Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 28th November 2018, 11am to 1pm
Oak Suite, W12 Conference Centre, Hammersmith Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Sir Richard Sykes	Oral
	2.	**Apologies:**	Sir Richard Sykes	Oral
	3.	**Declarations of Interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting*	Sir Richard Sykes	Oral
1105	**4.**	**Minutes of the meeting held on 26th September 2018** *To approve the minutes from the last meeting*	Sir Richard Sykes	01
	5.	**Record of items discussed in Part II of Board meeting held on 26th September 2018** *To note the report*	Sir Richard Sykes	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Sir Richard Sykes	03
1110	**7.**	**Patient story** *To note the patient story*	Prof. Sigsworth	04
1125	**8.**	**Chief Executive Officer's report** *To note the Chief Executive's report*	Prof. Orchard	05
1135	**9.**	**Integrated Quality and performance report** *To receive the monthly integrated quality and performance report for months 5 and 6*	Prof. Redhead	06
1145	**10.**	**Finance report** *To note and discuss the month 7 position and year to date and other financial matters*	Richard Alexander	07
For decision / approval				
1155	**11.**	**Healthier hearts and lungs: a patient-centred solution for specialist NHS services and research**	Prof. Orchard	Paper will be tabled at the meeting
For discussion				
1200	**12.**	**CQC update** *To discuss and note the update on CQC related activity at and/or impacting the Trust*	Prof. Sigsworth	08
1210	**13.**	**Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report: Q1 2018/19** *To discuss and note the quarterly report*	Eimear Brannigan	09
1220	**14.**	**Mid-year update on safe, sustainable and productive nursing and midwifery staffing** *To receive an update on the findings from the establishment review*	Prof. Sigsworth	10
1230	**15.**	**Verita Report into the management of the Trust's disciplinary processes** *To receive an update on the actions*	Kevin Croft	11

For noting				
1240	**16.**	**Committee reports** *To note the summary reports from the Trust Board Committees held during quarter 3 of 2018/19*		
	16.1.	Audit, Risk & Governance Committee, 3rd October 2018	Sir Gerald Acher	12a
	16.2.	Redevelopment Committee, 31st October 2018 and 21st November 2018	Victoria Russell	12b
	16.3.	Remuneration and Appointments Committee, 13th November 2018	Sarika Patel	12c
	16.4.	Quality Committee, 14th November 2018	Prof. Bush	12d
	16.5.	Finance and Investment Committee, 21st November 2018	Andreas Raffel	12e
1245	**17.**	**Any other business**	Sir Richard Sykes	Oral
1250	**18.**	**Questions from the public**	Sir Richard Sykes	
Close	**19.**	**Date of next meeting** 30th January 2019, 11am, Charing Cross Hospital, New Boardroom		

Updated: 27 November 2018

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 26 September 2018
10.45 – 12.30
Clarence Wing Boardroom, St. Mary's Hospital

Present:

Sir Richard Sykes	Chairman
Sir Gerry Acher	Deputy chairman
Dr Andy Bush	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Sarika Patel	Non-executive director
Prof Tim Orchard	Chief executive officer
Prof Julian Redhead	Medical director
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing

In attendance:

Dr Frances Bowen	Divisional director, MIC
Dr TG Teoh	Divisional director of operations, WCCS
Dr Katie Urch	Divisional director of operations, SCCS
Jeremy Butler	Interim Director of Transformation
Kevin Croft	Director of people and organisational development
Michelle Dixon	Director of communications
Joanne Hackett	NExT Director
Kevin Jarrold	Chief information officer
Prof Jonathan Weber	Dean, Imperial College Medical School
Peter Jenkinson	Trust company secretary (minutes)

1.	**Chairman's opening remarks, apologies and declarations of interests** Sir Richard welcomed all members and attendees, and members of the public, to the meeting.
2.	**Apologies** Apologies were noted from Victoria Russell and Nick Ross.
3.	**Declarations of interest** There were no declarations made at the meeting.
4.	**Minutes of the meetings held on 25 July 2018** The minutes of the previous meeting, held on 25 May, were confirmed as an accurate record.
5.	**Record of items discussed in private at the Board meeting on 25 July 2018** The Trust Board noted the report.
6.	**Action log and matters arising** The Trust board noted the action log.

7.	**Patient story**
7.1	The Board welcomed Steph Harrison-White to the meeting.
7.2	The Board received a summary, via a video, of the experiences of a deaf patient with chronic health problems, summarising her different experiences of using the Trust's services over the past year and how these experiences varied. The story highlighted the need to recognise individual patient needs and to adapt the approach to accommodate any special needs. It also highlighted the importance of staff training in supporting staff to make reasonable adjustments and improve patients' experience.
7.3	The Board noted the lessons learned from the patient story and agreed that lessons should be published on the staff intranet. Prof Sigsworth advised that such lessons are included in statutory and mandatory training, with a focus on care as well as statutory duties to recognise and make reasonable adjustments for those with protected characteristics.
7.4	The Board noted the report.
8.	**Chief executive officer's report**
8.1	Prof Orchard presented his chief executive officer's report and highlighted key points, including a summary of financial performance at month 5 and actions being taken by the executive team to address the current position and ensure achievement of the year-end forecast. It was noted that Jeremy Butler had been appointed as interim Director of transformation and would focus on transformation projects that would have an impact on in-year performance. He also summarised performance against key access standards, highlighting the impact that a recent failure of lifts in Clarence Wing had on bed capacity and therefore performance. It was noted that the Trust had received an additional £5m funding, in the form of being allowed to spend some of the sustainability provider funding (SPF) funds received at the end of 2017/18, in order to provide an additional 50 beds for winter. In addition to this, work continued to ensure that processes involved in the patient journey were as efficient and effective as possible.
8.2	Prof Orchard highlighted the launch of the Delivering our Promise initiative, with the aim of reinforcing the behaviours expected and required of all staff in living the trust values and leading to improved patient care.
8.3	The Board noted an update on developments across the North West London sector, including the Trust's response to Royal Brompton's proposed move to join King's Health Partners and the potential impact on patients in North West London.
8.4	The Board noted an update on key risks, including the management of the impact from the Paddington Square development and an update on the implementation of the e-referrals system. It was noted that the implementation of e-referrals had gone well so far, with controls in place to ensure any patient safety risk from referrals not received electronically was mitigated, and it was noted that the risk of loss of referrals through lack of capacity to book into had not materialised. It was noted that the payment element of the e-referrals system would come into force on 1 October and it was agreed that a post-project evaluation would follow in January 2019. **Action: Dr TG Teoh**
8.5	The Board considered the proposed revised regulatory undertakings, amended by NHS Improvement in recognition of the progress made by the Trust against the previous set of undertakings. The Board agreed to accept the revised undertakings, noting the progress and timescales for the development of the financial recovery plan. It was agreed that this would be presented to the Board for approval in November. **Action: Richard Alexander**

	The Trust board noted the report and approved the revised regulatory undertakings.
9	**Integrated performance report**
9.1	The Trust Board received and considered the Integrated performance report for July 2018 (months 3 and 4), noting the exceptions highlighted in the report.
9.2	SAFE and EFFECTIVE: Prof Redhead presented the Safe and Effective section of the integrated performance report, highlighting continued excellent results in the Trust's SHMI mortality data, with the Trust reporting the lowest HSMR of all specialist providers for March 2018. The Board noted the reporting of a never event in July, relating to a retained object. Prof Redhead advised that following investigation it had been concluded that this was not a never event, but would be treated as a serious incident. The Board noted that the patient had come to no harm. The Board also noted current levels of compliance with the Duty of Candour, noting an improvement in compliance levels. However an audit of duty of candour completed in Q1 2018/19 had provided limited assurance on the overall assessment of compliance. It was noted that areas of poor compliance included internal process issues, which could be rectified with agreed changes to the policy or procedure. The Board noted the improvement in compliance rate for the assessment of patients for risk of VTE since April 2018, with the Trust now showing sustained achievement of the 95% target.
9.3	CARING: Prof Sigsworth presented the Caring section of the report, highlighting an exception in Friends and Family Test (FFT) responses in A&E. The Board noted the actions being taken to increase the response rate, but also noted the pressures within the department that might impede the completion of the survey. The Board discussed the need to support the Emergency Department (ED) in achieving the required improvement, and agreed the need to consider other mechanisms to increase the response rate.
9.4	WELL-LED: The Board noted current sickness, turnover and vacancy rates, noting positive progress being made in recruitment of overseas and student nurses. The Board discussed the risks arising from a vacancy rate of 16%, noting that the risk to patient safety was managed through management action to fill shifts and rotas, however there was a financial impact from use of expensive temporary staffing. Mr Croft reported that the Trust was currently retendering the contract for bank staff provision, with the aim of increasing the size and usage of bank staff.
9.5	Prof Sigsworth provided assurance to the Board regarding the controls in place to ensure safe staffing levels, and provided an update on the implementation of the recruitment strategy and 'on-boarding' initiatives to improve retention. The Board noted that the apprenticeship scheme had not produced the expected numbers of recruits and the need to revisit that. It was also noted that the voluntary turnover rate was lower than the London average, indicating the Trust's ability to retain staff and the need to focus particularly on recruitment.
9.6	The Board also noted improved compliance with statutory and mandatory training, as a result of increased focus on compliance through management action. The Board discussed the compliance levels and in particular the appraisal rates and compliance levels for doctors. Prof Redhead reported that compliance levels were increasing but additional controls were also being applied to ensure continued improvement.
9.7	Prof Weber advised that there was a significant retention issue for the NHS in respect of

	doctors, with only 50% of medical graduates committing themselves to the NHS by the third year of training. It was noted that the Trust and Imperial College were using research and specialist training programmes to attract and retain junior doctors. It was agreed that Prof Redhead and Joanne Hackett would discuss other opportunities for the Trust from national programmes to increase the attraction and retention of medical staff. **Action: Julian Redhead**
9.8	RESPONSIVE: The Board considered the exceptions to performance in the Responsive section of the report, noting the current performance against the waiting time standard in ED. It was noted that performance remained challenging but there was an improving trajectory against the ED 4 hour waiting time standard, with the 90% standard being achieved.
9.9	The Board noted current performance in RTT, and performance against the 18 week and 52 week waiting time standard, noting that the number of patients waiting for longer than 52 weeks had increased in August due to a number of patients choosing not to be treated during August. There was a focus on reducing the number of patients waiting more than 40 weeks.
9.10	The Board noted that the level on 'on the day' (OTD) non-clinical cancelled operations remained high during the first half of 2018, with the number of cancelled operations in the first quarter ending June 2018 equating to 1.3% of total elective admissions, compared with the national average of 1.0%. The 28 day rebooking breach also remained high with 20.7% of patients were not treated within 28 days of their operation being cancelled compared with the national figure was 10.8%. The Board noted that this was due to the continued lack of bed capacity and the level of demand remaining high. The Trust board noted the integrated performance report
10	**Finance – monthly financial performance update**
10.1	The Board received and noted the summary of financial performance at the end of month 5, noting that the Trust was £2.0m behind plan in month, bringing the Trust to a £3.4m adverse variance to plan year to date.
10.2	The Board noted that it had discussed financial performance, and the actions being taken by the management team to address the risks of not achieving the year-end control total, in the private meeting held just prior to this meeting. The Trust board noted the report.
11	**CQC update, including the ward accreditation programme**
11.1	The Board received an update on the CQC inspection programme, noting the focus on the core services expecting inspections over the next 12 months and the four key workstreams.
11.2	The Board noted the Trust-level headlines from the Trust's latest CQC Insight report (July 2018), including a decline in performance in patients spending less than 4 hours in major A&E, which was much worse than other trusts, and the submission of a whistleblowing report to CQC in April 2018 meaning that the Trust had returned to being much worse than other trusts on this measure.
11.3	The Board noted that lessons were being learnt from other best practice exemplars, such as Cambridge and Bristol, and that these lessons had been shared at the last Leadership Forum.
11.4	The Board also received an update from the Ward accreditation programme (WAP)

	completed in 2017/18, comprising of annual unannounced inspections across inpatient wards, critical care areas, outpatients, recovery rooms and day case areas and resulting in ratings for each area using principles aligned to the CQC's methodology. The Board noted that 90 areas had been reviewed in 2017/18, compared to 76 in 2016/17 and 68 in 2015/16, with the number of areas awarded 'gold' increasing from 12 in 2015/16 to 31 in 2017/18, and the number of 'white' areas reducing from 27 in 2015/16 to 4 in 2017/18. It was noted that the 2018/19 WAP was currently underway and the results would be reported to the Board in March 2019. **Action: Janice Sigsworth** The Trust board received and noted the report.
12. 12.1 12.2 12.3 12.4	**Infection prevention and control report** The Board welcomed Dr Alison Holmes to the meeting to present the quarterly update report. The Board received and considered the update report, noting the highlights including no Trust-attributed MRSA BSI cases identified during the period and the level of Trust-attributed *C. difficile* cases identified during the period was within the Trust ceiling. The Board noted that all 74 inpatient wards had undergone the revised hand hygiene auditing in May, with wide variation in compliance observed. Hand hygiene champions have been identified on all 74 inpatient wards and each ward had undergone improvement activities during August and September. The Board congratulated Dr Holmes on the progress made in improving infection control, given the challenges arising from the physical condition of many areas of the Trust, and the Board acknowledged the effective us of data in the report and in driving improvement. The Trust board noted the report
13. 13.1 13.2	**Learning from deaths: update on implementation and data reporting** The Board received and considered an update on compliance with the National Quality Board framework for identifying, reporting, investigating and learning from deaths in care, including the updated 'learning from deaths dashboard' containing data for the financial year 2017/18 and Q1 2018/19. The Board noted the number of staff trained in structured judgment reviews (SJR) and the emerging themes arising from the 285 reviews completed in the past 12 months, which had been aligned with six of the Trust's safety streams. The Trust board noted the report
14. 14.1	**2018 General Medical Council national training survey results** The Board received and considered a summary of the results of the 2018 General Medical Council (GMC) National Training Survey (NTS), published in July 2018. The Board noted that the Trust results showed a significant deterioration in the results with a 56% increase in red flags and 33% less green flags, and also 132 pink flags compared to 107 in 2017. Prof Weber referenced the recent medical trainee survey, which also showed a decline in Trust results and reflected on the current training and education provision. The Board noted that work was ongoing to understand the underlying cause of the flags, and to develop action plans.

	The Trust board noted the report
15.	**Local staff engagement survey results**
15.1	The Board considered a summary of the results from the "Our Voice our Trust" local engagement survey carried out in June/July 2018, noting a response rate of 34% (3164 responses). Key headlines included a slight decline in the overall staff engagement score, from 80% to 78%; the lowest five scoring questions remained the same as the last two previous years and centred around 'senior leader visibility, communication and interest in staff opinions'; 'I have enough time to complete all of my work'; and 'poor behaviour is addressed effectively in this organisation'.
15.2	The Board noted the action in progress across the Trust to respond to the survey and noted the particular focus in 2018/9 to using the results at ward level to make improvements. The Board agreed the key areas for improvement – to improve engagement of the first line of management, recognition and addressing issues regarding diversity and to ensure staff have the ability and confidence to speak up.
15.3	The Board considered proposals for the submission of an application for the NHS Improvement Leadership for Improvement Leadership programme for all Board members. The Board noted the report and approved the submission of an application for the NHS Improvement Leadership for Improvement Leadership programme for all Board members.
16.	**Freedom to speak up – self assessment**
16.1	The Board considered the findings of a self-assessment against guidance published jointly by the national guardian's office and NHS improvement. The Board noted that the recommendation from the self-assessment was that the Trust needed to consider the vision for, and purpose of, the Speak up Guardians, in order to then agree the appropriate structure for the service, including executive leadership and reporting arrangements. Nick Ross agreed with this approach and added reflections from his meeting with the Speak Up Guardians, including concerns about the amount of time allowed to the Guardians to perform their role. Prof Orchard advised that the Guardians were committed to their roles, but that they needed support in terms of resources and time allocated. He reported that the Director of People and OD would be reviewing these issues and would consider how to strengthen the support for the Guardians. It was agreed that this review should also include benchmarking against arrangements employed by other trusts. It was agreed that the output of the review and recommendations would be shared with the Board in December. **Action: Kevin Croft** The Board noted the report and agreed the next steps.
17.	**Annual equality and Workforce Race Equality Standard (WRES) report**
17.1	The Board received and considered the annual equality report and the annual Workforce Race Equality Standard (WRES) report, outlining the key findings of the Trust's workforce equality performance in the 2017/18 equality report and WRES report, and highlighting the areas of focus for the coming year.
17.2	The Board noted that it would have a more detailed discussion on race equality as part of the December Trust Board seminar.
17.3	The Board discussed the issues arising from the report, including the ethnicity and gender of staff, by agenda for change band, and discussed the need for additional development and support for staff with protected characteristics to enable them to take career opportunities. Prof Sigsworth agreed with this, advising that feedback from the Trust's BME

	group was the same.
17.4	The Board also noted and discussed the diversity of the Board itself and discussed the opportunities in the recruitment process to increase the diversity of the Board. The Board noted the report.
18.	**Board committee reports** The Trust board noted summary the reports from the following Trust Board committees: • Finance & investment committee – 19 September 2018 • Quality Committee – 12 September 2018 • Redevelopment committee – 19 September 2018
19. 19.1	**Any other business** No other business was discussed.
20. 20.1 20.2 20.3 20.4 20.5	**Questions from the public relating to agenda items** The following responses were given to questions raised by members of the public present at the meeting: A member of the public asked whether the Trust would guarantee that GP referrals to the Trust would be respected under the new e-referrals system. Prof Teoh confirmed that the referral process remained the same, that a consultant would review any referral and could advise GPs appropriately. A member of the public asked what had happened to the art and decorative tiles in Charing Cross Hospital. Prof Orchard confirmed that the art had been moved to near the chapel at Charing Cross Hospital and would be displayed as part of the celebrations for the 200th anniversary of Charing Cross Hospital. A member of the public asked whether the Trust was intending to reduce the hours of the Urgent Care Centre. Prof Orchard advised that the Trust did not manage the urgent care centres at Hammersmith Hospital and Charing Cross, but that he had raised the Trust's concerns about any change in the opening times for both urgent care centres with commissioners, and the Trust would expect to be consulted on any proposed changes. A member of the public asked whether the Trust had identified any options for redeveloping the Trust's hospitals. Prof Orchard reported that the Trust was in discussion with NHS Improvement and other officials regarding the various options for redeveloping the Trust's ageing sites, with a view to providing the best quality care and the most effective use of public money. All options were being explored but that currently there was no evidence that the preferred option was not redeveloping the three existing hospitals.
21.	**Date of next meeting** Public Trust board: Wednesday 28 November 2018 11:00-13.00, Oak Suite, W12 Conference Centre, Hammersmith Hospital

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC
REPORT SUMMARY

Title of report: Record of items discussed at the confidential Trust board meeting on 26th September 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 28th November 2018	**Item 5, report no. 02**
Responsible Non-Executive Director: Professor Tim Orchard, Chief Executive Officer	**Author:** Peter Jenkinson, Trust company secretary

Summary:

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

September 2018

The Board received a report from the Chief Executive, including reflections from his first three months in post, in which he outlined his priorities and summarised progress against his objectives and associated risks and opportunities.

The Board considered and approved a recommendation to appoint Falck UK to provide non-emergency services to the Trust from 1 April 2019.

The Board received a confidential briefing on the current financial position at month 5, noting the risks in achieving the plan at year-end and mitigating action being taken.

The Board received an update on actions taken following the publication of the Verita report, including the completion of a review of all existing cases in the disciplinary pipeline and the introduction of pre and post investigation checklists that must be undertaken when contemplating an investigation or at the completion of an investigation. In addition, two new training sessions were now offered to managers, one for investigators and one for those who chairing a disciplinary hearing. A further update would be provided at this month's (November) public Trust Board meeting.

Recommendations:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 26 September 2018

Updated: 22 November 2018

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 July 2018 2.1	Actions arising from Patient story	a) The Board thanked Dr Buxton, noted the report and agreed that this story should be considered as an exemplar story for national learning. b) The Board agreed that it would monitor progress in End of Life Care in 12 months. November 2018 update: Oral update	Prof. Sigsworth	November 2018 July 2019
2.	26 Sept 2018 8.5	Financial recovery plan (arising from CEO report item)	The financial recovery plan would be presented to the Board for approval in November. November 2018 update: Main agenda item	Richard Alexander	November 2018
3.	26 Sept 2018 9.7	Retention of medical staff (arising from Integrated quality and performance report item)	It was agreed that Prof Redhead and Joanne Hackett would discuss other opportunities for the Trust from national programmes to increase the attraction and retention of medical staff. November 2018 update: Professor Redhead is in discussion with Genomics England and is looking at opportunities to bring Genomics into frontline medicine and ensure ICHT is at the forefront.	Julian Redhead	November 2018
4.	26 Sept 2018 16.1	Freedom to speak up – self assessment	Prof Orchard advised that the Guardians were committed to their roles, but that they needed support in terms of resources and time allocated. It was agreed that this review should also include benchmarking against arrangements employed by other trusts. It was agreed that the output of the review and recommendations would be shared with the Board in December.	Kevin Croft	January 2019
5.	25 July 2018 3.3.2	Corporate risk register and Board Assurance Framework / Risk Appetite	The Board noted that an update on the Trust's risk appetite would be presented to the next meeting. September 2018 update: Deferred to January 2019	Prof. Sigsworth	January 2019
6.	26 Sept 2018 8.4	Implementation of e-referrals (arising from CEO report item)	A post-project evaluation would follow in January 2019.	Dr TG Teoh	January 2019
7.	26 Sept 2018 11.4	Ward accreditation programme (WAP)	It was noted that the 2018/19 WAP was currently underway and the results would be reported to the Board in March 2019.	Janice Sigsworth	March 2019

Items closed at the last meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	28 Mar 2018 2.1 25 July 2018 2.2.2 26 Sept 2018 15	Staff survey results – Bullying	A detailed action plan regarding bullying to be presented to a future Board meeting. July 2018 update: The staff survey results would be presented to the Board at its October board seminar. September 2018 update: The Board noted the action in progress across the Trust to respond to the survey and noted the particular focus in 2018/9 to using the results at ward level to make improvements. The Board agreed the key areas for improvement – to improve engagement of the first line of management, recognition and addressing issues regarding diversity and to ensure staff have the ability and confidence to speak up. The Board considered proposals for the submission of an application for the NHS Improvement Leadership for Improvement Leadership programme for all Board members.	K Croft	Closed
2.	March 2018 3.2	Gender pay gap report	The Trust board approved the publication of the gender pay gap report on the Trust website, supported the data being incorporated into the annual quality and diversity report, and sought assurance that any issues identified were addressed robustly. July 2018 update: To be picked up by new Director of HR & OD September 2018 update: Included in the annual equality and workforce race equality standard report on the main agenda.	K Croft	Closed
3.	28 Mar 2018 2.1	CQC – Improvements for patients	A future Board seminar to be arranged for a focussed discussion. July 2018 update: Scheduled for 31 October 2018	J Sigsworth	Closed

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

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 28 November 2018	**Item 7, report no. 04**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Steph Harrison-White

Summary:

This month's patient story is about a patient's experience of being in our intensive care unit at St. Mary's Hospital, following a life threatening road traffic accident.

The patient (Nigel) will describe the excellent care he received and will highlight the importance of sleep and mobility in helping him to recover so quickly.

The Trust is currently working on a project that is focusing on promoting sleep and encouraging patients to be mobile. Nigel's story captures this and will be shared with staff as part of this work.

Recommendations:
The Committee is asked to note the issues raised.

This report has been discussed at: N/A

Quality impact:
Sleep and moving can lead to a positive patient experience as the patient recovers more quickly, pain is reduced and the hospital stay is reduced. This story impacts not only on the individual but also the organisation and as such is relevant to all CQC domains.

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

Risk impact and Board Assurance Framework (BAF) reference: Not applicable

Workforce impact (including training and education implications): Not applicable

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

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

What impact will this have on the wider health economy, patients and the public?
☐ Yes ☐ No ☒ Not applicable

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

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

Trust strategic objectives supported by this paper:

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):

Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

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

- What should senior managers know?
  That the Trust is currently promoting the Patient Well-being campaign to 'Help patients feel better'. The focus is on 'EAT&DRINK; SLEEP and MOVE with the overall aim of improving patient's health and ultimately reducing their length of stay in hospital. This campaign is driven by patient feedback.

- What (if anything) do you want senior managers to do?
  The campaign is being rolled out across the Trust and we are looking for wards to become part of the initial pilot.

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

- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why? To promote engagement and improve patient experience

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

This month's patient story will be presented in person by Nigel. Nigel was involved in a road traffic accident and sustained life threatening injuries. He was nursed initially in our intensive care unit at St. Mary's Hospital and he will focus on this experience in his story.

As Nigel began to improve on the unit, he will describe how starting to move and being able to sleep were an important part of his recovery. At first he struggled to sleep due environmental factors such as noise and light.

Nigel's story is not atypical and we know through patient feedback that issues such as noise at night do prevent patients from getting enough rest.

The Trust has begun work on a project to address those areas that matter to our patients in terms of their experience and ultimately the speed of their recovery. The 'Eat & Drink; Move and Sleep' campaign has started led by the patient experience and the frailty teams.

This project involves:

- reducing noise at night and promoting sleep
- promoting independence through increased mobility and wearing own clothes
- increasing food intake and promoting hydration

2. Purpose

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

The perceived benefits of patient stories are:

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

3. Background

'Deconditioning' is a term used to describe the impact that a period of hospitalisation can have on a person. This syndrome, as it is referred to, comes about after a period of

immobilisation and can be caused by a prolonged hospital stay. The impact on a person can be significant including a reduction in bone mass and muscle strength; reduced mobility; increased dependence; confusion and demotivation.

NHS England has been leading projects earlier in the year to 'end PJ paralysis'. Evidence has shown that not only do 3 out of 5 older people stay in bed unnecessarily but that walking while in hospital reduces the length of stay as well as promoting people's dignity.

Sleep and rest contribute to the overall well-being of patients and will help them to be motivated to move. Patients have told us through their feedback that sleep can be difficult whilst they are in hospital due to a number of environmental factors.

Nigel's story will highlight the importance of sleep and mobility and will describe how rest and moving have contributed to his recovery.

4. Summary/Key points

Nigel was knocked off his scooter and sustained significant chest injuries that culminated in an admission to our intensive care unit at St. Mary's Hospital and major thoracic surgery to repair his fractured ribs. Nigel spent 10 days on the intensive care unit.

Nigel will describe his memories of those initial moments and will then focus on two, what he describes as 'euphoric' moments on the intensive care unit. The first of these moments was when he began to mobilise for the first time. On the first occasion he was asked by the consultant to 'sit out' of bed. At first Nigel could not understand this request as he was still so critically unwell, it was only when he sat out did he feel the immediate benefit in terms of his breathing was much easier and his pain levels reduced.

The second 'euphoric' moment for Nigel was his first shower. He describes how standing up and walking to the shower made him feel human again and the positive psychological impact this had on him.

Another significant part of Nigel's recovery was in getting a good night's rest. He will describe how this was difficult initially due to the noise and light in the intensive care unit but that once staff had moved his bed away from the light and provided him with ear plugs and an eye mask, he was able to sleep. In Nigel's words, getting enough rest was a major factor in his recovery.

5. Conclusion and Next Steps

Sleep and moving can improve patient experience and aid patient's recovery, benefitting not only the patient but the organisation as length of stays reduces. Nigel's story highlights the impact of this on his overall health and well-being.

The Trust is currently working on a number of projects related to the Eat & Drink; Move; Rest campaign. The purpose of this campaign is to encourage and support our patients to start moving safely sooner. The frailty team are co-ordinating the

MOVE element of this work, focusing on elderly care in the first instance. This multidisciplinary approach relies on our staff working in collaboration, so that MOVE becomes the 'normal' for our patients.

The patient experience team is working with a number of wards to pilot 'sleep/ care' packs that provide patients with essentials such as eye masks and ear plugs and information on how they can prepare for sleep such as reducing caffeine drinks, ensuring they are warm. Nigel describes how he had to wait before he had an eye mask and ear plugs and that at night he sometimes felt cold. This project will try to address these issues before they become a problem for our patients.

Good nutrition not only helps with wound healing but helps reduce the risk of pressure ulcers. The MOVE project links in with the EAT & DRINK element as patients are encouraged to sit out to eat.

We will share Nigel's story as part of this campaign to reinforce to our staff the positive impact on our patients overall health and psychological well-being that moving and rest can have.

Author: Steph Harrison-White
Date; November 2018

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 28 November 2018	**Item 8, report no. 05**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

Summary:

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

1) Financial performance
2) Financial improvement programme
3) Operational performance
4) Leading change through vision, values and behaviours
5) Leadership and workforce
6) Stakeholder engagement
7) Risk management
8) Trust undertakings
9) Celebrating achievements

The report also includes draft revised undertakings, to be agreed between the Trust and NHS Improvement, for Board approval.

Recommendations:

The Trust board is asked to note this report, and to approve the revised undertakings to be agreed between the Trust and NHS Improvement.

This report has been discussed at (delete/tick as relevant): N/A

Quality impact: N/A

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

Risk impact and Board Assurance Framework (BAF) reference:

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

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

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

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

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

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

Chief Executive's Report to Trust Board

1. Financial performance

Year to date (i.e. from April 2018 to October 2018) the Trust was on plan with a £19.8m deficit. Year to date the Trust is over plan on NHS clinical income on emergency inpatient and day cases activity. There have been costs incurred to meet the additional activity in both pay and non-pay. Increased non-elective activity may cause constraints in the Trust's elective capacity, and there is work being undertaken in the Trust focusing on patient flow to help mitigate any capacity issues. Year to date there are adverse variances in clinical divisions these are driven by delays in the identification and implementation of cost improvement programmes (CIPs).

The Trust's capital position is £7.1m underspent against the capital resource limit (CRL) of £28.8m year to date. The capital plan for the year is £41.5m and the Trust is expecting to meet the plan. The programme continues to be actively managed by the Trust's Capital Expenditure Assurance Group (CEAG) and Capital Steering Group (CSG) to ensure that the Trust does not breach its plan for the year.

The cash position for the Trust is £28.6m at the end of October. The trust must maintain a cash balance of at least £3m to meet its loan conditions. There is not expectation of any further drawn down of the working capital loan in this year.

2. Financial improvement programme

The Trust set a challenging £48m cost improvement programme in 2018/19 as part of its overall financial plan, against which there is currently £42.9m of identified programmes (at various stages of planning and implementation), and further ideas being worked up.

Against the Month 7 cumulative plan of £22.3m, there has been £15.9m of CIP delivery year to date (YTD), resulting in a £6.4m adverse variance to plan. The main reasons for this have been underperformance against £2.4m of income and activity based productivity schemes, including private patients, and £2.8m of unidentified CIP plans.

The current forecast CIP delivery for the year is £36.3m, though this is against developed programmes, and does not include the further CIP opportunities that continue to be worked up. It also does not include any other mitigating actions being taken, to meet the overall Trust financial plan – still expected, which can be regarded as CIP.

The Programme Support Office continues to work with Clinical and Corporate teams to support delivery of current programmes; further progress opportunities already identified; as well as identify additional efficiencies, drawing on both internal and external expertise and resources.

3. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance in August and September 2018 (months 5 and 6).

The executive team have agreed a revised reporting process for the integrated quality and performance report to strengthen the assurance process for operational performance. Each executive committee receives sections of the scorecard / exception reports for their respective indicators only. The executive (finance) committee then reviews the whole performance report, in order to:

- To receive assurance that all exceptions have been considered by the appropriate executive committee
- To identify interdependencies between key performance indicators and resolve any conflicts in prioritisation
- To agree escalation and key messages to the Board and Board sub-committees so that performance is reported at Board in an integrated way

The Board will note from the report where performance is above target, or within tolerance, and also where performance did not meet the agreed target / threshold. In the development of the report, additional slides have been included to highlight issues and related improvement plans and actions.

Exceptions in performance are highlighted in the following key areas:

- **Never events** - Three never events have been reported in this financial year; one wrong route medication incident in May 2018, one retained swab in July 2018 and one retained foreign object incident in cardiac surgery in September 2018. Actions taken to date are included in the performance report and these actions will be monitored by the executive (quality) committee and the Board Quality Committee.

- **Referral to Treatment Waiting times** - RTT performance at the end of September reported 82.62% of patients waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%, and below the trajectory target of 85.59%. The Trust experienced an extended period of RTT Patient Tracking List (PTL) downtime in late September and early October, that impacted on scheduling patients in turn and validating the accuracy of the RTT waiting times prior to submission. A serious incident investigation is being completed, in line with the Trust's Incident Policy, and the deep dive into the impact of the incident on the RTT PTL is also ongoing.

  In September 2018 the Trust reported 46 52-week breaches for September. This was an increase of 6 from the previous month, with the breaches associated with downtime in reporting. In September 2018 the Trust reported 46 52-week breaches for September. The clinical harm review process for patients waiting over 52 weeks for treatment continues with no patients found to have come to harm during the most recent reviews. At the end of October the Trust reported 22 patients waiting over 52 weeks for treatment, a reduction of 24 compared to the previous month and above the zero trajectory target. Continued progress towards zero is expected in November.

- **Accident & Emergency** – September A&E performance was 89.0% of patients seen within the four hour standard, against the trajectory plan of 90.2%. The month began behind trajectory, however implementation of additional measures, supported by the Executive Team, led to improved performance in the latter half of the month, with the week ending 30th September achieving 90.5%. The trajectory was met in October 2018, achieving a monthly performance of 90.6%; the challenge remains in sustaining this level of performance.

- **Cancelled operations** – The Trust improved its performance in reportable non-clinical cancellations during the quarter to September 2018. 288 reportable cancellations were reported, equating to 0.9% of total elective admissions. This improved position brings the Trust cancellation rate into line with the national figure for England for the same quarter which was also 0.9%. The Trust also improved time to rebooking for the 28-day guarantee. In the quarter to September 2018, 45 breaches were reported which was a reduction of 40 on the previous quarter.

Additional capacity
As reported at the previous Board meeting, the Trust has secured £5m in capital funding to support the opening of an additional 50 inpatient beds in time for winter. The successful bid was based on an assessment of our requirements to meet anticipated demand at our busiest times and to achieve the A&E and RTT trajectories for 2018/19. The analysis demonstrated a shortfall of approximately 100 beds against the current bed base.

Through the Care Journey and Capacity Collaborative we have already made improvements to our pathways that will deliver a benefit equivalent to circa 35 extra beds and work continues to make further improvements, especially through better bed management and roll out of the SAFER 'flow bundle' – national best practice to support 'flow' throughout our care pathways and prompt discharge.

4. Leading change through vision, values and behaviours

The new programme of work, leading change through vision, values and behaviour, was launched by the chief executive at the leadership forum on Tuesday 6 November.

During the session, senior leaders from across the Trust took part in activities that have been developed to stimulate thoughts and actions about how each of us can help to achieve our vision (of 'better health,for life') and to live our values (to be kind, aspirational, expert and collaborative). The activities are also designed to generate feedback to inform organisational strategies, priorities and business plans and to describe the behaviours we want our values to generate, and those we don't.

Senior leaders are now taking these activities out into the wider organisation, running exercises as part of team meetings, events or workshops. We are also building a wider pool staff from across the organisation to help run these activities to ensure we engage and reach as many staff as possible. So far, activities have taken place or have been planned that reach just under 1.500 people. We have also begun to involve external stakeholders and patients in this work and will focus on these audiences more in the new year. We'll collate and analyse all of the feedback to share back with staff and stakeholders and to shape plans and developments for 2019/20 and beyond.

5. Leadership and workforce

Senior staff changes
Jeremy Butler has been appointed as substantive Director of Transformation and Claire Hook has been appointed as Director of Operational Performance. The recruitment of a substantive Divisional Director for Medicine and Integrated Care will be completed in December.

'New staff intranet
We have gone live with the new intranet for staff. The launch will be in phases, with the first sections and functionality to go live including:

- news
- working here (previously 'your working life')
- policies and clinical guidelines
- people and department directories
- a powerful new search

The new intranet is now accessible via mobile devices through normal Trust login and password. Areas of the old intranet that haven't moved over to the new intranet will still be available while we transition so staff still have access to everything they need. The plan is to have the new intranet as the primary intranet from January and to close down the old intranet completely by the July. The new intranet is expected to have a big impact on improving internal communications and engagement and to enable staff to work more efficiently.

Brexit – supporting EU colleagues
All EU residents currently living in the UK have until the end of June 2021 to register for "settled status", if they wish to remain. The Trust recognises the huge contribution made by EU nationals to the services provided by the Trust and is therefore supporting staff who wish to apply for "settled status"

by funding their application.

Flu Campaign – 2018/19
We are very cognisant of the extra strain that seasonal flu has on hospitals during winter months, and that vaccination is our best way of reducing this. I am therefore encouraging all staff to have the flu vaccination to help protect them, their family, patients and colleagues from the flu.

This year's staff vaccination campaign has been ongoing for the last nine weeks and, to date, 2,189 of our 8,120 (27%) frontline staff have been vaccinated. We urgently need to improve this rate of uptake over the next three weeks and have agreed a series of actions to ensure that this is achieved.

6. Stakeholder engagement

Below is a summary of some significant meetings that I have had with key stakeholders:

Strategic Lay Forum
The Trust's strategic lay forum met on Wednesday 10 October for the latest of its bi-monthly meetings.

Meeting with Councillors from Royal Borough of Kensington and Chelsea
On Tuesday 2 October, I met with Cllr Robert Freeman, Chair, and Cllr Pat Healy, Member, of the Royal Borough of Kensington and Chelsea's Adult Social Care and Health Scrutiny Committee. The main item for discussion was the future of specialist respiratory and cardiovascular services in north west London.

Meeting with Save our Hospitals Group
On Thursday 4 October, I met with Merril Hammer and Anne Drinkell from the Save our Hospitals group. The main items for discussion were: the future of Charing Cross Hospital; integrated care; electronic referrals; urgent care centre services; and, site redevelopment.

Meeting with Healthwatch Central West London
On Monday 15 October, I met with Christine Vigars (Chair) and Olivia Clymer (Chief Executive Officer) from Healthwatch Central West London. The main items for discussion were: the future of Charing Cross Hospital; integrated care; patient participation; proposal to move Royal Brompton Hospital services; Trust Quality Account; and, Winter planning.

Meeting with Cllr Heather Acton, Westminster City Council
On Wednesday 24 October, I met with Cllr Heather Acton, Westminster City Council's Cabinet Member for Adult Social Services and Public Health, when the following issues were discussed: Dudley House affordable homes for medical staff; Paddington Cube development and St Mary's Hospital redevelopment; integrated care and community services funding; CCG relations; proposal for HIV inpatient services; proposal to move Royal Brompton Hospital services; winter planning; CQC inspections; and, our Trust vision and values programme.

Meeting with Cllr Jonathan Glanz, Westminster City Council
On Tuesday 30 October, I met with Cllr Jonathan Glanz, Westminster City Council's Chair of the Family and People Services Policy and Scrutiny Committee, when the following issues were discussed: Paddington Square development and St Mary's Hospital redevelopment; mental health funding announcement; winter planning; CQC inspections; potential proposal for HIV inpatient services; proposal to move Royal Brompton Hospital services; and, our Trust vision and values programme.

Scheduled regular meeting with local MPs
On Friday 23 November, I am due to meet with our local MPs Karen Buck, Rt Hon Mark Field and Andy Slaughter.

7. Risk management

A revised risk reporting structure for the Executive Committee has been implemented since September 2018, establishing the Executive (Finance) Committee as the executive risk committee with the remit

for reviewing all key divisional risks and the corporate risk register on a monthly basis, and ensuring that other executive committees review relevant risks as appropriate. The Audit, Risk and Governance Committee will continue receiving a report providing assurance on overall risk management at the Trust, including assurance on the management of risk at divisional level.

The Executive (Finance) Committee reviewed the corporate risk register on 20 November and will report progress in the management of key risks to the next Audit, Risk and Governance Committee.

In my last report to Trust Board I highlighted two key risks – the implementation of the NHS e-Referral Service and managing the impact of the Paddington Square development.

We continue to monitor the impact of the Paddington Square development, and the impact on clinics and administrative work due to high levels of noise, dust and vibration and continue to work with the developer to mitigate the risk and minimise the impact on patient services.

The NHS e-Referral Service went live on 1 August 2018, as planned, and we have assurance that the risk has been managed effectively.

8. Trust undertakings

Following Board approval at its last meeting, NHS Improvement (NHSI) have now finalised the revised undertakings. Progress against these undertakings continue to be monitored through the monthly Performance Oversight Meetings with NHSI and are included in the integrated quality and performance report.

9. Celebrating achievements

Children's services and prostate cancer teams win awards for innovations in care
Two teams at the Trust have been recognised for their work to improve patient care, with awards from leading industry publication the Health Service Journal (HSJ). The Connecting Care for Children (CC4C) initiative won in the acute or specialist services redesign category for London and the south, while a collaboration with a number of neighbouring trusts to introduce a world-leading approach to diagnosing prostate cancer, won the award for acute sector innovation.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Bi-monthly Integrated Quality and Performance Report (at month 6)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: Wednesday 28 November 2018	**Item 9, report no. 06**
Responsible Executive Director: Catherine Urch (Divisional Director) Frances Bowen (Divisional Director) Janice Sigsworth (Director of Nursing) Julian Redhead (Medical Director) Kevin Croft (Director of People and Organisational Development) Richard Alexander (Chief Finance Officer) Tg Teoh (Divisional Director)	**Author(s):** Terence Lacey (Business Partner, Performance Support Team); Julie ODea (Head of Performance Support)

Summary:

This is the bi-monthly integrated quality and performance report which outlines the key headlines for the reporting months of August 2018 and September 2018 (months 5 and 6). It is based on the agreed indicators, goals and targets for 2018/19.

The report is presented in three main sections:

1. Summary report of key headlines
2. Indicator scorecard
3. Exception report slides

- Appendix 1 Exception report tracker
- Appendix 2 NHS Improvement undertakings

Recommendations:

The committee is asked to note the full bi-monthly integrated quality and performance report (covering months 5 and 6).

This report has been discussed at the following:

- Executive Committee (Quality) - Tuesday 30 October 2018
- Board Quality Committee - Wednesday 14 November 2018
- Executive Committee (POD) – Tuesday 13 November
- Executive Committee (Finance) – Tuesday 20 November

Quality impact:

The delivery of the full integrated quality and performance report will support the Trust to more effectively monitor delivery against internal and external targets and service deliverables. This includes the quality strategy goals and targets within which lay representatives have been engaged and consulted.

The inclusion of a monthly integrated scorecard will allow the Trust to identify variance. With the adoption of exception reporting approaches this will allow the Trust to take action to deliver improvements as necessary.

The report focusses on a comprehensive set of indicators that measure the key areas for safe, effective, caring, well-led and responsive services for patients from ward to Trust Board. All CQC

domains are impacted by the paper.

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

1) Has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
Links to risks for the full IQPR framework as follows:
- 2510 Failure to maintain key operational performance standards
- 2477 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
- 2480 There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust
- 2485 Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks
- 2539 Risk of using medical devices that are out of testing date due to lack of scheduled maintenance
- 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)
- 2490 Failure to deliver safe and effective care
- 2499 Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff
- 2540 Risk of negative impact on patient and staff safety due to failure to achieve and/ or maintain full compliance to core skills training amongst substantive staff
- 1660 Risk of delayed treatment to patients due to data quality problems (e.g. NHS Number, elective waiting times), which can also result in breach of contractual and regulatory requirements

Workforce impact (including training and education implications):
none

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

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

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

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

Trust strategic objectives supported by this paper:
Retain as appropriate:
- To achieve excellent patients experience and outcomes, delivered with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.
- To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers? N

Section 1 Summary report for month 6

The key headlines in performance for this bi-monthly reporting period (months 5-6) are provided below.

1.1 Safe

Patient safety - incidents

Degree of harm

We have reported fewer incidents that cause the most harm to patients than average so far this year when compared to the most recent data published by the National Reporting and Learning System (NRLS) in August 2018 (for the October 2017 – March 2018 period). In total we have reported five severe/major harm incidents and five extreme harm/death incidents, one of which was reported in this data period (September 2018).

The data has been updated to include a case that was reported by SCC in April that has now been upgraded following the structured judgement review (SJR) as part of our mortality review process. The SJR finding was that there was slight evidence of avoidability in a patient who had an unexpected cardiac arrest and so an SI investigation is now being undertaken. The investigation is due to complete in November when the level of harm will be confirmed and updated if required.

Incident reporting rate

The Trust's incident reporting rate for September 2018 was 47.44, placing us above the highest quartile nationally based on the latest published NRLS data (46.96). This is a positive measure of our reporting culture with work in place to encourage reporting including the pilot of 'learning from excellence' and the trial of the reporting app expected to go live in the emergency department at St Mary's in December 2018.

Never events

Three never events have been reported in this financial year; one wrong route medication incident in May 2018, one retained swab in July 2018 and one retained foreign object incident in cardiac surgery in September 2018. The investigation for the recent incident has commenced and will be concluded before the end of October 2018. Immediate actions taken are described in the report. Progress is also included with two outstanding actions from two wrong route medication never events, one reported in July 2017 and the other in July 2018.

Safety alerts

Zero patient safety alerts were closed late in September 2018 and zero were closed late in the preceding 12 months. We previously reported that a PSA from October 2018 had been reopened internally by the Trust about reducing the risk of oxygen tubing being connected to

air flowmeters. The pending actions have now been completed by the clinical technical services team and the PSA has been re-closed. Quarterly updates on PSAs are now discussed at the Quality & Safety Subgroup with input from each of the divisions to increase oversight and improve governance of the monitoring of PSA action plans.

Duty of candour

We continue to make progress with compliance with the completion of duty of candour for all appropriate incidents. This is monitored weekly at the medical director's incident panel with additional support in place to improve compliance in North West London Pathology where there are complexities with compliance. The percentage of incidents reported between September 2017 – August 2018 that have had stage 1 and stage 2 of the duty of candour process completed is 91% for SIs, 90% for internal investigations and 94% for moderate and above incidents.

Infection prevention and control

One case of MRSA BSI was assigned to the Trust in September 2018 and one case of *Clostridium difficile* was identified as a lapse in care. There have been 8 identified *C. difficile* lapses in care so far this year, compared to one this time last year. Each case is reviewed to understand the cause and identify any shared themes; so far none have been identified.

There was one case of BSI caused by CPE in September 2018 which is currently under investigation. We have seen five CPE BSI cases year to date, compared to two cases at this point in 2017/18.

We reported thirteen healthcare-associate BSIs caused by *E.coli* in September 2018. This is above trajectory. A working group is in place looking at reducing Gram-negative BSI.

VTE

We have achieved compliance rates above our target of 95% for the assessment of patients for the risk of VTE since April 2018. Compliance data in September 2018 was 96.3%.

Questions were raised at the executive committee in August 2018, regarding whether VTE assessment might be preventing positive VTE diagnosis and whether there is an association between increasing assessment and reduced complications. Data available has been reviewed by clinical analytics colleagues, however additional information is needed and not easily available in Cerner as it is recorded in non-structured notes. This continues to be investigated and progress will be reported in January 2019.

Safe staffing

We remained above target for overall safe staffing levels for registered nurses and midwives and care staff.

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	92.8%	94.8%	95.9%	98.4%
Hammersmith	96.3%	95.0%	98.6%	96.8%
Queen Charlotte's	98.3%	87.9%	95.9%	91.3%
St. Mary's	95.0%	96.4%	96.1%	98.4%
Trust wide	**94.8%**	**95.1%**	**96.5%**	**97.9%**

Vacancy rate

The vacancy rate was 13.3% reflective of 1,463 WTE vacancies. For all nursing & midwifery roles, the vacancy rate was 16.6% (872 WTE vacancies)

Safeguarding training

At end September 79% of eligible staff were compliant with level 3 safeguarding children training and the figure has plateaued. A comprehensive schedule of training in place with a large number of confirmed forward bookings and is anticipated to meet the 90% target by the end of the year. A risk will be added to the register if an expected increase is not shown in the latest report (due week beginning 12/11/18).

Fire warden training

At end September 1224 (12%) staff trained as Fire Wardens. The Executive target of 10% staff trained has now been reached.

Medical devices

There has been a continual improvement in maintenance compliance figures for medical devices. The target for High Risk has not yet been achieved (September performance was 94% against 98% target).

1.2 Effective

Mortality indicators

The Trust HSMR rate in June 2018 was 55 which is the fourth lowest of all acute non specialist providers in month. Over the last 12 months the Trust has had the lowest HSMR (67.3) for acute non-specialist trusts nationally. The most recent full year data for SHMI (Q1 17/18 to Q4 17/18) shows the Trust to be the third lowest of acute non specialist providers at 74.13.

Mortality reviews

The number of deaths reported for July 2018 has decreased from 159 to 158 due to system reporting issues which were highlighted during the quality checking process and corrected. The number of avoidable deaths has also decreased from 2 to 1 in July 2018 as a case was revised and re-graded to 'not avoidable' after being re-presented to the Mortality Review Group (MRG) at the request of MIC.

Mortality reviews continue to be completed however the data confirms that clinical teams are struggling to complete these within the trust target within a week of the death occurring. Structured judgement reviews (SJRs) are undertaken for all relevant deaths in line with national requirements and Trust policy. Eighty three completed reports have been received to date for this financial year with 5 avoidable deaths reported. 4 of these 5 cases are also subject to serious incident investigation. SJRs should be completed within 30 days, compliance with completion continues to be below target and actions are in place to support improvement. Cases are reviewed at the monthly Mortality Review Group (MRG) with a focus on any avoidable factors and learning themes.

National clinical audits

We have made progress in our divisions in the management of national audit outcome reports. The process is now more embedded with a focus now on the timeliness of the reviews (4 remain outstanding from 2017/18 and 6 from this year). We set an internal target of completing these reviews within three months of publication however this is proving challenging given the specialty and divisional governance meeting timelines. Eight national audits have been published up to the end of June 2018, all of which were relevant to the Trust and in which we participated. The internal review process has been completed for two of these audits, neither of which were identified as showing a significant risk.

Clinical trials recruitment

Good progress has also been made in improving the number of clinical trials recruiting their first patient within 70 days of a valid research application this year. NIHR-validated data for Q1 2018/19 shows 85% compliance against our target, which compares favourably with Q4 (67.6%).

PROMs

The provisional Quarterly PROMS report (April 2017- March 2018) released in August 2018 shows improvement in health gain scores for hip and knee replacement. The EQ VAS score is above national average for both procedures; EQ-5D Index is consistent with the national average score for both procedures; Oxford Hip score is consistent with the national average and there is scope for improvement for Oxford Knee score.

1.3 Caring

Friends and Family Test

The FFT % recommended (inpatients) continued to be above the 94% standard. For A&E, Outpatients and maternity the FFT % recommended was below the target however this has remained stable and is above our exception reporting threshold of 90%.

Performance remains below the target FFT response rates in A&E and there has been a decline in the submitted FFT response numbers over the course of the last few months, with SMH Emergency Department being of particular concern. A paper was presented to the Executive Quality Committee on 30 October and the challenges were noted as not unique to Imperial. A number of key actions are now being taken forward or considered in order to refocus efforts on the FFT response collection in this service. This includes the introduction of a new fixed position terminal (a kiosk) in SMH ED.

Mixed sex accommodation

The Trust reported 41 mixed-sex accommodation (MSA) breaches in September 2018. All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed.

1.4 Well-led

Workforce and people

The sickness absence rate flagged as amber (within 5% above threshold) for August and September and we will continue to monitor this during the next bi-monthly reporting period.

Consultant grade appraisal compliance is at 88.5% compliance compared to 89.02% in July. Career grade compliance is at 84.67%, from 86.98% in July. Performance had been on an upward trajectory since March, but reduced slightly in September. A letter from the Medical Director has been sent to all doctors who are overdue an appraisal.

The job planning round for 2018/19 closed in July. Final compliance was 99.5% which is the highest return rate the trust has ever recorded.

1.5 Responsive

RTT

The latest RTT submitted performance position is end September where 82.62% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%; this did not meet the trajectory target which was 85.59%.

The Trust experienced an extended period of RTT Patient Tracking List (PTL) downtime in late September and early October (20/09 to 7/10). The main impact has been on scheduling patients in turn (waiting lists are used for this purpose) and validating the accuracy of the RTT waiting times prior to submission. A serious incident investigation is being completed, in line with the Trust's Incident Policy, and the deep dive into the impact of the incident on the RTT PTL is also ongoing.

In September 2018 the Trust reported 46 52-week breaches for September. This was an increase of 6 from the previous month and the breaches were associated with downtime in reporting. In September 2018 the Trust reported 46 52-week breaches for September. This was an increase of 6 from the previous month and the breaches were associated with downtime in reporting.

The clinical harm review process for patients waiting over 52 weeks for treatment continues with no patients found to have come to harm during the most recent reviews.

Cancer 62-day waiting times

The Trust recovered performance against the 62 day GP referral to first treatment standard in August, reporting performance of 85.4% against the 85% target and 85.8% in September.

Critical care admissions

The indicator measuring critical care admissions is newly included in the scorecard and exception report. The national standard is that 100% of admissions of critically unwell patients should be admitted within 4 hours. In September 2018, 93.1% of patients admitted to critical care were admitted within 4 hours of their referral for all units combined.

The proposed actions and improvements are summarised in the exception report; interdependencies with the Trust's on-going Trust capacity and flow work and the EMSA are highlighted.

Cancelled operations

The Trust improved performance for reportable non-clinical cancellations during the quarter to September 2018. 288 reportable cancellations were reported, equating to 0.9% of total elective admissions. This improved position brings the Trust cancellation rate into line with the national figure for England for the same quarter which was also 0.9%.

The Trust also improved time to rebooking for the 28-day guarantee. In the quarter to September 2018, 45 breaches were reported which was a reduction of 40 on the previous quarter. However the breach rate remained above the national average for England of 8%.

Accident & Emergency

The September A&E performance was 89.0% of patients seen within the four hour standard against the trajectory plan of 90.2%. The month began behind trajectory, after taking additional measures supported by the Executive Team performance improved significantly in the latter half of the month, with the week ending 30th September achieving 90.5%. It is predicted that the trajectory will be met in October 2018.

There were seven 12-hour breaches in September 2018 all of which were mental health related and on the SMH site (two were out of London repatriations).

Diagnostics

Diagnostic test waiting times continued to meet the national standard. In September the Trust reported 0.75% of patients waiting more than 6 weeks for a diagnostic test, below the tolerance of 1%.

Outpatient DNA

The overall DNA rate was 10.8% in September 2018. In the 6 months to September 2018 the DNA rate was 10.7% compared to the 6 months to September 2017 of 11.8%; showing an improvement to the Trust position. The target for outpatient DNA was reduced from 11% for 2017/18 to 10% for 2018/19. The overall DNA rate appears to have plateaued and analysis to inform the next steps for targeted intervention is progressing.

Data quality indicators (DQIs)

Three priority DQIs are reported through the trust scorecard (OP appointments not checked-in; Op appointments not checked-out; and Patients on the Add/Set Encounter request list >2 working day).

The numbers of appointments/orders waiting to be cleared has increased and exception reporting has therefore been established with input from the waiting times data quality group which is represented by each of the clinical divisions.

Over 80% of outpatient appointments not being checked-in or checked-out on our system are from decentralised areas; there will be increased focus on driving improvement across top 3 specialties with highest volume of appointments unresolved.

Complaints

Complaints and PALS concerns were within the threshold for September 2018.

Section 2: Indicator scorecard for Month 6

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 6

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	M 6 Report	Reported performance at: Jun-18	Jul-18	Aug-18	Sep-18

Key: E = Exception report available for Month 6

Safe

Patient safety - incident reporting	Serious incidents	number	-	Sep-18	Julian Redhead	ExQu		11	9	2	**17**
	All Incidents (cumulative financial YTD)	number	-	Sep-18	Julian Redhead	ExQu		4,338	5,867	7,233	**8,596**
	Incidents causing severe/major harm	number	-	Sep-18	Julian Redhead	ExQu		1	0	1	**1**
	Incidents causing severe/major harm (cumulative financial YTD)*	number	<14	Sep-18	Julian Redhead	ExQu		3	3	4	**5**
	Incidents causing severe/major harm (cumulative financial YTD)**	%	<0.28%	Sep-18	Julian Redhead	ExQu		0.07%	0.05%	0.06%	**0.06%**
	Incidents causing extreme harm/death	number	-	Sep-18	Julian Redhead	ExQu		0	1	0	**0**
	Incidents causing extreme harm/death (cumulative financial YTD)*	number	<13	Sep-18	Julian Redhead	ExQu		4	5	5	**5**
	Incidents causing extreme harm/death (cumulative financial YTD)**	%	<0.11%	Sep-18	Julian Redhead	ExQu		0.09%	0.09%	0.07%	**0.06%**
	Patient safety incident reporting rate (against top quartile of trusts)	incidents / 1,000 bed day	>=46.96	Sep-18	Julian Redhead	ExQu	E	50.05	53.22	47.55	**47.44**
	Never events	number	0	Sep-18	Julian Redhead	ExQu	E	0	1	0	**1**
	PSAs overdue (by month)	number	0	Sep-18	Julian Redhead	ExQu		0	0	0	**0**
	PSAs closed late in the preceding 12 months	number	0	Sep-18	Julian Redhead	ExQu		0	0	0	**0**
	MDAs overdue (by month)	number	0	Sep-18	Janice Sigsworth	ExQu		1	0	0	**0**
	MDAs closed late in the preceding 12 months	number	0	Sep-18	Janice Sigsworth	ExQu		12	14	15	**15**
	Compliance with duty of candour (SIs)	%	100%	Aug-18	Julian Redhead	ExQu		77.8%	77.8%	75.0%	**100.0%**
	Compliance with duty of candour (SIs) (rolling 12 month)	%	100%	Aug-18	Julian Redhead	ExQu		94.0%	92.0%	92.0%	**91.1%**
	Compliance with duty of candour (Level 1)	%	100%	Aug-18	Julian Redhead	ExQu	E	100.0%	75.0%	80.0%	**75.0%**
	Compliance with duty of candour (Level 1) (rolling 12 month)	%	100%	Aug-18	Julian Redhead	ExQu		90.0%	91.0%	89.4%	**89.8%**
	Compliance with duty of candour (Moderate)	%	100%	Aug-18	Julian Redhead	ExQu		100.0%	87.5%	87.5%	**100.0%**
	Compliance with duty of candour (Moderate) (rolling 12 month)	%	100%	Aug-18	Julian Redhead	ExQu		92.0%	91.0%	88.9%	**93.6%**

**Total Incidents for 17/18*

*** NRLS Apr17 -Sep17*

Infection prevention and control	Trust-attributed MRSA BSI	number	0	Sep-18	Julian Redhead	ExQu		0	1	0	**1**
	Trust-attributed MRSA BSI (cumulative financial YTD)	number	0	Sep-18	Julian Redhead	ExQu		0	1	1	**2**
	Trust-attributed Clostridium difficile	number	5	Sep-18	Julian Redhead	ExQu	E	4	8	2	**2**
	Trust-attributed Clostridium difficile (cumulative financial YTD)	number	33	Sep-18	Julian Redhead	ExQu		18	26	28	**30**
	Trust-attributed Clostridium difficile (related to lapses in care)	number	0	Sep-18	Julian Redhead	ExQu		2	2	0	**1**
	Trust-attributed Clostridium difficile (related to lapses in care) (cumulative)	number	0	Sep-18	Julian Redhead	ExQu		5	7	7	**8**
	E. coli BSI	number	5	Sep-18	Julian Redhead	ExQu	E	8	7	8	**13**
	E. coli BSI (cumulative financial YTD)	number	33	Sep-18	Julian Redhead	ExQu		21	28	36	**49**
	CPE BSI	number	0	Sep-18	Julian Redhead	ExQu	E	0	1	0	**1**
	CPE BSI (cumulative financial YTD)	number	0	Sep-18	Julian Redhead	ExQu		3	4	4	**5**

Section 2: Indicator scorecard for Month 6

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 6

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	M 6 Report	Reported performance at: Jun-18	Jul-18	Aug-18	Sep-18
							Key: E = Exception report available for Month 6				
Medicines Management	Fridge temperature (fridges containing medicines in clinical areas)	%	>=95%	Sep-18	Julian Redhead	ExQU					
	Controlled drugs checks	%	100%	Sep-18	Julian Redhead	ExQU					
VTE	VTE risk assessment	%	>=95%	Sep-18	Julian Redhead	ExQU		96.6%	96.6%	96.3%	**96.3%**
Sepsis	Sepsis - Antibiotics	%	>=90%	Sep-18	Julian Redhead	ExQU					
Maternity standards	Ratio of births to midwifery staff	ratio	1:30	Sep-18	Tg Teoh	ExQU		1.30	1.30	1.26	**1.26**
	Puerperal sepsis	%	<=1.5%	Sep-18	Tg Teoh	ExQU		0.60%	0.30%	0.40%	**1.00%**
Safe staffing	Safe staffing - registered nurses	%	>=90%	Sep-18	Janice Sigsworth	ExQU		96.9%	96.2%	96.1%	**95.6%**
	Safe staffing - care staff	%	>=85%	Sep-18	Janice Sigsworth	ExQU		96.9%	97.1%	95.9%	**96.3%**
Workforce and people	Core skills training	%	>=85%	Sep-18	Kevin Croft	ExQU		88.5%	89.2%	89.2%	**89.5%**
	Core clinical skills training	%	>=85%	Sep-18	Kevin Croft	ExQU		87.1%	88.1%	88.6%	**89.2%**
	Safeguarding children training (level 3)	%	>=90%	Sep-18	Janice Sigsworth	ExQU	E	79.3%	81.0%	79.9%	**79.3%**
	Vacancy rate - Trust	%	<10%	Sep-18	Kevin Croft	ExPOD	E	13.6%	13.2%	13.5%	**13.3%**
	Vacancy rate - nursing and midwifery	%	<13%	Sep-18	Kevin Croft	ExPOD		15.7%	15.9%	16.5%	**16.6%**
Health and safety	Departmental safety coordinators	%	>=75%	Sep-18	Kevin Croft	ExQU	E	57.2%	58.6%	61.6%	**71.5%**
	RIDDOR	number	0	Sep-18	Kevin Croft	ExQU		5	6	4	**6**
	Fire warden training	%	>=10%	Sep-18	Janice Sigsworth	ExQU	E	9.8%	10.1%	11.0%	**12.0%**
	Medical devices maintenance - high risk	%	>=98%	Sep-18	Janice Sigsworth	ExQU	E	89.0%	91.0%	94.0%	**94.0%**
	Medical devices maintenance - medium risk	%	>=80%	Sep-18	Janice Sigsworth	ExQU		79.0%	86.0%	86.0%	**96.0%**
	Medical devices maintenance - low risk	%	>=70%	Sep-18	Janice Sigsworth	ExQU		84.0%	89.0%	88.0%	**88.0%**
Estates and Facilities	Cleanliness audit scores (very high risk patient areas)	%	>=98%	Sep-18	Janice Sigsworth	ExQU					
	Cleanliness audit scores (high risk patient areas)	%	>=95%	Sep-18	Janice Sigsworth	ExQU					
	Lifts in service (main passenger and bed lifts)	%	>=90%	Sep-18	Janice Sigsworth	ExQU		-	-	94.0%	**96.0%**
	Reactive maintenance tasks completed within the allocated timeframe	%	>=70%	Sep-18	Janice Sigsworth	ExQU		-	-	36.9%	**44.7%**
	Planned maintenance tasks are completed within the allocated timeframe	%	>=70%	Sep-18	Janice Sigsworth	ExQU		-	-	72.0%	**61.0%**
	Compliance with statutory and mandatory estates requirements	%	>=85%	Sep-18	Janice Sigsworth	ExQU		-	-	89.0%	**98.8%**

Section 2: Indicator scorecard for Month 6

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 6

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	M 6 Report	Reported performance at: Jun-18	Jul-18	Aug-18	Sep-18

Key: E = Exception report available for Month 6

Effective

Mortality indicators	Trust ranking as per monthly data (HSMR)	rank	top 5 lowest risk acute Trusts	Jun-18	Julian Redhead	ExQU		1st	4th	2nd	**4th**
	HSMR	ratio		Jun-18	Julian Redhead	ExQU		60.00	66.00	52.00	**55.00**
	Trust ranking as per most recent full year data (SHMI)	rank		Q1 17/18–Q4 17/18	Julian Redhead	ExQU		3rd	3rd	3rd	**3rd**
	SHMI	ratio		Qtr 4 17/18	Julian Redhead	ExQU		66.10	70.10	73.18	**78.62**
	Palliative care coding	%	100%	Jun-18	Julian Redhead	ExQU		100.0%	100.0%	100.0%	**100.0%**
Mortality reviews *(at 04/10/2018)*	Total number of deaths	number	n/a	Aug-18	Julian Redhead	ExQU	E	136	122	158	**118**
	Number of local reviews completed	number	n/a	Aug-18	Julian Redhead	ExQU		133	111	143	**91**
	Local reviews completed	%	100%	Aug-18	Julian Redhead	ExQU		97.8%	91.0%	90.5%	**77.1%**
	SJR reviews requested	number	n/a	Aug-18	Julian Redhead	ExQU		29	22	22	**15**
	Number of SJR reviews completed	number	n/a	Aug-18	Julian Redhead	ExQU		26	17	14	**7**
	SJR reviews completed	%	100%	Aug-18	Julian Redhead	ExQU		89.7%	77.3%	63.6%	**46.7%**
	Avoidable deaths	number	0	Aug-18	Julian Redhead	ExQU		1	1	1	**0**
	Avoidable deaths (cumulative financial YTD)	number	0	Aug-18	Julian Redhead	ExQU		3	4	5	**5**
Readmissions	Unplanned readmission rates - under 15 yr olds	%	<9.33%	Mar-18	Tg Teoh	ExQU		5.6%	5.3%	5.5%	**5.0%**
	Unplanned readmission rates - over 15 yr olds	%	<8.09%	Mar-18	Frances Bowen	ExQU		7.2%	6.3%	6.3%	**6.5%**
Patient reported outcomes	PROMs - participation rates (Hips)	%	>=80%	Aug-18	Julian Redhead	ExQU	E	0.0%	100.0%	100.0%	**100.0%**
	PROMs - reported health gain (Hips)***	-	>national avg	April17–Mar18	Julian Redhead	ExQU		EQ-5D Index:**0.457**	EQVAS:**22.897**	Oxford Hip score:**22.628**	
	PROMs - participation rates (Knees)	%	>=80%	Aug-18	Julian Redhead	ExQU		0.0%	100.0%	100.0%	**100.0%**
	PROMs - reported health gain (Knees)***	-	>national avg	April17–Mar18	Julian Redhead	ExQU		EQ-5D Index:**0.398**	EQVAS:**11.325**	Oxford Knee score:**14.230**	

****Reported Bi-Annually***

17/18 Year End Position

National Clinical Audits	Participation in relevant national clinical audits (cumulative financial YTD)	%	100%	Jun-18	Julian Redhead	ExQU	E	94.0%	100.0%	100.0%	100.0%
	High risk/significant risk audits with action plan in place (cumulative financial YTD)	%	100%	Jun-18	Julian Redhead	ExQU		100.0%	100.0%	100.0%	100.0%
	Review process not completed within 90 days	number	0	Jun-18	Julian Redhead	ExQU		29	3	4	6

								Qtr 4 17/18	**Qtr 1 18/19**
Clinical trials	Clinical trials - recruitment of 1st patient within 70 days (%)	%	>=90%	Qtr 1 18/19	Julian Redhead	ExQU	E	67.6%	85.1%

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Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	M 6 Report	Reported performance at: Jun-18	Jul-18	Aug-18	Sep-18

Key: E = Exception report available for Month 6

Caring

Friends and Family	FFT A&E service - % recommended	%	>=94%	Sep-18	Janice Sigsworth	ExQU		93.2%	93.9%	93.8%	**93.9%**
	FFT inpatients - % recommended	%	>=94%	Sep-18	Janice Sigsworth	ExQU		97.1%	97.5%	97.7%	**97.2%**
	FFT outpatients - % recommended	%	>=94%	Sep-18	Janice Sigsworth	ExQU		92.1%	92.9%	92.8%	**92.1%**
	FFT maternity - % recommended	%	>=94%	Sep-18	Janice Sigsworth	ExQU		94.1%	92.4%	95.7%	**93.1%**
	FFT A&E service - % response rate	%	>=20%	Sep-18	Janice Sigsworth	ExQU	E	13.2%	15.0%	13.2%	**10.8%**
	FFT PTS service - % recommended	%	>=90%	Sep-18	Janice Sigsworth	ExQU		91.9%	93.4%	90.4%	**92.7%**
Mixed sex accommodation	Mixed-sex accommodation (EMSA) breaches	number	0	Sep-18	Catherine Urch	ExQU	E	47	46	47	**41**

Well led

Workforce and people	Staff retention (Stability)	%	>=80%	Sep-18	Kevin Croft	ExPOD		85.4%	86.1%	85.5%	**86.0%**
	Voluntary staff turnover rate (12-month rolling)	%	<12%	Sep-18	Kevin Croft	ExPOD		11.9%	12.0%	11.5%	**11.5%**
	Sickness absence rate (12-month rolling)	%	<=3%	Sep-18	Kevin Croft	ExPOD		3.01%	3.02%	3.05%	**3.06%**
	Personal development reviews	%	>=95%	Sep-18	Kevin Croft	ExPOD	E	39.3%	87.3%	89.6%	**-**
	Doctor appraisal rate	%	>=95%	Sep-18	Julian Redhead	ExQU	E	87.4%	88.2%	87.8%	**87.5%**
	Consultant job planning completion rate	%	>=95%	Sep-18	Julian Redhead	ExQU	E	94.5%	94.5%	94.5%	**99.5%**
NHSI segmentation	NHSI - provider segmentation	number	-	Sep-18	Richard Alexander	ExOp		3	3	3	**3**

Section 2: Indicator scorecard for Month 6

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 6

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	ExCo	M 6 Report	Reported performance at: Jun-18	Jul-18	Aug-18	Sep-18
							Key: E = Exception report available for Month 6				
Responsive											
Referral to treatment (elective care) 10%	RTT incomplete pathways 18 weeks performance	%	>=92%	Sep-18	Catherine Urch	ExOp	E	84.8%	85.0%	83.4%	**82.6%**
	RTT variance against 2018/19 trajectory target	%	85.6%	Sep-18	Catherine Urch	ExOp		*0.4%*	*0.2%*	*-1.8%*	***-2.97%***
	RTT total waiting list (incomplete PTL)	number	n/a	Sep-18	Catherine Urch	ExOp		**66,726**	**67,187**	**65,718**	**64,342**
	RTT incomplete pathways over 18 weeks	number	n/a	Sep-18	Catherine Urch	ExOp		10,117	10,048	10,880	11,178
	RTT patients waiting 52+ weeks****	number	0	Sep-18	Catherine Urch	ExOp	E	101	34	40	**46**
	RTT patients waiting 52+ weeks reviewed for clinical harm	%	100%	Sep-18	Catherine Urch	ExOp		100.0%	100.0%	100.0%	100.0%
	RTT cases of clinical harm found after the clinical harm review	number	0	Sep-18	Catherine Urch	ExOp		0	0	0	**0**
	*****Breaches are allocated to the last specialty seen on their pathway. Some patients have subsequently been referred on and are awaiting treatment under another speciality.*										
Cancer waiting times 0%	Cancer - 62 day urgent GP referral to treatment	%	>=85%	Sep-18	Catherine Urch	ExOp		80.6%	71.1%	85.4%	**85.8%**
Theatre utilisation	Theatre Touchtime Utilisation	%	>=95%	Sep-18	Catherine Urch	ExOp		-	**80.5%**	**79.1%**	**80.6%**
Cancelled operations	Cancelled operations*****	%	0.90%	Sep-18	Catherine Urch	ExOp	E	0.9%	1.1%	0.8%	**0.8%**
	28 day rebooking breach rate	%	8%	Sep-18	Catherine Urch	ExOp		18.9%	11.9%	18.6%	**17.9%**
	****** Cancelled ops target based on England national average for Quarter to Sep-18*										
Urgent and Emergency Care 1%	A&E patients seen within 4 hours (all types)	%	>=95%	Sep-18	Frances Bowen	ExOp		87.4%	88.4%	89.0%	**89.0%**
	A&E variance against 2018/19 trajectory target	%	90.2%	Sep-18	Frances Bowen	ExOp		*1.3%*	*0.5%*	*0.1%*	***-1.2%***
	A&E patients seen within 4 hours (type 1)	%	>=95%	Sep-18	Frances Bowen	ExOp		70.4%	73.0%	73.6%	**73.8%**
	A&E patients spending >12 hours from Decision to Admit	number	0	Sep-18	Frances Bowen	ExOp	E	4	4	4	**7**
Bed management	Patients with length of stay over 7 days	%	tbc	Sep-18	Frances Bowen	ExOp		32.9%	40.3%	33.6%	**33.6%**
	Patients with length of stay over 21 days	%	50% from baseline	Sep-18	Frances Bowen	ExOp		8.8%	12.4%	10.4%	**10.5%**
	Delayed transfer of care	%	3.50%	Sep-18	Frances Bowen	ExOp		3.0%	3.3%	2.6%	**2.7%**
	Discharges before noon	%	>=33%	Sep-18	Frances Bowen	ExOp		13.40%	13.96%	13.80%	12.65%
Diagnostics 13%	Diagnostic waits – over 6 weeks	%	<1%	Sep-18	Tg Teoh	ExOp		0.9%	0.7%	0.97%	**0.7%**

Key: Data reliability score

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

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

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							Key: E = Exception report available for Month 6				
Outpatient management	Waiting times for first outpatient appointment	weeks	<8	Sep-18	Tg Teoh	ExOp		7.2	7.4	7.2	**7.9**
	Outpatient DNA	%	<10%	Sep-18	Tg Teoh	ExOp	E	10.5%	10.7%	11.0%	**10.8%**
	Outpatient HICS rate with less than 6 weeks' notice	%	<7.5%	Sep-18	Tg Teoh	ExOp		8.2%	8.3%	8.2%	**7.8%**
	Outpatient appointments within 5 working days of receipt	%	>=95%	Sep-18	Tg Teoh	ExOp		89.7%	97.4%	96.2%	**97.2%**
Complaints management	PALS concerns	number	<250	Sep-18	Janice Sigsworth	ExOp		293	269	240	**199**
	Complaints - formal complaints	number	<90	Sep-18	Janice Sigsworth	ExOp		94	82	83	**67**
	Complaints – the average number of days to respond	days	40	Sep-18	Janice Sigsworth	ExOp		**31**	30	37	**31**
	Patient satisfaction with overall handling of complaints		>=70%	Sep-18	Janice Sigsworth	ExOp					
Data quality indicators	[ERAP42B] Orders waiting on the Add/Set Encounter request list (over 2 working days)	number	881	Sep-18	Catherine Urch	ExOp	E	1,233	1,544	1,425	**1,736**
	[OPCL78B01] OP appointments 'not checked-in' or DNA'd (app within last 90 days)	number	1,329	Sep-18	Tg Teoh	ExOp	E	2,024	1,996	2,062	**2,377**
	[OPCL83B01] OP appointments 'not checked out' (app within the last 90 days)	number	1,033	Sep-18	Tg Teoh	ExOp	E	1,165	1,343	1,387	**1,819**
Patient Transport	All Journeys: Collection Time (60 Mins)	%	>97%	Sep-18	Janice Sigsworth	ExOp		93.3%	91.3%	94.0%	**94.7%**
	All Journeys: Collection Time (150 Mins)	%	100%	Sep-18	Janice Sigsworth	ExOp		99.5%	97.6%	99.5%	**99.6%**
	Journeys 0-5 Miles: Time On Vehicle (60 Mins)	%	>95%	Sep-18	Janice Sigsworth	ExOp		93.1%	93.8%	93.9%	**92.9%**
	Journeys 5-10 Miles: Time On Vehicle (60 Mins)	%	>85%	Sep-18	Janice Sigsworth	ExOp		77.6%	78.8%	80.3%	**78.1%**
Critical Care	Critical care patients admitted within 4 hours	%	100%	Sep-18	Catherine Urch	ExOp		94.3%	93.4%	93.0%	**93.1%**

Use of Resources

Finance KPIs	Monthly finance score (1-4)	number	-	Sep-18	Richard Alexander	ExFin		3	3	3	**3**
	In month Position	£m	-	Sep-18	Richard Alexander	ExFin		3.59	-1.32	-1.67	**3.21**
	YTD Position £m	£m	-	Sep-18	Richard Alexander	ExFin		0.37	2.37	3.43	**2.04**
	Annual forecast variance to plan	£m	-	Sep-18	Richard Alexander	ExFin		-1.37	-3.57	-7.10	**-6.13**
	Agency staffing	%	-	Sep-18	Richard Alexander	ExFin		3.9%	3.9%	4.1%	**4.1%**
	CIP (cumulative financial YTD)	%	-	Sep-18	Richard Alexander	ExFin		74.0%	69.9%	77.8%	**75.8%**

Additional metrics on Use of Resources are being developed for reporting

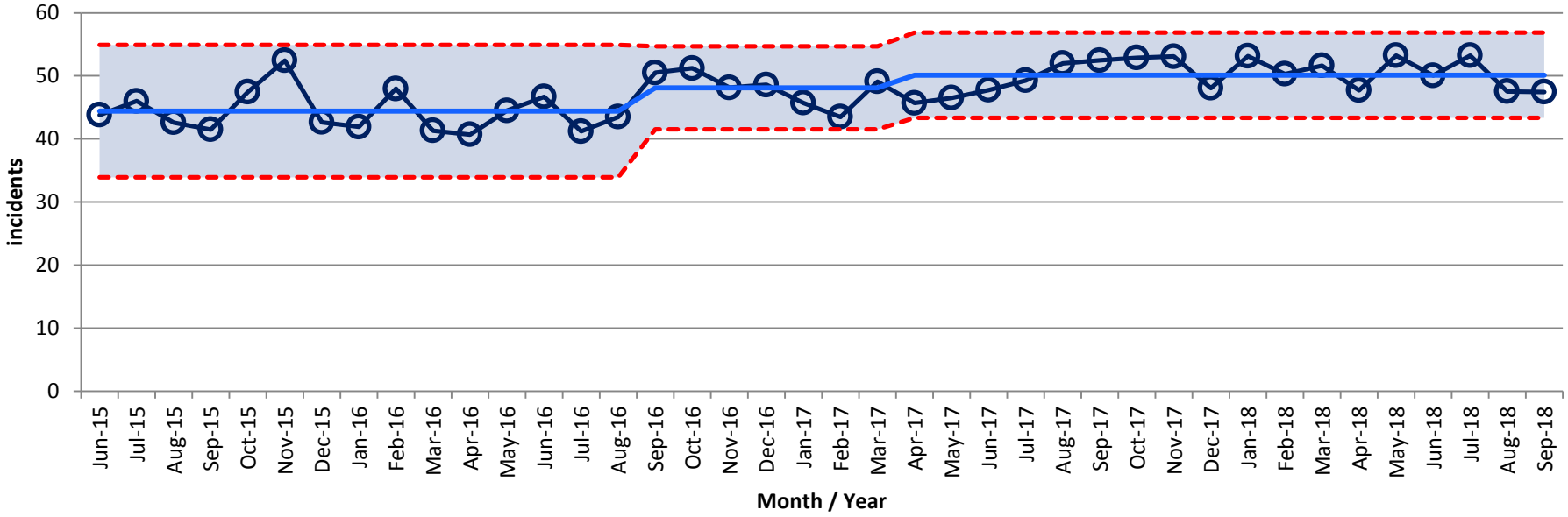
Section 3 Exception report slides summary for months 5-6

Domain	Report	Executive committee
Safe	Patient safety incident reporting	ExQu
Safe	Never events	ExQu
Safe	Compliance with duty of candour	ExQu
Safe	MRSA BSI and C.difficile	ExQu
Safe	E.coli	ExQu
Safe	CPE	ExQu
Safe	Departmental safety coordinators	ExQu
Safe	Fire warden training	ExQu
Safe	Safeguarding training	ExQu
Safe	Vacancy rates	ExPOD
Safe	Medical devices maintenance	ExQu
Effective	National Clinical Audits	ExQu
Effective	Mortality reviews	ExQu
Effective	PROMs	ExQu
Effective	Clinical Trials Recruitment	ExQu
Caring	FFT A&E service - % response	ExQu
Caring	Mixed sex accommodation	ExQu
Well led	Doctor appraisal rate	ExQu
Well led	Consultant job planning completion rate	ExQu

Domain	Report	Executive committee
Responsive	RTT 18 weeks	ExOp
Responsive	52 week waits	ExOp
Responsive	Critical care admissions	ExOp
Responsive	Cancelled operations	ExOp
Responsive	12-hour trolley waits	ExOp
Responsive	Outpatient DNA	ExOp
Responsive	Data Quality Indicator: (Outpatients not checked in / not checked out)	ExOp
Responsive	Data Quality Indicator: (orders for diagnostic and surgical procedures waiting to be processed)	ExOp

Safe – Patient safety incident reporting

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain our incident reporting numbers and be within the top quartile of trusts	In top quartile (46.96)	47.55 – August 2018 47.44 – September 2018	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

Our incident reporting rate in September was 47.44. This puts the Trust in the top quartile according to data published by the National Reporting and Learning System (NRLS) for the October 2017 – March 2018 period.

National bed day data is released 6 months in arrears. Therefore we use the previously known data as a proxy until new data is available. Last month we reported that our August reporting rate was 46.95 which placed us just outside the highest quartile nationally. However, the national top quartile rate has since reduced to 46.96 and so we are again within this target. This means that the Trust has now met the target to be in the top 25% of reporters for every month since the start of the financial year.

Safe – Patient safety incident reporting

Key issues	A high reporting rate with low levels of harm is one indicator of a positive safety culture and is one of the key focus areas for the safety culture improvement programme launched in July 2016. Actions being taken to further improve our incident reporting rate are outlined below.

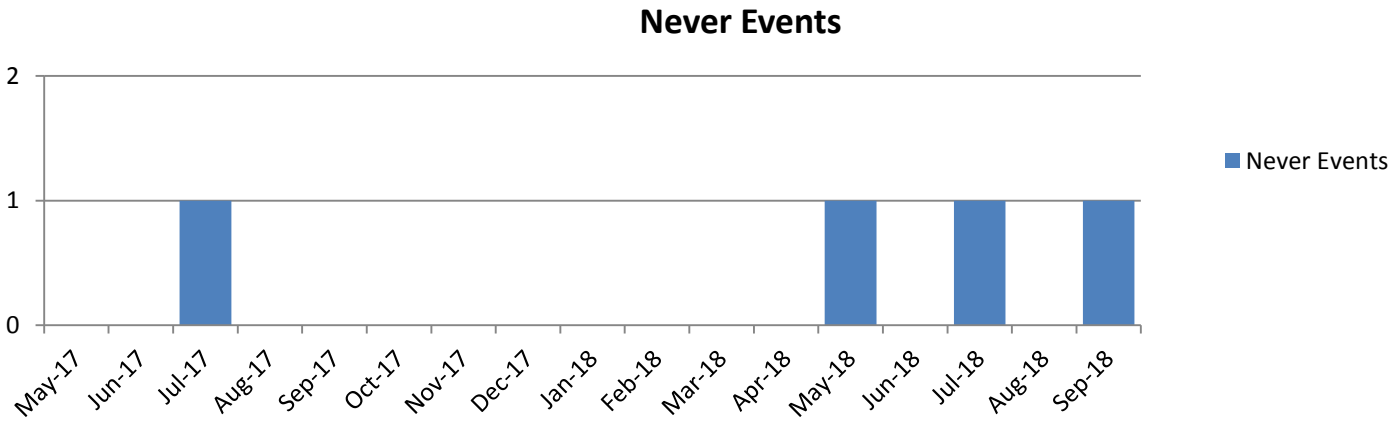
Improvement plans and actions (taken and proposed)1	Lead	Timescales	Progress update
'Safety shorts' to be developed as an outcome of the 'trigger list' pilot	Improvement Programme Manager, Safety	Ongoing	'Trigger lists' have been piloted in 8 wards since October 2017, highlighting the value of discussions with staff about incident reporting generally on their understanding of safety culture. This has prompted a piece of work to scope out 'safety shorts' which can be delivered to staff in their workplace. The Freedom to Speak up Guardians have expressed an interest in co-designing the first safety short, with support from the improvement team, and a meeting is being scheduled for the end of October.
Introduction of anonymous incident reporting in response to feedback from staff	Head of Quality Compliance and Assurance	March 2018	Complete. The ability to report incidents anonymously was introduced in the Trust on 1st March 2018. Since 1st March 2018 132 anonymous incidents have been reported.
Learning from excellence communications and roll out	Improvement Lead	November 2018	The communications plan for learning from excellence is being finalised to support the Trust wide roll out in November 2018. Areas in the pilot are already reviewing and sharing their reported events locally. The plan for data analysis and triangulation will be included in next months report.
Pilot of Care Report	Head of Quality Compliance and Assurance	December 2018	The technical specification for CareReport has now been agreed, and the full pilot plan will be agreed with the Trust and PSTRC in the coming weeks, with the pilot due to commence in December 2018.

Risk

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

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	August 2018 – 0 September 2018 – 1 (YTD – 3)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	A never event was declared in cardiac surgery in September 2018 which was a 'retained foreign object'. A cannula was unintentionally retained in a patient's chest cavity following a coronary artery bypass graft. Although all counts were completed and documented as correct during theatre, the cannula is not part of a set and should have been recorded as an 'extra'. The investigation has commenced and the final report is scheduled to go to panel the week commencing 5th November 2018. Immediate actions taken to mitigate further occurrence include reiteration of the Trust policy on counting all extras used during a procedure in the theatre setting through a Trust wide cascade of a never event alert. The Trust has also reconvened a group, chaired by the Medical Director, to review safety with interventional procedures in response to this year's never events and a number of near misses. Three never events have been reported so far in 2018/19; one wrong route medication incident in May 2018, one retained swab in July 2018 and the retained foreign object incident detailed above.

Safe – Never Events

Key issues	Actions remain outstanding for two wrong route medication never events, one reported in July 2017 and the other in July 2018. Progress is shown below.

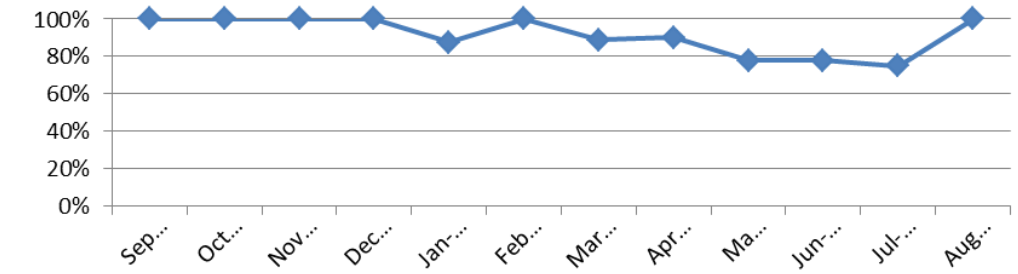
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of a standardised product that will prevent epidural lines from being connected to the inappropriate access device e.g. a peripheral cannula	Division of SCC	ASAP	A full suite of NRFit connectors are still not available from our suppliers and as an interim measure yellow stickers which state “epidural” have been placed on the epidural line near to the port connection to highlight the route in all clinical areas. In August 2018 an audit led by the pain service collected compliance data for a number of areas including storage, labelling, equipment and staff training. The report highlighted that only 50% of cases audited complied with the NPSA guidance for the epidural line to be labelled , and only 17% complied with our internal Trust guideline for labelling lines and giving sets. A number of immediate actions were agreed including escalation of the request for Cerner to add label checking to the epidural observation chart and changes to storage which are now compliant. A second audit is currently underway and results will be available in November 2018.
Update the current enteral feeding policy following oral and enteral medication audit	Chief Pharmacist	November 2018	A full oral and enteral medication audit was completed in July 2018 and divisional action plans were presented to the quality & safety subgroup in September. The Trust’s Chief Pharmacist is now leading on an update of the current enteral feeding policy to include the availability of 3 way taps as ENFit connectors. This is due to be presented for approval at subgroup in November.

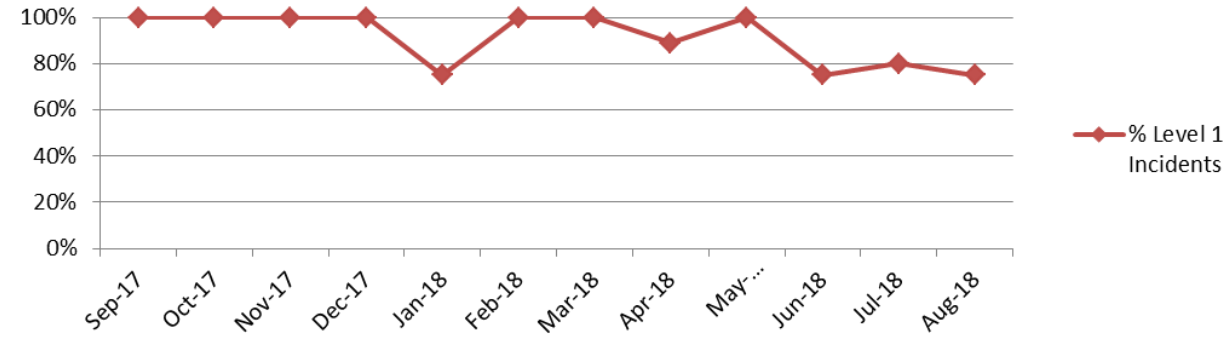
Risk

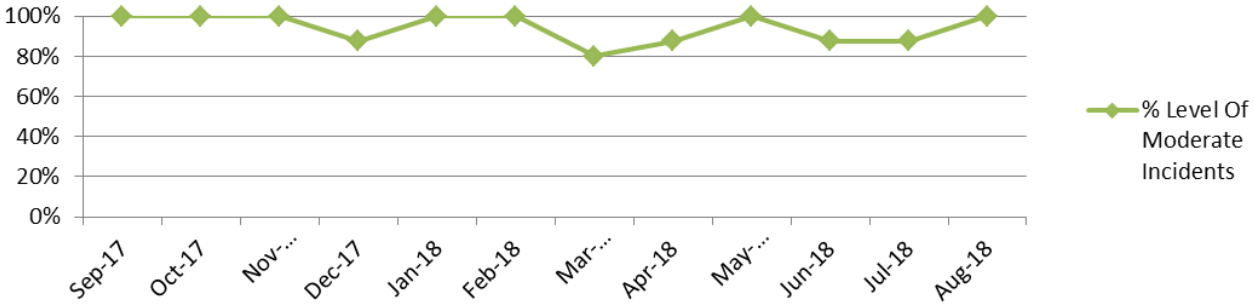
- Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2490 Failure to deliver safe & effective care)

Safe – Compliance with duty of candour

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	SIs: 91.1% Internal investigations: 89.8% Moderate and above incidents: 93.6% (cumulative data for incidents reported September 2017 – August 2018)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance







Latest performance

In month performance as follows:

Serious Incidents
75% compliance for July 2018 and 100% compliance for August 2018

Level 1s
80% compliance for July 2018 and 75% compliance for August 2018

All other moderate and above incidents
87.5% compliance for July 2018 and 100% compliance for August 2018

Safe – Compliance with duty of candour

Key issues	A number of the outstanding duty of candour cases are for cases in NWL Pathology. These incidents are now being discussed at the weekly MD panel in line with other divisions. Each individual case was reviewed by the Medical Director's Office and the Pathology team on 19th October and a number of cases were either appropriately removed from the denominator or transferred to the correct division.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Director's Incident Meeting.	Head of Quality Compliance & Assurance	Ongoing	Progress has been made over the past year, all outstanding cases are reviewed at the weekly MD panel. Communications will be sent in the RO newsletter in October reminding consultants of the required timeframe for the completion of the DoC letter.
Review of duty of candour policy.	Head of Quality Compliance & Assurance	Autumn 2018	Complete. The policy was approved at Quality & Safety Subgroup in October, with a six month review period to align with new national guidance due to be issued.
95% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisions	March 2018	Overdue. Divisions continue to be below the 95% target. As of 11th October 2018 consultant compliance is 77% (MIC), 77% (SCC) and 86% (WCCS). Issues with non-compliance are being addressed by the divisional directors.
Duty of candour letter templates to be reviewed	Head of Quality Compliance & Assurance	End November 2018	Templates are being reviewed centrally to develop a comprehensive library of standardised letter templates to support consultants when dealing with complex cases.

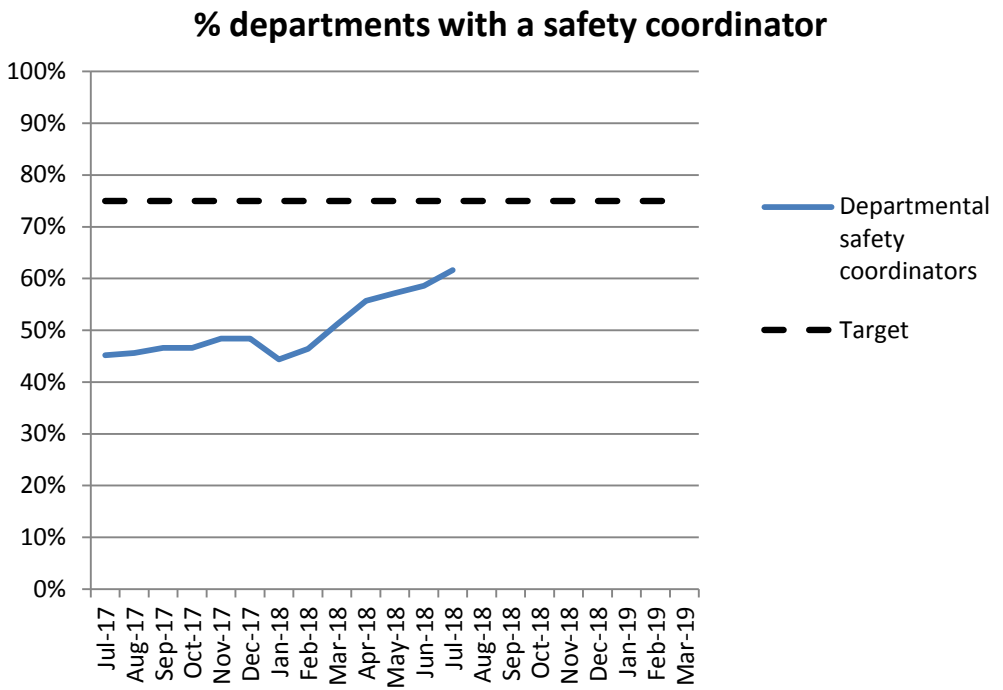
Risk

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

Safe – Departmental safety coordinators

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	75% or greater	September 2018 performance was 71.5%	Kevin Croft, Director of People and Organisational Development	Bryan Joseph (Associate Director Occupational Health and Safety)

Clin/Corp Division	%
Division of Medicine & Integrated Care	71%
Division of Surgery, Cancer & Cardiovascular	55%
Division of Women's, Children's & Clinical Support	75%
Finance	83%
P&OD	93%
ICT	76%
Imperial Private Healthcare	100%
Office of the Medical Director	100%
Office of the Chief Executive	100%
Office of the Chief Nurse	100%
Press & Communications	100%
NWL Pathology	94%



Latest performance

At 30 September 2018 of the 421 staffed departments/locations, 301 had a trained departmental safety coordinator equating to 71.5% compliance. The department performance is shown above.

Safe – Departmental safety coordinators

Key issues	Clinical divisions and corporate directorates / offices have been asked to take effective action to ensure the 75% target is achieved. The majority are aiming to reach 75% by end September and two remaining areas are updating their data and finalising their plans.

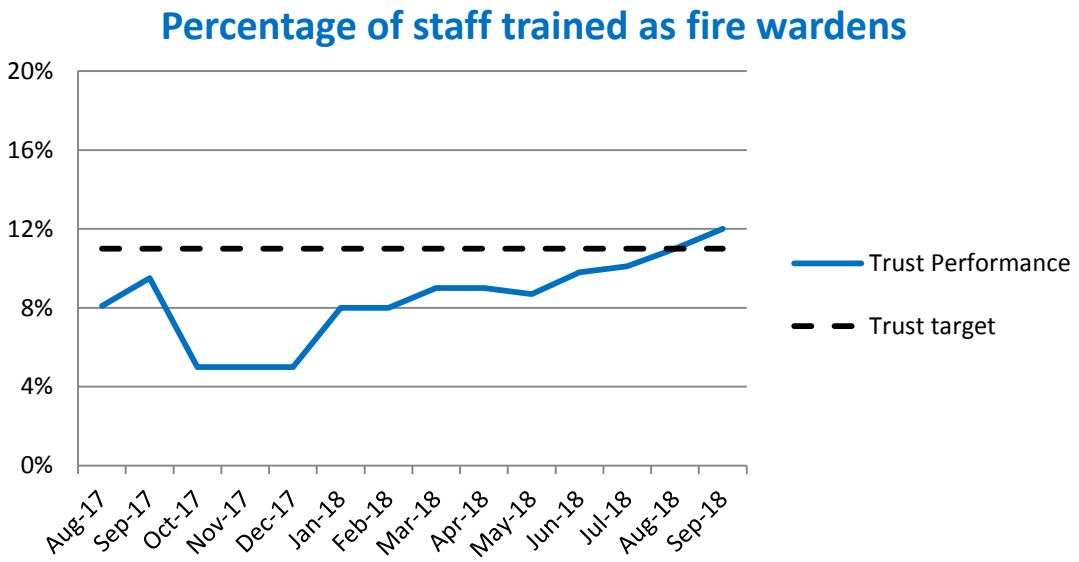
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Engagement from the Divisions to agree actions	Bryan Joseph	Ongoing	• All senior management were contacted to agree milestones to meet the Trust target. COMPLETE • Surgery, Cancer & Cardiovascular Division expected to be above 75% by the end of September 2018. NOT MET • Medicine and Integrated Care Division expect to be above 75% by the end of October 2018.

Risk

- Is it on the (divisional / corporate) risk register? YES Risk 2481 Failure to implement, manage and maintain an effective health & safety management system

Safe – Fire warden training

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure at least 10% of our staff are trained as fire wardens	11% or greater (10% with 1% variation to account for staff movement)	September performance was 12%	Janice Sigsworth (Director of Nursing)	Stuart Low (Fire Safety Officer)



Latest performance

At 31 July 2018 there were a total of 1028 staff trained as Fire Wardens – a current shortfall of 137 to achieve the target agreed by the Executive. It is anticipated that this target will be achieved by November 2018.

Note: Performance is reported using a target of 11%. This is to adjust for staff who have left the trust.

Safe – Fire warden training

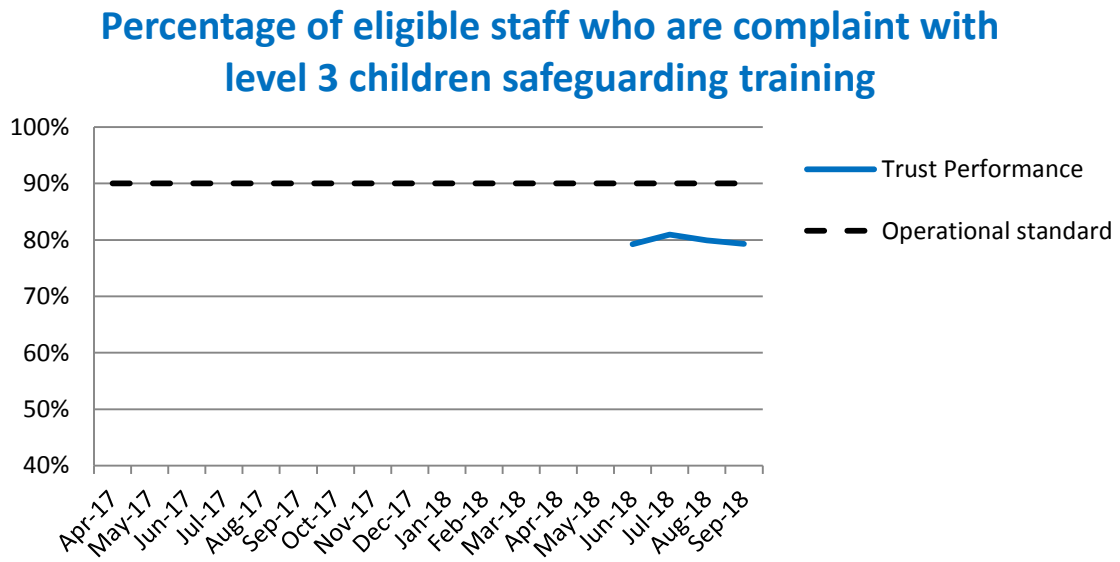
Key issues	Following data cleaning in October 2017 a significant reduction in the number of staff were shown to be trained as a Fire Warden. The cleansing removed staff who were listed as trained, but have since resigned from the Trust. This significantly reduced the number shown as trained from 9.5 to 5 %, however after a number of training sessions were held in January 2018 the training rate has been steadily improving. The target of 10% has been enhanced to 10% + 1% to reflect staff movement. To increase the number of staff trained as fire wardens, the fire safety team have developed a one hour concise training package. The aim of the training is to reach more staff by making use of the core skills sessions, and the requests for ad hoc training by staff groups. The approach has now started to show more staff trained and feedback has been positive. Managers will still need to nominate staff in their respective departments to attend training. Staff need to be appointed to be fire wardens following the training.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Fire Warden Training	Fire safety team	Ongoing	• Fire Warden Training is part of the on-going fire safety training programme; the training is now a one hour session. The courses are delivered monthly at SMH, HH and CHX and at workplaces on a request basis.

Risk
• Is it on the (divisional / corporate) risk register? NO

Safe– Safeguarding children training (level 3)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90% or more	September 18 was 81%	Janice Sigsworth (Director of Nursing)	Guy Young



Latest performance

In September 2018,

- 79% of eligible staff were compliant with level 3 safeguarding children training

Safe – Safeguarding children training (level 3)

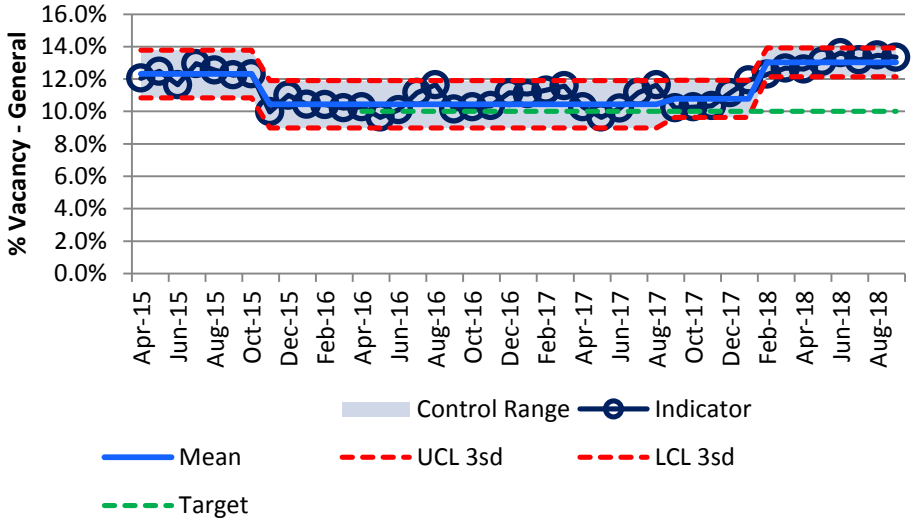
Key issues	This training cannot be done online and requires staff to attend a face-to-face session of at least half a day. This makes it more challenging to increase compliance. The safeguarding team have planned sessions organised throughout the year. These are bookable through Yodel. At the time of writing there are 150 staff booked onto the training between now and December. There are still 250 available places available and managers need to ensure that relevant staff who are not complaint book onto a session. Local compliance data are available on Wired for managers to determine who needs to attend.

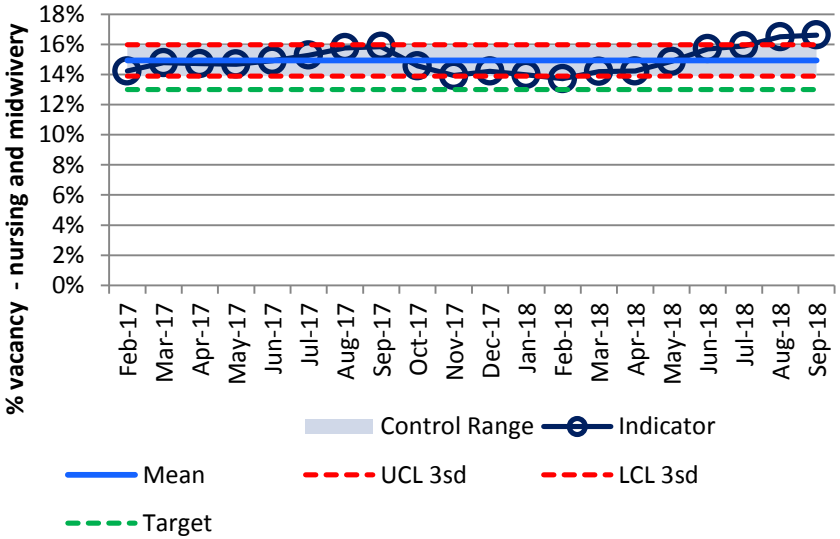
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Comprehensive schedule of training in place with a large number of confirmed forward bookings	Nicci Wotton	Compliance anticipated by the end of the year.	• Currently stalled at around 80%

Risk
• Is it on the (divisional / corporate) risk register? A risk will be added to the register if an expected increase is not shown in the latest report (due week beginning 12/11/18).

Safe – Vacancy rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less; We will have a nursing and midwifery vacancy rate of 13% or less.	10% target for overall Trust vacancies and 13% for overall N&M vacancies	September 2018 position was; All Trust 13.3% All N&M 16.6%	Kevin Croft, Director of People and Organisational Development	Pen Parker Dawn Sullivan





Latest performance

- at end September the vacancy rate was 13.3% reflective of 1,463 WTE vacancies
- the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,502 WTE; an increase of 75 WTE from those employed in August
- for all nursing & midwifery roles, the vacancy rate was 16.6% (872 WTE vacancies)
- the overall vacancy rate for our Clinical and Corporate Divisions has decreased marginally from the 13.5% reported in August due to an establishment increase of 70 WTE against an increase in directly employed staff of 75 WTE

Safe – Vacancy rates

Key issues

- Workforce is a key issue across the NHS – in 2017 more nurses left the profession than joined. Imperial has an overall nursing and midwifery vacancy rate of 16.6%. There are a wide range of recruitment initiatives in place however these maintain our position rather than reduce the vacancy rate significantly
- There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff very difficult: Brexit, the removal of the bursary, the sustained low pay increases, contractual issues with the trainee doctors, the pressure of work and the reduction in CPD funding
- The London recruitment market is very difficult and there is more demand than supply. The majority of London trusts have been actively involved in international recruitment for many years and this is reflected in their vacancy rate e.g. Kings and UCL
- There are national skills shortages and workforce planning across the NHS has not been a high priority to date
- High vacancy rates impact on patient safety and on staff engagement and morale

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
There is a Recruitment & Retention Action Plan in place for Band 2-6 N&M staff	Dawn Sullivan	1-3 years	• The plan has been refreshed for 2018/2019 and to date has delivered an increase in student retention to 70%, an increase in internal appointments and a more engaged workforce
The business case and funding for the Strategic Supply of Nursing	Dawn Sullivan/Sue Grange	1-5 years	• Funding secured for Nursing Associates, Graduate Apprentices, Retention schemes, International recruitment & resource to support N&M staff. The international campaign has secured 146 recruits to date. Effective on-boarding will be key to its success
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan/ Sue Burgess	1 year	• A plan was submitted in August, NHSI are visiting on 24th July to discuss the plan
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust is recruiting on average 85 N&M staff each month against an average t/o of 65 N&M staff each month. The big ticket items in the plan are students, international recruitment and Band 5 and HCA talent pools

Risk

Corporate risk register id 2499 (Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff)

Safe – Medical devices maintenance

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve medical devices maintenance compliance according to risk categorisation	98% for High risk, 80% for Medium Risk and 70% for Low risk	September compliance was as follows: High risk = 94% Medium risk = 96% Low risk = 88%	Janice Sigsworth (Director of Nursing)	Max McClements (Head of Clinical Technical Services)

Risk category	Target	March 2018	April 2018	May 2018	June 2018	July 2018	August 2018	September 2018
High risk	98%	76%	77%	89%	89%	91%	94%	94%
Medium risk	75%	70%	74%	80%	79%	86%	86%	96%
Low risk	50%	64%	72%	80%	84%	89%	88%	88%

Latest performance

- There has been a continual improvement in maintenance compliance figures for medical devices.
- Although High Risk is improving the target figure was not achieved. This was due, in part, to hoists being transferred to Clinical Technical Services (CTS) and these are classed as High Risk devices.
- CTS will work with supplier to action the required work to improve maintenance and reliability of hoists.

Safe – Medical devices maintenance

Key issues	The Trust outsourced the medical device maintenance service in 2015 and a number of issues regarding medical device management that are both historical to the Trust and specific to the contract have been identified. In Year 1 there were 17,366 assets whereas now, as Year 3 of the 5 year contract is ending, there are almost 25,000 assets registered that demonstrates the inventory was inaccurate. Medical devices continually move around resulting in devices not being located for maintenance and affecting the scheduled maintenance plan. A number of initiatives have been put in place. To improve sight of medical device locations, and to improve maintenance compliance, radio-frequency identification (RFID) technology is being introduced that will enable medical device location to be tracked. With the introduction of RFID technology, use of new 'Next Test Due' labels and improved awareness of staff the aim is to continue the upward trend until all maintenance KPI's are achieved.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of medical device categorisation	Aheed Syed (Operations Manager)	October 2018	• Risk based approach implemented and labels attached as part of RFID project. As maintenance is completed further updates will be made.
Radio-frequency identification (RFID) Implementation	Aheed Syed (Operations Manager)	October 2018	• Strategy developed and labels affixed, though still numerous devices to be located to get RFID label • Interaction between IT systems being developed
Training process for staff	Drushtee Ramah (Medical Device Principal)	Completed 2018	• e-Learning package is being developed which will then be rolled out in 2018 • Safety alert issued
Introduction of Equipment libraries	Max McClements (Head of CTS)	SMH (Completed); CXH (Completed); HH (Apr-19)	• SMH library open and systems being introduced. CHX library staff recruited and refurbishment scheduled to be completed by end of September. • HH library location being reviewed

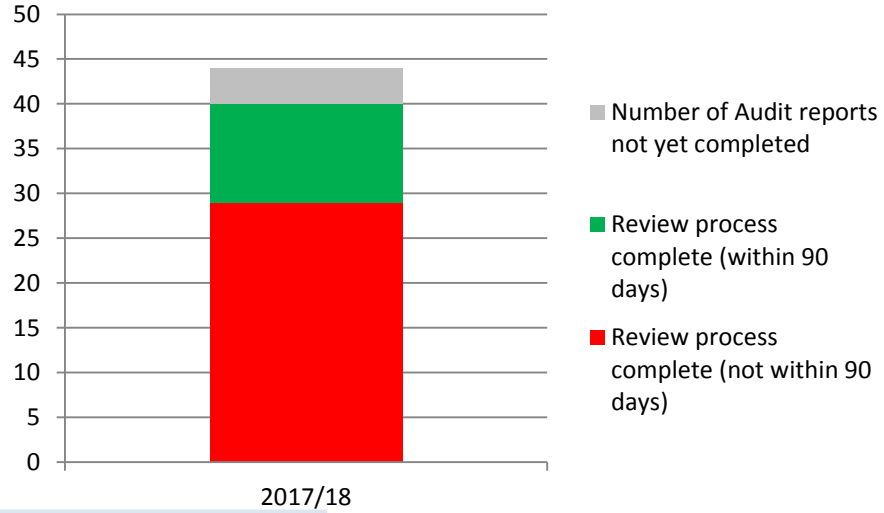
Risk

- Corporate risk register id 2557 (Risk of using medical devices that are out of testing date due to lack of scheduled maintenance)

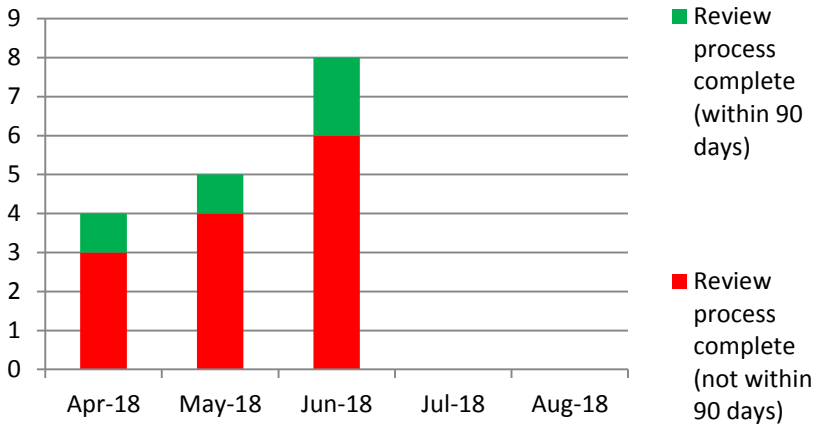
Effective – National clinical audit

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits Number of audits that have not completed the review process within 90 days	100% - June 2018 6 - June 2018 (for audits reported in 2018/19)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor

Graph 1



Graph 2



Latest performance

The first graph demonstrates performance against Quality Account reportable National audit activity for the previous financial year 2017/18. 42 National audits have completed the review process (as of 10.10.2018) however, four remain outstanding.

The second graph demonstrates performance against Quality Account reportable National audit activity up to April 2018 for the financial year 2018/19. The number of National audits will increase as the financial year progresses as further national audit reports are published. Data is reported on a monthly basis, but the data presented here is three months in arrears to allow time to go through the Trust ratification process.

Eight National audits were published up until the end of June 2018. All of these were relevant to ICHT. ICHT participated in 100% of the relevant national clinical audits. Two audits have completed the review process and six audits have not completed the internal review process within 90 days.

Effective – National clinical audit

Key issues	Six of the 2018/19 national clinical audits are still with the divisions for review and are now overdue as they have exceeded the internally set 90 day review process. The four outstanding 2017/18 national audits are in the division of medicine and integrated care. Since preparing this report they have confirmed that two more have now completed the process and this will be reflected in next months data. The national pregnancy in diabetes and national diabetes foot care audit remain outstanding and are under review by the Trust leads. Progress continues to be tracked at the weekly incident panel.

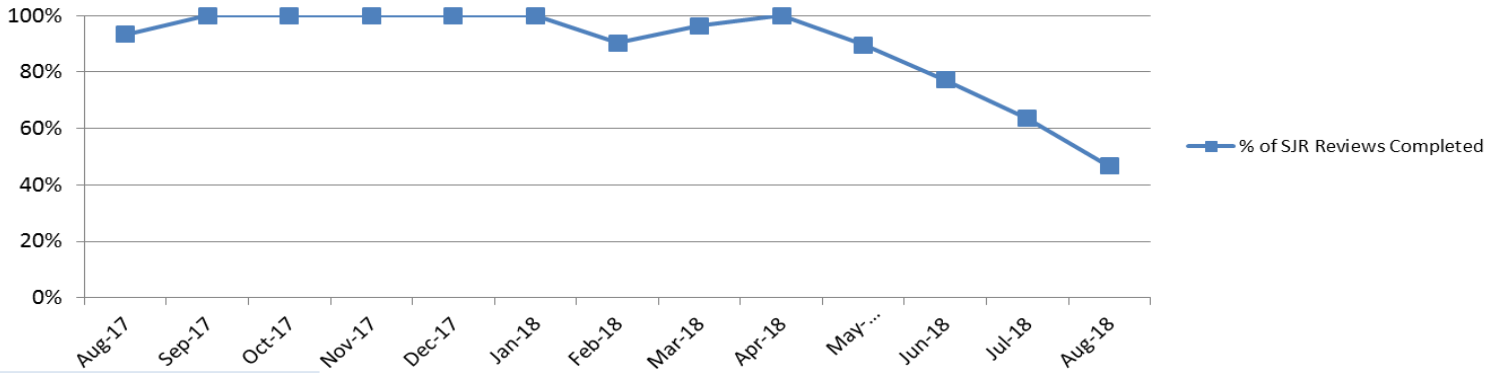
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
All significant risk audits to have an action plan in place that is presented to the quality & safety subgroup.	Raymond Anakwe/Audit Leads	On-going	Four audits from 2017/18 were identified as 'significant risk/little assurance'. Action plans were presented to the quality & safety sub-group and are monitored through the divisional Q&S committees. So far, no audits from 2018/19 have been identified as significant risk.
Low risk and acceptable risk audits to be presented at divisional quality and safety committees.	Audit Leads	On-going	On-going. So far, two of the audits published in 2018/19 have completed the review process.
Overdue audits escalated at the weekly Friday MD panel for review.	Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings.
The internally set timescale for completion of the review process (90 days) to be reviewed	Clinical Auditor/Improvement Programme Manager – Safety	November 2018	A review of the internal target will take place with the divisions to agree if it is achievable or needs extended. If achievable a trajectory for improvement will be agreed.

Risk

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

Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJR reviews completed: 63.6% July 2018 46.7% August 2018	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager



Latest performance

- Data is refreshed on a monthly basis as SJRs are requested and completed. This data is now reported 1 month in arrears to allow time for the SJR cycle to be completed. 83 completed reports have been received to date for this financial year (18/19), with 5 avoidable deaths reported. Trust compliance for SJRs is 63.6% for July and 46.7% for August 2018, against a target of 100%.
- Trust compliance for local level 1 mortality review is 91% for July and 77% for August 2018, against a target of 100%.
- All data is now to be reviewed at the weekly incident panel with trajectories then set for improvement by division.

Effective – Mortality reviews

Key issues	Cases are reviewed at the monthly Mortality Review Group with a focus on any avoidable factors and learning themes. A review will take place of how data and intelligence from the mortality reviews could be utilised more effectively to inform safety improvement work and reduce avoidable harm as part of the quality account improvement priorities.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	Mortality Auditor	Dec 2018 (originally Sept 2018)	33 members of staff have undergone structured judgment review (SJR) training. Further recruitment has commenced to ensure we have at least one reviewer in each specialty to facilitate local feedback of findings and divisions have been asked to provide nominations. These additional reviewers will support with increasing the SJR completion rates.
Consolidation of outstanding SJRs since the process was implemented including timescales for completion and a review of actions.	Mortality Auditor	End July 2018	Complete. An 'overdue' report for any outstanding SJRs has been compiled, and is now circulated with the monthly MRG papers.
Strengthen and formalise the process for triangulating data from cases that have both SJRs and SI investigations undertaken, this includes the recording and accessibility of the data generated.	Head of Quality Compliance & Assurance	End Nov 2018 (originally Oct 2018)	A proposed process was presented for discussion at the October Quality & Safety Subgroup. Final process will be presented to the November meeting for approval.
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Auditor	End Oct 2018	Report presented to the October Quality & Safety subgroup with a number of actions required from the divisions before this action can be closed.

Risk

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

Effective – Patient reported outcome measures PROMs

Indicator	Target	Latest data	Executive lead	Report author(s)
We will increase PROMs participation rates to 80% and report above average health gain	80% Above average	As detailed below	Julian Redhead, Medical Director	Anne Hall, General Manager Trauma Services

August Position			
Hip Replacement		**Knee Replacement**	
Participation Rate	**Reported Health Gain**	**Participation Rate**	**Reported Health Gain**
July 2018 - 100% August 2018 - 100%	EQ-5D Index: 0.457 EQVAS: 22.897 Oxford Hip score: 22.628 (Provisional Quarterly PROMs April 2017- March 2018 report August 2018 release)	July 2018 - 100% August 2018 - 100%	EQ-5D Index: 0.398 EQ VAS: 1.325 Oxford knee score: 14.230 (Provisional Quarterly PROMs April 2017- March 2018 report August 2018 release)

Latest performance

According to NHS Digital, the Trust's monthly participation rate was 100% in August (most recent data available) for both hip and knee replacement. Participation rates have been 100% since June 2018 against the target of 80%. This is following the implementation of an improved process, including dedicated resource.

The provisional Quarterly PROMS report (April 2017- March 2018) released in August 2018 shows improvement in health gain scores for hip and knee replacement. The EQ VAS score is above national average for both procedures; EQ-5D Index is consistent with the national average score for both procedures; Oxford Hip score is consistent with the national average and there is scope for improvement for Oxford Knee score.

Effective – Patient reported outcome measures PROMs

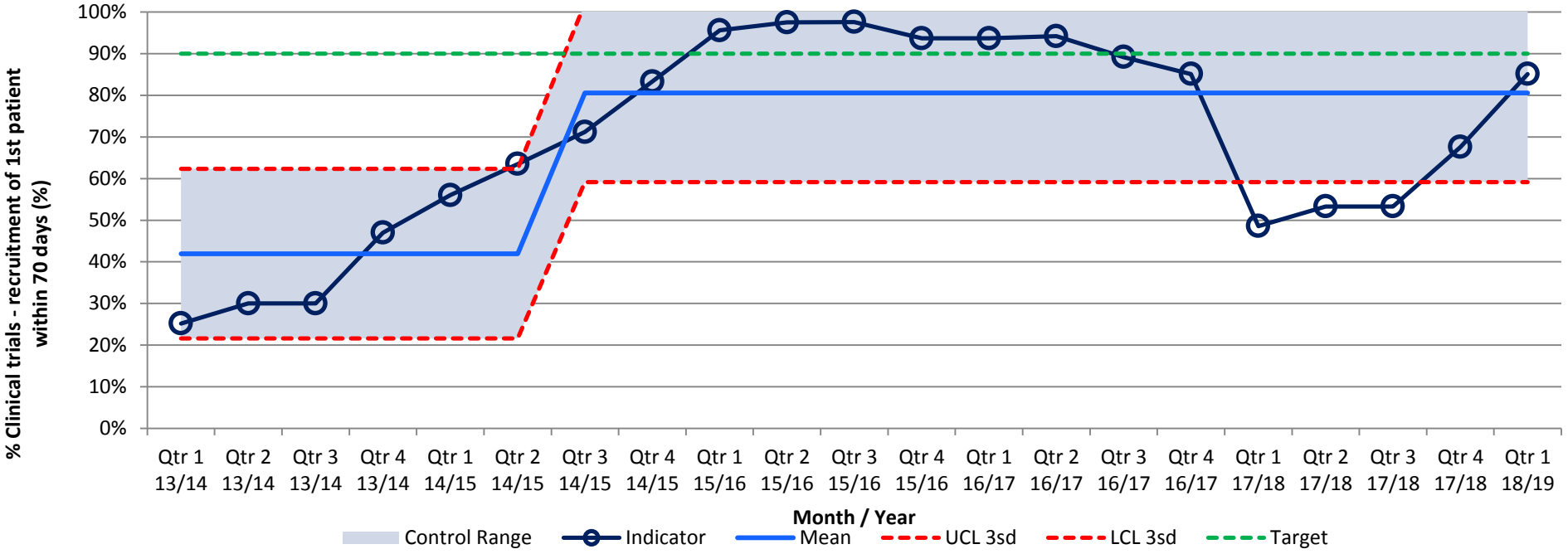
Key issues	An external agency Capita is responsible for sending patients the second questionnaire post-surgery. In the past there have been issues with data collection from Capita. Procurement is in discussion with other external suppliers to address this issue. A tendering process is underway, with three shortlisted external suppliers due to present to the directorate leadership in November 2018.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Proposal being developed to contract new external supplier to replace Capita.	Anne Hall- GM /Lee Matthews – procurement	October 2018	Three external suppliers shortlisted to present to directorate.

Risk
• Is it on the (divisional / corporate) risk register? YES (reference 2683)

Effective – Clinical Trials Recruitment

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of clinical trials recruit their first patient within 70 days	Above 90%	Q1 2018/19: 85.1%	Julian Redhead, Medical Director	Heidi Saunders (Head of Clinical Research Operations) and Paul Craven (Head of



Latest performance

We have not achieved our target of 90% of clinical trials recruiting their first patient within 70 days of a valid research application this year. However, NIHR-validated data for Q1 2018/19 shows 85% compliance against our target, which is a significant improvement on Q4 (67.6%) . This is a result of a weekly review of all studies by the JRO & Divisional Research Management teams, and escalation of “blockages” in the set-up process.

The Trust expects to meet the 90% target in Q3 2018/19.

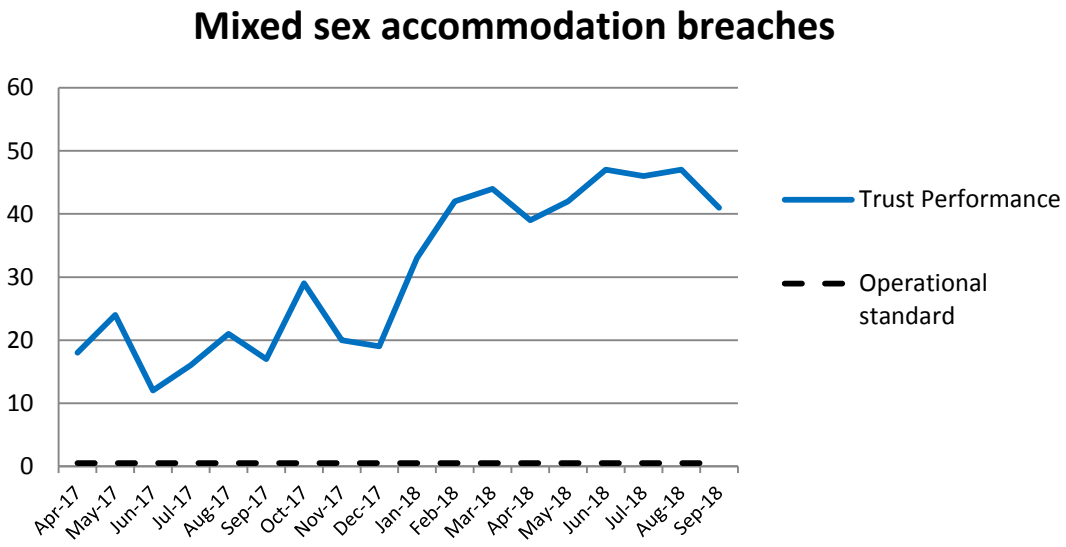
Effective – Clinical Trials Recruitment

Key issues	Performance declined nationally following the process and data changes introduced by the DoH in 2016/17, but the national trend is now upward again. An ongoing consultation by NHS England is currently proposing to establish a single set of national clinical trials metrics – agreed by the industry sector – by Q3 2018/19, which are more robust and which are resistant to different interpretations by NHS Trusts as is currently the case.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Historically, much of the delay for ICHT studies has been at the contract negotiation stage. The last 6-9 months have been spent re-staffing the ICHT Joint Research Office (JRO) with new contracting experts and new leadership.	Paul Craven, Head of Research Operations	Complete	Now fully resourced.
Team are taking a more pragmatic and proactive approach to contract and cost negotiation (within agreed negotiation boundaries).	Paul Craven / Heidi Saunders (Joint Research Office)	Ongoing	Contract and cost negotiations are carried out faster than previously. The team is more proactive in chasing the Sponsor on response too and this is having a positive impact.
Performance against the metrics is monitored and managed in a systematic way.	Paul Craven / Heidi Saunders (Joint Research Office)	Ongoing	ICHT Research Performance Management Group was established in January 2018. The Group meets on a weekly basis to review all studies in set up and take any actions required to meet the NIHR performance metrics. We are starting to see a positive impact of this Group.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have zero mixed-sex accommodation breaches	0	41 breaches (September 2018)	Dr Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care



Latest performance

The Trust reported 41 mixed-sex accommodation (MSA) breaches in September 2018. 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.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

Key issues	Breaches are exclusively incurred by patients awaiting step down from the Critical Care units to ward areas. Imperial appears to be an outlier for reported MSA breaches. Other Trusts report discharge delays from Critical Care but report fewer or no MSA breaches. The reason for this is unclear, as the two indicators are seemingly contradictory. Breach rates are increasing as a result of Critical Care bed expansion. This causes complexities with segregation, increased overall numbers of discharges and discharges all being L1/0 (therefore EMSA applicable). There are clinical risks associated with moving Critical Care patients to create single sex bays or to vacate side rooms (whereby they would not be reported as a breach). Bed moves increase the risk of infection outbreak. There is no evidence locally (from patient feedback) that being in MSA after being declared fit for discharge has an adverse effect on patient experience. The preferred option for elimination of MSA in Critical Care would be to reduce step-down delays as this has benefits beyond resolving the immediate MSA concern. It is recognised however that this is dependent on downstream bed availability and bed allocation prioritisation. The delayed discharges from the ICUs will form part of the on-going Trust capacity and flow work.

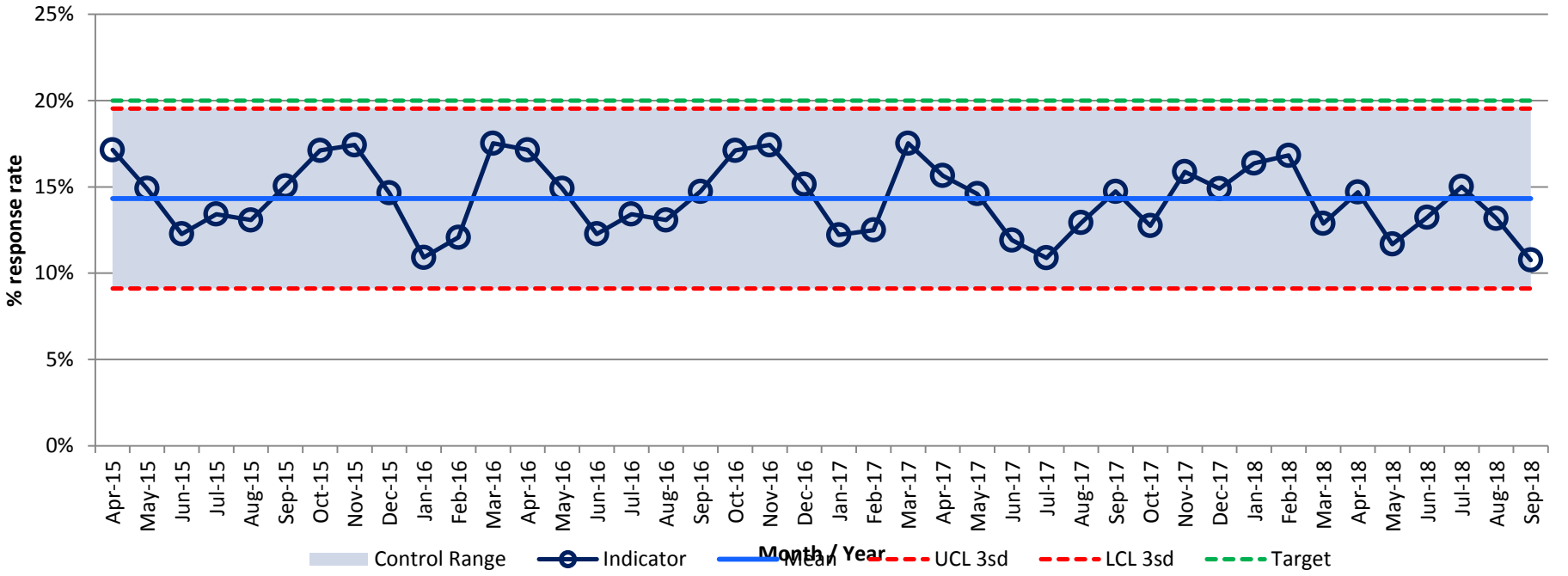
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Presentation of ICHT Mixed sex accommodation (MSA) breaches audit results with CCG Clinical Quality Forum	Julie Oxton	Jul-18	• Complete
Comparison of reporting methodologies and mitigations at other Trusts	Mary Mullix	tbc	• Following presentation at CQG, a review is to take place on MSA reporting in other Trusts to ensure all are following the same reporting methodology.
In conjunction with the Site Director, discussions to be held to review the prioritisation of discharges from Critical Care in relation to admission of patients from ED.	Melanie Denison; Phil Lunn; Roseanne Meacher	tbc	• Senior Nurse and GM to commence attending Trust Patient Flow – 4 Hour meeting to raise profile of delayed discharge situation in CC and highlight impact on EMSA.
Previous work completed within the Directorate in conjunction with the Quality Improvement Team, related to avoiding delayed discharges to be restarted.	Lilian Davies	• October 2018 – for workstream to recommence	• Work streams being prepared include reviewing bottle necks (including local discharge processes), analysing flow of patients in and out of Critical Care, improving communication with the Site Team and identifying potential patients for step downs earlier.

Risk

- This appears on the Critical Care Directorate Risk Register as risk ID 2457- EMSA breaches in ICU

Caring – Friends and Family response rate (A&E)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve and maintain an FFT response rate of 20% in A&E	20% or greater	September2018 performance was 10.8%	Janice Sigsworth	Stephanie Harrison-White (Head of Patient Experience & Improvement)



Latest performance

In September 2018

- FFT response rates for inpatients, outpatients and maternity birth were met
- A&E did not meet the 20% target for response rates.

Caring – Friends and Family response rate (A&E)

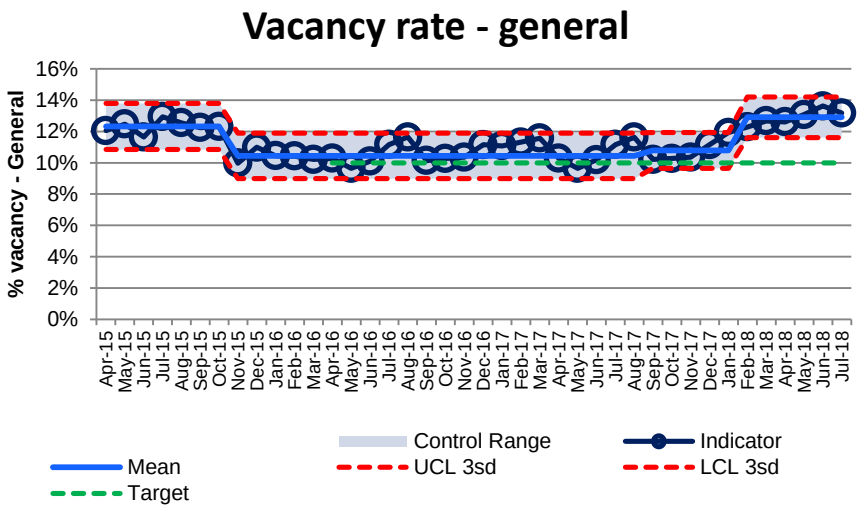
Key issues	Response rates have fallen again in August/Sept. It is unclear why this is but the focus on waiting times may have diverted attention from collection of FFT. A wide variety of collection options are available in A&E including paper surveys and online (all attenders are sent a text with a link to the survey). A paper was presented to the Executive Quality Committee on 30 October. The Committee noted the challenges in achieving the required response rate for FFT in Urgent Care & Emergency noted that this problem is not unique to Imperial. There are no simple solutions and a collective, multi-disciplinary approach and focus is required. The directorate senior team, with the communications and patient experience teams will be encouraging staff to refocus efforts on the FFT response collection. A number of key actions are being taken forward or considered. This includes the introduction of a new fixed position terminal (a kiosk) in SMH ED and its impact will be reported in updates to this exception report.

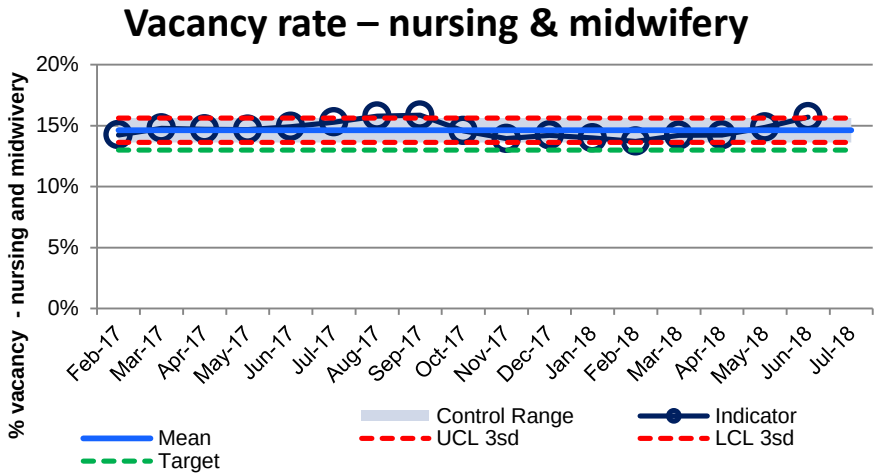
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
A kiosk is being installed in St Mary's A&E.	Stephanie Harrison-White (head of patient experience)	Oct 2018	• Once operational impact will be ascertained.

Risk
• Is it on the (divisional / corporate) risk register? NO

Safe – Vacancy rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less; We will have a nursing and midwifery vacancy rate of 13% or less.	10% target for overall Trust vacancies and 13% for overall N&M vacancies	September 2018 position was; All Trust 13.3% All N&M 16.6%	Kevin Croft, Director of People and Organisational Development	Pen Parker Dawn Sullivan





Latest performance

- at the end of September the vacancy rate was 13.3% reflective of 1,463 WTE vacancies
- the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,502 WTE; an increase of 75 WTE from those employed in August
- for all nursing & midwifery roles, the vacancy rate was 16.6% (872 WTE vacancies)
- the overall vacancy rate for our Clinical and Corporate Divisions has decreased marginally from the 13.5% reported in August due to an establishment increase of 70 WTE against an increase in directly employed staff of 75 WTE

Safe – Vacancy rates

Key issues

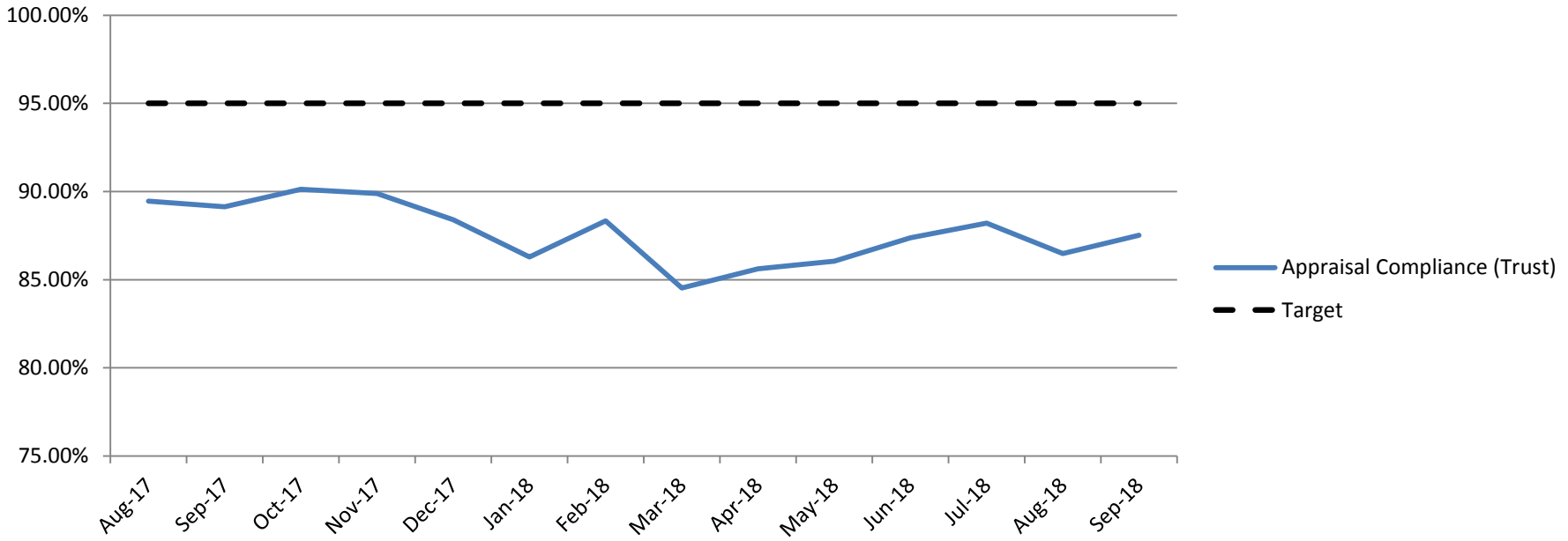
- Workforce is a key issue across the NHS – in 2017 more nurses left the profession than joined. Imperial has an overall nursing and midwifery vacancy rate of 16.6%. There are a wide range of recruitment initiatives in place however these maintain our position rather than reduce the vacancy rate significantly
- There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff very difficult: Bexit, the removal of the bursary, the sustained low pay increases, contractual issues with the trainee doctors, the pressure of work and the reduction in CPD funding
- The London recruitment market is very difficult and there is more demand than supply. The majority of London trusts have been actively involved in international recruitment for many years and this is reflected in their vacancy rate e.g. Kings and UCL
- There are national skills shortages and workforce planning across the NHS has not been a high priority to date
- High vacancy rates impact on patient safety and on staff engagement and morale

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
There is a Recruitment & Retention Action Plan in place for Band 2-6 N&M staff	Dawn Sullivan	1-3 years	• The plan has been refreshed for 2018/2019 and to date has delivered an increase in student retention to 70%, an increase in internal appointments and a more engaged workforce
The business case and funding for the Strategic Supply of Nursing	Dawn Sullivan/Sue Grange	1-5 years	• Funding secured for Nursing Associates, Graduate Apprentices, Retention schemes, International recruitment & resource to support N&M staff. The international campaign has secured 146 recruits to date. Effective on-boarding will be key to its success
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan/ Sue Burgess	1 year	• A plan was submitted in August, NHSI are visiting on 24th July to discuss the plan
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust is recruiting on average 85 N&M staff each month against an average t/o of 65 N&M staff each month. The big ticket items in the plan are students, international recruitment and Band 5 and HCA talent pools

Risk
Corporate risk register id 2499 (Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff)

Well led – Doctor Appraisal Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	87.83% - August 2018 87.52% - September 2018	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance

Performance had been on an overall upward trajectory since March 2018.

Consultant grade compliance is at 88.5% compliance compared to 89.02% in July. Career grade compliance is at 84.67%, from 86.98% in July.

The total number of appraisals overdue by more than six months is currently 43.

The target date for achieving the 95% compliance rate is September 2018 (M6). This has been added to the risk register as we have not met our internal compliance target. An improvement trajectory is in development.

Well led – Doctor Appraisal Rate

Key issues	The number of appraisals overdue by over six months remains static and therefore will continue to follow the existing escalation framework. The most recent comparative performance data available is based on AOA reports submitted applicable to 2016-17 appraisals. This shows an average appraisal rate of 93.6% for consultants in the same sector (and 91.7% nationally). At the time of this report the Trust was at 92.3% and has therefore reduced significantly since this time. The most recent data will not be reported for several months. Trust grade doctors is currently at 84.67% compliance. When compared to the last national data set, the same sector was 87.5% and nationally 87%. When doctors exceed their appraisal due dates they receive a number of automatic reminders via email from PreP, the electronic appraisal system up to 12 weeks after the date their appraisal was due. After this time, the internal escalation procedure commences. In addition to this, there will be a letter sent to all doctors who have exceeded their appraisal due date from the Medical Director, asking them to raise any issues or mitigation to completing a timely appraisal for this month. This will allow us to monitor whether this approach has a direct impact on appraisal performance.

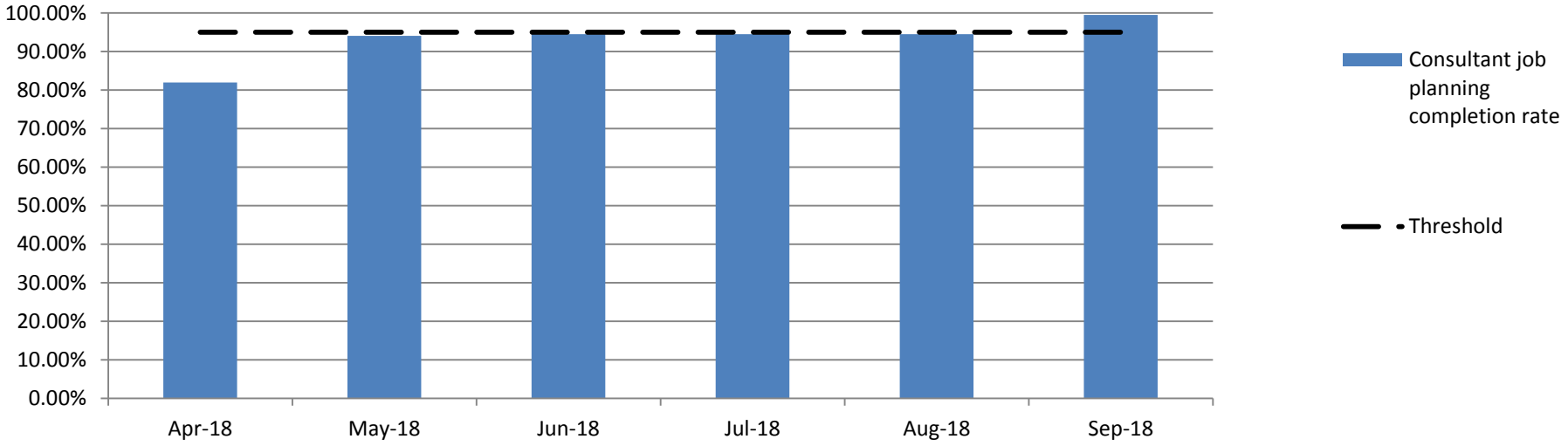
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Overdue appraisals not being consistently monitored and escalated - Implement policy for overdue appraisals.	Andrew Worthington, GM	Monthly from June 2018	Completed for the first cohort of doctors with overdue appraisals. Next cohort of overdue appraisals in escalation process.
Quality of PreP data - Professional Development team to perform data cleanse.	Victoria Ward, Prof Dev Team Manager	December 2018	Work has started to improve the quality of data recorded in PreP. This is being monitored through the Professional Development monthly performance team with the Medical Director.
Letters to be sent from MD to all doctors who have exceeded their appraisal due date this month. This will allow us to monitor whether this approach has a direct impact on appraisal performance.	Andrew Worthington, GM	End of October 2018	In progress.

Risk

- Is it on the (divisional / corporate) risk register? Appraisal performance will be added to the Risk Register this month

Well led – Consultant Job Planning

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a consultant job planning completion rate of 95% or more	>=95%	99.5% - September 2018	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance

The job planning round for the financial year 2018/19 closed in July. Final compliance was 99.5%.

Well led – Consultant Job Planning

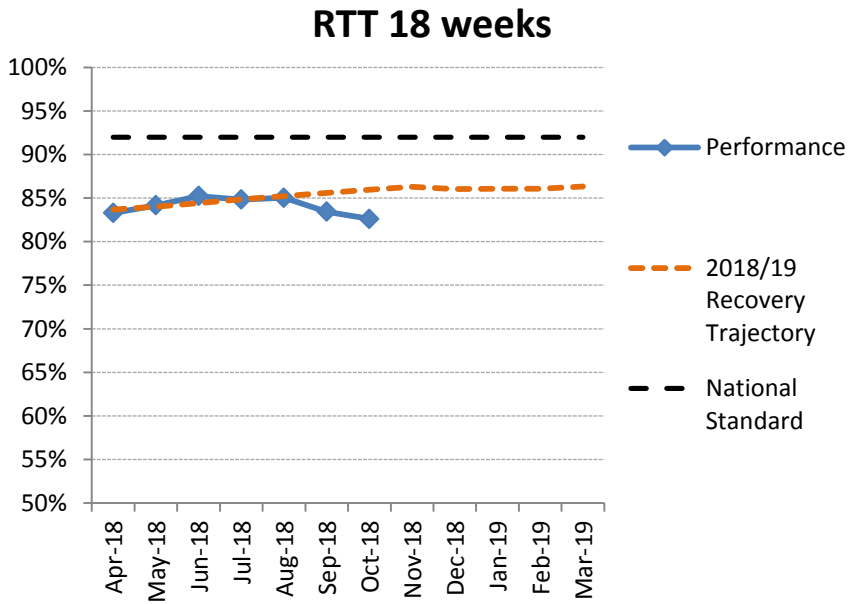
Key issues	The 2018/19 job planning round ended in July. The analysis of the data available on SARD has proven to be complicated, largely due to inconsistencies in the way that activity is recorded. The Professional Development team have been able to extract some useful information from the completed job plans and are in the process of consolidating this into a paper that will be presented Executive POD committee in November. The job planning round for 2019/20 will commence in October 2018.

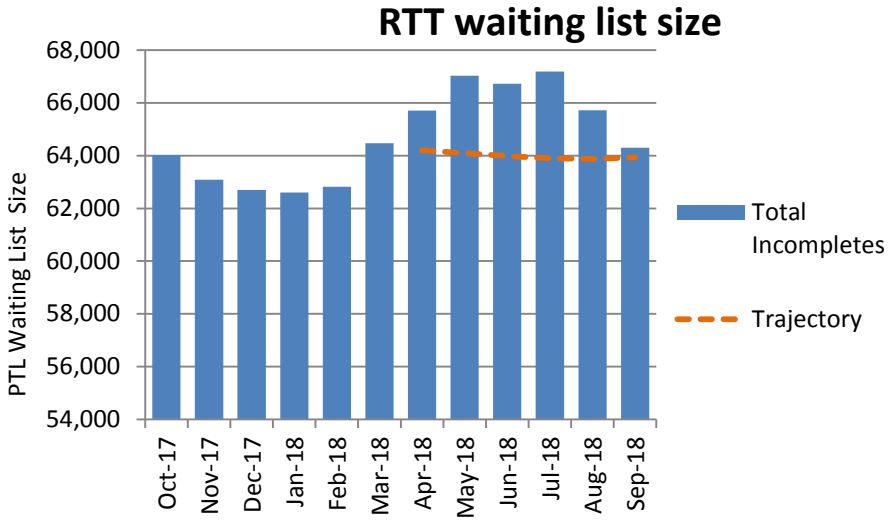
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Communication to Clinical Line Managers regarding sign-off requirements and additional training ahead of new job plan round.	Geoff Smith, AMD Professional Development	September 2018	To be completed by October 2018.
Analysis of the components of job plans (SPA, EPA, research activity etc.) will commence to provide useful data for divisions.	Victoria Ward, Prof Dev Team Manager	August 2018	Final analysis will be completed in October 2018, shared with the divisions and reported to ExPOD in November.

Risk
• Is it on the (divisional) risk register? YES – Divisional risk register ID 2465 Risk of non-compliance with annual consultant job planning process.

Responsive – 18 weeks referral to treatment (RTT) - reporting downtime

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT incomplete performance target in line with the agreed trajectory for 2018/19	85.59% at end September 2018	82.62% at end September 2018	Dr Catherine (Katie) Urch	Performance Support Business Partner





Latest performance

<u>Reporting downtime</u>

The Trust experienced an extended period of RTT Patient Tracking List (PTL) downtime in late September and early October (20/09 to 7/10).

The latest RTT submitted performance position is end September where 82.62% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%; this did not meet the trajectory target which was 85.59%.

See root causes below.

Responsive – 18 weeks referral to treatment (RTT)

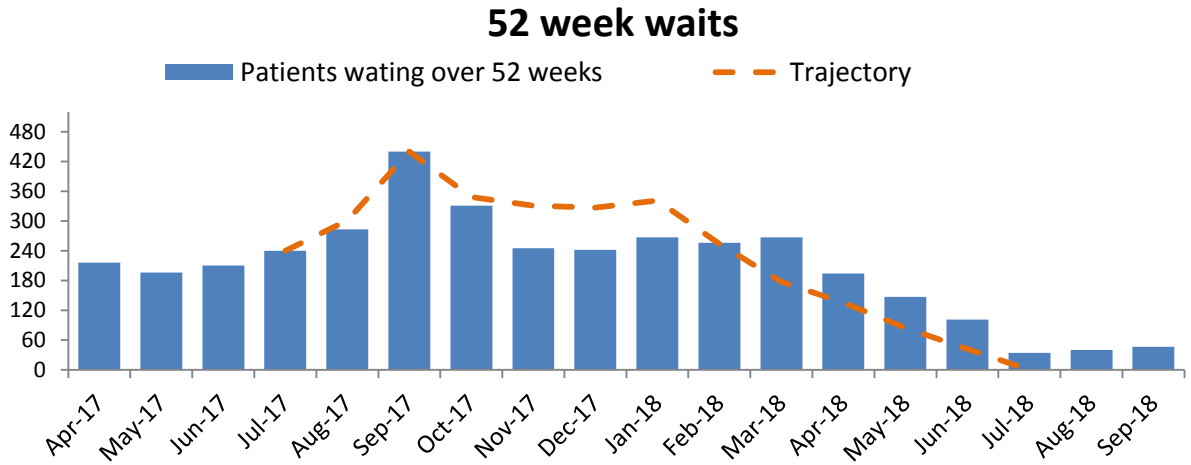
Key issues and actions	• The Trust experienced an extended period of RTT Patient Tracking List (PTL) downtime which impacted service validation and tracking of patients on the waiting list due to lack of visibility through this period. The main impact has been on scheduling patients in turn (waiting lists are used for this purpose) and validating the accuracy of the RTT waiting times prior to submission. A serious incident investigation is being completed, in line with the Trust's Incident Policy, and the deep dive into the impact of the incident on the RTT PTL is also ongoing. • Recommendations and actions for the October assurance are being taken forward by the Performance Support, BI and Divisional Teams. The outcome will be presented to the RTT Steering Group. • The Trust is currently not in Business as Usual for RTT PTL reporting. • Root cause analysis has also highlighted the likely contribution of System Errors to the increasing size of the RTT PTL and non delivery again the Trust plan. The fix for System Errors has been delayed and a timescale for implementation is to be confirmed.

Risk

- 2510 Failure to maintain key operational performance standards
- Reporting downtime also links to Risk ID 1660: Risk of inaccurate data, which can result in delayed treatment to patients, inaccurate data sets being published externally and therefore breach of contractual and regulatory requirements and loss of Trust reputation

Responsive – RTT patients waiting 52+ weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the number of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0 at end September 2018	At end September 2018 46 patients were waiting 52+ weeks	Dr Catherine (Katie) Urch	Performance Support Business Partner



Latest performance

The Trust experienced an extended period of RTT Patient Tracking List downtime in late September and early October. In September 2018 the Trust reported 46 52-week breaches for September. This was an increase of 6 from the previous month and the breaches were associated with downtime in reporting.

- Of the 46 patients over 52 weeks at the end of September, 31 had tipped-over in the month (a tip-over is defined as a pathway previously known on the PTL that tipped over 52 weeks in the month leading up to the census date) and there were 15 over 52 week pop-ons (a pop-on is defined as a pathway not on the previous month's submission) in September.

Responsive – RTT patients waiting 52+ weeks

Key issues

- Reporting downtime
- Some challenges to reach the zero trajectory target due to patient choice and treating a number of complex pathways
- Risks continue with some individual consultant capacity
- The impact of continued cancellations of elective care owing to emergency/non-elective surge requiring beds and theatre lists to treat emergency patients continues to be a risk
- Patient initiated cancellation or reschedule of appointments
- Incorrect clock stops being corrected , administrative error and pop-ons.
- The number of 'system errors' appearing through the validation process is a cause for concern – multiple checks are in place to review these and system solutions are being sort where possible to eradicate them.

However:

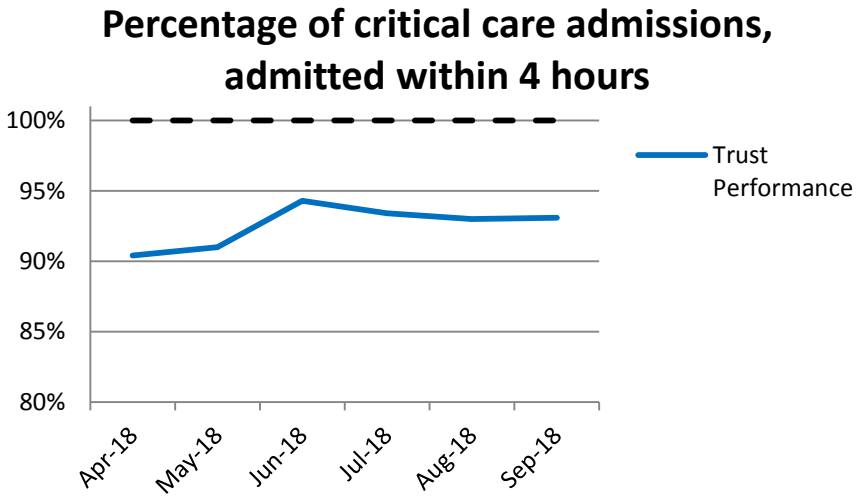
- The sustained review and provision of RTT training aims to improve knowledge and application of RTT
- The use and development of validation tools is providing greater visibility of progress within services
- There is on-going review and monitoring of the Trust's 52 week wait position
- All patients waiting over 52 weeks continue to be reviewed for clinical harm in line with the agreed validation process. The clinical harm review of the August 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
SCC Division hold a weekly touch-point meeting with WCCS and MIC Divisions	Martina Dinneen	Bi - Weekly to 30 November 2018	• Improved oversight and monitoring of forecast and provisional position to ensure that both NHSI, CCG and Trust are informed and appraised
SRO meetings in place for challenged services	Catherine Urch/Martina Dinneen	Bi - Weekly to 30 November 2018	• Challenged specialties are forecasting an improved position by end of December 2018 with significant progress in November.

Risk
• 2510 Failure to maintain key operational performance standards

Responsive – Critical care admissions

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% of critical care patients are admitted within 4 hours	100%	93.1% (September 2018)	Dr Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care



Site	August 2018 performance	September 2018 performance
CXH Critical Care	94.9% (YTD 91.7%)	88.3% (YTD 91.1%)
HH General Critical Care	90.7% (YTD 93.6%)	90.0% (YTD 93.1%)
SMH Adult Critical Care	92.2% (YTD 93.0%)	99.0% (YTD 94.1%)
All Units Combined	**93.0% (YTD 92.3%)**	**93.1% (YTD 92.7%)**

Latest performance

The national standard is that 100% of admissions of critically unwell patients should be admitted within 4 hours. Delays to admission are harmful to critically ill patients who need to be urgently managed within a specialised environment with expert medical and nursing care.

In September 2018, 93.1% of patients admitted to critical care were admitted within 4 hours of their referral for all units combined. The site level performance is shown above.

Responsive – Critical care admissions

Key issues	The main reasons for delayed admission to critical care are as follows: • Units running at high occupancy - usually >90% • A large number of CC patients unable to be discharged to the wards in a timely fashion due to lack of ward beds. • The high occupancy in both the hospital and critical care units can result in a “one -in -one out” situation with ward beds not being allocated unless there is pressure to admit/patient waiting. The units then have to “turn around” the bed. • ED patients taking priority • Delays can also result from cleaning and portering. Other delays on discharge can occur where wards are not fully comfortable with the discharge or particular ward facilities are not available e.g. tracheostomy beds

Improvement plans and action

Summary of proposed improvement areas requiring development

1. The improvements are reducing step down delays which is dependent on downstream bed availability and bed allocation prioritisation. Improving the delayed discharge situation in CC will include reviewing patients in and out of CC, communications with site team and identifying potential patients for step down earlier.

2. As highlight within the EMSA exception report the delayed discharges from the ICUs will form part of the on-going Trust capacity and flow work.

3. We are also working to improve ‘turn around’ times for each bed, preparing ahead as much as possible each bed which includes documentation/patient preparation and cleaning.

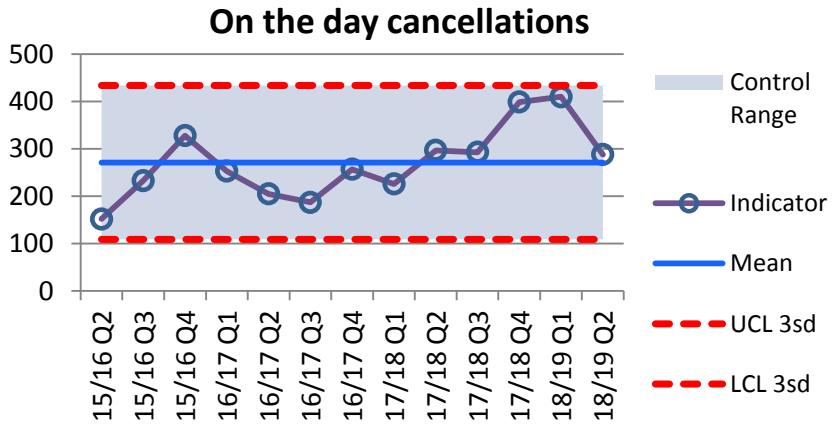
4. Scoping the inclusion of ICU capacity within the full capacity protocol –currently this does not happen until black status and however lack of ICU capacity on any one site could be a trigger for a red status.

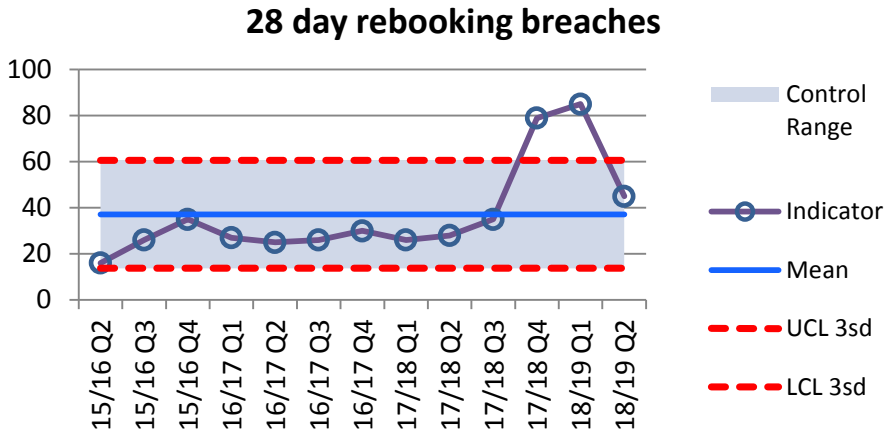
Risk

- Is it on the (divisional) risk register? NO

Responsive – cancelled elective operations

Indicator	Target	Latest data (Q2)	Executive lead	Report author(s)
Reduce cancelled operations and ensure patients are rebooked to within 28 days of their cancelled operation	Below national average	• Cancellations = 0.9% (below national average) • 28-day breach rate = 16% (above national average	Dr Catherine (Katie) Urch	Terence Lacey (Performance Support Business Partner); David Woollcombe-Gosson (Programme Manager, Surgical Productivity)





Latest performance

(*This indicator tracks nationally reportable on the day cancellations, i.e. those where a patient's operation is cancelled by the hospital at the last minute for non clinical reasons. In these cases the hospital should offer another binding date within a maximum of the next 28 days*)

The latest reported quarter is quarter ending September 2018:

- There were 288 reportable cancellations, equating to less than 1% of total elective admissions. This improved position brings the cancellation rate into line with the national figure for England of 0.9%.
- The Trust also improved time to rebooking for the 28-day guarantee. In Quarter 2, 45 breaches were reported which was a reduction of 40 on the previous quarter. However the breach rate remains above the England average for the same quarter of 8%.

- *Source: Quarterly Monitoring of Cancelled Operations (QMCO), NHS England*

Responsive – cancelled elective operations

Key issues	OTD non-clinical cancellations and 28-day breaches increased during the early part of 2018. This was related to the national mandate to support emergency pathways through temporary postponement of non-urgent elective activity. Alongside this there were continued operational pressures. Overall cancellation rates and reasons vary significantly by site and appear to be largely driven by specialties and case mix completed on each site rather than site-specific issues. The reasons for reportable (QMCO) cancellations are more consistent, with ward bed unavailable, earlier case overran and higher priority case accounting for 64% of all non-clinical cancellations. The Trust has a number of mitigating workstreams in place to both improve understanding and monitoring of cancellations, and to address the root causes wherever possible. This includes a dedicated supporting workstream within the overarching surgical productivity programme, which will cover all cancellations (incl. DNA) and not just those non-clinical cancellations that are reportable for national QMCO monitoring.

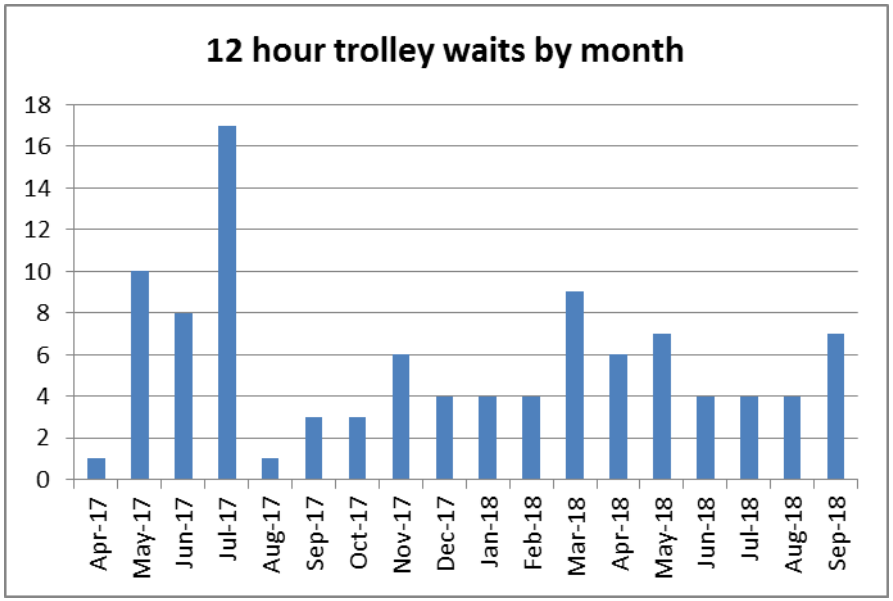
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Establish OTD cancellations group to develop workstream	Ksenya Kirnitski	September 2018	Completed. Scoping meeting held and review of cancellation reporting arrangements is underway with input from operational, BI and performance teams.
Develop On the Day cancellations Standard Operating Procedure	David Woollcombe-Gosson	Q3 2018/19	A draft OTD cancellations SOP has been drafted and is being prepared for piloting within a specialty prior to wider roll out.
Strengthen review of OTD cancellations and tracking of 28-day re-book patients via theatre planning process	Nadja Yohannes	Q3 2018/19	To be tested out through above SOP
Fund the move elective care procedures to CXH that do not require critical adjacencies/infrastructure on SMH site through the provision of an additional procedure room in Riverside CXH	Martina Dinneen/ Hugh Gostling	Nov 18	

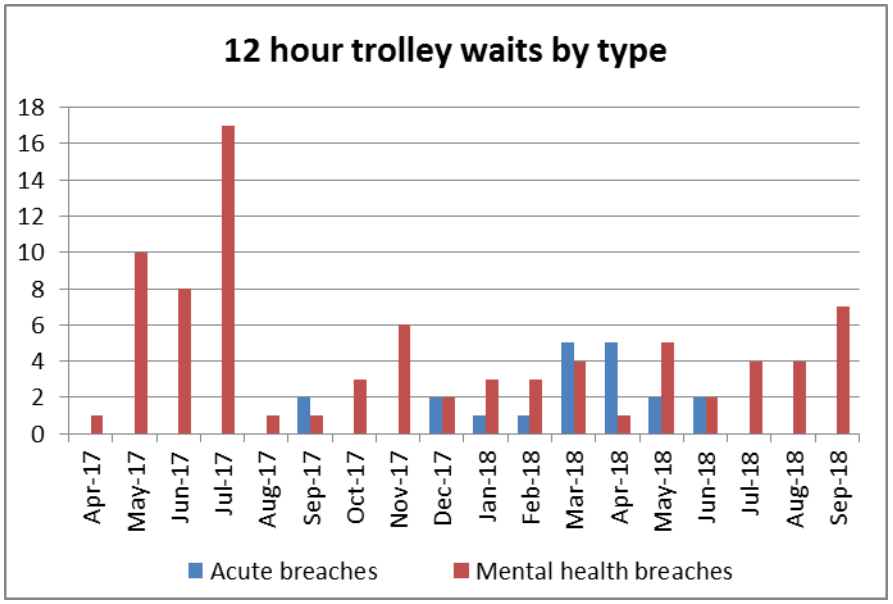
Risk

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

Responsive – 12 hour trolley waits

Indicator	Target	Latest data	Executive lead	Report author(s)
Number of waits for admission over 12 hours from DTA	0 breaches	4 breaches – August 2018 7 breaches – September 2018	Dr Frances Bowen	Sarah Buckland





Latest performance

- The number of 12 hour breaches rose to 7 in the month of September 2018.
- All 7 breaches were mental health related and on the SMH site in September 2018. There were no acute 12 hour breaches reported for the month.

Responsive – 12 hour trolley waits

Key issues	By exception
	• The Trust is working closely with CNWL to improve the patient pathway and reduce delays for Mental Health beds. • Insufficient bed availability and high occupancy rates at SMH are being managed through aspects of the Improving Patient Flow Programme .

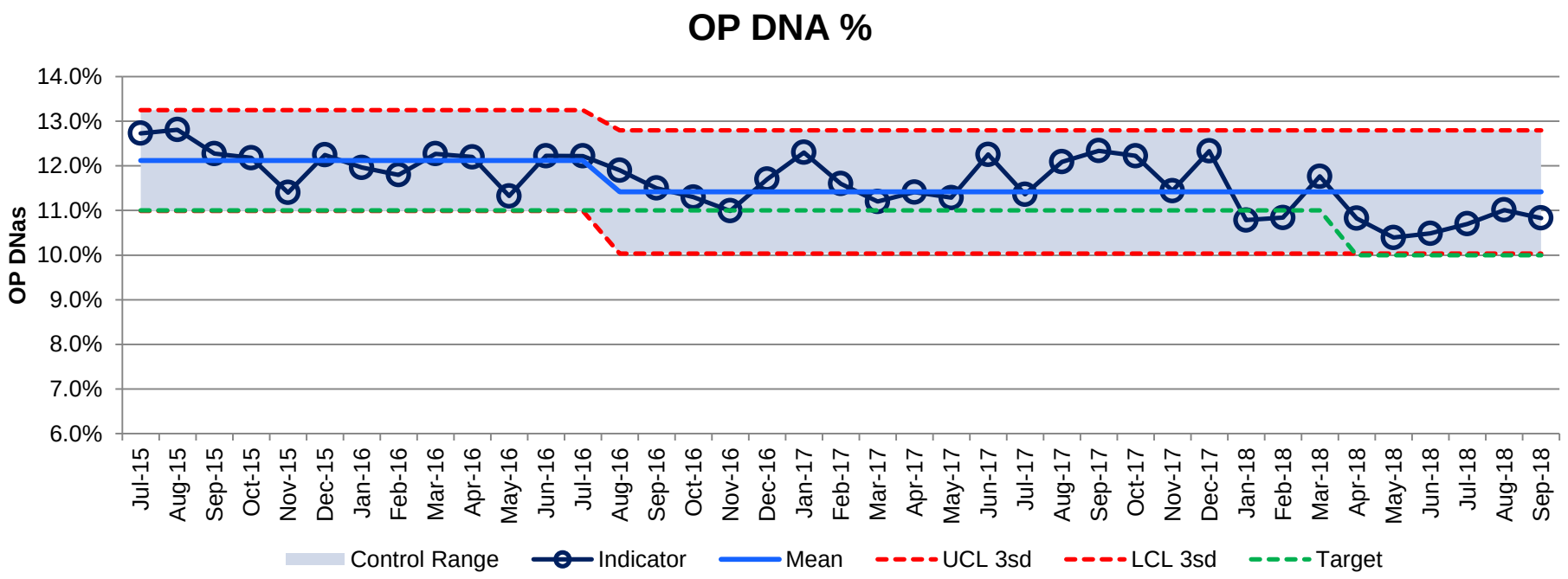
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review current escalation procedures	Sarah Buckland	July 18	Completed
Develop 12 hour trolley wait SOP	Sarah Buckland	Q3 2018/19	The timescale has been revised to reflect the complexity of this SOP and required input from teams currently under pressure.
Creation of 2 crisis calming rooms in CXH ED (part of the ED redevelopment & 136 compliant)	Sarah Grace	December 18	On track for delivery
Improvement of the ED environment for mental health patients at SMH	Sarah Grace	Q4 2018/19	5k grant awarded and plan of work agreed, further funding being sourced
Joint working with CNWL to develop ‘gold standard’ pathway for mental health	Sarah Grace	Q3 2018/19	Work to begin Q3.
Agreement of breach reduction trajectory for the 4 hour standard for mental health	Sarah Grace	Q2 2018/19	10% reduction by September 2018 agreed following audit with CNWL, West London MH and NWL CCG. Data to form regular part of partnership working.
Presentation of RCA reports for all breaches to the A&E Delivery Board	Claire Hook	Monthly	Commenced

Risk

- Is it on the (divisional / corporate) risk register? YES linked to corporate risk 2510, failure to maintain operational performance standards which includes 12 hour trolley waits. The risk score is currently graded at 20 with a target of 12.

Responsive – Outpatient did not attend rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%	10.8% (September 2018)	Tg Teoh	Damien Bruty (General Manager)



Latest performance

- The target for outpatient DNAs was reduced from 11% for 2017/18 to 10% for 2018/19
- The overall DNA rate was 10.8% in September 2018, a decrease on the 11.1% for August 2018. This was within the control limits for this indicator and did not highlight special cause variation.
- The outpatient DNA rate in the 6 months to September 2018 was 10.7% compared to the 6 months to September 2017 of 11.8%; showing an improvement to the Trust position.
- Targeted intervention undertaken in December 2017 to increase the utilisation of text and voicemail reminder services has reduced the DNA rate, but subsequent performance has plateaued

Responsive – Outpatient did not attend rates

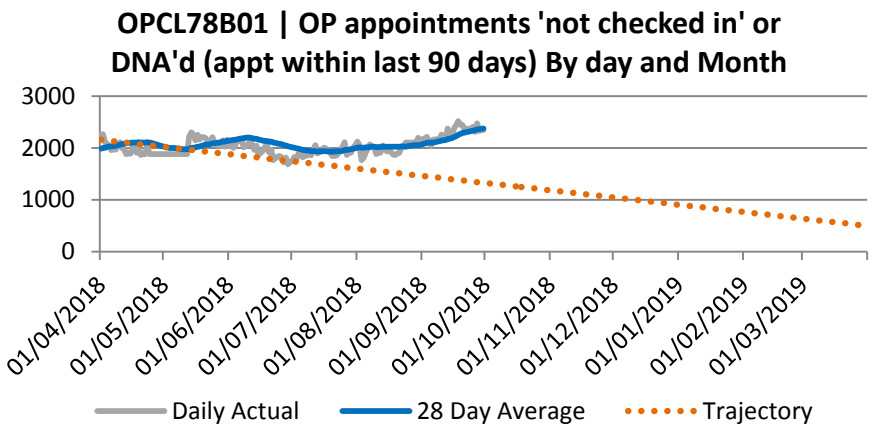
Key issues	• Whilst outpatient DNA rates have reduced during 2018, achieving a DNA rate of <10% requires a step change in approach. • Efforts to increase the coverage and usage of text and voice reminder services have been exhausted, with no further gains anticipated. • Since March 2018, patients have been unable to receive appointment letters by email due to a Trust ICT database issue and an associated data protection breach. Consequently, all appointment letters are being sent by post, negating the benefits of instant notification and delivery via email. This service was resumed on 4th October 2018, with anticipated benefits to follow. • The impact of the transition to the electronic referral service (e-RS) for GP referrals is not yet known. It is anticipated that through providing patients with the ability to choose their own appointment date and times, this will reduce the outpatient DNA rate for first appointments. Monitoring and analysis of the impact for patients referred via e-RS is required, post the full implementation of this service in October 2018.

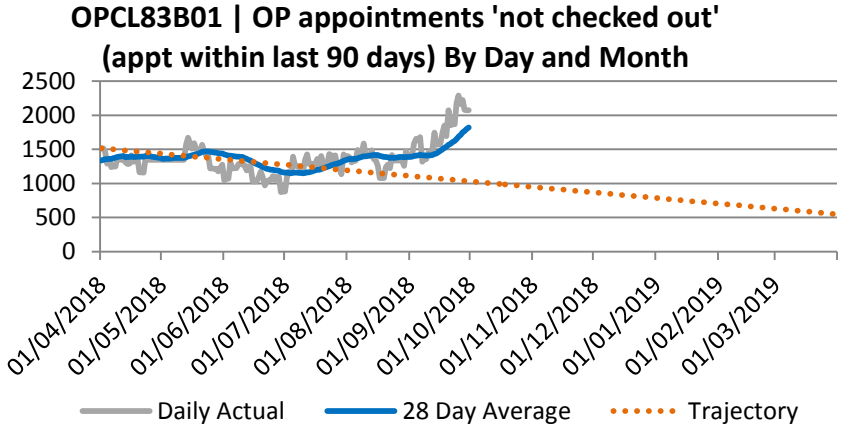
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Analysis of e-RS Outpatient DNA rate to be undertaken, to inform next steps for targeted intervention	Cameron Behbahani / Damien Bruty	November 2018	
Assurance review of Trust PIMS database to be completed to enable appointment letters to be sent by email	Sanjay Gautama / John Kelly	September 2018	Assurance review complete. Recommendations implemented. Email service reinstated 4th October 2018.
Deep dive analysis of Outpatient DNA rate for all services (new and follow up) to be undertaken, post stabilisation of e-RS	Cameron Behbahani / Damien Bruty	November 2018	

Risk
• Is it on the (divisional / corporate) risk register? NO

Responsive – DQI: Outpatient appointments not checked in / not checked out

Indicator	Target	Latest data	Executive lead	Report author(s)
We improve data quality by reducing outpatient appointments not checked-in or checked-out on our system in line with trajectories	Not checked in: 1329 Not checked out: 1032	At end September 2018: • 2377 OP appointments not checked in; • 1819 OP appointments not checked out	Tg Teoh	Caroline O'Dea, (Performance Support Team Business Partner)





At end Sep-18	Daily Actual	28 Day Average
Total	2349	2377
Central	*93*	*110*
Devolved	*2256*	*2267*

At end Sep-18	Daily Actual	28 Day Average
Total	2076	1819
Central	*338*	*336*
Devolved	*1738*	*1483*

Latest performance

In September 2018, an average total of 2377 outpatient appointments were not checked in or DNA'd across the Trust. This is an increase on the previous month by 315 appointments. Performance did not meet trajectory by 1048 appointments. Of the total number of not checked in or DNA'd appointments across the Trust, 95% are from decentralised outpatient departments.

In addition to the above, an average total of 1819 outpatient appointments were checked in and not checked out across the Trust. This is an increase on the previous month by 432 appointments. Performance did not meet trajectory by 787 appointments. Of the total number of appointments checked in and not checked out across the Trust, 82% are from decentralised outpatient departments.

Responsive – DQI: Outpatient appointments not checked in / not checked out

Key issues	• Incomplete recording of patient attendance impacting financial activity • Incomplete recording of patient DNA's impacting management of patient pathways • Delays to completing next steps for patients, impacting on waiting times • Risk to RTT 18 week pathway

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
New DQI dashboard reviewed on a monthly basis with operational teams with a focus on driving improvement across top 3 TFCs with highest volume of appointments unresolved.	Caroline O'Dea	March 19	Process agreed with each division for highlight reports to go via relevant senior level divisional meetings to ensure the information on high volume areas is shared with senior directorate colleagues for action.
Specialty training deep dives led by ECOF programme.	Gareth Gwynn	On-going	All priority specialty deep dives completed and plans for training now in place
Weekly monitoring process in place for central OPD with communication to specialties as per OPWL SOP	Damien Bruty	On-going	
Weekly PTL management meetings to include DQIs for areas off track in their performance.	SCC	November 18	

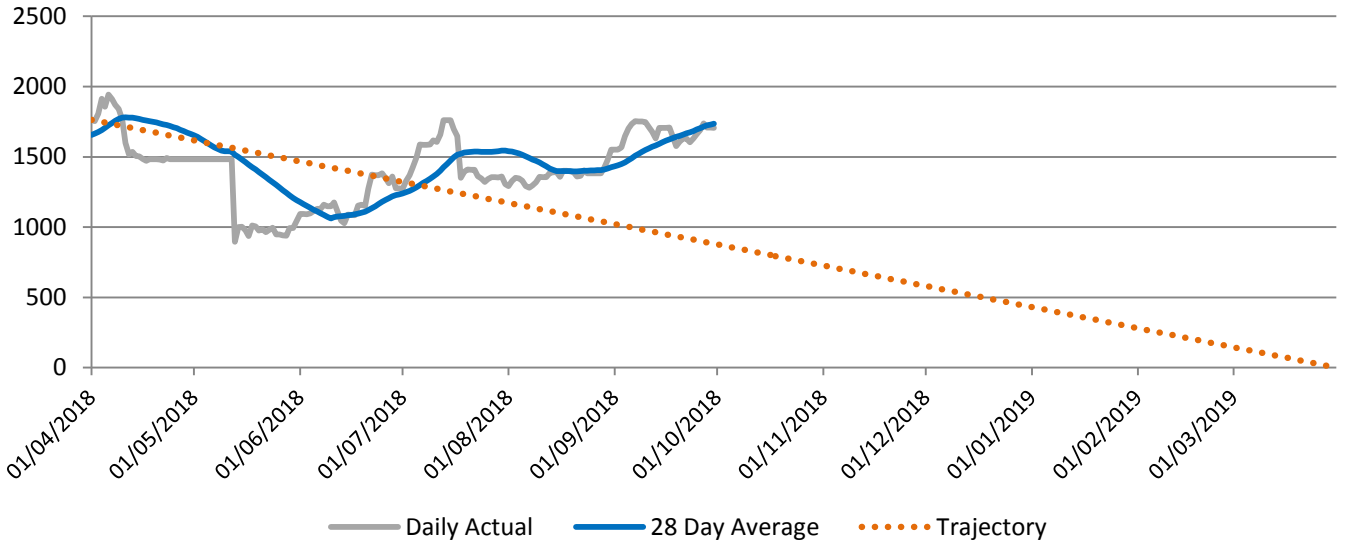
Risk

- Risk ID 1660 on corporate risk register – Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality.
  - ➢ Current risk rating: 20

Responsive – DQI: Orders waiting on the Add/Set Encounter request list

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve data quality by reducing orders for diagnostic and surgical procedures waiting to be processed on our system in line with trajectories	881	1736	Dr Catherine (Katie) Urch	Caroline O'Dea, (Performance Support Team Business Partner)

ERAP42B | Orders waiting on the Add/Set Encounter request list (over 2 working days) By day and month



Latest performance

In September 2018, an average total of 1736 orders across the Trust remained on the add/set encounter list in Cerner over 2 working days. Performance did not meet trajectory by 855 orders. The number of orders remaining on add/set encounter over 2 working days has increased by 311 orders since the end of August 18.

Responsive – DQI: Orders waiting on the Add/Set Encounter request list

Key issues	• Delay in adding patients to the inpatient waiting list causing hidden waits. • Potential risk to patient waiting times. • Potential impact on RTT 18 week pathways and performance.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Reported to elective care via the control of legacies update.	Karina Malhotra	Weekly	Current process currently in place
New DQI dashboard reviewed on a monthly basis with operational representatives, with a focus on driving improvement across top 3 TFCs with the highest volume of orders on the add/set list over 2 working days.	Caroline O'Dea	March 19	Process agreed with each division for highlight reports to go via relevant senior level divisional meetings to ensure the information on high volume areas is shared with senior directorate colleagues for action.
Focus on add/set DQI in specialty training deep dives.	Gareth Gwynn	On-going	All priority specialty deep dives completed and plans for training now in place

Risk
• Risk ID 1660 on corporate risk register – Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality. ➢ Current risk rating: 20

Appendix 1 Exception report slides tracker

This table provides the list exception reports included within section 3 of the report.

	Indicator heading	Executive Committee Reporting	Status
Safe	Serious incidents	ExQu	Within tolerance / target
	Incidents causing severe/major harm	ExQu	Within tolerance / target
	Incidents causing extreme harm/death	ExQu	Within tolerance / target
	Patient safety incident reporting rate	ExQu	**Exception report slides provided**
	Never events	ExQu	**Exception report slides provided**
	Patient safety alerts and medical devices	ExQu	Within tolerance / target
	Compliance with duty of candour (SIs)	ExQu	**Exception report slides provided**
	MRSA BSI and C.difficile	ExQu	**Exception report slides provided**
	E. coli BSI	ExQu	**Exception report slides provided**
	CPE BSI	ExQu	**Exception report slides provided**
	Ratio of births to midwifery staff	ExQu	Within tolerance / target
	Puerperal sepsis	ExQu	Within tolerance / target
	VTE risk assessment	ExQu	Within tolerance / target
	Safe staffing	ExQu	Within tolerance / target
	Core skills training	ExPOD	Within tolerance / target
	Safeguarding children training (level 3)	ExQu	**Exception report slides provided**
	Vacancy rate	ExPOD	**Exception report slides provided**
	Departmental safety coordinators	ExQu	**Exception report slides provided**
	RIDDOR	ExQu	Within tolerance / target
	Fire warden training	ExQu	**Exception report slides provided**
	Medical devices maintenance	ExQu	**Exception report slides provided**
Effective	HSMR and SHMI	ExQu	Within tolerance / target
	Palliative care coding	ExQu	Within tolerance / target

	Indicator heading	Executive Committee Reporting	Status
	Mortality reviews	ExQu	**Exception report slides provided**
	Unplanned readmission rates	ExQu	Within tolerance / target
	PROMs	ExQu	**Exception report slides provided**
	National Clinical Audits	ExQu	**Exception report slides provided**
	Clinical trials - recruitment	ExQu	**Exception report slides provided**
Caring	FFT - % recommended	ExQu	Within tolerance / target
	FFT A&E service - % response	ExQu	**Exception report slides provided**
	Mixed-sex accommodation (EMSA) breaches	ExQu	**Exception report slides provided**
Well led	Staff retention	ExPOD	Within tolerance / target
	Voluntary staff turnover rate	ExPOD	Within tolerance / target
	Sickness absence rate	ExPOD	Within tolerance / target
	Personal development reviews	ExPOD	Within tolerance / target
	Doctor appraisal rate	ExQu	**Exception report slides provided**
	Consultant job planning completion rate	ExQu	**Exception report slides provided**
	NHSI - provider segmentation	ExOp	Within tolerance / target
Responsive	RTT 18 weeks performance	ExOp	**Exception report slides provided**
	RTT 52+ weeks	ExOp	**Exception report slides provided**
	RTT 52+ weeks clinical harm reviews	ExOp	Within tolerance / target
	Cancer - 62 day waits	ExOp	Within tolerance / target
	Cancelled operations	ExOp	**Exception report slides provided**
	Theatre touchtime utilisation	ExOp	Report being developed
	A&E 4 hour waits	ExOp	Within tolerance / target
	A&E 12 hour trolley waits	ExOp	**Exception report slides provided**
	Discharges before noon	ExOp	Threshold is being set
	Stranded and super stranded	ExOp	Threshold is being set
	DTOC rate	ExOp	Within tolerance / target
	Diagnostic waits – over 6 weeks	ExOp	Within tolerance / target

	Indicator heading	Executive Committee Reporting	Status
	Waiting times for first Op appointment	ExOp	Within tolerance / target
	Outpatient HICS	ExOp	Metric being reviewed
	Outpatient DNA	ExOp	**Exception report slides provided**
	Outpatient apps within 5 working days	ExOp	Within tolerance / target
	PALS concerns	ExOp	Within tolerance / target
	Complaints - formal complaints	ExOp	Within tolerance / target
	Complaints – the average number of days to respond	ExOp	Within tolerance / target
	Orders waiting on Add/Set Encounter list	ExOp	**Exception report slides provided**
	OP apps not checked-in or DNAd	ExOp	**Exception report slides provided**
	OP apps checked In AND not checked out	ExOp	**Exception report slides provided**
	Patient transport	ExOp	Report being developed
	Critical care patients admitted within 4 hours	ExOp	**Exception report slides provided**
Use of Resources	Additional metrics on Use of Resources are being developed for reporting	ExFIN	Under development

Imperial College Healthcare NHS Trust – Action plan to deliver the agreed undertakings

At 23 November 2018

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Finances	1.1	Return to underlying surplus with year on year improvements in the underlying position	Start of 2021/22	In progress	We have agreed a framework for identifying the required savings focusing on: • Business as usual CIPs • Income and productivity opportunities • Private patients and commercial • Specialty review opportunities • Other (incl. transformation) We expect to move from our current deficit to un underlying deficit of £20-£25m by 2021/22, with further improvements thereafter depending on support to address structural issues relating to our estate. We are looking at options for coordinating the work, and the resources and structures necessary to support delivery of the plan. A permanent appointment has been made for the Director of Transformation to lead the delivery of the trust's transformation programme which started at the beginning of September.
	1.2	Develop and submit a financial recovery plan to return to surplus by the start of 2021/22	30 November 2018	In progress	We are submitting a draft plan to our Board for approval at the end of November. The agreed 2018/19 plan will form the first year of the recovery plan.
	1.3	Take reasonable steps to deliver the Financial Recovery Plan, ensuring adequate capacity and capability in place	30 November 2018	In progress	The financial recovery plan itself will address delivery factors including capacity over the four year plan timeframe. We already have a work group and resources in place to address capacity requirements for 2018/19.
	1.4	Keep Financial Recovery Plan under review and agree necessary amendments with NHS Improvement	30 November 2018	In progress	Meetings were held with NHSI on 10th October and 5th November to review status of recovery plan.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Emergency care	2.1	Take reasonable steps in order to achieve sustainable compliance with the 4 hour A&E target	2018/19	In progress	A number of additional measures were introduced in September 2018 with the support of 2020 Delivery, many of these are continuing, including the sustainability phase of work following the rapid improvement events around SAFER and faster moves improvement work, and the daily executive oversight continues. Furthermore at the end of October a measure to review performance within the 12:30 site capacity call was introduced with the aim to take immediate steps to support ED performance. The additional senior management support in the EDs was stepped down for a period this has been reinstated from mid-November. The Trust is on track to open additional inpatient capacity this winter with the support of capital funding secured. Current plans are to open c. 50 extra beds; with 20 beds at HH, 22 at CXH, and 13 at SMH. In addition the ED will create an additional 3 trolley spaces.
	2.2	Maintain A&E target at or above 90% throughout Winter 2018/19	2018/19	In progress	Performance against the 4 hour standard for October 2018 was 90.6%, the Trust achieved 0.4% above the trajectory for the month of 90.2%. System wide performance (this includes 100% ICHT and 52% CLCH activity and breaches) for the month of October 2018 was 93%, the quarter three target to achieve PSF funding is 90%.
	2.3	Maintain A&E performance of 95%	2018/19	In progress	As above

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
RTT	3.1	Ensure no patients are waiting more than 52 weeks on RTT pathways	31 October 2018	In progress	RTT long waiters (40+ weeks) are managed by clinical Directorates and Divisions, supported by the Elective Care Delivery Manager. All long-waiting patients are validated and actively tracked on a weekly basis, and monitored through specialty-led PTL meetings. The Trust continued to experience some challenges to achieving its trajectory. At the end of October the Trust reported 22 patients waiting over 52 weeks for treatment, a reduction of 24 compared to the previous month and above the zero trajectory target. Continued progress towards zero is expected in November. The performance team are meeting with the 12 challenged specialties to support action plans to improve performance against trajectories. This expected to have a positive impact on the trajectories going forward.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	3.2	Delivers the RTT incomplete performance target in line with the trajectory agreed in the 2018/19 plan through delivery of the agreed action plan	2018/19	In progress	The Trust submitted an updated RTT trajectory for 2018/19 to NHSE on 20th April, in line with national deadlines. This was a revision of the 2nd March draft, based on an 18/19 activity model developed with our CCGs. This activity plan was converted to RTT performance in the context of ongoing system challenges around demand & capacity, data quality and operational responsiveness. Additionally, an adjustment was made to projected waiting list size and performance over the winter period to reflect recent experience and anticipated impact in 18/19. A robust review of the 12 specialty action plans was completed and now being reviewed and updated, with support from performance. An RCA was completed and shared identifying the increase in "system errors" on the RTT PTL as the likely driver for the variance from the trajectory. A technical fix for the issue is required.
Data Quality	4.1	Amend the RTT action plan to ensure that it addresses the concerns set out in the independent review of clinical and administrative processes within elective pathways and clinical oversight of avoidable harm	31 October 2018	In progress	The MBI data assurance report was published 31 July 2018. Nine high level recommendations were provided which also have 45 sub-recommendations associated with them. A finalised action plan will be provided to the Executive Operational Committee and the Trust Board in November 2018.
	4.2	Implement the amended RTT action plan	Date to be agreed with NHS Improvement	In progress	As above. The Trust is setting up the governance structure to oversee the recommendations delivery of the actions will be tracked through the RTT improvement steering group.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Programme Management	5.2	Trust Board to oversee delivering undertakings, and risks to the successful achievement and hold individuals to account for the delivery of the undertakings	With immediate effect	On-going	From November 2018 the undertakings report will be included in the CEO's report to Board

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Finance Report for October 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of meeting: 28th November 2018	**Item 10, report no. 07**
Responsible Executive Director: Richard Alexander, Chief Financial Officer	**Author:** Michelle Openibo – Associate Director of Finance

Summary:

This report provides a brief summary of the Trust's financial results for the 7 months ended 31 October.

The Trust is on plan before Provider Sustainability Funding (PSF) in month and year to date. Control measures are in place in the Trust to ensure that the position remains on plan and that the control total is met for the year.

The Trust closed the month with £28.6m cash, there are no plans to access any further working capital facility.

Gross capital spend is £7.1m underspent against plan year to date. Spend has increased in month and the trust expects to meet the Capital Resource Limit (CRL) for the year.

Recommendations:

The Committee is asked to note the report.

This report has been discussed at:

Finance and Investment Committee, 21 November 2018

Quality impact: N/A

Financial impact:

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

1) Has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:

This report relates to risk ID:2473 on the trust risk register - Failure to maintain financial sustainability

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

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

Has an Equality Impact Assessment been carried out?

☐ Yes ☐ No ☒ Not applicable

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

Paper respects the rights, values and commitments within the NHS Constitution.

☒ Yes ☐ No

Trust strategic objectives supported by this paper:

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

FINANCE REPORT – 7 MONTHS ENDED 31st October 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 7 months ended 31st October 2018.

2. Financial Performance

The Trust is on plan in month and year to date, not including Provider Sustainability Funding (PSF). There is over performance in clinical income offset by underachievement of cost improvement programmes (CIPs) causing expenditure overspends. In September the Trust implemented additional controls to manage emerging cost pressures. These measures remain in place as we enter what will doubtless be a challenging winter.

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	97.35	102.96	5.61	653.68	661.27	7.59
Pay	(51.80)	(53.11)	(1.31)	(363.04)	(364.13)	(1.09)
Non Pay	(38.20)	(43.43)	(5.23)	(266.66)	(283.53)	(16.87)
Internal Recharges	-	0.00	0.00	-	0.00	0.00
Reserves	(2.99)	(2.15)	0.84	(16.60)	(8.15)	8.45
EBITDA	4.36	4.27	(0.09)	7.38	5.47	(1.91)
Financing Costs	(3.69)	(3.90)	(0.21)	(27.17)	(24.60)	2.57
SURPLUS / (DEFICIT) inc. donated asset treatment	0.67	0.37	(0.30)	(19.79)	(19.13)	0.67
Donated Asset treatment	(0.20)	0.10	0.30	(0.02)	(0.68)	(0.67)
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT)	0.47	0.47	(0.00)	(19.81)	(19.81)	(0.00)
PSF Income	3.42	3.42	0.00	15.37	13.84	(1.54)
SURPLUS / (DEFICIT) after PSF income	3.89	3.89	0.00	(4.44)	(5.98)	(1.54)

2.1 Provider Sustainability Funding

PSF is assessed on a quarterly basis, 30% is achieved for meeting the 4 hour A&E target and 70% for achieving the control total. The funding is phased so that it increases throughout the financial year. At quarter 1 the Trust was slightly below the A&E four hour target compared to the same quarter in the last year, though above agreed trajectory, as such the Trust did not achieve the £1.5m A&E element of PSF. The Trust has been successful in achieving the A&E and financial targets of quarter 2 and therefore will receive all PSF. The current forecast is to achieve the remaining PSF.

2.2 NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Total Division of Medicine & Integ. Care	472,211	441,594	(30,617)	156.98	158.41	1.43
Total Division of Surgery, Cancer & Cardiov.	363,492	375,528	12,036	194.16	197.71	3.55
Total Division of Women, Children & Clin. Support	1,288,540	1,311,896	23,356	93.65	93.19	(0.46)
Central Income			-	82.81	86.51	3.70
Clinical Commissioning Income	2,124,243	2,129,018	4,775	527.60	535.82	8.22

The Trust is over performing on income year to date; this is mainly in non-electives and day cases, with underperformance in maternity and outpatients. Income has increased over the year and is expected to increase further over winter, in line with previous years. The current income over performance will be a cost pressure for commissioners and the Trust is working closely with them to understand the drivers to manage the financial risk.

Medicine and Integrated Care (MIC) is over performing on non-elective activity across all sites. Surgery, Cancer and Cardiovascular (SCC) has significant over performance on cardiology and clinical haematology. Other surgical specialties are behind plan year to date but the division has recovery plans to bring elective activity in line with the plan. Women, Children and Clinical Support (WCCS) is behind plan year to date due to underperformance on gynaecology and reproductive medicine. In previous months there has been underperformance in maternity activity but the division has seen an increase in activity in October.

2.3 Private Patient Income

Private patient income is above plan in month bringing the overall position £0.9m adverse year to date. Year to date there has been over performance in gynaecology and reproductive medicine where the growth planned has been overachieved. There is under performance in SCC directorates where cost improvement plans for growth have not yet been delivered. SCC is working closely with the IPH team to identify opportunities to deliver private activity.

2.4 Clinical Divisions

The financial position by 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
Medicine and Integrated Care	Income	24.78	25.48	0.70	167.91	168.17	0.26
	Expenditure	(18.37)	(19.38)	(1.01)	(128.48)	(131.91)	(3.42)
		6.41	6.09	(0.32)	39.43	36.26	(3.17)
Surgery, Cancer and Cardiovascular	Income	30.87	32.39	1.53	203.36	201.58	(1.78)
	Expenditure	(24.24)	(26.11)	(1.87)	(168.37)	(174.59)	(6.22)
		6.63	6.29	(0.34)	34.99	26.99	(8.00)
Women, Children & Clinical Support	Income	15.56	16.16	0.60	104.11	102.24	(1.87)
	Expenditure	(16.17)	(17.13)	(0.96)	(115.64)	(118.92)	(3.28)
		(0.61)	(0.97)	(0.36)	(11.53)	(16.68)	(5.15)
Imperial Private	Income & Expenditure	1.25	1.78	0.54	8.36	9.64	1.27
Total Clinical Division		13.68	13.20	(0.48)	71.26	56.21	(15.05)

Clinical Divisions are £15m behind plan year to date. This adverse variance to plan is being mitigated by reserves releases.

MIC is adverse to plan year to date, mainly due to unidentified or unmet CIPs. The division has seen increasing activity on non-electives and has had additional nursing costs to cover high acuity patients.

SCC is adverse to plan year to date, the in-month position, though still adverse, is an improvement on previous months due to additional income over performance. Expenditure is over plan; this is as a result of unmet CIPs and additional costs of outsourcing. The Division also has the costs of the waiting list improvement programme within its position which is above budget; the costs of this programme are being reviewed.

WCCS is behind plan year to date and in month. Year to date the division is behind plan on income with underperformance in NHS maternity activity, private and NHS gynaecology and NHS paediatrics. In month there has been an increase in maternity activity. The adverse position in expenditure is due to unmet CIPs.

Imperial Private Health (IPH) is above plan due to additional private activity. This income mainly relates to gynaecology over performance with smaller movements in other specialties.

3. Efficiency programme

The Trust is £6.4m adverse to its submitted CIP plan YTD which is largely due to under performance on income related schemes and gaps for unidentified schemes.

The forecast is £11.7m adverse to plan, largely due to £5.1m of unidentified schemes, £4.8m on income backed productivity schemes and some additional risk against pay and non-pay savings.

The organisation continues to work with the Divisions to identify and embed efficiencies, drawing on Trust expertise, Model Hospital, GIRFT and our own Specialty Review Programme. Work is being completed within procurement to unlock further savings and efficiencies where possible and understand and mitigate risk. The Trust has been working on a pay efficiency framework and recovery plan to support delivery of our control total and longer term sustainability. The Trust has also implemented a number of additional controls in order to manage expenditure.

4. Cash

The cash positional at the end of October was £28.6m. In-month cash has decreased by £10.6m from the opening balance. The Trust is required to keep a balance of £3m cash to meet the requirements of the working capital facility agreement. The Trust does not anticipate requiring any further draw down of the facility.

5. Capital

Against the Capital Resource Limit (CRL) capital expenditure is £2.1m overspent in month. This reflects work done within the Trust to catch up on under delivery of capital schemes year to date. Year to date against the CRL the Trust is £7.1m behind plan mainly on equipment and ICT spend.

The Trust is expecting to increase its CRL spend for the year by £11.7m; £5m investment in additional bed capacity funded by Winter Pressures capital and £6.7m further capital investment to support a number of projects including work on the Charing Cross Emergency Department refurbishment. In additional the Trust has requested £35.4m capital funding from NHSI.

The Trust is expecting to meet the CRL spend in year and the programme is actively managed by the Capital Expenditure Assurance group and Capital Steering Group.

6. Conclusion

The Trust is on plan year to date before PSF but there remain risks to the achievement of the control total for the year. The Trust must continue to deliver cost savings and improving the expenditure position of the organisation. The level of NHS clinical income over performance also causes a risk to the Trust if it is unaffordable for commissioners. The Trust is working closely with commissioners to mitigate any risks from over performance.

7. Recommendation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 7 months to 31st October 2018

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	81.8	86.7	4.9	545.0	550.1	5.1
Private Patients	4.4	4.7	0.2	31.1	30.2	(0.8)
Research, Development and education	7.8	7.9	0.1	54.2	55.2	0.9
Other non-patient related income	3.3	3.7	0.4	23.4	25.8	2.4
Total Income	97.4	103.0	5.6	653.7	661.3	7.6
Pay - in post	(48.8)	(46.3)	2.6	(342.5)	(318.4)	24.0
Pay - Bank	(0.7)	(4.3)	(3.7)	(4.4)	(31.0)	(26.6)
Pay - Agency	(2.3)	(2.5)	(0.2)	(16.2)	(14.7)	1.4
Drugs and Clinical supplies	(21.7)	(23.1)	(1.4)	(147.9)	(144.5)	3.4
General Supplies	(2.9)	(3.4)	(0.5)	(20.4)	(21.8)	(1.4)
Other	(13.6)	(16.9)	(3.3)	(98.4)	(117.2)	(18.9)
Total Expenditure	(90.0)	(96.5)	(6.5)	(629.7)	(647.7)	(18.0)
Reserves	(3.0)	(2.2)	0.8	(16.6)	(8.1)	8.5
Earnings before Interest, Tax, Depreciation and Amortisation	4.4	4.3	(0.1)	7.4	5.5	(1.9)
Financing Costs	(3.7)	(3.9)	(0.2)	(27.2)	(24.6)	2.6
SURPLUS / (DEFICIT) including financing costs	0.7	0.4	(0.3)	(19.8)	(19.1)	0.7
Donated Asset treatment	(0.2)	0.1	0.3	(0.0)	(0.7)	(0.7)
SURPLUS / (DEFICIT) including donated asset treatment	0.5	0.5	(0.0)	(19.8)	(19.8)	(0.0)
Impairment of Assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	0.5	0.5	(0.0)	(19.8)	(19.8)	(0.0)
PSF	3.4	3.4	0.0	15.4	13.8	(1.5)
SURPLUS / (DEFICIT) after PSF	3.9	3.9	0.0	(4.4)	(6.0)	(1.5)

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: CQC Update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 28 November 2018	**Item 12, report no. 08**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Authors:** Priya Rathod, Deputy Director of Quality Governance

Summary:

This report is the regular update to the Board on CQC-related activity at and/or impacting the Trust. Following a review of critical care at the Trust in July 2018, outcomes were presented at the Improving Care Programme Group in September 2018. Highlights of good and outstanding practice and areas for improvement are presented here.

In lieu of a core service review for children and young peoples' services at the Trust, the divisional triumvirate is undertaking walk rounds for each unit in the core service.

The CQC met with leads from the core service of critical care in October and this was well received. During the second part of the Trust-level meeting, information about changes to the CQC's inspection scheduling for the remainder of 2018/19 and for 2019/20 was shared with the Trust.

- Routine inspections originally scheduled to take place later in the current financial year are being brought forward.
- More inspections are being planned than was previously expected.

The Trust received its annual Provider Information Request from the CQC on 21st November 2018

The Board will recall that the Trust previously developed and implemented a *Compliance and Improvement Framework* in 2015 which was then revised in 2016 and again in 2017.

Moving forward, it is envisaged that the previous framework will be refreshed and re-launched. Further detail will be discussed at the next improving care programme group meeting and an update brought back to the Board thereafter.

Trust-level headlines from the Trust's latest CQC Insight report (published October 2018) include:

- The Trust has not performed well in relation to the 4 hour A&E target, which is a known issue; we are currently performing much worse than other trusts on this measure.
- The Trust has recently had a whistleblowing raised with the CQC and continues to be 'much worse than other trusts' on this measure.
- The Trust is performing 'worse than other trusts' for the occurrence of never events.
- The Trust improved in the most recent national inpatient survey in relation to confidence and trust in nurses, and is now performing about the same as other trusts on this measure.
- The Trust has improved and is now performing better than other trusts for:
    - Staffing ratios to bed occupancy.

- Ratios of senior nurses to staff nurses.
- % of ward staff who are registered nurses.

- The Trust has improved and is now performing much better than other trusts for deaths in low-risk groups.

A number of general updates are also included in the paper.

Recommendations: To note the updates.

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

Financial impact: This paper has no financial impact.

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

Workforce impact: None

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

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

Trust strategic objectives supported by this paper:
- To achieve excellent patients experience and outcomes, delivered with care and compassion.
- To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Update for the leadership briefing and communication and consultation issues:
All aspects of this paper can be included in leadership briefings and can be shared by leaders with all staff.

CQC Update

1. Purpose

1.1. The following report is the regular update to the Board on CQC-related activity at and/or impacting the Trust.

2. Preparation for Possible CQC Inspections during 2018/19

Core service of Critical Care

2.1. Following an internal review of the critical care core service at the Trust against current CQC standards in July 2018, the full report was circulated to areas on 30 August 2018 to check for factual accuracy.

2.2. Outcomes of the review and high level actions were presented to the Improving Care Programme Group at its meeting on 17 September 2018.

2.3. Areas of good and outstanding practice included:

- Even when concerns were raised, staff across areas and sites described positive and effective team working, cross team working, cross site working, and collaborative relationships among staff and teams.
- Many staff in the ICU at St Mary's Hospital referred to the morning safety meeting as a key forum for sharing information and supporting staff. It was referred to as 'the best thing' and the most important meeting, and clearly works well.
- The culture among medical staff on the ICU at Hammersmith Hospital was praised for strong team working and multi-disciplinary working, accessibility and support of consultants though they are small in number, and the unit being highly rated on the latest GMC survey.
- Several positive findings related to the Outreach service, including responsiveness and support provided to areas, cross working with the Site Operations team, and going 'above and beyond' to provide excellent care. These findings were particularly impressive given the capacity and demand challenges currently facing the service.

2.4. Areas for improvement included:

- Staffing establishments among therapists and for the Outreach service were not adequate.
- Variations in record keeping systems among sites (different IT platforms and some paper records) meant staff did not always have all relevant information needed to care for patients.
- Some equipment was out of date for safety and /or electrical testing to confirm it is safe to use.
- Expired medications were found in some areas visited; the exceptions were the ARUs at both sites and the CICU.

2.5. The critical care CQC readiness group will take forward the actions identified and report on progress to the Improving Care Programme Group.

2.6. Leads for critical care at the Trust met with the Trust's CQC relationship manager on 10 October 2018 as part of the Trust's routine engagement with the CQC and this was well received by the CQC.

Core service of Children's and young people

2.7. The divisional triumvirate is currently undertaking walk rounds for each unit in the core service.

2.8. Actions resulting from walk rounds will be managed via the children's CQC task & finish group, which reports to the Improving Care Programme Group by exception.

3. Trust engagement and new information about upcoming Trust inspections

- **Engagement meeting with the CQC**

3.1. During the engagement meeting with the CQC on 10th October, 2018, information was shared with the Trust about changes to the CQC's inspection scheduling for the remainder of 2018/19 and for 2019/20. The implications for the Trust are summarised below:

- **Routine inspections currently planned to take place towards the end of the current year (i.e. Q4) are being brought forward.**
  - This is likely to mean that Critical care and Services for children and young people will be inspected before the end of December 2018.

- **Services not previously inspected by the CQC are being prioritised.**
  - At the Trust, this includes the Western Eye Hospital and Partnership for Health, the Trust's GP practice.

- **The CQC may prioritise re-inspection of services which were recently inspected and were rated overall as 'Requires improvement'.** At the Trust, this includes:
  - Medical care at St Mary's and Hammersmith hospitals
  - Maternity at St Mary's Hospital
  - Urgent and emergency services at St Mary's and Charing Cross hospitals
  - Surgery at St Mary's and Charing Cross hospitals

  - **The CQC has previously indicated that where it has not inspected a service at all sites, it is likely to visit all sites when it carries out a re-inspection.**
    - This could mean a re-inspection of Maternity at both St Mary's (inspected in March 2017) and Queen Charlotte's and Chelsea Hospital (not re-inspected since 2014).
    - The Heart Attack Centre and Urgent Care Centre at Hammersmith Hospital were not visited during the inspection of Urgent and emergency services in November 2017; these areas were last visited during the Trust-wide inspection in 2014.

- **Annual Provider Information Request**

3.2. The Trust received its annual Provider Information Request (PIR) on 21st November 2018.

3.3. Receipt of the PIR initiates a six month period during which at least one core service will be inspected, and which concludes with an inspection of well-led at Trust level.

3.4. The inspections carried out in this programme (i.e. after receipt of the PIR) **will be in addition** to any core service inspections carried out between now and the end of December 2018.

4. Improving Care Programme Group

4.1. The group continues to meet twice monthly with a focus on the 'Big 4' work streams as well as core services.

5. Trust's approach to CQC compliance and assurance going forward

5.1. The Trust's approach to improving the Trust's level of achievement against the CQC standards is made up of three key elements. Improving the quality of services will be driven through the implementation of the Trust's 'improving quality strategy', supported by the 'Leading Change through vision, values and behaviours' programme, which will create the culture in the organisation to deliver excellent care, and the implementation of an improving care assurance framework which will provide assurance that services are delivering excellent care and achieving 'good' or 'outstanding' in all areas.

Improving Quality Strategy

5.2. The Trust's 'Improving Quality Strategy' is being drafted and will set out our ambitions for quality over the next five years with the aim to be rated as outstanding by our regulators, the CQC, during its lifetime. It will give a clear narrative around how we will plan, improve and monitor the quality of care we provide putting our standardised improvement methodology into action in everything we do. It focuses on getting the basics right as well as fulfilling our role of pushing the boundaries of innovation. It has been developed following an extensive listening campaign with over 1,000 members of staff, patients and members of the public and will be presented in draft to the executive in December 2018 and then quality committee in January.

5.3. This strategy will align our efforts to the CQC domains as well as to the National Quality Board's Shared Commitment to Quality as part of the Five Year Forward View. The strategy will therefore be framed around the seven steps that the NQB set out as being key to improving quality; implementing them should support us to get to outstanding. These steps include setting direction and priorities, being clear about our plans for improvement and implementing them using improvement methodology, having a rigorous approach to measurement, building capability and capacity for improvement and staying ahead with innovation and research to push the boundaries. The strategy will be our commitment to the continuous improvement of our services.

Leading Change through vision, values and behaviours

5.4. A new programme of work, leading change through vision, values and behaviour, was launched by the chief executive at the leadership forum on Tuesday 6 November. During the session, senior leaders from across the Trust took part in activities that have been developed to stimulate thoughts and actions about how each of us can help to achieve our vision (of 'better health,for life') and to live our values (to be kind, aspirational, expert and collaborative). The activities are also designed to generate feedback to inform organisational strategies, priorities and business plans and to describe the behaviours we want our values to generate, and those we don't.

5.5. Senior leaders are now taking these activities out into the wider organisation, running exercises as part of team meetings, events or workshops. We are also building a wider pool staff from across the organisation to help run these activities to ensure we engage and reach as many staff as possible. So far, activities have taken place or have been planned that reach just under 1.500 people. We have also begun to involve external stakeholders and patients in this work and will focus on these audiences more in the new year. We'll collate and analyse all of the feedback to share back with staff and stakeholders and to shape plans and developments for 2019/20 and beyond.

Improving care assurance framework

5.6. In order to underpin the Trust's approach to CQC, a robust process of compliance and assurance against the standards is required that is evidence based. This has been one of the fundamental drivers when Trusts have been rated a 'Good' or 'Outstanding' rating by the CQC.

5.7. The Board will recall that the Trust previously developed and implemented a *Compliance and Improvement Framework* in 2015 which was then revised in 2016 and again in 2017. The purpose of the framework was '*to set out procedures for assessing and monitoring compliance with the CQC's regulations to ensure the Trust meets the requirements of CQC registration, and to support the delivery of 'good' and 'outstanding' care'.*

5.8. Elements of the framework included; self-assessments ward accreditation, rolling programme of internal core service reviews, monthly CQC assurance reports and other assurance tools that enabled the Executive Committee and Board to have a line of sight regarding compliance with the CQC KLOEs by core service.

5.9. Moving forward, it is envisaged that the previous framework will be refreshed and re-launched. Further detail will be discussed at the next improving care programme group meeting and an update brought back to the Board thereafter.

6. CQC Insight

6.1. Trust-level headlines from the latest CQC Insight report (published in October 2018) include:

- The Trust has not performed well in relation to the 4 hour A&E target, which is a known issue; we are currently performing much worse than other trusts on this measure.
  - The Board will be aware of the work being undertaking regarding 4 hour performance.
- The Trust has recently had a whistleblowing raised with the CQC and continues to be much worse than other trusts on this measure.
  - The whistleblowing has been investigated by the Trust and a response submitted to the CQC who consider the matter now closed.
- The Trust is performing worse than other trusts for the occurrence of never events.
  - An update on never events is presented as a separate item to this committee.
- The Trust improved in the most recent national inpatient survey in relation to confidence and trust in nurses, and is now performing about the same as other trusts on this measure.
- The Trust has improved and is now performing better than other trusts for:

- Staffing ratios to bed occupancy.
- Ratios of senior nurses to staff nurses.
- % of ward staff who are registered nurses.

- The Trust has improved and is now performing much better than other trusts for deaths in low-risk groups.

7. General updates

- ***Registration Status***

7.1. The Trust continues to be registered at all sites with no conditions.

- ***Statutory notifications made to the CQC***

7.2 A statutory notification was submitted to the CQC during Q2 regarding the breakdown of a lift in the Clarence wing at St Mary's Hospital, which resulted in a disruption to two services (one medical ward and Maternity) (the lift was repaired in less than one week but the CQC requires notice about a disruption lasting longer than 24 hours).

7.3 No changes were made to Trust services during Q2 which required notification to the CQC.

7.4 One statutory notification was made to the CQC during Q2 in relation to the Trust's application of the Mental Health Act 1983. This was in relation to certified treatment of a detained person.

- ***Concerns, Complaints and Whistleblowing Raised with the CQC***

7.5 One whistleblowing alert (the same one as outlined in section 6.1) was made to the CQC during Q2 about a department at Hammersmith Hospital, in relation to a long-standing estates issue and the behaviour of an individual member of staff. None of the allegations were substantiated; the CQC are content with the Trust's response and consider the matter closed.

7.6 During Q2 the CQC asked the Trust to investigate six concerns/complaints raised with them. None of the concerns was substantiated by the Trust's investigations. The CQC was satisfied with all of the Trust's responses and considers these matters closed.

7.7 The Trust notified the CQC about one incident during Q2 which related to patient at the Charing Cross site. A serious incident investigation is currently underway and the outcome will be shared with the CQC.

- ***CQC Publications***

7.8 In September 2018 the CQC published a report on quality improvement (QI) in acute, mental health and community trusts. The report was based on interviews with staff, interviews with CQC inspectors, visits to six trusts, inspection reports, trust board papers and trust QI publications.

7.9 This report was discussed at the Executive Quality Committee in October 2018.

7.10 The CQC published its annual State of Care Report on 11 October 2018.

8. Next Steps

8.1. Support for inspection preparations will continue to be provided to children's services and critical care with a view to extend this to other core services/areas that are likely to be inspected during 2018/19.

8.2. The Improving Care Assurance Framework will be finalised and an implementation plan established.

9. Recommendations

9.1. To note the updates.

Authors: Priya Rathod, Deputy Director of Quality Governance

21th November 2018

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q1 2018/19	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 28 November 2018	**Item 13, report no. 09**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Jon Otter, General Manager, IPC Eimear Brannigan, Deputy Director of IPC

Summary:

- There were two Trust-attributed MRSA BSI cases identified during Q2 (July and September). Actions around clearer record keeping for line insertions were identified and have been addressed. The case in September is still under review.
- There have been 12 cases of Trust-attributed *C. difficile* identified during Q2, below the Trust ceiling for this period. Three of these 12 cases had a 'lapses in care' identified due to antibiotic choices.
- There have been two CPE BSI in Q2, which makes 5 for 2018/19; healthcare-associated CPE BSIs have been selected as a new internal performance metric for the Trust.
- Overall consumption of antibiotics continues to fall, and the increasing trend in carbapenem consumption is at its lowest level since Q2 2016/17.
- A Trust-wide project is in progress to improve hand hygiene practice. All inpatient areas are currently leading local improvement activity using a toolkit with ideas for change. Wards with the lowest compliance have commenced a structured hand hygiene improvement programme supported by the IPC and improvement teams. All inpatient areas will be re-audited during Q3 & Q4 to track progress. Hand hygiene soap and gel dispensers are also being upgraded across the Trust, improving visual cues.
- An outbreak of *Pseudomonas aeruginosa* occurred: eight babies became colonised with this organism in the neonatal unit, which has highlighted issues related to water hygiene management and environmental hygiene, and laboratory turnaround times.
- The process around ensuring that the operational management of water hygiene is performed by Trust Estates and their contractors is being strengthened, specifically related to testing for Pseudomonas and Legionella and associated remedial actions.
- An outbreak of MRSA in the ICU at SMH has occurred affecting 15 patients and highlighting the role of occupational health and staff carriage in outbreak management and issues related to laboratory turnaround times.
- Issues related to environmental hygiene in the Trust have been identified, and Trust-wide steps are in place to improve cleaning standards; this is reflected on a new risk on the IPC risk register.
- Laboratory related issues have occurred during Q2, including delays in testing diagnostic specimens, and communication of results from the hospital laboratory and PHE. The risk related to microbiology laboratory support has been updated to reflected challenges in turnaround time for diagnostic specimens.

Recommendations:

The Board is asked to note the report.

This report has been discussed at:
☒ Executive Quality Committee
☒ Board Quality Committee

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

Financial impact:
No direct financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
This report includes a summary update of the IPC risk register.

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

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

What impact will this have on the wider health economy, patients and the public?
☐ Yes ☒ No ☐ Not applicable

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

The report content respects the rights, values and commitments within the NHS Constitution
(see report writing guidance for further information)
☒ Yes ☐ No

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.

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers? N
If the details can be shared, please provide the following in one to two line bullet points:
- What should senior managers know? That the quarterly IPC report is available to review.
- What (if anything) do you want senior managers to do? Read the relevant sections of the report.
- Contact details or email address of lead and/or web links for further information Jon Otter (jon.otter@nhs.net)

Should senior managers share this information with their own teams? Senior managers could share this report with their teams for information.

1 Healthcare-associated infection (HCAI)

1.1 *HCAI mandatory reporting summary*

'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital. For MRSA, MSSA, E. coli, CPE, P. aeruginosa and *K. pneumoniae BSI, Trust cases are those that are identified after two days of hospitalisation; for C. difficile, Trust cases are those that are identified after three days.*

Table 1 provides a summary of Public Health England's healthcare-associated infection (HCAI) mandatory reporting, showing the number of cases by month.

	Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	**YTD (ceiling)**
Trust *C.difficile*	8	7	6	6	4	5	8	5	2	5	2	5	**30**	**33**
Trust MRSA BSI	0	0	0	0	0	0	1	0	0	0	1	0	**2**	**0**
Trust MSSA BSI	2	-	5	-	3	-	2	-	4	-	1	-	**17**	**-**
Trust *E.coli* BSI	5	-	8	-	8	-	7	-	8	-	13	-	**49**	**-**
Trust CPE BSI	3	-	0	-	0	-	1	-	0	-	1	-	**5**	**-**
Trust *Pseudomonas aeruginosa* BSI	3	-	3	-	0	-	5	-	5	-	5	-	**21**	**-**
Trust *Klebsiella pneumoniae* BSI	7	-	2	-	4	-	5	-	4	-	6	-	**28**	**-**

'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital. For MRSA, MSSA, E. coli, CPE, P. aeruginosa and *K. pneumoniae BSI, Trust cases are those that are identified after two days of hospitalisation; for C. difficile, Trust cases are those that are identified after three days.*

Table 1: HCAI mandatory reporting summary.

1.2 *C. difficile*

There have been 12 Trust-attributed cases this quarter, against a quarterly ceiling of 15 cases (Figure 1). *C. difficile* assigned as Trust-attributed was detected in 0.8% of 1471 specimens of stool tested during Q2. The Trust has a comprehensive set of measures in place to optimise antibiotic usage and minimise the risk of antibiotics driving *C. difficile* infection, and to reduce its transmission, including multidisciplinary clinical review of all cases, and rapid feedback of lapses in care to prompt ward-level learning. This needs to be supported by maintaining the highest standards of environmental hygiene and IPC practices. The Trust's serious incident framework is used to investigate lapses in care where appropriate. To further reduce the risk of transmission of *C. difficile* and other pathogens and to improve the cost-efficiency and operational delivery of hydrogen peroxide vapour (HPV) room decontamination already performed in the Trust, a procurement process for the on-site HPV / ultraviolet (UV) room decontamination service is almost complete. It is proposed that HPV/UV will be used to decontaminate rooms and bays for patients with pathogens such as *C. difficile*, CPE, MRSA and VRE. In addition it will be used for the control of outbreaks of these and other organisms.

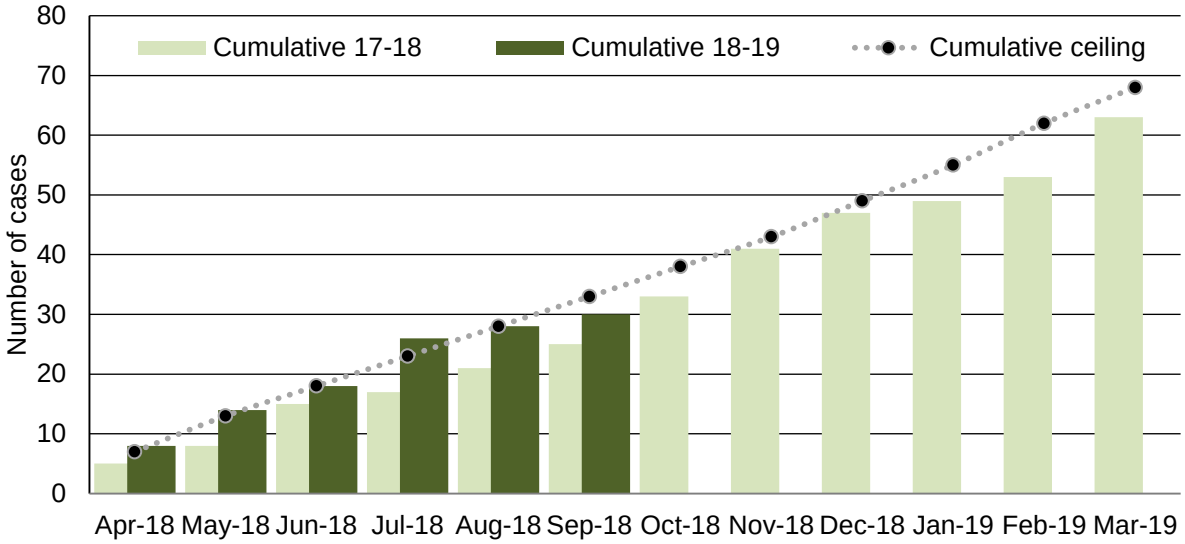


Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in 2018/19 (dark green bars) compared with 2017/18 (light green bars).

1.2.1 *C. difficile*: 'lapses in care'

Three of the 12 cases of Trust-attributed *C. difficile* identified during Q2 had 'lapses in care'* identified (Table 2). This compares with one lapse in care in Q2 of 2017/18, and seven in total in 2017/18. Two of the three cases occurred on wards in the Division of Medicine, with one on a ward in the Division of Surgery Cancer and Cardiovascular. All were related to antibiotic choices and have been discussed with the prescribers and clinical team involved to ensure that lessons are learned. Learning from the lapses in care in 2018/19 (eight in total) has been reviewed and shared with the clinical teams involved. In addition the Trust wide antibiotic policy and its associated antibiotic app are being re-launched in November 2018 and will provide an opportunity to reemphasise the antibiotic choices and their durations. This will be disseminated through clinical and managerial structures within the Trust.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Total number of toxin positive cases 17/18	8	6	4	8	2	2
Specimens sent for *C.difficile* testing	505	507	456	481	498	492
Lapse in care*	2	1	2	2	0	1

**The definition of a lapse in care associated with toxin positive C. difficile disease is non-compliance with the ICHT antibiotic policy, or potential transmission. Potential transmission is identified if, following a review of the patient's journey prior to the positive test, there is a point at which the patient shared a ward with a patient who was symptomatic with C. difficile positive diarrhoea of the same ribotype.*

Table 2: Summary of lapses in care related to C. difficile.

1.2.2 *C. difficile*: time to isolation

The Trust has a policy to isolate patients who develop diarrhoea within two hours of the start of their symptoms which is recommended by the Department of Health. 77% of patients were isolated within two hours during Q1 and Q2 (Figure 2), which is an increase from 73% during 2017/18. The measures undertaken to improve the time to isolation for patients who develop diarrhoea include real-time feedback and education by the IPCNs to the clinical team for each individual case. This seeks to address the specific reason for non-compliance and is reinforced by a one-page training sheet, which is disseminated to the ward team. If a single room is not available within 2 hours from the time the decision to isolate has been made this is escalated to the Site Operations Team who follow the

standard operating procedure for prevention of delayed transfers to isolation for patients with infectious diarrhoea.

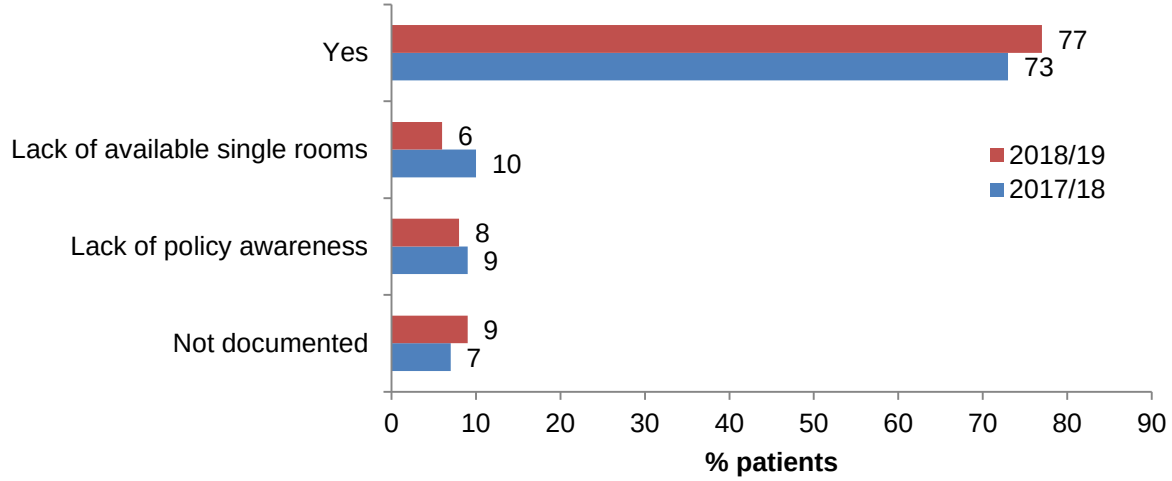


Figure 2: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with C. difficile diarrhoea.

1.2.3 *C. difficile:* comparison with the Shelford group

The rate of Trust-attributed *C. difficile* at ICHT ranks 5 in the Shelford group of hospitals, based on 28 cases for the period Apr-18 and Aug-18 (using the latest available data from PHE) (Figure 3), compared to a rank of 2 (second lowest rate) in 2017/18. The rate of specimens tested for *C. difficile* in the other Trusts is unknown, but remains broadly constant at ICHT (see Table 2).

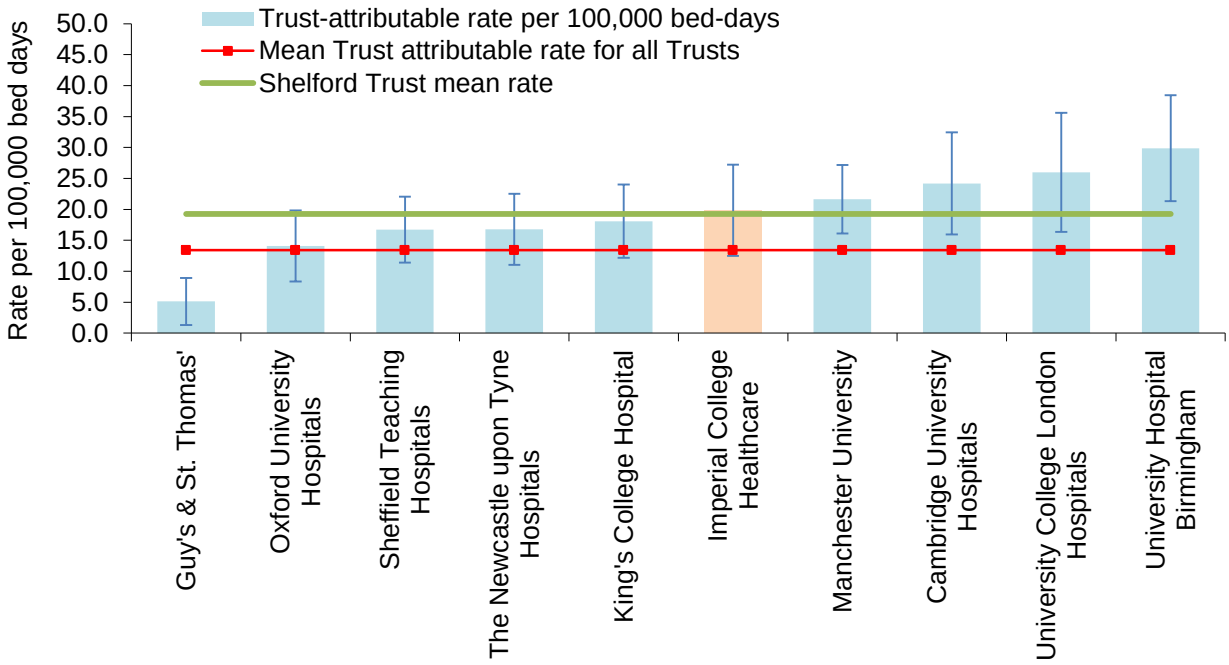


Figure 3: C. difficile Shelford Group comparison, 2018/19. Error bars denote the 95% confidence interval around the rate for each hospital.

1.3 MRSA BSI

There were two cases of Trust-attributed MRSA BSI during Q2, from the 7969 blood cultures tested bringing our YTD figure to 2 (compared to 1 case for the same period in 2017/18). Any Trust-attributed MRSA BSI undergoes a detailed investigation by IPC in conjunction with the clinical team

involved, to identify any learning points and implement any improvements in practice. In September 2018, an elderly patient was admitted via the Emergency Department and then diagnosed with an MRSA BSI whilst on a medical ward. The source of the BSI is yet to be confirmed. IPC is investigating this with the clinical team. In July 2018, an elderly patient, undergoing palliative care developed an MRSA BSI on a medical ward. No definitive source was identified. The two cases occurred on the same medical ward, however they are not linked in time and cross transmission is not suspected. Lessons learnt for these complex patients were around clearer record keeping on line insertions on CERNER, which have been shared with the clinical team and via the Line Safety Management Group and the Trust weekly HCAI Taskforce call which has representation from each of the Divisions. There were no issues with screening for MRSA in both these patients' pathways.

MRSA admission screening continues to be monitored monthly via the IPC Scorecard; compliance for Q2 was 90% (8522 of 9461 patients were screened), increased from 88% in Q1 2018/19

1.4 MSSA BSI

There have been seven cases of Trust-attributed MSSA BSI in Q2, compared with 10 in Q2 2017/18. There is no national threshold for MSSA BSI at present. Three of the seven cases were associated with a vascular access device (one with a peripheral cannula, one with a central line, and one with a Hickman line). Each case of MSSA BSI is reviewed by a multidisciplinary group (including the clinical team), and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases. Actions identified from these cases include education and improved monitoring of the length of time vascular access devices are in place.

1.5 Gram-negative BSIs (*E. coli, Pseudomonas aeruginosa, and Klebsiella pneumoniae)*

There have been 28 cases of Trust-attributed *E. coli* BSI in Q2, compared with 15 cases in Q2 in 2017/18 (Figure 4). This gives a total of 49 cases during 2018/19 year to date compared with 35 at the end of Q2 during 2017/18. There have been 15 Trust-attributed *P. aeruginosa* BSI in Q2 and 21 during 2018/19. There have been 15 Trust-attributed *K. pneumoniae* BSIs during Q2 and 28 during 2018/19. The sources of these BSIs are summarised in Table 3. Gram-negative BSI caused by CPE has been selected as a performance metric for the Trust: there have been two CPE BSIs in Q2 and five during 2018/19.

In each case, clinical management was advised by an infection clinician at the time of the result becoming available. There is no national threshold for *E. coli, P. aeruginosa, or K. pneumoniae* BSI at present. However, achieving a 10% reduction in healthcare-associated *E. coli* BSIs has been selected as a new internal performance metric for the Trust for 2018/19. Cases of *E. coli* and other Gram-negative BSI are reviewed monthly to identify any potential trends. It seems likely that many of the cases of healthcare-associated *E. coli* BSI are a direct result of necessary therapy and interventions and are not preventable (e.g. those associated with neutropenia).[1] However, other sources of infection are more likely to be preventable (e.g. *E. coli* BSIs associated with urinary catheters). Addressing the various sources of *E. coli* BSI, especially urinary sources, is a focus of a multidisciplinary group working around reducing Gram-negative BSI (see section 1.5.2).

[1] Otter JA, Galletly TJ, Davies F, Hitchcock J, Gilchrist MJ, Dyakova E, Mookerjee S, Holmes AH, Brannigan ET. Planning to halve Gram-negative bloodstream infection: getting to grips with healthcare-associated *Escherichia coli* bloodstream infection sources. *J Hosp Infect* 2018 in press.

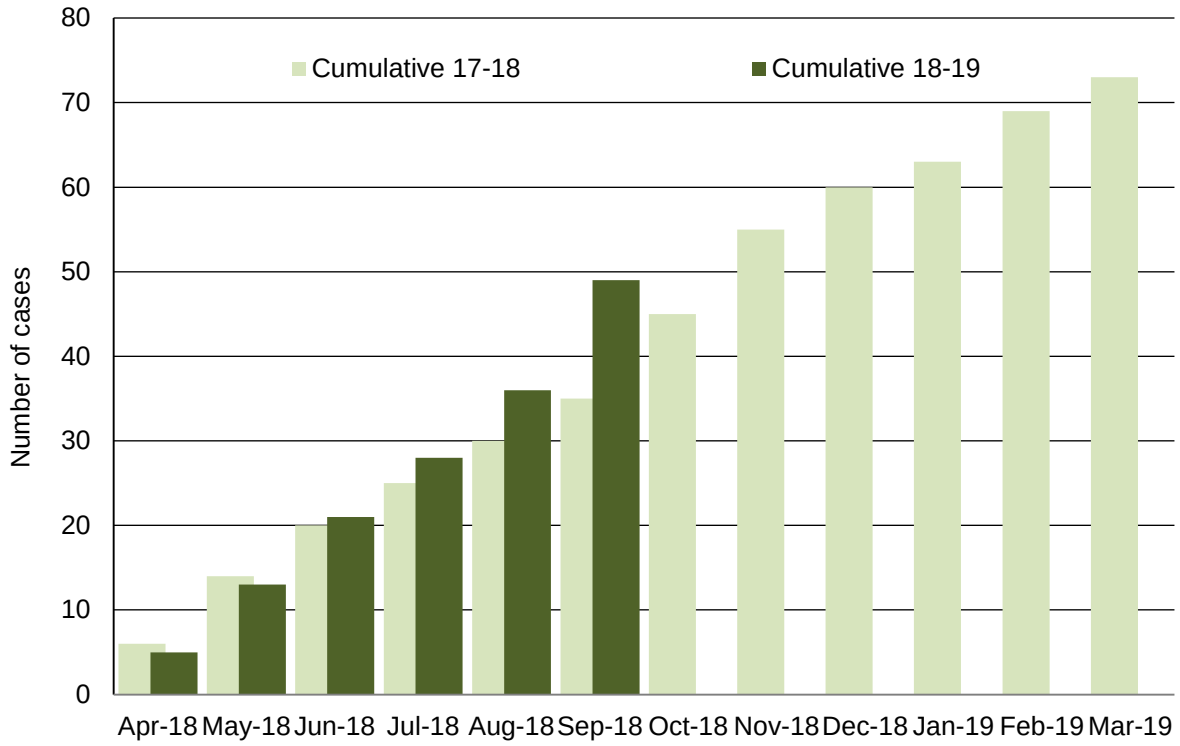


Figure 4: Cumulative monthly 2018/19 Trust-attributed E. coli BSI (dark green bars) compared to 2017/18 (light green bars).

GNBSI	**Quarter 2**		
Sources	*E. coli* BSI	*K. pneumoniae* BSI	*P. aeruginosa* BSI
Urinary - urinary catheter associated	7	3	2
Urinary - other	3	0	0
Neutropenic sepsis	9	3	4
Neonatal sepsis	0	3	0
Hepatobiliary	2	0	1
Gastroinstestinal	5	2	0
SSI	0	1	1
Vascular access device	0	0	4
Surgery	0	0	1
Pneumonia	0	1	1
Other/Unknown	2	2	1

Table 3: Summary of GNBSI sources.

1.5.1 *E.coli* BSI: comparison with the Shelford group

Imperial ranks 5 in the Shelford group of hospitals, based on 150 healthcare and community-associated *E. coli* cases for the period Apr-18 and Aug-18 (Figure 5); this is the same rank as during 2017/18.

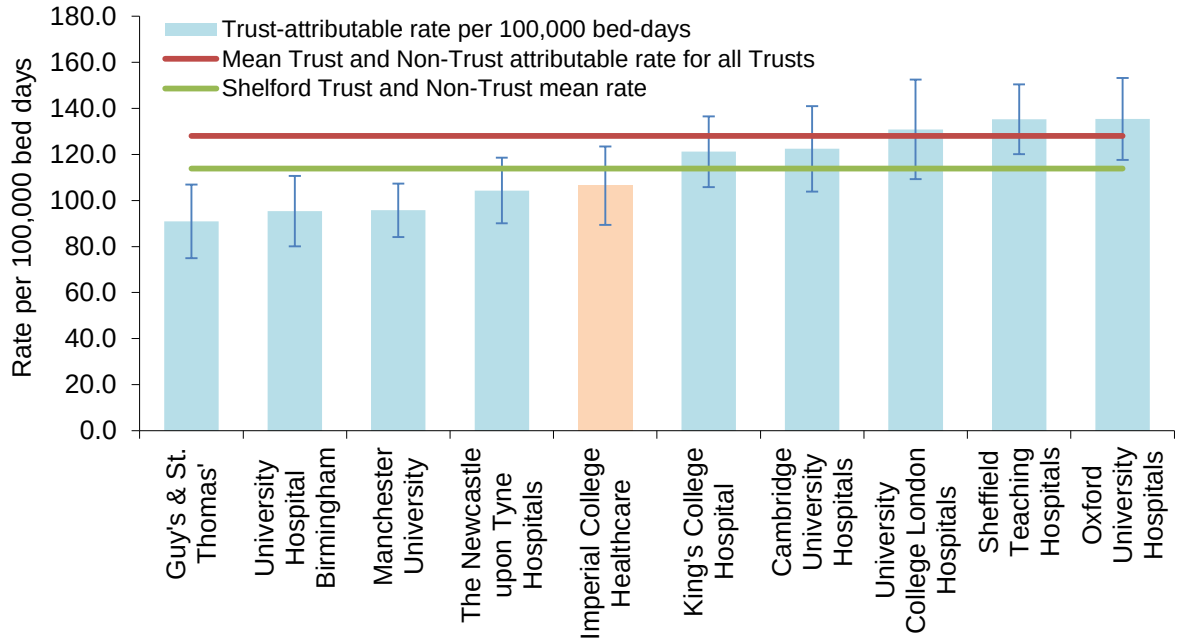


Figure 5: E.coli BSI Shelford Group comparisons, 2017/18. Error bars denote the 95% confidence interval around the rate for each hospital.

1.5.2 Gram-negative BSI reduction target

The government has announced an ambition to halve healthcare-associated Gram-negative BSI by 2021. Since outlining the Trust's approach to reducing Gram-negative BSIs (outlined in the 2017/18 Q2 report), the following progress has been made:

- enhanced case review and reporting to PHE including regular review of local antibiotic susceptibility and guidelines,
- supporting the CCG in investigating non-Trust attributed Gram-negative BSIs,
- close working with the sepsis identification and management plans in the Trust that may impact Gram-negative BSIs.

The following steps are planned during Q3 via a new Gram-negative BSI reduction group:

- improving the appropriate use of urinary catheters and hydration management in conjunction with the nursing directorate,
- planning new prevention initiatives in partnership with high-risk clinical areas (for example haematology, renal, NICU, and post-surgical wards).

1.6 *Blood culture surveillance summary*

The overall trend in BSIs (all positive blood cultures, Trust and community attributable) by organism / organism-group for Q3 2017/18 – Q2 2018/19 remains relatively unchanged (Figure 6.) Gram-negative bacteria predominate, with *E. coli* accounting for an average (median) of 37 BSI per month and for 16.4% of all positive blood cultures. There have been 15 Trust-attributed *Klebsiella pneumoniae* cases and 15 Trust-attributed *Pseudomonas aeruginosa* cases during Q2, compared to 13 *Klebsiella pneumoniae* cases and 6 *Pseudomonas aeruginosa* cases in Q1 2018/19 and we continue to monitor these cases closely. *Staphylococcus aureus* accounted for 8.2% of all positive blood cultures; MRSA accounts for 0.2% of all BSIs. Bacteria identified in blood cultures that are associated with patients' skin and considered not to be representing infection ('contaminants') accounted for 2.3% of 33,439 blood cultures taken during this period which is below our local benchmark of 3%.[2] We have an ambition to assess all clinical staff for competency in aseptic non-touch technique (see section 3.1) to further reduce contaminants.

[2] Benchmark for contaminated blood cultures set based on published literature, which suggests a rate of 3%: Self et al. *Acad Emerg Med* 2013; 20:89-97.

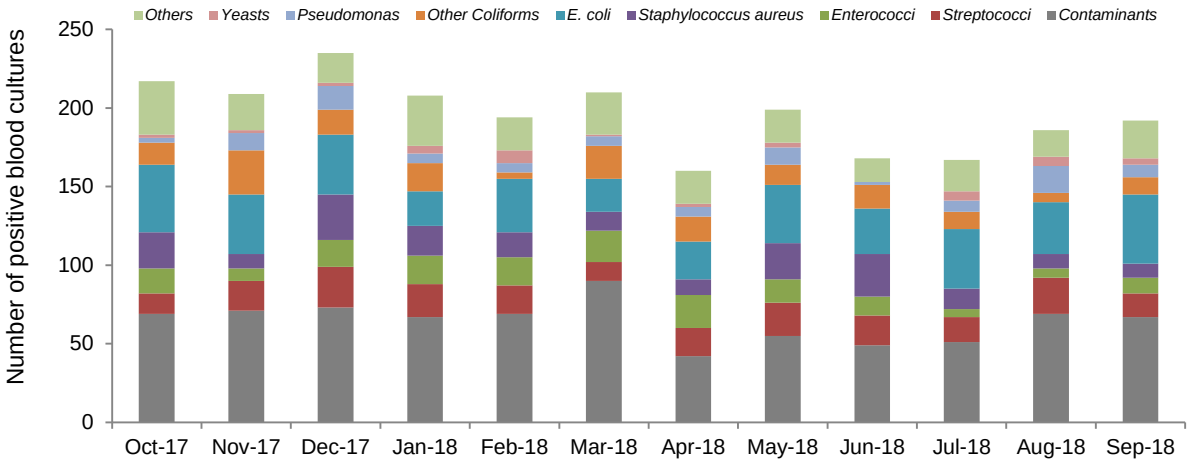


Figure 6: All positive blood cultures (Trust and non-Trust attributed) by organism / organism-group from Q3 2017/18 to Q2 2018/19.

1.6.1 Bloodstream infection (BSI) surveillance in ICUs

1.6.1.1 Adult ICUs

The catheter line-associated BSI (CLABSI) rate in the adult ICUs over the past 12 months (Oct 17 - Sep 18) is 1.7 per 1000 catheter line-days (Figure 7), which is below the benchmark of 3.0 per 1000 catheter-line days (ECDC benchmark). Split by site, the CLABSI rate is 1.5 for Charing Cross Hospital, 1.8 for Hammersmith Hospital, 1.6 for St. Mary's Hospital. There have been four CLABSI episodes during Q2 2018/19 for all three ICUs. We continue with detailed surveillance, weekly ward rounds, ANTT competency assessments, and infection discussions with clinicians in maintaining the low rate of CLABSI in our intensive care units.

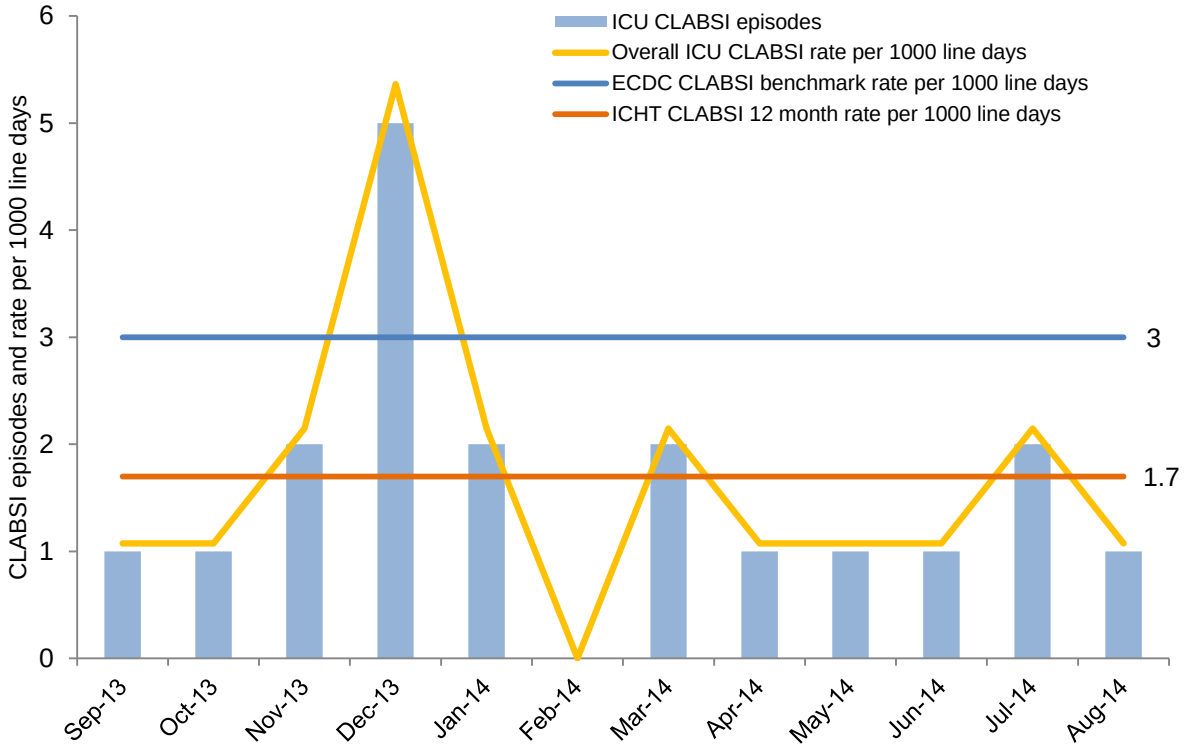


Figure 7: CLABSI episodes on the adult ICUs against the benchmark rate.

1.6.1.2 Paediatric ICU (PICU)

There have been three CLABSIs in 1821 catheter-line days between Oct 17 and Sep 18 on the PICU. Two CLABSI cases were in Dec-17, with one of the CLABSI cases confirmed as a catheter-related BSI (CRBSI), with an additional case Jun-18. The 12-month rate of 1.6 per 1000 catheter-line days is below the ECDC European benchmark of 3.0 per 1000 catheter line days.

1.6.1.3 Neonatal ICU (NICU)

In the 12 month period, Oct 17 to Sep 18, the CLABSI rate on the neonatal ICU (NICU) at SMH and QCCH combined was 6.1 per 1000 catheter line days. The National Neonatal Audit Programme (NNAP) benchmark is 3.0 per 1000 line days. The difference between the rate at ICHT and the benchmark is most likely explained by the high acuity of babies cared for on the NICUs at ICHT. The 12 month CLABSI rate in Very Low Birth Weight (VLBW) babies in the NICU was 8.2 per 1000 catheter line days, below the NEO-KISS nosocomial infections surveillance project benchmark figure of 8.6 per 1000 catheter line days. NICU have implemented actions to maintain the CLABSI rate, which includes a review of guidelines for the insertion of intravascular devices, improved insertion techniques, and a focus on aseptic non-touch technique for all clinical staff.

1.7 Surgical site infection

The Trust reports SSI rates following selected orthopaedic procedures in line with national mandatory reporting, and selected cardiothoracic procedures participating in a national voluntary reporting scheme. A business case to invest in more resources to create a programme of SSI surveillance in improvement in all surgical categories in the Trust is being finalised.

1.7.1 Orthopaedics

The latest quarter (Jul – Sept 18) has seen:

- 0 SSI in 121 knee procedures so far recorded.
- 0 SSI in 74 hip procedures so far recorded.

The 12-month average for knee procedures is 0.3% (1 SSI in 377 operations) (national average 0.6%). The 12-month average for hip procedures is 0.0% (0 SSI in 264 operations) (national average 0.6%).

1.7.2 Cardiothoracic

The latest quarter (Jul – Sept 18) has seen:

- 3 (5.6%) SSI of 54 CABG operations so far recorded.
- 2 (5.6%) SSI of 38 non-CABG operations so far recorded.

The 12-month average for CABG procedures is 5.1% (14 SSI in 277 operations) (national average 3.7%). The 12-month average for non-CABG procedures is 2.4% (4 SSI in 178 operations) (national average 1.2%). The slightly elevated rate of SSI in CABG and non-CABG procedures in the last quarter and over the past 12 months has been highlighted to the Division and patient level investigations are being undertaken which will be reviewed at the Trusts Surgical Infection Group in November 2018. An update will be provided in the next report.

1.7.3 Vascular SSIs

Following surgical site infection surveillance findings in 2017 and a serious incident investigation in vascular surgery, an extensive quality improvement programme and action plan was implemented to review and enhance practice across the patient pathway. The action plan emerging from the serious incident to investigate SSI in Vascular surgery (STEIS 2017/19226) has been strengthened to have clearer defined actions, with support from IPC and the Surgical Infection Group. The action plan is designed around the patient pathway through the vascular service, from pre-operative, through peri-operative, to post-operative. The plan includes all of the domains covered in the NICE 'SSI: prevention and treatment' guidelines (Clinical guideline [CG74]), and the Trust's 'SSI: Prevention of Infection Guideline'. Prospective collection of SSI surveillance data is being piloted in vascular; this data will be used to participate in PHE's national SSI surveillance scheme, which will allow benchmarking with other vascular centres. Effective surveillance of SSI is a critical outcome in the quality of patient care,

and an important component of identifying areas of clinical practice that require improvement. NICE guidance recommends that 'people having surgery are cared for by healthcare providers that monitor surgical site infection rates (including post-discharge infections) and provide feedback to relevant staff and stakeholders for continuous improvement through adjustment of clinical practice' (NICE 2013). A business case is underway to extend SSI surveillance by building a surveillance team in the corporate IPC service, to support the Clinical Divisions in implementing surveillance in each surgical category, and prompting a reduction of SSIs.

1.8 *Carbapenemase-producing Enterobacteriaceae (CPE)*

1.8.1 Detection of CPE

Figure 8 provides a breakdown of CPE detected at the Trust by bacterial species and mechanism of carbapenem resistance. The majority of patients were identified by screening cultures, without evidence of clinical infection (Figure 9). The number of screens taken each month and number of new CPE cases detected have plateaued over previous six months.

1.8.2 CPE admission screening compliance

During Q2, overall compliance with CPE admission screening was 84% (2707/3233), against a target of 90%. The CPE action plan in section 1.8.3 details actions taken and planned in order to reach this target. Screening compliance in high risk areas during Q2 was 97% (285/294) for ICUs, 96% (223/232) for Renal, 95% (45/47) for Haematology, 88% (152/174) for Vascular, and 89% (113/127) for Private Patients. CPE admission screening compliance is included by ward in the monthly Harm Free Care report. This provides a mechanism to prompt targeted improvement at the ward level to address areas of low compliance.

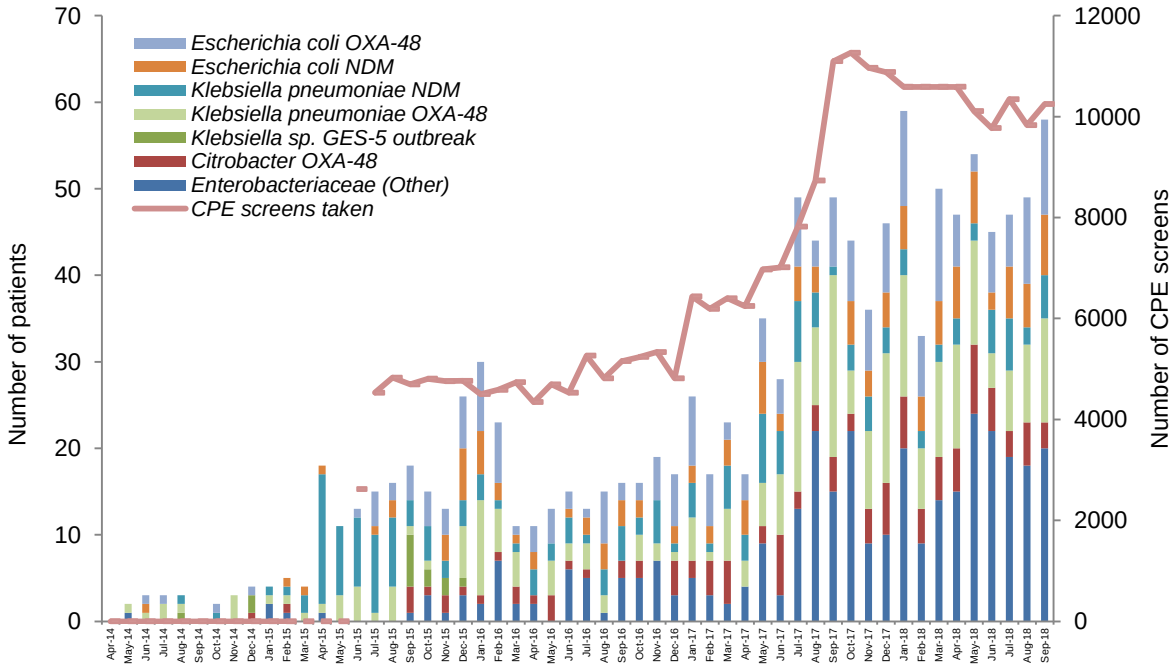


Figure 8: CPE detected at the Trust, by bacterial species and mechanisms, deduplicated by patient. The line represents the total number of screens taken each month.

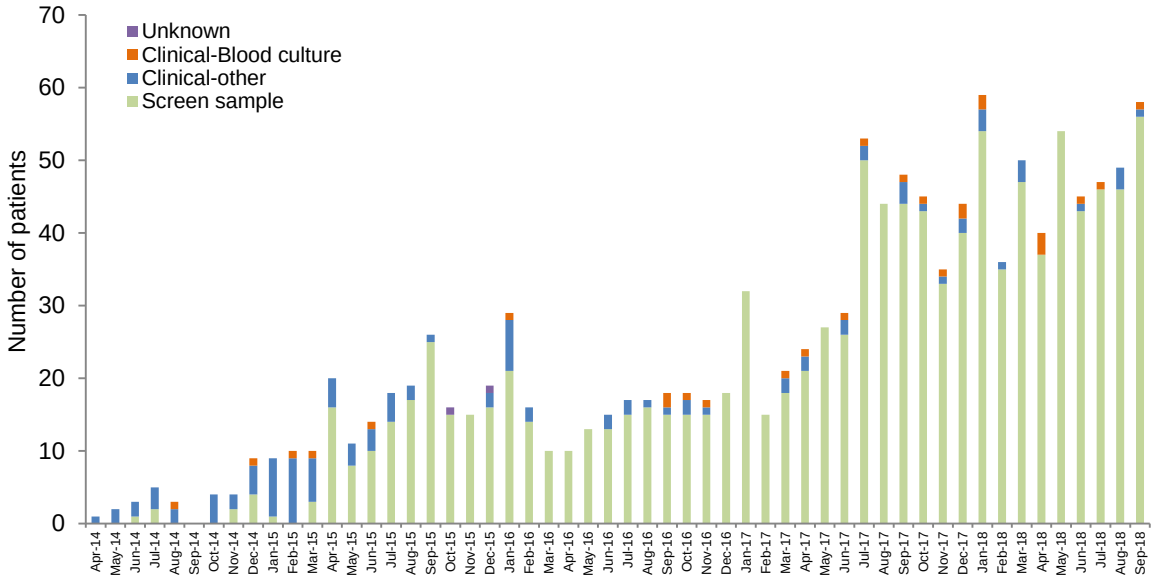


Figure 9: CPE detected at the Trust by culture type.

1.8.3 CPE Action Plan

In response to the Trust-wide increase in the detection of CPE, the CPE Action Plan was revised in December 2017. This is to provide additional focus on reducing acquisition, improving screening, laboratory, epidemiology, and surveillance (including a focus on increasing compliance with CPE admission screening), improving ward-level IPC practice (including the development of specific criteria for ward re-opening in the event of a CPE outbreak, reviewing toilet ratios, usage and access, and reviewing cleaning standards), and optimising antimicrobial strategies for CPE management and treatment (including the implementation of a new report from Cerner relating to patients on carbapenem antibiotics). All but one of the actions have been completed (the outstanding action relates to the development of a daily report of the number of patients with CPE current in the hospital, and their location, which requires support from the Cerner/IT team. All of the actions lin the plan are being reviewed to determine whether they can be developed further in light of the continued clusters.

2 Antibiotic stewardship

Antibiotic Stewardship (AS) encompasses all activities intended to improve patient outcomes from infection related to the use of antibiotics while minimising negative consequences such as HCAI and limiting development of bacterial resistance. AS is considered a key aspect of patient safety.

2.1 *Assurance regarding quality of antibiotic prescribing*

2.1.1 Point Prevalence Results – Prescribing and Safety Indicators

The biannual antibiotic point prevalence study (PPS) (based on a review of inpatients) examines a suite of key antibiotic prescribing and safety indicators as advised by the Department of Health's "Start Smart then Focus" antibiotic programme and acts as a mechanism to identify areas for improvement. The first PPS of 2018/19 was conducted in August 2018.

1236 patients were reviewed. 40% of inpatients were scheduled to receive an antibiotic. 862 antibiotics were prescribed (59% intravenous). Of these, 91% were prescribed according to policy or on the advice of infection teams with 98% having a documented indication on the drug chart or medical notes. 89% of antibiotic prescriptions had a documented review within 72 hours of initial prescribing and 93% had a duration in line with policy or approved by microbiology / ID. The Trust has a suggested compliance of 90% for these indicators (Table 4). The results from Private Patients showed an increase in compliance for indicators A and C following discussions of the February 2018 results at their Private Patients Quality and Safety Committee. IPC will continue to work closely with Private Patients and the other Divisions to develop and maintain improvement across all four indicators.

Division	Number of patients on anti-infective(s)/total patients seen (%)		Number of anti-infectives prescribed		INDICATOR A % anti-infectives in line with policy or approved by Microbiology/ ID		INDICATOR B % indication documented on drug chart or in notes		INDICATOR C % review within 72 hours of initial prescribing		INDICATOR D % duration in line with policy or approved by Microbiology /ID	
	Feb 2018	Aug 2018	*Feb 2018*	Aug 2018	*Feb 2018*	Aug 2018	*Feb 2018*	Aug 2018	*Feb 2018*	Aug 2018	*Feb 2018*	Aug 2018
Trust Results	589/1369 (43%)	**494/1236 (40%)**	1015	**862**	92%	91%	98%	98%	90%	89%	95%	93%
Medicine	274/650 (42%)	**205/542 (38%)**	436	**339**	92%	92%	99%	99%	92%	92%	96%	96%
Surgery, Cardiovascular and Cancer	216/420 (51%)	**198/424 (47%)**	404	**353**	90%	88%	97%	97%	87%	84%	94%	92%
Women's and Children's	84/239 (35%)	**80/231 (35%)**	148	**148**	97%	96%	99%	100%	96%	95%	96%	89%
Private	15/60 (25%)	**11/39 (28%)**	27	**22**	74%	81%	100%	95%	56%	88%	85%	82%
Trust Target 2017/18					**90%**		**90%**		**90%**		**90%**	

Table 4: PPS results summary from August 2018 survey

2.1.2 Point Prevalence Results - Safety Indicators

As part of the bi-annual antibiotic point prevalence study there were 8615 antibiotic doses prescribed at the time of data collection with 250 doses (3%) documented as not given. Of these 250 doses, 131 were intravenous doses of antibiotics. In addition, 99% of patients who received an antibiotic had their allergy status completed. Divisions have been given a breakdown of missed doses by speciality to review and discuss at their local Quality and Safety Committee meetings and to determine if these require further action.

2.2 *Antimicrobial Consumption*

The Trust continues to participate in the 'Reducing the impact of serious infections' CQUIN around antibiotic consumption reductions. This was supported by the fixed term infection pharmacist position, which ended in June 2018. We continue to report our antimicrobial usage to PHE and participate in their national programme, facilitating benchmarking and helping to drive improvement. Antimicrobial prescribing data for ICHT is now available for public viewing on the PHE Fingertips website.

PHE is expected to confirm the percentage reduction targets for total antibiotic consumption and carbapenem (DDD's/ 1000 admissions) in Q3 2018/19. The baseline for percentage reduction is calculated on 2016 data minus 2017/18 targets. As a result, it is predicted that ICHNT will have to achieve a 4% reduction in total antibiotic consumption (DDDs/1000 admissions) and a 5% reduction for carbapenem consumption. In addition, there is a target that 55% of total antimicrobial use should be the WHO Access group of the adapted AWaRe index (refer to section 2.2.3).

2.2.1 Overall consumption

Following an increase in antimicrobial consumption in Q4 2017/18 (attributed to secondary infections linked to increases in influenza cases), the Trust had a decrease in its overall consumption of antimicrobials in Q1 2018/19 which was sustained in Q2 (Figure 10). Intravenous and oral antimicrobial consumption remained constant during this period and this was observed in both inpatient and outpatient settings. Over the last 4 years, ICHT has continued to have a year-on-year decrease in total antimicrobial use.

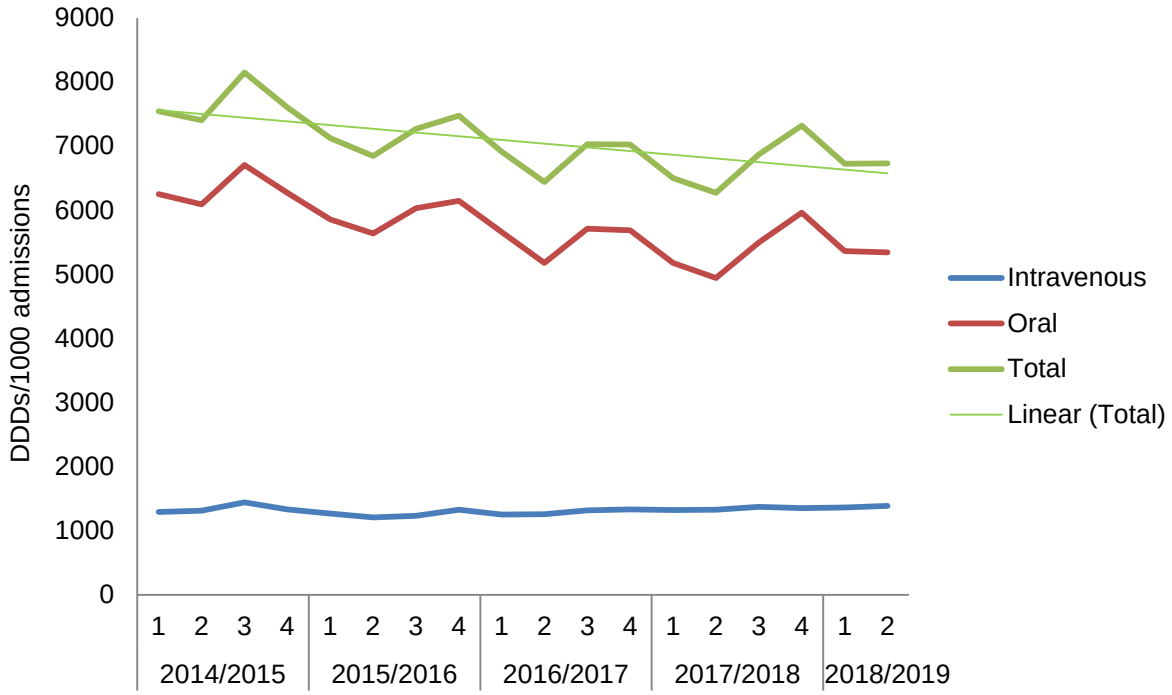


Figure 10: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration. 'Linear (Total)' is the linear trendline for total antimicrobial consumption.

When compared with our Shelford peers for total antimicrobial consumption via the PHE fingertips portal, ICHT ranks 6th (Figure 11).

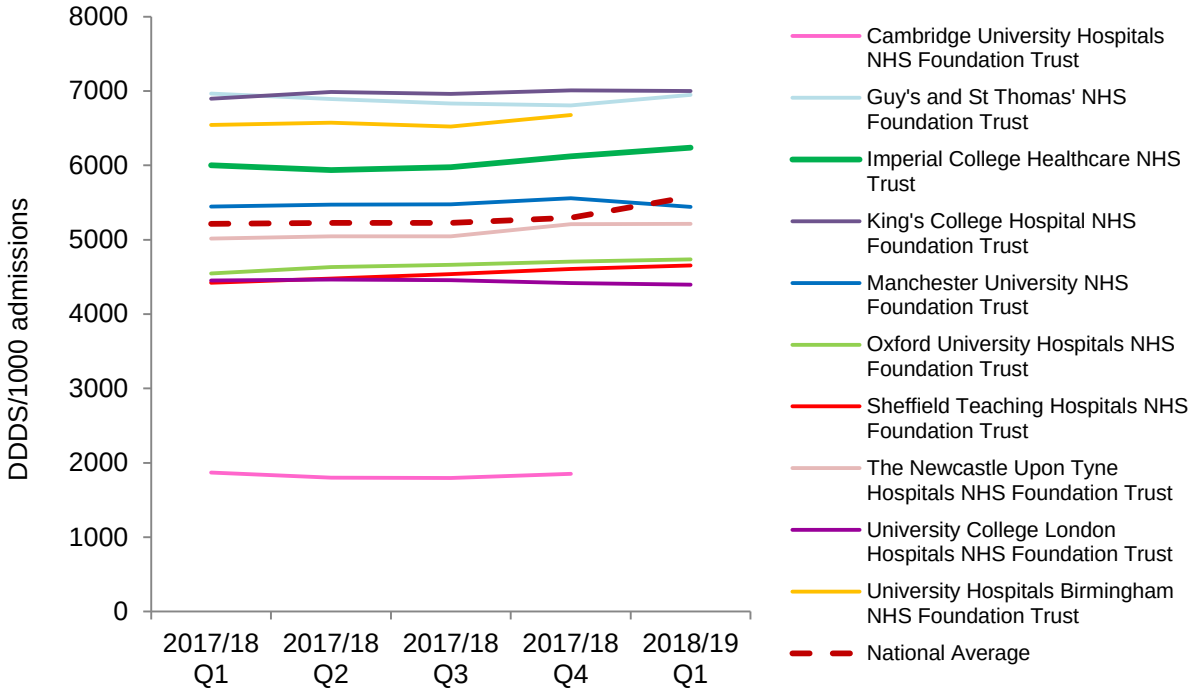


Figure 11: PHE antimicrobial consumption (DDD / 1000 admissions) Q4 2016/17 to Q1 2018/19 compared to other Trusts within the Shelford group and national average. This data has been taken from the Fingertips portal and is only available up until Q1 2018/19. Data for Cambridge University Hospitals and University Hospitals Birmingham are published only until Q4 2017/18 on the PHE Fingertips portal.

2.2.2 Piperacillin/ Tazobactam (Tazocin®) / Carbapenem consumption

A 2% reduction in consumption of Piperacillin/Tazobactam (Tazocin®) and carbapenems was requested as part of the CQUIN in 2017/18. Piperacillin/Tazobactam is not included in the 2018/19 CQUIN but we have taken the decision locally to still monitor consumption of this agent as it is an important indicator of broad spectrum antimicrobial use and Gram-negative resistance. A 2% reduction has been requested for carbapenems in the 2018/19 CQUIN.

The reintroduction of Piperacillin/Tazobactam is likely to have contributed to reduced carbapenem consumption from Q4 2017/18 to Q2 2018/19 (Figure 12). Carbapenem usage is currently at its lowest level since Q2 2016/17.

Compared with our Shelford peers, ICHT ranks 2nd (second lowest) for Piperacillin/ Tazobactam and 8th (second highest) user of carbapenems. In order to facilitate stewardship efforts to decrease carbapenem usage, the Pharmacy Infection teams will be introducing a patient-specific electronic report from Cerner in Q3 2018/19. This will highlight patients prescribed carbapenems to enable targeted, timely reviews by Infection teams.

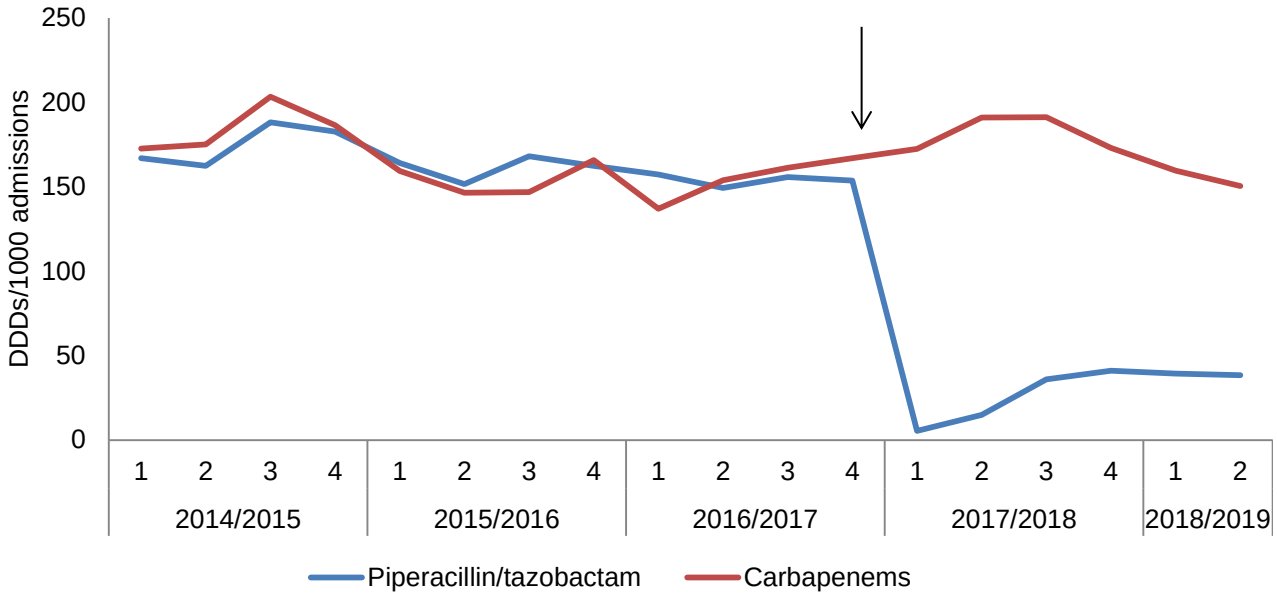


Figure 12: Trust wide Piperacillin / Tazobactam and carbapenem DDDs / 1000 admissions 2014/15 – present. The arrow denotes when the shortage in Piperacillin / Tazobactam began.

2.2.3 AWaRe index

The AWaRe index has been adapted for use nationally and incorporated into the 'Reducing the impact of serious infections' CQUIN for 2018/19. The AWaRe index categorises antibiotics into three groups: Access antibiotics are those that should be available to treat a wide range of infections; the Watch group are antibiotics recommended for a small number of infections; and the Reserve group should be considered last resort options.

The Trust has been set a target of 55% of all antimicrobial consumption in 2018/19 being from agents within the Access group. In Q2 2018/19, the Trust access group rose from 38% to 40% (Figure 13). Currently none of the Trusts within the Shelford group are reaching the 55% target of AWaRe group antibiotics with only Guy's and St Thomas' NHS Foundation Trust and Manchester University NHS Foundation Trust using Access group antibiotics at a proportion above the national average of 46.8% in Q1 2018/19 (Fingertips data for Q2 was not available at the time of this report).

To try and optimise AWaRe index access group agents, the Trust Antibiotic Review Group has embarked on a full review of the Empirical Treatment of Infection Policy, which will include reviewing

all first line therapies and resistance rates. This is due for final review in October and to be launched in November to coincide with World Antibiotic Awareness Week.

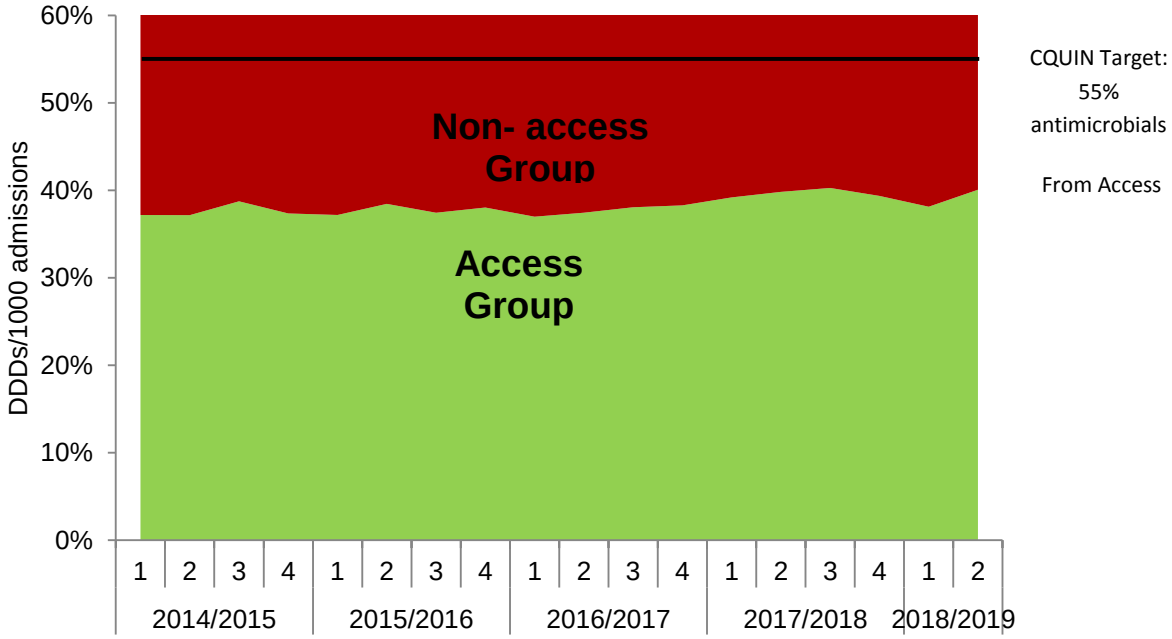


Figure 13: Proportion of antimicrobial consumption of agents within the Access group from 2014/15 to current using ICHNT local consumption data.

2.3 Antibiotic Expenditure

Trust-wide there was approximately £693k spent on antibacterials and £639k on antifungals in Q2 compared to an average spend of £883k on antibacterials and £652k on antifungals per quarter in 2017/18 (Figure 14). The decrease in antibacterial costs is likely to be due to more stability within the antibacterial supply chain and introduction of generic daptomycin and ertapenem.

There is a pan-London contract for echinocandins (a type of antifungal agent) where cost is calculated on a volume based matrix of drug usage. From 1st September 2017, the cost of anidulafungin and micafungin decreased. There was a corresponding decrease in antifungal expenditure in Q3 (2017/18) which then increased again in Q4 (2017/18) before remaining stable in Q1 2018/19. It should be noted that high-cost antifungals are funded by NHS England with the exception of patients within 90 days of renal transplant or bone marrow transplant.

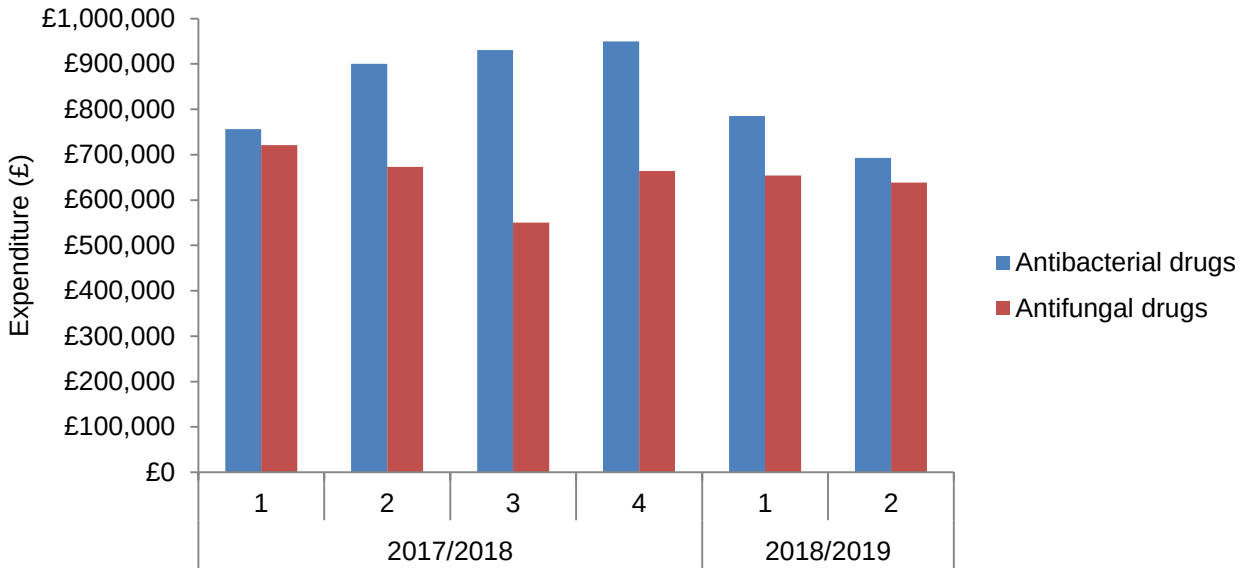


Figure 14: antibiotic expenditure for inpatients and outpatients by site and quarter 2017/18 FY to date.

2.4 Antibiotic Review Group

The Trust Antibiotic Review Group's (ARG) role is to support the improvement of antibiotic use within the Trust by promoting the safe, rational, effective and economic use of antibiotics by the multidisciplinary teams. In Q2 the ARG has primarily focussed on reviewing the empirical adult antimicrobial treatment guideline. In addition, the following have also been reviewed:

- Fever in BMT Oncology Paediatric Patients
- Antibiotic prophylaxis for Nephrostomy insertion
- Azithromycin and metronidazole PGD in hysteroscopy
- Adult Intermittent IV Vancomycin Guideline
- Trust Influenza Vaccination PGD for staff

2.4.1 Antimicrobial Shortages

The Trust continues to experience the impact of national antimicrobial shortages in a number of agents which has been identified on the risk register. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis. There is no evidence of patient harm as a result of these shortages.

2.5 Anti-fungal CQUIN

The Trust is participating in the NHSE Anti-fungal CQUIN with 0.4 WTE 8a pharmacy support. This work is part of the wider Medicines Optimisation CQUIN. The post is working with key stakeholders involved in antifungal treatment management.

The Trust met its Q1 and Q2 antifungal CQUIN requirements which included mapping anti-fungal use across the Trust. Within Q3, work will examine two key interventions: (a) identifying and facilitating timely review of patients on Ambisome® therapy (intravenous Ambisome represents approximately 50% of the expenditure within antifungals), and (b) a review of the Trust adult, paediatric and neonatal antifungal guideline based on new emerging literature and current local resistance rates.

2.6 Sepsis

IPC have contributed to the development of the Trust Sepsis Guideline, and continues to support the roll-out of the Cerner sepsis alert to improve the identification and management of sepsis. This includes reporting functionality to monitor the time to the first dose of antibiotics. This will help to drive

improvement around sepsis treatment, supporting optimised therapy, enabling de-escalation, and reducing antimicrobial consumption.

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

3.1 *Aseptic Non Touch Technique (ANTT)*

The Trust has a requirement that ANTT assessment is undertaken and documented for all staff working in a clinical environment. The target for compliance with ANTT training for Trust clinical staff is set at 95%; currently the compliance rate is 84.3% (6759/8022 clinical staff), which has increased from the last quarter. Of the 1263 non-compliant staff, 76.3% (964) have never had an assessment for ANTT, and 23.7% (299) have had an assessment in the past, but have gone beyond the deadline for re-assessment. Plans are in place to improve compliance with ANTT competency assessment for all clinical staff along with other core clinical skills. This includes a Division specific implementation plan to undertake ANTT competency assessments for new doctors at local induction and targeted improvements through the Improving Care Programme Meeting

3.2 *Hand hygiene*

3.2.1 Background

A new approach to hand hygiene compliance auditing commenced this year to improve the quality of audit data in order to guide improvement. Auditing of inpatient wards was undertaken by IPC and senior Divisional staff during May 2018. Overall compliance was 56% (1965 of 3532 observations), which is slightly higher than the figure of 45% in a published systematic review of hand hygiene compliance.[3] A weekly Task and Finish group reconvened in June and continues to meet to oversee the review of the results, improvement interventions (including local auditing as appropriate), and communications. The progress of the Trust-wide hand hygiene improvement work is being reviewed and monitored monthly via the Executive Improving Care Programme Group, which has been formed to track several Trust-wide improvement projects.

3.2.2 Improvement plans

3.2.2.1 All ward areas

All 74 wards included in the May audits (all inpatient wards at ICHT) are undergoing a series of locally developed improvement interventions during October and November. Hand hygiene champions have been identified on each of the wards to co-ordinate local improvement planning. IPC and the Improvement Team have developed a 'Hand Hygiene Improvement Toolkit', which outlines the established principles of hand hygiene improvement methodology. This has been shared with the ward areas so that local improvement plans can be developed. As the improvement plans take shape and begin to be implemented, the network of hand hygiene champions will share learning, successes and, challenges, facilitated by the Improvement Team.

3.2.2.2 Wards selected for focussed improvement

The 10 wards with the lowest levels of hand hygiene compliance (<40%) have been selected for focussed improvement. This includes:

- Weekly hand hygiene 'huddles', supported by IPC and the Improvement Team.
- An assigned Improvement Lead to join the ward-based huddles and support the development and implementation of a ward-led local improvement plan.
- An assigned IPC expert to provide hand hygiene training sessions and join regular huddles.

3.2.2.3 Additional areas and staff groups

In addition, the ICUs and EDs on all sites, Neonatal ICUs, and a private patients' ward have been selected for additional support with intervention planning.

[3] Erasmus *et al.* Systematic review of studies on compliance with hand hygiene guidelines in hospital care. *Infect Control Hosp Epidemiol* 2010; 31:293-294.

Low levels of hand hygiene compliance have been identified in therapists / AHP staff. In response to these findings, the Chief Allied Health Professional has developing plans to improve hand hygiene compliance in this group. The first step is to re-train all of the therapists / AHP staff in the principles of hand hygiene, and perform an assessment of hand hygiene in clinical practice. Low levels of compliance were also identified in Sodexo staff. Sodexo are improving their IPC-related training (including hand hygiene) for their staff, which is supported by IPC.

3.2.2.4 Examples of improvement progress

Improvement work on the NICU at QCCH has been in progress since early September, linked to an outbreak on the unit. This has included a review of local hand hygiene compliance data, weekly education sessions delivered to multidisciplinary staff groups by IPC, the embedding of hand hygiene educational messages in handovers, the co-development of a mechanism to disseminate general themes and strategies from audits, and (where indicated) constructive feedback provided to individual practitioners. Weekly audits have been performed by IPC, and illustrate an increasing trend in hand hygiene compliance (see Figure 15).

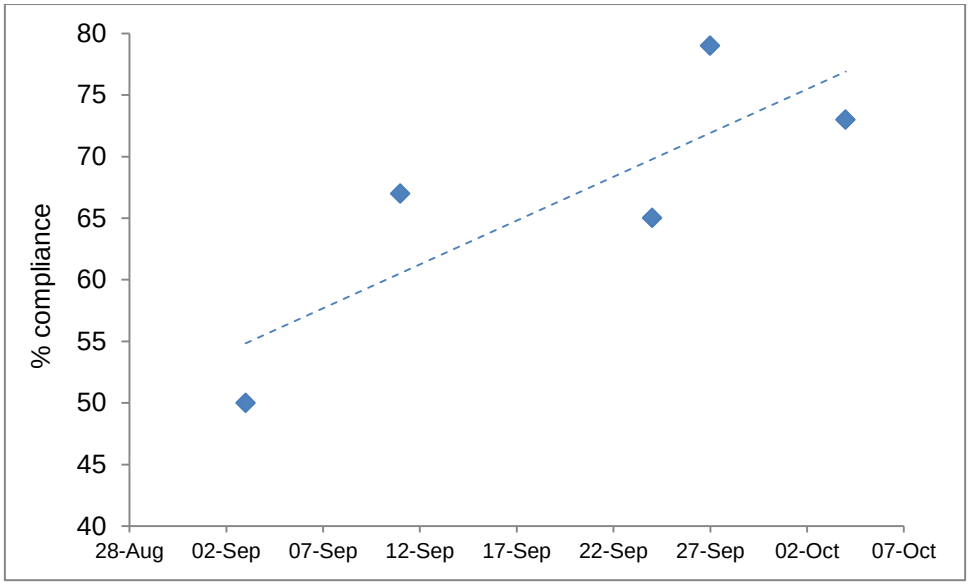


Figure 15: Trends in hand hygiene compliance on the neonatal unit.

3.2.2.5 Follow up audit

Audits of selected clinical areas are planned for November (the 10 focus wards, additional areas (the EDs, Critical Care, NICU, an Imperial Private Healthcare ward, and the Children and Young People pathway wards). Audits of all clinical areas are planned by February 2019 to track the progress of the improvement work.

3.2.3 Hand hygiene communications update

3.2.3.1 Upgrade of hand hygiene dispensers and their surrounds

Hand hygiene dispensers and their surrounds are currently inconsistent, and some are in a poor state of disrepair. For example, see Figure 16 below.

Ecolab, the company which supplies the hand hygiene products used in the Trust, have offered to upgrade the dispensers in the Trust to their latest model, and upgrade their surrounds without charge. This upgrade has been piloted on a vascular ward at SMH (Figure 17), and the feedback is excellent. This upgrade will be rolled out across the Trust.

Figure 16: A selection of images of hand hygiene dispensers and their surrounds in the Trust.

Figure 17: The new Ecolab dispensers (the style of dispensers at the point of care will not change, because they need to have a plunger on the top, but the current blue holders will be replaced with bright orange ones). Orange is the colour for alcohol gel dispensers, and purple for soap.

3.2.4 Hand hygiene awareness campaign

A new hand hygiene awareness campaign is being developed to produce organisation-wide consistent messaging for staff and patients. This has been informed by feedback from front-line clinical staff. One of the key outcomes of this engagement work is that communications materials should be more persuasive than challenging. An initial review of the available material suggests that it falls into the 'challenging' category (e.g. "STOP and wash your hands"); therefore, IPC and the Improvement Team have commissioned a design agency to develop persuasive hand hygiene materials. This campaign will be piloted in November and launched in December.

3.2.5 Hand hygiene improvement milestones

- Revised approach to auditing (completed May 2018)
- Pilot upgraded hand hygiene dispensers (completed August 2018)
- Agree roll-out plan for Trust-wide upgrade of hand hygiene dispensers (October 2018)
- Complete upgrade of hand hygiene dispensers in focus wards and areas selected for additional support (November 2018)
- Novel communications campaign piloted (November 2018)
- Novel communications campaign launched Trust-wide (December 2018)
- Audit of selected areas (November 2018)
- Audit of all 130 clinical areas in the Trust, including inpatient and outpatient areas (January 2019)
- Develop revised improvement plans, encompassing all clinical areas (March 2019)

4 Water hygiene, decontamination, ventilation, and environmental hygiene management

4.1 *Water hygiene management*

- The assurance of water hygiene is a high priority for the Trust, with the policies and approaches developed by the Water Hygiene Group, and the operational management of water hygiene delivered by Trust Estates and their contractors.
- The Trust's water hygiene plans are summarised in the Water Safety Plan, which has been written to reflect the relevant national guidance (in HTM 04-01).
- Issues relating to the execution of the Water Safety Plan have been identified during Q2 in relation to an outbreak of *Pseudomonas aeruginosa* in a NNU at the Trust.
- The Trust Water Hygiene Group meets quarterly and is chaired by a representative of the DIPC. The group will meet monthly to ensure more timely compliance with the Water Safety Plan.
- A report will be presented by Estates to the Executive Quality Committee summarising the communication processes and clear mapping and tracking of actions.
- IPC continues to support Estates and their water contractors in auditing of the water testing and remedial actions to identify areas for improvement.
- The list of augmented care areas for regular *Pseudomonas* testing has been updated following the HDU moves at SMH.
- The facilities for hand hygiene relating to sinks and drains are audited annually, and improvements resulting from this annual audit are being implemented.

4.2 *Ventilation*

The Specialist Ventilation Committee (and a working sub-group) continues to meet quarterly, chaired by a representative of the Director of Nursing. Specialist ventilation is crucial for several aspects of IPC including patient isolation and surgery. The group are developing an updated reporting schedule to highlight out-of-specification ventilation, and ventilation related to new projects.

4.3 *Decontamination*

The Decontamination Steering Group meets quarterly, and provides a monthly exception report to the Medical Devices Management Group. Key decontamination issues include:

- Reiteration of advice that the Trust needs to invest in new surgical instruments to ensure compliance with NICE 196 to reduce the risk of transmitting prions. This issue is being managed through a Task and Finish Group, led by the Division of Surgery.
- The creation of a decontamination room for disinfecting the water heater coolers (at risk of contamination with *Mycobacterium chimaera*) is in progress.

Both these issues have been identified as risks on the Division of Surgery's Risk register.

4.4 *Environmental hygiene (cleaning and disinfection)*

Significant issues have been identified with the quality of cleaning and disinfection in the Trust. This is reflected on the IPC risk register (see section 7) and highlights the known risk with cleaning. Cleaning and disinfection services are contracted to Sodexo; this contract is managed by Trust Facilities. IPC have contributed to the Trust-wide efforts to improve cleaning and disinfection standards.

5 IPC incidents and clinical activity during Q2

5.1 *CPE cluster in haematology*

As detailed in the Q1 report, between January and September 2018 a total of 15 patients in haematology at HH had *Citrobacter freundii* OXA-48 identified from screening samples. Typing has identified two clusters (cluster one with 9 cases and cluster 2 with 3 cases). Typing is pending for one case. All but one of these samples were identified from screening. This was declared as a serious incident (2018/11857). Immediate actions include addressing issues with cleaning, IPC practice and the environment.

5.2 *Pseudomonas aeruginosa on a neonatal unit*

Between July and September 2018, 8 babies were identified to be colonised with *Pseudomonas aeruginosa* on a neonatal unit. Typing has identified two clusters (cluster one with 6 babies and cluster 2 with two babies). Routine water testing has identified *Pseudomonas* in a small number of outlets on the unit and remedial action has been undertaken in line with HTM 04. A number of issues have been identified in the environmental and water hygiene management process. Actions have been put into place to address these issues, which are improving. These actions are being managed by a weekly Task and Finish group, which includes Estates, Facilities, IPC, and ward staff. Actions include improving the processes around water outlet sampling, ensuring that remedial actions are completed on time, processes for regular cleaning of water outlets, and improving communication with ward staff. Typing information from the positive water samples suggests a genetic link between the water samples taken from the unit and the affected babies. No harm came to any of the babies and they have now been discharged and the outbreak has been declared as over.

5.3 *MRSA outbreak on an adult intensive care unit*

Fifteen patients were identified with MRSA (methicillin-resistant *Staphylococcus aureus*) on a Critical Care Unit between June 2018 and September 2018. These were found to be indistinguishable by typing and transmission was suspected. Public Health England advised that screening of the Critical Care workforce be undertaken to identify the possibility of a long-term carrier. Staff screening and subsequent actions have now been completed and the outbreak has been declared as over. This was declared as a serious incident (2018/18472).

5.4 *Salmonella transmission on an elderly medicine ward*

Two patients on the same elderly medicine ward were identified with *Salmonella mbandaka* in August 2018. These were found to be indistinguishable by typing and transmission was suspected. Contact screening was performed and no other cases were identified. Both patients did not require treatment and have since been discharged home. The investigation included an environmental health review of the hospital food chain and did not identify this as a potential source.

5.5 *Congenital rubella infection in maternity*

A patient attending the maternity unit has been identified as having Rubella during her pregnancy and her child born in September 2018 identified with suspected congenital Rubella infection. Contact screening of patients and staff was undertaken and no further action was required.

5.6 *Pertussis in maternity*

A patient attending the antenatal triage unit has been identified as having pertussis in August 2018. Contact tracing of patients and staff was undertaken and advice given.

5.7 *Key learning points from Serious Incident (SI) investigations*

Serious incidents (SIs) reported during Q1 and Q2 are listed in Table 5. Table 5 summarises key learning points arising from HCAI-related SIs reported so far this financial year.

STEIS	**Location**	**Summary**	**Date reported**	**Actions**
2018/ 18472	AICU	MRSA outbreak	June 2018	Awaiting panel
2018/11857	Haematology	CPE Transmission (*Citrobacter freundii* OXA48 x9)	May 2018	Environmental review of Fraser Gamble and the Haematology day care ward Review of cleaning action plan and escalation to the cleaning sub-group. Patient pathways to be reviewed to minimize movement where possible across the Directorate.
2018/10021	A7	Norovirus outbreak	April 2018	Trust wide outbreak policy to be shared with all staff Teaching on the wards with the MDT Spot check audits via back to the floor Thursdays Completion of symbiotic audits for the five moments of hand hygiene
2018/12482	JHW	CPE and *C. difficile* transmission	April 2018	Escalate the quality of cleaning to the divisional directors for feedback to the facilities team. To complete the critical remedial work on the ward estate. On finalising the antibiotic policy, a communication plan should be developed to share the guidance Trust-wide to reduce high risk antibiotics in high risk areas.

Table 5: HCAI-related SIs reported during 2018/19.

6 Compliance and Policies

IPC reporting and assurance structures in the Trust are being reviewed to ensure that they are optimal and reflect various regulatory requirements.

6.1 Compliance

- Cleaning audits are performed by Facilities. Facilities, supported by the Divisions and IPC, are undertaking a review of cleaning policies and processes across the Trust in order to improve standards of cleaning and disinfection in the Trust.
- The Trust has two tiers of annual core skills IPC training: Level 1 for all staff, and Level 2 for clinical staff. Compliance with Level 1 is 89% (up from 86% in Q1), and with Level 2 is at 86% (up from 85% in Q1) (Figure 18). A Trust wide group has been convened by the Core Skills team to improve compliance with all core skills training.

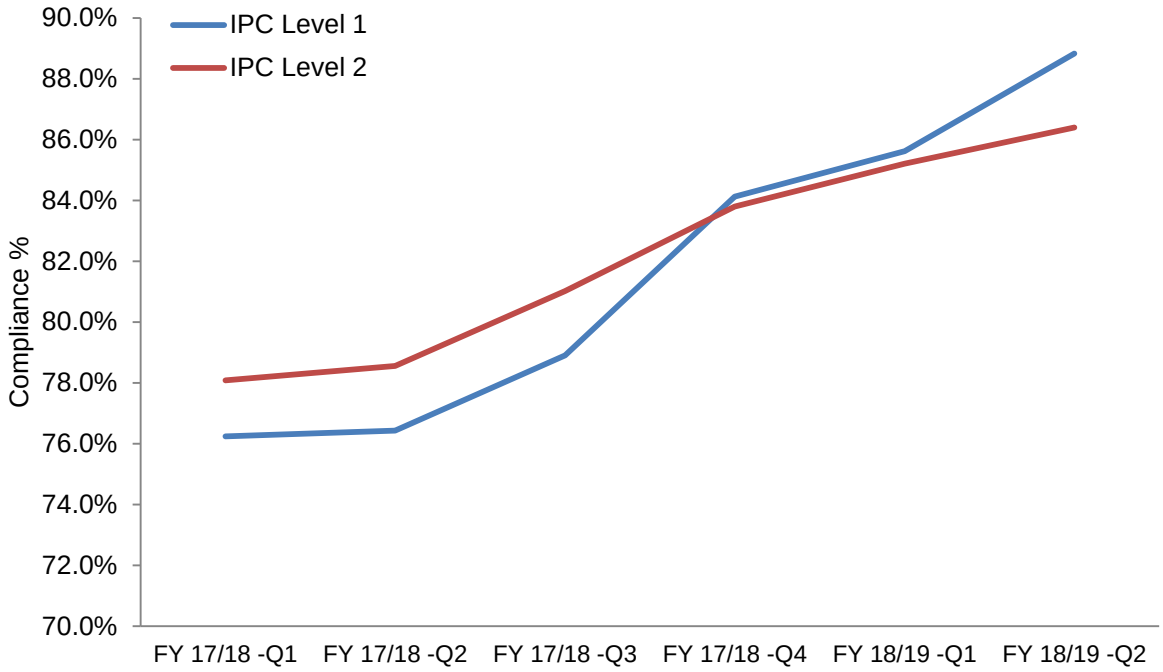


Figure 18: Compliance with IPC training.

6.2 *Policies*

Policies and Guidelines approved at the Trust Infection Prevention and Control Committee (TIPPC) in August 2018:

- Measles Policy

Policies and Guidelines requiring review during Q3 of 2018/19:

- Viral Haemorrhagic Fever Policy, and Ebola Virus Disease Clinical Guideline.
- *Clostridium difficile* Policy.
- Venepuncture guidelines

7 Risks

New risks:

- Poor standards of cleaning. In order to reflect the challenges with cleaning and disinfection identified throughout the Trust, a new risk has been added to the IPC risk register.

Updated risks:

- The risk related to Estates work affecting IPC practice has been updated to include more detail on the challenges around the management of water hygiene in light of the outbreak of *Pseudomonas aeruginosa* in the NNU at QCCH.
- The risk related to microbiology laboratory support has been updated to reflected challenges in turnaround time for diagnostic specimens.

8 Other issues

8.1 External directives

None were received during Q2.

9 Publications in Q1

Abdolrasouli A, Petrou MA, Park H, Rhodes JL, Rawson TM, Moore LSP, Donaldson H, Holmes AH, Fisher MC, Armstrong-James D. Surveillance for Azole-Resistant *Aspergillus fumigatus* in a Centralized Diagnostic Mycology Service, London, United Kingdom, 1998-2017. Front Microbiol. 2018;9:2234.

Chatterjee A, Modarai M, Naylor NR, Boyd SE, Atun R, Barlow J, Holmes AH, Johnson A, Robotham JV. Quantifying drivers of antibiotic resistance in humans: a systematic review. Lancet Infect Dis. 2018 ;S1473-3099(18)30296-2.

Knight GM, Costelloe C, Deeny SR, Moore LSP, Hopkins S, Johnson AP, Robotham JV, Holmes AH. Quantifying where human acquisition of antibiotic resistance occurs: a mathematical modelling study. BMC Med. 2018 Aug 23;16(1):137.

Alividza V, Mariano V, Ahmad R, Charani E, Rawson TM, Holmes AH, Castro-Sánchez E. Investigating the impact of poverty on colonization and infection with drug-resistant organisms in humans: a systematic review. Infect Dis Poverty 2018;7(1):76.

Knight GM, Dyakova E, Mookerjee S, Davies F, Brannigan ET, Otter JA, Holmes AH. Fast and expensive (PCR) or cheap and slow (culture)? A mathematical modelling study to explore screening for carbapenem resistance in UK hospitals. BMC Med. 2018 Aug 16;16(1):141.

Rawson TM, Ming D, Gowers SA, Freeman DM, Herrero P, Georgiou P, Cass AE, O'Hare D, Holmes AH. Public acceptability of computer-controlled antibiotic management: An exploration of automated dosing and opportunities for implementation. J Infect 2018 in press.

Otter JA, Galletly TJ, Davies F, Hitchcock J, Gilchrist MJ, Dyakova E, Mookerjee S, Holmes AH, Brannigan ET. Planning to halve Gram-negative bloodstream infection: getting to grips with healthcare-associated Escherichia coli bloodstream infection sources. J Hosp Infect. 2018 in press.

Ledwoch K, Dancer SJ, Otter JA, Kerr K, Roposte D, Rushton L, Weiser R, Mahenthiralingam E, Muir DD, Maillard JY. Beware biofilm! Dry biofilms containing bacterial pathogens on multiple healthcare surfaces; a multi-centre study. J Hosp Infect. 2018 in press.

Mookerjee S, Dyakova E, Davies F, Bamford K, Brannigan ET, Holmes A, Otter JA. Evaluating serial screening cultures to detect carbapenemase-producing Enterobacteriaceae following hospital admission. J Hosp Infect. 2018;100(1):15-20.

Nellums LB, Thompson H, Holmes A, Castro-Sánchez E, Otter JA, Norredam M, Friedland JS, Hargreaves S. Antimicrobial resistance among migrants in Europe: a systematic review and meta-analysis. Lancet Infect Dis. 2018 Jul;18(7):796-811.

Jauneikaite E, Kapatai G, Davies F, Gozar I, Coelho J, Bamford KB, Simone B, Begum L, Katiyo S, Patel B, Hoffman P, Lamagni T, Brannigan ET, Holmes AH, Kadhani T, Galletly T, Martin K, Lyall H, Chow Y, Godambe S, Chalker V, Sriskandan S. Serial Clustering of Late-Onset Group B Streptococcal Infections in the Neonatal Unit: A Genomic Re-evaluation of Causality. Clin Infect Dis. 2018;67(6):854-860.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Mid-year update on safe, sustainable and productive nursing and midwifery staffing	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 28th November 2018	**Item 14, report no. 10**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Priya Rathod, Deputy Director of Quality Governance

Summary:

The following paper is split into two parts:

Part1 - Update on key initiatives being undertaken by the Trust

- The future supply of the nursing and midwifery workforce is a well-documented challenge for all NHS Trusts in the UK at the current time.
- A number of key initiatives and work streams are being undertaking in light of the current national nursing and midwifery staffing landscape.
- The Trust is also undertaking a range of actions to grow and develop its nursing and midwifery workforce and include the introduction of; the nursing associate role and apprenticeships in nursing.
- A safe staffing task and finish group has been established to drive forward key work streams in response to the publication of various national guidance.

Part 2 – Mid-year nursing and midwifery establishment review

- A range of national guidance/recommendations on safe staffing has published over the recent years. More recently, the publication by NHSI of Developing workforce safeguards in October 2018, outlines a number of new recommendations **(see Appendix 1)** designed to support Trusts in making informed, safe and sustainable workforce decisions.
- In particular, it is important to note that from 2019/20, NHSI will annually assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements as described in the NQB's guidance.
- As part of the annual assessment, NHSI will also seek assurance through the standard operating framework (SOF), and in addition, Trusts will be required to confirm their staffing governance processes are safe and sustainable in their annual governance statement.
- A mid-year establishment review has been undertaken for nursing and midwifery
- All clinical areas (inpatient, outpatient, theatres, endoscopy, renal satellite units, support services etc.) have been included.
- Overall, there has been an actual increase of **23.26 WTE** in the nursing and midwifery establishment when compared with the data from the establishment review undertaken in March 2018.
- A detailed breakdown of the data by division can be found in **Appendix 2.**
- The next annual establishment review will take place by March 2019 and reported in May 2019.

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

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

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

- No additional financial impact outside of divisional budgets
-

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

2499 - Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff

2472 - Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC

Workforce impact (including training and education implications):
The impact is captured within the detail of the paper

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

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

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

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

- To achieve excellent patients experience and outcomes, delivered 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.

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):

- A number of sustainable, productive and safe nursing and midwifery staffing initiatives are underway at the Trust.
- A mid-year establishment review of nursing and midwifery has taken place.

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

PART 1 – Update on key initiatives being undertaken by the Trust

1. Purpose

The following part of the report provides a summary of the key initiatives and work streams the Trust is currently undertaking in light of the current national nursing and midwifery staffing landscape.

2. National context

- The future supply of the nursing and midwifery workforce is a well-documented challenge for all NHS Trusts in the UK at the current time.
- Data published by NHS Digital in January 2018 highlighted that 33,500 nurses left the NHS in 2016/17 compared to 30,500 who joined in the year. The level of increase in leavers was 20% when compared to the figures in 2012/13.
- The Trust is not exempt from this issue with similar challenges in midwifery vacancy rates.
- Health Education England states that there are 36,000 nursing vacancies in the NHS in England, equating to a vacancy rate of 11%.
- The Trust has experienced an average vacancy rate for Band 5 nurses of 15% over the last 12 months and a total vacancy rate for nursing and midwifery staff of between 13% and 14%.
- The risk related to this is currently captured on the Trust's corporate risk register at a risk score of 16.
- The shortage in supply of nursing has been caused by a range of factors including:
  - Increasing numbers of UK nurses and midwives are leaving the profession each year.
  - Just over 29,000 UK nurses and midwives left the Nursing and Midwifery Council (NMC) register in 2016–17, up 9% from the previous year.
  - There has been a reduction in new entrants to the nursing register of 25% in the last 3 years.

The Trust has developed a comprehensive set of schemes to help mitigate the impact of the anticipated skills shortages, which is being led by the Director of People and Organisation Development. A 'strategic supply of nursing' business case outlining the detail of these schemes was approved in May 2018 and is currently being implemented.

3. Sustainable and productive staffing

In order to respond to the challenges outlined in section two, the Trust is undertaking a range of actions to grow and develop its nursing and midwifery workforce.

3.1 Nursing Associate role

- The Board will be aware that a new regulated role of Nursing Associate' has been introduced into the nursing profession.
- The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients.
- The two year training programme will enable the Nursing Associates to work in both community and acute settings within a regulated role at band four once qualified under the direction of a registered nurse.
- An internal recruitment plan in partnership with Chelsea and Westminster NHS Trust (C&W) for 30 apprentices has been underway since the summer of 2018.
- Currently there are only seven confirmed applicants from the Trust and four from C&W for the programme due to a number of factors:
  - The funding model results in a significant drop in salary for the training period
  - The strict academic entrance for the course has excluded a number of applicants
- These issues are not confined to the Trust and C&W – recent figures suggest that there are very few applicants across the whole of London for the same reasons.
- Concerns have been escalated to Health Education England but it is unlikely that the entrance criteria will be modified.
- Further work is now underway to reconsider the salary package and to ensure that internal applicants

are prepared academically to meet the criteria for application

3.2 Graduate Apprenticeships in Nursing

- The nursing degree apprenticeship was introduced in September 2017.
- The apprenticeship enables people to train to become a graduate registered nurse through an apprentice route over a period of four years.
- Apprentices will be released by their employer to study part-time in a higher education institution which has been accredited by the NMC and they will train in a range of practice placement settings.
- A graduate nurse apprenticeship recruitment plan for the Trust is currently being developed.
- The plan will take into consideration the variety and number of different types of learners in our clinical areas – this includes overseas adaptation nurses- and the support required.

4. Safe staffing

The Trust has an established safe staffing task and finish group chaired by the Director of Nursing. An update on progress against some of the work streams being overseen by that group is outlined below.

4.1 Mid-year establishment review

- In order to ensure the right people, with the right skills, are in the right place at the right time, a mid-year establishment review has taken place.
- The findings of the review are presented in **part two** of this paper.

4.2 Implementation of 'Safe Care'

- The SafeCare electronic module has been utilised by adult inpatient wards since 2014.
- Patient acuity data is entered into the SafeCare module of HealthRoster to provide an indication of the staffing levels required based on the acuity of the patients on the ward, these required hours are then compared to the actual staffing on the roster to identify whether there are any potential safety issues regarding staffing levels.
- This information has been utilised within the divisions to support establishment reviews and the monthly Actual vs. Planned data, as the dataset provides the ability to review acuity levels throughout the year instead of during a set timeframe.
- The next steps for SafeCare are currently being reviewed within the task and finish group.
- Areas that the e-Rostering team are supporting the nursing and midwifery staff groups are:
    - The roll out of the updated Safer Nursing Care Tool (SNCT) multipliers for Adult Inpatient wards are being uploaded into SafeCare for a selection of trial wards to begin recording acuity data in line with the revised tool. Following 3 months of trailing the new tool, the data is currently be analysed to understand the implications of implementing them across the remaining adult inpatient wards.
    - The new children and young people SNCT multipliers and definitions have been updated and are currently been trialled in paediatric ward areas.
- A number of actions are being undertaken to explore how SafeCare can be optimised fully. These include; the ability to raise 'red flags' through HealthRoster and alert relevant managers to take action, the potential of transferring acuity data from Cerner into HealthRoster and utilising SafeCare for operational use on a day-to-day basis to highlight staffing issues.

4.3 'Red flags' and escalation

- The Trust has an escalation process in place for when nursing and midwifery staffing levels fall below the requirement which is set out in the Trust's *Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments.*
- NICE recommends the use of specific 'red flag' indicators to highlight these instances to be able to identify a 'rising tide' situation where patient outcomes are or may be adversely affected by staffing that is not optimal.
- As outlined in section 4.2, the Trust has explored the use of specific real time 'red flags' through the SafeCare live module and a number of ward areas have been identified to trial this.

4.4 Care hours per patient day (CHPPD)

- The Board will recall that in order to provide a single consistent way of recording and reporting the deployment of nursing staff working on inpatient wards/units, the Department of Health have developed the CHPPD metric.
- CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight).
- The Trust has been capturing this data since June 2016 using the 'safe care' module and the data is submitted each month through UNIFY as part of the mandated safe staffing return. This is then published on model hospital in order to use as a comparative with other similar trusts.
- It has been identified due to the implementation of the real time bed state that the virtual bed state has not aligned with the actual bed state, therefore not providing an accurate reflection of CHPPD. The Trust wrote to NHSI Digital in August 2018 to highlight this issue.
- Going forward, once the virtual and actual bed states are reconciled, the CHPPD data will be accurate.
- From January 2019 CHPPD will be published on 'NHS choices' and 'My NHS' instead of replace the published staff fill rates (actual vs. planned).

4.5 Review of the Trust's safe staffing policy

- A further review of the policy will be undertaken early next year to reflect the outputs from the work being undertaken through the safe staffing task and finish group.

5. Next steps

- Progress the key work steams outlined in section 4 through the safe nurse staffing task and finish group.
- Present this paper to the Trust Board in November 2018.

6. Recommendations

- To note the paper and work being undertaken

END OF PART 1

PART 2 – Mid-year nursing and midwifery establishment review

1. Background and policy context

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the NHS Constitution, and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18.

A range of national guidance/recommendations on safe staffing has published over the recent years and includes;

- The National Quality Board's (NQB) guide to nursing, midwifery and care staffing capacity and capability(2013) which was subsequently updated in 2016 and more recently in January 2018
- NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014).
- The Lord Carter report (2016) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards/units.

More recently, the publication by NHSI of Developing workforce safeguards in October 2018, outlines a number of new recommendations **(see Appendix 1)** designed to support Trusts in making informed, safe and sustainable workforce decisions across **ALL groups** (including; doctors, AHPs and scientists).

The document offers advice on governance issues related to redesigning roles and responding to unplanned changes in workforce, and it describes NHS Improvement's role in helping providers achieve high quality, sustainable care by assessing the effectiveness of workforce safeguards annually.

In particular, it is important to note that from 2019/20, NHSI will annually assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements as described in the NQB's guidance which combines evidence-based tools, professional judgement and outcomes.

As part of the annual assessment, NHSI will also seek assurance through the standard operating framework (SOF), in which a provider's performance is monitored against five themes. In addition, Trusts will be required to confirm their staffing governance processes are safe and sustainable in their annual governance statement.

The Director of People and Organisation Development will be leading this work going forward.

2. Purpose

The Trust undertakes an annual and mid-year nursing and midwifery establishment review to provide assurance both internally and externally that ward establishments are safe and that staff is able to provide appropriate levels of care to patients. The mid-year nursing and midwifery establishment review follows the annual review which was undertaken in March 2018 and presented to this Board and Trust Board in July 2018.

The following part of this report presents the outputs of the mid-year establishment review undertaken in September 2018.

3. Establishment review process

- The establishment reviews for all areas have been undertaken by Directorate teams and approved by the Divisional Directors of Nursing (DDN) during September 2018 and the Divisional triumvirates.
- Since completing the establishment reviews, each of the DDNs have met with the Director of Nursing to discuss their approach, the findings, the assurances that they have taken with regard to clinical quality and patient outcomes and the level of engagement and involvement they have had with their staff during the process.
- They have also confirmed that any change in the establishments is reflected in the divisional baseline budgets.

- All clinical areas (inpatient, outpatient, theatres, endoscopy, renal satellite units, support services etc.) have been included.

4. Establishment review findings

- Overall, there has been an actual increase of **23.26 WTE** in the nursing and midwifery establishment when compared with the data from the establishment review undertaken in March 2018.
- A detailed breakdown of the data by division can be found in **Appendix 2.**

4.1 Division of Women's, Children's and Clinical Support Services

Overall there has been a reported increase of 6.97 whole time equivalents (WTE) when compared to the establishment data reported for March 2018.

TABLE 1 - Division of women's, children's and clinical support services

Establishment in March 2018 WTE	Establishment in September 2018 WTE	Change to establishment WTE	Registered nurse/midwife and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
872.07	879.04	+6.97	676.99	202.05	77%	23%

Key reasons for this are:

- Additional staff to support the new paediatric intensive care unit (PICU) that is currently in development.
- An additional role to support the expansion of imaging thrombectomy service.
- A review and change in skill mix to create new posts.

4.2 Division of surgery, cancer and cardiovascular sciences

Overall there has been a reported 'increase' of 25.54 WTE when compared to the establishment data reported for March 2018. However, it is important to note that the **actual** increase in establishment is 6.98 WTE.

TABLE 2 - Division of surgery, cancer and cardiovascular sciences

Establishment in March 2018 WTE	Establishment in September 2018 WTE	Change to establishment WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
1546.91	1572.45	+25.54 reported (+6.98 actual)	1295.23	277.22	82%	18%

The reported increase of 25.54 WTE is broken down as follows:

- An actual increase of 6.98 WTE due to:
  - A review and change in skill mix due to a reduction in activity in some areas that has created new Advance Nurse Practitioner and pre-assessment nursing roles.
  - Increased acuity of patients due to the co-location of the ITU and HDU at the St. Mary's site.
  - An increase in the bed base and therefore activity in Fraser Gamble ward.

- The remaining reported 'increase' of 18.56 WTE can be attributed to an establishment reconciliation exercise with finance where posts that were previously incorrectly assigned as 'scientific and technical', have now been correctly assigned as nursing posts. These are not new or additional posts but are nursing posts that were not previously included in the establishment figures as they were included in the scientific and technical establishment instead.

4.3 Division of Medicine and integrated care

Overall there has been a reported increase of 0.84 WTE when compared to the establishment data reported for March 2018.

TABLE 3 - Division of Medicine and integrated care						
Establishment in March 2018 WTE	Establishment in September 2018 WTE	Change to establishment WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
1657.63	1658.47	+0.84	1241.36	417.11	75%	25%

Key reasons for this are:

- Band mix adjusted to ensure safe staffing on AMU.
- Alignment of budgets with establishments captured in e-rostering templates

4.4 Imperial private healthcare

Overall there has been an increase of 8.47 WTE when compared to the establishment data reported for March 2018.

TABLE 4 - Imperial private healthcare						
Establishment in March 2018 WTE	Establishment in September 2018 WTE	Change to establishment WTE	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio	
			RN	CS	RN	CS
187.11	196.58	+8.47	153.67	42.91	78%	22%

Key reasons for this are:

- Review of skill mix
- Increased activity
- Provision of additional services

5. Next steps

- A gap analysis against the recommendations from the 'Developing workforce safeguards' publication will be undertaken for the nursing and midwifery workforce over the coming month and the actions taken forward through the safe nurse staffing task and finish group.
- Agreement to be reached between Director of People and Organisation Development, Chief Allied Health Professional and the Medical Diretcor regarding the implementation of 'Developing workforce safeguards' recommendations.
- An annual establishment review will take place by March 2019 aligned to business planning and the outputs reported to the Trust Board in May 2019.

6. Recommendations

- Note the outcomes from the establishment review

Appendix 1 – Recommendations from Developing Workforce Safeguards (October 2018)

1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.

2. Trusts must ensure the three components are used in their safe staffing processes:
- Evidence-based tools (where they exist)
- Professional judgement
- Outcomes.

We will check this in our yearly assessment.

3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable.

4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.

5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes.

6. As part of the safe staffing review, the director of nursing and medical director **must** confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

7. Trusts **must** have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.

NQB guidance contains further principles boards **must** follow:

8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.

9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance5 and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.

11. As stated in CQC's well-led framework guidance (2018)6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.

12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.

13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety,

quality, finance, performance and staff experience must be clearly described in these risk assessments.

14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

Appendix 2 – Divisional summary of establishment review findings September 2018

Clincial Division	Total registered nurse and unregistered care staff WTE March 2018	Total registered nurse and unregistered care staff WTE September 2018	WTE Change to establishment	Registered nurse and unregistered care staff breakdown WTE		Registered nurse to unregistered care staff ratio	
				RN	CS	RN	CS
Women's children's and clincial support	872.07	879.04	6.97	676.99	202.05	77%	23%
Surgery, Cancer and Cardiovascular sciences	1546.91	1572.45	25.54	1295.23	277.22	82%	18%
Medicine and integrated care	1657.63	1658.47	0.84	1241.36	417.11	75%	25%
Imperial Private Healthcare	188.11	196.58	8.47	153.67	42.91	78%	22%
GRAND TOTAL	4,264.72	4,306.54	41.82	3,367.25	939.29	78%	22%
			Less 18.56 (Within surgery that has been reconciled with finance)				
			23.26 ACTUAL INCREASE				

**RN = registered nurse*
**CS = care staff*

END OF PART 2

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Update on actions arising from Verita's independent review of the Trust's disciplinary processes	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 28th November 2018	**Item 15, report no. 11**
Responsible Executive Director: Kevin Croft, Director of People &OD	**Author:** Kevin Croft, Director of People & OD

Summary:

The Trust Board were updated on the immediate actions taken in response to the Verita Report - an independent investigation into the management of the Trust's disciplinary process resulting in the dismissal of Mr Amin Abdullah - in September. This paper provides an update on further actions taken as well as the recommendations from the wider review undertaken by the new Director of People and Organisational Development that have been agreed by the Executive People and Organisational Development Committee. In addition, the paper updates on the review process and progress to follow up individual members of staff highlighted in the Verita Report.

Recommendations:

In addition to noting the progress and additional actions already agreed, it is proposed that the following actions are approved to embed the actions into the Trust's planning, management and strategic processes:

1. Progress on the above actions to be monitored bi-monthly through the Executive People & Organisational Development Committee (Nov 2018 – Mar 2020)
2. The issues arising from the Verita Report and the Trust's response to be part of the new People Strategy (Mar 2019)
3. Six monthly updates on the above actions to the Trust Board (Jun 2019 & Dec 2019)

This report has been discussed at:
☒Executive People & OD Committee

Quality impact: Effective performance improvement processes which support staff but also protect patients are critical to our organisation being safe, caring and well-led.

Financial impact: Additional resources have been allocated to support some of the agreed interim actions.

Risk impact and Board Assurance Framework (BAF) reference:
Risks attached to this project and how they will be managed. Reference to risk register and BAF where appropriate, and clear reference to key risks and mitigations.
The actions in this paper mitigate risks in the current formal approaches to improving performance and deployment of the current disciplinary procedures.

Workforce impact (including training and education implications):
The updates in this paper are designed to make improvements in processes for the workforce.

What impact will this have on the wider health economy, patients and the public?
This will provide assurance to staff, patients and the public that our disciplinary processes are fair and effective.

Has an Equality Impact Assessment been carried out?
☐ Yes ☐ No ☒Not applicable because the disciplinary outcomes are subject to extensive review on an annual basis

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

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

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

- To achieve excellent patients experience and outcomes, delivered with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.
- To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
-

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
Yes – not relevant. Work is already underway with the communications team to communicate updates throughout the Trust.

1. Introduction

Following the Verita Report - an independent investigation into the management of the Trust's disciplinary process resulting in the dismissal of Mr Amin Abdullah - a number of changes were made to the Trust disciplinary processes. In addition, the Trust committed to a wider review of our approach to managing disciplinary cases by the new Director of People and Organisational Development and a review of the role of individuals highlighted in the report. This paper provides an update on all three aspects of the Trust's response.

2. Verita Report Recommendations

The table below shows the recommendations of the Verita Report and the action the Trust has taken in response. It also shows the additional actions that have been recommended and agreed in these areas by the People and Organisational Development Committee following the review by the new Director of People and Organisational Development.

Verita Recommendations	**Actions Taken or Recommended by Director of People & OD**
R10 The trust should ensure that investigations are given sufficient resources, that reports are of good quality and that allegations are properly defined.	Actions Implemented: • Introduced pre-investigation checklists to ensure there is no alternative to a formal investigation and the terms of reference are clear. Additional Actions Agreed: • Create a dedicated in-house investigations team to conduct investigations that are quality assured (Mar 2019)
R11 Managers conducting disciplinary hearings should show greater rigour in evaluating evidence, particularly when allegations are poorly defined.	Actions Implemented: • Additional in-house training delivered on chairing panels. Additional Actions Agreed: • Commission an annual programme of training from an external provider for those most likely to be chairing panels (Jan 2019). • Ensure high-level HR advice and presence at formal disciplinary panel hearings (Nov 2018).
R12 Better training should be provided to those who conduct investigations and hearings about how to ask questions, gather evidence, record, classify and evaluate it. Such training should ensure that staff are aware of the danger of relying too heavily on impressions of how people come across at interview.	Actions Implemented: • Additional in-house training delivered for Investigating Officers. Additional Actions Agreed: • Create a dedicated in-house investigations team to conduct investigations (Mar 2019) • Commission an annual programme of training from an external provider for those most likely to be chairing panels (Jan 2019).
R13 Management responses to appeal letters should not be overly defensive and should allow for the fact that evidence is open to different interpretations.	Actions Implemented: • Policy change to ensure greater independence of appeals. • Template letter changed to highlight independence of appeal process. Additional Actions Agreed: • Create a dedicated in-house investigation team to increase the independence of investigations and avoid conflicts of interest or potential bias of those involved in decision-making (Mar 2019)

R14 Communications after a hearing where a punishment has been imposed should make clear that this is not the end of the process and that the appeal process is a genuine one, which will look at all representations fairly.	Actions Implemented: • Policy change to ensure greater independence of appeals. • Template letter changed to highlight independence of appeal process. • Policy change to ensure feedback of sanctions is given face-to-face. Additional Actions Recommended: • None
R15 The trust should take active steps to support staff going through a disciplinary process.	Actions Implemented • Pro-active communication and offer of support is being provided by the Trust's Contact service. Additional Actions Recommended: • None
R16 The trust should provide regular written updates to staff under investigation if their case is not dealt with within the agreed time.	Actions Implemented: • Monthly executive oversight meetings to review live cases, ensure delays are minimised and communication happening. • Monthly review meetings between the Employee Relations Advisory Service and HR Business Partners to resolve or escalate delays. Additional Actions Agreed: • Monthly oversight and escalation information shared with divisional management team (Nov 2018) • Case management key performance indicators included in the consolidated workforce performance report submitted to the People & OD Committee (Jan 2019)
R17 The trust should provide clear guidance on the purpose of internal reviews which should be carried out professionally and with objectivity. It needs to be made clear to authors that their primary objective is to determine the truth rather than tell the organisation what they think it wants to hear.	Actions Implemented: • Executive team reflection on lessons from how the assurance report was commissioned and reviewed through the Trust's governance system. Additional Actions Recommended: • None
R18 The trust should give higher priority to ensuring that records of disciplinary cases are properly stored for future reference.	Actions Implemented: • Currently no mitigating actions have been implemented against this recommendation Additional Actions Agreed: • Administration support incorporated into the central investigations team proposal (Nov 2018)* • Digital document management system to support ERAS, the central investigations team (if approved) or existing line managers if central team proposal not approved. (Mar 2019)

3. Director of People & OD Review Recommendations

The new Director of People and Organisational Development joined the Trust the week after the Verita Report was published and was tasked with conducting a wider review of lessons and changes that are required in relation to managing disciplinary cases. The review has included engagement with:

- internal stakeholders and those who have experienced the current processes – senior leaders, line managers and staff representatives
- the central HR team and the Trust's HR Business partners
- external experts and a brief review of approaches in other organisations

The issues and recommendations agreed by the Executive (People & OD) Committee of this wider review are shown in the table below.

Issue	**Recommendation**
1. Overuse of formal HR processes to manage some individuals whilst other performance issues are not managed effectively.	• Engagement activities to help reflect on the Trust's approach to managing performance and behaviours as part of the Leading change through vision, values and behaviours programme (Nov-Dec 2018) • A programme of people management development (training and coaching) to build the capability and confidence of managers to deal with performance issues without relying on formal HR procedures using the staff survey results to prioritise delivery (Apr 2019). • Actions to develop an organisational culture that genuinely reflects our values to be included within the new People Strategy (Apr 2019-Mar 2020)
2. Managers involved in formal HR procedures not always clear of their roles or confident and capable to fulfil their roles.	• Commission external provider of training for those most likely to be chairing panels (Jan 2019). • Create a dedicated in-house investigation team to increase the independence of investigations and avoid conflicts of interest or potential bias of those involved in decision-making (Mar 2019) • Review the guidance for managers and staff jointly through the Trust's Partnership Committee (Mar 2019) • Ensure high-level of HR advice and presence at formal disciplinary panel hearings (Nov 2018).
3. Role and support provided by the Employee Relations Advisory Service (ERAS)	• Review of the ERAS service as part of the wider HR Service review being undertaken to support the new People Strategy (Dec 2018)
4. Role of HR Business Partners in employee relations advice and guidance.	• Review of the role of HR Business partners as part of the wider HR Service review being undertaken to support the new People Strategy (Dec 2018)
5. The approach of line managers conducting investigations increases the risk conflicts of interest, is inefficient and can lead to a low quality output.	• Create an appropriately resourced, dedicated in-house investigations team to conduct investigations that are quality assured (Mar 2019)

6. Lack of tracking and resolution of issues causing delays.	• Monthly executive oversight meetings to review live cases, ensure delays are minimised and communication happening (underway). • Monthly review meetings between the Employee Relations Advisory Service and HR Business Partners to resolve or escalate delays (Nov 2018). • Monthly oversight and escalation information shared with divisional management team (Nov 2018)
7. Consistency between bank and permanent staff	• Dealing with issues with bank only staff incorporated into the new bank contract specification (actioned)
8. Data and perceptions that not all staff are treated consistency – with a perception of differences between staff groups (e.g. medical versus non-medical) and between staff from different backgrounds (e.g. black, Asian and minority ethnic staff versus white British staff).	• Engagement activities to help reflect on the Trust's approach to managing performance and behaviours as part of the Leading change through vision, values and behaviours programme (Nov-Dec 2018) • Management development interventions to achieve a greater consistency of approach across staff groups (Q1 2019/20) • Implement learning from the London HR Directors' initiative to reduce the disparity in the proportion of formal disciplinary interventions with staff from Black, Asian and Minority Ethnic backgrounds (Apr 2019 – Mar 2020).
9. HR policy accessibility and content not supportive of using more informal approaches.	• Review of HR policies (Mar 2019)
10. Learning from best practice to improve culture, approaches to performance management and costs of lengthy formal procedures.	• Leadership workshops to learn from best practice inside and outside the NHS (Q1 2019/20)

In addition to the recommendations already agreed it is proposed that the following actions are approved to embed the actions into the Trust's planning, management and strategic processes:

- Progress on the above actions monitored bi-monthly through the Executive People & Organisational Development Committee (Nov 2018 – Mar 2020)
- The issues arising from the Verita Report and the Trust's response to be part of the new People Strategy (Mar 2019)
- Six monthly updates on the above actions to the Trust Board (Jun 2019 & Dec 2019)

4. Review of roles of staff highlighted in the Verita Report

The Verita Report's recommendations were focused at an organisational level. However, the body of the report and conclusions also criticised the role of three specific individuals. To determine any individual accountability and potential action, we have established a review process that we believe is fair to everyone involved. This process involves:

- Two executive directors (Director of People & OD and Chief Nurse) identified to conduct the review supported by the Corporate Services HR Business Partner.
- A third executive director (Medical Director) to oversee the process and review any recommendations for action.
- A review of the Verita Report, supported by the Trust's external HR legal advisors, highlighting the areas of concern relating to each individual.
- A request to the individuals concerned for a written response to the criticisms raised in the Verita report and a statement of any reflections from the incidents and experience.
- A meeting with each individual and, where requested, their representative to review all of the available evidence and inform the most appropriate action.
- The use of the pre-investigation checklist to guide decision-making about the need for the Trust's formal disciplinary process.
- A review of training and support needs in relation to any knowledge or skills gaps.
- A recommendation on the way forward from the executive reviewers
- Review of the recommended way forward by the independent executive director
- Notification to the Chief Executive Officer and NHS Improvement of the outcome of the review

During this process each individual has been offered support from a senior manager and the Trust's welfare services, Occupational Health and Contact. Two of the three individuals have also been supported by their professional associations. So far, two out of the three reviews have been completed, with the final one expected to be completed by the end of November.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 28th November 2018	**Item 16.1, report no. 12a**
Responsible Non-Executive Director: Sir Gerald Acher	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:

The Audit, Risk and Governance Committee met on 3 October 2018. Key items to note from that meeting include:

External Audit report
Annual audit letter
The Committee noted that the final version of the annual audit letter for 2017/18 had been issued to the Trust, reflecting comments received at the previous meeting and management responses. The Committee noted that the National Audit Office had written to the Trust to ask for more information regarding the issues raised in the audit letter and this request had been responded to.

Internal Audit progress report
The Committee received and noted the internal audit progress report, including the status of audit work against the plan. The Committee considered progress in finalising reports from audits completed in 2017/18 by TIAA and actions from those reports. The Committee agreed that the list of outstanding actions would be validated by PwC, including checking the assignment of actions, and then follow up on outstanding actions. The Committee agreed that all outstanding actions should be closed by end of December 2018.

The Committee considered the report from the internal audit of risk management, noting that the overall risk from the review was low. The Committee discussed the findings and recommendations from the review, noting the findings regarding the inconsistent application of the risk management framework in the Divisions, particularly in relation to ensuring agreed actions for risk mitigation are followed through. The Committee reviewed the table of risks overdue for review across divisions and corporate directorates, included in the report, and agreed that an updated position on this would be presented at the next meeting.

The Committee noted the number of outstanding risks on the North West London Pathology (NWLP) risk register, and sought assurance that these risks were being managed in the same way as divisions. It was noted that the NWLP Host Committee reviews the risk register and that updates would be reported through executive committees in the same way as other divisions.

The Committee noted that there were no other final reports to consider at this meeting.

Counter fraud progress report
The Committee received and noted the counter fraud progress report, noting a summary of ongoing referrals and investigations, as well as action being taken to raise awareness. The Committee noted that PwC continued to manage the handover from TIAA, progressing cases handed over from TIAA.

The Committee noted that 27 new referrals had been received since April 2018.

The Committee discussed how embedded counter fraud was in the organisation and how success could be measured. It was agreed that initiatives to raise awareness needed to continue which would enhance the skills and awareness of staff, leading to increased appropriate management referrals, and that tools such as staff surveys and assessments would measure the level of awareness.

Corporate risk register and Board assurance framework
The Committee considered the joint corporate risk register and board assurance framework paper.

The Committee noted the updated Corporate Risk Register, including a summary of key changes made since the last meeting. The Committee noted the addition of new risks relating to implementation of e-referrals and the impact of the development of Paddington Square on patient services, and received assurances regarding the management controls in place to manage those risks. The Committee noted the increase in GPs using the system since implementation of the e-referrals system and the safeguards in place to ensure patient safety was not compromised if referrals were not received electronically. The Committee also noted that there was currently no evidence of loss of referrals to other providers, and that 'Assigned Slots Issues' (ACIs) were being identified and fed to divisions for action.

The Committee noted the key divisional risks and agreed that receiving assurance that risks were being managed at divisional level was important, in light of the findings of the recent internal audit review and the last CQC well-led review.

The Committee noted the latest version of the board assurance framework and agreed to a proposed review of the format of the framework to include more detail on actual assurances received.

The Committee discussed the lessons learned from the recent lift failure and the impact on patient services, and the importance of proactive risk management to identify potential issues. It was noted that a risk assessment would be completed to identify all points of failure, including ICT and estates, and assess the controls in place to mitigate these risks. The Committee reviewed the existing risk on the corporate risk register regarding capital funding for estates maintenance and recommended that its current rating of '16' should be reviewed, as the impact would be significant if additional capital was not received.

Cyber security update

The Committee received an update on cyber security, including the Trust's cyber security dashboard, and noted an update on the risks faced by the Trust and the controls in place to manage those risks. The Committee welcomed the views of both internal and external auditors who commented that the cyber security dashboard was an exemplar in the NHS.

The Committee noted that the executive team had agreed additional capital funding for key ICT projects, including network replacement, network access control and Windows 10 upgrade, which would support the management of cyber security risks. The Committee noted that the risk rating on the corporate risk register would be reduced with the implementation of these additional controls.

The Committee noted that cyber security would be subject of an internal audit review during 2018/19. It was noted that the scope of this audit was subject to agreement with executive leads.

Clinical audit report: A multi-professional audit of compliance with the Trust Duty of Candour Policy
The Committee received and considered the results of a clinical audit review of compliance with the Trust's Duty of Candour Policy. The Committee noted an overall improvement in compliance and reasonable assurance.

VTE trust-wide action plan update
The Committee received and noted an update on progress being made in regard to VTE compliance, noting that compliance levels had now returned to 95% and that there was increased confidence in the

quality of data and in sustaining this level of performance. The Committee welcomed the improvement, noting that this was a result of system changes and changes in behaviour through training. The Committee noted some variation in compliance at a local level, which was being addressed.

Progress update against MBI's data assurance report
The Committee received and considered the Trust response to the data assurance report, considered by the Committee at its previous meeting. It was noted that the Surgery, Cardiovascular and Cancer division was leading on the development and implementation of an action plan to address the recommendations in the report, mapping those recommendations against a pre-existing action plan.

The Committee discussed the governance arrangements for monitoring progress in implementing the action plan. It was agreed that the action plan and progress report would be presented to the next meeting of this Committee.

Tender waiver report
The Committee received and noted a summary of the number and value of waivers for Q1 2018/19. The Committee welcomed the reduction in use of tender waivers.

Losses and payments report
The Committee noted the schedule of losses and special payments, discussed the circumstances of individual cases and noted actions being taken to mitigate the risk of future losses.

The Committee will next meet on 5 December 2018.

Recommendations: The Trust Board are requested to note this report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Redevelopment committee report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 28th November 2018	**Item 16.2, report no. 12b**
Responsible Non-Executive Director: Victoria Russell, Non-executive director	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:

Key items to note:

The Committee has met twice, on 31 October and 21 November. Key topics of discussion in both meetings have included:

- strategic updates from the Chief Executive, including updates on the development of a London estates strategy and the work of the new London Estates Board and of Sir Robert Naylor.
- updates on key initiatives within the Trust's redevelopment programme.
- updates from Imperial Health Charity.
- updates on the management of the risk of adverse impact on patient services from the Paddington Square redevelopment, noting ongoing actions to mitigate the impact.
- updates on the Triangle project, noting that no further resource or action would be committed to the project until the outcome of the review of redevelopment options was clearer.

The next meeting of the Committee will be held on 12 December 2018.

Recommendations:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Remuneration and Appointments Committee 13 November 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 28 November 2018	**Item 16.3, report no. 12c**
Responsible Non-Executive Director: Sarika Patel	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:

The Remuneration and Appointments Committee met on 13 November 2018. Key points to note include:

Executive team annual performance reviews
The Committee agreed the process for Committee members to input into executive team appraisals, to inform the chief executive's review of performance.

National executive pay review
The Committee considered and agreed the proposed 2% uplift to executive directors' salaries for 2018/19.

Strengthening the executive team and the chief executive's office
The Committee received an update on appointments to the executive team, to strengthen the existing executive team and the support provided to the chief executive.

The Committee noted the appointment of Jeremy Butler as Director of Transformation and Claire Hook as Director of Operational Performance, and noted that interviews for the Divisional Director of MIC would be held in December.

The Committee also noted that the role of the Trust company secretary had been extended to incorporate the Chief of Staff function, supporting the chief executive by leading specific projects. The Committee also noted the planned development of a commercial function to build on existing successful ventures and enable increased re-investment in NHS operations, and noted the decision to expand the role of the current IPH Director, for six months, to develop this function.

Policy for executive directors taking on NED appointments or similar roles
The Committee considered and agreed the policy in regard to Executive Directors taking on Non-executive Director and other posts outside the Trust.

Executive director 360 degree appraisal
The Committee agreed an approach for the implementation of 360 degree appraisals for members of the executive team, including a proposed tool for the appraisal.

Remuneration and Appointments Committee terms of reference
The Committee agreed its terms of reference.

Recommendations:
The Trust Board is requested to note the report.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC
BOARD SUMMARY

Title of report: Report from Quality Committee, 14th November 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 28th November 2018	**Item 16.4, report no. 12d**
Responsible Non-Executive Director: Professor Andrew Bush	**Author:** Professor Andrew Bush, Non-executive Director Ginder Nisar, Interim Deputy Trust Secretary

Summary:

The Quality Committee met on 14th November 2018. Key items to note from that meeting include

Imperial College Healthcare NHS Trust and NWL Pathology Host Committee Terms of Reference
The Host Committee Terms of Reference were noted and approved. The Quality Committee will receive regular updates from NWL Pathology.

Integrated Quality and Performance Report
The bi-monthly integrated quality and performance report outlined the key headlines relating to the reporting months of August and September 2018. The Trust was achieving in the areas it expected to achieve in and areas that were not being achieved were the areas of focus. Learning and training featured as an emerging theme to drive excellence. Three never events were reported in 2018/19: one wrong route medication incident in May 2018; one retained swab in July 2018; and one retained foreign object incident in cardiac surgery in September 2018. The actions arising from the investigations are progressing.

Key Divisional Risks
The Committee received updates from the divisions on key divisional risks, current and new and the actions being taken forward to mitigate the risks.

Improvement Team Progress Update
The Committee noted that since September 2015, when the programme launched, significant progress has been made in delivering the core aim to create a culture of continuous improvement in the organisation. The team continue to actively support the organisation to drive improvement in service-led projects and a wide range of strategic transformation programmes including reducing unwarranted variation with demonstrable impacts ensuring patient and public involvement is at the heart of everything. The evidence from 19 Trusts rated 'Good' or 'Outstanding' (outlined in the two CQC publications) shows that "these Trusts have a strategic plan for QI, which is supported with unwavering commitment from the senior leaders, who model appropriate improvement-focused leadership behaviours and a visible, hands-on approach." Therefore the Trust must continue to ensure that it engages with and have commitment from senior leadership colleagues within divisions and corporate areas to promote the strategic importance of QI, role-model improvement language and behaviours and give permission to staff at all levels to make improvements.

Quality Account Improvement Priorities – Mid-year Progress Report
The Trust's 2017/18 Quality Account which was published at the end of June 2018 and set out 13 improvement priorities for 2018/19. These were developed using the driver diagrams for each quality domain included in the Quality Account, feedback from the quality strategy listening campaign and CQC inspections as well as the Trust operational objectives. The Committee noted the progress with the improvement priorities noting that the defined work plans are progressing with regular reporting through the appropriate Executive Committee.

CQC Update
The Committee received an update on CQC related activity at and/or impacting the Trust since the last update in September 2018, including the Trust-level headlines from the Trust's latest CQC Insight report. Following a review of critical care at the Trust in July 2018, outcomes were discussed at the Improving Care Programme Group in September 2018 and areas of good and outstanding practice and areas for improvement noted. Information about changes to the CQC's inspection scheduling for the remainder of 2018/19 and for 2019/20 was noted. The Trust's *Compliance and Improvement Framework* was being refreshed. The feedback from staff in

regard to anticipating a CQC visit and the general feel appears to be positive. Noted that a new Board member visit programme will shortly be launched.

Incident Monitoring Report
The Committee noted the incident reporting rate for September 2018 was 47.44, and the rolling 12 month average reporting rate (October 2017 to September 2018) is 50.48. 17 serious incidents (SIs) were declared with 34 ongoing (open) SI investigations and nine that are overdue. 11 level 1 internal investigations were declared. All cases are currently under investigation. Work will continue to focus on reducing the volume of overdue level 1 internal investigations as well as improving the quality and standard of reports along with subsequent action planning. Where appropriate, the actions and learning from SI's and level 1 internal investigations will be aligned through the Trust's nine safety streams to maximise local and Trust wide learning.

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report
The Committee noted that two Trust-attributed MRSA BSI cases identified during Q2 (July and September); 12 cases of Trust-attributed *C. difficile* identified during Q2; Two CPE BSI in Q2; overall consumption of antibiotics continues to fall, and the increasing trend in carbapenem consumption is at its lowest level since Q2 2016/17; a Trust-wide project is in progress to improve hand hygiene practice; an outbreak of *Pseudomonas aeruginosa* occurred in the neonatal unit and the process around ensuring that the operational management of water hygiene performed by Trust Estates and their contractors is being strengthened, specifically related to testing for Pseudomonas and Legionella and associated remedial actions. Issues related to environmental hygiene in the Trust have been identified, and Trust-wide steps are in place to improve cleaning standards; this is reflected as a new risk on the IPC risk register. Laboratory related issues have occurred during Q2, including delays in testing diagnostic specimens, and communication of results from the hospital laboratory and PHE. The risk related to microbiology laboratory support has been updated to reflect challenges in turnaround time for diagnostic specimens. The report detailed the actions and progress to address areas raised in the full report.

Occupational Health and Safety Report
The report provided an update on the Trust's occupational health and safety arrangements which included achievement of the 75% Quality Account target for Departmental Safety Coordinators (77%). Compared to the same period last year, there has been an increase in the number of violent incidents per 100 employees and actions are underway, and a separate report was discussed by the Quality Committee regarding violence and aggression.

Mid-year Update on Safe, Sustainable and Productive Nursing and Midwifery Staffing
The Committee received an update on the key initiatives being undertaken by the Trust in regard to nursing and midwifery workforce. In relation to the Trust's mid-year review, all clinical areas (inpatient, outpatient, theatres, endoscopy, renal satellite units, support services etc.) were included. Overall, there has been an actual increase of 23.26 WTE in the nursing and midwifery establishment when compared with the data from the establishment review undertaken in March 2018. A detailed breakdown was provided to the Committee. The next annual establishment review will take place by March 2019 and will be reported in May 2019. Following NHS Improvement recommendations in the 'Developing workforce safeguards' publication, the next report to the Committee will include the Trust's position in response to the recommendations.

PLACE Report
The 2018 National Patient Led Assessment of the Care Environment (PLACE) results were published on 16th August 2018 by NHS Digital as part of an annual inspection process. The Committee noted the assessment results and recommended process to achieve improvements. The annual PLACE assessments covered six key areas: Cleanliness; Food & Hydration; Condition, Appearance & Maintenance; Privacy, Dignity & Wellbeing; Dementia; and Disability. The results showed an improved overall Trust position in three key areas, Food & Hydration, Privacy Dignity & Wellbeing, and Disability. However, Privacy Dignity & Wellbeing, Dementia, and Disability failed to meet the national average this was largely due to the physical constraints of the old estate which limits the Trust's ability in a number of areas to deliver care in an optimum environment. Actions were progressing to address the areas highlighted.

Fire Wardens Update
The Committee noted that the target of 12% of trained Fire Wardens had been achieved and the aim was to train more than the target specified. The Director of Nursing briefed the Committee on the fire that occurred at Charing Cross Hospital on 7th November 2018. Fortunately there were no casualties and she commended the quick response by the Security Team and London Fire Brigade. After the investigation a report will be provided to the Quality Committee.

Review of Violence and Aggression against Staff
The Committee received a report which set out the levels of verbal and physical abuse experienced by Trust staff over the last three years and compared this to the levels of current activity. The Committee noted the actions that have taken place over the last 12 months to control and reduce violence and aggression, and next

steps required to implement a successful action plan. Actions include staff Training and education in dealing with violent or aggressive situations; security of the physical environment and improved communication; and increase of security staff presence and roster allocations. The Security service in conjunction with Divisional leads in key areas, instigated a number of actions from 2016/17 onwards to control and reduce incidents, whilst supporting staff which are reviewed and monitored.

Medical Education Performance Report
The Committee received a report which provided an update on key activities within medical education in the last quarter relating to Undergraduate Education, Postgraduate Education, Continued work on education improvement programme and Education risks.

Recommendations:
To note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC
BOARD SUMMARY

Title of report: Report from Finance and Investment Committee, 21st November 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 28th November 2018	**Item 16.5, report no. 12e**
Responsible Non-Executive Director: Chairman	**Author:** Sir Richard Sykes, Trust Chairman Ginder Nisar, Interim Deputy Board Secretary

Summary:

The Finance and Investment Committee met on 21st November 2018. Key items to note from that meeting include:

Finance Report

Noted the Month 7 report. Before Provider Sustainability Funding (PSF) the Trust was on plan in month 7, and reported an improvement in its forecast of £1.9m, taking the forecast to £4.1m adverse to plan. Efforts to turn the position around were paying off, but continued focus is required to achieve divisional forecasts and deliver a further £4.1m improvement to meet the control total.

Month 6 saw a £1m improvement in the forecast; for month 7 the divisions have again updated their forecasts for the year and the Trust's forecast now stands at £4.1m adverse to plan, a further £1.9m improvement. At month 5 divisional forecasts included improvements for which there are not yet fully worked up delivery plans; during month 6 and 7 divisions and directorates have identified improvements to close most of this gap and the risk is significantly reduced. This suggests efforts to turn the position are paying off but continued focus is required to deliver this and mitigate the remaining risks in order that the Trust will meet its control total.

In relation to PSF, as reported last month following an appeal the Trust had confirmation that it did not meet the A&E target for PSF in Q1 which is driving the £1.5m adverse variance year to date and in the forecast. The Trust is assuming that it will meet its control total and A&E target for PSF purposes for the remainder of the year.

The Trust is £7.1m behind on the capital plan compared to the capital resource limit, there has been a £2.0m overspend in month bringing the Trust closer to the capital plan. The Trust is forecasting to meet plan by the end of the year. Additional capital funding of £35.4m which has been requested from NHS I is not yet included in the plan. The programme is closely monitored by the Capital Expenditure Assurance Group and Capital Steering Group.

Four Year Financial Recovery Plan and 19/20 Business planning

Endorsed the Four Year Financial Recovery Plan to be presented to the Board and submitted to NHS Improvement by the end of November 2018 and noted that the control totals for 2019/20 have not yet been communicated by NHSI. The Committee noted that the 2019/20 business planning guidelines and timelines have been shared with stakeholders and the divisions and directorates have commenced their planning for 2019/20. NHS planning instructions are due in mid-December, after the publication of the long term plan for the NHS. We expect the final 2019/20 plan to be due to NHSI on 4th April 2019 having been approved by Trust board at the end of March 2019.

As in previous years the executive will oversee the progression of the financial plan in three steps,

1. 18/19 baseline and recurrent pressures impacting 2019/20
2. Unavoidable 2019/20 Cost Pressures
3. Income growth schemes

Starting now and running alongside these three steps divisions will develop their 2019/20 Cost improvement programmes which will be monitored at monthly meetings with the executives throughout the planning cycle.

Summary of Capital spending progress as at 30 September 2018
Noted that the Trust has spent a total of £17.849m against a planned position of £25.948m year to date at month 6. There are a combination of current under and overspends in a number of where the variances relate to timing of expenditure rather than absolute under or overspends. A significant number of commitments were made in October and continue to be raised in November which will bring the forecast back in line with initial projections. No projects are causing any specific concerns at this time.

Currently the Trust is forecasting to increase its Capital Resource Limit (CRL) for the year by £6.7m which has been agreed with NHSI and will be funded from internal cash reserves. This will support a number of projects including £2m acceleration of spend for the Charing Cross Emergency Department refurbishment and £2.8m mitigating Trust risks on ICT infrastructure.

In addition the Trust has received £5m Winter Pressures capital funding to invest in additional bed capacity.

The Trust is continuing to pursue additional capital funding streams, including an Emergency Capital loan via NHS Improvement (NHSI), and the North West London STP wave 4 capital bid. We are awaiting confirmation as to the level of success of these.

Cash flow review and optimisation
Noted the overview of how the Trust is managing its working capital position as at 31st October 2018. Whilst the Trust already takes active steps to manage its level of debt, it is recognised that a more structured and focused approach will improve the overall management of debt and cash. The Committee noted the active steps taken in contract negotiations with NWL CCGs to improve cash payment; and noted the issues faced with the Trust's Accounts payable supplier and actions taken to address this with the provider, and within the Trust.

Research and Education – Improving financial transparency
Noted the update on the work to improve the transparency of how research and education income and costs are reported. The key points to note are the research model has been completed for 2016/17 and 2017/18. There has been a review undertaken by research and finance teams and further work is being undertaken to improve the modelling for overhead charges. Work has started on a model for medical education costs, this is being refined with the view to review with the Medical Education leads.

Summary of business cases approved by The Executive since 1st April 2018
Noted that 21 business cases have been approved by the Executive since the start of the 2018/19 financial year, with five of these cases being worth more than £2m and less than £5m in either expenditure and or capital.

Recommendations:
To note this summary.