Imperial College Healthcare NHS Trust

Trust Board – Public

Wednesday, 27th March 2019, 10.30am to 1.30pm
Clarence Wing Boardroom, St Mary's Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1030	**1.**	**Opening remarks**	Sir Gerald Acher	Oral
	2.	**Apologies:** Kevin Croft (Sue Grange representing) Prof Martin Wilkins, Acting Dean	Sir Gerald Acher	Oral
	3.	**Declarations of Interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessarywithdraw from the meeting*	Sir Gerald Acher	Oral
1035	**4.**	**Minutes of the meeting held on 30th January 2019** *To approve the minutes from the last meeting*	Sir Gerald Acher	01
	5.	**Record of items discussed in Part II of Board meeting held on 30th January 2019** *To note the report*	Sir Gerald Acher	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Sir Gerald Acher	03
1040	**7.**	**Patient Story** *To note the patient story*	Professor Sigsworth	04
1050	**8.**	**Chief Executive Officer's Report** *To note the report*	Professor Orchard	05
For decision / approval				
1100	**9.**	**Developing our organisational strategy (including the outputs of our leading change through vision, values and behaviours programme)** *To formally approve Better health, for life: our vision and strategy for 2019-2029 (incorporating 2019/20 objectives and priorities; appendix A – strengths, weaknesses and strategic challenges); and Organisational behaviour framework.* *To discuss and endorse next steps to widen engagement to develop our three and ten year objectives and strategic implementation plans, including a programme of activities to achieve the behaviours set out in our organisational behaviour framework.*	Michelle Dixon / Dr Bob Klaber	06
1120	**10.**	**CNST – Avoiding Term Admissions Into Neonatal units (ATAIN) Action Plan** *To approve the action plan as required by CNST – year two compliance*	Professor Teoh	07
For discussion				
1125	**11.**	**Bi-monthly Integrated Quality and Performance Report** *To receive the bi-monthly integrated quality and performance report for month 10*	Professor Redhead	08
1135	**12.**	**Finance Report** *To note and discuss the month 11 position, year to date and other financial matters*	Richard Alexander	09

1145	**13.**	**Corporate Risk Register and Risk Management Update** *To note the changes to the corporate risk register and approve the revised risk appetite statement*	Professor Sigsworth	10
1155	**14.**	**CQC Update** *To discuss and note the update on CQC related activity at and/or impacting the Trust*	Professor Sigsworth	11
1210	**15.**	**Learning from Deaths Quarterly Report** *To note progress since the last report to the Board and the learning from deaths dashboard. To note key points regarding progress made with implementation of the framework*	Professor Redhead	12
1220	**16.**	**Infection Prevention and Control Quarterly Report** *To note the progress report*	Eimear Brannigan	13
1230	**17.**	**Quality Account Priorities for Next Year (for endorsement)** *To endorse the proposed priorities for 2019/20*	Professor Redhead	14
1240	**18.**	**Freedom to Speak Up Strategy (for endorsement)** *To endorse the strategy*	Sue Grange	15
1250	**19.** 19.1.	**Updated Workforce Equality & Diversity Work Programme 2019 (for approval)** *To approve the updated programme* **Gender Pay Gap (for approval)** *To approve the submission*	Sue Grange Sue Grange	16a 16b
For noting				
1300	**20.**	**National Staff Survey Results 2018** *To note the results and actions*	Sue Grange	17
	21.	**Flu Campaign 2018/19 – Review and way forward** *To note the report*	Sue Grange	18
	22.	**EU Exit – Update on operational readiness in the event of "no deal"** *To note the planning and preparation and support a response to a no deal EU Exit should it be required*	Claire Hook	19
	23.	**Trust Board Declarations of Interest Annual Report** *To note the report*	Peter Jenkinson	20
	24.	**Trust Board Effectiveness Review** *To note the approach to the self-assessment*	Peter Jenkinson	21
1310	**25.**	**Trust Board Committee Summary Reports** *To note the summary reports from the Trust Board Committees*		
	25.1.	Audit, Risk & Governance Committee, 6th March 2019	Sir Gerald Acher	22a
	25.2.	Remuneration and Appointments Committee, 13th March 2019	Peter Goldsbrough	22b
	25.3.	Redevelopment Committee, 27th February and 20th March 2019	Victoria Russell	22c
	25.4.	Quality Committee, 13th March 2019	Professor Bush	22d
	25.5.	Finance and Investment Committee, 20th March 2019	Dr Andreas Raffel	22e
1315	**26.**	**Any other business**	Sir Gerald Acher	Oral
1320	**27.**	**Questions from the public**	Sir Gerald Acher	
Close	**28.**	**Date of next meeting** 22nd May 2019, 11am, Clarence Wing Boardroom, St Mary's Hospital		

Updated: 21 March 2019

Imperial College Healthcare NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING

Wednesday 30 January 2019
11.00 – 13.30
New Boardroom, Charing Cross Hospital

Present:	
Sir Gerry Acher	Interim Chairman
Dr Andy Bush	Non-executive director (from item 9)
Victoria Russell	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Prof Tim Orchard	Chief executive officer
Prof Julian Redhead	Medical director
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Dr Frances Bowen	Divisional director, MIC
Dr TG Teoh	Divisional director of operations, WCCS
Dr Katie Urch	Divisional director of operations, SCCS
Jeremy Butler	Interim Director of Transformation
Kevin Croft	Director of people and organisational development
Michelle Dixon	Director of communications
Joanne Hackett	NExT Director
Claire Hook	Director of operational performance
Kevin Jarrold	Chief information officer
Peter Jenkinson	Director of corporate governance & Trust secretary (minutes)

1.	**Chairman's opening remarks, apologies and declarations of interests** Sir Gerry welcomed board members, attendees and members of public to the meeting. He welcomed Claire Hook to her first meeting as Director of operational performance.
2.	**Apologies** Apologies were noted from Nick Ross and Prof Weber.
3.	**Declarations of interest** There were no declarations made at the meeting.
4.	**Minutes of the meetings held on 28 November 2018** The minutes of the previous meeting, held on 28 November, 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 28 November 2018.
6. 6.1	**Action log and matters arising** The Board reviewed the action log, including an update on actions arising from previous

	meetings.
6.2	The Board noted that an update on the Trust's risk appetite would be presented to the next Board meeting in March. The Board also noted the positive assurance provided by the internal auditors regarding the trust's application of risk appetite. The Trust board noted the action log.
7.	**Patient story**
7.1	The Board welcomed Linda, a patient and member of staff, to the meeting. Linda shared her experiences as a patient and her use of the Care Information Exchange to help manage her care. The Board considered the use of technology to empower patients and to enable them to manage their care. In Linda's case it was noted that access to the Care Information Exchange had allowed her to avoid a 48 hour stay in hospital.
7.2	The Board noted that to date 26,000 patients had signed up for the Care Information Exchange, one of the largest systems in the UK. Kevin Jarrold updated on the process implemented enabling patients to self-register that had led to an increased sign-up of around 500 patients per week. The Board noted that the project start-up had been possible through charity funding and a procurement exercise was currently ongoing for a future system provider; the north west London STP was involved in the system, including six trusts and GPs, and other London STPs had been approached regarding them also joining.
7.3	The Board agreed that the system would be demonstrated to the Board at a future Board seminar. **Action: Kevin Jarrold**
7.4	The Board thanked Linda for her story and welcomed the development of the patient portal that provides benefits to patients and clinicians through the sharing of clinical information, noting the potential to extend this to a national system. The Board also noted the potential to support virtual outpatient appointments. The Board noted that the system was being publicised and clinicians were promoting it to patients. 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, noting risks to performance from winter pressures but reporting that the Trust was expecting to achieve the control total by year-end. He reported that CIP planning was underway for 2019/20, with transformation resource in support and SRP data being used to identify opportunities.
	Operational performance
8.3	Prof Orchard reported that seven never events had been declared for 2018/19. This would be considered as a separate item at this meeting.
8.4	The Trust had almost completed its flu campaign for 2018/19 and had achieved a similar level of take-up as the previous year. A review would be completed to consider additional actions that might be taken for the next winter to achieve increased take-up of the vaccination.

8.5	The Board noted a summary of other operational performance, including performance against the A&E waiting time standard.
	NHS Long term plan
8.6	Prof Orchard summarised the key points included in the long term plan, published for consultation, including collaboration across providers and addressing health inequalities. The long term plan would be a key input into the revised organisational strategy along with the output from the *Leading change through vision, values and culture* staff engagement programme.
8.7	The findings and actions arising from the *Leading change through vision, values and culture* programme and the development of the Trust's strategy and priorities for 2019/20 would be the focus of the next Leadership Forum.
	Redevelopment
8.8	Prof Orchard provided an update on the Trust's development of a joint response, working with Imperial College and Chelsea & Westminster Foundation Trust, to Royal Brompton's proposal to move services to South London. The Board also noted the award of £1.8m in funding for the development of the hybrid theatre.
	Leadership and workforce
8.9	Prof Orchard reported the appointment of Dr Bowen as Divisional director of medicine and integrated care division, and the appointment of Claire Hook as Director of operational performance.
8.10	Prof Orchard highlighted the success of Project SEARCH in supporting young people with learning disabilities to obtain permanent employment, with ten of the twelve delegates on the last programme attaining permanent employment. The Chairman stressed the need to follow through on the support over the longer-term to ensure the delegates remain supported. It was agreed that the delegates would be invited to present to the Board at a future meeting. **Action: Kevin Croft**
8.11	The Board discussed the launch of the Streams App that allowed clinicians to access test results remotely, noting that the initiative was the result of a collaborative agreement with DeepMind to develop the technology to share data; there was no financial benefit to DeepMind. The Board also noted that the Trust retained the role of data controller and that DeepMind would not hold any patient data.
8.12	Mr Raffel asked for reason for the delay in the start of the non-emergency patient transport contract. The Board noted that the delay was due to additional steps being added in the procurement process to ensure a robust tendering process and to address challenges to the process, and then to select the most appropriate time in the year for the transfer of contractors. The Board noted the risks in handover of the contract to new providers and the need to maintain the existing service until handover, noting actions being taken to minimise this risk.
8.13	The Board discussed the risk assessment completed regarding the impact of a 'no-deal' Brexit, and in particular the impact on staff recruitment and retention. Claire Hook advised that the risk regarding staff retention was not significantly greater than the current risk and there was currently no indication of increased turnover of EU staff. The Board noted the actions being taken to support EU staff and also the ongoing recruitment of staff from outside the EU. The Trust board noted the report.

9.	**Integrated Quality and Performance Report**
9.1	The Board received the Integrated quality and performance report for month 10, noting exceptions as presented:
9.2	Effective *Mortality* – the Board noted that the Trust's HSMR rate in August 2018 was the fifth lowest of all acute providers, and the lowest for acute non-specialist trusts nationally. That rate had increased recently and the Trust had therefore commissioned a review of mortality data, including CRAB, to ensure there were no underlying issues.
9.3	Safe *Incident reporting* – the Board noted that the incident reporting rate was above highest quartile nationally but with a low harm profile, suggesting a positive culture of openness and willingness to learn from adverse incidents. *Never events* – the Board noted that seven never events had been reported year to date. This was subject of a separate paper to be presented at this meeting. *Infection prevention and control* – the Board noted there had been no incidence of *Clostridium Difficile* or CPE over the past period. The Board noted the exception in performance against the *E.Coli* trajectory. VTE assessment – the Board noted the achievement of the 95% target.
9.4	Caring *PALS / complaints* – the Board noted that more patient concerns were being resolved informally by PALS. *Friends and Family Test (FFT)* – the Board noted a summary of actions taken in the A&E department at St. Mary's Hospital to improve the rate of return of FFT questionnaires, and noted that proposals for further actions would be presented to the next Executive (Quality) Committee. *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. **Action: Janice Sigsworth (March 2019)**
9.5	Responsive *RTT* – the Board noted the current performance against the 52 week and 18 week waiting time standard, noting progress being made towards ensuring that no patients were waiting more than 52 weeks. *Diagnostic waiting times* – the Board noted that the Trust was now meeting the target. *ED performance* – the Board noted a year on year improvement in achieving the waiting time target. The Board noted the issue reporting regarding care for mental health patients, noting that the Trust held regular meetings with mental health providers to ensure appropriate support for mental health patients, including more suitable environment and responsiveness. It was noted that this was an issue London-wide.
9.6	Well-led *Recruitment and retention* – the Board noted the current vacancy rate and progress in recruitment. The Board noted that the nurse apprenticeship scheme had not worked out as well as planned and was being reviewed with a view to improving take up. *Equality & diversity* – the Board noted the actions being taken to support diverse staff groups, such as the establishment of a BAME nurses group. The Trust board noted the report.

10.	**Finance report**
10.1	The Board received and noted the finance report for month 10, noting performance against budget and the control total. The Board noted and discussed the risks in achieving the control total at year-end, including commissioner challenges and the financial impact of winter pressures. The Board acknowledged the positive actions taken in responding to the financial performance earlier in the year that had had a positive impact on current performance, but also recognised the challenges remaining to achieve the year-end control total. The Trust board noted the report.
11.	**CQC update**
11.1	Prof Sigsworth presented an update on CQC-related issues, including an update on planned assessments. The Board noted that core service reviews would be taking place between 26 and 28 February, and noted ongoing preparations including the introduction of weekly peer reviews, a look back exercise to review progress on actions arising from previous inspections and a focus on the 'big four' workstreams including medicines management, medical devices, hand hygiene, statutory and mandatory training.
11.2	The Board also noted that the trust-wide well-led assessment would take place between 2 and 4 April.
11.3	Mr Goldsbrough asked about the level of awareness of CQC among staff. The Board noted increased awareness amongst staff and action being taken to increase this awareness further, particular amongst junior ward staff and junior doctors.
11.4	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. **Action: Kevin Croft / Janice Sigsworth**
11.5	The Board noted that the WRES data showed that BAME staff were being shortlisted for posts but were not being appointed; it was important to understand and address the reasons for this.
11.6	The Board welcomed the approach to preparing for the CQC assessments and agreed the importance of these initiatives being part of 'business as usual' practice and behaviours.
11.7	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. **Action: Tim Orchard / Peter Jenkinson** The Trust board noted the report.
12.	**Never events**
12.1	Prof Redhead presented a summary of two never events declared in the last period since the last meeting highlighting the declaration of seven never events year to date, six of which related to interventional procedures. Prof Redhead summarised the actions being taken in response to each event and to prevent further occurrences. The key actions

	included additional education and coaching through simulation training, supported by engagement with clinical teams and strengthening leadership of patient safety. These actions would be validated through an external review commissioned by the Trust.
12.2	The Board welcomed the action being taken and noted the importance of the *Leading change through vision, values and culture* programme to embed the behaviours required to support patient safety. The Board noted that the Trust's overall track record in patient safety was good, including the Trust's low mortality rates. It also noted that no long term harm had come to the patients involved in these incidents; however the Board also agreed the importance of taking the recent increase in never events seriously and in responding to the issues arising from them. The Trust board noted the report and agreed the action being taken.
13.	**Learning from deaths**
13.1	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. Prof Redhead advised that this was one element of the Trust's approach to continual quality improvement. The Board noted that 37 staff had been trained in the SJR methodology and 338 SJRs had been completed since September 2017. The Board also noted the requirement from April 2019 for the Trust to appoint a forensic examiner to support the learning from deaths.
13.2	The Board considered the value derived from this statutory process and agreed that it was important to learn from any adverse incident, and that this process was useful in triangulation with other feedback mechanisms such as complaints and adverse incident investigations. The Trust board noted the report.
14.	**Corporate risk report and Board assurance framework**
14.1	The Board received and noted the paper summarising the corporate risk report and a summary of the review of the corporate risk register by the Executive (Finance) Committee and the Audit, Risk and Governance Committee.
14.2	The Board noted the positive assurance provided from an internal audit review of risk management, noting the need to continue to embed risk management within the divisional processes. Prof Orchard added that the executive would ensure clear and consistent presentation of risks across all meetings, including the original and target ratings and the acceptance of risks, if appropriate, in the context of the agreed appetite.
14.3	The Board noted the responsibility of the Executive (Finance) Committee as the executive risk committee in order to ensure an executive focus on risk management, including oversight of divisional risk management.
14.4	The Board considered new and amended risks as summarised, including the risk assessment completed into the impact of a no-deal Brexit. It was noted that this risk assessment would be considered by the Executive (Finance) Committee with a view to adding the risk to the corporate risk register. The Board noted recent media coverage of the response by UCLH, but agreed that the Trust was following appropriate process to consider its response to the risk.
14.5	The Board considered the latest version of the Board assurance framework and the summary of assurances received during the period since the last meeting. The Board also noted the process agreed by the Audit, Risk and Governance Committee to revise the

	format of the framework. The Trust board noted the report.
15. 15.1 15.2	**Emergency preparedness, resilience and response (EPRR) report** The Board received and noted the paper reporting progress in the development of the Trust's emergency preparedness, resilience and response (EPRR) planning and positive assurance provided by NHS England's annual review of the Trust's level of compliance against the revised core EPRR standards. The Board noted that the level of compliance had improved to full compliance and noted a summary of recommendations to be addressed in the next year. The Board noted that executive responsibility for business continuity had passed to Claire Hook, Director of operational performance. The Board welcomed the external assurance and noted the Trust's response to the recent lift failure as an example of the Trust's emergency planning processes being effective in ensuring business continuity. The Trust board noted the report.
16. 16.1 16.2 16.3	**Research and development report** The Board received and noted the quarterly update report, highlighting the appointment of divisional research leads to oversee and support an increase in trials and the number of patients being recruited to trials, the assurance provided from the latest BRC report and recommendations, and recent examples of translating research into clinical practice. The Board welcomed the assurance provided from the BRC report, noting the importance of the BRC to ensure alignment between the Trust and Imperial College's research approach; it also noted that with strong research base and as a digital exemplar, the Trust was in a strong position to take a lead in research. The Board discussed the opportunities arising in research and noted that the Trust was in a position to take advantage of opportunities due to the breadth of clinical services. For example it was noted that Novartis was looking to partner with the Trust in a research unit being established in White City. Dr Bush also highlighted the establishment of a paediatric trials unit. The Board also discussed the opportunities for non-medical research, noting that there were approximately nine non-medical professors in the Trust driving forward non-medical trials. The Trust board noted the report.
17. 17.1	**Cost Improvement Plans (CIPs) – Quality impact assessment** The Board received and noted the six monthly report, providing assurance to the Board regarding the quality impact assessment process for CIPs. The Trust board noted the report.
18. 18.1	**Board sub-committees – terms of reference** The Board received and considered the terms of reference for each of the Board's sub-committees, noting that each set had been agreed by the respective committee as part of an annual review cycle. The Trust board noted the report and approved the terms of reference for the Board's sub-committees.
19. 19.1	**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 5 December 2018 • Remuneration and Appointments Committee meeting held on 7 December 2018 • Redevelopment committee meeting held on 12 December 2018 • Quality Committee meeting held 16 January 2019 • Finance & investment committee held on 23 January 2019 The Trust Board noted the reports.
20. 20.1	**Any other business** No other business was discussed.
21. 21.1	**Date of next meeting** Public Trust board: Wednesday 27 March 2019 11.00 – 13.00, Clarence Wing Boardroom, St. Mary's Hospital.
22. 22.1 22.2 22.3 22.4 22.5 22.6 22.7	**Questions from the public** The Chairman invited questions from the members of public present. A member of the public asked whether the Trust had made any progress since the discussion at the previous meeting in relation to cleanliness, including toilets. Prof Sigsworth gave a summary of actions being taken to improve cleanliness, including increasing the frequency of cleaning and checking public areas such as toilets. The Trust was also in the process of changing the contractor responsible for cleaning and ensure that standards set out in the contract were being delivered. A member of the public asked whether the Board had considered the implications of the CCG's financial position and their financial recovery plans. Mr Alexander agreed that the financial challenges facing the CCGs were of concern to the Trust; however this was seen as a sector-wide issues and there was increased collaboration across the sector and between organisations to manage the risks and to maximise efficiency. A member of the public asked for an update on Pembridge Hospice not admitting patients due to the lack of medical consultant cover. Prof Orchard advised that there was no update to provide but he understood the impact on the Trust and patients; he would therefore reiterate the importance of recruitment with the CLCH management. A member of the public asked for an update on the discussions with NHS England regarding the Royal Brompton Hospital. Prof Orchard reported that the Trust and partners had held constructive discussions with NHS England and ideas continued to be developed. The aim of those discussions was to develop a solution that delivered the best care and outcomes for patients in north west London. A member of the public asked for an update on the investigation into a news story regarding treatment being withheld from an overseas patient, as discussed at the previous meeting. Prof Orchard provided an update on the findings of the investigation, namely the learning regarding clarity of communication between the Trust and GPs, and clarity for staff on the rules and exemptions applicable to overseas patients. 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 campaigns already underway. It was agreed that Prof Orchard would meet Ms Craven to discuss further. **Action: Tim Orchard**

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Record of items discussed at the confidential Trust board meetings held on 30th January and 27th February 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 30th January 2019	**Item 05, report no. 02**
Responsible Non-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.

January 2019

The Board received a report from the Chief Executive, including an update on discussions with NHS England and NHS Improvement regarding *Healthier hearts and lungs* – the joint response to proposals submitted to NHS England for the move of the Royal Brompton Hospital to join King's Health Partners – plus feedback from meetings with NHS Improvement regarding the NHS Long Term plan and impact on the Trust's organisational strategy, and an update on Trust redevelopment plans.

The Board received and noted an update on the strategy development programme, including an update on the Leading change through vision, values and culture programme and a summary of how the output of this programme would form a key input into the refresh of the Trust's organisational strategy and the 2019/20 priorities and objectives, along with other inputs such as the NHS long term plan, the findings from the last staff survey and the outputs from the weekly 'Big Room' strategy development sessions. This is a substantive agenda item on this meeting's agenda.

February 2019

The Board also met in seminar mode in February 2019 and focused the session on board development, using the key lines of enquiry from the CQC well led framework to assess the strengths and weaknesses of our leadership arrangements and agree next steps in the organisation's development.

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 30 January 2019

Updated: 21 March 2019

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: Main agenda item	Janice Sigsworth	January 2019
2.	26 Sept 2018 16.1	Freedom to speak up – self assessment	Prof Orchard advised that the Guardians were committed to their roles, but that they needed support in terms of resources and time allocated. It was agreed that this review should also include benchmarking against arrangements employed by other trusts. It was agreed that the output of the review and recommendations would be shared with the Board in December. January 2019 update: Deferred to March 2019 March 2019 update: Main agenda item	Kevin Croft	March 2019
3.	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 campaigns already underway. It was agreed that Prof Orchard would meet Ms Craven to discuss further. March 2018 update: Meeting took place on 25th February 2019	Tim Orchard	March 2019

4.	30 Jan 2019 11.4	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: Main agenda item	Kevin Croft	March 2019
5.	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.	Janice Sigsworth	May 2019
6.	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.	Janice Sigsworth	May 2019
7.	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.	Tim Orchard, Peter Jenkinson	May 2019
8.	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	Dr TG Teoh	May 2019

Items closed at the January 2019 meeting

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	30 Jan 2019 7.3	Care Information Exchange	The Board agreed that the system would be demonstrated to the Board at a future Board seminar.	Kevin Jarrold	Added to Board Seminar forward planner
2.	30 Jan 2019 8.10	Project search arising from CEO report	Prof Orchard highlighted the success of Project SEARCH in supporting young people with learning disabilities to obtain permanent employment, with ten of the twelve delegates on the last programme attaining permanent employment. The Chairman stressed the need to follow through on the support over the longer-term to ensure the delegates remain supported. It was agreed that the delegates would be invited to present to the Board at a future meeting.	Kevin Croft	Added to Board Seminar forward planner
3.	30 Jan 2019 9.4	Friends and Family Test (FFT)	The Board noted a summary of actions taken in the A&E department at St. Mary's Hospital to improve the rate of return of FFT questionnaires, and noted that proposals for further actions would be presented to the next Executive (Quality) Committee.	Janice Sigsworth	Added to ExQu forward planner

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: 27 March 2019	**Item 07, report no. 04**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Author:** Stephanie Harrison-White

Summary:
This month's patient story is about a patient's experience of being cancelled at late notice twice (on the day) for a cardiac ablation procedure.

Dianne will describe how she used this experience to work with the SCCS division to develop patient information about short notice cancellations that she would have found helpful at the time.

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

This report has been discussed at:
None

Quality impact:
The ability to improve patient experience through good communication.

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?
☒ Not applicable

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

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

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement):
Is there a reason the key details of this paper cannot be shared more widely with senior managers?
☐ 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 Patient Information leaflet 'When your procedure is cancelled on the day or at short notice' is being launched as part of the pre-assessment pathway. This leaflets provides patients with relevant information about why cancellations are sometimes made at such short notice and advise on what they can do.
- What (if anything) do you want senior managers to do?
  Make staff aware of the leaflet.
- Contact details or email address of lead and/or web links for further Joanna.fisher1@nhs.net
- Should senior managers share this information with their own teams? ☒ Yes ☐ No
  If yes, why? To encourage use of the leaflet and understanding of the process

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

This month's patient story will be presented in person by Dianne. Dianne was diagnosed with atrial fibrillation in June 2017. Atrial fibrillation is a heart condition which causes the heart to have an irregular beat and to beat faster. Dianne required a cardiac ablation procedure to treat this condition.

Dianne was initially given a date in March 2018. On the morning of the procedure, Dianne's procedure was cancelled due to the extreme bed pressures (trust was on black alert at the time). A second appointment was arranged for early April (6th). Dianne's procedure was again cancelled on the day, this time staffing issues and an outbreak of diarrhoea were cited as the reasons for the cancellation.

Dianne will describe the impact of these cancellations on her and how she worked with the Trust using her experience to help develop our services and specifically patient information on short notice cancellations.

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

According to NHS England, last minute cancellations of operations and procedures are defined as those that occur on the day the patient was due to arrive, after they have arrived or on the day of their operation. The causes are multi-factorial including non-clinical issues such as a lack of ward beds; surgeon unavailable; critical care bed unavailable.

Whilst we may be able to quantify the number of last minute cancellations, the impact is more difficult to measure in terms of patient experience. Dianne will describe how she felt being cancelled at such short notice on two occasions and how she decided to use her experience to help other patients.

Imperial College Healthcare NHS Trust

4. Dianne's story

In June 2017, Dianne was diagnosed with atrial fibrillation. This is when the heart has an irregular rhythm and beats faster than normal. Dianne will describe some of the impact this had on her life and how much she was looking forward to having this treated via a cardiac ablation procedure to move forward with her life and work plans. Cardiac ablation is a procedure to scar or destroy tissue in your heart that's allowing incorrect electrical signals to cause an abnormal heart rhythm.

Dianne's first appointment was on March 6th 2018. This appointment was cancelled on the day due to extreme capacity issues (the Trust was on black alert at the time). A second date was arranged for April 6th.

Dianne was again cancelled on the day of the procedure. The reasons given on this occasion were an outbreak of diarrhoea on the ward she was planned to go to and a shortage of night staff. She'd been pre-identified as needing an overnight stay.

On both occasions, Dianne was in hospital, gowned and ready for theatre. Dianne underwent the procedure on her third visit on April 25th.

Dianne initially fed back to PALS after her first cancellation and then wrote to the chief executive's offices following the second cancellation. The head of patient experience met with Dianne alongside the deputy divisional nurse for SCCS division, Jo Fisher.

Through this initial conversation, Dianne expressed an interest in working with the Trust to see how we could learn from her experience to improve our service and processes.

When asked what could we have done differently, Dianne thought having a leaflet to explain why short notice cancellation happens and the next steps for the patient would have been helpful. She kindly agreed to work with the division to develop this.

5. Conclusion and Next Steps

Working in collaboration is a key Trust value. Dianne has worked in partnership with the division and continues to do so. She has helped to co-design a patient information leaflet titled 'When your procedure is cancelled on the day or at short notice***'.***

Dianne is now part of the Pre-Operative Assessment Steering Group as an involved patient. She has shared her experience at the Strategic Lay Forum and is now working with the division to introduce this leaflet into practice.

Dianne and the division would appreciate the Board's support in promoting this leaflet across the organisation and also helping to reduce procedures cancelled for non-clinical reasons.

Author: Steph Harrison-White Date; March 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: 27 March 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) Leadership and workforce
7) Stakeholder engagement
8) Risk management
9) 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 objectives supported by this paper:
- To achieve excellent patients experience and outcomes, delivered with care and compassion.

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

Chief Executive's Report to Trust Board

1. Financial performance

Year to date (i.e. from April 2018 to February 2019) before Provider Sustainability Funding (PSF) the Trust was on plan with a £24.6m deficit. The Trust receives PSF based on meeting financial plans and the 4 hour A&E trajectory across the delivery board area, this is measured quarterly. The Trust has achieved £22m by meeting both targets in the first 3 quarters of the financial year and there is an additional £12m available for achievement in the last quarter.
Year to Date the Trust is over plan on NHS clinical income, especially on non-electives. The Trust has incurred additional costs to deliver this activity in year and the over performance has put pressure on the Trust's ability to achieve cost reduction savings. These factors have caused over spends against the plan in both pay and non-pay.
The Trust agreed a control total deficit of £20.6m before PSF for this financial year and is forecasting to meet its plan.

The Trust's capital position is £3.3m underspent against the capital resource limit (CRL) of £47.9m year to date. The programme is actively managed by the Trust's Capital Expenditure Assurance Group (CEAG) and Capital Steering Group (CSG). The Trust's total capital plan is £54.8m for the year and the Trust is forecasting to meet this spend.

The Trust has been set a £16.1m deficit as the control total for the next financial year. This will require a similar level of cost improvement plans to this financial year. 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 there is currently £47m of identified programmes at Trust level.

Against the Month 11 year to date plan of £40.6m, there has been £34.1m (84%) of CIP delivery resulting in a £6.5m adverse variance. The current forecast CIP delivery for the year is £44.1m, a £3.4m improvement from December. The Programme Support Office continues to work with clinical and corporate teams to support delivery of current programmes; further progress opportunities already identified; as well as identify additional efficiencies, drawing on both internal and external expertise and resources.

3. Business planning

The final version of the 2019/20 business plan is due to be submitted to NHS Improvement on 4th April. The Trust's control total for 2019/20 has been set by NHS Improvement as £16m deficit before PSF and MRET funding. At the time of writing there is a £23m planning gap to achieve the control total.

4. Transformation programme update

The immediate focus for the transformation programme is on progressing the 'Specialty Review Programme', converting the review recommendations into agreed plans. Sessions with the clinical teams began in February, and are being held in conjunction with the Deputy CFO. Two members of the new transformation team have been recruited and are due in post in March and April. Separately,

improvement projects are being scoped, including looking at operational issues impacting the Patient Services Centre. The Director of Transformation is also assisting the CFO with CIPs planning for the next financial year.

5. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance as at January 2019 (month 10).

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 have now been reported in this financial year. As reported at the last Board meeting, a trustwide action plan was 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.

- **Flu vaccination campaign** – The 2018/19 flu campaign has almost concluded, with 60% of staff having been confirmed as receiving the vaccination, against a total of 60% achieved last year. Lessons learnt from that campaign and details as to how they will be incorporated into the arrangements for future flu campaigns to ensure continual improvement towards attaining the current NHSE target of 75%, is included in a paper being presented to the Board.

- **Accident & Emergency** – Performance against A&E four-hour access target continues to improve. While the January 2019 performance, at 86.7% was below the improvement target of 90.4%, the performance was 1.6 percentage points higher than performance in January 2018 and type 1 performance was 4.9 percentage points higher. This is against increased numbers of A&E attendances (up by 674 to 25,363 in January 2019). During January 2019 there were 23 black alerts and 18 red alerts across St Mary's and Charing Cross. The number of twelve hour breaches of wait from decision to admit was 10 for January. All breaches were delays to admission for mental health provider beds (1x CAMHs, 2 out of area, remainder CNWL).

  We have continued to improve through February, achieving 88.1%. This was 5.7 percentage points higher than February 2018, although it fell below the improvement target of 90.5%. Type 1 performance was 13.5 percentage points higher in February 2019 (72.6%) than February 2018.

- **Referral to treatment** – The Trust reported that 44 patients had been waiting over 52-weeks as of Month 10. All but nine of these long waits were due to the Ophthalmology email account incident, reported to the Board at its last meeting, which is under investigation. There is continued focus on planning and treating the Ophthalmology patients identified to be waiting > 52 weeks. The Trust is currently forecasting 10 patients waiting over 52 weeks at the end of March and zero for April.

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

6. Strategic development

We have completed the first phase of the development of a refreshed organisational strategy as well as of our leading change through vision, values and behaviours programme. A large amount of feedback from staff and some partners on vision, values and behaviours has fed into the strategy documents presented later in the agenda for approval as well as into a new behaviour framework. The framework is also presented later in the agenda and is due to be launched next month alongside changes to our staff appraisal approach which mean that half of each staff member's personal

development review will be based on how well they have lived our values in practice, while the other half will continue to focus on achievement against objectives. The strategy documents set out how we plan to approach and oversee implementation.

7. Stakeholder engagement

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

Strategic Lay Forum: 14 February
The Trust's strategic lay forum met on Thursday 14 February for the latest of its bi-monthly meetings.

London Borough of Brent Community and Wellbeing Scrutiny Committee: 30 January
On Wednesday 30 January, Dr Frances Bowen, divisional director of medicine and integrated care, and Claire Hook, director of operational performance, attended Brent Council's Community and Wellbeing Scrutiny Committee to discuss the issue of winter pressures on the NHS and adult social care in the borough. The committee meeting was also attended by representatives of NHS Brent Clinical Commissioning Group and London North West University Healthcare NHS Trust.

Meeting with Save our Hospitals Group: 31 January
On Thursday 31 January, I met with Merril Hammer and Jim Grealy from the Save our Hospitals group. The main items for discussion were: the joint proposal on 'Healthier hearts and lungs'; NHS finances in north west London; cleanliness at Charing Cross Hospital; mental health services in emergency departments; and overseas visitors eligibility.

Westminster City Council Family and People Services Policy and Scrutiny Committee: 4 February
On 18 January, I wrote to Councillor Jonathan Glanz, Chair of Westminster City Council's Family and People Services Policy and Scrutiny Committee, outlining the service change proposal relating to specialist oesophago-gastric (OG) cancer surgery. At its meeting on Monday 4 February, the Committee formally noted the proposal to co-locate OG cancer surgery and Hepatobiliary (HPB) surgery in a new specialist surgical unit at Hammersmith Hospital which will protect our excellent cancer outcomes and improve the experience of our patients.

Meeting with Healthwatch Central West London: 18 February
On Monday 18 February, I met with Christine Vigars (Chair) and Olivia Clymer (Chief Executive Officer) from Healthwatch Central West London. The main items for discussion were: the joint 'healthier hearts ad lungs' proposal; NHS north west London Long Term Plan; urgent care centres at Hammersmith and St Mary's hospitals; strategic lay forum; and, forthcoming CQC inspections.

Meeting with local MPs: 5 March
On Tuesday 5 March, I met with our local MPs Karen Buck, Rt Hon Mark Field and Andy Slaughter. The main items for discussion were: new Trust Chair announcement; operational and financial performance; joint 'Healthier hearts and lungs' proposal; CQC inspections; site redevelopment; North West London long term plan; proposal for night-time closure of Hammersmith Hospital urgent care centre; and Sodexo staff salaries.

Letter to Hammersmith & Fulham Council regarding proposed changes to physiotherapy services: 5 March
On 5 March, I wrote to Councillor Lucy Richardson, Chair of the Health, Inclusion and Social Care Policy and Accountability Committee for the London Borough of Hammersmith & Fulham. My letter outlined our plan to seek the views of patients, carers, local residents and other stakeholders on a proposal to close the hydrotherapy pool at Charing Cross Hospital and replace the service it provides with land-based therapies. We have developed the proposal following a safety and effectiveness review prompted by the increasing challenge of maintaining and running the pool combined with evidence that land-based therapies produce very similar benefits to aquatic therapies. By closing the pool, our therapy staff would be able to provide more land-based therapy, increasing capacity and reducing waiting times across our wider therapy service for all patients. We would also be able to use the hydrotherapy pool space to provide expansion for other clinical services.

8. Celebrating achievements

Stem cell therapy
A patient at Hammersmith Hospital has achieved a sustained remission from HIV-1 after ceasing antiretroviral treatment – becoming only the second person globally to do so. The patient was treated with a stem cell transplant at Hammersmith Hospital. Following the transplant in 2016, antiretroviral therapy was discontinued and the patient has now remained in remission for 18 months. The case is similar to the 'Berlin Patient' of eleven years ago, though the treatment strategy was not identical.

The treatment was offered as part of a collaboration by the stem cell transplant team at Imperial College Healthcare/Imperial College, led by Professor Eduardo Olavarria and Dr Ian Gabriel and HIV scientists at University College London, led by Professor Ravindra Gupta.

Nurses in research
Two senior nurses from the Trust have been offered places on the National Institute for Health Research's 70@70 Research Leader Programme, starting in April 2019. Dr Enrique Castro-Sanchez (honorary consultant nurse in communication and patient engagement) and Dr Anne-Marie Russell (honorary nurse consultant in interstitial lung disease) were both successful in the highly competitive scheme set up to strengthen nursing and midwifery research leadership across England.

70 nurses and midwives have been selected to participate in the 70@70 programme, which aims to improve the visibility of nursing and midwifery in all NIHR activities, to raise the profile of the NIHR and to improve and secure the development of the academic pathway for nurses and midwives.
Each senior nurse or midwife research leader will be funded part-time to promote and support an integrated research culture in their organisation, and to form a national community which will better link the research assets across England.

Wayfinding
Our wayfinding pilot at St Mary's – covering the first four floors of the Queen Elizabeth the Queen Mother building, maps across our estate and the route from the QEQM to main outpatients – has got underway. The new signage system – plus decluttering and redecoration - is near fully installed and will be evaluated over the next few months by Imperial College Patient Experience Research Unit. We have also been able to make a number of urgent, interim improvements to wayfinding across the rest of St Mary's and at our other hospitals to allow us time to decide on next steps for the new system. Our roll out of AccessAble – detailed, online route guides to help patients with disabilities to access our hospitals – will begin in May.

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

At 11 March 2019

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Finances	1.1	Return to underlying surplus with year on year improvements in the underlying position	Start of 2021/22	In progress	We have agreed a framework for identifying the required savings focusing on: • Business as usual CIPs • Income and productivity opportunities • Private patients and commercial • Specialty review opportunities • Other (incl. transformation) We expect to move from our current deficit to an underlying deficit of £20-£25m by 2021/22, with further improvements thereafter depending on support to address structural issues relating to our estate. We are looking at options for coordinating the work, and the resources and structures necessary to support delivery of the plan. A permanent appointment has been made for the Director of Transformation to lead the delivery of the trust's transformation programme which started at the beginning of September.
	1.2	Develop and submit a financial recovery plan to return to surplus by the start of 2021/22	30 November 2018	Completed	We submitted our plan to our Board for approval at the end of November and to NHSI on 29 November. The agreed 2018/19 plan will form the first year of the recovery plan. Acknowledged by NHSI on 20th December that the submission meets the Undertakings Obligations.
	1.3	Take reasonable steps to deliver the Financial Recovery Plan, ensuring adequate capacity and capability in place	30 November 2018	In progress	We are putting in place the appropriate governance through our executive and board committee structure. We have also recruited a Director of Transformation and a supporting team to support delivery of the plan, alongside existing resources in the corporate and clinical divisions.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	1.4	Keep Financial Recovery Plan under review and agree necessary amendments with NHS Improvement		In progress	NHSI have reviewed and acknowledged receipt of our 4 year financial recovery plan. This will be updated later in 2019/20 for consistency with the long term planning guidelines accompanying the NHS 10 year plan
Emergency care	2.1	Take reasonable steps in order to achieve sustainable compliance with the 4 hour A&E target		In progress	The care journey and capacity collaborative refreshed strategy is now completed; the full project plan for 2019/20 will be shared at the end of March. Long stay review meetings have been rolled out on key sites and will be supported going forward by newly appointed directors for each site.
	2.2	Maintain A&E target at or above 90% throughout Winter 2018/19	2018/19	In progress	Performance against the 4 hour standard for February 2019 was 88.1%. This was below the local trajectory of 90.5%. February 2019 performance was 5.7% higher than performance in February 2018 and type 1 performance was 13.5% higher.
	2.3	Maintain A&E performance of 95%	31 March 2019	In progress	As above.
RTT	3.1	Ensure no patients are waiting more than 52 weeks on RTT pathways	March 2019	In progress	RTT long waiters (40+ weeks) are managed by Clinical Directorates and Divisions, supported by the Elective Care Delivery Manager. All long-waiting patients are validated and actively tracked on a weekly basis, and monitored through specialty-led PTL meetings. The Trust reported 44 patients waiting >52-week in January 2019 which was an increase of 33 from the previous month. Of the 44 patients waiting over 52 weeks at the end of January, 35 were related to the ophthalmology email account incident. The number of 52WW patients is forecasted to increase in February (to 100) in relation to the ophthalmology incident. The Trust is forecasting to be 0 (with the exception of pop-ons) by the end of April 2019 The performance team meets monthly with the 12 challenged services. Within these services Neurosurgery again achieved over 92% but did not achieve its trajectory. Out of the 12 challenged services none achieved their trajectory, but six have improved on the previous month's performance

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	3.2	Delivers the RTT incomplete performance target in line with the trajectory agreed in the 2018/19 plan through delivery of the agreed action plan	March 2019	In progress	The Trust submitted an updated RTT trajectory for 2018/19 to NHSE on 20th April, in line with national deadlines. This was a revision of the 2nd March draft, based on an 18/19 activity model developed with our CCGs. This activity plan was converted to RTT performance in the context of ongoing system challenges around demand & capacity, data quality and operational responsiveness. The Trust continues to work to reduce and maintain the PTL size. The Trust is planning to maintain the PTL size to c.64,000 patients by the end of March 2019 (M12). An action plan to reduce and maintain the PTL size to the same position as M1 (18/19) has been developed and implemented. In M10 the PTL reduced by 3,191 to 64,600 patients, which is still 1,117 above the agreed PTL size trajectory. The reason for the reduction is the work that is being delivered centrally and in accordance with the PTL size trajectory action plan.
Data Quality	4.1	Amend the RTT action plan to ensure that it addresses the concerns set out in the independent review of clinical and administrative processes within elective pathways and clinical oversight of avoidable harm	31 October 2018	In progress	The MBI data assurance report was published 31 July 2018. Nine high level recommendations were provided which also have 45 sub-recommendations associated with them. A finalised action plan was presented to the Executive Operational Committee in November 2018 and the Trust Board (ARG) in December 2018.
	4.2	Implement the amended RTT action plan	Date to be agreed with NHS Improvement	In progress	As above. The Trust is setting up the governance structure to oversee the recommendations delivery of the actions will be tracked through the RTT improvement steering group.

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

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Developing our organisational strategy (including the outputs of our leading change through vision, values and behaviours programme)	☒ Approval ☐ Endorsement/Decision ☐ Discussion ☐ Information
Date of meeting: 27 March 2019	**Item 09, report no. 06**
Responsible executive director: Prof Tim Orchard, Chief executive	**Authors:** Michelle Dixon, Director of communications Dr Bob Klaber, Deputy medical director

Summary:
As previously discussed at Trust board, we have been undertaking a focused piece of work over the past five months to bring together work and thinking to set a clearer and more cohesive direction for our organisation. This work has drawn on a range of programmes, particularly the development of our organisational vision, values and behaviours.

Our vision statement and values were co-designed with staff and partners in 2015/16. We then focused on roll out and embedding, including through our new quality improvement methodology, appraisals and linking to annual business plans. We achieved consistently high levels of awareness of our vision and values but identified a disconnect with how our values are sometimes lived in practice as well as insufficient alignment between our vision and our plans and priorities across the organisation.

In November 2018, we launched the 'leading change through vision, values and behaviours' programme to find out from staff the barriers they face in living our values and achieving our vision and what we could do – at an individual, team and organisational level – to make it easier. We wanted to establish what we should be able to expect from each other and what our patients should be able to expect from us. The insights developed from this work have fed into the organisational strategy and 2019/20 objectives and, in response to a clear need articulated by many staff, they have also led us to develop a new organisational 'behaviours framework'.

We have now completed the first phase of our strategy development and vision, values and behaviour programme. The outputs, presented here for approval, are:

- Better health, for life: our vision and strategy for 2019-2029
  - incorporating a new mission statement, three new strategic goals (intended to replace our existing strategic objectives) and 2019/20 objectives and priorities
  - appendix A – strengths, weaknesses and strategic challenges

- Organisational behaviours framework.

We have also set out next steps to widen engagement to develop our three and ten year objectives and strategic implementation plans and to achieve the behaviours set out in our organisational behaviours framework.

Recommendations:
To formally approve:
- Better health, for life: our vision and strategy for 2019-2029
  - incorporating 2019/20 objectives and priorities

○ appendix A – strengths, weaknesses and strategic challenges • Organisational behaviours framework To discuss and endorse next steps to widen engagement to develop our three and ten year objectives and strategic implementation plans, including a programme of activities to achieve the behaviours set out in our organisational behaviours framework.
This report has been discussed at: strategy 'big room', executive transformation group
Quality impact: the strategy and values and behaviours programme are intended to have a very significant positive impact over time, which we will seek to measure
Financial impact: no immediate impacts on finance but one of the goals will be to direct more resource to our agreed priorities as we develop them; in year one, we will also need to ensure we are able to resource the continued roll out of the values and behaviours work appropriately
Risk impact and Board Assurance Framework (BAF) reference: Our risk register is one of the factors we have taken in to account in developing our analysis, especially around strengths and weaknesses. The further development of our strategy – and especially the strategic implementation plans – will need to have very clear governance that is integrated with our board assurance framework.
Workforce impact (including training and education implications): the strategy and values and behaviours programme are intended to have a very significant positive impact over time, which we will seek to measure; in year one, there will be requirements for additional and bespoke leadership, management and behaviours training.
What impact will this have on the wider health economy, patients and the public? the strategy and values and behaviours programme are intended to have a very significant positive impact over time, which we will seek to measure; in year one, we plan to widen out engagement to include many more patients, partners and local communities
Has an Equality Impact Assessment been carried out? ☐ Yes ☒ No ☐ Not applicable If yes, are there any further actions required? ☐ Yes ☐ No
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: • To achieve excellent patients experience and outcomes, delivered with care and compassion. • To educate and engage skilled and diverse people committed to continual learning and improvements. • As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care. • To pioneer integrated models of care with our partners to improve the health of the communities we serve. • To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Developing our organisational strategy

1 Introduction

As previously discussed at Trust board, we have been undertaking a focused piece of work over the past five months to bring together work and thinking to set a clearer and more cohesive direction for our organisation.

We wanted to achieve the following objectives:

- Our staff, patients and partners will be able to see a genuine 'golden thread' running through our decisions and plans, linking our overarching vision to work in practice. We will be able to explain our story and vision in a clear and simple way.

- A tangible improvement in the way we coordinate different developments and work programmes across the Trust including:
    - the way we prioritise (as much *how* we do things as *what* we do)
    - the way we join up initiatives once they are started.

- A clear statement of how the Trust plans to respond to, and influence, the key strategic opportunities and challenges in our changing environment. This will have sufficient granularity to influence individual pieces of work or developments.

This work drew on a range of programmes, particularly the development of our organisational vision, values and behaviours.

Our vision statement and values were co-designed with staff and partners in 2015/16. We then focused on roll out and embedding, including through our new quality improvement methodology (also launched in 2016), appraisals and linking to annual business plans. We achieved consistently high levels of awareness of our vision and values but identified a disconnect with how our values are sometimes lived in practice as well as insufficient alignment between our vision and our plans and priorities across the organisation.

In November 2018, we launched the 'leading change through vision, values and behaviours' programme to find out from staff the barriers they face in living our values and achieving our vision and what we could do – at an individual, team and organisational level – to make it easier. We wanted to establish what we should be able to expect from each other and what our patients should be able to expect from us. The insights developed from this work have fed into the organisational strategy and 2019/20 objectives and, in response to a clear need articulated by many staff, they have also led us to develop a new organisational 'behaviours framework'.

We have now completed the first phase of our strategy development and vision, values and behaviour programme. The outputs, presented here for approval, are:

- Better health, for life: our vision and strategy for 2019-2029
    - incorporating a new mission statement, three new strategic goals (intended to replace our existing strategic objectives) and 2019/20 objectives and priorities
    - appendix A – strengths, weaknesses and strategic challenges

- Organisational behaviours framework

2 Developing our strategy

We began work in 2017/18 to develop new, organisational strategic goals and mission to ensure a clearer 'golden thread' between our vision and our decisions and plans. Last autumn, Dr Bob Klaber, deputy medical director, and Michelle Dixon, director of communications, took on the lead for completing this work. We commissioned some dedicated support from Imperial College Health Partners and Ross Gribbin and Piers Milner have been attached to the project since then on a part-time basis. We also established a strategy 'big room' - a weekly session open to any staff involved – or just interested – in strategy development to input to and test specific aspects of the strategy development. The strategy big room has worked well and has an attendance of between 15-25 people; as well as a range of Trust clinicians and managers, regular attenders also include representatives from Imperial Health Charity and the chair of our strategic lay forum.

Since the start of the year, the development of the strategy has also been taken for input and guidance to a dedicated fortnightly meeting of the executive management team. In addition, it has been discussed and developed at a leadership forum event, a meeting of the strategic lay forum and a Trust board seminar.

The following diagram shows the approach we have taken to the strategy development, including how we have drawn on a wide range of existing information and analysis, especially the extensive feedback we have had from staff, patients and partners over the past year through, for example, our quality listening exercise and annual staff survey, as well as insight from our involvement in the north west London sustainability and transformation partnership and other local and national fora.

The final draft of our strategy document - Better health, for life: our vision and strategy for 2019-2029 – is attached for formal approval. It includes, as an appendix, a summary of the strengths, weaknesses and strategic challenges analysis that was undertaken to inform the strategy.

The mission, vision and strategic goals included in the strategy (and see diagram above) are intended to replace, from 1 April 2019, our current strategic objectives, which are:

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

And also to replace our current strategic vision, which is: to be a world leader in transforming health through innovation in patient care, education and research.

The strategy document is intended to establish a clear strategic vision and direction of travel and is not intended to cover every aspect of the important work we do or all of our current, day-to-day challenges. Delivering our operational and financial commitments is part of our 'business as usual' and we will continue to do that to the best of our abilities while also progressing the key areas for change set out in our strategy. We have also only started to link these broad strategic goals to more specific priorities and developments, incorporating objectives only for 2019/20.

With the Board, we want to continue to engage with our staff, as well as with patients and partners, to map out more detail for what we will do over the next 3-5 years and ten years, looking to develop strategic implementation plans for key areas of our work. These will be in areas that are directly linked to our three strategic goals – such as the development of new clinical models, new clinical roles and quality improvement - as well as in areas that establish the foundations and infrastructure that will be essential to their delivery – such as estates, digital and workforce development.

As part of our implementation planning, we will also need to set out clear leadership and programme management responsibilities, establish measurement and evaluation approaches and provide clarity on resource and priorities.

3 Leading change through vision, values and behaviours

In a programme led jointly by the communications and HR teams, we have gathered feedback on our vision and values from more than 2,000 staff over the past five months. We did this by developing a set of eight activities plus resources for use in a range of meeting or event set ups, to prompt discussion, feedback and action on barriers, solutions and examples of 'good' and 'bad' behaviours. We launched the programme and the activities at the November 2019 leadership forum and our senior leaders – plus participants on our Aspire leadership courses – took on responsibility for helping to run and cascade activity sessions and to feedback view and insights.

Analysis of the feedback showed high awareness of our values and many positive examples of our values in action and we also identified eight key areas for action. In addition, many staff identified the need for greater clarity on how our values should be lived in practice. We tested the eight areas for

action – with staff and with partners, via our intranet and website – and asked for input on a new behaviours framework.

The eight areas for action are as follows; the top three priorities are bolded:

- **lack of humanity / poor relationships**
- systems, process and policy
- **role modelling of behaviours**
- email
- environment
- competition / lack of common goal
- headspace/ development
- **am I OK? Are we OK?**

We have completed and tested a new organisational behaviours framework that we aim to launch on 1 April. It is presented to the Board for formal approval. We will develop a full implementation programme to ensure this framework can be, and is, used meaningfully across our organisation. This is likely to involve additional and new approaches to leadership, management and behaviours training as well as further embedding behaviours in our performance management and governance processes. As a first step we will use the framework to inform planning for the 2019/20 round of personal development reviews and have made changes to our staff appraisal approach which mean that half of each staff member's personal development review will, for the year ahead, be based on how well they have lived our values in practice, while the other half will continue to focus on achievement against objectives.

4 Recommendations

The board are asked formally to approve:

- Better health, for life: our vision and strategy for 2019-2029
    - incorporating a new mission statement, three new strategic goals (intended to replace our existing strategic objectives) and 2019/20 objectives and priorities
    - appendix A – strengths, weaknesses and strategic challenges

- Organisational behaviours framework.

The board are also asked to discuss and endorse next steps – set out in sections 2 and 3 - to widen engagement to develop our three and ten year objectives and strategic implementation plans and to achieve the behaviours set out in our organisational behaviours framework.

Trust Board March 2019

Better health, for life: our vision and strategy for 2019-2029

Imperial College Healthcare NHS Trust is here to be a key partner in our local health system and to drive health and health care innovation, delivering outstanding care, education and research with local, national and worldwide impact. Our promise is better health, for life.

This strategy brings together work and thinking over the last four years to set a clearer and more cohesive direction for our organisation, rooted in a set of core values. We believe that *how* we go about achieving our vision is as important as *what* we do to achieve our vision; behaviour change will be a critical aspect of any health and care strategy for the future.

In 2015/16, we worked with our staff and partners to define our vision and values. Since then, we have sought to embed them in everything we do, for example by incorporating them in our quality improvement methodology and our appraisal framework. There is still more to do and, alongside more recent work on our strategy, we have now developed a behaviours framework that sets out how we want to see and be seen to live our values in practice.

In 2017/18, we began to articulate three new and overarching strategic goals to create a stronger connection to the delivery of our vision. In 2018/19, we have drawn on a range of feedback and analysis to finalise these goals and to assess our strengths and weaknesses in relation to them, as well as to consider the long term challenges facing our organisation and the wider NHS. We have now brought all of these elements together to set out what changes we want to achieve as a result.

This strategy does not try to cover every aspect of the important work we do or all of our current, day-to-day challenges. Delivering our operational and financial commitments is part of our 'business as usual' and we will continue to do that to the best of our abilities while also progressing the key areas for change set out in our strategy.

We have also begun to link these broad strategic goals to more specific priorities and developments, starting with our plan for 2019/20. We want to continue to engage with our staff, as well as with patients and partners, to map out more detail for what we will do over the next 3-5 years and ten years, looking to develop strategic implementation plans for key areas of our work. These will be in areas that are directly linked to our three strategic goals – such as the development of new clinical models, new clinical roles and quality improvement - as well as in areas that establish the foundations and infrastructure that will be essential to their delivery – such as estates, digital and workforce development.

Our vision

Better health, for life

Our values

- **Kind** - we are considerate and thoughtful so everyone feels valued, respected and included
- **Expert** - we draw on our diverse skills, knowledge and experience so we provide the best possible care
- **Collaborative** - we actively seek others' views and ideas so we achieve more together
- **Aspirational** - we are receptive and responsive to new thinking, so we never stop learning, discovering and improving

Strategic goal 1: To help create a high quality integrated care system with the population of north west London

Successful integrated care is about collaboration: with our partners, with our patients and within our organisation. Unlike many NHS changes of the past, we will prioritise the building of relationships rather than top down structural changes. This change is for everyone in our organisation and not just those involved in specific programmes around integrated care.

What is going to be different:

- **With our partners and patients, we will define a set of priority outcomes that we are seeking to improve.** We will be clear how collaborative working can improve these outcomes and what contribution we will make
- We will focus on **health inequalities** within our services and communities and act to address these, going beyond the measurement of average outcomes
- We will follow **a principle of collaboration not competition** with other partners, with new financial arrangements, joint working, shared services and better information sharing
- We will do more to encourage **the sharing of expertise, skills and information** that improves health and care, both within our organisation and with patients and partners.

What we will do this year:

2019/20 objective	2019/20 key initiatives
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** **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**	***Keeping care flowing collaborative*** A range of projects to ensure patients are able to move through our care pathways as quickly and smoothly as possible – focusing on improving real-time operational data, emergency department pathways, ward-level processes and discharge from hospital. ***New care models*** Key developments include new approaches to outpatient services, the children's hospital network and new adult respiratory pathway and facilities within our 'healthier hearts and lungs' proposal, and collaborations such as RM cancer partners, a sector-wide imaging network and Hammersmith and Fulham Integrated Care Partnership. ***Digital connectors*** The programme includes the expansion of the care information exchange, providing patients and clinicians in north west London with secure online access to health records and two-way communications, working with Chelsea and Westminster to roll out our Cerner electronic patient record system across their hospitals, and improving the accurate capture and use of digital data. ***Primary care partnerships*** Piloting new ways of working with primary care networks and building on learning to date from our connecting care programmes, patient-focused collaborations with GPs and other partners. ***The care environment*** Making better use of our physical spaces for patients and visitors, to explain, promote and involve, focusing on wayfinding, digital information screens and welcome areas.

Strategic goal 2: To develop a sustainable portfolio of outstanding services

We have one of the largest and most diverse service portfolios of any NHS organisation in the country. We also undertake some of the most complex and specialist procedures while maintaining one of the lowest mortality rates and achieving many excellent outcomes. This is all underpinned by a long and successful track record in clinical research and education. We need to maximise the value of this breadth and depth of expertise for all our patients and wider population. We must also plan for the significant changes we know will be needed to respond to new expectations, needs and technology.

What is going to be different:

- We will **more clearly define the areas where we have particular strengths** and focus resources and attention on maximising their benefits
- We will seek to **align our priorities with our academic partners** and maximise the value of research for better health and care
- We will focus on **value not just cost**, taking account of outcomes, quality and efficiency to develop our services; this will also guide our partnerships with other providers
- We will **measure meaningful outcomes** across all our services and pathways and use this knowledge to inform our continuous improvement work.

What we will do this year

2019/20 objective	2019/20 key initiatives
3 To **reduce unwarranted variations** in care pathways – focusing this year on projects supported by the **Imperial flow coaching academy** and guided by external benchmarking on quality and efficiencies. **4** To develop **strategic solutions to key challenges** - focusing this year on staff **recruitment and retention**, reducing our underlying **financial deficit** and **estates redevelopment**. **5** To strengthen the **connections between our service developments and our research** – focusing this year on **data and digital** initiatives and expanding **translational opportunities.**	***Safety improvement*** Includes nine improvement work streams, focusing on use of real-time data to drive improvements, to tackle sepsis and deteriorating patients for example, and behaviour change, to improve compliance with surgical checklists and hand hygiene for example. ***Specialty review programme*** Priority developments across all services to help ensure alignment with our organisational strategy. ***Planned care improvement*** A range of initiatives to improve our management of waiting lists and to reduce waiting times. ***Strategic workforce programme*** Work streams include developing new roles, apprenticeships, overseas recruitment and improving career development opportunities ***Research*** Key developments include widening access to research opportunities, the development of Imperial Health Knowledge Bank – a register of patients who want to support and/or be more involved in research, and developing an aligned strategy around patient data and research. ***Estates and facilities programme*** Projects include creating a hybrid theatre at St Mary's, re-tendering our catering, cleaning and portering contract and developing our strategic imaging assets programme, as well as progressing options for a major estates redevelopment.

Strategic goal 3: To build learning, improvement and innovation into everything we do

We take huge pride in the contribution that our hospitals and staff have made to health and care innovation over many years. We must continue to encourage and support this level of aspiration but also widen opportunities, both to lead and participate in formal research and development projects as well as in continuous improvement as part of our day-to-day work. There is always potential to improve and we will support everyone in every role to be part of this.

What is going to be different:

- We will **support every member of staff to play an active part in an improvement or innovation initiative**; we recognise that we need to learn from what doesn't work as much as by what does work in order to be effective
- **We will measure how encouraged and supported staff feel** in these efforts, publicly report on this and act to do better
- We will encourage **learning as part of every role in our organisation,** ensuring these opportunities are fairly accessible to all staff
- We will create **new opportunities for staff to develop their skills** and careers with our organisation.

What we will do this year

2019/20 objective	**2019/20 key initiatives**
6 To achieve a measurable improvement in our **organisational culture** - focusing this year on improvements in **leadership**, **fairness** and **collaboration.**	***Leading change through vision, values and behaviours*** Embedding our new behaviours framework, focusing on feedback, appraisals, leadership, management and behaviours training and measuring impact. ***Equality, diversity and inclusion*** A renewed focus on ensuring our leadership and management development, HR processes and talent management actively promote diversity and fairness; our first priority is to implement the NHS workforce race equality standard across the organisation. ***Workplace wellbeing and collaboration*** A programme to create better working and social spaces and other opportunities to facilitate connections, support and learning ***Patient and public involvement*** Key developments include further expansion and support for our lay partner programme, a new focus on learning from complaints and patient feedback, actions to embed involvement in day-to-day activities and processes and improving evaluation of impact.

Imperial College Healthcare NHS Trust

Better health, for life – our vision and strategy 2019-2029

Appendix A
Strengths, weaknesses and strategic challenges

March 2019

Our strengths

Imperial College Healthcare NHS Trust

Strength	Why is this in our top 5 strengths?	Counter issues
Our reputation and brand	▪ Attracts NHS and private patients ▪ Allows us to attract and retain excellent staff ▪ Generates funding opportunities ▪ Encourages others to collaborate with us	How do we retain the positive aspects of a strong identity in a future with fewer organisations?
Size and scale	▪ Broader range of expertise and services than most NHS ▪ Can support strong corporate support, training, QI etc. ▪ Innovation and learning potential ▪ 'Anchor' institution with £1bn+ influence on community	Can our size exacerbate the risk of siloes and communication issues? Can we sometimes lose focus?
Our outcomes	▪ Nationally leading trauma, stroke and heart centres ▪ Many other specialties high performing in peer reviews ▪ Consistently low mortality rates (HSMR)	Could there be a risk of complacency, are there inequalities, is there inconsistency?
Links with world class research	▪ 'Integration' and co-location with Imperial College (especially at White City) ▪ Ability to leverage an extensive network of expertise for our patients and communities	Are we clear which areas are our real strengths? Do we sometimes let these areas be defined for us rather than us defining them?
The potential of digital and data	▪ NHS global digital exemplar - attracts funding and partners to create digital products ▪ Deepens our ties to Imperial College and industry ▪ Single ePR across all 5 hospitals and soon ChelWest and West Mid	Is there added risk in being early adopter of new digital technologies? How do we distinguish hype from real potential?

Our weaknesses

Imperial College Healthcare NHS Trust

Weakness		Why is this in our top 5 weaknesses?	Counter issues
Our estate		▪ Creates significant operational and finance issues ▪ Adverse impact on working environment and staff ▪ May cause patients to choose other providers ▪ A culture of uncertainty around future choices	Is it really *all* the estate? Or is there a risk that this becomes a 'catch all' reason for not making change?
Culture and behaviours	Processes	▪ Staff talk about petty or complex processes and rules that inhibit them improving care or making change ▪ At the same time, disrespect for processes makes it less likely that genuine priorities are followed ▪ Culture of 'under the radar' stifles spread of learning	Are the processes really the problem or are there behavioural issues underpinning the problems?
	Difficulty making change	▪ Some scepticism at all levels of the organisation about whether there will really be change with new initiatives ▪ Questions about whether our leaders and managers have right skills, accountabilities and support ▪ Haven't managed to improve CQC ratings sufficiently	How much is this genuine resistance to change versus people being unclear on the strategic direction or priorities?
	Siloed working	▪ Staff highlight presence of professional and site 'tribes' ▪ Tensions between divisions and centre will inhibit implementation of priorities ▪ Directly contrary to integrated care agenda and patient/person-focused processes and pathways	There are also positives to distinctive local cultures and pride in services. We should be wary of over centralising
Structural challenges in local NHS		▪ Many local NHS partners have long term structural problems with estates, finance and sustainability ▪ Our referral flows are not geographically concentrated and there's a high overlap with other providers ▪ Limited capital and transformation funding	Are these challenges any different to other areas? What is Imperial's wider leadership role?

Some key strategic challenges

Imperial College Healthcare NHS Trust

Commitments in the NHS long term plan

Changing structures and finances

- **Organisational change**: Commissioners will be in transition for next 2-3 years and there will be pressure for provider integration. Structural change carries a high risk of failure and can distract management attention from core work if not carefully managed.
- **Financial constraints.** Demand for capital in NHS will far outstrip supply in next CSR. Revenue will remain tight and existing tariff structures don't support integrated care.

Workforce challenges

- **Changing roles.** Major changes in workforce with blurring of traditional roles and continuing staff and skills shortages in key areas.
- **More automation.** Clinical and non-clinical workforce will experience greater automation and use of AI. Significant investment in physical/digital infrastructure, skills and change management will be needed to support this and realise the potential benefits.

New digital technology

- **Remote and digital care.** Major national ambitions for remote and digitally-enabled outpatient services; accelerating digital innovations across all service areas.
- **Too much information?** Significant increase in the availability of data as records are integrated, automated data collection increases and more personalised information is introduced. Do we have the skills and capacity to make use of this?

Shifting needs and expectations

- **Changing needs.** ONS predicts that Imperial's 60+ population will increase even faster than national average in the next ten years. Highly diverse and widening inequalities.
- **Higher expectations.** Patients will have higher expectations of user experience, access to information and personalisation. More services will be available on the market and NHS and individual trusts' offers will be compared to this.

Our organisational behaviours framework

Trust board March 2019

KIND	Love to see	Expect to see	Don't want to see
We are considerate and thoughtful so everyone feels valued, respected and included	Always go out of your way to make others feel welcome	Make eye contact, smile, and introduce yourself	Ignore or avoid others; appear unapproachable, rude, abrupt or moody
	Pro-actively offer help and support to patients, visitors and colleagues - 'go the extra mile' for others	Help patients, visitors or colleagues who seem lost or confused; if you can't help, find someone who can	Make others feel they are a burden; not be helpful; ignore visitors who are lost
	Make time to actively listen and respond, even when busy; tailor your approach to the individual and 'listen with fascination'	Listen to others attentively and with patience; show empathy	Appear disinterested, distracted or dismissive; talk over others
	Help others to challenge unkind or disrespectful behaviour and to understand their impact	Constructively challenge unkind or disrespectful behaviour	Condone or ignore disrespectful or unkind behaviour in others; fail to challenge it directly or indirectly
	Understand and respond to the diverse needs of patients, visitors and colleagues – show you value their time	Treat everyone as an equal and a valued individual; see things from others' points of view	Ignore others' feelings or needs; make others feel bullied, excluded, belittled or judged

COLLABORATIVE	Love to see	Expect to see	Don't want to see
We actively seek others' views and ideas so we achieve more together	Encourage and support others to find better ways of working within and across teams	Work as part of a team; co-operate and engage with colleagues and partners	Exclude others and work in isolation; resist others' attempts at collaboration
	Pro-actively seek diverse views and feedback in all aspects of your work	Respect other's expertise and value advice; involve others in the development of ideas and projects	Do not recognise others' expertise or views; ignore or dismiss ideas or do not seek input
	Develop genuine and generous partnerships with others, internally and externally, to achieve a common goal	Respond and contribute to partnerships and collaborations to achieve a common goal	Act in your own interests or to the detriment of other teams or partners to achieve your own goals
	Create a culture of proactive, tailored and transparent communication	Openly share information freely with others	Do not share information freely or accurately or provides incomplete information
	Be generous with your time and actively make yourself visible and available to others	Respond positively to requests for help or support from others	Be elusive or hard to contact; do not respond to others in a timely or positive way

Our organisational behaviours framework

Trust board March 2019

EXPERT	Love to see	Expect to see	Don't want to see
We draw on our diverse skills, knowledge and experience so we provide the best possible care	Actively inspire and encourage others to act responsibly and always act in line with best practice	Understand and comply with policies, procedures and reporting	Ignore best practice, policies and procedures; take unwarranted risks or short cuts
	Role model continuing development and encourage others to do the same; be generous with your knowledge and networks	Demonstrate competence in current practice, be sure of your facts and opinions and know the limits of your knowledge	Do not keep up to date or maintain knowledge and best practice
	Promote a culture of delivery; highlight issues, challenges and risks in delivery and help find solutions and mitigations	Do what you say you will do and strive to deliver on your commitments	Do not follow through on actions or commitments; miss deadlines and do not highlight actions not on track
	Always consider impact on cost, resource or environment and actively seek to reduce the impact; encourage others to do the same	Use money, time and other resources as efficiently and sustainably as possible	Show disregard for resources, time and facilities
	Constantly find improvement opportunities in every aspect of your work	Use our quality improvement methodology to tackle problems and make improvements	Fail to recognise or act on opportunities for improvement

ASPIRATIONAL	Love to see	Expect to see	Don't want to see
We are receptive and responsive to new thinking, so we never stop learning, discovering and improving	Actively help others to identify improvements and find solutions to problems, focusing on outcomes	Initiate improvements and look for opportunities to learn from others	Resist or avoid change because "we've always done it this way"
	Create a culture where achievement is proactively identified and celebrated	Recognise and celebrate achievement	Fail to notice or appreciate others' efforts or achievements
	Promote and role model reflection and learn openly with others	Build in reflection and learning to support daily practice	Fail to make time for learning and reflection; show little or no interest in learning from incidents, patients or best practice
	Promote a culture of feedback and role model high quality feedback conversations as part of daily practice	Ask for, listen to and accept feedback to improve performance and practice	Do not ask for or do not be open to feedback; be defensive when it is offered
	Take proactive steps to contribute to wider improvement initiatives and bring a positive mindset to new ideas	Support improvement initiatives in your own role or team	Have a cynical or negative mind-set to improvement initiatives or change

Our organisational behaviours framework

Trust board March 2019

Our organisational behaviours framework

Trust board March 2019

Our organisational behaviours framework

Trust board March 2019

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Avoiding Term Admissions Into Neonatal units (ATAIN) Action Plan	☒ Approval ☒ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 27 March 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 CNST Yr 2 maternity incentive scheme to continue to support the delivery of safer maternity care.

This requires Trusts to demonstrate they have achieved all of the **ten safety actions** in order to recover the element of their contribution relating to CNST Maternity Incentive Fund (approx. £1M) and a share of any unallocated funds. (£500K in Yr 1, Unkown for Yr 2).

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

Required standard includes evidence that an action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews by 10th March 2019.

Chairman's approval has been confirmed for ICHT's Action Plan from both the LMS and ODN on 5th and 6th March respectively. Initial approval has been confirmed by the Trust Board Maternity Safety Champion, Prof TG Teoh, in advance of approval by EXFIN Committee on 13th March and Trust Board on 27th March 2019.

The Action Plan is being presented for approval to meet governance requirements for CNST compliance. There will also need to progress with Action plan documented within minutes of meetings at future Board ODN/LMS.

Recommendations:
The Committee is asked to approve the ATAIN Action Plan as required for CNST Yr 2 compliance.

This report has been discussed at:
FASRG 11th March, LMS, ODN

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

Quality impact:
Safe, responsive and 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.

Risk impact and Board Assurance Framework (BAF) reference:
Risk to CNST compliance and associated financial incentive if required governance evidence is not provided. Appropriate mitigation includes appropriate approval in advance of March 10th timeline. Further monitoring of progress against Action Plan will also be required from LMS/ODN and Trust Board and has been factored into CNST Compliance tracker.

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. This particular action plan will focus on Avoiding Term Admissions Into Neonatal units.

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

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

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

If the details can be shared, please provide the following in one to two line bullet points:
- What should senior managers know?
- ATAIN Action Plan for information
- Trust Board approval required for CNST compliance
- 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-claims/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/
- Should senior managers share this information with their own teams? ☐ Yes ☒ No

Imperial College Healthcare NHS Trust

Avoiding Term Admissions Into Neonatal units (ATAIN)

Action Plan to address local findings from ATAIN

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	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	Complete
	Midwife training for Neonatal Abstinence Syndrome scoring	Education leads	May 2019		May 2019
	Medical/Neonatal consultant ward rounds in TC	Lidia Tyszczuk	In progress		Ongoing
	Regular bite sized teaching TC staff	Education leads / Lidia Tyszczuk	In progress		Ongoing
Admissions for respiratory support following ELSCS and Emergency LSCS	Joint audit obstetric/neonatal on CS rates neonatal morbidity.	Serap Akmal / Lidia Tyszczuk	May 2019	Presentation in biannual morbidity meeting	May 2019
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		Ongoing

	Bi annual presentation of findings at joint obstetric and neonatal morbidity meetings	Serap Akmal	In progress		

Date when discussed at LMS Board Meeting: Chair's approval 6th March 2019 in advance of LMS meeting on 22nd March 2019

Date when discussed at ODN Board Meeting: Chair's approval 5th March 2019 in advance of ODN meeting

Trust Board Maternity Safety Champion approval: 6th March 2019 (*with approval at EXFIN Committee 19th March and full ratification at Trust Board: 27th March 2019)*

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Bi-monthly integrated quality and performance report	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27 March 2019	**Item 11, report no. 08**
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:** Terence Lacey (Business Partner, Performance Support Team); Julie O'Dea (Head of Performance Support)

Summary:

This is the bi-monthly integrated quality and performance report for data published at month 10 (January 2019).

The report is presented in three main sections:

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

Appendix 1: Imperial Undertakings

Note: Since the Executive Quality Committee meeting the metrics for cleanliness audits have been added to the scorecard so are reported for the first time.

Recommendations:
The committee is asked to note the bi-monthly integrated quality and performance report at month 10 for onward publication to the public meeting of the Trust Board.

This report has been discussed at the following:
Executive Quality Committee; Board Quality Committee; Executive Finance Committee.

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

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

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

domains are impacted by the paper.

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

Risk impact and Board Assurance Framework (BAF) reference:
Links to risks for the full IQPR framework as follows:

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

Workforce impact (including training and education implications):
None

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

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

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

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

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

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

Section 1 Summary report

The key headlines in performance for month 10 are provided below.

1.1 Safe

Patient safety - incidents

Degree of harm

We have reported fewer incidents that cause the most harm to patients than average so far this year when compared to the most recent data published by the National Reporting and Learning System (NRLS) in August 2018 (for the October 2017 – March 2018 period). There were no severe or extreme harm incidents reported in January 2019. In total we have reported four severe harm and four extreme harm incidents so far this financial year.

Incident reporting rate

The Trust's incident reporting rate for December 2018 was 52.50, placing us above the highest quartile nationally based on the latest published NRLS data (46.96).

Never events

We have declared seven never events so far this financial year, six of which are related to invasive procedures. Two of these were declared in January:

- CT guided nerve root injection on the wrong side at SMH on 2nd January 2019. Initial investigation shows a WHO checklist was not completed during this procedure. The patient did not suffer any harm however they have not had their intended procedure. The never event was declared on 11th January.
- Retained vaginal swab following an episiotomy in a midwife led delivery at QCCH on 3rd January. Initial investigation shows issues with compliance with the swab count policy. This was identified when the woman re-presented on 15th January. The never event was declared on 21st January.

A trustwide action plan was developed in response to the first four invasive procedure never events. This was presented to executive quality committee on 8th January 2019. Additional actions have since been added in response to the two incidents declared in January, 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. At the time of writing, the first SIM training session had been undertaken in maternity, with dates for the other areas planned throughout the remainder of February and March.

Weekly updates on progress with the action plan are being provided to the executive committee.

Duty of candour

Compliance with the completion of duty of candour for all appropriate incidents is monitored weekly at the medical director's incident panel. The percentage of incidents reported

between January 2018 – December 2018 that have had stage 1 and stage 2 of the duty of candour process completed is 90.7% for SIs, 95.9% for internal investigations and 93.6% for moderate and above incidents. Data is reported one month in arrears. In month compliance improved in December 2018, with 100% compliance for level one and moderate harm incidents, and 66.7% compliance for SIs, which represents one SI which did not have DoC completed within the timeframe.

Infection prevention and control

There were no cases of MRSA BSI assigned to the Trust in January 2019.

There was one case of *Clostridium difficile* identified as a lapse in care in January 2019. There have therefore been ten identified *C. difficile* lapses in care so far this year. These have been reviewed and no clear themes emerge. We continue to work with Divisions in reviewing each case and identifying opportunities for preventative action.

There were no cases of BSI caused by CPE in January 2019.

Six cases of Trust *E.coli* BSI have been reported for January 2019. This makes a total of 74 cases for 2018/19, compared with 64 cases for this period in 2017/18. This means we have not met our target of a 10% reduction in cases compared to last year. 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). An internal IPC working group, led by the Deputy DIPC, has been exploring the available Trust resources relevant to reducing Gram-negative BSI through discussions with key stakeholders from the Nursing Directorate, and the Divisions. To date this has focused on hydration, continence, and promotion of early removal of catheters. High risk areas may require more detailed work on understanding the use of specific prophylactic antibiotics. Additional work centres on deciphering community drivers of hospital-onset Gram-negative BSI, done alongside the CCG.

VTE

VTE assessment compliance rates were below the target of 95% in January 2019, at 93.48%. This is the second month in a row that we have been below target. Performance at divisional level is above target in WCCS and SCCS, however as reported previously, MIC are not meeting the target.

The MIC division have reviewed the data and identified stroke and neurosciences and acute and specialist medicine at Charing Cross as the areas where the target is not being met. The Divisional Director for Governance has met with team members of both these directorates to help find an urgent solution. Actions have been put in place to support completion of the assessment. Preliminary data for February 2019 shows that improvements have been made, however we are not expecting to return to target until March 2019.

Questions were raised at the executive committee in August 2018, regarding whether VTE assessment might be preventing positive VTE diagnosis and whether there is an association between increasing assessment and reduced complications. Analysis has been undertaken which was presented to ExDig in February however it has not been included here as additional review is underway including agreement of next steps. This will be provided in the next report.

Flu

By the end of January, 53.3% of frontline staff had had the vaccination; this is slightly below where we were last year. Take up of the vaccination across London has been low this year, with a milder climate and limited national news contributing to lower vaccination numbers.

A communications campaign is in place to encourage staff to have the vaccine and there are a number of ways that staff can obtain the vaccine – through peer vaccinators and at occupational health walk in centres. Weekly dashboards are provided to the divisions to support increased uptake which are being reviewed at the executive team meeting with improvement actions in place across all divisions.

Sepsis

Antibiotic administration for patients diagnosed with sepsis is calculated from time of diagnosis to administration. In January 2019, 71.3% of patients received antibiotics within one hour of sepsis diagnosis, compared to 68.9% in December, against our target of 50%. These figures are for the emergency departments at SMH and CXH and acute inpatient areas. Work continues to roll out the Trust approach to sepsis monitoring to all areas of the Trust. The management of sepsis alerts in paediatric settings is currently not the same as adult areas due to differing IT systems and approaches to recording observations. This does not mean that antibiotics are not administered within 60-minutes in paediatric cases, but rather capturing this is difficult. The sepsis big room will continue to explore how this can be done and will provide a further update on this in Q1 19-20.

From April 2019, the Trust target will be amended to 90% to be in line with CQUIN requirements.

Safe staffing

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

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	94.93%	94.49%	98.05%	96.23%
Hammersmith	94.73%	90.06%	97.95%	96.94%
Queen Charlotte's	96.96%	95.88%	98.68%	94.14%
St. Mary's	96.11%	93.44%	98.34%	97.00%

Trust wide	95.52%	93.46%	98.21%	96.49%

Workforce and people – vacancy rates

At the end of January 2019 the vacancy rate was 13.3% (1,475 WTE vacancies) and for all nursing & midwifery roles, the vacancy rate was 15.5% (816 WTE vacancies); marginal increase from November due to establishment growth to support additional beds. Based on current activity and establishment the projection is that targets would be met by end May 2019.

Safeguarding training

The compliance rate increased to 83.3% in January 2019 (from 77.2% in November 2018. Action within the divisions has ensured that attendance at level 3 sessions has increased. This has been monitored weekly through the Improving Care Programme Group and the Trust expected the target of 90% to be achieved by the end of March.

Medical devices

There has been a continual improvement in maintenance compliance figures for medical devices and in December 2018 and January 2019 all three metrics (low, medium and high risk) achieved the target.

Estates Maintenance

Recognising that there has been an issue with the performance in rectifying reactive tasks, this KPI has been under investigation. Overall there is a build-up of uncompleted tasks within the logging system, this was reduced by a third as a result of removing duplicate entries and other data discrepancies. A Group led by the Director of Estates and Facilities has been set up, meeting bi-weekly to prioritise these works. The current focus has been on reducing the historic issue in February and the list has been reduced by a further 25% with over 1000 jobs being completed in January and further progress planed for February. This focus assisted the Clinical Divisions in their preparations for the CQC visit. Whilst this has had a detrimental effect on the KPI which measures completing the works within the time frame, there has been an overall benefit.

Cleanliness audit scores

Very High Risk: 11 audits were within 2% of achieving a pass and this would have brought the cleanliness audit score to 91% in January.

High Risk: 15 audits were within 2% of achieving a pass and this would have brought the cleanliness audit score to 92% in January.

The Trust monitoring team continue to undertake audits to assess performance.

1.2 Effective

Mortality indicators

The Trust has the lowest HSMR rate for the last 12 months of data. However, for October 2018 the Trust's HSMR is 74, which places us seventeenth nationally. This is a statistically significantly low HSMR but is out with our target to be within the top 5 nationally. Dr Foster have confirmed that this was due to normal variation in the data as the monthly performance is influenced by the quality of data from each provider.

The most recent full year data for SHMI (Q2 17/18 to Q1 18/19) shows the Trust to be the fourth lowest of acute non specialist providers at 74.38.

Mortality reviews

Mortality reviews continue to be completed however the data confirms that clinical teams are struggling to complete these within the trust target within a week of the death occurring. Structured judgement reviews (SJRs) are undertaken for all relevant deaths in line with national requirements and Trust policy. One hundred and fifty-six completed reports have been received to date for this financial year with six avoidable deaths reported. Four of these six cases are also subject to serious incident investigation. One case has been investigated as an internal level one incident, while the other was discussed at the medical director's incident review meeting in January and is being investigated locally by the division. Cases are reviewed at the monthly Mortality Review Group (MRG) with a focus on any avoidable factors and learning themes.

SJRs should be completed within 30 days, compliance with completion continues to be below target and actions are in place to support improvement. 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. All overdue SJRs are expected to be completed by the end of the April.

A review of the mortality processes has been undertaken by a General Manager in the Office of the Medical Director and a number of recommendations have been made to strengthen the governance, compliance and learning from the review process. A Learning from Deaths steering group, which includes the divisional governance directors, has been established to oversee the implementation of all recommendations made following the review and will include how learning is disseminated across directorates and specialties.

The review also looked at how we transition to a medical examiner model in 2019/20 which has been nationally mandated. This will require investment in the role of medical examiner and support staff and so a full review and proposal is being brought through executive committee in March. This has been included as a cost pressure for business planning purposes.

Following feedback at board quality committee, we are reviewing how this data is presented so that progress in completing the reviews is better represented. We will move to reporting from date of death to date of SJR request. This will take effect in Q1 2019/20. We are also

reviewing this metric as part of the refresh of the IQPR; we are proposing to change this to measure the number of SJRs which breach the 30 day timeline for completion as this will allow us to monitor performance in a more transparent manner.

PROMs

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

The PROMS NHS Digital dashboard reports that the Trust's submission rates for December 2018 for both procedures are 100%.

National clinical audits

We continue to make progress in our divisions in the management of national audit outcome reports. The process is more embedded, with reviews being completed however we continue to be challenged in completing these within the internally set target of three months of publication. For this financial year eighteen audits were published up to the end of October 2018, all of which were relevant to the Trust and in which we participated. The internal review process has been completed for fifteen of these audits, ten of which were completed within the required timeframe. None of these were identified as showing a significant risk. Three reviews are overdue and are being managed by the divisions through their governance processes. There are now no audit reviews outstanding from 2017/18.

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. A paper outlining SCC's decision to not participate in BAUS was reviewed separately by ExQu in February; further details were required from the division and this is due to be discussed with the medical director in March. As we will not have participated in either audit this year, this position will need to be explained in the quality account.

Clinical trials recruitment

Excellent progress has also been made in improving the number of clinical trials recruiting their first patient within 70 days of a valid research application this year. NIHR-validated data for Q2 2018/19 shows 95.7% compliance against our target of 90%.

1.3 Caring

Friends and Family Test – Response rate

The A&E response rate was 12.2% in January 2019. The Trust QI team will be running 90-day QI programme at St Mary's Hospital and the initiative is expected to commence March 2019

Mixed sex accommodation

The Trust reported 50 mixed-sex accommodation (MSA) breaches in January 2019. The MSA breaches at SMH site have increased from July 18, following the co-location of HDU beds to Critical Care, and then again in Oct 18 as a result of increased activity during the winter months, reducing capacity across the Trust limiting downstream bed availability.

All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed. The root cause of EMSA breaches in Critical Care is delayed step down of patients within the national 4 hour target once they have been identified as fit for discharge.

1.4 Well-led

Workforce and people

Doctors' appraisal compliance has increased slightly again this month. At 91.7% it is at its highest since April 2018. All overdue doctors have been written to, and there are plans in place to support individuals that need help to complete their appraisal.

1.5 Responsive

RTT

The incomplete performance was 84.57%. This was 0.62% improvement on December 2018 and 1.53% below trajectory of 86.1%. The total size (all CCGs) of the incomplete PTL was 64,660 (from 67,860 in December 2018) of which 9,977 were over 18 weeks (from 10,893 in December 2018). The target PTL size for January was 63,543. The Trust continues to work to reduce PTL to meet our undertakings (the Trust needs to reduce to under c64,000 by end March 2019).

The Trust reported 44 52-week breaches Month 10. This comprised 9 confirmed breaches in addition to an additional 35 breaches relating to the Ophthalmology email account incident which is under investigation. There is continued focus on planning and treating the Ophthalmology patients identified to be waiting > 52 weeks.

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

Theatre touchtime utilisation

Touchtime utilisation in January was down on the Q3 average at 75.1%. This was 0.97% better than January 2018, largely due to improvements in session utilisation (91.54% of planned sessions ran) and an ongoing focus on improving scheduled time. This was counter-acted, however, by an increase in last minute cancellations during the month (13.15% of scheduled elective procedures). Notable, albeit seasonally anticipated, increases were seen in cancellations for patient reasons (including DNAs), patients unfit for surgery and no bed available (both ward beds and ICU).

Cancelled operations

In Q3 the Trust reported fewer on the day non-clinical cancellations than in previous quarters and remained below national average of 1.0%. In Q3 the Trust rebooking 28-day breach rate was 20.6%, above the national average of 8.3%. Nearly half (21) of the 44 rebooking breaches in Q3 occurred December, resulting in a breach rate of 32% for the month.

Critical care admissions

Overall performance improved at the SMH and CXH site. At HH performance for the GICU has deteriorated due to high occupancy on the ward from Nov 18 – Jan 19. The Trust recognises that 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.

Accident & Emergency

Performance against the 4-hour standard was 86.7%. This was below the local trajectory of 90.4%. The January 2019 performance was 1.6% higher than performance in January 2018 and type 1 performance was 4.9% higher. This is against increased numbers of A&E attendances (up by 674 to 25,363 in January 2019). During January 2019 there were 23 black alerts and 18 red alerts across SMH and CXH.

The number of twelve hour breaches of wait from DTA to admission was 10 for January. All breaches were delays to admission for mental health provider beds (1x CAMHs, 2 out of area, remainder CNWL).

Diagnostics

The Trust achieved the performance target of 1%, reporting an overall position of 0.78%.

Outpatient DNA

The Trust DNA rate remained above our 10% target, reporting a DNA rate of 11.1%, and this remained within SPC control limits.

Outpatient Hospital Initiated Cancellations

The HICs performance was 7.6% against the 7.5% target. Following discussions through the executive committee and a detailed review of HICs data a new metric is being finalised and we expect to report on this in March 2019.

Complaints

The numbers of PALS concerns increased in January 2019 to 253 which is slightly above the threshold. However, we believe that this is natural variation and we will monitor it to see what happens next month. There are no specific themes emerging although, as ever, delays and cancellations feature highly. December 2018 was an unusually low month so the January increase seems more pronounced.

Data quality indicators

Work is in progress with high volume areas with adverse performance to agree recovery plans. A refresh of the Trust approach to data quality is being carried out and immediate priorities for quarter 1 and quarter 2 have been identified. From April 2019, the Executive Operational Performance Committee will receive a monthly report of progress.

2. Indicator scorecard

See below

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Safe									
Patient safety - incident reporting	Serious incidents	number	-	Jan-19	Julian Redhead	21	13	3	**5**
	All Incidents (cumulative financial YTD)	number	-	Jan-19	Julian Redhead	9,919	11,295	12,597	**14,104**
	Incidents causing severe/major harm	number	-	Jan-19	Julian Redhead	0	0	0	**0**
	Incidents causing severe/major harm (cumulative financial YTD)*	number	<14	Jan-19	Julian Redhead	4	4	4	**4**
	Incidents causing severe/major harm (cumulative financial YTD)**	%	<0.25%	Jan-19	Julian Redhead	0.04%	0.04%	0.03%	**0.03%**
	Incidents causing extreme harm/death	number	-	Jan-19	Julian Redhead	0	0	0	**0**
	Incidents causing extreme harm/death (cumulative financial YTD)*	number	<13	Jan-19	Julian Redhead	4	4	4	**4**
	Incidents causing extreme harm/death (cumulative financial YTD)**	%	<0.10%	Jan-19	Julian Redhead	0.04%	0.04%	0.03%	**0.03%**
	Patient safety incident reporting rate (against top quartile of trusts)	incidents / 1,000 be	>=46.96	Jan-19	Julian Redhead	47.55	47.93	45.36	**52.50**
	Never events	number	0	Jan-19	Julian Redhead	1	1	0	**2**
	PSAs overdue (by month)	number	0	Jan-19	Julian Redhead	0	0	0	**0**
	PSAs closed late in the preceding 12 months	number	0	Jan-19	Julian Redhead	0	0	0	**0**
	MDAs overdue (by month)	number	0	Jan-19	Janice Sigsworth	0	0	0	**0**
	MDAs closed late in the preceding 12 months	number	0	Jan-19	Janice Sigsworth	6	6	5	**5**
	Compliance with duty of candour (SIs)	%	100%	Dec-18	Julian Redhead	100.0%	78.6%	80.0%	**66.7%**
	Compliance with duty of candour (SIs) (rolling 12 month)	%	100%	Dec-18	Julian Redhead	91.4%	87.4%	91.0%	**90.7%**
	Compliance with duty of candour (Level 1)	%	100%	Dec-18	Julian Redhead	100.0%	90.0%	71.4%	**100.0%**
	Compliance with duty of candour (Level 1) (rolling 12 month)	%	100%	Dec-18	Julian Redhead	90.0%	95.2%	92.4%	**95.9%**
	Compliance with duty of candour (Moderate)	%	100%	Dec-18	Julian Redhead	100.0%	75.0%	75.0%	**100.0%**
	Compliance with duty of candour (Moderate) (rolling 12 month)	%	100%	Dec-18	Julian Redhead	97.3%	95.8%	92.4%	**93.6%**

**Total Incidents for 17/18*

*** NRLS Apr17 -Sep17*

Infection prevention and control	Trust-attributed MRSA BSI	number	0	Jan-19	Julian Redhead	0	1	0	**0**
	Trust-attributed MRSA BSI (cumulative financial YTD)	number	0	Jan-19	Julian Redhead	2	3	3	**3**
	Trust-attributed Clostridium difficile	number	6	Jan-19	Julian Redhead	3	2	2	**4**
	Trust-attributed Clostridium difficile (cumulative financial YTD)	number	55	Jan-19	Julian Redhead	33	35	37	**41**
	Trust-attributed Clostridium difficile (related to lapses in care)	number	0	Jan-19	Julian Redhead	0	0	1	**1**
	Trust-attributed Clostridium difficile (related to lapses in care) (cumulative)	number	0	Jan-19	Julian Redhead	8	8	9	**10**
	E. coli BSI	number	3	Jan-19	Julian Redhead	4	10	5	**6**
	E. coli BSI (cumulative financial YTD)	number	59	Jan-19	Julian Redhead	53	63	68	**74**
	CPE BSI	number	0	Jan-19	Julian Redhead	1	0	0	**0**
	CPE BSI (cumulative financial YTD)	number	0	Jan-19	Julian Redhead	6	6	6	**6**

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Safe									
VTE	VTE risk assessment	%	>=95%	Jan-19	Julian Redhead	96.0%	95.3%	94.5%	**93.8%**
Flu	Flu vaccination for frontline healthcare workers	%	>=75%	Jan-19	Kevin Croft	26.5%	45.2%	49.8%	**53.3%**
Sepsis	Sepsis - Antibiotics	%	>=50%	Jan-19	Julian Redhead	-	73.5%	68.9%	**71.3%**
Maternity standards	Ratio of births to midwifery staff	ratio	1:30	Jan-19	Tg Teoh	1.26	1.26	1.26	**1.26**
	Puerperal sepsis	%	<=1.5%	Jan-19	Tg Teoh	1.14%	1.10%	1.03%	**0.40%**
Safe staffing	Safe staffing - registered nurses	%	>=90%	Jan-19	Janice Sigsworth	96.1%	97.5%	96.6%	**96.7%**
	Safe staffing - care staff	%	>=85%	Jan-19	Janice Sigsworth	95.4%	96.2%	94.1%	**94.8%**
Workforce and people	Core skills training	%	>=85%	Jan-19	Kevin Croft	89.9%	90.2%	90.2%	**90.5%**
	Core clinical skills training	%	>=85%	Jan-19	Kevin Croft	89.8%	90.2%	90.7%	**90.8%**
	Safeguarding children training (level 3)	%	>=90%	Jan-19	Janice Sigsworth	78.0%	77.2%	81.3%	**83.3%**
	Vacancy rate - Trust	%	<10%	Jan-19	Kevin Croft	12.6%	12.7%	13.4%	**13.3%**
	Vacancy rate - nursing and midwifery	%	<13%	Jan-19	Kevin Croft	15.4%	15.3%	16.1%	**15.5%**
Health and safety	Departmental safety coordinators	%	>=75%	Jan-19	Kevin Croft	77.0%	80.0%	79.0%	79.0%
	RIDDOR	number	0	Jan-19	Kevin Croft	7	3	2	**6**
	Fire warden training	%	>=10%	Jan-19	Janice Sigsworth	12.0%	13.0%	13.0%	**13.0%**
	Medical devices maintenance - high risk	%	>=98%	Jan-19	Janice Sigsworth	95.0%	96.0%	98.0%	**98.0%**
	Medical devices maintenance - medium risk	%	>=80%	Jan-19	Janice Sigsworth	88.0%	89.0%	89.0%	**89.0%**
	Medical devices maintenance - low risk	%	>=70%	Jan-19	Janice Sigsworth	91.0%	91.0%	91.0%	**91.0%**
Estates and Facilities	Cleanliness audit scores (very high risk patient areas)	%	>=98%	Jan-19	Janice Sigsworth	82.0%	90.0%	90.0%	**80.0%**
	Cleanliness audit scores (high risk patient areas)	%	>=95%	Jan-19	Janice Sigsworth	89.0%	93.0%	94.0%	**89.0%**
	Lifts in service (main passenger and bed lifts)	%	>=90%	Jan-19	Janice Sigsworth	97.0%	97.0%	98.0%	**97.0%**
	Reactive maintenance tasks completed within the allocated timeframe	%	>=70%	Jan-19	Janice Sigsworth	44.0%	34.9%	44.0%	**26.0%**
	Planned maintenance tasks completed within the allocated timeframe	%	>=70%	Jan-19	Janice Sigsworth	56.6%	50.0%	90.0%	**100.0%**
	Compliance with statutory and mandatory estates requirements	%	>=85%	Jan-19	Janice Sigsworth	99.7%	99.9%	95.0%	**100.0%**

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Effective									
Mortality indicators	Trust ranking as per monthly data (HSMR)	rank	top 5 lowest risk acute Trusts	Oct-18	Julian Redhead	13th lowest	5th lowest	5th lowest	**17th lowest**
	HSMR	ratio		Oct-18	Julian Redhead	69.00	54.00	61.00	**74.00**
	Trust ranking as per most recent full year data (SHMI)	rank		Q2 17/18–Q1 18/19	Julian Redhead	3rd lowest	3rd lowest	4th lowest	**4th lowest**
	SHMI	ratio		Qtr 1 18/19	Julian Redhead	70.10	73.18	78.62	**69.08**
	Palliative care coding	%	100%	Oct-18	Julian Redhead	100.0%	100.0%	100.0%	**100.0%**
Mortality reviews (at 08/02/2019)	Total number of deaths	number	-	Dec-18	Julian Redhead	131	162	133	**145**
	Number of local reviews completed	number	-	Dec-18	Julian Redhead	121	155	124	**128**
	Local reviews completed	%	100%	Dec-18	Julian Redhead	92.4%	95.7%	93.2%	**88.3%**
	SJR reviews requested	number	-	Dec-18	Julian Redhead	14	16	19	**22**
	Number of SJR reviews completed	number	-	Dec-18	Julian Redhead	13	16	15	**19**
	SJR reviews completed	%	100%	Dec-18	Julian Redhead	92.9%	100.0%	78.9%	**86.4%**
	Avoidable deaths	number	0	Dec-18	Julian Redhead	0	0	1	**0**
	Avoidable deaths (cumulative financial YTD)	number	0	Dec-18	Julian Redhead	6	6	7	**7**
Readmissions	Unplanned readmission rates - under 15 yr olds	%	<9.33%	Jul-18	Tg Teoh	6.8%	3.9%	4.5%	**3.8%**
	Unplanned readmission rates - over 15 yr olds	%	<8.09%	Jul-18	Frances Bowen	5.3%	6.7%	6.7%	**7.0%**
Patient reported outcomes	PROMs - participation rates (Hips)	%	>=80%	Dec-18	Julian Redhead	0.0%	100.0%	0.0%	**100.0%**
	PROMs - reported health gain (Hips)***	-	>national avg	April17–Mar18	Julian Redhead	EQ-5D Index:**0.462** EQVAS:**19.588** Oxford Hip score:**23.060**			
	PROMs - participation rates (Knees)	%	>=80%	Dec-18	Julian Redhead	0.0%	100.0%	100.0%	**100.0%**
	PROMs - reported health gain (Knees)***	-	>national avg	April17–Mar18	Julian Redhead	EQ-5D Index:**0.304** EQVAS:**8.402** Oxford Knee score:**13.918**			
National Clinical Audits	Participation in relevant national clinical audits (cumulative financial YTD)	%	100%	Oct-18	Julian Redhead	100.0%	100.0%	100.0%	**100.0%**
	High risk/significant risk audits with action plan in place (cumulative financ	%	100%	Oct-18	Julian Redhead	100.0%	100.0%	100.0%	**100.0%**
	Review process not completed within 90 days	number	0	Oct-18	Julian Redhead	4	6	7	**8**

****Reported Bi-Annually*

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Qtr 1 18/19	Qtr 2 18/19
Clinical trials	Clinical trials - recruitment of 1st patient within 70 days (%)	%	>=90%	Qtr 2 18/19	Julian Redhead	85.1%	**95.7%**

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Caring									
Friends and Family	FFT A&E service - % recommended	%	>=94%	Jan-19	Janice Sigsworth	95.8%	96.8%	96.5%	**95.4%**
	FFT inpatients - % recommended	%	>=94%	Jan-19	Janice Sigsworth	97.5%	97.7%	98.0%	**97.7%**
	FFT outpatients - % recommended	%	>=94%	Jan-19	Janice Sigsworth	92.3%	92.5%	93.3%	**93.8%**
	FFT maternity - % recommended	%	>=94%	Jan-19	Janice Sigsworth	92.8%	94.7%	92.7%	**93.6%**
	FFT A&E service - % response rate	%	>=20%	Jan-19	Janice Sigsworth	11.1%	15.9%	13.9%	**12.2%**
	FFT PTS service - % recommended	%	>=90%	Jan-19	Janice Sigsworth	92.0%	88.4%	93.1%	**92.4%**
Mixed sex accommodation	Mixed-sex accommodation breaches	number	0	Jan-19	Catherine Urch	61	64	34	**50**

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Well led									
Workforce and people	Staff retention (Stability)	%	>=80%	Jan-19	Kevin Croft	85.6%	84.8%	84.8%	**85.0%**
	Voluntary staff turnover rate (12-month rolling)	%	<12%	Jan-19	Kevin Croft	10.6%	11.9%	11.7%	**11.7%**
	Sickness absence rate (12-month rolling)	%	<=3%	Jan-19	Kevin Croft	3.10%	3.13%	3.12%	**3.13%**
	Personal development reviews	%	>=95%	Aug-18	Kevin Croft	18.1%	39.3%	87.3%	**89.6%**
	Doctor appraisal rate	%	>=95%	Jan-19	Julian Redhead	88.2%	90.1%	91.03%	**91.68%**
	Consultant job planning completion rate	%	>=95%	Jan-19	Julian Redhead	99.5%	99.5%	-	**-**
NHSI segmentation	NHSI - provider segmentation	number	-	Jan-19	Richard Alexander	3	3	3	**3**

Section 2: Indicator scorecard for Month 10

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Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Responsive									
Referral to treatment (elective care) 7%	RTT incomplete pathways 18 weeks performance	%	>=92%	Jan-19	Catherine Urch	83.0%	83.8%	83.9%	**84.6%**
	RTT variance against 2018/19 trajectory target	%	86.1%	Jan-19	Catherine Urch	*-2.9%*	*-2.5%*	*-2.1%*	***-1.5%***
	RTT total waiting list (incomplete PTL)	number	-	Jan-19	Catherine Urch	65,985	66,953	67,860	**64,660**
	RTT patients waiting 52+ weeks****	number	0	Jan-19	Catherine Urch	22	10	11	**44**
	RTT patients waiting 52+ weeks reviewed for clinical harm	%	100%	Nov-18	Catherine Urch	100.0%	100.0%	100.0%	**100.0%**
	RTT cases of clinical harm found after the clinical harm review	number	0	Nov-18	Catherine Urch	0	0	0	**0**
	****Breaches are allocated to the last specialty seen on their pathway. Some patients have subsequently been referred on and are awaiting treatment under another speciality.*								
Cancer waiting times 1%	Cancer - 62 day urgent GP referral to treatment	%	>=85%	Dec-18	Catherine Urch	85.8%	86.2%	86.8%	**86.8%**
Theatre utilisation	Theatre Touchtime Utilisation (elective)	%	>=95%	Jan-19	Catherine Urch	81.4%	79.3%	79.8%	**75.1%**
Cancelled operations	Cancelled operations (elective)	%	<=0.9%	Dec-18	Catherine Urch	0.7%	0.5%	0.8%	**0.7%**
	28 day rebooking breach rate	%	<=8%	Dec-18	Catherine Urch	21.1%	19.6%	13.2%	**31.8%**
	***** Cancelled ops target based on England national average for quarter to Sep-18								
	Next quarterly submission end April 2019, covering quarter to Mar-18								
Critical Care	Critical care patients admitted within 4 hours	%	100%	Jan-19	Catherine Urch	93.1%	92.6%	92.3%	**92.5%**
Urgent and Emergency Care 1%	A&E patients seen within 4 hours (all types)	%	>=95%	Jan-19	Frances Bowen	90.6%	90.1%	88.4%	**86.7%**
	A&E variance against 2018/19 trajectory target	%	90.4%	Jan-19	Frances Bowen	*0.4%*	*-0.3%*	*-1.8%*	***-3.7%***
	A&E patients seen within 4 hours (type 1)	%	>=95%	Jan-19	Frances Bowen	78.0%	76.9%	73.9%	**69.3%**
	A&E patients spending >12 hours from Decision to Admit	number	0	Jan-19	Frances Bowen	5	4	5	**10**
Bed management	Patients with length of stay 7+ days*****	%	tbc	Jan-19	Frances Bowen	-	-	-	**57.5%**
	Patients with length of stay 21+ days *****	%	25% from baseline	Jan-19	Frances Bowen	-	-	-	**25.3%**
	Delayed transfer of care	%	3.50%	Jan-19	Frances Bowen	2.1%	3.1%	2.5%	**2.5%**
	Discharges before noon	%	>=33%	Jan-19	Frances Bowen	13.99%	15.94%	16.35%	**15.20%**
	***** A reporting issue was identified in November 2018 which resulted in the number of long stay patients being undercounted. A correction to the report was implemented from 1st January 2019 and this is reflected in the M10 IQPR scorecard								
Diagnostics 3%	Diagnostic waits – over 6 weeks	%	<1%	Jan-19	Tg Teoh	0.59%	0.47%	2.10%	**0.78%**

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
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.								
Responsive									
Outpatient management	Waiting times for first outpatient appointment	weeks	<8	Jan-19	Tg Teoh	7.4	7.5	7.0	**7.8**
	Outpatient DNA	%	<10%	Jan-19	Tg Teoh	10.5%	10.5%	11.2%	**11.1%**
	Outpatient HICS rate with less than 6 weeks' notice	%	<7.5%	Jan-19	Tg Teoh	7.8%	7.6%	7.4%	**7.6%**
	Outpatient appointments within 5 working days of receipt	%	>=95%	Jan-19	Tg Teoh	98.0%	97.2%	96.3%	**97.6%**
Complaints management	PALS concerns	number	<250	Jan-19	Janice Sigsworth	220	242	165	**253**
	Complaints - formal complaints	number	<90	Jan-19	Janice Sigsworth	99	91	89	**89**
	Complaints – the average number of days to respond	days	40	Jan-19	Janice Sigsworth	**35**	27	28	**29**
Data quality indicators	Orders waiting on the Add/Set Encounter request list	number	286	Jan-19	Catherine Urch	*964*	*1,067*	*1,051*	**1,145**
	OP appointments 'not checked-in' or DNA'd	number	769	Jan-19	Tg Teoh	*2,413*	*2,682*	*3,097*	**3,212**
	OP appointments 'not checked out'	number	707	Jan-19	Tg Teoh	*2,118*	*2,451*	*2,167*	**2,363**
Patient Transport	All Journeys: Collection Time (60 Mins)	%	>97%	Jan-19	Janice Sigsworth	93.9%	93.0%	95.0%	**94.2%**
	All Journeys: Collection Time (150 Mins)	%	100%	Jan-19	Janice Sigsworth	99.6%	99.3%	99.3%	**99.4%**
	Journeys 0-5 Miles: Time On Vehicle (60 Mins)	%	>95%	Jan-19	Janice Sigsworth	92.5%	91.6%	92.7%	**91.1%**
	Journeys 5-10 Miles: Time On Vehicle (60 Mins)	%	>85%	Jan-19	Janice Sigsworth	76.7%	75.4%	80.5%	**75.3%**

Section 2: Indicator scorecard for Month 10

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 10

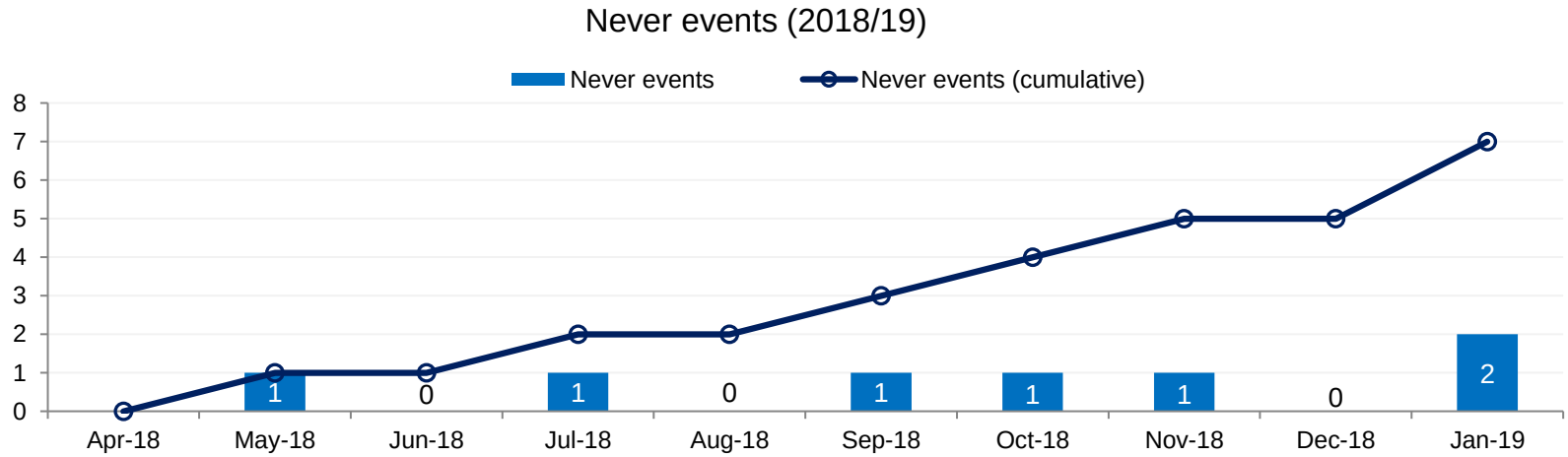
Domain	Indicator	Unit	Target	Latest Period	Exec Lead	Reported performance at: Oct-18	Nov-18	Dec-18	Jan-19
Use Of Resources									
Finance KPIs	Monthly finance score (1-4)	number	-	Jan-19	Richard Alexander	3	3	3	**3**
	In month Position	£m	-	Jan-19	Richard Alexander	-0.30	-0.44	-0.52	**-3.61**
	YTD Position £m	£m	-	Jan-19	Richard Alexander	7.59	6.04	5.62	**7.59**
	Annual forecast variance to plan	£m	-	Jan-19	Richard Alexander	-4.23	-3.86	-1.92	**-4.00**
	Agency staffing	%	-	Jan-19	Richard Alexander	4.2%	4.3%	4.1%	**4.2%**
	CIP (cumulative financial YTD)	%	-	Jan-19	Richard Alexander	65.2%	73.6%	73.8%	**77.5%**

Section 3 Exception report slides summary at month 10

Domain	Report
Safe	Never events
Safe	Compliance with duty of candour
Safe	VTE
Safe	MRSA BSI and C.difficile
Safe	E.Coli
Safe	CPE
Safe	Flu vaccination
Safe	Safeguarding training
Safe	Vacancy rates
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	RTT 52 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 (all types)
Responsive	A&E 12-hour waits
Responsive	Outpatient DNA
Responsive	Data quality indicator: inpatient orders waiting to be processed
Responsive	Data quality indicator: outpatient appointments not checked in / not checked out on the system

Safe – Never Events

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	December 2018 – 0 January 2019 – 1 (YTD – 7)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	Seven never events have been reported in this financial year; one wrong route medication incident in May 2018, one retained swab in July 2018, one retained foreign object incident in September 2018, one wrong site surgery in October 2018, one wrong site block in November 2018, one wrong site block in January 2019 and one retained swab in January 2019. The two most recent never events were: • CT guided nerve root injection on the wrong side at SMH on 2nd January 2019. Initial investigation shows a WHO checklist was not completed during this procedure. The patient did not suffer any harm however they have not had their intended procedure. The never event was declared on 11th January. • Retained vaginal swab following an episiotomy in a midwife led delivery at QCCH on 3rd January. Initial investigation shows issues with compliance with the swab count policy. This was identified when the woman re-presented on 15th January. The never event was declared on 21st January.
Return to target / trajectory	A trust wide action plan has been developed in response to the invasive procedure never events. Once implemented, this should support us to meet our objective of having no never events in the next financial year.

Safe – Never Events

Issues and root causes	The six most recent never events are all related to invasive procedures. Our audit of 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 trust wide 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	Complete	All staff emails sent from MD and ND 11th and 29th Jan. Safety alerts issued for all Never events Extraordinary MD meeting with clinical directors on 24th Jan Emails sent to all doctors from MD on 4th Jan ND met with cross-site theatre leads, nursing leads and clinical site managers on 05/02/19 and the head of midwifery and all lead midwives on 08/02/19 Deep dive maternity meeting occurred 28th Jan with follow up 11th Jan to review all quality metrics. All variance on quality metrics confirmed to be being managed and mitigated with a plan for additional staffing included in business planning.
Deliver simulation and coaching programme to all invasive procedure staff	Trust lead surgeon	TBC	Programme expedited using risk based approach; 5 specialties where there have been never events prioritised. First maternity session occurred 11/02/19. Dates in place for three of the other specialties.
External review of actions and response to Never events	Medical Director	March 2019	Meeting with national director of patient safety taking place on 21st March. Meeting confirmed with Jane Carthey (recommended by NHSI), a human factors and patient safety specialist on March 7th.

Safe – Never Events

Issues and root causes	The six most recent never events are all related to invasive procedures. Our audit of 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 .

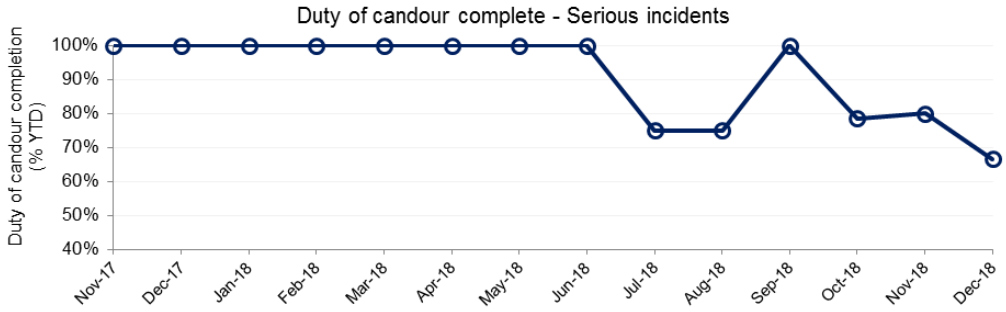
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review all Trust policies and guidelines relating to invasive procedures to ensure they are in line with national guidance and are audited	Divisions	March 2019	The count policy and invasive procedures policy are currently under review. Both are expected to be ratified by the end of March 2019. Leads are being agreed at T&F group on 28/02/19 to review the remaining outstanding invasive procedure policies. A list of LocSSIPs identified as being required by the divisions is being reviewed as a standing agenda item at the Invasive Procedures Group. The aim is to get these in place by the end of March 2019. A template for LocSSIPs has been agreed and will be appended to revised Invasive Procedures Policy. Audits of Count policy and Stop Before You Block protocol to take place in Q1 2019/20.
Ensure 100% compliance for all staff with the invasive procedure electronic training module	Divisions	Overdue	Compliance is 91.3% as at 22/02/19. The list of non-compliant staff is sent to the divisions each time WIRED is updated. Staff who are non-compliant have been prevented from operating by the divisions. The medical director is now writing personally to all non-compliant staff to remind them of the requirement to complete the training.
Review and evaluation of all actions taken previously in response to never events	Divisions	March 2019	Evaluation of 'don't interrupt the anaesthetist when the patient is in the anaesthetic room' underway. Testing of radiopaque markers in radiology underway. Plan to roll out trustwide following evaluation. Review of previous actions being undertaken by PSTRC. Due for completion by end of February 2019.

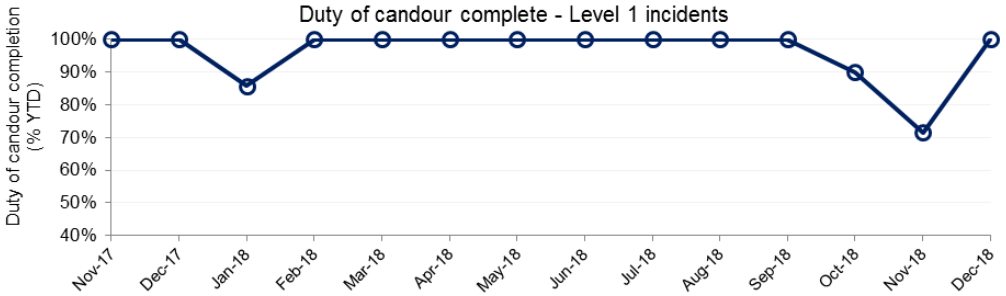
Risk

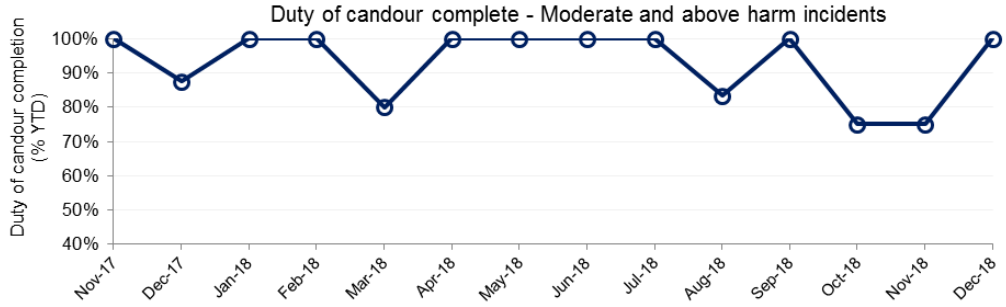
- Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2490 Failure to deliver safe care)

Safe – Compliance with duty of candour

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	SIs: 90.7% Internal investigations: 95.9% Moderate and above incidents: 93.6% (cumulative data for incidents reported Jan 2018 – Dec 2018)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance







Latest performance

Serious Incidents
Nov 2018 – 1 SI has not had DoC completed. In month compliance is therefore 80%.
Dec 2018 – 1 SI has not had DoC completed. In month compliance is therefore 66.7%.

Level 1s
Nov 2018 – 2 level 1s have not had DoC completed. In month compliance is therefore 71.4%.
Dec 2018 – All level 1s have had DoC completed. In month compliance is therefore 100%.

All other moderate and above incidents
Nov 2018 – 2 moderates and above have not had DoC completed. In month compliance is therefore 75%.
Dec 2018 – All moderates and above have had DoC completed. In month compliance is therefore 100%.

Return to target / trajectory

There are currently 8 SIs, 4 Level 1s and 5 moderate and above incidents which have been reported between April and December 2018 which have not had DoC completed. These are expected to be completed by the end of March 2019.

Safe – Compliance with duty of candour

Issues and root causes	In month compliance improved in December 2018, with 100% compliance for level one and moderate harm incidents, and 66.7% compliance for SIs, which represents one SI which did not have DoC completed within the timeframe. There were previously a number of outstanding duty of candour cases in NWL Pathology and the Trust's corporate area (private patients). These incidents are now discussed at the weekly MD panel in line with other divisions, which has led to improvements in compliance.

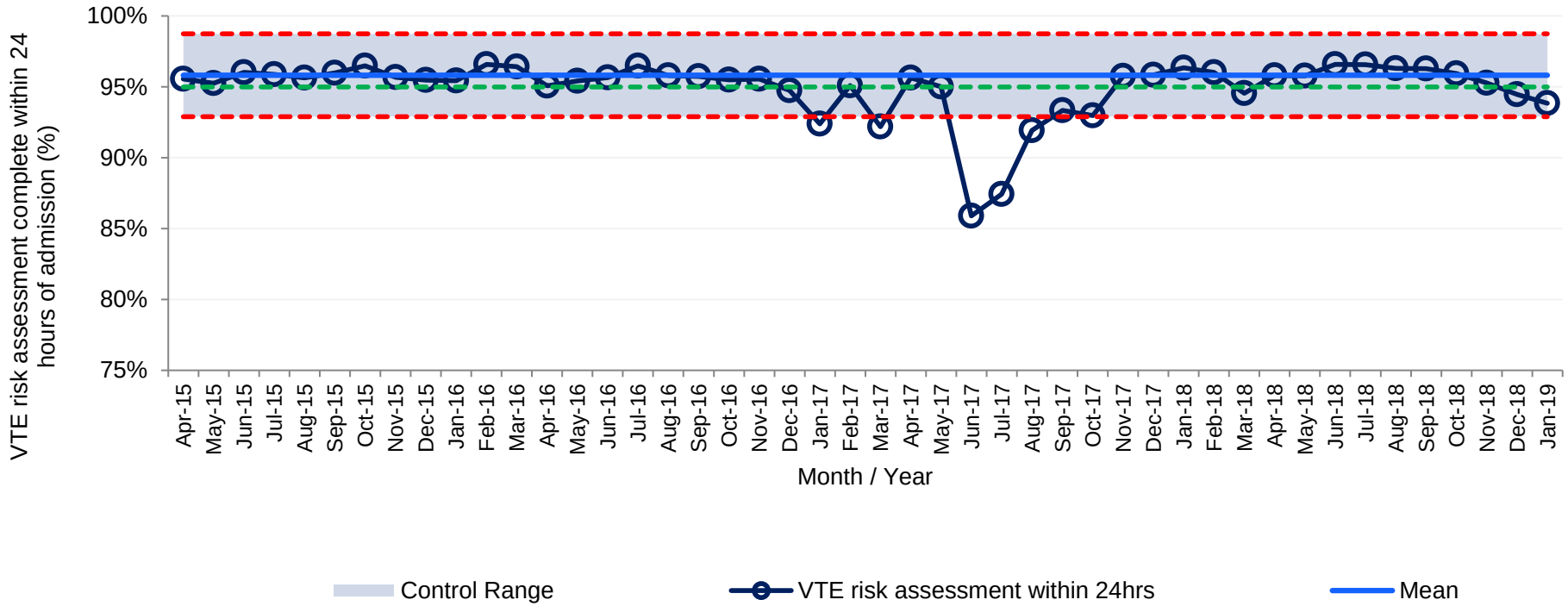
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Director's Incident Meeting.	Head of Quality Compliance & Assurance	Ongoing	Progress has been made over the past year, all outstanding cases are reviewed at the weekly MD panel. A reminder to consultants of the required timeframe to complete the DoC letter has been written and will be sent in the next RO newsletter at the end of February 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 12th February 2019 consultant compliance is 84% (MIC), 82% (SCC) and 90% (WCCS). Issues with non-compliance are being addressed by the divisional directors.
Duty of candour letter templates to be reviewed	Head of Quality Compliance & Assurance	End November 2018 (amended to end of March 2019)	Templates have been reviewed centrally to develop a comprehensive library of standardised letter templates to support consultants when dealing with complex cases. These were reviewed at sub-group in Feb 2019 and are being amended following comments. They will be published on the Intranet in March once finalised.

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%	Dec 2018 – 94.47% Jan 2019 – 93.48%	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance	VTE assessment compliance rates were below the target of 95% in December 2018 and January 2019, for the first time this year. Performance at divisional level is above target in WCCS and SCCS, however as reported last month, MIC are not meeting the target.
Return to target / trajectory	Preliminary data for February 2019 shows that improvements have been made, however we are not expecting to return to target until March 2019.

Safe – VTE

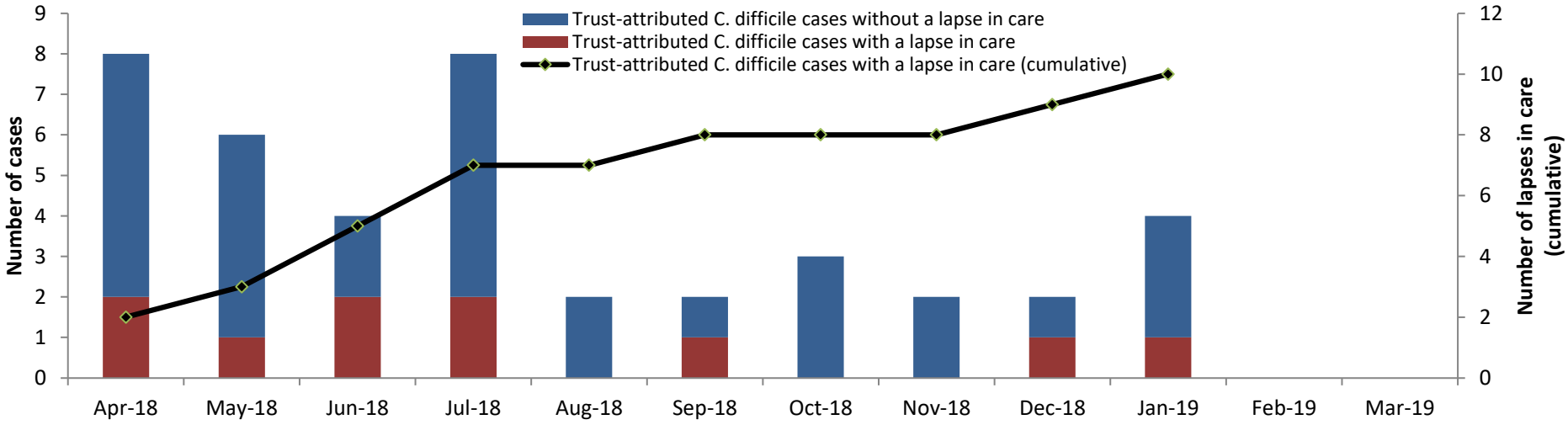
Issues and root causes	The MIC division have reviewed the data and identified stroke and neurosciences and acute and specialist medicine at Charing Cross as the areas where the target is not being met. The Trust will remain below target until MIC performance has improved. The Divisional Director for Governance has met with team members of both these directorates to help find an urgent solution. Actions have been put in place to support completion of the assessment.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Acute and specialist medicine: develop actions to improve compliance	Directorate triumvirate	March 2019	Actions include education of clinical assessors and identification of junior doctor VTE champions and ensuring the assessments are confirmed as complete on the ward round.
Stroke and neurosciences: develop actions to improve compliance	Directorate triumvirate	March 2019	The deputy divisional director for nursing with the directorate manger has investigated all the non-compliant the cases for all three departments (stroke, neurology and neurosurgery). Each responsible consultant looking after these patients has been notified and personal action requested to address this. Specific actions have been developed on each ward to ensure checks are in place to facilitate completion of the assessment.
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, following questions raised at ExQu in August 2019	Data analytics team	March 2019	Analysis has been undertaken which was presented to ExDig in February however it has not been included here as additional review is underway including agreement of next steps. This will be provided in the next report.

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

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 – December 2018 0 – January 2019 MRSA BSI YTD: 3 *C.difficile* lapse in care: 1 – December 2018 1 – January 2019 *C.difficile* lapse in care YTD: 10	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Zero Trust-attributable MRSA cases were reported for December 2018 and January 2019. There have been three cases reported so far for 2018/19. • December 2018 saw two cases of Trust-attributable *C.difficile*, one of which was identified as a lapse in care. • January 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*

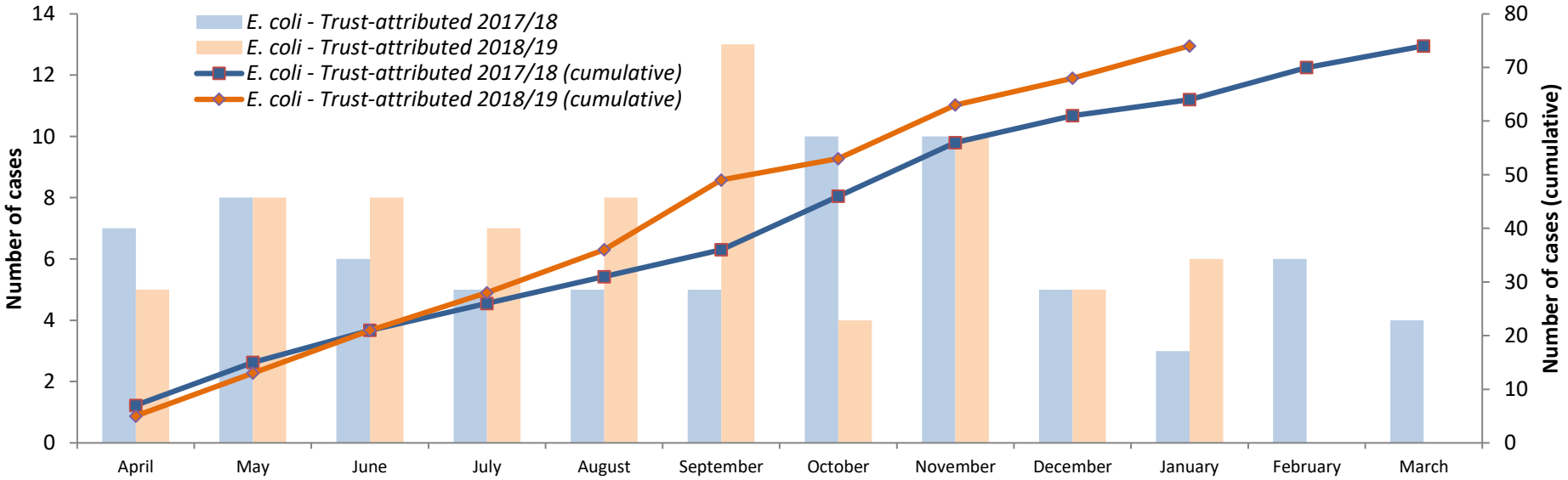
Key issues	***C.difficile*:** December 2018 saw one lapse in care of two Trust-attributable *C.difficile* cases, a patient on a Medicine ward overlapped with a second patient who was *C.difficile* positive, therefore a lapse in care due to transmission as the ribotypes for the two cases were the same. January 2019 saw one lapse in care of four Trust-attributable *C.difficile* cases. The patient on a surgical ward was identified as a lapse in care owing to lack of adherence to antibiotic policy, this has been followed up with the relevant clinicians.

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.

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)	5 - December 2018 6 - January 2019 YTD = 74	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Five cases of Trust *E.coli* BSI have been reported for December 2018, with six cases for January 2019. This makes a total of 74 cases for 2018/19, compared with 64 cases for this period in 2017/18. • Of the 11 cases - 5 had neutropenic sepsis, 3 urinary sources two of which had removal or manipulation of urinary catheter and 3 with hepatobiliary sources.
Return to target / trajectory	• 10% reduction target will not be met this FY 18/19

Safe – *E.coli*

Key issues	There were 11 cases of Trust attributable *E.coli* BSI in December 2018 and January 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). An internal IPC working group, led by the Deputy DIPC, has been exploring the available Trust resources relevant to reducing Gram-negative BSI through discussions with key stakeholders from the Nursing Directorate, and the Divisions. To date this has focused on hydration, continence, and promotion of early removal of catheters. High risk areas may require more detailed work on understanding the use of specific prophylactic antibiotics. Additional work centres on deciphering community drivers of hospital-onset Gram-negative BSI, done alongside the CCG.

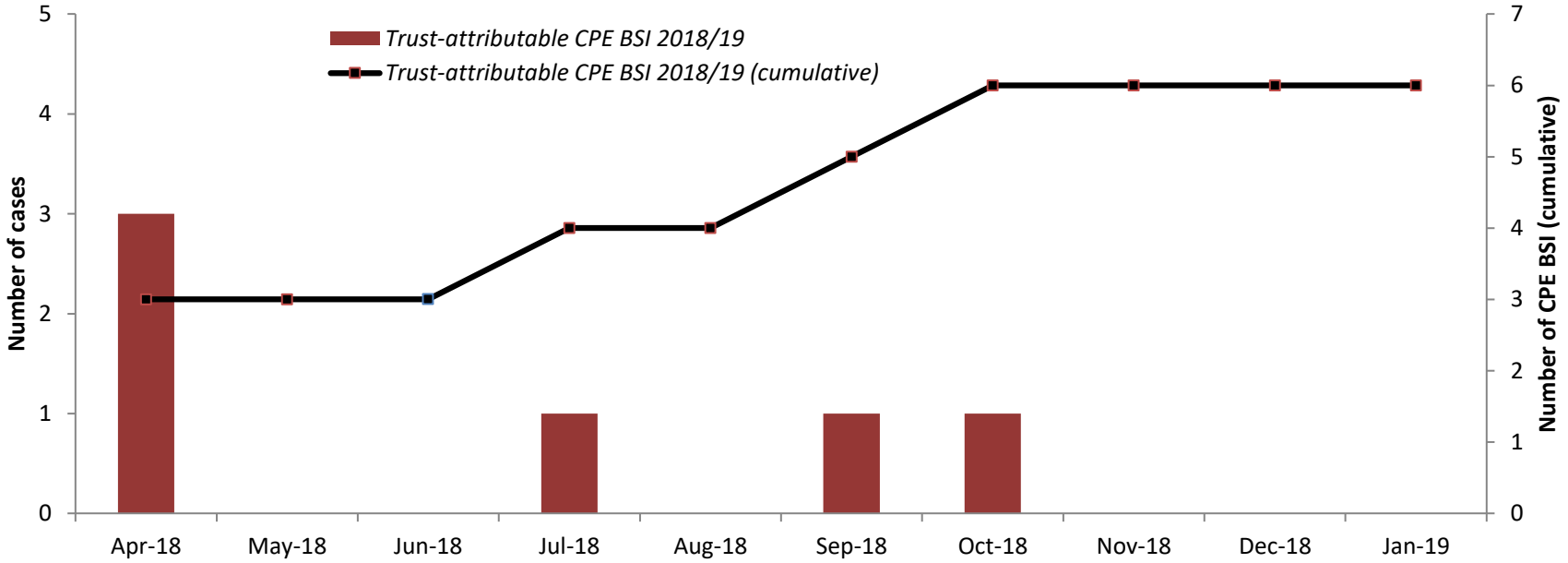
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify those cases with potential for prevention interventions.	Eimear Brannigan, Deputy DIPC	March 2019	Urinary catheter-associated Gram-negative bacteraemias to be initial focus. Scoping of current Trust monitoring of urinary catheters / participation in LUTS Big Room. Share with Divisional colleagues existing NHSI resources for prevention interventions.
Review high risk areas (haematology, renal, NICU for example) for Gram-negative bacteraemias and identify potential prevention initiatives.	Eimear Brannigan, Deputy DIPC	March 2019	Surveillance of bacteraemias established in these units. Ongoing monitoring and review of cases to identify prevention strategies. *Timescale extended to Q4.*

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 - December 2018 0 – January 2019 YTD = 6	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	Zero Trust-attributable CPE BSI cases were identified in December 2018 and January 2019. We have seen six CPE BSI cases YTD 18/19 as compared to six cases this time last year 17/18. The 6 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 this FY 18/19

Safe - CPE

Key issues	There have been six CPE BSI cases this FY 2018/19, with zero cases for December 2018 and January 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 we aim to develop a daily report of the number of patients with CPE current in the hospital, and their location, with support from the Cerner/IT and microbiology teams. A review of six 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	April 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	End- March 2019	The tool offered by Cerner does not meet the original specification and is being redesigned.

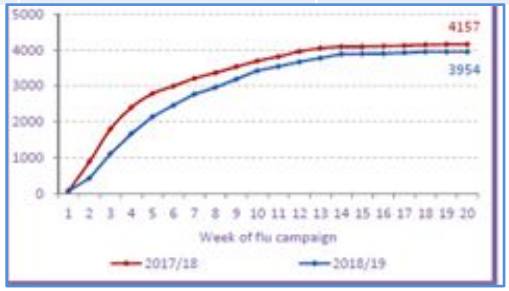
Risk

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

Safe – Flu vaccination

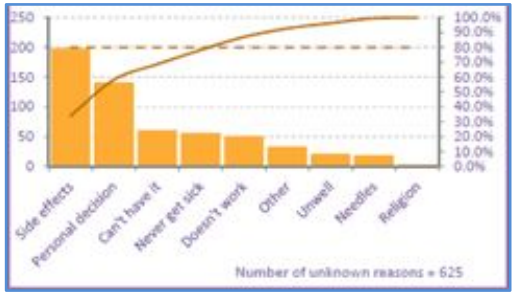
Indicator	Target	Latest data	Executive lead	Report author(s)
We will meet flu vaccination targets for frontline workers	75%	53.3%	Kevin Croft, Director of P&OD	Elaine Fry, Flu Campaign Programme Manager

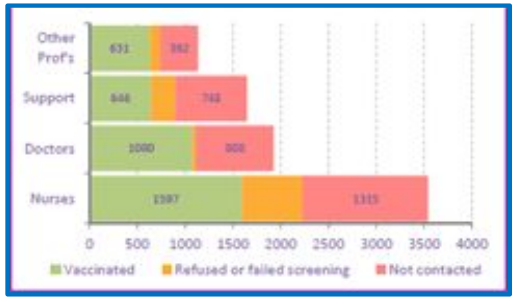
This graph reflects vaccination rates up to 31st January 2019, and compares vaccinations rates for two Campaign years

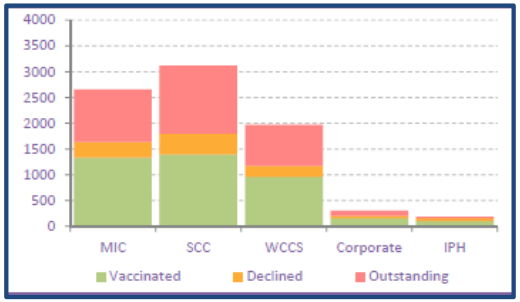


Latest performance

Of the 8974 frontline health care workers, 1064 members staff declined the vaccination for a number of reasons, as demonstrated below left. The myths and concerns about the vaccine is an area that is being address and this work will continue into next years campaign, recommendations are being built into the lessons learnt and close down documents.







The Graph in the middle demonstrates % of healthcare workers (HCW) who have had the flu vaccination by profession with the graph on the right demonstrating this breakdown by Division. The table below reflects the NHSe data submissions as at 11th February 2019. There is a small variance between this and last years vaccination rates as demonstrated by the graph above

Month	Frontline Staff	Vaccinated	%
October	8330	2208	26.5%
November	8712	3938	45.2%
December	8740	4353	49.8%
January 2019	8974	4779	53.3%

Return to target / trajectory

The final submission to NHSe is the 11th March 2019 for this years flu Campaign.
Up to this point, communication to staff will continue. A mailing to staff who have not responded so far was sent out in early February; 200 staff members have responded so far and this number will be reflected in next month's report.

Safe – Flu vaccination

Issues and root causes	Take up of the vaccination across London has been low this year, a milder climate and limited national news have contributed to lower vaccination numbers. NHSe continue to look at how they can support trusts to encouraging staff to have the vaccination. Internal Communication (emails and myth Busters) have been used to encourage staff to have the vaccination.

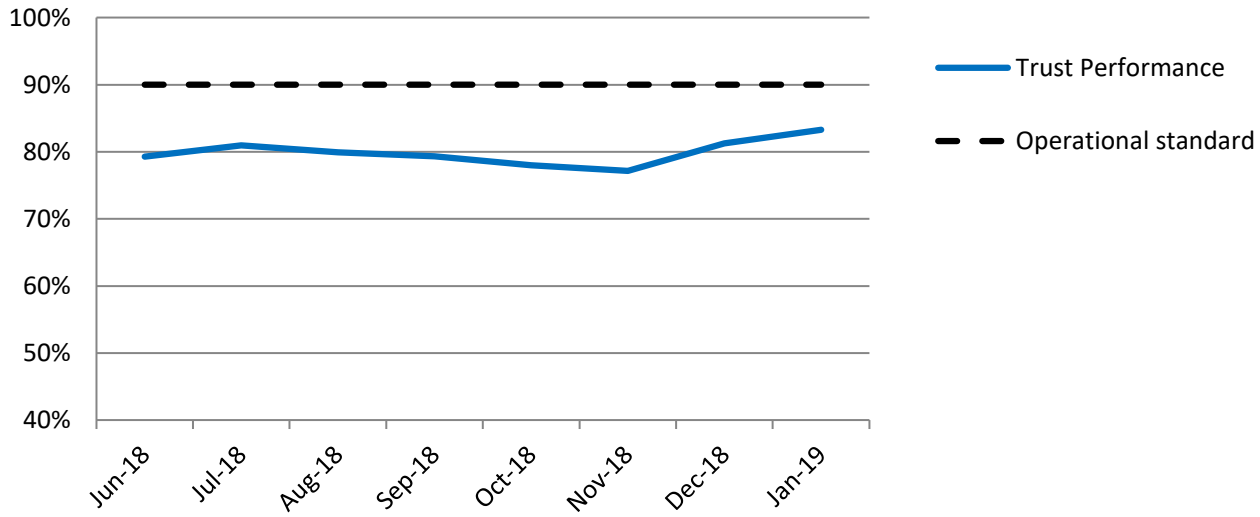
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Maintain and develop ongoing staff communication plans. Including Emailing staff who have not had the vaccination. Updated screen savers and Intranet with regular Flu updates and posters	Data intelligent (emails) Intranet (communications) Flu Campaign team	Early February 2019 Life of the campaign	• Email sent out 1st week of February - 200 staff members have responded so far and this number will be reflected in next month's report.
Co-ordinate attendance Peer vaccinators to areas with low take up, including any off site locations	Flu Campaign team	Life of the campaign	• On going proactive booking and co-ordination of vaccinators attending:
Undertake weekly briefing sessions with Divisional Flu leads to discuss progress and actions plans for the upcoming week, providing the executive (ETM, EPOD) with regular updates on progress	Kevin Croft	Life of the campaign	• Progress is tracked and documented at the weekly huddles.
Addressing myths and reasons staff are declining vaccinations	Flu Campaign team/ Communications team	Life of the campaign	• Liaising with NHSe for initiatives that have worked in other trust. • Writing and maintaining a myth busters which are included in communications out to staff through the communications team

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

Safe – Safeguarding children training (level 3)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90% or greater	January 2019 performance was 83.3%	Janice Sigsworth	Guy Young Deputy Director – Patient Experience

Percentage of eligible staff who are complaint with level 3 children safeguarding training



Latest performance	• Compliance increased slightly in January and subsequent updates on Wired is showing that this upward trend is continuing
Return to target / trajectory	• Action within the divisions has ensured that attendance at level 3 sessions has increased. This has been monitored weekly through the Improving Care Programme Group. It is expected the target of 90% will be achieved by the end of March.

Safe – Safeguarding children training (level 3)

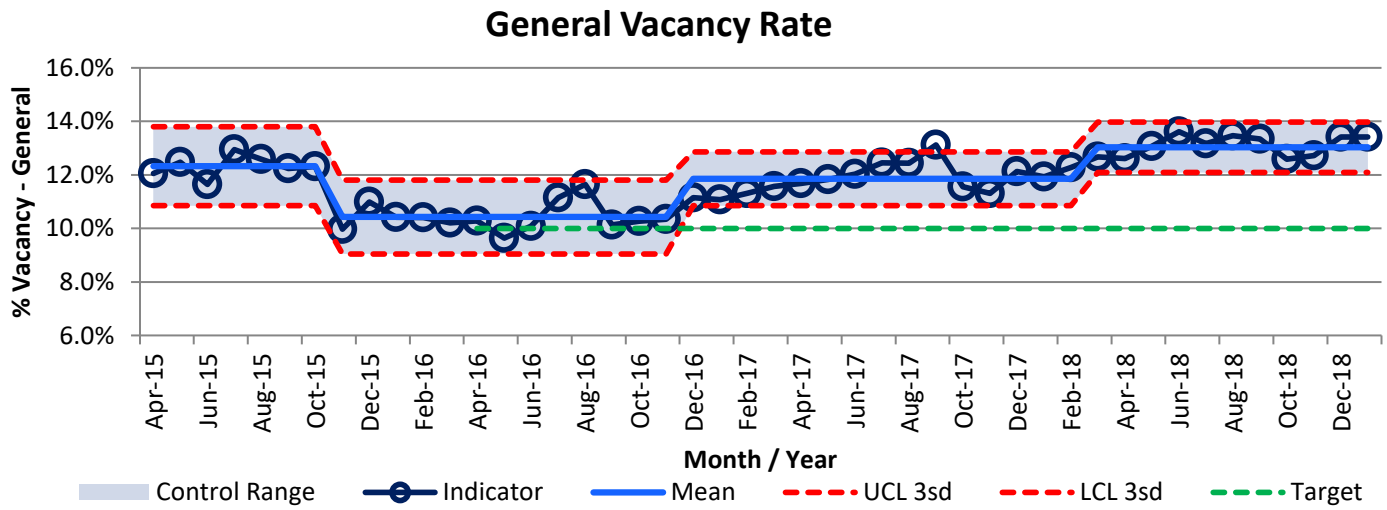
Issues and root causes	Level 3 training requires attendance at a classroom based session. We are providing the shortest session possible to meet the current Intercollegiate requirements, but it seems to be a challenge for staff to be released.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Provide adequate training places to meet requirement	SG children's team	By April 2019	• Sessions planned and set up on Moodle (i.e ready to be booked on)
Ensure staff and managers know who is non-compliant	All	By Jan 2019	• Reports available on Wired
Explore alternative methods of training	Deputy director – patient experience	By Jan 2019	• A plan for a blended learning approach has been agreed to commence in 19/20 once a baseline level of compliance has been achieved.

Risk register
Is it on the (divisional / corporate) risk register? General compliance with stat/man training in CQC risk 2472 on corporate risk register.

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	January 2019 position was; All Trust 13.3% All N&M 15.5%	Kevin Croft, Director of People and Organisational Development	Dawn Sullivan, Deputy Director of People and Organisational Development



Latest performance	• at the end of January the vacancy rate was 13.3% reflective of 1,475 WTE vacancies; 373 WTE non-clinical roles and 1,103 WTE clinical roles • the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,610 WTE; an increase of 15 WTE from those employed in November • for all nursing & midwifery roles, the vacancy rate was 15.5% (816 WTE vacancies); marginal increase from November due to establishment growth to support additional beds
Return to target / trajectory	• the projection is that we will hit the 13% N&M vacancy rate target by the end of May 2019 based on current activity and establishment • the 10% overall trust vacancy rate target is projected to be met by the end of May 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 15.3%. 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

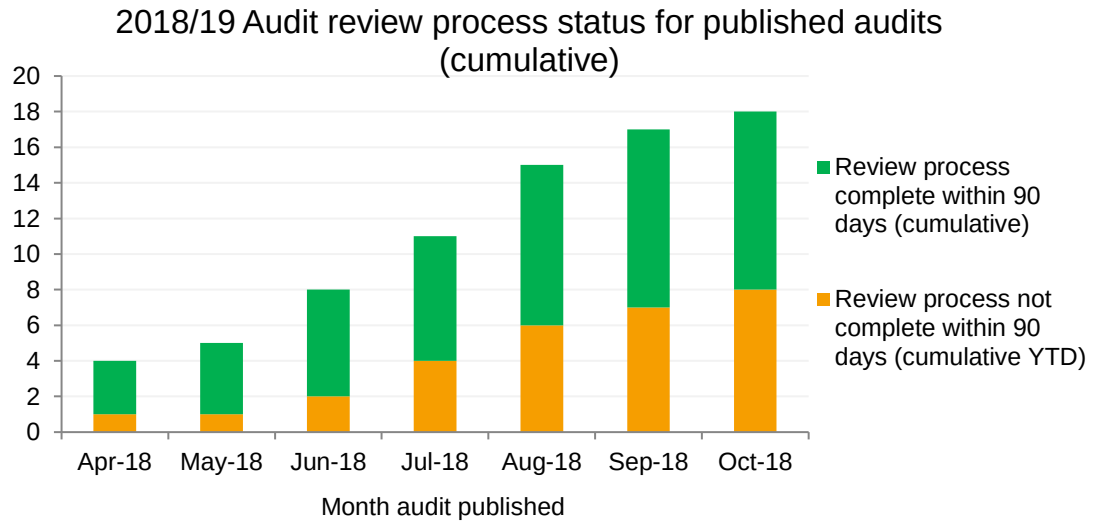
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
There is a Recruitment & Retention Action Plan in place for Band 2-6 N&M staff	Dawn Sullivan	1-3 years	• The plan has been refreshed for 2018/2019 and to date has delivered an increase in student retention to 75% an increase 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 300 plus recruits to date. 15 are already with the Trust
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan/ Sue Burgess	1 year	• A plan was submitted in August, NHSI are visiting on 24th July to discuss the plan
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust is recruiting on average 85 N&M staff each month against an average t/o of 60 N&M staff each month. The big ticket items in the plan are students, international recruitment and Band 5 and HCA talent pools . From April onwards we plan to recruit 100 N&M staff each month

Risk register

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

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% – October 2018 8 - as at October 2018 (of which 5 have been completed but not within 90 days, and 3 are overdue and have 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 October 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. Eighteen National audits were published up until the end of October 2018. All of these were relevant to ICHT. The review process was completed within 90 days for ten of these audits. Of the remaining eight, five reviews have now been completed, but were not done in 90 days and three are 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 Trust target of 90 days, although progress is being made. Of the eighteen audits published between April-Oct 2018, fifteen have completed reviews. Ten of these were completed within the required timeframe. All audits from 2017/18 have now completed the internal review process. 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. A paper outlining SCC's decision to not participate in BAUS was reviewed separately by ExQu in February; further details were required from the division and this is due to be discussed with the medical director in March. As we will not have participated in either audit this year, this position will need to be explained in the quality account.

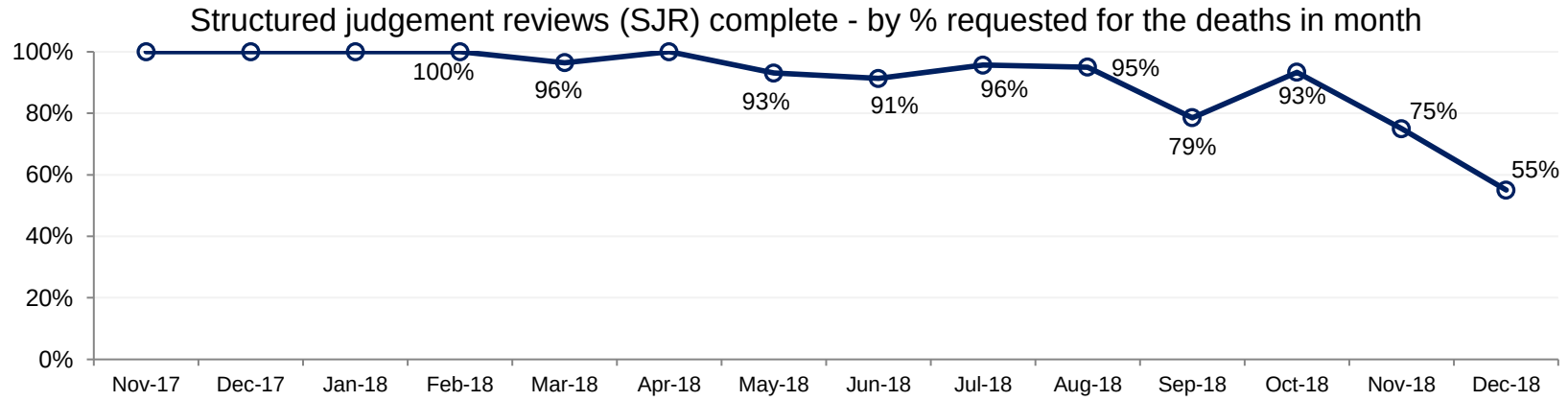
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
All significant risk audits to have an action plan in place that is presented to the quality & safety subgroup.	Raymond Anakwe/Audit Leads	On-going	Four audits from 2017/18 were identified as 'significant risk/little assurance'. Action plans were presented to the quality & safety sub-group and are monitored through the divisional Q&S committees. So far, no audits from 2018/19 have been identified as significant risk.
Low risk and acceptable risk audits to be presented at divisional quality and safety committees.	Audit Leads	On-going	On-going. So far, eleven 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 February 2019	Divisions provide regular updates based on discussions at divisional quality & safety meetings. A revised escalation algorithm will be developed and appended to the Trust audit policy.
The internally set timescale for completion of the review process (90 days) to be reviewed	Clinical Auditor/Improvement Programme Manager – Safety	November 2018	Complete. A review of the internal target to review National audits took place with the divisions. It was agreed at the November CAEG that the internally set timescale for completion of the review process will remain at 90 days.

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)

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: 75% November 2018 55% December 2018	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager



Latest performance	• The chart above 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. 156 completed reports have been received to date for this financial year (18/19), out of 179 requested, meaning 87% of SJRs have been completed YTD. In month compliance for SJRs is 75% for November and 55% for December 2018, against a target of 100%. This is a slight improvement on the position reported in November, and a significant improvement on October's position. Trust compliance for local level 1 mortality review is 88% for November and 77% for December 2018, against a target of 100%. • Following feedback at board quality committee, we are reviewing how this data is presented so that progress in completing the reviews is better represented. We will move to reporting from date of death to date of SJR request. This will take effect in Q1 2019/20. We are also reviewing this metric as part of the refresh of the IQPR; we are proposing to change this to measure the number of SJRs which breach the 30 day timeline for completion as this will allow us to monitor performance in a more transparent manner.
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. All overdue SJRs are expected to be completed by the end of the April.

Effective – Mortality reviews

Issues and root causes	Cases are reviewed at the monthly Mortality Review Group with a focus on any avoidable factors and learning themes. A review of how data and intelligence from the mortality reviews could be utilised more effectively to inform safety improvement work and reduce avoidable harm as part of the quality account improvement priorities is currently underway. Six 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	March 2019	39 members of staff have undergone structured judgment review (SJR) training, an increase of 2 from the previous report. We are undertaking an analysis of the capacity of the current cohort of reviewers which will allow us to identify the optimum number of reviewers required to completed SJRs on 15% of deaths. This will be completed by the end of March.
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	March 2019 (originally Oct 2018)	A SOP to formalise the process for triangulating data was reviewed at sub-group in November 2018 and this is being used, however issues were raised including the need to modify the SI process when there is a death to ensure the SJR and SI investigations are joined up. A review of cases where the SI and SJR have identified different findings is being undertaken as a learning opportunity to enable a triangulation process to be agreed going forward. This will be completed in March 2019.
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Auditor	March 2019	Report presented to the October Quality & Safety subgroup with a number of actions required from the divisions before this action can be closed. This will be monitored through the sub-group. The next report will be presented to sub-group in March 2019.
Undertake review of the mortality processes	General Manager, MDO	March 2019	Review completed in January 2019.. A Learning from Deaths steering group, which includes the divisional governance directors, has been established to oversee 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

December Position

(M9 Dashboard data release on NHS Digital)

Hip Replacement		Knee Replacement	
Participation Rate	**Reported Health Gain**	**Participation Rate**	**Reported Health Gain**
December 2018 - 100%	EQ-5D Index:0.462 EQVAS:19.588 Oxford Hip score:23.060 (Provisional Quarterly PROMs April 2017-March 2018 report - August 2018 release)	**December 2018 - 100%**	EQ-5D Index:0.304 EQVAS: 8.402 Oxford Knee score:13.918 (Provisional Quarterly PROMs April 2017-March 2018 report - August 2018 release)

Latest performance

PROMs M9 December data release on NHS Digital reports the participation rate for Hip and Knee replacement procedures at 100%.

The tables below provides a comparison of the hip and knee replacement adjusted average health gain score, and improved and worsened scores for the Trust with the national average. The EQ VAS score is above national average for both procedures; EQ-5D Index is consistent with the national average score for both procedures; Oxford Hip score is consistent with the national average and there is scope for improvement for Oxford Knee score.

Hip Replacement

		Adjusted Average Health Gain	Improved	Worsened
EQ-5D Index	Trust	0.462	84.2%	7.9%
	England	0.46	89.80%	4.90%
EQVAS	Trust	19.588	76.9%	17.9%
	England	13.53	67.5%	22.5%
Oxford Hip score	Trust	23.06	95.3%	4.7%
	England	22.138	96.9%	2.6%

Knee Replacement

		Adjusted Average Health Gain	Improved	Worsened
EQ-5D Index	Trust	0.304	82.8%	12.9%
	England	0.338	82.6%	8.4%
EQVAS	Trust	8.402	65.1%	24.1%
	England	7.938	59.1%	29.1%
Oxford Knee score	Trust	13.918	90%	8.0%
	England	16.971	94.2%	4.9%

Return to target / trajectory

On-going process

Effective – Patient reported outcome measures PROMs

Issues and root causes	Following the initiative to improve PROMs data management, a dedicated Band 7 nurse oversees the process to ensure submission rates are above 80% and contacting eligible patients to remind them to complete post op questionnaire. 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.

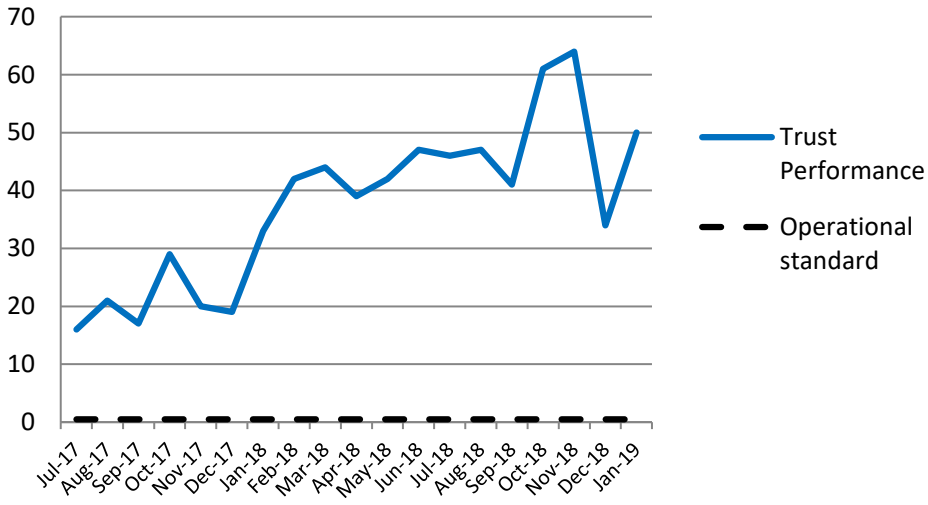
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Proposal being developed to contract new external supplier to replace Capita.	Anne Hall- GM /Lee Matthews – Procurement	Overdue	Three external suppliers shortlisted to present to Directorate. Further delays due to IG checks.

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

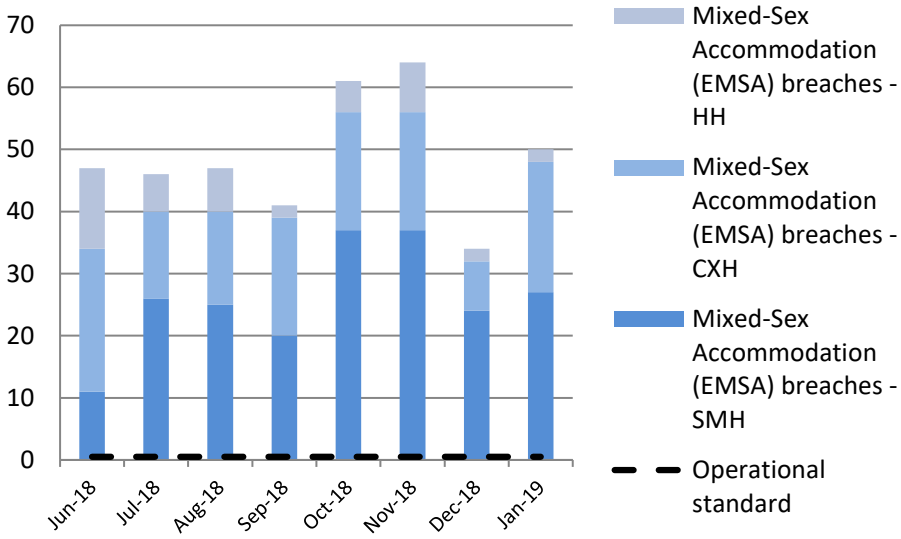
Caring - Eliminating Mixed Sex Accommodation (EMSA)

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)	Prof Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care

Mixed sex accommodation breaches



Mixed sex accommodation breaches (Site Breakdown)



Latest performance	The national standard is a target of 0 for 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 January 2019. The MSA breaches at SMH site have increased from July 18, following the co-location of HDU beds to Critical Care, and then again in Oct 18 as a result of increased activity during the winter months, reducing capacity across the Trust limiting downstream bed availability.
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 avoid mixed sex breaches.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

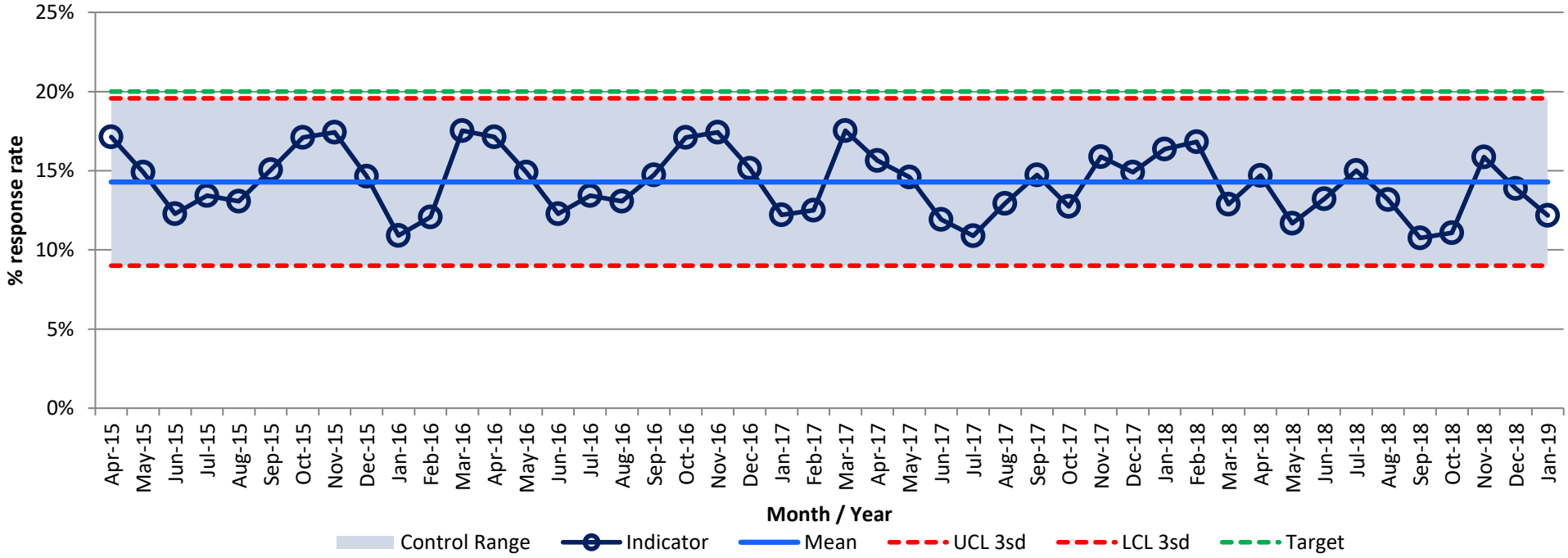
Issues and root causes	Breaches are incurred by patients awaiting step down from the Critical Care units to ward areas. Imperial appears to be an outlier for reported MSA breaches. Other Trusts report discharge delays from Critical Care but report fewer or no MSA breaches. The reason for this is unclear, as the two indicators are seemingly contradictory. The root cause of MSA breaches in Critical Care is 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 these 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 Critical Care would be to reduce step-down delays as this has benefits beyond resolving the immediate MSA concern. It is recognised however that this is dependent on downstream bed availability and bed allocation prioritisation. The delayed discharges from the ICUs will form part of the on-going Trust capacity and flow work.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
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.
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	March 2019	• Develop literature pack to provide information for patients on their right to be cared for in single sexed accommodation and explanation on why this is disrupted with delayed discharges in Critical Care. This will be written with the latest guidance subject to the release of updated national guidance.
Patient experience feedback	Melanie Denison	April 2019	• Develop a questionnaire for patients on step down wards to assess the impact of MSA breaches during their time on Critical Care.

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

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	January 2019 performance was 12.2%	Janice Sigsworth	Guy Young Deputy Director – Patient Experience



Latest performance	• Performance dropped across the board in January 2019
Return to target / trajectory	• It is proving exceptionally challenging to drive improvement in the indicator. A wide range of interventions have been put in place with little impact. It is unlikely the target will be met in this financial year.

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

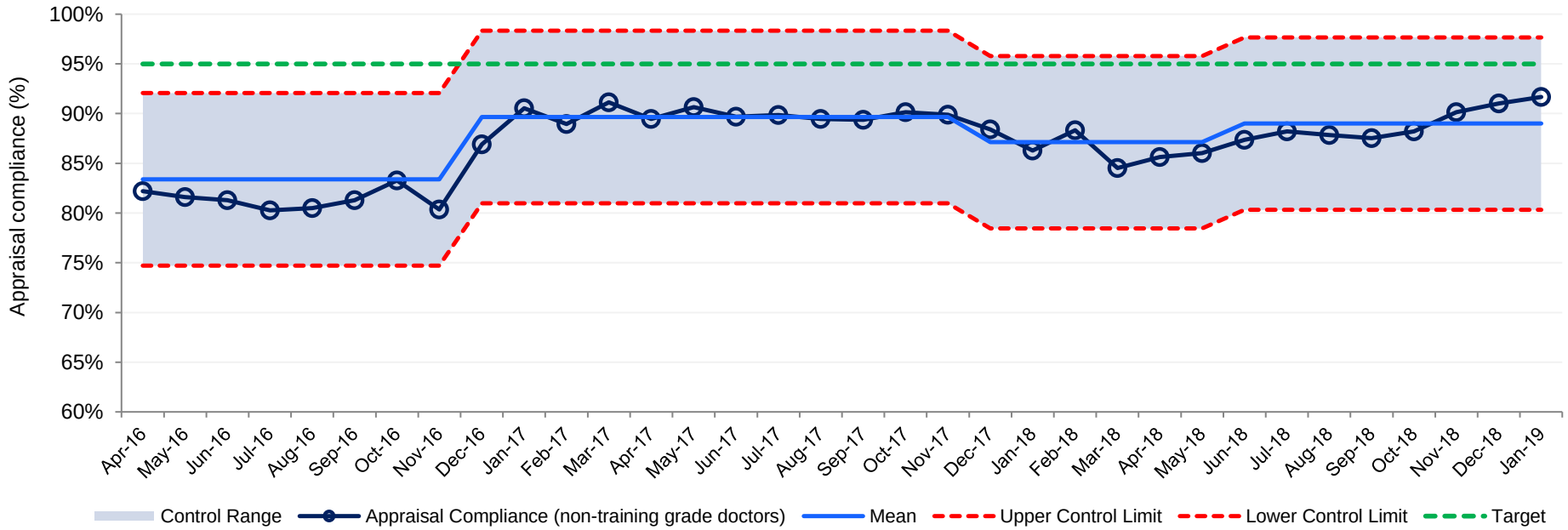
Issues and root causes	A paper setting out the challenges and issues was presented to ExQual in October 2018. This paper included a plan describing a number of actions to improve the rate, particularly at SMH. These are now in progress. To support sustained improvement the QI team will be running 90-day 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

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% - Dec 2018 91.7% - Jan 2019	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO

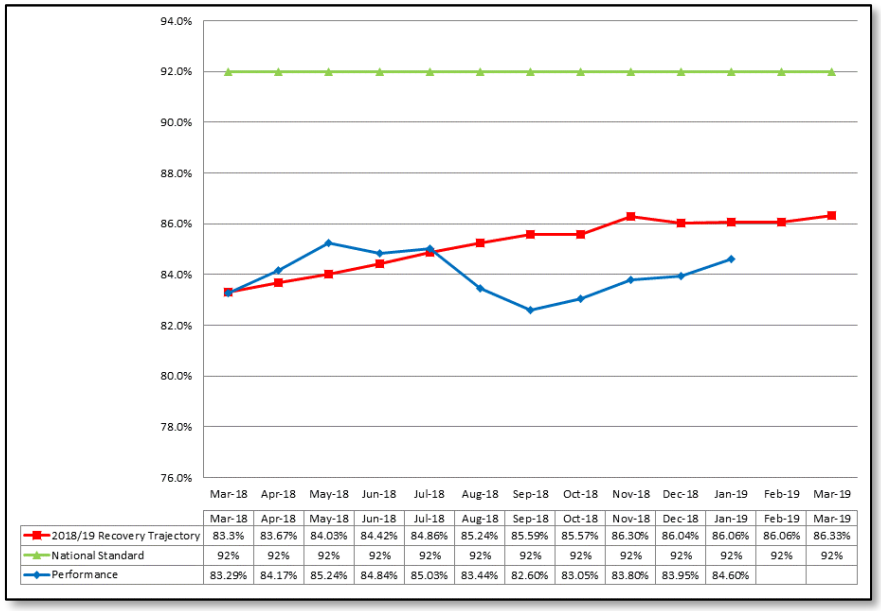


Latest performance	Performance continues to improve. At 91.7% it is the highest since April 2016. Consultant grade compliance is at 92.9% compared to 93.2% in December. Career grade compliance is at 88.4%, from 84.7% in December. The total number of appraisals overdue by more than six months is currently 33.
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.

Responsive – RTT 18 weeks

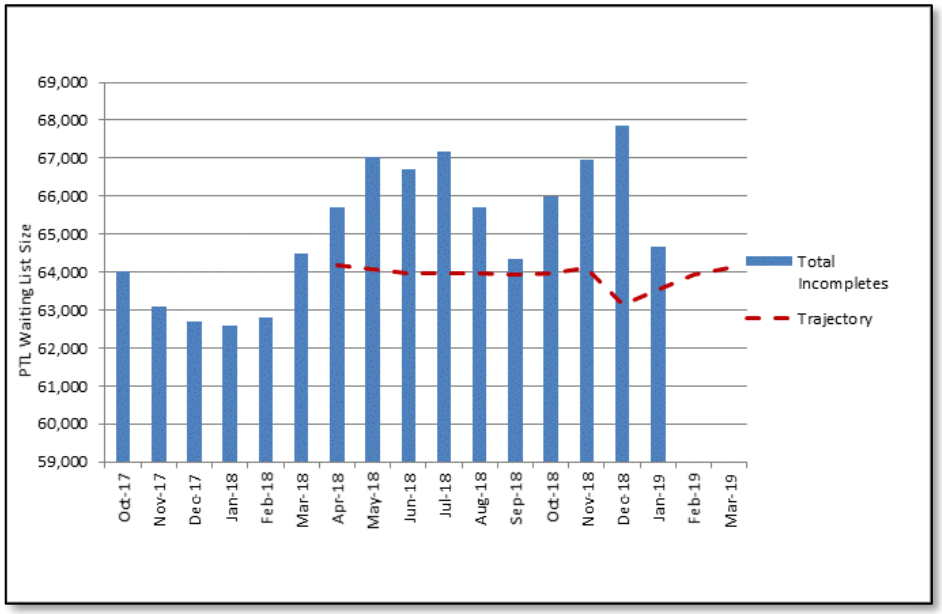
Indicator	Target	Latest data	Executive lead	Report author(s)
RTT incomplete performance target in line with the agreed trajectory for 2018/19	86.06% at end January 2019	84.6% at end January 2019	Prof Catherine (Katie) Urch	Steven Crouch, Performance Support Business Partner

RTT 18 Weeks



	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
2018/19 Recovery Trajectory	83.3%	83.67%	84.03%	84.42%	84.86%	85.24%	85.59%	85.57%	86.30%	86.04%	86.06%	86.06%	86.33%
National Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Performance	83.29%	84.17%	85.24%	84.84%	85.03%	83.44%	82.60%	83.05%	83.80%	83.95%	84.60%		

RTT waiting list size



Latest performance	The latest RTT submitted performance position is end January 2019 where 84.6% 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 86.06%.

Responsive – RTT 18 weeks

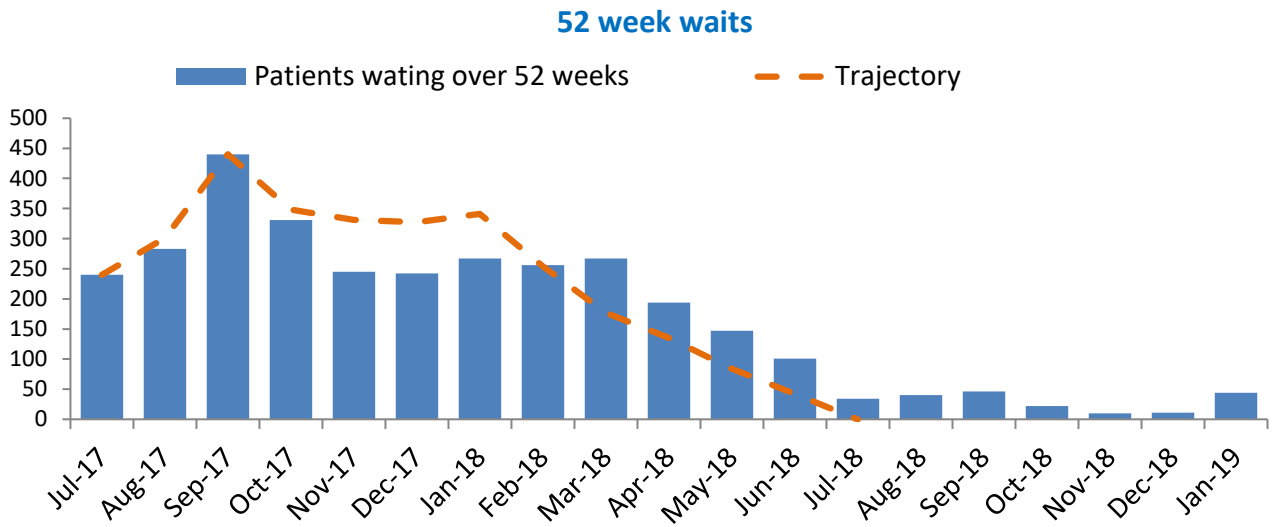
Return to target / trajectory	• The performance business support partner has continued to meet monthly with the "challenged" services. Of these services 4 have seen improvement in their RTT, and Neurosurgery has delivered over the 92% standard for the last two months. • The RTT Improvement Programme has developed and started to implement an elective performance framework with a focus on managing patient waiting times and the RTT PTL size. • The RTT PTL reduced in January to 64,660 from 67,860 in December (which had seen a growth from 66,953 in November). This area will continue to be focussed on through March to support compliance with ICHT Undertakings 18/19.

Key issues and actions	<u>PTL size</u>
	• A separate piece of work focussing on reducing the PTL size has been developed and this is being led by SCCS and monitored in weekly meetings to track the piece of work.
	
	<u>System errors</u>
	
	• The number of system errors has not returned to the level of 4,098 in June 2018 and in January 2019 there were 494 agreed system errors reported.
	• There are three phases of work associated with managing system errors and these are as follows:
	  • Phase one: Implementation of updated Data Warehouse logic 07/08 reduced volume from 3,870 (June 18 month end) to 2,306 (July 18 month end).
	  • Phase two: Cerner fix applied week commencing 08/10 didn't have an immediate impact on the backlog of system errors but reduced the number being created from that point onwards.
	  • Phase three: Further dialogue with Cerner has identified additional fixes to resolve two more scenarios of System Errors. The Trust is working with Cerner to identify a timescale for testing and deployment. A recent audit has confirmed a reduction in system errors, now tracking at 3%.

Risk register
• 2510 Failure to maintain key operational performance standards

Responsive – RTT patients waiting 52+ weeks

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the number of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0 at end January 2019	At end January 2019 44 patients were waiting 52+ weeks	Prof Catherine (Katie) Urch	Jan Palmer, Elective Care Delivery Manager; Steve Crouch, Performance Support Business Partner



Latest performance	The Trust reported 44 patients waiting >52-week in January 2019; this was an increase of 33 from the previous month. • Of the 44 patients waiting over 52 weeks at the end of January, 35 were related to the ophthalmology email account incident.
Return to target / trajectory	The Trust is forecasting to be 0 (with the exception of pop-ons) by the end of April 2019 Forecast breakdown: February: 54 (increase relates to the ophthalmology incident and the number of validation letters that do not expire until March) March: 12 April: 0

Responsive – RTT patients waiting 52+ weeks

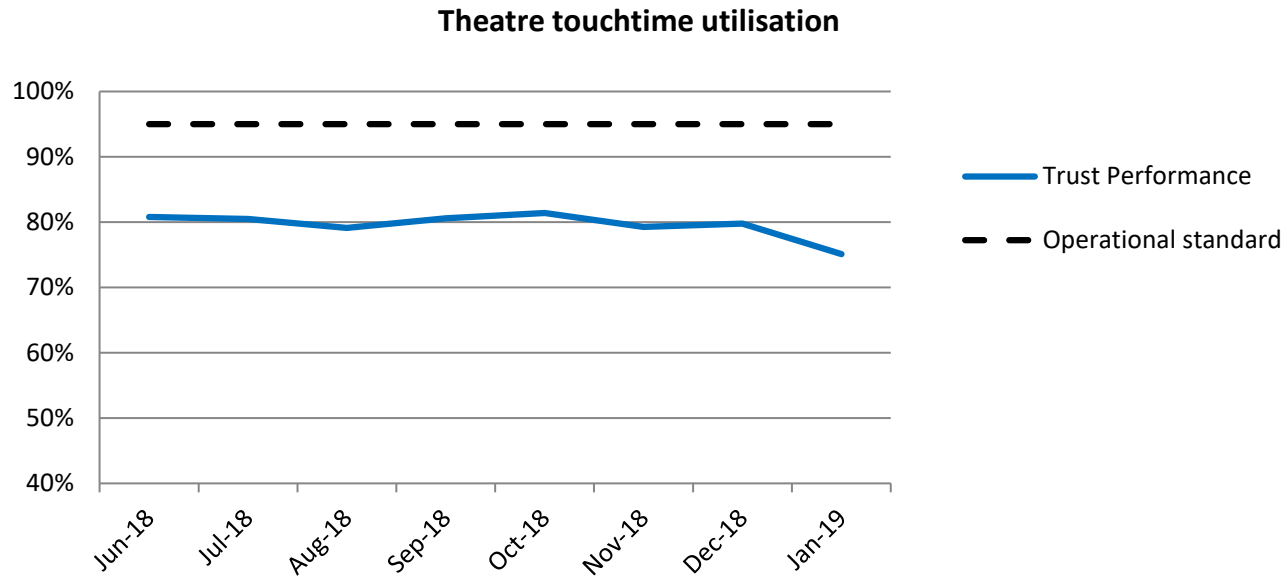
Issues and root causes	• Some challenges to reach the zero trajectory target due to patient choice and on the day cancellations in January • A number of complex patients were rescheduled/cancelled due to lack of HDU beds • Incorrect clock stops being corrected , administrative error and pop-ons continue and work with the Elective care Training Team is on-going to improve this • The number of 'system errors' appearing through the validation process has improved and work continues to eradicate these issues. However: • The sustained review and provision of RTT training aims to improve knowledge and application of RTT • The use and development of validation tools is providing greater visibility of progress within services • There is on-going review and monitoring of the Trust's 52 week wait position and weekly SRO oversight • All patients waiting over 52 weeks continue to be reviewed for clinical harm in line with the agreed validation process. The clinical harm review of the December 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
RTT Improvement Action Plan – system , processes and people	Catherine Urch/Martina Dinneen	Monthly Steering Group	• Improved oversight and monitoring of forecast and provisional position at Elective Care Delivery meeting to ensure that both NHSI, CCG and Trust are informed and appraised • Comprehensive plan addressing education, validation and performance improvement.
SRO meetings in place to support challenged services	Catherine Urch/Jan Palmer	Weekly March 2019	• Challenged specialties are forecasting an improved position by end of March 2019 with significant progress in January.

Risk register
• 2510 Failure to maintain key operational performance standards

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%	75.1% January 2019	Prof Catherine (Katie) Urch	David Woollcombe-Gosson (Programme manager surgical productivity)



Latest performance	Touchtime utilisation in January was down on the Q3 average at 75.1%. This was however 0.97% better than January 2018, largely due to improvements in session utilisation (91.54% of planned sessions ran) and an ongoing focus on improving scheduled time. This was counter-acted, however, by an increase in last minute cancellations during the month (13.15% of scheduled elective procedures). Notable, albeit seasonally anticipated, increases were seen in cancellations for patient reasons (including DNAs), patients unfit for surgery and no bed available (both ward beds and ICU).
Return to target / trajectory	An improvement trajectory is under development. A slight but steady improvement in performance of approximately 1% p.a. is apparent since mid 2016. Workstreams within the theatre improvement and subsequent surgical productivity programmes have accelerated this trend during the second half of 2018, but it is not yet clear to what extent and how quickly a step-change in productivity can be achieved.

Responsive – Theatre management (touchtime utilisation)

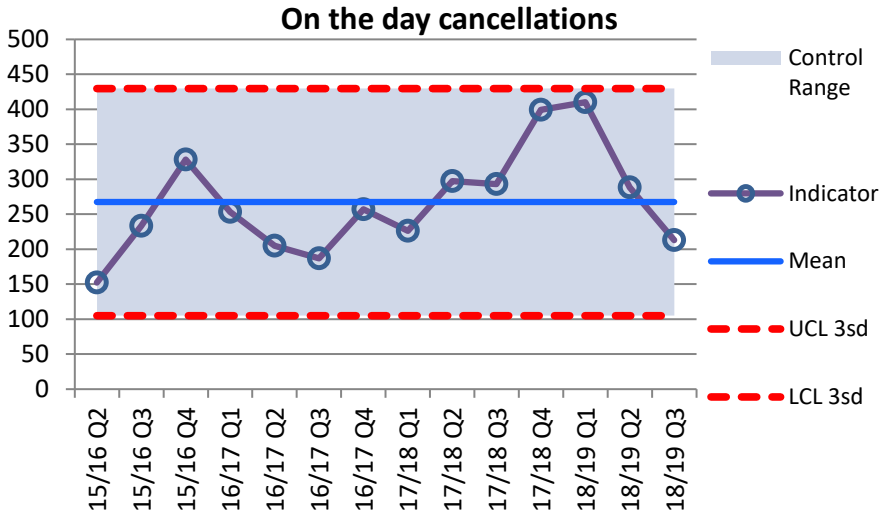
Issues and root causes	Initial programme analysis identified that the most significant area of productivity opportunity lay in more efficiently or effectively scheduling theatre lists – both the volume of patients booked and the 'quality' of booking the right, properly prepared, patients onto the right theatre lists and in the right order. The broad theme to date has therefore been on enhancing staff knowledge, coordination and information flows between pre-operative assessment, schedulers, surgical specialties and theatres. Collectively, this work has started to improve oversight of elective theatre activity, session utilisation, and assurance that lists will run efficiently which, in turn, has improved the ability of scheduling staff to plan and build theatre lists properly.

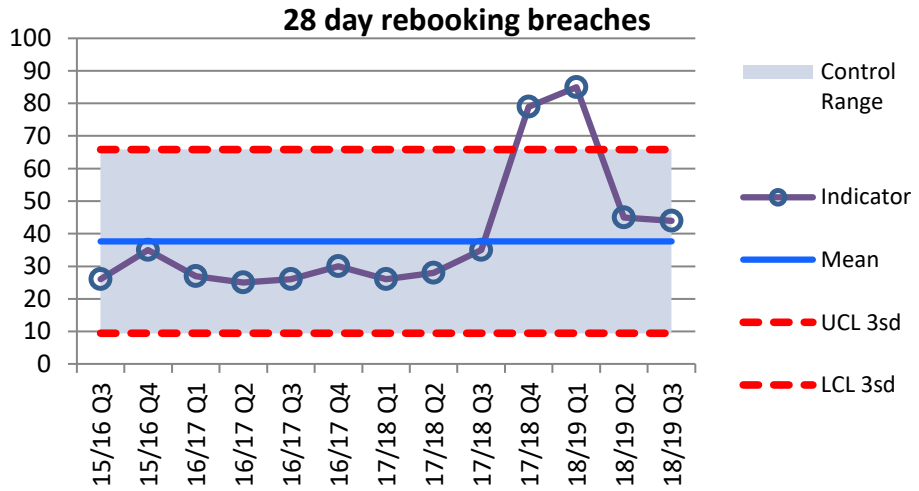
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Surgical productivity programme (overall coordination – high-level workstreams shown below)	Prof C Urch (Executive SRO)	Established June 2018	Programme activity in January focussed on continuing to embed new ways of working in their pilot sites, and beginning the process of expanding implementation where this will be helpful. The SIC and DSU workstreams supported by Johnson & Johnson Medical completed their implementation phase and have now entered a 12-month evaluation phase. In parallel, the POA workstream have started an evaluation of the pilot staff education & coordination MDT and have developed a high-level model for the future state of the service, which is now being aligned with the Surginet end-to-end review and new OEF workflow. As project initiatives and lessons identified mature they are being shared with other sites, and workstreams are now being established at SMH, CXH and HH (the latter supported by J&J). This work is also being coordinated with the PSC where there is an impact on theatre planning and list scheduling. This work is being supported by reviews of Cerner workflows for procedures times and cancellations reporting.

Risk register
• 2510 Failure to maintain key operational performance standards

Responsive – Cancelled operations and 28-day rebooking

Indicator	Target	Latest data (at Q3)	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 1.0%) 28-day breach rate: 21% (above national average of 8%)	Prof Catherine (Katie) Urch	Terence Lacey (Performance Support Business Partner); David Woollcombe-Gosson (Programme Manager, Surgical Productivity)





Latest performance (*This indicator tracks nationally reportable on the day cancellations, i.e. those where a patient's operation is cancelled by the hospital at the last minute for non clinical reasons. In these cases the hospital should offer another binding date within a maximum of the next 28 days*)	The latest reported quarter is quarter ending December 2019: • There were 213 reportable cancellations, equating to less than 0.7% of total elective admissions. This continued improved position remained below the national average which was 1.0%. • The Trust sustained an improved position in the time to rebooking patients however the overall rate remains relatively high. In Quarter 3, 44 breaches were reported (45 in Q2) which was a 28-day breach rate was 20.6%, above the national average of 8.3%. There appeared to be some seasonality with nearly half (21) of the 44 rebooking breaches in Q3 occurring December. *Source: Quarterly Monitoring of Cancelled Operations (QMCO), NHS England*
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	OTD non-clinical cancellations and 28-day breaches increased during the early part of 2018. This was related to the national mandate to support emergency pathways through temporary postponement of non-urgent elective activity and continued operational pressures. Performance for both metrics has improved. 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 of patients whose operations are cancelled. The Division of SCC have recently approved a Performance accountability framework via the January 2019 Executive Committee for Operational Performance. Within this framework the expectation is that cancellations and 28-day rebookings can be tracked at speciality level.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Develop On the Day cancellations Standard Operating Procedure	David Woollcombe-Gosson	Q3 2018/19	A draft OTD cancellations SOP has been drafted and is being prepared for wider roll out. This is dependent on updating cancellation reasons within Cerner to enable reliable capture. A revised list has been agreed a change request is being prepared (for the joint Imperial and Chelsea and West Change Board).
Strengthen review of OTD cancellations and tracking of 28-day re-book patients	Gareth Gwynn / Jan Palmer	Q3 2018/19	Performance to be highlighted by exception through the accountability and performance framework (agreed by ExOp January 2019). Meetings commenced February 2019..
Design and implement robust weekly process to highlight potential breaches on the 28-day patient tracker	Terence Lacey, Performance Support Team	June 2019	Business Manager recruited in Performance Support Team and in post (25/02). This will provide a direct point of contact with service reps on the 28-day patient tracking list to highlight and action plan potential breaches.

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

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	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.

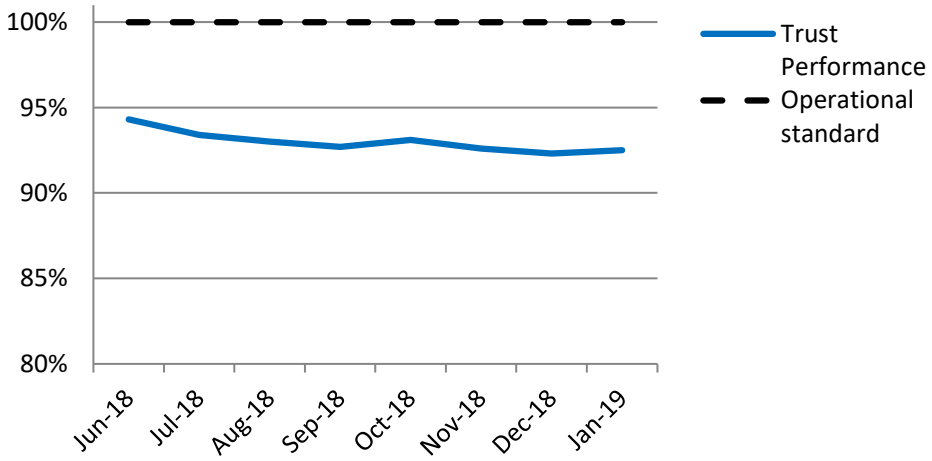
Risk

- Is it on the (divisional / corporate) risk register? Yes

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%	92.6% (November 2018)	Prof Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care

Percentage of critical care admissions, admitted within 4 hours



Site	December 2018 performance	January 2019 performance
CXH Critical Care	88.8% (YTD 91.8%)	93.3% (YTD 91.9%)
HH General Critical Care	85.4% (YTD 90.9%)	75.7% (YTD 89.7%)
SMH Adult Critical Care	98.1% (YTD 94.9%)	97.3% (YTD 95.2%)
All Units Combined	92.3% (YTD 93.0%)	92.5% (YTD 92.9%)

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 in this metric for the SMH and CXH site. At HH performance for the GICU has deteriorated due to high occupancy on the ward from Nov 18 – Jan 19. One of the key benefits of the Critical Care co-location at SMH has been the improvement in ICU admission time (of patients within 4 hours).
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.

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.

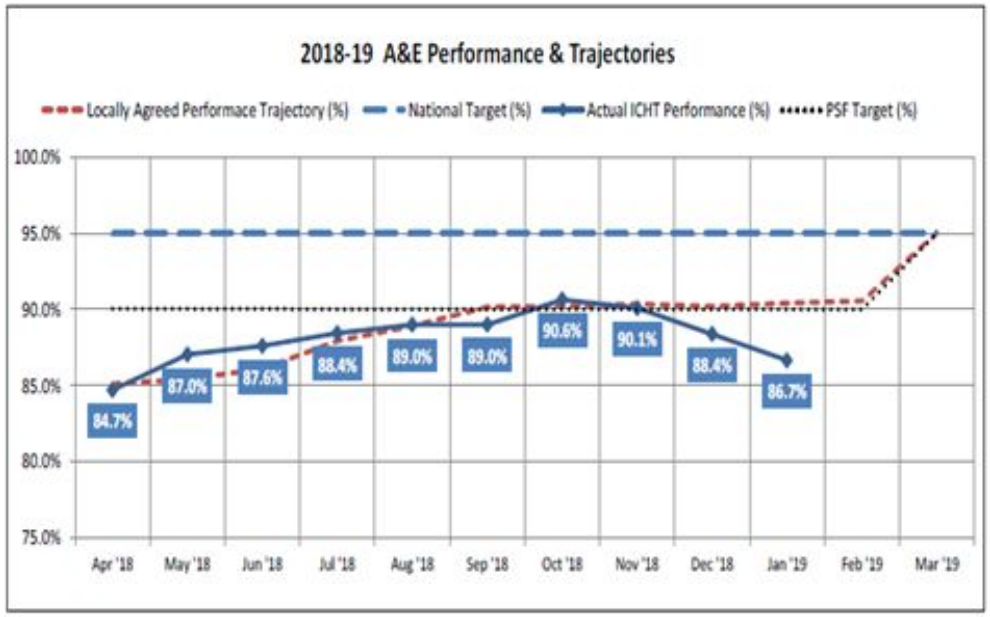
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Early preparation of potential and confirmed discharges in Critical Care	Claire Gorham	March 2019	• SOP being developed to define clear process for de-escalation of care in preparation of discharge. Draft out for consultation.
Identification of surgical pathways with quick turnaround and discharge straight home	Felicity Bevan	March 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
Potential harm review of patients with delayed admission to Critical Care	Roseanne Meacher	Completed Jan 2019	• Clinical review of any patients with delayed admission to a Critical Care unit.
Trust wide of prioritisation of Critical Care flow.			• Agreement within the system to prioritise admissions and discharges within Critical Care with increased priority when Critical Care on black capacity status.

Risk register

This risk is 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	90.4% at end January 2019	86.7% at end January 2019	Dr Frances Bowen	Sarah Buckland, Performance Support Business Partner



Trust	Jan-19	Jan-18	Variance Jan-18 to Jan-19
Attendances	25,363	24,689	+ 674 (2.3%)
Breaches	3,380	3,670	- 290 (7.9%)
Performance	86.7%	85.1%	+ 1.6%

Activity and attendances in January 2018 compared with January 2019

Latest performance	• Performance against the 4 hour standard was 86.7% in January 2019, 3.7% below the local trajectory. • January 2019 performance was 1.6% higher than January 2018 and Type 1 performance was 5% higher. • This is against increased numbers of A&E attendances: ○ Attendances were 2.3% higher overall than in January 2018 and 4 hour breaches 7.9% lower (shown in the above table). Type 1 attendances were 7.4% higher with performance 4.9% higher, with increases seen at SMH in both adults and paediatrics.
Return to target / trajectory	• Recent pressures across the system highlight that, whilst we are in a better position this year compared with the same period last year, there is further work to do to maintain performance at 90% through February and March. The areas for priority focus during February and March 2019 are reducing the number of long stay patients, non-admitted ED pathways and ambulance handover times. The outline programme for 2019/20 Care Journey and Capacity Collaborative has been agreed and the full plan will be presented to the Executive Committee for Operational Performance for approval in March 2019. This is central to delivery of the trajectory.

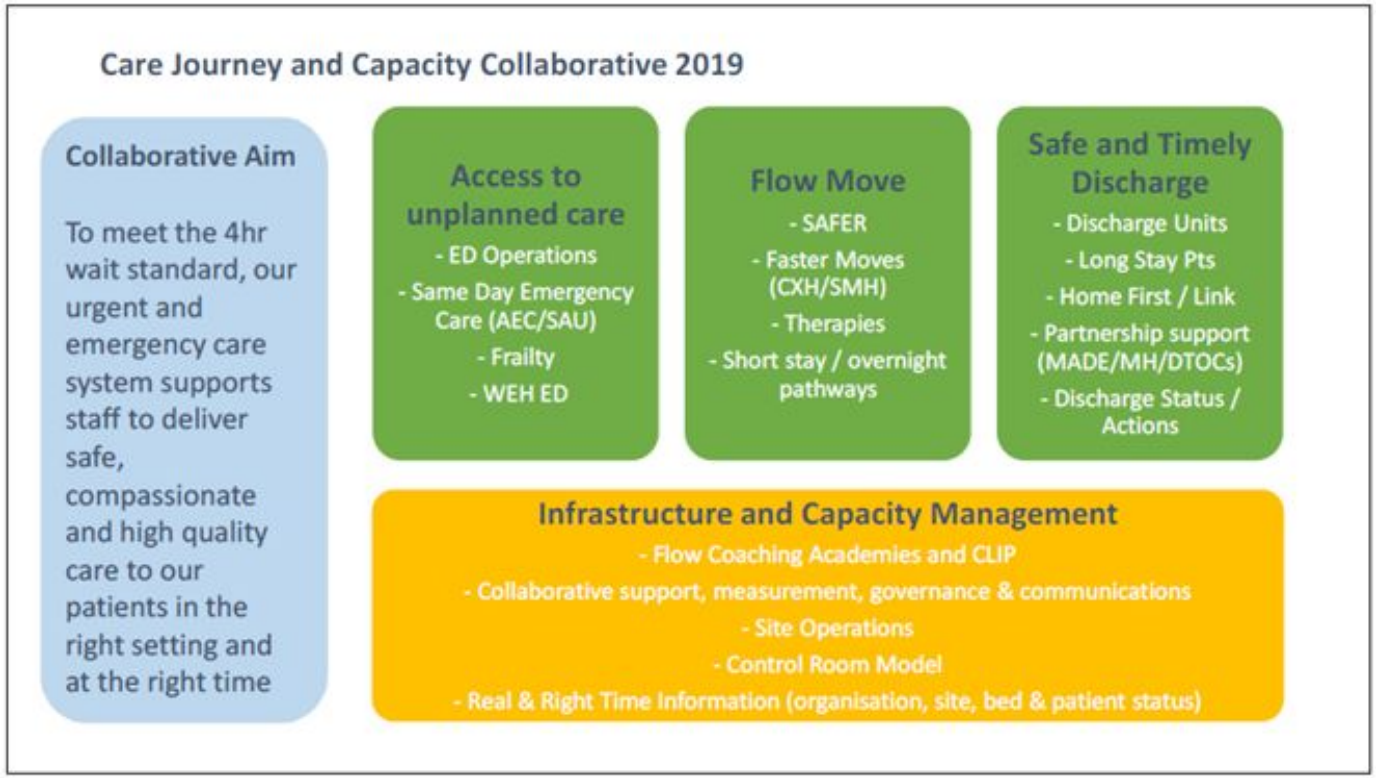
Responsive – A&E 4 hour performance against trajectory

Key issues and actions

The main contributing factors to performance in January have been continued winter pressures, with increased urgent and emergency care attendances across the ICHT system leading to capacity constraints. The priority areas for priority focus during February and March 2019 are reducing the number of long stay patients, non-admitted ED pathways and ambulance handover times.

Improvement Initiatives

The Care Journey and Capacity Collaborative is central to delivery of the trajectory for 4 hour performance. The 2019/20 outline work programme has been agreed and the full plan will be presented to the Executive Committee for Operational Performance for approval in March 2019.



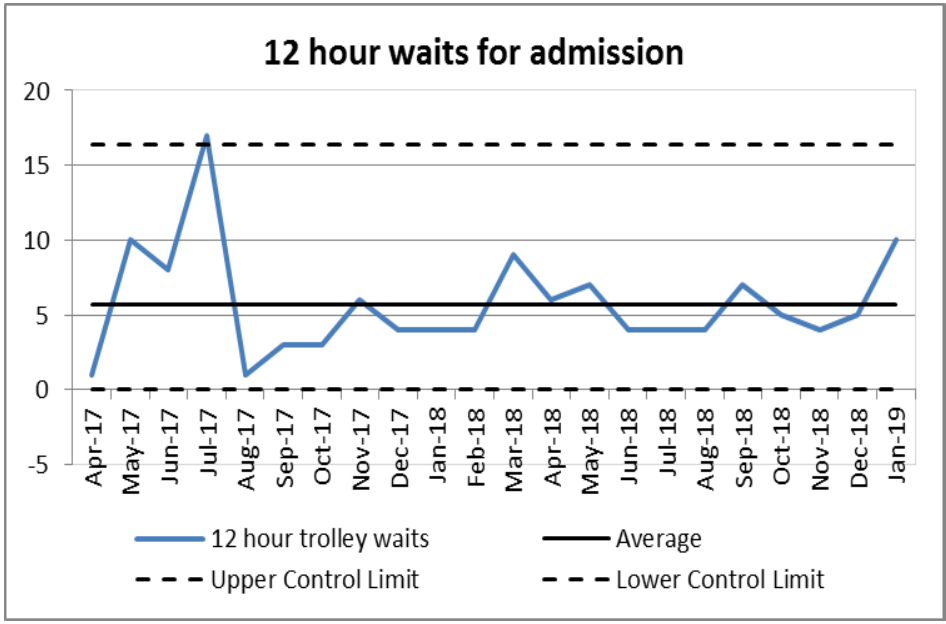
Outline 2019/20 work programme for the Care Journey and Capacity Collaborative

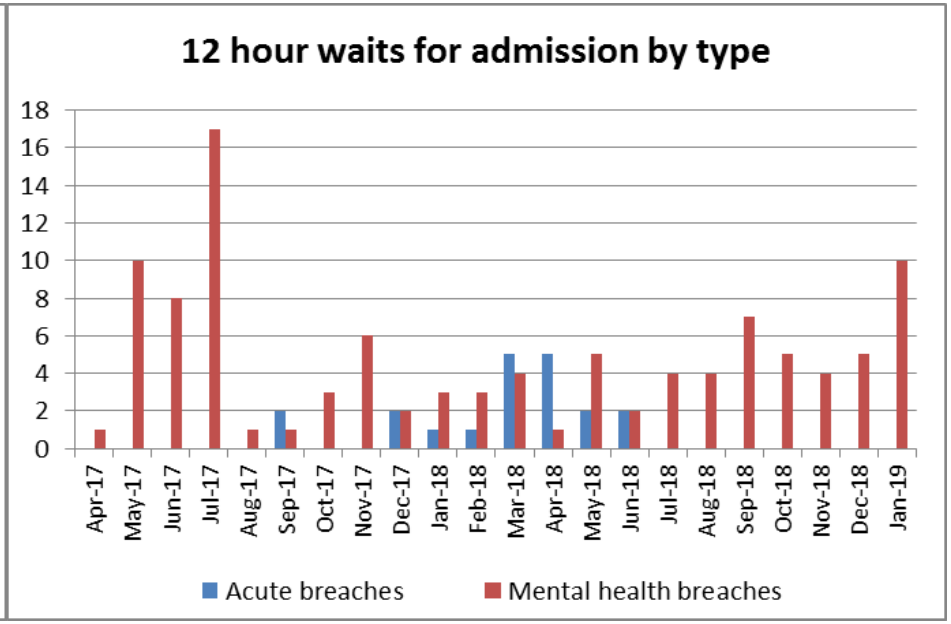
Risk register

- 2510 Failure to maintain key operational performance standards

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 – Jan 5 breaches – Dec	Dr Frances Bowen	Sarah Buckland





Latest performance	• The number of twelve hour breaches of wait from DTA to admission rose to 10 in January 2019, an increase of 5 from December 2018. • All breaches in January were delays to admission for mental health provider beds. • All of the breaches occurred at SMH; 6 patients were transferred within the greater London area and remaining 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

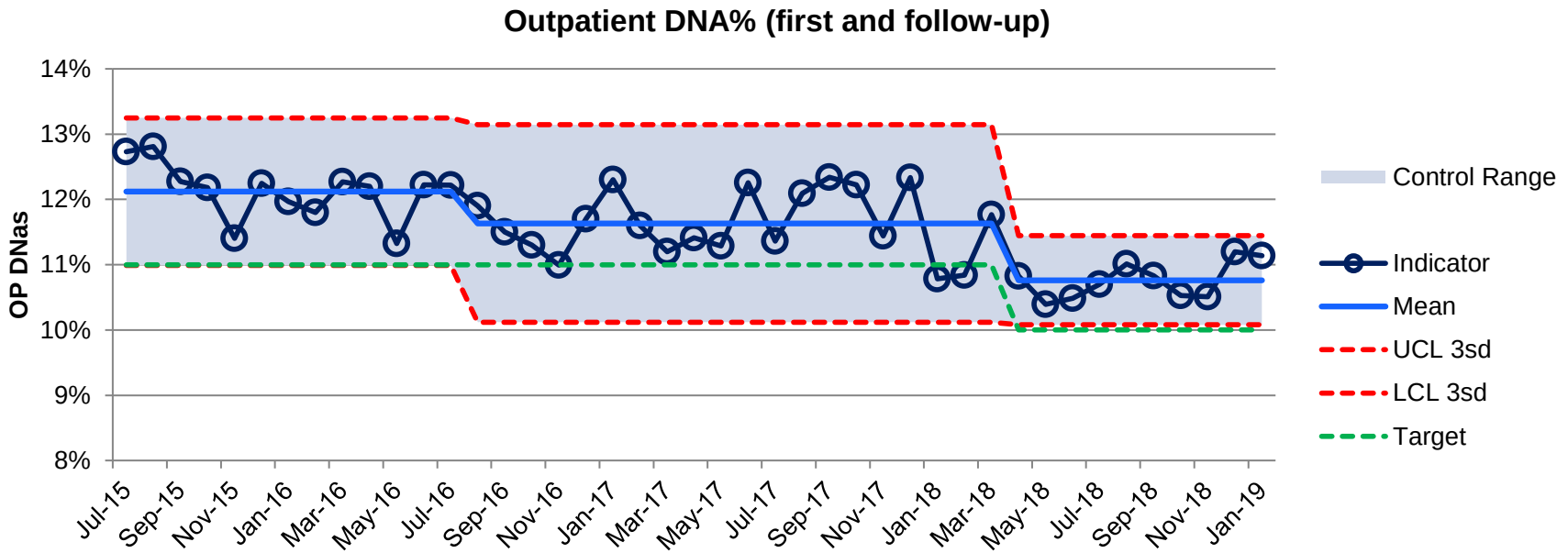
Issues and root causes	• Lack of available mental health beds • Extended waits for AMHPs (Approved Mental Health Professional) due to availability of staff • Delays with provision of out of hours HTT (Home Treatment Team) at SMH, due to end of night time cover in Westminster • Increasing proportion of 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	Q4 2018/19	Work on-going
CCG to ensure rapid escalation process when funding issues become an obstacle	Milan Tailor	In progress	Support from Surge Hub much improved – rapid escalation occurring when necessary
Implement actions from SI reports		Q4 2018/19	Monitored through MIC Q&S Committee

Risk register
This performance metric is on the risk register and linked to corporate risk 2510; failure to maintain operational performance standards which includes 12 hour trolley waits. The risk score is currently graded at 20 with a target of 12.

Responsive – Outpatient Did Not Attend Rates

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%	11.1% (January 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 11.1% in January 2019, a small reduction from December 2018 (11.2%). Although this is an increase compared to previous months, it is within the SPC control limits for this indicator. • Compared to the same period last year, when the DNA rate was 10.8% (January 2018), there is a small decline in the Trusts overall position. • Targeted intervention undertaken in December 2017 to increase the utilisation of text and voicemail reminder services has reduced the DNA rate, but subsequent performance has plateaued
Return to target / trajectory	No formal trajectory has been agreed to reduce the DNA rate to below 10%

Responsive – Outpatient Did Not Attend Rates

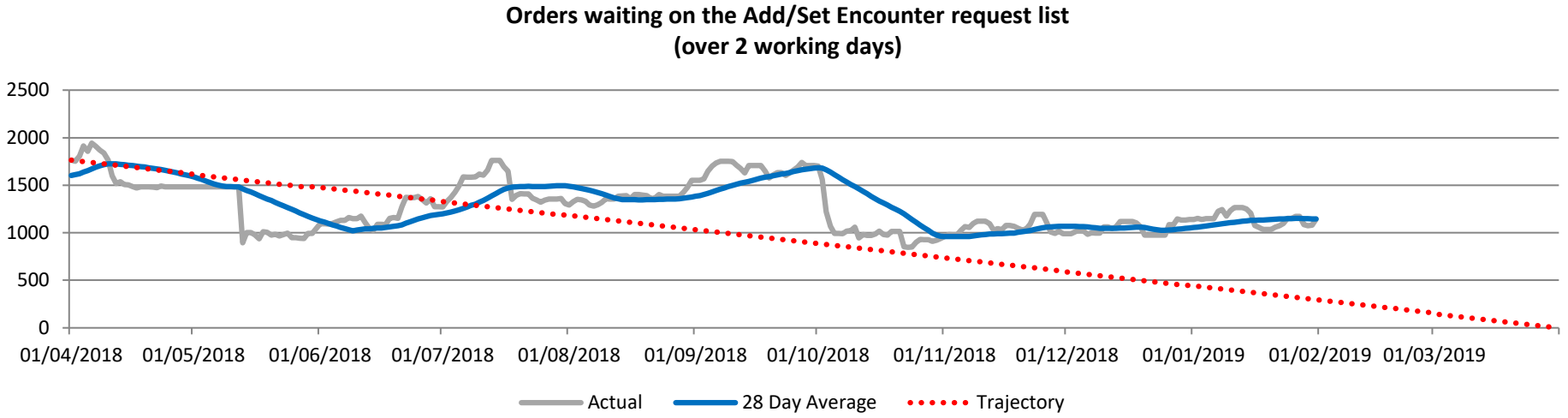
Issues and root causes	• Whilst outpatient DNA rates have reduced during 2018, achieving a DNA rate of <10% requires a step change in approach. • In March 2018 patient appointment letters by email were stopped due to Trust ICT database issues. The service was resumed in October 2018. Now all patients who have signed up to email appointment letters are now getting emails within 15 minutes of the appointment being made • The deep-dive being undertaken is reviewing whether the use of email or post has an impact on the DNA rate. • 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 full 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. • This will be reviewed within the deep-dive report due to review in March 2019 by service and booking mechanism.

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	Danya Cohen	April 2019 TBC	
DNAs • Patient leaflets are being updated to include the impact of DNAs (financial and service efficiency) • 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. April 2019 TBC	

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

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	286 (at end January 2019)	1145 (at end January 2019)	Prof Catherine (Katie) Urch	Caroline O'Dea, (Performance Support Team Business Partner)



Latest performance	In January 2019, an average total of 1145 orders across the Trust remained on the add/set encounter list in Cerner over 2 working days. This number has increased by 94 orders since the end of December 18 and the overall Trust performance still remains over trajectory by 859 orders.
Return to target / trajectory	The Trust continues to not meet trajectory for this DQI. Work is in progress with high volume areas with adverse performance to agree recovery plans and a refresh of the overall approach to data quality led by the Director of Operational Performance is due to take place to accelerate improvement.

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

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

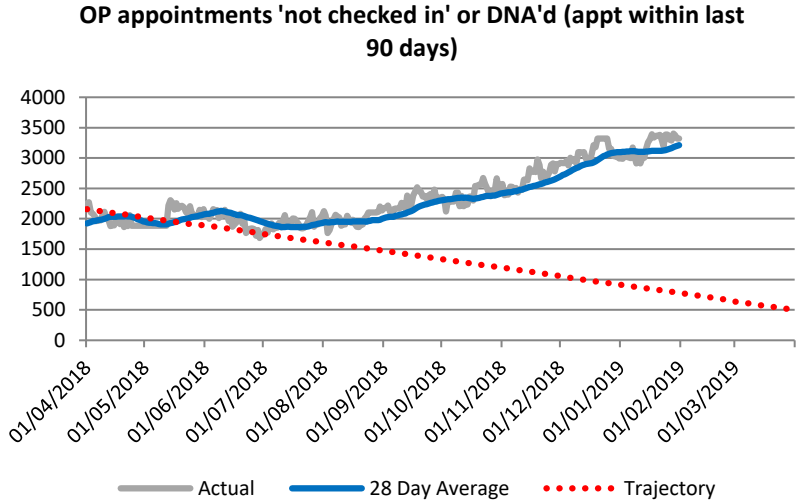
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Reported to elective care via the control of legacies update.	Karina Malhotra	Weekly	On-going process in place.
DQI dashboard reviewed on a monthly basis with operational representatives, a focus on driving improvement across top 3 TFCs with the highest volume of orders on the add/set list over 2 working days. Recovery plans to be agreed with high volume specialities.	Caroline O'Dea	March 19	On-going process in place.
A refresh of the Trust approach to data quality.	Claire Hook	April 19	Initial plan proposed at ExOp Feb 19, further paper due in April 19 outlining full plan and timeline for improvements through 19/20
Monthly data quality report to be developed to accompany the IQPR and to inform senior leaders of the current status of data quality within the Trust.	Caroline O'Dea	April 19	Draft report to be presented at Data Quality Steering Group in April 19.
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	

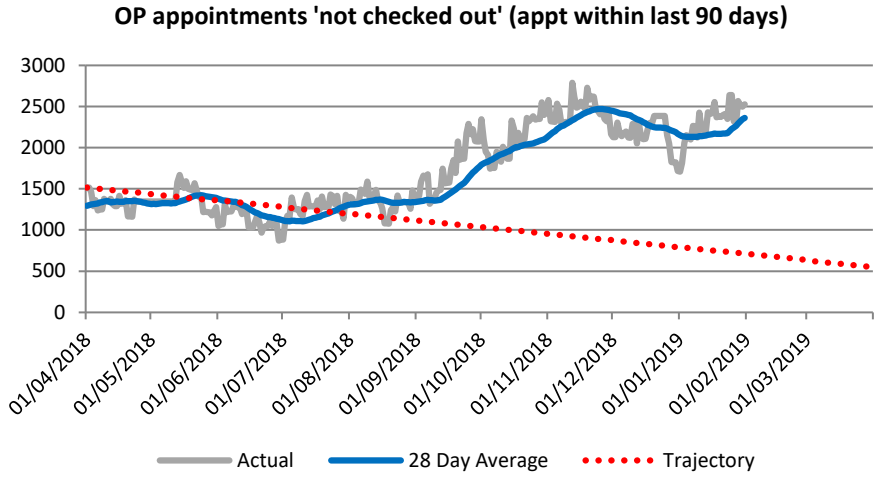
Risk

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

Responsive – DQI: 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: 769 Not checked out: 707	January 2019: • 3,212 OP appointments not checked in; • 2,363 OP appointments not checked out	Tg Teoh	Caroline O'Dea, (Performance Support Team Business Partner)





Latest performance	In January 2019, an average total of 3,212 outpatient appointments were not checked in or DNA'd across the Trust. This is a increase since December 18 by 115 appointments. Performance did not meet trajectory by 2443 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, an average total of 2,363 outpatient appointments were checked in but not checked out across the Trust. This is an increase on the previous month by 196 appointments. Performance did not meet trajectory by 1656 appointments. Of the total number of appointments checked in and not checked out across the Trust, 79% 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.

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

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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
DQI dashboard reviewed on a monthly basis with operational representatives, a focus on driving improvement across top 3 TFCs with the highest volume of orders on the add/set list over 2 working days. Recovery plans to be agreed with high volume specialities.	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 – 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.	Claire Hook	April 19	Initial plan proposed at ExOp Feb 19, further paper due in April 19 outlining full plan and timeline for improvements through 19/20
Monthly data quality report to be developed to accompany the IQPR and to inform senior leaders of the current status of data quality within the Trust.	Caroline O'Dea	April 19	Draft report to be presented at Data Quality Steering Group in April 19.

Risk

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Finance Report for February 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27th March 2019	**Item 12, report no. 09**
Responsible Executive Director: Richard Alexander, CFO	**Author:** Michelle Openibo – Associate Director of Finance

Summary:

This report provides a brief summary of the Trust's financial results for the 11 months ended 28th February.

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

The Trust closed the month with £35.8m cash, there are no plans to access any further working capital facility.

Gross capital spend is £4.7m underspent against plan year to date. The Trust expects to meet the Capital Resource Limit (CRL) for the year.

Recommendations:
The Committee is asked to note the report.

This report has been discussed at:
Finance and Investment Committee

Quality impact: N/A

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

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

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

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

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

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

Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

FINANCE REPORT – 11 MONTHS ENDED 28th February 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 11 months ended 28th February 2019.

2. Financial Performance

The Trust is on plan in month and for the 11 months year to date i.e. until the end of February. In month the Trust has undertaken a revaluation of assets, this has resulted in a favorable movement in financing costs offset in the impairment line to cause a zero overall effect on the Trust's position.

The financial performance year so far puts the Trust in a good position going into the last month of the year to achieve the full year control total of £20.6m. There remains a risk to the achievement of the plan if the Trust is unable to sustain the financial control seen in the last 6 months. The Trust Executive monitors the financial position with divisions regularly to ensure that any risks to the position are known and mitigations identified.

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	89.26	85.75	(3.51)	1,024.76	1,035.89	11.13
Pay	(51.63)	(53.28)	(1.66)	(570.74)	(575.92)	(5.18)
Non Pay	(42.89)	(40.76)	2.14	(430.05)	(439.90)	(9.85)
Internal Recharges	-	0.00	0.00	-	(0.00)	(0.00)
Reserves	6.16	9.66	3.49	(5.82)	(1.80)	4.03
EBITDA	0.91	1.37	0.46	18.14	18.27	0.13
Financing Costs	(3.77)	(1.91)	1.87	(39.99)	(41.70)	(1.71)
SURPLUS / (DEFICIT) inc. donated asset treatment	(2.86)	(0.54)	2.33	(21.85)	(23.43)	(1.57)
Donated Asset treatment	(0.11)	(0.30)	(0.19)	(2.74)	0.97	3.71
Impairment of Assets	-	(2.14)	(2.14)	-	(2.14)	(2.14)
SURPLUS / (DEFICIT)	(2.98)	(2.97)	0.00	(24.59)	(24.59)	0.00
PSF Income	3.99	3.99	-	30.18	30.18	-
SURPLUS / (DEFICIT) after PSF income	1.01	1.01	0.00	5.59	5.59	0.00

2.1 Provider Sustainability Funding

PSF is assessed on a quarterly basis, 30% is achieved for meeting the 4 hour A&E target and 70% for achieving the control total. Year to date at quarter 3 the Trust has recovered this position and therefore was eligible for £22m of PSF. The Trust will be eligible for the remaining £12m if it achieves the quarter 4 targets.

2.2 NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Total Division of Medicine & Integ. Care	870,494	805,612	(64,882)	246.52	251.52	5.00
Total Division of Surgery, Cancer & Cardiov.	668,327	698,401	30,073	304.36	306.80	2.44
Total Division of Women, Children & Clin. Support	2,379,719	2,399,856	20,137	147.46	146.89	(0.58)
Central Income			-	128.56	133.71	5.15
Clinical Commissioning Income	3,918,540	3,903,869	(14,672)	826.90	838.92	12.01

The Trust is over performing year to date due to additional non elective and day case activity. The Trust works closely with commissioners to understand the drivers of over performance and agree an outturn position for the year.

Within Medicine and Integrated Care Division (MIC) the favourable variance to plan is due to non-elective over performance on the Charing Cross and St Mary's sites. Surgery, Cancer and Cardiovascular (SCC) is over performing year to date from both non elective and day case over performance. There has been growth in cardiac services and in oncology. This is somewhat offset by underperformance in specialist surgery and orthopaedics. Both areas had planned for growth which has not been delivered. Within Women's, Children's and Clinical Support (WCCS) maternity continues to underperform against plan. The service has seen decreased activity over the last two years reflecting wider trends in birth numbers. There has been over performance in the Paediatric service with additional winter activity.

2.3 Private Patient Income

Private Patient income is £0.5m behind plan year to date, an improvement on previous months and is now expected to achieve £53m for the year. The Trust planned for private growth in the year in SCC, this has not been fully achieved with some under performance in cardiology, general and vascular surgery and specialist surgery. This has been offset with income over performance in WCCS in gynaecology and paediatric services.

The private patient team is working with the clinical divisions to develop activity plans for the next financial year. The financial contribution from this activity will be used to support delivery of NHS care and will be included in the financial plans of clinical divisions.

2.4 Clinical Divisions

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

		In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	22.50	22.16	(0.34)	263.69	266.97	3.27
	Expenditure	(17.90)	(18.81)	(0.91)	(203.31)	(208.80)	(5.49)
		4.60	3.35	(1.25)	60.39	58.17	(2.22)
Surgery, Cancer and Cardiovascular	Income	27.56	27.44	(0.12)	318.82	313.50	(5.32)
	Expenditure	(24.65)	(25.19)	(0.54)	(269.57)	(274.84)	(5.27)
		2.91	2.25	(0.65)	49.26	38.66	(10.59)
Women, Children & Clinical Support	Income	14.47	11.18	(3.28)	163.75	157.84	(5.90)
	Expenditure	(22.04)	(21.12)	0.92	(187.66)	(188.55)	(0.89)
		(7.57)	(9.94)	(2.37)	(23.91)	(30.70)	(6.80)
Imperial Private	Income & Expenditure	1.31	1.46	0.16	13.19	16.11	2.92
Total Clinical Division		1.25	(2.87)	(4.12)	98.92	82.23	(16.69)

MIC has over performed on NHS clinical income year to date. The adverse expenditure position is due to unmet cost improvement programmes (CIPs). The division expects to continue over performance in March offset with expenditure overspends.

Though SCC is over performing on NHS clinical income overall income is under plan year to date due to the failure to deliver private patient growth schemes that sit within the division's budget. The division is overspent due to additional costs incurred for outsourced activity, the costs of the waiting list improvement programme and unmet CIPs.

WCCS is underperforming on income from private patients that sits within the service, mainly in gynaecology and maternity. Costs overspent by £0.9m, the division has unidentified CIPs of £6.8m year to date offset by underspends in pay enabled delays to recruitment of budgeted posts.

Within Imperial Private Health (IPH) the position is favourable to plan due to income growth. This activity is shown within the private position and offsets underperformance in SCC and WCCS. From next year private income contribution will be shown within divisional positions.

3. Efficiency programme

The Trust is £6.5m adverse to plan year to date on CIPs, which is largely due to unidentified schemes in Estates, WCCS and MIC. There is also under performance in SCCS, primarily against additional income schemes. The forecast for CIPs is £3.9m adverse to plan, largely due to unidentified schemes across Estates and WCCS as well as delays to the benefits planned from North West London Pathology. This position is an improvement of £3.4m from December.

The organisation continues to identify and embed efficiencies, drawing on Trust expertise, Model Hospital, GIRFT and the Specialty Review Programme.

4. Cash

The cash position at the end of February was £35.8m. In-month cash has decreased by £6.7m due to purchases of capital items. Overall for the year to date the Trust cash balance has increased by £11.3m. The Trust is required to keep a balance of £3m cash to meet the requirements of the working capital facility agreement and does not anticipate requiring any further draw down of the facility.

5. Capital

Against the Capital Resource Limit (CRL) capital expenditure £3.3m underspent year to date mainly on projects to increased bed capacity and the PICU redevelopment. The Trust overspent in month by £4.8m and is forecasting to increase spend further in March to meet the CRL. The capital programme is actively managed by the Capital Expenditure Assurance group and Capital Steering Group. Where it is appropriate, elements of next year's capital pipeline are being brought-forward to ensure full in-year utilisation.

6. Finance Plan for 2019/20

The Trust has been set a control total of £16.1m for the next financial year which if accepted gives access to £27m of central funding. This would require CIPs of approximately £45m, which is a similar value to the current year. However, both our local and national commissioners have alerted us to expected affordability issues next year and this means that there will be very limited opportunity for income growth in the Trust plan. Both Trust and Sector are working on a plans to reduce the gaps to control totals.

7. Conclusion

The Trust is on plan year to date but there remain risks to the achievement of the Control Total for the year. The Trust must continue to deliver cost savings and improve the expenditure position in order to meet the plan for the year.

The Trust has been set a control total of £16.1m before PSF in the next financial year. A financial plan is being developed by the Trust with the aim of achieving the control total in 2019/20.

8. Recommendation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 11 months to 28th February 2019

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	73.4	73.5	0.1	854.3	862.7	8.5
Private Patients	4.4	4.3	(0.1)	48.1	47.6	(0.5)
Research, Development and education	7.8	7.6	(0.2)	85.4	87.8	2.4
Other non-patient related income	3.7	0.4	(3.3)	37.0	37.8	0.8
Total Income	89.3	85.8	(3.5)	1,024.8	1,035.9	11.1
Pay - in post	(48.7)	(47.4)	1.3	(538.6)	(505.2)	33.4
Pay - Bank	(0.6)	(4.0)	(3.5)	(6.7)	(48.2)	(41.5)
Pay - Agency	(2.3)	(1.8)	0.5	(25.5)	(22.5)	2.9
Drugs and Clinical supplies	(20.4)	(19.4)	1.0	(230.8)	(224.3)	6.5
General Supplies	(2.9)	(3.0)	(0.1)	(32.0)	(34.2)	(2.2)
Other	(19.6)	(18.4)	1.2	(167.3)	(181.4)	(14.2)
Total Expenditure	(94.5)	(94.0)	0.5	(1,000.8)	(1,015.8)	(15.0)
Reserves	6.2	9.7	3.5	(5.8)	(1.8)	4.0
Earnings before Interest, Tax, Depreciation and Amortisation	0.9	1.4	0.5	18.1	18.3	0.1
Financing Costs	(3.8)	(1.9)	1.9	(40.0)	(41.7)	(1.7)
SURPLUS / (DEFICIT) including financing costs	(2.9)	(0.5)	2.3	(21.9)	(23.4)	(1.6)
Donated Asset treatment	(0.1)	(0.3)	(0.2)	(2.7)	1.0	3.7
SURPLUS / (DEFICIT) including donated asset treatment	(3.0)	(0.8)	2.1	(24.6)	(22.5)	2.1
Impairment of Assets	0.0	(2.1)	(2.1)	0.0	(2.1)	(2.1)
SURPLUS / (DEFICIT)	(3.0)	(3.0)	0.0	(24.6)	(24.6)	0.0
PSF	4.0	4.0	0.0	30.2	30.2	0.0
SURPLUS / (DEFICIT) after PSF	1.0	1.0	0.0	5.6	5.6	0.0

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TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Corporate Risk Register and Risk Appetite	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27 March 2019	**Item 13, report no. 10**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Authors:** Valentina Cappo, Corporate Risk Manager Priya Rathod, Deputy Director of Quality Governance

- **Summary:**

This report is split into two parts:

- **Part 1 -** Includes the outcomes of a deep dive review of all corporate risks that was undertaken between February and March 2019. Please refer to **Appendix 1** for the Trust's Corporate Risk Register.
- **Part 2** – Summarises the improvements to risk management that have been made over the last 12 months and presents the revised risk appetite statement for approval. Please refer to **Appendix 2** for the summary improvements and to **Appendix 3** for the revised risk appetite statement.

PART 1: Corporate Risk Register

The Trust Board reviewed the Corporate Risk Register at its meeting in January 2019. Since then, a deep dive review of all corporate risks has been undertaken, the outcomes of which are reflected in this paper.

There are 24 corporate risks within the risk register; these include 3 risks that are commercial in confidence. The highest risks are scored as 20 and the lowest is scored as 8.

Key themes include:

- Operational performance
- Financial sustainability
- Estates critical equipment and facilities
- Workforce
- Delivery of care (including regulation and compliance, medicines management and safety)
- ICT infrastructure (including cyber security, data quality, infrastructure, Information Governance and security).

- **Changes to the Corporate Risk Register**

Since the last meeting, the corporate risk profile has been reviewed to include the life cycle of each risk over the previous 12 months. The 'risk response' has also been included against each corporate risk which will support the Board in considering the current level of residual risk in the context of the agreed level of risk appetite.

The following risks have been disaggregated:

- **Risk 2510** - *Failure to maintain key operational performance standards;* this risk has been closed and the following risks have been escalated onto the Corporate Risk Register in its place:

- **Risk 2937** – *Failure to maintain timely elective (RTT) care. The current score is 16 (C4 x L4)*
- **Risk 2938 –** *Risk of delayed diagnosis and treatment leading to poor clinical outcomes and failure to maintain key operational performance standards relating to the Diagnostic target (DM01).* The current score is 12 (C4 x L3)
- **Risk 2943** - *Failure to maintain the agreed trajectory targets for the Emergency Department (ED) 4 hours waiting and 12 hours decision to admit performance*. The current score is 20 (C4 x L5).

- **Risk 2490** – *Failure to deliver safe care* has been closed and the following risk has been escalated in its place:
  - **Risk 2942** - *Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines*. The current risk score is 16 (C4 x L4).

The following risks have been de-escalated from the Corporate Risk Register or closed:

- **Risk 2481** - *Failure to implement, manage and maintain an effective Health and Safety management system*
- **Risk 2681** - *Loss of system availability due to Windows 7 end of life*
- **Risk 2680** - *Increased risk of PC failure due to delay in PC Replacement Programme*
- **Risk 2540** – *Risk of not achieving full compliance for Core Skills Training*
- **Risk 2499** – *Failure to meet required or recommended Band 2-6 vacancy rate*
- **Risk** – *Commercial in confidence*

The following risks have been escalated onto the Corporate Risk Register:

- ***Risk 2922*** – *Unmanaged shared email boxes - Risk of delay in patient treatment*. The current risk score is 12 (C4 x L4)
- ***Risk 2944*** – *Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas.* The current risk score is 12 (C3 x L4)
- **Risk 1** – *Commercial in confidence.* The current risk score is 20 (C4 x L5)
- **Risk 2** – *Commercial in confidence*. The current risk score is 16 (C4 x L4)

The score of the following risks has reduced:

- **Risk 2677** - *Risk of failure of Network Core devices as they reach End of Life*
- The initial risk score was 20 (C5 x L2). The current risk score is 15 (C5 x L3). The target risk score is 10 (C5 x L2)
- **Risk 2538 -** *Risk of medication safety being adversely affected by poor adherence to medication safety policies*
- The initial risk score was 16 (C4 x L4). The current risk score is 9 (C3 x L3). The target risk score is 6 (C3 x L2)
- **Risk 2472** - *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC*
- The initial risk score was 16 (C4 x L4). The current risk score is 12 (C4 x L3). The target risk score is 8 (C4 x L2)
- **Risk 2480** - *There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust*
- The initial risk score was 15 (C3 x L5). The current risk score is 12 (C3 x L4). The target risk score is 6 (C3 x L2)
- **Risk 2487** - *Risk of spread of CPE (Carbapenemase- Producing Enterobacteriaceae)*

- The initial risk score was 12 (C3 x L4). The current risk score is 12 (C3 x L4). The target risk score is 9 (C3 x L3)
- **Risk 1660** - *Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality*
- The initial risk score was 20 (C4 x L5). The current risk score is 16 (C4 x L4). The target risk score is 12 (C4 x L3)

The target risk score for the following risk has been revised:

- ***Risk 2482 –*** *Risk of Cyber Security threats to Trust data and infrastructure*
- It is considered that even after the mitigation plan has been implemented, it will always be 'possible' to receive a malicious attack, and it is unrealistic to expect the probability of this risk to become 'unlikely'.
- The target risk score has therefore increased from 8 (C4 x L2) to 12 (C4 x L3).

The target risk score dates for a number of risks have been revised.

- **Next steps**

- A deep dive review of all corporate risks will be undertaken every 6 months. To this end the next review will take place by the end of August 2019 and the outputs presented to the Board in September 2019.

PART 2: Summary of Risk Management Improvements and Future Developments (including risk appetite statement and operational framework)

- A review of the Trust's risk management processes has been undertaken to improve the understanding and management of risk, as well as to implement a more sophisticated approach to risk management based on best practice. The outcome of the review is included within the paper.
- Following approval of the risk appetite statement, a risk appetite operational framework has been developed.

- **Next steps**

- The Risk Appetite Implementation Framework will be presented to the divisions between April and May 2019.

Recommendations:
The Committee is asked to:
- Note the changes to the corporate risk register
- Approve the revised risk appetite statement

This report has been discussed at:
- The Audit, Risk and Governance Committee on 6 March 2019.
- The Executive Finance Committee (Executive risk committee) on 19 March 2019.

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

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

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Risk impact and Board Assurance Framework (BAF) reference: Evidence of assurance to the effectiveness of controls for risks included onto the Corporate Risk Register is reflected on the Board Assurance Framework.
Workforce impact (including training and education implications): N/a
What impact will this have on the wider health economy, patients and the public? Individual risks have different impact on the above topics, as reflected within each risk description.
Has an Equality Impact Assessment been carried out? ☐ Yes ☐ No ☒ Not applicable
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with compassion. ▪ To educate and engage skilled and diverse people committed to continual learning and improvements. ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Please use the detail outlined in the Executive Summary.

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PART 1
Corporate Risk Register

1. Background

- The Trust Board reviewed the Corporate Risk Register at its meeting on 30 January 2019.
- The Board will recall that a review of risk management reporting and presentation to learn lessons, include recommendations of the internal audit report and build on good practice has concluded. The outputs of this are summarised in this paper.
- The Board will also recall that the Executive Finance Committee is the Executive risk committee.

2. Improvements to risk management reporting and presentation

- Improvements to the presentation of risks have been planned in two phases to provide the Executive and the Board with a more robust and agile presentation of the Trust's risk profile, to include the life cycle of a risk over a twelve month period.
    - **Phase one** - Focused on the review of the corporate risk profile within the corporate risk register document.
    - **Phase two** - Replicates the outputs of phase one but focuses on the review of the clinical divisional risk profile within divisional risk registers.
- The outputs of phase one and the changes to the corporate risk profile were presented to the Executive Finance Committee on 19 February 2019 and to the Audit, Risk and Governance Committee on 6 March 2019, and are included in **Appendix 1** as follows:
    - A chart reflecting the risk movement over the previous 12 months is now included.
    - The chart tracks the journey of the risk (over the last 12 months) considering the initial, current and target risk scores and also includes the initial and target risk score dates.
    - The target risk score date that was agreed when the risk was first identified is also reflected to demonstrate if this has been delayed and by how long.
    - Finally, the 'risk response' has been added against each of the corporate risks on the corporate risk register. This provides the Board with greater transparency regarding the Trust's approach to managing risks and in particular those risks where all possible mitigations have been implemented but the risk cannot be reduced further due to external factors and is therefore 'tolerated'.
- The provision of the above information, together with the risk appetite for each risk, will support the Board further in monitoring how effectively risks are being; managed in the organisation, if they are managed within the risk appetite framework, if the relevant risk response is appropriate and if resources should be reallocated or the risk appetite reviewed when inconsistencies are identified.

3. Deep dive review of the Corporate Risk Register

- The Executive Finance (risk) Committee requested that a deep dive review of each risk be undertaken to consider; if the current risk description is reflective of the actual risk and in light of this review the current risk and target risk scores and the target risk score date.
- A focus was given in particular to those risks where the risk score has not reduced/increased.
- The outputs of this deep dive review are reflected in the paper.
- Moving forward a deep dive review of all corporate risks will be undertaken every six months. To this end, the next review will take place in September 2019. This will include reviewing:
  - Risks where the score has not reduced over the previous 12 months
  - Risks where the score has increased since the initial risk score over the previous 12 months
  - Risks where the risk response is to 'tolerate'.
- In addition, through the monthly review of the corporate risk register focus will continue on those risks where there is no movement.

4. Changes to the Corporate Risk Register

- The following changes have been made to the corporate risk register and approved by the Executive Committee since it was last presented to the Board in January 2019.

4.1 Disaggregation of risks (including the escalation of new risks and the closure of existing risks)

- **Risk 2510** - *Failure to maintain key operational performance standards*

Initial Risk Score	Current Risk score	Target Risk Score
15 (C3 x L5)	20 (C4 x L5)	12 (C4 x L3)

- In February 2019, the Executive Finance Committee agreed that this risk be split into three separate risks focusing on specific operational performance standards.
- Subsequent to that, at the Executive Finance Committee on 19 March 2019 it was agreed that this risk (2510) be closed and the following new risks be escalated onto the Corporate Risk Register in its place:

- ***NEW*** **Risk 2943** *Failure to maintain the agreed trajectory targets for the Emergency Department (ED) 4 hours waiting and 12 hours decision to admit performance.*

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	20 (C4 x L5)	16 (C4 x L4)

- The four hour target continues being met inconsistently and the internal trajectory was not met in January 2019.

- Root cause analysis is done for all 12 hour breaches and reviewed at the Improving 4 Hour Performance working group.
- Further bedded units have been opened at St Mary's and Charing Cross hospitals to increase capacity and flow.
- The Charing Cross Emergency Department is being redeveloped.
- This risk (including target risk score date) will be reviewed further in April 2019 in light of the revised national 4 hour performance target.

- ***NEW*** **Risk 2937** – *Failure to maintain timely elective(RTT) care*

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	16 (C4 x L4)	12 (C4 x L3)

- There is a risk of failing to achieve; the maximum waiting time of 18 weeks from GP referral to treatment (RTT), including zero > 52 week waits and the maintenance of the size and volume of the RTT PTL (waiting list).
- An RTT Improvement Programme has been established, the work of which is reported to the Executive Operational Performance Committee each month.
- The monthly Elective RTT Care Steering Group also meet, which includes NHS England, NHS Improvement and NWL CCG representatives.
- An Elective Care Performance Framework was approved by the Executive Operational Performance Committee in January 2019.
- A mitigation plan, including training, operational team review and RTT validation tool enhancement is in place.
- Following implementation of the mitigation plan, the risk is expected to achieve its target score.

- ***NEW*** **Risk 2938** – *Risk of delayed diagnosis and treatment leading to poor clinical outcomes and failure to maintain key operational performance standards relating to the Diagnostic target (DM01)*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x C4)	12 (C4 x L3)	8 (C4 x L2)

- The DMO1 performance target has been met consistently for over a year, with the exception of December 2018, when demand suddenly increased through the use of Babylon Health Ltd by GPs.
- An increase in demand is forecasted in the next financial year and there is a risk that relevant services are unable to meet this.
- A business case for additional equipment is being developed to address capacity issues.
- Ultrasound capacity is currently being reviewed with a view to expanding the establishment to deliver additional capacity.
- Following implementation of the mitigation plan, the risk is expected to achieve its target score.

- **Risk 2490** – *Failure to deliver safe care*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	16 (C4 x L4)	8 (C4 x L2)

- The Board will recall that this risk was reviewed in January 2019 following discussion at the Audit, Risk and Governance Committee in December 2018.
- During the deep dive, and following discussion at the Executive Finance Committee in January 2019, it was considered that there is good assurance around most of the aspects related to 'safe care' following extensive improvement work.
- Individual risks related to these aspects of care are currently monitored on the divisional risk register for the Office of the Medical Director as follows:
  - *Risk 2054 Compliance with the Duty of Candour Legislation*
    Current score: 4 (C x 2 L x 2).
  - *Risk 2149 Non-compliance with VTE assessment and prevention*
    Current score: 8 (C4 x L2).
  - *Risk 2070 Investigation and management of Serious Incidents (SI)*
    Current score: 6 (C3 x L2).
- These risks will continue being managed on the divisional risk register for the Office of the Medical Director.
- There remains a higher risk around failure to follow invasive procedure policies and guidelines, which could result in harm to patients.
- In light of the above, at the Executive Finance Committee on 19 March 2019 it was agreed that the current *Risk 2490* be closed and a new risk is escalated onto the Corporate Risk Register as per below:

- ***NEW*** **Risk 2942** - *Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	16 (C4 x L4)	9 (C3 x L3)

- A Trust wide action plan has been agreed in response to recent invasive procedure never events.
- Weekly updates on progress with the action plan are presented to the Executive Committee.
- An external review of Trust actions has been undertaken by the National Director of Patient Safety and a meeting has been organised with a human factors and patient safety specialist.
- A simulation training and coaching programme is being developed to be delivered to all invasive procedure staff.
- Following implementation of the mitigation plan, the risk is expected to achieve its target score.

4.2 Risks de-escalated from the Corporate Risk Register or closed

- **Risk 2481** - *Failure to implement, manage and maintain an effective Health and Safety management system*
- **Lead Director:** Director of People and Organisation Development.

Initial Risk Score	Current Risk score	Target Risk Score
12 (C4 x L3)	9 (C3 x L3)	6 (C3 x L2)

- Progress has been made with regard to the implementation, management and maintenance of health and safety systems and processes across the Trust.
- There remain some risks around violence and aggression, sharps management and recording of workplace reviews on AssessNet.
- At the Executive Committee on 19 February 2019 it was agreed that this risk would be de-escalated from the Corporate Risk Register.
- Three focused risks around the topics described above will be captured on the People and Organisation Development divisional risk register.

- **Risk 2681** - *Loss of system availability due to Windows 7 end of life*
- **Lead Director:** Chief Information Officer.

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	12 (C4 x L3)	8 (C4 x L2)

- A business case of Year 1 of the mitigation plan for this risk was approved in the 2018/19 capital planning and funding is secured.
- Windows 10 early rollout has commenced and is on track with the plan of completing 1500 deployments by the end of March 2019.
- At the Executive Committee on 19 February 2019 it was agreed that the risk score be reduced from 20 (C5 x L4) to 12 (C4 x L3) and that this risk be de-escalated from the Corporate Risk Register onto the ICT divisional risk register for continued monitoring.

- **Risk 2680** - *Increased risk of PC failure due to delay in PC Replacement Programme*
- **Lead Director:** Chief Information Officer.

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	12 (C4 x L3)	6 (C3 x L2)

- Funding has been secured that will allow the procurement of over 1000 devices to replace the oldest and PCs and Computers on Wheels. Five hundred old PCs have already been replaced and 600 more have been procured for deployment by the end of Q1 2019/20. 80 Computers on Wheels have been procured.
- At the Executive Committee on the 19 February 2019 it was agreed that the risk score be reduced from 20 (C4 x L5) to 12 (C4 x L3) and that the risk be de-escalated from the Corporate Risk Register to the Information and Communication Technology divisional risk register for continued monitoring.

- **Risk 2540** – *Risk of not achieving full compliance for Core Skills Training*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C3 x L4)	6 (C3 x L2)	6 (C3 x L2)

- The Trust has been meeting the Core Skills training compliance target consistently over recent months.
- The risk achieved its target score in January 2019, when the Executive Finance Committee agreed to continue monitoring the risk until March 2019 to get further assurance that improvements are sustained.
- Further to continued internal assurance received and no immediate concerns reported by the CQC following its inspection in February 2019, at the Executive Finance Committee on 19 March 2019 it was agreed that this risk be de-escalated from the Corporate Risk Register to the People and Organisation Development divisional risk register.

- **Risk 2499** – *Failure to meet required or recommended Band 2-6 vacancy rate*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C4 x L3)	8 (C2 x L4)	8 (C4 x L2)

- Although the Trust continues to be challenged in meeting the target for vacancy rates for Band 2-6 nursing and midwifery staff, staffing levels on the wards are consistently safe through a range of mechanisms that are deployed. The safe staffing actual vs. planned rates are monitored monthly and reported to the Board.
- Vacancy rates are also reflective of the additional activity the Trust is undertaking which requires the recruitment of new staff to deliver this.
- Of the staffing related incidents reported in the past six months, 11 incidents affecting patients caused low harm and only 5% of those 'affecting the organisation' resulted in low harm. The remaining incidents were either near misses or resulted in no harm. This demonstrates a reduction in the risk consequence from 'major' to 'minor'.
- At the Executive Finance Committee on 19 March 2019, it was therefore agreed to reduce the risk score from 16 (C4 x L4) to 8 (C2 x L4) and de-escalate the risk from the Corporate Risk Register. The risk will continue to be monitored on the divisional risk register for the division of People and Organisation Development.
- A new risk for escalation regarding failure to deliver appropriately skilled and competent nursing care in hard to recruit areas is being proposed as outlined in section 2.3 of this paper.

- **Risk** – *Commercial in confidence*
- **Lead Director:** Chief Financial Officer.

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	9 (C3 x L3)	4 (C2 x L2)

- One risk that is commercial in confidence was de-escalated from the Corporate Risk Register in February 2019.
- Risks that are commercial in confidence are discussed and reviewed at the Audit, Risk and Governance Committee as part of the complete Corporate Risk Register.

4.3. New risks escalated onto the Corporate Risk Register

The following risks have been escalated onto the Corporate Risk Register since January 2019:

- **Risk 2944** – *Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C3 x L4)	12(C3 x L4)	9 (C3 x L3)

- There is a risk of failing to deliver appropriately skilled and competent nursing care in hard to recruit areas across the Trust.
- This is mainly due to:
  - A national shortage of nursing staff in some disciplines, including Acute and Specialist Medicine at Charing Cross Hospital (CXH), Neurosciences and Stroke, Clinical Haematology, Trauma, Gynaecology & Reproductive Medicine, Imaging, and Private Patients at CXH.
  - High turnover of staff.
  - Areas expanding their services when there is limited supply.
- Despite vacancies in these areas, safe staffing has been maintained throughout.
- Regular review of safe staffing and clinical quality data through the actual vs. planned and harm free care reports provides assurance that the impact on patient safety is minimised.
- A recruitment and retention plan has been approved for 2019/20, which will support further reducing the risk.

- **Risk 2922 –** *Unmanaged Shared Email Boxes - Risk of delay in patient treatment*
- **Lead Director:** Chief information Officer

Initial Risk Score	Current Risk score	Target Risk Score
12 (C4 x L3)	12 (C4 x L3)	4 (C4 x L1)

- There is a risk that "unknown" unmanaged shared email accounts are active and published to patients.
- All mailboxes at risk have now been identified.
- The creation of new shared mailboxes has been suspended until a revised process is implemented.

- A new process to request shared mailboxes is being agreed and an automated process for on-going failsafe implemented.
- A process is being agreed to monitor, alert and escalate non-active shared mailboxes with Divisional Directors of Operations.
- An audit of shared mailboxes, activity and owners is currently being completed.

- **Risk 1 and Risk 2** – *Commercial in confidence*
- **Lead Director:** Director of Redevelopment.
  - ***Risk 1***

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	20 (C4 x L5)	12 (C3 x L4)

  - ***Risk 2***

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	16 (C4 x L4)	12 (C3 x L4)

- Two risks that are commercial in confidence were escalated onto the Corporate Risk Register in February 2019.
- Risks that are commercial in confidence are discussed and reviewed at the Audit, Risk and Governance Committee as part of the complete corporate risk register.

4.4. Changes to risk score

- **Risk 2487** - *Risk of spread of CPE (Carbapenemase- Producing Enterobacteriaceae)*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C3 x L4)	12 (C3 x L4)↓	9 (C3 x L3)

- Screening compliance has increased close to the target of 90% and there are no current outbreaks of CPE, although there continues to be a number of patients who screen positive for a CPE organism in various locations within the Trust.
- The likelihood of the risk materialising has subsequently reduced from ‘almost certain’ to ‘likely’ and the risk score has reduced accordingly.
- The risk will be further reviewed at the end of March 2019 after all the actions have been completed, with a view to further reduce the score if screening compliance remains high and after 6 months have passed without an outbreak of CPE.
- **Risk 2480** - *There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust*

Initial Risk Score	Current Risk score	Target Risk Score
15 (C3 x L5)	12 (C3 x L4)	6 (C3 x L2)

- Since April 2018, no infection control issues directly related to cleaning have been reported.
- A review of incidents and complaints related to cleaning and infection control over the past six months shows a reduction in the number reported.

- Additional staff has been recruited by Sodexo and cleaning standards have improved overall, although there remain some areas of concern needing continued close focus.
- In addition, a deep dive assurance report outlining the progress with the on-going actions to mitigate this risk was presented to the Audit, Risk and Governance Committee in March 2019.
- The likelihood of this risk occurring has subsequently reduced from 'almost certain' to 'likely'.
- In line with the above, the target risk score date has been changed to September 2019, when improvements are expected to be achieved to a satisfactory and sustained level.

- **Risk 2538 -** *Risk of medication safety being adversely affected by poor adherence to medication safety policies*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	9 (C3 x L3)	6 (C3 x L2)

- In light of the adoption of phase 1 medicines improvement materials and the audit programme showing good adherence to policy, it is considered that the consequences of this risk have reduced and therefore the risk score has reduced from 12 (C4 x L3) to 9 (C3 x L3).
- The risk score will be further reviewed following launch of the phase 2 Medicines Matters materials at the end of Q1 2019/20.
- The target risk score date has been amended to the 30 May 2019 to reflect the launch timescales for phase 2 materials and post launch evaluation.

- **Risk 2677** - *Risk of failure of Network Core devices as they reach End of Life*

Initial Risk Score	Current Risk score	Target Risk Score
20 (C5 x L4)	15 (C5 x L3)	10 (C5 x L2)

- Funding was secured as part of the 2018/19 capital planning to address this risk and the network replacement programme is on track.
- A tender for the procurement of a replacement network has commenced and a preferred option identified.
- The likelihood of this risk materialising has reduced from 'likely' to 'possible'.
- At the Executive Finance Committee in February 2019 it was therefore agreed to reduce the current risk score from 20 (C5 x L4) to 15 (C5 x L3).

- **Risk 1660** - *Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality*

Initial Risk Score	Current Risk score	Target Risk Score
20 (C4 x L5)	16 (C4 x L4)	12 (C4 x L3)

- The error rate associated with reporting of waiting times for A&E, diagnostics and cancer are below the 5% threshold advised by NHSI.
- The error rate associated with reporting of waiting times for RTT has improved from 10% to 8%.

- In addition, the MBI action plan is being delivered and an annual progress update was provided to the Audit, Risk and Governance Committee in March 2019.
- The likelihood has subsequently reduced from 'almost certain' to 'likely' and the risk score has reduced accordingly.
- Further work will continue to be delivered until 2020/2021 to achieve a standard of data quality in the Trust that is more robust and can sustainable.
- The target risk score date has subsequently been changed to March 2021 by which time the work plan will be delivered, with an expectation that the current risk score will reduce as the work is completed.

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

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	12 (C4 x L3)	8 (C4 x L2)

- Based on the continued work of the Improving Care Programme group and the divisions together with the positive high level feedback received following the CQC core service inspections in February 2019, the likelihood of this risk materialising has been changed from 'likely' to 'possible', therefore reducing the risk score.
- The target score date remains as August 2019, by which time the Trust will have received the CQC inspection reports from the core service and well led inspections therefore providing external assurance with regards to mitigating this risk.

4.5. Change to target risk score

- **Risk 2482 –** *Risk of Cyber Security threats to Trust data and infrastructure*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	16 (C4 x L4)	12 (C4 x L3)

- Organisations worldwide have seen an increase in malicious emails and malicious attacks.
- The Trust is undertaking a number of actions to respond to this including; decommissioning the old 'imperial.nhs.net' email domain which is expected to reduce the risk of receiving malicious emails and replacing the core network.
- The implementation of these mitigation measures is expected to reduce the likelihood of a cyber-security threat to the Trust.
- However, it is felt that even after the mitigation plan has been implemented, it will always be 'possible' to receive a malicious attack, and it is unrealistic to expect the probability of this risk to become 'unlikely'.
- The target risk score was therefore increased from 8 (C4 x L2) to 12 (C4 x L3) at the Executive Finance Committee in February 2019.

- The target risk score date will be reviewed after in April 2019, once the timeline for the replacement of the core network and the overall mitigation plan has been finalised.

4.6. Changes to Target Risk Score Dates

The target risk score dates have changed for the following risks:

- **Risk 2697 -** *Impact of Paddington Square development on Trust services at St. Mary's Hospital*

Initial Risk Score	Current Risk score	Target Risk Score
12 (C3 x L4)	12 (C3 x L4)	9 (C3 x L3)

- The Contractor's target date for sub-structure work, i.e. structural work below ground level such as piling, is to commence on 09 April 2019. The Contractor expects to then spend the next 12 months in the ground to complete excavations, foundations, etc. to support the structure above.
- The next phase of construction is likely to be noisy and with constant vibration, and the works are unlikely to be able to be stopped.
- The target risk score date has subsequently changed from March 2019 to April 2022, by which time the works will be completed.

- **Risk 2477 -** *Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues*

Initial Risk Score	Current Risk score	Target Risk Score
15 (C3 x L5)	15 (C3 x L5)	9 (C3 x L3)

- Delays continue to be experience by patients presenting with mental health issues.
- A Safety Stream has been established for the care of mental health patients in the Emergency Department.
- The Trust has been involved in drafting a joint statement to NHS Improvement regarding the situation for Mental Health beds availability.
- The target risk score date has been changed to March 2020 when some improvements should be realised following the establishment of the safety stream and escalation to NHS Improvement. However, this will be reviewed further in April 2019 in light of the revised national 4 hour target which may support the mitigation of this risk further and allow for the target risk score dare to be achieved earlier.
- It is recognised that full mitigation of this risk remains outside of the Trust's control.

4.7. Other changes made/ planned to corporate risks

- **Risk 2476** - *Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust*

Initial Risk Score	Current Risk score	Target Risk Score
16 (C4 x L4)	16 C4 x L4)	6 (C3 x L2)

- A number of mitigations have been implemented since the risk was first identified in June 2016, including the relocation of critical care services at St Mary's and Charing Cross hospitals.
- The risk will be further reviewed in April 2019 to ensure it reflects the current risk, including timely access to critical care beds.

- **Risk 2473** - *Failure to meet control total and deliver the financial recovery plan* (previously titled: *Failure to maintain financial sustainability)*

Initial Risk Score	Current Risk score	Target Risk Score
20 (C5 x L4)	20 (C5 x L4)	15 (C5 x L3)

- This risk has been reviewed with a view to make it more reflective of the actual current risk and therefore the risk title has been amended.
- The Trust will be working on a 5 year plan in the latter part of 2019 and dependent on the outcome of this work, there is an expectation to achieve the target risk score of 15 (C5 x L3) by 2020/21, consistent with the ambition set out in the NHS 10 Year Plan for providers to get back to financial sustainability.

5. Risk management structure and reporting

- The Director of Operational Performance came into post in January 2019.
- The portfolio includes operational performance, data quality, fire management and site operations and emergency planning. All relevant risks have been re-assigned under the new structure.
- Within the Corporate Risk Register, ***Risk 1660*** *Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality*, has also been assigned to the Director of Operational Performance.

6. Next steps

- The Corporate Risk Register will be presented to the Executive Finance Committee in April and May 2019 and to the Audit, Risk and Governance Committee on 22 May 2019.
- The next deep dive review of the Corporate Risk Register will be undertaken by the end of August 2019 and the outputs of this presented to the Board in September 2019 where it will receive the Corporate Risk Register.

7. Recommendations

- Note the changes to the Corporate Risk Register

End of part 1

Imperial College Healthcare NHS Trust

PART 2
Summary of Risk Management Improvements and Future Developments (Including risk appetite statement and operational framework)

1. Purpose

- This part of the report provides a summary of the improvements made to the Trust's risk management processes over the last 12 months and outlines future developments. A more comprehensive summary of the review is attached as **Appendix 2**.

2. Summary of key improvements

- Risks are now reviewed monthly at all divisional forums with responsibility for risk management within the corporate divisions, as well as in the clinical divisions, and this is documented as appropriate.
- Key divisional risks are presented to the Executive Finance Committee monthly, compared to quarterly in the past, and they are managed directly by the divisions (clinical and corporate) on the Datix Risk Management software.
- The Corporate Risk Register is reviewed monthly at the Executive Finance Committee, which is the executive risk committee.
- The Audit Risk and Governance Committee also receive themes from key divisional risks at each meeting, which supports better Board oversight of the Trust's risk profile.
- The risk management paper that comes to the Board and the Audit Risk and Governance Committee now includes an update on the Board Assurance Framework, as well as the Corporate Risk Register; this supports the Committees to determine the effectiveness of the relevant risk controls.
- The revised risk profile dashboard included in the Corporate Risk Register now allows the Executive and the Board to consider the journey of each risk over the previous 12 months therefore allowing focused discussion, especially for those risks that are more challenging to mitigate and those where the Trust is successfully addressing.
- Risk registers are also now considered during the business and capital planning and processes to support decision making regarding investment.
- Bespoke on-line risk management training for managers has been developed on the Trust's e-learning system. Since the introduction of the training in October 2018, over 120 staff has been trained.

3. Risk appetite statement and operational framework

- In addition to the improvements outlined in section 2, the Trust has a risk appetite statement and framework, which was approved by the Trust Board in March 2018.
- Given the impact on the organisation and the influence it has on operational data, the following new additional statement was discussed at the Executive Committee on 19 February 2019 for addition to the Trust risk appetite statement:

- *Recognising the challenging operational and financial environment, the Trust will be cautious when responding to any risk that could compromise data quality, which also carries performance and reputational risks. The Trust will commit to continual improvement in data quality.*

- The revised risk appetite statement can be found in **Appendix 3** together with a risk appetite operational framework which has been developed.
- The operational framework is aimed to provide staff with guidance on how to respond when a risk is identified so that they can agree a risk response in the context of the agreed level of risk appetite.
- Following approval by the Board, the risk appetite operational framework will be socialised throughout the Trust via existing forums/meetings within divisions and corporate areas.

4. Next Steps

- The Risk Appetite Implementation Framework will be presented to the divisions between April and May 2019.

5. Recommendations

- Approve the revised risk appetite statement

Authors: Valentina Cappo, Corporate Risk/ Project Manager
Priya Rathod, Deputy Director of Quality Governance

Date: 19 March 2019.

Appendices: Appendix 1 - Corporate Risk Register
Appendix 2 - Summary of Risk Management Improvements and Future Developments
Appendix 3 – Risk Appetite Statement and Operational Framework

APPENDIX 1

Corporate Risk Register

Trust Board

March 2019

Scoring Matrix

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

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

Key:

Initial Score: The score of the risk when first identified

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

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

Corporate Risk Profile

Risks scored 15:

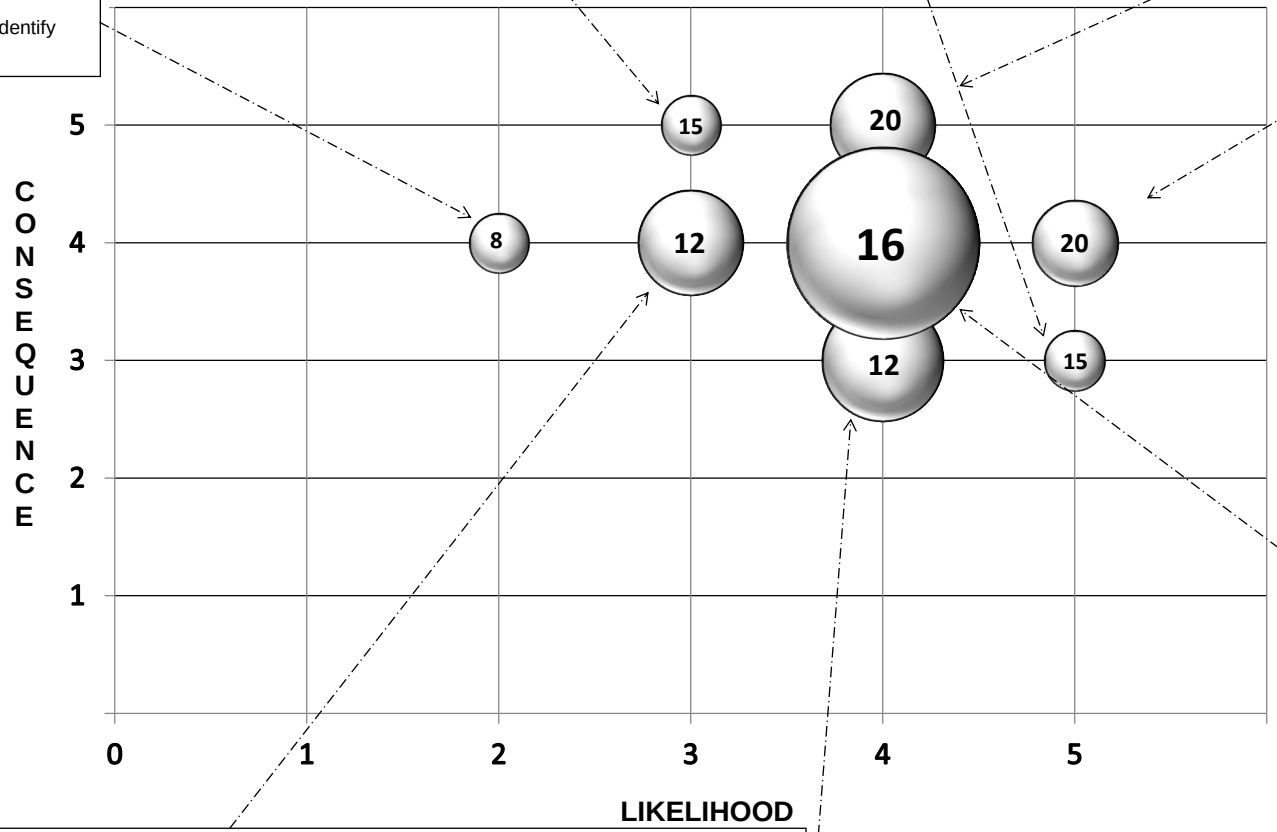
1. 2477 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (3x5)
2. 2677 Risk of failure of Network Core devices as they reach End of Life. (5x3)

Risk scored 8:

1. 2475 Failure to actively identify educational issues (4x2)

Risks scored 20:

1. 2485 Failure of estates critical equipment and facilities (5x4)
2. 2473 Failure to meet control total and deliver the financial recovery plan (5x4)
3. 2943 Failure to maintain ED trajectories (4x5)
4. Commercial in confidence (4x5)



Risks scored 16:

1. 2482 Risk of Cyber Security threats (4x4)
2. 2476 Failure to currently meet some of the core standards and service specifications for High Dependency areas (4x4)
3. 2498 Failure to gain funding approval for the redevelopment programme (4x4)
4. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards (4x4)
5. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (4x4)
6. 1660 Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality (4x4)
7. 2613 Compliance with General Data Protection Regulation (GDPR) (4x4)
8. 2942 Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines (4x4)
9. 2937 Failure to consistently achieve timely elective (RTT) care (4 x 4)
10. Commercial in confidence (4 x 4)

Risks scored 12:

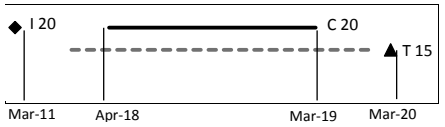
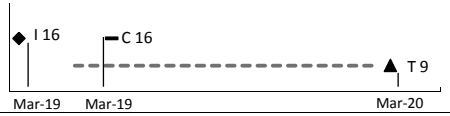
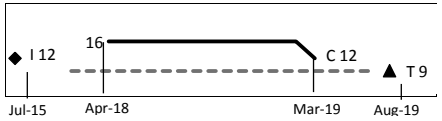
1. 2538 Risk of medication safety being adversely affected by poor adherence to medication safety policies (4x3)
2. 2922 Unmanaged Shared Email Boxes - Risk to delay in patient treatment (4x3)
3. 2938 Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards (4 x 3)
4. 2697 Impact of Paddington Square development on Trust services at St. Mary's Hospital (3x4)
5. 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust (3x4)
6. 2944 Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas (3 x 4)
7. Commercial in confidence (3 x 4)

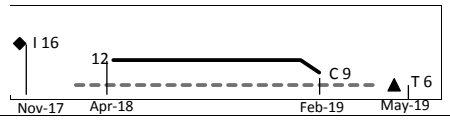
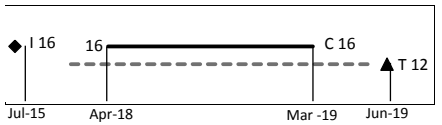
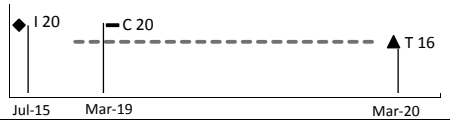
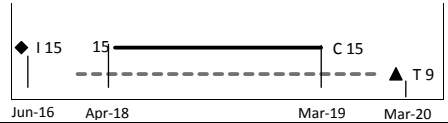
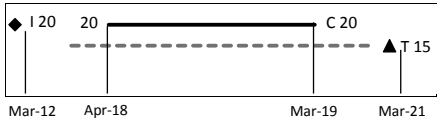
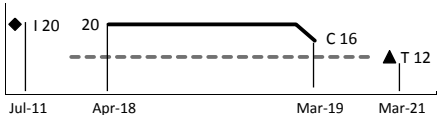
Corporate Risk Register Dash Board

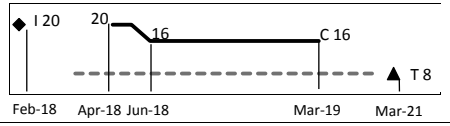
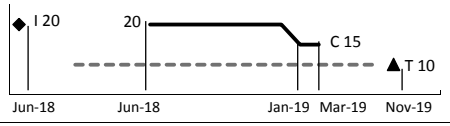
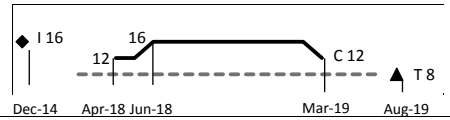
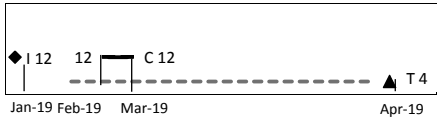
Key:	
♦	Initial Risk Score
▲	Target Risk Score
-------	Benchmark target risk score
IRS	Initial Risk Score
CRS	Current Risk Score
TRS	Target Risk Score

Risk appetite		
Avoid/ Minimal (ALARP - As little as reasonably possible)	**Low**	Strives to avoid risk and uncertainty and works to minimize unavoidable risk. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	**Medium**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Open		Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek/ Mature	**High**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in accepting or setting high levels of risk because controls, forward scanning and responsiveness systems are robust.

Risk Response:	
Treat	The risk is being managed and the mitigation plan is being implemented
Tolerate	Accept that all possible mitigations have been implemented from the Trust and the risk has to be tolerated until further mitigations that are dependent on external stakeholders are implemented
Transfer	The risk can be transferred to a third party (e.g. insurance)
Terminate	The risk is too severe and the Executive has decided to terminate the activity that is causing it

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 6	2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing		IRS 20 / CRS 20 / TRS 15 TRSD initially agreed: Oct-17	Medium	Tolerate
Page 7	2476	Safe Responsive	Failure to currently meet some of the core standards and service specifications for High Dependency areas within the Trust	Divisional Director of SCCS		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Jan-18	Low	Treat
Page 8	2942	Safe	*NEW* Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines	Medical Director		IRS 16 / CRS 16 / TRS 9 TRSD initially agreed: Mar-20	Low	Treat
Page 10	2487	Safe	Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Apr-18	Low	Treat
Page 11	2480	Safe Responsive	There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust	Director of Nursing		IRS 15 / CRS 12 / TRS 6 TRSD initially agreed: Dec-17	Low	Treat
Page 12	2944	Safe	*NEW* Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas	Director of People & OD		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Mar-18	Low	Treat

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 13	2938	Safe Responsive	*NEW* Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards	Divisional Director of WCCS		IRS 16 / CRS 12 / TRS 8 TRSD initially agreed: Dec-20	Low	Treat
Page 14	2538	Safe	Risk of medication safety being adversely affected by poor adherence to medication safety policies	Divisional Director of MIC Divisional Director of SCCS Divisional Director of WCCS		IRS 16 / CRS 9 / TRS 6 TRSD initially agreed: May-18	Low	Treat
Page 15	2475	Effective	Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results	Medical Director		IRS 12 / CRS 8 / TRS 6 TRSD initially agreed: Sep-18	Medium	Treat
Page 16	2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer		IRS 16 / CRS 16 / TRS 12 TRSD initially agreed: Mar-18	Low	Treat
Page 17	2697	Caring	Impact of Paddington Square development on Trust services at St. Mary's Hospital	Director of Redevelopment		IRS 12 / CRS 12 / TRS 9 TRSD initially agreed: Mar-19	Low	Treat
Page 18	2943	Responsive	*NEW* Failure to maintain ED trajectories	Divisional Director of MIC		IRS 20 / CRS 20 / TRS 16 TRSD initially agreed: Mar-20	Medium	Treat
Page 19	2937	Responsive	*NEW* Failure to consistently achieve timely elective (RTT) care	Divisional Director of SCCS		IRS 20 / CRS 16 / TRS 12 TRSD initially agreed: Mar-20	Medium	Treat
Page 20	2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC		IRS 15 / CRS 15 / TRS 9 TRSD initially agreed: Dec-17	Low	Treat
Page 21	2473	Well Led	Failure to meet control total and deliver financial recovery plan	Chief Financial Officer		IRS 20 / CRS 20 / TRS 15 TRSD initially agreed: Mar-21	Medium	Treat
Page 22	1660	Well Led	Risk of delayed treatment to patients and loss of Trust reputation due to poor data quality	Director of Operational Performance		IRS 20 / CRS 20 / TRS 12 TRSD initially agreed: Mar-18	Medium	Treat

Page	Risk ID	CQC Domain	Risk Description	Lead Director	Risk movement in the last 12 months, Initial and Target risk scores and dates	Original Target Risk Score date	Risk Appetite	Risk Response
Page 23	2613	Well Led	Compliance with General Data Protection Regulation (GDPR)	Chief Information Officer		IRS 20 / CRS 16 / TRS 8 TRSD initially agreed: Mar-21	Low	Treat
Page 24	2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Director of Redevelopment		IRS 12 / CRS 16 / TRS 8 TRSD initially agreed: Dec-20	Medium	Treat
Page 25	2677	Well Led	Risk of failure of Network Core devices as they reach End of Life	Chief Information Officer		IRS 20 / CRS 15 / TRS 10 TRSD initially agreed: Nov-19	Medium	Treat
Page 26	2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Nursing		IRS 16 / CRS 12 / TRS 8 TRSD initially agreed: Apr-18	Medium	Treat
Page 27	2922	Well Led	*NEW* Risk of delay in patient treatment due to unmanaged shared email boxes	Chief Information Officer		IRS 12 / CRS 12 / TRS 4 TRSD initially agreed: Apr-19	Low	Treat

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

Current Risk Controls

• Implementation of new Hard Facilities Management (Hard FM) Managed Service solution through specialist maintenance provider CBRE Ltd from 1/4/16 for 5 years to provide improved compliance and responsive reactive repair maintenance service.
• Retention of Senior Estates Management team structure to deliver 'informed client role' to ensure effective and compliant delivery of contract against specification and performance standards.
• Statutory and regulatory inspections have been re-scheduled to ensure compliance with statutory and mandatory undertakings and to minimise impact on front line service
• All planned (PPM) and reactive (repair) maintenance works managed through computer aided maintenance management system (CAMMS) to provide improved programming and management reporting.
• Current backlog maintenance capital funding for 2018/19is £19m.
• Formal reviews of Hard FM operational performance are conducted continually review performance against contract.
• PLACE (Patient-Led Assessment of the Care Environment) lead by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works.
• Monthly Estates & Facilities Quality Committee for closer collaborative working with front line services and appropriate reporting to monitor/improve performance.
• Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services
• Estates & Facilities H&S, Fire and Compliance committee has been established to formally report and monitor statutory/mandatory compliance.
• Estates and facilities issues discussed three times a day on site calls so ensure timely resolution of any issues identified.

Mitigation Plan

Action:
Coimplete 2018/19 capital Backlog maintenance programme *Due Date:* 29/03/19
Update on action:
On Plan

Action:
Establish Estate Improvement Plan to make recommendation options to get better reactive maintenance times. EIP to include: • Process review; • Workforce review; • Bi-monthly backlog review and prioritisation. *Due Date:* 28/06/19
Update on action:
The process has been delayed due to a number of jobs having to be reprioritised across the clinical areas. Four work streams have been identified, these being:
1)Reactive works
2)Workflow process
3)£1000.00 CBRE Comprehensive agreement
4)E-mandates
Moving forward a project plan will be created giving times lines for delivery on each of the above, and a new delivery date project work streams will be issued.

Contingency Plans

• Capital plan to align to clinical strategy within financial abilities
• Major incident plan / sector wide contingency plans
• Development and implementation of integrated business continuity plan
• NHSLA insurance cover
• Estates Strategy with conting

Key Summary Updates & Challenges

The Trusts continues to undertake work to deliver the action plan and the Estate strategy. The delivery of this is expected to reduce the risk score to 15 in 2020/21.

ID: 2476 **Title: Failure to currently meet some of the core standards and service specifications for High Dependency areas** **Page 7**

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

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

Effect:
- Delivery of care provided to patients
- Patients being nursed in inappropriate areas (C8 ward) due to lack of level 2 beds
- Inability to meet critical care standards on medical HDU with consequent impacts on patient safety.
- Inability to open additional capacity on demand and potentially impacts on staff activity and morale and patient safety.
- Possible unannounced CQC inspection

Current Risk Controls

- Review of the HDU's against the standards completed and paper written and reviewed at EX QU
- Meeting completed with Medical Director to agree immediate actions and review risk, date for further meeting agreed.
- Review of all incidents and SI's by critical care and two independent consultants
- Cover arrangements under review with Clinical Directors in relation to cover being provided out of hours SOPs to be produced for each unit, links with medical firms strengthened by surgical HDUs
- Options papers to Critical Care Committee 9/6/16 to review long term options
- Patients are managed within existing medicine areas on the Hammersmith Site. C8 ward is operating as a level 1 area with monitored beds.
- Escalation of staffing issues within agreed framework. Early requests for bank shift and agency where required. Requests for cross coverage from other clinical areas.
- Current mitigations continue to be ICU support and use of Outreach. Outreach hours have been extended on CXH site and a proposal is in preparation to extend this to weekends and to HH. Outreach now established on all sites from 8am to 8pm Monday to Sunday.
- Cohorted level 2 /3 together at CXH – compliant with standards
- Clinical teams from medicine and ICU meeting daily to discuss inpatient cases to form a processes/relationships

Mitigation Plan

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

Action:
Recruitment to fill vacant posts on ward *Due Date:* 29/06/18
Update on action:
Action complete.

Action:
Critical Care to take over management of HDUs Trustwide *Due Date:* 29/06/18
Update on action:
Co-location has occurred at CXH and SMH. HH colocation and the extension of the HDU outreach services are currently being planned. The action due date should be reviewed in March when a final plan of this work will be available.

Action:
Develop and implement a Trust wide colocation plan for all sites *Due Date:* 21/12/18
Update on action:
Trust wide colocation plan in place. Colocation successfully achieved at CXH and SMH sites with an outreach service implemented at HH. Plan under review regarding colocation of HDU are cardiac ITU areas at HH

Contingency Plans

Continue to work towards an integrated model and utilisation of current services provided by the Site team and outreach.

Key Summary Updates & Challenges

An escalation SOP is in place to detail plans for increased demand for Critical Care, including actions for increased staffing requirements

A number of mitigations have been implemented since the risk was first identified in June 2016, including the relocation of critical care services at St Mary's and Charing Cross hospitals.

The risk will be further reviewed in April 2019 to ensure it reflects the current risk, including timely access to critical care beds.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of potential harm to patients caused by a failure to follow invasive procedure policies and guidelines	16	16	9	*NEW*	Medical Director	Incidents, SIs and Never Events Trustwide safer surgery audit Training compliance

Cause:
- Non-compliance with surgical WHO checklist
- Lack of Local Safety Standards for Invasive Procedures (LocSSIPs)
- Trust policies too complex and difficult to put into practice
- Ineffective team working and leadership leading to human error
- Staff inadequately trained
- Inadequate staffing levels
- Interruptions to procedures leading to human error
- Inadequate or faulty equipment

Effect:
- Increase in SIs and Never Events
- Risk of increased level of harm
- Reduced patient confidence
- Reputational damage
- Increased staff stress & reduced morale

Current Risk Controls

- Trustwide action plan in place in response to never events
- Weekly updates on progress with the action plan provided to the executive committee
- Bi-weekly invasive procedure task and finish group in place, chaired by the medical director with representation from all divisions
- Divisional invasive procedure task and finish groups established
- Safer surgery safety stream in place, led by the Trust Lead Surgeon
- Programme manager from the office of the medical director in place to support implementation
- Policies and guidelines to support safe invasive procedures in place
- Invasive procedure e-learning module part of core clinical skills training
- Trustwide safer surgery audit included in annual audit plan focused on simulation, coaching, human factors and support

Mitigation Plan

Action:
Develop and deliver trustwide action plan in response to recent invasive procedure never *Due Date:* 31/03/19
Update on action:
Progress with individual actions is outlined separately. The action plan is being delivered through the divisions reporting to the invasive procedure task and finish group, with monthly reporting to the quality and safety sub-group and the executive quality committee. A weekly update on implementation of the action plan is being brought to executive committee until it is progressing given the complexity.

Action:
Undertake engagement with clinical workforce in response to never events *Due Date:* 31/03/19
Update on action:
Communication and engagement has occurred through divisional management and governance routes as well as through:
- Never event safety alerts published on the intranet and circulated through the divisional cascade.
- All staff emails sent from the medical director and nurse director on 11th January and 29th January.
- Extraordinary meeting with the medical director for all clinical directors on 24th January to discuss the never events.
- Emails sent to all doctors from the medical director on 4th February.
- Theatre visits on all sites by the medical director/divisional director.
- Deep dive meeting with maternity on 28th January with a follow up on 11th February to review quality metrics. All variance on quality metrics confirmed to be being managed and mitigated with a plan in place for additional staffing included in business planning.
- Meetings with the nurse director for all nursing leads and radiology managers on 5th February and all lead midwives on 8th February.

Communication and engagement will continue as the work progresses so that staff remain informed of the actions we are taking and the part they play in them.

Action:
External review of actions and response to never events *Due Date:* 31/03/19
Update on action:
The meeting with the national director of patient safety to review the actions we are taking and get advice on what else we should consider is due to take place on 21st March. Following a recommendation from NHSI, a meeting is also taking place with Jane Carthey, a human factors and patient safety specialist, on 7th March. The PSTRC has undertaken a review of all actions taken as a result of previous never events to determine their effectiveness and support identification of further actions. This is currently being finalised. Findings will be reported by the end of March 2019.

Action:
Develop simulation training and coaching programme to be delivered to all invasive procedure staff *Due Date:* 31/03/19
Update on action:
Phase one of the programme is in progress, with sessions completed/planned for the five specialties where we've had never events. Phase two, an 18 month programme for all specialties involved in invasive procedures, is being planned. A final draft of the programme with training dates and costs will be presented to the Invasive Procedures Task and Finish Group and circulated to the divisions in March. Once reviewed and content agreed then the programme will be presented at ExQu on Tuesday 2nd April for approval and sign off.

Action:
Review all Trust policies and guidelines relating to invasive procedures to ensure they are line with national guidance and are audited *Due Date:* 31/03/19
Update on action:
We are currently reviewing policies and processes relating to invasive procedures to ensure that they are in line with national guidance, consistent and easy for staff to follow. Progress so far includes:
- Invasive procedures policy review completed – due to be approved at quality and safety sub-group on 20th March
- Count policy review completed – due to be approved at quality and safety sub-group on 20th March
- Consent policy review underway – due to be completed by end of April 2019.
- List of all other invasive procedure related policies being reviewed by Trust Lead Surgeon to ensure they are fit for purpose – due to be completed by end of March 2019.
- A list of LocSSIPs identified as being required by the divisions is being reviewed as a standing agenda item at the Invasive Procedures Group. The aim is to get these in place by the end of March 2019. A template for LocSSIPs has been agreed and appended to revised Invasive Procedures Policy. A number of LocSSIPs have already been approved and launched e.g. pleural tap/drain, bronchoscopy, OPAT, Cath lab LocSSIPs. The division of surgery have undertaken a review of LocSSIPs in place in other organisations and are planning to use some of these as the basis for their outstanding LocSSIPs. These have been shared with the other divisions who are reviewing them for use in their areas too. An update will be provided at the next task and finish group on 13th March 2019.

Action:
Undertake actions to improve, monitor and provide assurance around compliance with key safety *Due Date:* 31/03/19
Update on action:
- Divisions have confirmed that 'Stop before you block' has been implemented for anaesthetic procedures. An audit tool is in development to monitor progress with implementation. The audit is planned for Q1 2019/20. The SB4YB protocol has been incorporated into the revised invasive procedures policy.
- Audit of the Count Policy planned for Q1 2019/20. Audit tool being drafted using the revised policy.

	• Divisions have confirmed that the intended site of surgery is now displayed on the white boards in theatres. Spot check audits are being planned by the division. Date TBC. • Signs are now up on the doors of anaesthetic rooms reminding staff not to interrupt the anaesthetist when the patient is in the anaesthetic room. Spot check audits are being planned by the division. Date TBC. • Pilot of use of radiopaque markers in urology underway. Progress update is being provided at the next task and finish group. • A review is being undertaken by SCC to look at the possibility of switching to electronic records for the safer surgery checklists. Progress update is being provided at the next task and finish group. • Review of surgical never events by NHSI recommend that each patient has a treatment plan in place, which includes the procedure, the site, the side and direction of surgery. An audit is being planned to review the use of these across the Trust. This will take place in Q2 2019/20. • SSC have confirmed that there is already a process in place for regularly checking equipment and replacing/removing faulty equipment. The process will be reviewed at the next task and finish group. • Following a recommendation in the NHSI review of surgical never events, SCC are reviewing storage in theatre for equipment that is 'sided'. An update on progress will be provided at the next task and finish group. • Meeting occurred on 15th February with the medical director's office and the director of communications regarding implementation of safety 'nudges'. This is being taken forward as part of a winder piece of work looking at the priorities for quality and safety in terms of communication and engagement. The first meeting to discuss this is taking place on 25th March. **Action:** Ensure 100% compliance for all doctors with the invasive procedure electronic training module *Due Date:* 31/03/19 **Update on action:** Compliance is 91.3% as at 22/02/19. The list of non-compliant staff is sent to the divisions each time WIRED is updated. Staff who are non-compliant have been prevented from operating by the divisions. The divisions have been asked to confirm back the medical director's office which of the remaining staff on the non-compliant list have either left or are not required to do the training. This will allow the medical director to write personally to all non-compliant staff setting out the next steps should they not complete the training. This approach has been reviewed with the Associate Director of HR.
Contingency Plans	**Key Summary Updates & Challenges**
Process to be managed through the Medical Director's office with nominated clinical leads	None of the never events reported so far in 2018/19 have caused harm to the patients involved. The trust wide action plan in response to the seven invasive procedure never events continues to be delivered, with weekly reporting to the Executive Committee. The action plan is progressing well. An external review of actions and response to never events has been undertaken by the national director of patient safety. The risk score will be reduced after the simulation and coaching programme has commenced in all specialties and we have been never event free for a period of no less than 6 months.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
The number of patients presenting to the Trust who are infected or colonised with CPE is likely to increase in line with global and national trends. The risk is uncontrolled spread of CPE within the Trust. **Cause:** • CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, environmental hygiene, and optimised use of antibiotics. • Easy transmission from patient to patient will occur if correct IPC procedures are not followed. • With increased cases of CPE presenting to the Trust there is a risk for potential transmission and in particular in the renal, vascular and haematology cohorts with frequent admissions and outpatient appointments. • Current isolation capacity (sideroom capacity) insufficient to implement the PHE toolkit recommendations. • Recent changes in the spectrum of CPE producing organisms resulting in increasing identification of CPE in Citrobacter and Enterobacter species resulting in increased pressure on isolation facilities and infection teams to trace potential transmission • Location of services across the Trust for diagnostics and treatments, resulting in a frequent need for cross-site transfer. • Estates not ideal for IPC practice, compounded by backlog maintenance issues. **Effect:** • Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotic choices for treatment and ultimately worse patient outcomes. • Increased demand for isolation facilities, potentially exceeding available capacity more frequently, and risking the spread of other organisms between patients. • This will result in direct and indirect financial losses to the Trust (including bed and ward closures with resulting lower throughput, and increased costs of litigation), and reputational damage. • Increased movement of patients and possible transmission during these movements for diagnostics and treatments. • Increased risk of further transmission due to estates issues, particularly in toilets and bathrooms.	**12**	**12**	**9**		**Medical Director**	• High level of compliance with CPE admission screening(>90%) • No increase in CPE BSIs • Reduction in the use of carbapeneme antibiotics where there is no indication • 6 monthly antibiotic point prevalence audit to monitor correct antibiotic use. Automated room decontamination available on site for CPE Daily sit-rep available to know where current inpatients are situated Validation of current screening approach performed Reduction in outbreak frequency

Current Risk Controls *(what we are doing now to manage risk)*

• Measures to combat CPE have been implemented around improved screening and isolation, laboratory and epidemiological investigations, internal and external communications, hand hygiene, environmental cleaning and disinfection, and antimicrobial usage and stewardship.
• The Trust has a CPE Policy in place, and has patient and staff information available on the Source.
• Flagging system on CERNER for identifying known carriers is in place.
• Serious Incident investigation following transmission events and ward closures resulting in increased emphasis on hand hygiene, environmental improvements and cleaning.
• CPE management is discussed weekly at the HCAI Taskforce meeting
• CPE action plan has been revised in light of recent increases in CPE.
• CPE screening data now available at ward level through the IPC scorecard and is included in the harm free care reports.
• Regional and national involvement in CPE prevention and policy development

Contingency Plans *(what we will do if the risk materialises)*

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

Mitigation Plan *(what we will do further to reduce the risk)*

Action:
Development of an in-house HPV decontamination service *Due Date:* 29/03/19
Update on action:
The tender process for the HPV UV decontamination service is in progress.

Action:
Implementation of a CPE screening tool through Cerner *Due Date:* 29/03/19
Update on action:
Cerner are in the process of re-designing the tool in the form of a notation record, but no timeline for completion is available at present.

Action:
Develop a daily 'sitrep' report on current known CPE patients and their location *Due Date:* 29/03/19
Update on action:
A draft proposal has been developed. This has been circulated to the divisions for consultation. It is due to be finalised by the end of March.

Action:
Review the cost and feasibility of performing a one-off point prevalence survey of all inpatients for CPE carriage *Due Date:* 29/03/19
Update on action:
Proposal being re-drafted following comments at quality & safety sub-group in February. This will be re-presented to the meeting on 20th March.

Action:
Ensure processes for cleaning sink and shower drains are in place and being implemented on all sites *Due Date:* 28/02/19
Update on action:
Closed. SOP for drain cleaning procedures produced by Estates/CBRE. This is being monitored through the water safety plan which reports to the Water Hygiene Group.

Action:
Review the value of rapid screen for CPE using PCR to support outbreak management *Due Date:* 29/03/19
Update on action:
This is being developed and reviewed to maximise patient safety and reduce bed day losses, especially during outbreak management.

Action:
Explore funding options for in-house sequencing of CPE *Due Date:* 29/03/19
Update on action:
An application to the charity is being developed to fund an in-house option to assist with outbreak management.

Key Summary Updates & Challenges

The current risk score has been downgraded from 16 to 12 because screening compliance has increased to close to the target of 90% and there are no current outbreaks of CPE.

An SOP for drain cleaning procedures has been produced. by Estates/CBRE

There continues to be a number of patients who screen positive for a CPE organism in various locations within the organisation.

The target risk score date has been extended to the end of March 2019 to complete the outstanding actions, which include: development of an in-house HPV decontamination service, implementation of CPE screening tool through Cerner, reviewing the value of rapid screen for CPE using PCR to support outbreak management, etc.

The target risk score will be achieved once the actions have been completed, screening compliance remains high and we have gone 6 months without an outbreak of CPE.

ID: 2480 **Title: There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust** **Page 11**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust **Cause:** Inconsistent cleaning provision across the Trust estate through: • Domestic services; effectiveness of training, staff competency and provision of necessary equipment and materials • Failure to follow infection control practices as part of cleaning duties • Equipment cleaning: frequency and effectiveness • Access; ability to clean inhibited by activity due to operational issues or inappropriate storage **Effect:** Increased risk of infection, risk of reduced CQC score, risk of reduced patient satisfaction. Ultimately, this might result in the following impacts: • Potential infection control issues and response to outbreak • Potential for CQC related penalties due to a failure identified by inspection. • Potential for penalties/ fines or enforcement notice. • Impact on reputation through Friends and Family Test (FFT) responses, NHS Choices feedback, other satisfaction surveys and Patient-Led Assessments of the Care Environment (PLACE) scores	**15**	**12**	**6**		**Director of Nursing**	Planned and unannounced Audit results against the National Cleaning Standards. Estates and Facilities Quality Committee. Monitoring of overall action plan. Infection Prevention Control team observation audits.

Current Risk Controls

• Contract with Sodexo to provide cleaning services in line with National Specification for Cleanliness in the NHS
• Trust Cleaning Policy detailing responsibilities, methods and materials with reference to detailed procedures for specific tasks.
• Comprehensive training schedule and modules provided by domestic services contractor Sodexo.
• Scheduled regime of cleaning and auditing of standards conducted and reported on a weekly basis. Timetables are in place for cleaning within departments. Regular cleaning audits are performed with oversight from area clinical manager.
• Advising on specific / specialist cleaning requirements. Educating staff about the importance of following the correct processes for decontamination and cleaning.
• Escalation of issues by users to Cleaning provider and Facilities team.
• Monthly contract review meetings between Facilities and Sodexo to monitor, review and agree any necessary actions related to quality and performance against contract.
• Monthly report provided by Sodexo detailing results of cleaning audits including if audits are conducted in partnership with clinical staff.
• Cleaning outcomes will be regularly monitored and reviewed to ensure the appropriate cleaning services are provided to each clinical activity.
• Bi-monthly quality meetings between service providers and cross section of multi-disciplinary Trust staff
• Additional senior cleaning resource from Sodexo in place.
• New Contract Manager on site
• Invoking contractual clauses to remedy failures
• Facilities Matron appointed by Sodexo
• Escalation of issues to CEO level and regular CEO/ Director of Nursing to CEO meetings.

Mitigation Plan

Action:
Maintain and raise standards of cleaning *Due Date:* 29/03/19
Update on action:
Some improvement has been achieved but it needs to be demonstrated that it is sustained. Due date postponed to end of March 2019.

Action:
Re-tender cleaning services *Due date:* 30/04/20
Update on action:
The recommendation to re-tender services using an existing procurement framework was agreed at Executive Finance Committee on 22nd January 2019

Contingency Plans

• Invoke the terms and clauses of the Hotel Service Contract to impose escalations, rectifications and as appropriate breach of contract leading to possible termination of contract as follows:
• Without prejudice to any other right or remedy it might have, including escalation and rectification, the Trust may terminate the Agreement by written notice to the Supplier with immediate effect, for example for material breaches not capable of remedy or where they have not been remedied with the specified number of days in the notice provided to the Supplier.

Key Summary Updates & Challenges

An assurance report including ongoing cleaning workstreams was presented to the Audit, Risk and Governance Committee in March 2019.

Since April 2018, no serious infection control issues with direct impact on patients safety have been reported. A review of incidents and complaints related to cleaning and infection control over the past 6 months reflects lower number of issues reported.

Further staff have been recruited by Sodexo and cleaning standards have imporved overall, although there remain some areas of concern needing continued close focus.

The risk score has therefore reduced from 15 to 12 as its likelihood has reduced.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to deliver appropriately skilled and competent nursing care in hard to recruit areas across the Trust and areas where there is a national shortage of nurses. **Cause:** • National shortage of nursing staff in some disciplines, including nurses for children, medicine for elderly, stroke etc. • High turnover of staff • Areas expanding their services when there is limited supply **Effect:** • Reduced staff morale /increased turnover /Increased rates of sick absence • Inadequate skill mix on wards • Poor patient experience • Potentially increased incidents.	**12**	**12**	**9**	*NEW*	**Director of P&OD**	Workforce Establishment & Vacancy Indicators (QlikView) People KPI (QlikView) Harm Free Care report

Current Risk Controls

• Revised recruitment and retention plan for 2019/2020 developed to reduce the turnover for all nursing and midwifery staff
• Resourcing & Retention Steering Group established, chaired by the Director of People & Organisation Development and/or Director of Nursing reviews progress of plan on a monthly basis.
• Careers clinic and internal transfers are in place to support action plan as well as a range of retention initiatives to reduce turnover. Additional resource has been recruited to support the action plan
• Student and newly qualified attraction strategy is in place which includes students' automatic offers and working in partnership with the Nursing Directorate to engage this group before and after they qualify
• Leavers data to be analysed more rigorously as part of 2019/2020 action plan
• Monthly meetings in place with Divisions to review vacancy rate, recruitment activity and impact of this
• Proactive attraction and recruitment plan in place to attract passive and active candidates
• A new Applicant Tracking System will be in place by September 2019
• Four Resourcing Business Partners have been added to the team act as account managers for Divisions, run centralised campaigns, manage campaigns for hard to recruit areas and manage international recruitment
• All current vacancies for hard to recruit roles advertised through rolling adverts
• Safe staffing on wards monitored through monthly fill rate reports for nursing by division.
• Monthly exception reports produced for Divisional Quality and Safety Committee
• Procedures implemented to manage establishment, staffing, sickness & turnover information
• Business case was signed off to increase supply which includes: international recruitment, Nursing Associates, Graduate Nurse Apprenticeships and addition Practice Educators to support newly qualified staff.

Mitigation Plan

Action:
Delivery of Recruitment and Retention Action Plan *Due Date:* 31/03/20
Update on action:

Action:
Delivery of proactive recruitment and attraction plan *Due Date:* 31/03/20
Update on action:

Action:
Implement a new Applicant Tracking System *Due Date:* 30/09/19
Update on action:

Action:
Divisional Recruitment and Retention plans to be developed to manage turnover, expanding services and hard to recruit areas *Due Date:* 30/09/19
Update on action:

Action:
Delivery of Strategic Supply of Nursing Business *Due Date:* 31/03/20
Update on action:

Contingency Plans

Reduction in activity

Key Summary Updates & Challenges

This risk was escalated onto the Corporate Risk Register on 19 March 2019.

Hard to recruit areas include Acute and Specialist Medicine at CXH, Neuroscience and Stroke, Clinical Haematology, Trauma, Gynaecology & Reproductive Medicine, Imaging, and Private Patients at Charing Cross Hospital.

Despite high vacancies > 20% in these areas, safe staffing has been maintained throughout through the use of bank and agency staff.

A recruitment and retention plan has been approved for 2019/20, which will support further reducing the risk. A proactive recruitment and attraction plan is also being delivered.

ID: 2938 **Title: **NEW** Risk of delayed diagnosis and treatment and failure to maintain key diagnostic operational performance standards**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of delayed diagnosis and treatment leading to poor clinical outcomes and failure to maintain key operational performance standards relating to the Diagnostic target (DM01)	**16**	**12**	**8**	*NEW*	**Director of WCCS**	• Delivery of the performance trajectory agreed with Commissioners • Local level scorecards • Clinical harm review (MD Office)

Cause:
- Mismatch of accurate reporting and poor data quality due to implementation and embedding of new systems and processes
- Mismatch of capacity and demand
- Financial challenges and subsequent limited capability to increase capacity
- Imaging capacity being lost due to equipment failure
- User related data entry issues
- Cerner system issues
- Lack of sufficient BI, Cerner/Cerner change and data warehouse resource which can compromise reporting
- Lack of sufficient BI resource to manage emerging and backlog issues rapidly
- Forecasted increase in demand
- Recruitment issues in certain areas

Effect:
- Increased risk of clinical harm to patients who remain on waiting lists for a long time
- Reduced quality of patient experience / staff morale
- Increased operational inefficiencies
- Failure to meet contractual / regulatory / performance requirements and trajectories
- Loss of reputation and reduced confidence from key stakeholders
- Increased cost pressures through funding of improvement programmes.

Mitigation Plan

Action:
Agree diagnostics metrics and include in weekly PTL meetings *Due Date:* 30/04/19
Update on action:
In progress.

Action:
Develop a business case for additional equipment to deliver increased capacity for MRI *Due Date:* 30/04/19
Update on action:
In progress.

Action:
Review ultrasound capacity with a view to expand establishment to deliver increased capacity *Due Date:* 30/05/19
Update on action:
In progress.

Current Risk Controls

- Extended operational hours
- Imaging Reporting - Additional radiologist sessions to report on images and reduce turnaround time
- Data quality monitoring
- Development and implementation of site/clinical strategy
- Prioritising of urgent inpatient and cancer 2WW patients.
- Outsourcing of MRIs to Alliance and the Steiner unit
- Weekly RTT Planning meetings held cross site for improved work flow co-ordination, service escalations, potential breach alerts and validation, resolution of in week challenges and sign off for 6 week and beyond capacity planning and review
- Increased work of pathway reviews being undertaken through modality meetings led by Heads of Service.
- Endoscopy – Additional capacity in place to reduce backlog
- IT team have escalation process in place with Cerner through weekly meetings for managing system issues.

Contingency Plans

- Mitigation plans in development with local services.
- Clinical harm review.

Key Summary Updates & Challenges

DMO1 target met in January 2019 with 0.78% of patients not having a diagnostic examination within 6 weeks from request.

A business case is being developed for additional equipment to deliver increased capacity for MRI.
Ultrasound capacity is also being reviewed with a view to expand establishment to deliver increased capacity.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of medication safety being negatively affected due to poor adherence to medication safety policies, particularly with regard to: • Effectiveness of medication storage • Security of medicines • Risk of expired medications in clinical areas. **Cause:** • Limited storage facilities, particularly IV fluids • Failure to monitor temperature of storage areas and fridges and document remedial actions • Inability to maintain required room temperature in some areas due to lack of temperature control / air conditioning. • Lack of secured access in some areas and response time from estates to redress • Failure to effectively check expiry dates of medicines • Failure to segregate and maintain personal control of CD keys. **Effect:** • Loss of medication • Tampering with medication by unauthorised people • Drugs may not be effective if stored incorrectly or expired • Failure to comply to statutory/ mandatory regulations related to medicines.	**16**	**9**	**6**	↓	**Divisional Directors**	Storage audits Temperature audits Six-monthly drug stock security audit undertaken Compliance to medicines management training module on Wired Monthly medicines matters audits - Synbiotix

Current Risk Controls	Mitigation Plan
• Policy for Security, Safe Storage and Transport of Medicines includes a section on the safe storage of medicines • Annual bedside locker audit undertaken • Induction training • Medicines management mandatory training module • Pharmacy assistant checks stock cupboard for medicines expiry dates on a monthly basis • Application of a green expiry sticker if expiry is due in less than 6 months • Six-monthly control drug audits • Six-monthly safety and security audits • Monthly audits via Synbiotix for CD, Fridge and Security • Medicines Matter programme to raise awareness • Updated Do-designed materials to make following policy simpler for users. • Monthly Medicines management committee to oversee compliance	**Action:** Delivery of the Medicine Management Improvement Plan *Due Date:* 30/05/19 **Update on action:** Significant progress has now been made against the plan, with the lunch of the medicines matters phase 1 materials and synbiotix audit programme. Phase 2 of the medicines matters materials will be launched at the end of Q1 2019/20.

Contingency Plans	Key Summary Updates & Challenges
• Areas found to be significantly out of temperature range - consider relocation of Medicines,Increase stock rotation to reduce impact to individual medicine lines through prolonged exposure • Security issues; prioritise with estates for action • Increase monitoring in areas where expired medications are found.	In light of adoption of phase 1 medicines improvement materials and broad audit programme showing good adherence to policy, risk downgraded to a score of 9. This reflects the intelligence indicating significant / major failings relating to medicines management at ward level is far less likely as a result of the improvement programme. The risk score will be reviewed following launch of the phase 2 medicines matters materials at the end of Q1 2019/20.

ID: 2475 **Title: Identification of educational issues** **Page 15**

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

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

Mitigation Plan
Action: Further development of the education reviews process underway with the aim to embed within the specialty and enhance divisional oversight of improvement plan. *Due Date:* 31/03/19 **Update on action:** New process has been implemented and five specialties identified for review by the medical director. Two of out of five of these have taken place with actions noted which are being taken through the divisional committees. The three remaining reviews are taking place in March 2019. **Action:** Implement the junior doctor engagement model. *Due Date:* 01/04/19 **Update on action:** 80% of specialities now have a trainee representative in place. The model for trainee representation was approved at ExPOD in January and work has begun on developing the implementation plan. It is anticipated that the new model for junior doctor representatives will be in place by April 2019 and fully implemented in time for the August rotations. An education programme has been designed to support the development of senior trainees. The first session on Leadership was delivered on 14th February and was well received by those in attendance. We continue to work on developing the implementation plan for divisional representatives. **Action:** Review of education structure to ensure adequate support for clinical leaders and strengthen accountability. *Due Date:* 31/03/19 **Update on action:** Action complete. **Action:** Increase attendance at the junior doctor forum. *Due Date:* 01/08/19 **Update on action:** Action plan in place to improve attendance, this includes: moving to monthly meetings, quarterly presentations from CEO/Medical Director, implementation of a junior doctor chair.

Contingency Plans	Key Summary Updates & Challenges
Re-establish annual educational specialty review process for all specialties chaired by the medical director	The education structure has been reviewed to ensure adequate support for clinical leaders and strengthen accountability We continue to monitor and manage educational issues through our agreed governance processes. 80% of specialities now have a trainee representative in place. The undergraduate governance and monitoring visit took place in February 2019, the report for which will be due in July 2019.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk to Data: A cyber security incident can result in data being stolen, destroyed, altered or ransomed. Risk to Infrastructure: A cyber security incident can result in all or part of Trust ICT infrastructure being disabled, or destroyed. There would be a prolonged period of recovery. **Cause:** In order to function, the Trust needs to maintain an ICT environment connected to the internet and other networks. This exposes the Trust to a constant flow of infection and attack. **Effect:** • Data: o Stolen; reputational damage, breach of obligations as regards data security, fines, notification to the victim (s), compensation and legal claims. o Destroyed; almost all patient data is being created and stored digitally including medications, observations and treatment decisions.. It is possible for hackers to destroy not only online data but all backups. o Altered; connected medical devices are vulnerable to external hacking. Staff with access to data are the most likely insider threat. Maliciously altering data can affect both corporate and clinical systems and can result in either patient data or corporate data being changed. o Ransomed; the data doesn't leave the Trust infrastructure but is unable to be accessed until a ransom is paid. Even if a ransom is paid, there is no guarantee that the encryption key will be handed over and access to the data restored. • Infrastructure o Disabled; there would be a prolonged period of downtime while networks, servers and storage were restored to service. An outage is likely to be anywhere between a week to a month. o Destroyed; there would be up to 6 months downtime, several million pounds of expenditure to replace equipment and restore services.	**16**	**16**	**12**	⟺	**Chief Information Officer**	• DSP Toolkit Return (Independently audited) • Monthly Cyber Security Dashboard (reviewed by IGCS) • Annual Penetration Test (Top 3 risks and associated action plans to be presented the Board) • Annual Informatics Audit Plan (reviewed by IGCS)

Current Risk Controls

Technical Controls:
• The Trust tries to maintain the lowest possible attack profile to reduce exposure to malware and hacking. Access to social networking, webmail, tor browsers and other high risk sites are all blocked.
• The Trust maintains firewalls and a documented change control process to block threats.
• The Trust maintained Servers and Desktops are installed with antivirus software.
• Trust uses a secure web gateway to detect and prevent any malicious network activity from coming into or leaving the network.
• The Trust has invested in a backup and restore system that, to date, has been able to restore files compromised by ransomware with minimal data loss.
• There is a monthly cyber security dashboard reviewed at the Information Governance and Cyber Security (IGCS) meeting to track threat activity and effectiveness of response.
• The Trust has a Cyber Incident Response Plan and an ICT Disaster Recovery Plan to ensure that ICT staff can effectively contain and respond to cyber threats. This procedure is reviewed and updated annually to ensure that the documented processes are current and aligned to industry best practices.
• The Trust works in accordance with the DSP Toolkit requirements, such as performing an annual penetration test on the Trust critical assets.
• The Trust has an ICT Security team consisting of two members of staff.
• The Trust has procured multiple security solutions which are being implemented.

Mitigation Plan

Action:
Update of the Annual Mandatory DSP Training through the imposition of a revised SCORM package *Due Date:* 31/03/19
Update on action:
Scorm package containing the additional questions and answers to be implemented before the end of March 2019

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

Action:
Process Controls: Continual deployment of critical and security patches to Servers and Desktops in accordance with ITIL standards *Due Date:* 31/03/20
Update on action:
Automated server and workstation patching remains at a good level.

Action:
Security Software Investment: Multi Layered Security Software currently in the process of being implemented *Due Date:* 30/06/19
Update on action:
The Logpoint solution has been developed further to integrate with the Trust ICT infrastructure.

Contingency Plans

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

Key Summary Updates & Challenges

The annual ICT infrastructure penetration test is being performed. Remediating issues highlighted will strengthen the Trust's security posture.

Various ICT teams, including the ICT Security team, are working to complete the DSP Toolkit submission which is due at the end of March 2019.

A HIMSS (Healthcare Information and Management Systems Society) mock assessment was held. HIMSS is a global, cause-based, not-for-profit organization focused on better health through information and technology. HIMSS leads efforts to optimize health engagements and care outcomes using information and technology. The outcome of the assessment was positive with some work required to meet the HIMSS Level 6 target.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of disruption to clinics and administrative work due to high levels of noise, dust and vibration expected from the Paddington Square demolition programme. The Paddington Square development has a demolition programme of a minimum of 7 months - phase 1. This is due to complete in late March 2019 having been delayed. The excavation for substructure of the new building will follow this. Construction programme unknown (total demolition and construction period likely to be 4 years). Trust buildings likely to be affected by the development include the three Outpatients buildings owned by the Charity, Mint Wing, Mary Stanford, and part of the Clarence Wing fronting Winsland Street. **Cause:** Extended demolition and construction programme working next to live hospital buildings may cause noise, vibration and dust **Effect:** • Unsuitable environment for clinicians to effectively deliver clinical services • Unsuitable environment for administrative and managerial practices • Poor patient experience • Delays to appointment times, or stopping of clinics or relocation of services to another site due to impact of demolition and construction • Potential loss of income and activity • Loss of market share • Lower staff morale	**12**	**12**	**9**		**Director of Redevelopment**	• Protocol note produced which sets out how SPG will ensure that the Trust will be provided with advance notification and kept informed of the scaffolding, demolition works and subsequent construction programme for the Paddington Square development on an on-going basis to assess the implications for and assist the Trust with managing its day to day operations and to keep its own stakeholders informed. • Communications strategy developed for Trust staff, and patients/visitors. • Weekly meetings with developer, SPG, and Westminster City Council when required. • Weekly meetings including nominated Divisional Leads, PALS and appropriate corporate and support functions. • Mapping complaints to identify and measure responses, problem areas and prioritise issues. •Daily monitoring and review mitigation measures in place to manage impact on Trust operations.

Current Risk Controls

Mitigation plans: Clinical services will continue to operate from the surrounding buildings. A number of mitigation measures have been agreed between Sellar and the Trust:
• Secured working outside of Trust operational hours for scaffolding on outpatient buildings and demolition of the bays directly adjacent to Trust outpatient buildings at weekends-only to minimise disruption.
• Information on potential disruption provided to patients and staff through the Source and Trust website.
• Escalation Protocol agreed between developer and Trust. Key contact information can be found on the Source, posters located at impacted building entrances / wait area TV monitors.
• Weekly meetings held between developer and Trust. Westminster City Council in attendance as required.
• A Project Steering Group has been set up to discuss the impact of the development on the operation of the hospital and how disruption can be mitigated. This group currently meets bi-weekly, and has representation from each clinical division, PALS, and appropriate corporate and support functions.
• Disruption schedule developed of upcoming works to allow services time to manage risks where possible. This is shared via appointed clinical leads and site manager.
• Local alerts and thresholds agreed over and above those set out by the council.
• Noise and vibration monitors installed in buildings where services are likely to be affected and monitored daily to ensure no breaches.
• Developer will need to stop work if agreed levels are breached.
• Regular reports to Executive Committee and Redevelopment Committee.
• CBRE to re-instate existing plant, air flow and air con in the three outpatients buildings to ensure they now function normally. [Complete].
• CTS to install anti-vibration mats and procure vascular Doppler headphones funded by the developer to impacted services as required. [Complete].
• Developer-funded mitigation works including installation of secondary glazing, air con and air transfer grilles. [Phase one works to the outpatient buildings expected to complete by March 2019. Phase two works to Mint, Clarence Wing Building and Mary Stanford Wing require submission of planning application].
• Regular update and discussion at Executive Committee and Redevelopment Committee.

Mitigation Plan

Action:
Developer to fund technical solutions e.g. vibration mats *Due Date:* 20/09/18
Update on action:
Action complete. Developer offered to contribute to physical mitigation measures such as vibration mats and air conditioning units. Trust may need to contribute financially.

Action:
Communications to be cascaded in divisions and to be sent to all stakeholders *Due Date:* 20/09/18
Update on action:
Action complete. Information on the intranet and Trust website provided for patient and staff and communications cascaded across trust.

Action:
Seek support from Westminster City Council to undertake some scaffolding and demolition at weekend *Due Date:* 20/09/18
Update on action:
Action complete. Working outside of trust operational hours for scaffolding on outpatient buildings and in the bay adjacent to the buildings to be demolished at weekends has been secured.

Contingency Plans

No contingency plan. St. Mary's Hospital is very constrained.
Divisions have advised they will stay in situ. This will be monitored by divisions and executive.

Key Summary Updates & Challenges

•The Contractor's target date for sub-structure work, i.e. structural work below ground level such as piling, is to commence on 09 April 2019. The Contractor expects to then spend the next 12 months in the ground to complete excavations, foundations, the basement etc. to support the structure above.
•The Trust have appointed AECOM as sub-consultant engineer under the Party Wall Act to advise the Trust on the technical content of the substructure works and to interpret impact on Trust operations.
•Redevelopment Team Manager to interface with the developer on a daily basis.
•Note next phase of construction is likely to be noisy and constant vibration. Works unlikely to be able to be stopped. Divisions reviewing impact.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain the agreed trajectory targets for Emergency Department (ED) 4 hours waiting and 12 hours decision to admit performance. **Cause:** • Inadequate ED estate to meet demand • Insufficient bed capacity across sites • Impact of winter bed pressures **Effect:** • Increased risk of clinical harm to patients waiting for a long time • Reduced quality of patient experience • Reduced staff morale • Provider Sustainability funding being withheld • Loss of reputation and reduced confidence from key stakeholders	**20**	**20**	**16**	*NEW*	**Director of MIC**	• ED Performance Reports • Outcome of external review of ED performance with emergency care intensive support team (ECIST) • Clinical harm review (MD Office and division)

Current Risk Controls	Mitigation Plan
• Improving 4 Hour Performance Working Group • Full capacity protocol • Support from 2020 Delivery and SAFER flow bundle • Improving Care Journey and Capacity Collaborative • Urgent and Emergency Performance and Accountability Framework • A&E Operational Group established to identify areas of focus for improvement • A&E Operational Group established to identify areas of focus for improvement • Assessment of Imperial College Healthcare Partners (ICHP) report to confirm next steps with the development of a specification for a digital tool that will deliver against its operational and strategic objectives, with regards to Red2Green, capacity management and flow. • Extended operational hours for ambulatory emergency care services at St Mary's and Charing Cross • Roll out of long stay review meetings across all sites to expedite decision making • Root cause analysis done following every 12 hour breach and reviewed at Improving 4 hour performance working group • SOP for boarding piloted since January 2019 • Extra beds in place at SMH and CXH since January 2019	**Action:** Redevelopment of CXH Emergency Department *Due Date:* 31/07/19 **Update on action:** **Action:** Trial planned for 2019/20 to support ED with additional resource when overcrowded *Due Date:* 30/04/19 **Update on action:** **Action:** Opening of 11 beds at CXH and 11 at SMH *Due Date:* 29/03/19 **Update on action:** Action on track. Most beds are open now with further 4 to be opened in the week commencing 18 March 2019.

Contingency Plans	Key Summary Updates & Challenges
• Continued drive of above controls and standards • Escalation of 12 hour breaches to A&E Delivery Board for further support from external partners	Performance against the 4 hour standard for February 2019 was 88.1%. This was below the local trajectory of 90.5%. February 2019 performance was 5.7% higher than performance in February 2018 and type 1 performance was 13.5% higher. The number of twelve hour breaches of wait from DTA to admission dropped to 4 in February, a decrease of 6 from January 2019. All breaches in February were delays to admission for mental health provider beds. All of the breaches occurred at SMH; 3 patients were transferred within the greater London area and 1 out of area. Further bedded units have been opened at St Mary's and Charing Cross hospitals to increase capacity and flow. The Charing Cross Emergency Department is being redeveloped. This risk will be reviewed further in April 2019 in light of the revised national 4 hours performance target, which is being changed from 95% to 90%.

ID: 2937 **Title: **NEW** Failure to consistently achieve timely elective (RTT) care** **Page 19**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
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). **Cause:** • Ineffective RTT Patient Tracker Management (Waiting List), insufficient capacity accross pathways and increasing demand. • Cancellations of elective care patients during emergency care surge and/or delays in discharges. • Incomplete suite of visible waiting lists i.e. follow-up waiting list. • Business continuity impacted by the quality and resilience of the estates and availability of equipment. • Data quality issues driven by both front end user error, extraction and reporting. • Theatre capacity not fully utilised. **Effect:** • Clinical harm to patients, poor experience of care and unacceptable delays for patients. • Deterioration in ICHT's regulatory compliance rating. • Poor experience for the multidisciplinary teams and referrers. • Enforcement of contractual financial penalties and loss of income. • Diversion of care to other NHS and private providers. • Impact to organisational reputation and partnerships including the NWL STP.	**20**	**16**	**12**	*NEW*	**Director of SCC**	• Clinical harm review | • Datix Reporting • RTT performance reports and governance structures including specialty level compliance with 0 >52 weeks waits and RTT PTL size • RTT Clock Stop Audit • Delivery of the 19/20 performance trajectory agreed with commissioners/NHSI • Theatre utilisation | • Surgical Productivity Programme PIs. • Cancellations(including QMCO) • CQC Ratings for Responsive • Monthly integrated performance scorecard

Current Risk Controls

• ICHT Access Policy
• ICHT Clinical Harm Standard Operating Procedure
• RTT Improvement Programme Governance and oversight by Executive Operational Committee(bi-monthly report) – trustwide elective performance framework, validation systems and MDT education.
• Monthly Elective RTT Care Steering Groups including NHSE/I and NWL CCG commissioners
• Trust Data Quality Framework including RTT Clock Stop Audits and NHSI RTT DQ
• Elective Assurance Review Action Plan(MBI)
• Fortnightly CEO RTT meetings
• PTL size control task force(short term action)
• Data Quality Steering Group providing digital enhancement and action where needed

Mitigation Plan

Action:
Design, develop and embed an Elective Care Performance Framework *Due Date:* 31/03/19
Update on action:
The framework has been designed. It was authorised by the Executive Operational Committee in January 2019 and is currently being implemented at specialty and divisional level. SCCD inaugural meeting completed on 28 February 2019.

Action:
Design and deliver relevant training packages using classroom and digital platforms *Due Date:* 30/09/19
Update on action:
Investment business case authorised and in implementation
RTT Education & Steering Steering Group established, overseeing the development of training material for classroom training digital platforms
Classroom Training(pilot form)commenced.
Digital(Learning Management System) procured and in implementation.

Action:
Enhance management of RTT PTL through the review and restructure of the validation team to provide greater resilience and consistency around RTT PTL management and move towards prospective tracking. *Due Date:* 31/07/19
Update on action:
Consultation complete. Interdependency on enhancement on enhancement of RTT validation tool.

Action:
Enhance RTT Validation tool (Qubit), to deliver further efficiency and data quality benefits for RTT management *Due Date:* 30/04/19
Update on action:
Phase 1 delivered and embedded moving the process to a single platform and reporting suite. Phase 2 in testing but experiencing delays associated with specialist project resource. Sustainability plans to be developed by the project board.

Action:
Develop a follow-up waiting list *Due Date:* 31/12/19
Update on action:
Technical data extraction and reporting under design. This will be followed by extensive validation and data clean up in advance of clinical operational implementation.

Action:
Deliver IST and Elective Care Assurance Report action plans *Due Date:* 31/12/19
Update on action:
Action plan reviewed amd agreed by the Executive Operational Committee and Audit and Risk Committee with quarterly updates.
Business case being developed to address the recommendation to increase Business Intelligence capacity. Funding required in 2019/20 to enable completion of the action plan as per due date above.

Action:
Establish a Surgical Productivity Programme *Due Date:* 31/01/19
Update on action:
Programme resourced and established including commencement of reporting to the Executive Operational Committee

Contingency Plans

• Stand up ad hoc clinical capacity
• Diversion/outsourcing to third party providers
• Escalation to Divisional Directors of MIC/SCCD/WCCS and Director of Operational Performance
• Enactment of "special measures"/SRO meetings providing intensive support to mitigate long waiting time
• Discretionary use of external data clean up resource

Key Summary Updates & Challenges

RTT - The Trust is working on ways to improve the Data Quality on and the accuracy of the RTT PTL as it has been growing since Sep 18. These actions will also control the size of the PTL and relate to the following:
• Systems Improvements to reduce errors on PTL via System Errors and ERS issues
• Improve the Quality of Validation through targeting and removing duplicates (coupled with training)
• Increase focus on improving validation productivity
• Operational Specialty level analysis of additions vs removals to review and target capacity needs
Elective Resilience – The learning and planning deployed to improve winter elective and emergency resilience has resulted in significant benefits across the care system, however SMH site continued to experience cancellations on certain pathways, particularly general surgery for level 1 and and specialties requiring access to critical care(level 2 & 3) on all sites.

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

Current Risk Controls

• Reporting of all 12 hour trolley wait breaches as Serious Incidents.
• Agreeing and piloting a new escalation framework with commissioners.
• Meetings with the mental health trusts to raise concerns.
• Increased engagement from mental health Trust and CAMHS service in Serious Incident investigation process.
• Regular meetings with CNWL and ongoing engagement with mental health trusts and ICHT with regards to pathways and management of patient group.
• Escalation to the A&E Delivery Board.
• Escalation at Provider Oversight Meetings with NHS Improvement.
• Escalation of delays in real time to both the relevant mental health trust and commissioners.
• Augmenting the nursing establishment in the emergency departments with registered mental health nurses.
• Increasing the security presence in the emergency department at SMH.
• The establishment of a dedicated consultant lead for mental health in both emergency departments.
Ongoing discussions with the commissioners regarding liaison psychiatry role
• Conference call established for paediatric MH patients likely to require admission
There has been an increase in the RMN presence at SMH to 24/7
Safety stream established reviewing mental health care within the Emergency Departments.
Mental Health Big Room in progress.

Mitigation Plan

Action:
To complete investigation into latest 12 hour breach incidents *Due Date:* 31/12/18
Update on action:
Action complete. Report submitted to CCG in November 2018.

Contingency Plans

Management within department with existing controls, ongoing investigation of serious incidents for 12 hour trolley wait incidents.

Key Summary Updates & Challenges

Sixteen incidents were declared as Serious Incidents across December 2018 to February 2019. Work with the Mental Health Big Room continues.
All 12 hour trolley wait breaches continue being reported as Serious Incidents and a root cause analysis is undertaken.
This risk will be reviewed further in April 2019 in light of the revised national ED performance target, which is being changed from 95% to 90%.

ID: 2473 **Title: Failure to meet control total and deliver the financial recovery plan** **Page 21**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to meet control total and deliver the financial recovery plan **Cause:** • Reduction in Market Forces Factor (MFF) funding • Underfunding of complex specialist treatment • CCG affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Additional costs of operating across three sites & with outdated estate and aged equipment • Capacity limitations constrain activity growth, especially in private patients • Annual reductions in Education and Training funding, significant cut to 2018/19 funding • Correction of historic usage of R&D funding for clinical subsidy • Delays to Transformation programme caused by CEO role instability • Agency costs (at premium rates) incurred to cover substantive roles • Investments in Acute medical model • Investment in implementation costs of Cerner including data validation • Continuing dependence upon significant non-recurrent financial gains to deliver Control Total targets & receipt of STF funding masks underlying deficit • Deterioration in Estate limits ability to deliver plan • Inability to identify and deliver cost improvement programmes at a local level **Effect:** • Failure to deliver a financial surplus • Failure to receive provider sustainability funding and equivalent bonus funding • Inability to generate required additional Capital funding • Reputational risk of being in deficit • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Dependence upon DH revolving working capital facility • Impacts ability to run and invest in services - Dependence upon external initiatives and funding for required capital investments	**20**	**20**	**15**	⇔	**Chief Financial Officer**	Trust met its control total in 2017/18 and received a full payout of STF. The plan for 2018/19 is to deliver a control total surplus of £13.6m after £34.2m of STF funding support. Year to date the Trust was on plan at the end of month 10 and has access to PSF funding for Q3, which is determined on a quarterly basis. Cash balance never less than £3m – monitored monthly and reported to Exec and Board. Internal forecast outturn (monthly refreshed).

Current Risk Controls

• Bi-weekly FASRG meetings with divisions and senior finance teams (CEO and CFO attend at least monthly)
• Additional Executive review for any division forecasting to miss budget
• Monthly financial reporting, cash and performance reviews reported to ExFin, bi-monthly to FIC and Trust board
• Oversight with Regulator via Provider Oversight Meeting (POM)
• Causes of the Deficit work incorporated into financial recovery plans and business planning processes
• CEO & CFO engagement with Provider Network, AUKUH, Shelford etc, to lobby on system issues pressures including Tariff and Diamond – reports to FIC and Trust board
• The Improvement Team and all major change programmes report to monthly Executive Digital & Transformation Committee (ExDST)and then to FIC
• Speciality Review Program (SRP) started Apr 2017 reviewed all 31 specialities for sustainability (financial and clinical). SRP phase 2 now merged into Transformation and Recovery Plans reporting to SRP, SROs and ExDST
• Full engagement in health economy wide initiatives, e.g. seek to maximise Trust gain and mitigate risks from broader initiatives
• CEO member of STP Provider Board addressing STP financial challenge.
• Financial recovery plan.

Mitigation Plan

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

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

Action:
Phase 2 SRP merging into the transformation programme is expected to bring greater rigour to the implementation of Model Hospital and GIRFT learnings and support CIP identification and delivery *Due Date:* 29/03/19
Update on action:
Consultants (FTI) engaged to support 2019/20 CIP development.

Action:
Recruitment approvals *Due Date:* 31/03/19
Update on action:
All requests for new or replacement permanent staff be reviewed at a weekly meeting of the 'financial recovery team' (a subgroup of the executive team). There are also enhanced sign offs for bank and agency staff in all professions.

Action:
Recovery reviews *Due Date:* 31/03/19
Update on action:
Regular, targeted support sessions for directorate teams whose budgets are off plan with their divisional leadership plus the financial recovery team to plan and monitor actions to get back on track.

Action:
Update the accepted 4 year financial recovery plan for new NHS planning and tariff assumptions and extend to 5 years per NHS planning guidelines. *Due Date:* 30/09/19
Update on action:

Action:
Executive and board approval of achievables 2019/20 plan which meets control total. *Due Date:* 29/03/19
Update on action:
Draft plan submitted on 12th February.

Contingency Plans

Revolving working capital facility provides cash support cover of up to £26m (£16m has been drawn down YTD) – with the ability to extend the limit up to £65m. (However, note that these national arrangements are interim while a permanent process is being agreed between DH and NHSI)

Key Summary Updates & Challenges

In month 10 the Trust is on plan year to date for 2018/19.

The trust has submitted its 2019/20 draft plan to NHSI with an underlying deficit of £31m, an improvement from £35m in 2017/18. The trust aims to achieve its control total of £11m surplus (after £27m PSF and MRET funding) through meeting a challenging £60m efficiency. The transformation team , supported by FTI is working with divisions on this.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of inaccurate data, which can result in delayed treatment to patients, inaccurate data sets being published externally and therefore breach of contractual and regulatory requirements and loss of Trust reputation **Cause:** • Inaccurate,incomplete or delayed data entry, e.g. high RTT clock stop errors • Inconsistent use of waiting list and non-chronological booking • Failure to comply with standard workflows and/or operating procedures • Limited formal structures in place to monitor adherence to processes • Lack of data validation and correction • Incorrect design/build of system, workflows reports • Reduced clinical coding capacity/capability • Staff are not trained adequately **Effect:** • Possible delay to treatment of patients, e.g. high number of "pop on" to the RTT PTL over 18 weeks • Possible failure of governance • Inefficient working, e.g. high levels of Hospital Initiated Cancellations (HICs) • Loss of Trust reputation • Possible financial penalty for Trust or loss of income • Breach of contractual and regulatory requirements.	**20**	**16**	**12**		**Director of Operational Performance**	• Operational Data Quality Dashboard and reports for services to monitor their data quality performance directly. Trajectories agreed for some priority data quality indicators. • Data quality indicators included in Trust Board and Divisions' scorecards so aligned with Trust's performance framework and shared with commissioners. • Routine audits of reasons for removing patients from waiting lists by dedicated team. • Implementation of MBI Elective Assurance review recommendations.

Current Risk Controls

• A Data Quality Framework has been developed. The framework includes 160 data quality indicators (DQIs) across 32 datasets and also includes in its scope the optimisation of the 10 systems used to collect them and the data processing involved. Key DQIs have been agreed as the priority focus for 2018/19. The data quality indicators underpin the Trust's integrated performance framework - responsiveness and money/use of resources domains only.
• New validation system for Referral to Treatment (RTT)Pathway in place since February 2018 which has streamlined validation processes for RTT.
• Latest version of Elective Access Policy published October 2017 and underpinning Standard Operating Procedures for entry and validation of waiting times data on the Patient Administration System launched in October 2017.
• Diagnostic Reporting working group is implementing an agreed action plan.
• Data clean up of 8,000 diagnostic patients completed in July 2018.

Mitigation Plan

Action:
Design and implement Elective Care Operating Framework underpinned by staff training and digital optimisation. *Due Date:* 29/03/19
Update on action:
Staff training is in place. The elective care performance framework was formally launched in January 2019 to govern the management of elective care waiting lists. The second phase of the project to implement an RTT validation tool will be completed in March 2019.

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

Action:
Delivery of recommendations in MBI Report on Waiting List Management & Reporting *Due Date:* 31/12/19
Update on action:
All MBI recommendations have been linked to existing programmes of work for delivery. Progress is reported through the monthly Elective Care Steering Group and to ExOp.

Action:
ECOF training programme and SOP roll out *Due Date:* 30/09/19
Update on action:
The RTT Training Deep Dives project has delivered Phase 1 of training to the Top 13 specialties on the key data quality indicators in October 2018. Remaining services received training by December 2018. Service specific classroom training is in design as well and will be delivered through to September 2019. A Steering Group to lead the overarching Education & Training work stream commenced in January 2019 to provide further governance and clinical input.

Action:
New digital learning strategy HRIS *Due Date:* 30/04/19
Update on action:
The RTT Training Deep Dives project has delivered Phase 1 of training to the Top 13 specialties on the key data quality indicators in October 2018. Remaining services were trained by December 2018. Service specific classroom training is in design as well and will be delivered through to September 2019. A Steering Group to lead the overarching Education & Training work stream commenced in January 2019 to provide further governance and clinical input.

Action:
Review of the Trust's validation resources supplemented by a managed service for Referral to Treatment Pathway validation to undertake data clean up of waiting lists *Due Date:* 30/04/19
Update on action:
The consultation has been concluded with staff. A financial assurance paper was presented to the Executive in February 2019 for final approval ahead of implementation of the new structure in April 2019.

Action:
Audit of all submissions to external organisations to identify all external submission and ensure senior authorisation before data is shared externally *Due Date:* 31/10/18
Update on action:
Final Report presented to Executive Operational Performance Committee in November 2018 and recommendations agreed.

Action:
Review of sign off process for external submissions *Due Date:* 31/01/19
Update on action:
Action complete.

Contingency Plans

Urgent review of data sets and external submission requirements leading to delayed/partial submission for some data sets.

Key Summary Updates & Challenges

Annual progress update provided to ARG in March 2019
Error rate associated with reporting of waiting times for A&E, diagnostics and cancer are below the 5% threshold advised by NHSI
Error rate associated with reporting of waiting times for RTT has improved from 10% to 8%

The elective care performance framework was formally launched in January 2019 to govern the management of elective care waiting lists.
The sign-off process for external submissions has been reviewed.
A new digital learning strategy HRIS is being implemented.

ID: 2613 **Title: Compliance with General Data Protection Regulation (GDPR)** **Page 23**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of financial and reputational damage to the Trust resulting from failure to fully comply to the General Data Protection Regulation (GDPR), which became effective in May 2018. The GDPR is a Directive for the European Union that has been enacted in UK legislation under the Data Protection Act 2018.	20	16	8	⇔	Chief Information Officer	The Trust will be measuring its assurance against the new NHS Digital Data Protection and Security Toolkit. This sets out the ten National Data Guardian Standards and these are underpinned by 41 assertions where the Trust can measure compliance. The Trust will be launching the Trust Privacy Programme (TPP) to deliver this compliance.

Cause:

• The change in legislation to the GDPR will make Data Controllers more accountable for their data processing. Subsequently, the Trust will be required to demonstrate how they:
  o Uphold the rights of patients and staff as data subjects, including provision of appropriate privacy notice information, upholding rights of access,
  o Provide demonstrable legal basis for the processing of data
  o Mitigate risk of data breaches caused by failure of technical security or failure of management procedure or misuse of authorised access
  o Map data flows to and from third parties that have been privacy risk assessed and the liabilities allocated appropriately through appropriate information sharing agreements / contracts
  o Undertake robust privacy risk assessment and the reporting of high residual risk processing to the ICO
  o Provide demonstrable legal compliance through accurate, complete, valid and timely records of processing
  o Establish a robust Data Protection framework
• The Trust will not have sufficient processes and systems in place by May 2018 to ensure all of the above is delivered.

Effect:

• Identified breaches can be fined to up to 4% of global turnover
• Reputational Damage possibly leading to brand toxicity
• Loss of research funding and potential losses of inward investment
• Loss of confidence in the senior management of the Trust

Current Risk Controls

• The Trust Data Protection Structure has been evolving to meet the challenges of the current threat environment and the current legislation.
• Trust has previously submitted satisfactory IG Toolkit Returns since 2012/13 (meeting a minimum of Level 2) in each IG Toolkit Standard
• The Trust is now required to submit a satisfactory and independently audited assessment to the new Data Security and Protection (DSP) Toolkit from 31/03/2019 - the control will be the independent audit taking place providing assurance of the submission.
• Information Governance and Cyber Security Committee (IGCS) meets on a monthly basis to review Cyber Security Dashboard, ICT Risk Register, Informatics audit and IG Compliance Issues
• GDPR (TPP) Business case and Investment Plan has been developed to manage implementation of GDPR leading to development and implementation of the Trust Privacy Plan (TPP)
• Prioritisation of more risky requirements in the implementation plan.

Mitigation Plan

Action:
Launch of the Trust Privacy Programme (TPP) to deliver compliance to GDPR *Due Date:* 30/09/19
Update on action:
The TPP is launched and ongoing

Action:
Implementation of ONE TRUST Data Protection Management Console *Due Date:* 31/07/19
Update on action:
08/02/2019 - elements of ONETRUST have been launched but there are some implementation technical issues preventing full roll out. This is expected within 3 - 6 months

Contingency Plans

• Report breaches to the ICO
• Report non compliance to Information Sharing Partners in NW London and elsewhere
• Escalation of non compliances and attendant risks to the Trust board

Key Summary Updates & Challenges

The Trust Data Protection Structure has been evolving to meet the challenges of the current threat environment and the current legislation.
The Trust Privacy Programme (TPP) to deliver compliance to GDPR is ongoing.
A data protection management console is being implemented.

There will be a "checkpoint" review meeting of progress in April 2019 and a full review of progress in June.

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

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

Effect:
• Poor organisational performance – inefficient pathway management
• Poor reputation with regulatory bodies
• Failure/delays in implementing new clinical models and new ways of working
• Deteriorating and / or inadequate estate
• Failure of critical equipment and facilities that prejudices trust operations
• Reduced staff morale and staff engagement
• Reduced confidence in our services/public concern about their services
• Difficulty in programming interim capital projects
• Project cannot proceed.
• Patients continue to be seen in poor accommodation,
• Poor staff morale and increased turnover
• Increase in project costs
• Planning application may lapse.

Current Risk Controls

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

Mitigation Plan

Action:
Review all redevelopment options for the Trust *Due Date:* 28/06/19
Update on action:
Trust exploring options

Action:
Agree scope of works sufficient to protect existing planning approval leading to certificate of lawfulness. *Due Date:* 04/01/20
Update on action:
Action re-opened.

Action:
Notices to be formulated and served on the residents of Westcliffe Apartments by August 2019 to prevent acquisition of rights of light over the Trust. *Due Date:* 31/08/19
Update on action:
Bevan Brittan LLP and GVA appointed to serve Light Obstruction Notices on residents of Westcliffe Apartments.

Action:
Development of contingency plan in the event of failure to gain funding and approvals for redevelopment programme. *Due Date:* 30/04/19
Update on action:
Action with Hugh Gostling, Director of Estates and Claire Hook, Claire Hook, Director of Operational Performance.

Contingency Plans

Implementation of Contingency Plan from late April 2019.

Key Summary Updates & Challenges

Condition of St. Mary's Hospital has deteriorated. A strategic planning vision document was approved by Trust Board in March 2018 and was submitted to NHS Improvement, North West London Collaboration of CCGs and Department of Health and Social Care for consideration.
Outpatient & Ophthalmology building: on hold.
Structural issues in Cambridge Wing and associated works, impact on the decant space required for the phase 1 project. This results in a delay to the programme and increased costs to deliver the facility.
Planning permission has two years left as of 04/01/2019.
Trust wide options: under consideration.

ID: 2677 **Title: Risk of failure of Network Core devices as they reach End of Life** **Page 25**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of failure due to age of Network Core devices - Cisco Nexus7K 8 years old for SMH and CXH, and at HH Cisco Catalyst 6509 13 years old. The CORE devices are also running software/firmware 5 years old. Additionally, the devices will come to End of Life in November 2019. The Network Core devices provide the network backbone to all the primary sites within Imperial: CXH, HH and SMH. End of Life indicates the manufacturer of the hardware will no longer provide support or software updates to their devices. **Cause:** Cisco will not longer support Nexus 7Ks and 6509 cores from November 2019 Lack of funding in ICT capital allocation to fund replacement **Effect:** In the event of hardware component failure or security vulnerabilities requiring software updates, there will be no new parts or software updates provided by the manufacturer. This will likely lead to a Trust-wide or Site-wide network failure which will result in the inability to access Clinical or Corporate systems. In the event of a Security Breach : Theft or Corruption of Data Shutdown of Network Services Shutdown of Data Centre and Server Services	**20**	**15**	**10**		**Chief Information Officer**	Part of the ICT Operations Strategy overseen by the Senior Management Team within ICT. Review of this Strategy is discussed at these team meetings to ensure business cases are developed and submitted in a timely manner. Along with the justification and funding of these key projects. Business Case approved and tender specification commenced. Support contract in place for current Cisco 6509 and Cisco Nexus 7000 cores. Tender completed, but due to cost of preferred option identified by the procurement process, a revised business case will need to be submitted to ICT SLT, DSP, CSG, ExFIN, FIC and Trust Board due to over £5m commitment in single contract (see FSIs)

Current Risk Controls

The Network Core is currently under support.
Business case approved at ExOp in August 2018. Funding levels insufficient to procure and implement mitigations.
Tender for replacement network has commenced.
Remediation of the old core at HH underway. Phase 1 of 2 scheduled for 13th March 2019 (Internal link restoration and OTV remediation)

Mitigation Plan

Action:
Tender assessment and award. Procurement of new cores *Due Date:* 29/03/19
Update on action:
Tender released and submissions have been received. Tender closed. Assessments in progress. Public sector framework (NHS SBS Link Framework) used for compliance reasons.

Action:
Create and Submit revised Business Case *Due Date:* 19/04/19
Update on action:
Meeting held with strategic finance, procurement and ICT to confirm the process and review draft of revised business case to be submitted via the stated governance process.

Contingency Plans

The Trust will need to fast-track the procurement, installation, configuration and testing of all 10 network cores costing approximately £1.5M and taking approximately 6 weeks to complete.

During this 6 week period, the Trust will have no IT network, acc

Key Summary Updates & Challenges

A new network is being procured. Tender released and preferred option identified.

The FBC business case will require Trust board ratification. The revised business case is awaiting key financial technical information before it will be submitted via the identified governance process of approvals via ICT SLT, DSP, CSG, ExFIN, FIC and the Trust Board.

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the Trust by the CQC. **Cause:** • Lack of robust systems and processes which enable the trust to achieve regulatory compliance and to drive improvement to address previous inspection findings / resolve internally identified problems • Failure of staff to adhere to trust and local area policies, procedures, guidelines, etc. • Lack of resource to support business as usual and improvement activities • Failure of staff to take account of advice from the Trust's CQC team **Effect:** • Reduction in the quality and safety of patient care: o Greater number of incidents relating to patient safety, and of potentially greater severity o Increase in poor patient experiences and complaints • Breach of regulatory requirements and failure to achieve regulatory standards	**16**	**12**	**8**	⇩	**Director of Nursing**	CQC inspections outcome and reports CQC Insight report and benchmarking data contained within it Performance on key quality indicators outlined in the Trust's quality report/Trust scorecard Outcomes from internal reviews and audits Outcomes from external reviews, e.g. inspections by other regulators, accreditation bodies, professional bodies and peer reviews Patient feedback. e.g. FFT result, local and national surveys Staff engagement survey results (local and national)

Current Risk Controls

• The trust has a dedicated Head of Regulation with a significant background in healthcare regulation, including experience with CQC inspections and the CQC's current regulatory approach
• A framework for managing CQC compliance has been in place at the trust since April 2015. The framework is aligned with the CQC's inspection methodology for NHS acute trusts and is adapted when the CQC make changes to their regulatory approach.
• Centralised oversight of compliance by the Improving Care Programme Group
• Support to areas for business as usual, improvement activities and management of CQC inspections from the Trust's CQC team
• Governance via divisional governance processes, the Improving Care Programme Group, the Executive (Quality) Committee and Quality Committee, and the Trust board
• Other trusts that have improved their CQC ratings have been engaged to share learning

Contingency Plans

• Commission external review and support, including other trusts, NHS Improvement, etc.
• Work with commissioners where demand is outstripping capacity

Mitigation Plan

Action:
To address core service inspection findings, a Trust wide work stream for medicines management has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:
Medicines Management Improvement Group in place. See risk 2538.

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

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

Action:
To address core service inspection findings, a Trust wide work stream for hand hygiene has been established with support from the QI team and a monthly update on progress is to be provided to the Executive Quality Committee *Due Date:* 29/03/19
Update on action:
On-going during 2018/19

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

Action:
Actions required following the Well-led inspection which relate to equality and diversity and patient and public involvement will be taken forward and regular updates provided ot the Executive Quality Committee *Due Date:*29/03/19
Update on action:
E&D actions go through E&D steering group. Michelle Dixon is leading the PPI group.

Action:
Development of the Trust's risk appetite, including internal audit on risk management re: board oversight of risk, is being taken forward following the Well-led inspection and regular updates will be provided to the Executive Quality Committee *Due Date:*29/03/19
Update on action:
Trust Risk Appetite agreed in March 2018 and added to BAF and CRR. Operational framework presented to ExFin in March 2019.

Key Summary Updates & Challenges

A programme of core service peer reviews began the week commencing 14 January 2019.
The CQC inspected four services in February 2019: Critical care, Services for children and young people, Maternity and Neonates (the QCCH NICU). Initial high level feedback was positive and it does not appear there were any serious or major concerns identified which means no immediate action is required. The internal peer review programme will resume and the remaining reviews are expected to be completed by the end of April 2019.
The Trust's CQC framework for 2019/20 will include amendments which reflect the past year's CQC activities at the Trust, as well as lessons learned from them. It has already been agreed that a full programme of internal peer reviews of all services will be carried out, and quality improvement work will be undertaken which supports changes in practice. .

Based on the high level feedback received following the core service inspections in February 2019, the risk score has been lowered as it is considered that its likelihood has reduced from 'likely' to 'possible'. The target score date remains 30/08/2019 after the CQC inspection reports from the core service inspections in February 2019 and the well-led at Trust level inspection in April 2019 have been published.

ID: 2922 **Title: **NEW** Unmanaged Shared Email Boxes - Risk to delay in patient treatment** **Page 27**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
There is a risk that "unknown" unmanaged shared email accounts are active and published to patients. **Cause:** • Current process to request generic email accounts does not include failsafe to ensure that relevant email accounts are managed by requestors for the lifecycle • Failure of people to highlight/ re-allocate relevant email accounts when generic email account handler is changing role/ leaving the Trust **Effect:** Risk to delay of patient care.	**12**	**12**	**4**	*NEW*	**Chief Information Officer**	•Number of unmanned email addressed identified. Process for validation agreed Notification to divisional DDOs completed All 2200 email address have been sent an email requesting a 5 working day response with key information Clarification of mailbox owner responsibilities have been updated in the revised ICT Information Security Policy which is die for review and approval by IGCS committee on 12/03/2019

Current Risk Controls

•Creation of new shared mailbox has been suspended until a new assured process is implemented

Mitigation Plan

Action:
Agree new process to request shared mailboxes and implement automated process for ongoing failsafe *Due Date:* 30/04/19
Update on action:
Automated process for ongoing failsafe under scope. Potential solution identified - next step to ensure fitness for purpose and costs.

Action:
Agree process to monitor, alert and escalate non-active shared mailboxes with Divisional Directors of Operations. *Due Date:* 30/04/19
Update on action:
In progress.

Action:
Audit of shared mailboxes, activity and owners to be completed. *Due Date:* 30/04/19
Update on action:
In progress.

Action:
Where a mailbox is identified by ICT as not being monitored, the relevant department or division will carry out a complete a review of all emails and take whatever action is needed *Due Date:* 28/06/19
Update on action:
In progress.

Contingency Plans

Full audit of shared mailboxes, activity and owners in progress
New process to request shared mailboxes required
New process to monitor, alert and escalate non-active shared mailboxes to be implemented.
Responsibilities of shared mailbox owners clarified

Key Summary Updates & Challenges

A new process for requesting shared mailbox has been drafted and is being discussed.
All 2200 active mailboxes have been emailed and a response within 5 working days requested.
Mailbox owner responsibilities have been clarified as stated in the revised ICT Information Security Policy.
An automated check of unread messages is being designed via Prasad Kolas (ICT Software Development Team).

Imperial College Healthcare NHS Trust

APPENDIX 2

Review of risk management improvements and future developments

December 2017 to February 2019

1. Purpose

This part of the report provides a summary of the improvements made to the Trust's risk management processes over the last 12 months and outlines future developments.

2. Where were we in December 2017?

2.1. Risk management reporting and monitoring

- In the clinical divisions, risks were discussed at the divisional quality and safety committees monthly; and a more systematic approach was required in the corporate divisions.
- At Executive and Board level, the following reporting arrangements were in place until August 2018:
  - The Corporate Risk Register was presented monthly to the Executive Committee
  - The Audit, Risk and Governance Committee received the corporate risk register at each meeting and the Board every six months.
  - Key divisional risks were presented to the Executive Committee quarterly and quality related risks also went to the Quality Committee
  - Key divisional risks were collated by the corporate risk management team. However at this time there was some inconsistency around the divisional risk management processes.

2.2. Trust Risk Appetite

- The Trust board reviewed the organisational risk appetite in October 2014, but did not develop a risk appetite framework or statement at this time.

2.3. Trust risk profile

- The dashboard reflecting the Trust risk profile within the Corporate Risk Register document historically presented visual representation of the initial, current and target risk score and any change to a risk score since the previous meeting (monthly for Executive Committee, quarterly for ARG and 6 monthly for the Board).

3. Where are we now?

- An internal audit of risk management was carried out by PwC between June and July 2018, with the scope to assess the design and operating

effectiveness of risk management controls in place at divisional level and the consistency of processes across divisions.

- Overall, the report was classified as 'Low risk', which is the best classification the Trust can be awarded for an internal audit, according to the internal auditor's ratings matrix.
- Three 'minor' findings were identified, with regard to **monitoring, reporting and assurance processes relating to risk**.

The above findings have been addressed, as reflected in this part of the document. Further assurance work is underway.

3.1. Risk management reporting and monitoring

- In the divisions (clinical and corporate), risks are reviewed at the relevant divisional forum with responsibility for risk management monthly and relevant discussion is documented.
- Following a wider review of the Executive Committee structure, in September 2018 risk management reporting at Executive and Board level was also reviewed. As a result:
  - The Executive Finance Committee now functions as the Trust Executive Risk Committee and reviews the corporate risk register monthly.
  - Key divisional risks are now presented to the Committee every month and are submitted directly from the (corporate and clinical) divisions.
  - In order to support this, Datix functionality has been developed that allows the divisions to select, manage and download their key risks directly from Datix.
  - The Audit, Risk and Governance (ARG) Committee also receives a summary of themes from the key divisional risks based on discussion at the Executive Finance Committee.
  - This information is included in a joint paper including the Corporate Risk Register and Board Assurance Framework. This supports the ARG determine the effectiveness of the relevant risk controls.
- The divisions are provided with quarterly risk management reports, which reflect overall risk management figures in the divisions, also with regard to number of risks overdue for review, details of actions overdue for review and number of risks that have been on the risk register for longer than 2 years.
- At Executive level, divisional performance with regard to timely review of the risk registers has been included as a regular item in the risk management report since July 2018.

3.3. Trust Risk Appetite

- The Trust Risk Appetite statement and framework was approved by the Trust Board in March 2018.
- Risk appetite ratings have now been included against each risk on the corporate risk register, together with relevant risk response. This will support the Board considering the current level of residual risk in the context of the agreed level of risk appetite.

3.4. Trust risk profile

- The dashboard reflecting the Trust risk profile within the Corporate Risk Register document has been reviewed to provide the Executive and the Board with visual representation of each risk movement over the previous 12 months.
- This is also compared to the initial and target risk score, the original target risk score date identified and the agreed risk appetite.
- This provides better reporting and supports more effective monitoring of how effectively risks are being managed.
- This also supports the identification and management of long-term risks.
- A deep dive of any risk with a current score the same as or above the initial score is undertaken every 6 months to review relevant circumstances and additional mitigation required to get the risk to the target score.

3.5. On-line training

- A risk management e-learning module was launched in September 2018.
- This allows reaching a wider pool of staff who are able to complete the training at their own pace.
- Completion of training is a compulsory requirement in order to get access to the risk register module on Datix.

3.6. Business planning and capital planning

- Reference to the risk register has been included in the Trust Business Plan template since 2018.
- Risk registers have also been submitted as part of the documentation used in the capital planning process to help prioritise allocation of resources.

4. What are we planning to do?

4.1. Risk management monitoring

- A review will be undertaken of the content and frequency of the quarterly risk management reports.
- Escalation of number of risks without action plans and number of overdue actions to the Executive will be introduced.

- A review of all corporate risks with a current score the same as or above the initial score will be undertaken.

4.2. Trust Risk Appetite

- Describing our risk appetite helps our staff and stakeholders understand the level of risk that we are prepared to accept in any given area and reduces the likelihood of erratic or inopportune risk taking. It also helps with prioritising resource allocation when there are competing priorities.
- In order to support staff with this, a risk appetite operational framework has been developed, which will be presented to the Executive Finance Committee in February 2019 and to the Trust Board in March 2019.
- Following approval, the framework will be cascaded to the divisions as guidance for operational managerial staff.
- Consideration will need to be given to those risks which are out of our ability to resolve.
- The goal in these cases should be to mitigate to a safe level so that our hospitals offer safe and effective care in line with our risk appetite approach and risk treatment options.

Imperial College Healthcare NHS Trust

APPENDIX 3

Risk appetite statement and operational framework

1. Introduction

Risk is unavoidable in any business and for this reason it is important that the organisation provides its staff with some guidance on how to respond when a risk is identified or an opportunity arises. Some risks will be avoided at all cost (e.g. risks putting patients safety in serious danger), while others can be accepted within certain tolerance levels (e.g. a temporary administrative vacancy that can be covered by agency staff).
The risk appetite describes the amount of risk that the organisation is willing to pursue or accept at a given time and under certain circumstances. The Trust risk appetite was approved by the Trust Board in March 2018.

In the process of determining the Trust risk appetite, as well as the internal context and organisation's strategic objectives, the external landscape has also been taken into account, as follows:

- Regulatory requirements, in particular compliance to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to the Care Quality Commission (Registration) Regulations 2009;
- Financial context, including the need to continue dealing with financial pressure to meet the NHS England Five Year Forward View, while maintaining quality of health through sustainability and transformation plans (STP);
- Political context, including changes in leadership and the upcoming leave of Britain from the European Union (Brexit).
- The requests, feedback and concerns of our patients and stakeholders.

2. Risk appetite matrix

- A simplified version of the matrix for Risk Appetite for NHS Organisations proposed by the Good Governance Institute has been developed to describe the Trust risk appetite. This is reflected in the table below.
- This proposal was approved by the Trust Board in March 2018.

Risk appetite level*		Description
Avoid/ Minimal (ALARP - As little as reasonably possible)	**Low**	Strives to avoid risk and uncertainty and works to minimize unavoidable risk. Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
Cautious	**Medium**	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Open		Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)
Seek/ Mature	**High**	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). Confident in accepting or setting high levels of risk because controls, forward scanning and responsiveness systems are robust.

**Adapted from Risk Appetite for NHS Organisations, the Good Governance Institute*

Imperial College Healthcare NHS Trust

3. Trust risk appetite statement

The Trust risk appetite statement is described below:

It is recognised that the Trust is currently operating within a challenging financial and operational environment and is not comprehensively achieving national standards and targets. Rather than through choice, it is considered that a higher level of risk appetite is inherent in the scale of challenge faced in these areas. The Trust is cognisant of the need to actively manage the financial and operational risks whilst ensuring that patient safety is not compromised. In view of this:

- *The Trust will not take any unnecessary risk that has a direct impact on patient safety; however, it will be open in accepting risks that emerge while developing intra and inter-provider pathways which do not impact on any individual patient negatively.*
- *The Trust will minimise any risk posed to patients or staff as a result of staff competence, conduct, health and behaviour.*
- *Recognising the challenging recruitment environment, the Trust will be open to taking opportunistic risk in improving staff recruitment and retention.*
- *The Trust will tolerate a higher reputational risk associated with ensuring the implementation of its redevelopment plan. This will ensure sustainable mitigation to the estates risk.*
- ****NEW* Recognising the challenging operational and financial environment, the Trust will be cautious when responding to any risk that could compromise data quality, which also carries performance and reputational risks. The Trust will commit to continual improvement in data quality.***
- *In view of this, the Trust is open to the risks associated with the implementation of emerging technology; however, it will minimise exposure to cyber risk.*
- *The Trust has a significant appetite to exploit opportunistic risks where positive gains can be anticipated, particularly in relation to promoting and delivering excellent research and education.*

4. Aligning business activities to the Trust risk appetite

It is important that risk management activities are aligned to all business and clinical activities, so that risk is identified promptly and mitigated as appropriate.

Referring to the Trust risk appetite helps our staff understand the level of risk that the organisation is prepared to accept in any given area and reduces the likelihood of erratic or inopportune risk taking, which could expose the Trust to a risk that it cannot tolerate, or prevent it from exploiting opportunities it could take. It also helps with prioritising resource allocation when there are competing priorities.

Risk management should be aligned to every Trust managerial and operational activity and the Trust risk appetite should be taken into account at each stage of the risk management process, as described in the paragraphs that follow.

4.1 Risk Identification

- **Identify risks during strategic and business planning**

Strategic and business objectives are identified every year at Trust, divisional and directorate level. The Board Assurance Framework provides an account of any principal area of risk to the achievement of strategic objectives and enables focused management of the assurance arrangements for such risks.
Each division and directorate should also consider the risks to their objectives, through the following questions:

- ✓ What are the risks associated with the delivery of your objectives or work, especially those that impact on delivering high quality, safe services?
- ✓ What could happen and what could go wrong?
- ✓ How and why could this happen?
- ✓ What is required for continued success?
- ✓ Is there anyone else who might provide a different perspective of your risks?
- ✓ Is the risk within the risk appetite agreed by the Trust Board; if not can it be mitigated?

Strategic objectives can result in exploring a new business **opportunity**, e.g. introducing a new service, expanding an existing service, acquiring an external business, etc. While exploring new opportunities, relevant risks should be considered and the risk appetite should be used to weight alternative options. A number of opportunistic risks are reflected in the Trust risk appetite, for example with regard to recruitment, retention and education. This means that the Trust is open to relevant teams exploring more risky recruitment strategies, and implementing innovative retention and education projects. Examples of this in practice include the graduate programme for newly qualified nurses and allied health professionals, the apprenticeship programme for healthcare support workers, etc.

Objectives definition will determine the content of the **annual business plan**, which includes budget allocation to:

- ✓ Capital investment,
- ✓ Non Recurrent Revenue investment
- ✓ Recurring Revenue investment.

During this process, the risk appetite statement will support with ensuring that investments are prioritised to mitigate risk. So a project that is aimed to mitigate a patient safety risk (a type of risk that the Trust wants to avoid) should be prioritised over one that may not address a particular concern.

On a larger scale, the same process applies to **Trust Capital Planning**; for this reason the risk registers are used by the capital planning group and the Executive Committee to determine allocation of capital to proposals. This process should also take into account the Trust risk appetite, both in regard to risks to be mitigated or avoided and opportunistic risks to be undertaken.

- **Identify risks associated to core processes**

Divisions have access to intelligence such as performance scorecards, incident reports, outcome of reviews and visits, complaints, etc. This wealth of information supports identifying risk when a change in performance is noted.

Risk appetite is not only reflective of the amount of risk that the organisation is *willing* to undertake (usually opportunistic risk), but also the risk that the organisation can *accept* (usually hazard risk) within certain tolerance levels. Subsequently, when reviewing activity and performance as part of routine management the divisions should ask themselves: which risk can be accepted?

4.2 Risk analysis and risk response

In order to determine whether a risk falls within Trust risk appetite levels, it is necessary to confirm how serious the risk is. Its basic causes are thus considered, and the impact and likelihood of it materialising are assessed.

Once the level of risk is determined, this should be compared to the risk appetite to agree the risk response, as follow:

- ✓ **Tolerate:** if the risk is well within Trust risk appetite levels, there is usually no need for further action and the risk can be tolerated as it is. Of course, this depends on the nature of the risk. Most patient safety risks will be mitigated through the implementation of relevant Trust policies and governance processes and no further action is required unless the risk increases due to a change in circumstances.
  Risks are also tolerated when all possible actions have been put in place to mitigate them and no further mitigation action can be done at that time.
- ✓ **Treat:** when a risk is outside the Trust risk appetite, a number of mitigations should be implemented to bring the risk to a tolerable level. The lower the risk appetite, the earlier the risk should be mitigated, proportionally to the nature and complexity of the risk and the issues that generate it. If the risk cannot be mitigated to a tolerable level, or it cannot be mitigated within an appropriate timeframe, than it should be escalated so that controls can be reviewed for effectiveness and either new actions are agreed, or a review of the relevant risk appetite is endorsed.
- ✓ **Transfer:** there are certain risks that the organisation decides to transfer to a third body. This usually occurs through insurance or external resourcing and it often applies to part of the risk. For example, the financial risk of losing expensive equipment can be covered by insurance but the reputational risk would still remain with the Trust
- ✓ **Terminate:** if the impact of the risk on organisational objectives and core services is too high and it goes well outside the risk appetite and tolerance boundaries set by the Board, consideration should be given to terminating the activity that causes the risk. An example of this would be to stop using an IT software that exposes the Trust to an unacceptably high cyber security risk.

Risk registers are used to document the risks identified; level of severity and probability, ownership and mitigation measures for each risk. Risk registers should be reviewed at least monthly so that the controls effectiveness is assessed.

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4.3 Risk monitoring and assurance

The Board Assurance Framework and the corporate risk register include risk appetite ratings against each area of risk. This will support the executive team ensure the risk management plan for each risk is appropriate. Where a discrepancy is identified, the executive should review current risk controls for effectiveness and consider new actions. If no further actions can be implemented, then it should be considered whether the current risk appetite is reflective of the Trust risk capacity and if a review should be endorsed to align the two.

Risk appetite statements should also be used by the divisions while monitoring their risks, particularly, when key risks are selected for escalation.

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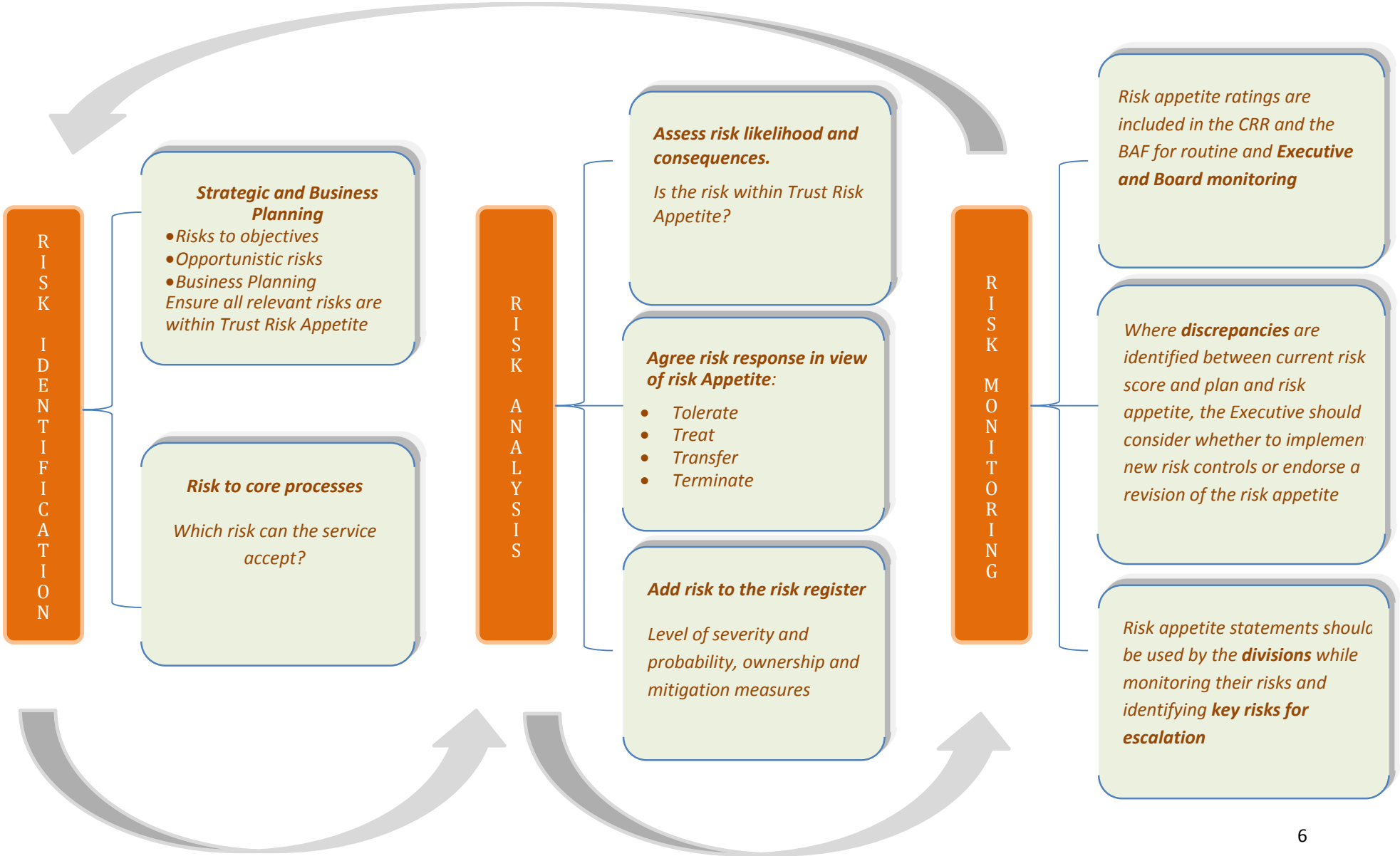
Risk Appetite Operational Framework



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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: CQC Update	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 March 2019	**Item 14, report no. 11**
Responsible Executive Director: Janice Sigsworth, Director of Nursing	**Authors:** Priya Rathod, Deputy Director of Quality Governance Kara Firth, Head of Regulation

Summary:

- The board is aware:
  - The Trust received its annual CQC PIR in November 2018 and submitted it in December 2018.
  - The PIR initiates a six month time period for CQC inspections to take place at the Trust, which means the 2018/19 programme could have potentially run until mid-May 2019 (**Appendix 1**).
- The CQC wrote to the Trust on 28 January 2019 to announce:
  - Inspections of four core services would take place on 26, 27 and 28 February 2019:
  - Its inspection of well-led at Trust level will take place on 2, 3 and 4 April 2019.
- In relation to the February 2019 core service inspections:
  - A programme of pre-inspection activities was set up to support the areas being inspected.
  - A pre-inspection data request was received on 6 February and submitted on 21 February.
  - High level feedback was received following the inspections:
    - The inspection was a positive experience for inspectors as it was well-organised and they were welcomed by staff.
    - Improvements since the previous inspections of the core services were seen.
    - Examples of good and exemplary findings were given, along with some areas for improvement
    - No concerns were raised which require urgent or immediate action.
  - The draft inspection reports are expected no later than July 2019, when the Trust will have an opportunity to check their factual accuracy.
  - Final inspection reports, including all ratings (for core service well led inspections), are expected to be published on the CQC's website no later than August 2019.
- The Trust continues to be registered at all sites without conditions.
- During Q3 the Trust was asked to investigate four concerns / complaints made to the CQC about the Trust. None of these were substantiated when the Trust investigated and the CQC now considers these matters closed.
- The 2018 CQC Maternity survey was published earlier this year.The Trust's overall performance improved since the last survey, in particular in relation to patients' trust and confidence in Trust staff.
- The CQC is making changes to how it assesses performance in relation to equality and diversity; these changes are expected to have come into effect from January 2019 for inspections of both core services and well-led at Trust level.
- Key Trust level headlines from the CQC Insight reports for January and February 2019 included:
  - The Trust was 'much better than other trusts' when compared nationally in relation to several mortality and sickness indicators.
  - A further two never events occurred in January 2019 and the Trust continues to be 'worse' than other trusts for this indicator. A large programme of work is underway to address this.
  - In relation to meeting the 4 hour A&E target:

– The Trust's actual performance in December 2018 declined since November 2018 however, when compared to the same time period in 2017, the Trust has improved its performance. • The CQC has recently taken enforcement action against three NHS acute trusts. These reports will be reviewed for any learning for the Trust.
Recommendations: To note the updates.
Quality impact: This paper applies to all five CQC domains.
Financial impact: This paper has no financial impact.
Risk impact and Board Assurance Framework (BAF) reference: This paper relates to **Risk 81 (corporate risk register):** *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*
Workforce impact: None
Has an Equality Impact Assessment been carried out? ☐ Yes ☐ No ☒ Not applicable
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with care and compassion. ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues: All aspects of this paper can be included in leadership briefings and can be shared by leaders with all staff.

CQC Update

1. Purpose

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

2. CQC's 2018/19 Inspection Programme for the Trust

2.1. The board is aware that:
- The Trust received its annual CQC PIR in November 2018 and submitted it in December 2018.
- The PIR initiates a six month time period for CQC inspections to take place at the Trust which is outlined in **Appendix 1**.

2.2. The CQC wrote to the Trust on 28 January 2019 to announce:
- The inspection of four core services to take place on 26 - 28 February 2019:
  - Critical care at St Mary's, Charing Cross and Hammersmith hospitals
  - Children's services at St Mary's and Hammersmith hospitals
  - Maternity at St Mary's Hospital and Queen Charlottes and Chelsea Hospital (QCCH)
  - Neonatal services (the neonatal ICU (NICU)) at QCCH.
- The inspection of well-led at Trust level to take place on 2 - 4 April 2019.

2.3. A data request covering the four services being inspected was received on 6 February and submitted on 21 February 2019.

2.4. The core services inspections were carried out by the CQC on 26 - 28 February 2019. The Trust received high level feedback from the CQC following the visit:
- The inspection was a positive experience for inspectors as it was well-organised and they were welcomed by staff.
- Improvements since the previous inspections of the core services were seen.
- Examples of good and exemplary findings were given, along with some areas for improvement.
- No concerns were raised which require urgent or immediate action.

2.5. A post-inspection data request was received and submitted by the Trust on 14th March 2019.

2.6. As per the CQC's inspection framework, further unannounced site visits may be undertaken in any of the core services inspected until the inspection of well-led at Trust level is completed on 4 April 2019.

2.7. Once the well-led at Trust level inspection has taken place the CQC will prepare the Trust's draft inspection reports.
- There will be one summary report which presents:
  - High level findings from the core service inspections and the well-led inspection at Trust level.
  - CQC ratings for each core service, each site overall, well-led at Trust level, and the Trust overall.

  - Any actions the CQC requires the Trust to take ('must-do' actions) and proposes the Trust consider taking ('should-do' actions).
  - Any regulations which the CQC considers the Trust was breaching at the time of the inspection.
- There will be one evidence appendix which presents detailed findings from the core service inspections and the well-led inspection at Trust level.

2.8. The draft inspection reports are expected no later than July 2019 (three months after the inspection of well-led at Trust level), at which time the Trust will have an opportunity to check the factual accuracy of the summary report and evidence appendix.

2.9. The final inspection reports, including all ratings (for core service and well led inspections) are expected to be published on the CQC's website no later than August 2019.

- The CQC will combine the new ratings for recently inspected core services with the existing ratings for all other core services.

<u>For the core services inspected in February 2019</u>

- A rating will be awarded for each domain (Safe, Effective, Caring, Responsive and Well-led) for each core service, at each site.
- The five domain ratings for each core service will be aggregated into an overall rating for the core service at each site.

<u>For all core services, sites and the Trust</u>

- The ratings for all core services at each site will be aggregated for each domain, and subsequently, for an overall rating of each site.
- All ratings for the Safe, Effective, Caring and Responsive domains at the Trust's sites are aggregated into an overall rating for each of these domains for the Trust overall.
- The overall Trust rating for the well-led domain is based solely on the well-led inspection at Trust level (it is not an aggregation of ratings of this domain within the core services).
- The Trust's overall ratings for the five domains are aggregated into an overall quality rating for the Trust.

2.10. The board will be aware that the NHS Improvement use of resources assessment took place on 13 February 2019. NHS Improvement will award a use of resources rating.

3. Trust Approach to Managing CQC Activities during 2019/20

3.1. The improving care programme group (ICPG) will continue to be chaired by the CEO and will continue meet weekly.

3.2. A 'lessons learned' review post-inspection is scheduled to take place on 17 April 2019 and will include a range of topics such as the; management of the PIR, pre-inspection preparations and the actual site visit.

3.3. The outcomes of the lessons learned review will inform discussions at the ICPG about the Trust's overall approach to getting to good and beyond.

3.4. The internal peer review programme will resume and the remaining reviews are expected to be completed by the end of April 2019.

3.5. Once the remaining reviews have been completed a programme of intensive support will be provided for any emerging themes.

4. General updates for Quarter 3 (Q3) 2018/19

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

Statutory notifications to the CQC

4.2. The Trust did not make any statutory notifications to the CQC in quarter 3 (Q3) in relation to its activities under the Mental Health Act 1983.

4.3. The Trust submitted statutory notifications to the CQC in order to update its CQC registration, in relation to the opening and closure of a small number of community outpatient clinics.

Concerns, Complaints and Whistleblowing Raised with the CQC

4.4. No whistleblowing alerts were made to the CQC about the Trust during Q3.

4.5. During Q3 the CQC asked the Trust to investigate four concerns / complaints raised with them. Two related to possible Trust-acquired pressure ulcers and two related to alleged staff behaviour towards patients. None of the concerns was substantiated by the Trust's investigations. The CQC was satisfied with all of the Trust's responses and considers these matters closed.

4.6. The CQC advised the Trust that it considers closed a serious incident which occurred in Q2. The incident occurred at Charing Cross Hospital in September 2018.

National surveys and publications

4.7. The CQC did not publish any national survey during Q3, however, the 2018 Maternity survey was published earlier this year.

- The Trust's overall performance improved since the last survey, in particular in relation to patients' trust and confidence in Trust staff.
- An update on the survey outcomes and any action being taken in response will be presented to the Executive Quality Committee in April 2019 by the division of Women, Children and Clinical Support and to the Board thereafter.

4.8. The Board will recall that in 2016, the CQC looked into how acute, community and mental health trusts investigate and learn from deaths. This resulted in new national guidance – Learning, candour and accountability which the Trust implemented.

4.9. Following the publication of the guidance, the CQC have undertaken a review of the implementation of that guidance and published Learning from deaths – a review of the first year of NHS trusts implementing the national guidance on 20th March 2019. Key findings are:

- The CQC have seen variation in how Trusts are implementing the new guidance.

- While awareness of the guidance is high, some Trusts are finding it more difficult than others to make the changes they need.
- The factors that help trusts to put the guidance into practice are:
    - values and behaviours that encourage engagement with families and carers
    - clear and consistent leadership
    - a positive, open and learning culture
    - staff with resources, training and support
    - positive working relationships with other

4.10. The publication will be reviewed internally for any learning.

5. CQC Insight

5.1. Trust-level headlines from the CQC Insight report for *January 2019* included:

- The Trust was 'much better than other trusts' when compared nationally in relation to:
    - Hospital Standardised Mortality Ratio
    - Sick days for medical and dental staff
    - Deaths in Low-Risk Diagnosis Groups
    - Summary Hospital-level Mortality Indicator (SHMI)
- There were no indicators where the Trust was 'much worse than other trusts' when compared nationally.
- The Trust's performance in relation to never events is 'worse than other trusts'. The Board will be aware of the large programme of work that is underway to address this.

5.2. Trust-level headlines from the CQC Insight report for *February 2019* included:

- The Trust continues to perform 'much better than other trusts' when compared nationally in relation to the same indicators highlighted in the January 2019 report (as above).
- A further two never events occurred in January 2019 which led to the Trust's performance to decline further.
- In relation to meeting the 4 hour A&E target:
    - The Trust's actual performance in December 2018 declined since November 2018 however, when compared to the same time period in 2017, the Trust has improved its performance.

6. Changes to Assessments of Performance in Relation to Equality and Diversity

6.1. The Workforce Race and Equality Standards (WRES) team within NHS England has taken the position that failure to implement is a breach of the NHS Constitution.

6.2. The CQC has been working with the WRES team within NHS England on how it can improve its assessments of equality and diversity among staff.

6.3. Although no timeframe was identified for proposed changes to take effect, it is reasonable to expect these began in Q4 of 2018/19, i.e. January 2019.

- All inspectors are receiving dedicated training in relation to the WRES.
- The CQC may hold a focus group for BME staff either during a quarterly engagement meeting or during inspection.

- Information in the annual Provider Information Request (PIR) will be used to assess progress against meeting the WRES.

6.4. The Trust continues to take a number of actions in relation to equality and diversity and WRES, including:

- An equality and diversity steering group
- A draft WRES action plan
- Briefings to non-executive directors regarding the national WRES agenda
- Staff undertaking national WRES expert training (currently one member fully trained and a further two in training)
- A ward sister joining the national WRES frontline staff forum
- An established nursing and midwifery BME network
- A closed Schwartz round for BME staff group in January 2019
- Inviting the national WRES lead to an upcoming Trust Board seminar.

6.5. Progress against the above actions is overseen by the equality and diversity steering committee and the Executive People and Organisation Development Committee.

7. Recent CQC Enforcement Action Against NHS Acute Trusts

7.1. The CQC has recently taken enforcement action against three NHS acute trusts. The related inspection reports will be reviewed to identify any learning for the Trust.

7.2. NHS trust fined by the CQC for breaching the Duty of Candour regulation

- The Duty of candour regulation sets out specific requirements for actions trusts must take when certain types of incidents occur.
- On 17 January 2019, the CQC published a press release indicating that it had issued a fixed penalty notice (including a fine) to an NHS trust for breach of the Duty of candour in relation to a specific incident.
  - The breach primarily related to the trust not apologising to the family in a timely manner for the incident that occurred.
- The committee is aware that the Trust has a programme of work in place regarding duty of candour and compliance with the requirements is captured in the integrated performance report.

7.3. The CQC has placed conditions on the CQC registration of two trusts.

- A condition means restrictions on the operation / delivery of certain services.
- Failure to adhere to conditions can lead to further enforcement action.

Services for children & young people, East Kent Hospitals University NHS Foundation Trust

- Five conditions were placed on the trust's registration as described in the CQC's press release.
  - These conditions relate to the use of adult trolleys for children, safe nurse and medical staffing, demonstrating how clinical outcomes are being audited, monitored and acted upon, risk management and risk registers and staff training rates.
- The report from this inspection contains the detailed findings which led to these conditions being imposed.

Urgent & emergency services at John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust

- Three conditions were placed on the trust's registration as described in the CQC press release.
  - These conditions relate to maintaining patients' privacy, risk of infection and the risk to the health and safety of service users receiving care and treatment and the risk to staff in the main operating department.
- The related inspection report has not yet been published on the CQC website so the detailed findings that led to the conditions being placed are not yet known.

- The above reports will be reviewed by the Trust for any learning.

8. Next steps

8.1. The Trust's CQC well-led inspection will take place on 2 -4th April 2019.

8.2. Carry out the 'lessons learned' exercise in April 2019.

8.3. Complete the remaining internal peer reviews by the end of April 2019.

8.4. Agree the Trust's approach to managing its CQC activities for 2019/20.

9. Recommendations

9.1. To note the updates.

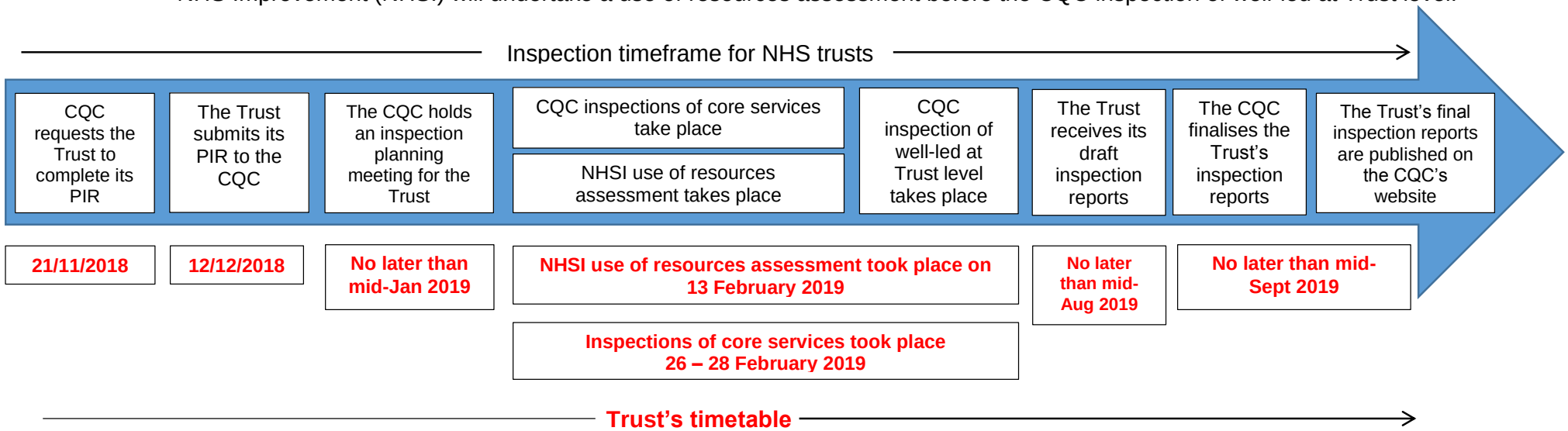
Authors: Priya Rathod, Deputy Director of Quality Governance
Kara Firth, Head of Regulation

27 March 2019

Appendix 1: CQC Inspection Timeline for NHS Trusts

The CQC has a published timeline for the planning and carrying out of its inspections of NHS trusts.

- Notice to complete the PIR initiates the inspection programme, which will be carried out over a maximum six month period.
- The Trust has 3 weeks to submit its completed PIR to the CQC.
- The CQC analyses the PIR and then holds an inspection planning meeting, where it will decide what service(s) will be inspected and when.
- The PIR notice indicates that inspections of core services can take place any time from the date of the notice; however, core service inspections will normally take place after the planning meeting has been held.
- CQC inspections of core services will always take place before the CQC inspection of well-led at Trust level.
- NHS Improvement (NHSI) will undertake a use of resources assessment before the CQC inspection of well-led at Trust level.



Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Learning from Deaths: Update on implementation and reporting of data	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 March 2019	**Item 15, report no. 12**
Responsible Executive Director: Prof Julian Redhead, Medical Director	**Author:** Dr Ian Maconochie, Associate Medical Director for Patient Safety

Summary:

This paper is to update the Board on progress since the last report (January 2019) and includes an updated 'learning from deaths dashboard' (**Appendix A**). The dashboard includes data for the financial year 2017/18 to Q3 2018/19.

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

- We are compliant with reporting requirements as set out by NHS Improvement.
- 37 members of staff have undergone structured judgment review (SJR) training, which is a slight increase. Further recruitment continues, with the aim of confirming at least one trained reviewer per specialty.
- There have been 401 SJR reports that have been completed since commencing the review programme in September 2017 (17/18=245, 18/19= 156) up to Q3 2018/19.
- There have been six avoidable deaths between Q1 and Q3 2018/19 reviewed and signed off via the Mortality Review Group (Q1-3 2019). There were 17 cases of avoidable death in 2017/18. Out of the 23 avoidable deaths in 2017/18 and 2018/19 to date 18 have undergone SI investigations, with the remaining cases having been subject to internal investigations (one case) or local review (four cases).
- A review of the Trust's mortality processes has been undertaken by one of the General Managers in the Office of the Medical Director and a number of recommendations have been made in relation to the process and governance arrangements as well as the compliance and learning aspects of SJRs. The outputs from this review will also support the Trust's transition to a Medical Examiner model during 2019/20. This will require investment in the role of medical examiner and so a full review and proposal was brought through executive quality committee in March 2019. This has been included as a cost pressure for business planning purposes.

Recommendations:
This paper is being presented to the Board for noting.

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

Quality impact:
This process supports improved learning from deaths which occur in the Trust, therefore supporting

the safe, effective and well-led quality domains.

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

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

Workforce impact (including training and education implications):
Six staff received Tier 1 training provided externally by the Royal College of Physicians, the remaining staff were then trained internally in a mixture of individual or small group sessions, dependent on need. Training remains available via the Mortality Auditor.

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

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

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

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

Trust strategic objectives supported by this paper:
- To achieve excellent patient experience and outcomes, delivered with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.

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

If the details can be shared, please provide the following in one to two line bullet points:
- To know: The trust has implemented an updated mortality policy in line with national requirements
- To do: Review the data and be aware of any implications in your area
- For more information: patricia.bourke1@nhs.net
- Should senior managers share this information with their own teams? Yes

Imperial College Healthcare NHS Trust

Learning from Deaths: Update on implementation and reporting of data

1. Executive Summary

1.1. This paper is to update the Board on progress since the last report (January 2019) and includes an updated 'learning from deaths dashboard' (**Appendix A**). The dashboard includes data for the financial year 2017/18 to Q3 2018/19.

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

- We are compliant with reporting requirements as set out by NHS Improvement.
- 37 members of staff have undergone structured judgment review (SJR) training, which is a slight increase. Further recruitment continues, with the aim of confirming at least one trained reviewer per specialty.
- There have been 401 SJR reports that have been completed since commencing the review programme in September 2017 (17/18=245, 18/19= 156) up to Q3 2018/19.
- There have been six avoidable deaths between Q1 and Q3 2018/19 reviewed and signed off via the Mortality Review Group (Q1-3 2019). There were 17 cases of avoidable death in 2017/18. Out of the 23 avoidable deaths in 2017/18 and 2018/19 to date 18 have undergone SI investigations, with the remaining cases having been subject to internal investigations (one case) or local review (four cases).
- Data reporting is one month in arrears, to allow the reporting cycle to complete, and for performance data to more accurately reflect compliance.
- Since November 2017, mortality-reporting metrics have been incorporated into both Trust and divisional scorecards.
- No individual specialty concerns have been raised.
- Early emerging themes are linked to five of the Trust's safety streams. 'falls and mobility' (three cases), 'responding to the deteriorating patient' (eight cases), 'safer medication' (two cases), 'safer surgery' (one case), and 'fetal monitoring' (five cases). Additional themes include poor communication (one case) and treatment delays (three cases). Cases will continue to be shared with the safety work stream leads to ensure the improvement work covers the findings of the SJRs. Case specific actions are recorded and tracked through the Datix actions module. Data fields have now been incorporated within the online mortality module to facilitate thematic reporting into the future.
- The Trust continues to report any applicable cases to the LeDeR programme, and complies with all reporting and reviewing requirements for LeDeR.

1.3. A review of the Trust's mortality processes has been undertaken by one of the General Managers in the Office of the Medical Director and a number of recommendations have been made in relation to the process and governance arrangements as well as the compliance and learning aspects of SJRs. The

outputs from this review will also support the Trust's transition to a Medical Examiner model during 2019/20. This will require investment in the role of medical examiner and so a full review and proposal was brought through executive quality committee in March 2019. This has been included as a cost pressure for business planning purposes.

1.4. A Learning from Deaths steering group has been established to oversee the implementation of the recommendations made by the review and will include how learning is disseminated across directorates and specialties.

2. Purpose

2.1. The purpose of this paper is to update the Board on progress with ensuring Trust compliance with the mandatory framework on learning from deaths since the previous report in January 2019.

3. Background

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

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

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

3.4. In July 2018 the National Quality Board published further guidance on "*Learning form Deaths: Guidance for NHS trusts on working with bereaved families and carers".* The trust is currently reviewing the recommendations within this guidance and will adapt its processes accordingly.

4. Summary/Key points

4.1. The data required for Trust Board publication is shown in **appendix A**.

Imperial College Healthcare NHS Trust

4.2. All clinical teams are required to provide a review of mortality cases within their specialty areas. All cases undergo a Level 1 review, which consists of a short number of questions, followed by assigning an avoidability score within 7 days of death. Based on that review, cases may proceed to a team based Morbidity & Mortality (M&M) meeting, which should occur within 30 days. Where local teams have highlighted issues in the care of a patient, an independent SJR review should be undertaken.

4.3. Charts demonstrating the trust performance, both for local review as well as SJR, for 2017/18 and for Q1-Q3 2018/19 can be found in **Appendix B**. For deaths occurring in Q1-Q3 2018/19, 93% of local reviews have been undertaken with 179 SJRs requested; of these, 156 SJRs have been completed with six avoidable deaths confirmed. N.B. Data included here covers Q1-Q3 2018/19 for external reporting requirements.

4.4. Data is refreshed monthly, in order to update all reporting metrics. This is particularly important when reviewing SJR requests which are made a significant period after the death. Delays occur due to SJRs being requested more than 30 days after death, e.g. as a result of coronial requests being confirmed, or concerns being raised by clinical teams from local M&M procedures, or are commenced as a response to formal complaints.

4.5. Overdue SJR reviews are being managed where reviewers are struggling to complete them, for example due to capacity, by reallocating them to another reviewer. Additional dates for the mortality review group (MRG) have been provided as the availability of investigators to the monthly meeting is limited, removing a factor that had caused delay.

4.6. Data is reported one month in arrears to allow time for the reviews to be completed within the agreed timeframe as per trust policy. This was introduced to ensure that data reported was more accurately reflecting performance.

4.7. The Trust target is to review 15% of hospital deaths using the SJR methodology. Cases are selected using the principles set out in the Trust policy. The Trust has currently reviewed 12% of hospital deaths up to Q3 18/19, and we are on track to review 15% by year-end.

4.8. A national dashboard remains under development. Until such time as this is launched Trusts have been asked to publish data in their public board papers.

4.9. The Mortality Review Group (MRG) reviews all cases that are potentially avoidable (scored 1-4) Trust-level sign-off. Cases that the reviewers feel have learning or have wider discussion points are also presented. Discussions focus on any avoidable factors and learning themes. Early emerging themes map to five of the safety streams: falls, responding to the deteriorating patient, safer medication, safer surgery and fetal monitoring. These safety streams have improvement plans in place and cases will continue to be shared with the safety work stream leads to ensure the improvement work covers the findings of the SJRs.

4.10. A key focus of the updated guidance is the need to actively involve families, including offering opportunities for them to raise questions or share concerns in relation to the quality of care received by their relatives. Guidance on working with bereaved families was published in July 2018. The Trust is in the process of adapting its policies and processes to incorporate the new guidance. In the interim we have included guidance in the bereavement pack for families on how to raise concerns; we are also currently working with the Trust Communications team on other signposting options.

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

4.12. The Trust reports all deaths of patients with a learning disability to the national database. We reported 12 deaths in 2017/18, of which two were subject to a full review. We have reported eight cases in Q1-Q3 2018/19. These cases all have an SJR completed, in addition to the external LeDeR review. To date those SJR reviews have not revealed any concerns in relation to deficiencies in care, and do not form any of the reported avoidable deaths. LeDeR reports are held at CCG level and not actively shared with acute providers unless issues or concerns are identified relating to the Trust.

5. Options appraisal including financial appraisal (as relevant)

Not applicable

6. Conclusion and Next Steps

6.1. The Trust is compliant with reporting requirements and will continue to report quarterly to the Trust Board.

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

6.3. A review of the Trust's mortality processes has been undertaken with a number of recommendations made. The outputs from the review will also support the Trust's transition to a Medical Examiner model during 2019/20. This will require investment in the role of medical examiner and so a full review and proposal was brought through executive quality committee in March 2019. This has been included as a cost pressure for business planning purposes.

6.4. A Learning from Deaths steering group has been established to oversee the implementation of all recommendations made following the review and will include how learning is disseminated across directorates and specialties.

Imperial College Healthcare NHS Trust

7. Recommendations

7.1. This paper is being presented to the Board for noting.

Author: Ian Maconochie, Associate Medical Director
Date: 15 March 2019

Appendices:

Appendix A: NQB Learning from Deaths Dashboard

Appendix B: Trust Performance Dashboard

- 2017/18
- 2018/19

Imperial College Healthcare NHS Trust

Appendix B

Trust performance dashboard 2017/18

Trust Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	**YTD**
Total Deaths	120	152	137	138	163	151	161	167	161	191	176	178	**1895**
No. Level 1 Reviews Completed	120	152	137	138	163	150	161	167	160	190	176	178	**1892**
% Level 1 Reviews Completed	100%	100%	100%	100%	100%	99%	100%	100%	99%	99%	100%	100%	**100%**
No. of SJR Reviews Requested	3	3	4	21	30	22	36	19	21	28	32	28	**247**
No. of SJR Reviews Completed	3	3	4	21	29	22	36	19	21	28	32	27	**245**
% SJR Reviews Completed	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	96%	**99%**
No. of Avoidable Deaths (Score 1-3)	2	0	0	2	2	1	3	2	0	2	2	1	**17**

NHS
Imperial College Healthcare
NHS Trust

Trust performance dashboard 2018/19 (data to December 2018)

Trust Total	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	**YTD**
Total Deaths	155	136	122	159	118	131	162	133	145	**1261**
No. Level 1 Reviews Completed	155	136	118	153	108	121	152	117	111	**1171**
% Level 1 Reviews Completed	100%	100%	97%	96%	92%	92%	94%	88%	77%	**93%**
No. of SJR Reviews Requested	19	29	23	23	20	14	15	16	20	**179**
No. of SJR Reviews Completed	19	27	21	22	19	11	14	12	11	**156**
% SJR Reviews Completed	100%	93%	91%	96%	95%	79%	93%	75%	55%	**87%**
No. of Avoidable Deaths (Score 1-3)	2	1	1	1	0	0	0	1	0	**6**

Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - December 2018-19

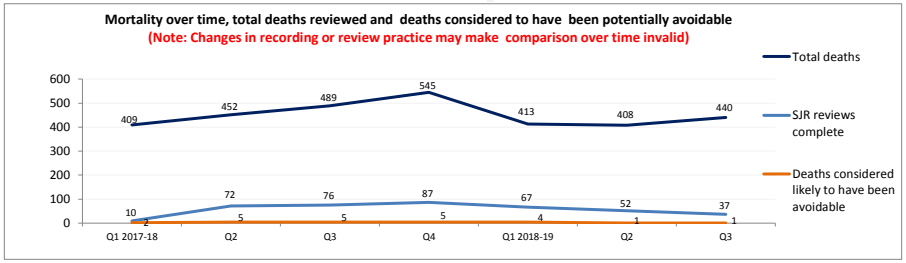
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
145	133	11	12	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
440	408	37	52	1	1
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
1261	1895	156	245	6	17

Time Series: Start date 2017-18 Q1 End date 2018-19 Q3



Total Deaths Reviewed by RCP Methodology Score

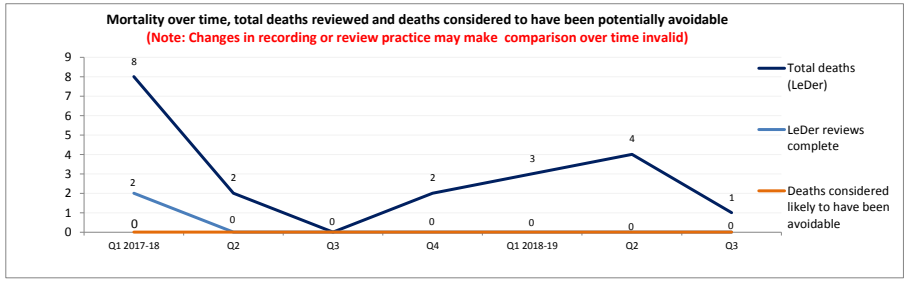
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	18.2%	This Month	9	81.8%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.7%	This Quarter (QTD)	3	8.1%	This Quarter (QTD)	3	8.1%	This Quarter (QTD)	30	81.1%
This Year (FYTD)	0	0.0%	This Year (FYTD)	1	0.6%	This Year (FYTD)	5	3.2%	This Year (FYTD)	12	7.7%	This Year (FYTD)	17	10.9%	This Year (FYTD)	121	77.6%

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	4	0	0	0	0
This Year (FYTD)	Last Year	This Year (FYTD)	Last Year	This Year (FYTD)	Last Year
8	12	0	2	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q3



TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q3 2018/19	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 March 2019	**Item 16, report no. 13**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Jon Otter, General Manager, IPC Professor Alison Holmes, Director of IPC

Summary:

- There were 7 Trust-attributed cases of *C. difficile* in Q3, against a quarterly ceiling of 16. ICHT now ranks 3rd best in the Shelford group for its rate of *C. difficile,* compared with 7th in 2017/18. This rate of *C. difficile* infection is very low, and represents a success of IPC and antibiotic stewardship activity.
- One of the 7 cases of Trust-attributed *C. difficile* in Q3 was a 'lapse in care' due to transmission being suspected. This has improved from five in Q1 and three in Q2.
- Whilst ICHT ranks 4th best in the Shelford group for its rate of *E. coli* BSI, the Trust is not on track to meet its internal 10% reduction target for healthcare-associated *E. coli* BSIs; this will be a focus for targeted work.
- The rate of SSI following elective orthopaedic procedures is very low, with only 1 SSI in the past 12 months following hip and knee procedures, considerably below the national average.
- Compliance with CPE admission screening has increased, with all specialities performing universal admission screening for CPE now screening in excess of the 90% target.
- Compliance with IPC core skills training has increased; compliance with Level 1 training (for all staff) is at 91% and compliance with Level 2 training (for clinical staff) is at 89% against a target of 90%.
- A monthly Water Hygiene Group is now in place to oversee the processes to ensure water hygiene, which are delivered operationally by Trust Estates and their contractors.
- The Trust continues to prescribe fewer antimicrobials than 4 years ago, but rates of prescribing have increased slightly in Q3, probably due to winter pressures.
- Outbreaks of *Pseudomonas aeruginosa* in the neonatal units at SMH and HH, and an outbreak of MRSA in the ICU at SMH have been closed.
- A refreshed Trust-wide project to improve hand hygiene practice continues. The programme of activities and the improved practice captured in observational audits is presented.

Recommendations:
The Board is asked to note the report.

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

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

Financial impact:
No direct financial impact.

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

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

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

What impact will this have on the wider health economy, patients and the public?
☐ Yes ☒ No ☐ Not applicable
If yes, briefly outline. ☐ Yes ☐ No
……

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

Trust strategic objectives supported by this paper: Retain as appropriate: ▪ To achieve excellent patient experience and outcomes, delivered efficiently and with compassion. ▪ To educate and engage skilled and diverse people committed to continual learning and improvements. ▪ As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care. ▪ To pioneer integrated models of care with our partners to improve the health of the communities we serve.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): *Is there a reason the key details of this paper cannot be shared more widely with senior managers? N* *If the details can be shared, please provide the following in one to two line bullet points:* ▪ *What should senior managers know? That the quarterly IPC report is available to review.* ▪ *What (if anything) do you want senior managers to do? Read the relevant sections of the report.* ▪ *Contact details or email address of lead and/or web links for further information Jon Otter (jon.otter@nhs.net)* ▪ *Should senior managers share this information with their own teams? Senior managers could share this report with their teams for information.*

1 Healthcare-associated infection (HCAI)

1.1 *C. difficile*

There have been 7 Trust-attributed cases this quarter, against a quarterly ceiling of 16 cases (Figure 1). *C. difficile* assigned as Trust-attributed was detected in 0.5% of 1360 specimens of stool tested during Q3. This rate of *C. difficile* infection is very low since this infection usually peaks in the winter months, and represents a success of Trustwide IPC and antibiotic stewardship activity. This includes a comprehensive set of measures to optimise antibiotic usage, minimising their risk in driving *C. difficile* infection, and to reduce its transmission.

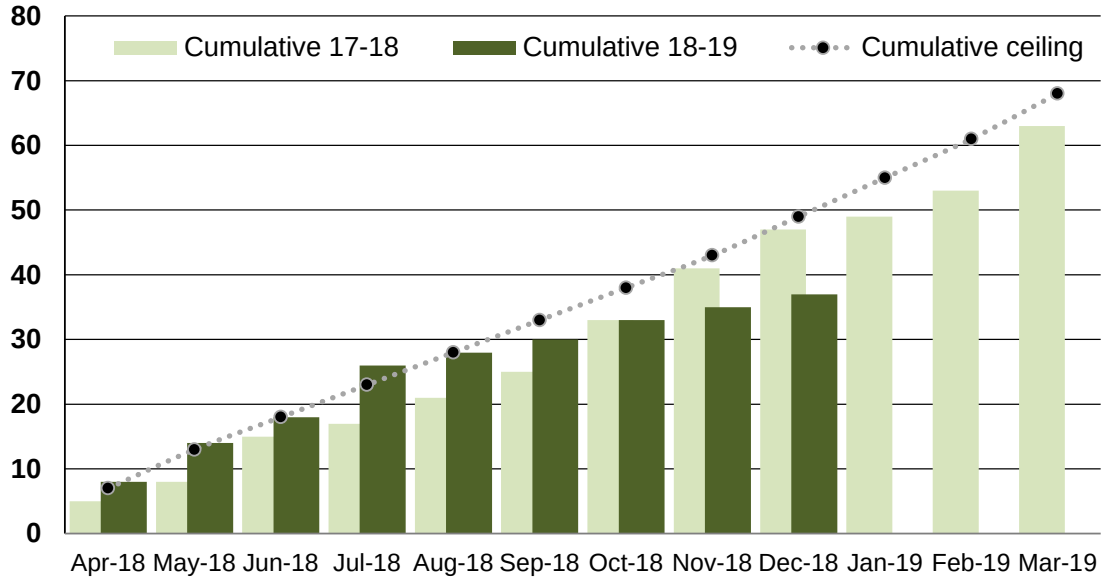


Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in 2018/19 (dark green bars) compared with 2017/18 (light green bars).

1.1.1 *C. difficile*: lapses in care

One of the 7 cases of Trust-attributed *C. difficile* in Q3 had a lapse in care[1] identified (Table 1). This has improved from five in Q1 and three in Q2. The case was likely due to transmission, (FY18/19) on a ward in the Division of Medicine, and has been discussed with the clinical team to ensure that lessons are learned. The learning from the lapses in care to date in 2018/19 (nine in total, compared with seven during 2017/18) has been reviewed and shared with the clinical teams involved.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Total number of Trust-attributed cases 2017/18	8	6	4	8	2	2	3	2	2
Specimens sent for *C.difficile* testing	505	507	456	481	498	492	459	471	430
Lapse in care*	2	1	2	2	0	1	0	0	1

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

1.1.2 *C. difficile*: time to isolation

The Trust has a policy to isolate patients who develop diarrhoea within two hours of the start of symptoms. 77% of patients were isolated within two hours during Q1, Q2, and Q3 of 2018/19 (Figure 2), which is an increase from 73% during 2017/18. On each occasion when a *C. difficile* case is not isolated within two hours, the IPCNs provide prompt feedback and education to the clinical team. This seeks to address the specific reason for non-compliance and is reinforced by a one-page training sheet, which is disseminated to the ward team.

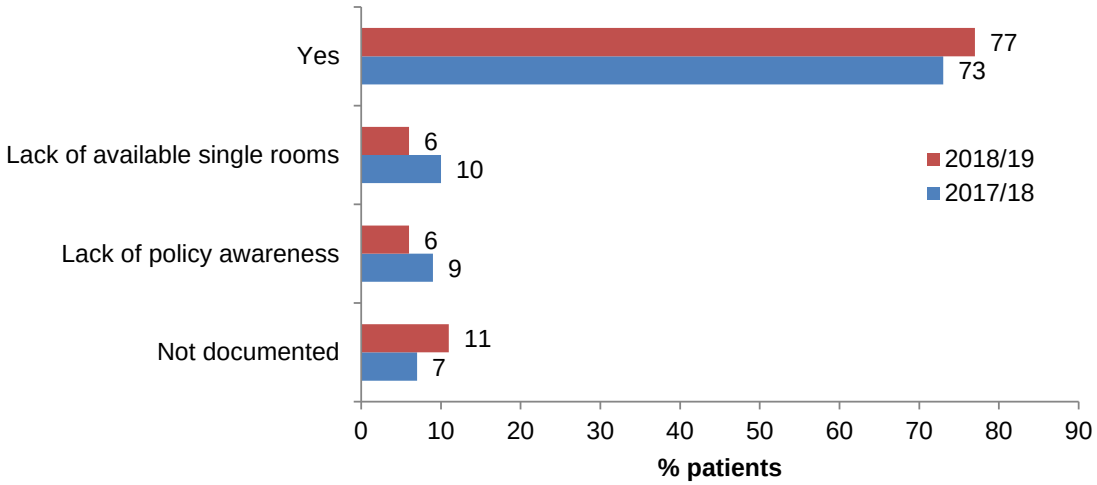


Figure 3: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with C. difficile diarrhoea.

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

The rate of Trust-attributed *C. difficile* at ICHT ranks 3rd best in the Shelford group (Figure 3), compared to a rank of 5th in 2017/18. The rate of specimens tested for *C. difficile* in the other Trusts is unknown, but remains broadly constant at ICHT (see Table 2).

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

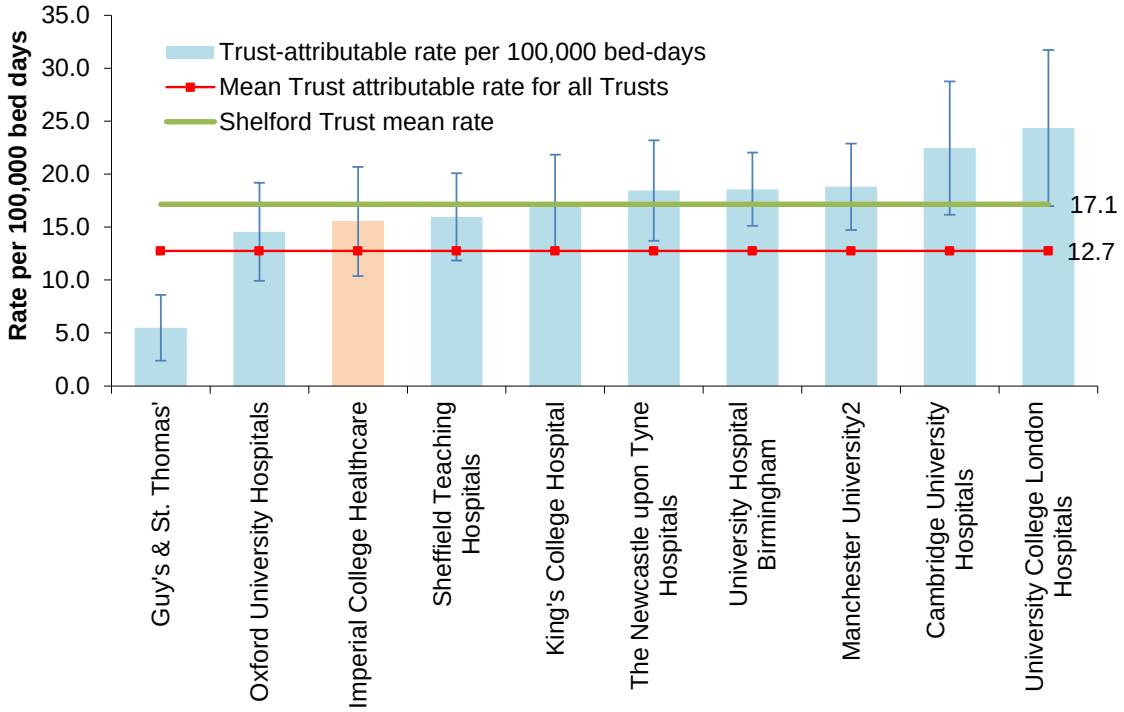


Figure 4: C. difficile Shelford Group comparison, 2018/19. Error bars denote the 95% confidence interval around the rate for each hospital.

1.2 MRSA BSI

There was one case of Trust-attributed MRSA BSI during Q3, from the 8517 blood cultures tested. Any Trust-attributed MRSA BSI undergoes a detailed investigation by IPC in conjunction with the clinical team involved, to identify any learning points and implement any improvements in practice. In November 2018 a neonate had an MRSA BSI, who subsequently recovered. No definitive source was identified. Lessons learnt were around clearer record keeping on line insertions on Cerner, which have been shared with the clinical team.

1.2.1 MRSA admission screening

Compliance with MRSA admission screening was on target at 90% for Q3 (8766 of 9717 patients were screened).

1.3 MSSA BSI

There have been 8 cases of Trust-attributed MSSA BSI in Q3, compared with 11 in Q3 2017/18. There is no national threshold for MSSA BSI. Three of the eight cases were associated with a vascular access device (one with a central line, and two with a peripheral cannula). Each case of MSSA BSI is reviewed by a multidisciplinary group (including the clinical team), and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases. These reviews identified a need to improve documentation around vascular access, which has been discussed and shared with clinical teams and their management structures.

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

The number of cases of *E. coli, P. aeruginosa, and K. pneumoniae* BSI cases during Q3 and their sources is summarised in Table 2. There has been one CPE BSI in Q3 and six during 2018/19.

The Trust is not on trajectory to meet the 10% year-on-year reduction in *E. coli* BSIs, which is an internal performance metric for the Trust (Figure 4). Addressing the various sources of *E. coli* BSI,

especially urinary sources, is a focus of a multidisciplinary group working around reducing Gram-negative BSI (see section 1.4.2).

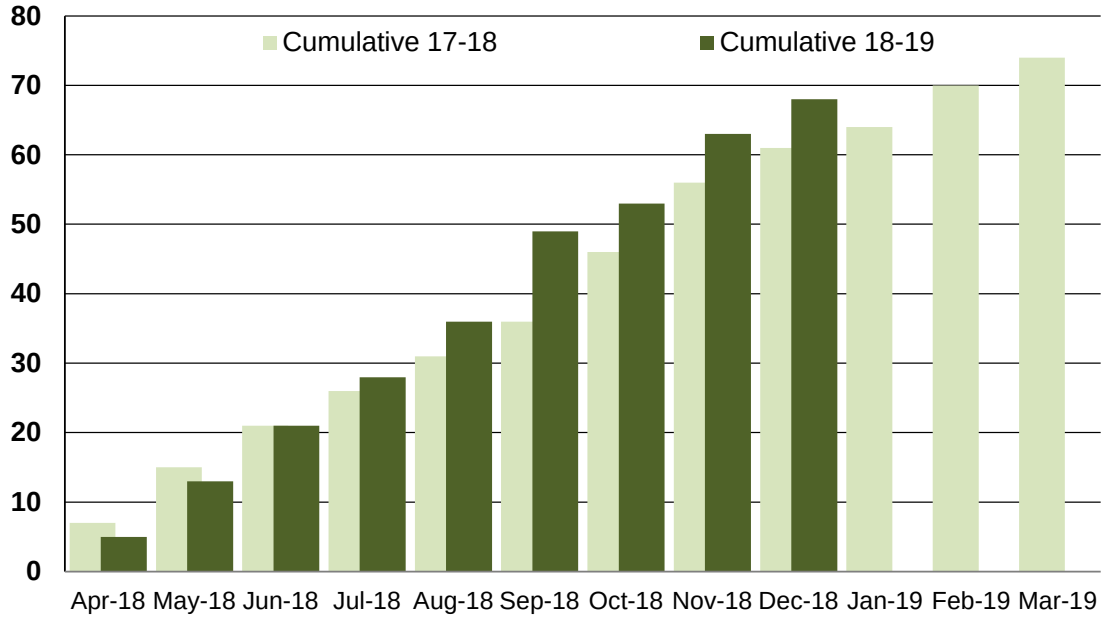


Figure 4: Cumulative monthly 2018/19 Trust-attributed E. coli BSI (dark green bars) compared to 2017/18 (light green bars).

	Q3		
Sources	*E. coli* BSI	*K. pneumoniae* BSI	*P. aeruginosa* BSI
Hepatobiliary	5	2	0
Urinary - urinary catheter associated	4	0	0
Gastroinstestinal	4	2	0
Neutropenic sepsis	3	2	2
Urinary - other	1	2	0
Vascular access device	1	0	1
Other/Unknown	1	2	2
Total number of cases Q3 2018/19	19	10	5
Total number of cases Q3 2017/18	25	14	7

Table 2: Summary of GNBSI sources.

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

Imperial ranks 4th best in the Shelford group for healthcare and community-associated *E. coli* BSI (Figure 5), compared with 7th in 2017/18.

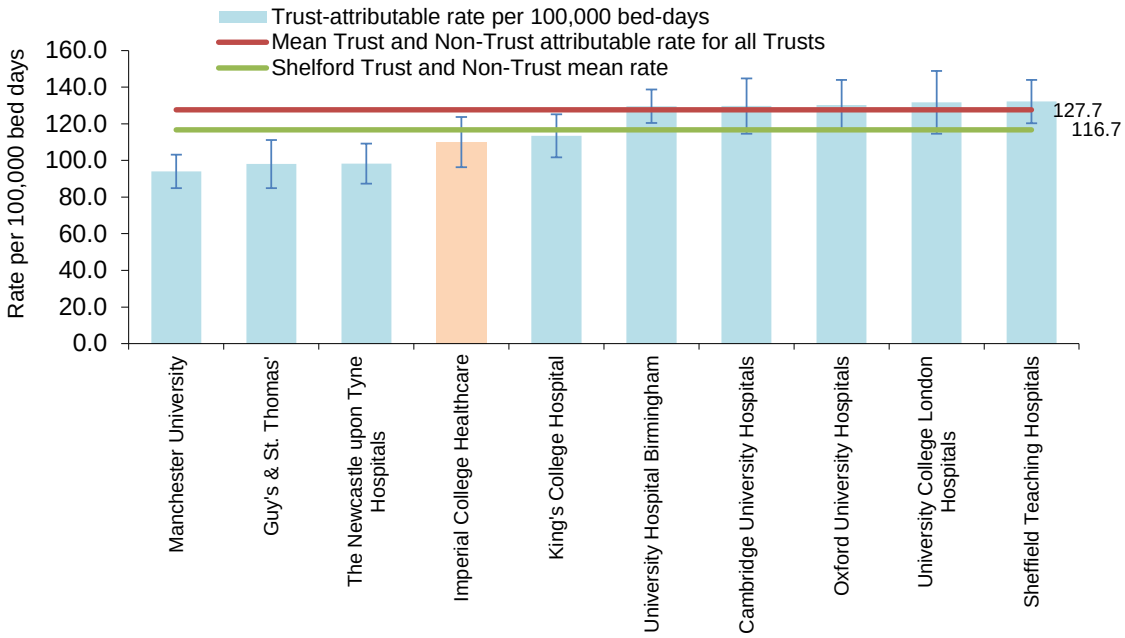


Figure 5: E.coli BSI Shelford Group comparisons, 2017/18. Error bars denote the 95% confidence interval around the rate for each hospital.

1.4.2 Gram-negative BSI reduction target

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

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

The following steps are planned during Q4:

- establish a multidisciplinary Gram-negative BSI reduction group;
- improving the appropriate use of urinary catheters and hydration management with the nursing directorate;
- planning new prevention initiatives in partnership with high-risk clinical areas (for example elderly patients and those in haematology, renal, NICU, and post-surgical wards).

1.5 Blood culture surveillance summary

'Contaminants'[2] accounted for 2.2% of 33,669 blood cultures taken during Q3 which is below our local benchmark of 3%.[3]

1.5.1 Bloodstream infection (BSI) surveillance in ICUs

1.5.1.1 Adult ICUs

There have been 16 catheter line-associated BSI (CLABSI) episodes over the past 12 months (Jan – Dec 2018), with seven identified during Q3 2018/19 for all adult ICUs. The rate of CLABSI over the past 12 months is 1.4 per 1000 catheter line-days, and during Q3 is 2.5 per 1000 catheter-line days, which are both below the benchmark of 3.0 per 1000 catheter-line days (ECDC benchmark).

[2] Bacteria identified in blood cultures that are associated with patients' skin and considered not to be representing infection.
[3] 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.

1.5.1.2 Paediatric ICU (PICU)

There have been two CLABSIs in Jan 18 and Dec 18 on the PICU, with one identified during Q3. The 12-month rate of 1.1 per 1000 catheter-line days is below the ECDC European benchmark of 3.0 per 1000 catheter line days.

1.5.1.3 Neonatal ICU (NICU)

In the 12 month period, Jan 18 and Dec 18, the CLABSI rate on the neonatal ICU (NICU) at SMH and QCCH combined was 7.1 per 1000 catheter line days. The National Neonatal Audit Programme (NNAP) benchmark is 3.0 per 1000 line days. The difference between the rate at ICHT and the benchmark is most likely explained by the high acuity of babies cared for on the NICUs at ICHT. The 12 month CLABSI rate in Very Low Birth Weight (VLBW) babies in the NICU was 9.3 per 1000 catheter line days, slightly above the NEO-KISS nosocomial infections surveillance project benchmark figure of 8.6 per 1000 catheter line days. NICU have implemented actions to reduce the CLABSI rate, which includes a review of guidelines for the insertion of intravascular devices, improved insertion techniques, and a focus on aseptic non-touch technique for all clinical staff.

1.6 Surgical site infection

The Trust reports SSI rates following selected orthopaedic procedures in line with national mandatory reporting, and selected cardiothoracic procedures participating in a national voluntary reporting scheme. A business case to invest in more resources to create a programme of SSI surveillance and improvement in all surgical categories in the Trust has been approved and will be launched during Q4.

1.6.1 Orthopaedics

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

- Knee procedures: 0 SSI in 120 procedures; 12-month average is 0.3% (1 SSI in 376 operations); national average is 0.6%.
- Hip procedures: 0 SSI in 74 procedures; 12-month average is 0% (0 SSI in 264 operations), national average is 0.6%.

1.6.2 Cardiothoracic

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

- CABG: 7 SSI (7.8%) of 90 procedures; 12-month average is 5.8% (18 SSI in 313 operations); national average is 3.8%.
- Non-CABG: 2 SSI (4.5%) of 52 procedures; 12-month average is 2.1% (4 SSI in 192 operations); national average is 1.2%.

The slightly elevated SSI rate in CABG and non-CABG procedures in the last quarter and over the past 12 months has been highlighted to the Division for investigation to prompt a reinforcement of the measures outlined in the Trust's 'SSI: Prevention of Infection Guideline'. A patient-level review of data from this period has validated this rate of SSI, and strengthens the need to ensure that the Trust's SSI prevention of infection guideline, which is being implemented by the Division. This is being monitored through the Surgical Infection Group.

1.7 *Carbapenemase-producing Enterobacteriaceae (CPE)*

1.7.1 Detection of CPE

Figure 6 provides a breakdown of CPE detected at the Trust by bacterial species and mechanism of carbapenem resistance. The majority of patients were identified by screening cultures, without evidence of clinical infection (Figure 7). The number of screens taken each month and number of new CPE cases detected have plateaued over the previous six months.

1.7.2 CPE admission screening compliance

During Q3, overall compliance with CPE admission screening was 84% (2806/3354), against a target of 90%. Screening compliance during Q3 was 97% (338/350) for ICUs, 93% (251/269) for Renal, 100% (48/48) for Haematology, 93% (115/123) for Vascular, and 88% (111/126) for Private Patients. CPE admission screening compliance is included by ward in the monthly Harm Free Care report. This provides a mechanism to prompt targeted improvement at the ward level to address areas of low compliance.

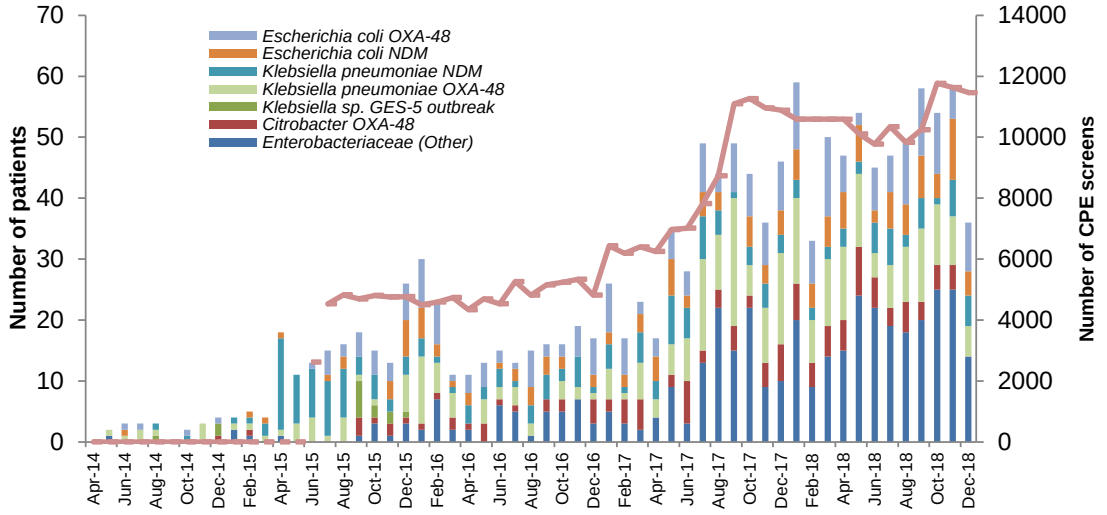


Figure 6: CPE detected at the Trust, by bacterial species and mechanisms, deduplicated by patient. The line represents the total number of screens taken each month.

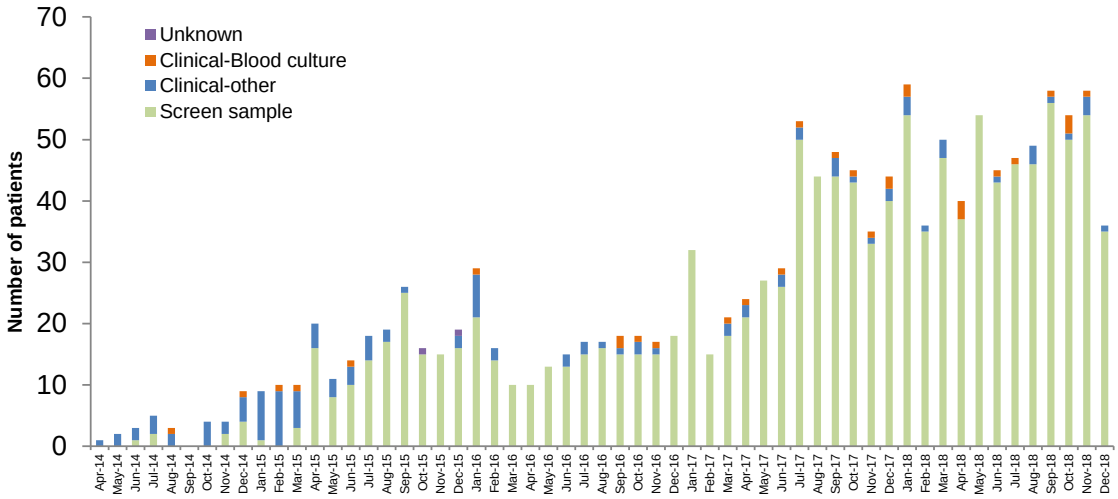


Figure 7: CPE detected at the Trust by culture type.

1.7.3 CPE Action Plan

Following a review of the CPE Action Plan, originally launched in December 2017, two actions remain outstanding: the development of a daily 'sitrep' report on current known CPE patients and their location is in progress; and the CPE admission screening tool has not been built to meet the original specification by Cerner so is being redesigned. These are expected to be completed during Q4. Also, a number of new actions have been added. These actions include plans to enhance the laboratory management of CPE (through investment in in-house whole genome sequencing and rapid screening for CPE), enhancing recording of CPE admission screening data, and to review the cost and feasibility

of a point prevalence screen of all inpatients to evaluate the effectiveness of the Trust's screening programme. The CPE Action Plan is updated and discussed weekly on the HCAI sit-rep call, and bi-monthly at the Quality and Safety Sub-Group.

2 Antibiotic stewardship

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

2.1 Assurance regarding quality of antibiotic prescribing

The next biannual antibiotic point prevalence study (PPS) (based on a review of inpatients) was conducted in February 2019. Results will be outlined in the next report.

2.2 Antimicrobial Consumption

The Trust continues to participate in the 'Reducing the impact of serious infections' CQUIN around antibiotic consumption reductions, which facilitates benchmarking and helps to drive improvement. Antimicrobial prescribing data for ICHT is now publically available on the PHE Fingertips website. PHE have not yet confirmed the percentage reduction targets.

2.2.1 Overall consumption

Following an overall reduction in antimicrobial consumption in Q1 2018/19, which was sustained in Q2, the Trust saw a rise in Q3 2018/19 (Figure 8). This rise 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" (see section 2.2.3) group as recommended by PHE and WHO to curb the threat of resistance. The Trust continues to prescribe fewer antimicrobials than 4 years ago.

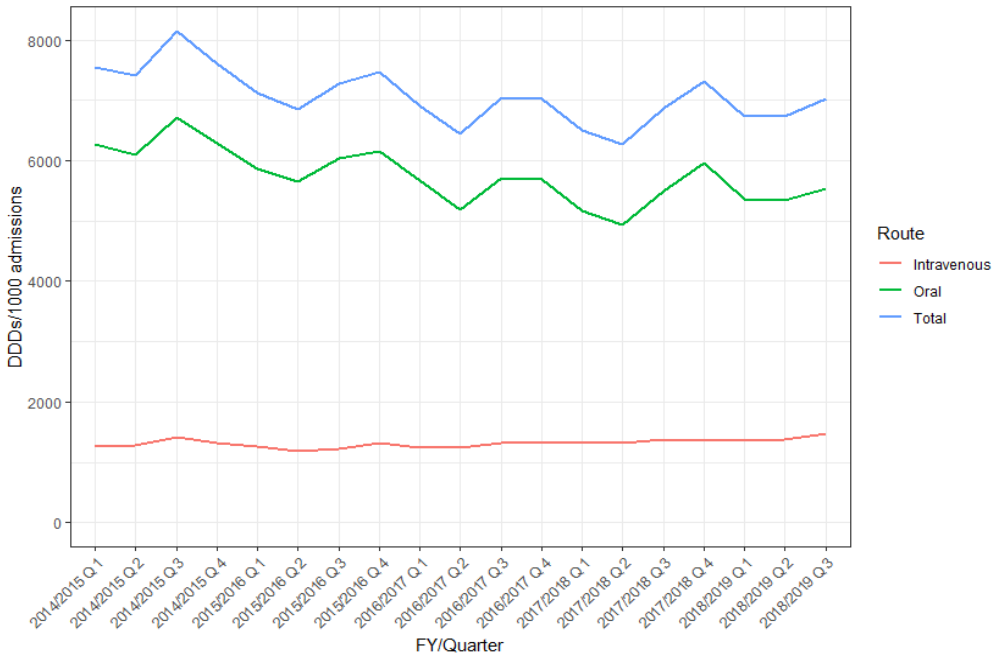


Figure 8: Trust-wide antimicrobial consumption (DDD / 1000 admissions) 2014/15 – present, including the split between intravenous and oral administration.

When compared with our Shelford peers for total antimicrobial consumption via the PHE fingertips portal, ICHT ranks 7th (Figure 9).

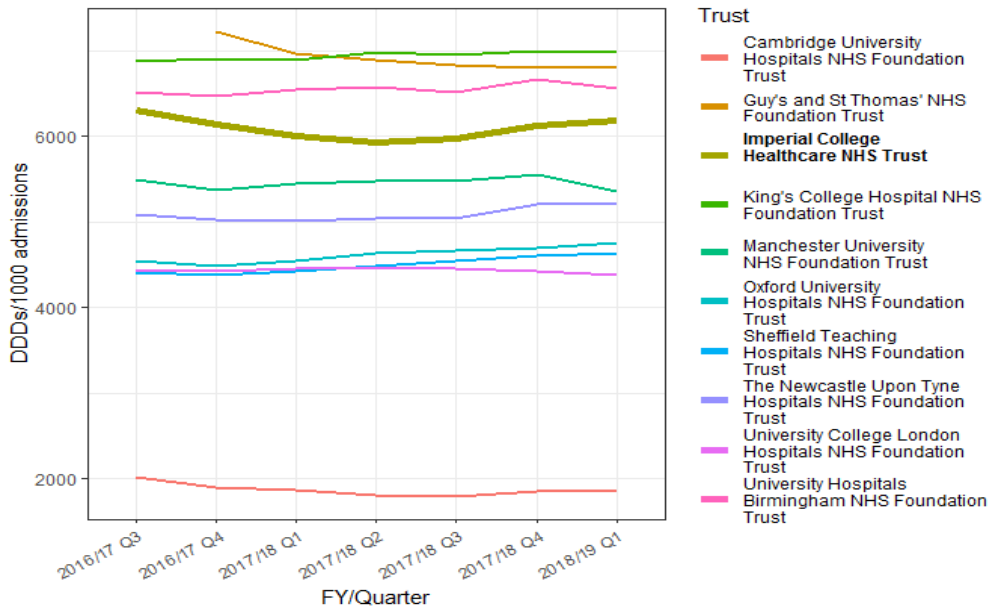


Figure 9: PHE antimicrobial consumption (DDD / 1000 admissions) Q4 2016/17 to Q1 2018/19 compared to other Trusts within the Shelford group and national average. This data has been taken from the Fingertips portal and is only available up until Q1 2018/19.

2.2.2 Piperacillin/ Tazobactam (Tazocin®) / Carbapenem consumption

The reintroduction of Piperacillin/Tazobactam following the national shortage that began in 2017 is likely to have contributed to reduced carbapenem consumption from Q4 2017/18 to Q2 2018/19 (Figure 10). Piperacillin/Tazobactam increased in Q3 2018/19, which can be attributed to targeted use on Critical Care on the St Mary's site, to limit fluroquinolone exposure during an MRSA outbreak. This will be reviewed with Critical Care teams in Q4 2018/19. Overall carbapenem usage has increased since Q2 2018/19 and this rise can be accounted for by increased use within the Medicine and Integrated Care Division. High consumers within this Division include Renal, Infection services and Respiratory, who experienced the greatest rise in carbapenem usage in Q3 2018/19. Compared with our Shelford peers, ICHT ranks 2nd best for Piperacillin/ Tazobactam but ranks 9th for carbapenems (based on Q1 2018/19 PHE consumption data). Carbapenem-reduction plans are being developed via the Antibiotic Review Group. One carbapenem-reducing strategy is the introduction of a patient-specific electronic report from Cerner via the Pharmacy Infection team in Q4 to highlight patients to both infection and clinical teams to enable timely review and potential de-escalation.

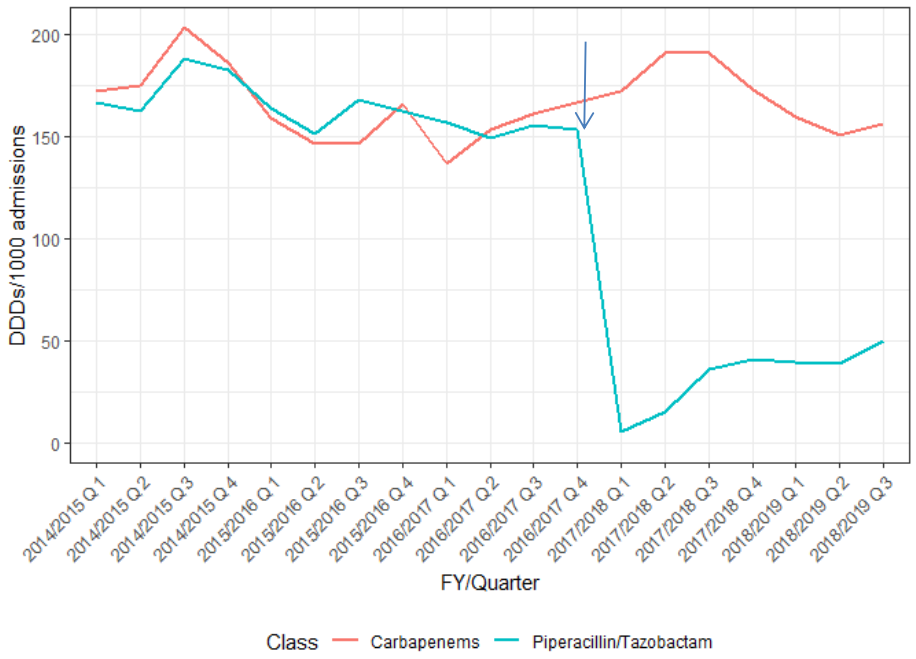


Figure 10: Trust wide Piperacillin / Tazobactam and carbapenem DDDs / 1000 admissions 2014/15 – present. The arrow denotes when the shortage in Piperacillin / Tazobactam began.

2.2.3 AWaRe index

The Trust has been set a target of 55% of all antimicrobial consumption in 2018/19 being from agents within the Access group[4]. In Q3 2018/19, the Trust access group remained stable at 40% (Figure 11). Currently none of the Shelford Trusts are reaching the 55% target of AWaRe group antibiotics.

To try and optimise AWaRe index access group agents, the Trust Antibiotic Review Group has embarked on a full review of the Empirical Treatment of Infection Policy, which was launched in December 2018. However, there was a national shortage of intravenous co-trimoxazole and oral pivmecillinam during this time which will have impacted the Trust's attainment of the target, as both agents fall within the Access category. This will be monitored in Q4 with an expected rise in access antimicrobials as new shortages resolve.

2.3 Antibiotic Expenditure

Trust-wide there was approximately £710k spent on antibacterials and £618k on antifungals in Q3 compared to an average spend of £883k on antibacterials and £652k on antifungals per quarter in 2017/18. The decrease in antibacterial costs is likely to be due to more stability within the antibacterial supply chain and introduction of generic daptomycin and ertapenem.

There has since been a continued reduction every quarter in antifungal expenditure which may be due to the anti-fungal CQUIN work and creation of an antifungal MDT to review complex patients.

2.4 Antibiotic Review Group

The Trust Antibiotic Review Group's (ARG) role is to support the improvement of antibiotic use within the Trust by promoting the safe, rational, effective and economic use of antibiotics by the multidisciplinary teams. In Q3 the ARG has primarily focussed on the launch of the empirical adult antimicrobial treatment guideline. In addition, the following have also been reviewed:

[4] 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.

- Febrile Neutropenia in Adult Haematology PGD
- Malaria – management in children
- Colistimethate Sodium (Colistin) intravenous high dose guideline for the treatment of multi drug resistant Gram-negative organisms
- Amikacin extended interval guideline
- Antenatally detected urinary tract abnormalities in neonates and its management
- Intrathecal anti-infective administration for adult patients via an External Ventricular Drain or Lumbar Drain in adult neurosurgical patients
- Febrile Neutropenia; Management of Febrile Neutropenia in Adult Oncology Patients.

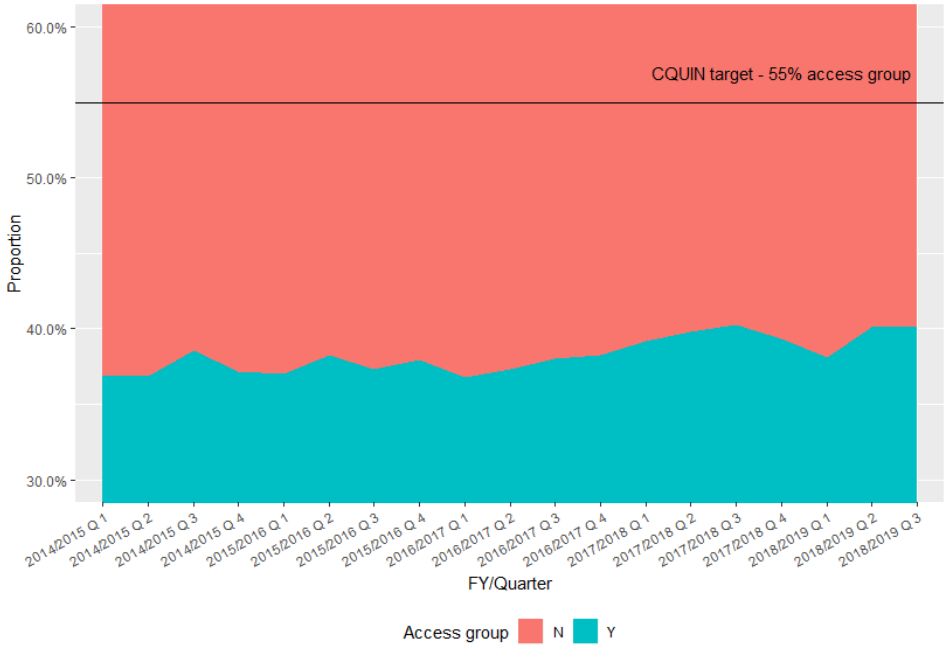


Figure 11: Proportion of antimicrobial consumption of agents within the Access group from 2014/15 to current using ICHNT local consumption data.

2.4.1 Antimicrobial Shortages

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

2.5 Anti-fungal CQUIN

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

The Trust met its Q1 and Q2 antifungal CQUIN requirements which included mapping anti-fungal use across the Trust. The deadline for submitting Q3 data falls in Q4. Within Q3, work has examined two key interventions: (a) identifying and facilitating timely review of patients on Ambisome® therapy (intravenous Ambisome represents approximately 50% of the expenditure within antifungals), and (b) a review of the Trust adult, paediatric and neonatal antifungal guideline based on new emerging literature and current local resistance rates. An updated Trust guideline is due for ratification in Q4.

2.6 Sepsis

IPC have contributed to the development of the Trust Sepsis Guideline, and continues to support the Cerner sepsis alert to improve the identification and management of sepsis. This includes reporting functionality to monitor the time to the first dose of antibiotics. This will help to drive improvement around sepsis treatment, supporting optimised therapy, enabling de-escalation, and reducing antimicrobial consumption.

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

3.1 *Aseptic Non Touch Technique (ANTT)*

The Trust has a requirement that ANTT assessment is undertaken and documented for all staff working in a clinical environment. The target for compliance with ANTT training for Trust clinical staff is set at 90%; currently the compliance rate is 85.5% (6890/8062 clinical staff), which has increased from the last quarter. Of the 1172 non-compliant staff, 72.3% (847) have never had an assessment for ANTT, and 27.7% (325) have had an assessment in the past, but have gone beyond the three-year deadline for re-assessment. Plans are in place to improve compliance with ANTT competency assessment for all clinical staff along with other core clinical skills, including a new model for Divisionally-led ANTT assessment for new doctors when they arrive at the Trust.

3.2 Hand hygiene

3.2.1 Background

A new approach to hand hygiene compliance auditing to improve the quality of audit data in order to guide improvement commenced this year. Auditing of inpatient wards was undertaken by IPC and senior Divisional staff during May 2018. A bi-weekly Task and Finish group reconvened in June and continues to meet to oversee the review of the results, improvement, and communications.

3.2.2 Auditing

3.2.2.1 Audit plans

Audits of clinical areas selected as high-risk areas by the Divisions were completed during November 2018 (the EDs, Children and Young People pathway wards, and critical care along with the focus wards identified for additional support following the May audits). All clinical areas in the Trust (including inpatient, outpatient and other areas) are being audited in February/March 2019.

3.2.2.2 Results from the November audits

Overall compliance was 61% (hand hygiene compliance was observed in 975 of 1586 observed opportunities). The focus wards, which received the most intensive support from the QI team and IPC in developing local improvement plans, were the most improved, with compliance increasing from 29% in the May audits to 67% in the November audits. Compliance in all but one of the focus wards improved between May 2018 and November 2018. The wards selected for additional support in developing local improvement plans, who received lighter input from the QI team and IPC, recording compliance improving from 56% in May 2018 to 66% in November 2018. Compliance improved in 6/7 wards selected for additional support. Compliance in the other wards included in both the May 2018 and November 2018 audits, which received limited on-the-ground support from the QI team and IPC did not increase between the May 2018 (60%) and November 2018 (58%) audits. These findings suggest that the efforts of the QI team and IPC supported the development of effective local improvement plans in the focus wards and the wards selected for additional support. Examples of interventions that have taken place to improve hand hygiene include empowering patients to be involved in hand hygiene, local review and feedback of hand hygiene data, and collection of local data on the availability of hand gel at the point of care.

In order to support improvements going forward, it is helpful to set a local target for hand hygiene compliance. This was previously set at 95% for the Trust. However, in order to reach this, a successful quality improvement programme needs to be established with a dynamic compliance target, set initially at a level that is achievable but challenging. Following consultation and a review of internal and

external data, it is proposed that a hand hygiene compliance target of 70% will be used initially, which will be stretched higher for future audits.

3.2.2.3 Improvement planning

Improvement work continues in areas across the Trust. Bi-weekly reports outlining progress of local improvement plans are being received by the Hand Hygiene Task and Finish group from the focus wards and areas identified for additional support. The group has requested details of the local improvement plans from the other 62 inpatient ward areas that were included in the May 2018 audits. These have been received from 44 and are outstanding from 18 wards; the 18 wards that have not submitted an improvement plan are being followed up by the Divisions. This reporting structure provides a forum for shared learning around hand hygiene across the organisation.

3.2.3 Hand hygiene communications

3.2.3.1 Upgrade of hand hygiene dispensers

The upgrade of the hand hygiene dispensers in the focus wards and areas selected for additional support in generating improvement plans (ICUs, NICUs, EDs, and an IPH ward) has been completed. The new dispensers and signage will be rolled out across the Trust, by site, during 2019. Since there is a stockpile of existing hand hygiene products for the old dispensers to use up, this roll-out will need to be phased. It is anticipated that it will be completed before the end of Q1 of 2019/20.

3.2.3.2 Hand hygiene awareness campaign

Design Science, a creative design agency, have been commissioned to assist the Trust in creating a novel hand hygiene awareness campaign to produce 'nudge' reminders for use in clinical areas. Design Science held a focus group in December to garner feedback from staff and patients about the campaign concept. The feedback from the group was useful and positive. Pilot materials will be produced for testing on the focus wards in January 2019.

4 IPC incidents and clinical activity during Q3

4.1 *Pseudomonas aeruginosa on neonatal units*

There have been two different outbreaks involving the two neonatal units between July 2018 and December 2018. At Queen Charlottes Hospital, 10 babies were found to be colonised with *Pseudomonas* classified into three different clusters according to their typing results. At St. Mary's Hospital, four babies were found to be colonised with *Pseudomonas* classified into two clusters according to their typing results. Routine water testing has identified *Pseudomonas* in a small number of outlets on both of the units and remedial action has been undertaken in line with the relevant national guidance (HTM 04). Typing information from the positive water samples suggests a genetic link between the water samples taken from both of the unit and some of the affected babies. No harm came to any of the babies and they have now been discharged and both outbreaks have been declared over.

4.2 *CPE outbreak on a vascular surgery ward*

Seventeen patients were identified with CPE colonisation on a Vascular Surgery ward between July 2018 and December 2018. These were found to be indistinguishable by typing and transmission was suspected. The ward was closed for ten days in November whilst issues surrounding IPC practice, cleaning, and the environment were addressed. The ward is now open and the outbreak was declared over in December 2018. This was declared as a serious incident (2018/18472), which is under investigation.

4.3 *Candida auris*

Two patients on the same renal ward were identified with *Candida auris* in November 2018 and cross transmission is suspected. Contact screening was performed and no other cases were identified. One patient has died; the cause of death unrelated to this organism. One patient remains an inpatient and in single room isolation. Contact screening will continue for the duration of the patient's admission.

4.4 *Legionella pneumonia*

A patient who had inpatient and outpatient contact with our oncology services in November 2018 has been identified with *Legionella* pneumonia. They have also had inpatient contact at Ealing, where they were diagnosed. The local investigation did not identify any issues with water hygiene.

A member of portering staff was identified with *Legionella* pneumonia in October 2018. As part of the investigation acquisition at the Trust was considered and although unlikely, could not be ruled out. This has been declared as an SI (2018/25973), which is under investigation.

4.5 *Respiratory virus summary*

Figure 12 shows the trend in respiratory viruses identified during Q3. These trends are in line with expected seasonal changes in the detection of respiratory viruses. No evidence of hospital transmission has been identified.

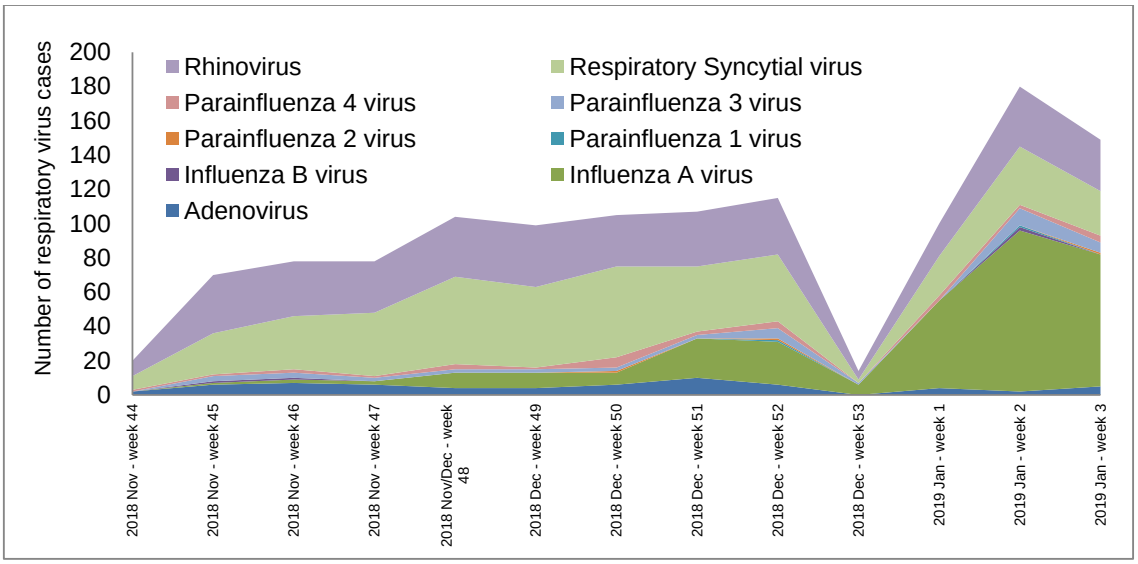


Figure 12: Trends in respiratory viruses.

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

Serious incidents (SIs) reported during Q1, Q2 and Q3 are listed in Table 3. Table 3 summarises key learning points arising from HCAI-related SIs reported so far this financial year.

5 Compliance and Policies

IPC reporting and assurance structures in the Trust have been reviewed and small changes to the Divisional IPC reporting and assurance structures have been made to ensure that they are optimal and reflect various regulatory requirements.

5.1 Compliance

- Cleaning audits are performed by Facilities. Facilities, supported by the Divisions and IPC, are undertaking a review of cleaning policies and processes across the Trust in order to improve standards of cleaning and disinfection in the Trust.
- The Trust has two tiers of annual core skills IPC training: Level 1 for all staff and Level 2 for clinical staff. Compliance with Level 1 is 91% (up from 89% in Q2), and with Level 2 is at 88% (up from 86% in Q2). A Trust wide group has been convened by the Core Skills team to improve compliance with all core skills training.

5.2 *Policies*

Policies and Guidelines approved at the Trust Infection Prevention and Control Committee (TIPPC) on 13th November 2018:

- *Clostridium difficile* Infection Prevention and Control Policy

Policies and Guidelines requiring review during Q4 of 2018/19:

- Standard Precautions Policy
- Chickenpox and Shingles Policy
- Infection Prevention and Control Management of Carbapenem-Resistant Enterobacteriaceae (CRE)
- Viral Haemorrhagic Fever Policy

STEIS	Location	Summary	Date reported	Lessons learnt
2018/25973	WEH	Legionella acquisition	October 2018	Awaiting panel
2018/24831	ZCO	CPE transmission	September 2018	Awaiting panel
2018/ 18472	AICU	MRSA outbreak	June 2018	Poor compliance with IPC practices. There are issues with the cleaning on the ITU Review OH process of supporting staff members with skin conditions
2018/11857	Haematology	CPE Transmission (*Citrobacter freundii* OXA48 x9)	May 2018	Lack of isolation facilities and issues related to space and estates may have contributed to the infection risk. There are issues with the cleaning on the Clinical Haematology wards. Poor compliance with IPC practices.
2018/10021	A7	Norovirus outbreak	April 2018	A delay in escalation of diarrhoea symptoms led to a 48 hour delay in ward closure
2018/12482	JHW	CPE and *C. difficile* transmission	April 2018	The cleanliness on the ward fell below the expected standard. Aspects of IPC practice also fell below a reasonable standard. The patients were prescribed high risk broad-spectrum antibiotics contrary to Trust guidance.

Table 3: HCAI-related SIs reported during 2018/19.

6 Risks

New risks:

The risk of patients becoming exposed to microbiologically unsafe water has been added to the risk register as a stand-alone risk. Previously this risk was covered in a broader Estates risk, but this

approach allows more focus on this important issue. Key actions include a monthly meeting of the Water Hygiene Group (rather than quarterly), a survey of all water appliances and outlets across the Trust is in progress so that each outlet has a unique identifier, the routine 6-monthly *Pseudomonas* sampling of augmented care areas is being staggered on a rolling programme, and the communications around positive water results are being improved. A report summarising the processes, gaps, and risks associated with water hygiene management was discussed at the March 2019 Executive Quality Committee.

Updated risks:

- No major updates to the other IPC risks.

7 Other issues

7.1 External directives

None were received during Q3.

8 Publications in Q3

Rawson TM, Hernandez B, Moore LSP, Blandy O, Herrero P, Gilchrist M, Gordon A, Toumazou C, Sriskandan S, Georgiou P, Holmes AH. Supervised machine learning for the prediction of infection on admission to hospital: a prospective observational cohort study. J Antimicrob Chemother. 2018 Dec 22.

Charani E, Ahmad R, Rawson TM, Castro-Sanchèz E, Tarrant C, Holmes AH. The Differences in Antibiotic Decision-making Between Acute Surgical and Acute Medical Teams: An Ethnographic Study of Culture and Team Dynamics. Clin Infect Dis. 2018 Nov 15.

Blandy O, Honeyford K, Gharbi M, Thomas A, Ramzan F, Ellington MJ, Hope R, Holmes AH, Johnson AP, Aylin P, Woodford N, Sriskandan S. Factors that impact on the burden of Escherichia coli bacteraemia: multivariable regression analysis of 2011-2015 data from West London. J Hosp Infect. 2018 Nov 4. pii: S0195-6701(18)30585-1.

Mizuno S, Iwami M, Kunisawa S, Naylor N, Yamashita K, Kyratsis Y, Meads G, Otter JA, Holmes AH, Imanaka Y, Ahmad R. Comparison of national strategies to reduce meticillin-resistant Staphylococcus aureus infections in Japan and England. J Hosp Infect. 2018 Nov; 100(3):280-298.

Marbach H, Vizcay-Barrena G, Memarzadeh K, Otter JA, Pathak S, Allaker RP, Harvey RD, Edgeworth JD. Tolerance of MRSA ST239-TW to chlorhexidine-based decolonization: Evidence for keratinocyte invasion as a mechanism of biocide evasion. J Infect. 2018 Oct 24. pii: S0163-4453(18)30312-8.

Chatterjee A, Modarai M, Naylor NR, Boyd SE, Atun R, Barlow J, Holmes AH, Johnson A, Robotham JV. Quantifying drivers of antibiotic resistance in humans: a systematic review. Lancet Infect Dis. 2018 Dec; 18(12):e368-e378.

Ledwoch K, Dancer SJ, Otter JA, Kerr K, Roposte D, Rushton L, Weiser R, Mahenthiralingam E, Muir DD, Maillard JY. Beware biofilm! Dry biofilms containing bacterial pathogens on multiple healthcare surfaces; a multi-centre study. J Hosp Infect. 2018 Nov; 100(3):e47-e56.

Herrero P, Rawson TM, Philip A, Moore LSP, Holmes AH, Georgiou P. Closed-Loop Control for Precision Antimicrobial Delivery: An In Silico Proof-of-Concept. IEEE Trans Biomed Eng. 2018 Oct; 65(10):2231-2236.

Castro-Sánchez E, Iwami M, Ahmad R, Atun R, Holmes AH. Articulating citizen participation in national anti-microbial resistance plans: a comparison of European countries. Eur J Public Health. 2018 Oct 1; 28(5):928-934.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Quality Account 2018/19: Review of improvement priorities	☒ Approval ☒ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 27th March 2019	**Item 17, report no. 14**
Responsible Executive Director: Julian Redhead, medical director	**Author:** Clemmie Burbidge, compliance and assurance improvement lead Shona Maxwell, chief of staff

Summary:
Last year's quality account set out thirteen improvement priorities, and a number of associated metrics, for the Trust for 2018/19. These priorities were defined following an extensive listening exercise conducted in Q4 2017/18 as part of the process for reviewing the quality strategy in addition to the normal annual review with stakeholders. They were signed off by the board in May 2018. The metrics are being monitored through the integrated quality and performance reports, with the improvement priorities, being varied in nature and scope, having separate reporting arrangements in place through the appropriate executive committee. A quarterly report summarising progress with all 13 is reviewed at executive quality committee, with the last report presented in October 2018.

We are currently preparing the draft of the annual quality account which is due to executive quality committee in April 2019. As part of this work we must set out a backward view of what we have achieved during this financial year as well as setting out our priorities for improvement during 2019/20. To enable this to be completed the priorities need to be reviewed and agreed.

To support this review, this paper summarises progress with the quality improvement priorities set for this current year and provides suggestions for what we might prioritise for 2019/20; these were agreed at executive quality committee (ExQu) and board quality committee in March. It is important that these are set in a way that will allow us to align them with our organisational strategy and our improving quality strategy both of which we will publish later in 2019. However, given the deadlines for the quality account we accept that this will not be a seamless process this year.

The paper does not include any details on the review of the integrated quality performance report which is currently underway nor does it try to set out all of the improvement work that we have completed this year. This will all be included in the draft in April, which will be circulated to board members for consultation following review at ExQu. The final quality account will be presented to the Board in May for approval.

Recommendations:
This paper is being presented to the Trust Board to allow for final approval of the proposed priorities for 2019/20 which were agreed at ExQu and Board quality committee in March.

The Board are asked to approve that the following improvement priorities are continued into 2019/20:

- To reduce avoidable harm to patients
- To improve the safety culture across the Trust (refocused on the behaviours that support safety improvement.
- To improve permanent nurse staffing levels (incorporating non-consultant doctors as a minimum)
- To continue to define, develop, implement and evaluate an organisation approach to reducing

unwarranted variation
- To improve access to services across the Trust through a focus on increasing capacity and improving emergency flow through the hospital (combination of two previous priorities)
- To improve access for patients waiting for elective surgery
- To improve compliance with the equality and diversity standards

The Board are asked to approve that the following are managed as business as usual:
- To ensure our staff are up to date with the mandatory skills to do their jobs
- To ensure our equipment has planned maintenance in line with targets
- To improve the management of medicines
- To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists
- To improve access to services across the Trust through a focus on increasing capacity (combined with emergency flow priority – see above)
- Specialty review and clinical strategy development

The Board are asked to approve that an additional priority is included – to review our approach to inspection, accreditation and reviews.

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

Quality impact:
The improvement priorities span all five of the CQC domains (safe, caring, responsive, effective, well-led) and were developed in consultation with stakeholders both internal and external to the Trust as part of the annual quality account process.

Financial impact:
This paper has no financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
There is an associated divisional risk on Datix (ID 1640 – new quality strategy development and implementation)

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

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?
☒ Yes ☐ No ☐ Not applicable
The priorities outlined in our quality account will directly impact on the quality of care that we provide for our patients.

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

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

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

Quality Account 2018/19: Review of improvement priorities

1. Executive Summary

1.1. The Trust's improving quality strategy for 2019-2024 is currently under development. As with our previous strategy, it will be delivered through the achievement of a number of quality standards and improvement priorities which are described annually in our quality account, along with progress in delivering the priorities for the previous year.

1.2. We are currently preparing the draft of the annual quality account which is due to be circulated to board members for consultation following review at executive quality committee in April 2019. As part of this work we must set out a backward view of what we have achieved during this financial year as well as setting out our priorities for improvement during 2019/20. To enable this to be completed the priorities need to be reviewed and agreed.

1.3. To support this review, this paper summarises progress with the quality improvement priorities set for this current year and provides suggestions for what we might prioritise for 2019/20; these were agreed at executive quality committee and board quality committee in March. It is important that these are set in a way that will allow us to align them with our organisational strategy and our improving quality strategy both of which we will publish later in 2019. However, given the deadlines for the quality account we accept that this will not be a seamless process this year.

1.4. The paper does not include any details on the review of the integrated quality performance report which is currently underway nor does it try to set out all of the improvement work that we have completed this year. This will all be included in the draft in April. The final quality account will be presented to the Board in May for approval.

2. Purpose

2.1. This paper is being presented to Trust Board to allow for approval of the proposed priorities for 2019/20 which were agreed at ExQu and Board Quality Committee in March.

3. Background

3.1. The Trust's annual quality account sets out the organisation's improvement priorities and metrics for the following year, and describes progress in delivering the priorities outlined in the previous document.

3.2. Since 2015, the document has been aligned with the Trust's quality strategy, with the annual priorities set out in the quality account designed to support delivery of the strategy.

4. Summary/Key points

4.1. Last year's quality account set out thirteen improvement priorities in addition to the metrics measured in the integrated quality performance scorecard for the Trust for 2018/19.

4.2. These priorities and the metrics that underpin them were defined following an extensive listening exercise conducted in Q4 2017/18 as part of the process for reviewing the quality strategy. They were signed off by the board in May 2018.

4.3. The metrics are being monitored through the integrated quality and performance arrangements, with the improvement priorities, being varied in nature and scope, having separate reporting arrangements in place through the appropriate executive committee. A report summarising

progress with all 13 is reviewed at ExQu on a quarterly basis, with the last report presented in October 2018. This is to ensure that progress with the priorities is able to be triangulated and considered together, and to allow the executive to take stock of progress and support improvements as required.

4.4. Appendix 1 provides a summary of progress for each improvement priority, as provided by the executive lead or outlined in the papers presented to the relevant executive committee. Following feedback at the meeting in October, it also includes outcome measures, such as the relevant metrics in the integrated quality and performance scorecard where appropriate. The data used is from December 2018 as the scorecard showing data for January 2019 was not yet finalised when this report was prepared. Looking to the year ahead the metrics are being reviewed for 2019/20 through the annual refresh of the integrated quality and performance framework.

4.5. This progress update will provide the basis for the draft quality account section related to our performance with our improvement priorities throughout 2018/19. The draft quality account will be circulated to the executives and their teams for comment in March ahead of presentation to ExQu in April. Following review at ExQu, the draft will be circulated to the board members for consultation. The final draft will be presented to Trust Board in May for approval.

4.6. It has been agreed that the following seven improvement priorities are continued into 2019/20:

- **To reduce avoidable harm to patients**: work will continue in the 9 safety streams although they will be redefined following evaluation of impact and current data. Additional work is also required to strengthen how we learn from incidents and avoidable deaths.
- **To improve the safety culture across the Trust:** we will refocus this on improving the behaviours that contribute to improving safety. This will fit better with the trust wide work on delivering our promise through our values and the implementation of a behaviours framework. We will focus on the behaviours we expect staff to display. These include being open and transparent when things go wrong, being encouraged to report, reflect and learn and being supported in a just and caring way.
- **To improve permanent nurse staffing levels:** We will maintain this as a priority for 2019/20 given the challenges we face at ICHT and nationally. It is proposed that this is widened to include other staffing groups. To note it is now a requirement to report staffing levels for non-consultant level doctors so as a minimum we should consider including them.
- **To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation:** We continue to make progress through FCA Imperial with the first and second cohort of pathways showing demonstrable impacts. The 9 internal pathways which form part of cohort 3 will begin their teaching sessions in April 2019. As the programme and trustwide approach to unwarranted variation develops clearer outcome measures will be developed and reported on through the divisions to allow for improved monitoring of the impact of the programme. Co-ordinating and realising the benefits from the GIRFT programme needs to be further refined.
- **Emergency flow through the hospital:** We will focus on delivering the Care Journey and Capacity Collaborative 2019/20 work programme. We propose that this priority is combined with the increasing capacity priority.

- **To improve access for patients waiting for elective surgery:** Through ECOF, we will continue to work to ensure we meet our target set by the commissioners that at least 92% patients wait for no longer than 18 weeks for non-urgent consultant led treatments at Imperial College Healthcare Trust by March 2020.
- **To improve compliance with the equality and diversity standards:** The E&D programme action plan was approved at ExPOD in January 2019. Work for 2019/20 will focus on its implementation, with reporting through agreed governance structures to trust board.

4.7. It has been agreed that the following improvement priorities are taken forward through business as usual governance processes in 2019/20. This is because they have made progress to achieve their initial goal or that they will be picked up in other priorities.

- **To ensure our staff are up to date with the mandatory skills to do their jobs:** Current compliance with core skills training has been consistently above our stretch target of 90% since November 2018. It is proposed that this returns to business as usual monitoring through the integrated quality performance report with reporting to the executive P&OD committee.
- **To ensure our equipment has planned maintenance in line with targets:** All medical equipment has a planned maintenance programme and associated target KPIs, which are being met. This should now be managed through business as usual through routine governance processes. Work will be on-going to ensure we continue to meet the targets and this should be considered as part of the review of how we undertake inspection/assurance/reviews.
- **To improve the management of medicines**: Medicines management group continues to meet monthly and is making progress e.g. suite of medicines management products developed with staff, improved training rates, weekly audits in place. Trustwide improvement targets remain in development but should be published in the integrated quality performance report in 2019/20. It is proposed that this should move to business as usual monitoring through routine governance processes.
- **To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists:** The hand hygiene safety stream has shown demonstrable improvements in wards receiving focused support (using a new, more robust audit methodology), which is supported by trust wide communications and an equipment upgrade. Hand hygiene improvement is a safety stream and so this is proposed to be managed under that priority (‘To reduce avoidable harm to patients’) rather than sitting separately.
- **To improve access to services across the Trust through a focus on increasing capacity:** This work will continue into 2019/20, however it will be merged into the emergency flow priority.
- **Specialty review and clinical strategy development:** The clinical strategy will be published in 2019/20 in line with timescales for the organisational strategy. The Director for Transformation is now the SRO for the SRP and is taking forward the next stage where we translate the specialities’ visions into tactical plans to implement during FY19/20 (‘Realising the Vision’). As this is being taken forward as part of the development of the organisational strategy, we propose that this should not be an improvement priority for the quality account.

4.8. It has been agreed that an additional priority is included – to review our approach to inspection, accreditation and reviews. Learning from the work undertaken in the lead up to the recent trust inspection it is timely to review the approach and plans going forward to supporting teams to improve against key lines of enquiry and expected standards.

5. Conclusion and Next Steps

5.1. All improvement priorities set out in the quality account have defined work plans that are progressing, with regular reporting through the appropriate executive committees.

5.2. The executive and board quality committees have agreed that six of the priorities are transitioned to business as usual for next year.

5.3. The executive and board quality committees have agreed that an additional priority is included - to review our approach to inspection, accreditation and reviews.

5.4. The Trust will therefore have eight improvement priorities for 2019/20.

5.5. The agreed priorities will be incorporated into the draft quality account which will be circulated to the board members for consultation in April 2019, following review at ExQu.

5.6. An update on progress with the agreed priorities will be provided in a quarterly report to executive quality committee and board quality committee, and summarised in next year's quality account, alongside performance against the metrics in the IQPR and a description of other key pieces of improvement work being undertaken across the Trust.

5.7. The final quality account will be presented to Trust Board in May for approval.

6. Recommendations

6.1. The Board is asked to approve that the following improvement priorities are continued into 2019/20:

- To reduce avoidable harm to patients
- To improve the safety culture across the Trust (refocused on the behaviours that support safety improvement.
- To improve permanent nurse staffing levels (incorporating non-consultant doctors as a minimum)
- To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation
- To improve access to services across the Trust through a focus on increasing capacity and improving emergency flow through the hospital (combination of two previous priorities)
- To improve access for patients waiting for elective surgery
- To improve compliance with the equality and diversity standards

6.2. The Board is asked to approve that the following are managed as business as usual:

- To ensure our staff are up to date with the mandatory skills to do their jobs
- To ensure our equipment has planned maintenance in line with targets
- To improve the management of medicines
- To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists

- To improve access to services across the Trust through a focus on increasing capacity (combined with emergency flow priority – see above)
- Specialty review and clinical strategy development

6.3. The Board is asked to approve the inclusion of an additional priority – to review our approach to inspection, accreditation and reviews.

Author: Shona Maxwell, chief of staff
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Date: 15 March 2019

Appendices as relevant (referenced in summary)

Appendix 1: Quality Account Improvement Priorities progress update

Appendix 1: Quality Account Improvement Priorities Progress Update

Improvement priority 1	**To reduce avoidable harm to patients**
Executive lead	Medical Director
Why this was included	Reducing avoidable harm is implicit in our strategic objective to achieve excellent outcomes for patients and is central to our operational objective to make care safer. Although our incident reporting rates and harm profile are good we take avoidable harm seriously and strive to continuously minimise it.
What we achieved	This year, we have seen a reduction in the number of incidents causing the most harm to patients, whilst maintaining high incident reporting rates. We had reported 8 severe/extreme harm incidents up to the end of January 2019, compared to 27 at the end of last year. We have also reported fewer avoidable deaths – 6 this year, compared to 17 last year and continue to have some of the lowest mortality rates in the country. Our HSMR is the lowest nationally over the last year of data. Some of the ways in which we have achieved this are: **Progress with the 'safety streams'** Work continued in our nine priority safety streams which address the key risks identified through a review of our most reported SIs – progress with each of these is outlined in more detail in the safe domain (see px). Key improvements include: • **Fetal monitoring**: The introduction of a central monitoring system with associated guidelines and education & training has been completed and 'fresh eyes' and audit rolled out. We have seen a reduction in the number of incidents where issues with fetal monitoring are a contributory factor – none have been reported since August 2018. • **Failure to rescue**: Launch of national NEWS2 planned through this safety stream; a pilot of using NEWS score in safety huddles to identify and act on deteriorating patients is underway. Other actions include the launch of a new deteriorating patient guideline, and the piloting of tools such as the deterioration patient action cards and escalation ladders. As a result of work undertaken by this stream, we have seen a significant reduction in out of ICU cardiac arrests.

	• **Hand Hygiene**: A Trust wide improvement plan commenced in September 2018 including a new approach to hand hygiene compliance auditing, an upgrade of hand gel dispensers, and a novel hand hygiene campaign. Wards chosen for focused improvement support from ICP and the Improvement Team have seen a significant improvement in hand hygiene compliance (29% in May 2018 compared to 61% in November 2018). • **Positive patient identification:** New policy launched and new audit tools in draft which will be piloted prior to Trust wide audit. An action plan is in place which has resulted in a 50% reduction in wrong blood in tube incidents. • **Reducing falls with harm:** Actions include five pilot wards participating in a 90 day improvement cycle (1-2-1 care of patients at risk, patient information in renal care, use of equipment, model for patients in a side room, early identification of patient at risk). Overall we have seen a reduction in the number of SIs related to falls with harm, although this requires further analysis owing to changes in the way these are reported. • **Endorsement of abnormal results**: New process for the endorsement of results in in-patient areas finalised; process endorsement of radiology results in outpatients is due to launch before the end of Q4 18/19. • **Medicines safety** – Phase 1 focused on improving compliance with medicines management best practice, with a specific focus on storage security and disposal (see improvement priority 6 for further detail). Phase 2 of this stream has now been scoped and will focus on improving the management of high risk medicines to reduce harm to patients. This work commenced in Q4 2018/19. • **Safer surgery** – development of simulation and coaching programme with successful tests in a number of areas across the divisions. The roll out of this to all invasive procedure areas has been expedited as part of the trustwide action plan in response to 6 invasive procedure never events, as well as a number of SIs related to the WHO checklist. • **Mental health delays** - We continue to have significant delays for mental health patients in the emergency departments; a safety stream was established in October following a diagnostic review to help tackle the root causes. **Learning from deaths** In September 2017 the Trust updated its existing mortality review policy and process to include the requirements of the national learning from deaths policy, and the Structured Judgement Review (SJR) process. We have a standardised approach to reporting and reviewing inpatient deaths. To date there have been six avoidable deaths in 2018/19, compared to 17 last year – the themes from these largely link to the safety streams. The SJR process identifies learning opportunities from each death these are shared across the Trust. Where relevant this is done via the Trust's nine safety-streams and all avoidable cases are discussed in divisional quality and safety meetings. **Implementation of our Sepsis policy and alert** Our Sepsis policy was launched in August 2018. Sepsis care in the Trust is now supported by an electronic screening protocol which fires a sepsis alert in the patient record to prompt clinical review and diagnosis. The alert does not override clinical judgement and the need for prompt review in a deteriorating patient. In order to support this process, a sepsis module in the Trust Electronic Patient Record (EPR) has been deployed across all acute

	inpatient settings in the Trust, as well as the two Emergency Departments. The module supports clinical staff in early recognition and management of sepsis, incorporating Trust Adult Treatment of Infection Guidelines and sepsis management principles. The Trust sepsis guidelines have been reviewed and updated via a multi-stakeholder engagement process, incorporating the EPR sepsis alert, and the National Early Warning Score 2 (NEWS2) methodology. Clear processes exist across the Trust for the management of suspected sepsis, identified either through the EPR trigger, NEWS2 or independent practitioner opinion. Work to improve the care of patients with suspected sepsis has continued via the use of quality improvement methodology, and most notably the Sepsis Big Room. The Sepsis Big Room is a weekly, hour-long coached meeting where staff and patients come together to discuss improvements in sepsis identification and management across the Trust. Progress against all measures in the sepsis 6 bundle is tracked utilising data on a weekly basis, and the views of staff members responsible for the care of patients on a daily basis. Since the Trust has implemented these changes we have seen a reduction in mortality for all patients coded with a diagnosis of sepsis.
Further work we need to do	We are undertaking a full evaluation of each of the safety streams which will inform the improvement plans of each going forward. The numbers of incidents in each safety stream will be reported in the draft quality account. We have work to do to strengthen how we learn from incidents and avoidable deaths. This is not always clear or able to be evidenced. A recent review of our learning from deaths process has identified opportunities to improve; these will be taken forward in 2019/20. This will continue to be an improvement priority.

Improvement priority 2	**To improve the safety culture across the Trust**
Executive lead	Medical director
Why this was included	Safety culture is embedded in our operational objective to make our care safer. We tested our culture during 2016 by inviting staff feedback through the safety attitudes questionnaire. A programme was then set up based on intelligence from research and experience from organisations at national and international level; incident themes; safety culture workshops; staff surveys and qualitative feedback including from work conducted in theatres. Culture is not something that changes quickly so it is important that we continue our focus on this programme. However for 2019/20 we will refocus this on improving the behaviours related to safety. This will fit better with the trust wide work on delivering our promise through our values and the implementation of a behaviours framework. We will focus on the behaviours we expect staff to display. These include being open and transparent when things go wrong, being encouraged to report, reflect and learn and being supported in a just and caring way.
What we achieved	We have maintained a high incident reporting rate with low levels of harm when compared nationally, which is a good indication of a positive reporting

	culture. In our staff survey we saw a further improvement in the percentage of staff feeling able to raise concerns (77% compared to 75% in 2016), with performance being maintained for staff being encouraged to report patient safety concerns (85%) and for staff feeling that the Trust encourages staff to report incidents (78%). As well as being a requirement under the duty of candour legislation, the Trust recognises the importance of being open with patients when things go wrong. We have continued to improve how we are enacting the duty of candour; current compliance is at over 90% for all incidents which is an improvement on last year. This continues to be a focus, with the aim of achieving 100% compliance. Using our live driver diagram to target improvement work, we have achieved the following: **Serious Incident improvement programme** This was launched in 2017 to improve the way we investigate, manage and learn from SIs. Key improvements as a result include: • Over 140 staff members trained as SI investigators and a new role of lead investigator agreed with divisions. A live data base detailing all trained investigators has been created and the divisions have identified senior clinicians who will be trained as Trust level investigators. This register will be an integral component of the new Trust wide incident investigation model, which will be implemented at the end of Q4. • A suite of new products to support staff to complete quality investigations, including new templates for the 72 hour report and the final SI report. The use of these documents has been evaluated throughout the Trust during 2018 and further changes will be made in the coming months. **Incident reporting improvement programme** In 2017 we launched this programme to plan, develop and oversee improvements to our reporting and management processes. Progress made this year includes the launch of 'Learning from excellence' (LfE). Traditional incident reporting focuses on identifying and learning when things go wrong; LfE aims to capture learning from when things go well, with the added benefit of improving staff engagement and motivation. The programme went live in five pilot areas in August (paediatrics at SMH, neonatology (QCCH and SMH), critical care at SMH and the acute admissions unit at CXH) and was rolled out across the Trust in the Autumn. We have targeted a number of interventions aimed at increasing and sustaining our incident reporting rates including Trust wide communications, focussed awareness and education with staffing groups that have been identified as low reporters (trainee doctors, therapists and pharmacists) and local engagement work within individual directorates. Through collaboration with software developers, healthcare staff and clinical academics and in partnership with the PSTRC, we have developed an app-based incident reporting system called CareReport. The aim is to assess whether CareReport increases the yield of incident reports and improves the usability and user experience of the reporting process. This will be assessed by conducting a 6 month prospective crossover trial amongst healthcare professionals in the Accident & Emergency Department at St Mary's Hospital. The pilot has been delayed, however this is now planned to occur in Q1 2019/20.

	The achievements of the first phase of the Incident Reporting Improvement Programme were published in a peer-reviewed journal 'Health Affairs' in November 2018. **Safety culture communications strategy** In response to staff feedback, the Trust developed a safety communications plan. This includes a number of safety communications templates, designed with staff, which have been in use for nine months now. The monthly briefing addresses safety issues that have arisen during the previous four weeks and also gives an update on the progress of the Trusts safety streams. It is presented on the Source along with a further document for staff to use locally to capture safety messages on 'Your Big 4'. The safety alert (including never event alerts) has been distributed on sixteen occasions since it was launched and for both the monthly safety briefing and the alerts, there is evidence that they are being used in practice
Further work we need to do	Metrics related to SI submission and action completion show that more work is required around improving the quality of our investigations. A 'stock take' of progress to date and next steps for the SI improvement programme has been undertaken. This involved interviews with key stakeholders and has put forward a number of recommendations on how we make the process more patient-centred, improve systems and processes and better support staff to embed learning when things go wrong that will be taken forward in Q1 2019/20. A general review of our SIs shows that we have issues with staff not always following Trust policies and processes and feedback from staff following our never events show we still have issues in relation to teamwork and behaviours. The roll out of our simulation and coaching programme will support improvements in these areas for staff involved in invasive procedures. We need to consider how this is taken forward in other areas. We will continue to develop and co-design communications with staff, including creating an Imperial safety campaign and video.

Improvement priority 3	**To improve permanent nurse staffing levels**
Executive lead	Director of P&OD
Why this was included	Feedback from the listening campaign has unanimously reported the importance of having the right number of staff to enable care to be provided, with a specific focus on nursing. Vacancy rates at the Trust are above target with variance across departments. Safe staffing is routinely maintained through the use of temporary staff and cover provided by senior nurses however it is accepted that substantive staffing should be maximised. One of the operational objectives is to make the Trust a great place to work with staff feeling supported, valued and fulfilled. Increasing our permanent workforce and retaining them will be key to this. We will maintain this as a priority for 2019/20 given the challenge we face. It is proposed that this is widened to include other staffing groups NB it is now a requirement to report staffing levels for non-consultant level doctors so as a minimum we should consider including them.

What we achieved	A strategy was approved in March 2018 to improve the supply of nurses, requiring significant investment. Our nursing and midwifery vacancy rate was at 16.1% against a target of 13% (December data). The projection is that we will hit the target by the end of March based on current activity and establishment. Staffing levels are consistently reported as met. Progress includes: • Refer a friend scheme launched in October covering hard to fill roles in a number of specialities across all divisions • Careers clinics were piloted successfully and ran until December 2018. • International recruitment is underway, with a pipeline of over 300 nurses who are all expected to have joined by the end of Q2 2019/20 • Recruitment and retention premiums are being offered across a number of hard to recruit areas and have resulted in an increase in applications and attendance at open days. • 8 nurse associate apprenticeships are now in place. • Additional Practice Educators have been recruited to support the student nurses and the nurse workforce.
Further work we need to do	Further work will continue with our recruitment and retention plan into 2019/20.

Improvement priority 4	**To ensure our staff are up to date with the mandatory skills to do their jobs**
Executive lead	Director of P&OD
Why this was included	Core skills and core clinical training rates have been below target despite many interventions. This has been identified as one of the priorities for the Trust as we have not managed to reach our target and this has been repeated cited by CQC as an area of concern at their inspections. This is central to our operational objective to making our care safer. It is proposed that this returns to business as usual monitoring through the integrated quality performance report with reporting to the executive P&OD committee.
What we achieved	Current compliance with core skills training has been consistently above our stretch target of 90% since November 2018. A Core Skills Governance Committee, comprising medical and nursing representation from the divisions, reviewed the Core Skills requirements 7 modules were identified as either duplication of other courses or not a Core Skill requirement and have therefore been taken off the mandatory list of Core Clinical topics. The denominators for the Core Skills were also reviewed and staff groups aligned with appropriate Core Skills training, reducing unnecessary mandatory training for staff groups where it is not required. Individual emails were sent to all non-compliant staff. A communications campaign and focused targeting has supported our achievement of this priority.
Further work we need to do	A new learning management system which will further support staff to undertake the training and provide more accurate data has been procured and is mid-implementation. Work is ongoing to cleanse data, upload historic records and convert e-learning content, and a soft go live is planned for late April.

	Areas of focus now remain Doctors in training, Honorary staff and areas of classroom training; (Resuscitation, Manual Handling, Safeguarding Children level 3).

Improvement priority 5	**To ensure our equipment has planned maintenance in line with targets**
Why this was included	The Trust recognises that the safe and appropriate use of medical devices is critical to the delivery of high quality patient care. Equipment maintenance oversight and management have been problematic in the past most recently in assuring it is completed within manufacturing recommendations. At the last CQC inspection this was raised as a safety issue and although work was underway our staff were not clear on actions to take when equipment was due for routine maintenance.
What we achieved	All our medical equipment has a planned maintenance programme at a frequency determined by the manufacturer's instructions or on a risk based strategy by Clinical Technical Services. Our targets for planned maintenance are monitored monthly through the IQPR and are being consistently met. An e-learning package has been developed to inform staff of essential safety aspects prior to using a medical device and went live in December. Work is being undertaken to produce reports to allow compliance to be monitored.
Further work we need to do	This is now business as usual so it is proposed that this is stepped down as a priority for 2019/20 and monitored through routine governance processes. Work will be on-going to ensure we continue to meet the targets and compliance with the e-learning module will start to be monitored in 2019/20.
Executive lead	Director of nursing

Improvement priority 6	**To improve the management of medicines**
Executive lead	Director of nursing / Divisional Director for WCCS
Why this was included	Management of medicines has been raised at each of our CQC inspections since 2014. In November 2017 the CQC reported that medicines were not consistently prescribed, given, recorded and stored well and outlined the following additional actions: • The Trust must ensure that control drugs cupboard key is kept securely and access is appropriately restricted. • The Trust must ensure that there are effective checking systems for airway trolleys and emergency medicines stored in the resuscitation bays. • The Trust must ensure that IV fluids are stored appropriately. The CQC report of 2018 identified similar concerns. A new approach is clearly needed to support improvement.
What we have achieved	Our approach to improving medicines management focused on us reviewing the processes under the four key governance principles: • Awareness – are our staff aware of what they should be doing and

	why? • Enablement – are our staff able to do what they should be doing with appropriate training, competencies and resources? • Accountability - are we doing what we say and proving it? • Continual Improvement – are we improving what we do? Using this approach in conjunction with staff focus groups and the Medicines Management Improvement Group has resulted in the following work to date: **Storage and Security** Considerable work has gone into assuring that medicines held at ward level are stored and secured appropriately. Whilst the trust is not aware of any incidents where actual harm has been caused due to inappropriate storage or security it receives significant focus from the CQC and is one of the eight key lines of enquiry. In some areas of the Trust storage is hampered by the age of the estate and the space/facilities available. We are working with estates where this is the case. The trust had an issue with excess unwanted stock remaining at ward level in some areas. The procedure for 'returns to pharmacy' has been revised Trust wide and improved tote boxes for all areas on the St Mary's site (the site where they were lacking). In addition the policy for the destruction of medicines at ward level has also been revised and re-issued. Pharmacy staff have been reminded on the importance of highlighting short dated lines to aid stock rotation using fluorescent green stickers indicating that the product has less than 6 months expiry A number of areas have flagged as having an ambient ward temperature greater than 25°C in their storage rooms. We are working with estates with regard to this however in addition we have undertaken a risk assessment on the storage of medicines at temperatures between 25°C and 30°C and this has been included in our risk register. A review of the fridge temperature monitoring policy has also taken place. A new algorithm has been drawn up (see Appendix 1) and also clearer paperwork for the daily monitoring. The pharmacy within the trust is currently trialling RFID monitoring in three of its fridges with a view to rolling out to the whole hospital in due course when capital investment is available. A standardised Controlled Drug (CD) Key fob has been designed and will be issued to every ward in addition we are also trialling a revision of the CD register to ensure that it is 'fit for purpose' for the management of patient's own CDs. An algorithim regarding the disposal of CDs at ward level has also been drawn up. **Roles and Responsibilities** In discussion with staff it rapidly became apparent that there was a degree of lack of clarity in the roles and responsibilities of staff members. All staff who handle, prescribe or administer medicines have a responsibility for their management. Pharmacy have worked with the key staff to draw up a 'Roles and Responsibilities' document so that there is less ambiguity.

	Medicines Management Training A change was made to Medicines Management training during 2017 from primarily face to face taught to an e-learning module that is assessed. The trust monitors the uptake of training every fortnight and is currently at 90.56% compliance in line with target. **Medicines Matter Standards and Audit** Standards and audit have been drawn up for the three key areas of: • Storage and security of medicines • Controlled drugs • Medicines Fridges There are 33 standards in total and each has an audit question associated with it so that the level of practice compliance can be tested. The trust is currently focusing on auditing these standards weekly. These audits are in addition to the two six monthly audits undertaken by pharmacy looking at Controlled Drugs and Safe Storage. A comprehensive Ward Accreditation Programme is in place. Medicines Management is covered within this. Any clinical area scoring a 'white' rating for the medicines management element of the Ward Accreditation Programme (WAP) has been invited to meet with the Chief Nurse, the Chief Pharmacist and their DDN to discuss their improvement plans and address practice gaps. **Medicines Matter Co-Design Activity and Products** A piece of work was commissioned early Summer 2018 to start to co-design our medicines management messages and products. A group of clinical staff from a range of professional groups, the Patient Safety Translational Research Centre and colleagues from a design company met to discuss what may make it easier for staff to do the right thing and to provide clear instruction on how do to this at the point of need. Further to this a number of products have been developed and launched at trust wide 'Medicines Matter' events including: • A 'Medicines Matter' look and feel • A standardised Controlled Drug key fob • An algorithm regarding the disposal of CDs on wards • A new fridge monitoring form and fridge temperature action lists • An algorithm regarding fridge checking actions • A list of roles and responsibilities of pharmacy, nursing, midwifery and operating department assistant staff Phase 2 of the medicines safety stream has been scoped and agreed and will focus on improving the management of high risk medicines to reduce harm to patients.
Further work we need to do	Medications audits and core service reviews continue to identify issues with storage, security, out of date medications and controlled drug registers not being completed properly. Trustwide improvement targets remain in development but should be published in the integrated quality performance report in 2019/20. It is proposed that this should move to business as usual monitoring through routine governance processes

Improvement priority 7	**To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists.**
Executive	Medical director

lead	
Why this was included	Monthly hand hygiene audits have been completed by front line nurses for the last 10 years. Results consistently show excellent performance however independent audits do not always give the same results. This and feedback from inspections has raised concerns about consistency of compliance. When research is considered compliance would be expected to be lower than that seen in our point prevalence results. Hand hygiene improvement is a safety stream and so this is proposed to be managed under that priority rather than sitting separately.
What have we achieved?	The Trust has historically performed monthly ward-led hand hygiene audits. A new approach to hand hygiene compliance auditing to improve the quality of audit data in order to guide improvement commenced in May 2018 during which all inpatient areas were audited. This new model involved a partnership between IPC and Divisional staff in collecting hand hygiene audit data for compliance with the WHO's 5 Moments For Hand Hygiene. The first round of auditing took place in May 2018. Overall compliance in these audits was 56% (1965 of 3532 observations). Published evidence suggests that hand hygiene in clinical areas is typically around 45%. The results of the May 2018 audits prompted a Trust-wide hand hygiene improvement programme, and the identification of a small number of 'focus wards', which received intensive support in developing local improvement plans. The inpatient areas along with some other high risk areas were re-audited in November 2018. Overall compliance was 61% (hand hygiene compliance was observed in 975 of 1586 observed opportunities) in the November 2018 audits. The focus wards, which received the most intensive support from the Improvement team and IPC in developing local improvement plans, were the most improved, with compliance increasing from 29% in the May audits to 67% in the November audits. All clinical areas in the Trust (including inpatient, outpatient and other areas) are being audited in February/March 2019. The hand hygiene improvements across the Trust are being supported by an upgrade of the hand hygiene dispensers, and a novel hand hygiene communications campaign, which is being piloted during February and March 2019.
Further work we need to do	Improvement plans are now in place for all wards and the impact of these needs to be monitored, as does the new communications and gel dispensers which are being rolled out in Feb/March 2019. The results of the Feb/March 2019 audit will be published in April 2019; it is expected that this will identify further wards for focused improvement support. In terms of the outcomes for HCAIs, we are above target for avoidable infections (11 against stretch target of 0) and above trajectory for E.Coli BSI and CPE BSI. Improvements in hand hygiene should lead to overall reductions in HCAIs, however there are a number of other factors which need to be considered including environment and anti-microbial reduction.

Improvement priority 8	**To continue to define, develop, implement and evaluate an organisational approach to reducing unwarranted variation**

Executive lead	Medical Director
Why was this included	Variation in care can be unacceptable as it may be harmful or inefficient. This is referred to as "unwarranted variation"; occurring by chance and being characterized by patients not consistently receiving high quality care. One of our approaches to reduce variation is the use of 'flow coaching' within a clinical pathway. Three pilot pathways (Sepsis, Diabetic Foot and Children's Asthma and Wheeze) were used to test the flow coaching approach in 2017/18 and in March 2018 we launched Flow Coaching Academy (FCA) Imperial to support a further nine pathways. The reduction of unwarranted variation across patient pathways is a key part of how we will improve sustainability and experience for our patients.
What have we achieved	**Organisational Approach** • A discussion paper outlining the key considerations for an organisational approach to reducing unwarranted variation will be drafted in Q4. • Oversight of GIRFT is being coordinated by PSO with clear lines to the MD although there is further work to do in embedding the processes and linked them together with other data and intelligence. • The recently appointed Director of Transformation is leading on phase 2 of the specialty review programme which will include the mapping of GIRFT recommendations to the actions identified through the Specialty Review Programme (SRP). • As part of a wider piece of Improvement Team evaluation work, due to conclude in Q4, the FCA programme team have been working with Finance team colleagues to develop a framework for assessing "value for money" benefits which will be employed prospectively for future cohorts of FCA and other improvement programmes & projects. **Capability Building** • The Improvement Team have developed a teaching module focussed on Reducing Unwarranted Variation as part of their 'Skills Shorts' series. Following testing with stakeholders this has now been launched with dates advertised throughout Q4. Consideration is being given to whether this should be targeted at key stay groups whose role are more likely to benefit, i.e. business managers & general managers. • All Improvement Team education & training offerings will be reviewed to ensure that the concept of reducing unwarranted variation is raised, where appropriate, and other resources are signposted. • Reducing Unwarranted Variation also forms a key part of the FCA Imperial curriculum (see below). **FCA Imperial** FCA Imperial has so far trained 24 flow coaches within the Trust, and established five staff as faculty who are able to deliver the programme training autonomously. It has generated ~£90k income for the Trust and influenced the establishment of other 'big rooms' including Digital; Strategy; Faster moves (part of Care Journey and Capacity Collaborative); Paediatric Flow Collaborative; and Frailty. Demonstrable achievements being shown by the pathways participating include: • ***FCA Cohort 1:*** ➢ *Sepsis* – Sustained reduction in mortality for all patients coded with a

	diagnosis of sepsis from 18% to 14 % from June 2017 onwards; Increased percentage of patients receiving antibiotics within an hour of screening across ED setting from 60% to an average of 67.2% since April 2018. ➢ *Diabetes* – Decreased length of stay for diabetes foot patients from 24 days to 18 days in 2018 ➢ *Paediatric Asthma and Wheeze* – Increased percentage of written management plans received by paediatric asthma and wheeze patients from 25% average to 60% from September 2018 onwards • ***FCA Cohort 2:*** ➢ *Lower Urinary Tract Symptoms* - Increased proportion of new LUTS patients either discharged or listed for surgery from 24% to 91%; reduced DNAs from 19% to 2% ➢ *Recovery* - Reduced number of patients staying overnight in Recovery per month from average of 70 to under 30 from August 2018 onwards; and reduced average total time in Recovery per patient from 8 hours to 3 hours from September onwards ➢ *Antenatal* - Reduced length of stay in maternity triage/day assessment units from average of 154 minutes to 110 minutes from November 2018 onwards ➢ *Vascular* - Reduced length of stay average by 2 days for all elective patients; Increased number of total discharges per week in Zachary Cope ward from a mean of 11 to 18 patients; Secured £100,000 funding to pilot a supportive discharge model ➢ *Acute Respiratory* - Trend indicating the percentage of NIV patients dying in hospital has decreased from 24 % to 17% from May 2018 onwards ➢ *Young People* - Established a new renal transition clinic at Hammersmith to provide focus care for paediatric patients transitioning to adult services.
Further work we need to do	Each of the current pathways big rooms will continue and become part of business as usual' to identify, test and implement changes to improve care. The Improvement Team will continue to provide support and direction as part of the overall programme management. This will include ensuring each pathway from the 2018/19 cohort reports their work via an agreed governance channel within their division, with clear measurement of impact against their specific aims. The 9 internal pathways which form part of cohort 3 will begin their teaching sessions in April 2019. As the programme and trustwide approach to unwarranted variation develops clearer outcome measures will be developed and reported on through the divisions to allow for improved monitoring of the impact of the programme. Co-ordinating and realising the benefits from the GIRFT programme needs to be further refined.

Improvement priority 9	**Emergency flow through the hospital**
Executive lead	Divisional Director, MIC
Why this was included	The 'improving patient flow programme' was launched in early 2017 to improve operational performance across the whole urgent care patient pathway at the Trust and to enable us to meet the trajectory for performance against the four hour A&E wait standard. Significant work was completed against the programme milestones and improvements have been realised in

	a number of areas, however we have not met our performance target. Achievement of the 4 hour wait standard is a national priority with new targets set for 2018/19 to meet 90% from September and 95 % in March 2019.
What we have achieved	We have been bucking a negative trend nationally for A&E four-hour access performance. The measure is important as it shows how well 'flow' through the whole of our care pathways is working and is a reflection of collaboration and co-ordination across services and teams. Even with a year-on-year increase of nearly 700 patients attending A&E this January, our four-hour-access performance was 1.6 percentage points better compared with last January. For type 1 patients – those who are the sickest – performance was 4.9 percentage points better. Across England, January was the worst month for A&E four-hour access on record, with a 0.9 percentage dip on last year. However, our performance remains below target and off trajectory at 86.7% and we are not currently on track to meet the trajectory for February 2019. A number of workstreams are in place to support improvements. Highlights include: • Ambulance handover action plan which sets out agreed protocols, escalation processes and action cards to ensure that reducing ambulance handover delays is embedded into everyday practice. Additional actions have been added in response to new national guidance. • 27 new beds opened, with work being undertaken to open a further 28. • Long stay review meetings in place on all sites, with a weekly roving review process being trialled at SMH. • 2019/20 outline work programme for the Care Journey and Capacity Collaborative has been agreed. • The A&E Operational Group, a sub-group of the A&E Delivery Board with representatives from all member organisations, has now met three times. The group has identified a number of areas of focus, including care homes and mental health. • Work to improve non-elective flow continues through the Improving 4 Hour Performance Working Group with the support of the Quality Improvement Team. • 'Keeping care flowing' intranet site now live, with all relevant policies and operating procedures and latest materials to support improved flow through our hospitals. • New majors area opened at CXH A&E. • Electronic live bed state in place. • Further roll out of best practice 'red to green', ward round and board round approaches. • Roll out of the SAFER care bundle.
Further work we need to do	We will focus on delivering the Care Journey and Capacity Collaborative 2019/20 work programme. This brings together actions identified from 2020 Delivery, the ECIST review, along with existing identified areas of work. The structure and main work stream areas are: access to unplanned care, flow move, safe and timely discharge and infrastructure and capacity management.

	The aim of the programme is: to meet the 4hr wait standard, our urgent and emergency care system supports staff to deliver safe, compassionate and high quality care to our patients in the right setting and at the right time.

Improvement priority 10	**To improve access to services across the Trust through a focus on increasing capacity**
Executive lead	Chief executive officer
Why was this included	Emergency and RTT performance has been challenged during 2017/18 with deterioration over the winter period. Although elective activity was reduced this was not sufficient to ensure patients were admitted in line with standards. Bed modelling has historically shown that demand does not meet capacity. To achieve these important access targets, additional capacity will be required as well as efficiency improvements.
What we have achieved	Emergency and RTT performance continue to be challenged, with both being below target and off trajectory in January 2019. Improvements are being made with a reduction in the number of patients waiting over 52 weeks (11 in January 2019) and we are meeting our target for cancelled operations. Bed capacity/demand modelling in 2018/19 identified a 100 bed shortfall. Since then we have invested in 50 additional beds whilst delivering another 35 through efficiencies in A&E and patient flow. We have established the Care Journey and Capacity Collaborative as the overarching vehicle for delivering improvement across the urgent and emergency pathway, driving successes including: • Delivery of pathway efficiencies equivalent to creating an additional 35 inpatient beds • Trust-wide implementation of R2G and SAFER leading to improvements in the number of pre-noon discharges and a significant increase in utilisation of the discharge units. Average discharge time has been brought forward by 1.25 hours. • Expansion of AEC (Ambulatory Emergency Care) services; both in relation to service provision and growth with 18,000 people seen in 17/18, and a further increase of 30% in 18/19, helping reduce growth in emergency admissions • Expansion of our frailty services – including OPAL (older persons assessment liaison service), frailty at the front door, the “red bag” project – avoiding admissions and reducing LoS • Active participation in the development of a NWL-wide DTOC escalation procedure • Frequent attenders programme – working alongside voluntary sector colleagues and the mental health trust to case manage high users of ED, reducing attendances for this group of patients
Further work we need to do	This work will continue into 2019/20; however it will be merged into improvement priority 9.

Improvement	**To improve access for patients waiting for elective surgery**

priority 11	
Executive lead	Divisional director of surgery, cardiovascular and cancer
Why was this included	Over a sustained period of time, the Trust has encountered a number of data quality & operational performance challenges to delivering a balanced position on elective care. Many of these challenges have been overcome through focused internal interventions and support from external agencies. Despite this the trust has not achieved the RTT standards since 2015 and we are struggling to meet improvement trajectories set for the 92% incompletes target and for the number of patients who are waiting over 52 weeks for treatment. This is an integral part of our operational objective to improve the way we run our hospitals and is a measure of whether the trust is responsive and well led. We know we need to improve our performance and are committed to continue to do so.
What have we achieved	RTT performance continues to be challenged, being below target and off trajectory in January 2019. Improvements are being made with a reduction in the number of patients waiting over 52 weeks (11 in January 2019). We are working to fully implement the Trust elective care operating framework (ECOF) which is the change programme redesigning the way we manage elective care. The overall aim of ECOF is that our patients have timely access to elective services. Progress includes: • **Systems** - Qubit Phase 2 – progressing with the testing of the new system functionality. • **Model Clinics** - Synergies with the Model clinics project are being mapped to ensure that the projects can be aligned in terms of improving the RTT end to end pathways utilising the systems available. • **Processes** - Elective Care (RTT) Performance Framework draft document was produced iteratively over November and December 2018. Soft launch occurred throughout Jan 2019. • **People** – Elective care training and education steering group established in Jan 2019. Core content for elective care classroom training is under development. • **MBI review**: action plan developed and approved in December 2019. 7 of the actions are complete, with the remaining 19 on track to be delivered through Q4. Three actions are delayed but are progressing.
Further work we need to do	Through ECOF, we will continue to work to ensure we meet our target set by the commissioners that at least 92% patients wait for no longer than 18 weeks for non-urgent consultant led treatments at Imperial College Healthcare Trust by March 2020.

Improvement priority 12	To improve compliance with equality and diversity standards
Executive lead	Director of P&OD
Why was this included	The equality and diversity system 2 is a tool to help NHS organisations improve the services they provide to local communities and provide better working environments, free from discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. Trusts are expected to self-assess their compliance against four objectives across 18 outcomes for each of the 9 protected characteristics. Although work has been undertaken in this area progress has not been overseen or co-ordinated in a systematic way.

	These standards are central to the operational objective to make the Trust a great place to work. This is also a key element of the CQC well led framework.
What have we achieved	The 2017-18 annual equality and diversity report and workforce race equality standard report (WRES) along with actions was submitted to executive committee and approved in September 2018. The Committee recommended a more structured and specific action plans where short- or medium-term progress are tracked against the long term equality and diversity goals. The E&D work programme with sets of actions covering the main protected characteristics groups was reviewed at ExPOD in January 2019. Key deliverables are outlined below. WRES key deliverables: • Improve workforce representation of BME people on Band 7+ • Mitigate disproportionate representation of BME people entering formal workforce procedures • Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR) • Address harassment and bullying issues reflected in the 2017-18 NHS staff survey Gender equality key deliverables: • Improve female workforce representation at Band 8A+ • Reduce the differentials of bonus pay gap (LCEAs) between female and male Workforce Disability Equality Standard (WDES) key deliverables: • Improve quality of disability data on ESR • Identify Trust priorities for disability equality work Key deliverables are not yet available to be reported on. Once available, the impact of the E&D work programme will be monitored though these and progress will be able to be demonstrated, with regular reporting to trust board.
Further work we need to do	Our action plan was approved in January 2019. Work for 2019/20 will focus on its implementation, with reporting through agreed governance structures to trust board.

Improvement priority 13	**Specialty review and clinical strategy development**
Executive lead	Medical director
Why was this included	The Trust specialty review programme (SRP) is our clinically led process to develop a five-year clinical strategy, which is built upwards from specialty level strategic plans. The outputs of the SRP will be used to inform the bottom-up development of a refreshed Clinical Strategy. The refreshed clinical strategy will set out how we propose to organise, deliver and develop our services over the next five years, providing excellent high quality care whilst responding to the significant challenges faced by the NHS. The clinical strategy will be a core product of the Trust's wider strategy and, in turn, will influence the development of other Trust-wide strategies. The clinical strategy will also sit within the wider strategic context of the North West London STP.

	A key feature of the SRP is that the reviews are 'owned' by each specialty, with a focus on MDT input, such that specialty teams recognise the resulting strategies and are able to engage with and buy into them. Specialty specific strategies ensure teams are clear on what they need to do to support the delivery of the Trust clinical strategy.
What have we achieved	All 37 specialties have now completed their clinical strategy & sustainability workshops and 5 of 37 specialties are still to complete their workforce workshops. The outputs of the workshops for each specialty are being used to produce draft specialty specific strategies and 17 of these have now been reviewed by the 3 SROs for the programme. An action plan is in place to progress the remaining specialties through the SRO review progress by the end of Q4. An initial draft of the Clinical Strategy has been produced and was shared with key stakeholders for comment in mid-November, informed by outputs from the SRP. Stakeholder engagement & consultation will now be undertaken, in conjunction with the engagement and consultation for related Trust-wide strategies including organisational strategy and quality strategy. The clinical strategy is expected to be published in Q1 2019/20. The outputs of the SRP were a key mechanism for of identifying high-volume, high variation pathways to participate in FCA Imperial cohort 3.
Further work we need to do	The clinical strategy will be published in early 2019/20. The Director for Transformation is now the SRO for the SRP and is taking forward the next stage where we translate the specialities' visions into tactical plans to implement during FY19/20 ('Realising the Vision'). These sessions are currently being scheduled for 11 of the specialties which have moved through the SRO process. As this is being taken forward as part of the development of the organisational strategy, we propose that this is stepped down as an improvement priority.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Freedom to Speak Up Strategy	☐ Approval ☒ Endorsement/Decision ☐ Discussion ☐ Information
Date of Meeting: 27th March 2019	**Item 18, report no. 15**
Responsible Executive Director: Kevin Croft, Director of P&OD	**Author:** Mia Hull, HR Manager for Wellbeing Barbara Britner, Associate Director of P&OD

Summary:
Following the recent FTSU self-assessment in September 2018, this paper sets out our Freedom to Speak Up (FTSU) strategy, developed to outline the Trust vision for speaking up and implement more robust arrangements.

The self-assessment identified that there is significant evidence that the Trust board robustly challenges themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. The role of the FTSU guardians has some areas of strength, particularly in relation to role modelling and support from the non-executive director.

However, the current model applied at the Trust does not enable the FTSU guardians to carry out the full range of the role, according to best practice. The self-assessment also identified the need for increased awareness across the organisation regarding the role of guardians and the support available to staff.

The Trust has therefore revised its FTSU strategy, including some changes in structure and resources to enable the delivery of the strategy.

The strategic aims of the strategy are to:

- Create a culture where all staff feel safe to raise concerns
- Enable our leaders to be responsive to concerns and act on these promptly
- Celebrate concerns raised and share the learning to improve patient safety

Core work streams are identified to progress and strengthen the work undertaken so far. These include:

- Refreshed structure and reporting arrangements for FTSU guardians, including additional resources to improve impact and effectiveness.
- Celebration of concerns raised and sharing of the learning to improve patient safety and staff experience.
- Development of a campaign to promote speaking up culture
- Introduction of a Senior Independent Adviser to help support the resolution of staff concerns about their own treatment.

Outcomes and measures of impact of the strategy include:

- Annual staff survey results
- Use and feedback of the FTSU Guardian service

- High level findings provided to the Trust board and policy annually reviewed and improved

Following discussions at the Executive (P&OD) Committee and Quality Committee the following recommendations have been agreed:

1. Transfer of responsibility for speaking up arrangements from People and Organisational Development to the Chief Executive's Office.
2. Adopt the recommendation to appoint a 0.5wte lead guardian and provide funding for backfill of the current FTSU guardians equivalent to 0.5wte of an 8a position
3. Introduce a Senior Independent Adviser

Recommendations:
The board is asked to endorse the decision of the Executive POD committee to:

1. Transfer of responsibility for speaking up arrangements from People and Organisational Development to the Chief Executive's Office.
2. Adopt the recommendation to appoint a 0.5wte lead guardian and provide funding for backfill of the current FTSU guardians equivalent to 0.5wte of an 8a position
3. Introduce a Senior Independent Adviser

This report has been discussed at:
A previous version of this report has been discussed at the Executive (P&OD) Committee and the Board Quality Committee.

Quality impact:
The speaking up agenda is pivotal to patient safety. The Trust will be assessed under the well-led domain for this work.

Financial impact:
The financial impact of this proposal will be kept under consideration and taken to the relevant committee for relevant approvals. The cost of the new structure has the potential to reduce costs associated with unresolved conflict and the use of formal procedures, where informal resolutions are possible.

Risk impact and Board Assurance Framework (BAF) reference:
Risks are yet to be identified but will be kept under review and paced on the risk register when identified.
A risk of maintaining the current approach is that FTSU guardians are not able to effectively promote a culture of speaking up across the Trust because of time spent helping individuals with concerns.

Workforce impact (including training and education implications):
Better speaking up arrangements will have a positive impact on the workforce to support staff in feeling safe and comfortable in raising concerns without fear of repercussions and with confidence that their concerns will be appropriately addressed. This is likely to have a positive impact on staff retention, engagement, wellbeing and attendance.

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

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

This strategy is of relevance to the equality and diversity agenda as it has been identified that staff from BAME backgrounds are more likely to experience barriers in raising concerns.

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

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

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

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

Key messages for senior management:
- The Board is committed to Freedom to Speak Up to promote and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work. The Board is committed to embedding an open and transparent culture; one in which staff members and volunteers feel empowered to raise concerns, with confidence that these concerns will be acted upon and without fear of detriment for speaking up.
- The revised strategy for Freedom to Speak Up will provide additional support and resource to the guardians to assist them in their roles and will increase the awareness of the service amongst all staff, as well as ensuring that statutory reporting requirements are met and appropriate action is taken as a result of referrals to the guardians.

Freedom to Speak Up Vision and Strategy: 2019-2021

1. Introduction

In February 2015, Sir Robert Francis QC published the report on his independent review into creating an open and honest reporting culture in the NHS. He highlighted the need for the creation of the National Guardian and Freedom to Speak Up Guardians at every Trust in England as a 'vital step towards developing the right culture and environment for speaking up'.

Since the review was published in February 2015, there has been extensive work nationally to further develop these principles and to ensure delivery of this programme across the NHS. The National Guardian's Office (NGO) was set up with an appointed National Freedom to Speak Up Guardian. In addition, workshops, training sessions and learning events have taken place across the country. Additional guidance issued by the NGO in May 2018 prescribes the requirement for all NHS organisations to develop a Freedom to Speak Up vision and strategy to strengthen and support delivery.

This strategy sets out our vision for speaking up and demonstrates our commitment to making it safe for our staff to raise concerns and always keeping the patient at the centre of everything we do. It has been revised as a result of a self-assessment against national guidance completed in September 2018. The findings of this self-assessment have identified areas of improvement that have been incorporated into this current strategy.

1.1 Our vision

Imperial College Healthcare NHS Trust is committed to embedding an open and transparent culture; one in which staff members and volunteers feel empowered to raise concerns, with confidence that these concerns will be acted upon and without fear of detriment for speaking up. This includes creating the appropriate structure and process that supports speaking up and ensuring that all staff members demonstrate the values and behaviours required to deliver this in practice.

1.2 Freedom to Speak up strategic aims

Freedom to Speak Up promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work.

In order to achieve this, positive leadership and a culture that places less emphasis on blame when things go wrong, and more importance on transparency and learning from mistakes is required.

We aim to work with our staff members, patients and volunteers to:

- Create a culture where all staff feel safe to raise concerns
- Enable our leaders to be responsive to concerns and act on these promptly
- Celebrate concerns raised and share the learning to improve patient safety and staff experience.

2. Current arrangements (2017-2018)

2.1 Current arrangements

The Trust arrangements so far has seen the introduction of five FTSU guardians across a variety of departments, with representation on each of the main sites.

The appointment of FTSU guardians was overseen by a Non-Executive Director, according to the principle that guardians should not be in management positions and should be working within operational parts of the organisation, so that they are embedded within the workforce, have the credibility of being front-line workers, and are from a diverse set of backgrounds which is likely to increase their accessibility to staff.

The guardians therefore come from a broad range of backgrounds in profession, personal characteristics, banding and location and so are representative of the workforce. The roles are on a volunteer basis in addition to the FTSU guardians' substantive posts at the Trust.

The guardians are:

- St Mary's: Andrew Hartle, Consultant Anaesthetist
- Hammersmith: Richard Allen, Assistant Practitioner - Imperial Clinical Research Facility
- Queen Charlotte's and Chelsea: Mitra Bakhtiari, Lead Midwife, Antenatal Clinic
- Charing Cross: Claudia Primus, Radiotherapy Review Radiographer
- Western Eye: Adam Heritage, Senior Ophthalmic Photographer

In addition, the Trust has a non-executive director lead for Freedom to Speak Up, who champions the delivery of this strategy.

The FTSU guardians can be contacted on a dedicated phone number or directly via email. Posters are displayed on screensavers with pictures of the FTSU guardians. Physical posters with these details have also been widely distributed around the Trust.

To date the FTSU guardians have been supported and managed by the employee relations team. A meeting takes place every other month facilitated by an HR manager. The guardians each have 1 hour per week protected time to carry out their duties. Appendix 1 details a process map of the current FTSU guardian remit
The employee relations advisory service maintain log of whistleblowing cases that have been raised within the organisation and actions taken as a result. A six monthly report outlining these cases is submitted to the audit, risk and governance committee.

2.2 Review of current arrangements

A completed self-assessment tool on the Trust's speaking up arrangements was conducted and submitted to the board in September 2018. The findings of this self-assessment have identified areas of improvement that have been incorporated into this current strategy.

The original concept of the FTSU Guardians was to provide an informal mechanism, outside of the line-management arrangements, for staff to raise concerns about patient safety. Given the findings in the recently published Gosport Report, this remains as important now as when the concept was introduced. Based on the current pattern of referrals to the guardians, the majority of referrals are concerned with workforce issues. However there is a clear link between culture, values and behaviours and patient care, so this is not to be discouraged.

The significant issues arising from the self-assessment included:

- Lack of time for the FTSU Guardians to perform their role
- Given the majority of the referrals to guardians are related to HR issues, is it right that the FTSU guardian service sits within P&OD?
- Lack of strategic direction and visibility.

3. Delivering improvement

The Trust is committed to progressing and strengthening the work undertaken so far to continue to build an open and transparent culture that supports staff to raise safety concerns. There is more work to be done to embed this further and these will be focused by our strategic aims.

The delivery of the strategy will be focused around two main phases:

- Phase 1 – strengthening the governance arrangements and support for the FTSU guardians to provide the additional capacity and infrastructure required to make the service a success.

- Phase 2 – implementation of a trust-wide awareness campaign, aligned to other Trust workstreams around vision, values and culture, to promote the importance of an open, transparent culture where staff can raise concerns and to promote the role of the guardians.

Phase 1 - Refreshed structure and reporting arrangements for FTSU guardians
The structure and reporting arrangements for FTSU guardians will be amended to provide additional time to the guardians to perform their roles.

Each of the five site-based FTSU guardians will have their protected time for FTSU activities increased to the equivalent of 0.5 day per week (or one PA), to enable them to support staff and raise the profile of speaking up at their sites.

In addition, the Trust will second an existing member of staff into a 0.5 wte Lead Guardian role. The Speaking Up Lead will supervise the FTSU guardians and ensure that they are receiving the right levels of support, giving the right advice and have an ability to escalate issues they do not feel equipped to resolve. They will support and co-ordinate the site-based guardians and liaise with the National Guardian's Office.

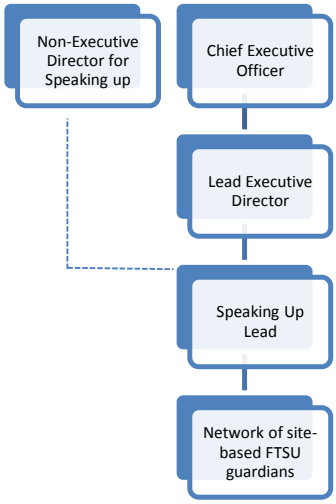
The Speaking Up Lead will also be focused on delivery of this strategy, including proactive outreach work to engage with staff via communication and speak up campaigns, running training on speaking up, attending induction, and involvement in relevant meetings such as partnership committee. They will work with the Non-executive director for speaking up and the lead Executive Director to develop a robust governance and assurance process including reporting mechanism to the Trust Board.

This additional capacity will enhance and support the role of the FTSU guardians and enable the delivery of the speaking up strategy.

We will establish some structure to support the guardians in their day to day work, including:

- A consistent and reliable contact mechanism
- a mechanism for initiating and closing a referral, including establishing a central register accessible by all guardians
- introducing a protocol and feedback mechanism from managers in response to concerns raised by guardians concerns raised to ensure follow up, with escalation if required

Proposed Structure



Responsibilities

Our Board and senior leadership team will support this agenda by:

- modelling the behaviours to promote a positive culture in the organisation;
- providing the resources required to deliver an effective Freedom to Speak Up function; and
- having oversight to ensure the policy and procedures are being effectively implemented.

Our Speaking Up Lead and FTSU guardians have a key role in:

- helping to raise the profile of raising concerns in our organisation
- providing confidential advice and support to staff in relation to concerns they have about patient safety
- providing confidential advice and support to staff in relation the way their concern has been handled.

Phase 2 – Raising awareness and developing the culture

Celebrating concerns raised and share the learning to improve patient safety

To help deliver a change in culture we know that staff members need to have confidence in raising concerns, know that they will be taken seriously, the concerns will be acted upon and they will not suffer detriment as a result of speaking up.

In order for us to do this we must share learning and feedback from the process that evidences this. We will:

- Actively share and celebrate improvements made as a result of speaking up
- Report nationally on our concerns raised and benchmark against other Trusts so that we can share learning
- Share results from the feedback received from those who have accessed the Freedom to Speak Up process
- Support all of those involved in raising concerns
- Measure our success using feedback mechanisms such as the NHS Staff Survey to assess any improvements in raising concerns
- Share good practice and learning from concerns raised, through a variety of forums, with the key aim of fostering openness and transparency, such as, newsletters, staff briefings, team meetings and the intranet; and actively seek the opinion of staff to assess that they are aware of and, are confident in using local processes and use this feedback to ensure

Developing a campaign to promote speaking up culture

To support the culture change all staff including leaders need to have an awareness of speaking up and recognise the importance of it. The Guardian and Advocates need to promote this in all interactions with staff and we hope for raising concerns to be part of 'business as usual'.

We will aim to deliver:

- Training for guardians
- Training and awareness for staff and management
- Appointment of champions at ward level

This will be supported by a communications plan, including inclusion of key messages in CEO's updates, articles on the intranet and inclusion of key messages in other staff communications on vision, values and culture. The key messages will include a clear Board commitment to support the role of FTSU guardians and the ability for staff to raise concerns without fear of reprisals.

Measures to support this workstream include:

- Speaking up lead to lead on proactive engagement with staff, through activities such as ward walks and lunch and learn sessions
- Develop a wide network of FTSU advocates across the Trust to promote the agenda
- Develop awareness training for all staff so they are clear about what concerns they can raise and how to raise them
- Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively
- Provide regular communications to all staff (including those permanently employed on a fulltime/part-time basis, temporary/ contracted workers and

volunteers) to raise the profile and understanding of our raising (whistleblowing) concerns arrangements

4. Additional Role of Senior Independent Adviser

It is proposed that a new role is also introduced to support resolving concerns that staff have about their own treatment. This will be a senior member of staff that the FTSU guardians can refer to in order to support the resolution or progression of concerns staff have about how they are being treated by their manager or regarding formal HR processes.

This individual will be senior member of staff who has influence and relationships across the most senior level of the Trust. They will be an experienced facilitator at a high level.

They will be independent as:

- They will not be involved in the matters raised.
- They will not form part of any formal management process.
- They do not benefit from any potential outcome of a formal process, one way or another.

They will act as an adviser by:

- Not being a decision-maker or part of the formal management line.
- Having knowledge of the formal and informal resolution mechanisms.
- Being accessible to the FTSU guardians, senior managers and P&OD teams.

5. Outcomes and Measures

It is important that the Trust monitors the delivery of this strategy and the impact that the support available to staff has on staff well being and quality of services provided to patients.

The NGO has worked in partnership with the CQC to support the development of the new inspection framework for the well-led domain. The CQC assesses a trust's speaking up culture during inspections under Key Line Of Enquiry (KLOE) as part of the well-led question which aims to assess that the leadership, management and governance of the organisation assures the delivery of high quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

In addition there are internal sources of assurance that the Board will use to measure success.

5.1 Annual staff survey results.

There are a number of staff questions in our internal Our Voice engagement survey about speaking up, most notably:

- Key Finding 30: the fairness and effectiveness of the procedures for reporting errors, near misses and incidents
- Key Finding 31: staff confidence and security in reporting unsafe clinical practice.

Year on year improvements in staff survey results would be indicative of the success of this strategy

5.2. Use and Feedback from FTSU Guardian service

This would include numbers of staff who have utilised the service through interaction with the FTSU Guardians or advocates, as well as feedback from these staff through an anonymous online survey.

5.3 Evidence that investigations are evidence-based and led by someone suitably independent in the organisation, producing a report which focuses on learning lessons and improving care, in a timely manner.

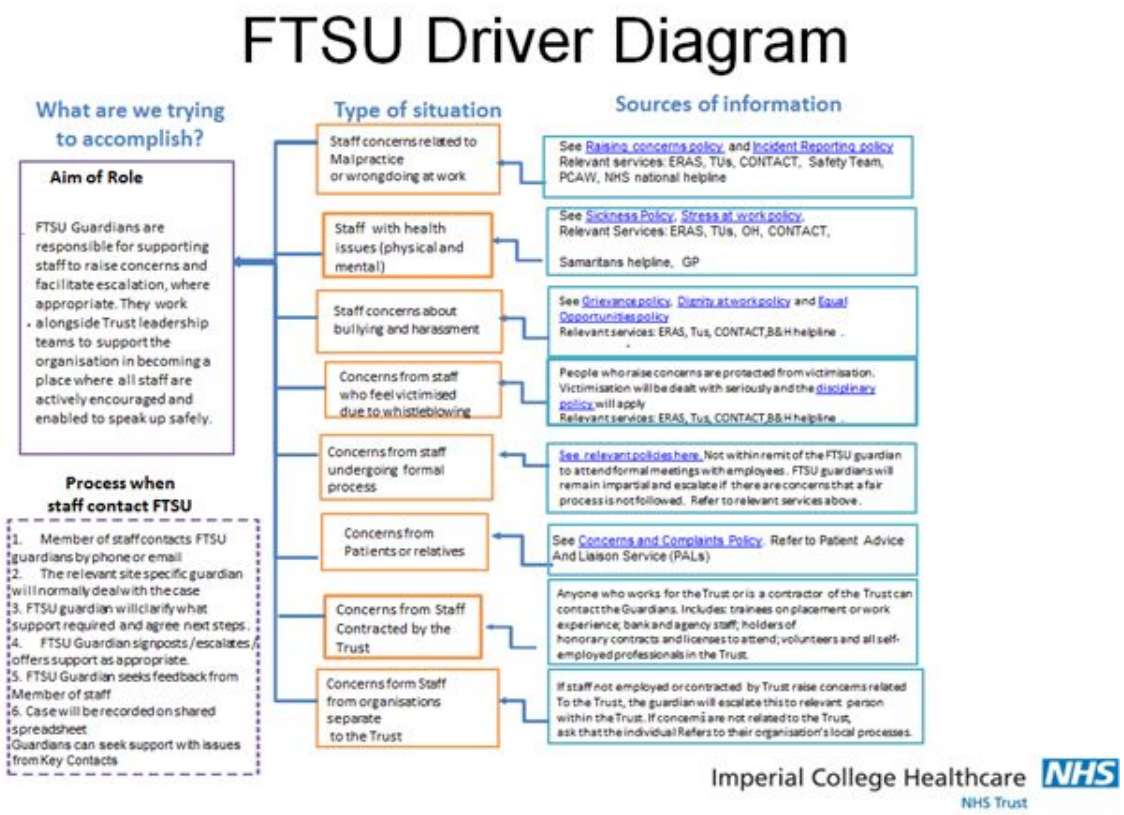
The implementation of a central investigations team with P&OD will ensure that people carrying out investigation into misconduct are suitably qualified and trained. They will also be independent of the department in which the allegations originate.

5.4 High level findings provided to the Trust board and policy annually reviewed and improved

A FTSU Annual Report will be presented to the Board each year by the Speaking Up Lead and the Executive Lead for Raising Concerns which will include:

- An assessment of the Trust's Raising Concern (Whistleblowing) Policy;
- An overview of the cases reported and the themes identified;
- Benchmarking
- An improvement plan for the next 12 months

Appendix 1: FTSU Driver Diagram



Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Updated Workforce Equality & Diversity Work Programme 2019	☒ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27th March 2019	**Item 19, report no. 16a**
Responsible Executive Director: Kevin Croft, Director of P&OD	**Author:** Barbara Britner, Associate Director of Employee Relations Daisy Tsai, HR Manager

Summary:

Following the Committee's recommendation for a more structured and specific equality and diversity action plans, the Workforce Equality & Diversity Work Programme 2019 was developed and presented to the Committee in January 2019. The Work Programme was also presented to the Equality and Diversity Steering Committee for feedback. The attached paper is an updated E&D work programme, which provides an overview of the E&D agenda in the Trust with sets of actions covering the main protected characteristics groups that the Trust needs to demonstrate its compliance for the legal and regulatory purposes, namely ethnicity equality, gender equality and disability equality.

For year 2019/20 the E&D Work Programme will be carried out with a particular focus on Workforce Race Equality Standard (WRES), with continuous work done on gender pay gap and initiation of and preparation for disability work. The Work Programme will be underpinned by a number of equality enablers that contribute to overall E&D work through increasing awareness and advancing relationships among all.

The attached paper outlines the structure and governance of the E&D work programme, Trust WRES progress, focus and its performance compared to the peer organisations, as well as individual workstreams with key deliverables:

WRES key deliverables

- Improve workforce representation of BME people on Band 7+
- Mitigate disproportionate representation of BME people entering formal workforce procedures
- Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR)
- Address harassment and bullying issues reflected in the 2017-18 NHS staff survey

Gender equality key deliverables

- Improve female workforce representation at Band 8A+
- Reduce the differentials of bonus pay gap (LCEAs) between female and male

Workforce Disability Equality Standard (WDES) key deliverables

- Improve quality of disability data on ESR
- Identify Trust priorities for disability equality work

Workforce Equality Enablers

This entails a group of key deliverables that contribute to general E&D work through promoting

and increasing awareness.

Following discussion at the executive POD committee further work will be undertaken with the quality improvement team to define more clearly the drivers and targets for improvement.

In addition, the national workforce race equality standard team recently published the model employer strategy. The strategy presents aspirational goals to achieve equity for BME representation by 2028. This includes setting bespoke aspirational targets for each NHS trust based on the data submitted in the WRES report. The aspirational targets for Imperial are included in the document at appendix 1. The executive POD committee has committed incorporating these additional targets into the E&D work programme.

Recommendations:
The Board is asked to:

1. Review and approve the updated E&D work programme and input any additional ideas or suggestions.
2. Support and participate in reverse mentoring and unconscious bias training listed under WRES.
3. Approve the inclusion of the bespoke aspirational targets set by the national WRES team.

This report has been discussed at:
☒ Equality and Diversity Steering Committee
☒ Executive People & OD Committee
☒ Quality Committee

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:
There is clear evidence to suggest that better workforce equality and diversity contributes positively to patient care and patient satisfaction. In addition, the work programme and actions outlined in this paper enable the Trust to provide evidence under the CQC domain for well-led.

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

1) Has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
There is a risk to the organisation if further progress is not made in the areas of promoting equality and diversity and eliminating experiences of harassment and bullying.

Workforce impact (including training and education implications):
The equality and diversity agenda has a significant impact on the workforce which makes the work programme essential to mitigating any negative 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

The work programme is to advance the E&D work in the Trust and address potential issues that impact on equality. The level of focus for each of the nine protected characteristics is determined by available data within the Trust.

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

☒ Yes ☐ No ☐ Not applicable

If yes, briefly outline.

Evidence shows that failing to address equality and diversity issues has a wider impact on the health economy and patients.

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

Trust strategic objectives supported by this paper:

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

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

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

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

- In line with the legal and regulatory requirements, the Trust is required to demonstrate its compliance in the E&D work.
- Attached is the paper with an overview of the overall E&D work programme in the Trust, outlining the structure and governance of the E&D work programme as well as the focus of individual workstream in 2019.

Workforce Equality and Diversity Work Programme

2019

Content

I. Introduction

The Trust's 2017-18 annual equality and diversity report and workforce race equality standard report (WRES) along with actions were submitted and approved by the trust board in September 2018. The board, however, requested more structured and specific action plans where short- and medium term progress is tracked against the long term equality and diversity goals. It was also recommended that we need to establish a smaller number of higher impact priorities. A workforce EDI programme has therefore been developed to address inequity identified across the largest groups of protected characteristics. That is, race equality, gender equality and disability equality. Some work will continue on other protected characteristics but, in 2019, this will be more limited and opportunistic rather than part of a structured programme.

Ethnicity has consistently been the most commonly reported reason for discrimination in the past five years according to NHS staff survey results held by NHS England. In addition, the annual E&D report published in September 2018 identifies that four out of the five areas of focus for priority improvement are related to ethnicity. Additionally, when we take out those staff where ethnicity is 'unknown' on our staff records 53% of our staff are from an ethnic minority background. For this reason, within the three areas outlined above (race, gender and disability) our primary focus in 2019 will be implementing the actions to meet the workforce race equality standard (WRES).

Outlined below is the structure and governance of the EDI work programme for 2019 and detailed actions for WRES, gender pay gap and the creation of a disability action plan to meet the requirements of the Workforce Disability Equality Standard (WDES). In summary:

Workforce Race Equality Standard (WRES)

- Improve workforce representation of BME people on Band 7+
- Mitigate disproportionate representation of BME people entering formal workforce procedures
- Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR)
- Address harassment and bullying issues reflected in the 2017-18 NHS staff survey

Gender equality

- Improve female workforce representation at Band 8A+
- Reduce the differentials of bonus pay gap (LCEAs) between female and male

Workforce Disability Equality Standard (WDES)

- Improve quality of disability data on ESR
- Identify Trust priorities for the workforce disability equality scheme (WDES)

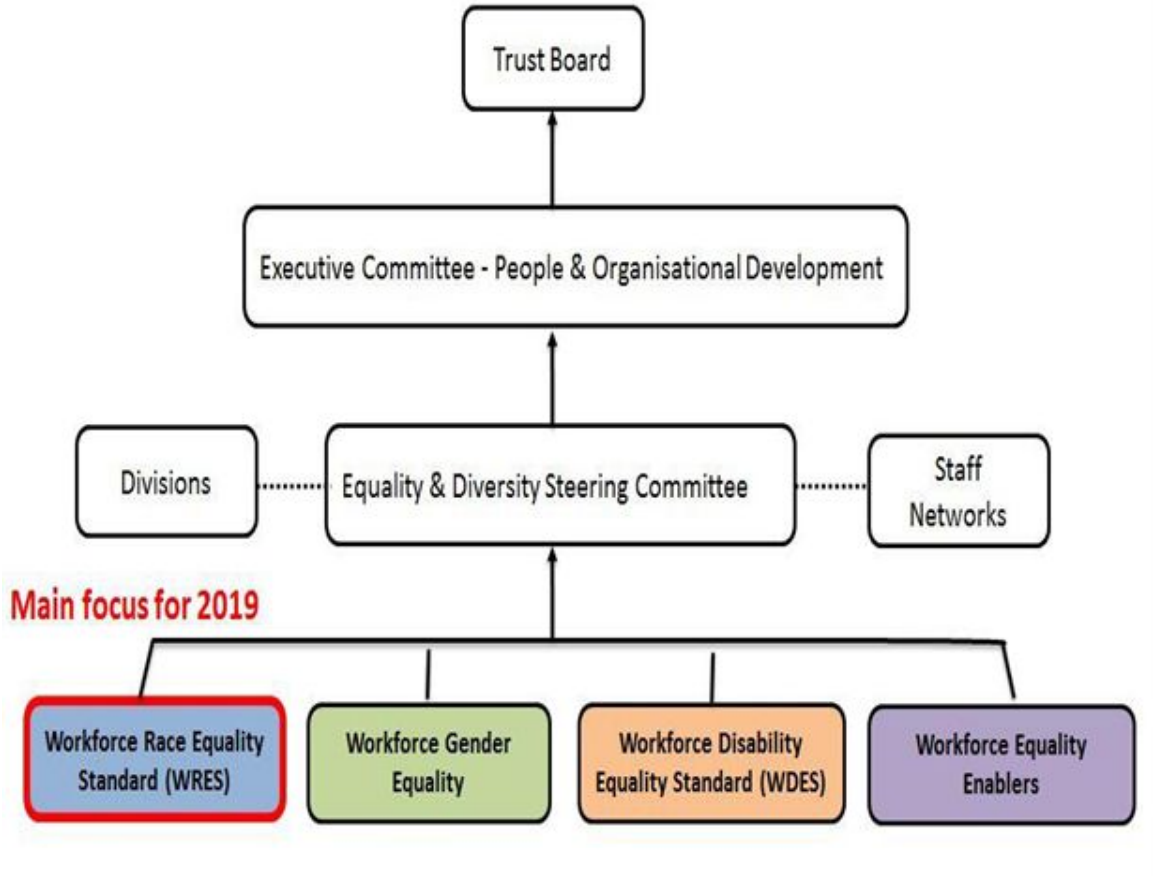
Workforce Equality Enablers

- Key deliverables that ensure compliance with legal and regulatory requirements and contribute to general E&D work through promoting and increasing awareness.

II. EDI programme structure and governance

As outlined in the governance structure below:

- The EDI work programme comprises 4 workstreams, covering the three main areas of focus for 2019 plus an enablers workstream
- This is overseen by the EDI steering committee that, going forward, will be chaired by the Trust CEO. The EDI Committee includes with representatives from divisions and staff networks and supervises the work carried out by the workstreams.
- The Ex-POD committee oversees the EDI steering committee on the overall work programme and is accountable for the Trust workforce EDI performance.
- The Trust Board receives reports on the EDI programme and other statutory reports as well as playing a pivotal role in shaping the strategy and vision for the long term EDI agenda.



III. Workforce Race Equality

a. Trust WRES performance and comparison with peer organisations

The Model Hospital tool has recently introduced a section on workforce race equality. Using the model hospital to benchmark us against nationally-designated peer organisations we can see our relative position on the WRES indicators. In summary, it shows that whilst the experience of staff is either better or at the peer median in many areas there is still a significant difference between the experience of white staff and those from an ethnic minority

Workforce Race Equality Standard Indicators	Data period	Trust value	Performance band description	Peer median	Benchmark value
2: Recruitment; relative likelihood of white staff to BME staff	**2018**	**1.57**	**Above the benchmark (red)**	**1.63**	**0.80 - 1.25**
3: Formal Disciplinary; relative likelihood of BME to white staff	2018	1.43	Above the benchmark (red)	2.13	0.80 - 1.25
4: Non-Mandatory Training and CPD; relative likelihood of white staff to BME	2018	0.89	Between the lower and upper benchmark (green)	1.01	0.80 - 1.25
9: Board Diversity; BME representation on board compared to all staff	2018	-40%	Below the benchmark (red)	-33%	-10% - 10%

Workforce Race Equality Standard Indicator 2: Recruitment	Data period	Trust value	Performance band description	Peer median	National median
Shortlisting to recruitment rate; white staff	2018	20.4%	In quartile 2 - Mid-Low 25% (blue)	23.2%	20.9%
Shortlisting to recruitment rate; BME staff	2018	13.0%	In quartile 2 - Mid-Low 25% (blue)	14.5%	13.1%

Workforce Race Equality Standard Indicator 3: Formal Disciplinary	Data period	Trust value	Performance band description	Peer median	National median
Formal disciplinary rate; white staff	2018	0.7%	In quartile 2 - Mid-Low 25% (blue)	0.7%	0.9%
Formal disciplinary rate; BME staff	2018	0.9%	In quartile 2 - Mid-Low 25% (blue)	1.0%	1.2%

Workforce Race Equality Standard Indicator 4: Non-Mandatory Training and CPD	Data period	Trust value	Performance band description	Peer median	National median
CPD and training rate; white staff	2018	10.3%	In quartile 1 - Lowest 25% (blue)	16.2%	46.2%
CPD and training rate; BME staff	2018	11.6%	In quartile 1 - Lowest 25% (blue)	17.9%	48.8%

Workforce Race Equality Standard Indicator 7: Belief in Equal Opportunities	Data period	Trust value	Performance band description	Peer median	National median
Perceived fairness in progression; white staff	2017	88.3%	In quartile 3 - Mid-High 25% (blue)	84.2%	87.6%
Perceived fairness in progression; BME staff	2017	82.7%	In quartile 4 - Highest 25% (blue)	68.6%	75.0%

Workforce Race Equality Standard Indicator 8: Discrimination by Colleagues	Data period	Trust value	Performance band description	Peer median	National median
Experience of discrimination; white staff	2017	5.2%	In quartile 1 - Lowest 25% (blue)	8.1%	6.3%
Experience of discrimination; BME staff	2017	17.4%	In quartile 4 - Highest 25% (blue)	17.6%	14.0%

Workforce Race Equality Standard Indicator 9: Board Diversity	Data period	Trust value	Performance band description	Peer median	National median
Percentage of staff who are BME	2018	48.3%	In quartile 4 - Highest 25% (blue)	43.8%	13.7%
Percentage of board who are BME	2018	8.3%	In quartile 3 - Mid-High 25% (blue)	10.8%	6.7%

Trust WRES progress and focus 2019

When compared the Trust WRES performance in 2015/16 (published 2017) and 2016/17 (published 2018), improvement has been observed in some areas and a decision has therefore been made to keep up the momentum and continue focusing on the targeted areas for improvement from the year before.

Areas with improvement from the previous year:

- The relative likelihood of BME staff entering the formal disciplinary procedure, compared to white people was 1.439 times greater. This is an improvement from 2015-2017 when it was 2.125.
- The percentage of BME or White staff experiencing harassment, bullying or abuse from staff in last 12 months has both dropped from 32% to 28%.
- The percentage of staff believing that the trust provides equal opportunities for career progression or promotion has increased for both groups, BME from 74% to 83%, White from 87% to 88%
- In the last 12 months staff reporting personally experienced discrimination at work from manager/team leader or other colleagues has dropped by 2% for both BME and White staff to 17% and 5% respectively

2019 objectives

- Improve workforce representation of BME staff on Band 7 and above
- Mitigate disproportionate representation of BME people entering formal workforce procedures
- Reduce the differential in the relative likelihood of BME staff receiving a D or E Personal Development Review (PDR) rating
- Address harassment and bullying issues reflected in the 2017-18 NHS staff survey

Actions to support improvement and performance

- **Recruitment**

  From the data above it can be seen we need to address the end-to-end recruitment cycle from attraction to appointment. The priority actions for 2019 are:

  Application to shortlisting stage:
  - widen the reach of job adverts to improve the diversity of applicants
  - adopt inclusive language on job adverts to attract people of diverse backgrounds
  - review criteria included in person specifications to ensure they are not unnecessarily restricting the chances of candidates with non-traditional or culturally diverse backgrounds and career paths

  Shortlisting to appointing stage:
  - introduce ethnically-mixed interview panels for Band 7 and above roles
  - expand and encourage take-up on recruitment and selection training to all staff with managerial responsibilities

- **Leadership and development**

  To develop cultural awareness amongst managers and leaders we will implement to areas of development used more extensively in other Trusts.

  Introduce reverse mentoring:
  - A reverse mentoring programme is being developed and will be introduced in 2019/20, starting with the executive directors at the trust, with an aim to promote and advance relationships between staff from different ethnicity and cultural backgrounds.

  Implement unconscious bias training:
  - Unconscious bias training will be implemented in 2019/20 in support of leadership development on equality and diversity.

- **Staff networks**
  In 2018, two staff networks were formed: women's network and nursing and midwifery Black, Asian and Minority Ethnic (BAME) network. The Trust is now planning to establish a trust-wide network for ethnic minority staff and expects the networks to play a pivotal role in shaping and growing the Trust EDI work in the future.

- **Employee relations – disciplinary process**
  In 2018, the Trust introduced pre- and post-investigation checks, before the formal disciplinary procedure is commenced to ensure consistency and fairness in the process. Additional training has also been provided to the Chairs and investigators to prepare them for the process. In 2019 we will be reviewing the disciplinary policy and considering how we review the outcomes and fairness of formal disciplinary sanctions on staff from an ethnic minority background. We will also be taking account of the recommendations from the NHS Improvement's National Advisory group that was set up following the publication of the Verita report.

An overview of the plan with associated milestones is shown in figure 1.

Figure 1 - Workforce Race Equality Standard Actions Summary

Objectives	Baseline performance 17-18	Key focus 2019/20
A more representative workforce by ethnicity at all levels and eliminate ethnicity differentials in workforce performance outcome	• Workforce ethnicity: 47% BME, 43% White, 10% Unknown • BME under-represented at Band 7+ • BME staff 1.44 times more likely to enter formal disciplinary procedures	• Increase diversity on interview panels • Introduce reverse mentoring • Introduce unconscious bias training

Key deliverables	Lead	Milestones
Improve workforce representation of BME people on Band 7+		
1. Introduce diverse panels at B7+ interviews, gender and ethnicity mix (ideally mixed panels, only use observers if not possible)	Dawn Sullivan	Increase BME representation at Band 7+ by 5% within each band by Mar 2020
2. Introduce reverse mentoring	Sue Grange	
3. Implement unconscious bias training for all levels, from the Board/Executives	Sue Grange	
Mitigate disproportionate representation of BME people entering formal disciplinary workforce procedures		
1. Introduce two check points, pre- and post-investigation, to be carried out by senior managers in formal disciplinary process	Barbara Britner	Reduce BME participation rate by 10% at formal disciplinary procedures by Mar 2020
2. Introduce mandatory training specifically for Chairs of disciplinary hearings and Investigators	Barbara Britner	
3. Identify common issues in formal procedures and develop training and support for prevention	Barbara Britner	
4. Executives/seniors to review dismissal decisions	Barbara Britner	
Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR)		
1. Provide monthly reports of PDR grades to divisional senior management team throughout PDR period for calibration	Sue Grange	Quarter 1
Address harassment and bullying issues reflected in the 2017-18 NHS staff survey		
1. Re-energise Trust values and behaviours through 'Leading our vision, values and behaviours programme	Sue Grange	Decrease the overall staff-reported B&H experiences by 2% in 2019 NHS staff survey results – reported Feb 2020
2. Develop a 'speaking up' strategy and action plan	Barbara Britner	
3. Staff survey action plans	Sue Grange	

IV. Other EDI Workstreams

a. Workforce Gender Equality

Objectives	Baseline performance 16-17	Key focus 2019/20
A flexible work environment that enables career development and progression at different life stages	• Workforce: ♀ 71% vs. ♂ 29% • Band 8A+: ♀ 54% vs. ♂ 46% • Mean hourly rate: ♂18.7% higher than ♀ • Median hourly rate: ♂13.3% higher than ♀ • Mean bonus pay: ♂ 26.6% higher than ♀ • Median bonus pay: ♂ 40% higher than ♀	• Flexible working • LECAs process review

Key deliverables	Lead	Milestones
Improve female workforce representation at Band 8A+		
1. Refresh guide for and promote flexible working	Barbara Britner	Quarter 2
2. Career clinics	Dawn Sullivan	On-going
3. Provide coaching/mentoring opportunities	Sue Grange	Quarter 3
4. Commit to advertise post with part time/job share options	Dawn Sullivan	Quarter 2
5. Speed mentoring with themes	Sue Grange	Quarter 2
Reduce the differentials of bonus pay gap (LCEAs) between female and male		
1. Identify factors in LCEA process that contribute to the bonus pay differences and develop a process guide to address the issues	Medical Director's office	Quarter 1

b. Workforce Disability Equality Standard (WDES)

Objectives	Baseline performance 17-18	Key focus 2019/20
A flexible work environment where disabled staff are treated equitably	• Disability data on ESR – c.70%	• Improve quality of disability data on ESR • Produce and publish 1st WDES report

Key deliverables	Lead	Milestones
Improve quality of disability data on ESR		
1. Thorough data collection and input for new joiners, both medical and non-medical	Dawn Sullivan	Quarter 3
2. Promote data input via employee self service	Dawn Sullivan	Quarter 2
Identify Trust priorities for disability equality work		

1. Review staff survey outcomes, national & local, by disability group to identify areas for improvement	Sue Grange	Quarter 1
2. Divisional representatives to identify priorities for their divisions and suggest recommendations	Divisional E&D reps	Quarter 2
3. Produce and publish 1st WDES report in Aug 2019 and identify key issues for action plan	Barbara Britner	August 2019

c. Workforce Equality Enablers

Objectives	Baseline performance 17-18	Key focus 2019/20
Increase awareness of and promote E&D	• Staff feedback suggested limited understanding of E&D agenda and work carried out in the Trust • Interests in staff support networks • Need a system to track and acknowledge small progress on E&D improvement trajectory	• EDS2 baseline assessment • Measures to track short-/medium-term progress

Key deliverables	Lead	Milestones
Promote and increase awareness of E&D agenda		
1. Set up new Ethnic Minority Staff Network	Joselyn King	Quarter 1
2. Develop E&D intranet section	Barbara Britner	Quarter 1
3. Produce a set of measures, annual targets and a reporting mechanism to track short and medium-term progress against longer-term equality objectives	Barbara Britner	Quarter 2
4. EDS2 baseline assessment	Barbara Britner	Quarter 2
5. Establish an informal route for protected discussion on concerns	Kevin Croft	Quarter 1
6. Introduce Equality Impact Assessments for policy reviews	Peter Jenkinson	Quarter 1
. E&D leadership, including E&D representation at Board	Kevin Croft	Quarter 3

V. References – Trust E&D Reports

The above work plan, with various foci under each work stream is developed based on the Trust assessment of its E&D performance in the following E&D reports. For details of the performance review, please go to the website: https://www.imperial.nhs.uk/about-us/who-we-are/publications

a. Annual Workforce Equality and Diversity Reports

b. Workforce Race Equality Reports

c. Gender Pay Gap report

NHS Improvement

NHS England

Draft

A Model Employer:

Increasing black and minority ethnic representation at senior levels across Imperial College Healthcare NHS Trust

Implementing the NHS Workforce Race Equality Standard (WRES) leadership strategy

Background

There exists a huge reservoir of talent which is not being tapped into by the barriers that are often placed in the way of staff development and opportunities. Greater diversity and inclusion improves opportunities to tap into that diverse talent pool. The NHS is at its best when it reflects the diversity of the country and where the leadership of organisations reflects its workforce.

Research shows that organisations that have diverse leadership are more successful and innovative than those that do not. Employees who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. Such organisations are better placed to reduce health inequalities of our diverse communities and leads to better patient care, satisfaction and outcomes.

This document sets out the ambitious challenge of ensuring black and minority ethnic (BME) representation at all levels of the workforce. This includes leadership being representative of the overall BME workforce by 2028. The document outlines both the aspirational goals for your organisations as well as a comprehensive and holistic set of objectives to support the NHS, as part of the existing Workforce Race Equality Standard (WRES) programme of work.

This content of this document presents an example of a commitment to meet the aspirations on improving BME representation across the workforce and at leadership positions in the NHS, as set-out in the in both the NHS Long Term Plan[1] and within the WRES 'Model Employer' leadership representation strategy[2].

NHS trusts are encouraged to work with the national WRES Implementation team to agree and finalise the detail of the aspirational goals and action plans.

1. The need for accelerated improvement

Since its introduction in 2015, NHS England's WRES programme has been providing direction and tailored support to the NHS, enabling organisations to continuously improve their performance in this area.

The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity, and to develop and implement robust action planning for improvement.

WRES data for the last three years shows year-on-year improvement for BME staff on a range of indicators. Increasing the representation of BME staff at senior and leadership levels across the NHS is an area that requires further accelerated support.

The overall BME workforce in the NHS is increasing, however this is not reflected at senior positions where there is an acute under-representation of BME staff. Aspirational goals to increase BME representation at leadership levels, and across the pipeline, will reinforce the existing WRES programme of work.

[1] https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
[2] https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

2. Current workforce

Table 1. Imperial College Healthcare NHS Trust workforce by ethnicity: March 2018

	Total headcount	Overall %	% known ethnicity
BME workforce	5457	48.3%	52.7%
White workforce	4889	43.3%	47.3%
Unknown workforce	943	8.4%	
Total	11289		

The table above shows organisation staff breakdown by ethnicity for Imperial College Healthcare NHS Trust. The staff are split into three broad ethnic categories: 'BME' (Black and Minority Ethnic), 'white' and 'unknown'. The ethnic categorisation follows the national reporting requirements of Ethnic Category as outlined in the NHS Data Model and Dictionary, and as used in NHS Digital data.

Table 2. Goal setting for bands 8a-VSM BME recruitment for Imperial College Healthcare NHS Trust

	Proportion of BME workforce (n)	Additional BME recruitment over the next 10 years to reach equity[1]	Total BME staff in AfC band by 2028 to reach equity[1]
Band 8a	34.3% (153)	**82**	235
Band 8b	22.4% (52)	**70**	122
Band 8c	19.1% (18)	**32**	50
Band 8d	18.2% (10)	**19**	29
Band 9	13.8% (4)	**11**	15
VSM	8.3% (2)	**11**	13

[1] Reaching the value in column "Proportion of BME workforce" (note: by 2028 this may have changed)

The table above shows the additional recruitment of BME staff required, in AfC bands 8a to VSM, to achieve equity of representation at Imperial College Healthcare NHS Trust by 2028.

3. Key points of consideration

- The data source for the above modelling is the trust workforce data 2018 WRES submission.

- Modelling assumptions:
  - Assumes no change in the number of staff in the organisation over the next ten years.
  - Assumes constant number of employees and leavers per year based on data between March 2017 and March 2018.
  - The model considers the number of BME recruits to replace leavers and increase representation up to equality by 2028.
  - BME proportions are recorded as a total of known ethnicities.

- The above model presents the aspirational goals relating to managerial staff. The trust will need to replicate this approach for its clinical workforce.

- Staff and staff-side within the trust, and other key stakeholders, should be engaged in a meaningful way regarding the strategic direction of travel.

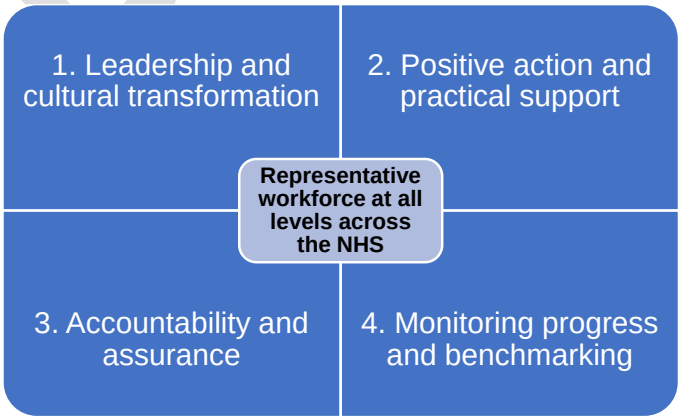
- Commitment and accountability regarding the aspirational goals and supporting plans should lay with the trust board.

4. Supporting delivery of the ambition

The WRES team will support the wider system to focus on driving improvements in BME representation at senior levels across the NHS – building a sustainable talent pipeline for the future. A clear focus will be upon both growing and supporting existing BME talent from within the NHS, as well as attracting talent from outside of the NHS.

To help meet the aspirations set-out above, dedicated support to individual organisations, and parts of the NHS, will be provide by the WRES Implementation team. This support is presented under four broad headings, as outlined below.

Figure: WRES model of support for improving BME representation across the NHS workforce



4.1 Leadership and cultural transformation

- Demonstrate commitment to becoming an inclusive and representative employer - role modelling on race equality – **work will be carried out to transform deep-rooted cultures of workforce inequality via organisational leadership strategies** – a focus here will be upon NHS Improvement's Culture and Leadership Programme; engage supporters and including stakeholders in the planning process and in helping to share messaging, rationale and process.

- Require VSMs and board members to mentor/reverse mentor and sponsor at least one talented ethnic minority staff at AfC band 8d or below – coaching skills and structured support will be made available to senior staff to carry this out. **Mentoring, reverse mentoring and sponsoring will be part of the senior leader's performance objectives** that will be monitored and appraised against.

- Recruitment drive on BME non-executive directors (NEDs) – as a starting point, **a drive to appoint BME NEDs will be encouraged**. Existing NEDs will be encouraged to play an active role in mentoring and sponsoring BME staff that have the potential to get to an executive role within three years.

4.2 Positive action and practical support

- Talent management – to meet set aspiration, concrete measures to remove barriers to our most talented ethnic minority staff succeeding, will be put in place. To enable this to happen, there needs to be a consistent narrative within organisations, based on a **fit-for-purpose national approach to effective talent management across the NHS**.

- Diverse shortlisting and interviewing panels – **recruiting managers will be held accountable for institutionalising diverse shortlisting and interview panels**. There would seldom, if ever, be acceptable exceptions for not having a BME member on shortlisting and interview panels; this is firmly within the organisation's control. Where BME interviewees are not appointed, justification should be sent to the organisation's chair setting out, clearly, the process followed and the reasons for not appointing the BME candidate.

- Batch interviews should be considered where appropriate – panel interviews of single applicants may not always provide the optimum assessment of a candidate's skills and capabilities, and can contribute towards creating conditions for bias. **Organisations will be encouraged to examine the merits of interviewing a batch of candidates** for a number of different roles/positions.

- Technical WRES expertise at regional levels – the WRES Experts Programme aims to develop cohorts of race equality experts from across the NHS to support the implementation of the WRES within their organisation. Participants become part of **a network of professionals across the NHS that advocate, oversee and champion the implementation of the WRES** at regional and local level. The work on meeting leadership aspirations at local level will be built into the existing WRES Experts Programme.

- Promote success and share replicable good practice – **identification and dissemination of models of good practice, evidence based interventions** and processes from across the NHS – from the wider public, private, voluntary and charitable sectors – will help support NHS organisations to achieve the required outcomes.

4.3 Accountability and assurance

- Build assurance and accountability for progress – NHS organisations across the country will be supported to **develop workforce race equality strategies and robust action plans that are reflective of their WRES data**. These action plans provide an ideal vehicle to continuously improve on the issues that, the data show, are of key concern for the organisation. Progress against the aspirations will form part of an organisation's action planning for the WRES. This work will be included in the Single Oversight Framework; Care Quality Commission (CQC) inspection; and the CCG Assurance and Improvement Framework.

- Senior leaders and board members will have performance objectives on workforce race equality built into their appraisal process – senior leaders should be held accountable for the level of progress on this agenda. Working with national healthcare bodies, **progress on workforce race equality will be embedded within performance reviews of chairs and chief executives** – including emphasis on WRES implementation and on progress in meeting the set goals for their respective organisation.

- Building the capability and capacity of BME staff networks across the NHS – to play a key part of the accountability and transparency approach will play a key role. There will be a concerted effort towards **supporting leaders of BME staff networks and trade union representatives, across the NHS to raise the visibility of their work**, and to provide a source of meaningful and sustained engagement with the WRES programme of work.

4.4 Monitoring progress and benchmarking

- Benchmarking progress – **benchmarking and progress will be established and published as part of NHS Improvement's Model Hospital hub and WRES annual data reporting**, through which the monitoring of progress against set aspirations over time will be undertaken, and good practice shared.

- Periodic update – due to the changing nature of BME workforce composition across the NHS, the right approach will be to **periodically update the assessment of the overall progress that has been made on meeting the aspirations** – starting at the end of 2020, and local organisations will be supported via the national WRES team to do the same.

- Oversight – the lack of BME leadership is a system-wide issue that requires a system-wide response. CEOs within a regional healthcare footprint are encouraged to come together on this agenda regularly. **Collaborative working between healthcare organisations at local level, and with key partners, will be essential.** This will require all relevant organisations to focus resource on workforce race equality in a more intentional manner.

5. Further information

Further information and support will be available from the NHS England WRES Implementation team.

Email: england.wres@nhs.net

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Gender pay gap report 2018/19	☒ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27th March 2019	**Item 19.2, report no. 16b**
Responsible Executive Director: Kevin Croft, Director of P&OD	**Author:** Barbara Britner, Associate Director of employee relations Mia Hull, HR Manager

Background

An organisation's gender pay gap refers to the difference between the average earnings of men and women, expressed relative to men's earnings. This is a broad measure of the difference in the average earnings of men and women, regardless of the nature of their work.

This report is published in line with gender pay gap reporting requirements for organisations with more than 250 staff. All calculations relate to the pay period in which the snapshot day falls, which is **31 March 2018**. This is the second gender pay gap report the Trust will publish, the first can be found here.

The below are the 6 mandatory calculations that the report details:

1. Proportion of males and females in each pay quartile
2. Mean gender pay gap for ordinary pay
3. Median gender pay gap for ordinary pay
4. Proportion of males and females receiving a bonus payment
5. Mean gender pay gap for bonus pay
6. Median gender pay gap for bonus pay

Summary of gender pay gap calculations 2018/19

There are a higher proportion of male employees in the upper pay quartile of the Trust compared to proportions of male and female employees in the lower quartiles.

When considering ordinary pay, the mean hourly rate of male employees is **18.1%** higher than that of female employees. When median calculations are used, the hourly rate of male employees' ordinary pay is **11.6%** higher than that of female employees. There has been a small decrease in the gender pay gap for ordinary pay, compared to the previous year's data.

Considering overall the Trust population**, 4.7%** of male employees received a bonus payment compared to **1.6%** of female employees. Relevant bonus pay relates to Clinical Excellence Awards (CEA) for Consultants and Long Service Awards (LSA) for staff who have achieved 20 years of service at the Trust.

When considering both these types of bonus pay together, there is a **46%** mean gender pay gap and a **75%** median gender pay gap between men and women's' bonus pay. This can be partly explained by the fact that a higher proportion of women received a LSA and a higher proportion of men received a CEA, which is of a much higher monetary value.

When considering CEA payments only, there is a **28%** mean pay gap between male and female consultants' CEA pay and a **46%** median pay gap. There have been slight increases in the gender pay gap for bonus pay, compared to previous year's data.

However, recent changes to the local CEA process and analysis on those who have achieved a local CEA for the first time in 2017/18 suggest positive changes in addressing the bonus pay gap for future years.

There is no difference in the mean or median values of LSA payment awarded to male and female employees, as all payments are of the value of £150. Proportions of staff receiving LSAs are reflective of the overall gender mix in the organisation.

Actions to address issues identified within the Gender Pay Gap report have been set under the Trust's 2019 Workforce Equality and Diversity Work Programme.

Following discussion at the executive POD and Quality committees some minor revisions have been made to the report.

Recommendations:
The Board is asked to approve this report for submission of the data in line with statutory obligations and for publication on the Trust website.

This report has been discussed at:
☒ Equality and Diversity Steering Committee
☒ Executive People & OD Committee
☒ Quality Committee

Quality impact:
The analysis and actions outlined in this paper enable the Trust to provide evidence under the CQC domain for well-led.

Financial impact:
Has no financial impact.

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

Workforce impact (including training and education implications):
The equality and diversity agenda has a significant impact on the workforce which makes these reports essential to mitigating any negative impact.

What impact will this have on the wider health economy, patients and the public?
Evidence shows that failing to address equality and diversity issues has a wider impact on the health economy and patients.

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

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

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

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

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

Detail as per executive summary with associated appendices

Summary

In line with gender pay gap reporting requirements, this report provides the six mandatory calculations, with additional analysis and commentary:

1. Proportion of males and females in each pay quartile
2. Mean gender pay gap for ordinary pay
3. Median gender pay gap for ordinary pay
4. Proportion of males and females receiving a bonus payment
5. Mean gender pay gap for bonus pay
6. Median gender pay gap for bonus pay

There are a higher proportion of male employees in the upper pay quartile of the Trust compared to proportions of male and female employees in the lower quartiles.

When considering ordinary pay, the mean hourly rate of male employees is **18.1%** higher than that of female employees. When median calculations are used, the hourly rate of male employees' ordinary pay is **11.6%** higher than that of female employees. There has been a small decrease in the gender pay gap for ordinary pay, compared to the previous year's data.

Considering overall the Trust population**, 4.7%** of male employees received a bonus payment compared to **1.6%** of female employees. Relevant bonus pay relates to Clinical Excellence Awards (CEA) for Consultants and Long Service Awards (LSA) for staff who have achieved 20 years of service at the Trust.

When considering both these types of bonus pay together, there is a **46%** mean gender pay gap and a **75%** median gender pay gap between men and women's' bonus pay. This can be partly explained by the fact that a higher proportion of women received a LSA and a higher proportion of men received a CEA, which is of a much higher monetary value.

When considering CEA payments only, there is a **28%** mean pay gap between male and female consultants' CEA pay and a **46%** median pay gap. There have been slight increases in the gender pay gap for bonus pay, compared to previous year's data.

However, recent changes to the local CEA process and analysis on those who have achieved a local CEA for the first time in 2017/18 suggest positive changes in addressing the bonus pay gap for future years.

There is no difference in the mean or median values of LSA payment awarded to male and female employees, as all payments are of the value of £150. Proportions of staff receiving LSAs are reflective of the overall gender mix in the organisation.

Actions to address issues identified within the Gender Pay Gap report have been set under the Trust's 2019 Workforce Equality and Diversity Work Programme.

1. Background

This report is published in line with gender pay gap reporting requirements for organisations with more than 250 staff. All calculations relate to the pay period in which the snapshot day falls, which is **31 March 2018.** This is the second gender pay gap report the Trust has published, the first can be found here.

A gender pay gap is the difference between the average earnings of men and women across an organisation, expressed relative to men's earnings.

The mean pay gap is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce.

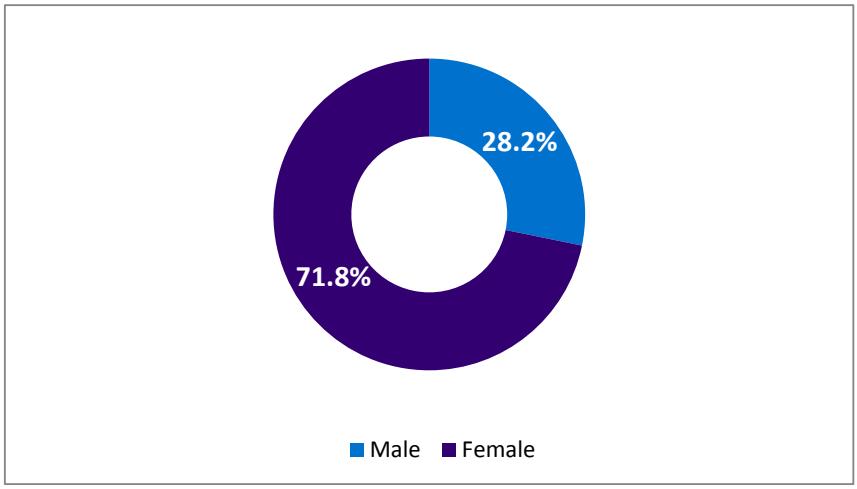
The median pay gap is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

The gender pay gap is different to equal pay for equal value work. The Trust operates within a national pay structure and job evaluation system for staff on agenda for change terms and conditions and those on Medical and Dental terms and conditions.

Please see Appendix 1 for further definitions and inclusion criteria.

2. Trust Gender Mix

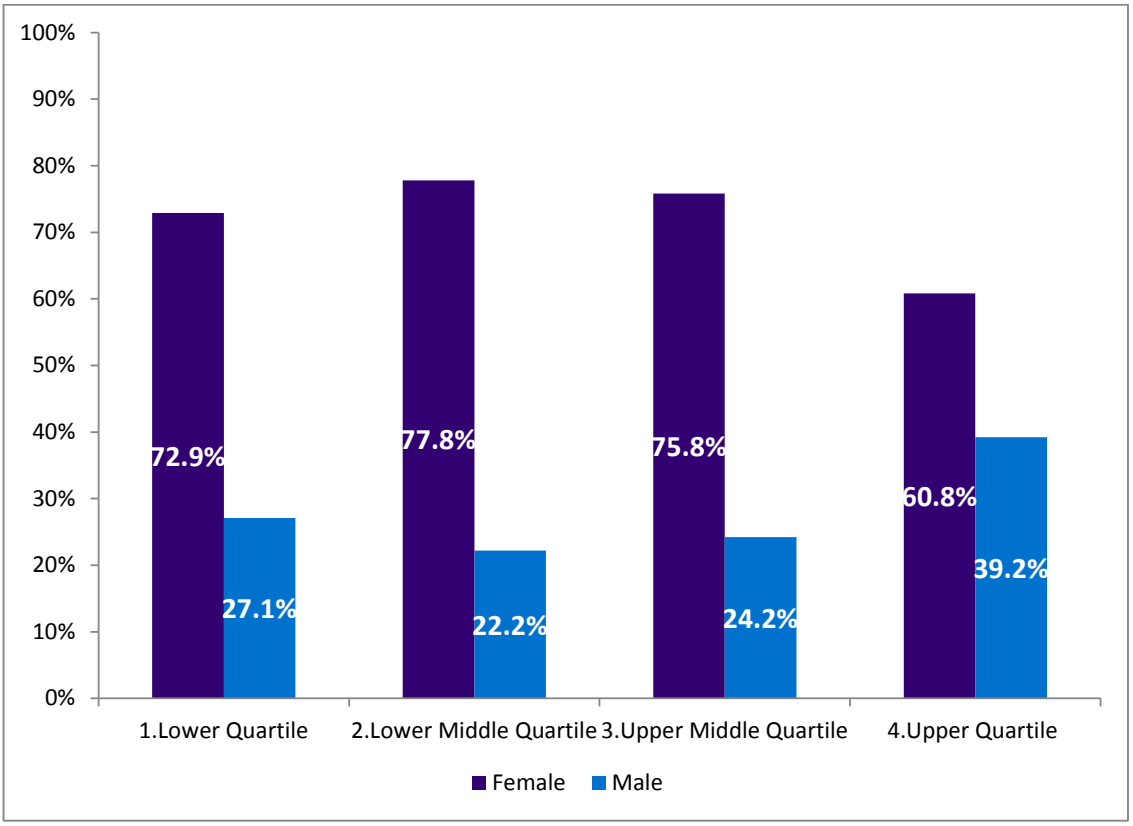
Overall, **72%** (9,286) of Trust employees are female, while **28%** (3,655) are male. These percentages relate to the 12,941 staff included for the purposes of this calculation.



3. Quartile pay band gender representation

The data below ranks our full-pay employees from lowest to highest paid, divides this into four equal parts (quartiles) to establish the percentage of men and women in each quartile. Quartile 1 contains the lowest pay groups, while Quartile 4 contains the highest pay groups.

Percentage of male and female employees within each quartile pay band



Within quartile 1, the proportions are highly similar to that of the overall organisation, varying by 1%.

In comparison, within the middle quartiles, there are slightly higher proportions of female employees and lower proportions of male employees, with broadly **78%** female and **22%** male employees in quartile 2 and **76%** female and **24%** male employees in quartile 3.

However, within quartile 4, there are fewer women compared to the overall Trust proportions, with broadly **61%** female and **39%** male employees. This suggests that the gender pay gap can be partly explained by an underrepresentation of women in the upper quartile band.

The proportions of male and female employees in each quartile are very similar to the figures from 2017/18:

Quartile 1: The proportion of female employees has decreased by around 1%

Quartile 2: There has been a less than 1% change

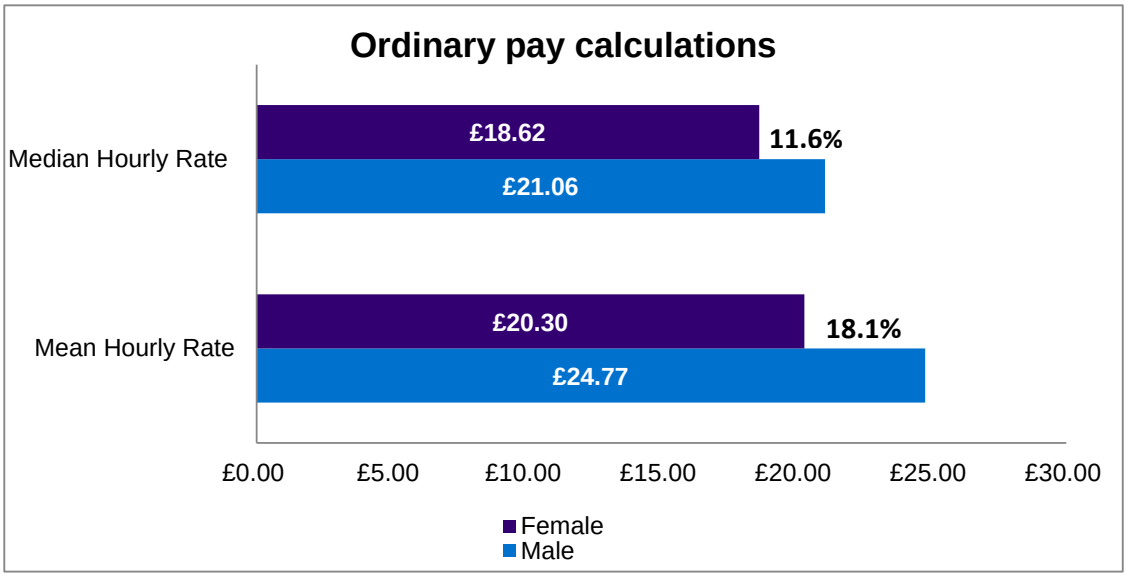
Quartile 3: The proportion of female employees has decreased by around 2%

Quartile 4: The proportion of female employees in the upper quartile has increased by 1%

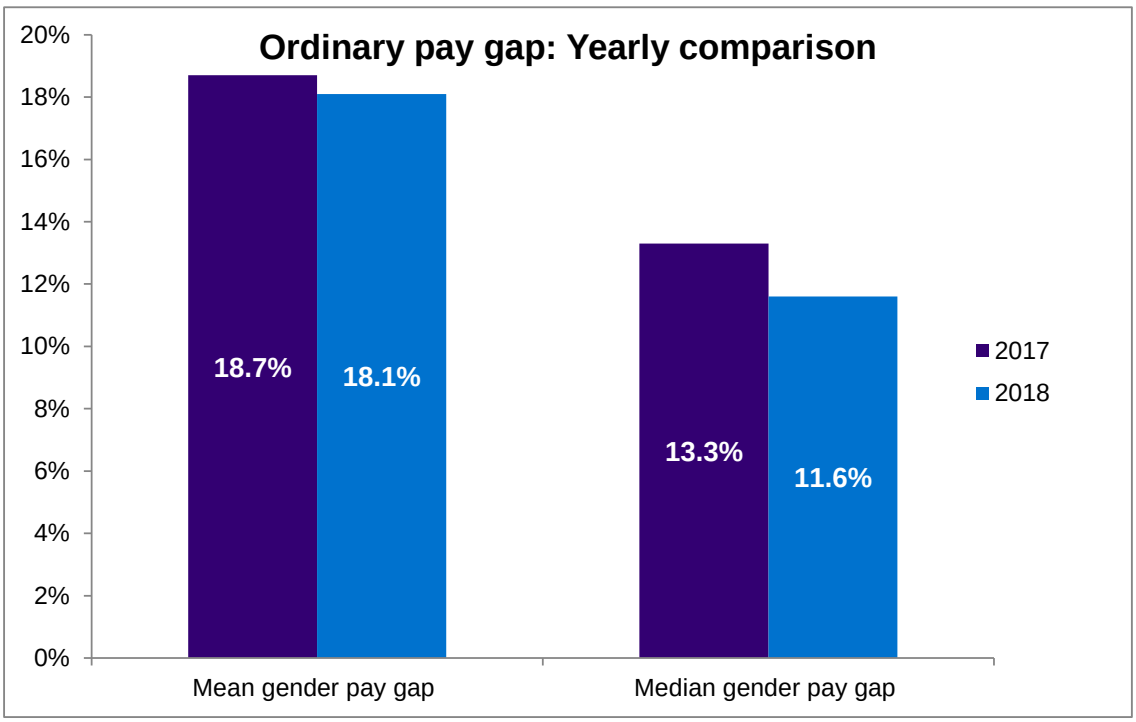
4. Ordinary Pay

This section establishes the mean and median differences in hourly rates of ordinary pay between male and female employees.

During the defined pay period that includes the snapshot date of 31 March 2018, the mean hourly rate of male employees was **18.1%** higher than that of female employees and the median hourly rate of male employees was **11.6%** higher than that of female employees.



The graph below demonstrates that there have been small reductions in the mean and median ordinary pay gaps, compared to last year's calculations:



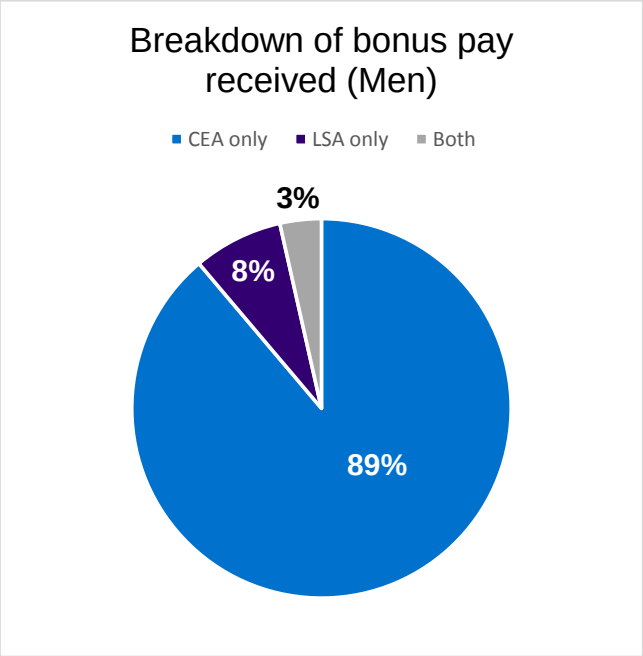
5. Bonus Pay

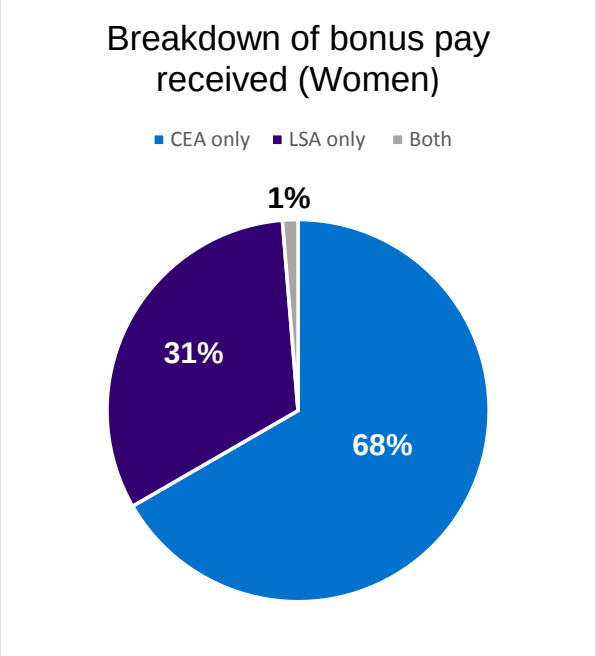
Guidance was issued by NHS Employers in February 2019 to ensure consistency amongst Trusts regarding what should be included within bonus pay gap calculations. Following this guidance, Clinical Excellence Awards (CEA) and Long Service Awards (LSA) have been identified as the relevant bonus payments made within the 12-month period ending on the snapshot date of 31 March 2018. Analysis is presented for the combined overall bonus payments and for each type of bonus pay separately, in order to explain the bonus pay gap.

5.1 Overall calculations

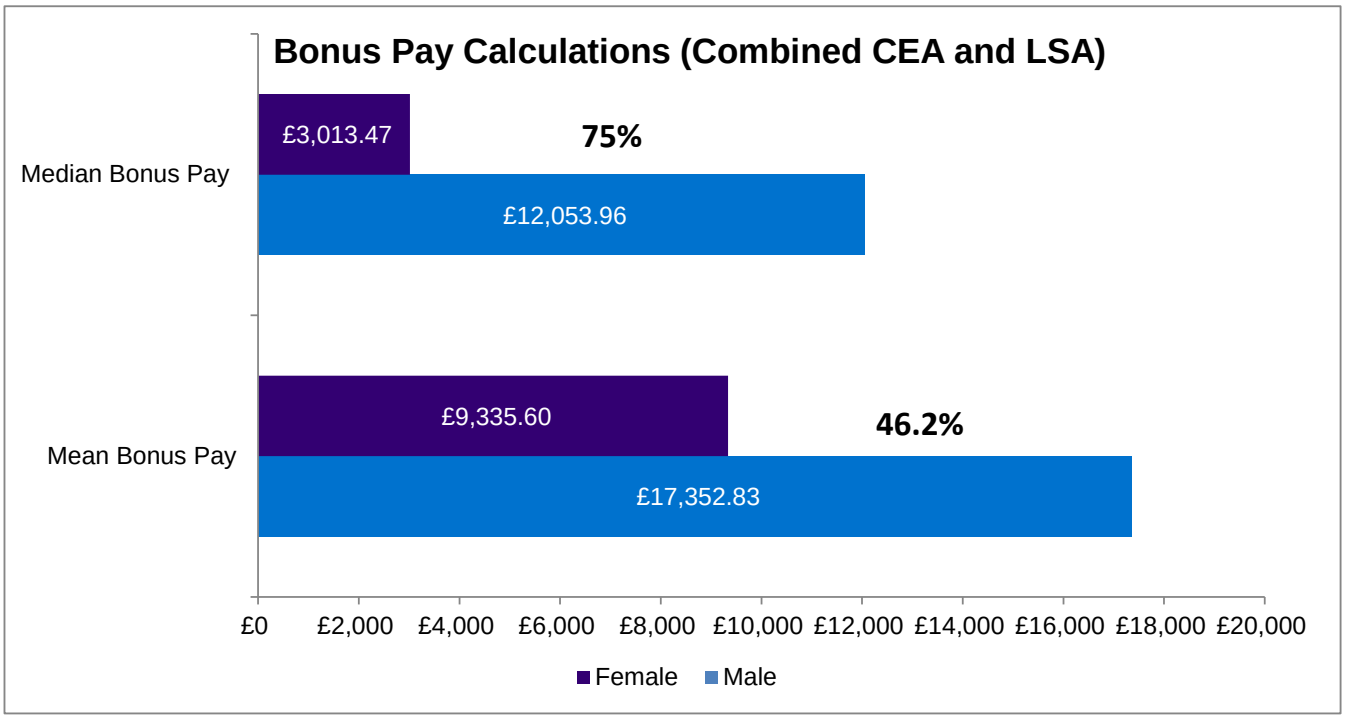
When considering the overall Trust gender populations, **4.7%** of male employees receive a bonus payment, while **1.6%** of female employees do. Therefore**, 3.1%** more men receive bonus payments compared to women across the Trust. Only specific groups of employees are eligible for CEA and LSA payments.

Overall there were 170 male and 151 female employees who received a form of bonus payment over the relevant period. Within this group, there were 8 Consultants who received both a CEA and LSA. For the purposes of the overall bonus calculations, both types of bonus payment made to these individuals were combined, so the individuals were not counted twice. The charts below detail the breakdown of the types of bonus pay received for each gender.





When considering the CEA and LSA data together, the figure below indicates that men receive significantly more bonus pay than women. This can be partly explained by the fact that a higher proportion of women received a LSA (which is of the value of £150) and a higher proportion of men received a CEA (overall average yearly payment of £16,664.59).

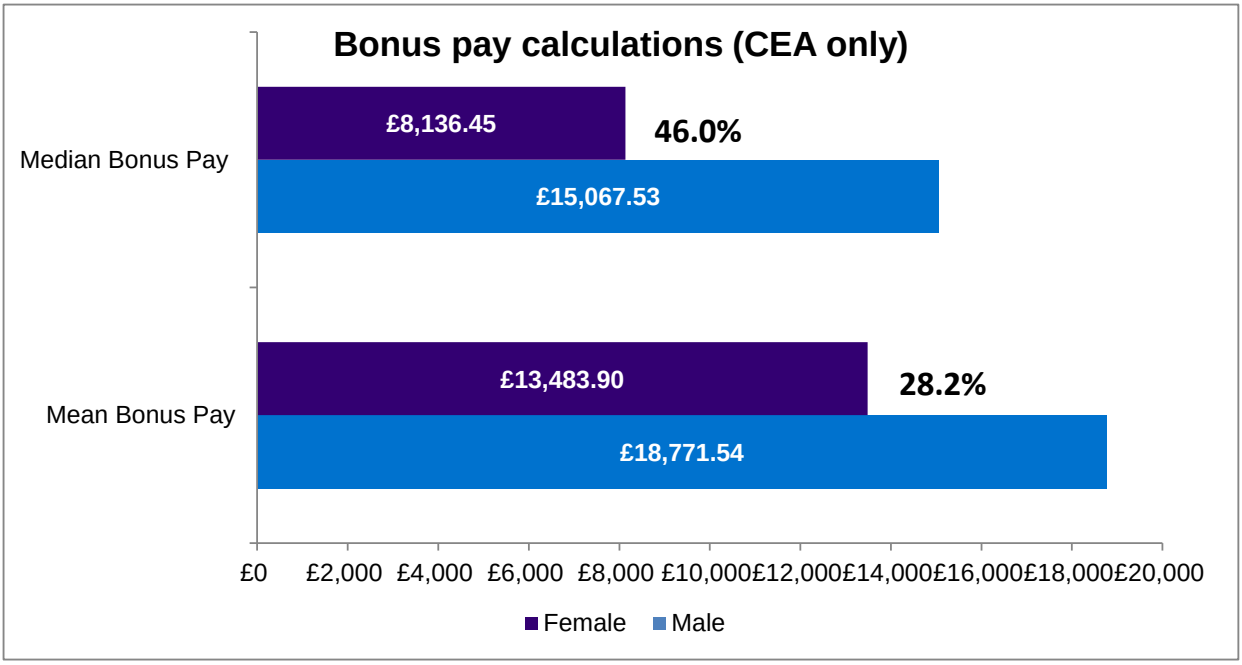


5.2 Clinical Excellence Awards (CEAs)

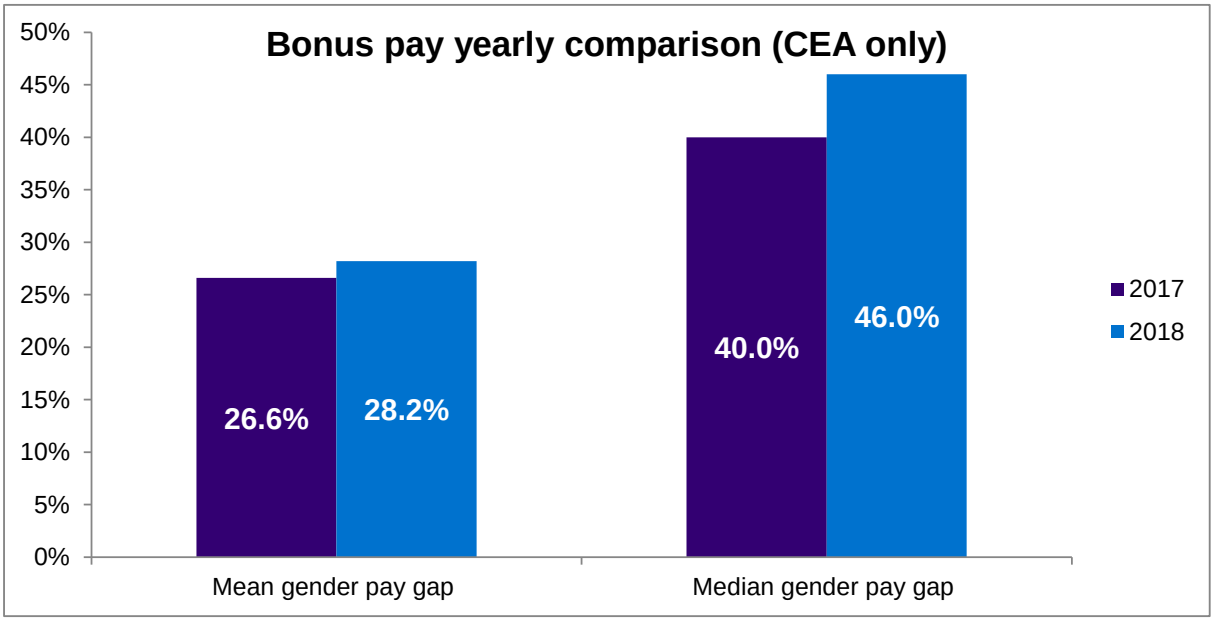
The CEA scheme is intended to recognise and reward those Consultants who contribute most towards the delivery of safe and high quality care to patients and to the continuous improvement of NHS services. For the previous year's gender pay gap report, CEAs were the only relevant bonus pay considered, therefore, yearly comparisons are provided.

When considering proportions of CEAs awarded out of the population of eligible consultants only, **39%** of male consultants received a CEA payment, compared to **32%** of female consultants. Both proportions have decreased compared to the previous year's calculations, where **49%** of male consultants received CEA payment, compared to **45%** of female consultants. Eligible consultants are those in substantive posts with more than one year's Trust service at the time of the application.

The diagram below demonstrates that there is a **28.2%** mean pay gap between male and female consultants' CEA pay. When looking at the median difference, this is higher, with male consultants receiving **46.0%** more bonus pay than female consultants.



The below demonstrates that the mean and median bonus pay gaps have increased compared to last year.



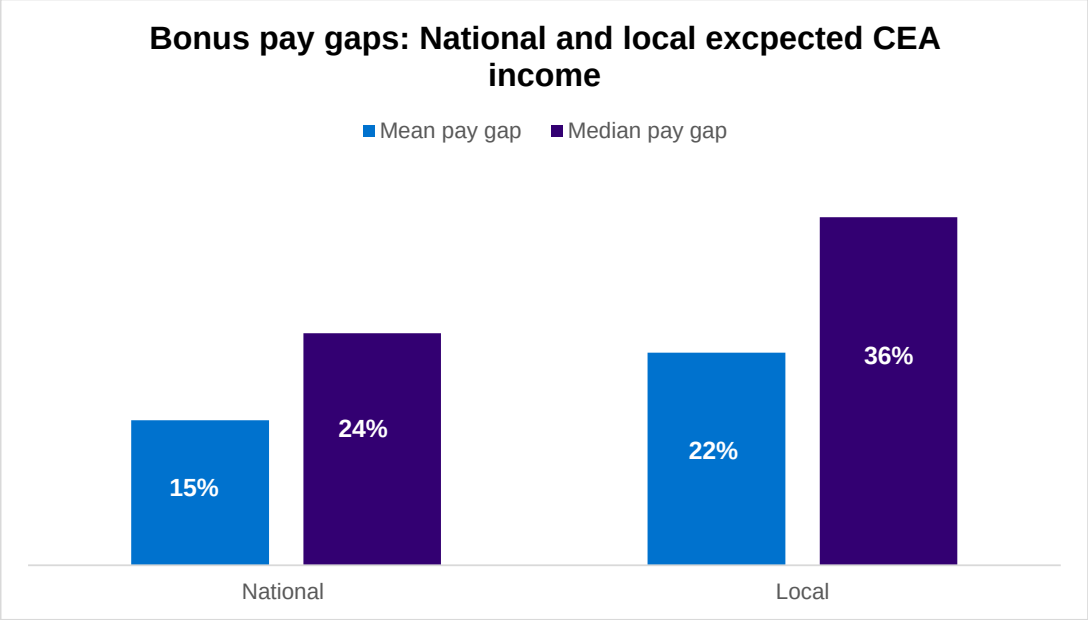
5.3 CEA Additional Analysis

For the purpose of the bonus pay gap calculations, all CEA payments made to relevant employees in the 12 months to the snapshot date are included. This includes local awards, which are awarded by the Trust and national awards which are awarded by the Department of Health and Social Care paid via the Trust payroll.

In order to better understand what is driving the bonus pay gap in CEA payments, bonus pay gap analysis has been conducted on the total expected amounts of bonus pay to be awarded to Consultants for the financial year nationally and locally. Please note that this data does not account for changes in payments that arise, for example, when recipients leave the Trust.

For nationally awarded CEAs, there were 22 male recipients and 9 female recipients. For locally awarded CEAs, there were 145 male recipients and 104 female recipients.

The below demonstrates the breakdown in bonus pay gap calculations when national and local CEA payments are considered separately.



The decision to award CEA bonus payments to individuals may have been made in previous CEA round years. In contrast to the overall calculations, when the bonus pay calculations are conducted on expected bonus income amounts for Consultants who were first awarded a local CEA in the 2017/18 award round only, women receive **12%** more bonus pay than men, and there is no difference in the median pay received.

While the impact of this is not reflected in the overall CEA bonus pay gap due to the previously awarded local CEAs, that consultants are still in receipt of, and the nationally awarded CEAs, this suggests a positive trend going forward in reducing the gender pay gap for bonus pay.

Furthermore, new arrangements to local CEA awards (brought in from April 2018) seek to reward consultants for providing high-quality standards of service to patients, rather than acting as a discretionary incremental payment which was linked to consultants' historical rather than current performance, which should have a positive impact going forward.

5.3 Long Service Awards

LSAs are awarded to staff who have completed 20 years of service at the Trust. Recipients are awarded a gift voucher of the value of £150.00. Therefore, there is no difference in the mean or median values of this type of bonus payment awarded to male and female employees.

Out of the 68 recipients of a LSA, **28%** were male and **72%** recipients were female, which is representative of the overall organisational gender mix.

6. Actions

Imperial College Healthcare NHS Trust recognises the gender pay gaps identified by this report and is taking action as a result.

Following the publication of the 2017/18 report, further analysis was conducted into occupational groups and within Agenda for Change pay bands to better understand factors driving the gender pay gap.

There was also a review into the local CEA process, including what factors are driving the differences in mean and median bonus pay of local and national awards which are made at a set number of different levels.

Actions have been set under the Trust's 2019 Workforce Equality and Diversity Work Programme, with the aim to improve female workforce representation at Band 8A+ and to further analyse and address factors driving the pay gap within the local CEA process.

7. References

Gender pay gap reporting: Capsticks/ NHS Employers Briefing note on bonus pay and allowances (2019)
Gender pay gap reporting – Government Guide (2019)
Gender pay gap reporting- NHS Employers Guide (2019)
Imperial College Healthcare NHS Trust Annual Equality and Diversity Report (2017/18)

Appendix 1: Definitions

Gender pay gap: The difference between the average earnings of men and women, expressed relative to men's earnings. This is a broad measure of the difference in the average earnings of men and women, regardless of the nature of their work.

Equal pay: A legal requirement that within an organisation, male and female staff members who are engaged in equal or similar work or work of equal value must receive equal pay and other workplace benefits. This definition is included for clarification purposes as this report relates to the gender pay gap, and not equal pay.

Ordinary pay: Basic pay, paid leave, including annual, sick, maternity, paternity, adoption or parental leave (except where an employee is paid less than usual or nothing because of being on leave), high cost area and other allowances, shift premium pay, and pay for piecework. This would include on call framework and banding supplement in Doctor's pay, for example.

Bonus pay: 'Bonus pay' is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. For the purposes of this report, the relevant bonus pay relates to Consultant Clinical Excellence Awards (CEA) and Long Service awards, in line with guidance from NHS Employers. While under this guidance, monetary vouchers awarded as part of the 'Make a Difference' staff recognition scheme could also be included. However, due to data quality issues for 2017/18, this has been excluded, with a view to review this for future years.

Inclusion Criteria: A wider definition of who counts as an employee is used for gender pay gap reporting. This means staff who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff, very senior managers and Trust bank workers.

Agency workers and people employed by another employer to provide services to the Trust e.g. Sodexo staff, are excluded from the Trust's calculations, but counted directly by the agency/employer. Apprentices at the Trust are employed by an apprentice training agency, therefore the contract of apprenticeship is with the agency. Doctors under honorary contracts are also excluded from calculations, but counted by their academic institution

Self-employed workers and contractors of the Trust are also excluded as it is not reasonably practicable to obtain the data to include within the calculations. This is in line with Regulation 2(3) of the Gender Pay Gap Information Regulations 2017.

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TRUST BOARD – PUBLIC
REPORT SUMMARY

Title of report: National Staff Survey Results 2018	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 27 March 2019	**Item 20, report no. 17**
Responsible Executive Director: Kevin Croft, Director of People and OD	**Author:** Sue Grange, Associate Director of People & OD Nate Johnston, Head of Talent, Leadership and Engagement

1. Summary

The paper provides a summary of the National Staff Survey Results 2018 (survey conducted in Oct – Dec 2018). There are two reports available, an overall benchmark report and a directorate breakdown report which can be viewed fully at:
http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RYJ_full.pdf
http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RYJ_directorate.pdf

The methodology has changed from previous years and the overall engagement score is now expressed as a score on a 1-10 scale. All scores are now compared against the best, worse and average. Key highlights include

(i) Improved response rate of **45.6%** (41.5% last year) (from a sample of 10% of Trust staff). This is better than Acute Trust average of 44.4%.

(ii) Overall Engagement score of **7.0** (on a 10-point scale) which is **average** against all acute Trusts (compared with 7.0 and 7.1 in the last previous 2 years). Under the previous methodology, which used a 5-point scale, we were "above average" in 2017, and worst 20% in 2015.

(iii) Out of 8 Key themes, only 1 shows a significant change which is equality, diversity and Inclusion reduction from 8.7 to 8.4. The other 7 themes remain unchanged.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.7**	462	**8.4**	520	↓
Health & wellbeing	**5.8**	478	**5.6**	534	Not significant
Immediate managers	**6.6**	468	**6.6**	533	Not significant
Morale		0	**5.7**	516	N/A
Quality of appraisals	**5.6**	402	**5.8**	451	Not significant
Quality of care	**7.7**	446	**7.7**	492	Not significant
Safe environment - Bullying & harassment	**7.5**	462	**7.3**	523	Not significant
Safe environment - Violence	**9.3**	461	**9.3**	517	Not significant
Safety culture	**6.6**	466	**6.6**	523	Not significant
Staff engagement	**7.1**	490	**7.0**	545	Not significant

(iv) Question 21c (FFT) “I would recommend my organisation as a place to work has reduced from 66.4% to 60.8% in the last 12 months, and is now below the average of 62.6%, compared to above average last year

(v) Question 21d (FFT) “if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation” is static at 71.7% and shows a consistent trend line over the last 3 years

(vi) Themes which are “below average” and of concern are
-Equality, Diversity and Inclusion
-Health and well being
-Immediate Managers
-Morale
-Safe Environment: Bullying and Harassment
-Safe Environment: Violence

(vii) A new theme of “Morale” is included, in which we score a little below the average 5.7, against the average of 6.1. The biggest contributor to this lower score were the questions “relationships at work are strained”, “I often think about leaving this organisation”, “I will probably look or a job at a new organisation in the next 12 months”, and “as soon as I can find another job I will leave this organisation”.

(viii) The theme of Equality, Diversity and Inclusion, is the primary area of focus, as it has decreased overall from 8.7 to 8.4, and is below average of 9.1. The major contributors to this reduction were the questions
“does your organisation act fairly with regard career progression/promotion”, “in the last 12 months have you personally experienced discrimination at work from patients/service users. Their relatives or other members of the public” and “has your employer made adequate adjustments to enable you to carry out your work”

2. Action

Our core action plans were developed based on the results of the local survey which a greater total response (3000+), which has also this year been supplemented with the feedback from the values and behaviours programme which has reinforced the need for action in a similar number of areas. The national survey for us has to date always been a sample and therefore a lower number of people than the local survey. We are therefore using this national survey as a checkpoint of whether anything is missing or needs to be changed about current plans.

There are a number of corporate wide action plans already in place which will be reviewed in the light of these results
-Equality, Diversity and Inclusion/WRES Action Plan
-Health and Well-being action plan/strategy
-Recruitment and Retention work programme/steering group
-Leading change through Vision, Values and Behaviours
-Safety Culture workstream
-Violence at work
It is proposed that a more detailed report is prepared for these sub groups to discuss and examine results in more detail.

3. Local Action: The directorate benchmark report shows data down to divisional level and directorate level where total responses allow. This can be used to compare trends and help cross check results with current existing local directorate action plans

4. Future of Surveys

In the last 4 years, the Trust has run a sample national survey in Sept – Dec (10% of workforce) and supplemented this with a Local Full census survey (100% of workforce) in June. The response rates have averaged 40% for the National Survey (500 staff) and 35% for the local (3200 staff) totalling approx. 4000 in total. There are several reasons for reviewing this at this time

- The National Survey has made considerable improvements in the data analysis and presentation, with a more interactive results pack and wider range of suppliers
- Recognition of the workload involved in servicing two surveys per year
- Concern expressed about survey fatigue, and lack of a high response rate especially in the national survey

It is therefore agreed at Executive people committee that we recommend a move to:

(i) A single national survey once year and that it is a full census survey, with 100% workforce.

(ii) Running separate pulse surveys in-between, which focus on the particular areas of concern, in order to measure progress and track improvement

Recommendations:

The Board is asked to note:

(i) The summary of national survey results 2019

The Board is asked to agree the following recommendations:

(ii) People & OD to lead a deeper review of the national staff survey results at all relevant sub groups on areas of focus from the survey and amend or reinforce action plans as required

(iii) Divisions and directorates to review local results and develop or amend their engagement action plans based on the results

(iv) Adopt the changes to the annual survey approach and move to a full census national survey in Sept – Dec 2019, supplemented by single topic pulse surveys on areas of concern

This report has been discussed at:

☒ Executive People and OD Committee
☒ Quality Committee

Quality impact:

Staff engagement links to patient experience, retention and turnover

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:

Risks attached to this project and how they will be managed. Reference to risk register and BAF where appropriate, and clear reference to key risks and mitigations.

Workforce impact (including training and education implications):

Staff Survey feedback is a critical KPI of our workforce, and links to vacancy rates, turnover, performance

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

Staff wellbeing and morale benefits patients and public.
Has an Equality Impact Assessment been carried out? ☒ Yes ☐ No ☐ Not applicable
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with compassion. ▪ To educate and engage skilled and diverse people committed to continual learning and improvements.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? No

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2018 National Staff Survey Results

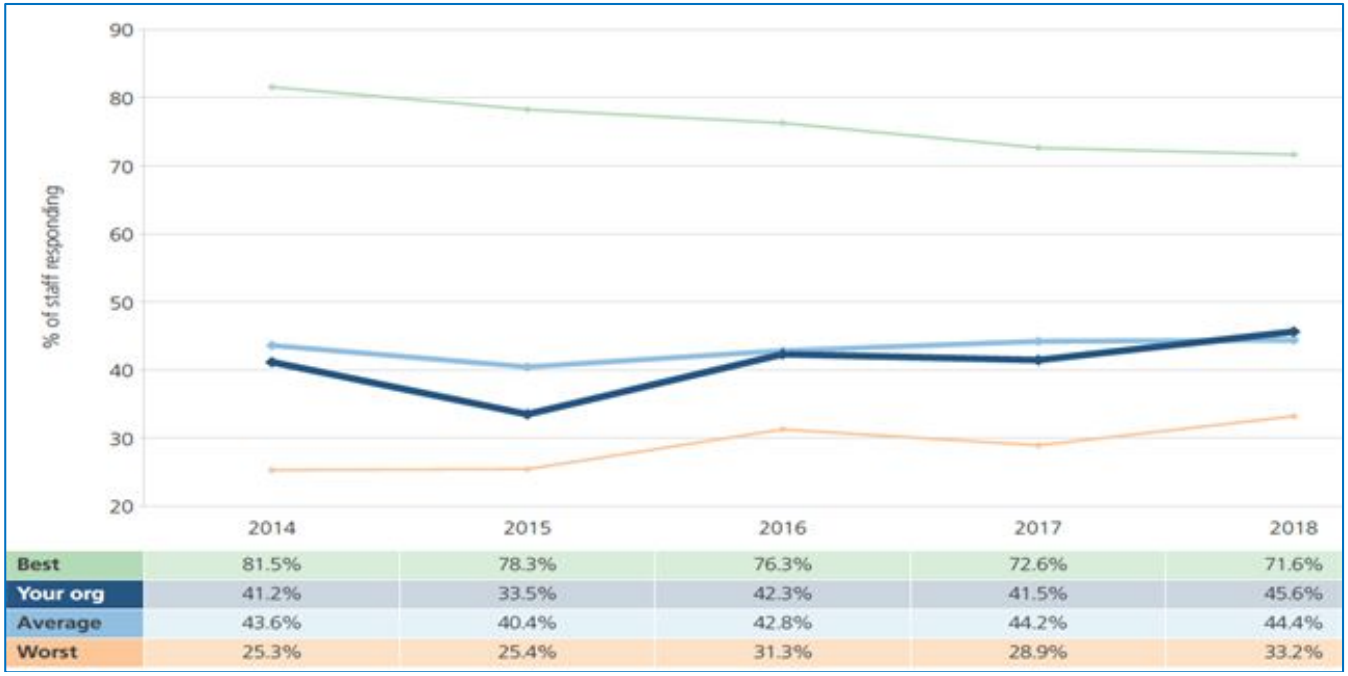
Annual engagement cycle and response rates

Imperial College Healthcare NHS Trust

Currently the Trust has 2 annual surveys; the national survey NHS and the local survey. The local survey is full census (all staff) and the national survey is 10% sample

	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Local survey	Our Voice" local engagement survey launches- full census		Survey closes	Action plan development	Directorate action plans submitted					
National Survey						National NHS Staff survey launches to a 10% sample		National survey closes		Results published

Table 1: National Response rate over time



	2014	2015	2016	2017	2018
Best	81.5%	78.3%	76.3%	72.6%	71.6%
Your org	41.2%	33.5%	42.3%	41.5%	45.6%
Average	43.6%	40.4%	42.8%	44.2%	44.4%
Worst	25.3%	25.4%	31.3%	28.9%	33.2%

Trust response rate in the National Survey has increased from 41.5% to 45.6% in 2018 and is now above the Acute Trust average in 2018

Imperial College Healthcare NHS Trust

Engagement scores

These graphs show the trend lines for our engagement scores in the local and national surveys. Note: these are measured differently and not directly comparable

Table 2: Engagement score over time: Local Survey

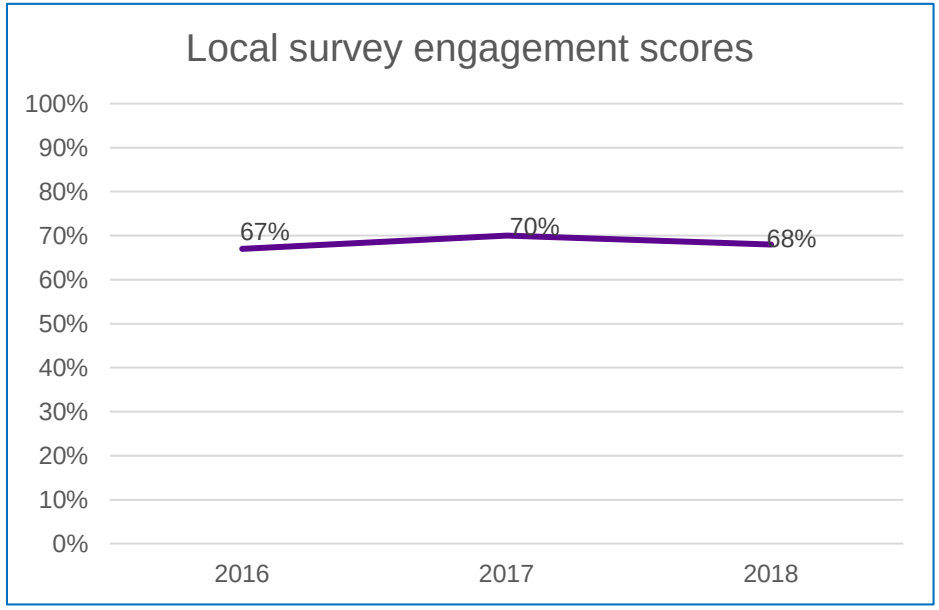
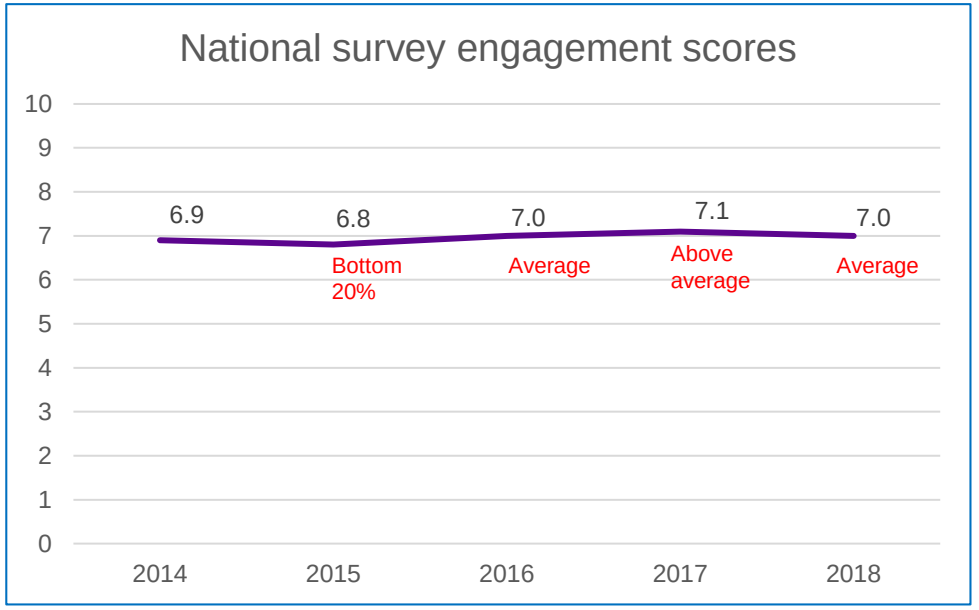


Table 3: Engagement score over time: National Survey



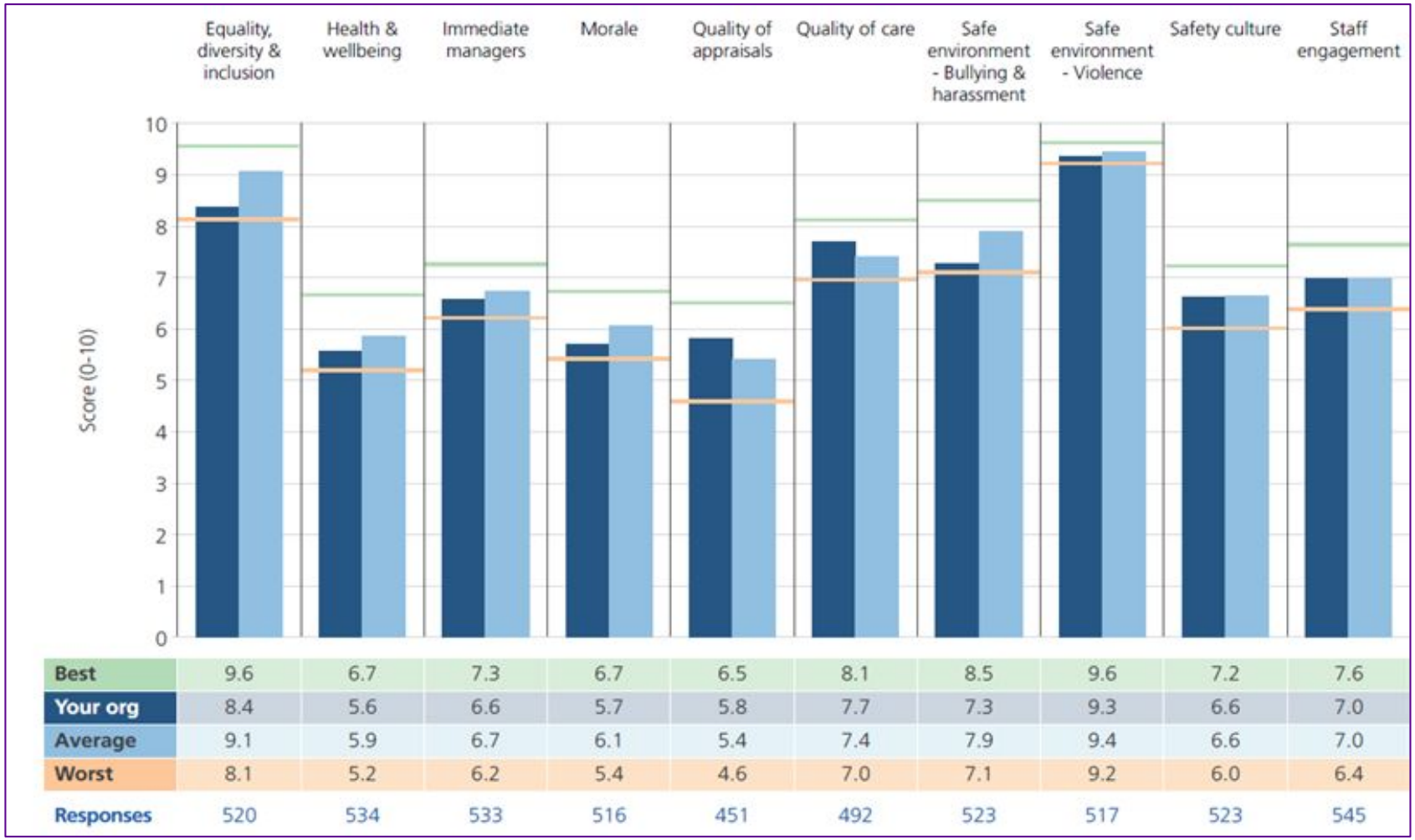
*Red text indicates the ranking that was used prior to the 2018 survey when results were on a 5 point scale

Notes:

- The scoring for the national survey has changed in 2018 from a 5 point scale to a 10 point scale. The rankings from previous years and the previous methodology are shown in red
- The surveys measure engagement differently and are not directly comparable i.e. 68% in the local survey should not be translated to 6.8 in the national survey
- The ranking system of "top" and "bottom 20%" has now been removed from the national reporting

Imperial College Healthcare NHS Trust

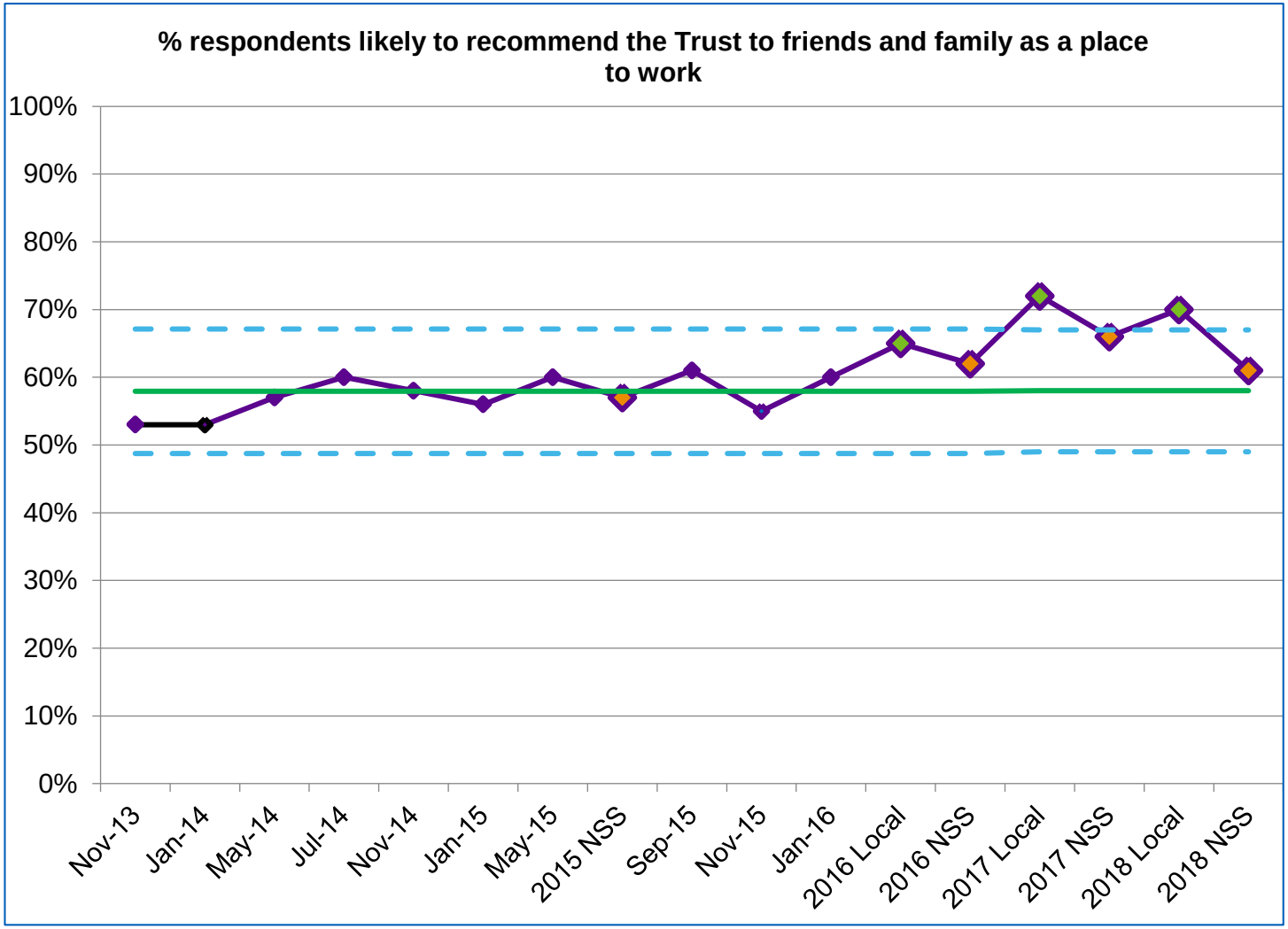
Theme results overview 2018



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	8.4	5.6	6.6	5.7	5.8	7.7	7.3	9.3	6.6	7.0
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
Responses	520	534	533	516	451	492	523	517	523	545

Staff Friends and Family Test: Recommend as place to work

Imperial College Healthcare NHS Trust



Mean score

Local survey

National survey

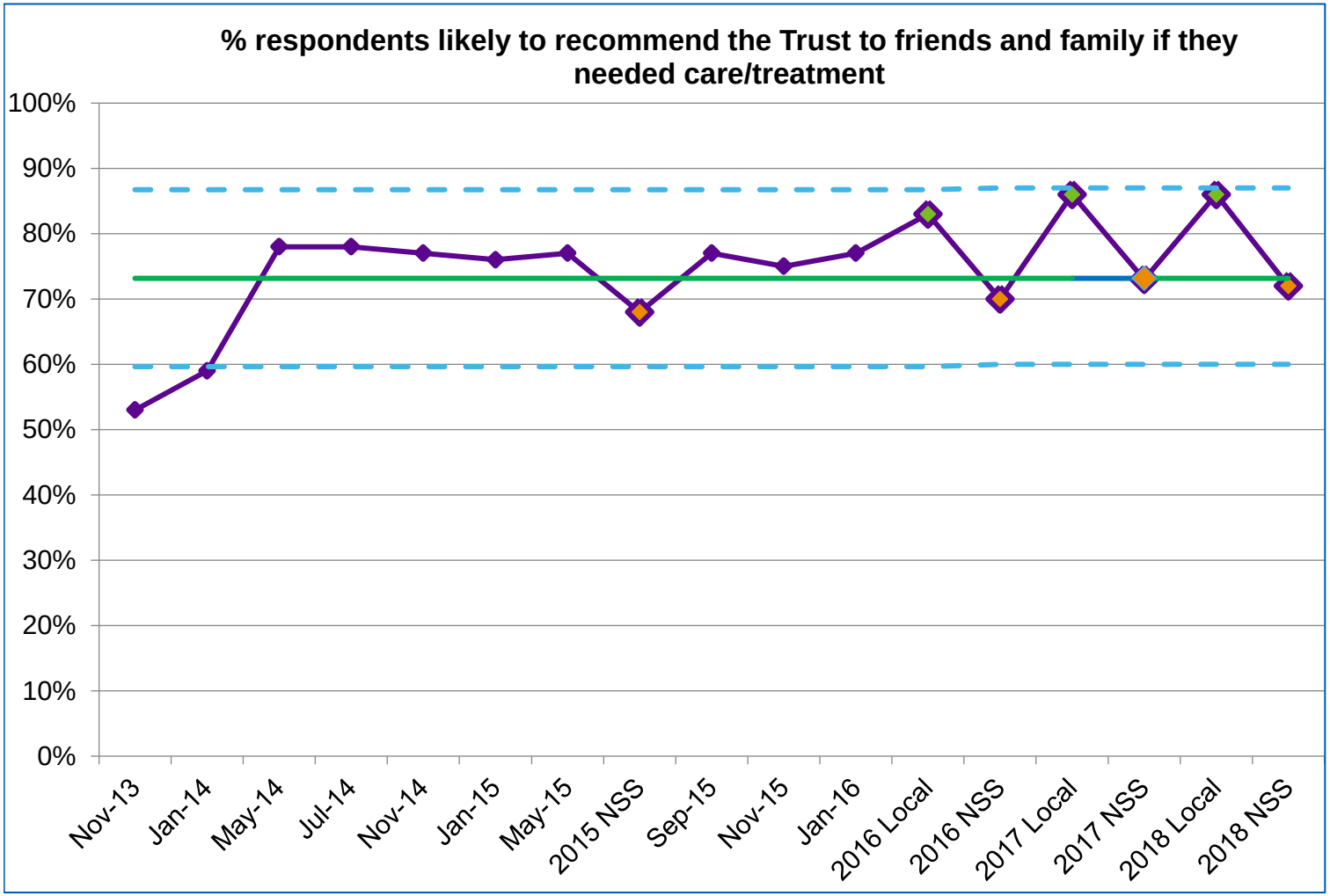
Other surveys

Our 2018 national score for recommend as a place to work was 61% against an NHS average of 62% and a Trust score of 66.4% in 2017.

We continue to see a trend of national results scoring less favourably than our local survey results.

Staff Friends and Family Test: Recommend for care and treatment

Imperial College Healthcare NHS Trust



Mean score

Local survey

National survey

Other surveys

Our 2018 national score for recommend as a place for care/treatment was 71.7% against an NHS average of 71.3% and against a Trust score of 72.8% in 2017

We continue to see a trend of national results scoring less favourably than local survey results.

Imperial College Healthcare NHS Trust

London and Shelford Trust comparisons

London Acute Trusts	Overall engagement score 2018	Overall engagement score 2017	Overall engagement score 2016
Guy's and St Thomas' NHS Foundation Trust	**7.4** ↓	7.5	7.6
Chelsea and Westminster Hospital NHS Foundation Trust	**7.3** →	7.3	7.0
University College London Hospitals NHS Foundation Trust	**7.2** →	7.2	7.2
Royal Free London NHS Foundation Trust	**7.1** ↑	7.0	7.0
Imperial College Healthcare NHS Trust	**7.0** ↓	7.1	7.0
Barts Health NHS Trust	**7.0** ↑	6.9	6.9
St George's University Hospitals NHS Foundation Trust	**6.8** ↓	6.9	6.8
King's College Hospital NHS Foundation Trust	**6.8** ↓	6.9	6.9

Apart from Imperial swapping with Royal Free (Imperial moving from 4th to 5th) this table remains the same as in 2017

Shelford Trusts	Overall engagement score 2018	Overall engagement score 2017	Overall engagement score 2016
Guy's and St Thomas' NHS Foundation Trust	**7.4** ↓	7.5	7.6
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	**7.3** →	7.3	7.4
University College London Hospitals NHS Foundation Trust	**7.2** →	7.2	7.2
Cambridge University Hospitals NHS Foundation Trust	**7.2** ↑	7.1	7.2
Manchester University Hospitals NHS Foundation Trust	**7.1**	/	/
Imperial College Healthcare NHS Trust	**7.0** ↓	7.1	7.0
University Hospitals Birmingham NHS Foundation Trust	**7.0**	/	/
Sheffield Teaching Hospitals NHS Foundation Trust	**7.0** ↓	7.1	7.0
Oxford University Hospitals NHS Foundation Trust	**6.9** ↓	7.0	7.2
King's College Hospital NHS Foundation Trust	**6.8** ↓	6.9	6.9

Imperial has slipped into joint 6th this year (joint 5th in 2017).

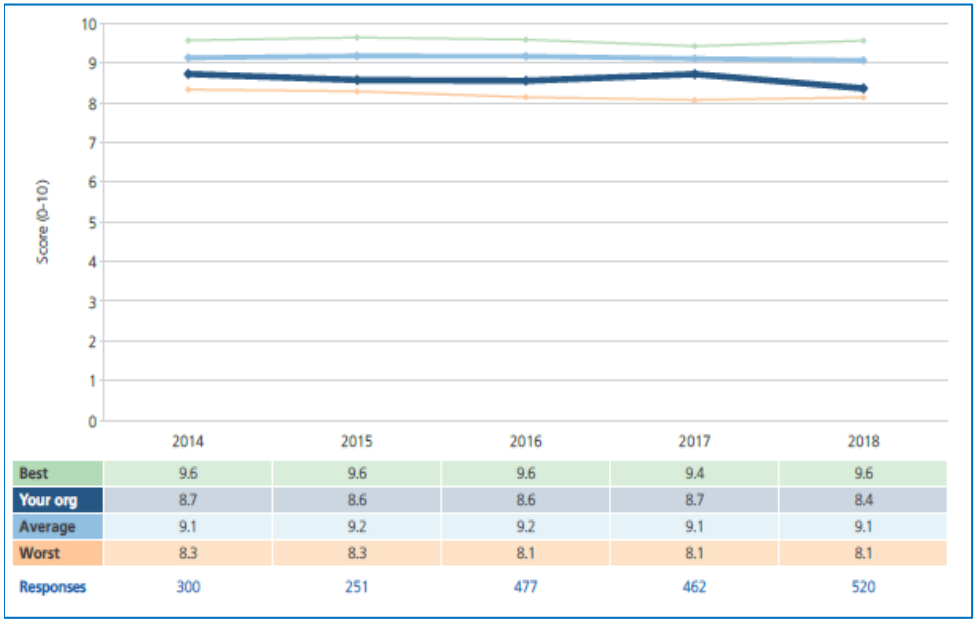
Changes in structures at Manchester and Birmingham mean there are no equivalent results for past years

Survey themes: trend lines

Imperial College Healthcare NHS Trust

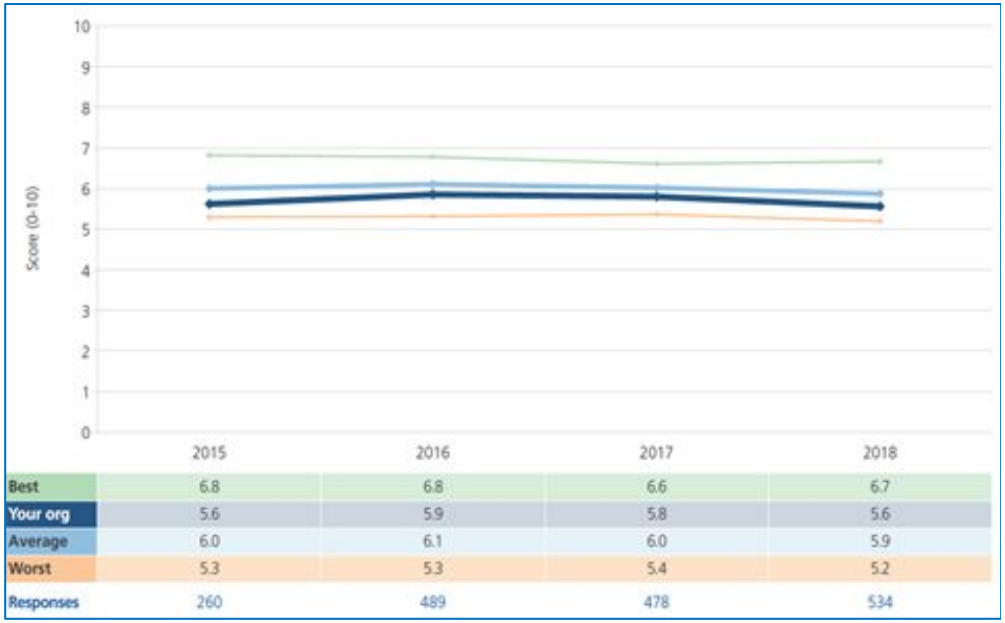
The questions in the survey are grouped into key themes. The only theme that had a statistically significant change from 2017 was the Equality, Diversity and Inclusion theme which worsened in 2018.

Equality, diversity & inclusion



	2014	2015	2016	2017	2018
Best	9.6	9.6	9.6	9.4	9.6
Your org	8.7	8.6	8.6	8.7	8.4
Average	9.1	9.2	9.2	9.1	9.1
Worst	8.3	8.3	8.1	8.1	8.1
Responses	300	251	477	462	520

Health & wellbeing



	2015	2016	2017	2018
Best	6.8	6.8	6.6	6.7
Your org	5.6	5.9	5.8	5.6
Average	6.0	6.1	6.0	5.9
Worst	5.3	5.3	5.4	5.2
Responses	260	489	478	534

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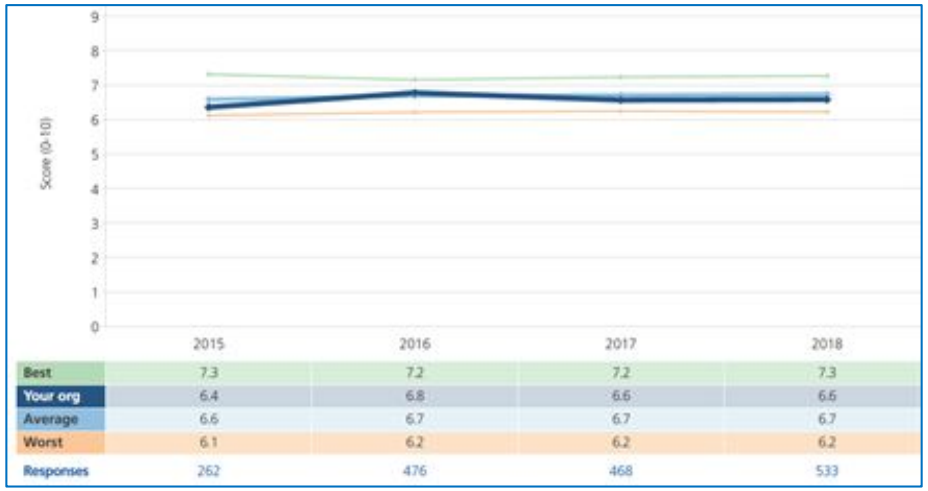
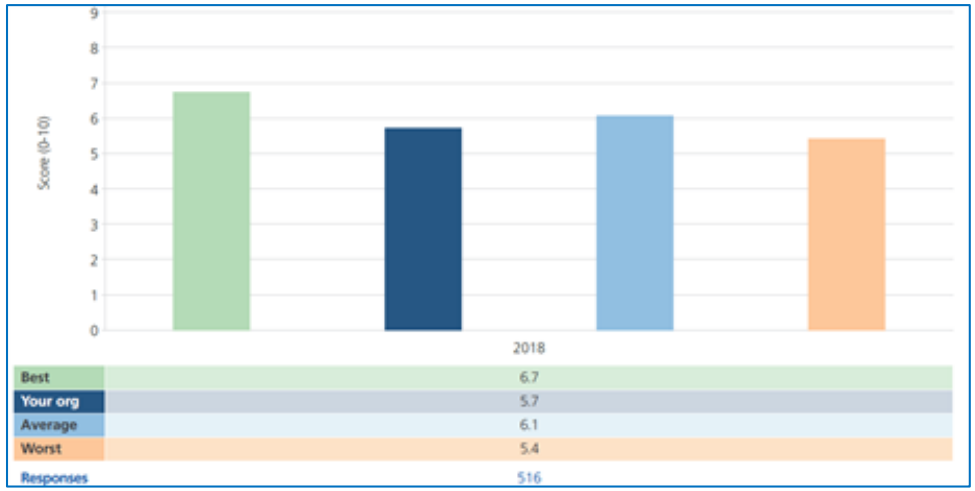
Survey themes: trend lines

Immediate managers



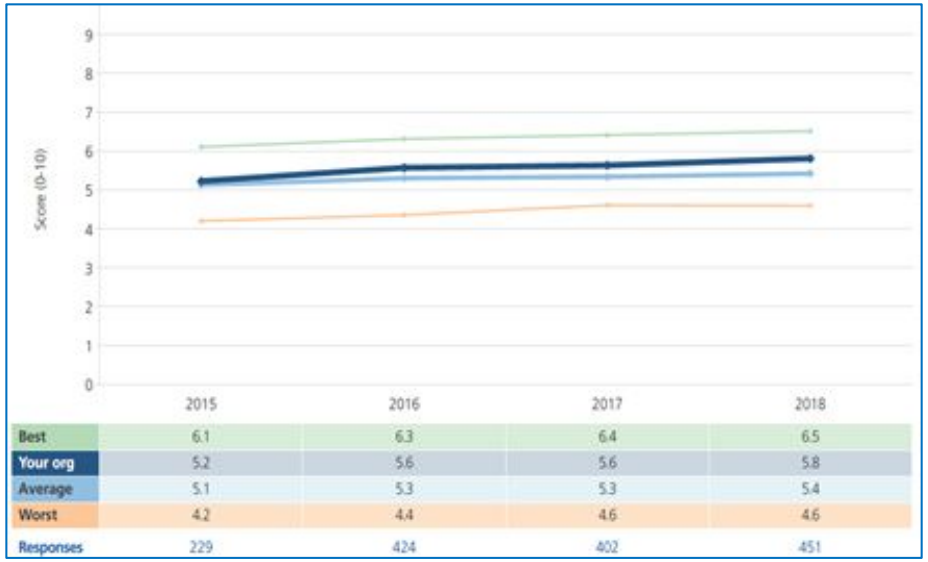
	2015	2016	2017	2018
Best	7.3	7.2	7.2	7.3
Your org	6.4	6.8	6.6	6.6
Average	6.6	6.7	6.7	6.7
Worst	6.1	6.2	6.2	6.2
Responses	262	476	468	533

Morale



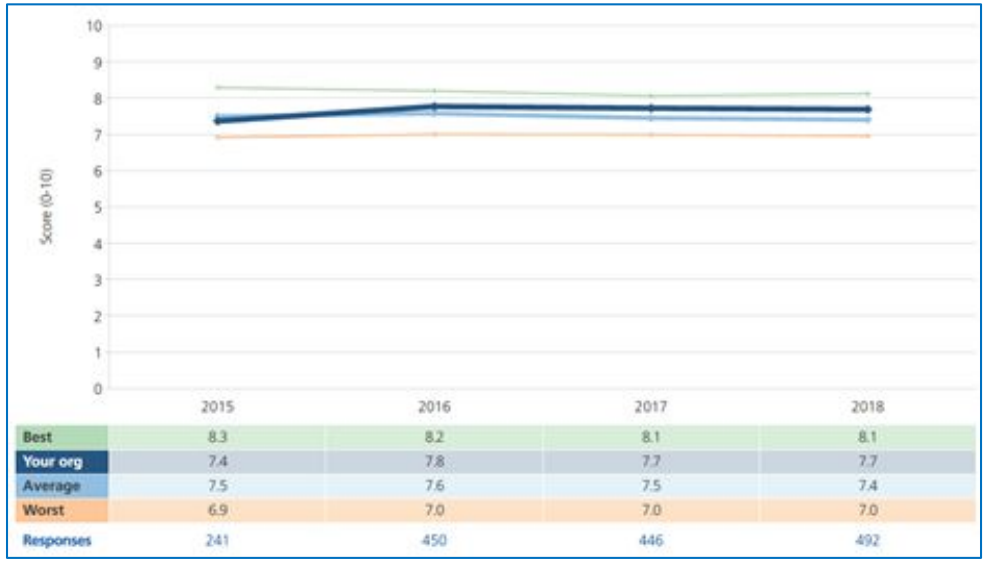
	2018
Best	6.7
Your org	5.7
Average	6.1
Worst	5.4
Responses	516

Quality of appraisals



	2015	2016	2017	2018
Best	6.1	6.3	6.4	6.5
Your org	5.2	5.6	5.6	5.8
Average	5.1	5.3	5.3	5.4
Worst	4.2	4.4	4.6	4.6
Responses	229	424	402	451

Quality of care

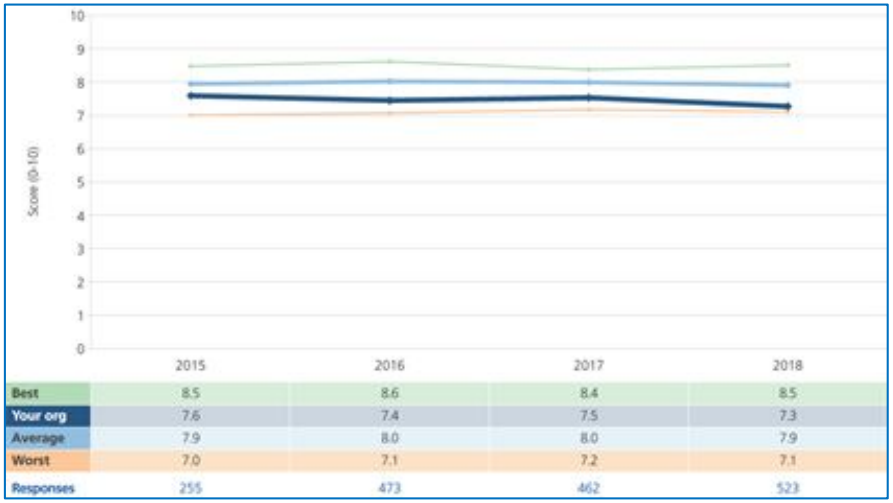


	2015	2016	2017	2018
Best	8.3	8.2	8.1	8.1
Your org	7.4	7.8	7.7	7.7
Average	7.5	7.6	7.5	7.4
Worst	6.9	7.0	7.0	7.0
Responses	241	450	446	492

Imperial College Healthcare NHS Trust

Survey themes: trend lines

Safe environment: B&H



	2015	2016	2017	2018
Best	8.5	8.6	8.4	8.5
Your org	7.6	7.4	7.5	7.3
Average	7.9	8.0	8.0	7.9
Worst	7.0	7.1	7.2	7.1
Responses	255	473	462	523

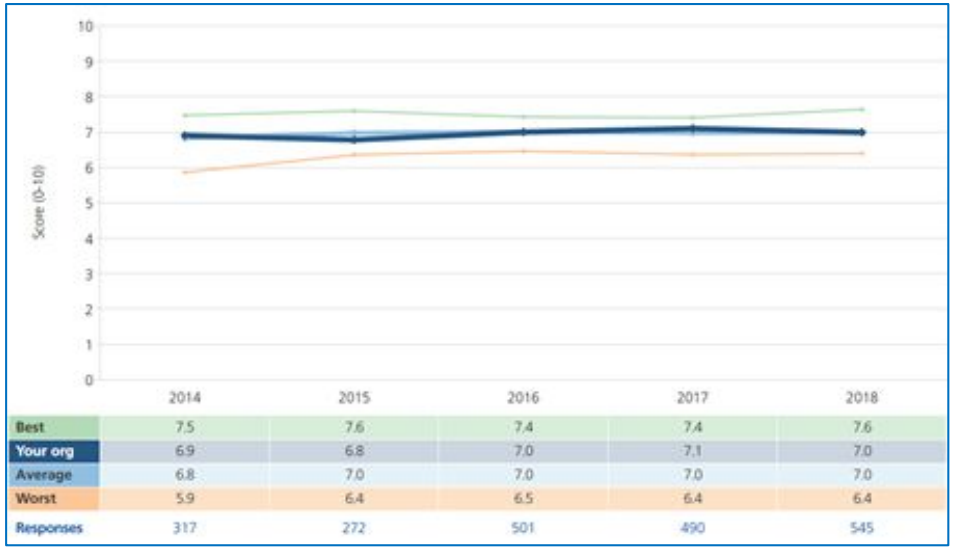
Safe environment: violence

	2015	2016	2017	2018
Best	9.6	9.7	9.6	9.6
Your org	9.4	9.4	9.3	9.3
Average	9.4	9.4	9.4	9.4
Worst	9.1	9.2	9.1	9.2
Responses	254	475	461	517

Safety culture

	2015	2016	2017	2018
Best	7.2	7.1	7.0	7.2
Your org	6.3	6.6	6.6	6.6
Average	6.5	6.6	6.6	6.6
Worst	5.9	6.0	5.9	6.0
Responses	258	483	466	523

Staff engagement



	2014	2015	2016	2017	2018
Best	7.5	7.6	7.4	7.4	7.6
Your org	6.9	6.8	7.0	7.1	7.0
Average	6.8	7.0	7.0	7.0	7.0
Worst	5.9	6.4	6.5	6.4	6.4
Responses	317	272	501	490	545

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Flu campaign 2018/19 – Review and way forward	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 27 March 2019	**Item 21, report no. 18**
Responsible Executive Director: Kevin Croft, Executive Director People and Organisation Development	**Author:** Bryan Joseph, Associate Director, Occupational Health and Safety

Summary:
This paper provides assurance on the Trust's 2018/19 flu campaign. It reviews the lessons learnt from that campaign and details how they will be incorporated into the arrangements for future flu campaigns, for which a 'business as usual' approach will be taken.

The key areas for the committee to note are:

- 60.2% of Trust staff received the flu vaccine (compared with 60.5% last year). This year, the (provisional) London-wide average for vaccine uptake is 62.9%, (compared with 63.5% last year);
- the budget for the flu campaign requires review to ensure it is delivering excellent value for money;
- strong visible management engagement at all levels is essential e.g. to lead by example and to support and address any concerns their teams may have. This should be complemented with a strong communication plan and high visibility of the campaign;
- the drive and ownership of the campaign needs to continue to sit within each division, with the Flu Campaign team providing support;
- staff have a number of misconceptions about flu, with over 1000 staff declining the vaccination. A key future focus will be on supporting line managers to address these concerns;
- standard management reports and summaries need to be agreed in advance, so they are in place for the start of the campaign. This will help teams to make informed decisions and identify priorities; and
- the 'NHS Improvement Best Practice' return submitted by the Trust.

Recommendations:
The Committee is asked to note the contents.

This report has been discussed at:
Quality Committee, March 2019

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

If additional costs are believed to be needed for next year's campaign, a suitable business case will be written.

Quality impact:
An effective flu campaign will ensure the health and safety of patients, Trust staff and workers and those others who use or interact with Trust services. Patients have not been engaged in developing this paper. This work concerns two CQC domains: Safe and Well-led.

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

Risk impact and Board Assurance Framework (BAF) reference:
There is no risk associated with flu on the Trust risk register. At this stage, none is thought to be required

Workforce impact (including training and education implications):
None. However, it should be noted that all staff peer vaccinators need to undertake annual training to deliver intra muscular injection. Currently, this impacts circa 140 staff in total.

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?
An effective flu vaccination campaign reduces the risk of people contracting flu (or, if they do contract flu, being incapacitated by flu), reduced flu transmission between individuals and leads to a healthier community than would otherwise be the case.

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

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

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

If the details can be shared, please provide the following in one to two-line bullet points:
What should senior managers know?
- Engaging fully with the annual flu campaign from campaign start will lead to a successful Trust campaign.
- Engagement with their team and discussing and addressing their staff concerns about the flu vaccine early is likely to lead to a high uptake of the vaccine.

What (if anything) do you want senior managers to do?
- Engage fully with the annual flu campaign from campaign start.
- Engage early and fully with their team and discuss and address their staff concerns about the flu vaccine.

Contact details or email address of lead and/or web links for further
- bryan.joseph@nhs.net

Should senior managers share this information with their own teams? ☒ Yes ☐ No
If yes, why? …to promote the flu campaign and to increase vaccine uptake

Flu Campaign 2018/19 – Review and way forward

1 EXECUTIVE SUMMARY

1.1 This paper reviews the Trust's Flu campaign 2018/19. It summarises the lessons learnt from that campaign and details how those lessons learnt will be translated into action and incorporated into the running of future campaigns, leading to consistent achievement of a staff vaccine rate of, at least, 75%. Also, those actions are designed to make annual delivery of the flu vaccine 'business as usual'.

1.2 This paper was developed through 1-2-1 interviews with those Imperial teams involved in the 2018/19 campaign. It incorporates discussion with and feedback from areas of poor take-up and with other Trusts; this has helped determine the changes that need to occur to enable the Trust to build and develop an improved trajectory and programme for subsequent campaigns and attain the current NHSe target of 75%.

1.3 Learning from previous campaigns, it is clear that planning needs to start in April, with a senior project Manager (PM) in place to drive the programme forward, for details see appendix 1- Project Plan 2019/20.

2 PURPOSE

2.1 This paper reviews the 2018/19 Flu campaign, highlighting the key lessons learnt, and details how those lessons learnt will be used in future campaigns to secure high staff vaccination rates and make organising and delivery of staff flu vaccination 'business as usual'.

3 BACKGROUND

3.1 An effective flu campaign results in high staff vaccination rates and ensures that staff do not contract flu. Also, it minimises sickness absence due to flu, reduces flu transmission between individuals and leads to a healthier community than would otherwise be the case.

4 SUMMARY/ KEY POINTS

Key Learning points

4.1 Key learning points concern:

(i) *Campaign start* - Planning for each annual campaign should start in April;
(ii) *Funding* - The campaign funding needs should be reviewed and a more accurate estimate compiled on the finance required for an effective campaign;
(iii) *Senior management engagement* – management at all level needs to be demonstrably engaged;
(iv) *Peer vaccinator support* – More peer vaccinators are required and those trained need to be fully utilised;
(v) *Communication* – a more effective and routine communication plan is required;
(vi) *Incentives* – Incentives for staff and peer vaccinators need agreement;
(vii) *Myth-busting* – More work on myth-busting is required; and
(vii) *Reporting* – A standard set of reports and their recipients should be agreed.

4.2 To minimise disruption to service delivery and secure high staff vaccination rates, the campaign needs to become 'business as usual' and a routine part of normal operations. The steps that need to be taken to achieve this are described, below, in paragraphs 4.15 to 4.18.

Campaign Start

4.3 Campaign planning and organisation needs to start from April. This includes the appointment of a Campaign Project Manager (PM) is in place to deliver the programme (see appendix 1- Project Plan 2019/20)

Funding

4.4 The budget for the flu campaign requires review to ensure it is delivering excellent value for money

Senior management engagement

4.5 The 2018/19 flu campaign demonstrated that strong operational management, divisional clinical leadership and a highly visible executive team presence is essential as a driving force to a successful flu campaign. The planning for the 2019/20 campaign will encompass a proactive approach between the flu campaign team the communications team and the senior teams to strength the engagement in the 2019/20 campaign.

Peer Vaccinators support

4.6 The 2018/19 campaign saw a drop in the number of trained and active peers, it is essential that we support this group in undertaking their role as flu vaccinators. Many of the peers undertake vaccinations in their own time, it is important that they are allocated protective time, with the time allocation agreed and managed locally.

Communication – Visibility of the campaign

4.7 Visibility and awareness of the campaign needs to be expanded for future years. Feedback highlighted that other Trust such as Georges, Kings and UCLH, is that Flu is a regular agenda item for meetings from executive forums to team's meetings and clinical handovers.

4.8 Visual reminders are seen to be key and range from posters that stand out from the crowd, banners and life size imagery. NHSe have a variety of flu aids that can be purchase with further investigation with "digital science" for strong flu imagery for the trust. Technology (blogs, tweets, screen savers) were used in the current campaign, however we need to be mindful that certain groups such as nurses have limited access to pcs, this is a communication area to be expanded upon for future campaigns.

Incentives

4.9 Incentives were considered as drivers for staff to have the vaccination which could include sweets and a slice of cake, first 'nn' receive a hot drink, which could be a weekly site event. The high end prizes given out in the last two campaigns were seen by staff as an end of campaign incentives for top peers/ wards etc. and could include £'nn' vouchers, an extra days holiday. Some peer vaccinators were purchasing incentives out of their pockets for their teams; the trust needs to look at how they compensated for this.

Planning and accountability

4.10 The weekly flu huddle is the central flu team and represents each division; it is pivotal to agreeing the campaign logistics and driving this forward within their divisions, roles and responsibility for this team should be clearly agreed at the commencement of the campaign.

Addressing Myths around the vaccination

4.11 Addressing myths and resistance to the vaccination needs to be positively addressed; Imperial has one of the highest decline rates among London trust. In another London trust (i.e. Georges) peers are equipped to discuss with staff their concerns; addressing myths during peer training can be expanded on; In addition, line managers at PDRs can discuss with their teams any concerns they may have and possible book a vaccination slot for them.

4.12 It is also important to note that staff currently have concerns about how their information on the flu consent form is used, especially if they decline the vaccination, this also needs to be addressed with any mythbuster discussions

Reporting

4.13 A standard set of reports needs to be agreed and readily available at the start of the campaign. For example, the Flu scorecard below identifies hotspots services where the campaign team will support and focus on in the early stages of the 2019/20 campaign addressing the myths and concerns staff has had with the vaccine during the current campaign. Similarly, reports need to be produced for a number of audiences e.g. the huddle / campaign team, Peer vaccinators, Executive Team, divisional management. The reports need to be easily compiled and disseminated through divisions to their teams.

4.14 Timings and content of all staff e-mails need to be agreed and dispatched at agreed points throughout the campaign.

BECOMING 'BUSINESS AS USUAL'

4.15 The organisation and delivery of staff flu vaccination needs to be achieved through the existing organisational management arrangements. So for example, managers, as part of their usual routine discussions with their staff, early in the year will identify a suitable time and place for staff to receive their vaccine flu vaccination. This discussion could take place, for example, during the PDR discussions at the beginning of the year. Such discussions would also present an opportunity to engage with those staff who are hesitant about having the vaccine.

4.16 The Flu Campaign team will support management (both collectively, e.g. the senior management team, and individually) by facilitating the provision on regular reports on staff vaccination rates, which can be used to help drive up compliance in areas of low take-up.

4.17 Typically, Flu campaigns appear to run each year from July to February, with the vast majority of flu vaccinations having been delivered by the end of November. Becoming 'business as usual' (BAU) would mean future campaigns should be run from April to November, with the period from November to formal campaign end being 'mop up'.

4.18 There would be 4 phases to a BAU approach to flu vaccination: (1) planning, engagement and education (2) scheduling (3) vaccination (4) DNAs and follow up. Some of the key actions performed during each of those phases are shown below. More detail can be found in the draft Project Plan at appendix 1

Planning, engagement and education (April to June)

- Setting up systems to enable mangers to review and book vaccination appointment, review data applications, and review communication options.
- OH developing training plans for peer vaccinators.
- Incentives agreed and procurement process started

Scheduling and Vaccination (*July through to September)*

- Managers start booking staff into vaccination appointments following 1-1 discussions.
- Communication and reporting timelines and process in place and signed off

Vaccination (September to November)

- Vaccines arrive in the Trust and are made available to vaccinators
- Staff vaccinations carried out.

DNAs and follow-up (November onwards)

- Mop up off any staff who have DNA'ed or deferred their vaccination

NHS IMPROVEMENT

4.19 In September 2018, NHS Improvement (NHSi) asked all NHS Trusts and NHS Foundation Trusts to publicly report information on frontline healthcare worker flu vaccination via their boards by early February 2019. There were four pieces of information Trusts were expected to publish:

(i) total flu vaccination uptake and opt-out numbers and rates;
(ii) a list of areas designated higher-risk and the uptake and opt-out rates for each;
(iii) details of actions taken to deliver the 100% uptake ambition; and
(iv) a breakdown of the reasons that staff have given for opting-out.

4.20 Although this deadline was not met, the Trust staff flu vaccination rate was reported widely throughout the campaign and displayed in prominent public places around the Trust e.g. in hospital receptions. Associated with the same NHSi request, by 5th March 2019 (which was before this Trust's campaign campaign end date, on 11th March 2019) Trusts were required to send NHSi a completed return on aspects of their flu campaign; this is attached at appendix 3.

5 OPTION APPRAISAL INCLUDING FINANCIAL APPRAISAL

5.1 Different options with different financial implications are not presented in this paper. However, the budget for the flu campaign should be reviewed to ensure its adequacy. The budget should include sufficient funding, at least, for the items listed below. The overall resources aspect of the campaign will be considered in more detail in the coming month:

- Incentives for staff that will be utilised throughout the campaign;
- Marketing/ communication material to build staff awareness and engagement into the campaign;
- Programme Manager and an administrator; and
- Any future apps that could be used for the campaign need to be clearly scoped;

6 CONCLUSIONS AND NEXT STEP

6.1 Continued strong executive support, movement of the campaign to BAU and early commencement of the flu campaign are essential to enable the Trust to have a successful campaign and attain the NHSe 75% target.

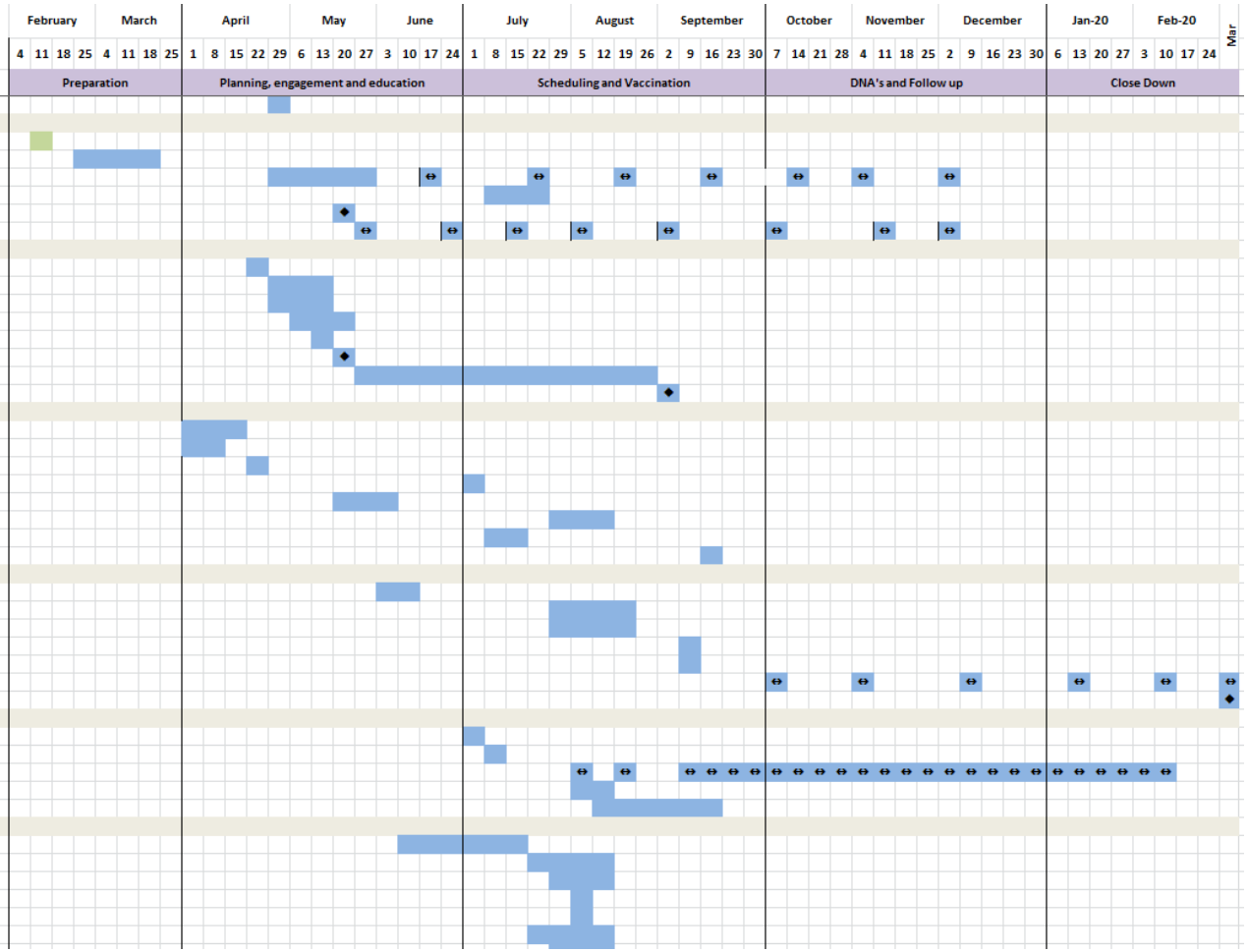
7 RECOMMENDATIONS

7.1 To note and support the recommendations of this report

APPENDIX 1
PROJECT PLAN FOR 2019/20

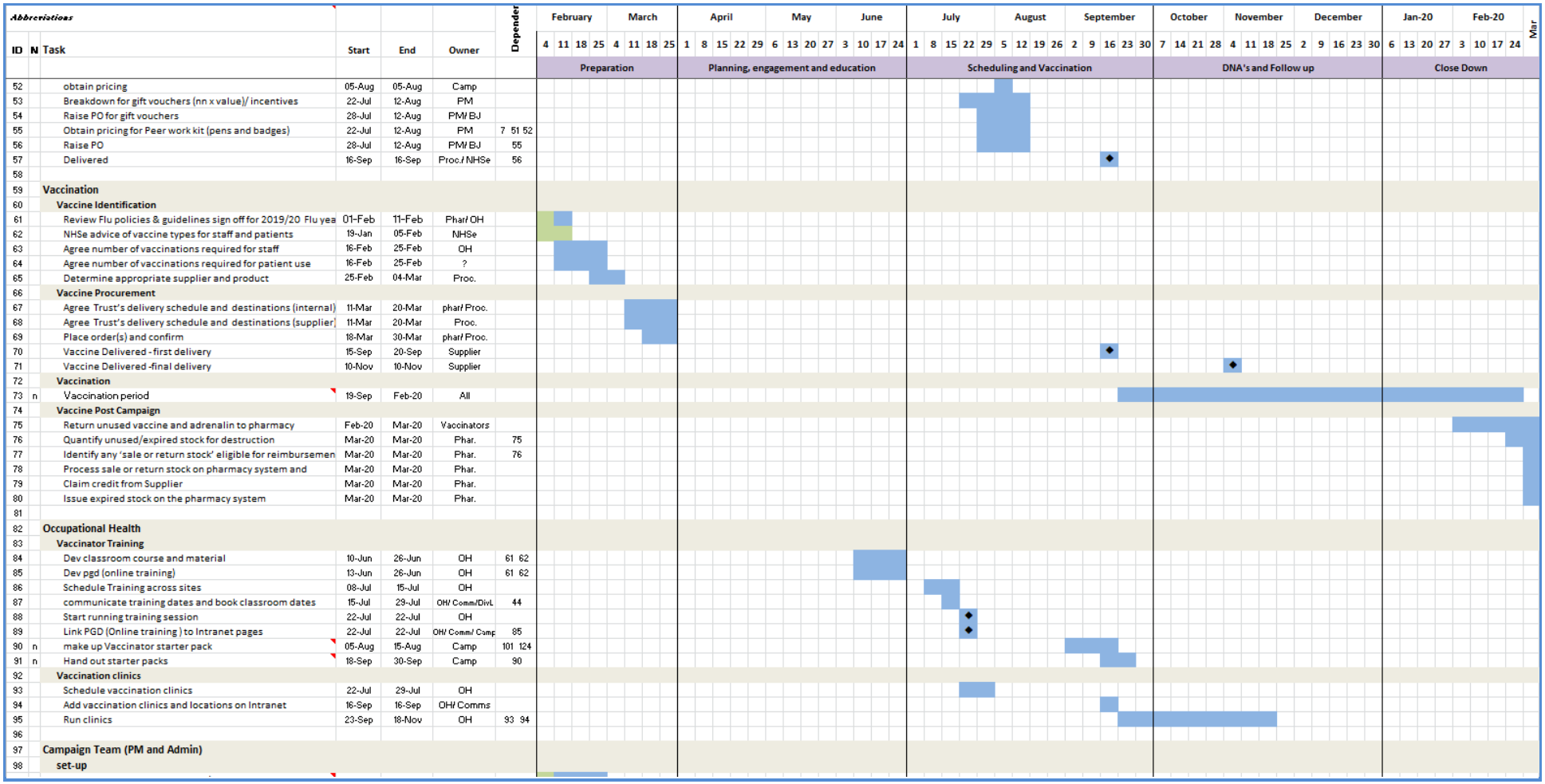
Abbreviations

ID	N	Task	Start	End	Owner	Dependen
7		Budget sign off Flu Campaign	29-Apr	30-Apr	Exec	6
8		**Learning Management System (LMS)**				
9		Investigate application for Flu bookings	11-Feb	11-Mar	BJ	
10		Review feasibility and process for bookings	25-Feb	18-Mar	BJ	9
11		Set-up vaccination events process	29-Apr	01-Dec	Camp	27
12		Link to Vaccinators bookings	08-Jul	22-Jul	Camp	28
13		Notify managers availability of LMS to book	17-Jun	22-Jun	Camp/ Comms	11
14		Line managers/ staff start book	27-May	01-Dec	Trust	
15		**Application**				
16		Review existing specification	20-Apr	22-Apr	Camp	27
17	n	Review data capture and exception options	29-Apr	13-May	Camp	
18		site visits other trust	29-Apr	13-May	Camp	
19	n	Agree core reports	06-May	20-May	Camp/BJ/KC	
20		Review data extraction for NHSe returns	10-May	15-May	DI Hub	
21		Sign off for development	20-May	20-May	Camp/BJ/KC	
22	n	Development/ AT	27-May	26-Aug	ICT	21
23		Sign off for use	02-Sep	02-Sep	Camp/BJ/KC	
24		**Staff**				
25		Write/ amend JD for PM and administration support	01-Apr	17-Apr	BJ	7
26	n	Agree base for Admin and PM (campaign team)	01-Apr	10-Apr	BJ	
27		Recruit & start PM	15-Apr	20-Apr	BJ	25
28		Recruit & start Admin	01-Jul	08-Jul	BJ	25
29		Write / amend IT and DI support requirements for campaign	20-May	03-Jun	BJ/ Camp	7
30	n	Agree IT/ DI Support for campaign period	01-Aug	12-Aug	KC	29
31		Write/ amend JD for Roaming Vaccinators	08-Jul	15-Jul	BJ/ CH	7
32		Recruit and start Roaming Vaccinators	16-Sep	20-Sep	CH/ PM	31
33		**Inclusions / Guidelines**				
34		Review campaign lessons learnt from 18/19 campaign	27-May	03-Jun	BJ/ KC/ KH	
35	n	IG Guidelines, data management sign off	30-Jul	19-Aug	BJ / PM	
36		Sign off who can be vaccinated (ISS, Sodexo etc.)	30-Jul	19-Aug	KC	
37	n	Communicate vaccination targets for 19/20 campaign	09-Sep	15-Sep	KC/ PM	
38		Obtain NHSe Inclusion/exclusion guidelines for denominato	26-Aug	02-Sep	BJ/ KC/ DIT	
39		Apply guidelines to NHSe submissions and benchmark data	07-Oct	01-Mar	DIT	38
40		Final sweep of Denominator/ numerator	11-Mar	11-Mar	PM/ DIT	
41		**Flu Campaign Team - Huddle**				
42		Agree core members & responsibilities of Flu huddle/ board	01-Jul	04-Jul	KC/ PM	
43		Book regular meeting (F2F and Conference calls)	08-Jul	11-Jul	PM	
44	n	Undertake regular huddle meetings - **LINK**	05-Aug	10-Feb	KC/ DivL/ PM	43
45		Agree roles and responsibilities of shop floor leads	05-Aug	15-Aug	DivL	44
46	n	Provide DI and Campaign team with contact details	15-Aug	16-Sep	DivL	45
47		**Incentives**				
48	n	Agree incentive types for 19/20 campaign	10-Jun	15-Jul	KC/ BJ	7
49	n	Negotiate with Sodexo and ISS coffee vouchers	22-Jul	12-Aug	PM, BJ	7 48
50		Obtain pricing for small treats (sweets)	29-Jul	12-Aug	Proc/PM	
51	n	Review NHSe flu aids (pens, lanyards, banners)	29-Jul	05-Aug	camp/BJ	
52		obtain pricing	05-Aug	05-Aug	Camp	
53		Breakdown for gift vouchers (nn x value)/ incentives	22-Jul	12-Aug	PM	



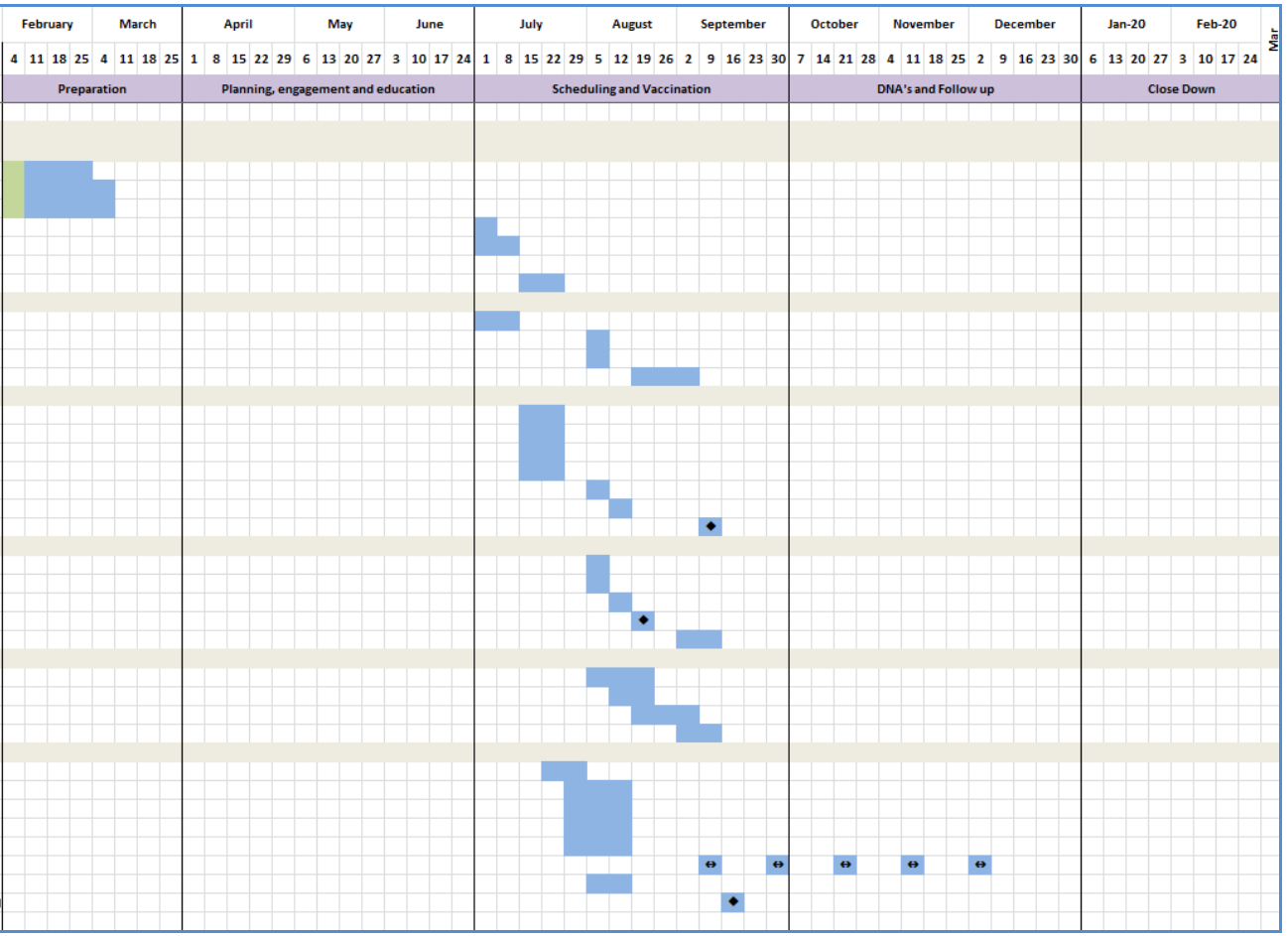
Abbreviations

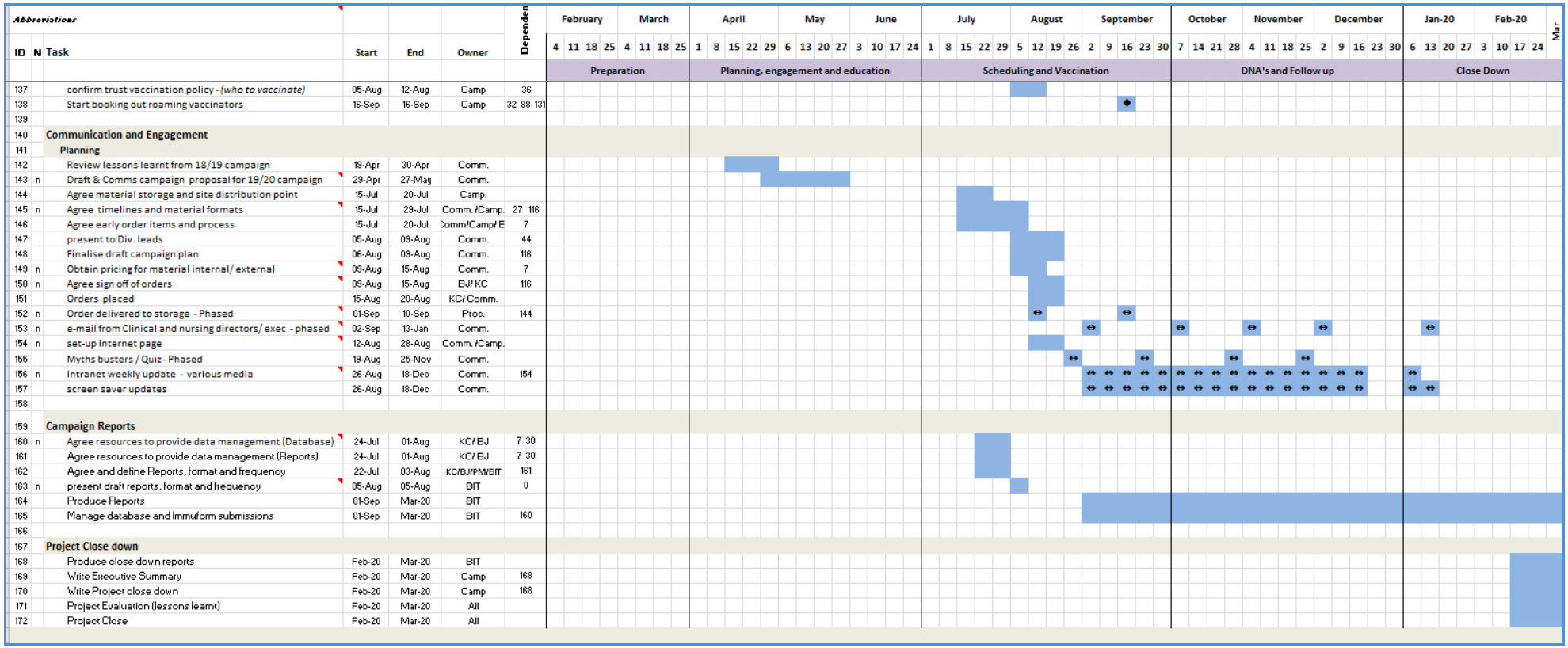
ID	N	Task	Start	End	Owner	Depender
52		obtain pricing	05-Aug	05-Aug	Camp	
53		Breakdown for gift vouchers (nn x value)/ incentives	22-Jul	12-Aug	PM	
54		Raise PO for gift vouchers	28-Jul	12-Aug	PM/ BJ	
55		Obtain pricing for Peer work kit (pens and badges)	22-Jul	12-Aug	PM	7 51 52
56		Raise PO	28-Jul	12-Aug	PM/ BJ	55
57		Delivered	16-Sep	16-Sep	Proc./ NHSe	56
58						
59		**Vaccination**				
60		**Vaccine Identification**				
61		Review Flu policies & guidelines sign off for 2019/20 Flu yea	01-Feb	11-Feb	Phar/ OH	
62		NHSe advice of vaccine types for staff and patients	19-Jan	05-Feb	NHSe	
63		Agree number of vaccinations required for staff	16-Feb	25-Feb	OH	
64		Agree number of vaccinations required for patient use	16-Feb	25-Feb	?	
65		Determine appropriate supplier and product	25-Feb	04-Mar	Proc.	
66		**Vaccine Procurement**				
67		Agree Trust's delivery schedule and destinations (internal)	11-Mar	20-Mar	phar/ Proc.	
68		Agree Trust's delivery schedule and destinations (supplier)	11-Mar	20-Mar	Proc.	
69		Place order(s) and confirm	18-Mar	30-Mar	phar/ Proc.	
70		Vaccine Delivered - first delivery	15-Sep	20-Sep	Supplier	
71		Vaccine Delivered -final delivery	10-Nov	10-Nov	Supplier	
72		**Vaccination**				
73	n	Vaccination period	19-Sep	Feb-20	All	
74		**Vaccine Post Campaign**				
75		Return unused vaccine and adrenalin to pharmacy	Feb-20	Mar-20	Vaccinators	
76		Quantify unused/expired stock for destruction	Mar-20	Mar-20	Phar.	75
77		Identify any 'sale or return stock' eligible for reimbursemen	Mar-20	Mar-20	Phar.	76
78		Process sale or return stock on pharmacy system and	Mar-20	Mar-20	Phar.	
79		Claim credit from Supplier	Mar-20	Mar-20	Phar.	
80		Issue expired stock on the pharmacy system	Mar-20	Mar-20	Phar.	
81						
82		**Occupational Health**				
83		**Vaccinator Training**				
84		Dev classroom course and material	10-Jun	26-Jun	OH	61 62
85		Dev pgd (online training)	13-Jun	26-Jun	OH	61 62
86		Schedule Training across sites	08-Jul	15-Jul	OH	
87		communicate training dates and book classroom dates	15-Jul	29-Jul	OH/ Comm/DivL	44
88		Start running training session	22-Jul	22-Jul	OH	
89		Link PGD (Online training) to Intranet pages	22-Jul	22-Jul	OH/ Comm/ Comp	85
90	n	make up Vaccinator starter pack	05-Aug	15-Aug	Camp	101 124
91	n	Hand out starter packs	18-Sep	30-Sep	Camp	90
92		**Vaccination clinics**				
93		Schedule vaccination clinics	22-Jul	29-Jul	OH	
94		Add vaccination clinics and locations on Intranet	16-Sep	16-Sep	OH/ Comms	
95		Run clinics	23-Sep	18-Nov	OH	93 94
96						
97		**Campaign Team (PM and Admin)**				
98		**set-up**				



Abbreviations

ID	N	Task	Start	End	Owner	Dependen
96						
97		**Campaign Team (PM and Admin)**				
98		**set-up**				
99	n	complete close down report 18/19	Jan-19	Feb-19	camp	
100		Write 2019/20 flu campaign project plan	Feb-19	Mar-19	camp	
101		Put 2018/19 campaign material into storage in OH	Feb-19	Feb-19	camp	
102	n	Set-up campaign base 2019/20	01-Jul	05-Jul	BJ/CH	27
103		Review 18/19 documentation	08-Jul	11-Jul	Camp	
104		Walk through database management	05-Aug	11-Aug	DIT/ Camp	
105	n	Source any equipment for the campaign	15-Jul	22-Jul	proc/ camp	
106		**Internal Communication set-up**				
107		check email address (getwinterready)	08-Jul	11-Jul	camp	
108		Develop intranet page	05-Aug	11-Aug	Comp/ Camp	
109		Set-up WhatsApp app group	05-Aug	11-Aug	Camp	
110	n	Set-up Peer communication format	23-Aug	07-Sep	Camp	
111		**Communication Documentation - NHSe**				
112	n	Determine material available through NHSe from 2019/20	15-Jul	22-Jul	Camp.	
113		Move stock into campaign storage	15-Jul	22-Jul	Camp.	
114		Stock take useable material from 2018/19 campaign	15-Jul	22-Jul	Camp.	
115		Determine what material is required for what	15-Jul	22-Jul	Camp/ comp	99 145
116	n	Complete NHSe order and sign off	05-Aug	05-Aug	Camp.	150
117		Submit order request to NHSe	12-Aug	12-Aug	e4	
118		Delivered	01-Sep	01-Sep	NHSe	
119		**Vaccinator Kit**				
120		Agree clinical kit to be ordered for vaccinators	05-Aug	11-Aug	OH/ PM	
121	n	Agree storage and vaccinator collection points	05-Aug	11-Aug	PM/OH	
122		compile kit order for vaccinators	12-Aug	18-Aug	PM	
123		Sign off and process order	19-Aug	19-Aug	BJ	
124		Kit delivered	02-Sep	03-Sep	Proc	123 121
125		**Buddy System - *(New)***				
126		Obtain a list of active 18/19 vaccinators	05-Aug	22-Aug	Camp/ DIT	
127		determine their plans for peer vaccination 19/20	12-Aug	24-Aug	Camp/ DivL	
128	n	Identify Buddies	24-Aug	05-Sep	Camp/ DivL	
129	n	Offer new vaccinators an option of a buddy	05-Sep	12-Sep	OH/Camp	
130		**Roaming Vaccinators Bookings**				
131		Set-up Roaming vaccinator booking sheets	22-Jul	29-Jul	Camp	
132	n	contact Exec PAs to link vaccinators to meetings	29-Jul	12-Aug	Camp	
133		Identify & book training dates to attend	29-Jul	12-Aug	Camp	
134		Identify and book other events to attend	29-Jul	12-Aug	Camp	
135		Identify Great Place to work dates	29-Jul	12-Aug	Camp	
136		Announce Roaming vaccinators availability for bookings	09-Sep	30-Dec	Camp	
137		confirm trust vaccination policy - *(who to vaccinate)*	05-Aug	12-Aug	Camp	36
138		Start booking out roaming vaccinators	16-Sep	16-Sep	Camp	32 88 131
139						





Abbreviations

ID	N	Task	Start	End	Owner	Dependen
137		confirm trust vaccination policy - *(who to vaccinate)*	05-Aug	12-Aug	Camp	36
138		Start booking out roaming vaccinators	16-Sep	16-Sep	Camp	32 88 131
139						
140		**Communication and Engagement**				
141		**Planning**				
142		Review lessons learnt from 18/19 campaign	19-Apr	30-Apr	Comm.	
143	n	Draft & Comms campaign proposal for 19/20 campaign	29-Apr	27-May	Comm.	
144		Agree material storage and site distribution point	15-Jul	20-Jul	Camp.	
145	n	Agree timelines and material formats	15-Jul	29-Jul	Comm. /Camp.	27 116
146		Agree early order items and process	15-Jul	20-Jul	Comm/Camp/ E	7
147		present to Div. leads	05-Aug	09-Aug	Comm.	44
148		Finalise draft campaign plan	06-Aug	09-Aug	Comm.	116
149	n	Obtain pricing for material internal/ external	09-Aug	15-Aug	Comm.	7
150	n	Agree sign off of orders	09-Aug	15-Aug	BJ/ KC	116
151		Orders placed	15-Aug	20-Aug	KC/ Comm.	
152	n	Order delivered to storage - Phased	01-Sep	10-Sep	Proc.	144
153	n	e-mail from Clinical and nursing directors/ exec - phased	02-Sep	13-Jan	Comm.	
154	n	set-up internet page	12-Aug	28-Aug	Comm. /Camp.	
155		Myths busters / Quiz - Phased	19-Aug	25-Nov	Comm.	
156	n	Intranet weekly update - various media	26-Aug	18-Dec	Comm.	154
157		screen saver updates	26-Aug	18-Dec	Comm.	
158						
159		**Campaign Reports**				
160	n	Agree resources to provide data management (Database)	24-Jul	01-Aug	KC/ BJ	7 30
161		Agree resources to provide data management (Reports)	24-Jul	01-Aug	KC/ BJ	7 30
162		Agree and define Reports, format and frequency	22-Jul	03-Aug	KC/BJ/PM/BIT	161
163	n	present draft reports, format and frequency	05-Aug	05-Aug	BIT	0
164		Produce Reports	01-Sep	Mar-20	BIT	
165		Manage database and Immuform submissions	01-Sep	Mar-20	BIT	160
166						
167		**Project Close down**				
168		Produce close down reports	Feb-20	Mar-20	BIT	
169		Write Executive Summary	Feb-20	Mar-20	Camp	168
170		Write Project close down	Feb-20	Mar-20	Camp	168
171		Project Evaluation (lessons learnt)	Feb-20	Mar-20	All	
172		Project Close	Feb-20	Mar-20	All	

APPENDIX 2
REPORTS FROM THE 2018/19 CAMPAIGN

Weekly Cumulative vaccination rates

1. This diagram shows the weeks where frontline staff vaccinations were undertaken and a week-on-week cumulative total. By the middle of December (week 14) you can see a noticeable slowdown in the number of vaccinations undertaken, for this reason it is essential that future campaigns are planned well in advance and plans are ready to be mobilised as soon as the vaccination arrives into the Trust (mid/end September).

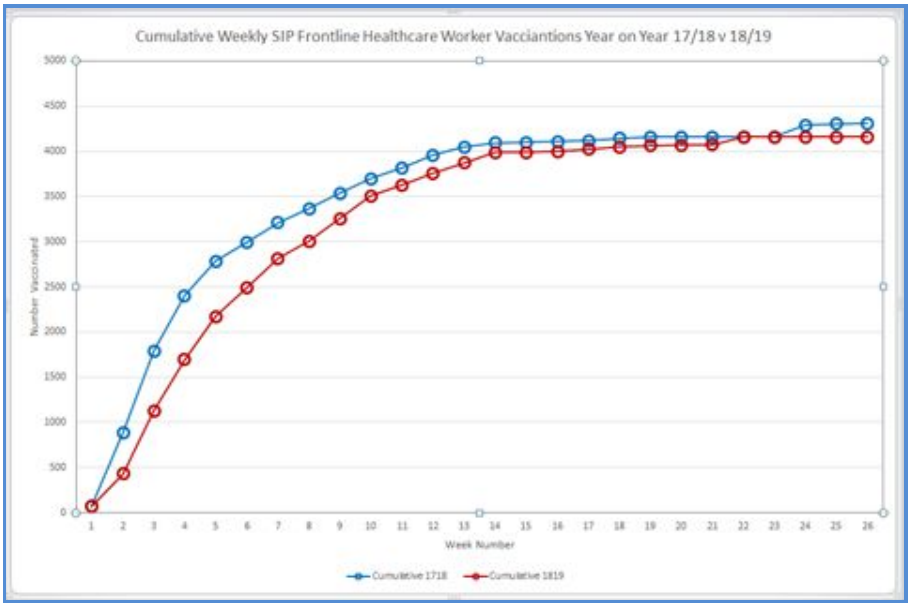


Diagram 1: Weekly staff cumulative vaccination rate

NHSe monthly submission Data on staff vaccination rate			
	2017/18	2018/19	Month on month comparison
Oct	32.3%	26.5%	▼
Nov	42.7%	45.2%	▲
Dec	50.1%	49.8%	▼
Jan	52.2%	53.3%	▲
Feb	60.5%	60.2%	▼

Table 1: ICHNT staff vaccination rates reported to NHS England

2017/18 and 2018/19 staff vaccination rates in London NHS Trusts

3. This year's Trust uptake is similar to last year's uptake. Compared to the other London Trusts, Imperial College NHS Trust has a lower then average staff vaccination rate (the provisional figure for a London average is 62.9%).

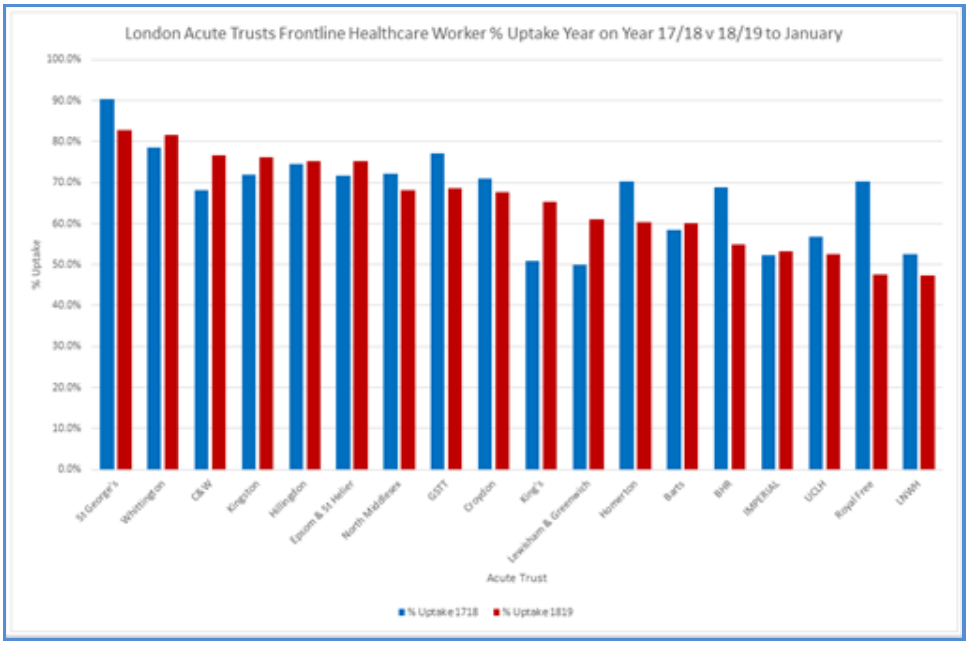


Diagram 2: Vaccine take-up by London NHS Trusts, 2017/18 and 2018/19

Staff declination rate by (London-wide) Trust

4. The number of frontline healthcare workers declining the vaccine, by London-wide Trust (as at mid-February 2019), is reported below.

Org Name	Additional HCW information	
	No. of HCWs with Direct Patient Care offered the vaccine but declined	%
NHS ENGLAND LONDON HCWs	800	33.0
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	149	29.4
BARTS HEALTH NHS TRUST	3180	26.3
NORTH EAST LONDON NHS FOUNDATION TRUST	941	22.9
CROYDON HEALTH SERVICES NHS TRUST	570	21.3
EAST LONDON NHS FOUNDATION TRUST	825	17.4
THE ROYAL MARSDEN NHS FOUNDATION TRUST	632	17.3
LONDON AMBULANCE SERVICE NHS TRUST	567	14.1
HOUNSLOW AND RICHMOND COMMUNITY HEALTHCARE NHS TRUST	113	14.1
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	600	13.7
KINGSTON HOSPITAL NHS TRUST	297	12.6
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	411	12.2
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	223	11.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1064	11.9
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	155	11.7
BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	261	10.8
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	551	10.7
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	504	10.5
ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	268	9.6
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	80	8.1
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	156	6.4
CENTRAL LONDON COMMUNITY HEALTHCARE NHS TRUST	194	6.3
THE WHITTINGTON HEALTH NHS TRUST	169	5.9
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	460	5.4
ROYAL FREE LONDON NHS FOUNDATION TRUST	407	4.7
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	102	4.7
CAMDEN AND ISLINGTON NHS FOUNDATION TRUST (Trust based)	60	4.5
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	486	4.4
LEWISHAM AND GREENWICH NHS TRUST	198	3.3
CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	121	3.2
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	266	2.9
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	75	1.9
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	71	1.0
OXLEAS NHS FOUNDATION TRUST	25	0.9
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	2	0.1
ST GEORGE'S HEALTHCARE NHS TRUST	0	0.0
WEST LONDON MENTAL HEALTH NHS TRUST	0	0.0

Table 2: Staff declination rate, by London-wide NHS Trust

Vaccination uptake by division

5. The number of frontline healthcare workers receiving the vaccine, by division, is reported below.

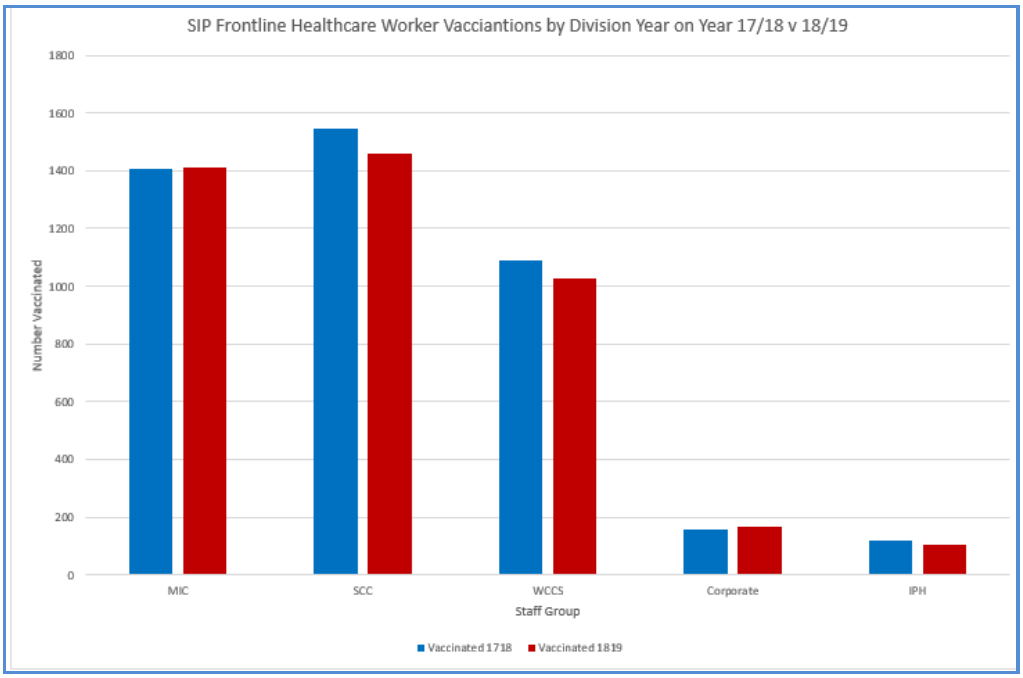


Diagram 3: Vaccine take-up by division, 2017/18 and 2018/19

STAFF VACCINATED (BROKEN DOWN BY TRUST DIVISION)						
	VACCINATED	REFUSED	NOT CONTACTED	TOTAL STAFF	% VACCINATED	% REFUSED
MIC	1049	321	924	2654	53.1%	12.1%
SCC	1457	442	1220	3119	46.7%	14.2%
WCCS	1028	253	693	1974	52.1%	12.8%
IPH	106	64	21	191	55.5%	33.5%
Total	3640	1080	2858	5284	51.8%	18.5%

Table 3: Staff vaccination rates by Division

'Not contacted' includes staff who did not want to complete a consent form, due to concerns a negative response may have.

Vaccination rate by Division and directorate

6. The table below reports on the vaccine take-up by division, from November to date (17th February).

	% VACCINATED				
	TOTAL STAFF @ 04/01/2019	14-NOV	11-DEC	11-JAN	17-FEB
MIC DIVISION					
MIC Div Management	12	28.6%	66.7%	66.7%	60.0%
Integrated Care	357	44.8%	64.3%	68.9%	70.0%
HIV, Sexual health &	137	41.2%	66.2%	69.3%	75.4%
CXH Acute and Specialist	470	31.0%	45.3%	47.2%	52.7%
SMH Acute and Specialist	339	28.6%	41.3%	44.2%	45.9%
Urgent care	356	33.7%	40.8%	49.7%	52.4%
Neuro & Stroke	271	23.3%	40.7%	41.7%	45.2%
HH Specialist Med	224	22.4%	34.8%	36.6%	44.4%
Renal	528	19.9%	35.8%	44.1%	49.1%
TOTAL	2694	29.7%	44.7%	49.2%	53.1%
SCC DIVISION					
SCC Divisional	14	85.7%	92.9%	92.9%	92.9%
Critical Care	440	16.2%	50.0%	56.8%	58.4%
Oncology& Palliative	308	37.7%	49.0%	50.6%	52.4%
Clinical Heam	205	31.4%	44.6%	49.3%	52.7%
Ophthalmology	143	25.0%	37.8%	48.3%	50.4%
Cardiac	490	26.6%	44.3%	45.7%	47.0%

	% VACCINATED				
	TOTAL STAFF @ 04/01/2019	14-NOV	11-DEC	11-JAN	17-FEB
Corp Cancer	79	23.1%	44.3%	44.3%	48.1%
General & vascular	293	20.6%	38.9%	43.0%	44.9%
Theatres Anaesthetics &	635	16.7%	38.3%	39.2%	40.5%
Speciality Surgery	318	21.9%	34.9%	36.1%	40.3%
Trauma	271	20.2%	33.2%	34.7%	35.5%
TOTAL	3196	23.1%	41.9%	44.8%	46.7%
WCCS					
Pathology Residual	2	100.0%	100.0%	100.0%	100%
WCCs Div. Management	2	100.0%	100.0%	100.0%	100%
Children Services	519	42.4%	59.7%	62.8%	66.0%
Pharmacy	196	49.2%	56.6%	61.7%	65.5%
Imaging	439	30.5%	44.6%	47.4%	46.6%
Outpatients	89	38.9%	43.8%	44.9%	52.2%
Gynaecology & repro	209	16.4%	42.1%	43.1%	48.5%
Maternity	541	13.2%	32.4%	36.0%	39.4%
TOTAL	1997	29.9%	46.2%	49.3%	52.1%
IPH					
Hammersmith PP	35	\	45.7%	57.1%	63.2%
Lindo Wing	96	\	42.7%	55.2%	53.5%
Charing Cross Hospital	33	\	40.6%	51.5%	50.0%
IPH Management	24	\	45.8%	50.0%	60.0%
TOTAL	188	\	43.3%	54.3%	55.5%

NHSE RAG RATING		
<45%	>45%	75%>

Table 4: Staff vaccination rates by Division and directorate

Peer vaccinators and vaccination rate, a breakdown of active peer vaccinators for the last two campaigns

7. The diagram below shows the number of staff immunised by peer vaccinators in both 2017/18 and 2018/19

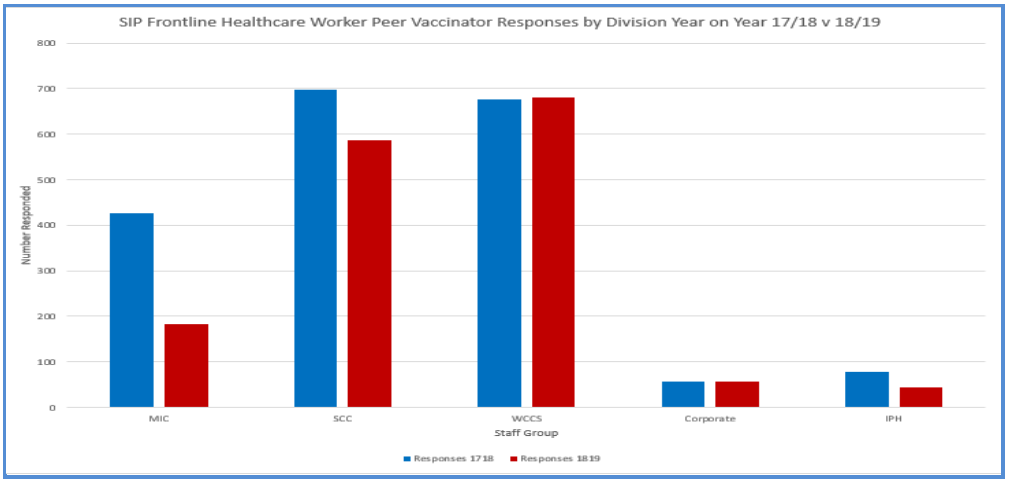


Diagram 4: number of staff immunised by peer vaccinators in both 2017/18 and 2018/19

	% Staff non-responders*	Peer vaccinated 2017/18	Peer Vaccinated 2018/19	Notes
MIC	35%	427	182	Despite MIC seeing a large drop in peers, their vaccination rate remains constant see ("Vacation Rate by Division" above), this was archived by a focused efforts by the roaming vaccinators
SCC	39%	697	586	SCC also saw a drop in Peer vaccinations and also had a reduction of circa 100 vaccinations
WCCS	35%	1087	1028	WCCS had the most active peer vaccinators, but overall the division vaccination rate has dropped
IPH	11%	79	45	For IPH the drop in vaccination take up also reflects the decline in peer vaccinators.

Table 5: Staff vaccination numbers by peer vaccinators 2017/18 and 2018/19
**Non-responders are those staff who have either refused to complete a consent form or not been offered a flu vaccination.*

Appendix 3

NHS Improvement – Vaccination of Healthcare Workers

NHSi Best Practice

This is the Healthcare worker flu vaccination best practice management NHSi checklist – for public assurance via trust boards by December 2018

In order to ensure our organisation is doing everything possible as an employer to protect patients and staff from seasonal flu, NHSi has asked that we complete the best practice management checklist (below) for healthcare worker vaccination

For numbers in the table in bracket see the reference links at the bottom of this table.

NHSI BEST PRACTICE MANAGEMENT CHECK LIST		
	MEASURES	TRUST SELF-ASSESSMENT
A	**COMMITTED LEADERSHIP**	
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	The Trust set itself a target uptake of 75% (the national CQUIN Top Tier target) which was felt to be a challenging, but realistic target improvement from the previous 2 years of 60% (2017) and 35% (2016). Reasons for declination were captured, reported and acted upon through the campaign.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	Quadrivalent (QIV) vaccine was ordered for all healthcare workers and was made available to staff from date of delivery
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	A close down and evaluation report has been written for the end of March Trust Board on 2018/19 campaign that completes on 1st March 2019. The Trust Board report includes data analysis, lessons learnt and approach to addressing these challenges in 2019.
A4	Agree on a board champion for flu campaign (3,6)	The board champion for the 2018/19 campaign is Kevin Croft - Director of People and Organisation Development
A5	Agree how data on uptake and opt-out will be collected and reported	Both opt in and out data was collected via Flu consent forms. Information was centrally consolidated into a database with weekly dashboards and cost centre reports disseminated through to the management teams, from the central Flu campaign team. Executive weekly updates were provided to the Trust Executive Team Meeting and updates provided to the Trust Board.
A6	All board members receive flu vaccination and publicise this (4,6)	The flu vaccination was given to board members at the end of board meetings during the flu campaign Publicity from this was used to support and reinforce the communication strategy for the wider campaign, for example imagery of board members being vaccinated on the Trust intranet page and via twitter.

NHSI BEST PRACTICE MANAGEMENT CHECK LIST		
	MEASURES	**TRUST SELF-ASSESSMENT**
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	A Flu team was formed in August and included representatives from each clinical division, including communications, data team and pharmacy. A union representative was not part of the core team but discussions and updates took place with staff representatives and union officials through the Trust's Partnership Committee. **T**he group was a cross section of Nurses, clinicians, therapist, managers, pharmacists and occupational health. .
A8	Flu team to meet regularly from August 2018 (4)	The flu team (Huddle) met on a weekly basis from late August 2018
B	**COMMUNICATIONS PLAN**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Multiple communications – both physical, verbal and electronic - went out to staff, including from the Chief Executive and clinical leaders outlining the importance of the vaccination. Myth busting information was shared through divisional/clinical teams as well as used by peer and roaming vaccinators when staff were reluctant to take the vaccine. Myth information was regularly refreshed on the intranet to maintain engagement.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	OH provided drop in clinics across the trust 3 main sites. Roaming vaccinators provided vaccinations at satellite sites and provided drop in clinics on specific wards/ theatres and clinics. Peer vaccinators also provided vaccination opportunities among their teams. These were promoted through electronic media. Staff had the opportunity for roaming vaccinators to attend at the end and start of shifts to enable night shift staff to be vaccinated.
B3	Board and senior managers having their vaccinations to be publicised (4)	Images of senior staff being vaccinated were visible and published through • Dedicated intranet page • in brief newsletter • Screen savers
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	All staff clinical and non-clinical had the opportunity to have the vaccination at their induction day. Clinical teams were offered vaccinations as part of their OH assessment.
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	Programme was published on the following • Twitter • Intranet page • Screen savers • Posters
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	Management reports and dashboard were discussed and presented at the weekly Flu team meeting and circulated to divisional teams weekly. In addition, updates were provided to the executive at the Executive People and Organisational Development Committee (ExPOD) and weekly Executive Team Meeting (ETM) meetings
C	**FLEXIBLE ACCESSIBILITY**	

NHSi Best practice management check list		
	Measures	**Trust self-assessment**
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	Peer vaccinators were locally identified and trained, in both the vaccine and myths. Over one hundred peer vaccinators were trained to support a central team of 3 roaming vaccinators.
C2	Schedule for easy access drop in clinics agreed (3)	Clinics were set-up at each site and undertaken by the OH team. The schedule for these were published on the intranet and promoted to divisional and directorate teams. These clinics were available throughout the campaign. In addition, line managers could book a roaming vaccinator to attend their area providing a dedicated service to their team.
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	Opportunities for vaccinations at the night shift handover were provided in a number of areas including ED, Paediatrics and Maternity
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this (3,6)	Incentives were agreed as a drive for December take up Weekly winners were published on the intranet
D2	Success to be celebrated weekly (3,6)	Names of weekly winners were published on the intranet. Large posters were placed at the front of each of our hospitals showing a league table of best performers. Awards were given and promoted for most improved department.

Reference links

1. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Vaccine-ordering-for-2018-19-influenza-season-06022018.pdf?la=en&hash=74BF83187805F71E9439332132C021EFA3E6F24C
2. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/Reviewing-your-campaign-a-flu-fighter-guide.pdf
3. http://www.nhsemployers.org/-/media/Employers/Documents/Flu/Flu-fighter-infographic-final-web-3-Nov.pdf
4. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-acute-trusts-TH-formatted-10-June.pdf
5. http://www.nhsemployers.org/-/media/Employers/Publications/Flu-Fighter/good-practice-ambulance-trusts-TH-formatted-10-June.pdf
6. https://www.nice.org.uk/guidance/ng103/chapter/Recommendations

VACCINATION UP TAKE FOR HIGH RISK AREA

"Vaccination take up for these areas should work towards 100% take up, with medical and nurse directors working with union representatives to undertaking appropriate risk assessment where staff have declined the vaccination and to determine how best to respond to this."

DETAILS REQUESTED

report their performance on overall vaccination uptake rates and numbers of staff declining the vaccinations

To include details of rates within each of the areas you designate as 'higher-risk'

	VACCINATED	DECLINED	NOT RESPONDED	TOTAL STAFF	% UPTAKE
Haematology (clinical haematology)	107	32	62	201	53.2%
Oncology (cancer specialty)	100	30	54	184	54.3%
Bone Marrow Transplant (paeds haematology)	15	0	4	19	78.9%
Neonatal Intensive Care	108	2	54	164	65.9%
Special Care Baby Unit	as above	as above	as above	as above	as above
Critical Care *	251	78	101	430	58.4%
Maternity *	214	92	232	538	39.8%
Paediatrics *	218	4	101	323	67.5%
Care of the elderly *	58	6	41	105	55.2%
Respiratory *	79	1	16	96	82.3%

* Locally identified, all other specialities are NHSi identified.

High Risk Areas - Actions taken

The trust formed a Flu campaign team (huddle) which was represent from all clinical areas of the Trust, the team meet weekly and review divisional management reports and up take trends to determine where focus and support was needed to improve the services vaccination position.

- It was essential that services acted upon this data to address area of low take up.

Local leadership and engagement was seen as key to help drive up the vaccination rates. With poor performing areas discussed at the weekly flu team meetings.
With each flu lead asked to provide updates on how they planned to address low take up areas

The communication programme and our occupational health team addressed myths with different modes of communication ranging from covering myths with peer vaccinators at their training sessions, intranet updates, screen savers, blogs and posters.

- We were particular focused on confronting the myths and opt our reasons out lined in the diagram below.

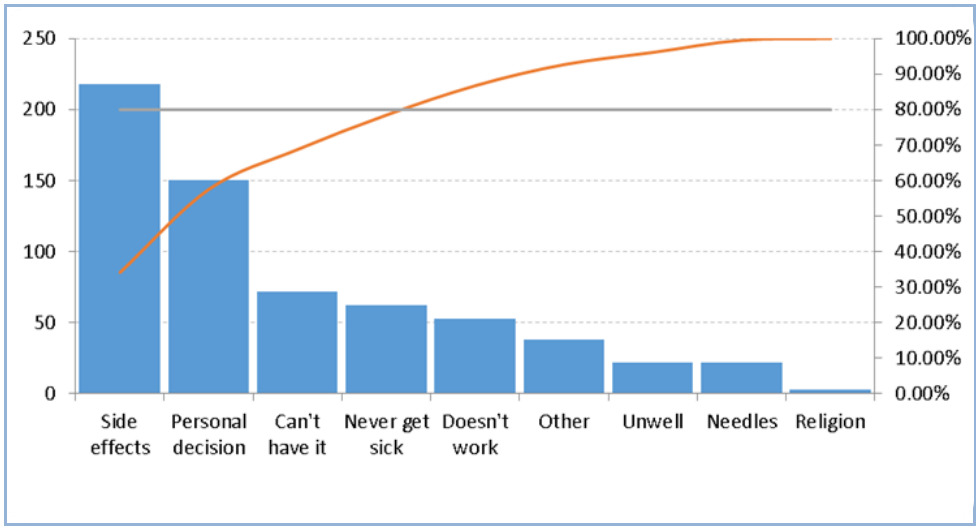
It was seen as important to provide staff with a number of opportunities to undertake the vaccination as possible, these included:

- Utilising roaming vaccinators to undertake vaccinations at staff handovers, this allowed nightshift staff to be vaccinated at the end of their shift but also day staff to have their vaccination.
  - Timings of these events were booked in advance with the ward managers
- Peer vaccinators ran their own local clinics and published when they would be available to their teams
- Occupation health ran drop in clinics on all sites so that staff could obtain their vaccination at times that was most suitable for them.

Incentives were available for top wards and peer vaccinator to encourage competition between wards, clinical areas and peers.

OPT OUT REASON

These are the opt out reasons are for healthcare workers across the Trust and incorporate the “high risk areas”



There were a further 704 members of staff who did not provide a reason for opting out of the flu vaccination.

TOTAL FLU VACCINATION UPTAKE AND OPT OUT NUMBERS

NHSe submission as at 11th February 2019

Denominator	8974
Vaccinated	4779
Declined	1064
Up take	53.3%

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: EU Exit – Update on operational readiness in the event of "no deal".	☐ Approval ☒ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27th March 2019	**Item 22, report no. 19**
Responsible Executive Director: Claire Hook, Director of Operational Performance	**Author:** Merlyn Marsden, Hospital Director

Summary:

To inform preparations in the event of a "no deal" EU Exit, all NHS organisations have been requested to undertake local EU Exit readiness planning, local risk assessments and to consider wider potential impacts.

The Department of Health and Social Care (DHSC) has issued guidance to support this process and appointed Keith Willet, Medical Director for NHS England, as the EU Exit Strategic Commander who is leading the preparations and readiness.

The ICHT Senior Responsible Officer (SRO) for EU Exit, Claire Hook has formed a working group with representatives from across the Trust to oversee our preparations for EU Exit. The group is coordinating the work that is happening Trust-wide to ensure we understand, and are able to respond to, the impact of a "no deal" EU Exit scenario.

A national Operational Response Centre (ORC) has been set up which will lead the response to any disruption to the delivery of health and care services across England and will work with devolved administrations. The ORC will also co-ordinate information flows, reporting and enable rapid support and response to emerging issues via an Operational Support Structure (OSS) which for ICHT will be the London OSS.

The purpose of this paper is to share the preparations that we are taking alongside NHS England and DHSC to ensure that guidance is followed where applicable and to provide assurance that our actions are appropriate and proportionate to respond to the outcome of an EU Exit with "no deal".

Recommendations:

The Board is asked to:

- Note the planning, preparation and response to a no deal EU Exit;
- Note the risk associated with significant disruption to the continued provision of service in the event of a "no deal" EU exit has a score of 8; and
- Support a response to a no deal EU Exit should it be required.

This report has been discussed at:

☒ EU Exit working group
☒ Executive Finance Committee

Quality impact:

This paper relates to the CQC domains of safe, responsive, effective and well-led. The potential impact on quality has been considered as part of the overall risk assessment.

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:
The risk associated with significant disruption to the continued provision of service in the event of a "no deal" EU exit has been added to the risk register for the Division of Operational Performance. This risk is assessed as having a score of 8.

Workforce impact (including training and education implications):
The workforce implications have been considered as part of the overall risk assessment.

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

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

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?
  A working group has been formed with representatives from across the Trust to oversee our preparations in the event of a "no deal" EU exit.

  Led by Claire Hook, director of operational performance, the group is coordinating the work that is happening Trust-wide to ensure we understand, and are able to respond to, the impact of EU exit in a "no deal" scenario.

  While there is still a lot of uncertainty, the group has reviewed the guidance that has been received from the Department of Health and is sharing this information via the Divisional teams.

  European Union staff are reminded that the EU Settlement Scheme process will open to everybody by 30th March 2019 and as announced by Prime Minister Theresa May there is no fee associated with this application.

- Contact details or email address of lead and/or web links for further information:
  Claire Hook, Director of Operational Performance claire.hook@nhs.net

- Should senior managers share this information with their own teams? ☒ Yes ☐ No

1. Background

In the event of a “no deal” EU Exit, all NHS organisations have been requested to undertake local EU Exit readiness planning, local risk assessments and to plan for wider potential impacts.

The Department of Health and Social Care (DHSC) has issued guidance to support this process and appointed Keith Willet, Medical Director for NHS England, as the EU Exit Strategic Commander who is leading the preparations and readiness.

ICHT Senior Responsible Officer (SRO) for EU Exit, Claire Hook, has formed a working group with representatives from across the Trust to oversee our preparations for EU Exit. The group is coordinating the work that is happening Trust-wide to ensure we understand, and are able to respond to, the impact of a “no deal” EU Exit scenario.

A national Operational Response Centre (ORC) has been set up which will lead the response to any disruption to the delivery of health and care services across England and will work with devolved administrations. The ORC will also co-ordinate information flows, reporting and enable rapid support and response to emerging issues via an Operational Support Structure (OSS) which for ICHT will be the London OSS.

ICHT is working with NHS England and DHSC to ensure that guidance is followed where applicable and this is achieved through our working group members.

2. NHS Planning & Preparation

All NHS organisations have been asked to focus on EU Exit readiness planning, local risk assessments and to consider wider potential impacts.

Specifically, providers were required to undertake an assessment of risks associated with EU Exit by the end of January 2019 and to test existing business continuity and incident management plans against EU Exit risk assessment scenarios by the end of February 2019.

It was recommended that the risk assessment and subsequent planning covered the following areas of activity across the health and care system:

- supply of medicines and vaccines
- supply of medical devices and clinical consumables
- supply of non-clinical consumables, goods and services
- workforce
- reciprocal healthcare
- research and clinical trials and
- data sharing, processing and access

DHSC has completed further focussed work with NHS Blood and Transplant (NHS B&T) to co-ordinate “no deal” planning for blood, blood components, organs, tissues and cells. The NHS is asked not to stock pile and behave as normal unless contacted directly by NHS B&T.

NHS providers have been requested to complete the following actions:

- Undertake organisational risk assessment by end of January 2019 - completed
- Test Business Continuity Plans against EU exit scenarios by end of February 2019 - completed
- Appoint a board level SRO for EU exit, supported by a team from within the trust - completed

Specific advice has been shared across the NHS not to stock pile so as to ensure there are “business as usual” stock supplies within the country. Suppliers to NHS Supply chain and with large contracts with the NHS have been requested to stockpile within the UK following Government approval to assist with securing our supply chains.

Advice has also been issued regarding potential border delays. Should this become an issue, especially with cold store supply chain goods or good that have a short shelf-life, arrangements have been made for supplies to be delivered by airfreight.

3. ICHT Planning & Preparation

ICHT has been working with its suppliers and stakeholders to ensure we have sufficient assurance of our supply chains, equipment required and workforce arrangements to continue to operate business as usual should there be a no deal EU exit.

DHSC and NHS England have requested that NHS providers focus on the seven areas of activity listed above to ensure that there are sufficient business continuity plans to respond to a no deal EU Exit for a minimum of 6 weeks. The working ground and subsequent business continuity exercise have shown that the Trust can respond accordingly (Appendix 1).

The risk assessment has been completed (Appendix 2) and was presented to the Executive Finance Committee. The overall risk associated with significant disruption to the continued provision of service in the event of a “no deal” EU exit is assessed as having a score of 8.

ICHT completed an organisation wide Business Continuity update last year including aligning all our business continuity plans to ISO 22301. Following an NHS England Emergency Planning Resilience and Response annual review, our incident plans were rated as having FULL compliance.

Our incident response plans are flexible and scalable to respond to any incident and were tested in February 2019 against a no deal EU Exit scenario. The exercise provided assurance that we have no major business continuity issues with any of the seven areas of activity listed above, including continuity of service for North West London Pathology.

Following a paper to Audit, Risk & Governance Committee, the Emergency Planning Resilience and Response (EPRR) team have requested that all Divisions and their Directorates update their business continuity plans as part of the annual update, but also to look at these specifically against a no deal EU exit scenario.

The EPRR team will continue to undertake horizon scanning to ensure that any information through their networks is picked up quickly and responded to rapidly. The requests for information and assurance are being channelled through our SRO and information to the Trust is shared via our established EU Exit working group. The group is regularly meeting (Appendix 3 – membership list) to ensure that we are bringing our key stakeholders together to discuss issues and concerns and share good working practices.

4. Post 29th March 2019

Should there be a no deal EU exit on 29th March 2019, ICHT has well-rehearsed command and control plans and there are processes are in place to ensure that we are able to respond to any incident, if required to do so. We continue to follow advice and guidance from NHS England and are horizon scanning for any possible issues, both internally and externally.

5. Conclusion

While there is still uncertainty as to the actual impact of a no deal EU Exit, the Trust has responded to the requests of NHS England, taken on board the guidance and advice from DHSC to ensure robust plans are in place to respond to a no deal EU exit.

ICHT has a successful history of robust response to major incident as well as business continuity incidents and continues to remain focussed on ensuring our business continuity plans are robust and ready to respond to any scenario or incident.

6. Recommendations

The Board is asked to:

- Note the planning, preparation and response to a no deal EU Exit;
- Note the risk associated with significant disruption to the continued provision of service in the event of a “no deal” EU exit has a score of 8; and
- Support a response to a no deal EU Exit should it be required.

Appendix 1 – DHSC seven health activity areas of focus

DHSC area of focus	NHS/ DHSC contingency	ICHT contingency response	Outstanding actions
Supply of medicines and vaccines	Companies requested to have six weeks' additional supply in the UK, over and above their business as usual (BAU) operational buffer stocks. Suppliers to make arrangement to air freight medicines with a short shelf life, such as medical radioisotopes. The NHS should NOT stockpile. PHE have been tasked to support vaccine supply chains. A "Serious Shortage Protocol" has been developed to be used as necessary and escalated through EU ORC.	Pharmacy has provided assurance that the additional stock levels are in hand. Medical radioisotopes for imaging and radiotherapies have provided assurance they are able to provide BAU bar x1 isotope. **Pharmacy also notes that pre EU Exit there were BAU supply chain issues. Ann Mounsey presented to the Executive Quality Committee in February 2019.	Merlyn Marsden to check outstanding isotope with radiotherapy
Supply of medical devices and clinical consumables	Stock levels increased nationally. Air freight to be utilised if necessary DHSC continues to engage directly with industry suppliers, trade associations, NHS providers and other government departments to develop its contingency planning.	ICHT have sufficient stock and contacted major suppliers to ensure ability to continue to supply BAU for the Trust.	None
Supply of non-clinical consumables, goods and services	DHSC is engaging with suppliers and industry experts to identify and plan for any supply disruption. Where necessary, there will be cross-government work to implement arrangements on food, linen etc.	ICHT suppliers contacted and contingency plans in place. Most suppliers (e.g. food) are in the UK	None
Workforce	The current expectation is that there will not be a significant degree of health and care staff leaving around exit day.	The Trust continues with its recruitment programmes to ensure workforce across all specialties. No major issues identified in the 1000 EU staff we currently employ. EU settlement scheme utilised. Sodexo have confirmed that they are not expecting any immediate issues.	None
Reciprocal healthcare	In a 'no deal' scenario, UK national's resident in the EU, EEA and Switzerland may experience limitations to their access to healthcare services.	Waiting for further guidance as this is one area where there is little advice centrally. ICHT does not expect this to impact on service delivery.	None
Research and clinical trials and	The Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a 'no deal' scenario. All organisations participating in and/or recruiting patients to clinical trials or clinical investigations in the UK should contact their relevant trial sponsors for confirmation of plans for supply chains for IMPs and medical devices as soon as possible.	ICHT foresee no major issues.	None
Data sharing, processing and access	It is imperative that personal data continues to flow between the UK, EU and EEA member states, following our departure from the EU. Further information will be issued in due course. For now, health and adult social care organisations should identify data flows that may be at risk in a 'no deal' exit.	ICHT foresee no major issues.	None

Appendix 2 - No deal EU Exit Risk Assessment

ID: 2896 **Title: Risk of significant disruption to the continued provision of service in the event of a "no deal" EU exit**

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk associated with significant disruption to the continued provision of service in the event of a "no deal" EU exit **Cause:** The UK leaving the EU without a ratified deal (a "no deal" exit) **Effect:** Significant disruption to the continued provision of service with regard to: • Supply of medicines and vaccines • Supply of medical devices and clinical consumables • Supply of non-clinical consumables, goods and services • Workforce • Reciprocal healthcare • Research and clinical trials • Data sharing, processing and access.	**8**	**8**	**4**	*NEW*	**Director of Operational Performance**	Business continuity exercise scheduled for 14 February 2019

Current Risk Controls

• Plans and resources are in place at the Trust to continue to report current medicines shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels.

• Local contingency and collaboration arrangements have been agreed.

• Assurance has been obtained from Lloyds that they are appropriately prepared.

• The current medicines stock level to maintain normal business is circa 4 weeks. The Secretary of State has advised all healthcare providers to not stockpile medicines beyond their business as usual stock levels

• A self-assessment has been completed for any contracts for the supply of medical devices and clinical consumables not covered centrally for high priority categories

• Commercial preparation for EU Exit has been undertaken as part of the Trust usual resilience planning, addressing any risks and issues that need to be managed locally.

• The Trust is prepared to update planning/processes re the procurement of non-clinical consumables, goods and services based on further guidance provided by the Department of Health and Social Care on where actions should be taken locally by commissioners and providers of NHS-commissioned services.

• A review of EU nationals workforce has been undertaken and the Trust has not incurred a significant reduction in the number of relevant staff

• EU nationals staff have been informed with regard to the validity of their professional registration and recognition of qualification

• The Trust is engaging through Imperial College with the Department of Health and Social Care "deep-dive" on clinical trials and clinical investigations.

• Reliance on transfers of personal data from the EU/EEA to the UK has been investigated and the Trust is not currently transferring any personal data outside the EEA

• Advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a "no deal" scenario,has been used to determine where to use and how to implement standard contractual clauses on data protection in the case of a 'no deal' scenario

• Engagement with other NWL Trusts to confirm consistent approach and

Mitigation Plan

Action:
EU Exit Group to carry out a timely review new guidance published and ensure appropriate measures are undertaken at local level. *Due Date:* 31/05/19 LEAD: Claire Hook
Update on action:

Action:
Complete the Annual Data Security and Protection Toolkit Assessment. *Due Date:* 29/03/2019 LEAD: Philip Robinson
Update on action:

Contingency Plans

Implement the business continuity plan

Key Summary Updates & Challenges

Appendix 3 – EU Exit working group membership

Name	Title
Claire Hook (CH) - Chair	Director of Operational Performance
Merlyn Marsden (MM)	Hospital Director
Johann Oseni-Momodu (JOM)	Overseas Visitors Manager
Janice Stephens (JS)	Deputy Chief Finance Officer
Susan Postlethwaite (SP)	Procurement Business Partner for Medicine and Integrated Care
Mark Evans (ME)	Deputy Chief Pharmacist
Dawn Sullivan (DS)	Associate Director of HR Operations & Resourcing
Sally Squires (SS) - Note taker	Executive Assistant
Clare Robinson (CR)	Associate Director of Service Development & Commissioner
Denis Kelliher (DK)	Head of Purchasing and supply chain
Michelle Robinson (MR)	Senior Finance Manager
Max McClements (MMC)	Head of Clinical Engineering
Tim Powell (TP)	Head of Recruitment and Medical Staffing
Philip Robinson (PR)	Data Protection Officer
Paul Craven (PC)	Research Operations
Andrew Murray (AM)	Head of Facilities

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TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Trust Board – Declarations of Interests	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 27 March 2019	**Item 23, report no. 20**
Responsible Executive Director: Chief Executive Officer	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:
As part of the annual process all board members were asked to confirm, and update where required, their declaration of interests submissions. This is part of an annual cycle of reporting to the Trust Board and publishing on the Trust's website.

Recommendations:
The Committee is asked to note this report.

This report has been discussed at: N/A

Quality impact:
This report is part of the Well-Led CQC domain, ensuring all Trust Board members are open and transparent with roles they undertake outside of their substantive post.

Financial impact:
No financial impact.

Risk impact and Board Assurance Framework (BAF) reference:
None applicable.

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

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

Trust strategic objectives supported by this paper:
- To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

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?.....

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Trust Board – Declarations of Interests Report

1. Executive Summary

1.1 As part of the annual process all board members were asked to confirm, and update where required, their declaration of interest submissions. This is part of an annual cycle of reporting to the Trust Board.

2. Purpose

2.1. To promote openness and adherence to national guidance in ensuring the Trust Board have an up to date and accurate record of their declaration of interests.

3. Background

3.1. As part of the Trust's 'Declarations of Interests and Hospitality Policy' all Trust Board members are required to complete, or update, their declarations of interests submissions to allow this to be reported to the Trust Board on an annual basis and for the declarations to be published on the Trust website.

4. Summary/Key points

4.1. Sir Gerald Acher – Interim Chair:

- Vice Chairman: Motability;
- President: Young Epilepsy;
- Chairman: Brooklands Museum Trust;
- Chairman: Chatterbus CIC;
- Chairman: Cobham Conservation and Heritage Trust;
- Trustee: Motability 10th Anniversary Trust.

4.2. Mr Peter Goldsbrough – Non-Executive Director:

- Non-Executive Director: R J Young (Properties) Ltd;
- Non-Executive Director: Jenkinsons Holding Ltd;
- Senior Advisor: The Boston Consulting Group;
- Visiting Professor: Institute of global Health Innovation, Imperial College London;
- Spouse: Non-Executive Director, NHS England.

4.3. Victoria Russell – Non-Executive Director:

- Consultant: Fenwick Elliott LLP;
- Chairman: Livery Committee;
- Committee Member: Sulgrave Club for Young People;
- Governor: St Peter's CE Primary School W6.

4.4. Professor Andrew Bush – Non-Executive Director:

- Chairman: Publications Committee of the European Respiratory (Executive and Steering Committees);
- Senior Investigator: NIHR;
- Various research grants (information available upon request).

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4.5. Dr Andreas Raffel – Non-Executive Director:

- Member of the International Advisory Board: Cranfield School of Management;
- Deputy Chair: Change Grow Live (CGL);
- Member of Board of Trustees: University of Bristol;
- Senior Advisor: Rothschild;
- Senior Advisor: Flagstone Investment Management;
- Senior Advisor: Moonfare.

4.6. Nick Ross – Non-Executive Director:

- Freelance Journalist;
- Broadcaster;
- Conference Moderator;
- Vice President: Institute of Advance Motorists;
- President: The Kensignton Society;
- Chairman and Visiting Professor: UCL Jill Dando Institute of Crime Science;
- President: Healthwatch;
- Member: RCP Committee of Ethical Issues in Medicines;
- Trustee: UK Stem Cell Foundation;
- Affiliate: James Lind Alliance;
- Trustee: Sense About Science;
- Trustee: Imperial College Charity;
- Life Fellow: RSM;
- Member: RCS Research Initiative Steering Group;
- Trustee: Crimestoppers;
- Fellow: WWF.

4.7. Professor Tim Orchard – Chief Executive Officer:

- Director: Imperial College Health Partners;
- Pharmaceutical Advisory Boards (adhoc): Vifor Pharma, Celgene, Abbvie and Ferring;
- Medical Advisor: NW London Crohn's and Colitis UK.

4.8. Professor Julian Redhead – Medical Director:

- Outside employment with The Royal Society for the Prevention of Accidents;
- Medical Director: Fortius;
- Major Incident Doctor; London Ambulance Service;
- Outside employment with Chelsea Football Club;
- Shareholding and Ownership interests with Stadium Doctors Ltd;
- Shareholding and Ownership interests with Fortius Clinic;
- Shareholding and Ownership interests with Opus Clinic;
- CQC Inspector;
- Trustee: Imperial Health Charity;
- Private Practice: Fortius Clinic;
- Private Practice: Lindo wing.

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4.9. Richard Alexander – Chief Financial Officer:

- Non-Executive Director: HDI (Health Data Insights);
- Ex-Oracle employee and current shareholder.

4.10. Professor Janice Sigsworth – Director of Nursing:

- Honorary professional appointments at: King's College London; Bucks New University; and Middlesex University;
- Trustee of General Nursing Council Trust and Clinical Adviser to the NMC of pre-registration midwifery standards;
- Chair of Shelford Safer Nursing Care Tool Board;
- Joint Chair Safer Nursing Care Faculty Steering;
- Member of Shelford Chief Nurses Group.

5. Options appraisal including financial appraisal (as relevant)

5.1. None applicable.

6. Conclusion and Next Steps

6.1. None applicable.

7. Recommendations

7.1. None applicable.

Peter Jenkinson, Trust Company Secretary
27 March 2019

Imperial College Healthcare NHS Trust

TRUST BOARD REPORT SUMMARY	
Title of report: Board self-assessment review of effectiveness	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 6th March 2019	**Item 24, report no. 21**
Responsible Executive Director: Professor Tim Orchard, Chief Executive	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The questionnaire developed by the Audit Commission for use in NHS Trusts is attached for all Trust Board members and some of the attendees for completion, to enable reflection on the effectiveness of the Board. This is an annual process and has also been applied to the Committees of the Trust Board.

Members and attendees are asked to rate the effectiveness of the Board in response to 28 statements, using the scale below in their responses:

n/a = Not applicable or unknown
1 = Hardly ever/Poor
2 = Occasionally/Below average
3 = Some of the time/Average
4 = Most of the time/Above average
5 = All of the time/Fully satisfactory

The questionnaire should be returned to the Trust Secretariat by 30th April 2019. The results and a summary of this review and that of the Board Committees will be shared with the Board in July 2019.

Recommendations:

The Board is asked to note this approach.

This report has been discussed at: N/A

Quality impact: No direct impact on quality of service, but relates to the Well-led domain within CQC framework.

Financial impact: The paper has no direct financial impact.

Risk impact and Board Assurance Framework (BAF) reference:

Ensuring an annual self-assessment of the effectiveness of the Board and its Committees lessens the risk that the Board and Committees' contribution to assurance and oversight is reduced.

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

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

Has an Equality Impact Assessment been carried out?

☐ Yes ☐ No ☒ Not applicable

If yes, are there any further actions required? ☐ Yes ☐ No
Paper respects the rights, values and commitments within the NHS Constitution. ☒ Yes ☐ No
Trust strategic objectives supported by this paper: ▪ To achieve excellent patients experience and outcomes, delivered with compassion. ▪ To educate and engage skilled and diverse people committed to continual learning and improvements. ▪ As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care. ▪ To pioneer integrated models of care with our partners to improve the health of the communities we serve. ▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): N/A

Assessment of the effectiveness of the TRUST BOARD – 2018/19

For completion by Committee members, regular attendees	
Role	NED / Executive / Attendee (delete those which are not relevant)

	n/a	1	2	3	4	5
Behaviours						
1. **Understanding of core business, business model and risks:** All Committee members have a good understanding of the different risks inherent in the Trust's activities.						
2. **Understanding the risk management framework:** All Committee members have a good understanding of the risk management and internal controls framework.						
3. Understanding of how assurance is gained: The Committee understands the interaction between the various sources of assurance available to it; and how these sources map to the significant risks described in the board assurance framework and risk register.						
4. **Focus on appropriate areas:** The Committee focuses on the right questions, and is effective in avoiding the minutiae.						
5. **Quality of interaction with external auditors:** The Committee actively engages with the external auditors regarding scope of work, audit findings and other relevant matters.						
6. **Quality of interaction with internal auditors and counter fraud:** The Committee demonstrates an appropriate degree of involvement in setting the remit of the internal audit and counter fraud; and in the findings of internal audit and counter fraud and in their resolution.						
7. **Understanding of key financial issues:** The Committee has a good understanding of the key financial issues, for example critical accounting policies and complex transactions.						
8. **Rigour of debate:** Committee meetings encourage a high quality of debate with robust and probing discussions.						
9. **Reaction to bad news:** The Committee responds positively and constructively to bad news in order to encourage future transparency.						
10. **Quality of chairmanship:** The chairman operates satisfactorily in terms of promoting effective and efficient meetings, with an appropriate level of involvement outside of the formal meetings.						
11. **Frank, open working relationship with executive directors:** The Committee members have a frank and open relationship with the executive directors, without themselves becoming 'executive'.						
12. **Open channels of communication:** The Committee has open channels of communication with Trust contacts which facilitates the surfacing of issues.						
13. **Perceived to have a positive impact:** There is an appropriate balance between the monitoring role of the Committee and it being an ''influencer for good''.						
14. **Impact at board level:** The Committee exercised judgement and assiduously pursues issues to influence management						

n/a = Not applicable or unknown
1 = Hardly ever/Poor
2 = Occasionally/Below average
3 = Some of the time/Average
4 = Most of the time/Above average
5 = All of the time/Fully satisfactory

	n/a	1	2	3	4	5
and board decisions.						
15. **Appropriate links with other board committees:** The Committee has appropriate links with the other board committees.						
Processes						
16. **Clear terms of reference:** There are clear terms of reference, with clarity as to role vis a vis the board as a whole and other committees, including in relation to risk management.						
17. Sufficient number and timing of meetings: The number and length and timing of meetings is appropriate.						
18. **Right people invited to attend and present at meetings:** Executive management and others are asked to present on topics, as appropriate.						
19. Concise and relevant information: Committee papers are concise and relevant						
20. Timely information: Committee papers are received sufficiently in advance of meetings.						
21. Sufficient commitment to undertake responsibilities: All Committee members demonstrate sufficient commitment to fulfilling their responsibilities.						
22. **Contribution at meetings:** All Committee members actively and effectively contribute at meetings.						
23. **Feeding back to board meetings:** All key issues are identified and reported back to board.						
24. **Appointment and independence of external audit:** The Committee fulfils its responsibilities to assess the independence and objectivity of the auditor annually, taking into consideration relevant UK law, regulation and professional requirements.						
25. **Adequate resources:** The Committee has sufficient resources available to support it in its role.						
26. **Members with appropriate skills and experience:** The Committee comprises members with an appropriate mix of skills and experience, including recent and relevant financial experience.						
27. **Private meetings with internal and external auditors:** Private meetings with the Committee, without management, are held at least annually with both the external auditors and internal audit.						
28. **Role in relation to whistleblowing:** The Committee has been informed of the whistleblowing procedures in place within the organisation and undertakes its defined role in relation to them.						

Comments: To support improvement, it is requested that you particularly add a comment should you have scored any questions 1 or 2:

Return to Trust Secretariat by 30th April 2019 imperial.trustcommittees@nhs.net

n/a = Not applicable or unknown
1 = Hardly ever/Poor
2 = Occasionally/Below average
3 = Some of the time/Average
4 = Most of the time/Above average
5 = All of the time/Fully satisfactory

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TRUST BOARD - PUBLIC SUMMARY REPORT	
Title of report: Audit, Risk & Governance Committee report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27th March 2019	**Item 25.1, report no. 22a**
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 6 March 2019. Key items to note from that meeting include:

External audit
The Committee received external audit's progress report, including a summary of issues that could potentially impact on the year-end accounts, such as changes in tariffs and market forces factor. The Committee noted the issues raised and noted that such issues had been included in the planning assumptions and were therefore not financial sustainability issues; however they were a risk. The Committee discussed the risk arising from the sector's financial position, and the impact on commissioning decisions, and discussed the Trust's response.

Internal audit progress report
The Committee received the internal audit progress report and discussed reasons for delays in completing some of the reviews planned. It was noted that the plan would be completed by year-end, but that lessons would be considered from this year via the Internal Audit Liaison Group and reflected in the approach for the following year. The Committee noted the improved relationship between the internal auditors, the executive team and management teams across the organisation.

The Committee received and considered executive summaries of published internal audit reviews. The Committee also considered the draft findings from the internal audit review of Board and Divisional Governance, noting the good practice in commissioning the report. It was noted that the draft report would be considered by the Chief executive and then shared with the Board.

The Committee also noted the good progress made in closing outstanding actions, noting one outstanding action remaining from 2018/19.

Draft internal audit report 2018/19
The Committee noted the outline structure of the internal audit report, including the Head of Internal Audit Opinion, for 2018/19, and the process to finalise the report following the completion of the outstanding audits. The Committee noted that to date, no significant concerns had been raised.

Internal audit plan 2019/20
The Committee considered the internal audit plan for 2019/20, noting that the draft plan had been reviewed with the executive team and at an executive committee meeting. The Committee considered other potential audit areas not included in the 2019/20 plan, noting their inclusion in the following year's plan, and agreed additional areas to be considered in the future, including equality and diversity and follow up on the governance structures.

Counter fraud
The Committee received the progress report and noted progress against the plan, including the results of an awareness survey and a summary of ongoing referrals.

The Committee received an update on the National Fraud Initiative, noting that matches were being reviewed; a progress report would be reported at the next meeting.

The Committee also received a summary of the fraud toolkit self-assessment, noting an overall rating of 'green'. The Committee agreed the need to learn from external examples and translating learning from one area to another.

Annual accounts and year-end considerations
The Committee considered a summary of changes in the financial environment and the proposed treatment in the year-end accounts, including the proposed bad debt methodology, the 'going concern' judgement and onerous lease provisions.

Risk management and Board assurance framework
The Committee received an update on risk management, including updates to the corporate risk register. The Committee welcomed the development of the risk profile for each risk showing the changes in risk rating over time, and noted the addition of the risk appetite and response. The Committee also welcomed the disaggregation of some generic risks, to enable the measurement of the impact of controls. The Committee discussed the risk response in the case of long-standing risks such as the estates management risk and agreed the need to consider the response in the context of the risk appetite. The Committee reviewed the corporate risk register and agreed the addition of new key risks and downgrading of others.

The Committee noted an update on the development of risk appetite statements and also considered the changes made to the board assurance framework to make the framework more dynamic and linked to corporate objectives. The Committee welcomed the proposal to rate the level of assurances for each risk and to disseminate the assurance framework by board committee so that committees could review the assurances relevant to their respective terms of reference. The new framework will be effective from April.

Risk 'deep dive' review of cleaning
The Committee reviewed the risk regarding compliance with cleaning standards and discussed the actions being taken to manage the risk, including the relationship between the Trust and Sodexo and the management of the contract. The Committee noted that the contract for cleaning services was due to be retendered in April 2019, with a view to the new contract being implemented from April 2020. The Committee discussed the specification and process for the tender and agreed that an appropriate data pack should be included in the specification.

North West London Pathology (NWLP)
The Committee welcomed NWLP senior management to the meeting and considered the governance arrangements for NWLP, including the three roles that the Trust played in the partnership – owner, customer and host. The Committee received assurance regarding the governance arrangements to ensure regulatory compliance and the management of risks, noting the robustness of the quality governance arrangements.

Quality account – indicator testing for 2018/19
The Committee received an update on the selection and testing of quality indicators by external audit as part of the 2018/19 audit. The Committee agreed with the proposal not to audit SHMI this year but to consider how this might be audited in the following year, including learning from foundation trusts who must audit it this year. This will be explained in the 2018/19 Quality Account. It was agreed that it would be considered whether it was possible to include this in the internal audit plan for 2019/20.

Data quality framework
The Committee received and noted a summary of progress against the Trust's data quality framework and improvement plans, noting that progress had been made but that there was more to do. The Committee noted summary of priorities for 2019/20 and noted the transfer of executive leadership for

data quality to the Director of Operational Performance, who would oversee the development and delivery of the plan for 2019/20.

Standing orders, SFIs and scheme of delegated financial authority
The Committee approved updates to the standing orders and scheme of delegated financial authority.

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 23 April 2019.

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

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Remuneration and Appointments Committee – report from meeting on 13 March 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27 March 2019	**Item 25.2, report no. 22b**
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 13 March 2019. Key points to note include:

Mid-year review of Chief Executive
The Committee reviewed the outcome of the Chief executive's six-month review of progress against objectives, completed by Sir Richard Sykes on 3 December, in line with best practice and in accordance with Trust policy for evaluating the performance of the CEO and completion of mid-year performance development reviews (PDRs).

The mid-year review included an assessment of progress across the performance objectives and support and development actions agreed with NHS Improvement in May 2018, including:

- Operational performance objectives, including elective and non-elective performance
- Quality improvement, including agreeing a plan and governance arrangements to achieve a 'good' rating by the CQC
- Development of a financial plan to achieve the control total for 2018/19 and a transformation plan to achieve transformational change in 2019/20
- Staff recruitment and retention, including appointments to the executive team
- Site redevelopment, and
- Implementation of the global digital exemplar strategy.

The Committee is satisfied that the Trust has achieved, or is making good progress towards achieving, these objectives. The Trust has achieved continued improvement in the Trust's elective and non-elective performance, is on target to achieve the financial control total at year-end and Tim had overseen the implementation of an approach to drive the Trust's readiness for a CQC inspection and 'Well-led' assessment. The Committee have also noted that there is an appropriate development plan and support mechanisms in place for the Chief executive.

The Committee therefore agreed to recommend Tim's continuation as Chief Executive on a substantive basis to the Trust Board.

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 the latest statement from the Chief Executive of NHS Employers updating on national changes and an outline of what would and would not be likely in terms of national reform.

Recommendations:
The Trust Board is requested to note the satisfactory completion of the mid-year review and to confirm Tim's continuation as Chief Executive on a substantive basis.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Redevelopment committee report – report from meetings held on 27 February and 20 March	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27 March 2019	**Item 25.3, report no. 22c**
Responsible Non-Executive Director: Victoria Russell, Non-executive director	**Author:** Peter Jenkinson, Director of Corporate Governance & Trust Secretary

Summary:

The Redevelopment Committee met on 27 February and 20 March 2019. Key topics of discussion in this meeting included:

- strategic updates from the Chief Executive, including feedback from meetings with regulators, central government departments and other interested parties.
- updates on key initiatives within the Trust's redevelopment programme, including the commissioning of a report into the benefits of different redevelopment options.
- updates from Imperial Health Charity.
- updates on the risks of adverse impact on patient services from the Paddington Square redevelopment, and other neighbourly matters, noting the ongoing actions to mitigate the impact.

The next meeting of the Committee will be held on 24 April 2019.

Recommendations:

The Trust board is requested to:

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

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from Quality Committee, 13th March 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27th March 2019	**Item 25.4, report no. 22d**
Responsible Non-Executive Director: Professor Andrew Bush (Committee Chair)	**Author:** Victoria Russell, Non-executive Director Ginder Nisar, Interim Deputy Trust Secretary

Summary:

The Quality Committee met on 13th March 2019. Key items to note from that meeting include:

Freedom to Speak Up Strategy
The Committee discussed and approved the Freedom to Speak Up (FTSU) strategy developed following the FTSU self-assessment in September 2018. The strategy outlined the Trust's vision for speaking up and implementation of more robust arrangements.

Integrated Quality and Performance Report
The bi-monthly report covering months 9 and 10 was noted which highlight key issues and related improvement plans and actions. In particular the Committee discussed the degree of harm, never events, Infection prevention and control, VTE, sepsis, mortality indicators and reviews, national clinical audits and estates maintenance. Updates from each of the divisions were noted.

Key Divisional Quality Risks
The Divisional Directors and Corporate Directors provided an update on their key divisional risks which largely remained the same as previous and the Committee noted the risks that were either escalated or de-escalated.

CQC Update
The Committee received an update on CQC related activity at and/or impacting the Trust since the last report to the Committee and noted the headlines from the CQC Insight reports and actions. Noted that the Maternity satisfaction survey results will be discussed at the Executive and Board Quality Committees. Key points in relation to assessments of performance in relation to Equality and Diversity were noted. The Trust received its annual CQC PIR in November 2018 and submitted it in December 2018. The inspection of four core services took place on 26, 27 and 28 February 2019 and the inspection of well-led at Trust level will take place on 2, 3 and 4 April 2019. The NHS Improvement use of resources assessment took place on 13 February 2019. High level feedback was received following the site visits and draft inspection reports expected no later than July 2019, when the Trust will have an opportunity to check their factual accuracy. Final inspection reports, including all ratings (for core service well led inspections), are expected to be published on the CQC's website no later than August 2019.

Incident Monitoring Report
The Committee noted that the incident reporting rate at Imperial College Healthcare NHS Trust (ICHT) for January 2019 was 52.50, and the rolling 12 month average reporting rate (February 2018 to January 2019) is 49.31. Five Serious incidents (SIs) were declared with 37 on-going (open) SI investigations and 21 that are overdue, which is an increase compared to last month. The MD's office has sourced additional resource to reduce the back log as well as improve the quality of reports and embed a robust QA process. Improvement programmes (safety streams) are in place for the SI categories that have been reported most. Two level one/internal investigations were declared and under investigation. Two never events were declared in January. Seven never events have been declared so far this financial year, six of which are related to invasive procedures. A Trust wide action plan is in place and progressing.

Learning from Deaths Quarterly Report
The Committee received an update on progress since the last report to the Committee and the updated 'learning from deaths dashboard' for the financial year 2017/18 to Q3 2018/19. The Committee noted the key points

regarding progress made with implementation of the framework. A review of the Trust's mortality processes has been undertaken and a Learning from Deaths steering group will be established to oversee the implementation of the recommendations made by the review and will include how learning is disseminated across directorates and specialties.

Never Events Trust wide Action Plan Update
The Committee noted progress with the seven never events declared so far this financial year; the most recent six are all related to invasive procedures. A Trust wide action plan was created in response to the first four never events and discussed at the Executive Quality Committee on 8th January. Additional actions were then added in response to the two never events declared in January. The final action plan was presented to Trust Board on 30th January 2019. The action plan is progressing, with weekly updates on implementation being presented at the Executive Committee. The action plan include engagement, learning and assimilation training. An external review is scheduled to take place on 22nd March as discussed with NHS Improvement..

Occupational Health and Safety Report
The Committee received a progress report and assurance on aspects of the Trust's occupational health and safety arrangements discussed at the Executive Quality Committee. The key items included violent incidents, the number of slips, trips and falls, sharps incidents and controlling the risk of injury arising from patient manual handling by the purchase of two 'Flat lift' patient hoists.

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q3 2018/19
The Committee noted there were seven Trust-attributed cases of C. difficile in Q3, against a quarterly ceiling of 16. ICHT now ranks 3rd best in the Shelford group for its rate of C. difficile. Whilst ICHT ranks 4th best in the Shelford group for its rate of E. coli BSI, the Trust is not on track to meet its internal 10% reduction target for healthcare-associated E. coli BSIs thus this will be a focus for targeted work. The rate of SSI following elective orthopaedic procedures is very low, with only one SSI in the past 12 months following hip and knee procedures. Compliance with Carbapenemase-producing Enterobacteriaceae (CPE) admission screening has increased, with all specialities performing universal admission screening for CPE now screening in excess of the 90% target. Compliance with IPC core skills training has increased. A monthly Water Hygiene Group is in place to oversee the processes to ensure water hygiene, which are delivered operationally by Trust Estates and their contractors. The Trust continues to prescribe fewer antimicrobials than four years ago, but rates of prescribing have increased slightly in Q3. Outbreaks of Pseudomonas aeruginosa in the neonatal units at St Mary's Hospital (SMH) and Hammersmith Hospital, and an outbreak of MRSA in the ICU at SMH have been closed. A refreshed Trust-wide project to improve hand hygiene practice continues.

Patient Safety Translational Research Centre collaboration and themes
The report described the partnership between the Patient Safety Translational Research Centre (PSTRC) and ICHT. The PSTRC is an NIHR infrastructure grant held jointly by Imperial College London and ICHT (noted that the PSTRC is housed and operationally managed by a team within the Institute of Global Health Innovation (IGHI) at Imperial College). The report included examples of collaborative work being undertaken between the PSTRC and the wider Trust, including the governance structures and lines of communication which facilitate that collaboration. The report included some of the joint projects between ICHT and PSTRC and proposed upcoming work and a list of key roles integral to the collaboration.

Quality Account 2018/19: Review of improvement priorities
The Committee discussed and endorsed the proposed priorities for 2019/20 for consultation, which were agreed at Executive Quality Committee on 5th March. The following improvement priorities are proposed to be continued into 2019/20:

- To reduce avoidable harm to patients
- To improve the safety culture across the Trust (refocused on the behaviours that support safety improvement.
- To improve permanent nurse staffing levels (incorporating non-consultant doctors as a minimum)
- To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation
- To improve access to services across the Trust through a focus on increasing capacity and improving emergency flow through the hospital (combination of two previous priorities)
- To improve access for patients waiting for elective surgery
- To improve compliance with the equality and diversity standards

The Committee endorsed that the following are managed as business as usual:

- To ensure our staff are up to date with the mandatory skills to do their jobs
- To ensure our equipment has planned maintenance in line with targets
- To improve the management of medicines
- To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists

- To improve access to services across the Trust through a focus on increasing capacity (combined with emergency flow priority – see above)
- Specialty review and clinical strategy development

The Committee also endorse that an additional priority is included – to review the Trust's approach to inspection, accreditation and reviews.

Quality Account 2018/19 – Indicator testing
At Audit, Risk and Governance Committee in December 2018, external audit raised that acute Trusts were being recommended by NHS Improvement (NHSI) to adopt their audit requirements for Foundation Trusts and audit an additional indicator as part of their overall review of the quality account. The Medical Director reviewed this recommendation following discussion with the external auditors, including a review of the potential benefits and the additional costs required. The Committee noted that the Trust will not be auditing a third indicator this year.

NHS Staff Survey: NHS comparative report
The Committee noted the summary of national survey results 2019 and agreed to review the National Staff Survey results at all relevant sub groups on areas of focus from the survey and amend or reinforce action plans as required; and divisions and directorates to review local results and develop or amend their engagement action plans based on the results; adopt the changes to the annual survey approach and move to a full census national survey in September – December 2019, supplemented by single topic pulse surveys on areas of concern.

Equality, diversity and inclusion report
Following the Committee's recommendation for a more structured and specific equality and diversity action plans, the Workforce Equality & Diversity (E&D) Work Programme 2019 was developed and presented to the Committee in January 2019. The Committee noted the updated E&D work programme, which provides an overview of the E&D agenda in the Trust with sets of actions covering the main protected characteristics groups that the Trust needs to demonstrate its compliance for the legal and regulatory purposes. For year 2019/20 the E&D Work Programme will be carried out with a particular focus on Workforce Race Equality Standard (WRES), with continuous work done on gender pay gap and initiation of and preparation for disability work. The Work Programme will be underpinned by a number of equality enablers that contribute to overall E&D work through increasing awareness and advancing relationships among all.

Gender Pay Gap
The report is published in line with gender pay gap reporting requirements for organisations with more than 250 staff. All calculations relate to the pay period in which the snapshot day falls which is 31 March 2018. This is the second gender pay gap report the Trust will publish. Actions to address issues identified within the Gender Pay Gap report have been set under the Trust's 2019 Workforce Equality and Diversity Work Programme. The Committee recommended the report to Trust Board for approval and publication on the Trust's website. The report will be used to inform specific actions within the equality and diversity report work programme.

ICHT response to the report of the Gosport Independent Panel – Final assessment
Following previous discussions at the Quality Committee, key learning points were reported to the Executive Quality Committee in September 2018, with examples of systems/governance processes in place at ICHT that would contribute to prevention of a similar situation happening at the Trust. Several actions were identified which would provide additional assurance for the Trust. The report provides an update on the progress made with delivering on these actions. The Committee noted the progress with completion of a self-assessment of the systems and processes in place at ICHT that should prevent the issues that happened at Gosport occurring at ICHT. A final self-assessment will be presented to the Committee in Q1 2019/20.

Flu campaign 2018/19 – Review and way forward
The report provided assurance on the Trust's 2018/19 flu campaign with final response rate at 60%. It reviews the lessons learnt from that campaign and details how they will be incorporated into the arrangements for future flu campaigns, for which a 'business as usual' approach will be taken.

Board Committee Effectiveness Review
The self-assessment of the effectiveness of the Committee was launched and members were asked to complete a questionnaire.

Recommendations:
To note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC
BOARD SUMMARY

Title of report: Report from Finance and Investment Committee, 20th March 2019	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 27th March 2019	**Item 25.5, report no. 22e**
Responsible Non-Executive Director: Dr Andreas Raffel, Non-executive Director (Committee Chair)	**Author:** Peter Goldsbrough , Non-executive Director Ginder Nisar, Interim Deputy Board Secretary

Summary:

The Finance and Investment Committee met on 20th March 2019. Key items to note from that meeting include:

Finance Report
The Committee noted that after 11 months the Trust is reporting it is on plan in month and forecasting to meet the control total. It is essential the Trust maintains effective cost control to ensure the 2018/19 control total is met and to provide a good foundation for 2019/20. In month the Trust was on plan before Provider Sustainability Funding (PSF). Overall the Trust is forecasting to meet the control total. The Committee received an update on divisional and corporate positions. Any further deterioration in the clinical or corporate position is likely to place the Trust's ability to meet the control total at risk and divisions must continue to maintain controls on pay and non-pay to meet the control total in year.

The Trust is continuing negotiations with commissioners relating to challenges for 2018/19. An agreement has been made with NWL CCGs within the current forecast position. NHS England has put forward challenges above the level in the plan. The Trust is working to agree a position and expects this to be within provisions, though this remains a risk.

In month the Trust overspent on the capital plan by £4.7m bringing the underspend year to date to £3.3m. The Trust is forecasting to meet plan by the end of the year and the position is being closely monitored by the Capital Expenditure Assurance Group and Capital Steering Group.

The Committee commended the divisions and corporate teams on delivering their commitments, noting that early intervention by the Executive Team was beneficial.

2019/20 Business Planning Update & Financial Recovery Plan Update
The Committee discussed and noted the Trust's intention to accept the control total of -£16m deficit before PSF and Marginal Rate Emergency Tariff (MRET) funding and discussed the efficiency target and actions thus far. Income and activity plans for 2019/20 remain subject to agreeing contracts with commissioners. A capital plan has been internally agreed subject to Executive and Board approval. A collaborative cross sector approach has been maintained through the planning rounds with increased transparency on Trust and commissioner positions. In the time remaining before the plan is submitted for Board approval, the Trust is focussed on reducing the unidentified CIP gap. It was acknowledged that there are still variables related to CIPs and Income. The final 2019/20 Trust plan will be submitted for Board approval on 27th March and submitted to NHSI on 4th April.

The Committee agreed to recommend the plan to the Board subject to (a) being provided with transparency about the planned activity levels for next year to confirm that the anticipated growth in non-elective activity is realistic in light of historic trends and that the resulting planned elective activity level will enable the trust to meet commissioner KPIs (b) that a concrete transformation plan is brought forward during the first quarter of next year to enable the trust to make continuing progress against its underlying deficit.

Specialty Review Programme
The Committee received a progress update and noted the approach to the programme which has been restarted under the Director of Transformation and Deputy CFO. Specialities are at different stages in the existing process and 20 are ready for the next stage where the specialities' strategies are further aligned with the organisational strategy and translated into tactical plans to implement during FY 2019/20. The next report to the Committee will include further detail including correlation with CIP and benefits realisation.

Summary of Capital Spending Progress
The Committee noted the progress on the capital expenditure to date and the risks associated with the capital plan, as well as the position in respect of additional funding stream applications.

CIPs and Control Total for FY 2019/20
The Committee received an update noting that the divisions were in the process of working up deliverable plans and will be reflected in the business plan.

Summary of business cases approved by The Executive since 1st April 2018
The Committee noted that 30 business cases have been approved by the Executive since the start of the 2018/19 financial year, with five of these cases being worth more than £2m and less than £5m in either expenditure and or capital.

Hotel Services Contract Retender Update
The Committee noted that the current Hotel Services contract expires at the end of March 2020. The Committee noted the procurement timetable for agreed tender process; the governance structure in place for agreed tender process; and learning from previous large tenders.

Legal Services Review Update
The Committee noted the report and the actions agreed by the Executive Team to provide additional control over the access to external non-clinical legal advice in order to improve the quality of legal advice provided and to apply appropriate control over expenditure.

Board Committee Effectiveness Review
The self-assessment of the effectiveness of the Committee was launched and members were asked to complete a questionnaire.

Recommendations:
To note this summary.