Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 22nd May 2019, 11am to 1pm
Clarence Wing Boardroom, St Mary's Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Paula Vennells	Oral
	2.	**Apologies:** Professor Bush	Paula Vennells	Oral
	3.	**Declarations of Interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessarywithdraw from the meeting*	Paula Vennells	Oral
1105	**4.**	**Minutes of the meeting held on 27th March 2019** *To approve the minutes from the last meeting*	Paula Vennells	01
	5.	**Record of items discussed in Part II of Board meeting held on 27th March 2019 and 24th April 2019** *To note the report*	Paula Vennells	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Paula Vennells	03
1110	**7.**	**Patient Story** *To note the patient story*	Professor Sigsworth	04
1125	**8.**	**Chief Executive Officer's Report** *To note the report*	Professor Orchard	05
For decision / approval				
1135	**9.**	**Corporate objectives 2019/20 – key performance indicators**	Professor Orchard	06
1145	**10.**	**Clinical Negligence Scheme for Trusts (CNST) – Compliance update** *To note progress against the CNST standards and to approve the action plan*	Professor Teoh	07
1150	**11.**	**Annual self-certification for NHS Trusts** *To approve the Trust's self-certification of compliance against the NHS Improvement provider standards*	Peter Jenkinson	08
1155	**12.**	**Approval of annual accounts, report and quality account – delegated authority** *To approve the delegation of authority to the Audit, Risk and Governance Committee to approve the annual accounts, report and quality account for 2018/19 on behalf of the Board.*	Peter Jenkinson	Oral
For discussion				
1200	**13.**	**Integrated Quality and Performance Report** *To receive the integrated quality and performance report for month 12*	Professor Redhead	09
1210	**14.**	**Referral to Treatment (RTT) Performance at ICHT** *To receive a 'deep dive' update on the management of Referral to Treatment waiting times*	Professor Urch	10

1215	**15.**	**Finance Report** *To note and discuss the month 12 position, year to date and other financial matters*	Richard Alexander	11
1220	**16.**	**CQC and Ward Accreditation Programme Update** *To discuss and note the update on CQC related activity at and/or impacting the Trust and also progress with the Ward accreditation programme*	Professor Sigsworth	12
1225	**17.**	**Infection Prevention and Control and Antimicrobial Stewardship Quarterly Report** *To note the quarter 4 progress report*	Dr Eimear Brannigan	13
1230	**18.**	**7 Day Services Standards** *To review the proposed submission and agree the delegation of authority for future submissions to the Quality Committee*	Professor Redhead	14
1235	**19.**	**CIP QIA - Update on the outcomes of the post-implementation reviews of Quality Impact Assessments for Cost Improvement Programmes** *To note the progress with the post implementation evaluations.*	Professor Sigsworth	15
1240	**20.**	**Research and Development Report** *To note the quarters 3 & 4 report*	Professor Thursz	16
For noting				
1245	**21.**	**Annual report of Trust Seal** *To note the use of the Trust Seal 2018-19*	Peter Jenkinson	17
1250	**22.**	**Trust Board Committee Summary Reports** *To note the summary reports from the Trust Board Committees*		
	22.1.	Audit, Risk & Governance Committee, 23rd April 2019	Sir Gerald Acher	18a
	22.2.	Quality Committee, 8th May 2019	Sir Gerald Acher	18b
	22.3.	Finance and Investment Committee, 15th May 2019	Dr Andreas Raffel	18c
	22.4.	Remuneration and Appointments Committee, 15 May 2019	Peter Goldsbrough	18d
1255	**23.**	**Any other business**	Paula Vennells	Oral
1300	**24.**	**Questions from the public**	Paula Vennells	
Close	**25.**	**Date of next meeting** 24th July 2019, 11am, W12, Hammersmith Hospital		

Updated: 17 May 2019

Imperial College Healthcare NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Wednesday 27 March 2019
10.30 – 13.30
Clarence Wing Boardroom, St. Mary's Hospital

Present:	
Sir Gerry Acher	Interim Chairman
Victoria Russell	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Dr Andy Bush	Non-executive director
Prof Tim Orchard	Chief executive officer
Prof Julian Redhead	Medical director
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Nick Ross	Designate Non-executive director
Dr Frances Bowen	Divisional director, MIC
Prof TG Teoh	Divisional director, WCCS
Prof Katie Urch	Divisional director, SCCS
Jeremy Butler	Director of Transformation
Michelle Dixon	Director of communications
Joanne Hackett	NExT Director
Claire Hook	Director of operational performance
Kevin Jarrold	Chief information officer
Peter Jenkinson	Director of corporate governance & Trust secretary (minutes)
Sue Grange	Deputy director of people & OD

1.	**Chairman's opening remarks, apologies and declarations of interests** Sir Gerry welcomed board members, attendees and members of public to the meeting. He reminded those present that this was a meeting of the Trust Board held in public rather than a public meeting, but that there would be an opportunity for questions at the end of the meeting. Sir Gerry noted that this was the last meeting for Joanne Hackett, who had attended Board meetings for the past year as part of NHS Improvement's NExT Director programme to develop aspiring non-executive directors. He thanked Joanne for her contribution and wished her well in applying for a substantive non-executive director role.
2.	**Apologies** Apologies were noted from Kevin Croft and Prof Weber.
3.	**Declarations of interest** There were no declarations made at the meeting.
4.	**Minutes of the meetings held on 30 January 2019** The minutes of the previous meeting, held on 30 January, were confirmed as an accurate

	record.
5.	**Record of private items discussed at Board** The Board noted a summary of confidential items discussed at the board meeting held on 30 January 2019.
6.	**Action log and matters arising**
6.1	The Board reviewed the action log, including an update on actions arising from previous meetings.
6.2	The Trust board noted the action log.
7.	**Patient story**
7.1	The Board welcomed Diane, a patient who underwent a cardiac ablation procedure. Diane presented her story and summarised her experiences, including multiple cancellations of her procedure on the day of her surgery. She shared with the Board the emotional impact that such cancellations, but commended the approach taken by Trust staff in communicating the reasons for the cancellation and the actions that would follow; in particular she highlighted the honesty and openness of the communication. Diane welcomed the fact that the Trust had listened to patients and urged the Trust to share this best practice and the leaflet used in Cardiology with other departments, and to do everything possible to eliminate the cancellation of appointments.
7.2	Prof Orchard reported that the number of days when the Trust was on 'black alert' – when the Trust is 'unable to deliver comprehensive care [and] there is increased potential for patient care and safety to be compromised' – had reduced in February and March when compared with the same period in 2018. This was an indication of the improvement in operational efficiency and effectiveness, including the 'flow' of patients through the hospital. This was as a result of the implementation of initiatives such the SAFER bundle which aimed to reduce delays for patients in adult inpatient wards by applying five elements of best practice.
7.3	The Board agreed the need for honest and open communication, and the need to involve patients in their care, noting the positive impact on reducing anxiety. The Board thanked Diane for sharing her experiences and agreed that the leaflet used in Cardiology should be shared as an example of best practice, and agreed that a focus would continue on minimising cancellations. The Trust board noted the report.
8.	**Chief executive officer's report**
8.1	Prof Orchard presented his report, highlighting key updates on strategy, performance and leadership. *Financial performance*
8.2	Prof Orchard presented a summary of financial performance to date and the year-end forecast, highlighting that current expectation was to achieve the control total at year-end. He reported that the Board has considered the financial plan for 2019/20 and had agreed its commitment to achieve the next year's control total, but had noted the risks and challenges faced in achieving that ambition. The Board noted the update provided regarding the development of the Transformation function and the aim to use transformation to support achievement of financial sustainability. *Operational performance*
8.3	Prof Orchard provided a summary of the response to the recent spate of never events declared, noting that a more detailed update would be considered as a separate item at this meeting. The Board discussed the outcome of the 2018/19 flu campaign, noting

8.4	achievement of a similar level of vaccination as the previous year. The Board noted the aim to achieve 75% in the following year and discussed the challenges in achieving this, including creating the culture to drive staff acceptance. The Board noted the project plan for the 2019/20 campaign, noting that the campaign would commence earlier than the previous year and would include a focus on communicating to staff the reason for having the vaccination, including the duty to protect patients.
8.5	*Strategic update* Prof Orchard reported the public announcement made the previous day regarding the cancellation of the *Shaping a Better Health* programme in north west London. Prof Orchard advised the Board on the impact on the Trust, stressing the Trust's commitment to maintaining Charing Cross Hospital and its Emergency Department, demonstrated by the £7m investment in refurbishing the department and other investments. The Board noted that Imperial Charity had supported the Trust on capital projects, but not on backlog maintenance works. The Trust board noted the report.
9.	**Organisational strategy and objectives for 2019/20**
9.1	The Board welcomed Dr Bob Klaber to the meeting.
9.2	The Board received a presentation on the outcome of the strategy development work to date and an outline of the process to follow. The Board considered the strategy summary and vision, and objectives for 2019/20, noting the SWOT analysis used to inform the strategy.
9.3	The Board also considered the draft behaviours framework developed as a product of the *Vision, values and behaviours* staff engagement programme, acknowledging the importance of the link between vision and values; the vision providing the common purpose for the trust and partners, and the values providing the 'how'. The Board noted that this was a continuation of work commenced in 2015, and noted the involvement of the Trust's strategic lay partners in the development of the strategy, as well as other stakeholders including community and GPs through external listening campaigns and staff. That process of engagement would continue through the strategy development process.
9.4	The Board discussed the behaviours framework, noting the aim of providing staff to tackle poor behaviour and hence to address the issue raised by staff through the staff survey. The Board discussed how the framework would be embedded and it was noted that, among other initiatives, the Performance & Development Review (PDR) process would be amended so that appraisals would focus on two elements; half on achievement of objectives and half on behaviours exhibited. The Board welcomed the introduction of a framework that would enable the consistent application and measurement of behaviours, to enable the embedding of behaviours. The Board approved the vision and strategic aims, and the annual objectives for 2019/20. The Board endorsed the approach being taken to the strategy development and to embedding the values and behaviours.
10.	**CNST – Avoiding term admissions into neonatal units (ATAIN) action plan**
10.1	The Board considered the action plan for avoiding term admissions into neonatal units, noting that this was a requirement in order to achieve the discount in CNST premium. The Board noted the achievement of the ten safety actions within the action plan and noted the assurance regarding the quality of neonatal services. The Board approved the action plan and agreed that the plan should be shared with NHS Litigation Authority as evidence to achieve the CNST discount.

11.	**Integrated Quality and Performance Report**
11.1	The Board received the Integrated quality and performance report for month 10, noting exceptions as presented:
	<u>Effective</u>
11.2	*Mortality* – the Board noted that the Trust's SHMI rate had increased recently but that the rate was now improving once again.
	<u>Safe</u>
11.3	*Never events* – the Board noted that two never events had been reported in this period, and seven year to date. The Board noted the summary of actions taken in relation to invasive procedures, including simulation training and coaching, and developing a culture to encourage staff to speak up and challenge non-compliance with policy or procedures. *VTE assessment* – the Board noted the increased performance achieved versus the 95% target and discussed the change in behaviour that had led to the improved performance.
	<u>Caring</u>
11.4	*Estates issues* – the Board welcomed the recent focus on rebasing the list of estates backlog maintenance works and reduction in the number of outstanding jobs, but agreed that more still needed to be done. The Board also noted that a 'deep dive' review of cleaning standards and the risk of not achieving those standards was conducted by the Audit, Risk and Governance Committee.
11.5	The Board discussed estates management, including resources, processes and clearing the backlog of maintenance works. The Board agreed the approach to target resources at key maintenance themes, such as repairing doors, or painting). It was noted that plans would be considered by the executive team in the next week to this effect.
	<u>Responsive</u>
11.6	*RTT* – the Board noted and welcomed the reduction achieved in the PTL size and the further reduction in the number of patients waiting more than 52 weeks for treatment. *A&E* – The Board also noted improved performance against the A&E waiting time standard, but noted continued concern regarding the patient experience of patients in A&E with mental health issues. The Board discussed the issues faced in accessing mental health support and the ability of mental health providers to accept patients. *'Did not attend' rates* – The Board noted that the Trust's DNA rates were one of the lowest in London, and that the implementation of electronic referrals (ERS) and patient choice should reduce the rate further. *Hospital Initiated Cancellations (HICs)* – the Board, however, also noted the higher than expected levels of HICs.
	<u>Well-led</u>
11.7	*Recruitment and retention* – the Board noted the current vacancy rate (13% for all groups of staff and 15% for nursing & midwifery) and noted that, whilst high, the rate was similar to that experienced across other London providers.
11.8	The Board noted an improving trend in performance, but also noted a number of standards where the Trust was just under the standard set. The Board noted that improvement trajectories would be implemented for all exceptions in performance so that a target date for return to standard could be agreed and progress tracked. The Trust board noted the report.
12.	**Finance report**
12.1	The Board received and noted the finance report for month 11, noting performance against

	budget and the control total. The Board noted that the Trust was on track to achieve the control total at year end, but noted the outstanding risks in achieving this.
12.2	The Board noted that it had approved the budget for 2019/20, for submission to NHS Improvement, and confirmed its commitment to achieving the control total set by NHS Improvement for 2019/20, a £16m deficit. The Trust board noted the report.
13.	**Corporate risk register and risk management update**
13.1	The Board received and noted the latest version of the corporate risk register, noting changes in risks as agreed by the executive risk committee and discussed at Audit, Risk and Governance committee. The Board noted a review of risks on the corporate risk register and the disaggregation of some risks, such as the patient safety risk, to allow a greater focus on specific risks. The Board also noted escalation and de-escalation of risks.
13.2	The Board noted the continued risk regarding cyber security, noting the continuing risk arising from insufficient investment in IT.
13.3	The Board welcomed the improvements made in the management and presentation of risk, in particular the use of individual risk profiles so the trend in long-standing risks could be reviewed. This would allow the Board to understand the profile of long-standing risks and to focus on risks where the residual (current) risk rating remains the same as the original, or where the target risk rating was not likely to be achieved, so that additional mitigation could be considered and the Trust's response agreed. The Board noted the assurance provided from the internal audit review of risk management arrangements.
13.4	The Board noted the increase in risk relating to the care of patients with mental health needs in A&E, noting that this was a risk faced nationally. The Trust was working with the local mental health provider, Central and north west London NHS Foundation Trust (CNWL) and escalating the issue via NHS Improvement. The Board noted the report and approved the revised risk appetite statement.
14.	**CQC update**
14.1	The Board received and noted an update on CQC-related issues, including an update on the current inspection cycle. The Board noted that core service reviews had taken place between 26 and 28 February, with a well led assessment due the following week. It was noted that the final report, including the use of resources, core services and well led assessment, would be published in July 2019.
14.2	The Board discussed the update on the workforce related equality standards (WRES), and noted the update on equality and diversity initiatives being implemented by the Trust, as reported in an update on the WRES work plan later on in the agenda; these initiatives included the introduction of reverse-mentoring and inclusion of a BAME representative on interview panels for band 7s and above.
14.3	The Board discussed the WRES work plan and the proposed approach to equality and diversity. The Board endorsed the development of a prioritised action plan and welcomed the focus on developing middle management. The Board noted that the restructured People & OD directorate would add resource at divisional level and therefore provide greater support at operational level. The Trust board noted the report.
15.	**Infection prevention and control – quarter 3 report**

15.1	The Board welcomed Alison Holmes to the meeting.
15.2	The Board received and noted the quarterly update report on infection control and prevention, noting a new risk added regarding water hygiene following discussion at the last meeting that outlined the controls in place to manage the risk.
15.3	Professor Holmes raised her continued concerns about the ability to effectively control the risk of infection due to the overall condition of the estate. However all appropriate controls were in place to minimise the risk.
16.	**Learning from deaths**
16.1	The Board received and noted the statutory report presenting the learning from deaths dashboard, as mandated by the National Quality Board, summarising the process for investigating deaths and the use of structured judgement reviews (SJRs) into avoidable deaths, to support the learning of lessons from deaths.
16.2	The Board noted the requirement from April 2019 for the Trust to appoint a forensic examiner to support the learning from deaths and that the management of structured judgement reviews would transition to this role. The Trust board noted the report.
17.	**Quality account – priorities for 2019/20**
17.1	The Board considered the proposed quality priorities to be measured through the Quality Account in 2019/20, noting that other appropriate quality measures would be measured via 'business as usual' reporting mechanisms such as the integrated quality and performance scorecard.
17.2	The Board agreed the list of priorities, noting the recommendation from the Quality Committee and welcomed the alignment to the strategy and the streamlined approach being adopted.
18.	**Freedom to Speak Up – strategy**
18.1	The Board welcomed Richard Allen, one of the Trust's Speak Up Guardians, to the meeting. Mr Allen summarised his role and the priorities for the guardians.
18.2	The Board considered the strategy for the Freedom to Speak Up service, informed by the Trust's self-assessment against national guidance. The Board noted the key changes proposed, including increased dedicated time for guardians, the transfer of responsibility for the service to the Chief Executive's office and the appointment of a senior independent advisor to support with workforce issues.
18.3	The Board welcomed the additional independence and the positive endorsement provided by the transfer to the Chief executive's office. The Board noted that the role of FTSU guardian was originally created to support improvements in patient safety, however the majority of referrals made were related to workforce issues. However it was agreed that there was a clear link between staff suffering workforce issues and impact on patient safety. The Board agreed the principle that guardians should be in operational roles, but that they needed additional support to perform their roles, including increased time allocated to this role.
18.4	Nick Ross, non-executive lead for FTSU, agreed with the proposed approach and strategy, acknowledging the challenge in raising awareness of the service and noting that the strategy needed to focus on this. The Board agreed the commitment to raise awareness of FTSU through board member visits, and agreed other initiatives to raise awareness including celebrating Speak Up month in October 2019 and including regular articles in the

	staff intranet and magazine. The Board approved the strategy and agreed the change in management arrangements as recommended.
19. 19.1 19.2	**Workforce equality & diversity work programme 2019 and Gender pay gap** The Board considered the gender pay gap data to be submitted by the Trust and discussed gender equality issues including the representation of both genders in leadership development programmes and applications for senior posts. The Board noted that lessons learned from the approach to BAME were being applied to gender equality. Mr Ross noted the importance of flexible working practices to support gender equality. The Board agreed the need to understand the problem being solved, including barriers to females achieving senior posts. The Board noted the report and approved the submission of the data. The Board noted the discussion earlier in the meeting regarding the workforce race equality scheme.
20. 20.1 20.2	**National staff survey results 2018** The Board received a report outlining the results from the 2018 staff survey, noting that the overall engagement score was 7.0 ('average'), maintaining the same rating over the past two to three years. The Board considered the detailed results, noting the areas for improvement – equality and diversity, staff wellbeing, and bullying and harassment. It was noted that existing plans in these areas were being reviewed in light of the results. It was also noted that the survey methodology would be changed for the next survey, moving from a selection of staff to all staff being invited to complete the survey and a local survey being used to focus on areas of concern. The Board welcomed the change in methodology but agreed the need to communicate with staff to encourage them to complete the survey and to assure them about the anonymity of responses. It was also noted that it was important that staff could see response to the survey feedback, in order to encourage staff to provide feedback in the future. The Board noted the report and the response the survey feedback.
21.	**Flu campaign 2018/19 – review and way forward** The Board noted the paper and noted the discussion earlier in the meeting regarding the review of the 2018/19 campaign and the approach to be adopted in the next year's campaign.
22. 22.1	**EU exit – update on operational readiness in the event of 'no deal'** The Board received and noted the paper, providing assurance regarding the preparations for any possible 'No deal' exit, including review and updating of business continuity plans. The Board noted the risks and mitigations, and agreed with the current assessment of impact as low. The Board noted the report.
23.	**Trust Board declarations of interest annual report** The Board received and noted the annual register of board members' interests.
24.	**Trust Board committee effectiveness review** The Board received and noted the planned approach to reviewing the effectiveness of

	boards committees, via self-assessment.
25. 25.1	**Board committee summary reports** The Board received and noted reports from the following Trust Board committee meetings: • Audit, Risk and Governance committee meeting held on 6 March 2019 • Remuneration and Appointments Committee meeting held on 13 March 2019 – the Board noted the confirmation of the outcome of the six month review of the Chief executive's performance and endorsed the confirmation of his substantive appointment. It was noted that the process would from this point transition into the normal appraisal process. To this extent, the Chief executive would meet with the new Chair early in the new financial year in order to agree objectives for the forthcoming year. • Redevelopment committee meeting held on 27 February and 20 March 2019 • Quality Committee meeting held 13 March 2019 • Finance & investment committee held on 20 March 2019 The Trust Board noted the reports.
26. 26.1	**Any other business** No other business was discussed.
27. 27.1	**Date of next meeting** Public Trust board: Wednesday 22 May 2019 11.00hrs, Clarence Wing Boardroom, St. Mary's Hospital.
28. 28.1 28.2	**Questions from the public** The Chairman invited questions from the members of public present. A member of the public, representing the Save our Hospitals group, asked the Board to reflect on the announcement regarding the *Shaping a Healthier Future* and to outline the Trust's response. Prof Orchard reiterated that the Trust welcomed the opportunity to continue to work with the group, to consider the future of services and Trust sites, including Charing Cross Hospital, in order to create a plan. He advised that the public announcement regarding the end of the *Shaping a Healthier Future* would result in no change in the Trust approach, as it has always been planning on a future for Charing Cross Hospital including investment in areas such as the emergency department. Prof Orchard also confirmed that Imperial Charity funding was used on projects that would enhance the patient experience rather than backlog maintenance. For example the £7m investment in the emergency department was from NHS funding rather than the Charity. A member of the public asked whether the Board could emphasise the needs for redevelopment, recruitment and retention and community services to support services for the local population. Prof Orchard advised that the announcement had confirmed that the *Shaping a Healthier Future* was not the correct plan, but therefore a more appropriate plan for north west London was needed to create a seamless system within the financial envelope available. This would involve lobbying appropriately regarding the estate needs to support the services in the future.

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meetings held on 27th March and 24th April 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 22nd May 2019	**Item 5, report no. 02**
Responsible Executive Director: Professor Tim Orchard, chief executive officer	**Author:** Peter Jenkinson, Director of corporate governance & trust 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.

March 2019

The Board received a report from the Chief Executive, including an update from the CQC core service review held in February 2019, an update on 2019/20 business planning in the north west London sector, highlighting the financial challenges faced across the sector, and an update on local environmental developments around St. Mary's Hospital.

The Board also considered the draft financial plan for 2019/20. The Board approved the plan and agreed the target required to achieve the control total. It was agreed that the Finance & Investment Committee would monitor implementation.

April 2019

The Board also met in private in April 2019 and considered a business case for the replacement of the Trust's IT network.

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 27 March 2019

Updated: 13 May 2019

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	30 Jan 2019 11.7	Board members visit arising from CQC update	The Board also noted and welcomed the introduction of the board member visit programme in November, noting the purpose of the visits to promote engagement with staff and board awareness of issues facing staff. The Board also noted the importance of leadership at a local level and divisional directors agreed the positive effect that the reviews and visits were having on local leadership. The Board agreed that consideration should be given to how to share the common themes from these visits with the Board. May 2019 update: The next version of the Board member visit programme will be developed for implementation in June 2019. The governance process around this programme has been revised to include collation and dissemination of key themes from these visits to the Improving Care Programme Board and Quality Committee / Trust Board.	Tim Orchard, Peter Jenkinson	May 2019
2.	26 Sept 2018 11.4	Ward accreditation programme (WAP)	It was noted that the 2018/19 WAP was currently underway and the results would be reported to the Board in March 2019. March 2019 update: This item will be presented to the Board in May 2019 once the detailed results from the 2018/19 WAP programme are collated. May 2019 update: Main agenda item	Janice Sigsworth	May 2019
3.	26 Sept 2018 8.4	Implementation of e-referrals (arising from CEO report item)	A post-project evaluation would follow in January 2019. January 2019 update: Deferred to May 2019 meeting May 2019 update: Main agenda item	Dr TG Teoh	May 2019
4.	30 Jan 2019 9.4	Estates issues	The Board noted additional actions being taken to improve response to estates maintenance requests, including a weekly review meeting with divisions to review progress and prioritise requests. The Board welcomed the additional action being taken but agreed that this was one of the most significant risks facing the Trust. It was agreed that a validated view of the estate issues and the prioritisation of the resource to resolve would be presented to the next Board meeting. May 2019 update: Deferred to July 2019	Janice Sigsworth	July 2019

Items closed at the March 2019 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	25 July 2018 3.3.2	Corporate risk register and Risk Management (Board Assurance Framework / Risk Appetite)	The Board noted that an update on the Trust's risk appetite would be presented to the next meeting. September 2018 update: Deferred to January 2019 January 2019 update: The risk appetite framework has been agreed by the Board and is being utilised by the executive and senior leadership team when appropriate. An operational framework to support implementation of the framework throughout the organisation is under development and an update on progress with this will be presented to the Board in March 2019. March 2019 update: The revised risk appetite statement was approved by Board in March and the risk appetite operational framework is now being disseminated through divisions and corporate directorates via existing forums/meetings within divisions and corporate areas.	Janice Sigsworth	Closed
2.	30 Jan 2019 11.4 27 Mar 2019 19	Equality and diversity initiatives - arising from CQC update	The Board discussed the summary of initiatives to promote equality and diversity and ensure equal opportunities for all, and their impact. The Board noted that many of the initiatives would have an impact in the long-term, however some initiatives would have an immediate effect such as ensuring a fair time period for all job adverts. It was agreed that examples of such initiatives and their impact would be presented to a future Board meeting. March 2019 update:. The E&D action will be picked up through 'business as usual' reporting on E&D and our achievement of the WRES aspirational goals agreed by Board.	Kevin Croft	Closed
3.	26 Sept 2018 16.1 27 Mar 2019 18	Freedom to speak up – self assessment	Prof Orchard advised that the Guardians were committed to their roles, but that they needed support in terms of resources and time allocated. It was agreed that this review should also include benchmarking against arrangements employed by other trusts. It was agreed that the output of the review and recommendations would be shared with the Board in December. January 2019 update: Deferred to March 2019 March 2019 update: The Board noted the key changes proposed, including increased dedicated time for guardians, the transfer of responsibility for the service to the Chief Executive's office and the appointment of a senior independent advisor to support with workforce issues. The Board approved the strategy and agreed the change in management arrangements as recommended.	Kevin Croft	Closed
4.	30 Jan 2019 22.7	Meeting with V Craven	Victoria Craven introduced herself to the Board and summarised the research that she had been doing around infection control. She promoted her campaign to increase awareness and challenge regarding hand hygiene and infection control. Prof Orchard agreed to meet Ms Craven to discuss the Trust's infection prevention and control approach and to consider the findings of her research. He provided an update on cleanliness issues and the action being taken to achieve a step-change in standards of cleaning, and the changes being made to the hand hygiene audit process to provide better assurance. He noted the continued existence of CPE infection in the Trust but noted the infection prevention and control team's response in addressing the issue. He advised that any additional campaign would need to be considered in the context of other awareness	Tim Orchard	Closed

			campaigns already underway. It was agreed that Prof Orchard would meet Ms Craven to discuss further. March 2019 update: Meeting took place on 25th February 2019		

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 7, report no. 04**
Responsible Executive Director: Professor Janice Sigsworth, Director of Nursing	**Author:** Stephanie Harrison-White, Head of Patient Experience & Improvement Nursing Directorate

Summary:
This month's patient story is told by a mother on behalf of her daughter, Ruthie. Ruthie has learning disabilities and complex medical problems. She attended A&E earlier this year following an acute respiratory infection.

Cecilia will describe how she and her daughter were treated with respect and how staff made appropriate reasonable adjustments to ensure this experience was less stressful for Ruthie.

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

This report has been discussed at:
Due to be discussed at the Executive Team Meeting, 21st May 2019

Quality impact:
The ability to make reasonable adjustments and work in partnership with families/ carers can transform a potentially stressful A&E experience into a positive one.

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

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

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

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

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

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

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

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

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

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

- What should senior managers know?
  The Learning Disability and Autism Policy contains the Purple Pathways that are designed to help support and guide staff when caring for people with learning disabilities. They contain information on reasonable adjustments that if followed can greatly enhance the patient experience and that of their family.

- What (if anything) do you want senior managers to do?
  Continue to promote the use of the Purple Pathways in all areas.

- Contact details or email address of lead and/or web links for further
  margaret.smedlaey-stainer@nhs.net

- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why? To encourage the use of purple pathways for patients with learning disabilities.

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

This month's patient story will be presented in person by Cecilia on behalf of her daughter Ruthie. Ruthie has complex health needs including learning disabilities; cardiac problems and epilepsy. She lives at home.

Approximately 2% or 1:50 of the adult population have learning disabilities. Learning disabilities are associated with co-morbidities such as coronary heart disease (39%); hearing impairment (40%) and epilepsy (33%). People with learning disabilities are at increased risk of becoming unwell and once admitted to hospital they are likely to have a significantly longer length of stay (PHE 2014).

Ruthie attended our Emergency Department (ED) at St. Mary's Hospital in January 2019. She was acutely unwell with what transpired to be a severe chest infection. Ruthie has difficulty communicating her needs due to her learning disabilities and was accompanied to hospital by her mum, Cecilia. Cecilia will describe their journey whilst Ruthie was in our ED.

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

The Trust has been focusing on improving care for our patients with learning disabilities and their families and carers. Examples of this work include:

- Developing patient pathways referred to a 'Purple pathways'
- Promoting reasonable adjustments
- Launching the Learning Disabilities and Autism Policy
- Developing and rolling out the Communications Resource folder
- Reviewing and launching the Carer's Charter and passport
- Introducing an Email alert system to automatically notify the Inclusion & Vulnerability Officer (IVO); discharge team and head of patient experience each time a known patient with LD is admitted to one of our hospitals or attends A&E
- Staff training

This work has made a difference to our patients; however, we know that according to national data, people with learning disabilities have proportionately higher mortality rates

than those without (NQB 2018) and that our patients sometimes do not have a positive experience. A recent local Safeguarding Adult Review (an independent multiagency review of the death of an at risk patient) has highlighted the need for improved communication between the wards and the patients' place of residence to ensure we are confident of the level of care each patient is receiving prior to discharge. Work has begun on this with a joint meeting being held with community learning disabilities teams and care providers.

Another area we need to strengthen relates to conducting and recording mental capacity assessments and involving Independent Mental Capacity Advocates (IMCA). The safeguarding team and IVO are focusing on this area in staff training. We have also built an MCA form in Cerner which is due to go live this year.

4. **Summary/Key points**

In January 2019, Ruthie was brought into our Emergency Department (ED) at St. Mary's Hospital. She was accompanied by her mother who had returned home to find Ruthie very unwell with a severe respiratory infection and a subsequent seizure. Cecilia describes the care they both received.

A cubicle was found for Ruthie were they could stay together in a quieter environment. Cecilia describes the 'generosity, compassion and understanding' shown to both herself and Ruthie. Being offered a sandwich and cup of tea in the middle of the night was just one example of their kindness. Cecilia felt 'part of Ruthie's journey', she was listened to and describes how the doctors worked in collaboration with their cardiologist colleagues at Hammersmith hospital to understand Ruthie's cardiac condition. This provided great reassurance and comfort to Cecilia.

Cecilia has worked extensively in the nursing profession and held a high profile national job. This was not disclosed at the time although it did lead her to contacting the Trust following this experience as she felt her insight into the NHS made her appreciate all the more the care Ruthie and herself received.

5. Conclusion and Next Steps

Ruthie's story highlights the positive impact that our ongoing work has had for patients with learning disabilities. Staff demonstrated an awareness of making reasonable adjustments by ensuring they found a quiet environment for Ruthie and her mum. The compassion and kindness shown by our staff demonstrates our staff living the Trust values; '*going out of their way to make people feel welcome; 'going the extra mile'; actively listening'.*

There is scope to continue to improve our services for those with learning disabilities, Ruthie's experience demonstrates that our staff can make a difference to our patients and their families experience and it is these behaviours we want to continue to build upon, supported by education, knowledge and expert advice.

Author: Steph Harrison-White
Date: May 2019

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: 22 May 2019	**Item 8, report no. 05**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

Summary:

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

1) Financial performance
2) Financial improvement programme
3) Transformation programme update
4) Operational performance
5) Strategic development
6) Stakeholder engagement
7) Celebrating achievements

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

This report has been discussed at: N/A

Quality impact: N/A

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

Risk impact and Board Assurance Framework (BAF) reference:

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

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

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

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

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

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Chief Executive's Report to Trust Board

1. Financial performance

For the financial year 2018/19 (i.e. from April 2018 to March 2019) the Trust reported a deficit of £20.24m £0.32m favourable to our control total of £20.56m. The Trust spent £53.4m of capital in the year against a plan of £54.2m.

Achieving the control total, and meeting the A&E 4 hour targets, has given the Trust access to £34.2m of planned Provider Sustainability Funding (PSF) and £14.2m of "bonus" PSF. This brings the final reported position of the Trust to a £28.2m surplus.

The Trust's control total for 2019/20 has been set by NHS Improvement at £16.0m deficit before central funding. The Trust has signed up to this plan which involves achievement of around £50m of efficiencies. The Transformation Director is working closely with divisions to identify sustainable savings plans for the next 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 it delivered £44.1m or 92% of target. Also importantly, 98% of these savings were made recurrently, thereby improving financial performance in a more sustainable way.

The majority of these improvements were made through delivering more contracted patient services, more efficiently, as well as realising benefits through better procurement and commercial contract management and increased private patients, bringing profits into the hospital and NHS.

The main areas of underperformance where due to unidentified CIPs and delays to the structural benefits associated with NWL Pathology (a major consolidation programme of pathology services across the sector).

3. Transformation programme update

The Finance & Investment Committee received an update on the Transformation plan and Specialty Review Programme at its meeting in May, including the portfolio of projects established as part of the transformation plan. The financial impact and timescales for each of these projects will be confirmed and monitored through the Finance & Investment Committee. Recruitment to the transformation team continues, with one of the senior leads now in place, along with a fixed term contract Transformation lead.

Imperial will be hosting the Shelford Group Transformation network on 21 June, when we will showcase improvement work such as Flow Coaching, improving the Patient Services Centre and other clinical pathway work. Support to the CIPs work continues as the financial plan for 2019/20 approaches completion.

4. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance as at March 2019 (month 12).

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

Exceptions in performance are highlighted in the following key areas:

- **Never events** – Seven never events were reported during 2018/19. One never event was reported in April 2019, a retained swab in ENT at Charing Cross Hospital. As reported at the last Board meeting, a trust-wide action plan has been developed in response, including the expediting of a

simulation and coaching programme for all areas which undertake invasive procedures, starting with the specialties which have had never events. Weekly updates on progress with the action plan are being provided to the executive committee and assurance provided to the Quality Committee.

- **Friends and family test: response rate** – The A&E FFT response rate was 18.1% in March 2019, which is the best performance since collection began and is above the national average.

- **Referral to treatment** – At the end of March 2019, no patients had been waiting for more than 52 weeks for treatment and, following a further reduction in the total number of patients waiting, the Trust met the trajectory for the PTL size. Performance against the standard to treat patients within 18 weeks was lower than trajectory at 84.4%, but continues to show an improving trend.

- **Accident & Emergency** – Performance against A&E four-hour access target continues to improve. While the March 2019 performance, at 88.4%, was below the improvement target of 95%, it was 5.2 percentage points higher than performance in March 2018 and type 1 performance was 12.6 percentage points higher. Year-end performance for 2018/19 was 88.2%, a 1% increase compared with 2017/18. As a result, the Trust received the full allocation of PSF funding attributed to 4 hour performance. The improvements in RTT and Accident and Emergency performance have been delivered in the context of a reduced number of cancellations of elective surgery on the day of admission and improvements in the timeliness of admission to critical care, indicating improvements in operational processes overall.

- **Annual refresh of the performance framework** – As part of the annual refresh of the performance framework, and following a discussion at the Board Seminal in April 2019, the Director of Operational Performance has developed a proposal to amend the content and structure of the integrated performance scorecard. The initial changes are designed to better highlight the issues most in need of attention by streamlining the number of indicators. A first version of the updated scorecard will be used to report performance for April 2019. This work is the first step on a longer journey to transform how we use information to manage our services, and to ensure there is clearer correlation between corporate objectives and the scorecard metrics.

ED waiting time standards pilot

The Trust is participating in an NHS England pilot, to review the core set of NHS access standards, in the context of the model of service described in the NHS Long Term Plan, and informed by the latest clinical and operational evidence, recommend any required updates and improvements to ensure that NHS standards:

- promote safety and outcomes;
- are clinically meaningful, accurate and practically achievable;
- ensure the sickest and most urgent patients are given priority;
- ensure patients get the right service in the right place;
- are simple and easy to understand for patients and the public; and
- not worsen inequalities.

The review is considering the appropriateness of core access standards for:

- Urgent and emergency care: including physical and mental health services
- Mental Health services
- Cancer care: diagnostic and treatment services
- Elective care

The Trust is piloting the Urgent and emergency care standards, including:

- waiting Time to initial clinical assessment in EDs and UTCs (type 1, 2 and 3 A&E departments)
- time to emergency treatment for critically ill and injured patients
- average total time in A&E (all A&E departments and MH equivalents)
- increased utilisation of Same Day Emergency Care and on-site liaison psychiatry

Field testing of the pilot standards is due to start this month with timescales for the pilot to be confirmed.

Trust undertakings
The Board will note the latest update on progress against the Trust's updated regulatory undertakings, as agreed last September, attached at Appendix 1.

5. Strategic development

We continue in the development of a refreshed organisational strategy and the leading change through vision, values and behaviours programme. We are working on three key areas to further develop and implement our new strategy and ensure we achieve what we want to:

- Develop strategic implementation plans for key areas of our work – to be agreed at the Trust Board meeting in July – focusing on the clinical strategic implementation plan and also strategic implementation plans for quality, our people/workforce and digital.
- Linking into and out of these function strategic plans, describe in more detail what we will do as an organisation over the next three years and, looking longer term, ten years, to deliver the three strategic goals.
- Ensure we have the right detailed plans, resources and processes in place to deliver our strategic implementation plans and strategic goals, and therefore our overall strategy.

Strategy development will be the focus of the Trust Board's seminar on 26 June and the specific actions and measures for the 2019/20 corporate objectives, agreed by the Trust Board at its last meeting, are presented at this meeting.

6. Stakeholder engagement

Below is a summary of significant meetings and communications with key stakeholders:

Meeting with Cllr Heather Acton, Westminster City Council: 10 April
On Wednesday 10 April, I met with Cllr Heather Acton, Westminster City Council's Cabinet Member for Family Services and Public Health, when the following issues were discussed: estates redevelopment; issues relating to sub-structures underneath London Street and Mint Wing at St Mary's Hospital; joint proposal on 'Healthier hearts and lungs' services; CCG relations and financial issues; operational performance; and, CQC inspections.

Meeting with Cllr Ben Coleman, Hammersmith & Fulham Council: 17 April
On Wednesday 17 April, I met with Cllr Ben Coleman, Hammersmith & Fulham Council's Cabinet Member for Health and Adult Social Care, when the following issues were discussed: Government announcement on 'shaping a healthier future'; future of Charing Cross Hospital; GP extended hours change proposal; financial performance 2018/19 and plan for 2019/20, including cost improvement programme; service change proposal on physiotherapy services; and, approach to consultations.

Meeting with Cllr Jonathan Glanz, Westminster City Council: 23 April
On Tuesday 23 April, I met with Cllr Jonathan Glanz, Westminster City Council's Chair of the Family and People Services Policy and Scrutiny Committee, when the following issues were discussed: estates and redevelopment; operational and financial performance; financial plan for 2019/20; treatment of knife crime victims; testing new A&E standards; service change proposal on physiotherapy services; and, issues relating to sub-structures underneath London Street and Mint Wing at St Mary's Hospital.

Hammersmith & Fulham Council: Health, Inclusion and Social Care Policy and Accountability Committee: Wednesday 24 April
On Wednesday 24 April, we attended Hammersmith & Fulham Council's health scrutiny committee to discuss the Trust's draft Quality Account for 2018-19 and a proposed service change for physiotherapy services.

7. Celebrating achievements

British Medical Journal (BMJ) awards
The Trust has won awards in two separate categories at this year's prestigious British Medical Journal (BMJ) awards:

- ***Flow Coaching Academy***
  The Trust joined Sheffield Teaching Hospitals NHS Foundation Trust and the NHS in Northern Ireland in collecting the award for *Innovation in Quality Improvement Team* for their work on the Flow Coaching Academy (FCA). FCA is an innovative programme that trains NHS staff to use a systemic coaching approach to improve care pathways.

  The Trust was one of the early adopters of the FCA approach which was developed by Sheffield Teaching Hospital. It involves a group of around 30 staff receiving specialist quality improvement training to become coaches. Each pair of coaches, one clinical one non-clinical, then sets up a 'Big Room' in their specialty bringing together staff from across the care pathway to assess, develop and improve models of care.

  The Trust was recognised for improvements it has made to vascular surgery which has seen an 80 per cent increase in the number of patients being discharged once they no longer need hospital care, thanks to changes introduced through the Big Room.

- ***Digital Innovation Team of the Year***
  A multi-disciplinary team from the Trust has also been recognised for their innovative approach to improving patient care through technology.

  The team won the Digital Innovation Team of the Year for creating an algorithm to analyse the free text comments made by patients responding to the 'Friends and Family Test' – a test created by the NHS to provide feedback to NHS organisations so that they can identify where improvements can be made. The Trust receives 20,000 patient comments a month through the Friends and Family Test. This feedback provides a rich source of information, and this algorithm allows the Trust to categorise the comments, and use them for quality improvement.

Nursing associates take on new roles at Trust
The first cohort of nursing associates took up their positions last month, in a new role designed to work alongside registered nurses and healthcare support workers on our wards. Five nursing associates have completed a two-year training programme and are beginning their roles in a range of settings across the Trust including renal services and surgery.

Nursing associates are trained to undertake a range of takes such as administering medicines and recording clinical observations. The newly created support role exists to relieve pressure on wards by allowing registered nurses to focus on more complex clinical duties.

International nurses day – 12 May
Nurses Day is celebrated internationally on 12 May each year. It's a great opportunity to reflect on and show appreciation for the work nurses do. This year we've brought together a senior, newly-qualified, and student nurse to chat about their experiences - what their career paths have been like, how they discovered nursing was their vocation, and what we can all do to support student and newly qualified nurses at the Trust. This conversation with deputy divisional director of nursing for stroke and neuroscience Katharine Brown, staff nurse Jeff Somers, and student nurse Lulu Mohammed has been published on our website and staff intranet.

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Imperial College Healthcare
NHS Trust

TRUST BOARD - PUBLIC
REPORT SUMMARY

Title of report: 2019/20 objectives – more detailed actions and measurement	☒ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: Wednesday 22 May 2019	**Item 9, report no. 06**
Responsible Executive Director: Prof Tim Orchard, chief executive	**Author:** Michelle Dixon, director of communications

Summary

The Board approved a refreshed organisational strategy with three strategic goals setting out a direction of travel for the next five to ten years to achieve our vision of 'better health, for life'. One-year objectives for 2019/20 were also approved as a first step towards making a clearer link between the delivery of our organisational strategy and our annual plan.

We are working now to develop our first strategic implementation plans for four, key functional areas, with external and internal input, to be put forward for approval by the Board at its July public meeting. The first four strategic plans will be for: clinical, quality, people and digital. Linking into and out of these function-level strategic plans, we are working to describe in more detail what we will do as an organisation over the next three to five years and, looking longer term, ten years, to deliver our three strategic goals. A key part of this will be to explicitly define what will change and how we will measure progress. This will mean making decisions about what we prioritise, our level of ambition and essential

trade-offs.

Alongside this work, we have developed more detail to the objectives for 2019/20, setting out a summary of what we are trying to achieve, key activities and high level measurements to demonstrate progress and achievement. We are developing further detail and measurement at a divisional and directorate level to make the links through to local plans. Over the next few months, we want to align further the monitoring of our annual objectives with our scorecard and quality account and to develop new measures, particular ones that are better able to reflect impact on patient outcomes and experience.

The draft set of objectives for 2019/20 to be used at an organisational level are presented here for review and approval subject to any additional changes requested by the board.

This report has been discussed at:

- Executive management team
- Strategy big room

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

If yes, when……

Quality impact: n/a

Financial impact: n/a

Risk impact and Board Assurance Framework (BAF) reference: n/a

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

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

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

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

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

2019/20 objectives – detailed achievements and measurement

What is to be achieved?	Key areas of activity involved	How will we know it is working/ be able to measure progress?
Objective 1: To enable more patients to get the **right care and support, in the right place, at the right time** – focusing this year on improvements in **operational processes and use of data**		
Summary: Joining up our own services and pathways to improve the 'flow' of care and identify more opportunities for working in partnership with patients to improve health and care holistically	Flow – all aspects, including same-day emergency care Joined up care/pathway development Frailty programme Wayfinding/ 'user' experience Use of high quality data Vision, values and behaviours	• Meet the improvement trajectory for A&E 4-hour performance • Reduce the number of patients with an extended length of stay by at least 25 per cent • Achieve A&E and inpatient satisfaction score > 94 per cent • Achieve a data quality maturity index >95 per cent • Increase the number of patients discharged before noon by (tbc) • Conclude wayfinding pilot and agree next steps
Objective 2: To expand and connect developments that enable **better integration of care** – focusing this year on establishing strong **partnerships** and **involvement**, **new care models and systems to support collaboration**		

Summary: Establishing a clear and shared vision for our approach to integrated care and making tangible progress across key initiatives with patients and partners	Integrated care collaborations North west London long term plan Healthier hearts and lungs proposal – children's services Care information exchange Partnership building and behaviour change	• Agreed north west London framework for the sector's integrated care system and widespread stakeholder engagement in designing a delivery 'roadmap' • Agreed vision and programme plan with widespread support plus progress on implementation for at least six key integrated care pathways, including new outpatient models and integrated children's care • Increased breadth and range of integrated care activities involving the Trust against 2018/19 baseline • Agreed vision and programme plan with widespread support for the care information exchange • Establish a partnership programme with local primary care networks
Objective 3: To **reduce unwarranted variations** in care pathways – focusing this year on projects supported by the **Flow Coaching Academy Imperial** and guided by external benchmarking on quality and efficiencies		

Summary: Making our services and care pathways demonstrably and consistently more patient-centric, safe and efficient	Safety improvement programme Demand and capacity modelling Patient service centre transformation Imperial flow coaching academy Gathering and using benchmarking data including GIRFT, national clinical audit and quality insights Waiting list improvement programme Theatre efficiency programme Specialty review programme outputs and other major service-led change projects Cost improvement programme Recruitment and retention improvements Vision, values and behaviours EPR/digital programme	• Reduced harm to patients and staff in priority areas as set out in quality account • Achieve patient satisfaction across all services of > 94 per cent and improved perceptions of patient-focus • Meet RTT improvement trajectory • Reduce outpatient 'do not attends' to [tbc] and unnecessary hospital appointments • At least 'good' for any CQC inspection • Deliver CIP programme • Deliver agreed responses to GIRFT, model hospital, clinical audit and quality insights • Deliver measurable improvements for all 9 Imperial flow coaching pathways • Agree and begin to implement plans for at least 14 specialties in specialty review programme, working closely with partners, particularly Chelsea and Westminster
Objective 4: To develop **strategic solutions to key challenges** – focusing this year on staff **recruitment and retention**, reducing our underlying **financial deficit** and **estates redevelopment**		

Summary: establishing joined-up, long-term plans for delivering our strategy and to be on track for delivery of estates, finances and workforce sustainability.	Strategy development and implementation Strategic workforce programme – including new roles and access and development routes Major capital projects Major new contracts and procurements Estates redevelopment Longer term financial planning Strategic plan for private care and wider commercial offering Anchor institute development Brand and naming conventions Vision, values and behaviours	• Agreed 5-year strategic implementation plans for clinical, quality, digital and people • Capital programme delivered to plan • Agreed vision and widespread stakeholder support for a major estates redevelopment • Reduction of our underlying deficit • Reduction in vacancies to no more than 10 per cent • Shared vision for, and increased income from, private healthcare/commercial opportunities • Agreed vision and stakeholder support for Trust's approach to development as an anchor institute • Agreed patient-centric brand and naming approach
Objective 5: To strengthen the **connections between our service developments and our research** – focusing this year on **data and digital** initiatives and expanding **staff involvement**		

Summary: Improving alignment between the BRC and clinical specialties and models of care and increasing staff and patient awareness and understanding of research opportunities	Widening staff access to research Imperial Health Knowledge Bank Clinical trials recruitment Data sharing for research Vision, values and behaviours Staff engagement Speciality review programme Strategy development and implementation	• Agreed vision and stakeholder support for aligned College/Trust approach to patient data and research and to the links between the BRC and the development of specialties and models of care • Conclude Imperial Health Knowledge Bank pilots and agree next steps • Increase recruitment to clinical trials • Increased staff and patient awareness and understanding of research advances, innovation and opportunities (measurement to be established)
Objective 6: To achieve a measurable improvement in our **organisational culture** – focusing this year on improvements in **leadership, fairness** and **collaboration**		

Summary: Increasing staff awareness, understanding and engagement with our vision, values and behaviours – across all staff groups and levels – through focused support and capability building	Vision, values and behaviours Workplace improvements Equality and diversity programme Staff wellbeing HR processes and support transformation Patient and public involvement Staff development and education Communications capability and support Quality improvement capability and support	• Increase staff awareness and understanding of our vision, values and behaviours (measurement to be established) • Launch co-designed behaviours development programme and at least 30 per cent of staff to have participated • Lay partners programme to expand by at least 25 per cent and co-design evidenced in all significant changes. • Staff survey to be completed by 50 per cent of staff • Established a measure and improvement targets for how encouraged and supported staff feel to learn, improve and innovate • Deliver equality and diversity plan • Flu vaccination at 80 per cent uptake

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CNST Compliance update	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 10, report no. 07**
Responsible Executive Director: Prof.TG Teoh, Divisional Director, WCCS	**Author:** Lesley Young, Interim GM, Maternity

Summary:

It has been agreed that ICHT will endeavour to meet full compliance for the Clinical Negligence Scheme for Trusts - maternity incentive scheme Yr 2 to continue to support the delivery of safer maternity care. There are 10 Safety Standards to meet within conditions; copy attached (Appendix I). To comply the Trust must demonstrate that they have achieved all of the ten safety actions in order to recover their contribution relating to CNST (approx. £1M) and a share of any unallocated funds (£500k in Yr1, Unknown for Yr 2) Certain evidential elements need to be shared or approved at the Trust Board level.

The attached report sets out the evidential requirements for the Safety Actions below that need to be approved or noted for information and formally recorded at the Trust Board meeting on 22nd May 2019 in order to meet the timescales requested for CNST.

Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? – **For information**

Evidence required: Quarterly reports submitted to trust board evidencing standards met

Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admission Into Neonatal units (ATAIN) Programme – **For information**

Evidence Required: Progress with agreed action plans shared with Board

Safety Action 4: Can you demonstrate an effective system of medical workforce planning? – **For approval**

Evidence Required - Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1, 2.6.5.6.that are met. Ratified Action Plan by Board on how Trust is working to meet the standards for those areas not met.

Recommendations:
The Committee is asked to note for information the evidence requirements for SA1d, SA3d and approval for SA4b (Action Plan to meet ACSA standards).

This report has been discussed at:

- Divisional Quality and Safety meeting, 7th May 2019
- Executive Quality Committee, 7th May 2019

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☐ No ☒ Not applicable If yes, when……
Quality impact: Which CQC domain will be improved by this paper? Safe, responsive, effective
Financial impact: The financial impact of this proposal as presented in the paper enclosed can be fully accommodated within the existing departmental budget this year and into the future assuming deliverable levels of efficiency. If we are able to demonstrate full compliance against the standards the Trust may receive £1M net rebate.
Risk impact and Board Assurance Framework (BAF) reference: Risk to CNST compliance and associated financial incentive if required governance evidence is not provided.
Workforce impact (including training and education implications): N/A
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable If yes, are further actions required? ☐ Yes ☐ No
What impact will this have on the wider health economy, patients and the public? Compliance with CNST Maternity Safety Actions will support the delivery of safer maternity care to our patients.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No If yes, why?..... If the details can be shared, please provide the following in one to two line bullet points: ▪ What should senior managers know? Trust commitment to achieving full compliance of CNST ▪ What (if anything) do you want senior managers to do? For information and noting ▪ Contact details or email address of lead and/or web links for further information https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/ ▪ Should senior managers share this information with their own teams? ☐ Yes ☒ No If yes, why?.....

Imperial College Healthcare NHS Trust

CNST Maternity Incentive Scheme – Evidential Requirements

1. Executive Summary

1.1. It has been agreed that ICHT will endeavour to meet full compliance for the Clinical Negligence Scheme for Trusts (CNST) Yr2 maternity incentive scheme to continue to support the delivery of safer maternity care. To comply the Trust must demonstrate that they have achieved all of the ten safety actions in order to recover their contribution relating to CNST (approx. £1m) and a share of any unallocated funds (£500k in Yr1, Unknown for Yr2).

2. Purpose

2.1. The report below sets out the evidential requirements for the Safety Actions that need to be approved or noted for information and formally recorded at the Trust Board meeting on 22nd May 2019 in order to meet the timescales requested for CNST.

3. Background

3.1. In 2018, NHS Resolution introduced the CNST Maternity Incentive Scheme to support the delivery of safer maternity care. Trusts that evidenced their compliance against the safety standards are eligible to receive a rebate of 10% of their CNST maternity premium.

3.2. In 2018, the Trust was successful in meeting all 10 safety standards and received £1.8M and are endeavouring to meet the revised standards in 2019.

4. Summary/Key points

4.1. Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? – **For information**

Evidence required: Quarterly reports submitted to trust board evidencing standards met.

Quarterly Report on the Perinatal Mortality Review Tool

Standard A (Review of all deaths of babies suitable for review using the PMRT).	**Standard B (Multidisciplinary review including a draft report generated within four months of each death).**	**Standard C (Parents notified of the review and their perspectives and concerns included).**	**Standard D (Quarterly report submitted to the trust board, including details of all deaths reviewed and consequential action plans).**
19/19 (100%) Period: 12/12/2018 – 30/04/2019	8 reviews generated within four months. 11 pending, to be completed within the four month time frame (overall – 100% compliance with standard B)	19/19 (100%)	Complete (30.04.2019)

In line with **standard D** none of the deaths in this report highlighted any care and service delivery concerns that needed actioning; the actions that came out of the reports were specific to each of the women, as below:

- Five of the cases found that the cause of death was severe IUGR, which was detected and managed appropriately, but for various reasons was so severe that the overall outcome was inevitable. For these women the action plans were focused around future pregnancies and being referred to a consultant, for aspirin antenatally and for serial growth scans.
- Two cases were unexplained; with one occurring pre- viability and the other occurring in a low risk woman who presented with her first episode of reduced fetal movements when the IUD was confirmed.
- One case found twin – to – twin transfusion to be the cause of death

4.2. **Safety Action 3:** Can you demonstrate that you have transitional care services to support the Avoiding Term Admission Into Neonatal units (ATAIN) Programme – **For information**

Evidence Required: Progress with agreed action plans shared with Board

Action Plan to address local findings from ATAIN – progress report 30 April 2019

Local findings	Action	Lead	Complete by	Evidence of Progress and Completion	Progress (RAG)
Lack of cross site multidisciplinary sharing and learning from term admissions	Weekly cross site MDT ATAIN review meetings	Serap Akmal / Lidia Tyszczuk	October 2018	Weekly meetings in place attended by MDT, findings and action points discussed and documented	Complete and ongoing
Avoidable admission as a result of educational needs in Transitional Care	TC study day for midwifery staff	Education leads	March 2019	Study day held 18th February - Due to positive feedback this will now take place 4 times a year and replace the bite sized teaching. We are able to train 40 midwives on each of the study days. This is most effective use of resources and time.	Complete
	Midwife training for Neonatal Abstinence Syndrome scoring	Education leads	May 2019	To be covered in monthly simulation training and quarterly TC study days.	Ongoing
	Medical/Neonatal consultant ward rounds in TC	Lidia Tyszczuk	In progress	TC ward rounds by medical team take place daily	Ongoing
	Regular bite	Education	In	Due to feedback from	Ongoing

	sized teaching TC staff	leads / Lidia Tyszczuk	progress	study day the model for delivering TC teaching has now changed to 4 study days per year and monthly simulation/ workshops for midwives delivered by a MDT team – this includes midwives, medical staff, neonatal nursing staff and therapies.	
Admissions for respiratory support following ELSCS and Emergency LSCS	Joint audit obstetric/neonatal on CS rates neonatal morbidity.	Serap Akmal / Lidia Tyszczuk	May 2019	Audit information currently being collated – cases are reviewed on a weekly basis as part of ATAIN. Term admission audits are presented at biannual morbidity meeting.	Audit underway
Emerging themes following weekly cross site meetings to discuss term admissions	Feedback to staff in safety huddles through obstetric and neonatal risk teams	Maternity and neonatal Risk leads	In progress	Weekly safety huddles are facilitated by the Trust risk team.	Ongoing
	Bi annual presentation of findings at joint obstetric and neonatal morbidity meetings	Serap Akmal	In progress	Bi annual joint obstetric and neonatal morbidity meeting – date to be confirmed	Date TBC

4.3 Safety Action 4: Can you demonstrate an effective system of medical workforce planning? – **For approval**

Evidence Required - Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1, 2.6.5.6. that are met. Ratified Action Plan by Board on how Trust is working to meet the standards for those areas not met.

Standards	Action	Proportion of standards met	Action on how we are working to meet the standards
1.2.4.6	Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff findings at joint obstetric and neonatal	Standards partially met **QCCH:** There are dedicated theatre and midwifery staff for all elective caesarean sections lists and a dedicated consultant obstetrician.	Anaesthetic business case required for additional obstetric anaesthetic consultants to ensure all elective CS lists have a separate consultant

		SMH: Dedicated consultant anaesthetist present for elective lists (2 per week). No dedicated scrub nurse or midwifery staff. **SMH & QCCH** - The obstetric consultant is only paid for a 4 hour session whilst the list lasts 5 hours - There is no prospective cover for the consultant obstetrician when they are away on leave. - 1 out of five elective CS theatre lists has a dedicated consultant anaesthetist These risks are on the maternity risk register	anaesthetist and all lists have prospective cover. **For completion and approval by 31 July 2019** **Lead: M Danjal** Investment required for current obstetric obstetricians to provide prospective cover for elective caesarean section lists. **For completion and approval by 31 July 2019** **Lead: M Dhanjal** Additionally consultants need remuneration for a 5 hour session rather than a 4 hour session **Internal discussion underway. Sign-off and approval required by 30 June 2019**
2.6.5.1	A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident	Fully met both sites	
2.6.5.6	The duty anaesthetist for obstetrics should participate in labour ward rounds	Fully met both sites	

5. Conclusion and Next Steps

5.1. The Committee is asked to note for information evidence requirements for SA1d, SA3d
5.2. Approval for SA4b (Action Plan to meet ACSA standards).

6. Recommendations

6.1. Support the actions identified within the report to meet full CNST compliance

Author: Lesley Young, Maternity General Manager **Date:** 01/05/2019

Appendix 1 - CNST Maternity Incentive Scheme: Year Two: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form (see Appendix 1) to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:
• Trusts must achieve all ten maternity safety actions
• The Board declaration form must be signed and dated by the trust chief executive to confirm that:

- The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
- The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.

The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Annual self-certification for NHS Trusts	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 22 May 2019	**Item 11, report no. 08**
Responsible Executive Director: Tim Orchard, Chief executive officer	**Author:** Peter Jenkinson, Director of Corporate Governance

Summary:
Introduced in April 2017, NHS Improvement require that NHS trusts, as foundation trusts (FT) have always been required to do, self-certify compliance against a number of specific declarations. Providers must publish their self-certification by 30 June.

The self-certification declarations in this paper are, in essence, FT Licence requirements. However, the introduction of NHS Improvement's (NHSI) Single Oversight Framework in 2016/17 bases its oversight along similar lines, and NHS trusts are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate.

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
- complied with governance arrangements (condition FT4); and
- for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

Through the 'business as usual' governance arrangements in place across the Trust, including executive and Board committees, assurance has been provided to the Trust board during the year (and continues to be provided) to inform the Trust board's decision regarding the declarations in respect of conditions G6 and FT4.

The Trust board and its committees are informed and receive assurance in relation to the requirements of the specified conditions in a number of ways through the year. These include:

- Regulatory inspection and oversight, including CQC and NHS Improvement
- Risk-based annual internal audit plan, including review of key systems of internal control and a review of the risk management arrangements and board assurance framework, culminating in the Head of Internal Audit opinion
- External audit opinion on annual accounts, annual report and quality account
- Quality account
- Corporate risk register
- Executive director reports to Trust board
- Board committee reports to Trust board
- Board seminar presentations from divisions and areas of interest (eg education; research; integrated care), bi-monthly.

The Trust agreed on a series of undertakings with NHS Improvement in November 2017 in response to breaches of licence conditions. The delivery of the undertakings forms a key element of regulatory requirement, and NHS Improvement oversee the Trust's progress against the undertakings as part of the monthly Provider Oversight Meetings. These undertakings have been revised by NHS Improvement during 2018/19, to reflect the progress made by the Trust in achieving the undertakings and the Trust's improved operational and financial performance, and it is hoped that the undertakings will be removed completely in quarter 1 2019/20. However, currently, they remain in force.

In addition to the business as usual assurance mechanisms, the executive team have completed a self-assessment of compliance against the standards to support these proposed statements of compliance. These are included in Appendix 1 for reference.

The executive team have reviewed these assurance statements and the proposed compliance declarations and have agreed to recommend the proposed declarations for the two conditions contained within Appendix 2 to the Trust Board for approval.

Recommendations:
The Board is asked to approve the proposed declaration of compliance as follows:

- Condition G6(3)
  "Not later than two months from the end of the Financial Year (by 31 May 2018), the Trust board ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it has taken all precautions necessary to comply with the licence, NHS acts and the NHS Constitution."
  It is recommended that the Trust board formally sign-off the Self-Certification for Condition G6 as "Confirmed".
- Condition FT4 (8)
  "By 30 June 2018, the Trust board is required to self-certificate "Confirmed" or "Not confirmed" to compliance with required governance standards and objectives."
  It is recommended that the Trust board formally sign-off the Self-certification for Condition FT4 as "Not confirmed for (a) and confirmed for (b-h)".

This report has been discussed at: N/A

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)?
☐ Yes ☐ No ☒ Not applicable
If yes, when……

Quality impact: No impact.

Financial impact: No impact.

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

Workforce impact (including training and education implications): No impact

Has an Equality Impact Assessment been carried out or have protected groups been considered?
☐ Yes ☐ No ☒ Not applicable
If yes, are further actions required? ☐ Yes ☐ No

What impact will this have on the wider health economy, patients and the public? No impact.

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

Trust strategic goals supported by this paper: N/A

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?

Appendix One

Executive governance statements for Trust board – May 2019

SAFE	Executive lead
Q1. *The Trust board can be satisfied that, to the best of the Executive's knowledge, the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* *(This takes account of NHSI's oversight model, CQC information and its own data on serious incidence and patterns of complaints)* **Director response:** Yes **Explanation, where response is No:**	Prof Julian Redhead Medical director Claire Hook Director of Operational Performance Dr Frances Bowen, Dr Katie Urch, Prof TG Teoh Divisional directors
Q2. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.* **Director response:** Yes **Explanation, where response is No:**	Janice Sigsworth, Director of nursing Dr Frances Bowen, Dr Katie Urch, Prof TG Teoh Divisional directors
Q3. *The Trust board can be satisfied that processes and procedures are in place to ensure all clinical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **Director response:** Yes **Explanation, where response is No:**	Prof Julian Redhead Medical director Prof Janice Sigsworth, Director of nursing
EFFECTIVE	**Executive lead**
Q4. *The trust board can be satisfied that appropriate clinical audit arrangements are in place to ensure effective care and treatment is received in line with legislation, standards, evidence based guidance and service change.* **Director response:** Yes **Explanation, where response is No:**	Prof Julian Redhead Medical director
CARING	**Executive lead**
Q5. *The trust board can be satisfied that the trust takes appropriate measures to engage patient and public involvement in the development of services and in shaping patient care.* **Director response:** Yes **Explanation, where response is No:**	Michelle Dixon, Director of Communications
Q6. *The trust board can be satisfied that patients are treated with kindness, dignity, respect and compassion.* **Director response:** Yes **Explanation, where response is No:**	Prof Janice Sigsworth, Director of nursing
RESPONSIVE	**Executive lead**
Q7. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with all existing operational targets and a commitment to comply with all known targets going forward.* **ICHT Response:** No **Explanation, where the response is No:** <u>Emergency department:</u> The Trust is not currently achieving the national standard to see, treat and discharge 95 per cent of patients that present to an urgent or emergency care setting within four hours. Meeting the 4 hour standard for A&E has been a challenge during 2018/19 for a number of reasons including increasing demand, rising acuity, delayed transfers of care and on-going estate issues, but through the work of our Care Journey and Capacity Collaborative we have delivered improvements in performance in spite of this. We intend to sustain the improvement we have achieved in 18/19 during 19/20 and have agreed a trajectory for improvement with our commissioners and NHSE/I which will bring performance to 92 per cent by March 2020. This will be delivered through a refreshed programme of improvement comprised of the following work streams: •Access to unplanned care •Flow / move •Safe and timely discharge •Infrastructure and capacity management Each scheme includes a plan of delivery with clear measurement of the impact of the change and its effect on the minimising breaches of the four-4 hour standard. The programme is led by the division of medicine	Claire Hook Director of Operational Performance Dr Frances Bowen, Dr Katie Urch, Prof TG Teoh Divisional directors

and integrated care and progress is reported to the Executive Operational Performance Committee. Referral to treatment for elective care: The Trust is not currently achieving the national standard with respect to referral to treatment (RTT) within 18 weeks. The key drivers for this underperformance include: increasing demand on limited elective capacity (surgical, diagnostic and outpatient), limited training for staff to interact correctly with IT systems and consequently poor data quality. These key drivers are being addressed via six work streams: Waiting list recovery – focus on supporting long waiting patients through the system, using IST metrics to develop demand and capacity and trajectory mapping Elective care operating framework – focus on developing high quality user validation dashboards, supporting training and recruitment programs, link to correct input and performance. Use QI methodology and engagement to ensure adherence to SOP, GIRFT and rapid improvement cycles. Digital optimisation – on-going work to improve the data extraction and BI reporting suite Clinical harm reviews – patient safety and review Oversight and governance – reporting to CEO; CCG, NHSI/ NHSE, POM Audit framework – DQI / external audit / external assurance check Each work stream has a lead and reports through the internal to external reporting framework. We intend to sustain the progress we have made in 18/19 during 19/20 and have agreed a performance trajectory for with our commissioners and NHSE/I that will maintain the current waiting list size whilst delivering a small improvement in performance.	
WELL-LED:	
Q8. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with all existing financial targets and a commitment to comply with all known targets going forward.* **ICHT Response:** Yes **Explanation:** For the financial year 2018/19 the Trust reported a deficit of £20.24m, £0.32m favourable to our control total of £20.56m. The Trust spent £53.4m of capital in the year against a plan of £54.2m. Achieving the control total, and meeting the A&E 4 hour targets, has given the Trust access to £34.2m of planned Provider Sustainability Funding (PSF) and £14.2m of "bonus" PSF. This brings the final reported position of the Trust to a £28.2m surplus. The 2018/19 plan has been approved by the Board and submitted, to meet the control total set by NHS Improvement of £16.0m deficit. To achieve this plan the Trust will need to deliver around £50m of efficiencies. The Trust board exercises much of its financial governance via the finance and investment committee and the audit, risk and governance committee; both of these committees are engaged in the oversight of the issues and actions outlined above.	Richard Alexander, Chief financial officer Dr Frances Bowen, Dr Katie Urch, Prof TG Teoh Divisional directors
Q9. *The Board can be satisfied that they will be proactively, reliably & independently advised as to the going concern status of the Trust and the issues impacting that status, as defined by the most up to date accounting standards in force from time to time and financial best practice.* **ICHT Response:** Yes **Explanation, where response is No:**	Richard Alexander, Chief financial officer
Q10. *An Annual Governance Statement is in place, and the Trust board can be satisfied that the Trust is compliant with the risk management and assurance framework requirements that support the Statement and that significant issues are included within the board assurance framework.* **ICHT Response:** Yes **Explanation, where the response is No:**	Peter Jenkinson Director of corporate governance Prof Janice Sigsworth, Director of nursing
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the DSP Toolkit.* **ICHT Response:** Yes **Explanation, where the response is No:**	Kevin Jarrold Chief information officer
Q12. *The Trust board will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled appropriately, and that plans exist to fill any vacancies as required.* **ICHT Response:** Yes **Explanation, where response is No:**	Kevin Croft Director of people and organisational development Peter Jenkinson Director of corporate governance
Q13. *Fit and proper persons: The Board can be satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting*	Kevin Croft Director of people and organisational

strategy, monitoring and managing performance and risks, and ensuring management capacity and capability. **ICHT Response:** Yes **Explanation, where the response is No:**	development Peter Jenkinson Director of corporate governance
Q14. *The Board can be satisfied that: the management team has the capacity, capability and experience necessary to deliver the Trust objectives; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response:** Yes **Explanation, where the response is no:**	Kevin Croft Director of people and organisational development
Q15. *The Trust board can be satisfied that the Trust seeks to remain at all times compliant with the NHSI Single Oversight Framework and shows regard to the NHS Constitution at all times. All current key risks to compliance have been identified and addressed – or there are appropriate action plans.* **ICHT Response:** Yes **Explanation, where the response is No:**	Prof Tim Orchard, Chief executive officer

Appendix 2

Provider self-certification statements for Trust board – May 2019

G6 declaration for Imperial College Healthcare NHS Trust

Declaration required by General condition 6 of the NHS provider licence
The Trust board are required to respond 'Confirmed or Not confirmed to the following statements
1&2 General condition 6 – Systems for compliance with license conditions (FTs and NHS Trusts)
1 Following a review for the purpose of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee 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. **Confirmed** Signed on behalf of the Trust board of directors Signed . . . . . Signed . . . . . . Name . . . . . Name . . . . . . Capacity . . . . . Capacity . . . . . . Date . . . . . Date . . . . .

FT4 declaration for Imperial College healthcare NHS Trust

Corporate governance statement (FTs and NHS Trusts)		
The Trust board is required to respond 'confirmed' or 'not confirmed' to the following statements, settings out any risks and mitigating actions for each one where it is 'not confirmed'		
Corporate governance statement	**Response**	**Risks and mitigating actions**
1 The Trust board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of heat care services to the NHS	Confirmed	
2 The Trust board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3 The Trust board is satisfied that the Licensee has established and implements: (a) effective board and committee structures (b) clear responsibilities for its Trust board, for committees report to the Trust board and for staff reporting to the Trust board and those committees and (c) clear reporting lines and accountabilities throughout its organisation	Confirmed	
4 The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to	**Not confirmed**	Not confirmed for (a). The Trust is not currently achieving the national standard to see, treat

operate efficiently, economically and effectively (b) For timely and effective scrutiny and oversight by the Trust board of the Licensee's operations (c) To ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of healthcare professions (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/ or processes to ensure the Licensee's ability to continue as a going concern) (e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for the Trust board and committee decision-making (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) To ensure compliance with all legal requirements		and discharge 95 per cent of patients that present to an urgent or emergency care setting within four hours, or the national standard with respect to referral to treatment (RTT) within 18 weeks. The Trust achieved its control total for 2018/19 and, with allocated PSF (provider support funding), achieved a year-end surplus of £28m. However the Trust continues to have an underlying deficit and has a financial recovery plan in place to address this. The Trust Board approved the financial plan for 2019/20, to achieve the control total of £16m deficit, but recognises the risks in achieving the plan, including a CIP target of £50m.
5 The Trust board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/ or processes to ensure: (a) That there is sufficient capability at Trust board level to provide effective organisational leadership on the quality of care provided (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	
6 The Trust board us satisfied that there are systems to ensure that the Licensee has in place personnel on the Trust board, reporting to the Trust board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	Confirmed	
Signed on behalf of the Trust board Signature . . . . . Signature . . . . . Name . . . . . Name		

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Month 12 integrated quality and performance report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 22 May 2019	**Item 13, report no. 09**
Responsible Executive Director: Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) Catherine Urch (Divisional Director) Tg Teoh (Divisional Director) Frances Bowen (Divisional Director) Kevin Croft (Director of People and Organisational Development)	**Author:** Submitted by Performance Support Team

Summary:
This is the bi-monthly integrated quality and performance report for data published at month 12 (March 2019).

The report is presented as follows:

- Summary report
- Indicator scorecard
- Appendix 1: Exception reporting slides are provided for information. These highlight improvement plans where performance is outside the agreed tolerances / target.

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

This report has been discussed at:
Executive (Operational Performance) Committee – Tuesday 23 April 2019
Executive (Quality) Committee – Tuesday 7 May 2019
Board Quality Committee – Wednesday 8 May 2019

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☐ No ☒ Not applicable

Quality impact:
The delivery of the full integrated quality and performance report will support the Trust to more effectively monitor delivery against internal and external targets and service deliverables. 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:
- Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
- 1660 Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality
- 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards
- 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues
- 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust
- 2485 Failure of estates critical equipment and facilities
- 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)
- 2490 Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines
- 2937 Failure to consistently achieve timely elective (RTT) care
- 2938 Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards
- 2943 Failure to maintain ED trajectories
- 2944 Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas
- 2946 Failure to provide timely access to critical care services

Workforce impact (including training and education implications): None

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

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

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

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

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?.....

Imperial College Healthcare NHS Trust

Integrated quality and performance report – summary of performance at month 12 (March 2019)

1. Introduction

1.1. The Board are asked to consider the integrated quality and performance report and the key headlines relating to operational performance as at March 2019 (month 12).

1.2. The indicator scorecard and this summary report highlights where performance is above target, or within tolerance, and also where performance did not meet the agreed target / threshold.

1.3. In the development of the report, exception reporting slides have been included where performance is outside the agreed tolerances / target. These exception reports are provided for information in appendix 1 and cover the following metrics:

- Incident reporting rate
- Never events
- Compliance with duty of candour
- VTE
- MRSA BSI and C.difficile
- E.Coli
- CPE
- National clinical audits
- Vacancy rates
- Medical devices maintenance
- Mortality reviews
- PROMs
- FFT A&E service - % response
- Mixed sex accommodation
- Doctor appraisal rate
- RTT 18 week waits
- Theatre touchtime utilisation (elective)
- Cancelled operations / 28-day rebookings
- Critical care admissions
- A&E patients seen within 4 hours
- A&E 12-hour waits
- Outpatient DNA
- Outpatient HICs
- DQI: Orders waiting on the Add/Set Encounter request list
- DQI: Outpatient appointments not checked in / not checked out

Imperial College Healthcare NHS Trust

2. Summary/Key points

2.1. The key headlines in performance for month 12 are highlighted below for each domain.

Safe

2.2. Incident reporting: In March 2019, the NRLS published their bi-annual incident reporting data for acute non-specialist trusts for the period April 2018 – September 2018. Our incident reporting rate for this time period was 50.4 per 1,000 bed days, which is in the top quartile. The reporting rate increased nationally during this time period and the target to be in this quartile has now increased to 48.98.

To generate up to date reporting rates we use NRLS methodology using bed day data that is submitted to NHS England (quarterly in arrears). Bed occupancy levels have increased in the quarter 3 submission which has led to a reduction in our reporting rate when we apply that retrospectively.

Although the bed occupancy level was expected to rise due to changes in bed numbers and recording of our long stay patients this was higher than anticipated as the methodology for generating the data was changed in Q3. This methodology inflated the occupancy level which will be rectified for the Q4 submission.

Between August 2018 – March 2019 we also reported fewer incidents. The monthly total fell below the mean for five of those months. Therefore we are now below our target when comparing reporting rate and overall numbers.

2.3. Never events: Seven never events were reported during 2018/19. One never event was reported in April 2019, a retained swab in ENT at Charing Cross Hospital. As reported at the last meeting of the Trust Board, a trust-wide action plan has been developed in response, including the expediting of a simulation and coaching programme for all areas which undertake invasive procedures, starting with the specialties which have had never events. Weekly updates on progress with the action plan are being provided to the executive committee and assurance provided to the Quality Committee.

2.4. Duty of candour: Overall, compliance with the completion of duty of candour for all appropriate incidents continues to improve with performance over 90%.

2.5. Sepsis: In March 2019, 70% of patients diagnosed with sepsis received antibiotics within one hour of diagnosis, compared to 67.9% in February 2019, against our target of 50%.

Effective

2.6. Mortality rates: For the most recent full year data, the Trust had the lowest Hospital standardised mortality ratio (HSMR) score for acute non-specialist trusts nationally. The Trust was the fourth lowest of acute non-specialist providers for the Standardised hospital mortality indicator (SMHI) score.

2.7. Clinical trials recruitment: Improvements in the number of clinical trials recruiting their first patient within 70 days of a valid research application are being sustained. The NIHR-validated data for Q3 2018/19 shows performance remains high at 93.9% compliance against our target of 90%.

Imperial College Healthcare NHS Trust

Caring

2.8. Friends and family test response rate: The A&E FFT response rate was 18.1% in March 2019, which is the best performance since collection began and is above the national average.

Well-led

2.9. Vacancy: The Trust's vacancy rate at the end of March 2019 was 13.5%, which is higher than the 9.9% median for the London University Hospital Association. The majority of the Trust vacancies are within our nursing and midwifery staffing group where good progress is being made to fill the roles.

2.10. Turnover: At end March the voluntary turnover rate was 11.3%, which remained within the Trust target of 12.0% and was the lowest turnover rate amongst our peers within London.

2.11. PDRs: The new performance development review (PDR) cycle began for 2019/20 commended 1 April 2019. This year, there is greater emphasis on wellbeing at work, values and behaviours and how we continually improve care and services for patients.

Responsive

2.12. Referral to treatment: At the end of March 2019, no patients had been waiting for more than 52 weeks for treatment and, following a further reduction in the total number of patients waiting, the Trust met the trajectory for the overall RTT waiting list size. The performance of the standard to treat patients within 18 weeks of their referral was lower than trajectory at 84.4%, but continues to show an improving trend.

2.13. Accident & Emergency: Performance against the A&E four-hour access target continues to improve. While the March 2019 performance, at 88.4%, was below the improvement target of 95%, it was 5.2 percentage points higher than performance in March 2018 and type 1 performance was 12.6 percentage points higher. Year-end performance for 2018/19 was 88.2%, a 1% increase compared with 2017/18.

2.14. The improvements in RTT and Accident and Emergency performance have been delivered in the context of a reduced number of cancellations of elective surgery on the day of admission and improvements in the timeliness of admission to critical care.

3. Reporting performance in 2019/20

3.1. As part of the annual refresh of the integrated quality and performance framework, the content of the performance scorecard has been reviewed to ensure it incorporates any new requirements for 2019/20. In addition, a proposal to amend the format and structure of the scorecard has been developed by the Director of Operational Performance. The changes have been designed to better highlight the issues most in need of attention by streamlining the number of indicators.

3.2. As a result of the refresh, a small number of metrics will be added to the scorecard for 2019/20, but the total number will reduce. The reduction in the number of indicators has largely been achieved by adopting the principle that the scorecard should only contain the key targets, with removal of any which form part of a subsidiary cluster of metrics.

Executive leads will continue to be responsible for ensuring that removed metrics are monitored through the appropriate forum.

3.3. A first version of the updated scorecard (with a new glossary) will be used to report performance for month 1 (April 2019). The Trust Board will receive the new scorecard at the meeting on 24 July 2019.

3.4. This work is the first step on a longer journey to transform how we use information to manage our services, and to ensure there is clearer correlation between corporate objectives and the scorecard metrics.

4. Recommendation

4.1. The Board is asked to note the contents of this report.

Indicator scorecard for Month 12

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 12 Mar-19

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Safe									
Patient safety - incident reporting	Serious incidents	number	-	Mar-19	Julian Redhead	3	5	23	**13**
	All Incidents (cumulative financial YTD)	number	-	Mar-19	Julian Redhead	12,629	14,107	12,629	**12,629**
	Incidents causing severe/major harm	number	-	Mar-19	Julian Redhead	1	0	0	**1**
	Incidents causing severe/major harm (cumulative financial YTD)	number	<14	Mar-19	Julian Redhead	5	5	5	**6**
	Incidents causing severe/major harm (cumulative financial YTD)	%	<0.24%	Mar-19	Julian Redhead	0.04%	0.04%	0.03%	**0.04%**
	Incidents causing extreme harm/death	number	-	Mar-19	Julian Redhead	0	0	1	**0**
	Incidents causing extreme harm/death (cumulative financial YTD)	number	<13	Mar-19	Julian Redhead	4	4	5	**5**
	Incidents causing extreme harm/death (cumulative financial YTD)	%	<0.10%	Mar-19	Julian Redhead	0.03%	0.03%	0.03%	**0.03%**
	Patient safety incident reporting rate (against top quartile of trusts)	incidents / 1,000 bed days	>=46.96	Mar-19	Julian Redhead	42.35	47.60	43.38	**46.96**
	Never events	number	0	Mar-19	Julian Redhead	0	2	0	**0**
	PSAs overdue (by month)	number	0	Mar-19	Julian Redhead	0	0	0	**0**
	PSAs closed late in the preceding 12 months	number	0	Mar-19	Julian Redhead	0	0	0	**0**
	MDAs overdue (by month)	number	0	Mar-19	Janice Sigsworth	0	0	0	**0**
	MDAs closed late in the preceding 12 months	number	0	Mar-19	Janice Sigsworth	5	5	4	**2**
	Compliance with duty of candour (SIs)	%	100%	Feb-19	Julian Redhead	100.0%	66.7%	88.9%	**71.4%**
	Compliance with duty of candour (SIs) (rolling 12 month)	%	100%	Feb-19	Julian Redhead	91.0%	90.7%	90.8%	**90.9%**
	Compliance with duty of candour (Level 1)	%	100%	Feb-19	Julian Redhead	85.7%	100.0%	66.7%	**78.6%**
	Compliance with duty of candour (Level 1) (rolling 12 month)	%	100%	Feb-19	Julian Redhead	92.4%	95.9%	98.9%	**93.7%**
	Compliance with duty of candour (Moderate)	%	100%	Feb-19	Julian Redhead	100.0%	88.9%	100.0%	**100.0%**
	Compliance with duty of candour (Moderate) (rolling 12 month)	%	100%	Feb-19	Julian Redhead	92.4%	93.6%	97.6%	**97.5%**
Infection prevention and control	Trust-attributed MRSA BSI	number	0	Mar-19	Julian Redhead	0	0	0	**0**
	Trust-attributed MRSA BSI (cumulative financial YTD)	number	0	Mar-19	Julian Redhead	3	3	3	**3**
	Trust-attributed Clostridium difficile	number	7	Mar-19	Julian Redhead	2	4	6	**4**
	Trust-attributed Clostridium difficile (cumulative financial YTD)	number	68	Mar-19	Julian Redhead	37	41	47	**51**
	Trust-attributed Clostridium difficile (related to lapses in care)	number	0	Mar-19	Julian Redhead	1	1	1	**0**
	Trust-attributed Clostridium difficile (related to lapses in care) (cumulative)	number	0	Mar-19	Julian Redhead	9	10	11	**11**
	E. coli BSI	number	#N/A	Mar-19	Julian Redhead	5	6	6	**3**
	E. coli BSI (cumulative financial YTD)	number	#N/A	Mar-19	Julian Redhead	68	74	80	**83**
	CPE BSI	number	0	Mar-19	Julian Redhead	0	0	0	**1**
	CPE BSI (cumulative financial YTD)	number	0	Mar-19	Julian Redhead	6	6	6	**7**

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Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Safe									
VTE	VTE risk assessment	%	>=95%	Mar-19	Julian Redhead	94.5%	93.8%	94.3%	**93.8%**
Flu	Flu vaccination for frontline healthcare workers	%	>=75%	Mar-19	Kevin Croft	49.8%	53.3%	60.2%	**-**
Maternity standards	Ratio of births to midwifery staff	ratio	1:30	Mar-19	Tg Teoh	1.26	1.26	1.26	**1.26**
	Puerperal sepsis	%	<=1.5%	Mar-19	Tg Teoh	1.03%	0.40%	1.00%	**0.29%**
Safe staffing	Safe staffing - registered nurses	%	>=90%	Mar-19	Janice Sigsworth	96.6%	96.7%	97.1%	**96.9%**
	Safe staffing - care staff	%	>=85%	Mar-19	Janice Sigsworth	94.1%	94.8%	95.8%	**95.3%**
Workforce and people	Core skills training	%	>=85%	Mar-19	Kevin Croft	90.2%	90.5%	91.9%	**92.1%**
	Core clinical skills training	%	>=85%	Mar-19	Kevin Croft	90.7%	92.4%	92.0%	**91.7%**
	Safeguarding children training (level 3)	%	>=90%	Mar-19	Janice Sigsworth	81.3%	83.3%	90.6%	**90.1%**
	Vacancy rate - Trust	%	<10%	Mar-19	Kevin Croft	13.4%	13.3%	13.0%	**13.5%**
	Vacancy rate - nursing and midwifery	%	<13%	Mar-19	Kevin Croft	16.1%	15.5%	15.0%	**15.7%**
Health and safety	Departmental safety coordinators	%	>=75%	Mar-19	Kevin Croft	79.0%	79.0%	80.0%	82.0%
	RIDDOR	number	0	Mar-19	Kevin Croft	2	6	2	**5**
	Fire warden training	%	>=10%	Mar-19	Janice Sigsworth	13.0%	13.0%	13.0%	**13.0%**
	Medical devices maintenance - high risk	%	>=98%	Mar-19	Janice Sigsworth	98.0%	98.0%	97.0%	**96.0%**
	Medical devices maintenance - medium risk	%	>=80%	Mar-19	Janice Sigsworth	89.0%	89.0%	86.0%	**82.0%**
	Medical devices maintenance - low risk	%	>=70%	Mar-19	Janice Sigsworth	91.0%	91.0%	84.0%	**82.0%**
Estates and Facilities	Cleanliness audit scores (very high risk patient areas)	%	>=98%	Mar-19	Janice Sigsworth	90.0%	80.0%	89.0%	**88.0%**
	Cleanliness audit scores (high risk patient areas)	%	>=95%	Mar-19	Janice Sigsworth	94.0%	89.0%	92.0%	**91.0%**
	Lifts in service (main passenger and bed lifts)	%	>=90%	Mar-19	Janice Sigsworth	98.0%	97.0%	98.2%	**99.7%**
	Reactive maintenance tasks completed within the allocated timeframe	%	>=70%	Mar-19	Janice Sigsworth	44.0%	26.0%	35.3%	**33.2%**
	Planned maintenance tasks completed within the allocated timeframe	%	>=70%	Mar-19	Janice Sigsworth	90.0%	100.0%	100.0%	**99.9%**
	Compliance with statutory and mandatory estates requirements	%	>=85%	Mar-19	Janice Sigsworth	95.0%	100.0%	100.0%	**99.9%**

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Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Effective									
Mortality indicators	Trust ranking as per monthly data (HSMR)	rank	top 5 lowest risk acute Trusts	Dec-18	Julian Redhead	5th lowest	17th lowest	4th lowest	**3rd lowest**
	HSMR	ratio		Dec-18	Julian Redhead	61.00	74.00	60.00	**53.00**
	Trust ranking as per most recent full year data (SHMI)	rank		Q2 17/18–Q1 18/19	Julian Redhead	3rd lowest	4th lowest	4th lowest	**4th lowest**
	SHMI	ratio		Qtr 2 18/19	Julian Redhead	73.18	78.62	69.08	**66.84**
	Palliative care coding	%	100%	Dec-18	Julian Redhead	100.0%	100.0%	100.0%	**100.0%**
Mortality reviews (at 06/03/2019)	Total number of deaths	number	-	Feb-19	Julian Redhead	133	145	153	**124**
	Number of local reviews completed	number	-	Feb-19	Julian Redhead	124	134	143	**95**
	Local reviews completed	%	100%	Feb-19	Julian Redhead	93.2%	92.4%	93.5%	**76.6%**
	SJR reviews requested	number	-	Feb-19	Julian Redhead	19	24	20	**18**
	Number of SJR reviews completed	number	-	Feb-19	Julian Redhead	16	22	17	**6**
	SJR reviews completed	%	100%	Feb-19	Julian Redhead	84.2%	91.7%	85.0%	**33.3%**
	Avoidable deaths	number	0	Feb-19	Julian Redhead	0	0	1	**1**
	Avoidable deaths (cumulative financial YTD)	number	0	Feb-19	Julian Redhead	6	6	7	**8**
Readmissions	Unplanned readmission rates - under 15 yr olds	%	<9.33%	Sep-18	Tg Teoh	4.5%	3.8%	4.0%	**5.3%**
	Unplanned readmission rates - over 15 yr olds	%	<8.09%	Sep-18	Frances Bowen	6.7%	7.0%	7.6%	**7.1%**
Patient reported outcomes	PROMs - participation rates (Hips)	%	>=80%	Feb-19	Julian Redhead	0.0%	100.0%	100.0%	**67.2%**
	PROMs - reported health gain (Hips)	-	>national avg	April17–Mar	Julian Redhead	EQ-5D Index:**0.464** EQVAS:**15.379** Oxford Hip score:**21.950**			
	PROMs - participation rates (Knees)	%	>=80%	Feb-19	Julian Redhead	100.0%	100.0%	100.0%	**80.1%**
	PROMs - reported health gain (Knees)	-	>national avg	April17–Mar	Julian Redhead	EQ-5D Index:**0.298** EQVAS:**8.283** Oxford Knee score:**13.870**			
National Clinical Audits	Participation in relevant national clinical audits (cumulative financial YTD)	%	100%	Dec-18	Julian Redhead	100.0%	100.0%	100.0%	**100.0%**
	High risk/significant risk audits with action plan in place (cumulative financial YTD)	%	100%	Dec-18	Julian Redhead	100.0%	100.0%	100.0%	**100.0%**
	Review process not completed within 90 days	number	0	Dec-18	Julian Redhead	8	8	13	**13**

Clinical trials	Clinical trials - recruitment of 1st patient within 70 days (%)	%	>=90%	Qtr 3 18/19	Julian Redhead	Qtr 2 18/19	**Qtr 3 18/19**
						95.7%	**93.9%**

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Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Caring									
Friends and Family	FFT A&E service - % recommended	%	>=94%	Mar-19	Janice Sigsworth	96.5%	95.4%	94.9%	**93.6%**
	FFT inpatients - % recommended	%	>=94%	Mar-19	Janice Sigsworth	98.0%	97.7%	96.7%	**97.7%**
	FFT outpatients - % recommended	%	>=94%	Mar-19	Janice Sigsworth	93.3%	93.8%	94.6%	**94.2%**
	FFT maternity - % recommended	%	>=94%	Mar-19	Janice Sigsworth	92.7%	93.6%	93.5%	**92.9%**
	FFT A&E service - % response rate	%	>=20%	Mar-19	Janice Sigsworth	13.9%	12.2%	13.9%	**18.1%**
	FFT PTS service - % recommended	%	>=90%	Mar-19	Janice Sigsworth	93.1%	92.4%	93.4%	**95.7%**
Mixed sex accommodation	Mixed-sex accommodation breaches	number	0	Mar-19	Janice Sigsworth	34	50	33	**50**
Well led									
Workforce and people	Staff retention (Stability)	%	>=80%	Mar-19	Kevin Croft	84.8%	85.0%	84.9%	**85.3%**
	Voluntary staff turnover rate (12-month rolling)	%	<12%	Mar-19	Kevin Croft	11.7%	11.7%	11.6%	**11.3%**
	Sickness absence rate (12-month rolling)	%	<=3%	Mar-19	Kevin Croft	3.12%	3.13%	3.13%	**3.13%**
	Doctor appraisal rate	%	>=95%	Mar-19	Julian Redhead	91.0%	91.7%	91.1%	**93.8%**
NHSI segmentation	NHSI - provider segmentation	number	-	Mar-19	Richard Alexander	3	3	3	**3**

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Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Responsive									
Referral to treatment (elective care) 9%	RTT incomplete pathways 18 weeks performance	%	>=92%	Mar-19	Catherine Urch	83.9%	84.6%	84.3%	**84.4%**
	RTT variance against 2018/19 trajectory target	%	86.3%	Mar-19	Catherine Urch	*-2.1%*	*-1.5%*	*-1.8%*	***-2.0%***
	RTT total waiting list (incomplete PTL)	number	-	Mar-19	Catherine Urch	67,860	64,660	62,848	**61,317**
	RTT incomplete pathways over 18 weeks	number	-	Mar-19	Catherine Urch	10,893	9,977	9,864	**9,588**
	RTT patients waiting 52+ weeks	number	0	Mar-19	Catherine Urch	11	44	91	**0**
	RTT patients waiting 52+ weeks reviewed for clinical harm	%	100%	Mar-19	Catherine Urch	100.0%	100.0%	100.0%	**100.0%**
	RTT cases of clinical harm found after the clinical harm review	number	0	Mar-19	Catherine Urch	0	0	0	**0**
Cancer waiting times 1%	Cancer - 62 day urgent GP referral to treatment	%	>=85%	Mar-19	Catherine Urch	86.8%	82.4%	**86.2%**	**86.8%**
Theatre utilisation	Theatre Touchtime Utilisation (elective)	%	>=95%	Mar-19	Catherine Urch	79.8%	75.1%	79.4%	**78.6%**
Cancelled operations	Cancelled operations (elective)	%	<=0.8%	Mar-19	Catherine Urch	0.67%	1.09%	0.57%	**0.46%**
	28 day rebooking breach rate	%	<=5%	Mar-19	Catherine Urch	31.82%	7.20%	21.31%	**15.38%**
Critical Care	Critical care patients admitted within 4 hours	%	100%	Mar-19	Catherine Urch	92.3%	92.5%	91.8%	**95.8%**
Urgent and Emergency Care 1%	A&E patients seen within 4 hours (all types)	%	>=95%	Mar-19	Frances Bowen	88.4%	86.7%	88.1%	**88.4%**
	A&E variance against 2018/19 trajectory target	%	95.0%	Mar-19	Frances Bowen	*-1.8%*	*-3.7%*	*-2.5%*	***-6.6%***
	A&E patients seen within 4 hours (type 1)	%	>=95%	Mar-19	Frances Bowen	73.9%	69.3%	72.6%	**74.6%**
	A&E patients spending >12 hours from Decision to Admit	number	0	Mar-19	Frances Bowen	5	10	4	**10**
Bed management LoS 3%	Patients with length of stay 7+ days	%	tbc	Mar-19	Frances Bowen	-	57.5%	57.7%	**57.3%**
	Patients with length of stay 21+ days	%	25% from baseline	Mar-19	Frances Bowen	-	25.3%	25.6%	**24.8%**
Bed management Discharges	Delayed transfer of care	%	3.50%	Mar-19	Frances Bowen	2.5%	2.5%	2.8%	**2.8%**
	Discharges before noon	%	>=33%	Mar-19	Frances Bowen	16.51%	15.39%	14.32%	**14.54%**
Diagnostics 3%	Diagnostic waits – over 6 weeks	%	<1%	Mar-19	Tg Teoh	2.10%	0.78%	0.50%	**0.61%**

Data reliability scores are currently provided for the above RTT, Cancer, Emergency care and Long stay patient datasets

Key: Data reliability score

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

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

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Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Responsive									
Outpatient management	Waiting times for first outpatient appointment	weeks	<8	Mar-19	Tg Teoh	7.0	7.8	7.4	**7.4**
	Outpatient DNA	%	<10%	Mar-19	Tg Teoh	11.2%	11.1%	10.5%	**10.2%**
	Outpatient HICS rate with less than 6 weeks' notice	%	<7.5%	Mar-19	Tg Teoh	7.4%	7.6%	8.6%	**8.2%**
	Outpatient HICS rate pushed back to late date	%	<7.5%	Mar-19	Tg Teoh	7.0%	6.9%	7.8%	**7.2%**
	Outpatient appointments within 5 working days of receipt	%	>=95%	Mar-19	Tg Teoh	96.3%	97.6%	96.4%	**97.2%**
Complaints management	PALS concerns	number	<250	Mar-19	Janice Sigsworth	165	253	230	**180**
	Complaints - formal complaints	number	<90	Mar-19	Janice Sigsworth	89	89	100	**88**
	Complaints – the average number of days to respond	days	40	Mar-19	Janice Sigsworth	**28**	29	28	**28**
	Patient satisfaction with overall handling of complaints	%	>=70%	Mar-19	Janice Sigsworth	-	-	**89.0%**	**84.0%**
Data quality indicators	Orders waiting on the Add/Set Encounter request list	number	0	Mar-19	Catherine Urch	*1,051*	*1,145*	*1,149*	**1,320**
	OP appointments 'not checked-in' or DNA'd	number	500	Mar-19	Tg Teoh	*3,098*	*3,212*	*3,189*	**3,484**
	OP appointments 'not checked out'	number	550	Mar-19	Tg Teoh	*2,167*	*2,363*	*2,347*	**2,572**
Patient Transport	All Journeys: Collection Time (60 Mins)	%	>97%	Mar-19	Janice Sigsworth	95.0%	94.2%	93.4%	**94.1%**
	All Journeys: Collection Time (150 Mins)	%	100%	Mar-19	Janice Sigsworth	99.3%	99.4%	99.4%	**99.5%**
	Journeys 0-5 Miles: Time On Vehicle (60 Mins)	%	>95%	Mar-19	Janice Sigsworth	92.7%	91.1%	90.4%	**89.5%**
	Journeys 5-10 Miles: Time On Vehicle (60 Mins)	%	>85%	Mar-19	Janice Sigsworth	80.5%	75.3%	72.4%	**70.9%**

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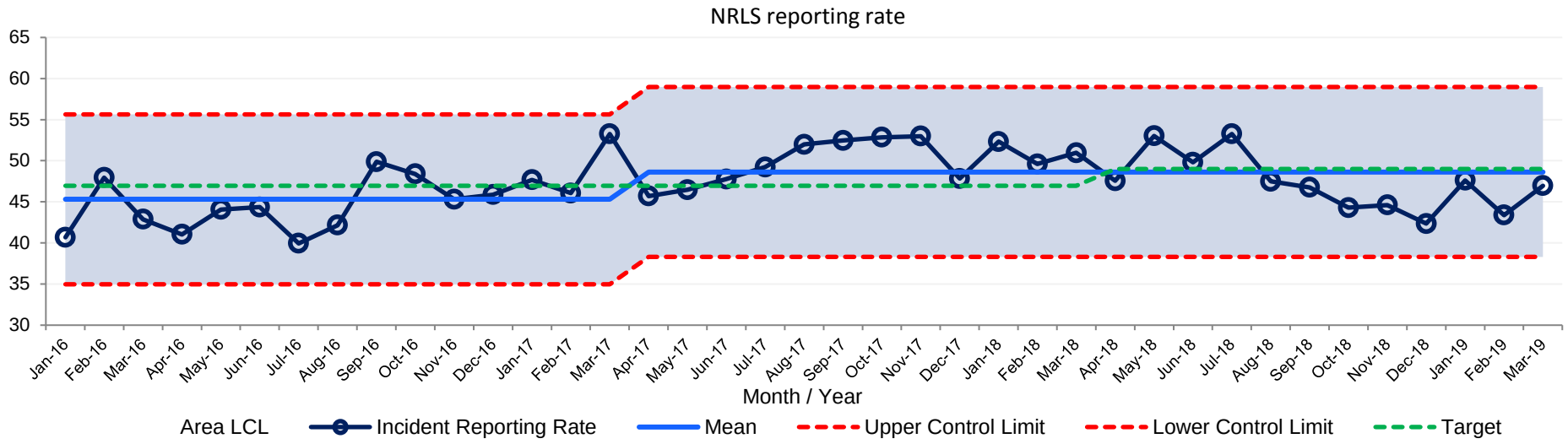
Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Dec-18	Jan-19	Feb-19	Mar-19
Use Of Resources									
Finance KPIs	Monthly finance score (1-4)	number	-	Mar-19	Richard Alexander	3	3	3	**3**
	In month Position	£m	-	Mar-19	Richard Alexander	-0.52	-3.61	2.33	**0.32**
	YTD Position £m	£m	-	Mar-19	Richard Alexander	5.62	7.59	8.72	**10.68**
	Annual forecast variance to plan	£m	-	Mar-19	Richard Alexander	-1.92	-4.00	-1.64	**0.32**
	Agency staffing	%	-	Mar-19	Richard Alexander	4.1%	4.2%	4.1%	**4.1%**
	CIP (cumulative financial YTD)	%	-	Mar-19	Richard Alexander	73.8%	77.5%	76.9%	**-**

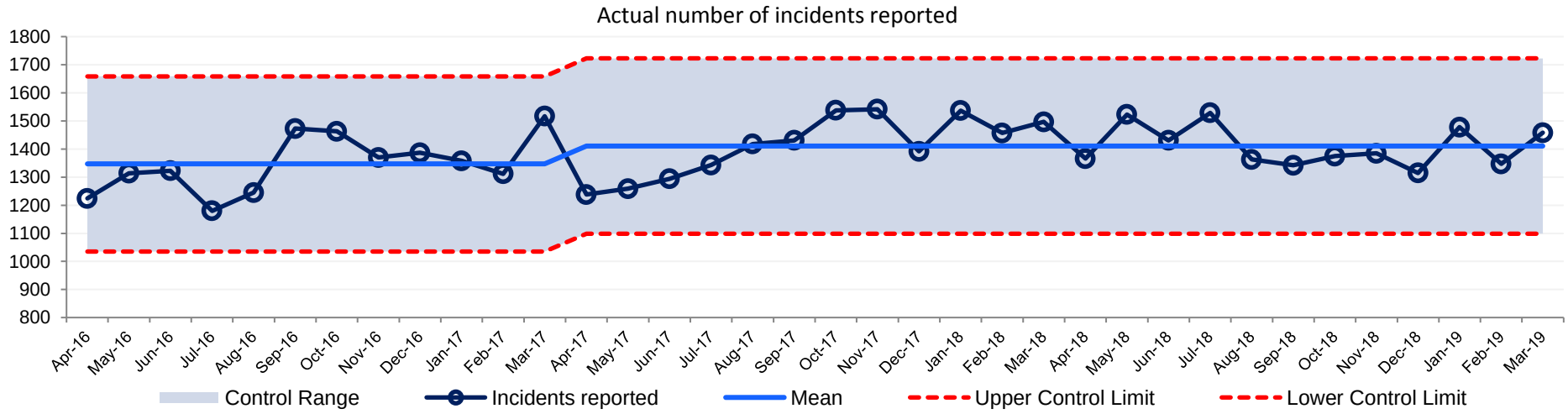
Appendix 1: IQPR Exception report slides at month 12

Domain	Report
Safe	Incident reporting rate
Safe	Never events
Safe	Compliance with duty of candour
Safe	VTE
Safe	MRSA BSI and C.difficile
Safe	E.Coli
Safe	CPE
Safe	National clinical audits
Safe	Vacancy rates
Safe	Medical devices maintenance
Effective	National clinical audits
Effective	Mortality reviews
Effective	PROMs
Caring	FFT A&E service - % response
Caring	Mixed sex accommodation
Well led	Doctor appraisal rate
Responsive	RTT 18 week waits
Responsive	Theatre touchtime utilisation (elective)
Responsive	Cancelled operations / 28-day Rebookings
Responsive	Critical care admissions
Responsive	A&E patients seen within 4 hours
Responsive	A&E 12-hour waits
Responsive	Outpatient DNA
Responsive	Outpatient HICs
Responsive	DQI: Orders waiting on the Add/Set Encounter request list
Responsive	DQI: Outpatient appointments not checked in / not checked out

Safe – Patient safety incident reporting

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain our incident reporting numbers and be within the top quartile of trusts	In top quartile (48.98)	43.38 – February 2019 46.96 – March 2019	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance





Safe – Patient safety incident reporting

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain our incident reporting numbers and be within the top quartile of trusts	In top quartile (48.98)	43.38 – February 2019 46.96 – March 2019	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance

Latest performance

In March 2019, the NRLS published their bi-annual incident reporting data for acute non-specialist trusts for the period April 2018 – September 2018. Our incident reporting rate for this time period was 50.4 per 1,000 bed days, which is in the top quartile. The reporting rate increased nationally during this time period and the target to be in this quartile has now increased to 48.98.

To generate up to date reporting rates we use NRLS methodology using bed day data that is submitted to NHS England (quarterly in arrears). Bed occupancy levels have increased in the quarter 3 submission which has led to a reduction in our reporting rate when we apply that retrospectively.

Although the bed occupancy level was expected to rise due to changes in bed numbers and recording of our long stay patients this was higher than anticipated as the methodology for generating the data was changed in Q3. This methodology inflated the occupancy level which will be rectified for the Q4 submission.

Between August 2018 – March 2019 we also reported fewer incidents. The monthly total fell below the mean for five of those months. Therefore we are now below our target when comparing reporting rate and overall numbers.

Safe – Patient safety incident reporting

Key issues	A high reporting rate with low levels of harm is one indicator of a positive safety culture. Actions being taken to improve our incident reporting rate are outlined below.

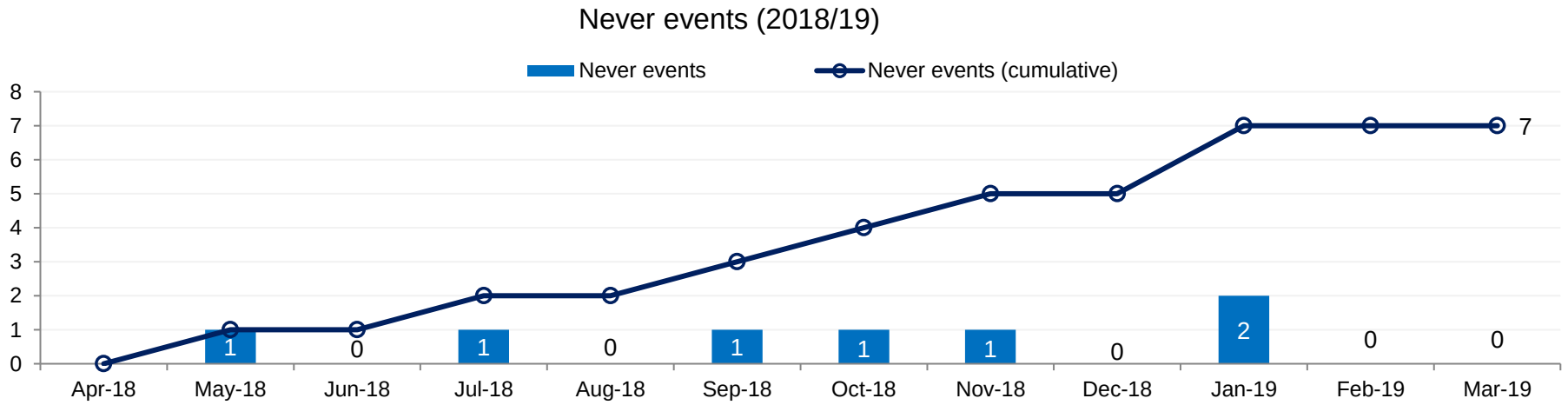
Improvement plans and actions	Lead	Timescale	Progress update
Trust wide communications via the intranet and monthly safety briefings	Improvement Manager for Safety Head of Quality Compliance and Assurance	31/05/19	Safety briefing for May to focus on incident reporting. To encourage consultants to report information will be included in June's Responsible Officer newsletter. Intranet story about the link between incident reporting numbers and positive culture to be published. A new safety page is being developed for the intranet which will provide information on incidents and highlighting that any incident, no matter how small should be reported.
Focussed awareness and education with key staffing groups	Head of Quality Compliance and Assurance	31/05/19	Corporate welcome and junior doctor sessions have been refreshed to encourage staff to report. A review of the training available is underway.
Local engagement work within individual directorates and divisions.	Divisional Directors of Nursing & Governance	Q1 2019/20	Analysis of reporting activity at divisional and directorate shared. Communication campaign to share examples of what incidents should be reported as well as improvements made in response to commence. Support to areas with low reporting numbers to encourage and train team members in identification and reporting to be arranged. Opportunities to shadow key staff groups to identify incidents that may not be reported planned – to pilot in SCCS.
Pilot of Care Report – to simplify reporting platform.	Head of Quality Compliance and Assurance	Q1 2019/20	This will be trialled in A&E at SMH in Q1 2019/20.

Risk

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

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	February 2019 - 0 March 2019 – 0 (YTD – 7)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	Seven never events were reported in 2018/19; one wrong route medication incident in May, one retained swab in July, one retained foreign object incident in September, one wrong site surgery in October, one wrong site block in November, one wrong site block and one retained swab in January 2019. There were no declared never events in February or March 2019. A request to re-categorise a Never Event to a SI was submitted to the CCG in October 2018 and was rejected. The incident related to a retained foreign body (vaginal pack). Following investigation, it was found that the swab concerned had been intentionally retained. The intention to retain the pack was documented therefore this does not technically meet the criteria for a Never Event. Advice was sought from NHSI and a meeting was held between the medical director, senior members of the Trust's quality and safety team and senior members of the CCGs quality and safety team in February to review their rationale for rejecting the de-escalation request. Following discussion with NHSI the CCG have agreed to re-categorise the incident to an SI once an assurance visit has been completed by the commissioners, which is being arranged before the end of May 2019.
Return to target / trajectory	A trust wide action plan has been implemented in response to the invasive procedure never events, which is outlined on the following slide; this should support a reduction in the number of never events.

Safe – Never Events

Issues and root causes	The seven most recent never events, including the one in April 2019, are all related to invasive procedures. Our audit of the WHO checklist (November 2018) also shows there is more to be done in relation to following the 5 steps to safer surgery (particularly the brief and debrief). In addition we have also declared a number of serious incidents where there were issues with the WHO checklist and/or which were related to safety with invasive procedures.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Develop and implement trustwide action plan to reduce the risk of never events and improve patient safety for interventional procedures	Medical Director	March 2019	Action plan developed and presented to ExQu 08/01/19. This was amended with additional actions included following the two most recent NEs. The final action plan was presented to Trust Board 30/01/19. It is being delivered through the invasive procedures T&F group. Progress with individual actions is outlined below, and on the following slide.
Undertake engagement with clinical workforce	Medical Director	May 2019	Communication regarding the most recent never event circulated within the division. Email to all staff being drafted from the medical director Conversation café with the staff involved took place on 3rd May
Deliver simulation and coaching programme to all invasive procedure staff	Trust lead surgeon	TBC	Programme expedited using risk based approach; the first 5 specialties where there have been never events were prioritised and will have had their first sessions by the end of May. Timetable in place for roll out to other specialties from June 2019.
External review of actions and response to Never events	Medical Director	Complete	Meeting with national director of patient safety took place on 21st March. Dr Fowler was supportive of the actions and approach we are taking.

Risk

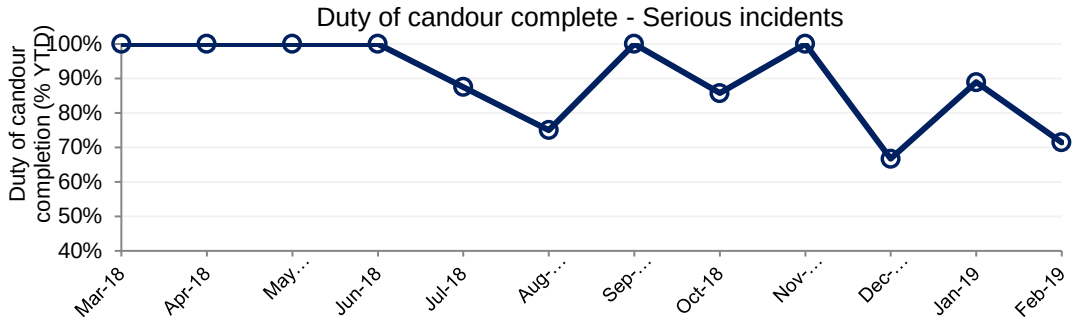
- Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2942 Potential harm to patients caused by a failure to follow invasive procedure policies and guidelines)

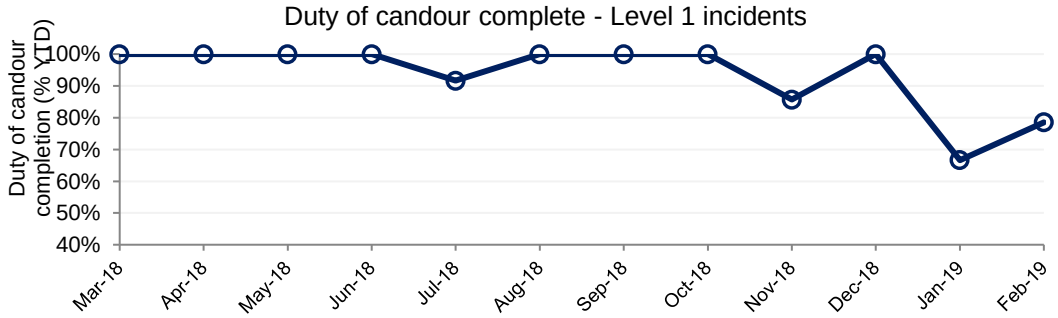
Safe – Never Events

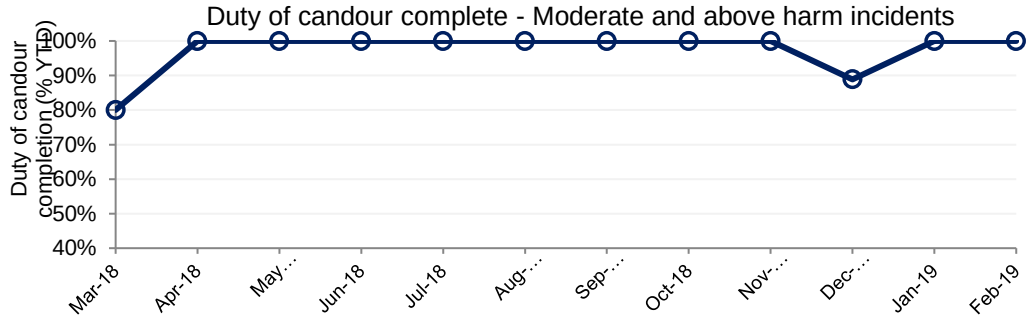
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review all Trust policies and guidelines relating to invasive procedures to ensure they are in line with national guidance and are audited	Divisions	March 2019	Count, Consent and Invasive procedures policies have been approved. The maternity adapted count guideline is due for approval at T&F on 15th May. The site marking policy is under review by the Trust Lead Surgeon and is expected to be completed in June 2019. The preparation for invasive procedures policy is being reviewed as part of a working group looking at pre-operative handover. This is expected to be completed in June 2019. Plans are in place within the divisions to implement any outstanding LocSSIPs by June 2019. The Trustwide audit of the WHO checklist, count policy and Stop Before You Block will commence on 3rd June 2019 – an audit tool has been agreed and an implementation plan is in place.
Ensure 100% compliance for all staff with the invasive procedure electronic training module	Divisions	Overdue	The divisions have confirmed that there are 17 staff members who are still required to undertake the invasive procedures training and have not done so. These staff members have had a letter from their manager setting out the HR process they are now entering.
Review and evaluation of all actions taken previously in response to never events	Divisions	March 2019	Spot check audits confirm that signs informing staff 'Don't interrupt the anaesthetist when the patient is in the anaesthetic room' and use of whiteboards to display intended site are in use. Testing of radiopaque markers in radiology complete – agreed not to be taken forward. Review of previous actions undertaken by PSTRC – this is being shared with the T&F group members for review and discussion at the meeting in mid-May.

Safe – Compliance with duty of candour

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	SIs: 90.9% Internal investigations: 93.7% Moderate and above incidents: 97.5% (cumulative data for incidents reported March 2018 – Feb 2019)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance







Latest performance

Serious Incidents
Jan 2019 – 1 SI out of 9 has not had DoC completed. In month compliance is therefore 88.9%.
Feb 2019 – 2 SIs out of 7 have not had DoC completed. In month compliance is therefore 71.4%.

Level 1s
Jan 2019 – 1 level 1 out of 3 has not had DoC completed. In month compliance is therefore 66.7%.
Feb 2019 – 3 level 1s out of 14 have not had DoC completed. In month compliance is therefore 78.6%.

All other moderate and above incidents
All moderates and above have had DoC completed in Jan and Feb 2019. In month compliance is therefore 100%.

Return to target / trajectory

There are currently 8 SIs, 6 Level 1s and 2 moderate and above incidents which have been reported between March 2018 and February 2019 which have not had DoC completed. The DIHub will provide the divisions with an exception report describing DoC activity and themes for gaps in compliance w/c 6th May The divisions will be asked to present specific actions for each individual case at the MD incident panel on 10th May and agree steps for closure by 17th May.

Safe – Compliance with duty of candour

Issues and root causes	Overall, duty of candour compliance has improved with performance over 90% for all incidents. Some issues remain around completion of both parts of the DoC process (Part 1 – the initial conversation, and part 2 – the follow up letter). As per the previous slide this is being reviewed by the divisions and a plan for closure of all cases will be provided at the medical director's incident panel on 10th May.

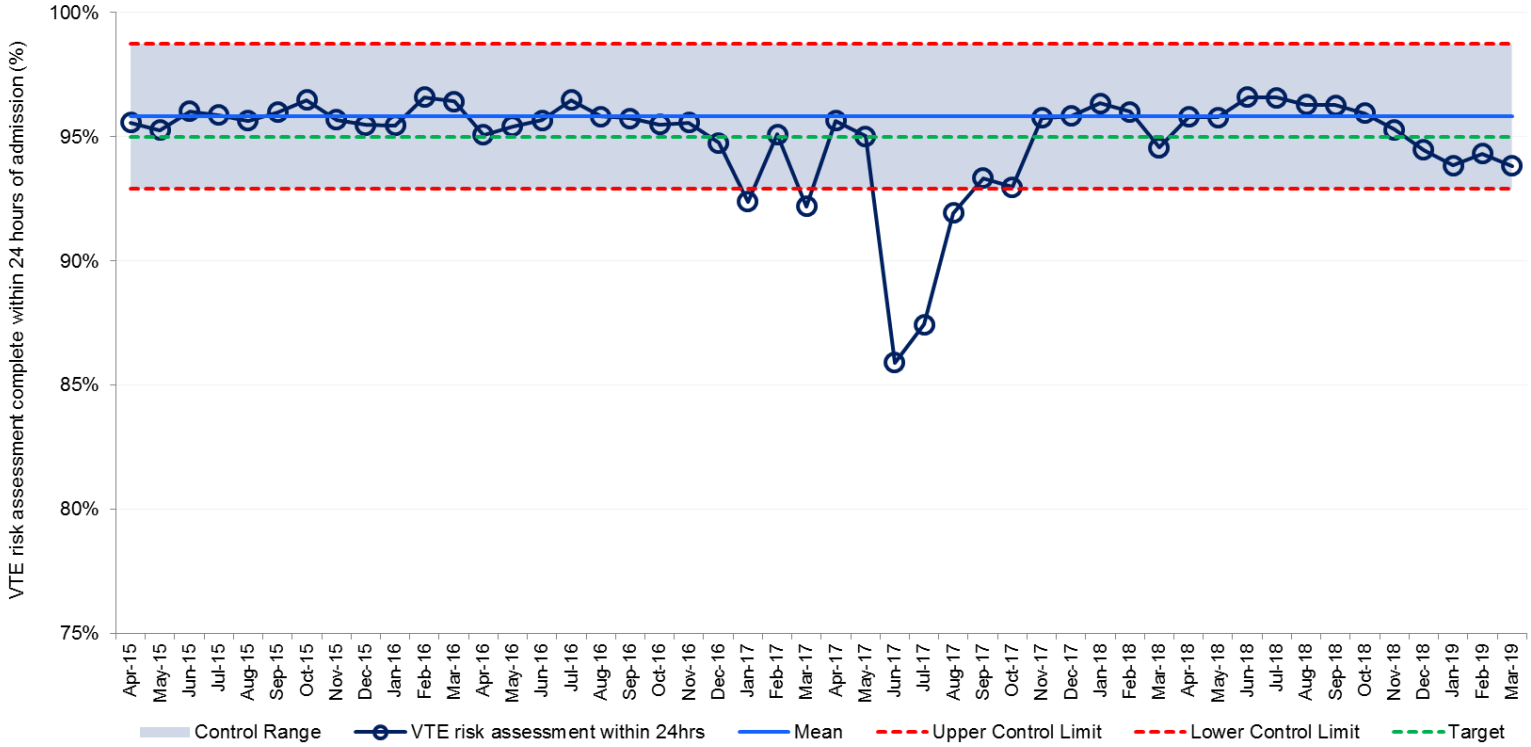
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Director's Incident Meeting.	Head of Quality Compliance & Assurance	Ongoing	Progress has been made over the past year, all outstanding cases are reviewed at the weekly MD panel. A reminder to consultants of the required timeframe to complete the DoC letter was included in the RO newsletter in March 2019.
95% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisions	March 2018 - overdue	Overdue. Divisions continue to be below the 95% target. As of 11th April 2019 consultant compliance is 86% (MIC), 90% (SCC) and 93% (WCCS). Trajectories to get to 95% will be presented to the sub-group in May. The denominator for nursing staff is being reviewed to ensure an accurate picture of nursing compliance can be provided.
Duty of candour letter templates to be reviewed	Head of Quality Compliance & Assurance	End November 2018 (amended to end of March 2019)	Complete. Templates were approved at sub-group in March.

Risk

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

Safe – VTE

Indicator	Target	Latest data	Executive lead	Report author(s)
We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission, and maintain zero cases of avoidable harm	95%	Feb 2019 – 94.32% March 2019 – 93.82%	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	VTE assessment compliance rates have been below the target of 95% since December 2018. Performance at divisional level is above target in WCCS, however MIC and SCCS are not meeting the target.
Return to target / trajectory	Preliminary data for April 2019 shows performance remains below target, although it is improving. The most recent data available is for w/c 21st April and is 94.85%. We are expecting compliance to return to 95% in May 2019.

Safe – VTE

Issues and root causes	Actions are in place within the divisions for the areas where the target is not being met, however a review of the data has identified some issues regarding the trigger for VTE assessment in Cerner which are contributing to the fall in compliance.

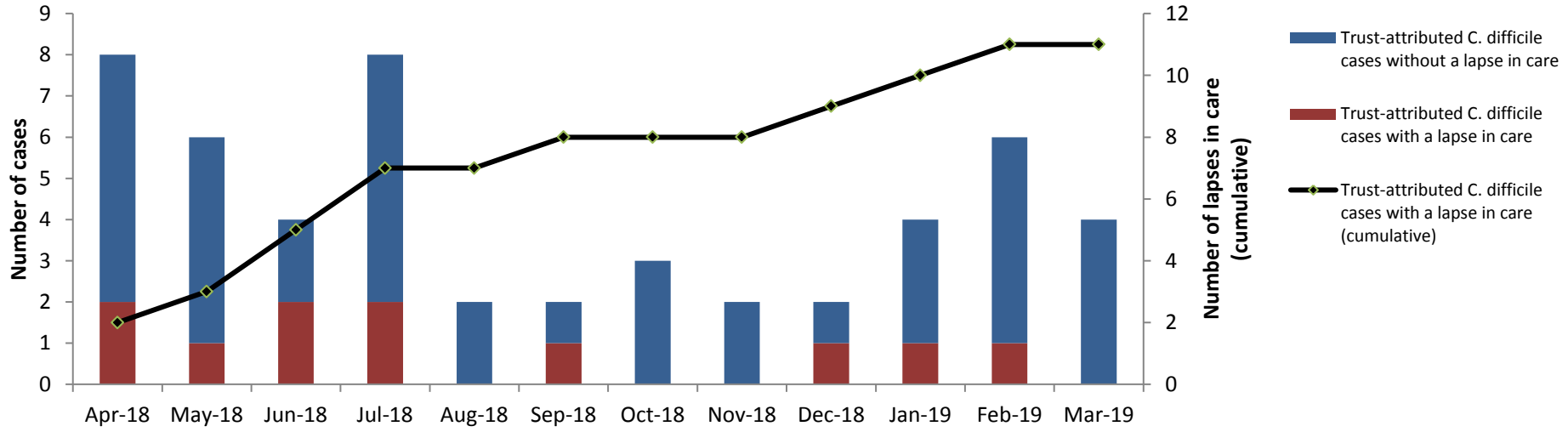
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review cohorting of low risk patients	Clinical Lead – VTE	April 2019	Divisions have been sent lists of all wards and asked to confirm which should be cohorted as low risk and therefore not requiring assessment by the end of April 2019.
Amend Cerner so that the prescribing module is locked until a VTE assessment is completed	Clinical Lead – VTE	May 2019	In progress – changes going to change board week commencing 29/04/19 with go live expected during May.
Review metric in light of new NICE guidance	Clinical Lead – VTE	May 2019	Updated NICE guidance indicates VTE assessment to be completed by first consultant review (standard 14 hours) as opposed to the 24 hours we currently report. This has not been amended in the standard contract. We will continue to report on performance against the 24 hour target set out in our policy while we review this.
Review data to see whether VTE assessment might be preventing positive VTE diagnosis and whether there is an association between increasing assessment and reduced complications.	Data analytics team	June 2019	The GDE Clinical Analytics team is reviewing the value of increasing VTE assessment completion from 95% to 100%. The first step was to understand whether there is any correlation between VTE episodes, risk assessment completion and prophylaxis administration. Although this is work in progress, the initial analysis implies that in those inpatients who have been assessed as being at Risk of Thrombosis (and have NO Bleeding risk OR Contraindication to medications or Stockings), there is over a two-fold increased incidence of VTE in patients who were not given appropriate prophylaxis within 24 hours of the risk assessment being undertaken. Further analysis is being undertaken and will be reported during Q1, We are developing reports which will allow us to better monitor the percentage of patients who received appropriate prophylaxis and the outcomes of RCAs.

Risk

- Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2149 Non-compliance with VTE assessment)

Safe – MRSA BSI and *C.difficile*

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 lapse in care	0	MRSA BSI: 0 – February 2019 0 – March 2019 MRSA BSI YTD: 3 *C.difficile* lapse in care: 1 – February 2019 0 – March 2019 *C.difficile* lapse in care YTD: 11	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Zero Trust-attributable MRSA cases were reported for February and March 2019. There have been three cases reported for 2018/19. • February 2019 saw six cases of Trust-attributable *C.difficile*, one of which was identified as a lapse in care. • March 2019 saw four cases of Trust-attributable *C.difficile*, one of which was identified as a lapse in care.
Return to target / trajectory	• Target for MRSA and *C.difficile* is zero, therefore no return to target this FY 18/19

Safe – MRSA BSI and *C.difficile*

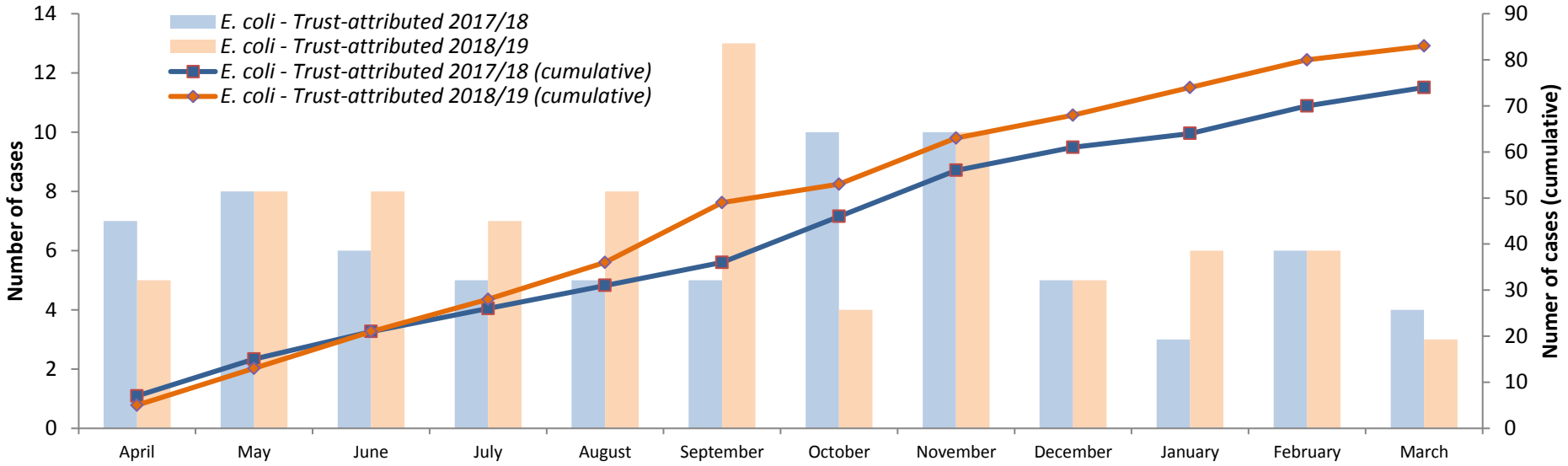
Key issues	***C.difficile*:** February 2019 saw one lapse in care of six Trust-attributable *C.difficile* cases. A patient on a Medicine ward did not have their antibiotics reviewed in line with policy, which meets the definition of a lapse in care. This has been fed back to the clinical team involved. March 2019 saw zero lapses in care of four Trust-attributable *C.difficile* cases.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Develop and implement hand hygiene improvement and communications plan	Jon Otter General Manager IPC	Ongoing	The hand hygiene improvement plans are now in progress. Implementation progress is being monitored through the Improving Care Programme Group.
Ongoing review of potential themes arising from lapses in care related to *C. difficile.*	Eimear Brannigan, Deputy DIPC	Ongoing	The lapses in care so far during 2018/19 have been reviewed and no clear themes emerge. We continue to work with Divisions in reviewing each case and identifying opportunities for preventative action, with any learning identified reviewed and shared with the clinical teams involved.

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

Safe – *E.coli*

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a 10% reduction in healthcare-associated BSIs caused by *E. coli*	10% reduction (n=65)	6 – February 2019 3 - March 2019 YTD = 83	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Six cases of Trust *E.coli* BSI have been reported for February 2019, with three cases for March 2019. This makes a total of 83 cases for 2018/19, compared with 74 cases for 2017/18. • Of the 9 cases in February and March 2019, 2 had hepatobiliary sources, 5 urinary sources and 2 were gastrointestinal or intra-abdominal collection related.
Return to target / trajectory	• 10% reduction target will not be met in 2018/19.

Safe – *E.coli*

Key issues	There were 9 cases of Trust attributable *E.coli* BSI in February and March 2019 Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. It seems likely that many of the cases of healthcare-associated *E. coli* BSI are a direct result of necessary interventions and are not preventable (e.g. those associated with neutropenia), or related to complex cases in patients with advanced malignant disease (such as those with biliary sources). However, other sources of infection are more likely to be preventable (e.g. *E. coli* BSIs associated with urinary catheters).

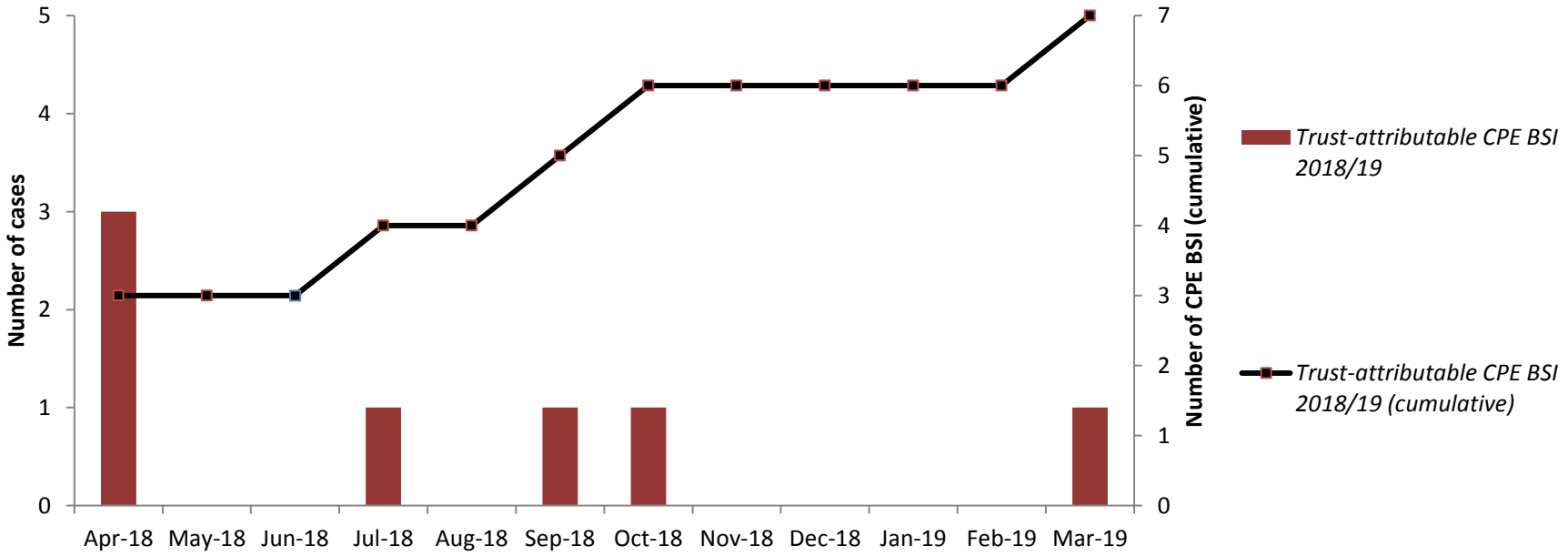
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify those cases with potential for prevention interventions.	Eimear Brannigan, Deputy DIPC	May 2019	Urinary catheter-associated Gram-negative bacteraemias to be initial focus.
Establishing an enhanced Gram-negative BSI review process via a monthly MDT group.	Eimear Brannigan, Deputy DIPC	June 2019	MDT group Terms of Reference being developed.
Circulate NHSI national toolkit for taking simple actions related to hydration, urinary catheters, and preventing surgical site infections to reduce the risk of Gram-negative BSIs.	Jon Otter, GM, IPC	April 2019	Completed. This toolkit has been circulated to frontline clinicians by the Divisions to prompt improvements aimed to prevent the development of Gram-negative BSIs.
Review the management of urinary cathertisation and patient hydration	Tracey Galletly	June 2019	Scoping of current Trust monitoring of urinary catheters / participation in LUTS Big Room. This will be performed in collaboration with the Nursing Directorate and the Divisions.
Review high risk areas (haematology, renal, NICU and post-surgical wards) for Gram-negative bacteraemias and identify potential prevention initiatives.	Eimear Brannigan, Deputy DIPC	May 2019	Surveillance of bacteraemias established in these units. Ongoing monitoring and review of cases to identify prevention strategies.

Risk

- Is it on the (divisional / corporate) risk register? Risk ID 2064 Limited surveillance of HCAI (especially SSI), which includes reference to limited capacity for CAUTI surveillance.

Safe - CPE

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have no healthcare-associated BSIs caused by CPE	0	0 – February 2019 1 – March 2019 YTD = 7	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	Zero Trust-attributable CPE BSI cases were identified in February 2019 and one case was identified in March 2019. The March 2019 case was a patient on a Medical ICU unit with multiple comorbidities. The BSI was classified as associated with a diagnosis of Ventilator-Associated Pneumonia (VAP). We have seen 7 CPE BSI cases during 2018/19 as compared to six cases this time last year 17/18. The 7 cases this year were all high risk patients with advanced malignant disease, or complex liver or urological conditions and found to be colonised with CPE prior to their BSI, which was not preventable due to unavoidable surgical and/ or medical interventions. The case reviews have not identified any specific learning points.
Return to target / trajectory	• Target for CPE BSI is zero, therefore no return to target for 2018/19

Safe - CPE

Key issues	There have been 7 CPE BSI cases during 2018/19, with zero cases for February 2019 and one case for March 2019. Each case undergoes clinical review to optimise management from the infection multidisciplinary team. A review is undertaken of each case and themes collated at intervals to identify learning and opportunities for preventive action. The Trust CPE action plan is in place and has been updated in light of an increase in cases of positive screens; this includes implementation of admission and regular CPE screening of patients on wards in which there have been transmission incidents, improving ward-level IPC practice (including the development of specific criteria for ward re-opening in the event of a CPE outbreak, reviewing toilet ratios usage and access, and reviewing cleaning standards), improving and supporting ward level screening through the development and launch of a Cerner CPE screening tool, optimising antimicrobial strategies for CPE management and treatment (including the implementation of a new report from Cerner relating to patients on carbapenem antibiotics), use of electronic patient record to flag affected patients to clinical staff, and use of serious incident processes to investigate and learn from clusters. Additionally have begun daily report of the number of patients with CPE currently in the hospital, and their location, with support from the Cerner/IT and microbiology teams. A review of the seven CPE BSIs this year have identified that all occurred in patients with advanced malignant disease or complex urological or hepatic conditions, and that no specific preventive action could have been taken.

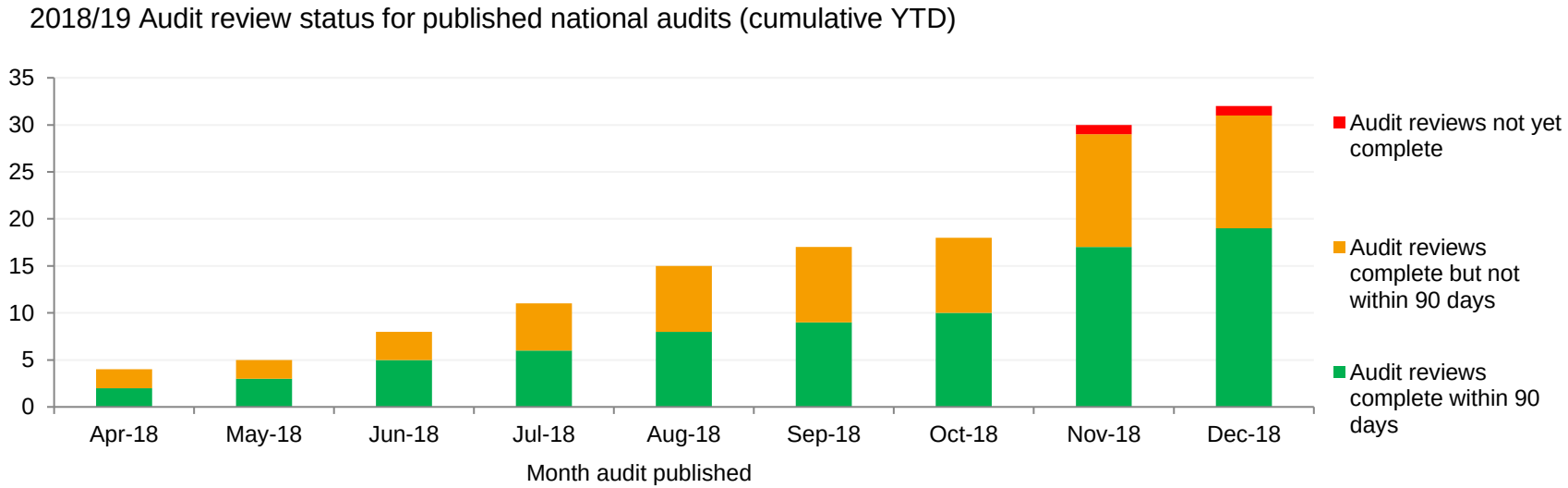
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Case review of BSIs to identify learning	Eimear Brannigan, Deputy DIPC	May 2019	The initial findings of the review of the CPE BSI cases during the FY were included in the Q3 IPC report. Updates will be provided in Q4 report.
Develop and launch Cerner CPE screening tool to promote and support implementation of CPE screening.	Tracey Galletly, Lead Nurse IPC	May 2019	The tool offered by Cerner does not meet the original specification and is being redesigned.

Risk

- Is it on the (divisional / corporate) risk register? YES (Risk ID 2487 - Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae))

Effective – National clinical audit

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits Number of audits that have not completed the review process within 90 days	100% – December 2018 13 - as at December 2018 (of which 12 have been completed but not within 90 days, and 1 is overdue and has not yet been completed)	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor



Latest performance	The graph above demonstrates performance against Quality Account reportable National audit activity up to December 2018 for the financial year 2018/19. The number of National audits will increase as the financial year progresses and as further National audit reports are published. Data is reported on a monthly basis, but the data presented here is three months in arrears to allow time to go through the Trust ratification process. There have been 33 National audits published up until the end of December 2018; 32 of these were relevant to ICHT. The review process was completed within 90 days for 19 of these audits. Of the remaining 13, 12 reviews have now been completed, but were not done in 90 days and one is overdue and not yet completed.
Return to target / trajectory	Progress is tracked weekly at the MD incident panel.

Effective – National clinical audit

Issues and root causes	Audits reports are not being consistently reviewed and risk-assessed by divisions within the internally set target of 90 days, although progress is being made. Of the thirty three audits published between April-December 2018, thirty two have completed reviews. Nineteen of these were completed within the required timeframe. Two of these audits have been identified as significant risk and have action plans in place. There have been concerns raised over Trust participation in two of the mandatory audits – BAUS and inflammatory bowel registry. MIC have confirmed that they are joining the registry and will participate from next month. SCCS have proposed that the Trust will participate in two out of six BAUS audits; for the Radical Prostatectomy Audit, we would not continue to enter data for this audit but we would continue to enter data to the National Prostate Cancer Audit which is based on HES data, and for this and the other three national audits not participated in we will review CRAB and GIRFT data whenever it is updated to provide assurance. This proposal is being discussed with the medical director.

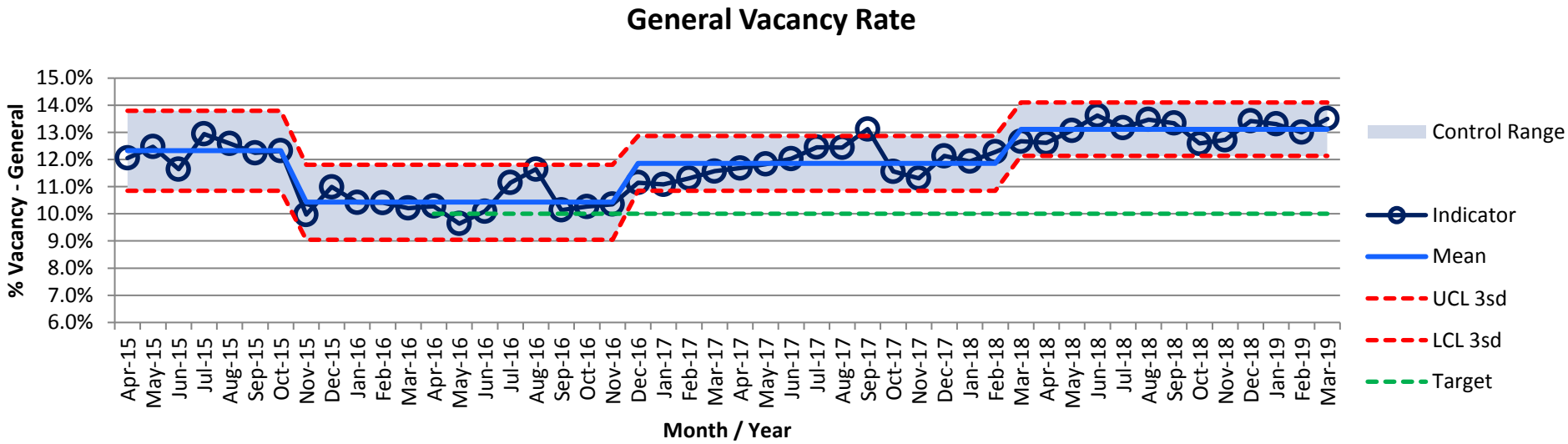
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
All significant risk audits to have an action plan in place that is presented to the quality & safety subgroup.	Raymond Anakwe/ Audit Leads	On-going	There are 2 audits from 2018/19 have been identified as significant risk so far. These are Serious Hazards Of Transfusion (SHOT) and the Case Mix (Intensive Care National Audit & Research Centre (ICNARC)), that sit within SCCS. SHOT identified issues with nurse training and the use of a checklist. ICNARC is site specific and identified issues with capacity, length of stay, out of hours discharges and VRE isolates at CXH and capacity, length of stay and discharges at SMH. Both reports and associated action plans were signed off at divisional Q&S in February. Progress against action plans will be reviewed at quality and safety sub-group in May.
Low risk and acceptable risk audits to be presented at divisional quality and safety committees.	Audit Leads	On-going	32 out of 33 of the audits published in 2018/19 have completed the review process.
Overdue audits escalated at the weekly Friday MD panel for review.	Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings.

Risk

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

Safe – Vacancy rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less; We will have a nursing and midwifery vacancy rate of 13% or less.	10% target for overall Trust vacancies and 13% for overall N&M vacancies	March 2019 position was; All Trust 13.5% All N&M 15.7%	Kevin Croft, Director of People and Organisational Development	Dawn Sullivan, Deputy Director of People and Organisational Development



Latest performance	• at the end of March the vacancy rate was 13.5% reflective of 1,512 WTE vacancies; 355 WTE non-clinical roles and 1,157 WTE clinical roles • the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,658 WTE; an increase of 48 WTE from those employed in January 2019 • for all nursing & midwifery roles, the vacancy rate was 15.7% (828 WTE vacancies); marginal increase from January 2019 due to approved establishment growth
Return to target / trajectory	• the projection is that we will hit the 13% N&M vacancy rate target by the end of June 2019 based on current activity and establishment. This is based on the current growth projected • the 10% overall trust vacancy rate target is projected to be met by the end of June 2019

Safe – Vacancy rates

Issues and root causes	• 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 15.7%. There are a wide range of recruitment initiatives in place however these maintain our position rather than reduce the vacancy rate significantly • There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff very difficult: the removal of the bursary, the sustained low pay increases, contractual issues with the trainee doctors, the pressure of work and the reduction in CPD funding • The London recruitment market is very difficult and there is more demand than supply. The majority of London trusts have been actively involved in international recruitment for many years and this is reflected in their vacancy rate e.g. Kings and UCL • There are national skills shortages and workforce planning across the NHS has not been a high priority to date • High vacancy rates impact on patient safety and on staff engagement and morale

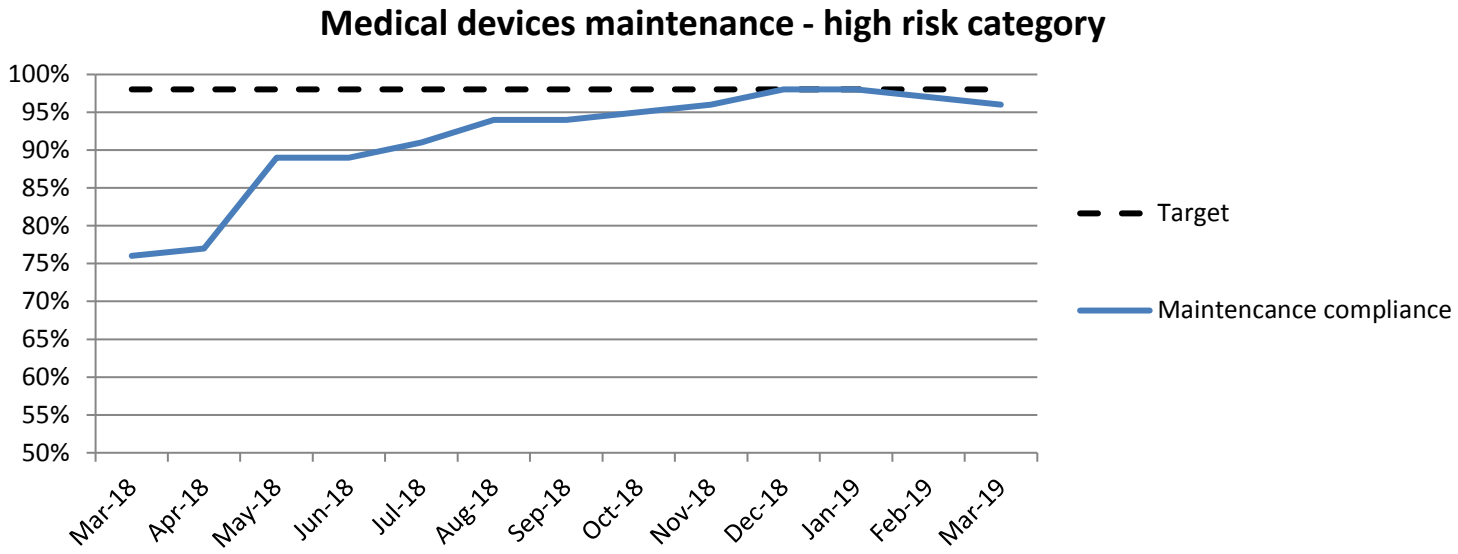
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
There is a Recruitment & Retention Action Plan in place for Band 2-6 N&M staff	Dawn Sullivan	1-3 years	• The plan has been refreshed for 2018/2019 and to date has delivered an increase in student retention to 70% an increase in internal appointments and a more engaged workforce
The business case and funding for the Strategic Supply of Nursing	Dawn Sullivan/Sue Grange	1-5 years	• Funding secured for Nursing Associates, Graduate Apprentices, Retention schemes, International recruitment & resource to support N&M staff. The international campaign has secured 280 plus recruits to date. 21 are already with the Trust
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan/ Sue Burgess	1 year	• The plan has been refreshed for 2019/2020. We are continuing to participate in this programme
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust is recruiting on average 85 N&M staff each month against an average t/o of 60 N&M staff each month. The big ticket items in the plan are students, international recruitment and Band 5 and HCA talent pools . The recruitment activity aims to recruit 100 N&M staff each month to bring down vacancy rate further

Risk register

Corporate risk register id 2499 Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas

Safe – Medical Devices Maintenance (high risk)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve medical devices maintenance compliance according to risk categorisation	98% for High risk, 80% for Medium Risk and 70% for Low risk	April compliance was as follows: High risk = 97% Medium risk = 80% Low risk = 82%	Janice Sigsworth (Director of Nursing)	Max McClements (Head of Clinical Engineering)



Latest performance	• Maintenance compliance figures for medical devices are continually reviewed. • Audits are being undertaken and this has identified a number of devices that had not been included in the database. • eMandate process being implemented to manage and control incoming medical devices to the Trust (expected June 2019) • Clinical Engineering are working with supplier to action the required work to improve maintenance across all areas.
Return to target / trajectory	The aim is to continually review and action to ensure all target KPI's are achieved as soon as possible.

Safe – Medical Devices Maintenance (high risk)

Issues and root causes	The Trust outsourced the medical device maintenance service in 2015 and a number of issues regarding medical device management that are both historical to the Trust and specific to the contract have been identified. In Year 1 there were 17,366 assets whereas now, as Year 4 of the 5 year contract is ending, there are over 27,000 assets registered that demonstrates the inventory was inaccurate. Medical devices continually move around resulting in devices not being located for maintenance and affecting the scheduled maintenance plan. A number of initiatives have been put in place. To improve sight of medical device locations, and to improve maintenance compliance, radio-frequency identification (RFID) technology is being introduced that will enable medical device location to be tracked. With the introduction of RFID technology, use of new 'Next Test Due' labels and improved awareness of staff the aim is to continue the upward trend until all maintenance KPI's are achieved.

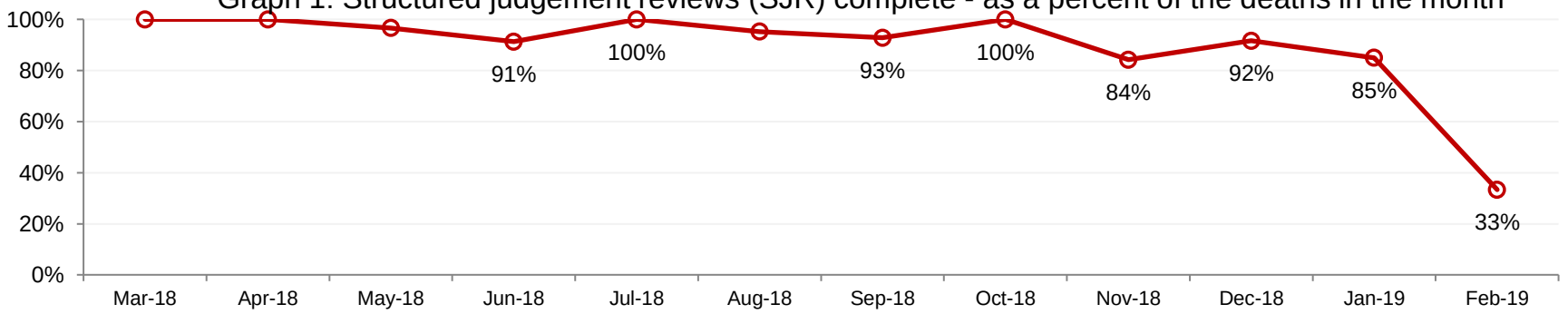
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of medical device categorisation	Aheed Syed (Operations Manager)	October 2018	• Completed
Radio-frequency identification (RFID) Implementation	Aheed Syed (Operations Manager)	June 2019	• Interaction between IT systems being developed and connectivity issues being addressed • Workshops and libraries (HH library being actioned) have active system installed to monitor equipment movement
Training process for staff	Drushtee Ramah (Medical Device Principal)	June 2019	• e-Learning package developed and implemented • Further work required to ensure maximum staff participation • Checklist issued to inform staff of responsibilities when using medical devices
Introduction of Equipment libraries on all sites	Max McClements (Head of CTS)	March 2019	• Completed

Risk register
Corporate risk register id 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards

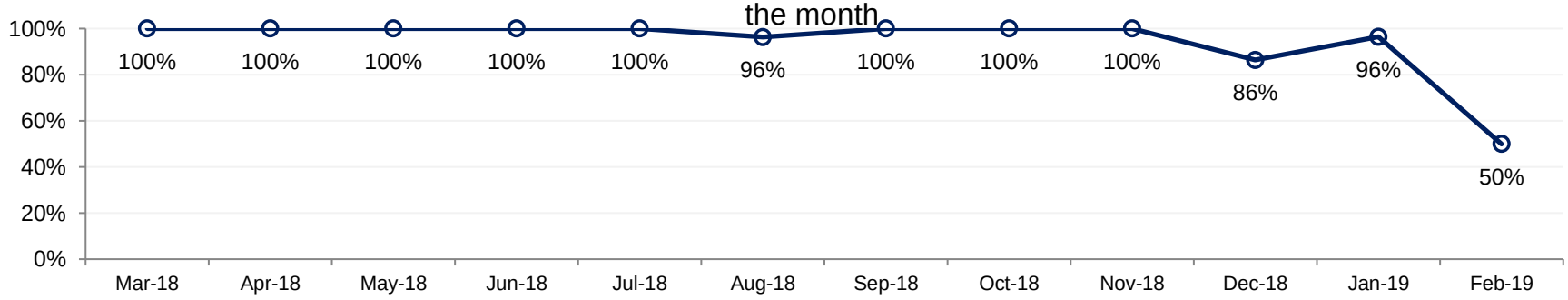
Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJR reviews completed – in month performance: 85% January 2019 33% February 2019	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager

Graph 1: Structured judgement reviews (SJR) complete - as a percent of the deaths in the month



Graph 2: Structured judgement reviews (SJR) complete - as a percent of the SJRs requested in the month



Effective – Mortality reviews

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJR reviews completed – in month performance: 85% January 2019 33% February 2019	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager

Latest performance	• Graph 1 shows the percentage of SJRs which have been completed for deaths which occurred in that month. Data is refreshed on a monthly basis as SJRs are requested and completed. • This data is reported 1 month in arrears to allow time for the SJR cycle to be completed. 202 completed reports have been received to date for this financial year (18/19), out of 227 requested, meaning 89% of SJRs have been completed YTD. • Following feedback at board quality committee, we have reviewed how this data is presented so that progress in completing the reviews is better represented. Graph 2 shows the percentage of completed reviews based on when the SJR was requested, as opposed to the date of death. Based on this, in month compliance is 96% for January and 50% for February 2019. We will move to reporting data solely in this way from when we report SJR data for the new financial year (June 2019).
Return to target / trajectory	Data is reviewed at the weekly incident panel, we are continuing to recruit additional SJR reviewers in order to deliver more capacity. SJRs are being reassigned where there is a delay in order to deliver timely outcomes.

Effective – Mortality reviews

Issues and root causes	Improvements are being seen in the completion of SJRs, with 25 outstanding from 2018/19. Actions are in place to support improvement. Cases are reviewed at the monthly Mortality Review Group with a focus on any avoidable factors and learning themes. Eight avoidable deaths have been reported so far this year.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Recruitment of additional structured judgement reviewers.	Mortality Auditor	May 2019	39 members of staff have undergone structured judgment review (SJR) training. More reviewers are due to be advertised for in May 2019 following agreement at the task and finish group. Plans are also in place to increase the number of senior nurses involved in the process.
Strengthen and formalise the process for triangulating data from cases that have both SJRs and SI investigations undertaken, this includes the recording and accessibility of the data generated.	Head of Quality Compliance & Assurance	Complete	The following changes have been made to ensure the SI process and SJR process align: • Presentation of all deaths assessed as having "avoidability" at the MD incident panel • All deaths leading to a SI investigation will have a SJR completed. The outcome of the SJR will be reviewed with the SI outcome at the SI panel. SI panel is responsible for deciding whether these deaths should be declared avoidable. • We have made contact with Cambridge University Hospitals who reference similar issues with regard to linking processes. We are aiming to work together to identify a solution.
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Auditor	In progress	We have completed this exercise for all 23 avoidable deaths reported as at March 2019. Seventeen deaths have undergone an SI investigation, 3 have undergone local investigations with a further three underway and one case linked to a previous SI. Further work will now commence to theme the findings of these investigations to support further learning.
Undertake review of the mortality processes	General Manager, MDO	Complete	Review completed in January 2019. A Learning from Deaths steering group is overseeing the implementation of all recommendations.

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

Effective – Patient reported outcome measures PROMs

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

March Position

(Finalised PROMs Apr17-March18) Feb19 release

Hip Replacement		Knee Replacement	
Participation Rate	**Reported Health Gain**	**Participation Rate**	**Reported Health Gain**
87.6%	EQ-5D Index:0.464 EQVAS:15.379 Oxford Hip score:21.950 (Finalised PROMs Apr17-March18) Feb19 release)	**90.5%**	EQ-5D Index:0.298 EQVAS: 8.283 Oxford Knee score:13.870 (Finalised PROMs Apr17-March18) Feb19 release)

Latest performance

In February 2019, NHS Digital published finalised PROMs data for 2017/18 and provisional data for April 2018 – September 2018. The finalised data for last financial year shows participation rates above our target of 80% for both knee and hip replacement. Our adjusted health gain score is above national average for hip replacement for all three indexes, and above or very similar to national average for knee replacement for two out of three indexes.

The provisional data for the first six months of this financial year shows participation rates of 80% for knee replacement and 67.2% for hip replacement.

Hip Replacement				
		Adjusted Average Health Gain	Improved	Worsened
EQ-5D Index	Trust	0.464	87.9%	6.9%
	England	0.458	90%	4.80%
EQVAS	Trust	15.37	74.1%	20.7%
	England	13.87	68.3%	22.0%
Oxford Hip score	Trust	21.95	95.4%	4.6%
	England	22.21	97.2%	2.3%

Knee Replacement				
		Adjusted Average Health Gain	Improved	Worsened
EQ-5D Index	Trust	0.337	82.6%	8.4%
	England	0.298	81.4%	13.2%
EQVAS	Trust	8.283	64.8%	23.8%
	England	8.153	59.7%	28.6%
Oxford Knee score	Trust	13.87	90%	9.1%
	England	17.102	94.6%	4.5%

Effective – Patient reported outcome measures PROMs

Return to target / trajectory	On-going process

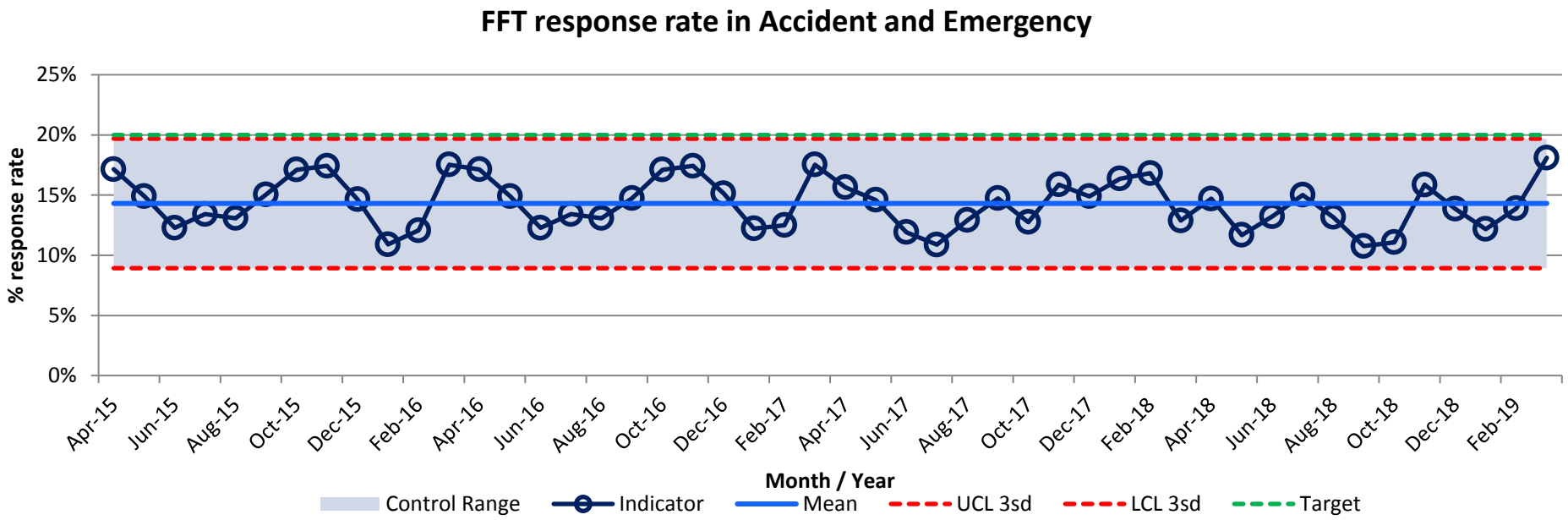
Issues and root causes	Adjusted average health gain for April 2018 – September 2018 is unable to be calculated as there were insufficient numbers of questionnaires returned. This issue is being addressed through actions including a dedicated nurse in post to oversee the process and the re-tendering of the external agency responsible for data collection post-surgery. We expect that our participation rates will have improved when the data is next reported and this should mean that adjusted health gain is able to be calculated. There were issues with Capita, the external agency responsible for data collection post surgery which affected the overall health gain score of the Trust. Procurement had shortlisted 3 external suppliers to address this issue. There was an initial delay in tendering and finalising the new supplier due to suppliers being accredited by the NJR. This was due to be completed by January 2019 but has been delayed to check the IG compliance with IT systems.

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	Overdue	Three external suppliers shortlisted to present to Directorate. Further delays due to IG checks.

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

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

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve and maintain an FFT response rate of 20% in A&E	20% or greater	March 2019 performance was 18.1%	Janice Sigsworth	Guy Young Deputy Director – Patient Experience



Latest performance	• Month 12 performance at 18.1% is the best achieved since collection began. It is also, based on previously reported data, significantly above the national average. This indicates that the actions that have been put in place are making an impact.
Return to target / trajectory	• The target is changing in 2019/20 to 15%, which means that if this level of performance is maintained the trust will achieve this target next month.

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

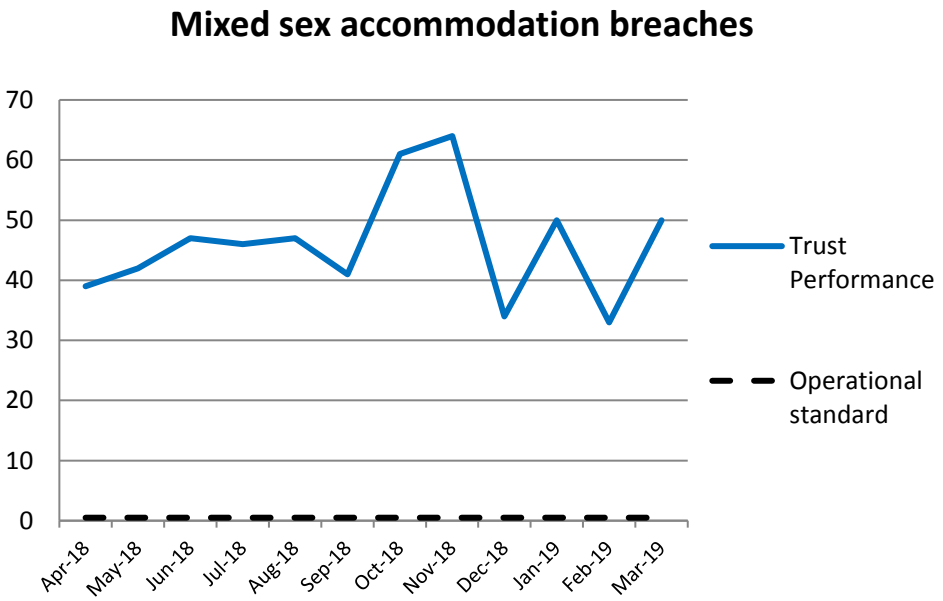
Issues and root causes	A paper setting out the challenges and issues was presented to ExQual in October 2018. This paper included a plan describing a number of actions to improve the rate, particularly at SMH. These are now in progress. To support sustained improvement the QI team will be running 90-day QI programme at St Mary's Hospital. This report will reflect progress throughout the improvement cycle. The initiative is expected to commence March 2019.

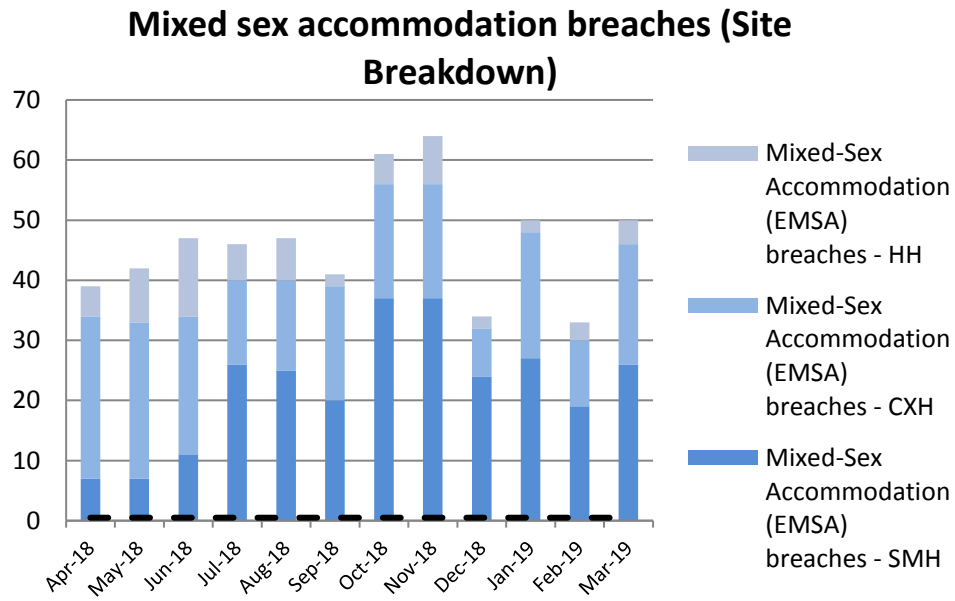
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Increase range of collection methods at SMH A&E	A&E and PEx team	Completed Dec 2018	• Kiosk now installed and functioning • PALS volunteers visiting and collecting feedback • Paper, handheld device and texting options available.
Raise awareness of importance collecting feedback	A&E team	Completed Dec 2018	• Posters displayed in the department • Staff reminded at team meetings/handovers • Local incentives for staff who collect the most replies
90-day QI programme at SMH	QI Team (with A&E and PEx team)	Commence March 2019	• In scoping stage

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

Caring - Eliminating Mixed Sex Accommodation (EMSA)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have zero mixed-sex accommodation breaches	0	50 breaches CXH – 21, HH – 2, SMH – 27, HH Cardiac - 0 (January 2019)	Janice Sigsworth	Melanie Denison Senior Nurse, Critical Care





Latest performance	The national standard is to eliminate all mixed sex breaches for Level 1/0 patients. Inability to care for patients in a same sex environment can have a detrimental effect on patient experience. The Trust reported 50 mixed-sex accommodation (MSA) breaches in March 2019, which arose exclusively in the ICU's, with patients awaiting discharge to a ward area. The most notable increase in breach rates in 18/19 occurred at the SMH site from July 18, following the co-location of HDU beds to ICU/Critical Care, resulting in all discharges from ICU being at Level 1 or 0 (where previously patients were discharged from ICU to HDU as a L2).
Return to Trajectory	In order for the directorate to achieve this standard, intervention and support is required within the system in order to prioritise Critical Care discharges. This will enable the directorate to achieve the national target of 4 hour discharge from Critical Care and avoid mixed sex breaches.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

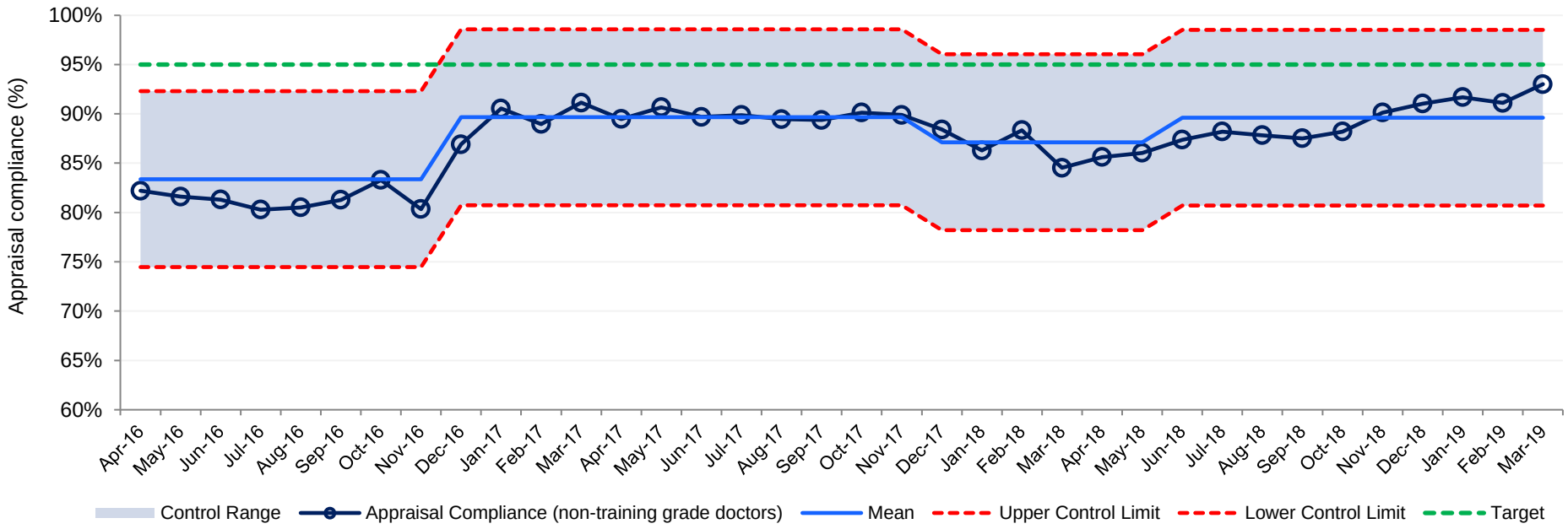
Issues and root causes	Breaches at Imperial are incurred by patients awaiting discharge from the ICUs to ward areas. Downstream flow is the main obstacle. Imperial appears to be an outlier for reported MSA breaches in London. Most other London hospitals report discharge delays from ICU but report fewer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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Comparison of reporting methodologies and mitigations at other Trusts	Mary Mullix	tbc	• Following presentation at CQG, a review is to take place on MSA reporting in other Trusts to ensure all are following the same reporting methodology.
DDN and Senior Nurse meeting with NHSI	Julie Oxton Melanie Denison	Completed Dec-18	• National EMSA policy is currently out for consultation. No update with regards to publication date.
In conjunction with the Hospital Directors, discussions to be held to review the prioritisation of discharges from Critical Care.	Felicity Bevan; Roseanne Meacher	On going	• Clinical Director attendance at Trust Patient Flow – 4 Hour meeting to raise profile of delayed discharge situation in CC and highlight impact on EMSA. Delayed discharges and MSA breaches focussed on in site management meetings.
Patient Information Leaflets	Melanie Denison	April 2019	• Develop literature to provide information for patients on their right to be cared for in single sex accommodation and explanation on why this is disrupted with delayed discharges in Critical Care. A draft of this document is available but we are awaiting publication of the latest NHSI guidance prior to finalisation.
Patient experience feedback	Melanie Denison	April 2019	• A question has been agreed by the Directorate, to add to our existing patient experience survey to assess the impact for patients exposed to a MSA breach in ICU.

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

Well led – Doctor Appraisal Rate

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	91.1% - Feb 2019 93% - March 2019	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance	Performance continues to improve. At 93% it is the highest since April 2016. Consultant grade compliance is at 93.4% compared to 92.7% in February. Career grade compliance is at 89.8%, from 82.3% in February. The total number of appraisals overdue by more than six months is currently 31.
Return to target / trajectory	The target date for achieving the 95% compliance rate was September 2018 (M6). This has been added to the risk register as we have not met our internal compliance target. An improvement plan has been developed and is being implemented.

Well led – Doctor Appraisal Rate

Issues and root causes	The appraisal rate for non-training grade doctors continues to improve although it is still below target of 95%. Reports are now being circulated to clinical directors and heads of specialty to review which doctors are not compliant with appraisal All overdue doctors have been written to, and there are plans in place to support individuals that need help to complete their appraisal. One doctor has been referred to the GMC for non-engagement. The team have developed a more robust tracker which records the actions that have been taken and which level of escalation the overdue consultants are at.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Report sent to each DD,CD and HoS with details of all their doctors and their due dates for appraisal. Overdue appraisals are highlighted for action.	Andrew Worthington, GM	Monthly from February 2019	Ongoing. First set of reports circulated in February 2019
Continue to target individual overdue doctors via the AMD for Professional Development	Geoff Smith, AMD Andrew Worthington, GM	February 2019	Complete
Arrange external appraiser training	Andrew Worthington, GM	May 2019	Appraiser training session arranged for 24 May 2019. Course is open for booking for consultants who are either already appraisers or who would like to become appraisers.

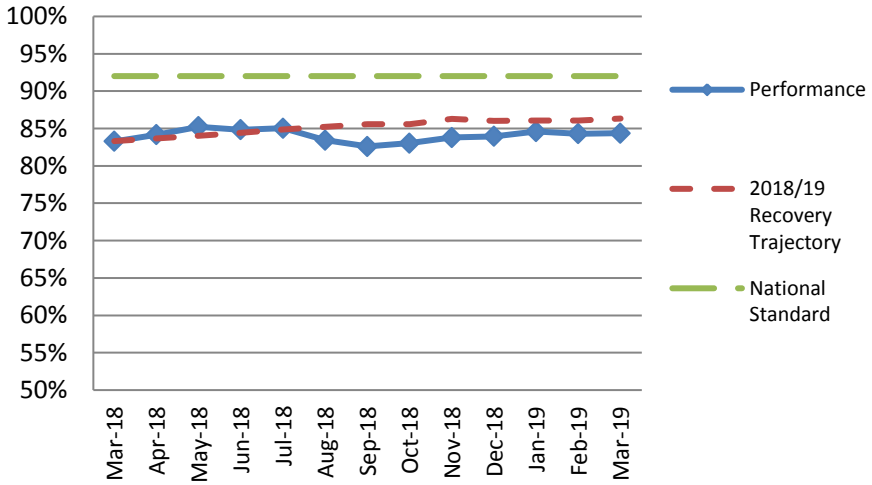
Risk

- Is it on the (divisional / corporate) risk register? Yes (Risk ID 2810 - Doctors' Appraisal Rates)

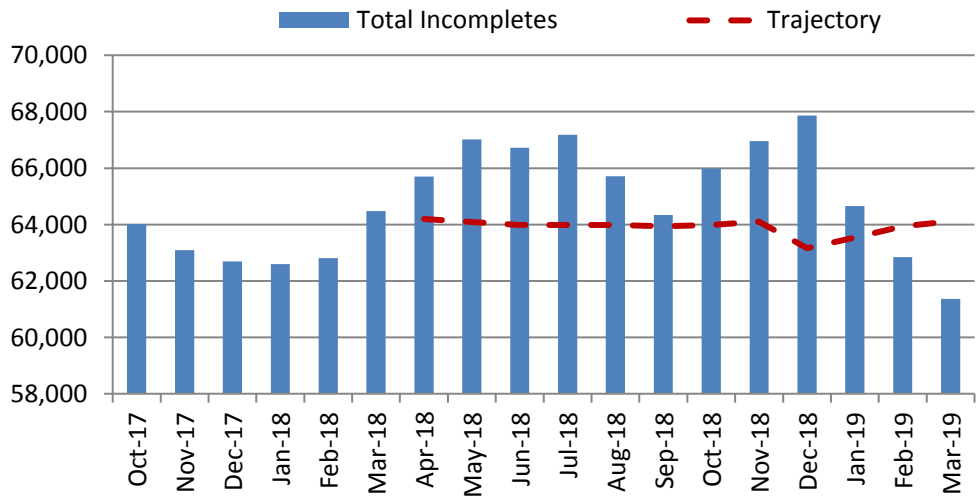
Responsive – RTT 18 weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
RTT incomplete performance target in line with the agreed trajectory for 2018/19	86.3% at end March 2019	84.38% at end March 2019	Prof Catherine (Katie) Urch	Toyin Lawoyin Performance Support Business Partner

RTT 18 Weeks



RTT waiting list size



Latest performance	• The Trust reported zero 52 week waiters in March 19 and there is continued focus. • RTT waiting list size for March was finalised as 61,371. There has been a reduction of 1,477 in the overall PTL size. This reduction has put the PTL size within the 18/19 Operating plan, and below the trajectory. • The latest RTT submitted performance position is end March 2019 is 84.4% of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the national standard of 92%; this did not meet the trajectory target which was 86.3%, but does show an improving trend over the last six months.

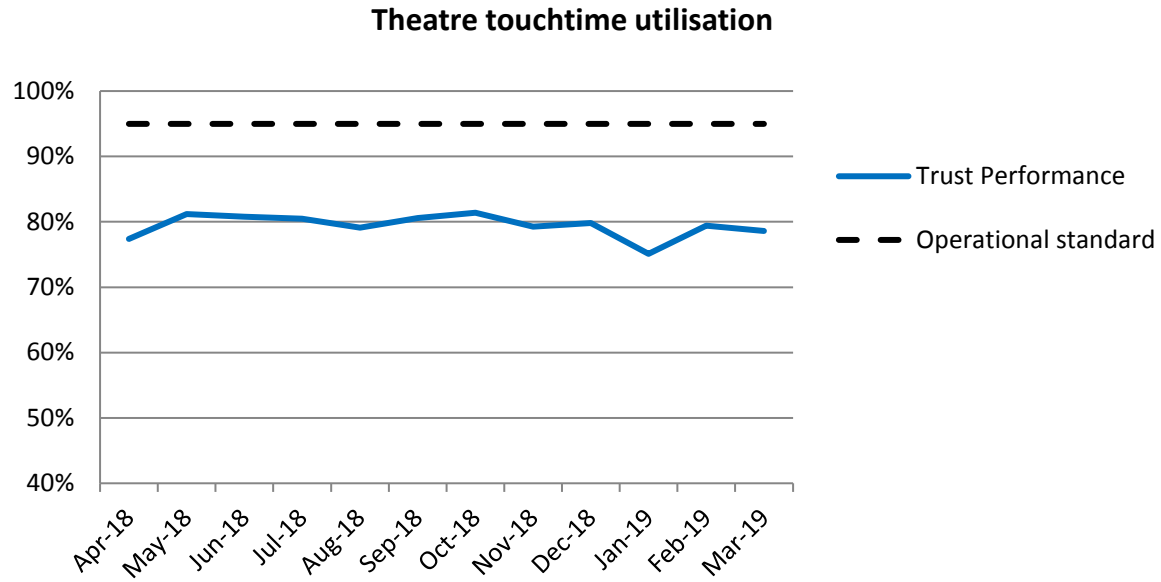
Responsive – RTT 18 weeks

Return to target / trajectory	• Over the last two months there has been additional focus on target validation and these step have had a positive effect on waiting list size. This work will continue to enable focused pathway management and compliance with PTL trajectory. • The performance business support partner has continued to meet monthly with the "challenged" services. There has been improvement month on month in some TFCs, and Neurosurgery has delivered over the 92% standard for the past four months. • The RTT PTL reduced in March to 61,371 from 62,848 in February whilst maintaining performance.
Key issues and actions	<u>RTT Improvement programme</u> • During the early phase of the RTT improvement programme the key two areas of focus were; - Diagnosis of the risks and challenges - Large scale data clean up. The current phase of the programme is focussed on establishing business as usual processes to deliver long term stability and sustained improvement. The key factors are training, support, governance and focussed long waiter management. • **Elective Care Performance Framework**: The RTT Improvement Programme designed a new Elective Care Operational Performance Framework in 2018 which was operational in January 2019. The framework embeds good practices across all TFCs with a focus on managing patient waiting times and the RTT PTL size. • **Training and support**: There has also been investment in training and education support to deliver a bespoke RTT training across all levels of organisation. This training is linked closely to the DQF output to ensure a cycle of continuous feedback and development. There is also increased intensive support with expertise by PST. This includes proactive project/task force approach to month end reporting of the RTT PTL by operational, validation and BI teams led by RTT Improvement Programme. <u>System errors & Data Quality (update at end March 2019)</u> • The number of system errors reported in March increased slightly to 485 compared to February which was 439. • Additional system improvements are required to improve data quality within the PTL created by System Errors and ERS issues. <u>Validation (update at end March 2019)</u> • Increased focus on improving validation productivity 92% of the backlog was validated at March month end which is an improvement on previous months. This is being driven by increasing benefits from the Quibit system in coalition with increasing education and the bedding in of the elective care performance framework. • Improve quality of validation by targeting and removing duplicates, aligned with specific training.

Risk register
Corporate risk ID 2937: Failure to consistently achieve timely elective (RTT) care

Responsive – Theatre management (touchtime utilisation)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will increase elective theatre touchtime utilisation to 95% in line with trajectories	95%	78.6% March 2019	Prof Catherine (Katie) Urch	David Woollcombe-Gosson (Programme manager surgical productivity)



Latest performance	Touchtime utilisation recovered in February from the usual winter dip (+4.3% on January), but stalled in March (-0.8% month-on-month). Both months, however, showed a year-on-year productivity improvement with an additional 369 patients treated compared to the same period in 2018 (2.06 patients/session in 2019 vs 1.99 in 2018). The headline month-on-month figures mask significant variation at specialty level. Quarterly trends, however, are positive in orthopaedics, general surgery, urology, vascular surgery and breast. Of the 17 surgical specialties, gynaecology and plastics currently show a downward trend. Across all specialties there has been a very marked improvement in 6-4-2 compliance, and small but steady improvement trends in session start times and on-the-day cancellations. In those specialties with opportunity, however, a general theme has been that these improvements are not yet being translated into additional patients being scheduled.
Return to target / trajectory	An improvement trajectory is under development.

Responsive – Theatre management (touchtime utilisation)

Issues and root causes	February and March saw recovery from the anticipated winter dip through December and January, and year-on-year improvement. The main contributing factors have been by improvements in session utilisation (94.6% of planned NHS sessions ran in Feb & Mar) and reduced last minute cancellations. Underpinning this has been a very marked improvement in 6-4-2 compliance over the past 8 months and greatly improved management information. Though there is significant variation at specialty level, the principal area of productivity opportunity lies in translating these process improvements into more effectively scheduling the theatre lists.

Improvement Initiatives: Surgical Productivity Programme

		Last period (Feb 2019)	This period (Mar 2019)
Programme Aim:	Surgical pathway management efficiently and sustainably enables the delivery of high quality, timely care for patients.		
Overall current status:		Partially functioning	Partially functioning
Primary drivers & current status:	1. Patients are assessed and prepared to be ready & optimised for surgery.	Partially functioning	Partially functioning
	2. Patients are engaged in their surgery and scheduled appropriately.	Functioning	Functioning
	3. Theatre scheduling is done collaboratively meeting clear planning timescales.	Partially functioning	Partially functioning
	4. Theatres are run to ensure the delivery of safe and efficient lists.	Partially functioning	Partially functioning
	5. Business plans are developed through agreed service plans for the delivery of activity within capacity & allocated resources.	Partially functioning	Partially functioning
	6. Service planning & delivery is enabled by appropriate information analysis & reporting.	Partially functioning	Partially functioning

Progress update:

Programme activity during February and March centred on refining and linking coordination processes. Work to amplify and clarify roles & responsibilities associated with the '6-4-2' timeline for theatre lists was combined with a draft adapted process for non-emergency urgent & expedited lists and is now out with stakeholders for consultation. The revised and expanded SOP should be published in May. Associated with this, sub-processes such as the 'golden patient' and 'perfect morning' are being brought together to provide a coherent bridge between theatre planning and the day of surgery. This work is also being coordinated and aligned with the Safer Surgery programme where appropriate.

In support of the POA service redesign, a staffing structure to support the new ways of working has been developed, job descriptions revised and appropriate ERAFs are being raised. The consultation with affected staff has begun.

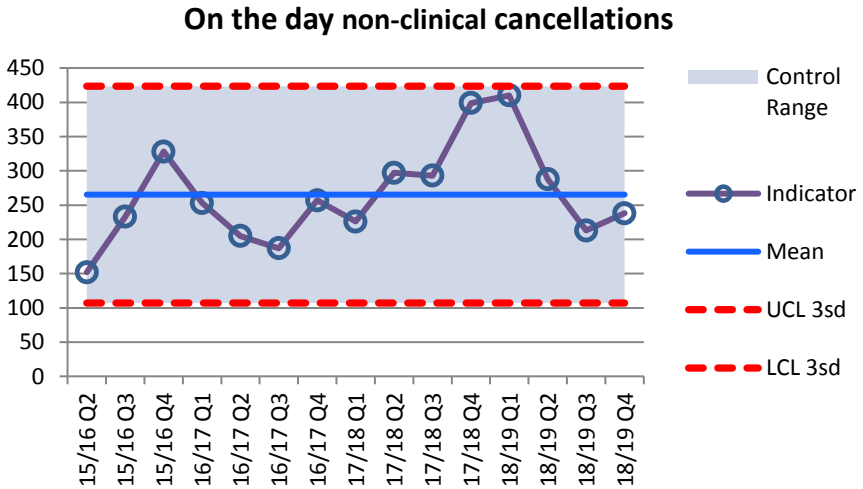
Following a review by the theatres big room at SMH, changes to the daily planning and coordination of the trauma lists (Th1 & 2) are being piloted with the aim of improving start times and hence trauma capacity. In parallel, a review for the MD's office of changes made to reduce overnight stays in recovery identified indicative annualised savings of c.£168K. Over the same period the average length stay in recovery has been halved, and the methodology and initiatives which achieved this are now being shared and coordinated with the new CXH theatres big room.

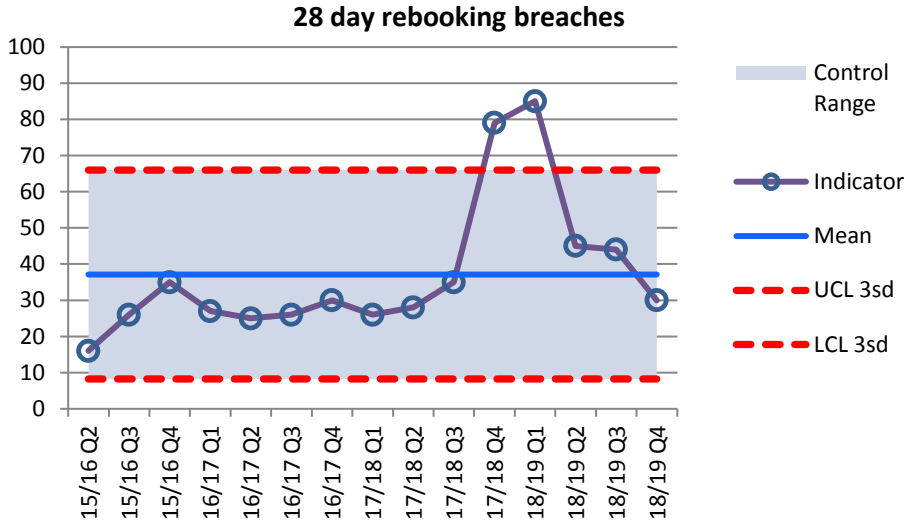
Risk register

Corporate risk ID: 2937 Failure to consistently achieve timely elective (RTT) care

Responsive – Cancelled operations and 28-day rebooking

Indicator	Target	Latest nationally reported data (Q4)	Executive lead	Report author(s)
Reduce cancelled operations and ensure patients are rebooked to within 28 days of their cancelled operation	Below national average	Cancellations = 0.7% (below national average of 1%) 28-day breach rate: 12.6% (above national average of 8%)	Prof Catherine (Katie) Urch	Terence Lacey (Performance Support Business Partner); David Woollcombe-Gosson (Programme Manager, Surgical Productivity)





Latest performance	For Q4, the Trust reported 238 reportable cancellations which is a cancellation rate of 0.7% (of all elective activity) and remains below the national average. The Trust reported30 28-day breaches which is a breach rate of 12.6%; an improved position on Q3 where 44 breaches were reported at a breach date of 21%. Reasons for beaches are being monitored. In Q4, 5 patients breached the standard in Anaesthetics due to a one off estates issue therefore the underlying improvement in the Trust position may be greater.
Return to target / trajectory	An improvement trajectory for the 28-day rebooking breaches is not yet developed.

Responsive – Cancelled operations and 28-day rebooking

Issues and root causes	Overall cancellation rates and reasons vary significantly by site and appear to be largely driven by specialties and case mix completed on each site rather than site-specific issues. The reasons for reportable (QMCO) cancellations are more consistent, with ward bed unavailable, earlier case overran and higher priority case accounting for 64% of all non-clinical cancellations. The Trust has a number of mitigating work streams in place to both improve understanding and monitoring of cancellations and ensure timely rebooking. This includes a dedicated supporting workstream within the surgical productivity programme with the intention of clarifying reporting and roles & responsibilities with regards to all OTD cancellations, and understanding root causes in support of other programme workstreams. The Trust also approved a Performance accountability framework for elective care via the January 2019 Executive Committee for Operational Performance. Within this framework the expectation is that rebooking performance can be tracked at specialty level.

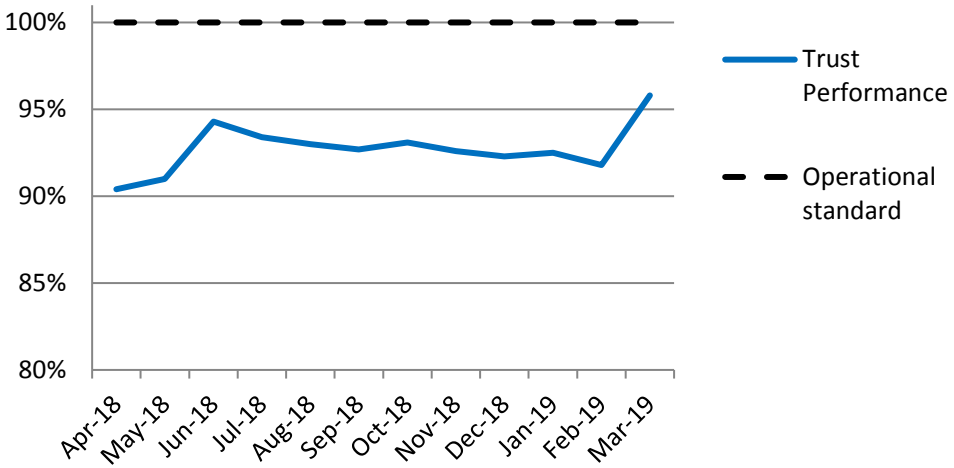
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Develop On the Day cancellations Standard Operating Procedure	David Woollcombe-Gosson	Complete 28 June 2019	• OTD cancellations SOP drafted and piloted. Feedback was that cancellation reasons in Cerner should be updated and SOP then aligned with new list. • Change to Cerner cancellation reasons. *Revised cancellation reasons developed with all stakeholders and Cerner change request is being prepared (for the joint Imperial and C&W Change Board).*
Strengthen review of OTD cancellations and tracking of 28-day re-book patients	Gareth Gwynn / Jan Palmer	31 March 2019 (Framework is now operational)	• Performance to be highlighted by exception through the accountability and performance framework. Framework is now operational.
Design and implement robust weekly process to highlight potential breaches on the 28-day PTL	Terence Lacey / Simone Brown	27 June 2019	• Performance Support Team to deliver mngt process to be agreed by Elective Care Delivery Group
		Interim controls completed	✓ Business Manager recruited in Performance Support Team, providing point of contact with service reps on 28-day PTL ✓ Weekly reports and monthly presentation to Elective Care Delivery Group ✓ Clean-up of weekly PTL report with more real time validation ✓ Training delivered on target and how to manage reports ✓ BM proactively highlighting potential breaches from the PTL to service reps and monitoring quality of validation responses

Risk register
Corporate risk ID: 2937 Failure to consistently achieve timely elective (RTT) care

Responsive – Critical care admissions

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% of critical care patients are admitted within 4 hours	100%	95.8% (March 2019)	Prof Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care

Percentage of critical care admissions, admitted within 4 hours



Site	February 2019 performance	March 2019 performance
CXH Critical Care	91.2% (YTD 91.9%)	92.0% (YTD 91.9%)
HH General Critical Care	88.1% (YTD 89.6%)	95.8% (YTD 90.1%)
SMH Adult Critical Care	94.3% (YTD 95.1%)	99.1% (YTD 95.5%)
All Units Combined	91.8% (YTD 92.8%)	95.8% (YTD 93.1%)

Latest performance	The national standard is that 100% of admissions of critically unwell patients should be admitted within 4 hours. Delays to admission are potentially harmful to critically ill patients who need to be urgently managed within a specialised environment with expert medical and nursing care. The site level and directorate performance is shown above. Overall trend is an improvement on all sites with ongoing work for this key metric.
Return to Trajectory	In order for the directorate to achieve this standard, intervention and support is required within the system in order to prioritise Critical Care step downs. This will enable the directorate to achieve the national target of 4 hour discharge from Critical Care and maintain flow on the units. Focus has been given to Critical Care flow via the Trust work stream with 20/20.

Responsive – Critical care admissions

Issues and root causes	The main reasons for delayed admission to critical care are as follows: • Units running at high occupancy - usually >90% • A large number of CC patients unable to be discharged to the wards in a timely fashion due to lack of ward beds, disrupting flow. • The high occupancy in both the hospital and critical care units can result in a "one-in-one out" situation with ward beds not being allocated unless there is pressure to admit/patient waiting. The units then have to "turn around" the bed. • Delays can also result from cleaning and portering. Other delays on discharge can occur where wards are not fully comfortable with the discharge or particular ward facilities are not available e.g. tracheostomy beds **Summary of proposed improvement areas requiring development** • Improvement is centred around reducing step down delays which is dependent on downstream bed availability and bed allocation prioritisation. • As highlighted within the EMSA exception report the delayed discharges from the ICUs will form part of the on-going Trust capacity and flow work. • We are also working to improve 'turn around' times for each bed, preparing ahead as much as possible including de-escalation of patient care, timely discharge documentation and cleaning.

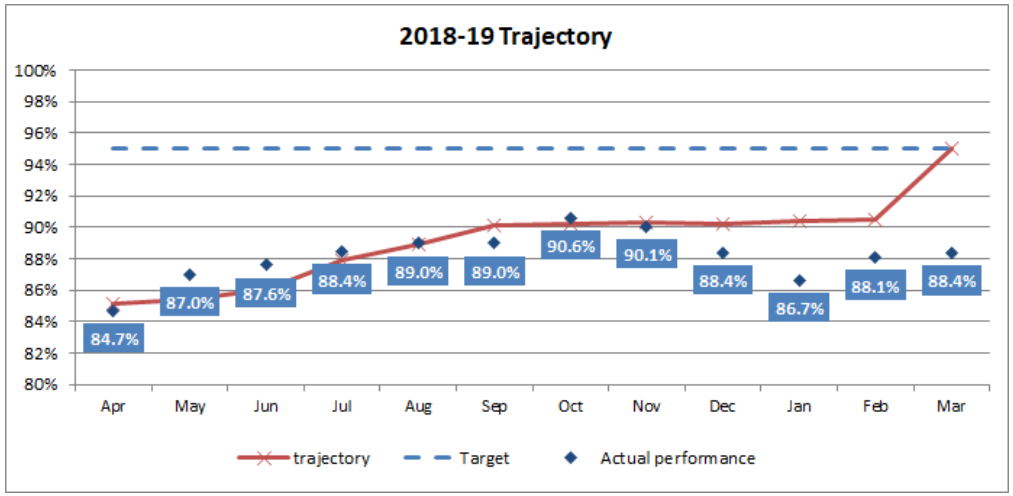
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Early preparation of potential and confirmed discharges in Critical Care	Claire Gorham	April 2019	• SOP being developed to define clear process for de-escalation of care in preparation of discharge. Draft out for consultation.
Trust wide of prioritisation of Critical Care flow.	Roseanne Meacher Lily Davies	Complete	• The directorate have been working with 20/20 consultancy as part of the Trust wide project to review flow in order to identify key challenges that result in disruption to flow. Project presented to senior Trust members for support within ongoing measures.
Review discharge pathways for Tracheostomy patients	Roseanne Meacher	Inaugural meeting 18th April 2019	• Establish a tracheostomy stakeholder group to review: training, flow and management of tracheostomy patients within the Trust.
Review internal processes to support flow	Lily Davies	Complete	• Review responsibilities of current senior nursing roles in AICU to enable a 24/7 focus on patient flow (previously role was provided by AICU matron in hours only).
Identification of surgical pathways with quick turnaround and discharge straight home	Felicity Bevan	June 2019	• Identify and develop a pathway for pathways whom require monitoring on Critical Care post surgery for several hours until fit for discharge. These patients become bed blockers

Risk register

Corporate risk ID: 2946 Failure to provide timely access to critical care services. This risk is also on the Directorate risk register (ID 2560) as a risk of delay to admission to Critical Care. The Critical Care escalation policy has been developed to detail process should Critical Care escalation occur. This also details the process of Critical Care support to patients awaiting admission into the unit where use of escalation areas is required. Data is collected for all breaches, any that lead to adverse incidents are reported on datix and reviewed at the directorate Quality and Safety meeting.

Responsive – A&E 4 hour performance against trajectory

Indicator	Target	Latest data	Executive lead	Report author(s)
A&E 4-hour performance target in line with the agreed trajectory for 2018/19	95% in March 2019	88.4% March 2019	Dr Frances Bowen, Divisional Director, MIC	Sarah Buckland, Performance Support Business Partner



Trust	Mar-19	Mar-18	Month Variance	Month % Variance	YTD 18/19	YTD 17/18	YTD Variance	YTD % Variance
Attendances	25015	23978	1,037	4.3%	290657	288960	1,697	0.6%
Breaches	2910	4030	-1,120	-27.8%	34440	37003	-2,563	-6.9%
Performance	88.4%	83.2%	5.2%		88.2%	87.2%	1.0%	

Type 1	Mar-19	Mar-18	Variance	% Variance
Attendances	10480	10057	423	4.2%
Breaches	2664	3828	-1,164	-30.4%
Performance	74.6%	61.9%	12.6%	

Activity and performance variances in month and year

Latest performance	• Performance against the 4 hour standard for March 2019 was 88.4%. Performance was 6.6% below the local trajectory for the month of 95%. Quarter four performance was 87.7% for the Trust. • March 2019 performance was 5.2% higher than March 2018 and Type 1 performance was 12.6% higher than the same month last year. • System wide performance (100% ICHT and 52% CLCH activity and breaches) for March 2019 was 91.2% and for quarter four 90.6%. We have received confirmation that the trust achieved PSF funding for quarter four. • Year-end performance for 2018/19 was 88.2%, this was a 1% increase on 2017/18 performance. Activity increased overall by 0.6% whilst breaches decreased by 6.9%. Figure 2 shows the month end and year end variances.
Return to target / trajectory	• The trajectory for 2019/20 has been submitted, the April 2019 trajectory is 90%. Performance for the month to date stands at 87.9% (at 15th April 2019). • The trust has agreed to be a pilot site for the proposed urgent and emergency care standards. Testing will begin in May 2019 with outcomes and national roll out due to be commencing in Autumn 2019. During this period the trust is required to break from reporting externally against the current 4 hour standard; internally we intend to work closely with the communications team to ensure there remains a focus on patient flow and that performance does not deteriorate as a consequence.

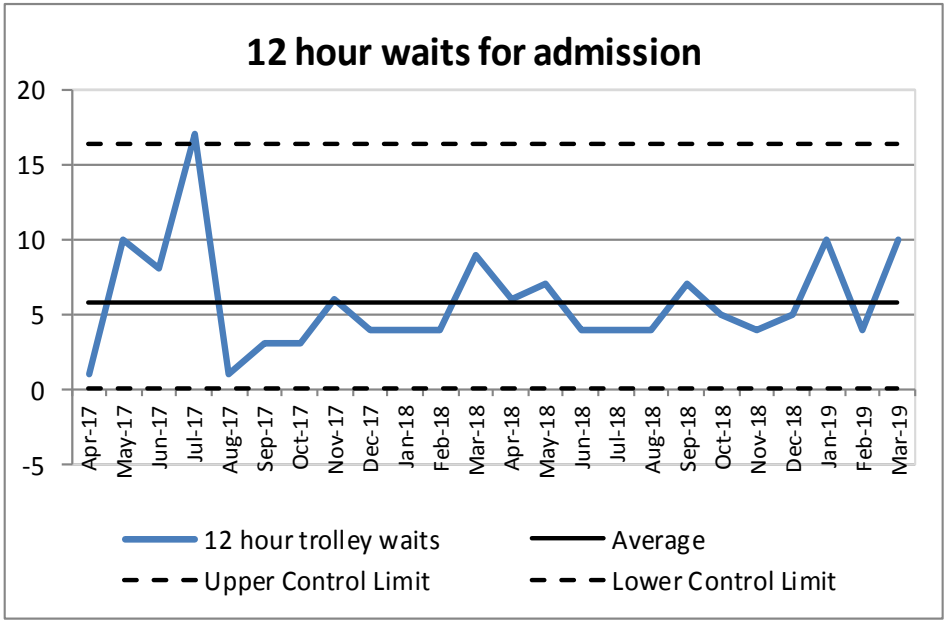
Responsive – A&E 4 hour performance against trajectory

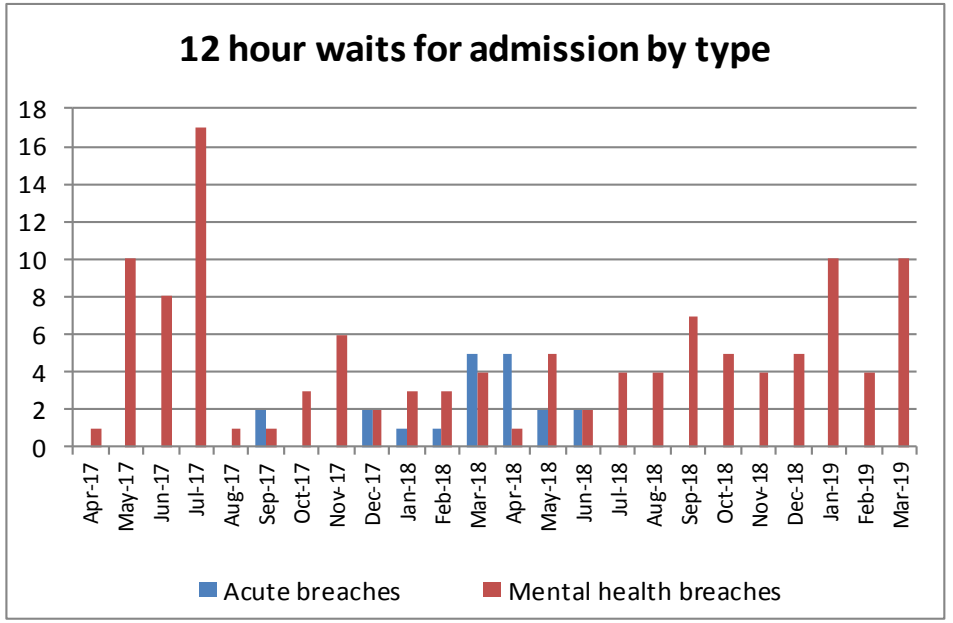
Key issues and actions	The main contributing factors to performance in March have been continued winter pressures, with increased urgent and emergency care attendances across the ICHT system (c.4% greater than March 2018) leading to capacity constraints. Admitted 4 hour performance improved during Q1 from c.45% in January to c.54% in March. Non-admitted performance dipped in February and then recovered in March. Type 2 attendances increased in March 2019 and performance remained consistent at 99.1%. Type 3 performance overall decrease to 98% in March, with achievement of 99.6% at CXH UCC, 99.7% at HH UCC and 95.3% at SMH UCC. Attendances increased at CXH and HH UCCs and decreased at SMH UCC. The priority areas moving into 2019/20 are reducing the number of long stay patients, non-admitted ED pathways and ambulance handover times alongside the long term improvement initiatives. **Improvement Initiatives** A system wide approach has been taken encompassing the entire non-elective pathway from A&E to discharge. This is overseen by the Care Journey and Capacity Collaborative and is managed through the weekly 4 hour performance meeting. The collaborative 2019/20 strategy was launched in March and focuses on four main areas of improvement work; • Access to Unplanned Care • Flow Move • Safe and Timely Discharge • Infrastructure and Capacity Management The work streams are progressing ongoing work identified in 2018/19, have begun moving forward with key actions for 2019/20 and continue to develop work plans for new improvement schemes. The schedule of reporting has been agreed for the coming year and work streams are reporting progress through the weekly 4 hour meeting.

Risk register
Corporate risk ID: 2943 Failure to maintain Emergency Department (ED) trajectories Corporate risk ID: 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

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

Indicator	Target	Latest data	Executive lead	Report author(s)
Number of waits for admission over 12 hours from decision to admit (DTA)	0 breaches	10 breaches – Mar 4 breaches – Feb	Dr Frances Bowen	Sarah Buckland





Latest performance	• The number of twelve hour breaches of wait from DTA to admission rose to 10 in March 2019, an increase of 6 from February 2019. • All breaches in February and March were delays to admission for mental health provider beds. • All of the breaches occurred at SMH; 10 patients were transferred within the greater London area and 4 out of area.
Return to target / trajectory	• The A&E department is working closely with the two mental health providers to minimise avoidable breaches of this metric. • There is an expectation that trolley breaches for patients requiring an ICHT bed will remain at zero.

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

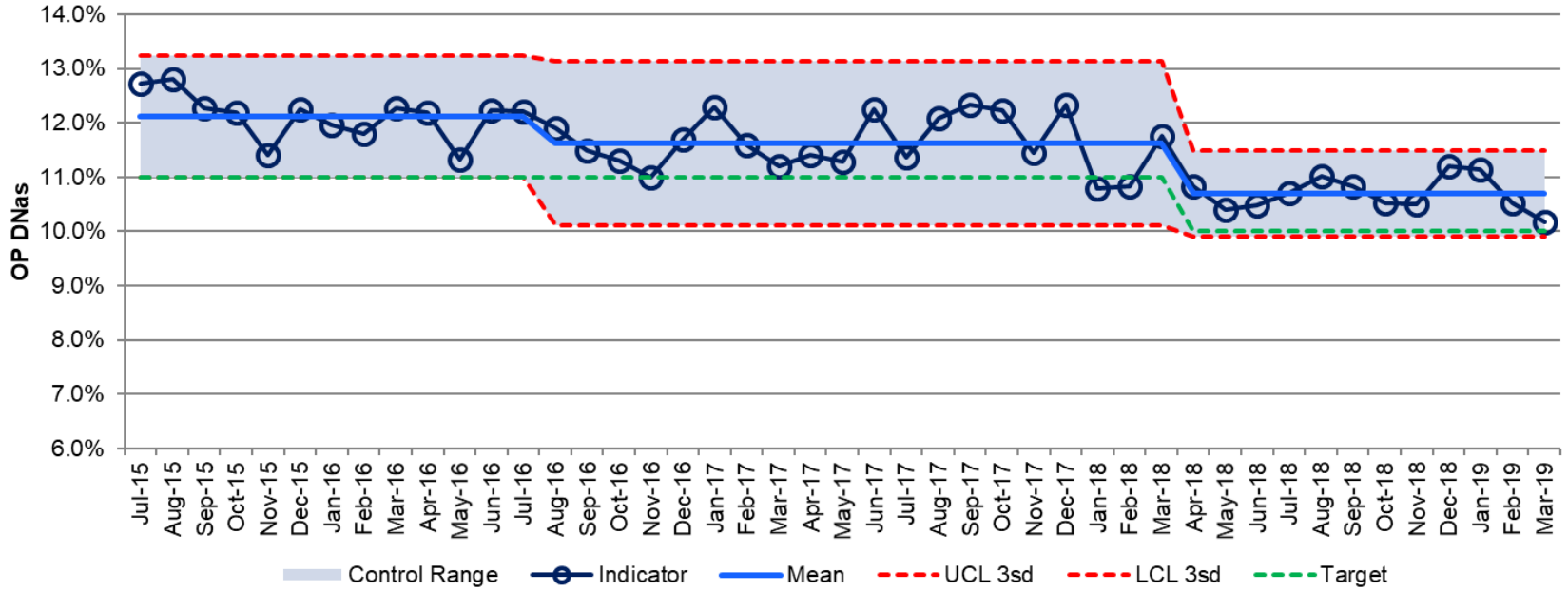
Issues and root causes	• Lack of available mental health beds • Extended waits for AMHPs (Approved Mental Health Professional) due to availability of staff • Delays with provision of out of hours HTT (Home Treatment Team) at SMH, due to end of night time cover in Westminster • Increasing proportion of out of area patients with more complex pathways requiring facilitated transfer to local organisation

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Ensuring both organisations recognise & agree 12hr wait data	Sarah Grace & James Hughes	Completed	Action completed in line with daily SITREP Mental Health patients in Emergency Departments requirements.
Establish task and finish group to focus on system wide actions to support mental health pathways including golden pathway	Toby Hyde	Completed	Group established (A&EDB ops group)
Creation of 2 crisis calming rooms in CXH ED (part of the ED redevelopment & 136 compliance), equivalent space already in place at SMH.	Sarah Grace	Completed	Rooms became available on 13th February 2019.
Joint agreement on actions to reduce number of mental health patients waiting over 4 hours in the ED by 10%	Sarah Grace & James Hughes	In progress	Work on-going
CCG to ensure rapid escalation process when funding issues become an obstacle	Milan Tailor (CCG)	In progress	Support from Surge Hub much improved – rapid escalation occurring when necessary
Implement actions from SI reports		In progress	Monitored through MIC Q&S Committee
Review and learning from benchmarking data submitted via the daily sitrep on mental health patients in EDs.	Sophie Pallet (NHSI)	In progress	Benchmarking request raised at the A&EDB and has been taken forward by Sophie, awaiting outcome.

Risk register
Corporate risk ID: 2943 Failure to maintain Emergency Department (ED) trajectories Corporate risk ID: 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

Responsive – Outpatient Did Not Attend Rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%	10.2% (March 2019)	Tg Teoh	Danya Cohen (General Manager)



Latest performance	• The target for outpatient DNAs was reduced from 11% for 2017/18 to 10% for 2018/19 • The overall DNA rate was 10.2% in March 2019, an improvement from February 2019 (10.5%). This remains within our control limits and is the lowest position achieved over the last 12 months. • Compared to the same period last year, when the DNA rate was 11.8% (March 2018), there is a improvement in the Trusts overall position.
Return to target / trajectory	No formal trajectory has been agreed to reduce the DNA rate to below 10%

Responsive – Outpatient Did Not Attend Rates

Issues and root causes	• Whilst outpatient DNA rates have reduced during 2018, achieving a DNA rate of <10% requires a step change in approach. • In March 2018 patient appointment letters by email were stopped due to Trust ICT database issues. The service was resumed in October 2018. Now all patients who have signed up to email appointment letters are getting emails within 15 minutes of the appointment being made • The impact of the transition to the electronic referral service (e-RS) for GP referrals is not yet fully known. It was anticipated that through providing patients with the ability to choose their own appointment date and times, this would reduce the outpatient DNA rate for first appointments. • Continued monitoring and full analysis of the impact for patients has not yet been completed. However, it is indicating that this is not having the benefit referred via e-RS, post the implementation of this service in October 2018. There seems to be many instances where patients are given appointments through GP surgeries and referral hubs without patient date approval. This appears to be contributing to the DNA plateau and apparent slight increased over Dec/Jan. • Actions identified through the deep-dive are being presented in April with a view of improvement work to commence once the recommendations have been agreed.

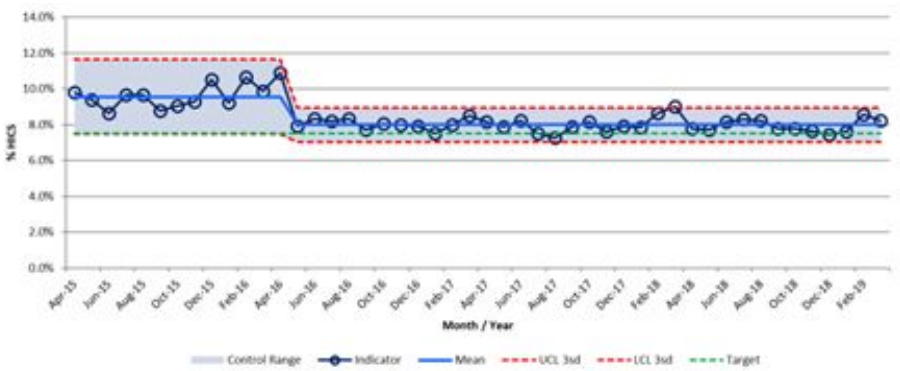
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Deep dive analysis of Outpatient DNA rate for all services (new and follow up) to be undertaken, post stabilisation of e-RS	Cameron Behbahani / Damien Bruty/ Bec DuBock	March 2019	Report due to ExOp in April 2019
Check in-check out – backlog is being cleared and management of the forms is being monitored to ensure completion on the day or next day for the late clinics. **Future plan**: outcome forms to be available electronically - Jayex meeting planned	Danya Cohen	April 2019 TBC	
DNAs • Patient leaflets are being updated to include the impact of DNAs (financial and service efficiency) and CIE sign up benefits • 7 day and 48 hour patient calls are being centralised to improve the reliability of the calls being made • Text reminders/letters to be re-visited to improve information and coverage to reduce confusion where there is re-scheduling. Email use to be maximised **Future plan**: video links for consultations especially in services with high DNA rates	Danya Cohen	Est. May 2019 TBC	

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

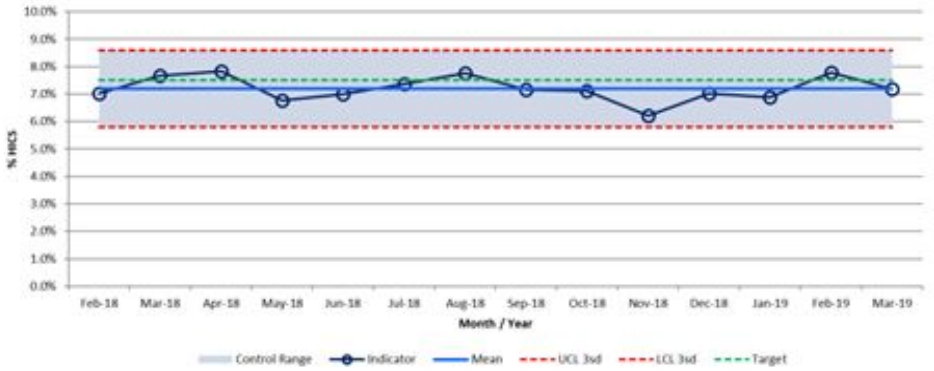
Responsive – Hospital Initiated Cancellations

Indicator	Target	Latest data	Executive lead	Report author(s)
A) Outpatient HICs rate with less than 6 weeks' notice	<7.5%	8.2% (March 2019)	Tg Teoh	Danya Cohen (General Manager)
B) Outpatient HICs, pushed back to a later date		7.2% (March 2019)		

Outpatient HIC rate with less than 6 weeks notice



Outpatient HICs, pushed back to a later date



Latest performance	• **Metric A**: The performance for the Hospital Initiated Cancellations <6weeks has decreased in March 2019 to 8.2%, compared to the previous month (February 2019 at 8.6%). Previously, this had been under 8% since September 2018 though has not achieved the 7.5% target. • Compared to the same period last year where performance was at 9.1% (March 2018), this is an improved position. • **Metric B**: The performance for the Hospital Initiated Cancellations pushed back to a later date has improved in March 2019 to be below the 7.5% target at 7.2%. • Compared to the same period last year when performance was 7.7% (March 2018), this is an improved position for the Trust.
Return to target / trajectory	No trajectory has been agreed for the current HICs metric

Responsive – Hospital Initiated Cancellations

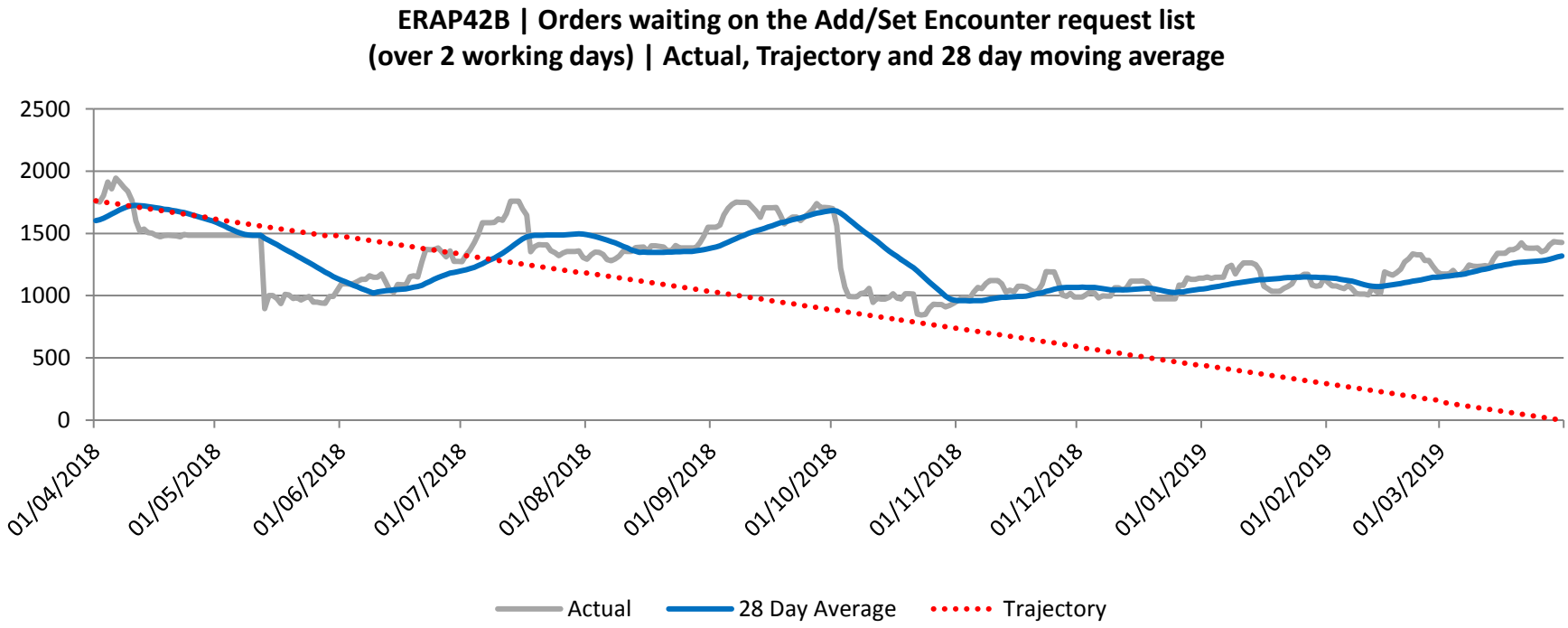
Issues and root causes	• The reasons for the pushed back appointments is unclear and work with the services is required to understand the issues causing these delays. The areas with a high push back rate will be identified through the quarterly deep-dive (Due April 2019) with the next steps to be confirmed by the service leads. • Lack of anaesthetists has been raised as a risk which is impacting on HICS (and cancellations with very short notice) • HICs with significantly less than 6weeks notice, is impacting on the PSC due to an increase in the number of patient complaints; additional overtime has been required to respond to these

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
To undertaken quarterly deep-dives to understand the reasons for the pushed back appointments, with a focus on the highest contributing areas	Service Leads	April 2019 (TBC)	
To share the data showing the number of appointments cancelled and not rebooked with the Waiting Time Data Quality Group for review and monitoring of actions	Bec DuBock / Caroline O'Dea / Service Leads	April 2019 (TBC)	

Risk register
Is it on the (divisional / corporate) risk register? Yes for anaesthetist availability

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

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve data quality by reducing orders for diagnostic and surgical procedures waiting to be processed on our system in line with trajectories	0	1,427	Katie Urch	Caroline O'Dea, (Performance Support Team Business Partner)



Latest performance	At the end of March 2019, a total of 1,427 orders across the Trust remained on the add/set encounter list in Cerner over 2 working days. This number has increased by 286 orders since the end of January 19.
Return to target / trajectory	Work is in progress with high volume areas to review backlogs and agree recovery plans.

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

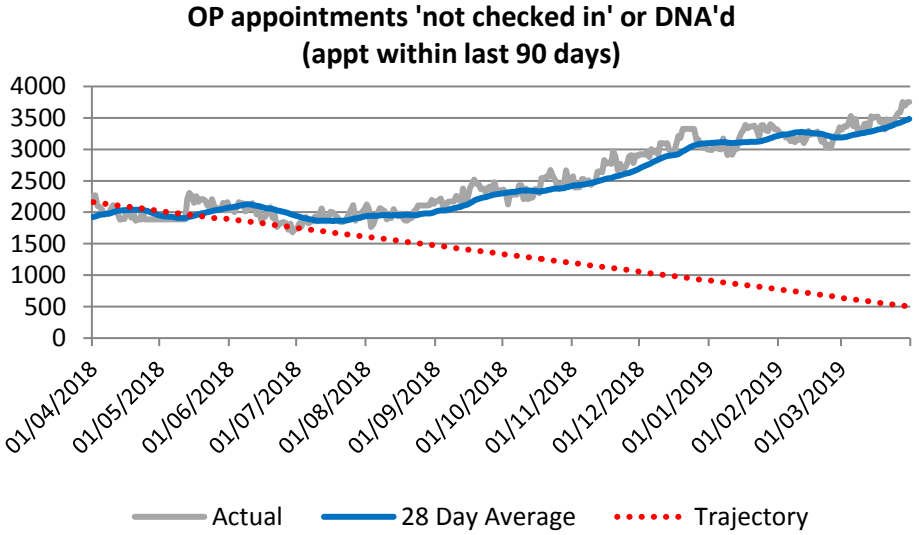
Key issues	Resource to clean up backlogs where services recognise there are duplicate orders or old order that do not require scheduling but unable to assign resource to remove these. Local service scheduling processes that are not aligned to the target, where services schedule on a weekly or fortnightly basis for non urgent procedures. Admin scheduling training to include information about DQIs Impact: • Delay in adding patients to the inpatient waiting list causing hidden waits. • Potential risk to patient waiting times. • Potential impact on RTT 18 week pathways and performance.

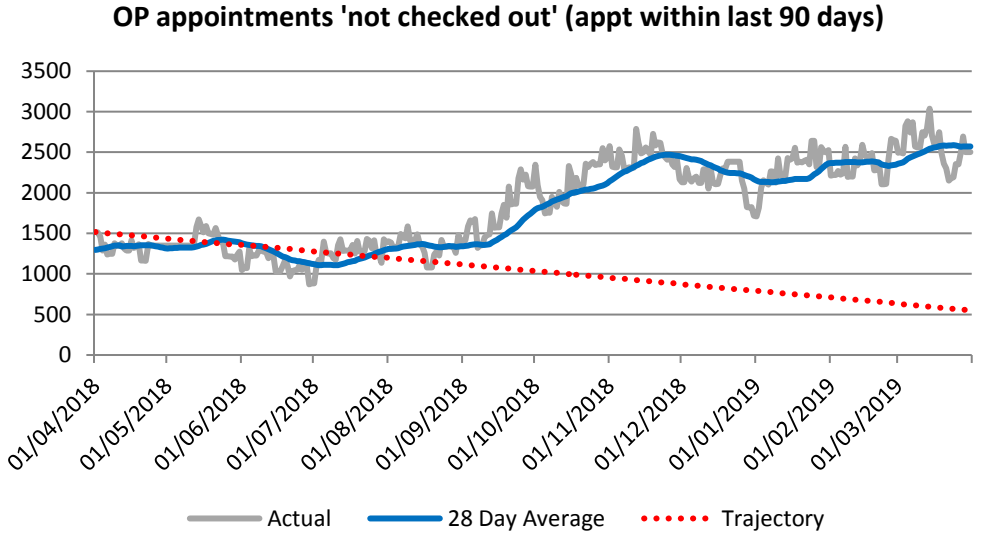
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Reported to elective care via the control of legacies update.	Karina Malhotra	Weekly	On-going process in place.
DQI dashboard reviewed on a monthly basis with operational representatives, a focus on driving improvement across top 3 TFCs with the highest volume DQ errors.	Caroline O'Dea	March 19	On-going process in place. Local service processes being reviewed where these do not align with the target of 0 at 2 working days.
A refresh of the Trust approach to data quality. This will include a monthly data quality report to inform senior leaders of the current status of data quality within the Trust.	Claire Hook	April 19	Update paper to ExOp in April 19 outlining proposed content of reporting for 2019/20.
Agree a development plan to move the current dashboard style report into Qliksense, to make data available at directorate and specialty level with the ability to drill down to patient level detail, to further improve the visibility and use of data quality metrics.	Neil McGurn	March 20	DQ month end report developed to support monthly data quality report to ExOp.

Risk
Corporate risk ID: 1660 Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality

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

Indicator	Target	Latest data	Executive lead	Report author(s)
We improve data quality by reducing outpatient appointments not checked-in or checked-out on our system in line with trajectories	Not checked in: 500 Not checked out: 550	March 2019: • 3,752 OP appointments not checked in; • 2,502 OP appointments not checked out	Tg Teoh	Caroline O'Dea, (Performance Support Team Business Partner)





Latest performance	At the end of March 2019, a total of 3,752 outpatient appointments were not checked in or DNA'd across the Trust. This is a increase since the end of January 19 by 432 appointments. Performance did not meet trajectory by 3252 appointments. Of the total number of not checked in or DNA'd appointments across the Trust, 91% are from decentralised outpatient departments. In addition to the above, a total of 2,502 outpatient appointments were checked in but not checked out across the Trust. This is a decrease since the end of January by 24 appointments. Performance did not meet trajectory by 1,952 appointments. Of the total number of appointments checked in and not checked out across the Trust, 78% are from decentralised outpatient departments.
Return to target / trajectory	The Trust is still not meeting trajectory for these DQIs. Work is in progress with high volume areas with adverse performance to agree recovery plans. New trajectories are due to be set for 19/20, work to agree these trajectories will include reviewing baselines and denominators across the Trust to inform future targets.

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

Key issues	• Resource at outpatient reception areas and cover arrangements for sickness and leave • Incomplete clinic outcome forms or forms not returned to reception • Admin and clinical staff training on outcome forms and RTT codes for check out • Lack of standardised monitoring process across the Trust for DQIs Impact: • Incomplete recording of patient attendance impacting financial activity • Incomplete recording of patient DNA's impacting management of patient pathways • Delays to completing next steps for patients, impacting on patient waiting times and risk to RTT 18 week pathway

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
DQI dashboard reviewed on a monthly basis with operational representatives, a focus on driving improvement across top 3 TFCs with the highest volumes of DQ errors.	Caroline O'Dea	March 19	On-going process in place
Weekly monitoring process in place for central OPD with communication to specialties as per OPWL SOP	Chandni Metha	On-going	New tracking process in place for outcome forms not returned since November 18.
Weekly PTL management meetings to include DQIs for areas off track in their performance.	Hina Khalid	November 18	Implemented in high volume areas, new specialty level SOPs being developed to support devolved OPDs.
A refresh of the Trust approach to data quality. This will include a monthly data quality report to inform senior leaders of the current status of data quality within the Trust.	Claire Hook	April 19	Update paper to ExOp in April 19 outlining proposed content of reporting for 2019/20.

Risk
Corporate risk ID: 1660 Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Referral to Treatment (RTT) Performance at ICHT	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 14, report no. 10**
Responsible Executive Director: Dr Catherine (Katie) Urch	**Author:** Karina Malhotra, RTT Improvement Partner

Summary:
This report provides the Trust Board with a summary of the Trust's current performance against the national Referral to Treatment (RTT) standard as at March 2019. This includes details against all key metrics measured nationally and show an improving trend against all. The April 2019 position is yet to be finalised and due for submission on 20 May 2019.

Key highlights from the March 2019 month end position are included within the full report and highlight over achievement against the reduction of the patient tracking list size trajectory as well as achievement of zero 52 week waiting patient pathways as at March 2019.

These improvements have been underpinned by the delivery of key milestones within the projects being managed under the RTT Improvement programme which has focused on – people (through Education & Training), systems (through a Validation and data visualisation tool – Qubit) and processes (through developing a performance management and accountability framework).

This work will continue in 19/20 through the implementation of an improved Elective care model to continue sustained improvements and delivery against all relevant RTT standards.

Recommendations:
The committee is asked to note the performance update for the March 2019 RTT submitted position and 52 weeks' position of zero, the outcome of the March 2019 clinical harm review process found no harm to patients waiting over 52 weeks and the three key work projects for RTT Improvement focused on people, processes and systems to support sustainable improvement on RTT performance through 19/20.

This report has been discussed at:
Due to be discussed at the Executive Operational Committee in May 2019

If this is a business case for investment, has it been reviewed by the Decision Support Panel (DSP)? ☐ Yes ☐ No ☒ Not applicable
If yes, when……

Quality impact:
This programme is essential to meet constitutional, CQC (Responsive) and operational standards

Financial impact:
The costs associated with the RTT Improvement Programme are under continual review and are included in the SCC Division's financial forecast.

Risk impact and Board Assurance Framework (BAF) reference:
The corporate risk register has a specific risk with ID 2937 regarding RTT Performance as per below

which is updated regularly in line with Trust governance procedures:

"Failure to achieve the maximum waiting times of 18 weeks from GP referral to treatment as set out in the NHS Operating Guidance 2019/20, including zero > 52 week waits and maintenance of the size and volume of the RTT PTL (waiting list)"

The RTT Improvement programme holds a risk register which is reviewed quarterly by the Elective Care Steering Group. These risks are also held on the SCC Divisional Risk Register and monitored via the Divisional governance processes.

Arrangements for mitigating clinical risk if a patient waits too long for treatment are managed by the RTT Clinical Harm Process, as per the ICHT Clinical Harm Policy.

Workforce impact (including training and education implications):
The RTT Improvement Programme has an Education and Training work stream currently working with services to train staff on various aspects of RTT.

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

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

What impact will this have on the wider health economy, patients and the public?
Provide better access to services at ICHT

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

Trust strategic goals supported by this paper:
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No

- What should senior managers know?
  - The Trust has seen key successes in 18/19 in terms of performance improvement against all key metrics on RTT.
  - These improvements have been underpinned by the delivery of key milestones within the projects being managed under the RTT Improvement programme which has focused on 3 key priorities – people, systems and processes.

- What (if anything) do you want senior managers to do?
  - To ensure they review their elective care standards performance regularly along with analysing the drivers for the results and addressing any issues identified.
  - To engage with the RTT Improvement Workstreams to ensure their staff are trained on RTT and delivery is managed through the framework developed and published in the Performance Framework document

Imperial College Healthcare NHS Trust

RTT Performance at ICHT

1. Executive Summary

1.1. This report provides an overview of the Referral to Treatment (RTT) performance at the Trust.

1.2. This includes an assessment of the RTT PTL size, the 52-week waiting patient pathway position for March 2019 as well as a forecast for the future. The report also provides trends of performance on all key performance metrics for information.

1.3. Note – the April 2019 RTT performance will be published post the submission of this report and therefore, could not be included.

2. Purpose

2.1. At the March 2019 Board, the improving performance against the RTT standard was noted. The Board also noted the progress made in achieving the 52 week waiting time standard at the Trust.

2.2. This report offers more detail against all key performance measures for the Board's information and review. This report especially summarises the trend of improvement achieved at the end of the financial year 18/19 and plans for future improvements.

3. Background

3.1. The Trust is currently not meeting the National RTT standard of 92%. In addition to this, the Trust had patients waiting more than 52 weeks through 18/19 for treatment which needed to be addressed.

3.2. To tackle these performance and associated data quality and patient experience issues, the Trust continues to be engaged in an RTT improvement programme which currently covers key work streams around people, systems and processes which need to be improved in order to sustainably improve waiting times.

3.3. Through 18/19 the aim of the programme has been to put in place key improvements in order for the delivery of RTT to move into the 'business as usual' structures within the Trust. In order to support this aim, the programme has been working towards delivering key projects and Workstreams whilst maintaining a focus on delivering significant improvement to RTT performance metrics in 2018/19.

4. Summary/Key points

Key highlights from the March 2019 month end performance are as follows (See Appendix 1 for a full Performance pack for March 2019):

4.1. The total RTT PTL size of incomplete pathways reduced by 1, 477 to 61,371 in March; 2,743 over achieving against the Trust's agreed trajectory of 64, 114. In particular,

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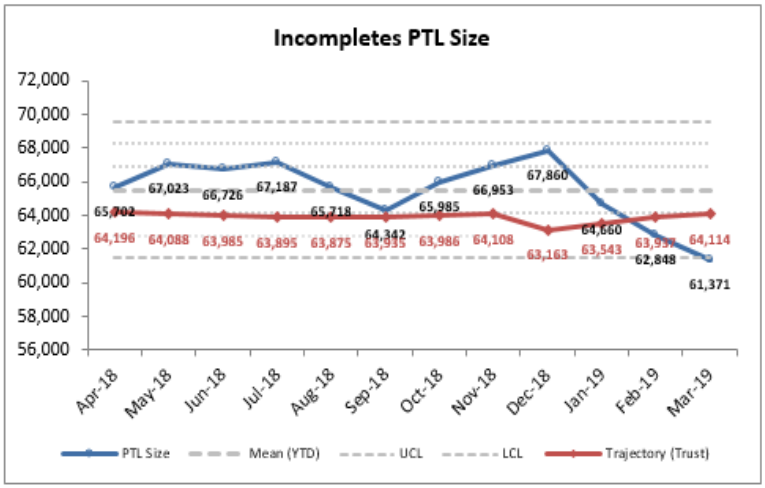
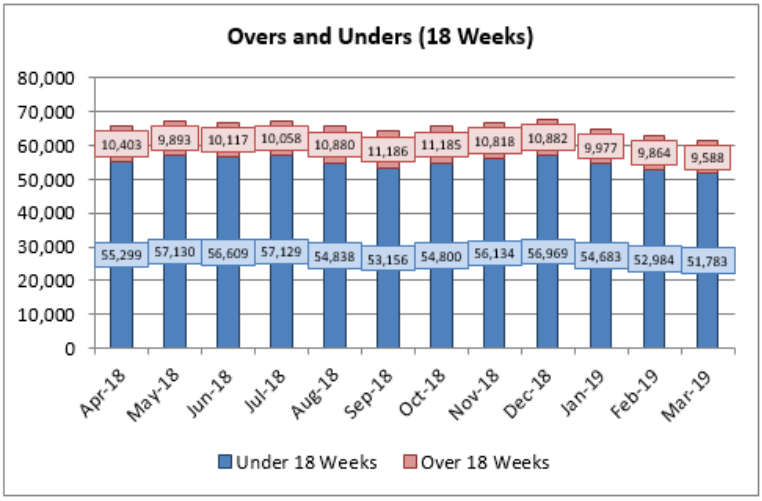
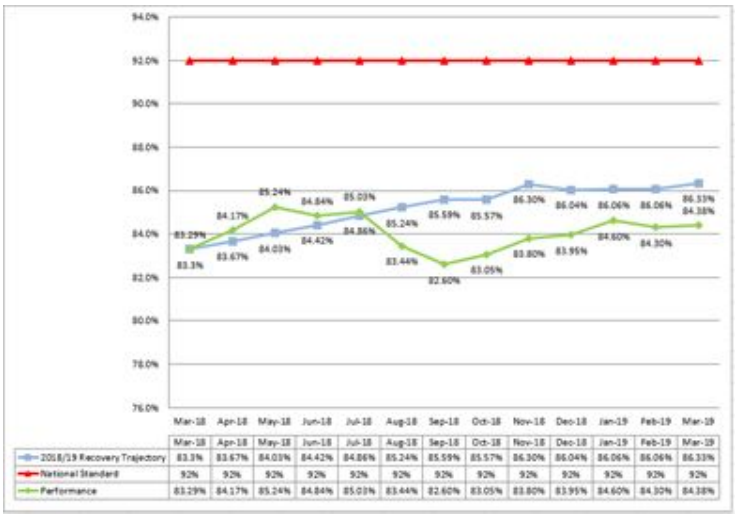
incompletes over 18 weeks (the backlog) decreased by 276 to 9,588 in March. This is the lowest they have been in the full year - See graphs below.





4.2. RTT Incomplete performance was 84.38% in March against a plan of 86.33% which is a gap of 1.95%. Having said that, there is a trend of improvement over the last six months in the performance at the Trust.

RTT Performance % Trend



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4.3. The Trust reported **Zero** 52-week breaches for March.

4.4. The teams are now being refocused to reducing any patient pathways waiting over 42 weeks and an internal trajectory has been drafted to achieve this aim. There was reduction of 45 over 42 WW patients in March when compared to February – See graph below.

Internal Trajectory for reducing patients waiting longer than 42 weeks

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Pop-ons	96	86	150	284	345	148	96	77	71	59	59	63	62	58	47	44	68	37	67	78	78	20	29
Tip Overs	374	440	418	407	491	526	392	299	327	382	287	362	320	238	164	171	172	153	83	124	102	78	92
Trajectory															540	610	529	468	427	407	366	305	244
Actual	1016	1002	1030	1112	1367	1079	1036	964	947	953	956	984	820	655	535	607	644	510	497	546	510	444	399

4.5. There have been improvements in RTT performances of all “challenged” services. However, Neurosurgery has consistently delivered performance in the last 4 months of over 92%.

4.6. Cerner System errors reported were 485 in March, this has increased by 46 compared to the previous month but considerably less than we were reporting earlier in the year

4.7. Clock starts were 22,844 in March. This was an increase of 1,477 in comparison to February which was 21,347. Total clock stops were 17,498 in March, this is an increase of 807 in comparison to February which was 16, 691. Within these clock stops, 12,407 patients were treatments which is 214 more than February (12,193)

4.8. The number of tip-overs has increased in March by 219 to 3,538 which is a focus area for performance improvement in 19/20.

4.9. The March 2019 clinical harm review process found no harm to patients waiting over 52 weeks.

4.10. It is expected that the Trust will continue to have zero 52 week waiting pathways in April 2019 as well as continued improvement in the % performance. Having said that, it is estimated that the PTL size will be slightly larger than March 2019 due to bank holiday periods in April 2019.

5. Conclusion and Next Steps

5.1. The Trust has seen key successes in 18/19 in terms of performance improvement against all key metrics on RTT which continue to be the goal in 19/20.

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5.2. These improvements have been underpinned by the delivery of key milestones within the projects being managed under the RTT Improvement programme which has focused on 3 key priorities – people (through Education & Training), systems (through a Validation and data visualisation tool – Qubit) and processes (through developing and implementing a performance management and accountability framework).

5.3. The Performance Framework is currently in implementation (since January 2019) in all divisions and going through an embedding process due to be evaluated in June 2019. This framework has already provided key benefits in providing a focussed and targeted information pack and performance management meetings for services to design and implement rapid interventions when required to support performance improvement in their areas.

5.4. Key milestones and deliverables against the Qubit Validation tool and Education & Training projects are due in Quarter 1 & 2 of 19/20 which will further support strengthening of the infrastructure in place in order to sustainably deliver improvements against performance metrics in the future. Note - a detailed report on these projects is submitted bi-monthly to the Executive Operational Committee with the next update due in May 2019.

5.5. As the programme progresses and embeds good practice, the Trust Executive has agreed a Target model of elective care delivery for RTT and Cancer at the Trust in May 2019. This is now going through to implementation with the key aim of building sustainability in the elective care system at the Trust which is in house and not dependent on bank and agency.

6. Recommendations

The committee is asked to note:

6.1. The performance update for the March 2019 RTT submitted position and 52 weeks' position of zero as at March 2019.

6.2. The improving trend of all performance metrics in 18/19 against the RTT standard at ICHT.

6.3. The March 2019 clinical harm review process found no harm to patients waiting over 52 weeks

6.4. The three key work projects for RTT Improvement focused on people, processes and systems to support sustainable improvement on RTT performance through 19/20.

Karina Malhotra, RTT Improvement Partner
15 May 2019

Appendices
Appendix 1 – RTT Performance Pack – March 2019

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RTT Performance Pack
M12 - March 2019

V1 Last updated 10/04/19

Executive Summary – M12 – March 19

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Key Messages	Slide
M12 – March RTT Performance Overview	3-10
• Total incompletes reduced by 1, 477 to 61,371 in March, 2,743 below Trust trajectory.	3
• Incomplete performance was 84.38% in March against a plan of 86.33% which is a gap of 1.95%. There is a trend of improvement over the last six months.	3
• System errors reported were 485, this has increased slightly by 46 but considerably less than we were reporting earlier in the year	3
• Clock starts were 22,844 in March. This was an increase of 1,477 in comparison to February which was 21,347.	4-5
• Total clock stops were 17,498 in March, this is an increase of 807 in comparison to February which was 16, 691. Within these clock stops, 12,407 patients were treatments which is 214 more than February (12,193)	4-5
• The number of tip-overs has increased in March by 219 to 3,538.	5
• The Trust reported **Zero** 52-week breaches for March.	6
• There have been improvements in RTT performances of the "challenged" services. However, Neurosurgery has consistently delivered performance in the last 4 months of over 92%.	7

RTT Incomplete Performance

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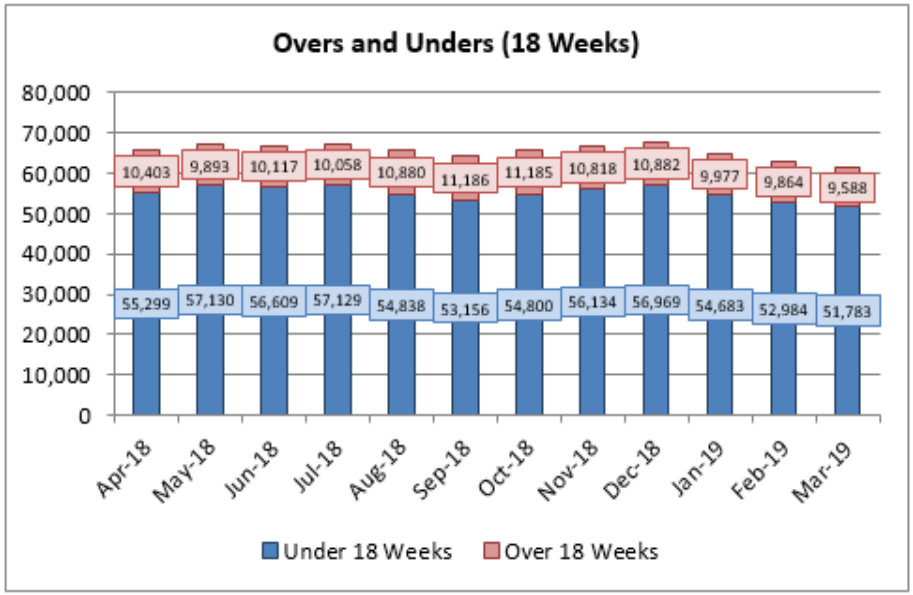
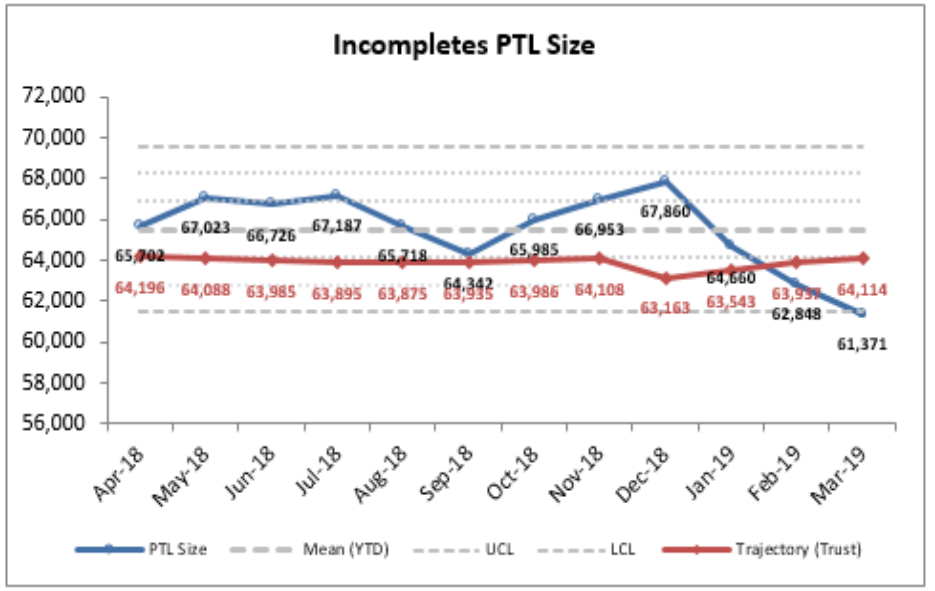
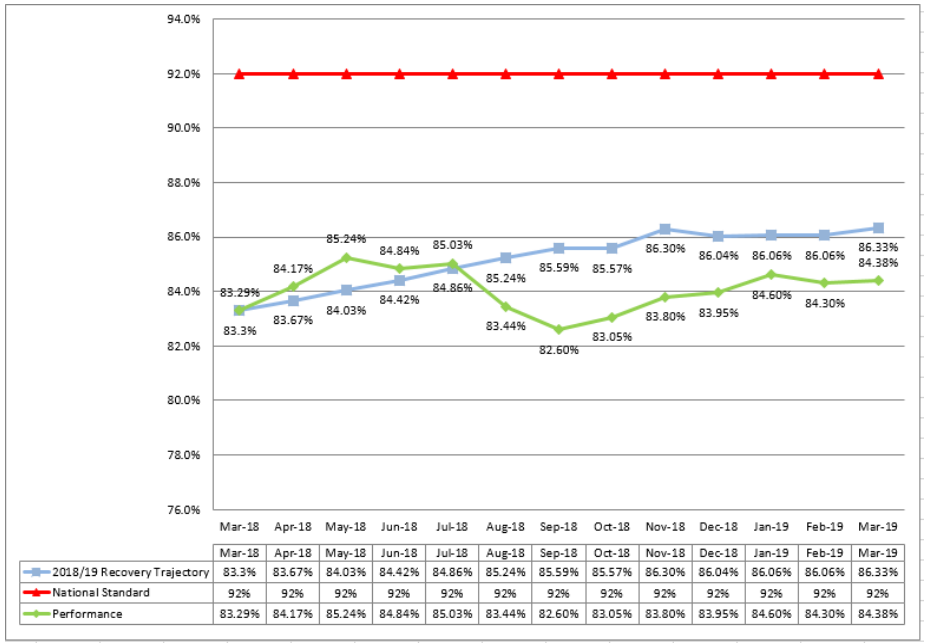




Headlines

- Incomplete performance was 84.38% in February against a plan of 86.33% which is a gap of 1.95%. There is a trend of improvement over the last six months.
- Total incompletes reduced by 1, 477 to 61,371 in March, 2,743 below Trust trajectory.
- Incompletes over 18 weeks decreased by 276 to 9,588 in February
- The number of patients <18 weeks decreased by 1,201 to 51,783 in March compared to February.
- System errors reported were 485, which is still 46 more than was reported in February but less than we were reporting earlier in the year



RTT Performance – Clock Starts & Stops

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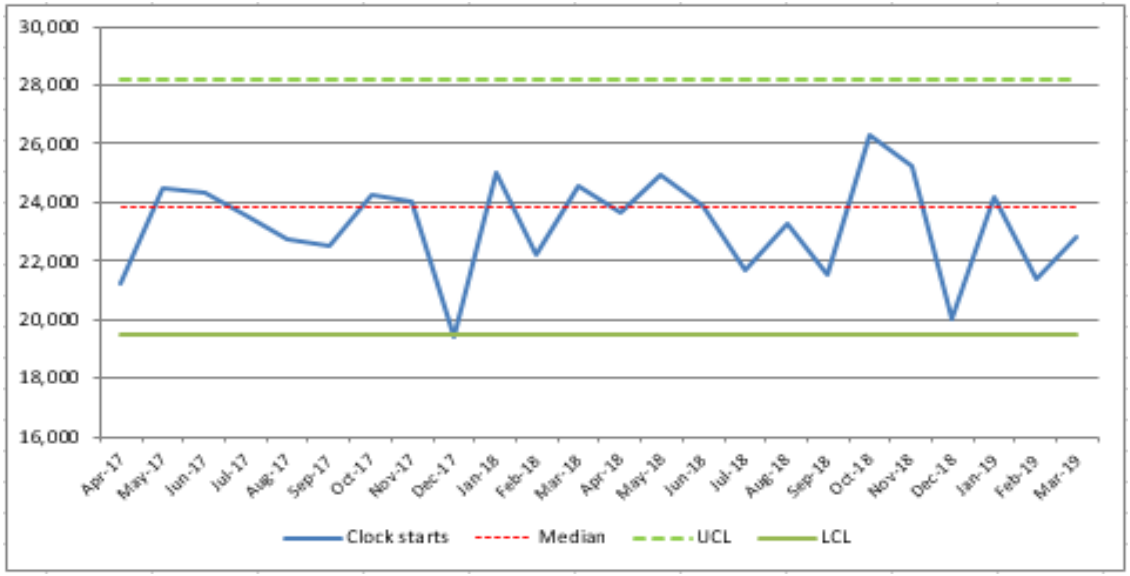
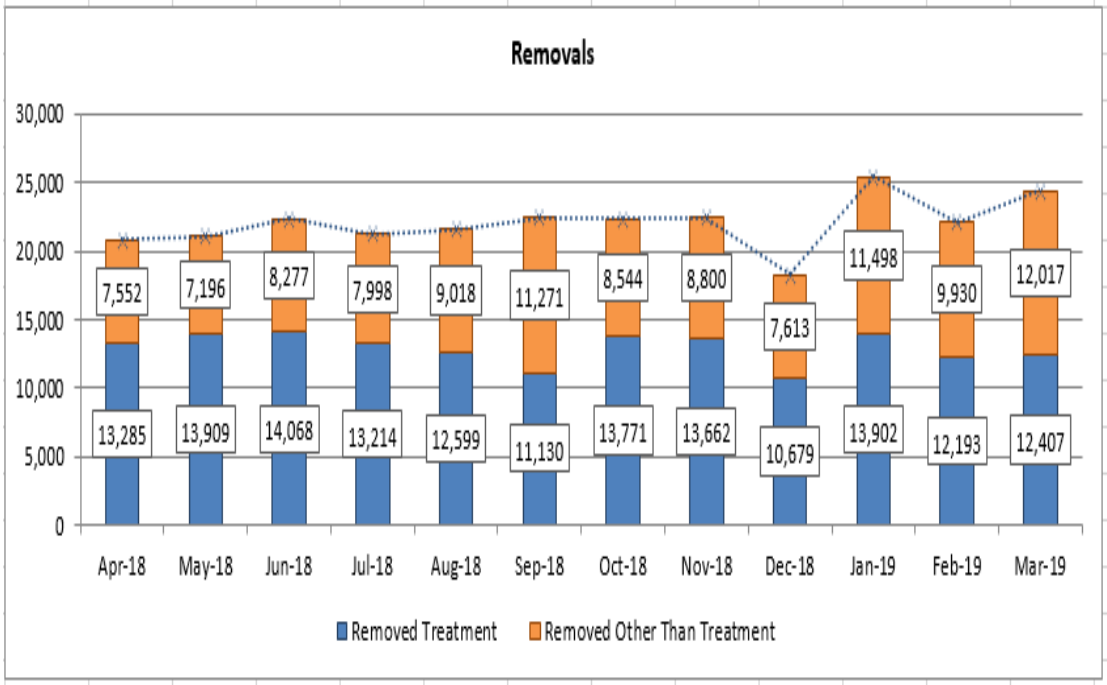


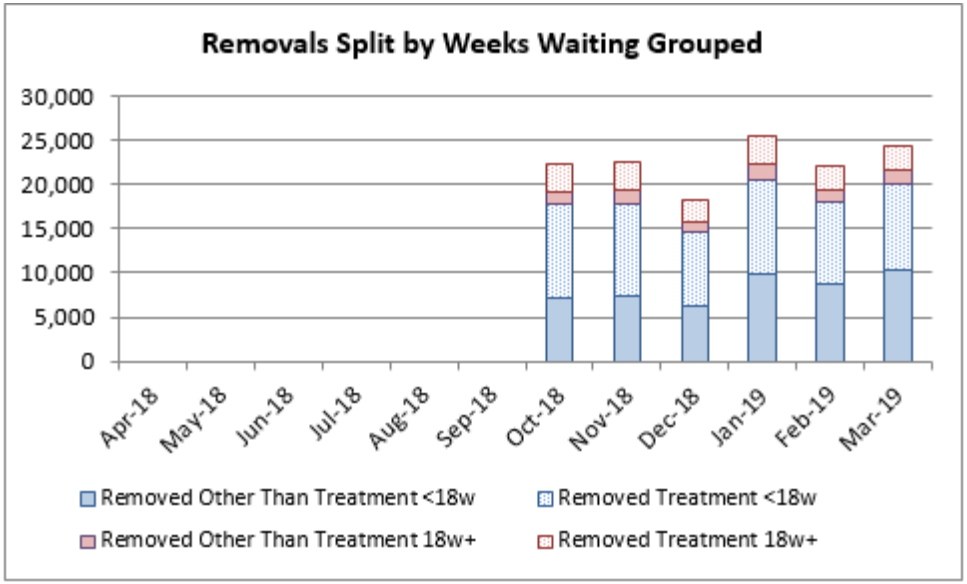
- **Clock starts** were 22,844 in March.
- This was an increase of 1,497 compared to February 2018.

- Total **clock stops** were 17,498 in March, this is an increase of 807 in comparison to February which was 16,691
- Within these clock stops, 12,407 patients were treatments which is 214 more than February (12,193)
- There were 12,017 ROTT patients in March which is 2,087 more than February (9,930).



RTT Performance – Clock Starts & Stops

Imperial College Healthcare NHS Trust



- The removed treated increased by 241 to 12,407 in March (12,193 in February)
- There is on going definition of ROTT as currently this includes historic treatment captured by Validation

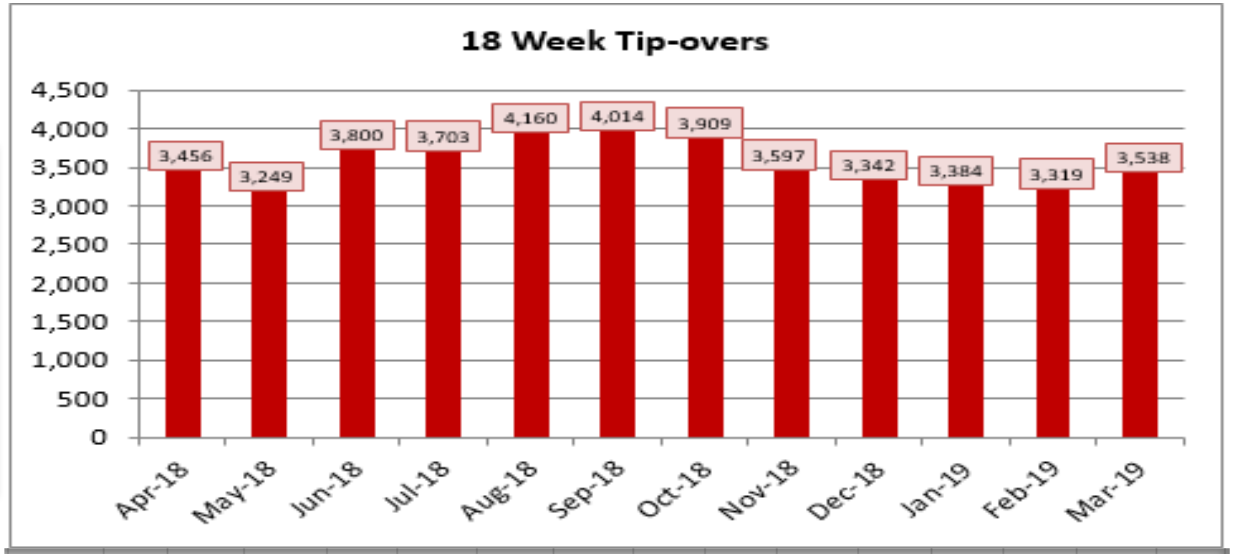
Under 18 Weeks

- The removed other than treatment (ROTT) increased by 1,718 in March to 10,399 (8,681 in February)
- The removed treatment increase by 203 to 9,611 in March. (February 9,408)

Over 18 Weeks

- The ROTT decreased by 369 in March to 1,618 (1,249 in January)

- The number of tip-overs has increased in March by 219 to 3,538.
- This is a small increase in March for tip-overs, and is still considerably less than August 2018.



Month	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
18 weeks Tip overs	3,277	3,403	3,666	3,456	3,249	3,800	3,703	4,160	4,014	3,909	3,597	3,342	3,384	3,319	3,538

RTT 42-Week Internal Trajectory

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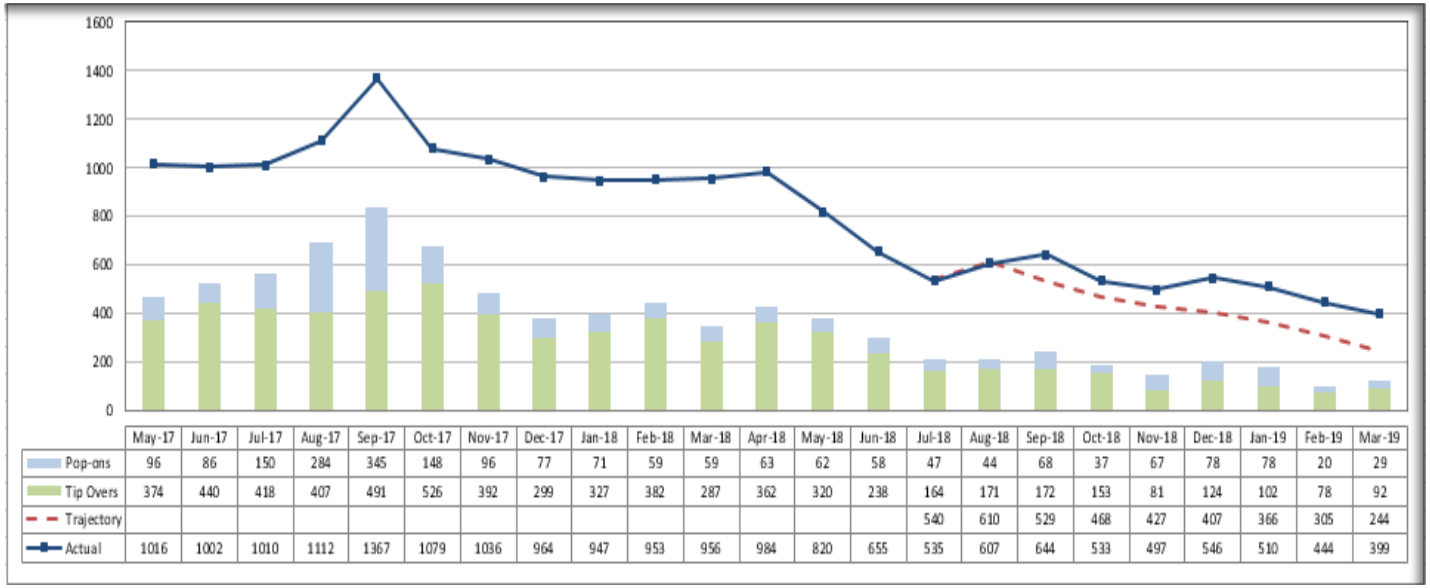
- There was reduction of 45 over 42 WW patients in March when compared to February (444)
- The 3 TFCs with the largest volume of patients waiting over 42W are as follows:
  - Trauma & Orthopaedics – 64
  - Urology– 61
  - Cardiology – 55



	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Pop-ons	96	86	150	284	345	148	96	77	71	59	59	63	62	58	47	44	68	37	67	78	78	20	29
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Trajectory															540	610	529	468	427	407	366	305	244
Actual	1016	1002	1010	1112	1367	1079	1036	964	947	953	956	984	820	655	535	607	644	533	497	546	510	444	399

RTT Recovery - Performance Against Specialty Trajectories

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NHS Trust

			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	MoM Trend
100	General Surgery	Trajectory	74.65%	76.91%	79.25%	81.95%	84.80%	87.30%	89.41%	92.05%	92.86%	92.86%	92.85%	92.85%	92.84%	92.84%	92.83%	92.83%	92.82%	92.82%	
		Performance	75.07%	73.56%	70.33%	70.90%	69.56%	67.30%	70.07%	73.31%	71.32%	71.86%	69.96%	69.85%	70.89%	71.87%	70.28%	70.57%	69.50%	70.60%	↑
		Variance	0.42%	-3.35%	-8.92%	-11.04%	-15.24%	-20.00%	-19.34%	-18.75%	-21.54%	-21.00%	-22.90%	-23.00%	-21.95%	-20.97%	-22.55%	-22.26%	-23.32%	-22.22%	
101	Urology	Trajectory	75.49%	75.48%	77.70%	78.20%	79.30%	81.20%	83.90%	86.10%	88.90%	91.70%	92.00%	92.10%	92.10%	92.20%	92.20%	92.30%	92.30%	92.30%	
		Performance	75.50%	75.04%	72.09%	72.67%	73.84%	69.53%	72.87%	77.05%	77.90%	78.50%	75.12%	73.21%	75.10%	75.75%	74.87%	74.18%	73.44%	74.40%	↑
		Variance	0.01%	-0.45%	-5.61%	-5.53%	-5.46%	-11.67%	-11.03%	-9.05%	-11.00%	-13.20%	-16.88%	-18.89%	-17.00%	-16.45%	-17.33%	-18.12%	-18.86%	-17.90%	
110	T&O	Trajectory	62.21%	62.02%	62.51%	63.14%	63.97%	64.79%	66.50%	69.00%	71.70%	74.40%	76.90%	79.30%	81.40%	83.00%	84.30%	85.70%	87.20%	88.40%	
		Performance	62.40%	62.21%	62.20%	62.38%	63.76%	63.05%	65.73%	70.60%	70.33%	72.33%	70.54%	69.89%	70.65%	70.42%	69.28%	68.97%	67.05%	70.00%	↑
		Variance	0.19%	0.19%	-0.31%	-0.76%	-0.21%	-1.74%	-0.77%	1.60%	-1.37%	-2.07%	-6.36%	-9.41%	-10.75%	-12.58%	-15.02%	-16.73%	-20.15%	-18.40%	
120	ENT	Trajectory	76.54%	76.40%	76.28%	76.07%	76.39%	77.88%	78.88%	80.41%	81.96%	84.18%	86.38%	89.07%	91.45%	92.75%	93.24%	93.75%	94.27%	94.79%	
		Performance	76.44%	79.39%	78.62%	80.35%	80.98%	81.44%	81.88%	83.99%	83.63%	82.36%	81.36%	79.71%	79.54%	81.99%	82.60%	84.63%	85.38%	86.40%	↑
		Variance	-0.10%	2.99%	2.34%	4.28%	4.59%	3.56%	3.00%	3.58%	1.67%	-1.82%	-5.02%	-9.36%	-11.91%	-10.76%	-10.64%	-9.12%	-8.89%	-8.39%	
130	Ophthalmology	Trajectory	86.70%	88.20%	89.40%	90.70%	92.40%	93.50%	93.70%	93.60%	93.50%	93.40%	93.30%	93.10%	93.00%	92.90%	92.80%	92.70%	92.50%	92.40%	
		Performance	88.83%	88.83%	87.46%	88.06%	88.69%	89.77%	89.53%	89.14%	89.16%	89.69%	88.98%	87.91%	88.30%	87.69%	88.08%	86.25%	86.38%	88.50%	↑
		Variance	2.13%	0.63%	-1.94%	-2.64%	-3.71%	-3.73%	-4.17%	-4.46%	-4.34%	-3.71%	-4.32%	-5.19%	-4.70%	-5.21%	-4.72%	-6.45%	-6.12%	-3.90%	
150	Neurosurgery	Trajectory	85.30%	86.30%	87.30%	87.70%	88.20%	88.60%	87.86%	89.13%	90.47%	91.84%	92.44%	92.85%	92.99%	93.13%	93.28%	93.43%	93.58%	93.75%	
		Performance	85.88%	85.76%	83.07%	84.23%	85.57%	86.65%	87.94%	87.78%	86.26%	89.55%	89.47%	88.99%	89.29%	91.72%	92.20%	92.05%	92.78%	85.70%	↓
		Variance	0.58%	-0.54%	-4.23%	-3.47%	-2.63%	-1.95%	0.08%	-1.35%	-4.21%	-2.29%	-2.97%	-3.86%	-3.70%	-1.41%	-1.08%	-1.38%	-0.80%	-8.05%	
160	Plastics	Trajectory	72.10%	75.35%	78.62%	82.03%	83.94%	87.22%	91.03%	92.58%	92.50%	92.46%	92.46%	92.46%	92.46%	92.46%	92.46%	92.46%	92.46%	92.46%	
		Performance	71.14%	72.95%	66.47%	63.60%	62.04%	66.19%	70.94%	68.81%	72.76%	74.02%	70.00%	70.07%	73.40%	74.92%	71.49%	72.88%	69.54%	72.60%	↑
		Variance	-0.96%	-2.40%	-12.15%	-18.43%	-21.90%	-21.03%	-20.09%	-23.77%	-19.74%	-18.44%	-22.46%	-22.39%	-19.06%	-17.54%	-20.97%	-19.58%	-22.92%	-19.86%	
301	Gastroenterology	Trajectory	75.55%	76.05%	77.83%	79.98%	81.92%	83.91%	86.28%	89.74%	93.03%	94.22%	94.68%	95.14%	95.61%	96.07%	96.54%	97.00%	97.47%	97.94%	
		Performance	80.29%	80.77%	78.79%	83.41%	87.66%	89.02%	90.13%	90.58%	90.61%	89.72%	89.23%	85.84%	85.45%	86.94%	87.60%	87.88%	86.04%	81.30%	↓
		Variance	4.74%	4.72%	0.96%	3.43%	5.74%	5.11%	3.85%	0.84%	-2.42%	-4.50%	-5.45%	-9.30%	-10.16%	-9.13%	-8.94%	-9.12%	-11.43%	-16.64%	
330	Dermatology	Trajectory	86.90%	84.70%	80.59%	80.97%	81.87%	82.26%	82.66%	83.88%	84.95%	85.98%	87.28%	88.64%	90.07%	91.58%	92.56%	94.40%	96.35%	98.42%	
		Performance	85.25%	83.48%	82.00%	81.60%	81.87%	84.06%	86.19%	86.46%	87.67%	87.18%	85.58%	83.47%	82.33%	81.30%	79.28%	79.17%	79.33%	76.60%	↓
		Variance	-1.65%	-1.22%	1.41%	0.63%	0.00%	1.80%	3.53%	2.58%	2.72%	1.20%	-1.70%	-5.17%	-7.74%	-10.28%	-13.28%	-15.23%	-17.02%	-21.82%	
400	Neurology	Trajectory	79.86%	80.54%	81.26%	82.47%	83.74%	85.10%	86.57%	88.15%	89.86%	91.72%	93.74%	95.96%	95.96%	95.96%	95.96%	95.96%	95.96%	95.96%	
		Performance	81.59%	81.77%	79.30%	82.65%	84.31%	85.88%	87.33%	88.07%	86.10%	86.26%	83.99%	86.35%	86.46%	88.28%	88.40%	87.65%	87.80%	85.70%	↓
		Variance	1.73%	1.23%	-1.96%	0.18%	0.57%	0.78%	0.76%	-0.08%	-3.76%	-5.46%	-9.75%	-9.61%	-9.50%	-7.68%	-7.56%	-8.31%	-8.16%	-10.26%	
104	Colorectal Surgery	Trajectory	86.08%	87.27%	88.91%	90.63%	92.07%	92.88%	93.25%	93.92%	93.92%	93.92%	93.92%	93.92%	93.92%	93.92%	93.92%	93.92%	93.92%	93.92%	
		Performance	84.71%	83.03%	82.55%	84.25%	83.10%	83.74%	84.81%	85.70%	83.92%	83.37%	80.98%	80.57%	79.53%	75.46%	72.62%	82.13%	80.22%	79.00%	↓
		Variance	-1.37%	-4.24%	-6.36%	-6.38%	-8.97%	-9.14%	-8.44%	-8.22%	-10.00%	-10.55%	-12.94%	-13.35%	-14.39%	-18.46%	-21.30%	-11.79%	-13.70%	-14.92%	
107	Vascular Surgery	Trajectory	86.73%	88.24%	89.29%	90.86%	91.27%	91.82%	92.46%	92.41%	92.41%	92.41%	92.41%	92.41%	92.41%	92.41%	92.41%	92.41%	92.41%	92.41%	
		Performance	85.26%	84.08%	81.20%	80.09%	80.30%	79.26%	82.13%	82.13%	77.69%	79.45%	74.74%	71.10%	65.73%	66.34%	67.52%	74.92%	76.62%	77.70%	↑
		Variance	-1.47%	-4.16%	-8.09%	-10.77%	-10.97%	-12.56%	-10.33%	-10.28%	-14.72%	-12.96%	-17.67%	-21.31%	-26.68%	-26.07%	-24.89%	-17.49%	-15.79%	-14.71%	

NHSE Performance Data for Local Area Acute Trusts (Feb 19)

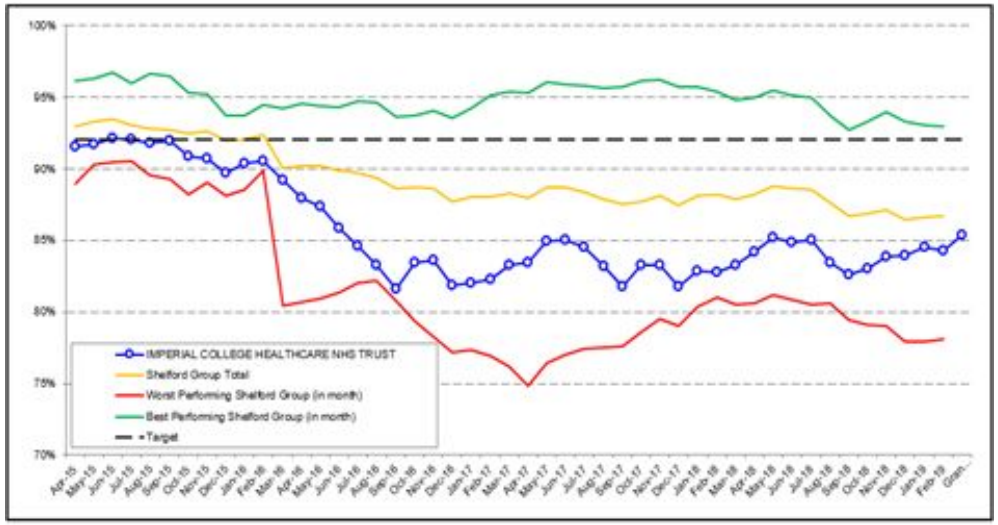
Imperial College Healthcare NHS Trust

	IMPERIAL COLLEGE HEALTHCARE NHS		LONDON NORTH WEST UNIVERSITY		THE HILLINGDON HOSPITALS NHS		CHELSEA AND WESTMINSTER HOSPITAL		ROYAL BROMPTON & HAREFIELD NHS	
Treatment Function	Total Incomplete Pathways	% Within 18 Weeks	Total Incomplete Pathways	% Within 18 Weeks	Total Incomplete Pathways	% Within 18 Weeks	Total Incomplete Pathways	% Within 18 Weeks	Total Incomplete Pathways	% Within 18 Weeks
Total	62,798	84.3%	**53659**	83.5%	22,752	88.1%	37,681	92.6%	5,520	94.3%
General Surgery	2,015	69.5%	8,027	81.4%	2,227	83.6%	2,331	86.8%	-	-
Urology	3,644	73.5%	3,135	92.1%	921	91.6%	2,468	90.8%	-	-
Trauma & Orthopaedics	3,753	67.0%	4,262	92.8%	3,999	82.9%	2,991	90.6%	-	-
Ear, Nose & Throat (ENT)	4,262	85.4%	6,003	59.6%	1,563	94.6%	1,728	92.4%	-	-
Ophthalmology	4,677	86.4%	991	92.9%	2,187	93.3%	637	98.1%	-	-
Oral Surgery	514	94.0%	6,590	74.5%	1,284	95.0%	566	96.8%	-	-
Neurosurgery	1,455	92.8%		-	-	-	-	-	-	-
Plastic Surgery	788	69.5%	1	100.0%	42	100.0%	1,434	86.7%	-	-
Cardiothoracic Surgery	243	79.4%		-	-	-	24	95.8%	862	91.8%
General Medicine	209	82.3%	64	96.9%	23	100.0%	170	100.0%	-	-
Gastroenterology	4,695	86.0%	2,528	87.9%	1,345	86.0%	1,705	95.3%	-	-
Cardiology	5,648	88.0%	2,317	96.8%	559	95.7%	1,672	94.9%	2,022	92.1%
Dermatology	2,544	79.4%	3,188	90.2%	1,327	88.8%	2,108	94.9%	-	-
Thoracic Medicine	2,084	93.2%	1,213	95.3%	338	97.9%	1,216	92.4%	1,799	98.1%
Neurology	2,957	87.8%	1,668	88.4%	1,026	85.8%	1,404	92.9%	-	-
Rheumatology	1,055	86.6%	881	97.6%	491	84.7%	970	94.7%	-	-
Geriatric Medicine	152	93.4%	187	99.5%	75	98.7%	331	90.0%	-	-
Gynaecology	5,514	93.6%	4,252	73.8%	1,054	97.2%	3,070	95.6%	-	-
Other	16,589	85.3%	8,352	93.5%	4,291	84.3%	12,856	92.8%	837	94.1%

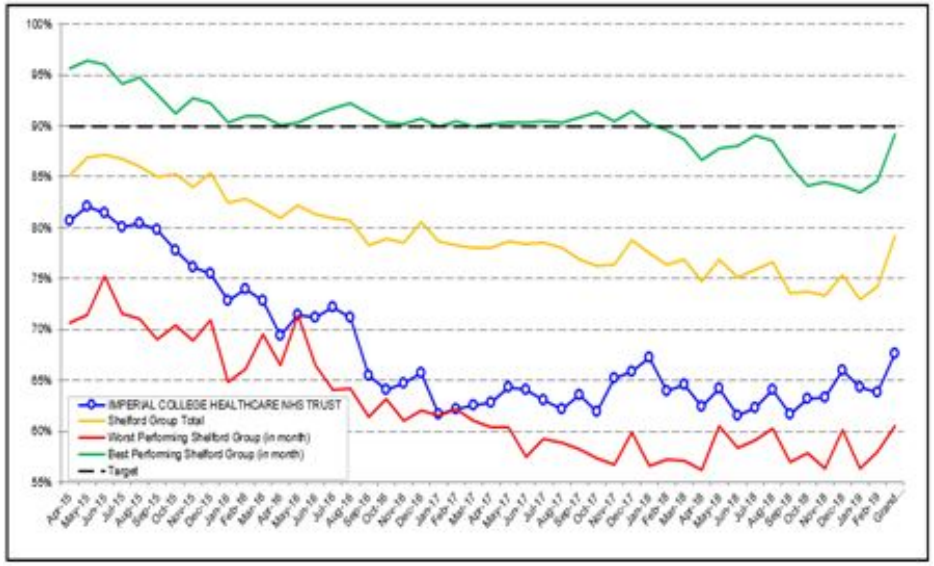
RTT Benchmarking Shelford Group Comparison (February 19)

Peer Group
Imperial College Healthcare
Cambridge University Hospitals
Central Manchester University Hospitals
Guy's & St Thomas'
King's College Hospital
Sheffield Teaching Hospitals
The Newcastle Upon Tyne Hospitals
University College London Hospitals
University Hospitals Birmingham
Oxford University Hospitals

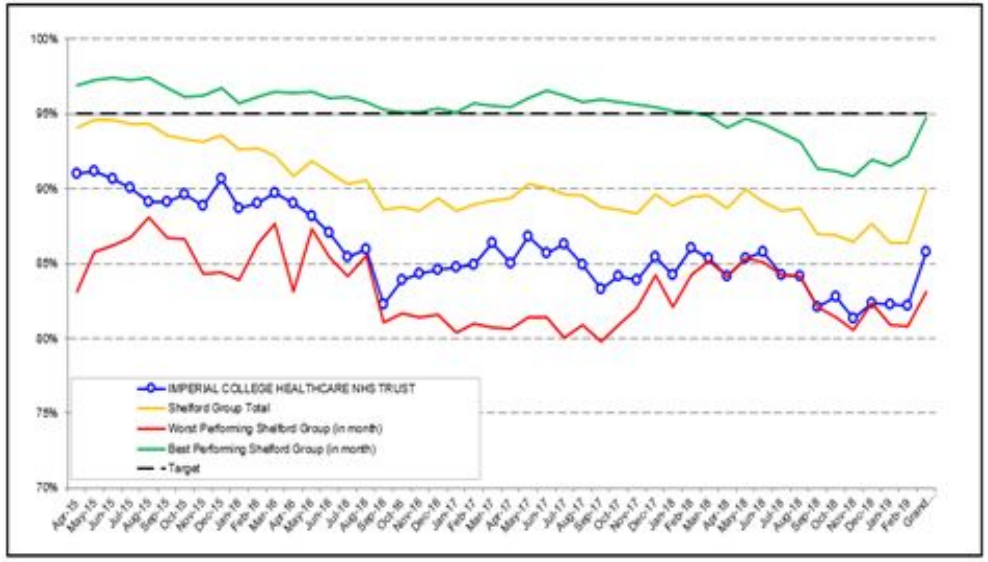
Incompletes Benchmark



Admitted Benchmark



Non-Admitted Benchmark



Imperial College Healthcare NHS
NHS Trust

NHSE Performance Data – Reported 52+ Pathways (Feb 19)

Provider Org Name	Dec-18 Reported	Jan-18 Reported	Feb-18 Report	MoM Change
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	248	261	262	1
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	143	179	153	-26
LEEDS TEACHING HOSPITALS NHS TRUST	168	157	128	-29
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	106	125	104	-21
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	99	116	17
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	143	96	110	14
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	74	90	92	2
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	92	81	68	-13
NORTHERN DEVON HEALTHCARE NHS TRUST	75	67	50	-17
ROYAL FREE LONDON NHS FOUNDATION TRUST	62	67		-67
ROYAL CORNWALL HOSPITALS NHS TRUST	87	62	34	-28
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	66	56	56	0
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	79	52	39	-13
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	11	44	91	47
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	74	38	27	-11
NORTH BRISTOL NHS TRUST	51	38	44	6
PENNINE ACUTE HOSPITALS NHS TRUST	39	38	29	-9
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	29	36	47	11
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	51	35	23	-12
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	26	32	30	-2
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	28	28	19	-9
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	28	28	12	-16
BARTS HEALTH NHS TRUST	44	25	24	-1
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	4	23	20	-3
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	61	20	14	-6
MEDWAY NHS FOUNDATION TRUST	13	20	27	7
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	39	19	8	-11
WYE VALLEY NHS TRUST	30	18	20	2
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	7	16	21	5
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	22	15	16	1
UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	13	15	11	-4
SURREY AND SUSSEX HEALTHCARE NHS TRUST	10	13	11	-2
EAST AND NORTH HERTFORDSHIRE NHS TRUST	13	9	3	-6
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	6	9	11	2
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	10	8	10	2
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	7	8	10	2
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	13	7	4	-3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	11	7	3	-4
WEST SUFFOLK NHS FOUNDATION TRUST	10	7	7	0
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	6	7	4	-3
BOLTON NHS FOUNDATION TRUST	5	7	5	-2
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	11	6	3	-3
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	7	6	13	7

Provider Org Name	Dec-18 Reported	Jan-18 Reported	Feb- 18 Reported	MoM Change
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	11	5	2	-3
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	3	5	10	5
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	7	4	5	1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	4	4	3	-1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	3	4	4	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	2	4	4	0
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	0	4	9	5
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	6	3	6	3
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	4	3	2	-1
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	3	3	1	-2
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	1	3	2	-1
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	1	3	1	-2
STOCKPORT NHS FOUNDATION TRUST	9	2	5	3
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	7	2	0	-2
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	6	2	4	2
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	5	2	0	-2
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	4	2	4	2
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1	2	3	1
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	0	2	3	1
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	10	1	19	18
CROYDON HEALTH SERVICES NHS TRUST	9	1	2	1
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	7	1	0	-1
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	1	0	-1
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	1	1	1	0
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	1	1	1	0
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	1	1	1	0
PORTSMOUTH HOSPITALS NHS TRUST	0	1	2	1
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	0	1	1	0
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	0	1	0	-1
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	0	1	3	2
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	0	1	1	0
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	0	1	2	1
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	10	0	0	0
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	0	2	2
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	2	0	0	0
EAST CHESHIRE NHS TRUST	2	0	0	0
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	1	0	1	1
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	1	0	1	1
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	1	0	0	0
LEWISHAM AND GREENWICH NHS TRUST	1	0	0	0
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1	0	0	0
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1	0	0	0

The Trust reported ***Zero*** 52 weeks in March

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Finance Report for year end March 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 15, report no. 11**
Responsible Executive Director: Richard Alexander – Chief Finance Officer	**Author:** Janice Stephens – Deputy Chief Finance Officer Michelle Openibo – Associate Director of Finance

Summary:

The position presented represents the draft management accounts of the Trust, the position will not be finalised until the accounts are audited in May.

The Trust has met the control total for 2018/19, before PSF, with a favourable variance to plan of £0.3m. As the A&E 4-hour target has also been met across the delivery board the Trust is eligible for £34m of core Provider Sustainability Funding. The Trust has also received an additional £14m of bonus and incentive PSF funding. This funding was allocated based on achievement of the control total and recurrent CIPs. This non recurrent funding brings the total reported surplus for the year to £28.2m.

The Trust capital spend was £53.4m against a Capital resource limit (CRL) of £54.2m.

We ended the year with £26.7m in the bank and have therefore underspent against our External Financing Limit (EFL), another key metric for the Trust.

Recommendations:
The Committee is asked to note the report.

This report has been discussed at:
Finance and Investment Committee 15 May 2019

Quality impact: N/A

Financial impact: N/A

Risk impact and Board Assurance Framework (BAF) reference:
This report relates to risk ID:2473 on the trust risk register - Failure to maintain financial sustainability

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

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

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

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

The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To develop a sustainable portfolio of outstanding services
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No If yes, why?..... If the details can be shared, please provide the following in one to two line bullet points: ▪ Should senior managers share this information with their own teams? ☒ Yes ☐ No If yes, why?. The financial plan can only be delivered if all staff are aware of and managing costs.

Imperial College Healthcare NHS Trust

FINANCE REPORT – 12 MONTHS ENDED 31st March 2019

1. Introduction

This report provides a brief summary of the Trust's financial results for the 12 months ended 31st March 2019.

2. Financial Performance Summary

The Trust reported a full year position, before Provider Sustainability Funding (PSF), of a £20.24m deficit, this was £0.32m favorable to the planned £20.56m deficit.

As a consequence of meeting the control total, and meeting the required A&E 4 hour targets, the Trust received 100% of planned PSF of £34.2m. The Trust also received bonus and incentive PSF for meeting the control total of £14.2m bringing the total PSF to £48.4m and the total reported Trust position to a £28.2m surplus.

	In Month			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	94.18	102.87	8.69	1,118.94	1,138.76	19.82
Pay	(51.82)	(53.44)	(1.62)	(622.57)	(629.37)	(6.80)
Non Pay	(47.84)	(57.03)	(9.19)	(477.89)	(496.93)	(19.04)
Internal Recharges	-	0.00	0.00	-	(0.00)	(0.00)
Reserves	13.40	15.51	2.11	7.58	13.72	6.14
EBITDA	7.92	7.90	(0.01)	26.06	26.17	0.12
Financing Costs	(3.93)	(2.43)	1.49	(43.92)	(44.13)	(0.21)
SURPLUS / (DEFICIT) inc. donated asset treatment	3.99	5.47	1.48	(17.86)	(17.96)	(0.10)
Donated Asset treatment	0.04	(1.12)	(1.16)	(2.70)	(0.14)	2.56
Impairment of Assets	-	0.00	0.00	-	(2.14)	(2.14)
SURPLUS / (DEFICIT)	4.03	4.35	0.32	(20.56)	(20.24)	0.32
PSF Income	3.99	18.23	14.24	34.16	48.40	14.24
SURPLUS / (DEFICIT) after PSF income	8.02	22.58	14.56	13.60	28.16	14.56

Imperial College Healthcare NHS Trust

2.1. NHS Activity and Income

Divisions	Year To Date Activity			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	951,258	877,388	(73,870)	269.14	274.90	5.76
Division of Surgery, Cancer & Cardiov.	730,276	766,740	36,464	332.44	334.88	2.44
Division of Women, Children & Clin. Support	2,597,988	2,626,537	28,549	161.03	160.69	(0.34)
Central Income			-	140.10	147.69	7.59
Clinical Commissioning Income	4,279,521	4,270,665	(8,857)	902.72	918.16	15.45

The Trust has over performed in year by £15.5m on NHS clinical income and activity. This over performance has been with both local CCGs and specialist commissioners. There has been 6% over performance on non-elective income over plan and 2% over performance on electives and day cases. In year the Trust budgeted for a reduction in income of £10.2m for commissioner demand management schemes, these have not delivered in year contributing to the over performance on income.

Medicine and Integrate Care (MIC) over performance was in the specialist and acute directorates across all three sites, driven by the non elective activity.

Surgery, Cancer and Cardiovascular (SCC) has over performed in cardiac, clinical haematology and oncology and palliative care. There has ben underperformance in specialist surgery and trauma surgery where the service has not grown to the level planned at the start of the year.

Women, Children and Clinical Support (WCCS) is slightly under plan. Maternity activity has reduced; this continues the trend seen in the previous financial year in line with activity in the sector.

2.2. Private Patient Income

Private patient income is slightly under plan for the year with an outturn of £52.2m against a plan of £52.5m. This position is an increase in private income of £1.5m compared to 2017/18. The Trust continues to focus on increasing private and commercial income, using the contribution generated to support the overall Trust. In 2019/20 the private patients team, working with clinical and operational colleagues across the Trust is aiming to improve the private income to £54m.

Imperial College Healthcare NHS Trust

2.3. Clinical Divisions

		In Month			Full Year		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	24.18	24.91	0.73	287.87	291.88	4.00
	Expenditure	(17.95)	(19.93)	(1.98)	(221.26)	(228.73)	(7.47)
		6.23	4.98	(1.25)	66.62	63.15	(3.47)
Surgery, Cancer and Cardiovascular	Income	29.40	28.73	(0.67)	348.22	342.23	(6.00)
	Expenditure	(24.89)	(26.45)	(1.56)	(294.46)	(301.29)	(6.83)
		4.51	2.28	(2.23)	53.77	40.94	(12.83)
Women, Children & Clinical Support	Income	15.14	17.64	2.50	178.89	175.49	(3.41)
	Expenditure	(15.98)	(19.55)	(3.57)	(203.64)	(208.10)	(4.46)
		(0.84)	(1.90)	(1.07)	(24.74)	(32.61)	(7.86)
Imperial Private	Income & Expenditure	1.31	1.59	0.28	14.50	17.70	3.20
Total Clinical Division		11.21	6.94	(4.27)	110.13	89.18	(20.96)

The clinical divisions ended the year £21m adverse to plan, this was offset in central and corporate divisions allowing the Trust to meet its control total.

MIC was £3.5m over plan in year, this was mainly due to failure to achieve the Cost Improvement Programme (CIP) and plan gap. The Division over performed on income but incurred additional costs with overspends on nursing for temporary agency cover, one to one additional nursing support for patients and mental health nursing support.

SCC was £12.8m over plan in year. The division failed to achieve additional income growth plans for both NHS and private income causing an adverse variance to plan. The division was overspent due to additional costs incurred to support the waiting list improvement programme and additional costs of outsourcing.

WCCS was £7.9m overspent in year. Maternity activity was below plan, in line with the decline in activity seen in 2017/18. There was also under performance in reproductive income where planned private growth was not able to be achieved. The division's adverse variance in expenditure was due to unidentified CIPs.

The private patient's division was favourable to plan in year due to income growth, offset with additional costs of delivery.

3. Cost Improvement Programme

The Trust set a CIP target of £48m and delivered £44.2m, £3.8m adverse to plan. The main area of underperformance was in income productivity schemes. There was also £2.9m of plan unidentified at year end, another factor in the adverse position for the year.

For 2019/20 the Trust must deliver in excess of £50m of CIPs to meet the control total. The transformation team and project support office are working closely with clinical and corporate areas to identify programmes to fully meet this challenging target.

Imperial College Healthcare NHS Trust

4. Cash and capital

The Trust has a statutory requirement to meet the External Financial Limit (EFL), which is based on the cash consumed in the Trust each year. The Trust may be under but not over the target. At the end of 2018/19 the Trust had a cash balance of £26.7m giving an EFL of £15.5m which is under target.

The Trust's capital spend for the year was £53.4m against a plan of £54.2m a £0.8m underspend. This underspend wasin areas agreed by NHS Improvement including £0.8m for the Health Information Exchange which will be brought forward into the 2019/20 Capital Resource Limit set by NHS Improvement for the Trust.

5. 2019/20 Business Plan

The Trust has been set a control total of £15.9m deficit by NHS Improvement in 2019/20 before central funding and has signed up to this plan. Achieving this plan requires over £50m of CIPs, a challenging requirement for the Trust, with a little higher than the ask in previous years.

The Trust is also working with all organisations in North West London Sustainability and Transformation Partnership (STP) to agree a sector control total. This requires providers and commissioners in North West London to work together to ensure the best value decisions are being made across the sector. The STP control total has not yet been met and further work is being undertaken to develop quality assured sector wide efficiencies.

6. Conclusion

The Trust has met the key financial targets for 2018/19 meeting the control total of £20.6m deficit, being within the agreed £0.8m of the CRL of £54.2 and by being under the EFL. Meeting the control total, along with meting the A&E 4 hour targets has given the Trust access to £48m of provider sustainability funding, £14m of which is a "bonus". It is possible that the Trust may be permitted to invest this in patient care in 2019/20.

The Trust has agreed the 2019/20 control total which is a deficit of £15.9m before central funding of £28m. This position will be challenging for the Trust requiring a higher level of recurrent efficiencies than achieved in 2018/19. There is additional support being provided to operational teams by the transformation director and project support office to ensure CIP plans are achievable and quality assured. The Trust is also working closely with the sector to ensure commissioner and provider CIPs drive benefits for the entire North West London Sector.

7. Recommendation

The Board is asked to note the report

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CQC and Ward Accreditation Programme Update: Part 1 – Trust related CQC update Part 2 – Ward Accreditation Programme update	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 16, report no. 12**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Authors:** Priya Rathod, Deputy Director of Quality Governance Sue Burgis, Acting Deputy Chief Nurse

Summary:

The following paper is separated into two parts:

Part 1 – Trust related CQC update

- During Q4 the CQC asked the Trust to investigate four concerns/complaints raised with them.
- The CQC has concluded its inspection programme for the Trust for 2018/19 and will publish its final inspection reports for the Trust no later than 8 July 2019.
- Trust level highlights from the April 2019 CQC Insight report are included within the report
- A lessons learned review was carried out on 17 April 2019 in relation to CQC activities and outcomes from this will inform changes to the Trust's 2019/20 *Improving Care and Assurance Framework*.
- Current activities being undertaken / planned with the support and oversight from the Improving Care Programme Group include: completion of the core service peer review programme, intense support reviews, quarterly "refresh" of the CQC's annual Provider Information Request (PIR) and establishing task & finish groups for all core services at the Trust.
- Informal intelligence was received from the CQC that it is planning to inspect the Trust's GP practice (at both Charing Cross and Hammersmith Hospitals) in July 2019.

Part 2 – Ward Accreditation Programme update

- The Ward Accreditation Programme (WAP) comprises annual unannounced inspections across inpatient wards, critical care areas, outpatient areas, theatre and recovery, and day case areas. The current tool provides assurance of the quality of care delivered by nurses and midwives.
- During 2018-19, 109 areas have been reviewed compared to 89 in 2017-18, 73 in 2016-17 and 65 in 2015-2016.
- The three key areas that require attention are; environment, medication and leadership.

Recommendations: To note the updates.

This report has been discussed at: Executive Quality Committee 7th May 2019. Quality Committee 8th May 2019
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 (including training and education implications): None
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable
What impact will this have on the wider health economy, patients and the public? As declared in the Trust's strategic goals below.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No All aspects of this paper can be included in leadership briefings and can be shared by leaders with all staff.

Part 1 – Trust related CQC update

1. Purpose

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

2. Registration Status

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

3. Statutory Notifications made to the CQC during Q4 2018/19

3.1. The Trust made three statutory notifications to the CQC in relation to its activities under the Mental Health Act 1983 during Q4.

- Two related to applications for deprivations of liberty (DoLS).
- One related to a request for a second opinion for certified treatment (SOAD).

4. Concerns/Complaints and Whistleblowings raised with the CQC Q4 2018/19

4.1. No whistleblowings were made to the CQC about the Trust during Q4.

4.2. During Q4 the CQC asked the Trust to investigate three concerns/complaints raised with them. These related to; the violation of a patient's rights under the mental health act, a delay in referral for urgent surgery and 'unsafe' discharge from hospital. None of the concerns were substantiated and the CQC was satisfied with the Trust's responses and considers these matters closed.

5. Inspections during Q4 2018/19

5.1. The committee is aware that CQC carried out inspections of the Trust during Q4. The CQC has advised the Trust that it aims to publish its final inspection reports no later than 8 July 2019 which means that the Trust expects to receive its draft inspection reports no later than early June 2019.

6. CQC Insight April 2019

6.1. The CQC's April 2019 Insight report for the Trust was made available on 23 April 2019. Trust level highlights from the report are:

- Active professional registration for medical and dental staff has decreased and the Trust is now performing worse than other trusts when compared nationally for this indicator (previously we were performing about the same as other trusts).
  - The deterioration in performance is due to a data quality error however, this issue has now been resolved and a process put in place by the P&OD team together with a KPI to ensure this does not occur again.
- The number of sick days taken due to stress has increased and the Trust is now performing about the same as other trusts when compared nationally for this indicator although the Trust is still better than the national average (previously we were performing better than other trusts).

  - Overall the Trust has one of the lowest sickness rates nationally and across London as well as low levels of long term absence.
  - A comprehensive update on a range of people metrics including sickness absence is presented at each meeting of the Executive people and Organisation Development Committee together with actions being undertaken.
- The report indicates that a whistleblowing was made to the CQC in April 2019 and that the Trust is now performing much worse than other trusts when compared nationally for this indicator (previously we were performing about the same as other trusts).
  - The CQC has provided limited information to the Trust about this and does not require the Trust to investigate the matter at this stage.

7. The Trust's CQC Framework for 2019/20

7.1. The committee will recall that a lessons learned review was carried out on 17 April 2019 in relation to CQC activities at the Trust. Outcomes of the lessons learned are being used to make improvements to the Trust's 2019/20 *Improving Care and Assurance Framework* which will be presented to the committee at the next meeting.

7.2. Current activities being undertaken/planned with the support and oversight from the Improving Care Programme Group (chaired by the CEO which meets weekly) include:

- Completion of the core service peer review programme
- Intense support reviews focusing on medicines management, consumables stock and required equipment testing
- Quarterly "refresh" of the CQC's annual Provider Information Request (PIR)
- Establishing task & finish groups for all core services at the Trust

Please refer to **Appendix 1** for a summary of activities to be undertaken over the coming months at the Trust.

8. Possible Inspection of the Trust's GP Practice

8.1. Informal intelligence was received from the CQC that it is planning to inspect the Trust's GP practice in July 2019. The GP practice has not been part of the CQC's annual inspection programme for the Trust as the programme is for acute services, whilst the GP practice is primary care. The Trust will be given two weeks' written notice that the inspection will take place.

9. Next steps

9.1. Continue to develop the 2019/20 Trust CQC framework and undertake associated activities as outlined in Appendix 1.
9.2. Await the draft inspection reports
9.3. Support the Trust's GP practice to be prepared for a possible CQC inspection.

END OF PART 1

Part 2 – Ward Accreditation Programme Update

1. Purpose

1.1 The purpose of this paper is to provide the Board with an overview of the ward accreditation process (WAP); analysis of the results for 2018-19 compared to previous years; key programmes of work that support findings and intended changes and expansion to the programme.

2. Background

2.1. The Ward Accreditation Programme (WAP) comprises annual unannounced inspections across inpatient wards, critical care areas, outpatient areas, theatre and recovery, and day case areas. The current tool provides assurance of the quality of care delivered by nurses and midwives.

2.2. During 2018-19 109 areas have been reviewed compared to 89 in 2017-18, 73 in 2016-17 and 65 in 2015-2016

2.3. Teams of senior nurses, midwives and AHPs led by senior nurses undertake the reviews. Prior to the visit the team review a wide range of data for the area that includes the nursing and midwifery harm free care report, cleaning audits, workforce data, directorate scorecard, incidents and risk registers, complaints, patient experience data, student nurse feedback and staff interviews. Ward sisters and charge nurses also provide feedback on the work they have undertaken since the last review.

2.4. During the review the team undertake interviews with staff and patients, observe all aspects of care, review documentation and inspect the environment

2.5. The area is rated against seven key domains; leadership, communication, record keeping, safe and clean environment, safe medication storage and administration, nutrition and hydration, responsive patient centred care.
Following the 18/19 process all wards awarded a gold rating were presented with a 'gold award' to celebrate their success.

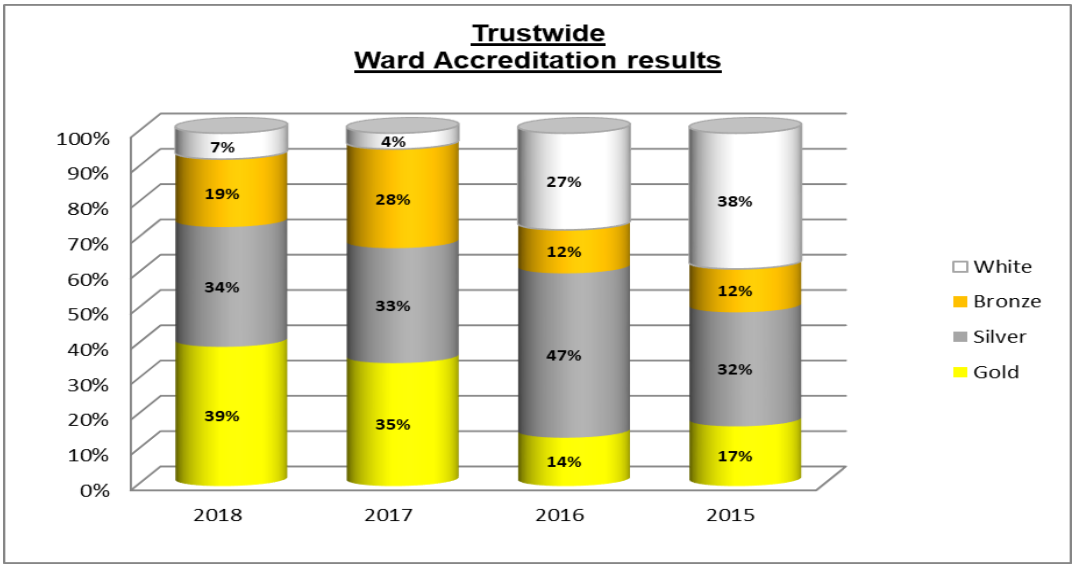
Ratings for the categories within each domain are as follows:

Gold - Achieving highest standards with evidence in data
Silver - Achieving minimum standards or above with evidence in improvement data
Bronze - Achieving minimum standards, or below with active improvement work underway
White - Not achieving minimum standards and no evidence of active improvement work

2.6. An overall ward rating is calculated for each domain and for the ward overall using principles aligned to the CQC domains.

3. Trust wide results

3.1. Trust wide results (expressed as percentage of all areas reviewed) for the 2018-19 compared to the previous results are shown in the graph below:



**To note: In 2017/18 the rating principles were revised to not disadvantage wards in old estate.*

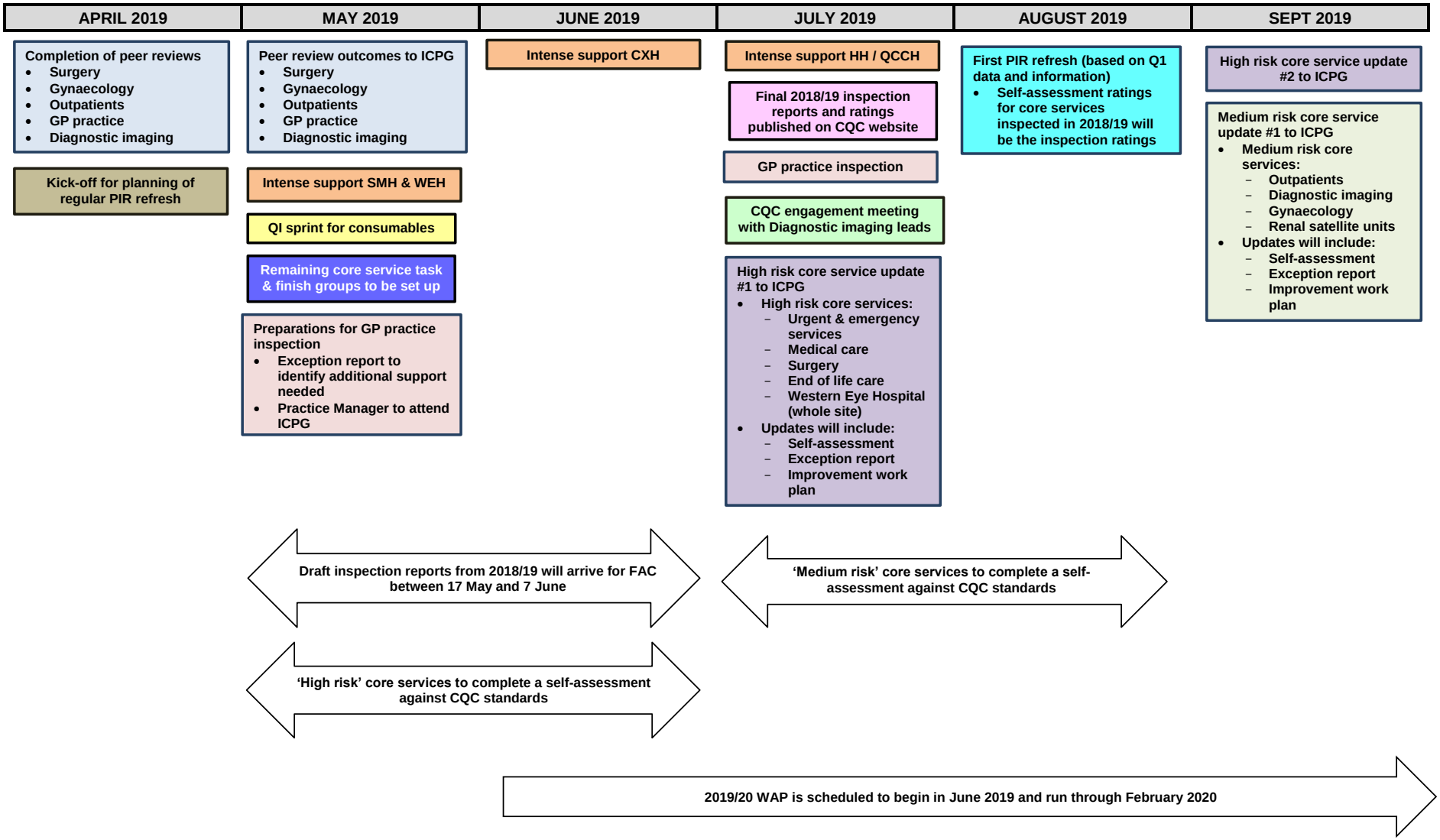
3.2 The three key areas highlighted for improvement are: environment, medication and leadership. This aligns with key areas of improvement work across the Trust.

4. Next steps

- Review the arrangements for supporting wards/areas that need help with improvement, especially those getting an overall white rating.
- Implement the 2019-20 programme.

Appendix 1

Proposed timeframes for next steps with CQC activities



Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC
REPORT SUMMARY

Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q4 2018/19	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 22 May 2019	**Item 17, report no. 13**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Jon Otter, General Manager IPC Professor Alison Holmes, Director IPC

Summary:

- 51 Trust-attributable *Clostridium difficile* cases were seen in 2018/19, a 20% reduction from 2017/18 (63 cases). Two of the 14 cases in Q4 included a 'lapse in care' related to antibiotics.
- The rate of orthopaedic Surgical Site Infection (SSI) following elective hip and knee procedures is very low, with only 1 SSI in the past 12 months, considerably below the national average.
- Carbapenemase-producing Enterobacteriaceae (CPE) admission screening compliance has increased to 82% across the Trust; wards performing universal CPE admission screening are now screening more than 90% of admissions for CPE.
- All quality indicators in the latest Trust-wide point prevalence survey of antibiotic prescribing were above the 90% target for the first time.
- During Q4, the following outbreaks were identified and managed: *Pseudomonas aeruginosa* and *Serratia marcescens* on the neonatal unit at QCCH, CPE on one surgical and two medical wards at CXH, and Influenza A in renal wards at HH. On-going issues with water hygiene management continue on the neonatal unit at QCCH. Three serious incident (SI) investigations were declared. Investigations of clinical incidents during the quarter highlighted cleaning issues; following discussion at the Executive Quality Committee, the processes of escalation and response have been reviewed and improved.
- The programme of activities and the improved practice captured in observational audits of hand hygiene is presented, with hand hygiene compliance improving from 29% in May 2018 to 69% in Feb/March 2019 in the 10 wards receiving focussed improvement support.

Recommendations:
The Board is asked to note the report.

This report has been discussed at:
☒ Executive Quality Committee May 2019
☒ Board Quality Committee May 2019

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

Financial impact:
No direct financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
Risks associated with IPC are managed through the Trust's risk management process. This report includes a summary update of the IPC risk register. There is a risk related to spread of CPE on the corporate risk register (ID 2487).

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

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

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

The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

1 Healthcare-associated infection surveillance and mandatory reporting

- 51 Trust-attributable ***Clostridium difficile*** cases were seen in 2018/19, a 20% reduction in cases from 2017/18 (63 cases) (Appendix 1, Table 1, Figure 1). Our rate of Trust-attributed *C. difficile* ranks 3rd best in the Shelford group, compared to 7th in 2017/18. This rate of infection continues to be very, and represents a success of IPC and antibiotic stewardship activity. This includes multidisciplinary clinical review of all cases, and rapid feedback of lapses in care to prompt ward-level learning.
    - Two of the 14 Trust-attributed *C. difficile* cases during Q4 included a 'lapse in care' due to antibiotic therapy not being in line with policy. Learning from the lapses in care in 2018/19 (11 in total, compared with seven during 2017/18) has been reviewed and shared with the clinical teams involved.
    - Public Health England (PHE) have altered the surveillance definitions around *C. difficile* infection, meaning that more cases will be considered "hospital acquired" in 2019/20; the annual Trust target for *C. difficile* has been increased by PHE to account for this change in surveillance definitions.
- There were no cases of Trust-attributed **MRSA bloodstream infection (BSI)** during Q4, from 8156 blood cultures tested. Our rate of Trust-attributed MRSA BSI ranks 6th best in the Shelford group.
- There were 83 Trust-attributed cases of ***E. coli*** **BSI** during 2018/19 (Appendix 1, Figure 2). We rank 4th best in the Shelford group for healthcare and community-associated *E. coli* BSI, compared with 7th in 2017/18. However, we have not met our internal target of a 10% year-on-year reduction in E. coli BSIs.
- The government has announced an ambition to halve healthcare-associated **Gram-negative BSI** by 2021.
    - Key local developments to support this national ambition include enhanced reports of epidemiological data to PHE; supporting the CCG in their investigation of cases that occur outside our hospitals; and supporting improvements in the identification and management of sepsis.
    - Future plans include: establishing an enhanced monthly Gram-negative BSI review process; circulation of a national Gram-negative BSI reduction toolkit to frontline clinicians; improving the management of urinary catheters and reviewing hydration management as these contribute to UTIs, which are the most common source of E. coli BSIs; and planning new prevention initiatives in partnership with high-risk clinical areas (for example haematology).
    - Timelines and deliverable actions for 2019/20 around the prevention of Gram-negative BSI are being discussed and agreed with the Nursing Directorate and the Divisions.
- The rate of **catheter-line associated bloodstream infections (CLBSI)** remains below benchmark rates in adult ICU, paediatric ICU, and in very-low birthweight babies in the neonatal ICU. The rate of 'contaminants'[1] also remains below the benchmark rate.[2]
- Rates of **surgical site infection (SSI)** remain below national benchmark rates following the selected elective orthopaedic procedures included in the mandatory national surveillance scheme (Appendix 2). Rates of SSI following CABG and non-CABG cardiothoracic procedures have been above the national benchmark rate over the past 12 months (Appendix 2). SSI rates in CABG procedures have reduced to below the national average in the latest quarter. The continued high rate of SSI in non-CABG procedures may be due in part to fewer procedures being performed since only 1 case of SSI was recorded during Q4. No major gaps in the established SSI prevention measures have been identified; the Division has reinforced the measures outlined in the Trust's 'SSI: Prevention of Infection Guideline'. The impact of these actions will be monitored through the Surgical Infection Group.

[1] Bacteria identified in blood cultures that are associated with patients' skin and considered not to be representing infection.
[2] Benchmark for contaminated blood cultures set based on published literature, which suggests a rate of 3%: Self et al. *Acad Emerg Med* 2013; 20:89-97.

  - A business case to invest in more resources to create a programme of SSI surveillance and improvement in all surgical categories in the Trust was approved and will be launched during Q1 2019/20 following recruitment.
  - The Getting It Right First Time (GIRFT) programme is running a prospective audit of SSI between May and October 2019. The specialties participating are those which have been identified as a priority for surveillance by the Surgical Infection Group: Vascular, General, and Cardiothoracic surgery. A Task and Finish Group are leading the programme as a sub-group of the Surgical Infection Group.
- Approximately 50 new patients with **carbapenemase-producing Enterobacteriaceae (CPE)** are identified each month across the Trust, 95% of which are from screening specimens rather than from sites indicating clinical infection. The number of screens taken each month and the number of new CPE cases detected have plateaued over the previous 18 months.
  - Overall compliance with CPE admission screening was 82%, and >90% in the four specialities performing universal admission screening (ICU, Renal, Haematology, and Vascular). CPE admission screening compliance is included by ward in the monthly Harm Free Care report. This provides a mechanism to prompt targeted improvement at ward level to address areas of low compliance.
  - The CPE Action Plan continues to progress. The daily list ("sit-rep") of CPE patients and their location is now live and being shared with clinical teams each weekday. Also, Estates and Facilities have confirmed that plans for regular cleaning of sink and shower drains have been implemented across the Trust. The operational delivery of these plans will be audited by Estates and Facilities. Two actions remain outstanding currently:
    - A Cerner tool to offer decision support to frontline staff and to track and report on CPE admission screening compliance, including patients who declined to be screened. The tool is being redesigned in conjunction with the Cerner Change Team and Infection Prevention and Control at Chelsea and Westminster Hospital. A timeline for implementation from the Cerner Change Team is awaited.
    - To perform an evaluation of the current Trust CPE screening approach. A proposal for a one-off prevalence screen of all inpatients is being reviewed with the Divisions. The aim is to understand the prevalence and risk factors for CPE across our inpatient population in order to optimise the screening approach, as recommended in the PHE guidance of 2013.

2 Antibiotic stewardship

- The biannual **antibiotic point prevalence study (PPS)** (based on a review of inpatients) examines key antibiotic prescribing and safety indicators as advised by the Department of Health's "Start Smart then Focus" antibiotic programme and acts as a mechanism to identify areas for improvement. The second PPS of 18/19 was conducted in February 2019 (Appendix 3, Table 2).
  - 1321 patients were included in the survey; approximately 43% of inpatients were scheduled to receive an antibiotic. 1006 antibiotics were prescribed (54% intravenous). Of these, 92% were prescribed according to policy or on the advice of infection teams with 99% having a documented indication on the drug chart or medical notes. 90% of antibiotic prescriptions had a documented review within 72 hours of initial prescribing and treatment duration was in line with policy or approved by the Microbiology/ID team in 94% of cases. The Trust has a target compliance of 90% for these indicators.
  - In Private Patients, 74% of antimicrobials were prescribed in line with policy or approved by Microbiology/ID (Indicator A); this is being taken forward by their Divisional clinical management team with support from the infection pharmacy team.
- Following an overall reduction in **antimicrobial consumption** in Q1 2018/19, we saw a rise in Q3 and Q4 2018/19 (Appendix 3 Figure 3). This was expected due to the winter

month pressures on antimicrobials and due to the Trust's change in antimicrobial policy to incorporate more of the oral "ACCESS"[3] group as recommended by PHE and WHO to curb the threat of resistance. The Trust continues to prescribe fewer antimicrobials than 4 years ago.
    - Overall **carbapenem usage** has increased since Q2 2018/19 and has continued to rise in Q4 2018/19. This is mainly explained by higher carbapenem consuming specialities, notably Renal, Critical Care and Haematology. Compared with our Shelford peers, we rank 8th for carbapenems (based on Q3 2018/19 PHE consumption data). Carbapenem-reduction initiatives are being developed via the Antibiotic Review Group.
- The Trust continues to experience the impact of national **antimicrobial shortages** for a number of agents identified on the risk register. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis. There is no evidence of patient harm as a result of these shortages.
- We are participating in the **NHSE Anti-fungal CQUIN** with 0.4 WTE 8a pharmacy support. The post is working with key stakeholders involved in antifungal treatment management. We met our quarterly targets for Q1-3 in 18/19.
- The Trust participated in the 2018/19 **'Reducing the impact of serious infection' CQUIN** focussed on the identification and management of sepsis, and the overall reduction in antibiotic usage. IPC have led on the overall reduction in antibiotic usage and supported the implementation of the Cerner sepsis alert to improve the identification and management of sepsis. This CQUIN ended in 2018/19; however, antimicrobial consumption reporting will continue, under the NHS Standard contract for total antibiotic consumption.
    - The antimicrobial resistance CQUIN indicators have been revised for 2019/20 and will include improvement schemes for the management of lower urinary tract infections in the elderly and appropriate use of antibiotic surgical prophylaxis in colorectal surgery. Initial planning is underway to support the delivery of this national plan.

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

- The Trust has a requirement that **ANTT competency assessment** is undertaken and documented for all staff working in a clinical environment. The target for compliance with ANTT training for Trust clinical staff is set at 95%; currently it is 86%.
    - ANTT compliance is improving (from 83% in Q1 to 86% in Q4).
    - Each Division has been asked to provide their plans and timelines to reaching the 95% target.
- A new approach to **hand hygiene** compliance auditing to improve the quality of data in order to guide improvement commenced during 2018.
    - Auditing of all inpatient wards was undertaken by IPC and senior Divisional staff during May 2018 and again during February/March 2019. In addition, a selection of wards (the EDs, Children and Young People pathway wards, and critical care areas along with the Focus Wards identified for additional support following the May audits) were also audited in November 2018 using the same methodology. A bi-annual audit of inpatient wards is planned going forwards.
    - Following consultation and a review of internal and external data, a compliance target was set at 70%.
    - 9/10 of the Focus Wards, which have received the most intensive support from the Improvement Team and IPC in developing local improvement plans, have demonstrated a sustained improvement. Overall compliance on these wards

[3] The AWaRe index categorises antibiotics into three groups: Access antibiotics are those that should be available to treat a wide range of infections; the Watch group are antibiotics recommended for a small number of infections; and the Reserve group should be considered last resort options.

improved from 29% in May 2018 to 69% in Feb/March 2019. All wards that are currently receiving intensive improvement support and that have demonstrated an increase in compliance will be 'stepped off' the intensive support programme. This will allow a second phase of 12 wards to be selected for intensive support, began during Q1.

- Hand hygiene dispensers are being upgraded across the Trust and a novel hand hygiene communications poster campaign aimed at staff has been piloted and will be rolled out during 2019/20.

4 Clinical activity, incidents and lookback investigations during Q4

- During Q4, several clusters and outbreaks were identified and managed, including *Pseudomonas aeruginosa* and *Serratia marcescens* on the neonatal unit at QCCH, CPE on one surgical and two medical wards at CXH, and Influenza A in renal wards at HH.
- These incidents have prompted three Serious Incident (SI) investigations.
- On-going issues with water hygiene management continue on the neonatal unit at QCCH.
- Investigations of clinical incidents during the quarter highlighted cleaning issues; following discussion at the Executive Quality Committee, the processes of escalation and response have been reviewed and improved.
- In Q4, a total of six communicable disease look backs were undertaken following potential exposure incidents. These included chickenpox, shingles, measles, tuberculosis and invasive group A streptococcal infection. One case of chickenpox involved a patient contact requiring prophylactic treatment due to the exposure.
- Trends in the detection of respiratory viruses are in line with expected seasonal changes.

5 Compliance, risks and other issues

- Cleaning audits are performed by Facilities. Facilities, supported by the Divisions and IPC, are undertaking a review of cleaning policies and processes to improve cleaning and disinfection standards.
- We have two tiers of annual core skills IPC training: Level 1 for all staff and Level 2 for clinical staff. Compliance with Level 1 is 93% (up from 91% in Q3), and 89% for Level 2 (up from 88% in Q3). These improvements are in line with increases in compliance in all core skills.
- Four policies were reviewed and approved at the Trust Infection Prevention and Control Committee (TIPCC).
- There have been no new IPC risks identified. The CPE corporate risk has been downgraded from a risk score of 16 to 12 to reflect a plateau in new patients with CPE , the number of CPE infections remains rare and is not increasing, and the CPE Action Plan has been implemented (with a few exceptions). Cleaning issues continue to be identified and flagged to Facilities for action by Sodexo.
- The Trust has responded to a CAS alert around the risk of spreading micro-organisms that can cause HCAI via cooling fans. A message has been sent to all staff to provide guidance on the appropriate use of cooling fans in clinical areas.
- Members of the IPC team have produced 21 peer-reviewed publications relating to applied research in HCAI and AMR during Q4.
- CQC inspected the Trust's Critical Care, Children and Young People including Neonatal, and Maternity services in February 2019 and performed a well-led inspection in April 2019. No specific IPC concerns were raised.

Appendix 1

Healthcare-associated infection surveillance and mandatory reporting

	Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19		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	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	3	0
Trust *C.difficile*	8	7	6	6	4	5	8	5	2	5	2	5	3	5	2	5	2	6	4	6	6	6	4	7	51	68
Trust *E.coli* BSI	5	-	8	-	8	-	7	-	8	-	13	-	4	-	10	-	5	-	6	-	6	-	3	-	83	-
Trust MSSA BSI	2	-	5	-	3	-	2	-	4	-	1	-	4	-	3	-	1	-	5	-	4	-	3	-	37	-
Trust CPE BSI	3	-	0	-	0	-	1	-	0	-	1	-	1	-	0	-	0	-	0	-	0	-	1	-	7	-
Trust Pseud BSI	3	-	3	-	0	-	5	-	5	-	5	-	3	-	1	-	1	-	4	-	3	-	4	-	37	-
Trust Kleb BSI	7	-	2	-	4	-	5	-	4	-	6	-	5	-	5	-	0	-	3	-	4	-	3	-	48	-

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

Table 1: HCAI mandatory reporting summary.

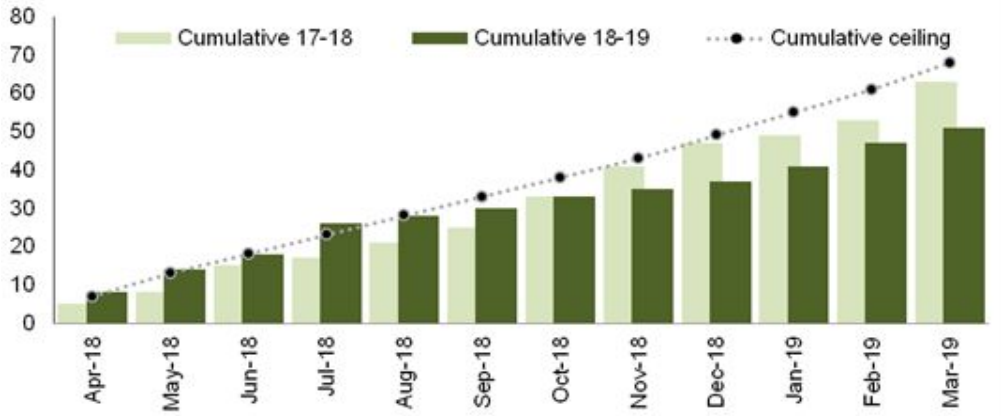


Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in 2018/19 (dark green bars) compared with 2017/18 (light green bars)

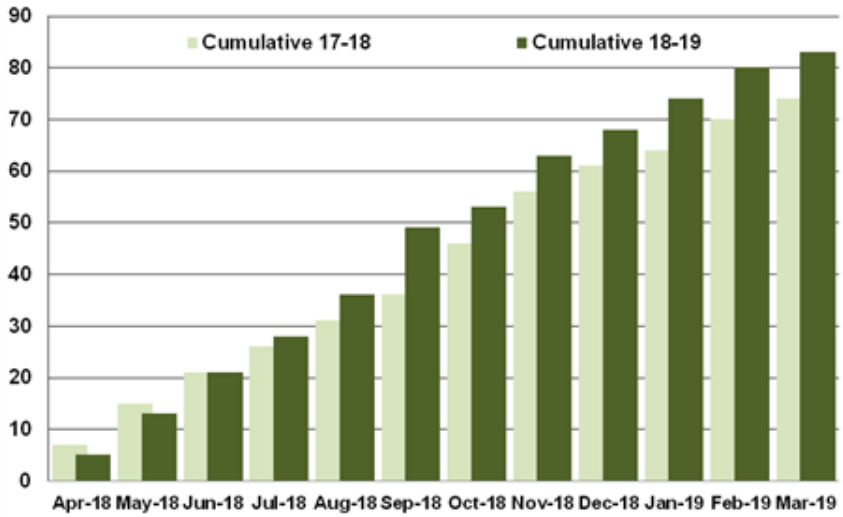


Figure 2: Cumulative monthly 2018/19 Trust-attributed E. coli BSI (dark green bars) compared to 2017/18 (light green bars)

Appendix 2 Surgical site infection

Orthopaedic SSI

The latest quarter (Oct - Dec 18 finalised data) has seen:

- Knee procedures: 0 SSI in 94 procedures; 12-month average is 0.26% (1 SSI in 385 operations); national average is 0.6%.
- Hip procedures: 0 SSI in 68 procedures; 12-month average is 0% (0 SSI in 282 operations), national average is 0.6%.

Cardiothoracic

The latest quarter (Oct – Dec 18 finalised data) has seen:

- CABG: 2 SSI (3.6%) of 56 procedures; 12-month average is 6.6% (19 SSI in 289 procedures); national average is 3.8%.
- Non-CABG: 1 SSI (4.5%) of 22 procedures; 12-month average is 2.3% (4 SSI in 171 procedures); national average is 1.3%.

Appendix 3 Antimicrobial stewardship

Assurance regarding quality of antibiotic prescribing

Division	Number of patients on antimicrobial(s)/total patients seen (%)		Number of antimicrobials prescribed		INDICATOR A % antimicrobials 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 2018	**Feb 2019**	*Aug 2018*	**Feb 2019**	*Aug 2018*	**Feb 2019**	*Aug 2018*	**Feb 2019**	*Aug 2018*	**Feb 2019**	*Aug 2018*	**Feb 2019**
Trust Results	*494/1236 (40%)*	**570/1321 (43%)**	*862*	**1006**	*91%*	**92%**	*98%*	**99%**	*89%*	**90%**	*93%*	**94%**
Medicine	*205/542 (38%)*	**284/655 (43%)**	*339*	**440**	*92%*	**88%**	*99%*	**98%**	*92%*	**90%**	*96%*	**93%**
Surgery, Cardiovascular	*198/424 (47%)*	**203/401 (51%)**	*353*	**404**	*88%*	**94%**	*97%*	**99%**	*84%*	**86%**	*92%*	**94%**
Women's and Children's	*80/231 (35%)*	**69/224 (31%)**	*148*	**142**	*96%*	**99%**	*100%*	**100%**	*95%*	**95%**	*89%*	**99%**
Private	*11/39 (28%)*	**14/41 (34%)**	*22*	**20**	*81%*	**74%**	*95%*	**100%**	*88%*	**100%**	*82%*	**85%**
Trust Target 2019/20					**90%**		**90%**		**90%**		**90%**	

Table 2: Antibiotic point prevalence survey results summary from February 2019.

5.1.1 Antimicrobial consumption

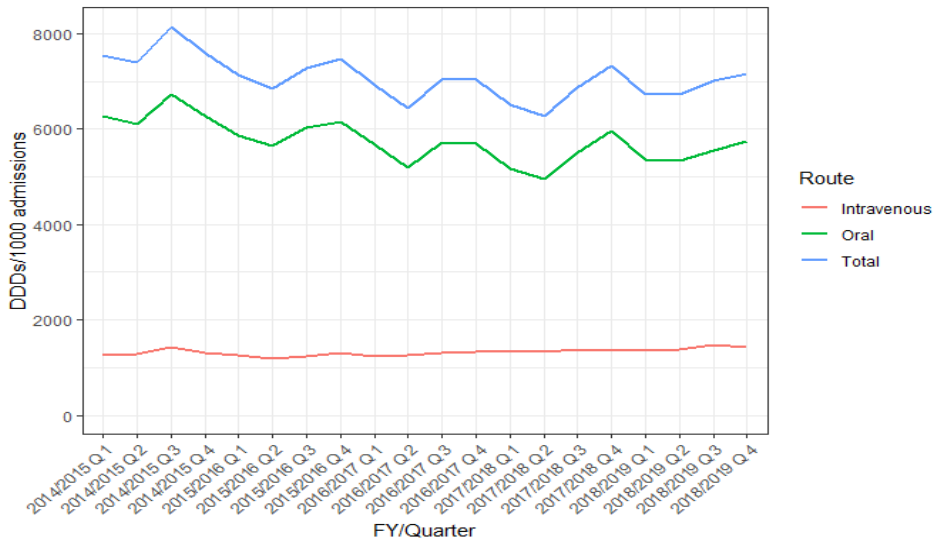


Figure 3: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Seven Day Hospital Standards (May 2019 update)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 18, report no. 14**
Responsible Executive Director: Julian Redhead, Medical Director	**Author:** Bob Klaber, Deputy Medical Director

Summary:
NHS Improvement has implemented a new process to measure progress with the Seven Day Hospital Services standards. This is now done through a board assurance framework in the form of a standard template which should be assured by the Trust Board before being submitted externally every 6 months.

The purpose of this report is to update the Board on our latest position against the priority national Seven Day Hospital Services standards, and to request approval for the submission of the programme template to NHS Improvement.

This template has been reviewed and approved for submission by Executive Quality Committee and Board Quality Committee. The committees also agreed to the proposal that future sign off of the submission is delegated to the Quality Committee, pending confirmation by the Board.

Recommendations: The Board is asked to:

- Approve the content of the June 2019 Seven Day Hospital Services standards submission (appendix 2).
- Agree to delegate responsibility for approving the bi-annual submission in future to the Board Quality Committee.

This report has been discussed at:
Executive Quality Committee (7th May 2019) and the Board Quality Committee (8th May 2019).

Quality impact:
The results summarised in the paper improve services in relation to all 5 CQC domains: Safe, caring, responsive, effective, well-led.

Financial impact:
This paper has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
Risks associated with not meeting standard two have been assessed and the decision made not to increase investment to implement extra consultant rotas was taken and has previously been approved by the Board.

Workforce impact (including training and education implications):
This paper has no workforce impact.

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

What impact will this have on the wider health economy, patients and the public?
The Seven Day Services agenda was originally adopted by the Department of Health to address a perceived gap between the quality of care offered by Trusts to patients admitted during the week, and those admitted during the weekend.

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

Trust strategic goals supported by this paper:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Summary of Seven Day Hospital Services Update (May 2019)

1. Executive Summary

1.1. In June 2018 Imperial College Healthcare Trust submitted its data from the final formal audit of performance against the priority Seven Day Hospital Services national standards. Key points:

- The audit was based on data collected 11th-17th April 2018 inclusive and was measured against the four priority national standards 2, 5, 6 and 8 (see appendix 1).
- Our results showed a continued improvement against the key national standard 2 (the percentage of patients reviewed by an appropriate consultant within 14 hours of admission).

1.2. In late 2018 it was acknowledged by NHS Improvement that, although useful in supporting implementation, this self-assessment survey placed a significant administrative burden on Trusts as it involved reviewing many patient case notes.

To reduce this burden NHS Improvement has decided that Seven Day Service progress will be measured through a board assurance framework. This process consists of a standard template to assess progress in delivering Seven Day Services, which is then assured by the Trust board before submitting results to regional and national Seven Day Services teams.

1.3 This paper demonstrates that:

- we continue to meet three of the four priority standards [standards 5,6 and 8]
- we continue to fall below the target in standard 2, but with the way we organise our specialist services we have confidence that the medical model offered provides appropriate expertise should patients require it.
- although not formally audited as priority standards, we have made good progress in improving the areas of care that relate to the experience, safety and flow of patients through our services [which are represented by the non-priority standards 1,3,4,7,9 and 10].

2. Purpose

The purpose of this paper is to (a) provide the Board with assurance that we are maintaining our performance against the 4 priority standards, and continuing to make improvements in the other 6 areas and (b) to ask for the Board's approval for the approach we are proposing for this new 'board assurance' model.

3. Background

3.1. The Seven Day Services agenda was originally adopted by the Department of Health to address a perceived gap between the quality of care offered by Trusts to patients admitted during the week, and those admitted during the weekend.

3.2. From March 2016 to June 2018 every acute Trust across England and Wales was required by NHS England to submit individual patient audits against the national Seven Day Service Standards. The Seven Day Service National Standards are listed at appendix 1.

3.3. With regards to standard 2, we previously made a risk based decision not to increase investment to implement extra consultant rotas at weekends as:

i. There is confidence that the medical model offered provides appropriate expertise should patients require it

ii. The forecasted recurrent cost of delivering such rotas (circa £2m) would not have had a significant enough impact on improving quality of care.

4. Key points

4.1. Our last set of formally audited and nationally reported results from April 2018 showed a continued improvement against the key national standard 2 (the percentage of patients reviewed by an appropriate consultant within 14 hours of admission). This demonstrated a steady rise from 64% on weekdays and 61% at weekends in September 2016 to 81% and 82% in April 2018. See Figure 1 and table 1 (below). Within these results the small gap between weekday and weekend provision has been closed.

4.2. These improvements reflect work undertaken to look at rotas and ward processes (such as those delivered by acute medicine) following previous audits.

Fig 1. ICHT audit performance vs Std 2.

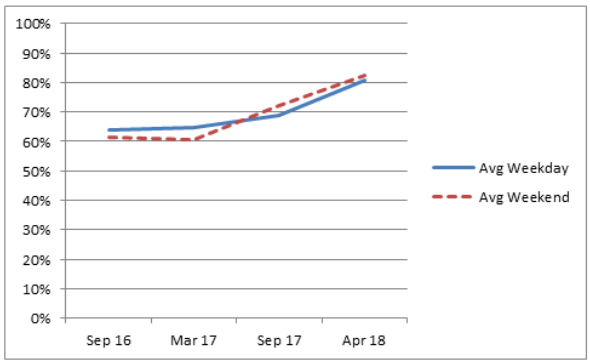


Table 1 ICHT audit performance vs Std 2

	Avg Weekday	Avg Weekend	Avg all
Sep 16	64%	61%	63%
Mar 17	65%	61%	64%
Sep 17	69%	72%	70%
Apr 18	81%	82%	81%

4.3. Performances against the other three priority standards measured were also sustained from previous audits and deliver the level expected by NHS England (see table 2).

Table 2: ICHT 7DS audit against other standards

Standard number	Standard Summary	Collection approach	ICHT performance
5	Scheduled inpatient access to diagnostic services	Self-assessed	100%
6	Timely inpatient access to consultant-directed interventions	Self-assessed	100%
8	Consultant reviews delivered twice and once daily as needed	From audit data	95%

4.4. Since the April 2018 audit there have not been any significant changes to how we deliver consultant level care to our patients. Consultant rotas and diagnostic services have remained the same and our position on rota configurations, as described in section 3.4, remains unchanged.

We are therefore not expecting any significant changes to our performance in standards 2, 5 and 6, which is reflected in our template submission (appendix 2). This needs to be submitted to NHS Improvement by 28th June 2019.

4.5. Audit data (from 11th to 17th April 2018) showed that standard 8 was met in over 90% of cases. Since that time we have made significant improvements to our critical care and high dependency services by co-locating them on the same floor, which means these patients now benefit from direct and expedited access to critical care review and resources. We re-looked at this standard in April 2019 using a combination of notes audit (using our electronic patient record) and a Clinical Director and Heads of Specialty led review of consultant job plans and working practices. We are confident that we are continuing to meet this standard for over 90% of patients across our three main sites.

Before the next submission we are planning to do some work to ensure the standard is also being met in the small number of patients with high dependency needs who are not being cared for in the formal High Dependency / Critical Care areas.

4.6. The template also asks for a commentary on Imperial College Healthcare NHS Trust's performance against the non-priority standards 1,3,4,7,9,10.

We have continued to place significant focus and resource on improving all areas of care that relate to the experience, safety and flow of patients through our services. Examples of this include the establishment in September 2018 of the Care Journey & Capacity Collaborative [in collaboration with NHS Improvement] which has involved the implementation of Faster Moves, the SAFER care bundle and more effective discharge approaches. The development and implementation of these programmes has involved significant consultant leadership and the use of continuous quality improvement methods. In addition the establishment of the Flow Coaching Academy (FCA) and the associated Big Rooms have also led to improvements in specific care pathways, and there have also been improvements made in the provision of liaison mental health services for both children and adults to be available to respond to referrals and provide urgent and emergency mental health care to our emergency departments [relating to Standard 7].

5. Conclusion and Next Steps

5.1 We continue to meet three of the four priority standards [standards 5, 6 and 8] and are making good progress in improving the areas of care that relate to the experience, safety and flow of patients through our services [represented by standards 1, 3, 4, 7, 9 and 10].

5.2 Once approved by the Board, we will submit the final template to NHS Improvement by the deadline of 28th June 2019. Our next bi-annual submission will be submitted in November 2019 following sign off at Board Quality Committee

6. Recommendations

6.1 The Board is asked to approve the content of the June 2019 Seven Day Hospital Services standards submission (appendix 2).

6.2 The Board is asked to agree to delegate responsibility for approving the bi-annual submission in future to the Board Quality Committee.

Author Bob Klaber, Deputy Medical Director **Date** 14 May 2019

Appendix 1

National Seven Day Services Clinical Standards Summary

(since September 2017)

- Trust performance is only assessed against the 4 standards written in black
- In September 2017 Trust performance was only audited against standard 2

	Standard
1	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
3	All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.
4	Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.
5	Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: - Within 1 hour for critical patients - Within 12 hours for urgent patients - Within 24 hours for non-urgent patients
6	Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.
7	Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.
8	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
9	Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.
10	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Appendix 2 – Seven Day Services Self-Assessment Template (attached)

7 Day Hospital Services Self-Assessment

Organisation	**Imperial College Healthcare NHS Trust**
Year	**2019**
Period	**Spring/Summer**

Imperial College Healthcare NHS Trust: 7 Day Hospital Services Self-Assessment - Spring/Summer 2019

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	When we first participated in this survey in September 2016, we delivered consultant led reviews within 14 hours to 64% of patients during the week and 61% of patients at weekends. By April 2018, this had increased to 81% during the week and 82% at weekends. Previously, ICHT made a risk based decision not to increase investment to implement extra consultant rotas at weekends as: i. We have confidence that the medical model offered provides appropriate expertise should patients require it; ii. The forecasted recurrent cost of delivering such rotas (circa £2m) would not have had a significant enough impact on improving quality of care to be cost-effective. We believe that this position remains unchanged.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	All diagnostic tests and reporting are available 7 days a week as needed.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	All consultant directed interventions are available 7 days a week	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Notes audit data (from 11th to 17th April 2018) showed that this standard was met in over 90% of cases. Since that time we have made significant improvements to our critical care and high dependency services by co-locating them on the same floor, which means these patients now benefit from direct and expedited access to critical care review and resources. We have re-looked at this standard in April 2019 in two ways, using a combination of notes audit (using our electronic patient record) and a Clinical Director and Heads of Specialty led review of consultant job plans and working practices. We are confident that we are continuing to meet this standard for over 90% of patients across our three main sites. Before the next submission we are planning to do some work to ensure the standard is met in the small number of patients with high dependency needs who are not being cared for in the formal High Dependency / Critical Care areas.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Imperial College Healthcare NHS Trust has continued to place significant focus and resource on improving all areas of care that relate to the experience, safety and flow of patients through our services. Examples of this include the establishment in September 2018 of the Care Journey & Capacity Collaborative [in collaboration with NHS Improvement] which has involved the implementation of Faster Moves, the SAFER care bundle and more effective discharge approaches. The development and implementation of these programmes has involved significant consultant leadership and the use of continuous quality improvement methods. In addition the establishment of the Flow Coaching Academy (FCA) and the associated Big Rooms have also led to improvements in specific care pathways, and there have also been improvements made in the provision of liasion mental health services for both children and adults to be available to respond to referrals and provide urgent and emergency mental health care to our emergency departments [relating to Standard 7].

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Standards met as per the table

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CIP QIA - Update on the outcomes of the post-implementation reviews of Quality Impact Assessments for Cost Improvement Programmes (2018/19)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 19, report no. 15**
Responsible Executive Director: Janice Sigsworth, Director of Nursing Julian Redhead, Medical Director	**Author:** Priya Rathod, Deputy Director of Quality Governance

Summary:

The Trust has a comprehensive Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) process in place to understand the risk/s to quality (aligned to the five CQC domains) as a result of introducing a cost improvement programme.

It is important that once a CIP scheme has been implemented, the on-going impact on quality is monitored and to this end, each year, a range of schemes that have been implemented from the previous/current financial year are selected for a post-implementation evaluation.

Over 30 PIEs have been completed by the clinical divisions and these were discussed at meetings held with the Medical Director and Director of Nursing during March 2019.

In summary, of the schemes evaluated, they largely demonstrated that the implementation of the scheme had either improved or maintained quality and that the original QIA risk score had either stayed the same or reduced once the scheme had begun.

The next routine quarterly meetings with divisions are scheduled to take place during quarter one 2019/20 where the focus will be to review the QIAs for schemes that will be delivered during the new financial year.

Recommendations:
The Committee is asked to note the paper and progress with the post implementation evaluations.

This report has been discussed at:
- Quality Committee: 8th May 2019
- Executive Quality Committee: 2nd April 2019

Quality impact:
The CIP QIA and PIE process ensures that any adverse impact on quality and patients (taking into account all five CQC domains) is mitigated.

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

Risk impact and Board Assurance Framework (BAF) reference:
This paper relates to the following corporate risks**: 2473 and 2472**

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

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

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

What impact will this have on the wider health economy, patients and the public?
As outlined above under 'quality impact'.

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

Trust strategic goals supported by this paper:
- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ Yes ☒ No
If yes, why?.....

If the details can be shared, please provide the following in one to two line bullet points:
- What should senior managers know?
  - PIEs for CIPs are to be carried out periodically throughout the year
- What (if anything) do you want senior managers to do?
  - Undertake the PIEs
- Contact details or email address of lead and/or web links for further
  - P.rathod@nhs.net
- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why?
  - Teams should be completing the PIEs for the schemes they are responsible for

CIP QIA - Update on the outcomes of the post-implementation evaluations of Quality Impact Assessments for Cost Improvement Programmes (2018/19)

1. Purpose

The following report provides a summary of the findings from the post-implementation evaluations of quality impact assessments for cost improvement programmes (2018/19).

2. Background

The Trust has a comprehensive Cost improvement Programme (CIP) Quality Impact Assessment (QIA) process in place to understand the risk/s to quality (aligned to the five CQC domains) as a result of introducing a cost improvement programme. As part of this process, the Medical Director and Director of Nursing periodically meet with divisions to review the QIAs presented. In terms of assurance about the robustness of the process, the Committee will recall that following the Trust's well-led inspection in December 2017, the CQC commented: *"There was a trust board approved policy and process in place for undertaking quality impact assessments (QIA) of implementing cost improvement programmes and reporting quarterly to The Executive Quality Committee and three times a year to the Quality Committee and Trust Board. The QIA process consisted of undertaking a risk scoring assessment to consider the level of risk the proposed CIP would have. Risk scores above an agreed certain level required both medical and nursing director approval in addition to local divisional / corporate director approval.* ***The process was tested and evidenced (to be operating as per policy) with the clinical divisional directors."*** *(Page 13, Evidence Appendix, CQC Well Led inspection report, February 2018).*

A bi-annual report on the outcomes from the most recent review meetings with the divisions was presented to this committee and the Trust Board in January 2019.

3. Post-implementation evaluation process

It is important that once a CIP scheme has been implemented, the on-going impact on quality is monitored to ensure that; the QIA risk score is still reflective of the current risk, there hasn't been an increase in risk and that any risk that was initially identified pre-implementation of the scheme is successfully being mitigated.
To this end, each year, a range of schemes that have been implemented from the previous/current financial year are selected for a post-implementation evaluation (PIE) based on;

- A mixture of scheme categories e.g. pay, non-pay, productivity and income
- A mixture of QIA risk scores (high, medium and low)

- Discussions from previous CIP QIA review meetings where a scheme/s has been identified to be reviewed at a later date.

The evaluation is undertaken in line with the process set out in the Trust's CIP QIA policy which includes the evaluation template to be completed.

4. Outcomes from post-implementation evaluations

- Over 30 PIEs have been completed by the clinical divisions and these were discussed at meetings held with the Medical Director and Director of Nursing during March 2019.
- In summary, of the schemes evaluated, they largely demonstrated that the implementation of the scheme had either improved or maintained quality and that the original QIA risk score had either stayed the same or reduced once the scheme had begun.
- The PIE example provided in **Appendix 1** demonstrates that with the introduction of this scheme in the renal service, quality improved and as a result the patient reported experience measure (PREM) improved from 5.1 in 2017 (below national mean) to 5.89 (above national mean) in 2019.
- In contrast, a scheme related to using new iron medication instead of an existing product was implemented in 2018/19. However, following implementation and through on-going review of the scheme, the directorate found that a small number of patients experienced an adverse reaction to the new drug. To this end, the scheme was stopped and no longer continued.
- Both of the examples above provide assurance that the Trust's CIP QIA process and monitoring thereafter are operating as per policy.
- The post implementation evaluation process allows for learning to be identified and whilst there were no particular themes identified across all divisions, any learning specific to a scheme/s will be taken forward within directorates and divisions for the implementation of schemes during 2019/20.

5. Next steps

- The next routine quarterly meetings with divisions are scheduled to take place during quarter one 2019/20 where the focus will be to review the QIAs for schemes that will be delivered during the new financial year.
- An update on the outcomes of these meetings will be presented to the Board in November 2019.

Appendix 1 – PIE example

Title of Scheme:	Dialysis Head Nurse Clinics, which are additional to, and which complement Consultant Nephrologist clinics.
StratPro reference number:	1819DMIC025
Division:	MIC
Name of Divisional Director and Director of Nursing:	Frances Bowen; Sally Heywood
Date discussed at CIP QIA Review meeting:	20/08/2018

Prepared By:	Chris Kennedy	**Approved By:**	Ginny Prout
Signed:	CHRIS KENNEDY	**Signed:**	GINNY PROUT
Date:	05/03/19	**Date:**	05/03/2019

Section 1: Background

Provide a brief description of the Project before/at the time of implementation:

PURPOSE OF SCHEME:	Participation in the national 2017 Patient Reported Experience Measurement Survey (PREM) conducted via UK Renal Registry and Kidney Care UK, showed that 28% of our dialysis patients had ranked us poorly (≤4, out of 7) with regard to facilitating bespoke goal setting / partnership / shared decision making. This scheme facilitated additional, less hurried clinic appointments with a particular focus on these areas. They are conducted by experienced Head Nurses who also perform routine blood test reviews. The Head Nurses at 4 of our satellites are NMPs who review / adjust medicines, with clinical (and often financial) benefit. 3 more Head nurses are undertaking NMP courses, leaving only one off site satellite without an NMP by 2020.
PLANNED SAVINGS:	£57,800
WHEN DID THE SCHEME START?	April 2018
QIA RISK SCORE:	2
QIA RISK DESCRIPTION:	Dialysis patients will not receive same care-level as Lead Nurse will be in formal clinic

Section 2: PIE – Evaluation against Key Performance Indicators

Time period used for evaluation:
April 2018 – March 2019

Please list below Key Performance Indicators (KPI) used for the evaluation, and outline the performance before and after implementing the scheme.

KPI *(please list)*	**Performance before scheme implementation**	**Performance after scheme implementation**
2018 PREM report Re Sharing decisions and enabling patients to feel partnership in care planning.	2017 National mean score (out of 7) was 5.5. **Our score was 5.1**	2018 National mean score (out of 7) was 5.5 **Our score was 5.89 which shows an improvement**

Appendix 1 – PIE example

QIA Risk Score Comparison

QIA Risk Score **at time** of implementation:	2
Revised QIA Risk Score (**post-implementation** and assessment)	2

Section 3: Assessment of Savings

This section should provide a comparison between the agreed and actual savings of the project.

Planned savings	£57,800	Actual savings	Absorbed into overall divisional income position during 2018/19

Section 4: Conclusions and Recommendations

Conclusions
Provide a summary of the scheme's overall performance from a Quality perspective. There has been no adverse impact from a quality perspective. In fact, end of life care has been demonstrably better planned and documented. Evidence of this comes from directorate review of deaths occurring in renal wards. Head nurses report high levels of satisfaction from patients and staff in performing these clinics.

Lessons Learned		
Provide a summary below of lessons learned.		
What could have gone better?	**What was the cause?**	**What can we learn from this?**
n/a		

Recommendations
Provide a summary of how and to whom the lessons learnt will be disseminated and any action you will take for future schemes
n/a

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Research & Development Quarterly Report (Q3 and Q4 2018/19)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 22 May 2019	**Item 20, report no. 16**
Responsible Executive Director: Professor Julian Redhead (Medical Director)	**Author:** Dr Paul Craven (Head of Research Operations) / Professor Mark Thursz (ICHT R&D Director)

Summary:
This quarterly scheduled report presents a summary of recent activity and progress with respect to various clinical research initiatives within the Imperial Academic Health Science Centre (AHSC). It covers:

A) Progress against plan to increase the number of commercial clinical trials at ICHT;
B) Details of recent performance in initiating clinical trials;
C) Translational research highlights and outputs from the Imperial BRC.

Recommendations:
The Board is asked to note the Q3/Q4 2018/19 R&D report.

This report has been discussed at:
Executive Quality Committee and Board Quality Committee. Both committees approved the report, noting in particular that the translational research examples were very helpful when demonstrating the value of research internally.

Quality impact:
The benefits of an active clinical research environment for NHS Trusts are well documented. ICHT currently benefits from a number of important NIHR infrastructure awards which form the basis of our joint clinical research strategy with Imperial College London Faculty of Medicine. 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).

Financial impact:
This paper 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):
The NIHR Imperial BRC supports a variety of training and development initiatives at all stages of the clinical academic pathway, and also for non-medical, associated healthcare professionals and nursing staff.

Has an Equality Impact Assessment been carried out or have protected groups been considered? (see report writing guidance attached for further information) ☐ Yes ☐ No ☒ Not applicable
What impact will this have on the wider health economy, patients and the public? Clinical and biomedical research, when validated, is adopted and embedded into the healthcare system, enabling better diagnostics and treatments, as well as informing preventative measures and taking advantage of 'big data' to develop improved service pathways.
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No
Trust strategic goals supported by this paper: ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do

Research & Development Quarterly Report (Q3 and Q4 2018/10)

1. Executive Summary

1.1. Imperial College Healthcare NHS Trust (ICHT) works in close partnership with Imperial College London, through the Faculty of Medicine, to initiate and delivery clinical and biomedical research across many specialties. The R&D Directorate produces a quarterly update on R&D activity and performance within ICHT, as well as highlighting key examples of translation – where new science has led (or is leading) directly to patient benefit.

2. Purpose

2.1. The purpose of this paper is to present the board with a quarterly update on recent activity and progress with respect to various research initiatives within the Imperial Academic Health Science Centre (AHSC).

3. Commercial Clinical Trials

3.1. ICHT hosts many commercial clinical trials each year. These are often later-phase trials, sponsored and funding by pharma, biotech or medtech companies, seeking validation and market authorization of new drugs, devices or diagnostics. These trials are fully funded and enable patients to access the latest treatments. They are also a source of revenue for the Trust.

3.2. ICHT has committed to doubling the number of patients (and associated revenue) in commercial clinical trials within the next 3 years.

3.3. In 2018/19, a total of 85 commercially-sponsored (NIHR Portfolio adopted) clinical trials recruited patients at ICHT (see Appendix 1). This was down from 97 in 2017/18. Over the past 6 months, we have put in place plans and investment to attract further trials. We have developed new business partnerships with, for example, Novartis and MSD (Merck Sharp Dohme). However, it may take some more months before we see the new studies coming through as global pharma companies often have a pipeline of studies and sites planned well in advance.

3.4. In addition, this can be a rapidly changing ‘market’ - for example, we have seen fewer commercial studies in hepatology due to the success of new treatments for hepatitis C.

3.5. Despite seeing fewer studies recruiting, we have seen a very significant increase in the number of patients recruited to NIHR Portfolio commercial clinical trials, from 480 in 2017/18 to 4,059 in 2018/19. However, this is primarily due to a single dementia study which recruited several thousand patients into an initial ‘screening’ arm of the trial and should not be taken as evidence of a real, sustained trend. Single studies can often skew the data within a given period. Nevertheless, revenue is associated with these recruits.

4. Non-commercial clinical research activity

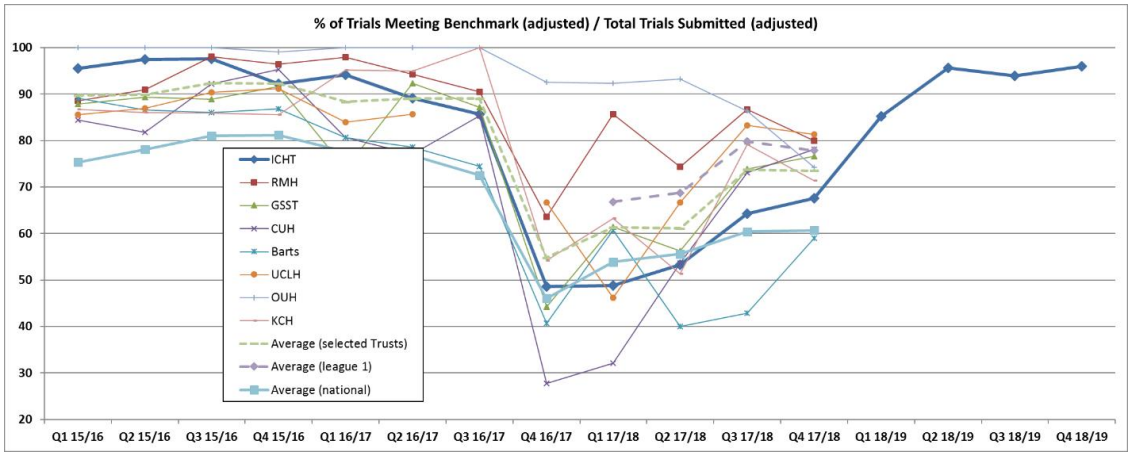
4.1. ICHT also hosts several hundred non-commercially sponsored / funded trials each year. These are often initiated by clinical academics in Imperial College London, with funding from external charities, research councils or government.

4.2. In 2018/19, we recruited 14,182 (latest figure available) patients into 325 different NIHR Portfolio non-commercial trials. The table in appendix 2 breaks down this number by specialty – oncology, paediatrics, infection and reproductive health were our highest recruiting specialties in 2018/19 (again, please bear in mind that single studies can significantly skew activity in any given year).

5. Performance in initiating clinical trials

5.1. Our 2018/19 performance for initiating clinical trials (70-day target) is much improved. The confirmed figure for Q3 is 93.9% and our provisional figure for Q4 is 96.0% (to be confirmed by NIHR). This improvement is due to changes within the ICHT Joint Research Office and Divisional Research Management teams, who now conduct weekly study review meetings with all Divisions, identify issues, and escalate as appropriate.

5.2. The longer-term trend for this metric can be seen in the graph below. Unfortunately, it is difficult to compare directly with peer organisations now, as NIHR no longer publish % compliance data (for the 70-day metric) for each NHS Trust.



6. NIHR Imperial Biomedical Research Centre (BRC): Translational research highlights

6.1. The NIHR Imperial BRC has provided direct support for more than specific 270 projects, fellowships and other initiatives in the 2018/19 financial year, investing just over £12.3m in early phase, experimental medicine research. This funding is deployed in 12 specialty-based or cross-cutting Themes. Some recent highlights from BRC-supported projects are included in the accompanying information. These are examples of science which is translating into the clinic, together with important peer-reviewed publications in high-impact scientific journals:

6.1.1. Artificial Intelligence can improve X-ray identification of pacemakers in emergencies – BRC researchers have created new artificial intelligence (AI) software that can identify cardiac rhythm devices in x-ray images more accurately and quickly than current methods. The team believes this software could speed up the diagnosis and treatment of patients with faulty devices in an emergency setting;

6.1.2. Women with benign ovarian cysts could avoid surgery - an international collaborative study has demonstrated that women with non-cancerous ovarian cysts could be monitored for changes in cyst size and appearance, instead of having them surgically removed;

6.1.3. New sensor technology can diagnose reproductive health problems in real-time - Imperial BRC researchers have developed new robotic sensor technology that has the capability to diagnose women's reproductive health problems in real-time by measuring hormones that affect fertility, sexual development and menstruation more quickly and cheaply than current methods;

6.1.4. AI system learns to predict survival rates from heart movement – we have developed a machine learning tool that can accurately predict a patient's risk of heart failure by tracking the motion of their heart from cardiac MRI scans without needing any human involvement;

6.1.5. Robust clinical utility of molecular phenotyping – this work provides important evidence for reliable and reproducible use of NMR spectroscopy in clinic, which can provide informative in-depth biochemical information to aid clinical decision-making at patient level;

6.1.6. Second patient in remission from HIV after stem cell treatment - in March 2019 it was announced that only the second patient ever had become free of HIV following stem cell treatment, this time at the John Goldman Cellular Therapy Unit at Hammersmith Hospital.

6.2. Executive and Board quality committees both noted that the translational research examples were helpful when demonstrating the value of research internally.

6.3. In addition, the BRC has recently submitted its 2018/19 Annual Research Report to the NIHR, providing the following translational highlights and achievements:

6.3.1 NIHR Imperial BRC researchers (Profs A Gordon and A Faisal) developed an Artificial Intelligence (AI) system that could be used to personalise the treatment of patients with sepsis in real time. The computational model, known as 'AI Clinician', learned the best individual treatment strategy from medical records of almost 100,000 sepsis patients, and provided recommendations that proved more reliable than decisions made by human doctors.

6.3.2 The ORBITA trial, led by researchers funded by the NIHR Imperial BRC Cardiovascular Theme, was the first research study – including over 200 patients with stable angina – 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). The primary results of the research showed no difference between patients who received a stent or the placebo treatment, in terms of the change to the length of time they could exercise on a treadmill before and after treatment. These results (published in The Lancet) could result in significant changes to clinical practice.

6.3.3 Since May 2017, the sepsis “big room” at ICHT has been looking at how the management of sepsis at the Trust can be improved to ensure the earliest possible identification and treatment. The “big room” brings together all the people involved in a patient’s pathway, such as doctors, nurses and pharmacists at the frontline, plus the patients themselves, the software engineers building our electronic patient record system (Cerner), information analysts and senior clinicians and managers involved in developing our services. We recognised that the electronic patient record system has a distinct advantage: the system captures patients’ observations, like pulse rate and blood pressure, as well as laboratory results. If a patient has a certain combination of observations and lab results, that can indicate sepsis. Using that data, the Cerner sepsis alert within the electronic patient record system flags that the patient could have sepsis. The alert prompts a doctor or nurse on the ward to review the patient immediately and, if they have sepsis, to record the diagnosis on the electronic record. This prompts the launch of sepsis ’power plans,’ which detail the investigations and treatments required to treat the patient. The alert and power plans help us ensure the patient gets the right antibiotic treatment as soon as possible. This new electronic system was developed with support from the NIHR Imperial BRC Research Informatics Team. The alert has made a significant impact: since its introduction a year ago, the number of patients across our hospitals coded with a diagnosis of sepsis has increased by 85%, from an average of 26 cases per week to 48 cases. Meanwhile, the proportion of patients with a diagnosis of sepsis who die in hospital has dropped by a third during this time. More of our patients are being diagnosed with sepsis, but more are surviving this dangerous condition.

7. Recommendations

7.1. The Board is asked to note the Q3/Q4 2018/19 R&D report.

Author **Dr Paul Craven, Head of Research Operations / NIHR Imperial BRC Manager**
Prof Mark Thursz, ICHT R&D Director / NIHR Imperial BRC Director

Date 15 May 2019

Appendix 1: Commercially-sponsored trials recruiting at ICHT by specialty (17/18 vs 18/19)

Specialty (CRN)	No. Recruiting 17/18	No. Recruiting 18/19	Difference
Cancer	37	39	2
Cardiovascular Disease	8	8	0
Diabetes	0	0	0
Metabolic and Endocrine Disorders	1	0	-1
Renal Disorders	3	1	-2
Stroke	2	0	-2
Children	1	1	0
Genetics	0	0	0
Haematology	3	4	1
Reproductive Health and Childbirth	1	2	1
Dementias and Neurodegeneration	12	8	-4
Mental Health	0	0	0
Neurological Disorders	1	5	4
Ageing	0	0	0
Dermatology	0	0	0
Specialty (CRN)	**No. Recruiting 17/18**	**No. Recruiting 18/19**	**Difference**
Health Services Research	0	1	1
Musculoskeletal Disorders	2	3	1
Oral and Dental Health	0	0	0
Primary Care	0	0	0
Public Health	2	1	-1
Anaesthesia, Perioperative Medicine and Pain Management	0	0	0
Critical Care	1	0	-1
Ear, Nose and Throat	0	0	0
Gastroenterology	4	0	-4
Hepatology	6	2	-4
Infection	3	3	0
Injuries and Emergencies	0	1	1
Ophthalmology	4	3	-1
Respiratory Disorders	2	1	-1
Surgery	4	2	-2
Totals	**97**	**85**	**-12**

Appendix 2: Non-commercial clinical research activity at ICHT by specialty (18/19)

Specialty (NIHR CRN categorisation)	No. of Patients
Cancer	3,402
Children	1,255
Infection	1,163
Reproductive Health and Childbirth	956
Genetics	911
Injuries and Emergencies	899
Surgery	739
Cardiovascular Disease	700
Neurological Disorders	567
Anaesthesia, Perioperative Medicine and Pain Management	541
Critical Care	426
Renal Disorders	363
Stroke	358
Metabolic and Endocrine Disorders	318
Musculoskeletal Disorders	316
Health Services Research	292
Public Health	283
Diabetes	137
Dermatology	85
Dementias and Neurodegeneration	80
Mental Health	76
Respiratory Disorders	69
Hepatology	62
Haematology	61
Ageing	47
Gastroenterology	38
Ophthalmology	22
Ear, Nose and Throat	14
Primary Care	2
Grand Total	**14,182**

Research & Development Quarterly Report Q3-Q4 2018/19
Supporting information: Translational Research Highlights

ARTIFICIAL INTELLIGENCE CAN IMPROVE X-RAY IDENTIFICATION OF PACEMAKERS IN EMERGENCIES

Researchers have created new artificial intelligence (AI) software that can identify cardiac rhythm devices in x-ray images more accurately and quickly than current methods. The team believes this software could speed up the diagnosis and treatment of patients with faulty devices in an emergency setting.

The software, created by researchers at Imperial College London and funded by the NIHR Imperial BRC, Medical Research Council and British Heart Foundation, has been able to identify the make and model of different cardiac rhythm devices, such as pacemakers and defibrillators, within seconds.

Dr James Howard, Clinical Research Fellow at Imperial College London and lead author of the study, said: “Pacemakers and defibrillators have improved the lives of millions of patients from around the world. However, in some rare cases these devices can fail and patients can deteriorate as a result. In these situations, clinicians must quickly identify the type of device a patient has so they can provide treatment such as changing the device’s settings or replacing the leads. Unfortunately, current methods are slow and out-dated and there is a real need to find new and improved ways of identifying devices during emergency settings. Our new software could be a solution as it can identify devices accurately and instantly. This could help clinicians make the best decisions for treating patients.”

The researchers will aim to carry out a further trial to validate the results in a larger group of patients and investigate ways to create a more portable device that can be used on hospital wards.

Cardiac Rhythm Device Identification Using Neural Networks

JACC: Clinical Electrophysiology

WOMEN WITH BENIGN OVARIAN CYSTS COULD AVOID SURGERY

An international collaborative study has demonstrated that women with non-cancerous ovarian cysts could be monitored for changes in cyst size and appearance, instead of having them surgically removed.

Ovarian cysts are very common and are often asymptomatic. In cases of pelvic pain and bloating, an ultrasound scan is performed, and cysts are classified as benign or cancerous. While in cases of suspected cancer cysts are always surgically removed, it is also often recommended for benign cysts too, as a prophylactic measure. However surgery is not without risk, and can cause multiple complications in short- and long-term.

A team of scientists from 14 different countries investigated whether surgery was necessary for women who were diagnosed with a benign ovarian cyst on the basis of ultrasound, as part of the international, prospective, cohort International Ovarian Tumour Analysis Phase 5 (IOTA5) study. Patients were monitored with ultrasound at intervals of 3 and 6 months, and 12 months thereafter.

Two-year follow-up interim analysis was recently published in The Lancet Oncology. IOTA5 recruited 8519 patients, of whom 1919 were eligible for this prospective analysis. Cumulatively, cysts spontaneously resolved (dissipated on own accord) in 20.2% of cases (1 in 5 women). Invasive and borderline tumours were subsequently diagnosed in 12 women, making cancer risk 0.4% (authors argue that these women could have been initially misdiagnosed as having benign cysts). Risk of cyst rupture was even lower, at 0.2%.

Risk of complications in patients with conservatively managed ovarian tumours (IOTA5): a 2-year interim analysis of a multicentre, prospective, cohort study.

Lancet Oncology

2

NEW SENSOR TECHNOLOGY CAN DIAGNOSE REPRODUCTIVE HEALTH PROBLEMS IN REAL-TIME

Researchers supported by the NIHR Imperial BRC have developed new robotic sensor technology that has the capability to diagnose women's reproductive health problems in real-time. The technology, developed by researchers at Imperial College London and the University of Hong Kong, can be used to measure hormones that affect fertility, sexual development and menstruation more quickly and cheaply than current methods.

A third of women in England suffer from severe reproductive health problems such as infertility and early menopause. Doctors usually diagnose these conditions by carrying out a blood test to measure the amount of luteinizing hormone (LH) in the sample. Current blood tests cannot easily measure the rise and fall of LH levels which is vital for normal fertility – so-called LH pulse patterns that are linked to reproductive disorders. It is not currently feasible to measure LH pulse patterns in a clinical setting as doctors need to take a blood sample from patients every 10 minutes for at least eight hours.

The researchers behind the trial have used a novel biosensor linked to a robotic system, which they call Robotic APTamer-enabled Electrochemical Reader (RAPTER). It has the potential to transform the clinical care of patients with reproductive disorders by monitoring the hormone patterns of patients in real-time. In the study, the prototype RAPTER device was used to measure LH in the blood of patients taken every ten minutes to yield an immediate result.

Professor Waljit Dhillo said: "Reproductive health issues are common amongst women in the UK and around the world. Diagnosis of some of these conditions can be lengthy resulting in delays to treatment. Reproductive health issues can also impact on women's mental and physical well-being. There is a clear need for new and better ways to diagnose these conditions more quickly. Our technology will be able to give clinicians a faster and more accurate diagnosis of hormone pulsatility which could lead to better, more targeted treatments for women."

Measuring luteinising hormone pulsatility with a robotic aptamer-enabled electrochemical reader

Nature Communications

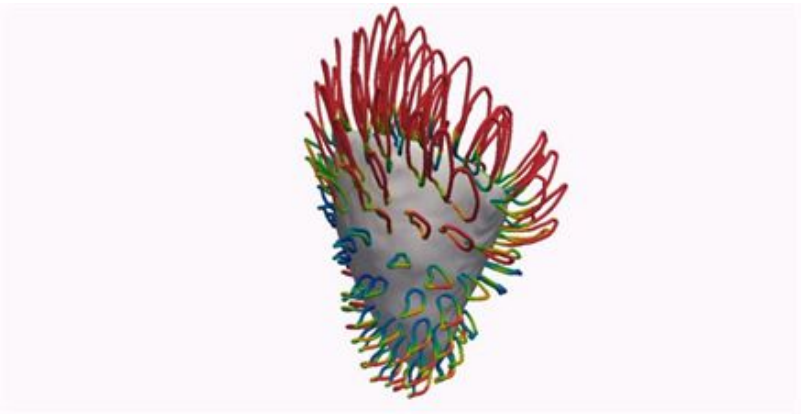
3

AI SYSTEM LEARNS TO PREDICT SURVIVAL RATES FROM HEART MOVEMENT

Cardiac imaging forms an important part of the initial assessment of patients suspected of having heart failure. Currently, doctors evaluate a patient's risk of heart disease by taking simple measurements of the volume and mass of the heart – but this approach is not accurate or patient-specific.

A team at the MRC London Institute of Medical Sciences (LMS) and funded by the NIHR Imperial BRC have found a way to harness AI to enable doctors to predict outcomes for heart patients more accurately and find the best treatment for individual patients. The research, published in the journal Nature Machine Intelligence, reports on a machine learning tool that can accurately predict a patient's risk of heart failure by tracking the motion of their heart from cardiac MRI scans without needing any human involvement.

The researchers used the technology to predict the prognosis for 302 people with a heart condition called pulmonary hypertension. Patients with pulmonary hypertension were chosen because the choice of their treatment is dependent on the individual patient's risk classification. The technology correctly predicts a patient's prognosis 75% of the time and outperforms doctors' measurements.



Dr. Declan O'Regan (PI) said: "Our ultimate goal is to see this technology used throughout the NHS, not just for cardiac events but for other applications too. But first we will be evaluating the algorithm on larger cohorts of cardiac patients, in collaboration with centres in the UK and Europe, to see how well it performs in a real-world environment. This would just be using motion analysis from cardiac MR images, but there is so much more data out there that can enrich this technology. Incorporating a patient's health records, genetic information, metabolic signature or even the heart data from your wearable device can give a much more precise and personalised recommendation of treatment." This exciting new imaging technology is not only the most precise prediction of future cardiac events yet, but crucially still allows doctors to interpret the outputs from the algorithm. This is the next step in allowing clinicians to tailor and guide a treatment option that is personalised to each patient.

Deep-learning cardiac motion analysis for human survival prediction

Nature Machine Intelligence

4

ROBUST CLINICAL UTILITY OF MOLECULAR PHENOTYPING

Imperial researchers demonstrated suitability and robustness of specialised spectroscopy for molecular analysis of human samples in a multi-laboratory trial. The Imperial College Phenome Centre (IPC) – the core facility of the NIHR Imperial BRC Molecular Phenomics Theme – led a multi-centre laboratory study to assess the precision and accuracy of measuring lipoprotein concentrations by NMR spectroscopy in human samples.

Lipoproteins are classified based on their density and size, into high-, low- and very low-density lipoproteins, and chylomicrons, which are composed of dietary fat triglycerides. Circulating lipoproteins in blood, more commonly known as ‘cholesterol levels’, are routinely measured in clinic and are used as an indicator of cardiovascular and other disorders. However standard examination has limitations with respect to turnaround time and the depth of information it provides.

Scientists from 5 laboratories in 3 institutions analysed 98 blood serum and plasma samples using 11 NMR spectrometers following the same protocols, while operators were not exchanged between labs, even within same institutions. Study results demonstrated exceptional reproducibility of lipoprotein quantification measured by NMR, compliant with NCEP requirements (National Cholesterol Education Program) for the measurement of lipids in certified clinical laboratories. In addition to lipoprotein amounts, quantification of 26 metabolites, including glucose, lactate, several amino acids and creatinine, was also possible by using the same 4–minute NMR measurement, with negligible analytical variation. However, the authors do caution that lower molecular weight metabolites would need to be considered on individual basis.

As with most medical tests, inter-institutional reproducibility is crucial to avoid operator bias and to ensure wider NHS implementation. This work provides important evidence for reliable and reproducible use of NMR spectroscopy in clinic, which can provide informative in-depth biochemical information to aid clinical decision-making at patient level in most disorders where lipid metabolism is deregulated.

Quantitative Lipoprotein Subclass and Low Molecular Weight Metabolite Analysis in Human Serum and Plasma by 1H NMR Spectroscopy in a Multilaboratory Trial

Analytical Chemistry

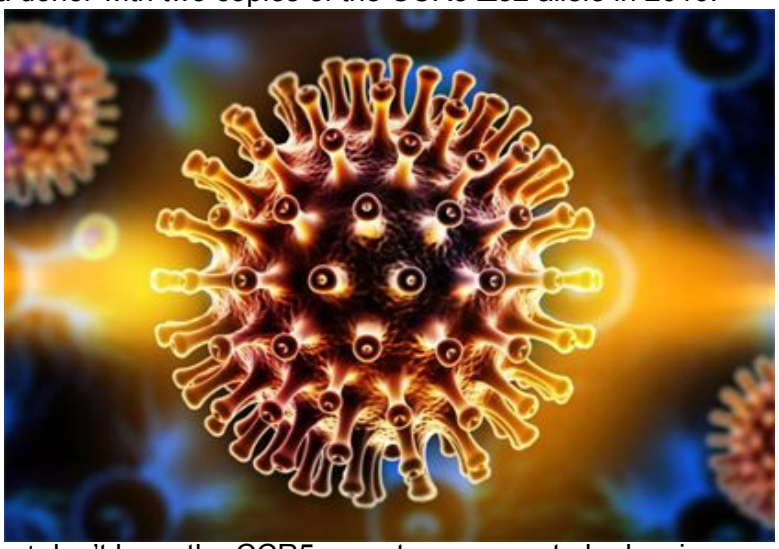
5

SECOND PATIENT IN REMISSION FROM HIV AFTER STEM CELL TREATMENT

Only one patient has been completely cured of HIV – the so-called 'Berlin patient' almost 10 years ago. This patient was able to stop taking antiretroviral drugs after an intensive round of chemotherapy and radiation and two bone marrow transplants.

In March 2019 it was announced that – following a long-term collaboration between 5 national NIHR BRCs (Imperial, Cambridge, UCL, Oxford and Guy's) – that a second patient had also become free of HIV following similar treatment. The patient was treated in the John Goldman Cellular Therapy Unit at Hammersmith Hospital,

Both patients were treated with stem cell transplants from donors carrying a genetic mutation that prevents expression of an HIV receptor CCR5. The case report describes a male patient in the UK who was diagnosed with HIV infection in 2003 and on antiretroviral therapy since 2012. Later in 2012, he was diagnosed with advanced Hodgkin's Lymphoma. In addition to chemotherapy, he underwent a haematopoietic stem cell transplant from a donor with two copies of the CCR5 Δ32 allele in 2016.



CCR5 is the most commonly used receptor by HIV-1. People who have two mutated copies of the CCR5 allele are resistant to the HIV-1 virus strain that uses this receptor, as the virus cannot enter host cells. Chemotherapy can be effective against HIV as it kills cells that are dividing. Replacing immune cells with those that don't have the CCR5 receptor appears to be key in preventing HIV from rebounding after the treatment. The transplant was relatively uncomplicated, but with some side effects including mild graft-versus-host disease, a complication of transplants wherein the donor immune cells attack the recipient's immune cells. The patient remained on ARV for 16 months after the transplant, at which point the clinical team and the patient decided to interrupt ARV therapy to test if the patient was truly in HIV-1 remission.

Regular testing confirmed that the patient's viral load remained undetectable, and he has been in remission for 18 months since ceasing ARV therapy (35 months post-transplant). The patient's immune cells remain unable to express the CCR5 receptor.

The subject of the new study has been in remission for 18 months after his antiretroviral therapy (ARV) was discontinued. The authors of the report say it is too early to say with certainty that he has been cured of HIV and will continue to monitor his condition.

The origins of this work lie with the CHERUB consortium which was established in 2009 to enable the BRCs to work together on a single project. This is a vindication of the concept, showing how long research investments and outputs can take to mature, and how powerful the BRCS can be both individually and working as a group.

HIV-1 remission following CCR5Δ32/Δ32 haematopoietic stem-cell transplantation

Nature

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Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Annual report of use of the Trust seal	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 22nd May 2019	**Item 21, report no. 17**
Responsible Executive Director: Peter Jenkinson, Director of Corporate Governance and Company Secretary	**Author:** Ginder Nisar, Deputy Trust Secretary
Summary: The Trust's standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis.	
Recommendations: The Trust board is asked to note the report.	
This report has been discussed at: N/A	
Quality impact: N/A	
Financial impact: No financial impact	
Risk impact and Board Assurance Framework (BAF) reference: Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse.	
Workforce impact (including training and education implications): N/A	
Has an Equality Impact Assessment been carried out or have protected groups been considered? ☐ Yes ☐ No ☒ Not applicable	
What impact will this have on the wider health economy, patients and the public? N/A	
The report content respects the rights, values and commitments within the NHS Constitution ☒ Yes ☐ No	
Trust strategic goals supported by this paper: ▪ To help create a high quality integrated care system with the population of north west London ▪ To develop a sustainable portfolio of outstanding services ▪ To build learning, improvement and innovation into everything we do	
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? ☐ Yes ☒ No	

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Use of the Trust common seal April 2018- March 2019

This table is a record of the use of the Trust seal as required by the Trust Standing Orders

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
211	Imperial College Healthcare NHS Trust, Imperial Health Charity and Great Western Development Ltd	Scaffolding and demolition licence to erect scaffolding over three outpatient buildings and demolition of Royal Mail Post Office buildings	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	26 July 2018
212	Imperial College Healthcare NHS Trust and 2020 Delivery Ltd	Project: Improving patient flow programme collaborative. Call-off order form and call-off terms for the management consultancy framework agreement RM3745	Richard Alexander, Chief Finance Officer Professor Janice Sigsworth, Director of Nursing	20 August 2018
213	Imperial College Healthcare NHS Trust and Playfords Electrical Ltd	Provision of generator back up to existing imaging substation	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	18 October 2018
214	Imperial College Healthcare NHS Trust and Metricab Power Engineering Ltd	Provision of electrical supply by replacing aged transformers	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	18 October 2018
215	Imperial College Healthcare NHS Trust and Metricab Power Engineering Ltd	Supply and install replacement intake LV panel for Patterson building	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	18 October 2018
216	Imperial College Healthcare NHS Trust, Imperial Health Charity and Great Western Development Ltd	Deed of variation	Michelle Wheeler, Director of Redevelopment Peter Jenkinson, Trust Company Secretary	18 January 2019
217	Imperial College Healthcare NHS Trust and The Trustees of Children of St Mary's Intensive	Supplemental Lease agreement	Professor Tim Orchard, Chief Executive Richard Alexander, Chief Financial	19 February 2019

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
	Care (COSMIC)		Officer	
218	Imperial College Healthcare NHS Trust and United Kingdom Institute – Medical Research Council	Contract (agreement to surrender old lease, new lease and licence works)	Professor Tim Orchard, Chief Executive Richard Alexander, Chief Financial Officer	19 February 2019
219	Imperial College Healthcare NHS Trust and Sodexo Ltd	Deed of settlement and variation (amendment to contract)	Professor Tim Orchard, Chief Executive Peter Jenkinson, Trust Company Secretary	1 March 2019

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee **–** report from meeting on 23 April 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 22 May 2019	**Item 22.1, report no. 18a**
Responsible Non-Executive Director: Sir Gerald Acher	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Audit, Risk and Governance Committee met on 23 April 2019. Key items to note from that meeting include:

External Audit report
The Committee received an update from the Trust's external auditors, noting that the year-end audit was due to commence week commencing 2 May.

The Committee discussed the arrangements for signing off the accounts, noting that the Committee would meet on 22 May, prior to the Board, to review the draft financial accounts and annual report, and to receive the auditor's opinion on both the accounts and reports. **The Trust Board is asked to delegate authority to the Audit Committee to approve the submission of financial accounts and annual report on its behalf, by close of play on 28 May 2019, and to approve the quality accounts following sign-off by Quality Committee.**

Internal audit progress report
The Committee received the internal audit progress report, noting progress of audit work against the 2018/19 plan. The Committee noted that four reviews were being finalised, including the review of IT disaster recovery planning which included some potential risks that needed to be discussed with management prior to finalising the report. It was noted that this report in particular would need to be finalised before the Head of Internal Audit opinion could be confirmed. The final report from this audit report will be presented at the Committee's next meeting in May.

The Committee considered executive summaries of audit reviews completed in the period, including capacity management, pseudonymisation and DSP toolkit, noting low risk ratings provided for these reviews.

The Committee discussed the findings of the audit review of capacity management, noting that although the overall risk rating for the report was moderate, individual high risk findings were highlighted in regard to trust-level systems such as policy and capacity planning. The Committee noted that there was evidence of divisional level capacity planning but that this needed to be formalised in the context of a trust-wide framework. The Committee also noted that the operational management of capacity was good, but that gaps were identified in capacity planning. The Chief executive advised the Committee that the trust had a model for capacity planning that would be rolled out across the Trust, and added that the new role of Director of Operational Performance would provide improved focus on trust-level capacity planning. The Committee agreed that there should be a follow-up review completed in six months.

Draft internal audit plan 2019/20 and risk assessment
The Committee agreed the internal audit plan for 2019/20, noting that the plan had been informed by the assessment of key risks, the 'risk universe' in which the Trust operated and through consultation with executive directors. Each audit will have terms of reference agreed by executive directors before the audit commences.

Management responses to limited assurance reports

Estates and facilities contracting
The Committee considered the management response to the findings of the internal audit review of estates and facilities contracting arrangements, noting improvements made to processes and systems, and a summary of the approach to reviewing and managing the reactive backlog maintenance.

The Committee discussed the challenges faced in estates maintenance, noting the general condition of the trust estate and the resource required to support the level of response required. The Committee welcomed the approach being taken by the Trust to address the issues, including the approach to backlog maintenance, and agreed that a follow-up review should be completed in Autumn 2019.

Internal audit review – Board governance and divisional governance
The Committee considered the findings from an internal audit review of Board governance and divisional governance arrangements, and noted the trust response including proposed actions over the next year to strengthen the governance arrangements. The Committee noted in particular the audit findings of variation in governance standards at divisional and directorate level, and the proposed response – the implementation of common governance standards at divisional and directorate level followed by an audit to check whether these standards had been embedded.

Local Counter Fraud Service (LCFS)

LCFS update and annual report 2018/19
The Committee received the counter fraud annual report, including a summary of the activity over 2018/19 against the agreed plan and the final version of the self-review toolkit and declaration. The Committee noted a summary of ongoing cases undergoing investigation and of closed cases, including the lessons learnt from an investigation launched in April 2018.

LCFS annual plan 2019/20
The Committee agreed the counter fraud plan for 2019/20, noting that the guidance had not changed significantly and therefore the plan remained largely the same from the previous year's, apart from additional capacity being provided to support the proactive counter fraud work.

Draft annual accounts 2018/19
The Committee reviewed the draft annual accounts, for submission to NHS Improvement on 24 April. The Committee noted that, with the additional Provider Sustainability Funding (PSF) allocation from NHS Improvement, the Trust had reported a £28m surplus for the year-end.

The Committee discussed the approach taken to PSF and the allocation of PSF by NHS Improvement, noting that the Trust would require an increase in its Capital Resource Limit to allow it to spend any of this PSF allocation.

The Committee also noted a summary of financial results against other external measures, noting improvements made in compliance with the Better payments practice code (BPPC) but with more still to do. It was agreed that an update on the procurement process for the trust's accounts payable function would be presented to the Committee in Autumn 2019.

The Committee reviewed the key assumptions supporting the draft statements and the response to perceived external audit risks. There was a discussion regarding the audit risks and the initial views of the external auditors, and the management responses. The Committee noted that materiality was set at £14.5m and the audit would commence on 2 May. The Committee discussed the issue of long term

financial sustainability and going concern and noted the progress made during the year in delivering the undertakings resulting in amended undertakings being agreed in September 2018.

The Committee also noted the declaration in the accounts regarding the condition and life span of the estate, highlighting the risk of significant estates failures occurring before the redevelopment of the estate.

Draft annual report 2018/19
The Committee reviewed the draft annual report, noting that it would be shared with the auditors on 2 May and then presented for approval at the Committee's meeting on 22 May. It was noted that the remuneration report and sustainability report would be included once drafted.

The Committee considered the proposed approach to significant issues in the governance statement and agreed that there had been no significant lapses of internal control during the year to be reported; however there were ongoing risks, such as the financial sustainability and the need for redevelopment of the estate, which the Trust continues to manage.

Draft quality account 2018/19
The Committee noted that the draft quality account had been circulated and reviewed outside of the meeting, and received a summary of the changes made in response to comments received. The Committee noted the mandated structure and contents of the account.

Tender waiver & Losses and special payments reports
The Committee received and noted a summary of the number and value of waivers for Q3 2018/19, and noted a summary of losses and special payments made in the last quarter.

The Committee will next meet on Wednesday 22 May 2019.

Recommendations: The Trust Board are requested to note this report and to delegate authority to the Audit Committee to approve the submission of accounts and annual report on its behalf, by close of play on 28 May 2019.

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TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from Quality Committee – report from meeting held on 8th May 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 22nd May 2019	**Item 22.2, report no. 18b**
Responsible Non-Executive Director: Sir Gerry Acher (Acting Committee Chair)	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Quality Committee met on 8th May 2019. Key items to note from that meeting include:

Integrated Quality and Performance Report
The Committee reviewed the integrated quality and performance report focusing on the quality aspects within the report. In particular the Committee discussed the level of incident reporting, noting the action being taken to increase awareness and encourage a culture of reporting actual incidents and 'near misses' in order to respond to a decline in the number of incidents being reported. The Committee discussed the barriers that prevent staff from reporting incidents and welcomed the launch of a Care Reporting app to enable doctors to report incidents more easily. We also noted that the possibility to link Datix with the electronic patient record was being investigated.

The Committee agreed that at the next meeting we will review the level of reporting by staff group and area to identify where further improvement is required.

As part of the discussion the Committee noted a number of areas that should be included in the guidance for board member visits, for board members to consider with respective clinical teams – to follow the prescribing journey to look at the proactive controls in place to prevent incidents from occurring and also to understand the reporting culture in the team.

The Committee noted that a never event had been declared in April 2019, relating to a retained swab in a complex ENT procedure. An investigation has commenced and the Committee will review the findings and recommendations once completed; the lessons learnt will include a review of the best time to complete a debrief in these types of cases. The Committee received an update on the actions taken in response to the previous cluster of never events, including the roll out of simulation training to all medical staff involved in invasive procedures. To date, 17 staff are not compliant with this mandated safety training but they are not practising and a process has commenced to ensure compliance. The Committee commended the simulation training and discussed ways of publishing this example of good practice

The Committee also reviewed performance in the degree of harm and VTE risk assessment.

Key Divisional Quality Risks
The Divisional Directors and Corporate Directors provided an update on their key divisional risks which remained largely the same as previous meeting. The Committee noted the common risk of cleaning across all divisions and noted the controls in place to manage the risk, including escalation of individual incidents feeding into contract discussions with Sodexo. The Committee discussed the impact of the condition of the estate on the ability to achieve cleaning standards, and the risk around backlog maintenance. It was agreed that a 'deep dive' review of incident data should be completed to establish whether there was a link between the standard of cleaning and clinical incidents such as infections, and the results presented to the Committee.

The Committee noted the risk in Surgery division regarding theatre equipment and estate, noting the need for backlog maintenance in theatres and for replacement of equipment. The Committee discussed the prioritisation process for capital expenditure and equipment replacement, and welcomed the establishment of a medical devices library that improves the central view of equipment and prioritisation of replacements.

The Committee also noted the risk in the Women's, Children's and Clinical Support division regarding the failure of lifts in Clarence and Cambridge Wing.

CQC Update
The Committee received an update on CQC related activity at and/or impacting the Trust since the last report to the Committee, noting the Insight report data for April 2019. The Committee noted that the final report from the CQC inspection process, now completed, would be published on 8th July; this would include ratings for well-led and use of resources as well as the core services. The Committee noted the outputs from a lessons learned review of the preparation and management of the CQC inspection, and noted the recommendations. We also noted that an inspection of the trust's GP practice at Hammersmith and Charing Cross hospitals, using the GP inspection methodology, is expected in July.

Incident Monitoring Report
The Committee considered the regular incident monitoring report, noting the profile of incidents reported. The Committee noted that the largest contributor to the number of serious incidents reported is delays in the treatment of patients with mental health issues in ED.

The Committee reviewed the current level of serious incidents (SI) reported and outstanding investigations overdue past their completion date (14 out of 49 open investigations). The Committee noted in particular two investigations that had been due for completion by July and December 2018; we were pleased to note that these reports would be presented to a panel this week but we noted the lessons learned regarding the need to identify complex investigations earlier and to apply for an extension to the deadline. The Committee welcomed the launch of an SI improvement programme to drive continued improvement to the SI process, noting the recommendation to establish a central investigations unit to improve the quality and timeliness of investigations.

Infection Prevention and Control (IPC) Quarterly Report: Q4 2018/19
The Committee received and noted the quarterly report, noting in particular that the Trust had met the target for
C. difficile for the year. The Committee noted an update on the action being taken in respect of water hygiene, noting the challenges faced in the condition of some parts of the estate.

Potential single points of failure
The Committee considered the output from an exercise, prompted by previous lift failures, to identify single points of failure across the trust and to consider the business continuity plans to mitigate these risks. The Committee noted high risk areas and welcomed the development of continuity plans where appropriate.

Quality account 2018/19
The Committee considered the latest draft version of the Quality Account, noting changes made since the last review and discussion at the Audit, Risk and Governance Committee. Changes have included moving some of the data to appendices to make the document easier to read. The Committee noted that the Trust had engaged with external stakeholders and had received largely positive feedback.

The Audit, Risk and Governance Committee will consider the audit opinion on the Quality Account at its meeting on 22 May. **The Trust Board is asked to delegate authority to the Committee to approve the final version of the Quality Account, subject to confirmation from auditors that it meets the requisite standard.**

Seven day services
The Committee received an update on the Trust's performance against the national priority Seven Day Hospital standards, and agreed the submission of the programme template to NHS Improvement as

part of a twice yearly submission. The Committee considered exceptions in compliance with the standards, and agreed with a decision not to seek achievement of compliance with standard 2 as management were confident that the current medical model offered provided appropriate expertise and the cost of achieving full compliance, estimated at circa £2m, would not be justified due to insufficient impact on improving quality of care.

Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme
The Committee considered the ten safety standards that the Trust needed to meet in order to achieve a refund (£1m) from the Trust's contribution to CNST and to a share of unallocated funds (c. £500k in year one). The Committee reviewed the evidence available to demonstrate compliance with three of the ten standards and noted the action plan to achieve the requisite standards.

National maternity survey results
The Committee also noted the results from the 2018 maternity services survey, noting that the Trust was rated 'about the same' as other trusts in all areas apart from one question – partners being involved as much as they wanted' – in which the trust was rated 'better' than other trusts.

CIP QIA update
The Committee noted a report on the outcomes of the post-implementation reviews of quality impact assessments (QIAs) for Cost Improvement Programmes (CIPs), noting that over 30 post-implementation reviews had been completed by divisions and reviewed by the medical director and director of nursing. The Committee was pleased to note that the reviews demonstrated that the implementation of the CIPs had either improved or maintained quality and that the original risk score had remained the same or reduced.

The Committee commended the process and noted the assurance provided by the CQC regarding the robustness of the process, noting the importance of having a robust process of review given the financial challenge to be addressed in 2019/20.

Research & Development update (quarters 3 & 4 2019/20)
The Committee received a summary of recent progress with respect to various clinical research initiatives with the Imperial Academic Health Sciences Centre (AHSC), noting progress against the plan to increase the number of commercial trials and performance in initiating clinical trials. The Committee also noted a number of case studies of translational research highlights from the Imperial Biomedical Research Centre (BRC). The Committee noted that a regular newsletter from the medical director disseminates the case studies to all consultants.

Recommendations:
Trust Board is asked to note this summary and to delegate authority to the Quality Committee to approve the final version of the Quality Account.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC BOARD SUMMARY	
Title of report: Report from Finance and Investment Committee meeting held on 15th May 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 22nd May 2019	**Item 22.3, report no. 18c**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Peter Jenkinson, Director of Corporate Governance

Summary:

The Finance and Investment Committee met on 15th May 2019. Key items to note from that meeting include:

Financial performance – year-end 2018/19
The Committee reviewed the draft management accounts for 2018/19, noting that they are subject to external audit. The Committee noted that the Trust has met the control total for 2018/19, before Provider Sustainability Funding (PSF), with a favourable variance to plan of £0.3m. As the A&E 4-hour target has been met across the delivery board the Trust is eligible for £34m of core PSF. The Trust has also received an additional £14m of bonus and incentive PSF funding. This funding was allocated based on achievement of the control total and recurrent CIPs. This non recurrent funding brings the total reported surplus for the year to £28.2m.

The Committee discussed divisional and corporate directorate performance and variations against plan, and discussed the allocation of contingency reserves. We discussed in particular reserves allocated to maternity services to offset decrease in demand and have agreed that we will review the short-term response at our next meeting, and then the output of a feasibility analysis regarding the long-term plan and engagement with sector partners in six months.

The Committee received a summary of progress on its management of capital expenditure against the Capital Resource Limit (CRL) for 2018/19, changes to the capital plan and an update on the 2019/20 capital plan. We noted a £750,000 underspend against the CRL in 2018/19, due to agreed underspends with NHS Improvement, mostly due to the expenditure for the Health Information Exchange (HIE) project being deferred to 2019/20 and an agreed postponement of some charity financed projects.

2019/20 business planning update recovery plan
The Committee considered an update on the business planning process and the financial plan for 2019/20, noting the level of efficiencies required to be achieved this year is at a similar level to the previous year but there is a greater risk due to the no growth activity assumptions across the Northwest London sector. The trust will therefore not be able to rely on activity growth to close the financial gap.

We reviewed the current underlying deficit and the impact of MRET funding in reducing this deficit, but noted the risk of increasing it if the Trust uses non-recurrent measures to close the gap in 2019/20 to achieve the control total.

The Committee agreed the need for the Trust to meet its required run-rates in terms of expenditure to deliver the plan and welcomed the introduction of run-rate targets across divisions and corporate directorates.

Transformation update
The Committee received an update on the Trust's transformation plan and the specialty review programme, both of which are critical to the Trust's financial sustainability. We welcomed the portfolio of projects established as part of the transformation plan and will review the financial impact and timescales for each project at the next meeting.

Procurement update
The Committee received an update on procurement efficiency and effectiveness and noted areas for further improvement.

The Committee also reviewed the lessons learned from a post-project evaluation of the implementation of a materials management contract, noting the lessons learned regarding communication between departments.

Redevelopment financials
The Committee received an update on the redevelopment programme and budget, noting an update on the ongoing procurement of some analysis work to consider the commercial impact of various options for redeveloping the Trust's sites. It was noted that the tender document has now been circulated to prospective bidders.

Cash flow management
The Committee received an update on ongoing work to maximise the available working capital, noting improvements in the cash balance through improved debt position and noting the ongoing steps to improve the performance of the outsourced accounts payable supplier.

Business cases approved by Committee – annual review
The Committee received a review of business cases approved by executive and Board, noting that a total of 32 business cases were approved by the Executive during the 2018/19 financial year, with five of these cases being worth more than £2m and less than £5m in either expenditure and or capital. One business case (Charing Cross Emergency Department) had expenditure above £5m. This compares with 35 business cases approved in 2017/18. At the next meeting we will receive a review how past business cases turned out relative to the assumptions at the time of approval

It was noted that one business case (ICT Network Replacement) has been approved by the Executive since the start of the 2019/20 financial year, with this case being worth more than £5m in capital expenditure. The Full Business Case has also been approved by the Board. The executive will propose a process to deal with cases that need approval in between the regular meeting cycle.

Reference Costs and Patient level costing update
The Committee received an update on reference costs and patient level costing and agreed that the processes in place are sufficient to provide assurance to the board on the plan to complete the mandated costing submissions for 2018/19.

Recommendations:
To note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Remuneration and Appointments Committee – report from meeting on 15 May 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 22 May 2019	**Item 22.4, report no. 18d**
Responsible Non-Executive Director: Peter Goldsbrough, Chair of Remuneration Committee	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Remuneration and Appointments Committee met on 15 May 2019. Key points to note include:

NHS Pension update
The Committee considered an update on the issues relating to tax on NHS Pension Benefits and how the changes to the annual and lifetime allowances affects staff in the NHS Pension scheme. The Committee considered an update on action being taken at a national level and options for the Trust response. The Committee agreed that more data is required regarding the groups and numbers of staff potentially affected before a specific response could be agreed, but that staff awareness of the potential issues arising from the tax changes should continue with guidance to staff about where they can obtain their own individual tax advice.

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