support to our teams. The strategy is driving more productive working internally and across the local health system, moving from paper records towards digital data capture and processing. This is progressing with the roll out of our electronic patient administration system, Cerner, and incorporates elements such as the Care Information Exchange, a secure platform to give individuals access to information about their care held by different health and social care providers.

In partnership with Chelsea and Westminster Hospital NHS Foundation Trust we were selected by NHS England to become one of 16 global digital exemplars in acute care. We aim to become an internationally recognised NHS care provider delivering exceptional care with the support of digital technology and will receive funding and support to drive this forward and create products and approaches that can be used by other organisations.

In addition to the above, we are currently developing a communications and engagement strategy for the organisation, which is being led by the director of communications. This will encompass elements such as the upgrade of our Trust intranet system.

1 https://www.imperial.nhs.uk/about-us/our-strategy/quality-strategy

2 https://www.imperial.nhs.uk/get-involved/join-an-involvement-programme/about-our-involvement-strategy
3 https://www.imperial.nhs.uk/about-us/our-strategy/clinical-strategy
4 https://www.imperial.nhs.uk/about-us/our-strategy/estate-strategy

Our quality improvement plan

This section of the report describes our approach to quality improvement, and how we monitor our performance throughout the year to ensure we are continuously improving our services. It also sets out the targets and workstreams we have chosen to prioritise in 2017/18.

Our approach to quality improvement

Our quality strategy was developed following an extensive consultation with internal and external stakeholders to ensure it met national, local and trust priorities. The strategy will support the North West London Sustainability and Transformation Plan (STP), by ensuring we provide safe, high quality, sustainable acute services, while working with our partners to deliver better care. STPs have been developed by the NHS and local councils together covering all of England to make improvements to health and care. Our STP was developed by 28 NHS, local authority and voluntary sector partners, including our Trust. You can read more about it by following this link[5].

Recognising that delivering the improvements outlined in our quality strategy required a culture shift across the organisation, in autumn 2015 we launched our new quality improvement (QI) programme.

Now into its second year of building a culture of continuous improvement across the organisation, the programme:

- engages with staff to ensure everyone knows about QI and feels empowered to see improving patient care as a key part of their role;
- builds improvement capability through a programme of QI education to enable staff to lead, champion and coach improvement work within their teams;
- supports teams to deliver focused QI projects and programmes aligned to our strategies;
- embeds rigorous improvement methods in our organisational approach to change.

In 2016/17, the QI team engaged directly with just under 3,000 staff, initiating a broad ranging education and coaching programme for 416.

To date, the QI team is actively supporting 17 strategic trust-wide initiatives as well as 45 service-led QI projects. Over 112 pieces of internal consultancy work have been completed.

Our priorities for 2017/18

Our quality strategy is delivered through the achievement of our quality goals, which are:

- **Safe:** To eliminate avoidable harm to patients in our care as showing a reduction in the number of incidents causing severe/major harm and extreme harm/death.
- **Effective:** To ensure improvement plans are in place for all national clinical audits.
- **Caring:** To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if they needed similar care or treatment to 94 per cent.
- **Responsive:** To consistently meet all national access standards.
- **Well Led:** To increase the percentage of our people who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis.

The original goals were developed in consultation with members of the public, our patients, shadow foundation trust members, Healthwatch, local authority overview and scrutiny committees, commissioners and Trust staff, through a series of development workshops held during 2014/15.

We have changed the effective goal for 2017/18 due to variations in reporting of national audits and therefore difficulties in reporting performance. The goal will now be to ensure that we have improvement plans in place for every audit which reports in year.

The goals are supported by specific annual targets which are monitored and improvements driven throughout the year via the governance structure described above. The targets are focused on sustaining achievements that we have made throughout 2016/17 and on continuing to drive improvements where performance is not as good as we would wish. Each target has a number of actions planned to ensure they can be met. Some of our targets do not currently have a defined measure; where this is the case, we will develop a trajectory for improvement and define the performance standard during the coming year.

This year, we have also developed 'driver diagrams' for each of our five quality domains to help provide clarity and direction for our improvement work going forward, and identify any gaps.

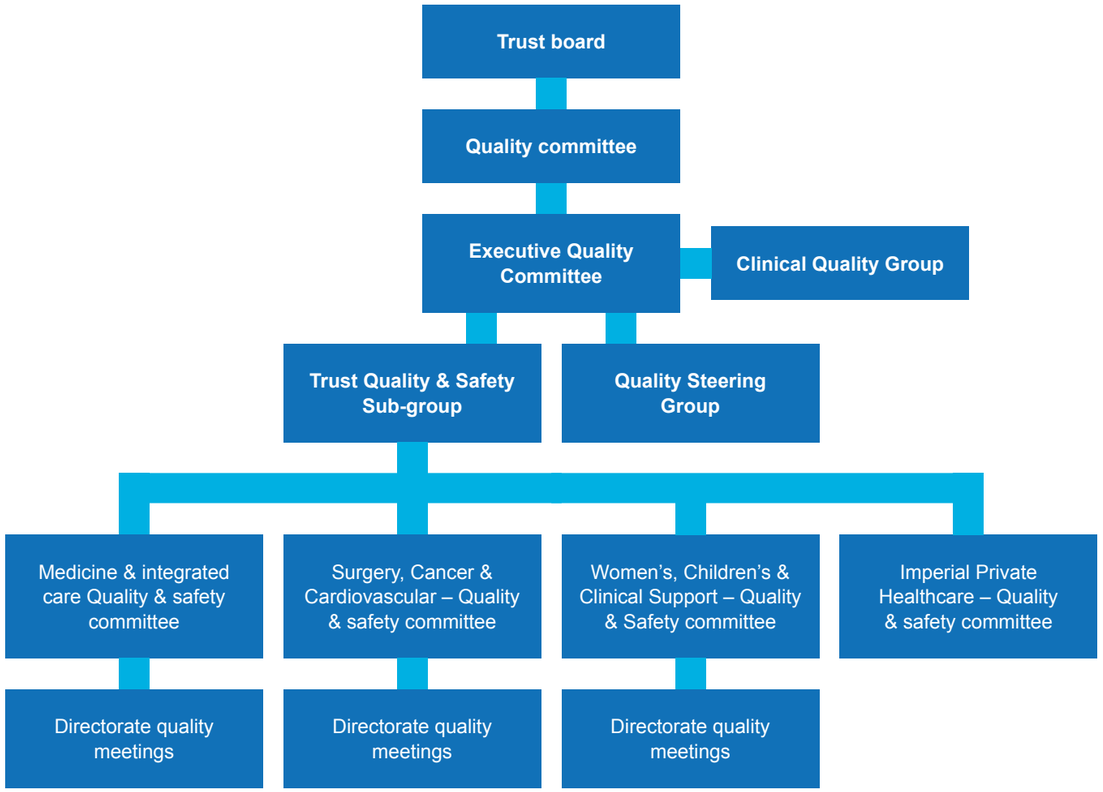
We use driver diagrams throughout the organisation as part of our quality improvement methodology to help teams in scoping out and planning their improvement activities and interventions. We start by developing a clear and measurable aim. The primary drivers outline a set of factors or improvement areas that we believe are collectively sufficient to achieve the aim and the desired outcome. The secondary drivers each contribute to at least one driver and lay out specific areas where we plan changes or interventions.

The driver diagrams for each domain can be found on the following pages.

Monitoring quality

The governance arrangements for clinical quality in our Trust are led by the Medical Director who has executive responsibility, and are summarised below. Progress with our quality priorities is reported through this framework, to enable monitoring from ward to board.

In addition, we work closely with our commissioners throughout the year to monitor our performance with the quality strategy, and develop the annual quality account, acute quality schedule and priorities through the monthly clinical quality group. This ensures that our quality agenda aligns with local and national priorities. We also develop and review progress with our quality account throughout the year through the quality steering group; this group incorporates members of local councils, Healthwatch, patient representatives as well as our commissioners.



5 https://www.healthiernorthwestlondon.nhs.uk/news/2016/11/08/nw-london-october-stp-submission-published

QUALITY DOMAIN 1:

SAFE

CQC Definition:

People are protected from abuse and avoidable harm

Trust Goal:

To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm and extreme harm/death. We believe harm is preventable, not inevitable.

In 2017/18 we will be focusing on achieving sustainable improvements in the target areas outlined below.

Target	Changes made to this target for 2017/18?
We will maintain our incident reporting numbers and be within the top quartile of trusts	Target changed from increase to maintain
We will have zero never events	No changes have been made to this target for 17/18
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist	No changes have been made to this target for 17/18
We will have no serious incidents where failure to complete the WHO checklist properly is a factor	No changes have been made to this target for 17/18
We will have a general vacancy rate of 10% or less	No changes have been made to this target for 17/18
We will have a vacancy rate for all nursing and midwifery staff of 12% or less	Target changed from band 2-6 ward staff to cover all nursing and midwifery staff and target increased from 10% to 12%
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff	No changes have been made to this target for 17/18
We will ensure we have no avoidable MRSA BSIs and cases of *Clostridium difficile* attributed to lapse in care	No changes have been made to this target for 17/18
We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	No changes have been made to this target for 17/18
We will reduce avoidable category 3 and 4 trust-acquired pressure ulcers by at least 10%	No changes have been made to this target for 17/18
We will assess at least 95% of all patients for risk of VTE, complete root cause analysis (RCAs) for all potentially avoidable trust acquired cases within the agreed timeframe and prevent avoidable death as a consequence	Target changed – added in 'complete RCAs for all potentially avoidable trust acquired cases within the agreed timeframe'
We will ensure that we comply with duty of candour and being open requirements for every incident graded moderate and above	New target

We are maintaining the majority of Safe targets for 2017/18. We have removed a target to reduce non-clinical transfers out of hours as it was achieved in 2016/17. We will continue to monitor this through our regular incident management processes.

We have added in a new target to support us to improve how we deliver the duty of candour requirements (see glossary on page 90 for definition).

Priority improvement worksteams

The newly developed driver diagram for Safe can be found on the following page. From this, we have developed the safety culture programme described below as the key priority improvement workstream for this domain.

Safety Culture Programme

Safety culture is about the attitudes, values and behaviours that staff share towards safety in the organisation, often described as 'the way we do things around here to keep patients and staff safe'. Our safety culture programme is led by the Medical Director with a steering group, which includes patient representatives, in place to drive it forward. The programme is designed to ensure safety, for patients and staff, is the priority of everyone in the Trust. It will also support the Trust to develop and embed a culture in which all staff can describe their contribution to patient safety, are supported to learn from mistakes and are confident in speaking up if they have concerns.

The programme has a detailed project plan which has been informed by an analysis of incidents, intelligence gathered through listening to our staff at a number of events and pioneering the use of a staff safety attitudes questionnaire, combined with research and experience from organisations at national and international level. This programme currently consists of a number of pieces of work including:

- 'Safety streams' – Nine safety improvement priority areas identified through a review of our most frequently reported incidents, never events, and safety commitments made in previous quality accounts and the national Sign Up To Safety campaign (see glossary for definition). These are all underway:
  - safe mobility and prevention of falls with harm: supporting patients as they move around and preventing falls that cause harm
  - reducing harm from pressure ulcers: ensuring patients have the right care in place to prevent possible skin damage
  - recognising and responding to the very sick patient: spotting quickly when a patient becomes more unwell and ensuring the correct action is taken
  - safer medicines: improving safety in medicines administration and storage
  - optimising hand hygiene: preventing the spread of infection by ensuring we follow hand hygiene best practice
  - acting on abnormal results: ensuring that findings from tests and investigations are responded to appropriately
  - safer surgery: making sure best practices are applied before, during and after any invasive procedure
  - foetal monitoring: effectively monitoring babies' heart beats to identify and act early where there may be concerns
  - positive patient confirmation: ensuring we have the correct information to identify patients and that we use this to match the correct patient with the right care.
- A project to improve how we record, manage and learn from incidents and near misses.
- A project to improve how we investigate and learn from serious incidents and better involve patients in the process, including a refresh of key policies.
- A project to improve how we implement the duty of candour (see glossary on page 90 for definition).
- A review of current education and training related to safety available to staff.
- A review of the ways in which we can best communicate patient safety messages to staff.
- Promotion of a 'just culture' in which errors are discussed openly and managed in a fair way, with an emphasis on learning to better design systems that promote safe behaviours.

DRIVER DIAGRAM:

SAFE

Aim	Primary drivers	Secondary drivers
Trust goal To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe and extreme harm. **CQC domain** People are protected from abuse and avoidable harm.	Develop organisational infrastructure to support the safest possible care.	Organise workstreams and provide organisational focus to drive improvements in areas where we report the most frequent numbers of incidents. Strengthen governance structures across the Trust and within divisions and directorates. Improve processes and staff experience of recording incidents and near misses. Work with staff and patients to co-design a culture of safety programme. Ensure policies and procedures are up to date and used in clinical practice. Minimise the risk of infection through adoption of standard precautions.
	Empower staff and patients to speak out and fix problems.	Develop and reward excellent team leaders e.g. focusing on ward managers and matrons. Increase awareness of patient safety concepts and best practice. Provide education and training opportunities.
	Promote a culture of openness, reflective learning and improvement.	Promote openness and honesty about issues affecting quality and safety without fear of retribution. Encourage staff to speak up when things go wrong. Develop operational definition of duty of candour to help patients receive accurate, truthful and timely information. Improve feedback and learning from patient safety incidents, complaints and compliments. Use rigorous improvement methods to design, test and implement changes.
	Improve team function and care processes.	Ensure teams are able to track patient preparation, medications, specimens taken, equipment used, and procedure times. Promote collective leadership where everyone takes responsibility for the safety of patients. Ensure staff can locate necessary information about a patient's health status. Improve ordering of equipment and supplies so everything needed for each patient's care is safe and readily available.

QUALITY DOMAIN 2:

EFFECTIVE

CQC Definition:

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Trust Goal:

To ensure improvement plans are in place for all national clinical audits.

This goal will enable us to have evidence that each of our services is effective and promotes the best outcomes for our patients.

Further assurance of this will be provided in 2017/18 by the following targets.

Target	Changes made for 2017/18
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	No changes have been made to this target for 17/18
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	No changes have been made to this target for 17/18
We will ensure that palliative care is accurately coded	No changes have been made to this target for 17/18
We will ensure mortality reviews are carried out in all cases and report specified information on deaths in line with national requirements, including those that are assessed as more likely than not to be due to problems in care, and ensure learning and action as a consequence.	Target changed – amended in light of national guidance issued by NHS Improvement
We will increase PROMs participation rates to 80% with reported health gain above the national average	No changes have been made to this target for 17/18
We will review all out-of-ICU/ED and coronary care unit cardiac arrests for harm and deliver improvements as a result	Target changed – we have excluded out of coronary care unit cardiac arrests
We will ensure that 90% of clinical trials recruit their first patient within 70 days.	No changes have been made to this target for 17/18

We have removed one target from 2016/17, relating to the Dr Foster Global Comparators dataset. This is because it has not been possible to report this data since 2013 owing to changes in the way it is collected.

Priority improvement worksteams

The newly developed driver diagram for Effective can be found on the following page. From this, we have identified the following priority improvement workstreams to ensure our services are in line with national and international best practice and promote excellent outcomes for our patients.

Mortality Review Programme

Since February 2016, every death which occurs in our hospitals is reviewed through our online mortality review system. Recent guidance issued by NHS Improvement requires all Trusts to report information on deaths, including those that are assessed as more likely than not to be due to problems in care. This programme will support implementation of the new national requirements, ensuring any learning from mortality reviews is shared and spread throughout the Trust.

Clinical Audit Programme

This is an annual comprehensive process of practice review which delivers a defined programme of priority audits to support our improvement priorities. It also ensures that we are participating in national clinical audits and that any recommendations and areas for improvement are acted upon. This programme is managed through the newly established Clinical Audit and Effectiveness Group.

Clinical Guidelines Programme

Overseeing the regular review of clinical guideline documents (recommendations of how healthcare professionals should care for people with specific conditions) to ensure they are fit for purpose and comply with current best practice. Our aim is to have no clinical guidelines that are out of date at any given time and to audit compliance.

Quality Surveillance Programme

A national programme of annual self-assessment and targeted peer review for all cancer and specialised commissioned services. Participation in this programme will support shared learning and provide assurance that improvements are being implemented.

West London Genomic Medicine Centre

We are the lead for the West London Genomic Medicine Centre, one of 13 NHS centres delivering the 100,000 Genomes Project nationally. The project aims to create a new genomic medicine service for the NHS, transforming the way people are cared for. It focuses on two main groups – patients with a rare disease and their families and patients living with common cancers.

These areas have been selected because eligible rare diseases and cancer are strongly linked to changes in the genome. By understanding these changes, there is potential to better understand how the disease develops and which treatments will be most effective. Patients may be offered a diagnosis where there wasn't one before. In time, there is the potential of new and more effective treatments.

Throughout the next year, we will be working to increase the number of patients and staff involved in the project.

DRIVER DIAGRAM:

EFFECTIVE

Aim	Primary drivers	Secondary drivers
Trust goal To show continuous improvement in national clinical audits with no negative outcomes. **CQC domain** People's care, treatment and support achieves good outcomes, promotes good quality of life and is based on the best available evidence.	Improve outcomes and reduce variation.	Support active learning when things go wrong e.g. through the mortality review programme. Standardise practices across the organisation, ensuring they are in line with national standards, guidelines and policy. Translate successful improvements into other areas of clinical practice. Learn from best practice, locally, nationally and internationally e.g. through audit and peer review. Ensure equipment and supplies are safe, clean and up-to-date.
	Ensure data drives improvement and team decision-making.	Improve the accuracy of clinical coding. Improve data quality and transparency through business intelligence. Ensure clinical teams own and use their data. Ensure patient data is stored, shared and used in line with information governance requirements. Improve the availability and quality of medical records.
	Translate research, development and technological advances into changes to clinical practice.	Collaborate with research partners e.g. Imperial College London, CLAHRC, the PSTRC, NIHR and regional research networks. Ensure timely and appropriate participation of patients in clinical trials. Continue to promote pioneering research into diagnostic methods and treatments. Support transformation of patient care through innovation e.g. delivery of the 100,000 genomes project.

QUALITY DOMAIN 3:

CARING

CQC Definition:

Staff involve and treat people with compassion, kindness, dignity and respect.

Trust Goal:

To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if they needed similar care or treatment to 94%.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we need to listen to our patients, their families and carers, and respond to their feedback.

The indicators outlined below will help deliver this goal and to determine whether our services are caring and patient centred in all aspects.

Target	Changes made for 2017/18
We will increase the percentage of outpatients who would recommend our trust to friends and family to 94% and achieve and maintain a FFT response rate of 6% in outpatient areas	No changes have been made to this target for 17/18
We will maintain the percentage of inpatients who would recommend our Trust to friends and family at 94% or higher and achieve and maintain a FFT response rate of 30% in inpatient departments	Target has been changed to say maintain rather than increase to reflect current performance
We will maintain the percentage of A&E patients who would recommend our Trust to friends and family at 94% or higher and achieve and maintain a FFT response rate of 20% in A&E	Target has been changed to say maintain rather than increase to reflect current performance
We will improve our national cancer survey scores year-on-year	No changes have been made to this target for 17/18
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	No changes have been made to this target for 17/18
We will maintain our responsiveness to complaints by responding to at least 95% within the timeframe agreed by the patient	Target changed – this has been amended to say maintain rather than increase

Priority improvement workstreams

The newly developed driver diagram for Caring can be found on the following page. From this, we have identified the following priority improvement workstreams to improve patient experience and help ensure staff demonstrate kindness and compassion at all times.

Accessible information standard

We will continue to implement the accessible information standard within the organisation, working to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and that they are given support so they can communicate effectively with our staff.

Schwartz rounds

These staff only meetings provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture. We will continue to run these on a monthly basis in 2017/18.

Nursing and midwifery postgraduate education programme

This work focuses on developing and supporting our nurses and midwives through a series of education programmes, including:

- Preceptorship programme to support student nurses to make the jump to confident and qualified practitioner;
- Specialty courses to allow our staff to continue to learn, develop and deliver high quality care to our patients;
- Revalidation to support registered nursing staff to reflect upon and develop their practice.

Wayfinding strategy

Patients often report having issues with finding their way around our sites and services. This project is working to make navigation easier for patients and staff. This includes improvements to signage and physical and digital wayfinding systems, and clearer information for patients.

Experience labs

This is a one year learning and development programme that will provide training and support to improve patient and staff experience in our outpatient departments. Staff will be trained to gather patients' feedback, generate and test solutions to achieve measurable improvements in outpatient experience and reduce hospital initiated cancellations. The programme started in April 2017 with 10 multi-disciplinary teams taking part.

Improving how we use patient experience data

We routinely collect a large amount of patient feedback data through our well-developed collection systems, but need to improve ways of understanding what this is telling us and how we can better use what our patients are telling us to improve. In 2017/18 we will focus on regularly sharing patient feedback data, including complaints and compliments, with the clinical services and triangulating it with other sources of information to ensure we are using it more effectively to improve the quality of patient care.

DRIVER DIAGRAM:

CARING

Aim	Primary drivers	Secondary drivers
Trust goal To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if they needed similar care or treatment to 94%. **CQC domain** Staff involve and treat people with compassion, kindness, dignity and respect.	Strengthen the involvement of patients, families and carers in their care.	Provide patient information that is clear and accessible to all. Involve the public in all aspects of the Trust's work, e.g. through the PPI strategy. Promote openness and honesty at all times, e.g. through duty of candour.
	Invest in staff through knowledge, skills and education.	Embed the Trust values into all interactions between staff, patients and the public. Provide support and training for staff in dealing with difficult situations. Develop excellent team leaders, including ward managers and matrons.
	Develop a patient centred organisation.	Ensure our sites are easy to access and navigate through programmes such as our wayfinding strategy. Ensure our patient facing services e.g. transport, have patient experience at their heart. Deliver improvements to key services e.g. outpatients, A&E, dementia and cancer care. Ensure impact on patient experience is considered during every service development or review.
	Translate patient feedback into positive changes.	Improve feedback & learning from events, complaints and compliments. Ensure team ownership of patient feedback data. Improve mechanisms for capturing patient feedback. Empower staff to fix problems themselves through quality improvement.

QUALITY DOMAIN 4:

RESPONSIVE

CQC Definition:

Services are organised so that they meet people's needs.

Trust Goal:

To consistently meet all national access standards by the end of year three of the quality strategy.

As well as aiming to achieve the national access standards, we will focus on the following targets to improve our responsiveness as a Trust. Each of these has a number of defined actions to support delivery.

Target	Changes made to this target for 2017/18?
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	No changes have been made to this target for 17/18
We will reduce the unplanned readmission rates for patients aged 16 or over and be below the national average	No changes have been made to this target for 17/18
We will have no inpatients waiting over 52 weeks for elective surgery, and reduce the number of patients waiting over 40 weeks and implement our agreed clinical validation process	Target changed from 'ensure a clinical validation process is in place for each patient who waits over 18 weeks' to 'implement our agreed clinical validation process'
We will reduce the proportion of outpatient appointments cancelled by the trust with less than 6 weeks' notice to 7.5% or lower	Target changed from 8.5% to 7.5%
We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	No changes have been made to this target for 17/18
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	No changes have been made to this target for 17/18
We will improve our PLACE scores year-on-year; aiming to maintain our score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition, appearance and maintenance and for privacy and dignity; and improve our scores compared to last year for dementia and disability	Target changed to specify degree of improvement for each element of PLACE
We will discharge at least 35% of our patients on relevant pathways before noon	No changes have been made to this target for 17/18
We will ensure 98% of admissions to an intensive care bed occur within 2 hours of the decision to admit/completion of surgery	New target

We have removed the target related to outpatients waiting no more than 45 minutes past their allotted appointment time as we have been unable to report data against it throughout 2016/17.

We have added a new target to reduce delayed admissions to intensive care beds, which will support improved care for ITU patients and reduce the possibility of harm caused by delays.

Priority improvement worksteams

The newly developed driver diagram for Responsive can be found on the following page. From this, we have identified the following priority improvement workstreams to drive efficiency in pathways which meet the needs of the individual patient.

Specialty review programme (SPR)

In early 2017/18 we launched a programme to develop local clinical strategies for each clinical speciality, which will in turn feed in to the Trust clinical strategy. The programme started in April, with each specialty participating in an event led by the Medical Director.

Telemedicine

This project is looking at opportunities across the organisation to connect people who use our services with healthcare practitioners using technology such as video consultation to speed up decision-making and treatment and improve patient experience.

Outpatient improvement programme

We will continue our work to improve our outpatient departments and develop new innovations and improvements in response to the findings of the CQC inspection in November 2016. For more information, see page 39.

Patient flow programme

We are participating in an innovative coaching programme, run by Sheffield Microsystem Coaching Academy, which aims to improve how patients flow through a specific care pathway (see glossary on page 90 for definitions) with positive impacts on patient experience, safety and efficiency. Three pathways are currently participating in this programme: diabetic foot, sepsis, and acute wheeze and asthma in children and young people. Through weekly 'big room' meetings, staff and stakeholders from all specialties and professions which impact on the care provided in each pathway will work together alongside patients and members of the community to develop, implement and monitor small tests of change. These changes will ultimately deliver improvements to care – making it safer, more effective, more efficient and providing a better experience for both patients and staff. We plan to run our own flow coaching programme in 2018/19, which will involve twelve new clinical pathways.

Waiting list improvement programme

We will continue the work of our waiting list improvement programme which is making good progress in cleaning up our waiting list data and ensuring delays in treatment are minimised. We have developed a clinical review process to ensure that patients are not coming to harm due to long waits, which we will embed and further refine in the coming year.

DRIVER DIAGRAM:

RESPONSIVE

Aim	Primary drivers	Secondary drivers
Trust goal To consistently meet all relevant national access standards. **CQC domain** Services are organised so that they meet people's needs.	Improve choice and access to services for our local population.	Support patient self-management of long term conditions. Improve transport services to and from hospital. Develop proactive relationships across hospital boundaries including with practitioners in primary, community and mental health settings. Develop efficient and integrated patient pathways. Involve patients, families and carers in shared decision making about care and discharge.
	Ensure patients receive timely care through proactive patient management.	Proactive workforce planning around the needs of patients 7 days a week e.g. pooling of junior doctor capacity / consultant job planning. Ensure patients are admitted to the right care setting first time round. Eliminate unnecessary patient moves. Actively manage waiting lists and reduce waiting times for treatment wherever possible. Optimise timing of senior and expert clinical decisions for patients.
	Ensure care is always provided in an appropriate setting.	Ensure data is accurate and available to inform clinical decision making. Provide clinical expertise in the community e.g. access to specialist advice, specialist outreach, ambulatory care and day case surgery. Enable staff to solve problems and make decisions through criteria led discharge and shared escalation practice. Improve quality and timeliness of patient discharge e.g. discharge to assess. Ensure care settings are responsive to the needs of the patients using them.

QUALITY DOMAIN 5:

WELL LED

CQC Definition:

The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Trust Goal:

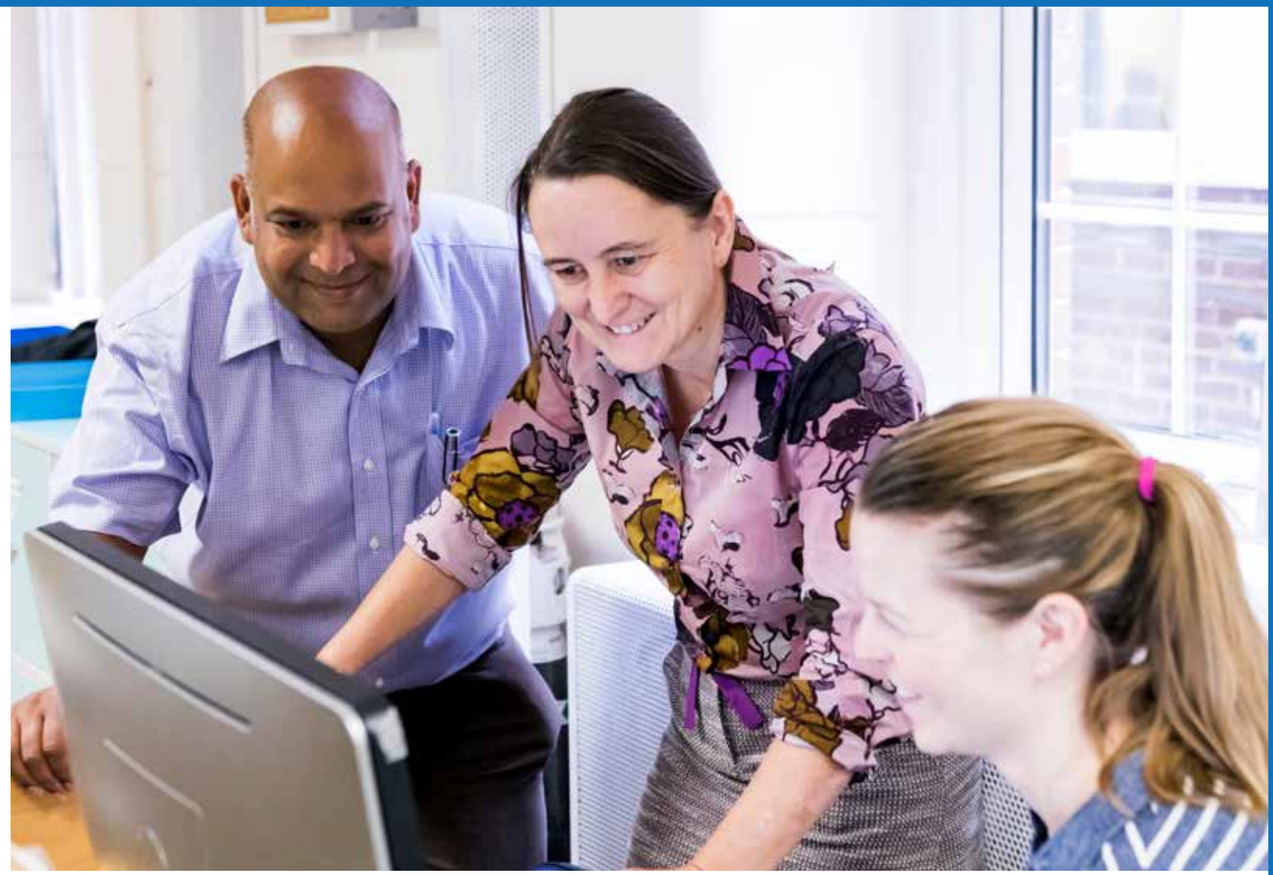
To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis.

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their patients. This will be delivered by the targets outlined below.

Target	Changes made to this target for 2017/18?
We will achieve a voluntary turnover rate of 10%	No changes have been made to this target for 17/18
We will maintain our sickness absence rate at below 3.10%	Target changed – We have achieved this target, so have changed the narrative to say 'maintain' rather than 'achieve'
We will have a departmental safety coordinator in 60% of clinical wards, clinical departments and corporate departments	Target changed to include all wards and departments
We will ensure at least 10% of our staff are trained as fire wardens	New target
We will achieve a performance development review rate of 95%	No changes have been made to this target for 17/18
We will achieve a non-training grade doctor appraisal rate of 95%	No changes have been made to this target for 17/18
We will achieve compliance of 90% with core skills training	No changes have been made to this target for 17/18
We will further develop our ward accreditation programme to ensure it links with other quality initiatives and has quality improvement at its heart	Target re-phrased
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5%	No changes have been made to this target for 17/18
We will increase the overall number of green flags in the GMC's national trainee survey by 5%	Target changed – added an increase of 5%
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	No changes have been made to this target for 17/18
We will ensure we respond to all exception reports from junior doctors within 14 days of an application being made and that we deliver improvements as a result	New target

We have included a new target, which is to respond to exception reports within 14 days and ensure improvements are delivered as a result. Exception reports were introduced in 2016 with the new junior doctor contract to enable trainees to quickly and easily flag up if their actual work has varied from their agreed work schedule and to allow the Trust to take action as a result.

Targets for departmental safety co-ordinators and fire wardens are included to drive improvements in health and safety.



Priority improvement worksteams

The newly developed driver diagram for Well-led can be found on the following page. From this, we have identified the following priority improvement workstreams to empower staff to make changes, encourage their development and improve engagement:

Leadership development programme

Building on our existing award winning schemes, we are further developing training programmes which focus on specific needs identified by our staff, including management skills, financial management, digital learning, data and analytics. We will also be looking at piloting management and leadership apprenticeship programmes.

Retention strategy

We have developed a recruitment and retention plan for bands 2-6 nursing and midwifery staff which will fully launch in 2017. This features a development programme, careers clinics which will run in summer 2017, automatic recruitment offers for student nurses working in the Trust, and a workshop for managers on how to engage and retain their staff. We are also one of eleven pilot sites training new band 4 associate nurses; a new role that will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients. We have recruited 13 staff members to this programme which started in April 2017.

Occupational Health Service review

Our Occupational Health team ensures the health and safety of patients, staff and contractors and other users of our services. We are currently reviewing the service to ensure it is set up in the most appropriate way to deliver an effective and high quality service for our staff.

Engagement programme

We will continue to develop the way we monitor and measure staff engagement and ensure the development of plans to improve based on what our staff tell us. The initial focus will be on driving improvements in the areas where we did not perform as well as we would wish in our staff engagement surveys in 2016/17, particularly around developing management skills in addressing poor performance, reducing staff experience of violence, bullying and harassment and ensuring equal opportunities for career progression.

Ward Accreditation Programme

Ward accreditation programmes (WAP) are designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed. We plan to run our ward accreditation programme for the third time in 2017/18, and will be implementing a number of changes to improve the process, such as live on-line dashboards of the results to facilitate immediate improvements and changes to the review team structure to ensure consistency and fairness.

DRIVER DIAGRAM:

WELL LED

Aim	Primary drivers	Secondary drivers
Trust goal To increase the percentage of our people who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis. **CQC domain** The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.	Build leadership and improvement capacity and capability at all levels.	Build a critical mass of people with QI expertise. Deliver an improved leadership development programme which focuses on the needs of our managers. Promote openness and honesty at all times; empowering staff to speak up when they have concerns. Create capacity and opportunities to implement improvements.
	Create universal commitment to the Trust's aims and objectives.	Develop a culture which celebrates and rewards achievement. Prioritise staff mental and physical health and wellbeing. Focus on retaining staff e.g. through effective talent management. Partner with staff and staff representatives to develop a team based and supportive culture.
	Develop effective organisational infrastructure (governance and staffing structures).	Value feedback and learning. Empower and engage staff across hierarchies including embedding our new management structures. Develop effective recruitment, attraction and onboarding strategies. Ensure effective staffing levels and working patterns are in place.
	Create an organisational culture of hearing staff and patient voice.	Widen community involvement in developing our organisation, e.g. through our apprenticeship and volunteering programmes. Develop strategies with our partners in North West London to improve the health of our communities e.g. through the STP. Ensure we consult, listen to and involve the public in decisions about our services. Strengthen ways of capturing staff voice, e.g. through 'In Our Shoes' and our engagement survey.

Statements of assurance from the Trust board

In this section of the quality account, we are required to present mandatory statements about the quality of services that we provide, relating to financial year 2016/17. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

A review of our services

In 2016/17, Imperial College Healthcare NHS Trust provided and/or sub-contracted 86 NHS services.

We have reviewed all the data available to us on the quality of care in all of these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2016/17.

Participation in clinical audits and national confidential enquiries

Clinical audit drives improvement through a cycle of service review against recognised standards, implementing change as required. We use audit to benchmark our care against local and national guidelines so we can put resource into any areas requiring improvement; part of our commitment to ensure best treatment and care for our patients.

National confidential enquiries investigate an area of healthcare and recommend ways to improve it.

The table below shows all national clinical audits and confidential enquiries which were mandated during 2016/17. Of these, two were not collecting data during 2016/17, and we were not eligible to participate in seven. Therefore, during 2016/17, the NHS services that we provide were covered by 49 national clinical audits and 13 national confidential enquiries.

During that period we took part in 98 per cent of national clinical audits (48 out of 49) and 100 per cent of national confidential enquiries (13 out of 13) in which we were eligible to participate.

The national clinical audits and national confidential enquiries that we participated in during 2016/17 are included in the table below alongside the number of cases submitted to each audit or enquiry as a percentage where this is available.

Title	Eligible	Participated	% Submitted
National Clinical Audits			
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	100%
Adult Asthma	✓	✓	100%
Adult Cardiac Surgery	✓	✓	100%
BAUS Urology Audits – Female Stress Urinary Incontinence Audit	✓	✓	100% (N.B. the number of procedures performed was not sufficient to be published)
BAUS Urology Audits – Radical Prostatectomy Audit	✓	✓	75.5%
BAUS Urology Audits – Nephrectomy audit	✓	✓	75.3%
BAUS Urology Audits – Percutaneous Nephrolithotomy (PCNL)	✓	✓	100%
Bowel Cancer (NBOCAP)	✓	✓	100%
Cardiac Rhythm Management (CRM)	✓	✓	Submission rate not available
Case Mix Programme (CMP)	✓	✓	100%
Chronic Kidney Disease in primary care	X	N/A	Primary care service only
Congenital Heart Disease (CHD)	X	N/A	Service decommissioned
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	✓	✓	100%
Diabetes (Paediatric) (NPDA)	✓	✓	100%
Elective Surgery (National PROMs Programme)	✓	✓	On-going data collection
Endocrine and Thyroid National Audit	✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP):			
Fracture Liaison Service Database	X	N/A	Only for Trusts with a Fracture Liaison Service
Inpatient Falls	✓	✓	100%
National Hip Fracture Database	✓	✓	83.1%
Head and Neck Cancer Audit	✓	✓	On-going data collection
Inflammatory Bowel Disease (IBD) programme / IBD Registry	✓	✓	100%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	On-going data collection
Major Trauma Audit	✓	✓	97.2%
Mental Health Clinical Outcome Review Programme	X	N/A	For mental health trusts only
Moderate & Acute Severe Asthma – adult and paediatric (care in emergency departments)	✓	✓	100%
National Audit of Dementia	✓	✓	100%
National Audit of Pulmonary Hypertension	✓	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme:			
Pulmonary rehabilitation	✓	✓	On-going data collection
Secondary Care	✓	✓	On-going data collection
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	N/A	Not collecting data in 2016/17
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	✓	N/A	Not collecting data in 2016/17
National Comparative Audit of Blood Transfusion programme:			
Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	✓	✓	Not yet started
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	✓	✓	On-going data collection
Audit of Patient Blood Management in Scheduled Surgery – Re-audit September 2016	X	N/A	ICHT not eligible (re-audit of pilot sites)

Title	Eligible	Participated	% Submitted
Audit of the use of blood in Lower GI bleeding (audit will not be repeated)	✓	X	ICHT did not participate
National Diabetes Audit – Adults:			
National Diabetes Foot Care Audit	✓	✓	99%
National Diabetes Inpatient Audit (NaDia) – reporting data on services in England and Wales	✓	✓	100%
National Pregnancy in Diabetes Audit	✓	✓	SMH – 100% QCCH – submission in progress
National Diabetes Transition	✓	✓	100%
National Core Diabetes Audit	✓	✓	Not yet started
National Emergency Laparotomy Audit (NELA)	✓	✓	SMH = 30% CXH = 60%
National Heart Failure Audit	✓	✓	58%
National Joint Registry (NJR)	✓	✓	On-going data collection
National Lung Cancer Audit (NLCA)	✓	✓	91.1%
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	✓	✓	100%
National Ophthalmology Audit	✓	✓	On-going data collection
National Prostate Cancer Audit	✓	✓	100%
National Vascular Registry	✓	✓	79%
Neurosurgical National Audit Programme	✓	✓	Submission rate not yet available
Oesophago-gastric Cancer (NAOGC)	✓	✓	100%
Paediatric Intensive Care (PICANet)	✓	✓	Submission rate not yet available
Paediatric Pneumonia	✓	✓	Submission rate not yet available
Prescribing Observatory for Mental Health (POMH-UK)	X	N/A	For mental health trusts only
Renal Replacement Therapy (Renal Registry)	✓	✓	100%
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	100%
Severe Sepsis and Septic Shock (care in emergency departments)	✓	✓	100%
UK Cystic Fibrosis Registry	X	N/A	Service not offered
National Confidential Enquiries			
Medical and Surgical Clinical Outcome Review Programme (NCEPOD):			
Perioperative diabetes	✓	✓	Data collection not yet commenced
Cancer in Children, Teens and Young Adults	✓	✓	On-going data collection
Heart Failure	✓	✓	Data collection not yet commenced
Acute Pancreatitis	✓	✓	85%
Non-invasive ventilation	✓	✓	75%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE):			
Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	✓	✓	100%
Perinatal Mortality Surveillance	✓	✓	100%
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	✓	✓	100%
Confidential enquiry into serious maternal morbidity	✓	✓	100%
Maternal mortality surveillance	✓	✓	100%
Maternal morbidity and mortality confidential enquiries (cardiac plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	✓	✓	100%
Child Health Clinical Outcome Review Programme (NCEPOD):			
Chronic Neurodisability	✓	✓	On-going data collection
Young People's Mental Health	✓	✓	On-going data collection

There were a total of 33 national clinical audit reports issued in the period April 2016 to March 2017 in which the Trust participated. We reviewed the reports of 32 national clinical audits in 2016/17. The outstanding report (national comparative audit of blood transfusion) remains under review by the service.

We continue to follow up the reports from all relevant national audits to identify how we make improvements. Many of these audits demonstrated effective care, with no actions being required. The actions we intend to take to improve the quality of healthcare provided can be found in appendix A

The reports of 41 local clinical audits were reviewed by the provider (out of 41 local audits registered and completed in 2016/17) and the actions we intend to take to improve the quality of healthcare provided can be found in appendix B (see appendix B for a selection of the local audits and actions/recommendations).

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 21,611.

14,023 patients have been recruited into 438 Portfolio studies in 2016-17. This included 439 patients within 80 studies sponsored by commercial clinical Research and Development organisations.

We are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into novel diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere. Our clinical staff keep abreast of the latest possible treatments – active participation in research leads to more successful patient outcomes.

The Trust has continued to make significant scientific advances in 2016/17 and to attract further new investment to support clinical research and development (R&D), including the following:

- **NIHR Imperial Biomedical Research Centre (BRC)** – this major programme of experimental medicine was renewed and awarded £90m over the next 5 years. This new funding will allow the BRC to continue its world-class research into cancer, heart disease, brain sciences, immunology, gut health, infection, surgery and metabolic disorders. It will also support cross-cutting research and technology development in areas such as genomics, imaging, molecular phenotyping and the use and storage of biomedical data and samples.
- **NIHR Imperial Clinical Research Facility (CRF)** – our experimental medicine CRF was awarded £10.9m over the next 5 years. This award will continue to provide dedicated bed space for up to 25 patients participating in research. It will also support a team of 40 dedicated healthcare professionals specialising in clinical

research. The award will allow us to continue to support experimental medicine clinical research studies in patients and healthy volunteers across a wide range of conditions.

- **NIHR Imperial Patient Safety Translational Research Centre (PSTRC)** – also renewed at £7m over the next 5 years. The investment will be spent on patient safety research across numerous clinical areas with the aim to turn patient safety discoveries into practice and impact NHS frontline services.

Our CQUIN performance – CQUIN framework

Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments to hospitals based on agreed quality improvement and innovation work.

A proportion of Imperial College Healthcare NHS Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals through the CQUIN framework.

In 2016/17 the value of the schemes was 2.8% of the contract value for NHS acute healthcare services as agreed with NHS England. This equated to £5.64 million of our planned income from NHS England.

A summary of the 2016/17 CQUIN goals and achievement is provided in the table below. The figures are based on our projected year end and are subject to final agreement.

We were unable to implement the Clinical Utilisation Review tool CQUIN in its current format as it required another IT system to be put in place which would have needed our staff to do double data entry. We are hoping to work with the national team to look at how we can implement this scheme using our existing electronic patient record.

In addition to these national schemes, we also agreed two CQUINs locally with our commissioners, which were focused on our outpatient transformation programme and improving communication with primary care. We are expecting to achieve 100% of the value of these schemes.

CQUIN scheme	Description of scheme	Full year Plan value £	Achieved £ projected year end	Achieved % projected year end
BI1 HCV Improving Treatment Pathways through ODNs	To support providers to deliver the infrastructure, governance and partnership working across Hepatitis C virus operational delivery networks	£3,222,450	£3,381,937	100%
GE1 Clinical Utilisation Review Tool	To reduce numbers of bed days (and emergency admissions) that do not meet criteria of clinical appropriateness.	£664,630	£0	0%
TR1 Adult Critical Care (ACC) Timely Discharge	To reduce delayed discharges from ACC to ward level care by improving bed management	£463,227	£291,692	60%
CA2 Nationally Standardised Dose Banding Adult Intravenous SACT	To standardise the doses of Systemic Anti-Cancer Therapy (SACT) in all units across England	£483,368	£507,290	100%
QIPP Telemedicine	To reduce or replace physical outpatient attendances, where appropriate, with virtual contact through phone calls or other technological methods.	£342,385	£359,331	100%
QIPP Ventilator acquired pneumonia	To support providers in procuring the appropriate product that demonstrates effective ventilator prevention measures against infection and potential pneumonia rates.	£201,403	£211,371	100%
QIPP ARV Switch	To ensure the appropriate and cost effective use of antiretroviral drugs and switching patients to newer regimens where clinically appropriate	£261,824	£274,782	100%

Care Quality Commission registration status

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care that meet fundamental standards.

The Trust is required to register with the CQC at all of our sites and our current registration status is 'registered without conditions'.

The CQC has not taken enforcement action against Imperial College Healthcare NHS Trust during 2016/17.

We have participated in one review by the CQC related to the following area during 2016/17:

- *Learning, candour and accountability:* A review of the way NHS trusts review and investigate the deaths of patients in England (published December 2016). This involved filling out a questionnaire with data about how the Trust has investigated deaths only.

We intend to take the following action to address the conclusions or requirements reported by the CQC:

- We have undertaken a review of the report and a gap analysis against our current mortality review process. We have developed an action plan to ensure we are fully implementing the recommendations in line with the national requirements.

In September 2014, the CQC inspected the Trust by visiting four of our main sites. We received an overall rating of 'requires improvement'. A summary of our overall ratings can be found below with a full report available on the CQC website.

The action plan developed following the Trust's CQC inspection in September 2014 was completed in March 2016.

In November 2016, the CQC carried out a re-inspection of the core service of Outpatients and diagnostic imaging.

This was the only service at the Trust to be rated overall as 'Inadequate' following the September 2014 inspection.

The final inspection reports were published by the CQC on 31st May 2017. The CQC found that outpatient services and diagnostic imaging across all of our sites have improved since our first inspection. Ratings for outpatient services overall at St Mary's and Hammersmith hospitals have increased by two levels, to 'good', while the rating for Charing Cross increased by one level, to 'requires improvement'.

The CQC did not set any compliance or 'must do' actions for us to take as a result of the inspection, and they highlighted our outpatient improvement programme, put in place following our first inspection in 2014, as 'outstanding practice' at each site. You can read more about this programme on page 58. They also singled out sexual health and HIV services at St Mary's Hospital as an example of outstanding practice for its "track record of building staff skill mix and service sustainability".

The reports do highlight a number of areas for improvement, especially in terms of waiting times across all sites and, specifically at Charing Cross, to ensure a clearer vision and a more inclusive and positive organisational culture for staff.

An action plan is currently in development in response to the inspection findings. We are ensuring that all of the concerns, recommendations and good practice identified by the CQC are fully captured in our plans for the next two years, especially in the on-going outpatient improvement programme.

On 7 March 2017, the CQC arrived unannounced at the Trust to carry out a three day focused inspection of two core services:

- Maternity at St Mary's Hospital
- Medical Care at St Mary's, Charing Cross and Hammersmith hospitals.

The draft inspection reports are due between July and September 2017.

Safe	Effective	Caring	Responsive	Well led	Overall
Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our data quality

High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct, secure and up to date.

We continued to experience some challenges with data quality in 2016/17 which we are working to improve through our data quality assurance framework which we introduced in 2016.

Key data quality indicators are reported every week and are also included within our monthly performance scorecards to ensure data quality governance is aligned with our Performance Management Framework.

An executive-led Data Quality Steering Group has been established and meets every month. It provides leadership and oversight of the development and delivery of all aspects of our Data Quality Framework.

There are over 100 data quality indicators in total in use across the Trust, which are available via a data quality dashboard tool (Cymbio). New data quality indicators continue to be developed in response to requirements.

NHS number and general medical practice code validity

The Trust submitted records during 2016/17 to the Secondary Users Service for inclusion in the Hospital Episode Statistics (see glossary on page 90 for definitions) which are included in the latest published data. The percentage of records in the published data to month 9 2016/17 (most recent available) which included the patient's valid NHS number was:

- 96.9 per cent for admitted patient care
- 98.7 per cent for outpatient care
- 90.2 per cent for accident and emergency care

The percentage of records in the published data which included the patient's valid general medical practice code was:

- 100 per cent for admitted patient care
- 100 per cent for outpatient care
- 100 per cent for accident and emergency care

Information governance toolkit scoring

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The information governance toolkit is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to Connecting for Health in order to assess compliance.

Our information governance assessment report overall score for 2016/17 was 67 per cent and was graded 'satisfactory'. The satisfactory rating was achieved by a minimum level 2 assessment against all standards. The information governance toolkit return was subject to an independent audit conducted in October 2016 and in March 2017. The final audit report gave the Trust 'reasonable assurance' of the self-assessment.

Clinical coding quality

Clinical coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable

The Trust was not subject to the Payment by Results clinical coding audit by Monitor during 2016/17. There are no Payment by Results audits currently planned.

National Outcomes framework indicators 2016/17

The NHS Outcomes Framework 2016/17 sets out high level national outcomes which the NHS should be aiming to improve. For full information about our performance, please see pages 70-73.

A review of our quality progress 16/17

This part of the report shares the quality improvement priorities that we set ourselves for 2016/17 and reports our progress against each of these. It also outlines our performance against the NHS Outcomes Framework 2016/17, the Quality Schedule agreed with our commissioners and national targets and regulatory requirements.

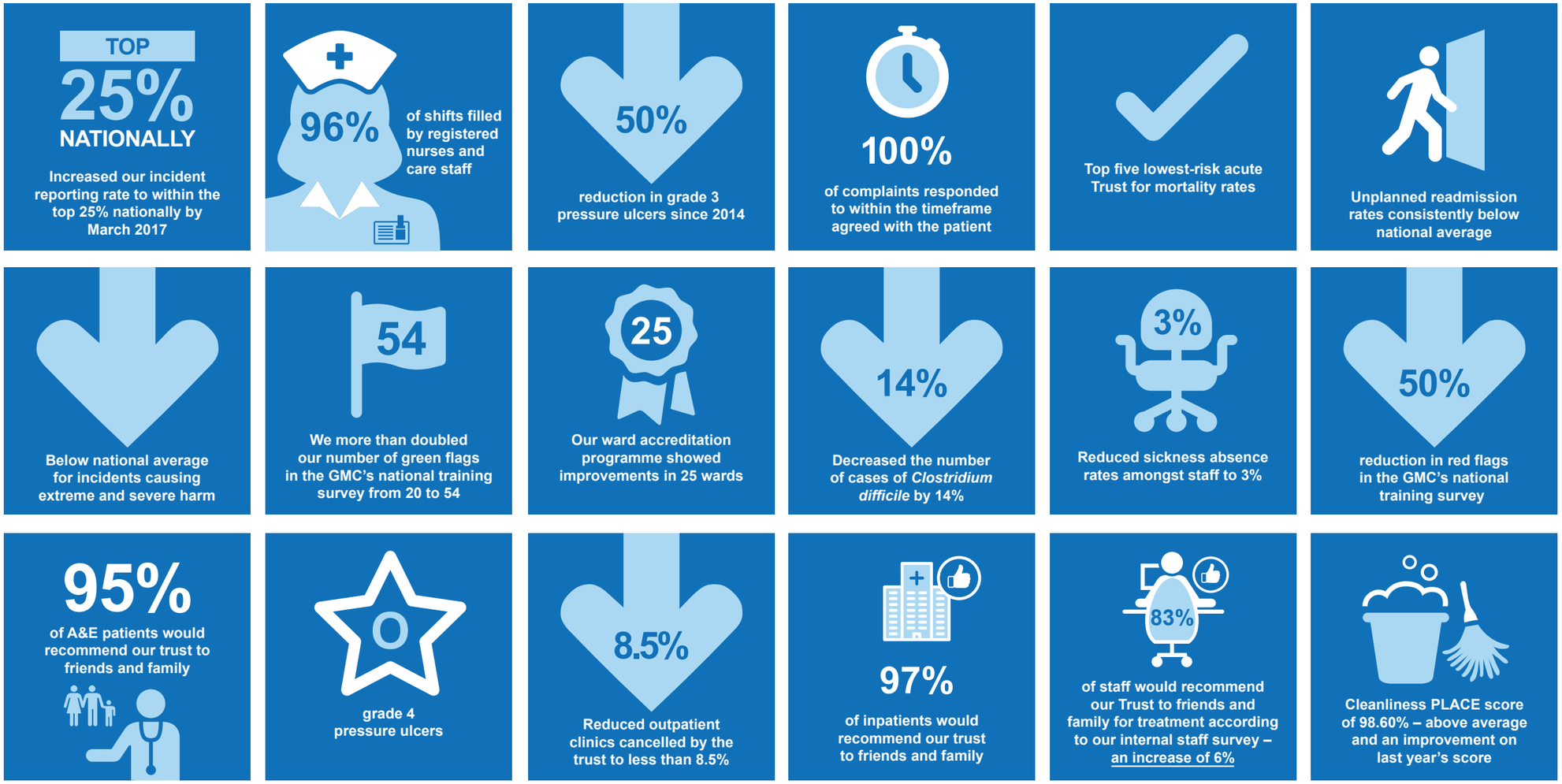
Our quality account improvement priorities for 2016/17 reflected the goals and targets defined in our quality strategy. They were outlined in our quality account last year following consultation with our clinical and management teams and with our external stakeholders, through the quality steering group.

Our progress with these goals and targets is described below under each quality domain.

As part of our quality strategy, we also developed measurable and structured improvement projects which were assessed for their potential to positively impact on the goals and targets we set. These are featured throughout the following sections.

Following feedback from both internal and external stakeholders and a review of the quality accounts produced by other providers, we have simplified and shortened this section of the quality account to help ensure it is clearer and more focused, highlighting areas of good work as well as areas where we have not performed as well as we would wish.

This page shows some of our quality highlights over the last year. These are explained in further detail throughout the following section.



SAFE

This section describes our progress with the targets under the Safe domain during 2016/17.

The table below sets out our performance and where applicable, presents national targets and averages, and information about our performance in 2016/17. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/ major harm	0.3% (April-Sept 2016)	0.1% (8 incidents) (April-Sept 2015)	below national average (0.3%)	0.1% (7 incidents) (April-Sept 2016)	Yes
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	0.1% (April-Sept 2016)	0.1% (5 incidents) (April- Sept 2015)	below national average (0.1%)	0.0% (2 incidents) (April-Sept 2016)	Yes
We will increase our incident reporting numbers and be within the top quartile of trusts	40.02 (April-Sept 2016)	41.38 (April-Sept 2015)	Over 44.89	42.3 (April-Sept 2016 as published by NRLS) 44.85 (full year)	No
We will have zero never events	0 never events	6 never events	0 never events	4 never events	No
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist in all relevant areas	N/A	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 72%	100% compliance	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 92%	No
We will have no SIs where failure to follow the WHO checklist properly is a factor	N/A	New reporting criteria – data not reported in this way	0	2	No
We will ensure we have no avoidable MRSA BSIs and cases of *C. difficile* attributed to potential lapse in care	N/A	13 (7 MRSA BSIs, 6 *C. difficile* lapses in care)	0 avoidable infections	12 (3 MRSA BSIs, 9 *C. difficile* lapses in care)	No
We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	N/A	89%	At least 90%	89%	No
We will reduce avoidable category 3 and 4 trust-acquired pressure ulcers by at least 10%	N/A	25 (42% reduction)	Less than 22 (at least 10% reduction)	27	No
We will assess at least 95% of all patients for risk of VTE and prevent avoidable death as a consequence	over 95%	95.87%	over 95% 0 avoidable deaths	95.33% 0 avoidable deaths	Yes
We will stop non-clinical inter-site transfers of patients out-of-hours without clinical agreement and prevent avoidable harm	N/A	New reporting criteria – data not reported in this way	0	0 cases without clinical agreement	Yes
We will have a general vacancy rate of 10% or less	N/A	10.21%	10% or less	11.57%	No
We will have a band 2-6 ward vacancy rate of 10% or less	N/A	14.69%	10% or less	19%	No
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff	90% for registered nurses 85% for care staff	95.16% for registered nurses 92.81% for care staff	90% for registered nurses 85% for care staff	97% for registered nurses 94.92% for care staff	Yes

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm.

Areas where we are proud of the improvements we have made or sustained in our Safe domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Safe quality highlights

We remain below average for incidents causing severe or extreme harm to patients: A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Incidents are categorised by degree of harm, from near miss and no harm up to extreme harm (for definitions, please see the glossary on page 90).

Reporting incidents allows us to investigate and learn from errors so we can prevent them from happening again. We investigate all patient safety incidents which are reported on our incident reporting system, Datix. In addition, all patient safety incidents graded moderate and above are reviewed at a weekly panel chaired by the medical director. Each incident is reviewed when it is first reported on Datix, and then again each week until the investigation has been completed and it is closed from a Trust perspective. Incidents that are deemed to be Serious Incidents (SIs) or never events also undergo an investigation which involves root cause analysis (see glossary on page 90 for definitions).

According to the latest data published by the National Reporting and Learning Service (NRLS) we have reported fewer of the incidents which cause the most harm to patients compared to our peers. Our internal data for the full year also shows a decrease in these incidents, with 28 reported in 2016/17 compared to 31 last year.

To support this, we have identified nine safety improvement priority streams for the trust, which are described in more detail on page 15. These are:

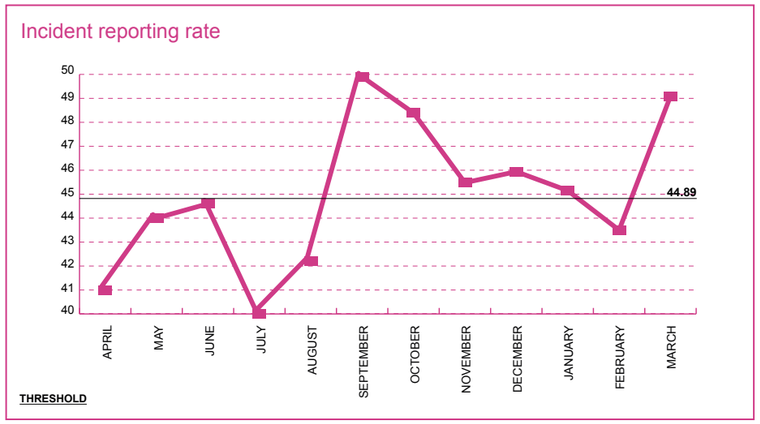
- safe mobility and prevention of falls with harm
- reducing harm from pressure ulcers
- recognising and responding to the very sick patient
- safer medicines
- optimising hand hygiene
- acting on abnormal results
- safer surgery
- foetal monitoring
- positive patient confirmation.

Work is progressing at different stages in each of these areas, with some safety streams only recently commenced. For those which are further developed, improvements are starting to be seen – you can read more about these in the rest of this section. The projects will continue into 2017/18 and progress will be reported in next year's quality account.

We increased our incident reporting rate: An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety, learn from them and deliver improved care. A high reporting rate reflects a positive reporting culture, as staff feel able to report incidents that occur.

The data for April to September 2016 published by the NRLS in March 2017 shows that we succeeded in increasing our incident reporting rate compared to last year, although we remained below the top quartile. Our internal data, which we use to monitor our incident reporting rate each month, shows an improvement in our performance since September 2016. We have been above the top quartile for all months except February 2017 since then, increasing our incident reporting rate to 49.09 per 1,000 bed days by the end of the year.

SAFE



We maintained safe staffing levels: Although our vacancy rates remain higher than our targets, we have ensured staffing meets planned safe levels this year. The use of temporary workers is one of the ways we have achieved this. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses taking the following actions:

- Using the workforce flexibly across floors and clinical areas;
- The nurse or midwife in charge of the area working clinically and taking a case load;
- Specialist staff working clinically during the shift to support their ward based colleagues.

Our divisional nurse directors regularly review staffing at ward level alongside local quality metrics to ensure there are no quality or safety concerns regarding safe staffing levels. We have also developed a recruitment and retention plan for bands 2-6 nursing and midwifery staff which will fully launch in 2017. For more information, please see page 31.

We have reduced the number of non-clinical inter-site transfers of patients out-of-hours (OHH) and have reported no cases which occurred without clinical agreement: The move of general acute medicine from Hammersmith Hospital to the Trust's other main sites has supported a decrease in the number of inter-site transfers out-of-hours occurring for capacity reasons, with none occurring in December 2016 (latest available data). In addition, since the beginning of the year, none of these transfers have occurred without clinical agreement, the requirement for which was put in place last year to minimise risk to patients and still allow flow through our hospitals. For the second year in a row, we have not reported any serious incidents where a non-clinical OOH transfer out-of-hours was a contributory factor.

We have achieved a 50 per cent reduction in the number of grade 3 and 4 pressure ulcers since 2014: A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue when the area is placed under too much pressure. These ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Pressure ulcers are graded from one to four to indicate their severity, with one indicating less damage and four indicating serious damage. All category three and four pressure ulcers are subject to an internal process of root cause analysis and are reported as serious incidents. Although we have not achieved our target of a 10 per cent decrease compared to last year, we are proud that we have reduced the occurrence of these types of pressure ulcer by nearly 50 per cent in three years and that we have not had a grade four pressure ulcer since March 2014.

reduction in grade 3 pressure ulcers since 2014

grade 4 pressure ulcers since March 2014

We continue to work to reduce pressure ulcers through our five year strategy and associated action plan and collaborate with our partners in the community to adopt a whole systems approach to reducing harm from pressure damage. Actions we are currently undertaking include: development of the SKIN champion roles, a review of our mattress contract, and a communications campaign to improve the use of the pressure ulcer prevention app amongst our patients, carers and families.

Safe quality challenges

We reported four surgical related never events and two SIs due to a failure to follow the WHO checklist: Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The Trust reported four never events in 2016/17, each related to practice in surgery. We also reported two serious incidents due to a failure to follow the WHO safer surgery checklist, which is an intervention introduced by the World Health Organisation to improve safety in theatres (see glossary on page 90 for full definition). Each of these incidents has individual actions in place to reduce the risk of recurrence, however the investigations highlighted similar issues with leadership and teamwork, the application of the WHO checklist, and Trust policies and procedures either not being followed or not complying with best practice. A safer surgery task and finish group was established in July 2016 to review how we were conducting interventional procedures across the Trust and to ensure we were providing the safest possible care for our patients. The work of this group has included:

- a baseline information collection, audit and observation process to bring to light any safe practice concerns;
- a review of all policies to ensure they are compliant with the national standards;
- standardisation of all local checklists to ensure consistency;
- the introduction of 'no brief, no start' which means that both the senior surgeon and anaesthetist must be present for the team brief to promote teamwork and ensure the safest possible start to surgery;
- development of a driver diagram for safer surgery to focus our improvement work.

As a result of this work, we are starting to see improvements in compliance with the five steps to safer surgery, with all five elements met by March 2017.

The group will continue to deliver improvements into 2017/18, including:

- the development of a long-term audit programme which provides sufficient assurance;
- co-designing an education model with staff and patients, for all theatre staff with patient stories at its heart;
- developing a revised simulation training programme in interventional areas;
- evaluating the impact of our interventions through re-auditing and a review of key measures e.g. staff engagement and patient safety indicators.

Feedback from staff and patients, and a review of how we meet the duty of candour requirements for SIs, has identified areas of improvement in how we manage and investigate SIs and never events. In addition, although our mortality rates are consistently excellent and our incident reporting rates are improving, patients continue to experience avoidable harms whilst in our care. Recognising that we have work to do to improve the safety culture at our Trust, in June 2016 we started a programme of work to develop, create and embed a culture in which all staff can describe their contribution to patient safety, feel confident in raising safety concerns and know how to address such issues within their place of work.

The initial focus has been purposely given to gaining intelligence, and communication and engagement with our teams, this has included a number of well-attended workshops and a questionnaire focused on staff attitudes to safety, to which over 1,500 staff members have responded. This intelligence is informing the development of a detailed project plan. Work so far includes:

- Improving staff experience of reporting incidents which will include a re-design of the Datix incident reporting system so that logging incidents is quicker and more straightforward, feedback takes place more quickly and themes can be spotted more swiftly, and escalated for prompt action.
- Improving the process for and quality of incident investigation, including training for staff and a more rigorous quality assurance process; clarification around timelines, roles and responsibilities of those involved in the investigation process; and improvements in practice regarding how we involve patients and families.
- Improving how we implement the duty of candour, providing staff with a summary of the requirements and FAQs to help clarify their responsibilities. We have also developed an online training package for staff which was rolled out in May. In addition, we will create a patient information sheet so patients are fully aware what they should expect from their healthcare workers.

We believe these actions will improve both staff and patients' experience when things go wrong, support open and honest communication and ultimately deliver better outcomes.

SAFE

We reported 12 avoidable infections: In 2015 we began to report 'avoidable' infections of MRSA blood stream infections (BSI) and *Clostridium difficile* infections. For how we define 'avoidable infections' please see the glossary on page 90. Although we did not meet our target, we had a slight decrease in avoidable infections in 2016/17, reporting 12 compared to 13 last year. We have also seen a reduction in total cases of both infections when compared to last year:

- Three trust-attributable cases of MRSA BSI compared to seven last year (see glossary on page 90 for definition).
- 63 cases of *Clostridium difficile* have been allocated to the Trust compared to 73 last year (see glossary on page 90 for definition).

There are two key elements to reducing the risk of infections occurring in hospital, which we will continue to work on into 2017/18:

1 Reducing the use of anti-infectives (antibiotics) – 89 per cent of anti-infectives were prescribed in line with our antibiotic policy this year; we will continue to work to improve this.

Cases of MRSA BSI and *Clostridium difficile*

THRESHOLD

2 Improving hand hygiene – we have recently developed a new audit of hand hygiene which will allow us to monitor compliance for all of the five moments of hand hygiene.

We have not met the VTE assessment target since December 2016: Venous thromboembolism (VTE) is a blood clot within a blood vessel that blocks a vein, obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission. Last year, an internal audit raised concern that recording of compliance with VTE assessment was being completed on patients' discharge summaries and evidence was not consistently available in their medical records that this assessment had been completed. We have been working all year to transfer recording of this assessment to the Cerner electronic record on admission to ensure that adequate assessment is taking place; this was completed in March.

Our performance dropped below the 95 per cent target for the first time in December and remained below target at 94.78% in March 2017. This dip coincided with pilots testing the use of the Cerner discharge process and stopping recording VTE assessment on the electronic discharge summary. Once the assessment process is fully embedded in Cerner, we expect to return to reporting above target. An action plan is in place, led by the deputy medical director to deliver the required improvements to meet the target.

Decreased the number of cases of *Clostridium difficile* by

14%

EFFECTIVE

The following section describes the progress we have made with the targets we set ourselves this year under the Effective domain.

The table below sets out our performance in 2016/17. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To show continuous improvement in national clinical audits with no negative outcomes	N/A	Unknown	All show continuous improvement No negative outcomes	We have not been able to fully report against this goal	Not available
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	100	73.8 (Oct 2014 – Sept 2015) 3rd lowest risk	Top 5	78.05 (Oct 2015 – Sept 2016) Fourth lowest risk	Yes
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	100	69.15 Second lowest risk (Jan – Dec 2015)	Top 5	65.42 Second lowest risk (Jan – Dec 2016)	Yes
We will improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third	100	Not available	To be in the top quarter	Not available*	Not available
We will ensure that palliative care is accurately coded	N/A	New target not previously measured	100%	100% (for all reviewed deaths)	Yes
We will ensure mortality reviews are carried out in all cases	N/A	Not available	100%	91% (Feb 2016 – March 2017)	No
We will increase PROMs participation rates to 80%	Groin hernia: 56.6% Hip replacement: 87.4% Knee replacement: 96.4% Varicose vein: 33.8% (national average April 2016 – Sept 2016)	Groin hernia: 30.1% Hip replacement: 71.4% Knee replacement: 168.9% Varicose vein: 34.3%	80%	Groin hernia: 9.4% Hip replacement: 87% Knee replacement: 119.8%** Varicose vein: 63.7% (April 2016 – Sept 2016)	No
We will improve PROMs reported health gain to be better than national average	See table on page 71 for full results	See table on page 71 for results	Over national average	Health gain unable to be calculated for groin hernia, hip and knee replacement as insufficient forms returned Varicose Veins: EQ-5D: 0.083 (below average) EQ-VAS: 0.3 (below average) Aberdeen: -0.1 (above average)	No
We will review all out-of-ICU/ED cardiac arrests for harm and deliver improvements as a result	N/A	N/A	All cases reviewed	Cases reviewed from December 2016	No
We will discharge at least 35% of our patients on relevant pathways before noon	N/A	28%	35% of patients discharged before noon	17.5%	No
We will ensure that 90% of clinical trials recruit their first patient within 70 days	72.5%	96.1% (2015/16)	More than 90%	85.4% (2016/17)	No

*We have not included data relating to the following target: ‘‘We will improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third’. This is because it has not been possible to report this data since 2013 owing to changes in the way it is now collected.

**Data from completed part A (pre-surgery) forms can sometimes arrive with NHS Digital after the closure of the annual reporting year; also non-NHS patients who may not appear on the Trust’s information system may complete PROMS forms and these factors can result participation rates in excess of 100%

The goal and targets in our Effective domain are designed to drive improvements to support good practice in our services and ensure the best possible outcomes for our patients. Areas where we are proud of the improvements we have made or sustained in our Effective domain are outlined below under ‘quality highlights’, areas where we have not performed as well as we would wish are summarised under ‘quality challenges’.

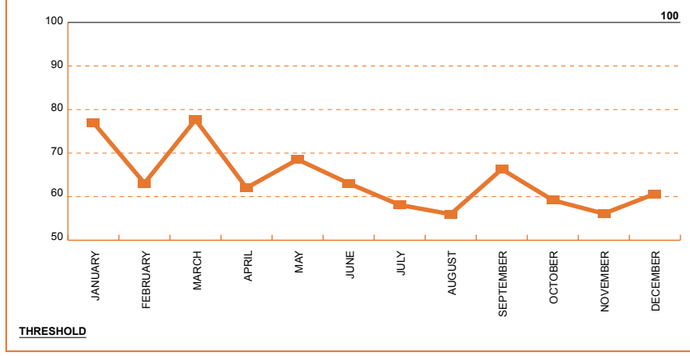
Effective quality highlights

Our mortality rates remain consistently low and we have a system in place to review all deaths that occur in the Trust:

As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), which enable us to compare our mortality rates with our peers. Both of these have remained low, with our Trust being amongst the top five lowest risk acute Trusts in the country throughout the year. As part of this, we also monitor the percentage of deaths with palliative care coded as this may affect the data (for definitions see glossary on page 90). Although our palliative care coding rates are high, we are confident that they are accurate as we have a robust clinical coding review process in place.

In February 2016, we introduced an online mortality review process to standardise the way all deaths are reported and reviewed across the Trust. Reviewing every death which occurs in our hospitals enables us to learn from any errors and pick up quickly on potential issues which could result in

Mortality rate as measured by HSMR, January 2016 – December 2016



EFFECTIVE

harm to other patients. This new process is starting to embed, with 91 per cent of deaths reported between February 2016 and March 2017 reviewed and plans in place to improve compliance in areas where reviews are overdue.

A large retrospective note review exercise conducted across the NHS and published in the BMJ in 2015 concluded that 3.6 per cent of deaths across the NHS were avoidable; in an organisation our size that equates to 55 deaths a year. Of the 1,897 deaths which have so far been reviewed through our new system, five of them have been confirmed as avoidable deaths. These have all been investigated as serious incidents and the actions and learning shared across the Trust through the Mortality Review Group. An additional thirteen cases of potential avoidable death currently remain under review. In 2017/18, we will publish information on avoidable deaths in line with national requirements set out in the CQC's review 'Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England'[6].

We developed a process to review all out-of-ICU/ED cardiac arrests for harm: Our initial target for the first year of the quality strategy was to reduce the number of cardiac arrests (see glossary on page 90 for definition) occurring outside our intensive care units and emergency departments. This is because when a cardiac arrest happens outside these two areas, it is often due to patients not being monitored properly or staff failing to recognise and act on deterioration in their condition. We achieved this target last year, and have reduced the number further this year (from 277 in 2015/16 to 241 in 2016/17). In December 2016 we introduced a robust system to enable us to review all out-of-ICU/ED arrests for harm, with all cases being reported on the Trust's incident reporting system to enable further review and root cause analysis. Any incidents where harm has been found are now able to be properly investigated and learning shared. Since this process was implemented, one case has been found to have resulted in harm.

Effective quality challenges:

We have not been able to report against our goal to show continuous improvement in national clinical audits with no negative outcomes: Clinical audit is a key improvement tool through which we can monitor and improve the quality of care that we provide. By taking part in national clinical audit programmes, we are able to benchmark our performance and measure improvements on a year-by-year basis. Action plans are developed in response to recommendations and areas for improvement. We review all national clinical audit reports in which we participate through our divisional governance structures and through the newly established Clinical Audit and Effectiveness Group. This group was introduced to improve how we manage clinical audit, but also to improve how we learn from the outputs and deliver improvements to patient care as a result. We have further work to do into 2017/18 to fully embed this effectively.

For the full list of audits we participate in, and the actions we are taking in response to the reports we have received so far this year, please see appendix A.

National clinical audits all report in different ways and have different rates of recurrence (e.g. some happen every year, some only once, and some every two or three years). Unfortunately this means we have struggled to demonstrate which audit reports show continuous improvement as we are not always able to compare them effectively with previous performance. In addition, not all audit reports provide trust level data, or a comparison to enable us to determine whether they represent a negative outcome. We will change our goal next year so that we are able to measure our performance more effectively.

Our PROMs health gain was unable to be measured for all procedures due to insufficient numbers of forms being returned: Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced following four surgical procedures: surgery for groin hernia, varicose veins, hip replacement and knee replacement.

Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. We are responsible for ensuring completion of the first questionnaire (part A). The number of pre-surgery forms sent into NHS Digital by us is compared to the number for surgical procedures carried out on our hospital information system; it is this figure which is used to calculate the Trust's participation rate.

An external agency, Capita, is responsible for posting out the second (part B) PROMs questionnaire to patients. The patient completes the form and returns it to Capita. It is the difference between the part A and part B forms which is used to calculate health gain. If insufficient Part B forms are returned, then NHS Digital, who publish the results, will supress an organisation's health gain score to protect patient confidentiality.

The most recent PROMs results were published by NHS digital in February 2017 for the data period April – September 2016. Although our participation rates are above average for all but one procedure (groin hernia), insufficient part B questionnaires were either sent out by Capita or returned by patients to allow health gain to be calculated for three out of the four procedures (hip and knee replacement and groin hernia) during this time period. We are working with Capita to resolve these issues.

PROMs data for this time period shows that our patients undergoing varicose vein surgery reported below average health gain. We believe the reason for this is that we had two different treatment pathways for patients with varicose veins depending on whether they were seen at St Mary's or Charing Cross Hospital, due to facility constraints. A new centralised varicose vein unit is now up and running, meaning all our patients will benefit from being offered treatment for varicose veins in one operation, rather than two. We expect that the change in practice will result in an improvement in PROMs reported health gain, and allow new innovative strategies of care and new technologies to be implemented for all varicose vein patients being cared for by the Trust.

We have not achieved our target to discharge at least 35 per cent of our patients on relevant pathways before noon: Untimely discharge has been identified as one of the most common reasons why A&E departments fill and patients have long waits to be seen and admitted or discharged. Planning discharges before the peak in admissions is an effective way to smooth the total demand for beds and run safer, more effective services.

By discharging patients earlier where clinically appropriate, we are in a better position to place all patients appropriately in the right ward, in the right bed and at the right time. Despite improvements made to our discharge processes we have not met our target this year, with 17.5% of patients being discharged from downstream wards by noon. This is partly due to issues such as patients being unable to be discharged as they are waiting for a bed at a care home. We are working with our partners in the community to solve this issue, including with Ealing, Brent and Hounslow through a north west London collaboration to deliver integrated adult social care services and with Central North West London to deliver an integrated community independence service.

In the meantime, we continue to make improvements to our discharge processes, such as:

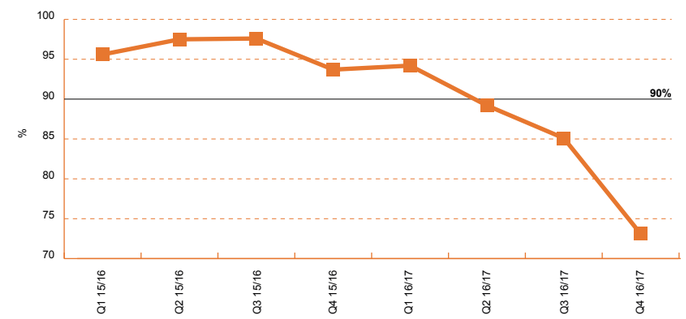
- Development of the 'discharge to assess model' with Community Care UK to ensure speedy discharge from hospital to home. Comprehensive assessment is undertaken in the patient's own home, instead of in hospital, where it is more comfortable and the patient's needs are clearer.
- Introduction of training for staff following implementation of the new discharge policy in February 2017.
- Development of a process for improved discharge review which includes follow up calls 24 hours after discharge for complex cases.

We did not meet our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days in quarters two to four this year: As one of the UK's six Academic Health Science Centres we are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into diagnostic methods and treatments across a broad spectrum of specialties and for some of the most complex illnesses, with benefits for patients everywhere.

Since 2012, the National Institute of Health Research (NIHR) has published outcomes against public benchmarks, including a target of 70 days from the time a provider receives a valid research application to the time they recruit the first patient for that study. This metric provides assurance that we are giving patients the opportunity to participate in research in a timely way.

Since 2014, up until quarter one this year, we have consistently reported above 90 per cent against this target. This is the result of having a robust feasibility assessment in place for every clinical trial. This ensures that everything is in place in advance, meaning patients are recruited to a fully operational trial that can be commenced in a timely manner. However, our results fell below target in quarter two, reflecting the impact of the full implementation of the new Health Research Authority (HRA) approvals process. The main reason for longer approval times in the new system is that the full duration of contract negotiation must now be included within the strictly-defined study initiation window of 70 days. The contracts team only receives legal agreements for review on the date when the HRA clock starts; no initial review or assessment can take place prior to that date (which was the practice previously). The average approval times have increased nationally as well as locally, according to the NIHR reports. We are reviewing processes for contractual review and negotiation, to identify ways of shortening these approval times and coming back within our target metric. This is likely to take another two quarters to achieve given the inherent lag involved in the clinical trials submission and set-up process.

Recruitment of patients to interventional studies



6 https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

CARING

The following section describes the progress we have made with the targets we set ourselves this year under the Caring domain.

The table below sets out our performance in 2016/17 as a trust. Where applicable, it presents national targets and averages and information about our performance in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To increase the percentage of inpatients who would recommend our trust to friends and family to 94%	96%	96%	94%	97%	Yes
To increase the percentage of A&E patients who would recommend our trust to friends and family to 94%	86%	92%	94%	95%	Yes
To increase the percentage of Outpatients who would recommend our trust to friends and family to 94%	93%	94%	94%	91%	No
We will achieve and maintain a FFT response rate of 30% in inpatient departments	25.01%	28%	30%	30%	Yes
We will achieve and maintain a FFT response rate of 20% in A&E	12.75%	11%	20%	15%	No
We will achieve and maintain a FFT response rate of 6% in Outpatients	Not reported	5%	6%	9.5%	Yes
We will improve our national cancer survey scores year-on-year	N/A	72% (annual results from 2014 survey published in 2015)	72%	8.6/10 (average rating of care) (annual result from 2015 survey published June 2016)	Yes – although it is not possible to compare scores directly, due to changes to the survey, our results show an improvement on last year
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	N/A	6.74 (annual result from 2015 survey published May 2016)	Over 6.85	6.72 (annual result from 2016 survey published May 2017)	No
We will increase our responsiveness to complaints – 95% of complaints responded to within the timeframe agreed with the patient (nominally 25 working days)	N/A	74%	95%	100%	Yes

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we ensure that we listen to our patients, their families and carers, and respond to their feedback.

Areas where we are proud of the improvements we have made or sustained in our Caring domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Caring quality highlights

We have exceeded our target for the percentage of our inpatients who would recommend us to friends and family and have maintained our performance in the national inpatient survey published in May 2017, with results very similar to our peers:

The Friends and Family Test (FFT) is one key indicator of patient satisfaction. Through our real time patient experience trackers, this test asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment. This system also means we can accurately track key protected characteristics (gender, age, ethnic group and disability) of those who respond, enabling us to compare experiences across these characteristics. We have continued to work to implement improvements based on any concerns that impact on one group more than another.

For patients reporting a positive experience, interaction with staff is usually the most significant factor. Work we have undertaken to support this includes:

- Providing patient feedback reports to every ward and department, and reviewing patient experience data alongside key safety metrics at local level to support the identification of quality improvement projects.
- Making sure we are compliant with the accessible information standard (see glossary on page 90 for definition) by providing information in a range of formats and languages, training our staff, undertaking promotional work to raise awareness about the need to ask patients if they have any specific communication needs and adding hearing loops in rooms where public meetings are held. We have also introduced an assessment process through our electronic patient record which enables automatic flagging of specific communication requirements.
- A new pathway for patients with learning disabilities who use our services. Known as the purple pathway, because of the flow chart colouring, it clearly lays out the pathways which patients will follow during their contact with the trust be it in A&E, as an outpatient or inpatient. It also covers the discharge process. A number of staff have been through a bespoke learning disabilities training programme in collaboration with Mencap and are now identified as learning disability champions in their departments.

97%

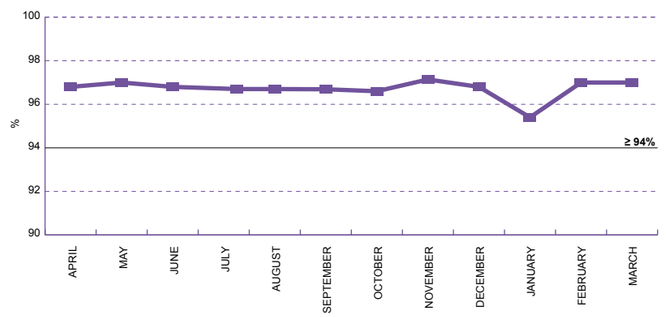
of inpatients would recommend our Trust to friends and family

- Continuing to improve care for our patients with dementia and consistently meeting the national standards for dementia screening and assessment throughout the year. On average, twenty five per cent of our beds are occupied by a person with dementia or cognitive impairment. Recognising the risks and concerns surrounding hospital admissions and dementia, our Dementia Care Team continues to provide tailored support, including:
  - twice weekly drop in sessions for patients and carers;
  - redevelopment of the Trust dementia champion role;
  - creation of a nutritional support pathway with three designated levels of support a patient can receive depending on what level their nutrition is affected;
  - implementation of 'My Improvement Network' technology, funded by the Charity, which provides activities including games, music, physical exercises and opportunities for social interaction all contained within a portable unit.

In 2017, we will be re-launching the carer's passport to raise the profile and provide additional support to carers, focusing on those who provide voluntary care for those with learning disabilities or dementia.

When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve and to ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible.

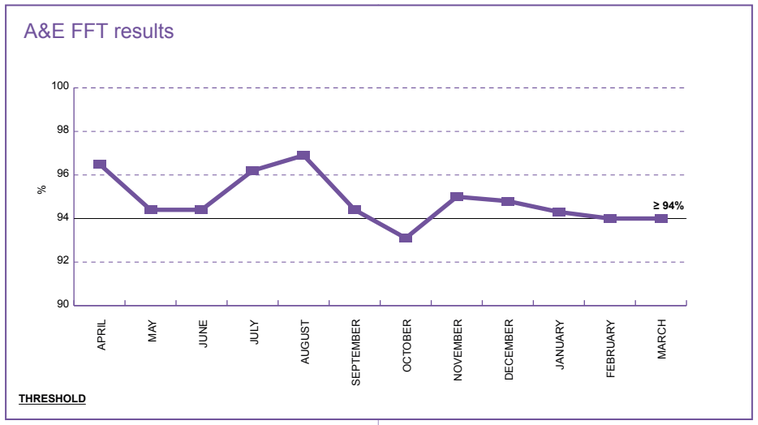
Inpatient FFT results



CARING

Changes we are making to improve include:

- A strategy to improve wayfinding across all of our sites (see page 23 for further information).
- Patient transport – Patient transport is a key issue for those who are not able to travel to appointments independently. Our FFT results for patient transport have been consistently below target this year. We reviewed our patient transport service, recruited an additional 28 drivers and introduced a new system that can match short notice requests to the earliest available vehicle. Once these are embedded we anticipate seeing an increase in the percentage of patients who would recommend the service. A Transport Working Group, comprising of members of Healthwatch as well as Trust staff, has been established to develop the collaborative approach to improving transport and travel to and across our sites with key stakeholders. Our current non-emergency patient transport contract will come to an end in 2018 so we will be re-tendering the service this year, focusing on creating a contract which will continue to deliver quality improvements for our patients.
- Discharge improvement – In the national inpatient survey, the Trust performed about the same as most other Trusts except for five questions where we performed worse, including one related to discharge: 'Did hospital staff discuss whether additional equipment or adaptions were needed in your home?'. Steps we are taking to improve the discharge process can be found on page 51.



The percentage of our A&E patients who would recommend us is over our target and significantly above national average: Like many NHS trusts, we continue to struggle to meet the national standard for A&E patients waiting under four hours to be treated and discharged or admitted. Despite this, we are pleased that over 95 per cent of our patients would still recommend our A&E services. We have detailed plans in place to improve performance in our A&E departments – please see page 58-59 for more information.

Our results in the national cancer patient experience survey show significant improvement: We have previously performed poorly in this survey, particularly in 2013 when we were ranked the worst in the country according to the Macmillan league table, so we are delighted to see a continuous year on year improvement in our results. Considerable work has been undertaken to improve the experience of patients with cancer since the 2013 results, most notably through our partnership with Macmillan Cancer Support, which has led to developments such as a Macmillan navigator function (see glossary on page 90 for definition) to support patients through the cancer pathway and the expansion of our nurse specialist service. We have also strengthened the functioning of our multi-disciplinary team meetings and run an internal programme centred around improving communication with patients (SMILE). The latest results demonstrate the positive impact of that work; they are the best set of results that we have returned in the 5 years that the survey has been running.

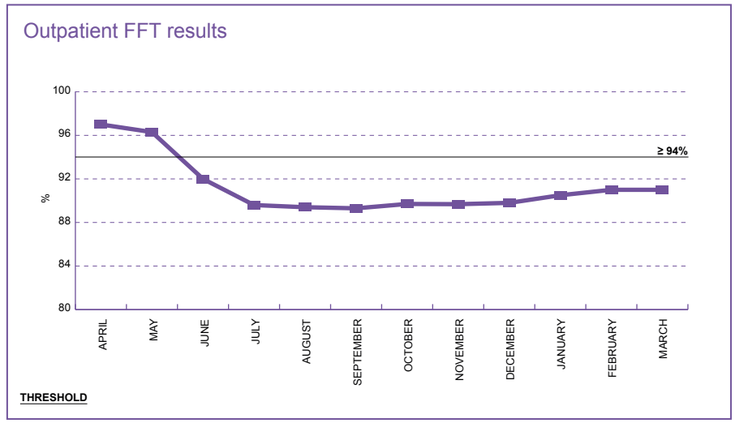
There were improvements in 22 out of 50 questions in the survey; we also scored above or within the expected range for 38 questions, with the number of questions which scored in the lowest range decreasing significantly (12 compared to 46 last year).

95%

of A&E patients would recommend our Trust to friends and family

100%

of complaints responded to within the timeframe agreed with the patient



Whilst there is clearly more to do, we are confident that we will continue to see improvements in our results. Since the survey was published in early 2016, we have been working to embed the improvements we've made, including rolling out the navigator service to all tumour groups, and have launched phase two of our partnership with Macmillan, focusing on improving the quality of life for the increasing number of people living with and beyond cancer. Phase two of our partnership specifically aims to:

- develop a deeper understanding of what enables people to live well with and beyond cancer, or stops them from doing so, by way of an in-depth research project;
- deliver services which enable people to access timely support and information to help them manage their condition.

Central to the ethos of the programme is strengthening the links between the Trust and the wide range of community-based services in north west London, including GP and primary care services and community and charitable groups.

We have exceeded our target to respond to 95 per cent of complaints within the timeframe agreed with the patient: In 2015/16 we restructured the complaints service and process following feedback to create a more responsive and caring service for our patients and identify learning for our staff. We adopted a new approach, shifting the focus from providing a response letter to resolving the concern.

We have continued to build on the improvements we made last year, embedding the new processes into practice. We are focusing on learning from and analysing themes from complaints, and are now providing monthly reports to each division, including trends and a weekly update of live complaints and received compliments to enable them to focus quality improvement based on what our patients are telling us. Appointments (including delays and cancellations) continue to account for the highest volume of complaints; work to improve this continues as part of the outpatient improvement programme (see page 58 for further detail).

We are one of a group of trusts working with Picker Europe to pilot a post complaint survey to understand complainants' experience of the process. 160 questionnaires have been sent out so far, with 20 responses received. Initial feedback suggests that they found the process satisfactory. One theme emerging is that complainants want the opportunity for more telephone contact and the option of having another nominated person to talk to if their designated point of contact is not available. The complaints team have therefore introduced a system of cover to ensure that there will be an alternative available.

We have also started to capture videos of patient stories arising out of complaints, with the first being shown at the Board meeting in January, supporting board decision making by illustrating the personal and emotional consequences of failing to deliver quality services.

Caring quality challenges

The percentage of outpatients who would recommend our Trust is below average and has dropped since last year: This drop coincided with the introduction of online completion of the survey. Although we are disappointed that our outpatient FFT rate has declined, we are confident that the changes we are making as part of our outpatient improvement programme will significantly improve outpatient experience in the long run. Work we are doing includes improving the content of appointment and follow-up letters, improving the clinic environment, delivering customer care training for staff, and increasing the use of digital technologies to support a better patient experience, such as patient kiosks and patient calling screens. You can read more about our outpatient improvement programme on page 58.

RESPONSIVE

The following section describes the progress we have made with the targets we set ourselves this year under the responsive domain.

The table below sets out our performance in 2015/16 as a trust. Where applicable, it presents national targets and averages, and information about our performance in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To consistently meet all relevant national access standards	N/A	5 out of 12 met in all 4 quarters	All targets met in all 4 quarters	4 out of 12 met in all 4 quarters	No
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	8.97% (Oct 15 – Sept 16)	4.81% (Jan-Dec 2015)	Below national average (8.97%)	5.15% (Oct 15 – Sept 16)	Yes
We will reduce the unplanned readmission rates for patients aged over 16 and be below the national average	7.98% (Oct 15 – Sept 16)	7.39% (Jan – Dec 2015)	Below national average (7.98%)	6.64% (Oct 15 – Sept 16)	Yes
We will have no inpatients waiting over 52 weeks for elective surgery, reduce the number of patients waiting over 40 weeks, and ensure a clinical validation is in place for each patient who waits over 18 weeks	N/A	52 week waits: 47 (month 12 performance)	0	52 week waits: 1,578 (16/17 total) Clinical validation process described on pages 59-60	No
We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice	N/A	9.5%	8.5%	8%	Yes
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	N/A	N/A – new target for 16/17	10%	11.8%	No
We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	N/A	N/A – new target for 16/17	95%	77%	No
We will reduce the proportion of outpatients who wait more than 45 minutes past their allotted appointment time	N/A	N/A	N/A	Unable to be reported	Unable to be reported

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
We will improve our PLACE scores annually to be in the top 25% nationally where possible	Cleanliness: 98.1% Food: 88.2% Privacy etc: 84.3% Condition etc: 93.4% Dementia: 75.3% Disability: 78.8%	Cleanliness: 98.60% (above average) Food: 86.07% (below average) Privacy etc. 78.39% (below average) Condition etc. – 86.76% (below average)	All scores above national average, except for condition where we will maintain current performance	Cleanliness: 98.73% (above average) Food: 87.1% (below average) Privacy: 71.77% (bottom 20%) Condition: 91.02% (below average) Dementia: 62.62% (bottom 20%) Disability: 64.82% (bottom 20%)	No

Having responsive services that are organised to meet people's needs is a key factor in improving experience and preventing delays to treatment, which can cause harm to our patients. Our goal is to consistently meet the national targets.

The table below shows our performance against the national access standards throughout 2016/17. We have consistently met four out of the12 standards however performance was challenged in the others. We know we have much work to do to tackle long-standing pressures around demand, capacity and patient flow (see glossary on page 90 for definition) to enable us to meet these targets. Areas where we are proud of the improvements we have made or sustained in our Responsive domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

National Targets and Minimum Standards	Measure	Threshold	Q1	Q2	Q3	Q4	Target achieved in all quarters
Access to treatment	18 weeks referral to treatment – incomplete pathway	92.00%	88.16%	84.57%	82.92%	82.48%	No
Access to Cancer Services	2 week wait from referral to date first seen all urgent referrals	93.00%	90.70%	92.40%	93.30%	90.16%	No
	2 week wait from referral to date first seen breast cancer	93.00%	92.00%	93.30%	95.30%	93.21%	No
	31 days standard from diagnosis to first treatment	96.00%	97.00%	96.70%	97.60%	96.15%	Yes
	31 days standard to subsequent Cancer Treatment – Drug	98.00%	100%	100%	100%	99.16%	Yes
	31 days standard to subsequent Cancer Treatment – Radiotherapy	94.00%	99.50%	98.20%	99.30%	97.95%	Yes
	31 days standard to subsequent Cancer Treatment – Surgery	94.00%	95.50%	97.50%	95.70%	96.75%	Yes
	62 day wait for first treatment from urgent GP referral	85.00%	70.20%	80.10%	82.00%	74.70%	No
	62 day wait for first treatment from NHS Screening Services referral	90.00%	92.80%	87.70%	90.80%	92.94%	No
	A&E maximum waiting times 4 hours	95.00%	90.86%	90.83%	87.67%	88.97%	No
A&E Performance	Cancelled operations for non-clinical reasons	0.80%	0.99%	0.73%	0.69%	0.88%	No
Cancelled Operations	Rebooking non-clinical cancellations within 28 days	<5%	9.82%	12.14%	13.40%	11.9%	No

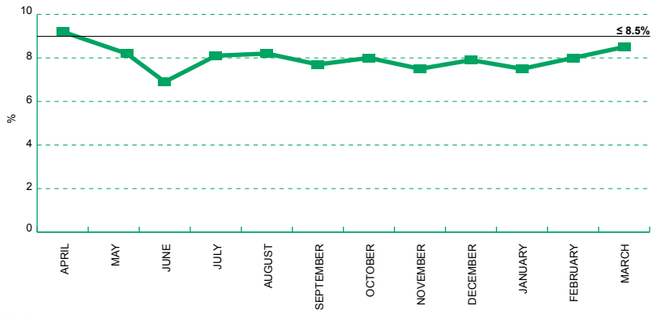
RESPONSIVE

Responsive quality highlights

We continue to deliver our outpatient improvement programme and are seeing improvements as a result: Around a million people come to the Trust's hospitals as outpatients every year and we have been running a major programme to improve the quality of their experience. This includes:

- £3 million of refurbishment works, creating a more patient-friendly environment at our clinics at Charing Cross and Hammersmith hospitals, funded by Imperial Health Charity who also gave £4m for a centralised patient services centre at Charing Cross and committed nearly £300,000 to update the outpatient department at Western Eye Hospital.
- Tackling issues with appointment letters, patients being rescheduled at short notice and long waiting times in some clinics with high demand – with outpatient staff winning a Trust award by keeping patients informed of any delays to their clinic.
- Improving how patients get their appointment details – 90,000 patients have now opted to receive email correspondence. For those who prefer having their appointments sent by post, we switched to a new postal service in June 2016 that is faster and more reliable. We also made the appointment letters clearer and more informative.
- Creating a single patient service centre at Charing Cross. Here, all of the outpatient administration teams are coming together to manage all calls and put in place new ways of working to make sure we get things right for patients and GPs, first time.

Outpatient appointments cancelled with less than 6 weeks notice by the Trust



- Introducing appointment reminders by voicemail and expanded text reminders, with more than half of patients contacted now confirming their attendance. All of the improved communication has meant that fewer people are missing their appointment – down from 17 per cent in 2014 to just over 11 per cent in 2017.
- Improving the availability of patient records, which are held electronically on a secure system ensuring when a doctor sees a patient in clinic, they have their key details to hand and there aren't delays waiting for paper records. Furthermore, GPs now receive 96 per cent of documentation, including patient discharge summaries, electronically.
- Increasing the percentage of GP electronic referrals to 50 per cent.

As a result of this work, we have seen improvements in some of our key targets, including reducing the amount of outpatient clinics cancelled by the trust and increasing the number of appointments made within five working days of receipt of referral from 70.70 per cent in August 2016 to 78.9 per cent in March 2017.

Our main outpatient departments were inspected again by the CQC in November 2016. The final inspection reports were published on 31st May 2017. We are ensuring that all of the concerns, recommendations and good practice inform further plans for improvement. For more information, please see page 39.

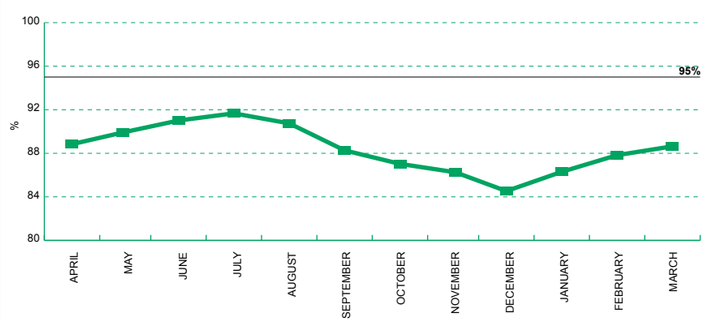
Responsive quality challenges

We have not met the national four hour A&E standard: A&E performance is measured by the percentage of patients that are seen, treated and discharged from an urgent or emergency care setting within four hours. Our overall performance is derived from attends across all our emergency areas. These include:

- The main Emergency Departments (Type 1)
- Western Eye Hospital (Type 2)
- The Urgent Care Centres at our three main sites (Type 3).

Like many NHS trusts, we struggled to meet the 95 per cent standard.

A&E four hour target



Pressures on A&E are complex and include pressures on the entire urgent and emergency care system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery. We saw a three per cent increase in A&E attendances and a five per cent increase in emergency admissions in 2016/17.

We have been rolling out a range of improvements to enable a better 'flow' through of patients through our urgent and emergency care pathways, working to ensure patients receive care in the right place at the right time by the right healthcare professional, from their first contact with us, through assessment, diagnosis and treatment, to ensuring a safe and timely discharge. This includes:

- Refurbishing St Mary's A&E and co-locating services for patients requiring urgent and emergency care on the ground floor at Charing Cross to improve the environment and increase capacity.
- Working with commissioners and local mental health trusts to improve the pathway for patients. We have increased the number of registered mental health nurses and established a dedicated consultant lead in both emergency departments.
- Extending the opening hours of the ambulatory emergency care (AEC) service at St Mary's and Charing Cross hospitals, including weekends. The AEC service provides specialist diagnostics and treatment for patients who have urgent needs but are well enough to go home in between procedures or consultations and, essentially, to be cared for on an urgent outpatient basis. See glossary on page 90 for further information.
- Opening a 12-space surgical assessment unit at St Mary's in January 2017 to enable faster access to a specialist surgical opinion where required.
- Promoting discharges before noon, streamlining and improving our discharge processes (see page 51 for further information).

Despite not achieving the national standard, reported patient experience in A&E has been above our target of 94 per cent for every month throughout the year except August 2016. We have also maintained low emergency readmission rates for both adult and paediatric patients, with both rates remaining below national average throughout the year. This a good measure of the effectiveness of our care, as if a patient is treated and discharged appropriately they should not require unplanned readmission.

We have not met the national performance targets for referral to treatment (RTT): With increasing demand for our services, keeping waiting times down for planned care has been a particular challenge. In early 2016, the Trust also identified some issues with how we were managing our waiting lists as well as underlying capacity problems in some areas. We have not met the standard of 92 per cent of patients treated within 18 weeks of referral this year, reporting 83.24 per cent at the end of March 2017.

We invited NHS Improvement's Elective Care Intensive Support Team (IST) to review our processes and to provide advice on improvements. Working with our commissioners and NHS Improvement, we established a waiting list improvement programme in response and are making good progress with:

- a data quality clean up – a systematic and detailed audit of all of our waiting lists to ensure we have identified all patients who should be on an open RTT pathway.
- improved waiting list management – better processes, training and on-going audit to make sure all lists are now managed correctly and consistently.
- systematic clinical review (see below for more information) – detailed reviews by doctors to ensure patients are not coming to clinical harm as a result of their wait. We have also rolled out a new clinical outcome form which is aiming to improve the recording of clinical outcomes in outpatient clinics as a driver to improving patient safety and RTT performance.
- additional clinical activity – including running more outpatient clinics and theatre sessions, both within the Trust and with the support of independent sector providers.
- improved theatres– our Riverside Theatres at Charing Cross Hospital were completely refurbished enabling us to expand the range of procedures undertaken there. A temporary mobile operating theatre was used to ensure that we were able to maintain our theatre capacity during the refurbishment period.

More work needs to be done and the programme will remain in place into 2017/18.

We have seen a significant increase in patients waiting over 52 weeks for treatment on an RTT pathway: As part of the Trust's waiting list improvement programme, a number of clinical review processes have been established to monitor the impact waiting for treatment is having on our patients and to ensure that avoidable harm has not/is not occurring as a result of delays in treatment.

A clinical harm review steering group was set up in August 2016 with external expertise invited to join in October. This external expert has shared lessons learnt from another large hospital trust's

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experience which has been used to review our clinical harm review processes.

The clinical harm reviews include all patients who have been added to the RTT waiting list following validation as part of the improvement programme as well as those who were already on an RTT list. The outcomes of the reviews so far are outlined below:

- **Retrospective review:** undertaken by the deputy medical director, this review looked at all patients who waited over 18 weeks for treatment on an RTT pathway between April 2015 and June 2016. This review is now complete; out of over 8,000 patients, none have been found to have come to severe harm as a result of waiting longer than the RTT target. Given the numbers of patients involved, it was not possible to review psychological pain or discomfort through this process as this would have involved an individual patient by patient review process.
- **Review of patients waiting over 52 weeks:** A senior nurse coordinates and oversees this process and ensures that the records of all patients waiting over 52 weeks for treatment are reviewed by a consultant. These reviews and the patients' treatment plans are used as part of the weekly specialty 'long waiters' meeting to track and expedite dates where needed. If any cases of potential harm are found, they are entered onto the Trust's incident reporting system and investigated. Two cases of moderate harm (see glossary on page 90 for definition of moderate harm) identified through this process have been confirmed. We have recently expanded the process to include 'on admission' reviews for patients in high risk specialties who have waited over 52 weeks. A dedicated email address has also been set up for GP colleagues to alert us to any patients that they are concerned about having increased risk of harm which will help us escalate patients for earlier care where appropriate.
- **On-going review:** we know that best practice would be for clinical reviews to occur for any patient waiting over 18 weeks to ensure at risk patients are prioritised. However, given the large number of patients waiting in this category we have adopted a targeted approach prioritising patients in specified high risk specialties for prospective review. Of the completed reviews in the specialties deemed 'high risk', no cases of clinical harm have been found.

We will continue the on-going reviews of patients throughout 2017/18.

We have not consistently met all eight cancer standards: We failed to meet the following cancer standards across all quarters this year:

Two week wait from urgent referral to first being seen

We have not met this standard consistently throughout the year, however we have been working to reduce delays and improve booking times. We have an on-going programme in place to deliver the CCG aim of reducing the median wait from referral to first appointment by one day across tumour groups. This will support continued improvement against this target.

Two week wait from referral for breast cancer to first being seen

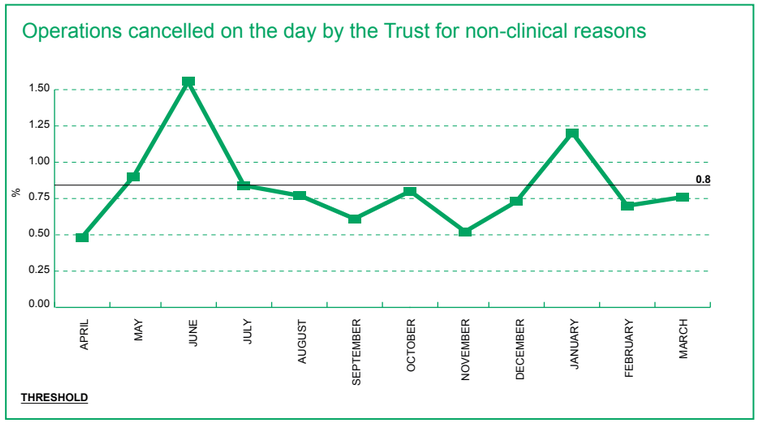
In quarter one, our performance against this target was largely affected by patient choice. Of 59 breaches, only four related to hospital initiated delays. We have since seen an improvement against this standard, partly due to the work to improve booking times outlined above. We have met this target in all quarters since.

62 day wait for first treatment from urgent GP referral and from screening

We have struggled to meet these standards throughout the year, mainly due to specific issues including late receipt of tertiary referrals from other organisations, and internal delays to the scheduling of diagnostics and treatment planning particularly in endoscopy, imaging and urology. With the support of our commissioners and NHS England, we agreed a cancer waiting times recovery plan and improvement trajectory to enable us to meet this target by the end of 2017/18.

Actions being taken include:

- working with the NHS Intensive Support Team to improve the transition of patients between surgical specialties and endoscopy;
- improved support for the urology rapid access clinic model to reduce delays experienced by patients during the diagnostic phase of the urology pathways;
- recruitment of a new administrative team to support the growing numbers of cancer referrals to the Trust who have been in post since September;
- integrating the Macmillan Navigator service into this work, to better support patient communication out of hours and facilitate the escalation of patient concerns to the Clinical Nurse Specialist (CNS) teams to avoid patient-initiated delays earlier in the treatment pathways;
- introducing the 'straight to test' pathway for all new suspected colorectal cancer referrals, which was rolled out across the Trust in November;
- Working with our commissioners to support a reduction in late referrals from other hospitals in North West London.



We are seeing improvements and are currently meeting the performance trajectory agreed with our commissioners.

We have not consistently met the national standard for non-clinical on-the-day cancellations of surgery: We experienced increased demand for emergency care in 2016/17 which did contribute to the cancellation of a number of planned operations, although we worked hard to minimise them being cancelled on the day of surgery. We also increased our theatre capacity in key surgical specialties and through the new Riverside Theatres at Charing Cross. Where operations are cancelled, this is usually because of bed availability, earlier cases overrunning or elective operations being cancelled for emergency cases.

As a major centre for emergency care and trauma in London, we do have to work to make sure that planned surgery is not impacted by the nature of our emergency work, and an elective care project is being developed for 17/18 to ensure that planned surgery and care gets the priority it needs.

Since April 2002, all NHS patients who have elective operations cancelled for non-clinical reasons on the day of surgery (or day of admission) should be offered another binding date within 28 days. We have not met this standard this year, with the number of patients not subsequently treated within the 28 day guarantee period remaining high. A full review of this is underway and any improvement actions will be reported in quarter one.

We have not improved our PLACE (patient led assessment of the care environment) scores in all categories: PLACE was introduced in 2013 as an annual patient led initiative that monitors and scores the patient environment under the following headings:

- Cleanliness
- Privacy, Dignity & Wellbeing
- Food & Hydration
- Condition, Appearance & Maintenance
- Dementia (introduced in 2015)
- Disability (introduced in 2016)

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments provide a clear message, from patients, about how the environment or services might be enhanced.

Patient representatives are always fully engaged with the assessment process, with an increased number of new patient assessors taking part this year. We have been commended by the Department of Health for our approach to the assessments and have been used as an exemplar for the correct application of the process.

We have improved our performance in three areas compared to last year's scores:

- Cleanliness – which scores above national average.
- Food and hydration – although our results remain below average, they have improved slightly since last year.
- Condition, appearance and maintenance – results remain below average, but have improved across all of our sites.

In the two other areas reported in 2015 (dementia and privacy, dignity and wellbeing) our results have deteriorated, with the Trust being in the bottom 20 per cent for these categories. We are also in the bottom 20 per cent for the disability category, which was introduced in 2016. A detailed action plan is being led by the PLACE steering group in response to the results, with themes of flooring repairs, access such as seating and hand rails, and improved signage which will be taken forward as part of the wayfinding strategy (see page 23 for more information). Dementia and disability requirements are at the heart of the designs for our new outpatients departments and A&E departments. Through our Clinical and Estates strategies, we continue to work to improve the condition of our hospitals to provide a more patient centred environment.

98.60%

Cleanliness PLACE score – above average and an improvement on last year's score

WELL-LED

The following section describes the progress we have made with the targets we set ourselves this year under the well-led domain.

The table below sets out our performance in 2016/17. Where applicable, it presents national targets and averages, and information about our performance in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To increase the percentage of staff who would recommend this trust to friends and family as a place to work	N/A	60 per cent (internal staff survey) 57% (national staff survey)	62% (internal staff survey)	65% (internal staff survey published Sept 2016) 62% (national staff survey published March 2017)	Yes
To increase the percentage of staff who would recommend this trust to friends and family as a place for treatment	70%	77% (internal staff survey) 68% (national staff survey)	81% (internal staff survey)	83% (internal staff survey published Sept 2016) 70% (national staff survey published March 2017)	Yes
We will achieve a voluntary turnover rate of 10%	N/A	10.58%	10%	10.22%	No
We will reduce our sickness absence rate to 3.10%	N/A	3.21%	3.10%	3.00%	Yes
We will achieve a performance development review rate of 95%	N/A	91.69%	95%	86.24%	No
We will achieve a non-training grade doctor appraisal rate of 95%	86.6%	83.3% (March 2016)	95%	91.13%	No
We will achieve compliance of 90% with statutory and mandatory training	95%	86.79%	90%	85.60%	No
We will re-run our ward accreditation programme with evidence of documented rapid improvements where issues arise	N/A	Programme launched	Programme re-run	Programme re-run	Yes
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5%	N/A	50 red flags (36% increase on previous year)	5% reduction	25 red flags (50% reduction on previous year)	Yes
We will increase the overall number of green flags in the GMC's national trainee survey	N/A	20	More than 20	54	Yes
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	N/A	73% (academic year 2015/16)	100% of placements with 0.5 or more	76% (academic year 2016/17)	No
We will have trained departmental safety coordinators in 90% of specialties	N/A	90.99%	90% departments with trained coordinators	91.87%	Yes

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We have implemented a number of improvements to increase staff engagement throughout the organisation and to help us to deliver our annual targets, many of which are described throughout this section.

Areas where we are proud of the improvements we have made or sustained in our Well-led domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Well-led quality highlights

We have achieved our goal and increased the percentage of staff who would recommend our Trust as a place to work and as a place for treatment:
We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice, Our Trust' which was run between July and September 2016. 3,244 of our people responded, which represents 38 per cent of the total workforce surveyed.

The survey included questions about whether staff would recommend the Trust to friends and family as a place for treatment or a place to work. We were very pleased to see a significant improvement in the scores for both of these; they are our best results for these two questions since the staff survey was introduced in November 2013.

In addition to these, the top 5 performing questions across our survey were:

- I understand how my work makes a difference to other people (96 per cent)
- I am clear about the values and behaviours expected of me at work (95 per cent)
- I am clear about my own objectives and responsibilities (94 per cent)
- I am trusted to prioritise my workload myself (92 per cent)
- Staff here are generally friendly and welcoming (89 per cent)

Other items we scored well on include "the people in my team work together to provide a great service" (88 per cent) and "I am encouraged by my colleagues to report any patient safety concerns I may have" (83 per cent).

Our staff were less positive about the following questions:

- Senior leaders are genuinely interested in staff opinions and ideas (52 per cent)
- I generally have enough time to complete all my work (51 per cent)
- Senior leaders communicate well with the rest of the organisation (50 per cent)
- Senior leaders are visible and approachable (49 per cent)
- Poor behaviour and performance is addressed effectively in this organisation (43 per cent)

Overall, the results identified opportunities to act and improve at an organisational level based on staff feedback.

We also focused on the way we developed and communicated our response to this survey so that staff see action and change resulting directly from completing it. We created a tool to support managers in using these results to drive improvement in their local areas, supporting the development of action plans and running 'In our shoes' focus groups, which are an opportunity for staff to share with each other what makes a good day and what makes a bad day at work, and identify what the Trust can do to improve staff experience. Over 700 employees across the organisation have participated.

The national staff survey results were published in March 2017, and we have also seen an improvement. Our overall engagement score rose to 3.8 out of 5, moving us up two categories to 'average' for all trusts of a similar type. This is the highest we have seen since 2013.

We achieved some very positive scores, above the national average, including in three particular areas:

- percentage of staff appraised in the past 12 months (92 per cent against an average of 87 per cent)
- staff satisfaction with the quality of work and care they are able to deliver (4.04 out of 5, against an average of 3.96)
- quality of non-mandatory training, learning or development (4.10 out of 5, against an average of 4.05)

While we are beginning to see the

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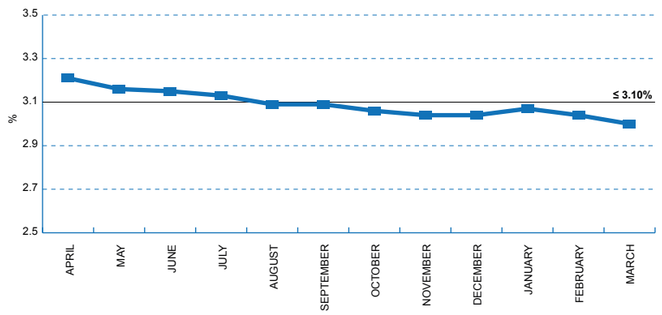
impact of a range of improvements at all levels, the survey results also make it clear we still have much more to do. Some of our lowest scores relate to staff experiencing and reporting violence at work. We have established a task group to oversee an action plan to tackle the unacceptable level of violent incidents. We also reported below average scores in relation to the workforce race equality standard:

- 31 per cent of staff surveyed reported that they had experienced harassment, bullying or abuse from staff in the last 12 months against an average of 25 per cent.
- 80 per cent of staff surveyed believed the Trust provides equal opportunities for career progression or promotion against an average of 87 per cent.

We are currently looking into the reasons why our scores are worse than average for these questions and developing a Trustwide response and action plan. To ensure we improve, we will be training more managers in addressing bullying and harassment, as well as further promoting general awareness of dignity and respect at work. We will also review the recruitment and training selection content to raise awareness of unconscious bias and ensure that each interview panel has at least one member who has been trained.

We have slightly decreased our voluntary turnover rate: Although we have not met our target, we are pleased that we have seen a slight decrease in staff voluntarily leaving the Trust this year. A key aspect of reducing the voluntary turnover rate is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. Some of the ways we are working to ensure this include:

Sickness absence rate



- Revising our leadership development programme – building on our existing award winning schemes, we are further developing training programmes which focus on specific needs identified by our staff, including management skills, financial management, digital learning, data and analytics. More than 1,000 staff participated in our staff development programmes in 2016/17.
- Running an active coaching and mentoring register and training programme, and an innovative 'paired-learning' programme which enables junior doctors and junior managers to learn together.
- Refreshing and further developing our talent management programme and succession plan which identifies the highest performers and the developmental support required to enhance their contribution.
- Increasing the people recruited from our existing workforce through our retention strategy, this includes a new quality improvement project called 'great place to work' which is looking at how we can improve the experience of staff when first joining the Trust.
- Introducing our quarterly magazine, Pulse, focusing on our staff, patients and volunteers, boosting pride and confidence in our organisation.
- Running our second admin and clerical network in December 2016, building on the success of the first and focusing particularly on career development.
- Developing a new integrated apprenticeship scheme which aims to create a talent pipeline of young people able to fill band 2 or 3 posts in key areas.
- Introducing a comprehensive package of benefits for staff.
- Appointing two 'Freedom to Speak Up Guardians', who are overseen by one of our non-executive directors, who encourage staff to raise concerns openly as part of normal day-to-day practice so that action can be taken to ensure high quality, compassionate care.
- Continuing to run monthly Schwartz Rounds (see page 23 for more information). Since 2015, when Schwartz rounds were launched, we have hosted 23 rounds across our three main hospitals, attended by over 1,000 staff.

Our sickness absence rate remains low: Low sickness absence is an indicator of effective leadership and good people management. This year, we have focused on embedding our sickness absence policy, which was launched last year.

The other focus of our work has been on supporting the health and wellbeing of our staff. Our Occupational Health service provides a range of activities and services, including staff counselling, stress management services, yoga and meditation classes, weight management programmes, smoking cessation clinics and rapid access physiotherapy. In September 2016, we ran our second Healthy Living Week; a campaign of events designed to get staff fit, active and having fun.

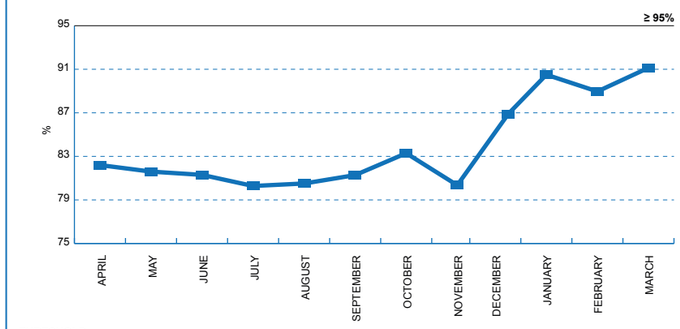
In addition, we are striving to improve health and safety for staff and patients alike across the Trust, which is supported by our departmental safety co-ordinators (DSCs – see glossary on page 90 for definition), who in addition to their day jobs, ensure that their department is fully compliant with health and safety regulations.

We have increased the percentage of our doctors who have had an appraisal and are now above national average: It is a national requirement that non-training grade doctors have an annual medical appraisal as part of the General Medical Council's Revalidation process (see glossary on page 90 for definitions), during which doctors have a formal structured opportunity to reflect on their work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. Although we are still slightly behind our target of 95 per cent, we are pleased that our appraisal rates for doctors have improved significantly since last year. This increase is due to improved guidance and increased numbers of drop-in sessions for doctors with queries relating to appraisal and revalidation, and the implementation of our revalidation and appraisal policy.

We have significantly improved our results in the General Medical Council's National Training Survey of junior doctors and have maintained our performance for placement satisfaction as measured by SOLE (student online assessment): As one of London's largest teaching hospitals, we want to provide the best training for our doctors. Two important elements we use to monitor the satisfaction of our trainee doctors and medical students are:

- **Student Online Evaluation (SOLE):** The feedback we receive from our medical students through the local SOLE system has previously been mixed. Our aim is to focus on improving their experience in a consistent manner, with the target of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all student placements. In 2015/16, we achieved this target for 73 per cent of our programmes, which was an improvement of almost 50 per cent on the previous year. We are pleased that we have succeeded in slightly improving still further, with 76 per cent of students agreeing that 'overall (they are) satisfied with their placement' in 2016/17.

Doctors' appraisal rate



50%

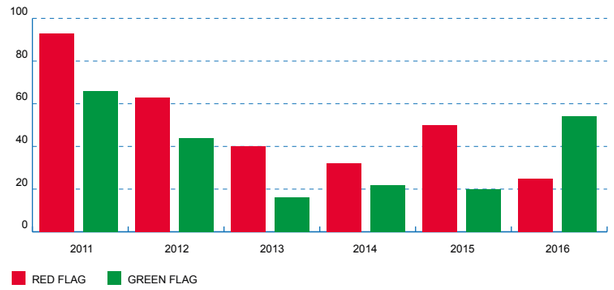
reduction in red flags in the GMC's national training survey

- **General Medical Council's national training survey (GMC NTS):** This annual survey can highlight not only problems with teaching in organisations, but also patient safety issues and problems with bullying and undermining. The results of the GMC NTS were published in July 2016. Our results have improved significantly with a reduction in red flags (where we are a significant national outlier) by 50 per cent. We have more than doubled the number of green flags from 20 to 54, with three times as many programmes having green flags than the previous year. As a result, we have gone from worst performing to best performing Trust compared to our peers in the Shelford Group within one year. Several specialties, including ophthalmology and GUM/HIV which were particularly challenged last year, underwent a complete transformation from multiple red flags to multiple green flags. We were also delighted that there were no bullying and undermining concerns raised by trainees in the survey this year, and a significant reduction in patient safety concerns.

These improvements are the result of our comprehensive education transformation programme launched in 2015, which included standardising local faculty group meetings (see glossary on page 90 for definition), providing improved access to educational resources and renovating our education centres and teaching rooms, delivering a 'day one ready' induction to ensure trainees are fully equipped to start their roles on the first day in their departments, and delivering a faculty development programme for unit training leads and educational supervisors.

WELL-LED

General Medical Council's National Training Survey Results



Since the results of the survey, we have been focusing on sustaining the improvements made and driving further change by:

- Sharing good practice from the specialties with green flags;
- Conducting focused specialty reviews, chaired by the medical director, with specialties that are still challenged;
- Embedding time for education in job plans and making it sustainable;
- Supporting the development of the multi-professional workforce through the implementation of the integrated education strategy;
- Working to ensure the new junior doctor contract is implemented with educational expectations and standards maintained. We have appointed a guardian of safe working to ensure safe working of junior doctors in the Trust. The guardian runs quarterly junior doctor forums and reports to the board highlighting rota exceptions (where hours have been exceeded) and fines imposed as a result, and gaps in the junior doctor rota. 100 'exception reports' have been received in the Trust so far this year, with no confirmed breaches requiring fines to be paid.

We re-ran our ward accreditation programme and saw improvements in 25 wards: Following our CQC inspection in September 2014, we launched our own internal programme of ward inspection to carry out regular checks and instigate immediate improvement where necessary. Our ward accreditation programme (WAP) is designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed. Areas are assessed against a number of criteria, and given a rating, from gold (achieving highest standards with evidence in data) to white (not achieving minimum standards and no evidence of active improvement work).

We ran our first WAP in 2015; our second was run between July and December 2016. Overall, out of 75 areas reviewed, 25 had improved since last year. The QI team is supporting improvement projects on individual wards to help address their key issues. Overall Trust results are summarised below:

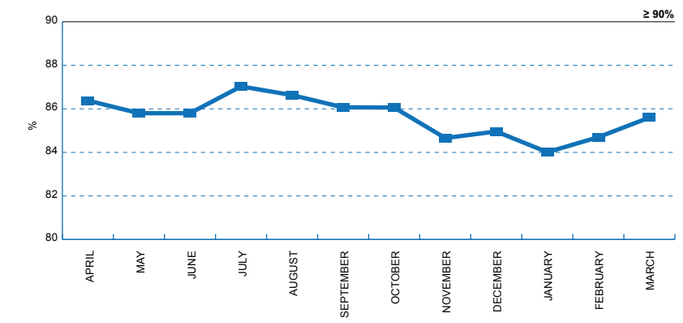
- Leadership: there has been a significant improvement in this domain, with 6 areas rated white for this element in 2016, compared to 13 in 2015.
- Record keeping: only one area was rated white in 2016, compared to 7 in 2015.
- Meals (nutrition and hydration): we continue to have good results in this category. Examples observed include efficient services with staff assisting patients where needed, facilities for families and carers, and hot drinks machines being available.
- Communication: this was rated gold in 19 areas this year. Examples of good practice include: intensive support rounds with the general manager, senior nurse and discharge team; good multi-disciplinary team working; excellent handover practice; and effective huddles and safety briefings.
- Environment: we continue to struggle in this area with issues often a result of our old estate. However there were also problems such as poorly organised storage and overstocking, and some dirty equipment. Actions are in place through the estates and facilities quality committee. Monthly environment walkrounds are taking place and the divisions are managing specific issues in their clinical areas to drive improvements.
- Medicines administration and storage: there were some examples of failure to comply with medication safety checks and storage standards. Medicines safety is one of our key safety priority areas and work is being taken forward by the Medicines Safety Group. We also ran task and finish groups with some of the wards who had issues in this area. With the QI team, they developed improvements including standardised locks for medicine pods, improved signage for medicines and controlled drug cupboards and a standard for medicines administration.

Well-led quality challenges:

We have not increased the percentage of staff who have had a performance development review (PDR): Our appraisal scheme 'Performance Development and Review (PDR)' for staff, excluding doctors, is aimed at driving a new performance culture across the Trust. Although we are below target and below last year's result, our PDR rate remains high with over 7,200 staff completing their PDR with their manager within the designated timeframe of April–September 2016. This year, we revised the PDR process with a new emphasis on our values and behaviours, improved quality of objectives and on-going regular performance conversations between annual reviews to improve the link between individual and organisational objectives. We have continued to run training sessions to ensure that managers have the tools and skills to have high quality performance conversations with all their staff. Despite the reduction in numbers, 92 per cent of staff responded that they had had an appraisal in the last two months in the national staff survey. We also believe that the 94 per cent of our staff who stated that they were clear about their objectives and responsibilities in our internal engagement survey shows that the PDR process is having a positive impact. We will continue to embed and improve the process in 2017/18.

We have not achieved our target of 90 per cent of staff being compliant with core skills training: Our core skills training programme ensures the safety and well-being of all our staff and patients; this includes modules which have a direct impact on patient safety. The percentage of staff who have completed all the core skills modules has slightly decreased this year; we continue to target areas where compliance is particularly low. We have also embedded compliance in the PDR process so that managers review compliance as part of normal performance management. We are reviewing all mandatory training modules to streamline them and make them more effective which will reduce the total number which staff are required to undertake.

Core skills training compliance



The Acute Quality Schedule 2016/17

Each year, we agree a number of quality metrics with our commissioners which we are required to deliver as part of our contract. These include nationally mandated metrics, as well as locally agreed ones. Our commissioners monitor our performance with these indicators throughout the year through the Clinical Quality Group. They include most of the quality strategy priority goals and targets described above. We have achieved the majority of the quality schedule metrics throughout the year and have agreed plans with our commissioners to help us improve in areas where we have not performed consistently, including in the following key areas:

Maternity performance indicators

The quality schedule includes 10 key targets to drive improvement in maternity care. We achieved the following six targets in all four quarters this year:

- 90 per cent breastfeeding initiation rate within 48 hours of the baby's birth
- 95 per cent of maternity booking assessments in 12 weeks and 6 days
- 95 per cent of women receiving one-to-one midwife care in established labour
- Less than 5 per cent of women smoking at the time of delivery
- Less than 13 per cent of women having an elective caesarean section
- Less than 6 per cent of women experiencing 3rd or 4th degree tears

We met the target for 100% of pregnant women having a named midwife/named team since July 2016.

Home births:
The number of women giving birth at home remains below the threshold of 1 per cent. Maternal choice is the main factor driving this. This is being driven by the popularity of our co-located 'home from home' midwifery led birth centres in which 17 per cent of our women choose to give birth. We continue to strive to increase home birth choices where clinically appropriate.

Percentage of women having a non-elective caesarean section
Performance against this target continues to fluctuate. We continue to work on improving the induction of labour patient pathway and share learning from case reviews of all non-elective caesarean sections to support improved performance.

Postpartum haemorrhage
Our performance against this target continues to fluctuate, with an average of 3.0 per cent against a target of 2.8 per cent. We have an action plan in place, and are seeing improvements; we met the target in three out of four of the last months.

In addition to the work outlined above to improve our maternity care, we are also taking forward recommendations from two national reviews:

- 'Better births', which considers how maternity services needed to change to meet the needs of the population, and to ensure that learning from the Morecambe Bay Investigation is embedded throughout the NHS, and;
- 'Saving babies' lives' which aims to reduce stillbirths across the UK. This includes four key elements: reducing smoking in pregnancy; risk assessment and surveillance for foetal growth restriction; raising awareness of reduced foetal movement; and effective foetal monitoring during labour.

Safeguarding training

We are committed to the protection and safeguarding (see glossary on page 90 for definition) of all patients, including children and young people. As part of this, we provide staff with different levels of safeguarding training, depending on their role. Throughout 2016/17, compliance with training has remained below our target of 90 per cent, this is an important but challenging priority for us.

Level 1 & 2 training for both adult and child training is delivered via e-learning modules. We have communication plans in place to improve compliance, including regular reminders to staff and reviews of monthly compliance reports with managers. In addition, all staff are now required to confirm that they are up to date with their core mandatory training as part of their annual personal development review; a failure to do so can prevent them progressing to the next pay increment. We have incorporated Prevent awareness training into the level 1 and 2 adult safeguarding training and have seen significant improvements in the uptake as a result, meaning we met our target of over 60 per cent compliance with Prevent training in December 2016, with 72% of appropriate staff trained by March 2017. In addition, we have increased the number of WRAP (Workshop to raise awareness of Prevent) facilitators and training sessions which has supported more staff to undertake this training.

Level 3 child safeguarding is delivered as a four hour face-to-face session. To improve compliance, we run three training sessions each month and have introduced bespoke sessions to support areas that can't release staff at the set times.

Further work we are undertaking to improve our safeguarding practices includes:

- Launching a joint adult and child action group in December which will be visiting areas across the trust throughout the coming year. It involves representatives from the adult and child safeguarding team visiting areas to answer questions about a range of safeguarding issues, aiming to be educational and supportive.
- Continuing to develop close links with Standing Together and Red Thread to support victims of domestic violence and gang related violence. Members of these organisations are embedded in the A&E department at St Mary's and in the maternity service.
- Working in partnership with local authority safeguarding forums.
- Working with Central North West London NHS Foundation Trust to support training at ward level in requirements of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

We have not reported any SIs related to safeguarding in 2016/17.

The NHS Outcomes framework indicators 2016/17

The NHS Outcomes Framework 2016/17 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators and our performance is outlined in the table below. Some of this data is repeated because we chose to include these indicators as our quality strategy targets for 2016/17. It is important to note that whilst these indicators must be included in the quality accounts, the most recent national data available for the reporting period is not always data for the most recent financial year. Where this is the case, the time period used is noted underneath. This data is included in line with reporting arrangements issued by NHS England. Further information about what we are doing to improve our performance can be found in the individual target pages.

Indicator	ICHT 2016/17	National Average	Where Applicable – Best performer	Where Applicable – Worst Performer	Trust Statement	2015/16	2014/15	2013/14
SHMI value and banding (Oct 2015 – Sept 2016)	78.05 Band 3 (band 3 = lower than expected) (Oct 2015 – Sept 2016)	100 (Oct 2015 – Sept 2016)	69 (Oct 2015 – Sept 2016)	116 (Oct 2015 – Sept 2016)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data • We were one of only 8 NHS trusts nationally that have consistently recorded a lower than expected SHMI rate for the last two years. • We have reported a lower than expected SHMI rate for the last three years. • ICHT has the fourth lowest SHMI of all acute non-specialist providers in England. We intend to take the following actions to improve this rate, and so the quality of our services, by: • Continuing to work to eliminate avoidable harm and improve outcomes. • Reviewing every death which occurs in our Trust and implementing learning as a result.	73.8 Band 3	73.17 Band 3	Band 3
% of admitted deaths with palliative care coded (Oct 2015 – Sept 2016)	54.9% (Oct 2015 – Sept 2016)	29.7% (Oct 2015 – Sept 2016)	Not applicable	Not applicable	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data. • it shows we have the highest rate of palliative care coding as measured by this indicator of all acute non-specialist providers. • We are confident that we have a robust process in place to ensure that we are coding patients correctly. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Continuing to work to improve the accuracy of our clinical coding.	53.5%	24.6%	32.70%
Patient reported outcome scores (PROMs) for groin hernia surgery (April – September 2016)	* (Low sample size) (April-Sept 2016)	EQ-5D: 0.089 EQ-VAS: -0.1 (April-Sept 2016)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the independently administered NHS Digital PROMS database. • We had no cases assessed for health gain for three of the four PROMs procedures as the data was supressed to protect patient confidentiality. Therefore, ICHT has no reportable PROMs outcome scores for groin hernia for the period April-September 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan and working with our external agency to improve submission rates to allow health gain to be calculated and improvements directed appropriately. See pages 50-51 for further information.	* (low sample size)	* (low sample size)	* (Low sample size)
PROMs for varicose vein surgery (April – September 2016)	EQ-5D: 0.083 EQ-VAS: 0.3 Aberdeen varicose vein score: -0.1 (April-Sept 2016)	EQ-5D: 0.099 EQ-VAS: 1.4 Aberdeen varicose vein score: -8.5 (April-Sept 2016)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the independently administered NHS Digital PROMS database. • It shows that we had below average reported health gain for varicose vein procedures in this time period for two out of the three indexes measured. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See pages 50-51 for information on our improvement plans.	EQ-5D: 0.038 EQ VAS: -2.966 Aberdeen varicose vein score: -2.724	EQ-5D: 0.047 EQ VAS: -1.093 Aberdeen varicose vein score: -2.224	EQ-5D: 0.221 EQ VAS: -1.946 Aberdeen varicose vein score: -3.707
PROMs for hip replace-ment surgery (April – September 2016	* (Low sample size) (April-Sept 2016)	EQ-5D: 0.449 EQ-VAS: 13.7 Oxford: 22 (April-Sept 2016)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the independently administered NHS Digital PROMS database. • We had no cases assessed for health gain for three of the four PROMs procedures as the data was supressed to protect patient confidentiality. Therefore, ICHT has no reportable PROMs outcome scores for hip replacement for the period April-September 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan and working with our external agency to improve submission rates to allow health gain to be calculated and improvements directed appropriately. See pages 50-51 for further information.	EQ-5D: 0.475 EQ VAS: 14.259 Oxford Hip Score: 24.229	EQ-5D: 0.453 EQ VAS: 12.756 Oxford Hip Score: 22.537	EQ-5D: 0.474 EQ VAS: 11.909 Oxford Hip Score: 22.223
PROMs for knee replace-ment surgery (April – September 2016)	* (Low sample size) (April-Sept 2016)	EQ-5D: 0.337 EQ-VAS: 8.1 Oxford: 16.9 (April-Sept 2016)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the independently administered NHS Digital PROMS database. • We had no cases assessed for health gain for three of the four PROMs procedures as the data was supressed to protect patient confidentiality. Therefore, ICHT has no reportable PROMs outcome scores for knee replacement for the period April-September 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan and working with our external agency to improve submission rates to allow health gain to be calculated and improvements directed appropriately. See pages 50-51 for further information.	EQ-5D: 0.292 EQ VAS: * low sample size Oxford Knee Score: 13.420	EQ-5D: 0.326 EQ VAS: 10.411 Oxford Knee Score: 14.940	EQ-5D: 0.324 EQ VAS: 4.117 Oxford Knee Score: 12.849

Indicator	ICHT 2016/17	National Average	Where Applicable – Best performer	Where Applicable – Worst Performer	Trust Statement	2015/16	2014/15	2013/14
28 day readmission rate for patients aged 0-15 (Dr Foster data – Oct 15-Sept 2016)	5.15% (Oct 15 – Sept 16)	8.97% (Oct 15 – Sept 16)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data obtained from Dr Foster • we have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Through our clinical strategy, continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission. • Working to tackle long-standing pressures around demand, capacity and patient flow.	4.81% (Jan-Dec 2015)	6.31%	5.95%
28 day readmission rate for patients aged 16 or over (Dr Foster data – Oct 15-Sept 2016)	6.64% (Oct 15 – Sept 16)	7.98% (Oct 15 – Sept 16)	Not available	Not available	See above.	7.39% (Jan-Dec 2015)	8.84%	7.90%
% of staff who would recommend the provider to friends or family needing care	70% [national staff survey – published March 2017]	70% [national staff survey – published March 2017]	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the National Staff Survey which was published in March 2017. • The results show an improvement in our national staff FFT score compared to last year, which is now average for acute trusts. • Results from our local engagement survey also show an improvement, with 83% of staff recommending the Trust. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See pages 63-64 for information on our improvement plans.	68%	71%	69%
% of admitted patients risk-assessed for VTE	95.33% (2016/17 – full year of data) Q1: 95.36% Q2: 96.01% Q3: 95.30% Q4: 94.61%	95.64% (Q3 16/17)	100% (Q3 16/17)	76.48% (Q3 16/17)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data published quarterly by NHS England. • Last year, an internal audit identified some issues with our data for this indicator which is being rectified as described on page 35. • we have monitored VTE risk assessments on a monthly basis throughout the year. We have been above the target of 95% throughout the year until December 2016 when we fell below 95%. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 46 for information on our improvement plans.	95.87%	96.56%	96%
Rate of C-Diff per 100,000 bed days	18.03 (2016/17 – full year of data) (Total cases: 63)	14.9 (2015/16 data)	0.0 (2015/16 data)	66 (2015/16 data)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data • we monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 46 for information on our improvement plans.	20.9 (73)	22.6 (79)	18.7 (59)

Indicator	ICHT 2016/17	National Average	Where Applicable – Best performer	Where Applicable – Worst Performer	Trust Statement	2015/16	2014/15	2013/14
Responsiveness to inpatients personal needs: National Inpatient survey score	8.2 (national inpatient survey overall score – published May 2017) 6.72 [responsiveness score – published May 2017]	Not available	9.2 [national inpatient survey overall score – published May 2017]	7.4 [national inpatient survey overall score – published May 2017]	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the National Inpatient Survey which was published in July 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See pages 53-54 for information on our improvement plans.	7.9 [national inpatient survey overall score – published May 2016] 6.74 [responsiveness score – published May 2016]	78.5 [overall score] 6.82 [responsiveness score]	74.4 [overall score] 6.78 [responsiveness score]
Rate of reported patient safety incidents per 1,000 bed days (NRLS data Apr 16 – Sept 16)	April – Sept 16: 42.3 (7,532 incidents) Full year internal data: 44.85	April-Sept 16: 40.02	April – Sept 16: 71.81	April – Sept 16: 21.15	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • the NRLS data is nationally reported and verified. • The data shows all incidents reported by ICHT for the period April – Sept 2016: our incident reporting rate for this period was 42.3 against a median peer reporting rate of 40.02. • Our individual incident reporting data is made available by the NRLS on a monthly basis. Our reporting rate for the full financial year is 44.85. There has been an improvement in our performance since September 2016, and except for February 2017, we have been consistently above the top quartile since then. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Improving how we report, manage and learn from incidents as part of our safety culture work. See page 15 for further information.	April – Sept 15: 41.38 Oct 15 – March 16: 43.18 (rate per 1,000 bed days)	April – Sept 14: 42.98 Oct 14 – March 15: 40.69 (rate per 1,000 bed days)	April – Sept 13: 6.86 Oct 13 – March 14: 7.38 (rate per 100 admissions)
% of patient safety incidents reported that resulted in severe/ major harm or extreme harm/death (NRLS data Apr-Sep 16)	April – Sept 16: 0.1% severe/ major harm (7 incidents) 0.0% extreme harm/death (2 incidents) Full year internal data: 28 in total	April-Sept 16: 0.3% (severe harm) 0.1% (extreme harm/ death)	April-Sept 16: 0.0% (severe harm) 0.0% (extreme harm/ death)	April-Sept 16: 1.4% (severe harm) 0.5% (extreme harm/ death)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the NRLS published in March 2017. • We reported 0.1% severe/major harm incidents (7 incidents) compared to a national average of 0.3%, and 0.0% extreme/death incidents (2 incidents) compared to a national average of 0.1%. • We have also achieved a reduction in the number of incidents causing extreme harm/death or severe/ major harm with a total of 28 in 2016/17, compared to 31 reported in 2015/16. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 43 for information on our improvement plans.	April-Sept 15: 0.1% – severe/ major harm (8 incidents) 0.1% – extreme harm/death (5 incidents) Oct 15 – March 16: 0.1% severe/ major harm (10 incidents) 0.1% extreme harm/death (8 incidents)	April-Sept 14: 0.1% severe/ major harm (6 incidents) 0.3% extreme harm/ death (19 incidents) Oct 14 – March 15: 0.1% severe/ major harm (9 incidents) 0.1% extreme harm/ death (8 incidents)	April – Sept 13: 0.2% severe/ major harm (11 incidents) 0.3% extreme harm/ death (20 incidents) Oct 13 – March 14: 0.0% severe/ major harm (3 incidents) 0.1% extreme harm/ death (8 incidents)
Inpatient Friends & Family Test	97% (April 2016 – March 2017)	96% (April 2016 – March 2017)	100% (March 2017)	82% (March 2017)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • we have actively monitored our performance throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See pages 53-54 for information on our improvement plans.	96% (2015/16)	95% (2014/15)	95% (2013/14)
A&E Friends & Family Test	95% (April 2016 – March 2017)	86% (April 2016 – March 2017)	100% (March 2017)	34% (March 2017)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • we have actively monitored our performance throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 54 for information on our improvement plans.	92% (2015/16)	88% (2014/15)	91.9% (2013/14)

Statements from stakeholders

Before the final document is published, our external stakeholders are given the opportunity to review and provide statements on our quality account. We would like to thank our stakeholders for submitting their statements, which provide helpful feedback on how we might improve the quality account next year. We will take them into account in our improvement plans for the coming year and when developing our next quality account. We look forward to continuing to work with our stakeholders throughout the year as we strive to achieve our goals.

HEALTHWATCH CENTRAL WEST LONDON RESPONSE TO IMPERIAL COLLEGE HEALTHCARE NHS TRUST 2016-17 QUALITY ACCOUNT

We welcome the opportunity to comment on Imperial College Healthcare NHS Trust's (the Trust) 2016-17 Quality Accounts (QA), and on the quality of the services delivered locally to meet the health needs of local residents.

In particular, we appreciate our close working relationship through the regular meetings of the Quality Steering Group. Healthwatch Authorised Representatives have also been involved through our Dignity Champion work and annual PLACE assessments and ongoing participation in the PLACE Steering Group. During 2016/17 the Trust adopted at Board level, a patient and public involvement strategy and established a strategic lay forum to ensure that the patient's voice is heard at all levels within the Trust and that patient experience is not only captured but used. Our members, welcome this opportunity to develop PPI initiatives across the Trust. Hitherto PPI has been piecemeal. It is hoped that this initiative will add substantial improvement to the patient experience, which we hope to see reflected in QA 2017-18.

The QA 2016-17 clearly demonstrates that the Trust has a culture of continuous improvements to benefit patients and learning from mistakes and where things have not gone well. For example, the QA reports on a big push to embed the safety culture throughout the Trust. The QA is open, honest and transparent about the Trust's successes and disappointments with specific targets. Where the Trust has not met targets the QA has set out the reasons concisely.

In the financial year 2017/18, we look forward to significant improvements in the meeting the Referral to Treatment (RTT) targets and seeing an improvement in discharge. We acknowledge that the Trust is taking significant steps to improve performance.

Comments on the Quality Accounts (QA)

Patient Satisfaction

Our members congratulate the Trust on exceeding its targets for the percentage of inpatients who would recommend the Trust to friends and family. The Friends and Family Test is an important indicator of patient satisfaction. In particular, our members are pleased that the Trust is providing patient feedback reports to every ward and reviewing this alongside safety data.

However, the Trust relies on traditional NHS methods for capturing patient experience, which do not lend themselves to capturing real time patient experience to drive improvements quickly. This is an area where the Trust has promised progress in this area in previous years; it is not clear how the QA has reported on this systematically. Our members would like to see more innovative methods being utilised and reported on over the next year.

Our members note the drop in percentage of outpatients who would recommend the Trust and that it is below average. Our members would like the outpatient improvement programme to be closely monitored over the next year.

Complaints

Our members welcome the fact that the Trust has met its target to increase responsiveness to complaints and reduce the overall number of complaints. In particular, our members welcome the emphasis on resolving issues rather than solely providing responses.

Quality Improvement Programme

The Trust has a Quality Improvement (QI) programme designed to empower frontline staff and teams in the Trust to make improvements on the way it works and how it provides services to benefit patients. The QA summarises the main QI projects as work in progress for 2017/18 under each domain but does not provide much detail on how the success of these improvement projects will be measured. Our members recommend that the Trust should include in the QA at the very least an indication of how these QI projects will measure outcomes and how these will be monitored over the year.

Wayfinding strategy

Our members are encouraged that the Trust are taking wayfinding very seriously. Wayfaring problems have been highlighted in the findings of every PLACE inspection. Improved signage & directions, IT systems and patient letter communications will be of considerable benefit to patients at a stressful time and should reduce the number of missed appointments caused by patients being in the wrong place.

Never Events and Serious Incidents

Our members are pleased to note that the Trust is taking the incidence of Never events and Sis extremely seriously. Members of the QA Steering Group have been given detailed explanations of the steps taken to ensure that these incidents are not repeated. Our members welcome the introduction of a programme of work with staff to embed an improved culture amongst staff to support open and honest communication that will keep the emphasis on "lessons learnt" to ensure that these avoidable events are not repeated. There has already been an improvement with 6 never events in 15 -16 and 4 in 16 -17.

Patient Reported Outcome Measures

Patient Reported Outcomes Measures (PROMs) are an important tool for the Trust to understand the health gain experienced by patients for the four surgical procedures highlighted in the QA: surgery for groin hernia, varicose veins, hip replacement and knee replacement. Our members are disappointed that this information has not been collected as robustly as possible and expect this to be closely monitored to ensure an improvement.

Appendix A: Drive Diagrams for the 5 QA Domains

This section describes how the Trust plans to improve the way it works during 2017/18. Our members welcomed this as a helpful way of summarising ways of working to drive continuous improvement.

Presentation of the Quality Account

We find the QA is generally well laid out and uses plain English, and we welcome the use of simple explanations of medical terminology. The presentation and layout are a big improvement on the 15-16 QA. It would help to understand more clearly the findings/issues before outlining improvements to be undertaken. Sometimes it is not clear what the improvement is addressing. The Trust in Numbers is a useful addition.

CONCLUSION

Overall our members welcome the Trusts' many initiatives aimed at improving quality. We are optimistic about ongoing and future opportunities for substantial Public and Patient Involvement. We look forward to continuing to work with Imperial College Healthcare NHS Trust in improving the care and support of patients and service users.

Statements from stakeholders

HEALTHWATCH BRENT'S RESPONSE TO IMPERIAL COLLEGE HEALTHCARE NHS TRUST QUALITY ACCOUNT FOR 2016-17

This is the response to Imperial College NHS Trust Quality Account 2016-201 from Healthwatch Brent. We welcome the opportunity to comment on the quality of the services provided by Imperial College Healthcare NHS Trust.

Imperial College Healthcare NHS Trust employs 10,000 people, providing care for around a million people every year, in five hospitals and a growing number of community services in north west London. The comments contained in this paper are the views of Healthwatch Brent and reflect our understanding of the needs and experiences of Brent residents, patients and service users. Its Patient and Public Involvement Strategy is led by the Director of Communications through its lay partner forum.

General comments

We are pleased to read about the work the trust is doing. The report is detailed and comprehensive. An executive summary would have been appreciated which could summarise the key achievements and points of learning over the past 12 months.

On a wider point, given that the trust operates over across so many local areas it would have been helpful if the data had been segmented into localities to better understand how the Trust was performing in its local area.

The aim of the Quality Account is to report on the quality of services provided by the Trust. Quality is measured by looking at patient safety, effectiveness of treatments that patients receive, and patient feedback about the care provided and to report on quality and show improvements in the services it has delivered to local communities and stakeholders. Therefore, we would recommend that in terms of the report structure the first part of the report began with a review of the 2016/17 priorities and the second part focussed on the 2017/18 Quality Improvement Plan.

Quality Improvement Plan – 2017/18 priorities

We welcome the fact that the Quality Improvement Plan underpins the 2015-18 Strategy. The 2017/18 priorities remain the same as the 2016/17 priorities yet are defined as quality goals namely: Safe, Effective, Caring, Responsive and Well led. Yet in Appendix A these goals are described as quality domains which are underpinned by 'driver diagrams'. We would recommend a consistency of terminology to avoid confusion particularly as these local terms have not been included in the glossary at the back.

A review of quality progress for 2016/17

Safe: To eliminate avoidable harm to patients in our care as showing a reduction in the number of incidents causing severe/major harm and extreme harm/death.

9/15 targets were missed. We welcome the Trust's vigilance to report progress in the 2017/18 Quality Accounts but remain concerned about the increase in 'never events'. We note the Trust's improvement programme to ensure better adherence to the WHO 5-step to safe surgery in November and will review progress next year. The improvement in Avoidable Infections is noted. However, it is difficult to understand how the VTE assessment targets are impacted by the introduction of the Cerner discharge process. We recommend that this link is more clearly explained in the report.

Effective: To ensure improvement plans are in place for national clinical audits.

We were surprised to read that the Trust has struggled to meet the clinical audit timelines given its comment that clinical audit is a key improvement tool and that is it one of the UK's six Academic Health Science Centres. We hope the measures being put in place will rectify this situation.

We recommend that the Trust works swiftly with Capita to increase the number of short Patient Reported Outcome Measure Forms returned so that it is better able to: calculate the health gain experienced from specified surgical procedures and to better understand treatment pathways between hospitals.

We will follow the development of the integrated community independence service with interest over the next 12 months and monitor patient discharge from hospital as it forms a key plank of the NWL STP.

We are pleased that the Trust now has an incident reporting system in place for out-of-ICU/ED cardiac arrests for harm.

Caring: To provide our patients with the best possible experience by increasing the % of in- patients and A&E Patients recommending the trust to friends and family… to 94%.

We were pleased to read that the Caring quality domain has performed well. We acknowledge the involvement of Healthwatch in the Patient Transport re-design and hope that transport options will improve for patients which will be reflected in the relevant Friends and Family Test (FTT).

It was heartening to read that 94.2% of A&E patients would recommend the services to family and friends compared to the 87% national target.

We are delighted that the Trust's partnership with Macmillan has improved the cancer patient experience and would like to see this replicated across the NWLSTP footprint.

We recommend the Trust seeks to increase it score of the National Inpatient Survey in relation to responsiveness. Similarly, we would like to better understand why the percentage of outpatients recommending the Trust has dropped.

Responsive: to consistently meet all access standards

This is a difficult set of standards and reflects the national challenges facing the NHS. However, we are concerned that around 4% of patients (316) have waited over 52 weeks for treatment and would like to see these figures improve over the next 12 months.

We would like the Trust to better explain why it has failed to meet all eight cancer standards and would recommend them to have a discussion with Healthwatch Brent about this. Additionally, we are concerned that only 71.77% of patients felt that their privacy had been respected compared to a national target of 87.3%. We would welcome an explanation from the Trust on this.

Well led: to increase percentage of …people who would recommend this Trust… a place to work or treatment…

We have no comments on this quality domain.

Statements from stakeholders

HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE:

Response to Imperial College Healthcare NHS Trust – Quality Account 2017/18

NHS bodies and certain other bodies which provide health services to the NHS are required by legislation to publish Quality Accounts, drafts of which must be submitted to the London Borough of Hammersmith & Fulham's Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (HASCSIPAC) for comment, in accordance with section 9 of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, as amended.

The Council's HASCSIPAC received the following reports from the Trust throughout 2016/17, followed by a brief summary of key points noted during this past year:

i) Clinical Service Improvements – Proposed new Pathways for Acute Medicine and Chest Pain Patients;

ii) Sustainability and Transformation Plan (STP) and Strategic Outline Case Part 1 (SOC1) – general overview, involving all local NHS trusts; and

iii) Accident and Emergency Service Performance November 2016-March 2017.

It was noted that before the introduction of the new pathway, patients would be admitted and wait several days before seeing a specialist doctor. The aim of the new pathway was to ensure that delays, evident in some specialisms such as cardiology, were reduced and that the patient accessed appropriate treatment more efficiently. Removal of an acute medical assessment stage would maintain the same level of intervention but without any delay. The Committee welcomed assurances provided by the Trust that service variations required by the new pathway would not result in a decrease in the number of beds (which would remain static) and the confirmation that there would be no bed closures.

The Committee was informed that staff rotas would become more robust as a result of the changes, as removing any delay to specialist treatment meant greater long term resilience for service delivery and patient care. Given the current uncertainties, the Committee considered that this was positive improvement, safeguarding workforce stability.

In March 2017, the Committee received a detailed presentation on the STP, SOC 1 and an update on the latest situation on plans for the Charing Cross Hospital site. The Committee reiterates its opposition to the proposal for the replacement of the current Charing Cross Hospital with a 'local hospital' on the same site. And so it will be interested in scrutinising the SOC Part 2 proposals, which it understands will relate to the proposed redevelopment of the Charing Cross site, later in 2017.

As part of an annual consideration of the Trust's winter resilience performance, the Committee received A&E service performance figures for November 2016 to March 2017. The Committee noted the operational challenges such as the refurbishment at St Mary's and Charing Cross, as part of on-going improvements to the model of care, together with significant changes to improve urgent care centres. An increase of Type 1 cases at Charing Cross was cause for concern, however, the Committee acknowledged that the level of demand caused significant pressure on the service, with the Trust unable to meet the national standard to see, treat and discharge 95% of patients that present to an urgent or emergency care setting within 4 hours.

Members of the Committee highlighted additional concerns around the length of waiting time, particularly at Western Eye Hospital, where waiting times of up to five hours had been experienced. The Committee would welcome closer analysis of public health education provision, which might potentially address this, together with a better understanding of how to achieve greater efficiencies around triage and initial assessments.

The Committee was disappointed that the waiting time targets had not been met. However, it welcomed the fact that the Trust had plans in place to improve its performance, particularly at the Charing Cross A&E. And members of the Committee commended the work of staff working in emergency care settings, understanding that the service had faced high levels of demand during this period. The Committee will be interested in receiving a further report on A&E waiting times later in 2017 to see what impact these changes have made.

The Committee welcomes the opportunity to comment on the Draft Quality Account for 2016/17 and understands that the Trust faces further challenges in the coming year. The Committee welcomes the high level of commitment demonstrated by NHS health colleagues, both administrators and clinicians, in the Trust, to provide the best care possible to the residents of Hammersmith and Fulham and looks forward to further engagement and co-operation with the Trust in order to achieve this.

Councillor Rory Vaughan
Chair, Health, Adult Social Care and
Social Inclusion, Policy and Accountability Committee
22nd May 2017

As Chair of the Community and Wellbeing Scrutiny Committee I would like to respond formally to the Quality Accounts 2016/17 for Imperial College Healthcare NHS Trust.

Firstly, I welcome the commitment to improving PLACE (Patient-Led Assessment of the Care Environment) scores year-on-year. However, it's disappointing that in 2016/17 the Trust did not improve its PLACE scores in three categories: Privacy, Dignity and Wellbeing; Dementia; and Disability. Furthermore, it's disappointing that results in those categories actually got worse. It's right that a detailed action plan to address this deterioration has been put in place and I hope that, working with patient representatives, this will be addressed over the coming year.

Brent residents who live in the south of the borough will be using your A&E services so I am concerned that there has been a failure to meet targets for A&E in terms of the four-hour waiting target. While I understand that A&E has experienced an increase in attendances and emergency admissions, this is clearly something which requires more attention. I noted that the Trust has not met its targets around early hospital discharges and that this may be a factor in pressure on A&E, and you are working with adult social care in Brent and other boroughs to deliver better integrated social care which should help to improve discharge from hospitals. However, I think it should be spelt out in detail how this will improve the situation.

Finally, the Trust is clearly committed to ensuring that its staff are trained so that they can fulfil their safeguarding responsibilities although you have not been able to meet your 90 per cent target for staff training. While I welcome the commitment to work in partnership with local authority safeguarding forums, I would say this needs to be set out more specifically and in terms of which adult or children's safeguarding boards you will be involved with and in which boroughs.

Please note that our letter and your response may be published with the papers at a future meeting of the Community and Wellbeing Scrutiny Committee.

Please could you send your final version of the Quality Accounts 2016/17 to James Diamond, who is the Scrutiny Officer for Brent Council who supports my committee.

Yours sincerely,
Councillor Ketan Sheth
Chair, Community and Wellbeing Scrutiny Committee
Brent Council

Statements from stakeholders

COUNCILLOR JONATHAN GLANZ CHAIRMAN, ADULTS, HEALTH AND PUBLIC PROTECTION POLICY AND SCRUTINY COMMITTEE:

Response from Westminster Adults, Health and Public Protection Policy and Scrutiny Committee

Introduction

We welcome the opportunity to comment on the Trust's Quality Account 2016/17.

Care Quality Commission (CQC) Inspection

We are aware that the latest published inspection of September 2014 saw the trust receive an overall rating of requires improvement. We are also aware of the significant programme of work carried out to deliver the CQC Action Plan.

More recently we are aware of a CQC review of Outpatients and Diagnostic Imaging which was rated as inadequate in September 2014. As there is no published report on this inspection, we await with interest this report.

Similarly we note the unannounced inspection by the CQC of Maternity services at St Mary's and of Medical Care at St Mary's, Charing Cross and Hammersmith Hospitals.

With all of these the Scrutiny Committee will be willing to play a play its role in assisting with the improvement of services if required.

Comments are set out in the five domains of quality.

We note the aim of the Quality Strategy of the Trust is to support the delivery of the STP and that the Trust introduced a new Quality Improvement Programme in autumn 2015.

Patient Feedback

Last year you acknowledged the need to roll out a wider patient involvement programme which you report has taken place this year. We welcome this and would welcome more details on who is involved and how the people can engage.

We welcome the fact that you have tried to incorporate a comment from last year about incorporating site based data rather than Trust wide data. However, this seems to be available in very few instances. We are unclear why this should be the case as trust wide data; we assume is compiled using data from each site?

Quality Progress 2016/17

1. Safe

- It is disappointing that the Trust has not achieved a number of important targets such as:
- 4 never events (better than last year but failed to meet the target)
- Not assessing for/preventing blood clots

We are pleased that:

- overall the Trust remains below average for causing severe or extreme harm to patients
- the programme of work to develop, create and embed a safety culture so that all staff feel able to report safety concerns is in place.

2. Effective

It is disappointing that key targets have been missed such as

- Ensuring that mortality reviews are carried out in all cases and
- discharging at least 35% of our patients on relevant pathways before noon where only 19% was achieved

These have the potential to damage public confidence in your services. We note that of the 1,987 deaths, only five of the deaths across the Trust have been confirmed as avoidable deaths.

We are also very aware of the case of a baby death as reported in the press and look forward to being able to share the lessons of how the Trust dealt with that case. On a positive note we are pleased that your mortality rates remain consistently low and that you have a system in place to review all deaths and that you are working with us and other partners to improve on the discharging of patients.

3. Caring

It is disappointing that

- the percentage of outpatients who would recommend the Trust is below average and has dropped since last year. We note however that this drop coincided with the introduction of online completion of the survey.

We are pleased to note that:

- The percentage of A&E patients who would recommend the trust is over the target and significantly above national average
- Your results in the national cancer patient experience survey (NPES) show significant improvement

4. Responsive

We are disappointed to read that a number of significant targets have been missed, including access to first appointments after referrals and cancer treatment. This is of concern to the Committee, although we do acknowledge that you have a significant improvement programme in place to deal with this.

The Committee is also aware that St Mary's is not meeting the national 4 hour A & E standard as they have recently reported on this. We are therefore aware of your plans to tackle this but note the increase in volume of patients.

It would be useful to know when you think these measures will bring you within the national target for A & E.

We are pleased to note that for cancer referrals you are seeing an improvement and meeting the performance trajectory agreed with the commissioners.

5. Well – led

We are concerned to learn that the target for 90% of staff to receive core skills training has not been met and has fallen from the previous year. This is a safety issue which we hope you can rectify urgently.

We are however pleased to note the increase in the percentage of staff who would recommend the Trust to others as a place to work and for treatment.

In conclusion, we have a number of concerns about some fundamental services where are not meeting targets but we can see that these are being managed, and within the constraints of the wider health and social care system, you are taking action to bring performance up to standard where required. If there is any role that scrutiny could perform to support the Trust in the improvement programmes you are currently working through, we would be very happy to collaborate in appropriate ways. We will also continue to monitor your progress and provide relevant scrutiny and transparency where we feel that will benefit our residents.

Councillor Jonathan Glanz
Chairman of the Adults, Health and Public Protection Policy and Scrutiny Committee

Statements from stakeholders

HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP RESPONSE TO THE IMPERIAL COLLEGE HEALTHCARE NHS TRUST QUALITY ACCOUNT 2016-2017

Hammersmith and Fulham Clinical Commissioning Group, in its role as Co-ordinating Commissioner welcomes the opportunity to provide this CCG commissioners' statement on the new format Imperial College Healthcare NHS Trust's Quality Account. The CCGs can confirm that the information contained within the Quality Account reflects the data, discussions, and contract performance issues. The trust has also included an overview of the work that has implemented in response to the initial findings the Care Quality Commissioner (CQC) hospital inspection that took place in November 2016 into Outpatients and Diagnostics and Hammersmith and Fulham CCG has worked collaboratively with the Trust and other stakeholders in monitoring progress throughout the year.

Hammersmith and Fulham CCG appreciate the collaborative approach with Imperial College Healthcare Trust over the year and has been able to contribute CCG commissioning views on content in relation to the production of the Quality Account. The Quality Account has been reviewed by Hammersmith and Fulham Clinical Commissioning Group and Associate Commissioners, who confirm that the contents comply with the Department of Health prescribed form and content. The Quality Account presents a summary and balanced overview of the quality of care at the Trust.

The 2016/17 Quality Account has the Trust Quality Strategy woven throughout supporting the focus on quality and safety for the organisation using the key priorities identified. Hammersmith and Fulham CCG were pleased to see that quality improvement is a key feature for the Trust and look forward to the outcomes for patients and staff.

The Trust acknowledges some of the areas of concern to commissioners such as RTT wait times, Accident and Emergency impacting upon on the day cancellations of surgery and safeguarding training and will continue to work with the Trust to address these. It is disappointing that the cancellation of operations rebooking target has not been met despite the reopening of additional theatres but the CCG looks forward to the report now scheduled for June 2017. It is heartening to see the renewed focus upon patient experience in relation to cancer and we look forward to improved consultation with our local population. In light of the Serious Incidents that have occurred within the Trust as clinical commissioners we acknowledge the work related to safer surgical checklists and look forward to improved patient safety outcomes for patients.

Hammersmith and Fulham CCG recognises the Trust on the improvement in outpatients and the recent CQC reports together with the divisional restructuring to assist in working with ward based staff, the achievement of five of the six cancer metrics and one of the lowest HSMR mortality risk scores in England. We were disappointed that the work that Imperial College Healthcare Trust completed in 2015/16 in relation to the 62 day wait for non-cancer diagnosis did not provide achievement of the standard but will continue to monitor this through the monthly Clinical Quality Group meetings.

Throughout 2016 / 2017 we recognise and have welcomed the opportunity to work more collaboratively with the Trust. As we enter the next year we wish to maintain and embed this joint collaborative approach to quality improvement and clinical assurance.

Yours sincerely

Janet Cree
Managing Director

James Cavanagh
(Joint) Vice Chair

Independent Auditor's Assurance Report

INDEPENDENT CHARTERED ACCOUNTANT'S LIMITED ASSURANCE REPORT TO THE DIRECTORS OF IMPERIAL COLLEGE HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We have been engaged by Imperial College Healthcare NHS Trust to perform an independent assurance engagement in respect of Imperial College Healthcare NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Accounts) Regulations 2010, the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (Quality Accounts) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections; and
- Percentage of reported patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Directors' responsibilities

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibilities

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance") as supplemented by the Quality Accounts: Reporting Arrangements 2016/17 letter dated 6 January 2017; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2016 to 24 May 2017;
- papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017;
- feedback from the Commissioners dated 2 June 2017;
- feedback from Local Healthwatch organisations dated 18 May 2017 and 22 May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 20 June 2017;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national inpatient survey 2016;
- the latest national staff survey 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated
- May 2017; and
- the annual governance statement dated 1 June 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Imperial College Healthcare NHS Trust as a body in accordance with the terms of our engagement letter dated 3 May 2016. Our work has been undertaken so that we might state to the Directors those matters we have agreed with them in our engagement letter and for no other purpose.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Imperial College Healthcare NHS Trust for our work or this report or for the conclusions we have formed save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

The indicators tested represent "point-in-time" measurements, and therefore may be subject to validation changes following completion of our limited assurance procedures.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Imperial College Healthcare NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

BDO LLP
Chartered Accountants
London, UK
29 June 2017

Appendix A: National Clinical Audit

National Audits reported 2016/17	Outcomes	Improvements made, or to be made as a result
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	For cases coming direct from the community our performance was better than the average reported in the national report, performance was worse for patients transferring from another hospital, however this is outside of our control	There are no specific actions
End of Life Care Audit: Dying in Hospital	We achieved above average for all End of Life quality indicators, however were below average for the organisational indicators.	• Deliver improved training for staff, including around advanced care planning, communication and DNACPR decision making • Improve documentation of assessment and support around artificial hydration/nutrition • Review care of the dying patient policy/ guidelines.
National Diabetes Audit – Adults Foot care 2014-2016	The Trust reported fewer deaths than average with healing rates in keeping with national average	• Review systems to ensure that on discharge, patients can still have access to service as “new” without referral • Review of non-medic supported Foot Clinic sessions.
Renal Replacement Therapy (Renal Registry)	The Trust performs well against the audit criteria	There are no specific actions
MBRRACE – UK Perinatal Mortality Surveillance Report	We had a neonatal mortality rate and stillbirth rate which is up to 10% higher than average (data is for 2014).	• Introduction of weekly neonatal grand rounds with increased and regular input from Microbiology and the Infectious Disease team; • Introduction of monthly neonatal M&M meeting where all neonatal deaths are discussed with learning points disseminated to all neonatal staff; • Validation of all neonatal mortality and stillbirths on monthly basis through named neonatal and maternity consultants; • Strengthening the neonatal nursing leadership; • Implementation of 24/7 Consultant Delivered Care model on level 3 NICU.
Diabetes (Paediatric) (NPDA)	We are in the top 3% for completion of care and the top 10% for outcomes of care.	There are no specific actions
National Diabetes Audit – Adults In-patient	The specialist nature of the trust means we are an outlier for end stage renal failure prevalence at HH and active foot disease prevalence at SMH	• Fully implement education strategy including an in-house inpatient diabetes course; • Incorporate insulin safety into junior doctors’ induction.
National Emergency Laparotomy Audit (NELA)	Our results have improved since the last report	• Improve consultant review before surgery and of CT scans
National Heart Failure	Our performance meets NICE guidelines	• Appointed heart failure consultant and additional heart failure nurses.
Rheumatoid and Early Inflammatory Arthritis	We do not currently meet all the audit standards	• Establish a named Arthritis Pathway Coordinator to align appointments and investigations • Establish dedicated, weekly, one-stop EIA clinic including ultrasound assessment and specialist nursing
National Oesophago-gastric cancer	The Trust performs well against the audit criteria	All recommendations and actions have been implemented by the service
National Hip Fracture Database	The audit identified issues with delay in time to an orthopaedic ward, patients in receipt of pre-op AMTS and a higher than average mortality rate.	• The ANPs will as part of clerking include a mental assessment, with the orthopaedic SHO doing this out of hours. • Mortality rates to be monitored via Trust process and HDU provision considered as part of the critical care re-organisation.
Inflammatory Bowel Disease Programme (IBD)	Our results improved for one of the audit criteria and remained the same for two.	• Weekly Virtual Biological MDT established to discuss and review treatment for all patients on biological therapy. • Weekly IBD MDT established to discuss cases of complex IBD in a multidisciplinary setting.
National Intensive and Special Care (NNAP)	We have improved for 3/7 of the audit criteria and remained the same for the other 4.	• Ensure temperatures meet required standards • Ensure ROP screening results are entered into the electronic records • Implement QI project to improve consultation with parents.
National Joint Registry	No concerns identified by the report	There are no specific actions
Specialist Rehabilitation following major Injury	We meet all the audit criteria.	• Work with commissioners and Major Trauma Network to improve service provision
Sentinel Stroke National Audit Programme (SSNAP)	Our performance has been rated ‘good’ in the SSNAP since April 2014.	• Work with North West London Stroke Steering Group tom improve bed availability • Recruit speech and language therapist
National Vascular Registry	All surgeons are in range for infrarenal aneurysm with a rate of 0.7%. Carotid stroke rate is 3.5% with all surgeons in expected range	• Focus on reducing length of stay and wait times for CEA after symptoms.
Paediatric Intensive Care (PICANet)	The audit shows good performance in terms of mortality rates and emergency readmissions, however nursing establishment is lower than the recommendations	• Review nursing establishment
National Lung Cancer Audit – Consultant Outcomes	Our mortality rates are good when compared nationally	• Recruit additional thoracic surgeon • Agree funding for additional Macmillan Nurse
MBRRACE – UK Maternal Mortality Surveillance Report	Audit identifies variable practice	• Establish an accepted method of cardiac assessment and liaise with reproductive medicine. • Initiate referrals from cardiology and establish referral pathway • Enquire at maternity booking re family history of sudden death
National Prostate Cancer Audit	Trust outcomes are broadly in line with national average	All recommendations and actions have been implemented by the service
National Bowel Cancer Audit	To be confirmed	All recommendations and actions have been implemented by the service

National Audits reported 2016/17	Outcomes	Improvements made, or to be made as a result
NCEPOD Physical and mental health care of mental health patients in acute hospitals	Trust level outcomes not included	There are no specific recommendations
National Lung Cancer	The Trust performs well against the audit criteria	There are no specific actions
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	The Trust performs well against the audit criteria	The majority of the report's recommendations are already in place.
Myocardial Ischaemia National Audit Project (MINAP)	Trust level outcomes not included	All recommendations and actions have been implemented by the service
Cardiac Rhythm Management Devices	Trust level outcomes not included	There are no specific recommendations
National Audit of Pulmonary Hypertension	Time from diagnosis of chronic thromboembolic pulmonary hypertension at PH centres to pulmonary endarterectomy surgery at Papworth Hospital is too long – this affects all PH centres	All actions are implemented with work continuing to refer appropriate patients to Papworth Hospital within 5 days.
Procedural Sedation in Adults (care in emergency departments) – CXH & SMH	We performed above average for a number of outcomes	Actions are under review by the service
Vital Signs in Children	We performed above average for 4/5 standards	Actions are under review by the service
VTE risk in lower limb immobilisation (care in emergency departments)	Our performance is below average	Implement assessment on the electronic record on admission to ensure that adequate assessment is taking place

Appendix B: Local Clinical Audit

Local Audits reported 2016/17	Improvements made, or to be made, as a result
CCG Discharge Letter Audit	• Escalation process for concerns established with CCG
A&E Safety Audit	• Development of further tools to validate patient data. • Staff to update patients movement in real time • Develop options on Cerner for reasons for non-documentation of patient's information to capture data
Duty of Candour – Annual Review	• Full action plan implemented (for further details see page 35)
Elective Weekend Mortality	• Include review of admission route and type to the clinical coding validation process that already exists for mortality cases • Ensure booking processes clearly embed the need for pre-assessment
Safer invasive procedures audit	• Full action plan implemented (for further details see page 34-35)
Haematological Cancers: improving outcomes – NG47	• Re-examine workload and staffing levels
Jaundice in Newborn Babies under 28 days – CG098	• Review current practice and develop a tool that identifies babies at risk of developing jaundice.
Routine Preoperative Tests for Elective Surgery – NG045	• Preoperative assessment clinics should examine whether a Full Blood Count test is required by taking into account the patient's ASA score and the severity of the surgery.
VTE Compliance Audit	• Full action plan implemented (for further details see page 36)
A study into patient satisfaction on neurosurgical ward round and whether a divided cranial/spinal ward round improves this	• Implement split cranial/spinal ward round where possible
Declined donor offers from the West London Renal Transplant Centre	• Ensure surgeons are fully aware of responsibilities
Documentation and consent audits – PUVA therapy	• Implement new consent form in keeping with guidelines • Ensure correct training for locum staff
Radiotherapy Patient Pathway – Breast	• Review documentation system • Promote risk management locally • Review and update training and competency management
Red Blood Cell Transfusion in Critical Care	• Develop further staff training
Documenting Consent for Anaesthesia	• All anaesthetic pre-op assessment charts should include a note relating to discussion of consent • Nurses in PAAC should document when anaesthetic information leaflets given to patients
An audit of the referral letters sent to the clinical genetics team	• Template to be produced to prompt referral letters to include all relevant details
IVF Cycle cancellations due to risk of OHSS	• Ensure AFC is assessed for all patients prior to ovarian stimulation
Management of acute pain in paediatric patients	• Focus on improving the time analgesia is given in response to severity of pain
Neonatal transfusion: assessment of QCCH neonatal unit compliance with local, JPAC and BCSH guidelines	• Improve documentation around transfusion and transfusing older babies
Use of Inotropes on ITU Audit	•Improve education and training for junior doctors and nursing staff •Develop new prescribing tool

Glossary

Academic Health Science Centre (AHSC) – a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

Accessible Information Standard (AIS) – launched in August 2016, The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.

Ambulatory Emergency Care (AEC) – a service where some conditions may be treated without the need for an overnight stay in hospital. It is a streamlined way of managing patients presenting to hospital who would traditionally be admitted. Instead, they can be treated in an ambulatory care setting and discharged the same day – offering benefits to patients, carers, and NHS trusts.

Anti-infectives – drugs that are capable of acting against infection. They include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics.

Avoidable infections – within the Trust we define the following as 'avoidable infections': a case of MRSA BSI occurring 48 hours after admission to hospital; and a case of Clostridium difficile that is both PCR and toxin (EIA) positive occurring 72 hours after hospital admission when there is non-compliance with the antibiotic policy or the patient crossed pathways with a known case of the same ribotype (a method used to compare the genetic relatedness of different C. difficile strains).

Cardiac Arrest – also known as cardiopulmonary arrest or circulatory arrest, a cardiac arrest is a sudden stop in blood circulation due to the failure of the heart to contract effectively or at all.

Care Pathway – an outline of anticipated care in an appropriate timeframe to treat a patient's condition or symptoms.

Care Quality Commission (CQC) – the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care, and encourages care services to improve.

Clinical Coding – the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

Clinical Guidelines – these are recommendations of how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. They aim to help health professionals and patients make the best decisions about treatment or care for a particular condition or situation. They include national guidelines, published by organisations such as NICE (National Institute for Health and Care Excellence), as well as locally developed guidelines.

Clinical Nurse Specialist (CNS) – provide expert advice related to specific conditions or treatment pathways. They focus on improving patient care and developing services.

Clostridium difficile – an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow *C. difficile* to multiply and produce toxins that damage the gut. Symptoms of *C. difficile* infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel.

Core Skills Training – nationally defined and mandated training programmes which all Trust staff must complete in accordance with the requirements of their roles.

CQUIN – Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments based on agreed quality improvement and innovation work.

Datix – patient safety and risk management software for healthcare incident reporting and adverse events. This is the system the Trust uses to report incidents, manage risk registers and as of 1st April 2016, to record mortality reviews.

Departmental Safety Coordinator (DSC) – appointed by departmental managers to assist them in meeting their health, safety and wellbeing responsibilities.

DNA ('did not attend') – when a patient misses a hospital appointment.

Dr Foster Global Comparators – an international hospital network, created by Dr Foster in 2011 as a global hospital benchmarking collaborative. It brings together data from hospitals in different countries, enabling comparison of the results within the network.

Duty of Candour – Secondary care providers registered with CQC in England are subject to a statutory duty of candour, introduced in November 2014. It is a statutory requirement to ensure that patients and their families are told about patient safety incidents that affect them, that they receive appropriate apologies, that they are kept informed of investigations that are being undertaken and are supported to deal with the consequences.

Emergency readmissions – unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

Flow – the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term generally denotes the flow of patients between staff, departments and organisations along a pathway of care.

Friends and Family Test (FFT) – The NHS FFT was launched in 2013 to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS.

Hospital Episode Statistics (HES) – HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver. HES data is designed to enable secondary use, that is use for non-clinical purposes, of this administrative data.

Hospital Standardised Mortality Ratio (HSMR) – an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for.

Information Governance – ensures necessary safeguards for, and appropriate use of, patient and personal information.

Integrated Care – person-centred and co-ordinated care within healthcare settings, across mental and physical health and across health and social care. For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.

Local Faculty Group – a group in each department which meets regularly to take responsibility for the learning environment, and undergraduate and postgraduate training in that service.

Macmillan Navigator – a single point of contact via telephone for cancer patients, from the point of diagnosis to the end of treatment, aiming to create a more streamlined service and positive experience for the patient.

Medical Appraisal – annual medical appraisal is the cornerstone of the General Medical Council (GMC) revalidation process. All doctors must undertake and record an annual medical appraisal in order to demonstrate that they comply with Good Medical Practice as required by the GMC.

Methicillin-resistant Staphylococcus aureus (MRSA) – a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections. Staphylococcus aureu is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and impetigo. If the bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or endocarditis.

National Reporting and Learning System (NRLS) – the NRLS enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. Participation enables us to compare our incident reporting rates with our peers.

Never events – serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Palliative Care – a multidisciplinary approach to specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness, whatever the diagnosis. Palliative care is normally offered to terminally ill patients, regardless of their overall disease management style, if it seems likely to help manage symptoms such as pain and improve quality of life.

Patient led assessments of the care environment (PLACE) – introduced in April 2013 this is a national system for assessing the quality of the patient environment. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. The assessments will see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The assessments take place every year, and results are reported publicly to help drive improvements in the care environment.

Patient reported outcome measures (PROMs) – tools we use to measure the quality of the service we provide for specific surgical procedures. They involve patients completing two questionnaires at two different time points, to see if the procedure has made a difference to their health.

Patient safety incident – any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Patient safety incidents

are categorised by harm level, defined as follows by the NRLS:

- Near miss – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm.
- No harm – any patient safety incident that ran to completion but no harm occurred.
- Low harm: Any patient safety incident that required extra observation or minor treatment and caused minimal harm.
- Moderate harm: Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
- Severe harm: Any patient safety incident that appears to have resulted in permanent harm.
- Extreme harm/death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Performance Development Review (PDR) – our annual performance review process which was introduced in 2014-5 for all staff, excluding doctors, which is aimed at driving a new performance culture across the Trust.

Pressure ulcer – a type of injury that affect areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

Quality Improvement (QI) – is a formal approach to the analysis of performance and systematic efforts to improve it. It is a method for developing, testing and implementing changes so that improvements can be made quickly. Our QI programme takes the form of training in QI methodology and a QI hub team who support teams undertaking QI projects.

Referral to Treatment (RTT) – consultant-led Referral To Treatment (RTT) waiting times, which monitor the length of time from referral through to elective treatment.

Revalidation – the process by which all licensed doctors and nurses are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field.

Root Cause Analysis (RCA) – a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened. Serious incidents and never events undergo RCA as part of the investigation.

Safeguarding – protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.

Schwartz Rounds – meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture.

Secondary Users Service (SUS) – the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Serious Incident (SI) – events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

Sign Up To Safety – a national campaign launched in 2014 by the Secretary of State for Health which aims to save 6,000 lives and halve avoidable harm, to deliver harm free care for patients.

Standardised hospital mortality indicator (SHMI) – a national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge.

Stakeholder – a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

Student Online Evaluation (SOLE) – online module evaluation which gives medical students the opportunity to feedback on their experience in a simple, secure and confidential way.

Venous thromboembolism (VTE) – a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood. There are two main types; venous thromboembolism (VTE) which is a blood clot that develops in a vein; and arterial thrombosis which is a blood clot that develops in an artery.

Ward accreditation programme (WAP) – Reviews of patient areas during which patient care is observed, documentation reviewed, the environment is assessed and discussion with patients, carers and staff members takes place.

WHO checklist – The World Health Organization Surgical Safety Checklist was introduced in 2008 to increase the safety of patients undergoing surgery. The checklist ensures that surgical teams have completed the necessary listed tasks to ensure patient safety before, during and after surgery.

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Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

STP Joint health and care transformation group - Meeting Summary

Executive summary:

22 June 2017

Cllr Sachin Shah (Leader Harrow council) chaired the meeting and began with the regular open forum. The Board discussed the response to the Grenfell tower block fire and acknowledged the collective response effort. Clare Parker (Chief Officer Central London, West London, Ealing, Hammersmith & Fulham and Hounslow CCGs) noted that there would be a significant amount of learning arising from this event in the local community and everyone agreed it was critical to continue working together. The Board also discussed the current financial position within North West London.

Cllr Shah then invited Rob Larkman (Chief Officer Brent, Harrow & Hillingdon CCGs) to introduce a paper which describes efforts underway within London and nationally to adopt a more 'systems-based' approach and looks at how local areas can be supported to achieve the goal of better integrated care for their populations. The board then discussed the paper. Richard Sumray (Chair The Hillingdon Hospitals) suggested that we need to do more to make the case for London's particular requirements (housing, resources, and workforce) and greater visibility of the role of Public Health. Clare Parker noted that a 'toolkit' has already been developed in NW London and this work should be built on. She also clarified that there would be no impact to the role of Health and Wellbeing Boards. The Board requested further clarification on whether the work would be funded within the current envelope of funding for the Healthy London Partnership (HLP) or whether further funding would be sought.

Stephen Webb (STP Communications project lead) then introduced the draft guide to the NW London Health and Care Partnership. The guide details the five areas of focus to making the biggest and quickest positive impact on resident's health, and the challenges facing our health and social care system. The guide was tested with patient representatives. It will inform web content, factsheets, briefings and presentations for both existing and new stakeholders. There is further scope for graphics, links, and data visualisation. The board commended the work and made suggestions for final sign off.

Cllr Shah then asked for the regular delivery area updates. Bill Sturman (Director of Informatics, NW London Collaboration of CCGs) provided an update on digital activity across NW London. Two Global Digital Exemplars projects had been awarded funding – Imperial College Healthcare NHS Trust (£10m) and Chelsea and Westminster Hospital NHS Foundation Trust (£5m). £7.7m of Estates and Technology Transformation Fund (ETTF) funding had been awarded for Primary Care (training, standardising templates, care plans, EMIS). The Harrow app (Digitally Enabled Patients bid) has received 25,000 downloads and the plan is to roll it out next to Brent and Ealing followed by all CCGs by the end of December 2017. This is not purely a health focused app but also signposts users to local authority services. The Board discussed the NHS 111 trial with Babylon and noted evaluation was crucial to determining what works and the effects on GP and A&E attendance.

Juliet Brown (Programme Director Local Services, NW London Collaboration of CCGs) introduced the update on enhanced care in care homes, which covered an introduction to the NHSE Enhanced Care in Care Homes Framework; NW London care home market analysis progress to date; benchmarking tool; market engagement; emerging elements of the model of care; next steps and critical path.

Finally Alasdair Ramage (Director of System Wide Transformation, NW London Collaboration of CCGs) introduced a proposal for future STP reporting structure which may include reports which Janice James (Deputy Director System Wide Transformation) walked the Board through – explaining what each could be used for and how it would help keep the STP on track for successful delivery.

Next meeting will be on 27 Thursday July 2017, 13.00-15.00

Quality impact:

The STP is focused on improving the integration and delivery of health and care services across NW London.

Financial impact:

No direct financial impact.

Risk impact:

Ensuring effective meeting structures and programme oversight will reduce the risk of poor integration of service developments.

Recommendation to the Trust board:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with care compassion.
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
STP team	Dr Tracey Batten, Chief executive	20 July 2017

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	26 July 2017

Key legislation for board members

Executive summary:

The attached document provides an outline of the key legislation affecting NHS Trusts; it highlighted aspects which may be of particular relevance to Trust board members. This replaces the document provided to board members in 2016; new or previously overlooked items are in blue ink:

- General Data Protection Regulation
- Ionising Radiation Regulations 1999 – implementation of European Directive 2013/59/EURATOM
- The Medical Profession (Responsible Officer) Regulations 2010
- Bribery Act 2010
- Criminal Finances Act 2017 (due to come into force during 2018)
- Health Service Medical Supplies (Costs) Act 2017

Quality impact:

An outline knowledge of key legislation will support informed board decisions.

Financial impact:

No direct impact

Risk impact:

Should help reduce likelihood of actions which risk non-compliance with legislative requirements

Recommendation to the Trust board:

The Trust board is asked to note the paper.

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	Dr Tracey Batten Chief Executive	20 July 2017

Duties, responsibilities & liabilities for NHS Trust boards

The Trust board, and directors therein, must be cognisant of:

- Common law (also known as case law);
- Statute (specific Acts of Parliament or Regulations);
- Trust standing orders;
- UK Code of governance (and FT Code);
- Letters of appointment & contracts entered between the director and the Trust;
- Codes of conduct and professional codes;
- The rules of relevant regulatory bodies (CQC and NHS Improvement (TDA/Monitor).

The main pieces of legislation for NHS Trust boards are as follows:

National Health Services Act 2006 – schedule 4 (detail attached as App 1)

Key points:

- Must have a unitary board: composition in accordance with regulation (for Imperial this is our Establishment order 2007, amended 2012);
- May do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions;
- Broad powers for the Secretary of State to make regulations and to confer powers by order.

Health and Social Care Act 2012 - sections 151 & 152 (detail attached as App 2)

Although this is predominantly about foundation trusts, it is becoming accepted that this would apply equally (where possible) to NHS trust directors as well.

Key points:

- The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public;
- A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the corporation;
- A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

A number of fact sheets covering the whole of the H&SCA are available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://healthandcare.dh.gov.uk/factsheets/

Companies Act 2006 - Part 10A, Chapter 2 (detail attached as App 3)

Key points:

- To act within powers;
- Promote the success of the company for its members;[*plus six sub provisions*]
- Exercise independent judgment;
- Exercise reasonable care, skill and diligence;
- Avoid conflicts of interest;
- Not to accept benefits from third parties; and
- Declare the nature and extent of any interest in proposed and existing transactions or arrangements with the organisation.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (detail attached as App4)

Key points:

- Fundamental standards: replace the 2010 Regulations and are a response to the second Francis Report into events at Mid Staffordshire. Covering similar subject matter as those dealt with under the 2010 Regulations, the Standards are now much more focused, the language is more direct and they set out clearly the standards to which all Health & Social Care providers must adhere in providing services;
- Duty of Candour: provides that where a notifiable safety incident occurs within a service, there are certain notification requirements which must be followed. The Regulations prescribe the definition of a notifiable safety incident and steps which must be taken;
- Potential criminal prosecution: Criminal prosecution for breaches of the Standards will now be more straightforward for the Regulator, as some of the Fundamental Standards are directly prosecutable criminal offences if breached, and can be prosecuted without the need for a Warning Notice from CQC.

The (reasonably) full list of legislation relating to NHS Trusts:

Legislation	What does a NED need to know?
NHS Act 2006 Health and Social Care Act 2012 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Companies Act 2006	These legislative instruments are described in the main body of the briefing
Freedom of Information Act 2000	The Act provides public access to any recorded information (printed documents, computer files, letters, emails, photographs, and sound or video recordings) held by public authorities. The Act does not give people access to their own personal data (See below). If a member of the public wants to see information that a public authority holds about them, they should make a subject access request under the Data Protection Act 1998.
Environmental Information Regulations 2004	The Regulations provide public access to environmental information held by public authorities in two ways: - public authorities must make environmental information available proactively; - members of the public are entitled to request environmental information from public authorities.
Data Protection Act 1998 (DPA)	Beyond detailing the requirements for holding and processing personal information, a key part of the DPA relates to 'subject access'. This is most often, I relation to the Trust, by patients who want to see a copy of their records; an individual who makes a written request and pays a fee is entitled to be: told whether any personal data is being processed; given a description of the personal data, the reasons it is being processed, and whether it will be given to any other organisations or people; given a copy of the information comprising the data; and given details of the source of the data.
Access to Health Records Act 1990 (AHRA)	AHRA provides a small cohort of people with a statutory right of to apply for access to information contained within a deceased person's health record.
Access to Medical Reports 1998 (AMR)	The AMR governs access to medical reports made by a medical practitioner who is, or has been responsible for the clinical care of the patient, for insurance or employment purposes. Reports prepared by other medical practitioners, such as those contracted by the employer or insurance company, are not covered by the Act.
Data Protection (Processing of Sensitive Personal Data) Order 2000 (DPO)	The DPO may be lawfully processed without explicit consent where there is a substantial public interest in disclosing the data for any of the following purposes: for the detection and prevention of crime; for the protection of members of the public from or publicise the fact of malpractice, incompetence, mismanagement etc.
Privacy and Electronic Communications (EC Directive) Regulations 2003	The Regulations (PECR) sit alongside the DPA and give people specific privacy rights in relation to electronic communications, such as: marketing calls, emails, texts and faxes; cookies (and similar technologies); keeping communications services secure; and customer privacy as regards traffic and location data, itemised billing, line identification, and directory listings.
General Data Protection Regulation	The GDPR will come into force in May 2018, and provides the following: - Enhanced patient access to records: Staff will have a stricter time-limit to respond to requests from patients to access their records, known as 'Subject Access Requests' (SARs), the GDPR will reduce the timeframe

Legislation	What does a NED need to know?
	for response from forty days to one calendar month and penalties can be issued for late responses. - Increased reporting requirements for data breaches: The GDPR will require that where individuals are likely to suffer some form of damage or risk to their rights and freedoms as a result of a breach the Information Commissioner be notified within 72 hours of staff becoming aware of it. The legislation will also introduce severe fines for data breaches. Staff will therefore be expected to notify the Data Protection IG Team and their line managers as soon as practicable - Changes to consent: under the legislation there will be a greater emphasis on the recording of consent. Further where explicit consent is taken patients will have greater rights to request that their information be deleted;
Care Act 2014	The Care Act outlines the way in which local authorities should carry out carer's assessments and needs assessments; how local authorities should determine who is eligible for support; the new obligations on local authorities; and how local authorities should charge for both residential care and community care. It related mainly to adults in need of care and support, and their adult carers.
Children Act 2004	The Children Act 2004 provides the legal basis for how social services and other agencies deal with issues relating to children, and provides the legal underpinning to 'Every Child Matters: Change for Children' (2004). It brought about the structural changes whereby education and social care services for children were brought together under a director of children's services.
Charities Act 2011	This is the main piece of legislation affecting charities and sets out how all charities in England and Wales are registered and regulated. It simplified and clarified the law, by: reducing bureaucracy, especially for smaller charities; providing a definition of charity; and modernising the Charity Commission's functions and powers.
The Procurement, Patient Choice and Competition Regulations 2013	The Regulations are intended to enable commissioners to decide in individual cases how to secure services in the best interests of patients, including deciding whether services could be improved by providing them in a more integrated way, by giving patients a choice of provider to go to, and/or by enabling providers to compete to provide services.
Competition Act 1998 / Enterprise Act 2000	The Competition Act 1998 is the current major source of competition law in the United Kingdom, along with the Enterprise Act 2002. The act provides an updated framework for identifying and dealing with restrictive business practices and abuse of a dominant market position. The Enterprise Act made major changes to UK competition law with respect to mergers and also changed the law governing insolvency bankruptcy.
The Public Contracts Regulations 2006 and the Public Contracts Regulations 2015	Public procurement law regulates the purchasing by public sector bodies and certain utility sector bodies of contracts for goods, works or services. The law is designed to open up the EU's public procurement market to competition, to prevent "buy national" policies and to promote the free movement of goods and services. It requires that where pre-conditions are met, a contracting authority must normally advertise the contract in the EU's Official Journal and follow the procedural rules set down in the Regulations.
Blood Safety and Quality Regulations 2005	These Regulations impose safety and quality requirements on human blood collection and storage.
The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006	These Regulations relate to the implementation of good clinical practice in the conduct of clinical trials on medicinal products in human use. In particular, they lay down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorisation of the manufacturing or importation of such products.

Legislation	What does a NED need to know?
The Civil Contingencies Act 2004	The Act, and accompanying regulations and non-legislative measures, delivers a single framework for civil protection. It is in two substantive parts: - Part 1: focuses on local arrangements for civil protection, establishing a statutory framework of roles and responsibilities for local responders - Part 2: focuses on emergency powers, establishing a framework for the use of special legislative measures that might be necessary to deal with the effects of the most serious emergencies.
Human Rights Act 1998	The Act sets out fundamental rights and freedoms for all. It has three main effects: It incorporates the rights set out in the European Convention on Human Rights (ECHR); it requires all public bodies to respect and protect human rights; it means that courts will, where possible, interpret laws in a way which is compatible with Convention rights.
Copyright, Designs and Patents Act 1988	Copyright in a healthcare environment mainly related to development of devices and drugs by an individual or team, and applies to a work if it is regarded as original, and exhibits a degree of labour, skill or judgement. Where such work is produced as part of employment then normally the work belongs to the person/company who hired the individual; this is dealt with under intellectual property rights.
Public Health (Control of Diseases) Act 1984 / Public Health (Infectious Diseases) Regulations 1988 / Health Protection (Notification) Regs 2010	This legislation paved the way for a suite of Health Protection Regulations which came into effect in April 2010, covering notifications, local authority powers and Part 2A Orders. Much of it relates to the requirements for reporting, and controlling spread, of notifiable diseases.
Law relating to Health and Safety including without limitation, the Health and Safety at Work etc Act 1974	The Act sets out the general duties which employers have towards employees and members of the public, and employees have to themselves and each other. These duties are qualified in the Act by the principle of 'so far as reasonably practicable'. The Management of Health and Safety at Work Regulations 1999 (the Management Regulations) generally make more explicit what employers are required to do to manage health and safety under the Health and Safety at Work Act. The main requirement on employers is to carry out risk assessment; other regulations require action in response to particular hazards, or in industries where hazards are particularly high.
Ionising Radiation Regulations 1999 – implementation of European Directive 2013/59/EURATOM laying down basic safety standards for protection against the dangers arising from exposure arising to ionising radiation	The Health & safety executive has consulted on changes as outlined below, the majority of which are brought in by the implementation of the EU Basic Safety Standards Directive (BSSD). The main changes are: - Dose Limit for exposure to the lens of the eye and implementation of the Directive – the Directive introduces a reduction of equivalent dose from 150 mSv to 20 mSv in a year. Currently exposure to ionising radiation is calculated and assessed on a calendar year basis, this would require individual dose limits to be re-calculated for the remainder of the year. HSE propose to transpose the BSSD early, on 1st January 2018, to avoid confusion and any additional cost burden to businesses. - Graded Approach - introduction of a new three tiered risk-based system of regulatory control. The Directive refers to these levels as notification, registration, and licensing - the higher the radiation protection risk associated with the work, the greater the requirements. It requires HSE to have in place a positive system of authorisation whereby permission is granted to dutyholders for higher risk activities through registration and licensing.
The Medical Profession (Responsible Officer) Regulations 2010	The Regulations came into force on 1 January 2011 and were amended on 1 April 2013. The regulations require all designated bodies to: - nominate or appoint a senior doctor (a responsible officer – RO) to oversee systems for governance and appraisal for doctors, for dealing with practice concerns about doctors and for advising the GMC about doctors' fitness to practise;

Legislation	What does a NED need to know?
	- provide resources to support ROs in their role. Their local governance arrangements should incorporate constructive challenge around the way services are delivered and monitored; - receive confirmation from ROs that they consider the quality of their systems supports the evaluation of doctors' fitness to practise in a fair and consistent way; - ensure that individual doctors demonstrate they continue to meet the values and principles expected of the profession set out in the GMC's core guidance Good medical practice. This is achieved by doctors reflecting on a portfolio of information and evidence at annual appraisal of the doctor's whole practice.
Bribery Act 2010 (formal briefing provided to Trust board in 2011)	The Act includes two general offences involving, firstly, the offering or paying of bribes ("active" bribery) and secondly the request or receipt of bribes ("passive" bribery). The Act also provides that trusts could be guilty of an offence if a person associated with it commits a bribery offence. The advised defence against prosecution will be the demonstration of having "adequate procedures" in place to prevent bribery. Currently the law in this area provides that guilt of a bribery offence will occur if senior management is involved. However, under the new Act, the offence applies to all staff in the Trust, which mean it may be guilty of an offence even if no-one within the Trust, apart from the offending individual, knew of the bribery. Furthermore, the Trust could be liable for the conduct of third parties that perform services for it, which could include contractors and sub-contractors. There are serious penalties for offences committed under the Act, including a maximum jail sentence of 10 years for individuals engaging in bribery and potentially unlimited fines for organisations which fail to implement "adequate procedures" to prevent bribery.
Criminal Finances Act 2017 (due to come into force during 2018)	The will give law enforcement agencies and partners, further capabilities and powers to recover the proceeds of crime, tackle money laundering, tax evasion and corruption, and combat the financing of terrorism. The act: - creates unexplained wealth orders which can require those suspected of serious crime or corruption to explain the sources of their wealth - creates new criminal offences for corporations who fail to prevent their staff from facilitating tax evasion - enables the seizure and forfeiture of proceeds of crime and terrorist money stored in bank accounts and certain personal or moveable items - provides legal protections for the sharing of information between regulated companies and extends the time period granted to law enforcement agencies to investigate suspicious transactions - extends disclosure orders to cover money laundering and terrorist finance investigations - extends the existing civil recovery regime in the Proceeds of Crime Act to allow for the recovery of the proceeds of gross human rights abuses or violations overseas.
Health Service Medical Supplies (Costs) Act 2017	The purpose of the Act is to 'secure better value for money for the NHS from its spend on medicines.', and give the government powers to reduce the price of unbranded generic medicines if the competitive market is not appropriately functioning in the case of a small number of specific products. - The Bill contained measures in three main areas: - Introducing a 'payment mechanism' on medicines in the statutory pricing scheme. This would see companies in the statutory scheme pay a fee to the Department of Health based on net sales. - Requiring companies at any point in the supply chain to provide additional data relating to medicine prices, profits and margins to ensure value for money to the NHS. - Introducing powers to determine prices of medicines. The legislation gives the Department of Health powers to limit the prices of generic

Legislation	What does a NED need to know?
	medicines which aren't covered by the PPRS, but are supplied by PPRS member companies.
Range of legislation relating to employment; the Trust board, unless directly involved with individual cases, would not usually need to understand the contents of these pieces of legislation	• Working Time Regulations 1998 • Transfer of Undertakings (Protection of Employment) Regulations 2006 • Equality Act 2010 • Protection from Harassment Act 1997 • Employment Rights Act 1996 • Employment Relation Act 2008 • Trade Union and Labour Relations (Consolidation) Act 1992 • Fixed-Term Employees (Prevention of Less Favourable Treatment) Regulations 2002 • Part-Time Workers (Prevention of Less Favourable Treatment) Regulations 2000 • Agency Workers Regulations 2010 • Equal Pay Act 1970 • Income Tax (Earnings and Pensions) Act 2003 • National Minimum Wage Act 1998 • Immigration, Asylum and Nationality Act 2006 • The law relating to maternity and paternity rights including without limitation, the Maternity and Parental Leave Regulations 1999 and the Paternity and Adoption leave Regulations 2002 • Law relating to pensions including without limitation the Pensions Act 2008 and all other legislation and regulations that may be applicable to the Trust from time to time

National Health Service Act 2006

SCHEDULE 4

NHS TRUSTS ESTABLISHED UNDER SECTION 25

PART 1 CONSTITUTION, ESTABLISHMENT, ETC

Status

1Each NHS trust is a body corporate.

2(1)An NHS trust must not be regarded as the servant or agent of the Crown or as enjoying any status, immunity or privilege of the Crown.

(2)An NHS trust's property must not be regarded as property of, or property held on behalf of, the Crown.

Board of directors

3(1)Each NHS trust has a board of directors consisting of—

(a)a chairman appointed by the Secretary of State, and

(b)executive and non-executive directors.

(2)Sub-paragraph (1)(b) is subject to paragraph 7(2).

(3)An executive director is a director who is an employee of the NHS trust, and a non-executive director is a director who is not an employee of the NHS trust.

(4)Sub-paragraph (3) is subject to any provision made by regulations under paragraph 4(1)(d).

Regulations

4(1)The Secretary of State may by regulations make provision with respect to—

(a)the qualifications for and the tenure of office of the chairman and directors of an NHS trust (including the circumstances in which they cease to hold, or may be removed from, office or may be suspended from performing the functions of the office),

(b)the persons by whom the directors and any of the officers must be appointed and the manner of their appointment,

(c)the maximum and minimum numbers of the directors,

(d)the circumstances in which a person who is not an employee of the NHS trust is nevertheless, on appointment as a director, to be regarded as an executive rather than a non-executive director,

(e)the proceedings of the NHS trust (including the validation of proceedings in the event of a vacancy or defect in appointment), and

(f)the appointment, constitution and exercise of functions by committees and sub-committees of the NHS trust (whether or not consisting of or including any members of the board).

(2)Regulations under sub-paragraph (1) may, in particular, make provision to deal with cases where the post of any officer of an NHS trust is held jointly by two or more persons or where the functions of such an officer are in any other way performed by more than one person.

Provision to be made by first NHS trust order

5(1)The first NHS trust order made in relation to any NHS trust must specify—

(a)the name of the NHS trust,

(b)the functions of the NHS trust,

(c)the number of executive directors and non-executive directors,

(d)where the NHS trust has a significant teaching commitment, a provision to secure the inclusion in the non-executive directors referred to in paragraph (c) of a person appointed from a university with a medical or dental school specified in the order,

(e)the operational date of the NHS trust, and

(f)if a scheme is to be made under paragraph 8, the Primary Care Trusts, Special Health Authority or Local Health Board which is to make the scheme.

(2)The functions which may be specified in an NHS trust order include a duty to provide goods or services so specified at or from a hospital or other establishment or facility so specified.

(3)For the purposes of sub-paragraph (1)(d), an NHS trust has a significant teaching commitment in the following cases—

(a)if the NHS trust is established to provide services at a hospital or other establishment or facility which, in the opinion of the Secretary of State, has a significant teaching and research commitment, and

(b)in any other case, if the Secretary of State so provides in the order.

(4)In a case where the order contains a provision made by virtue of sub-paragraph (1)(d) and a person who is being considered for appointment by virtue of that provision—

(a)is employed by the university in question, and

(b)would also, apart from this sub-paragraph, be regarded as employed by the NHS trust,

his employment by the NHS trust must be disregarded in determining whether, if appointed, he will be a non-executive director of the NHS trust.

(5)The operational date of the NHS trust is the date on which it will begin to undertake the whole of the functions conferred on it.

(6)An NHS trust order must specify the accounting date of the NHS trust.

Temporary availability of staff etc.

6(1)An NHS trust order may require a Strategic Health Authority, Special Health Authority, Primary Care Trust or Local Health Board to make staff, premises and other facilities available to an NHS trust pending the transfer or appointment of staff to or by the NHS trust and the transfer of premises or other facilities to the NHS trust.

(2)An NHS trust order making provision under this paragraph may make provision with respect to the time when the functions of the Strategic Health Authority, Special Health Authority, Primary Care Trust or Local Health Board under the provision are to come to an end.

Establishment of NHS trust prior to operational date

7(1)An NHS trust order may provide for the establishment of an NHS trust with effect from a date earlier than the operational date of the NHS trust and, during the period between that earlier date and the operational date, the NHS trust has such limited functions for the purpose of enabling it to begin to operate satisfactorily with effect from the operational date as may be specified in the order.

(2)If an NHS trust order makes the provision referred to in sub-paragraph (1), then, at any time during the period referred to in that sub-paragraph, the NHS trust must be regarded as properly constituted (and may carry out its limited functions accordingly) notwithstanding that, at that time, all or any of the executive directors have not yet been appointed.

(3)If an NHS trust order makes the provision referred to in sub-paragraph (1), the order may require a Strategic Health Authority, Special Health Authority or Local Health Board to discharge such liabilities of the NHS trust as—

(a)may be incurred during the period referred to in that sub-paragraph, and

(b)are of a description specified in the order.

Transfer of staff to NHS trusts

8(1)This paragraph applies to any person who, immediately before an NHS trust's operational date—

(a)is employed by a Special Health Authority, Primary Care Trust or Local Health Board to work solely at, or for the purposes of, a hospital or other establishment or facility which will become the responsibility of the NHS trust, or

(b)is employed by a Special Health Authority, Primary Care Trust or Local Health Board to work at, or for the purposes of, such a hospital, establishment or facility and is designated for the purposes of this paragraph by a scheme made by the Special Health Authority, Primary Care Trust or Local Health Board specified as mentioned in paragraph 5(1)(f).

(2)Sub-paragraph (1) is subject to sub-paragraph (6).

(3)A scheme under this paragraph does not have effect unless approved by the Secretary of State.

(4)Subject to sub-paragraphs (9) to (11), the contract of employment between a person to whom this paragraph applies and the Special Health Authority, Primary Care Trust or Local Health Board by whom he is employed has effect from the operational date as if originally made between him and the NHS trust.

(5)In particular—

(a)all the rights, powers, duties and liabilities of the Special Health Authority, Primary Care Trust or Local Health Board under or in connection with a contract to which sub-paragraph (4) applies are by virtue of this paragraph transferred to the NHS trust on its operational date, and

(b)anything done before that date by or in relation to the Special Health Authority, Primary Care Trust or Local Health Board in respect of that contract or the employee is deemed from that date to have been done by or in relation to the NHS trust.

(6)In any case where—

(a)an NHS trust order provides for the establishment of an NHS trust with effect from a date earlier than the operational date of the NHS trust,

(b)on or after that earlier date but before its operational date the NHS trust makes an offer of employment by the NHS trust to a person who at that time is employed by a Special Health Authority, Primary Care Trust or Local Health Board to work (whether solely or otherwise) at, or for the purposes of, the hospital or other establishment or facility which will become the responsibility of the NHS trust, and

(c)as a result of the acceptance of the offer, the person to whom it was made becomes an employee of the NHS trust,

sub-paragraphs (4) and (5) have effect in relation to that person's contract of employment as if he were a person to whom this paragraph applies and as if any reference in those sub-paragraphs to the operational date of the NHS trust were a reference to the date on which he takes up employment with the NHS trust.

(7)Sub-paragraphs (4) and (5) do not affect any right of an employee to terminate his contract of employment if a substantial change is made to his detriment in his working conditions; but no such right arises by reason only of the change in employer effected by this paragraph.

(8)A scheme under this paragraph may designate a person either individually or as a member of a class or description of employees.

(9)In the case of a person who falls within sub-paragraph (1)(b), a scheme under this paragraph may provide that, with effect from the NHS trust's operational date, his contract of employment (his "original contract") must be treated, in accordance with the scheme, as divided so as to constitute—

(a)a contract of employment with the NHS trust, and

(b)a contract of employment with the Special Health Authority, Primary Care Trust or Local Health Board by whom he was employed before that date (the "transferor authority").

(10)Where a scheme makes provision as mentioned in sub-paragraph (9)—

(a)the scheme must secure that the benefits to the employee under the two contracts referred to in that sub-paragraph, when taken together, are not less favourable than the benefits under his original contract,

(b)this paragraph applies in relation to the contract referred to in sub-paragraph (9)(a) as if it were a contract transferred under this paragraph from the transferor authority to the NHS trust, and

(c)so far as necessary to preserve any rights and obligations, the contract referred to in sub-paragraph (9)(b) must be regarded as a continuation of the employee's original contract.

(11)Where, as a result of the provisions of this paragraph, by virtue of his employment during any period after the operational date of the NHS trust—

(a)an employee has contractual rights against an NHS trust to benefits in the event of his redundancy, and

(b)he also has statutory rights against the trust under Part 11 of the Employment Rights Act 1996 (c. 18) (redundancy payments),

any benefits provided to him by virtue of the contractual rights referred to in paragraph (a) must be taken as satisfying his entitlement to benefits under that Part of that Act.

Transfer of property and liabilities to NHS trusts

9(1)The Secretary of State may by order transfer, or provide for the transfer of, any of the property and liabilities of a Strategic Health Authority, a Primary Care Trust, a Special Health Authority, a Local Health Board or the Secretary of State, to an NHS trust, with effect from any date as may be specified in the order.

(2)An order under this paragraph may create or impose such new rights or liabilities in respect of what is transferred or what is retained as appear to the Secretary of State to be necessary or expedient.

(3)Nothing in this paragraph affects the power of the Secretary of State or any power of a Strategic Health Authority, Primary Care Trust, Special Health Authority or Local Health Board to transfer property or liabilities to an NHS trust otherwise than under sub-paragraph (1).

(4)Stamp duty is not chargeable in respect of any transfer to an NHS trust effected by or by virtue of an order under this paragraph.

(5)Where an order under this paragraph provides for the transfer—

(a)of land held on lease from a third party, or

(b)of any other asset leased or hired from a third party or in which a third party has an interest,

the transfer is binding on the third party notwithstanding that, apart from this sub-paragraph, it would have required his consent or concurrence.

(6)"Third party" means a person other than the Secretary of State, a Strategic Health Authority, a Primary Care Trust, a Special Health Authority or a Local Health Board.

(7)Any property and liabilities which—

(a)belong to, or are used or managed by, a Strategic Health Authority, Special Health Authority or Local Health Board or belong to a Primary Care Trust, and

(b)will be transferred to an NHS trust by or by virtue of an order under this paragraph,

must be identified by agreement between the Strategic Health Authority, Primary Care Trust, Special Health Authority or Local Health Board and the NHS trust or, in default of agreement, by direction of the Secretary of State.

(8)Where, for the purpose of a transfer pursuant to an order under this paragraph, it becomes necessary to apportion any property or liabilities, the order may contain such provisions as appear to the Secretary of State to be appropriate for the purpose.

(9)Where any such property or rights fall within sub-paragraph (5), the order must contain such provisions as appear to the Secretary of State to be appropriate to safeguard the interests of third parties, including, where appropriate, provision for the payment of compensation of an amount to be determined in accordance with the order.

(10)In the case of any transfer made by or pursuant to an order under this paragraph, a certificate issued by the Secretary of State that any property specified in the certificate or any such interest in or right over any such property as may be so specified, or any right or liability so specified, is vested in the NHS trust specified in the order is conclusive evidence of that fact for all purposes.

(11)An order under this paragraph may include provision for matters to be settled by arbitration by a person determined in accordance with the order.

(12)Sub-paragraph (11) does not affect section 272(8).

Trust funds and trustees

10(1)The Secretary of State may by order provide for the appointment of trustees for an NHS trust to hold property on trust—

(a)for the general or any specific purposes of the NHS trust (including the purposes of any specific hospital or other establishment or facility at or from which services are provided by the NHS trust), or

(b)for any purposes relating to the health service.

(2)An order under sub-paragraph (1) may—

(a)make provision as to the persons by whom trustees must be appointed and generally as to the method of their appointment,

(b)make any appointment subject to such conditions as may be specified in the order (including conditions requiring the consent of the Secretary of State),

(c)make provision as to the number of trustees to be appointed, including provision under which that number may from time to time be determined by the Secretary of State after consultation with such persons as he considers appropriate, and

(d)make provision with respect to the term of office of any trustee and his removal from office.

(3)Where under sub-paragraph (1) trustees have been appointed for an NHS trust, the Secretary of State may by order provide for the transfer of any trust property from the NHS trust to the trustees.

Pay and allowances

11(1)An NHS trust must pay—

(a)to the chairman and any non-executive director of the NHS trust remuneration of an amount determined by the Secretary of State, not exceeding such amount as may be approved by the Treasury,

(b)to the chairman and any non-executive director of the NHS trust such travelling and other allowances as may be determined by the Secretary of State with the approval of the Treasury,

(c)to any member of a committee or sub-committee of the NHS trust who is not also a director such travelling and other allowances as may be so determined.

(2)If an NHS trust so determines in the case of a person who is or has been a chairman of the NHS trust, the NHS trust must pay such pension, allowances or gratuities to or in respect of him as may be determined by the Secretary of State with the approval of the Treasury.

(3)Different determinations may be made under sub-paragraph (1) or sub-paragraph (2) in relation to different cases or descriptions of cases.

Reports and other information

12(1)For each accounting year an NHS trust must prepare and send to the Secretary of State an annual report in such form as may be determined by the Secretary of State.

(2)At such time or times as may be prescribed, an NHS trust must hold a public meeting at which must be presented—

(a)its audited accounts and annual report, and

(b)any report on the accounts made pursuant to section 8 of the Audit Commission Act 1998 (c. 18) or paragraph 19 of Schedule 8 to the Government of Wales Act 2006 (c. 32).

(3)In such circumstances and at such time or times as may be prescribed, an NHS trust must hold a public meeting at which such documents as may be prescribed must be presented.

13An NHS trust must furnish to the Secretary of State such reports, returns and other information, including information as to its forward planning, as, and in such form as, he may require.

PART 2POWERS AND DUTIES

General

14(1)An NHS trust may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

(2)In particular it may—

(a)acquire and dispose of property,

(b)enter into contracts, and

(c)accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purposes relating to the health service).

(3)The reference in sub-paragraph (2)(c) to specific purposes of the NHS trust includes a reference to the purposes of a specific hospital or other establishment or facility at or from which services are provided by the NHS trust.

NHS contracts

15(1)In addition to carrying out its other functions, an NHS trust may, as the provider, enter into NHS contracts.

(2)An NHS trust may not, as the provider, enter into an NHS contract for the provision of high security psychiatric services (within the meaning of section 4) unless the NHS trust is approved for the purpose of this paragraph by the Secretary of State.

(3)Such approval—

(a)must be for a period specified in the approval,

(b)may be given subject to conditions, and

(c)may be amended or revoked at any time.

Research

16An NHS trust may undertake and commission research and make available staff and provide facilities for research by other persons.

Training

17An NHS trust may—

(a)provide training for persons employed or likely to be employed by the NHS trust or otherwise in the provision of services under this Act, and

(b)make facilities and staff available in connection with training by a university or any other body providing training in connection with the health service.

Joint exercise of functions

18An NHS trust may enter into arrangements for the carrying out, on such terms as the NHS trust considers appropriate, of any of its functions jointly with any Strategic Health Authority, Primary Care Trust, Special Health Authority, Local Health Board or other NHS trust, or any other body or individual.

Payment for accommodation or services

19(1)According to the nature of its functions, an NHS trust may make accommodation or services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS trust in respect of the accommodation or services.

(2)An NHS trust may exercise the power conferred by sub-paragraph (1) only—

(a)to the extent that its exercise does not to any significant extent interfere with the performance by the NHS trust of its functions or of its obligations under NHS contracts, and

(b)in circumstances specified in directions under section 8, with the Secretary of State's consent.

Additional income

20(1)For the purpose of making additional income available in order better to perform its functions, an NHS trust has the powers specified in section 7(2) of the Health and Medicines Act 1988 (c. 49) (extension of powers of Secretary of State for financing the health service).

(2)The power conferred by sub-paragraph (1) may be exercised only—

(a)to the extent that its exercise does not to any significant extent interfere with the performance by the NHS trust of its functions or of its obligations under NHS contracts, and

(b)in circumstances specified in directions under section 8, with the consent of the Secretary of State.

Provision of accommodation and services outside England and Wales

21An NHS Trust may arrange for the provision of accommodation and services outside England and Wales.

Conferral of further powers by order

22The Secretary of State may by order confer specific powers on NHS trusts, further to those provided for by paragraphs 15 to 21.

Powers of NHS trusts to enter into externally financed development agreements

23(1)The powers of an NHS trust include power to enter into externally financed development agreements.

(2)For the purposes of this paragraph, an agreement is an externally financed development agreement if it is certified as such in writing by the Secretary of State.

(3)The Secretary of State may give a certificate under this paragraph if—

(a)in his opinion the purpose or main purpose of the agreement is the provision of facilities or services in connection with the discharge by the NHS trust of any of its functions, and

(b)a person proposes to make a loan to, or provide any other form of finance for, another party in connection with the agreement.

(4)If an NHS trust enters into an externally financed development agreement it may also, in connection with that agreement, enter into an agreement with a person who falls within sub-paragraph (3)(b) in relation to the externally financed development agreement.

(5)"Another party" means any party to the agreement other than the NHS trust.

(6)The fact that an agreement made by an NHS trust has not been certified under this paragraph does not affect its validity.

Agreements under section 92 or 107

24An NHS trust may provide services under an agreement made under section 92 (primary medical services) or section 107 (primary dental services) and may do so as a member of a qualifying body (within the meaning given by section 93 or section 108).

Staff

25(1)An NHS trust may employ such staff as it considers appropriate.

(2)An NHS trust may—

(a)pay its staff such remuneration and allowances, and

(b)employ them on such other terms and conditions,

as it considers appropriate.

(3)An NHS trust must—

(a)in exercising its powers under sub-paragraph (2), and

(b)otherwise in connection with the employment of its staff,

act in accordance with regulations and any directions given by the Secretary of State.

(4)Before making any regulations under sub-paragraph (3), the Secretary of State must consult such bodies as he may recognise as representing persons who, in his opinion, are likely to be affected by the regulations.

Pensions, etc.

26(1)An NHS trust may, for or in respect of such of its employees as it may determine, make arrangements for providing pensions, allowances or gratuities.

(2)Such arrangements may include the establishment and administration, by the NHS trust or otherwise, of one or more pension schemes.

(3)The reference in sub-paragraph (1) to pensions, allowances or gratuities to or in respect of employees of an NHS trust includes a reference to pensions, allowances or gratuities by way of compensation to or in respect of any of the NHS trust's employees who suffer loss of office or employment or loss or diminution of emoluments.

(4)This paragraph does not affect the generality of paragraphs 14 and 25.

Compulsory acquisition

27(1)An NHS trust may be authorised to purchase land compulsorily for the purposes of its functions by means of an order made by the NHS trust and confirmed by the Secretary of State.

(2)Subject to sub-paragraph (3), the Acquisition of Land Act 1981 (c. 67) applies to the compulsory purchase of land under this paragraph.

(3)No order may be made by an NHS trust under Part 2 of the Acquisition of Land Act 1981 with respect to any land unless the proposal to acquire the land compulsorily—

(a)has been submitted to the Secretary of State in such form and together with such information as he may require, and

(b)has been approved by him.

PART 3DISSOLUTION

28(1)The Secretary of State may by order dissolve an NHS trust.

(2)An order under this paragraph may be made—

(a)on the application of the NHS trust concerned, or

(b)if the Secretary of State considers it appropriate in the interests of the health service.

(3)Except where it appears to the Secretary of State necessary to make an order under this paragraph as a matter of urgency, no such order may be made until after the completion of such consultation as may be prescribed.

29(1)If an NHS trust is dissolved under paragraph 28, the Secretary of State may by order transfer, or provide for the transfer, to himself or an NHS body of such of the property and liabilities of the NHS trust which is dissolved as in his opinion is appropriate; and any such order may include provisions corresponding to those of paragraph 9.

(2)The liabilities which may be transferred by virtue of sub-paragraph (1) to an NHS body include criminal liabilities.

(3)An order under this paragraph may make provision in connection with the transfer of staff employed by or for the purposes of the NHS trust which is dissolved; and such an order may include provisions corresponding to those of paragraph 8, including provision for the making of a scheme by such Strategic Health Authority, Special Health Authority, Local Health Board or other body as may be specified in the order.

(4)No order may be made under this paragraph until after completion of such consultation as may be prescribed.

30(1)If an NHS trust is dissolved under paragraph 28, the Secretary of State or such other NHS trust, Strategic Health Authority, Primary Care Trust, Special Health Authority or Local Health Board as he may direct must undertake the responsibility for the continued payment of any such pension, allowances or gratuities as, by virtue of paragraph 11(2) or paragraph 26, would otherwise have been the responsibility of the NHS trust which has been dissolved.

(2)Sub-paragraph (1) does not affect the generality of paragraph 29.

31An NHS trust may not be dissolved or wound up except in accordance with paragraph 28 or section 57.

PART 4MISCELLANEOUS

Use and development of consecrated land and burial grounds

32Section 128 of the Town and Country Planning Act 1971 (c. 78) (use and development of consecrated land and burial grounds) applies to consecrated land and land comprised in a burial ground, within the meaning of that section, which an NHS trust holds for any of its purposes as if—

(a)that land had been acquired by the NHS trust as mentioned in subsection (1) of that section, and

(b)the NHS trust were a statutory undertaker, within the meaning of that Act.

Instruments etc.

33(1)The fixing of the seal of an NHS trust must be authenticated by the signature—

(a)of the chairman or of some other person authorised (whether generally or specifically) by the NHS trust for that purpose, and

(b)of one other director.

(2)A document purporting to be duly executed under the seal of an NHS trust must be received in evidence and must, unless the contrary is proved, be taken to be so executed.

(3)A document purporting to be signed on behalf of an NHS trust must be received in evidence and must, unless the contrary is proved, be taken to be so signed.

Interpretation

34In this Schedule—

- "provide" includes manage,
- "operational date" has the meaning given by paragraph 5(5).

National Health Service Act 2012

Sections 151 and 152

Directors

(1)After paragraph 18 of Schedule 7 to the National Health Service Act 2006 insert—

"18AThe general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the corporation so as to maximise the benefits for the members of the corporation as a whole and for the public."

(2)After paragraph 18A of that Schedule insert—

"18B(1)The duties that a director of a public benefit corporation has by virtue of being a director include in particular—

(a)a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the corporation;

(b)a duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

(2)The duty referred to in sub-paragraph (1)(a) is not infringed if—

(a)the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

(b)the matter has been authorised in accordance with the constitution.

(3)The duty referred to in sub-paragraph (1)(b) is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

(4)In sub-paragraph (1)(b), "third party" means a person other than—

(a)the corporation, or

(b)a person acting on its behalf."

(3)After paragraph 18B of that Schedule insert—

"18C(1)If a director of a public benefit corporation has in any way a direct or indirect interest in a proposed transaction or arrangement with the corporation, the director must declare the nature and extent of that interest to the other directors.

(2)If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

(3)Any declaration required by this paragraph must be made before the corporation enters into the transaction or arrangement.

(4)This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

(5)A director need not declare an interest—

(a)if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

(b)if, or to the extent that, the directors are already aware of it;

(c)if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered—

(i)by a meeting of the board of directors, or

(ii)by a committee of the directors appointed for the purpose under the constitution."

(4)After paragraph 18C of that Schedule insert—

"18D(1)Before holding a meeting, the board of directors must send a copy of the agenda of the meeting to the council of governors.

(2)As soon as practicable after holding a meeting, the board of directors must send a copy of the minutes of the meeting to the council of governors."

(5)After paragraph 18D of that Schedule insert—

"18E(1)The constitution must provide for meetings of the board of directors to be open to members of the public.

(2)But the constitution may provide for members of the public to be excluded from a meeting for special reasons."

Companies Act 2006 - Part 10A, Chapter 2

CHAPTER 2 GENERAL DUTIES OF DIRECTORS

Introductory

170Scope and nature of general duties

(1)The general duties specified in sections 171 to 177 are owed by a director of a company to the company.
(2)A person who ceases to be a director continues to be subject—
(a)to the duty in section 175 (duty to avoid conflicts of interest) as regards the exploitation of any property, information or opportunity of which he became aware at a time when he was a director, and
(b)to the duty in section 176 (duty not to accept benefits from third parties) as regards things done or omitted by him before he ceased to be a director.
To that extent those duties apply to a former director as to a director, subject to any necessary adaptations.
(3)The general duties are based on certain common law rules and equitable principles as they apply in relation to directors and have effect in place of those rules and principles as regards the duties owed to a company by a director.
(4)The general duties shall be interpreted and applied in the same way as common law rules or equitable principles, and regard shall be had to the corresponding common law rules and equitable principles in interpreting and applying the general duties.
(5)The general duties apply to shadow directors where, and to the extent that, the corresponding common law rules or equitable principles so apply.

The general duties

171Duty to act within powers

A director of a company must—
(a)act in accordance with the company's constitution, and
(b)only exercise powers for the purposes for which they are conferred.

172Duty to promote the success of the company

(1)A director of a company must act in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole, and in doing so have regard (amongst other matters) to—
(a)the likely consequences of any decision in the long term,
(b)the interests of the company's employees,
(c)the need to foster the company's business relationships with suppliers, customers and others,
(d)the impact of the company's operations on the community and the environment,
(e)the desirability of the company maintaining a reputation for high standards of business conduct, and
(f)the need to act fairly as between members of the company.
(2)Where or to the extent that the purposes of the company consist of or include purposes other than the benefit of its members, subsection (1) has effect as if the reference to promoting the success of the company for the benefit of its members were to achieving those purposes.
(3)The duty imposed by this section has effect subject to any enactment or rule of law requiring directors, in certain circumstances, to consider or act in the interests of creditors of the company.

173Duty to exercise independent judgment

(1)A director of a company must exercise independent judgment.
(2)This duty is not infringed by his acting—
(a)in accordance with an agreement duly entered into by the company that restricts the future exercise of discretion by its directors, or
(b)in a way authorised by the company's constitution.

174Duty to exercise reasonable care, skill and diligence

(1)A director of a company must exercise reasonable care, skill and diligence.
(2)This means the care, skill and diligence that would be exercised by a reasonably diligent person with—
(a)the general knowledge, skill and experience that may reasonably be expected of a person carrying out the functions carried out by the director in relation to the company, and
(b)the general knowledge, skill and experience that the director has.

175Duty to avoid conflicts of interest

(1)A director of a company must avoid a situation in which he has, or can have, a direct or indirect interest that conflicts, or possibly may conflict, with the interests of the company.
(2)This applies in particular to the exploitation of any property, information or opportunity (and it is immaterial whether the company could take advantage of the property, information or opportunity).

(3)This duty does not apply to a conflict of interest arising in relation to a transaction or arrangement with the company.
(4)This duty is not infringed—
(a)if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or
(b)if the matter has been authorised by the directors.
(5)Authorisation may be given by the directors—
(a)where the company is a private company and nothing in the company's constitution invalidates such authorisation, by the matter being proposed to and authorised by the directors; or
(b)where the company is a public company and its constitution includes provision enabling the directors to authorise the matter, by the matter being proposed to and authorised by them in accordance with the constitution.
(6)The authorisation is effective only if—
(a)any requirement as to the quorum at the meeting at which the matter is considered is met without counting the director in question or any other interested director, and
(b)the matter was agreed to without their voting or would have been agreed to if their votes had not been counted.
(7)Any reference in this section to a conflict of interest includes a conflict of interest and duty and a conflict of duties.

176Duty not to accept benefits from third parties
(1)A director of a company must not accept a benefit from a third party conferred by reason of—
(a)his being a director, or
(b)his doing (or not doing) anything as director.
(2)A "third party" means a person other than the company, an associated body corporate or a person acting on behalf of the company or an associated body corporate.
(3)Benefits received by a director from a person by whom his services (as a director or otherwise) are provided to the company are not regarded as conferred by a third party.
(4)This duty is not infringed if the acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.
(5)Any reference in this section to a conflict of interest includes a conflict of interest and duty and a conflict of duties.

177Duty to declare interest in proposed transaction or arrangement
(1)If a director of a company is in any way, directly or indirectly, interested in a proposed transaction or arrangement with the company, he must declare the nature and extent of that interest to the other directors.
(2)The declaration may (but need not) be made—
(a)at a meeting of the directors, or
(b)by notice to the directors in accordance with—
(i)section 184 (notice in writing), or
(ii)section 185 (general notice).
(3)If a declaration of interest under this section proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.
(4)Any declaration required by this section must be made before the company enters into the transaction or arrangement.
(5)This section does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.
For this purpose a director is treated as being aware of matters of which he ought reasonably to be aware.
(6)A director need not declare an interest—
(a)if it cannot reasonably be regarded as likely to give rise to a conflict of interest;
(b)if, or to the extent that, the other directors are already aware of it (and for this purpose the other directors are treated as aware of anything of which they ought reasonably to be aware); or
(c)if, or to the extent that, it concerns terms of his service contract that have been or are to be considered—
(i)by a meeting of the directors, or
(ii)by a committee of the directors appointed for the purpose under the company's constitution.

Supplementary provisions
178Civil consequences of breach of general duties
(1)The consequences of breach (or threatened breach) of sections 171 to 177 are the same as would apply if the corresponding common law rule or equitable principle applied.
(2)The duties in those sections (with the exception of section 174 (duty to exercise reasonable care, skill and diligence)) are, accordingly, enforceable in the same way as any other fiduciary duty owed to a company by its directors.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

SECTION 2*Fundamental Standards*

General

8.—(1) A registered person must comply with regulations 9 to 19 in carrying on a regulated activity.

(2) But paragraph (1) does not require a person to do something to the extent that what is required to be done to comply with regulations 9 to 19 has already been done by another person who is a registered person in relation to the regulated activity concerned.

(3) For the purposes of determining under regulations 9 to 19 whether a service user who is 16 or over lacks capacity, sections 2 and 3 of the 2005 Act (people who lack capacity) apply as they apply for the purposes of that Act.

Person-centred care

9.—(1) The care and treatment of service users must—

(a)be appropriate,

(b)meet their needs, and

(c)reflect their preferences.

(2) But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11.

(3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

(a)carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user;

(b)designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met;

(c)enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;

(d)enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible;

(e)providing opportunities for relevant persons to manage the service user's care or treatment;

(f)involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's care or treatment;

(g)providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f);

(h)making reasonable adjustments to enable the service user to receive their care or treatment;

(i)where meeting a service user's nutritional and hydration needs, having regard to the service user's well-being.

(4) Paragraphs (1) and (3) apply subject to paragraphs (5) and (6).

(5) If the service user is 16 or over and lacks capacity in relation to a matter to which this regulation applies, paragraphs (1) to (3) are subject to any duty on the registered person under the 2005 Act in relation to that matter.

(6) But if Part 4 or 4A of the 1983 Act applies to a service user, care and treatment must be provided in accordance with the provisions of that Act.

Dignity and respect

10.—(1) Service users must be treated with dignity and respect.

(2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular—

(a)ensuring the privacy of the service user;

(b)supporting the autonomy, independence and involvement in the community of the service user;

(c)having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user.

Need for consent

11.—(1) Care and treatment of service users must only be provided with the consent of the relevant person.

(2) Paragraph (1) is subject to paragraphs (3) and (4).

(3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

(4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act.

(5) Nothing in this regulation affects the operation of section 5 of the 2005 Act, as read with section 6 of that Act (acts in connection with care or treatment).

Safe care and treatment

12.—(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

(a)assessing the risks to the health and safety of service users of receiving the care or treatment;

(b)doing all that is reasonably practicable to mitigate any such risks;

(c)ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

(d)ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

(e)ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

(f)where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g)the proper and safe management of medicines;

(h)assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

(i)where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

Safeguarding service users from abuse and improper treatment

13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

(4) Care or treatment for service users must not be provided in a way that—

(a)includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,

(b)includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,

(c)is degrading for the service user, or

(d)significantly disregards the needs of the service user for care or treatment.

(5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority.

(6) For the purposes of this regulation—

“abuse” means—

(a) any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(**17**),

(b)

ill-treatment (whether of a physical or psychological nature) of a service user,

(c) theft, misuse or misappropriation of money or property belonging to a service user, or

(d) neglect of a service user.

(7) For the purposes of this regulation, a person controls or restrains a service user if that person—

(a)uses, or threatens to use, force to secure the doing of an act which the service user resists, or

(b)restricts the service user’s liberty of movement, whether or not the service user resists,

including by use of physical, mechanical or chemical means.

Meeting nutritional and hydration needs

14.—(1) The nutritional and hydration needs of service users must be met.

(2) Paragraph (1) applies where—

(a)care or treatment involves—

(i)the provision of accommodation by the service provider, or

(ii)an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or

(b)the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.

(3) But paragraph (1) does not apply to the extent that the meeting of such nutritional or hydration needs would—

(a)result in a breach of regulation 11, or

(b)not be in the service user's best interests.

(4) For the purposes of paragraph (1), "nutritional and hydration needs" means—

(a)receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,

(b)receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,

(c)the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and

(d)if necessary, support for a service user to eat or drink.

(5) Section 4 of the 2005 Act (best interests) applies for the purposes of determining the best interests of a service user who is 16 or over under this regulation as it applies for the purposes of that Act.

Premises and equipment

15.—(1) All premises and equipment used by the service provider must be—

(a)clean,

(b)secure,

(c)suitable for the purpose for which they are being used,

(d)properly used

(e)properly maintained, and

(f)appropriately located for the purpose for which they are being used.

(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.

(3) For the purposes of paragraph (1)(b), (c), (e) and (f), "equipment" does not include equipment at the service user's accommodation if—

(a)such accommodation is not provided as part of the service user's care or treatment, and

(b)such equipment is not supplied by the service provider.

Receiving and acting on complaints

16.—(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of—

(a)complaints made under such complaints system,

(b)responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and

(c)any other relevant information in relation to such complaints as the Commission may request.

Good governance

17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d)maintain securely such other records as are necessary to be kept in relation to—

(i)persons employed in the carrying on of the regulated activity, and

(ii)the management of the regulated activity;

(e)seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f)evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

(a)a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

(b)any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

Staffing

18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

(2) Persons employed by the service provider in the provision of a regulated activity must—

(a)receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

(b)be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

(c)where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

Fit and proper persons employed

19.—(1) Persons employed for the purposes of carrying on a regulated activity must—

(a)be of good character,

(b)have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and

(c)be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.

(2) Recruitment procedures must be established and operated effectively to ensure that persons employed meet the conditions in—

(a)paragraph (1), or

(b)in a case to which regulation 5 applies, paragraph (3) of that regulation.

(3) The following information must be available in relation to each such person employed—

(a)the information specified in Schedule 3, and

(b)such other information as is required under any enactment to be kept by the registered person in relation to such persons employed.

(4) Persons employed must be registered with the relevant professional body where such registration is required by, or under, any enactment in relation to—

(a)the work that the person is to perform, or

(b)the title that the person takes or uses.

(5) Where a person employed by the registered person no longer meets the criteria in paragraph (1), the registered person must—

(a)take such action as is necessary and proportionate to ensure that the requirement in that paragraph is complied with, and

(b)if the person is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

(6) Paragraphs (1) and (3) of this regulation do not apply in a case to which regulation 5 applies.

Duty of candour

20.—(1) A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must—

(a)notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b)provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) The notification to be given under paragraph (2)(a) must—

(a)be given in person by one or more representatives of the health service body,

(b)provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification,

(c)advise the relevant person what further enquiries into the incident the health service body believes are appropriate,

(d)include an apology, and

(e)be recorded in a written record which is kept securely by the health service body.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a)the information provided under paragraph (3)(b),

(b)details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c)the results of any further enquiries into the incident, and

(d)an apology.

(5) But if the relevant person cannot be contacted in person or declines to speak to the representative of the health service body—

(a)paragraphs (2) to (4) are not to apply, and

(b)a written record is to be kept of attempts to contact or to speak to the relevant person.

(6) The health service body must keep a copy of all correspondence with the relevant person under paragraph (4).

(7) In this regulation—

"apology" means an expression of sorrow or regret in respect of a notifiable safety incident;

"moderate harm" means—

(a) harm that requires a moderate increase in treatment, and

(b) significant, but not permanent, harm;

"moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

"notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

(b) severe harm, moderate harm or prolonged psychological harm to the service user;

"prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

"relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

(a) on the death of the service user,

(b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or

(c) where the service user is 16 or over and lacks capacity (as determined in accordance with sections 2 and 3 of the 2005 Act) in relation to the matter;

"severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (18 July 2017)**

KEY ITEMS TO NOTE

The Committee:

- Noted that overall the Trust was on plan in month and year to date. The forecast had been set to plan which was a deficit of £41m pending full detailed forecasts being completed for all areas.
- Discussed at some length the Trust's financial challenge and how it should be addressed, guiding the Executive as to the expectations of FIC and the Board for the September presentation of an outline recovery plan. The committee noted the conditionality of the national funding for 2 new LINACS machines with acceptance of the 17/18 Control Total by August 31st and explored the possibilities for stretching the 17/18 plan further. Noting the current gap to the CIP total and the difficulties to close it, the committee was clear that any proposed further stretch in plan would have to be well-evidenced and should be in the context of returning the Trust to a sustainable financial future. The committee welcomed much of the approach outlined in the draft paper focused on collaboratively developing new models of care maintaining patient quality & building on the investment in values and innovation of the past two years but emphasised the need to learn lessons from previous change initiatives.
- Noted the capital programme which had increased by £0.2m which reflected the latest view of project activity. The Committee noted that one project had been added which was works required on 7 North ward to address infection control issues. Five projects were not being progressed in 2017/18 or were being rephrased across financial years.
- Noted the work in progress to implement a robust re-charging model within the Trust, in particular for clinical support services; a further update would be presented to the Committee in September.
- Reviewed, and supported for approval by the Trust board, the materials management business case, noting the clinical engagement in the tender process. A post project evaluation after 6 months would be presented to the Committee.

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: September 20 2017

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Redevelopment committee report (28 June 2017)**

KEY ITEMS TO NOTE

Phase one St Mary's redevelopment planning application: The determination of the application for the new outpatient services building was on going. The application had been delayed to be heard at the September meeting of Westminster City Council planning committee.

Phase one St Mary's redevelopment project progress: The Committee viewed a short video which had been developed as part of the briefing for planning committee and for general stakeholder briefings.

Outline Business Case is on hold pending future commercial negotiations.

Paddington Cube safety concerns over 'blue light' access to St Mary's Hospital: The Trust and London Ambulance Service had submitted a formal letter of concern to Westminster City council following limited changes having been made; the letter had been referred to in the LAS board meeting on 27 June, and would be made available in the Trust's July board papers.

St Mary's Hospital redevelopment programme: The Trust has embarked on a programme of soft market testing with potential developers. This will inform our master plan and strategic outline business case.

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: 6 September 2017 (to be confirmed)

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (5 July 2017)**

KEY ITEMS TO NOTE

Internal audit and counter-fraud report: The Committee were pleased to note that the occupational health audit had demonstrated improved management and leadership since the previous audit. The Committee noted that the counter fraud team reported no current areas of concern. Noting recent Bribery Act changes, it was agreed that board refresher training would be provided at a future meeting.

Management action plans following audits which had received a limited or no assurance rating: The Committee noted the reports and were pleased to note particular progress in relation to the culture change in completion of the WHO checklist.

Overseas income: The Committee were pleased to note progress with the new collection process within the overseas visitor's team; noting the helpful recent visit from the Department of Health's NHS cost recovery support team it was agreed that the report would be presented to the Committee in October.

Corporate risk register: The Committee noted that the staff immunisation risk had been reduced and welcomed the earlier flu planning that was in progress. The Committee noted that a new risk had been added reflecting the impact of delays in transferring mental health patients to appropriate care facilities; discussions continued with NHS Improvement, CCG and the NWL mental health Trust, and it was confirmed that a new mental health transition lounge at St. Charles' would be a key mitigation.

Cyber security: Following the recent cyber-attack, the Committee were assured by the processes in place to mitigate the risks to the Trust, but sought further assurance as to robustness of medical equipment IT systems in particular. The Committee welcomed the recent appointment of a cyber-security manager.

Data quality: The Committee welcomed the new data quality framework which would provide diligent monitoring processes to improve assurance on the 150 data quality indicators that had been agreed. Both internal and external audit were requested to support this work.

Terrorism threat security: Noting the Joint Terrorism Analysis Centre's assessment that the threat to the health sector was low, the Committee considered whether the Trust, particularly the St Mary's site, was of a higher risk due to being located next to Paddington Station (a key transport hub) as well as being a major trauma centre. Following discussion, it was confirmed that whilst it had been involved in a number of recent major incidents, the actual threat of a targeted attack remained low. The Committee were pleased to note the work in progress to improve the handling of relative liaison during major incidents; a further report would be presented to the Committee in October.

Recruitment and retention: The Committee noted the progress with the recruitment and retention programme; a further update would be presented to the October meeting.

Whistleblowing report: The Committee acknowledged the eight disclosures that had been made from October 2016 to March 2017 and sought assurance that such concerns were both handled and recorded as having been addressed in a timely manner. The Committee welcomed the work to increase the profile in the organisation of the freedom to speak up guardians; additional guardians were being sought for the Charing Cross and Western Eye Hospitals.

Imperial College Healthcare NHS Trust

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

Report from: Sir Gerry Acher as Chairman, Audit, Risk & Governance Committee
Report author: Jessica Hargreaves, Deputy board secretary
Next meeting: 4 October 2017

MINUTES OF THE AUDIT, RISK & GOVERNANCE COMMITTEE
Monday 24 April 2017
11.00 – 12.30
The Bay's meeting room
St Mary's Hospital

Present	
Sir Gerry Acher	Deputy chairman (Chair)
Dr Andreas Raffel	Non-executive director
Sarika Patel	Non-executive director
In attendance (part I) and present (part II):	
Dr Tracey Batten	Chief executive
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Leigh Lloyd-Thomas	Partner / public sector assurance, BDO LLP
Mike Townsend	Regional managing director, TIAA
William Simpson	Counter fraud manager, TIAA
Janice Stephens	Deputy CFO
Doyin Ogunbiyi	Financial controller
Shona Maxwell	Chief of staff, medical director's office
Michelle Dixon (for item 5.1)	Director of communications

1	**GENERAL BUSINESS (Part I &II)**	**Action**
1.1	**Chairman's opening remarks and apologies for absence** The Chair welcomed members and attendees to the meeting. Apologies were received from Prof Andy Bush, Dr Julian Redhead, Nick Ross and Kevin Limn.	
1.2	**Declarations of interest or conflicts of interest** There were no declarations of interest declared at the meeting.	
1.3	**Minutes of the Committee's previous meeting** The minutes of the meeting were approved as an accurate record, with a minor amendment from Phillip Lazenby to Kevin Limn in the attendance table.	
1.4	**Action log, forward plan, & matters arising report** Leigh Lloyd Thomas confirmed that he was content with the alternative site basis used. The Committee noted the updates provided.	
Part I		
2	**EXTERNAL AUDIT BUSINESS**	
	No items	
3	**INTERNAL AUDIT BUSINESS**	
3.1	**Draft internal audit plan 2017/18** Mike Townsend introduced the revised plan for 2017/18, noting that it had been amended following discussion at the March Committee and further review by the executive committee. Key points in discussion were: • as requested, audit of operational performance now focused on waiting list data (given the draft report from CQC, out-patients had been removed from the audit plan for 2017/18) • the strategic procurement audit would be amended to consider whether the supply chain was collaboratively focused in that an appropriate proportion of its procurement being undertaken nationally / regionally / locally (what was the	

	position, and what should the position be) • that there was a move away from small scale quasi-management analysis to more detailed compliance and assurance audit, with each audit having an executive owner • if necessary, internal audit would review issues arising from the external audit of the accounts • the plan would remain flexible to address in-year issues. The Committee approved the internal audit plan.	
3.2	**Draft counter-fraud plan 2017/18** William Simpson introduced the paper, and clarified the way in which the RAG rating had been used; it is the level to which the Trust is seen as being vulnerable to risk, rather than the level of identified risk. Querying TIAA's specific expertise in cyber-crime, Mr Simpson confirmed that the auditor had access to specialised qualified staff who could provide review of specific systems. Highlighting the enhanced data protection requirements from May 2017, he confirmed that the Trust was required to undertake a formal review of arrangements; this was being discussed ICT. The Chairman requested that in the Cyber-crime update due to the Committee in July 2017, there be a deep dive on the robustness of arrangements to minimise risks. Dr Batten confirmed that executive received regular updates on arrangements in place to minimise the risks from cyber-crime. The Committee approved the counter-fraud plan.	
3.3	**Draft head of internal audit opinion** Responding to a query from the Chairman, Mike Townsend confirmed that the Trust could decide how much of the head of internal audit statement to include; Imperial usually used the overall assurance level, and detailed the limited (or no) assurance audits, stating that management had acted on the recommendations. Mike Townsend also confirmed that, at year-end, all management actions would be confirmed as having been completed and reported to the committee should this not be the case. The apparent error in naming of one audit would be amended ('business planning' to read 'GE equipment maintenance contract). The final opinion would reflect any further reviews finalised. The Committee noted the draft head of internal audit opinion.	
3.4	**Annual counter-fraud report** In introducing the paper, William Simpson highlighted the key items. Recognising that the investigation into a potential allegation of conflict of interest was at an early stage, the chairman asked that serious investigations be highlighted to him and the chief executive at an early stage. Dr Andreas Raffel asked that the executive summary be reviewed to ensure greater clarity; and Richard Alexander asked that the 'commentary' be retitled 'looking ahead'. William Simpson outlined the awareness programme in place – it sought to increase awareness of the type of risks staff may encounter, and to raise awareness of to whom and how these should be reported. He also highlighted that the counter-fraud service itself had been rated as green, with action in place to address two amber ratings. Whilst recognising the counter-fraud work undertaken, Richard Alexander commented that the concern was that whilst we may investigate what we can identify, we simply did not know the scale of what we had yet to identify; this would require improved intelligence from other organisations. The Committee noted the report.	

MINUTES OF THE AUDIT COMMITTEE
Wednesday 24 May 2017
13.30 – 14.30
Oak Suite, W12, Hammersmith Hospital

Present	
Sir Gerald Acher (Chair)	Non-executive director
Dr Andreas Raffel	Non-executive director
Nick Ross	Non-executive director
In attendance:	
Richard Alexander	Chief financial officer
Dr Tracey Batten	Chief executive
In attendance:	
Janice Stephens	Deputy chief financial officer
Doyin Ogunbiyi	Financial controller
Leigh Lloyd-Thomas	Partner, BDO
Nuwan Indika	BDO
Jan Aps	Trust company secretary
Jessica Hargreaves	Deputy board secretary

1	**GENERAL BUSINESS**	**Action**
1.1	**Chairman's opening remarks and apologies for absence** The Chair welcomed everyone to the Committee. Apologies were received from Sarika Patel, Andrew Bush, Janice Sigsworth and Julian Redhead.	
1.2	**Declarations of interest or conflicts of interest** No declarations of interest were made.	
1.3	**Minutes will be reviewed at 31 May meeting**	
1.4	**Action log will be reviewed at 31 May meeting**	
2	**EXTERNAL AUDIT BUSINESS**	
2.1	**Draft annual accounts** The Committee reviewed the changes that had been made to the annual accounts since the previous meeting. Noting the Better Payment Practice Code (BPPC) compliance, it was agreed that the finance team would look into the cause of the reduction from the previous year, and an update would be provided to the Committee the following week; if necessary, a further review would take place following accounts sign off. Doyin Ogunbiyi reported that items in Note 1 had a more detailed explanation of relevant risks than had previously been required. Following discussion of the reporting of overseas income figure, it was agreed that the item would be submitted as drafted, but that the Committee would be provided with details of the on-going investigation at a future meeting.	**DO** **DO**
2.2	**Issues arising from accounts review** Leigh Lloyd-Thomas presented the draft ICHT audit completion report highlighting the salient points: • It had been recommended that the disclosure of the alternative site valuation could be expanded; the Committee agreed that they were happy with the alternative site valuation that had been received and Leigh Lloyd Thomas was content with that decision.	

	• It was confirmed that, given NHS legislation, the accounts would always be prepared on a going concern basis. However, the Trust's going concern position would be reported by the auditor as a 'emphasis of matter'; this had also been highlighted in the Trust's self-assessment return. The Committee noted that an assurance note had been added recognising the requirement for the working capital loan arrangement to achieve an appropriate cash position. • Leigh confirmed that there had been no material corrections to the financial statements, but noted that the Trust had taken a particularly prudent approach in a number of areas. • Due to the accumulating deficit, the auditors would be required to submit a Section 30 referral; a draft of the letter would be shared with Committee members in advance of the meeting on 31 May. The Committee recognised this was an appropriate disclosure. • Noting the audit fees schedule, the Committee were satisfied that there was no conflict of interest in BDO having provided the advice on accounting for the North West London Pathology service, and noted that NHSI had required such review be undertaken by the Trust's auditors. • Noting the draft letter of representation, it was agreed that this would be amended to use the expression 'reasonable endeavours'; it was also confirmed that that the letter was not disclosable under FoI. The Chairman said the Trust would want to consider carefully any changes in the audit report wording from the previous year and wanted to confirm this prior to the meeting on 31 May. Leigh Lloyd Thomas would circulate the auditor opinions to members of the Committee for both this year and the previous year. Responding to a query from Dr Andreas Raffel, Richard Alexander noted that the Trust's potential clinical negligence exposure was significantly higher than the NHS Resolution (was Litigation Authority) fee currently paid by the Trust. The Committee noted the work in progress which would be completed prior to the meeting on 31 May 2017.	**LLT** **LLT** **LLT**
2.3	**Amendments made to annual report and annual governance statement** The Committee noted the amendments made to the annual report and annual governance statement and also noted that the sustainability report would be added before the meeting on 31 May 2017.	**JA**
3	**INTERNAL AUDIT BUSINESS**	
3.1	There was no internal audit business; the Committee noted that there was no change of rating expected from that provided in the draft Head of internal audit opinion reviewed on 24 April.	

MINUTES OF THE AUDIT COMMITTEE
Wednesday 31 May 2017
10.00 – 11.00
Chief executive's office, The Bays, St Mary's Hospital

Present	
Sir Gerald Acher (Chair)	Deputy chairman
Dr Andreas Raffel	Non-executive director
Sarika Patel	Non-executive director
Prof Andy Bush	Non-executive director
Nick Ross	Designate non-executive director
In attendance:	
Richard Alexander	Chief financial officer
Dr Tracey Batten	Chief executive
Janice Stephens	Deputy chief financial officer
Doyin Ogunbiyi	Financial controller
Leigh Lloyd-Thomas	Partner, BDO
Kevin Limn	Director, TIAA
Jan Aps	Trust company secretary

1	**GENERAL BUSINESS**	**Action**
1.1	**Chairman's opening remarks and apologies for absence** The Chair welcomed everyone to the Committee, and thanked all those involved in the preparation and review of the documentation provided for the annual report and accounts.	
1.2	**Declarations of interest or conflicts of interest** No declarations of interest were made.	
1.3	**Minutes of meetings held on 24 April and 24 May 2017** The minutes of both meetings were accepted as accurate with a minor amendment 24 May, item 2.2, second bullet where 'matter of emphasis' should read 'emphasis of matter'.	**JA**
1.4	**Action log** The overseas action should note that Janice Stephens was responsible for completion. The committee noted the action log.	**JA**
2	**AUDIT BUSINESS**	
2.1	**Head of internal audit opinion and annual report** Kevin Limn, in introducing the opinion, noted that there had been no change in rating from the draft report, and confirmed that the opinion remained that there was 'reasonable' assurance with respect to internal control arrangements following completion of a number of final audit reports. He also reported that required actions in response to recommendations in limited assurance audit reports had been (or were being) completed to timelines agreed (a note to this effect would be added to the report). The original audit plan had allocated 700 days, but was adjusted in-year to 620 days; this neither affected the robustness of the judgement, nor had it been as a result of management pressure (this would be reflected in the opinion). Richard Alexander commented that the budget remained larger than he was used to requiring. There had been five limited assurance	KL KL

	reports; details were provided in three, but the remaining two would be raised at the Committee's July meeting. The Chair extended thanks to Kevin Limn and the team for the work undertaken during the year, and for ensuring that all had been completed satisfactorily for the end of the year. The Committee would review the annual report at the July meeting. The Committee received and agreed the head of internal audit opinion.	KL
2.2	Annual accounts 2016/17 Doyin Ogunbiyi, noting that that section 2.2 of the paper summarised the changes since both the draft accounts and the version reviewed by the Committee on 24 May, led a discussion on the following key points and amendments: • conflicting figures in relation to Trust position (£1.5m versus £1.4m) in the summary paper would be corrected. • The divergence in BPPC percentages for NHS performance was attributable to NHSLA premiums: recognition of the significant divergence between value and volume of these invoices. • Note 2, operating segments: had been included at the request of the external auditors. • Private income: had been included, but no cost had been attached • Going concern: the Committee considered and agreed the expanded comment which had been included in note 1.1. The Chair extended the Committee's thanks to the Trust finance team for their hard work and commitment in the way in which the accounts process had been completed, and in the way in which the accounts had been presented. The Committee recommended the annual accounts for approval by the Trust board subject to suitable treatment of the error in the remuneration report.	
2.3	**Annual report and annual governance statement** Jan Aps noted that all changes requested both by the Committee and by the external auditors had now been made to the report, particularly highlighted the sustainability report, which had been added to the report since the last meeting. She recognised that continuing discussions between finance and the auditor would result in further minor changes to the remuneration report. The Committee requested further consideration of the following: • Clearer alignment of tone between chairman, chief executive and chief finance officer statements in relation to the 'unprecedented financial challenge'; and a clearer reflection that the Trust had not signed up to the control total because it did not consider it to be a reasonable position to achieve • The inclusion, for 2017/18, of a performance comparison table, using the data destined for the info-graphic • Correction of the staff turnover figure • To note the management layers had reduced from eight to four • To simplify the text in the sustainability report, with clearer articulation as to whether there had been improvement or not; to remove the pie chart • To be clear that the redevelopment programme had not been triggered by the desire to address climate change • To include a definition of 'incremental drift' • To include appropriate footnote was included in relation to Prof Sigsworth's pension. Noting the above comments, the Committee recommended the annual report, including the governance statement, for approval by the Trust board.	

2.4	**External audit ISA+ 260** Leigh Lloyd Thomas, noting that the paper provided a comprehensive report, outlined the main points of the review of the accounts: • No material items requiring change to the accounts had been identified • The ISA+260 also captured management responses to audit issues identified and unadjusted items that were not material. The Chair extended the Committee's thanks to the external audit team for their work on this audit, and, noting this would be their last meeting as the Trust's auditors, also extended thanks for their support over the period that they had been the Trust's external auditors. The Committee received and accepted the External audit ISA+ 260 report.	
3	**ANY OTHER BUSINESS**	
	There was no other business.	
7	**DATE OF NEXT MEETING**	
Audit, Risk & Governance Committee: 5 July 2017 – 10.00 to 1.00pm, Clarence Wing board room, SMH		

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Remuneration Committee (10 July 2017)**

Key points to note:

Chief executive performance and bonus payment for 2016/17, and objective setting for 2017/18: The Committee noted that the chief executive had been awarded a 'performance exceeds expectations' rating, approved the payment of a performance bonus, and, agreed in principle, the chief executive objectives for 2017/18, but recognised these would be subject to review between the chairman and the in-coming chief executive.

Trust board executive director performance reviews 2016/17 and objectives for 2017/18: The Committee noted the completed performance reviews for each of the board executive directors, and confirmed agreement to the objectives outlined.

Chief information officer: The Committee supported the continued joint role across Imperial and Chelsea and Westminster trusts, approved continuation of the salary proposed, and noted the submission of the application for NHS Improvement approval.

Discussion on rewarding executive performance: The Committee noted the paper which outlined a variety of, mainly non-remuneration focused, options for rewarding and incentivising senior positions.

Recommendation:

The Trust Board is requested to:

- Note the report.

Report from: Sarika Patel, chairman, Remuneration committee
Report author: Jan Aps, Trust board secretary
Next meeting: tbc