Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 25 July 2018, 10:45am to 1pm
Boardroom, Charing Cross Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1045	**1.**	**Opening remarks**	Sir Gerald Acher	Oral
	2.	**Apologies:** Sir Richard Sykes, Dr Urch (Martina Dinneen representing), Nick Ross, Prof Teoh	Sir Gerald Acher	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 Gerald Acher	Oral
1050	**4.**	**Minutes of the meeting held on 23 May 2018** *To approve the minutes from the last meeting*	Sir Gerald Acher	01
	5.	**Record of items discussed in Part II of Board meeting held on 23 May 2018** *To note the report*	Sir Gerald Acher	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Sir Gerald Acher	03
1055	**7.**	**Patient story** *To note the patient story*	Prof. Sigsworth	04
1115	**8.**	**Chief Executive Officer's report** *To note the Chief Executive's report*	Prof. Orchard	05
1125	**9.**	**Integrated Quality and performance report** *To receive the monthly integrated quality and performance report for months 1 & 2*	Prof. Redhead, Divisional Directors, Divisional Directors of Nursing	06
1135	**10.**	**Finance report** *To note and discuss the month 3 position and year to date and other financial matters*	Richard Alexander	07
For decision				
	11.	No items for decision		
For discussion				
1145	**12.**	**CQC update, including the ward accreditation programme** *To note the update on CQC related activity at and/or impacting the Trust and to note the overview of the ward accreditation process*	Prof. Sigsworth	08
1155	**13.**	**Patient and Public involvement Engagement** *To note the progress, challenges and priorities for patient and public involvement over the past year*	Michelle Dixon	09
1205	**14.**	**Corporate Risk Register and Board Assurance Framework** *To note the changes to the corporate risk register and agree current ratings within the board assurance framework*	Prof. Sigsworth, Peter Jenkinson	10
For noting				
1215	**15.**	**Learning from deaths report** *To note the progress and dashboard for 2017/18*	Prof Redhead	11

	16.	**Emergency Preparedness, Resilience and Response plan** *To receive and update and assurance on the* EPRR arrangements and plans	Prof. Sigsworth	12
	17.	**Cancer update – RM Partners update report** *To note the report which provides an update on the Trust's work as part of RM Partners, the Cancer Alliance for west London*	Martina Dinneen	13
	18.	**Responsible Officer's annual report** *To note the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation*	Prof Redhead	14
	19.	**Safe, sustainable and productive nursing and midwifery staffing – annual report** *To note the report and the findings from the establishment review*	Prof. Sigsworth	15
	20.	**Research report** *To note the quarter 1 report*	Mark Thursz	16
	21.	**Safeguarding report – children and young people – annual report 2017/18** *To note the summary of activity in the Trust in 2017/18*	Prof. Sigsworth	17
	22.	**Safeguarding report – adults – annual report 2017/18** *To note the summary of activity in the Trust in 2017/18*	Prof. Sigsworth	18
	23.	**Infection prevention and control, and antimicrobial stewardship Annual Report 2017/18** *To note the annual report*	Eimear Brannigan	19
	24.	**Annual survey of adult inpatients – 2017** *To note the results of the survey*	Prof. Sigsworth	20
	25.	**Complaints – annual report 2017/18** *To note the annual report*	Prof. Sigsworth	21
	26.	**Annual Freedom of Information report** *To note the annual report*	Michelle Dixon	22
	27.	**Fire safety assurance report** *To note the Trust's compliance with the Fire Safety Order*	Merlyn Marsden	23
1235	**28.**	**Committee reports** *To note the summary reports from the Trust Board Committees held during June and July 2018*		
	28.1.	Audit, Risk & Governance Committee, 4th July 2018	Sir Gerald Acher	24
	28.2.	Finance and Investment Committee, 18th July 2018	Andreas Raffel	25 – To follow
	28.3.	Quality Committee, 11th July 2018	Prof. Bush	26
	28.4.	Redevelopment Committee, 27th June 2018	Victoria Russell	27
	28.5.	Remuneration and Appointments Committee, 20th June 2018	Sarika Patel	28
1245	**29.**	**Any other business**	Sir Gerald Acher	Oral
1250	**30.**	**Questions from the public**	Sir Gerald Acher	
Close	**31.**	**Date of Next Meeting** 25th September 2018, 11am, Clarence Wing Boardroom, St Mary's Hospital	Sir Gerald Acher	

Updated: 20 July 2018

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 23 May 2018
11.00 – 12.30
Oak Room, W12 Conference Centre, Hammersmith Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerry Archer	Deputy chairman
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Victoria Russell	Non-executive director
Prof Julian Redhead	Interim chief executive officer
Richard Alexander	Chief financial officer
Prof Tim Orchard	Medical director &divisional director, medicine & integrated care
Prof Janice Sigsworth	Director of nursing
In attendance:	
Nick Ross	Associate Non-executive director
Prof TG Teoh	Divisional director, women's, children's & clinical services
Dr Katie Urch	Divisional director, surgery, cancer & CV
Kevin Jarrold	Chief information officer
Michelle Dixon	Director of communications
David Wells	Director of people and organisational development
Prof Jonathan Weber	Dean, Imperial College Medical School
Peter Jenkinson	Trust company secretary (minutes)

1	**Administrative matters**	**Action**
1.1	**Chairman's opening remarks, apologies and declarations of interests** Sir Richard Sykes welcomed all members and attendees to the meeting. Apologies were noted from Sarika Patel, Prof Andy Bush and Dr Bill Oldfield. The Board noted that this was Mr Wells' last formal board meeting and thanked him for his contribution to the Trust as Director of people and organisational development.	
1.2	**Declarations of interest** There were no declarations made at the meeting.	
1.3	**Minutes of the meetings held on 28 March 2018** The minutes of the previous meeting, held on 28 March, were confirmed as an accurate record.	
1.4	**Record of items discussed in private at the Board meeting on 28 March** The Trust Board noted the report.	
1.5	**Action log and matters arising** The Trust board noted the action log.	
2	**Operational items**	

2.1	**Patient story** Prof Janice Sigsworth introduced a patient to the Board, who outlined her experiences of the Glaucoma Clinic at Western Eye Hospital and the ED at St. Mary's Hospital. She thanked the staff at Western Eye Hospital for the care she received and noted the improvements made to the environment. She also suggested some improvements, based on her experience, including the management of outpatient clinics and the dissemination of knowledge across the Trust to improve the diagnosis of symptoms in the ED. She also suggested a subtle change of approach to 'difficult patients' to one of management of 'patients with difficulties'. The Trust board thanked the patient and noted the patient story.	
2.2	**Chief executive officer's report** Prof Julian Redhead presented his chief executive officer's report and outlined the inclusion of updates on financial performance, major capital schemes, the implementation of Cerner at West Middlesex Hospital and the planned relocation of critical care services at St. Mary's Hospital to a single location to improve quality of care. Prof Redhead also provided a verbal update on research activity and recent outputs from the Imperial Biomedical Research Centre, including the recent successful trials of gene therapy for haemophilia. It was noted that trials continued on the safety and durability of the therapy prior to bringing the therapy to market. The Trust board noted the report.	
2.3	**Integrated performance report** The Trust Board considered the Integrated performance report for March 2018. SAFE and EFFECTIVE: Prof Tim Orchard presented the Safe and Effective section of the integrated performance report, highlighting a reduction in the number of serious incidents reported in the month and the Trust's patient safety incident reporting rate as a positive indicator of the Trust's safety culture one of the key focus areas for the safety culture improvement programme launched in July 2016. Prof Orchard also reported continued excellent results in the Trust's SHMI mortality data, with the Trust reporting the second lowest HSMR for acute non-specialist trusts nationally. The Board noted one case of MRSA blood stream infection was reported in March 2018, making a total of three for 2017/18. It was also noted that the rate of Clostridium difficile cases was below trajectory for 2017/18. The Board noted that Trust performance for Venous thromboembolism (VTE) risk assessment had dropped just below target at 94.56 per cent for the month of March, noting that action was being taken to ensure the robustness of compliance across divisions. The Board also noted that the most recently reported 28 day readmission rates continued to be lower in both age groups than the Shelford and National rates, reflecting the appropriateness and effectiveness of care provided. Mr Goldsbrough asked for an update on progress in areas of safety highlighted	

by the CQC, such as medicines management. Prof Orchard provided an update on the trust-wide approach being taken to medicines management, including the sharing of good practice, and reported that improvements were being made in compliance.

CARING: Prof Sigsworth presented the Caring section of the report, highlighting a reduction in the incidence of pressure ulcers. She also highlighted the continued positive results from Family and Friends Test (FFT) feedback and a consistent level of complaints received, although it was noted that the proportion related to appointments, delays and cancellations has increased due to winter pressures.

The Board noted the continued challenge and risk related to midwifery staffing levels, noting that the risks to patients were mitigated through senior staff being more operational but that this had a negative impact on the levels of supervision being available.

The Board noted slippage in the Trust's compliance with eliminating mixed-sex accommodation, noting that this was as a consequence of cohorting critical care patients in appropriate beds and subsequent delays in moving patients to appropriate wards and beds. The Board noted that safe treatment of patients was critical and that the focus should be on the timely movement of patients from critical care to wards.

WELL-LED: David Wells presented the well-led section of the report, highlighting the current vacancy and turnover rates, and the actions being taken to improve recruitment and retention of staff. He also highlighted an improvement in sickness absence. The Board noted the improvement in compliance with statutory and mandatory training.

Dr Raffel asked whether the Trust had encountered problems with visas for nursing staff recruited overseas, but Mr Wells confirmed that the Trust had not had such problems.

The Board noted the current doctor appraisal rates and noted the escalation process for those who remained non-complaint.

RESPONSIVE: Prof Tim Orchard presented the Responsive section of the report, highlighting the current performance against the waiting time standard in ED. It was noted that performance remained challenging but there was an improving trajectory. The Board noted that the key issue remained as capacity and noted the work being done on capacity planning for the following winter.

The Board noted that the Vocare service in the St. Mary's Hospital urgent care centre had been the subject of a CQC inspection, but the report had not yet been published.

Dr Katie Urch reported that performance against the Cancer waiting times standard remained above target. The Board noted current performance against the Referral to Treatment waiting times standards, noting improved performance in March against the 18 week standard. The Board noted that at March, 267

	patients had waited over 52 weeks for their treatment since referral from their GP. Further improvement in waiting times was being affected by the temporary postponement of non-urgent elective activity to support the emergency pathways and by continued bed pressures leading to significant numbers of cancellations. However actions plans were in place and there was a focus on treating those patients who had waited for more than 52 weeks and by end of May it was expected that no patient would be waiting for more than 100 weeks. The Board noted that capacity constraints was also having an adverse effect on the rate of rebooking cancelled appointments. Work continued to mitigate this risk, including collaboration with other providers, including the private sector, to identify suitable capacity. Prof TG Teoh reported that the diagnostics waiting times performance had been recovered to deliver 0.9 per cent of patients who had waited over six weeks for their diagnostic test, meeting the national target of less than 1 per cent. The Board noted the roll-out of e-referrals from August 2018 and the financial implications of referrals received by other means. The Board also noted the rate of outpatient appointments cancelled by the Trust, but agreed that the figures presented should reflect those appointments cancelled by the Trust in order to bring forward the appointment, as well as those delayed by the Trust. The Trust board noted the integrated performance report	
2.4	**Finance – month 1 finance update** The Board received and noted the summary of financial performance for 2017/18, subject to audit. The Trust had met the Control Totals and all statutory financial targets set by the Regulator and after the allocation of Sustainability and Transformation Funding (STF) would report a small surplus. The Board noted that before STF, the Trust would report a £2.6m favourable variance to the agreed deficit plan of (£25.2m), of which £0.1m was operational and £2.5m was an adjustment for winter funding. After STF the Trust reported £7.5m favourable to the Control Total as additional incentive and bonus STF were allocated. The Board noted that the financial plan for 2018/19, agreed at the previous meeting of the Trust Board, would require a further stretch, with the Control Total set at £20m deficit. The Trust board noted the report.	
3	**Items for decision**	
3.1	**Quality Account 2017/18** The Trust board received and considered the final draft of the Quality Account for 2017/18, noting that drafts had previously been discussed by the Audit, Risk and Governance Committee and the Quality Committee. The Trust board considered the review of performance for 2017/18 and the proposed quality priorities for 2018/19. It was noted that the stakeholders' comments on the accounts were still awaited. The Trust board agreed to delegate authority to the Chief executive to sign the Trust's Quality account for 2017/18.	

3.2	**NHSI self-certification declarations** The Trust board considered the self-certification declarations of compliance against the two conditions equivalent to foundation trust licence conditions, as required by NHS Improvement. The Board discussed the conditions and the regular assurances that it already received through other means, including the regular review of the board assurance framework and risks identified in other board papers. The Board therefore agreed that it was compliant with condition G6(3) that the Trust '…took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.' The Board considered its compliance, and risks to ongoing compliance with condition FT4, and agreed that it could not confirm compliance with condition FT4(4a) 'to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively' due to the Trust not achieving the waiting time standards for ED and referral to treatment (RTT). The Board noted the actions being taken to address this non-compliance, as reported in the integrated performance report. The Board also noted the risks to achieving the financial plan for 2018/19, as previously discussed. The Trust board agreed the self-certification declaration.	
4	**Items for discussion**	
4.1	**Infection prevention and control quarterly report** The Trust Board welcomed Dr Eimear Brannigan, Deputy Director of infection prevention and control, to the meeting. Dr Brannigan presented the quarter 4 infection prevention and control, and antimicrobial stewardship report, for 2017/18 and highlighted: • Two cases of Trust-attributed MRSA BSI identified during the quarter, resulting in three Trust-attributed MRSA BSI reported in 2017/18. This was the same as in 2016/17. • There had been 63 cases of Trust-attributed *C. difficile* for the year, the same as reported in 2016/17. This meant that the Trust had the third lowest rate of Trust-attributed *C. difficile* in the Shelford Group of hospitals. • The bi-annual antibiotic point prevalence survey had found that all indicators of antibiotic prescribing quality are in excess of the target level of 90%. • The first round of revised hand hygiene auditing would be performed throughout the Back to the Floor Thursdays in May. This programme aimed to provide accurate hand hygiene compliance information for all inpatient areas to inform improvement initiatives. Dr Brannigan advised the Board of the increased detection of CPE across the Trust. The Board noted that a screening programme was in place and cases isolated when identified. No new clusters of CPE had been identified in March and enhanced infection prevention and control measures had been put in place in the affected areas. In response to a question, Dr Brannigan highlighted the major risk areas in the Trust from an infection prevention and control perspective: the ageing estate and environment, making cleaning more difficult but mitigate through the excellent work of staff; the lack of real-time surveillance data making timely interventions	

	more difficult; and the capacity for ongoing surveillance. The Board also noted that the current acuity of patients being admitted, many of whom were immunocompromised, meant a greater risk of transfer of bacteraemia. The Board noted the exemplar of other health systems in provision of side rooms and isolation facilities to prevent spread of infections, but noted the constraints of the Trust's current estate. The Trust board noted the report.	
4.2	**CQC update** The Board received and noted the progress report, including an overview of CQC activities impacting the Trust and the Trust's approach to CQC during 2018/19. The Board noted the update to the CQC's regulatory framework for NHS trusts in March 2018 to reflect changes in relation to the Use of resources assessment and the fit and proper persons test. The Board also noted the update on actions being taken following the last CQC inspection, noting that the Quality Committee would receive regular progress reports. The Board discussed the most recent addition to the inspection regime, focusing on 'use of resources'. It was noted that the Trust had completed a desk top exercise to assess level of compliance and the model hospital benchmarks utilised to determine areas of improvement. The inspection methodology was not yet known but the Board acknowledged the risk of the condition of the Trust estate and lack of capacity in terms of compliance. Prof Sigsworth reported that the Leadership Forum had considered the lessons learned from Bristol and Cambridge in their respective paths to achieving a 'good' rating. She advised that the Trust was developing its plans for approaching the next inspections, expected in 2019, including strengthening its site-specific management as well as maintaining cross-organisational structures, to reflect the CQC approach to inspections. This approach would be presented to the Quality Committee in June. The Board noted the report.	
5	**Items for information**	
5.1	**Board Assurance Framework** The Trust board considered the revised version of the board assurance framework, including updates since the last review and risk appetite ratings following agreement of these by the Board at its meeting in March 2018. The Board noted the report.	
5.2	**Trust seal annual report** The Trust board received and noted the use of the Trust seal during 2017/18. The Board noted the report.	
5.3	**Board self-assessment of effectiveness** The Trust board considered the results of the annual self-assessment of effectiveness, noting an overall consistent feedback from the previous year's results. The Board noted the feedback related to 'focus on strategic direction' and agreed that this would be taken into account when reviewing the work plans for the Board meetings and seminars.	

	The Board noted the report.	
6	**For information: Board committee approved minutes**	
6.1-6.5	The Trust board noted the reports from the following committees: • Quality Committee • Finance & investment committee • Redevelopment committee • Audit, risk and governance committee • Remuneration Committee	
7	**Any other business**	
7.1	No other business was discussed.	
8	**Questions from the public relating to agenda items**	
8.1	The following responses were given to questions raised by members of the public present at the meeting: • A member of the public asked why the Trust had changed its internal auditors to PWC. The Board noted that it was good corporate governance practice to tender this service every few years, in order to retain the independence of auditors. A competitive tendering exercise had been completed and the selection panel had concluded that PWC were the best atuned to the organisation and its requirements.	
9	**Date of next meeting**	
	Public Trust board: Wednesday 25 July 2018 10:00-14:30, New Boardroom, Charing Cross 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 23 May 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 25th July 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.

May 2018

NHSI Cyber security assurance return
The Board considered and agreed a submission to NHS Improvement, setting out the Trust's compliance with the ten data security standards set out in the new Data Security and Protection Toolkit. This annual submission will replace the previous requirement to complete the NHS Digital's Information Governance Toolkit.

The Board noted the standards where the Trust had declared partially or not implemented, and the actions being taken to mitigate the gap in compliance.

June 2018

CNST for Maternity
The Board considered progress against the CNST incentive scheme maternity safety actions and approved the submission of this assessment to NHS Litigation Authority.

Patient Transport Tender
The Board considered and approved recommendations for the award of the contract for the provision of non-emergency patient transport services.

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 23 May 2018

Updated: 19 July 2018

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	28 Mar 2018 2.1	Staff survey results – Bullying	A detailed action plan regarding bullying to be presented to a future Board meeting. July 2018 update: To be picked up by new Director of HR & OD	K Croft	September 2018
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	K Croft	September 2018
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 October 2018	J Sigsworth	October 2018

Items closed at the [month**] meeting**

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.					

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: 25 July 2018	**Item 7, report no. 04**
Responsible Executive Director: Janice Sigsworth – Director of Nursing	**Author:** Steph Harrison-White - Head Of Patient Experience & Improvement

Summary:
This month's patient story is about a patient at the end of life who, despite efforts of the palliative care team, died in one of our hospitals rather than at home where he wanted to be.

The medical lead for End of Life Care within the trust will tell this patient's story and highlight the importance of supporting patients to die in their place of choice and the work the trust is embarking on to support this.

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

This report has been discussed at: N/A

Quality impact:
End of life care is an important part of a patient's journey. Failing to manage it effectively leads to poor quality of experience not just for the patient but also for the relatives.

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

Risk impact and Board Assurance Framework (BAF) reference: N/A

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

What impact will this have on the wider health economy, patients and the public?
Better end of life care will lead to improved quality of experience

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

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

Trust strategic objectives supported by this paper:
- To 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?

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 participating in an end of life Always Events®, supported by NHS England. This will enable us to identify and design with our patients, their families and / carers those aspects of care that should always happen to ensure a good quality patient care focused on those areas that matter most.

- What (if anything) do you want senior managers to do? (maximum two bullet points)

  Nothing

- Contact details or email address of lead and/or web links for further information (maximum one bullet point)

  stephanie.harrison-white@nhs.net

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

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

This month's patient story will be presented by a clinician who was directly involved in supporting a family through end of life care. Due to the nature of the case, it was deemed inappropriate to invite the family at this time.

This patient had wanted to die at home; however following an unexpected hospital attendance, he was admitted to hospital and sadly died there despite our best intentions and efforts to discharge him home.

We have reflected upon this and have consequently prioritised end of life care as being our first Always Events®. This involves working closely with families, carers and staff to identify and co-design what matters most to patients and developing improvements to ensure these changes are implemented into practice and always happen.

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

Death and dying are inevitable and whilst we cannot do anything to avoid death, we must work together to make sure that '*the care that surrounds the inevitability is as good as possible, for all'* (Ambitions for Palliative and End of Life Care 2015). We know from the first national strategy for end of life care in England (2008) that across the NHS we do not always get this right:

- People still don't always die in their preferred place of choice
- Larger numbers of people are dying and that not everybody receives high quality care

National Voices, the National Council for Palliative Care and NHS England have produced the statement below describing person centred care for people near the end of life:

- '*I can make the last stages of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including carer(s)*' (2015).

Dr Buxton, consultant in palliative medicine and the Trust Medical Lead for End of Life Care, will share one patient's story. This patient died in one of our hospitals in April 2018. It was decided it would not be appropriate to invite his family to speak at this stage, but that we needed to hear and learn from the experiences of this patient

4. Summary/Key points

A 58 year old gentleman with metastatic lung cancer diagnosed 6 months previously had decided to spend his remaining time at home with his family. He had made an informed decision based on all his treatment options and prognosis.

During his final six months, he unfortunately required a number of hospital admissions for repeated episodes of sepsis. On a final admission to one of our hospitals, he made the decision that he didn't want to come into hospital anymore. He accepted that his life was ending, and he wanted to spend the time he had left with his family. He also planned that he wanted to die at home with the support of the community services.

Following this conversation, plans were rapidly put into place to enable this to happen. Hospital teams including therapists, complex discharge team, community palliative care team, ward nurses and doctors worked together to liaise with community teams to co-ordinate and arrange this gentleman's care for his home environment. Once everything was in place he was discharged home.

Unfortunately for this gentleman as it turned out that was not his final admission. He was readmitted to one of our hospitals approximately 10 days later as he was unable to pass urine at home. The community team had been unable to pass a catheter, so he was admitted back to A&E where a catheter was passed.

By this point it was now the early hours of the morning, and despite the wishes of his partner this gentleman was admitted onto a ward and blood tests were taken instead of being quickly sent home. The palliative care team was called by the ward nursing staff early the following morning plans were made to get him back home as soon as possible. Unfortunately, despite our best efforts, we couldn't pull things together in time and he died on the ward several hours later.

5. Conclusion and Next Steps

The patient sadly did not die at home as was his preference. The teams involved in his care have reflected upon this. Whilst they recognise we may not always be able to meet everyone's preferences, we do need to start understanding more about what is important to our patients and their families or carers at this time. As the national framework for local action 2015-2020 states, we need to have 'honest conversations' and joined up care. There has been a reluctance nationally to discuss death and dying but in order to understand what really matters we need to have these open conversations.

The Trust has now signed up to the National Always Events® programme, coordinated by NHS England. Always Events® are defined as 'those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system'.

NHS England, in collaboration with Picker Institute Europe and the Institute for Healthcare Improvement (IHI), have been leading the Always Events® programme. The programme began in 2015 and involved 10 provider pilot sites across England. *A* toolkit based on the learning from pilot sites has been published and over 100 Always Events® are now in progress nationally supported by NHS England through a series of coaching calls, webinars and networking.

Always Events® use a co-design methodology to work with patients, service users, and clinicians to identify and develop care processes that transform patient experience.

End of life care will be one of the trust's first Always Events®. The patient experience team, SCCS divisional nursing team and the end of life team are working together on this project. The initial phase involves speaking with families and carers of deceased patients in the first instance and then staff, to help co-design relevant Always Events® that will ensure that patients who are approaching their end of life consistently receive care that has been identified by service users and their families as being important and that has been developed in true partnership.

Author: Steph Harrison-White
Date; July 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: 25th July 2018	**Item 8, report no. 5**
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) Update on major building improvements
5) Leadership and workforce
6) Stakeholder engagement
7) Key risks
8) Research and innovation

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

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.

1. Financial performance

The Trust has set a financial plan for 2018/19 of a £20.6m deficit before sustainability funding; this meets the control total set by NHS Improvement. Agreement to the control total gives the Trust access to £34.2m Provider Sustainability Funding (PSF), previously known as STF. This will be monitored based on meeting financial targets and the A&E four hour trajectory.

Year to Date at the end of June 2018 the Trust was on plan, with an £11.2m deficit before PSF. PSF was £5.1m for the quarter and the trust has shown achievement of both elements. The Trust has an over performance on income, mainly in non-electives, with some under performance on elective and maternity activity. There is some delay to cost improvement programmes (CIPs) causing adverse variances in the position. Despite the on plan position in the year there remains risks to the delivery of the financial plan. Additional non elective activity, and the capacity constraints it puts on the Trust, can cause disruptions to the delivery of the elective plan which has a financial impact on the trust. Work is being undertaken to improve the flow of patients in the trust with the aim of mitigating this risk.

The Trust's capital position is £3.8m underspent against plan year to date. The programme is closely monitored to ensure that the plan is met for the financial 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 £40.2m of identified programmes (at various stages of planning and implementation), and further ideas being worked up.

Against the Month 3 cumulative plan of £9.9m, there has been £5.8m of CIP delivery year to date (YTD), resulting in a £4.1m adverse variance to plan. The main reasons for this have been £2m of income and activity based productivity schemes, including private patients; £1.7m of unidentified CIP plans; and £0.4 of other Pay and Non-Pay schemes. Part of the underperformance in income has been associated with sustained bed pressures earlier in the year.

The current forecast CIP delivery for the year is £35.9m, 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 April 2018 and May 2018 (months 1 and 2).

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.

Performance is reported as being behind target for the following key areas:

- Referral To Treatment (RTT) 52 wait position – there has been a reduction of 47 patients waiting over 52 weeks between April and May 2018, however at end of May it was 63 behind trajectory.
- Cancelled operations increased in the quarter to end March 2018 (the most recent nationally submitted performance) and the 28 day rebooking performance deteriorated.
- Accident and Emergency 4 hour waits – the Trust is currently behind target for July 2018. The June performance was 87.4%, above the forecast trajectory of 86.1%, and it is anticipated that the trajectory for quarter 2 will be met. However there is significant concern regarding achieving the target during winter.

Given our very real operational pressures, there is a need to focus initially on making it easier for patients to move through our clinical pathways safely, quickly and smoothly, getting the care and support they need, when and where they need it. That means building on previous improvements in 'patient flow' as well as, importantly, finding other ways to create additional capacity.

The Executive Operational Committee continues to monitor the progress of the Improving Patient Flow Programme. Successful delivery of the programme is central to achieving the STF trajectory for 4 hour performance; however the work plan is not sufficiently comprehensive to support delivery of the 95% standard in March 2019, one of the requirements for STF funding. Further work is therefore needed to identify additional measures to improve non-elective flow over winter and work is underway, with internal and external support.

Following last year's expansion and refurbishment of A&E at St Mary's, we already have work underway to do the same at Charing Cross, with phase 1 to be completed before winter. I am also hopeful that we will be able to progress new, in-year plans to create additional inpatient beds across St Mary's and Charing Cross.

We are also exploring how we can ensure we all have the right data to help us target our resources and efforts as effectively as possible.

4. Update on major building improvements

As part of north west London STP's bid for capital funding, to be announced by the government in the autumn, the following Imperial schemes have been put forward:

- expansion and refurbishment of Charing Cross A&E
- new hybrid theatre and refurbishment of interventional radiology recovery at St Mary's
- creating additional ward areas at St Mary's and Charing Cross.

There is a different route to secure funding for phase 1 redevelopment of St Mary's – a new outpatient and ophthalmology building. We also have separate bids into NHS Improvement to support ICT improvements, new medical equipment, backlog maintenance and other estates projects at all sites.

5. Leadership and workforce

Senior staff changes

David Wells, Director of People and OD has now left the Trust. Kevin Croft will be joining the Trust in August as the new Director of People and OD; in the meantime Sue Grange and Dawn Sullivan will be acting as Director of P&OD.

Dr Frances Bowen has been appointed as interim Divisional Director for Medicine and Integrated Care.

Dr Bob Klaber has been appointed as Deputy Medical Director, replacing Dr William Oldfield.

Vision and values engagement programme

We renewed our values and developed a new promise – better health, for life - through a major staff co-design programme in 2015/16. We also began to develop a set of behaviours to show how the

values should work in action. There is very high awareness of our values and promise across the organisation but they are not yet shaping everything we do. We now want to take a step further with a second major co-design programme with staff, as well as partners, patients and local communities, to ensure we fully embed our values and promise in everything we do and use them to direct and align our emerging organisational strategy and transformation and improvement programmes. The original co-design programme also triggered proposals to simplify our name and our offer to patients, communities and staff through our hospitals and services – we will look at how we can best take this forward too.

We will launch the programme in late September, to coincide with our second 'Great place to work' week

I want it to help us deliver the following outcomes:

- clarity and shared ownership of our strategic vision and what that means in practical/tangible terms for staff and patients
- a stronger sense of belonging and understanding of an individual's place in the organisation and promise
- wide-ranging input to defining: barriers – and how they might be addressed; opportunities – and how they might be supported; our key priorities
- knowledge, permission and impetus to change things ourselves and for everyone to behave in line with our values

Staff survey results

The Trust has recently concluded its latest annual "Our Voice our Trust" local engagement survey, carried out in June and July 2018.

The executive team have considered the headline findings from the responses. Key headlines include:

- Response rate was 34% (3164 responses).
- Overall Staff Engagement is 78% compared to 80% in 2017
- FFT combined score is 78% (79% in 2017)
- FFT recommend as a place to work is 70% (72% in 2017)
- FFT recommend to receive care or treatment is 86% (unchanged)
- Most engaged staff groups include Pharmacists, AHP (Non registered), Training grade doctors, senior managers and non-registered Nursing.

The lowest 5 scoring questions remain the same as the last 2 previous years and centre around

- senior leader visibility, communication and interest in staff opinions
- I have enough time to complete all of my work
- Poor behaviour is addressed effectively in this organisation

The survey results will be considered in more detail and an action plan developed in response to the findings. They will play a major part in shaping our vision and values co-design programme to be launched in the autumn. The findings and action plan will be presented to the Trust Board in October.

6. <u>Stakeholder engagement</u>

The Trust's strategic lay forum met on 13 June for the latest of its bi-monthly meetings.

On 18 May we were pleased that Julie Ward MEP for North West England visited Queen Charlotte's & Chelsea Hospital to meet and discuss the work of our specialist FGM (female genital mutilation) Sunflower clinics team.

Interim chief executive Prof Julian Redhead met with representatives of the Save our Hospitals group on 24 May.

I met with Cllr Andrew Brown, Leader of the Opposition & Conservative Spokesman for Health, at

Hammersmith & Fulham Council on 22 June.

On 2 July Prof Julian Redhead, medical director, and Shona Maxwell, chief of staff to the medical director, attended a meeting of Hammersmith & Fulham Council's heath scrutiny committee to discuss the Trust's Quality Account report for 2017/18.

We were visited by Shadow Health Secretary Jonathan Ashworth MP on 3 July as a follow up to his work shadow programme with the anaesthetics team at St Mary's Hospital which took place in March.

On 17 July I also met with our local MPs Karen Buck, Rt Hon Mark Field and Andy Slaughter.

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

7. Key risks

The Trust Board will note in the risk report being presented that two new risks have been identified – the implementation of the NHS e-Referral Service and managing the impact of the Paddington Square development.

NHS e-Referral Service

The NHS e-Referral Service is a national development led by NHS Digital to ensure all consultant-led first outpatient appointments are made via the NHS e-Referral Service (eRS). From 1 August 2018, we have to 'switch off' paper referrals and only accept referrals made through eRS (in line with other hospitals in north west London). From 1 October 2018, all hospitals in England will only be paid for planned care resulting from referrals made through e-RS

The benefits of implementing this system include:

- enabling GPs and patients to see, at the point of referral, what services are available and how quickly the patient can be seen.
- enabling GPs to refer the patient and, in most cases, book their appointment while the patient is at the surgery
- helping to cut down on paperwork, eliminates the risk of letters going missing and enables clinicians and patients to track referrals more effectively.

The risks to the Trust from the implementation include:

- potential loss of income – GP referrals to first consultant-led outpatient appointments account for income of over £23m
- potential loss of activity – the system will make waiting times much clearer to patients and GPs and may result in activity moving to services with lower waiting times.
- potential poor patient experience – we need to ensure enough appointment slots are released for direct booking to prevent GPs booking patients into clinics showing no available appointments, resulting in booking team having to escalate capacity issues and patients repeatedly ringing up to chase.

Most relevant outpatient clinics are now mapped and published on eRS. A sector-wide paper referrals return process has been signed off for north west London to ensure that patient safety is maintained in the case of referrals not being submitting via the new service. Staff training is ongoing for admin staff, clinic staff and consultants who manage appointments and referrals, record outcomes for patients in clinic and/or triage referrals. In addition there will be 24 floorwalkers will support staff across all sites throughout August.

Paddington Square development update

The developer started demolition works on the former Post Office building, adjacent to the St. Mary's main Outpatient building, on Friday 13 July. The executive team are monitoring the impact of this development and the actions being taken by the clinical divisions to minimise the impact on patients and services. These include:

- Information on the intranet and Trust website has been updated to reflect the demolition works start date, and communications cascaded to all divisions advising them of the Escalation Protocol.
- Noise and vibration monitors to be installed in phases, in Winston Churchill, Jefferiss Wing, Main Outpatients Building, Mint Wing and the Mary Stanford

8. Research and innovation

The Executive Team received an update on research and innovation at the Executive Transformation Committee meeting on 10 July.

Non-Commercially-Sponsored Clinical R&D
We received a year-end review of non-Commercially-Sponsored Clinical R&D Activity for 2017/18, noting:

- The Trust recruited a total of 16,922 patients into non-commercially sponsored NIHR Portfolio studies, against an in-year target of 10,087;
- These studies essentially reflect successful grant applications, which may be sponsored / led by Imperial or by other external university/NHS partnerships;
- The Trust was the 5th highest such recruiter in the country, behind Oxford University Hospital, Guy's & St Thomas', Leeds Teaching Hospital and University Hospital Southampton.
- In terms of number of studies recruiting (331), Imperial College Healthcare was 10th in the country;

NIHR Imperial BRC – Annual Report 2017/18
The NIHR Imperial BRC Annual Research Report (ARR) for 2017/18 was submitted to NIHR on 18 May. The top three achievements included in the report were:

- A first-in-human, commercially-sponsored gene therapy trial, conducted in the NIHR Imperial Clinical Research Facility (CRF) and with Professor Mike Laffan as local study lead, showed remarkable success in treating patients with haemophilia A. The success of the study has led commentators to hail this as a potential cure for haemophilia A. Published in NEJM and larger trials now planned;
- ORBITA – the first, placebo-controlled double-blind randomised controlled trial of percutaneous coronary intervention (PCI) – demonstrated the potential placebo effect of heart stents. The trial exposed the flawed position of PCI in current clinical recommendations;
- A unique CAR-iNKT cell treatment strategy, developed by Dr Karadimitris in the Cancer Theme proved more effective than conventional treatments. It has clear clinical implications and a patent has been filed.

In terms of projects which are progressing (or have progressed) along the translational pathway, the annual report notes the following:

- Based on clinical evidence contributed from BRC projects and investigators, along with data supporting the cost effectiveness in comparison with other treatment strategies, Faecal Microbiota Transplantation (FMT) has now been accepted as an appropriate treatment option for recurrent/refractory C. difficile infection (CDI) by the National Institute for Health and Care Excellence, Public Health England and European guidelines. A clinical FMT service has now been established at ICHT.
- GripAble™, developed by BRC researcher Dr Paul Bentley with Dr Etienne Burdet (Bioengineering) launched as a new Imperial College spin-out company in November 2017, to commercialise a device which aims to improve arm and cognitive function of patients with arm disability through a physiotherapy-like computer game.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Bi-monthly Integrated Quality and Performance Report (month 2)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 25 July 2018	**Item 9, report no. 06**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director)	**Author:** 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 relating to the reporting months of April 2018 and May 2018 (months 1 and 2). It is based on agreed indicators, goals and targets for 2018/19. By exception, additional slides have been included to highlight issues and related improvement plans and actions (in progress or for where they may need to be planned).

As the first publication of the report using the revised format and process, the content and layout is expected to change over the coming months as we gain further feedback and make improvements.

The report is presented in three main sections as follows:

1. **Summary report:** Key headlines in performance and cross reference to additional exception report slides where provided.

2. **Indicator scorecard:** Trust performance indicator scorecard, providing 'at a glance' views of indicators under the domains including the target or point on the trajectory.

3. **Exception report slides:** By exception, additional slides have been included. Statistical process control charts are included where appropriate and this is an area we are continuing to develop. A short introduction on SPC charts is included.

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

Recommendations:

The Board is asked to note the bi-monthly integrated quality and performance report for months 1 and 2.

This report has been discussed at:

- Executive Quality Committee (Tuesday 3 July 2018);
- Board Quality Committee (Wednesday 11 July 2018); &
- Executive Committee for Operational Performance (Tuesday 17 July 2018).

Quality impact:

The delivery of an 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

- 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

Imperial College Healthcare
NHS Trust

Integrated quality and performance report

Month 2 (May 2018)

Summary

This is the bi-monthly integrated quality and performance report which outlines the key headlines relating to the reporting month of May 2018 (month 2).

This is the first publication of the report using the revised format and process; as a work in progress the content and layout is expected to change over the coming months as we gain further feedback and make improvements.

Contents

The report is presented in three main sections as follows:

1**.** Summary report

2**.** Indicator scorecard

3. Exception report slides

- By exception, additional slides have been included to highlight issues and related improvement plans (in progress or for where improvements may need to be planned).

Appendices

Appendix 1 Exception report slides tracker

Appendix 2 NHS Improvement undertakings

1. Summary report

1.1 Safe

Performance was above target / within tolerance for five key areas:

- Severe/major harm incidents – remained below national average
- MRSA BSI – no cases were assigned to the Trust during April and May 2018
- VTE risk assessment - compliance improved to above 95% standard during April and May 2018 following a dip in March 2018
- Core skills training and core clinical skills training
- We were also above target for overall safe staffing levels for registered nurses and midwives and care staff (with the fill rate below target in eight wards as detailed in the exception report)

Performance did not meet the agreed target / threshold for eleven areas and as a result exception reports are included as follows:

1. Incidents causing extreme harm/death
2. Incident reporting rate
3. Never events
4. CAS alerts outstanding
5. Duty of candour
6. Infection prevention and control (C.*difficile)*
7. Safe staffing
8. Vacancy rates
9. Departmental safety coordinators
10. Fire warden training
11. Medical devices maintenenace

1.2 Effective

We continued to meet our goal to be within the top 5 with the lowest risk acute trusts for mortality as measured by the Hospital Standardised Mortality Ratio (HSMR) (ranking 4th) and the Summary Hospital-level Mortality Indicator (SHMI) (ranking 3rd).

Performance did not meet the agreed target / threshold for three areas and as a result exception reports are included as follows:

12. Mortality reviews
13. Patient reported outcome measures (PROMS)

14. National clinical audits

1.3 Caring

Performance was above target / within tolerance for the FFT % recommended rates as follows:

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

Performance did not meet the target FFT response rates in A&E and an exception report is included:

15. FFT response rates in A&E.

The performance for mixed-sex accommodation (MSA) breaches continued to be significantly higher than the zero threshold standard (reporting 39 in April and 42 in May 2018). As previously reported the MSA breaches are mainly attributable to breaches occurring within ITU at Charing Cross. The Division of Surgery and Cancer are undertaking an audit of all breaches occurring within June 2018 to understand root causes and the results will be shared with our commissioners in July 2018.

For this reason an exception report is not included for MSA however this report will continue to be updated with the outcomes from these discussions.

1.4 Well-led

Performance for the recorded sickness absence rate remained within the 3% threshold.

Performance did not meet the agreed target / threshold for two areas and as a result exception reports are included as follows:

16. Doctor appraisal rates
17. Consultant job planning completion rate

The voluntary staff turnover rate increased (it was 11.9% in May 2018 from 9.2% in March 2018) although remained within the 12% threshold.

1.5 Responsive

Performance was above target / within tolerance for the following key areas:

- RTT 18 week standard – ahead of trajectory target.
- 52+ week clinical harm reviews - all patients waiting over 52 weeks continued to be

reviewed for clinical harm in line with the agreed validation process. The clinical harm review on the May 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

- 62-day cancer waiting time standard – performance was above target in April.
- Accident and Emergency 4 hour waits - ahead of trajectory target.
- Diagnostic test waiting times - continued to meet the national standard of 99% or more patients seen within 6 weeks.
- Data quality indicators - performance was in line with the trajectory for two of the three indicators represented.
- Formal complaints - remained within threshold.

Performance did not meet the agreed target / threshold for the areas and as a result exception reports are included:

18. RTT 52 wait position
19. A&E 12 hour trolley wait breaches

Exception reports are being developed for additional areas as follows:

- Outpatient Did not attend (DNA) - the rate is currently slightly above the 10% target.
- Outpatient appointments cancelled by the hospital – the rate is slightly above the 7.5% target. This metric is also being reviewed as currently it includes cancellations that do not result in delays for the patient.

  PALs concerns - in month 2 there were 314 PALs concerns and this was above the threshold of 250.
- Data quality: Appointments not checked-in on the system
- Outpatient appointments booking

<u>Other updates</u>

- Discharges Before Noon is not included as the performance threshold is being set.
- Cancelled operations is not included while the quarter 1 performance is being finalised as part of our national submission.

2. Indicator scorecard

See below

3. Additional slides by exception

Additional slides for 19 reports are presented.

SPC charts

As part of the updated quality and performance report format we are introducing statistical process control (SPC) charts. SPC is being widely used in the NHS to understand where the focus of work needs to be concentrated.

SPC charts are similar to a line graph but they also contain the average line (often the mean), and upper and lower reference lines. These are known as the upper control limit (UCL) and a lower control limit (LCL). The limits help us to understand whether further investigation might be needed in a process because of a specific circumstance, known as special cause variation.

In summary the benefits of using SPC are as follows:

- As a way of demonstrating and thinking about variation
  - is it natural or has there been an event which has caused the variation?
- To alert where performance may be deteriorating or if a situation is improving
- As a way to help plan improvements, trajectories and targets
- To show us if a process is reliable and in control or stable

Section 2: Indicator scorecard for month 2

Imperial College Healthcare NHS Trust

Month 2

Reported Month:

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Feb-18	Mar-18	Apr-18	May-18
Safe										
Patient safety - incident reporting	Serious incidents	number	-	May-18	Julian Redhead		9	7	**16**	**11**
	All Incidents (cumulative financial YTD)	number	-	May-18	Julian Redhead		15479	16982	**1372**	**2904**
	Incidents causing severe/major harm	number		May-18	Julian Redhead		0	1	**1**	**3**
	Incidents causing severe/major harm (cumulative financial YTD)*	number	<14	May-18	Julian Redhead		13	14	**1**	**4**
	Incidents causing severe/major harm (cumulative financial YTD)**	%	<0.28%	May-18	Julian Redhead		0.08%	0.08%	**0.07%**	**0.14%**
	Incidents causing extreme harm/death	number	-	May-18	Julian Redhead		1	3	**3**	**1**
	Incidents causing extreme harm/death (cumulative financial YTD)*	number	<13	May-18	Julian Redhead	E	10	13	**3**	**4**
	Incidents causing extreme harm/death (cumulative financial YTD)**	%	<0.11%	May-18	Julian Redhead		0.06%	0.08%	**0.22%**	**0.14%**
	Patient safety incident reporting rate (against top quartile of trusts)	incidents / 1,000 bed days	>=47.96	May-18	Julian Redhead	E	50.3	51.6	**47.3**	**52.6**
	Never events	number	0	May-18	Julian Redhead	E	0	0	**0**	**1**
	CAS alerts outstanding	number	0	May-18	Julian Redhead	E	0	0	**2**	**1**
	CAS alerts closed late in the preceding 12 months	number	0	May-18	Julian Redhead		-	-	**-**	**21**
	Compliance with duty of candour (SIs)	%	100%	Apr-18	Julian Redhead		75.0%	100%	**100%**	**90.0%**
	Compliance with duty of candour (SIs) (rolling 12 month)	%	100%	Apr-18	Julian Redhead		95.0%	98.0%	**99.0%**	**95.0%**
	Compliance with duty of candour (Level 1)	%	100%	Apr-18	Julian Redhead		86.0%	86.0%	**20.0%**	**67.0%**
	Compliance with duty of candour (Level 1) (rolling 12 month)	%	100%	Apr-18	Julian Redhead	E	69.0%	89.0%	**88.0%**	**88.0%**
	Compliance with duty of candour (Moderate)	%	100%	Apr-18	Julian Redhead		67.0%	56.0%	**60.0%**	**78.0%**
	Compliance with duty of candour (Moderate) (rolling 12 month)	%	100%	Apr-18	Julian Redhead		74.0%	79.0%	**85.0%**	**91.0%**

*Total Incidents for 17/18

** NRLS Apr17 -Sep17

Infection prevention and control	Trust-attributed MRSA BSI	number	0	May-18	Julian Redhead		0	1	**0**	**0**
	Trust-attributed MRSA BSI (cumulative financial YTD)	number	0	May-18	Julian Redhead		2	3	**0**	**0**
	Trust-attributed Clostridium difficile	number	6	May-18	Julian Redhead		2	6	**8**	**6**
	Trust-attributed Clostridium difficile (cumulative financial YTD)	number	13	May-18	Julian Redhead	E	53	59	**8**	**14**
	Trust-attributed Clostridium difficile (related to lapses in care)	number	0	May-18	Julian Redhead		0	1	**2**	**2**
	Trust-attributed Clostridium difficile (related to lapses in care) (cumlative)	number	0	May-18	Julian Redhead		4	7	**2**	**4**
VTE	VTE risk assessment	%	>=95%	May-18	Julian Redhead		96.0%	94.6%	**95.8%**	**95.8%**
Safe staffing	Safe staffing - registered nurses	%	>=90%	May-18	Janice Sigsworth	E	96.5%	95.9%	**96.8%**	**97.4%**
	Safe staffing - care staff	%	>=85%	May-18	Janice Sigsworth		94.6%	95.1%	**94.2%**	**98.2%**
Workforce and people	Core skills training	%	>=85%	May-18	David Wells		86.4%	87.4%	**87.4%**	**87.6%**
	Core clinical skills training	%	>=85%	May-18	David Wells		85.1%	85.9%	**85.9%**	**86.3%**
	Vacancy rate - Trust	%	<10%	May-18	David Wells	E	12.3%	12.7%	**12.6%**	**13.1%**
	Vacancy rate - nursing and midwifery	%	<13%	May-18	David Wells		13.7%	14.2%	**14.2%**	**14.9%**
Health and safety	Departmental safety coordinators	%	>=75%	May-18	David Wells	E	46.4%	56.0%	**57.0%**	**57.0%**
	RIDDOR	number	0	May-18	David Wells		3	6	**1**	**4**
	Fire warden training	%	>=10%	May-18	Janice Sigsworth	E	8.0%	9.0%	**9.0%**	**8.7%**
	Medical devices maintenance - high risk	%	>=98%	May-18	Janice Sigsworth		92.0%	76.0%	**77.0%**	**89.0%**
	Medical devices maintenance - medium risk	%	>=75%	May-18	Janice Sigsworth	E	63.0%	70.0%	**74.0%**	**80.0%**
	Medical devices maintenance - low risk	%	>=50%	May-18	Janice Sigsworth		76.0%	64.0%	**72.0%**	**80.0%**

Key: E = exception report available for month 2

Section 2: Indicator scorecard for month 2

Imperial College Healthcare NHS Trust

Month 2

Reported Month:

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Feb-18	Mar-18	Apr-18	May-18
						Key: E = exception report available for month 2				
Effective										
Mortality indicators	Trust ranking as per monthly data (HSMR)	rank	top 5 lowest risk acute Trusts	Feb-18	Julian Redhead		2nd	2nd	4th	4th
	HSMR	ratio		Feb-18	Julian Redhead		66.7	69.0	**63.0**	**62.0**
	Trust ranking as per monthly data (SHMI)	rank		Q2 2017/18	Julian Redhead		3rd	3rd	3rd	3rd
	SHMI	ratio		Q2 2017/18	Julian Redhead		80.5	66.1	**70.1**	**70.1**
	Palliative care coding	%	100%	May-18	Julian Redhead		100%	100%	100%	100%
Mortality reviews (*at 11/06/2018*)	Total number of deaths	number	n/a	May-18	Julian Redhead	E	176	178	**155**	**136**
	Number of local reviews completed	number	n/a	May-18	Julian Redhead		159	160	**129**	**92**
	Local reviews completed	%	100%	May-18	Julian Redhead		90.3%	89.9%	**83.2%**	**67.6%**
	SJR reviews requested	number	n/a	May-18	Julian Redhead		29	25	**20**	**19**
	Number of SJR reviews completed	number	n/a	May-18	Julian Redhead		21	20	**10**	**5**
	SJR reviews completed	%	100%	May-18	Julian Redhead		72.4%	80.0%	**50.0%**	**26.3%**
	Avoidable deaths	number	0	May-18	Julian Redhead		3	3	**2**	**1**
	Avoidable deaths (cumulative financial YTD)	number	0	May-18	Julian Redhead		2	1	**2**	**3**
Readmissions	Unplanned readmission rates - under 15 yr olds	%	<9.33%	Oct-17	Tg Teoh		4.6%	4.9%	5.0%	5.7%
	Unplanned readmission rates - over 15 yr olds	%	<8.09%	Oct-17	Frances Bowen		6.6%	6.6%	6.8%	6.4%
Patient reported outcomes	PROMs - participation rates (Hips)	%	>=80%	Mar-18	Julian Redhead	E	66.0%	100%	100%	
	PROMs - reported health gain (Hips)***	EQ5D	>national avg	Bi-annual	Julian Redhead		-	-	-	-
	PROMs - participation rates (Knees)	%	>=80%	Mar-18	Julian Redhead		100%	100%	**100%**	
	PROMs - reported health gain (Knees)***	EQ5D	>national avg	Bi-annual	Julian Redhead		-	-	-	-
	****In the most recent bi-annual report by NHS Digital, health gain could not be calculated due to low sample size*									
National Clinical Audits	Participation in relevant national clinical audits (cumulative financial YTD)	%	100%	Feb-18	Julian Redhead	E	97.7%	95.0%	95.0%	93.0%
	High risk/significant risk audits with action plan in place (cumulative financial	%	100%	Feb-18	Julian Redhead		n/a	n/a	n/a	100%
	Review process not completed within 90 days	number	0	Feb-18	Julian Redhead		9	11	**16**	**26**

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Q2 2017/18	Q3 2017/18
Clinical trials	Clinical trials - recruitment of 1st patient within 70 days	%	>=90%	Q4 2017/18	Julian Redhead		53.3%	64.3%

Section 2: Indicator scorecard for month 2

Imperial College Healthcare NHS Trust

Month 2

Reported Month:

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Feb-18	Mar-18	Apr-18	May-18
						Key: E = exception report available for month 2				
Caring										
Friends and family	FFT A&E service - % recommended	%	>=94%	May-18	Janice Sigsworth		92.5%	90.9%	**91.9%**	**91.5%**
	FFT inpatients - % recommended	%	>=94%	May-18	Janice Sigsworth		97.5%	97.8%	**97.2%**	**96.9%**
	FFT outpatients - % recommended	%	>=94%	May-18	Janice Sigsworth		92.9%	92.3%	**92.3%**	**92.9%**
	FFT maternity - % recommended	%	>=94%	May-18	Janice Sigsworth		94.4%	94.1%	**95.8%**	**94.5%**
	FFT A&E service - % response	%	>=20%	May-18	Janice Sigsworth	E	16.8%	12.9%	**14.7%**	**11.7%**
Mixed sex accommodation	Mixed-sex accommodation (EMSA) breaches	number	0	May-18	Catherine Urch		42	44	**39**	**42**

Section 2: Indicator scorecard for month 2

Imperial College Healthcare NHS Trust

Month 2

Reported Month:

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Feb-18	Mar-18	Apr-18	May-18
						Key: E = exception report available for month 2				
Well led										
Workforce and people	Staff retention (Stabilty)	%	>=80%	May-18	David Wells		-	-	**86.0%**	**86.1%**
	Voluntary staff turnover rate (12-month rolling)	%	<12%	May-18	David Wells		9.2%	9.1%	**10.5%**	**11.9%**
	Sickness absence rate (12-month rolling)	%	<=3%	May-18	David Wells		3.3%	3.1%	**2.3%**	**3.0%**
	Personal development reviews	%	>=95%	May-18	David Wells		-	-	**5.7%**	**18.1%**
	Doctor appraisal rate	%	>=95%	May-18	Julian Redhead	E	88.3%	84.5%	**85.6%**	**86.0%**
	Consultant job planning completion rate	%	>=95%	May-18	Julian Redhead	E	-	-	**82.0%**	**94.1%**
NHSI segmentation	NHSI - provider segmentation	number	-	May-18	Richard Alexander		3	3	**3**	**3**

Section 2: Indicator scorecard for month 2

Imperial College Healthcare NHS Trust

Month 2

Reported Month:

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Feb-18	Mar-18	Apr-18	May-18
						Key: E = exception report available for month 2				
Responsive										
Referral to treatment – elective care	RTT incomplete pathways 18 weeks performance	%	>=92%	May-18	Catherine Urch		82.8%	83.3%	**84.2%**	**85.2%**
	RTT variance against 2018/19 trajectory target	%	tbc	May-18	Catherine Urch		*-7.9%*	-8.8%	**0.47%**	**1.2%**
	RTT incomplete pathways over 18 weeks	number	n/a	May-18	Catherine Urch		10,793	10,776	**10,403**	**9,890**
	RTT patients waiting 52+ weeks	number	0	May-18	Catherine Urch	E	256	267	**194**	**147**
	RTT patients waiting 52+ weeks reviewed for clinical harm	%	100%	Apr-18	Catherine Urch		100%	100%	**100%**	**100%**
	RTT cases of clinical harm found after the clinical harm review	number	0	Apr-18	Catherine Urch		0	0	**0**	**0**
Cancer waiting times	Cancer - 62 day urgent GP referral to treatment	%	>=85%	Apr-18	Catherine Urch		85.1%	88.5%	**85.0%**	**86.7%**
Cancelled operations	Cancelled operations	%	<national avg	Mar-18	Catherine Urch			1.2%	**1.4%**	**1.3%**
	28 day rebooking breach rate	%	<national avg	Mar-18	Catherine Urch			15.1%	**16.9%**	**17.1%**
Urgent and Emergency Care	A&E patients seen within 4 hours (all types)	%	>=95%	May-18	Frances Bowen		82.4%	83.2%	**84.6%**	**86.9%**
	A&E variance against 2018/19 trajectory target	%	85.4%	May-18	Frances Bowen		*-8.7%*	-11.9%	**-0.5%**	**1.4%**
	A&E patients seen within 4 hours (type 1)	%	>=95%	May-18	Frances Bowen		59.1%	61.9%	**64.4%**	**68.6%**
	A&E patients spending >12 hours from Decision to Admit	number	0	May-18	Frances Bowen	E	4	8	**6**	**7**
Bed management	Patients with length of stay over 7 days	%	tbc	May-18	Frances Bowen		38.6%	36.3%	**37.8%**	**34.8%**
	Patients with length of stay over 21 days	%	50% from base	May-18	Frances Bowen		11.6%	9.9%	**12.4%**	**9.4%**
	Discharges before noon	%	>=33%	May-18	Frances Bowen		14.2%	13.3%	**13.8%**	**13.5%**
Diagnostics	Diagnostic waits – over 6 weeks	%	<1%	May-18	Tg Teoh		0.8%	0.9%	**0.6%**	**0.7%**
Outpatient management	Waiting times for first outpatient appointment	weeks	<8	May-18	Tg Teoh		8.5	7.9	**7.3**	**7.2**
	Outpatient DNA	%	<10%	May-18	Tg Teoh		10.9%	11.7%	**10.9%**	**10.4%**
	Outpatient HICS rate with less than 6 weeks' notice	%	<7.5%	May-18	Tg Teoh		8.7%	9.1%	**7.8%**	**7.7%**
	Outpatient appointments within 5 working days of receipt	%	>=95%	May-18	Tg Teoh		87.8%	87.3%	**85.8%**	**89.4%**
Complaints management	PALS concerns	number	<250	May-18	Janice Sigsworth		-	-	**291**	**314**
	Complaints - formal complaints	number	<90	May-18	Janice Sigsworth		90	88	**75**	**75**
Data quality indicators	Orders waiting on the Add/Set Encounter list (over 2 days)	number	1,472	May-18	Catherine Urch		1,508	1,763	**1,485**	**1,043**
	OP apps not checked-in or DNAd (app within last 90 days)	number	1,886	May-18	Tg Teoh		1,904	2,253	**1,886**	**2,160**
	OP apps checked In AND not checked out (app within the last 90 days)	number	1,359	May-18	Tg Teoh		1,458	1,516	**1,348**	**1,277**
Patient Transport	All Journeys: Collection Time (60 Mins)	%	>97%	May-18	Janice Sigsworth		92.2%	92.1%	**92.5%**	**92.7%**
	All Journeys: Collection Time (150 Mins)	%	100%	May-18	Janice Sigsworth		99.2%	99.0%	**99.4%**	**99.5%**
	Journeys 0-5 Miles: Time On Vehicle (60 Mins)	%	>95%	May-18	Janice Sigsworth		92.2%	92.4%	**93.0%**	**92.5%**
	Journeys 5-10 Miles: Time On Vehicle (60 Mins)	%	>85%	May-18	Janice Sigsworth		78.4%	75.9%	**75.9%**	**75.7%**

Section 2: Indicator scorecard for month 2

Imperial College Healthcare NHS Trust

Month 2

Reported Month:

Heading	Indicator (short description)	Unit	Target	Latest Period	Exec Lead	M2 report	Feb-18	Mar-18	Apr-18	May-18

Key: E = exception report available for month 2

Finance

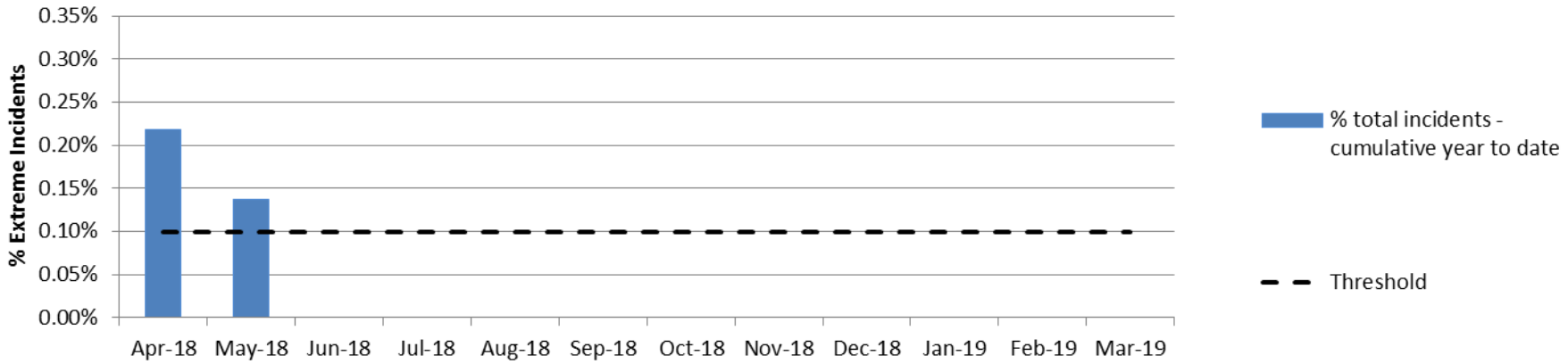
Finance KPIs	Monthly finance score (1-4)	number	-	May-18	Richard Alexander		3	3	**n/a**	**3**
	In month Position	£m	-	May-18	Richard Alexander		-2.3	1.2	**-2.87**	**1.35**
	YTD Position £m	£m	-	May-18	Richard Alexander		-7.5	-6.3	**-2.87**	**1.35**
	Annual forecast variance to plan	£m	-	May-18	Richard Alexander		-7.4	-6.3	**0.00**	**0.00**
	Agency staffing	%	-	May-18	Richard Alexander		4.4%	4.4%	**4.1%**	**4.1%**
	CIP (cumulative financial YTD)	%	-	May-18	Richard Alexander		73.9%	79.3%	**-**	**75.7%**

Section 3 Exception report slides summary for months 1-2

Domain	Report
Safe	1. Incidents causing extreme harm/death
Safe	2. Patient safety incident reporting rate
Safe	3. Never events
Safe	4. CAS alerts outstanding
Safe	5. Compliance with duty of candour
Safe	6. Infection prevention and control
Safe	7. Safe staffing
Safe	8. Vacancy rate
Safe	9. Departmental safety coordinators
Safe	10. Fire warden training
Safe	11. Medical devices maintenance
Effective	12. Mortality reviews
Effective	13. PROMs
Effective	14. National Clinical Audits
Caring	15. FFT A&E service - % response
Well led	16. Doctor appraisal rate
Well led	17. Consultant job planning completion rate
Responsive	18. Referral to Treatment - 52 week waits
Responsive	19. A&E 12-hour wait breaches

Safe – Incidents causing extreme harm/death (report 1)

Indicator	Target	Latest data	Executive lead	Report author(s)
To reduce the number of incidents causing extreme harm/death	Fewer incidents than last year (13) and below national average (0.11%)	3 (0.22%) - April 2018 1 (0.14%) - May 2018	Julian Redhead, Medical Director	Tam Moorcroft, Programme Manager, Safety & Effectiveness



Latest performance

We reported 3 extreme harm/death incidents in April 2018, and 1 in May 2018. Two of the incidents are subject to serious incident investigations where the root causes and any contributory factors will be identified. Three of the incidents will also be subject to structured judgement review.

2 incidents were declared in MIC, one related to failure to rescue when a deteriorating patient was not appropriately escalated by the nurse. The second was an unexpected cardiac arrest when a patient was escorted to and collapsed in a locked bathroom facility in AAU.

1 incident was a neonatal death declared in WCCS following a vaginal breech delivery.

1 incident was declared in SCC. This was a death following a known surgery complication which had been discussed with the patient in advance of the procedure with the relevant consent form signed. This case is likely to be downgraded following initial review. An update will be included in the next performance report.

Safe – Incidents causing extreme harm/death

Key issues	There have been 4 extreme harm incidents reported so far this year. This is above average when compared to data published by the National Reporting and Learning System (NRLS) for the April – September 2017 period. In 2017/18 the Trust had only reported two extreme harm/death incidents by M2.

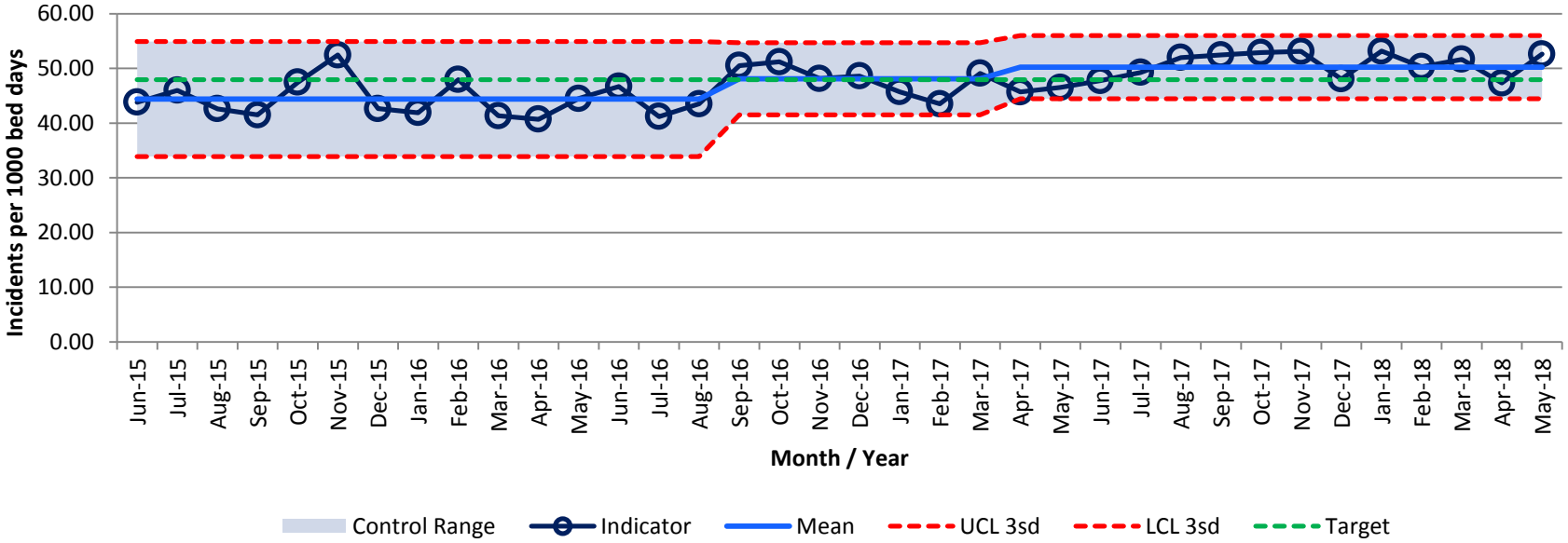
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify root causes and any contributory factors/organisational factors	Head of Quality Compliance & Assurance	End July 2018	The three cases that are subject to serious incident and level 1 investigation are having SJRs completed. Additional information will be included in the quarterly learning from deaths report.
Divisional governance teams to immediately review grade of incident as soon as it is declared to ensure accuracy of category of harm	Divisional Governance Leads	19 July 2018	
Divisional governance teams to immediately review incidents when declared and identify the root cause, level and type of investigation required	Divisional Governance Leads	19 July 2018	

Risk

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

Safe – Patient safety incident reporting rate (report 2)

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 (47.96)	47.31 - April 2018 52.64 - May 2018	Julian Redhead, Medical Director	Tam Moorcroft, Programme Manager, Safety & Effectiveness



Latest performance

Our incident reporting rate in April was 47.31. This did not put the Trust in the top quartile according to data published by the National Reporting and Learning System (NRLS) for the April – September 2017 period.

The incident reporting rate in May was 52.64 which put us above the 47.96 threshold to be in the top quartile.

Safe – Patient safety incident reporting rate

Key issues	The Trust's incident reporting rate is routinely within the top quartile of trusts however this was not the case in April 2018 when there was a drop in reporting. The last time the Trust was not in the top quartile was in December 2017.

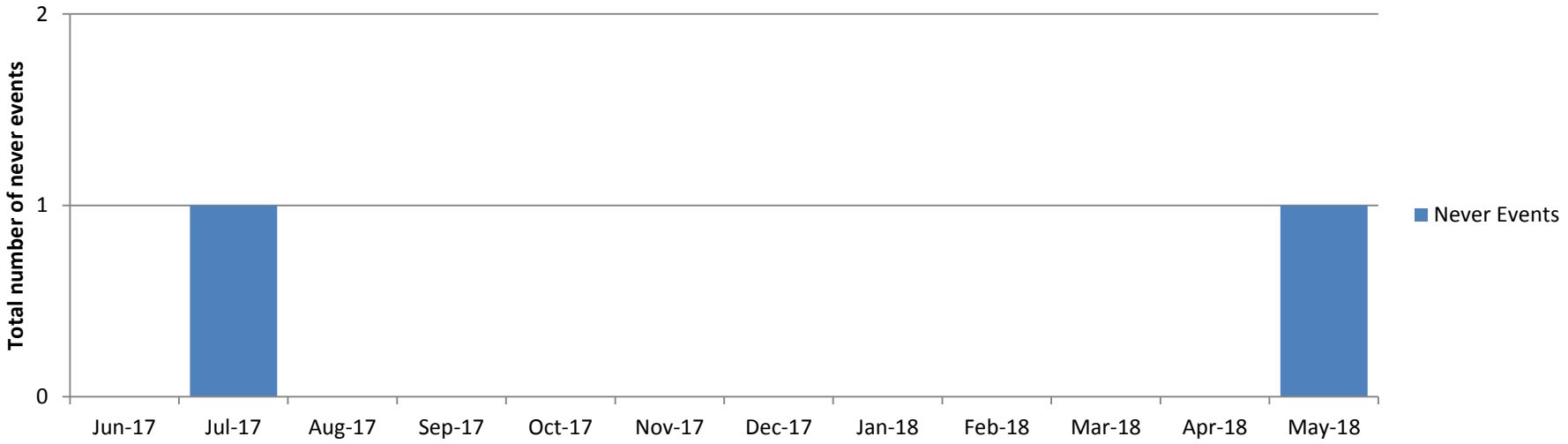
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
'Safety shorts' to be developed as an outcome of the 'trigger list' pilot	Improvement Programme Manager, Safety	Ongoing	The use of 'trigger lists' have been piloted in 8 wards since October 2017. It highlighted the value 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 to raise the profile of their role, with support from the improvement team.
Introduction of anonymous incident reporting in response to feedback from staff	Head of Quality Compliance and Assurance	Implemented	The ability to report incidents anonymously was introduced in the Trust on 1st March 2018. Since 1st March 2018 53 anonymous incidents have been reported. Increased Trust wide communications have been developed including a new screensaver, and information relating to the Freedom to Speak Up Guardian process is being refreshed so that the anonymous reporting option is aligned.
Pilot of Care Report	Improvement Programme Manager, Safety	TBC	This is moving forward in collaboration with PSTRC. The design work is almost complete and a plan to pilot in A&E being further developed with the CD and senior team.

Risk

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

Safe – never events (report 3)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	May – 1 (YTD – 1)	Julian Redhead, Medical Director	Tam Moorcroft, Programme Manager, Safety & Effectiveness



Latest performance

One never event was declared in May 2018. This was a wrong route medication incident where a student nurse, unsupervised by the RN, administered an enteral drug through an intravenous route to the wrong patient. There was no harm to the patient.

Following the 'never event' reported in July 2017, the Trust continues to work on a transition plan to safely introduce a standardised product that will prevent epidural lines from being connected to the inappropriate access device e.g. a peripheral cannula. An implementation plan is being led by the division of SCCS but NRFit connectors are still not available from our suppliers. 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.

Safe – never events

Key issues	The department did not stock the appropriate syringes to prevent this never event from occurring despite this being trust and national policy. Immediate action was taken to ensure stock was made available in the department affected. A trust wide audit of appropriate syringe availability was undertaken in the first week of June of all clinical areas that administer medication. 110 areas confirmed that they are compliant and have enteral syringes, and 5 areas were non-compliant and are being supported to become compliant by DDNs. A further 69 areas have not submitted a return at the time of this report. These results have been circulated to the DDNs. A more detailed audit is in the process of being agreed by the divisions. The event is currently under investigation and the full outcome will be reported in the next integrated quality and performance report.

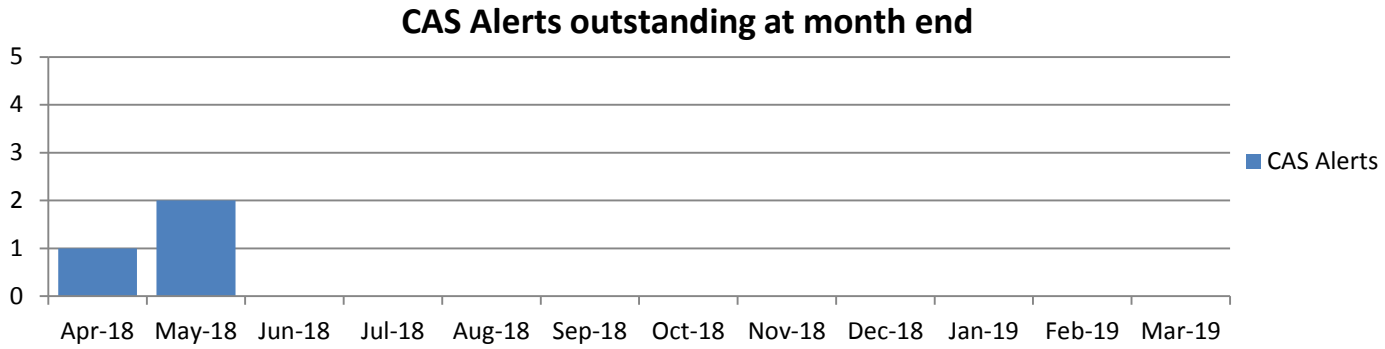
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Never event safety alert issued	Medical Director's Office	Complete	An 'administration of liquid medicines via the oral and enteral route' never event alert was issued on 31st May 2018.
Full oral and enteral medication audit to take place which addressed all elements of the patient safety alert for this never event category.	Divisions	July 2018	The audit tool has been agreed and is scheduled to be completed by the start of July 2018.
Medicines administration policy to be reviewed	Pharmacy	August 2018	The review will take place once we have the results of the oral and enteral medication audit.

Risk

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

Safe – CAS alerts outstanding (report 4)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure all patient safety alerts and medical devices alerts issued through the national central alerting system are reviewed and acted on in the specified timeframes	0 outstanding	April 2018 – 2 MDAs closed late, 0 PSA May 2018 – 1 MDA closed late, 0 PSA 21 CAS alerts have been closed late in the preceding 12 months.	Julian Redhead, Medical Director (PSAs) Janice Sigsworth, Director of Nursing (MDAs)	Tam Moorcroft, Programme Manager, Safety & Effectiveness Farzad Saghafi, Medical Device Safety & Quality Officer



CAS alerts closed late in the preceding 12 months: 21

Latest performance

All three MDAs in M1 and M2 have since been closed with actions implemented.

Medical Device Alert	Actions Complete Deadline	Closed date
MDA/2017/036R: Syringe pumps – required user actions in the event of PL3 alarm to prevent risk of interrupted infusion	23/04/2018	24/04/2018
MDA/2018/009: Bag valve mask manual resuscitation system – risk of damage to lungs by deliver of excessive pressure	17/04/2018	01/05/2018
MDA/2018/011: Bone cement: Optipac 40 Refobacin Revision and Optipac 80 Refobacin Revision – Risk of revision	14/05/2018	25/05/2018

The 21 CAS alerts closed late in the preceding 12 months were all MDAs. There were no PSAs closed late by the Trust.

Safe – CAS alerts outstanding

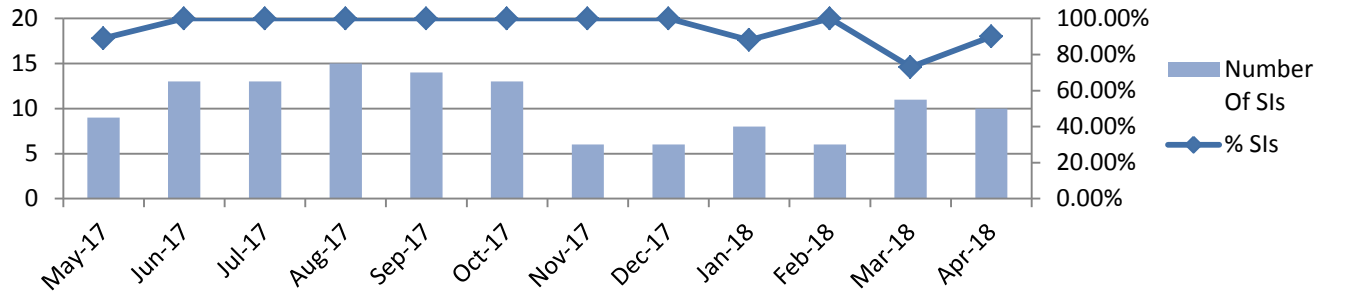
Key issues	At present MDAs are regularly closed after the nationally stipulated due date. Issues were identified with the internal cascade process which has now been addressed. The cascade of alerts will now be done through individualised and targeted emails instead of being automated through Datix. An initial response from the procurement team is expected within 5 days before relevant MDAs are then sent to the relevant Divisional Governance Lead. The Metal-on-metal hip replacements MDA was previously closed. Just under 300 patients were affected, all of which have now been contacted either by the Trust or by one of the concerned consultants who is now working at RNOH. Of the 175 patients followed up by the Trust, 10 were identified as requiring an outpatient follow up appointment. These appointments have been scheduled in June 2018.

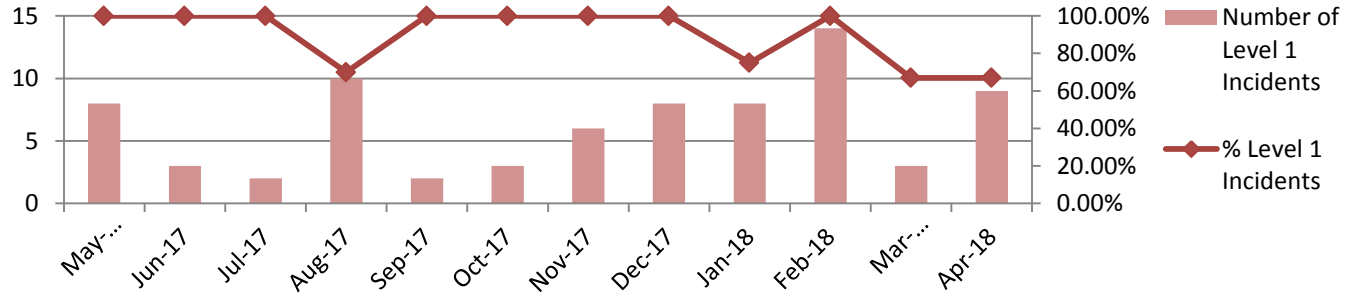
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
A quarterly CAS update report will go to Quality & Safety Subgroup. This will include information on both PSAs and MDAs. The purpose is to track progress with action plans for alerts that have been closed until all actions from the alert have been completed and implemented	Head of Quality Compliance and Assurance Head of Clinical Technical Services	Quarterly	This will include the recent oxygen therapy, NG tubes and the recently closed NEWS 2 alerts from NHSI (due for final implementation in April 2019)

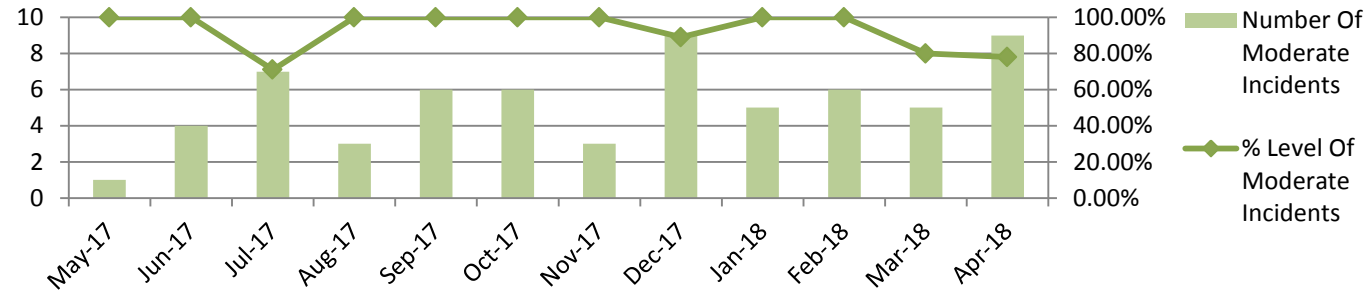
Risk
• Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2490 Failure to deliver safe & effective care)

Safe – Compliance with duty of candour (report 5)

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: 95% Internal investigations: 88% Moderate and above incidents: 78% (cumulative data for incidents reported May 2017 - April 2018)	Julian Redhead, Medical Director	Tam Moorcroft, Programme Manager, Safety & Effectiveness







Latest performance

In month performance as follows:

Serious Incidents
100% compliance for March 2018 and 90% compliance for April 2018

Level 1s
20% compliance for March 2018 and 67% compliance for April 2018

All other moderate and above incidents
60% compliance for March 2018 and 88% compliance for April 20

Safe – Compliance with duty of candour

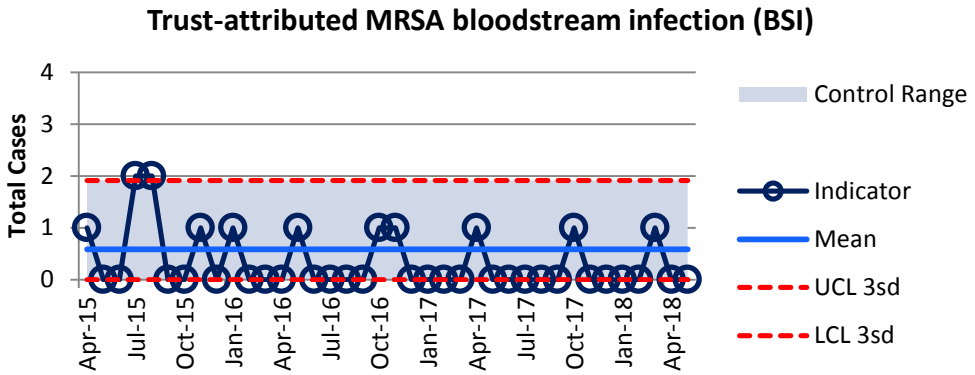
Key issues	Although performance is improving challenges remain in meeting the 100% target, in particular for moderate harm and above where a serious incident is not declared. Clinician engagement with the patient facing conversation is good however is variable in sending letters which can cause delay.

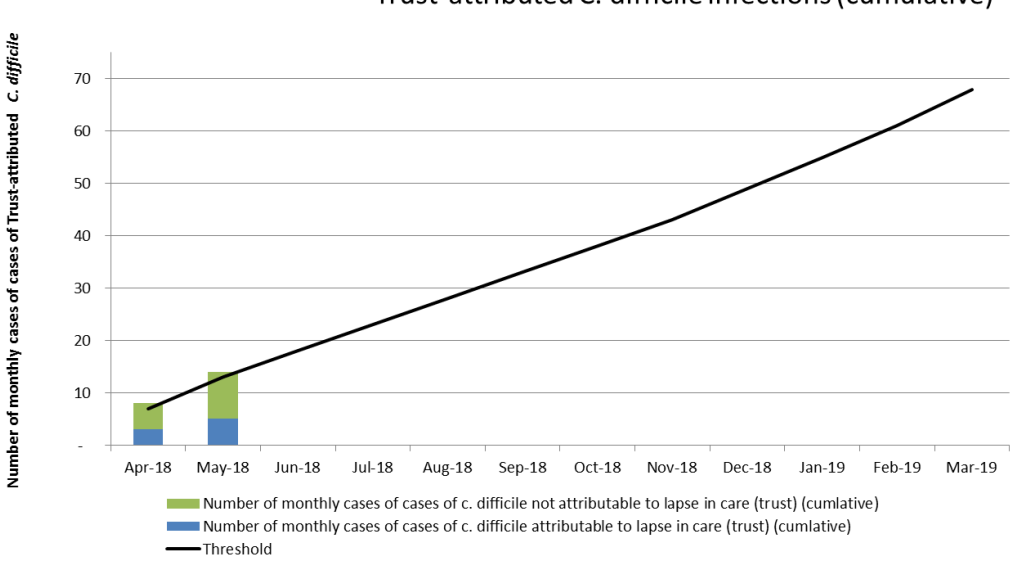
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Directors Incident Meeting	Head of Quality Compliance & Assurance	Ongoing	Progress has been made across over the past year but maintaining the consistency remains challenging.
Duty of candour annual audit	Head of Quality Compliance & Assurance	July 2018	This is a Trust priority audit. Data collection has been completed and data is being analysed. The report will be presented at the Quality & Safety Subgroup.
Review of duty of candour policy	Head of Quality Compliance & Assurance	Autumn 2018	A number of changes will be proposed following the audit as well as ensuring that it is fully aligned to changes in national guidance
95% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisions	TBC	Divisions continue to be below the 95% target. Whilst small improvements have been made, as of 14th June 2018 consultant compliance is 63% (MIC), 62% (SCC) and 72% (WCCS).

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

Safe – Infection prevention and control (report 6)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure we have no avoidable MRSA BSIs and cases of C.*difficile* attributed to lapses in care	0	April 2018: MRSA BSI: 0 C.*difficile* lapse in care: 2 May 2018: MRSA BSI: 0 C.*difficile* potential lapse in care: 2	Julian Redhead, Medical Director	Jon Otter, Interim Head of Operations IPC





Latest performance

No cases of Trust MRSA BSI have been reported for April and May 2018, thus none for this FY 2018/19.

April 2018 saw eight cases of Trust-attributable C.difficile, two of which have been identified as lapses in care due to transmission on a single ward as part of a cluster.

May 2018 has seen six cases of Trust-attributable C.difficile, two of which have been identified as potential lapses in care due to transmission. We await ribotyping data to provide confirmation of a lapse in care in both cases.

Ribotyping is delayed due to staffing changes to manage the LIMS transition.

Safe – Infection prevention and control

Key issues	*C.difficile*: In May 2018, a patient on a medical ward crossed pathways with another patient with *C.difficile* on the same ward. We await ribotyping results to confirm whether *C. difficile* transmission occurred, and therefore a lapse in care. This has prompted a ward-level investigation of potential transmission routes. This investigation did not identify any specific issues, although minor non-compliance with ICHT antibiotic policy was identified and communicated to the clinical team. A patient on a separate medical ward crossed pathways with another patient with *C.difficile* on the same ward. We await ribotyping to confirm whether *C.difficile* transmission occurred, and therefore a lapse in care. Ward level investigations were conducted, and did not identify any specific issues. However, the ward has had some issues with failing to isolate cases of *C. difficile* within 2 hours (as per Trust policy), which is being worked on. Ribotyping delays mean that it is slower than usual to potential lapses in care, meaning that the final number of lapses may be lower than reported. This issue has been added to the IPC risk register.

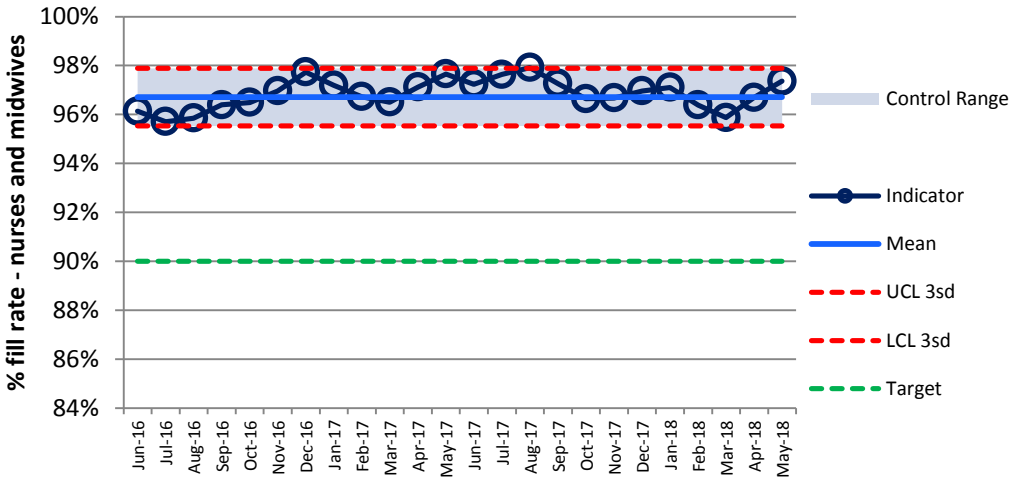
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Implement audit of 5 moments of hand hygiene	Jan Hitchcock, Interim General Manager IPC	July 2018	The revised approach to hand hygiene auditing has delivered accurate hand hygiene compliance data. An improvement plan and communications plan is being finalised to support these changes.
Monitor the impact of shortages of key antimicrobial agents on the rate of C. difficile infection	Mark Gilchrist, Consultant Pharmacist for Infection	July 2018	No impact of antibiotic shortages has been identified for C. difficile infection. This issue will continue to be monitored closely.
Potential increase in lapses in care related to *C. difficile*	Eimear Brannigan, Interim Deputy DIPC	July 2018	Review the lapses in care and potential lapses in care that have occurred in 2018/19 to see whether any themes emerge.

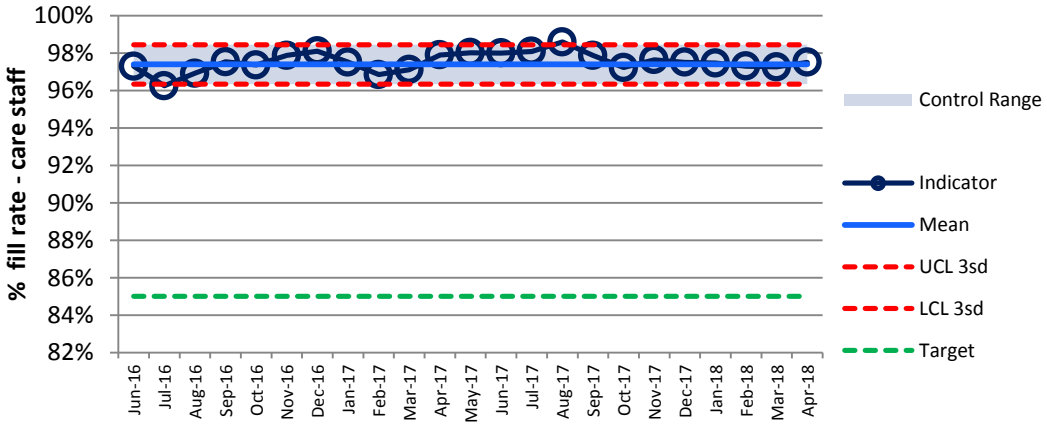
Risk

- Is it on the (divisional / corporate) risk register? YES (Directorate risk ID 2066 Poor practice related to vascular access, and Directorate risk ID 2059 Lack of laboratory support)

Safe – Safe staffing (report 7)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and at 85% for care staff	90 per cent for registered nurses and midwives 85 per cent for care staff	Registered nurses and midwives = 97.4%; Care staff = 98.2%	Janice Sigsworth (Director of Nursing)	Sinead O'Neill (Senior Nurse Workforce, Revalidation & Regulation)





Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses / midwives	Care staff	Registered nurses / midwives	Care staff
CXH	96.4%	94.9%	98.4%	97.9%
HH	97.4%	91.6%	98.8%	98.0%
QC	98.3%	95.2%	99.1%	98.9%
SMH	96.5%	94.2%	97.7%	98.8%
Trust wide	**96.8%**	**94.1%**	**98.3%**	**98.3%**

Latest performance

In May 2018 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The fill rate was below 85 per cent for care staff and 90 per cent for registered staff for wards detailed below. Performance remained with control limits as shown in the SPC charts.

The fill rate was below 85 per cent for care staff and 90 per cent for registered staff in eight wards and the detail of these exceptions is provided below.

Safe – Safe staffing

Exceptions - unfilled shifts

Division of Medicine and Integrated Care:

Kerr ward

The unfilled shifts related to care staff due to requirement of 121 enhanced care and patient transfers. The ward manager worked within the numbers rather than supervisory in order to allow redistribution of remaining staff to provide adequate support. No patient safety issues identified.

Peters ward

The unfilled shifts related to care staff due to escalation (these beds are now closed), requirement for 121 enhanced care, vacancy and patient transfers. The matron worked within the numbers to support the area to allow for re-allocation of staff. No patient safety issues identified.

Acute medical Unit St Marys

The unfilled shifts related to care staff due to requirement for 121 enhanced care and increased nursing requirement. Staff were re-allocated from 1st floor to cover this shortfall. No patient safety issues identified.

Jospeh Toynbee

The unfilled shifts related to care staff due to requirement for 121 enhanced care and vacancies. Staff are moved across the 1st floor to cover. There were no associated risks identified.

Witherow

The unfilled shifts related to care staff due to the requirement to support the Grafton ward escalation. This area is now closed. No patient safety issues identified.

Thistle

The unfilled shifts related to care staff due to requirement for 121 enhanced care. Following recent establishment review the skill mix has been increased to support this requirement. No patient safety issues identified.

Division of Surgery Cancer and Cardiovascular Sciences

Trauma & Orthopaedics

There was 1 unfilled shift equating to 11.5 hours. No patient safety issues identified

C8 cardiology

The unfilled shifts we due to unfilled shifts for registered nurse due to unavailability of bank or agency staff. The care staff unfilled shifts was related to a vacancy requirement for 121 enhanced care. The risk was mitigated by moving staff within the Directorate and the ward manager working within the numbers

There were no shortfalls in the Imperial Private Health or the Division of Womens and Children.

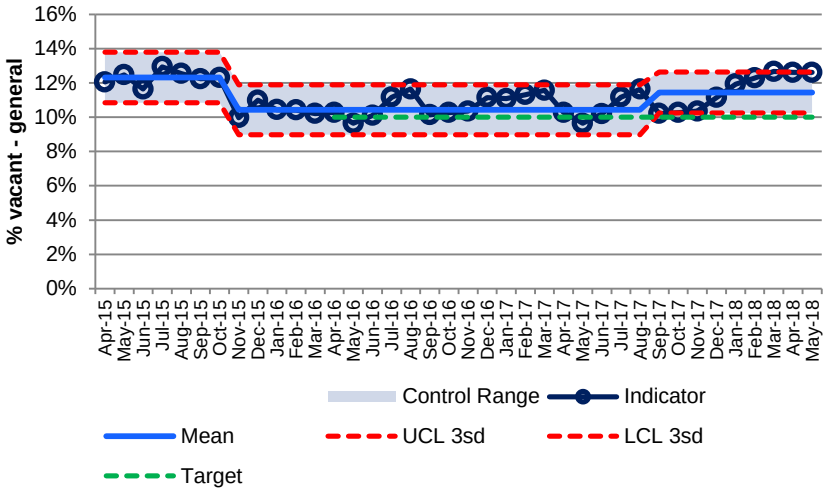
Safe – Safe staffing

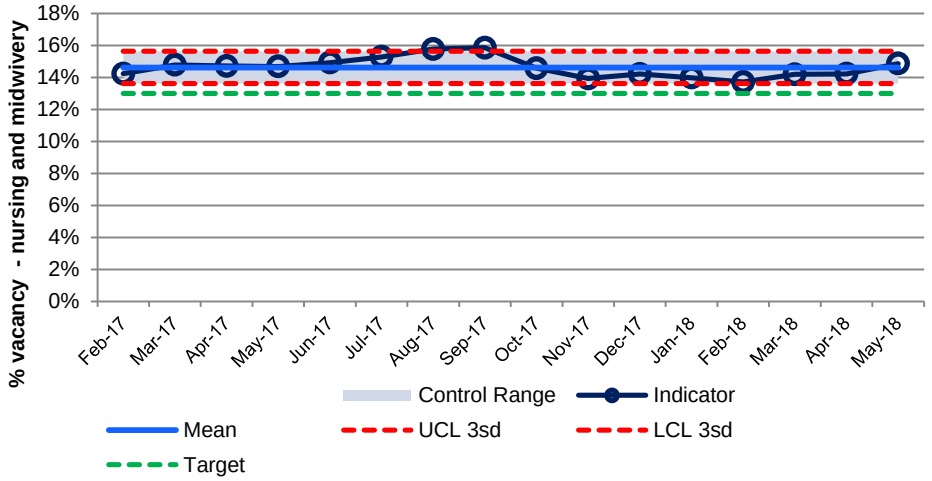
Key issues and actions	In order to maintain standards of care the Trust's Divisional Directors of Nursing, site directors and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways: - Reviewing staffing at the 5 x daily site calls - Using the workforce flexibly across floors and clinical areas as described and in some circumstances between the three hospital sites. - Cohorting patients and adjusting case mixes to ensure efficiencies of scale. - In addition, the Divisional Directors of Nursing regularly review staffing when, or if there is a shift in local quality metrics, including patient feedback. Nursing and midwifery workforce planning continues to be a major focus in the Trust. Work continues with our P&OD teams and NHSi to explore workforce retention strategies such as apprenticeships, rotation programmes and nursing associate development. All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in May 2018 were safe and appropriate for the clinical case mix.

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 – Vacancy rates (report 8)

Indicator	Target	Latest data	Executive lead	Report author(s)
The percentage of medical devices with a risk rating of low / medium / high in the asset register that has received planned maintenance	10% target for overall Trust vacancies and 13% for overall N&M vacancies	May position was; All Trust 13.07% All N&M 14.86%	David Wells (Director of People and Organisational Development)	Pen Parker Dawn Sullivan





Latest performance

- the vacancy rate was 13.1% reflective of 1,414 WTE vacancies
- the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,405 WTE; an increase of 14 WTE from those employed in April
- for all nursing & midwifery roles, the vacancy rate was 14.9% (770 WTE vacancies)
- overall, during May, the post establishments were re-based resulting in an additional 73 WTE was added to the Trusts establishment in support of service requirements and safe staffing levels
- of these new posts, the majority were within the nursing & midwifery staffing group with the remainder within the Consultant body

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 14.8%
- 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, visa caps, 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
- 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 the 2017/2018 delivered better student retention, more recruits and more internal appointments
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
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan/ Sue Burgess	1 year	• A plan will be submitted in August, NHSI are visiting on 24th July to discuss the plan & potentially we could get additional support and resource to deliver the plan
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust recruited 1000 N&M staff in 2017/2018 & maintained vacancy rates with a 5% increase in headcount

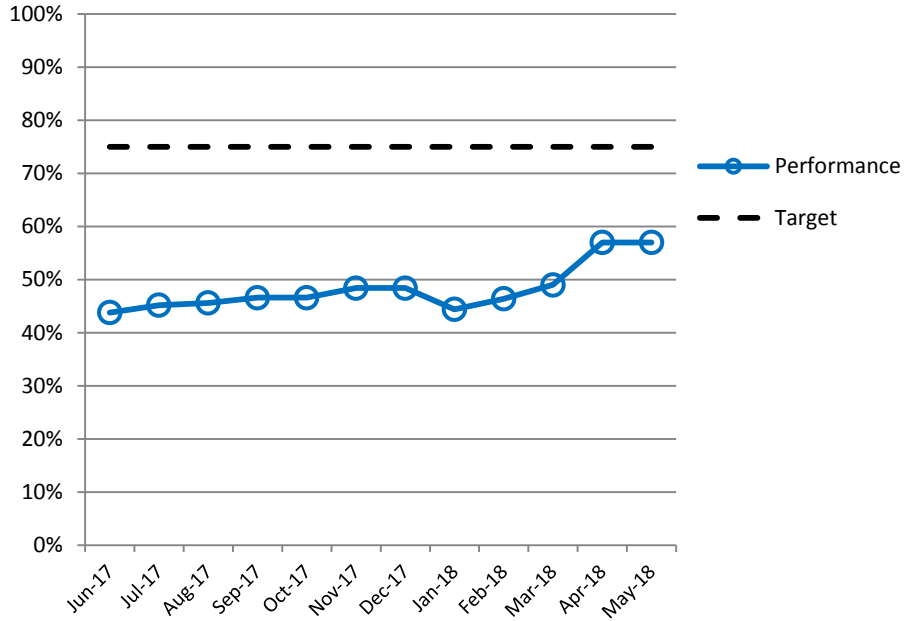
Risk

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 – Departmental safety coordinators (report 9)

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	May 2018 performance was 57%	David Wells (Director of People and Organisational Development)	Bryan Joseph (Associate Director Occupational Health and Safety)

Clin/Corp Division	% (May 2018)
Division of Medicine & Integrated Care	47%
Division of Surgery, Cancer & Cardiovascular	54%
Division of Women's, Children's & Clinical Support	71%
Finance	85%
P&OD	75%
ICT	76%
Imperial Private Healthcare	88%
Office of the Medical Director	44%
Office of the Chief Executive	50%
Office of the Chief Nurse	32%
Press & Communications	50%
Trust Total	**57%**
NWL Pathology	94%



Latest performance

At 31 May 2018 of the 416 staffed departments /locations, 238 had a trained departmental safety coordinator equating to 57% compliance. The department performance is shown above.

Safe – Departmental safety coordinators

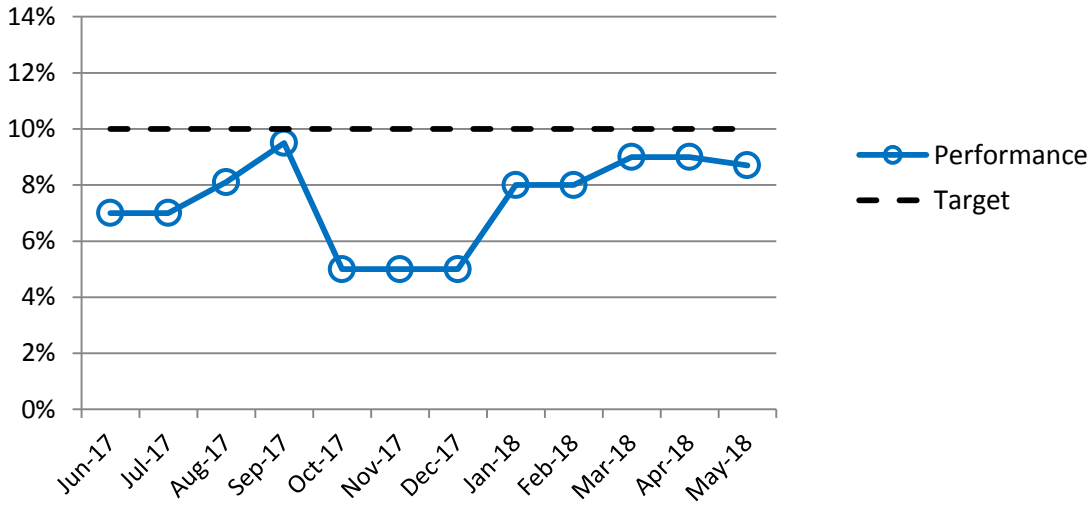
Key issues	Clinical divisions and corporate directorates / offices have been asked to take effective action to ensure the 75% target is achieved. All except two areas are aiming to reach 75% by end September; the two remaining areas are updating their data and finalising plans.

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 on the 05/06/2018 to agree milestones to meet the Trust target. • Women's, Children's and Clinical Support Division expect to be above 75% by the end of July 2018. • The Office of the Medical Director expect to be 100% compliant by the end of September 2018.

Risk
• Is it on the (divisional / corporate) risk register? YES/NO (reference to risk register where an entry has been made)

Safe – Fire warden training (report 10)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure at least 10% of our staff are trained as fire wardens	10% or greater	May 2018 performance was 8.7%	Janice Sigsworth (Director of Nursing)	Stuart Low (Fire Safety Officer)



Latest performance

At 31 May 2018 there were a total of 1010 staff trained as Fire Wardens – a current shortfall of 155 to achieve the 10% target agreed by the Executive. It is anticipated that this target will be achieved by October 2018.

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.

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. 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 with a significant increase in numbers. Feedback has been positive. The plan is to increase the numbers of fire wardens being trained each month from 35 to 50. Managers will still need to nominate staff in their respective departments to attend training.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Fire Warden Training as part of the Fire safety training programme (one hour training packages)	Fire safety team	Ongoing	• In May 2018, 5 Fire warden courses were delivered. 25 members of staff were trained as fire wardens to add to the running total.

Risk
• Is it on the (divisional / corporate) risk register? YES/NO (reference to risk register where an entry has been made)

Safe – Medical devices maintenance (report 11)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve medical devices maintenance compliance according to risk categorisation	98% for High risk, 75% for Medium Risk and 50% for Low risk	May compliance was as follows: High risk = 89% Medium risk = 80% Low risk = 80%	Janice Sigsworth (Director of Nursing)	Max McClements (Head of Clinical Technical Services)

Risk category	Target	March 2018	April 2018	May 2018
High risk	98%	76%	77%	89%
Medium risk	75%	70%	74%	80%
Low risk	50%	64%	72%	80%

Latest performance

- There has been a continued improvement in maintenance compliance figures for medical devices.
- In May 2018 the performance was as follows:
  - Overall maintenance compliance for Low risk was 80% which met the 80% target
  - Overall maintenance compliance for Medium risk was 80% which met the 75% target
  - Overall maintenance compliance for High risk was 89% against the 98% target.

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 in Year 3 there are over 24,000 assets registered that demonstrates the inventory is 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.

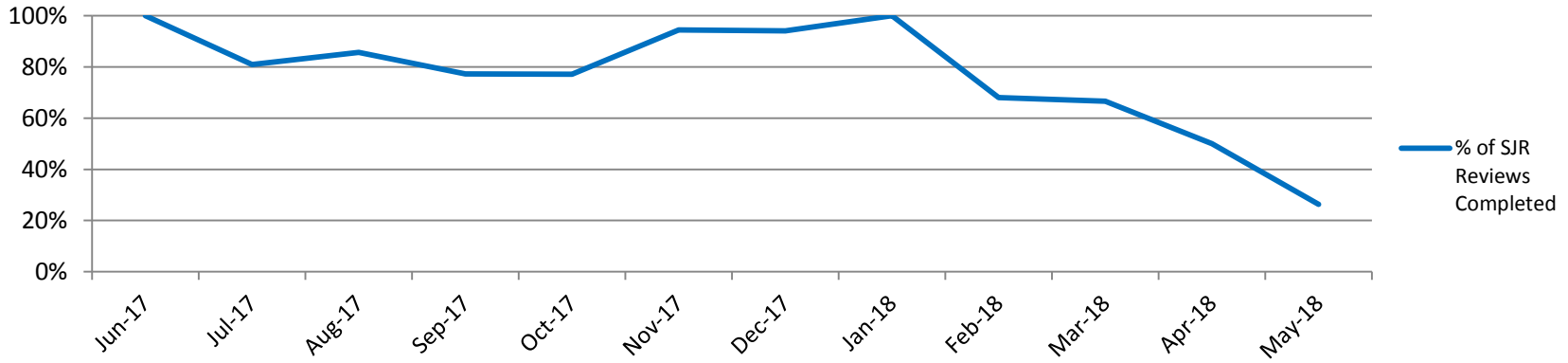
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of medical device categorisation	Aheed Syed (Operations Manager)	October 2018	• Risk based approach implemented and labels attached as part of RFID project. As maintenance is completed further updates will be made.
Radio-frequency identification (RFID) Implementation	Aheed Syed (Operations Manager)	July 2018	• Strategy developed and labels affixed • Interaction between IT systems being developed
Training process for staff	Drushtee Ramah (Medical Device Principal)	August 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 (Jul-18); CXH (Oct-18); HH (Apr-19)	• SMH Library refurbished and eMandate submitted for CHX • Recruitment process actioned

Risk

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

Effective – Mortality reviews (report 12)

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: 26% (May 2018)	Dr William Oldfield, Interim Medical Director	Trish Bourke, Mortality Audit Manager



Latest performance

Trust compliance for local level 1 mortality review is 76%, against a target of 100%. In order to instigate the SJR process at the earliest opportunity the timeframe for local mortality review has been shortened to 7 days (from 30 days). This came into effect from September 2017. A weekly performance report is now reviewed at the MD incident panel.

Data is refreshed on a monthly basis as SJRs are requested and completed. This refreshed data accounts for the higher completion rate on the graph for previous months. We will review how this data is presented before the next report.

15 completed reports have been received to date for this financial year (18/19), with 3 avoidable deaths reported. These will be reviewed at the next MRG for Trust sign off.

Effective – Mortality reviews

Key issues	Timely completion of local reviews and structured judgement reviews.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Data fields incorporated within the online module to facilitate thematic reporting future	Mortality Auditor	June 2018	A field has been added to Datix to select investigation themes. The options are the Trusts 9 safety streams or 'other'. Complete
Recruitment of additional structured judgement reviewers	Mortality Auditor	September 2018	33 members of staff have undergone structured judgment review (SJR) training. This number is sufficient, however, further recruitment has commenced to ensure we have at least one reviewer in each specialty to facilitate local feedback of findings.
Consolidation of outstanding structured judgement reviews since the process was implemented including timescales for completion and a review of actions	Mortality Auditor	End July 2018	

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

Effective – Patient reported outcome measures PROMs (report 13)

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

March Position			
Hip Replacement		Knee Replacement	
Participation Rate	Reported Health Gain	Participation Rate	Reported Health Gain
100%	*Not available (health gain unable to be calculated due to low sample size)*	100%	*Not available (health gain unable to be calculated due to low sample size)*

Latest performance

According to NHS Digital the Trust monthly participation rate was 100% in March 2018 for both hip and knee replacement. However, the 6 monthly NHS Digital data (Apr – Sept 17) showed us to be below target at 67% and 70% respectively. There has been a delay in the NHS Digital data for April and May 2018 which is still awaited.

Health gain was unable to be calculated for hip replacement and knee replacement due to low sample size.

Effective – Patient reported outcome measures PROMs

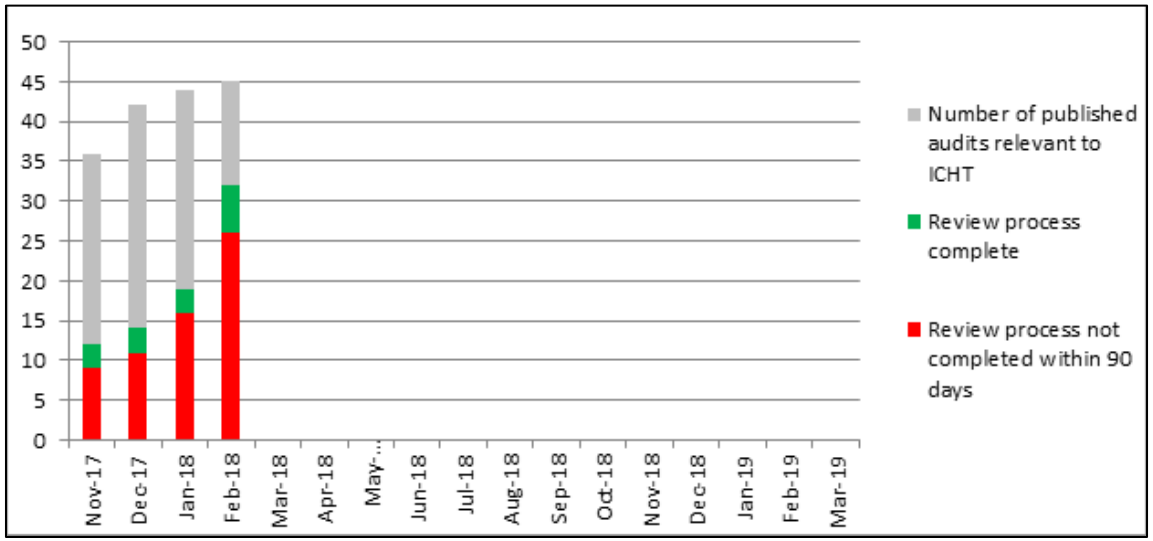
Key issues	In order to calculate PROMs, patients who have hip and/or knee replacement procedures are asked to complete a survey both before and after surgery. The Trust is responsible for ensuring completion of the first questionnaire pre-surgery. Completed forms are then sent to NHS Digital and compared to the number of surgical procedures performed at the Trust which provides the Trust participation rate. A new process has been introduced to try and drive improved participation rates as outlined below. An external agency, Capita, is responsible for sending patients the second questionnaire post-surgery. Analysis between the first and second questionnaires are then used to calculate overall health gain. If insufficient Part B questionnaires are returned to Capita and in turn to NHS digital who publish the results, they will not publish an organisations health gain score. The Trusts health gain data is currently unable to be measured due to insufficient return of forms. The Trust has recognised that there are issues with data collection from Capita and are pursuing alternative providers for PROMs data.

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	New supplier meeting end of June 2018
New process to contact all patients listed for elective hip/knee replacement surgery to complete the questionnaires	Lucia Gallager – Ward Matron	June 2018	Underway
Allocate dedicated Band 7 nurse to collate and drive service improvement for Trust PROMs initiative, to ensure submission rates are above 80% and calling each patient to remind them to complete post op questionnaire	Donna Rodden – Arthroplasty Nurse	July 2018	Underway

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

Effective – National clinical audit (report 14)

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 0 audits that have not completed the review process within 90 days	93% (Feb-18) 26 (Feb-18)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor



Latest performance

This slide represents performance against Quality Account reportable national audit activity. Data is reported on a monthly basis, but the data is presented 3 months in arrears to allow time to go through the full Trust ratification process. Although the number that had completed the review process increased in February, the number overdue also increased that month. Significant improvements have since been made to the number that have completed the review process and will be reflected in next months integrated quality and performance report dashboard.

46 national audits were published up until February 2018. 45 of these were relevant to ICHT. ICHT participated in 93% of the relevant national clinical audits. 3 audits were not participated in by ICHT, these were: Fracture Liaison service, Falls and Fractures Audit programme and National Ophthalmology audit.

Currently WCCS are up to date with all their national clinical audit reviews.

Effective – National clinical audit

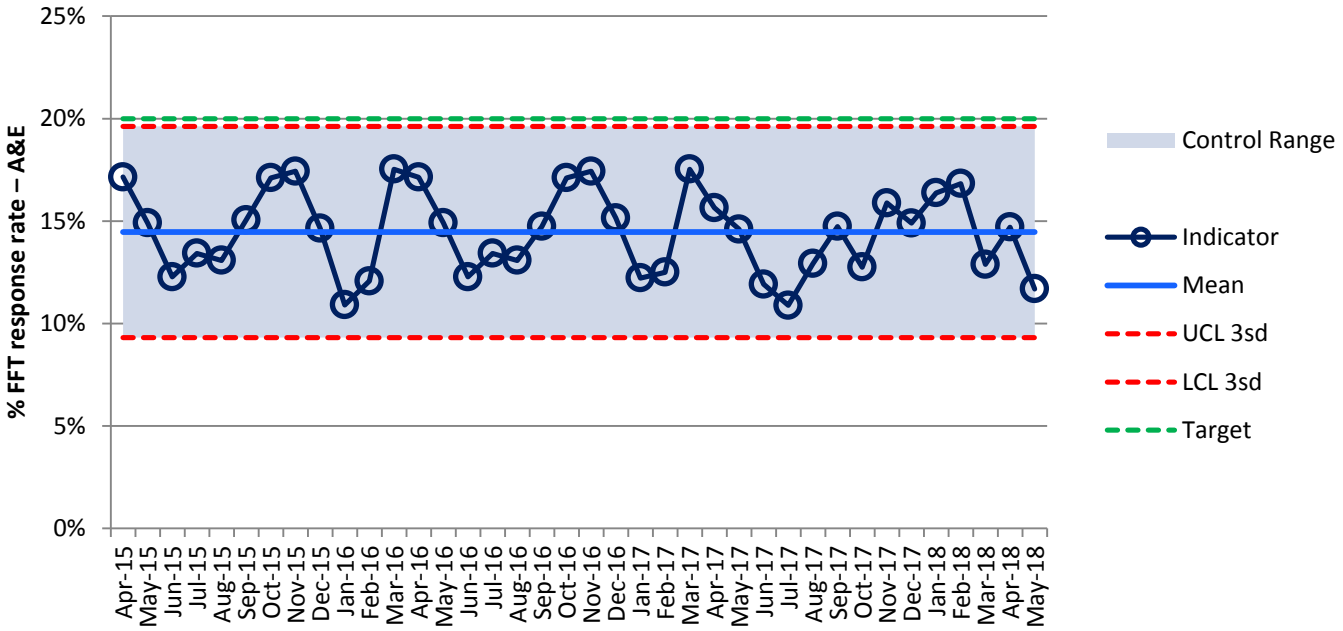
Key issues	26 national clinical audits that are currently with the divisions are now overdue as they have exceeded the internally set 90 day review process.

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	Ongoing	Two audits from 2017/18 were identified as 'significant risk/little assurance' 1. NCA- National diabetes audit, care processes and treatment targets MIC 2. Adult critical care case mix programme (ICNARC) SCCS These will be presented to the quality & safety subgroup in July 2018.
Low risk and acceptable risk audits to be presented at divisional quality and safety committees	Audit Leads	Ongoing	
Overdue audits escalated at the weekly Friday MD panel for review	Louisa Pierce, Clinical Auditor	Weekly - Ongoing	Divisions provide regular updates based on discussions at divisional quality & safety meetings

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)

Caring – Friends and Family response rate (A&E) (report 15)

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	May 2018 performance was 12%	Janice Sigsworth (Director of Nursing)	Stephanie Harrison-White (Head of Patient Experience & Improvement)



Latest performance

In May 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)

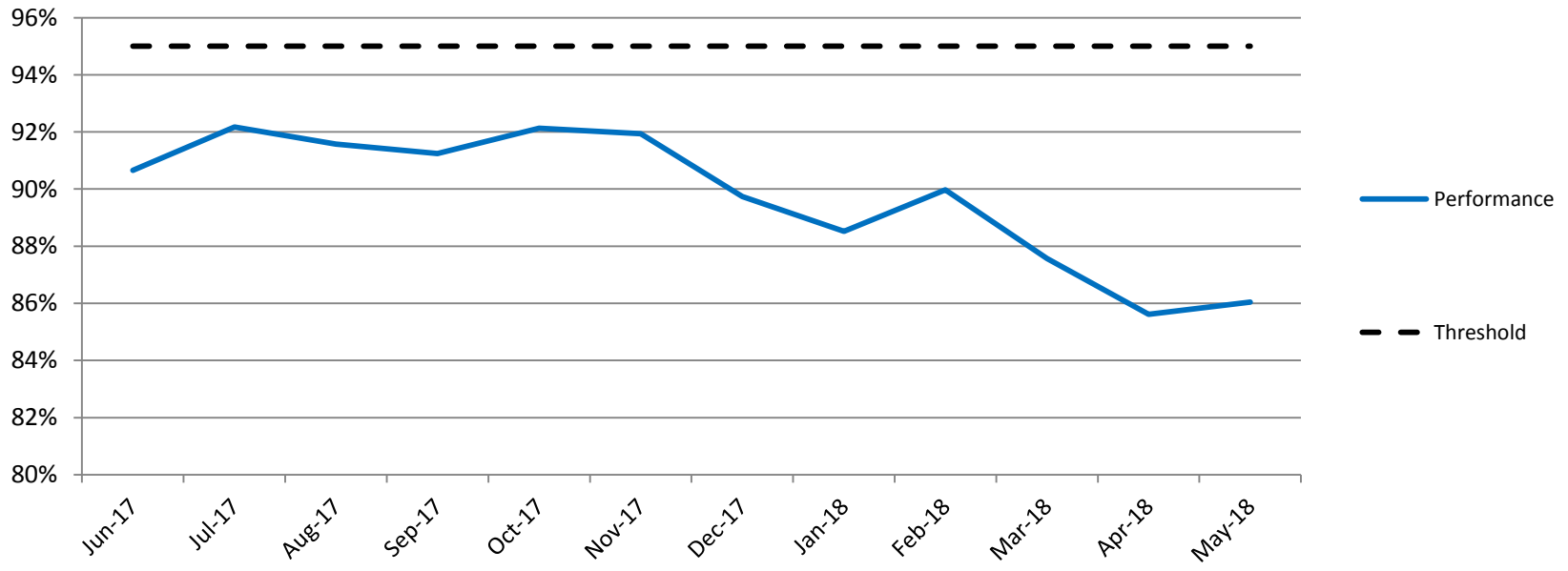
Key issues	Since April we have noted a reduction in FFT rates in CXH A&E. This has coincided with the introduction of additional patient experience questions to the FFT survey thereby increasing the overall length of the survey. The questions have been added to enable the departments to closely monitor areas that had been identified as requiring improvement in the national A&E survey. Prior to the changes to the survey, CXH A&E department was meeting the target of 20% response rate.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review the survey length	Stephanie Harrison-White (head of patient experience)	June 2018	• Meeting held with head of patient experience, deputy director of patient experience and A&E general manager. • Survey questions reviewed and agreed to remove 2 questions. • Survey amended and new survey to be introduced 1 July 2018.

Risk
• Is it on the (divisional / corporate) risk register? YES/NO (reference to risk register where an entry has been made)

Well led – Doctor appraisal rate (report 16)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	85.62% - April 18 86.04 % - May18	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance	Slight increase in performance from 85.62% to 86.04% in May 2018. Consultant grade compliance increased from 87.72% in April 2018 to 88.34% in May 2018. The total number of appraisals overdue by more than six months has increased from 32 in M1 to 38 in M2 The target date for achieving the 95% compliance rate is September 2018 (M6).

Well led – Doctor appraisal rate

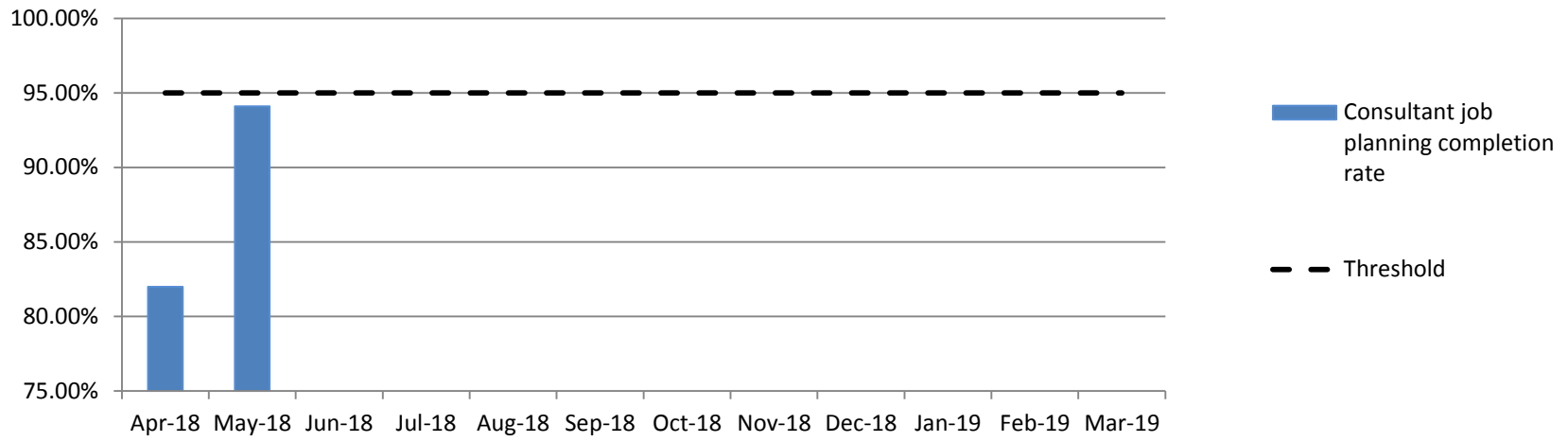
Key issues	Overdue appraisals (greater than 12 weeks) have not been consistently monitored by the PD team, and therefore not escalated to the RO in a timely way. As a result of this, the Trust policy for overdue appraisal has not been followed leading to an increase in the number of significantly overdue appraisals without a non-engagement referral to GMC. This was initially reported to be 66 doctors in April. The interim Medical Director wrote to each overdue doctor and their appraiser to notify them that they would be at risk of a non-engagement referral. By implementing the escalation policy, overdue doctors have received two further letters. This process has now been taken over by Geoff Smith as AMD for Professional Development. There are currently 22 doctors who remain at risk of escalation to the GMC but an improvement from last month. PREP data has not always been inputted accurately by the PD team, resulting in late appraisals not being identified easily from automatic reports. A further 17 doctors have been identified after manually updating appraisal due dates in the system. Geoff Smith has written a revised escalation SOP which has been implemented.

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	June 2018	Monthly report generated and escalated to Deputy RO for action. Escalation process implemented until appraisal is completed
Quality of PREP data- PD team to perform data cleanse	Victoria Ward	3 months	To start in July 2018

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

Well led – Consultant job planning completion rate (report 17)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a consultant job planning completion rate of 95% or more	>=95%	82% - April 18 94.1% - May18	Julian Redhead, Medical Director	Victoria Ward, Professional Development Team Manager



Latest performance	Job planning compliance has improved since April 2018, and in May was just under the 95% target at 94.1%.

Well led – Consultant job planning completion rate

Key issues	The job planning round for 2018/19 will close on 13th July and individuals will not be able to make any changes to this years job plan after this time unless there are exceptional circumstances (change in personal circumstances, changes within the service etc.). Any non-compliant consultants will be formally escalated to the AMD and their DD for further management. At the end of the round, the PD team will complete the QA of existing plans and target training to make improvements ahead of the 19/20 round starting in the autumn. Job planning round for 2019/20 will commence in October 2018.

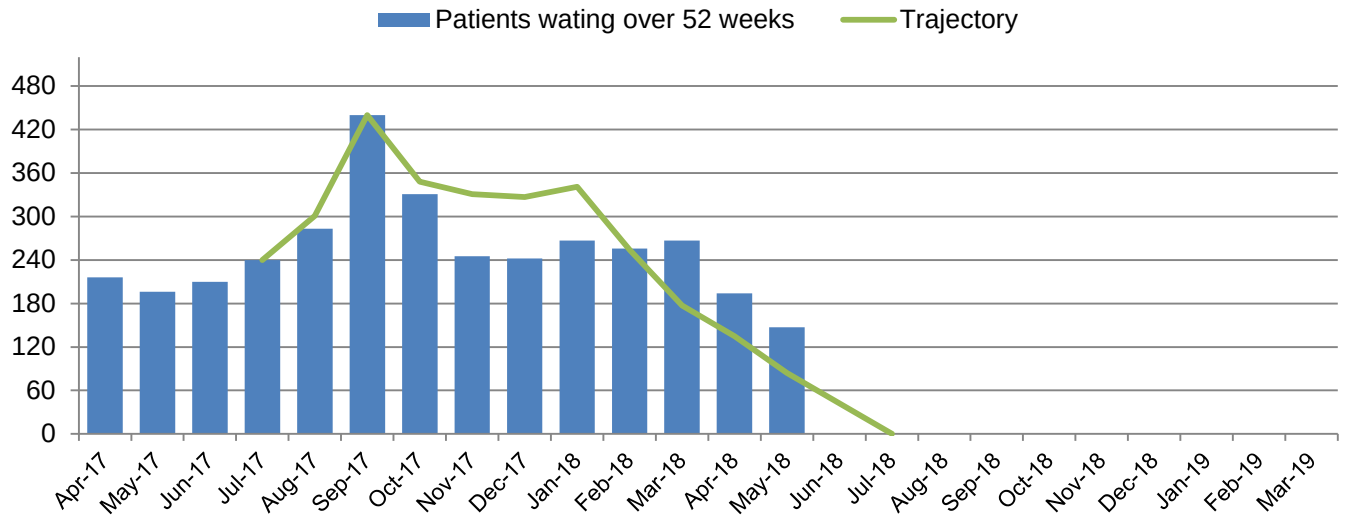
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
AMD Professional Development to write to all consultants to inform them that the round will close and that additional drop in sessions will be arranged during the preceding weeks.	Geoff Smith, AMD Professional Development	June 2018	Complete – 14th June 2018
Non-compliant doctors to be escalated to AMD following end of job planning round	Andrew Worthington, GM	July 2018	To commence following completion of job round
Job plan quality assurance to be undertaken following completion of current round	Victoria Ward, Prof Dev Team Manager	July 2018	To commence following completion of job round
Communication to Clinical Line Managers regarding sign-off requirements and additional training ahead of new job plan round	Geoff Smith, AMD Professional Decelopment	September 2018	To be completed by September 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	To commence following completion of job round

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 – RTT patients waiting 52+ weeks (report 18)

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 July 2018 84 at end May 2018	At end May 2018 147 patients were waiting 52+ weeks	Dr Catherine (Katie) Urch	Jan Palmer - Elective Care Delivery Manager Dominic Hart – Performance Support Business Partner



Latest performance

In May 2018 the Trust treated 138 patients who had waited over 52 weeks. At the end of May the Trust reported 147 patients waiting over 52 weeks for treatment, a reduction of 47 compared the previous month but 63 above trajectory.

- Of the 147 patients, 73 had tipped-over (a tip over is defined as a patient previously known on the PTL that tipped over to 52 weeks in the week leading up to the census date) in the month and there were 11 over 52 week pop-ons (a pop on is defined as a 52 week pathway not on the previous week's PTL extract) in May.

116 of the 147 patients have now been treated and 18 have a future TCI.

Responsive – RTT patients waiting 52+ weeks

Key issues

- The Trust continued to improve on its position in May but remains challenged to recover from the impact of winter pressures.
- The unforeseen delay to April reporting encroached onto the time for validating the May position
- Risks continue with some individual consultant capacity to treat patients before 31st July 2018
- 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 to the July exit trajectory
- 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
- Continued intensive support is in place to assist booking teams and challenged specialties
- 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 continued to be reviewed for clinical harm in line with the agreed validation process. The clinical harm review on the May 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

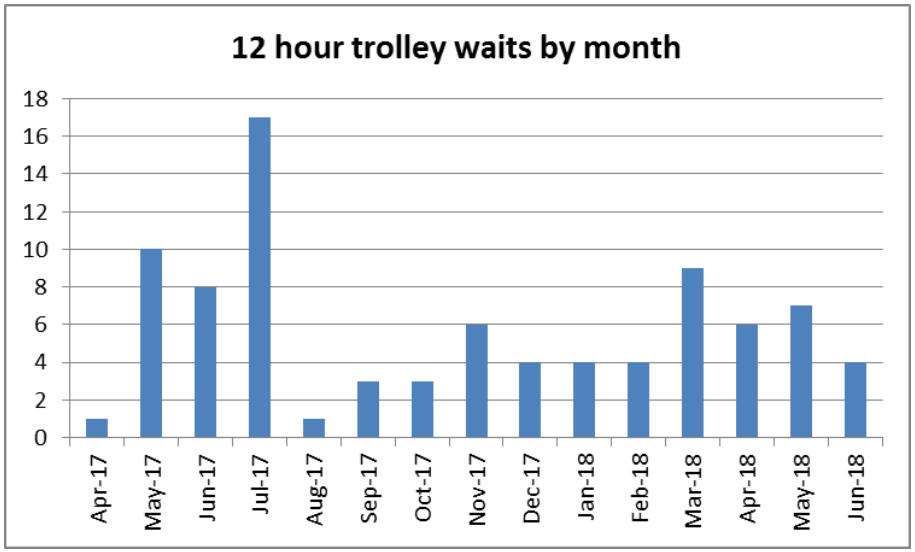
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
SCC Division hold a weekly touch-point meeting with WCCS and MIC Divisions	Martina Dinneen	Weekly to 31 July 2018	• Improved oversight and monitoring of forecast and provisional position to ensure that both NHSI, CCG and Trust are informed and appraised
SRO meetings in place for three challenged services	Catherine Urch/Martina Dinneen	Weekly to 31 July 2018	• All three specialties are forecasting an improved position by end of July 2018

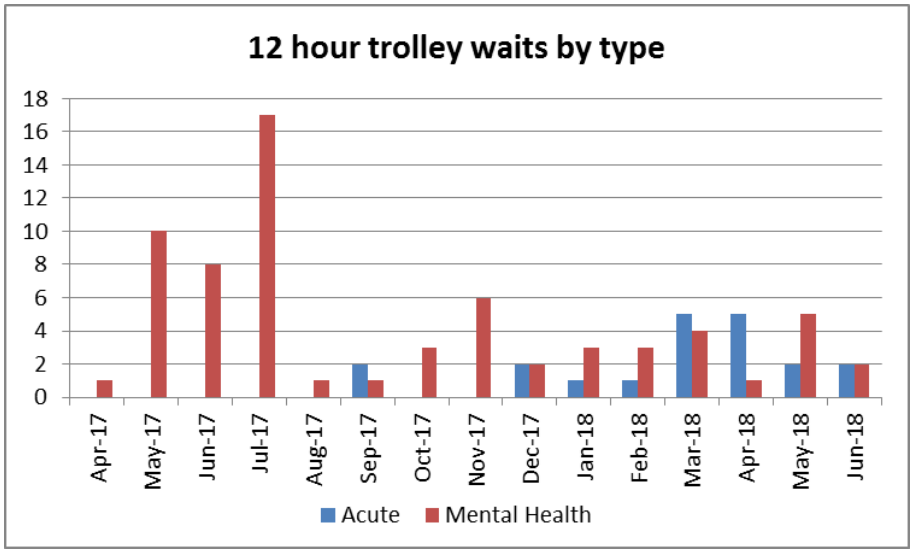
Risk

- Is it on the (divisional / corporate) risk register? YES - Datix Risk Report Number 2691 – Score 20

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	7 breaches - May 2018 4 breaches - June 2018	Dr Frances Bowen	Sarah Buckland Performance Support Business Partner





Latest performance

- The number of 12 hour breaches fell from seven in May 2018 to four in June 2018.
- The number of mental health related breaches has improved significantly since August 2017, however there has been an average of three per month since January 2018.
- The number of acute breaches rose in March and April 2108 and has decreased in May and June 2018.
- 9% of breaches in 2017/18 occurred at CXH with the remaining 91% at SMH. In 2018/19 100% of breaches have occurred at SMH.

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 12 hour trolley wait trust wide escalation procedures	Sarah Buckland	July 18	Gathering information from relevant teams involved in whole process
Develop 12 hour trolley wait SOP	Sarah Buckland	August 18	Gathering information to support SOP
Creation of 2 crisis calming rooms in CXH ED (136 compliant) as part of the ED redevelopment	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	Due to begin August 18
Agreement of breach reduction trajectory for the 4 hour standard for mental health	Sarah Grace	Q2 2018/19	10% reduction by September 2018 has been agreed following a joint audit conducted with CNWL, West London MH and NWL CCG
Presentation of RCA reports for all breaches to the A&E Delivery Board	Claire Braithwaite	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) [score 20, target 12] and Risk 2477 (patient experience and care due to delay for mental health patients in the ED) [score 15, target 9].

Appendices

Appendix 1 Exception report slides tracker

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

	Indicator heading	Progress update
Safe	Serious incidents	Within tolerance / target
	Incidents causing severe/major harm	Within tolerance / target
	Incidents causing extreme harm/death	**Exception report slides provided**
	Patient safety incident reporting rate	**Exception report slides provided**
	Never events	**Exception report slides provided**
	CAS alerts outstanding	**Exception report slides provided**
	Compliance with duty of candour (SIs)	**Exception report slides provided**
	Infection prevention and control	**Exception report slides provided**
	Trust-attributed Clostridium difficile	**Exception report slides provided**
	VTE risk assessment	Within tolerance / target
	Safe staffing	**Exception report slides provided**
	Core skills training	Within tolerance / target
	Vacancy rate	**Exception report slides provided**
	Departmental safety coordinators	**Exception report slides provided**
	RIDDOR	Within tolerance / target
	Fire warden training	**Exception report slides provided**
	Medical devices maintenance	**Exception report slides provided**
Effective	HSMR and SHMI	Within tolerance / target
	Palliative care coding	Within tolerance / target
	Mortality reviews	**Exception report slides provided**
	Unplanned readmission rates	Within tolerance / target
	PROMs	**Exception report slides provided**
	National Clinical Audits	**Exception report slides provided**
	Clinical trials - recruitment	Awaiting publication of latest quarterly data
Caring	FFT - % recommended	Within tolerance / target
	FFT A&E service - % response	**Exception report slides provided**
	Mixed-sex accommodation (EMSA) breaches	Pending root cause breach audit
Well led	Staff retention	Within tolerance / target
	Voluntary staff turnover rate	Within tolerance / target
	Sickness absence rate	Within tolerance / target
	Personal development reviews	Within tolerance / target
	Doctor appraisal rate	**Exception report slides provided**
	Consultant job planning completion rate	**Exception report slides provided**

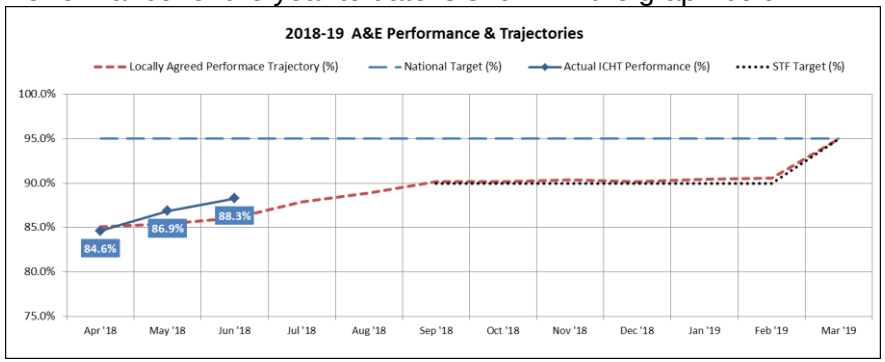
	Indicator heading	Progress update
	NHSI - provider segmentation	Within tolerance / target
Responsive	RTT 18 weeks performance	Within tolerance / target
	RTT 52+ weeks	**Exception report slides provided**
	RTT 52+ weeks clinical harm reviews	Within tolerance / target
	Cancer - 62 day waits	Within tolerance / target
	Cancelled operations	Awaiting publication of latest quarterly data
	A&E 4 hour waits	Within tolerance / target
	A&E 12 hour trolley waits	**Exception report slides provided**
	Discharges before noon	Threshold is being set
	Stranded and super stranded	Threshold is being set
	Diagnostic waits – over 6 weeks	Within tolerance / target
	Waiting times for first Op appointment	Within tolerance / target
	Outpatient HICS	Slides not provided – report being developed
	Outpatient DNA	Slides not provided – report being developed
	Outpatient apps within 5 working days	Slides not provided – report being developed
	PALS concerns	Slides not provided – report being developed
	Complaints - formal complaints	Within tolerance / target
	Orders waiting on Add/Set Encounter list	Within tolerance / target
	OP apps not checked-in or DNAd	Slides not provided – report being developed
	OP apps checked In AND not checked out	Within tolerance / target
	Patient transport	Within tolerance / target

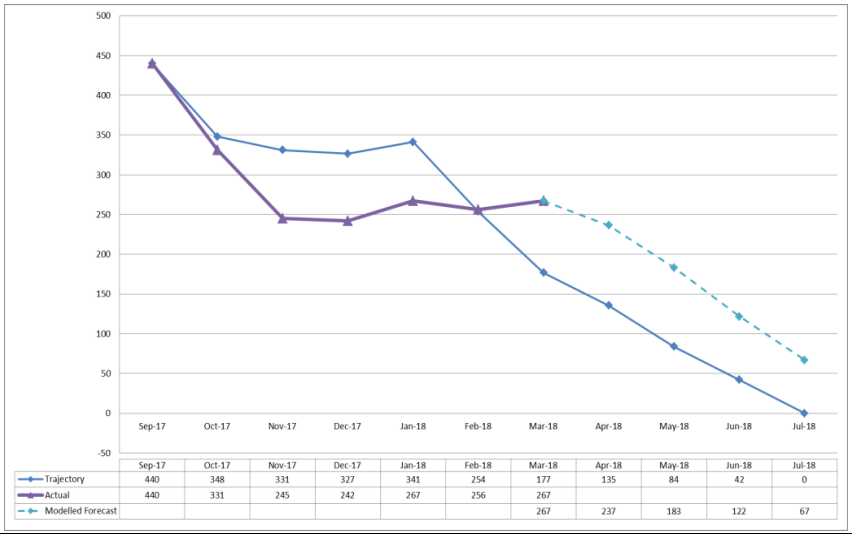
Appendix 2 NHS Improvement undertakings

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

At 15 June 2018

		Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Finance		Return to underlying surplus with year on year improvements in the underlying position	Start of 2021/22	In progress	Work is continuing on our Specialty Review Programme and our transformation programme which will form the building blocks of the recovery plan. We are looking at options for coordinating the work, and the resources and structures necessary to support delivery of the plan.
		Develop a financial recovery plan to return to surplus by the start of 2021/22	31 July 2018	In progress	We have a 'firm' 2018/19 plan with a proposal to go to FIC and the board for 2019/20.
		Clear timetable and milestones for Financial Recovery Plan including recurrent CIP to deliver 2018/19 control total	31 January 2018 23 January FROG	In progress	We have a Trust plan for 2018/19, including agreeing income with commissioners. As part of that we have developed a challenging CIP programme of £48m. Almost £40m of the £48m target has been identified.

		Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
A&E		Maintain A&E performance of at least 90%	2018/19	In progress	Performance for the year to date is shown in the graph below.  The refreshed Improving Patient Flow Programme has now gone live with agreed KPIs which are being monitored and reviewed regularly. Programme updates are being provided regularly to ensure oversight of development against individual targets and suggested milestones. Actions in place to improve A&E Performance are being managed both internally and via the wider committees such as the ICHT A&E Delivery Board.
		Maintain A&E performance of 95%	31 March 2018	In progress	As above
		Develop and submit to NHS Improvement a dashboard allowing the Trust Board to track the effectiveness of the Improving Patient Flow plan	To POM meetings	**Completed**	A scorecard has been developed for the Improving Patient Flow Programme 2018/19 and is shared regularly with the A&E Delivery Board, CCG and NHSI.

		Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
RTT & 52 weeks		Validate the number of 52 weeks waits and ensure all receive treatment or are discharged	July 2018	In progress	RTT long waiters (40+ weeks) are managed by clinical Directorates and Divisions, supported by the Elective Care Delivery Manager and the Trust's Waiting List Improvement Programme (WLIP). All long-waiting patients are validated and actively tracked on a weekly basis, and monitored through specialty-led PTL meetings. The Trust-level 52 week recovery trajectory was agreed and circulated in November 2017, and disaggregated to specialty level in December 2017. After a very challenging winter period the Trust is behind its trajectory, reporting 194 patients >52 weeks in April 2018 against a trajectory of 135. Additional governance and reporting has now been put in place for particularly challenged specialties. This is beginning to show progress, but further intense focus will be required to recover to trajectory by July. 

		Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
		Develop and submit an RTT recovery plan to deliver RTT incomplete performance target	To be confirmed in February 2018	**Completed**	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 being addressed by the Waiting List Improvement Programme. 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.
Data		Commission an independent review of the clinical and administrative processes within its elective pathways, clinical oversight of avoidable harm.	30 November 2017	In progress	An interim internal report has now been circulated.
Governance		Trust Board to oversee delivering undertakings, and risks to the successful achievement	With immediate effect	On-going	Reported to public Trust board (bi-monthly) as part of overall financial and performance reporting.

NHS
Imperial College Healthcare
NHS Trust

Trust Board - Public Report Summary	
Title of report: Finance Report for June 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th June 2018	**Item 10, report no. 07**
Responsible Executive Director: Richard Alexander, CFO	**Author:** Janice Stephens, Deputy CFO

Summary:

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

The Trust has met the financial plan in the 3 months to the end of June with a £11.2m deficit before sustainability funding.

Meeting the agreed control total for the quarter has given the trust access to £5.1m provider sustainability funding (PSF – previously known and Sustainability and Transformation Funding).

Recommendations:

The Committee is asked to note the report.

This report has been discussed at:

Finance and Investment Committee

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 – 3 MONTHS ENDED 30th June 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 3 months ended 30th June 2018.

2. Financial Plan for 2018/19

The Trust has agreed a financial control total for the year with NHS improvement. This is a plan of £20.6m deficit before any central sustainability funding.

The plan requires delivery of £48m of cost improvement programmes (CIPs), this is a challenging target for the Trust but in line with savings delivered in previous years (£43m in 2017/18 and £54m in 2016/17). The organisation continues to work to identify and embed efficiencies, drawing on Trust expertise, Model Hospital, Getting it Right First Time (GIRFT) and our own Specialty Review Programme.

Sustainability and Transformation Funding (STF) is now known as Provider Sustainability Funding (PSF). PSF is monitored on the same basis as STF, 30% on achievement of the A&E 4 hour trajectory and 70% on achievement of the financial control total. By agreeing to the control total the Trust has gained access to £34.2m of PSF.

3. Financial Performance

The Trust is on plan year to date with an element of 'catch-up' occurring in M3 correcting some estimates for M1 and M2.

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	92.42	95.79	3.37	276.91	277.28	0.37
Pay	(51.30)	(50.44)	0.87	(152.12)	(152.74)	(0.62)
Non Pay	(37.58)	(39.80)	(2.22)	(114.73)	(118.58)	(3.86)
Internal Recharges	0.00	0.00	0.00	0.00	0.00	0.00
Reserves	(3.31)	(1.97)	1.34	(9.60)	(6.14)	3.46
EBITDA	0.22	3.58	3.36	0.46	(0.19)	(0.65)
Financing Costs	(4.00)	(3.48)	0.51	(11.93)	(10.44)	1.49
SURPLUS / (DEFICIT) inc. donated asset treatment	(3.78)	0.10	3.88	(11.47)	(10.63)	0.84
Donated Asset treatment	0.11	(0.18)	(0.29)	0.27	(0.56)	(0.84)
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT)	(3.66)	(0.08)	3.59	(11.20)	(11.19)	0.00
PSF Income	1.71	1.71	-	5.12	5.12	-
SURPLUS / (DEFICIT) after PSF income	(1.96)	1.63	3.59	(6.07)	(6.07)	0.00

In order to deliver an on plan performance it was necessary to offset the impact of under performance in the clinical divisions with some releases from reserves which would otherwise have been held for unplanned events later in the year – this is a situation which both management and the board will keep under review as the year progresses.

3.1 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
Division of Medicine & Integ. Care	235,569	222,302	(13,267)	66.90	67.87	0.97
Division of Surgery, Cancer & Cardiov.	181,363	188,823	7,460	82.05	81.18	(0.87)
Division of Women, Children & Clin. Support	644,225	659,473	15,247	39.74	38.44	(1.30)
Central Income			-	34.63	36.79	2.17
Clinical Commissioning Income	1,061,157	1,070,598	9,440	223.31	224.29	0.97

Year to date the Trust in total is very slightly (0.5%) over-performing on NHS income. Clinical and operational teams within the Trust are working with commissioners to develop and implement achievable demand management schemes.

MIC is over performing in delivering more non-elective activity than planned. This activity is putting additional strain on the Trust's already overstretched capacity. If this over performance continues it could compromise the Trust's ability to meet the 4 hour A&E trajectory. There is a programme to improve patient flow with the aim of helping to meet the Trust's trajectory for A&E performance.

Within SCC there has been under performance on elective surgical specialties which have not been able to increase activity to the level planned. This has been offset by some over performance within cardiology and critical care.

Women, Children and Clinical Support (WCCS) underperformance is mainly due to maternity. This continues the trend over 2017/18 which saw a decrease in births throughout the year.

3.2 Private Patients Income

Private patient's income has continued to increase with a year on year growth in income of £0.8m. The position against plan however is an adverse variance of £0.8m; this is due to slower than expected delivery of some growth planned within surgical specialties.

3.3 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
Clinical Divisions						
Income	23.54	25.01	1.48	70.92	72.05	1.13
Expenditure	(17.81)	(18.56)	(0.75)	(53.84)	(55.69)	(1.85)
Internal Recharges	(3.31)	(3.61)	(0.30)	(3.31)	(3.61)	(0.30)
Medicine and Integrated Care	2.41	2.84	0.43	13.77	12.74	(1.03)
Income	28.99	29.51	0.52	85.99	82.91	(3.08)
Expenditure	(23.41)	(24.05)	(0.64)	(70.59)	(71.72)	(1.13)
Internal Recharges	1.00	1.19	0.19	1.00	1.19	0.19
Surgery, Cancer and Cardiovascular	6.58	6.65	0.07	16.40	12.38	(4.02)
Income	14.45	14.01	(0.44)	44.15	42.19	(1.96)
Expenditure	(16.36)	(16.79)	(0.43)	(49.18)	(50.33)	(1.15)
Internal Recharges	3.13	3.22	0.09	3.13	3.22	0.09
Women, Children & Clinical Support	1.22	0.44	(0.79)	(1.89)	(4.92)	(3.03)
Imperial Private Healthcare	0.37	0.83	0.46	2.77	3.05	0.28
Internal Recharges	0.00	0.00	-	0.00	0.00	-
Total Clinical Division	10.59	10.76	0.17	31.04	23.25	(7.79)

Within MIC the income over performance on non-electives is offset with additional costs of delivery. There is an adverse variance in expenditure due to unidentified CIPs within the division. SCC adverse position is due to the income underperformance, with activity under plan for both NHS and private income growth. WCCS is below its plan for income, mainly due to maternity but also with Children's and Gynaecology services. The overspend within the position is due to unidentified CIPs.

4. Efficiency programme

The Trust is £4.1m adverse to its submitted CIP plan YTD which is largely due to income productivity schemes (including private patients). This was partially impacted by sustained bed pressures.

The forecast is showing £12.1m adverse to plan, largely due to £9.4m unidentified, with some additional risk against pay and procurement savings.

The Project Support Office (PSO) continues to work with operational and clinical staff within the organisation to identify and embed efficiencies with further opportunities being worked up through the governance framework. Procurement continues to work with divisional colleagues to unlock further savings and efficiencies where possible and understand and mitigate risk. In addition there is work being undertaken on a pay efficiency framework and recovery plan to support delivery of our control total and longer term sustainability.

5. Cash

The Trust closed month 3 with a cash position of £31.7m. In month the increase in cash came from invoices paid for NHS income over performance. The Trust continues to closely monitor the cash position.

6. Capital

Against the capital resource limit (CRL) the Trust has spent £9.2m against a plan of £13.0m, an underspend of £3.8m. The main area of underspend is in medical equipment. 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.

7. Conclusion

The Trust has met the financial control total year to date. There are a number of risks to meeting the financial forecast for the year. The Trust must continue to work to identify and deliver CIPs to meet the current target. The pressures of non-elective demand on capacity may also have an effect on the Trust's financial and operational performance and will need to be closely monitored.

8. Recommendation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 3 months to 30th June 2018

	In Month				Year to Date		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	77.4	79.5	2.1		231.0	230.4	(0.7)
Private Patients	4.4	4.4	0.0		13.3	12.4	(0.8)
Research, Development and education	7.8	7.9	0.2		23.3	23.4	0.1
Other non-patient related income	2.8	3.9	1.1		9.3	11.1	1.8
Total Income	92.4	95.8	3.4		276.9	277.3	0.4
Pay - in post	(48.4)	(44.5)	3.9		(143.3)	(133.5)	9.8
Pay - Bank	(0.6)	(4.3)	(3.7)		(1.8)	(13.2)	(11.4)
Pay - Agency	(2.3)	(1.7)	0.6		(7.0)	(6.0)	1.0
Drugs and Clinical supplies	(20.5)	(21.1)	(0.6)		(63.0)	(61.2)	1.7
General Supplies	(2.9)	(3.1)	(0.2)		(8.7)	(9.1)	(0.4)
Other	(14.2)	(15.6)	(1.4)		(43.1)	(48.3)	(5.2)
Total Expenditure	(88.9)	(90.2)	(1.3)		(266.8)	(271.3)	(4.5)
Reserves	(3.3)	(2.0)	1.3		(9.6)	(6.1)	3.5
Earnings before Interest, Tax, Depreciation and Amortisation	0.2	3.6	3.4		0.5	(0.2)	(0.6)
Financing Costs	(4.0)	(3.5)	0.5		(11.9)	(10.4)	1.5
SURPLUS / (DEFICIT) including financing costs	(3.8)	0.1	3.9		(11.5)	(10.6)	0.8
Donated Asset treatment	0.1	(0.2)	(0.3)		0.3	(0.6)	(0.8)
SURPLUS / (DEFICIT) including donated asset treatment	(3.7)	(0.1)	3.6		(11.2)	(11.2)	0.0
Impairment of Assets	0.0	0.0	0.0		0.0	0.0	0.0
SURPLUS / (DEFICIT)	(3.7)	(0.1)	3.6		(11.2)	(11.2)	0.0
PSF	1.7	1.7	0.0		5.1	5.1	0.0
SURPLUS / (DEFICIT) after STF and winter income	(2.0)	1.6	3.6		(6.1)	(6.1)	0.0

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CQC and Ward Accreditation Update	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 25 July 2018	**Item 12, report no. 08**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Priya Rathod, Deputy Director of Quality Governance

Summary:

Part 1 – CQC update

- This report is the regular update to the Trust Board on CQC-related activity at and/or impacting the Trust.
- Support for a possible CQC inspection during 2018/19 is being focused on services previously rated overall as 'Requires improvement' and not re-inspected since 2014, and services not yet inspected by the CQC.
- The areas of the Trust which are included in each service are presented in **Appendix 1**.
- An internal mock core service review of critical care is scheduled to take place in July 2018.
- The division of Women, Children and Clinical support has set up a Task & Finish Group to support activities relating to Services for children and young people.
- A mock inspection of the GP practice was carried out on June 2018.
- The Western Eye Hospital is being supported to carry out a self-assessment against the CQC's standards.
- The Trust has been advised by the CQC that it will NOT receive another PIR request until after April 2019 and therefore will NOT have another trust level well-led inspection until after April 2019.
- Work is continuing to take place with the four trust-wide work streams of; medical devices, medicines management, hand hygiene and statutory and mandatory training.
- A new 'Improving Care' programme group has been established chaired by the Director of Nursing, to oversee the approach and progress for getting to Good and beyond
- A number of general updates are presented in the paper and include:
    - The latest CQC Insight report for the Trust was made available on 20 June 2018. Trust-level highlights since the previous Insight report are included within the paper.
    - New research indicators are being developed for use during CQC inspections
    - The National Guardian's Office, which sits within the CQC, and NHSI have jointly published guidance for the boards of NHS trusts in relation to freedom to speak up activities.
    - The Trust has been advised that the CQC will now review death notifications as part of its routine continuous monitoring of trusts
    - The CQC 2017 Adult Inpatient Survey was published in June 2018.
    - The CQC has published guidance and good practice in relation to managing emergency departments during periods of high demand, and for GP practices.
    - The organisation which operates the urgent care centre (UCC) at St Mary's Hospital, Vocare, was re-inspected by the CQC in March 2018. The overall rating improved to 'Requires improvement' and the service was taken out of special measures.

Part 2 – Ward accreditation programme (2017/18) update

- The Trust has a ward accreditation programme (WAP) in place since 2015/16
- During 2017/18, 90 areas have been reviewed compared to 76 in 2016-17 and 68 in 2015-16.
- The number of 'gold' areas increased from 12 in 2015/16 to 31 in 2017/18.
- The number of 'white' areas has reduced from 27 in 2015/16 to 4 in 2017/18 (reflective of the revised ratings principles as outlined in section 2.4 of the part 2 of the paper).
- Five areas have been awarded a 'gold' rating two years in a row and A6 (the cardiac recovery and high dependency unit at Hammersmith hospital) is the only clinical area to have received a gold rating three years in a row.
- The domains which had the most amount of white ratings within them are; leadership, medication and environment.
- A number of actions are being undertaken to address the findings.
- The 2018/19 WAP is currently underway and through the WAP steering group the standards within the domains have been reviewed and additional areas to be included have been agreed. A number of further developments will take place to enhance the WAP going forward.

Recommendations:
The Board is asked to note the updates.

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

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 ☒ Not applicable

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 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.

PART 1
CQC Update

1. Purpose

1.1. This following report is an update to the Trust Board on CQC-related activity at and/or impacting the Trust since the last update to the Board in May 2018.

2. Preparation for Possible CQC Inspections during 2018/19

2.1. The Trust Board will remember from its meeting in May 2018 that support for a possible CQC inspection during 2018/19 was being focused on services previously rated overall as 'Requires improvement' and not re-inspected since 2014, and services not yet inspected by the CQC.

2.2. **Appendix 1** identifies areas within the Trust that are included in each service which may be inspected during 2018/19.

2.3. It is important to note that the CQC can undertake an unannounced inspection of any core service if they have concerns based on intelligence/feedback from staff and/or patients and their families and carers.

Core service of Critical Care

2.4. The following actions are being undertaken to support a possible CQC inspection:

- A two weekly 'CQC readiness' meeting has been established by the directorate.
- A full internal mock core service review of critical care is scheduled to take place in July 2018.
- The review will focus on all areas included in the core service and will be undertaken against the full range of CQC standards. The review will focus on improvements since the previous inspection
- The outcomes from the review will be reported to this committee.

Core service of Children's and young people

2.5. The following actions are being undertaken to support a possible CQC inspection:

- Initial meetings have taken place with the divisional director of nursing, clinical lead and general manager for children's services to discuss support from the corporate nursing team.
- The division has set up a Task & Finish group to oversee inspection preparations. This is the same approach the division used for the successful inspection of Outpatient and diagnostic imaging in November 2016.
- An internal mock core service review of children's service across the Trust will take place in the autumn of 2018.
- The outcomes from the review will be reported to this committee.

Trust's GP Practice

2.6. The following actions are being undertaken to support a possible CQC inspection:
- An internal mock inspection of the Trust's GP practice was carried out at Charing Cross and Hammersmith hospitals on 8 June 2018. .
- Some actions were identified and the initial outcomes of the review have been shared with the practice and the division of Medicine and integrated care to take forward, which manages it on behalf of the Trust.

The Western Eye Hospital

2.7. The Western Eye Hospital is being supported to carry out an in-depth self-assessment against the CQC standards and will report the outcomes via the normal governance processes for the directorate of ophthalmology.

3. Annual provider information return (PIR) and Trust level well-led inspection 2018/19

- The Trust has been advised by the CQC that it will NOT receive another PIR request until after April 2019 and therefore will NOT have another trust level well-led inspection until after April 2019.
- This is because the CQC considers its five year strategy (launched in June 2017) to currently be in the implementation phase and as this is not due to end until March 2019 and the Trust has already had one well-led inspection during this phase, it will not be re-inspecting the Trust for well-led during this time.

4. Approach to CQC during 2018/19 – Getting to Good and beyond

4.1. The Trust Board will remember from its meeting in May 2018 that the Trust's executive team has been considering the Trust-wide approach to managing CQC activity at the Trust going forward.

4.2. Work is continuing to take place with the four trust-wide work streams of; medical devices, medicines management, hand hygiene and statutory and mandatory training.

4.3. A new 'Improving Care' programme group has been established chaired by the Director of Nursing, to oversee the approach and progress for getting to Good and beyond.
- The first meeting took place on 2 July 2018; and subsequent meetings have been held every other week.
- The group brings together the executive team with other senior directors and managers, for example the chief pharmacist and divisional directors of nursing, to review progress against the CQC findings and actions.

5. General updates

5.1. **CQC Registration**
- The Trust's CQC registration is being updated to reflect the change in CEO at the Trust. The CQC will issue the Trust with a new registration certificate in due course.

5.2. **CQC Insight**

- The latest CQC Insight report for the Trust was made available on 20 June 2018. Trust-level highlights since the previous Insight report include:
- Patient-led assessment of environment for dementia care has **improved** and the Trust is now performing about the same as other trusts.
- Deaths in low-risk diagnosis groups have **reduced** and the Trust is now performing much better than other trusts on this measure.
- The Trust has further **reduced** the number of outstanding CAS alerts.
- Stability of 'other clinical staff' has gone down; meaning turnover has **increased** among allied health professionals, healthcare support workers, etc. The Trust is now performing much worse than other trusts on this measure.
    - It is important to note that stability is different to turnover and measures the percentage of current staff that has more than a year's service compared to all staff employed a year ago.
    - For this very large staffing group it tells us that 80% of the staff has been with us for more than a year. There is naturally a lot of 'churn' in these groups particularly for AHPs band 5-7 where a lot of movement is often seen to progress careers through those bands.
    - Also included in this dataset is trainee Pharmacists who are on fixed-term contracts for 18 months so depending on when the data is pulled, this group may be picked up as 'less than a year's service'.

5.3. **Changes to the CQC's inspection methodology regarding research**

- In January 2018 a partnership was announced among the National Institute of Health Research (NIHR), the Health Research Authority (HRA), the Medicines and Healthcare Products Regulatory Agency (MHRA), and the Care Quality Commission (CQC), to develop research indicators for use during CQC inspections.
- Indicators are expected to focus on leadership of research and its integration into patient care; the aim is to better recognise how trusts ensure patients have access to research opportunities.
- The indicators are currently being developed.
- When the CQC publishes its research indicators, the Trust's CQC team will communicate with Trust staff / teams as appropriate and will ensure they are addressed in preparations relating to CQC inspections.

5.4. **Guidance relating to Freedom to Speak Up activities**

- On 2 May 2018, the National Guardian's Office, which sits within the CQC, and NHS Improvement jointly published guidance for the boards of NHS trusts in relation to freedom to speak up activities, which includes:
- Expectations of people in leadership roles.
- Individual responsibilities of board members.
- Good practice in relation to reporting within trusts.
- The guidance includes a self-assessment tool that Trusts are recommended to use
- NHSI have asked the Trust to confirm their commitment to using the guidance

- The guidance has been shared with the Director for People and Organisational Development as the executive lead for this area to take forward.
- The Trust's CQC team will incorporate the guidance into inspection preparation and planning during CQC inspections of its well-led domain at trust level

5.5. **New review of deaths notification by the CQC**

- The committee is aware that all NHS trusts are legally required to submit notifications about certain deaths via the NRLS. Review of death notifications has been delegated to the CQC.
- The Trust has been advised that the CQC will now review death notifications as part of its routine continuous monitoring of trusts.
- If the CQC has any concerns about death notifications, the Trust may be asked to provide additional data or information.
- The Trust has a robust process in place for reviewing deaths and data and information about deaths are captured in the Trust's quality reports.

5.6. **CQC national surveys and guidance**

5.6.1. **CQC 2017 National Inpatient Survey**

- The CQC 2017 Adult Inpatient Survey was published on the CQC's website on 13 June 2018 along with benchmarking reports for participating trusts.
- A report on the findings and actions are being presented to this committee as a separate agenda item.

5.6.2. **Guidance for managing emergency departments**

- The committee will remember that the CQC issued two sets of guidance in relation to emergency departments during 2017/18, and undertook weekly monitoring of A&Es for an eight week period in March and April 2018.
- The CQC has now published guidance which specifically focuses on maintaining safety and quality during periods of high demand.
- The guidance is based on findings from inspections of emergency departments during 2017/18.

5.6.3. **Guidance for GP practices**

- The CQC has published a report of case studies from GP practices which improved significantly in their performance during CQC inspections, from overall ratings of 'Inadequate' to 'Good'.
- This will be shared with the Trust's GP practice to inform further inspection planning.

5.7. **Summary report of inspections of urgent primary care services**

- The CQC has published a summary report of themes which emerged from its inspection programme for urgent primary care services, which includes urgent care centres.

5.8. **Improvements to the CQC Rating for the UCC at St Mary's Hospital**

- The Vocare run UCC at St. Mary's was inspected by the CQC in July 2017, and was rated as 'Inadequate' and placed in special measures.

- The CQC issued a Warning Notice in relation to radiology reporting and follow up within the service.
- The CQC re-inspected the UCC in March 2018 and rated it as 'Requires improvement' and took the UCC out of special measures.
- The follow up inspection report was published on the CQC's website on 8 June 2018.

6. Next Steps

- Outcomes from the internal mock critical care review scheduled to take place in July 2018 are expected to be reported to the Executive Committee in September 2018.
- Support for the Western Eye Hospital to carry out a self-assessment against the CQC standards will continue.
- The Trust-wide approach for managing CQC activity during 2018/19 will be driven forward through the newly established improving care programme group.

7. Recommendations

- To note the updates.

Appendix 1: Trust areas which may be included in CQC inspections during 2018/19

Service	Site	Areas included
Core service: Critical care	St Mary's Hospital	• ICU • Acute Respiratory Unit on Manvers ward
	Charing Cross Hospital	• ICU • Acute Respiratory Unit on Marjorie Warren
	Hammersmith Hospital	• GICU • CICU on ward A6 • Renal HDU on DeWardener ward
Core service: Services for children and young people	St Mary's Hospital	• Grand Union ward • Great Western ward • Westway ward • Paediatric haematology day unit • Winnicott baby unit • Paediatric intensive care unit (PICU) • The paediatric A&E is part of the core service, Urgent and emergency services. Though it would not be a focus of this inspection, it will be visited as part of paediatric pathways.
	Hammersmith Hospital	David Harvey Unit (outpatients and ambulatory care)
	QCCH	Neonatal intensive care unit (NICU)
Hammersmith and Fulham Centres for Health (GP practice)	Charing Cross Hospital	Practice premises including reception, consulting rooms and toilets
	Hammersmith Hospital	
Western Eye Hospital	Standalone facility	The three CQC core services operating at the site will be included in an inspection: • Urgent and emergency services • Outpatients • Surgery

END OF PART 1

PART 2
Ward Accreditation Programme (2017/18) Update

1. Purpose

1.1. This following report provides a summary of the outcomes from the 2017/18 Trust ward accreditation programme (WAP).

2. Background

2.1. The Board will recall that the Trust has a WAP in place since 2015/16.

2.2. The WAP comprises of annual unannounced inspections across inpatient wards, critical care areas, outpatients, recovery rooms and day case areas.

2.3. A team consisting of nurses, midwives and AHPs undertake the reviews using a tool which covers a number of domains such as; leadership, medicines management, and record keeping.

2.4. An overall rating (gold, silver, bronze of white) is calculated for each domain and for the ward/clinical area overall using principles aligned to the CQC's methodology. This is a change from previous years where a single white rating in any category rendered the ward white overall and was felt to be unduly harsh

2.5. The current WAP tool is designed to provide assurance of the quality of care being delivered by nurses and midwives. Discussion has taken place regarding the need for a more multi-professional approach and this will be explored further in light of the Trust's wider approach for 'getting to good and beyond' aligning with the quality strategy.

3. Summary of 2017/18 WAP outcomes

3.1. During 2017/18, 90 areas have been reviewed compared to 76 in 2016-17 and 68 in 2015-16.

3.2. The number of 'gold' areas increased from 12 in 2015/16 to 31 in 2017/18.

3.3. The number of 'white' areas has reduced from 27 in 2015/16 to 4 in 2017/18 (reflective of the revised ratings principles as outlined in section 2.4 above.

3.4. Five areas have been awarded a 'gold' rating two years in a row and A6 (the cardiac recovery and high dependency unit at Hammersmith hospital) is the only clinical area to have received a gold rating three years in a row.

3.5. The domains which had the most amount of white ratings within them are; leadership, medication and environment.

3.5.1. Leadership: During 2017/18, nurse in charge standards and competencies were developed to address issues identified through the WAP. This work has gone on to underpin the development of the Springboard programme- a bespoke band 5/6 nurse/midwife leadership course. Three cohorts of 20 students are currently on the programme with a further three being planned. The impact of these initiatives will continue to be monitored going forward.

3.5.2. Medicines management: A trust wide safety programme supported by the quality improvement (QI) team is in place for medicines management. The work stream is

underpinned by a robust governance framework and updates on progress against key actions presented to the Executive Quality Committee each month.

3.5.3. Environment: The two main issues within this domain relate to cleaning and backlog maintenance both of which the Board will be aware of in terms of actions being undertaken.

4. 2018/19 Ward accreditation programme and next steps

4.1. The 2018/19 WAP is currently underway. Through the WAP steering group the standards within the domains have been reviewed and additional areas to be included have been agreed. Changes and developments for the forthcoming year include:

- Expansion of the programme to include renal satellite units, divisionally led outpatient areas and theatres and a review of emergency department arrangements.
- Wards receiving a gold rating twice or more in a row will be excluded from the full review this year and undertake peer review of each other's areas led by a senior nurse
- Alignment with the refreshed Quality Strategy and Trust 's CQC framework
- Expansion of the teams to include colleagues from estates and facilities
- Consideration of including patients in the process
- Introduction of an awards programme that celebrates success Trust wide
- Consideration of a paired learning programme

4.2. A summary of the outcome from the 2018/19 WAP will be presented to the Board next year.

5. Recommendations

- To note the updates

END OF PART 2

Authors: Priya Rathod, Deputy Director of Quality Governance

Date: 25 July 2018
Appendix 1: Trust areas which may be included in CQC inspections during 2018/19

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Patient and public involvement: review and priorities for 2018/19	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: Wednesday 25 July 2018	**Item 13, report no. 09**
Responsible Executive Director: Michelle Dixon, director of communications	**Author:** Michael Morton, chair of the Trust strategic lay forum Linda Burridge, patient and public involvement project manager

Summary:

This report provides an update on progress of the Trust patient and public involvement strategy and highlights priorities for 2018/19 for the board to note. It draws particularly on a development session for all Trust lay partners, a strategy and planning day for the strategic lay forum and a recent Trust board seminar.

The report will be accompanied by a brief presentation from the chair of the strategic lay forum, Michael Morton.

The five-year PPI strategy was approved by the board in July 2016 and its development and implementation is overseen by the Trust's strategic lay forum which consists of 12 lay partners and representatives from the Trust's communications, governance, improvement, integrated care and patient experience teams as well as from Imperial Health Charity and Imperial College.

The strategic lay forum has achieved a good deal since it was formed, establishing and growing the role of lay partner and helping to ensure more effective patient and public involvement in a range of major developments.

This report summarises key areas of progress in patient and public involvement over the past year, both in terms of implementation of the strategy, including the work of the strategic lay forum itself, and with examples of more effective involvement approaches within key projects and programmes and 'business as usual' activities across the Trust.

The purpose of the strategy is essentially to establish the right infrastructure and to help create the right organisational culture for effective patient and public involvement to be an intrinsic part of what we all do, throughout the organisation.

As reflected in the Care Quality Commission's well-led inspection report earlier this year, we do not yet have shared ownership of patient and public involvement across the organisation. It can still be seen as a 'nice-to-have' or be a 'tick-box' exercise. This will take time to change and raising awareness and understanding of the impact and benefits of involvement will be an essential part of achieving this change.

As such, the report also summarises the priorities for involvement in 2018/19 as:

- To expand and embed the strategic lay forum and lay partner programme
- To determine how best to increase involvement with seldom-heard groups
- To create and launch a 'keep in-touch' offer for all patients and local residents

- To develop an organisation-wide staff campaign to raise awareness and understanding of the value of – and opportunities for – involvement
- To develop an integrated approach to understanding and acting on feedback
- To develop and test self-care and prevention approaches as part of an overall integrated care model
- To ensure involvement is a key element of our strategic change and improvement programme – both in terms of developing the programme and to embed within the programme.

Recommendations:
The board is asked to note the progress, challenges and priorities for patient and public involvement over the past year. The report will be presented by the chair of the Trust strategic lay forum.

This report has been discussed at:
The content has been discussed at executive committee and Trust board seminar as well as at the strategic lay forum

Quality impact:
Patient and public involvement aims to enable a major improvement in patient care and experience and overall health and wellbeing of our patients and communities. This strategy is crucial for the Trust and its partners to be proactive and enable person-centred care.

We have had significant external collaboration on this initiative and this report is written with our strategic lay forum.

Financial impact:
The financial impact of this proposal as presented in the paper enclosed:
3a) can be fully accommodated within the existing departmental budget this year and into the future assuming deliverable levels of efficiency

In 2018/19, we are increasing communications resources slightly to support central infrastructure aspects of the strategy implementation but we are meeting the financial impact by having a bigger income/contribution target. Imperial Health Charity continue to support this work with a financial and staff contribution.

Risk impact and Board Assurance Framework (BAF) reference:
- Failure to involve patients, public and local community in transformation plans and decision. If patient and public involvement is not completed, risk is reputational damage and loss of confidence in our health services (2589 on the corporate risk register).
- Insufficient resources and organisational focus to implement strategy and other supporting projects.
- Missed opportunities for better care for patients, poorer care for patients.

Workforce impact (including training and education implications):
This report will have no anticipated workforce impact.

What impact will this have on the wider health economy, patients and the public?
Patient and public involvement aims to achieve a major improvement in patient care and experience and overall health and wellbeing of our patients and communities by enabling collaboration

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

Senior managers should know, do and share:

- Our PPI strategy is now in its third year and we've delivered many projects to support PPI in the Trust. I.e. processes, lay partner role and associated policies, patient support volunteer, PPI education and toolkit.
- More needs to be done to ensure PPI is embedded in the Trust. This feedback was echoed in the CQC well-led inspection carried out in December 2017.
- In line with transformation plans, we will work with divisions to make PPI business and usual.

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Imperial College Healthcare
NHS Trust

Patient and public involvement: review and priorities for 2018/19

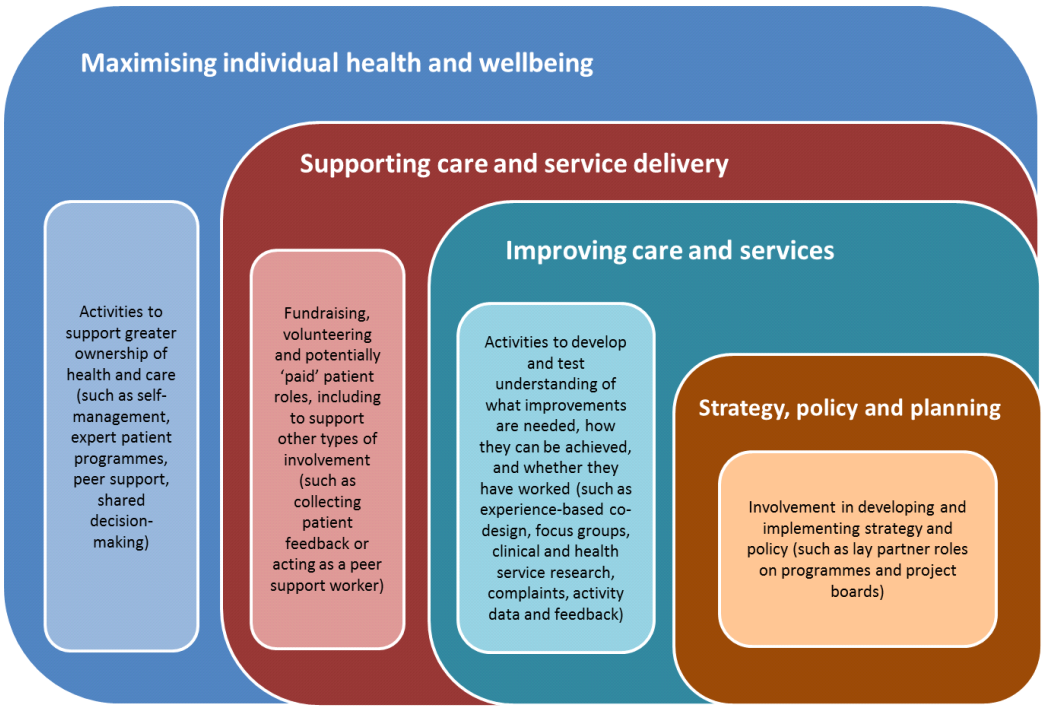
Report from the strategic lay forum

Contents

1. Introduction

Patient and public involvement refers to all of our activities and ways of working that help us focus on understanding and meeting the needs and preferences of the people who use, or may use, our services. It is not a single function but rather a way of thinking and behaving to be embedded at all levels of the organisation. Our approach to, and priorities for, patient and public involvement are set out in our five-year strategy approved by the Trust board in July 2016.

Our strategy defines four broad areas for involvement:



More detail about our strategy and approach is set out in section two of this report.

The strategy was the first major output of the first Trust-wide strategic lay forum, established in November 2015. The forum is chaired by a lay partner – members of the public, often patients or former patients, who work in partnership with staff to ensure we take a person-centred approach to our policy, planning and strategic developments. There are a further 11 lay partners on the forum as well as senior staff representing functions with particular responsibility for developing and embedding involvement – communications, improvement, patient experience, integrated care, governance, Imperial Health Charity and Imperial College.

The strategic lay forum has achieved a good deal since it was formed, establishing and growing the role of lay partner throughout the organisation and helping to ensure effective patient and public involvement in a range of major developments. It's also important to note that the forum's work built on existing pockets of very effective involvement approaches across the Trust. More detail on overall progress to date is set out in section three of this report.

We now need to do more to ensure patient and public involvement becomes ‘business as usual’ in all parts of the Trust, that it is consistently high quality, has impact and is co-ordinated and integrated effectively.

There are good examples where patient and public involvement is being genuinely embedded in projects and service development, such as in children’s services, where they use regular ‘listening campaigns’ to direct their plans, and the Hammersmith and Fulham integrated care partnership, where two lay partners have been part of the management board from the outset.

However, involvement can still be seen as a one-off, ‘tick-box’ exercise and it can be difficult to see how the views of patients and the public are really influencing – and, where necessary, changing – what we do.

The Care Quality Commission completed a ‘well-led’ inspection in December 2017 and their report made similar observations. It noted that inspectors perceived no shared ownership of patient and public involvement. There are other challenges we need to address too. In a very busy operational environment, involving patients and the public can be perceived as a ‘nice to have’ but not essential. We need to do more to demonstrate the benefits of involvement, to make sure staff know how to do it and how to do it well, and to encourage, develop and support patients and the public to play as full a role as they can.

Formal evaluation of involvement is particularly challenging and we struggle, along with other organisations, to show direct impact through our existing reporting and performance mechanisms. A systematic review of involvement in the NHS published in the *International Journal for Quality in Healthcare* in 2012 found that involvement has a range of impacts on healthcare services but there is little measurement or analysis of that impact.

We have taken the approach that developing partnerships with patients and developing our understanding of their needs and preferences is essential and that there are many basic building blocks still to put in place to make this possible. Alongside this, however, we do need to work out how best to understand impacts and learning so that we can focus resources on the activities that will deliver the best return.

We also need to progress a more strategic approach to building on-going, two-way relationships with our patients and local communities. More details on priorities for development are set out in section four.

Overall, this report seeks to provide the strategic lay forum’s analysis of progress and challenges with patient and public involvement over the past year and to set out priorities for the year ahead.

An organisation that excels at involvement has a healthy collaborative culture, staff have power to act and everyone feels united in their purpose to care for people as whole, not just to treat individual health issues. This is what we are striving to achieve through the actions set out in this document.

2. Background

The patient and public involvement strategy was agreed by the Trust board in July 2016 following a series of co-design events.

Our strategic lay forum, which was established in November 2015, oversaw the development of the strategy, its implementation and ongoing evolution.

The forum consists of 12 lay partners, including a lay chair, Michael Morton, and senior representatives from all areas of the Trust who have key roles to lead and shape our patient and public involvement approach:

- Communications
- Governance
- Improvement
- Integrated care
- Patient experience.

Representatives from Imperial Health Charity and Imperial College London's Patient Experience Research Centre are also part of the forum. This is especially useful in developing how we work across organisations on issues such as volunteering and patient participation in research.

What is involvement?

Patient and public involvement refers to all of our activities and ways of working that help us focus on understanding and meeting the needs and preferences of the people who use, or may use, our services. It is not a single function but rather a way of thinking and behaving to be embedded at all levels of the organisation.

What does this mean in practice?

Our vision is for:

- all patients to feel that they are understood, heard, and have control and choice over their health and care so that it meets their specific needs
- as many patients, families, carers and local residents as possible to feel encouraged and supported to take an active role in their own health as well as in shaping and delivering the care we provide to help ensure it better reflects patients' needs
- a core pool of patients, carers and local people able to directly influence the development and delivery of our organisational strategies and major programmes to help ensure we are making the best use of all of the insight, skills and knowledge available to us.

Implementation
Implementation of the patient and public involvement strategy is overseen by the strategic lay forum, reporting to the Trust board annually. We have organised our actions under four workstreams:

1. Patient and public involvement infrastructure – processes, policies, resources
2. Building awareness and engagement – including a 'keep in touch'/involvement offer that builds on our 'membership' offer
3. Systematically acting on feedback – meaningfully responding to feedback as part of business as usual
4. Patient ownership of health and wellbeing – to support new approaches to care that encourage and help everyone to stay as healthy as possible.

3. Progress to date

3.1 Infrastructure – setting up the processes, resources and policies

Strategic lay forum
Throughout 2017/18, the forum continued to meet every two months to provide input and advice on a wide range of strategic issues and developments. They also took part in an annual 'away day' where they contributed to business planning, reviewed the patient and public involvement action plan and set priorities for the coming year. We've been fortunate to have the same lay partners (biographies on the Trust website) on the forum over the last 12 months and have benefitted greatly from their knowledge, awareness and dedication.

Starting with patients
"I sit on the strategic lay forum and am committed to promoting and enabling co-production, ensuring that patients are at the centre of all we do.

That may sound dry, but if lay people are involved from the beginning, it makes sure that our voice is reflected from the outset and no one has to unpick things later.

From the start, we talk about patient care and pathways, experience as well as outcomes, not individual services, departments or hospital sites.

For example the strategic lay forum contributed to the review of disabled parking places, focussing on access for as many people as possible. This meant encouraging people whose treatment had finished to leave as well as making it easy to pay.
Trish Longdon, member of the strategic lay forum

Examples of key developments in 2017/18:

- Through their expertise and connections in other NHS organisations across north west London, forum members are making links to develop a consistent lay partner role across north west London and have influenced NHS England

to consider lay partnership as part of STP governance mechanisms. We're also now working more closely with North West London CCGs to explore how we might share involvement infrastructure.
- Establishment of a new digital patient reference group to get external views on how we develop and use online tools and digital platforms.
- Input to the development of the Trust's emerging organisational strategy and transformation programme.
- Co-creating the role of lay partner and developing its role profile.
- Defining and starting a project to investigate how we can best achieve more involvement with seldom-heard groups.

The lay partners on the strategic lay forum also had their own review session to consider their role and performance over the past year and what more they could and would like to do. This established work to review membership terms and processes and to expand the number of lay partners on the group.

Initiating improvements

"In my role as chair, I've commented on many strategic issues. An important part of that role is to also flag and help ensure that patients are at the centre of their care.

I discovered a significant issue in relation to the co-ordination of scans required before consultant appointments in urology.

I was able to kick start a review that has resulted in process changes that mean scans and urology outpatient appointments are now automatically co-ordinated via the Trust's electronic booking systems, ensuring a much better experience for the patient."

Michael Morton, chair of the strategic lay forum

Lay partners

Lay partners are members of the public, often patients or former patients, who work in partnership with staff to ensure we take a person-centred approach to our policy, planning and strategic developments. They join our programme and project groups as equal members of the team.

The strategy established the role of lay partners and set a target to have two lay partners on each major Trust project. Thirty new lay partners have been attached to projects since May 2017, bringing the total to 44 (including the 12 lay partners on our strategic lay forum). Lay partner opportunities are promoted on the Trust website and through our e-newsletters and social media and they join project groups through a process managed by the patient and public involvement project manager. During this phase they also meet the chair of the strategic lay forum and the project group.

Lay partners change our conversations

I've had the pleasure of collaborating with two lay partners on our waiting list improvement programme. It's a complex and sensitive project and they've offered great insights from a patient perspective. The hugely valuable, and almost intangible, thing they do however is to subtly affect our conversations, uniting us to put patients at the centre of our work.

Jo Fisher, deputy divisional director of nursing, division of surgery, cancer and cardiovascular

Lay partners have proved to be extremely valuable to projects, through:

- The expertise, experience, connections and external perspectives they bring – on the safety culture steering group, the lay partners' extensive experience and external points of view on safety and workforce development challenged discussions about culture change.
- Being independent means they can broker relationships and raise issues that might not otherwise be surfaced automatically.
- Our lay partners on the waiting list improvement programme steering group gave perspectives on how patients would view long wait times and how best we can share these messages with external audiences.
- Lay partners on the Hammersmith and Fulham integrated care partnership clinical and care reference group act as brokers between providers by ensuring the emerging care model is focused on bringing benefits to patients rather than to any one provider.

In April, we drafted our lay partner policy following feedback from a further co-design event held in March. At this event, 22 active lay partners and staff working together reviewed the process and discussed the challenges and culture change required to enable meaningful collaboration at this strategic level. Next steps are to finalise this policy and set up processes and resources to support the lay partners such as further training, induction and briefing material.

External perspectives provide helpful challenge

"By working with lay partners and patient representatives we are able to consider things through a different lens. In the NHS we're often inwardly focused and they provide a level of helpful challenge that wouldn't be there otherwise."

Hugh Gostling, director of estates and facilities

Patient and public involvement education and resources

In February 2018 we published our first patient and public involvement toolkit on the Trust intranet, designed to help Trust staff or patient/public representatives carry out their own involvement activities. It was developed by the improvement team and gives advice on how to carry out focus groups and interviews and use nominal group technique and emotional mapping. It's been well-received by staff because it's

practical and succinct. The current version will be reviewed and updated in the summer.

The Trust also offers staff involvement training through the improvement team. The improvement team offers a dedicated patient and public involvement education session and patient engagement/experience is a key theme within all quality improvement education and a fundamental part of the quality improvement methodology.

We are ambitious to continue a culture change where patient and public involvement is given the space and time it needs. We also need to improve the co-ordination and support of it across the Trust and build more of a co-ordinated approach to education. There is scope to offer ways for learnings to be shared between services and departments. We can reward staff for taking on the foundation behaviours of patient and public involvement – listening, teamwork and collaboration.

Expanding patient and public involvement roles and ways to collaborate

The patient and public involvement strategy vision is to have a wide range of roles and ways to collaborate. We want to cater to the needs of all members of our communities and their engagement preferences.

In late 2017 the patient advice and liaison service (PALS) developed the role of the patient support volunteer with the Charity to provide a point of contact for patients in wards and, where necessary, escalate challenges to ward staff or PALS.

To date we have 12 patient support volunteers. They are now embedded at St Mary's and we're looking at developing the role at Hammersmith hospital later this year. Feedback on these roles has been very positive. The volunteers deal with important issues for patients but ones they may feel are not significant enough to raise with clinical staff, such as locating personal items left behind when they were transferred from another ward. Because of this we are seeing issues resolved quickly and effectively and therefore avoiding potential complaints. The patient support volunteers are now working closely with the patient experience and PALS team to support on-going improvement work.

Since the start of the patient and public involvement strategy, we have established two 'reference groups' that focus on a particular theme or part of the healthcare journey.

In January 2017, we set up the patient communication reference group that reviews patient information. Throughout 2017/18, this group worked with 12 services and provided insightful feedback. The group made a huge difference to the quality of physiotherapy patient information. The team that treats chronic kidney disease said that improving communications so patients understand their condition is crucial and made all the difference to patients' health and ability to self-manage their condition.

"For physiotherapy to be successful it is vital that patients complete their exercises often and that they have a good understanding of their problem. The patient communications reference group have provided invaluable support in helping the physiotherapy department provide successful care.

We have produced a variety of publications together and key interventions include improving visual impact and ensuring they are easy to understand. Despite having read my versions several times before sending them, they always come back improved!"

Dan Bourke, clinical specialist physiotherapist

In 2017/18, we also set up a digital reference group of 12 members to focus specifically on how we embrace and use digital technologies as part of healthcare. This group met in March and June 2018. They commented on the strategic vision of how we use digital technologies and shared their views on sharing patient data amongst other NHS organisations.

3.2 Awareness workstream

While we have shared patient and public involvement developments with patients, communities and staff and engaged with peer organisations, it's become clear for real culture change, we need to increase the prominence of patient and public involvement in the Trust.

We need to clearly promote the benefits of involvement, what it means in terms of new ways of working and new relationships and how it is necessary for sustainable and effective healthcare delivery.

Examples of good practice during 2017/18

Quality strategy 2018-23

In autumn 2017, the Trust embarked on a listening campaign to develop the five-year quality strategy. This will set out how we will create a culture of continuous improvement to increase and sustain quality healthcare. Compared to previous quality strategies, this one featured more involvement with patients and the public.

The campaign focused on what quality means to different stakeholders with a key principle of inclusiveness: connecting with those who we find hardest to reach, taking steps to overcome barriers to participation and encouraging everyone to have their say.

The team had over 700 conversations face to face with staff, patients and community groups. This included 10 community groups which we do not regularly engage with. Despite the variety of voices, the issues staff and patients raised were remarkable similar. For example everyone was concerned about delays and long wait times.

To oversee and coordinate the work we convened a quality strategy design group involving representatives from across and beyond the organisation including members of our strategic lay forum, Healthwatch and Citizens UK.

When the strategy is launched we will continue to work together as we deliver the priorities set out as part of the new strategy. At the same time we will work with partners to ensure that patients, staff and community groups are involved in the co-design of improvement initiatives. The strategy will be published in the autumn of 2018.

Renaming our 'high dependency unit' based on patient feedback

When the Trust consolidated level two (high dependency care) and three (intensive care) beds at St Mary's in June 2018, there was strong debate between different clinical teams about the naming of the combined unit.

Through testing and feedback from patients, the final name was agreed to be 'intensive care' not 'critical care'. While critical care is the specialty name that staff use, patients found it to be a potentially frightening and negative term and preferred intensive care as that gave positive feelings of extra care. This is a seemingly small example, but steps like this will help us become more patient-focused.

Wayfinding project

Wayfinding is information which supports users to navigate our services and is a key project for 2018/19. Signage is the most visible part of wayfinding, but other elements are just as important. These include hospital, building and service names, information hierarchy, terminology, systems and environments.

As our sites are aging, complex and have been developed piecemeal over time, services and units have implemented their own signage and names. Without meaningful involvement, we haven't always considered what this is like for someone outside of the organisation. We can automatically use our internal references or terminology and as a result patients and visitors often struggle to find their way around our complex sites.

Involvement and testing our names and pathways is a key principle of this project. The project has engaged with patients, visitors and staff, as well as commissioners and local representatives of seldom heard groups. Through the project group, patients have also contributed to improved signage in A&E and challenged us to focus on improving accessibility for disabled people.

Children's services' 'what to matters to me' project

Children and young people of all ages across our sites have the opportunity to create a 'what matters to me' poster to share with staff. They can choose to share their likes and dislikes, how they wish to be treated, or give feedback on their experience. Popular themes are parents being able to sleep over, friendly staff, good internet access, favourite food, toys and games.

These colourful and highly individual posters can be read by the healthcare professionals treating them, enabling better rapport as they can immediately understand what makes the child feel comfortable and special, and allowing them to personalise their care where possible.

The project brings the child's voice to the forefront and enables a profound change in our interactions with our young patients. A simple poster can help everyone to see the whole child and what really matters to them, rather than focusing on their individual health issue.

Promoting involvement

In 2017/18 we included patient and public involvement events and developments in all our communications channels and published a blog of two of our lay partners on the website.

Significant time was also spent by the patient and public involvement project manager, meeting and consulting with managers and services about how to best approach their involvement needs. This process involves finding out about projects or services, understanding the type of feedback or involvement required and advising on and supporting next steps. For example, lay partners are relevant for strategic projects but sometimes services require a user forum or patient representative, to get feedback on recent, lived experience of a service.

We have also improved how we present involvement opportunities and our promotion methods now include social media and linking with organisations like Healthwatch. Our membership newsletter is sent to our contacts bimonthly. It now regularly includes involvement opportunities and events.

This year we plan to develop this further by creating and launching a mass 'involvement' offer for all patients and local residents, with allowing us to 'keep in touch' as the basic consent (outlined for The King's Fund: https://www.kingsfund.org.uk/blog/2018/01/engaging-public-designing-future-nhs)

3.3 Systematically acting on feedback

The goal of this workstream is that the vast majority of patients and staff are engaged with systematic gathering of meaningful feedback, which is used at all levels of the Trust to identify, shape, prioritise and evaluate problems. It's a workstream with many dependencies and requires the Trust have a mature and integrated approach to patient and public involvement. It's also dependent on the success of the first two workstreams. Due to this, and as anticipated, this workstream has not yet progressed significantly.

One key project that has supported this workstream is *'Listen, Learn & Improve'*, a joint Trust/College project, funded by The Health Foundation to develop a natural language processing tool. This will enable the Trust to analyse patient feedback, particularly free-text comments, in a more structured and meaningful way. The year-long project aims to deliver a tool that will support feedback analysis and these insights will be used rapidly to make improvements in care.

3.4 Patient ownership of health and wellbeing

Some areas of the Trust have developed innovative projects that support patients' health and wellbeing.

These include programmes such as Connecting care 4 children, a paediatric integrated care model, and Connecting care 4 adults (CC4A) initiative that is building mutual support between Trust clinicians and GPs caring for patients with long term conditions. As part of CC4A, consultants review notes of patients with long term conditions alongside the patient's GP to share learning and get the best outcome for them. A mobile app is also being trialled for patients suffering chronic obstructive pulmonary disease to help them better manage their condition.

The Hammersmith and Fulham integrated care is a partnership of four NHS organisations to develop a radically better way of providing care for the nearly 200,000 people living in Hammersmith and Fulham. This will deliver a joined up model of care for children, adults and older adults. Particularly for those living with long term conditions, this care model has a strong focus on prevention and self-care and to reduce the risk of them worsening. Patient representatives are included in care model design groups and performance is measured against outcomes co-produced with local residents and patient representatives.

The Care information exchange, which provides secure online access to medical records, is another project that aims to put patients in control of their care. It enables them to view clinicians and healthcare staff as partners in their care, rather than the decision makers.

This year we completed a discrete desk research project where we reviewed the NHS 'vanguards' to identify and considered relevant projects that use models of self-care and patient activation.

We plan to develop and test self-care and prevention approaches as part of an overall integrated care model, which is a key aspect of our strategic development plan.

4. 2018/19 priorities

We're aware it's a long journey to achieve the vision agreed as part of the involvement strategy but one that has already shown enormous value and very significant learnings.

This is very broad area of work. It affects and is affected by many areas of the Trust, it's dependent on other transformation projects and is unchartered in that we must be willing to try, test and review new projects and approaches.

For 2018/19, we have identified the following projects as our priorities:

- To expand and embed the strategic lay forum and lay partner programme
- To determine how best to increase involvement with seldom-heard groups
- To create and launch a 'keep in-touch' offer for all patients and local residents
- To develop an organisation-wide staff campaign to raise awareness and understanding of the value of – and opportunities for – involvement

- To develop an integrated approach to understanding and acting on feedback
- To develop and test self-care and prevention approaches as part of an overall integrated care model
- To ensure involvement is a key element of our strategic change and improvement programme – both in terms of developing the programme and to embed within the programme.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Corporate Risk Register and Board Assurance Framework	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 25 July 2018	**Item 14, Report no. 10**
Responsible Executive Directors: Janice Sigsworth, Director of Nursing Tim Orchard, Chief Executive Officer	**Authors:** Valentina Cappo, Corporate Risk Manager Priya Rathod, Deputy Director of Quality Governance Peter Jenkinson, Trust Company Secretary

Summary:
This is a new joint report including the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

The report supports alignment of the BAF and CRR, in line with best practice.

The report provides an update on the Corporate Risk Register and includes a summary of key changes made since it was reviewed by the Trust Board on 28 March 2018.

Please refer to **Appendix 1** for a copy of the Trust's Corporate Risk Register.

The report also includes changes made to the BAF since it was reviewed by the Trust Board in May 2018.

Please refer to **Appendix 2** for a copy of the Board Assurance Framework.

PART 1: Corporate Risk Register

The Trust Board reviewed the Corporate Risk Register at its meeting in March 2018. A number of changes have been made to the Corporate Risk Register since the last update to the Trust Board, which have been approved by the Executive Committee. Please refer to **Appendix 1** for a copy of the Trust's Corporate Risk Register.

At present, there are 24 corporate risks within the risk register. The highest risks are scored as 20 and the lowest are scored as 8.

- Key themes include:
  - Workforce
  - Operational performance
  - Financial sustainability
  - Clinical site strategy
  - Regulation and compliance
  - Estates critical equipment and facilities
  - Delivery of care
  - Cyber security
  - Data quality
  - Medicines management
  - Statutory and mandatory training
  - ICT infrastructure.

1. Changes to the Corporate Risk Register

- The following risks have been escalated onto the corporate risk register:
  - **Risk 2613** Risk of financial and reputational damage to the Trust resulting from failure to fully comply with the General Data Protection Regulation (GDPR), which will become effective in May 2018. (Score: 16 = C4 x L4)
  - **Risk 2677** - End of life Network CORE devices
  - The risk is presented for approval with a current score of 20 (C5 x L4).
  - **Risk 2680** - PC Replacement programme
  - The risk is presented for approval with a current score of 20 (C4 x L5).
  - **Risk 2681** - Windows 7 End of life support
  - The risk is presented for approval with a current score of 20 (C4 x L5).
- One risk that is commercial in confidence was escalated to the corporate risk register.

- The score of **Risk 2487** Risk of spread of CPE has reduced from 20 (C5 x L4) to 16 (C4 x L5).
- The target risk score dates for a number of risks have been revised.

2. Outcome of discussion at the Executive Committee meeting on 24 July 2018

- The following risks will be discussed at the Executive Committee meeting and it is likely that they be escalated onto the Corporate Risk Register:
  - **Risk 2714** - Failure to successfully implement the 2017/18 NHS e-Referral Service within timeframe - The risk has been presented with a proposed score of 16 (C4 x L4).
  - **Risk 2696** - Incorporation of Western Eye Hospital into Outpatient and Ophthalmology building - The risk has been presented with a proposed score of 9 (C3 x L3).
  - **Risk 2697** - Impact of Paddington Square development on Trust services at St. Mary's Hospital - The risk has been presented with a proposed score of 9 (C3 x L3).
- An update on the outcome of discussion at the Executive Committee will be given during the meeting.

3. Corporate Risk register and Risk Appetite

- Following approval of the risk appetite statements in March 2018, a risk appetite operational framework is being developed and a further update will be presented at the next meeting.
- Risk appetite ratings will be included against each corporate risk
- This will support the Board considering the current level of residual risk in the context of the agreed level of risk appetite.

PART 2: Board Assurance Framework

The purpose of the Board assurance framework is to enable the Board and its committees to ensure that it receives assurance that all key risks are being effectively managed and to commission additional assurance where it identifies a gap in assurance. This process enables the Board to, inter alia, have confidence in its self-assessment of compliance with regulatory standards and in the year-end reporting.

The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

The latest version of the framework, attached at Appendix 2, reflects amendments made since the last review by the Committee in October 2017. In particular, following approval by the Trust board in March 2018 of the risk appetite statements, risk appetite ratings have been included on the board assurance framework.

Recommendations:

The Committee is asked to:

- Note the changes to the corporate risk register
- Note and agree current ratings within the board assurance framework.

This report has been discussed at:

- The Corporate Risk Register and the Board Assurance Framework have been discussed at the Audit, Risk and Governance Committee on the 4 July 2018.
- The Corporate risk register will be discussed at the Executive Committee on 24 July 2018.

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

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

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

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

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

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

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

Trust strategic objectives supported by this paper:

- To 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):
Please use the detail outlined in the Executive Summary.

Corporate Risk Register and Board Assurance Framework

1. Background and purpose

1.1. To date, separate reports have been presented for the Corporate Risk Register and the Board Assurance Framework to the Audit Risk and Governance Committee and the Trust Board.

1.2. In line with best practice and following a review with the Trust Board Secretary, the following report is a joint report on the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF).

1.3. The report seeks to align the BAF and CRR more closely, which is in line with best practice and over time will present a deeper analysis of risks and assurance.

1.4. The report provides an update on the Corporate Risk Register and includes a summary of key changes made since it was reviewed by the Trust Board on 28 March 2018.

1.5. Please refer to **Appendix 1** for a copy of the Trust's Corporate Risk Register.

1.6. It also provides an update on the BAF since it was last reviewed by the Board in May 2018.

1.7. Please refer to **Appendix 2** for a copy of the Trust's Board Assurance Framework.

PART 1: Corporate Risk Register

1. Background

The Trust Board reviewed the Corporate Risk Register at its meeting on 28 March 2018. The following governance process for risk management is in place within the Trust:

- **Directorate risk registers**; these are in place for all clinical directorates and are discussed and approved at directorate quality and safety meetings or equivalent; risks that cannot be managed locally are escalated to the divisional risk registers.
- **Divisional risk registers;** these are discussed and approved at the designated forums with responsibility for risk; in the clinical divisions these are the divisional Quality and Safety Committee.
    - Key divisional risks are escalated to the Executive Quality Committee monthly by the attending directors and relevant updates are brought to the Quality Committee at every meeting.
    - Key divisional risks from all (clinical and corporate) divisions are presented to the Executive quarterly.
- **Corporate risk register:** This is discussed and approved monthly at the Executive Committee, and is presented quarterly at the Audit, Risk and Governance Committee and six-monthly at the Trust Board.

Please refer to **Appendix 1** for a copy of the Corporate Risk Register, which reflects the changes summarised in this paper.

2. Changes to the Corporate Risk Register

- The following changes have been made to the corporate risk register and approved by the Executive Committee since it was last presented to the Board in March 2018.

2.1. Risks escalated onto the Corporate Risk Register

There have been a number of IT related risks that have been escalated, as follows:

- ***Risk 2613*** *– Risk of financial and reputational damage to the Trust resulting from failure to fully comply to the General Data Protection Regulation (GDPR), which became effective in May 2018. The GDPR is a Directive for the European Union that has been enacted in UK legislation.*
- The change in legislation to the GDPR will make Data Controllers more accountable for their data processing.
- Currently, Trust processes and systems are insufficient to ensure full compliance
- A business case for resources to improve compliance has been approved.
- There will be a wide ranging Trust Privacy Programme (TPP) initiation document produced and circulated to the Information Governance and Cyber Security Committee.

- The current risk score is 16 (C4 x L4).

- ***Risk 2677*** *- Risk of failure of Network Core devices as they reach End of Life*
- The Network Core devices provide the network backbone to all the primary Trust sites.
- The devices will come to end of life in November 2019.
- End of Life indicates that in the event of hardware component failure or security vulnerabilities requiring software updates, the manufacturer will no longer provide new parts or software updates.
- The current risk score is 20 (C5 x L4).

- ***Risk 2680*** *- Increased risk of PC failure due to delay in PC Replacement Programme*
- The Trust is currently running a desktop estate of 10,300 devices.
- Due to a lack of capital investment, there are a number of devices which are over 5 years old; this number is estimated to significantly rise by March 2019.
- The current risk score is 20 (C4 x L5).

- ***Risk 2681*** *- Loss of system availability due to Windows 7 end of life*
- The Trust currently has over 10.000 desktop computers that run on Windows 7. Microsoft support for Windows 7 will end on the 14 January 2020.
- As a result of the above, Microsoft will no longer provide security patches for known vulnerabilities to Windows 7 PCs after this date, which will increase the probability of a major cyber security incident resulting in loss of access to systems and/or loss of Trust or patient data.
- Clinical and Corporate application suppliers are also no longer designing applications for windows 7 and the Trust will not be able to leverage the benefits of new functionality in applications with Windows 7 moving forward.
- The current risk score is 20 (C4 x L5).

- In order to mitigate the above risks, a number of business cases are being developed for approval.

- One risk that is commercial in confidence has been escalated to the corporate risk register.

2.2. Changes to risk scores

- ***Risk 2487*** *- Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae)*
- The improved screening rate has been sustained for several months.
- A number of smaller CPE outbreaks have been identified and controlled

- Following a discussion at the Executive Operational Committee on 20 March 2018, the risk score has been decreased from 20 (C4 x L5) to 16 (C4 x L4), due to the likelihood of this risk materialising being reduced.
- The Target Risk Score date has also been extended to September 2018 to allow for completion of outstanding actions and improvement in performance.

2.3. Changes to Target Risk Score Dates

- ***Risk 2538*** *Risk of medication safety being adversely affected by poor adherence to medication safety policies*
- Medicines management standards have been launched along with revised audit standards.
- Key performance indicators have been agreed to be included in the 2018/19 quality account and the integrated scorecard.
- The first set of audits has been undertaken against the revised standards in July 2018 and further audits are planned.
- The target Risk Score date for this risk has subsequently changed to September 2018.

- ***Risk 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*
- Although the Trust carries the risks of having the patients remain in the Emergency Departments (ED) for an extended period of time, it can only influence and not resolve the primary cause of the delays (a lack of mental health beds)
- An internal thematic review of all declared Serious Incidents for mental health delays is being conducted to support a programme of work to improve the ED service for these patients.
- The Trust is working with the mental health Trust and commissioners to reduce delays for patients in ED.
- The target risk score date has therefore been changed to December 2018.

- ***Risk 2480*** *There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust*
- In view of the above, the target risk score date has been changed to September 2018.

- ***Risk 2557*** *Risk of using medical devices that are out of testing date due to lack of scheduled maintenance*
- Good progress has been made in testing equipment and the implementing of site based equipment libraries will support greater compliance.
- The equipment libraries will be implemented over the coming 9 months.

- The target risk score date has been changed to October 2018, to allow time to ensure improvement is sustained further to improvement demonstrated in maintenance performance.

- ***Risk 2490*** *Failure to deliver Safe and Effective Care*
- Improvement has been achieved across a number of areas, including compliance with VTE risk assessment and Duty of Candour.
- The Target Risk Score date has been extended to end of July 2018 to ensure that improvements are maintained and assurance received.

- ***Risk 2499*** *- Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff*
- A business case for the strategic supply of nursing staff has been approved
- The Target Risk Score date has been changed to September 2018 to allow for actions from the business case to be undertaken.

- ***Risk 2481*** *Failure to implement, manage and maintain an effective health and safety management system*
- There have been some delays in fully implementing a number of initiatives, including:
  - Workplace inspection regime (including the software-based system);
  - Non-safe sharps procurement regime;
  - 'Reducing overly wet floors'.
- Roll out has now begun on the above but is delayed in terms of full implementation due to resourcing, technical issues and, in the case of the 'wet floors', contractor performance issues.
- The Target Risk Score date has subsequently been changed to December 2018.

- ***Risk 2540*** *Risk of not achieving full compliance for Core Skills Training*
- Junior Doctors compliance remains below target levels
- New rotation of Junior Doctors will start between August and September 2018 who will have a month to complete mandatory training.
- The Target Risk Score date has subsequently been changed to October 2018.

- ***Risk 2473*** *Failure to maintain financial sustainability*
- High level plans are to achieve break even position in 2020/21 with continuous improvement in the underlying position from then on.
- This position is under review and will be firmed up as relevant strategies, long term financial and business plans are developed over the coming months.
- The Target Risk Score Date has been changed to March 2021.

- ***Risk 2482*** *Risk of cyber security threats to Trust data and infrastructure*

- The projected allocation of ICT capital for 2018/19 does not appear to be sufficient to maintain and update Trust ICT infrastructure to a level that will minimise our exposure to cyber threat
- The target risk score date has been changed to September 2018 to allow for the completion of actions as outlined in section 2.1 of this paper.

3. Outcome of discussion at the Executive Committee on 24 July 2018

- Due to the timing of this meeting, further discussion will occur at the Executive Committee on 24 July 2018.
- It is likely that the following risks will be escalated onto the Corporate Risk Register:
    - ***Risk 2714*** *- Failure to successfully implement the 2017/18 NHS e-Referral Service within timeframe*
    - The risk has been presented with a proposed score of 16 (C4 x L4).
    - ***Risk 2696*** *- Risk of inefficient management of ophthalmologic surgical patients following the planned Incorporation of Western Eye Hospital into Outpatient and Ophthalmology building (Triangle Building) as part of the Trust Redevelopment Programme.*
    - The risk has been presented with a proposed score of 9 (C3 x L3).
    - ***Risk 2697*** *- Impact of Paddington Square development on Trust services at St. Mary's Hospital*
    - The risk has been presented with a proposed score of 9 (C3 x L3).
- A verbal update on the outcome of discussion at the Executive Committee will be given during the meeting.

4. Corporate Risk register and Risk Appetite

- Following approval of the risk appetite statements in March 2018, a risk appetite operational framework is being developed and a further update will be presented at the next meeting.
- The risk appetite operational framework will be socialised throughout the Trust via existing forums/meetings within divisions and corporate areas. A communications plan will be developed to support this.
- Risk appetite ratings will be included against each corporate risk
- This will support the Board considering the current level of residual risk in the context of the agreed level of risk appetite.

PART 2: Board Assurance Framework

1. Background

1.1 Assurance goes to the heart of the work of any NHS Trust board. The Trust risk management policy and procedures provide the Board and the Committee with a robust framework by which they ensure that risk is successfully controlled and mitigated. Assurance is then the bedrock of evidence that gives confidence to the Board that risk is being effectively managed, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed. The purpose of the Board assurance framework is therefore to enable the Board and its committees to ensure that it receives assurance that all key risks are being effectively managed and to commission additional assurance where it identifies a gap in assurance. This process enables the Board to, inter alia, have confidence in its self-assessment of compliance with regulatory standards and in the year-end reporting.

1.2 The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

1.3 The framework was last reported to the Committee in October 2017 and to the Board in May 2018. This version reflects amendments made since that date. In particular, following approval by the Trust board in March 2018 of the risk appetite statements, risk appetite ratings have been included on the board assurance framework. So the Committee can now consider the current level of residual risk in the context of the agreed level of risk appetite.

1.4 For example, the current level of residual risk for 'recruitment and retention' is high, yet the risk appetite is low. The Committee should therefore consider the effectiveness of controls in place to mitigate this risk and the assurance being provided.

2. Changes to the Board Assurance Framework – additional assurances received

2.1 During the period since the last presentation of the framework, the Trust has received additional 2nd line and 3rd line assurances, summarised below:

- Data quality – the Trust has received the MBI data assurance report reviewing the quality of the Trust's data with regard to RTT reporting. This report is being presented to the Committee at this meeting.
- Data quality – the Committee will also consider at this meeting the findings and recommendations from internal audit reviews of PIC and Radiology, both providing limited assurance.
- Financial control – during the period since the last review the Trust has completed the submission of annual accounts and external audit of financial controls as part of this process.
- Information Governance & Security – at its meeting in May 2018, the Board approved the submission of the Trust's assessment of compliance with the ten

data security standards recommended by the National Data Guardian and set out within the Department of Health and Social care and NHS England Document "2017/18 Data Security and Protection Requirements" (replacing the NHS Digital's Information Governance Toolkit). The Board noted non-compliance with standards relating to 'Checking Supplier Certification', due to this being a new requirement.

Next Steps

- The corporate risk register will be presented to the Executive Committee on 28 August 2018.
- The corporate risk register and Board Assurance Framework will go to the Audit, Risk and Governance Committee in October 2018.
- The corporate risk register and Board Assurance Framework will be presented to the Trust Board in January 2019.

3. Recommendations

- Note the changes to the corporate risk register
- Note and agree the current ratings within the board assurance framework.

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Priya Rathod, Deputy Director of Quality Governance
Peter Jenkinson, Trust Company Secretary
Date: 18 July 2018.

Appendices: Appendix 1 - Corporate risk register
Appendix 2 - Board Assurance Framework

APPENDIX 3

Corporate Risk Register

Trust Board

Scoring Matrix

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

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

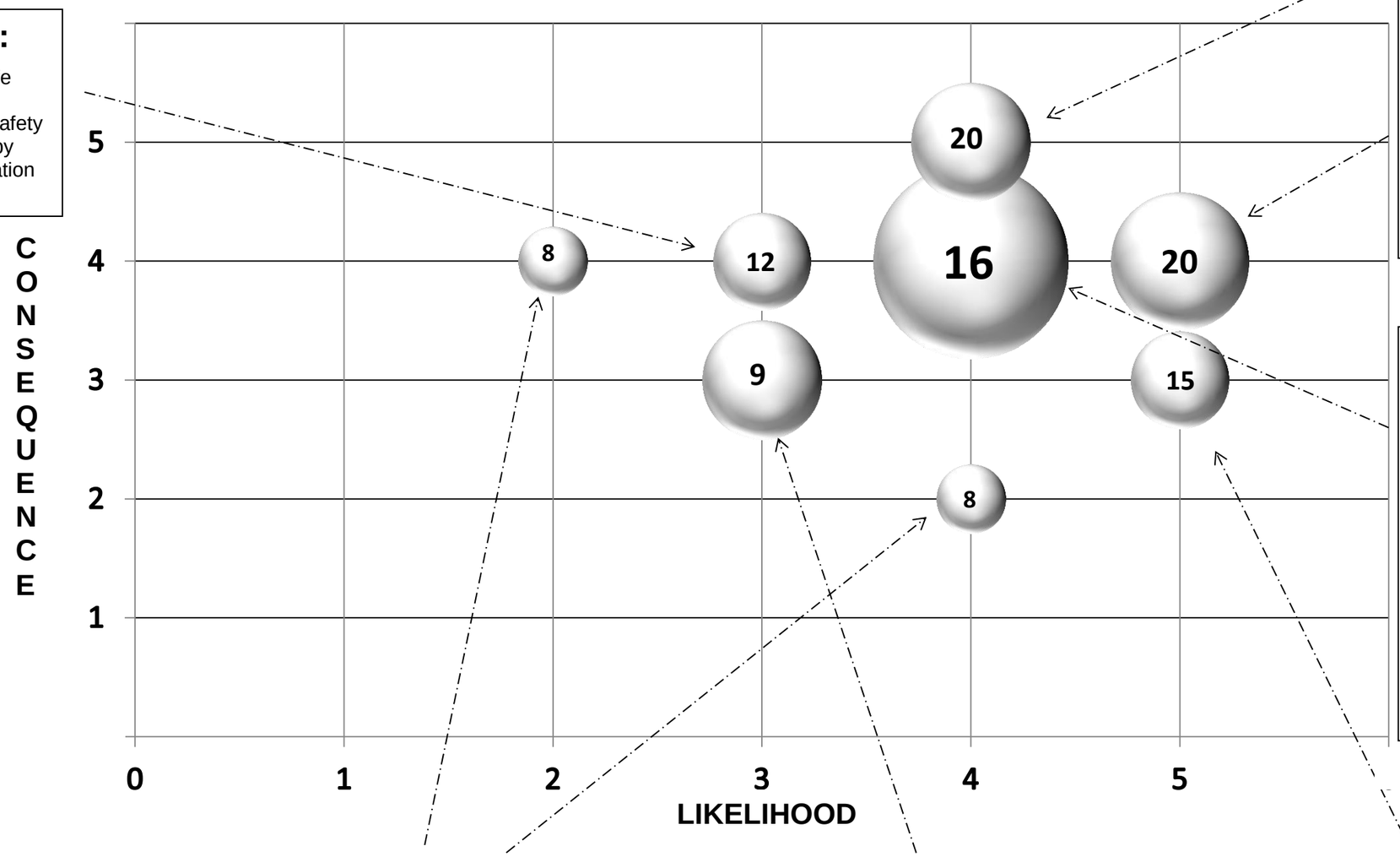
Key:

Initial Score: The score of the risk when first identified

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

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

Corporate Risk Profile



Risks scored 12:

1. 2490 Failure to deliver safe and effective care (4x3)
2. 2538 Risk of medication safety being adversely affected by poor adherence to medication safety policies (4x3)

Risks scored 20:

1. 2485 Failure of estates critical equipment and facilities (5x4)
2. 2473 Failure to maintain financial sustainability (5x4)
3. 2677 Risk of failure of Network Core devices as they reach End of Life (5x4)
4. 2510 Failure to maintain key operational performance standards (4x5)
5. 1660 Risk of delayed treatment to patients due to poor data quality (4x5)
6. 2681 Loss of system availability due to Windows 7 end of life (4x5)
7. 2680 Increased risk of PC failure due to delay in PC Replacement Programme (4x5)

Risks scored 16:

1. 2482 Risk of Cyber Security threats (4x4)
2. 2476 Failure to currently meet some of the High Dependency core standards (4x4)
3. 2498 Failure to gain funding approval for the redevelopment programme (4x4)
4. 2499 Failure to meet required or recommended Band 2-6 vacancy rate for N & M staff (4x4)
5. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards (4x4)
6. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (4x4)
7. 2613 Compliance with General Data Protection Regulation (GDPR) (4x4)

Risk scored 8:

1. 2475 Failure to actively identify educational issues (4x2)
2. 2489 Failure to develop and publish a refreshed Trust Clinical Strategy (2x4)

Risks scored 9:

1. 2481 Failure to implement, manage and maintain an effective health and safety management system (3x3)
2. 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 (3x3)
3. 2557 Risk of using medical devices that are out of testing date due to lack of scheduled maintenance (3x3)

Risk scored 15:

1. 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (3x5)
2. 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust (3x5)

Corporate Risk Register Dash Board

Page n.	Risk ID	CQC Domain	Risk Description	Lead Director	Date risk identified	≤6	8	9	10	12	15	16	20	25	Target Date
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion															
Page 4	2510	Responsive	Failure to maintain key operational performance standards	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS	Jun-07					●	¡		♦		*Under review*
Page 5	2538	Safe	Risk of medication safety being adversely affected by poor adherence to medication safety policies	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS Chief Executive	Nov-17	●				♦		¡			Sep-18
Page 6	2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC	Jun-16			●			¡♦				Dec-18
Page 7	2476	Safe Effective	Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust	Divisional Director of SCCs	Jun-16	●						¡♦			*Under review*
Page 8	2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Nursing	Dec-14		●					¡♦			Sep-18
Page 9	2480	Safe Responsive	There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust	Director of Nursing	Sep-17	●					¡♦				Sep-18
Page 10	2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing	Mar-11						●		¡♦		Mar-20
Page 11	2557	Safe Well Led	Risk of using medical devices that are out of testing date due to lack of scheduled maintenance	Director of Nursing	Nov-17	●		♦		¡					Oct-18
Page 12	2489	Well Led	Failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services and which is recognised and accepted by leaders of clinical services	Medical Director	Aug-17	●	¡♦								Jul-18
Page 13	2487	Safe	Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director	Jul-15			●		¡		♦←			Sep-18
Page 14	2490	Safe Effective	Failure to deliver safe and effective care	Medical Director	Oct-14		●			¡♦					Jul-18
Page 15	2499	Safe	Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff	Director of People & OD	Nov-16		●			¡		♦			Sep-18
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement															
Page 16	2475	Effective	Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results	Medical Director	Aug-17	●	♦			¡					Sep-18
Page 17	2481	Safe	Failure to implement, manage and maintain an effective health and safety management system	Director of People & OD	Oct-13	●		♦		¡					Dec-18
Page 18	2540	Safe Well Led	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	Director of People & OD	Dec-17	●		♦		¡					Oct-18
Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve															
Page 19	2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive	Oct-14		●			¡		♦			Dec-20
Trust Objective 5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance															
Page 20	2473	Well Led	Failure to maintain financial sustainability	Chief Financial Officer	Mar-12						●		¡♦		Mar-21
Page 21	2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer	Jul-15		●					¡♦			Sep-18
Page 22	1660	Well Led	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	Chief Information Officer	Jul-11					●			¡♦		Dec-18
Page 23	2613	Well Led	**NEW** Compliance with General Data Protection Regulation (GDPR)	Chief Information Officer	Feb-18		●					♦	¡		Mar-21
Page 24	2681	Well Led	**NEW** Loss of system availability due to Windows 7 end of life	Chief Information Officer	Jun-18				●				¡♦		Nov-19
Page 25	2680	Well Led	**NEW** Increased risk of PC failure due to delay in PC Replacement Programme	Chief Information Officer	Jun-18	●							¡♦		Dec-20
Page 26	2677	Well Led	**NEW** Risk of failure of Network Core devices as they reach End of Life	Chief Information Officer	Jun-18				●				¡♦		Nov-19

Key:

→ Arrow indicates movement since last report O Circle indicates target risk score ♦ Diamond indicates current score ¡ Indicates initial risk score * Star indicates new risk since last report

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain key operational performance standards including: Emergency Department (ED) target, Cancer waiting target, Diagnostic target and RTT target (Specifically for RTT – not delivering the Waiting List Improvement programme objectives). **Cause:** • Mismatch of accurate reporting and poor data quality due to implementation and embedding of new systems and processes. • Mismatch of capacity and demand¦ • Financial challenges¦ • Bed capacity across sites¦ • Volatility of non-elective demand • Increased requirements for elective RTT activity ¦ • Late discharges / delayed review by speciality doctors • Potential infection outbreak • Imaging capacity being lost due to equipment failure • Transfer of SMH UCC service to an external provider • Temporary Closure of beds on the SMH and CHX sites adding additional pressure • User related Data entry issues¦ • Cerner system issues • Lack of sufficient BI, Cerner/Cerner change and data warehouse resource • Lack of sufficient BI resource to manage emerging and backlog issues rapidly • Impact of winter bed pressures, including the request by NHSE to cancel elective patients in January 2018 to support emergency flow. **Effect:** • Reduced quality of patient experience / staff morale • Increased risk of clinical harm to patients waiting for a long time on waiting lists • Increased operational inefficiencies • Failure to meet contractual / regulatory / performance requirements and trajectories • Loss of reputation and reduced confidence from key stakeholders¦ • Delays to accessing services for patients • Elective patients on the waiting list have to be cancelled. • Delayed step downs from critical care. • Transfer of patients between sites impacting on patient experience • Increased cost pressures through funding of improvement programmes.	**15**	**20**	**12**	⇔	**Divisional Directors**	• ED Performance Reports • Outcome of review of ED performance with emergency care intensive support team (ECIST) • Delivery of the performance trajectory agreed with Commissioners • Local level scorecards • Outcome of internal peer review • Clinical harm review (MD Office and division) • Delivery of the performance trajectory agreed with Commissioners • WLIP performance reports and governance structures • Performance against agreed RTT and 52 week wait trajectories

Current Risk Controls

• Escalation to mental health providers¦ • Implementation of full capacity protocol
• Extended operational hours for ambulatory emergency care services at St Mary's and Charing Cross
• Escalation of ongoing issues with Vocare service to commissioners.
• Monthly Waiting List Improvement programme (WLIP) Steering Groups including Intensive Support Team (IST) NHSE and NWL CCG commissioners.
• Weekly WLIP management meetings and RTT meetings with General Managers to help ensure progress against actions and trajectories ¦ • Fortnightly CEO RTT meetings
• WLIP's development of 'Control of Current and Legacy Issues Framework' with regular tracking through the programme governance
• WLIP Programme Governance and oversight from Executive.
• RTT recovery planning and assurance process ¦ • Development of Elective Care Operating Framework
• 3 year MOU and funding agreement with Macmillan into cancer services
• Twice a year (May and November) internal peer review with all cancer MDTs
• Increased investment in cancer MDT Coordinators¦ • Investment into Somerset System (Cancer tracking tool)
• Imaging Reporting - Additional radiologist sessions to report on images and reduce turnaround time
• Monitoring forums¦ • Senior input into site operations¦ • Information peer review¦ • Clear escalation plans
• Participation in weekly sector operations executive ¦ • Development and implementation of site/clinical strategy
• Imaging Modalities - Additional ad hoc sessions based on voluntary overtime
• Prioritising of urgent inpatient and cancer 2WW patients ¦ • Fortnightly Task and Finish Group to support improved recruitment
• Weekly RTT Planning meetings held cross site for improved work flow co-ordination, service escalations, potential breach alerts and validation, resolution of in week challenges and sign off for 6 week and beyond capacity planning and review
• RTT IT utilisation project on-going to link service needs and IT capability of informing patient progression on pathways. Coupling efforts from Business Intelligence and Imaging data management processes
• Increased work of pathway reviews being undertaken through modality meetings led by Heads of Service.
• Endoscopy – Additional capacity in place to reduce backlog
• IT team have escalation process in place with Cerner through weekly meetings for managing system issues
• The development of RTT recovery and sustainability workstream within WLIP to address demand and capacity issues
• The development of Clinical Harm review workstream within WLIP
• Outsourcing of elective pathways to Independent sector to manage demand.
• Deployment of validation tool (Qubit phase1)¦ • Clinical Harm Standard Operating Procedure.

Mitigation Plan

Action:
Redevelopment of CXH Emergency Department *Due Date:* 29/03/19
Update on action:
Design phase initiated

Action:
Deliver the Waiting List Improvement Programme *Due Date:* 18/01/19
Update on action:
1) Daily / weekly GM portfolio review
2) Fortnightly CEO RTT meetings
3) Monthly MD office review clinical harm review / monthly divisional Q&S review
4) Monthly CCG/NHSI/E WLIP review meetings – service level trajectories / overview of legacy issues / ECOF and other work streams
5) Monthly POM meetings
6) CCG /NHSE submission
7) External RTT submissions
8) Key escalations to the Data Quality Steering Group for digital enhancement and action
   a. The increase in system errors on RTT PTL – working group established
   b. Cerner RTT clocks not starting on referral registration on outpatient encounters – Working Group established
   c. Progress on rationalising regular day attenders and diagnostics only pathways on the inpatient waiting list
   d. Follow up waiting list to be developed
   e. Next steps to make Outpatients waiting list operational to be completed
9) Workforce consultation in progress to centralise the Validation Team
10) Training and education plan pilot complete – deep dives at speciality level ongoing for targeted training
11) Working towards a performance management framework
   a. Metrics delivered for IPWL and RTT PTL,
   b. OPWL and Diagnistics metrics in progress
   c. Phase 2 – metrics to be used in weekly PTL meetings
12) Greater focus on patients waiting over 40 weeks to deliver trajectories by end of August
13) The next phase of the programme will focus on people, systems and processes.

Contingency Plans	Key Summary Updates & Challenges
• Agreed remedial action plan with commissioners for RTT and choose and book • Agreed trajectories for achieving RTT standard and reducing 52 week waits with external and internal stakeholders • ED recovery plan • Diagnostic trajectory plan being reviewed	Imaging - 22 breaches & 31 breaches declared by Imaging in May & June respectively. Imaging's DM01 position in May was 0.3% and 0.4% in June against the Trust tolerance of 1%. A total of 98 patients and 86 patients were outsourced in May & June respectively which has demonstrated a decrease. The current demand continues to be monitored. Whilst the number of unreported imaging examinations in May 2018 showed an increase to 3307 which is above the expected target , 396 unreported examinations were >2 weeks which has demonstrated a decrease when compared to the previous month. A&E - The NHS Improvement trajectory for A&E 4 Hour performance was met for Quarter 1 (April-June 2018) and the department is currently on track to meet the expected standard of performance for July 2018 (87.9%).

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of medication safety being negatively affected due to poor adherence to medication safety policies, particularly with regard to: • Effectiveness of medication storage • Security of medicines • Risk of expired medications in clinical areas. **Cause:** • Limited storage facilities, particularly IV fluids • Failure to monitor temperature of storage areas and fridges and document remedial actions • Inability to maintain required room temperature in some areas due to lack of temperature control / air conditioning. • Lack of secured access in some areas and response time from estates to redress • Failure to effectively check expiry dates of medicines • Failure to segregate and maintain personal control of CD keys. **Effect:** • Loss of medication • Tampering with medication by unauthorised people • Drugs may not be effective if stored incorrectly or expired • Failure to comply to statutory/ mandatory regulations related to medicines.	16	12	6	⇔	Divisional Directors	Storage audits Temperature audits Six-monthly drug stock security audit undertaken Compliance to medicines management training module on Wired

Current Risk Controls	Mitigation Plan
• Policy for Security, Safe Storage and Transport of Medicines includes a section on the safe storage of medicines • Annual bedside locker audit undertaken • Induction training • Medicines management mandatory training module • Pharmacy assistant checks stock cupboard for medicines expiry dates on a monthly basis • Application of a green expiry sticker if expiry is due in less than 6 months • Six-monthly control drug audits • Six-monthly safety and security audits • Monthly audit of fridge temperature monitoring.	**Action:** Delivery of the Medicine Management Improvement Plan *Due Date:* 28/09/18 **Update on action:** Action plan continues to be addressed through medicines management improvement group. As of April 18, a new group (medicines management communications working group)was formed to address actions related to updating and communicating guidance to staff in clinical areas. The over aching action plan has been updated to indicate this and a progress update will be provided following the meetings of these groups in May.

Contingency Plans	Key Summary Updates & Challenges
• Areas found to be significantly out of temperature range - consider relocation of Medicines,Increase stock rotation to reduce impact to individual medicine lines through prolonged exposure • Security issues; prioritise with estates for action • Increase	Extended Nurse Leadership Meeting held 28th June, including a presentation on importance of medicines management by Chief nurse and supported by project team - Materials co-designed showcased for feedback to nursing leadership - Medicines management standards launched along with audit standards on Symbiotix. 1st round of audits undertaken July 2018 - Medicines matters week planned for w/c 3rd September, including launch of materials

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues as a result of increasing volume of attendances and significant delays for those patients requiring admission to a mental health bed **Cause:** • Lack of mental health bed capacity • Delayed access to mental health input for patients in the department (for example the Home Treatment Team) **Effect:** • Extended stay for patients in a sub-optimal care environment for mental health patients (the Emergency Department)	15	15	9	⇔	Divisional Director of MIC	

Mitigation Plan

Action:
Summary paper to be presented to the next EM Governance meeting covering 12 months of incidents *Due Date:* 10/01/18
Update on action:
Action complete. The paper has been presented at both the EM Governance and Divisional Quality & Safety Committees.

Action:
To establish an agreed conference call covering the management of paediatric MH patients likely to require admission *Due Date:* 30/11/17
Update on action:
Action complete.

Current Risk Controls

• Reporting of all 12 hour trolley wait breaches as Serious Incidents.
• Agreeing and piloting a new escalation framework with commissioners.
• Meetings with the mental health trusts to raise concerns.
• Increased engagement from mental health Trust and CAMHS service in Serious Incident investigation process.
• Regular meetings with CNWL and ongoing engagement with mental health trusts and ICHT with regards to pathways and management of patient group.
• Escalation to the A&E Delivery Board.
• Escalation at Provider Oversight Meetings with NHS Improvement.
• Escalation of delays in real time to both the relevant mental health trust and commissioners.
• Augmenting the nursing establishment in the emergency departments with registered mental health nurses.
• Increasing the security presence in the emergency department at SMH.
• The establishment of a dedicated consultant lead for mental health in both emergency departments.
Ongoing discussions with the commissioners regarding liaison psychiatry role
• Conference call established for paediatric MH patients likely to require admission

Contingency Plans	Key Summary Updates & Challenges
Management within department with existing controls, ongoing investigation of serious incidents for 12 hour trolley wait incidents.	A further two investigations have been completed for CAMHS related delays with CAMHS involved in the investigation. A specific mental health safety round is to be developed. A thematic review of all declared Serious incidents for mental health delays is being conducted to support a programme of work to improve the ED service for these patients.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust	16	16	6	⇔	Director of SCCS	Weekly reports to the project board on progress against the standards

Cause:
• Poor Environment
• Poor equipment
• Insufficient level of staff trained to meet some of the standards set out by the CQC
• Lack of Staffing on the St Mary's Hospital Medical HDU
• Lack of Level 2 beds at Hammersmith Hospital
• Current level of medical cover does not meet standard for critical care
• Lack of Critical Care outreach team on the Hammersmith site
• Lack of medical cover on the medical high dependency unit at SMH and CXH, which does not meet the standard for Critical Care

Effect:
• Delivery of care provided to patients
• Patients being nursed in inappropriate areas due to lack of level 2 beds
• Inability to meet critical care standards on medical HDU with consequent impacts on patient safety.
• Inability to open additional capacity on demand and potentially impacts on staff activity and morale and patient safety.
• Possible unannounced CQC inspection

Current Risk Controls

• Review of the HDU's against the standards completed and paper written and reviewed at EX QU
• Meeting completed with Medical Director to agree immediate actions and review risk, date for further meeting agreed.
• Review of all incidents and SI's by critical care and two independent consultants
• Cover arrangements under review with Clinical Directors in relation to cover being provided out of hours SOPs to be produced for each unit, links with medical firms strengthened by surgical HDUs
• Options papers to Critical Care Committee to review long term options
• Patients are managed within existing medicine areas on the Hammersmith Site. C8 ward is operating as a level 1 area with monitored beds.
• Escalation of staffing issues within agreed framework. Early requests for bank shift and agency where required. Requests for cross coverage from other clinical areas.
• Current mitigations continue to be ICU support and use of Outreach. Outreach hours have been extended on CXH site and a proposal is in preparation to extend this to weekends and to HH. Outreach now established on all sites from 8am to 8pm Monday to Sunday.
• Cohorted level 2 /3 together at CXH – compliant with standards
• Clinical teams from medicine and ICU meeting daily to discuss inpatient cases to form a processes/relationships
Co-location of HDU areas on SMH site to completed 6th June 2018.

Mitigation Plan

Action:
Develop SOP for the management of the new High Dependency Units *Due Date:* 29/06/18
Update on action:
Action complete. Critical Care SOP, final version submitted.
Work has also commenced on the following clinical working groups – Vascular, General Surgery, Major Trauma/Neuro/Ortho/Spine, Post operative short stay environment.
HH Critical Care Service review with Options Appraisal circulated. Meeting to discuss to be set for end of July/August.

Action:
Recruitment to fill vacant posts on ward *Due Date:* 28/09/18
Update on action:
Nursing posts, mostly recruited into, however many staff still in the pipeline for these posts, including Student Nurses, who will not gain registration until September 2018. Nursing staff also require 5 weeks supernumerary training once in post.
Action due date subsequently changed to September 2018.

Action:
Critical Care to take over management of HDUs Trustwide *Due Date:* 29/06/18
Update on action:
Co-location of HDU areas on SMH site to completed 6th June 2018.

Contingency Plans	Key Summary Updates & Challenges
Continue to work towards an integrated model and utilisation of current services provided by the Site team and outreach.	Co-location of adult intensive care (level 3) beds and high dependency (level 2) beds at St Mary's Hospital has been completed successfully on the 6th June 2018. Project debrief meeting held on the 22nd June 2018. At meeting, project group de-established. Outstanding works noted and Risk Register updated, with risks moved to local Risk Registers. Need for Critical Care delivery group and KPI's to monitor effect of co-location raised.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC **Cause:** • Lack of organisational understanding and experience of the 2017/18 CQC regulatory approach which includes the 'well led' inspection and the annual provider information return. • Lack of robust systems and processes which enable the trust to achieve regulatory compliance and to drive improvement • Failure of staff to adhere to trust and local area policies, procedures, guidelines, etc. • Failure of staff to: o Seek and take account of regulatory advice o Participate in the trust's Improvement and Assurance Framework, and ensure action is taken in response to recommendations resulting from framework activities o Participate in the trust's Improvement and Assurance Framework • Lack of resource to support work and improvements relating to identified non-compliances and failures to deliver improvements **Effect:** • Reduction in the quality and safety of patient care: o Greater number of incidents relating to patient safety, and of potentially greater severity o Increase in poor patient experiences and complaints • Breach of regulatory requirements and failure to achieve regulatory standards	**16**	**16**	**8**	⟺	**Director of Nursing**	CQC inspections outcome and reports CQC Insight report and benchmarking data contained within it Performance on key quality indicators outlined in the quality report/trust scorecard Outcomes from internal reviews e.g. WAP/core service Outcomes from external reviews that are recognised by the CQC e.g. royal colleges, accreditation bodies, HTA etc. Patient feedback e.g. FFT results/surveys (local and national) Staff engagement survey results (local and national)

Current Risk Controls

• The trust has a dedicated Regulation Manager with a significant background in healthcare regulation, including experience with CQC inspections and the CQC's current regulatory approach
• A framework for managing CQC compliance has been in place at the trust since April 2015 (currently under review). The framework is aligned with the CQC's inspection methodology for NHS acute trusts and is adapted when the CQC make changes to their regulatory approach.
• Activities carried out under the framework during 2017/18 align with the CQC's new approach published in June 2017 and include:
o Quarterly checks to ensure the trust's CQC registration is kept up to date with services delivered by the Trust
o Regular meetings with the Trust's CQC relationship manager
o Managing preparation and submission to the CQC of the Trust's annual Provider Information Return (PIR)
▪ The PIR includes a self-assessment of core services and the Trust overall, against the CQC's domains
▪ Self-assessed ratings were debated and agreed by the Executive (Quality) Committee and Quality Committee
o Regular self-assessments against the CQC's five domains of care
o Ward accreditation programme for inpatient areas and main outpatient services
o Managing CQC inspections and supporting the Trust to respond to inspection findings
• Delivery of the framework and outcomes of framework activities are reported via divisional governance processes as well as to the Executive (Quality) Committee and Quality Committee, and the Trust board
• In addition to the Trust's Regulation Manager, other Trust staff have experience with the CQC including some who act as specialist advisors during CQC inspections of other organisations. The input and expertise of these staff are captured during development of the framework each year and during the carrying on of framework activities.
• Liaised with other trusts which improved their CQC ratings to learn best practice
• An 'Improving care programme' group has been established to look at delivery against CQC standards.

Mitigation Plan

Action:
To address core service inspection findings, a Trust wide work stream for medicines management has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:

Action:
To address core service inspection findings, a Trust wide work stream for medical devices has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:

Action:
To address core service inspection findings, a Trust wide work stream for statutory and mandatory training has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:
Core skills governance group in place since April 2018.

Action:
To address core service inspection findings, a Trust wide work stream for hand hygiene has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:

Action:
Divisional colleagues will take forward the specific 'must do' actions and will also take forward recommended 'should do' actions that are designed to get core services to 'good' and beyond. *Due Date:* 29/03/19
Update on action:

Action:
Actions required following the Well-led inspection which relate to equality and diversity and patient and public involvement will be taken forward and regular updates provided ot the Executive Quality CommitteeDivisional colleagues will take forward the specific 'must do' actions and will also take forward recommended 'should do' actions that are designed to get core services to 'good' and beyond. *Due Date:3/29/2019*
Update on action:
E&D actions go through E&D steering group. Director of Communications is leading the PPI group.

Action:
Development of the Trust's risk appetite, including internal audit on risk management re: board oversight of risk, is being taken forward following the Well-led inspection and regular updates will be provided to the Executive Quality Committee. *Due Date:* 29/03/19
Update on action:
Trust Risk Appetite agreed in March 2018 and added to BAF and CRR. Operational framework under development.

Action:
The next Leadership Forum will focus on CQC improvement activitiesDivisional colleagues will take forward the specific 'must do' actions and will also take forward recommended 'should do' actions that are designed to get core services to 'good' and beyond. *Due Date:* 31/05/18
Update on action:
Action complete. The previous Medical Director from University Hospitals Bristol NHS Foundation Trust (currently head of medical leadership at NHSI) to be invited as a keynote speaker

Action:
The revised improvement approach for CQC 2018/19 will be agreed early July with the exec teamDivisional colleagues will take forward the specific 'must do' actions and will also take forward recommended 'should do' actions that are designed to get core services to 'good' and beyond. *Due Date:*27/07/18
Update on action:
An 'Improving care programme' group has been established to look at 'getting to good and beyond. Meeting to take place two-weekly. First meeting took place on 02/07/2018.

Contingency Plans	Key Summary Updates & Challenges
• Commission external review and support, including other trusts, NHS Improvement, etc. • Work with commissioners where demand is outstripping capacity	There are four trustwide workstreams in place related to the common finding from Trust CQC inspections: hand hygiene, medical devices, medicines management and statutory and mandatory training. Robust governance and reporting are in place for these. A new group has been established to look at how to drive improvement at core service level. This will meet every two weeks.

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

Current Risk Controls	Mitigation Plan
• Contract with Sodexo to provide cleaning services in line with National Specification for Cleanliness in the NHS • Trust Cleaning Policy detailing responsibilities, methods and materials with reference to detailed procedures for specific tasks. • Comprehensive training schedule and modules provided by domestic services contractor Sodexo. • Scheduled regime of cleaning and auditing of standards conducted and reported on a weekly basis. Timetables are in place for cleaning within departments. Regular cleaning audits are performed with oversight from area clinical manager. • Advising on specific / specialist cleaning requirements. Educating staff about the importance of following the correct processes for decontamination and cleaning. • Escalation of issues by users to Cleaning provider and Facilities team. • Monthly contract review meetings between Facilities and Sodexo to monitor, review and agree any necessary actions related to quality and performance against contract. • Monthly report provided by Sodexo detailing results of cleaning audits including if audits are conducted in partnership with clinical staff. • Cleaning outcomes will be regularly monitored and reviewed to ensure the appropriate cleaning services are provided to each clinical activity. • Bi-monthly quality meetings between service providers and cross section of multi-disciplinary Trust staff • Additional senior cleaning resource from Sodexo in place since September 2017. • New Contract Manager commenced on site 5th February 2018 • Invoking contractual clauses to remedy failures	**Action:** Maintain and raise standards of cleaning *Due Date:* 31/12/18 **Update on action:** Progress has plateaued despite efforts of Trust staff to engage with Sodexo management at all levels. Regular meetings in place between Trust and Sodexo representatives to discuss actions.

Contingency Plans	Key Summary Updates & Challenges
• Invoke the terms and clauses of the Hotel Service Contract to impose escalations, rectifications and as appropriate breach of contract leading to possible termination of contract as follows: • Without prejudice to any other right or remedy it might have	

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

Current Risk Controls	Mitigation Plan
• Implementation of new Hard Facilities Management (Hard FM) Managed Service solution through specialist maintenance provider CBRE Ltd from 1/4/16 to provide improved compliance and responsive reactive repair maintenance service. • Retention of Senior Estates Management team structure to deliver 'informed client role' to ensure effective and compliant delivery of contract against specification and performance standards. • Statutory and regulatory inspections have been re-scheduled to ensure compliance with statutory and mandatory undertakings and to minimise impact on front line service • All planned (PPM) and reactive (repair) maintenance works managed through computer aided maintenance management system (CAMMS) to provide improved programming and management reporting. • ExCo updated on 10/10/15 of current Trust Backlog Maintenance Liability of £1.3b (total project investment costs) and request for £131m Capital Backlog Maintenance funding over the period 2016/2021 to mitigate high and significant risk items. • Successful delivery of 2015/16 Capital Backlog Maintenance programme to mitigate Risks ≥ 16 Investment programme funding of £14m subsequently reduced mid-year to £11.5mand programme re-profiled accordingly. Risk prioritised Projects to the value of £11m delivered. • The 2016/ 17 Capital Backlog Maintenance programme of £10.42m Capital Backlog Maintenance, plus £0.8m contingency has been allocated to target the highest risk areas focusing on addressing single points of failure, emergency plant, equipment and infrastructure upgrades. • £1.1m additional Capital funding allocated to upgrade HH electrical Infrastructure to support known increase in supply capacity requirements. • Formal reviews of Hard FM operational performance are conducted continually review performance against contract. • PLACE (Patient-Led Assessment of the Care Environment) lead by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works. • Monthly Estates & Facilities Quality Committee for closer collaborative working with front line services and appropriate reporting to monitor/improve performance. • Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services • Estates & Facilities H&S, Fire and Compliance committee has been established to formally report and monitor statutory/mandatory compliance. • Estates and facilities issues discussed three times a day on site calls so ensure timely resolution of any issues identified.	**Action:** Implementation of the 2017/18 Backlog Maintenance Programme *Due Date:* 30/03/18 **Update on action:** Good progress at Month 9. **Action:** Complete 2018/19 capital Backlog maintenance programme *Due Date:* 29/03/19 **Update on action:** Maintenance programme on track and to plan.
Contingency Plans	**Key Summary Updates & Challenges**
• Capital plan to align to clinical strategy within financial abilities • Major incident plan / sector wide contingency plans • Development and implementation of integrated business continuity plan • NHSLA insurance cover • Estates Strategy with conting	Bid for emergency Capital funding has been submitted.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of using medical devices that have not been tested due to lack of scheduled maintenance. **Cause:** • Users not aware of responsibility when using medical devices • Failure to register all medical devices; devices arriving in Trust through loans, trials and revenue purchases without the knowledge of Clinical Technical Services • Communication between maintenance providers and users ineffective • Lack of agreement on the use of Key Trainers • Unable to identify location of required medical device • Increased in inventory **Effect:** • Out of date maintenance of medical devices. • Risk to patients and staff safety if device breaks down during use • Poor patient experience due to delay of treatment leading to increased incidents reported • Increased cost of managed maintenance service contract • Failure to meet regulatory requirements	12	9	3	⇔	**Director of Nursing**	• Monthly report taken to MDMG to advise on KPI's of maintenance compliance. • Monthly report to MDMG on Datix incidents involving medical devices. • Quality check undertaken by CTS and reported at monthly contract review meeting.

Current Risk Controls	Mitigation Plan
• Medical device policy on management and training ratified and issued. • Training and Procurement & Standardisation MDMG subgroups implemented. • Introduced High, Medium and Low risk categories of medical devices to focus attention in key areas. • Radio Frequency Identification (RFID) introduced to track medical devices. • Implemented loan/trial process to regulate devices coming into the Trust.	**Action:** Introduce Radio Frequency Identification (RFID) to track medical devices. *Due Date:* 01/10/18 **Update on action:** RFID labelling complete and several hundred devices will need adding to equipment database. Integration of equipment and RFID databases complete and software being loaded onto laptops that will facilitate equipment audits. **Action:** Introduce E-learning package to inform users of safety issues when using medical devices *Due Date:* 06/08/18 **Update on action:** eLearning questions being finalised by MDMG training subgroup and then will be uploaded to Moodle for all staff to action **Action:** Achieve maintenance performance as agreed at MDMG *Due Date:* 31/10/18 **Update on action:** Performance for May 2018 is: • High Risk = 88% (target 98%) • Medium Risk = 79% (target 75%) • Low Risk = 78% (target 50%) This covers 24,535 assets Action is being taken to address the shortfall with respect to high risk devices and will be reported monthly

Contingency Plans	Key Summary Updates & Challenges
• Agency staff recruited to undertake backlog maintenance. • Arrange for suppliers to provide medical device training (potential cost). • Purchase/Loan additional medical devices	Maintenance performance is improving and consideration to reducing the risk will be undertaken assuming the performance continues to improve.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services for the medium to long term and which is recognised and accepted by leaders of clinical services. **Cause:** • Failure to conduct the agreed Specialty Review Programme and generate specialty specific strategies as an output of this process. • Lack of engagement with clinical and managerial staff due to operational pressures • Lack of support from commissioning colleagues • Lack of engagement from external stakeholders • Lack of clarity or progress with the planned estates redevelopment • Misalignment with the NW London STP • Misalignment with other key Trust strategies including Quality Strategy and financial strategy • Unknown / changing economic and demographic landscape affecting health care needs • Modelling assumptions for services are based on incorrect or inappropriate data • External stakeholders and public consultations do not support the proposed changes • Lack of finance and information capacity • Changes in senior leadership responsible for the SRP programme **Effect:** • Trust capacity for both elective and non-elective pathways remains constrained • Clinical services are not configured appropriately to optimise the space available as the estate is redeveloped resulting in sub-optimal clinical agencies • Unable to deliver highest possible quality of care • Failure to deliver services efficiently • Failure to grasp opportunities in development of personalised medicine • Inability to support integrated out of hospital care • Loss of market share • Unable to identify opportunities for and adopt new models of care • Unable to identify and reduce unwarranted variation • Poor patient experience and clinical care as not responding to changes in clinical practice and advances in clinical care • Failure to meet Trust strategic objectives • Failure to maintain high calibre employees • Loss of reputation with commissioners and public • Maintain focus as an organisational priority through regular report to the Executive Committee	**8**	**8**	**4**	⇔	**Medical Director**	• Clinical services are configured appropriately to optimise the space available as the estate is redeveloped • Improving patient experience • Delivering services efficiently • Able to support integrated out of hospital care • Identification and adoption of new models of care • Reduction in unwarranted variation • Good patient experience and clinical care • Meeting Trust strategic objectives • Maintaining high calibre employees

Current Risk Controls

• Medical Director is executive lead
• Deputy Medical Director (Interim Medical Director as of 4th December 2017) responsible for development of clinical strategy
• Specialty Review Programme (SRP) established in collaboration with CFO and Director of P&OD
• Improvement programme and associated change methodology in place
• Consultant in Public Health and Quality improvement appointed to lead the reducing unwarranted variation programme
• Links with Global Digital Excellence and Clinical Analytics
• Links with Estates Redevelopment Programme established – Deputy Medical Director is clinical lead
• Reporting established through clinical transformation sub-group to Executive Transformation Committee
• Links to STP clinical board through the Medical Director who is co-chair and Deputy Medical Director who represents the Trust.
• Engage with clinical specialties through the SRP to undertake horizon scanning in order to ensure the refreshed clinical strategy is sufficiently transformative & innovative to meet the need of the Trust over the medium to long term.

Mitigation Plan

Action:
Progress SRP & conclude clinical strategy workshops *Due Date:* 31/05/18
Update on action:
The final clinical strategy workshop as part of the SRP was held on 31/05/2017. This action is now complete.

Action:
Use outputs from SRP to develop a draft Clinical Strategy *Due Date:* 11/09/18
Update on action:
Following the completion of the Clinical Strategy SRP workshops in May 2018, an outline Clinical Strategy is currently being developed, utilising intelligence gathered from the SRP workshops to date, and will be presented to ExTra during Quarter 2 2018/19. This will include a draft approvals timeline and communications plan for the clinical strategy which will be developed in conjunction with relevant internal stakeholders. It was previously planned to bring the draft Clinical Strategy to ExTra in Quarter 1 2018/19 but this was not felt to be practical given that the Clinical Strategy SRP workshops were not yet complete. There is also an opportunity to better align the development of the Clinical Strategy with the evolving organisational strategy which was outlined at the Trust Leadership Forum in May 2018.
Due date updated to reflect the plan to take the outline clinical strategy to ExTra during Quarter 2 2018/19.

Action:
Begin to engage & consult with relevant internal and external stakeholders on the draft Clinical Strategy and make revisions where appropriate. The approach will be developed and agreed with the Director of Communications *Due Date:* 31/10/18
Update on action:
Due Date: 31/10/2018 (previously 15/06/2018). Updated to reflect the plan to take the outline clinical strategy to ExTra during Quarter 2 2018/19.

Action:
Gain approval for the Clinical Strategy from the Executive Committee & Trust Board within the Trust's defined governance arrangements. *Due Date:* 31/03/19
Update on action:
An approval timeline will be developed in conjunction with relevant internal stakeholders. A paper outlining the approach to developing the Clinical Strategy will be presented to the Executive Committee for approval which will include approval timescales and communications plan. Updated to reflect the plan to take the outline clinical strategy to ExTra during Quarter 2 2018/19)

Action:
Publish refreshed Clinical Strategy and communicate to staff, patients, the public and Trust partners *Due Date:* 01/04/19
Update on action:
The approach will be developed and agreed with the Director of Communications. An approval timeline will be developed in conjunction with relevant internal stakeholders. A paper outlining the approach to developing the Clinical Strategy will be presented to the Executive Committee for approval which will include approval timescales and communications plan. Due date updated to reflect the plan to take the outline clinical strategy to ExTra during Quarter 2 2018/19.

Contingency Plans

Utilisation of current clinical strategy and monitoring of progress with individual specialties through divisional governance structures.

Key Summary Updates & Challenges

The clinical strategy workshops as part of the Specialty Review Programme were completed at the end of May 2018.
An outline Clinical Strategy is currently being developed, utilising intelligence gathered from the SRP workshops to date, and will be presented to ExTra during Quarter 2 2018/19. This needs to be aligned with the ongoing development of the organisational stratgey. This will include a draft approvals timeline and communication outlineclinical strategy which will be developed in conjunction with relevant internal stakeholders. It was previously planned to bring the draft Clinical Strategy to ExTra in Quarter 1 2018/19 but this was not felt to be practical given that the Clinical Strategy SRP workshops were not yet complete. There is also an opportunity to better align the development of the Clinical Strategy with the evolving organisational strategy which was outlined at the Trust Leadership Forum in May 2018.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust. **Cause:** • CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, environmental hygiene, and optimised use of antibiotics. • Easy transmission from patient to patient will occur if correct IPC procedures are not followed. • With increased cases of CPE presenting to the Trust there is a risk for potential transmission and in particular in the renal, vascular and haematology cohorts with frequent admissions and outpatient appointments. • Current isolation capacity (sideroom capacity) insufficient to implement the PHE toolkit recommendations. • Recent changes in the spectrum of CPE producing organisms with increasing identification of CPE in Citrobacter and Enterobacter species with increased pressure on isolation facilities and infection teams to trace potential transmission • Location of services across the Trust for diagnostics and treatments, resulting in a frequent need for cross-site transfer. • Estates not ideal for IPC practice, compounded by backlog maintenance issues. **Effect:** • Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotic choices for treatment and ultimately worse patient outcomes. • Increased demand for isolation facilities, potentially exceeding available capacity more frequently, and risking the spread of other organisms between patients. • This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage. • Increased movement of patients and possible transmission during these movements for diagnostics and treatments. Estates issues being addressed slowly where transmission of CPE has occurred means increased risk of further transmission, particularly in toilets and bathrooms.	**12**	**16**	**9**		**Medical Director**	• High level of compliance with CPE admission screening(>90%) • No increase in CPE BSIs • Reduction in the use of carbapeneme antibiotics where there is no indication • No endemicity of CPE within our patient population • No increase in demand for isolation facilities

Current Risk Controls

• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship.
• The Trust has a CPE Policy in place, and has patient and staff information available on the Source.
• Flagging system on CERNER for identifying known carriers is in place.
• Serious Incident investigation following transmission events and ward closures resulting in increased emphasis on hand hygiene, environmental improvements and cleaning.
• CPE management is discussed weekly at the HCAI Taskforce meeting
• CPE action plan has been revised in light of recent increases in CPE.
• CPE screening data now available at ward level through the IPC scorecard and is included in the harm free care reports. Patient level CPE screening is not routinely available for all clinical areas, but can be provided upon request to clinical areas who wish to review patient level data.

Mitigation Plan

Action:
6 monthly antibiotic point prevalence audit to monitor correct antibiotic use *Due Date:* 28/02/18
Update on action:
Action complete. The antibiotic point prevalence was performed in Feb 2018; all indicators of antibiotic prescribing quality are in excess of the target level of 90%. The next antibiotic point prevalence survey will be conducted in Q2 2018/19.

Action:
Revised Trust CPE action plan to be developed and implemented due to the recent increase in risk score *Due Date:* 01/09/18
Update on action:
The action plan is implemented in the main, with a small number of actions still in progress. An update is due to quality and safety subgroup in July.

Action:
Development of an in-house HPV decontamination service *Due Date:* 01/09/18
Update on action:
The tender process for the HPV.UV decontamination service is being explored.

Action:
Patient level review of recent CPE screening data using a standardised template in high risk clinical areas *Due Date:* 27/10/17
Update on action:
Completed

Action:
Implementation of a CPE screening tool through Cerner *Due Date:* 01/09/18
Update on action:
CPE screening tool is visible on Cerner but not correct. The timeline for correcting these issues brings us to Q2 2018 due to a freeze on Cerner developments.

Contingency Plans

• The Trust has in place a local contingency plan to implement ward-level cohorting in the renal speciality.
• Seek guidance and support from NHSE and PHE.

Key Summary Updates & Challenges

There continues to be a number of patients who screen positive for a CPE organism in various locations within the organisation, the risk date has been extended to September 2018 to complete the outstanding actions. CPE outbreaks are ongoing in haematology at HH, and ID/medicine ward at HH.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to deliver safe and effective care in respect of: • Investigation processes • Incident reporting and Serious Incidents • Occurrences of Never Events • Deteriorating HSMR & SHMI and rising mortality alerts • Infection Prevention & Control • CAS alerts Compliance with: • NICE guidance and standards • National audits • Clinical guidelines **Cause:** • Appropriate governance process not in place • Visibility of current compliance not available or known • Insufficient resource in place to manage the process • Non-compliance with Trust policies and procedures • Non-compliant with surgical WHO checklist • Continued change in HCAI landscape • Increasing incidence of antimicrobial resistance **Effect:** • Unable to demonstrate that practice is evidence based • Limited oversight of externally reported data • Inability to demonstrate adequate audit trail • Unable to benchmark care against peers • Increase in SIs and Never Events • Increased mortality rates • Increased potential for Healthcare Acquired Infection (HCAI)	**12**	**12**	**8**	⇔	**Medical Director**	Incidents HCAI rates Complaints/Claims Succesful delivery of quality strategy goals and targets Clinical Audit programme delivery

Current Risk Controls

• Associate Medical Directors for Safety and Infection Prevention & Control in post
• Executive responsibility for clinical governance revised
• A new centralised safety and effectiveness structure was implemented in September 2016 to ensure streamlined management and governance
• Compliance and improvement monitoring governance process through the Executive Quality Committee (ExQu) in place
• Trustwide reports including performance data in place
• Root cause analysis and learning from incidents
• Weekly incident review meeting with Medical Director
• Quality Accounts to be published in June 2018 (aligned with the 2015/2018 Quality Strategy)
• Quarterly IPC report to ExQu and Quality Committee in place
• Quality Strategy published and QI programme in place (new 2018 - 2021 Quality Strategy currently under development, due to be published Q3 2018)
• Trust Quality & Safety Sub-group established in June 2016, reporting to Executive Quality Committee
• Action plans for areas of key risk in place and monitored through sub-group.
• A process for the management of high risk SIs, inquests and claims has been implemented, which is reported monthly.
• Safety culture programme project plan established – it has been informed by intelligence gathered through research and experience from organisations at national and international level, incident themes and learning, safety culture workshops, staff surveys and work conducted with staff in theatres through the safer surgery work. Current work includes a programme to improve incident reporting, and nine safety priority areas called 'safety streams' which have associated action plans.
• Actions in place to improve the assessment and management processes for VTE through the Thrombosis Committee and VTE Working group. VTE RCA SOP has been developed and agreed with divisions. The deputy medical director has developed a detailed action plan, which is being monitored via the Q&S subgroup.
• Strategies for ANTT and hand hygiene improvement approved by Quality & Safety Sub-Group in February 2017. Implementation commenced in March 2017 with a training programme for staff. The new hand hygiene audit process went live in April 2017. Progress is being monitored through the sub-group with exception reporting to ExQu.

Mitigation Plan

Action:
Achieve 95% compliance for Duty of Candour online training for consultants *Due Date:* 31/08/18
Update on action:
Mandatory online training has been in place for nurses at Band 7 and above, and all consultants since June 2017. However. a Trustwide review of all core skills training is currently taking place which includes work to cleanse denominators. Until this piece of work is completed it has been agreed with the divisions that we will only report on consultant compliance (who are ultimately responsible for DOC). Divisions are responsible for ensuring compliance and it was agreed with them that 100% compliance should be achieved by March 2018 as part of the annual appraisal cycle. Data is being circulated to divisions on a monthly basis so that they can track progress and meet the target as agreed, however, Divisions continue to be below the 95% target. Whilst small improvements have been made, as of 14th June 2018 consultant compliance is 63% MIC, 62% SCC and 72% WCCS.

Action:
100% compliance with duty of candour requirements for all serious incidents *Due Date:* 20/06/18
Update on action:
Although performance is improving challenges remain in meeting the 100% target, in particular for moderate harm and above where a serious incident is not declared. Clinician engagement with the patient facing conversation is good however is variable in sending letters which can cause delay.

Action:
Action plan to be put into place to ensure implementation of the Learning from Deaths framework within the timeframe stipulated by NHSE *Due Date:* 30/03/18
Update on action:
Action complete - compliance will continue to be monitored on the directorate risk register.

Action:
SI process review *Due Date:* 31/08/18
Update on action:
The entire SI process is under review through a multi-stakeholder quality improvement programme; this work commenced in June 2017 which aims to increase our capability and capacity to undertake robust and high quality investigations of serious incidents. A programme of training and development for SI investigations and quality assurance of reports commenced in December 2017 and is on going. There are further training dates commissioned for July and September, on completion of these dates over 200 members of staff will completed the training This training will ensure more consistent processes for investigations and the development of SMART actions to mitigate recurrence. A revised SI template is being piloted in March and April; the finalised version will be implemented August. An operational tracker is now in place which will assist divisional teams to identify slippage in key milestones for serious incident investigations which could result in delays to reports being finalised.

Action:
Retrospective look-back of compliance with NICE guidance *Due Date:* 30/11/17
Update on action:
The divisions continued to undertake the look-back exercise to determine compliance with NICE guidance published in 2016/17 as well as the guidance published so far during 2017/18. WCCS have now completed their review of all NICE guidance from 2016/17. MIC and SCCS still have guidance reviews outstanding, but progress is being overseen by the Quality and Safety sub-group.

Action:
Trust clinical audit plan outcomes *Due Date:* 30/03/18
Update on action:
The clinical audit plan is in place and underway. The reporting and review process will be agreed at the outset for each trustwide priority audit. These will usually be reported via the CAEG with reporting by exception to sub group however, where there are particular areas of concern to the organisation or where wider trust consultation and review are required, audits and action plans may be selected for review at the Q&S subgroup meeting.This action is complete and will continue to be monitored through the divisional risk register.

Action:
Assess at least 95% of all patients for risk of venous thromboembolism *Due Date:* 28/09/18
Update on action:
After a dip in performance in March (94.56%) due to specific issues in maternity and CDU wards, compliance has improved. Performance in April was 95.8% and in May is 95.78% The month to date performance for June is currently 96.53%. Progress is monitored through the integrated quality and performance report. Once compliance has been achieved for 6 months in a row this action on the corporate risk will be downgraded to the divisional risk register – the action due date has been extended to reflect this (from May 2018 to September 2018). The TIAA audit results showed substantial assurance.

Action:
Safer surgery task and finish group and action plan *Due Date:* 30/12/17
Update on action:
Trust level results of the WHO checklist observational audit carried out in Q1 2017/18 showed varied performance, with some specialties making significant improvements in particular areas, and other areas which are more challenged. The safer surgery task and finish group ended in December 2017 as planned, with leadership continuing by the trust lead surgeon as part of the safety stream. The new approach to the safer surgery work was approved at executive quality committee in April with a shift in focus from reducing never events and serious incidents to improving culture in theatres and in areas where invasive procedures are undertaken. Reducing SIs will be an outcome of this work rather than the aim. The final proposal is due to be presented to ExQu in July 2018. Targeted monthly auditing of WHO checklist compliance in specialties, divisional actions plans and a trust wide priority audit plan continues.
The next Trustwide observational audit will take place in Q2 2018/19.

Contingency Plans

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

Key Summary Updates & Challenges

Work continues across a number of areas. Two actions this month have been completed and will continue to be monitored on the divisional/directorate risk register. Compliance with duty of candour requirements show ongoing improvement, and after a dip in performance for VTE assessment compliance has now returned to above target. If improvements are maintained these actions will be closed on the corporate risk register, and continue to be monitored on the divisional risk registers.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to meet required or recommended vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff **Cause:** • National shortage of N&M in some disciplines • Conflicting operational priorities slowing down recruitment process. • Competition from neighbouring Trusts attracting potential employees • High turnover especially for Band 2 & 6 & N&M staff • High turnover of Band 5& 6 N&M staff within two years of joining • Tier 2 visa requirements • The increase in emergency activity has resulted in additional capacity which requires the recruitment of staff. • Additional beds opened • Planning for additional posts is reactive compared to planning for additional beds **Effect:** • Reduced staff morale /increased turnover /Increased rates of sick absence – vicious circle • Increased bank and agency usage • Poor patient experience • Poor organisational performance • Inability to recruit high quality candidates • Potentially increased incidents	**12**	**16**	**8**	⇔	**Director of P&OD**	Workforce Establishment & Vacancy Indicators (QlikView) People KPI (QlikView) Benchmarking ICHT performance against neighbouring organisations, with a target to 13% vacancies across all nursing and midwifery

Current Risk Controls

• Restructured recruitment teams in place to reduce the total time to hire. Additional checks being monitored daily to increase the pace & quality of activity. Three Resourcing Business Partners have been added to the team act as account managers for Divisions, run centralised campaigns and also manage campaigns for hard to recruit areas.
• Monthly meetings in place with Divisions to review vacancy rate, recruitment activity and impact of this
• Recruitment and attraction strategy and plan in place which focuses on Divisional (rolling adverts and bespoke strategies) and across Trust activity (Student Nurse campaign and Open Days), as well as broadening channels used to increase the pipeline
• All current vacancies for nursing in key areas advertised
• Safe staffing on wards monitored through monthly fill rate reports for nursing by division.
• Bank and agency support available
• Monthly exception reports now produced for Divisional Quality and Safety Committee
• A new revised retention plan is being developed to reduce the turnover for all N&M staff and for Band 2-6 ward based staff
• Associate Director of HR Operations and Resourcing working with Business Partners to monitor vacancy levels.
• Resourcing & Retention Task and Finish Group established, chaired by the Director of People & Organisation Development. Ward by ward focus and action plan to fill vacancies.
• Procedures implemented to manage establishment, staffing, sickness & turnover information
• SOP for switching off posts in place
• Careers clinic and students' automatic offers workstreams implemented in September 2017.
• Brand and attraction strategy reviewed; attraction strategy for newly qualified nurses and enhanced international recruitment in place

Mitigation Plan

Action:
Enhance the reward & benefits scheme to support recruitment and retention strategies. To include further developing flexible recruitment & retention premium (RRP), exploring flexible benefits as part of RRP and benchmarking Trust offer with competitors *Due Date:* 31/12/18
Update on action:
A market sensitive supplement policy has been drafted and will be available on the Source.

Action:
Implement a range of tool and interventions internally to encourage current Band 5/6 to stay longer. This will be supported by the implementation of a Steering Group for Nurse leadership Band 5/6 development and new exit interviews *Due Date:* 30/11/17
Update on action:
Action complete. A number of actions identified, including the new Springboard leadership programme for Band 5/6 nurses, which has been launched. The take up has been good, with another cohort starting later this year.

Action:
Review current development and support for nurses during and after Preceptorship, through a review of the Preceptorship scheme and Capital Nurse Rotation Programme *Due Date:* 30/11/17
Update on action:
Nurse retention is improving and the Preceptorship programme has been in place for one year. The take up of the Capital Nurse Rotation Programme is good and this has inspired more local rotations.

Action:
Develop a 1-3 year workforce plan for the N&M population *Due Date:* 31/07/18
Update on action:
The Executive Operational Performance Committee approved the proposed plan and funding.

Action:
Develop project plans that address the vacancy, turnover and sickness issues in the clinical divisions, ensure they are implemented including a self-assessment checklist for retention initiatives. *Due Date:* 30/11/17
Update on action:
All divisions have plans in place and these are being regularly reviewed and updated.

Contingency Plans

• Continue to monitor impact of changes and implement further corrective measures as needed
• Use of Bank & Agency staff
• Reduction in activity
• Escalation of staffing issues through divisional management structure and site team
• Early identification

Key Summary Updates & Challenges

The Recruitment & Retention action plan has been agreed and work has commenced:
• A comprehensive attraction strategy is in place including rolling adverts, open days, fairs, quarterly recruitment campaigns and a proactive student attraction strategy. For hard to recruit areas, recruitment videos have been developed and attached to job adverts
• Work is underway to enhance the careers site. A procurement process for a new recruitment system has also started. The functionality of a new recruitment system will enable the recruitment team to be more proactive in the sourcing and attraction of candidates
• The monthly strategic planning meetings has been extended to cover the recruitment of hard to recruit areas and allied health professionals as well as N&M staff
• The Recruitment & Retention project team are part of the NHS Improvement national pilot programme (COHORT 3) for improving retention across the NHS. Being part of this pilot will enhance the Trust's ability to track and manage retention in the Trust
• The target vacancy rate has been amended to 13% across all nursing and midwifery. This is more achievable than the previous target of 12% and is a more accurate reflection of where we will be
• The target turnover rate has been amended to 13% (previously 14%). The Trust will be changing the way leavers are processed on ESR. Historically when a substantive member of staff leaves the organisation but remained on the bank, they were not processed as a leaver. Going forward, staff leaving a substantive post will be processed as a leaver and a new ESR record will be set up if they wish to work on the bank. This will enable more accurate reporting of turnover
The overall vacancy rate for all Nursing & Midwifery at the end of May 2018 was 14.7% for all bands.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results **Cause:** • Inadequate communication within the Medical Education team failing to ensure issues are shared and discussed in a timely way • Ineffective Local Faculty Groups (LFGs) • Lack of functioning escalation processes from LFGs to senior management team • Poor engagement with trainees/students with minimal feedback or multiple avenues of feedback leading to lack of clarity • Ineffective monitoring processes for actions developed in response to surveys/feedback/exception reporting **Effect:** • Deterioration in SOLE (student online evaluation tool) results • Deterioration in General Medical Council (GMC) survey results • Increased monitoring from external bodies e.g. GMC, Health Education England (HEE) • Failure to provide high quality learning and training environments • Failure to deliver high quality training • Reduction in medical student and postgraduate trainee posts commissioned by Imperial College or HEE • Damage to reputation as a world class medical education provider • Risk of trainees being removed • Failure to support trainers effectively	**12**	**8**	**6**	⇔	**Medical Director**	• GMC NTS results • SOLE results • Reduced numbers of patient safety/bullying & undermining concerns raised through GMC NTS • Retention of trainees

Current Risk Controls

• Established LFGs in each specialty with standardised agendas and admin support
• Associate Medical Director (AMD) in post, reporting to the medical director
• Directors of Medical Education (DME) in post for each divisions with effective engagement with Divisional Directors and divisional committees
• DCSs in post for each site with regular meetings with DMEs and AMD
• Education specialty review process in place, with regular monitoring of specialities where there are concerns
• Effective monitoring of Action plans in response to GMC and SOLE surveys - through LFGs and escalated where action not complete.
• Regular meetings between Director of Clinical Studies (DCS) and AMD
• Unit training leads for each specialty effective members of the directorate boards
• Process in place for escalation of issues from LFGs to DMEs via UTLs
• Trainee reps engaged with each LFG
• Medical Education Committee in place, reporting to Trust Education Committee and Executive Quality Committee
• Appointment and engagement of senior specialty trainees in all specialties to link service, education
• Multiple avenues for feedback from trainees, including monthly junior doctor forums chaired by the Guardian of Safe Working (GoSW)
• Strengthened senior management in postteam to support AMD/DMEs/DCS' etc.
• Monthly review of exception reports
• Education Workforce Committee
• Protecting Educational Programme Activities (EPAs) in job plans
• Providing new starters with a good quality induction
• Day One Ready Steering Group continuing fortnightly

Mitigation Plan

Action:
Clarify escalation processes for education issues identified within specialties and ensure remedial process is in place *Due Date:* 18/07/18
Update on action:
Action complete.

Action:
Develop action plans for areas of concern in NTS not externally reported and monitor through LFGs, with reporting to Medical Education Committee *Due Date:* 31/08/18
Update on action:
Action complete for 2017. Internal action plans developed, progress being monitored at local faculty group meetings and education specialty reviews
GMC results anticipated 9th July 2018 then commence annual specialty leveleducation reviews process

Action:
Ensure clarity of all opportunities for all trainees/medical students to provide feedback throughout the year *Due Date:* 30/11/17
Update on action:
A programme for medical student feedback sessions has been developed to provide an opportunity to enhance the feedback received from SOLE results
Trainee meetings (deep dives) are held prior to education specialty reviews, further opportunities for feedback are provided at regular intervals during the academic year.
Action closed.

Action:
Education report part of performance review of Divisions *Due Date:* 30/09/18
Update on action:
Education specialty review process started. Specialty review programme also occurring, administered by the Medical Directors Office.
06/06/18 Education reviews completed for 2017.

Action:
All specialties to have elected senior specialty trainees. *Due Date:* 31/10/18
Update on action:
76% of specialties have confirmed senior trainees have been allocated to this role. Training day postponed until Autumn 2018 (after changeover)

Action:
Review of education structure to ensure adequate support for clinical leaders and strengthen accountability. *Due Date:* 31/10/18
Update on action:
Action in progress

Contingency Plans

Re-establish annual educational specialty review process for all specialties chaired by the medical director

Key Summary Updates & Challenges

Action plans remain open for cardiology, haematology, intensive care medicine and oncology, which are being monitored through the local faculty group meetings. These specialities will have follow up education review meetings scheduled, once the GMC NTS results have been published (anticipated early July 2018).
The annual Undergraduate Governance Visit has concluded and we continue to work with the College to ensure a robust governance structure is in place for undergraduate education.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
• Failure to implement, manage and maintain an effective health and safety management system including: • Appropriate health and safety policies, procedures and safe systems of work • Risk assessments and risk control measures • Information, instruction, training, support and supervision • Monitoring, measuring and auditing • Governance and assurance arrangements In order to protect the health, safety, and wellbeing of employees, contractors, students, patients and visitors whilst at or on behalf of the Trust. **Cause:** • Lack of appropriate and effective H&S management structures • Lack of appropriate H&S information and guidance – including policies, procedures and safe system of work • Lack of induction, job specific and refresher training • Lack of management ownership and accountability • Poor employee engagement, awareness and culture • Lack of competent H&S advice and resources • Failure to report and investigate accidents/incidents/near misses **Effect:** • Increase in accidents, incidents and ill health • Damage to property and equipment • Impact on business continuity • Reduced morale, quality & productivity • Increased rates of sickness absence due to injuries and ill health • Poor patient experience • Poor reputation with regulatory bodies such as HSE and CQC	**12**	**9**	**4**		**Director of P&OD**	(Reductions in) the incident rate of the most significant risks, which are: violence; slips, trips and falls; and sharps. Health and safety regular performance reporting at Divisional and Trust-wide level e.g. respectively, in the Division Quality and Safety Committees and the Trust Strategic Health and Safety Committee

Current Risk Controls

• Fully staffed Health and Safety Service
• Strategic Health and Safety Committee
• Division/Corporate Functions Health and Safety Committees/ Quality and Safety Committees
• Divisional Health and Safety Leads
• Departmental Safety Coordinators
• Accident/incident reporting via DATIX
• H&S risk assessments undertaken and recorded on Assessnet
• Trust and Divisional Health and Safety dashboards
• Health and safety training, including Health and Safety e-learning, Manual handling training, Fire Safety training
• Periodic updates to Executive (Quality) Committee and Quality Committee
• Readily accessible H&S information e.g. webpages on Source
• Health and safety policy, supported by Division local procedures

Mitigation Plan

Action:
Implement all aspects of the slips, trips and falls incident reduction action plan *Due Date:* 28/12/18
Update on action:
Delayed indefinitely, due to issues identified with Sodexo. This will be reviewed periodically to see if there is any progress

Action:
Implement effective Violence incidence reduction plan *Due Date:* 30/03/18
Update on action:
This is an ongoing action which is now managed by the Security Committee. Although the statistics on Violence show no reduction in the incidence of violence, the matters requiring attention to being the risk of violence more under control are now evident

Action:
Devise and implement appropriate sharps incidence reduction plan *Due Date:* 30/04/18
Update on action:
Roll out of new non-safe sharps procurement process has begun. Comms went out on the Source on Tuesday 15th May. Health and Safety service managers to set up meetings with the directorates that want additional support with its implementation

Action:
Recruit to the vacant H&S Manager post *Due Date:* 26/01/18
Update on action:
Action complete.

Action:
Roll out completely the Qualsys Workplace inspection software tool *Due Date:* 28/09/18
Update on action:
Pilot underway in P&OD and part of W&C

Contingency Plans

• Prioritise and utilise internal H&S expertise e.g. DSCs, Security, Trade Union Reps (external additional support may be required)
• Monitor effectiveness of health and safety action plans

Key Summary Updates & Challenges

Issues with Sodexo performing their contractual duties with the Trust are making the delivery of the slips trips and falls incident reduction plan challening.

Trial of the software workplace inspection tool continues. Tablets purchased to facilitate the recording of inspection findings whilst 'on the go'

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
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. **Cause:** • Staff have not completed their e-learning modules or attended the right classroom training frequently enough to remain compliant. • Failure to check individual compliance reports • Difficulty to release staff from clinical duty • IT systems currently used for mandatory training monitoring are non-integrated and can provide inconsistent figures. **Effect:** • Unsafe environment for patients and staff if staff are unaware of good practice standards.	12	9	6	⇔	**Director of P&OD**	The 3 metrics are reported monthly to the Executive Committee: • Core 10 compliance • Core Clinical skills compliance • Junior doctors compliance

Current Risk Controls

• Communication of Performance levels at individual, team, department and Divisional level via WIRED and Divisional/Executive reports.
• Link to PDR and Consultant appraisal; up to date compliance is a pre requisite for a "Good" PDR rating and a successful consultant appraisal. It is also linked to being awarded study leave for any other topic.
• Communication campaigns to promote topics via In Brief, Leadership briefing and other communication tools.
• Restriction to study leave allowance for staff who have not completed their mandatory training.

Mitigation Plan

Action:
Complete Business case to upgrade/replace current learning management systems *Due Date:* 31/01/18
Update on action:
Business Case approved and procurement process is now underway.

Action:
Secure funding for a Data cleanse of Medical staff data on ESR to provide better management of junior doctors compliance data *Due Date:* 28/09/18
Update on action:
Data cleanse in in progress. Due date postponed from June to September 2018.

Action:
Establish Core Skills Governance group to review all denominators and core skills topics with a view to reducing total number of topics and make denominators more targeted that staff that need to complete them *Due Date:* 28/09/18
Update on action:
In progress. ExQual has approved the reduction of the Core Clinical list: 4 topics have already been removed and a further 6 topics will be removed by August 2018. Action due date subsequently changed to September 2018.

Action:
Roll our use of iPDF for Junior doctors to minimise need for re-doing training that has been done at previous rotation *Due Date:* 28/09/18
Update on action:
iPDFs are available for the Core 10 and planned roll out of Core Clinical by August 2018. New action due date is September 2018.

Action:
Divisional directors to confirm local plans for achieving compliance, which will be reflected on the next mandatory training paper to ExCo *Due Date:* 28/09/18
Update on action:
Divisional Directors report to ExQual monthly on their local action plans.

Action:
Implement new Learning Management system for Core skills *Due Date:* 29/03/19
Update on action:
In progress.

Contingency Plans	Key Summary Updates & Challenges
	Latest Core Skills compliance figures demonstrate sustained achievement of the 85% target, as follows: • Core 10 = 88.10% • Core Clinical = 87.10% Junior Doctors compliance figures were last validated in May 2018 and are as follows: • Core 10 Doctors in Training = 75% • Core Clinical Doctors in Training = 65% Further improvement is required to achieve the new compliance target of 85% for Doctors in training, as reflected in the action plan.

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

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

Effect:
• Poor organisational performance – inefficient pathway management
• Poor reputation with regulatory bodies
• Failure/delays in implementing new clinical models and new ways of working
• Deteriorating and / or inadequate estate
• Failure of critical equipment and facilities that prejudices trust operations
• Reduced staff morale and staff engagement
• Reduced confidence in our services/public concern about their services
• Difficulty in programming interim capital projects

Current Risk Controls

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

Mitigation Plan

Action:
Soft Market Test exercise *Due Date:* 31/10/17
Update on action:
Soft market testing exercise has been completed and findings discussed at Redevelopment Committee

Action:
Production of Strategic Outline Case (SOC) for SMH Masterplan *Due Date:* 31/03/18
Update on action:
Production of Strategic Planning Vision Document completed to programme in March. Approved by Trust Board on 28 March 2018.

Contingency Plans

• Develop site based redevelopment solutions
• Maintain flexibility to respond to any changes in demand as required
• Identify and develop alternative options
• Increase priority of stakeholder engagement activities

Key Summary Updates & Challenges

Outpatient & Ophthalmology facility:
• Planning permission received on 04 January. Therefore full planning is now active. The permission is granted for three years.
• The Outline Business Case for the facility was approved on behalf of Trust Board by Redevelopment Committee at the meeting on 28 February. The business case has been submitted to NHS Improvement, NHS England and the CCGs. Support is now to be given via prioritisation across all NWL schemes through the STP process.
SMH redevelopment:
• Condition of SMH has deteriorated and a business case is being developed to expedite this. A strategic planning vision document was approved by Trust Board in March 2018 and was submitted to NHSI, CCG's and DH for consideration.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain financial sustainability **Cause:** • Loss of DH/NHS England (Diamond) income for complex specialist treatments • CCG affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Historic dependence on non-recurrent funding sources masked underlying financial picture • Capacity limitations constrain activity growth, especially in private patients • Annual reductions in Education and Training funding, significant cut to 2018/19 funding • Correction of historic usage of R&D funding for clinical subsidy • Additional costs of operating across three sites & with outdated estate and aged equipment • Delays to Transformation programme caused by CEO role instability • Agency costs (at premium rates) incurred to cover substantive roles • Investments in Acute medical model • Investment in implementation costs of Cerner including data validation • Continuing dependence upon significant non-recurrent financial gains to deliver Control Total targets & receipt of STF funding masks underlying deficit • Deterioration in Estate limits ability to deliver activity plan **Effect:** • Failure to deliver a financial surplus • Reputational risk of being in deficit • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Dependence upon DH revolving working capital facility • Dependence upon SaHF for site redevelopment project costs & Charity for required capital investments	**20**	**20**	**15**		**Chief Financial Officer**	Year to date performance vs plan: Trust was able to meet its control total in 2017/18 (-£22.1m against plan of -£25.2m). The plan for 2018/19 is to deliver a control total surplus of £16.3m after £34.2m of STF funding support. Cash balance never less than £3m – monitored monthly and reported to Exec and Board. Internal forecast outturn (monthly refreshed).

Current Risk Controls

• Bi-weekly FASRG meetings with divisions and senior finance teams (CEO and CFO attend at least monthly)
• Additional CEO review for any division forecasting to miss budget
• Monthly financial reporting, cash and performance reviews reported to ExOp, bi-monthly to FIC and Trust board
• Oversight with Regulator via Provider Oversight Meeting (POM)
• PWC Causes of the Deficit work completed
• CEO & CFO engagement with Provider Network, AUKUH, Shelford etc, to lobby on system issues pressures including Tariff and Diamond – reports to FIC and Trust board
• The Improvement Team and all major change programmes report to monthly Executive Transformation Committee and then to FIC
• Speciality Review Program (SRP) started Apr 2017 to review all 31 specialities for sustainability (financial and clinical). SRP progress reports to Exec & FIC
• PWC commissioned (Aug 2017) to accelerate & improve Trust's usage of Carter Model Hospital and other benchmarks
• CEO led joint planning meeting with Charity
• Full engagement in SaHF programme seek to maximise Trust gain and mitigate risks from broader initiatives
• CEO member of STP Provider Board addressing STP financial challenge.

Mitigation Plan

Action:
Two-year deal agreed with Regulator setting a Control Total for 2017/18 and 2018/19 *Due Date:* 31/07/17
Update on action:
Revised plan for 2018/19 being developed in line with agreed control total.

Action:
Engagement with NHS Improvement's 'Financial Improvement' programme (FIP2); support for WCCS division *Due Date:* 30/03/18
Update on action:
Action complete. PWC identified a number of areas of cost control for the division. These have been implemented and delivery monitored on a monthly basis. The PWC close out report has been issued to NHSI.

Action:
Fortnightly meeting of STP CFOs to facilitate sector-level change and sharing of gains *Due Date:* 29/03/19
Update on action:
CFO team have: proposed business rules to remove the financial barriers to joint working; set-up team focusing on sector-wide analytics to support sector wide decision-making; aligned provider contracts

Action:
Cost management teams of 3 (known as Cost Control Trios) for each directorate (Pilot began in April 2016, full implementation with advice / assistance from FIP partner). *Due Date:* 31/03/19
Update on action:
Not due

Action:
Trust wide engagement in SAHF & STP programme (including consideration of long term financial modelling, sustainability and site strategy) *Due Date:*31/03/19
Update on action:

Action:
Phase 2 SRP merging into the transformation programme is expected to bring greater rigour to the implementation of Model Hospital and GIRFT learnings *Due Date:*31/08/18
Update on action:

Action:
Request for additional backlog maintenance funding *Due Date:*30/04/18
Update on action:
Completed.

Action:
Redevelopment plans submission for funding *Due Date:*30/04/18
Update on action:
Completed

Contingency Plans	Key Summary Updates & Challenges
Revolving working capital facility provides cash support cover of up to £26m (£16m has been drawn down YTD) – with the ability to extend the limit up to £65m. (However, note that these national arrangements are interim while a permanent process is being	YTD trust is £3.6m adverse to plan before STF.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk to Data; A cyber security incident can result in data being stolen, destroyed, altered or ransomed. Risk to Infrastructure: A cyber security incident can result in all or part of Trust ICT infrastructure being disabled, or destroyed. There would be a prolonged period of recover. **Cause:** In order to function, the Trust needs to maintain an IT environment connected to the internet. This exposes the Trust to a constant flow of infection and attack. **Effect:** • Data: o Stolen; reputational damage, breach of obligations as regards data security, fines, notification to the victim (s), compensation and legal claims. o Destroyed; almost all patient data is being created and stored digitally including medications, observations and treatment decisions.. It is possible for hackers to destroy not only online data but all backups. o Altered; connected medical devices are vulnerable to external hacking. Staff with access to data are the most likely insider threat. Maliciously altering data can affect both corporate and clinical systems and can result in either patient data or corporate data being changed. o Ransomed; the data doesn't leave the Trust infrastructure but is unable to be accessed until a ransom is paid. Even if a ransom is paid, there is no guarantee that the encryption key will be handed over and access to the data restored. • Infrastructure o Disabled; there would be a prolonged period of downtime while networks, servers and storage were disinfected and restored to service. Outage is likely to be anywhere between a week to a month. o Destroyed; There would be up to 6 months down time, several million pounds of expenditure to replace equipment and restore services.	**16**	**16**	**8**	⟺	**Chief Information Officer**	Information Governance Toolkit Return (Independently Audited) Monthly Cyber Security Metrics Dashboard Cyber Essentials External Assessment (2017) Annual Penetration Test Annual Informatics Audit Plan (reviewed by IGCS)

Current Risk Controls

Technical Controls:
• The Trust tries to maintain the lowest possible attack profile to reduce exposure to malware and hacking. Access to social networking, webmail, tor browsers and other high risk sites are all blocked.
• The Trust maintains firewalls and a documented change control process to block threats.
• The Trust maintained Servers and Desktops are installed with anti - virus software.
• Trust has contracted with iBoss for software to detect and mitigate any threats discovered inside the firewalls.
• The Trust has invested in a backup and restore system that, to date, has been able to restore files compromised by ransomware with minimal data loss. There are about 3 – 4 incidents a month.
• There is a monthly cyber security dashboard reviewed at Information Governance and Cyber Security meeting to track threat activity and effectiveness of response.
• The Trust has an Anti-Malware Procedure to ensure that ICT engineers can efficiently contain, and resolve cyber threats. This procedure is reviewed and updated annually to ensure that the documented processes are current and aligned to industry best practices.
• The Trust have contracted a 3rd party supplier to provide Security as a Service. This enables ICT to tap into specialist resources for support and assistance. In addition, PEN testing and Security Risk assessments are conducted annually to ensure that the Trust addresses and resolves these security gaps
ICT Technical Security Manager:
• This post has been filled since 02/05/17 and security controls are to be reviewed. New security software is to be assessed and implemented.

Mitigation Plan

Action:
Awareness Training: Supplement the Annual Mandatory Information Governance Training Programme through being an early adopter of the "Knowledge Training" when it is released by NHS Digital *Due Date:* 31/03/19
Update on action:
GDPR Awareness, Expert Lawyer Presentation to the Trust Executive and Trust Board. GDPR Awareness Video for all staff to be released via the Trust intranet by 31/03/2018.
The Trust's strategy for Data Protection and Cyber Security Training remains that it will adopt the national training packages. Operational level plans to adopt the new national training will be formulated starting in April 2018

Action:
Cerner 7 24 PCs: A pilot project funded from 2016/17 capital has configured a new Cerner 7 24 PC which is more resilient to Cyber threat. Funding request to deploy this new configuration are in 2017/18 Capital Plans. *Due Date:* 31/12/18
Update on action:
Daily monitoring is in place with status updates sent out three times a day.The ICT Tech support team are acting on the updates. This constitues ongoing assurance for the Cerner application. This is action is considered complete now.

Action:
Process Controls: Continual deployment critical and security patches to Servers and Desktops in accordance with the following ITIL Standard *Due Date:* 31/03/20
Update on action:
The number of servers being patched per week is increasing. A suitable vendor has been identified to assist with the automation of server patching.

Action:
Security Software Investment: Multi Layered Security Software currently in the process of being tendered *Due Date:* 31/12/18
Update on action:
Further deployment of the new antivirus to servers is progressing, there are some outstanding actions before this project is deemed complete, including in a final health check. After implementing a new auditing solution, Active Directory auditing is enabled and is close to production.

Contingency Plans

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

Key Summary Updates & Challenges

NHS England require the Trust to submit a plan by the 18th of July 2018 to be Cyber Essentials certified by June 2021.
A Cyber Security table top exercise is planned for the 19th of July 2018.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
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 **Cause:** • Inaccurate,incomplete or delayed data entry • Failure to comply with standard workflows and/or operating procedures • Lack of data validation and correction • Incorrect design/build of system or reports • Reduced clinical coding capacity/capability **Effect:** • Possible delay to treatment of patients • Possible failure of governance • Possible (criminal) investigation of Trust/individuals • Loss of Trust reputation • Possible financial penalty for Trust or loss of income • Breach of contractual and regulatory requirements.	**20**	**20**	**12**	⇔	**Chief Information Officer**	• Operational Data Quality Dashboard and reports for services to monitor their data quality performance directly. Trajectories agreed for some priority data quality indicators. • Data quality indicators included in Trust Board and Divisions' scorecards so aligned with Trust's performance framework and shared with commissioners. • Routine audits of reasons for removing patients from waiting lists by dedicated team.

Current Risk Controls

• A Data Quality Framework and new governance was approved by the Executive Committee in June 2017 and presented to the Audit, Risk and Governance Committee of the Trust Board in July 2017. It is being implemented during 2017/18 and 2018/19. The framework includes 150 data quality indicators (DQIs) across 32 datasets and also includes in its scope the optimisation of the 10 systems used to collect them and the data processing involved. Key DQIs have been agreed as the priority focus for 18/19. The data quality indicators underpin the Trust's integrated performance framework - responsiveness and money/use of resources domains only.
• Review of the Trust's validation resources supplemented by a managed service for Referral to Treatment Pathway validation to undertake data clean up of waiting lists. Now use a validation system since Feb 2018 which has streamlined validation processes for RTT.
• Latest version of Elective Access Policy published October 2017 and underpinning Standard Operating Procedures for entry and validation of waiting times data on the Patient Administration System launched in October 2017.
•Commissioned external data quality review. Actions to be taken forward following report and progress overseen by Executive Committee.

Mitigation Plan

Action:
Design and implement Elective Care Operating Framework underpinned by staff training and digital optimisation *Due Date:* 31/12/18
Update on action:

Action:
Recruit to clinical coding vacancies or outsource *Due Date:* 31/03/18
Update on action:
Recruitment successful 29/05/2018

Action:
Delivery of recommendations in MBI Report on Waiting List Management & Reporting *Due Date:* 31/03/19
Update on action:
Report received and action plan under development.

Contingency Plans	Key Summary Updates & Challenges
	Risk escalated onto the Corporate Risk Register. Escalation approved at the Executive Digital Strategy Committee meeting on 23 January 2018.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of financial and reputational damage to the Trust resulting from failure to fully comply to the General Data Protection Regulation (GDPR), which became effective in May 2018. The GDPR is a Directive for the European Union that has been enacted in UK legislation. **Cause:** • The change in legislation to the GDPR will make Data Controllers more accountable for their data processing. Subsequently, the Trust will be required to demonstrate how they: o Uphold the rights of patients and staff as data subjects, including provision of appropriate privacy notice information, upholding rights of access, o Provide demonstrable legal basis for the processing of data o Mitigate risk of data breaches caused by failure of technical security or failure of management procedure or misuse of authorised access o Map data flows to and from third parties that have been privacy risk assessed and the liabilities allocated appropriately through appropriate information sharing agreements / contracts o Undertake robust privacy risk assessment and the reporting of high residual risk processing to the ICO o Provide demonstrable legal compliance through accurate, complete, valid and timely records of processing o Establish a robust Data Protection framework • The Trust will not have sufficient processes and systems in place by May 2018 to ensure all of the above is delivered **Effect:** • Identified breaches can be fined to up to 4% of global turnover • Reputational Damage possibly leading to brand toxicity • Loss of research funding and potential losses of inward investment • Loss of confidence in the senior management of the Trust	**20**	**16**	**8**	*NEW*	**Chief Financial Officer**	The Trust will be measuring its assurance against the new NHS Digital Data Protection and Security Toolkit. This sets out the ten National Data Guardian Standards and these are underpinned by 41 assertions where the Trust can measure compliance. The Trust will be launching the Trust Privacy Programme (TPP) to deliver this compliance.

Current Risk Controls	Mitigation Plan
• The Trust Data Protection Structure has been evolving to meet the challenges of the current threat environment and the current legislation. • Trust has submitted satisfactory IG Toolkit Returns since 2012/13 (meeting a minimum of Level 2) in each IG Toolkit Standard • Information Governance and Cyber Security Committee (IGCS) meets on a monthly basis to review Cyber Security Dashboard, ICT Risk Register, Informatics audit and IG Compliance Issues • GDPR (TPP) Business case and Investment Plan has been developed to manage implementation of GDPR. • Prioritisation of more risky requirements in the implementation plan.	**Action:** GDPR Films - Part 1 All Staff - Part 2 Managers *Due Date:* 12/07/18 **Update on action:** Film has been held up in post production due to issues with presentation and content. Further work is indicated to bring the film into order **Action:** Submission of GDPR (TPP) Business Case and Investment Plan *Due Date:* 29/03/18 **Update on action:** Business case and investment plan for GDPR compliance via the TPP has been subjected to rigorous line by line review in order to reduce cost pressures. Final summary to be presented to EXDIG **Action:** Launch of the Trust Privacy Programme (TPP) to deliver compliance to GDPR *Due Date:* 02/09/18 **Update on action:** The TPP Overview document has been produced and will be reviewed by the Caldicott Review meeting on Monday **Action:** Implementation of ONE TRUST Data Protection Management Console *Due Date:* 31/12/18 **Update on action:** Supplier weekly meetings booked, initial access to the console provided. Project plan required to bring it online

Contingency Plans	Key Summary Updates & Challenges
• Report breaches to the ICO • Report non compliance to Information Sharing Partners in NW London and elsewhere • Escalation of non compliances and attendant risks to the Trust board	GDPR Film marked as complete as it will now be subsumed into formal DSP Training First gap analysis and action plan derived from the DSP Toolkit to be presented to IGCS on 23/07/2018

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The trust currently has 10,300 desktop computers that currently run on Windows 7. Microsoft support for Windows 7 ends on the 14th of January 2020. As a result of the above, Microsoft will no longer provide security patches for known vulnerabilities to Windows 7 PCs after this date. Running windows 7 after this date probability of a major cyber security incident resulting in loss of access to systems and/or loss of Trust or patient data. Clinical and Corporate application suppliers are no longer designing applications for windows 7 - the Trust will not be able to leverage benefits of new functionality in applications with Windows 7 moving forwards. **Cause:** Microsoft no longer support Windows 7 from 14th January 2020 Windows 7 cannot be protected from above date New applications and updates to existing are not designed for windows The Trust PC estate has 10,300 Windows 7 devices ICT capital allocation is currently not sufficient to fund the upgrade to Windows 10 **Effect:** Increased cyber security risk Increased risk of loss of clinical and corporate system availability Risks to patient care and safety as a result of loss of IT systems Risk of loss of status as "Global Digital Exemplar" Hospital	**20**	**20**	**10**	*NEW*	**Chief Information Officer**	Confirmation that Windows 10 licences have been secured received (NHS digital) Full asset inventory of PCs in place Basic testing of compatibility with existing applications have shown positive results

Current Risk Controls	Mitigation Plan
Windows 10 and VDI business case to migrate all desktops to Windows 10 currently in progress. Trust has secured Windows 10 licences Basic Windows 10 testing has commenced Basic application compatibility testing in progress	**Action:** Submit draft business case to finance *Due Date:* 20/07/18 **Update on action:** Draft in progress
Contingency Plans	**Key Summary Updates & Challenges**
Harden anti-virus protection Implement restricted network access Put share drives into "read only" Highly restrict internet access Clinical and corporate application upgrades will be put on hold Seek custom support contracts with each software vendor to s	

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
ICHT are currently running a desktop estate of 10,300 devices. Due to a lack of capital investment the programme is now seriously behind schedule and as things stand the trust has over 3567 desktop PCs which are over 5 years old in April 2018. By March 2019 this figure will reach up to 6000 PC devices. This figure includes 800 "computers on wheels" (COW) which are now beyond their recommended production life and now display persistent and frequent problems. **Cause:** Continued lack of funding for PC replacement programme ICT have zero stock of replacement devices **Effect:** Over 6000 will be over 5 years old at end of 18/19 FY These PCs run slowly and are prone to complete failure Multiple complaints and risks raised over slow and unreliable PCs in clinical and corporate areas	**20**	**20**	**6**	*NEW*	**Chief Information Officer**	the 5 year business case exists and has been reviewed by the executive.

Current Risk Controls	Mitigation Plan
Capital SOP submitted for device replacement in 2018/19 requesting funds for device replacement. Funded project to temporarily fix the broken cows to extend life by 12 months via GDE programme. Escalation to Trust finance that the proposed £2.7m capital for ICT will be insufficient to address this risks and other ICT related infrastructure risks.	**Action:** Re-submit Business Case *Due Date:* 03/08/18 **Update on action:** Business case written Must be re-submitted for 2018/19 FY NHSI application for funds has been submitted

Contingency Plans	Key Summary Updates & Challenges
Spare PC parts Reliable agency for staff	

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of failure due to age of Network Core devices - Cisco Nexus7K 8 years old for SMH and CXH, and at HH Cisco Catalyst 6509 13 years old. The CORE devices are also running software/firmware 5 years old. Additionally, the devices will come to End of Life in November 2019. The Network Core devices provide the network backbone to all the primary sites within Imperial: CXH, HH and SMH. End of Life indicates the manufacturer of the hardware will no longer provide support or software updates to their devices. **Cause:** Cisco will not longer support Nexus 7Ks and 6509 cores from November 2019 Lack of funding in ICT capital allocation to fund replacement **Effect:** In the event of hardware component failure or security vulnerabilities requiring software updates, there will be no new parts or software updates provided by the manufacturer. This will likely lead to a Trust-wide or Site-wide network failure which will result in the inability to access Clinical or Corporate systems. In the event of a Security Breach : Theft or Corruption of Data Shutdown of Network Services Shutdown of Data Centre and Server Services	**20**	**20**	**10**	*NEW*	**Chief Information Officer**	Part of the ICT Operations Strategy overseen by the Senior Management Team within ICT. Review of this Strategy is discussed at these team meetings to ensure business cases are developed and submitted in a timely manner. Along with the justification and funding of these key projects.

Current Risk Controls	Mitigation Plan
The Network Core is currently under support and will come to end of life in Nov 2019. ICT will need funding in 18/19 to ensure we have enough time to complete the Business Case and get it approved, run through the procurement and tender process, appoint, design/scope, resource, implement, test and handover to BAU.	**Action:** Business Case Approval and secure funding *Due Date:* 03/09/18 **Update on action:** Business case in draft Submitted to finance ahead of DSP
Contingency Plans	**Key Summary Updates & Challenges**
The Trust will need to fast-track the procurement, installation, configuration and testing of all 10 network cores costing approximately £1.5M and taking approximately 6 weeks to complete. During this 6 week period, the Trust will have no IT network, acc	

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Learning from Deaths: Update on implementation and reporting of data	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 15, report no. 11**
Responsible Executive Director: Dr Julian Redhead, Medical Director	**Author:** Trisha Bourke, Mortality Auditor Dr Ian Maconochie, Associate Medical Director for Patient Safety

Summary:
In December 2016, the Care Quality Commission published its review titled "Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England". In response, the Secretary of State accepted the report's recommendations and made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die. In March 2017 a framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care was published by the National Quality Board including the need to report a quarterly 'learning from deaths dashboard' to the Trust Board.

This paper is to update the Trust Board on progress since the last report (March 2018) and includes an updated 'learning from deaths dashboard' (**appendix A**). The dashboard includes data for the financial year 2017/18

A number of key points are also set out in the report for noting by the Board.

Recommendations:
This Board is asked to note the content of the report.

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

Quality impact:
This paper covers the CQC domain of Safe.

Financial impact:
There is a financial impact and resource requirement in terms of medical time to conduct structured judgment review of deaths, which divisions have agreed to and is included in their forecasts.

Risk impact and Board Assurance Framework (BAF) reference:
There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting. Learning from Deaths is on the Corporate Risk Register (no. 2439)

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

What impact will this have on the wider health economy, patients and the public?
The aim of this work is to identify avoidable factors in the deaths of patients, provide learning opportunities, and guide future improvement works to reduce avoidable deaths.

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 compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.

Learning from Deaths: Update on implementation and reporting of data

1. Executive Summary

1.1. This paper is to update the Trust Board on progress since the last report (March 2018) and includes an updated 'learning from deaths dashboard' (**appendix A**). The dashboard includes data for the financial year 2017/18.

1.2. The Board is asked to note the following key points regarding progress made with implementation of the framework:

- We are compliant with reporting requirements as set out by NHS Improvement.
- 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 help reduce the time taken for reviews and to facilitate local feedback of findings.
- 176 SJR reports have been completed to date.
- 13 avoidable deaths to date of reporting (03/05/18) have been reviewed and signed off via the Mortality Review Group. This number is comparable to last year's figure of 12 avoidable deaths.
- Since November 2017 mortality reporting metrics have been incorporated into both Trust and divisional scorecards.
- No Trust specialties are currently causing concern in respect to avoidable deaths.
- Early emerging themes are linked to three of the Trust's nine safety streams. Two are linked to 'falls and mobility', four to 'responding to the deteriorating patient' and two to 'fetal monitoring'. These cases have been shared with the safety work streams leads to ensure the improvement work covers the findings of the SJRs.
- Data fields have now been incorporated within the online mortality module to facilitate thematic reporting into the future.
- The first national LeDeR report has been published, though it does not contain Trust specific data we are experiencing the same issues with receiving feedback on the independent reviews. The Trust complies with all reporting requirements for LeDeR.

2. Purpose

2.1. The purpose of this paper is to update the Board on progress with ensuring Trust compliance with the mandatory framework on learning from deaths since the previous report in March 2018. This includes an updated 'learning from deaths dashboard' (**appendix A**). The dashboard includes data for the financial year 2017/18.

3. Background

3.1. In December 2016, the Care Quality Commission published its review "*Learning, candour and accountability; A review of the way NHS trusts review and investigate deaths of patients in England".* In response, the Secretary of State accepted the report's recommendations and made a range of commitments to improve how the NHS learns from the care provided to patients who die.

3.2. In March 2017 the National Quality Board published a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care. This included a number of standards and deadlines and gives guidance on the review process, the need to use structured judgment review (SJR) in selected deaths and the new reporting requirements which were mandated from quarter 3 2017/18. This included the requirement to submit quarterly data externally, which populates the 'learning from deaths dashboard'.

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

4. Summary/Key points

4.1. Reporting in line with the national framework is in place and the trust has achieved all reporting milestones.

4.2. The data required for Trust Board publication is shown in **appendix A**. The Trust published this mortality data in the annual Quality Account for 2017/18.

4.3. All clinical teams are required to provide a review of mortality cases within their specialty areas. All cases undergo a Level 1 review, which consists of a short number of questions, followed by assigning an avoidability score within 7 days of death. Based on that review, cases may proceed to a team based Morbidity & Mortality (M&M) meeting, which should occur within 30 days. Where local teams have highlighted issues in the care of a patient, an independent SJR review should be undertaken. A chart demonstrating the trust performance, both for local review as well as SJR, up to the end of March 2018 can be found in **Appendix B**. This shows that 94 % of local reviews had been undertaken with 229 SJR's requested. Of these, 176 had been completed with 13 avoidable deaths confirmed. This is comparable to data from the last previous year, in which we reported 12 avoidable deaths. Progress with completing outstanding SJRs are now being reviewed weekly with divisions at the MD incident review panel. Timescales for reviews and reporting are being reviewed to be realistic, thorough but sufficiently quick to ensure learning and feedback can be achieved in a timely manner.

4.4. The trust target is to review 15% of hospital deaths using the SJR methodology. Cases are selected using the principles set out in the Trust policy. To date we have completed reviews on 11% of trust deaths since July 2017, with the remaining 4% requested and underway.

4.5. A national dashboard remains under development by NHS Improvement and the Department of Health. Trusts have been asked to publish data in their public board papers until this has been finalised.

4.6. The Mortality Review Group (MRG) is now well established. All cases that are potentially avoidable (scored 1-4) are reviewed within the group for trust level sign-off. Cases that the reviewers feel have learning or have wider discussion points are also presented. Discussions focus on any avoidable factors and learning themes. Early

emerging themes map to the 'falls', 'responding to the deteriorating patient' and "fetal monitoring" safety streams which have improvement plans in place. As more cases are reviewed the group will be able to recommend work streams to be considered as part of the trust improvement programme. Data fields have now been incorporated within the online module to facilitate thematic reporting into the future.

4.7. A key focus of the guidance is the need to actively involve families including offering opportunities for them to raise questions or share concerns in relation to the quality of care received by their relatives. Guidance on working with bereaved families was recently issued for consultation following a two-day workshop facilitated by NHS England in November 2017. Once this has completed the national consultation process and has been formally ratified the trust will adopt this. However, until then we have included guidance in the bereavement pack for families on how to raise concerns, and the new learning from deaths policy includes a quick reference guide on how to involve families. We are also working with the Trust Communications team on other signposting options.

4.8. The Trust is actively participating in the LeDeR programme, which was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward that learning into service improvement initiatives. The programme has developed a process whereby all deaths receive an initial review and those where there are areas of concern in relation to their care, or if it is felt that further learning could be gained, receive a full multi-agency review of the death.

4.9. The Trust reports all deaths of patients with a learning disability to the national database. At ICHT these cases all have an SJR completed, in addition to the external LeDeR review. To date those SJR reviews have not revealed any concerns in relation to deficiencies in care, and do not form any of the reported avoidable deaths.

4.10. The annual report of the national Learning Disabilities Mortality Review (LeDeR) programme was published in May and is included in **appendix C**. During 2017 just over 1300 deaths were reported to LeDeR of which 103 full reviews were completed in the year. During this period ICHT reported 12 deaths of which 2 were subjected to a full review. The nationally reported learning and recommendations made as a result of the full reviews were in relation to the need for:

- Inter-agency collaboration and communication
- Awareness of the needs of people with learning disabilities
- The understanding and application of the Mental Capacity Act

4.11 The Trust has developed extensive and robust links with local learning disability organisations and is able to collaborate and communicate effectively with other agencies when we are caring for patients with learning disabilities. Extensive training and awareness raising has taken place in the trust and Purple Pathways have been introduced for elective, non-elective and outpatient care. Mental Capacity Act training is available online for all clinical staff and additional training has been provided in areas where there are high volumes of patients with mental

capacity issues. An NHS app, Deciding Right, is available to support staff in making mental capacity decisions.

5. Options appraisal including financial appraisal (as relevant)

Not applicable

6. Conclusion and Next Steps

6.1. The Trust is compliant with reporting requirements and will continue to report quarterly to the Trust Board – commenced and on-going.

6.2. The Trust awaits the publication of the national guidance on involving families in the review process and will scope out the processes and procedures to ensure we comply with this guidance.

6.3. The Trust awaits confirmation of national reporting procedures, which will include all metrics once finalised.

6.4. An updated framework will be published by the National Quality Board in 2018 and is likely to contain a number of alterations to the current process. We will need to implement these once confirmed, and may be required to make alterations to the current process that is in place.

7. Recommendations

7.1. This paper is being presented to the Trust Board for information.

Author: Trisha Bourke, Mortality Auditor
Date: 19/06/2018

Appendices as relevant (referenced in summary)

Appendix A: NQB Learning from Deaths Dashboard

Appendix B: Trust Performance Dashboard

Appendix C: Learning Disabilities Mortality Review (LeDeR) Programme Annual Report

Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - March 2017-18

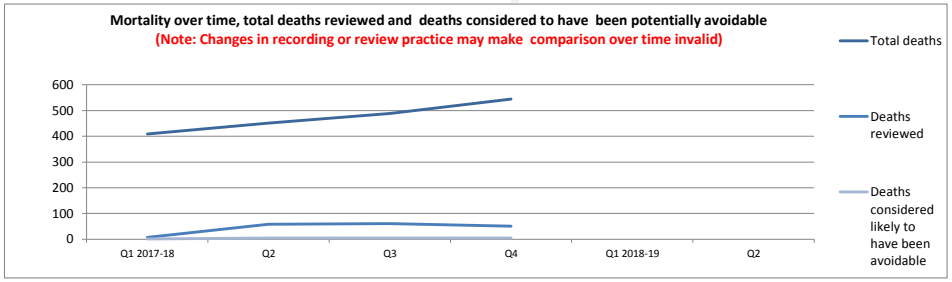
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
178	176	14	17	0	2
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
545	488	51	60	4	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1893	0	176	0	13	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

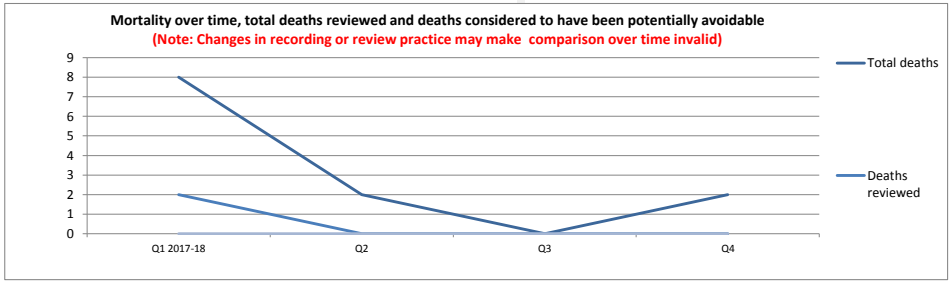
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	14.3%	This Month	2	14.3%	This Month	10	71.4%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	3.9%	This Quarter (QTD)	2	3.9%	This Quarter (QTD)	4	7.8%	This Quarter (QTD)	6	11.8%	This Quarter (QTD)	37	72.5%
This Year (YTD)	1	0.6%	This Year (YTD)	4	2.3%	This Year (YTD)	8	4.5%	This Year (YTD)	14	8.0%	This Year (YTD)	33	18.8%	This Year (YTD)	116	65.9%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	0	2	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Trust Level Performance

Trust Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Total Deaths	120	152	137	138	162	151	161	167	160	191	176	178	1893
No. Level 1 Reviews Completed	120	152	136	138	162	147	159	151	148	178	147	138	1776
% Level 1 Reviews Completed	100%	100%	99%	100%	100%	97%	99%	90%	93%	93%	84%	78%	94%
No. of SJR Reviews Requested	3	3	2	21	28	22	37	19	18	25	27	24	229
No. of SJR Reviews Completed	2	3	2	17	24	17	27	17	16	20	17	14	176
No. of Avoidable Deaths (Score 1-3)	1	0	0	1	2	1	3	1	0	2	2	0	13

The Learning Disabilities Mortality Review (LeDeR) Programme

Easy Read

University of Bristol Norah Fry Centre for Disability Studies

This information can be made available in formats such as easy read or large print, and may be available in alternative languages, upon request

Annual Report

December 2017

University of BRISTOL

NHS England

The Learning Disabilities Mortality Review (LeDeR) Programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England.

What is in this report

Some of the words we use

Word	Meaning
Inequality	Not everyone having the same chance
General population	Everyone in England
Care Quality Commission	Checks up on the care provided in care homes, hospitals and GP surgeries
Review	Checking up on
Reviewer	The person who checks up on something
Respiratory System	To do with breathing and the lungs
Circulatory System	To do with the blood and the heart
Sepsis	An infection that spreads through the body
Mental Capacity Act	The law about how to decide if someone can make a decision or choice at a certain time
Coordination	People working together

Chapter 1. Introduction

Not everyone shares the same chances of having good health. We call this **inequalities in health**.

People with learning disabilities tend to have poorer health than people in the general population.

This is an inequality, and it is unfair.

Often, people with learning disabilities also die at an earlier age than people in the general population.

Some of the people with learning disabilities who die could have received better healthcare.

The Care Quality Commission says that hospital Trusts are not doing enough to look at the deaths of people in their care

They need to learn what they could do better, and to make changes to improve care.

The government has set up a programme called **Learning from Deaths** to help with this.

The new guidance says that all deaths of people with learning disabilities aged four years and older should be checked up on as part of the LeDeR programme.

Chapter 2. The LeDeR programme

The LeDeR programme is based at the University of Bristol. It is funded by NHS England.

The LeDeR programme helps local areas to **review** the deaths of people with learning disabilities.

This means having an independent person looking at what happened before somebody died.

The LeDeR programme has set up a system for reviewing deaths. It collects information about why people have died.

And what we could do to help other people with learning disabilities live longer.

How this Works...

Anyone can tell us about the death of someone with learning disabilities

Then, someone checks up on what happened before the person died.

The checks are done by someone who did not know them.

They speak with family and others who worked with the person - for example, doctors or social workers.

Then they write a report. They say if they think that any changes are needed to services, to make them better.

Sometimes, the reviewer decides to have a meeting.

Everyone who was involved with the person is invited.

They talk about what happened and decide if they need to make any changes to services.

Where changes are needed, an action plan is set up in the local area.

We look at some deaths in more detail.

This year we are taking a closer look at the deaths of:

- People who were aged 18 to 24 years when they died, or
- People from a Black or Ethnic Minority group

The LeDeR programme includes people with learning disabilities and their families in the work.

That is very important to us.

We wrote a report about setting up the LeDeR programme last year (2016). You can read this on our website.

This year we have tested out how to do reviews of deaths in four areas of England.

We have trained over 1,000 reviewers, and updated our process for reviewing deaths.

The LeDeR programme will be running across the whole of England from the end of 2017.

Our biggest challenge is helping reviewers to get reviews completed.

Some have found it difficult to have the time to do reviews when they have their usual job to do. some give up being a reviewer because of this.

Chapter 3. What the reviews are telling us

From July 2016-November 2017, we were told about 1,311 deaths of people with learning disabilities.

Who lets us know when someone with learning disabilities dies?

Mostly, this has been people who work in community learning disabilities teams, or staff from hospitals.

Who were the people who died during this period?

Just over half were men.

Most were single.

Most were White.

Most had moderate or severe learning disabilities.

Most lived with other people.

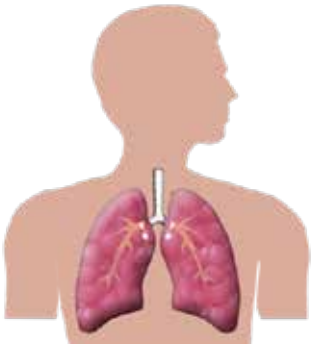
Where did they die?

More people with learning disabilities died in hospital than we would expect.

How old were they when they died?

The average age of death was 58 years.

People with more severe learning disabilities had shorter lives.

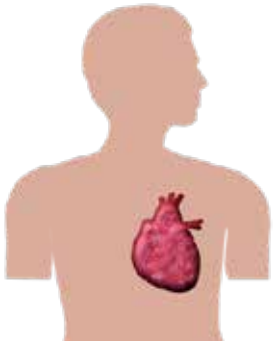


Cause of death.

The causes of death that were most common:

1. Diseases of the **respiratory** system. These are to do with breathing and the lungs. They were mentioned in about 3 out of 10 deaths.

Lots of these problems were caused by infections or by people having food or drink ‘going down the wrong way’.



2. Diseases of the **circulatory** system, which involves the blood or the heart (for example heart disease).

They were mentioned in 1-2 out of 10 deaths.

Sepsis was mentioned in about 1 out of 10 deaths. It is caused by an infection, which spreads through the body.

Did any of these people experience poor care?

Some people might not have died if they had received good quality healthcare.

The reviewers felt that 6 people had recieved poor standards of care.

Chapter 4. Learning from the reviews

From the reviews looked at so far, many have made recommendations for changes that need to be made to improve services.

Many of these focus on the need for better communication, and coordination of care.

An example of this would be: carers talking to hospital staff when someone goes into hospital.

This is to make sure they know the important information about what someone needs, and what they like.

Good communication is needed for people when they come out of hospital.

Another recommendation that was often made was for more training for staff. Training is required for staff, to raise awareness of the needs of people with learning disabilities.

An example of this is that staff need to understand that some people may communicate through their behaviour.

Changes in a person's behaviour could mean that they are ill.

Training is also needed so that health and care workers know about each other.

Training is needed about Annual Health Checks too.

Another recommendation was that lots of staff need to have a better understanding of the Mental Capacity Act.

This is important because the law says that someone who is able to understand the information, can then make their own decisions.

If someone cannot understand their choices about treatment, then there is a process that staff have to follow. They need to make decisions in their best interests.

Staff need to write this clearly in a person's notes. They must explain how the decision about a person's care was made.

Because of these recommendations, changes are now being made to improve services in local areas.

National recommendations

By looking at the findings from all of the reviews together, we can see the changes that need to be made across the whole country.

We think that these are:

1. There should be a senior person in each health and social care service to make sure that communication between services is good.

2. Health and social care records should be improved so that important information can be shared between services, using a computer.

3. Health Action Plans should be shared between services, if the person says this is OK.

4. People with learning disabilities with health problems that will last a long time need a named person to help different professionals work well together with them.

5. Services must know if people need changes to the way things are usually done. They need to write this in people's notes, and check that people with learning disabilities can use services as easily as everybody else.

6. Those providing support to people with learning disabilities must have training about the needs of people with learning disabilities.

   The training should be provided with people with learning disabilities and their families.

7. People need to understand more about the problems with infections in people with learning disabilities.

8. Professionals need to follow the Mental Capacity Act.
   Someone in each service needs to help make sure this happens.

9. Lots of people review deaths. We need to work together. We need to make sure that everyone is properly trained.

Next year the LeDeR programme will be checking up on what services are doing to make things better for people with learning disabilities

Thank-you for reading this report.

For more information about the LeDeR programme, please contact us:

Phone: **0117 3310686**

Email: **leder-team@bristol.ac.uk**

Or visit our website at

www.bristol.ac.uk/sps/leder

Norah Fry Centre for Disability Studies, 8 Priory Road, Clifton, Bristol, BS8 1TZ

You can find more information at

bristol.ac.uk

University of BRISTOL

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Emergency Preparedness, Resilience and Response Plan	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 16, report no. 12**
Responsible Executive Director: Prof Janice Sigsworth – Director of Nursing	**Author:** Merlyn Marsden – Site Director

Summary:

The purpose of this paper is to provide an update and assurance in relation to the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements and plans. The paper contains the following updates:

1. Threat Level
2. EPRR Activity and Incidents
3. EPRR Exercises and Training
4. NHS England Assurance Action Plan for 2017/18 update
5. EPRR Incident Action tracker update
6. Mutual aid agreement with West London Mental Health Trust
7. NHS England EPRR Assurance 2018

Recommendations:

The Board is asked to note the paper and the continued support in relation to our support the annual EPRR assurance to NHS England due in September 2018.

This report has been discussed at:

☒ EPRR & Fire Steering Group, July 2018
☒ Executive Committee – Operational Performance, July 2018

Quality impact:

In addition to our statutory requirements through the Civil Contingencies Act (2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012, the NHS funded organisations must also meet the EPRR requirements within NHS Standard Contract, the NHS England Core Standards for EPRR and NHS England Business Continuity Management Framework. EPRR also forms part of the Patient Safety and Quality Agenda of Care Quality Commission Regulation.

Financial impact:

Has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:

The paper seeks to assure the Trust that risks associated with EPRR are being mitigated and managed appropriately. EPRR risks are raised through the Trust's internal risk process DATIX and monitored through the EPRR Steering Group.

Workforce impact (including training and education implications):

EPRR training of staff is required to adhere to Civil Contingencies Act 2004 and NHS EPRR Framework 2015.

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

Robust incident and continuity plans will ensure coordinated plans during an incident for patient care and experience.

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.

Update for the leadership briefing and communication and consultation issues (including patient and public involvement): No

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

- What should senior managers know? (maximum three bullet points)
  - The threat level
  - Recent incidents
  - Support requirement relating to the EPRR Assurance 18/19
- What (if anything) do you want senior managers to do? (maximum two bullet points)
  - Support for the annual EPRR assurance process
- Contact details or email address of lead and/or web links for further information (maximum one bullet point)
  - Niina.bell@nhs.net 02033133661
- Should senior managers share this information with their own teams? Y/N (And if not – why?)

Yes

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: RM Partners	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25 July 2018	**Item 17, report no. 13**
Responsible Executive Director: Dr Catherine Urch	**Author:** Dr Catherine Urch

Summary:
The report provides the Board with an update on the Trust's work as part of RM Partners (RMP), the Cancer Alliance for west London. It provides an update on RM Partners wide progress 2017/18, Imperial specific programmes, achievements and priorities for 2018/19.

Recommendations:
The Committee is asked to note this update.

This report has been discussed at:
Executive Transformation Committee

Quality impact:
CQC domain: Safe, caring, responsive and effective

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

Risk impact and Board Assurance Framework (BAF) reference: N/A

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

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

RM Partners
Accountable Cancer Network

NHS

RM Partners Update

Executive summary

This report provides the Board with an update on the Trust's work as part of RM Partners (RMP), the Cancer Alliance for west London. The Trust has played a key role in improving outcomes and working in partnership to deliver sector wide operational performance and transformation in cancer services.

2017/18 was an exciting year in which RMP transitioned from being one part of the national Cancer Vanguard to becoming one of the 19 Cancer Alliances across England. Serving a population of over 3.9m, we have had some significant successes, and overall our population has the highest one year cancer survival rate of any Alliance in the country. Building on this success, and using our nationally acclaimed analytics, we are identifying further areas of work to reduce variation in outcomes and access, in order to continue to improve survival and quality of life for our population.

The Trust is one of the first three sites in the world to pilot an innovative new prostate cancer diagnostic service, RAPID (Rapid Assessment Prostate Imaging and Diagnosis). During 2018/19, it will also implement the RMP new colorectal diagnostic service. Trust patients are also participating in world leading clinical trials, such as our NICE FIT (National Institute for Health and Care Excellence, Faecal Immunochemical Test). The research study, the largest in England, examines the effectiveness of FIT, an innovative non-invasive test, in ruling out bowel cancer, reducing the need for patients to have unpleasant and invasive colonoscopies.

Background

Imperial is a partner in RM Partners, the Cancer Alliance across west London, hosted by The Royal Marsden. Over the last two years, RMP has partnered with colleagues in University College London Hospitals Cancer Collaborative and Greater Manchester Cancer Vanguard Innovation as part of the Cancer Vanguard to trial new technologies and new ways of working to improve cancer outcomes. RMP has built further on these strong relationships in west London to ensure that cancer priorities are aligned across stakeholders in our geography. Our successful bid for transformation funding in March 2017 has secured more than £20m of ring-fenced money over a two year period to improve and provide earlier and faster diagnosis for our cancer patients.

Together we are working to improve outcomes for all our population, using data to identify opportunities to reduce variation and transform pathways. Our model is one of collaborative working. Patient engagement is at the heart of all our work, with an engaged and dedicated Patient Advisory Group, who guide and shape our overall programme and provide targeted input to all our projects. The Clinical Oversight Group includes experts and professionals from cancer and research teams, drawn from across our geography, to advise on best practice and drive innovation. The programme of work is implemented through project teams made up of subject matter experts, clinicians, managers and commissioners. Our work is overseen by RMP's Executive Group, made up of our 10 acute Trust Chief Executives, alongside commissioners and primary care leads.

As an established Cancer Alliance with a track record of delivery, we contribute to the National Cancer Programme and support other emerging Alliances by sharing our work and learning. The aim over the coming years is to continue to deliver our vision of working in partnership to achieve world-class cancer outcomes for the population we serve.

RM Partners Wide Progress 2017/18

2017/18 has been an eventful year for RM Partners. We have been working together to sustain and improve on our operational performance, supported by an investment in diagnostic capacity, alongside transforming key pathways. We have set up over 20 projects, spanning all of our partner Trusts and CCGs.

Successes to date

- Number one ranked Cancer Alliance for one year survival
- Number one ranked Cancer Alliance in Q3 for system delivery of 62 day standard
- One of the few Cancer Alliances to secure early diagnosis cancer transformation funding for both 17/18 and 18/19
- Circa 2,800 patients through our redesigned colorectal diagnostic pathway pilot
- Over 25 hospitals across England recruiting to our NICE FIT research study, and nearly 1,600 patients returned FIT tests
- Over 570 patients seen by the RAPID prostate pathway, in three hospitals sites
- Over 30 cancers identified through multi diagnostic clinics (MDC) pilots at Croydon, Epsom and St George's hospitals
- Over 70% of patients having a Holistic Needs Assessment (HNA) within 31 days of diagnosis in Q2
- Our biosimilar web-based education tool contributed to over 80% of Trusts in England switching to bioisimilar rituximab, saving the NHS around £80m in just six months
- More than 40 pathway group meetings held in west London
- Around 7,000 responses from patients through our patient experience feedback tool
- 17 enthusiastic volunteers joined our Patient Advisory Group
- Over 7,300 downloads from our informatics cloud
- Leading the national design of a new oesophageal pathway
- Working to implement the National Optimal Lung Cancer Pathway
- One of the first Cancer Alliances to trial low dose CT scans to find cases of lung cancer
- Shaping an innovative Radiology Reporting Network

Imperial Specific Programmes and Achievements

The Trust has been pivotal to the achievements in redesigning a number of high volume cancer pathways, ensuring that patients benefit from the latest technologies and innovations available in diagnostics and treatment. These include:

- RM Partners have funded and project managed Imperial's world leading Rapid model, a 'one stop shop' for men with suspected prostate cancer. Professor Hashim Ahmed, ICHT, has pioneered and led the design of the new RAPID prostate diagnostic pathway. Imperial is one of only three hospitals in the world piloting this innovative 'one stop shop' prostate cancer diagnostic service. The service uses new cutting edge 'fusion' technology for targeted, precise biopsies and so reduces the risk of side effects such as life-threatening sepsis. 30% of men find out on the day that they need no further investigation. As a result of implementing the new RAPID pathway at Imperial, 62 day performance for prostate improved from 69% in Q1 2017/18 to 86% in Q2 2017/18.
- During 2018/19, Imperial will launch RMP's new colorectal diagnostic pathway. In this service, specialist nurses work to an algorithm to support patients and ensure they have the most appropriate diagnostic test. The new pathway improves patient experience, allows a speedier diagnosis, and avoids unnecessary invasive tests.
- Imperial continues to have a leadership role in the RMP funded Radiology Reporting Network which is developing and implementing a collaborative sector strategy for Radiology, enabled by a technology solution.
- Significant investment to support diagnostic services supported the Trust to continue to deliver faster diagnosis at the front end of patients' cancer 62 day pathways.

- Working with RM Partners has given Imperial's patients access to a wider range of world-leading clinical trials, such as NICE FIT, and a wider research network through the RMP Vanguard Research Group.

Priorities for 2018/19

We have a busy work plan for 2018/19, with a number of exciting developments on the horizon. We are delivering year two of our transformation programme whilst continuing to support Trusts with the operational delivery of their constitutional cancer targets. The majority of our work will be to improve early diagnosis (ED), with continued focus on piloting and roll out of rapid diagnostic models for prostate, lung, colorectal. We will also be one of the first Cancer Alliances to pilot low dose CT scanning in CCGs where survival rates are lowest, to identify cases of lung cancer early. We are leading a new Radiology Reporting Network, increasing uptake of bowel and cervical screening. Our work with primary care clinicians, including GP education and training, digital solutions and redesigned and more streamline referral routes, all support our aim to diagnose cancers earlier in our population.

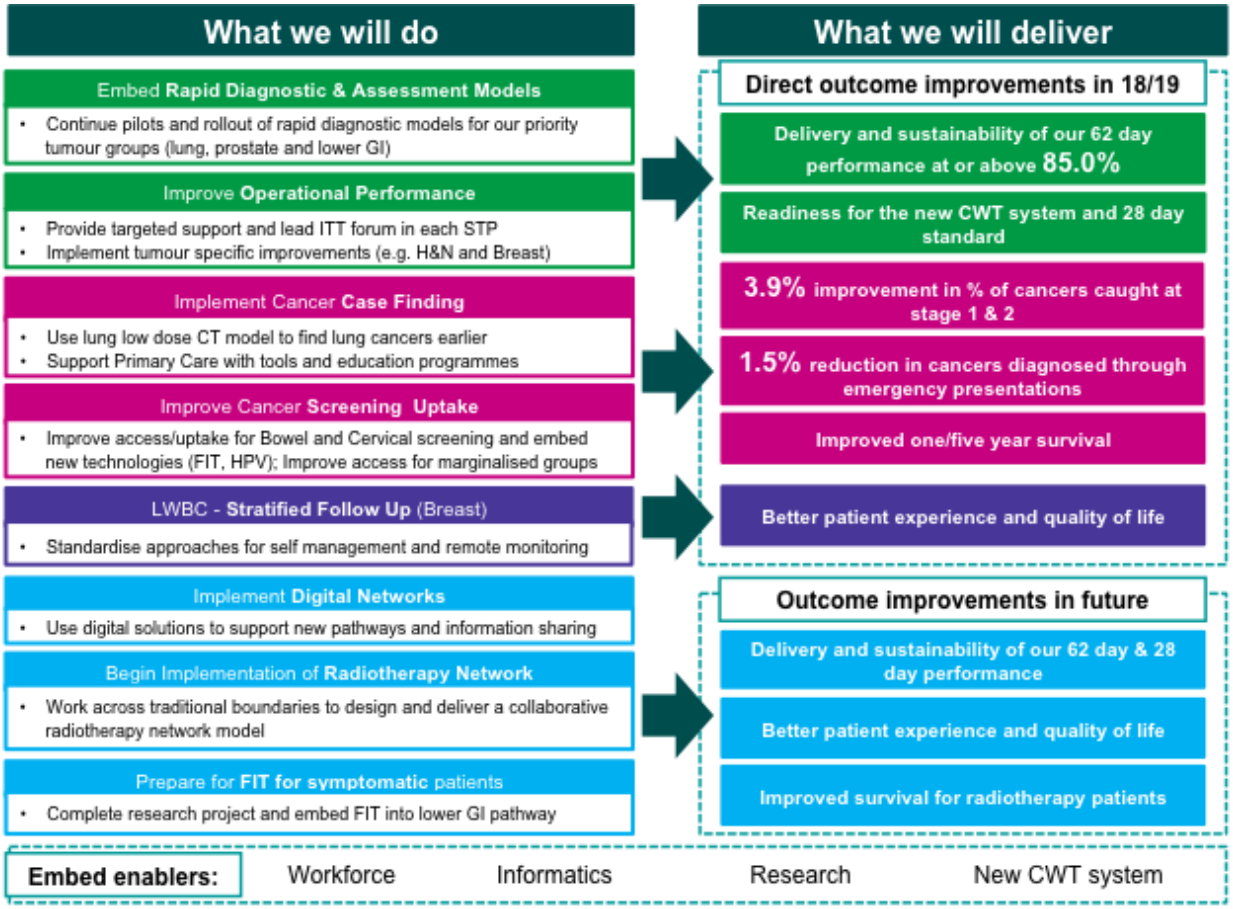
Underpinning this work, we have an active and committed research and innovation strategy, translating cutting edge technologies for our patients as quickly as possible. We are privileged to benefit from the research expertise at our host Trust, The Royal Marsden, and across all our partner organisations including our Academic Health Science Centre partners. The NICE FIT trial and RAPID prostate work would not have been possible without such close working relationships beyond our traditional research boundaries.

Working pan London we secured £2.8m of funding to improve care for those in our communities who are living with and beyond cancer. As part of this, RMP will work with individual Trusts and pan-London colleagues to implement the Recovery Package and risk-stratified follow up pathways for breast cancer patients.

Our transformation funding for Q3 and Q4 is dependent on 62 day performance across west London. RMP is facilitating its Trusts to deliver this sustainably in a number of ways, including providing targeted intensive support to Trusts where required. We are also leading on system level redesign including a head and neck task and finish group, maximising diagnostic capacity, and improving processes for the transfer of patients between Trusts. We will provide leadership in the move towards the 28 day Faster Diagnosis Standard, of which the 2018/19 deliverables include implementing a new national cancer waiting times system and the capture of new data to support the standard.

Cancer workforce will also be a key focus during 2018/19, and we are responding as a partnership to Health Education England (HEE)'s Cancer Workforce Strategy, published in December 2017. Work is already underway to support the priority professions which HEE has identified as having capacity issues over the next two years. Across RMP we are accessing education funding for reporting radiographers, and investigating innovative models of clinical mentorship. We also have projects looking at histopathology, and how to support retired consultants to continue to contribute to the NHS workforce.

The below infographic sets out our programme of work and the outcomes it will deliver:



Recommendations

The Board is asked to:

- note the progress in 2017/18;
- endorse the 2018/19 work programme, and support the Trust's continued contribution to delivery of the programme; and
- discuss how it would like to be informed of future progress.

Appendix

1. Cancer Scorecard May 2018

Appendix 1:
Cancer Scorecard May 2018

Domain	Measure	Benchmark	Period	North West London STP	South West London STP	**RM Partners overall**	Change since last period	Providers/ sites meeting standard	CCGs meeting standard	England average	Ranking against other Alliances
Best Practice Care	1. 2 week wait: Urgent suspected cancer GP referral to 1st seen (Population)	93%	March 2018	93.2%	97.3%	**95.0%**	+0.5%	9/10	12/14	93.2%	
	2. 2 week wait Breast symptomatic referral to 1st seen (Population)	93%	March 2018	89.4%	97.4%	**92.4%**	+0.6%	5/8	8/14	91.0%	
	3. 62 day: Urgent suspected cancer GP referral to 1st treatment (Population)	85%	March 2018	85.7%	89.1%	**87.2%**	+3.2%	8/10	11/14	84.5%	4/19
	4. 62 day: Screening referral to 1st treatment (Population)	90%	Q4 2017/18	81.0%	88.5%	**84.2%**	-7.3%	2/8	5/14	88.7%	
	5. Bowel screening coverage (60-74 year olds)	60%	May 2017	47.4%	54.1%	**50.2%**	+0.3%		0/14	59.1%	18/19
	6. Breast screening coverage (50-70 year olds)	70%	May 2017	64.4%	65.8%	**65.3%**	+.0.2%		1/14	72.3%	18/19
	7. Cervical screening coverage (25-64 year olds)	80%	May 2017	61.4%	68.7%	**64.4%**	-0.8%		0/14	71.8%	19/19
Positive experience	8. NCPES - Q2 – How do you feel about the time you had to wait for your 1st appointment?	England average	NCPES 2016 - Admissions Q1 2016/17	78.7%	80.0%	**79.%**	+1.4%	4/10	2/14	83.3%	18/19
	9. NCPES – Q9 – How do you feel about the way you were told you had cancer.			84.2%	81.1%	**82.1%**	-0.6%	6/10	8/14	84.2%	14/19
	10. NCPES – Q59 – Overall, how would you rate your care?			8.46	8.76	**8.66**	+0.02	4/10	4/14	8.74	17/19
Best Clinical Outcomes	11. Proportion of cancers stage 1 or 2 (Taskforce definition)	England average	2016	52.1%	55.1%	**53.5%**	-0.4%		6/14	53.7%	12/19
	12. Proportion of cancers stage 1 or 2 (CCG IAF definition)	England average	2016	48.6%	53.6%	**50.9%**	+1.6%		4/14	52.9%	15/19
	13. Proportion of patients diagnosed via an emergency (population based)	England average	October 2016 to September 2017	20.9%	17.0%	**19.2%**	-1.5%		7/14	19.2%	
	14. 1 year cancer survival index	England average (95% CI)	2015	74.6%	74.6%	**74.6%**	+0.8/0.9 %			72.3%	1/19
Quality of life	15. Proportion of patients receiving a Holistic Needs Assessment around diagnosis	70%	Q3 2017/18	64.6%	65.8%	**65.0%**	-5.4%	4/10			
	16. Proportion of patients receiving an End of Treatment Summary at end of treatment	70%	Q3 2017/18	17.0%	25.2%	**21.0%**	+5.4%	0/10			
Data quality	17. % completeness of stage at diagnosis – COSD level 2	70%	2017	54.7%	66.3%	**60.1%**	-1.1%	3/10		57.4%	
	17. % completeness of performance status – COSD level 2	70%	2017	48.7%	58.4%	**53.1%**	-12.6%	4/10		48.3%	

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Responsible Officer Annual Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 18, report no. 14**
Responsible Executive Director: Julian Redhead, Medical Director	**Author:** Andrew Worthington, General Manager

Summary:
The Responsible Officer is mandated to produce an annual report for submission to the Trust Board. The purpose of this report is to detail the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation. The Chief Executive Officer will then sign a statement of compliance to confirm that the core standards as mandated by NHS England are being met by the organisation.

This report is being presented for review at Trust Board, following presentation at Executive Quality Committee in July 2018. The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 28th September 2018 to NHS England.

Recommendations:
The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 28th September 2018 to NHS England.

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

Quality impact:
There is a statutory requirement for the RO to produce an annual report. Medical revalidation aims to improve standards, safety and promote trust in the medical profession. The CQC domains that will be improved from this paper are safe, effective and well-led.

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

Risk impact and Board Assurance Framework (BAF) reference:
There are no risks attached to this paper

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

What impact will this have on the wider health economy, patients and the public?
None

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.

Imperial College Healthcare
NHS Trust

Responsible Officer's Annual Report

1. Executive Summary

1.1. The role of Responsible Officer (RO) is set out in statute and includes making sure there are systems in place in healthcare organisations to evaluate doctors' practice on an on-going basis. This includes making sure doctors are regularly appraised and there are processes to investigate and refer any fitness to practice concerns to the GMC. The RO makes recommendations to the GMC about each doctor's revalidation and is usually an executive member of the board.

1.2. The RO of each organisation is expected to complete an annual report which describes activities and the processes in place that guarantee the appropriate safe management of revalidation.

1.3. Each year, the Trust board is asked to confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations". The Chief Executive Officer will then sign a statement of compliance to confirm that the core standards as mandated by NHS England are being met by the organisation prior to submission to the higher-level responsible officer by 28th September 2018 to NHS England.

2. Purpose

2.1. This report is being presented for review at Trust Board, following presentation at Executive Quality Committee in July 2018. The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 28th September 2018 to NHS England.

3. Background

3.1. The background to the requirement of this report is described in detail within the report in **appendix 1**. The purpose of this report is to:

- Provide an annual report on compliance with the Framework of Quality Assurance (FQA) standards;
- Provide assurance of the Trust's compliance with the FQA standards.

4. Summary/Key points

The RO annual report is included as **Appendix 1**. The report demonstrates that the Trust meets the requirements for compliance with the FQA and that the Trust meets its statutory duty to support the RO to discharge their duties. The report describes how the ten standards are met by the organisation and this should provide the assurance required for the Trust board to sign the statement of compliance.

5. Options appraisal including financial appraisal (as relevant)

N/A

6. Conclusion and Next Steps

6.1. Once approved by the Trust Board the statement of compliance will be signed off by the Chief Executive Officer. The statement of compliance is included as an appendix to the RO report.

7. Recommendations

7.1. The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 28th September 2018 to NHS England.

Author Andrew Worthington, General Manager
Date 20th June 2018

Responsible Officer's Annual Report – Revalidation & Appraisal

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

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

The purpose of this report is:

- Provide an annual report on compliance with the Framework of Quality Assurance (FQA) standards;
- Provide assurance of the Trust's compliance with the FQA standards.

1. Background

Revalidation is the process by which all licensed doctors with a license to practice are required to demonstrate that they are up to date and fit to practice in their chosen field and able to provide a good level of care. Medical Revalidation started on 3rd December 2012 and comprises a five year cycle; therefore, the majority of doctors are now starting their second revalidation cycle.

The purpose of revalidation is to strengthen the way that doctors are regulated, improve the quality of care provided to patients, improve patient safety and increase public trust and confidence in the medical system. Licensed doctors revalidate by having an annual appraisal (based on the GMC core guidance for doctors, *Good medical practice*), and a five-yearly recommendation from their Responsible Officer.

Most licensed doctors have a prescribed connection with one organisation where they conduct the majority of their clinical work that provides them with an annual appraisal, and helps to support the revalidation process. This organisation is referred to as a 'designated body'.

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

In December 2017, the Trust's Medical Director, Professor Julian Redhead, became the Interim CEO which meant he was unable to fulfil the role of RO. As such, one of the two interim medical directors, Prof Tim Orchard, completed his RO training and was approved by the board to undertake this role. Professor Redhead returned to the RO role when he resumed his position as Medical Director in May 2018.

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

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;

- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locum doctors) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

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

2. External Monitoring & Assurance

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

- the Annual Statement of Compliance (see Appendix A and section 2.2) to NHS England, due by 28th September 2018;
- the Annual Organisational Audit (AOA) End of Year Questionnaire return to NHS England, which was submitted on 8th June 2018 (see Appendix B);
- An Annual Report to the Trust Board on compliance with these standards (this report).

2.1. Statement of Compliance

The Responsible Officer Regulations (ROR) set out the obligation on the part of designated bodies to provide support to the RO. In demonstrating this support, the chief executive is asked to sign a statement of compliance with the ROR. This statement is due to be submitted to NHS England by 28th September 2018.

The completed statement can be found in Appendix A. The Trust is compliant with all ten standards, as detailed below.

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

The Trust is a recognised designated body. The Trust's RO is Professor Julian Redhead, Medical Director who has received the appropriate RO training. The 'Alternative Responsible Officer' is Dr Geoff Smith, Associate Medical Director, who came into post in May 2018 and is due to complete RO training in September. Dr Smith has already participated in the Appraisal Lead and RO networks held in London in June. The RO and ARO have PAs that are dedicated to fulfilling this role and are supported by a General Manager in the Medical Directors Office and the Professional Development team.

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

The Professional Development (PD) Team is part of the Office of the Medical Director and reports to the General Manager. The PD Team maintains and verifies an accurate electronic record of all doctors with a prescribed connection to ICHT using the GMC Connect database.

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

All appraisers are required to undertake appraiser training and then receive refresher training every 3 years. This is delivered internally, and the curriculum has been validated with NHS England and complies with their guidance 'Training Specification for Medical Appraisers in England'.

As of 31 March 2018, there are 208 trained appraisers in the Trust, and a total of 1170 requiring appraisal. The ratio of appraisers to appraisees is 1**:**5.6, which complies with the NHS England recommendations.

Departments with fewer numbers of appraisers, or those with a high turnover of staff or inactive appraisers, are being offered the opportunity to train more appraisers to make up any shortfall. All Heads of Speciality are aware that they must have adequate numbers of trained appraisers within their speciality, as stated in the Appraisal policy.

STATEMENT 4 **- Medical appraisers participate in on-going performance review and training / development activities**

In addition to the training described in statement 3, appraiser forums are run on a quarterly basis. These forums rotate between each site and allow appraisers the opportunity to share best practice and development opportunities and benchmark performance.

A questionnaire was sent to all the appraisers to establish if there was any further training or development requirements, and the appraiser refresher training took into account these results. The last Appraiser Refresher training was run in June 2018.

The Trust commissioned an external company, Miad Healthcare, to audit compliance against the RO regulations in December 2017. This audit showed that we met the required core content for Appraisers (p.34 and p.36). They included general recommendations for further quality assurance of the appraisers outputs of appraisal, that will be incorporated into future training sessions (Appendix c p.26), but stated that overall:

"… the calibre and commitment of the appraisers… interviewed, was extremely high. Their enthusiasm to ensure appraisal was meaningful and of value, and their insight on the value of their personal development was clear. They were very complimentary about the support they received"

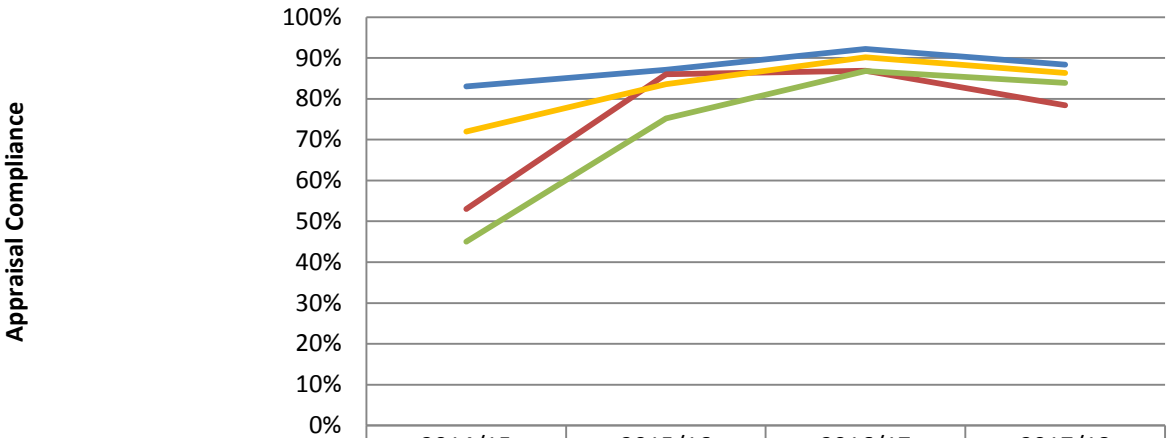
STATEMENT 5 **- All licensed medical practitioners either have an annual appraisal in keeping with GMC requirements or, where this does not occur, there is full understanding of the reasons why and suitable action taken;**

In addition to the contractual requirement, annual appraisal for doctors is a requirement for GMC revalidation. Compliance with annual appraisal for 2017/18 was submitted to NHS England on 8th June as part of the AOA submission and can be found in appendix B.

FQA appraisal compliance for 2017/18 has decreased from 2016/17 by -3.86%, and there is a further breakdown of this in table A. This is being addressed by the updated Appraisal and Revalidation policy (published February 2018), that sets out a clear escalation process for doctors who are non-compliant with annual appraisal. Overdue appraisals are being reported monthly, and there is an escalation process for those doctors whose appraisal is over 12 weeks late. There are

currently 22 doctors engaged in this escalation process.

Table A: Annual Appraisal Compliance



	2014/15	2015/16	2016/17	2017/18
Consultants	83%	87.10%	92.20%	88.34%
Staff grade, associate specialist, specialty doctor	53%	86%	86.90%	78.45%
Temporary or short-term contract holders	45%	75.20%	86.80%	83.93%
Total Staff	72%	83.60%	90.20%	86.34%

An annual audit of all missed appraisals will be included in the comparator report for the Annual Organisational Audit (AOA) for appraisal and revalidation due in September.

***STATEMENT 6* - There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners and ensuring that information about these matters is provided for doctors to include at their appraisal;**

Performance is managed through the clinical divisions' local quality governance structures. Clinical outcome data, such as directorate specific mortality reports, is provided to Heads of Specialty and Clinical Directors. Clinical Governance information is provided to doctors and the RO by the Safety and Effectiveness Team in line with DH, NHS England and NICE guidelines.

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

The Trust has published a Raising Concerns policy. There is an established process within the Trust for dealing with any concerns about a doctor's fitness to practise; all concerns and investigations are logged electronically and centrally by the Medical Director's office. The Trust has an on-going programme of delivering investigation training to the standards required by the National Clinical Assessment Service.

STATEMENT 8 **- There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers in other places where the licensed medical practitioner works;**

There is a procedure in place for obtaining and sharing information about doctors between our RO and those of other designated bodies, and with the GMC. The Trust uses the approved NHS Medical Practice Information Transfer (MPIT) form to share this information. We routinely request information from other organisations where a doctor clinically practices during their revalidation period in line with the NHS Revalidation Support Team document (now NHS England) 'Information Management for Medical Revalidation in England'.

STATEMENT 9 **- The appropriate pre-employment background checks are carried out to ensure that all licenced medical practitioners have qualifications and experience appropriate to the work performed;**

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

An audit of recruitment and engagement background checks will be included in the comparator report for the AOA for appraisal and revalidation due to be completed later in the year.

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

The development plan includes the areas where risk is identified and recorded on the risk register as follows:
There is a risk that doctors are working without a valid honorary contract due to inefficiencies with the current system for the issue and management of these contracts within HR. ESR is not being used correctly to record professional registrations and contractual information. This can mean that the PD team are not able to determine which doctors have a valid contract in order to be revalidated by the Trust, and there is a risk that doctors could end up working in the Trust without a valid contract.

In addition to this risk, there are also data quality issues within the various systems used to keep connections and information about doctors employment status up to date. This can result in late connections being made to the Trust, which in turn can result in late referrals or missed appraisals. The PD team and HR have worked closely together during recent job planning exercises to cleanse some of this data, but data quality remains an issue that requires continued focus within the PD and HR teams.

The contract with Premier IT who provides the electronic appraisal and revalidation database ('PrEP') will require renewal next year. Ahead of this, there will be an exercise to review other products that are available before commencing a tendering process.

Reminders to complete appraisal, and additional reminders once appraisal is overdue, are generated by email automatically from the PrEP system. However, there is no automated reporting system that allows central monitoring of this, and therefore a manual check is required. This has often led to delays in escalating overdue appraisals. New processes to monitor this monthly have recently been implemented and progress will be reported retrospectively.

2.2 Annual Organisational Audit

The annual audit provides assurance to patients, the public, the service and the profession that the systems and processes underpinning revalidation are in place and are working effectively. The Responsible Officer has confirmed that the Trust is compliant with all aspects of the AOA End of Year Questionnaire. This was submitted on 8th June and the final version of the submitted audit is attached as appendix B.

2.3 Quality Assurance

Governance Arrangements

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

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

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

Policy and Guidance

The Appraisal Policy has been updated with input from the LNC and ratification at ExCo. MIAD reviewed the policy as part of their audit and found:

"…this to be an excellent policy and some minor suggestions for additional detail can be found in section 4, Summary of Recommendations." (P.8, Appendix C)

Access, security and confidentiality

Information is stored either in a secure area on the Trust network electronic drives, or on the appraisal system PReP. PReP has been approved by the Caldicott Guardian and confirmed their compliance with GDPR requirements on the 09/03/2018. The Trusts' IAR records have been updated to reflect this.

The Data Protection Act governs the collection, retention, and transmission of information held about living individuals and the rights of those individuals to see information concerning them. The Act also requires the use of appropriate security measures for the protection of personal data. Any information management breaches are escalated to the Professional Development team.

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

2.4 Quality Review Visit

Higher Level Responsible Officer (HLRO) Quality Review Visit

The NHS England London Revalidation Team visited the Trust, in February 2018 for a HLRO quality review visit. As well as highlighting examples of good practice, the team offered some recommendations. An action plan has been developed to address these recommendations, with a 6 monthly update due (see Appendix E for the report that was submitted to ExQu following this visit).

Recommendations

The Board is asked to note this report and confirm that they are satisfied that "the organisation, as a designated body, is in compliance with the FQA regulations" to enable sign off and submission to the higher-level responsible officer by 28th September 2018 to NHS England.

APPENDIX A

Designated Body Statement of Compliance

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

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

   Comments: Yes

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

   Comments: Yes

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

   Comments: Yes

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

   Comments: Yes

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

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

   Comments: Yes

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

   Comments: Yes

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

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

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

Comments: Yes

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments: Yes

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

Comments: Yes

Signed on behalf of the designated body

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

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

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

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

APPENDIX B

AOA report

Imperial College Healthcare NHS Trust

APPENDIX C

MIAD report

Imperial College Healthcare NHS Trust

APPENDIX D

HLRO Visit

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Report title: Safe, Sustainable and Productive Nursing and Midwifery Staffing Annual Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 19, report no. 15**
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

- A number of key initiatives and work streams are being undertaking in light of the current national nursing and midwifery staffing landscape.
- 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.
- 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 presented to the Executive Committee and approved in May 2018.
- 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, apprenticeships in nursing and advanced clinical practitioner roles.
- A safe staffing task and finish group has been established to drive forward key work streams in reponse to the publication of various national guidance.
- In light of this, the Trust's safe staffing policy has been reviewed.

Part 2 - Annual nursing and midwifery establishment review

- An annual 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.
- It is important to note that this year, the establishment data has been extracted from the electronic staff record (ESR).
- As part of a data cleansing exercise to ensure the integrity of the data is robust, the data has been reconciled against the budget and the actual establishment where any anomalies have been identified.
- The changes to establishments can be found in Appendix 2
- In line with best practice, a mid-year establishment review will be undertaken later this year and the outcomes reported to this committee thereafter.
- The next annual establishment review will take place by March 2018 and reported in May 2018,

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

Report discussed at:
Executive Quality Committee
Quality Committee

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.
- An annual establishment review of nursing and midwifery has taken place.

Annual 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.
- This is believed to be partly due to the loss of the student bursary has resulted in a reduction in students commencing nurse training on the traditional degree pathway.
- There is also uncertainty about the funding for PG Diploma students which will reduce student pipelines even further.
- There has been a reduction in funding for Continuing Personal and Professional Development (CPPD) 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 presented to the Executive Committee and approved in May 2018.

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 committee 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.
- There will be up to 30 nursing associate apprentices starting at the Trust in the autumn of 2018 and another cohort of nursing associate apprentices starting in early 2019.
- Filling these places is dependent upon running a successful internal and external recruitment

campaign.

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 Nursing and Midwifery Council (NMC) and they will train in a range of practice placement settings.
- 50 registered nurse apprenticeship places will be available at the Trust from September 2018.

3.3 Advance Clinical Practitioner

- Advanced clinical practitioners come from a range of professional backgrounds such as nursing, pharmacy, paramedics and occupational therapy. They are healthcare professionals educated to Masters level and have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.
- Advanced clinical practitioners (ACPs) enhance capacity and capability within multi-professional teams by supporting existing and more established roles. They help to improve clinical continuity, provide more patient-focused care, enhance the multi-professional team and help to provide safe, accessible and high quality care for patients.
- Currently at the Trust, ACPs are developed through continuing professional and personal development.
- The Advanced Clinical Practitioner (ACP) apprenticeship standard and assessment has been nationally approved and going forward, the Trust will tender for the a supplier to deliver the ACP apprenticeships

4. Safe staffing

The Trust has established a safe staffing task and finish group chaired by the Director of Nursing to take forward a range of work streams. An update on progress against some of these is outlined below.

4.1 Annual establishment review

- In order to ensure the right people, with the right skills, are in the right place at the right time, an annual 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 v 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 safe staffing 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. This will be reviewed after 3 months to understand whether the multipliers can be cascaded to the remaining adult inpatient wards
    - the new Children and young people SNCT multipliers and definitions have been recently released and will follow the same path as the adult inpatient wards to trial the collection of data

- Exploring optimisation of SafeCare functionality – ability to raise red flags through HealthRoster and alert relevant managers to take action, the potential of transferring acuity data from Cerner into HealthRoster & 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 is currently exploring the use of specific real time 'red flags' through the SafeCare module which is being take forward by the safe staffing task and finish group.

4.4 Care hours per patient day

- 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 *Care Hours Per Patient Day* (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.
- The CHPPD information is also included in the model hospital data set
- Through the safe staffing task and finish group, a specific CHPPD work stream has been established.
- The work stream will; review the current process of capturing and submitting the data and will also develop a framework for utilising this data (as well as the benchmarking data through model hospital) internally to support establishment reviews and decision making where appropriate.
- The Trust is also working with NHS Improvement to develop the CHPPD metric to include Allied Health Professionals.

4.5 Review of the Trust's safe staffing policy

- In light of the current work being undertaken through the task and finish group, a review of the Trust's *Policy for the Provision of Safe Nurse Staffing and Skill Mix Establishments* has been undertaken and the changes approved by the Executive Committee in July 2018.
- A further review of the policy will be undertaken in the autumn 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 above through the safe nurse staffing task and finish group.

6. Recommendations

- To note the paper and work being undertaken

END OF PART 1

PART 2 - Annual 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 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.

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 are able to provide appropriate levels of care to patients. The annual 2018/19 nursing and midwifery establishment review follows that which was undertaken in the summer of 2017 and presented to the Board in September 2017.

2. Purpose

Following the publication of safe staffing guidance by the National Quality Board in 2016, an updated improvement resource for adult inpatient wards in acute hospitals was published in January 2018. It sets out that '*Boards should carry out a strategic staffing review as outlined by NQB (2016) at least annually, aligned to the operational planning process, or more frequently if changes to services are planned. Boards should be assured that these key elements of planning are followed:*

- *Using a systematic, evidence based approach to determine the number and skill mix of staff required*
- *Exercising professional judgement to meet specific local needs, but ensuring this does not duplicate elements included in the tool used – for example, if the tool takes account of patient turnover, any additional allowance for this would be duplication*
- *Benchmarking with peers – for example, care hours per patient day (CHPPD) through the Model Hospital*
- *Taking account of national guidelines, bearing in mind they may be based on professional consensus.*

The following part of this report presents the outputs of the *'strategic staffing review'* (establishment review) and addresses each of the *'key elements of planning'* as outlined above.

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) between November 2017 and March 2018 and have been aligned to the operational planning and budget setting process.
- A summary of the establishment review process is outlined in *Appendix 1.*
- ***A systematic, evidence based approach to determine the number and skill mix of staff required*** has been followed using the tools outlined below:
    - *Adult inpatient areas:* The Safer Nursing Care Tool (SNCT) has been used and is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity /

dependency terms.
    - Children and young people inpatient areas: The multipliers within the SNCT for children's and young people have been used.
    - Maternity: The birth rate plus tool has been utilised and a full assessment been undertaken.
- In addition to the evidence based tools described above, the following have been considered:
    - A range of quality indicators
    - Changes in bed base and activity
    - Changes in the environment of care (e.g. the ward design or layout)
- ***National guidelines*** such as those outlined in section 1 and 2 of this paper have been taken into account as well as *Guidance On Safe Nurse Staffing Levels in the UK* which sets out the following principles:
    - Staying above a 65%: 35% ratio (registered nurse : unregistered care staff) unless a different skill mix has been deemed appropriate by the Directorate Lead Nurse and the DDN.
    - Not going above a 1:8 ratio (registered nurse : patient) in adult inpatient areas during the day.
    - Optimising the visibility and supervisory status of the Ward Sister/ Charge Nurse/Matron
- All of the above has been underpinned by the nursing and midwifery leadership teams ***exercising professional judgement to meet specific local needs.***
- As outlined in part 1 of this paper, the Trust is currently reviewing the use of ***benchmarking*** data such as CHPPD through the model hospital data set and will look to incorporate this in future establishment reviews.
- 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.
- The Director of Nursing has also subsequently met with a sample of ward sisters/charge nurses and matrons from each division to discuss the staffing and skill mix arrangements in their areas.

3.1 Changes to the establishment review process since 2017

3.1.1 Data source

- It is important to note that this year, the establishment data has been extracted from the electronic staff record (ESR).
- As part of a data cleansing exercise to ensure the integrity of the data is robust, the data has been reconciled against the budget and the actual establishment where any anomalies have been identified.

3.1.2 Areas included in the review

- In previous reports to this committee, establishment data largely relating only to inpatient areas was included.
- For the recent review undertaken, all clinical areas (inpatient, outpatient, theatres, endoscopy, renal satellite units, support services etc.) have been included.
- This is keeping in line with good practice which suggests that the same review process should be undertaken and reported for all areas.
- The data therefore being presented in section four of this report for 2018/19 includes additional areas which have not previously been reported.
- To this end, comparator data from the review reported in September 2017 has only been included at divisional level within the report but not at ward level.

4. Establishment review findings

An overall divisional summary is presented in *Appendix 2* and a more detailed breakdown of the current establishments for each clinical area is presented in *Appendices 3a-3d.*

4.1 Division of surgery, cancer and cardiovascular sciences

Overall there has been a reported increase of 163.08 whole time equivalents (WTE) when compared to the establishment data reported for March 2017. However, it is important to note that the actual increase in establishment for inpatient areas reported on in 2017 is 43 WTE.

TABLE 1 - Division of surgery, cancer and cardiovascular sciences

Establishment in March 2017 WTE	Establishment in March 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
1383.35	1546.43	+163.08	1276.29	270.62	83%	17%

Key reasons for this are:

- An actual increase in establishment of c.43 WTE to support the reconfiguration of critical care at the St. Mary's site which took place in June 2018.
- Approximately 63 WTE of the increase can be attributed to areas that have not previously been reported to this committee. These areas include; the cardiac catheter lab and day unit and the surgical assessment unit.
- An increase in bed base in areas such as ward C8
- An increase in activity in theatres at the St. Marys and Charing Cross sites
- Increased acuity and dependency of patients.

4.1 Division of women's, children's and clinical support services

Overall there has been a reported reduction of 8.95 WTEs when compared to the establishment data reported for March 2017.

TABLE 2 - Division of women's, children's and clinical support services

Establishment in March 2017 WTE	Establishment in March 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
881.02	872.07	-8.95	672.26	199.81	77%	23%

Key reasons for this are:

- A review of the skill mix within children's services where although the actual number of WTEs has reduced, the skill mix has been enhanced to meet the increased acuity of patients.
- A review of the capacity and acuity levels within gynaecology
- Reduction in activity and income in some areas resulting in not as many WTEs required

4.2 Division of Medicine and integrated care

Overall there has been a reported 'increase' of c.580 WTE when compared to the establishment data reported for March 2017. However, it is important to note that the actual increase in establishment for inpatient areas reported on in 2017 is 72 WTE.

TABLE 3 - Division of Medicine and integrated care						
Establishment in March 2017 WTE	Establishment in March 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
1077.00	1657.63	+580.63 (All areas, including newly reported areas)	1235.21	422.42	75%	25%

Key reasons for the increase are:

- An actual increase in establishment of c.72 WTE to support additional activity, new specialties e.g. acute respiratory units and an increase in patient acuity and bed base.
- The remaining 'increase' can be attributed to areas that have not previously been reported to this committee such as; endoscopy (400+ WTE) and renal satellite units.

4.3 Imperial private healthcare

Overall there has been an increase of 3.11 WTE when compared to the establishment data reported for March 2017.

TABLE 4 - Imperial private healthcare						
Establishment in March 2017 WTE	Establishment in March 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
184.00	187.11	3.11	144.59	42.52	77%	23%

Key reasons for this are:

- The registered nursing presence at night on each hospital site has been enhanced
- The nursing management structure has been flattened with the removal of some posts and an increase in skill mix of others to ensure more robust site based leadership.
- The establishments have been re-aligned so that wards on all sites are using a consistent approach to staffing.

5. Next steps

- In line with best practice, a mid-year establishment review will be undertaken later this year and the outcomes reported to the Board in November 2018.
- In preparation for this, an updated set of multipliers for calculating acuity and dependency (as outlined in Part 1, section 4.2 of this paper) will be trialled within some adult inpatient areas with a view to roll-out across all adult inpatient areas.
- The next annual establishment review will take place by March 2019 and reported in July 2019.

6. Recommendations

- Note the outcomes from the establishment review

END OF PART 2

Appendix 1 – Establishment review process

- Divisions assess each ward / department for adult inpatient acuity and dependency using the past 3 months' data taken from the electronic 'Safe Care' module (this uses the Safer Nursing Care Tool).
- The Association of UK University Hospitals (AUKUH) multipliers are then used for adult inpatient areas to inform the setting of establishments allied to the acuity and dependency measurement.
- For children and young people inpatient areas, the multipliers within the SNCT for children's and young people are used.
- For maternity a full assessment using the birth rate plus tool is undertaken.
- Professional judgement is also applied in addition to this to consider factors such as; average patient turnover, layout and size, and staff factors such as nursing activities and responsibilities other than direct patient care.
- The registered staff to unregistered staff ratios are reviewed by taking into account the level of knowledge, skill and competence of the healthcare assistants in relation to the care that needs to be given and the requirement for registered nurses to support and supervise healthcare assistants.
- The registered staff to patient ratios are reviewed
- Divisions will review whether the ward nursing staff establishment adequately meets patients' needs using the indicators outlined in the Trust's Harm Free Care and Patient experience reports
- An uplift of 20.5% is applied to take account of sickness, study leave and annual leave
- An allowance of 2.5% for maternity leave is centrally managed within the Trust.
- The nursing establishment is turned into an operational rota, which determines how many nurses and at what level (band) are working on each shift.
- All establishments post the establishment review is agreed by the divisional director of nursing, directorate teams and ward / department sister/charge nurse.
- The establishments are also approved by the divisional leadership team to include colleagues from finance and people and organisation development.
- The establishments are then signed off by the director of nursing

Appendix 2 – Divisional summary of establishment review findings

Clincial Division	Total registered nurse and unregistered care staff WTE March 2017	Total registered nurse and unregistered care staff WTE March 2018	Change to establishment (including newly reported areas for 2018/19)	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	881.02	872.07	-8.95	672.26	199.81	77%	23%
Surgery, Cancer and Cardiovascular sciences	1383.35	1546.91	163.56	1276.29	270.62	83%	17%
Medicine and integrated care	1077	1657.63	580.63	1235.21	422.42	75%	25%
Imperial Private Healthcare	184	187.11	3.11	144.59	42.52	77%	23%
GRAND TOTAL	3,525.37	4,263.72	738.35	3,328.35	935.37	78.06%	21.94%

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

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Research Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 20, report no. 16**
Responsible Executive Director: Prof Julian Redhead, Medical Director	**Author:** Paul Craven (Head of Research Operations) / Mark Thursz (Director of Research)

Summary:

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

- A summary of non-commercially sponsored clinical trials activity hosted by ICHT in 2017/18 and associated metrics;
- A summary of – and key examples from – the recently-submitted BRC annual report;
- Translational research-related news and some important publications from the NIHR Imperial Biomedical Research Centre (BRC).

Recommendations:

The Board is asked to note the Q1 2018/19 R&D report.

This report has been discussed at:

☒ Executive Transformation Committee
☒ Board Quality Committee

Quality impact:

The quality and scale of biomedical and clinical research carried out across the Imperial Academic Health Sciences Centre (AHSC) will impact patient care in the future in terms of innovative treatments, diagnostics and devices. Research activity includes many specific examples of patient benefit. Patient and public involvement in research is enabled through the Imperial Patient Experience Research Centre (PERC), and a strategy exists to involve/engage patients and the public in the research we do.

Financial impact:

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

1) Has no financial impact.

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

Risk impact and Board Assurance Framework (BAF) reference:

There are no specific risks attached to this report. The general risks associated with research are financial and reputational. Competition for research funds is extremely high and Imperial must continue to demonstrate a high level of high-quality research outputs and activity, as well as value for money.

Workforce impact (including training and education implications):

None.

What impact will this have on the wider health economy, patients and the public?
Evidence has shown that NHS Trusts which are research-active demonstrate better clinical outcomes. Being involved in research offers clinicians innovative new techniques, as well as the opportunity for medical and non-medical staff to consider how best to improve healthcare for their patients. Patients benefit from new and innovative treatments before they reach market, and also benefit from the additional visits, tests and monitoring provided by trial teams.

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:

- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.

A) 2017/18 Non-Commercially-Sponsored Clinical R&D Activity: Year-End Review

1.1. This report focusses on research trials in 2017/18 which were non-commercially sponsored, reflecting on the more academic / publicly-funded work which goes on at ICHT.

i) Recruitment

1.2. The following data comes from the NWL Clinical Research Network (March 2018 report and Online Data Platform);

1.3. ICHT recruited a total of 16,922 patients into non-commercially sponsored NIHR Portfolio studies, against an in-year target of 10,087;

1.4. These studies essentially reflect successful grant applications, which may be sponsored / led by Imperial or by other external university/NHS partnerships;

1.5. ICHT was the 5th highest such recruiter in the country, behind Oxford Univ Hospital, Guy's & St Thomas', Leeds Teaching Hospital and Univ Hospital Southampton. The top 20 recruiting NHS Trusts are shown in Table 1 below (datacut: 19 June 2018);

1.6. In terms of number of studies recruiting (331), ICHT was 10th in the country;

Trust Name	Trust Type	Studies	Participants
Oxford University Hospitals NHS Foundation Trust	Acute	409	19,282
Guy's and St Thomas' NHS Foundation Trust	Acute	433	18,794
Leeds Teaching Hospitals NHS Trust	Acute	355	17,718
University Hospital Southampton NHS Foundation Trust	Acute	324	17,537
Imperial College Healthcare NHS Trust	Acute	331	16,922
The Newcastle Upon Tyne Hospitals NHS Foundation T	Acute	412	16,494
King's College Hospital NHS Foundation Trust	Acute	258	16,130
Barts Health NHS Trust	Acute	274	15,889
Sheffield Teaching Hospitals NHS Foundation Trust	Acute	347	14,008
Bradford Teaching Hospitals NHS Foundation Trust	Acute	139	13,917
NHS Lothian	-	266	13,673
University College London Hospitals NHS Foundation Tr	Acute	335	10,812
Nottingham University Hospitals NHS Trust	Acute	354	10,564
NHS Greater Glasgow and Clyde	-	332	10,423
Alder Hey Children's NHS Foundation Trust	Acute	72	9,599
Royal Liverpool and Broadgreen University Hospitals NH	Acute	111	9,517
University Hospitals of Leicester NHS Trust	Acute	260	9,517
Cambridge University Hospitals NHS Foundation Trust	Acute	336	8,728
Manchester University NHS Foundation Trust	Acute	293	8,479
University Hospitals Birmingham NHS Foundation Trust	Acute	213	7,736

Table 1. Non-commercial NIHR Portfolio study recruitment by NHS Trust (top 20).

1.7. When broken down by clinical specialty (see Table 2), Children's was the highest recruiter in 2017/18 (this is primarily a result of a single study – PERFORM – which involved a retrospective analysis of >4400 patients' data);

1.8. Renal, Infection, Surgery, Injuries & Emergencies, Cancer and Cardiovascular all recruited more than 1,000 patients into non-commercial studies;

1.9. The Cancer specialty recruited to the highest number of individual studies (80), followed by Cardiovascular, Children, Reproductive Health & Childbirth and Infection;

1.10. Caveat: 'Badging' of studies into particular clinical specialties is carried out nationally and can lead to some misrepresentation of current levels of activity.

Specialty	No. of Studies	No. of Participants
Children	24	4,953
Renal Disorders	11	2,114
Infection	19	1,572
Surgery	15	1,207
Injuries and Emergencies	9	1,181
Cancer	80	1,091
Cardiovascular Disease	41	1,004
Reproductive Health and Childbirth	22	945
Critical Care	8	420
Metabolic and Endocrine Disorders	9	345
Musculoskeletal Disorders	16	291
Hepatology	9	250
Anaesthesia, Perioperative Medicine and Pain Management	4	220
Diabetes	9	210
Genetics	5	144
Gastroenterology	3	127
Dementias and Neurodegeneration	8	122
Dermatology	2	115
Health Services Research	4	114
Ophthalmology	4	111
Respiratory Disorders	7	88
Mental Health	4	73
Haematology	4	71
Neurological Disorders	4	64
Stroke	9	59
Ageing	1	31
Grand Total	**331**	**16,922**

Table 2. Non-commercial NIHR Portfolio study recruitment by specialty in 2017/18.

ii) Recruitment to Time and Target

1.11. In 2017/18, 73% of ICHT non-commercial studies (79 out of 108) recruited to time and target, against a national High Level Objective (HLO) of 70%. The performance in this metric across NWL as a whole was 78%.

1.12. ICHT represents ~45% of the total non-commercial study activity in NWL.

iii) Study Set-Up Times

1.13. In 2017/18, according CRN metrics, only 45% of studies met our target of confirming capacity and capability within 40 calendar days. This is against a national metric of 80% of studies.

1.14. This is an issue we are actively focusing on each week, by dealing with costing and contractual negotiations faster, by escalating issues, by identifying and eliminating duplication in processes, and by working closer with clinical teams. It should be noted that our performance in the roughly equivalent metric (reported to a different part of NIHR) is significantly better than this, in that>65% of interventional studies recruit their first patient within 70 calendar days.

1.15. NIHR are currently in the process of aligning these two metrics to provide one consistent study set-up measure and we await this.

B) NIHR Imperial BRC – Annual Report 2017/18

1.16. The NIHR Imperial BRC Annual Research Report (ARR) for 2017/18 was submitted to NIHR on 18 May, following CEO approval. It was circulated to ExCo prior to this.

1.17. The narrative part of the ARR consists of a number of specific sections, which must be completed in a structured format according to NIHR guidance. An over-arching progress update for the BRC is required including top 3 achievements for the previous year, as well individual Theme sections providing progress against their objectives as described in our original application. Also sections on PPI/E, training, industry collaborations, and links with other NIHR infrastructure. Finally, NIHR want to see examples of projects that have progressed along the translational pathway and which are beginning to have an impact on patient health or the healthcare system.

Top 3 achievements

1.18. We described the top 3 achievements of the BRC in the 2017-18 FY as follows:

1.19. A first-in-man, commercially-sponsored gene therapy trial, conducted in the NIHR Imperial Clinical Research Facility (CRF) and with Professor Mike Laffan as local study lead, showed remarkable success in treating patients with haemophilia A. The success of the study has led commentators to hail this as a potential cure for haemophilia A. Published in NEJM and larger trials now planned;

1.20. ORBITA – the first, placebo-controlled double-blind randomised controlled trial of percutaneous coronary intervention (PCI) – demonstrated the potential placebo effect of heart stents. The trial exposed the flawed position of PCI in current clinical recommendations;

1.21. A unique CAR-iNKT cell treatment strategy, developed by Dr Karadimitris in the Cancer Theme proved more effective than conventional treatments. It has clear clinical implications and a patent has been filed.

Translational Pathway

1.22. In terms of projects which are progressing (or have progressed) along the translational pathway, the annual report notes the following:

1.23. Based on clinical evidence contributed from BRC projects and investigators, along with data supporting the cost effectiveness in comparison with other treatment strategies, Faecal Microbiota Transplantation (FMT) has now been accepted as an appropriate treatment option for recurrent/refractory C. difficile infection (CDI) by the National Institute for Health and Care Excellence, Public Health England and European guidelines. A clinical FMT service has now been established at ICHT.

1.24. The deployment of a clinical app called “Streams” provides mobile pathology and radiology results viewing for doctors, speeding up access to results and helping to ensure that patients receive the right care from the right clinician at the right time. The app encompasses other functionality including task management, which are underpinned by academic research and early product development carried out by the NIHR Imperial BRC and piloted at ICHT as part of an app called ‘Hark’.

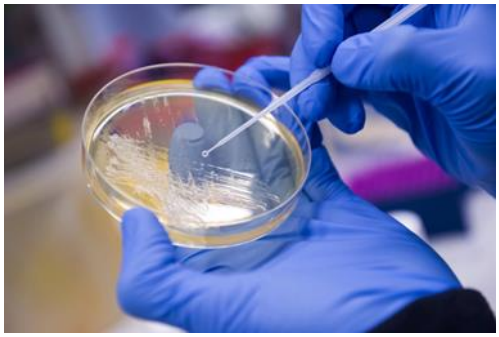
1.25. GripAble^{TM}, developed by BRC researcher Dr Paul Bentley with Dr Etienne Burdet (Bioengineering) launched as a new Imperial College spin-out company in November 2017, to commercialise a device which aims to improve arm and cognitive function of patients with arm disability through a physiotherapy-like computer game.

Added Value Examples

1.26. We highlighted 3 Added Value Examples of how the BRC has contributed to new translational medicine, from the following BRC Themes: Surgery (Micro-IGES), Cancer (CDK7 Inhibitor) and Immunology (fostamatinib in IgA Nephropathy).

Annex A NIHR Imperial BRC: Translational Research Examples

The following case studies are of biomedical or clinical research which has been (or is in the process of being) 'translated' into the clinic for patient benefit, or commercialised. More details of all these examples can be found on the BRC website (https://imperialbrc.nihr.ac.uk/):



Genomic analysis provides new insights for infection transmission

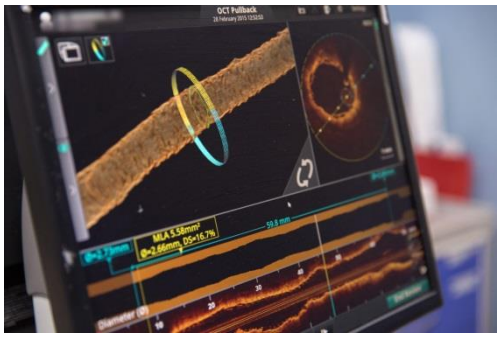
Research supported by the NIHR Imperial BRC has provided new insights into the transmission of Group B streptococcus bacteria within the hospital setting. Group B strep is a very common bacteria which is thought to be present in approximately 2 in 5 people and is normally harmless. However, in newborn babies, the bacteria can cause serious infection, with transmission occurring during birth. In late-onset cases, which occur up to three months after birth, the source of infection is often unclear. In this study, led by Professor Shiranee Sriskandan, genomic analysis of 11 late-onset cases clustered into four groups provided evidence to suggest a greater role for the bacteria being transmitted between patients. As a result of this study, a range of interventions have now been introduced to reduce the risk to patients.

Interaction of faulty gene with alcohol may accelerate heart failure

The TTN gene provides instructions for making a very large protein called titin. Titin is crucial for maintaining the elasticity of the heart muscle, but a faulty mutation of the titin protein gene affects approximately 1% of the population.

These faulty versions are linked to a type of heart failure called dilated cardiomyopathy, which is a condition where the heart's ability to pump blood is decreased because the heart's main pumping chamber, the left ventricle, is enlarged and weakened.

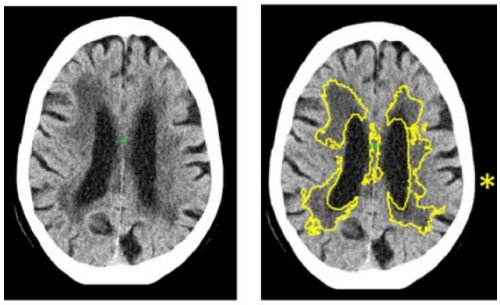
Researchers from Imperial, the Royal Brompton Hospital, and the MRC London Institute of Medical Sciences, supported by the BRC, have investigated faulty versions of the titin protein gene and demonstrated that the faulty gene may interact with alcohol to accelerate heart failure in some patients, even if they only drink moderate amounts of alcohol.



Arterial stents mean patients are more likely to be free from angina symptoms

The ORBITA trial, led by researchers funded by the BRC Cardiovascular Theme, was the first research study where the researchers compared stenting (artery-widening coronary angioplasty with stent or Percutaneous Coronary Intervention) with a simulated procedure but where a stent was not implanted (placebo).

New secondary analyses of the data allowed the researchers to investigate the number of patients who reported being free from symptoms. The latest results show a benefit of stenting compared to placebo, with more patients who received a stent reporting that they had no angina symptoms at follow-up. The researchers also reported that patients who had the greatest narrowing of their coronary arteries, had the greatest benefit from stenting in terms of improvement in their heart function because they had the greatest reduction in blood flow, and this was shown using ultrasound scans.



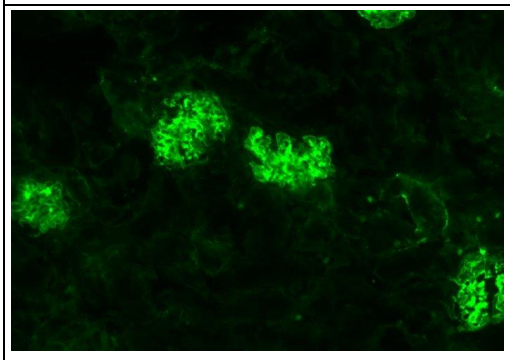
Artificial Intelligence (AI) improves stroke and dementia diagnosis in brain scans

The NIHR Imperial BRC, in collaboration with the University of Edinburgh have developed new software capable of detecting small vessel disease (SVD), a leading cause of stroke and vascular dementia.

Currently, doctors diagnose SVD by looking for changes to white matter in the brain during MRI or CT scans. However, this relies on a doctor gauging from the scan how far the disease has spread, and it is often difficult to determine where the edges of the SVD are and, therefore, difficult for doctors to diagnose the severity of the disease by the human eye. This new method allows for precise and automated measurement of the disease. This also has applications for widespread diagnosis and monitoring of dementia, as well as for emergency decision-making in stroke.

The study took place at Charing Cross Hospital and used historical data of 1082 CT scans of stroke patients across 70 hospitals in the UK between 2000-2014, including cases from the Third International Stroke Trial. The software identified and measured a marker of SVD, and then gave a score indicating how severe the disease was ranging from mild to severe. The researchers then compared the results to a panel of expert doctors who estimated SVD severity from the same scans. The level of agreement of the software with the experts was as good as agreements between one expert with another. In 60 cases they obtained MRI and CT in the same subjects and used the MRI to estimate the exact amount of SVD. This showed that the software is 85% accurate at predicting how severe SVD is.

This technology may help clinicians to administer the best treatment to patients more quickly in emergency settings, and predict a person's likelihood of developing dementia. The development may also pave the way for more personalised medicine.



Novel role for immune cells in making lupus worse

Lupus is an autoimmune condition which occurs when the immune system malfunctions, resulting in skin and joint problems and organ damage. It affects 1/1000 people and approximately 30,000 in the UK, occurring more commonly in women than men.

BRC researchers have shown that an immune cell, normally protective against viruses and cancer, could make lupus worse, and trigger flare-ups of the condition.

Although the causes of lupus are not fully understood, it is thought to result from complex genetic and environmental interactions, with evidence to suggest a link between lupus and complement C1q deficiency. C1q is part of the complement pathway, which is a component of the immune system involved in coordinating the body's defence against pathogens such as bacteria and virus.

In the study published in the journal Science, Professor Marina Botto's team used pre-clinical models to identify an important role for C1q in regulating the metabolism of virus-killing immune cells. The team showed that when the number of cytotoxic T cells becomes too high, the immune system starts to malfunction and attacking the body, which may be the reason for a flare-up in symptoms when a lupus patient contracts a virus. The next stage of this research is to conduct further studies with lupus patients to gain more insight into how these cells are controlled.

Annex B NIHR Imperial BRC: Major Research Publications in Previous Quarter

Some key research publications from the previous quarter are listed below:

1. David L Phelps, Júlia Balog, Louise F Gildea, Zsolt Bodai, Adele Savage, Mona A El-Bahrawy, Abigail VM Speller, Francesca Rosini, Hiromi Kudo, James S McKenzie, Robert Brown, Zoltán Takáts & Sadaf Ghaem-Maghami . *The surgical intelligent knife distinguishes normal, borderline and malignant gynaecological tissues using rapid evaporative ionisation mass spectrometry (REIMS).* **British Journal of Cancer**. 118, pages1349–1358 (2018). **IMPACT FACTOR = 6.176.**
2. Guang Sheng Ling, Greg Crawford, Norzawani Buang, Istvan Bartok, Kunyuan Tian, Nicole M. Thielens, Isabelle Bally, James A. Harker, Philip G. Ashton-Rickardt, Sophie Rutschmann, Jessica Strid, Marina Botto. *C1q restrains autoimmunity and viral infection by regulating CD8+ T cell metabolism*. **Science**; Vol. 360, Issue 6388, pp. 558-563 DOI: 10.1126/science.aao4555 (2018). **IMPACT FACTOR = 37.205**
3. Sheraz R. Markar, Tom Wiggins, Stefan Antonowicz, Sung-Tong Chin, Andrea Romano, Konstantin Nikolic, Benjamin Evans, David Cunningham, Muntzer Mughal, Jesper Lagergren, George B. Hanna. *Assessment of a Noninvasive Exhaled Breath Test for the Diagnosis of Oesophagogastric Cancer.* JAMA Oncology. doi:10.1001/jamaoncol.2018.0991 (2018). **IMPACT FACTOR = 16.559**
4. James S. Ware, Almudena Amor-Salamanca, Upasana Tayal, Risha Govind, Isabel Serrano, Joel Salazar-Mendiguchía, Jose Manuel García-Pinilla, Domingo A. Pascual-Figal, Julio Nuñez, Gonzalo Guzzo-Merello, Emiliano Gonzalez-Vioque, Alfredo Bardaji, Nicolas Manito, Miguel A. López-Garrido, Laura Padron-Barthe, Elizabeth Edwards, Nicola Whiffin, Roddy Walsh, Rachel J. Buchan, William Midwinter, Alicja Wilk, Sanjay Prasad, Antonis Pantazis, John Baski, Declan P. O'Regan, Luis Alonso-Pulpon, Stuart A. Cook, Enrique Lara-Pezzi, Paul J. Barton and Pablo Garcia-Pavia. *Genetic Etiology for Alcohol-Induced Cardiac Toxicity,* **Journal of the American College of Cardiology**, Volume 71, Issue 20, May 2018 DOI: 10.1016/j.jacc.2018.03.462 (2018). **IMPACT FACTOR = 19.896**
5. Jonathan Pearson-Stuttard, Chris Kypridemos, Brendan Collins, Dariush Mozaffarian,Yue Huang, Piotr Bandosz, Simon Capewell, Laurie Whitsel, Parke Wilde, Martin O'Flaherty, Renata Micha. *Estimating the health and economic effects of the proposed US Food and Drug Administration voluntary sodium reformulation: Microsimulation cost-effectiveness analysis.* **PLoS Medicine**. doi.org/10.1371/journal.pmed.1002551 (2018). **IMPACT FACTOR = 11.862**
6. Rasha Al-Lamee, James P. Howard, Matthew J. Shun-Shin, David Thompson, Hakim-Moulay Dehbi, Sayan Sen, Sukhjinder Nijjer, Ricardo Petraco, John Davies, Thomas Keeble, Kare Tang, Iqbal S. Malik, Christopher Cook, Yousif Ahmad, Andrew S.P. Sharp, Robert Gerber, Christopher Baker, Raffi Kaprielian, Suneel Talwar, Ravi Assomull, Graham Cole, Niall G. Keenan, Gajen Kanaganayagam, Joban Sehmi, Roland Wensel, Frank E. Harrell, Jamil Mayet, Simon A. Thom, Justin E. Davies, Darrel P. Francis. *Fractional Flow Reserve and Instantaneous Wave-Free Ratio as Predictors of the Placebo-Controlled Response to Percutaneous Coronary Intervention in Stable Single-Vessel Coronary Artery Disease: Physiology-Stratified Analysis of ORBITA.* **Circulation.** doi.org/10.1161/CIRCULATIONAHA.118.033801 (2018). **IMPACT FACTOR = 19.309**.
7. Jake Dunning, Simon Blankley, Long T. Hoang, Mike Cox, Christine M. Graham, Philip L. James, Chloe I. Bloom, Damien Chaussabel, Jacques Banchereau, Stephen J. Brett, MOSAIC Investigators, Miriam F. Moffatt, Anne O'Garra & Peter J. M. Openshaw. *Progression of whole-blood transcriptional signatures from interferon-induced to*

neutrophil-associated patterns in severe influenza. **Nature Immunology**. 19, pp625–635 (2018). **IMPACT FACTOR = 21.506.**

8. Ben Jones, Teresa Buenaventura, Nisha Kanda, Pauline Chabosseau, Bryn M. Owen, Rebecca Scott, Robert Goldin, Napat Angkathunyakul, Ivan R. Corrêa Jr, Domenico Bosco, Paul R. Johnson, Lorenzo Piemonti, Piero Marchetti, A. M. James Shapiro, Blake J. Cochran, Aylin C. Hanyaloglu, Asuka Inoue, Tricia Tan, Guy A. Rutter, Alejandra Tomas & Stephen R. Bloom. *Targeting GLP-1 receptor trafficking to improve agonist efficacy*. **Nature Communications**. 9, Article number: 1602 (2018). **IMPACT FACTOR = 12.124.**

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Safeguarding children and young people annual report 2017/18	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 21, report no. 17**
Responsible Executive Director: Professor Janice Sigsworth – Director of Nursing	**Author:** Nicci Wotton - Consultant Nurse Safeguarding Children & Young People Guy Young - Deputy Director Of Patient Experience

Summary:
This report provides a summary of activity related to children and young people (CYP) safeguarding in the trust in 2017/18. It provides assurance that the necessary systems and processes are in place to ensure that adults with safeguarding needs are adequately protected.

The Corporate Nursing directorate continues to develop the systems and infrastructure to support adult safeguarding including clear governance structures, a strong policy framework and training. In addition good progress has been made in better integrating adult, children and maternity safeguarding functions.

The issue of domestic abuse is significant for the CYP safeguarding team and the report describes interventions that the trust introduced in 2017/18 to support the associated increased activity.

Recommendations:
The Board is asked to note the report.

This report has been discussed at (delete/tick as relevant):
Executive Quality Committee
Quality Committee
Trust safeguarding committee

Quality impact:
Appropriate systems and processes are necessary to protect patients who are experiencing or at risk of neglect or abuse. The trust is required to be compliant with The Children Act (1989 & 2004). Safeguarding CYP sits within the CQC safe domain.

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

Risk impact and Board Assurance Framework (BAF) reference:
N/A

Workforce impact (including training and education implications):
No new impact. Compliance with mandatory training required.

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 X 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.

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

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

- What should senior managers know?
  - The trust has good systems and processes in place to support the safeguarding of CYP
  - There is comprehensive information to support staff dealing with safeguarding issues on the safeguarding children and domestic abuse webpages of the intranet
- What (if anything) do you want senior managers to do?
  - Continue to encourage staff to complete their mandatory adult safeguarding training
- Contact details or email address of lead and/or web links for further information
  - http://source/safeguarding/index.htm
- Should senior managers share this information with their own teams? Yes

Safeguarding children and young people annual report 2017/18

1. Introduction

The Children Act (1989), the Children Act 2 (2004) and the Government's Statutory Guidance contained within Section 11 of the Children Act (2004) specify that trust boards have a legal responsibility to safeguard and promote the welfare of children and young people (C&YP).

This report outlines the systems and processes in place at Imperial College Healthcare NHS Trust (ICHT) to ensure that it fulfils that responsibility.

The report provides an update on progress against 2017/18 key priorities and outlines the key priorities for the current year.

2. Trust governance arrangements for safeguarding C&YP

2.1 Executive leadership

The Intercollegiate Guidance (Royal College of Paediatrics and Child Health, 2014) defines roles and responsibilities of named doctors, nurses and midwives. The document also specifies that named individuals and the nominated Trust Board representatives have a duty to monitor safeguarding throughout the organisation. In accordance with this, the Director of Nursing is the Trust Executive Lead for Safeguarding C&YP. The Deputy Director – Patient Experience is the managerial lead and chairs the newly formed ICHT Safeguarding Committee which now includes adults and C&YP.

2.2 The C&YP safeguarding team

The team sits within the corporate nursing division.

The team is made up of:

- a Named doctor (for 4 programmed activities)
- a Consultant Nurse (Named Nurse)
- four clinical nurse specialists (one of whom is a lead CNS)
- a Named Midwife and two safeguarding midwives
- two administrators

Safeguarding supervision is important for the team to maintain resilience as well as ensuring that actions are taken in the child's best interests. Staff (band 7 and below) have access to monthly supervision which they must have at least quarterly and the Named Midwife and Lead CNS attend Tavistock Institute monthly (October to July) and then have in-house supervision for the other months. The Consultant Nurse receives supervision bi-monthly. Supervision is also mandatory for all level 3 trained staff.

2.3 The ICHT Safeguarding C&YP Committee

The ICHT Safeguarding Children and Young People Committee merged with the Adult Safeguarding Adult Committee. This occurred in November 2017 to ensure that the Think Family when safeguarding ethos is maintained. The committee is held quarterly and reports to the Trust Board via the Executive Quality Committee.

From quarter 3, the trust launched a single safeguarding committee that subsumed the activities and responsibilities of the trust adult safeguarding and children & young people safeguarding committees. This committee is chaired by the Deputy Director of Patient Experience and includes all the trust safeguarding named professionals as well as designated professionals from the CCG and local authority representatives. The committee focuses on assurance and key decision making.

2.4 Policy framework

ICHT has a comprehensive suite of policies and procedures designed to safeguard C&YP:

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

2.5 Training

ICHT has a requirement to provide training at different levels from level 1 (all staff) up to level 4 (named professionals and CYP safeguarding specialists). Levels 1 and 2 are delivered as e-learning modules, level 3 in face-to-face workshops and level 4 through specialist sessions or tri-borough organised events.

The CYP safeguarding team has made significant efforts in this year to ensure all staff are trained to the required level. Apart from level 4, where compliance was 100%, the trust struggled to achieve the required compliance level of 90%, with the figures being between 75% - 85% throughout the year. Training compliance continues to be a key priority for the coming year. During the year initiatives to address this have included contacting all non-compliant staff directly to remind them complete either e-Learning or to book onto training or, alternatively, providing their transferable training certificates. There has also been additional face-to-face training delivered across all sites and where necessary tailored to individual departments.

2.6 Safer recruitment

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

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

NHS Digital have introduced CP-IS to help health professionals and social care to work together to share information when children or pregnant women attend an unscheduled healthcare setting. This is only used for patients attending ED, UCC, HAU, Maternity Triage and Labour Ward.

As not all authorities are on CP-IS the safeguarding team are training staff regarding CPIS and giving out regular updates as to who is 'live'. Teaching from the safeguarding CNS' and midwives commenced 19th February.

2.8 Domestic Abuse

Domestic abuse (DA) is a significant issue in the safeguarding field. Nationally 1 in 3 women and 1 in 7 men are subjected to some form of domestic abuse. Each week in the UK two women are killed as a direct result of domestic abuse.

In previous years the trust had two charity funded Independent Domestic Violence Advisors (IDVA) covering predominantly A&E, maternity and sexual health services. In 2017 funding for these posts ceased and they were therefore lost. The trust introduced a range of mitigating actions including, increased training and the development of DA champions in key areas, the introduction of a DA bleep held by the safeguarding team and the development of a discrete DA webpage on the Source. At the end of the year, a new charitable funding stream was identified to support the appointment of a trust based IDVA. Work was also ongoing with Standing Together (a domestic abuse support organisation) in regard to securing more IDVA support across the Imperial sites.

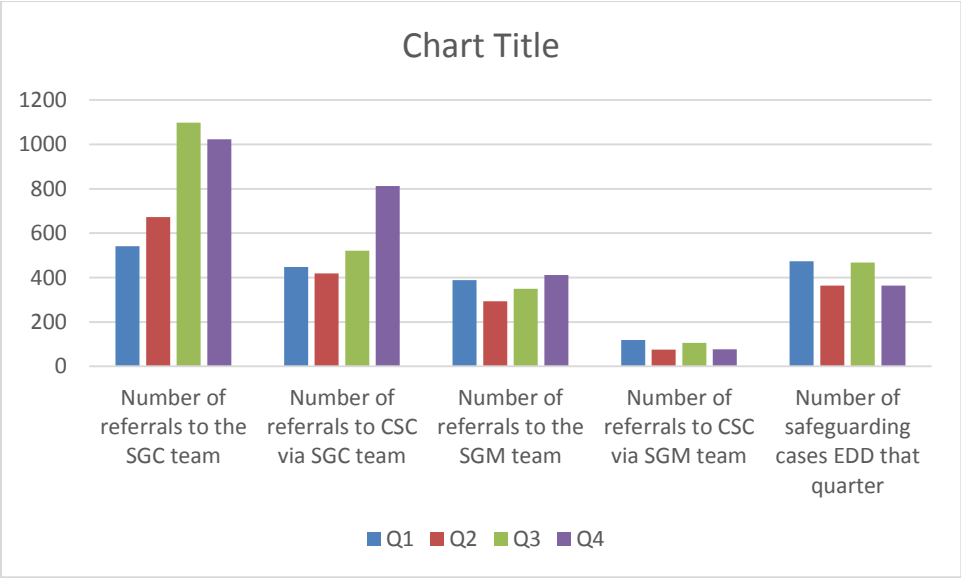
High risk cases, i.e. those where someone is at significant risk of harm or death, are referred to a Multi Agency Risk Assessment Conference (MARAC). ICHT service five borough MARACs which requires significant input for the safeguarding team. As awareness increased during the year the volume of referrals from ICHT also increased, with around 10 high risk cases being referred by ICHT each month in the last quarter of the year.. Bank staff have been used to manage this increase in referral activity. Attendance by ICHT at MARACs improved during the year as well as feedback to referrers and Imperial is one of the few agencies without any outstanding actions.

3. Safeguarding activity

Safeguarding cases increased across the hospital as staff became more proficient in recognising them and are more aware of the processes. However there was also an increase in the numbers of children who attended that required safeguarding intervention and/or additional support. Serious youth violence and mental health issues are increasing nationally and this had an impact on the number of cases the

safeguarding teams dealt with. Below is a chart that shows referrals into the safeguarding children team (SGC) and safeguarding maternity (SGM) and referrals via those teams into children's social care (CSC) - it does not capture the liaisons with the health visitors, school nurses, allocated social workers nor family nurse partnerships.

It can be seen that the CYP safeguarding team dealt with significant numbers of referrals throughout the year with a notable increase in the last two quarters. A large proportion of these were referred onward to CSC.



4. Notable practice and initiatives

During the year there were a number of developments worth highlighting:

- The trust went "live" with CP-IS
- Improved continuity of MARAC representation and feedback to staff
- Strengthening of internal systems to support DA with the Consultant Nurse taking on the strategic lead for this
- The trust underwent a *Section 11* review by the Tri-borough Local Safeguarding Children's Board (an audit of trust safeguarding systems) which found systems to be satisfactory; no actions or recommendations were identified for the trust.
- Increased attendance at strategic and operational external meetings
- Positive comments were made about safeguarding arrangements in the CQC reports
- Communications shared across the Trust via different newsletters
- The introduction of bleeps to enhance contractibility for advice. There are 3 bleeps for, maternity, children and domestic abuse and modern slavery exploitation
- Development of safeguarding forms in Cerner including extra questions regarding DA
- The trust contributed to a Multi-agency audit into child sexual abuse

5. Update on key priorities for 2017/18

The following table summarises progress against key priorities for the year.

Priority	Progress
To work in conjunction with multi agency colleagues to launch the nationwide initiative - The Child Protection Information System (CP-IS)	ICHT preparations complete. Awaiting local authority to go live
To review processes around timely discharge of high risk midwifery safeguarding cases in conjunction with the multi-agency teams.	Ongoing
To continue to work with North West London colleagues to ensure a joined-up response with partner agencies through care and referral pathways for treatment and recovery services for children who have been sexually exploited.	Ongoing – with active input to relevant agencies and panels
To launch a Safeguarding Children and Young People's Action Group across sites. This will ensure that the Safeguarding Agenda is discussed on a regular basis on the three main sites.	Commenced in Q3. Quarterly attendance at Q&S Children's and Maternity Meetings.
To implement the practice of health professionals asking patients whether they have children at home and assess they are being cared for.	In development with Cerner
Increase support for staff dealing with domestic abuse cases	Bleeps in place. Consultant Nurse now strategic lead. MARAC covered by nurses who are undertaking all research and attendance.
Create of safeguarding Cerner pages/forms to aid assessments of children and aid data collection for a scorecard	On-going
Develop a clear process regarding liaison of non-safeguarding cases to Health Visitors and School Nurses.	On-going
Develop an inpatient process for dealing with high risk cases such as stabbings and shootings	On-going
Achieve target levels of training and safeguarding supervision	On-going
Strengthen mental health services for children in and out of hours across all sites	On-going at CX and HH
Completion of section 11 review (an external review of all C&YP services)	Completed -no feedback by LSCB

6. Key priorities for 2017/18

These will include the priorities that have not been completed for 2017/18. In addition the team will:

- Increase safeguarding provision to staff 7 days a week
- Introduce safeguarding concern form to Cerner to provide better integration of safeguarding documentation with the patient record raising of concern
- Introduce a Cerner solution to support the Female Genital Mutilation Risk Indication System (a Department of Health and Social Care initiative to reduce risk of FGM in girls under 18)
- Continued focus on improving safeguarding training levels and the reporting of supervision data

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Adult Safeguarding Annual Report 2017/18	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 22, report no. 18**
Responsible Executive Director: Professor Janice Sigsworth – Director of Nursing	**Author:** Guy Young – Deputy Director of Patient Experience

Summary:
This report provides a summary of activity related to adult safeguarding in the trust in 2017/18. It provides assurance that the necessary systems and processes are in place to ensure that adults with safeguarding needs are adequately protected.

The Corporate Nursing directorate continues to develop the systems and infrastructure to support adult safeguarding including clear governance structures, a strong policy framework and training. In addition, good progress has been made in better integrating adult, children and maternity safeguarding functions.

After much effort, the trust was finally able to establish the right systems to be able to raise safeguarding concerns with the local authorities by email. This has resulted in much better oversight of active safeguarding concerns and a small rise in the volume of referrals.

Recommendations:
The Board is asked to note the report.

This report has been discussed at:
Executive Quality Committee
Quality Committee
Trust safeguarding committee

Quality impact:
Appropriate systems and processes are necessary to protect patients who are experiencing or at risk of neglect or abuse. The trust is required to be compliant with The Care Act (2014). Safeguarding adults sits within the CQC safe domain.

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

Risk impact and Board Assurance Framework (BAF) reference:
N/A

Workforce impact (including training and education implications):
No new impact. Compliance with mandatory training required.

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 X 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.

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

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

- What should senior managers know?
  - The trust has good systems and processes in place to support the safeguarding of adults
  - There is comprehensive information to support staff dealing with safeguarding issues on the safeguarding adults webpage of the intranet
- What (if anything) do you want senior managers to do?
  - Continue to encourage staff to complete their mandatory adult safeguarding training
- Contact details or email address of lead and/or web links for further information
  - http://source/safeguardingadults/index.htm
- Should senior managers share this information with their own teams? Yes

Adult safeguarding annual report 2017/18

1. Summary

Safeguarding adults is an important responsibility of the Trust. The primary objective of adult safeguarding activity is to prevent harm to patients who are at risk from abuse or neglect, whilst supporting individuals in maintaining control over their lives and in making informed choices about their care and safety.

In 2017/18 the Trust continued to work closely with Tri-Borough partners to ensure consistent, effective and safe systems for protecting vulnerable adults.

2. Background

The 2014 Care Act is a wide ranging piece of legislation that outlines the way in which local authorities should provide for adults in need of care and support. There is specific reference in chapter 14 of the Act to safeguarding arrangements and, whilst the guidance is aimed primarily at local authorities, collaborative working with partners such as the NHS, is critical to delivering appropriate safeguarding systems.

The Trust has developed systems, processes and a policy framework to ensure that the Care Act principles are properly applied.

3. Trust governance arrangements for safeguarding adults

The Director of Nursing provides executive leadership for adult safeguarding. The Deputy Director of Patient Experience has managerial responsibility for adult safeguarding. The Deputy Director of Patient Experience chairs the trust Adult Safeguarding Committee (and latterly the joint committee) and represents ICHT on the Tri-borough Safeguarding Adults Executive Board (SAEB). Quarterly adult safeguarding update reports are provided to the commissioners via the Clinical Quality Group.

There is a named doctor for adult safeguarding and an adult safeguarding nurse specialist. Each clinical division has a designated adult safeguarding lead (either the Divisional Director of Nursing or one of their deputies). A trust inclusion and vulnerability officer provides support for patients with learning disability.

The trust adult safeguarding committee was in place for the first half of 2017/18. From quarter 3, the trust launched a single safeguarding committee that subsumed the activities and responsibilities of the trust adult safeguarding and children & young people safeguarding committees. This committee is chaired by the Deputy Director of Patient Experience and includes all the trust safeguarding named professionals as well as designated professionals from the CCG and local authority representatives. The committee focuses on assurance and key decision making.

The trust has a number of policy and procedural documents to support the safeguarding of adults:

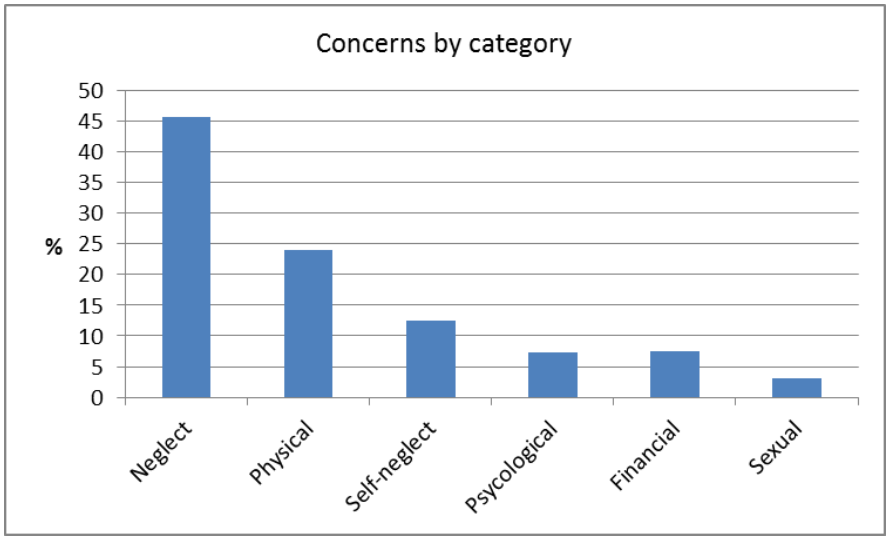
- Safeguarding adults policy and procedure (2016)
- Domestic abuse operational policy (2017) updated 2018
- Learning disability and autism policy and procedure (2017)
- Deprivation of Liberty Safeguards policy & procedure (2017)
- Prevent policy (2017)

4. Adult Safeguarding Activity

There was a significant change to the method of reporting adult safeguarding concerns in 2017/18. After many years of faxing forms the trust moved to the use of email. Data protection issues and the lack of secure email addresses prevented this from happening sooner; the move in year to NHSmail services provided the security required.

This change has resulted in more effective communication, better oversight by the local safeguarding team and in increase in the number of concerns raised. There has also been an improvement in the quality and appropriateness of referrals being made, although there is still work to do in this area as there is sometimes confusion between safeguarding and welfare concerns.

During the year, 318 adult safeguarding concerns were raised to the trust and local authority safeguarding teams. This compares with 273 in the previous year. The 318 concerns fell into the following categories:



Consistent with previous years, neglect accounts for the highest percentage and generally relates to patients arriving at the emergency department in a poor state of care, often with pressure ulcers. Neglect relates to a perceived lack of care by a third party, which could include nursing or care homes, social services provided care or in some cases families or carers. Self-neglect usually relates to patients who have not had contact with services prior to them needing hospital treatment and also includes hoarding which is a relatively new but important issue managed under safeguarding. Physical abuse includes, but is not exclusively related to, domestic abuse.

5. **Adult Safeguarding Training**

The trust provides 3 levels of adult safeguarding training:

- Level 1 – all staff, delivered by an e-learning module
- Level 2 – clinical staff, delivered by an e-learning module
- Level 3 – staff with specific adult safeguarding responsibilities, delivered through a variety of methods such as attendance at seminars and SAEB events.

Training compliance has improved over the course of the year, but still falls short of the commissioner set target of 90%. At the end of the year, level 1 compliance was 85% compared with 81% in 2016/17 and level 2 was 88% compared with 87% the previous year. Level 3 training compliance is 100%.

6. MCA and DoLS

Mental Capacity Act (MCA) online was provided for clinical staff in addition to the level 2 safeguarding training described above. The named doctor for safeguarding does face-to-face MCA training for doctors.

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) remain a challenge to implement in the acute hospital setting, for which they were not specifically designed. The Ferreira ruling from early 2017 has answered some of the issues for intensive care units, but in ward areas DoLS legislation is complex to administer. A review of the legislation is going through parliament following the Law Commission review which found it unfit for purpose. A new framework, the Liberty Protection Safeguards is possible in 2018/19, which though potentially easier to understand is likely to have a significant impact on the Trust's responsibilities.

In 2016/17 the trust made 166 DoLS applications to the local authority (the authorising body), a significant increase from the previous year (94). This increase is thought to be due to increasing awareness of the legislation. That said, because of the complexity of the legislation, applications are not always appropriate; staff tend to err on the side of caution by submitting an application when the patient could be deprived of their liberty in their best interests under the general Mental Capacity Act legislation without recourse to DoLS.

7. Prevent

Prevent is a component of the Government's counter terrorism strategy. Its aim is to stop people becoming terrorists or supporting terrorism. Focusing on radicalisation of at risk individuals, the strategy sits under the safeguarding umbrella. This means the trust executive and management leads are the same for Prevent as for safeguarding.

The focus in 2017/18 was to increase the level of Prevent training compliance, particularly in relation to the face-to-face Workshop to Raise Awareness of Prevent (WRAP). There were significant improvements in year with 87% of staff being compliant with basic prevent awareness training (e-learning) and 90% having undertaken WRAP. Both these figures meet the required trajectory for this training.

Despite the extensive training provided and the heightened awareness as the result of terrorist incidents in Manchester and London during the year, the actual volume of Prevent concerns raised in the trust is small. In 2017/18 only 8 concerns were raised to the trust Prevent lead, of these 4 were referred for further intervention. This is felt to be more a reflection of the fact that not many prevent issues are coming to the fore rather than staff not recognising them.

8. Update on key priorities for 2017/18

The following table provides as progress update of the identified priorities for the year.

Priority	Progress
Achieving the required training compliance for Prevent training and delivery of WRAP sessions	This was achieved
Strengthening links between adult and child safeguarding, with a view to centralising functions into a corporate safeguarding team	This was achieved
Improving the application of the MCA across the trust and addressing any actions arising from the Law Commission review of DoLS	Progress has been made but ongoing work is required. A change in the DoLS legislation is still pending
Introducing a more streamlined method for raising adult safeguarding concerns, i.e. by email	This was achieved
Review the adult safeguarding dataset to provide a greater oversight of safeguarding issues and themes	This has happened but is ongoing

9. Summary and priorities for 2018/19

In the coming year the ongoing priorities above will continue. In addition it is planned that:

- The trust will prepare for the introduction of the Liberty Protection Safeguards.
- A new intercollegiate document outlining the responsibilities of healthcare organisations in relation to adult safeguarding training is expected to be published in 2018/18. The trust will ensure that it amends, where necessary, its training approach to ensure it complies with the principles of this document.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection prevention and control, and antimicrobial stewardship Annual Report 2017/18	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 23, report no. 19**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Authors:** Alison Holmes, Director of IPC Jon Otter, Interim Head of Operations, IPC Jan Hitchcock, Interim General Manager, IPC

Summary:
The IPC team produce an annual report, which is a requirement of the Health and Social Care Act. This report will be made available to the public upon request via the Trust's website. The report is approved by the Director of Infection Prevention and Control, and is being sent to the Board for information.

Key points from the report include:

- There have been three Trust-attributable MRSA bloodstream infections (BSIs) out of 32,794 blood cultures taken in financial year (FY) 17/18, which is the same number as in 2016/17, and a > 50% reduction from the seven cases in FY 15/16.
- There have been 63 cases of Trust-attributed C. difficile out of 7040 of diarrhoeal specimens tested for the FY, which is the same as in 2016/17. This means that Imperial College Healthcare NHS Trust had the third lowest rate of Trust-attributed C. difficile in the Shelford Group of hospitals.
- There has been a 28% reduction in the number of E. coli BSI (73 in 2017/182017/18 vs. 102 in 2016/17), which has been commended by NHS Improvement in line with the national objective to halve Gram-negative BSIs by 2020/21.
- The number of new cases of CPE positive patients detected each month has increased in proportion to the number of screens taken. The majority of cases are from screens, without evidence of clinical infection.
- The bi-annual antibiotic point prevalence survey has found that all quality indicators of antibiotic prescribing exceed the target level of 90%.
- The overall consumption of antibiotics has reduced by 1% compared with the end of the previous FY, although the usage of some key agents, especially the carbapenems, has increased.
- There were several outbreaks/transmission events across the Trust that required expert management.
- The service responded to a number of external national directives, which required coordinated Trust level responses, including the Getting It Right First Time (GIRFT) Surgical Site Infection (SSI) audit initiative, a patient notification exercise related to the risk of Mycobacterium chimaera infection from heater-cooler units used in cardiothoracic surgery, the national CQUIN on 'Reducing the impact of serious Infection', and rapidly adapting to the multiple national shortages of antimicrobial agents.

Recommendations:
The Board is asked to note the report.

This report has been discussed at:
☒ Trust Infection Prevention and Control Committee (via the HCAI Taskforce)
☒ Executive Quality Committee
☒ Board Quality Committee

Quality impact:
The information in this report summarises the activity of the IPC team to improve patient safety and outcomes throughout 2017/18. It touches all CQC domains (safe, caring, responsive, effective, well-led).

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

Risk impact and Board Assurance Framework (BAF) reference: None.

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

What impact will this have on the wider health economy, patients and the public?None.

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

Imperial College Healthcare
NHS Trust

Infection prevention and control, and antimicrobial stewardship Annual Report

2017/18

Contents

1 Executive summary

- There have been three Trust-attributable MRSA bloodstream infections (BSIs) out of 32,794 blood cultures taken in financial year (FY) 17/18, which is the same number as in 2016/17, and a > 50% reduction from the seven cases in FY 15/16.
- There have been 63 cases of Trust-attributed *C. difficile* out of 7040 of diarrhoeal specimens tested for the FY, which is the same as in 2016/17. This means that Imperial College Healthcare NHS Trust had the third lowest rate of Trust-attributed *C. difficile* in the Shelford Group of hospitals.
- There has been a 28% reduction in the number of *E. coli* BSI (73 in 2017/18 vs. 102 in 2016/17), which has been commended by NHS Improvement in line with the national objective to halve Gram-negative BSIs by 2020/21.
- The reduction in MRSA BSI, *E. coli* BSIs, and *C. difficile* infection in recent years represents the outcome of multifaceted action plans to tackle these infections
- The number of new cases of CPE positive patients detected each month has increased in proportion to the number of screens taken. The majority of cases are from screens, without evidence of clinical infection.
- The bi-annual antibiotic point prevalence survey has found that all quality indicators of antibiotic prescribing exceed the target level of 90%.
- The overall consumption of antibiotics has reduced by 1% compared with the end of the previous FY, although the usage of some key agents, especially the carbapenems, has increased.
- The Trust continues to experience shortages of key antimicrobials due to national supply problems, presenting a major clinical challenge and requiring Trust-wide introduction of alternative regimens, based on local resistance data and on advice from Public Health England.
- 82% of staff (6551 clinical facing staff from a denominator of 7926) were completed the Trust's aseptic non-touch technique (ANTT) training and competency assessment programme; this has increased from 71% since March 2017.
- The number of patients referred to the specialist vascular access service for assessment and line insertion continues to increase.
- The service has provided decontamination expert input in key areas, including the refurbishment of a surgical ward at CXH, the remodelling of the high dependency units (HDUs) at CXH, an additional hospital scanner at HH, and plans for new hospital buildings at SMH. Expert input has also been provided to assure effective specialist ventilation and hygienic water.
- There were several outbreaks/transmission events across the Trust that required expert management.
- The service responded to a number of external national directives, which required coordinated Trust level responses. These included the Getting It Right First Time (GIRFT) Surgical Site Infection (SSI) audit initiative, a patient notification exercise related to the risk of *Mycobacterium chimaera* infection from heater-cooler units used in cardiothoracic surgery, the national CQUIN on 'Reducing the impact of serious Infection', and rapidly adapting to the multiple national shortages of antimicrobial agents.

2 Introduction

Preventing the spread of pathogens that cause healthcare-associated infection (HCAI) is a fundamentally important aspect of the operation of any healthcare facility. At Imperial College Healthcare NHS Trust (ICHT), the prevention and control of infection remains a top priority for all hospital staff. The Infection Prevention and Control (IPC) service is responsible for ensuring that policies and procedures for reducing the risk of HCAI are in place, and that expert advice is available continuously.

The hospital population is aging, and procedures are becoming ever more complex. This means that patients are increasingly at risk of HCAI. Nonetheless, strides have been taken on a local and national level in reducing the rate of MRSA and *C. difficile* infection (CDI). However, there are still improvements to be made with these pathogens. Furthermore, new challenges and pathogens continue to emerge nationally and locally. For example, carbapenemase-producing Enterobacteriaceae (CPE) is a national threat and have led to central directives regarding screening and a Toolkit for acute Trusts. Also, the government has outlined early plans to focus national attention on the local prevention of Gram-negative bloodstream infections in the coming years. IPC has a group of data scientists, who monitor real-time trends to guide interventions, and provide a suite of metrics to measure the effectiveness of the activities of the team, and analyse the impact of the various interventions that have been put in place to reduce the risk of transmission.

One of the key drivers for resistance in HCAI and *C. difficile* infection is the misuse of antibiotics. ICHT continues to introduce new strategies to monitor antibiotic use, and ensure that antibiotics are used appropriately. Another key risk is the use of indwelling devices and intravenous lines, which can become infected if not managed appropriately. Intravenous lines are therefore another important area of focus, led by a dedicated vascular access team, with a Trust-wide aseptic non-touch technique (ANTT) training and assessment programme in place. The correct management and decontamination of high-risk medical devices (such as endoscopes) is a crucial function of the team. IPC is closely involved in decisions around the hospital estate, ensuring that it is fit for purpose in order to minimise the risk of transmission.

The IPC team (IPCT) continues to work with all levels of hospital staff to ensure that no preventable infections occur in patients served by the Trust.

3 Infection prevention and control governance

During 2017/18, the Trust maintained compliance with all criteria set out in the Hygiene Code of Practice (2008). The annual plan for infection prevention and control for April 2017 - March 2018 set out the proposed activities for IPC at the Trust. This plan ensured that the Trust continued to meet the requirements of the Hygiene Code, Department of Health and the Care Quality Commission. The plan also accounted for locally agreed actions as well as internal programmes of work that IPC would deliver throughout the financial year.

The Trust has on-going action plans focussing on preventing, and managing HCAIs across our hospitals and these ‘live’ documents underpin the programmes of work referenced in this plan.

The plan is reviewed annually, with progress and evidence of completing actions documented. Actions are examined at the Trust infection prevention and control committee (TIPCC). Progress on actions is also followed up by weekly operational meetings. While the Trust has many examples of excellent work and high-quality care, it recognises that there is more to do to achieve its goals and ambitions. The IPC annual plan and associated action plans support the Trust to deliver its strategic objectives.

3.1 Organisation of the infection prevention and control service

IPC service is a corporate directorate situated in the office of the medical director. The comprehensive IPC team is multidisciplinary and is led by the director of IPC, who is responsible for overseeing all IPC and antimicrobial stewardship activity in the Trust. The team includes doctors, nurses, pharmacists, data scientists and other technical and operational experts who create structures working collaboratively across the organisations

with the Divisions to ensure patient safety through effective infection control practices and optimal use of antimicrobials. The service also works closely with key external regulatory and public health agencies and experts. The service provides expertise to the clinical and operational teams throughout the Trust.

3.2 Budget

The IPC budget is summarised in Table 1.

Budget in 2017/18	
Pay	1,607,187
Non-Pay	64,783
Total	1,671,970

Table 1: IPC budget

3.3 Trust Infection Prevention Committee (TIPCC)

The role of the Trust infection prevention committee (TIPCC) is to oversee the delivery of IPC across the organisation. TIPCC reports to the quality committee, Trust board, and chief executive office through quarterly reports. Meetings are held quarterly, and attended by external stakeholders representing Public Health England and the CCG. The committee receives reports from the clinical divisions and subsidiary committees including:

- divisional IPC / quality committees
- decontamination steering group
- line safety management group
- surgical infection group
- water hygiene group
- ventilation group
- antimicrobial review group
- occupational health
- health & safety
- hand hygiene steering group
- estates and facilities

3.4 HCAI Taskforce

A weekly meeting is held to support the operational delivery of IPC throughout the organisation. The Taskforce ensures weekly engagement with senior leaders in the Trust, including a lead from each of the clinical divisions. Live clinical front line issues, real time surveillance information, and actions from investigations are reviewed across all sites. This meeting has a critical function in the management of patient flow and inpatient capacity related to IPC.

3.5 Risk management

The service manages a risk register, designed to ensure that the known risks are flagged and mitigated. There is currently a corporate risk related to spread of CPE.
Risks on the IPC directorate risk register include:

- Staffing and bed capacity.
- Lack of microbiology laboratory support.
- Estates work affecting IPC practices.

- Lack of Level 3 negative pressure single rooms at the Charing Cross site.
- Occupational health provision.
- Inflexible IT infrastructure.
- Limited surveillance of HCAI (especially SSI).
- Inappropriate use of antibiotics.
- Poor practice related to vascular access.
- Prolonged high capacity.
- The shortage of key antimicrobials due to national supply problems.
- Levels of hand hygiene compliance and inappropriate use of gloves.

These risks are reviewed and updated regularly, and a summary of new and updated risks is included in the IPC quarterly report.

4 Healthcare-associated infections – mandatory reporting

Table 2 shows the number of cases reported to PHE in their mandatory reporting scheme. 'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital.

	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	**3**	0
Trust *C.difficile*	5	7	3	6	7	5	2	5	4	5	4	5	8	5	8	6	6	6	2	6	4	6	10	7	**63**	69
Trust *E.coli* BSI	6	-	8	-	6	-	5	-	5	-	5	-	10	-	10	-	5	-	3	-	6	-	4	-	**73**	-
Trust MSSA BSI	3	-	3	-	2	-	2	-	4	-	4	-	7	-	1	-	3	-	4	-	3	-	0	-	**36**	-

Table 2: Summary of the number of cases reported to PHE in their mandatory reporting scheme. For MRSA, MSSA, and E. coli BSI Trust cases are those that are identified after 2 days of hospitalisation; for C. difficile, Trust cases are those that are identified after 3 days of hospitalisation

4.1 MRSA bloodstream infection

There is a national expectation of zero MRSA BSI for all Trusts. In 2017/18, out of 32,794 blood cultures taken from patients at the Trust and processed by our microbiology laboratory, there were 6 cases of MRSA BSI identified, 3 of which were allocated as 'Trust-associated' (Figure 2). Potential sources of infection in these 3 complex cases included an infected vascular graft (April 2017), central line in a renal patient (January 2018), and a surgical site infection (March 2018).

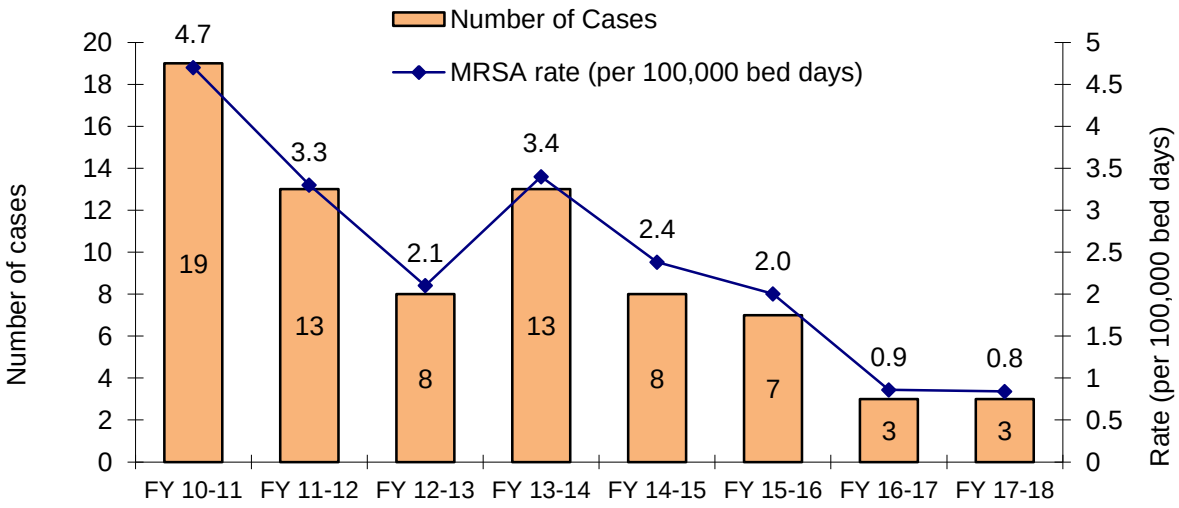


Figure 1: Number of cases and rate of MRSA bloodstream infection attributed to the Trust (2010/11-2017/18)

4.1.1 MRSA admission screening

An average of 3,200 admissions were screened for MRSA each month in 2017/18, with the average compliance at 88%.

4.2 Clostridium difficile infection

7,040 individual samples were sent for *C. difficile* testing in the microbiology lab during 2017/18. Out of these 63 cases of 'Trust-associated' (i.e. diagnosed after 72 hours of admission) *C. difficile* cases were identified (Figure 2). This is below the Department of Health threshold of 69 assigned for the Trust for 2017/18.

4.2.1 C. difficile infection: 'lapses in care'

Each case of *C. difficile* is reviewed to determine whether a 'lapse in care' contributed. The definition of a 'lapse in care' 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. 7 of 63 (11%) of the cases of *C. difficile* reported have had a 'lapse in care' relating to pathway crossover (3), or antibiotic exposures (4). 'Lapses in care' are reported to the relevant ward and divisional teams as soon as they are identified to address any poor practice identified.

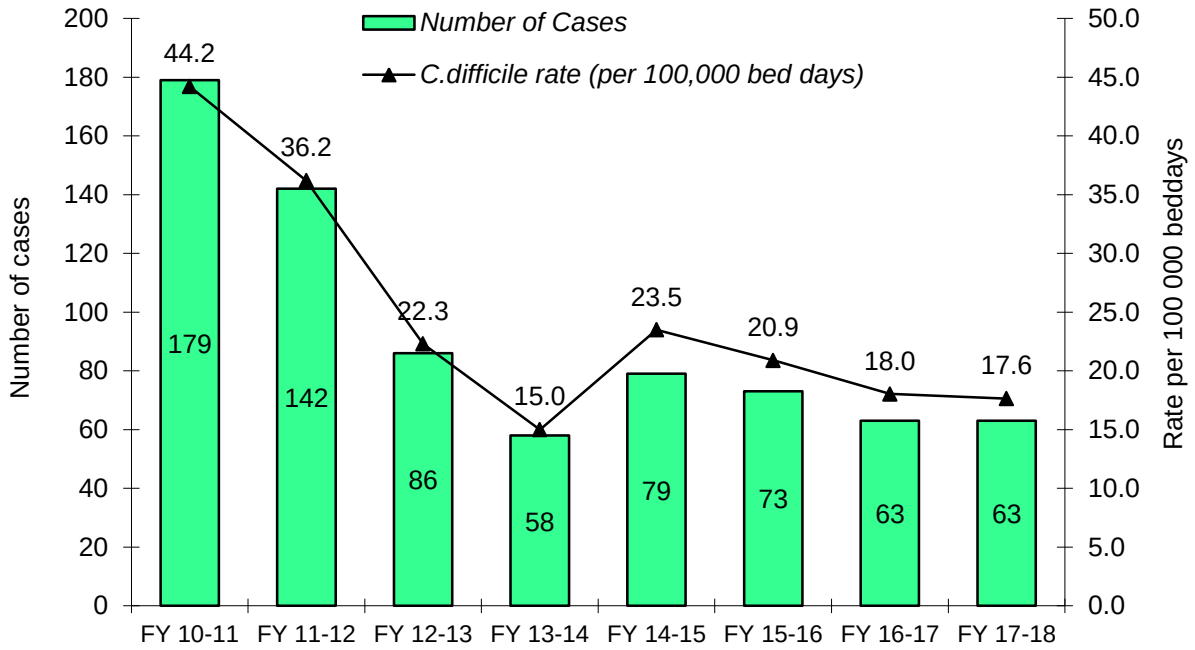


Figure 2: Number of cases and rate of C. difficile infection at the Trust (2010/11-2017/18)

4.3 Escherichia coli & MSSA bloodstream infection

There is no threshold for *E. coli* and MSSA BSI indicators at present. The national rise in *E. coli* BSIs is a cause of significant concern, and is being investigated by Public Health England and has led to the drive to reduce Gram negative BSIs. There have been 36 cases of MSSA BSI in 2017/18, compared with 30 in 2016/17. The total number of cases of E. coli BSI in 2017/18 (73) is considerably lower than in 2016/17 (102). This reduction has been noted in a letter from NHSI.

5 Other healthcare-associated infections and surveillance activities

5.1 Gram-negative BSIs

The government has announced an ambition to halve healthcare-associated Gram-negative BSI by 2021. The Trust is developing a Gram-negative BSI reduction plan, in conjunction with the CCG. Key elements of the plan include:

- Enhanced reporting of Gram-negative BSI cases to PHE, including *E. coli, Klebsiella pneumoniae,* and *Pseudomonas aeruginosa.*
- Supporting our CCG in identifying non-Trust attributed Gram-negative BSIs for further investigation.
- Establishing an enhanced Gram-negative BSI review process via a monthly MDT group. This will include a detailed review of the sources of healthcare-associated BSIs to inform targeted prevention initiatives.
- Regular local review of antibiotic susceptibility and prescribing policy.
- Trust-wide review of antibiotic prescribing indicators and indicators of relevance to Gram-negative BSI.
- Close working with the sepsis identification and management plans in the Trust that may impact Gram-negative BSIs.

- Improving the management of urinary catheters in conjunction with the Nursing Directorate, and enhancing surveillance of urinary catheter-associated BSI.
- Reviewing hydration management, especially in elderly patients.
- Furthering work to ensure that CPE admission screening is performed as per policy to ensure that appropriate antibiotics are used for patients who are colonised with CPE and subsequently develop a BSI.
- Planning new prevention initiatives in partnership with high-risk clinical areas (for example haematology, renal, NICU, and post-surgical wards).

5.2 Central line-associated BSI (CLABSI) in adult and paediatric ICUs

The CLABSI rate for the three adult ICUs combined during 2017/18 was 1.4 per 1000 catheter days (16 individual cases), benchmarked against the ECDC (Annual Epidemiological Report, 2014) ICU CLABSI rate of 3.0 per 1000 catheter days Figure ***3***).

PICU have had a CLABSI rate of 1.4 per 1000 line-days during 2017/18 (two cases), which is below the ECDC European benchmark of 3.0 per 1000 catheter line days.

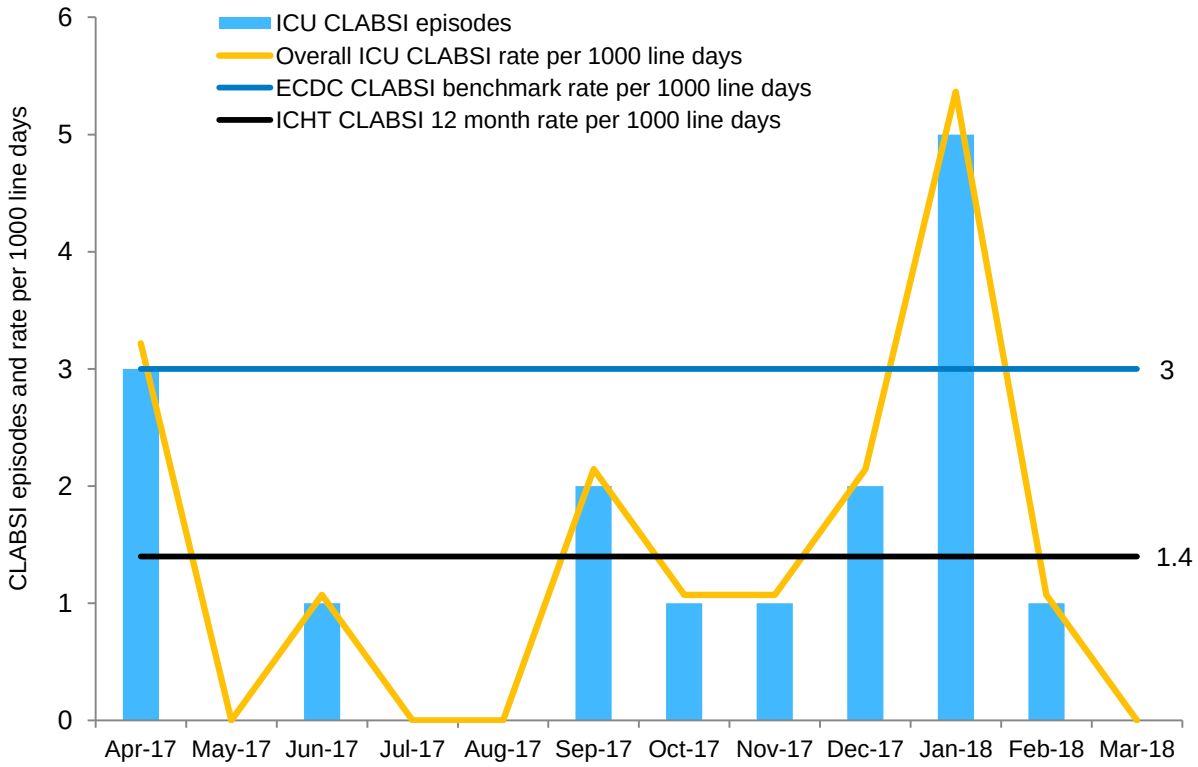


Figure 3: CLABSI number and rate in the adult ICUs

5.3 *Carbapenemase-producing Enterobacteriaceae (CPE) surveillance*

Enhanced surveillance of carbapenemase-producing Enterobacteriaceae (CPE) began in May 2014. All patients with CPE colonisation or infection are recorded in a centralised database, accessible to Trust microbiologists, infection control doctors, nurses, and pharmacists. Information on the type of isolate, molecular mechanism underpinning carbapenemase activity and culture collection date are collected. Detailed data about each affected patient is collected and submitted to PHE. Figure 4 below shows the number of isolates of CPE detected across the Trust (2014/15 to 2017/18). Figure 4 provides a

breakdown of CPE detected at the Trust by bacterial species and mechanism of resistance. The number of new cases detected each month has increased in proportion to the number of screens taken. The majority of cases are from screens, without evidence of clinical infection. The number of clinical cultures has decreased from a peak of 10 in February 2015 to approximately 3 per month over the last quarter (Figure 5). This suggests that the widespread screening programme to detect CPE carriers has resulted in or contributed to less CPE clinical infection.

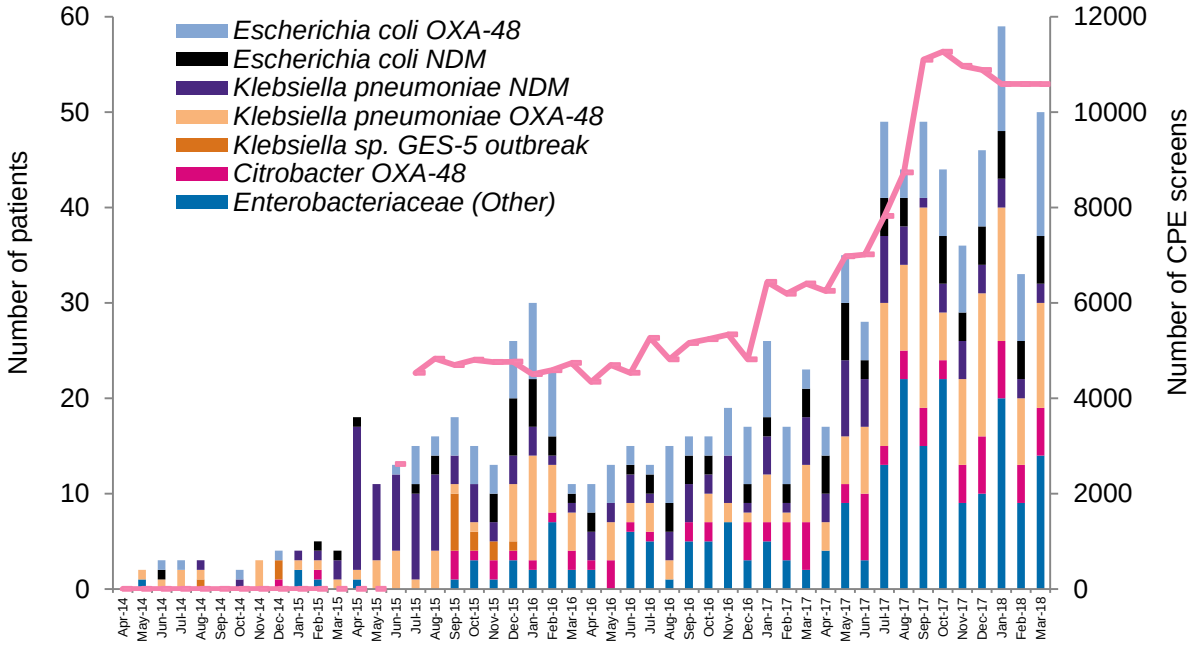


Figure 4: CPE cases of colonisation and infection identified at the Trust (2014/15 to 2017/18)

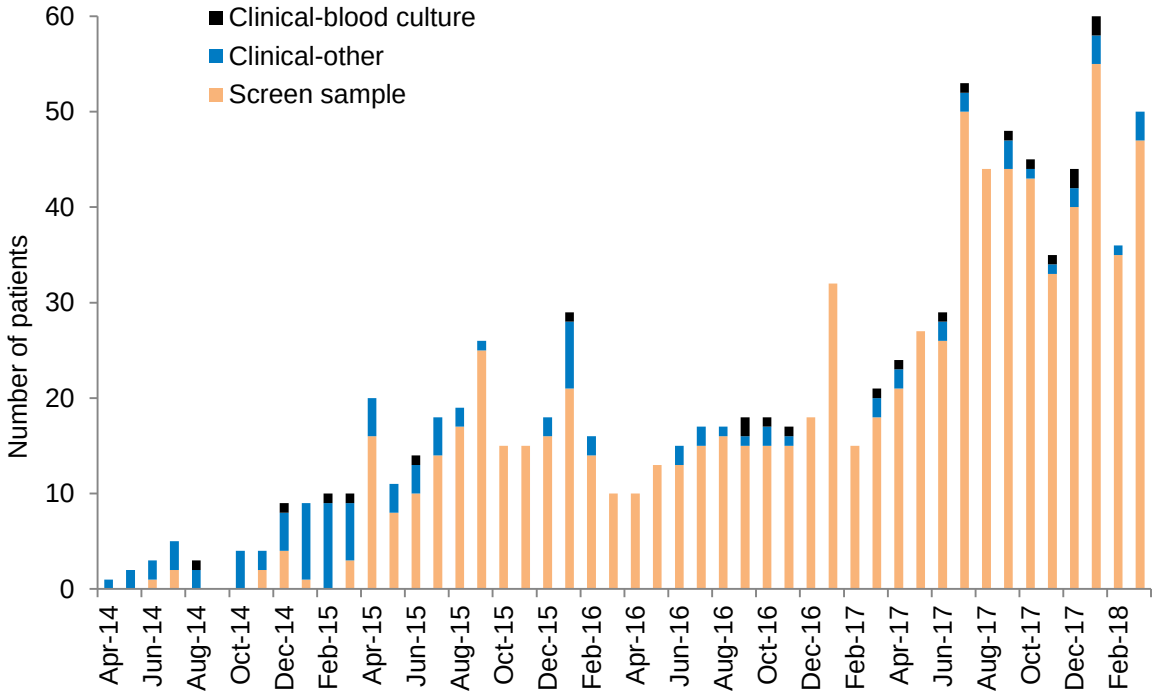


Figure 5: CPE detected at the Trust by culture type, 2014/15 to 2017/18)

5.4 Surgical site infection (SSI) surveillance

The Trust-wide surgical infection group, chaired by a senior consultant clinical microbiologist, oversees the quality improvement programme for the prevention of SSIs. Plans are in place to develop enhanced SSI surveillance, embracing innovation to implement IPC-led SSI in all surgical categories. There is also a new quarterly surgical outcomes group, chaired by the associate medical director, which reviews a range of important surgical outcomes, including infection related outcomes.

For orthopaedic surgery, the 12-month average for knee procedures is 0.3% (1 SSI in 344 operations) (national average 0.6%). The 12-month average for hip procedures is 0.5% (one SSI in 185 operations) (national average 0.6%).

For cardiothoracic surgery, the 12-month average for CABG procedures is 4.0% (11 SSI in 291 operations) (national average 3.7%). The 12-month average for non-CABG procedures is 1.1% (2 SSI in 194 operations) (national average 1.2%).

5.4.1 Getting It Right First Time (GIRFT) SSI audit

As part of the national 'Getting it Right First Time (GIRFT)' programme, the Department of Health, Public Health England, and NHS Improvement asked that all Trusts participate in a period of surveillance for surgical site infections (SSIs). The SSI audit requested that trainees in 13 surgical specialties (12 of which are performed in this Trust) perform a prospective audit for SSIs between May and October 2017, and submit retrospective SSI data (if available) between November 2016 and May 2017. The Trust participated in the GIRFT SSI audit in obstetrics and gynaecology, breast, ENT, general, ophthalmology, paediatrics, and vascular.

A higher than expected rate of SSI in vascular was reported by the GIRFT SSI audit. This has prompted a review of SSI prevention measures in vascular surgery that began based on the interim results of the GIRFT SSI audit. A number of interventions around improving patient bathing prior to surgery (including implementing chlorhexidine bathing), providing assurance around antibiotic prophylaxis, and improvements in wound care post operatively have been implemented. The resulting action plan has been presented at the Surgical Infection Group and will be included in the SI related to this issue and cross transmission of CPE on the vascular surgery ward at SMH (STEIS 2017/19226).

6 Hand hygiene

Prior to April 2017, the Trust monitored compliance with only one of the five WHO 'Moments' for hand hygiene (immediately before patient contact), which reported rates of compliance that were much higher than would be anticipated based on published literature (usually >95%). Although this provided pragmatic data capture across all sites and clinical areas, a new approach was implemented in April 2017 to move to audit all five WHO Moments. It was envisaged that this would result in lower level of compliance being reported, to prompt focussed attention on clinical areas that require improvement. However, rates of compliance continued to be higher (>95%) than would be expected based on published data (typically 40%). Furthermore, the IPC team performed validation hand hygiene audits over the month of September 2017 in a selection of wards across the Divisions. This was to compare compliance reported by wards with audits performed by the IPC team. Overall compliance was 56% in the IPC audits (122 compliant observations from a total of 223), compared with 97% (457 compliant observations from a total of 471 observations) as reported by clinical areas on Synbiotix. IPC and the Divisions agree that, based on these findings, a new approach to hand hygiene auditing and improvement is required.

The Trust is currently transitioning away from monthly ward and department-led hand hygiene auditing to expert auditing undertaken by IPC and senior Divisional staff. This will prompt improvement focussed on the areas with the lowest levels of hand hygiene. The changes will be complemented by a new programme of communications related to improving hand hygiene, including a campaign to promote awareness of hand hygiene and sepsis on the 4th of May to co-ordinate with the 2018 WHO Global Hand Hygiene Campaign.

7 Aseptic non touch technique (ANTT)

The aseptic non-touch technique (ANTT) competency framework was established in December 2011 to assist in the prevention of HCAI. The framework outlines what patient-facing staff must do to ensure they continue to remain compliant with ANTT. The framework has been revised and developed into a policy. Key changes include that compliance is now valid for three years, and the recording of compliance has been devolved to the Divisional assessors. Throughout the year, the Trust monitors the level of compliance with ANTT assessment. All non-consultant level medical staff are ANTT assessed on the day of induction in a skills lab setting by assessors from the IPC team with assistance from the Divisions. ANTT assessment can also be performed by ward-based staff, provided the ANTT assessors are themselves assessed by those judged by IPC to be competent to make this assessment, for quality assurance; this group of ward-based assessors are revalidated every three years. Monthly reports are sent to the divisional performance reviews and the line safety management group. Compliance at the end of March 2018 was 83% (6551 clinical facing staff from a denominator of 7926); an 11 percentage point increase from March 2017.

8 Antimicrobial stewardship

8.1 Prescribing surveillance: point prevalence survey (PPS)

The standards of antimicrobial prescribing continued to be measured biannually through infection pharmacy-led point prevalence surveys which took place in August 2017 and February 2018. The standards are advised by the Department of Health “Start Smart then Focus” antibiotic programme. The results of the surveys were circulated via clinical and managerial structures, with detailed action plans where appropriate (Table 3).

Approximately 43% of inpatients were on antimicrobials at any one time. The Trust was 98% compliant with documenting an indication for use and 92% compliant with prescribing antimicrobials as per Trust policy or on the advice of or approved by Microbiology/ ID / Infection control team. Historically stop or review date documentation had been reviewed, however 2 new indicators were introduced in August 2017 to strengthen how we review antimicrobials. Out of the total antimicrobials prescribed for inpatients, 90% were reviewed within 72 hours of their initial prescribing with 95% within a duration that is stated in our policy or on the advice of infection teams. The Trust has a suggested compliance of 90% for these indicators.

8.2 Antimicrobial consumption and reduction

Antimicrobial consumption data continued to be analysed and the Trust participated in part 2d of the Reducing the impact of serious infections CQUIN set for 2017/2018. An infection pharmacist was appointed on a fixed term contract to enable the pharmacy infection team to look at the antibiotic consumption (including carbapenem consumption) across the Trust by site and speciality. This provided valuable information together with resistance data to understand where greater stewardship activity should be targeted.

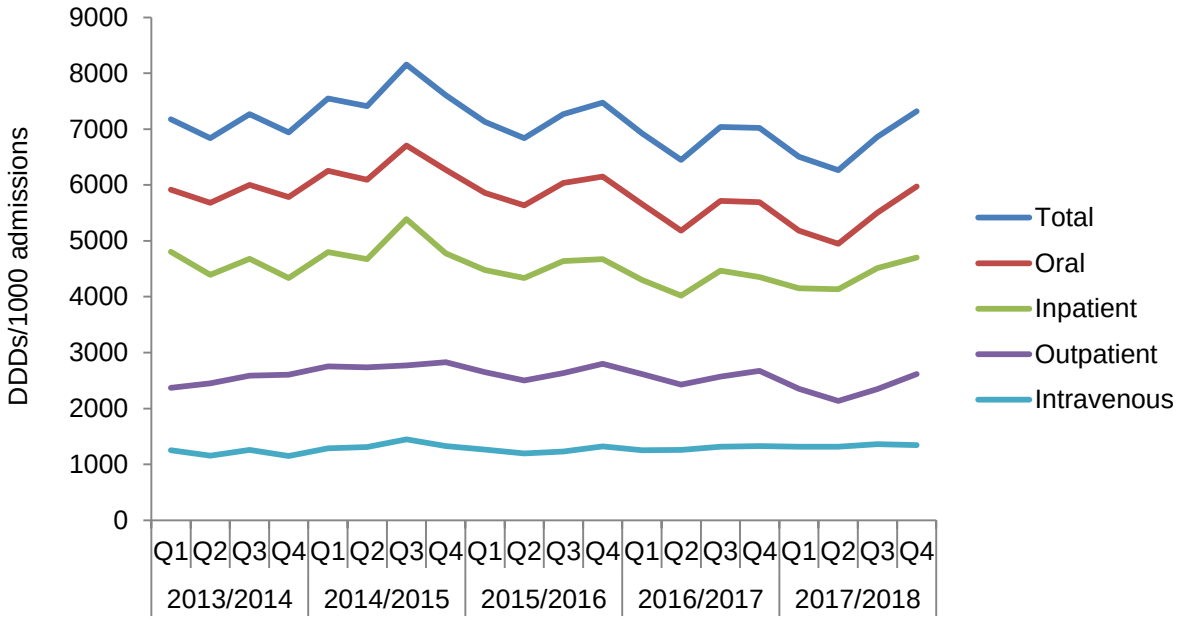


Figure 6: Trust wide antimicrobial usage, 2013 to present, detailing total, oral, intravenous consumption, along with consumption in inpatient and outpatient areas.

Overall antimicrobial use was reduced by 1% from 2016/2017. In the first three quarters the Trust achieved an 8% reduction in antimicrobial use with quarter 4 accounting for a significant rise in oral antimicrobial use. This increase in use is thought to be as a result of increased influenza clinical cases and respiratory pathogens over the winter months. Intravenous antimicrobial uses remained steady throughout the year. We continue to analyse closely key Gram-negative agents such as piperacillin / tazobactam, meropenem together with amikacin and colistin use and the impact of these on antimicrobial resistance (Figure 6).

8.3 Antimicrobial shortages

The Trust was made aware of eight antimicrobial drug shortages in 17/18. The shortage of key antimicrobials such as Piperacillin/Tazobactam (Tazocin®), Amikacin, Gentamicin, Meropenem and Ceftriaxone presented a major clinical challenge. The antimicrobial shortage programme reviewed adult, paediatric and speciality guidelines to seek alternative regimens based on information provided by Public Health England, together with local antimicrobial resistance patterns and expert clinician views. All appropriate guidelines were updated and communicated across the Trust.

8.4 Sepsis

The identification and clinical management of sepsis remains a Trust priority. In order to support this process, a sepsis module in Cerner has been piloted within the Trust and will be rolled out across the Trust for adult patients in 2018/2019. The module supports clinical staff in early recognition and management of sepsis, incorporating Trust Adult Treatment of Infection Guidelines and sepsis management principles. Reports from the module related to the time to prescribing antibiotics and other metrics linked to sepsis care standards are now available to help drive improvement around sepsis management, thus supporting antimicrobial consumption reduction.

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	
	Aug 2017	Feb 2018	*Aug 2017*	Feb 2018	*Aug 2017*	Feb 2018	*Aug 2017*	Feb 2018	*Aug 2017*	Feb 2018	*Aug 2017*	Feb 2018
Trust Results	*513/1271 (40%)*	589/1369 (43%)	*908*	1015	*91%*	92%	*98%*	98%	*89%*	90%	*93%*	95%
Medicine	*210/561 (37%)*	274/650 (42%)	*337*	436	*92%*	92%	*97%*	99%	*90%*	92%	*95%*	96%
Surgery, Cardiovascular and Cancer	*220/415 (53%)*	216/420 (51%)	*422*	404	*92%*	90%	*97%*	97%	*86%*	87%	*91%*	94%
Women's and Children's	*75/238 (32%)*	84/239 (35%)	*135*	148	*88%*	97%	*100%*	99%	*96%*	96%	*96%*	96%
Private	*8/57 (14%)*	15/60 (25%)	*14*	27	*75%*	74%	*100%*	100%	*60%*	56%	*86%*	85%
Trust Target 2017/18					90%		90%		90%		90%	

Table 4: Antibiotic point prevalence survey summary results: August 2017 & February 2018

8.5 Antimicrobial Review Group

The Antimicrobial Review Group (ARG) met on five occasions in 2017/2018. The role of ARG is to improve anti-infective use within the Trust by promoting safe, evidence-based use of anti-infectives, which is in line with good antibiotic stewardship. Anti-infective policy development is a key part of the ARG role; 23 guidelines were approved in 2018/19. A further Women's and Children's ARG sub-group was formed in 2017/18 which reviewed an additional 13 guidelines.

8.6 Collaboration and research

In November 2017, the Trust engaged in a week long high profile campaign around antimicrobial prescribing. Trust teams collaborated with Imperial College's academic staff, members of the Lloyd's community pharmacy team and patient representatives to highlight best-practice use of antibiotics. Activities included an 'antibiotic amnesty' in which unwanted medications could be handed in to pharmacy teams and positive promotional messages regarding how best to utilise and prescribe antimicrobials. The campaign coincided with European Antibiotic Awareness Day, a public health initiative aimed at raising the profile of using antibiotics appropriately. Each day of the week was focused on a different aspect of antimicrobial prescribing including the practical & safety aspects, policy awareness, the importance of appropriate sampling, and how to ensure the right antibiotic at the right dose for the right indication for patients. Education and awareness of the campaign was promoted by microbiology, infectious diseases, infection pharmacy and infection control. Our campaign was also viewed more than 30,000 times on social media attracting national and international interest. The activity helped to encourage everyone to think about their use of antibiotics and to raise awareness to help prevent the spread of antibiotic resistance.

The Trust is working with other NHS organisations (Oxford, Royal Free, Wirral, St Georges) around how best to utilise Cerner (Electronic Prescribing) for infection management activities. This includes designing core antimicrobial reporting to automatically alert healthcare professionals when antibiotics need reviewed. All involved are benefiting from this shared learning and helping to improve patient care.

8.7 Future

In 2018-2019, the Trust will continue to monitor and aim to reduce antimicrobial consumption in line with PHE objectives to produce a further 1-2% reduction in key antimicrobial groups. This together with resistance data will aid in identifying if Trust antimicrobial guidelines require updating.

ARG has scheduled a planned review of the Trust empirical adult and paediatric antimicrobial guideline which is due to be completed in the second half of the year. Further a new paediatric surgical antimicrobial prophylaxis guideline is being developed in response to an increase in paediatric surgical specialities.

The Trust will continue to work with Cerner colleagues to identify new ways of working around antimicrobial and sepsis management.

9 Vascular access

9.1 Intravascular device insertions

During 2017/18, the vascular access service had a total of 708 referrals. Referrals included requests for the insertion of vascular access devices, and for expert advice, support, and management of existing vascular access devices. Of the vascular access devices inserted,

475 were peripherally inserted central catheters (PICC), and 49 were midline catheters. The team introduced power injectable extended dwell catheters, which were inserted in 11 patients. This new catheter is used for patients requiring up to 28 days of intravenous therapy and contrast radiological investigations. The median dwell of all our catheters was 41 days with a range from 1 - 471 days. We had four patients who had an exceptionally long dwell, averaging 447 days (three in haematology and one in vascular) with no complications. Only one patient had a catheter-related BSI in 2017/18 linked to a vascular line inserted by the team.

9.2 Line safety management group

The line safety management group (LSMG) is the Trust-wide committee where all matters relating to the safe insertion, dwell, use, and removal of intravascular devices is scrutinised. The clinical divisions are represented on this group by senior clinicians and nurses. The multidisciplinary team reviews all MRSA and MSSA bacteraemia at the meeting; trends are noted and acted upon to provide safe practice for our patients. The focus in 2018/19 has been product standardisation and ensuring the use of cost effective products to ensure patient safety. The trend noted last year between lack of insertion records and on-going care continues and will be addressed this year within the divisions. All guidelines related to intravascular devices are reviewed within LSMG to ensure they adhere to recognised national and international guidance and best practice.

9.3 Cancer and vascular access research trial

In conjunction with interventional radiology, the team has participated in the cancer and vascular access (CAVA[1]) trial. This multi-centered randomised trial compared three central venous catheters: peripherally inserted central catheter, implantable port, or skin tunnelled catheter in patients undergoing 12 weeks or more of chemotherapy in the oncology setting, and is now in year 3. Recruitment ended on 28th Febuary 2018. We recruited 104 patients, which placed us in the top five (of 17) recruiting hospitals. Patient follow up is continuing, with results form the study not expected until 2019.

10 Decontamination and Estates issues

10.1 Sterile services

Sterile services are outsourced to a third party provider, IHSS Ltd. IPC advise on the development, monitoring, and audit of Key Performance Indicators (KPIs), which are managed by Trust Facilities.

10.2 Reprocessing units and medical devices

Each main hospital site has a centralised reprocessing unit. All three units have maintained external accreditation. Flexible endoscopes reprocessed through the units including external work has increased by 5%. Internal audits continue to be undertaken as part of the quality system. New mechanisms are in place to ensure that appropriate decontamination plans are in place for new, loaned, or experimental surgical equipment. All other local areas of decontamination, which includes bedpan washers and laboratory sterilisers, continue to be compliant with the relevant regulations.

10.3 CJD and NICE 196 risk management

No patients at increased risk for CJD were identified for surgery during this financial year.

[1] This Cancer Research UK trial is comparing different types of central lines that doctors use to give long term chemotherapy.

The business case to purchase a separate pool of instruments for high risk surgery for patients born after 01/01/1997 to comply with NICE 196 is being led by the Surgery, Cancer and Cardiovascular Division.

10.4 Projects and estates

Bedspaces in the neonatal unit at HH have been demarcated more clearly. Other projects include PICU, remodelling of HDUs, and parent accommodation at SMH; an additional MRI scanner at HH; refurbishment of a surgical ward, and angiography suite at CXH. The refurbishment project in the A&E at CXH is scheduled to commence in May 2018. The decontamination lead is advising on technical IPC issues related to the proposed Triangle development.

10.5 Single room audit

The proportion of single rooms in general ward areas (excluding critical care and some other specialist areas) is summarised in Figure 7. The proportion of single rooms suitable for IPC isolation at the three sites is 19.5% at SMH, 33.7% at HH, and 23.8% at CXH. This compares with 18.1% at SMH, 30.9% at HH, and 24.0% at CXH the last time the survey was performed. The limited number of rooms suitable for IPC isolation is included on the IPC risk register.

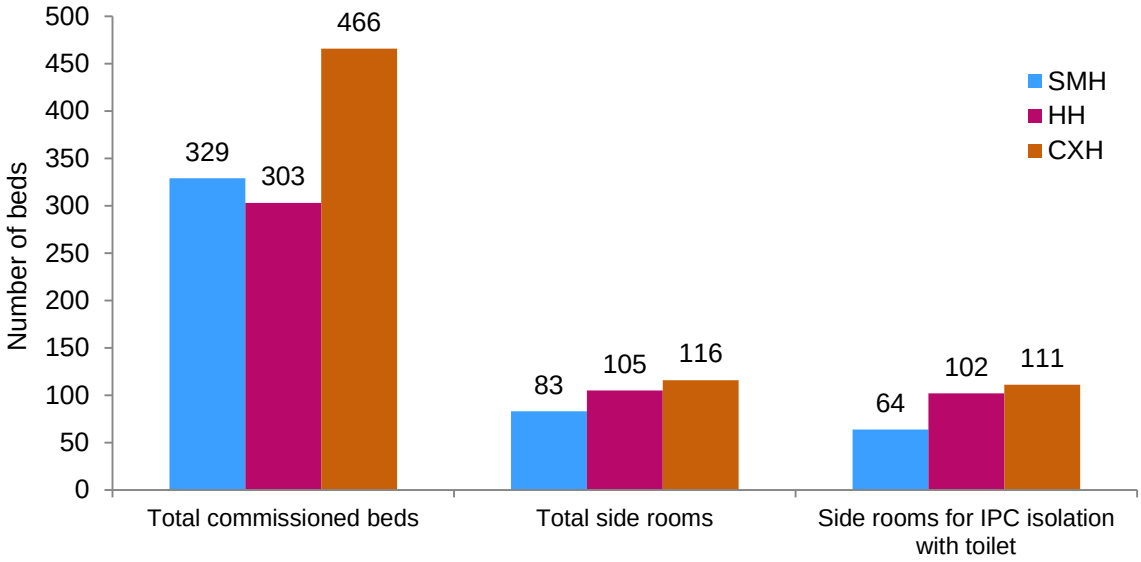


Figure 7: Summary of total number of commissioned beds, single rooms, and single rooms suitable for IPC isolation (with toilet), by site.

10.6 Water hygiene and ventilation

The procedures around the delivery of a safe supply of water continue to improve. In addition, improvements resulting from the hand hygiene facilities audit relating to sinks and drains have been delivered. A new ventilation group to oversee the Trust's specialist ventilation provision has been launched and meets quarterly.

11 Serious incident investigations

There have been 15 serious incidents (SIs) related to IPC in 2017/18, summarised in Table 5.

SI type	Number of incidents
Outbreak of HCAI pathogens (*C. difficile*)	1
Outbreak of HCAI pathogens (Resistant Gram-negative)	10
Outbreak of HCAI pathogens (norovirus)	1
Surgical Site Infection (MRSA)	1
Resistant gram negative bacteraemia (HCAI)	2

Table 5: SIs due to infection related causes

12 Freedom of Information (FOI) requests

During 2016/17, the IPC service received 11 requests for data and information under the Freedom of Information Act (2000). The information provided met the legislated timeframe for completion.

13 Review of infection prevention and control policies and audit of compliance

In 2017/18 the following policies and guidelines were reviewed/ratified:

- CJD (and other prion disease) policy.
- Decontamination policy.
- Infection prevention clinical competency assessment for patient safety, including hand hygiene, the use of personal protective equipment, and aseptic non touch technique policy.
- Isolation of patients to prevent the transmission of infection policy.
- Personal protective equipment policy.
- Infection prevention and control management of *Candida auris*.
- Peripherally inserted central catheter (PICC) continuing care guidelines.
- Non tunnelled central venous catheter guideline.
- Midline continuing care guideline
- Implantable port guideline.
- Peripheral cannula guidelines.
- Skin tunnelled catheter guidelines.

A comprehensive review of all policies related to IPC continues to be undertaken on a rolling basis.

14 Responding to external issues and directives

14.1 National Investigation of Mycobacterium species in heater-cooler units

There is an emerging global issue related to the use of water heater-cooler units (HCUs) used in cardiothoracic surgery. These HCUs become contaminated with bacteria (especially non-tuberculosis mycobacteria sometimes including *Mycobacterium chimaera*) and can release contaminated aerosols, which have been linked with SSIs and endocarditis. In February 2017 NHS England mandated a national patient notification exercise for patients who have undergone cardiac valve repair or replacement procedures since January 2013. In March, the Trust wrote to 946 patients to notify them of the risk of *Mycobacterium chimaera* infections linked with HCUs. 23 patients have contacted the Trust with symptoms, but most were discounted following initial review. 4 patients have been seen in clinic; 3 patients are attending their local hospital and the Infectious Diseases service has seen 2 patients. No patients had symptoms consistent with *M. chimaera* infection, required on-going treatment, or had blood cultures obtained as a result.

14.2 Respiratory virus trends

The number of respiratory viruses is monitored during winter months. The number of respiratory viruses detected, by week, is summarised in Figure 8. This shows the expected increases in winter respiratory viruses, such as Rhinovirus. The number of cases of influenza has risen sharply since the beginning of December, in line with national trends. The Trust asked to report the daily census of patients with Influenza to NHS Improvement over the winter months. No nosocomial transmission of influenza was detected.

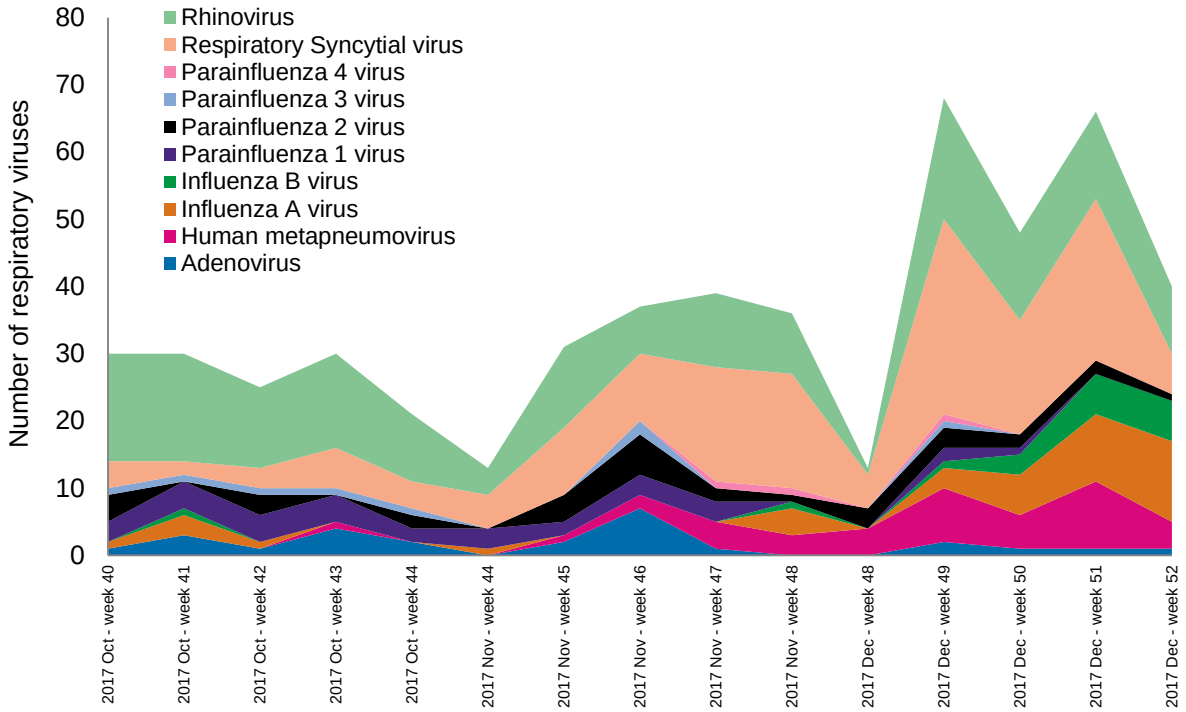


Figure 8: Number of respiratory viruses detected, by week.

14.3 Other external directives and issues addressed

The Trust has participated in the CQUIN to 'Reduce the impact of serious infection) (see section 8.2), the GIRFT SSI audit (see section 5.4.1), and developed plans to reduce Gram-negative BSI in line with the national ambition to halve these infections by 2021 (see section 5.1) and addressed the challenges of the national shortages of key antimicrobial agents (see 8.3).

15 Responding to local issues and events

15.1 CPE clusters

Probable CPE transmission was identified in 15 wards during 2017/18. Clusters ranged in size from 2 to 17 patients. Outbreak measures were implemented and all outbreaks were controlled. These clusters mostly involved screening cultures, although a small number of clinical cultures were involved. This resulted in 9 serious incident investigations.

15.2 Increased incidence of VRE and C. difficile on an Intensive Care Unit

An increased incidence of vancomycin resistant enterococci (VRE) was identified on the intensive care unit at Charing Cross during April, May and June, above the baseline screening rate of 1-2 cases per week. In total, eight cases were identified as being the same type. Six of these eight cases were from screening samples. One patient required treatment for a clinical infection but recovered well and was discharged. One patient had a clinical sample but treatment was not indicated and the patient was subsequently discharged well.

The rate of VRE detection has returned to baseline levels. During June, one transmission event related to *C. difficile* was detected.

15.3 Diarrhoea and vomiting on the an Intensive Care Unit

Seven patients and four staff members (three clinical and one non-clinical) on the intensive care unit at Charing Cross developed symptoms of diarrhoea and / or vomiting in December 2017, which was presumed to be due to norovirus (although this was not laboratory confirmed). The unit was closed for four days to ensure that no patients or staff were incubating gastrointestinal infection. The unit was reopened on the fifth day and no further cases occurred.

15.4 Parainfluenza 3 on a neonatal unit

An outbreak of parainfluenza 3 was identified in April 2017 on the neonatal unit at St Mary's. Following confirmation of Parainfluenza 3 from two cases linked in time and place, screening of all inpatients on the unit was undertaken. This identified a further two cases, leading to a total of four affected patients. The unit remained open and the affected babies were isolated and cohorted together. There is no obvious source for this incident. It is known that outbreaks of Parainfluenza 3 infections occur seasonally, mainly in spring and summer, and it was recognised that there was an increased prevalence of Parainfluenza 3 virus in the community during this period. No further cases were identified.

15.5 PVL-positive MSSA on a neonatal unit

An investigation was undertaken into seven babies identified with the same strain of a PVL *Staphylococcus aureus* on the neonatal unit between December 2016 and February 2018. Actions taken on advice of Public Health England included administering suppression therapy to all staff across both units on two occasions and a proactive screening programme for all babies. Screening of staff for this organism was also undertaken.

15.6 *Legionella* related to renal wards

A case of *Legionella* pneumoniae was identified at another hospital in London and the patient had had a recent inpatient stay at Hammersmith Hospital. An extensive review of possible sources of *Legionella* along the patient pathway identified several water outlets contaminated with *Legionella*. These outlets have been managed as per the Water Safety Plan. Hospital acquisition of *Legionella* at Hammersmith Hospital could not be ruled out.

15.7 Basidiomycetes fungi in a bronchoscopy suite

Eight patients who have had bronchoscopies at Hammersmith Hospital between early December 2017 and the end of March 2018 grew an unusual environmental fungus; there are no signs of clinical infection in any of the patients. A mixed group of immunocompromised patients was affected. The source of the environmental fungus was not identified definitively. Routine bronchoscopy at HH was suspended temporarily for three weeks whilst the issue was investigated; bronchoscopies were performed on other sites during this period.

15.8 MRSA joint infections

There have been two MRSA joint infections (both total knee replacement surgeries) at Charing Cross due to unrelated strains of MRSA. This led to a temporary suspension of joint surgery, which resumed after seven days. This is being investigated as a Serious Incident.

16 Publications

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Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: 2017 Annual survey of adult inpatients	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 24, report no. 20**
Responsible Executive Director: Professor Janice Sigsworth – Director of Nursing	**Author:** Guy Young – Deputy Director of Patient Experience

Summary:

The 2017 National survey of adult inpatients was published in June.

The survey relates to a sample of inpatients who were discharged during July 2017. Overall the results show a slight improvement on previous years with the trust performing about the same as other trusts in all but two questions. Improvements were seen in a number of areas, most notably in the section related to nurses.

When benchmarked against other London trusts there has been an improvement on previous years with ICHT now on equal footing with Guy's & St Thomas and UCLH, which have historically been the top performing acute trusts in the Capital.

Recommendations:
The Board is asked to note the report.

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

Quality impact:
Delivering a good patient experience is a key part of the Trust's quality strategy. This report provides assurance that the experience of patients is about the same as other trusts. There are no aspects of the report that cause any significant concern.

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:
Poor reported experience can be reputationally damaging to the trust and this report will provide assurance that this is not the case.

Workforce impact (including training and education implications):
No new impact.

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: Retain as appropriate: ▪ 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): N/A

Imperial College Healthcare
NHS Trust

2017 National survey of adult inpatients

1. Background

The 2017 national survey of inpatients was published in June 2018. This is the 15th year this survey has taken place. The survey is based on a sample of 1250 inpatients who were discharged during July 2017.

The ICHT results are generally better than the 2016 survey this year with notable improvements in questions related to noise at night and the questions related to nursing. Respondents rated the quality of food better than the previous year, but the score for getting help with meals fell.

Benchmarking against other London trusts improved this year with there now being virtually no difference in the results between ICHT, Guy's & St Thomas and UCLH.

The full report can be found at:
http://www.nhssurveys.org/Filestore/IP17_BMK_Reports/IP17_RYJ.pdf

Or in a simplified format on the CQC website:

https://www.cqc.org.uk/provider/RYJ/survey/3

2. Methodology

The survey is administered as a postal questionnaire. 392 patients returned a completed questionnaire, giving a response rate of 32% which is the same as the previous year: the national response rate was 41% a drop from 2016 when it was 47%.

The survey is split into 11 sections; 9 covering various aspects of the patients experience and 2 that focus on overall impressions.

Results are standardised by age, sex and method of admission (emergency or elective) to ensure that no trust appears better or worse than another because of its respondent profile. For each question the standardised response is converted into scores on a scale of 0 to 10; a score of 10 represents the best possible response and a score of 0 the worst.

The results in the attached report are presented as a bar with 3 sections. The black diamond is the ICHT score. Where the trust score lies in the grey section the result is 'about the same' as most other trusts, in the green section it is 'better' than most other trusts and in the amber section it is 'worse' than most other trusts.

The 'about the same', 'better' and 'worse' categories are based on an analysis technique called the *expected range*, which is uniquely calculated for each trust for each question. This is the range within which a trust would be expected to score if it performed '*about the same'* as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance. The colours should not therefore be viewed as a traditional RAG rating; in effect a score in the grey band demonstrates that the trust is performing as expected when compared with other trusts.

3. Summary of results

Out of 62 questions, ICHT scored about the same as in 60, better than in 1 and worse than in 1. This is an improvement on the previous year when the trust scored worse than in 5 questions and better than in none.

This year the trust scored better than in response to the question *"During your hospital stay, were you ever asked to give your views on the quality of your care?"* This is consistent with our performance in the inpatient Friends and Family Test response rate which is generally above the national average.

The question which the trust scored worse than for was "*Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?"*. It could be argued that this is not actually a reflection on the trust.

Last year two of the five questions that scored worse than, were in the section related to the patients' experience of nurses. This section showed a marked improvement in 2017 with all questions rated as about the same. In particular the question "*Did you have confidence and trust in the nurses treating you?"* showed a statistically significant improvement. Patients also experienced less noise at night.

The section relating to waiting lists or planned has got marginally worse, though the section is rated about the same as overall. This section reflects that people are less satisfied with the time they were on the waiting list as well as the issue of specialists not having all the necessary information (see above).

Overall this is a positive survey result and one of the best the trust has seen in a number of years. This is felt to reflect our continuous focus on patients' experience of care over an extensive period of time. The nature of the national surveys is that changes, positive or negative, tend to be small over long periods of time, so these results are encouraging.

The table below shows how ICHT performs related to a selection of London trusts in key elements of the survey.

Trust	Overall rating of care	Average score (all sections)	Number worse than	Number same as	Number better than
ICHT	8.2	7.7	1	60	1
GSTT	8.2	7.8	0	62	0
UCLH	8.3	7.8	1	60	1
C&W	8.0	7.6	3	58	1
Barts	7.7	7.3	27	35	0
Kings	8.0	7.6	5	57	0
London NW	7.7	7.5	9	53	0

4. Actions arising out of the survey

The trust has previously relied on existing programmes of work to support improvements rather than having a specific inpatient survey action plan. This approach appears to be working and it is proposed that this should continue.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Complaints Annual Report 2017/18	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 25, report no. 21**
Responsible Executive Director: Professor Janice Sigsworth – Director of Nursing	**Author:** Daniel Marshall - Complaints & Service Improvement Manager Guy Young – Deputy Director of Patient Experience

Summary:

In 2017/18 the Patient Advice & Liaison Service (PALS) and Complaints Teams maintained the high standard of service provided in previous year, meeting all the key targets for timeliness and responsiveness of service.

The quality of responses provided by the complaints team was demonstrated by the low number of complaints being reopened as well as being referred to the Parliamentary & Health Service Ombudsman (PHSO) during the year, with only three of those being partly upheld upon investigation. The proportion of cases "re-opened" by the complaints team also fell during the year.

PALS continued to build on previous successes by developing the PALS Volunteer service which allows the team to take a pro-active, visible approach to anticipating and resolving patients' concerns before they are allowed to escalate.

The complaints process was audited in October 2017 on "Learning Lesson from Complaints" and the assurance provided was substantial.

Overall the volume of formal complaints and PALS concerns fell slightly compared to the previous year.

Recommendations:
The Board is asked to note the report.

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

Quality impact:
The trust needs to have effective systems to respond to and manage concerns raised by users of its services. Complaints management sits under the responsive CQC domain.

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

Risk impact and Board Assurance Framework (BAF) reference:
N/A

Workforce impact (including training and education implications): No new impact.
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: Retain as appropriate: ▪ 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): N/A

2016/17 Trust complaints service annual report

1.0 Summary

Last year saw the Patient Advice & Liaison Service (PALS) and Complaints Teams maintain the high standard of service provided in previous year, meeting all the key targets for timeliness and responsiveness of service. The quality of responses provided by the complaints team was demonstrated by the low number of complaints being reopened as well as being referred to the Parliamentary & Health Service Ombudsman (PHSO) during the year, with only three of those being partly upheld upon investigation. PALS continued to build on previous successes by developing the PALS Volunteer service which allows the team to take a pro-active, visible approach to anticipating and resolving patients' concerns before they are allowed to escalate.

The complaints process was audited in October 2017 on "Learning Lesson from Complaints" and the assurance provided was substantial.

The headline performance figures for 2017/18 are:

- 979 formal complaints received and 2710 PALS cases resolved.
- 99% of complaints were responded to within their agreed deadlines. Only four cases breached their agreed deadlines for the whole year.
- 99.2% of acknowledgment letters were sent within 3 working days.
- The average number of days to respond to complaints was 29 days, which is well below the local target of 40 days.
- The number of complaints referred to the PHSO fell to 11, from 17 cases in the year previously. During the year the PHSO shared the outcomes of 14 cases (11 not upheld, 3 partly upheld and 0 fully upheld). This is the Trust's best ever performance and reflects the improvements made to the quality of our investigations and responses since the function was centralised in October 2015.
- The proportion of reopened complaints continues to fall; from 14% in 2015/16 to 10% in 2016/17, to 5.7% in 2017/18.
- Various members of the complaints team continue to be nominated by directorates for Make a Difference instant recognition awards.

Engagement between the Central Complaints Team, PALS and the divisions remains strong and there is an established complaints presence at divisional monthly and quarterly governance meetings. This is supported by regular reports provided by the Complaints & Service Improvement Manager. A fortnightly tracker is sent out to key staff. This shows a summary of complaints performance across the Trust and allows queries and delays to be identified and dealt with promptly. The report continues to highlight the great work being done around the Trust by including compliments. This helps balance feedback and improves general engagement with the complaints team.

A system for ensuring that actions arising from complaint investigations are captured is in place, and all actions are followed up systematically with the Divisions and evidence is collected to ensure that they have taken place. The first significant service improvement

resulting from trends in formal complaints was completed during 2017/18. This related to improving the discharge process for vulnerable patients.

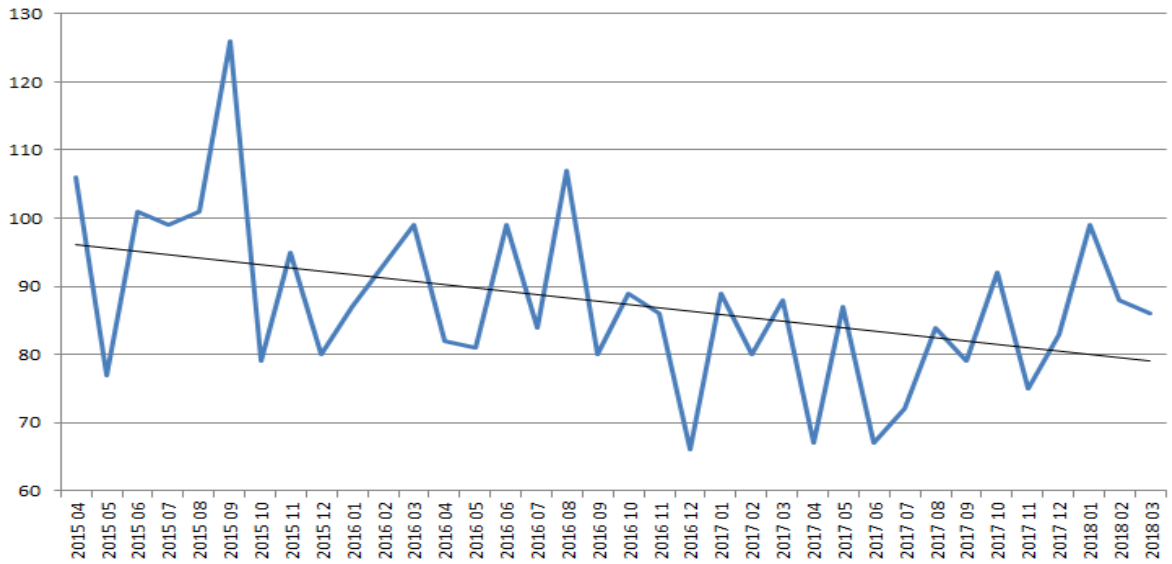
When looked at in relation to other comparable trusts, ICHT has performed particularly well in terms of meeting response targets and in the number of PHSO cases relative to our overall case load. The Shelford Group represents ten of the leading NHS multi-specialty academic healthcare centres in England. Along with Sheffield Teaching Hospitals NHS Trust, ICHT had the fewest cases upheld or jointly upheld at Ombudsman review. The complaints team set a target of reducing the number of complaints being re-opened during 2017/2018 to 5% of all caseloads received. This was narrowly missed with 5.7% being achieved but was still a significant reduction on 10% in 2016/2017. The complaints team is on track to re-open fewer than 5% of complaints during 2018/2019.

2.0 Numbers of Formal Complaints Received

Last year the Trust received a total of 979 formal complaints. Following the pattern established in the previous year the volume of complaints fell by 5%, from 1032, albeit at a slower rate than in 2016/17 when a 10% year on year fall was recorded. This year's reduction in the number of formal complaints was particularly pleasing because of the concurrent increase in the Trust's activity and the challenges on services across the NHS. This was especially apparent during the winter period when non-urgent elective surgery was being rescheduled. This reflects the quality and timeliness of the Trust's complaints handling and the contribution of PALS in swiftly resolving concerns so that they do not unnecessarily escalate to formal complaints. Additionally, the Complaints & Service Improvement Manager has been delivering regular training sessions to preceptorship nurses and junior doctors on complaints handling to provide them with the skills to resolve low level concerns at the bedside. Feedback from these sessions has been very positive.

The graph below shows the trend in the number of formal complaints being raised over the last three financial years. This graph demonstrates a slow but steady year-on-year fall in the volume of complaints received by the trust. The rate of the fall is expected to reduce over the next two years as numbers reach a sustainable minimum level

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

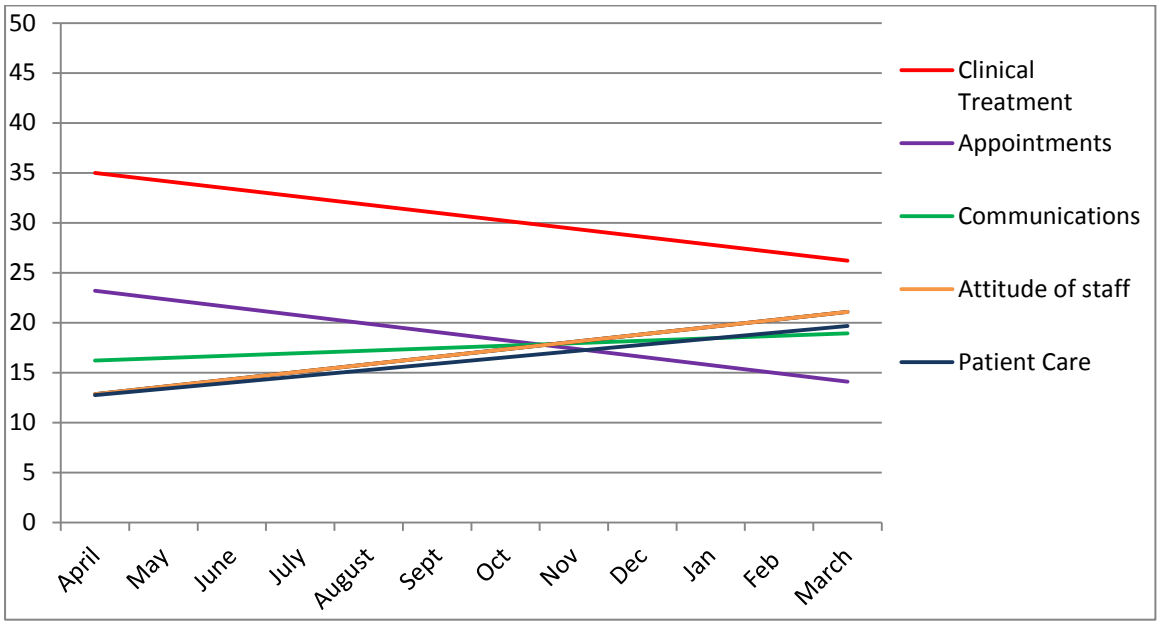


3.0 Complaints cases

Overall trends in formal complaints received

Graph 2 demonstrates general trends in formal complaints themes (top 5) raised as a proportion of the overall caseload for that month. Increases can be observed in issues relating to Attitude of Staff, Patient Care and Communications. However, there has been an overall reduction in the proportion of complaints about Clinical Treatment and Appointments over the year. This fall in the average was observed despite a spike in the number of Appointment related complaints raised during the winter months.

Graph 2: Trends in PALS and complaints themes last year



Since 1 April 2016 ICHT has been reporting using standardised categories, set by NHS Digital, which allow for benchmarking across NHS Trusts. Table 1 highlights the top 5 categories of formal complaints received in the year in comparison with the previous year.

Table 1: Formal complaints by category

Category	2017/18	% of total	2016/17	% of total
Clinical treatment/patient care	357	37%	475	46%
Appointments	141	15%	185	18%
Communications	133	14%	114	11%
Values and Behaviours (Staff)	132	13%	108	10.5%
Admissions & Discharges	57	6%	83	8%
TOTAL	**820**	**84%**	**965**	**93.5%**

Interestingly the proportion of complaints about clinical care has fallen significantly between 2016/17 and 2017/18 from 46% to 37% of the overall total. This appears to demonstrate that despite unprecedented pressures on services, our clinicians continue to deliver safe and effective care to patients.

Despite the pressures on services, the proportion of formal complaints about appointments has also fallen slightly although only by a small amount. This is likely to be a reflect the impact of the central booking function and the work PALS does to ensure that issues about appointment delays and cancellations are, where possible, dealt with quickly and at source without being escalated to the formal stage.

Values and behaviours (staff attitude) and communication were identified as emerging themes during 2016/17 and have unfortunately continued to increase during 2017/18. Complaints about poor staff attitude were of a particular concern in Maternity Services. The most common themes of these complaints are rudeness, unhelpful attitude and poor communication. A plan of action is in place to address this which we expect to have an impact during the course of 2018/19. This is will be followed up in next year's report. A summary of the action plan is outlined below:

- Back to the Floor Thursday: Senior midwifery staff have set aside Thursdays to get out and about in their clinical areas to enable them to:
    - Monitor standards of care
    - Engage with staff and patients
    - Facilitate the resolution of problem
    - Support operational readiness for the weekend
    - Gain feedback that supports the improvement of patient care

Table 2 provides a breakdown by service area. During 2016/17 ICHT received more complaints about outpatients than inpatient services. During 2017/18 that situation reversed. This is likely to be a reflection of the success of the Outpatient Improvement Programme in addressing previous shortcomings in services for outpatients. In terms of the increase for inpatients, there have been significant pressures on our inpatient services due to the cancellation of non-urgent elective surgery during the winter months across the NHS in England. Additionally there has been a great deal of pressure on HDU/ITU capacity which will have negatively affected the experience of our inpatients. Complaints about Emergency Medicine and Maternity remain more or less stable as an overall proportion of complaints received.

Table 2: Complaints by service area

Service area	2017/18	% of total	2016/17	% of total
Outpatients	350	36%	470	46%
Inpatients	469	48%	412	40%
A&E	83	8%	77	7%
Maternity	77	8%	73	7%
Total	**979**	**100%**	**1032**	**100%**

Table 3 shows the number of complaints received by division compared with the previous year. We have also looked at the Directorates that have attracted the most complaints in Table 4.

Table 3: Complaints by division

Division	2017/18	% of total	2016/17	% of total
Medicine & Integrated Care	298	30%	389	38%
Surgery, Cancer & Cardiovascular	373	38%	314	30%
Women's, Children's & Clinical Support*	205	21%	192	19%
Corporate (including IPH)	101	10%	137	13%
NWL Pathology	2	<1%	N/A	N/A
Total	**979**	100%	**1032**	100%

Table 4: Complaints by Directorate

Division	2017/18	2016/17	% change year on year
Trauma	98	84	+16%
Urgent Care & Emergency Medicine	85	78	+8%
Maternity	79	70	+11%
General Surgery & Vascular	67	94	-40%
Gynaecology & Reproductive Medicine	68	54	+21%

Orthopaedics and Imperial Private Healthcare (IPH) featured in the Top 5 complaints by Directorate during 2016/17 and no longer appear on the list this year. The General Surgery and Vascular Directorate has also significantly decreased its volume of complaints. All other areas on the list above have shown increases, notably Gynaecology & Reproductive Medicine with a 21% increase as well as an 11% increase in Maternity. As outlined above, the allocated Patient Complaints Investigator is continuing to work with the Maternity Directorate to look at strategies to improve patient experience and of avoiding complaints becoming formal.

All complaints are risk assessed upon receipt by a senior member of the complaints team. They are assigned a risk grade which informs the timescale for completing the investigation as well as who approves and signs off the final response. Table 5 shows the number of complaints per division by risk grade.

Table 5: Risk grade by division

Division	LOW	MEDIUM	HIGH
Medicine & Integrated Care	259	42	0
Surgery, Cancer & Cardiovascular	355	16	3
Women, Children & Clinical Support	178	24	4
Corporate (including) IPH	96	0	0
NWL Pathology	2	0	0
Total	**890 (91%)**	**82 (8%)**	**7 (1%)**

The outcome of trust complaint investigations is that the complaint can be "not upheld", "partly upheld" or "upheld". For those cases which are partly upheld or upheld, actions and

learning are extracted and recorded on complaints change register for follow-up. Please see Section 8 for more information about how we learn from complaints. Table 6 shows the outcomes of the 921 complaints investigations completed in 2017/18. Approximately half of all complaints investigated were not upheld, which is in keeping with previous years. Surgery, Cancer and Cardiovascular along with Corporate (including IPH) had the highest proportion of upheld cases whilst Medicine and Integrated Care had a significantly lower proportion. A complaint is upheld, or partly upheld, when a failing in care or process is identified.

Table 6: Outcome by division

	Upheld	Partly upheld	Not upheld	Total
Medicine and Integrated Care	63	58	150	271
Surgery, Cancer and Cardiovascular	122	69	167	358
Women's, Children's and Clinical Support	40	65	91	196
NWL Pathology	1	0	1	2
Corporate (Inc. IPH)	41	14	39	94
Total	**267**	**206**	**448**	**921**
Percentage	**29%**	**22%**	**49%**	

4.0 The year ahead for the Central Complaints Team

The focus in 2018/19 will be on maintaining the current high standard of performance in terms of quality and timeliness of responses. We will continue to be empathetic, explain clearly what has gone wrong in the cases where we find failings, and we will be very clear about what actions we will take to put things right. We will then make sure those actions happen.

Following a small restructure as the result of a vacancy, we will recruit an additional investigator. This will allow increased focus on the investigation and learning processes and free up time more time for the Complaints & Service Improvement Manager to develop quality improvement initiatives arising out of complaints.

We will ensure actions continue to be logged and monitored and that they are followed up with the Divisions who will provide confirmation when the actions are implemented. The Complaints & Service Improvement Manager will analyse complaints data to identify trends/themes and hotspots and raise them with the service areas concerned so that they can be supported to make any necessary service improvements.

The quality of the complaints service will be demonstrated by a reduction in the number of cases we re-opened. We have set ourselves a target of reducing them to 5% or below. We will continue to respond to all complaints received in fewer than 40 working days and we are also introducing a new key performance measure of “overall satisfaction” with the handling of patients’ complaints, for which we have set ourselves an initial target of 70%. This will be measured via the feedback questionnaire which we are sending to complainants six weeks after conclusion of their complaint. Feedback gained via the questionnaire will be discussed by the Complaints and Service Improvement Manager during regular 1:1 meetings with the

Patient Complaints Investigators to examine how they can make immediate improvements to their complaints handling, where necessary.

The Complaints & Service Improvement Manager will continue to offer expert advice to colleagues across the Trust and carry out regular training sessions with colleagues from all service areas on how to effectively manage and resolve complaints.

5.0 PALS cases

The PALS team resolved 2710 informal concerns and enquiries during 2017/18. Table 7 displays a breakdown of the cases received by Division.

Table 7: PALS cases by Division

Division	2017/18	% of total	2016/17	% of total
Medicine & Integrated Care	933	34.5%	885	31%
Surgery, Cancer & Cardiovascular	1145	42.5%	1140	40%
Women's, Children's & Clinical Support	442	16%	327	11%
NWL Pathology	3	<1%	N/A	N/A
Corporate	187	7%	507	18%
Total	**2710**	**100%**	**2859**	**100%**

This year has seen a 5% increase in the number of formal complaints being dealt with by PALS. PALS offer an increasingly pro-active service which aims to resolve issues before they have the chance to escalate unnecessarily. PALS continue to deal with a greater proportion of cases for Surgery, Cancer & Cardiovascular than the complaints team. Many of these cases relate to delays and cancellations in surgery appointments, issues which are particularly amenable to quick resolution. The proportion of PALS cases regarding corporate issues has decreased significantly as complaints about patient transport have fallen. There has however been a significant increase in PALS dealing with concerns regarding Women's Children's and Clinical Support from 11% to 16%.

Table 8 shows the breakdown of PALS cases by specialty (for those specialties receiving more than 100 concerns in the year).

Table 8: PALS cases by specialty

Speciality	**Number of cases received**	**% of all PALS cases**
Orthopaedics	292	11%
Neurosurgery	158	6%
Ophthalmology	155	6%
Emergency Medicine	133	5%
Neurology	133	5%
Urology	131	5%
Dermatology	108	4%
Gynaecology	104	4%

Table 9 shows a breakdown of PALS cases by category (top 5 categories only)

Table 9: PALS cases by category

Subject	2017/18	% of total	2016/17	% of total
Appointments	923	34%	1082	38%
Communications	530	20%	486	17%
Values & Behaviours (Staff)	205	8%	122	4%
Clinical Treatment	154	6%	183	6%
Facilities	59	2%	69	3%
TOTAL	**1871**	**69%**	**1942**	**68%**

The above table reflects the pressures the Trust is under in terms of demand for services as well as short notice cancellations of appointments and delays to treatment resulting from the aforementioned winter pressures. PALS continue to deal with the bulk of such queries and do their best to assure patients that they are in the system and that they will be seen as soon as possible. The emerging theme of *Values and Behaviours* is also highlighted in this table with concerns about staff attitude doubling from 4% to 8% as a proportion of all cases received.

6.0 The year ahead for PALS

The manner in which concerns are raised through PALS has changed over the past year. There is a growing increase in the volume of emails and phone calls. The vision last year was to shift PALS from a reactive service model to a proactive service model. The service has successfully adapted a proactive approach and is working more closely with patients and staff by attending inpatient and outpatient areas. The PALS service focus is to provide hands on support to patients and staff. This has helped to ensure that every opportunity is taken to resolve concerns in house and at source. PALS Officers have been issued with mobile phones so that when they are out of the office, meeting with patients and staff they are contactable; making it easier for PALS to spend the time and effort required to resolve concerns. PALS are seen as the ‘go to’ people for both patients and staff with the ability to provide immediate support.

To increase a PALS presence within the Trust, the PALS Manager, with the support of the Head of the Patient Experience team and the Imperial Health Charity, launched a Patient Support Volunteer pilot scheme at St Mary's site this year. The Project commenced in February 2018. So far the PALS Manager has recruited 12 volunteers for the St Marys site. The purpose of a Patient Support Volunteer is to provide a friendly and personal point of contact for patients on the wards to listen to their experience both positive and negative and then feedback all comments to PALS Manager after their volunteer shift. This feedback is recorded by the PALS Manager and shared with the individual wards. When there are concerns that require immediate action our Patient Support Volunteers will either escalate to the staff on the ward or to the PALS Team. The PALS Officer will visit the patient/relative and take their concern forward.

The approach of volunteers working within the PALS Service has provided an easier feedback mechanism for our patients. It has enabled the PALS service to be in a strong position to proactively help reduce formal complaints and resolve patients' concerns at the bed side or in the service area.

The plan is to continue to expand the number of volunteers at St Marys Hospital and extend to other sites, the agreed project plan, with the next phase to launch the service at Hammersmith Hospital, summer 2018 and then, Phase 3, launch at Charing Cross Hospital later in the year. The purpose is to continue to build relationships between PALS volunteers/PALS and staff. An additional roles such as the library trolley service has also been launched and Youth Volunteering Programme will commence during the summer

7.0 PHSO Cases

Table 10 provides a breakdown of all the PHSO decisions last year. The PHSO reviewed 11 cases, which amounts to 1.1% of the Trust's annual caseload. This was a significant decrease in the 2.1% of cases reviewed by the PHSO during 2016/17. The PHSO shared 14 outcomes (some cases were carried over from 2016/17) and only three were partly upheld, the rest being not upheld.

We followed the structured approached to managing PHSO cases developed in 2017/18. This ensures that we report and share learning with our divisional triumvirates and that we involve them in devising any necessary service improvements.

Table 10: Decisions the PHSO made last year by division

Division	Upheld	Partly Upheld	Not Upheld
Medicine & Integrated Care	0	2	6
Surgery, Cancer & Cardiovascular	0	1	4
Women's, Children's & Clinical Support	0	0	2
TOTAL	0	3	12

Table 11: Decisions the PHSO made last year for the Shelford Group of Trusts

TRUST	Number Upheld/Partly Upheld by PHSO
Imperial College Healthcare NHS Trust	3
Sheffield Teaching Hospitals NHS Foundation Trust	3
Guy's and St Thomas' NHS Foundation Trust	6
King's College Hospital NHS Foundation Trust	6
University College London Hospitals NHS Foundation	6
Cambridge University Hospitals NHS Foundation Trust	6
Manchester University NHS Foundation Trust	7
University Hospitals Birmingham NHS Foundation Trust	8
Oxford University Hospitals NHS Trust	9
The Newcastle Upon Tyne Hospitals NHS Foundation	11

Financial remedy

The Trust made monetary payments totaling £3050 last year to help remedy complaints where a service failure occurred. We are also required to put a complainant back to the same financial position they would have been in had the problem not occurred. Of the total amount, £750 was paid as a result of specific recommendations from the PHSO (for comparison, in 2016/17 the PHSO awarded £3250 to complainants and the Trust paid a total of £11696). The remaining amount was paid pro-actively by the Complaints Team, for example to reimburse travel costs or in recognition of inconvenience caused. This proactive approach prevents cases unnecessarily escalating to the PHSO, which incurs even a greater cost to the Trust not only in terms of a financial remedy but staff time.

8.0 Learning and Service Improvements following a formal complaint investigation

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

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

The following table provides a small sample of some of the service improvements made last year following a formal complaint investigation.

Medicine & Integrated Care:

Directorate	Description	Action Taken
Emergency Medicine	Patient's medical notes had incorrect details when he was transferred to the Zachary cope Ward from A&E At St. Mary's	The system was revised and a three point checklist put in place. We printed posters on put onto walls to remind A&E reception staff of new procedure.
HIV/Sexual Health	Complainant concerned about the wording of a Jefferiss Wing sexual health screening questionnaire, as	Following a discussion within the team, we removed the laminated questionnaires from the pathway for

Directorate	Description	Action Taken
	they believed it was stigmatising to certain groups of people	asymptomatic patients. We wrote to the complainant to explain the rationale for doing this.
Renal	The patient complains that, on the day that he was due to have surgery on a fistula on his left hand, the surgery was cancelled and he was told he would need a fistulagram instead.	Internal processes have been amended to perform earlier pre-surgical checks to allow identification of potential complications. These earlier checks should result in fewer on-the-day cancellations and an improved experience for our patients.

Surgery, Cancer & Cardiovascular

Directorate	Description	Action Taken
Trauma & Orthopaedics	Patient had to wait over two months for an Individual Funding Request form to be completed. This caused distress to the patient and delays in treatment.	The Plastics team is introduced a new administration system to deal with funding applications.
ENT	Patient was instructed to come in for surgery at 7.30am even though it was known that they were last on the list and their operation would therefore not take place until 2.30pm or 3.00pm.	The ENT surgeons are now staggering the arrival times of their patients and we are currently reviewing the spinal lists with a view to doing the same.
Ophthalmology	Patient complained about unclear and out of date information such as wrong telephone numbers on appointment letters at the Western Eye Hospital	We reviewed the appointment letters and changed them. Contact numbers have been updated

Women's, Children's & Clinical Support

Directorate	Description	Action Taken
Maternity	The patient rang to inform QCCH that they were delayed and was told that it was okay, but the sonographer initially refused to see them and began to speak over the	We apologised for the experience with us. We arranged a new scan and spoke with the sonographer concerned about being friendly and welcoming. The Complaints Team is supporting

Directorate	Description	Action Taken
	patient and became quite argumentative.	wider service improvement work in Maternity Service to improve patient experience.
Gynaecology & A&E	The patient complained of uncaring behaviour and a lack of empathy and understanding from staff when attending St Mary's A&E suffering from a miscarriage.	Refresher training given to A&E receptionists on customer service. Two of the senior sisters from the Gynaecology Emergency Room and Early Pregnancy and Acute Gynaecology Units have delivered training sessions with nursing and clinical staff in the main A&E department on managing cases such as this, with a particular focus on how women experiencing miscarriage can be better supported, both in terms of receiving prompt dignified treatment and ensuring that they receive the emotional support they need. Plans are underway to relocate and extend the opening hours of Gynae ER and relocate it next to the main gynae. Ward.
Pharmacy	The patient complained that complained that communication between the pharmacy and the wards is inadequate in the afternoon.	The Deputy Chief Pharmacist is looking rearranged the rosters, so more staff are available in the afternoon.

As well as immediate improvements, the Complaints & Service Improvement Manager uses complaints data to identify and make two significant service improvements each year. The first such piece of work agreed in Q4 of 2016/2017 related to ensuring the dignified discharge of vulnerable patients. The Complaints & Service Improvement Manager worked with the Discharge Managers and the Trust Communication Team on an awareness raising drive for staff (via The Source) to make them aware of the importance of pre-planning and pre-assessing their patients' discharge needs including ensuring that their patients are appropriately dressed before they are discharged.

By the end of Q3 in 2017/18 the actions were completed and the Complaints & Service Improvement Manager reviewed the number of complaints received about the discharge process to see if there has been a fall:

- From 1 March 2016 to 31 March 2017 there were 39 complaints regarding the above
- From 1 March 2017 until 31 March 2018 there were 32 complaints regarding the above.

Therefore, it is reassuring that appear that concerns about discharge in general have showed a significant year on year fall. More strikingly, there were only two complaints during Q3 and Q4 of 2017/18 (a period of winter pressures and exceptionally cold weather) regarding patients being inappropriately dressed on discharge.

Unfortunately, due to capacity issues within the team only one of the two significant service improvements planned for 2017/18 was achieved during the year. However, the recruitment of an additional Patient Complaints Investigator will allow the Complaints & Service Improvement Manager additional time to focus on service improvements. The next significant service improvement plan is currently being prepared and is likely to be aimed at reducing complaints about staff attitude. The Complaints & Service Improvement Manager is preparing a paper for ExQual approval in Q2 of 2018/2019.

9.0 Conclusion

The primary task for the Complaints Team during 2017/18 was to embed a structured approach to learning from complaints, which has shown some clear benefits, although there is more work still to be done in 2018/19 to follow up on learning to measure its effectiveness. The complaints team will also focus on the coming year on the quality of its responses and on reducing the “re-open” rate as well as ensuring that cases are not upheld upon review by the PHSO.

The Trust continues to register a gradual year-on-year reduction in the number of complaints although the rate of reduction has fallen and will likely plateau in the next year or two. PALS concerns have increased slightly which is a reflection of the number of the increased accessibility and visibility of the service as well as its proactive approach to resolving queries as soon as they arise. Improvements to Outpatient Services as well as hospital transport have translated into a fall in complaints, but concerns about appointment delays and cancellations continue to be registered. This is to be expected as the Trust experiences unprecedented demand for services especially during winter months. The significant increase in complaint about Values and Behaviours (Staff attitude) is concerning and is perhaps partly a reflection of the pressure some staff members have been working under. However, it does not always take extra effort to get customer service right and this is certainly an area of focus for improvement during the next year.

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Freedom of Information (FOI) Annual Update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25th July 2018	**Item 26, report no. 22**
Responsible Executive Director: Michelle Dixon – Director of Communications	**Author:** Barney Langrish – Freedom of Information Manager

Summary:
This paper provides a summary of the Trust's compliance with the Freedom of Information Act 2000 during the financial year 2017/18.

As a public authority, the Trust is legally bound to respond to requests for information under the Act, and must aim to do so within 20 working days. This report details the numbers of requests received by the Trust in 2017/18 and our compliance with the deadline for responses.

Recommendations:
The Board is asked to note the update.

This report has been discussed at: N/A

Quality impact: N/A

Financial impact: N/A

Risk impact and Board Assurance Framework (BAF) reference: N/A

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.

Freedom of Information (FOI) report 2017/18

Summary/key points

Month	Number of FOI requests received	Number of FOI requests processed within the 20 day deadline	Number of FOI requests processed outside the 20 day deadline	% compliance with 20 day deadline
April 2017	58	52	6	90
May 2017	62	56	6	90
June 2017	45	41	4	91
July 2017	61	55	6	90
August 2017	89	79	10	89
September 2017	43	37	6	86
October 2017	62	55	7	89
November 2017	61	51	10	83
December 2017	53	48	5	91
January 2018	70	59	11	84
February 2018	82	70	12	85
March 2018	76	68	8	89
Total	**762**	**671**	**91**	**88**

The Trust saw a decrease in the number of requests received in 2017/18 (762 received) when compared to 2016/17 (821 received). Of the 762 requests received, 88 per cent were responded to within the 20 working days specified by the Act. This is the same rate as in 2016/17.

Whilst the number of requests received has decreased, the information requested has been larger and more complex which is primarily why our response rate has stayed the same. However, we also need to reinforce to all staff the importance of responding promptly to requests for information to feed into FOI responses, as it is a legal obligation for us to respond within 20 working days and an important indicator of our openness and transparency as an organisation.

Specific areas of interest covered by requests received in 2017/18 have been:

- Estates and facilities
- HR policies and processes
- IT systems and suppliers.

The majority of requests received by the Trust are from the media and commercial parties.

The Trust applied 72 exemptions under the Act to requested information in 2017/18. These were most commonly applied when the release of information would be prejudicial to the commercial interests of any person, and where the release of information would breach the principles of the Data Protection Act 2018.

One request for an internal review was received in 2017/18. Internal reviews can be requested by an applicant where they believe the Trust has not responded appropriately to

their request. This internal review related to copies of reports into deaths at the Trust. Our initial response exempted the requested information under sections 40(2) (personal information) and 41 (information provided in confidence) due to the risk of identifying individuals. On review, it was found that the exemptions were appropriately applied but that we could – and did - release anonymised data instead. We have taken on board learning from this case for future, similar requests.

One complaint was made to the Information Commissioner's Office in 2017/18, with the complainant stating the Trust had taken more than 20 working days to respond. We had, in fact, responded within three working days and so no further action was taken.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Fire Safety Assurance Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 25 July 2018	**Item 27, report no. 23**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Merlyn Marsden, Site Director

Summary:

The purpose of this paper is to provide a Fire Safety update to the Board and;

1. To provide assurance on our Fire Safety compliance with Fire Safety legislation and in line with HTM Fire Code
2. The status of the Trust's fire safety programme

The Trust has statutory obligations for fire safety under the Regulatory Reform (Fire Safety) Order 2005; and the recommendations of the Firecode suite of documents HTM-05 (2014). Each is designed to protect staff, patients, and visitors from the risk of an outbreak of fire. The update to the Board includes the work the team undertakes to ensure this compliance including: the Fire Risk Assessment (FRA) process, fire alarm installation, fire training and the work we are doing on false fire alarm activation with staff.

The Trust has a Memorandum of Understanding (MoU) with the London Fire Brigade (LFB) and with this brings a good understanding of the Trust's infrastructure issue relating to fire safety, good relationship with fire teams for training and exercising together. The Trust meet annually to discuss upcoming fire audits, joint evacuation simulation exercises and staff training. We are the fires t Trust to set up an MoU with LFB.

The Trust Fire Safety training has seen an increase in staff training and this is due to revised training programme that is shorter, includes the use of e-learning, face to face training that also include fire warden training and bespoke training on specialist ward e.g. PICU

Recommendations:
The Committee is asked to note the report and the Trust's compliance with the Fire Safety Order.

This report has been discussed at:

- Executive Committee
- EPPR and Fire Steering Group
- Estates Compliance and Quality
- Health and Safety Committee

Quality impact:
Care-To achieve excellent patients experience and outcomes, delivered with care and with compassion.

Well Led-To educate and engage skilled and diverse people committed to continual learning and improvement. To realise the organisations potential through excellent leadership efficient use of resources and effective governance.

Financial impact:

Has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
Fire safety risk is held on the divisional risk register after being deescalated from corporate risk register due to the controls that the fire safety team put in place with training, fire alarm installation and evacuation devices on the hospital sites.

Workforce impact (including training and education implications):
Training sessions are in place for staff through the statman training programme, annual an e-learning refresher course and every 3 years face to face training.

What impact will this have on the wider health economy, patients and the public?
Fire compliance with the Fire Code provides a safe environment for our staff, patients and visitors.

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):
Paper can be shared.

- Fire Safety is being managed across the site to ensure safety of staff, patients and visitors.
- Senior managers are encouraged to release staff for an hour to complete their fire warden training to increase uptake and numbers across the organisation.
- Staff can contact the fire safety team via the email below if they require bespoke fire safety evacuation plans due to the specialist nature of their patients.
- imperial.firesafety.team@nhs.net

1. Introduction

1.1. The purpose of this paper is to provide a Fire Safety update to the Board and;

1.1.1. To provide assurance on our Fire Safety compliance with Fire Safety legislation and in line with HTM Fire Code

1.1.2. The status of the Trust's fire safety programme

1.2. The Trust has statutory obligations for fire safety under the Regulatory Reform (Fire Safety) Order 2005; and the recommendations of the Firecode suite of documents HTM-05 (2014). Each is designed to protect staff, patients, and visitors from the risk of an outbreak of fire. The update to the Board includes the work the team undertakes to ensure this compliance including: the Fire Risk Assessment (FRA) process, fire alarm installation, fire training and the work we are doing on false fire alarm activation with staff.

1.3. The Trust has a Memorandum of Understanding (MoU) with the London Fire Brigade (LFB) and with this brings a good understanding of the Trust's infrastructure issue relating to fire safety, good relationship with fire teams for training and exercising together. The Trust meet annually to discuss upcoming fire audits, joint evacuation simulation exercises and staff training. We are the first Trust to set up an MoU with LFB.

1.4. The Trust Fire Safety training has seen an increase in staff training and this is due to revised training programme that is shorter, includes the use of e-learning, face to face training that also include fire warden training and bespoke training on specialist ward e.g. PICU

2. Fire Risk Assessment Inspection programme

2.1. The Trust fire risk assessment programme is an on-going comprehensive inspection and review of the fire safety measures in place at every site and area within the Trust.

2.2. The Trust now has a comprehensive database of fire risk assessments for all five hospitals.

2.3. Fire Risk Assessment Significant Findings Overview

2.4. A risk assessment software package (purchased from FCS Cloud) has been used within the Trust since August 2016. Assessments are completed electronically and have improved efficiencies for the team. Supporting information has been revised and is available via the Source.

The current status of reviews at 7thJune 2018 is shown in table 1.

Site	No. FRA	No. reviewed	% Completed	No. in progress/pending
Charing Cross	101	48	48%	53
Queen Charlotte	5	5	100%	0
Hammersmith	94	67	71%	27
St Mary`s	100	85	85%	15
Western Eye	8	8	100%	0
Satellite	12	3	25%	9
Total	308	216	67%	65

2.5. A quality assurance process has been implemented ensuring that the fire risk assessment ratings accurately reflect the significant findings applying the Trust's 5x5 risk matrix has brought this in line.

2.6. Whilst the number of outstanding FRA is at 33%, the employment of a new FS officer, plus a contractor, will give sufficient resources to complete the outstanding FRA within the annual timeframe.

2.7. Local departmental managers are reminded that they are responsible for ensuring that significant findings identified in the fire risk assessment for their area of responsibility are addressed. Divisions are to be reminding managers to take action as a priority.

2.8. The Estates team are currently working on a significant number of backlog repairs and are addressing significant findings as identified by the fire risk assessment process. A large percentage of issues identified are already part of the 6 year fire improvement plan as agreed with the London Fire Brigade.

2.9. As part of the Estates assessment a number of queries have arisen and as result the Fire Safety Manager is undertaking an assessment of the Fire Risk Assessments to ensure that they are consistent across the Trust's estate.

3. Fire detection and alarm systems

3.1. The fire alarm systems throughout the Trust are being upgraded in line with HTM Requirements to bring the classification of fire alarms to L1 Standard (Life Safety). This is an on-going project currently being undertaken on the SMH, HH and QEQM Sites.

3.2. WEH has recently been upgraded. The building now has a modern L1 standard fire alarm. This will enable Phased Horizontal Evacuation (PHE) rather than a demanding full evacuation system.

3.3. The fire alarm system is being replaced and upgraded to a full coverage system across all sites. As part of a wider project fire doors are being repaired or replaced and compartmentation being improved.

Site	Update
QEQM	Cause and effect final review is being assessed by key staff and is being supported by an appointed engineer with the aim of closing down queries. Compartmentation and fire stopping on going on floor 10 with doors now being prepared for fitting.
St Marys	Fire door works, fire stopping and compartmentation works ongoing within basement.
Hammersmith	1st stage installation nearing completion
QCCH	1st stage installation nearing completion
Western Eye	Installation 100% complete. System now commissioned and running. Final piece of work is the training of staff on alarm response. All fire stopping/fire door work completed.

4. Training

4.1. Fire safety training is on-going throughout the Trust with training sessions being held at each of the main Hospital Sites across the Trust.

4.2. Fire Warden Training is on – going, currently 1011 fire wardens trained Trust wide.

4.3. Fire Safety Training Compliance (Trust Target 90%) as of June 2017.

Staff count	Staff Compliant	% target is 90%
7688	6867	89%

4.4. The Trust target is 90% and current compliance is at 89% an increase from last quarter 88.51%.

4.5. Currently there are a total of 1010 staff trained as Fire Wardens (at 31st May 18) – a current shortfall of 155 to achieve the 10% target agreed by the Executive. It is anticipated that this target will be achieved before October 2018.

4.6. All staff are required to complete fire safety training as part of Fire Safety compliance. This takes the form of;

- face to face training every 3 years and
- Refresher e-learning training annually.

4.7. All face to face training provided by the fire safety team is by default also fire warden training.

This increases our numbers of fire wardens across the organisation.

4.8. To note that with the new proposal of fire training this will support local managers fulfilling their role within the HTM 05-01- Managing healthcare fire safety which outlines the responsibilities for local management to ensure that sufficient Fire Wardens are identified and appointed for their specific areas of responsibility.

5. Fire alarm activations Trust wide

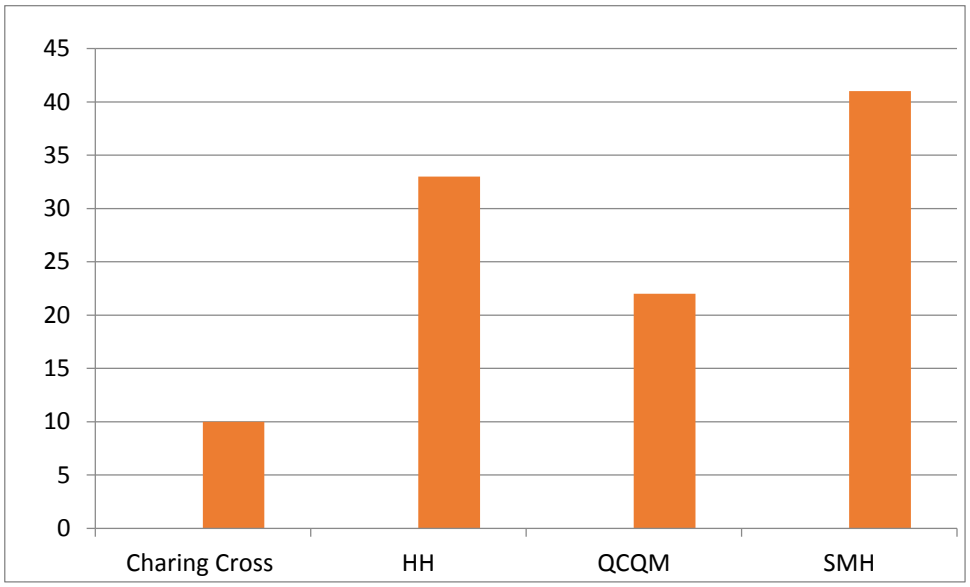


Table 1 Fire Alarm Activations 1st April-11th June

5.1. Typical causes of false alarms are toasters, microwaves, hair spray, deodorant, steam leaks.

5.2. A recent review has identified some inconsistencies in recording causes of alarm and associated actions. A meeting arranged with DATIX team (17th April 2018) enabled a change to DATIX fire categories which will ensure that incidents are recorded in a consistent manner assisting in future monitoring and identification of trends going forward. Table 1 outlines fire alarm activations 1st April to 11th June 2018 by site.

5.3. The London Fire Brigade have sited the Trust as a leading example in reducing fire alarm calls requiring an attendance by fire engines. A request has recently been received from South Wales Fire Service.

6. Evacuation Devices

6.1. Installation

- CXH Complete, with some minor adjustments to locations to be made.
- HH & SMH and CHX now complete, with Clarence to complete. This placement was delayed due to survey work in the area.

7. Evacuation Exercises

7.1. October 2017 – QEQM Valentine Ward staff volunteered to conduct an evacuation of patients using beds. The London Fire Brigade attended, deploying breathing apparatus, hose lines and securing the fire fighting lift. A debrief involving all agencies was held.

7.2. WEH – following the 2 fires at the WEH at the end of 2017 – the fire safety team along with the division have worked through a robust action plan to ensure compliance and staff awareness on site. Together the teams have worked hard to ensure all staff are fire trained, site specific fire plans are in place and were tested during the recent exercise on3rd May 2018.

7.3. The fire alarm system has also been upgraded on the WEH site to enable phased horizontal evacuation, which brings it in line with the rest of ICHT fire evacuation procedures.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee (4 July 2018)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 25th July 2018	**Item 28.1, report no. 24**
Responsible Non-Executive Director: Sir Gerald Acher	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:

KEY ITEMS TO NOTE

External audit report – annual audit letter
The Committee received and considered the annual audit letter, including a summary of the main findings and conclusions from the external audit work for the year ended 31 March 2018. The Committee noted that any lessons from the year-end audit work would be shared between executive directors and Deloitte.

The Committee discussed the audit letter, in particular the commentary regarding the Trust's undertakings agreed with NHS Improvement in November 2017. The Committee were concerned to ensure that the specific performance issues that led to the undertakings were highlighted and that a management response to the audit letter was available to provide the context. It was therefore agreed that the audit letter would be published on the Trust's website, but with an introductory text to explain the context and progress against the undertakings.

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 noted the process agreed for agreeing the scope and timing of audits on the plan, and urged the auditors to ensure that audits were spread evenly across the year. The Committee also noted the agreed process for agreeing any changes to the plan, including sign off of requests for change by the executive team. The Committee reviewed the internal audit plan and agreed that executive leads for each audit should be included in the table.

The Committee noted the summary of progress in the handover of the internal audit from TIAA, noting that some audit reports remained in draft and had not been signed off by management. It was agreed that these should be expedited and signed off by management as soon as possible. The Committee also noted the number of outstanding actions included in the report, noting that the list would be finalised once the outstanding reports from 2017/18 had been finalised. It was noted that 12 of the 80 outstanding actions were high risk, but it was agreed that the number of overdue outstanding actions should also be identified. It was agreed that the final list of outstanding actions would be shared with the executive team so that actions could be followed up.

Internal Audit reports – management responses to limited assurance reports
The Committee reviewed internal audit reports and the associated management responses, for audits where limited assurance was provided:

- PICU data quality
- Radiology data quality
- Accounts payable

- Community services – Ophthalmology
- Compliance review of income data quality – Community cardiology and respiratory services
- CPR and escalation

The Committee noted a common theme of data quality across a number of limited assurance reports and raised concerns regarding the actions being taken by the executive to address data quality. The Committee noted that the Trust had a data quality framework in place and actions were being taken to address the consistency of data entry. Kevin Jarrold reported on actions were being taken to mitigate the risk, including staff training to raise awareness of the importance of data quality and the impact of getting it wrong, and training in processes. The Committee also noted the importance of clear roles and responsibilities for ensuring the accuracy of data.

Counter fraud progress report
The Committee received and noted the quarterly counter fraud progress report, noting a summary of ongoing referrals and investigations. The Committee also noted that there were a number of live investigations not yet closed by TIAA. These had been followed up with TIAA by PwC.

Overseas visitor cost recovery
The Committee received a progress report, noting the summary of assurances regarding the controls in place and noting the summary of actions being taken. The Committee noted that the DH sponsor pilot to check patient IDs before treatment had concluded and the DH had decided not to mandate this process across all trusts. The Committee noted how the Trust was implementing checks on patient waiting lists to identify elective patients who were potentially not entitled to free NHS care as part of the new legislation and noted progress with implementation of recommendations following the limited assurance audit report from 2017/18. As a result of work on these initiatives, awareness about overseas patient legislation had been increased. The Committee received assurance that the Trust would be implementing the new legislation and regulations regarding overseas patients.

External review of RTT – MBI assurance report
The Committee considered the final report from an independent review of data management with regard to RTT performance and reporting, commissioned by the Trust. The Committee noted the findings and recommendations, noting no assurance recorded in three elements – data quality, training and clinical admin. The Committee's Chair would be meet with the authors of the report, MBI, along with the Chief Executive, to review the report in more detail. This will also include consideration of the timing of a follow-up review, if considered appropriate.

The Committee also considered the recommendation to appoint a non-executive director as a 'champion' of RTT data, in order to strengthen the Board's understanding of RTT data and therefore increase engagement and challenge. The Committee agreed that this role should be extended to include the wider issues regarding data quality, including training, systems and compliance. The Committee agreed a recommendation that Peter Goldsbrough be recommended to the Board for this role.

Corporate risk register and Board assurance framework
The Committee received and noted the new joint corporate risk register and board assurance framework paper, endorsing the proposed developments to align the two reports in order to map assurances received with risks while maintaining the benefits of having two separate reports.

The Committee noted the updated Corporate Risk Register, including a summary of key changes made since it was reviewed by the Committee in March 2018. The Committee noted that the executive had identified two new risks at its last meeting, regarding the impact of demolition work in Paddington Cube and the implementation of e-referrals; both risks would be added to the corporate risk register for the next meeting.

Sodexo hotel services contract (cleaning services)
The Committee noted the previously reported concerns regarding the standard of cleaning provided by Sodexo and the ongoing issues. It was noted that action had been taken by Soxdexo in response to concerns raised by the Trust but were still not delivering a sustained level of performance. The Trust

had therefore issued a contract breach notice in respect of adherence to infection control standards.

The Committee noted the update regarding the management of this contract and it was agreed that a further update on the contract management would be provided in December 2018.

North West London Pathology governance arrangements
The Committee noted previous discussions regarding the clarity and robustness of the governance arrangements for North West London Pathology (NWLP) and considered an update following a review of those arrangements. The Committee noted that the review had concluded that the arrangements were sound but that the implementation of the governance arrangements needed strengthening, including revision to the terms of reference and membership of the Host Committee to provide Trust oversight of compliance with statutory requirements, to resolve any issues with the governance arrangements, and to provide a coordinating function to ensure that agreed reporting arrangements was being followed appropriately.

Raising concerns (whistleblowing)
The Committee received and noted a six-monthly report on concerns raised by staff, including a summary of incidents and the outcomes and actions arising from investigations. The Committee noted that new guidance had been published by NHS Improvement, including a self-assessment, and an update on this self-assessment would be reported to the Trust Board in July.

The Committee discussed the impact on staff of raising concerns, noting the difference between 'speaking up' to raise concerns and whistleblowing. It was agreed that there was a need to encourage staff to be able to speak up regarding any concerns and it was important to celebrate those willing to raise concerns.

Losses and special payments
The Committee noted the schedule of losses and special payments, noting the level of losses with regard to overseas patients and the funding arrangements agreed with commissioners for the underwriting of bad debts from overseas patients.

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Report from Quality Committee, 11th July 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 25th July 2018	**Item 28.3, report no. 26**
Responsible Non-Executive Director: Professor Andrew Bush	**Author:** Professor Andrew Bush, Non-executive Director and Ginder Nisar, Interim Deputy Board Secretary

Summary:

Integrated Quality and Performance Report

The Committee received the Integrated Quality and Performance report in its new form with updates on key indicators for the months of April and May 2018 showing the activity which had met the performance target/threshold and the areas that did not. In particular the Committee noted the performance for mixed-sex accommodation (MSA) breaches which continued to be significantly higher than the zero threshold standard reporting 39 in April and 42 in May 2018. The MSA breaches are mainly attributable to breaches occurring within ITU at Charing Cross and the Division of Surgery and Cancer (SCC) are undertaking an audit of all breaches occurring within June 2018 to understand the root causes. A further update would be provided to the next Quality Committee. The Committee discussed the RTT 52 wait position which had improved with a reduction of 47 patients waiting over 52 weeks between April and May 2018, however it was 63 behind trajectory target for the month. All patients waiting over 52 weeks continue to be reviewed for clinical harm in line with the agreed validation process. Accident and Emergency 4 hour waits, although ahead of trajectory, the target had slipped slightly recently and actions are underway to address the issues. The Committee discussed the Trust's mortality rates in light of the Gosport report and noted that the data was being reviewed and would in future be reported one month in arrears which would provide a more accurate position.

Divisional key risks

The Committee received updates from the divisions on key divisional risks current and new. Capacity issues remains a risk however the demand and capacity work had concluded and actions are underway to address the gaps and making the process more efficient. A common theme was identified across some of the divisions regarding cleaning and the Committee noted the actions underway with the contractor to address these issues, including the issue of security in some areas of the Trust, in particular the birthing centre. In terms of Imperial Private Health, a new risk concerning funding in order to develop and improve the services was noted. The new risk concerning the impact on the some services of the Trust due to the demolition works of Paddington Cube were noted as well as the actions underway to minimise the impact and seeking alternative solutions for some services; the Committee was reassured that immunosuppressed Haematology-oncology patients would not be put at risk from *Aspergillus* infection. The risks relating to the new e-referral system due to go live on 1st August was noted which related to GP referrals and the Trust had agreed an internal arrangement for a period of time to ensure GP referred patients would receive an appointment instead of being returned to the GP. RTT 52 weeks is mentioned above and in light of the Gosport report, the SCC division was reviewing the dosage policy for opioids and was confident with its policy in that the dosage is provided once a day and the prescribing data was available should it be requested.

Gosport War Memorial Hospital, independent panel report

The Committee received the Gosport War Memorial Hospital, independent panel report. The report was noted and the Medical Director's Office would review the report in detail and provide a briefing report for discussion at the next Executive Quality Committee followed by a report to the next Board Quality Committee. Initial discussions assured the Committee that Imperial College Healthcare NHS Trust was confident that it was not an outlier in any of the areas raised in the report and the report to the next

Committee would provide further assurance. The Committee received assurance that the Trust has sufficient data sources for mortality issues to be flagged as well as other controls such as FOI requests, Responsible Officer, GMC liaison and the Integrated Quality and Performance report. Subsequently, Dr Urch was able to reassure the Committee that there are robust monitoring processes for the use of opiates in terminal care as well as the use of syringe drivers in this context

CQC update and ward accreditation programme
The CQC update report was noted as were the actions in place to support for a possible CQC inspection during 2018/19 focussing on services previously rated overall as 'Requires improvement' and not re-inspected since 2014, and services not yet inspected by the CQC. Work is continuing to take place with the four Trust-wide work streams of; medical devices, medicines management, hand hygiene and statutory and mandatory training. A new 'Improving Care' programme group has been established chaired by the Director of Nursing, to oversee the approach and progress for getting to Good and beyond engaging with a range of people. The Committee noted that the organisation which operates the urgent care centre (UCC) at St Mary's Hospital, Vocare, was re-inspected by the CQC in March 2018. The overall rating improved to 'Requires improvement' and the service was taken out of special measures.

The Committee received the detailed analysis of the ward accreditation programme (WAP) results for 2017/18. The WAP process comprises annual unannounced inspections across inpatient wards, critical care areas, out patients, recovery rooms and day case areas. The tool is designed to provide assurance of the quality of care being delivered by nurses and midwives. Action plans were being developed for the wards rendered 'white' (not achieving minimum standards and no evidence of active improvement work) which was a small percentage compared to previous with most wards rated gold, silver or bronze.

Incident monitoring report
The incident reporting rate for the Trust for May 2018 was 52.64 which places the Trust in the top quartile nationally. 11 Serious incidents (SIs) were declared during May 2018, and one never event. There are currently 38 on-going serious incident investigations underway. Safety improvement programmes are in place for the highest reported categories of SIs to support reduction in recurrence. Hand hygiene was discussed and the next report to the Committee would include the outcome of the audit.

Annual update on safe, sustainable and productive nursing and midwifery staffing
Noting that the future supply of the nursing and midwifery workforce is a challenge for all NHS Trusts in the UK, the Committee received an update on the annual nursing and midwifery establishment and an update on key initiatives being undertaken by the Trust which included a number of key initiatives and work streams which are being undertaken. 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. 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, apprenticeships in nursing and advanced clinical practitioner roles. 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. The Trust's safe staffing policy has been reviewed. The Committee noted that steps are being taken to ensure quality is monitored as part of these initiatives.

Safeguarding children and young people annual report 2017/18
The Committee received the annual report of activity related to children and young people (CYP) safeguarding in the Trust in 2017/18. It provided assurance that the necessary systems and processes are in place to ensure that adults with safeguarding needs are adequately protected. The Corporate Nursing directorate continues to develop the systems and infrastructure to support adult safeguarding including clear governance structures, a strong policy framework and training. It was noted that good progress has been made in better integrating adult, children and maternity safeguarding functions. The issue of domestic abuse is significant for the CYP safeguarding team and the report described interventions that the Trust introduced in 2017/18 to support the associated increased activity. This report was discussed in detail at the June 2018 Board Seminar.

Adult Safeguarding Annual Report 2017/18
The Committee received the annual report of activity related to adult safeguarding in the Trust in 2017/18. It provided assurance that the necessary systems and processes are in place to ensure that adults with safeguarding needs are adequately protected. The Corporate Nursing directorate continues to develop the systems and infrastructure to support adult safeguarding including clear governance structures, a strong policy framework and training. It was noted that the Trust had finally been able to establish the right

systems to be able to raise safeguarding concerns with the local authorities by email which resulted in much better oversight of active safeguarding concerns and a small rise in the volume of referrals.

Learning from Deaths: Update on implementation and reporting of data
The Committee received an update on progress since the last report to the Committee which included an updated 'learning from deaths dashboard'. Key points included:

- The Trust is compliant with reporting requirements as set out by NHS Improvement.
- 176 structured judgment review (SJR) reports completed to date.
- 13 avoidable deaths to date of reporting (03/05/18) reviewed and signed off via the Mortality Review Group. This number is comparable to last year's figure of 12 avoidable deaths.
- No Trust specialties are currently causing concern in respect to avoidable deaths.
- Early emerging themes are linked to three of the Trust's nine safety streams. Two are linked to 'falls and mobility', four to 'responding to the deteriorating patient' and two to 'fetal monitoring'. These cases have been shared with the safety work streams leads to ensure the improvement work covers the findings of the SJRs.
- The first national LeDeR report has been published, though it does not contain Trust specific data we are experiencing the same issues with receiving feedback on the independent reviews. The Trust complies with all reporting requirements for LeDeR.

Responsible Officer's Report
The Committee noted the Responsible Officer's report which detailed the activity, policies and procedures in place to manage the process of doctor's appraisals and revalidation. The report would be presented to the Trust Board in July 2018 for approval of the statement of compliance which is due to be submitted by 28th September 2018 to NHS England.

Infection prevention and control, and antimicrobial stewardship Annual Report 2017/18
The Committee noted the annual report and commended the work for the excellent outcomes. Key points include:

- Three Trust-attributable MRSA bloodstream infections (BSIs) out of 32,794 blood cultures taken in financial year 2017/18, which was the same number as in 2016/17, and a > 50% reduction from the seven cases in 2015/16.
- 63 cases of Trust-attributed C. difficile out of 7040 of diarrhoeal specimens tested for 2017/18, which was the same as in 2016/17.
- 28% reduction in the number of E. coli BSI (73 in 2017/182017/18 vs. 102 in 2016/17), which has been commended by NHS Improvement in line with the national objective to halve Gram-negative BSIs by 2020/21.
- The number of new cases of CPE positive patients detected each month has increased in proportion to the number of screens taken. The majority of cases are from screens, without evidence of clinical infection.
- The bi-annual antibiotic point prevalence survey has found that all quality indicators of antibiotic prescribing exceed the target level of 90%.
- The overall consumption of antibiotics has reduced by 1% compared with the end of the previous financial year, although the usage of some key agents, especially the carbapenems, has increased.
- There were several outbreaks/transmission events across the Trust that required expert management.
- The service responded to a number of external national directives, which required coordinated Trust level responses, including the Getting It Right First Time (GIRFT) Surgical Site Infection (SSI) audit initiative, a patient notification exercise related to the risk of Mycobacterium chimaera infection from heater-cooler units used in cardiothoracic surgery, the national CQUIN on 'Reducing the impact of serious Infection', and rapidly adapting to the multiple national shortages of antimicrobial agents.

2017 Annual survey of adult inpatients
The Committee noted the 2017 National survey of adult inpatients. The survey related to a sample of inpatients who were discharged during July 2017. Overall the results showed a slight improvement on previous years with the Trust performing about the same as other Trusts in all but two questions. Improvements were seen in a number of areas, most notably in the section related to nurses. The Committee commended the work and a staff communication would be prepared to share the good news.

End of Life Care Update
The Committee noted the progress in relation to the End of Life Care Quality Improvement Programme for 2017– 2020. Key points included, CQC in 2014 rated end of life care as good; in depth review of End of life care in Trust undertaken in 2017 against new standard; new End of life Clinical lead and lead nurse

appointed in 2017; and refreshed governance structure and action plan. The Committee also noted the update on patients dying in their preferred place of death and progress towards delivery of a Trust bereavement survey. In terms of the Gosport report the Divisional Director of SCC confirmed that the new syringe drivers were used appropriately which can be tracked as well as doses.

Trust Complaints Report 2017/18
The Committed noted the report which showed that in 2017/18 the Patient Advice & Liaison Service (PALS) and Complaints Teams maintained the high standard of service provided in the previous year, meeting all the key targets for timeliness and responsiveness of service. The quality of responses provided by the complaints team was demonstrated by the low number of complaints being reopened as well as being referred to the Parliamentary & Health Service Ombudsman during the year, with only three of those being partly upheld upon investigation. The proportion of cases "re-opened" by the complaints team also fell during the year. PALS continued to build on previous successes by developing the PALS Volunteer service which allows the team to take a pro-active, visible approach to anticipating and resolving patients' concerns before they are allowed to escalate. The complaints process was audited in October 2017 on "Learning Lesson from Complaints" and the assurance provided was substantial. Overall the volume of formal complaints and PALS concerns fell slightly compared to the previous year. On balance the picture was one of improvement and the Committee commended the service.

R&D Quarterly Report (Q1 2018/19)
The Committee noted the report which provided a summary of recent progress with respect to various clinical research initiatives within the Imperial Academic Health Science Centre covering a summary of non-commercially sponsored clinical trials activity hosted by ICHT in 2017/18 and associated metrics; a summary of and key examples from the Biomedical Research Centre (BRC) annual report. Future reports would include non-medical and all other research.

Medical education performance report
The Committee noted the report on key activities within medical education in the last quarter as follows:

Improvement Team progress update
The Committee noted the report which provided an update on progress being made to realise the Trust's aim of creating a culture of continuous improvement by focusing on its six primary drivers.

Recommendations:
The Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Redevelopment committee report (27 June 2018)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 25th July 2018	**Item 28.4, report no. 27**
Responsible Non-Executive Director: Sir Richard Sykes – Chairman	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:

KEY ITEMS TO NOTE

The committee received an update on key design activities in phase 1 of the redevelopment programme.

Redevelopment programme update
The Committee noted an update on the bids for capital submitted to the STP, currently under consideration. The Chief executive reported that, in addition to the STP process, discussions were ongoing with NHS Improvement regarding possible other sources of capital to fund the winter capacity schemes and emergency capital funding.

The Committee discussed the Triangle project (Outpatients and Ophthalmology at St. Mary's) and noted that the process for approving the capital for this scheme was not yet known. The Committee discussed the value for money assessment for the Triangle scheme, noting the challenges due to age and condition of the buildings, payback period advised by the regulators and increase in capital costs. The Committee discussed options around the funding for the scheme, and agreed that any value for money assessment should include recognition of funding from the Charity, in order to provide a transparent view of the financial case for the development.

The Committee also discussed the strategic case for the Triangle in light of the STP bid submissions and the value for money tests set by the regulators. The Committee reminded itself of the background to the original decision to support the scheme, given clinical safety as to the separation of the building from QEQM and Acrow, the strategic context, including the need to re-provide the existing outpatient services and improve patient experience and efficiency. The Committee agreed the need to develop a new facility that is designed with flexibility to deliver alternative services required in the future. Michele Wheeler confirmed this has been the basis of design development.

The Committee considered this in the context of Sir Robert Naylor's review of NHS property and estates and the wider strategy for London and confirmed continued support for the Project.

Paddington Cube
The Committee noted an update on ongoing discussions between the Trust and Sellar Property Group and their sub-contractors.

The Committee noted that demolition work on Paddington Cube had now started and would run to December 2018. It was not currently known how long the subsequent redevelopment would take but likely to take four years. The Committee noted work being done by the executive to assess the impact of the demolition work on the three Outpatient buildings, Mary Stanford, Mint Wing and the end of Clarence Wing, and action being taken to mitigate any impact on services and patient care. Discussions were also ongoing with Sellar Property Group to consider possible solutions to mitigate

the impact. Following discussion by the executive, the risk of adverse impact on services and patients from the demolition work had been added to the corporate risk register.

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: Appointments and Remuneration Committee 20 June 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 25th July 2018	**Item 28.5, report no. 28**
Responsible Non-Executive Director: Sarika Patel	**Author:** Peter Jenkinson – Trust Company Secretary

Summary:

Key points to note:

CEO objectives
The Committee agreed the Chief Executive's objectives for 2018/19 and the proposed structure of the Chief Executive's bonus performance contract for 2018/19.

Executive Board member annual performance reviews
The Committee reviewed the 2017/18 performance reviews for executive board members, completed by Prof Redhead as interim Chief Executive.

Executive pay review
The Committee reviewed benchmarking data for executive director remuneration and considered the national context of NHS staff pay awards. The Committee agreed the proposed 'cost of living' increase in remuneration for executive directors in principle, but agreed that final approval would be considered once NHS Improvement approve and publish the agenda for change salary increases.

Executive director appointments
The Committee noted an update on the recruitment to the Director of strategic development, approving the proposed amendment of job title and job description to Director of transformation. The new title and job description better expresses the needs of the organisation. The Committee noted that recruitment process for this role would now commence.

The Committee also agreed the recommendation to appoint Dr Frances Bowen as interim Divisional director for medicine and integrated care.

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