Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC

Oak Suite, W12 Hammersmith Hospital

29 November 2017

11:00-13:00

		Presenter	Timing	
1	**Administrative Matters**			
1.1	Chairman's opening remarks and apologies	Chairman	11.00	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 27 September 2017	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 27 September 2017	Chairman		2
1.5	Record of Annual general meeting – 14 September 2017	Chairman		3
1.6	Action log and matters arising	Chairman		4
2	**Operational items**			
2.1	Patient story	Director of nursing	11:05	5
2.2	Chief Executive Officer's report	Chief executive officer		6
2.3	Integrated performance report	Safe/effective: Medical director Caring: Director of nursing Well-led: Director of P&OD Responsive: DD Medicine & Int care DD surgery, cancer & CV DD Women's, chil'n & CS		7
2.4	Month 7 Finance report	Chief finance officer		8
3	**Items for decision or approval**			
3.1	Corporate risk register	Director of nursing	11:40	9
3.2	Board assurance framework	Trust company secretary		10
3.3	NWL local maternity service - Better births maternity implementation plan	Divisional director, women's, children's and clinical support		11
4	**Items for discussion**			
4.1	CQC quarterly update – quarter 2	Director of nursing	11:55	12
4.2	Learning from deaths report	Medical director		13
4.3	Infection prevention & control report – quarter 2	Director of infection control		14
4.4	Quality strategy 2018-2021	Medical director		15
4.5	Research quarterly report	Director of research		16
4.6	Freedom to speak up guardian	Director of people & organisational development		17
4.7	Engagement survey action update	Director of people & organisational development		18
4.8	2016 National cancer patient experience report	Director of nursing		19
5	**Items for information**			
5.1	CIP QIA quarterly update – quarter 2	Director of nursing		20
6	**Board committee reports**			
6.1	Finance and investment committee	Committee chair		21
6.2	Redevelopment committee	Committee chair		22
6.3	Quality committee	Committee chair		23
6.4	Audit, risk & governance committee	Committee chair		24
6.5	Remuneration & appointments committee	Committee chair		25
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
9	**Date of next meeting**			
	Public Trust board: Wednesday 31 January 2018, New Boardroom, Charing Cross Hospital			

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 27 September 2017
11.30 – 13.00
Boardroom, Charing Cross Hospital

Present:	
Sir Richard Sykes	Chairman
Sarika Patel	Non-executive director
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Prof Andy Bush	Non-executive director
Victoria Russell	Non-executive director
Nick Ross	Designate non-executive director
Ian Dalton CBE	Chief executive
Richard Alexander	Chief financial officer
Dr Julian Redhead	Medical director
Prof Janice Sigsworth	Director of nursing
In attendance:	
Michelle Dixon	Director of communications
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Prof Tim Orchard	Divisional director, medicine & integrated care
Dr Katie Urch	Divisional director, surgery, cancer & CV
Prof TG Teoh	Divisional director, women's, children's and clinical support
Jan Aps	Trust company secretary (minutes)
Stephanie Harrison-White	Head of patient experience (item 2.1)
Dr David Wingfield	Chair, Hammersmith & Fulham GP Federation
Anna Bozobza	Associate director of integrated care

1	**Administrative Matters**	**Action**
1.1	**Chairman's opening remarks and apologies** Sir Richard Sykes welcomed all members and attendees to the meeting, and noted apologies from Sir Gerry Acher.	
1.2	**Board member's declarations of interests** There were no additional declarations of interest made at the meeting.	
1.3	**Minutes of the meeting held on 26 July 2017** The minutes were accepted as an accurate record of the meeting.	
1.4	**Record of items discussed at Part II of board meeting held on 26 July 2017** The Trust board noted the report.	
1.5	**Action Log and matters arising** The Trust board noted the updates provided.	
1.6	**Trust board committee terms of reference - annual review** The Trust board approved the terms of reference for the Quality, Finance and Investment, and Redevelopment Committees; and approved in principle, noting there may be further minor changes, the terms of reference of the Audit, Risk and	

	Governance, Remuneration Committee, and Integrated Care Partnership Board.	
1.7	**Trust board and committee meeting schedule** The Trust board agreed the meeting schedule for the Trust board and committees for 2018/19.	
2	**Operational items**	
2.1	**Patient story** Prof Janice Sigsworth reported that the patient who was to attend the meeting had chosen not to attend in person as she felt anxious about bringing her reflections to a public meeting, but was happy for her experiences to be shared anonymously. Her experiences were an important reflection of the Trust's commitment to focus on the protected characteristic, gender reassignment, as defined by the Equality Act 2010, as part of the equality delivery system (EDS2) work, recently presented to the Quality Committee. Stephanie Harrison-White outlined that Susan (anonymised), a transgender patient, had recently attended hospital, where she had felt well cared for and appropriately addressed. However, on discharge, she had been presented with a copy of her GP letter, in which she had been 'misgendered' through an inappropriate use of pro-nouns; this had 'devastated' her and she had left in tears. She had not wished to formally complain but had shared this experience as part of a wider interface with the Trust working on training for staff on gender recognition. Prof Sigsworth noted that the Gender recognition policy had been developed following a previous complaint about how the Trust made available patient's prior notes; this had been well-received. As the main NHS centre for male to female surgery, there was much learning to do to ensure patients were treated appropriately and with the dignity and privacy they warranted. Responding to a query from Nick Ross, Prof Sigsworth assured the Trust board that clinical staff supported patients in dealing with their new identity, working closely with local mental health trusts, particularly in relation to children. Responding to Peter Goldsbrough's enquiry, she commented that Susan had felt that a formal complaint gave a level of exposure with which she was not comfortable; many transgender patients live in fear of such exposure. Prof Sigsworth reflected that many patients, rather than wishing to formally complain, sought confirmation that the Trust learnt from their feedback. The Trust has a number of communications channels through which patients can provide feedback and as research confirms patients' focus is often on learning rather than the formal complaints procedure. The Trust board noted the patient story.	
2.2	**Chief Executive's report** Ian Dalton particularly noted the following items: • the Trust had agreed a revised control total with NHS Improvement, a planned deficit of £25.15m, a £15.85m improvement on the previously planned deficit outturn of £41m. Whilst the stretch on the clinical divisions remained the same, the Trust had agreed with the regulator a number of additional, mainly non-recurrent, areas of movement • Westminster City Council planning committee had granted planning permission for the proposed outpatient building, subject to usual requirements; however, there were a number of other considerations yet to address • the s106 agreement for the Paddington Quarter development (the 'Cube') had been signed, providing full planning permission; the Trust had submitted evidence to the courts, requesting a judicial review • infrastructure issues in the Cambridge Wing at St Mary's had meant that 31 patient beds had been closed to ensure patient and staff safety; this was increasing the already high pressure on bed availability and often leading to the highest level of operational alert. There were both operational and financial impacts of the required works, but staff across the Trust were handling this	

	extremely well; patients were asked to continue to be patient with the impacts on their experience. The Trust board noted the report.	
2.3	**Integrated performance report** SAFE / EFFECTIVE: Dr Julian Redhead reported that overall, the Trust continued to provide safe services, reporting: a good HSMI, high incident reporting with low patient harm, low threshold for C difficile cases and no MRSI or never events in the period. Completion of consultant appraisal rates was, at 89%, above the national average, and work continued to get total compliance, with lower but improved position for staff grade doctors. Improvements were also being seen in the mandatory training for junior doctors, but the hoped for 'training passport' had yet to be brought into effect. CARING: Prof Janice Sigsworth noted that mixed sex accommodation continued to be limited to the intensive care unit only; advice was being sought from other trusts as to potential resolution. The condition of the estate was recognised as having an impact on patient experience, and the reactive maintenance performance indicators still had room for improvement, but the teams had responded well in recent emergencies. Responding to a query from the chairman, the divisions commented that, whilst the wards may report that not all issues are dealt with in a timely way, they are reassured that patient safety issues are dealt with urgently, and they recognise the pressure they were working under in responding to the high volume of issues. WELL-LED: David Wells reported that: the vacancy rate had now flat-lined and was expected to improve as the new cohort of students joined the Trust; voluntary turnover remained good; 90% of staff had received a personal development review, changes in timing were hoped to improve the management of poor performance and increase the number of half yearly reviews completed. RESPONSIVE: Prof Orchard reported that 88% of A&E patients had been treated and discharged or admitted in four hours in August; the continuing increase in referrals and admissions was balancing off the improvements in process and capacity, and the fact that performance had not fallen even further was a real credit to the team. Looking forward the additional impact of winter, and projected flu impact, the Trust was considering further escalation options, and also planning an enhanced communications programme such that patients can appropriately access the range of services available. Responding to a query from Dr Raffel, Prof Orchard noted an improvement in Vocare's performance in the urgent care centre, although there were still problems with late registering of patients; given that the Trust had no direct role in the CCGs contract with Vocare it remained difficult to address issues. Increase to the capacity at Charing Cross Hospital emergency department would commence in January and complete in March 2018. Dr Urch reported that all cancer standards had been met in the reporting period, but noted continuing late referrals made this a constant challenge; there had been no patient wait breaches for prostate cancer patients since the introduction of the new diagnostic pathway. However, waiting time performance for non-cancer routine patients remained a challenge; issues identified and considered addressed in 2016 had now been found not to have been effectively resolved, and further long-wait patients had now been identified. Immediate action was being taken, and comprehensive improvements introduced to 'business as usual' arrangements. All long-wait patients had been reviewed, and no clinical harm found, although the impact on patients' lives was not underestimated; all patients identified as having extended waits would be treated by late spring/ early summer 2018. Theatre efficiency was improving; key issues in the way that patients were pre-assessed and scheduled were being addressed. Responding to a question from Dr Raffel, Dr Urch commented that achieving 85% theatre efficiency would depend on improvement in these areas, it had become apparent that theatre efficiency was not isolated, whole	

	pathway improvement was required and being addressed, including reasons for patients not attending for their operations Prof Orchard reported that the endoscopy patient waiting time issues previously reported were being addressed with patients being treated at weekends, and the Trust would shortly return to its performance trajectory. Prof Teoh reported that outpatient patients not attending their appointments remained static as 12%, but work continued to improve this; hospital led cancellations continued to improve, and the target had just been lowered to 7.5%; the focus throughout outpatients' services was one of continuous improvement. The Trust board noted the integrated performance report.	
2.4	**Month 5 Finance report** Richard Alexander reported that, as noted in the chief executive officer's report, the Trust had agreed a revised control total with NHS Improvement. He then reported the financial position for month five (August); the Trust had met its financial plan in month and year to date. However, he reported that the Trust's latest year-end forecast was not as required, and further work was being done with clinical and non-clinical divisions to review potential improvement. The Trust was in discussion with NHS Improvement regarding the scheduling of a Use of resources review; this was a new assessment being introduced across the NHS. The Trust board noted the report.	
3	**Items for decision or approval**	
3.1	**Nursing and midwifery annual establishment review and safe staffing update** Prof Janice Sigsworth introduced the annual report which provided an overview of the establishment review process adopted by the Trust to provide assurance that ward nursing and midwifery establishments provided for safe and effective care. Responding to a query from Sarika Patel, she noted that the review took into account other trust's approaches and where a move from the national recommendation of 65/35% qualified nurses was proposed the rationale was recorded. Reflecting on Peter's Goldsbrough's comment as to the timeliness of the review, Prof Sigsworth commented that although this was an extended review to align with timings of business planning, the divisions reviewed acuity and dependency on a monthly basis, and planned for the flexibility required in the planning of staffing by having created a level of additional available staff. The Trust board noted: the completion of the annual establishment review and associated establishment changes: noted the national and local work to deliver safe, sustainable and productive staffing; and approved the review for publishing on the Trust website.	
3.2	**Annual workforce equality report** David Wells introduced the paper which provided an overview of key workforce equality metrics for 2016/17, and included the workforce race equality standard report which was required, by the Equality Act, to be published on the Trust website. He outlined the four key actions which formed part of the Trust's boarder wellbeing, equality and diversity strategy. Mr Wells highlighted that these actions were specific to race, but noted that similar attend was being paid to other forms of diversity and equality. Responding to a query from Peter Goldsbrough, he reflected that it was important to differentiate correlation from cause and effect when reviewing the findings, and this was being further investigated. It was concerning that 30% staff had reported bullying; Mr Wells outlined continuing work to understand and address this, including analysis of incidents reported on Datix, given low reporting through formal systems. Prof Sigsworth commented that greater comfort was being given by the 'speak-up' activities, and Dr Urch reflected that there was a more open culture across the Trust. The Trust board approved the report for publishing on the Trust website.	

3.3	**Hammersmith & Fulham Integrated Care Partnership** Anna Bokobza and Dr David Wingfield, introduced the partnership agreement, for which they sought Trust board approval to sign, as part of the latest briefing to board members on the progress of the accountable care partnership. Anna Bokobza outlined the proposal to introduce a 'committees in common' structure to allow joint working whilst ensuring the independence of sovereign organisations. The partnership agreement created no financial risk; it would be followed by an alliance contract outlining the specifics of services to be delivered. Organisations would need to consider the resourcing requirements of the partnership. The partnership proposed to test the accountable care concept on a population of 43,000, a level of risk which each of the organisation considered appropriate. Sarika Patel commented that this was clearly the future direction, but reflected that the data sharing consequences needed to be carefully considered; Kevin Jarrold confirmed that the requirement of the new legislation was being addressed as part of wider work across the STP footprint, and were appropriately reflected on the risk register. It was not expected that there would be any impact on CQC registration as services would, for now, remain with the existing provider. Dr Raffel noted that, as benefits started to be realised, it would be important to have benefit sharing arrangements in place. Responding to a query from Sir Richard Sykes, Anna Bokobza confirmed that the chosen population, whilst not necessarily reflecting a proportionate income flow, did appear to be a representative population in terms of care needs; the cohort would not be used for capitation funding. Peter Goldsbrough commented that the alliance contract would benefit from the articulation of specific clinical and financial benefits, a stronger position that the 'goodwill agreement' which was currently in place. Responding to Nick Ross, Anna Bokobza commented that all boroughs were at different points in the journey, but that the vision remained the same for all; currently services were very different, so implementing this would not increase that 'difference', and with a NW London plan (as part of the STP) services would become increasingly consolidated. The Trust board approved the signing of the partnership agreement, and the creation of a board committee to enable a committee in common approach.	
4	**Items for discussion**	
4.1	**Care Quality Commission (CQC) update** Prof Janice Sigsworth introduced the report which outlined: • The draft reports for the CQC inspections of medical care and maternity (March 2017), had been received and were being checked for accuracy prior to the awarding of a final rating. • That the Trust had submitted its first annual routine Provider Information Request (PIR) to the CQC. The PIR consists of a wealth of data related to performance against the CQC's five domains, and a self-assessment by the Trust of its core services and the organisation as a whole. • The new approach to the assessments of 'well-led' (jointly by CQC and NHSI) at the Trust, which would include an annual inspection of the well-led domain (review of the governance and decision-making processes among senior managers, and the board) using the jointly agreed KLOEs. NHSI had also introduced a 'use of resources' assessment and the Trust was currently awaiting confirmation as to when this would take place. • The revisions to the Trust's 2017/18 CQC Registration and Inspection Framework, including the introduction of self-assessments against the CQC domains by core service and by site, three times each year to the Executive (Quality) Committee and the Quality Committee. Prof Sigsworth also noted that CQC were expected to become more closely engaged with the Trust attending Trust board meetings, and requesting attendance at board committee meetings. Responding to Peter Goldsborough's concern at the risks and wasted resources of two regulators reviewing leadership, Prof Sigsworth's confirmed	

	that this concern had been reflected by trusts at national level. The Trust board noted the paper.	
5	**For information**	
5.1	**Board assurance framework** Jan Aps introduced the latest version of the framework, noting the addition of two new areas of activity – the transformation programme, and the impact of repeated major incidents on the Trust. The most recent executive assurance statements to the Trust board were also included; these were designed to provide assurance to the Trust that areas covered by the NHSI 'licence' requirements were appropriately managed and reviewed. Jan Aps noted that the board assurance framework had been subject to a recent internal audit and had been rated as providing 'substantial assurance'. The Trust board approved the board assurance framework.	
5.2	**Postgraduate medical education: report on the results of the General medical Council National Training Survey 2017** Dr Redhead introduced the results of the survey, which demonstrated that the significant improvements achieved in 2016 had been maintained, with further improvement in histopathology, GP paediatrics and child health, and no reporting of bullying or undermining concerns. Small pockets of less positive feedback remained, and these were being addressed. The Trust board noted the report.	
6.1-6.3	**Board committee reports** The Trust board noted the reports from the following committees: • Finance and investment committee • Redevelopment committee • Quality committee, particularly the robust 'flu plan which had been developed to ensure a higher uptake of the 'fly vaccine amongst staff.	
7	**Any other business**	
	There was no other business.	
8	**Questions from the public relating to agenda items**	
	• A member of the public outlined a less than positive experience whereby her husband had an extended stay in the Charing Cross Hospital emergency department, and an uncomfortable time on a ward, caused by air conditioning failure, pressures on nursing and inadequate cleaning. Also, other patients, apparently with dementia, were creating an unpleasant environment, and not being appropriately cared for. She commented that people felt that this reflected that the Trust were allowing the hospital to run down. Responding, Prof Tim Orchard, extended sincere apologies for the experience, and asked for further details as he would wish to further understand and improve the situation. He recognised the issues described as being problems that the Trust was seeking to address, and assured that the Trust was committed to improvement. • Another member of the public asked a number of questions relating to the integrated care paper; her details were taken so that she could be put directly in touch with Anna Bokobza to discuss further.	
	Date of next meeting	
	Public Trust board: Wednesday 27 September 2017, Clarence Wing Boardroom, SMH	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Record of items discussed at the confidential Trust board meetings on 27 September 2017

Executive summary:

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

Issues of note and decisions taken at the Trust board's confidential meetings held on 27 September 2017:

Referral to treatment waiting time target issues: further issues had been found in the accuracy of information held in the waiting list systems, and additional patients had been identified who had experienced extended waits. All cases had been reviewed to ensure there was no clinical harm to the patients involved, but members recognised this did not take account of the impact on patients' lives.

LINACs business case: noting that the final business case for the purchase and installation of two linear accelerators would be similar to the outline case presented to the Trust board in March 2017, the Trust board agreed to the delegation of approval to the chief executive officer and chief financial officer.

Transformation and sustainability plan: Board members discussed the executive's proposal for reshaping the Trust's business whilst delivering a reduction in underlying spend of £40m over four years along with an annual cost improvement programme of approximately £50m. The proposals would be discussed further at the Board seminar.

North West London Pathology (NWLP): the Trust board welcomed a report from the Chairman (Kingsley Manning) and Managing Director (Stephen Snewin) of NWL Pathology, who outlined the progress since NWLP had gone live in April 2017.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Jan Aps, Trust company secretary	Ian Dalton CBE, Chief executive officer

Annual General Meeting
13 September 2017

Members of the Trust board present:

Sir Richard Sykes	Chairman
Dr Andreas Raffel	Non-executive director
Ian Dalton CBE	Chief executive officer
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
Dr Julian Redhead	Medical director

Members of the executive team in attendance:

Kevin Jarrold	Chief information officer
Michelle Dixon	Director of communications
David Wells	Director of people and organisational development
Prof TG Teoh	Divisional director, women's, children's and clinical support
Prof Tim Orchard	Divisional director, medicine and integrated care
Dr Katie Urch	Divisional director for surgery, cardiovascular and cancer

The Chairman, Sir Richard Sykes welcomed members of the public and staff to the meeting, which was a key opportunity to reflect on what the Trust had achieved for patients and local communities in 2016/7, to consider priorities for 2017/18, and to account for how the Trust had used its valuable resources. He highlighted how the Trust was continuing to build on the great care, innovation and education our staff provide across its five hospitals and, increasingly, in the community. He expressed his gratitude to all of staff, supporters and volunteers, and partners in the NHS, local authority and voluntary sectors, for their hard work and commitment. He also expressed gratitude to Dr Tracey Batten, the former chief executive, who had left the Trust at the end of July, and welcomed the new chief executive officer, Ian Dalton, CBE.

Ian Dalton, in introduction, provided an outline of his background and experience as both a chief executive of two other NHS trusts and in senior posts at NHS England and the Department of Health. Most recently he had been president of global health and government at BT, and considered that leading an organisation with the expertise, values and commitment of Imperial College Healthcare NHS Trust, made him feel very proud and also excited about what he believed could be achieved for patients and local communities and for our staff and partners.

He then highlighted the key achievements and challenges of the Trust during 2016/17 and the plans for 2017/18. Recognising that 2016/17 had been a tough year for the whole of the NHS, as demand increased while financial constraints tightened, he noted that the Trust did hugely well in caring for more people than ever before while maintaining an excellent record on safety. It also continued to have one the lowest mortality rates of all acute hospital trusts in the country and delivered over £54 million of efficiency improvements to achieve the 'stretch' financial plan and the year-end target set by NHS England.

Ian Dalton outlined progress made across a wide range of service improvements:

- The impact of major investment in new digital systems and processes, facilities and training across our outpatient services had been recognised by the Care Quality Commission. After their inspection in November, they moved their ratings for outpatient services to 'good' overall at St Mary's and Hammersmith hospitals and up one level to 'requires improvement' at Charing Cross.
- Following extensive engagement with patients and the public, the Trust had introduced new 'direct entry' urgent care routes at Hammersmith Hospital, streamlined urgent cardiac care pathways and brought acute medicine services at Charing Cross together in new, expanded facilities.
- The Trust had embarked on the biggest estates improvement programme in years, largely thanks to the support of Imperial Health Charity, with building improvements worth

£18 million underway or completed at Riverside Theatres at Charing Cross, St Mary's A&E, outpatient clinics at Charing Cross, Hammersmith and the Western Eye hospitals, and the children's intensive care unit at St Mary's (also supported by COSMIC).

Ian Dalton also reflected that the quality improvement (QI) programme launched two years previously was going from strength to strength. Last year, the QI team engaged with around 3,000 staff, providing targeted training and coaching for over 400. More than 50 QI projects were completed or underway. He noted the significant investment being made in digital technologies to support all services. The Trust had been rewarded for this pioneering role when it was selected by NHS England, along with our partner Chelsea and Westminster Hospital NHS Trust, to be one of 16 global digital exemplars for acute care. This came with £10 million of additional funding over three years.

Moving to research, Ian Dalton described how the Trust continued to develop its long legacy of innovation in care and treatments across all of our hospitals, recruiting around 20,000 volunteers into clinical research studies each year, with around 600 such studies open at any one time. He noted that, in September 2016, the Trust had been awarded £90 million of funding by the National Institute of Health Research to run the biomedical research centre in partnership with Imperial College for a further five years.

Ian Dalton then spoke about education which, combined with clinical care and research, enabled the Trust to push the boundaries of what was possible, presently and for the future. He highlighted that, alongside the undergraduate teaching of over 800 doctors and 500 nurses and midwives, and the continuing training of almost 800 junior doctors, the Trust had expanded the scope and scale of the learning and development we provide. Over 100 apprentices had joined the Trust in a range of roles. The Trust was also helping pioneer the role of the associate nurse across acute and community services, and was offering more multi-professional development, supporting and investing in all of our staff including the increasingly important role of therapists.

Turning to the significant operational challenges which, like many other NHS trusts, the Trust had faced Ian Dalton acknowledged that the Trust had struggled to meet all of the national waiting time standards. The reasons were complex, and included increased demand for services, pressure on our health and care partners making it harder to discharge patients to more appropriate care and growing problems with the Trust's ageing estate. Specifically, this had meant that:

- Overall, 90 per cent of patients attending A&E had been treated and discharged or admitted within four hours, against the national standard of 95 per cent. The Trust was making improvements across our urgent and emergency pathways, from expanding the 'outpatient' emergency care to working with partners to streamline discharge processes.
- For waiting times for planned care, the Trust treated 84 per cent of patients within 18 weeks of referral, against the national standard of 92 per cent, and also identified some patients who had been waiting over a year. The Trust took this very seriously and had a comprehensive waiting list improvement programme, including a systematic data clean-up, better processes and training for managing lists and additional clinical and theatre capacity.
- The Trust had met four out of the eight cancer waiting standards consistently across the year but had not always meet the other four, including the two-week wait from urgent referral to first being seen, and the 62-day wait from urgent GP referral and from screening for first treatment. A focus on improvement continued, including through our long standing partnership with Macmillan Cancer Care.

Ian Dalton reported that operational performance had improved over recent months through a whole range of initiatives and huge effort on the part of our staff. But he recognised that sustainable improvement would require more strategic change in response to strategic challenge, which would be his focus in the coming months in association with the executive team, staff and all stakeholders. He acknowledged that while the Trust's most pressing challenge often appears to be the financial

one, the way in which the Trust would become financially sustainable was inextricably linked with the even more important strategic challenges.

- Responding to growing and changing needs, particularly in relation to long term health conditions. Ian Dalton reflected that the Trust was engaged in making some real headway in developing a more sustainable response to those changing needs:
  - working more collaboratively including with our patients and local communities
  - the establishment of the strategic lay forum and appointment of over 30 lay partners to specific programmes and projects
  - the North West London Sustainability and Transformation Plan
  - the five-year strategy for tackling shared challenges in health and care
  - the Hammersmith and Fulham Integrated Care Programme, bringing together GPs, acute, community, mental health and social care providers to re-organise care around the needs of local people
  - the pilot of the Care Information Exchange, offering patients and their health and care professionals in north west London secure online, access to care records and to sharing information.
- Ensuring that the Trust had enough people with the right skills in the right roles. Ian Dalton noted that while the Trust's vacancy rate, just over 12 per cent, was better than the London average, it was not where the Trust needed it to be, especially given that it was likely to get harder to attract and retain staff. He highlighted the need to continue to create an organisational culture and an offer that draws and rewards a diverse and motivated workforce, and welcomed the fact that the Trust had achieved its highest ever staff engagement score in the recent staff survey, following a major focus on this area.
- Securing investment for the sorts of buildings and facilities. Ian Dalton reflected that this was essential in order to support high quality care, research and education for the future. He reported that the Trust had some of the highest levels of backlog estate maintenance across the whole NHS. He appreciated that the estates team do amazing work to keep the buildings – including many Victorian and pre-war facilities – available, including having upgraded boiler plants and theatre ventilation and replaced ceilings and floors. However, it was getting harder and he was clear that patients and staff deserved better. He reported that the Trust had progressed its planning application for a first phase redevelopment of the St Mary's estate, the oldest of the sites; he recognised that it was also important for the Trust to have an overall strategic plan for our estates redevelopment.

Looking forward, Ian Dalton highlighted that his priority was to build on what had been achieved already, to empower staff and to strengthen partnerships with patients, carers, GPs, other health and care providers in order to accelerate more strategic improvements. He shared his commitment to the public that the Trust would always be open and transparent about the challenges and opportunities it faced and would ensure that patients and the public were able to actively shape and contribute to every aspect of its work. He acknowledged that change was inevitable and much needed, but recognised that more needed to be done to explain, to listen and to work with others.

Ian Dalton closed by giving particular mention to two aspects of the Trust's work deserving of a special mention:

- Acknowledging the BBC2 series 'Hospital', which went behind the scenes at our hospitals, and provided an opportunity to show the amazing care and commitment of the staff as well as the growing challenges we face as we respond to changing needs and demands.
- Recognising and paying tribute to the staff's response to three major incidents: the terrorist attacks at Westminster Bridge and London Bridge, and the tragic fire at Grenfell Tower in north Kensington.

Richard Alexander took to the rostrum to present the Trust's annual accounts for 2016/17. He started by commenting that after a really disappointing 2015/16, it was good to have delivered the financial plan again in 2016/17.

He noted that the Trust's position had actually been £1.5 million better than the planned deficit due to a slightly better in-year performance for which the Trust had received a bonus from NHS Improvement. However, while it reduced the overall reported deficit, it had not been cash that the Trust could spend.

Confirming the year-end position as a deficit of £15.3 million, Richard Alexander acknowledged that, nonetheless this was still a deficit, which demonstrated that the Trust had spent more money on patient care than it had received, and was dependent upon cash support from NHS Improvement.
He noted that while the deficit was a real problem, it was important to recognise that normal business continued. Nearly £50 million had been spent on capital schemes to improve the estates and equipment. Of this, £8.3 million had been received from the Imperial Health Charity, for which he extended thanks. £1 million had been a loan to invest specifically in energy saving measures and £200,000 had been received as government grants.

Returning to the deficit position, Richard Alexander noted that, to reach this position, the Trust had delivered record savings of nearly £54 million. While this was slightly lower than the challenging target it had been a big achievement and had required a huge effort from all our staff. Moving to the Trust's cash position, he noted that the Trust's cash balance of £21.0 million ensured the Trust met its required cash target, and the Trust borrowed £15.8 million to meet its day-to-day obligations.
Showing 2016/17 figures against those of 2014/15 and 2015/16, Richard Alexander noted that the Trust had delivered more activity and received more income than ever before, and highlighted the impact the Sustainability and Transformation funding, at £25.5 million, had on our numbers. It improved our deficit from what would have been another £40m deficit (little improved on 2015/16) to a reported deficit of £15.3m.

He then reflected that £1 billion was a lot of taxpayer's money, and outlined where it came from and where it was spent. Three quarters of all income was directly spent on treating NHS patients and another ten per cent on education and research, one of the biggest budgets in this area of any UK hospital at £110 million.

Richard Alexander highlighted that non-NHS patient care (£68 million) included work for local authorities, overseas patients, and £46 million of private patient care delivered He emphasised that every pound the Trust made delivering private care came back into the NHS. Non-patient care services included the provision of pathology to other organisations, something the Trust hoped to grow now that it had set up a shared operation with Chelsea and Westminster and Hillingdon foundation trusts. He reported that a total of £600 million had been spent on staff. He noted that while recruiting staff continued to be a challenge, the Trust had managed to reduce its dependency on temporary staff.

Turning to the £53.8 million of savings which had been delivered as part of delivering sustainable services for our patients and an improved financial position for the tax payer, Richard Alexander outlined the types of savings that had been made across the organisation. These included:

- delivering more services to our patients in a cost effective manner
- providing additional joined up services to our patients in a more appropriate and accessible setting
- reducing our reliance on, and the amount we pay to, agencies for temporary staff
- reduced use of external consultancy
- improving procurement, including switching to alternatives and non-brand items as well as better stock management.

In taking a quick look at the current year, 2017/18, which started in April, Richard Alexander particularly noted that:

- income and activity continued to increase, primarily in the areas of specialist care
- the capital budget included £36m of internally generated funds, £7m from Imperial Charity and anticipated PDC awards (subject to control total)

- the Trust has enough cash to meet its obligations.

Bringing his presentation to a close, Mr Alexander looked forwards, highlighting the challenge in the underlying numbers. He drew attention to the big gap between our underlying position and the reported numbers after the sustainability and transformation funding and also non-recurrent savings that the Trust can generate from its balance sheet. The encouraging news was that the Trust was focusing on improving the underlying position.

Sir Richard Sykes then invited all the executive team to the rostrum. He then invited questions from the floor:

Question	Response
A patient expressed their frustration at having to travel to different sites for different parts of their care.	Julian Redhead assured the member of public that the same level of care was provided at each of the sites, adding that the Trust needed to try and manage the way in which beds and services were spread across sites.
A member of the public brought to the panel's attention that their elderly mother had been discharged into the community without appropriate care organised.	Julian Redhead offered an apology to the member of public for their mother's poor experience adding that Trust policy was to discharge patients safely at all times.
A member of the public asked whether they could do anything to support the redevelopment issues particularly around the road access at the St Mary's Hospital site.	Michele Wheeler thanked the member of public for their support and provided an update on the progress of the Trusts redevelopment programme: Phase one St Mary's redevelopment planning application: It was confirmed that the Trust's application would be heard at 26 September meeting of Westminster City Council planning committee. Paddington Cube safety concerns over 'blue light' access to St Mary's Hospital: It was confirmed that the s106 agreement in relation to the Paddington quarter development had been signed. The Trust was seeking legal advice and considering its position.
A patient expressed concern at the estate of the lifts and escalators, particularly at the Charing Cross site.	Prof Sigsworth recognised the frustrations relating to the condition of the estate and offered apologies to the patient, assuring them that there was a comprehensive programme in place to address the backlog maintenance of the Trust's poor estates.
A member of the public and 'Save our hospitals' welcomed Ian Dalton as the new chief executive and added that they were happy to have had constructive discussions with Dr Tracey Batten; they extended an invitation to Ian Dalton to continue these.	Ian Dalton thanked the member of public and confirmed that he would be happy to continue the regular discussions with the 'Save our hospitals' members.
A member of the public asked about the outcome of the general election and whether this had affected the STP	The panel confirmed that the STP direction and pace had not changed and pan-economy discussion as to the most appropriate way in which to deliver care services in the longer term continued.
A member of the public expressed concern that restructuring of nursing shifts could possibly lead to less breaks.	Prof Janice Sigsworth assured the member of public that there had not been any changes to the nursing shifts and that, whilst twelve hour shifts would not be her preferred option, often this was the personal choice of some staff, particularly if fitting work around bringing

Question	Response
	up young children for example. She added that the Trust wanted to support a work life balance for its staff.

Bringing questions to a close, Sir Richard Sykes then introduced Dr Sanjay Guatama. Dr Guatama highlighted progress with the Care Information Exchange, a patient and clinician portal which provided access to a range of information. The system was currently populated with 700,000 patients' data from across six NHS Trusts, with over 2,000 active patients on the system. Clinicians were using this to drive transformation and had reported high levels of benefit to the small cohort of patients that had piloted it. He highlighted the key areas that it would impact including the management of complex pathways including virtual multi-disciplinary teams and shared care plans across the wider NHS. Information would be shared between organisations which would be available for authorised users to view and patients would have access to their own records and be able to contribute to the content. Data could also be shared for research purposes.

Dr Gautama introduced Parker Moss, a member of the public whose daughter received cancer treatment at the Trust and in other settings, to discuss the benefits that he had experienced with the Care Information Exchange first hand. The system had enabled Mr Parker to access timely blood test results each morning, enabling him to notify her school if they needed to take specific action. It allowed him and his family to take control of their daughter's care, when and where they needed it. Mr Moss reported that as well as reducing his stress, it saved the amount of time that he spent communicating with site practitioners, as well as avoiding hospital admissions where possible. During his presentation, Parker Moss shared with the audience the tragic news that his beloved daughter had lost her battle with the cancer and had recently died - the heartfelt sorrow of all present was reflected in the applause that he received.

Question	Response
Data protection – what is the Trust doing to ensure that data is correct?	Dr Sanjay Guatama confirmed that the programmes of work in place across the Trust to ensure that the input of data was correct, confirming that patient identifiable data was removed before being released for the use in research.

Sir Richard Sykes closed the meeting by extending thanks to Parker Moss and all speakers, the production team, staff who had provided the stands, and the members of the public and staff who had attended. He asked attendees to provide feedback on the event to enable continued improvement, and confirmed that the proceedings of the meeting would be made available on the Trust website.

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status update

MATTERS ARISING

Minute Number	Action /issue	Responsible	July 2017 Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board	29 November 2017

Patient Story

Executive summary:

Patient stories are seen as a powerful method of bringing the experience of patients to the Board. Their purpose is to support the framing of patient experience as an integral component of quality alongside clinical effectiveness and safety.

This month's patient story highlights how those moments of 'small acts of kindness' can have a significant impact on patient experience as staff demonstrate kindness, care and compassion.

Nicky D was admitted to our hospital in July 2017 following a traumatic road traffic accident when she was knocked from her cycle and sustained significant leg injuries. Nicky D was initially nursed in an acute surgical ward and then moved to our private patient services almost a week later. She will reflect upon a number of 'moments of care' where staff demonstrated those 'small acts of kindness' that positively impacted on her overall experience.

Quality impact:

The Board will hear how positive human interactions – such as a smile, a hug, calling someone by their name, introducing yourself, spending time listening and talking – can bring comfort at a time of personal crisis.

This activity is relevant to the safe and caring CQC domains.

Financial impact:

None

Risk impact:

None

Recommendation(s) to the Trust board:

The board is asked to note this paper and the patient story

Trust strategic objectives supported by this paper:

To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Guy Young Stephanie Harrison-White	Janice Sigsworth	07.11.2017

Patient Story

1. Background

The use of patient stories at Board and committee level is increasingly seen as a 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 (most stories will feature positive as well as negative experiences) and that the organisation is capable of learning from poor experiences;
- To illustrate the personal and emotional sequelae of a failure to deliver quality services, for example following a serious incident.

The Board has previously approved the patient and public involvement strategy, a key part of which is engagement with users of our services and increasing the number of patients who are actively involved.

2. Nicky D's story

It is well documented in the field of patient experience that it is those seemingly 'small acts of kindness' that can transform a patient's experience. Kenneth Schwartz, an American healthcare attorney and cancer patient, is quoted as saying 'And yet, the ordeal has been punctuated by moments of exquisite compassion. I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness, the simple human touch from my caregivers, have made the unbearable bearable'. Schwartz's legacy was the introduction of Schwartz rounds now embedded in our organisation.

Dr Kate Grainger, a British geriatrician and cancer patient, reminded us 'in my mind the little things aren't little at all, they are indeed huge and of central importance in any practice of healthcare. When I say 'little things' I mean someone sitting down next to you rather than standing over you; someone holding your hand when you're upset or distressed; someone taking that extra moment to really listen and allow you to express your fears; someone recognising you are in pain and being gentle when they examine you." Dr Grainger was largely responsible for driving the 'hello my name is' national campaign in the UK, recognising the importance of knowing someone's name.

Our Trust values confirm our commitment to demonstrating kindness in all of our interactions. Nicky D will describe how she experienced many moments of 'small acts of kindness' during her extended admission and how these moments transformed her care.

Nicky D was involved in a serious cycle accident on 12 July 2017 when she sustained significant leg injuries resulting in her becoming temporarily 'bed bound' and needing multiple operations. She described feeing that she 'regressed' during this period from being an independent professional woman to one who could no longer take care of her own basic needs. The injury impacted on her overall health and well-being – mentally, physically and emotionally.

Nicky D was nursed in the NHS side of our organisation and in one of our private wards. The

initial period was on the NHS side whilst she had her immediate life and limb saving surgery. During this time, Nicky was aware of some challenges faced by our staff, for example a lack of intensive care beds which meant she was nursed in Recovery in the immediate post operative period and a lack of towels and linen on the wards, impacting on her own comfort and hygiene. Throughout these challenges, Nicky describes the staff and how kind and compassionate they were. She will recount how one anaesthetist for example hugged her when she was upset and how this made her feel.

On moving to the private side of our organisation these resource issues were not evident. However, the biggest impact was the continued kindness and compassion shown by our staff. Nicky D describes how all staff displayed the 'human' touch; smiling, hugging her and introducing themselves. At those times when her dignity was compromised due to her physical condition and injuries, staff were sensitive and treated her with dignity and respect. For example, she will describe the hostess taking extra time with her when nutrition was so important but she did not have an appetite; encouraging her and offering her additional choices.

3. Lessons learnt

The human connection demonstrated through positive behaviours can transform the most difficult and painful physical experience into an overwhelmingly positive experience. We are proud that our values have been shown to have a positive impact on Nicky's experience, as staff demonstrated ***kindness*** through meaningful interactions including active listening; introducing themselves by name, smiling and human contact. It was evident that all grades of staff demonstrated these behaviours at all times.

Nicky is keen to continue working with the patient experience team to share her story wider so that we can continue to learn and embed our values and behaviours in practice.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	**29 November 2017**

Chief Executive Officer's Report

Executive summary:

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

Key strategic priorities:

1) Financial performance
2) Financial improvement programme
3) Operational performance
4) Stakeholder engagement
5) Update on major building improvements
6) Redevelopment update
7) The future of Charing Cross Hospital
8) Winter planning

Key strategic issues:

9.) NHS Improvement single oversight framework update
10.) NHS Improvement undertakings agreement

Quality impact:

N/A

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered 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.

Author	Responsible executive director	Date submitted
Ian Dalton, Chief Executive Officer	Ian Dalton, Chief Executive Officer	22 November 2017

Chief Executive Officer's report

Key Strategic Priorities

1. Financial performance

The Trust has an agreed control total with NHS Improvement for a planned deficit of £25.2m- including £20.7m of Sustainability and Transformation funding (STF). The Trust will obtain the STF funding if it achieves the financial control total and if it achieves the agreed trajectories for Accident and Emergency four hour patient wait target and primary care streaming.

In October 2017, the Trust reported an in-month deficit, before STF of £0.9m which was £2.0m worse than plan for the month. The key factor driving the adverse variance was the phasing of the plan with an increase in CIPs expected in month 7. Year to date (i.e. the seven months up to the end of October 2017) the Trust reported a deficit of £21.6m which is also £2.0m worse than plan.

The Trust expects to meet the control total for the full financial year (i.e. by the end of March 2018).

STF achievement is monitored on a quarterly basis and the first assessment was at the end of September. The Trust achieved the financial targets and therefore was eligible for the 70% of STF but failed to meet the A&E target for the quarter and so did not receive £1.5m of funding.

2. Financial improvement programme

The Trust has set a £54.4m cost improvement programme (CIP) in 2017/18 as part of its overall financial plan; this is in line with the value achieved in 2016/17 of £53.8m.

The year to date plan is £26.9m, there has been achievement of £19.0m giving a £7.9m underperformance. This underperformance is due to a combination of slippage against planned schemes and yet to be identified plans. Divisions meet weekly with the Programme Support Office and Trust management team to review progress on identification and achievement of CIPs.

The specialty review programme is continuing across the Trust. This is a clinically- led approach to supporting clinical specialties to develop sustainable plans, including clinical, workforce and financial data. PWC have provided some targeted support to the Women's Children's and Clinical Support Division to help identify and achieve CIPs**.**

3. Operational Performance

Cancer 62 day waits: In October 2017, performance was reported for the Cancer waiting times for September 2017. The Trust delivered performance of 89.6% against the 62-day standard for September which is above the national standard of 85% and ahead of trajectory (85.1%).

Accident and Emergency: Performance against the four-hour access standard for patients attending Accident and Emergency was 86.6% in October 2017 which did not meet the performance trajectory target for the month. The key issues remain as follows:

- Difficulties with transfer of patients from the Vocare Urgent Care Clinic to the Emergency Department at SMH;
- Increased demand and acuity within type 1 departments;

- High levels of bed occupancy;
- High numbers of bed days lost through a combination of delayed transfers of care from the hospital, delays for mental health beds and on-going estate issues.

A four-hour performance steering group has been established to oversee a programme of improvements across six work streams and a new system to measure impact of the schemes has been put in place. The group is chaired by the divisional director for medicine and integrated care. Each work stream is led in partnership by a senior clinician and a senior manager.

4. Stakeholder engagement

The Trust's strategic lay forum met on 9 October for the latest of its bi-monthly meetings.

I held my first meeting with representatives of Save Our Hospitals in October. In November, together with local commissioners, we responded to Healthwatch Central West London who put forward a set of questions regarding Charing Cross Hospital. We are also holding an Open Door event for the local community and stakeholders at Charing Cross Hospital on 27 November. This event marks and celebrates Charing Cross Hospital's past, as well as sharing and clarifying current plans and looking to the future.

We were pleased to host a visit by Health Minister Lord O'Shaughnessy to the cardiac catheter laboratories at Hammersmith Hospital in November. And we were delighted to welcome the President of Malta to Charing Cross Hospital this month to visit the Ear, Nose and Throat service which treats patients from Malta under a bilateral agreement providing specialist healthcare.

5. Update on major building improvements

Refurbishment of Main Outpatients: Main outpatients and renal outpatient department refurbishment works at Hammersmith have recently been completed, with just minor snagging items outstanding. Phase one works in main outpatients at Charing Cross Hospital has been completed and works have started on phase 2. Planned overall completion date of March 2018. The whole refurbishment programme for outpatients has been funded by Imperial Health Charity.

Paediatric intensive care unit (PICU) at St Mary's Hospital: Works continue to support the expansion of, and improvements to PICU. Phase one is near complete to prepare new space in Cambridge Wing to allow relocation of the paediatric research unit in December 2017, which, in turn, will allow works to start in early January 2018 for the expansion space for PICU in the Queen Elizabeth Queen Mother(QEQM) building. The redeveloped unit will have 15 beds, almost doubling the current number, plus new equipment, a dedicated parents' room and a private room. This project is divided into three phases with a final completion date scheduled for mid-February 2019. The project is funded through both Trust capital and Imperial Health Charity funding.

Reorganisation of critical care to create co-located high dependency unit (HDU) provision-St Mary's Hospital: Works are currently underway in Zachary Cope ward and also in Charles Pannett Ward within the Queen Elizabeth Queen Mother building. The works consist of alterations to provide new clinical service rooms, new research office and MDT space. Works are planned to be completed before Christmas 2017 with the exception of the 5 bed bays in HDU, which should start in the New Year.

7 North Ward at Charing Cross Hospital: Major refurbishment works to 7 North ward has recently commenced to provide improved patient bed bay areas and associated clinical

rooms. Works are being carried out in phases to ensure there is minimum disruption to services and beds over the coming winter period. The works are planned to be completed end of March 18.

Imaging replacement programme: This scheme runs over two financial years and consists of the upgrade and replacement of imaging equipment throughout all three of the Trust main sites. The order with the supplier has been raised and works will commence shortly, starting with St Mary's site, followed by Charing Cross and Hammersmith sites .

Other capital projects currently in feasibility or out to tender include:

- Emergency Department re-configuration at Charing Cross hospital to expand the resuscitation and majors areas. Currently out for tender and will be put forward for Full Business Case in December 2017. Works are planned to start in the New Year, once approved.
- 6th Cath Lab at Hammersmith Hospital. The scheme will consist of a new cath lab and recovery area to support the existing Cardiac service on the Hammersmith Site. The scheme is currently in design and anticipated to start construction in the new financial year.
- Grand Union Ward at St Mary's Hospital, QEQM. This project is in feasibility and will be developed to FBC for approval in the new financial year. The works consist of upgrading the ward to include new isolation rooms and associated clinical service rooms.

6. Redevelopment update

Phase one St Mary's redevelopment planning application: The application had been given resolution to grant at the September meeting of Westminster City Council (WCC) planning committee. The Mayor's Stage 2 referral decision - confirming that he is content to allow WCC to determine the case itself, subject to any action that the Secretary of State may take -was received in October. The next stage in the process is to agree the Section 106 with WCC.

Paddington Cube safety concerns over 'blue light' access to St Mary's Hospital: The Trust had submitted court papers for a Judicial Review. The Trust's desired outcome remains to achieve a safe and operable road access.

7. Future of Charing Cross Hospital

In response to concerns raised by staff and the public about the future of Charing Cross Hospital and the potential impact on staff morale, recruitment and retention, we organised two days of activities in November – one for staff (16 November) and one for patients and the public (27 November).

The events aimed to mark and celebrate the hospital's past, share and clarify current plans and look to the future. The events were also intended to showcase the significant investments being made at Charing Cross, in partnership with Imperial Health Charity, and to generate discussion about how we can best work in partnership with our staff, patients and local community on change.

Information about the events, including the full presentation, are being made available on our intranet and website.

8. Winter planning

The Trust is implementing a series of additional measures to help manage winter pressures. These include:

- 20 flex beds plus processes for bringing them into use as quickly and safely as possible
- Creating up to 42 extra 'permanent' winter beds – four are now open in paediatrics, the

rest will all be open by early December
- Expanding frailty team with additional dedicated pharmacy and occupational therapy input, starting in early December
- Expanding weekend 'acute take' team with additional registrar, senior nurse and occupational therapy – enhanced take team and senior nurse presence was put in place at St Mary's on 18 November
- Additional transport and porter resource – porter increase began 20 November, transport will start early December
- Improving escalation process for delays in transferring patients to their 'home' hospital
- Reviewing the clinical criteria for urgent chest pain pathway to enable more patients to go directly to the specialist heart attack centre – clinical protocol is being developed and expected to launch in early December
- 'Get winter ready' campaign, including tailored checklists and factsheets for staff, GPs and the public.

There is a fortnightly, Trust-wide group to oversee operational delivery of the winter schemes, and we are finalising a suite of key performance indicators to monitor the programme.

9. NHS Improvement single oversight framework update

The first version of the single oversight frame work (SOF) was published by NHS Improvement (NHSI) in September 2016; the Trust board received a full briefing at its meeting that month. Since introduction of the framework, the Trust has been placed, by NHSI, in segment 3 of 4 segments, relating predominately to financial position and performance on constitutional standards.

In light of recent developments and to reflect learning from the framework's first year of operation, NHSI conducted this feedback exercise on making some changes to the SOF, including:
- Changes to improve the structure and presentation of the document, updating the introductory sections and summarising key information more succinctly
- Introducing a separate sect ion outlining the five key themes of the SOF and summarising under each theme what would trigger consideration of a support need
- Changes to some of the metrics that NHSI uses to assess providers' performance under the SOF themes and the indications that trigger consideration of a potential support need (including removing some metrics and adding new ones).
- Making clear under all themes that in addition to specific trigger s, other material concerns arising from intelligence gathered by or provided to NHSI could trigger consideration of a support need
- Making explicit that providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring.

NHSI did not propose any changes to the underlying framework itself- i.e. there will be no changes to the five themes, NHSI's approach to monitoring, how support needs are identified, and how providers are segmented.

10. NHS Improvement undertakings agreement

As the Trust board is aware, the Trust has been in discussion with NHS Improvement (NHSI) to enable agreement on a series of 'undertakings', sought by NHSI, as the Regulator, from the Trust. A form of words has now been agreed between the Trust and NHSI; a copy of the document is attached to this briefing.

The delivery of the undertakings forms a key element of regulatory requirement, and NHSI will expect a robust monitoring mechanism to be in place to review progress, and ultimately delivery, of each element. It is recognised that much of the undertaking reflects existing

commitments monitored as part of the Trust's overall performance, but to ensure all items are addressed, bi-monthly summary monitoring reports will be provided to the Trust board.

NHS Improvement

NHS TRUST:

Imperial College Healthcare NHS Trust
The Bays
South Wharf Road
St Mary's Hospital
London
W2 1NY

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS Improvement has decided to accept undertakings from the Trust.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TDA Directions;

"NHS Improvement" means the National Health Service Trust Development Authority;

"TDA Directions" means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. The Trust

   The Trust is an NHS trust all or most of whose hospitals, facilities and establishments are situated in England.

2. Issues and need for action

   2.1. NHS Improvement has reasonable grounds to suspect that the Trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following equivalent conditions to that of the Monitor Licence: FT4(5)(a), (c) and (d).

2.2. In particular:

Finances

2.2.1. The Trust went into deficit in 2015/16 and was unable to agree its control total at the beginning of the 2016/17 financial year. After intensive support as part of the Financial Improvement Programme, a revised control total of a deficit of £16.8m was accepted and delivered. The Trust has recently accepted a revised control total of £25.1m deficit before STF and £4.5m deficit after STF. This will be reflected in reporting from month 5.

2.2.2. The Trust has started to develop a financial recovery plan to return to surplus.

Operational performance

2.2.3. The Trust has failed to meet the A&E waiting time target since June 2015.

2.2.4. The Trust is not delivering the RTT incomplete performance target.

2.2.5. The Trust has a number of patients waiting more than 52 weeks for elective treatment.

2.2.6. The Trust's endoscopy booking process is not fully functioning which means that a considerable number of patients have not had their scope appointments within the DM01 target time standard.

2.3 Need for action:

NHS Improvement believes that the action which the Trust has undertaken to take pursuant to these undertakings, is action required to secure that the failures to comply with the relevant requirements of the equivalent Licence conditions do not continue or recur.

UNDERTAKINGS

NHS Improvement has agreed to accept and the Trust has agreed to give the following undertakings.

1. Finances

1.1. The Trust will take all reasonable steps to return to underlying surplus by the start of 2021/22 with year on year improvements in the underlying position, including the actions set out in paragraphs 1.2 to 1.5 below.

1.2. The Trust will by the end of January 2018, or such a date as specified by NHS Improvement, develop a financial recovery plan (the "Financial Recovery Plan") to return to surplus by the start of 2021/22,.

1.3. The Trust will agree a clear timetable and milestones for delivering the Financial Recovery Plan with NHS Improvement and submit such progress reports as NHS Improvement shall request. Including agreeing a cost improvement plan to deliver 2018/19 control total recurrently.

1.4. The Trust will take all reasonable steps to ensure adequate capacity and capability is in place to deliver the Financial Recovery Plan.

1.5. The Trust will keep the Financial Recovery Plan under review, and agree necessary amendments with NHS Improvement.

2. Emergency care

2.1. The Trust will take all reasonable steps in order to achieve sustainable compliance with the four hour A&E target, including the actions set out in paragraph 3.2 to 3.5 below.

2.2. The Trust will take all reasonable steps to maintain its A&E target at or above 90% throughout Winter 2017/18.

2.3. The Trust will take all reasonable steps to achieve and maintain a performance of 95% by the end of March 2018, or such other date as specified by NHS Improvement.

2.4. The Trust will, by a date to be agreed with NHS Improvement, develop and submit to NHS Improvement a dashboard allowing the Trust Board to track the effectiveness of the Improving Patient Flow plan.

3. Referral to Treatment standard

3.1. The Trust will take all reasonable steps to validate the accurate number of patients waiting more than 52 weeks and ensure that all patients waiting over 52 weeks for elective treatment have either received treatment or been discharged by such date as specified by NHS Improvement.

3.2. The Trust will develop and submit an RTT recovery plan by a date to be agreed with NHS Improvement; such plan will confirm that the RTT incomplete performance target will be achieved by a date specified by NHS Improvement.

4. Data Quality

4.1. The Trust will commission an independent review by end November 2017 of the clinical and administrative processes within its elective pathways, and the clinical oversight of those processes which ensure patients do not suffer avoidable harm, in order to assure NHS Improvement that the processes are fit for purpose.

5. Programme management

5.1. The Trust will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

5.2. Such programme management and governance arrangements must enable the Trust board to:

5.2.1. obtain clear oversight over the process in delivering these undertakings;

5.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and

5.2.3. hold individuals to account for the delivery of the undertakings.

6. Meetings and reports

6.1. The Trust will attend meetings or, if NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS Improvement.

6.2. The Trust will provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.

Any failure to comply with the above undertakings may result in NHS improvement taking further regulatory action. This could include giving formal directions to the Trust under section 8 of the National Health Service Act 2006 and paragraph 6 of the TDA Directions.

THE TRUST

Signed

Ian Dalton CBE

(Chief Executive Officer)

Dated: 7 November 2017

NHS IMPROVEMENT

Signed

[Chair OR Member] of the Regional Provider Support Group (London)

Dated: 23 November 2017.

Imperial College Healthcare NHS Trust

Report to:	Date
Trust board - public	**29 November 2017**

Integrated Performance Report

Executive summary:

This is a regular report and outlines the key headlines that relate to the reporting month of October 2017 (month 7).

Recommendation to the Trust board:

The Board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Terence Lacey (Performance Support Business Partner) Julie O'Dea (Head of Performance Support)	Julian Redhead (Medical Director) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Catherine Urch (Divisional Director) Tim Orchard (Divisional Director) Tg Teoh (Divisional Director)

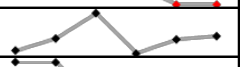
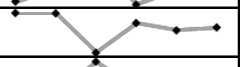
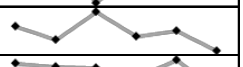
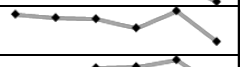
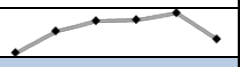
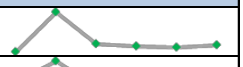
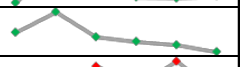
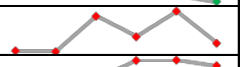
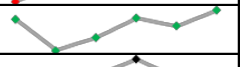
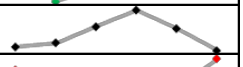
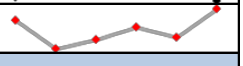
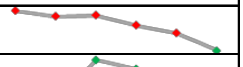
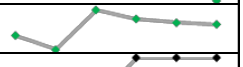
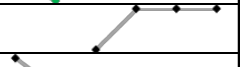
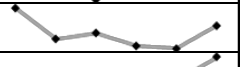
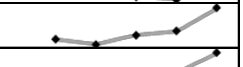
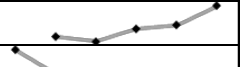
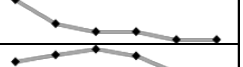
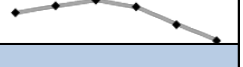
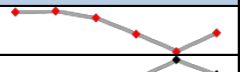
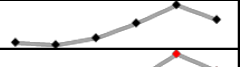
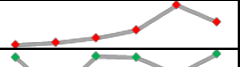
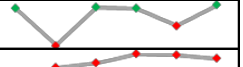
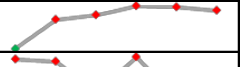
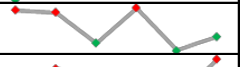
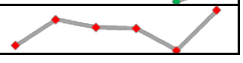
Contents

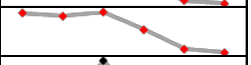
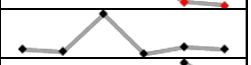
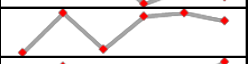
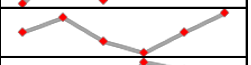
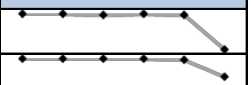
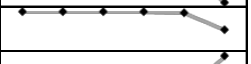
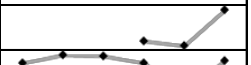
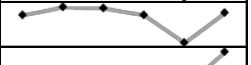
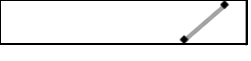
1. Scorecard

ICHT Integrated Performance Scorecard - 2017/18

Month 7 Report

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	Julian Redhead	Oct-17	-	**18**	
Incidents causing severe harm (number)	Julian Redhead	Oct-17	-		
Incidents causing severe harm (% of all incidents YTD)	Julian Redhead	Oct-17	-	**0.08%**	
Incidents causing extreme harm (number)	Julian Redhead	Oct-17	-	**1**	
Incidents causing extreme harm (% of all incidents YTD)	Julian Redhead	Oct-17	-	**0.09%**	
Patient safety incident reporting rate per 1,000 bed days	Julian Redhead	Oct-17	44.0	**56.6**	
Duty of candour compliance (Feb 17 - Sep 17) at 31/10/17:					
Compliance with duty of candour (SIs)	Julian Redhead	Sep-17	100%	**98.0%**	
Compliance with duty of candour (Level 1 - internal investigations)	Julian Redhead	Sep-17		**48.0%**	
Compliance with duty of candour (Moderate and above incidents)	Julian Redhead	Sep-17		**74.0%**	
Never events (number)	Julian Redhead	Oct-17	0	**0**	
MRSA (number)	Julian Redhead	Oct-17	0	**0**	
Clostridium difficile (cumulative YTD) (number)	Julian Redhead	Oct-17	62	**33**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	Julian Redhead	Oct-17	95.0%	**93.0%**	
CAS alerts outstanding (number)	Janice Sigsworth	Oct-17	0	**3**	
Avoidable pressure ulcers (number)	Janice Sigsworth	Oct-17	-	**0**	
Staffing fill rates (%)	Janice Sigsworth	Oct-17	tbc	**96.5%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Oct-17	2.8%	**2.8%**	
Core Skills (excluding Doctors in Training) (%)	David Wells	Oct-17	90.0%	**84.0%**	
Core Skills (Doctors in Training) (%)	David Wells	Oct-17	90.0%	**71.5%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Oct-17	tbc	**80.4%**	
Core Clinical Skills (Doctors in Training) (%)	David Wells	Oct-17	tbc	**63.4%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Oct-17	0	**1**	
Effective					
Hospital standardised mortality ratio (HSMR)	Julian Redhead	Jun-17	100	**66.0**	
Mortality reviews at 21/11/17:					
Total number of deaths	Julian Redhead	Sep-17	-	**161**	
Number of local reviews completed	Julian Redhead	Sep-17	-	**112**	
% of local reviews completed	Julian Redhead	Sep-17	100%	**70.0%**	
Number of SJR reviews requested	Julian Redhead	Sep-17	-	**24**	
Number of SJR reviews completed	Julian Redhead	Sep-17	-	**1**	
Number of avoidable deaths (Score 1-3)	Julian Redhead	Sep-17	-	**0**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Effective					
Clinical trials - recruitment of 1st patient within 70 days (%)	Julian Redhead	Sep-17	90.0%	**48.8%**	
Unplanned readmission rates (28 days) over 15s (%)	Tim Orchard	Mar-17	-	**6.9%**	
Unplanned readmission rates (28 days) under 15s (%)	Tg Teoh	Mar-17	-	**5.0%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days) (number)	Tg Teoh	Oct-17	-	**1326**	
Outpatient appointments checked-in AND not checked-out (number)	Tg Teoh	Oct-17	-	**1916**	
Diagnostic and surgical orders waiting to be processed (Add/Set Encounter)	Kevin Jarrold	Oct-17	0	**1925**	
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Oct-17	95.0%	**97.0%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Oct-17	85.0%	**93.1%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Oct-17	95.0%	**93.2%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Oct-17	94.0%	**91.2%**	
Complaints: Total number received from our patients	Janice Sigsworth	Oct-17	100	**96**	
Non-emergency patient transport: waiting times of less than 2 hours for outward journey	Janice Sigsworth	Oct-17	-	**74.8%**	
Mixed-Sex Accommodation (EMSA) breaches	Janice Sigsworth	Oct-17	0	**29**	
Well Led					
Vacancy rate (%)	David Wells	Oct-17	10.0%	**11.6%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Oct-17	10.0%	**9.5%**	
Sickness absence (%)	David Wells	Oct-17	3.1%	**2.7%**	
Personal development reviews (%)	David Wells	Jul-17	95.0%	**-**	
Doctor Appraisal Rate (%)	Julian Redhead	Oct-17	95.0%	**90.1%**	
Staff FFT (% recommended as a place to work)	David Wells	17/18 Q1	-	**70.6%**	
Staff FFT (% recommended as a place for treatment)	David Wells	17/18 Q1	-	**85.1%**	
Education open actions (number)	Julian Redhead	Oct-17	-	**1**	
Reactive maintenance performance (% tasks completed within agreed response time)	Janice Sigsworth	Oct-17	98%	**18.1%**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	Oct-17	92.0%	**83.3%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	Oct-17	-	**10744**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	Oct-17	0	**331**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	Sep-17	85.0%	**87.8%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Sep-17	0.8%	**1.1%**	
28 day rebooking breaches (% of cancellations)	Catherine Urch	Sep-17	8.0%	**7.6%**	
Theatre utilisation (%)	Catherine Urch	Oct-17	85.0%	**76.0%**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Oct-17	95.0%	**68.9%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Oct-17	95.0%	**86.6%**	
A&E patients spending >12 hours from decision to admit to admission	Tim Orchard	Oct-17	-	**3**	
Waiting times for first outpatient appointment (routine) (average weeks waited for attended appointments)	Tg Teoh	Oct-17	-	**8.1**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Oct-17	1.0%	**4.3%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Oct-17	11.0%	**12.2%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Oct-17	7.5%	**9.0%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Oct-17	95.0%	**83.0%**	
Money and Resources					
In month variance to plan (£m)	Richard Alexander	Oct-17		**-1.39**	
YTD variance to plan (£m)	Richard Alexander	Oct-17		**-0.67**	
Annual forecast variance to plan (£m)	Richard Alexander	Oct-17		**-3.69**	
Agency staffing (% YTD)	Richard Alexander	Oct-17		**4.4%**	
CIP % delivery YTD	Richard Alexander	Sep-17		**87.1%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Eighteen serious incidents were reported in October 2017, all of which are undergoing root cause analysis investigations.

The themes to note include an increased number of SIs related to treatment delay (availability of mental health beds). This category is an internally amended version of the StEIS category; 'Treatment Delay' which was introduced to enable the capture of any patient safety risks that are being experienced in the emergency departments due to a lack of downstream mental health beds.

The other area to note is an increasing number of incidents relating to infection prevention and control issues. This increase relates to the number of incidents related to carbapenemase-producing Enterobacteriaceae (CPE) transmission. Screening for these organisms and their subsequent identification has increased in the last year however transmission is concerning and therefore an SI investigation is undertaken where this is suspected. Whilst the root cause of these incidents is multifactorial, there are themes and actions in common including ensuring high compliance with CPE admission screening locally, improved hand hygiene and aseptic non-touch technique (ANTT) practice, assurance around cleaning standards and the environment, and a focus on appropriate use of antibiotics. The Trust CPE action plan is currently being refreshed.

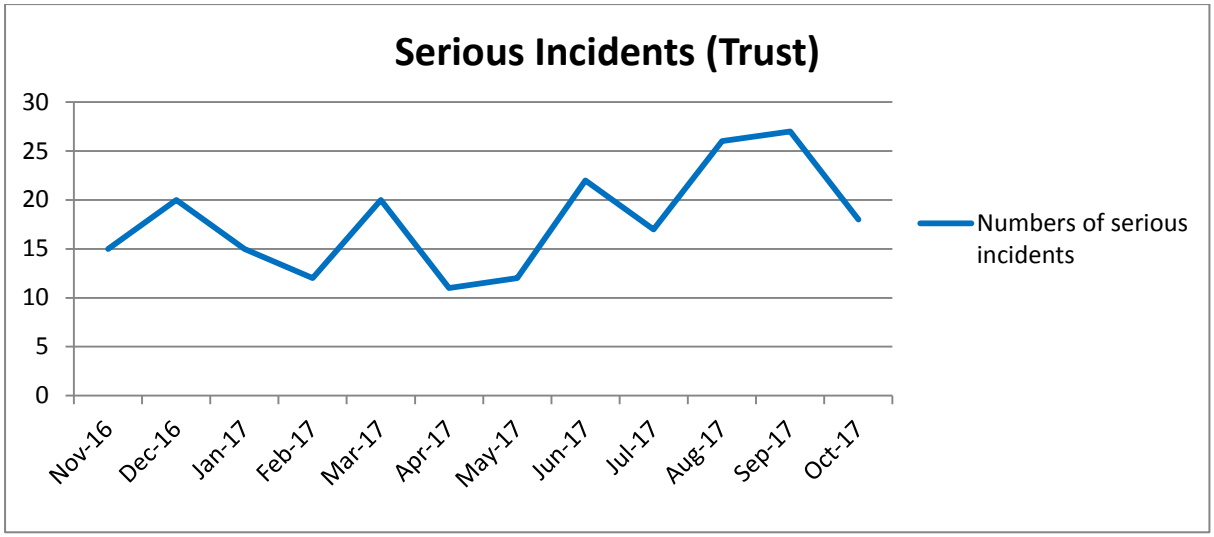


Chart 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period November 2016 – October 2017

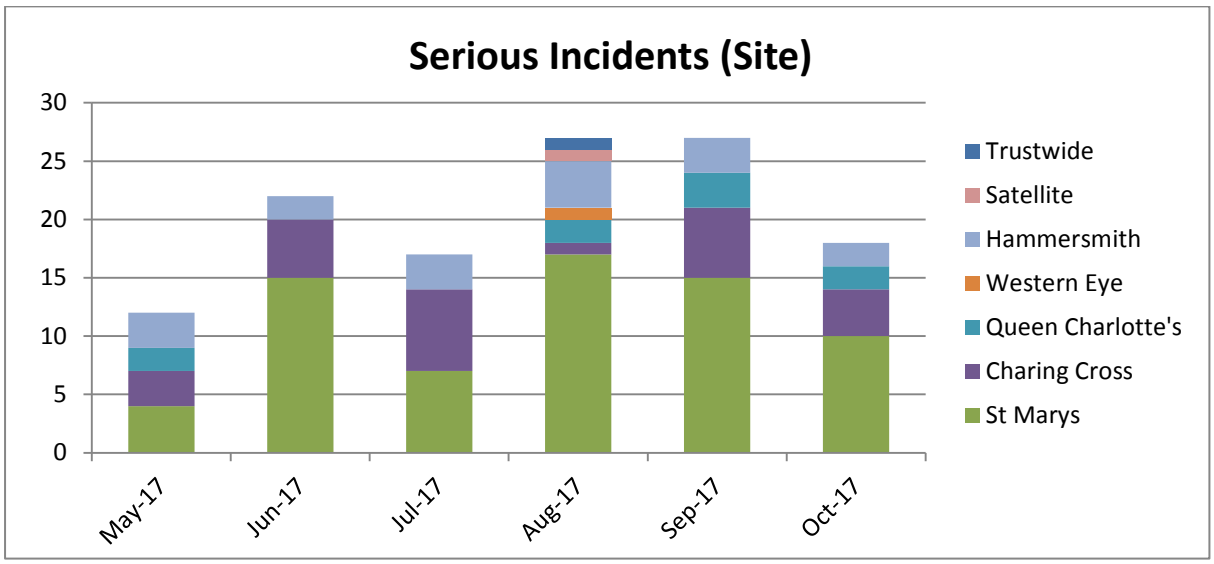


Chart 2 - Number of Serious Incidents (SIs) (Site level) by month for the period May 2017 – October 2017

In the last 12 months there has been an overall increase in the number of SIs reported compared to the preceding 12 month period. The increase reflects the Trust's commitment to improving the culture of safety through encouraging transparent identification of issues to enhance the opportunities for learning in a supportive environment. The increases are understood and our harm profile is not raising a specific cause for concern.

Safety improvement programmes (safety streams) are in place to support reducing recurrence for the categories that have been reported most frequently. The nine safety improvement programmes are:

1. Pressure Ulcers
2. Safe Mobility and Prevention of Falls with Harm
3. Recognising and Responding to the Very Sick Patient

4. Optimising Hand Hygiene
5. Safer Surgery
6. Fetal Monitoring
7. Safer Medicines
8. Abnormal Results
9. Positive Patient Confirmation

2.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported one severe/major harm incidents and one extreme harm/death incident in October 2017. Both incidents are being investigated as SIs.

There have been seven severe and eight extreme harm incidents reported so far this year. This is below average when compared to data published by the National Reporting and Learning System (NRLS) in September 2017 for the October 2016 – March 2017 period. According to NRLS, the national average for extreme harm/deaths incidents has increased slightly from 1 per cent to 1.2 per cent when compared to data for the April 2016 – September 2016 period and has remained the same for severe/major harm incidents.

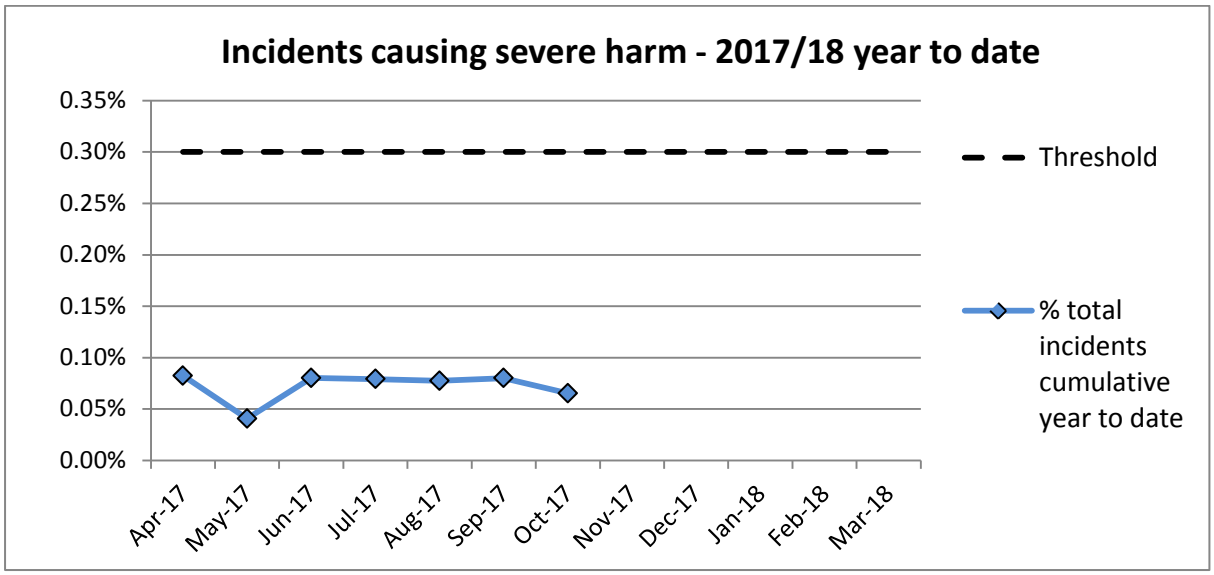


Chart 3 – Incidents causing severe harm by month from the period April 2017 – October 2017 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

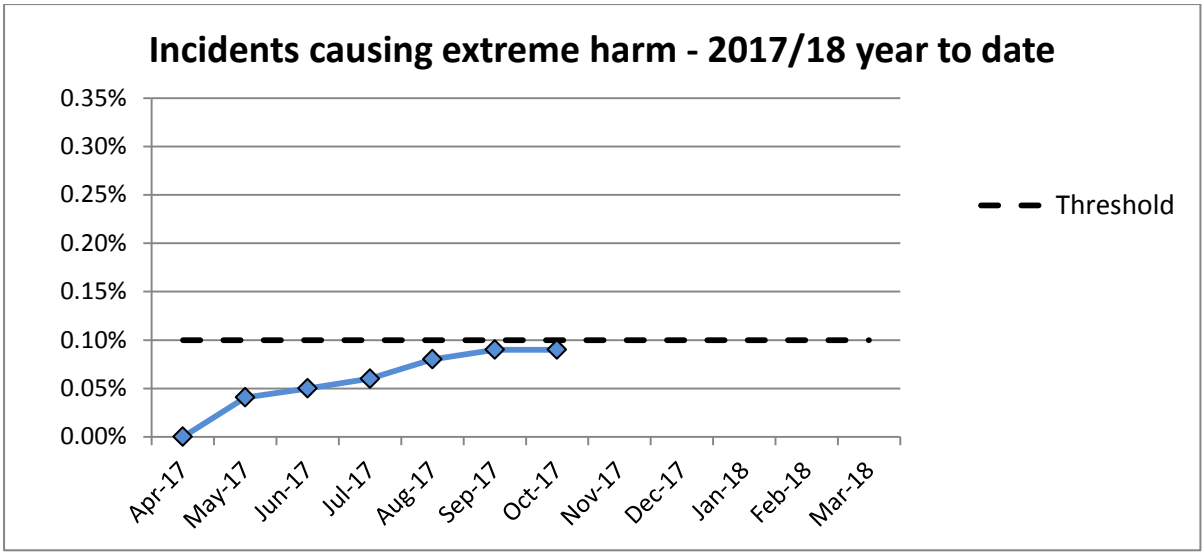


Chart 4 – Incidents causing extreme harm by month from the period April 2017 – October 2017 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

Patient safety incident reporting rate

The Trust's incident reporting rate for October 2017 is 56.6. This means that the organisation is meeting the target to be within the highest 25 per cent of reporters nationally. Through the safety culture programme we are committed to continuing to encourage and support increased reporting; the overall number of incidents reported in October increased by 130 compared to the September reporting number.

Over the last 6 months there has been a steady increase in patient safety incident reporting in a number of directorates, particularly children's services and critical care, as a result of focussed local improvement work.

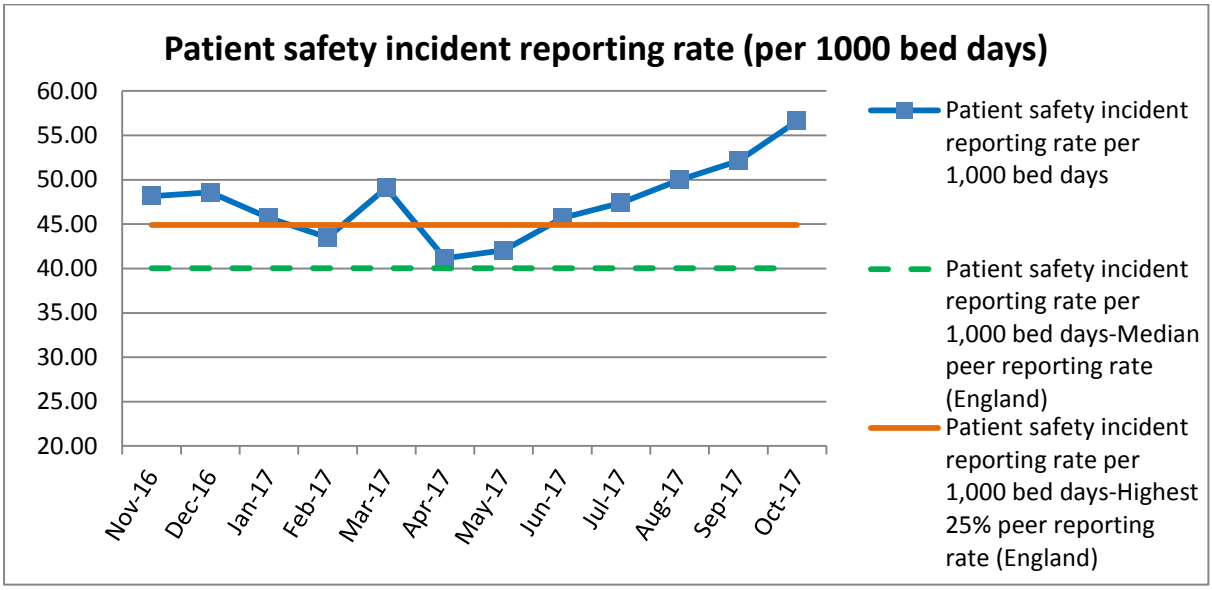


Chart 5 – Trust incident reporting rate by month for the period November 2016 – October 2017

1. Median reporting rate for Acute non specialist organisations
2. Highest 25% of incident reporters among all Acute non specialist organisations

2.1.3 Safe: Duty of candour

Concerns were raised in February 2017 about Trust compliance with duty of candour for incidents that have been declared as SIs. These concerns originated from a retrospective compliance audit in September 2016 (limited assurance) and also from an SI where the candour process was not adequate. A full review of processes across the Trust was commissioned by the Medical Director, and since April 2017 compliance for SI investigations has been monitored through the medical director's incident review panel, with improvements seen. This commenced in July 2017 for incidents graded moderate and above and all level one investigations.

The table below shows the number of SIs, internal investigations and cases of moderate harm reported between February and September 2017, and the percentage of these which have had stage 1 and stage 2 of the duty of candour process completed. The data goes back to February 2017 because the look back exercise covered the preceding months and all letters were sent as appropriate.

Although we are making improvements across all areas, we will now commence more focussed work on improving compliance for level 1 investigations. The compliance for October 2017 is not yet available as data are reported one month in arrears.

	SIs	Level 1 (internal investigations)	Moderate and above incidents
Number of incidents (Feb 2017 – Sept 2017)	128	60	23
Total with stage 1 complete	125	29	18
Total with stage 2 complete	126	28	18
Total with both stages complete	125	27	17
Percentage fully compliant with duty of candour requirements	98%	45%	74%

Percentage of incidents fully compliant with duty of candour requirements at 31 October 2017

2.1.4 Safe: Never events

There have been no further never events declared since the case in July 2017. The root cause analysis for that event has not been approved by the Medical Director as it was not as thorough as required and is now overdue. The division of SCCS are reviewing this investigation but have implemented immediate action to minimise recurrence by using an alert on epidural lines in the form of a printed sticker. An audit of compliance with this will be reported in December 2017. This is a short term measure until new products which do not allow connection to inappropriate devices

become available (expected in Quarter 4). An implementation plan has been developed and a Task and Finish group is being set up by the division of SCCS to manage the roll out trust wide.

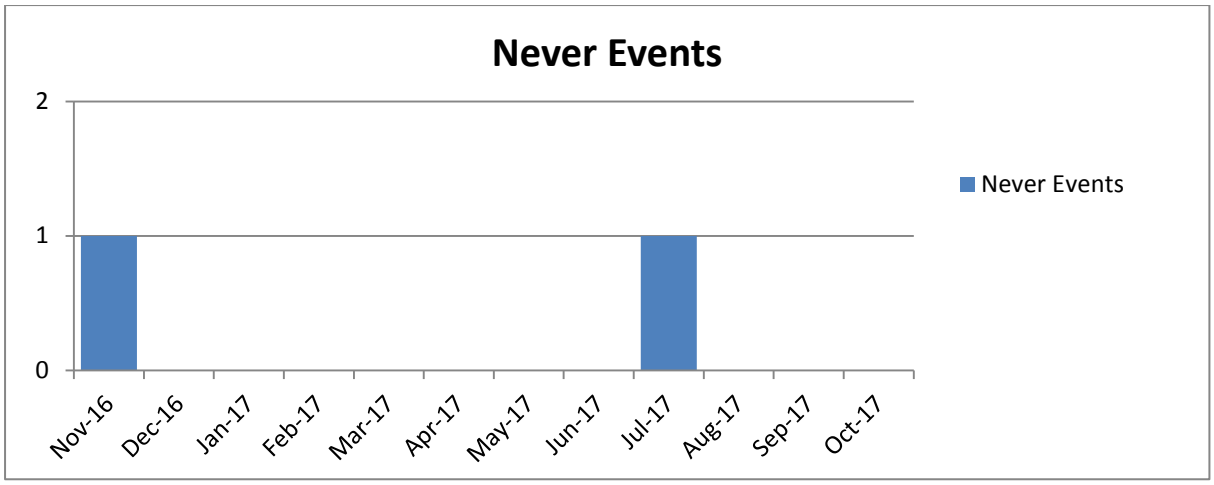


Chart 6 – Trust Never Events by month for the period November 2016 – October 2017

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

There were no cases of MRSA BSI identified at the Trust in October 2017. One case of MRSA BSI has been allocated to the Trust so far in 2017/18; this occurred in April 2017.

2.1.6 Safe: *Clostridium difficile*

Eight cases of Clostridium difficile were allocated to the Trust for October 2017, one of which was identified as a lapse in care.

Thirty three cases of Clostridium difficile have so far been allocated to the Trust in 2017/18, which is below trajectory. Two cases have been identified as a lapse in care so far in 2017/18, following multi-disciplinary team review, held monthly.

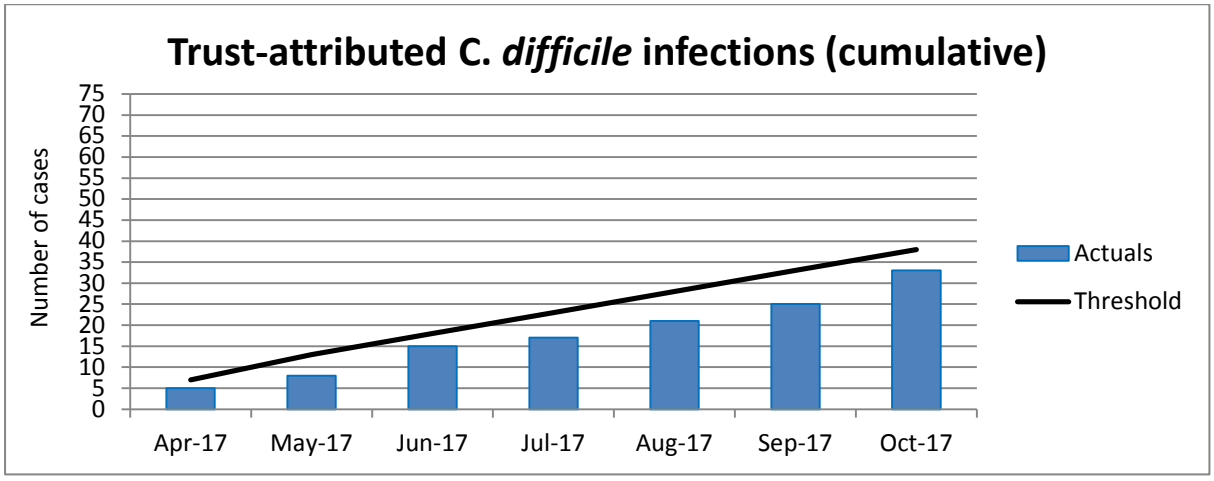


Chart 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – October 2017

2.1.7 Safe: Venous thromboembolism (VTE) risk assessment

Performance is below target at 92.98 per cent at the end of October.

Divisions have local action plans in place to drive up and monitor improvements in compliance and a key area of focus is in maternity. All divisions provide a weekly progress update to the VTE task and finish group, chaired by the Medical Director. A Trust wide action plan is in place and progress is reported to Executive Quality Committee through the Trust's Quality Report.

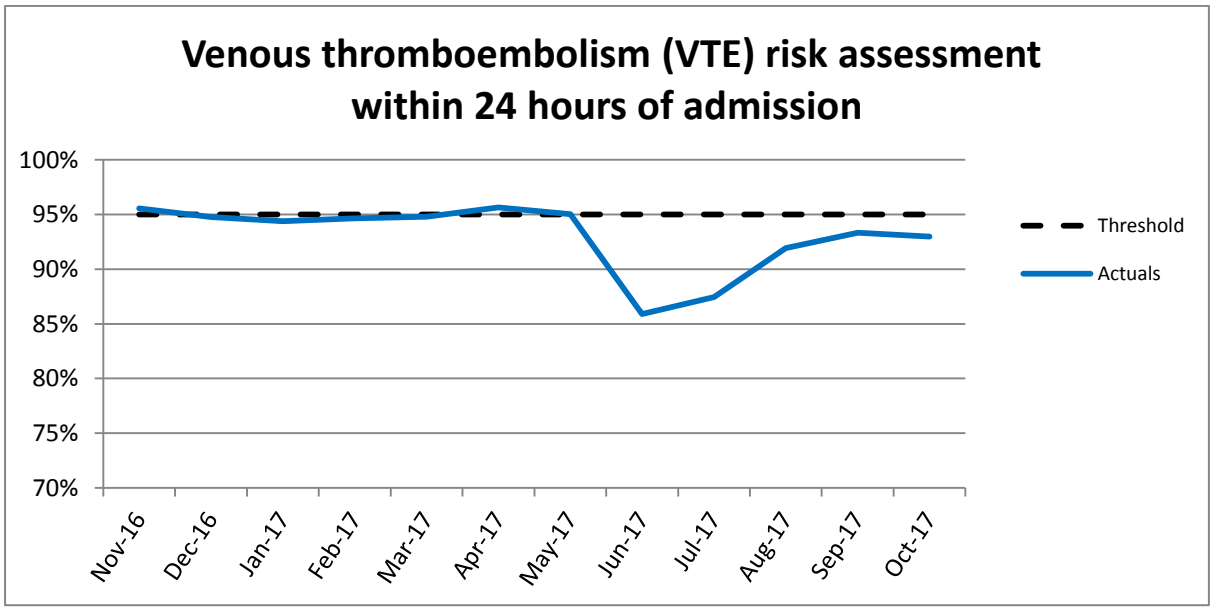


Chart 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period November 2016 – October 2017

2.1.8 Safe: CAS alerts outstanding

The Department of Health Central Alerting System (CAS) is a system for issuing patient safety alerts, public health messages and other safety critical information and guidance to the NHS and others. At end October 2017 three alerts were outstanding and all are being reviewed so that actions can be put in place and alerts closed.

- MDA/2017/018 (metal-on-metal (MoM) hip replacements: updated advice for follow-up of patients) - An action plan has been produced.
- MDA/2017/028R (replacement bileaflet mechanical heart valves: risk of inverted implantation) - A response is being completed by the SCCS Division.
- MDA/2017/031 (IntelliVue patient monitors used with 12-lead ECG: risk of ECG trace distortion Specific models and software versions affected) – Devices have been identified and the software upgrade has been booked with Phillips Healthcare.

2.1.9 Safe: Avoidable pressure ulcers

There were zero avoidable hospital acquired pressure ulcers recorded for October 2017 across all Divisions. The 2017/18 year to date total is 11.

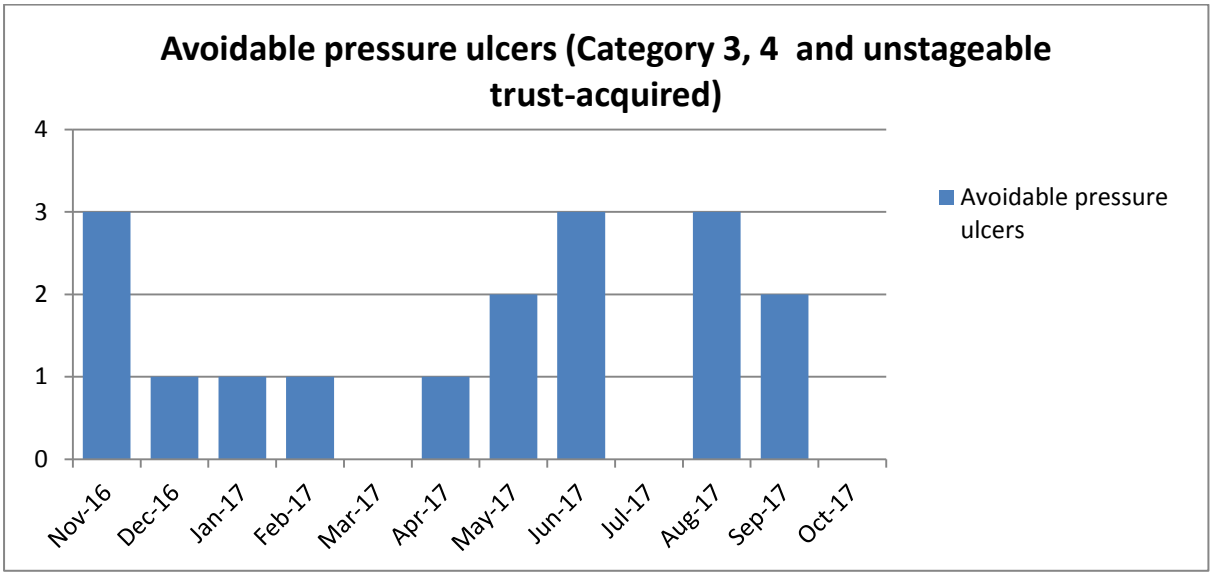


Chart 9 – Number of category 3 and category 4 (including unstageable) Trust-acquired pressure ulcers by month for the period November 2016 – October 2017

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

In October 2017 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff.

The percentage of shifts meeting planned safe staffing levels by hospital site are as follows:

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	94.89%	89.31%	97.14%	96.12%
Hammersmith	96.37%	87.38%	98.52%	97.58%
Queen Charlotte's	98.15%	91.48%	97.99%	89.41%
St. Mary's	95.74%	93.66%	96.91%	96.06%

In order to maintain standards of care the Trust's Divisional Directors of Nursing and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways:

- Using the workforce flexibly across floors and clinical areas and in some circumstances between the three hospital sites.
- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

In addition, the Divisional Directors of Nursing regularly review staffing when, or if

there is a shift in local quality metrics, including patient feedback.

In order to respond to the continued challenge of filling shifts for health care staff from the nurse bank, plans are being established to improve the uptake of these shifts to reduce future staffing gaps.

There is also renewed focus on recruitment and retention of staff across bands 2-6 and a strategic reponse to the challenges has been developed and lead by Organisational Development with senior nursing input.

The Nursing Associate pilot commenced in April and 21 new trainees were employed across our partner organisations, 13 of which are based at Imperial.

The development of the apprentice nurse pathway in the coming months will also offer an opportuntiy to bolster up the workforce whilst new recruits train towards registration over a four year period, whilst being employed as apprentices. The divisons will consider increasing numbers of trainees in the coming months.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in October 2017 were safe and appropriate for the clinical case mix.

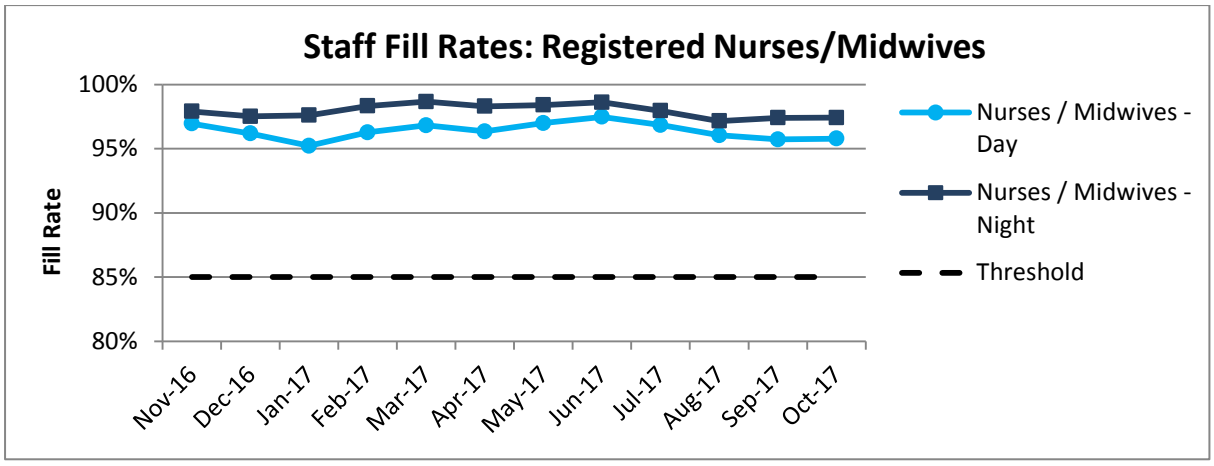


Chart 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period November 2016 – October 2017

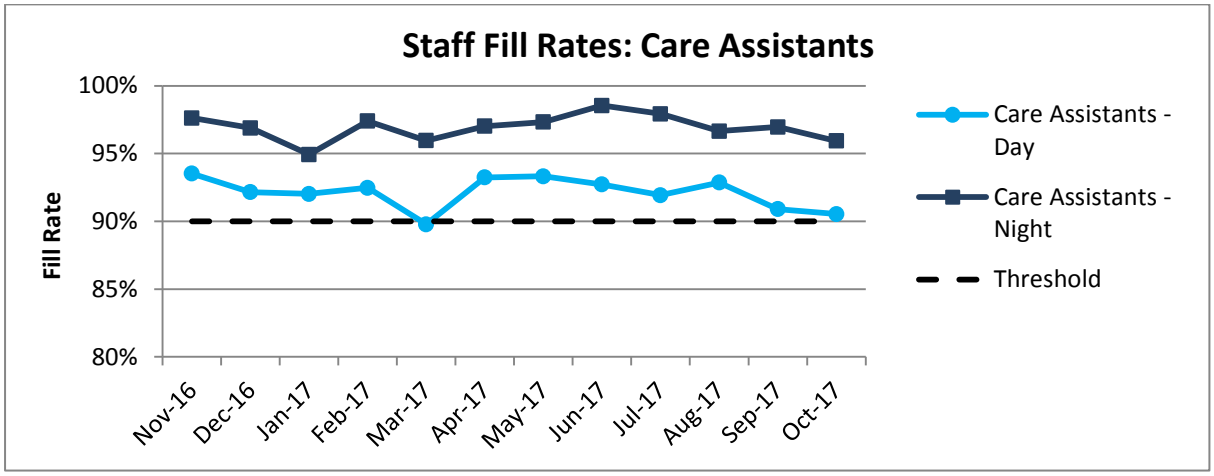


Chart 11 - Monthly staff fill rates (Care Assistants) by month for the period November 2016 – October 2017

2.1.11 Safe: Postpartum haemorrhage

In October 2.8 per cent of women who gave birth at the Trust had a postpartum haemorrhage (PPH), involving an estimated blood loss of 1500ml or more within 24 hours of the birth of the baby. This met the Trust target of 2.8 per cent or less.

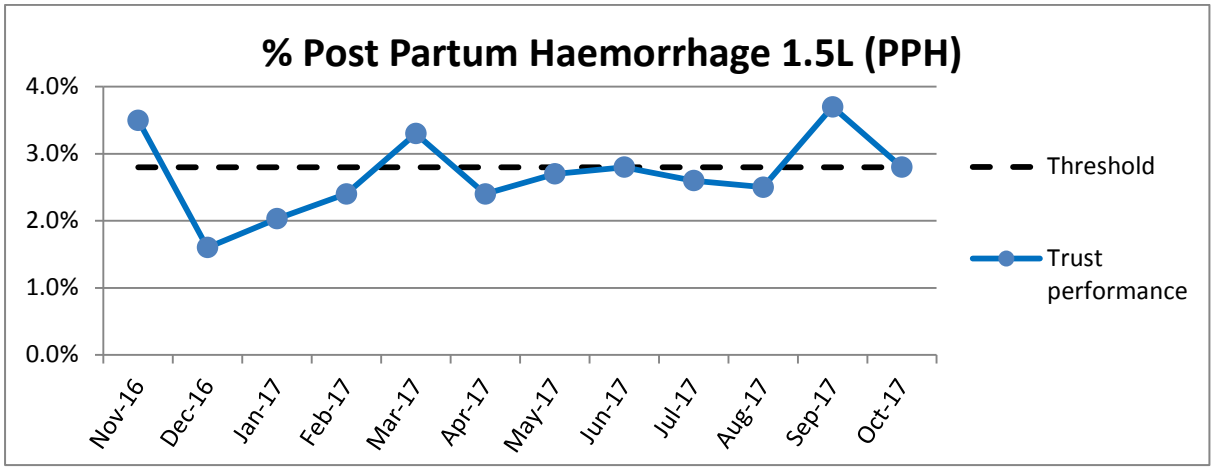


Chart 12 – Postpartum haemorrhage (PPH) for the period November 2016 – October 2017

2.1.12 Safe: Core skills training

Core Skills Training (statutory mandatory): The compliance rate for doctors in training was 71.5 per cent and for all other staff, 84.0 per cent

Core Clinical Skills Training: The compliance rate for doctors in training was 61.1 per cent and for all other staff, 81.2 per cent.

A campaign is running to improve compliance rates for Core Skills. A managers' briefing has been cascaded, with ideas for improving compliance within teams (such as checking establishments and removing staff on honorary contracts who are no longer in the Trust). Core skills and subject matter experts continue to work together to address under-performing areas. The compliance rate for Juniors Doctors continues to improve since introducing a new process.

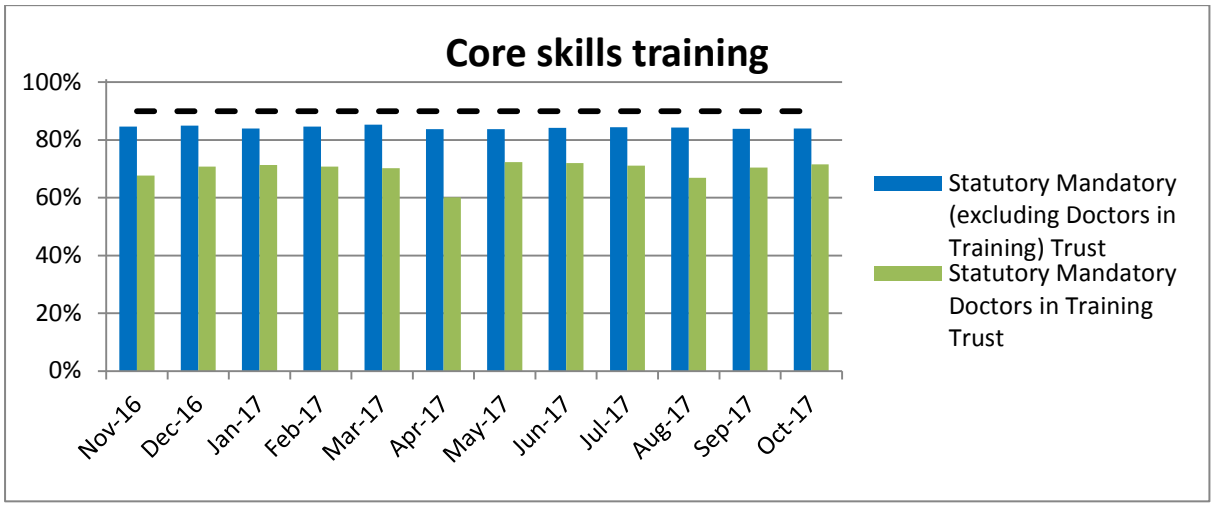


Chart 13 - Statutory and mandatory training for the period November 2016 – October 2017

2.1.13 Safe: Work-related reportable accidents and incidents

There was one RIDDOR-reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incident in October 2017.

The incident involved a member of staff sustaining a needle-stick injury with a medical 'sharp' contaminated with blood from a Hep C +ve patient. The incident was reportable to the HSE as a Dangerous Occurrence (release or escape of a biological agent).

In the 12 months to 31st October 2017, there have been 49 RIDDOR reportable incidents of which 20 were slips, trips and falls. The Health and Safety service continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

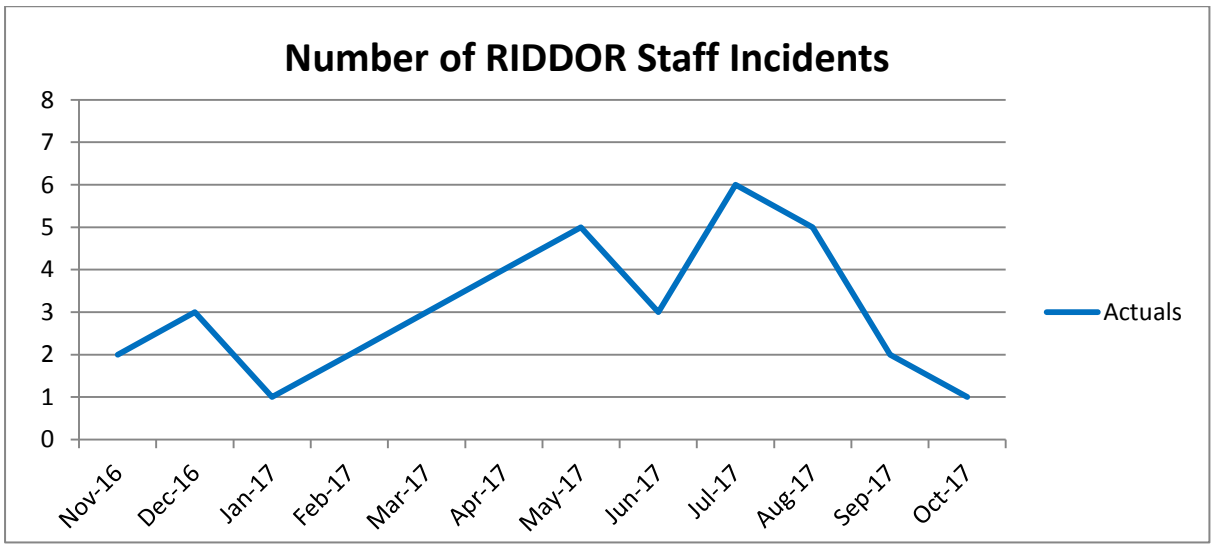


Chart 14 – RIDDOR Staff Incidents for the period November 2016 – October 2017

2.2 Effective

2.2.1 Effective: National Clinical Audits

Since April 2017, a total of 26 national study reports have been published for studies that the Trust participated in. The reports for these 26 studies have been issued to the relevant divisions for a full review and are progressing through the specialty and divisional review processes. Progress is being monitored by the divisional quality and safety committees and reviewed by the quality and safety subgroup.

Two reports have completed the review cycle in the WCCS division. These were the MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme and the National Pediatrics Diabetes Audit. The division approved substantial assurance for both and the Trust was commended as being a positive outlier.

2.2.2 Effective: Mortality data

The Trust target for mortality rates in 2017/18 is to be in the top five lowest-risk acute non-specialist trusts as measured by the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI).

The most recent HSMR is 60 (June 2017). Over the last 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust now has the 2nd lowest SHMI of all non-specialist providers in England for Q1 2016/17 – Q4 2016/17 compared to the 4th lowest, last quarter.

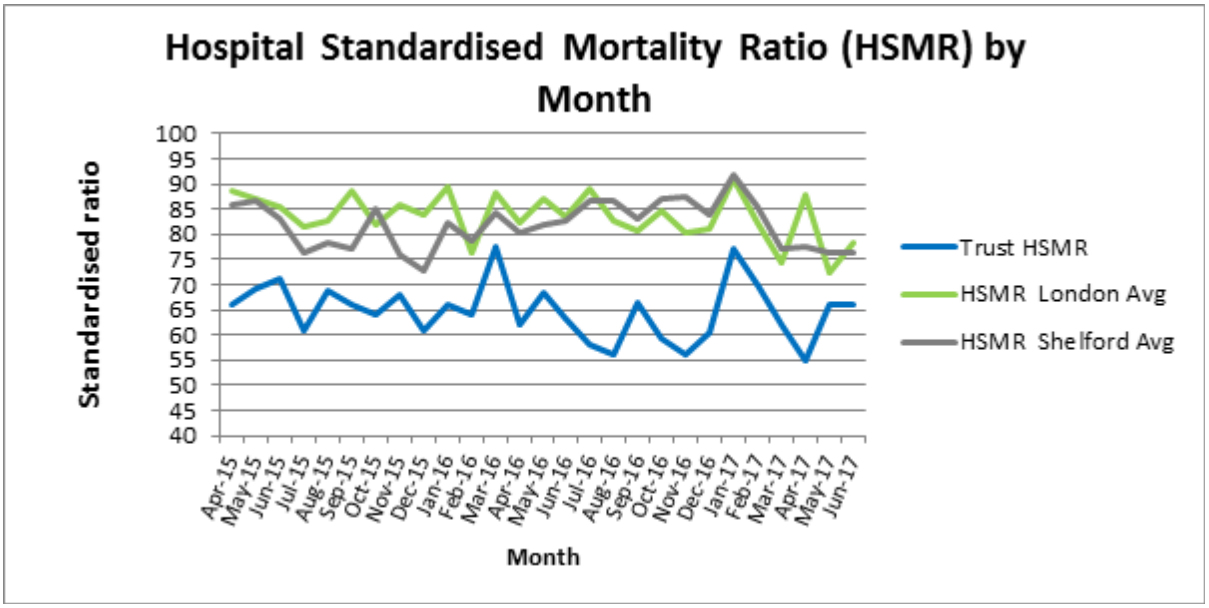


Chart 15 - Hospital Standardised Mortality Ratios for the period April 2015 – June 2017

2.2.3 Effective: Mortality reviews completed

Since the online mortality review system went live in February 2016, twelve avoidable deaths have been confirmed. These have all been investigated either as serious incidents or internal investigations, with learning and actions shared through the mortality review group (MRG).

In March 2017 a framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care was published by the National Quality Board. This includes a new requirement to a quarterly 'learning from deaths dashboard' to the Trust Board. This is being presented as a separate paper to the Trust Board this month in line with the reporting requirement.

The Trust has implemented the structured judgement review methodology (SJR) and reports are starting to be received. Data are refreshed on a monthly basis as SJRs are completed. In order to instigate the SJR process at the earliest opportunity the timeframe for local, level 1 review completion has been shortened to 7 days, from the previous 30 days, effective from September 2017. This shortened process is reflected in the lower local level 1 review data whilst the transition to the new timeframe takes place.

Mortality review measure	2017/18							
	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
Total number of deaths	119	150	137	137	161	149	161	1014
Number of local reviews completed	117	149	135	133	155	131	112	932
% Local reviews completed (target 100%)	98%	99%	98%	97%	96%	88%	70%	92%
Number of SJR reviews requested	3	3	2	20	24	18	24	94
Number of SJR reviews completed	1	0	0	1	4	3	1	10
Number of avoidable deaths (Score 1-3)	0	0	0	0	0	0	0	0

Mortality reviews (at 20 November 2017) Note: The timeframe for local, level 1 review completion was shorted from 30 days to 7 days, effective September 2017.

2.2.4 Effective: Recruitment of patients into interventional studies

The Trust did not achieve its target of 90 per cent of clinical trials recruiting their first patient within 70 days of valid research application in Q1. Our validated performance by NIHR was 48.6% which although below target was above the national average of 46%. The Trusts forecast performance for Q2 is 63.6%. The anticipated improvement is due to the implementation of plans to speed up contract negotiations internally through more joined up processes, clearer escalation points and standard terms to enable more studies to be initiated within the 70 days,

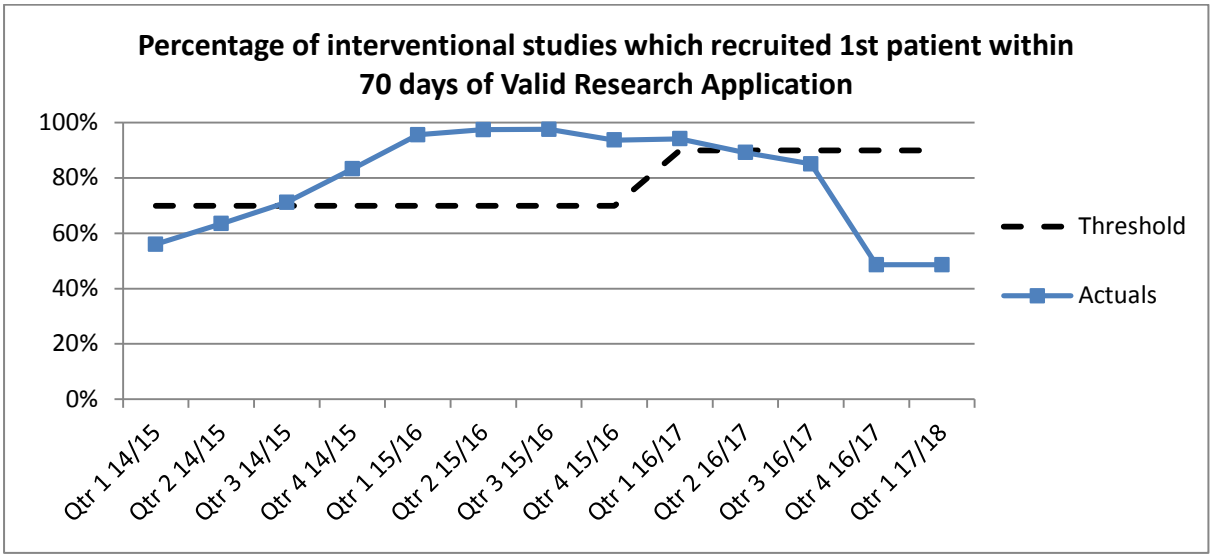


Chart 16 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q1 2017/18

2.2.5 Effective: Readmission rates

For April 2017 (the latest month reported), the Trust 28 day readmission rates as reported through Dr Foster intelligence continued to be lower in both age groups than the Shelford and National rates for both age groups (0-15 years and ages 16 plus).

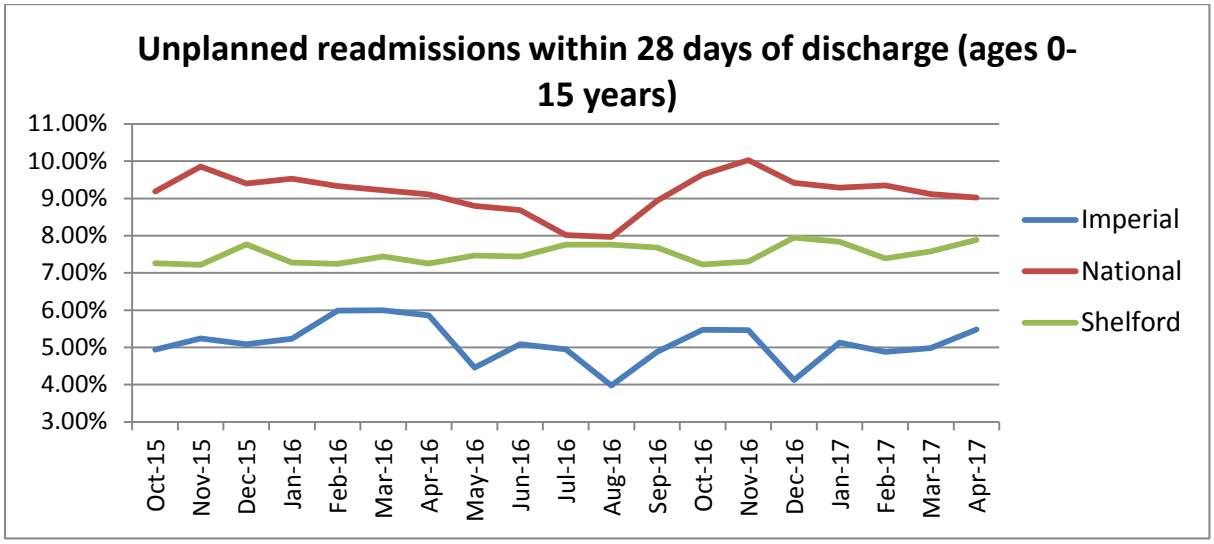


Chart 17 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – April 2017

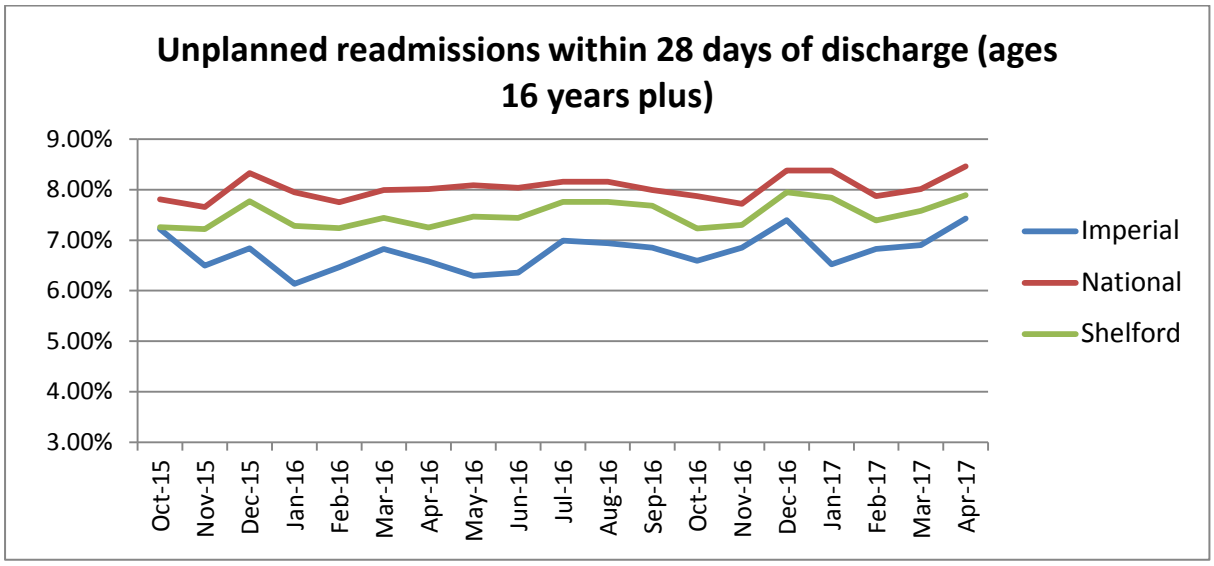


Chart 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – April 2017

2.2.6 Effective: Diagnostic and surgical orders waiting to be placed on the inpatient waiting list

This is a key data quality indicator (DQI) in the Trust's new Data Quality Framework which is being implemented during 2017/18. It measures all patients who have had an order for a diagnostic or surgical procedure placed by the clinical team, but these have not yet been processed by the administration team. Processing orders quickly

ensures patients are appropriately placed onto the inpatient waiting list and facilitates the offer of timely treatment in line with RTT targets. The Trust operating standard is that orders should be routinely processed within 2 working days of being placed by the clinician.

A data quality action group is being established, with representation from the responsible divisional data quality leads. The group will review and monitor all DQIs and provide assurance to the Data Quality Steering Group. This will include agreeing local plans with the divisional data quality leads to process clinical orders within the trust standard and trajectories.

It should be noted that a new endoscopy workflow went live in June 2017 to provide full visibility of all endoscopy orders on Cerner; this is consistent with the increase in orders on the list from June onwards, as shown in the chart below.

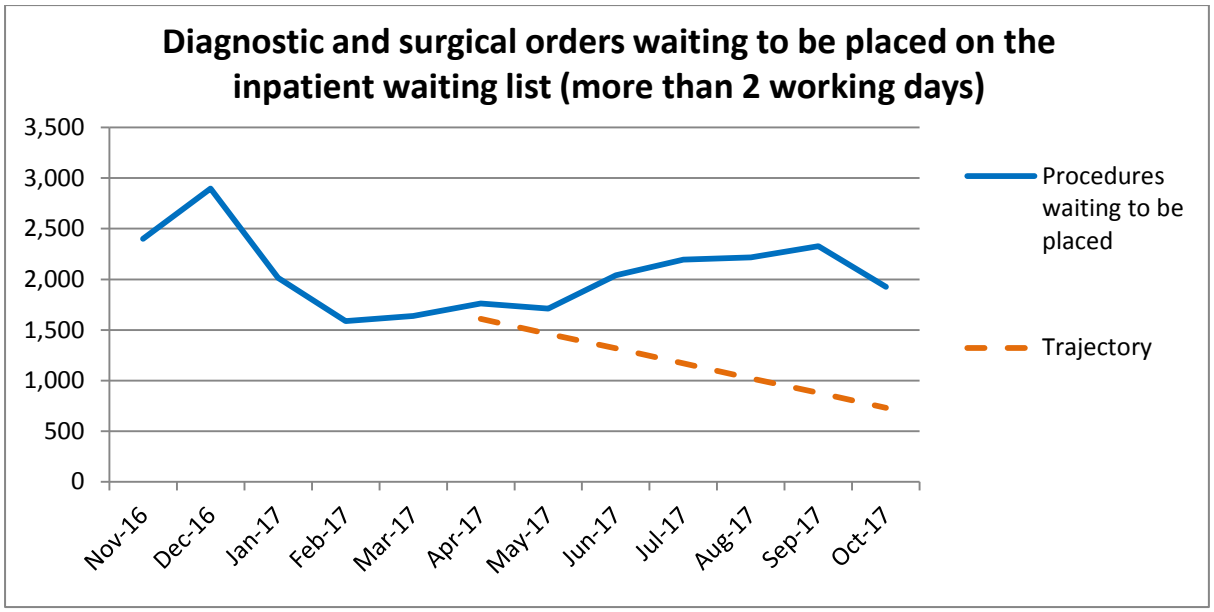


Chart 19 – Number of patients on the Add/Set Encounter request list of more than 2 working days for the period November 2016 – October 2017

2.2.7 Effective: Outpatient appointments checked in and checked out

When patients attend for their outpatient appointment they should be checked-in on the Trust patient administration system (CERNER) and then checked-out after their appointment. This is important so that the record of the patient's attendance is accurate and it is clear what is going to happen next in the patient's treatment journey. The escalation processes to clear appointments on the system in a timely manner continue to be implemented.

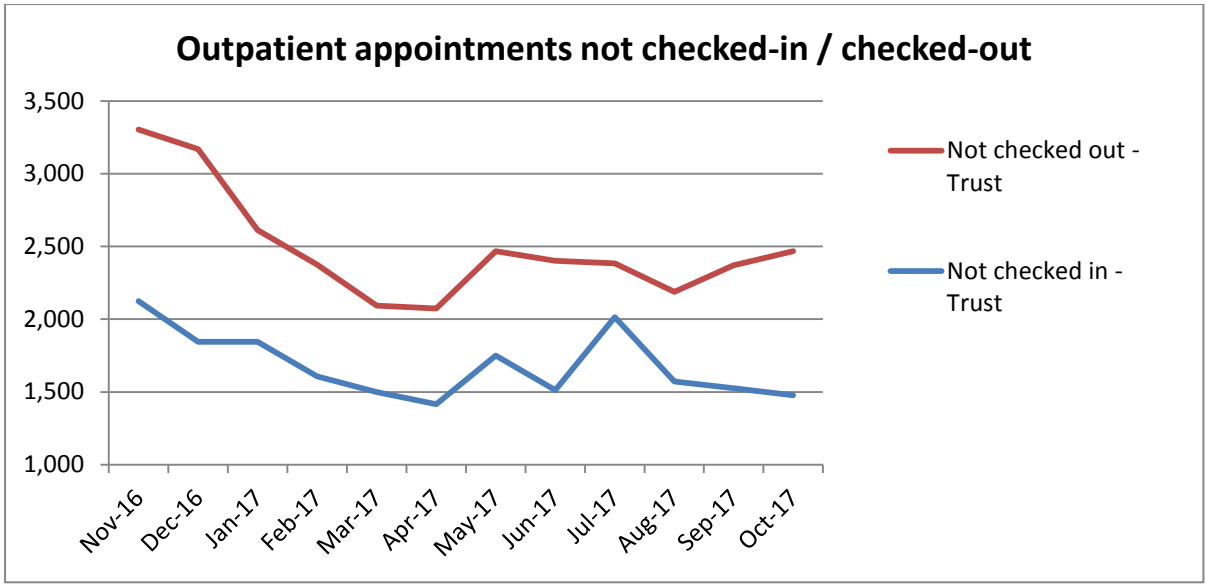


Chart 20 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days) AND number of outpatient appointments checked-in and not checked-out for the period November 2016 – October 2017

2.3 Caring

2.3.1 Caring: Friends and Family Test

Generally the likelihood to recommend score remains high across the board. A&E response rates have dipped again, but an improvement plan has been presented in November.

Friends and Family test results

Service	Metric Name	Aug-17	Sep-17	Oct-17
Inpatients	Response Rate (target 30%)	33.0%	32.5%	**31.9%**
	Recommend %	97.0%	96.9%	**97.0%**
	Not Recommend %	1.0%	1.1%	**0.8%**
A&E	Response Rate (target 20%)	13.0%	14.7%	**12.8%**
	Recommend %	95.0%	94.2%	**93.1%**
	Not Recommend %	3.1%	3.6%	**3.7%**
Maternity	Response Rate (target 15%)	26.0%	20.3%	**32.9%**
	Recommend %	94.0%	94.9%	**93.2%**
	Not Recommend %	3.0%	2.4%	**2.9%**
Outpatients	Response Rate (target 6%)	10.0%	10.1%	**10.0%**
	Recommend %	91.0%	91.5%	**91.2%**
	Not Recommend %	4.0%	4.2%	**4.5%**

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

Generally the response times have remained static between 70-80 per cent.

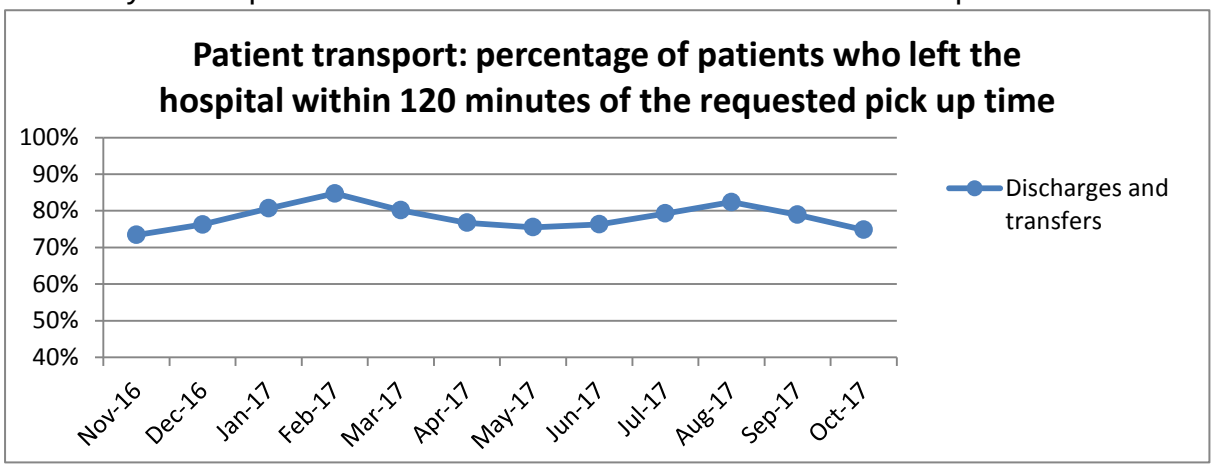


Chart 21 - Percentage of patients who left the hospital as part of the patient transport scheme within 120 minutes of their requested pick up time between Nov 2016 and October 2017

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 29 mixed-sex accommodation (MSA) breaches for October 2017. All breaches were incurred by patients awaiting step down from critical care to ward areas and whose discharge is delayed.

For critical care (level 2 and 3) mixing is acceptable as it is recognised nursing acuity requires gender mixing, however it is not acceptable when a patient in the critical care units no longer requires level 3 or 2 care, but cannot be placed in an appropriate level one ward bed. The increase in breaches since October 2016 has been mainly attributable to breaches occurring within ITU at Charing Cross. The Division of Surgery and Cancer continue to undertake a deep dive into the situation to understand root causes and an action plan is being put in place to address the recommendations.

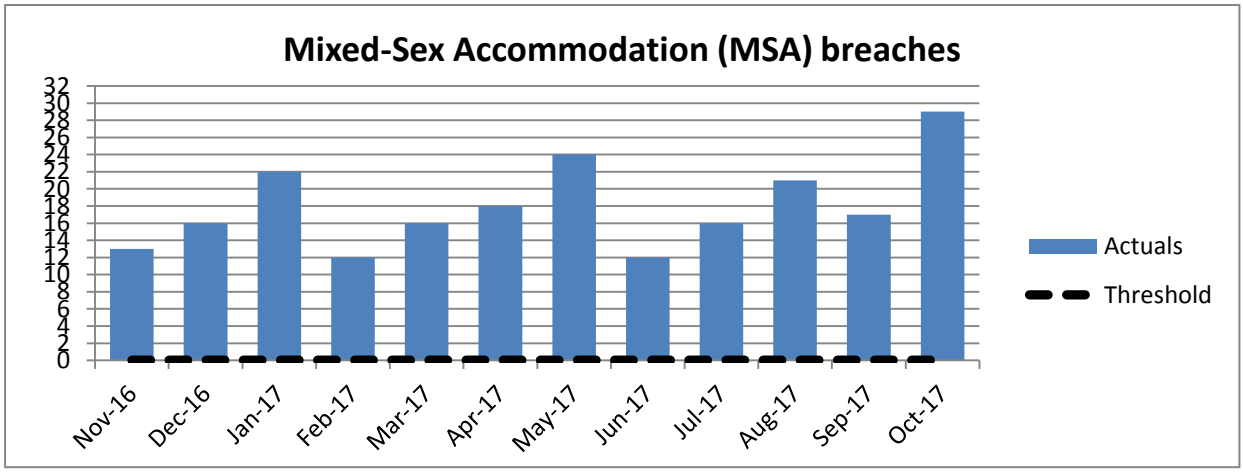


Chart 22 – Number of mixed-sex accommodation breaches reported for the period November 2016 – October 2017

2.3.4 Caring: Complaints

Complaints were up slightly in October, but remain below the threshold. All complaints were responded to within 3 days and in month 100 per cent were responded to within the timeframe agreed with the complainant.

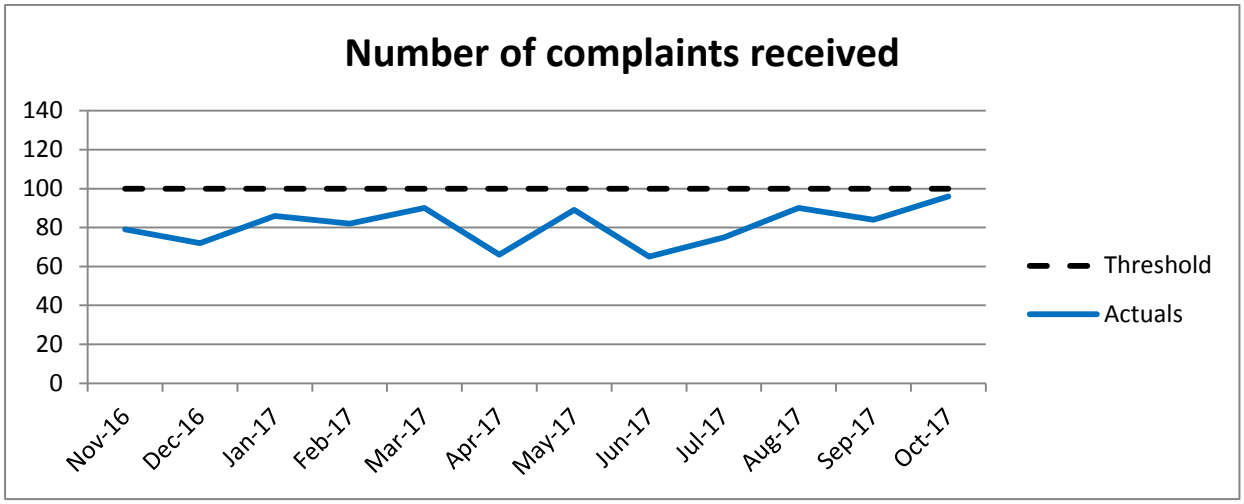


Chart 23 – Number of complaints received for the period November 2016 – October 2017

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

<u>All roles</u>

At the end of October 2017, the Trust directly employed 9,273 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions; an increase of 141 WTE from September 2017. The contractual vacancy rate for all roles was 11.6 per cent against the target of 10 per cent; below the average vacancy rate of 13.2 per cent across all London Trusts.

There were 299 WTE joiners and 158 WTE leavers across all staffing groups. The voluntary turnover rate (rolling 12 month position) was 9.5 per cent.

Actions being taken to support reduction in vacancies include:

- Bespoke campaigns and advertising for a variety of specialities.
- Open Days, Fairs, social media and print advertising. A preferred supplier list is in place to support hard to recruit areas.
- The Careers website content is being redrafted and further materials are being developed to support recruitment activity.
- A retention campaign including 'Our Working Lives' pages on the Source and a ‘Great Place to Work’ week which was ran in September and had positive feedback.

All Nursing & Midwifery Roles

At end of October 2017, the contractual vacancy rate for all Nursing & Midwifery ward roles was 14.6 per cent with 736 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate was 15.8 per cent and we continue to work with other London Acute Teaching Trusts to benchmark and share information to reduce vacancies.

Actions being taken to support reduction in our Nursing and Midwifery vacancies include:

- Nursing recruitment campaigns.
- Automatic conditional offer letters to our student nurses.
- A 'Student Attraction Strategy' to make the Trust 'employer of choice'.
- Open Days and social media campaigns planned for Haematology, ITU, Specialist Surgery, Trauma and Children's services.
- Reducing the time an advert is open and centralising shortlisting to reduce the time to hire time.
- New launched careers clinics for Band 5 and 6 nursing and midwifery staff to help support them with career options and opportunities.

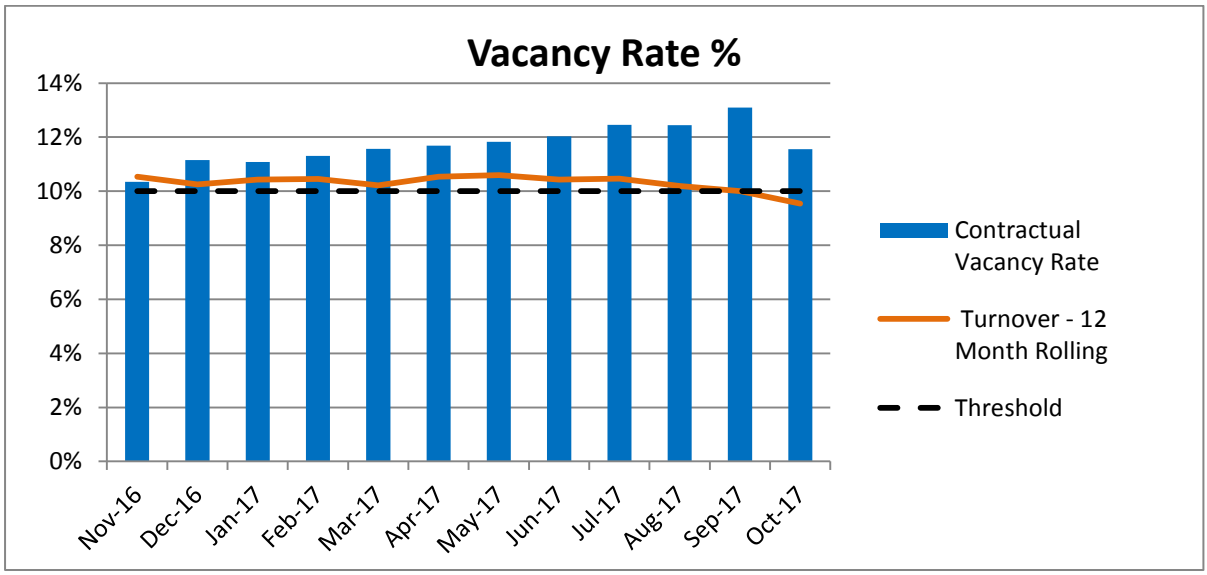


Chart 24 - Vacancy rates for the period November 2016 – October 2017

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in October was 2.7 per cent, maintaining the Trusts rolling 12 month sickness position at 2.9 per cent against the year-end target of 3.1 per cent or lower.

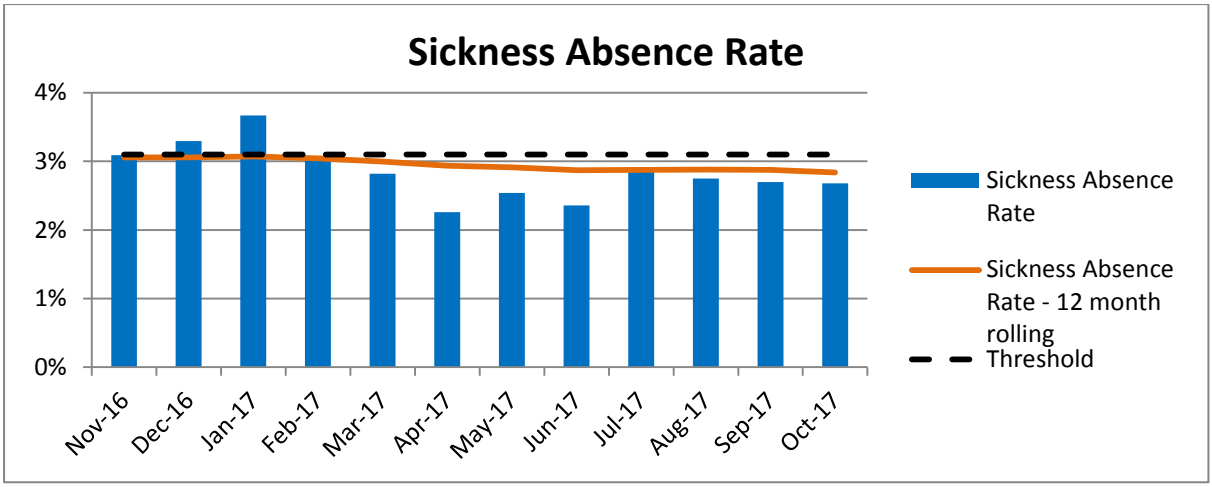


Chart 25 - Sickness absence rates for the period November 2016 – October 2017

2.4.3 Well-Led: Performance development reviews

The PDR cycle for 2017/18 began on 1 April 2017 and closed on the 31 July 2017 with 88.5 per cent of staff having completed a PDR with their line manager.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates are 90.1 per cent this month which is in line with the national average of 90.1 per cent for designated bodies within the same sector (source: Medical Revalidation Annual Organisational Audit Comparator Report, published July 2017). Actions being taken to increase compliance include continuing to promote the Professional Development monthly drop-in sessions to provide one to one assistance for doctors with all aspects of their professional development and updating The Source with advice for a doctor if their appraisers are not able to see them in a timely manner which has been a recurring problem. Additionally, work has been undertaken with the PREP team to ensure that the system remains user friendly and easy to navigate by doctors whilst completing their appraisal on the system. Doctors who have not completed their appraisal are being managed in line with GMC guidance.

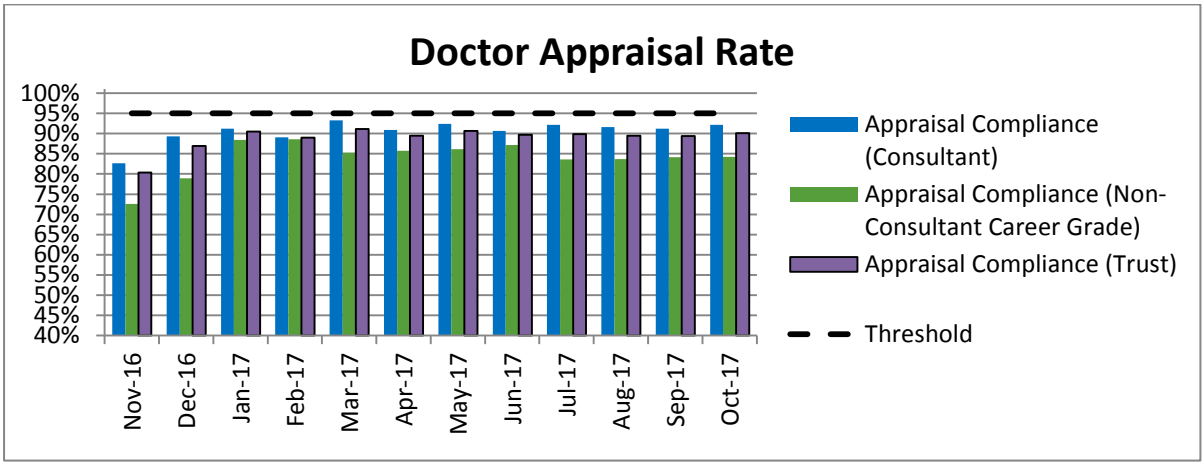


Chart 26 - Doctor Appraisal Rates for the period November 2017 to October 2017

2.4.5 Well-Led: Staff Friends and Family

As well as the annual NHS National Staff Survey, ICHT runs a trust-wide local engagement survey entitled: “Our Voice, Our Trust”. The survey was last run between May and June 2017 and had 2,809 responses. The overall Engagement score increased from 77% in 2016 to 80% in 2017. The headlines of the Staff Friends and Family test results showed that:

- 86% of staff recommend the Trust as a place for care or treatment
- 72% of staff recommend the Trust as a place to work

The FFT scores were our highest performance to date in the last three years. The results and associated action plans were reported to the Trust’s executive committee in July and October 2017. The Trust is currently undertaking the 2017 NHS National Staff Survey and the results will be published in March 2018.

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

Health Education England quality visit

One action remains open from the quality visit and is being monitored through the local faculty group meetings (LFGs).

2016/17 General Medical Council National Training Survey

The results of the General Medical Council’s National Training Survey 2017 were published in July. The 2016 survey demonstrated significant improvements on previous results. The 2017 results indicate that we have maintained our performance overall, with some specialties demonstrating significant improvements, while others either remain challenged or have seen a deterioration in performance. On-going internal monitoring is being undertaken for specialities of concern through education specialty reviews.

In 2015 three specialities were put under enhanced monitoring by the GMC – critical care at Charing Cross Hospital, ophthalmology and neurosurgery. Formal actions plans were put in place with progress monitored at monthly meetings with the Medical Director, and locally through local faculty groups. The 2017 results for both ophthalmology and neurosurgery demonstrated changes made are sustainable therefore the GMC have agreed to remove from enhanced monitoring. We continue to monitor critical care and the division have an action plan in place to support improvement.

Health Education England (HEE) have specified 10 programmes which require actions in response to red flags; an action plan consisting of 12 actions has therefore been developed in response and was submitted to HEE in September 2017. Progress with completion of these actions will be monitored through the medical education committee and be reported in this report.

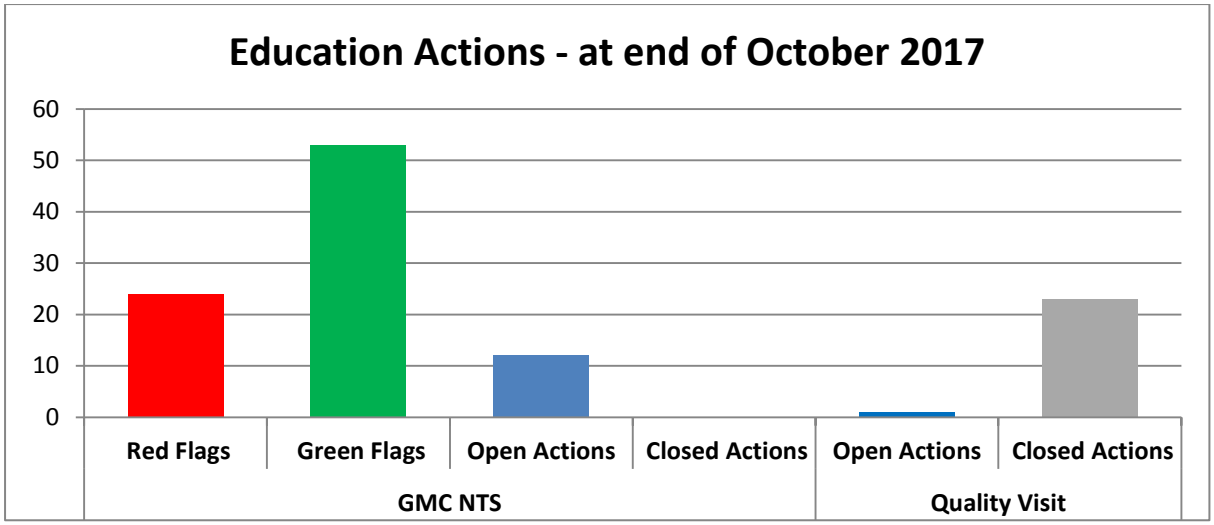


Chart 27 – General Medical Council - National Training Survey action tracker, updated at end October 2017

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

The performance for reported repair tasks completed on time, as delivered by the Trust's maintenance contractor (CBRE), deteriorated further in October to 18 per cent. There does not appear to be any external influences e.g. staff training, sickness or absences, for an allowance to be made for this. The backlog of repairs tasks not completed was 1481 which is an unacceptably high number. The Deputy Head of Estates is in discussion with the contractor to produce the required action plan and improvement process. Further contractual meetings with CBRE are taking place in December.

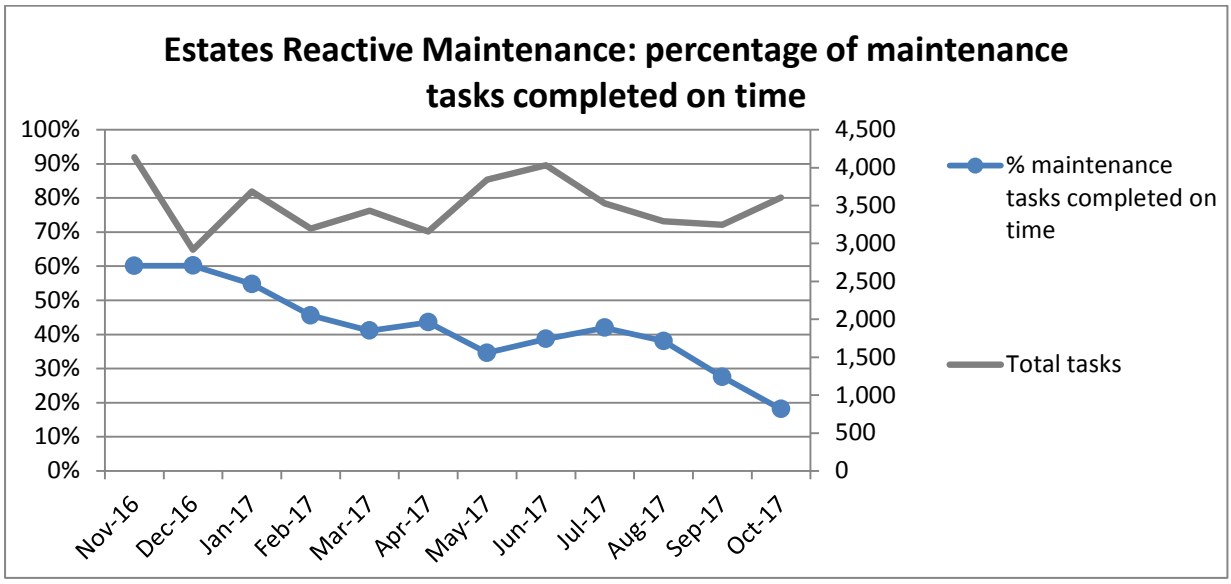


Chart 28 – Estates: percentage of maintenance tasks completed on time for the period November 2016 – October 2017

2.5 Responsive

2.5.1 Responsive: Consultant-led Referral to Treatment waiting times

At the end of October 2017, 83.3 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent. This was below the trajectory target of 86.4 per cent.

There were 331 patients who had waited over 52 weeks for their treatment since referral from their GP. As previously reported a significant majority of these patients were identified during a review and data clean-up of our inpatient waiting lists. Each patient is subject to a clinical review to make sure that their care plan is appropriate in view of the time they have waited for treatment, and we are expediting the treatment of these patients wherever possible.

The Trust has already seen a notable reduction in reported breaches from the September position; additional measures have been implemented to monitor and mitigate any further areas of risk in our waiting lists.

The Trust's waiting list improvement programme (WLIP) has been restructured into three key work streams responsible for delivery of the programme objectives: RTT recovery and sustainability, elective care operating framework and digital optimisation. Although a number of challenges remain, significant progress has been made across projects. The workstreams are supported by associated work on clinical harm review processes, outsourcing, elective care pathway transformation and training strategy.

The programme continues to be overseen by a Waiting List Improvement Programme Steering Group, with external representation from Commissioners and NHS Improvement. The Trust has also introduced the Trust's quality improvement team as additional support to the programme.

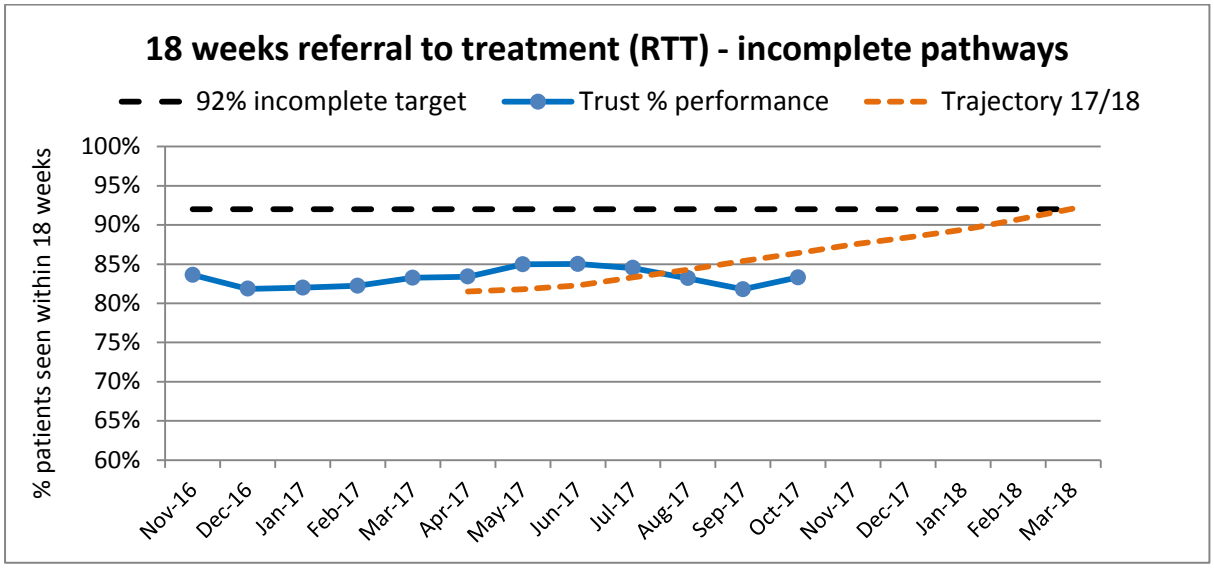


Chart 29 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period November 2016 – October 2017

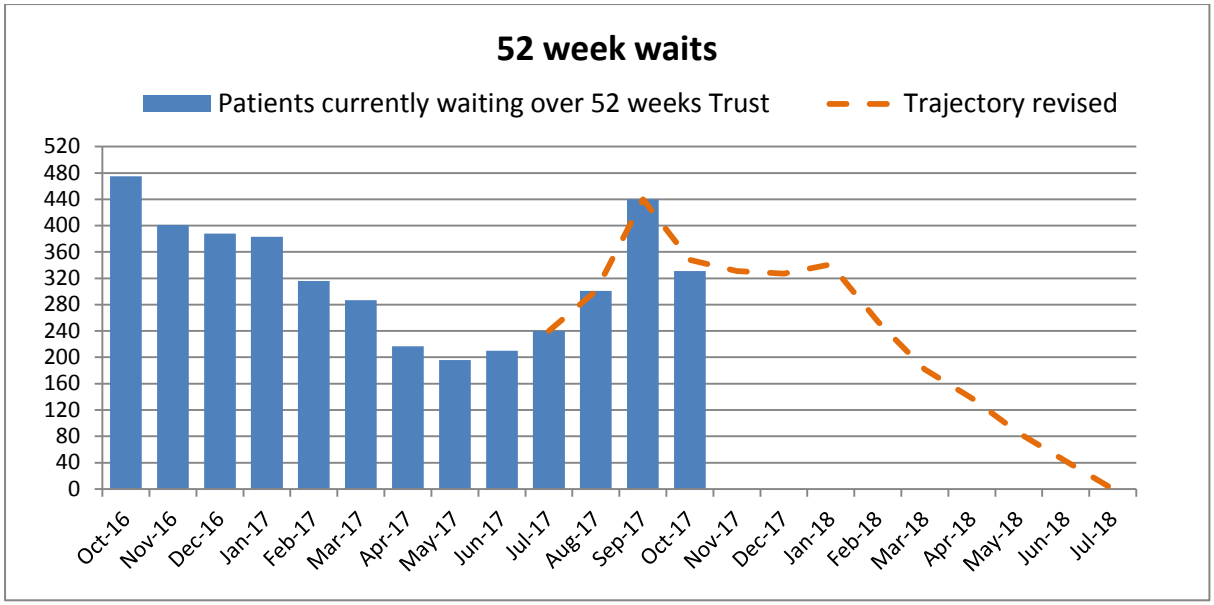


Chart 30 - Number of patients waiting over 52 weeks for the October 2016 – November 2017

2.5.2 Responsive: Cancer 62 day waits

In November 2017, performance is reported for the Cancer waiting times for September 2017. The Trust delivered performance of 89.6 per cent against the 62-day standard, above the trajectory target of 85.1 per cent.

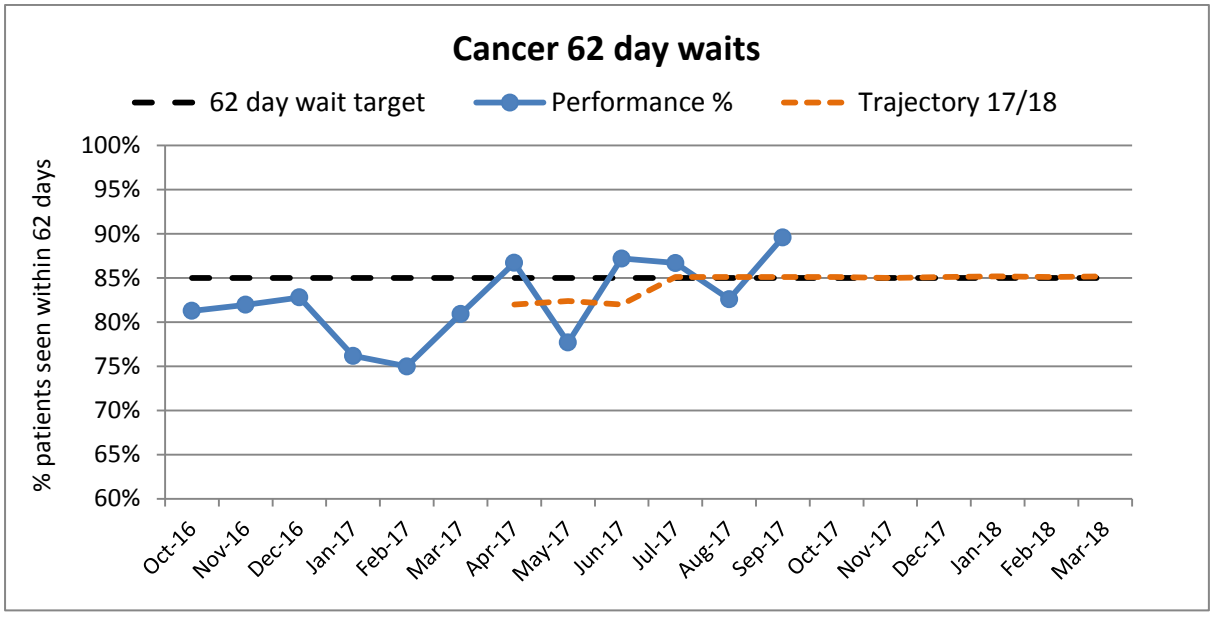


Chart 31 – Cancer 62 day GP referral to treatment performance for the period October 2016 – September 2017

2.5.3 Responsive: Theatre utilisation

The Trust overall theatre utilisation performance was 76 per cent in October 2017 against a target of 85 per cent. The key issues remain as follows:

- High levels of on the day cancellations at CXH and SMH (DNA's and patient unfit

for anaesthetic being the two biggest reasons);

- Scheduling processes leading to under utilised capacity in Riverside Day Surgery
- Capacity issues at SMH often leading to late starts and/or cancellations on the day

Performance is continually being reviewed monthly with the specialities at the Trust's Theatre Efficiency Group.

The Trust is taking the following steps to improve overall theatre performance:

- Undertaking deep dive analysis of under performing lists and agreeing further interventions with specialties where off-trajectory;
- Strengthening scheduling processes within the Patient Services Centre through the introduction of the Four Eyes scheduling tool which gives visibility of 'list fullness'; and
- Improving the consistency of 7 Day and 48 hour reminder calls to patients for their operations.

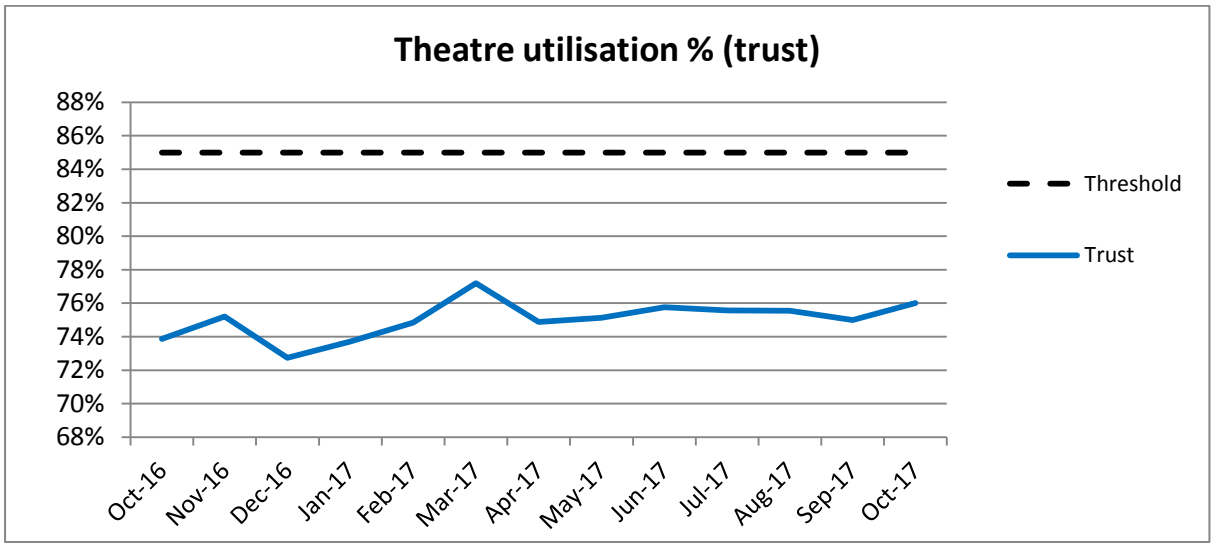


Chart 32 – Theatre utilisation average % (Trust) for the period October 2016 – October 2017

2.5.4 Responsive: 28-Day Rebookings

Cancelled operations (for on the day, non-clinical reasons only) during quarter 2 represented 1 per cent of all elective activity, which brought it slightly higher than the national rate of 0.9 per cent. Of these cancellations 28 patients (9 per cent) were not treated within the national standard 28 days. The national average was 8 per cent breach rate. There is now increased monitoring and engagement with teams to ensure all steps are being taken to prevent breaches from occurring.

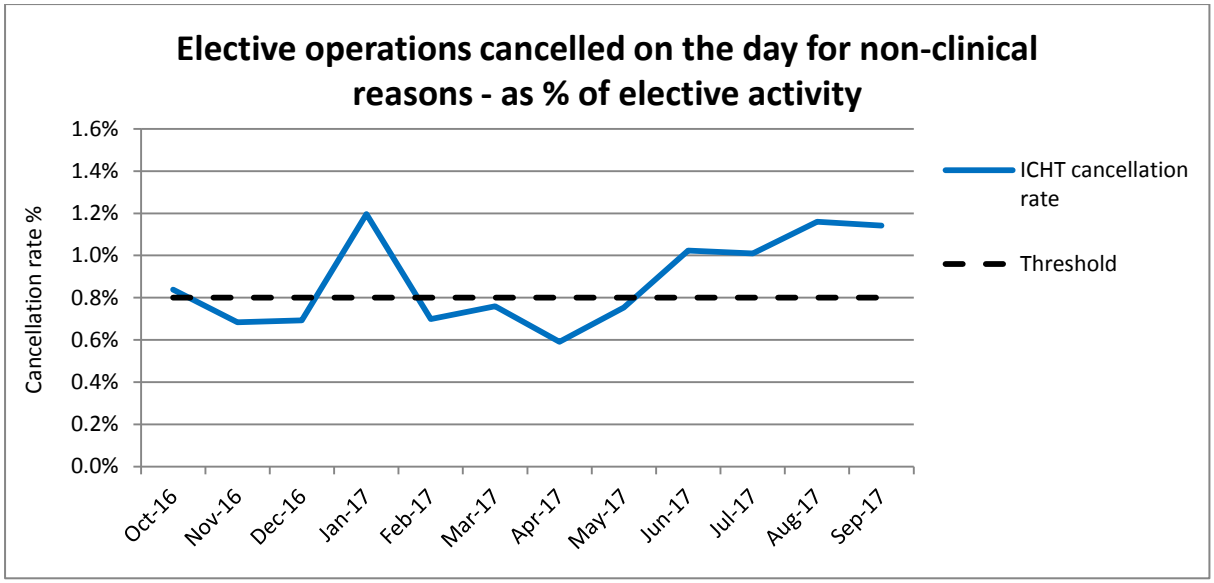


Chart 33 – Non-clinical cancellations as a % of total elective activity Trust for the period October 2016 – September 2017

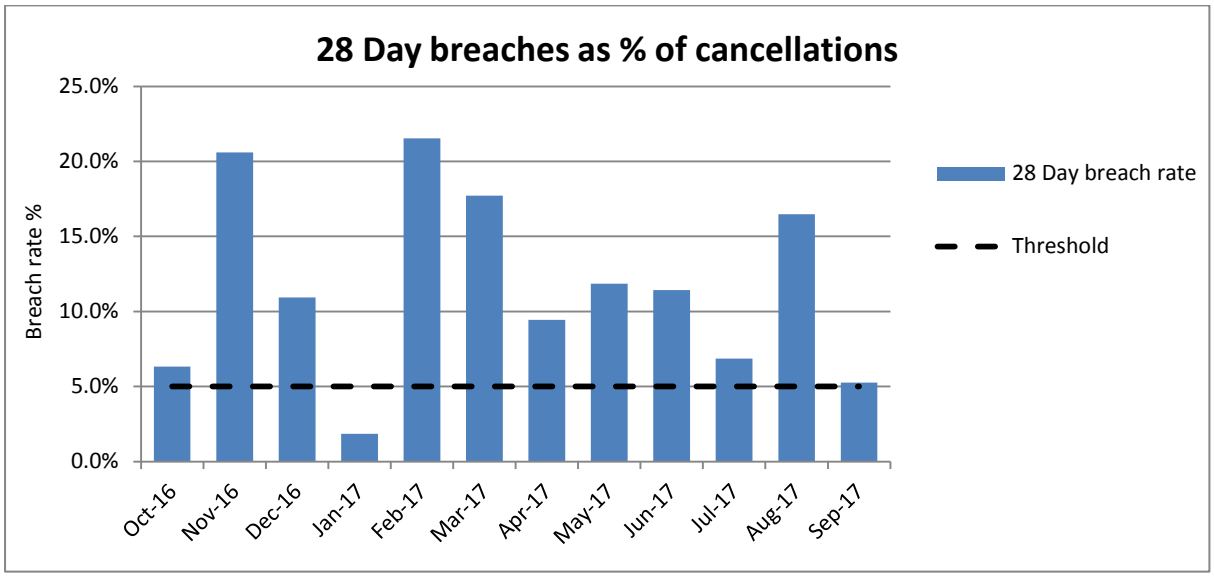


Chart 34 – Patients not treated within 28 days of their cancellation as a % of cancellations for the period October 2016 – September 2017

2.5.5 Responsive: Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 86.6 per cent in October 2017 against the 90.2 per cent Sustainability and Transformation Fund (STF) target for the month. Three 12-hour trolley wait breaches were reported (A&E patients spending >12 hours from decision to admit to admission).

The key issues remain as follows:

- Difficulties with transfer of patients from the Vocare UCC to the Emergency Department at SMH;

- Increased demand and acuity within type 1 departments;
- High levels of bed occupancy;
- High numbers of bed days lost through a combination of delayed transfers of care from the hospital, delays for mental health beds & on-going estate issues.

The Trust has launched a programme of developments, focussing on the following six work streams:

1. Streaming and admission avoidance strategies
2. Effective emergency department operations
3. Efficient specialist decisions and pathways
4. Managing beds effectively
5. Improving ward processes
6. Effective discharge processes

A four-hour Performance Steering Group has been established to oversee the activities within the six work streams. In addition a programme scorecard has been developed to measure the impact of the individual work streams. The group is chaired by the Divisional Director of the Medicine and Integrated Care and attended by the Chief Executive Officer. Each work stream is led in partnership by a senior clinician and a senior manager.

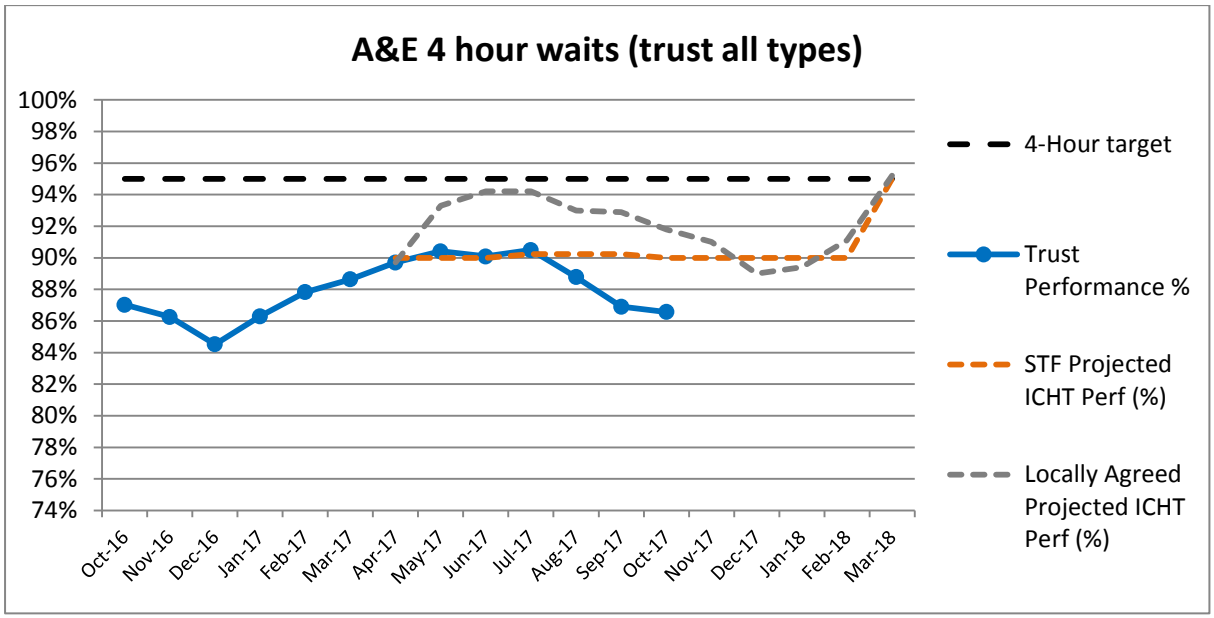


Chart 35 – A&E Maximum waiting times 4 hours (Trust All Types) for the period October 2016 – October 2017

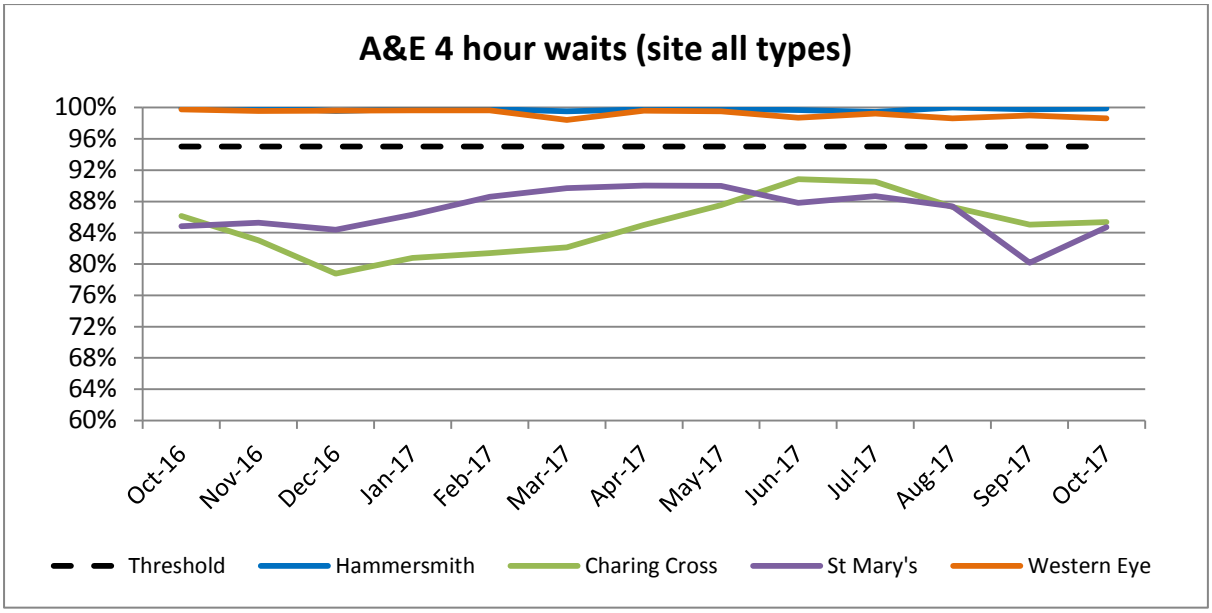


Chart 36 – A&E Maximum waiting times (Site All Types) 4 hours for the period October 2016 – October 2017

2.5.6 Responsive: Diagnostic waiting times

In October, 4.3 per cent of patients were waiting over six weeks against a tolerance of 1 per cent. The deterioration in performance resulted from a deep dive into local data records, this identified an issue with patient tracking and the recording of offer dates for some patients. The Trust has continued to hold a weekly steering group which is carrying out a full assessment. The Trust expects to return to delivering performance against the standard over the next few months. Steps are being taken to ensure the improvement of performance and weekly progress updates are being made to NHS Improvement and Commissioners.

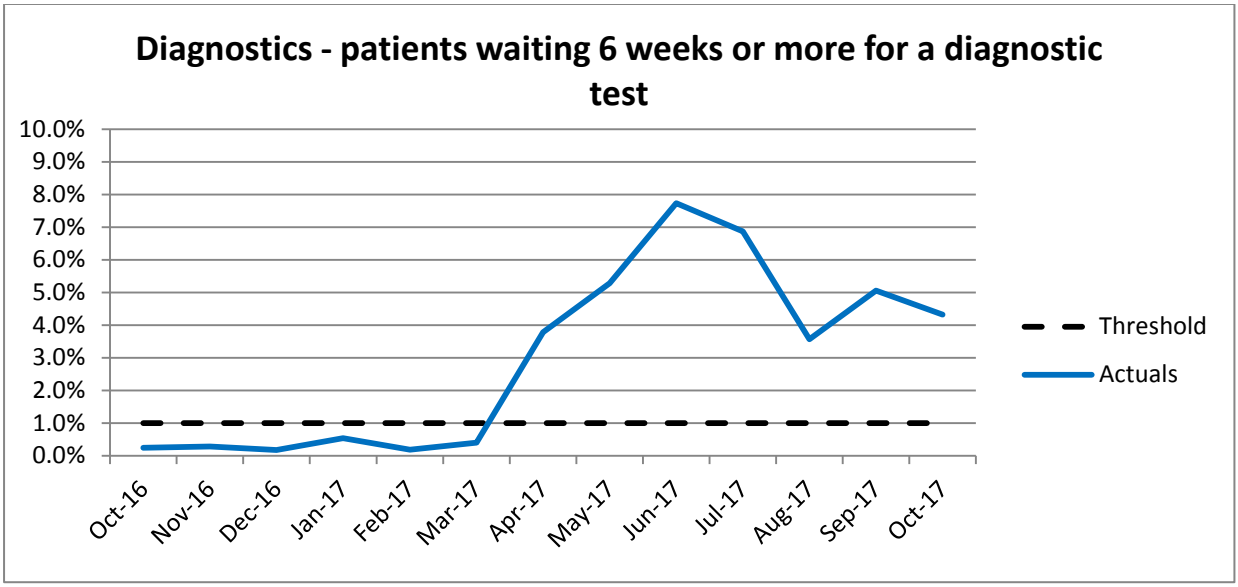


Chart 37 – Diagnostic waiting times for the period October 2016 – October 2017

2.5.7 Responsive: Waiting times for first outpatient appointment

A key milestone of the 18 week RTT pathway is the first outpatient appointment. This is where the patient will be assessed by a specialist and decisions on whether further tests are needed and the likely course of treatment are made. This indicator shows the average number of weeks that patients waited before attending their first outpatient appointment following a referral for routine appointments only.

ON average patients who attended their appointment in October had waited for 8.1 weeks. At overall Trust level the average waiting time was 9.1 weeks to attending first appointment from referral. However the average waiting times vary widely between clinical services, ranging from 4 – 13 weeks. Future updates to this section will highlight progress of specialty level actions plans relating to this indicator.

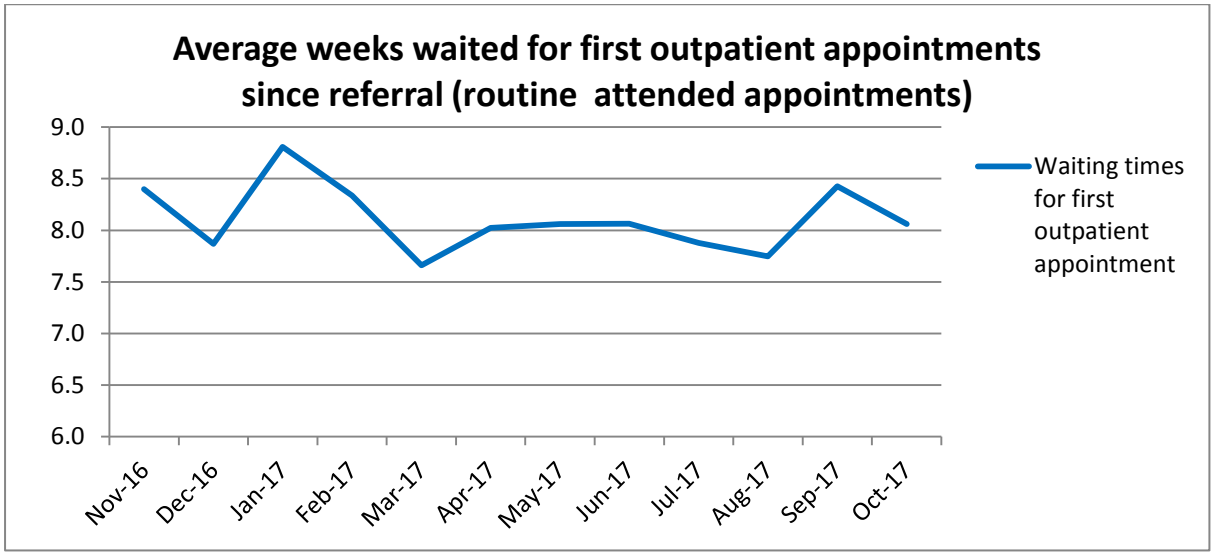


Chart 38 – Average weeks waiting time from referral to first outpatient appointment for the period November 2016 – October 2017 (census date: 17/11/17) (routine appointments)

2.5.8 Responsive: Outpatient DNA

The overall DNA rate (first and follow up) was 12.5 per cent in October and remains above the target threshold. The priority is to reduce the numbers of patients not attending their appointments to less than 11 per cent. Actions include:

- Continue to promote option for patients to receive appointment letters via email providing instant notification of appointments;
- Deliver a single point of access for appointment handling and queries; &
- Carrying out specialty and sub-specialty analysis of DNA rates to identify clinical pathways with increased opportunity for targeted intervention.

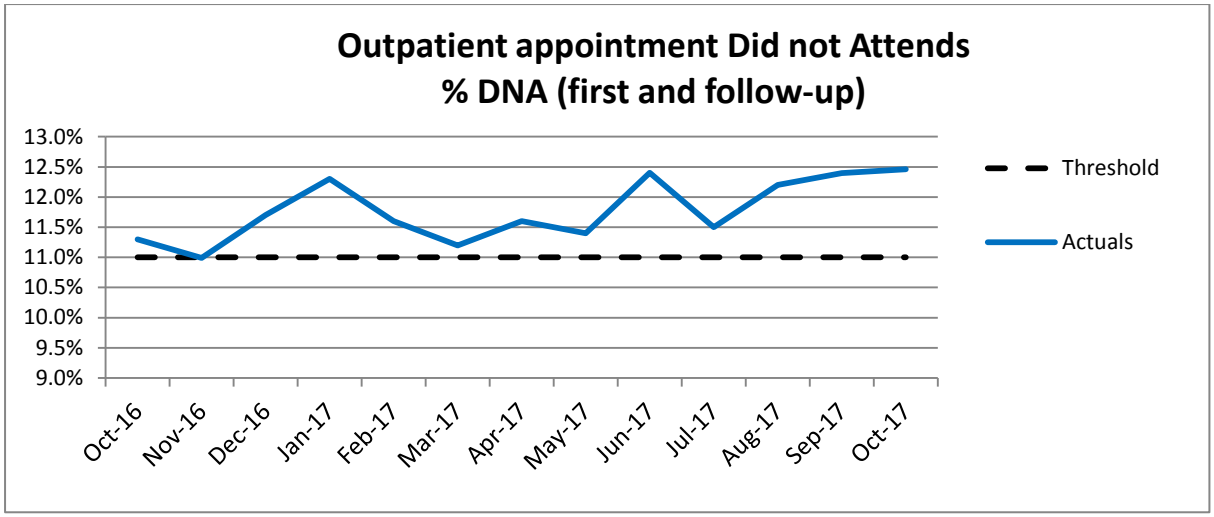


Chart 39 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period October 2016 – October 2017

2.5.9 Responsive: Outpatient appointments cancelled by the Trust

In October, 8.6 per cent of outpatient appointments were cancelled by the hospital with less than 6 weeks' notice. Performance remains above the agreed threshold of 7.5 per cent. The priority areas for improvement to reduce such cancellations are as follows:

- A one-year quality improvement project, funded by Imperial Health Charity, is underway to improve the patient experience and reduce the cancellations of outpatient appointments. Running until March 2018.
- Undertake a deep dive to understand the impact of expediting appointments on cancellation rates.
- Continue to work with specialty teams to embed the Trust Elective Access Policy, ensuring a minimum of six weeks' notice is provided for planned leave requiring the cancelling of clinics

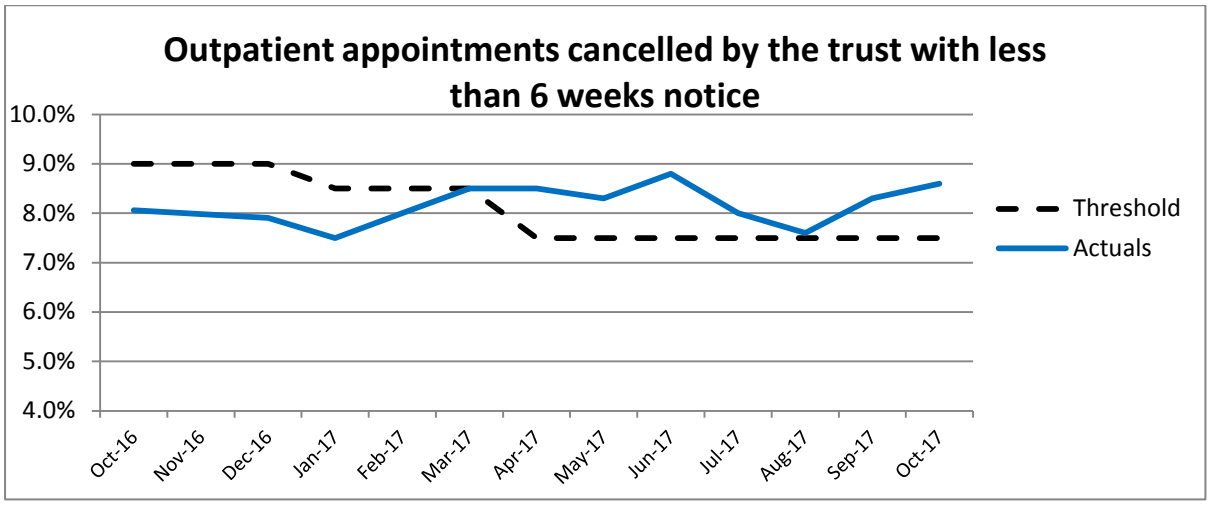


Chart 40 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period October 2016 – October 2017

2.5.10 Responsive: Outpatient appointments made within 5 days of receipt

There has been steady improvement since January 2017 in the percentage of referrals booked for a first outpatient appointment within 5 working days since receipt. Work continues to establish new ways of working to increase responsiveness including improved tracking and roll-out of e-vetting for services within the Patient Service Centre.

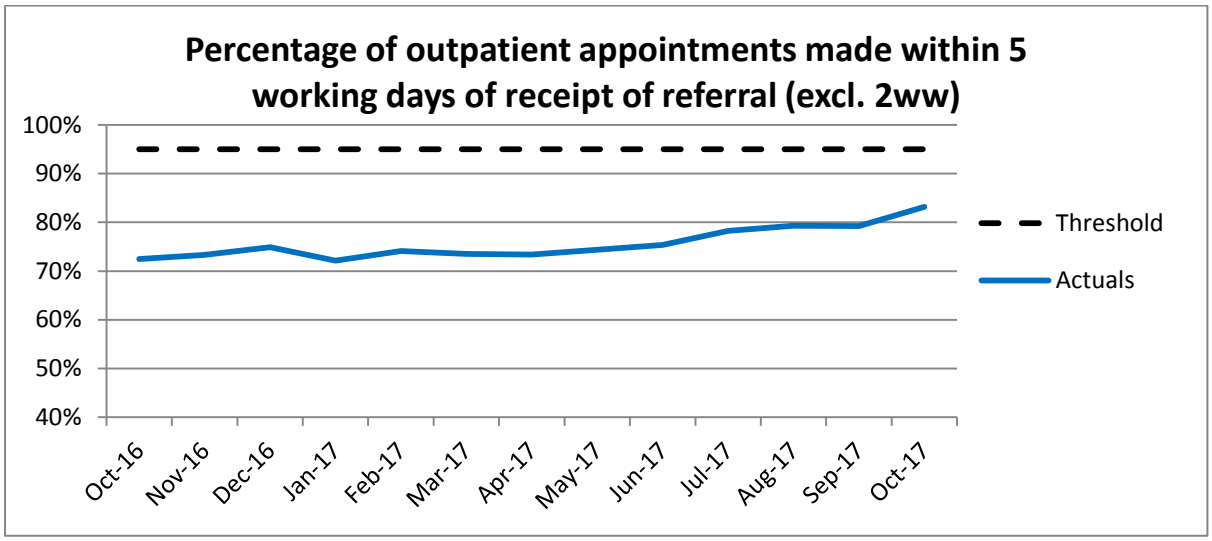


Chart 41 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period October 2016 – October 2017

3. Finance

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

Appendix 1 Safe staffing levels below target by ward (additional detail)

The fill rate was below 85 per cent for care staff and 90 per cent for registered staff in the following wards:

- Weston ward had a day fill rate of 78.83 per cent for care staff. This equated to 8 shifts unfilled for enhanced care. These shifts were safely covered by cross cover of care staff and cohorting patients with nurse in charge oversight. The overall day fill rate was 89.59 per cent.
- 10 North had a day fill rate of 83.52 per cent for care staff. This equated to 9 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill rate was 94.05 per cent.
- CXH AAU had a day fill rate of 69.70 per cent for care staff. This equated to 12 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill rate was 86.56 per cent.
- CXH AMU had a day fill rate of 82.04 per cent for care staff. This equated to 27 shifts unfilled for enhanced care. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill rate was 89.50 per cent.
- John Humphrey had a day fill rate of 70.69 per cent for care staff. This equated to 42 shifts unfilled for enhanced care and staffing vacancies. These shifts were safely covered by the Ward Manager and cross cover of care staff by the ward. The overall day fill rate was 80.62 per cent.
- Peters Ward had a day fill rate of 82.04 per cent for care staff, This equated to 17 unfilled for enhanced care, patient transfers and staffing vacancies. These shifts were safely covered by the Matron and cross cover of care staff by the ward. The overall day fill rate was 87.46 per cent.
- DAAU AMU had a day fill rate of 89.53 per cent for registered nurse staff. This equated to 19 shifts unfilled, 10 of which were due to an extra registered nurse added to the establishment to improve patient flow and the remaining due to sickness absence. These shifts were safely covered by the Matron and redeployment of care staff. The overall day fill rate was 89.57 per cent.
- DAAU Joseph Toynbee had a day fill rate of 84.02 per cent for care staff. This equated to 11 shifts unfilled for enhanced care and staffing vacancies. These shifts were safely covered by cross cover of carer staff from the first floor. The overall day fill date was 92.19 per cent.
- Manvers Ward had a day fill rate of 88.26 per cent for registered nurse staff. This equated to 23 shifts unfilled due to an extra registered nurse added to the establishment to improve patient flow and sickness absence. These shifts were safely covered by the Matron and redeployment of care staff. The overall day fill rate was 90.65 per cent.
- Samuel Lane had a day fill rate of 83.82 per cent for care staff. This equated to 11 shifts unfilled for enhanced care and staffing vacancies. These shifts were safely covered by the Ward Manager and redeployment of care staff. The overall day fill date was 93.27 per cent.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Finance Report for 2017/18 for the seven months to October

Executive summary:

This paper presents the financial position for the first seven months of the financial year to the end of October 2017.

Overall, The Trust is £2.0m adverse to plan in month and year to date, before Sustainability and Transformation Funding (STF). The executive is working on mitigation plans to recover the position and although there are risks to the position the Trust expects to meet the control total for the year.

As the Trust has missed the A&E target for quarter 2 (July-September) it is not eligible for the full STF, year to date this causes a £1.5m adverse variance to the plan.

Capital spend is behind plan year to date by £11.5m, although this relates largely to phasing of spend and the Trust expects to live within the capital resourcing limit.

There was £18.5m in the bank at the end of August. The Trust is not anticipating drawing down any additional working capital.

Quality impact:

N/A

Financial impact:

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

Risk impact:

Risks are highlighted in the summary pages

Recommendation(s) to the Committee:

The Board is asked to *note the paper, including the risks and recommended actions*

Trust strategic objectives supported by this paper:

Retain as appropriate:
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Paul Doyle, Deputy CFO Janice Stephens, Deputy CFO Michelle Openibo, Associate Director: Business Partnering	Richard Alexander, CFO	22 November 2017

FINANCE REPORT – 7 MONTHS ENDED 30th October 2017

1. Introduction

This report provides a brief summary of the Trust's financial results for the 7 months ended 30th October 2017.

2. Financial Performance

The Trust is behind plan in month and year to date by £2.0m before Sustainability and Transformation Funding (STF). The adverse position in month is mainly due to the phasing of expected cost improvement programmes (CIPs) in the plan. When the budgets were set at the start of the financial year the unidentified CIPs were phased equally from October.

Where clinical and corporate areas have an adverse variance to plan the Chief Executive and Chief Financial Officer have met to review their finances for the remainder of the financial year and agree plans to improve. With these mitigation plans and some non-recurrent mitigation the Trust expects to meet the control total for the year acknowledging that there are both risks and opportunities in that assumption.

STF is reviewed quarterly; there are two criteria for obtaining the funding, 70% for meeting the financial plan and 30% on achievement of the A&E 4 hour trajectory and primary care streaming targets. In quarter 2 (i.e. to the end of September) the trust achieved the finance element but did not achieve the A&E trajectory. The failure to meet the A&E target means that the Trust will receive £1.5m less STF year to date.

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	94.41	93.394	(1.02)	627.38	626.70	(0.68)
Pay	(48.37)	(49.810)	(1.44)	(341.99)	(342.21)	(0.22)
Non Pay	(37.80)	(38.604)	(0.80)	(267.10)	(271.49)	(4.38)
Reserves	(2.99)	(2.050)	0.94	(9.05)	(8.12)	0.94
EBITDA	5.26	2.929	(2.33)	9.23	4.89	(4.35)
Financing Costs	(3.61)	(2.671)	0.94	(25.30)	(21.63)	3.67
SURPLUS / (DEFICIT) including donated asset treatment	1.64	0.258	(1.39)	(16.07)	(16.74)	(0.67)
Donated Asset treatment	(0.51)	(1.123)	(0.61)	(3.57)	(4.89)	(1.32)
Impairment of Assets	-		-	-		-
SURPLUS / (DEFICIT)	1.13	(0.864)	(2.00)	(19.64)	(21.64)	(2.00)
STF Income	2.43	2.429	-	7.29	5.83	(1.46)
SURPLUS / (DEFICIT) after STF income	3.56	1.565	(2.00)	(12.35)	(15.81)	(3.46)

In month income shows below plan mainly due to pass through income of £2.0m adverse without which income would have been £1.0m over plan. These pass through costs are offset in non-pay expenditure. Year to date pass through income is underperforming by £5.6m, without which income would be over plan by £4.9m. The over performance is mainly in activity based clinical commissioning income.

Pay costs are favorable year to date but adverse in month, there has been an increase in costs relating to support to the waiting list improvement programme and additional nursing costs for patients with additional acuity. There are underspends in pay in clinical areas where growth schemes have not yet started. Agency spend is below plan and the NHS Improvement agency cap.

Non Pay expenditure is adverse to plan year to date. Within the expenditure position there are some adverse variances caused by unidentified cost improvement programmes (CIPs). The PSO and operational teams are working to identify schemes to meet the Trust's plan. There is also overspending on the costs of outsourced services to help the trust meet its access targets.

2.1. NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Year To Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Total Division of Medicine and Integrated care	502,960	498,425	(4,535)	149.75	150.53	0.78
Total Division of Surgery, Cancer and Cardiovascular	411,705	402,508	(9,197)	177.17	181.66	4.49
Total Division of Women, Children and Clinical Support	1,539,781	1,469,464	(70,317)	93.00	89.37	(3.63)
Central Income			-	79.94	75.66	(4.28)
Clinical Commissioning Income	2,454,446	2,370,397	(84,049)	499.86	497.22	(2.64)

Within clinical divisions there is over performance on clinical activity year to date. The adverse variance within central is mainly due to pass through drugs and devices income which is £5.6m under plan year to date.

Overall over performance in the Trust is mainly in non-elective income, with year to date non elective over performance of £11.6m which is 11% over plan. MIC over performance is in the main due to this non elective increase. This is offset by underperformance in renal and critical care. SCC has over performance in clinical hematology and critical care offset by some underperformance in general surgery. WCCS is underperforming, with reduced activity in maternity services; this is in line with trends across North West London.

The Trust's income plan is higher than the commissioner plan, as when agreeing the control total the plan was revised based on actual activity seen. Therefore the current position will represent over performance to the commissioners. The Trust has agreed a 70% marginal rate on over performance with North West London CCGs and this has been factored into the year to date income.

2.2. Private Patients Income

Private patient's income is behind plan year to date; the income has been increasing throughout the year and is expected to continue this increase. Year to date there have been delays in planned growth schemes are reductions in previous years activity within the children's and reproductive medicine services than have caused a large level of underperformance. However this is being offset with increase income in other areas specifically general medicine, adult oncology and hematology and specialist surgery. Comparing April to October this year compared to 2016 private income has increased by £1.6m.

2.3. Clinical Divisions

The devolved financial position for clinical divisions is set out in the table below. Clinical Divisions are adverse to plan in month and year to date.

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	23.74	23.69	(0.06)	160.11	160.45	0.34
Expenditure	(16.90)	(17.95)	(1.05)	(123.04)	(126.68)	(3.64)
Medicine and Integrated Care	6.84	5.73	(1.11)	37.07	33.77	(3.30)
Income	27.30	27.56	0.26	180.09	185.51	5.42
Expenditure	(21.53)	(23.99)	(2.46)	(155.78)	(161.77)	(5.99)
Surgery, Cancer and Cardiovascular	5.77	3.57	(2.20)	24.31	23.74	(0.57)
Income	15.96	14.34	(1.63)	106.39	97.91	(8.48)
Expenditure	(16.39)	(16.32)	0.07	(115.90)	(114.37)	1.53
Women, Children & Clinical Support	(0.42)	(1.98)	(1.56)	(9.51)	(16.46)	(6.95)
Imperial Private Healthcare	1.43	1.62	0.20	8.69	9.14	0.45
Total Clinical Division	13.61	8.94	(4.67)	60.55	50.19	(10.37)

MIC is showing an adverse variance to plan year to date. There is a large adverse variance in expenditure due to unidentified CIPs and income not commissioned which was budgeted against expenditure. The adverse position in SCC is primarily due to CIPs and the additional costs to support the waiting list improvement programme. The position in WCCS is mainly due to income. Pathology is within WCCS and is £2.2m adverse to plan year to date. There has been a reduction in income for tests provided to other organisations, and the Division is reviewing this variance to ensure all income for the Trust has been received. Within the rest of the WCCS position the adverse variances are caused by underperformance on maternity NHS income and private paediatric and gynaecology income. For Imperial Private Health there has been over performance on income with associated costs of delivery.

3. Efficiency programme

The Trust has set a £54.4m CIP in 2017/18 as part of its overall financial plan; this is in line with the value achieved in 2016/17 of £53.8m.

The year to date plan is £26.9m there has been achievement of £19.0m giving a £7.9m underperformance year to date. This underperformance is due to a combination of slippage against planned schemes and yet to be identified plans. The key areas of underperformance are on income generation schemes not yet fully implemented. A number of actions and workstreams continue across the organisation, in order to further close the gap, mitigate against further slippage and strengthen the current deliverables supported by the Project Support Office

Cash

The Trust closed month 7 with a cash position of £18.5m. It is currently anticipated that the Trust will not require further draw down of working capital. The closing cash balance for the year is forecast to be £23.1m. The Trust continues to develop opportunities to further improve the Trust's cash position and avoid additional borrowing plan.

4. Capital

In-month gross capital expenditure was £4.3m against a planned spend of £5.2m and cumulatively the gross spend is £16.4 against a planned spend of £27.9m. The capital programme continues to have close oversight by the Capital Expenditure Assurance Group and is forecast to be on plan and the end of the year and meet the Capital Resource Limit.

5. Conclusion

The Trust is adverse to plan in month and year to date. The operational teams are working closely with the PSO and finance to identify efficiency opportunities to help mitigate the position. However there remains risk to the delivery of the control total if current forecasts are not maintained or additional financial risks occur which cannot be mitigated.

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 7 months to 30th October 2017

	In Month			Year To Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	78.5	76.0	(2.5)	516.5	511.4	(5.1)
Private Patients	4.4	4.3	(0.2)	30.2	28.7	(1.5)
Research, Development and education	8.3	9.1	0.9	58.1	59.6	1.5
Other non-patient related income	3.2	4.0	0.8	22.6	27.0	4.5
Total Income	94.4	93.4	(1.0)	627.4	626.7	(0.7)
Pay - in post	(44.4)	(42.7)	1.7	(317.9)	(298.7)	19.2
Pay - Bank	(0.7)	(4.3)	(3.7)	(4.2)	(27.8)	(23.5)
Pay - Agency	(3.3)	(2.8)	0.5	(19.8)	(15.8)	4.1
Drugs and Clinical supplies	(21.4)	(19.8)	1.6	(145.4)	(141.4)	4.0
General Supplies	(2.8)	(3.0)	(0.2)	(19.5)	(21.0)	(1.4)
Other	(13.6)	(15.7)	(2.2)	(102.1)	(109.1)	(6.9)
Total Expenditure	(86.2)	(88.4)	(2.2)	(609.1)	(613.7)	(4.6)
Reserves	(3.0)	(2.1)	0.9	(9.1)	(8.1)	0.9
Earnings before Interest, Tax, Depreciation and Amortisation	5.3	2.9	(2.3)	9.2	4.9	(4.3)
Financing Costs	(3.6)	(2.7)	0.9	(25.3)	(21.6)	3.7
SURPLUS / (DEFICIT) including financing costs	1.6	0.3	(1.4)	(16.1)	(16.7)	(0.7)
Donated Asset treatment	(0.5)	(1.1)	(0.6)	(3.6)	(4.9)	(1.3)
SURPLUS / (DEFICIT) including donated asset treatment	1.1	(0.9)	(2.0)	(19.6)	(21.6)	(2.0)
Impairment of Assets	0.0	0.0	0.0	0.0	0.0	0.0
SURPLUS / (DEFICIT)	1.1	(0.9)	(2.0)	(19.6)	(21.6)	(2.0)
STF	2.4	2.4	0.0	7.3	5.8	(1.5)
SURPLUS / (DEFICIT) after STF income	3.6	1.6	(2.0)	(12.3)	(15.8)	(3.5)

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board – public	29 November 2017

Corporate Risk Register

Executive summary:

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

At present, there are 17 corporate risks within the risk register. The highest risks are scored as 20 and the lowest is scored as 8.

Key themes include:

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

The following changes to the Corporate Risk Register have been made since the last review by the Trust Board in July 2017:

- The Corporate Risk Register is presented in a new template.

- Two risks have been closed:
  - *Risk 73 Failure to deliver the Clinical Strategy Implementation programme (CSIP) to achieve long term sustainability, enhance acute services and support out of hospital care.*
  - *Risk 65 Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors, resulting in suspension of training.*

- Two risks have been de-escalated from the Corporate Risk Register to the relevant divisional risk register:
  - *Risk 87 Failure to comply with the statutory and regulatory duties and requirements, including failure to deliver OPD improvement plan*
  - *Risk 67 Failure to achieve benchmark levels of workforce engagement.*

- Five new risks have been escalated to the Corporate Risk Register:
  - *Risk 2478 Risk of excess organisational pressure associated with major malicious attack*
  - *Risk 2479 Increased risk of delayed fire evacuation due to old buildings which do not meet current safety standards and fire regulations*
  - *Risk 2480 Risk to patient safety and reputation due to inconsistent provision of cleaning services across the Trust*
  - *Risk 2489 Risk of potential failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services and which is recognised and accepted by leaders of clinical services*
  - *Risk 2475 Failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results*

- The risk scores for the following risks have increased:
  - *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.*
  - *Risk 2487 Risk of spread of CPE (Carbapenemase Producing Enterobacteriaceae)*
  - *Risk 2481 - Failure to implement, manage and maintain an effective health and safety management system.*

- The Corporate Risk Register was discussed at the Executive Operational Performance Committee on 21 November 2017 and a verbal update will be given at the Board meeting on the outcome of that discussion.

- Following discussion at the Executive Operational Performance Committee on 21 November 2017, the Trust's proposed risk appetite and framework will be presented to the Audit, Risk and Governance Committee (ARG) on the 6 December 2017 and at the Trust Board seminar on 13 December 2017. The approach to risk appetite will be formalised and presented to the Trust Board in March 2018.

Quality impact:

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

Financial impact:

Some of the mitigation for risks as outlined in Appendix 1 will have a financial impact and this is considered as part of existing work streams in relation to the risks.

Risk impact:

The impacts of each risk are captured within Appendix 1.

Recommendation(s) to the Committee:

- Note the changes to the Corporate Risk Register
- Note the Corporate Risk Register

Trust strategic objectives supported by this paper:

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

and improvements. • To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Valentina Cappo, Corporate Risk/ Project Manager	Janice Sigsworth, Director of Nursing	21 November 2017

Corporate Risk Register

1. Purpose

The following report provides a summary of key changes to the Corporate Risk Register since it was reviewed by the Trust board in July 2017.

2. Background

The Trust Board reviewed the Corporate Risk Register at its meeting on 26 July 2017 as part of the agreed bi-annual process. The following governance process for risk management is in place within the Trust:

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

- The layout and format of the corporate risk register has been revised following discussion with the Executive Committee and Audit, Risk and Governance Committee.
- Please refer to **Appendix 1** for a copy of the Corporate Risk Register, which reflects the changes summarised in this paper.

3. Changes to the Corporate Risk Register

3.1 Changes to the format

- This month the Corporate Risk Register is presented in a new template that was approved by the Trust Executive Committee on the 26 September 2017. This template draws on best practice.
- Main changes from the previous template include:
  - *Changes to the corporate risk register dash board:*
  - Initial scores have been moved to the RAG graded grid, together with current and target scores, to provide better visibility of the risk scoring history.
  - Target risk score dates have been replaced by risk outlook, i.e. expected risk movement in the following three months.
  - Risks are now mapped against the CQC domains.

  - *Individual risk descriptions have been amended as follows:*
  - The following fields have been removed:
    - ✓ Two digit risk ID (only the Datix ID now remains)
    - ✓ Risk source/ type
    - ✓ Risk proximity

- ✓ BAF reference
- ✓ Target risk score date

- The following fields have been added:
  - ✓ Assurance KPIs, i.e. which information we use to assess whether the exiting controls are working as planned
  - ✓ Specific action plans, including due dates and individual updates.

3.2 Risks that have been closed

- ***Risk 73*** *Failure to deliver the Clinical Strategy Implementation programme (CSIP) to achieve long term sustainability, enhance acute services and support out of hospital care. (Score 9 L3 x C9)*
- The Clinical Strategy Implementation Programme is now complete.
- All Phase 1 projects have been implemented, with residual actions transferred to the relevant divisions. Governance of Phase 2 Projects has transferred to the "Emergency Department (ED) Improving 4 hour performance Working Group", chaired by the Divisional Director for Medicine and Integrated Care.
- At the Executive Committee in July 2017 it was agreed that this risk be closed and elements of the CSIP programme that have been transferred to other areas be risk assessed as appropriate in those areas.

- ***Risk 65*** *Failure to achieve benchmark levels of medical education performance and provide adequate and appropriate training for junior doctors, resulting in suspension of training*
- 2017 GMC National Training Survey (NTS) results were published in July 2017. There have been improvements in several specialties, although other remain challenged or have deteriorated. A full action plan was submitted to Health Education England (HEE) in September 2017.
- A programme of internal monitoring is in place through the education specialty review process for specialties of concern (e.g. through previous GMC NTS results, SOLE feedback and Quality Visits). This will be expanded to include any specialties identified as concerns through the recent GMC NTS results.
- The risk description included a number of cause and effects that have been addressed; the risk was subsequently de-escalated and closed and replaced with another risk (Risk **2475**, as described in paragraph 3.4) that reflects the current issues.

3.3 Risks de-escalated from the Corporate Risk Register

- ***Risk 87*** *Failure to comply with the statutory and regulatory duties and requirements, including failure to deliver OPD improvement plan*
- On 31 May 2017 the CQC published the reports of the inspection of the Outpatient and Imaging services that was held in November 2016.
- The CQC has acknowledged an improvement in outpatient services across all Trust sites.
- The risk score was subsequently reduced from 16 (L4xC4) to 12 (L3xC4) and the Executive Committee agreed that this risk be de-escalated from the Corporate Risk register to the Women's, Children's and Clinical Support divisional risk register in July 2017.

- ***Risk 67*** *Failure to achieve benchmark levels of workforce engagement*
- The report of the latest Local Engagement Survey "Our Voice our Trust", which was run across the Trust between 2 May and 30 June 2017, has shown an overall

increase in the engagement score from 77% in 2016 to 80% in 2017. The staff Friends and Family Test scores in the Local Survey were the highest scores we have had to date at 85% of people recommending the place for care and treatment and 72% recommending the Trust as a place to work.

- Both the 2016 National Staff Survey results and the 2017 Local Engagement Survey results have demonstrated an increase in staff engagement. The likelihood therefore of this risk materialising has decreased from possible to unlikely.
- The risk has achieved its target risk score of 6 (L2 x C3) and it was de-escalated from the Corporate Risk Register to the People and Organisation Development Divisional Risk Register in August 2017.

3.4 New risks escalated to the Corporate Risk Register

- ***Risk 2478*** *Risk of excess organisational pressure associated with major malicious attack*
- This risk from the Facilities, Estates, Nursing and Site divisional risk register was reviewed following the Westminster terrorist attack in March 2017 and the London Bridge terrorist attack in June 2017
- Due to the increased likelihood and impact of this risk materialising, this risk was escalated to the Corporate Risk Register in August 2017 and has a current score of 20 (L5 x C4).

- ***Risk 2479*** *Increased risk of delayed fire evacuation due to old buildings which do not meet current safety standards and fire regulations*
- Trust old buildings do not meet current standards and regulations.
- Risk of inability to evacuate buildings in a timely manner in the event of a major fire
- The risk was escalated to the Corporate Risk Register in September 2017 and has a current score of 16 (L4 x C4).

- ***Risk 2480*** *Risk to patient safety and reputation due to inconsistent provision of cleaning services across the Trust.*
- Cleaning provision is inconsistent across the Trust estate due to issues with domestic services, frequency and effectiveness of equipment cleaning and access to relevant areas due to operational issues.
- This poses an increased risk of infection.
- The risk was escalated to the Corporate Risk Register in September 2017 and has a current score of 15 (L5 x C3).

- ***Risk 2489*** *Risk of potential failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services and which is recognised and accepted by leaders of clinical services*
- There is a risk of failing to conduct the agreed Specialty Review Programme and generate specialty specific strategies as an output of this process.
- Potential for the strategy to be misaligned with other external and internal strategies and potential for lack of support from external stakeholders and public consultations.
- If this risk materialises, it would result in: Trust capacity for both elective and non-elective pathways remaining constrained, a failure to deliver services efficiently and loss of market share.
- The risk was escalated to the Corporate Risk Register in September 2017 with a score of 8 (L2 x C4).

- In light of the de-escalation and closure of risk 65 (paragraph 3.3), the following new risk has been approved for inclusion onto the Corporate Risk Register:
- ***Risk 2475*** *Failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results*
- Poor engagement with trainees/students with minimal feedback or multiple avenues of feedback leading to lack of clarity and inadequate communication within the Medical Education team could result in failure to deliver high quality training and reduction in students and training places commissioned to the Trust.
- The risk was escalated to the Corporate Risk Register in October 2017 and has a score of 12 (L3 x C4).

3.5 Changes to risk scores

- ***Risk 2472*** *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards.*
- On the 12 June 2017 the CQC published a new regulatory framework for NHS Acute Trusts, which includes the 'Well Led' inspection and the Annual Provider Information Return.
- Due to limited information and given this is entirely a new approach, the likelihood of this risk materialising has increased.
- The risk score was subsequently increased from 8 (L2xC4) to 12 (L3xC4) in July 2017.

- ***Risk 2487*** *Risk of spread of CPE (Carbapenemase Producing Enterobacteriaceae)*
- There has been an increase in the number of CPE cases in the Trust.
- Actions are in place to improve infection control practices in each area. Outbreaks will be declared 'closed' when there are no new cases in a four week period.
- Owing to the recent outbreaks, the current risk score was increased from 16 (L4 x C4) to 20 (L5 x C4) in September 2017.

- ***Risk 2481*** *– Failure to implement, manage and maintain an effective Health and Safety management system.*
- There is one vacancy in the Health and Safety service since October 2017, which will affect the ability of the service to provide a number of functions, including: departmental safety coordinator (DSC) training, to respond to divisional requests for assistance, to monitor and participate in work and, ultimately, to obtain assurance.
- There is an plan to recruit into the vacant Health & Safety post by the end of January 2018
- Risk score increased from 8 (L2xC4) to 12 (L3xC4) in October 2017.

4. Outcome of discussion at the Executive Operational Performance Committee on 21 November 2017

Due to the timing of the Trust board meeting, there will be further discussion of the Corporate Risk Register at the Executive Operational Performance Committee on 21 November 2017, where it is likely that the following changes will be agreed:

4.1 New risk for escalation onto the Corporate Risk Register

- *Risk 2364 'Risk of being unable to use key antimicrobials used within ICHNT for patients with sepsis of some form'*
- The Trust is currently experiencing the effects of a fragile antimicrobial supply

chain within the global and national pharmaceutical market. This has meant an inability to source key antimicrobials used within ICHNT.
- As a result, the ICHNT empirical adult/ paediatric/ speciality treatment guidance has been changed, but the risk exists around changes to local antimicrobial resistance patterns, increased carbapenem prescribing, increased in adverse drug reactions/ HCAIs and the inability to adequately treat/ manage patient specific infections.
- The risk has been presented for approval with a current score of 10 (C2 x L5).

Changes to target scores described below have been provisionally included in Appendix 1:

4.2 Changes to target risk score

- *Risk 2482 - Cyber Security Threats to Trust Data and Infrastructure*
- No new technical controls have been implemented since the "WannaCry" incident. However, the Cyber Security Response Plan is being developed and investment requests have been put forward.
- The target risk score has been reduced from 16 (C4 x L4) to 8 (C4 x L2).

4.3 Emerging risks

An unannounced CQC inspection of urgent care and surgery services took place on the 7, 8 and 9 November 2017. Following the inspection, which identified some issues, the Executive Operational Performance Committee has discussed the following risk areas with a view of considering whether they should be included onto the Corporate Risk Register:

- Compliance with statutory and mandatory training
- Medicines management
- Compliance with Aseptic Non Touch Technique (ANTT)
- Maintenance of medical devices.

A verbal update will be given at the board meeting on the outcome of the discussion from the Executive Operational Performance Committee which took place on 21 November 2017.

4.4 Risk Appetite

- Following discussion at the Executive Operational Performance Committee on 21 November 2017, the Trust's proposed risk appetite and framework will be presented to the Audit, Risk and Governance Committee (ARG) on the 6 December 2017 and at the Trust Board seminar on 13 December 2017. The approach to risk appetite will be formalised and presented to the Trust Board in March 2018.

5. Next steps

- The Corporate Risk Register will continue to be discussed at the Executive Committee each month and at the Audit, Risk and Governance Committee at each meeting.
- The proposed risk appetite statement and framework will be presented to the Audit, Risk and Governance Committee on the 6 December 2017 and at the Board Seminar on the 13 December 2017.

6. Recommendations to the board:

- Note the changes to the Corporate Risk Register,
- Note the Corporate Risk Register.

7. Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.
- To educate and engage skilled and diverse people committed to continual learning and improvement.

APPENDIX 1

Corporate Risk Register

Scoring Matrix

To calculate the risk score it is necessary to consider both how severe the consequences would be and also 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

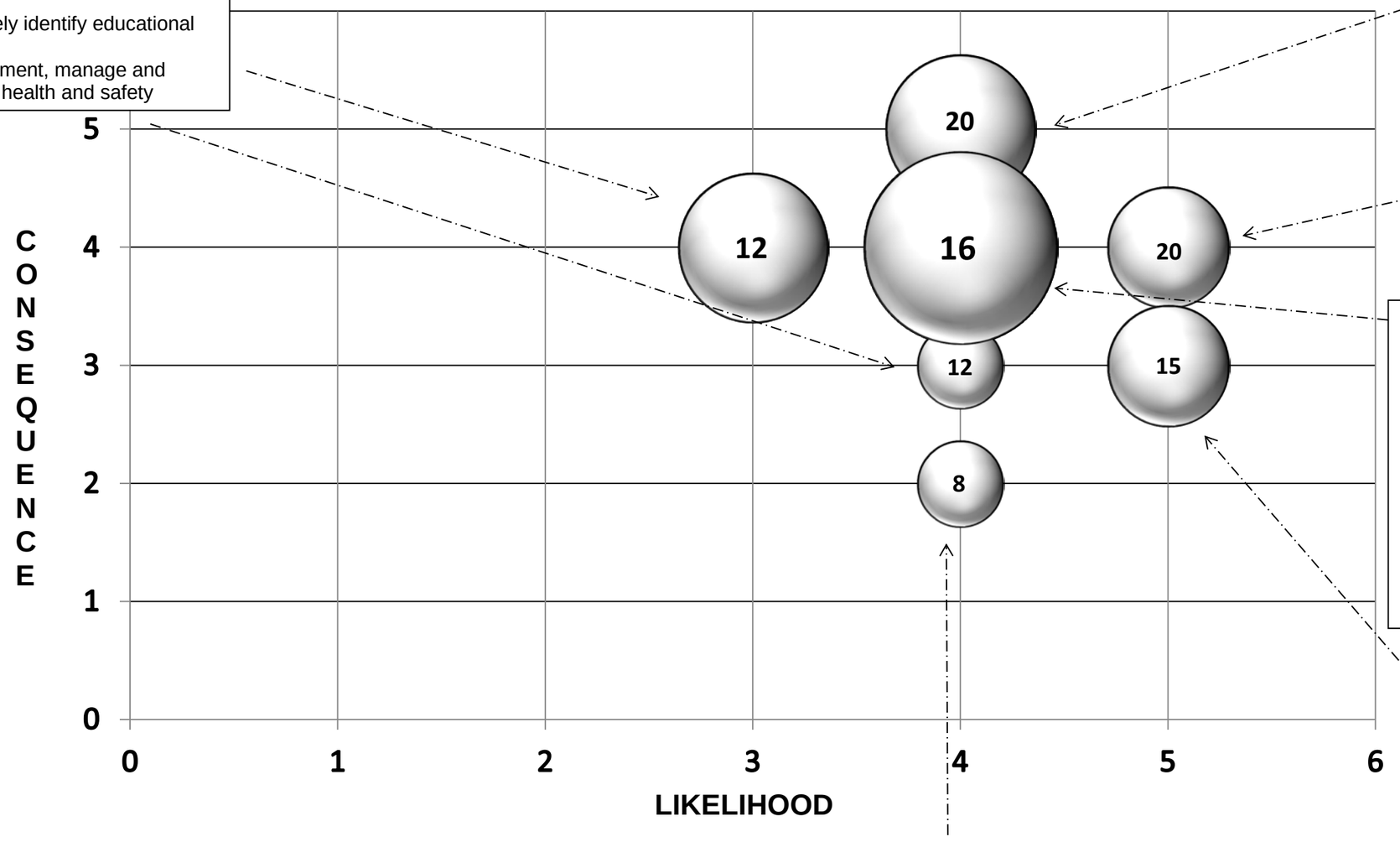
Current Score: The current risk score including key controls to mitigate this risk

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

Corporate Risk Profile

Risks scored 12:

1. 2472 Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards (4x3)
2. 2490 Failure to deliver safe and effective care (4x3)
3. 2475 Failure to actively identify educational issues (4x3)
4. 2481 Failure to implement, manage and maintain an effective health and safety



Risks scored 20:

1. 2479 Failure of estates critical equipment and facilities (5x4)
2. 2473 Failure to maintain financial sustainability (5x4)
3. 2510 Failure to maintain key operational performance standards (4x5)
4. 2478 Risk of excess organisational pressure associated with major malicious attack (4x5)
5. 2487 Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae) (4x5)

Risks scored 16:

1. 2482 Risk of Cyber Security threats (4x4)
2. 2476 Failure to currently meet some of the High Dependency core standards (4x4)
3. 2498 Failure to gain funding approval for the redevelopment programme (4x4)
4. 2499 Failure to meet required or recommended Band 2-6 vacancy rate for N & M staff (4x4)
5. 2479 Risk of delayed evacuation in case of fire (4x4)

Risk scored 15:

1. 1992 Risk to patient experience and quality of care in the ED caused by the significant delays experienced by patients presenting with mental health issues (5x3)
2. 2480 Patient safety risk due to inconsistent provision of cleaning services across the Trust (5x3)

Risk scored 8:

1. 2489 Failure to develop and publish a refreshed Trust Clinical Strategy (4x2)

Corporate Risk Register Dash Board

Page n.	Risk ID	CQC Domain	Risk Description	Lead Director	Date risk identified	≤6	8	9	10	12	15	16	20	25	Risk Outlook
Trust Objective 1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion															
Page 4	2510	Responsive	Failure to maintain key operational performance standards	Divisional Director of MIC Divisional Director of SCC Divisional Director of WCCS	Jun-07					●	¡		♦		☺
Page 5	2477	Responsive	Risk to patient experience and quality of care in the Emergency Departments caused by the significant delays experienced by patients presenting with mental health issues	Divisional Director of MIC	Jun-16		●				¡♦				😐
Page 6	2476	Safe Effective	Failure to currently meet some of the core standards and service specifications (as set out by the CQC) for High Dependency areas within the Trust	Divisional Director of SCCs	Jun-16	●						¡♦			😐
Page 7	2472	Well Led	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC	Director of Nursing	Dec-14		●	→		♦		¡			☹
Page 8	2478	Well Led	*Risk of excess organisational pressure associated with major malicious attack	Director of Nursing	Jul-17							¡●	♦		😐
Page 9	2479	Safe	*Risk of fire delayed evacuation within older parts of the Trust Estate needs enhanced level of assessment and on-going management due to building age, infrastructure and layout of the buildings	Director of Nursing	Aug-14			●				♦	¡		😐
Page 10	2480	Safe Responsive	*There is a risk to patient safety and reputation caused by the inconsistent provision of cleaning services across the Trust	Director of Nursing	Sep-17	●					¡♦				☺
Page 11	2485	Safe	Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks	Director of Nursing	Mar-11						●		¡ ♦		😐
Page 12	2489	Well Led	*Failure to develop and publish a refreshed Trust Clinical Strategy which outlines the direction of travel for all clinical services and which is recognised and accepted by leaders of clinical services	Medical Director	Aug-17	●	¡♦								😐
Page 13	2487	Safe	Risk of Spread of CPE (Carbapenem-Producing Enterobacteriaceae)	Medical Director	Jul-15		●			¡		→	♦		😐
Page 14	2490	Safe Effective	Failure to deliver safe and effective care	Medical Director	Oct-14		●			¡♦					😐
Page 15	2499	Safe	Failure to meet required or recommended Band 2-6 vacancy rate for Band 2-6 ward based staff and all Nursing & Midwifery staff	Director of People & OD	Nov-16		●			¡		♦			😐
Trust Objective 2. To educate and engage skilled and diverse people committed to continual learning and improvement															
Page 16	2475	Effective	*Risk of failure to actively identify educational issues and develop actions in response before they result in negative feedback/poor results*	Medical Director	Aug-17		●			¡♦					😐
Page 17	2481	Safe	Failure to implement, manage and maintain an effective health and safety management system	Director of People & OD	Oct-13	●		→		¡♦					😐
Trust Objective 4. To pioneer integrated models of care with our partners to improve the health of the communities we serve															
Page 18	2498	Well Led	Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration	Chief Executive	Oct-14		●			¡		♦			😐
Trust Objective 5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance															
Page 19	2473	Well Led	Failure to maintain financial sustainability	Chief Financial Officer	Mar-12						●		¡ ♦		😐
Page 20	2482	Caring Well Led	Risk of cyber security threats to Trust data and infrastructure	Chief Information Officer	Jul-15		●					♦¡			😐

Key:

→ Arrow indicates movement since last report

¡ Indicates initial risk score

♦ Diamond indicates current score

● Circle indicates target risk score

* Star indicates new risk since last report

☺ Indicates risk score expected to reduce in the next 3 months

😐 Indicates risk score expected to remain unchanged in the next 3 months

☹ Indicates risk score expected to increase in the next 3 months

ID: 2510 — Failure to maintain key operational performance standards

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain key operational performance standards including: Emergency Department (ED) target, Cancer waiting target, Diagnostic target and RTT target. **Cause:** • Mismatch of accurate reporting and poor data quality due to implementation and embedding of new systems and processes. • Mismatch of capacity and demand • Financial challenges • Bed capacity across sites • Volatility of non-elective demand • Increased requirements for elective RTT activity • Late discharges / delayed review by speciality doctors • Potential infection outbreak • Imaging capacity being lost due to equipment failure • Transfer of SMH UCC service to an external provider • Temporary Closure of beds on the SMH and CHX sites adding additional pressure **Effect:** • Reduced patient experience / staff morale • Increased operational inefficiencies • Failure to meet contractual / regulatory / performance requirements • Loss of reputation and reduced confidence from key stakeholders • Delays to accessing services • Elective patients on the waiting list have to be cancelled. • Delayed step downs from critical care. • Transfer of patients between sites impacting on patient experience	**15**	**20**	**12**	⇔	**Divisional Director of SCCS**	• ED Performance Reports • Outcome of review of ED performance with emergency care intensive support team (ECIST) • Delivery of the performance trajectory agreed with Commissioners • Local level scorecards • Outcome of internal peer review • Clinical harm review (MD Office and division) • Delivery of the performance trajectory agreed with Commissioners

Current Risk Controls

• Escalation to mental health providers
• Implementation of full capacity protocol
• Extended operational hours for ambulatory emergency care services at St Mary's and Charing Cross
• Escalation of ongoing issues with Vocare service to commissioners.
• Monthly Waiting List Improvement programme (WLIP) Steering Groups including Intensive Support Team (IST) NHSE and NWL CCG commissioners.
• Weekly WLIP management meetings and RTT meetings with General Managers to help ensure progress against actions and trajectories.
• Weekly CEO RTT meetings
• 3 year MOU and funding agreement with Macmillan into cancer services
• Twice a year (May and November) internal peer review with all cancer MDTs
• Increased investment in cancer MDT Coordinators
• Investment into Somerset System (Cancer tracking tool)
• Imaging Reporting - Additional radiologist sessions to report on images and reduce turnaround time
• Monitoring forums
• Senior input into site operations
• Information peer review
• Clear escalation plans
• Participation in weekly sector operations executive
• Development and implementation of site/clinical strategy
• Imaging Modalities - Additional ad hoc sessions based on voluntary overtime
• Prioritising of urgent inpatient and cancer 2WW patients.
• Fortnightly Task and Finish Group to support improved recruitment
• 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
• RTT IT utilisation project on-going to link service needs and IT capability of informing patient progression on pathways. Coupling efforts from Business Intelligence and Imaging data management processes
• Increased work of pathway reviews being undertaken through modality meetings led by Heads of Service.
• Endoscopy – Additional capacity in place to reduce backlog

Mitigation Plan

Action:
Renovation and re-opening of Thistlewaite ward at SMH *Due Date:* 22/12/17
Update on action:
In progress.

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

Action:
Deliver the Waiting List Improvement Programme *Due Date:* 27/04/18
Update on action:
1)Daily / weekly GM portfolio review
2)Continued weekly CEO RTT meetings
3)Monthly MD office review clinical harm review / monthly divisional Q&S review
4)Monthly CCG/NHSI/E WLIP review meetings – service level trajec

Contingency Plans

• Agreed remedial action plan with commissioners for RTT and choose and book.
• ED recovery plan
• Diagnostic trajectory plan
• Additional elective activity focused on CXH / HH sites
• Increased senior (executive) scrutiny of the emergency pathway and in patient discharge planning
• Validation of closed pathways on-going. Patients to be contacted as appropriate.

Key Summary Updates & Challenges

Improvements achieved in cancer performance and also the recovery plans for RTT.
September DM01 performance was 481 breaches / 5.06% against a 1% tolerance. These breaches were mainly in Endoscopy (378) and Imaging (80). Both services are reviewing trajectory plans for returning to target.

ID: 2477

Risk to patient experience and care due to delay for mental health patients in the ED

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

Mitigation Plan

Action:
Summary paper to be presented to the next EM Governance meeting covering 12 months of incidents *Due Date:* 29/12/17
Update on action:
In progress.

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

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

Contingency Plans	Key Summary Updates & Challenges
Management within department with existing controls, ongoing investigation of serious incidents for 12 hour trolley wait incidents.	3 further serious incidents currently under investigation. Recently completed investigations have demonstrated an improvement in the standard of documentation and adherence to escalation policies.

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

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 **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 • Absence of Critical Care outreach team on the Hammersmith site **Effect:** • Delivery of care provided to patients • Patients being nursed in inappropriate areas (C8 ward) due to lack of level 2 beds • Inability to open additional capacity on demand and potentially impacts on staff activity and morale and patient safety. • Possible unannounced CQC inspection	**16**	**16**	**6**	⟺	**Divisional Director of SCCS**	Weekly reports to the project board on progress against the standards

Current Risk Controls	Mitigation Plan
• 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 • 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. • Cohorted level 2 /3 together at CXH – compliant with standards	**Action:** Develop SOP for the management of the new High Dependency Units *Due Date:* 29/06/18 **Update on action:** First draft has been distributed to the Critical Care Group. **Action:** Recruitment to fill vacant posts on ward *Due Date:* 29/06/18 **Update on action:** Full recruitment plan in progress which reports to the critical care board. **Action:** Critical Care to take over management of HDUs Trustwide *Due Date:* 29/06/18 **Update on action:** Project board for HH commencing in November 2017 to aim for implementation in Q2 2018-19. Business case for 24/7 outreach team being developed.

Contingency Plans	Key Summary Updates & Challenges
Continue to work towards an integrated model and utilisation of current services provided by the Site team and outreach.	No incidents and work continues to amalgamate the HDU areas on the SMH site in order to meet the National Guidelines for the Provision of Intensive Care Services (GPICS) standards.

ID: 2472

Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards

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

Mitigation Plan

Action:
Presentation of Divisional CQC Assurance reports at the Executive Quality Committee *Due Date:* 07/11/17
Update on action:
These assurance reports have begun in November 2017 (ExQual was delayed to the 14th from the 7th) and will be presented three times each year.

Action:
Prepare for CQC Well Led inspection at Trust level *Due Date:* 07/12/17
Update on action:
An inspection project plan is in place with oversight at executive level. Preparations are underway in line with the plan, with no delays or barriers to achievement yet encountered.

Current Risk Controls

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

Contingency Plans	Key Summary Updates & Challenges
• Commission external review and support, including other trusts, NHS Improvement, etc. • Work with commissioners where demand is outstripping capacity	It should be noted that the divisional CQC assurance reports which began in November 2017 are intended to be presented to the executive committee three times each year - they are not a one-off.

ID: 2478

Risk of excess organisational pressure associated with major malicious attack

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of excess organisational pressure associated with major malicious attack **Cause:** • There is currently a severe threat level for international terrorism including potential attacks to crowded places, transport system and infrastructure. • Four terrorist related major incidents have occurred in London since March 2017. As a major trauma centre the likelihood of being declared as a major incident receiving hospital is high. **Effect:** • Disruptions to services and business interruption. • Impact on operational / performance targets. • Poor patient and staff experience. • Low staff morale. • Reputational risk associated.	**16**	**20**	**16**	⇔	**Director of Nursing**	• NHS England reviewed incident plans • Annual Emergency Preparedness, Resilience and Response (EPRR) exercises • Post incident and exercise debriefs and action plans

Current Risk Controls

• Civil Contingencies Act 2004
• Emergency Preparedness, Resilience and Response (EPRR) Framework 2013
• Counter terrorism awareness and training
• Participation to Project ARGUS counter terrorism testing and exercising initiative
• Operation Fairway
• Warning and informing duties with multi-agency partners
• Command and control training
• Major incident awareness training
• Planned major incident exercises and drills
• Major Incident plan with integrated trauma and mass casualties plans
• Command and Control Plan
• Capacity and escalation plan
• Lockdown plan
• Business Continuity plan
• Internal communication cascade
• PageOne communication to/from LAS/NHS
• Recovery plan
• Staff Counselling and Stress management Service
• Security 'lockdown' plan is instigated in cases of terrorism or other threat. Security are able to automatically lock external doors using the access control system, and provide personnel to control the flow of people into and out of our hospital buildings at key entrances.
• Heightened visibility and control to our hospital sites thanks to Security 'lockdown' plan.
• Liaison between the Security team and any police teams arriving on site to ensure a complete knowledge sharing of the incident being responded to.

Mitigation Plan

Action:
Annual Major Incident Plan review *Due Date:* 18/10/18
Update on action:
2017 Major Incident Plan review complete

Action:
Annual Command and Control plan review *Due Date:* 18/10/18
Update on action:
2017 Command and Control plan review complete

Contingency Plans

• Emergency Prevention, Preparedness and Response (EPRR) Strategy
• Major Incident plan with integrated trauma and mass casualties plans
• Command and Control Plan
• Capacity and escalation plan
• Lockdown plan
• Business Continuity plan
• Internal communication cascade
• PageOne communication to/from London Ambulance Service (LAS)/NHS
• Recovery plan

Key Summary Updates & Challenges

Risk reviewed within Emergency Preparedness, Resilience and Response (EPRR)Steering group. The current threat level for international terrorism in the UK is unchanged; it remains SEVERE.
Risk unchanged, Major Incident (MI) plans tabled, MI action tracker reviewed.

ID: 2479

Increased risk of fire

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk of fire delayed evacuation within older parts of the Trust Estate needs enhanced level of assessment and on-going management due to building age, infrastructure and layout of the buildings **Cause:** Old buildings not meeting current standards and regulations or having consistent easily understood floor layout. **Effect:** Inability to evacuate buildings in timely manner in the event of a major fire. This might ultimately have the impact to: • Loss of Life • Injury • Damage to infrastructure • Damage to Estate • Damage to Trust Reputation • Financial implications to replace / rebuild • Litigation • Prosecution from London Fire Brigade and other authorities • Impact on bed capacity • Impact on service delivery • Loss of Income • Displacement of Staff / Services	**20**	**16**	**9**	⟺	**Director of Nursing**	Minutes of the EPRR & Fire Steering Group. Records of Staff Training Continuing programme of Fire Risk Assessments Memorandum of Understanding with the Fire Brigade Capital works programme related to Fire Safety. Mock evacuation undertaken and issue lessons learnt

Mitigation Plan

Action:
Continue agreed programme of staff training, estate works and assessements. Progress review to concluded at the end of 2017/18 *Due Date:* 30/03/18

Update on action:
Interim review to be provided by 31/12/2017.

Current Risk Controls

• Implementation of new Estates Operations service delivery model as from 01/4/16 with commencement of new Hard FM Managed Service solution for operation and maintenance of the Trusts estates assets.
• Fire Compartmentation programme of works currently underway.
• Fire Alarm Testing, Fire Training, Fire Policy and Procedures, FFE Maintenance and annual inspections.
• Fire Risk Assessments carried out on a regular basis
• Significant findings from fire risk assessments are addressed in order priority according to risk and measures are in place to mitigate risks where necessary.
• Provision of localised evacuation / fire awareness training within local departments with bespoke evacuation training with emphasis on high risk areas identified by fire risk assessments.
• Unit specific evacuation plans are in place, to safe evacuation routes are identified and practised providing safe progressive horizontal evacuation to a place of safety and continued patient care.
• Additional vertical evacuation equipment has been purchased and in process of being installed to facilitate vertical evacuation as a last resort.
• Specialised paediatric evacuation devices have been purchased to ensure safe evacuation of paediatrics (NICU) additional training and information with fire safety team.
• Fire wardens – Older buildings are targeted to ensure robust fire warden coverage to assist in the day-day management of fire safety and coordination during evacuations.
Eg. SMH Pharmacy.

Contingency Plans

• Unit specific evacuation plans are in place, to safe evacuation routes are identified and practised providing safe progressive horizontal evacuation to a place of safety and continued patient care.
• Regular inspections of the areas and dialogue with staff by the Fire Safety Advisors
• Fire wardens – Older buildings are targeted to ensure robust fire warden coverage to assist in the day-day management of fire safety and coordination during evacuations.

Key Summary Updates & Challenges

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

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 • Equipment cleaning: frequency and effectiveness • Access; ability to clean inhibited by activity due to operational issues or inappropriate storage **Effect:** Increased risk of infection, risk of reduced CQC score, risk of reduced patient satisfaction. Ultimately, this might result in the following impacts: • Potential infection control issues and response to outbreak • Potential for CQC related penalties due to a failure identified by inspection. • Potential for penalties/ fines or enforcement notice. • Impact on reputation through Friends and Family Test (FFT) responses, NHS Choices feedback, other satisfaction surveys and Patient-Led Assessments of the Care Environment (PLACE)Scores	**15**	**15**	**6**	⟺	**Director of Nursing**	Planned and unannounced Audit results against the National Cleaning Standards. Estates and Facilities Quality Committee. Monitoring of overall action plan.

Mitigation Plan

Action:
Raise Cleaning Standards to agreed standard *Due Date:* 12/01/18
Update on action:
Detailed Action Plan submitted to Executive Committee.

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 since September 2017

Contingency Plans	Key Summary Updates & Challenges
• Invoke the terms and clauses of the Hotel Service Contract to impose escalations, rectifications and as appropriate breach of contract leading to possible termination of contract as follows: • Without prejudice to any other right or remedy it might have, 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.	Review of audit results will be undertaken at end of November and trend reported to Executive Committee.

ID: 2485 **Failure of estates critical equipment and facilities that prejudices trust operations and increases clinical and safety risks**

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.

Mitigation Plan

Action:
Implementation of the 2017/18 Backlog Maintenance Programme *Due Date:* 30/03/18
Update on action:
Good progress at Month 7.

Current Risk Controls

• Implementation of new Hard Facilities Management (Hard FM) Managed Service solution through specialist maintenance provider CBRE Ltd from 1/4/16 to provide improved compliance and responsive reactive repair maintenance service.
• Retention of Senior Estates Management team structure to deliver 'informed client role' to ensure effective and compliant delivery of contract against specification and performance standards.
• Statutory and regulatory inspections have been re-scheduled to ensure compliance with statutory and mandatory undertakings and to minimise impact on front line service
• All planned (PPM) and reactive (repair) maintenance works managed through computer aided maintenance management system (CAMMS) to provide improved programming and management reporting.
• ExCo updated on 10/10/15 of current Trust Backlog Maintenance Liability of £1.3b (total project investment costs) and request for £131m Capital Backlog Maintenance funding over the period 2016/2021 to mitigate high and significant risk items.
• Successful delivery of 2015/16 Capital Backlog Maintenance programme to mitigate Risks ≥ 16 Investment programme funding of £14m subsequently reduced mid-year to £11.5mand programme re-profiled accordingly. Risk prioritised Projects to the value of £11m delivered.
• The 2016/ 17 Capital Backlog Maintenance programme of £10.42m Capital Backlog Maintenance, plus £0.8m contingency has been allocated to target the highest risk areas focusing on addressing single points of failure, emergency plant, equipment and infrastructure upgrades.
• £1.1m additional Capital funding allocated to upgrade HH electrical Infrastructure to support known increase in supply capacity requirements.
• Formal reviews of Hard FM operational performance are conducted continually review performance against contract.
• PLACE (Patient-Led Assessment of the Care Environment) lead by Estates and Facilities to understand patient perceptions and identify priorities from a patient perspective helping to provide independent feedback and prioritise future works.
• Monthly Estates & Facilities Quality Committee for closer collaborative working with front line services and appropriate reporting to monitor/improve performance.
• Regular meetings with the operations team to co-ordinate and minimise the impact of operations and planned maintenance closures on patient areas and services
• Estates & Facilities H&S, Fire and Compliance committee has been established to formally report and monitor statutory/mandatory compliance.
• Estates and facilities issues disucussed three times a day on site calls so ensure timely resolution of any issues identified

Contingency Plans	Key Summary Updates & Challenges
• Capital plan to align to clinical strategy within financial abilities • Major incident plan / sector wide contingency plans • Development and implementation of integrated business continuity plan • NHSLA insurance cover • Estates Strategy with contingency plans agreed. • Mitigation of 'single points of failure' and improved infrastructure resilience providing improved business continuity planning. • Trust is reviewing options to utilise potential land receipts to use to re-invest in modernising the estate in addition to the Capital Programme will need to continue to increase, reflecting the degree of depreciation that is attributable to estates buildings and equipment and will continue to be targeted on the highest risks.	High Occupancy of the Hospital and demand on Clinical Services has made progress sluggish but programme is now gaining momentum. Patterson Wing restored to full utilisation. The main area of damaged flooring in Cambridge Wing has been completed and repairs are in progress to Thistlewaite and Grafton Ward is being assessed.

ID: 2489

Failure to develop and publish a refreshed Trust Clinical Strategy

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

Current Risk Controls

• Medical Director is executive lead
• Deputy Medical Director responsible for development of clinical strategy
• Specialty Review Programme (SRP) established in collaboration with CFO and Director of P&OD
• Improvement programme and associated change methodology in place
• Consultant in Public Health and Quality improvement appointed to lead the reducing unwarranted variation programme
• Links with Global Digital Excellence and Clinical Analytics
• Links with Estates Redevelopment Programme established – Deputy Medical Director is clinical lead
• Reporting established through clinical transformation sub-group to Executive Transformation Committee
• Links to STP clinical board through the Medical Director who is co-chair and Deputy Medical Director who represents the Trust.

Mitigation Plan

Action:
Progress SRP & conclude clinical strategy workshops *Due Date:* 01/02/18
Update on action:
Clinical strategy workshops completed for 17 specialties as of 7/11/2017 with 6 having completed all three workshops.
Dates for clinical strategy workshops confirmed for all additional specialties.
Now that all Clinical Strategy sessions are booked, bookings for sustainability & workforce can be completed as they are dependent upon the clinical strategy workshop date. It is expected that bookings for sustainability & workforce workshops will be completed by mid-December 2017.
For those specialties which have completed all 3 workshops, the outputs from the workshops currently being consolidated into a specialty specific strategy. Following approval at divisional level a core group, including the 3 SROs for the individual strands of the SRP (MD, CFO & DP&OD), the relevant Divisional Director and the Specialty Review Programme Leads (Improvement Programme Manager, Director of Strategy and Associate Director of P&OD) will meet to review the integrated outputs and provide critical challenge. The first of these meetings is scheduled for 22nd November 2017 at which the Division SCCS specialties who have undergone all three parts of the SRP will be reviewed.

Action:
Identify pathways for first cohort of 'Pathway Coaching' as part of the Reducing Unwarranted Variation Programme *Due Date:* 31/10/18
Update on action:
Potential priority pathways have been discussed at quality and safety as well as clinical transformation subgroups. It is proposed that places on 'Pathway Coaching' will be awarded via a competitive application process but with pathways of strategic importance (i.e. Frailty) being strongly encouraged to apply.
A paper to this effect was submitted to ExTra for review in October 2017. Key programme management tasks are currently being completed to allow for the application process to be launched (including identification of faculty, teaching dates, venue booking, development of application pack & documentation of the selection process). The application process has been launched following completion of these keys tasks.
The newly appointed Consultant in Public Health & QI has now started in post (26th Sept 2017) and will responsible for leading the development of this programme.

Action:
Prioritisation of pathways requiring input from Improvement Team *Due Date:* 01/04/18
Update on action:
The format for consolidated outputs from the 3 workshops was agreed at ExTra in September. Outputs from completed specialty reviews can now progress through the agreed approvals process. During this process improvement opportunities may be identified. If input from the Improvement Team is required this will be commissioned through the standard route, of which the clinical transformation sub-group has oversight.

Contingency Plans	Key Summary Updates & Challenges
Utilisation of current clinical strategy and monitoring of progress with individual specialties through divisional governance structures.	Development of a refreshed Trust Clinical Strategy is underway. Dates for all clinical strategy workshops have now been confirmed, and sustainability and workforce workshop bookings will now be finalised. Outputs for specialties that have completed all three workshops are currently being consolidated into specialty specific strategies.

ID: 2487 **Risk of spread of CPE (Carbapenem-Producing Enterobacteriaceae)**

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. Recent changes in the spectrum of CPE producing organisms with increasing identification of CPE in citrobacter and enterobacter species presents a further risk compounded by complexity, increased pressure on isolation facilities and teams to trace potential transmission	12	20	9	⇔	Medical Director	• No endemicity of CPE within our patient population which has lead to more limited antibiotics choices for treatment and worse outcomes. • No increase in demand for isolation facilities • Sufficient isolation facility capacity.

Cause:

• CPE will spread if it is not controlled through infection prevention and control interventions, chiefly screening and isolation, hand hygiene, and environmental hygiene.
• Easy transmission from patient to patient if correct IPC procedures are not followed.
• With increased cases of CPE there is a risk in all areas for potential transmission.
• Current isolation capacity insufficient to implement the PHE toolkit recommendations.
• Recent changes in the spectrum of CPE producing organisms with increasing identification of CPE in Citrobacter and Enterobacter species with increased pressure on isolation facilities and teams to trace potential transmission

Effect:

• Failure to contain the spread of CPE will result in endemicity of CPE within our patient population, which will lead to more limited antibiotics choices for treatment and ultimately worse outcomes.
• Increased demand for isolation facilities, potentially exceeding available capacity more frequently.
• Resource impact:
o 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.

Mitigation Plan

Action:
6 monthly Antibiotic point prevalence audit to monitor correct antibiotic use *Due Date:* 13/10/17
Update on action:
The review was completed in August 2017, results were disseminated in the first two weeks of October 2017.

Action:
Revised Trust CPE action plan to be developed and implemented due to the recent increase in risk score *Due Date:* 29/12/17
Update on action:
CPE action plan under revision in light of recent increases in CPE, as requested by the Medical Director
This has been requested by the Medical Director due to the recent increase in risk score

Action:
Development of an in-house HPV decontamination service *Due Date:* 01/06/18
Update on action:
All actions from the investigations into the 2015 CPE outbreaks are now closed, except for the development of an in-hour HPV decontamination service; the business case for this will be reviewed at ExOp in November.

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

Action:
Implementation of a CPE screening tool through Cerner *Due Date:* 29/12/17
Update on action:
Some progress with Cerner but not yet implemented. Once solution has been reached, divisions will develop improvement plans for areas of low compliance which will be monitored through the subgroup.

Current Risk Controls

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

Contingency Plans

• The Trust has in place a local contingency plan to implement ward-level cohorting in the renal speciality.
• Pods may provide additional single room capacity suitable for isolating patients with CPE in some areas.
• Seek guidance and support from NHSE and PHE.
• Plans to add CERNER prompt for CPE on screening.
• Weston has implemented chlorine disinfection, and the environment will be reviewed again in light of this to ensure that all other risk mitigating measures are in place

Key Summary Updates & Challenges

CPE screening rate compliance has improved to 81% of all admissions eligible for screening.
Several new smaller CPE outbreaks have been identified and controlled.
There are four current outbreaks of CPE in three separate clinical areas. Weston with Enterobacter cloacae VIM and Klebsiella pneumonia, MDM, the ward was not closed. Zachary Cope, with klebsiella pneumonia OXA48, which resulted in the ward being closed for operational reasons for a short period and bay closures throughout this period. Samuel Lane has an outbreak of Enterobacter cloacae OXA48, which intermittent bay closures 8 West is closed currently with an outbreak of Klebsiella pneumonia OXA-48. . Outbreaks will be declared closed when there are no new cases in a four week period. Actions are in place to improve infection control practices in each area.

ID: 2490

Failure to deliver safe and effective care

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to deliver safe and effective care in respect of: • Incident reporting and Serious Incidents. • Never Events • HSMR, SHMI and mortality alerts • Infection Prevention & Control • CAS alerts • NICE guidance and standards • National audits • Clinical guidelines	12	12	8	⇔	Medical Director	Incidents HCAI rates Complaints/Claims Succesful delivery of quality strategy goals and targets Clinical Audit programme delivery

Cause:
- Appropriate governance process not in place
- Visibility of current compliance not available or known
- Insufficient resource in place to manage the process
- Non-compliance with Trust policies and procedures
- Non-compliant with surgical WHO checklist
- Continued change in HCAI landscape
- Increasing incidence of antimicrobial resistance

Effect:
- Unable to demonstrate that practice is evidence based
- Limited oversight of externally reported data
- Inability to demonstrate any or adequate audit trail
- Unable to benchmark care against peers
- Increase in SIs and Never Events
- Increased mortality rates
- Increased potential for Healthcare Acquired Infection (HCAI)

Current Risk Controls

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

Mitigation Plan

Action:
Achieve 95% compliance for Duty of Candour online training for consultants and all nurses band 7 and above *Due Date:* 31/03/18
Update on action:
Current compliance (7/11/17) for completion of the training module is 28% for consultants and 54% for nursing. The divisions will receive monthly training compliance data to enable targeted communication to individual members of staff. We do not expect everyone to have completed the module yet as it is an new training requirement to be completed as part of the annual training cycle, managed through the annual appraisal process.
Action:
100% compliance with duty of candour requirements for all serious incidents *Due Date:* 29/09/17
Update on action:
DoC compliance as evidenced on Datix is improving for SIs, with compliance of 98% for all SIs reported between February and August 2017. Monitoring of compliance for incidents graded moderate and above commenced through the weekly incident panel in July 2017 with improvements starting to be seen.
Action:
Action plan to be put into place to ensure implementation of the Learning from Deaths framework within the timeframe stipulated by NHSE *Due Date:* 30/11/17
Update on action:
The Learning from Deaths policy was approved and published in September 2017, and the number of structured judgement reviewers are being finalised within the divisions. Reporting will commence from November 2017.
Action:
SI process review *Due Date:* 31/01/18
Update on action:
The entire SI process is currently under review through a multi-stakeholder quality improvement programme; this work commenced in June 2017 and the aim of the project is to identify what is good about the current process and what could be improved as well as increasing the Trusts investigation capability and capacity. The programme includes co-design events to redefine the SI processes at ICHT with involvement from patients, external experts, clinical directors, senior nurses, divisional management teams and any corporate teams involved in the process. A full day event took place on 24/07/17, and 5 work streams with action plans have been developed in response. A bespoke program of training and education for lead investigators and key stakeholders identified by the divisions will be delivered as part of this improvement work.
Action:
Retrospective look-back of compliance with NICE guidance *Due Date:* 30/11/17
Update on action:
A retrospective look-back of compliance with NICE guidance was undertaken throughout August/September 2017. Following the August 2017 CAEG meeting, the divisions continued to undertake the look-back exercise to determine compliance with NICE guidance published in 2016/17 as well as the guidance published so far during 2017/18. A full report on the outcome of this look back was presented at the November Executive Quality Committee.
Action:
Trust clinical audit plan *Due Date:* 30/11/17
Update on action:
The Clinical Audit and Service Evaluation Policy was published in October 2017. The final Trust audit plan was taken to the Executive Quality Committee for approval in November. Audit activity is however, already underway.
Action:
Assess at least 95% of all patients for risk of venous thromboembolism *Due Date:* 29/12/17
Update on action:
The Trust moved to assessment for VTE at drug prescription on admission rather than at discharge. This went live in Cerner at the end March 2017. Progress is monitored through the quality and safety sub-group and in September 2017 the Trustwide assessment percentage was 93.34%
Action:
Safer surgery task and finish group and action plan *Due Date:* 30/12/17
Update on action:
Four never events occurred between March and November 2016. A safer surgery task and finish group and action plan is in place. Trust level results of the WHO checklist observational audit carried out in Q1 2017/18 show varied performance, with some specialties making significant improvements in particular areas, and other areas which are more challenged. Directorates and divisions were required to produce action plans to address the gaps identified by the audit and these will be reviewed with the chair of the safer surgery task and finish group. Data and action plans will be owned by the divisions and reported quarterly to the quality & safety subgroup.
The safer surgery task and finish group will end in December 2017 but focussed work on 'de-briefs' will continue as part of the safety stream.

Contingency Plans

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

Key Summary Updates & Challenges

Work continues across a number of areas. A new clinical audit and service evaluation policy was published in October and the Trust audit plan is going to Executive Quality Committee for approval in November. It has been agreed with divisions that 100% compliance of mandatory online duty of candour training should be achieved by March 2018 as part of the annual appraisal process. Directorates and divisions are producing action plans to address gaps identified by the WHO checklist observational audit.

ID: 2499

Failure to meet required or recommended Band 2-6 vacancy rate

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

Current Risk Controls

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

Mitigation Plan

Action:
Enhance the reward & benefits scheme to support recruitment and retention strategies. To include further developing flexible recruitment & retention premium (RRP), exploring flexible benefits as part of RRP and benchmarking Trust offer with competitors *Due Date:* 31/12/17
Update on action:
A policy has been circulated for comments and feedback has been received. This will be finalised in December and actions will be prioritised to start to be implemented soon after.
Action:
Develop accurate establishment, staffing, sickness & turnover information ensuring clear procedures in place to manage this. Include an SOP for switching off posts and develop accurate benchmark data for all N&M band 2-6 staff in London Acute Hospitals *Due Date:* 30/06/17
Update on action:
Action complete.
Action:
Ensure staff feel they can grow and develop with the Trust and opportunities are made available 'internally first' to increase staff retention. This will be delivered by a number of workstreams, including careers clinic and students' automatic offers. *Due Date:* 30/09/17
Update on action:
Action complete.
Action:
Review brand & attraction strategy; ensure recruitment process for high volume roles (including HCA and Band 5) delivers right quality & volume of candidates. Design attraction strategy for newly qualified nurses, and enhance international recruitment *Due Date:* 31/08/17
Update on action:
Action complete.
Action:
Implement a range of tool and interventions internally to encourage current Band 5/6 to stay longer. This will be supported by the implementation of a Steering Group for Nurse leadership Band 5/6 development and new exit interviews *Due Date:* 30/11/17
Update on action:
The new Springboard leadership programme for Band 5/6 nurses has been launched and the take up is good. The Engagement toolkit and workshop is being well received. The extended version of the Pulse magazine in July was well received, the Great Place to Work week in September was a huge success and the automatic offer for students has increased student retention to over 70% which is 10% higher than target
Action:
Review current development and support for nurses during and after Preceptorship, through a review of the Preceptorship scheme and Capital Nurse Rotation Programme *Due Date:* 30/11/17
Update on action:
Nurse retention is improving and the Preceptorship programme is now one year and the quarterly intake landing well. The take up of the Capital Nurse Rotation Programme is good and this has inspired more local rotations.
Action:
Develop a 3-5 year workforce plan for the Band 2-6 N&M population *Due Date:* 30/11/17
Update on action:
A plan has been developed and is being socialised. This is being tabled with the Chief Executive in December 2017 and discussed with the Executive in the new year.
Action:
Develop project plans that address the vacancy, turnover and sickness issues in the clinical divisions, ensure they are implemented including a self-assessment checklist for retention initiatives. *Due Date:* 30/11/17
Update on action:
All divisions have plans in place and these are being regularly reviewed and updated.

Contingency Plans

• Continue to monitor impact of changes and implement further corrective measures as needed
• Use of Bank & Agency staff
• Reduction in activity
• Escalation of staffing issues through divisional management structure and site team
• Early identification of staffing issues with shifts put out to bank and agency.
• Reed introducing a "refer a friend" scheme to attract more bank workers.

Key Summary Updates & Challenges

Good progress is being made on the Recruitment and Retention Plan. The supply remains a challenge, the student intake has dropped and the number of registered N&M staff has dropped. However in October Imperial saw a 1.7% decrease in our vacancy rate and a 1% decrease in our N&M vacancy rate. A number of the actions from the plan are working well however others are slower to take off, for example the Careers Clinics, and will take time to embed.

ID: 2475

Identification of educational issues

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

Current Risk Controls

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

Mitigation Plan

Action:
Education report part of performance review of Divisions *Due Date:* 31/01/18
Update on action:
In progress

Action:
All specialties to have elected senior specialty trainee and joint training meeting *Due Date:* 31/10/18
Update on action:
In progress

Action:
Clarify escalation processes for education issues identified within specialties and ensure process is in place *Due Date:* 31/01/18
Update on action:
Medical Education Governance guidance being further developed with escalation process and risk management process defined
Faculty Development programme in place to provide training
Education specialty reviews have commenced

Action:
Develop action plans for areas of concern in NTS not externally reported and monitor through LFGs, with reporting to Medical Education Committee *Due Date:* 31/01/18
Update on action:
Internal action plans developed, progress being monitored at local faculty group meetings and education specialty reviews

Action:
Ensure clarity of all opportunities for all trainees/medical students to provide feedback throughout the year *Due Date:* 30/11/17
Update on action:
Deep dives prior to Education Specialty Reviews
Trainee attendance at LFGs
Specialty trainee surveys are run either regionally or locally - Med Ed to identify when surveys run for all specialties

Contingency Plans	Key Summary Updates & Challenges
Re-establish annual educational specialty review process for all specialties chaired by the medical director	Work continues to try and actively identify and respond to educational issues before they result in negative feedback or poor results. The education specialty review process has commenced. Not all specialties have elected senior specialty trainees and the request to do this is now overdue.

ID: 2481

Failure to implement, manage and maintain an effective health and safety management system

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

Current Risk Controls

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

Mitigation Plan

Action:
Implement all aspects of the slips, trips and falls incident reduction action plan *Due Date:* 30/03/18
Update on action:
Sodexo are putting in place a quality assurance regime which monitors the quality of floor cleaning. Improvements in the floor cleaning regime will reduce the presence of wet floors and, consequently, slips trips and falls arising from wet floors

Action:
Implement effective Violence incidence reduction plan *Due Date:* 30/03/18
Update on action:
The Security Committee is overseeing the devising and implementing of the actions to reduce the incidence of violence. This committee provides assurance to the Trust Health and Safety Committee

Action:
Devise and implement appropriate sharps incidence reduction plan *Due Date:* 30/03/18
Update on action:
Line Safety Management Group devises and oversees improvements in the use of medical sharps for vascular access and intravenous therapy. Nov 17 - Divisions have agreed, in principle, that their directorates will be responsible for approving the use of non-safe sharps (where either their use is clinically justified or there is no safer sharps alternative

Action:
Recruit to the vacan H&S Manager post *Due Date:* 26/01/18
Update on action:
Recruitment underway. ERAF completed and forwarded for approval

Contingency Plans

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

Key Summary Updates & Challenges

One FTE health and safety manager post is vacate currently. The post is being recruited to.
Devising and implementing a suitable incident reduction action plan for each of these key health and safety topics is necessarily long-term. And the incident reduction plans will have to be tweaked as work progresses

ID: 2498

Failure to gain funding approval from key stakeholders for the redevelopment programme

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

Cause:

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

Effect:

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

Current Risk Controls

• Regular meetings with NHS England, NHS Improvement, CCG partners for early identification of potential issues/changes in requirements
• Reports to Trust Board, Redevelopment Committee and Executive Committee
• 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:
Production of Strategic Outline Case (SOC) for SMH Masterplan *Due Date:* 31/03/18
Update on action:
Production of SOC for SMH currently on hold. Trust is reviewing strategic estate options.

Contingency Plans

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

Key Summary Updates & Challenges

November update:
Outpatient building:
• The Mayor's Stage 2 decision confirmed that the Mayor is content to allow Westminster City Council to determine the Outpatient building planning application itself. Section 106 reviewed by Trust and advisors. Awaiting response from WCC.
SMH redevelopment:
• Production of the SOC2 for St. Mary's is currently on hold while the Trust reviews its strategic estate options.

Paddington Cube planning application:
• Awaiting a decision to be made on the judicial review papers submitted to the courts as to whether the Trust has permission to proceed with the judicial review claim. Chairman and Chief Executive to review decision and decide on next steps once decision has been received.

ID: 2473

Failure to maintain financial sustainability

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Failure to maintain financial sustainability **Cause:** • Loss of DH/NHS England (Diamond) income for complex specialist treatments • CCG affordability pressures and difficulties in delivering QIPP demand reduction targets may put payment for over performance at risk • Historic dependence on non-recurrent funding sources masked underlying financial picture • Failure to increase private patient income as planned • Annual reductions in Education and Training funding, very significant cut to 2018/19 funding threatened • Correction of historic usage of R&D funding for clinical subsidy • Additional costs of operating across three sites & with outdated estate and aged equipment • Slower-delivery of Clinical Strategy Implementation Plan • Agency costs (at premium rates) incurred to cover substantive roles • Investments in Acute medical model • Investment in implementation costs of Cerner including data validation • Continuing dependence upon significant non-recurrent financial gains to deliver Control Total targets & receipt of STF funding masks underlying deficit **Effect:** • Q1 STF funding of £6m lost (but wasn't budgeted) • Failure to deliver a financial surplus • Reputational risk of being in deficit • Loss of financial autonomy & reputational damage associated with the risk of being put into Financial Special Measures should we fail to deliver the stretching target • Dependence upon DH revolving working capital facility • Dependence upon SaHF for site redevelopment project costs & Charity for required capital investments	**20**	**20**	**15**	⇔	**Chief Finance Officer**	Year to date performance vs plan: As at end Sept, Income and expenditure of £(20.77)m vs plan of £(20.77)m Cash balance never less than £3m – monitored monthly and reported to Exec and Board. Internal forecast outturn (monthly refreshed.

Current Risk Controls	Mitigation Plan
• Bi-weekly FASRG meetings with divisions and senior finance teams (CEO and CFO attend at least monthly) • Additional CEO review for any division forecasting to miss budget • Monthly financial reporting, cash and performance reviews reported to ExOp, bi-monthly to FIC and Trust board • Ovsersight with Regulator via Provider Oversight Meeting (POM) • PWC Causes of the Deficit work completed • CEO & CFO engagement with Provider Network, AUKUH, Shelford etc, to lobby on system issues pressures including Tariff and Diamond – reports to FIC and Trust board • The Improvement Team and all major change programmes report to monthly Executive Transformation Committee and then to FIC • Speciality Review Program (SRP) started Apr 2017 to review all 31 specialities for sustainability (financial and clinical). SRP progress reports to Exec & FIC • PWC commissioned (Aug 2017) to accelerate & improve Trust's usage of Carter and other benchmarks • CEO led joint planning meeting with Charity • Full engagement in SaHF programme seek to maximise Trust gain and mitigate risks from broader initiatives • CEO member of STP Provider Board addressing STP financial challenge.	**Action:** Working capital *Due Date:* 06/04/16 **Update on action:** Agreement of revolving working capital facility up to £65m from the Department of Health Implementation of 13 week cash flow management and weekly cash committee to review working capital position Effective management of all working capital arrangements, improvement in effectiveness of forecasting and further action to recover income and manage accounts payable **Action:** PWC commissioned to support trusts use of Model hospital benchmarks (work referenced under key controls) *Due Date:* 30/11/17 **Update on action:** In progress, PWC are on site. Work to feed into NHSI use of resources assessment and develop a productivity benchmarking tool for the trust **Action:** Two-year deal agreed with Regulator setting a Control Total for 2017/18 and 2018/19 *Due Date:* 31/07/17 **Update on action:** Completed and updated plans for revised control totals **Action:** Presentation of outline plan for return to financial sustainability to Sept 27th Board & October board seminar *Due Date:* 27/09/17 **Update on action:** Completed – Board accepted the programme outline; further work required to develop the overall programme and resourcing and work up quick start projects. **Action:** Engagement with NHS Improvement's 'Financial Improvement' programme (FIP2); support for WCCS division *Due Date:* 30/11/17 **Update on action:** PWC have identified a number of areas of opportunity within WCCS. The division are working with PWC to formalise hand over and implementation planning of the schemes. Many of the schemes identified are cost control as opposed to sustainable efficiency.
Contingency Plans	**Key Summary Updates & Challenges**
Revolving working capital facility provides cash support cover of up to £26m (£16m has been drawn down YTD) – with the ability to extend the limit up to £65m. (However, note that these national arrangements are interim while a permanent process is being agreed between DH and NHSI)	Year to date, the Trust remains on track to meet the 17/18 control total. However financial forecasts show that maintaining this for the remainder of the year will be challenging. The target risk score will be reviewed in December based on latest financial position and after the transformation programme has been reviewed by the Board.

ID: 2482

Cyber Security Threats to Trust Data and Infrastructure

Risk Statement	Risk Assessment (Scores)			Risk movement	Risk Owner	Assurance KPIs
	Initial	Current	Target			
Risk to Data; A cyber security incident can result in data being stolen, destroyed, altered or ransomed. Risk to Infrastructure: A cyber security incident can result in all or part of Trust ICT infrastructure being disabled, or destroyed. There would be a prolonged period of recover.	16	16	8	⇔	**Chief Information Officer**	Information Governance Toolkit Return (Independently Audited) Monthly Cyber Security Metrics Dashboard Cyber Essentials External Assessment (2017) Annual Penetration Test Annual Informatics Audit Plan (reviewed by IGCS)

Cause:

In order to function, the Trust needs to maintain an IT environment connected to the internet. This exposes the Trust to a constant flow of infection and attack.

Effect:

• Data:
o Stolen; reputational damage, breach of obligations as regards data security, fines, notification to the victim (s), compensation and legal claims.
o Destroyed; almost all patient data is being created and stored digitally including medications, observations and treatment decisions.. It is possible for hackers to destroy not only online data but all backups.
o Altered; connected medical devices are vulnerable to external hacking. Staff with access to data are the most likely insider threat. Maliciously altering data can affect both corporate and clinical systems and can result in either patient data or corporate data being changed.
o Ransomed; the data doesn't leave the Trust infrastructure but is unable to be accessed until a ransom is paid. Even if a ransom is paid, there is no guarantee that the encryption key will be handed over and access to the data restored.
• Infrastructure
o Disabled; there would be a prolonged period of downtime while networks, servers and storage were disinfected and restored to service. Outage is likely to be anywhere between a week to a month.
o Destroyed; There would be up to 6 months down time, several million pounds of expenditure to replace equipment and restore services.

Mitigation Plan

Action:
Awareness Training: Supplement the Annual Mandatory Information Governance Training Programme through being an early adopter of the "Knowledge Training" when it is released by NHS Digital *Due Date:* 31/03/18
Update on action:
October 2017: The NHS Digital Knowledge training material is available, but the national system to deliver it, is not. The outcome is that we have added the material to the source material for the annual mandatory IG Training IG Team provided the additional training material to Robert Stacey for incorporation as learning materials in the annual mandatory IG Training – this is an interim position until online IG Training is provided from NHS Digital

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:
"September 2017: ICT submitted a proposal for security funding to strengthen our cyber security position. The Cerner 724 PCs is included in this proposal
October 2017: CSG to advise in Feb 2018 as to whether or not funds will be allocated for this"

Action:
Process Controls: Continual deployment critical and security patches to Servers and Desktops in accordance with the following ITIL Standard? *Due Date:* 31/03/20
Update on action:
"September 2017: Telecoms and Switchboard Business Impact Analysis and Service Continuity Plans completed and ICT Operations Service Continuity Plans in development.
October 2017: ICT Operations Service Continuity Pl

Action:
Security Software Investment: Multi Layered Security Software currently in the process of being tendered *Due Date:* 31/03/18
Update on action:
"September 2017: Liaising with procurement team for next steps for tender framework required
October 2017: The tender has been published, and the successful bidder will be announced at the end of November 2017."

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

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

October 2017:- Risk rating static <->
No new technical controls have been implemented since the "WannaCry" incident. However, the CYBER Security Response Plan is being developed and investment requests have been put forward.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Board assurance framework

Executive summary:

Assurance goes to the heart of the work of any NHS Trust board. The Trust risk management policy and procedures provide the executive team with a robust framework by which they ensure that risk is successfully controlled and mitigated. Assurance is then the bedrock of evidence that gives confidence to the Trust board that risk is being effectively managed, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed. The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

Although the framework has recently been reported to the Trust board (September 2017), a number of changes, including to residual risk scores, are proposed, and make it appropriate for the Trust board to consider these revisions:

- Staff - recruitment and retention: this was highlighted at the October board seminar as being 'one of the top risks'; the BAF residual risk to be increased to HIGH (from medium)
- ICT - data quality: again, was listed at the October board seminar as a 'top risk'; the BAF residual risk to be increased to HIGH (from medium)
- ICT – information security: no change to risk score, but text extended to reflect GDPR requirements

Given that the Trust's corporate committee structure and executive assurance statements were presented reviewed, these have not be included on this occasion.

Quality impact:

Ensuring that we seek to continuing improve various areas of our corporate governance will demonstrate that the Trust strives to be a well-led organisation.

Financial impact:

The framework has no direct financial impact.

Risk impact:

Each of the work streams within corporate governance are regularly reviewed for risk impact, and risk register entries developed, including controls and mitigations as appropriate.

Recommendation to the Trust board:

The Trust board is asked to:

- Note and agree the proposed changes to the board assurance framework

Trust strategic objectives supported by this paper:

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

Author	Responsible executive director
Jan Aps, Trust company secretary	Ian Dalton, Chief executive officer

Board Assurance Framework

Revised Nov 2017 (v2.7 - working document)

New objectives being developed - will amend Spring 2018

Corporate objectives

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

CQC domain	Areas of activity	Corporate objective	Lead	Area of risk	Corporate risk register reference	Sources of Assurance			Principal Assurance Committee(s)	Timetable of assurance reporting	Board reporting		Risk classification (see guidance)	
						1st line Reporting	2nd line Internal assurance	3rd line External assurance			What	When	Inherent assurance risk	Residual assurance risk
Safe	**Patient safety: Infection control**	1	DIPC	Risk of spread of CPE	88	Reports on outbreaks reports against key metrics	Quarterly report to quality committee	CQC inspection	Quality Committee	Quarterly	Quality committee report to the board	Bi-monthly	High	Medium
Safe	**Patient safety: Medicine management**	1 5	Medical director / chief pharmacist	Failure to: - adopt best practice may lead to sub-optimal treatment - controlled medicines usage may lead to unnecessary costs - controlled drugs may lead to improper use / theft of medicines	Following CQC inspection report, this is being added to CRR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	MRHA annual submission and review CQC inspection	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	Medium	Medium
Safe	**Patient safety: Staff: Fire**	1	Director of estates & facilities	Failure to ensure that required fire prevention and management systems are in place, including effective evacuation systems	Held on relevant dept RR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	Review and on-going oversight by London Fire Brigade	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	High	Low
Safe Effective	**Patient safety: Critical care**	1	Divisions directors, DDC & MIC	Failure to achieve specific standards and specifications in delivering critical care standards	91	Reporting to executive committee of issues and potential resolution. Any patient risk issues would be covered in Quality report	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly.	CQC inspections	Quality Committtee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	High	Medium
Safe Effective	**Patient safety: Clinical governance**	1 5	Medical director	Failures of quality governance may allow poorer standards of care and may lead to non-compliance with statutory /contractual obligations	81 /71	Divisional governance leads review directorate and divisional arrangements	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly. Internal audit	Commissioner Quality Group have oversight CQC inspections	Quality Committee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low
Safe Effective	**Patient care**	1	Medical dir / dir of nursing/ divisional directors	Failure to safe and effective care affects CQC rating / incurs penalties/ impacts support for Trust strategic plans	81	Incidents raised on Datix Complaints Whistleblowing Service line self-assessments	Board member visits Core service reviews Deep dive reviews Internal audit support to core service reviews	CQC inspections PLACE audits	Quality Committee Ad-hoc risk reports are reported to the ARG Comm)	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium
Safe	**Patient safety: Mental health**	1	Divisional director, MIC	Failure to maintain high quality patient care and experience in ED due to extended delays experieinced by mental health patients awaiting transfer	94	Incidents raised on Datix Regularly reported at executive committee	Core service reviews	CQC inspections	Quality Committee	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium
Safe Effective Well-led	**Patient safety: Safeguarding**	1	Director of nursing	Failure of systems and processes (including training of staff) may under-identify safeguarding issues and/or may lead to a failure to respond appropriately	71	Incidents raised on Datix	Six monthly report to the executive committee	Serious case review outcomes Ofsted reports	Quality Committee	Six-monthly report	Update on safeguarding cases and position	Six-monthly	Medium	Low
Safe Caring Well-led	**Staff: recruitment and retention**	1 2	Dir P&OD	Inability to recruit and retain appropriately skilled staff poses risk to quality of patient care Inability to deliver a workforce that enables the required changes for the clinical model	93	Vacancy rates Time to recruit	Executive committee monitoring programme looks at the efficiency and effectiveness of the recruitment process Internal audit	Safe staffing reported to Commissioners and NHSI at Commissioners Quality Group	Quality Committee receives report on safer staffing and by exception on other risks associated with shortage of appropriate staff Also ARG	Bi-monthly	Safer staffing figures published monthly Update by exception through the quality committee report	Bi-monthly	High	High
Safe Caring Well-led	**ICT: Data quality**	1 2 5	CIO, CFO, Divisional directors, Dir P&OD	Technology / human interface: failing to enable staff to input data in a consistently accurate manner Poor quality of patient information may undermine patient care Poor data quality of Trust information may undermine strategic and contractual	Following continued issues, this will be added to the CRR	Standardised business and reporting rules that are aligned to national policy with standard definitions and robust change control processes	Snap-shot audits via carried out at team and individual level Monthly audit of backing data at patient level and cross checking against clinical systems Programme of internal audit DQ Steering Group reporting to Exec	The external auditors provide a limited audit of information reported as part of their work on annual report and accounts	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Quarterly	High	High
Safe Responsive Well-led	**Patient safety: Availability of necessary equipment**	1	Dir of estates & facilities Divisional directors	Failure to provide safe equipment impacts patient and staff safety Equipment failure reduces ability to achieve operational targets	55	Incidents raised on Datix	Capital steering group oversees prioritisation of critical equipment spend Medical devices management group & quarterly report to ExQual Internal audit	Oversight of IRMER Regulations	Quality committee Finance & investment committee	Bi-monthly	Update by exception through the committee reports	Bi-monthly	High	Medium
Safe Responsive Well-led	**Patient safety: Staff safety: Management of estates**	1 5	Director of estates & facilities	Failure to: - provide safe estate impacts patient and staff safety - provide an appropriate environment impacting patient experience and outcomes - manage property portfolio impacts on financial position	55	Incidents raised on Datix Trust's outsourced hard FM have clear procedures for responding to priorities issues	Capital programme reports to executive committee External review of backlog maintenance identified £1.3bn of which £130m of high risk; programme in place to continually monitor priorities as issues are addressed	NHSI aware of external review outcome, and Trust's approach to managing the risk	Finance and investment committee	Bi-monthly capital report toF&I Comm	Update by exception through the report of the F&I Comm, the report of the Redevelopment Comm Specific report on Backlog maintenance	Bi-monthly	High	High
Safe Well-led	**Patient & staff experience: Site redevelopment**	4 1 5 2 3	Dir of redevelopment	Failure to: - secure redevelopment approval - secure redevelopment funding - secure support for moving services (Impact on equipment replacement)	74	Project board oversight and reporting	Reporting to executive committee and board redevelopment committee and commercila sub-group	Approval and programme oversight by NHS Improvement / CCG / NHS England	Redevelopment Committee	Monthly	Update by exception through the redevelopment committee report	Bi-monthly	High	Medium

Safe Responsive Well-led Caring	**Staff:** **Health & safety**	5	Dir P&OD	Failure to ensure: - appropriate arrangements in place to protect staff - that staff are immunised fully against biological agents to which they may be exposed	92 /72	Incidents raised on Datix Incidents reported by Occ Health	Bimonthly report to the executive committee	HSE inspections CQC inspections Internal audits	Quality committee	Bi monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low
Safe Well-led	**Research**	3	Medical director	Failure to: - secure development of NIHR BRC - ensure research embedded in divisions - to develop AHSC to potential	Held on medical director's risk register	Research lead in each division reporting through management reporting structure	Research and AHSC reports to executive committee	National research oversight bodies	Quality committee	Six monthly research report	Overview of AHSC and other research activity	Annual Six monthly	Medium	Low
Effective	**Patient pathway:** **Development of ACP arrangements & other STP arrangements**	4,1	Chief executive	Failure to deliver the clinical strategy programme to enhance acute services and support out of hospital care and the STP	Held on MIC division risk register	Clear governance arrangements across STP, with H&FGPF, and within Trust	Regular reports to Executive Committee	NHSI have oversight of the STP plans, and engaged in development of ACP arrangements	Audit, risk & governance committee	Propose an annual review of governance arrangements	Annual seminar on integrated care developments; regular updates in CE report	Annual Bi-monthly	Medium	Low
Effective Caring	**Staff:** **Education and training (including mandatory training)**	2,3	Medical director / Dir POD / Dir of nursing	Failure to: - adequately train staff poses risk to quality of patient care - achieve benchmark levels of medical education performance	65 POD RR	On-line register for all staff	Monthly reporting to the executive committee Internal audits of the systems and processes	Various Royal College and and GMC inspections and visits	Quality committee	Annual report of validation; performance report	Annual seminar on educational activities; mandatory elements in performance report; revalidation report	Annual Bi-monthly	Medium	Medium
Effective Well-led	**Finance:** **Short-term financial performance** **Should this now be a red risk or are we going to deliver original trajectory**	5	Chief financial officer	Failure to deliver financial plan	48	Divisional reporting Review financial review meetings for each division	The F&I scrutinise the financial position of the Trust The Exec Comm monitor delivery of achievement against savings plans, and performance against NHSI targets	External audit review during annual accounts preparation NHSI oversight, particularly in relation to control total and the STF	Finance and investment committee	Bi-monthly	Monthly finance report circulated Full reporting every other month in Finance report F&I Committee reports every other month	Monthly Bimonthly	High	Medium
Effective Well -led	**Finance:** **Long term sustainability**	5	Chief executive	Failure to deliver the transformation programme required to achieve long term efficiencies and financial sustainability	48	??	Regular reports to Executive Committee and Trust board		Finance and investment committee	Bi-monthly	??Transformation programme report	Bi-monthly	High	High
Responsive	**Operational performance**	5 1	Divisional directors	Failure to deliver: - against NHSI targets (particular ED performance & emergency flow & RTT & elective performance)	7	Divisional review / ICT reporting Senior level committees in place addressing ED / emergency flow, RTT/elective activity, and outpatient improvement	Executive committee reviews performance each month, including reports from committees	NHSI and commissioners - monthly reporting	Executive committee	Bi-monthly	Operations performance report reported to Trust board	Monthly	High	High
Responsive Well-led	**Patient and staff experience:** **major incidents**	1 2 5	Chief executive	Excess organisational pressure associated with major malicious attack leads to: undue pressure on staff; reduction in patient experience; reduced bed capacity	95	Silver and gold command oversight; Hot and cold debrief ; site team meetings and escalation arrangements. Schwartz Rounds.	Lessons learned reports are presented to the Executive committee, and are reflected in the business continuity plans; internal audit	Business continuity plan submitted to NHSE;	Audit, Risk & Governance committee	Following major incidents	Exception reporting as required	Following major incidents	High	Medium
Well-led	**Finance:** **Financial control**	5	Chief financial officer	Failures of financial control risk leads to unanticipated budget overspends	48	Standing financial instructions; scheme of delegated authorities; discretionary spend controls	SFIs; SoDFA reviewed annually at executive and relevant board committee Internal audit opinion	External audit opinion CQUIN achievement	Audit, Risk & Governance Committee	Quarterly, and annual	Audit opinions reported as part of the annual accounts	Annual April/May	High	Medium
Well-led	**Counter fraud**	5	Chief financial officer	Poor systems and processes lead to financial loss	48	Cases raised Cases pursued	Internal audit	LCFS reports National benchmarking Home Office feedback	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Bimonthly	Medium	Low
Well-led	**ICT:** **Programmes & systems**	5 1	Chief information officer	Failure to: - optimise use of GDE award - maintain control may lead to overspend on major investments - potential distraction of shared ICO	ICT risk register	Clear governance arrangements within ICT and between Imperial and C&W to ensure planned progress achieved, and manage risk of 'shared ICO'	Dedicated Executive Digital Strategy Comm monitors delivery against key ICT projects, and ensure engagement Business cases and post-implementat'n reports are presented to the F&I Committee	NHS England - Global Digital Excellence oversight	Finance and investment committee / ARG Committee	Bi-monthly	Reports of the F&I Committee to each Trust board	Bi-monthly	Medium	Low
Well-led	**ICT:** **Information security and cyber crime**	5	Chief information officer / SIRO	Breaches indicate a detriment to patients or staff. Serious breaches may incur financial penalties Ransomware challenges Failure to comply with GDPR requirements	90	Process in place for reporting breaches Clear awareness and actions in place to minimise the impact of cyber crime	Annual report on performance in the Annual governance statement Exception reports on serious breaches IG annual return Internal audit ARG review of GDPR actions	DH Information Governance return NHSIC have overview of all cyber crime issues External audit oversight of processes	Audit, risk & governance committee	Quarterly	Annual performance in the Annual governance statement Exception reports on serious breaches IG annual return	Annual	High	Medium
Well-led Responsive	**Finance:** **Commissioning environment**	5	Chief financial officer	Failure to secure contracts impacts on the financial security of the Trust and may adversely affect quality of service	48	Clear direction and guidance in place within commissioning team	Executive and F&I Comm receive regular updates on contract position Review as part of the Business Planning process	Monthly NHSI oversight, and review of contracts agreed with Commissioners	Finance and investment committee	Bi-monthly	Exception reporting through Committee report Considered as part of	Bi-monthly Annual	High	Low

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board – public	29 November 2017

Better Births, Maternity Implementation Plan

Executive summary:

- The North West London Local Maternity System (LMS) was established in January 2017, bringing together representatives from the complete maternity system (e.g. obstetric and midwifery leads, commissioners, GPs). The LMS is chaired by Imperial's Clinical Director for Maternity. The LMS is the board responsible for driving maternity transformation under the STP. One of the first deliverables for the LMS was to conduct a gap analysis against the 2016 National Maternity Review, *Better Births* recommendations.
- The gap analysis showed that North West London is delivering fully on 10 of the 19 recommendations which are applicable to a local level to providers and CCGs. There are 8 recommendations that North West London is partially delivering on (amber-rated), and one red-rated recommendation (sector wide electronic maternity records) which have not yet been implemented.
- From the outputs of the gap analysis, the LMS identified next steps to reach full implementation and delivery of these recommendations by 2020/21. These next steps form the North West London commitment to maternity improvement under the STP.
- This document outlines North West London's proposed implementation plan to reach full delivery of the complete recommendations within *Better Births*. The plan is being reviewed at STP board level, Clinical Board and CCG quality committees. Additionally the LMS agreed that each maternity provider Trust should review the plan at board level and endorse.
- To deliver the plan, North West London is requesting transformation funding from NHS England to support the delivery of the STP initiatives to cover both backfill clinical time and project management support.

Quality impact:

The proposed implementation plan is designing to directly improve women's care and experience of maternity services. Many of the initiatives are designed at increasing safety and quality (e.g. system review of SIs, implementing still birth bundle, maternal death review). The second focus is improving personalisation and choice, through enhanced continuity of care, clear information and digital tools developed as a sector.

To develop this plan, there has been extensive engagement to understand the needs of the local population and service users:

- online, using a purpose built engagement website (https://maternitynwlondon.commonplace.is/)
- a dedicated STP plan session, following a Whose Shoes workshop
- user feedback from early adopters launch event
- review of user comments in Healthwatch reports
- maternity champions

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.

The Local Maternity System is requesting transformation funding from NHS England to cover the backfill clinical time of the LMS Chair (Imperial Maternity Clinical Director), an Obstetric lead and the Head of Midwifery from the Trust to support the delivery of the plan. A dedicated project manager resource has also been requested, to be employed centrally, to support the implementation of the recommendations and the administration of the LMS.

Risk impact:

There are a number of risks and challenges associated with delivery of the maternity vision through the STP. Risks are categorised by the following and can be found on page 41 of plan :

- Strategic
- Financial
- Workforce
- IT/ Technology

Recommendation(s) to the Trust board:

The Trust board is asked to:

- endorse the plan on behalf of Imperial College Healthcare NHS Trust (ICHT), with actions to be taken forward by the North West London Local Maternity System.
- support the ICHT maternity leads (Clinical Director and Head of Midwifery) to lead on maternity transformation work through the LMS and a commitment to implement the remaining recommendations from Better Births in the Trust.

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.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Mandish Dhanjal, Maternity Clinical Director and Co-Chair of LMS	Prof TG Teoh, Divisional Director, WCCS	4 October 2017

North West London STP – Da5ciii

Better Births, Maternity Implementation Plan

North West London shared vision and plan to implement recommendations from *Better Births*, National Maternity Review by 2020/21.

Vision Statement

Our vision is to lead the way in providing first class, safe maternity care that offers choice, individualised continuity and that has the family at the heart of everything we do.

We will do this by working in partnership to provide outstanding maternity services that are evidenced based and in line with the recommendations of the national maternity review '*Better Births*'.

Working as a collaborative *Local Maternity System*, we will build trust and breakdown boundaries across our area. By doing this we aim to improve the clinical outcomes and care experience for women and families using our services.

Section 1. Introduction to North West London

In October 2016, North West London published its Sustainability and Transformation Plan. The STP makes a commitment to deliver on the vision for maternity set out in *Better Births* under Delivery Area 5 – "*safe, high quality and sustainable hospital services',* under sub-objective DA5ciii – '*improvements to women's services'.*

Section 2. North West London's long-established history of transformational change in maternity

North West London is proud of what we have achieved to date for Maternity under Shaping a Healthier Future and recognise that our next steps are to build on this model further to deliver fully on the complete recommendations set out in *Better Births.*

Through our Local Maternity System we have now agreed a shared vision for maternity in our area going forward under the STP, and we have defined the next steps to deliver this shared vision and respond to the ask set out in *Better Births* by NHS England.

Section 3. Gap analysis

- In summer 2016, the former Maternity Network (Local Maternity System) conducted a gap analysis against the newly published National Maternity Review recommendations. In April 2017, the LMS updated the previous gap analysis to reflect the most recent developments to the North West London maternity model of care, and the planned changes under the new transformation programmes underway, including the Early Adopters Programme, perinatal mental health community services development programme, and HENWL's developing the maternity support workforce project.
- The gap analysis sets the baseline, and shows that across the 19 recommendations applicable to local providers and commissioners; North West London is fully delivering on 10 of these (58%).
- There are 8 recommendations that North West London is partially delivering on (amber rated), and one red-rated recommendation (electronic maternity records) which has not yet been implemented, with identified high-level next steps to reach full implementation and delivery of these by 2020/21.

Section 4. Summary of remaining actions to reach full delivery of Better Births by 2020/21

The table below outlines the packages of work to deliver the final 9 recommendations from *Better Births*, as identified by the gap analysis .

Work delivery area	Activities	Timeline
1. Personalised care	• Implement maternity 'app' across all North West London sites	Q3 2018/19
	• Develop consistent and clear maternity offering	Q4 2017/18

	information for women, including booklet and website content, promoting choice	
	• Implement national maternity tool to allow women to access their own health record	Pending tool from NHSE
	• Contribute content to LCN 'myhealthlondon' website to communicate clear London maternity offering	Q4 2017/18
2. Continuity of carer ***(Early Adopters)***	• Implement new models of care which provider greater continuity of care for women o Caseloading model for vulnerable women, with continuity in the antenatal, intrapartum and postnatal period o A minimum of antenatal and postnatal continuity for uncomplicated cases o A midwife navigator to provide continuity on a shared obstetric pathway	Q3 2018/19
	• Ensure each team of midwives has a named obstetrician	Q3 2018/19
3. Safer care	• Implement quarterly review of SIs at Local Maternity System	Q2 2017/18
	• Implement stillbirth bundle o Reducing smoking in pregnancy o Risk assessment and surveillance for fetal growth restriction o Raising awareness of reduced fetal movement o Effective fetal monitoring during labour	Q4 2020/21
	• Implement actions from London maternal death review	Q4 2020/21
	• Develop NWL maternal medicine hub and clear pathways for referral	Q4 2020/21, pending community hubs business cases
	• Develop NWL abnormally invasive placenta hub and clear pathways for referral	Q4 2020/21
	• Implement recommendation from Each Baby Counts (RCOG, 2015 summary report) to ensure all local reviews have the involvement of an external panel member • Use LMS to plan how this can be achieved as a network	Q3 2018/19
	• Work with the neonatal ODN to ensure that neonatal services have the capacity to provide all neonatal care for at least 95% of babies who require admission for neonatal intensive care and are born to women booked for delivery in the network • To ensure that neonatal care services do not operate above the 80% occupancy averaged over the year and that babies requiring neonatal services receive care from a unit with the appropriate level of care as close to the family home • Annual assessment and gap analysis for transfer capacity (using Neonatal transport group data) • Work with neonatal network to implement ATAIN scheme • Share the neonatal dashboard on a quarterly basis with LMS	Q4 2020/21,
4. Improving postnatal and perinatal mental health care	• Enhance and standardise the extended role of the maternity support worker	Q4 2017/18
	• Implement postnatal care 'care plans'	Q4 2017/18
	• Devise and implement standardised postnatal discharge summary	Q1 2018/19

	• Increase the consistency of information given to women	Q4 2017/18
	• Agree a common specification for transitional care, with clear pathways and shared process across all sites	Q4 2020/21
	• Implement perinatal mental health pathway across all boroughs	Q4 2020/21
5. Multi-professional working	• Agree an interoperable IT system across NWL to support the transfer of information provider to provider (covered by wider STP IT system work)	Q4 2020/21
	• Work with HENWL to identify workforce needs to support STP delivery	Q4 2019/20
	• Implement electronic records - pending IT requirements from national team that can share information across providers	Pending
	• Develop and commission a model of shared GP care	Q1 2018/19
6. Working across boundaries	• Agree a joint, single approach to maternity commissioning which enables commissioning for outcomes	Q2 2018/19
	• Appoint a lead maternity commissioner	Q2 2018/19
	• Establish community hubs and commission community maternity services and a new model of care to operate in hubs	Pending sign off from community hubs business cases
	• Develop a single point of access for women to access maternity care, through a centralised booking service	Awaiting findings from pioneer sites

Section 5. Implementation plan

The implementation plan outlines the strategy to implement the vision over the next three and a half years, delivering the complete recommendations in *Better Births* by 2020/21.

This implementation plan has been co-produced with service users, through a consultation process using the North West London maternity engagement website (https://maternitynwlondon.commonplace.is/) and through a dedicated session (following Whose Shoes event), working with LMS members and ten service users to co-develop the plan.

Delivery of the vision

The programme to deliver the full recommendations set out in *Better Births* will be clinically-led under the Local Maternity System. To enable North West London to implement the transformation effectively, efficiently and safely we will work with clinical experts from our complete local maternity system, ensuring that our guiding principle is improving the quality and safety of care and women's experience.

North West London will nominate clinical senior responsible officer (SRO) to formally oversee the programme of work to deliver the maternity vision. Each work area will also be supported by experts, namely the heads of midwifery, obstetric leads at each Trust, and other representatives from across the maternity system, which forms the North West London Local Maternity System board.

The LMS has representation from neonatology colleagues and will be working in partnership to deliver integrated planning with the neonatology operational delivery network.

To deliver this vision, a dedicated project manager will be required to support implementation across the Trusts and to manage the PMO administration of the LMS.

The maternity STP programme will have user and stakeholder involvement throughout. We will continue to seek views from women, their families and other local stakeholders as this work develops. We will also work with colleagues in neighbouring CCGs and providers to ensure all parts of the system are adequately involved in preparing for and delivering changes and improvements to the model of care.

Responsible owners

The recommended clinical SRO is the clinical chair of the Local Maternity System, Mandish Dhanjal, Consultant Obstetrician and Gynaecologist, Clinical Director of Maternity (ICHT).

The clinical SRO will be supported by a commissioning lead and midwifery lead.

- Mohini Parmar (Ealing CCG Chair, GP, LMS co-chair)
- Pippa Nightingale (Chief Nurse, CWHFT, Clinical SRO for Early Adopters)

The ownership of *Da5ciii 'improvements to women's services'* is jointly held by the Local Maternity System, which has representatives from midwifery, obstetrics from each Trust, as well as a GP and commissioner lead.

Assumptions

The following assumptions have been accounted for in the implementation plan.

- NHSE will provide transformation funding to support this work
- There will be continued support from the senior management at Trusts and CCGs to prioritise maternity through the STP plans, given the competing priorities facing the North West London health system
- NHSE deliver the necessary tools and resources as described in *Better Births* to implement key initiatives – e.g. maternity app, electronic records, personal care budgets
- The maternity transformation work is driven through the LMS and clinical leads who are suitably supported (via PMO function) and clinically backfilled time
- There is significant buy-in from all the relevant health system stakeholders
- NHSE and NHSI are the owners of the recommendation 'payment systems' within *Better Births* and will reform the payment system so that it is fair and pays providers appropriately for the services they provide

Section 6. Governance and key stakeholders

Detailed in the full report

Section 7. Benefits case

Implementing the remaining recommendations from Better Births aim to deliver the following benefits

- Safer care, improved health outcomes
- More personalisation and choice, and improved experience for women and families
- A sector wide approach, leading to efficiency and shared learning

See full plan for benefits case, engagement with service users and feedback, population profiling

Section 8. Challenges and risks

There are a number of risks and challenges associated with delivery of the maternity vision through the STP. Risks are categorised by the following and can be found on page 41 of plan :

- Strategic
- Financial
- Workforce
- IT/ Technology

Section 9. Request for additional support

North West London STP footprint request the £371,400 additional support in order to deliver the full recommendations set out in *Better Births*.

The additional support request is focused on utilising our existing workforce and clinical leads to establish a clinically-led transformation programme to implement the full recommendations in *Better Births* by 2020/21.

The amount requested for clinical backfill time at Imperial is **£70,150.**

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board – public	**29 November 2017**

CQC Update

Executive summary:

This paper is split into two parts:

PART 1: CQC Quarterly Update for Q2, 2017/18

- The Trust continues to be registered at all sites without any conditions.
- The Trust was not inspected by the CQC in Q2.
- The CQC inspection reports for Maternity at St Mary's Hospital, and Medical care at St Mary's, Charing Cross and Hammersmith hospitals were published on the CQC's website on 19 October 2017.
- The Trust is required to submit an action plan template in response to the findings, to the CQC by 24 November.
- Vocare Ltd., which operates the urgent care centre (UCC) at St Mary's Hospital, was inspected by the CQC in Q2.
- An unannounced inspection of the following core services took place on 7-9 November 2017:
  - *Urgent and emergency services:* St. Mary's Hospital and Charing Cross
  - *Surgery:* St. Mary's Hospital, Hammersmith Hospital and Charing Cross Hospital
- The Trust is currently awaiting the draft inspection reports which are expected by 19 January 2018
- The Trust introduced a ward accreditation programme in 2014 and the programme is now in its third year.
- For the 2017/18 programme, 71 clinical areas have been reviewed with a further 13 to be completed by the end of the calendar year.
- A number of clinical areas have improved in their rating since the programme was introduced.

PART 2: CQC Well-led Inspection

- The CQC inspection of its well-led domain at Trust level will take place from 5-7 December 2017.
- A variety of activities are underway to prepare for the upcoming inspection.

Quality impact:

The report applies to all five CQC domains.

Financial impact:

This paper has no financial impact at present.

Risk impact:

This paper relates to the following risk on the corporate risk register:

- **Risk 81:** *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*

Recommendation(s) to the Committee:

- To note the updates provided in both parts of the paper.

Trust strategic objectives supported by this paper:

This paper supports the following strategic objectives for the Trust:

- Improving the way we run our hospitals and services.
- Making our care safer.
- Developing more patient-centred approaches to care.

Authors	Responsible executive director	Date submitted
Priya Rathod, Deputy Director of Quality Governance	Janice Sigsworth, Director of Nursing	22 November 2017

CQC Update

PART 1 - CQC Quarterly Update for Q2, 2017/18

1. Purpose

The following report is the regular quarterly report to the Board providing an update in relation to the Trust's CQC registration. This report covers quarter 2 (Q2) of 2017/18.

2. Registration Status

- The Trust continues to be registered at all sites without any conditions.
- A quarterly confirmation of registered services continues to be undertaken and any amendments are shared with the CQC accordingly.

3. Statutory Mental Health Notifications Made to the CQC

The following statutory notifications were made to the CQC in relation to the Trust's application of the Mental Health Act 1983.

Notification	Q1	Q2
Applications made to deprive patients of their liberties (DoLS)	23	0*
Patient deaths which occurred whilst being detained under the Mental Health Act	0	0
Certified treatment sought or delivered (i.e. by a panel or second opinion appointed doctors (SOAD))	0	0

** The CQC have recently updated the requirement to submit notifications of DoLS applications; these are now only required when an outcome is known or an application is withdrawn. Both scenarios are rare within the Trust; most patients are discharged before the Local Authority processes the DoLS application.*

4. Concerns and Complaints Raised with the CQC

- During Q2 the CQC asked the Trust to investigate one complaint raised with them about the Trust.
- A concern raised in Q1 continued to be managed during Q2.
- No whistleblowing alerts were made to the CQC about the Trust in Q2.

5. Inspections and Reviews

- No CQC inspections were carried out at the Trust during Q2.

5.1 Update on maternity and medical care inspections (March 2017)

- The final reports for the inspections carried out in March 2017 were published on the CQC's website on 19 October 2017.
- Two requirement notices (previously called 'compliance actions') were set by the CQC following the inspections and are related to medicines management and statutory training.
- The Trust has submitted a high level summary of the action it will take to address the requirements, which the Executive Committee approved.

5.2 Vocare Ltd., July 2017

- Since April 2016 the Urgent Care Centre (UCC) at St Mary's Hospital has been operated by an external provider, Vocare, which is registered with the CQC in its own right.
- The CQC carried out an inspection of the UCC on 13 July 2017 and published its report on 5 October 2017, rating the UCC as 'Inadequate'.

- **This was not an inspection of the Trust**. However, the Trust is legally responsible for the safety of the premises and facilities.
- Additionally, the Trust is sub-contracted by Vocare to provide access via the A&E reception, paediatric streaming and imaging procedures.
- The following two areas were raised by CQC in relation to the A&E reception (patients are initially managed by A&E reception staff)
    - Information given to UCC patients was only available in English, including directions to the UCC and what to do if symptoms worsened.
    - There was no hearing loop to accommodate patients with hearing impairments.
- The Medicine and Integrated Care Division have taken forward actions related to these findings.

5.3 Trust inspections during Q3

- An unannounced inspection of the following core services took place on 7-9 November 2017:
    - *Urgent and emergency services:* St. Mary's Hospital and Charing Cross
    - *Surgery:* St. Mary's Hospital, Hammersmith Hospital and Charing Cross Hospital
- The Trust is currently awaiting the draft inspection reports which are expected by 19 January 2018.

- The CQC will inspect the Trust against the well-domain on 5, 6 and 7 of December 2017 (see Part 2 of this paper).

6. National Surveys and Reviews

6.1 CQC Annual A&E Patient Survey

- The CQC's annual patient survey for A&Es was published on 17 October 2017.
- The report identifies the Trust as one of the 'worst performing' trusts.
- The survey reports can be accessed via the following links:
  http://www.cqc.org.uk/publications/surveys/emergency-department-survey-2016
  http://www.cqc.org.uk/sites/default/files/20171017_ED16_outliers.pdf
- A plan to address key areas will be presented to the Executive Quality Committee in December 2017.

6.2 CQC Children and young people survey

- The Children and Young People's (CYP) national survey is due to be published by CQC on 28 November 2017.
- The survey covered all paediatric inpatient and day case patients who had been discharged from our Trust between November and December 2016.
- 1137 surveys were sent out with age specific questionnaires and 260 were returned giving a response rate of 23%. The average response rate for Picker Trusts was 26%.
- The Picker report identified 7 out of 63 questions that were significantly worse than average (in 2014 there was 1) and 2 questions were significantly better, based on comparison with Picker Trusts only.
- A more detailed update will be presented by the division to the Executive Quality Committee in December 2017 and to the Quality Committee thereafter.

6.3 CQC IR(ME)R Annual Report

- Each year the CQC publishes a summary of its activity in relation to compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R).
- The 2016 report was published on 23 October 2017 and can be accessed via the following link:
  http://www.cqc.org.uk/guidance-providers/ionising-radiation/key-findings-reports

- The report does not refer to the performance of individual trusts.
- The report has been shared with relevant colleagues in order to share learning and good practice.

7. CQC Insight

- The Board will recall that as part of its on-going monitoring of NHS acute trusts, the CQC has introduced 'CQC Insight', which collates all available data and information about each trust.
- As part of its on-going monitoring, the CQC will alert trusts if they show poor performance against what are considered key safety indicators.
- The CQC alerted the Trust on 21 September 2017 that it was an outlier for puerperal sepsis and/or other specified puerperal infections within 42 days of delivery.
- The Trust's response was shared with the Executive Committee on 14 November and subsequently submitted to the CQC.

7.1 Management of CQC Insight in the Trust

- A comprehensive report will be produced by the CQC for the Trust on a monthly basis
- The Trust's reports are accessible via a secure online portal and are not in the public domain or published on the CQC's website.
- The first CQC Insight report was made available to the Trust on 29 September 2017 and subsequently shared with the executive team and divisional colleagues.
- The nursing team has met with the Medical Director's office and Head of Performance and Business Intelligence to consider how the Trust might use the data and report going forward.
- It has been agreed that the use of CQC insight will be considered as part of the annual routine performance framework review.
- A proposal will be presented to the Executive Committee in January 2018.

8. Ward Accreditation programme

- The Trust introduced a ward accreditation programme in 2014 and the programme is now in its third year.
- For the 2017/18 programme, 71 clinical areas have been reviewed with a further 13 to be completed by the end of the calendar year.
- A number of clinical areas have improved in their rating since the programme was introduced.
- Areas of high performance identified during the 2017/18 programme include; communication and food service.
- Areas for further development include; environmental issues and leadership development for more junior staff.
- A summary report will be produced at the end of the 2017/18 programme and presented to the Trust Board.

9. Recommendations the committee

- To note the updates

END OF PART 1

PART 2 - CQC Well-led Inspection

1. Purpose

This part of the paper presents an update on the Trust's first annual CQC inspection of its well-led domain at Trust level.

2. Background

- The CQC notified the Trust on 6 October 2017 that the inspection of its well-led domain at Trust level will take place on 5, 6 and 7 December 2017.
- In addition the CQC has also sent a draft inspection schedule which sets out key tasks/events for each day of the inspection.
- It also includes a list of staff they will interview and key documents they will review.
- They have also confirmed there will be eight inspectors and have previously informed us that staff focus groups will also be undertaken.

3. Preparations

- NHS Improvement's Head of Quality Governance has been on site at the Trust from mid-August to undertake a review of the Trust's performance in relation to the key lines of enquiry (KLOE) for the well-led domain. The Trust is currently awaiting the report from this piece of work.
- A session on the well-led KLOEs was run at the Trust Board seminar on 25 October 2017.
- The Communications team will support communications for both staff and external stakeholders throughout the inspection process.
- An inspection preparations project plan has been developed and will be overseen by the Trust's CQC team.

4. Outcomes of the inspection

- The CQC will award a rating for its well-led domain at Trust level.
- The CQC aims to provide a draft inspection report for the well-led domain at Trust level within three months of the inspection; for the Trust this would be March 2018.
- The Trust will have an opportunity to check the report for factual accuracy.
- The final report will be published on the CQC's website together with a rating for well-led.

5. Next steps

- Consider the report from the Head of Quality Governance from NHSI once received and what action is needed.
- Inspection preparations will continue in line with the project plan.

6. Recommendations to the committee

- To note the update

END OF PART 2

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Learning from Deaths: update on implementation and reporting of data

Executive summary:

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

This paper outlines progress with implementing the framework across the trust and includes the first 'learning from deaths dashboard' (appendix A). This was developed using available guidance however the national dashboard remains under development by NHS Improvement and the Department of Health and the reporting portal is not yet available. Trusts have been asked to publish data in their public board papers until final guidance is released.

The Board is asked to note the following key points in respect of progress made with the framework implementation:

- A cohort of staff have been identified to undertake structured judgment reviews (SJR) and they are undergoing the necessary training
- Structure judgment reviews have been implemented in a specified subsection of patients and completed reports are starting to be received
- Mortality reporting metrics are currently being incorporated into both trust and divisional scorecards and will be available in November
- We are compliant with reporting requirements as set out by NHS Improvement, which require reporting of data in Q3 17/18 of the following:
  - Number of deaths
  - Number of SJRs undertaken
  - Number of deaths deemed avoidable using the 6 point avoidability scale
  - Number of learning disability deaths
  - Number of learning disability reviews
  - Number of learning disability deaths deemed avoidable
- The reported mortality data is in line with what the Trust has previously reported. There has been no abnormal spike or dip in overall numbers and the numbers of avoidable deaths are comparable.

Quality impact:
Implementation of this framework will support improved learning from deaths which occur in the Trust, therefore supporting the safe, effective and well-led quality domains.
Financial impact:
The financial impact has been forecast within the divisional budgets to deliver the SJR's.
Risk impact:
There is potential for reputational risk associated with the ability to deliver reviews within the specified time periods, thus impacting on national reporting.
Recommendation(s) to the Board:
The Board is asked to note the progress made to ensure full implementation of the learning from deaths framework and the information in the first 'learning from deaths dashboard'
Trust strategic objectives supported by this paper:
To achieve excellent patient experience and outcomes, delivered efficiently and with compassion. To educate and engage skilled and diverse people committed to continual learning and improvements.

Author	Responsible executive director	Date submitted
Justin Vale Associate Medical Director for Safety Shona Maxwell Chief of Staff	Julian Redhead Medical Director	22 November 2017

Learning from Deaths: update on implementation and reporting of data

Purpose

The purpose of this paper is to update the Trust Board on progress with ensuring trust compliance with the mandatory framework on learning from deaths. The first 'learning from deaths' dashboard is also being reported to the Board in line with the mandated reporting requirements. This was developed using available guidance however the national dashboard remains under development by NHS Improvement and the Department of Health and the reporting portal is not yet available. Trusts have been asked to publish data in their public board papers until final guidance is released.

Background

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.

In March 2017 a framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care was published by the National Quality Board. This includes 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 are mandated from quarter 3 2017/18. This includes the requirement to submit quarterly data externally, which populates a "learning from deaths" dashboard.

The data required is shown in appendix A. All trusts are required to publish this mortality data in the annual Quality Account for 2017/18.

Although the trust had an established mortality review process and associated policy, these have been amended to ensure compliance with the new requirements. These

Progress

There were a number of key milestones required within Q1 and Q2 to ensure the Trust was in a position to fully implement the framework and report the required data set by Q3 2017/18.

Good progress has been made through the task and finish group led by the associate medical director to review all aspects of the learning from deaths framework and ensure Trust policies and processes are compliant.

A summary of the key areas of focus and progress with each is set out below:

Policy review

The Trust's 'Standardised Mortality Review Policy' was revised to incorporate all requirements, including the use of SJR methodology. The new 'Learning from Deaths' policy was published at end of September 2017 in line with national requirements. A training programme is currently underway for staff who will undertake SJR.

Process review

A number of key principles have been agreed, including:

- In line with recommendations, at least 15% of hospital deaths will undergo SJR.
- Any case may be referred for SJR, either at the discretion of the clinical team, because concerns have been raised, or because the case falls within pre-selected cohorts of patients as set out in the policy. These cohorts include:

- Where concerns have been raised by the bereaved family;
- Where concerns have been raised by staff;
- Where first stage case record review suggests a more in-depth review may be helpful or where the death is judged to have a greater than 50:50 chance of being avoidable;
- Patients with a learning disability (in-line with the national LeDeR process);
- Patients detained under the Mental Health Act;
- Any case that is subject to a coroner's Inquest or enquiry;
- Any case that is subject to a serious incident (SI) investigation;
- Deaths in patients aged between the ages of 16 and 25;
- Cases of maternal death;
- Stillbirths, neonatal and paediatric deaths;
- Any mortality alert from Care Quality Commission, via benchmarking systems including the HES system (for SHMI and HSMR) or the CRAB Clinical Informatics system (we will review a random sample of deaths identified with 4 or more medical triggers).

- Historic mortality reviews undertaken under the previous trust mortality review process will not be re-reviewed under the SJR process.

- SJR implementation will be undertaken in a phased approach.

- Q1 2017/18: SJR will be completed in cases identified through local review as having suboptimal care.

- Q2 onwards: SJR will be completed in cases in the designated groups listed above.

- The divisions will nominate a set number of people to undertake SJR, estimated to be a maximum of 10 clinicians for MIC and SCCS and 4 for WCCS. Divisions have achieved these numbers.

- Training will be required for all staff undertaking SJR. The Royal College of Physicians "train the trainers" programme will be utilized in the first instance with 4 ICHT staff having completed in October, and a further 5 booked to attend over before the end of this calendar year. A half day work shop for SJR reviewers is planned for the 30th November where those externally trained will facilitate on-site workshops for the remaining reviewers. A coaching and learning approach will be utilized to support the SJR team going forward with ongoing education built in to this.

- The trust has changed the scoring tool used for mortality review to the RCP national mortality record review scoring tool which has a 6 point grading tool.

- The scope of the reviews at ICHT will achieve the minimum requirements of the Learning from Deaths framework (adult in-patient deaths). The trust will not be reviewing out of hospital or post-discharge deaths.

Involving families

A key focus of the guidance is the need to actively involve families including offering opportunities for them to raise questions or share concerns in relation to the quality of care received by their relatives.

The complexity of achieving this in a meaningful way both logistically, and also at an emotional and distressing time has been recognised nationally. A two-day workshop facilitated by NHS England is planned for early November, which brings families together with clinicians involved in mortality review, as well as CQC, NHS Improvement, and the

National Quality Board. Further guidance is due for publication in early 2018 and ICHT will implement this in full. However, until then the trust has included guidance in the bereavement pack for families on how to raise concerns, and the new learning from deaths policy includes a quick reference guide on how to involve families.

Staff within the complaints team have been briefed on the new policy and have been provided with the necessary guidance on how to refer complaints relating to the care of a deceased patient to the mortality review group.

LeDeR – Learning Disabilities Mortality Review (LeDeR)
The trust is actively participating in the LeDeR programme, reporting all deaths of patients with a Learning Disability to the national database. At ICHT these cases will all have an SJR completed, in addition to the external LeDeR. Cases that require a LeDeR are assigned by a national team, and involve a time delay, of approximately 6-8 weeks from death.

Not all regions in the UK have started carrying out LeDeRs. Where a patient resided out of the London region before their death the case will be reported however, if that region is not yet live, no separate LeDeR will take place. An SJR will always occur.

Reporting
"Avoidable" mortalities are currently reported through the quality report to ExQu and Quality Committee, and in the Trust Board scorecard. In addition to this, from Q3 2017/18, we are required to report the following information to the Trust Board:

- Number of deaths
- Number of SJRs undertaken
- Number of deaths deemed avoidable using the 6 point avoidability scale
- Number of Learning Disability Deaths
- Number of Learning Disability Reviews
- Number of Learning Disability deaths deemed avoidable

The dashboard for ICHT showing data for relevant deaths that occurred in Q1-2 2017/18 is included in appendix A. This was developed using available guidance however the national dashboard remains under development by NHS Improvement and the Department of Health and the reporting portal is not yet available. Trusts have been asked to publish data in their public board papers until final guidance is released.

- The final format is expected to include addition information, including :Cases where a serious incident has been declared either as a result of SJR or concurrently;
- Key themes, learning and actions from any investigations undertaken.

Review of data
The key data reported within the dashboard in appendix A which the Board should be aware of is outlined below including commentary on our current performance for each measure:

Data Field	Data Definition	Commentary
Total Deaths	Number of in hospital deaths	Reported numbers are in line with previous trends.
Total Deaths Reviewed	The number of completed SJR reviews.	To date 8 reviews have been undertaken. This number will increase in the next reporting period as the process continues to be implemented (there is a 30 day review period for each

		SJR).
Deaths Avoidable	The number of cases which have been deemed avoidable following SJR completion (scored 1-3 on the RCP tool).	No avoidable deaths have been reported to date.
LD Deaths	Number of in hospital deaths in which the patient had an identified Learning Disability	The trust has reported 9 cases to LeDeR year to date.
LD Deaths Reviewed	The Trust is awaiting allocation of cases for review from the LeDeR programme board on the portal. Once allocated these reviews will be completed within the mandatory time frames.	There are currently 2 LD deaths allocated to the Trust to review on the portal. These investigations are ongoing.
LD Deaths Avoidable	Number of deaths deemed avoidable following a LeDeR review process	There are currently no cases of avoidable LD deaths.

There are currently no cases of completed SJR that have undergone an SI investigation, or have been deemed necessary following review.

Local Mortality Reviews

All clinical teams are required to provide a review of mortality cases within their specialty areas. All cases are required to have a Level 1 review, which consists of a short number of questions, followed by assigning an avoidability score. Based on that review, cases may proceed to a team based Morbidity & Mortality (M&M) meeting. Where local teams have highlighted issues in the care of a patient, an independent SJR review will be undertaken.

	Apr	May	Jun	Jul	Aug	Sep
Total number of deaths (17/18):	**119**	**152**	**137**	**138**	**163**	**151**
Percentage of deaths reviewed locally (Level 1):	98%	99%	99%	96%	96%	78%
Number of deaths reviewed via SJR methodology:	1	0	0	0	4	3
Number of confirmed avoidable deaths (Score 1-3):	0	0	0	0	0	0
Number of confirmed avoidable deaths (Score 1-3) YTD:	0	0	0	0	0	0

Data is refreshed on a monthly basis as local reviews and SJR reviews are completed. In order to instigate the SJR process at the earliest opportunity the timeframe for local, Level1 review completion has been shortened to 7 days, from the previous 30 days, effective from Sept 2017 which is reflected in the lower percentage of reviews completed that month.

Next steps

- Continue to develop Trust Board reporting including learning;
- Incorporate mortality reporting to the divisional and directorate scorecards to enable review at local committees;
- Await publication of national guidance on involving families in the review process and develop processes and procedures to ensure we comply with this guidance –

outstanding;

- Await confirmation of national reporting procedures, including all metrics once finalised.

Appendix A:

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

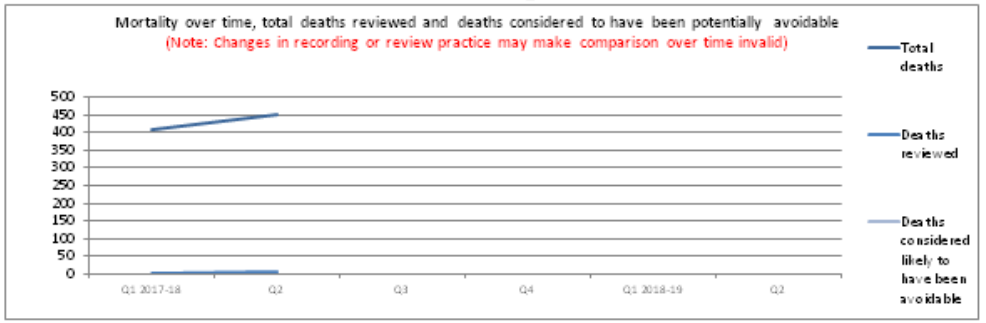
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
151	163	3	4	0	0
This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter	This Quarter (QTD)	Last Quarter
452	408	7	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
860	0	8	0	0	0

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



Total Deaths Reviewed by RCP Methodology Score

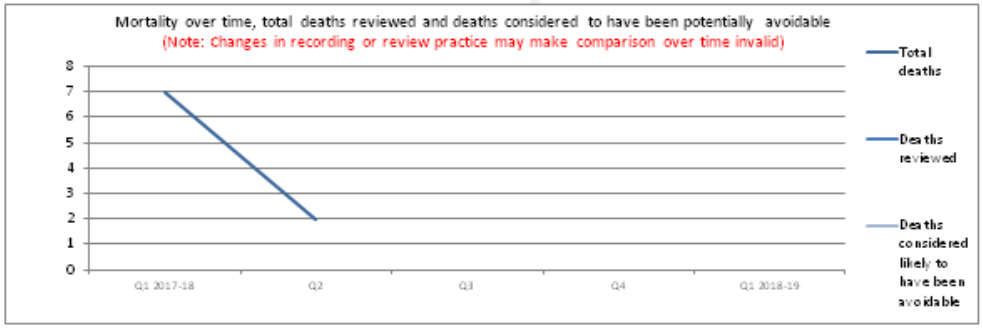
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	33.3%	This Month	1	33.3%	This Month	1	33.3%
This Quarter (Q	0	0.0%	This Quarter (Q	0	0.0%	This Quarter (QTI	0	0.0%	This Quarter (QTD)	2	28.6%	This Quarter (QTD	3	42.9%	This Quarter (	2	28.6%
This Year (YTD)	0	0.0%	This Year (YTD	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	3	37.5%	This Year (YTD)	3	37.5%	This Year (YT	2	25.0%

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
2	0	0	0	0	0
This Quarter (QTD	Last Quarter	This Quarter (QTD	Last Quarter	This Quarter (QTD)	Last Quarter
2	7	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
9	0	0	0	0	0

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



Trust	Imperial College Healthcare NHS Trust
Org Code	
Month	September
Year	2017-18

Financial Year	Month	Total Deaths	Total Deaths Reviewed	Deaths Avoidable > 50%	RCP1	RCP2	RCP3	RCP4	RCP5	RCP6	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2017-18	April	119	1	0	0	0	0	1	0	0	0	0	0
2017-18	May	152	0	0	0	0	0	0	0	0	3	0	0
2017-18	June	137	0	0	0	0	0	0	0	0	4	0	0
2017-18	July	138	0	0	0	0	0	0	0	0	0	0	0
2017-18	August	163	4	0	0	0	0	1	2	1	0	0	0
2017-18	September	151	3	0	0	0	0	1	1	1	2	0	0
2017-18	October												
2017-18	November												
2017-18	December												
2017-18	January												
2017-18	February												
2017-18	March												

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q2 2017/18

Executive summary:

- There has been only one MRSA bloodstream infection (BSI) identified YTD out of 16176 blood cultures taken.
- There have been 30% fewer cases of Trust-attributed *C. difficile* infection YTD compared with the first half of the last financial year (25 vs. 35 cases), and the Trust is under trajectory for its annual ceiling for *C. difficile* cases. Only 1 lapse in care has been reported YTD in these cases, compared with seven in the same period last year.
- There has been an overall increase in detection of CPE across the Trust during Q2, mainly from screening cultures; seven new clusters of CPE have been identified by screening programmes and managed, with five declared as serious incidents due to potential cross-transmission.
- The bi-annual point prevalence survey of antimicrobial usage reported 93% overall compliance with key prescribing metrics , above the target of 90% (91% prescribed according to policy or on the advice of infection teams, 98% with documented indication, 89% reviewed within 72 hours, and 93% with a duration in line with policy or approved infection teams).

Quality impact:

IPC and careful management of antimicrobials are critical to the quality of care received by patients at ICHT, crossing all CQC domains.

Financial impact:

No direct financial impact.

Risk impact:

The report highlights key risks related to IPC from the risk register, and how they are being managed.

Recommendation(s) to the Board:

To note

Trust strategic objectives supported by this paper:

- To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.
- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Alison Holmes, DIPC Jan Hitchcock, IPC Interim General Manager	Julian Redhead, Medical Director	8 November 2017

1 Healthcare-associated infection (HCAI)

1.1 HCAI mandatory reporting summary

Table 1 provides a summary of Public Health England's HCAI mandatory reporting, showing the number of cases by month.

	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Trust *C.difficile*	5	7	3	6	7	5	2	5	4	5	4	5	**25**	**33**
Trust *E.coli* BSI	6	-	8	-	6	-	5	-	5	-	5	-	**35**	**-**
Trust MSSA BSI	3	-	3	-	2	-	2	-	4	-	4	-	**18**	**-**

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

Table 1: HCAI mandatory reporting summary.

1.2 C. *difficile*

There have been 25 Trust-attributed cases to date this financial year (FY), against a trajectory ceiling of 33 cases to reach an annual ceiling of 69 cases; Trust-attributed *C. difficile* was detected in 1.5% of 1693 stool specimens tested (Figure 1). The Trust has a comprehensive set of measures in place to minimise antibiotic usage, especially antibiotics that are associated with *C. difficile* infection, and to reduce the transmission of *C. difficile*, including multidisciplinary clinical review of all cases, rapid feedback of lapses in care to prompt ward-level learning, and use of the Trust's serious incident framework to investigate lapses in care related to transmission of *C. difficile* or inappropriate antibiotic usage contributing to *C. difficile* infection. To reduce the risk of transmission of *C. difficile*, CPE, and other pathogens and to maximise the efficient use of resources, a business case for introducing an on-site hydrogen peroxide vapour (HPV) / ultraviolet (UV) room decontamination service will be submitted in Q3.

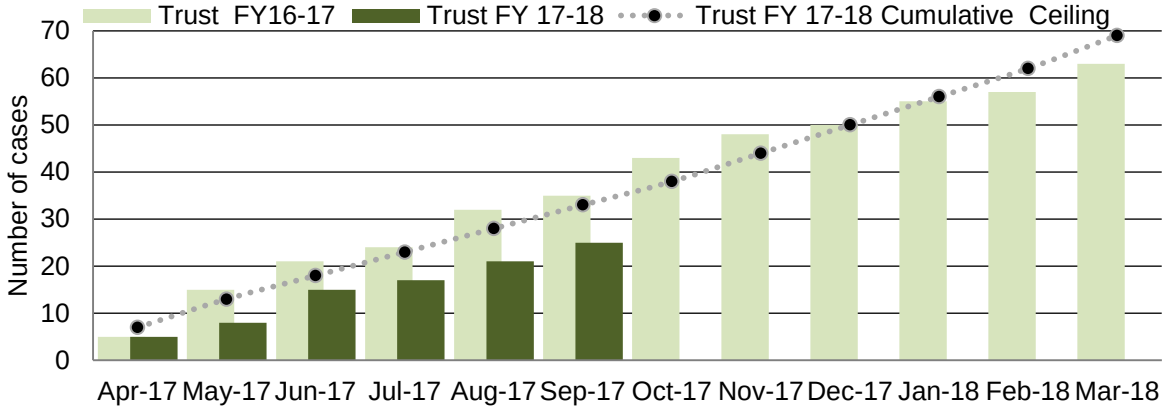


Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in FY 17-18 (dark green bars) compared with FY 16-17 (light green bars).

1.2.1 *C. difficile*: lapses in care

There has been one *C. difficile* reported case that has had a lapse in care relating to pathway crossover or antibiotic exposures during Q2 (Table 2). This related to two cases of *C. difficile* with the same ribotype on a medical ward. This was fed back to the division to prompt ward-level investigation. 60 days have elapsed between the last lapse in care related to *C. difficile* and the end of the Q2. For comparison, there were seven lapses in care related to *C. difficile* in the first half of the last financial year.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Total number of toxin positive cases 17/18	5	3	7	2	4	4
Specimens sent for *C.difficile* testing	547	615	558	553	551	589
Antibiotics						
No exposure	0	0	1	1	0	0
Prescribed as per policy	5	3	6	1	4	4
Outside of policy and action taken	0	0	0	0	0	0
Transmission						
No contact with other patients with *C. difficile*	3	2	6	1	2	4
Had contact with other patients with *C. difficile*	2	1	1	1	2	0
Lapse in care*	0	0	0	0	1	0

*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. Where there is patient contact but no lapses in care, this is because the patients had different *C. difficile* ribotypes.

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

1.2.2 *C. difficile*: time to isolation

The Trust has a policy in place to isolate patients who develop diarrhoea within two hours of the start of their symptoms (Figure 2). Compliance with this policy has improved compared with FY 2016/17; lack of policy awareness, poor documentation around time to isolation and lack of available side rooms for isolation are the main reasons for non-compliance with this standard, and have improved compared with FY 2016/17. This improvement has been supported by targeted real-time education delivered by the IPCNs. 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. The importance of improving rapid isolation of patients with diarrhoea is also discussed with Divisions on the weekly HCAI Taskforce call. The proportion of single rooms available for isolation is summarised in section 8.1. The overall improvement in time to isolation may have contributed to the reduction in lapses in care related to *C. difficile* transmission of *C. difficile*.

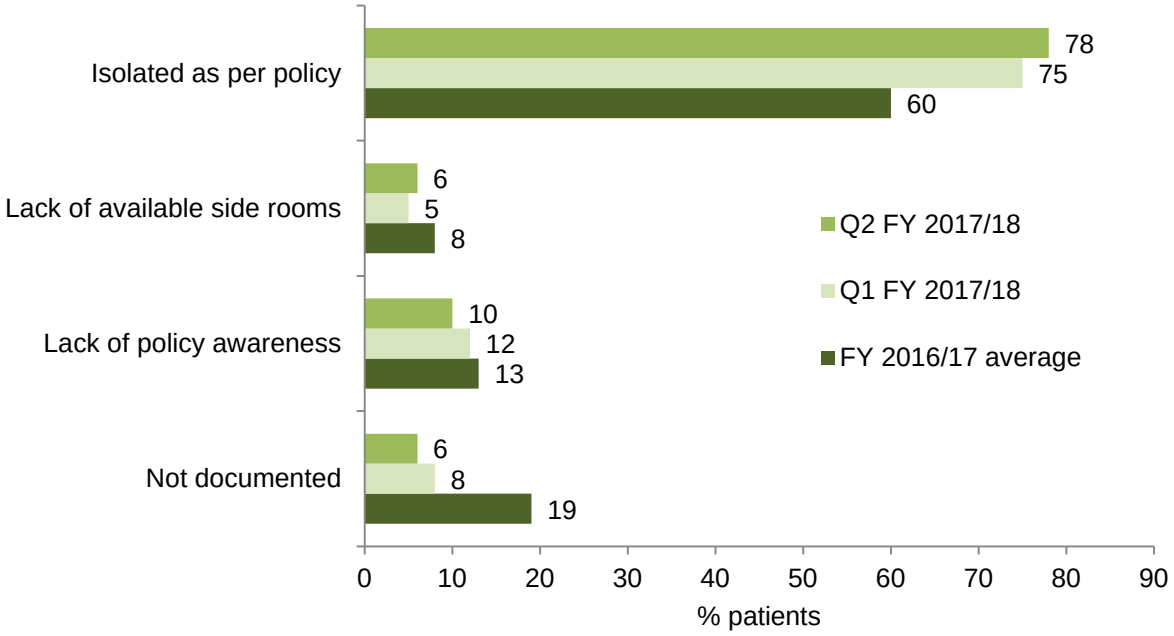


Figure 2: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with C. difficile *diarrhoea.*

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

Imperial has the 2nd lowest Trust-attributed *C. difficile* rate in the Shelford group of hospitals, based on 21 cases for the period Apr to Aug-17 (using the latest available data); this has improved from the last FY, where Imperial ranked 6th lowest. The rate of specimens tested for *C. difficile* in the other Trusts is unknown, but remains broadly constant at ICHT.

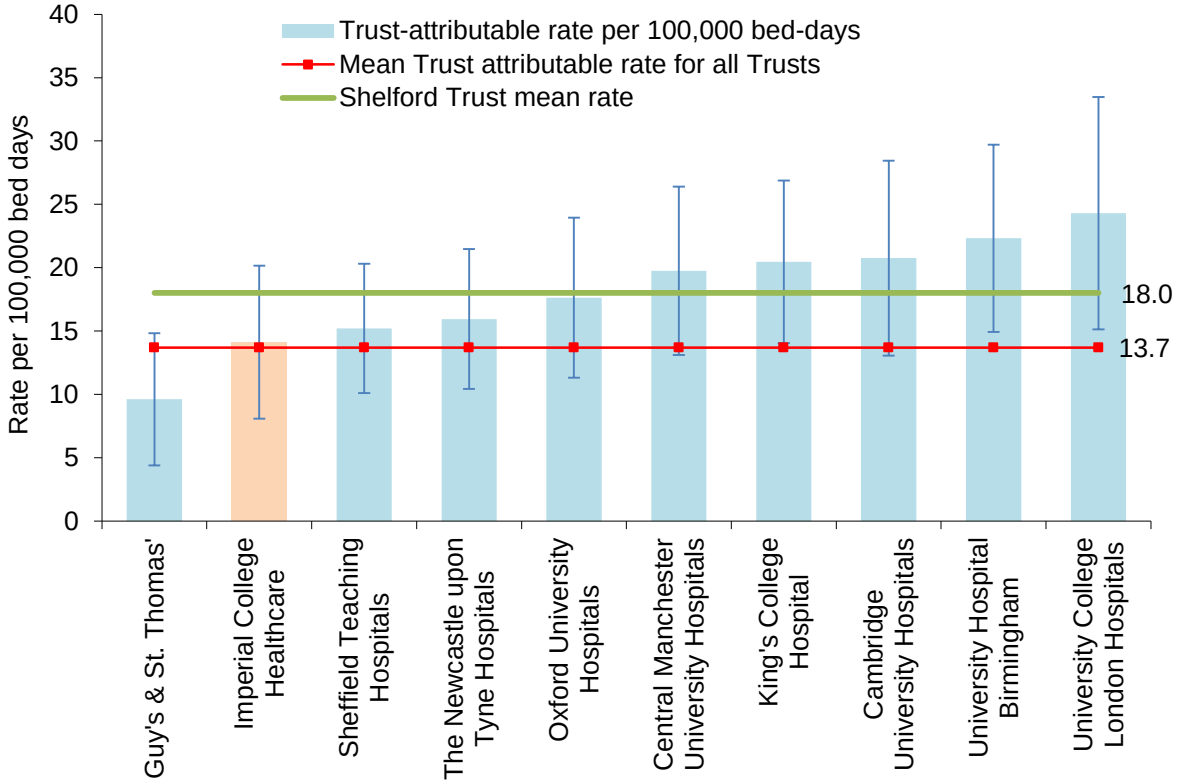


Figure 3: C. difficile *Shelford Group comparison, FY 17/18. Error bars denote the 95% confidence interval around the rate for each hospital.*

1.3 MRSA BSI

8,223 blood cultures were tested during Q2. There has been no case of MRSA BSI identified at the Trust during Q2. This means that there has been only one Trust-attributed MRSA BSI in the last six months (this case occurred in April 2017); 158 days elapsed between the last Trust-attributed MRSA BSI and the end of the quarter. MRSA admission screening continues to be monitored monthly via the IPC Scorecard; compliance for the latest quarter was 89% (8996 of 10120 patients were screened).

1.4 MSSA BSI

There have been 10 cases of Trust-attributed MSSA BSI in Q2 FY17/18, and 18 cases YTD, compared with 12 in the first half of the last financial year. There is no national threshold for MSSA BSI at present. Eight cases were associated with a vascular access device (four associated with peripheral cannulae, one with an acute central venous access device, and three with skin tunnelled catheters); six occurred at Charing Cross. These cases are being reviewed by IPC in conjunction with the Divisions to determine whether further specific actions are required. Initial findings suggest that practice around the insertion and maintenance of vascular access devices could be a contributing factor to this apparent increase. A comprehensive point prevalence survey of the use of vascular access devices has been completed and results will be reported early in Q3, which will also inform action.

1.5 *E. coli* BSI

There have been 15 cases of Trust-attributed *E. coli* BSI in Q2 FY17/18, compared with 33 cases in Q2 FY 16/17 (Figure 4). There is no national threshold for *E. coli* BSI at present. Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. Two cases in the same calendar month were identified on an oncology ward. Overall, 4 of the 15 cases were considered to have a urinary source, 2 of which were related to a catheter-associated UTI (CAUTI). Addressing the various sources of *E. coli* BSI, especially urinary sources, is a focus of multidisciplinary group working around reducing Gram-negative BSI (see section 1.6.2).

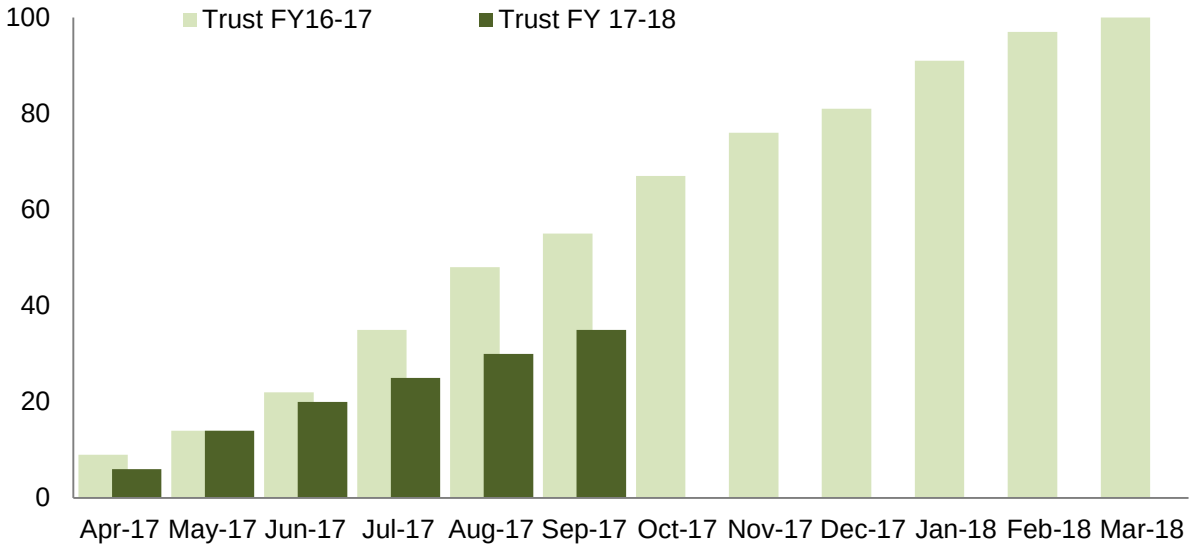


Figure 4: Cumulative monthly FY 17-18 Trust-attributed E. coli BSI (dark green bars) compared to FY 16-17 (light green bars).

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

Imperial has the 4th highest rate in the Shelford group of hospitals for the combined rate of Trust and non-Trust-attributed *E. coli,* based on 157 cases for the period Apr to Aug-17; this is the same rank as for the last FY.

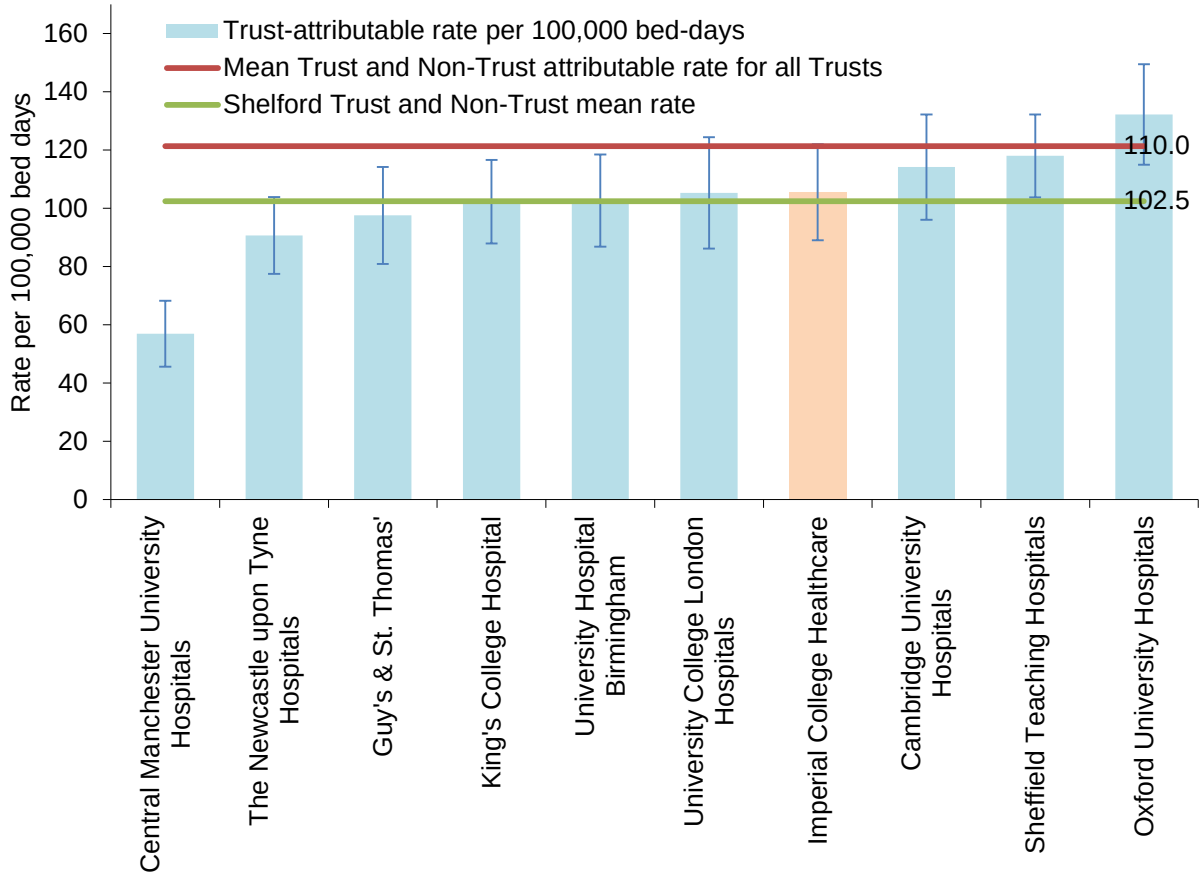


Figure 5: E.coli BSI Shelford Group comparisons, FY 16/17. Error bars denote the 95% confidence interval around the rate for each hospital.

1.6 BSI summary

The trend in BSIs by organism / organism-group for Q1 and Q2 FY 17-18 is presented in Figure 6. Gram-negative bacteria predominate, with *E. coli*, accounting for approximately 36 BSI per month (median 39, range 22 to 41), and for 18.0% of all positive blood cultures. *Staphylococcus aureus* accounted for 10.0% of all positive blood cultures; MRSA accounts for 0.1% of all BSIs. Blood cultures caused by bacteria usually associated with patients' skin and not representing infection ('contaminated blood cultures') accounted for 2.4% of 16,612 blood cultures taken during this period (Q1 and Q2 FY 17-18), which is below our local benchmark of 3%[1]. We continue to assess all clinical staff for competency in aseptic non-touch technique to further reduce contaminants.

[1] Benchmark set based on published literature, which suggest 3%: Self et al. *Acad Emerg Med* 2013; 20:89-97.

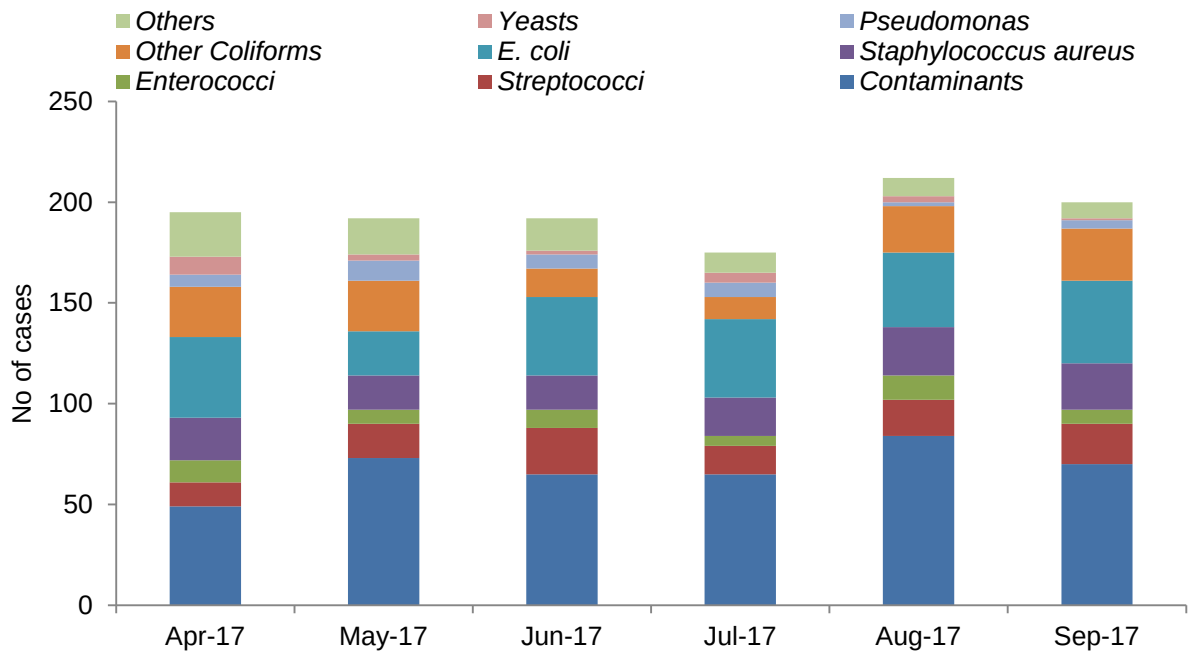


Figure 6: Blood cultures by organism / organism-group Q1 and Q2 FY 17-18.

1.6.1 Antibiotic resistance in Gram-negative BSI

Amikacin resistance decreased from 4.6% in Q1 to 1.1% in Q2, which is back to baseline from (FY 16-17); no other significant changes in resistance were noted. Four CPE BSIs occurred in Q2: three patients were treated successfully; one patient died from their underlying disease rather than from CPE.

1.6.2 Gram-negative BSI reduction target

The government has announced an ambition to halve healthcare-associated Gram-negative BSI by 50% by 2021. The Trust is developing a Gram-negative BSI reduction plan, in conjunction with the CCG, which will be discussed at a joint meeting in November 2017. Key elements of the plan include:

- Enhanced reporting of Gram-negative BSI cases to PHE, including *E. coli, Klebsiella pneumoniae,* and *Pseudomonas aeruginosa.*
- Supporting our CCG in identifying non-Trust attributed Gram-negative BSIs for further investigation.
- Establishing an enhanced Gram-negative BSI review process via a monthly MDT group. This will include a detailed review of the sources of healthcare-associated BSIs to inform targeted prevention initiatives.
- Regular local review of antibiotic susceptibility and prescribing policy.
- Trust-wide review of antibiotic prescribing indicators and indicators of relevance to Gram-negative BSI.
- Close working with the sepsis identification and management plans in the Trust that may impact Gram-negative BSIs.
- Improving the management of urinary catheters in conjunction with the Nursing Directorate, and enhancing surveillance of urinary catheter-associated BSI.
- Reviewing hydration management, especially in elderly patients.
- Furthering work to ensure that CPE admission screening is performed as per policy to ensure that appropriate antibiotics are used for patients who are colonised with CPE and subsequently develop a BSI.
- Planning new prevention initiatives in partnership with high-risk clinical areas (for example haematology, renal, NICU, and post-surgical wards).

1.6.3 Bloodstream infection (BSI) surveillance in ICUs

1.6.3.1 BSI summary in Trust ICUs

Adult ICUs: The catheter line-associated BSI (CLABSI) rate over the past 12 months (Oct-16 to Sep-17) is 1.1 per 1000 catheter line-days (Figure 7), which is below the benchmark of 3.0 per 1000 catheter-line days (ECDC benchmark). Split by site, the CLABSI rate (per 1000 catheter line days) is 0.9 for Charing Cross Hospital, 1.3 for Hammersmith Hospital, 0.9 for St. Mary's Hospital. There have been two CLABSI episodes during Q2 FY17-18 for all three ICUs, with zero CLABSI episodes for the months of July and August 17. We continue with robust surveillance, weekly ward rounds, ANTT competency assessments, and infection discussions with clinicians (MDT) in reducing CLABSI in our intensive care units.

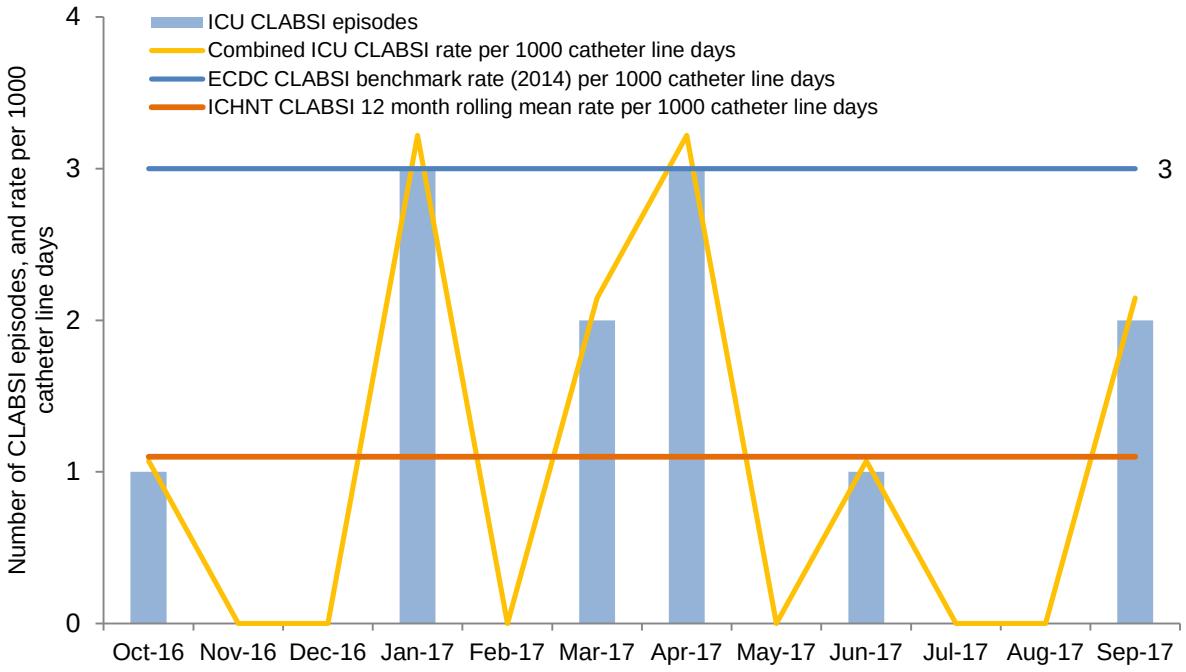


Figure 7: CLABSI episodes on the adult ICUs against the benchmark rate.

Paediatric ICU (PICU): In the 12 month period, Oct-16 to Sep-17, PICU has seen only one CLABSI episode in 1478 catheter-line days. This rate of 0.6 per 1000 catheter-line days is below the ECDC European benchmark of 3.0 per 1000 catheter line days.

Neonatal ICU (NICU): In the 12 month period, Oct-16 to Sep-17, the CLABSI rate on the neonatal ICU (NICU) at SMH and QCCH combined was 7.3 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 (Oct-16 to Sep-17) CLABSI rate in Very Low Birth Weight Babies (VLBW) in the NICU was 8.5 per 1000 catheter line days, marginally below the NEO-KISS nosocomial infections surveillance project benchmark figure of 8.6 per 1000 catheter line days. This was due to a transient increase in VLBW CLABSI rate in the Jul to Sep 16 (19.3 per 1000 line days) and Oct to Dec 16 (10.1 per 1000 line days) quarters. NICU have implemented actions to improve 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. The rate during Q1 and Q2 was 6.4 and 7.5 per 1000 catheter line days, respectively (below the benchmark for VLBW babies of 8.6), suggesting that these actions have made some impact.

1.7 Surgical site infection

The Trust reports SSI rates following selected orthopaedic procedures in line with national mandatory reporting, and selected cardiothoracic procedures in participation in a national voluntary reporting scheme.

1.7.1 Orthopaedics

- The latest quarter (Jul – Sep 17) has seen:
  - Zero SSI in 96 knee procedures so far recorded.
  - One deep-incisional SSI in 48 hip procedures so far recorded. This rate of 2.1% is higher than the national average (0.6%). The 12 month rate of SSI following hip procedures is 1.0% (2/201 procedures), which is marginally above the national average. Both hip SSIs have undergone a detailed review, which has been reported to the Surgical Infection Group. No specific actions have arisen from these reviews.

1.7.2 Cardiothoracic

Q1 and Q2 data for cardiothoracic is not yet available. The cardiothoracic team are on track to meet the mid-September deadline for Q1 data and the end-December submission deadline for Q2 data. The latest available data (Apr 16 - Mar 17) shows that the SSI rate in cardiothoracic procedures is less than the national average.

1.7.3 SSI: implementing semi-automated surveillance

IPC, microbiology and the NIHR Health Protection Research Unit at Imperial College are collaborating to implement improved SSI surveillance. The principle is to merge data from microbiology, pathology, procedure and diagnosis codes to algorithmically detect patients who might have an SSI for detailed case review. There are two overlapping work streams currently in progress: retrospective analysis of cardiothoracic SSIs, and implementing a real-time trigger for new suspicious cases for detailed review. A workshop of the retrospective analysis tool in cardiac surgery by a multidisciplinary working group suggested improvements to the dashboard which will be made before the tool can be considered for roll-out to other specialties. There have been delays with making these improvements due to limited availability of QlikView developers. Work to validate the real-time trigger on retrospective data showed that the real-time trigger again needs improvements, and the team are now working with machine learning specialists to refine the algorithm. This is being overseen by the Surgical Infection Group.

1.7.4 Getting It Right First Time (GIRFT) SSI audit

As part of the national ‘Getting it Right First Time (GIRFT)’ programme, the Department of Health, Public Health England, and NHS Improvement have asked that all Trusts participate in a period of surveillance for surgical site infections (SSIs). The SSI audit requests that trainees in 13 surgical specialties (12 of which are performed in this Trust) perform a prospective audit for SSIs between May and October 2017, and submit retrospective SSI data (if available) between November 2016 and May 2017. The prospective auditing began during Q2 in most specialities, and the first data sets from eight specialties were reviewed in the September Surgical Infection Group (SIG). A higher than expected rate of SSI in vascular was reported by the GIRFT SSI audit, supported by data on wound infection trends from the Copeland Risk Adjusted Barometer (CRAB) data. This has prompted a review of SSI-prevention measures in vascular surgery, which has been discussed at the vascular surgery audit meeting, and will be presented at the next Surgical Infection Group and Surgical Outcomes Group.

1.8 Carbapenemase-producing Enterobacteriaceae (CPE)

1.8.1 Detection of CPE

Risk-factor based screening of all admissions was introduced in June 2015 to extend universal screening that was being performed in high-risk specialties. The majority of cases are from screens, without evidence of clinical infection (Figure 8).

1.8.2 CPE admission screening compliance

A number of high-risk specialties are performing universal admission screening (renal, vascular, ICUs and haematology wards) (Figure 9). The rest of the Trust is performing risk-factor based admission screening of all admissions, identifying those patients with previous overnight hospitalisation in the past 12 months or overseas residents. CPE admission screening results has been included in the Harm Free Care report since January 2017. This provides a mechanism to prompt ward-level action to address areas of low compliance. A CPE Action Plan, which includes compliance with CPE screening, is reviewed monthly at the Medical Director's Quality and Safety Sub-Group. This CPE Action Plan is being reviewed in light of the Trust-wide increase in CPE identified in recent months and will be discussed at the Quality and Safety Sub-Group in November and approved at the Trust Infection Prevention and Control Committee (TIPCC) (see section 1.8.3. below). A patient level validation exercise is in progress to investigate the accuracy of CPE admission screening data, focussing on areas that show low or declining compliance including renal, vascular and private patients. Whole ward CPE screening is also performed weekly where there are CPE inpatients and for 4 weeks after discharge. This may account for the increase in the total number of CPE screens performed in Q2 due to the high number of wards currently undertaking weekly screening.

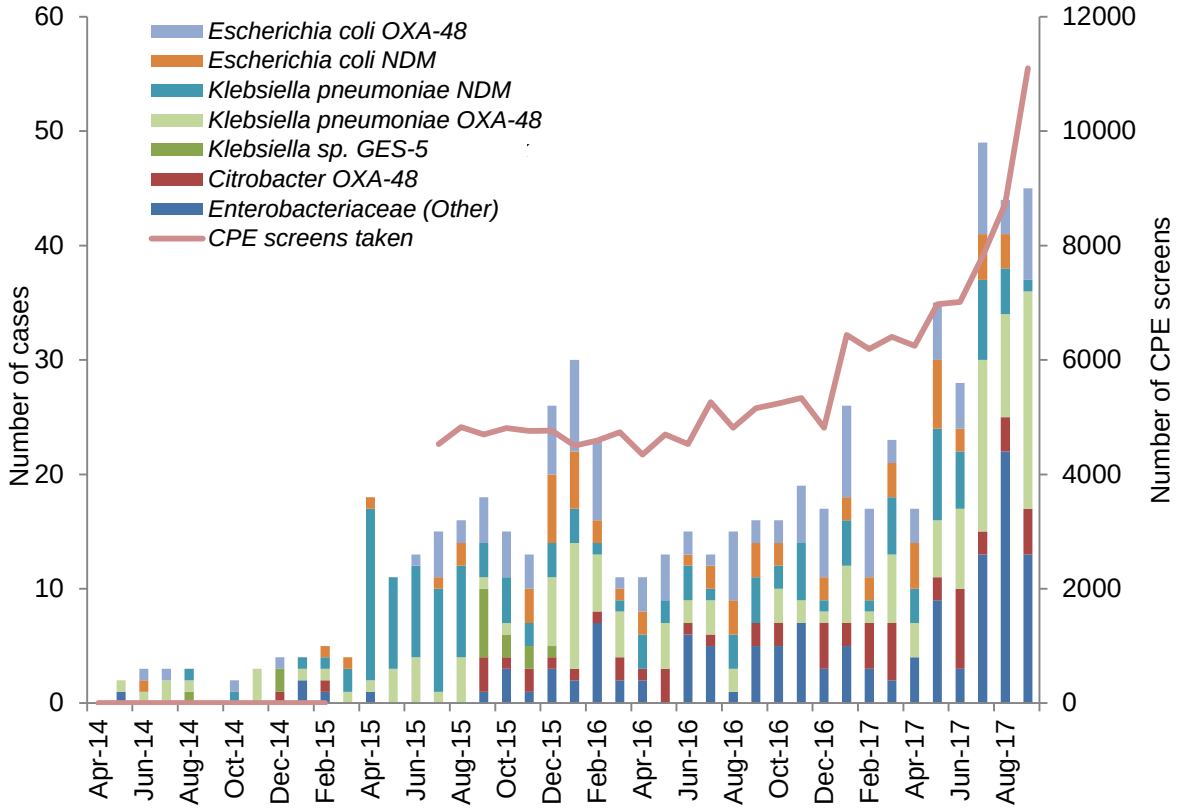


Figure 8: CPE detected at the Trust, deduplicated by patient.

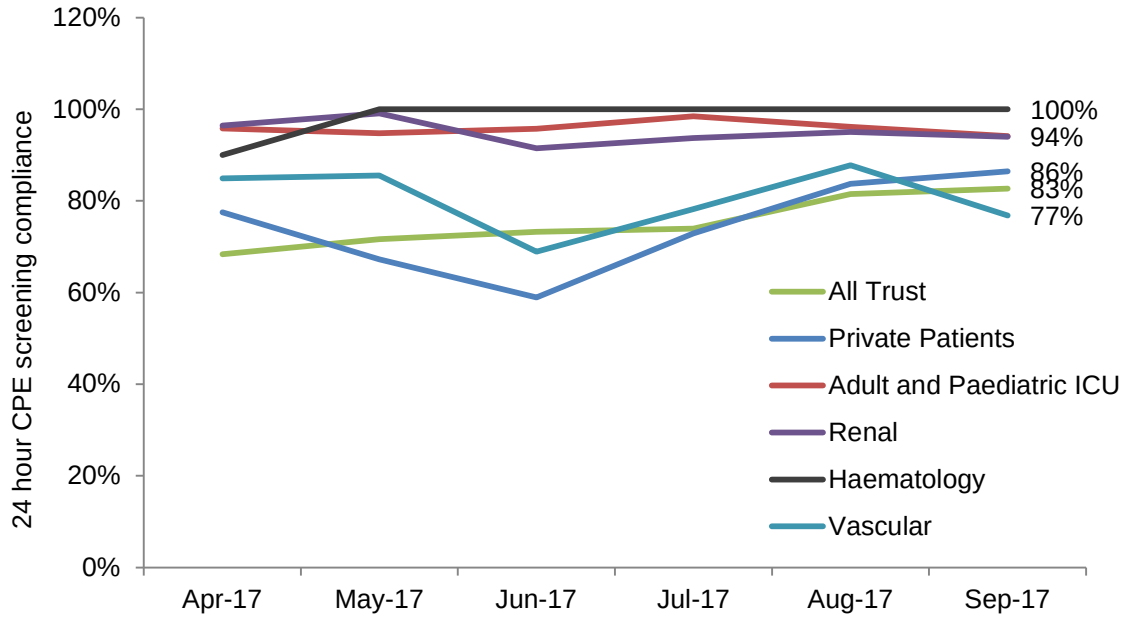


Figure 9: CPE admission screening compliance

1.8.3 Increased incidence of CPE detection across the organisation.

There has been an increased incidence in detection of CPE across the Trust in Q2. Several different epidemiologically-linked clusters have been identified:

- In July and August thirteen patients on a vascular surgical ward (including a separate vascular bay on the adjacent medical ward) had *Klebsiella pneumoniae* OXA-48 (a type of CPE) identified from routine weekly screening samples. Eight of these samples were found to be indistinguishable on typing. Two further patients have been found with the same organism on another surgical ward.
- In August two patients on a medical ward had *Klebsiella pneumoniae* OXA-48 identified from weekly screening samples. These were found to be indistinguishable on typing (but not the same type as the vascular ward above) and cross transmission is suspected.
- Two patients on another medical ward had *Enterobacter cloacae* OXA-48 (a type of CPE) identified from weekly screening samples. These were found to be indistinguishable on typing and cross transmission is suspected.
- Two separate CPE incidents are under investigation on a haematology ward. Two patients with *Klebsiella pneumoniae* NDM and three patients with *Enterobacter cloacae* VIM have been identified from weekly screening. These samples were found to be indistinguishable on typing.
- In September thirteen patients on a medical ward had *Klebsiella pneumoniae* OXA-48 identified. All but one of these were from screening samples and all were found to be indistinguishable on typing. The ward remains closed to admission and transfers.
- Two patients on another medical ward had *Citrobacter freundii* OXA-48 identified from weekly screening samples. These were found to be indistinguishable on typing and cross transmission is suspected.
- All the above have been discussed with the Trust's CCDC and there are regular reviews of CPE management. PHE are providing typing but the service is limited and the turnaround time is around three weeks, which means that timely typing information is not always available to support cluster management.

- Five serious incidents have been declared as a consequence of these outbreaks (see Section 5).

2 Antibiotic stewardship

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

2.1 Assurance regarding quality of antibiotic prescribing

2.1.1 Point Prevalence Results – Prescribing & Quality Indicators

The biannual antibiotic point prevalence study (PPS) (based on a review of inpatient data only) examines a suite of key antibiotic prescribing and safety indicators as advised by the Department of Health's "Start Smart then Focus" antibiotic programme and acts as a mechanism to identify areas for improvement. Historically, the documentation of a stop or review date has been reviewed; however two new indicators have been introduced instead around whether a review occurred within 72 hours and whether the antibiotic had an appropriate duration to strengthen how we review anti-infectives. These are a better measure of antibiotic stewardship practice and are in line with updated guidelines (e.g. Start Smart and Focus, and the 2017/19 CQUIN on Reducing the Impact of Serious Infections).

Overall 1271 patients were reviewed which is all inpatients at the time; approximately 40% of inpatients were scheduled to receive an antibiotic. 908 antibiotics were prescribed (57% intravenous). Of these 908 antibiotics, 91% were prescribed according to policy or on the advice of infection teams with 98% having a documented indication on the drug chart or medical notes. 89% of anti-infective prescriptions had a documented review within 72 hours of initial prescribing and 93% had a duration in line with policy or approved by microbiology / ID. The Trust has a suggested compliance of 90% for these indicators (Table 3). The average of these indicators is 93%.The percentage of patients on an antibiotic has reduced and each of the four prescribing indicators has improved compared with the 2016/17 FY (Table 3).

To continue the increased engagement around stewardship the results are due to be discussed at division and speciality's Quality and Safety Committees together with being included on the IPC Scorecard and discussed on the IPC Taskforce call on the first Tuesday of every month.

2.1.2 Point Prevalence Results – Safety Indicators

As part of the biannual antibiotic point prevalence study there were 8263 antibiotic doses prescribed at the time of data collection with 183 doses (2.2%) documented as not given. This figure has reduced from 4% in the 2016/17 FY, and 3.4% in February 2017. The introduction of Cerner prescribing may have resulted in an increase in missed antibiotic doses (from a baseline of 1.2% in June 2015), which prompted focussed education. Of these 183 doses, 100 were intravenous doses of antibiotics. In addition, 98% of patients who received an antibiotic had their allergy status completed.

There has been a reduction in the missed dose rate from 3.4% in February 2017 to 2.2% in this study. It is thought this reduction is due to focussed education and the embedding of the electronic prescribing system. Divisions have been given a breakdown of missed doses by speciality to review.

2.2 Antimicrobial Consumption

In Q2, the Trust continued to decrease its overall consumption of antimicrobials to a total of 6108 defined daily doses (DDD) per 1000 admissions. This was a 5.5% reduction from the same period in 2016/17 and the lowest point in 5 years (Figure 10).

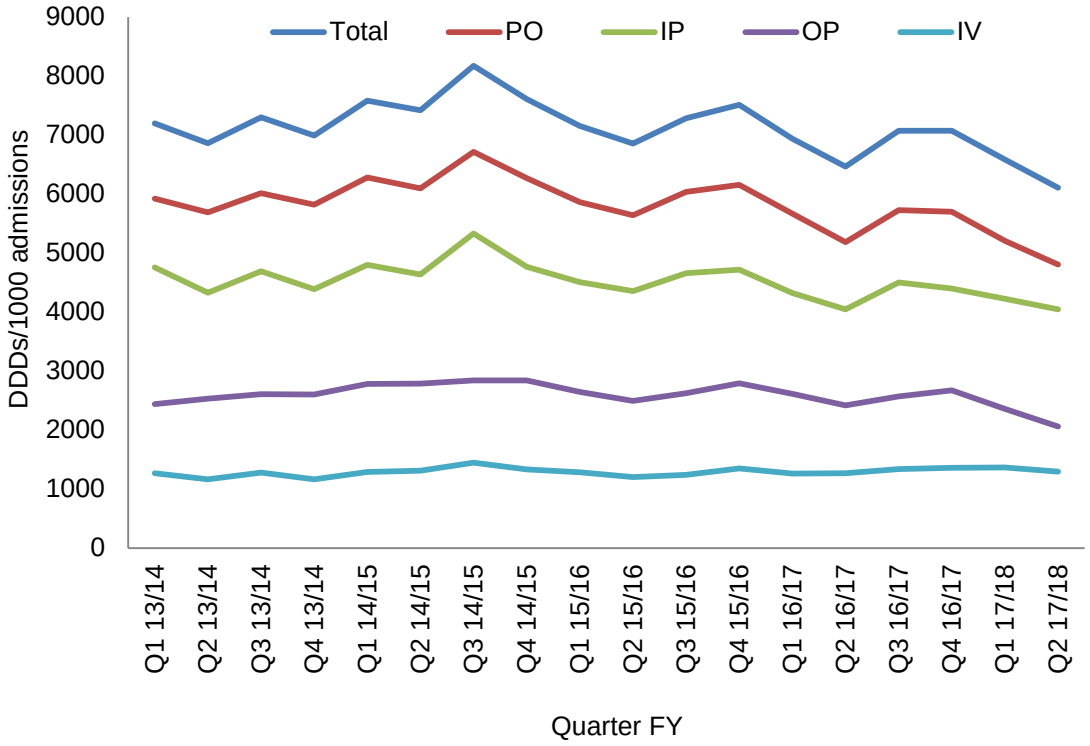


Figure 10: Trust wide antimicrobial DDD / 1000 admissions 2013 – present detailing total, oral (PO), intravenous (IV) consumption together overall consumption in inpatient (IP) and outpatient (OP) areas.

Table 3: PPS results summary from August 2017 survey

Divisions	Number of patients on anti-infective(s)/total patients seen (%)		Number of anti-infectives prescribed		INDICATOR A % anti-infectives in line with policy or approved by Microbiology/ ID		INDICATOR B % indication documented on drug chart or in notes		INDICATOR C % review within 72 hours of initial prescribing		INDICATOR D % duration in line with policy or approved by Microbiology/ID	
	Average 16/17	Aug 2017	*Average 16/17*	Aug 2017	*Average 16/17*	Aug 2017	*Average 16/17*	Aug 2017	*Average 16/17*	Aug 2017	*Average 16/17*	Aug 2017
Trust Results	*548/1246 (44%)*	**513/1271 (40%)**	*893*	**908**	*88%*	**91%**	*96%*	**98%**	*83%*	**89%**	**80%**	**93%**
Medicine	*252/560 (45%)*	**210/561 (37%)**	*379*	**337**	*89%*	**92%**	*99%*	**97%**	*84%*	**90%**	**82%**	**95%**
Surgery, Cardiovascular and Cancer	*214/408 (52%)*	**220/415 (53%)**	*370*	**422**	*90%*	**92%**	*94%*	**97%**	*84%*	**86%**	**80%**	**91%**
Women's and Children's	*70/225 (31%)*	**75/238 (32%)**	*124*	**135**	*84%*	**88%**	*93%*	**100%**	*79%*	**96%**	**74%**	**96%**
Private	*12/53 (23%)*	**8/57 (14%)**	*20*	**14**	*70%*	**75%**	*100%*	**100%**	*81%*	**60%**	**64%**	**86%**
Trust Target 2017/18					**90%**		**90%**		**90%**		**90%**	

Piperacillin/ Tazobactam (Tazocin®) consumption reduced by 96% in Q1, primarily due to a global shortage of this agent. Although there are still constraints on supply, ICHNT have now been given an allocation of 40% of the Trust's 2016/17 consumption. Piperacillin/ Tazobactam was reintroduced into empirical guidelines for the treatment of neutropenic sepsis in haematology and oncology patients in late August 2017. For all other indications, piperacillin/tazobactam must be authorised by the infection team. As a result use of piperacillin/tazobactam usage has increased in Q2 (Figure 11).

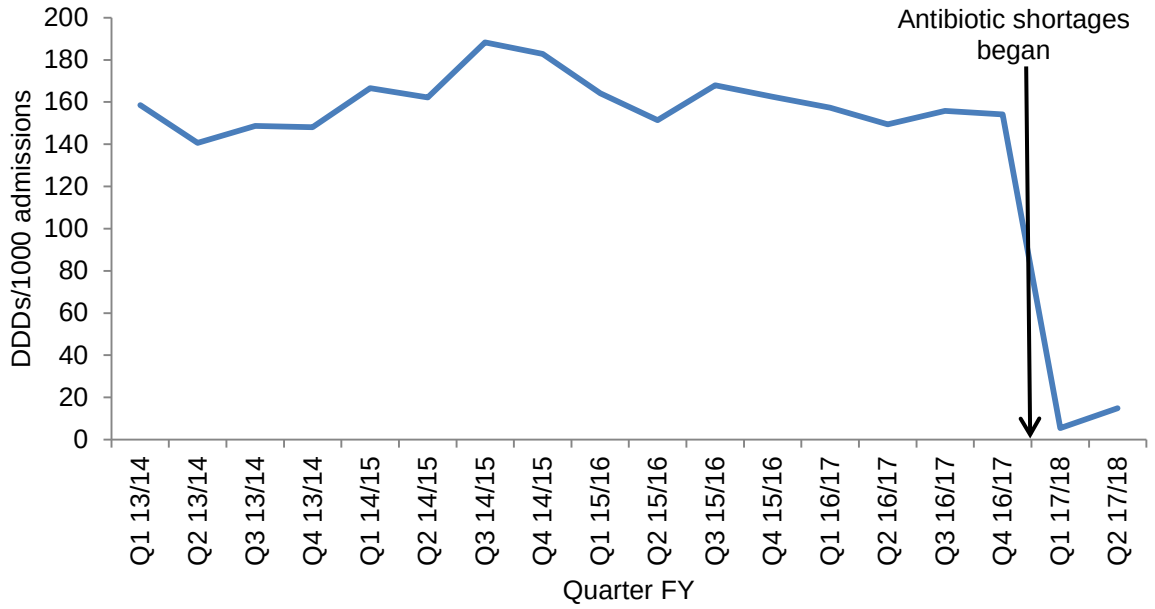


Figure 11: Trust wide piperacillin/tazobactam DDD/ 1000 admissions 2013-present.

Carbapenem consumption has increased in Q2 (Figure 12). There was a 22% increase in carbapenem consumption from Q2 2016/17. This was in part due to the shortage of Tazocin® and lack of alternative agents in Q1 17/18 combined with the challenge of treating multidrug resistant Gram-negative infections within our healthcare setting across 2016/17.

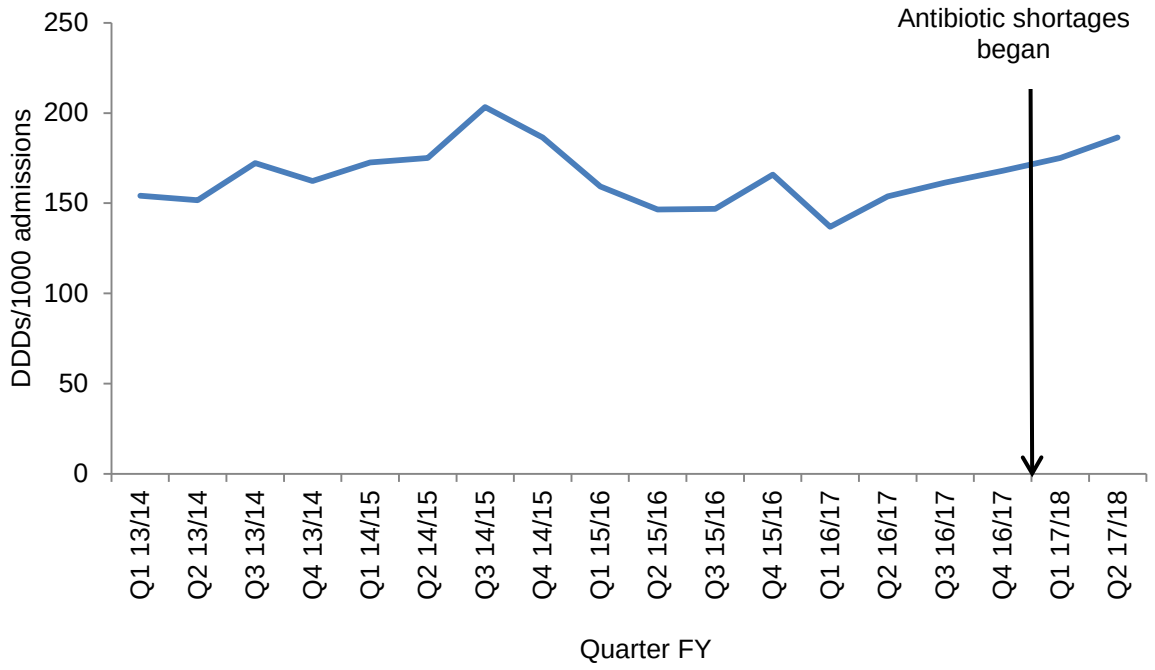


Figure 12: Trust wide carbapenem DDD/ 1000 admissions 2013-present.

With the recruitment of a fixed term infection pharmacist for one year, work started in July 2017 on analysing the Trust antimicrobial consumption data looking specifically into the classes of antibiotics used within specialities and reasons for variation. This data will be used with antibiotic resistance data and local point prevalence studies to help target stewardship interventions and work with Divisions to drive improvement. A dedicated infection stakeholder meeting is being scheduled for November 2017 to open this discussion further with agreed actions.

2.2.1 Antimicrobial Resistance (AMR) CQUIN & Public Health England

The Trust continues to take part in the AMR CQUIN, supported by the fixed term infection pharmacist position. We continue to report our antimicrobial usage to Public Health England (PHE) and participate in their national programme, facilitating benchmarking and helping to drive improvement. Antimicrobial consumption data for 2016 has been submitted to PHE and a 2% reduction in consumption (as measured by total antimicrobial DDDs/1000 admissions) for piperacillin/tazobactam and carbapenems has been requested for 2017/18. Q2 data has been submitted to PHE in October 2017.

2.3 Antibiotic Expenditure

Antimicrobial expenditure can be used as a surrogate to monitor antibiotic use, although changes in trends can be associated with changes in contract prices and may not accurately reflect consumption.

Trust-wide there was an average spend of £835k per quarter on antibacterials and £697k on antifungals in 2016/17 YTD. The increase in antibacterial costs in Q2 (Figure 13) is due to the antibacterial drug shortages, because of the need to procure a number of agents off-contract to maintain Trust antibiotic guidelines and patient safety. The agents include piperacillin/tazobactam, ceftriaxone, amikacin, meropenem, and vancomycin.

There is a pan-London contract for echinocandins where cost is based on a volume based matrix of drug usage. From 1st September 2017, the cost of anidulafungin and micafungin decreased which is predicted to result in a cost saving. It should be noted that high cost antifungals are funded by NHS England with the exception of patients within 90 days of renal transplant or bone marrow transplant.

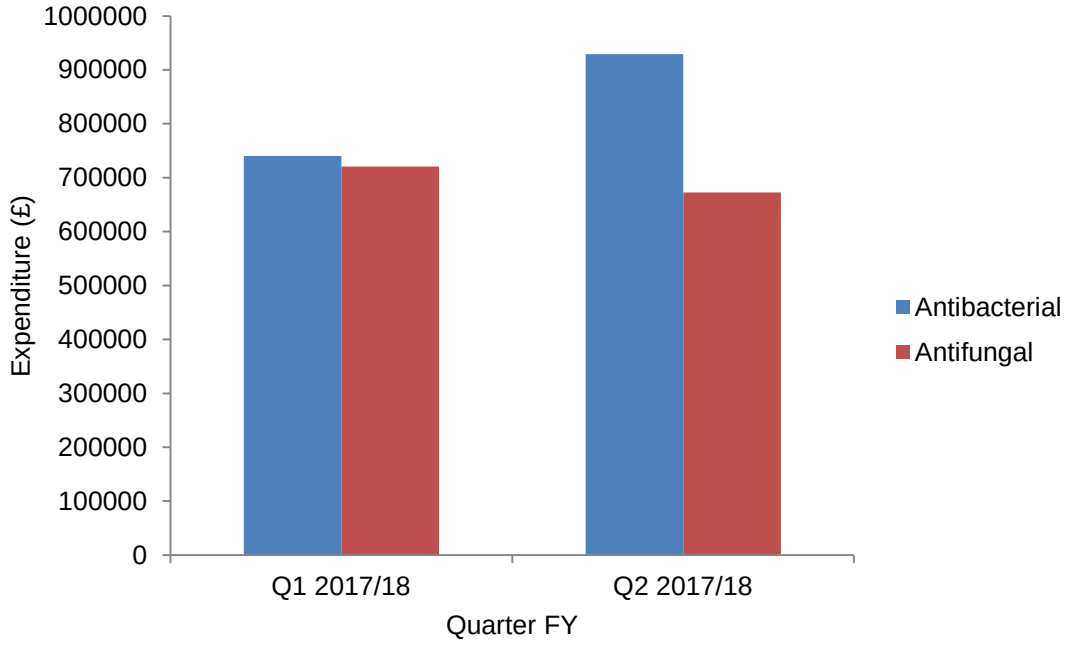


Figure 13: antibiotic expenditure for inpatients and outpatients by site and quarter 2016/17 FY to date.

2.4 Antibiotic Review Group

The Trust Antibiotic Review Group's (ARG) role is to improve antibiotic use within the Trust by promoting the safe, rational, effective and economic use of antibiotics by the multidisciplinary teams.

2.4.1 Review of non-formulary antimicrobials

In Q2, ARG have approved Ceftolozane / tazobactam for use in 8 infection episodes (n=3 patients) and Ceftaroline for use in 1 infection episode (n=1) together with Brincidofovir on haematology patients.

Ceftolozane / tazobactam was approved at the Trust New Drugs Panel in September 2017 for use in infections caused by microorganisms known to be susceptible and for which no other antibiotics can be used either due to resistance or patient's intolerance. This may include use outside of the licensed indication. Recommendation for initiation must come from a senior member of infection team.

2.4.2 Antimicrobial Shortages

The Trust continues to experience critical antimicrobial shortages of Piperacillin/ Tazobactam (Tazocin®) and Ceftazidime. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis.

2.5 Antibiotic resistance data

The Trust empirical antibiotic policy will be updated in Q3 2017, informed by antibiotic resistance data, which is awaited from the laboratory. This data will aid in the revision of the Adult and Paediatric empirical antimicrobial guidelines.

2.6 Cerner Infection Collaborations

The Trust is working with other NHS organisations (Oxford, Royal Free, Wirral, St Georges) around how best to utilise Cerner for infection management activities. These include designing core antimicrobial reporting to automatically alerting healthcare professionals to when antibiotics need reviewed. All involved are benefiting from this shared learning and helping to improve patient care.

It is expected that the Trust will have antimicrobial patient specific report by November 2017 which will aid stewardship rounds.

2.7 Sepsis

The Cerner sepsis module is currently being piloted within the Trust and will be followed by a Trust-wide launch and post-launch improvement work. The module will support clinical staff in early recognition and management of sepsis, incorporating Trust Adult Treatment of Infection Guidelines and sepsis management principles. It will include reporting functionality to monitor time to first dose of antibiotics and help drive improvement around sepsis management, thus supporting antimicrobial consumption reduction.

October saw the first iteration of the sepsis reporting metrics and these are currently being validated clinically. Further, a revision of the Trust sepsis policy is being undertaken via a multi-stakeholder engagement process. A report on sepsis metrics will be available for the Q3 report, including: The number of sepsis alerts and location it fires, number of patients with confirmed sepsis, and percentage of patients who receive antibiotics within one hour.
The sepsis module will be rolled out across the Trust through December 2017.

3 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. ANTT has become the term to describe an umbrella local competency assessment approach including i) practical assessment of hand hygiene ii) the use of personal protective equipment for all staff who work in a clinical setting, and an iii) assessment of Aseptic Non-Touch Technique (ANTT) for staff who require this skill. The target for compliance with ANTT training for Trust clinical staff is set at 95%; currently the compliance rate has plateaued at 73.6% (5729/7783 clinical staff) (Figure 14). During Q2, 1250 clinical staff were assessed, which is an average of 416 per month. The management of ANTT compliance for staff has been devolved to the Divisions, so that they can have increased visibility of individual-level compliance to drive improvement. The revised policy for ANTT has been developed and is going through the approval process. The Divisions are developing ANTT improvement plans centred on working with HR to ensure that staff records are up-to-date, and identifying areas of genuinely low ANTT compliance for focussed improvement efforts. These are being discussed at the Quality and Safety Sub-Group.

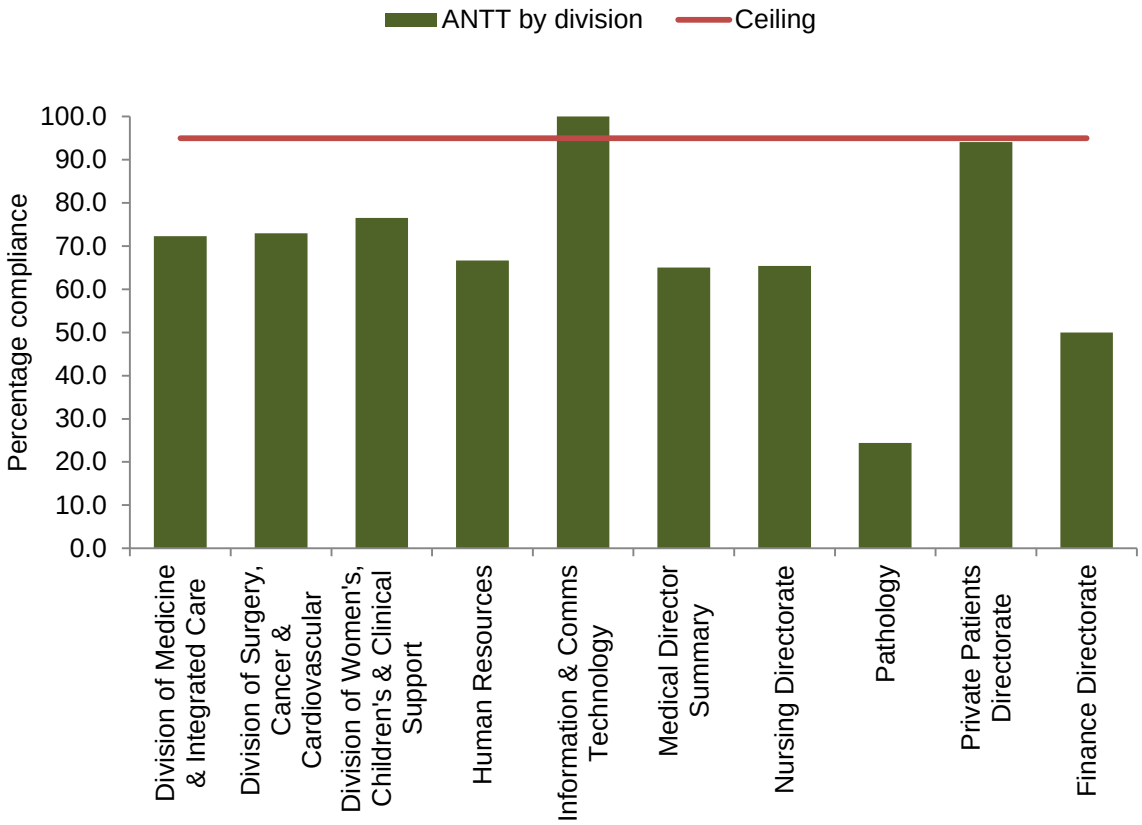


Figure 14: ANTT compliance by Division. A small number of clinical staff are situated in Finance (e.g. procurement clinical specialist) and Human Resources (e.g. occupational health clinicians).

4 Hand hygiene

The Trust has a Hand Hygiene Strategy in place, which is overseen by the Hand Hygiene Steering group. This strategy includes improvements to the way that hand hygiene auditing is performed in the Trust, regular auditing of the facilities available for hand hygiene, and communications around hand hygiene. The Trust transitioned from auditing Moment 1 (before patient contact) of the WHO's Five Moments for Hand Hygiene to all 5 Moments (before patient contact, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings) from April 2017. Since May 2017, monthly auditing of the 5 Moments for Hand Hygiene indicates compliance of 97% (n=32,505 observations). This is considerably higher than would be expected based on published data. In order to investigate this, IPC validation of hand hygiene compliance data has been performed in nine selected ward areas, indicating compliance of 56% (122 compliant observations from a total of 223). These areas will continue to received focused attention in order to improve the accuracy of hand hygiene compliance data.

The annual hand hygiene facilities audit was performed during Q2, which has identified a number of areas in which Estates work is required to improve the facilities for hand hygiene.

5 Serious incident investigations

Serious incidents (SIs) reported during Q2 are listed in Table 4. The outbreaks of Resistant Gram-negatives relate to the CPE outbreaks outlined in section 1.8.3. The number of incidents relating to infection prevention and control has increased to 19 in the current period (from 16 in the previous 12 months). The number of incidents related to CPE transmission has increased (11 compared to 8) whilst the number related to other infections have stayed the same (8 for both periods). Screening for these organisms and their subsequent

identification has increased in the last year and this enhanced screening is amongst a number of measures put in place to address these transmission incidents. Whilst root causes are complex and multifactorial, common themes include ensuring high levels of compliance with CPE admission screening, improving hand hygiene and ANTT practice, assurance around cleaning and disinfection of the environment and timely response to Estates issues, the use of bank and agency staff, the challenges of working in an estate with limited isolation and toilet facilities, and optimising use of antibiotics. In the event that clinical areas are closed to admissions, the IPC team requires assurance that these issues have been addressed before a clinical area is re-opened.

Steis number	Date reported	Description
2017/19226	25/07/2017	Outbreak of HCAI pathogens (Resistant Gram-negative)
2017/22957	07/08/2017	Outbreak of HCAI pathogens (Resistant Gram-negative)
2017/22986	15/08/2017	Outbreak of HCAI pathogens (Resistant Gram-negative)
2017/22053	23/08/2017	Outbreak of HCAI pathogens (Resistant Gram-negative)
2017/25234	22/09/2017	Outbreak of HCAI pathogens (Resistant Gram-negative)
2017/22962	08/09/2017	Outbreak of HCAI pathogens (C. difficile)

Table 4: SIs due to infection-related causes.

6 Compliance and Policies

6.1 Compliance

- Cleaning audits are performed by Facilities. This is reported on a ward-level in the monthly Harm Free Care report, to prompt action to improve cleaning performance where necessary. Whilst these regular cleaning audits have not suggested a Trust-wide issue with cleaning, recent outbreak investigations suggest sub-optimal levels of cleaning and disinfection practice and governance; this combined with concerns from other clinical areas has prompted a review of cleaning standards and processes across the Trust led by the Nursing Directorate.
- 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 76%, and with Level 2 is at 79%. This data is now included in the monthly IPC Scorecard to prompt improvement in the Divisions, and the issue has been raised on the HCAI Taskforce to support improvement

6.2 Policies

Policies and guidelines under review during this quarter:

- Non Tunnelled Central Venous Catheter Guideline
- Midline Guideline
- Implantable Port Guideline

Policies and Guidelines awaiting approval in Q3:

- CJD (and other prion disease) policy.
- Peripheral cannula guidelines.
- Skin Tunnelled Catheter guidelines.
- Hand hygiene technique, PPE and ANTT competency assessment for patient safety policy.

7 Risks

Key risks for IPC include:

- The shortage of key antimicrobials due to national supply problems continues to present a major clinical challenge and is being considered for escalation to the corporate risk register. Mitigation is in place in that all appropriate guidelines have been updated and have been communicated across the Trust.
- On-going. Trust-wide antibiogram data. Discussions are underway with the microbiology laboratory to provide the appropriate antibiotic resistance reporting.
- On-going. Occupational Health service capacity. This issue has improved now that a clinical lead of the Occupational Health service has been appointed, but remains on the IPC risk register.
- On-going. Challenges within Estates related to responsiveness, ventilation and water hygiene management. Estates has been asked to provide a monthly report to the HCAI Taskforce group, providing exception reports of areas of concern in terms of water hygiene and ventilation.
- On-going. A limited capacity to perform surveillance of HCAI, specifically related to surgical infections. A business case to build an SSI surveillance team is under development.

8 Other issues

8.1 Single room audit

The proportion of single rooms in general ward areas (excluding critical care and some other specialist areas) is summarised in Figure 15. The proportion of single rooms suitable for IPC isolation at the three sites is 19.5% at SMH, 33.7% at HH, and 23.8% at CXH. This compares with 18.1% at SMH, 30.9% at HH, and 24.0% at CXH the last time the survey was performed. The limited number of rooms suitable for IPC isolation is included on the IPC risk register.

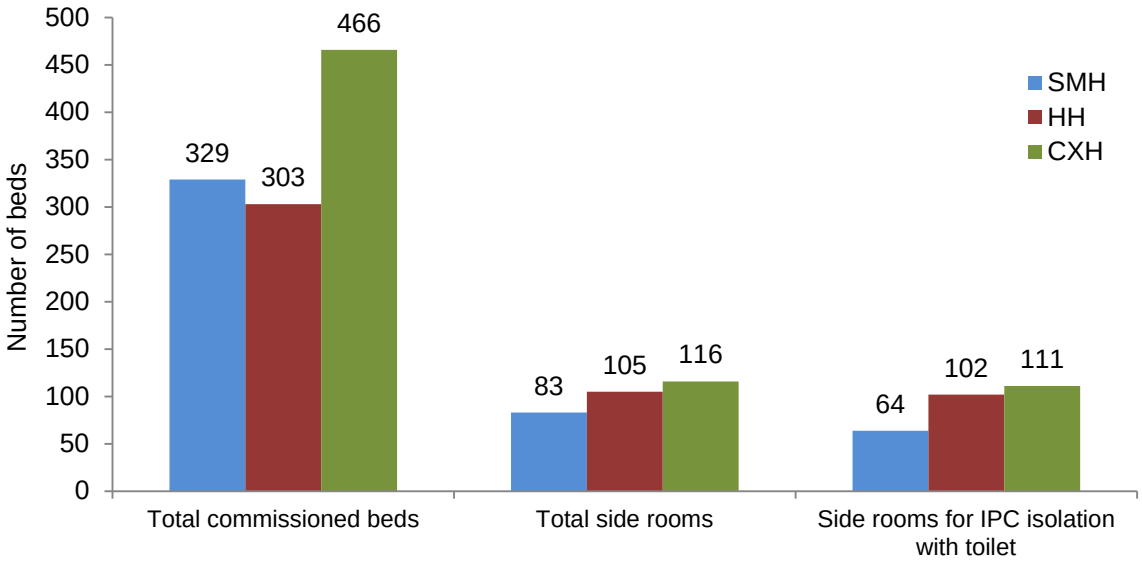


Figure 15: Summary of total number of commissioned beds, single rooms, and single rooms suitable for IPC isolation (with toilet), by site.

8.2 Respiratory virus trends

The number of respiratory viruses reported, by week, is summarised in Figure 16. This shows the expected increases in winter respiratory viruses, such as Rhinovirus.

IPC have undertaken a number of lookbacks related to cases of chickenpox (3 in total, 2 at SMH, 1 at HH), and measles (3 in total, 1 at CXH, 2 at SMH). These lookbacks have been supported by PHE and have resulted in a review of how these incidents are managed.

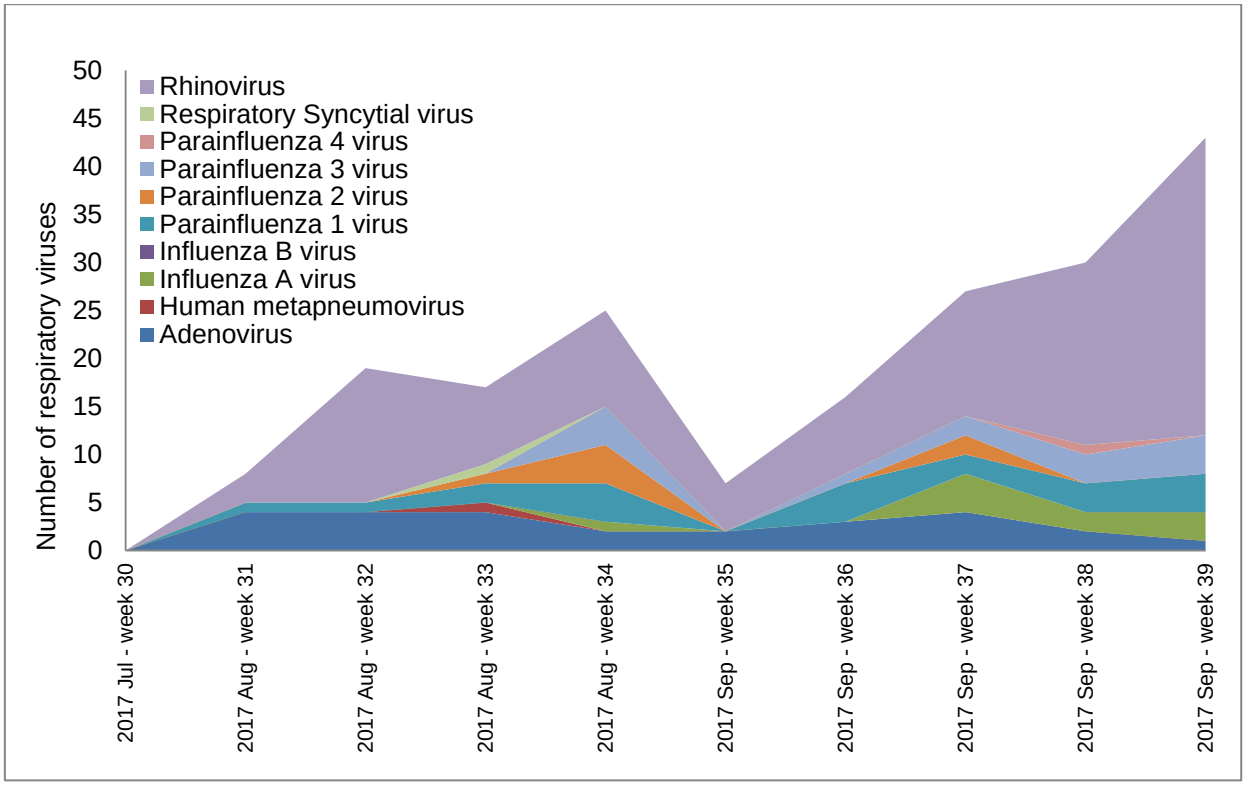


Figure 16: Number of respiratory viruses detected, by week.

9 Publications in Q2

Human resources estimates and funding for antibiotic stewardship teams are urgently needed. Pulcini C , Morel CM, Tacconelli E, Beovic B, de With K, Goossens H, Harbarth S, Holmes A, Howard P, Morris AM,. Nathwani D, Sharland M, Schouten J, Thursky K, Laxminarayan R, Mendelson M. Clin Microbiol Infect, online August 2017

Towards a minimally invasive device for beta-lactam monitoring in humans. Rawson TM, Sharma S, Georgiou P, Holmes A, Cass A, O'Hare D Electrochemistry Communications, July 2017 online

Opportunities for system level improvement across antibiotic use in the surgical pathway. Charani E, Ahmad R, Tarrant C, Birgand G, Leather A, Mendelson M, Moonesinghe SR, Sevdalis N, Singh S, Holmes A. Int J Infect Dis, July 2017

Addressing the unknowns of antimicrobial resistance: quantifying and mapping the drivers of burden. Knight GM, Costelloe C, Murray KA, Robotham JV, Atun R, Holmes AH. Clin Infect Dis 2017 Aug 23.

Combination therapy for carbapenemase-producing Entero-bacteriaceae: INCREMENT-al effect on resistance remains unclear. Boyd SE, Moore LSP, Rawson TM, Hope WW, Holmes AH. Lancet Infect Dis. 2017 Sep;17(9):899-900.

What Makes a Tweet Fly? Analysis of Twitter Messaging at Four Infection Control Conferences. Mitchell BG, Russo PL, Otter JA, Kiernan MA, Aveling L. Infect Control Hosp Epidemiol. 2017 Aug 22:1-6. doi: 10.1017/ice.2017.170. [Epub ahead of print]

Involving citizens in priority setting for public health research: Implementation in infection research. Rawson TM, Castro-Sánchez E, Charani E, Husson F, Moore LSP, Holmes AH, Ahmad R. Health Expect. 2017 Jul 21. doi: 10.1111/hex.12604. [Epub ahead of print]

Faecal microbiota transplant: a novel biological approach to extensively drug-resistant organism-related non-relapse mortality. Innes AJ, Mullish BH, Fernando F, Adams G, Marchesi JR, Apperley JF, Brannigan E, Davies F, Pavlů J. Bone Marrow Transplant. 2017 Oct;52(10):1452-1454.

Can Copper-Coated Surfaces Prevent Healthcare-Associated Infections? Weber DJ, Otter JA, Rutala WA. Infect Control Hosp Epidemiol. 2017 Jul;38(7):772-776.

Blogging in Infectious Diseases and Clinical Microbiology: Assessment of 'Blogosphere' Content. Birgand G, Troughton R, Moore LSP, Charani E, Rawson TM, Castro-Sánchez E, Holmes AH. Infect Control Hosp Epidemiol. 2017 Jul;38(7):832-839.

Secondary use of data from hospital electronic prescribing and pharmacy systems to support the quality and safety of antimicrobial use: a systematic review. Micallef C, Chaudhry NT, Holmes AH, Hopkins S, Benn J, Franklin BD. J Antimicrob Chemother. 2017 Jul 1;72(7):1880-1885.

A systematic review of clinical decision support systems for antimicrobial management: are we failing to investigate these interventions appropriately? Rawson TM, Moore LSP, Hernandez B, Charani E, Castro-Sanchez E, Herrero P, Hayhoe B, Hope W, Georgiou P, Holmes AH. Clin Microbiol Infect. 2017 Aug;23(8):524-532.

Efficacy and acceptability of rectal and perineal sampling for identifying gastrointestinal colonization with extended spectrum β-lactamase Enterobacteriaceae. Dyakova E, Bisnauthsing KN, Querol-Rubiera A, Patel A, Ahanonu C, Tosas Auguet O, Edgeworth JD, Goldenberg SD, Otter JA. Clin Microbiol Infect. 2017 Aug;23(8):577.e1-577.e3.

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Quality Strategy 2018-2021

Executive summary:

The Trust's current quality strategy is due to end in 2018 after its three year life span. The new quality strategy will be published in June 2018 at the same time as the Trust quality account.

The Trust's approach and methodology for quality improvement and the associated programme had not been launched when the current strategy was written and so it has been increasingly difficult to describe how these are aligned. The new strategy will allow us to clearly articulate how our improvement methodology is at the heart of our approach to quality and how we plan to further strengthen and develop this going forward. It is also an opportunity for us as an organisation to explore the improvement journey that we want to set for the coming three years i.e. how we will deliver our aims for quality using our agreed methodology rather than the current list of projects targets.

This gives us the opportunity to decide which of our previous targets we want to carry over to the new strategy and what will now become 'business as usual' as well as our priorities for improvement going forward.

Importantly it also gives us the opportunity to engage with our staff, our patients, the public and external stakeholders in the development of the strategy in a meaningful way.

The attached paper outlines our plans to co-design the new 2018-2021 strategy. It also summarises progress to date and the timeline for delivery.

Quality impact:

The trust's quality strategy is the plan through which we focus on the quality of clinical care, ensuring that quality is central to all that we do and that we are focused on continuous improvement at all levels of the organisation.

The strategy is designed to deliver improvements in all five quality domains, ensuring our services are safe, effective, caring, responsive and well-led.

Financial impact:

This paper has no financial impact.

Risk impact:

There are numerous risks associated with delivery of the quality strategy goals and targets, which are described in the trust's corporate risk register.

Recommendation(s) to the Board:
The Board is invited to give feedback on our approach to developing the 2018-2021 quality strategy.
Trust strategic objectives supported by this paper:
To achieve excellent patient experience and outcomes, delivered efficiently and with compassion. To educate and engage skilled and diverse people committed to continual learning and improvements. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care. To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Eleanor Carter, Compliance and Assurance Improvement Lead	Julian Redhead, Medical Director	18 November 2017

Quality Strategy 2018-2021 – targets and timetable

Purpose of the report: The purpose of this paper is to outline the proposed approach for the development of the next version of the Trust quality strategy, and the timetable for delivery.

Introduction:
The Trust's current quality strategy is due to end in 2018 after its three year life span. The new quality strategy will be published in June 2018 at the same time as the quality account.

The current strategy sets out our quality goals under the five CQC domains (safe, effective, caring, responsive and well-led) with associated targets. Progress is reported against these as part of the monthly quality report (to executive quality committee and the board sub-committee for quality) and annually in the quality account.

The Trust's approach and methodology for quality improvement and the associated programme had not been launched when the current strategy was written and so it has been increasingly difficult to describe how these are aligned. The new strategy will allow us to clearly articulate how our improvement methodology is at the heart of our approach to quality and how we plan to further strengthen and develop this going forward. It is also an opportunity for us as an organisation to explore the improvement journey that we want to set for the coming three years i.e. how we will deliver our aims for quality using our agreed methodology rather than the current list of projects and targets.

This gives us the opportunity to decide which of our previous targets we want to carry over to the new strategy and what will now become 'business as usual' as well as our priorities for improvement going forward.

Importantly it also gives us the opportunity to engage with our staff, our patients, the public and external stakeholders in the development of the strategy in a meaningful way.

Approach to consultation and development of the strategy:
It is important that we engage people internally and externally in the development of the strategy in a meaningful way. This includes our staff, patients, carers, the public and our external stakeholders including CCGs, local councils, Healthwatch and lay partners.

A refreshed approach was presented to our strategic lay forum in October who were supportive of the following proposals:

- **Engagement & Listening campaign**
  A formal engagement and listening campaign which will be launched at the end of 2017, led by the Improvement team. This will allow us to build on intelligence we have already gathered from our staff and patients through the safety attitudes questionnaire, our staff survey, complaints, PALs, FFTs etc. The intelligence will be used as the baseline for a series of co-design workshops during January 2018.

  In addition a "quality" roadshow will be taken to all hospital sites which will be an opportunity to engage with our staff and patients in an informal setting e.g. at open events, training events, entrance foyers.

It is proposed that the stories we hear from patients, staff and our public are used in the strategy with an invitation to tell us what is important to them. We also want to include priorities that they want us to improve.

- **Co-design workshops**
  Co-design workshops will run throughout January 2018. Staff who have completed the coaching and leading for improvement programme will be invited to participate in these workshops. The strategic lay forum will be key participants as well as our patients, commissioners and external stakeholders.

  These workshops will be structured using improvement methodology to develop the aims for the strategy and the resultant drivers and improvement programmes.

- **Development of a quality network**
  We see the co-design of the strategy as only the beginning of the journey. We plan to develop of a network of people who are passionate about improving the quality of our services. This movement will be developed with leadership from the improvement team and will be key to the ongoing engagement and continuous improvement.

Progress:
Work to develop the listening campaign is already underway and a core project team has been set up with representatives from a number of departments across the organisation including communications, the improvement team, HR and the nursing directorate. The team have started to share intelligence we already have across the Trust which will be used to inform the campaign. In addition a wider steering group has been formed to oversee and advise on plans and progress with representation from Heatlhwatch, our strategic lay forum and Citizens UK.

The Trust has engaged Citizens UK to support with the development and delivery of the listening campaign. In early November they hosted a session on community organising for the steering group.

Timeline

Key Dates	
November 2017	Launch of engagement and listening campaign
December – January 2017	Co-design workshops on all hospital sites & quality “roadshow”
February 2018	Analysis of feedback and write first draft of Quality Strategy
March & April 2017	Draft Quality Strategy out for consultation (internal and external)
May 2018	Quality Strategy approved by Trust Board, Executive Quality Committee and Quality Committee
June 2018	Annual Quality Accounts published against the last year of the 2015-2018 Quality Strategy 2018-2021 Quality Strategy published

Recommendations to the committee:
The Board is invited to give feedback on our approach to developing the 2018-2021 quality strategy.

Imperial College Healthcare NHS
NHS Trust

Report to:	Date of meeting
Trust board – public	29 November 2017

Research: Quarterly Report

Executive summary:

This report presents a summary of recent progress with respect to various clinical research initiatives within the Imperial Academic Health Science Centre (AHSC). It covers the NIHR Imperial Biomedical Research Centre (BRC), activity on the NWL Clinical Research Network portfolio, commercially-sponsored research, and any other relevant research-related news.

Quality impact:

The quality and scale of biomedical and clinical research carried out across the Imperial AHSC will impact patient care in the future in terms of innovative treatments, diagnostics and devices. Research activity includes many specific examples of patient benefit. Patient and public involvement in research is enabled through the Imperial Patient Experience Research Centre (PERC), and a strategy exists to involve and engage patients and the public in the research we do.

Financial impact:

This paper has no direct financial impact. However, overall research income to ICHT is valued at ~£48m per annum. Delivery of high quality clinical research (experimental and applied) for the benefit of patients is essential to future revenue streams, to the reputation of the AHSC, and to the continuation of a culture of innovation and continuous improvement.

Risk impact:

The risks associated with research are financial and reputational. Competition for research funds is extremely high and Imperial must continue to demonstrate a high level of high-quality research outputs and activity, as well as value for money.

Recommendation(s) to the Board:

The Trust Board is asked to note the recent developments in clinical research.

Trust strategic objectives supported by this paper:

As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care. To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Paul Craven, Head of Research Operations	Dr Julian Redhead, Medical Director	8 November 2017

RESEARCH: QUARTERLY REPORT: October 2017

Purpose of the Report:

The purpose of this report is to provide an update on recent progress with respect to the various sources of funding for clinical R&D, and an indication of forthcoming priorities and actions in 2017-2018.

1) NIHR Imperial Biomedical Research Centre (BRC): 2017-22

- Since starting in April 2017, the NIHR Imperial BRC (£90.1m 2017-22) has now implemented more than 130 individual projects in experimental medicine.
- The following changes to leadership and management of the BRC have taken place in the previous quarter;
    - Professor Jonathan Weber has stepped down as BRC Director to take on the position of Acting Dean in the Faculty of Medicine;
    - Professor Mark Thursz has been appointed as Interim BRC Director;
    - The permanent BRC Director position is progressing;
    - The BRC Office has recruited 3 Research Programme Managers, reconfiguring the office with each now having responsibility for all operations in 4 Themes.
- We responded to an opportunity to bid for DH/NIHR capital funding to support the BRC's research into Anti-Microbial Resistance (AMR). A £2.9m proposal was submitted on 27 October requesting a) refurbishment of space to establish a dedicated clinical research microbiology laboratory, b) an expanded bioresource for infectious diseases, c) a faecal matter transplantation (FMT) lab space, plus d) various items of equipment to support research into;
    - optimising the use of current antibiotic agents via precision prescribing and diagnostics,
    - researching methods to reduce AMR transmission and outbreaks, and
    - developing alternative strategies for treatment and decolonisation.

There are 8 Research Themes within the BRC, each with a devolved budget and focusing on a number of projects/programmes. Highlights are as follows, giving a flavour of some of the experimental medicine research being undertaken within (and supported by) the BRC:

Brain Sciences (Professor Paul Matthews)

- Professor David Nutt and colleagues have received approval to begin the world's first trial of MDMA, the active ingredient in ecstasy pills, to determine whether – in conjunction with psychotherapy – it could help patients overcome alcohol addiction more effectively than conventional treatments.

Cancer (Professor Charles Coombes)

- Chronic myeloid leukaemia (CML) is a type of cancer where too many white blood cells are produced. Tyrosine kinase inhibitor (TKI) therapy has transformed the outcomes of patients with this disease. Most of these patients are now expected to live a normal life span, provided they continue TKI treatment for the rest of their lives. However prolonged exposure to TKIs often leads to adverse side effects, thereby reducing patients' quality of life. Taken together with a high cumulative cost of TKI treatment, patients and professionals have questioned whether treatment de-escalation or discontinuation could be a feasible solution for some CML patients.
  Imperial Department of Haematology was one of the largest recruitment sites participating in a phase II trial (DESTINY) – in collaboration with centres in Glasgow, Liverpool and Newcastle – investigating whether CML patients with excellent response are being over-treated, and if effective disease control is possible at either a lower TKI dose, or without

treatment at all. Monthly monitoring for all patients in the study was carried out at Imperial Molecular Pathology central laboratory at Hammersmith Hospital, supported by NIHR Imperial BRC and led by Jane Apperley, Dragana Milojkovic and Letizia Foroni. Results of an interim analysis of this study, published in The Lancet Haematology, demonstrated that decreasing the dose of TKIs in half proved to be a feasible and safe approach for 98% of patients with prolonged deep molecular response, as well as in 81% of patients with molecular recurrence. All patients who relapsed during the study (12 out of 174) returned to stable disease or better within 4 months of resuming full dose of TKI treatment. Furthermore, there was a general improvement in quality of life of patients in both groups, with no new side effects reported. In addition to positive patient outcomes, halving the dose of treatment translated into impressive savings in TKI costs (~£1.9m per year). Taken altogether, the data implies that CML patients with stable response or better could be unnecessarily over-treated.

- Prof Iain McNeish from the Beatson Institute, Univ of Glasgow, has been appointed to the Chair of Oncology, with a particular interest in ovarian cancer research. He will be in post from November 2017.

Cardiovascular (Professor Sian Harding)

- A new study led by researchers from the Imperial BRC (Neil Poulter, Peter Sever and others), published in The Lancet, has shown that patients report more side effects when they know they are taking a statin than when they are not told whether they are taking the actual drug or a placebo pill. The team analysed data from a large randomised clinical trial – called the ASCOT study – in which patients were randomly chosen to receive either a statin or a placebo, but were not told which they were taking. Analysis of the trial data revealed that when patients knew they were taking statins, reports of muscle-related side effects in particular increased by up to 41%. On the other hand, if patients were unaware whether they were taking a statin or a placebo, the number of side effects reported was similar in both groups. This “nocebo” effect (where muscle-related symptoms worsen when patients know they are taking the drug) may explain the difference between patient reports in clinical trials, which have found little to no increase in side effects, and those in observational studies, where up to one-fifth of the patients report side effects.
- The Acute Coronary Syndrome (ACS) theme of the NIHR Health Informatics Collaborative (NHIC) is preparing its first publication for submission. Using routinely-collected electronic clinical information from more than 250,000 patients in 4 NHS Trusts, standardised and anonymised, this project provides a very large pool of data to help our understanding of the factors that are important in the outcome of patients with acute coronary syndromes.

Gut Health (Professor Elaine Holmes)

- Imperial has launched the Nutrition and Food Network with the aim of bringing together researchers from different faculties with diverse expertise to focus on the major health problems associated with diet. Professor Gary Frost, Chair in Nutrition and Dietetics at Imperial College, and a key researcher in the NIHR Imperial BRC Metabolic Medicine and Endocrinology Theme, is head of the new network.
- In collaboration with the Infection & AMR Theme, Prof J Marchesi has begun a BRC-funded project entitled “Faecal microbiota transplantation as a novel tool to decolonise Multi-Antibiotic Resistant infections of the gut”. Faecal microbiota transplantation (FMT) is the transfer of faecal material containing bacteria and natural anti-bacterials from a healthy individual into a recipient patient.

Immunology (Professor Marina Botto)

- The BRC has helped to establish a joint flow cytometry facility at Hammersmith, in partnership with the MRC London Institute of Medical Sciences, under the leadership of Professor Marina Botto. The analysis and physical isolation of cells according to their phenotypic and functional properties is an essential technique in cell biology. By measuring the fluorescence emitted by individual cells labelled with fluorescent probes, specific subpopulations of cells can be characterized and isolated for further investigation.

As such, the flow cytometry facility is a valuable component of our clinical research infrastructure, providing services to a number of Themes.

Infection & AMR (Professor Peter Openshaw)

- A device with the potential to revolutionise the diagnosis and treatment of sepsis was unveiled at an Imperial College / Royal Institution event, showcasing the best in British technology in combatting global infection. Sepsis is a potentially life-threatening condition caused by bloodstream infections which can lead to multiple organ failure, proving fatal in approximately 6 million people worldwide and 44,000 people in the UK each year. Currently, diagnosis of sepsis can take several days; the novel, point of care LiDiaTM test uses semiconductor-based genomic analysis technology to detect up to 95% of sepsis-causing infections within 2-3 hours. The technology which forms the basis of this test has been developed by Professor Chris Toumazou, founder of DNA Electronics and Regius Professor at the Department of Electrical and Electronic Engineering at Imperial. The NIHR Imperial BRC has supported multiple collaborations to investigate semiconductor technology applied to point-of-care diagnostics in a variety of clinical conditions. Professor Anthony Gordon (NIHR Research Professor) is working with the NIHR London IVD Cooperative (Professor George Hanna) to move this work into early clinical trials.

Metabolic Medicine (Professor Steve Bloom)

- Dr Isabel Garcia Perez, Lecturer in Precision & Systems Medicine at Imperial, has won a Developing Capacity award from the BRC's most recent ITMAT call for proposals. The project is entitled "Assessing the impact of a healthy and an unhealthy diet on gut microbial metabolites".
  Bacterial transformation of dietary components may play a critical role in host health and disease. For example, the production of short-chain fatty acids by the gut microbial community from dietary fibre has been related with appetite regulation and glucose homeostasis. However understanding how changes in dietary habits of healthy people affect gut microbial metabolites will provide a deeper insight into diet-microbiota-host interactions which is necessary for the development of future strategies for microbiota modulation. A total of 120 gut microbial metabolites will be targeted by mass spectrometry (funded by the BRC) in the urine and serum samples collected during an in-patient clinical trial. In addition, a cohort of 225 urine samples from the UK INTERMAP population will be measured. This outcome of the project will be an initial understanding of the relationship between gut microbial metabolites, diet and clinical measurements related to the risk of development of non-communicable diseases.

Surgery & Technology (Professor Ara Darzi)

- The Surgery & Technology Theme are about to begin two 'first in human' trials of robotic systems, both supported by the BRC. The first is a study of CYCLOPS, a novel robotic tool for single-access and natural-orifice endoscopic surgery. The second is of a technology known as micro-IGES – a robot with bimanual controls designed for incision-less transanal microsurgery, integrating novel mechatronics, force/contact sensing, and noninvasive structural and endo-microscopic imaging. The 'arm' has been trialled in patients and this study will be a first-in-human validation of whole robotic system.

Cross-Cutting Themes

- There are 5 Cross-Cutting Themes within the BRC, providing core platforms and technologies: Genetics & Genomics (Professor Jorge Ferrer), Imaging (Professor Eric Aboagye), Informatics & Biobanking (Professor Paul Elliott) and Molecular Phenomics (Professor Jeremy Nicholson), and Core Costs. Together with the Data Science Institute, ICHT Research Informatics and Computational Medicine, these form ITMAT – the BRC's Institute for Translational Medicine and Therapeutics.

2) NWL Clinical Research Network 2017/18

- NWL CRN received a 5% uplift overall in its allocation for 17/18 (to just over £14m). As a partner organisation, ICHT has been allocated a total of £4.2m of Activity Based Funding

(ABF) for 2017/18 from the NWL Clinical Research Network. This funding has been disbursed to Divisions and to essential clinical services to support delivery of non-commercial studies. Allocations are based on retrospective recruitment activity over the past 2 years (with activity weighted for study complexity).

- According to NWL CRN data, as of 27 October 2017 ICHT had recruited 7,089 patients to date in the 17/18 financial year, across 294 individual studies. This is against a year-to-date target of 5,884 and a full-year target of 10,087, meaning that ICHT is comfortably ahead of its recruitment objective as this stage of the year (i.e. 7 months in).
- ICHT is 7th nationally at this point of the year, in terms of absolute numbers of participants recruited to NIHR Portfolio studies (Figure 1 below). This is one place lower than the previous year.
- Work to support initiation and delivery of studies to time and target is continuing, through interfacing of our local trial management database with central systems, and reviewing operational processes. In addition, the ICHT team of the Joint Research Office (JRO) has experienced a number of significant staffing changes over the past 12-18 months. We are re-organising management and leadership of the office, and moving to employ permanent staff rather than agency staff in critical areas such as contract negotiation and costing.
- Ultimately however, recruitment of patients to portfolio studies depends on the level of delivery staff resource allocated by the NWL Clinical Research Network each year, and on the availability of consultants to act as Principal Investigator on studies.
- ICHT is already among the most efficient Trusts in the country, when looking at 'patients recruited per £ allocated'. NWL as a region is second in terms of the number of patients it recruits per head of population.

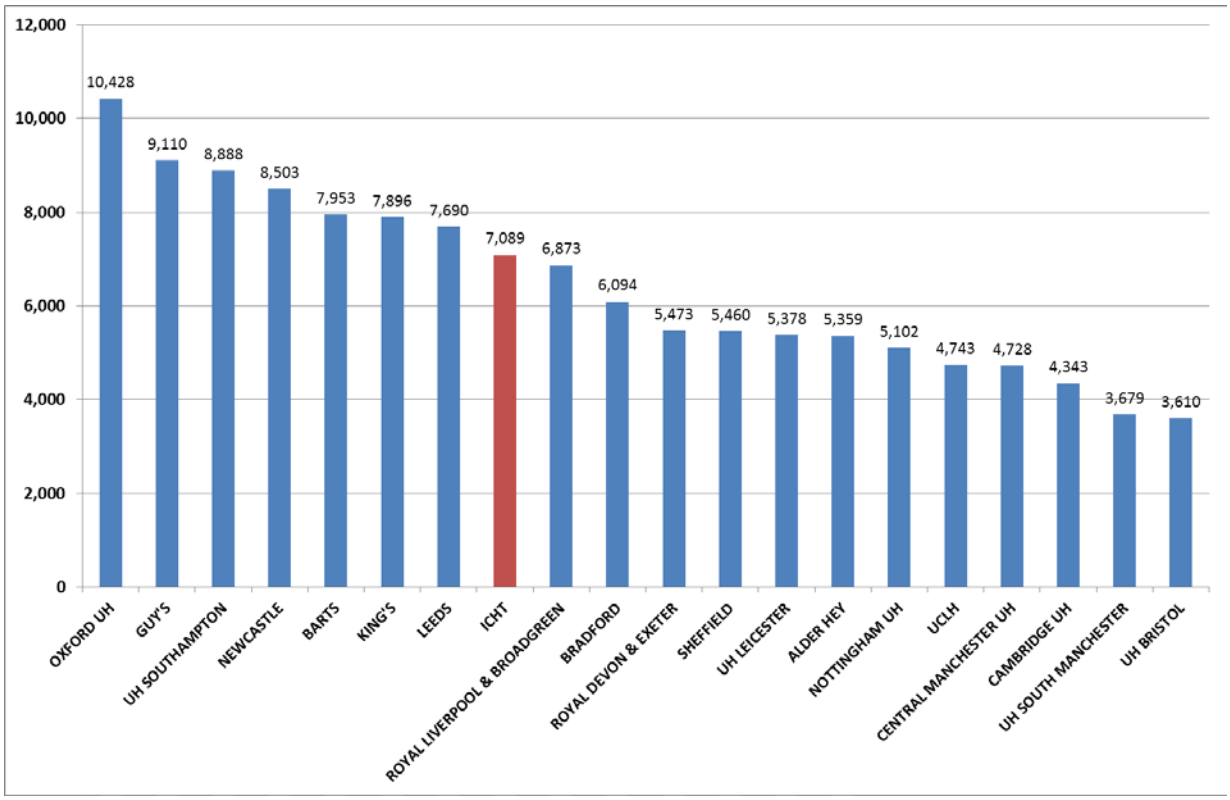


Figure 1. Participant recruitment to NIHR portfolio studies to date 17/18 (by NHS Trust).

3) Commercial Clinical Research

- Approximately 90-100 new commercially-sponsored clinical trials are hosted by ICHT each year, from a variety of external companies (pharma, biotech, medtech, CROs). This is a competitive global market and commercial trials generate revenue for ICHT.
- For these trials (generally later phase), the sponsoring company assumes the legal and

financial management responsibilities under the Research Governance Framework and, as such, also takes on risks relating to study design, patient safety, IMP preparation, etc. The Sponsor usually has rights to any intellectual property that emerges.

- ICHT acts as a host site – providing access to / consent / recruitment of eligible patients within its own clinical space, and carrying out the relevant procedures as specified in the protocol (e.g. blood tests, scans, IMP administration).
- Figure 2 shows the number of new commercially-sponsored studies registered at ICHT per year since 2014. Already, at 10 months through the current calendar year, 94 such studies have registered at ICHT and have either started, are in set-up or are being assessed for feasibility (already more than in 2016 in total).
- Figure 3 shows the number of new commercial trials started in this period, by sponsor. Gilead, Novartis and Merck are the top 3 sponsors for ICHT.
- ICHT negotiates a 'price per patient' to cover the full cost of each trial. This has been a growing income stream (see Figure 4).
- Work is underway to identify opportunities for growing commercial trial activity, working with the Divisions and Principal Investigators to ensure appropriate systems and incentives are in place, and to develop frameworks for re-investing revenue to deliver additional capacity in R&D.

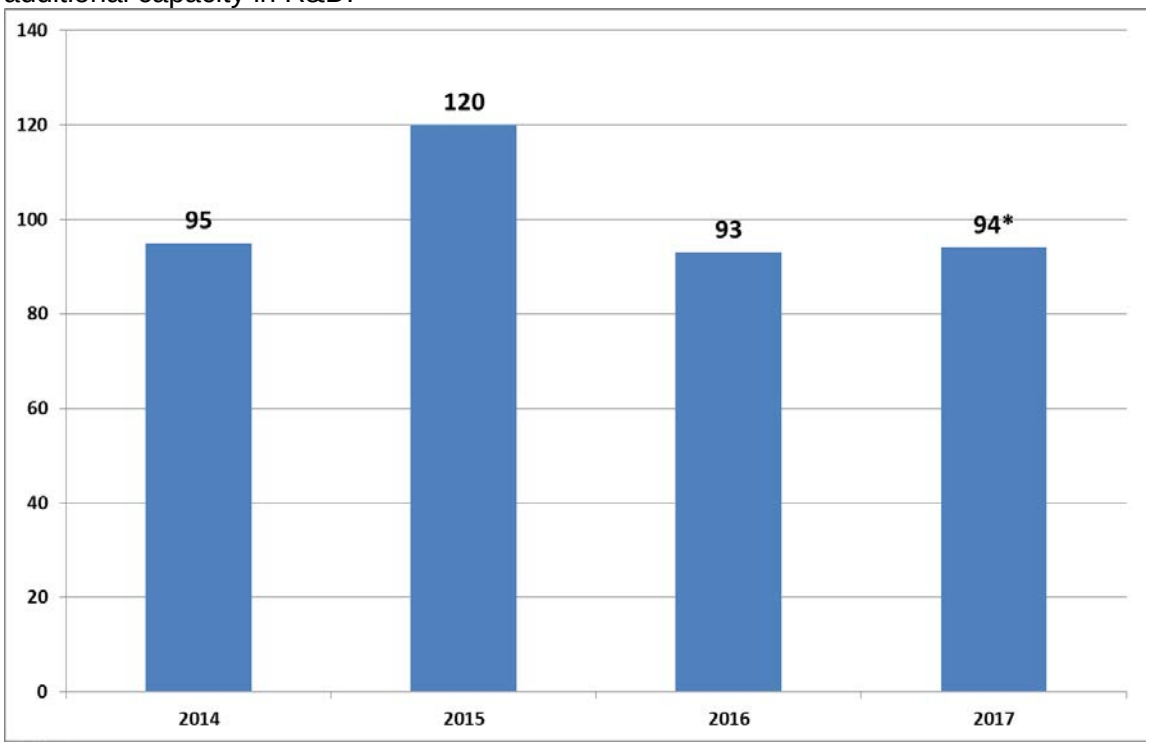


Figure 2. Number of new commercially-sponsored studies registered on ICHT study management system (as of 27/10/17; **year to date*)

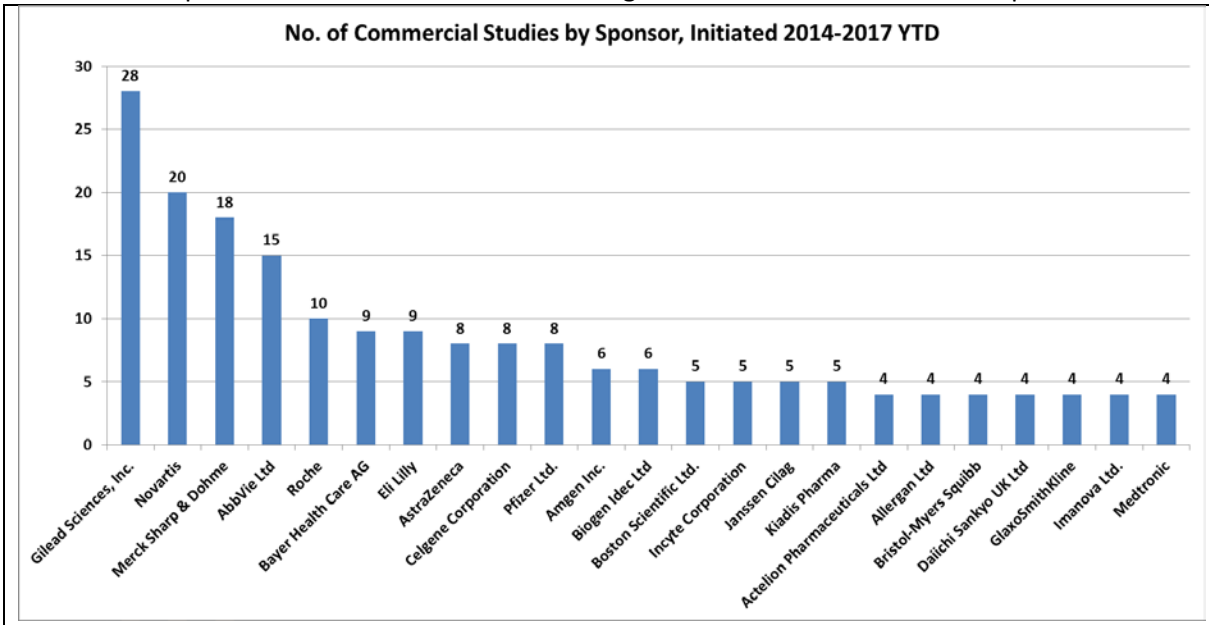


Figure 3. Number of new commercially-sponsored studies (registered on DOCUMAS) by sponsor, for period 2014-2017 YTD.

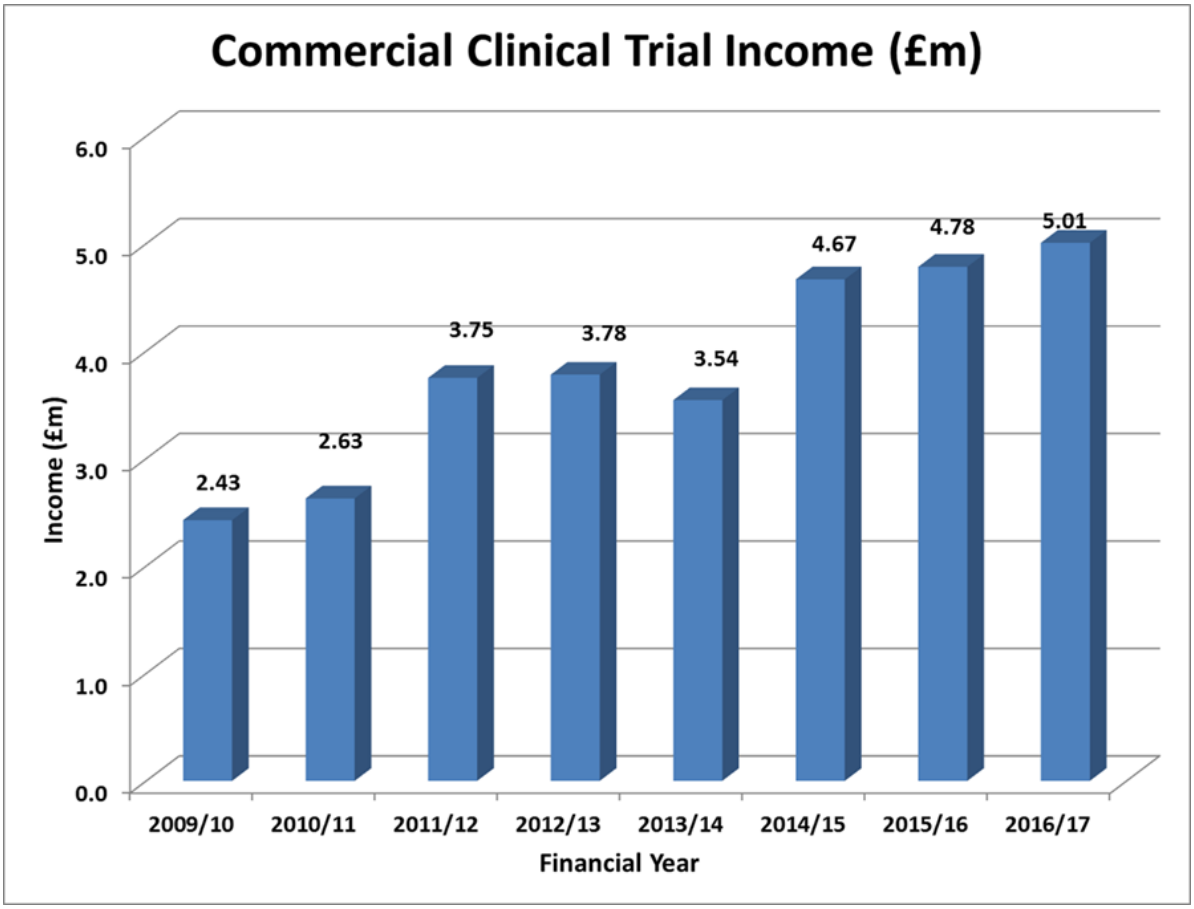


Figure 4. Growth in commercial clinical trials income at ICHT since 2009/10.

4) Performance in Initiating Clinical Research (NIHR 70-day metric)

- As a BRC contractual obligation, NIHR/DH require that – for all interventional clinical trials – the first patient is recruited within 70 calendar days of a "valid document pack" being submitted to ICHT. Previous work has established the principle of requiring study feasibility, contract negotiation, and liaison with support services to be initiated as soon as possible and, if possible, before submission of a full set of study documents which

represents 'clock start'.

- ICHT completed its most recent (Q2 2017/18) metrics submission via the BRC Office in October. This encompassed all interventional clinical trials which were given 'confirmation of capacity and capability (CCC)' in the 12-month period 1 October 2016 to 30 September 2017. Figure 5 shows ICHT performance against selected other 'peer' NHS Trusts. We are forecasting performance of 68% for Q2 17/18 (to be confirmed by NIHR), against our internal performance target of 90%.
- The most recent results reflect the impact of the full implementation of the new Health Research Authority (HRA) approvals process. The main reason for longer approval times in the new system is that the full duration of contract negotiation (with Sponsors) must now be included within the strictly-defined study initiation window of 70 days. This is challenging as the contract negotiation process must also ensure appropriate insurance/indemnity protection for patients in the trials and for ICHT, and also recovery of appropriate costs.
- Average approval times have increased nationally in the last three quarters, meaning that many NHS Trusts are no longer meeting the 70-day benchmark (see Figure 5). ICHT are reviewing processes for contractual review and negotiation, to identify ways of shortening these approval times and coming back within our target metric. This is likely to take another two quarters to achieve given the inherent lag involved in the clinical trials submission and set-up process.

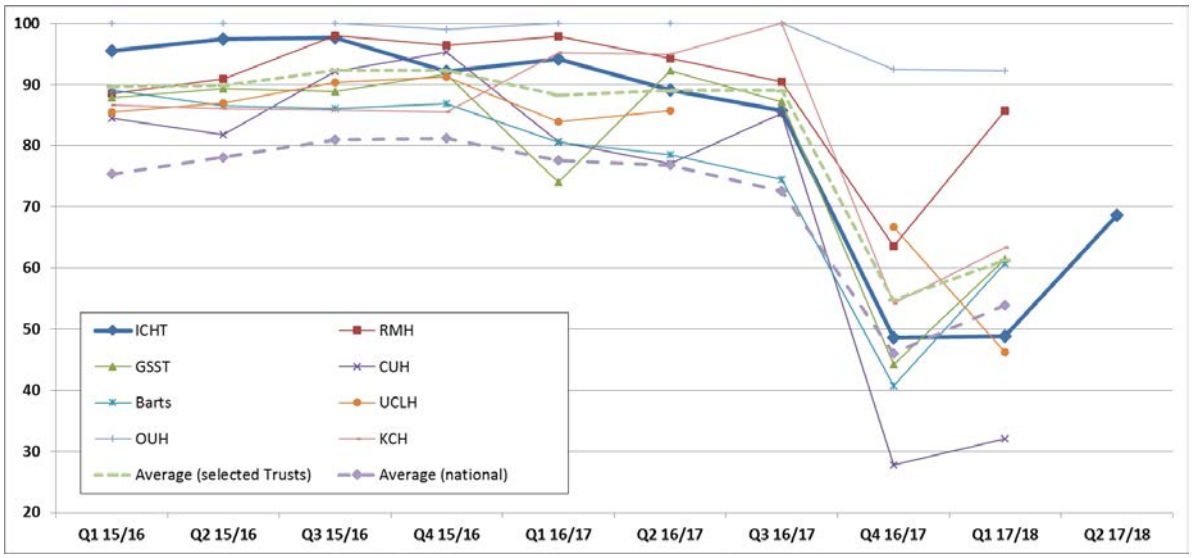


Figure 5. Performance against NIHR 70-day metric, compared to other selected NHS Trusts (Q2 17/18 data-point is estimated by ICHT, subject to confirmation by NIHR).

5) Additional Points to Note

- Professor Mark Thursz has taken over as Interim BRC Director as of 1 October 2017, and will review all current Themes and funded initiatives. Paul Craven has been appointed Head of Research Operations in the Faculty of Medicine with responsibility for all JRO grants and contracts operations (College and ICHT). This enables opportunities for improved process efficiencies around costing of research, study set-up, and contract negotiation.
- A joint response from ICHT and the College was submitted over the summer to the recent consultation from NIHR/DH entitled "Health Futures: 20 year forward view". The final report, compiled by RAND, can be found here: https://www.rand.org/randeurope/research/projects/exploring-healthfutures.html
- The Life Sciences: Industrial Strategy report by Professor John Bell, to the government from the life sciences sector, has been published: https://www.gov.uk/government/publications/life-sciences-industrial-strategy

- The NIHR Strategic Review of Training has recently been published: https://www.nihr.ac.uk/our-faculty/documents/TCC-NIHR-Strategic-Review-of-Training-2017.pdf

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board – public	29 November 2017

Freedom to Speak Up Guardians

Executive summary:

The standard NHS contract requires all trusts and foundation trusts to nominate a Freedom to Speak Up Guardian.

The purpose of this paper is to facilitate a discussion between the board and the guardians and agree how the guardians will engage with the board in the future.

The Trust currently has five FTSU guardians across a variety of departments, with representation on each of the main sites.

Measures taken to increase the guardians' profile include circulating their contact details in payslips, promotion through In Brief, the source and a screensaver, and updating the raising concerns policy to reflect their roles.

The guardians will be meeting with the CQC as part of the Well-Led inspection in December 2017 to discuss their roles.

The areas for discussion will be case studies, challenges of the role and future engagement with the board.

Quality impact:

The FTSU guardian service will positively impact the quality of care through supporting staff to raise concerns about patient care.

Financial impact:

There is no financial impact of this paper.

Risk impact:

The FTSU guardian service reduces the risk of staff not feeling able to report concerns.

Recommendation(s) to the Committee:

The board is asked to note the contents of this report

Trust strategic objectives supported by this paper:

Making the Trust a great place to work.
Making our care safer

Author	Responsible executive director	Date submitted
Barbara Britner, Associate Director & Mia Hull, HR Manager	David Wells Director of People and Organisation Development	22 November 2017

Introduction

The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in "Freedom to Speak Up" in 2015. The standard NHS contract requires all trusts and foundation trusts to nominate a Freedom to Speak Up Guardian. The role is not centrally funded, with trusts being expected to implement the role according to local need and resources.

The purpose of this paper is to facilitate a discussion between the board and the guardians and agree how the guardians will engage with the board in the future.

1. The role of a Freedom to Speak Up Guardian (FTSU)

Acting in a genuinely independent capacity, the FTSU Guardian will be appointed by the Board, working alongside them and members of the executive team to help support the organisation to become a more open, transparent place to work.

FTSU Guardians are responsible for supporting staff to raise concerns and facilitate escalation, where appropriate. The role is to increase the profile of the raising concerns process within the organisation and provide confidential advice and support to staff in relation to concerns they have or the way their concern has been handled.

Guardians do not have a remit to assist staff who are employed outside of their trust, or get involved in investigations or complaints. They are there to help facilitate the process where needed, ensuring organisational policies in relation to raising concerns are followed correctly.

The characteristics of the individual are outlined in detail and require that they be an approachable, trusted, non-judgemental individual, who is comfortable with talking with 'front line' staff from all disciplines and all grades and can build a rapport which demonstrates compassion and understanding. The role specification is listed at appendix 1.

2. The role of the FTSU at the Trust

The Trust currently has five FTSU guardians across a variety of departments, with representation on each of the main sites. All FTSU guardians were appointed following informal recruitment processes, overseen by Nick Ross, Non-Executive Director. They come from a broad range of backgrounds in profession, personal characteristics, banding and location and so are representative of the workforce.

- 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

The remit of the FTSU guardian role is to support staff to raise concerns, facilitate escalation and increase the profile of the raising concerns process. There is an expectation that the guardians will work alongside Trust leadership teams to support the organisation in becoming a place where all staff are actively encouraged and enabled to speak up safely. As such, it is important that the FTSU guardians have access to the Trust board, so they have the opportunity to champion concerns at the most senior levels of the organisation.

The guardians have been supplied with a mobile telephone and dedicated number. A generic email address has also been set up. Measures taken to increase the guardians' profile include circulating their contact details in payslips, promotion through In Brief, the source and a screensaver, and updating the raising concerns policy to reflect their roles. FTSU guardians attended the great place to work week road shows during the last week of September 2017 to meet with staff and promote the service. Their roles are also promoted at the Trust Corporate and Junior Doctors' inductions and CEO sessions.

While the profile of the guardians has been raised in recent months, there is further work to be done in this area. A poster that has been designed by the guardians is going to be prominently displayed across the organisation. A speak up campaign is being planned to enhance a culture of speaking up as positive and to remove the stigma attached to whistleblowing.

As this is a role carried out in addition to the guardians' substantive roles, it can be difficult to dedicate time.

The guardians will be meeting with the CQC as part of the Well-Led inspection in December 2017 to discuss their roles.

3. Areas for discussion:

- Case study from Richard Allen – Richard is the longest service guardian with the others only recently appointed. He will outline a couple of the cases that he has been involved in to give a flavour of the nature of the concerns escalated to him.

- Challenges - The guardians would like to discuss some of the challenges in the role the main one being having sufficient time to dedicate to the role.

- Future arrangements – A discussion about how the FTSU guardians will engage with the board in the future.

Appendix 1

National Guardian Freedom to Speak Up

Role specification for the Freedom to Speak Up Guardian

Acting in a genuinely independent capacity, the Freedom to Speak Up Guardian will be appointed by the Board, working alongside them and members of the executive team to help support the organisation to become a more open, transparent place to work.
In particular the Freedom to Speak Up Guardian will:

• Work with the chief executive and Board to help create an open culture which is based on listening and learning and not blaming.

• Develop, alongside the Board, chief executive and executive team a range of mechanisms, in addition to the formal processes, which empower and encourage staff to speak up safely.

• Ensure that staff with disabilities and those from black and other minority ethnic backgrounds are encouraged to speak out and are not disadvantaged by doing so.

• Participate in the organisation's educational programme for all staff so that they understand how they can raise concerns and for managers about how they respond to concerns and supporting the member of staff appropriately.

• Be entirely independent of the executive team, so they are able to challenge senior members of staff, reporting to the Board or externally as required.

• Be a highly visible individual, who spends the majority of their time with 'front line' staff, providing expertise in developing a safe culture which supports and encourages staff to speak up using the local procedures and if necessary advising them on how to raise concerns, including externally.

• Act in an independent and impartial capacity, listening to staff and supporting them to raise concerns they may have by using the available structures and policies, both within the organisation and outside.

• Independently review any complaints from members of staff about the way they have been treated as a result of raising a concern and report back to the individual and, with their agreement, to their manager, the chief executive and the director of human resources.

• Ensure members of staff who speak up are treated fairly through the investigation, inquiry and or review and that there is effective and open communication during this time.

National Guardian Freedom to Speak Up

• Ensure that information about those who speak up is kept confidential at all times, subject to requirements around safeguarding and illegality.

• Meet quarterly with the chief executive to feedback themes from the concerns raised and to share positive and negative experiences and outcomes.

• Report at least every six months to the Board and the organisation as a whole.

• Participate in the national network for the guardians, sharing and helping to develop excellent practice in supporting members of staff who speak up.

Those appointed as Freedom to Speak Up Guardian should have these characteristics:
• Understand the trust, its values and key priorities and challenges.

• Have a track record of supporting and listening to staff and in demonstrating the values of the trust and the NHS constitution in their daily working lives.

• Be able to facilitate a conversation between members of staff and their managers.

• Have a good understanding of how to raise concerns and the barriers that can exist for those who speak up.

• Be an approachable, trusted, non-judgemental individual, who is comfortable with talking with 'front line' staff from all disciplines and all grades and can build a rapport which demonstrates compassion and understanding.

• Have the ability to set boundaries, be concise, synthesise and present information and be able to write reports for the chief executive and the Board.

• Have an understanding of mediation and managing confidential matters; this includes an understanding of managing and keeping confidential records of cases.

• Be responsive and resilient.

• Have an ability to work with a range of stakeholders, especially those responsible for patient safety and patient and staff experience, to ensure that lessons are learnt, themes identified and necessary changes are made.

• Confident in speaking at internal and external events.

March 2016

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	29 November 2017

Update on Action from the 2017 Local Engagement Survey

Executive summary:

The results of the 2017 ICHT local "Our Voice our Trust" staff survey were presented at Trust Board on 27 July 2017.

The headlines of the results show that

- the overall Engagement score increased from 77% in 2016 to 80% in 2017
- the FFT recommend as a place for care or treatment improved from 83% to 86%
- the FFT recommend as a place to work improved from 65% to 72%

The FFT scores were our highest performance to date in the last 3 years

This paper provides an update of the action taken in response to the Survey results. The results were published across the Trust in July 2017 and therefore this update includes the action which has been taken in the 3 months since the survey, as well as on-going progress on longer term areas of focus.

Quality impact:

There is growing research identifying a link between staff engagement/staff well-being, and patient well-being, hospital acquired infections, mistakes, outcomes, mortality rates and patient experience. The Staff Engagement Strategy links to aspects of CQC domains, but in particular to Well-led.

Financial impact:

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

1) Has no financial impact

Risk impact:

There are a number of risks associated with low staff engagement.
Low staff engagement correlates strongly with retention and the associated vacancy rates.

Recommendation(s) to the Committee:

The committee is asked to NOTE

1. The results of the 2017 engagement survey
2. Activity undertaken to improve engagement in the Trust
3. The main themes of the local survey feedback and action

Trust strategic objectives supported by this paper:

2. To educate and engage skilled and diverse people committed to continual learning and improvement.

Author	Responsible executive director	Date submitted
Sue Grange, Associate Director of P & OD	David Wells, Director of P & OD	22 November 2017

1. Background

2017 Local Engagement Survey

The latest Local Engagement Survey **"Our Voice Our Trust**" was run across the trust between May 2 and June 30 2017. This was the second Local Engagement survey run in this format and therefore can provide us with comparative data over time.

The headlines of the results showed that

- the overall Engagement score increased from 77% in 2016 to 80% in 2017
- the FFT recommend as a place for care or treatment improved from 83% to 86%
- the FFT recommend as a place to work improved from 65% to 72%

The FFT scores were our highest performance to date in the last 3 years

The majority of our Divisions show an increase in Engagement, most notably in WCCS (76% to 82%) and SCCS (76% to 80%). Within Job role/profession, there has been a 6% increase (79% to 85%) in Nursing (Qualified) and 11% increase amongst Consultants (69% to 80%).

An analysis of the highest and lowest performing questions shows a very consistent result to last year; the lowest performing questions remain the same as last year but have all improved by a minimum of 3%:-

Lowest Performing Questions: Local Our Voice our Trust Survey (June 2017)
Senior leaders are genuinely interested in staff opinions and ideas (52% to 57%)
Senior leaders communicate well with the rest of the organisation (50 to 57%)
Senior leaders and visible and approachable (49% to 56%)
I generally have enough time to complete all of my work (51% to 54%)
Poor behaviour and performance is addressed effectively in this organisation (43% to 48%)

2016 National Survey

The Last National Survey was run October – December 2016 and results released in February 2017. Our overall engagement score is calculated using 3 Key Findings (9 individual questions).
-KF1 Staff recommendation of the Trust as a place to work
-KF4 Staff motivation at work
-KF7 Staff ability to contribute towards improvements at work

Our overall score improved from 3.71 to 3.8 and we moved from "Bottom 20" to "Average" compared to Acute Trusts

Top 5 ranking questions	Imperial	Average Acute Trusts
% staff appraised in last 12 months (this was in top 5 in 2015)	92%	87%
Staff satisfaction with the quality of work and care they are able to deliver	4.04	3.96
Quality of non-mandatory training, learning or development (this was in the bottom 5 in 2015)	4.10	4.05
Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (this was in top 5 in 2015)	52%	56%
Percentage of staff reporting good communication between senior management and staff	36%	33%

Bottom 5 ranking questions	Imperial	Average Acute Trusts
% staff experiencing discrimination at work in last 12 months (also in bottom 5 in 2015)	21%	11%
% of staff experiencing physical violence from staff in the last 12 months	4%	2%
% Staff believing that the organisation provides equal opportunities for career progression or promotion (also in bottom 5 in 2015)	80%	87%
% of staff/ colleagues reporting most recent experience of violence	60%	67%
% of staff experience harassment, bullying or abuse from staff in the last 12 months	31%	25%

2. Dissemination of Results

The results of the most recent Local "Our Voice our Trust" Survey were made available to local managers during week commencing 24th July 2017 via an online dashboard. In all directorates, the General Manager and/or lead nurse were granted access to an on line results portal and can access detailed reports and breakdowns of their local results. Additional access was given to staff on request. Directorates were required to communicate their results to teams and to complete an action plan by 8th September 2017.

3. Summary of Action Taken in response to the Surveys

The two surveys ask different questions and explore slightly different domains but the action planning phase is designed to address both surveys as a whole rather than separate action. The action planning phase is split into key parts

(i) Local Bottom up action planning in divisions and directorates
(ii) Trust Wide action plan to address common themes

Appendix 1 illustrates provides a summary of the link between local led actions and Trust wide themes and areas of targeted Trust action

4. Local Bottom up action

All Directorates delivered a local action plan by September 8th 2017. These contained a range of locally led actions to address the specific feedback obtained at ward level, speciality level and Directorate level.

The Directorate actions plans show enormous breadth of action and activity to promote engagement. Some activity centres on effective implementation of pre-existing processes (i.e. PDR, make a Difference) whilst many focus on innovative actions to address very local concerns. Some examples include

- Introduce safety huddles
- Welcome new doctors event
- A & C quarterly engagement sessions
- Introduce RCM "Caring for You" campaign
- All Clinical teams to work clinical shifts to increase visibility
- Improve rest areas for staff
- Engage in Trust Violence and aggression training
- Away Days and Christmas events
- Introduce new newsletters
- Commission a local Schwartz Round
- Training and education plan for administrators
- Introduce PDR mid year reviews
- Introduce Start the Day Briefings
- Celebrating successes
- Empowerment / ability to influence in role
- Impact of job on health & wellbeing
- Management of poor behaviour and performance

A video was also made "You Said we did" to promote the type of actions that managers have made in response to the survey which was widely promoted

Two key tools were also launched and made available to local managers to support their local action planning:-

(i) The "Engage" Toolkit and Workshop

The "Engage" workshop is a 3 hour facilitated workshop run for multi-disciplinary group designed to help managers think about the attributes of an engaging manager, understand

motivational theory, consider why people are leaving the Trust and how they can use the Trust's engagement drivers to think about how they can improve engagement in their area. This is accompanied by the new ICHT "Engage Toolkit" as a resource for local managers to support the behaviours which promote engagement and retention. Sessions run monthly and are fully booked.

(ii) In our Shoes

The "In Our Shoes" workshop is an opportunity for teams to share what makes a good day and bad day at work and also what they would like from the Trust, their manager and their team to help them have more good days at work. The final aspect of In Our Shoes is for staff to think about their own responsibility in improving staff experience and what they will do to help themselves and their colleagues have more good days at work. Over 750 staff have been part of an In Our Shoes workshop since launch, and they are a key part of local action planning.
(See Appendix 2)

5. Trust wide action to address common themes

A number of specific actions plans have been developed and presented to Executive Committee, which take on key themes from the Surveys results collectively. These include

(i) Health and Wellbeing Strategy and Plan

The Health and Welllbeing Strategy and plan was agreed at Executive Committee in November 2017 and focuses on the four pillars of
-Physical
-Mental
-Economic and Social
-People management practices
Year 1 actions focus on eliminating harassment and bullying, improving fitness, support with financial planning, healthy eating

(ii) Harassment and Bullying Action Plan

This has a focus on prevention and includes
-Analysing array of data to develop action plans that can be delivered locally
-Cascade briefing to encourage managers to have a conversation about peoples experiences at a department level
-Speak up campaign to normalise raising concerns rather than having to become a whistleblower

(iii) Equality and Diversity Plan 2017-9

A Steering group is being established to set E&D objectives for the future and implement the equality deliver system 2 (EDS2)

-Deliver action plan from annual E&D report which incorporates workforce race equality standard (WRES)
-Comply with statutory public sector equality duty (PSED)
-Develop a gender pay gap report

(iv) Retention Programme and Plan 2017

Trust wide group to address Recruitment and Retention is working multiple workstreams to improve engagement and retention including:-
-Reward: flexible benefits and recruitment premia
-Internal recruitment including career clinics, streamlined internal recruitment, automatic student offers
-Retention, exit survey, "Engage" toolkit and training, new Springboard leadership programme, nurse rotations, improved preceptorship

(v) Executive Staff Survey Action Plan

The Executive team identified two key themes to work on from the survey which are
-Visibility of Senior Leaders, through increasing leadership walkabouts, rotating executive meetings to other sites, Leadership Briefings
-Poor Performance not addressed: A number of changes to the PDR process have been implemented including changing the window, increase in training n poor performance cases, increased emphasis on values in PDR, increased emphasis on mid-year reviews

Appendix 1 provides a high level summary of the content of each of these action plans and work programmes.

6. Next Steps

The next opportunity for measuring impact will be in the 2017 National Staff Survey, results of which are released in February 2018.

Trust Strategic Objective: Making the Trust a great place to work

People and OD Strategy

Maximise the engagement of our people as a key driver to organisational success and to achieve goal as a "great place to work"

CQC: Well Led Domain

Well-led KLOE #1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?
Well-led KLOE #3: Is there a culture of high-quality, sustainable care?
Well-led KLOE #7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

Measurement

(i) Annual Trust Local Engagement Survey (June) (Results to ward level)
(ii) Annual National NHS Survey (Oct – Dec)

Directorate Action Plans

Each Directorate (27) produced in Sept 2017 a Directorate specific action plan outlining action to address the local results in that area. Actions ranged from
-Introduce safety huddles
-welcome new doctors event
-A & C engagement events
-Improve rest areas for staff
-local newsletters
-Local Schwartz rounds
-Mid year PDR reviews
-Away days and Christmas events

Well Being Strategy Action Plan

A revised Well being strategy was agreed at ExCo in Nov 2017. Four pillars of Health and Well being
(i) Physical
(ii) Mental
(iii) Economic and Social
(iv) People Management

Year 1 actions include
- Focusing on eliminating harassment and bullying
- Improving fitness
- Support with financial planning
- Healthy eating

Harassment and Bullying Action Plan

- Focus on **prevention**
- Analysing array of data to develop action plans that can be delivered locally
- **Cascade briefing** to encourage managers to have a conversation about peoples experiences at a department level
- **Speak up campaign** to normalise raising concerns rather than having to become a whistleblower

Equality and Diversity Action Plan -Steering group

-**Steering group** to set E&D objectives for the future and implement the equality deliver system 2 (EDS2)
-Deliver action plan from **annual E&D report** which incorporates workforce race equality standard (WRES)
-Comply with **statutory public sector equality duty** (PSED)
-Develop **a gender pay gap** report

Retention Plan

Trust wide group to address Recruitment and Retention is working multiple workstreams to improve engagement and retention including
-**Reward:** flexible benefits and recruitment premia
-**Internal recruitment** including career clinics, streamlined internal recruitment, automatic student offers
-**Retention,** exit survey, "Engage" toolkit and training, new Springboard leadership programme, nurse rotations, improved preceptorship

Executive Action Plan

Focus on
-**Visibility of Senior Leaders**
Increase in senior leader walkabouts, Rotation of ExCo meetings
across all sites etc
-**Poor performance Not addressed**
Changes to PDR scheme,
Increase in training on poor performance Cases, increased Emphasis on values in PDR, increased emphasis on mid year Reviews

Imperial College Healthcare NHS
NHS Trust

Help to hear what it's like

In OUR SHOES

Improving staff experience

In Our shoes is a genuine opportunity for staff to let us know what it's like working here. In the sessions staff share with each other what makes a good day and what makes a bad day at work. They then identify what the Trust can do to improve staff experience and what teams and individuals can do to help each other and themselves to have more good days.

In the session, facilitators:

- share skills to manage our own and other people's attitudes and behaviours.
- create opportunities for staff to talk in pairs about their experiences at work; sharing, listening to and writing down what makes a good day and bad day at work.
- enable staff to look for common themes across discussions and work in small groups to identify priority actions to improve staff experience.

Do you want to help improve staff experience, develop your facilitation technique, or learn a new skill?

Learn how to facilitate these sessions and then roll them out in your area as part of your engagement strategy

To book your place please email
claudine.brolly@imperial.nhs.uk

In OUR SHOES OUR TRUST

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**29 November 2017**

2016 National Cancer Patient Experience Report

Executive summary:

The 2016 National Cancer Patient Experience Survey (NCPES) was conducted last year and the results were published in July 2017. The results indicated small changes to individual questions, but the majority of these are not considered to be statistically significant. Given the improvements seen in the 2015 survey, it was hoped this would continue into the 2016 results. Although this was not the case, it is believed that the programme of work already underway, notably phase 2 of the cancer improvement programme with Macmillan, is the right way to achieve sustained improvement. It is important to note that this work had not commenced at the time that the patients responding to the 2016 survey were receiving treatment here. An action plan was agreed by the Quality Committee on 15 November 2017.

This paper highlights key results and shows comparisons with other organisations and with previous years. The full report is available on the Quality health website.

Quality impact:

Delivering a high quality experience to patients with cancer is a key quality objective for the trust. It is a high priority given previous NCPES results.

Financial impact:

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

Risk impact:

ICHT's previous performance in the NCPES has had an impact on the reputation of the trust. Failure to remain in a respectable position amongst NHS peers would present a reputational risk to the trust.

Recommendation(s) to the Committee:

The Committee is asked to note the report.

Trust strategic objectives supported by this paper:

To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Stephanie Harrison-White Guy Young	Janice Sigsworth, Director of Nursing	21 November 2017

1. Background

The 2016 National Cancer Patient Experience Survey (NCEPS) results were published on 21 July 2017. This is the sixth national survey of cancer patients, and included all adult patients (aged 16 and over) with a primary diagnosis of cancer, who were admitted to hospital as inpatients for cancer related treatments, or who were seen as day case patients for cancer related treatments and were discharged between 01 April 2016 and 30 June 2016.

1,313 patients treated at ICHT were sent questionnaires and 728 responded to the survey; a response rate of response rate 55% (national response rate = 67%). The survey includes questions from right across the patient pathway from the GP experience to experience as an inpatient, day-case patient and outpatient.

2. Results

In comparing results for Imperial College Healthcare NHS Trust (ICHT) with last year there is, overall, little change from the 2015 to 2016 results. Of the 52 questions only 5 showed a potentially significant variation from the previous year. Of these five questions, two improved:

- Given understandable information about whether radiotherapy was working
- Taking part in cancer research was discussed with the patient

…and three got worse:

- Patient given practical advice and support in dealing with side effects of treatment
- All staff asked patient what name they preferred to be called by
- Hospital staff definitely did everything to help control pain

There are often year-on-year swings in particular responses and it is important to try and avoid focusing too much on individual questions. However, it is of concern that patients do not feel that staff are doing everything possible to control patients' pain. This may have been related to staffing issues in the acute pain service at the time these patients were being treated. These issues have since been addressed and improvements may be seen in the 2017 survey, but it will be explored further.

Each question is rated *as expected, lower or higher than expected.* In the 2015 survey ICHT was as expected for 37 questions, higher than for 1 question and lower than for 12. In 2016 this changed to 27, 2 and 23 respectively (see table below).

2016	GSTT	C&W	UCLH	King's	ICHT	Barts	NMH
Lower than expected	2	5	8	13	23	28	36
As expected	45	47	42	39	27	24	16
Higher than expected	5	0	2	0	2	0	0
Average rating of care	8.8	8.6	8.6	8.6	8.5	8.5	8.3

The overall rating of care for ICHT in 2016, the only score not presented as a percentage, was 8.5, which is consistent with peers.

Overall these are not poor results. As an illustration, some of the questions in the lower than expected category are still high scoring questions, for example the trust scored 93% for *the doctor had the right notes and documentation with them*, but this still sat in the lower than expected range.

The current programme of work in conjunction with Macmillan to improve the experience of cancer patients is felt to be delivering benefits and is the right approach. The proposed work for the coming year is noted below. It is however important to remember that the patients who will be the subject of the 2017 NCPES have already been treated and discharged, so any actions outlined below that have not already started will not have an effect on the next survey.

4. Actions (Including the Cancer Patient Experience Work Programme)

The Trust has been working in close partnership with Macmillan since 2014. The role of the navigator became operational in April 2015. Last year we saw improvements in some of the key questions relating to the Clinical Nurse Specialist (CNS) role as a result of the navigator role being introduced. For example, patients knew the name of their CNS and were able to contact them. This year those improvements have been sustained.

Phase two of the cancer improvement programme commenced almost 6 months ago. This phase is focusing on 'living with and beyond cancer, linking with primary care'. This is an area that needs further work, with questions relating to home care and support and care from general practice not performing as well as others.

The action plan approved by the Quality Committee focuses on the following areas where there is room for improvement:

- Effectively managing patients' pain
- Building trust and confidence in doctors and nurses
- Being treated with dignity and respect
- Being given time to discuss worries and fears
- Being given information about their condition
- Strengthening communication with GPs
- Reviewing the trust holistic needs assessment process
- Utilising the RM Partners led patient feedback system to enable the use of more current data
- Increasing the response rate to the 2017 survey

5. Next steps

The work programme has not had the impact on our survey results that we had hoped for this year. However, they may be translated into improvements in the 2017 survey. Nonetheless it is fully recognised that the Trust needs to use this feedback to develop an action plan, the content of which is outlined above and was presented to the Quality Committee at its last meeting.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board	29 November 2017

Update on the outcomes of Quality Impact Assessments (QIAs) for Cost Improvement Plans (CIPs)

Executive summary:

This paper provides an update on the outcomes of the CIP QIA meetings undertaken since it was last reported to the Board in May 2017.

- Since the last update to the Board, the Medical Director and Director of Nursing have met with the three clinical divisions and some of the corporate areas to review the QIAs for 2017/18 cost improvement programmes.
- All QIAs were approved with three exceptions.
- The next routine quarterly meetings with divisions have taken place throughout November 2017, along with the corporate areas of; finance, ICT, corporate nursing and communications.
- Divisions will undertake post-implementation reviews of 2016/17 schemes over the next quarter.
- An update on the outcomes of the next round of meetings and post-implementation reviews will be presented to the Board in March 2018.

Quality impact:

This paper describes the approach on-going within the Trust to minimise the likelihood of a risk to quality from the implementation of cost improvement programmes and aligns with all five CQC domains.

Financial impact:

This paper has no financial impact other than those associated with delivering the CIP schemes.

Risk impact:

The corporate risk register has two risks which link to clinical risk and financial management:

- **Risk 71:** Failure to deliver safe and effective care and
- **Risk 48:** Failure to maintain financial stability

Recommendation(s) to the Committee:

The Committee is asked to note the report.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion

Author	Responsible executive director	Date submitted
Priya Rathod, Deputy Director, Quality Governance	Julian Redhead, Medical Director Janice Sigsworth, Director of Nursing	8 November 2017

Imperial College Healthcare NHS
NHS Trust

Update on the outcomes of Quality Impact Assessments (QIAs) for Cost Improvement Plans (CIPs)

1. Purpose

The agreed reporting schedule for CIP QIA outcomes is quarterly to the Executive Quality Committee and three times a year to the Quality Committee and Trust Board. This paper provides a second update on the outcomes of the CIP QIA meetings undertaken since it was last reported to the Board in May 2017.

2. Background

In light of the revised CIP QIA policy approved by the Executive Committee in February 2017, the following QIA approval process is in place:

- Schemes scoring 6 or below are considered to be 'low risk' from a QIA view and can be initiated following approval by the divisional triumvirate. These QIAs must be shared with the Medical Director and/or Director of Nursing at the next QIA review meeting.
- Schemes scoring 6 or below are considered to be low risk and can be initiated following approval by the divisional triumvirate. These low risk scores must also be finally approved by the Medical Director and/or Director of Nursing at some point, but waiting for this need not hold the scheme up.
- The QIA for schemes scoring 7 or above require approval by the Medical and/or Nursing Director before they commence.
- In cases where time is pressing this can be done by email, but more often than not review and approval of schemes is undertaken at a meeting between the divisional teams and the Medical and/or Nursing Director or their nominated representatives.

3. Outcomes from CIP QIA meetings undertaken (May 2017 to October 2017)

Since the last update to the Board, the Medical Director and Director of Nursing have met with the following areas to review the QIAs for CIP schemes. The outcomes of these meetings are summarised below.

3.1 Clinical divisions

- **Medicine and Integrated Care**
- Schemes for the division had a QIA score of 6 or below and were approved.

- **Surgery, cancer and cardiovascular**
- Schemes for the division had a QIA score of 9 or below and were approved with the exception of:
    - *1718DSCC075, Upper GI transfer from Watford*
    - This was due to start at the end of June 2017. However, given current discussions regarding the provision of critical care across the hospital sites and sign-off from the executive (transformation) committee, it was agreed that the scheme be delayed until early 2018.

- **Women's, Children's and Clinical Support**:
- Schemes for the division had a QIA score of 12 or below and were approved with the exception of:
    - *1718DWCC074 Reduction in Interpreting Services expenditure.*
    - The possible impact of this within services and on other divisions was discussed.
    - It was agreed that before this scheme goes ahead, other divisions are consulted with in terms of the proposal and possible impact.

3.2 Corporate areas

- **Estates and Facilities**
- Schemes for this area had a QIA score of 12 or below and were approved with the exception of:
    - *1617CORP064 – Smart Scrubs: Phase 1.*
    - Following discussion, it was agreed that while the infection control team had been involved with this scheme, further discussion was required to agree the detail.

- **Imperial Private healthcare**
- Confirmed to the Medical Director and Director of Nursing that no new CIP QIA schemes commenced in Q1.

- The CIP QIAs for the **medical director's office, CEO's office and for people and organisation development** were all scored between 1 and 6.
- All QIAs were approved for these areas.

4 Next steps

- The next routine quarterly meetings with divisions took place throughout November 2017, along with the corporate areas of finance, ICT, corporate nursing and communications.
- Divisions will undertake post-implementation reviews of 2016/17 schemes over the next quarter.
- An update on the outcomes of the next round of meetings and post-implementation reviews will be presented to the Board in March 2018.

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (22 November 2017)**

KEY ITEMS TO NOTE

The Committee:

- Agreed that a consultant job plans for 2018/19 should be completed by February 2018; an update on progress would be presented to the Committee in January 2018.
- Noted that the year-end forecast had improved from a £7m adverse forecast in September to a £3m adverse forecast; whilst welcoming this improvement, it was clear that further work needed to be undertaken to close the remaining gap.
- Noted the progress with the transformation and sustainability plan, particularly that Trust's leadership team would be focusing on taking forward the proposed 'quick start programmes', at a workshop on 28 November. The plan would be discussed in further detail at the December board seminar.
- Noted the proposed business plan framework for 2018/19, noting that the Trust was a year into its two-year agreed plan; the focus would be on the activity underpinning the financial plan. The Committee were pleased to note that there was a clear level of executive scrutiny and challenge throughout the process.
- Were pleased to note the progress with the speciality review programme, particularly the level of engagement across the clinical specialties.
- Acknowledged that, although the capital programme was currently £12m behind plan, requiring significant spend in quarter four, there was still confidence that the planned spend would be met by the end of the financial year. The Committee were pleased to note the work to develop a 'pipeline' over the following 2-3 years, which would improve the overall capital programme.
- Received its first update on North West London Pathology's performance, noting the current financial position, and expectation to deliver a break-even position at year-end. There was some discussion as to how the business could most effectively approach new contract opportunities.
- Noted the NHS Improvement use of resources assessment was scheduled to take place on 14 December 2017. The Committee welcomed the most recent model hospital data, which appeared to show improvements in productivity.
- Noted the summary of business cases approved by the executive, including that to address ionising radiology regulation requirements. Dr Raffel queried the £1.6m increase in the HDU business case; it was confirmed that these related to addressing the patient quality and safety requirements.

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: January 17 2018

Imperial College Healthcare NHS Trust

Report to:	**Trust board**
Report from:	**Redevelopment committee report (20 September 2017)**

KEY ITEMS TO NOTE

Phase one St Mary's redevelopment planning application: The application had been given resolution to grant at the September meeting of Westminster City Council planning committee. The Mayor's Stage 2 decision was expected during October, and the section 106 was also under development.

Paddington Cube safety concerns over 'blue light' access to St Mary's Hospital: The Committee noted that the Trust had submitted court papers for a Judicial Review. The Trust's desired outcome remained to negotiate with the owners of the Royal Mail site to achieve a safe and operable road access.

Review of Trust redevelopment options: The Committee heard a synopsis of the Trust's redevelopment programme to date. Further work is required on updating the activity model which will form the basis of the future options.

Project Phoenix: This was a national initiative, creating a purpose designed infrastructure company that would support new models of care, transform the environment for patients, visitors and clinical teams, and would, by producing an off balance-sheet option, improve the national NHS financial position. It will provide the NHS and social care a way of obtaining advisors and finance. Further detail is awaited.The Committee agreed to support the Trust's engagement with Project Phoenix.

RECOMMENDATION:

The Trust board is requested to:

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

Report from:	Sir Richard Sykes, Chairman
Report author:	Jan Aps, Trust company secretary
Next meeting:	13 December 2017 (to be confirmed)

Imperial College Healthcare NHS
NHS Trust

Report to**: Trust board**

Report from: **Quality Committee (15 November 2017)**

KEY ITEMS TO NOTE

Divisional director's risk register update: The Committee reviewed the divisional risks:
Estates - the Committee noted the continuing risks relating to the infrastructure of the Trust (overall backlog maintenance identified as £1.3bn); the divisions continued to work closely with the estates team to mitigate the impact of these risks.
RTT – The Committee noted the continuing work to address the RTT performance issues, recognising that small groups of additional patient records requiring attention were still being found; clinical harm reviews continued and an external review of elective processes and systems was being commissioned in order to provide further support to the management teams and assurance to the Trust board.
Critical care – the Committee noted the continuing risk, and that work to cohort both ICU and HDU critical care patients together was in progress.
Aged imaging assets – The Committee noted the continuing risks relating to the aged imaging assets but noted that an asset replacement programme was being developed which would begin at the end of the year.

Serious Incident (SI) monitoring report: The Committee noted that there had been 27 serious incidents reported in September, which was higher than previous months; this had included six mental health delay incidents and five incidents relating to CPE (a specific infectious isolate). External support had been sought to tackle the backlog of overdue serious incident investigation reports in the division of surgery, cancer and cardiovascular.

Venous Thromboembolism (VTE) assessments: The Committee were pleased to note that VTE assessments (undertaken for all patients on admission) were on trajectory, and that the Trust were on track to achieve the 95% trajectory by the end of November 2017.

CQC Puerperal sepsis outlier response: The Committee noted that a high level turnover of clinical coding staff (possibly reducing overall expertise) appeared to be a key reason for the Trust's continued outlier status. Noting that learning needed to be shared between both the maternity teams and the clinical coding teams, the Committee were assured that weekly meetings had been arranged to monitor the sepsis rates using the new maternity sepsis tool. The review had found that instances of non-sepsis infection had been included in these figures; the infection control team had confirmed that the Trust's caesarean section surgical site infection (SSI) rate was below the national average. The Committee raised concern that the CQC had highlighted the issue rather than it having been previously raised internally; it was agreed that there needed to be clear senior oversight and monitoring and regular updates would be provided to the Committee.

Infection Prevention & Control (IPC) report: The Committee were pleased to note the significant in–year reduction in the number of hospital acquired incidents of MRSA and C-Difficle. Incidence of positive CPE isolates continued to be an increasing concern across the Trust, with 40-45 cases being reported each month. The Committee noted that such increase was being experienced internationally; the Trust's increased reporting was due to increased and more advanced screening, with the positive result of early detection and interruption of transmission. The Trust continued to work closely with NHS England as part of national action to address this issue. The Committee

congratulated the team on the reduced antibiotic use across the Trust.

Complaints: The Committee were pleased to note that the changes made to the complaints' response process continued to deliver such good outcomes, and that this had been confirmed in the internal audit review.

Research report: The Committee noted that more than 130 individual projects in experimental medicine had commenced as part of the Biomedical Research Centre since April 2017, across the eight theme areas: brain sciences, cancer, cardiovascular, gut health, immunology, infection and AMR, metabolic medicine, surgery and technology; and the five cross-cutting themes. The Committee also noted the key aspects of the NWL clinical research network, including that 7,089 patients had been recruited across 294 individual studies (20% ahead of target year to date) and that the Trust was among the most efficient in 'patients recruited per pound (£) allocated'.

Health and safety report: The Committee noted that there was a continued focus on compliance with the use of 'safe' sharps. It was also noted that the fire training continued to progress well, with a focus on the training of fire wardens, which had recently included a live evacuation practice at St Mary's involving the London Fire Brigade.

Flu plan: The Committee were pleased to note the progress with the flu plan implementation, noting that at the time of the meeting, nearly 5,000 staff had received the vaccine, twice as many as the previous year.

St Mary's Hospital Emergency Department Friends and Family Test (FFT) response plan: The Committee noted the plans in place that sought to improve the response rate of the friends and family test within the emergency department at St Mary's Hospital. The Committee were pleased to note that CQC feedback following the recent inspection had been that staff demonstrated compassionate care and maintained patients' dignity at all times; the Committee were also pleased to note that ED performance had improved since the previous year by 1%, despite a 10% increase in admissions.

RECOMMENDATION:
The Trust board is requested to:

- Note the report

Report from: Prof Andy Bush, Chair, Quality Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: 10 January 2018

Imperial College Healthcare NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (4 October 2017)**

KEY ITEMS TO NOTE

Internal audit progress report including limited assurance audit reports and management progress against previous limited assurance audit reports

The Committee noted the internal audit progress and progress against the plan.

Management action progress updates were presented in response to two of the limited assurance audit reports from internal audit. The Committee acknowledged that high priority actions had been completed and were pleased to note that the new RISPACS system had significantly improved data consistency within the imaging department.

It was noted that the newly formed internal audit liaison group was already improving the timeliness of actions being addressed.

Counter-fraud update including: LCFS work plan, NFI progress report & cases and investigations

The Committee noted the activity since the previous meeting, particularly that there were five live investigations and six cases in which further enquiries were being made; the outcome of these would be discussed with the finance team once investigation was completed. The Committee noted the Trust's engagement with the national fraud initiative, with focus on high priority cases.

The Committee noted that the Trust had met the recent additional NHS England requirements to publish a register of interests of a broader cohort of staff on the Trust's website.

The Committee were pleased to note the Trust's position in relation to counter-fraud, and the processes in place to minimise exposure to fraudulent activities.

Major incident report including lessons learned

The Committee noted the major incident report, particularly that lessons learned during recent major incidents had been implemented immediately, enabling areas of improvement to the response to later incidents. The Committee welcomed the decision to engage palliative care staff, in future, in the support of patients' families in the relative's waiting area (resulting from learning from the Grenfell fire tragedy), and was pleased to hear that learning had been shared with other major trauma centres across London; wider learning had also been shared through revised national guidance.

The Committee noted the report and commended staff for their response to the recent incidents.

Corporate risk register including the risk management policy

The Committee reviewed the corporate risk register, noting the new risks that had been escalated since the previous meeting. Noting the risk relating to the failure of estates critical equipment and facilities, it was confirmed that the estates and facilities team would ensure that mitigation was as effective as possible.

Committee members felt that it would be timely for the Trust board to review its risk appetite; it was agreed that the executive committee would discuss this further and that a workshop would be arranged for a future board seminar.

The Committee noted the updated risk register, risk management policy and template.

Information Governance – general data protection regulation (GDPR) compliance

The Committee noted the report, in particular actions to ensure compliance with GDPR requirements; this work was being overseen by the data protection committee, which was chaired by the Trust's Caldicott Guardian. The Committee acknowledged that cyber security was a

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significant area of risk for the NHS as a whole, but felt assured that the Trust had robust processes in place to mitigate the risk as much as possible. Noting this confidence in the processes and protocols around cyber security, it was agreed that the target risk score on the corporate risk register would be reviewed.

The Committee noted with concern the issues relating to data verification in terms of the RTT issues. Recognising that the technology and systems were basically sound, it was confirmed that the relevant teams were working closely together to improve the human/ technology interface. Issues here focused on whether staff had sufficient training and support in using the complex systems, and the way in which staff, sometimes not having a clear understanding of the purpose of their work, at times created 'workarounds' to processes which had unintentional impact. The Trust was also commissioning an external review to provide assurance to the Trust board that the all issues had been comprehensively rectified, and that the risk of recurrence had been reduced as much as possible.

The Committee noted the report and thanked the chief information officer and his team for their continuing efforts to ensure the Trust were as protected as possible.

Board assurance framework

The Committee, recognising that the framework had recently been presented at Trust board, noted the updates and were pleased to note that the board assurance framework had received a substantial assurance rating in a recent internal audit.

Losses and special payments

The Committee were pleased to note the continuing reduction in losses and special payments.

Tender waivers report

The Committee were pleased to note the continuing significant reduction in both the value and number, of waivers being approved.

Action requested by Trust board
The Trust board is requested to: • Note the report

Report from: Sir Gerry Acher as Chairman, Audit, Risk & Governance Committee
Report author: Jessica Hargreaves, Deputy board secretary
Next meeting: 6 December 2017

Imperial College Healthcare NHS
NHS Trust

Report to: **Trust board**

Report from: **Remuneration Committee (10 October 2017)**

Key points to note:

Joint chief information officer post – Imperial College Healthcare NHST and Chelsea & Westminster Hospital FT: David Wells confirmed that approval for the permanent appointment of Kevin Jarrold has been received from the Department of Health.

Committee terms of reference: It was agreed that the Committee would have oversight as to how equality and diversity were being addressed within the Trust's broader approach to leadership, and seek assurance that the executive were giving the role of Equality and Diversity an appropriate priority.

Chief Executive Officer performance objectives for 2017/18: The Committee approved the objectives, but noted that a greater balance between strategic objectives and operational objectives would be reflected in future years, build within an objectives framework.

New post of Director of Strategic Development: The Committee approved the creation of a permanent executive director role as described (driving major operational projects which cut across divisions, as well as leadership of interfaces including NWL Pathology and the Sustainability & Transformation Partnership), and the submission of the proposal to NHS Improvement for Department of Health approval of salary, in line with regulatory requirements.

Recommendation:

The Trust Board is requested to:

- Note the report.

Report from: Sarika Patel, chairman, Remuneration committee
Report author: Jan Aps, Trust board secretary
Next meeting: 6 December 2017