NHS
Imperial College Healthcare
NHS Trust

Trust Board – Public

Wednesday, 26th September 2018, 11am to 1pm
Clarence Wing Boardroom, St Mary's Hospital

AGENDA

Time	Item no.	Item description	Presenter	Paper / Oral
1100	**1.**	**Opening remarks**	Sir Richard Sykes	Oral
	2.	**Apologies:** Victoria Russell	Sir Richard Sykes	Oral
	3.	**Declarations of Interests** *If any member of the Board has an interest in any item on the agenda, they must declare it at the meeting, and if necessary withdraw from the meeting*	Sir Richard Sykes	Oral
1105	**4.**	**Minutes of the meeting held on 25th July 2018** *To approve the minutes from the last meeting*	Sir Richard Sykes	01
	5.	**Record of items discussed in Part II of Board meeting held on 25th July 2018** *To note the report*	Sir Richard Sykes	02
	6.	**Matters arising and review of action log** *To note updates on actions arising from previous meetings*	Sir Richard Sykes	03
1110	**7.**	**Patient story** *To note the patient story*	Prof. Sigsworth	04
1125	**8.**	**Chief Executive Officer's report** *To note the Chief Executive's report*	Prof. Orchard	05
1135	**9.**	**Integrated Quality and performance report** *To receive the monthly integrated quality and performance report for months June & July 2018*	Prof. Redhead	06
1145	**10.**	**Finance report** *To note and discuss the August 2018 position and year to date and other financial matters*	Richard Alexander	07
For decision				
	11.	No items for decision		
For discussion				
1155	**12.**	**CQC and Ward Accreditation Programme update** *To discuss and note the update on CQC related activity at and/or impacting the Trust*	Prof. Sigsworth	08
1205	**13.**	**Infection prevention and control report** *To discuss and note the quarterly report*	Prof. Holmes	09
1210	**14.**	**Learning from Deaths: Update on implementation and reporting of data** *To discuss and note the data and progress since the last report*	Prof. Redhead	10
1215	**15.**	**2018 General Medical Council National Training survey results** *To discuss and note the results and the actions underway*	Prof. Redhead	11
1220	**16.**	**Results of local Staff Engagement Survey July 2018** *To discuss and note the results and the actions underway*	Kevin Croft	12
1225	**17.**	**Freedom to speak up self assessment** *To discuss and agree the self assessment*	Kevin Croft	13

1235	**18.**	**Annual Equality and Workforce Race Equality Standard (WRES) Report** *To discuss and note the annual report*	Kevin Croft	14
For noting				
1240	**19.**	**Committee reports** *To note the summary reports from the Trust Board Committees held during September 2018*		
	19.1.	Finance and Investment Committee, 19th September	Andreas Raffel	15
	19.2.	Quality Committee, 12th September 2018	Prof. Bush	16
	19.3.	Redevelopment Committee, 19th September 2018	Sir Richard Sykes	17
1250	**20.**	**Any other business**	Sir Richard Sykes	Oral
1255	**21.**	**Questions from the public**	Sir Richard Sykes	
Close	**22.**	**Date of Next Meeting** Board Seminar: 31st October 2018, 9am to 1pm, Clarence Wing Boardroom, St Mary's Hospital Trust Board: 28th November 2018, 10am, Oak Suite W12, Hammersmith Hospital	Sir Richard Sykes	

Updated: 21 September 2018

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING

Wednesday 25 July 2018
10.45 – 12.30
Boardroom, Charing Cross Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerry Acher	Deputy chairman
Dr Andreas Raffel	Non-executive director
Peter Goldsbrough	Non-executive director
Victoria Russell	Non-executive director
Prof Tim Orchard	Chief executive officer
Prof Julian Redhead	Medical director
Richard Alexander	Chief financial officer
Prof Janice Sigsworth	Director of nursing
In attendance:	
Dr Frances Bowen	Divisional director, MIC
Kevin Jarrold	Chief information officer
Michelle Dixon	Director of communications
Dawn Sullivan	Acting Director of people and organisational development
Joanne Hackett	NExT Director
Martina Dineen	Divisional director of operations, SCCS
Patricia Reyes	Divisional director of operations, WCCS
Peter Jenkinson	Trust company secretary (minutes)

1	**Administrative matters**	**Action**
1.1	**Chairman's opening remarks, apologies and declarations of interests** Sir Gerry Acher welcomed all members and attendees, and members of the public, to the meeting. Sir Gerry noted that this was Professor Orchard's first formal board meeting as chief executive and thanked Professor Redhead for his contribution as interim chief executive.	
1.2	**Apologies** Apologies were noted from Sir Richard Sykes, Prof TG Teoh, Dr Katie Urch and Nick Ross.	
1.3	**Declarations of interest** There were no declarations made at the meeting.	
1.3	**Minutes of the meetings held on 23 May 2018** The minutes of the previous meeting, held on 23 May, were confirmed as an accurate record.	
1.4	**Record of items discussed in private at the Board meeting on 23 May and 27 June 2018** The Trust Board noted the report.	
1.5	**Action log and matters arising** The Trust board noted the action log.	

2	**Operational items**	
2.1	**Patient story**	
2.1.1	The Board welcomed Dr Katherine Buxton, Trust lead for End of Life Care, and Steph Harrison-White to the meeting.	
2.1.2	The Board received a summary of the experiences of a deceased patient and their end of life care, highlighting issues experienced by the clinical team and patient in supporting the patient to fulfil their wish to die at home, and the lessons learnt from this experience regarding the care and mechanisms required to enable end of life care. The board noted in particular the need for good liaison between the Trust's clinical team and the community services and discussed the role of the STP in designing clinical pathways and support mechanisms across organisations.	
2.1.3	The Board welcomed the establishment of the 'co-ordinate my care' initiative, to provide better and more co-ordinated access to healthcare records and training for health professionals in managing end of life care, including out of hours. The Board also endorsed the agreement to categorise end of life care as an 'always event', defined by NHS England as 'an aspect of patient and family experience that should always occur when patients interact with health professionals and the healthcare delivery system'.	
2.1.4	The Board also noted the risks of over-medicalisation through excessive blood tests, and noted that training was ongoing to raise awareness in junior doctors. It was noted that the second phase of the 'delivering our promise' work to embed the trust values would also include a focus on empowering the clinicians in these kinds of circumstances.	
2.1.5	The Board thanked Dr Buxton, noted the report and agreed that this story should be considered as an exemplar story for national learning.	**JR**
2.1.6	The Board also agreed that it would monitor progress in End of Life Care in 12 months.	**JR / PJ**
2.2	**Chief executive officer's report**	
2.2.1	Prof Orchard presented his chief executive officer's report and highlighted key points, including a summary of discussions with NHS Improvement regarding A&E performance and associated Provider Sustainability Funding (PSF), progress in the financial improvement programme, a summary of operational performance, and an update on capital funding bids submitted to the STP and NHS Improvement. Prof Orchard gave feedback from an A&E performance meeting with NHS Improvement, noting the positive patient flow indicators including delayed transfers of care and the additional actions being taken to improve the efficiency in patient flow. NHS Improvement had noted the current risks to achieving the waiting times standards and had agreed that the Trust's bed capacity was critical in this, and that additional funding would be required to provide the additional capacity required.	
2.2.2	Prof Orchard also provided an update on workforce and leadership, including a summary of senior staff appointments, the launch of the phase two of the 'delivering our promise' work to embed the vision and values, and a summary of the staff survey results. It was agreed that the details of the staff survey results would be presented to the Board at its October board seminar.	**DS / KC**
2.2.3	The Board also noted an update on the controls being implemented to manage emerging key risks, including the implementation of e-referrals and the impact of	

	the demolition and redevelopment of the Paddington Cube. The Trust board noted the report.	
2.3	**Integrated performance report** The Trust Board considered the Integrated performance report for July 2018, noting the implementation of new format with a focus on exceptions to standards.	
2.3.1	SAFE and EFFECTIVE: Prof Redhead presented the Safe and Effective section of the integrated performance report, highlighting continued excellent results in the Trust's SHMI mortality data, with the Trust reporting the second lowest HSMR for acute non-specialist trusts nationally. The Board noted the reporting of a never event during the period, relating to oral medication via syringe. An investigation was ongoing. The Board discussed the need to identify and address cultural root causes of incidents as well as technical aspects of care. The Board also noted the exception report for Patient reported outcome measures (PROMs), involving surveys of patients undergoing hip and/or knee replacement procedures, noting the absence of 'Trust health gain data' due to the low number of responses to the follow up survey sent to patients. It was noted that the Trust was pursuing alternative providers for this data service. The Board agreed the need to obtain better data by increasing the return rate, and the need to then publish the data. The Board also noted current levels of compliance with the Duty of Candour, noting an improvement in compliance levels but also the remaining challenges in achieving 100% compliance. The Board noted that this was an important indicator of organisational culture and noted the actions being taken to improve, including a trust-wide audit.	
2.3.2	CARING: Prof Sigsworth presented the Caring section of the report, highlighting an exception in Friends and Family Test (FFT) responses in A&E. The Board noted the need to increase the current response rate and the need to support the Emergency Department (ED) in achieving this.	
2.3.3	RESPONSIVE: The Board considered the exceptions to performance in the Responsive section of the report, noting the current performance against the waiting time standard in ED. It was noted that performance remained challenging but there was an improving trajectory against the ED 4 hour waiting time standard and number of patients waiting more than 12 hours. The Board noted that the key issue remained as capacity and noted the work being done on capacity planning for the following winter. The Board noted the actions being taken to improve operational performance, including the patient flow programme, and additional support being sought to help drive this programme. The Board discussed the mechanisms and indicators being used to track progress in this programme, noting the use of length of stay, delayed transfers of care and 'stranded patient' indicators to monitor progress. The Board also noted the reduced waiting times and improved facilities for mental health patients. The Board noted current performance in RTT, and performance against the 18 week and 52 week waiting time standard, noting continued reduction in the number of patients waiting for longer than 52 weeks and the achievement of the commitment to eliminate the number of patients waiting for more than 100	

	weeks. The Trust board noted the integrated performance report	
2.4 2.4.1 2.4.2	**Finance – monthly financial performance update** The Board received and noted the summary of financial performance for the first quarter of 2018/19, noting that the Trust had met the financial plan for the first three months with a £11.2m deficit before sustainability funding. The Board noted that meeting the agreed control total for the quarter had provided access to £5.1m provider sustainability funding. The Board welcomed the achievement of the control total, but noted the significant risks in achieving the year-end control total and noted ongoing actions being taken to improve financial performance, including the closing of the remaining gap in the CIP programme. The Trust board noted the report.	
3	**Items for discussion**	
3.1 3.1.1 3.1.2	**CQC update, including the ward accreditation programme** The Board received an update on the CQC inspection programme, noting that the Trust was not expecting a well-led review in 2018/19, but that it was likely that the CQC would inspect core services not previously inspected. The Board noted the actions being taken to improve the quality of care across the organisation, including a focus on four key workstreams and the establishment of a fortnightly Improving Care Steering Group meeting to review progress. It was also noted that a Board member visit programme was being developed, to support improved engagement with core services and to help raise awareness of issues faced in operational areas. The Board welcomed the approach to achieving specific improvements and the general approach being taken to achieve 'Getting to Good'. The Board noted the latest results from the Trust's ward accreditation programme, established in 2015/16, noting the increase in areas being reviewed and the number of areas awarded 'gold' rating. The Board also noted the correlation between the ward accreditation programme and the themes from the reviews, with the CQC findings, noting the key themes as leadership, medication and environment. The Board noted the variation in leadership on wards and the ongoing work to develop band 6 ward leaders, including the Trust's Springboard Programme. The Board agreed that there was a need for staff to want to strive to achieve excellence and noted that phase two of the 'delivering our promise' programme, starting in September, would focus on culture, values and behaviours, and staff recruitment and development would also focus on the willingness and ambition for continuous learning. The Trust board received and noted the report.	
3.2 3.2.1 3.2.2 3.2.3	**Patient and Public Involvement (PPI) and engagement** The Board welcomed Michael Morton, Chair of the Strategic Lay Forum, to the meeting. Michelle Dixon reminded the Board that the PPI strategy had been agreed in 2017 and presented the annual report on the activities and achievements over the past year, as well as the priorities for the following year. Michael Morton presented a summary of the role of strategic lay partners, and a	

	summary of their activities over the past year. He advised the Board that challenges remained in raising the understanding of the role of lay partners and their involvement, but gave examples of where the relationship worked well and the benefits of the partnership approach. He welcomed the level of good will and support given to lay partners but acknowledged the challenges in ensuring timely engagement of lay partners in developing new initiatives and the challenges arising from the complexity of the organisation. The Board noted the focus of the Strategic Lay Forum in ensuring that these challenges are addressed. 3.2.4 Prof Bush welcomed the work of the lay partners, and in particular the focus on children's services and the championing of services for children and families, ensuring that their voices are heard. The Trust board thanked Mr Morton and all lay partners for their contribution to the Trust and to patient care, and noted the annual report of activities.	
3.3 3.3.1 3.3.2	**Corporate risk register and Board Assurance Framework** The Trust board considered the latest versions of the corporate risk register and board assurance framework. The Board noted the risks included on the register relating to lack of capital and discussed the impact of lack of funding for ICT replacement. The Board noted that the Trust had applied for emergency capital funding from NHS Improvement to address this risk and were waiting for a decision. The Board also noted the ongoing contract issues with Sodexo regarding the standard of cleaning services. The Board noted that an update on the Trust's risk appetite would be presented to the next meeting. The Board noted the report.	**JS**
3.4	**Learning from deaths report** The Trust board received and noted the progress report and dashboard. The Board noted the report.	
3.5	**Emergency preparedness, resilience and response (EPRR) plan** The Trust board received and noted the update and assurance on the Trust's EPRR arrangements and plan. The Board noted that the Trust would be complete a self-assessment in September and noted the lessons learned from major incidents such as Grenfell fire and London Bridge terrorist attacks. The Board noted the report.	
3.6	**Cancer update – RM Partners update report** The Trust board received and noted the report, providing an update on the Trust's work as part of RM Partners, the Cancer alliance for west London. The Board welcomed the progress being made in improving cancer services, noting national recognition for the work being done in specific services such as urology. The Board noted the report.	
3.7 3.7.1 3.7.2	**Responsible Officer's annual report** The Trust board received and noted the annual report, noting the activity, policies and procedures in place to manage the process of doctors' appraisals and revalidation. The Board noted that Prof Redhead would resume his role as Responsible Officer now that he had resumed his role as Medical Director.	

3.7.3	The Board noted that the appraisal rate for doctors remained an issue and noted the additional actions being taken to address this, including referral of non-compliant medical staff to the GMC in accordance with Trust policy. The Board endorsed this approach, noting the importance of medical staff complying with registration requirements in order to practise and noting the importance of staff understanding what is mandatory and understanding their responsibilities. The Board noted the report.	
3.8	**Safe, sustainable and productive nursing and midwifery staffing – annual report** The Trust board received and noted the annual report, noting the findings from the establishment review. The Board also noted the assurance provided regarding the systems and processes in place to monitor nurse staffing levels and noted the update on nurse development programmes, including the introduction of apprenticeships. The Board noted the report.	
3.9	**Research and development – quarterly report** The Trust board received and noted the quarterly progress report, noting the highlights in the recruitment to trials. It was noted that the recruitment strategy for commercial trials had been agreed by the executive and an external review of the Biomedical Research Centre was expected in October 2018. The Board also noted ongoing initiatives in genomics research. The Board noted the report.	
3.10	**Safeguarding - annual report – children and young people & adults** The Trust board received and noted the annual safeguarding reports for children and young people, and adults, noting that the Board had had a more detailed discussion and a training session in safeguarding at the Board seminar in June 2018. The Board noted the report.	
3.11	**Infection prevention and control – annual report** The Trust board received and noted the annual report. The Board noted the report.	
3.12	**Annual survey of adult inpatients – 2017** The Trust board received and noted the results from the annual survey of adult patients, noting the positive results and the improvement when compared with comparative trusts. The Board noted in particular an improvement in patient confidence in nursing staff and the reduction in night-time disturbance. The Board noted the report.	
3.13	**Complaints – annual report 2017/18** The Trust board received and noted the annual report, noting the reduction in the number of complaints received and the focus on learning from complaints. The Board noted the use of a survey to gauge complainants' satisfaction in both whether their complaint was addressed and how their complaint was managed. The Board noted the report.	
3.14	**Freedom of Information – annual report 2017/18** The Trust board received and noted the annual report. The Board noted the report.	
3.15	**Fire safety assurance report – annual report 2017/18** The Trust board received and noted the annual assurance report, noting the	

	actions taken to improve fire safety, including increased fire awareness training across the organisation. The Board noted the report.	
4	**For information: Board committee approved minutes**	
4.1-4.5	The Trust board noted the reports from the following committees: • Remuneration Committee – 20 June 2018 • Redevelopment committee – 27 June 2018 • Audit, risk and governance committee – 4 July 2018 • Quality Committee – 11 July 2018 • Finance & investment committee – 18 July 2018	
5	**Any other business**	
5.1	No other business was discussed.	
6	**Questions from the public relating to agenda items**	
6.1 6.1.1 6.1.2	The following responses were given to questions raised by members of the public present at the meeting: A member of the public asked for the Trust to comment on reports that the STP had invested £1.3bn on external consultants to help address a £1.4bn shortfall in savings, while the Trust struggled to find sufficient capital to invest in the patient environment. Prof Orchard advised that the Trust was aware of the consultancy spend by the commissioners and the STP over time, but could not comment on whether this investment represented value for money as he did not know how it had been spent. However, he advised that the savings reported would be recurrent savings as opposed to the one-off spend of £1.3bn. Prof Orchard explained the structure of the STP and governance, and the aim of the STP to take an holistic view of models of care. He advised that the north west London STP initiatives were leading to improvement in partnership working across providers which in turn would lead to improved patient care. He advised that the role of the STP was as a vehicle for ensuring that capital investments were aligned with patient needs across the sector.	
7	**Date of next meeting**	
	Public Trust board: Wednesday 26 September 2018 10:00-12:30, Clarence Wing Boardroom, St. Mary's Hospital	

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC
REPORT SUMMARY

Title of report: Record of items discussed at the confidential Trust board meeting on 25th July 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 26th September 2018	**Item 5, report no. 02**
Responsible Non-Executive Director: Professor Tim Orchard, Chief Executive Officer	**Author:** Peter Jenkinson, Trust company secretary

Summary:

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

July 2018

The Board received a report from the Chief Executive, including an update on senior appointments, the development of commercial enterprise within the Trust and site redevelopment. The Board also noted progress in the development of a north London partnership to deliver the NHS England centralised genomic lab services bid.

The Board discussed the findings of the Verita report, commissioned by the Trust to review the disciplinary process followed by the Trust in respect of a member of staff who committed suicide. Prof Orchard advised that he felt that the draft report was fair and objective, and was critical of several aspects of the Trust's disciplinary proceedings. These findings would be reviewed by the executive team to learn lessons and would be used as a major change driver as part of the Trust's work on behaviours and culture.

The Board noted that the final report would be shared once received, and that the Board would review the findings and the Trust's response at a future meeting.

The Board considered the guidance published by NHS Improvement regarding Freedom to Speak Up (FTSU) and noted the requirement to complete a self-assessment against the guidance by the end of September 2018. The Board noted that a stakeholder group had been established to oversee completion of the self-assessment and development of an appropriate action plan. The recommendations from this group would be presented to the Board in September.

Recommendations:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

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

Imperial College Healthcare NHS Trust

TRUST BOARD (PUBLIC) - ACTION POINTS REGISTER, Date of last meeting 25 July 2018

Updated: 21 September 2018

Item	Meeting date & minute reference	Subject	Action and progress	Lead Committee Member	Deadline (date of meeting)
1.	28 Mar 2018 2.1	Staff survey results – Bullying	A detailed action plan regarding bullying to be presented to a future Board meeting. July 2018 update: To be picked up by new Director of HR & OD September 2018 update: Covered under main agenda item 'Results of local Staff Engagement Survey July 2018'.	K Croft	September 2018
2.	March 2018 3.2	Gender pay gap report	The Trust board approved the publication of the gender pay gap report on the Trust website, supported the data being incorporated into the annual quality and diversity report, and sought assurance that any issues identified were addressed robustly. July 2018 update: To be picked up by new Director of HR & OD September 2018 update: Included in the annual equality and workforce race equality standard report on the main agenda.	K Croft	September 2018
3.	25 July 2018 2.2.2	Staff survey results	The staff survey results would be presented to the Board at its October board seminar.	Kevin Croft	October Board Seminar
4.	28 Mar 2018 2.1	CQC – Improvements for patients	A future Board seminar to be arranged for a focussed discussion. July 2018 update: Scheduled for October 2018	J Sigsworth	October 2018
5.	25 July 2018 2.1	Actions arising from Patient story	a) The Board thanked Dr Buxton, noted the report and agreed that this story should be considered as an exemplar story for national learning. b) The Board agreed that it would monitor progress in End of Life Care in 12 months.	Prof. Sigsworth	November 2018 July 2019
6.	25 July 2018 3.3.2	Corporate risk register and Board Assurance Framework	The Board noted that an update on the Trust's risk appetite would be presented to the next meeting. September 2018 update: Deferred to January 2018	Prof. Sigsworth	January 2019

Items closed at the last meeting

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

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

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Patient Story	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 26th September 2018	**Item 7, report no. 04**
Responsible Executive Director: Prof Janice Sigsworth – Director of Nursing	**Author:** Stephanie Harrison-White – Head of Patient Experience & Improvement

Summary:
This month's patient story is about a patient who is deaf and relies upon lip reading to understand others. The patient (Jeanette) will describe mixed experiences of using our services and will share how staff training on deaf awareness helped to improve her overall care.

Jeanette has chosen to record her story as she has chronic health problems that make travelling more difficult. Her story has highlighted the need for increased deaf awareness training in the Trust and Jeanette is helping to support this through developing a training video for our staff.

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

This report has been discussed at: None

Quality impact: The ability to communicate is an important part of a patient's journey. Failing to communicate effectively leads to poor quality of experience for the patient.

Financial impact:
Has no financial impact.

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

Workforce impact (including training and education implications): None

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

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

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

Trust strategic objectives supported by this paper:
- To achieve excellent patients experience and outcomes, delivered with compassion.

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

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

- What should senior managers know?

  That the Trust is developing a deaf awareness training video using a real patient story. This will enable us to share learning across the organisation so that our staff know how to communicate with someone who lip reads to promote independence and safe care.

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

  Support the training through departmental meetings

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

  stephanie.harrison-white@nhs.net

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

Imperial College Healthcare NHS Trust

Patient Story

1. Executive Summary

The Equality Act 2010 outlines 9 Protected Characteristics of which disabilities is one. As a public service provider we are required to make reasonable adjustments for people with disabilities. This month's patient story focuses on a patient who is deaf. Jeanette has chosen to present her story via a short film clip for practical reasons.

Jeanette has chronic health problems and has been deaf for 35 years. She will describe 4 different experiences of using our services over the past year and how these experiences have varied. She will demonstrate the importance of staff training to highlight how we can support our staff to make reasonable adjustments and improve our patients' experience.

2. Purpose

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

The perceived benefits of patient stories are:

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

3. Background

Hearing loss is often referred to as the 'hidden or invisible disability'; it affects approximately 1 in 6 people in the UK that equates to almost 11 million people. About 900,000 of these people are severely or profoundly deaf and approximately 4 million are of a working age.

There are different causes and levels of deafness. Some people use British sign language to communicate whereas others may be able to hear with the use of hearing aids.

Jeanette has been deaf for 35 years. She speaks clearly but relies upon lip reading to understand others. Lip reading itself is challenging and can be exhausting, requiring intense concentration for deaf people; it does however empower someone with a hearing loss to lead an independent and fulfilled life.

Factors such as the speed with which people normally speak, which can be up to 200 words a minute and the different dialects that change the way we pronounce words and therefore our mouth shapes differ, make lip reading difficult .

Jeanette will describe her experience of using our services and her unique perspective as a lip reading patient.

4. Summary/Key points

Jeanette has a number of chronic health problems that require frequent hospital attendances and on-going investigations. Her daily living activities are affected by her health as she is oxygen dependent and is deaf.

Jeanette will describe 3 recent experiences of attending our endoscopy services for 3 separate investigations over the past 12 months and 1 renal outpatient appointment.

Jeanette's experiences were mixed. During the first two appointments, staff in the recovery area of the department did not understand how to communicate with someone who was deaf and relied upon lip reading. This resulted in Jeanette almost taking the wrong discharge letter home in the first instance.

Jeanette contacted PALS on each occasion to raise her concerns. The deaf awareness training did not take place until after Jeanette's second appointment. Deaf awareness training was then organised for staff working in the recovery area. In June 2018, Jeannette attended the department for a third time. On this occasion, she noticed that staff were much more informed and were clear in their communication with her. This transformed her experience.

Since these appointments, Jeanette has also attended a renal outpatient clinic; she has described how the clinician was attentive and listened to her and communicated effectively with her.

5. Conclusion and Next Steps

Communication is pivotal to patient experience, safety and independence. It involves not only the spoken word but the ability to hear and listen. Jeanette is able to speak clearly but as described in her story she needs our staff to understand how to speak with someone who lip reads.

There are many strategies that our staff can use to support patients, who lip read, including:

- Speaking clearly and looking at the person
- Not covering your mouth when you speak
- Making sure the room is well lit and the light is on the other persons face

The teams involved in Jeanette's care in the endoscopy department have subsequently received deaf awareness training and this did have a positive impact on Jeanette's experience

The patient experience team is now working with Jeanette to develop a training video that can be shared with other departments. The first priority will be recovery areas.

In addition, we are working with Jeanette to co-design a ‘deaf awareness’ band that patients may choose to wear in areas such as recovery, to alert staff to their specific communication needs.

Author: Steph Harrison-White
Date; September 2018

Imperial College Healthcare NHS Trust

TRUST BOARD – PUBLIC REPORT SUMMARY	
Title of report: Chief Executive Officer's Report	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 26 September 2018	**Item 8, report no. 5**
Responsible Executive Director: Prof Tim Orchard, Chief Executive Officer	**Author:** Prof Tim Orchard, Chief Executive Officer

Summary:

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

1) Financial performance
2) Financial improvement programme
3) Operational performance
4) Update on major building improvements
5) Leadership and workforce
6) Stakeholder engagement
7) Key risks
8) Research and innovation

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

Recommendations:

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

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

Quality impact: N/A

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

Risk impact and Board Assurance Framework (BAF) reference:

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

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

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

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

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

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

Chief Executive's Report to Trust Board

1. Financial performance

Year to date (i.e. from April 2018 to August 2018) the Trust had a £19.0m deficit against a plan of £15.6m, a £3.4m adverse variance. The Trust Executive is committed to maintaining financial balance and ensuring that the financial plan for the Trust is achieved. Clinical and corporate areas are completing action plans with the aim to mitigate any risks in the position and ensure that the Trust is able to meet the control total.

The year to date adverse variance has been caused by a number of issues. There have been delays in the identification and implementation of cost improvement programmes (CIPs) which drives a large part of this adverse position. The Trust also did less activity than was planned in April and May, though this position has improved in the subsequent three months. The increase in activity has mainly been in non-elective activity, which is over plan. Additional non-elective activity may cause constraints in the Trust's elective capacity, and there is work being undertaken across the Trust focusing on improving care pathways and creating additional capacity in order to ensure we continue to provide high quality care through the winter, and to review the elective activity plan.

The Trust's capital position is £7.8m underspent against plan year to date. The programme continues to be actively managed by the Trust's Capital Expenditure Assurance Group (CEAG) and Capital Steering Group (CSG) to ensure that the Trust does not breach its plan for the year.

2. Financial improvement programme

The Trust set a challenging £48m cost improvement programme in 2018/19 as part of its overall financial plan, against which there is currently £42.6m of identified programmes (at various stages of planning and implementation), and further ideas being worked up.

Against the Month 5 cumulative plan of £14.6m, there has been £10.4m of CIP delivery year to date (YTD), resulting in a £4.3m adverse variance to plan. The main reasons for this have been underperformance against £2.3m of income and activity based productivity schemes, including private patients, and £1.3m of unidentified CIP plans.

The current forecast CIP delivery for the year is £37.3m, though this is against developed programmes, and does not include the further CIP opportunities that continue to be worked up. It also does not include any other mitigating actions being taken, to meet the overall Trust financial plan – still expected, which can be regarded as CIP.

The Programme Support Office continues to work with Clinical and Corporate teams to support delivery of current programmes; further progress opportunities already identified; as well as identify additional efficiencies.

3. Operational Performance

The Trust Board will consider the integrated quality and performance report and the key headlines relating to operational performance in June 2018 and July 2018 (months 3 and 4).

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

- Referral to Treatment Waiting Times – At the end of July the Trust reported 34 patients waiting over 52 weeks for treatment, a reduction of 67 compared to the previous month, and a significant reduction from the 330 we reported a year ago, but still above the zero trajectory target. The clinical harm review of the July 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment.
- Accident & Emergency – The Accident and Emergency 4 hour waits were ahead of trajectory target in July 2018, with the Trust reporting 88.4% of patients seen within the four hour standard against the trajectory target of 87.9%. Cancer waiting times – In August 2018, performance is reported for the cancer waiting times standards in June 2018 due to the lag in reporting. In June the Trust delivered six of the eight national cancer standards, but underperformed against the 62 day GP referral to first treatment standard due to diagnostic capacity issues on the prostate pathway and sustained pressure from late referrals from other NWL sites. The Trust underperformed against the 62 day screening standard in some part due to patient choice within the breast screening service.
- Cancelled operations - The number of operations cancelled for non-clinical reasons has remained high during the first half of 2018. In the quarter ending June 2018 the cancelled operations equated to 1.3% of total elective admissions which was above the national figure for NHS cancelled elective operations in England of 1.0% for the same period. The 28 day rebooking breach also remained high with 20.7% of patients not treated within 28 days of their operation being cancelled; the national figure was 10.8%.

Additional bed capacity

We are very pleased to have secured this month an extra £5 million funding to enable us to make estate changes to create 50 more inpatient beds across our hospitals this winter. The works have been made possible with £5 million of additional capital funding announced by the Secretary of State for Health on 7 September. The Trust's 50 additional beds will be spread across its Charing Cross, Hammersmith and St Mary's hospitals and this extra capacity will support the Trust's wider urgent and emergency care improvement programme.

Care journey and capacity collaborative

Even with the impact of these additional beds on top of achievements already made through the urgent and emergency care improvement programme, we will need to make more changes to the way we work in order to meet expected need this winter. This means really focusing on what will make the most difference and working together to get the changes in place in a way that will have the most impact.

Because of this, we've launched the 'care journey and capacity collaborative' to engage and involve more staff – and patients – in in shaping and delivering key improvements in bed management and discharge from hospital. We have also just completed phase 1 of improvements to Charing Cross A&E.

4. Embedding our vision, values and behaviours

We are developing a new programme to get as many of our 11,000 staff as possible involved in activities over the next few months to ensure we all own and live our organisational values – to be kind, collaborative, expert and aspirational – and our promise – better health, for life. We need all of our staff to be clear of their own roles within the bigger picture and especially of what our patients and partners can expect of us and what we can expect of each other. This is an important initiative in helping us to continue to build a more effective an organisational culture.

5. Future of specialist respiratory and cardiovascular services in north west London

The Royal Brompton Hospital has proposed moving of all its services to St Thomas's Hospital in south London (to become part of King's Health Partners). This has been prompted by NHS England's decision that the Royal Brompton is not able to meet standards for providing level one specialist care for those with congenital heart disease (CHD) in its current configuration.

We have shared our concerns regarding this proposal. As the Brompton's partners in north west London, Imperial College Healthcare and Chelsea and Westminster have been committed over many years to supporting the delivery and development of specialist respiratory and cardiovascular services for our local population and more beyond. Imperial College has also played a key role in supporting research and innovation. The move of services out of the area would have a negative impact on care for far wider a patient population than cardiology and respiratory patients alone. Acute, specialist trusts and academic institutions are part of a wider network that includes joint appointments, facilities and many shared services such as cancer surgery, specialist paediatrics, cardiology support and palliative care.

Whilst we recognise many of the ambitions set out by the proposed King's Health Partners approach, we firmly believe that all of the benefits, and more, could be realised more practically through the evolution of the existing partnership arrangements in north west London. We are currently exploring how best to ensure an option that takes this approach is properly considered.

6. Leadership and workforce

Senior staff changes
Kevin Croft joined the Trust in August as the new Director of People and OD, and Jeremy Butler has joined the Trust as interim Director of Transformation. The recruitment of a substantive Director of Transformation is ongoing.

Great Place to Work week
Following last year's successful series of events and activities, we are pleased to run Great Place to Work Week (GPTWW) again this year. This year events will run across the Trust from Monday 24 to Friday 28 September.

The week focuses on the Trust's staff offer – the opportunities and benefits available and how staff can take advantage of them. During this week we celebrate:

- working with amazing people in a huge variety of roles,
- pushing the boundaries of what's possible,
- making the most of a vast range of learning and development opportunities,
- being part of a community that values wellbeing, reward and recognition.

7. Stakeholder engagement

The Trust's strategic lay forum met on 8 August for the latest of its bi-monthly meetings.

We ensured that key stakeholders were informed about the report of the independent investigation into our disciplinary processes which was published last month.

Around 100 people attended our 2018 Annual General Meeting which was held on 12 September at St Paul's Church in Hammersmith.

We were delighted to welcome Minister of State for Care, Caroline Dinenage MP to St Mary's Hospital on 13 September to mark World Sepsis Day. Dr Anne Kinderlerer, our Trust sepsis lead, presented on our Alert to Sepsis! patient safety programme and together with medical director, Professor Julian Redhead, the Minister visited the Acute Assessment Unit to talk with staff.

On 17 September I attended Hammersmith & Fulham Council's health scrutiny committee together with Professor Janice Sigsworth, director of nursing, to discuss our staff engagement, recruitment and

retention.

8. Key risks

In last month's report to Trust Board I highlighted the escalation of two new risks – the implementation of the NHS e-Referral Service and managing the impact of the Paddington Square development.

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

The NHS e-Referral Service went live on 1 August 2018, as planned, and we have therefore now 'switched off' paper referrals and now only accept referrals made through eRS (in line with other hospitals in north west London), but with safeguards in place to ensure that patient safety is maintained in management of referrals.

9. Research and innovation

The Trust has been recognised by the National Institute for Health Research (NIHR) North West London Clinical Research Network for its continued contribution in delivering high quality research in the region. The letter received is attached at Appendix 1 to my report, highlighting key achievements in 2017/18, including:

- ICHT was the highest recruiting Trust in North West London and the 5th highest recruiting NHS Trust in England (17,202 participants)
- The Trust increased patient recruitment by 33% compared to the previous year (17,202 patients recruited in 2017-18)
- ICHT had the largest commercial Portfolio in North West London and the 8th largest in England (97 commercial studies)
- The Trust was among the highest recruiting NHS organisations in England for the following specialties: Metabolic and Endocrine (1st), Renal (1st), Surgery (1st), Injuries and Emergencies (2nd), Children (3rd), Infection (3rd), Hepatology (4th), Non-malignant Haematology (6th), Cancer (7th), Cardiovascular (7th), and Critical Care (8th)

10. Trust undertakings

NHS Improvement have reviewed the progress made against the Trust's undertakings, approved in November 2017, and have proposed amended undertakings to reflect that progress and the outstanding priorities for the Trust. The draft undertakings are attached at appendix 2, to replace and supersede the previous undertakings.

The Board is asked to approve these undertakings.

National Institute for Health Research

Clinical Research Network
North West London

3rd Floor Administrative Block South
Hammersmith Hospital
Du Cane Road
London, W12 OHT

Tel: +44 (0)20 3313 4116
Email: @nihr.ac.uk
Web: www.nihr.ac.uk/nwlondon

Tim Orchard
Trust Chief Executive
Imperial College Healthcare NHS Trust
The Bays
St Mary's Hospital
Praed Street, London W2 1NY

15th August 2018

Dear Tim

On behalf of the NIHR North West London Clinical Research Network, we should like to thank Imperial College Healthcare NHS Trust for its continued contribution in delivering high quality research in the region. We wish in particular to extend our gratitude to all the research and clinical staff, whose professionalism, enthusiasm and commitment enabled patients and the public to take part in and benefit from high quality research during 2017-2018.

As you are well aware, the Department of Health continues to emphasise the vital role of NHS organisations in enhancing the health and the wealth of the nation through research. Data show that patient outcomes are better in hospitals taking part in interventional clinical trials; clinical research supported by the NIHR Clinical Research Networks is calculated to have contributed £2.4 billion to the UK economy in 2014-2015, as well as supporting nearly 39,500 jobs.

While it is a challenge to single out particular individuals, and we recognise that many others not named are also contributing significantly in various ways to the success of clinical research in your organisation, the following are some important achievements for your Trust in 2017-18 that NWL CRN would like to highlight:

- ICHT was the highest recruiting Trust in North West London and the 5th highest recruiting NHS Trust in England (17,202 participants)
- The Trust increased patient recruitment by 33% compared to the previous year (17,202 patients recruited in 2017-18)
- ICHT had the largest commercial Portfolio in North West London and the 8th largest in England (97 commercial studies)
- The Trust was among the highest recruiting NHS organisations in England for the following specialties: Metabolic and Endocrine (1st), Renal (1st), Surgery (1st), Injuries and Emergencies (2nd), Children (3rd), Infection (3rd), Hepatology (4th), Non-malignant Haematology (6th), Cancer (7th), Cardiovascular (7th), and Critical Care (8th)

We should particularly like to acknowledge the Principal Investigators and their research teams who were the top recruiters in large multi-centre studies (more than 15 sites):

- Colin Bicknell: 1st out of 28 sites for the ETTAA study (cardiovascular)
- Zacchary Whinnett: 1st out of 21 sites for the HOPE-HF study (cardiovascular)
- Michael Levin: 1st out of 24 sites for the Genetic Determinants of Kawasaki Disease (children)

- Paul Edison: 1st out of 19 sites for the ELAD study (dementias and neurodegeneration)
- Mark Wilson: 1st out of 19 sites for the RESCUE-ASDH trial (surgery)
- Caroline Foster: 1st out of 25 sites for the Stigma Survey UK-YP study (infection)
- Desmond Johnston: 1st out of 38 sites for the ADDRESS C-Peptide study (diabetes)

We should also like to thank the Principal Investigators and their research teams who delivered the three highest recruiting studies in the Trust:

- Jethro Herberg: 4,486 participants recruited to the PERFORM study (children)
- Adam Mclean: 1,781 participants recruited to the Biomedical Informatics for post-transplant recurrent GMN study (renal)
- Ashley Brown: 983 participants recruited to the A&E BBV Screening Study (injuries & emergencies)

Finally, we should like to acknowledge the following Principal Investigators and their research teams for their particular contribution to NIHR portfolio research:

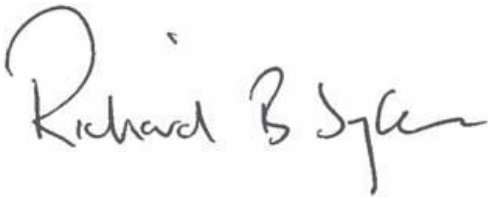
- Stephen Mangar: 1st out of 7 sites for ENZARAD and a successful portfolio of studies* (cancer)
- Harpreet Wasan: 1st out of 7 sites for ACTICCA-1 and a successful portfolio of studies (cancer)
- Susan Cleator: 1st out of 9 sites for IBIS-3 and a successful portfolio of studies (cancer)
- Naveed Sarwar: successful recruitment of the first 4 patients to a commercial trial in the UK (cancer)
- David Inwald: a successful portfolio of studies (children)
- Nicola Cooper: s successful portfolio of studies (haematology)
- Mike Laffan: a successful portfolio of studies (haematology)
- Mark Layton: a successful portfolio of studies (haematology)
- Tom Bourne: a successful portfolio of studies (reproductive health)
- Christoph Lees: a successful portfolio of studies (reproductive health)
- Prapa Kanagaratnam: CI on AVATAR-AF which successfully closed to time and target. Involved 13 centres, being the 3rd best recruiting centre in the country (cardiovascular)

*A 'successful portfolio of studies' refers to a number of studies recruiting to time and target

Please pass on our congratulations to all the staff involved in these achievements. We appreciate that it is their efforts which contribute to the success of the NWL CRN and give our patients access to high quality research.

We look forward to working with you in 2018-19.

Yours sincerely



Sir Richard Sykes FRS
Chair, Imperial College Healthcare NHS Trust

Dr Julian Redhead
Medical Director, Imperial College Healthcare NHS Trust

Dr Robina Coker
Clinical Director, NIHR CRN: North West London

cc. Sir Richard Sykes g.nisar@nhs.net
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ENFORCEMENT UNDERTAKINGS

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.

BACKGROUND

NHS Improvement accepted undertakings from the Trust on 23 November 2017 having reasonable grounds to suspect the Trust was providing health care services for the purposes of the NHS while failing to comply with conditions of the Licence as set out in the undertakings.

A compliance certificate has been issued for paragraph 2.4 of the undertakings. The remaining undertakings are deemed to be no longer effective as a means of securing compliance with the conditions of the Licence due to the passage of time and intervening events.

NHS Improvement is therefore now accepting further undertakings, which replace and supersede those accepted on 23 November 2017. The undertakings accepted on 23 November 2017 cease to have effect from the date of these undertakings.

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 conditions of the 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 and 2017/18 financial years. After intensive support as part of the Financial Improvement Programme, a revised control total of a deficit of £16.8m including STF was accepted and delivered in 2016/17 and £4.5m including STF in 2017/18. The Trust has accepted its control total in 2018/19 but remains in underlying deficit.

   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.

   2.3. 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 November 2018, or such date as specified by NHS Improvement, develop and submit a financial recovery plan (the "Financial Recovery Plan"), approved by the Trust's Board, to return to surplus by the start of 2021/22.

    1.3. The Trust will take all reasonable steps to deliver the Financial Recovery Plan, including ensuring it has adequate capacity and capability in place.

    1.4. 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 2018/19.

    2.3. The Trust will take all reasonable steps to achieve and maintain a performance of 95% by the end of March 2019, or such other date as specified by NHS Improvement.

3. Referral to Treatment standard

    3.1. The Trust will take all reasonable steps to ensure there are no patients waiting more than 52 weeks on RTT pathways.

    3.2. The Trust will ensure that it delivers the RTT incomplete performance target in line with the trajectory agreed in the 2018/19 plan through delivery of the agreed action plan.

4. Data Quality

4.1. The Trust will amend the RTT action plan by 31 October 2018 to ensure that it addresses the concerns set out in the independent review of clinical and administrative processes within elective pathways and clinical oversight of avoidable harm.

4.2. The Trust will implement the amended RTT action plan by a date to be agreed with NHS Improvement.

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

Professor Tim Orchard – Chief Executive Officer

Dated: xxxx 2018

NHS IMPROVEMENT

Steve Russell - London Regional Managing Director

Dated: xxxx 2018

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Bi-monthly Integrated Quality and Performance Report (at month 4)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 26 September 2018	**Item 9, report no. 06**
Responsible Executive Director: Prof Julian Redhead - Medical Director Prof Janice Sigsworth - Director of Nursing Dr Catherine Urch - Divisional Director Prof Tg Teoh Divisional Director Dr Frances Bowen Divisional Director Kevin Croft - Director of People and Organisational Development	**Author:** Terence Lacey (Business Partner, Performance Support Team); Julie ODea (Head of Performance Support)

Summary:
This is the bi-monthly integrated quality and performance report which outlines the key headlines relating to the reporting months of June 2018 and July 2018 (months 3 and 4). It is based on agreed indicators, goals and targets for 2018/19. By exception, additional slides have been included to highlight issues and related improvement plans and actions.

The report is presented in three main sections as follows:

1. Summary report - key headlines in performance to be read alongside additional exception report slides where provided.

2. Indicator scorecard at month 4.

3. Exception report slides - Additional slides for 30 exception reports are presented.

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

Data reliability scores
As part of the Trust's data quality framework, implemented from June 2017, the waiting times indicators within Responsiveness section of the performance framework have been given a rating to reflect the latest level of assurance for the underpinning data sets (RTT, diagnostics, A&E, cancer). A 5% error rate threshold is used to inform a Red or Green data quality rating. This has been indicated for the four operational performance datasets in the month 4 scorecard.

Recommendations:
The committee is asked to note the bi-monthly integrated quality and performance report covering months 3 and 4.

This report has been discussed at the following:

Executive Quality Committee - Tuesday 4 September 2018
Board Quality Committee - Wednesday 12 September 2018
Executive Operational Performance Committee [Tuesday 25 September 2018]

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

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

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

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

1) Has no financial impact.

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

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

Workforce impact (including training and education implications): none

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

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

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

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

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

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

▪ To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.
Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Is there a reason the key details of this paper cannot be shared more widely with senior managers? N

Imperial College Healthcare
NHS Trust

Integrated quality and performance report

At month 4 (July 2018)

Summary

This is the bi-monthly integrated quality and performance report which outlines the key headlines relating to the reporting months June 2018 and July 2018.

Contents

The report is presented in three main sections as follows:

1**.** Summary report

2**.** Indicator scorecard

3. Exception report slides

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

Appendices

Appendix 1 Exception report slides tracker for months 3-4

Appendix 2 NHS Improvement undertakings

1. Summary report

The key headlines in performance for this bi-monthly reporting period are provided below.

These are to be read alongside additional exception report slides where provided in section 3.

1.1 Safe

Patient safety - incidents

Degree of harm

We reported one severe/major harm incident in June 2018, and zero in July 2018. This is below average when compared to the most recent data published by the National Reporting and Learning System (NRLS) in March 2018 (for the April – September 2017 period). One severe/major harm incident previously reported in April 2018 and one previously reported in June 2018 have since been downgraded.

We reported zero extreme harm/death incidents in June 2018, and one in July 2018. This is below average when compared to the most recent data published by the National Reporting and Learning System (NRLS) in March 2018 (for the April – September 2017 period). One extreme harm/death incident previously reported in April 2018 has since been downgraded.

Incident reporting rate

Our incident reporting rate in July 2018 was 52.16. This puts the Trust in the top quartile according to data published by the National Reporting and Learning System (NRLS) for the April – September 2017 period. A high reporting rate with low levels of harm is one indicator of a positive safety culture and is one of the key focus areas for the safety culture improvement programme launched in July 2016.

Never events

A never event was declared by the Trust in July 2018 following an incident where a swab and balloon were intentionally retained following treatment of a post-partum haemorrhage and repair of a perineal tear. The balloon was removed but the swab was left in-situ. Although a pink wristband was in place, there was a failure to document the presence of the swab consistently in the Cerner records and the planned date/time for removal. The patient did not come to any harm and immediate actions have been taken.

Safety alerts

Zero Patient Safety Alerts (PSA) were closed late in month, or in the preceding 12 months however a previously closed alert has now been reopened on our internal system whilst all

actions are fully implemented. This relates to a PSA issued in October 2016 about reducing the risk of oxygen tubing being connected to air flowmeters.

Duty of candour

Completion of duty of candour for all appropriate incidents is monitored weekly at the medical director's incident panel. The percentage that have had stage 1 and stage 2 of the duty of candour process completed for SIs is 92%, for internal investigations is 91% and for moderate and above incidents is 91%.

The Trust completed an audit of duty of candour in Q1 2018/19. The audit provided limited assurance on the overall assessment of compliance; however 10 of the 21 compliance statements did show reasonable assurance. The areas of poor compliance were internal process issues, which can be rectified with agreed changes to the policy or procedure.

Infection prevention and control

One case of MRSA BSI was assigned to the Trust in July 2018. Two cases of Clostridium difficile were identified as lapses in care in June 2018, and two in July 2018. We previously reported that there were potentially two lapses in care in May 2018 but this was not confirmed as we were awaiting ribotyping data. This data has now been received and we can confirm that there was only one confirmed case attributed to a lapse in care in May.

Two new infection prevention and control metrics are included in the scorecard this month. These relate to reducing healthcare associated BSIs caused by E.coli at the Trust as well as having no healthcare associated BSIs caused by CPE.

VTE

We have maintained a compliance rate above our target of 95% for assessment of patients for risk of VTE since April 2018. Compliance data in June 2018 was 96.59% and in July 2018 it was 96.57%.

Safe staffing

We remained above target for overall safe staffing levels for registered nurses and midwives and care staff (with the fill rate below target in seven wards in July 2018 as detailed in the exception report)

Vacancy rate

The vacancy rate was 13.1% reflective of 1,430 WTE vacancies. For all nursing & midwifery roles, the vacancy rate was 15.9% (830 WTE vacancies)

Safeguarding training

In July 2018, 81% of eligible staff were compliant with level 3 safeguarding children training. Compliance is increasing month on month and is anticipated to meet the 90% target by the end of the year.

1.2 Effective

Mortality indicators

The Trust HSMR rate in March 2018 was 60. Each year the NHS has a revalidation episode for all the data from the previous financial year, coordinated by NHS Information. Following this validation there has been no change to the Trust's March HSMR rate but other providers figures have changed which means that ICHT now have the lowest HSMR of all specialist providers for March 2018. Prior to this revalidation we reported that we were 5th lowest of all acute non specialist NHS providers. This meets our target to be within the top 5 with the lowest risk.

Mortality reviews

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. The Trust implemented the structured judgement review methodology (SJR) in September 2017, which included deaths from July 2017 onwards. Data is refreshed on a monthly basis as SJRs are completed. It is also now reported one month in arrears to allow time for the SJR process to be completed. 47 completed reports have been received to date in 2018/19, with three avoidable deaths reported. Cases are reviewed at the monthly Mortality Review Group (MRG) with a focus on any avoidable factors and learning themes.

National clinical audits

In 2017/18 a total of 49 national clinical audits have been published which were relevant to ICHT. The Trust participated in 46 of these (94%). Six of these national clinical audits remain overdue for review within the divisions. Four audits from 2017/18 were identified as having 'significant risk/little assurance' but all have actions plans in place which are presented to the quality and safety subgroup. In April 2018 a total of four national clinical audits were published which were relevant to ICHT. The Trust participated in all of these (100%).

Clinical trials recruitment

We did not achieve our target to ensure that 90% of clinical trials recruit their first patient within 70 days in Q4 2017/18, with validated data showing 67.6%. However provisional data for Q1 2018/19 shows compliance of 85%. This will be validated by NIHR and confirmed in the next report.

1.3 Caring

Friends and Family Test

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

Performance remains below the target FFT response rates in A&E as detailed in the exception report.

Mixed sex accommodation

The performance for mixed-sex accommodation (MSA) breaches continued to be significantly higher than the zero threshold standard (reporting 47 in June and 47 in July 2018). As previously reported the MSA breaches are mainly attributable to breaches occurring within ITU at Charing Cross. The Trust has completed a breach audit and results have been discussed with our commissioners. The outcomes and improvement actions are detailed in the exception report.

1.4 Well-led

Workforce and people

The staff turnover rate and sickness absence rate both flagged as amber (within 5% above threshold) for July and we will continue to monitor this during the next bi-monthly reporting period (covering August 2018 and September 2018)

Overall Personal Development Review (PDR) Compliance for the 2018 season is 86.7% compared to 88.5% in 2017 (target is 95%). The PDR report will be re-run in September 2018 to take account of any additional PDR's recorded late on the system during August 2018.

Doctors' appraisal rates were 87.4% in June 2018 and 88.2% in July 2018. However, the total number of appraisals overdue by more than six months has increased from 38 to 43. The target date for achieving the 95% compliance rate is September 2018 (M6).

Consultant job planning compliance stood at 94.5% in July 2018 but this is expected to rise to above 95% compliance as the quality assurance work is completed by the Professional Development team.

1.5 Responsive

Consultant-led Referral to Treatment Waiting Times

The RTT 18 week standard remained ahead the trajectory target. In July 2018 the Trust reported 85.03% of patient pathways (incomplete) waiting under 18 weeks against the trajectory target of 84.9%.

At the end of July the Trust reported 34 patients waiting over 52 weeks for treatment, a reduction of 67 compared to the previous month but still above the zero trajectory target. The clinical harm review of the July 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment

Accident & Emergency

The Accident and Emergency 4 hour waits remained ahead of trajectory target. In July 2018 the Trust reported 88.4% of patients seen within the four hour standard against the trajectory target of 87.9%.

There were four 12-hour breaches in July 2018 all of which were mental health related and on the SMH site.

Diagnostic waiting times

Diagnostic test waiting times continued to meet the national standard. In July 2018 the Trust reported 0.7% of patients waiting more than 6 weeks for a diagnostic test, below the tolerance of 1%.

Cancer waiting times

In August 2018, performance is reported for the cancer waiting times standards in June 2018 due to the lag in reporting. In June the Trust delivered six of the eight national cancer standards. The Trust underperformed against the 62 day GP referral to first treatment standard due to diagnostic capacity issues on the prostate pathway and sustained pressure from late referrals from other NWL sites. The Trust underperformed against the 62 day screening standard due to issues with the management of patient choice within the breast screening service.

Cancelled operations

The reportable on the day (OTD) non-clinical cancelled operations remained high during the first half of 2018. In the quarter ending June 2018 the cancelled operations equated to 1.3% of total elective admissions which was above the national figure for NHS cancelled elective operations in England of 1.0% for the same period. The 28 day rebooking breach also remained high with 20.7% of patients were not treated within 28 days of their operation being cancelled and the national figure was 10.8%.

Outpatient Did not Attend rates

The target for outpatient DNAs was reduced from 11% for 2017/18 to 10% for 2018/19. The overall DNA rate was 10.7% in July 2018. Targeted intervention undertaken in December 2017 to increase the utilisation of text and voicemail reminder services has reduced the DNA rate, but subsequent performance has plateaued. The scope of further interventions is detailed in our exception report.

Data quality indicators

Three data quality indicators are reported in the trust scorecard and performance is reviewed by operational representatives via the Waiting Times Data Quality Meeting. The trajectory targets were met in June 2018 however they were below trajectory in July 2018. The performance will be monitored during the next bi-monthly reporting period (covering August and September 2018) with a view to developing the exception reports if they continue to be off trajectory. Currently the performance rating is based on snapshots of the last day of the month; this methodology is being reviewed to give a better representation of the overall monthly figure as this is open to daily fluctuation.

Complaints

The numbers of PALS concerns remained above the threshold of 250; formal complaints remained within the target threshold.

<u>Other updates for Responsive domain</u>

- Discharges Before Noon is not currently included as the performance threshold is being set.
- Critical care patients admitted within 4 hours is a newly included indicator for the period and is too early to develop exception reporting.
- The indicator outpatient appointments within 5 working days of receipt is being reviewed in light of implementation of the NHS e-Referral System.
- The defintions for hospital initiatied cancellation rates are being updated.

2. Indicator scorecard

See below

3. Additional slides by exception

Additional slides for **30** exception reports are presented.

SPC charts

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

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

In summary the benefits of using SPC are as follows:

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

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18
Safe										
Patient safety - incident reporting	Serious incidents	number	-	Jul-18	Julian Redhead		16	10	11	**9**
	All Incidents (cumulative financial YTD)	number	-	Jul-18	Julian Redhead		1,371	2,900	4,341	**5,871**
	Incidents causing severe/major harm	number	-	Jul-18	Julian Redhead	E	0	2	1	**0**
	Incidents causing severe/major harm (cumulative financial YTD)*	number	<14	Jul-18	Julian Redhead		0	2	3	**3**
	Incidents causing severe/major harm (cumulative financial YTD)**	%	<0.28%	Jul-18	Julian Redhead		0.00%	0.07%	0.07%	0.05%
	Incidents causing extreme harm/death	number	-	Jul-18	Julian Redhead	E	2	1	0	**1**
	Incidents causing extreme harm/death (cumulative financial YTD)*	number	<13	Jul-18	Julian Redhead		2	3	3	**4**
	Incidents causing extreme harm/death (cumulative financial YTD)**	%	<0.11%	Jul-18	Julian Redhead		0.15%	0.10%	0.07%	0.07%
	Patient safety incident reporting rate (against top quartile of trusts)	incidents / 1,000 bed days	>=47.96	Jul-18	Julian Redhead		46.68	52.06	49.06	52.16
	Never events	number	0	Jul-18	Julian Redhead	E	0	0	0	0
	PSAs overdue (by month)	number	0	Jul-18	Julian Redhead	E	0	0	0	0
	PSAs closed late in the preceding 12 months	number	0	Jul-18	Julian Redhead		-	0	0	0
	MDAs overdue (by month)	number	0	Jul-18	Janice Sigsworth		2	1	1	0
	MDAs closed late in the preceding 12 months	number	0	Jul-18	Janice Sigsworth		-	21	12	14
	Compliance with duty of candour (SIs)	%	100%	Jun-18	Julian Redhead	E	88.9%	90.0%	77.8%	66.7%
	Compliance with duty of candour (SIs) (rolling 12 month)	%	100%	Jun-18	Julian Redhead		99.0%	95.0%	94.0%	92.0%
	Compliance with duty of candour (Level 1)	%	100%	Jun-18	Julian Redhead		100.0%	88.9%	100.0%	100.0%
	Compliance with duty of candour (Level 1) (rolling 12 month)	%	100%	Jun-18	Julian Redhead		88.0%	88.0%	90.0%	91.0%
	Compliance with duty of candour (Moderate)	%	100%	Jun-18	Julian Redhead		80.0%	87.5%	100.0%	87.5%
	Compliance with duty of candour (Moderate) (rolling 12 month)	%	100%	Jun-18	Julian Redhead		85.0%	91.0%	92.0%	91.0%

*Total Incidents for 17/18

** NRLS Apr17 -Sep17

Infection prevention and control	Trust-attributed MRSA BSI	number	0	Jul-18	Julian Redhead	E	0	0	0	1
	Trust-attributed MRSA BSI (cumulative financial YTD)	number	0	Jul-18	Julian Redhead		0	0	0	1
	Trust-attributed Clostridium difficile	number	5	Jul-18	Julian Redhead		8	6	4	8
	Trust-attributed Clostridium difficile (cumulative financial YTD)	number	23	Jul-18	Julian Redhead		8	14	18	26
	Trust-attributed Clostridium difficile (related to lapses in care)	number	0	Jul-18	Julian Redhead		2	1	2	2
	Trust-attributed Clostridium difficile (related to lapses in care) (cumlative)	number	0	Jul-18	Julian Redhead		2	3	5	7
	E. coli BSI	number	5	Jul-18	Julian Redhead	E	5	8	8	7
	E. coli BSI (cumulative financial YTD)	number	23	Jul-18	Julian Redhead		5	13	21	28
	CPE BSI	number	0	Jul-18	Julian Redhead	E	3	0	0	1
	CPE BSI (cumulative financial YTD)	number	0	Jul-18	Julian Redhead		3	3	3	4
VTE	VTE risk assessment	%	>=95%	Jul-18	Julian Redhead		95.8%	95.8%	96.6%	96.6%
Maternity standards	Ratio of births to midwifery staff	ratio	1:30	Jul-18	Tg Teoh		1:30	1:30	1:30	1:30
	Puerperal sepsis	%	<=1.5%	Jul-18	Tg Teoh		0.0%	0.4%	0.6%	0.3%

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18
Safe										
Safe staffing	Safe staffing - registered nurses	%	>=90%	Jul-18	Janice Sigsworth	E	96.7%	97.4%	96.8%	96.0%
	Safe staffing - care staff	%	>=85%	Jul-18	Janice Sigsworth		97.5%	98.2%	98.2%	97.7%
Workforce and people	Core skills training	%	>=85%	Jul-18	Kevin Croft		87.3%	87.6%	88.5%	89.2%
	Core clinical skills training	%	>=85%	Jul-18	Kevin Croft		85.9%	86.3%	87.1%	88.1%
	Safeguarding children training (level 3)	%	>=90%	Jul-18	Janice Sigsworth	E	-	-	79.3%	81.0%
	Vacancy rate - Trust	%	<10%	Jul-18	Kevin Croft	E	12.6%	13.1%	13.6%	13.2%
	Vacancy rate - nursing and midwifery	%	<13%	Jul-18	Kevin Croft		14.2%	14.9%	15.7%	15.9%
Health and safety	Departmental safety coordinators	%	>=75%	Jul-18	Kevin Croft	E	57.2%	58.6%	61.6%	65.0%
	RIDDOR	number	0	Jul-18	Kevin Croft		1	5	5	6
	Fire warden training	%	>=10%	Jul-18	Janice Sigsworth	E	9.0%	8.7%	9.8%	10.1%
	Medical devices maintenance - high risk	%	>=98%	Jul-18	Janice Sigsworth	E	77.0%	89.0%	89.0%	91.0%
	Medical devices maintenance - medium risk	%	>=75%	Jul-18	Janice Sigsworth		74.0%	80.0%	79.0%	86.0%
	Medical devices maintenance - low risk	%	>=50%	Jul-18	Janice Sigsworth		72.0%	80.0%	84.0%	89.0%

Key: E = exception report available for month 4

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18

Key: E = exception report available for month 4

Effective

Mortality indicators	Trust ranking as per monthly data (HSMR)	rank	top 5 lowest risk acute Trusts	Mar-18	Julian Redhead	E	2nd	4th	4th	**1st**
	HSMR	ratio		Mar-18	Julian Redhead		**66.92**	**63.00**	**62.00**	**60.00**
	Trust ranking as per monthly data (SHMI)	rank		Qtr 3 17/18	Julian Redhead		3rd	3rd	3rd	**3rd**
	SHMI	ratio		Qtr 3 17/18	Julian Redhead		80.5	66.1	70.1	**73.2**
	Palliative care coding	%	100%	Jun-18	Julian Redhead		**100.0%**	**100.0%**	**100.0%**	**100.0%**
Mortality reviews *(at 09/08/2018)*	Total number of deaths	number	n/a	Jun-18	Julian Redhead	E	178	155	136	**122**
	Number of local reviews completed	number	n/a	Jun-18	Julian Redhead		175	146	132	**107**
	Local reviews completed	%	100%	Jun-18	Julian Redhead		**98.3%**	**94.2%**	**97.1%**	**87.7%**
	SJR reviews requested	number	n/a	Jun-18	Julian Redhead		28	19	29	**22**
	Number of SJR reviews completed	number	n/a	Jun-18	Julian Redhead		26	16	24	**15**
	SJR reviews completed	%	100%	Jun-18	Julian Redhead		**92.9%**	**84.2%**	**82.8%**	**68.2%**
	Avoidable deaths	number	0	Jun-18	Julian Redhead		**1**	**2**	**1**	**1**
	Avoidable deaths (cumulative financial YTD)	number	0	Jun-18	Julian Redhead		**17**	**2**	**3**	**4**
Readmissions	Unplanned readmission rates - under 15 yr olds	%	<9.33%	Jan-18	Tg Teoh		**5.0%**	**5.7%**	**5.6%**	**5.3%**
	Unplanned readmission rates - over 15 yr olds	%	<8.09%	Jan-18	Frances Bowen		**6.8%**	**6.4%**	**7.2%**	**6.3%**

Patient reported outcomes	PROMs - participation rates (Hips)	%	>=80%	Jun-18	Julian Redhead	E	**100.0%**	**68.8%**	**0.0%**	**100.0%**
	PROMs - reported health gain (Hips)***	-	>national avg	April – Dec 17	Julian Redhead		**EQ-5D Index:0.404**	**EQVAS:18.048**	**Oxford Hip score:21.913**	
	PROMs - participation rates (Knees)	%	>=80%	Jun-18	Julian Redhead		**100.0%**	**100.0%**	**0.0%**	**100.0%**
	PROMs - reported health gain (Knees)***	-	>national avg	April – Dec 17	Julian Redhead		**EQ-5D Index:0.381**	**EQVAS:11.469**	**Oxford Knee score:13.966**	

****Reported Bi-Annually***

National Clinical Audits	Participation in relevant national clinical audits (cumulative financial YTD)	%	100%	Apr-18	Julian Redhead	E	**95.0%**	**93.0%**	**94.0%**	**100.0%**
	High risk/significant risk audits with action plan in place (cumulative financial YT	%	100%	Apr-18	Julian Redhead		N/A	**100%**	**100%**	**100%**
	Review process not completed within 90 days	number	0	Apr-18	Julian Redhead		**16**	**26**	**29**	**0**

							Qtr 3 17/18	**Qtr 4 17/18**
Clinical trials	Clinical trials - recruitment of 1st patient within 70 days (%)	%	>=90%	Qtr 4 17/18	Julian Redhead	E	**53.3%**	**67.6%**

Section 2: Indicator scorecard at Month 4

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18

Key: E = exception report available for month 4

Caring

Friends and Family	FFT A&E service - % recommended	%	>=94%	Jul-18	Janice Sigsworth		91.9%	91.5%	93.2%	93.9%
	FFT inpatients - % recommended	%	>=94%	Jul-18	Janice Sigsworth		97.2%	96.9%	97.1%	97.5%
	FFT outpatients - % recommended	%	>=94%	Jul-18	Janice Sigsworth		92.3%	92.9%	92.1%	92.9%
	FFT maternity - % recommended	%	>=94%	Jul-18	Janice Sigsworth		95.8%	94.5%	94.1%	92.4%
	FFT A&E service - % response rate	%	>=20%	Jul-18	Janice Sigsworth	E	14.7%	11.7%	13.2%	15.0%
	FFT PTS service - % recommended	%	>=90%	Jul-18	Janice Sigsworth		86.0%	85.0%	91.9%	93.4%
Mixed sex accommodation	Mixed-sex accommodation (EMSA) breaches	number	0	Jul-18	Catherine Urch	E	39	42	47	47

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18

Key: E = exception report available for month 4

Well led

Workforce and people	Staff retention (Stabilty)	%	>=80%	Jul-18	Kevin Croft		86.0%	86.1%	85.4%	86.1%
	Voluntary staff turnover rate (12-month rolling)	%	<12%	Jul-18	Kevin Croft		10.5%	11.9%	11.9%	12.0%
	Sickness absence rate (12-month rolling)	%	<=3%	Jul-18	Kevin Croft		2.95%	2.97%	3.01%	3.02%
	Personal development reviews	%	>=95%	Jul-18	Kevin Croft	E	5.7%	18.1%	39.3%	87.3%
	Doctor appraisal rate	%	>=95%	Jul-18	Julian Redhead	E	85.6%	86.0%	87.4%	88.2%
	Consultant job planning completion rate	%	>=95%	Jul-18	Julian Redhead	E	82.0%	94.1%	94.5%	94.5%
NHSI segmentation	NHSI - provider segmentation	number	-	Jul-18	Richard Alexander		3	3	3	**3**

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18

Key: E = exception report available for month 4

Responsive

Referral to treatment – elective care	RTT incomplete pathways 18 weeks performance	%	>=92%	Jul-18	Catherine Urch		84.2%	85.2%	84.8%	85.0%
	RTT variance against 2018/19 trajectory target	%	84.9%	Jul-18	Catherine Urch		*0.5%*	*1.2%*	*0.4%*	*0.2%*
	RTT total waiting list (incomplete PTL)	number	n/a	Jul-18	Catherine Urch		**65,702**	**67,023**	**66,726**	**67,187**
	RTT incomplete pathways over 18 weeks	number	n/a	Jul-18	Catherine Urch		10,403	9,893	10,117	10,048
	RTT patients waiting 52+ weeks****	number	0	Jul-18	Catherine Urch	E	194	147	101	34
	RTT patients waiting 52+ weeks reviewed for clinical harm	%	100%	Jul-18	Catherine Urch		100%	100%	100%	100%
	RTT cases of clinical harm found after the clinical harm review	number	0	Jul-18	Catherine Urch		0	0	0	0

*****Breaches are allocated to the last specialty seen on their pathway. Some patients have subsequently been referred on and are awaiting treatment under another speciality.*

Cancer waiting times	Cancer - 62 day urgent GP referral to treatment	%	>=85%	Jun-18	Catherine Urch	E	85.0%	86.7%	80.6%	80.6%
Cancelled operations	Cancelled operations	%	<national avg	Jun-18	Catherine Urch	E	1.3%	1.7%	1.3%	**0.9%**
	28 day rebooking breach rate	%	<national avg	Jun-18	Catherine Urch		21.2%	13.5%	30.6%	**18.9%**
Urgent and Emergency Care	A&E patients seen within 4 hours (all types)	%	>=95%	Jul-18	Frances Bowen		84.6%	86.9%	87.4%	88.4%
	A&E variance against 2018/19 trajectory target	%	87.9%	Jul-18	Frances Bowen		*-0.5%*	*1.4%*	*1.3%*	*0.5%*
	A&E patients seen within 4 hours (type 1)	%	>=95%	Jul-18	Frances Bowen		64.4%	68.6%	70.4%	73.0%
	A&E patients spending >12 hours from Decision to Admit	number	0	Jul-18	Frances Bowen	E	6	7	4	4
Bed management	Patients with length of stay over 7 days	%	tbc	Jul-18	Frances Bowen		37.8%	34.8%	32.9%	**40.3%**
	Patients with length of stay over 21 days	%	50% from base	Jul-18	Frances Bowen		12.4%	9.4%	8.8%	**12.4%**
	Delayed transfer of care	%	3.50%	Jul-18	Frances Bowen		2.4%	2.6%	3.0%	3.3%
	Discharges before noon	%	>=33%	Jul-18	Frances Bowen		13.70%	13.31%	13.40%	**13.96%**
Diagnostics	Diagnostic waits – over 6 weeks	%	<1%	Jul-18	Tg Teoh		0.6%	0.7%	0.9%	0.7%
Outpatient management	Waiting times for first outpatient appointment	weeks	<8	Jul-18	Tg Teoh		7.39	7.28	7.18	7.40
	Outpatient DNA	%	<10%	Jul-18	Tg Teoh	E	10.8%	10.4%	10.5%	10.7%
	Outpatient HICS rate with less than 6 weeks' notice	%	<7.5%	Jul-18	Tg Teoh		7.8%	7.7%	8.2%	8.3%
	Outpatient appointments within 5 working days of receipt	%	>=95%	Jul-18	Tg Teoh		89.4%	85.8%	89.7%	-

Key: Data reliabilty score

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

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

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18

Key: E = exception report available for month 4

Responsive

Complaints management	PALS concerns	number	<250	Jul-18	Janice Sigsworth	E	291	314	293	269
	Complaints - formal complaints	number	<90	Jul-18	Janice Sigsworth		74	74	94	82
	Complaints – the average number of days to respond	days	40	Jul-18	Janice Sigsworth		-	-	31	30
Data quality indicators	Orders waiting on the Add/Set Encounter list (over 2 days)	number	1,177	Jul-18	Catherine Urch		*1,485*	*1,043*	*1,274*	*1,306*
	OP apps not checked-in or DNAd (app within last 90 days)	number	1,608	Jul-18	Tg Teoh		*1,886*	*2,160*	*1,734*	*2,047*
	OP apps checked In AND not checked out (app within the last 90 days)	number	1,195	Jul-18	Tg Teoh		*1,348*	*1,277*	*882*	*1,384*
Patient Transport	All Journeys: Collection Time (60 Mins)	%	>97%	Jul-18	Janice Sigsworth		92.5%	92.7%	93.3%	91.3%
	All Journeys: Collection Time (150 Mins)	%	100%	Jul-18	Janice Sigsworth		99.4%	99.5%	99.5%	97.6%
	Journeys 0-5 Miles: Time On Vehicle (60 Mins)	%	>95%	Jul-18	Janice Sigsworth		93.0%	92.5%	93.1%	93.8%
	Journeys 5-10 Miles: Time On Vehicle (60 Mins)	%	>85%	Jul-18	Janice Sigsworth		75.9%	75.7%	77.6%	78.8%
Critical Care	Critical care patients admitted within 4 hours	%	100%	Jul-18	Catherine Urch		90.4%	91.0%	94.3%	93.4%

Section 2: Indicator scorecard at Month 4

Imperial College Healthcare NHS Trust

Imperial Business Intelligence

Month 4

Domain/Sub-Domain	Indicator	Unit	Target	Latest Period	Exec Lead	M 4 Report	Reported performance at: Apr-18	May-18	Jun-18	Jul-18
Finance										
Finance KPIs	Monthly finance score (1-4)	number	-	Jul-18	Richard Alexander		3	3	3	**3**
	In month Position	£m	-	Jul-18	Richard Alexander		**-2.87**	**1.35**	**3.59**	**-1.32**
	YTD Position £m	£m	-	Jul-18	Richard Alexander		**0.00**	**-3.00**	**0.37**	**2.37**
	Annual forecast variance to plan	£m	-	Jul-18	Richard Alexander		**0.00**	**0.00**	**-1.37**	**-3.57**
	Agency staffing	%	-	Jul-18	Richard Alexander		4.1%	4.1%	3.9%	**3.9%**
	CIP (cumulative financial YTD)	%	-	Jul-18	Richard Alexander		-	75.6%	74.0%	**69.9%**

Key: E = exception report available for month 4

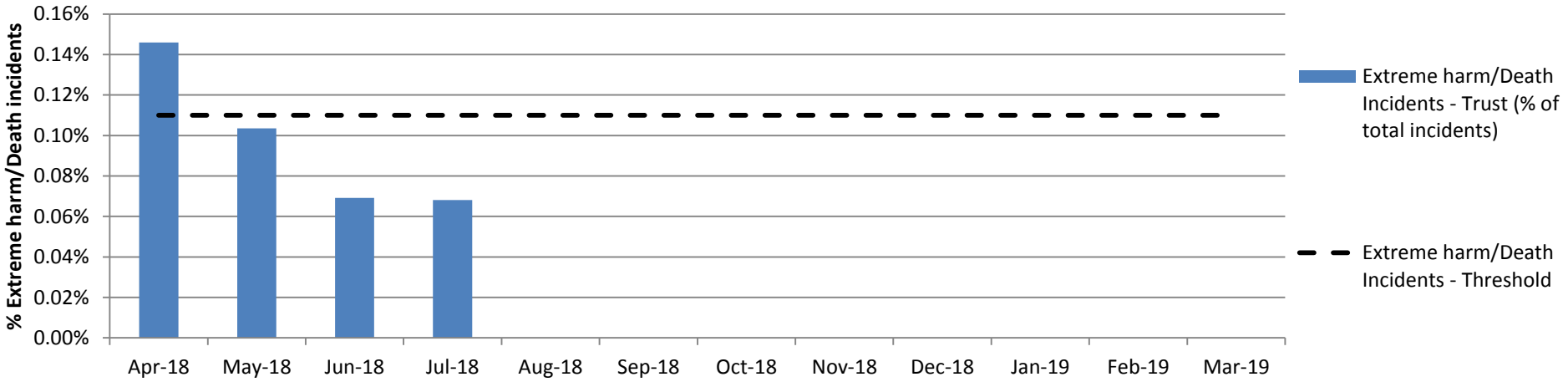
Section 3 Exception report slides summary for months 3-4

Domain	Report
Safe	1. Incidents causing extreme harm/death
Safe	2. Incidents causing severe/major harm
Safe	3. Never events
Safe	4. Patient safety alerts and medical devices
Safe	5. Compliance with duty of candour
Safe	6. MRSA BSI and C.difficile
Safe	7. E.coli
Safe	8. CPE
Safe	9. Safe staffing
Safe	10. Vacancy rate
Safe	11. Departmental safety coordinators
Safe	12. Fire warden training
Safe	13. Safeguarding training (level 3)
Safe	14. Medical devices maintenance
Effective	15. HSMR
Effective	16. Mortality reviews
Effective	17. PROMs
Effective	18. National Clinical Audits
Effective	19. Clinical Trials Recruitment

Domain	Report
Caring	20. FFT A&E service - % response
Caring	21. Mixed sex accommodation
Well led	22. Personal Development Reviews
Well led	23. Doctor appraisal rate
Well led	24. Consultant job planning completion rate
Responsive	25. Referral to Treatment - 52 week waits
Responsive	26. Cancer waiting times – 62 day
Responsive	27. Cancelled operations
Responsive	28. A&E 12-hour wait breaches
Responsive	29. Outpatient DNA
Responsive	30. Complaints – PALs concerns

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

Indicator	Target	Latest data	Executive lead	Report author(s)
To reduce the number of incidents causing extreme harm/death	Fewer incidents than last year (13) and below national average (0.11%)	0 (0.07%) - June 2018 1 (0.07%) - July 2018	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

We reported zero extreme harm/death incidents in June 2018, and one in July 2018. This incident, declared by MIC, is subject to a serious incident investigation where the root causes and any contributory factors will be identified. It will not be subject to structured judgement review as the death happened outside the hospital.

One incident reported by WCCS in April has been downgraded. This was a neonatal death that was subject to a level 1 investigation. One service delivery issue was highlighted but this would not have affected the outcome and the case has been downgraded to moderate harm. The SJR concluded that this was not avoidable.

There have been four extreme harm/death incidents reported so far this year. We previously reported that we were above average when compared to data published by the National Reporting and Learning System (NRLS) for the April – September 2017 period in M1 and M2. As a result of the downgrade in April we have now dropped below the average for the last three consecutive months.

Safe – Incidents causing extreme harm/death

Key issues	In April 2015 the CQC became the lead enforcement body for health and safety incidents in health and social care involving people who use health and adult social care services. This responsibility transferred from the Health and Safety Executive. CQC is now responsible for taking action when patients die, or have suffered serious harm, due to unsafe care. In response, the CQC has been consolidating its work in relation to deaths which includes bringing together information about deaths that they receive from a range of sources including Coroners reports. A recent exercise undertaken by the CQC to ensure that they have carried out a thorough assessment into all deaths of people using NHS services highlighted seventeen cases at the Trust where they required additional information. This information was requested in a letter from the CQC to the Trust Chief Executive Officer in July 2018. The information was submitted to the CQC on Wednesday 15th August 2018. A number of actions have been identified to further facilitate the triangulation of investigations following the death of a patient as well as ensuring a robust process for recording and managing the data that is generated.

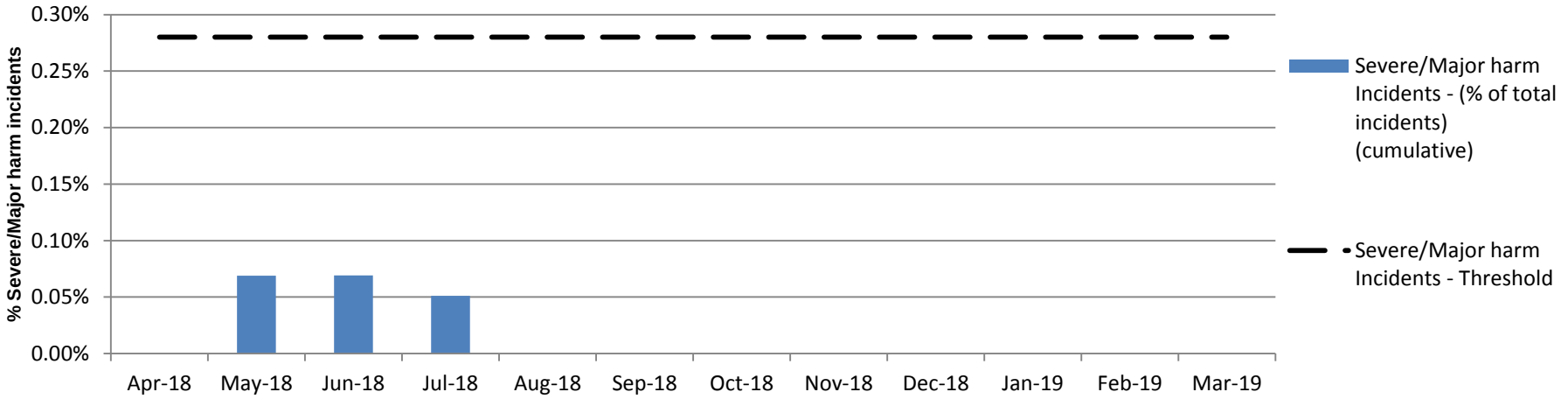
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify root causes and any contributory factors/organisational factors.	Head of Quality Compliance & Assurance	End July 2018	In the last report we stated that the three cases subject to serious incident and level 1 investigation were undergoing SJRs. These have now been completed. Two of the cases were graded 'not avoidable' and one was graded 'probably avoidable'.
Review of the issues highlighted from the incident investigations (SI/level 1) and SJRs for each case since April 2018.	Mortality Audit Manager	End October 2018	A draft report will be presented to the September Quality & Safety Subgroup.
Strengthen and formalise the process for triangulating data from cases that have both SJRs and SI investigations undertaken, this includes the recording and accessibility of the data generated.	Head of Quality Compliance & Assurance	End October 2018	A proposed standard operating procedure will be presented to the September Quality & Safety Subgroup.

Risk

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

Safe – Incidents causing severe/major harm (report xx)

Indicator	Target	Latest data	Executive lead	Report author(s)
To reduce the number of incidents causing severe/major harm	Fewer incidents than last year (14) and below national average (0.28%)	1 (0.07%) – June 2018 0 (0.05%) – July 2018	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

We continue to be below the national average for the percentage of incidents causing severe/major harm. Two incidents reported as severe/major harm in previous months have since been downgraded (one in April 2018 and one in June 2018) and the updated data is reflected in the above chart. Details are included on the next slide. There have been three severe/major harm incidents reported so far this year. This is below average when compared to data published by the National Reporting and Learning System (NRLS) for the April – September 2017 period.

We reported one severe/major harm incident in June 2018 and zero in July 2018. The June incident was declared by NWL Pathology and relates to a missing sample. The incident is subject to a serious incident investigation where the root causes and any contributory factors will be identified.

Safe – Incidents causing severe/major harm

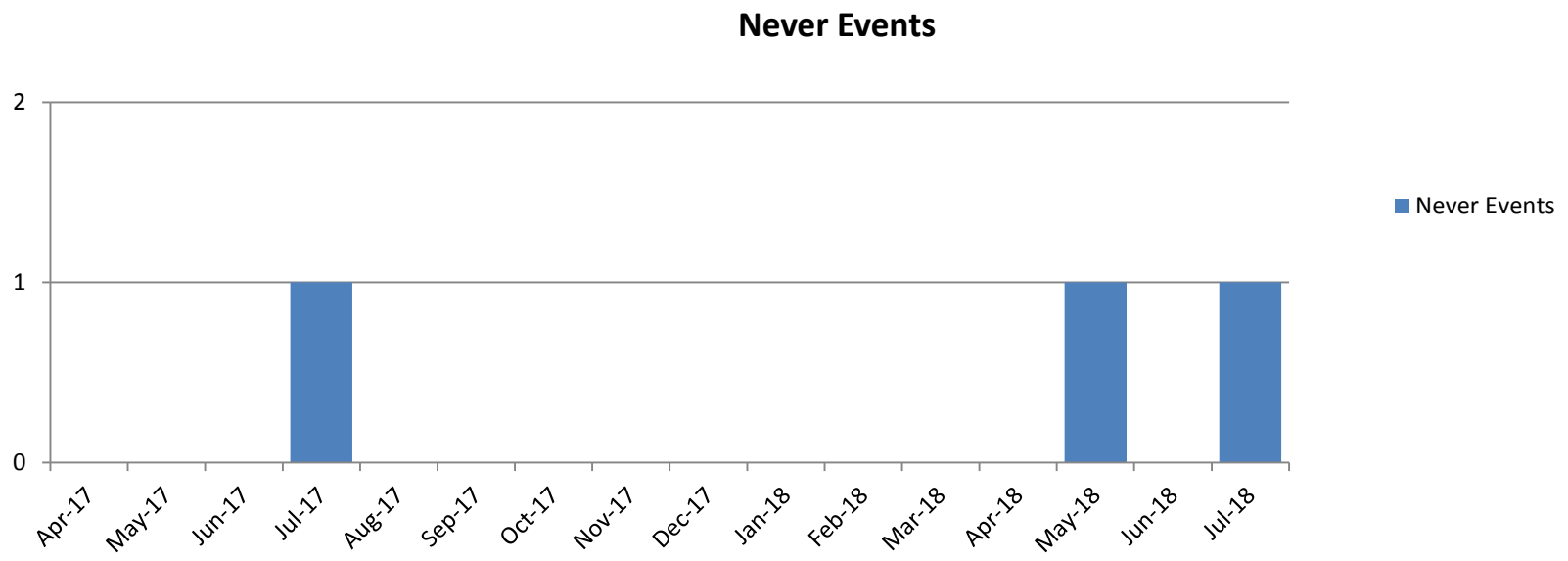
Key issues	The two downgraded incidents were in the division of medicine. The first was a falls incident which was downgraded at the point of initial investigation and the harm was confirmed on completion of the level 1 investigation. The level of harm (moderate) is in line with what we attribute to other injuries of this type. The second incident related to a patient that died after absconding. It was downgraded following the initial assessment however a level 1 investigation is being undertaken and once this is complete the final level of harm will be confirmed.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Divisional governance teams to immediately review grade of incident as soon as it is declared to ensure accuracy of category of harm.	Divisional Governance Leads	19 July 2018 End August 2018	This action is now closed. This was communicated to the DGLs by the Head of Quality Compliance and Assurance in July. In addition an extraordinary meeting has been called between the Head of Quality Compliance and Assurance and the DGLs to further discuss categorisation of incidents on 23rd August 2018.
Divisional governance teams to immediately review incidents when declared and identify the key issues to inform the decision making regarding the level and type of investigation required.	Divisional Governance Leads	19 July 2018	This action is now closed. All information for these incidents is captured in the 72 hour report, which is required for all incidents reported as moderate or above.

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

Safe – Never Events (report 03)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have 0 never events	0	June 2018 – 0 July 2018 – 1 (YTD – 2)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance



Latest performance

A never event was declared in July 2018 following an incident where a swab and balloon were intentionally retained following treatment of a post-partum haemorrhage and repair of a perineal tear. The balloon was removed but the swab was left in-situ. Although a pink wristband was in place, there was a failure to document the presence of the swab consistently in the Cerner records and the planned date/time for removal.

The patient did not come to any harm. Immediate actions include issuing a never event safety alert across the Trust and reiterating the appropriate documentation process for intentionally retained items post procedure.

Safe – Never Events

Key issues	Following the 'never event' reported in July 2017, the Trust continues to work on a transition plan (led by SCCS) to safely introduce a standardised product that will prevent epidural lines from being connected to the inappropriate access device e.g. a peripheral cannula. NRFit connectors are still not available from our suppliers and as an interim measure yellow stickers which state "epidural" have been placed on the epidural line near to the port connection to highlight the route in all clinical areas. In August 2018 an audit led by the pain service collected compliance data for a number of areas including storage, labelling, equipment and staff training. The report highlighted that only 50% of cases audited complied with the NPSA guidance for the epidural line to be labelled , and only 17% complied with our internal Trust guideline for labelling lines and giving sets. A number of actions have been agreed and are in progress including an immediate check that individual nurses working in recovery and ITU are aware of the Trust guideline regarding the labelling of lines, and the pain service reinforcing labelling during daily rounds. Concerns have also been raised about the stickers falling off and an urgent discussion is taking place with procurement to identify an alternative. A re-audit will take place in two months with results presented to the quality & safety subgroup. Following the 'never event' reported in May 2018 (wrong route medication incident) a trust wide audit of appropriate syringe availability was undertaken of all clinical areas that administer medication. Final results have been circulated to the divisions for review and development of action plans. Action plans will be presented to quality & safety subgroup in September.

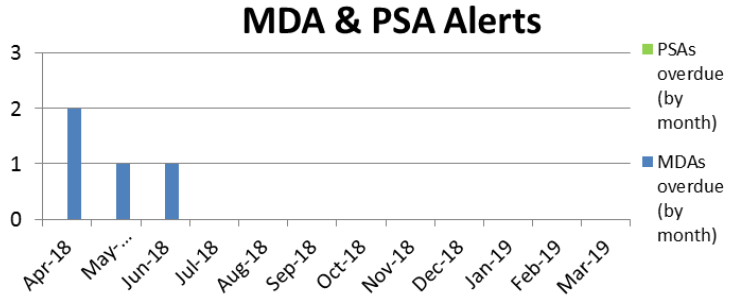
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Full oral and enteral medication audit to take place which addressed all elements of the patient safety alert for this never event category.	Divisions	19th September 2018	The audit was completed in July 2018 and results were circulated to divisions for review in August. Divisional action plans are scheduled to be presented to the quality & safety subgroup in September.

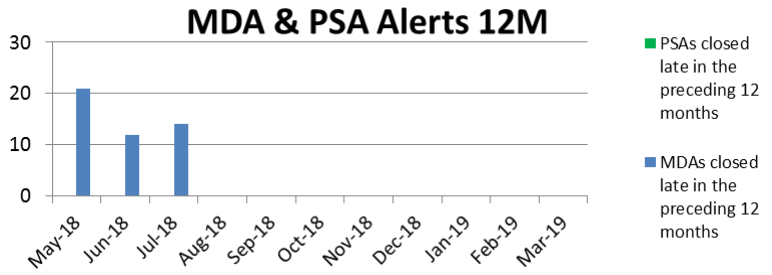
Risk

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

Safe – Patient Safety Alerts and Medical Devices Alerts (report 04)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure all patient safety alerts and medical devices alerts issued through the national central alerting system are reviewed and acted on in the specified timeframes	0 outstanding	June 2018 – 1 MDA closed late, 0 PSA July 2018 – 0 MDA closed late, 0 PSA 14 MDAs and 0 PSAs have been closed late in the preceding 12 months.	Julian Redhead, Medical Director (PSAs) Janice Sigsworth, Director of Nursing (MDAs)	Darren Nelson, Head of Quality Assurance and Compliance Farzad Saghafi, Medical Device Safety & Quality Officer





Latest performance

The one overdue MDA in June 2018 has now been closed with actions implemented. The delay in closure was because the user requested additional time to check their stock and find a suitable replacement product. MDA details as follows:

Medical Device Alert	Actions Complete Deadline	Closed date
MDA/2018/018: Various arrow critical care devices – recall due to incomplete packaging seals	28/06/18	23/08/18

There were 14 MDA/PSAs closed late in the preceding 12 months, all of which were MDAs. This is a reduction on the 21 medical device alerts that were reported to be closed late in the preceding 12 months in the last report. There were no PSAs closed late by the Trust although one has been reopened internally as detailed on the next slide.

Safe – Patient Safety Alerts and Medical Devices Alerts

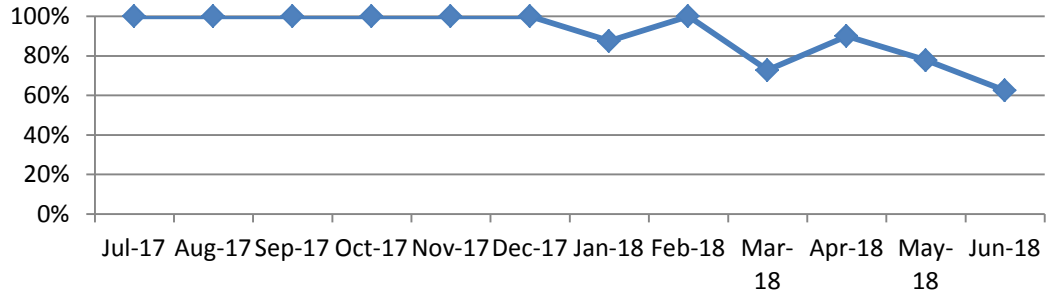
Key issues	A patient safety alert was issued in October 2016 about reducing the risk of oxygen tubing being connected to air flowmeters. This is also now included in the revised Never Event list published in February of this year. The Trust had previously closed the alert on 3rd July 2017 in advance of the due date as an action and implementation plan was in place. It has now been internally reopened on Datix although it cannot be reopened on the CAS system. The main area of concern for the Trust was progress against the following actions: • Cover medical air terminal units with designated caps in areas where there is no need for medical air. • Remove medical air flowmeters from terminal units and store in an allocated place when not in active use. • Fit air flowmeters with labelled, moveable flaps Although air flaps had been fitted to all air flowmeters and they had been removed and stored securely the blanking of the air outlets had not been completed. Led by the Clinical Technical Services team, a checking process is currently underway to ensure all areas have plugs in place, flaps on flowmeters and that not in use air flowmeters are stored securely. Once completed and an audit plan in place the PSA will be re-closed.

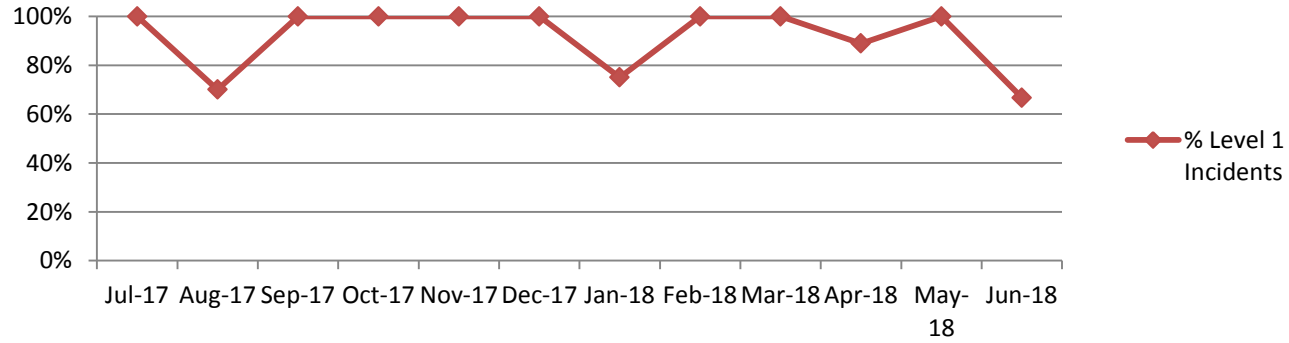
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
A quarterly CAS update report will go to Quality & Safety Subgroup. This will include information on both PSAs and MDAs. The purpose is to track progress with action plans for alerts that have been closed until all actions from the alert have been completed and implemented.	Head of Quality Compliance and Assurance Head of Clinical Technical Services	Quarterly	The first quarterly update on PSAs went to subgroup in August 2018. Of the 18 alerts that have been closed since August 2016, 10 required an action plan to be developed and monitoring currently takes place at divisional/directorate level. Divisions have been asked to review the 10 alerts with on-going action plans and provide evidence of completion or on-going monitoring at the September quality & safety subgroup meeting.

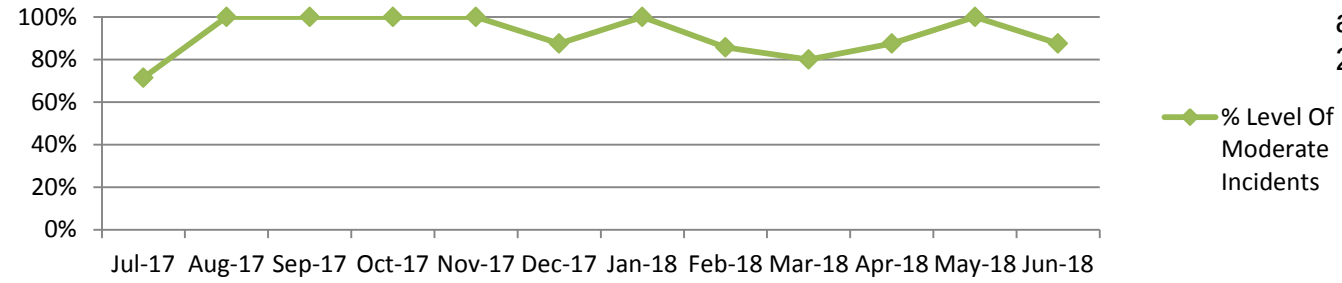
Risk
• Is it on the (divisional / corporate) risk register? YES (Corporate Risk ID 2490 Failure to deliver safe & effective care)

Safe – Compliance with duty of candour (report 05)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%	SIs: 92% Internal investigations:91% Moderate and above incidents: 91% (cumulative data for incidents reported July 2017 - June 2018)	Julian Redhead, Medical Director	Darren Nelson, Head of Quality Assurance and Compliance







Latest performance

In month performance as follows:

Serious Incidents
78% compliance for May 2018 and 63% compliance for June 2018

Level 1s
100% compliance for May 2018 and 67% compliance for June 2018

All other moderate and above incidents
100% compliance for May 2018 and 88% compliance for June 2018

Safe – Compliance with duty of candour

Key issues	A number of the outstanding duty of candour cases are for cases in NWL Pathology. Going forward these incidents will be discussed at the weekly MD panel in line with other divisions (NWLP now attend the panel weekly).

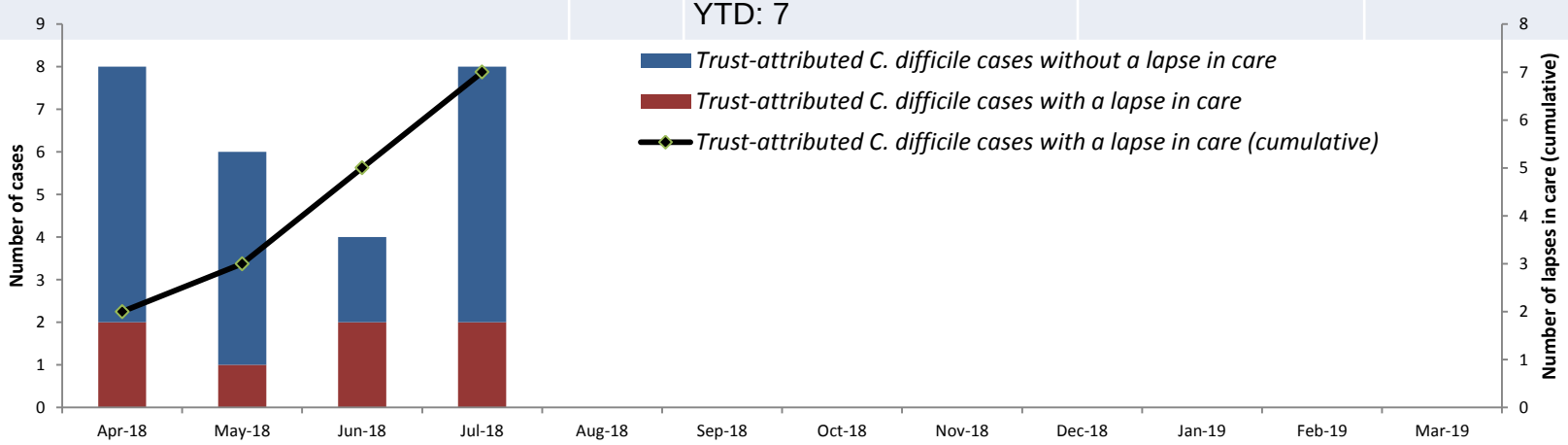
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Outstanding duty of candour is followed up and monitored at the weekly Medical Directors Incident Meeting.	Head of Quality Compliance & Assurance	Ongoing	Progress has been made over the past year, all outstanding cases are reviewed at the weekly MD panel - issues with NWLP cases have been highlighted and are being resolved in collaboration with the appropriate division. Communications will be sent in the next RO newsletter reminding consultants of the required timeframe for the completion of the DoC letter.
Review of duty of candour policy.	Head of Quality Compliance & Assurance	Autumn 2018	In response to the duty of candour audit in Q1 2018/19 a number of changes will now be made to the policy. This includes how and where to record the evidence of compliance for each case.
95% compliance with mandatory online duty of candour training for nurses at Band 7 and above and all consultants.	Divisions	TBC	Divisions continue to be below the 95% target. As of 11th July 2018 consultant compliance is 68% (MIC), 71% (SCC) and 83% (WCCS). Issues with non-compliance are being addressed by the divisional directors.

Risk

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

Safe – MRSA BSI and C.difficile (report 06)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure we have no avoidable MRSA BSIs and cases of C. difficile attributed to lapse in care	0	MRSA BSI: 0 – June 2018 1 – July 2018 MRSA BSI YTD: 1 *C.difficile* lapse in care: 2 – June 2018 2 – July 2018 *C difficile* lapse in care YTD: 7	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance

- One case of Trust MRSA BSI has been reported for July 2018, with no cases for June 2018, thus one case for 2018/19.
- June 2018 saw four cases of Trust-attributable C.difficile, two of which were identified as a lapse in care, one due to transmission, the other due to lack of adherence to antibiotic policy .
- July 2018 saw eight cases of Trust-attributable C.difficile, two of which were identified as a lapse in care, both due to lack of adherence to antibiotic policy.

May 2018 saw six cases of Trust-attributable C.difficile, one of which was identified as a lapse in care due to potential transmission, concerning two patients on the same medical ward. A second case originally identified as a potential lapse in care in May 2018, due to transmission with a patient on a medical ward, was later confirmed as not a lapse in care on the basis of differing ribotypes. Updated data for May is reflected in the above graph.

Safe – MRSA BSI and C.difficile

Key issues	**MRSA BSI**: Elderly patient, significantly unwell on a medical ward, under palliative care, was found to be positive for MRSA BSI in July 2018 during their hospital stay. Source of bacteraemia is yet to be confirmed. Lessons learnt were around clearer record keeping on line insertions on CERNER. **C.difficile:** June 2018 saw four cases of Trust-attributable C.difficile, two of which were identified as a lapse in care, one due to transmission on a medical ward, the other, also on a medical ward owing to lack of adherence to antibiotic policy, due to antibiotic choice within the elderly medicine population. July 2018 saw eight cases of Trust-attributable C.difficile, two of which were identified as a lapse in care, both due to lack of adherence to antibiotic policy, on different medical wards, owing to inappropriate antibiotic choice within the elderly medicine population. 26 Trust-attributable C.difficile cases have been confirmed this FY 2018/19, of which seven have been identified as a lapse in care, compared to 17 Trust-attributable C.difficile cases and zero lapses in care this time last year. Four lapses were transmissions and three were related to lack of adherence to antibiotic policy. Issues with delay in receiving ribotyping results from the lab post-LIMS changeover still pertained for the period of this report, but are now improved

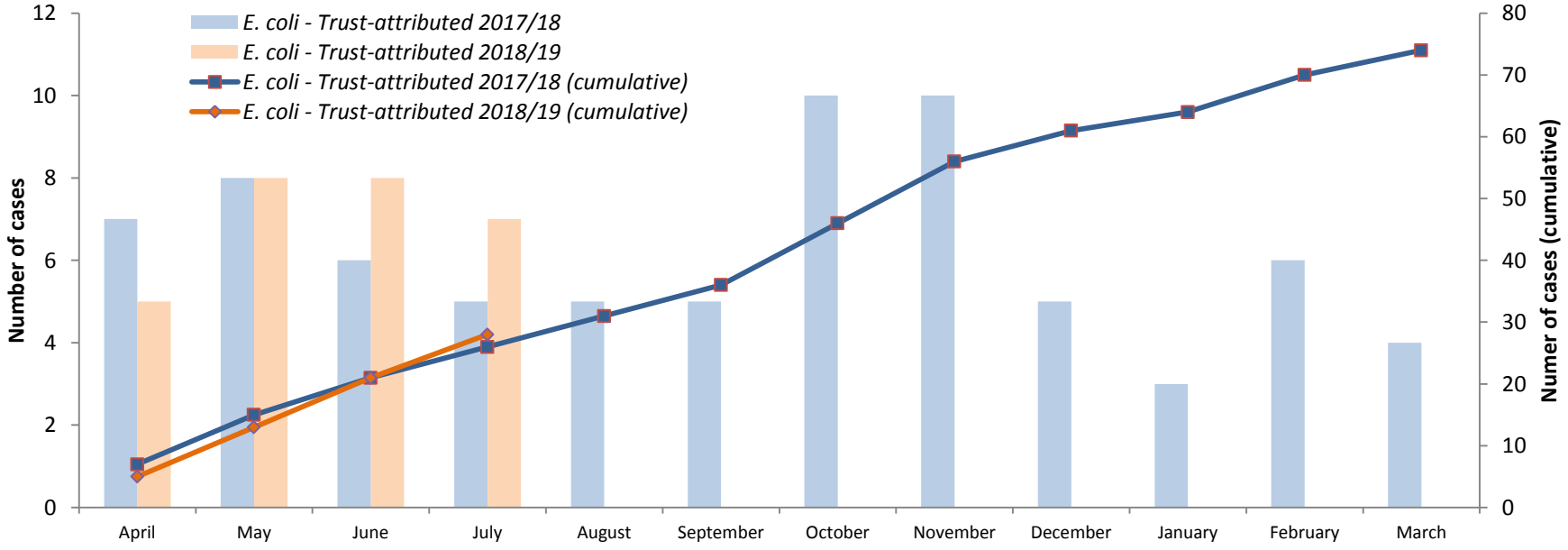
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Implement audit of 5 moments of hand hygiene.	Jon Otter General Manager IPC	Sept 2018	The revised approach to hand hygiene auditing has delivered accurate hand hygiene compliance data. An improvement plan and communications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

Risk

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

Safe – E.coli (report 07)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a 10% reduction in healthcare-associated BSIs caused by E. coli	10% reduction (n=65)	8 - June 2018 7 - July 2018 YTD = 28	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	• Seven cases of Trust E.coli BSI have been reported for July 2018, with eight cases for June 2018, thus 28 cases for 2018/19, compared to 25 cases for this period in 2017/18. • Of the 28 cases, 11 episodes in ten patients had urinary sources (one patient accounted for two separate episodes), of which four cases associated with urinary catheters.

Safe – E.coli

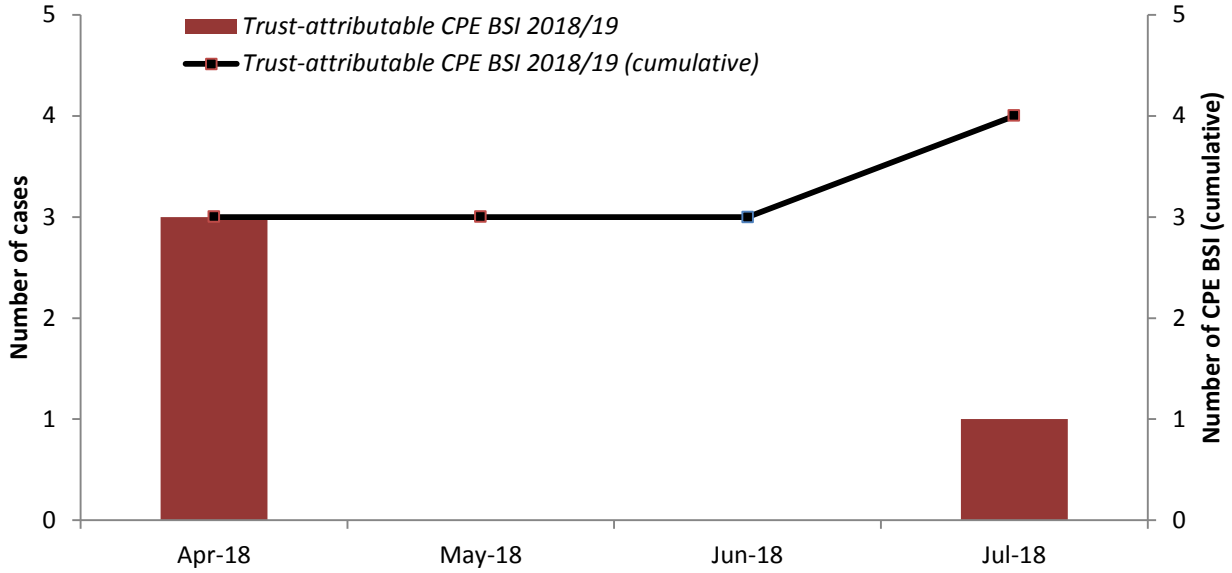
Key issues	There have been 28 cases of Trust attributable E.coli BSI this FY 2018/19. Cases of E. coli BSI are reviewed monthly to identify any potential trends. It seems likely that many of the cases of healthcare-associated E. coli BSI are a direct result of necessary interventions and are not preventable (e.g. those associated with neutropenia). However, other sources of infection are more likely to be preventable (e.g. E. coli BSIs associated with urinary catheters). Addressing the various sources of E. coli BSI, especially urinary sources, is a focus of a multidisciplinary group working around reducing Gram-negative BSI. These will focus on hydration, continence, promotion of early removal of catheters and other core actions. High risk areas may require more detailed work on understanding the use of specific prophylactic antibiotics.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Identify those cases with potential for prevention interventions.	Eimear Brannigan, Deputy DIPC	November 2018	Urinary catheter associated Gram negative bacteraemias to be focus of prevention interventions.
Review high risk areas (haematology, renal, NICU for example) for Gram negative bacteraemias and identify potential prevention initiatives.	Eimear Brannigan, Deputy DIPC	November 2018	Surveillance of bacteraemias established in these units. Ongoing monitoring and review of cases to identify prevention strategies.

Risk
• Is it on the (divisional / corporate) risk register? Risk ID 2064 Limited surveillance of HCAI (especially SSI)

Safe – CPE (report 08)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have no healthcare-associated BSIs caused by CPE	0	0 - June 2018 1 – July 2018 YTD = 4	Julian Redhead, Medical Director	Jon Otter, General Manager IPC



Latest performance	One Trust attributable CPE was identified in July 2018, from a complex patient on an oncology ward, isolate confirmed as a *Escherichia coli* OXA-48 and NDM, suspected line related. Case is currently under investigation by IPC and Vascular Access team.

Safe - CPE

Key issues	There have been four CPE BSI cases this FY 2018/19. Each case undergoes clinical review to optimise management from the infection multidisciplinary team. A review is undertaken of each case and themes collated at intervals to identify learning and opportunities for preventive action. The Trust CPE action plan is in place and has been updated in light of an increase in cases of positive screens; this includes implementation of admission and regular CPE screening of patients on wards in which there have been transmission incidents, use of electronic patient record to flag affected patients to clinical staff, and use of serious incident processes to investigate and learn from clusters.

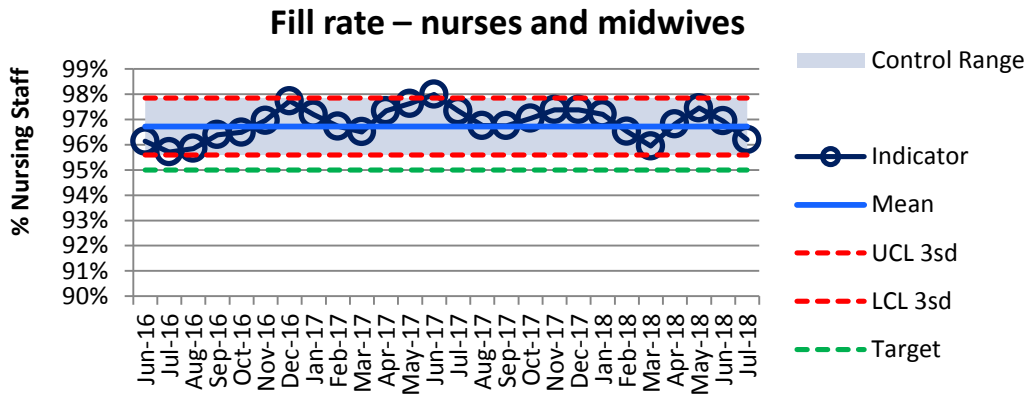
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Case review of BSIs to identify learning.	Eimear Brannigan, Deputy DIPC	November 2018	Case reviews and analysis in progress.
Develop and launch Cerner CPE screening tool to promote and support implementation of CPE screening.	Tracey Galletly, Lead Nurse IPC	December 2018	Tool complete and available in Cerner for use. Planning underway for roll out with relevant communications and staff information.

Risk

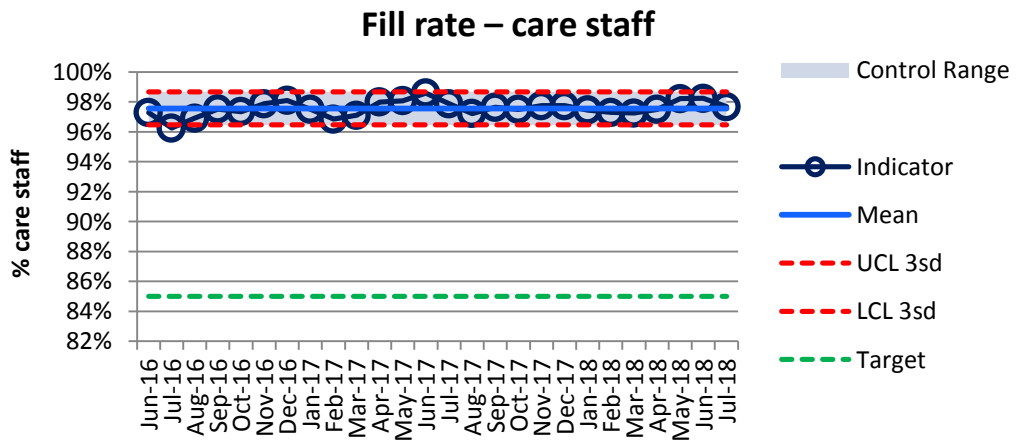
- Is it on the (divisional / corporate) risk register? YES (Risk ID 2487 - Risk of spread of CPE (Carbapenemase-Producing Enterobacteriaceae))

Safe – Safe staffing levels (report 09)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and at 85% for care staff	90 per cent for registered nurses and midwives 85 per cent for care staff	(July 2018) Registered nurses and midwives = 96.2%; Care staff = 97.1%	Janice Sigsworth (Director of Nursing)	Sinead O'Neill (Senior Nurse Workforce, Revalidation & Regulation)



Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses / midwives	Care staff	Registered nurses / midwives	Care staff
CXH	93.0%	95.6%	95.8%	99.2%
HH	96.8%	94.6%	98.5%	98.8%
QC	97.1%	95.4%	97.5%	97.8%
SMH	95.6%	97.1%	98.2%	98.1%
Trust wide	**95.1%**	**96.0%**	**97.5%**	**98.6%**



Latest performance

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

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

Safe – Safe staffing levels

Exceptions - unfilled shifts

Division of Medicine and Integrated Care

7 West ward

The unfilled shifts related to staff sickness and annual leave. The shifts were covered by the Ward Manager. Care provided with no patient safety issues identified.

9 North ward

The unfilled shifts related to current vacancy. Managed on a daily basis in conjunction with bed occupancies. Staff moved across from other wards to cover. Care provided with no patient safety issues identified.

9 South ward

The unfilled shifts related to current vacancy and 121 enhanced care. The Ward Manager and care staff provided additional cover. Care provided with no patient safety issues identified.

CXH AMU

The unfilled shifts were covered by adjusting Registered Nurse hours and Care staff hours to ensure shifts are covered. Care provided with no patient safety issues identified.

Lady Skinner ward

The unfilled shifts were covered by both the Ward Manager and the Clinical Practice Educator. Care provided with no patient safety issues identified.

Handfield Jones ward

The unfilled shifts related to 121 enhanced care and ward vacancy. The Ward Matron provided additional cover and staff moved across from other ward to cover. Care provided with no patient safety issues identified.

Division of Surgery Cancer and Cardiovascular Sciences

ISIC Surgical Assessment Unit

The unfilled shifts related to trained nurses shift not filled. These shifts were covered by the Ward Manager or moving staff within the Directorate. Care provided with no patient safety issues identified.

There were no shortfalls in the Imperial Private Health or the Division of Women's and Children.

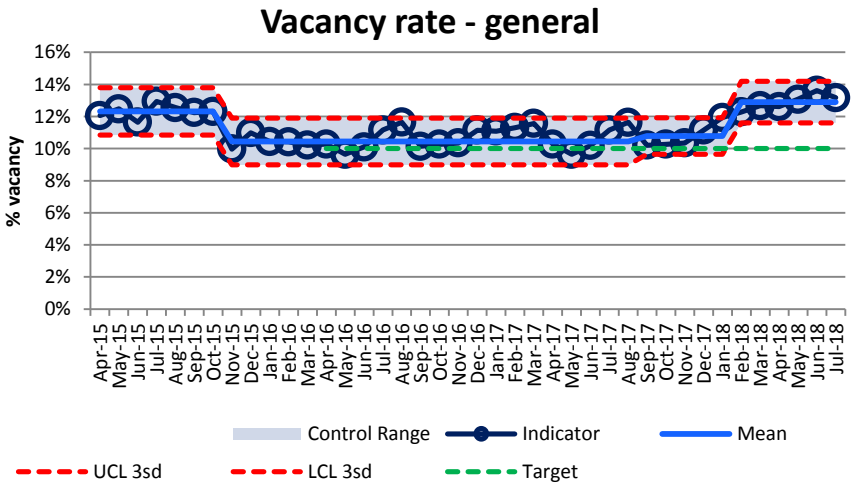
Safe – Safe staffing levels

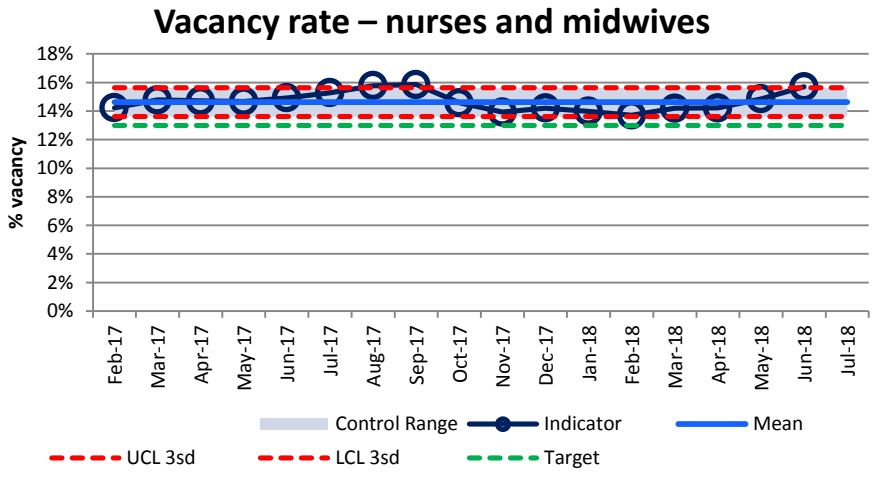
Key issues and actions	In order to maintain standards of care the Trust's Divisional Directors of Nursing, site directors and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways: - Reviewing staffing at the 5 x daily site calls - Using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

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

Safe – Vacancy rates (report 10)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a general vacancy rate of 10% or less; We will have a nursing and midwifery vacancy rate of 13% or less.	10% target for overall Trust vacancies and 13% for overall N&M vacancies	July 2018 position was; All Trust 13.1% All N&M 15.9%	Kevin Croft, Director of People and Organisational Development	Pen Parker Dawn Sullivan





Latest performance

- At the end of July the vacancy rate was 13.1% reflective of 1,430 WTE vacancies
- the number of staff directly employed, across all of the Trusts Clinical and Corporate Divisions was 9,427 WTE; an increase of 32 WTE from those employed in June
- for all nursing & midwifery roles, the vacancy rate was 15.9% (830 WTE vacancies)
- the overall vacancy rate for our Clinical and Corporate Divisions has decreased from the 13.6% reported in June due to an establishment reduction of 20 WTE and the 32 WTE more directly employed staff
- overall, total staffing numbers for July, including bank and agency, was 79 WTE under the total Trust post establishment

Safe – Vacancy rates

Key issues

- Workforce is a key issue across the NHS – in 2017 more nurses left the profession than joined.
- There are a number of factors that are compounding the workforce issue and making recruitment and retention of staff difficult: Brexit, the removal of the bursary, the sustained low pay increases, visa caps, the pressure of work and the reduction in CPD funding
- The London recruitment market is very difficult and there is more demand than supply
- There are national skills shortages and workforce planning across the NHS has not been a high priority to date
- High vacancy rates impact on patient safety and on staff engagement and morale

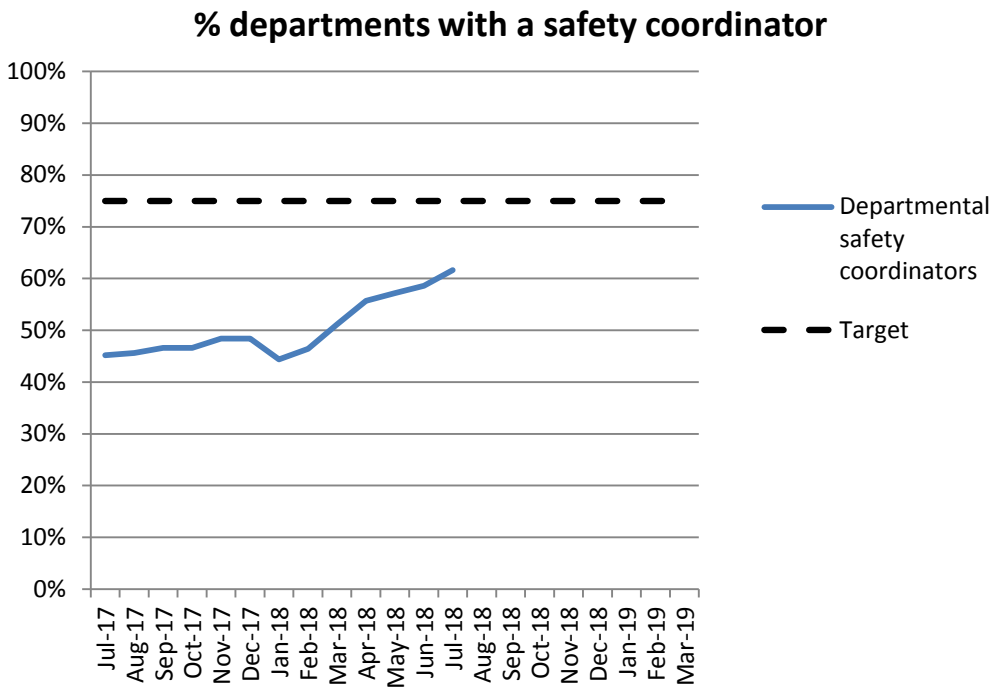
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
There is a Recruitment & Retention Action Plan in place for Band 2-6 N&M staff	Dawn Sullivan	1-3 years	• Plan refreshed for 2018/2019; retained approx 140 students, international recruitment commenced, campaigns in place for hard to recruit areas, tender underway to procure a new recruitment system to maximise recruitment activity and no. internal appointments continues to increase
The business case and funding for the Strategic Supply of Nursing	Dawn Sullivan/Sue Grange	1-5 years	• Funding secured for Nursing Associates, Graduate Apprentices, Retention schemes, International recruitment & resource to support N&M staff – all schemes underway
Participation in Cohort 3 of the NHSI Direct Support for Retention	Dawn Sullivan	1 year	• A plan will be submitted in August, NHSI visited on 24th July to discuss the plan & potentially and we received positive feedback on our progress
10-point recruitment plan	Dawn Sullivan	1 year	• The Trust recruited 1000 N&M staff in 2017/2018 & maintained vacancy rates with a 5% increase in headcount

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

Safe – Departmental safety coordinators (report 11)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	75% or greater	July 2018 performance was 61.6%	Kevin Croft, Director of People and Organisational Development	Bryan Joseph (Associate Director Occupational Health and Safety)

Clin/Corp Division	%
Division of Medicine & Integrated Care	60%
Division of Surgery, Cancer & Cardiovascular	52%
Division of Women's, Children's & Clinical Support	72%
Finance	83%
P&OD	93%
ICT	76%
Imperial Private Healthcare	100%
Office of the Medical Director	44%
Office of the Chief Executive	100%
Office of the Chief Nurse	93%
Press & Communications	50%
NWL Pathology	94%



Latest performance

At 17 August 2018 of the 424 staffed departments/locations, 276 had a trained departmental safety coordinator equating to 65% compliance. The department performance is shown above.

Safe – Departmental safety coordinators

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

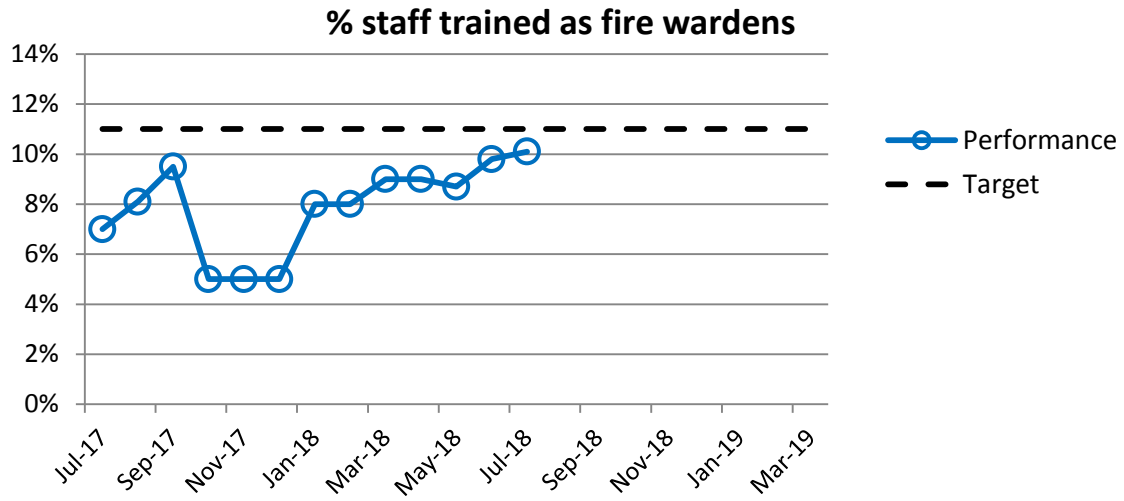
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Engagement from the Divisions to agree actions	Bryan Joseph	Ongoing	• All senior management were contacted on the 05/06/2018 to agree milestones to meet the Trust target. • Women's, Children's and Clinical Support Division expect to be above 75% by the end of July 2018. • Surgery, Cancer & Cardiovascular Division expect to be above 75% by the end of September 2018. • The Office of the Medical Director and Press & Communications expect to be 100% compliant by the end of September 2018.

Risk

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

Safe – Fire warden training (report 12)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure at least 10% of our staff are trained as fire wardens	11% or greater (10% with 1% variation to account for staff movement)	June performance was 9.8%; July performance was 10.1%	Janice Sigsworth (Director of Nursing)	Stuart Low (Fire Safety Officer)



Latest performance

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

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

Safe – Fire warden training

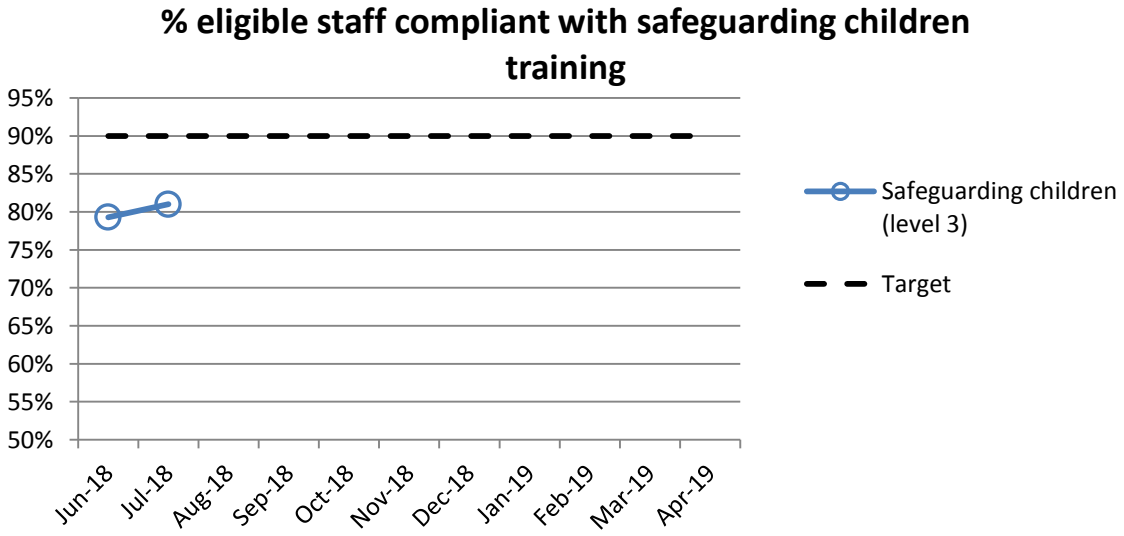
Key issues	Following data cleaning in October 2017 a significant reduction in the number of staff were shown to be trained as a Fire Warden. The cleansing removed staff who were listed as trained, but have since resigned from the Trust. This significantly reduced the number shown as trained from 9.5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

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Fire Warden Training	Fire safety team	Ongoing	• Fire Warden Training is part of the on-going fire safety training programme; the training is now a one hour session. The courses are delivered monthly at SMH, HH and CHX and at workplaces on a request basis. • 74 staff were trained in June and July. 10 courses were delivered. Uptake of the course is low. Courses can be booked on Yodel.

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

Safe– Safeguarding children training (level 3) (report 13)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90% or more	June 18 was 80% July 18 was 81%	Janice Sigsworth (Director of Nursing)	Guy Young



Latest performance

In July 2018,

- 81% of eligible staff were compliant with level 3 safeguarding children training

Safe – Safeguarding children training (level 3)

Key issues	The cohort of staff required to undertake level 3 safeguarding children training was expanded at the beginning of the financial year to include sexual health and the emergency departments. This was deemed necessary because of the increase in child safeguarding issues in these areas, for example in relation to child sexual exploitation. This had a negative affect on the compliance rate but this is increasing steadily month on month. This training cannot be done online and requires staff to attend a face-to-face session of at least half a day. This makes it more challenging to increase compliance.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Comprehensive schedule of training in place with a large number of confirmed forward bookings	Nicci Wotton	Compliance anticipated by the end of the year.	• Increasing month on month

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

Safe – Medical devices maintenance (report 14)

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

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

Latest performance

- There has been a continued improvement in maintenance compliance figures for medical devices.
- As the commitment is to improve the service, Head of CTS proposed to MDMG that the percentages, with effect 1st August 2018, are raised to
    - 98% for High risk
    - 80% for Medium risk
    - 70% for Low risk
- These will be the latest target figures going forward.

Safe – Medical devices maintenance

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

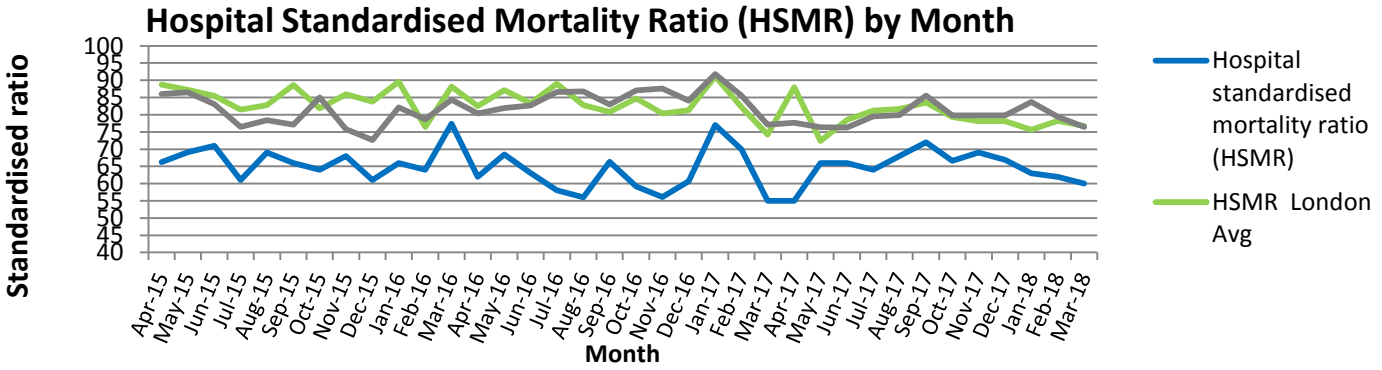
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Introduction of medical device categorisation	Aheed Syed (Operations Manager)	October 2018	• Risk based approach implemented and labels attached as part of RFID project. As maintenance is completed further updates will be made.
Radio-frequency identification (RFID) Implementation	Aheed Syed (Operations Manager)	October 2018	• Strategy developed and labels affixed, though still numerous devices to be located to get RFID label • Interaction between IT systems being developed
Training process for staff	Drushtee Ramah (Medical Device Principal)	September 2018	• e-Learning package is being developed which will then be rolled out in 2018 • Safety alert issued
Introduction of Equipment libraries	Max McClements (Head of CTS)	SMH (Jul-18); CXH (Oct-18); HH (Apr-19)	• SMH library open and systems being introduced. CHX library staff recruited and refurbishment scheduled to be completed by end of September. • HH library location being reviewed

Risk

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

Effective – HSMR (report 15)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will improve our mortality rates as measured by HSMR to remain in the top 5 lowest-risk acute trusts	Top 5 lowest-risk acute trusts	60 (Mar 2018) Lowest HSMR value of acute non specialist providers 64.2 (Full year data Apr 17 - Mar 18) 2nd lowest HSMR value of acute non specialist providers	Julian Redhead, Medical Director	Ellie Carter, Assurance and Compliance Improvement Lead



Latest performance

- Revalidation of the year's data via the HES dataset has now taken place, coordinated by NHS Information.
- Following this validation there has been no change to our March HSMR (60) but other providers figures have changed which means that ICHT now have the lowest HSMR of all specialist providers for March 2018. This suggests that, as has been the experience with previous revalidations, Imperial data hasn't changed that much (although other providers have).
- There is only a very small (0.2) change in the Financial Year 2017/18 HSMR (from 64.0 to 64.2) and no change in rank

Effective – HSMR

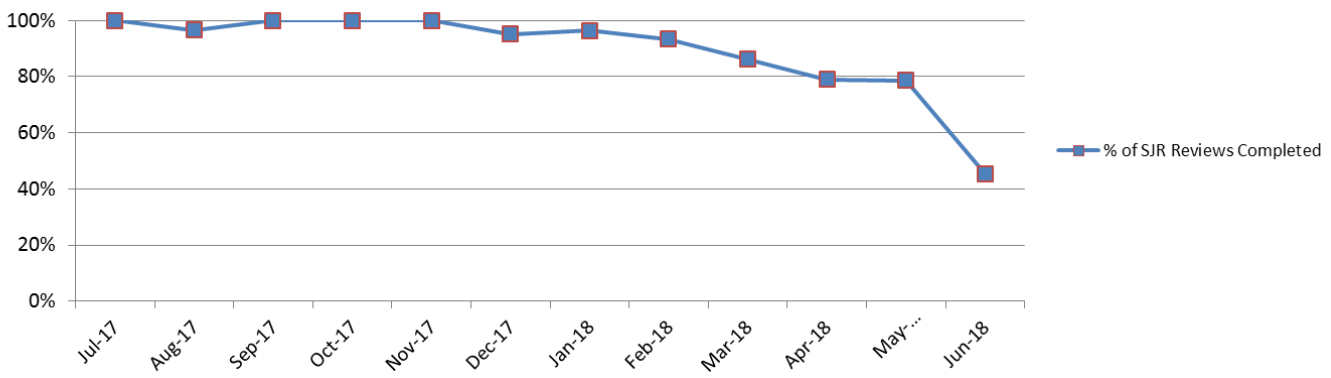
Key issues	Divisions receive divisional and directorate level HSMR data each month as part of their divisional scorecards. Although the Trust also receives specialty level HSMR data from Dr Foster, there is not currently a process for dissemination of this additional level of information.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Governance arrangements for sharing specialty level HSMR data as well as reporting on elevated HSMR scores to be agreed	Divisional Director's of Nursing	October 2018	Specialty level HSMR data has been shared with the divisions for review. All divisions have confirmed that there are not currently any areas of concern.
A plan for dissemination of the safety alert information provided by Dr Foster	Medical Director's Office/Business Intelligence	September 2018	Medical Director's Office to agree a new process for this with the Business Intelligence team to ensure that divisions are receiving the information.

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

Effective – Mortality reviews (report 16)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of all relevant deaths	SJR reviews completed: 79% - May 2018 45% - June 2018	Julian Redhead, Medical Director	Trish Bourke Mortality Audit Manager



Latest performance

- Trust compliance for local level 1 mortality review is 95% for May and 79% for June 2018, against a target of 100%. In order to instigate the SJR process at the earliest opportunity the timeframe for local mortality review is 7 days and a weekly performance report is now reviewed at the MD incident panel.
- Data is refreshed on a monthly basis as SJRs are requested and completed. This data is now reported 1 month in arrears to allow time for the SJR cycle to be completed. 47 completed reports have been received to date for this financial year (18/19), with 3 avoidable deaths reported. Trust compliance for SJRs is 79% for May and 45% for June 2018, against a target of 100%.

Effective – Mortality reviews

Key issues	Cases are reviewed at the monthly Mortality Review Group with a focus on any avoidable factors and learning themes. Early emerging themes map to six of the safety work streams: falls, abnormal results, safer medication, safer surgery, fetal monitoring, and responding to the deteriorating patient. As more cases are reviewed the group will be able to recommend any additional work streams to be considered as part of the trust improvement programme.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Data fields incorporated within the online module to facilitate thematic reporting future.	Mortality Auditor	June 2018	Complete. A field has been added to Datix to select investigation themes. The options are the Trusts 9 safety streams or 'other'.
Recruitment of additional structured judgement reviewers.	Mortality Auditor	September 2018	33 members of staff have undergone structured judgment review (SJR) training. This number is sufficient, however, further recruitment has commenced to ensure we have at least one reviewer in each specialty to facilitate local feedback of findings. Further nominations are required from divisions.
Consolidation of outstanding structured judgement reviews since the process was implemented including timescales for completion and a review of actions.	Mortality Auditor	End July 2018	An 'overdue' report for any outstanding SJRs has been compiled, and will now be circulated with the monthly MRG papers. Reviews completed to date currently align to 6 of the safety work streams.
Audit of completed SJR / correlation of results / second marking.	Mortality Auditor/AMD Safety	Dec 18	
Involving families in the review process.	Mortality Auditor/AMD Safety	Dec18	The National Quality Board have recently published their guidance on involving bereaved families and carers. New reporting measures may be required pending this introduction.

Risk

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

Effective – Patient reported outcome measures PROMs (report 17)

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

June Position			
Hip Replacement		**Knee Replacement**	
Participation Rate	**Reported Health Gain**	**Participation Rate**	**Reported Health Gain**
May 2018 – 0% June 2018 - 100%	EQ-5D Index: 0.404 EQ VAS: 18.048 Oxford hip score: 21.913 (Provisional Quarterly PROMs April2017-December2017 report June 2018 release)	May 2018 – 0% June 2018 - 100%	EQ-5D Index: 0.381 EQ VAS: 11.469 Oxford knee score: 13.966 (Provisional Quarterly PROMs April2017-December2017 report June 2018 release)

Latest performance

According to NHS Digital the Trust monthly participation rate was 0% in May 2018 and 100% in June 2018 for both hip and knee replacement.

The provisional Quarterly PROMS report (April2017- December 2017) report released in June 2018 shows improvement in health gain scores for hip and knee replacement. The EQ VAS score is more than the national average for both the procedures.

Effective – Patient reported outcome measures PROMs

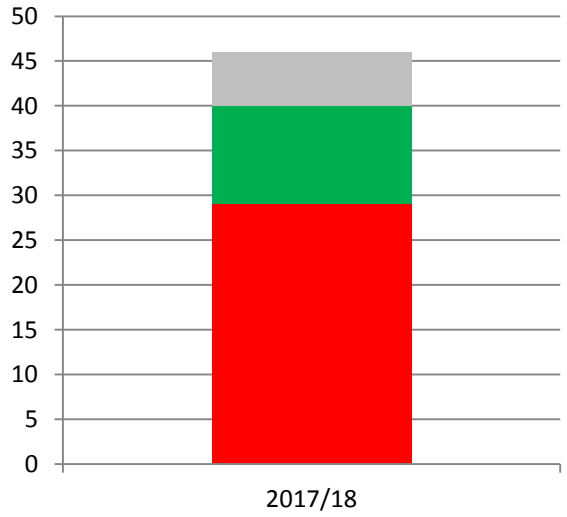
Key issues	Following the 0% participation rate in May, additional people have been allocated to support with the PROMs initiative as outlined in the improvement plans below. 78 forms were sent in June 2018. An external agency Capita is responsible for sending patients the second questionnaire post-surgery. In the past there have been issues with data collection from Capita. Procurement is in discussion with other external suppliers to address this issue.

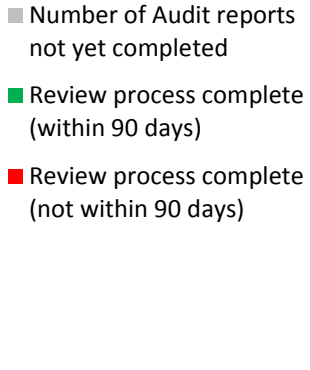
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Proposal being developed to contract new external supplier to replace Capita.	Anne Hall- GM /Lee Matthews – procurement	October 2018	Procurement in discussion with other external suppliers.
New process to contact all patients listed for elective hip/knee replacement surgery to complete the questionnaires.	Lucia Gallagher –Ward Matron	June 2018	Process in place.
Allocate dedicated Band 7 nurse to collate and drive service improvement for Trust PROMs initiative, to ensure submission rates are above 80% and calling each patient to remind them to complete post op questionnaire.	Donna Rodden – Arthroplasty Nurse	July 2018	Process in place. Two members have joined the team to support the process and expedite the submission rates, cover absences etc.

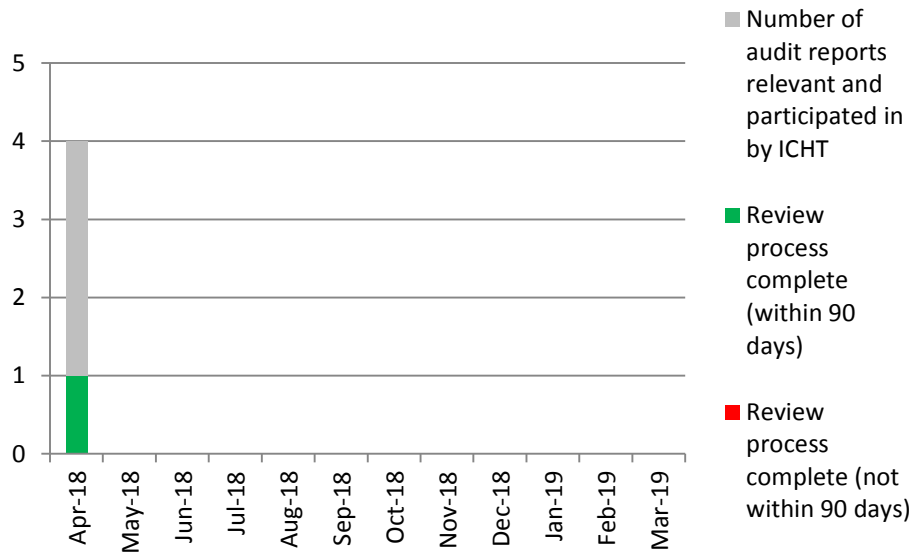
Risk
• Is it on the (divisional / corporate) risk register? YES (reference 2683)

Effective – National clinical audit (report 18)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	Participation in 100% of relevant national clinical audits	100% - April 2018	Julian Redhead, Medical Director	Louisa Pierce, Clinical Auditor
	Number of audits that have not completed the review process within 90 days	3 - April 2018		







Latest performance

The first graph demonstrates performance against Quality Account reportable National audit activity for the previous financial year 2017/18. 40 National audits have completed the review process (as of 17.08.2018) however, six remain outstanding and progress is tracked weekly at the incident panel.

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

Four National audits were published up until the end of April 2018. All of these were relevant to ICHT. ICHT participated in 100% of the relevant national clinical audits. One audit has completed the review process and three audits have not completed the internal review process within 90 days.

Effective – National clinical audit

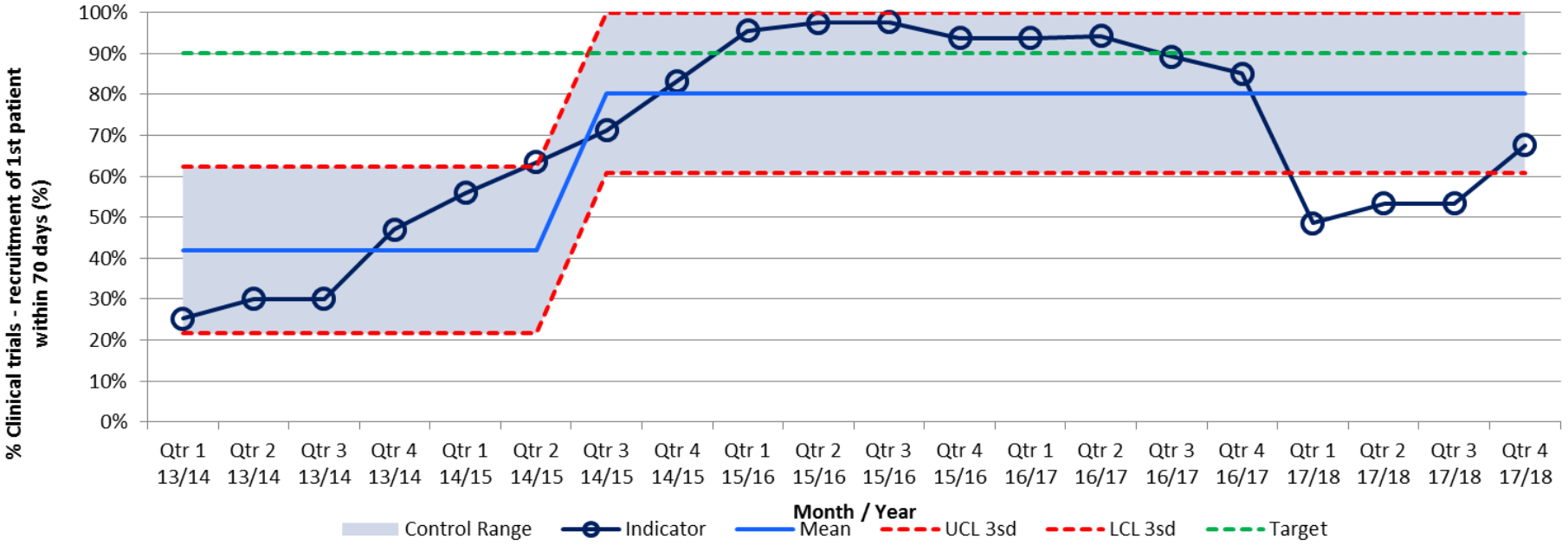
Key issues	Three of the 2018/19 national clinical audits are still with the divisions for review and are now overdue as they have exceeded the internally set 90 day review process.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
All significant risk audits to have an action plan in place that is presented to the quality & safety subgroup.	Raymond Anakwe/Audit Leads	Ongoing	Four audits from 2017/18 were identified as 'significant risk/little assurance'. Actions plans are in place and presented to the Quality & Safety Committee: 1. NCA- National diabetes audit, care processes and treatment targets MIC; 2. Adult critical care case mix programme (ICNARC) SCCS; 3. National Lung Cancer Audit Annual Report 2017; 4. National Heart Failure Audit NICOR.
Low risk and acceptable risk audits to be presented at divisional quality and safety committees.	Audit Leads	On-going	On-going.
Overdue audits escalated at the weekly Friday MD panel for review.	Louisa Pierce, Clinical Auditor	Weekly – On-going	Divisions provide regular updates based on discussions at divisional quality & safety meetings.

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

Effective – Clinical Trials Recruitment (report 19)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will ensure that 90% of clinical trials recruit their first patient within 70 days	Above 90%	Q4 2017/18: 67.6% *Q1 2018/19: 85.2% (provisional data)*	Julian Redhead, Medical Director	Heidi Saunders (Head of Clinical Research Operations) and Paul Craven (Head of Research Operations)



Latest performance

We have not achieved our target of 90% of clinical trials recruiting their first patient within 70 days of a valid research application. NIHR-validated data for Q4 2017/18 showed performance at 67.6% (a slight improvement on 64.3% in Q3 and above the national average of 60.7%). However, more encouragingly, provisional data for Q1 2018/19 shows 85% compliance against our target (to be validated by NIHR), which is a significant improvement on Q4. This is a result of weekly review of all studies by the JRO & Divisional Research Management teams, and escalation of “blockages” in the set-up process.

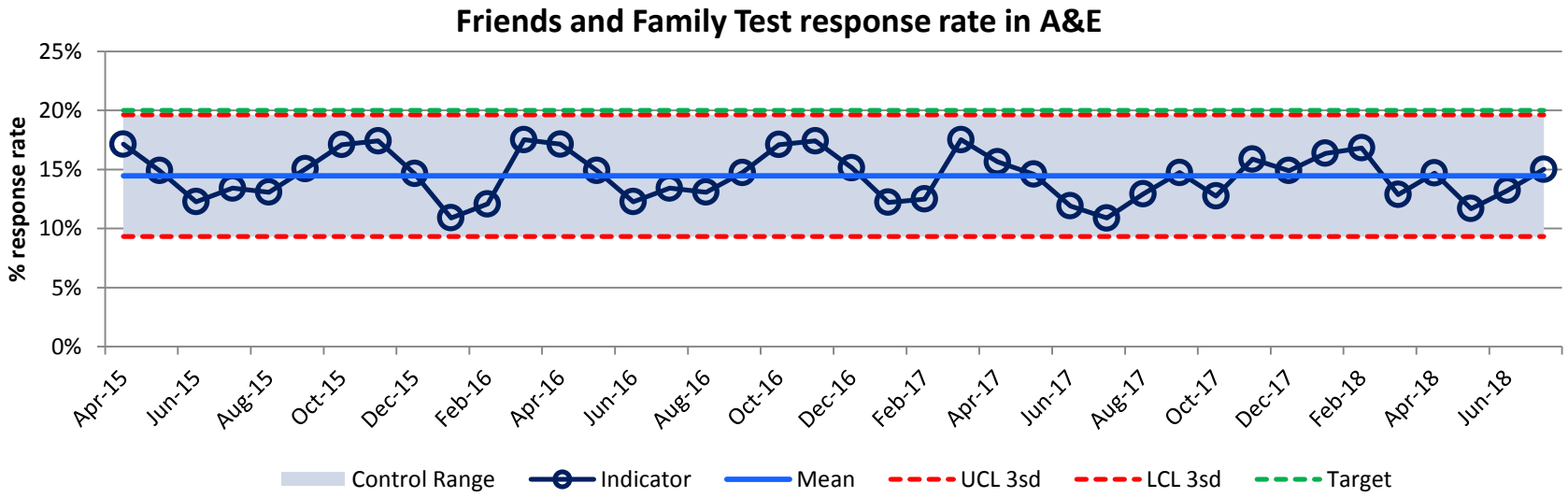
Effective – Clinical Trials Recruitment

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

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

Caring – Friends and Family response rate (A&E) (report 20)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve and maintain an FFT response rate of 20% in A&E	20% or greater	July 2018 performance was 15%	Janice Sigsworth	Stephanie Harrison-White (Head of Patient Experience & Improvement)



Latest performance

In July 2018

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

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

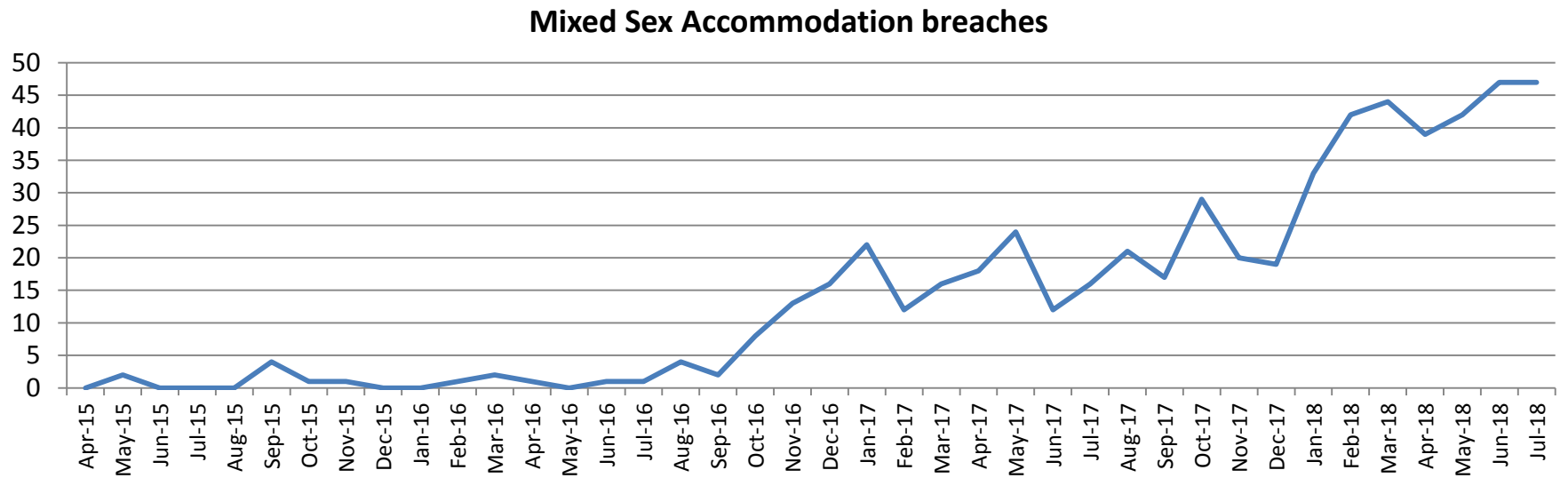
Key issues	In July we noted an increase in CXH and HH UCC's and CXH A&E response rates. This has coincided with the reduction in the length of survey as per action below. There has been some staffing changes within CXH A&E which are expected to be resolved in August so we are hopeful we will see a further rise in their response rates then.

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

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

Caring - Eliminating Mixed Sex Accommodation (EMSA) (report 21)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have zero mixed-sex accommodation breaches	0	July 2018 performance was 47 breaches	Dr Catherine (Katie) Urch	Melanie Denison Senior Nurse, Critical Care



Latest performance

The Trust reported 47 mixed-sex accommodation (MSA) breaches in July 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.

Caring - Eliminating Mixed Sex Accommodation (EMSA)

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

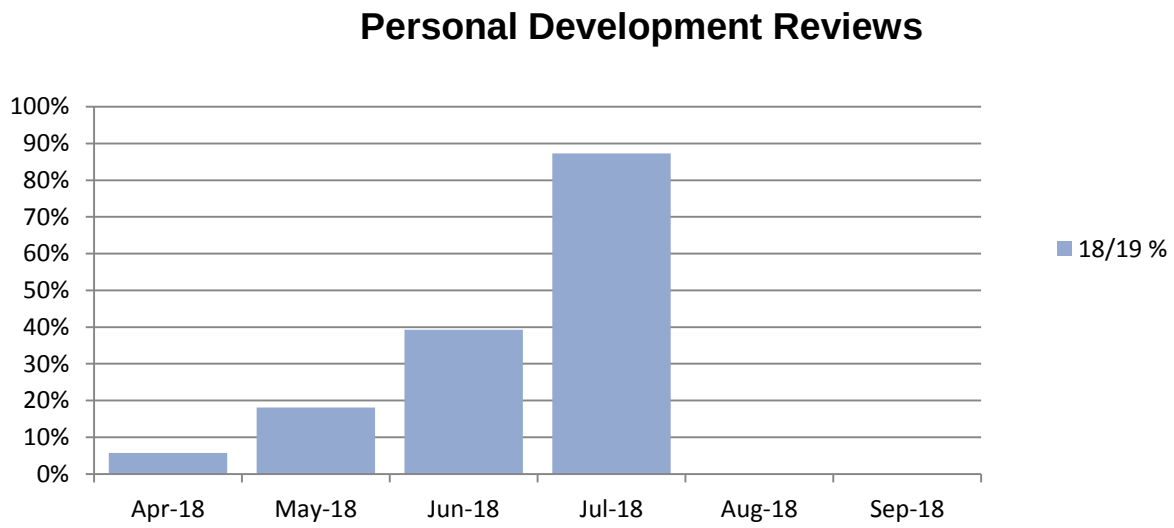
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Presentation of ICHT Mixed sex accommodation (MSA) breaches audit results with CCG Clinical Quality Forum	Julie Oxton	Jul-18	• Complete
Comparison of reporting methodologies and mitigations at other Trusts	Mary Mullix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

Risk

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

Well led – Performance development review (report 22)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a performance development review rate of 95%	95% by July 2018	July 2018 position was 86.7%	Kevin Croft (Director of People and Organisational Development)	Nathaniel Johnston



Latest performance

- Overall PDR Compliance for the 2018 season is 86.7% compared to 88.5% in 2017.
- WCCS: 91.5%, MIC: 85.8%, SCC: 83.4%, NWLP: 82.2%,
- IPH: 99.6%, Finance: 98.9%, Press & Comms: 95.5%,
- P&OD: 93.7%, ICT: 89.4%, Nursing: 87.1%, OMD: 86.1%, OCE: 44.4%

Well led – Performance development review

Key issues

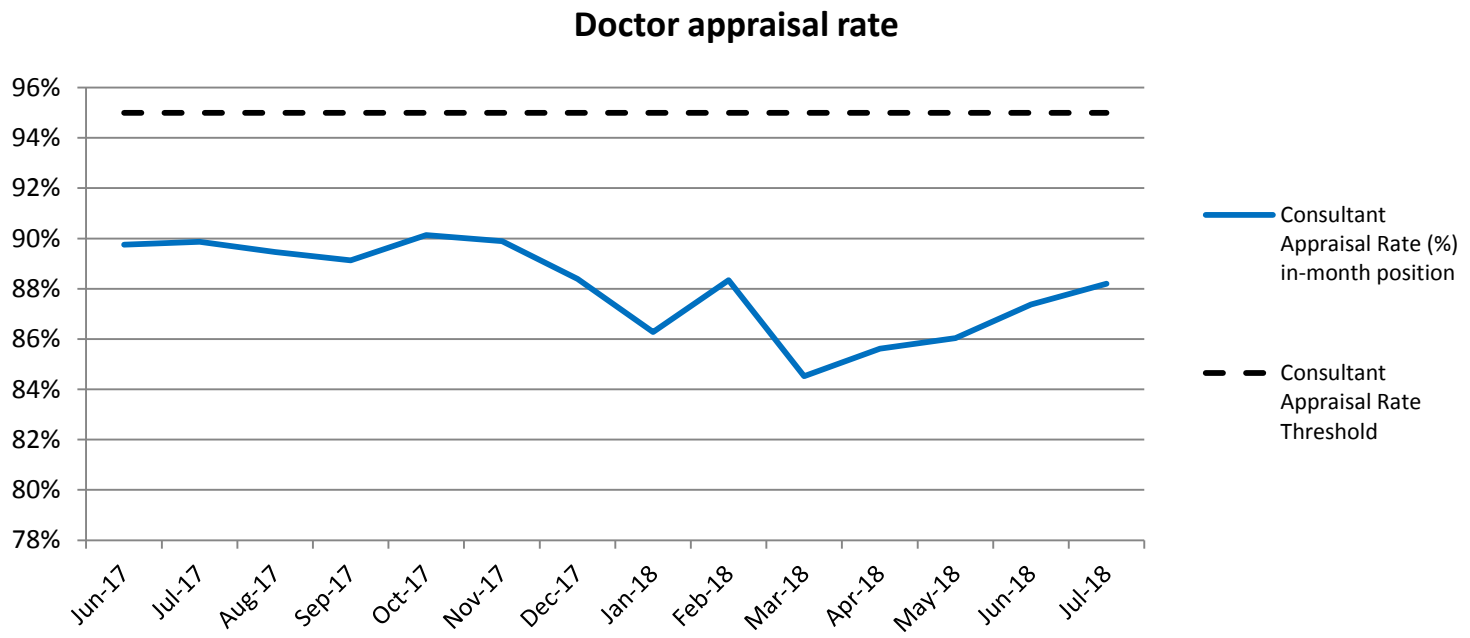
- A number of NWLP staff do not have full access to the Source to enter dates and grades into the e-PDR system. This has led to delays in recording PDRs into the system. This has been raised in NWLP senior team meetings with an action to ensure PDRs are timetabled for anyone who is not on long term sick. This will be raised at the NWLP board in September
- Operational pressures as well as senior leadership changes in a number of directorates in SCC have meant that PDR compliance has not had the same focus as last year.
- A number of managers in MIC have reported that PDRs are continuing to be entered throughout August and General Managers have asked staff to ensure any outstanding PDRs are timetabled. Slightly higher sickness absence in the division has added to delays in PDR's being undertaken
- PDR compliance to be reviewed at the August WCCS Senior team meeting
- Examples given of confusion about who should record PDRs as completed on the system, especially when PDRs are delegated to supervisors or shift leaders.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
PDR report will be re-run in September 2018 to take account of any additional PDR's recorded during August	Nathaniel Johnston	By end September 2018	
Review the reporting functionality of e-PDR/ new LMS system to send receipt/confirmation that PDR has been successfully recorded	Nathaniel Johnston	By end March 2018	
Revised guidance on responsibilities for recording PDRs	Nathaniel Johnston	By end March 2018	
Roll out the mid-year review process across the Trust as an additional mechanism to ensure regular conversations about performance and development are taking place	Learning & OD team, HRBPs	October 2018 – January 2019	

Risk

Well led – Doctor Appraisal Rate (report 23)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will achieve a non-training grade doctor appraisal rate of 95%	>=95%	87.37% - June 2018 88.20% - July 2018	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance

Performance continues to improve each month. Overall Trust performance has increased from 85.62% in April to 88.02% in July 2018.

Consultant grade compliance is at 89.02% compliance compared to 87.72% in April 2018 and career grade compliance has increased from 79.38% in April to 86.98% in July.

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

The target date for achieving the 95% compliance rate is September 2018 (M6).

Well led – Doctor Appraisal Rate

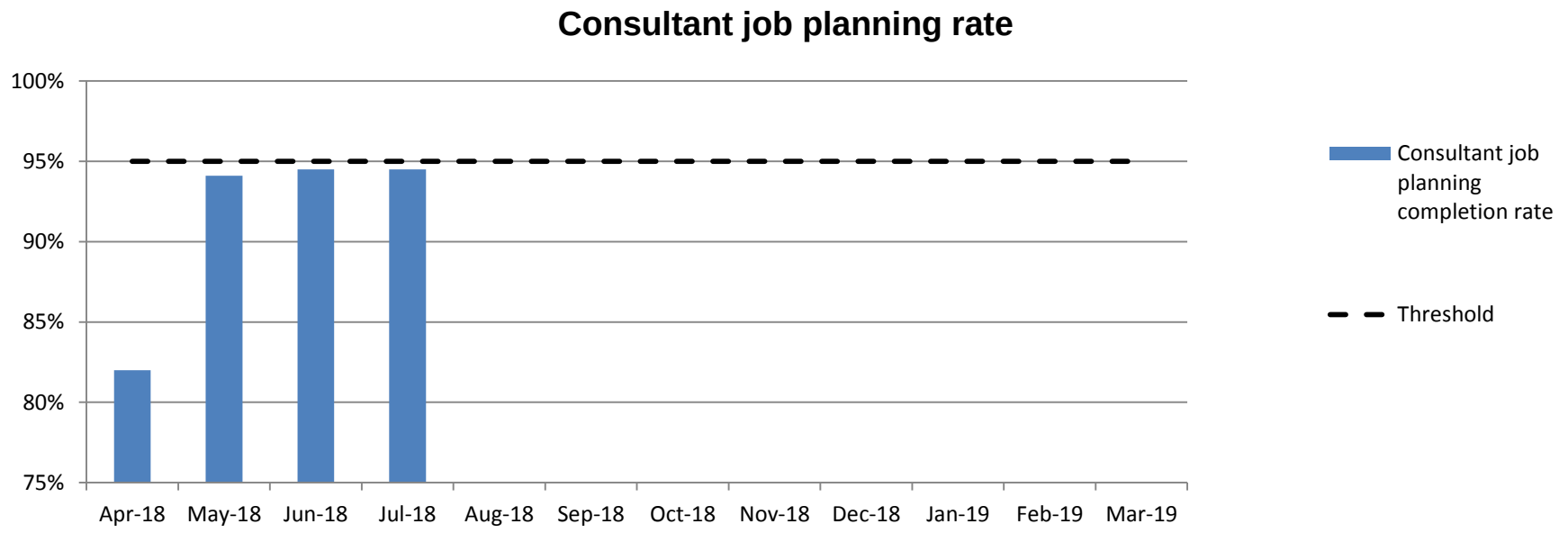
Key issues	Overdue appraisals (greater than 12 weeks) have not been consistently monitored by the Professional Development team, and therefore not escalated to the RO in a timely way. The first cohort of doctors who are significantly overdue appraisals have been escalated using the Trust policy. This has involved individual communication form the Deputy RO and engaging the Heads of Specialty and Divisional Directors where required. Initially there were 66 doctors identified in April who were 12 weeks overdue and risked being referred to the GMC for non-engagement. There is currently one doctor from this cohort who have not completed their appraisal and their individual circumstances are being considered by the deputy RO before definitive action is taken on GMC referrals. Once appraisals become overdue, the doctor has an additional 12 weeks after this date to compete their appraisal before entering the formal escalation process. Therefore the number of overdue appraisals does not necessarily correlate with the number of doctors who are in the escalation process. The AMD Professional Development has written a revised escalation SOP which has been implemented.

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Overdue appraisals not being consistently monitored and escalated- Implement policy for overdue appraisals.	Andrew Worthington, GM	Monthly from June 2018	Completed for the first cohort of doctors with overdue appraisals. Next cohort of overdue appraisals in escalation process.
Quality of PREP data- Professional Development team to perform data cleanse.	Victoria Ward, Prof Dev Team Manager	3 months	Work has started to improve the quality of data recorded in PReP. To be monitored at monthly performance meeting.

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

Well led – Consultant Job Planning (report 24)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will have a consultant job planning completion rate of 95% or more	>=95%	94.50% - June 2018 94.50% - July 2018	Julian Redhead, Medical Director	Andrew Worthington, General Manager MDO



Latest performance

The job planning round for 2018/19 has completed and analysis is in progress. Performance for July 2018 is 94.5% but this is expected to rise to above 95% compliance as the quality assurance work is completed by the Professional Development team.

Well led – Consultant Job Planning

Key issues	The job planning round for 2018/19 closed on 13th July 2018. Analysis of completed job plans will be completed this month. There are a small number of doctors who have not completed a job plan, and have been escalated to the Deputy RO for further intervention. The Professional Development team are currently completing a QA of existing plans and target training to make improvements ahead of the 19/20 round starting in the autumn. Job planning round for 2019/20 will commence in October 2018.

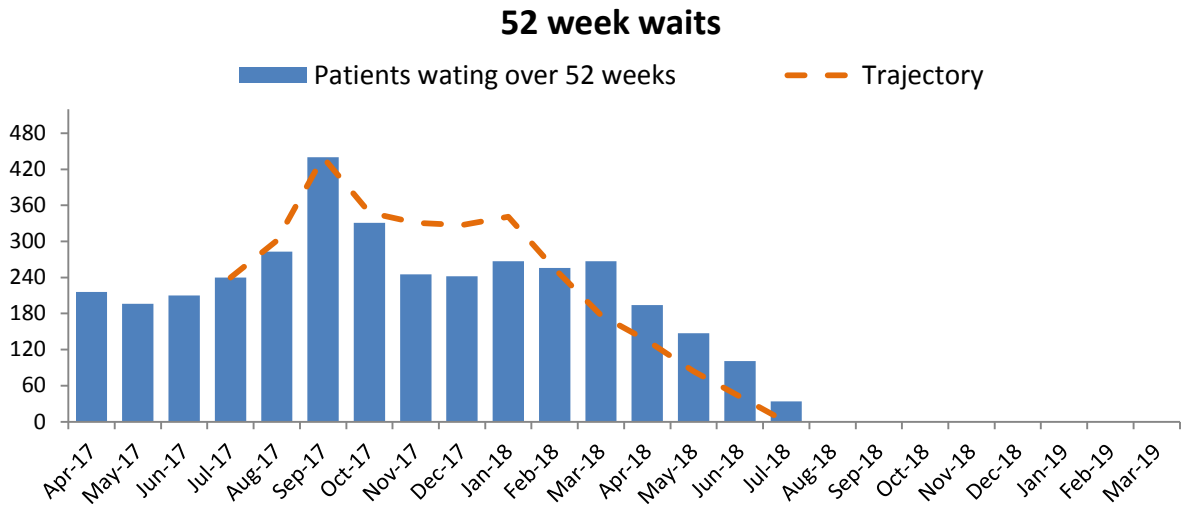
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
AMD Professional Development to write to all consultants to inform them that the round will close and that additional drop in sessions will be arranged during the preceding weeks.	Geoff Smith, AMD Professional Development	June 2018	Complete – 14th June 2018.
Non-compliant doctors to be escalated to AMD following end of job planning round.	Andrew Worthington, GM	July 2018	The Deputy RO has been notified of the doctors who have not completed a job plan for review.
Job plan quality assurance to be undertaken following completion of current round.	Victoria Ward, Prof Dev Team Manager	August 2018	Underway - to be completed in August 2018.
Communication to Clinical Line Managers regarding sign-off requirements and additional training ahead of new job plan round.	Geoff Smith, AMD Professional Development	September 2018	To be completed by September 2018.
Analysis of the components of job plans (SPA, EPA, research activity etc.) will commence to provide useful data for divisions.	Victoria Ward, Prof Dev Team Manager	August 2018	Currently in progress to be completed in August 2018.

Risk

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

Responsive – RTT patients waiting 52+ weeks (report 25)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the number of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0 at end July 2018	At end July 2018 34 patients were waiting 52+ weeks	Dr Catherine (Katie) Urch	Dominic Hart – Performance Support Business Partner



Latest performance

In July 2018 the Trust treated 115 patients who had waited over 52 weeks. At the end of July the Trust reported 34 patients waiting over 52 weeks for treatment, a reduction of 67 compared the previous month but still above the zero trajectory target.

- Of the 34 patients over 52 weeks at the end of July, 20 had tipped-over in the month (a tip-over is defined as a pathway previously known on the PTL that tipped over 52 weeks in the month leading up to the census date) and there were 7 over 52 week pop-ons (a pop-on is defined as a pathway not on the previous month's submission) in July.

12 of the 34 patients have now been treated and 10 have a future TCI in August or September.

Responsive – RTT patients waiting 52+ weeks

Key issues

- The Trust continued to improve on its position in July but still faces some challenges to reach the zero trajectory target due to patient choice over the summer period and treating a number of complex pathways.
- Risks continue with some individual consultant capacity over the summer period.
- The impact of continued cancellations of elective care owing to emergency/non-elective surge requiring beds and theatre lists to treat emergency patients continues to be a risk.
- The number of 'system errors' appearing through the validation process is a cause for concern – multiple checks are in place to review these and system solutions are being sort where possible to eradicate them.

However:

- The sustained review and provision of RTT training aims to improve knowledge and application of RTT
- The use and development of validation tools is providing greater visibility of progress within services
- There is on-going review and monitoring of the Trust's 52 week wait position
- All patients waiting over 52 weeks continued to be reviewed for clinical harm in line with the agreed validation process. The clinical harm review of the July 52 week breach patients did not identify any incidences of patients receiving clinical harm due to their extended wait for treatment
- One 'system error' fix has been applied to the PTL reducing the number of repeat validations required for specific pathways. Another system error fix scheduled in the near future.

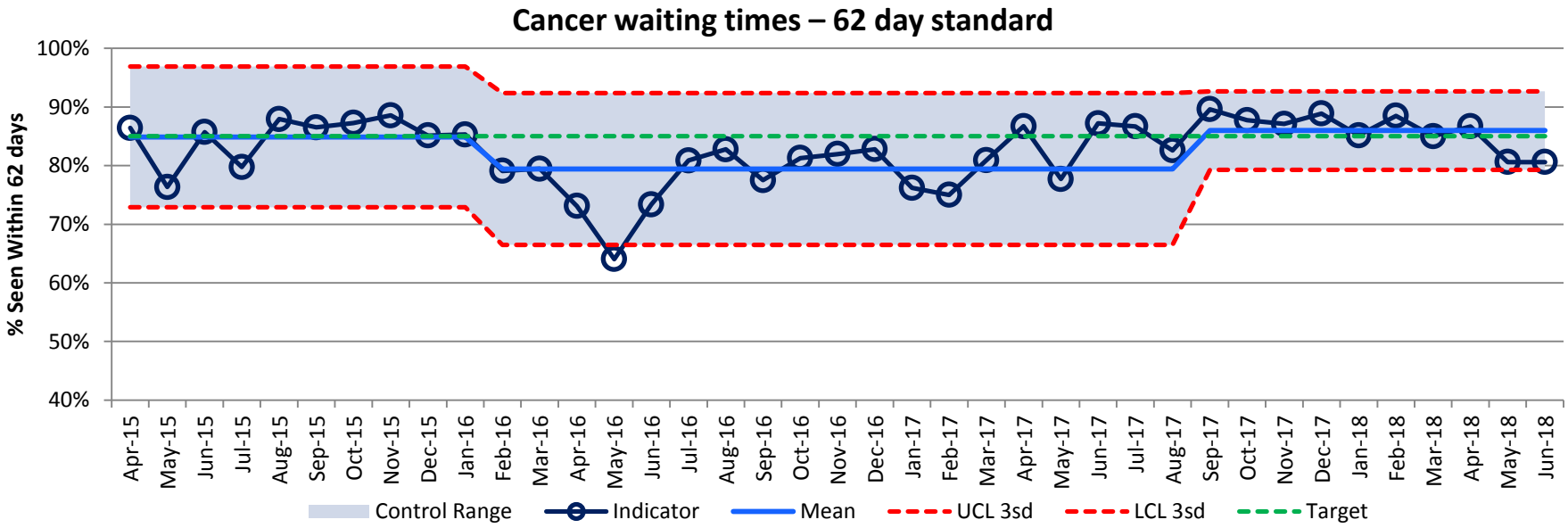
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
SCC Division hold a weekly touch-point meeting with WCCS and MIC Divisions	Martina Dinneen	Bi - Weekly to 31 August 2018	• Improved oversight and monitoring of forecast and provisional position to ensure that both NHSI,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

Risk

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

Responsive – Cancer 62-day waits (report 26)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will maintain the percentage of cancer patients who are treated within 62 days from urgent GP referral at 85% or more	85% or more	April-18: 86.7% May-18: 80.6% June-18: 80.6%	Dr Catherine (Katie) Urch	Gareth Gwynn



Latest performance

- In August 2018, performance is reported for the cancer waiting times standards in June 2018 due to the lag in reporting.
- In June the Trust delivered six of the eight national cancer standards.
- The Trust underperformed against the 62 day GP referral to first treatment standard due to diagnostic capacity issues on the prostate pathway and sustained pressure from late referrals from other NWL sites.
- The Trust underperformed against the 62 day screening standard due to issues with the management of patient choice within the breast screening service.

Responsive – Cancer 62-day waits

Key issues	• Prostate diagnostic biopsy shortfall was driven by: a) capacity not being sufficient to manage increasing demand following improvements to the diagnostic pathway under the RAPID project and the subsequent national media coverage; b) dependence on ad hoc sessions, exposing the underlying problem of insufficient biopsy capacity; c) service coordination, impacted by vacancies and handover processes since January 2018. • In Q1 and June there was an improvement in the median days waited at the point of referral from other NWL sites. However, for those referred after the nationally agreed target of day 38, the waiting times increased significantly, with many patients being referred after day 62. • There was also an increase in the number of patients being referred to ICHT requiring diagnostic work up, including for diagnostic modalities available at the referring trust.

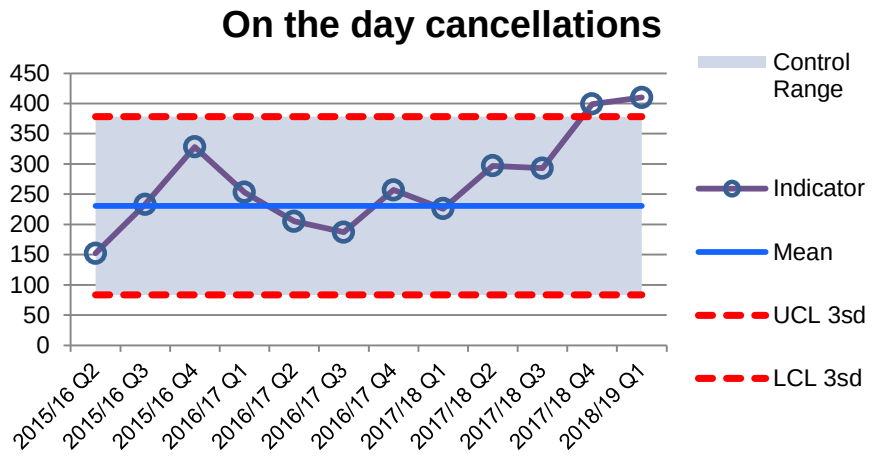
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Resolve the prostate biopsy backlog	Mark Robson	July 2018	Completed
Establish sufficient baseline capacity for future prostate 2WW referrals	Norma Gibbons	September 2018	Interim capacity plan agreed to increase slots from 7 to 15 per week through to September. Service developing sustainable plan for capacity beyond September
Increase capacity for HIFU and cryotherapy	Norma Gibbons	September 2018	As above. Capacity increased from 6 to 10 slots per month for each modality to the end of September
Implement full RAPID pathway	Hash Ahmed	October 2018	£943k investment agreed with RMP and MPU signed in September 2017. Recruitment and capital procurement initiated
Shared pathway performance improvements	Gareth Gwynn/ CCG	October 2018	Activity audit underway. Actions specific to referring sites to be agreed with CCG

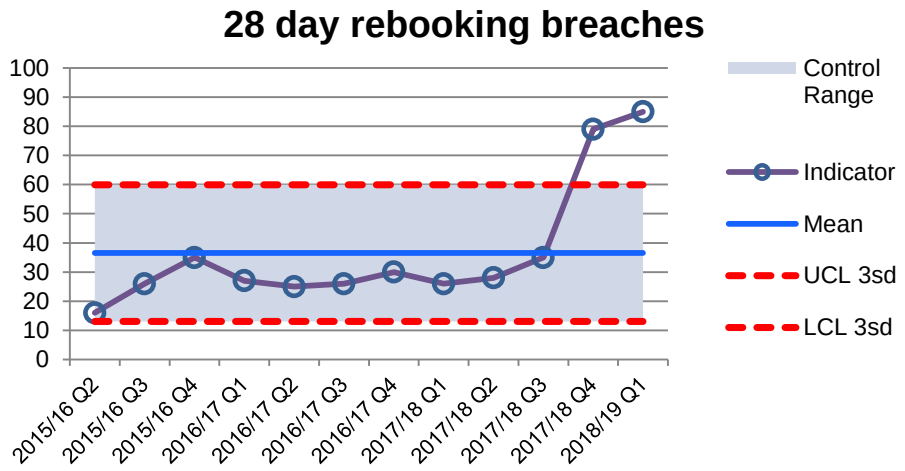
Risk

- Is it on the (divisional / corporate) risk register? YES linked to corporate risk 2510, failure to maintain operational performance standards.

Responsive – cancelled elective operations (report 27)

Indicator	Target	Latest data	Executive lead	Report author(s)
Reduce cancelled operations and ensure patients are rebooked to within 28 days of their cancelled operation	Below national average	Latest fully reported quarter is quarter ending June 2018	Dr Catherine (Katie) Urch	Terence Lacey (Performance Support Business Partner); David Woollcombe-Gosson (Programme Manager, Surgical Productivity)





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

In the quarter ending June 2018:

- On the day (OTD) non-clinical cancelled operations remained high. There were 410 such cancellations, equating to 1.3% of total elective admissions. This was above the national figure for NHS cancelled elective operations in England of 1.0% for the same period.
- The 28 day rebooking breach remained high. Of the 410 cancellations, 20.7% of patients were not treated within 28 days of their operation being cancelled. This was above the national figure of 10.8%.
- Using quarterly data points the above SPC charts demonstrate process changes in reportable cancellations and rebookings. As discussed overleaf this is being assessed.
- *Source: Quarterly Monitoring of Cancelled Operations (QMCO), NHS England*

Responsive – cancelled elective operations

Key issues

OTD non-clinical cancellations and time to rebooking increased during the early part of 2018. This was related to the national mandate to support emergency pathways through temporary postponement of non-urgent elective activity. Alongside this there were continued operational pressures.

Overall cancellation rates and reasons vary significantly by site and appear to be largely driven by specialties and case mix completed on each site rather than site-specific issues. The reasons for reportable (QMCO) cancellations are more consistent, with ward bed unavailable, earlier case overran and higher priority case accounting for 64% of all non-clinical cancellations. The principal reasons and affected specialties on each site are:

- SMH (48% of reportable cancellations) - Top 3 reasons: Ward bed unavailable, earlier case overran, higher priority case. Top 3 affected TFCs: General surgery, ENT, vascular
- CXH (27%) – Top 3 reasons: Earlier case overran, staff unavailable, ward bed unavailable. Top 3 TFCs: T&O, urology, neurosurgery.
- HH (20%) – Top 3 reasons: Earlier case overran, higher priority case, ward bed unavailable. Top 3 TFCs: Cardiothoracic, nephrology, transplantation.
- WEH (5%) – Top 3 reasons: Higher priority case, earlier case overran, patient inadequately prepared.

The Trust has a number of mitigating workstreams in place to both improve understanding and monitoring of cancellations, and to address the root causes wherever possible. This includes a dedicated supporting workstream within the overarching surgical productivity programme, which will cover all cancellations (incl. DNA) and not just those non-clinical cancellations that are reportable for national QMCO monitoring.

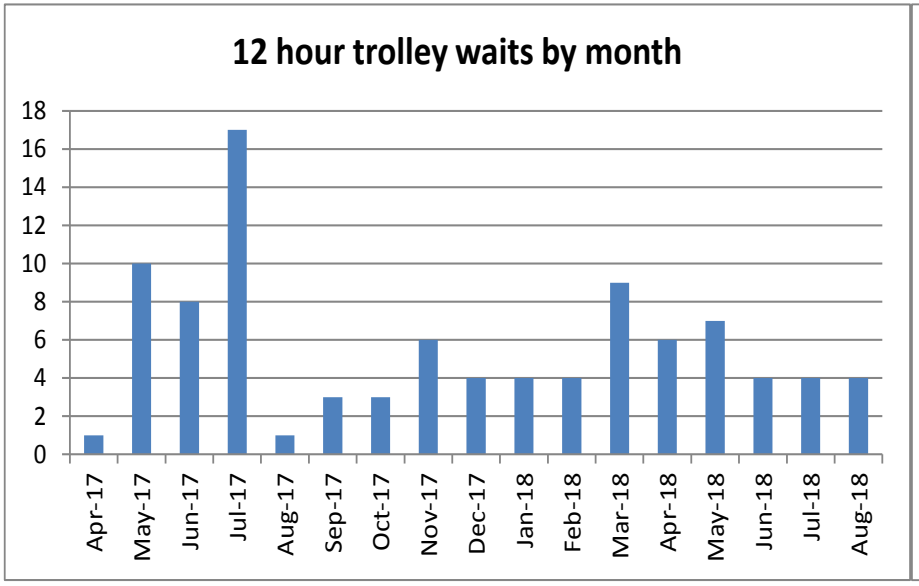
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Establish OTD cancellations group to develop workstream	Ksenya Kirnitski	Sep 18	Due to begin September with an in-depth review of OTD cancellations by site and speciality to establish root causes
Develop On the Day cancellations Standard Operating Procedure	David Woollcombe-Gosson	Q3 2018/19	Review current trust wide escalation procedures completed and outline review & authorisation process drafted
Strengthen review of OTD cancellations and tracking of 28-day re-book patients via theatre planning process	Nadja Yohannes	Q3 2018/19	
Fund the move elective care procedures to CXH that do not require critical adjacencies/infrastructure on SMH site through the provision of an additional procedure room in Riverside CXH	Martina Dinneen/ Hugh Gostling	Nov 18	

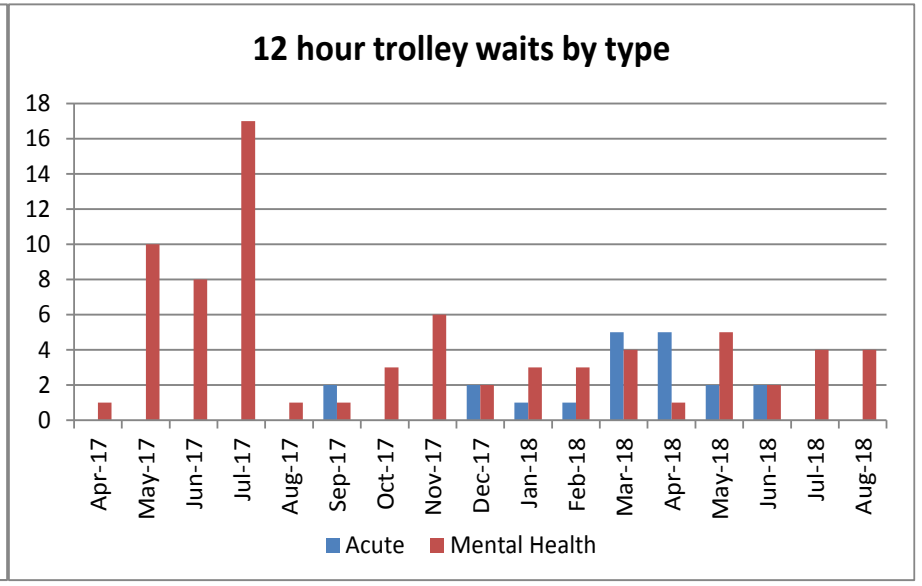
Risk

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

Responsive – 12 hour trolley waits – August 2018

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





Latest performance

- The number of 12 hour breaches remained at 4.
- All 4 breaches were mental health related and on the SMH site. There were no Acute 12 hour Breaches reported for the month.

Responsive – 12 hour trolley waits

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

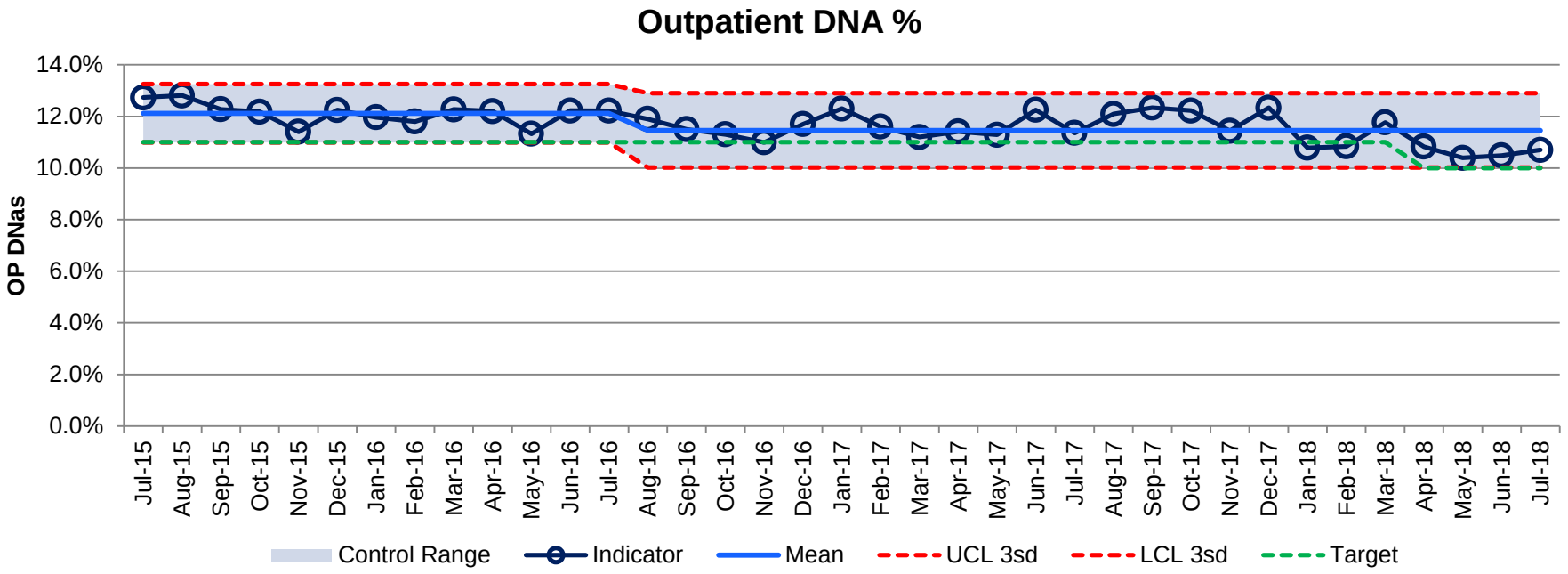
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Review current 12 hour trolley wait trust wide escalation procedures	Sarah Buckland	July 18	Completed
Develop 12 hour trolley wait SOP	Sarah Buckland	August 18	Document in draft
Creation of 2 crisis calming rooms in CXH ED (136 compliant) as part of the ED redevelopment	Sarah Grace	December 18	On track for delivery
Improvement of the ED environment for mental health patients at SMH	Sarah Grace	Q4 2018/19	5k grant awarded and plan of work agreed, further funding being sourced
Joint working with CNWL to develop 'gold standard' pathway for mental health	Sarah Grace	Q3 2018/19	Due to begin August 18
Agreement of breach reduction trajectory for the 4 hour standard for mental health	Sarah Grace	Q2 2018/19	10% reduction by September 2018 has been agreed following a joint audit conducted with CNWL, West London MH and NWL CCG
Presentation of RCA reports for all breaches to the A&E Delivery Board	Claire Braithwaite	Monthly	Commenced

Risk

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

Responsive – Outpatient did not attend rates (report 29)

Indicator	Target	Latest data	Executive lead	Report author(s)
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%	10.7% (July 2018)	Tg Teoh	Damien Bruty (General Manager)



Latest performance

- The target for outpatient DNAs was reduced from 11% for 2017/18 to 10% for 2018/19
- The overall DNA rate was 10.7% in July 2018, an increase on the 10.4% for June 2018. This was within the control limits for this indicator and did not highlight special cause variation.
- The outpatient DNA rate of 10.82% for January - July 2018 remains higher than the Trust target of 10%. This compares to an 11.95% DNA rate for July – December 2017.
- Targeted intervention undertaken in December 2017 to increase the utilisation of text and voicemail reminder services has reduced the DNA rate, but subsequent performance has plateaued

Responsive – Outpatient did not attend rates

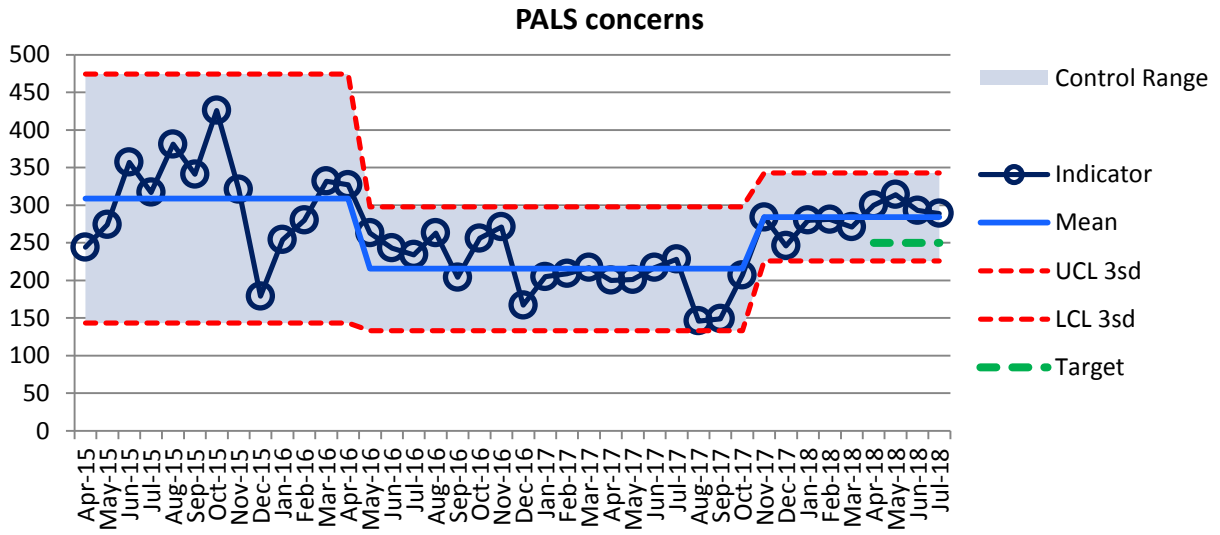
Key issues	• Whilst outpatient DNA rates have reduced during 2018, achieving a DNA rate of <10% requires a step change in approach. • Efforts to increase the coverage and usage of text and voice reminder services have been exhausted, with no further gains anticipated. • Since March 2018, patients have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

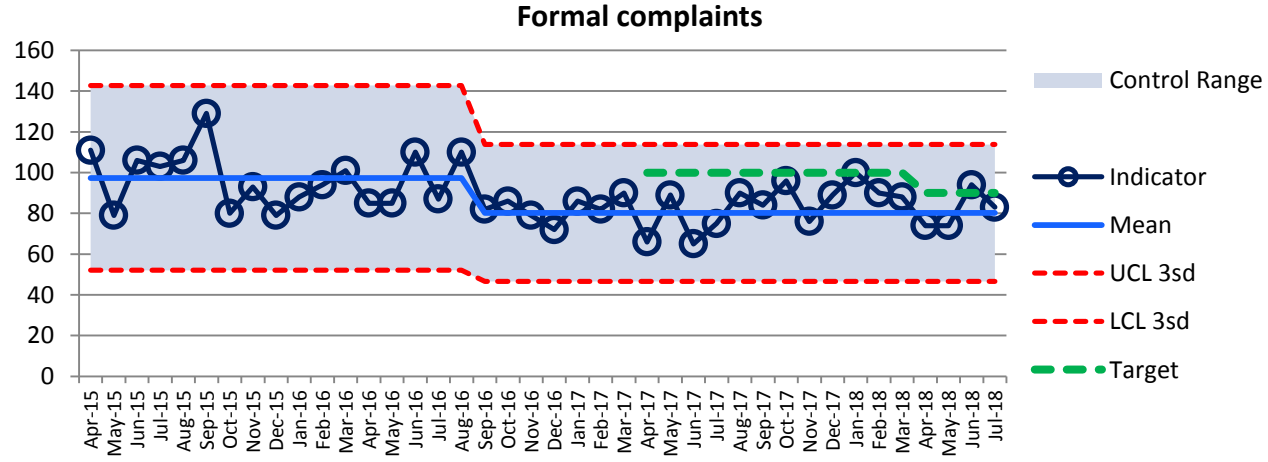
Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Analysis of e-RS Outpatient DNA rate to be undertaken, to inform next steps for targeted intervention	Cameron Behbahani / Damien Bruty	November 2018	
Assurance review of Trust PIMS database to be completed to enable appointment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

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

Responsive – Complaints management (report 30)

Indicator	Target	Latest data	Executive lead	Report author(s)
• We will maintain numbers of PALS concerns at less than 250 per month	250	289 PALS concerns reported July 2018	Janice Sigsworth (Director of Nursing)	Guy Young





Latest performance

PALS concerns remain above the threshold of 250, but remain within the SPC control limits and performance appears stable.

Formal complaints remain stable and within the target threshold.

Responsive – Complaints management

Key issues	The higher numbers appear to be for a range of reasons, but concerns about appointments (predominantly outpatient delays and cancellations continue to account for a significant volume).

Improvement plans and actions (taken and proposed)	Lead	Timescales	Progress update
Liaison and communication of complaints		Ongoing	PALS & complaints continue to liaise with the clinical services and through divisional governance meeting; actions required sit primarily under the outpatient improvement programme.

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

Appendices

Appendix 1 Exception report slides tracker

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

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

	Indicator heading	Executive Committee Reporting	Progress update
Effective	HSMR and SHMI	Executive Quality Committee	**Exception report slides provided (HSMR)**
	Palliative care coding	Executive Quality Committee	Within tolerance / target
	Mortality reviews	Executive Quality Committee	**Exception report slides provided**
	Unplanned readmission rates	Executive Quality Committee	Within tolerance / target
	PROMs	Executive Quality Committee	**Exception report slides provided**
	National Clinical Audits	Executive Quality Committee	**Exception report slides provided**
	Clinical trials - recruitment	Executive Quality Committee	**Exception report slides provided**
Caring	FFT - % recommended	Executive Quality Committee	Within tolerance / target
	FFT A&E service - % response	Executive Quality Committee	**Exception report slides provided**
	Mixed-sex accommodation (EMSA) breaches	Executive Quality Committee	**Exception report slides provided**
Well led	Staff retention	Executive People & OD Committee	Within tolerance / target
	Voluntary staff turnover rate	Executive People & OD Committee	Within tolerance / target
	Sickness absence rate	Executive People & OD Committee	Within tolerance / target
	Personal development reviews	Executive People & OD Committee	**Exception report slides provided**
	Doctor appraisal rate	Executive People & OD Committee	**Exception report slides provided**
	Consultant job planning completion rate	Executive People & OD Committee	**Exception report slides provided**
	NHSI - provider segmentation	Executive People & OD Committee	Within tolerance / target
Responsive	RTT 18 weeks performance	Executive Operational Performance Committee	Within tolerance / target
	RTT 52+ weeks	Executive Operational Performance Committee	**Exception report slides provided**
	RTT 52+ weeks clinical harm reviews	Executive Operational Performance Committee	Within tolerance / target
	Cancer - 62 day waits	Executive Operational Performance Committee	**Exception report slides provided**
	Cancelled operations	Executive Operational Performance Committee	**Exception report slides provided**
	A&E 4 hour waits	Executive Operational Performance Committee	Within tolerance / target

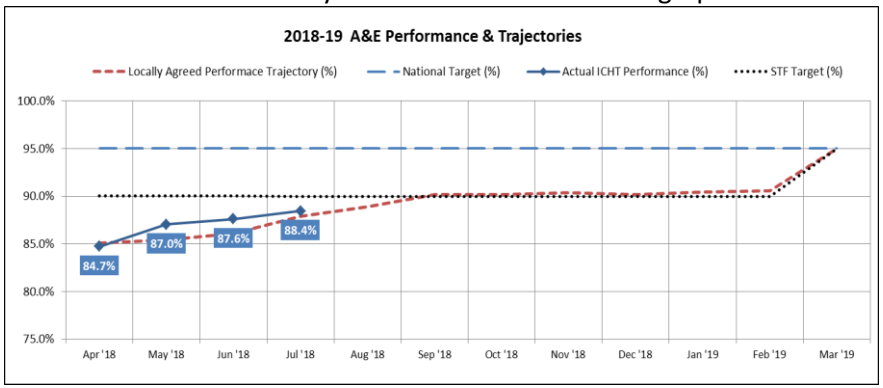
	Indicator heading	Executive Committee Reporting	Progress update
	A&E 12 hour trolley waits	Executive Operational Performance Committee	**Exception report slides provided**
	Discharges before noon	Executive Operational Performance Committee	Threshold is being set
	Stranded and super stranded	Executive Operational Performance Committee	Threshold is being set
	DTOC rate	Executive Operational Performance Committee	Within tolerance / target
	Diagnostic waits – over 6 weeks	Executive Operational Performance Committee	Within tolerance / target
	Waiting times for first Op appointment	Executive Operational Performance Committee	Within tolerance / target
	Outpatient HICS	Executive Operational Performance Committee	Metric being reviewed
	Outpatient DNA	Executive Operational Performance Committee	**Exception report slides provided**
	Outpatient apps within 5 working days	Executive Operational Performance Committee	Metric being reviewed
	PALS concerns	Executive Quality Committee	**Exception report slides provided**
	Complaints - formal complaints	Executive Quality Committee	Within tolerance / target
	Complaints – the average number of days to respond	Executive Quality Committee	Within tolerance / target
	Orders waiting on Add/Set Encounter list	Executive Operational Performance Committee	Slides not provided – report being developed
	OP apps not checked-in or DNAd	Executive Operational Performance Committee	Slides not provided – report being developed
	OP apps checked In AND not checked out	Executive Operational Performance Committee	Slides not provided – report being developed
	Patient transport	Executive Operational Performance Committee	Slides not provided – report being developed
	Critical care patients admitted within 4 hours	Executive Operational Performance Committee	Indicator only included at month 4 and too early to develop report

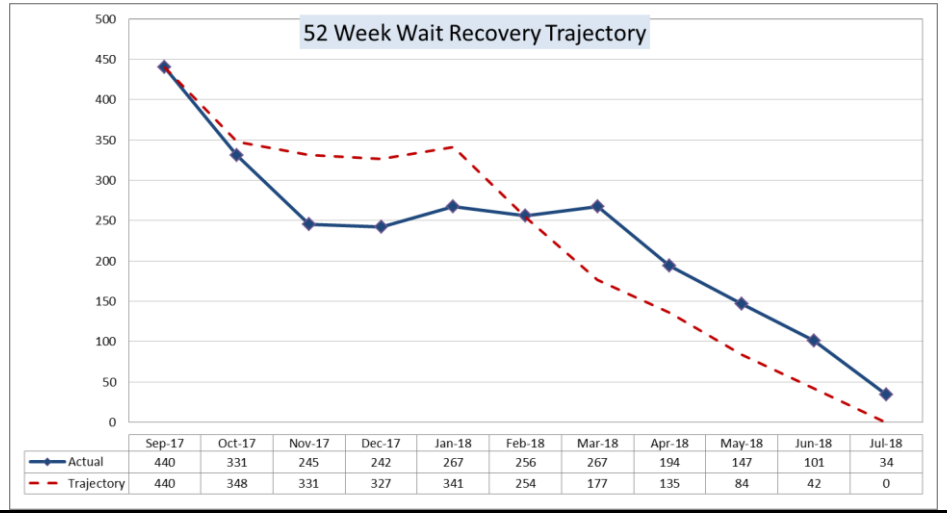
Appendix 2 Imperial Undertakings Tracker

NHS Improvement

At 21 August 2018

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
Finance	1.1	Return to underlying surplus with year on year improvements in the underlying position	Start of 2021/22	In progress	Work is continuing on our Specialty Review Programme and our transformation programme which will form the building blocks of the recovery plan. We are looking at options for coordinating the work, and the resources and structures necessary to support delivery of the plan. An interim Director of Transformation to lead the delivery of the trust's transformation programme will start at the beginning of September.
	1.2	Develop a financial recovery plan to return to surplus by the start of 2021/22	30 November 2018	In progress	We are modelling a four year path to sustainability, identifying and testing assumptions on the level of cost improvement programmes required to close the underlying deficit. The agreed 2018/19 plan will form the first year of the recovery plan
	1.3	Clear timetable and milestones for Financial Recovery Plan including recurrent CIP to deliver 2018/19 control total	31 January 2018 23 January FROG	In progress	We have a Trust plan for 2018/19, including agreeing income with commissioners. As part of that we have developed a challenging CIP programme of £48m. Almost £40m of the £48m target has been identified.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
A&E	2.2	Maintain A&E performance of at least 90%	2018/19	In progress	Trust Performance for the year to date is shown in the graph below.  • Performance for the month of July 2018 was 88.4%. This is 0.5% above the locally agreed target for the month as well as a 0.8% improvement from June 2018. The Trust is currently on track to deliver 90% internal performance by September. • The Improving Patient Flow Programme initiatives are progressing alongside an internal 90 day Patient Flow Collaborative. In addition between August and December 2020 Delivery will be working with the Trust to support patient flow and performance improvements. • Fortnightly programme updates are provided to NHSI to ensure oversight of development against individual targets and suggested milestones. • Actions in place to improve A&E Performance are being managed both internally and via the wider committees such as the ICHT A&E Delivery Board.
	2.3	Maintain A&E performance of 95%	31 March 2018	In Progress	As above.
	2.4	Develop and submit to NHS Improvement a dashboard allowing the Trust Board to track the effectiveness of the Improving Patient Flow plan	To POM meetings	Completed	The Improving Patient Flow Programme 2018/19 continues to be shared weekly with the A&E Delivery Board, CCG and NHSI.

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
RTT & 52 weeks	3.1	Validate the number of 52 weeks waits and ensure all receive treatment or are discharged	July 2018	In progress	RTT long waiters (40+ weeks) are managed by clinical Directorates and Divisions, supported by the Elective Care Delivery Manager and the Trust's Waiting List Improvement Programme (WLIP). All long-waiting patients are validated and actively tracked on a weekly basis, and monitored through specialty-led PTL meetings. The Trust-level 52-week recovery trajectory was agreed and circulated in November 2017, and disaggregated to specialty level in December 2017. After a very challenging winter period the Trust is behind its trajectory, reporting 34 patients >52 weeks in July 2018 against a trajectory of 0. Additional governance and reporting is now in place for particularly challenged specialties. This has been a contributory factor to the progress made so far, but continued intense focus will be required to deliver to the July trajectory target of zero 52-week waits. 

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Actual	440	331	245	242	267	256	267	194	147	101	34
Trajectory	440	348	331	327	341	254	177	135	84	42	0

	No	Summary of undertaking	Timeframe [date]	Not started/ in progress/ completed	Trust actions and comments
	3.2	Develop and submit an RTT recovery plan to deliver RTT incomplete performance target	To be confirmed in February 2018	completed	The Trust submitted an updated RTT trajectory for 2018/19 to NHSE on 20th April, in line with national deadlines. This was a revision of the 2nd March draft, based on an 18/19 activity model developed with our CCGs. This activity plan was converted to RTT performance in the context of ongoing system challenges around demand & capacity, data quality and operational responsiveness being addressed by the Waiting List Improvement Programme. Additionally, an adjustment was made to projected waiting list size and performance over the winter period to reflect recent experience and anticipated impact in 18/19.
Data	4.1	Commission an independent review of the clinical and administrative processes within its elective pathways, clinical oversight of avoidable harm.	30 November 2017	In progress	The MBI data assurance report was published 31 July 2018. The Chair of Audit, Risk and Governance Committee and CEO have met with MBI to review draft report and recommendations and an action plan to address the recommendations has been developed. The Trust response will be presented to the September Provider Oversight Meeting.
Governance	5.2	Trust Board to oversee delivering undertakings, and risks to the successful achievement	With immediate effect	On-going	Reported to public Trust board (bi-monthly) as part of overall financial and performance reporting.

TRUST BOARD - PUBLIC
REPORT SUMMARY

Title of report: Finance Report for August 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information
Date of Meeting: 26th September 2018	**Item 10, report no. 07**
Responsible Executive Director: Richard Alexander, Chief Financial Officer	**Author:** Michelle Openibo – Associate Director of Finance

Summary:
This report provides a brief summary of the Trust's financial results for the 5 months ended 31 August.

The Trust has a £3.5m adverse variance to plan at the end of August. Mitigation plans are being put in place to ensure that the Trust is able to meet the financial control total for the year.

The Trust closed the month with £34.2m cash, there are no plans to access any further working capital facility.

Gross capital spend is £7.8m underspent against plan year to date. The programme continues to be actively managed to ensure that the Trust does not breach its plan for the year.

Recommendations:
The Committee is asked to note the report.

This report has been discussed at: n/a

Quality impact: n/a

Financial impact:
Has no financial impact.

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

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

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

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

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

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

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

FINANCE REPORT – 5 MONTHS ENDED 31st August 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 5 months ended 31st August 2018.

2. Financial Performance

The Trust is £2.0m behind plan in month bringing the Trust to a £3.4m adverse variance to plan year to date. Mitigation plans are being developed to ensure that the financial plan is met for the year.

It has been necessary in the year to offset the impact of adverse variances in the clinical and corporate divisions with some releases from reserves which would otherwise have been held for unplanned events later in the year – this is a situation which both management and the board will keep under review as the year progresses.

	In Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	92.72	92.85	0.13	465.77	466.82	1.05
Pay	(54.87)	(54.74)	0.13	(259.54)	(258.98)	0.57
Non Pay	(38.07)	(42.08)	(4.01)	(191.24)	(202.77)	(11.52)
Internal Recharges	-	-	-	-	-	-
Reserves	0.48	1.86	1.38	(11.17)	(5.85)	5.32
EBITDA	0.27	(2.10)	(2.37)	3.82	(0.77)	(4.59)
Financing Costs	(3.85)	(3.15)	0.70	(19.63)	(17.29)	2.34
SURPLUS / (DEFICIT) inc. donated asset treatment	(3.59)	(5.26)	(1.67)	(15.82)	(18.06)	(2.24)
Donated Asset treatment	(0.03)	(0.40)	(0.37)	0.21	(0.90)	(1.11)
Impairment of Assets	-	-	-	-	-	-
SURPLUS / (DEFICIT)	(3.62)	(5.65)	(2.04)	(15.61)	(18.96)	(3.35)
PSF Income	2.28	2.28	-	9.68	9.68	-
SURPLUS / (DEFICIT) after PSF income	(1.34)	(3.37)	(2.04)	(5.93)	(9.28)	(3.35)

3.1 NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	395,352	369,717	(25,635)	111.98	112.44	0.45
Division of Surgery, Cancer & Cardiov.	305,050	315,733	10,683	137.84	137.77	(0.07)
Division of Women, Children & Clin. Support	1,080,625	1,092,994	12,369	66.63	65.36	(1.28)
Central Income			-	59.08	61.54	2.90
Clinical Commissioning Income	1,781,027	1,778,444	(2,583)	375.53	377.11	2.00

Year to date the Trust is over performing on NHS income; in April and May the Trust underperformed on income but there was an increase in June which has continued in July and August. Overall the Trust has over performed on non-elective activity and underperformed on electives.

Medicine and Integrated Care (MIC) is over performing year to date due to additional non elective activity. This is offset by lower than planned activity in renal and on neurosurgery.

Surgery, Cancer and Cardiovascular (SCC) is underperforming year to date due to low elective activity in specialist surgery areas and ophthalmology. The service has plans to recover some of this underperformance in the latter half of the year. There has been over performance on cardiac due to increases in complexity.

Women, Children and Clinical Support (WCCS) are underperforming year to date. In 2017/18 there was a reduction in maternity activity in the Trust, this has continued in year. There is some underperformance in gynaecology and children's services but this is expected to be back to plan by year end.

3.2 Private Patients Income

Private patient's income has continued to increase with year on year growth. The position against plan however is an adverse variance of £1.3m; this is due to slower than expected delivery of some growth planned within surgical specialties and IVF service.

3.3 Clinical Divisions

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

		In Month			Year to Date		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Medicine and Integrated Care	Income	23.83	23.08	(0.75)	119.89	119.31	(0.58)
	Expenditure	(19.00)	(19.81)	(0.81)	(91.96)	(94.11)	(2.15)
		4.84	3.27	(1.57)	27.93	25.21	(2.73)
Surgery, Cancer and Cardiovascular	Income	28.35	28.08	(0.28)	144.42	140.51	(3.91)
	Expenditure	(25.32)	(26.62)	(1.31)	(120.01)	(123.80)	(3.80)
		3.04	1.45	(1.59)	24.41	16.70	(7.71)
Women, Children & Clinical Support	Income	14.77	14.50	(0.26)	74.11	71.82	(2.30)
	Expenditure	(17.40)	(17.93)	(0.53)	(83.00)	(85.14)	(2.14)
		(2.63)	(3.42)	(0.79)	(8.89)	(13.32)	(4.43)
Imperial Private	Income & Expenditure	1.12	1.23	0.11	5.92	6.41	0.49
Total Clinical Division		6.36	2.53	(3.84)	49.38	35.00	(14.38)

Within MIC there was underperformance on total income in month there were adverse movements relating to previous months from lower than expected activity in neurosurgery. Year to date there is over performance on NHS clinical income and underperformance on other income driving an overall adverse variance. The adverse position on expenditure relates to CIP gap, there is also an adverse movement in month due to a budget transfer from MIC to WCCS.

SCC is overspent in month and year to date. The position in month is driven by overspends on expenditure with additional costs from outsourcing, costs to manage the waiting list improvement programme and the adverse effect of unmet CIPs. Year to date the division has an adverse variance in income due to delays in private income growth schemes.

WCCS is adverse to plan in month due to CIP and plan gaps. Year to date underperformance on NHS maternity income drives a large proportion of the overspend. There are also additional costs for imaging outsourcing and adverse variances due to unmet CIPs.

3. Efficiency programme

The Trust is £4.3m adverse to its submitted CIP plan YTD which is largely due to under performance on income related schemes, to phasing of delivery which is still forecast to happen and gaps for unidentified schemes.

The forecast is showing £10.7m adverse to plan, largely due to £5.4m unidentified, with some additional risk against non-pay savings.

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

4. Cash

The Trust closed month 4 with a cash position of £34.2m; this was a £12.9m decrease in cash since the previous month and a £9.7m increase in since the start of the financial year. The Trust continues to closely monitor the cash position.

5. Capital

Against the capital resource limit (CRL) the Trust has spent £13.4m against a plan of £22.4m, an underspend of £9.0m. The main areas of underspend is in medical equipment, ICT and backlog maintenance. For Gross capital spend the Trust has spent £14.9m against £22.8m plan so a £7.8m underspend. The Trust is expecting to meet the CRL spend in year and the programme is actively managed by the Capital Expenditure Assurance group and Capital Steering Group.

6. Conclusion

The Trust has an adverse variance to plan year to date of £3.4m. This position is under review by trust management and mitigation plans are being put in place to bring the Trust back to the control total. There remain risks to meeting the financial forecast for the year. The Trust must continue to work to identify and deliver CIPs to improve the position of the Trust.

7. Recommendation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 5 months to 31st August 2018

	In Month				Year to Date		
	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	74.7	75.0	0.2		375.5	377.1	1.6
Private Patients	4.6	4.0	(0.5)		22.3	21.0	(1.3)
Research, Development and education	7.7	7.9	0.3		38.8	39.4	0.7
Other non-patient related income	5.8	5.9	0.1		29.2	29.3	0.1
Total Income	92.7	92.9	0.1		465.8	466.8	1.1
Pay - in post	(52.0)	(47.8)	4.2		(245.0)	(226.6)	18.4
Pay - Bank	(0.6)	(4.7)	(4.0)		(3.3)	(22.2)	(18.9)
Pay - Agency	(2.3)	(2.3)	(0.0)		(11.2)	(10.2)	1.0
Drugs and Clinical supplies	(21.2)	(21.1)	0.1		(105.9)	(103.5)	2.4
General Supplies	(2.9)	(3.4)	(0.5)		(14.6)	(15.4)	(0.9)
Other	(13.9)	(17.5)	(3.6)		(70.8)	(83.8)	(13.0)
Total Expenditure	(92.9)	(96.8)	(3.9)		(450.8)	(461.7)	(11.0)
Reserves	0.5	1.9	1.4		(11.2)	(5.9)	5.3
Earnings before Interest, Tax, Depreciation and Amortisation	0.3	(2.1)	(2.4)		3.8	(0.8)	(4.6)
Financing Costs	(3.9)	(3.2)	0.7		(19.6)	(17.3)	2.3
SURPLUS / (DEFICIT) including financing costs	(3.6)	(5.3)	(1.7)		(15.8)	(18.1)	(2.2)
Donated Asset treatment	(0.0)	(0.4)	(0.4)		0.2	(0.9)	(1.1)
SURPLUS / (DEFICIT) including donated asset treatment	(3.6)	(5.7)	(2.0)		(15.6)	(19.0)	(3.4)
Impairment of Assets	0.0	0.0	0.0		0.0	0.0	0.0
SURPLUS / (DEFICIT)	(3.6)	(5.7)	(2.0)		(15.6)	(19.0)	(3.4)
PSF	2.3	2.3	0.0		9.7	9.7	0.0
SURPLUS / (DEFICIT) after STF and winter income	(1.3)	(3.4)	(2.0)		(5.9)	(9.3)	(3.4)

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: CQC and Ward Accreditation Programme update	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 26 September 2018	**Item 12, report no. 08**
Responsible Executive Director: Prof Janice Sigsworth, Director of Nursing	**Authors:** Priya Rathod, Deputy Director of Quality Governance Sue Burgis, Head of Practice Development

Summary:
Part 1 – CQC update

This report is the regular update to the committee on CQC-related activity at and/or impacting the Trust.

The division of Women, Children and Clinical Support has convened a Task & Finish Group to oversee inspection preparations for children's services.

The division of Surgery, Cancer and Cardiovascular is running an inspection preparations group for all areas at the Trust which are included in the core service, including those which sit in the division of Medicine and integrated care.

A review of the critical care core service at the Trust was carried out in July 2018 to help areas prepare for a possible CQC inspection during 2018/19.

Brief, high level feedback from the visits was delivered to areas the week following the review. The full report is currently with areas for factual accuracy checks; outcomes are expected to be presented to the Improving Care Programme Group on 17 September 2018.

As part of the Trust's approach to managing its CQC activity during 2018/19, the Improving Care Programme Group launched in July 2018, and is currently meeting bi-weekly.

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

- Performance regarding patients spending less than 4 hours in major A&E was 68.6%, which is a decline in performance and much worse than other trusts
- The CQC received a whistleblowing about the Trust in April 2018 which means the Trust has returned to being much worse than other trusts on this measure

Flu vaccine uptake doubled in 2017/18 compared to the previous year, increasing from 31% to 60.5%, which is an outstanding achievement that has been noted in our engagement with the CQC.

The Trust continues to be registered at all sites without conditions.

During Q1 the CQC asked the Trust to investigate two concerns about patient safety.

One whistleblowing was reported to the CQC about the Trust in Q1, which related to extended patient stays on the recovery unit at St Mary's Hospital.

The CQC did not carry out any inspections of the Trust in Q1, nor did the Trust participate in any national or thematic reviews undertaken by the CQC during this period.

During the Trust's regular meeting with its CQC relationship manager in July 2018, the Trust was advised that the CQC is increasing its scrutiny in relation to serious incidents.

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

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

An overall rating (gold, silver, bronze of white) is calculated for each domain and for the ward/clinical area overall using principles aligned to the CQC's methodology.

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

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

The number of 'white' areas has reduced from 27 in 2015/16 to 4 in 2017/18.

The 2018/19 WAP is currently underway. Through the WAP steering group the standards within the domains have been reviewed and additional areas to be included have been agreed.

A summary of the outcome from the 2018/19 WAP will be presented to the Board next in quarter 4.

Recommendations: To note the updates.

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

Financial impact: This paper has no financial impact.

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

Workforce impact: None

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

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

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

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

PART 1
CQC Update

1. Purpose

1.1. The following report is the regular update to this committee on CQC-related activity at and/or impacting the Trust since the last update to this Committee in July 2018.

2. Preparation for Possible CQC Inspections during 2018/19

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

Core service of Children's and young people

2.2. Leads for children's services met with the Trust's CQC relationship manager on 18 July 2018 as part of the Trust's routine engagement with the CQC.

2.3. The division has convened a Task & Finish Group to oversee inspection preparations, chaired by the divisional director of nursing. Progress is monitored divisionally and reports to the Improving Care Programme Group by exception.

2.4. An internal mock core service review of children's service across the Trust will take place in the autumn of 2018.

Core service of Critical Care

2.5. The division of Surgery, Cancer and Cardiovascular, where the critical care directorate sits, is leading an inspection preparations group for all areas in the core service, including those which sit in the division of Medicine and integrated care. Progress is reported by exception to the Improving Care Programme Group.

2.6. The committee will remember that a review of the critical care core service at the Trust against current CQC standards was carried out in July 2018. The review took place on 23, 24 and 25 July and initial, high level findings from the visits to areas were shared with areas the week following the review.

2.7. High level outcomes and actions will be presented to the Improving Care Programme Group at its meeting on 17 September 2018.

2.8. Leads for critical care at the Trust are meeting with the Trust's CQC relationship manager in October 2018 as part of the Trust's routine engagement with the CQC to discuss progress since the service was inspected in 2014.

3. Improving care programme group

3.1. The committee will recall that an 'Improving Care' programme group has been established chaired by the Director of Nursing, to oversee the approach and progress for getting to Good and beyond.

3.2. The group continues to meet twice monthly and oversee the progress of the 'Big 4' work streams as well as preparations for anticipated CQC inspections as outlined in section 2 of this paper.

4. CQC Insight

4.1. Trust-level headlines from the latest CQC Insight report (July 2018) include:

- Performance regarding patients spending less than 4 hours in major A&E was 68.6% (as at May 2018), which is a decline in performance and much worse than other trusts.
    - The committee will be aware of the work being undertaking regarding 4 hour performance.
- The CQC received a whistleblowing about the Trust in April 2018 which means the Trust has returned to being much worse than other trusts on this measure.
    - Although this alert has been closed by the CQC, due to the timing of the insight report, it has not been reflected in the report.
- Flu vaccine uptake doubled in 2017/18 compared to the previous year, increasing from 31% to 60.5%, which is an outstanding achievement that has been noted in our engagement with the CQC.

5. General updates

- ***Registration Status***

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

- ***Statutory Notifications made to the CQC***

5.2. A statutory notification was submitted to the CQC during Q1 regarding the appointment of a substantive CEO. The Trust has received its updated CQC registration certificate reflecting Professor Orchard as the Nominated Individual for the Trust's CQC registration.

5.3. No changes were made to Trust services during Q1 which required notification to the CQC.

5.4. There were no statutory notifications made to the CQC in relation to the Trust's application of the Mental Health Act 1983 during Q1.

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

5.5. A whistleblowing alert was made to the CQC during Q1 in relation to extended patient stays on the recovery unit at St Mary's Hospital. The division of Surgery, Cancer and Cardiovascular presented its response to the executive committee at its meeting in May 2018. The CQC are content with the Trust's response and consider the alert closed.

5.6. The CQC asked the Trust to investigate two concerns during Q1; one related to safeguarding and the other related to inadequate nutrition. Neither of the concerns was substantiated by the Trust's investigations. The Trust has submitted its responses to the CQC and is currently awaiting feedback.

- ***Inspections, National Reviews and Surveys***

5.7. The CQC did not carry out any inspections of the Trust during Q1.

5.8. The Trust did not participate in any national or thematic reviews undertaken by the CQC in Q1.

5.9. In response to the inspections of three NHS acute trusts which raised similar, serious concerns about radiology reporting, the CQC asked a sample of trusts across England in November 2017 to submit data and information relating to reporting in radiology.

- The Trust was included in the sample for the national review and provided the CQC with the requested data and information.
- On 19 July 2018, the CQC published its report following the review, which states that NHS trust boards should ensure that:
  - They have effective oversight of any backlog of radiology reports
  - Risks to patients are fully assessed and managed
  - Staffing and other resources are used effectively to ensure examinations are reported in an appropriate timeframe.
- It is important to note that going forward; the CQC will use the outcomes of the review to inform how it inspects Diagnostic imaging services.
- The report has been shared with relevant colleagues to take the recommendations forward.

- ***New Requests for Information about Serious Incidents***

5.10. The committee will remember that at its regular monthly meeting with the CQC in June 2018, the Trust was advised that the CQC will review death notifications as part of its routine continuous monitoring of trusts.

5.11. During the Trust's regular meeting with its CQC relationship manager in July 2018, the Trust was advised that the same approach will be taken with serious incidents.

- If the CQC has any concerns about a serious incident, the Trust may be asked to provide additional data or information.
- If concerns are substantiated, it may lead to the CQC carrying out a focused inspection or taking enforcement action with the Trust.
- This is in line with the CQC's normal approach for responding to concerns which are identified outside of an inspection process.

5.12. Data and information about serious incidents are captured in the Trust's quality reports. The corporate nursing team has advised the Medical Director's office about this change and will liaise with them as needed in relation to any queries from the CQC.

- **Publication of Guidance in Response to CQC National Review**

5.13. In response to a recommendation made by the CQC in its report on investigating and learning from deaths, published in July 2017, on 11 July 2018 NHS England published bereavement guidance for trusts.

5.14. It is anticipated that the CQC will take account of the new guidance when it carries out future inspections of core services at acute trusts.

5.15. The guidance has been shared with relevant colleagues within the Trust and any actions will be taken forward through the end of life steering group and medical director's office going forward.

6. Next Steps

6.1. Support for inspection preparations will continue to be provided to children's services and critical care over the coming months.

6.2. The Improving care programme group will continue to meet twice a month.

7. Recommendations

7.1. To note the updates.

END OF PART 1

PART 2
Ward Accreditation Programme (2017/18) Update

1. Purpose

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

2. Background

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

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

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

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

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

3. Summary of 2017/18 WAP outcomes

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

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

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

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

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

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

3.5.2. Medicines management: A trust wide safety programme supported by the quality improvement (QI) team is in place for medicines management. The work stream is underpinned by a robust governance framework and updates on progress against key actions presented to the Executive Quality Committee each month.

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

4. 2018/19 Ward accreditation programme and next steps

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

- Expansion of the programme to include renal satellite units, divisionally led outpatient areas and theatres and a review of emergency department arrangements.
- Alignment with the refreshed Quality Strategy and Trust 's CQC framework
- Expansion of the teams to include colleagues from estates and facilities
- Consideration of including patients in the process
- Introduction of an awards programme that celebrates success Trust wide
- Consideration of a paired learning programme
- Bespoke quality improvement support through identified ward coaches who will link to clinical areas

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

5. Recommendations

- To note the updates

END OF PART 2

Authors: Priya Rathod, Deputy Director of Quality Governance
Sue Burgis, Head of Practice Development

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q1 2018/19	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 26th September 2018	**Item 13, report no. 09**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Authors:** Jon Otter, Interim Head of Operations, IPC Sid Mookerjee, Hospital Epidemiologist IPC Alison Holmes, Director of IPC

Summary:

- There were no Trust-attributed MRSA BSI cases identified during Q1.
- There have been 18 cases of Trust-attributed *C. difficile* identified during Q1, which is on the Trust ceiling for this period.
- There have been three CPE BSIs in Q1 compared with 11 during 2017/18; healthcare-associated CPE BSIs have been selected as a new internal performance metric for the Trust so that the board are aware of the trend in serious infections due to CPE.
- Achieving a 10% reduction in healthcare-associated *E. coli* BSIs has been selected as a new internal performance metric for the Trust for 2018/19 as a first step towards halving healthcare-associated Gram-negative BSIs in line with the national objective.
- This report includes an expanded antimicrobial consumption section, including comparisons with Shelford Group hospitals. Overall consumption of antibiotics continues to fall, and the increasing trend in carbapenem consumption has been reversed.
- All 74 inpatient wards underwent the revised hand hygiene auditing in May, with wide variation in compliance observed. Hand hygiene champions have been identified on all 74 inpatient wards included in the May audits and each ward will undergo improvement activities during August and September.
- This report provides assurance that IPC within the Trust is being addressed in line with the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.'

Recommendations: The Board is asked to note the report.

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

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

Financial impact: No direct financial impact.

Risk impact and Board Assurance Framework (BAF) reference: None.

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

What impact will this have on the wider health economy, patients and the public? None.

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

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

Trust strategic objectives supported by this paper:

- To achieve excellent 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.

1 Healthcare-associated infection (HCAI)

1.1 *HCAI mandatory reporting summary*

'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital. For MRSA, MSSA, 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*** 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		Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	0	0	0	0	0	0																			**0**	0
Trust *C.difficile*	8	7	6	6	4	5																			**18**	18
Trust *E.coli* BSI	5	-	8	-	8	-																			**21**	-
Trust MSSA BSI	3	-	3	-	0	-																			**10**	-

'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 18 Trust-attributed cases this quarter, against a quarterly ceiling of 18 cases (Figure 1). *C. difficile* assigned as Trust-attributed was detected in 1.2% of 1468 specimens of diarrhoea tested during Q1. The Trust has a comprehensive set of measures in place to optimise antibiotic usage and minimise the risk of them driving *C. difficile* infection, and to reduce its transmission, including multidisciplinary clinical review of all cases, and rapid feedback of lapses in care to prompt ward-level learning. The Trust's serious incident (SI) framework is used to investigate lapses in care where appropriate; there has been one new SI due to cross-transmission of *C. difficile* during Q1 compared with two during 2016/17. Hydrogen peroxide vapour (HPV) room decontamination is used on an ad hoc basis during outbreaks of CPE; it is not currently used for *C. difficile.* To further reduce the risk of transmission of *C. difficile* and other pathogens and to improve the cost-efficiency and operational delivery of hydrogen peroxide vapour (HPV) room decontamination already performed in the Trust, a tender process for the on-site HPV / ultraviolet (UV) room decontamination service will begin in Q2.

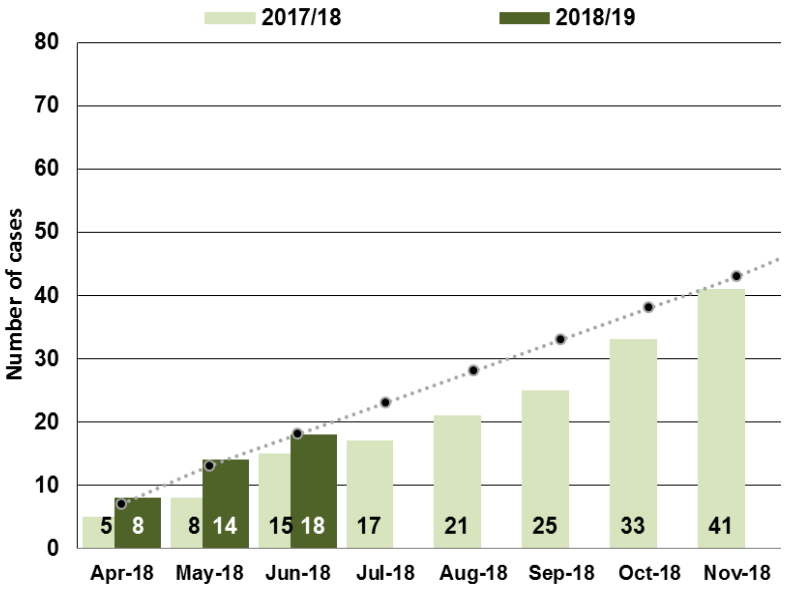


Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in 2018/19 (dark green bars) compared with 2017/18 (light green bars).

1.2.1 *C. difficile*: lapses in care

There have been 18 cases of Trust-attributable *C. difficile* during Q1; five of these cases had lapses in care identified (Table 2). This compares with no lapses in care in Q1 of 2017/18, and seven in total in 2017/18. The five cases occurred on wards in Medicine, with four related to cross-transmission and one related to antibiotic choices. The lapse in care related to antibiotic choices has been discussed with the prescribers and clinical team involved in the care of the patient to ensure that lessons are learned. Two of the lapses in care due to transmission were related to laboratory delays and missed opportunities to culture and type the *C. difficile* bacteria. In these cases, the *C. difficile* could not be grown and ribotyped, so the conservative assumption was made that they were the same type as the index case, which has resulted in these lapses in care potentially being 'overcalled'. This issue has been raised with the North West London Pathology governance committee, and an action plan has been produced to improve *C. difficile* typing processes and turnaround times. The other two lapses in care due to transmission relate to a single ward cluster. The ward was closed due to this transmission event, and reopened 14 days later. This allowed for immediate actions to be put into place to prevent further cross-transmission, including validated hand hygiene audits, Estates issues identified by IPC being addressed, a review of antimicrobial prescribing indicators, a review of cleaning scores and standards, and assurance that all staff had documented up-to-date ANTT compliance. This has been declared as an SI, through which a specific ward-level action plan will be developed during Q2.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total number of toxin positive cases 2017/18	8	6	4									
Specimens sent for *C.difficile* testing	505	507	456									
Lapse in care*	2	1	2									

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

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

1.2.2 *C. difficile*: time to isolation

The Trust has a policy to isolate patients who develop diarrhoea within two hours of the start of their symptoms. 75% of patients were isolated within two hours during Q1 (Figure 2), which is similar to 73% in 2017/18. Failing to isolate patients who are symptomatic with *C. difficile* infection promptly introduces transmission risk. Lack of policy awareness and poor documentation remained largely static in Q1, and lack of available single rooms reduced from 10% in Q4 2017/18 to 6% in 2018/19, probably reflecting less acute bed pressures in Spring and Summer months.

On each occasion when a *C. difficile* case is not isolated within two hours, the IPCNs provide real-time feedback and education to the clinical team. This seeks to address the specific reason for non-compliance and is reinforced by a one-page training sheet, which is disseminated to the ward team. The importance of improving rapid isolation of patients with diarrhoea was discussed with the Divisions during Q1 on the weekly HCAI Taskforce call. This included sharing results stratified by Division, which showed variable compliance by Division and focussed communications in Surgery. However, progress has been limited compared with 2017/18, so the focus of these discussions in Q2 will be to develop specific actions in order to improve documentation and policy awareness among front-line clinical staff.

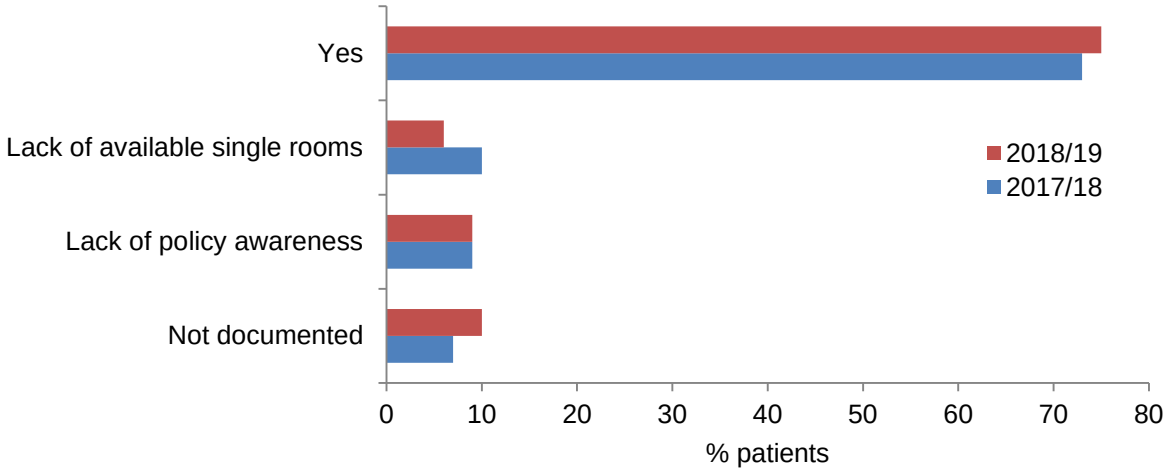


Figure 2: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with C. difficile diarrhoea.

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

ICHT has the 5th highest rate of Trust-attributed *C. difficile* in the Shelford group of hospitals, based on 14 cases for the period Apr-18 and May-18 (using the latest available data from PHE) (Figure 3). Eight of the 10 Shelford Group hospitals use HPV at the time of patient discharge for rooms occupied by patients with *C. difficile*. This additional measure will be implemented at ICHT, as described above. In 2017/18, ICHT had the third lowest rate of *C. difficile* in the Shelford group. The rate of specimens tested for *C. difficile* in the other Trusts is unknown, but remains broadly constant at ICHT (see Table 2).

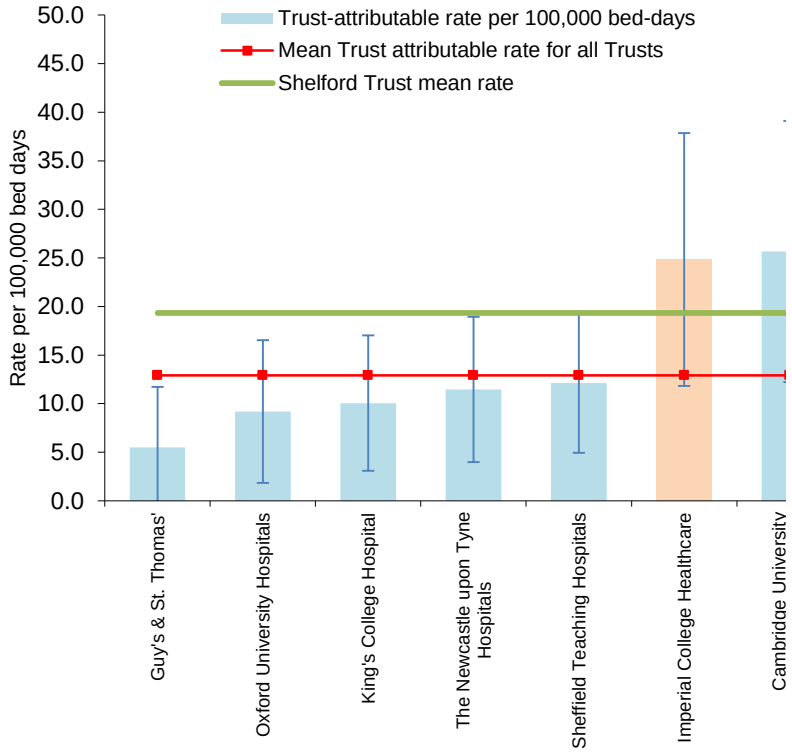


Figure 3: C. difficile Shelford Group comparison, 2017/18. Error bars denote the 95% confidence interval around the rate for each hospital.

1.3 MRSA BSI

There were no cases of Trust-attributed MRSA BSI during Q1 from the 8754 blood cultures tested. All Trust-attributed MRSA BSI undergoes a detailed investigation by IPC in conjunction with the clinical team involved, to identify any learning points and implement any improvements in practice. This investigation used to be reported to PHE (until the end of 2017/18), but is no longer a requirement. However, we will continue to review each MRSA BSI case in detail to ensure that learning is captured to prompt improvement.

MRSA admission screening continues to be monitored monthly via the IPC scorecard; compliance for Q1 was 87% (5606 of 6463 patients were screened), compared with 88% for Q4 2017/18. The target for MRSA screening is 90%. The availability of ward-level MRSA screening compliance data in the monthly Harm Free Care report will be used to identify areas where compliance is low so that local actions can be developed to ensure that MRSA screening is included in the patient admission pathway. Patient-level validation exercises of MRSA admission screening data performed in 2017/18 using Paediatric and Medicine datasets have confirmed that the methods used to report MRSA screening compliance represent an accurate picture of actual compliance.

1.4 MSSA BSI

There have been 10 cases of Trust-attributed MSSA BSI in Q1, compared with eight in Q1 2017/18. There is no national threshold for MSSA BSI at present. Four of the ten cases in Q1 were associated with a vascular access device (one with a peripheral cannula, two with a Vascath, and one with a central venous catheter). Each case of MSSA BSI is reviewed by a multidisciplinary group (including the clinical team), and those related to a vascular access device are reviewed by vascular access specialists, in order to identify and implement learning from these cases.

1.5 *E. coli* BSI

There have been 21 cases of Trust-attributed *E. coli* BSI in Q1, compared with 20 cases in Q1 in 2017/18 (Figure 4). In each case, clinical management was advised by a microbiologist at the time of the result becoming available to ensure that care was optimised. There is no national threshold for *E. coli* BSI at present. However, achieving a 10% reduction in healthcare-associated *E. coli* BSIs has

been selected as a new internal performance metric for the Trust for 2018/19. Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. In our setting, approximately one third of cases are associated with diverse gastrointestinal sources or febrile neutropaenia. It is likely that most of these cases occur as a result of translocation of endogeneous flora as a direct result of necessary interventions and are therefore not preventable. However, other source of infection are more likely to be preventable (e.g. *E. coli* BSIs associated with urinary catheters). Addressing the various sources of *E. coli* BSI, especially urinary sources, is a focus of a multidisciplinary group working around reducing Gram-negative BSI (see section 1.6.2).

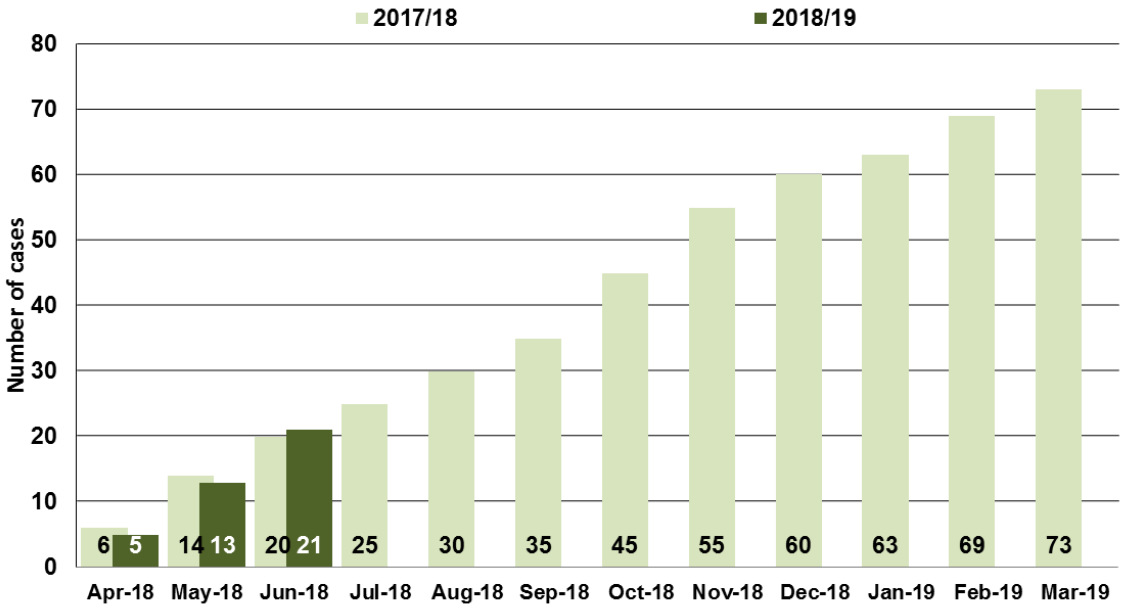


Figure 4: Cumulative monthly 2018/19 Trust-attributed E. coli BSI (dark green bars) compared to 2017/18 (light green bars).

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

Imperial has the 4th lowest rate in the Shelford group of hospitals for the combined rate of healthcare and community-associated *E. coli,* based on 57 cases for the period Apr-18 and May-18 (Figure 5); this is one rank lower than in 2017/18.

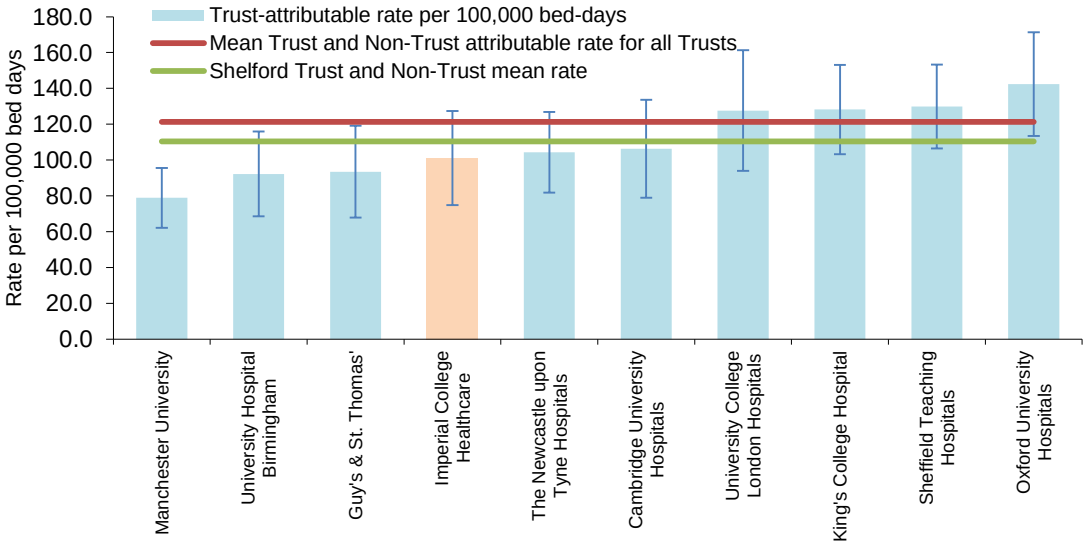


Figure 5: E.coli BSI Shelford Group comparisons, 2017/18. Error bars denote the 95% confidence interval around the rate for each hospital.

1.6 *BSI summary*

The trend in BSIs (all positive blood cultures, Trust and community attributable) by organism / organism-group for Q2 2017/18 – Q1 2018/19 is presented in Figure 6. Gram-negative bacteria predominate, with *E. coli*, accounting for approximately 34 BSI per month (median 37) and for 16.0% of all positive blood cultures. There have been 13 Trust-attributed *Klebsiella pneumoniae* cases and six Trust-attributed *Pseudomonas aeruginosa* cases during Q1. In line with the national ambition to focus on a reduction in Gram-negative BSIs, we have begun to report *K. pneumoniae* and *P. aeruginosa* BSIs weekly via the HCAI Taskforce call, in addition to submitting these cases to PHE monthly. This will help to identify trends and potential clusters closer to real-time.

Staphylococcus aureus accounted for 9.0% of all positive blood cultures; MRSA accounts for 0.1% of all BSIs. Bacteraemia caused by bacteria usually associated with patients' skin and not representing infection ('contaminated blood cultures') accounted for 2.4% of 33,998 blood cultures taken during this period which is below a benchmark of 3% (based on published literature)[1]. We have an ambition to assess all clinical staff for competency in aseptic non-touch technique (see section 3) to further reduce contaminants.

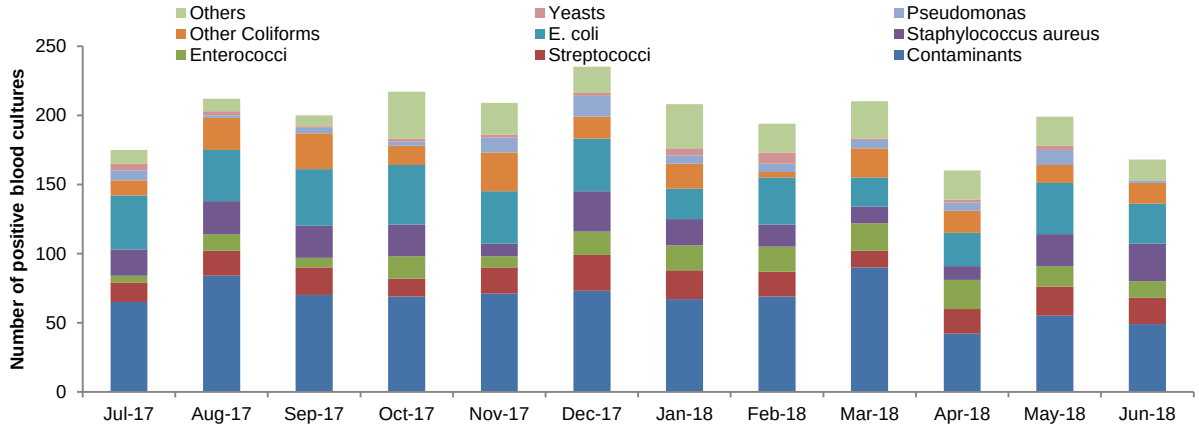


Figure 6: All positive blood cultures (Trust and community attributable) by organism / organism-group Q2 2017/18 – Q1 2018/19

1.6.1 Antibiotic resistance in Gram-negative BSIs

The rate of antibiotic resistance in Gram-negative BSIs remains largely unchanged (Figure 7) comparing 2016/17 to 2017/18 (Figure 7). There was an increase in the rate of extended-spectrum-beta-lactamase producers (ESBLs) from 22 to 26%; gentamicin resistance rose from 14% in 2016/17 to 16% in 2017/18, and resistance to ciprofloxacin remained consistent (28% in 2016/17 and 29% in 2017/18). Since changes in antibiotic resistance profiles are limited year on year, this data will be reported again in Q1 or 2019/20.

There were 16 cases of CPE BSI over 2016/17 and 2017/18 combined, 5 in FY 2016/17 and 11 in 2017/18. Healthcare-associated CPE BSIs have been selected as a new internal monthly Trust performance metric from Q2 2017/18.

There were two meropenem-resistant *Pseudomonas* BSIs in 2016/17 and two in Q1 of 2017/18. None of these isolates were MDR *Pseudomonas* isolates, or carbapenemase producers. Each multidrug resistant Gram-negative BSI is reviewed by a multidisciplinary team to identify any specific learning, which is shared with clinical teams.

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

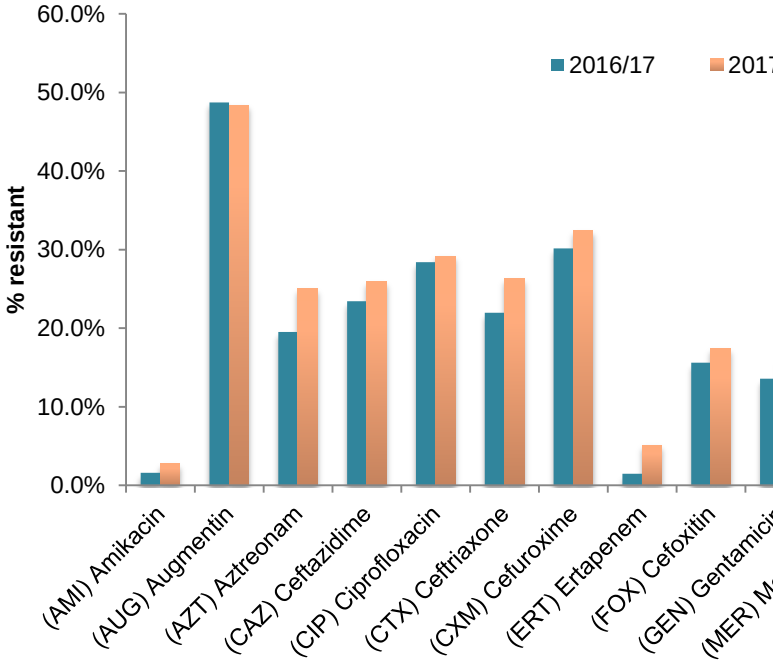


Figure 7: Resistance to key antibiotics in Gram-negative BSIs; 2016/17 and 2017/18.

1.6.2 Gram-negative BSI reduction target

The government has announced an ambition to halve healthcare-associated Gram-negative BSI by 2021. No specific targets have been provided for acute care providers. However, the Trust has shared its Gram-negative BSI reduction plans with the CCG through a series of joint meetings. The details of the Trust's approach to reducing Gram-negative BSIs were provided in the 2017/18 Q2 report, encompassing:

- enhanced case review and reporting to PHE including regular review of local antibiotic susceptibility and guidelines,
- supporting the CCG in investigating non-Trust attributed Gram-negative BSIs,
- close working with the sepsis identification and management plans in the Trust that may impact Gram-negative BSIs,
- improving the appropriate use of urinary catheters and hydration management with the nursing directorate,
- and 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 Adult ICUs

The catheter line-associated BSI (CLABSI) rate over the past 12 months (Jul 17 - Jun 18) is 1.5 per 1000 catheter line-days (Figure 8), which is below the benchmark of 3.0 per 1000 catheter-line days (ECDC benchmark). Split by site, the CLABSI rate is 0.9 for Charing Cross Hospital, 1.6 for Hammersmith Hospital, 1.8 for St. Mary's Hospital. There have been four CLABSI episodes during Q1 2018/19 for all three ICUs. We continue with detailed surveillance, weekly ward rounds, ANTT competency assessments, and infection discussions with clinicians in maintaining the low rate of CLABSI in our intensive care units.

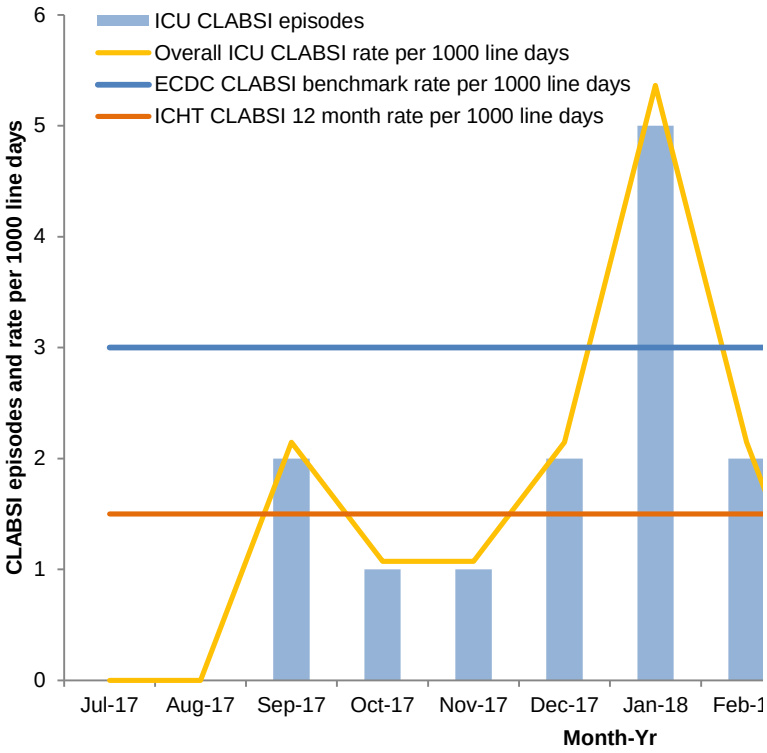


Figure 8: CLABSI episodes on the adult ICUs against the benchmark rate.

1.6.3.2 Paediatric ICU (PICU)

There have been three CLABSIs in 1637 catheter-line days between Jul 17 and Jun 18 on the PICU. Two CLABSI cases were in Dec-17, with one of the CLABSI cases confirmed as a catheter-related BSI (CRBSI), with an additional case Jun-18. The 12-month rate of 1.8 per 1000 catheter-line days is below the ECDC European benchmark of 3.0 per 1000 catheter line days.

1.6.3.3 Neonatal ICU (NICU)

In the 12 month period, Jul 17 to Jun 18, the CLABSI rate on the neonatal ICU (NICU) at SMH and QCCH combined was 5.8 per 1000 catheter line days. The National Neonatal Audit Programme (NNAP) benchmark is 3.0 per 1000 line days. The difference between the rate at ICHT and the benchmark is most likely explained by the high acuity of babies cared for on the NICUs at ICHT. The 12 month CLABSI rate in Very Low Birth Weight (VLBW) babies in the NICU was 6.6 per 1000 catheter line days, below the NEO-KISS nosocomial infections surveillance project benchmark figure of 8.6 per 1000 catheter line days. NICU have implemented actions to maintain the CLABSI rate, which includes a review of guidelines for the insertion of intravascular devices, improved insertion techniques, and a focus on aseptic non-touch technique for all clinical staff.

1.7 Surgical site infection

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

1.7.1 Orthopaedics

The latest quarter (Apr – Jun 18) has seen:

- 0 SSI in 99 knee procedures so far recorded.
- 0 SSI in 96 hip procedures so far recorded.

The 12-month average for knee procedures is 0.3% (1 SSI in 353 operations) (national average 0.6%). The 12-month average for hip procedures is 0.4% (1 SSI in 237 operations) (national average 0.6%).

1.7.2 Cardiothoracic

The latest quarter (Apr – Jun 18) has seen:

- 0 SSI of 29 CABG operations so far recorded.
- 0 SSI of 32 non-CABG operations so far recorded.

The 12-month average for CABG procedures is 4.9% (13 SSI in 262 operations) (national average 3.7%). The 12-month average for non-CABG procedures is 1.7% (3 SSI in 180 operations) (national average 1.2%).

The Division are currently investigating the slightly elevated rate of SSI in CABG over the past 12 months, and the findings will be discussed at the monthly Surgical Infection Group during Q2.

1.7.3 Vascular SSIs

1.7.3.1 Surveillance of vascular SSIs

A period of surveillance of vascular SSIs was performed between February and October 2017 focusing on high-risk procedures only. In this period of surveillance, 23.7% of patients (45/190) had a surgical site infection the breakdown was as follows:-

- Deep infections: 6.3% (12/190)
- Superficial infections: 17.3% (33/190)

A followup period of surveillance was undertaken in January to March 2018. This included all vascular procedures (both low- and high-risk). The overall SSI rate was 3.5% (16/456) with a breakdown as follows:-

- Deep infections: 0.9% (4/456)
- Superficial infections 2.6% (12/456)

When applying the 2017 methodology to the 2018 dataset (i.e. the high-risk procedures only), an SSI rate of 14.3% (16/110) was shown which is approximately a 10% reduction. Of note, no deep, destructive infections leading to patch/graft haemorrhage were recorded in this cohort. This suggests that the actions (outlined below) have been successful in reducing the SSI rate.

Finally, the vascular team participated in the GIRFT SSI surveillance between May and October 2017, which showed a rate of 7.7% (again using a different methodology to the internal SSI surveillance). The GIRFT SSI reports have not yet been published, but will allow for benchmarking with other centres.

Benchmarking these rates against other organisations in the UK is difficult. PHE run a voluntary SSI surveillance programme/ system, in which Imperial does not participate. The nationally reported average rate for vascular SSI of 2.8% is taken from those Trusts who contribute to the PHE surveillance system. The specific procedures contained in the PHE surveillance system are different to those in the internal surveillance of the Imperial Vascular Unit and so cannot be compared.

1.7.3.2 Improvements to reduce the risk of SSI

Following this initial surveillance findings in 2017, an extensive quality improvement programme and action plan was implemented to review and enhance practice across the patient pathway. This process was supported by a high risk serious incident investigation (STEIS 2017/19226). The action plan to improve the prevention of SSIs was developed by the vascular service, with support from IPC and the Surgical Infection Group. The action plan is designed around the patient pathway through the vascular service, from -pre-operative, through peri-operative, to post-operative. The plan includes all of the domains covered in the NICE 'SSI: prevention and treatment' guidelines (Clinical guideline [CG74]), and the Trust's 'SSI: Prevention of Infection Guideline'. Prospective collection of SSI surveillance data should be made live in Q2, which will provide a monthly review of the SSI rate; this

data will be used to participate PHE's national SSI surveillance scheme using standardised methods that will allow accurate benchmarking with other vascular centres.

1.8 *Carbapenemase-producing Enterobacteriaceae (CPE)*

1.8.1 Detection of CPE

Figure 9 provides a breakdown of CPE detected at the Trust by bacterial species and mechanism of resistance. The majority of patients were identified by screening cultures, without evidence of clinical infection (Figure 10). The number of screens taken each month and number of new CPE cases detected have plateaued over previous two quarters (Q4 2017/18, Q1 2018/19). The proportion of positive screens has remained at around 1.5%, suggesting this is increased ascertainment of an existing pool of carriers, rather than an expanding pool of carriers. This also suggests that a significant number of patients with CPE were going undetected prior to the implementation of widespread screening. Meanwhile, the number of clinical cultures has decreased from a peak of 10 in February 2015 to five in Q1. This suggests that the widespread screening programme to detect CPE carriers has resulted in or contributed to less CPE clinical infection.

1.8.2 CPE admission screening compliance

The ability to produce monthly CPE admission screening data has been interrupted by the Laboratory Information Management System (LIMS) changeover during Q1. Trust wide CPE screening compliance is now available for Jun-18 and is at 81%, compared with 82% in Mar-18. Compliance is at 100% for ICUs, 97% for Renal, 100% for Haematology, 82% for Vascular and 86% for Private patients. The target for CPE admission screening compliance is 90%. CPE admission screening compliance should be reported monthly during Q2, along with compliance data for Q1. CPE admission screening compliance is included by ward in the monthly Harm Free Care report. This provides a mechanism to prompt targeted improvement at the ward level to address areas of low compliance.

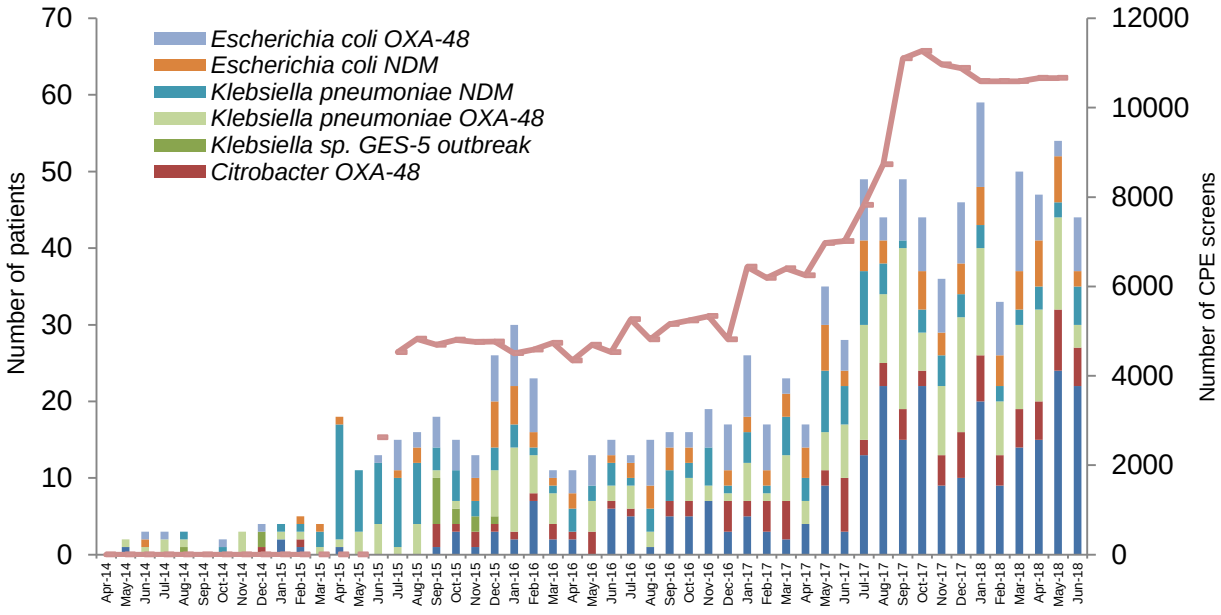


Figure 9: CPE detected at the Trust, by bacterial species and mechanisms, deduplicated by patient. The line represents the total number of screens taken each month.

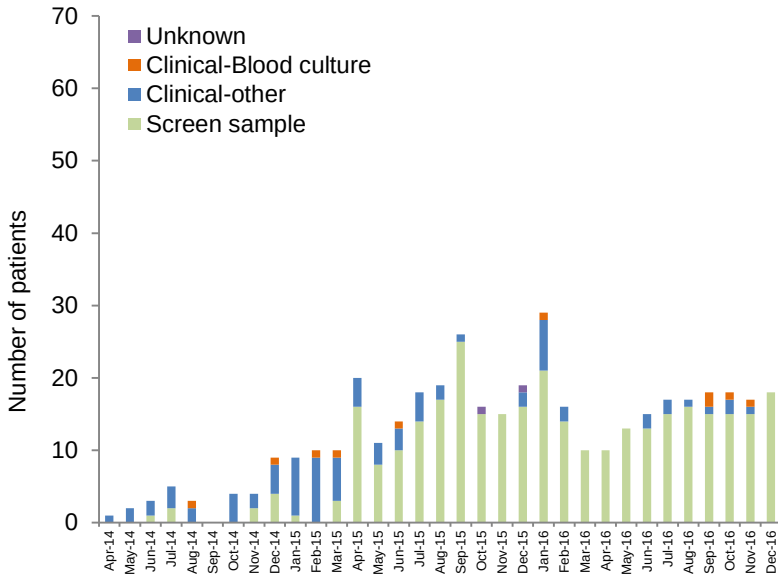


Figure 10: CPE detected at the Trust by culture type.

1.8.3 CPE Action Plan

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

2 Antibiotic stewardship

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

2.1 *Assurance regarding quality of antibiotic prescribing*

The next Point Prevalence Survey is scheduled for July / August 2018; reports will be included in the Q2 report.

2.2 *Antimicrobial Consumption*

Work has been on-going since July 2017 to analyse the Trust antimicrobial consumption data looking specifically into the classes of antibiotics used within specialities and reasons for variation. This data has and will continue to be used with antibiotic resistance data and local point prevalence studies to help target stewardship interventions and work with Divisions to drive improvement.

The Trust continues to take part in the ‘Reducing the impact of serious infections’ CQUIN specifically around antibiotic consumption reductions, which has been supported by the fixed term infection pharmacist position, which ended in June 2018. 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 prescribing data for ICHT is now available for public viewing on the PHE Fingertips website.

A target of a 2% reduction in total antimicrobial DDDs/1000 admissions and a 3% reduction in carbapenems DDDs/1000 admissions is expected for the 2018/19 CQUIN (to be confirmed by PHE in Q3 2018/19). The baseline for percentage reduction is calculated on 2016 data minus 2017/18 targets. As a result it is predicted that ICHNT will have a 4% reduction in total DDDs/1000 admissions and a 5% reduction for carbapenems. In addition there is a target that 55% of total antimicrobial use should be the WHO Access group of the adapted AWaRe index (refer to section 2.2.4). Q1 data will be submitted to PHE by the end of July 2018.

2.2.1 Overall consumption

Following an increase in antimicrobial consumption in Q3 and Q4 2017/18, the Trust had a decrease in its overall consumption of antimicrobials in Q1 2018/19 (Figure 11). When compared with our Shelford peers via the PHE fingertips portal, ICHT ranks the 3rd highest user of antimicrobials (Figure 12).

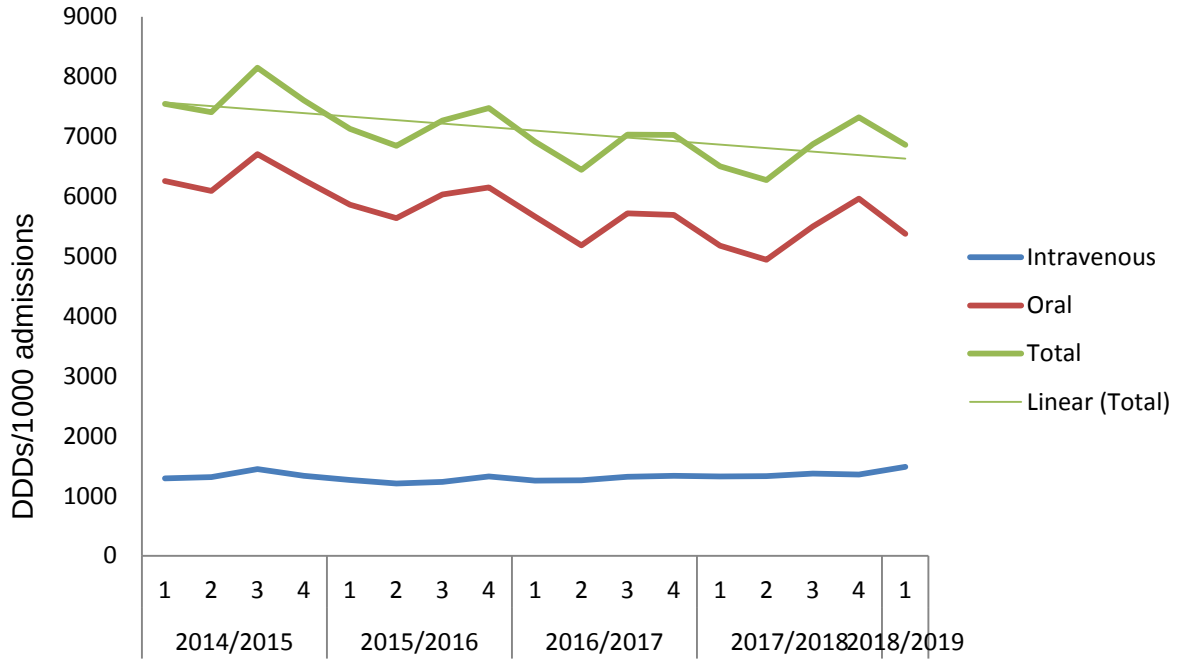


Figure 11: Trust-wide antimicrobial DDD / 1000 admissions 2014/15 – present, including the split between intravenous and oral administration. 'Linear (Total)' is the linear trendline for total antimicrobial consumption.

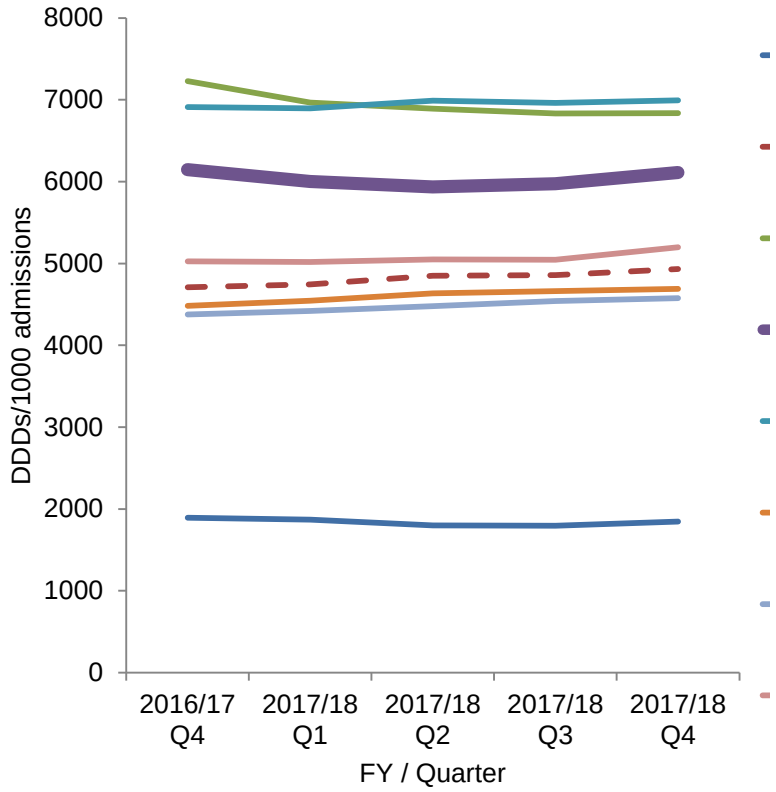


Figure 12: PHE antimicrobial DDD / 1000 admissions Q4 2016/17 to Q4 2017/18 compared to other Trusts within the Shelford group and national average. This data has been taken from the Fingertips portal and is only available up until Q4 2017/18. Data for Central Manchester University Hospitals and University Hospitals Birmingham are not currently published on the PHE Fingertips portal.

The greatest decrease in antimicrobial consumption during Q1 was for oral antibiotics (Figure 11) and this was observed in both inpatient and outpatient settings; intravenous usage remains steady. The rise in oral antimicrobial use in Q4 was linked to the increase in influenza cases and treatment of secondary infections.

2.2.2 Piperacillin/ Tazobactam (Tazocin®) / Carbapenem consumption

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

Piperacillin/Tazobactam, reduced by 96% in Q1 2017/18, primarily due to a global shortage of this agent. In August 2017, limited supplies of Piperacillin/Tazobactam started to be received and the Trust reintroduced it into empirical guidelines for the treatment of neutropenic sepsis in haematology and oncology patients. For all other indications, Piperacillin/Tazobactam must be authorised by the infection team. As a result, use of Piperacillin/Tazobactam increased from Q2 – Q4, with consumption levelling off in Q1 2018/19 (Figure 13).

The controlled rise in Piperacillin/Tazobactam is likely to have contributed to reduced carbapenem consumption in Q4 2017/18 and Q1 2018/19 (Figure 13). Carbapenem usage is currently at its lowest since level since Q2 2016/17. It is predicted that the CQUIN target will be a 5% reduction in carbapenems, with 2016 as a baseline.

Compared with our Shelford peers, ICHT is the lowest user of Piperacillin/ Tazobactam and second highest user of carbapenems.

The CQUIN carbapenem-reduction target will be an extremely challenging target given the increase in resistant Gram-negative infections globally. Although, the recent reduction in carbapenem usage is encouraging, achieving the challenging reduction target seems unlikely without the introduction of additional focussed stewardship rounds, which will not be possible without additional investment. In order to facilitate stewardship efforts to decrease carbapenem usage, a a patient-specific electronic report from Cerner will be introduced in Q2 2017/18. This will highlight patients prescribed carbapenems to enable targeted, timely reviews.

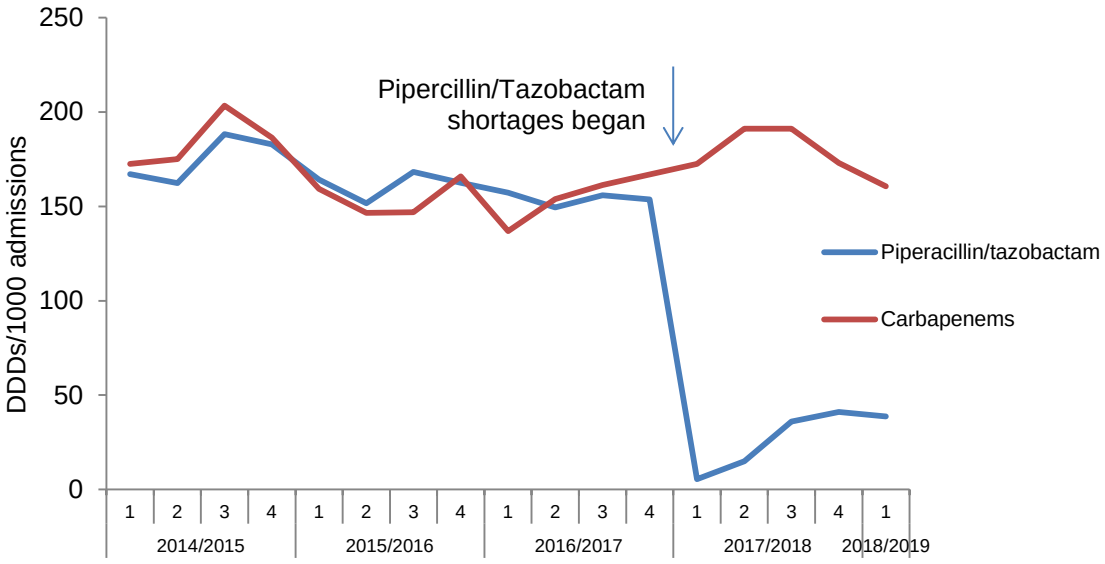


Figure 13: Trust wide Piperacillin / Tazobactam) and carbapenem DDDs / 1000 admissions 2014/15 – present.

2.2.3 AWaRe index

A comprehensive review on antibiotic use was commissioned by WHO for the 2017 update of the Essential Medicines List. During the review an expert committee categorised antibiotics into three groups (Access, Watch and Aware), with the goals of improving access and clinical outcomes, reducing the potential for development of antimicrobial resistance and preserving the effectiveness of the so-called last-resort antibiotics. Known as the AWaRe index, it is designed as a new stewardship metric to help estimate the relative use of narrow-spectrum and broad-spectrum antibiotics. The AWaRe index has been adapted for use nationally and incorporated into the 'Reducing the impact of serious infections' CQUIN for 2018/19. The Trust has been set a target of 55% of all antimicrobial consumption in 2018/19 being from agents within the Access group.[2]

The proportion of antimicrobial consumption from the Access group within the Trust is shown in Figure 14. At Q1 2018/19, the Trust antimicrobial consumption comprised 38% of agents from the Access group against a target of 55%. Currently none of the Trusts within the Shelford group are reaching the 55% target of AWaRe group antibiotics with only Guy's and St Thomas' NHS Foundation Trust and The Newcastle Upon Tyne Hospitals NHS Foundation Trust using Access group antibiotics at a proportion above the national average of 46% in Q4 2017/18 (Figure 15).

[2] The Access Group includes: Phenoxymethylpenicillin, Nitrofurantoin, Metronidazole, Gentamicin, Flucloxacillin, Doxycycline, Co-trimoxazole, Amoxicillin, Ampicillin, Benzylpenicillin, Benzathine Benzylpenicillin, Procaine Benzylpenicillin, Oral Fosfomycin, Fusidic Acid (sodium fusidate), Pivmecillinam, Tetracycline and Trimethoprim.

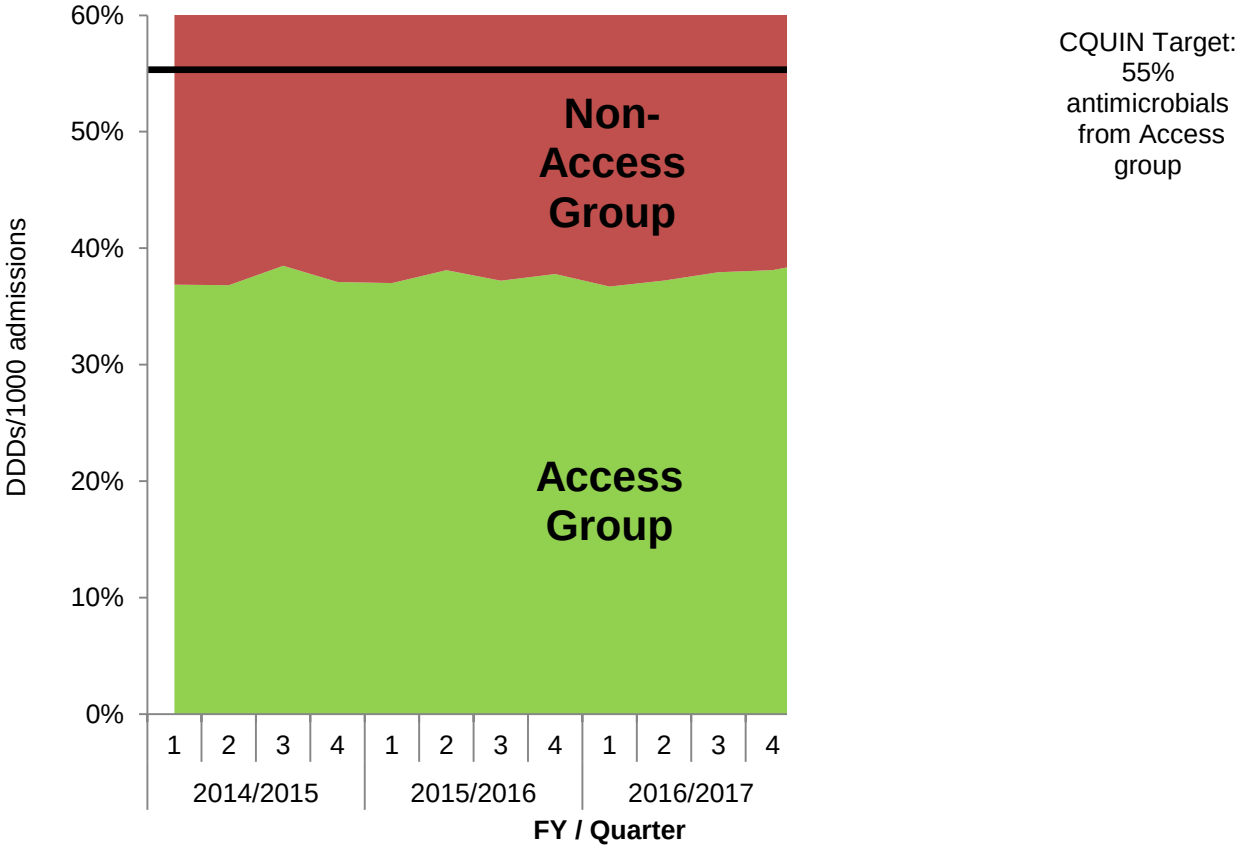


Figure 14: Proportion of antimicrobial consumption of agents within the Access group[2] from 2014/15 to current.

The Trust Antibiotic Review Group has embarked on a full review of the Empirical Treatment of Infection Policy, which will include reviewing all first line therapies and resistance rates to look for optimisation of use of the AWaRe index Access Group agents. This should support the focus on using Access Group agents as a priority, which will continue to be monitored quarterly. This is due for final review in August / September and to be launched in November to coincide with World Antibiotic Awareness Week. Whilst we expect to see an improvement in the ratio of Aware Group agents that are used, reaching the 55% CQUIN target seems unlikely without additional investment.

2.3 Antimicrobial Local Improvement Projects

- **Improving diagnosis , management and appropriate antibiotic prescribing in patients with community acquired pneumonia (CAP) admitted to the acute medical unit (MAU) at Charing Cross.** An initial audit within the medical admissions unit showed low uptake of CURB65 scores (a measure of pneumonia severity) in patients with suspected community acquired pneumonia (CAP) with more broad spectrum antibiotics being prescribed when CURB65 was not performed. A QIP trial, which lasted 2 weeks, was implemented where the admissions pharmacists prompted the review of CURB65 in all CAP patients. The result was an improvement to 100% for all CAP antimicrobial prescribing. The results are to be shared with the Medicine IPC committee with a view to rolling out on the St Mary's site.
- **Improving empirical antimicrobial medical unit prescribing.** The acute admission pharmacists have restarted feeding back monthly acute medical antimicrobial prescribing indicators similar to the Trust point prevalence studies within both Charing Cross and St Mary's MAU's. Results of these indicators will be included in Q2 report.
- **Improving vascular empirical antimicrobial surgical prophylaxis.** Following ongoing work around surgical site infection within vascular surgery, the specialist vascular pharmacist is

auditing surgical prophylaxis regimens (antimicrobial selection, duration, frequency) to drive local improvement. The results of these will be reported in Q2 report

2.4 Antibiotic Expenditure

Trust-wide there was approximately £790k spent on antibacterials and £654k on antifungals in Q1 compared to an average spend of £883k on antibacterials and £652k on antifungals per quarter in 2017/18 (Figure 16). The decrease in antibacterial costs is likely to be due to more stability within the antibacterial supply chain. However new contracts will be awarded in Q2 2018/19, which could result in increased costs.

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

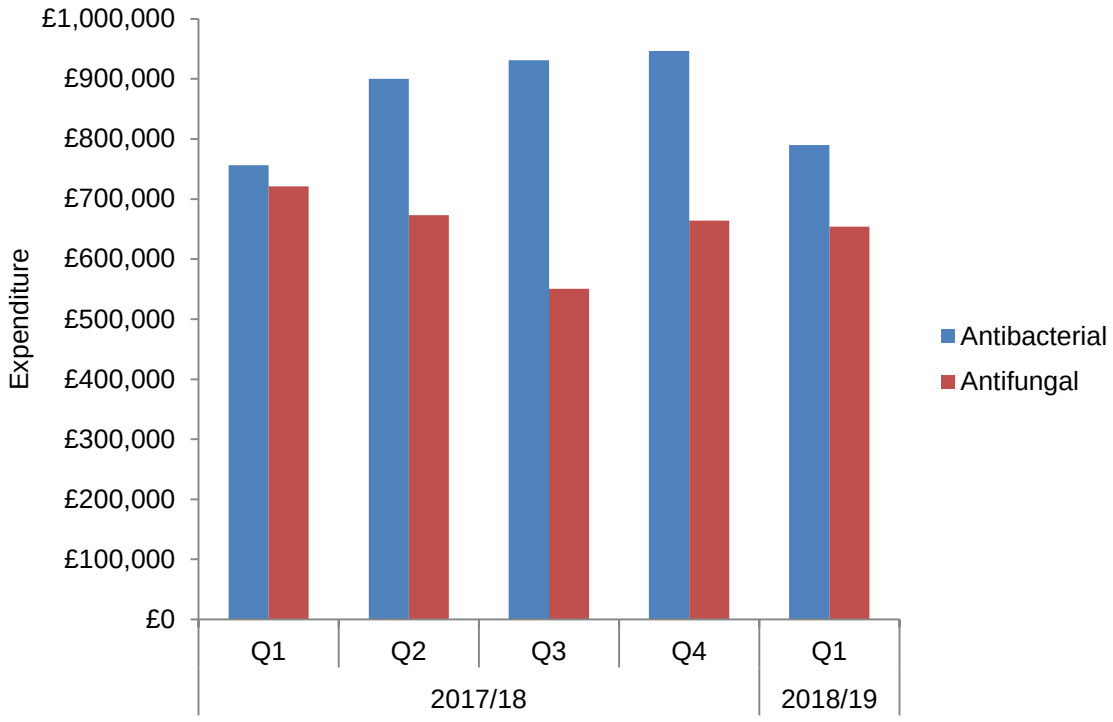


Figure 16: antibiotic expenditure for inpatients and outpatients by site and quarter 2017/18 FY to date.

2.5 Antibiotic Review Group

The Trust Antibiotic Review Group's (ARG) role is to support the improvement of antibiotic use within the Trust by promoting the safe, rational, effective and economic use of antibiotics by the multidisciplinary teams. In Q1 the ARG reviewed the following:

- Paediatric BMT - Management of infection in Neutropenic patients.
- Management of suspected encephalitis in children.
- Gentamicin – Guideline for the prescribing and administration of once daily gentamicin in paediatric ward areas.
- HIV dosing table in children.
- Vancomycin prescribing and monitoring guideline for children.
- Paediatric empirical antibiotic guideline.
- Hepatitis C (HCV) - Perinatal Management of Infected Mothers and their Infants.
- Septic shock / toxic shock guideline – PICU.

- Micturating cystourethorogram – Direct (MCUG): Guideline for antibiotic prophylaxis for children.
- Hepatitis B - Perinatal Management of Hepatitis B infected infants.
- Surgical antimicrobial prophylaxis guideline – penicillin allergy options.
- Mycobacterium Avium Complex (MAC) Infection in HIV Seropositive Adults.
- The Jefferiss Wing Centre for HIV and Sexual Health PGDs.
- Adult gentamicin extended interval guideline.

2.5.1 Antimicrobial Shortages

The Trust continues to experience the impact of national antimicrobial shortages in a number of agents. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis.

2.6 Anti-fungal CQUIN

The Trust is participating in the NHSE Anti-fungal CQUIN. This is being undertaken via the Medicines Optimisation CQUIN. Exact details of the anti-fungal components to the CQUIN were still under discussion at the time of this report.

2.7 Sepsis

IPC have contributed to the development of the Trust Sepsis Guideline, and continues to support the piloting and roll out of the Cerner sepsis alert to improve the identification and management of sepsis. This includes reporting functionality to monitor the time to the first dose of antibiotics. This will help to drive improvement around sepsis treatment, supporting optimised therapy, enabling de-escalation, and reducing antimicrobial consumption.

3 Aseptic Non Touch Technique (ANTT)

The Trust has a requirement that ANTT assessment is undertaken and documented for all staff working in a clinical environment. The target for compliance with ANTT training for Trust clinical staff is set at 95%; currently the compliance rate is 82.8% (6671/8052 clinical staff), which is unchanged from the last quarter. Of the 1381 non-compliant staff, 76.2% (1053) have never had an assessment for ANTT, and 23.7% (328) have had an assessment in the past, but have gone beyond the deadline for re-assessment. The Divisions are reviewing HR records to ensure that all clinical staff in the HR databases are active clinical staff (and therefore require ANTT assessment).

4 Hand hygiene

4.1 *Background*

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

4.2 *Baseline auditing*

The first round of auditing involving IPC and senior Divisional staff took place in May 2018. This has resulted in accurate hand hygiene compliance data from all 74 inpatient ward areas in the Trust. Overall compliance was 56% (1965 of 3532 observations), which is slightly higher than the figure of 45% in a published systematic review of hand hygiene compliance.[3] Compliance was broadly similar by Division (ranging from 53% to 60%) (Figure 17). However, compliance varied considerably by Moment (Figure 18),staff group, and ward.

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

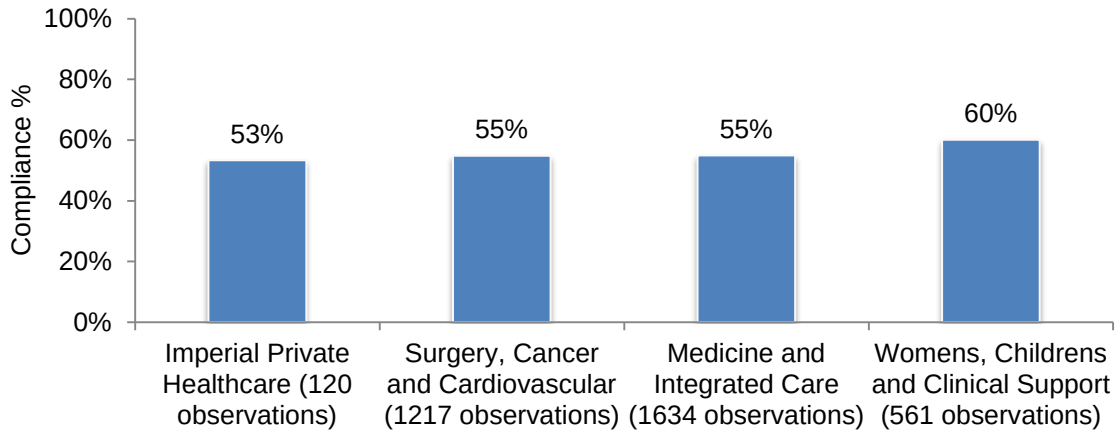


Figure 17: Hand hygiene compliance by Division, from audits performed in 74 inpatient ward areas in May 2018.

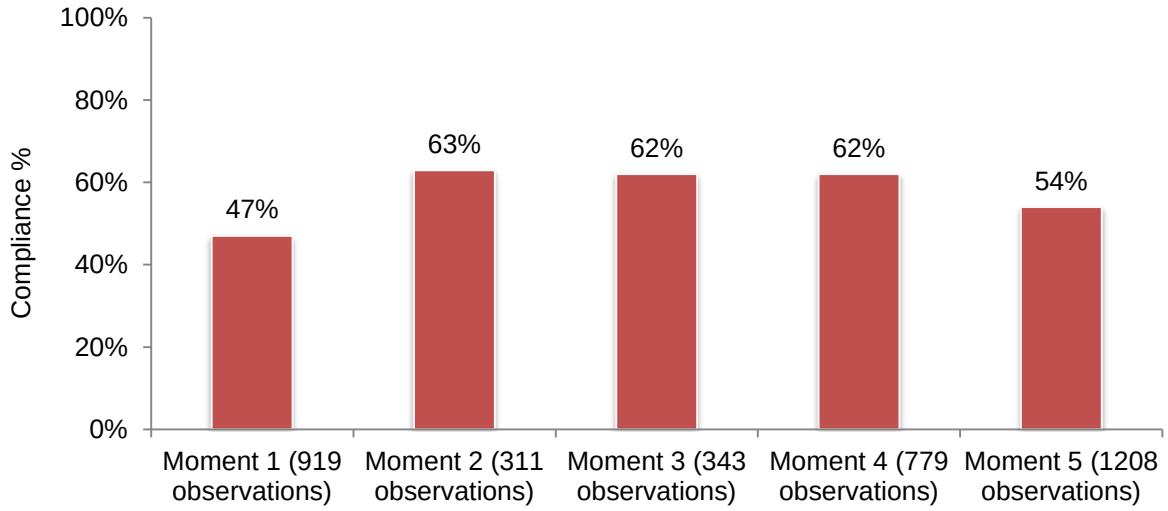


Figure 18: Hand hygiene compliance by Moment, from audits performed in 74 inpatient ward areas in May 2018. The WHO's 5 Moments for Hand Hygiene are: Moment 1 – before touching a patient. Moment 2 – before clean/aseptic procedures, Moment 3 – after body fluid exposure or risk, Moment 4 – after touching a patient, and Moment 5 – after touching patient surroundings.

These inpatient clinical areas will be audited again in October 2018 to track the progress of the improvement work. All other clinical areas will also be audit in October 2018 to provide baseline data for the rest of the Trust.

4.3 *Improvement plans*

4.3.1 All ward areas

All 74 wards included in the May audits (all inpatient wards at ICHT) will undergo a series of locally developed improvement interventions during August and September. Hand hygiene champions have been identified on each of the wards, and will co-ordinate local improvement planning. IPC and the Improvement Team have developed a 'Hand Hygiene Improvement Toolkit', which outlines the established principles of hand hygiene improvement methodology. This will be shared with the ward areas so that local improvement plans can be developed. As the improvement plans take shape and

begin to be implemented, the network of hand hygiene champions will share, learning, successes and, challenges, facilitated by the Improvement Team.

4.3.2 Specific staff groups

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

4.3.3 Wards selected for focussed improvement

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

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

In addition, the ICUs on all sites and the PICU/paediatric haematology ward at SMH have been selected as areas to test the Toolkit and for intensive support in their local improvement planning.

4.4 *Hand hygiene communications*

A new hand hygiene campaign is being developed to produce organisation-wide consistent messaging for staff and patients. This has been informed by a monthly hand hygiene steering group, which included clinical representation from the Divisions, and the Imperial Improvement Design Sprint in April, which took on a focus group format with front-line staff to understand barriers and enablers for hand hygiene compliance. One of the key outcomes of this engagement work is that communications materials should be more persuasive than challenging. An initial review of the available material suggests that it falls into the 'challenging' category (e.g. "STOP and wash your hands"); therefore, IPC and the Improvement Team will work with Trust Communications to develop persuasive hand hygiene materials. The first phase of these communications will focus on staff, and the second phase on engaging patients to improve hand hygiene compliance.

5 IPC incidents and clinical activity

5.1 *CPE cluster in haematology*

Between January and May 2018, ten patients in haematology at HH had *Citrobacter freundii* OXA-48 identified from screening samples; eight of these have been found to be indistinguishable by typing and cross transmission is suspected. One of these patients had the organism grown from a blood culture; this patient has responded to antibiotic treatment. This was declared as a serious incident (2018/11857).

5.2 *CPE and C. difficile cluster on a medical ward*

In May nine patients on a medical ward at HH had *Klebsiella pneumoniae and Citrobacter Freundii* (types of CPE) identified from screening samples; three of these have been found to be indistinguishable by typing and we are awaiting typing for the remaining six. Cross transmission is suspected. During the same period, five patients were identified with *C. difficile*. All of these were found to have the same ribotype and cross transmission is suspected. This was declared as a serious incident (2018/12482).

5.3 *Norovirus outbreaks*

In April there was an outbreak of norovirus on a cardiology ward at HH which affected 12 patients and 16 members of staff. The ward was closed to admissions and transfers for a total of ten days and managed in accordance with the Trusts Outbreak Policy. This was declared as a serious incident (2018/10021).

In April there was an outbreak of norovirus on a medical ward at SMH which affected 6 patients. No staff were affected. The ward was closed to admissions and transfers for a total of 8 days and managed in accordance with the Trusts Outbreak Policy.

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

Serious incidents (SIs) reported during Q1 are listed in Table 3. Table 3 summarises key learning points arising from HCAI-related SIs reported so far this financial year.

6 Compliance and Policies

6.1 Compliance

- Cleaning audits are performed by Facilities. Facilities, supported by the Divisions and IPC, are undertaking a review of cleaning policies and processes across the Trust in order to improve standards of cleaning and disinfection in the Trust.
- The Trust has two tiers of annual core skills IPC training: Level 1 for all staff, and Level 2 for clinical staff. Compliance with Level 1 is 86% (up from 85% in Q4), and with Level 2 is at 85% (unchanged from 85% in Q4). 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. Also, a Trust wide group is being convened by the Core Skills team to improve compliance with all core skills training.

6.2 *Policies*

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

- Hand Hygiene Policy.
- Blood Culture Guideline.

Policies and Guidelines requiring review during Q2 of 2018/19:

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

Table 7: HCAI-related SIs reported during 2017/18.

STEIS	Location	Summary	Date reported	Lessons learnt
2018/11857	Haematology	CPE Transmission (*Citrobacter freundii* OXA48 x9)	May 2018	Awaiting panel
2018/10021	A7	Norovirus outbreak	April 2018	Awaiting panel
2018/12482	JHW	CPE and *C. difficile* transmission	April 2018	Awaiting panel

7 Risks

New risks:

- None.

Updated risks:

- There have been no changes in our risk scores in the past quarter. They are updated monthly with any new information and actions to hand.

8 Other issues

8.1 External directives

None were received during Q1.

8.2 Annual review of compliance with the Hygiene Code

An annual review of extent to which compliance with the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance' (Hygiene Code) has been achieved, and is summarised in Figure 19. This self-assessment is performed by answering a series of questions, which automatically populate a spider diagram, which summarises percentage compliance with the 10 criteria in the Hygiene Code. The self-assessment with the Hygiene Code has identified issues that are highlighted in the IPC risk register, for example, around lack of single rooms, limitations in occupational health, and cleaning challenges. These have meant that the level of compliance is lower than in 2017/18.

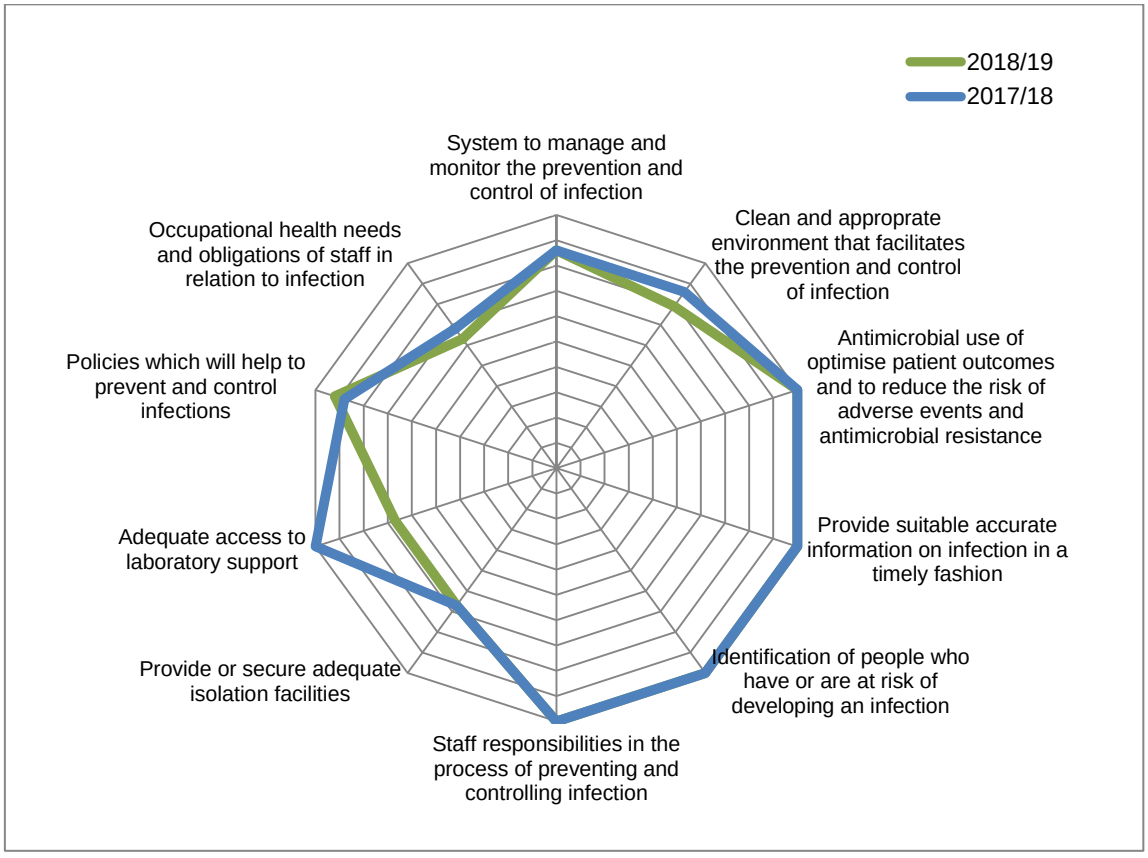


Figure 19: Summary of compliance with the Hygiene Code.

9 Publications in Q1

Fukuda K, Limmathurotsakul D, Okeke IN, Shetty N, van Doorn R, Feasey NA, Chiara F, Zoubiane G, Jinks T, Parkhill J, Patel J, Reid SWJ, Holmes AH, Peacock SJ; Surveillance and Epidemiology of Drug Resistant Infections Consortium (SEDRIC). Surveillance and Epidemiology of Drug Resistant

Infections Consortium (SEDRIC): Supporting the transition from strategy to action. Wellcome Open Res. 2018 May 16;3:59.

Mookerjee S, Dyakova E, Davies F, Bamford K, Brannigan ET, Holmes A, Otter JA. Evaluating the benefit of serial screening cultures to detect carbapenemase-producing Enterobacteriaceae (CPE) following hospital admission. J Hosp Infect. 2018 Jun 5. pii: S0195-6701(18)30312-8.

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

Rawson TM, Charani E, Moore LSP, Gilchrist M, Georgiou P, Hope W, Holmes AH. Exploring the Use of C-Reactive Protein to Estimate the Pharmacodynamics of Vancomycin. Ther Drug Monit. 2018 Jun;40(3):315-321.

Rawson TM, O'Hare D, Herrero P, Sharma S, Moore LSP, de Barra E, Roberts JA, Gordon AC, Hope W, Georgiou P, Cass AEG, Holmes AH. Delivering precision antimicrobial therapy through closed-loop control systems. J Antimicrob Chemother. 2018 Apr 1;73(4):835-843.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Learning from Deaths: Update on implementation and reporting of data	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 26th September 2018	**Item 14, report no. 10**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Trisha Bourke, Mortality Auditor Dr Ian Maconochie, Associate Medical Director for Patient Safety

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

This paper is to update the Trust Board on progress since the last report (July 2018) and includes an updated 'learning from deaths dashboard' (**appendix A**). The dashboard includes data for the financial year 2017/18 and Q1 2018/19.

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

- SJR compliance
- Staff training for SJR and further recruitment of reviewers
- SJR progress report of activity including numbers of avoidable deaths
- Learning themes emerging from reviews
- LeDeR Compliance

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

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

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

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

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

Workforce impact (including training and education implications):
6 staff received Tier 1 training provided externally by the Royal College of Physicians. 27 staff were then trained internally in a mixture of individual or small group sessions, dependent on need. Training

remains available via the Mortality Auditor.

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

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

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

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

Trust strategic objectives supported by this paper:
- To achieve excellent patients experience and outcomes, delivered with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.

Learning from Deaths: Update on implementation and reporting of data

1. Executive Summary

1.1. This paper is to update the Trust Board on progress since the last report (July 2018) and includes an updated 'learning from deaths dashboard' (**appendix A**). The dashboard includes data for the financial year 2017/18 and Q1 2018/19.

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

- We are compliant with reporting requirements as set out by NHS Improvement.
- 33 members of staff have undergone structured judgment review (SJR) training. Whilst this number is sufficient, not all reviewers have commenced undertaking reviews, mostly due to capacity and annual leave arrangements. Further recruitment has commenced to ensure we have at least one active reviewer in each specialty to facilitate local feedback of findings.
- 285 SJR reports have been completed since commencing the review programme in September 2017.
- 21 avoidable deaths to date of reporting (13/08/18) have been reviewed and signed off via the Mortality Review Group.
- 16 of these cases have undergone SI investigations, with the remaining 5 cases having been subject to level one/internal investigation.
- Data is now reported 1 month in arrears, to allow the reporting cycle to complete, and for performance data to more accurately reflect compliance.
- Since November 2017 mortality-reporting metrics have been incorporated into both Trust and divisional scorecards.
- The avoidable deaths are not clustered by specialty and therefore no individual specialty concerns have been raised.
- Early emerging themes are linked to six of the Trust's safety streams. Five are linked to 'falls and mobility', two to 'abnormal results', eleven to 'responding to the deteriorating patient' one to 'safer medication', two to 'safer surgery', and four to 'fetal monitoring'. Cases will continue to be shared with the safety workstream leads to ensure the improvement work covers the findings of the SJRs. Case specific actions are recorded and tracked through the Datix actions module. Trust-wide non patient specific actions are managed and reviewed through the monthly MRG.
- Other emerging themes for future learning include two cases focusing on 'access to specialist services', two to 'senior involvement/leadership', two to 'communication', four to 'documentation, and two to 'end of life'. End of life issues have been highlighted to the end of life working party. Further work is required to agree sustainable processes for highlighting emerging themes to Trust level groups and forums and commissioning of future improvement work which is not currently managed through the existing safety streams.

- Data fields have now been incorporated within the online mortality module to facilitate thematic reporting into the future.
- The Trust continues to report any applicable cases to the LeDeR programme, and complies with all reporting and reviewing requirements for LeDeR.

2. Purpose

2.1. The purpose of this paper is to update the Board on progress with ensuring Trust compliance with the mandatory framework on learning from deaths since the previous report in July 2018.

3. Background

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

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

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

3.4. In July 2018 the National Quality Board published further guidance on "*Learning form Deaths: Guidance for NHS trusts on working with bereaved families and carers".* The trust will review the recommendations within this guidance and adapt its processes accordingly.

4. Summary/Key points

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

4.2. The data required for Trust Board publication is shown in **appendix A**.

4.3. All clinical teams are required to provide a review of mortality cases within their specialty areas. All cases undergo a Level 1 review, which consists of a short number of questions, followed by assigning an avoidability score within 7 days of death. Based on that review, cases may proceed to a team based Morbidity & Mortality (M&M) meeting, which should occur within 30 days. Where local teams have highlighted issues in the care of a patient, an

independent SJR review should be undertaken. Charts demonstrating the trust performance, both for local review as well as SJR, for 2017/18 and Q1 2018/19 can be found in **Appendix B**. This shows that 97 % of local reviews had been undertaken with 315 SJR's requested. Of these, 283 SJR's have been completed with 21 avoidable deaths confirmed.

4.4. Data is refreshed monthly, in order to update all reporting metrics. This is particularly important when reviewing SJR requests which are made a significant period after the death. 18 of the outstanding 32 cases were requested more than 30 days following death. 10 of these were as a result of coronial inquests being confirmed. 6 reviews were commenced following questions or concerns being raised by the clinical teams within their local M&M procedures and 2 were commenced following complaints from family members, both of which are following the formal complaints process.

4.5. We have 19 overdue SJR reviews (including some from 2017/18) where reviewers are struggling to complete them, for example due to capacity, and they have been reallocated to another reviewer.

4.6. Data is now reported 1 month in arrears to allow time for the reviews to be completed within the agreed timeframe as per trust policy. This was introduced to ensure that data reported was more accurately reflecting performance.

4.7. The Trust target is to review 15% of hospital deaths using the SJR methodology. Cases are selected using the principles set out in the Trust policy. For 2017/18 we have completed reviews on 12% of trust deaths, this is primarily because Q1 2017/18 is not included and the the process commenced in July 2017. The current trajectory for completion of SJRs in 2018/19 will ensure we meet the 15% target for this year.

4.8. A national dashboard remains under development. Until such time as this is launched Trusts have been asked to publish data in their public board papers.

4.9. The Mortality Review Group (MRG) is now well established. All cases that are potentially avoidable (scored 1-4) are reviewed within the group for trust level sign-off. Cases that the reviewers feel have learning or have wider discussion points are also presented. Discussions focus on any avoidable factors and learning themes. Early emerging themes map to six of the safety streams and includes 'abnormal results', 'falls', 'responding to the deteriorating patient', 'safer medication', 'safer surgery' and "fetal monitoring". These safety streams have improvement plans in place and cases will continue to be shared with the safety work streams leads to ensure the improvement work covers the findings of the SJRs.

4.10. Other emerging themes for future learning include two cases focusing on 'access to specialist services', two to 'senior involvement/leadership', two to 'communication', four to 'documentation, and two to 'end of life'. Data fields have now been incorporated within the online module to facilitate thematic reporting into the future. Further work is required to agree sustainable

processes for highlighting emerging themes to Trust level groups and forums and commissioning of future improvement work which is not currently managed through the existing safety streams.

4.11. A key focus of the guidance is the need to actively involve families including offering opportunities for them to raise questions or share concerns in relation to the quality of care received by their relatives. Guidance on working with bereaved families was published in July 2018. The Trust is in the process of adapting its policies and processes to incorporate the new guidance. In the interim we have included guidance in the bereavement pack for families on how to raise concerns, we are also currently working with the Trust Communications team on other signposting options.

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

4.13. The Trust reports all deaths of patients with a learning disability to the national database. We reported 12 deaths in 2017/18, of which 2 were subjected to a full review. We have reported 2 cases in Q1 2018/19. At ICHT these cases all have an SJR completed, in addition to the external LeDeR review. To date those SJR reviews have not revealed any concerns in relation to deficiencies in care, and do not form any of the reported avoidable deaths. LeDeR reports are held at CCG level and not actively shared with acute providers unless issues or concerns are identified relating to the Trust.

5. Options appraisal including financial appraisal (as relevant)

Not applicable

6. Conclusion and Next Steps

6.1. The Trust is compliant with reporting requirements and will continue to report quarterly to the Trust Board.

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

6.3. An updated framework has been published by the National Quality Board "*Learning from Deaths: Guidance for NHS trusts on working with bereaved families and carers".* It contains a number of recommendations that the trust is currently reviewing. We may be required to make alterations to the current process that is in place in order to comply with the new guidance.

7. Recommendations

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

Author: Trisha Bourke, Mortality Auditor
Date: 24/08/2018

Appendices as relevant (referenced in summary)

Appendix A: NQB Learning from Deaths Dashboard

Appendix B: Trust Performance Dashboard

- 2017/18
- 2018/19

Learning from Deaths: Update on implementation and reporting of data

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Author: Trisha Bourke, Mortality Auditor
Date: 24/08/2018

Appendices as relevant (referenced in summary)

Appendix A: NQB Learning from Deaths Dashboard

Appendix B: Trust Performance Dashboard

- 2017/18
- 2018/19

Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - June 2018-19

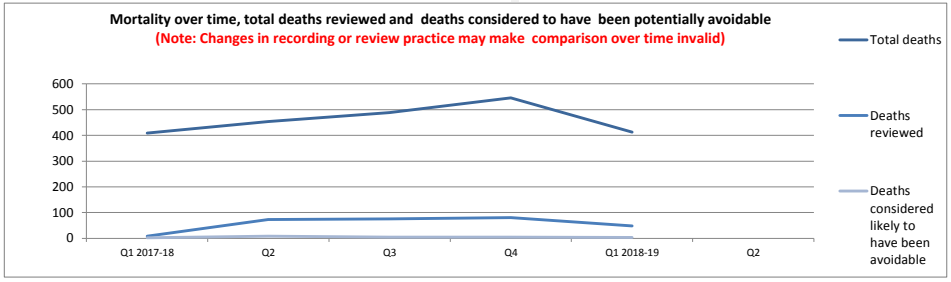
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
122	136	11	22	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
413	546	48	80	3	5
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
413	1898	48	237	3	20

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



Total Deaths Reviewed by RCP Methodology Score

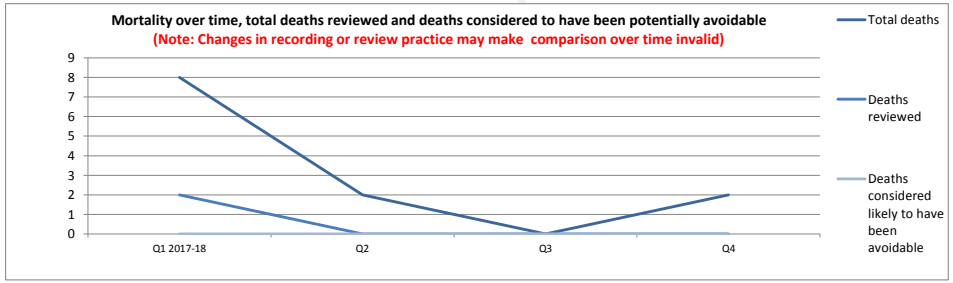
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	3	27.3%	This Month	8	72.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.1%	This Quarter (QTD)	2	4.2%	This Quarter (QTD)	1	2.1%	This Quarter (QTD)	9	18.8%	This Quarter (QTD)	35	72.9%
This Year (YTD)	0	0.0%	This Year (YTD)	1	2.1%	This Year (YTD)	2	4.2%	This Year (YTD)	1	2.1%	This Year (YTD)	9	18.8%	This Year (YTD)	35	72.9%

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

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

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

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



Trust Level Performance **2017-18**

Trust Total	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Total Deaths	120	152	137	138	163	151	161	167	161	191	176	178	1895
No. Level 1 Reviews Completed	120	152	137	138	163	150	161	166	156	186	172	175	1876
% Level 1 Reviews Completed	100%	100%	100%	100%	100%	99%	100%	99%	97%	97%	98%	98%	99%
No. of SJR Reviews Requested	3	3	4	21	29	22	36	19	21	28	30	29	245
No. of SJR Reviews Completed	3	3	2	21	28	22	36	19	21	27	28	25	235
% SJR Reviews Completed	100%	100%	50%	100%	97%	100%	100%	100%	100%	96%	93%	86%	96%
No. of Avoidable Deaths (Score 1-3)	2	0	0	3	2	1	3	2	0	2	2	1	18

Trust Level Performance **2018-19**

Trust Total	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
Total Deaths	155	136	122	0	0	0	0	0	0	0	0	0	413
No. Level 1 Reviews Completed	144	129	96	0	0	0	0	0	0	0	0	0	369
% Level 1 Reviews Completed	93%	95%	79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%
No. of SJR Reviews Requested	19	29	22	0	0	0	0	0	0	0	0	0	70
No. of SJR Reviews Completed	15	22	11	0	0	0	0	0	0	0	0	0	48
% SJR Reviews Completed	79%	76%	50%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69%
No. of Avoidable Deaths (Score 1-3)	2	1	0	0	0	0	0	0	0	0	0	0	3

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: 2018 General Medical Council National Training Survey - Results	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☒ Information
Date of Meeting: 26th September 2018	**Item 15, report no. 11**
Responsible Executive Director: Professor Julian Redhead, Medical Director	**Author:** Ruth Brown, Associate Medical Director Education Danielle Bennett, Head of Operational Management, Medical Education

Summary:

The purpose of this paper is to inform the Trust Board of the results of the 2018 General Medical Council (GMC) National Training Survey (NTS).

The results of the 2018 General Medical Council National Training Survey (GMC NTS) were published on 9 July 2018. The results for Imperial College Healthcare NHS Trust (ICHNT) show a significant deterioration in the results with a 56% increase in red flags and 33% less green flags. There are also 132 pink flags compared to 107 in 2017

Unit Training Leads (UTLs) are currently working with their Medical Education Managers (MEMs) and Heads of Specialty (HoS) to understand the underlying cause of the flags, and to develop action plans. Deep dive meetings, led by education managers, with trainees are underway which will be reported to the UTLs and HoS to use in the development of action plans.

Divisional Directors of Medical Education (DDME) are supporting divisional colleagues with understanding the results, and in doing so held a workshop for UTLs on the 18 July 2018.

External action planning is due on 28 September 2018 for training programmes by site with four or more red flags; repeated red flags over successive years; red flags for supervision and overall satisfaction.

Recommendations:

The Committee is asked to;

- Note the 2018 GMC National Training Survey results
- Note the detail provided in the appendices to this paper
- Note the action currently underway, or already completed with regard to these results
- Note the revised processes detailed at Para 5.7.1 – 5.7.4 of this paper

Quality impact:

Delivery of the actions determined through education review programme will further improve junior doctor and medical student experience and engagement, ensuring they are equipped to deliver high quality patient-centred care within a safe and supportive environment.

This report has been discussed at:

☒ Executive Committee (Workforce)
☒ Board Quality Committee

Financial impact: This paper has no financial impact

Risk impact and Board Assurance Framework (BAF) reference:
The actions described in this paper provide mitigation for the risk of failing to provide adequate and appropriate training for junior doctors and medical students and demonstrate the improvements made in medical education in the last quarter.

Workforce impact (including training and education implications): As above

What impact will this have on the wider health economy, patients and the public?
Maintaining high quality patient care

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

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

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

Trust strategic objectives supported by this paper:

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

2018 General Medical Council National Training Survey – result analysis and management plan

1. Executive Summary

1.1 The results of the 2018 General Medical Council National Training Survey (GMC NTS) were published on 9 July 2018. The results for Imperial College Healthcare NHS Trust (ICHNT) show a significant deterioration in the results with a 56% increase in red flags and 33% less green flags. There are also 132 pink flags compared to 107 in 2017

1.2 Unit Training Leads (UTLs) are currently working with their Medical Education Managers (MEMs) and Heads of Specialty (HoS) to understand the underlying cause of the flags, and to develop action plans. Deep dive meetings, led by education managers, with trainees are underway which will be reported to the UTLs and HoS to use in the development of action plans.

1.3 Divisional Directors of Medical Education (DDME) are supporting divisional colleagues with understanding the results, and in doing so held a workshop for UTLs on the 18 July 2018.

1.4 External action planning is due on 28 September 2018 for training programmes by site with four or more red flags; repeated red flags over successive years; red flags for supervision and overall satisfaction.

1.5 In view of the deterioration and to prevent any further decline, the executive have supported a new process for educational review and governance, as outlined in this paper.

2. Purpose

2.1 The purpose of this paper is to inform the Trust Board of the results of the 2018 General Medical Council (GMC) National Training Survey (NTS).

3. Background

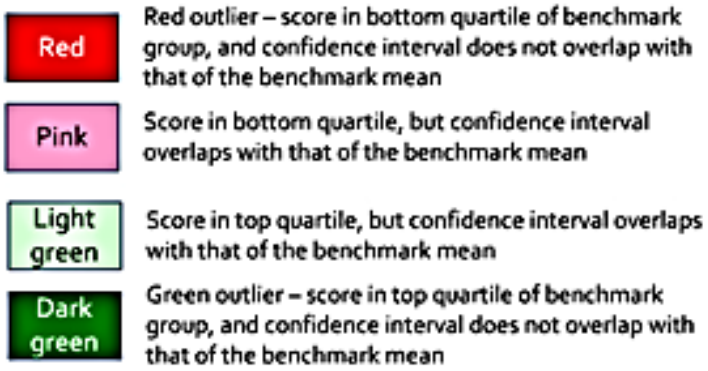
3.1 The GMC NTS is conducted on an annual basis. Formed of two parts, a survey for trainees and a survey for trainers, the GMC NTS is the largest and most detailed collection exercise of trainee and trainer perceptions with regard to the quality of medical education and training. Every postgraduate medical trainee in an approved training post and every approved trainer in the UK are invited to complete the survey. In 2018, the response rate was **95.69%** and **41.37%** for the trainee and trainer survey respectively. The response rate for the Trust was 98% and 35%.

3.2 The results are analysed by training programme (foundation, core and higher specialty training); post specialty (all grades in a department together), by Trust and site for multi-site organisations.

3.3 The trainee survey is made up of 71 generic questions across 18 domains. The domain of rota design is new in 2018.

The trainer survey is made up of 70 questions, across four themes: learning environment and culture; educational governance and leadership; supporting educators and developing and implementing education.

3.4 The trainee survey is designed on the allocation of a numerical score for each domain, derived from the responses made in the survey by trainees in a particular programme at the Trust (foundation, specialty core, or specialty higher). This numerical score is then compared to the national mean response for trainees in that programme. Scores for individual training programmes are then compared to the national mean generating the results – red flags, green flags etc.:



4. 2018 GMC National Training Survey Results

4.1 The results of the 2018 General Medical Council National Training Survey (GMC NTS) were published on 9 July 2018.

4.2 For ICHNT, there has been deterioration in the trainee feedback with a 56% increase in red flags and a 33% decrease in green flags measured across all programmes, by site.

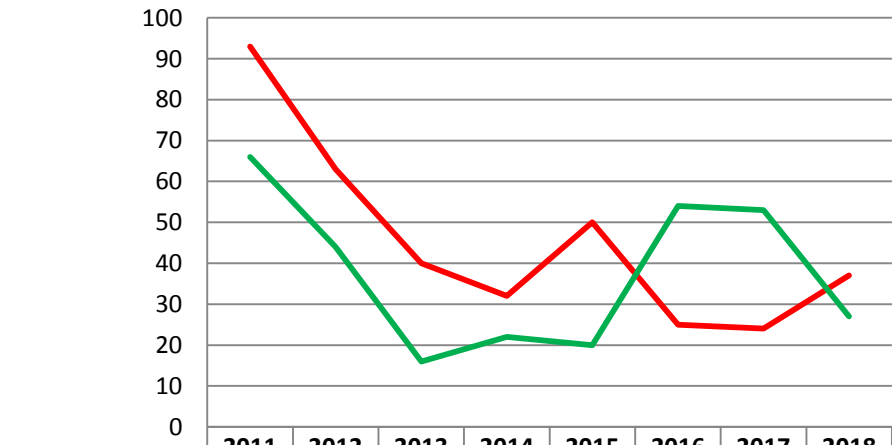
4.3 Table 1 below shows the results by domain for 2017, and 2018, alongside the improvement trend for that domain. The table shows that the increase in red flags is across nine of eighteen domain areas, the decrease in green flags affect 13 out of 18 domains.

Table 1: Overview of results by domain is shown below.

Domain	2017		2018			
	Red flags	Green flags	Red Flags	Trend	Green Flags	Trend
Overall Satisfaction	3	2	1	↓	1	↓
Clinical Supervision	2	3	1	↓	0	↓
Clinical Supervision out of hours	0	5	1	↑	1	↓
Reporting systems	0	3	0	↔	1	↓
Work Load	3	5	4	↑	6	↑
Teamwork	1	3	3	↑	1	↓
Handover	0	4	1	↑	3	↓
Supportive environment	2	4	5	↑	2	↓
Induction	2	5	2	↔	1	↓
Adequate Experience	1	1	2	↑	1	↔
Curriculum Coverage	1	0	3	↑	0	↔
Educational Governance	1	4	2	↑	2	↓
Educational Supervision	1	2	1	↔	1	↓
Feedback	2	2	1	↓	0	↓
Local Teaching	0	3	3	↑	4	↔
Regional Teaching	4	6	4	↔	1	↓
Study Leave	1	1	1	↔	0	↓
Rota Design	N/A	N/A	2	N/A	2	N/A
TOTAL COUNT	**24**	**53**	**37**		**27**	

4.4 Table 2 below shows the total number of red and green flags by year since 2011. The table clearly shows that the significant improvements made in 2016 were maintained in 2017, with a marked deterioration this year. Noting there's been a marked change in the domains and questions in this time.

Table 2: Trend analysis 2011-2018



	2011	2012	2013	2014	2015	2016	2017	2018
Reg Flags	93	63	40	32	50	25	24	37
Green Flags	66	44	16	22	20	54	53	27

4.5 Appendix A and B to this paper provides the detailed results for the Trust for the trainee and trainer survey respectively. The Board are asked to note the following:

4.5.1 It is of note that the results included at Appendix A are split by site. In some specialties the trainees work across the sites, although will be allocated to a specific site by the GMC; cardiology, clinical oncology, clinical radiology, histopathology, infectious diseases and ophthalmology. For these specialties it is better to analyse by combined sites for the purposes of triangulating any issues.

4.5.2 We are awaiting information from Health Education England (HEE) on the further analysis of paediatrics, to include results for paediatric sub specialties and neonatology.

4.5.3 The Trust has queried the ACCS results as there are no trainees in that programme at the Hammersmith site.

4.5.4 The majority of programmes have deteriorated if the balance of red/pink to greens is evaluated. There are ten site specific programmes with two or more RED flags, and sixteen with one flag.

4.5.5 Forty six programmes have pink flags. Twelve programmes (Clinical Oncology, Clinical Radiology, Core Anaesthetics, Dermatology, Gastroenterology, General Surgery, Neurosurgery, Plastic Surgery, Rheumatology and Trauma & Orthopaedics) have four or more, plastic surgery has 11 pink flags.

4.5.6 In 2017 there were 48 programmes with pink flags, and 10 programmes with four or more. Overall the total number of pink flags across the Trust has increased from 107 to 132.

4.5.7 While 10 specialties have reduced their red flags, only six have lost them completely and five of those have maintained pink flags.

4.5.8 Improvements have been made in 24 programmes if the combination of red/pink against greens is assessed.

4.5.9 The results for Intensive Care Medicine at Charing Cross Hospital demonstrate improvement. This programme is currently subject to GMC Enhanced Monitoring, it is not yet clear if the GMC will remove this.

4.5.10 The Lead Provider, hosted at the Trust until September 2017, previously organised regional teaching. When the management of programmes transferred to HEE, the organisation of regional teaching by the Trust ceased. With this in mind, the Trust will not be responding to the red outliers for regional teaching and will raise concerns regarding these outliers with Health Education England.

4.5.11 The Trainer's results in 2018 indicate 10 red flags and 26 green flags. In five specialties, insufficient numbers of trainers responded to analyse and in three others less than 25% of trainers responded. These specialties correlate with specialties with deterioration in the results for trainees. Full results are at Appendix B to this paper.

4.5.12 The GMC has issued an initial findings report of the national results in which they note: "This year, we added new questions to the surveys to help us better understand the extent of burnout amongst doctors in training and trainers. The results are stark. Long and intense working hours, heavy workloads and the challenges of frontline medical practice are affecting doctors' training experience and their personal wellbeing." We await the

results of these questions for the Trust to give further information on trainee morale to allow renewed focus of the ongoing junior doctor engagement programme.

5. Trust response to 2018 GMC National Training Survey Results

Important considerations

5.1 Transforming medical education is an iterative process which relies on:

- engagement with the trainees to explore the reasons for poor feedback;
- engagement with trainers to explore barriers to improvement;
- engagement with service leads and managers to ensure that the mode of service delivery supports a positive learning environment and does not impact negatively on the trainee experience, learning opportunities and access to supervision

While there is no standard formula for improvement, UTLs and HoS have the opportunity to learn from successful departments through the existing faculty development programme and network.

5.2 Where specialties have significantly improved or retained positive results the actions taken have included the following:

- Strong service review to manage clinic bookings
- Job plan reviews for consultants to ensure time for training and appropriate EPA allocation
- Review of trainee rotas to ensure optimum exposure to theatre time (craft specialties)
- Review of rotas and rota gaps to ensure appropriate medical staffing to allow learning
- Clarity over which consultant has supervisory responsibility for clinics and inclusion of prospective patient review in clinic, direct supervision and feedback
- Enhanced provision of access to educational equipment particularly for skills development
- Improved bleep-free local teaching programmes
- Regular meetings with trainees to share ideas, changes being planned and to invite contributions from them

5.3 The overall deterioration across the programmes is compounded by a general deterioration in many programmes (overall increase in total reds and pinks, or loss of greens and or deterioration in the underlying score generating the results). Therefore, while some specialties are not outliers this year; they may further deteriorate over the year unless proactive and focused work is undertaken to explore the causes and implement plans for improvement. With this in mind it is recommended that all specialties work with their UTL, HoS,

General Manager and DDME to further understand their NTS results, even if they have not generated any outliers. Where there has been deterioration in the numerical score assigned to each domain it is recommended that improvement plans are put in place. These action plans should be linked to the domains but should also be a general plan to support the continuous improvement of the learning environment.

5.4 In planning the Trust response to the 2018 GMC NTS it is important to consider correlation of the results with other markers of a positive learning environment:

5.4.1 Specialties may be identified as having problems with the learning environment through other mechanisms of trainee feedback (foundation school survey, CMT feedback, exception reporting (hours and rest), rota gaps and difficulty recruiting non trainees). There is frequently a correlation between the specialties whose results have deteriorated this year and those other markers. Appendix C shows the list of specialties where there has been **significant deterioration** and correlation with other information. Together with the actions underway in those specialties as agreed in the local faculty groups.

5.4.2 The electronic platform for exception reporting system changed in August 2017. There are 107 (from 623) outstanding exception reports which have not been closed (dating from February 2018). The doctors who filed these exception reports have now in most cases left the Trust.

The exception report distribution between the divisions is shown in Appendix D with the number outstanding.

<u>Recommended Trust response</u>

5.5 The Board are asked to note the following activity which is already underway, or has already been completed in response to the 2018 GMC NTS:

5.5.1 **Deep dives:** the medical education managers are in the process of meeting with trainees (deep dives) to explore the learning environment and specifically understand the reasons for the results by discussing the questions and current trainee feedback. These meetings are recorded via written minutes (anonymously) and shared with the UTL, DDME and HoS. These will be completed by mid-September 2018.

5.5.2 **Local Faculty Groups (LFG):** specialties are expected to hold a local faculty group with trainees. Where trainees changed on the 1 August 2018 due to rotations, this has already been completed where possible to ensure the relevant cohort was able to provide feedback via the

LFG. These meetings are recorded via written minutes and shared with the UTL, DDME and HoS. These will be completed by mid-September 2018.

5.5.3 **Unit training lead workshop:** the medical education team hosted a workshop in July 2018 to discuss results and share approaches to resolution. 14 unit training leads were in attendance.

5.6 For the past two years, a programme of education specialty reviews has been conducted by the Office of the Medical Director, in conjunction with the Medical Education Team.

These reviews consist of a programme of meetings (chaired by the Medical Director, or Associate Medical Director – Education (AMD-E). The meeting involved education leads, head of specialty and managers. The programme has supported the development of action plans, sharing of good practice and solutions from other specialties and monitoring the implementation of actions to provide support.

The success of these reviews has relied on engagement with the specialty leads and divisional directors whether within the meeting or for support for implementation of agreed actions. In some specialties this has resulted in transformation (histopathology, ophthalmology, neurosurgery, and neonatology). However as already noted, there has been a decline in the overall balance of flags in some of these specialties.

The education specialty review process has been effective in some specialties but failed to gain traction in others (haematology, cardiology, and oncology) and for this reason it is recommended that the Trust now adopt a revised and refocused approach to supporting the improvement of medical education.

5.7 There is a need to consider how the Trust responds to the 2018 GMC NTS results. In doing so it is important to learn from the education specialty reviews to date, while considering the need to deploy a robust proactive programme of improvement for medical education in order to ensure our results in 2019 do not deteriorate further, and hopefully improve. With this in mind the executive have endorsed the following revised processes/recommendations:

5.7.1 **External action planning:** The General Medical Council require action plans for five programmes:

- Anaesthetics
- Clinical Radiology

- Haematology
- Medical Oncology
- Obstetrics & Gynaecology

These actions plans are required because there is: four or more red flag outliers at site level, and or, red flags for overall satisfaction, clinical supervision, clinical supervision out of hours and educational supervision.

UTLs are working with the DDME and medical education team to support the development of these plans based on the outputs of the deep dive minutes and local faculty group discussions.

It is recommended that these should be reviewed and approved by the Divisional Directors before submission to the medical education team within the timescales already shared with the relevant UTL and DDME

5.7.2 **Divisional Education Review:** it is recommended that a process of Divisional Education Review is instigated, led by the Divisional Director (DD).

Each specialty would engage with the DD and Divisional Director for Operations (DDO) in a review of the educational environment at programme/specialty level, using the NTS results as the driver but incorporating the other markers of success including review of the LFG minutes.

Plans would be developed as part of the review meeting, providing divisional level sign off and endorsement of the action that needs to be taken to improve the quality of medical education in the specialty.

It is recommended that all specialties would have a Divisional Education Review over the coming 12-months. With priority given to those specialties with the most marked deterioration (see Appendix C). but include all specialties over the year.

The Divisional DME would be the lead education expert for advice and support and will attend all Divisional Education Reviews.

5.7.3 **Quarterly Education Review:** the DDME will meet with AMD-E on a quarterly basis in order to discuss the Divisional Education Review process, progress made and any risks associated with this. Where appropriate AMD-E will escalate concerns to the Medical Director and relevant Divisional Director.

The Quarterly Education Review will support the identification of Trust-wide, or cross-divisional education risks, and actions required. These may be associated to teaching, simulation, facilities or similar. Where identified AMD-E will lead the response to these issues.

AMD-E will report on all Quarterly Education Reviews to the Medical Director via existing mechanisms. Where appropriate the Medical Director will escalate issues to the Divisional Performance Meeting chaired by the CEO.

5.7.4 **Medical Director Education Assurance Meeting:** where concerns are escalated by AMD-E, or a Divisional Director, then the Medical Director will request specialty, directorate and divisional attendance at a Medical Director Education Assurance Meeting.

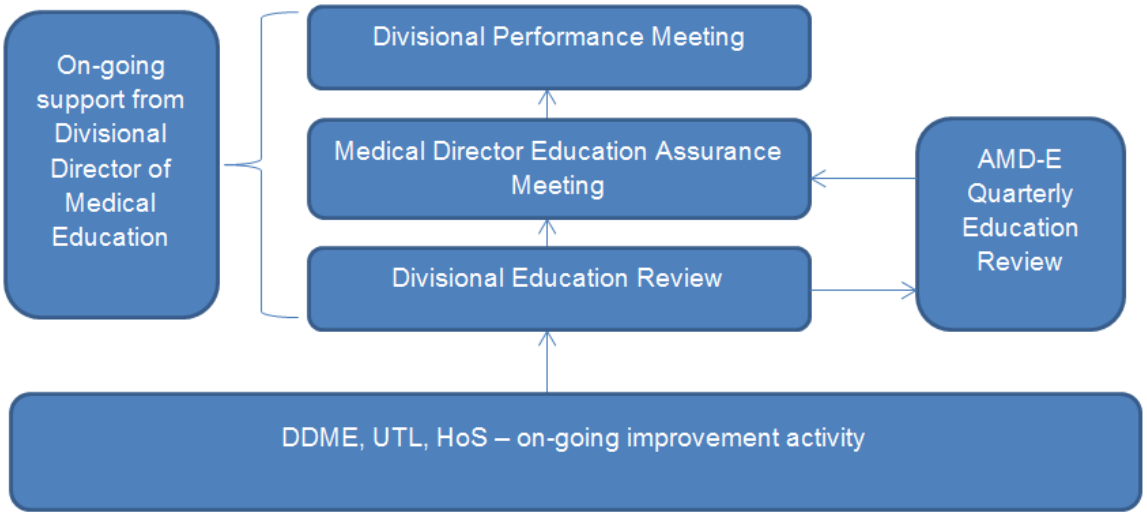
The purpose of this meeting is to ensure that, for the most high risk areas in terms of improvement, appropriate actions are in place, and where this is not the case to consider the level of risk that exists to the Trust, escalating this to the Trust CEO and Board as necessary.

Where appropriate the Medical Director will escalate issues to the Divisional Performance Meeting chaired by the CEO.

It is recommended that the following specialties are reviewed via a Medical Director Education Assurance Meeting as a result of their 2018 GMC NTS results. This will take place following the Divisional Education Review:

- **Cardiology**
- **Clinical/Medical Oncology**
- **Clinical Radiology**
- **Haematology**
- **Vascular Surgery**

5.8 The below info-graphic provides an overview of how the process will work:



5.9 This approach will support the further engagement of service leads and allow Divisional Directors transparency of the issues in the medical workforce. The benefits include visibility and correlation with other markers such as exception reporting, rota and workforce gaps and consultant time for supervision. The engagement with the medical education team via the DDME will be critical to ensure a shared understanding between service and education of the key issues and allow cross programme dissemination of good practice.

6 Recommendations

6.1 It is recommended that the Board:

- Note the 2018 GMC National Training Survey results
- Note the detail provided in the appendices to this paper
- Note the action currently underway, or already completed with regard to these results
- Note the revised processes detailed at Para 5.7.1 – 5.7.4 of this paper which the executive have endorsed

Ruth Brown, Associate Medical Director – Education
Danielle Bennett, Head of Operational Management - Medical Education

15 August 2018

Appendix A NTS Results 2018_Analysis by programme by site
Appendix B NTS Results 2018_Analysis Trainer by specialty
Appendix C High Risk Specialties
Appendix D Exception Reports by Division

Trainer Specialty	Response Rate	Red flags	Green flags	Response Rate	Red flags	Green flags
	2017			2018		
Acute Internal Medicine	100%	n/a	n/a	n/a	n/a	n/a
Allergy	n/a	n/a	n/a	100%	n/a	n/a
Anaesthetics	51%	0	0	29%	0	0
Audio vestibular medicine	100%	n/a	n/a	n/a	n/a	n/a
Cardio-thoracic surgery	40%	n/a	n/a	75%	3	0
Cardiology	27%	1	0	20%	1	0
Clinical oncology	67%	0	0	19%	1	0
Clinical radiology	51%	0	0	29%	0	0
Community Sexual and Reproductive Health	n/a	n/a	n/a	50%	0	1
Dermatology	25%	n/a	n/a	75%	1	0
Emergency medicine	62%	1	2	55%	1	4
Endocrinology and diabetes mellitus	35%	1	0	21%	0	0
Gastroenterology	44%	0	1	32%	1	0
General surgery	37%	0	0	23%	0	0
Genito-urinary medicine	64%	0	5	n/a	n/a	n/a
Geriatric medicine	50%	1	0	29%	0	0
Haematology	40%	1	0	6%	n/a	n/a
Histopathology	50%	0	1	25%	0	0
Infectious diseases	63%	0	0	57%	0	0
Intensive care medicine	33%	6	1	32%	1	1
Medical Virology	50%	n/a	n/a	n/a	n/a	n/a
Medical microbiology	100%	n/a	n/a	n/a	n/a	n/a
Medical microbiology and virology	33%	n/a	n/a	60%	0	1
Medical oncology	11%	n/a	n/a	n/a	n/a	n/a
Neurology	9%	n/a	n/a	10%	n/a	n/a
Neurosurgery	50%	0	1	25%	n/a	n/a
Obstetrics and gynaecology	50%	0	1	32%	0	0
Occupational medicine	100%	n/a	n/a	n/a	n/a	n/a
Ophthalmology	75%	0	3	47%	0	6
Otolaryngology	50%	0	0	50%	0	0
Paediatrics	57%	0	3	36%	0	3
Palliative medicine	67%	n/a	n/a	50%	n/a	n/a
Plastic surgery	57%	1	0	43%	1	0
Renal medicine	69%	0	3	41%	0	0
Respiratory medicine	44%	0	0	41%	0	0
Rheumatology	29%	n/a	n/a	n/a	n/a	n/a
Trauma and orthopaedic surgery	25%	0	0	n/a	n/a	n/a
Urology	44%	0	8	57%	0	10
Vascular surgery	29%	n/a	n/a	n/a	n/a	n/a

ALL PROGRAMMES	2017	2018
Total programmes	38	29
Total red flags	12	10
Total green flags	29	26
Total programmes with red flags	7	8
Percentage programmes with red flags	18%	28%
Total programmes with green flags	11	7
Percentage programmes with green flags	38%	27%

EXCLUDING PROGRAMMES WHICH DIDN'T REPORT IN 2017	2017	2018
Total programmes	38	28
Total red flags	12	10
Total green flags	29	25
Total programmes with red flags	7	8
Percentage programmes with red flags	18%	29%
Total programmes with green flags	11	6
Percentage programmes with green flags	38%	24%

Division	Specialty	Priority for review	Reasons for review	Further information	Local Faculty Group
Medicine and Integrated Care/Surgery, Cancer & Cardiovascular	Core Medical Training (CMT) HH Specialties: Renal, Haematology, ITU, Geriatrics, Cardiology, Gastroenterology, Infectious diseases, Rheumatology	medium	• Adequate experience (NTS) • Curriculum coverage (NTS) New Internal Medicine Training (IMT) programme requiring reconfiguration of CMT posts, affecting mainly HH from August 2018 will require monitoring	• No exception reports • EPA numbers not clear in all specialties • Letter to school from CMT trainees raising concerns regarding rotas and advance requests of leave • Some problems with regional training organisation	No CMT specific LFG has been held since 2016, although generally trainees feedback through specialty specific LFG.
Surgery, Cancer & Cardiovascular	Cardiology (cross site)	high	• Teamwork (NTS) • Supportive environment (NTS) • Local teaching (NTS)	• Shortages at SHO level and repeated negative feedback from junior rota about workload • Multiple SHO rota exception reports • EPAs not clear in job plans • Previous work on supportive environment, local feedback identified specific areas (ECHO, Catheter Lab)	Regular local faculty group meetings
Surgery, Cancer & Cardiovascular	Clinical Oncology	high	• Study leave (NTS) • Clinical supervision out of hours, induction, curriculum coverage, feedback, local teaching (NTS)	• 11 exception reports • EPAs identified • Workforce issues reported through specialties and supervision on non-acute ward • Faculty development session has been completed for acute service consultants • Job plan reviews for consultants has been implemented • New Trust post in place to alleviate some workload issues	Regular local faculty group meetings, combined with medical oncology

Surgery, Cancer & Cardiovascular	Clinical Radiology	high	• Clinical supervision (NTS) • Clinical supervision out of hours (NTS) • Workload (NTS) • Supportive environment(NTS) • Induction, feedback (NTS)	• No exception reports • EPAs identified • Previous workload issues reported on SMH site and action plan in place from last year to enhance consultant presence • Education review October 2017 – actions outstanding	Regular local faculty group meetings Deep dive held by specialty (3.8.18) and actions being worked up
Surgery, Cancer & Cardiovascular	Core anaesthetics CXH	medium	• Teamwork (NTS) • Study leave (NTS) • Reporting systems, induction, curriculum coverage, educational supervision, feedback, regional teaching (NTS)	• No exception reports • EPAs identified • No previous feedback	Regular local faculty group meetings
Surgery, Cancer & Cardiovascular	Core anaesthetics SMH	medium	• Workload, educational supervision, feedback and regional teaching (NTS) • Teamwork (NTS) and Handover (NTS)	• No exception reports • EPAs identified • No previous feedback	Regular local faculty group meetings
Medicine and Integrated Care	Dermatology SMH	medium	• Clinical supervision, clinical supervision out of hours, teamwork, supportive environment, educational governance (NTS)	• No exception reports • EPAs identified • Previous red flags (2016) with plans implemented for these flags.	Regular local faculty group meetings

Women & Children's and Clinical Support	GP Prog O&G (cross site)		• Workload (NTS) • Induction (NTS) • Local teaching (NTS) • Rota design (NTS) • Handover, educational governance and educational supervision (NTS)	• QCH post complaints in school survey • No exception reports • EPAs identified	Regular local faculty group meetings (Cross site GPVTS)
Medicine and Integrated Care	Endocrinology and diabetes SMH	medium	• Reporting systems (NTS) • Clinical supervision, clinical supervision out of hours and curriculum coverage (NTS)	• First time results available (no of trainees) • May be related to ongoing service reconfiguration and out of hours rota for acute medicine	Regular local faculty group meetings (Cross site)
Medicine and Integrated Care	Gastroenterology CXH	medium	• Teamwork (NTS) • Supportive environment (NTS) • Handover, curriculum coverage and local teaching (NTS)	• Exception reports none • EPAs identified • New Unit training lead in place	No recent local faculty group meetings
Medicine and Integrated Care	Gastroenterology combined with hepatology SMH	medium	• Clinical supervision, clinical supervision out of hours, feedback and regional teaching (NTS) • Supportive environment (NTS) and educational governance (NTS)	• Exception reports none • EPAs identified • As combined with Hepatology difficult to identify where the issues are	No recent local faculty group meetings

Surgery, Cancer & Cardiovascular	General Surgery SMH	medium	• Induction (NTS) • Clinical supervision out of hours, reporting systems, workload, supportive environment, adequate experience, curriculum coverage, feedback, study leave (NTS)	• First time vascular surgery removed from specialty results and general surgery independently analysed • No UTL for first 6 months of year • No exception reports • EPAs not identified	No local faculty group meetings held in 2018
Surgery, Cancer & Cardiovascular	Haematology HH	high	• Handover (NTS) • Educational governance (NTS) • Educational supervision (NTS) • Feedback (NTS) • Regional teaching (NTS) • Rota design (NTS)	• 96 exception reports • EPAs identified • Some red flags lost • New red flags in handover and educational governance • Education support meetings identified actions – not yet implemented in full for workforce • HEE quality educational discussion found positive changes in place and made no specific recommendations or actions required	Regular local faculty group meetings
Surgery, Cancer & Cardiovascular	Medical Oncology CXH	medium	• Cross site specialty red flag for adequate experience 4 years in a row and just lost overall satisfaction after 3 years in a row (NTS)	• No exception reports • EPAs identified • Education specialty review actions – in place including additional staff and combined with clinical oncology as above	Regular local faculty group meetings, combined with clinical oncology

Medicine and Integrated Care	Medicine F2 CXH Specialties: ITU, geriatrics, gastroenterology, acute internal medicine, oncology, respiratory, palliative medicine	medium	• Reporting systems (NTS) • Curriculum coverage (NTS) • Overall satisfaction, adequate experience, feedback, team work (NTS)	• 105 exception reports in a combination of SHO rotas at CX • EPAs identified • Known issues with oncology SHO supervision • Consultant presence on AAU difficult because of mat leave	Infrequent local faculty groups meetings, although generally trainees feedback through specialty specific LFG.
Medicine and Integrated Care	Medicine F2 HH Specialties: ITU, cardiology, geriatrics, gastroenterology, acute internal medicine, oncology, renal, respiratory	medium	• Adequate experience (NTS) • team work, curriculum coverage, educational supervision (NTS)	• EPAs identified • Xx exception reports	Infrequent local faculty groups meetings, although generally trainees feedback through specialty specific LFG.
Medicine and Integrated Care	Neurology SMH	low	• educational supervision, regional teaching (NTS) • Reporting systems, supportive environment (NTS)	• EPAs identified • Xx exception reports	Regular local faculty group meetings
Medicine and Integrated Care	Neurosurgery	medium	• Clinical supervision, Clinical supervision out of hours, educational supervision, feedback (NTS)	• EPAs identified • Xx exception reports • Aware of staff shortages and action plan in place to actively recruit • Some issues with cross cover and supervision noted	Regular local faculty group meetings

Surgery, Cancer & Cardiovascular	Ophthalmology	medium	• Clinical supervision, adequate experience (NTS) • Workload (NTS) • Local teaching (NTS)	• EPAs identified • Xx exception reports • Change in UTL	Infrequent local faculty groups meetings
Surgery, Cancer & Cardiovascular	Otolaryngology	medium	• Adequate experience (NTS) • Clinical supervision, teamwork, induction (NTS) • Rotas design(NTS) • Local teaching (NTS)	• EPAs identified • Xx exception reports • Change in UTL • Access to theatres lists limited by cancellation of elective surgery	No local faculty group meetings held in 2018
Surgery, Cancer & Cardiovascular	Plastic surgery	medium	• Overall satisfaction, clinical supervision, reporting systems, teamwork, handover, supportive environment, adequate experience, induction, curriculum coverage, educational governance, feedback (NTS)	• EPAs identified • Xx exception reports	No local faculty group meetings held in 2018
Medicine and Integrated Care	Respiratory HH	medium	• Regional teaching (NTS) • Clinical supervision out of hours, induction (NTS) • Workload (NTS) • Local teaching (NTS)	• EPAs identified • Xx exception reports	Infrequent local faculty groups meetings

Medicine and Integrated Care	Rheumatology HH	medium	• Overall satisfaction, supportive environment, adequate experience (NTS) • Clinical supervision, teamwork, induction, curriculum coverage, feedback, local teaching, study leave (NTS) • Workload (NTS)	• EPAs identified • Xx exception reports • Aware of issues with, developing action plan with department.	Infrequent local faculty groups meetings
Medicine and Integrated Care	Sports and exercise medicine	medium	• Curriculum coverage, educational governance (NTS)	• EPAs identified - none • Xx exception reports	Does not have a specialty specific local faculty group
Surgery, Cancer & Cardiovascular	Trauma & Orthopaedics CXH	medium	• Regional teaching (NTS) • Overall satisfaction, clinical supervision, clinical supervision out of hours, adequate experience, curriculum coverage, feedback (NTS)	• EPAs identified • Xx exception reports	No local faculty group meetings held in 2018
Surgery, Cancer & Cardiovascular	Urology	medium	• Workload (NTS) • Reporting systems (NTS) • Regional teaching (NTS)	• EPAs identified • Xx exception reports	No local faculty group meetings held in 2018

Surgery, Cancer & Cardiovascular	Vascular	high	• Workload, teamwork, supportive environment (NTS)	• EPAs identified • Xx exception reports • Fist time reporting as specialty (no longer included within general surgery)	No local faculty group meetings held in 2018

Division	Specialty	Number of reports	still open	% still open
Medicine & Integrated Care	Accident and emergency	9	0	0
	General Medicine	320	79	25
	Genito-urinary Medicine (Venereology)	3	0	0
	Medical microbiology	5	0	0
	Neurology	17	0	0
	Medicine foundation	17	10	59
	Renal medicine	22	10	45
Surgery, Cancer & Cardiovascular	Anaesthetics	9	0	0
	Cardiology	52	2	4
	General Surgery	14	6	43
	Haematology	96	1	1
	Medical Oncology	40	0	0
	Ophthalmology	1	0	0
	Radiotherapy (Clinical Encology)	11	0	0
	Traumatic and Orthopaedic Surgery	2	1	50
Women & Children's and Clinical Support	Neonatal medicine	1	0	0
	Obstetrics and gynaecology	1	0	0
	Paediatrics	3	0	0

Programme Group	Site	Red flags	Pink Flags	Red flags	Pink Flags	Trend	Green flags	Grass Flags	Grass Flags	Green flags	Trend
		2017		2018			2017		2018		
ACCS	Charing Cross Hospital - RYJ02	7	2	0	0	↓	0	0	1	0	↑
ACCS	Hammersmith Hospital - RYJ03	1	1	1	1	↔	1	0	0	2	↑
ACCS	St Mary's Hospital (HQ) - RYJ01	0	0	0	1	↑	3	0	0	1	↓
Anaesthetics	Charing Cross Hospital - RYJ02	0	0	1	0	↑	1	0	0	0	↑
Anaesthetics	Hammersmith Hospital - RYJ03	0	1	0	0	↓	0	0	0	0	↔
Anaesthetics	Queen Charlotte's Hospital - RYJ04	0	2	0	1	↓	1	0	0	4	↑
Anaesthetics	St Mary's Hospital (HQ) - RYJ01	0	0	0	0	n/a	0	0	0	1	↑
Anaesthetics F2	Hammersmith Hospital - RYJ03	0	0	n/a	n/a	n/a	7	1	n/a	n/a	n/a
CMT	Charing Cross Hospital - RYJ02	0	0	0	0	↔	0	0	2	0	↑
CMT	Hammersmith Hospital - RYJ03	1	2	2	1	↑	0	0	0	0	↔
CMT	St Mary's Hospital (HQ) - RYJ01	0	0	0	0	↔	4	0	0	1	↓
CST	Charing Cross Hospital - RYJ02	0	2	0	0	↓	1	0	0	1	↔
CST	St Mary's Hospital (HQ) - RYJ01	0	2	0	0	↓	0	0	2	1	↑
Cardiology	Hammersmith Hospital - RYJ03	2	2	1	1	↓	0	0	0	0	↔
Cardiology	St Mary's Hospital (HQ) - RYJ01	4	1	2	3	↑	1	0	0	0	↓
Clinical oncology	Charing Cross Hospital - RYJ02	2	6	1	5	↓	0	0	0	0	↔
Clinical oncology	Hammersmith Hospital - RYJ03	0	6	n/a	n/a	n/a	0	0	n/a	n/a	n/a
Clinical radiology	Charing Cross Hospital - RYJ02	4	0	0	0	↓	0	0	0	0	↔
Clinical radiology	Hammersmith Hospital - RYJ03	0	0	1	1	↑	1	0	0	0	↓
Clinical radiology	St Mary's Hospital (HQ) - RYJ01	2	1	5	4	↑	0	0	0	0	↔
Combined Infection Training	Charing Cross Hospital - RYJ02	0	1	n/a	n/a	n/a	1	2	n/a	n/a	n/a
Core Anaesthetics	Charing Cross Hospital - RYJ02	0	1	2	6	↑	1	1	0	0	↓
Core Anaesthetics	Hammersmith Hospital - RYJ03	0	4	n/a	n/a	n/a	0	0	n/a	n/a	n/a
Core Anaesthetics	St Mary's Hospital (HQ) - RYJ01	0	2	0	4	↑	0	0	1	1	↑
Dermatology	St Mary's Hospital (HQ) - RYJ01	n/a	n/a	0	5	↑	n/a	n/a	0	0	n/a
Emergency Medicine F2	Charing Cross Hospital - RYJ02	1	0	0	0	↓	2	0	0	2	↔
Emergency Medicine F2	St Mary's Hospital (HQ) - RYJ01	1	0	1	0	↔	0	0	0	2	↑
Emergency medicine	Charing Cross Hospital - RYJ02	0	2	0	0	↓	0	0	1	6	↑
Emergency medicine	St Mary's Hospital (HQ) - RYJ01	0	1	0	0	↓	0	0	0	0	↔
Endocrinology and diabetes mellitus	Charing Cross Hospital - RYJ02	0	0	0	2	↑	4	3	0	2	↓
Endocrinology and diabetes mellitus	Hammersmith Hospital - RYJ03	n/a	n/a	1	3	↑	n/a	n/a	0	0	n/a
Endocrinology and diabetes mellitus	St Mary's Hospital (HQ) - RYJ01	10	5	1	2	↓	0	0	3	1	↑
GP Prog - Medicine	Charing Cross Hospital - RYJ02	0	2	0	1	↓	0	0	0	1	↑
GP Prog - Medicine	St Mary's Hospital (HQ) - RYJ01	2	4	0	3	↓	0	1	0	1	↑
GP Prog - Obstetrics and Gynaecology	Hammersmith Hospital - RYJ03	1	3	n/a	n/a	n/a	1	1	n/a	n/a	n/a
GP Prog - Paediatrics and Child Health	St Mary's Hospital (HQ) - RYJ01	0	2	0	0	↓	9	0	3	7	↓
GP Prog - Surgery	Charing Cross Hospital - RYJ02	0	1	n/a	n/a	n/a	0	1	n/a	n/a	n/a
Gastroenterology	Charing Cross Hospital - RYJ02	0	0	2	3	↑	0	4	0	0	↑
Gastroenterology	Hammersmith Hospital - RYJ03	0	1	0	2	↑	1	4	1	0	↓
Gastroenterology	St Mary's Hospital (HQ) - RYJ01	0	0	0	4	↑	0	0	1	1	↑
General surgery	Charing Cross Hospital - RYJ02	0	1	0	1	↔	0	1	0	2	↑
General surgery	Hammersmith Hospital - RYJ03	0	2	0	3	↑	0	0	1	2	↑
General surgery	St Mary's Hospital (HQ) - RYJ01	0	3	1	8	↑	1	1	0	0	↓
Genito-urinary medicine	St Mary's Hospital (HQ) - RYJ01	0	0	0	2	↑	3	1	0	2	↓
Geriatric medicine	Charing Cross Hospital - RYJ02	0	1	0	2	↑	1	2	0	0	↓
Geriatric medicine	St Mary's Hospital (HQ) - RYJ01	0	0	0	0	↔	0	1	2	0	↓
Haematology	Hammersmith Hospital - RYJ03	6	4	5	1	↓	0	0	0	0	↔
Haematology	St Mary's Hospital (HQ) - RYJ01	0	2	n/a	n/a	n/a	1	0	n/a	n/a	n/a
Medical oncology	Charing Cross Hospital - RYJ02	0	0	0	2	↑	2	0	0	1	↓
Medicine F1	Charing Cross Hospital - RYJ02	0	0	0	0	n/a	0	0	0	0	↔

Programme Group	Site	Red flags	Pink Flags	Red flags	Pink Flags	Trend	Green flags	Grass Flags	Grass Flags	Green flags	Trend
		2017		2018			2017		2018		
Medicine F1	St Mary's Hospital (HQ) - RYJ01	0	0	0	0	n/a	1	0	0	0	↓
Medicine F2	Charing Cross Hospital - RYJ02	0	1	2	3	↑	0	0	0	0	↔
Medicine F2	Hammersmith Hospital - RYJ03	2	1	1	3	↑	0	0	0	0	↔
Medicine F2	St Mary's Hospital (HQ) - RYJ01	0	0	0	1	↑	0	0	0	1	↑
Neurology	Charing Cross Hospital - RYJ02	1	1	0	1	↓	0	0	0	1	↑
Neurology	St Mary's Hospital (HQ) - RYJ01	0	0	0	2	↑	2	3	2	0	↓
Neurosurgery	Charing Cross Hospital - RYJ02	0	4	0	4	↔	1	1	0	0	↓
Obstetrics and gynaecology	Queen Charlotte's Hospital - RYJ04	0	0	1	0	↑	3	0	0	1	↓
Obstetrics and gynaecology	St Mary's Hospital (HQ) - RYJ01	0	2	2	1	↑	0	0	0	0	↔
Ophthalmology	Charing Cross Hospital - RYJ02	0	0	0	2	↑	4	4	1	1	↓
Ophthalmology	Western Eye Hospital - RYJ07	n/a	n/a	0	0	n/a	n/a	n/a	0	3	↑
Otolaryngology	Charing Cross Hospital - RYJ02	1	0	0	2	↑	0	0	0	0	↔
Otolaryngology	St Mary's Hospital (HQ) - RYJ01	n/a	n/a	1	3	↑	n/a	n/a	1	1	↑
Paediatrics	Hammersmith Hospital - RYJ03	0	1	1	0	↑	2	1	0	1	↓
Paediatrics	St Mary's Hospital (HQ) - RYJ01	0	0	0	0	↔	2	0	0	3	↑
Paediatrics and Child Health F1	St Mary's Hospital (HQ) - RYJ01	0	0	0	2	↑	5	4	0	4	↓
Plastic surgery	Charing Cross Hospital - RYJ02	1	2	0	11	↑	0	0	0	0	↔
Renal medicine	Hammersmith Hospital - RYJ03	0	2	0	3	↑	1	1	1	0	↓
Respiratory medicine	Hammersmith Hospital - RYJ03	0	2	1	2	↑	0	2	1	1	↑
Respiratory medicine	St Mary's Hospital (HQ) - RYJ01	0	1	0	0	↓	4	2	3	2	↓
Rheumatology	Hammersmith Hospital - RYJ03	n/a	n/a	3	9	↑	n/a	n/a	0	1	↑
Sport and Exercise Medicine	Charing Cross Hospital - RYJ02	0	2	2	0	↑	4	2	1	1	↓
Surgery F1	Charing Cross Hospital - RYJ02	0	2	0	0	↓	1	1	0	3	↑
Surgery F1	St Mary's Hospital (HQ) - RYJ01	0	0	0	0	↔	0	0	0	0	↔
Surgery F2	Charing Cross Hospital - RYJ02	1	2	0	0	↓	2	0	0	4	↑
Surgery F2	Hammersmith Hospital - RYJ03	0	0	0	3	↑	2	0	0	1	↓
Surgery F2	St Mary's Hospital (HQ) - RYJ01	0	4	1	0	↑	0	0	0	0	↔
Trauma and orthopaedic surgery	Charing Cross Hospital - RYJ02	1	8	1	6	↑	0	1	0	0	↓
Trauma and orthopaedic surgery	St Mary's Hospital (HQ) - RYJ01	0	2	0	2	↔	0	0	1	0	↑
Urology	Charing Cross Hospital - RYJ02	0	0	1	0	↑	3	2	1	1	↓
Vascular surgery	St Mary's Hospital (HQ) - RYJ01	n/a	n/a	3	0	↑	n/a	n/a	0	0	n/a

ALL PROGRAMMES	2017	2018
Total programmes	75	74
Total red flags	51	47
Total green flags	84	72
Total programmes with red flags	20	28
Percentage programmes with red flags	27%	38%
Total programmes with green flags	36	38
Percentage programmes with green flags	48%	51%

PROGRAMMES REPORTING IN BOTH YEARS	2017	2018
Total programmes	68	68
Total red flags	50	39
Total green flags	74	67
Total programmes with red flags	19	24
Percentage programmes with red flags	28%	35%
Total programmes with green flags	32	35
Percentage programmes with green flags	47%	51%

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC
REPORT SUMMARY

Title of report: Results of local Staff Engagement Survey July 2018	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 27 September 2018	**Item 16, report no. 12**
Responsible Executive Director: Kevin Croft, Director of People & Organisational Development	**Author:** Sue Grange, Associate Director of HR Nathaniel Johnston, Head of Talent and Engagement

Summary:
The paper summarised the results of the "Our Voice our Trust" local engagement survey carried out in June/July 2018. The response rate was 34% (3164 responses). Key headlines include

1. Overall Staff Engagement is 78% compared to 80% in 2017
2. FFT combined score is 78% (79% in 2017)
3. FFT recommend as a place to work is 70% (72% in 2017)
4. FFT recommend to receive care or treatment is 86% (unchanged)
5. Most engaged staff groups include Pharmacists, AHP (Non registered), Training grade doctors, senior managers and non-registered Nursing.
6. The highest engagement score by site is Western Eye Hospital (81%); HH, CXH and SMH engagement scores all scored 78% or 79%.
7. The lowest 5 scoring questions remain the same as the last 2 previous years and centre around

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

8. The engagement drivers which correlate most closely with the overall engagement and therefore indicate which areas to focus action on are shown on page 16 and include "Direction and Purpose", "Contribution and Control" and "Recognition and Value"

The paper outlines the action in progress across the Trust to respond to the survey and notes the particular focus in 2018-9 to using the results at ward level to make improvements.

Recommendations:
1. Trust Board note the results of the survey and the action being taken in response to the survey
2. It is recommended that the Board makes an application for the NHSI Leadership for Improvement Leadership programme for all Board members

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

Quality impact: Staff Engagement is seen to have strong correlations with patient experience and quality; the survey provides results on a range of domains including perceptions of quality and safety

Financial impact:
Has no financial impact.

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

Workforce impact (including training and education implications): Poor staff engagement has the potential to lead to staff turnover and high vacancy rates

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

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

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

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

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

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

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

- The results of the 2018 Staff survey are now available to managers
- Managers are encouraged to feedback the results of the survey to staff locally in team briefings, meetings as appropriate
- Managers should now continue to review their own results locally at ward, department, directorate or Divisional level and consider what actions they will take to address the local issues raised in their results
- For further information contact nathaniel.johnston1@nhs.net

Imperial College Healthcare NHS Trust

2018 Our Voice Survey

Achieving CQC “Good” through our people

July 2018

OUR VOICE
OUR TRUST

The importance of staff engagement

The Trust continues to measure staff engagement in a number of different ways:-

(i) National NHS Staff Survey

This is a national survey conducted between Sept. and Dec. each year which allows internal analysis over time, as well as comparison with all Acute Trusts across the UK. Our current rating from the 2017 survey was “Above average” which is the second highest of 5 possible categories

(ii) Local Staff Survey

Unique to our Trust, this is conducted in June each year and the results are contained in this presentation

(iii) GMC Survey

This is a national survey for Doctors in Training only and allows internal and external comparison. It was reported in July 2018 and is subject to a separate action plan

Staff Engagement continues to be a key area of focus for the Trust and links to a number of our risks on the current risk register. Achieving a culture where strong staff engagement exists is a key driver for achievement of:

- CQC Good rating
- Reduced vacancy rate
- High patient experience
- Strong safety culture
- Patient outcomes

The evidence for Staff Engagement

Why would our staff's levels of engagement be important to us?

Staff engagement is defined as "*a set of positive attitudes and behaviors enabling high job performance of a kind which are in tune with the organisation's mission*," (Storey, 2008)[1].

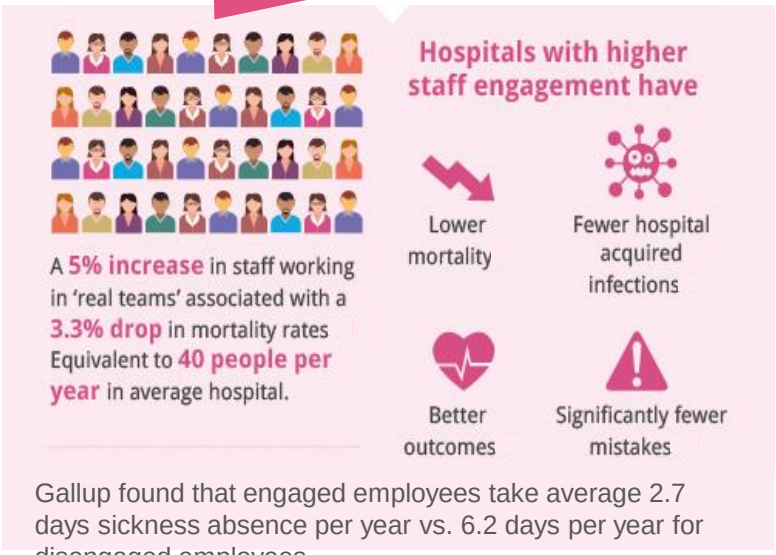
Why would we be concerned with this?

Because "…*there is a clear relationship between the wellbeing of staff and patients' wellbeing*" according to a major Kings Fund study in 2012[2].

Additional evidence shows that healthcare organizations with higher levels of staff engagement have:

- Fewer hospital acquired infections [3]
- Significantly fewer mistakes [4]
- Better outcomes [5]
- Lower mortality rates [6]
- A better patient experience [7]

"There is a clear relationship between the wellbeing of staff and patients' wellbeing." *Kings Fund 2012*



Gallup found that engaged employees take average 2.7 days sickness absence per year vs. 6.2 days per year for disengaged employees

Sources

Boorman NHS Health and Well-being: final report. London: Department of Health, 2009

Dawson JF, West MA, Admasachew L, Topakas A, NHS Staff Management and Health Service Quality; *London, Department of Health*, 2011

Boorman NHS Health and Well-being: final report. *London: Department of Health*, 2009 and *The Kings Fund* 2012

Prins JT et al, Burnout and engagement among resident doctors in the Netherlands: a national study'. *Medical Education*, 2010

West M., Creating a culture of high-quality care in health services, *Global Economics and Management Review*, 2013

Harter, JK et al (2006) Q12 Meta-analysis Gallup

2018 results summary

Background

The 2018 Our Voice Survey was completed by 3164 staff in June 2018 (34% response rate). (increase from 2807 in 2017)

Engagement Score

Our engagement score (which is made up of three questions) is **78**% ie. 78% staff report that they are positively engaged. This compares to 80% in 2017 and 77% in 2016.

FFT (friends and family test questions)

FFT combined score is 78% (79% in 2017)

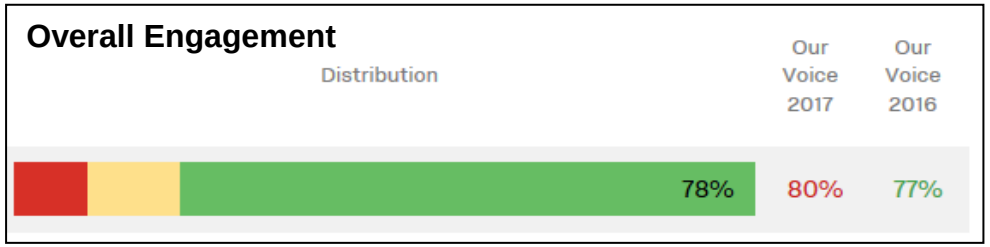
- FFT recommend as a place to work is 70% (72% in 2017)
- FFT recommend to receive care or treatment is 86% (unchanged)

Trends

- Most engaged **staff groups** include Pharmacists, AHP (Non registered), Training grade doctors, senior managers and Nursing non-registered
- The highest engagement score by **site** is Western Eye Hospital (81%); HH, CXH and SMH engagement scores all scored 78% or 79%.

Questions

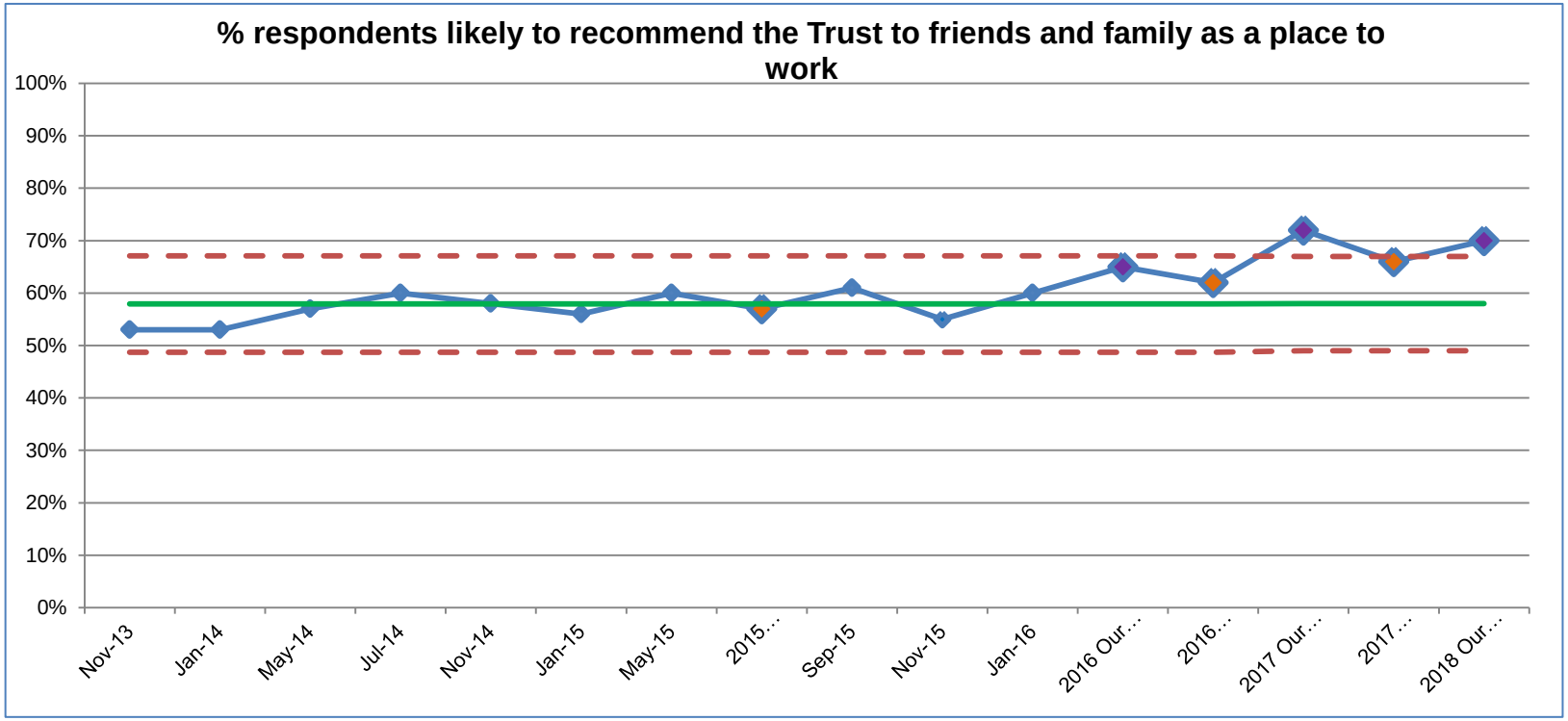
- 16 questions (24%) scored better than 2017
- 17 questions (26%) scored the same as 2017
- 32 questions (49%) scored worse than 2017



Staff Friends & Family Test –Place to work

These graphs show the trend of Staff Friends and Family Test scores in recent surveys. The FFT question is asked in both the National Survey and the local survey and both results are compared.

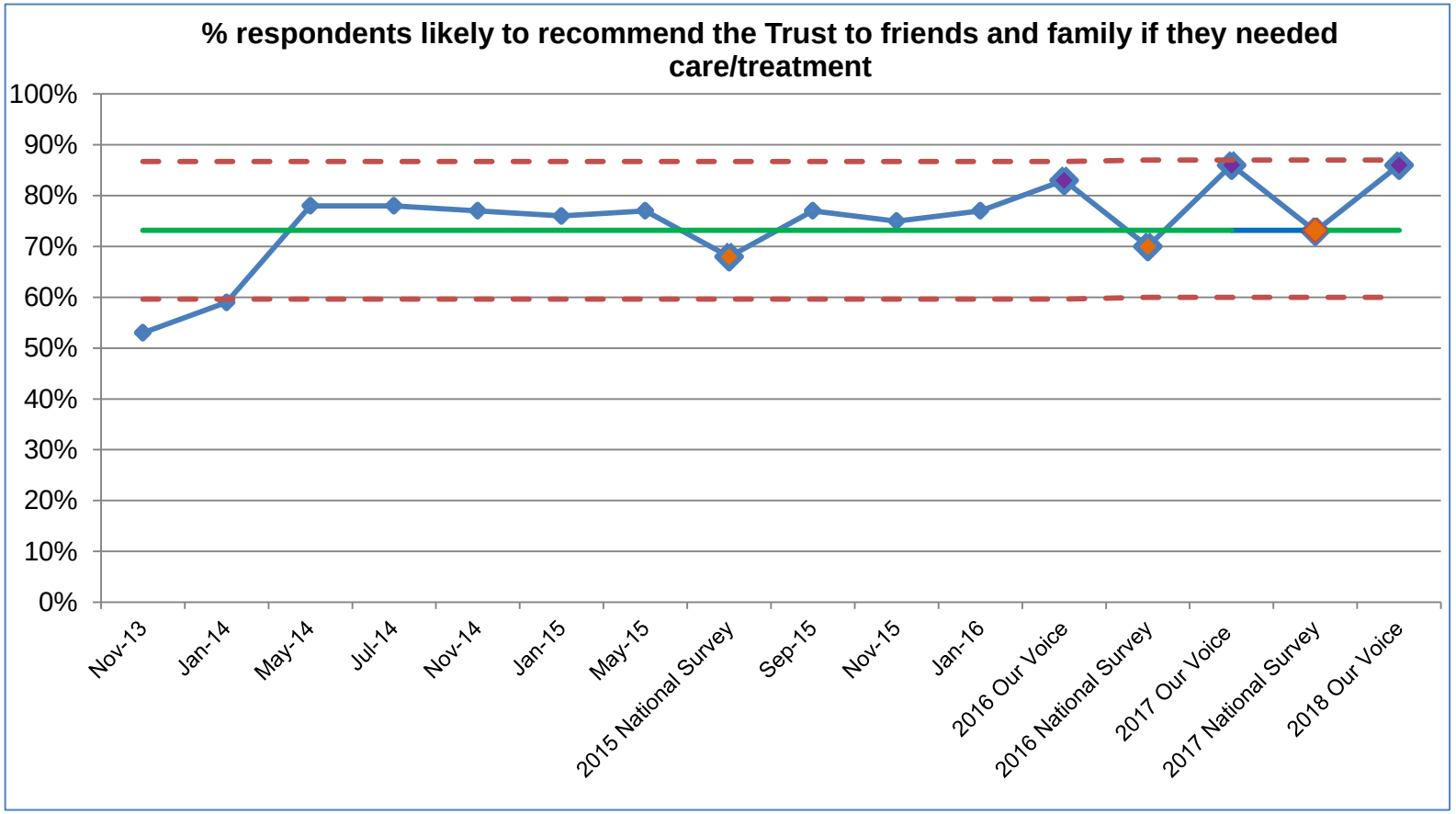
The trend that results are typically higher in the Local survey compared to the National survey continues in the latest data.



Notes:
Purple marker = Our Voice scores
Orange markers = National Staff Survey scores.
Green line = mean of first 12 survey results Red Line = indicate the highest and lowest expected scores based on the trend data

Staff Friends & Family Test – place for care or treatment

These graphs show the trend of Staff Friends and Family Test scores in recent surveys. The FFT question is asked in both the National Survey and the local survey and both results are compared. The trend line is that the results are typically higher in the Local survey compared to the National survey



Notes

Purple marker = Our Voice scores
Orange markers = National Staff Survey scores.
Green line = mean of first 12 survey results Red Line = indicate the highest and lowest expected scores based on the trend data

High 5/ Low 5

The 5 highest performing individual questions and 5 lowest performing individual questions are shown

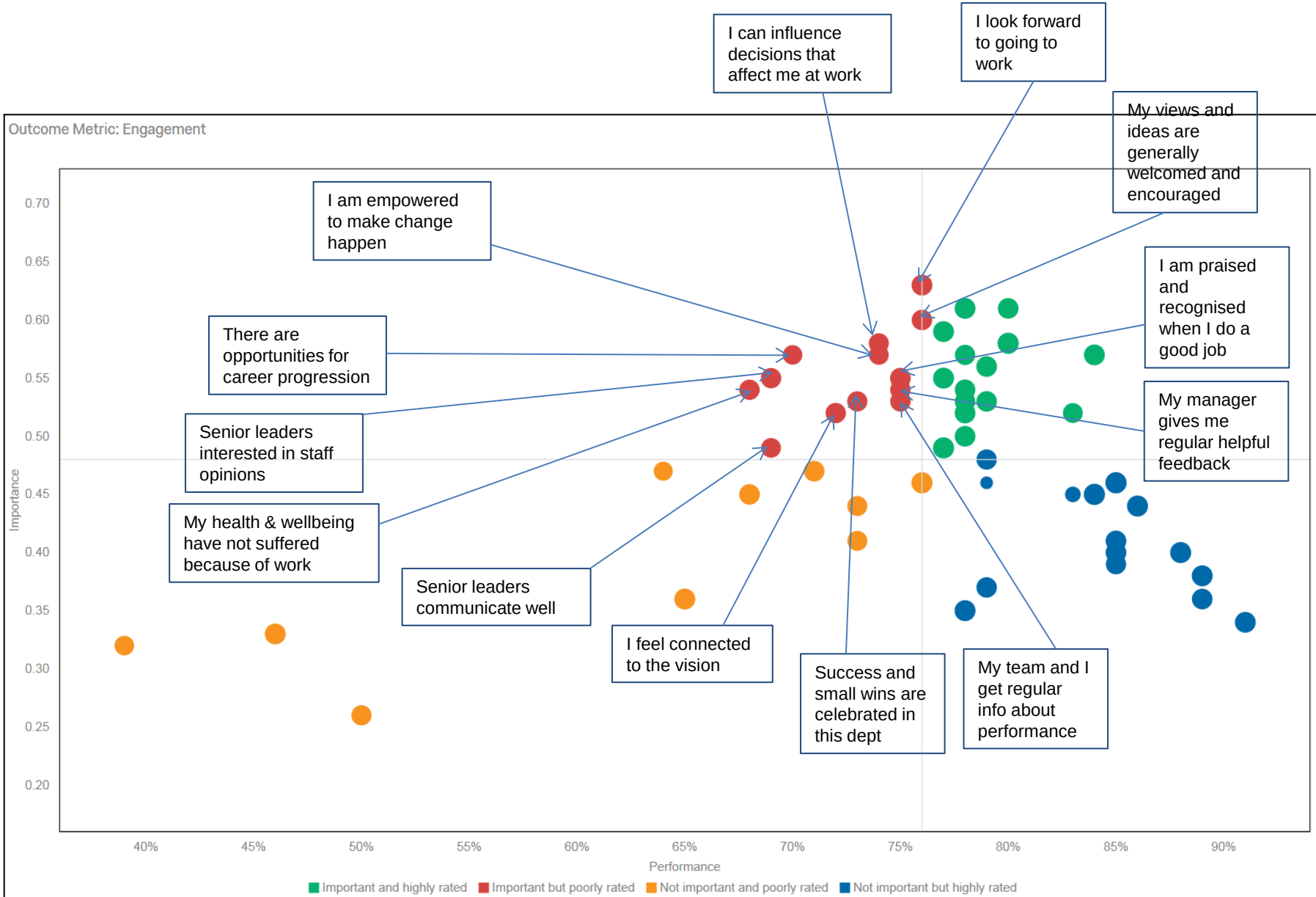
	Name	Responses	Distribution	Our Voice 2017	Our Voice 2016
1.	Q10. I understand how my work makes a difference to other people	3,129	95%	96%	96%
2.	Q8. I am clear about the values and behaviours expected of me at work	3,124	95%	94%	95%
3.	Q9. I am clear about my own objectives and responsibilities	3,133	93%	94%	94%
4.	Q14. I am trusted to prioritise my workload myself	3,139	92%	93%	92%
5.	Q50. I go the extra mile	3,095	92%	96%	95%
53.	Q18. Senior Leaders are genuinely interested in staff opinions and ideas Senior leaders in...	3,110	56%	57%	52%
54.	Q33. Senior leaders communicate well with the rest of the organisation	3,084	56%	57%	50%
55.	Q32. Senior leaders here are visible and approachable	3,118	55%	56%	49%
56.	Q46. I generally have enough time to complete all of my work	3,133	54%	54%	51%
57.	Q13. Poor behaviour and performance is addressed effectively in this organisation	3,059	48%	48%	43%

"I go the extra mile" is a new entry into the top 5 this year. The other 4 questions were in the top 5 in 2017

The low 5 scoring questions are the same 5 as in the 2017 survey

Areas of focus

The red dots represent questions that we know are important influencers on the overall engagement score. i.e. if staff respond positively to these questions, they are more likely to respond positively in the questions that measure the engagement score. As a result, these questions should be focused on to generate improvements in overall engagement.



Key Themes

Quantitative Questions

The following key themes therefore arise from an analysis of the quantitative question scores, Questions identified for action include those which are in the 5 lowest scoring and those which link most closely to overall Engagement from the analysis on slide 3

Key Engagement Driver	Lowest scoring questions AND questions which correlate most closely with overall Engagement
Direction and purpose	• Senior leaders are interested in staff opinions** • Senior leaders communicate well with the rest of the organisation** • I am connected to the vision of the organisation • Senior leaders here are visible and approachable
Contribution and Control	• My views and ideas are generally welcomed and encouraged* • I can influence decisions that affect me at work* • I am empowered to make change happen* • I generally have enough time to complete all my work
Recognition and Value	• There are opportunities for career progression* • Success and small wins are celebrated in my department* • I am praised when I do a good job* • My manager gives me regular helpful feedback* • My team and I get regular information about our performance*
Safety and Well being	• My health and wellbeing have not suffered because of work*
	• Poor performance and behaviour is effectively addressed in this organisation

4 Themes for action

(i) Senior Leadership Behaviours
- -Communication
- -Listening
- -Engaging and valuing staff

(ii) Health and wellbeing

(iii) Poor performance and behaviours

(iv) Recognition

Questions shown in **RED** are one of the 5 lowest scoring questions,
Questions in **BLACK** are identified as poor performing and important based on the analysis shown in slide 3
Questions with ** feature in both

Evidence of Impact

Focus in the last 12 months has been based on the lower performing question areas and the questions which are deemed to have highest impact on overall engagement from the 2016 and 2017 surveys

Over 2 years there is a positive trend to the questions identified

Rationale for Analysis	Question	2016	2017	2018	Trend since 2016
Lowest 5 questions	**Sen Leaders interested in staff opinion**	52	57	56	**+4**
Lowest 5 questions	**Sen Leaders communicate well with the organisation**	50	57	56	**+6**
Lowest 5 questions	**Sen Leaders are visible and approachable**	49	56	55	**+6**
Lowest 5 questions	**Poor behaviour and performance is addressed**	43	48	48	**+5**
High impact questions	**My health and well being have not suffered**	54	59	58	**+4**
High impact questions	**Success and small wins are celebrated**	56	61	66	**+10**
High impact questions	**I am praised and recognised when I do a good job**	66	70	69	**+3**
High impact questions	**I can influence decisions at work that affect me**	63	65	67	**+4**
High impact questions	**My views and ideas are generally welcomed and encourag**	68	72	71	**+3**
High impact questions	**I am empowered to make change happen**	60	65	66	**+6**
High impact questions	**There are opportunities for career progression**	57	60	59	**+2**

Stop-Start-Continue 2018

The results have been reviewed against all current work programmes and Trust wide Action plans to assessed against the following criteria

STOP: are there any current actions which are not having any impact and should stop?
CONTINUE: are there actions which are showing results and should continue?
START: are there areas in the 2018 results which require new actions?

STOP	No actions identified
CONTINUE	There are a number of action plans and work programmes which are in progress and should continue. These will be drawn together under the overarching strategies -**People Strategy** **-Clinical Strategy** **-Quality Strategy** **-Transformation Strategy** and include:- • Culture of Safety • Equality and Diversity action plan • Health and Well being action plan • Improvement Programme • Dignity and Respect action plan • Retention action plan • Leadership Development programmes • NHSI Board Leadership for Improvement programme (see slide 13) • Senior Leaders communications (CEO Briefings, Exec walkabouts,CEO emails) • Board Members Visits • Divisional walkabouts and make a Difference Visits • Divisional and Directorate action plans All action plans which fall under the People Strategy will be reported and monitored through the ExPod Committee

Stop/Start/Continue2018

START/ DO DIFFERENTLY

The change in focus for 2018 -9 is shown below

1.Delivering our promise
The Delivering our Promise 2 programme will support the underpinning values and behaviours essential for strong staff engagement

2. Ward Level Action
In 2018, 164 wards were able to access ward level results, an increase from 104 in 2017. (to review ward level results, the anonymity threshold of 5 respondents must be reached). This allows comparison with other ward indicators such as

- Ward accreditation results
- Turnover rates
- Sickness absence

3. Prioritise OD/Leadership support on High risk/High impact areas
OD/Leadership resource will be targeted to support areas of known risk including

- Core services expecting next CQC visits
- Wards below average based on engagement survey results over time and Ward accreditation status
- Wards/departments identified on previous CQC visits
- Wards/departments with above average turnover

We want to focus on local areas to have greater impact through supporting areas in difficulty and showcasing /sharing best practice

4. Implement actions arising from Verita report
Action to be confirmed by end of October

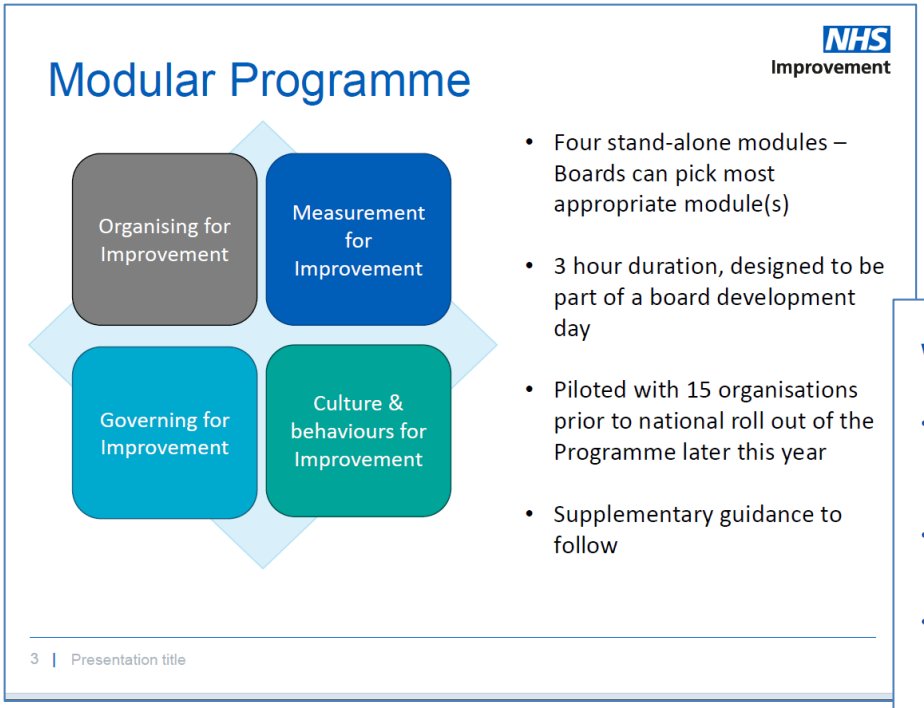
NHSI Leadership for Improvement Programme

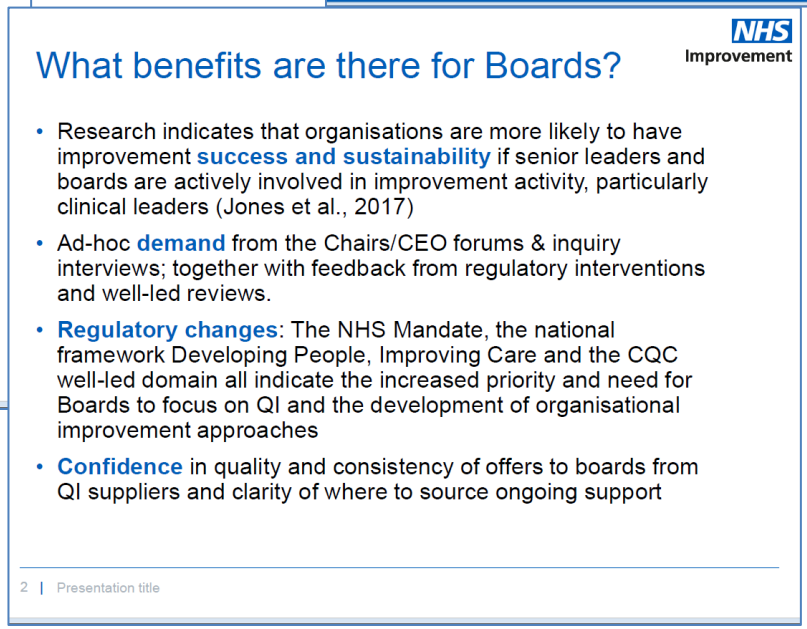
As part of “Getting to Good”, we have been engaging with NHSI about their board programme “Leadership for Improvement”. This is a modular programme for Boards rolling out from October and comprises:-

-4 half day sessions on site

-Maps to CQC well led domains

It is recommended that we make an application for this Board programme





Divisional response plans

All Divisions are currently working on Divisional or Directorate action plans. These are examples of the types of actions being developed at Directorate level

Children's Priorities	QCCH ACTION PLAN	WBU ACTION PLAN	PICU ACTION PLAN
Able to meet conflicting demands on my time at work	Ensure adequate staffing on each shift using the SOP for safe staffing. Encourage escalation of any difficulties arising from workload to the nurse in charge or matron.	Realistic , Agreed and Time based. Enough staff to support work demands.	PICU to adopt safer staffing operational policy. Ensue that all staff have the allocated mealtimes as per Trust Policy
Have adequate materials, supplies and equipment to do my work	Regularly work alongside the Eleanor representative to ensure stock par levels are appropriate. Staff to report any equipment or consumable shortages to the nurse in Charge/ matron.	Agreed upon and Specific. Ensure enough supplies according to the needs of the neonatal Unit.	Complete revamp on stock and supplies on PICU. e-Procurement link nurses allocated. Action plan for completion 31.05.19
Immediate manager asks for my opinion before making decisions that affect my work	Any changes to rota or work patterns are articulated to individuals 1:1 or at Team days. Global e-mails will be used to share changes and ask for comments.	Agreement; This encourages the feeling of being valued and is motivating.	All lines of communication are open to Senior PICU's Managers. Matron to allocate contact time on all Team Building Days.
Communication between senior management and staff is effective	Monthly Staff meetings and Band 7 meetings held. Quaterly Nursing team days run alongside for communication and educational updates.	Measureable; regular meetings and access minutes of meetings for all staff to read.	All staff will be given access to Divisional Comms and Redevelopment Plans

Team: Trauma A&C staff	**Insight** What have you learned from your results?	**Action** What action will be taken to improve/maintain your position?	**Progress** How will you monitor progress and articulate "You said, we did" stories
Direction & purpose	• There is a lack of understanding from administrative front line staff within the directorate as to how their work fits into the wider organisational aims. • Some lack of understanding from staff per expectations and definitive direction.	• Staff to be encouraged to attend Chief Executive sessions. • Initiate monthly team meeting. • Ensure PDR's are carried out annually with the relevant reviews in between	• Feedback via team meeting • Increase in completion rate of PDR's inside the PDR season.
Contribution & control	• Although initiative is encouraged, there is a lack of forum for junior staff to put forward their improvement ideas.	• Ensure staff are involved and encouraged to put forward ideas when looking at service changes • Potential for administrative champions if suitable for new projects. • Encourage discussion at staff meeting	• Feedback via team meeting
Recognition & value	• A lack of management feedback to staff in relation to day to day work. Although positive feedback is noted, it is the general regularity of feedback that is unfavorable.	• Recruitment to the vacant Administration manager 's position to facilitate day to day managerial feedback and guidance.	• Successful recruitment to the administration manager's post
Connection & support	• A lack of visibility of senior managers – this is assumed for the CHX site.	• More even distribution of the management team across the STM and CHX sites per day to increase visibility across the A&C offices	• Increased senior presence
Safety & wellbeing	• Communication between staff can be unfavorable. • The impact of work on Health and wellbeing has improved after the last 12 months .	• Suggest attendance of CONTACT team sessions • Build relationships through a regular team meeting • Recruitment and retention to continue to ensure staff health and wellbeing continues to improve	• Feedback from CONTACT sessions/team meetings.

Manager: Ann Mounsey	**Insight** What have you learned from your results?	**Action** What action will be taken to improve/maintain your position?	How will you monitor progress and articulate "You said, we did" stories
Direction & purpose	Overall, the team are clear about their own objectives and that of the organisation. Staff recognise the value of the work they undertake. Awareness of the dept objectives by staff is not captured in the survey. Similar to previous years, staff perception of the effective addressing of poor performance and behaviour is low. This will form a priority for this year.	Learning from other teams and working with our HR business partner we will develop an action plan to understand further and improve addressing poor performance and behaviour.	Improved results re: poor performance next year.
Contribution & control	Similar to last year, this area is strength for the team. The sustainment of these positive results under current working pressures is a real success for the department. Positive increase (14%) in staff reporting ability to influence decisions that affect them may reflect the engagement/co-design approach taken to the pharmacy transformation plan.	Continue to engage staff in transformation plan. Ensure changes made in dept are communicated widely through newsletter, team meetings, all site meetings.	Share the changes we have made and the impact they have had based on staff co-design and feedback. Welcome further ideas and ongoing feedback.
Recognition & value	Overall, the satisfaction of the team with their job has increased. Teamwork, people being friendly and welcoming, and staff feeling supported by others when needed reflect the way teams work in the dept. There are examples/recognition of inspiring work by individuals and teams but this not always widely shared. Overall increase in staff understanding of career progression and opportunities, but within people with 3-5years experience there is room for further improvement.	Continue to work with team and develop their roles as part of the transformation plan. New posts approved include: • B7 pharmacist rotations (active) • Band 6 senior medicines management tech • Band 8a operational technician role Focused piece of work to understand needs and opportunities to staff beyond current educational/development offerings (particularly staff 3-5 years in post). This will be linked in with our transformation programme.	Number of staff undertaking new informal and formal education/development opportunities. Communicate /celebrate internal promotions. Improvement in next years survey results.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Freedom to speak up self-assessment	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 26th September 2018	**Item 17, report no. 13**
Responsible Executive Director: Kevin Croft, Director of People & Organisational Development	**Author:** Barbara Britner, Associate Director of People & Organisational Development

Summary:
Guidance has been published jointly by the national guardian's office and NHS improvement that sets expectations of boards in relation to Freedom to Speak Up (FTSU) which is accompanied by a self-review tool. The CQC and NHSI require Trusts to provide them with copies of their self assessment and corresponding action plans.

A key stakeholder group was convened to carry out the self assessment. Once approved the final draft version will be presented to the Trust board in September 2018.

Recommendations:
The Board is asked to:

1. Approve the self-assessment as a fair and accurate representation of the Trust's current position.
2. Approve the recommendation that the self-assessment is used to inform a strategy and service delivery plan incorporating:

- An agreed vision and role for the service
- A resourcing plan and clear roles and responsibilities for Guardians and the other roles outlined in the self-assessment, including the executive leadership arrangements
- Clear governance, reporting and monitoring arrangements
- An engagement and communications plan to raise awareness of the service and how it is supporting staff and the Trust to create a more open culture

This report has been discussed at:
☒ Executive operations Committee
☒ Executive People & Organisational Development Committee

Quality impact:
The speaking up agenda is pivotal to patient safety. The Trust will be assessed under the well-led domain for this work.

Financial impact: The financial impact of this proposal will be kept under consideration and taken to the relevant committee for relevant approvals.

Risk impact and Board Assurance Framework (BAF) reference: Risks are yet to be identified but will be kept under review and placed on the risk register when identified.

Workforce impact (including training and education implications):
Better speaking up arrangements will have a positive workforce improvement.

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

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

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

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

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

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

Update for the leadership briefing and communication and consultation issues (including patient and public involvement): Detail as per executive summary with associated appendices.

1. Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts

Guidance has been published jointly by the national guardian's office and NHS improvement which is available at appendix 1. Expectations are set for NHS trust boards to create a culture responsive to feedback and focused on learning and continual improvement. This guide is accompanied by a self-review tool to facilitate regular and in-depth reviews of leadership and governance arrangements in relation to freedom to speak up (FTSU) to help boards to identify areas of development and improve.

The completed self-assessment tool with corresponding action plans will be reviewed by the care quality commission (CQC) when conducting inspections as part of the review of the well-led framework.

A key stakeholder group with members from P&OD, CEO's office, medical director's office and the corporate nursing directorate was convened to provide responses to the self-assessment for consideration by the Trust board. The initial assessment is available at appendix 2. The freedom to speak up guardians and the non-executive director for FTSU were consulted and had input into the assessment.

2. The current arrangements for speaking up:

The Trust arrangements so far has seen the introduction of five FTSU guardians across a variety of departments, with representation on each of the main sites. All FTSU guardians were appointed following a recruitment process, 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. The guardians are:

- St Mary's: Andrew Hartle, Consultant Anaesthetist
- Hammersmith: Richard Allen, Assistant Practitioner - Imperial Clinical Research Facility
- Queen Charlotte's and Chelsea: Mitra Bakhtiari, Lead Midwife, Antenatal Clinic
- Charing Cross: Claudia Primus, Radiotherapy Review Radiographer
- Western Eye: Adam Heritage, Senior Ophthalmic Photographer

The FTSU guardians can be contacted on a dedicated phone number or directly via email. Posters are now displayed on screensavers with pictures of the FTSU guardians. To date the FTSU guardians have been supported and managed by the employee relations team. A meeting takes place every other month facilitated by a HR manager. The guardians have 1 hour per week protected time to carry out their duties.

The employee relations advisory service maintain log of whistleblowing cases that have been raised within the organisation and actions taken as a result. A six monthly report outlining these cases is submitted to the audit, risk and governance committee. Around 20% of their cases relate to patient safety issues and the remaining cases tend to be related to HR matters. It has taken 3 years to embed the culture of speaking up and have advocates throughout the organisation. One of the key considerations going forward is whether current model gives Guardians enough protected time to discharge their responsibilities and whether the current concerns about HR and management requires the executive leadership to change.

There are a number of alternative arrangements at different Trusts throughout the Country. Some have dedicated FTSU Guardians while others have champions throughout their organisations. The responsible Executive Directors tend to be Nursing, Medical or HR. In responding to the self-assessment it is recommended we take lessons from others to shape any alternative approach.

3. Summary of findings from the self assessment:

Self-review indicator and current evidence of assurance	What are the principal actions required for development?
Leaders are knowledgeable about FTSU • Board received guidance and update at meeting 25 July 2018. • Assigned non-exec meets monthly with HR and gives feedback directly to CEO. • 6 monthly whistleblowing report submitted to executive committee and audit and risk governance committee. • Embedded within staff development and leadership programmes.	• CEO has set FTSU Guardians as a key priority for new HR Director due in September 2018. • Improved Trust strategy required, including a better vision and awareness campaign • Embed FTSU into NED / ED induction programme •
Leaders have a structured approach to FTSU • Quarterly reports on our safety culture programme that launched in 2016 are submitted to the Executive Quality Committee and will be raised to the Board through exception/minutes. • Annual quality account. • The Trust has a formal Speaking Up policy. • The Board recognises that having the right procedures is not enough. Lack of candour is, by definition, often not apparent, and all metrics can be misleading.	• CEO recognises the need for a thorough cultural change strategy, especially persuading middle management to be enablers for candour. • To review the policy with new HR Director in light of the NHS Improvement standards. • Quarterly returns to NHS Speak-Up Guardian to be shared with Board. • Qualitative and quantitative measures to be included in the strategy, to be developed.
Leaders actively shape the speaking up culture • NED appointed with responsibility for FTSU. • . • Regular meetings CEO and Trust Speak-Up Guardians. • Launch of anonymous incident reporting, positive incident reporting, making datix more user friendly to encourage reporting, SAQ undertaken with actions in progress in areas. • Some information in board reports. • Board seminar on Safety culture. • Patient safety and improvement are included in the Trust's Executive Committee (Quality) and the Board's Quality Committee. • Transformation programme includes improving quality of care (CQC rating) and transformation projects. • Moving Brands programme focusing on values and behaviours. • Safety streams have been developed to improve safety in the areas that cause most serious incidents. • Annual review of safety priorities as part of the quality account. • Safety improvement now a key part of the improvement team and programme with evidence of QI methodology in place for safety streams & culture work. • Safety alerts, monthly briefings in place to	• Staff survey action plan and response to local staff survey 2018. • Executive leadership responsibilities to be reviewed as some grievances involve HR • Board member visit programme being established, aligning board members with core services. • Linking SAQ and staff engagement surveys. • Senior leaders involvement in local safety activities –systematic approach to visiting each ward/department • Safety walk rounds to be linked to exec/NED engagement work. • Values and behaviours work is a good opportunity to strengthen this. • Regular meetings CEO and Trust Speak-Up Guardians. • Guardians to attend and present at the Board. • Good examples including asking for external review following concerns about an SI but work to be done to ensure consistency. • To audit / follow up on speak-up cases, to ensure that the person who raised concerns were treated fairly. Include in strategy re:monitoring arrangements. Some examples but work to be done to ensure consistency. Staff survey results show that staff don't agree

communicate important messages to staff. • DOC compliance has improved with more work to be done. • National audit processes & priority audits in place with evidence of actions for many areas however this needs to be linked more strongly with improvement. • Monthly incident report now includes the safety stream reports with evidence of measurement for improvement where available. • Integrated performance report includes information on Never Events, safety issues that have emerged with immediate actions as well as DOC compliance, audit results and actions where risk exists. • NEDs briefing used when Never Event or high risk SIs are declared. • Guardians have direct access to assigned NED and share views via WhatsApp. • CQC insight report used to highlight areas where the trust is an outlier with reporting to ExQu and then consideration for inclusion in integrated performance report.	that this is done consistently.
Leaders are clear about their role and responsibilities • Named roles for executive and non-executive directors • Regular meetings CEO and Trust Speak-Up Guardians, including Non-Executive Director.	• Codify responsibilities for both in job descriptions / strategy. • Assigned NED talk routinely with Guardians. Chair to attend meetings with guardians.
Leaders are confident that wider concerns are identified and managed • Regular meetings CEO and Trust Speak-Up Guardians, including Non-Executive Director.	• Whistleblowing reports are made available to the FTSU guardians. • Safety information is not triangulated with the guardian data that we are aware of. • Line management and divisional management links are those used by the FTSU guardians. • Links with anonymous reporting being considered with guardians. • Links to the MD office for safety related issues (when they occur) in place however this could be formalised & strengthened with regular safety related meetings with the guardians.
Leaders receive assurance in a variety of forms • Staff survey includes question re awareness of how to raise concerns – response close to national average. • CQC inspection report refers to staff awareness. • Raising Concerns (Whistleblowing) Policy accessible via Trust intranet. • There have been no cases where immediate PS concerns have been raised by the guardians. • Incident reporting process in place with weekly review with the MD if this was needed. • Awaiting new P&OD Director September	• Raising Concerns (Whistleblowing) Policy to be reviewed in light of NHSI guidance • Need to identify any barriers and address them as part of the strategy. • HR and ERAS process to be reviewed. Speaking up to be protected more even though most cases fall well short of legal whistleblowing safeguards. • Need systematic reporting process to share lessons learnt • Policy in existence but needs to be reviewed and evidence of staff input into development

2018. • Whistleblowing report submitted by HR rather than the guardians.	of policy. • Need to implement at least six monthly reporting to Board
Leaders engage with all relevant stakeholders • There are a number of staff questions in our internal Our Voice engagement survey about speaking upResults of our most recent survey [may-june 2018] show 92% of staff agreed or strongly agreed with the question; I understand the trusts processes for reporting concerns about incidents, errors or neat misses. 78% of staff say the trust encourages staff to speak up about concerns or incidents with 85% of staff saying they are encouraged by colleagues to speak up about concerns they have. 77% of staff agreed or strongly agreed that they would feel conformable and safe in raising concerns. • The Trust matches the average score of Acute trusts in the National Staff survey for Key Finding 30: the fairness and effectiveness of the procedures for reporting errors, near misses and incidents and Key Finding 31: staff confidence and security in reporting unsafe clinical practice. • Our safety culture programme is designed to support the development of a culture in which all staff can describe their contribution to safety, are aware of the potential for things to go wrong, are supported to learn from mistakes, take action to put things right and are confident in speaking up if they have concerns. • CQC and commissioners raise concerns identified through speaking up and Trust responds accordingly. • Assigned NED has met Guardians from other Trusts and is a member of the National Guardian's advisory group. • Guardians themselves have organised meetings with colleagues from other Trusts.	• Delivering our promise' phase 2 project will focus on culture, values and behaviours in the Trust. Will use this process to gather views re FTSU and reflect in the vision / strategy. • As part of strategy implementation, need to consider regular reporting to board. • Annual report to include summary of FTSU governance arrangements and anonymised data. • As part of strategy implementation, need to consider regular auditing and reporting, internally and externally. • Review the current model applied at the Trust as current model makes it difficult for all 5 guardians to participate in regional activity. • Review the model of FTSU to enable the guardians to have sufficient time for this • External input / validation of action plan following this assessment, FTSU strategy and governance arrangements.

Leaders are focused on learning and continual improvement
 	
• Schwartz rounds.
• Anonymous incident data being reviewed to identify any areas for improvement (no immediately different themes from other incidents yet).
 	
• Guardians themselves have organised meetings with colleagues from other Trusts.
• Examples of SIs.
• Mentoring of people who speak up.
• Central Quality Improvement team and method
	• To be addressed through the implementation of a speaking up strategy.
	• Review the model of FTSU to enable the guardians to have sufficient time to do this.
	• Board to consider any new guidance or case studies as part of regular reporting.
	
	• Better inclusion from guardians office of all relevant people within the Trust despite notification of guardians and NED
	•
	  • Case based learning.
	  • Recognition for those who speak up.
	  • As part of our serious incident improvement programme we have introduced a new training for those

	involved in investigating and assurance. • FTSU strategy / policy to include communication approach to share lessons and promote FTSU. • FTSU to be promoted via the 'Delivering our promise phase 2' project - September 2018.
Individual responsibilities	
Chief executive and chair • FTSU guardians have met with CEO	Speaking up strategy to outline: • How quality assurance will be measured, • the annual review of the processes for speaking up, • Operationalising learning, • Ensuring allegations of detriment are promptly and fairly investigated • Providing the board with assurance of effectiveness of trust strategy and policy.
Executive lead for FTSU • Director of People & OD engagement with Guardians and oversight of HR support and reporting to Trust Board. .	• Codify arrangements within the speaking up policy and job description of the individual • Speaking up strategy to review executive leadership arrangements and outline delivery of responsibilities for executive lead • Review the current model applied within the Trust to ensure that sufficient time is allocated to fulfil the requirements of the FTSU role
Non-executive lead for FTSU • NED lead is a strong and vocal advocate within the Trust at Board level and beyond as well as a national level. • FTSU Guardian function has sat with HR and robust challenge has thus far been to Director P&OD. FTSU was one of the first issues presented to the new CEO when appointed in July. More regular reporting of speaking up matters to be presented to the board. • Routine dialogue with Guardians all of whom have direct access 24/7. Shared social media. Recent lunch. • The NED has also taken up cases directly with staff who have spoken up and kept in regular contact. • No cases regarding concerns about board members have emerged but confident to oversee such cases.	
Human resource and organisational development directors • A note on FTSU is included at the bottom of each monthly safety briefing that is disseminated across the Trust • 'There is a safe space to speak up when things go wrong and listen and respond to all' is one of the secondary drivers in our 'safe' driver diagram	• This has presented challenges when those who speak up have complained about management and processes are overseen by the HR function which itself has been criticised. Moving the FTSU to another division (perhaps the Trust secretary) is now under consideration. • Experience has shown that we have the correct processes in place but dealing with staff who speak up cannot simply be process

	driven. It requires more sensitivity than is built into the system.
Medical director and director of nursing • Guardians have links to the division. • Number of routes available for clinicians to speak up regarding safety concerns (e.g. reporting and anonymous reporting). • FTSU guardians have a clear signposting. • Incident report and safety stream updates are presented to the Board Quality Committee. • Immediate cascade for never events and safety alerts is in place following the launch of a range of new communication tools to widen the learning for key safety improvement messages. There is also a monthly safety briefing in place which is disseminated across the Trust. • Divisional governance structures in place (TIAA audit reasonable assurance).	• Consider appropriate level of safeguarding training. • Consider creating quarterly FTSU guardian meetings / mentoring sessions. • Consider creating drop in sessions for staff to meet with FTSU guardians. • Increase the role of the FTSU guardians as advocates for proactive safety reporting. • Build on the strengths of safety stream work to increase the depth of local learning from incidents. Safety streams were established in 2016 to focus and target work to drive improvements in patient safety in nine well-recognised areas of clinical risk. • Involve FTSU guardians in feedback sessions when learnings are shared with clinicians.

In summary, the role of the FTSU guardians has some areas of strength, particularly the fact they continue to do their 'day jobs' and are fully embedded as part of the workforce. The self-assessment also shows a number of non-Guardian routes from which the Trust is taking assurance. However, the lack of time available to respond to concerns because of this is one of the key challenges and the current model applied does not enable the FTSU guardians to carry out the full range of the role. They are currently focused mainly on individual cases that are brought to them rather than developing a culture of speaking up. An additional strength of the current position is the role modelling, advocacy and support from the lead Non-Executive Director.

In terms of maximising the role of a guardian service the Trust needs to create a clearer vision and strategy that is then supported by the appropriate infrastructure and governance arrangements.

4. Recommendations:

It is recommended that the self-assessment is used to inform a strategy and service delivery plan incorporating:

- An agreed vision and role for the service
- A resourcing plan and clear roles and responsibilities for Guardians and the other roles outlined in the self-assessment, including the executive leadership arrangements
- Clear governance, reporting and monitoring arrangements
- An engagement and communications plan to raise awareness of the service and how it is supporting staff and the Trust to create a more open culture

5. Timescales

It is proposed that the above strategy and service delivery plan is brought to the December Trust Board with implementation starting in the new calendar year.

National Guardian
Freedom to Speak Up

1.

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

May 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Partially met	CEO has set FTSU Guardians as a key priority for new HR Director due in September 2018.	Board received guidance and update at meeting 25 July 2018. Assigned non-exec meets monthly with HR and gives feedback directly to CEO.
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Partially met	Improved Trust strategy required, including a better vision and awareness campaign	6 monthly whistleblowing report submitted to executive committee and audit and risk governance committee.
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Partially met	Embed FTSU into NED / ED induction programme	Embedded within staff development and leadership programmes.
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Not met	Trust strategy required, including a vision and awareness campaign, with more senior leader input.	
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Not met	CEO recognises the need for a thorough cultural change strategy, especially persuading middle management to be enablers for candour.	Quarterly reports on our safety culture programme that launched in 2016 are submitted to the Executive Quality Committee and will be raised to the Board through exception/minutes. Annual quality account.
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Partially met	To review the policy with new HR Director in light of the NHS Improvement standards.	The Trust has a formal Speaking Up policy.

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Not met	Trust strategy required, including a vision and awareness campaign, developed with input from key stakeholders.	
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Not met	Quarterly returns to NHS Speak-Up Guardian to be shared with Board. Qualitative and quantitative measures to be included in the strategy, to be developed.	The Board recognises that having the right procedures is not enough. Lack of candour is, by definition, often not apparent, and all metrics can be misleading.
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Partially met	FTSU guardians to be involved in 'great place to work' campaigns to promote speaking up culture. Executive leadership responsibilities to be reviewed as some grievances involve HR Culture is a key part of the quality strategy which will launch in 2018/19. SAQ actions to be linked to the staff survey results and campaigns structured around these.	NED appointed with responsibility for FTSU. Regular meetings CEO and Trust Speak-Up Guardians. Launch of anonymous incident reporting, positive incident reporting, making datix more user friendly to encourage reporting, SAQ undertaken with actions in progress in areas. Some information in board reports. Board seminar on Safety culture.

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Met		Patient safety and improvement are included in the Trust's Executive Committee (Quality) and the Board's Quality Committee. Transformation programme includes improving quality of care (CQC rating) and transformation projects. Moving Brands programme focusing on values and behaviours. Safety streams have been developed to improve safety in the areas that cause most serious incidents. Annual review of safety priorities as part of the quality account. Safety improvement now a key part of the improvement team and programme with evidence of QI methodology in place for safety streams & culture work. Safety alerts, monthly briefings in place to communicate important messages to staff. DOC compliance has improved with more work to be done. National audit processes & priority audits in place with evidence of actions for many areas however this needs to be linked more strongly with improvement.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
			Monthly incident report now includes the safety stream reports with evidence of measurement for improvement where available. Integrated performance report includes information on Never Event's, safety issues that have emerged with immediate actions as well as DOC compliance, audit results and actions where risk exists. NEDs briefing used when Never Events or high risk SIs are declared. Guardians have direct access to assigned NED and share views via WhatsApp. CQC insight report used to highlight areas where the trust is an outlier with reporting to ExQu and then consideration for inclusion in integrated performance report.
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Partially met	Staff survey action plan and response to local staff survey 2018. Board member visit programme being established, aligning board members with core services.	Executive Team walkabouts include discussion with staff. CEO briefing sessions The trust participates in the national NHS staff survey and in addition runs an annual trust-wide engagement survey called the Our Voice survey. In

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
		Linking SAQ and staff engagement surveys. Senior leaders involvement in local safety activities – systematic approach to visiting each ward/department Safety walk rounds to be linked to exec/NED engagement work. Values and behaviours work is a good opportunity to strengthen this.	2018, 3164 staff participated in the survey. 77% of staff said they knew who our senior leaders are within the organisation, and 54% of staff said that senior leaders are visible and approachable.
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Partially met	Regular meetings CEO and Trust Speak-Up Guardians. Guardians to attend and present at the Board.	NED appointed with responsibility for FTSU. Exec lead for FTSU – currently Director of P&OD.
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Partially met	Good examples including asking for external review following concerns about an SI but work to be done to ensure consistency.	Duty of Candour compliance reported regularly, along with other quality metrics including complaints responses. Staff survey includes question re senior staff modelling behaviour. Incident information goes to QC including actions and information on avoidable harm e.g. SJR outcomes.

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Partially met	To audit / follow up on speak-up cases, to ensure that the person who raised concerns were treated fairly. Include in strategy re monitoring arrangements. Some examples but work to be done to ensure consistency. Staff survey results show that staff don't agree that this is done consistently.	Staff survey includes question re awareness of how to raise concerns – response close to national average. CQC inspection report refers to staff awareness. In the 2017 National staff survey results 37% of staff sampled (450 people) said that they had witnessed potentially harmful errors, near misses or incidents in the last month. As a result we added a new question in the 2018 Our Voice staff survey which asked if staff understood the procedure for reporting concerns about incidents, errors or neat misses. 92% (3164 staff) agreed or strongly agreed that they did. 78% of staff said the trust encourages staff to speak up about concerns or incidents with 85% of staff saying they are encouraged by colleagues to speak up about concerns they have. 77% of staff agreed or strongly agreed that they would feel conformable and safe in raising concerns. The Trust matches the average score of Acute trusts in the National Staff survey for Key Finding 30: the fairness and effectiveness of the procedures for reporting errors, near misses and incidents and Key Finding 31: staff

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
			confidence and security in reporting unsafe clinical practice. However, the Board acknowledges it can be hard to assess how to interpret survey results of (e.g. whether high reporting of bullying shows high levels of staff expectation or unearths a more serious problem that is normally suppressed).
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named Non-Executive Director responsible for speaking up and both are clear about their role and responsibility.	Partially met	Codify responsibilities for both in job descriptions / strategy.	Named roles for executive and Non-Executive Directors
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Partially met	Assigned NED talk routinely with Guardians. Chair to attend meetings with guardians.	Regular meetings CEO and Trust Speak-Up Guardians, including Non-Executive Director.
Other senior leaders support the FTSU Guardian as required.	Partially met		
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Partially met	Whistleblowing reports are made available to the FTSU guardians.	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		Safety information is not triangulated with the guardian data that we are aware of.	
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Partially met	Line management and divisional management links are those used by the FTSU guardians. Links with anonymous reporting being considered with guardians. Links to the MD office for safety related issues (when they occur) in place however this could be formalised & strengthened with regular safety related meetings with the guardians.	Regular meetings CEO and Trust Speak-Up Guardians, including Non-Executive Director.
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partially met	Trust strategy required, including a vision and awareness campaign to raise awareness. Raising Concerns (Whistleblowing) Policy to be reviewed in light of NHSI guidance	Staff survey includes question re awareness of how to raise concerns – response close to national average. CQC inspection report refers to staff awareness. Raising Concerns (Whistleblowing) Policy accessible via Trust intranet.

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Not met	Need to identify any barriers and address them as part of the strategy.	
Speak up issues that raise immediate patient safety concerns are quickly escalated	[evidence]	Speaking up strategy to address how this would be managed.	There have been no cases where immediate PS concerns have been raised by the guardians. Incident reporting process in place with weekly review with the MD if this was needed.
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Partially met	HR and ERAS process to be reviewed. Speaking up to be protected more even though most cases fall well short of legal whistleblowing safeguards.	Awaiting new P&OD Director September 2018.
Lessons learnt are shared widely both within relevant service areas and across the trust	Partially met	Need systematic reporting process to share lessons learnt	
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Not met	Need to include audit process in the revised policy	
FTSU policies and procedures are reviewed and improved using feedback from workers	Partially met	Policy in existence but needs to be reviewed and evidence of staff input into development of policy.	
The board receives a report, at least every six months, from the FTSU Guardian.	Partially met	Need to implement at least six monthly reporting to Board	Whistleblowing report submitted by HR rather than the guardians.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Partially met	'Delivering our promise' phase 2 project will focus on culture, values and behaviours in the Trust. Will use this process to gather views re FTSU and reflect in the vision / strategy.	There are a number of staff questions in our internal Our Voice engagement survey about speaking up. The results of our most recent survey [may-june 2018] show: 92% of staff agreed or strongly agreed with the question; I understand the trusts processes for reporting concerns about incidents, errors or neat misses. 78% of staff say the trust encourages staff to speak up about concerns or incidents with 85% of staff saying they are encouraged by colleagues to speak up about concerns they have. 77% of staff agreed or strongly agreed that they would feel conformable and safe in raising concerns. The Trust matches the average score of Acute trusts in the National Staff survey for Key Finding 30: the fairness and effectiveness of the procedures for reporting errors, near misses and incidents and Key Finding 31: staff confidence and security in reporting unsafe clinical practice. Our safety culture programme is designed to support the development of a culture in which all staff can

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
			describe their contribution to safety, are aware of the potential for things to go wrong, are supported to learn from mistakes, take action to put things right and are confident in speaking up if they have concerns.
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Partially met		CQC and commissioners raise concerns identified through speaking up and Trust responds accordingly.
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Not met	As part of strategy implementation, need to consider regular reporting to board.	One update to date.
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Not met	Annual report to include summary of FTSU governance arrangements and anonymised data.	
Reviews and audits are shared externally to support improvement elsewhere.	Not met	As part of strategy implementation, need to consider regular auditing and reporting, internally and externally.	
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Partially met	Review the current model applied at the Trust as current model makes it difficult for all 5 guardians to participate in regional activity.	Assigned NED has met Guardians from other Trusts and is a member of the National Guardian's advisory group.

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Partially met	Review the model of FTSU to enable the guardians to have sufficient time for this	Guardians themselves have organised meetings with colleagues from other Trusts.
Senior leaders request external improvement support when required.	Not met	External input / validation of action plan following this assessment, FTSU strategy and governance arrangements.	
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Not met	To be addressed through the implementation of a speaking up strategy.	Schwartz rounds. Anonymous incident data being reviewed to identify any areas for improvement (no immediately different themes from other incidents yet).
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Partially met	Review the model of FTSU to enable the guardians to have sufficient time to do this.	Guardians themselves have organised meetings with colleagues from other Trusts.
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Partially met	Board to consider any new guidance or case studies as part of regular reporting. Better inclusion from guardians office of all relevant people within the Trust despite notification of guardians and NED	

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Not met	To be addressed through the implementation of a speaking up strategy.	
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Not met	FTSU strategy / policy to be developed	
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Not met	FTSU strategy / policy to be developed	
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Not met	FTSU strategy / policy to include regular audit process to include these standards. • Case based learning. • Recognition for those who speak up. • As part of our serious incident improvement programme we have introduced a new training for those involved in investigating and assurance.	• Examples of SIs. • Mentoring of people who speak up. • Central Quality Improvement team and method
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Not met	FTSU strategy / policy to include communication approach to share lessons and promote FTSU.	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		FTSU to be promoted via the 'Delivering our promise phase 2' project - September 2018.	
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Partially met	Codify this arrangement in the FTSU policy	Previously it has been the Non-Executive Director that appointed the guardians.
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Partially met	Codify this arrangement in the FTSU policy	
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Partially met	Codify this arrangement in the FTSU policy	
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Partially met	Codify this arrangement in the FTSU policy	
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Partially met	More regular meetings to be planned once the model of FTSU has been reviewed.	
Executive lead for FTSU			

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
Ensuring they are aware of latest guidance from National Guardian's Office.	Met	Codify this arrangement in the FTSU policy and job description	Director of People and OD engagement with Guardians and oversight of HR support and reporting to Trust Board.
Overseeing the creation of the FTSU vision and strategy.	Not met	Speaking up strategy to review executive leadership arrangements and outline delivery of responsibilities for executive lead.	
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Partially met	Codify this arrangement in the FTSU policy and job descriptions for Guardians	
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Partially met	Review the current model applied within the Trust to ensure that sufficient time is allocated to fulfil the requirements of the role.	
Ensuring that a sample of speaking up cases have been quality assured.	Not met	Speaking up strategy to address how this would be managed.	
Conducting an annual review of the strategy, policy and process.	Not met	Speaking up strategy to address how this would be managed.	
Operationalising the learning derived from speaking up issues.	Not met	Speaking up strategy to address how this would be managed.	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Not met	Speaking up strategy to address how this would be managed.	

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Not met	Speaking up strategy to address how this would be managed.	
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Met	Guidance needs to be sent directly to appropriate NED	NED lead is a strong and vocal advocate within the Trust at Board level and beyond as well as a national level.
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Partially met		FTSU Guardian function has sat with HR and robust challenge has thus far been to Director P&OD. FTSU was one of the first issues presented to the new CEO when appointed in July.
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Not met	More regular reporting of speaking up matters to be presented to the board.	
Role-modelling high standards of conduct around FTSU.	Met	Routine dialogue with Guardians all of whom have direct access 24/7. Shared social media. Recent lunch.	
Acting as an alternative source of advice and support for the FTSU Guardian.	Met	See above. The NED has also taken up cases directly with staff who have spoken up and kept in regular contact.	
Overseeing speaking up concerns regarding board members.	Unable to rate at present	No such cases have emerged but confident to oversee such cases.	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Partially met	This has presented challenges when those who speak up have complained about management and processes are overseen by the HR function which itself has been criticised. Moving the FTSU to another division (perhaps the Trust secretary) is now under consideration.	
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Partially met	Experience has shown that we have the correct processes in place but dealing with staff who speak up cannot simply be process driven. It requires more sensitivity than is built into the system.	A note on FTSU is included at the bottom of each monthly safety briefing that is disseminated across the Trust
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Partially met		'There is a safe space to speak up when things go wrong and listen and respond to all' is one of the secondary drivers in our 'safe' driver diagram
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Partially met	• Consider appropriate level of safeguarding training. • Consider creating quarterly FTSU guardian meetings / mentoring sessions.	Guardians have links to the division.

Self review indicator (Aligned to well-led KLOEs)	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
		• Consider creating drop in sessions for staff to meet with FTSU guardians.	
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Met	Increase the role of the FTSU guardians as advocates for proactive safety reporting.	• Number of routes available for clinicians to speak up regarding safety concerns (e.g. reporting and anonymous reporting). • FTSU guardians have a clear signposting.
Ensuring learning is operationalised within the teams and departments that they oversee.	Partially met	Build on the strengths of safety stream work to increase the depth of local learning from incidents. Safety streams were established in 2016 to focus and target work to drive improvements in patient safety in nine well-recognised areas of clinical risk. Involve FTSU guardians in feedback sessions when learnings are shared with clinicians.	Incident report and safety stream updates are presented to the Board Quality Committee. Immediate cascade for never events and safety alerts is in place following the launch of a range of new communication tools to widen the learning for key safety improvement messages. There is also a monthly safety briefing in place which is disseminated across the Trust. Divisional governance structures in place (TIAA audit reasonable assurance).

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: 2017-8 annual report for equality and diversity and the workforce race equality standard (WRES)	☐ Approval ☐ Endorsement/Decision ☒ Discussion ☐ Information
Date of Meeting: 26th September 2018	**Item 18, report no. 14**
Responsible Executive Director: Kevin Croft, Director of People & Organisational Development	**Author:** Barbara Britner, Associate Director of Employee Relations Daisy Tsai, HR Manager

Summary:
In line with the Equality Act 2010 the Trust is required to publish an annual equality report to demonstrate compliance with the public sector equality duty (PSED) to:

- eliminate unlawful discrimination
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster or encourage good relations between people who share a protected characteristic and those who do not

In addition, as an NHS provider, it is also a regulatory requirement that the Trust publishes annually a Workforce Race Equality Standard (WRES) report, which is mandated in the NHS Standard Contract.

This paper outlines the key findings of the Trust workforce equality performance in the 2017-18 equality report and WRES report (attached), and highlights the areas of focus for the coming year.

Our equality and diversity agenda is progressing steadily, with an equality and diversity steering committee established in early 2018 to provide leadership and guide the direction.

Recommendations:
The Committee is asked to note the report.

This report has been discussed at:
☒ Executive People & Organisational Development Committee
☒ Quality Board Committee

Quality impact: Realising the full potential and engagement of all staff, with or without protected characteristics, is linked to better quality of care.

Financial impact:
Has no financial impact.
Realising the full potential and engagement of all staff, with or without protected characteristics, is linked to improved efficiency and better financial management

Risk impact and Board Assurance Framework (BAF) reference:
There is a risk to the organisation if further progress is not made in the areas of promoting equality and diversity and eliminating experiences of harassment and bullying.

Workforce impact (including training and education implications):

Promoting and supporting equality and diversity in the workplace is an important aspect of good people management. However, to reap the benefits of a diverse workforce it is vital to have an inclusive environment where everyone feels able to participate and achieve their potential. An effective approach to equality and diversity goes beyond legal compliance and seeks to add value by contributing to employee well-being and engagement. (taken from the CIPD).

What impact will this have on the wider health economy, patients and the public?
Evidence shows that failing to address equality and diversity issues has a wider impact on the health economy and patients.

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

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

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

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

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

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

2017-18 Equality and Diversity Report and WRES report

The annual equality and diversity report provides an overview of the Trust workforce profile in 2017-18 and reviews the workforce equality performance by the legally defined nine protected characteristics, reporting on the categories where sufficient information and data is available, such as gender, ethnicity and age. The WRES report focuses solely on ethnicity, comparing specifically the relative experiences between White and BME (Black and Minority Ethnicity) staff based on the prescribed nine indicators.

There have been no significant changes to the Trust workforce profile. In 2017-18 the Trust workforce population comprises of 47% BME people, 43% White and 10% unknown. In terms of gender split, 71% of our staff is female and 29% is male. The majority of our staff, circa 80% is aged 25 to 54.

The Trust has made some progress in some priority areas of focus agreed last year, with continuous challenges faced by some. Below is a summary of some key achievement and positive changes in 2017-18:

- An Equality and Diversity Steering Committee has been established
- Progress on raising awareness on equality and diversity agenda, which is supported by various local initiatives, such as E&D drop-in sessions for staff, flying a Pride flag cross three sites to support participation in London Pride and women's network.
- Improvement on the disproportionate representation of BME people entering formal disciplinary procedures (focus for further improvement)
- Reduction in staff experiencing harassment, bullying or abuse from staff in the last 12 months (focus for further improvement)
- Noticeable improvement on the percentage of BME staff believing that the Trust provides equal opportunities for career progression or promotion (focus for further improvement)

Listed below are some of the key challenges identified in this year's reports:

- BME people are under-represented on Band 7 and above
- Female are under-represented at senior manager's level (Band 8A and above)
- Board composition: female and BME people under-represented
- BME people are more likely to enter formal workforce procedures
- Shortlisted white applicants are more likely to be appointed than their counterpart BME applicants
- BME people are more likely to be awarded D or E ratings at Performance Development Review (PDR)
- Staff experiencing harassment, bullying or abuse from the public or staff in last 12 months (NHS staff survey)

It is recognised that progressive improvement requires lasting concerted efforts and satisfactory equality outcome takes time to achieve. Therefore for the coming year we will continue focusing on the following priority areas from last year that remain as some of the key challenges in this year's reports:

- Improve workforce representation of BME people on Band 7 and above
- Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR)
- Mitigate disproportionate representation of BME people entering formal workforce procedures
- Address the concerns about harassment and bullying reflected in the 2017-18 NHS staff survey

Please see appendix 1 for detailed actions under each area of focus.

Areas of focus 1 ***Improve workforce representation of BME people on Band 7 and above***	
Resourcing	Carry out an analysis of the shortlisting to review all bands and all staff groups to better understand any hotspots
	Produce guidance on the panel mix to encourage a panel with diverse backgrounds
	Review where all adverts are placed and broaden advertising to better target BME candidates
	Promote best practice assessment and selection guides to ensure all managers are using the materials
	Re-launch the Careers Clinics and promote the support that is given to help people secure a new role
	Review the Recruitment and Selection policy to ensure the end to end process fully supports diversity and inclusion.
	Review Recruitment and Selection training to ensure that everyone is familiar with the new best practice guides and the principles of fair, objective and open recruitment and selection is fully embedded.
	Review the internal promotion process and outcomes to encourage all managers to promote opportunities within the Trust in an open and fair way which facilitates as diverse as possible coming forward.
Talent **Talent & HRBPs**	Proactively support and secure nominations for national BME programmes run by NHS Leadership Academy ("Stepping Up" and "ready now")
	Ensure that all participants on Trust leadership programmes who are from under-represented groups have access to a Mentor/Coach as part of the programme
	Develop Business Case for an online appraisal system to that in future, we can access records of objective setting and personal development plans for al staff, including those from under represented group in order to formulate future action
	Ensure that all leaders from underrepresented groups who are in scope for the Trust Talent management process have a PDP
	Develop and source funding for a pilot BME mentoring programme targeting those at band 7 and above who aspire to work in a more senior position.

Areas of focus 2 ***Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR)***	
Talent	Implement mid-year reviews to enable earlier notification of concerns and provide people with the opportunity to make the necessary improvements
	Provide monthly reports to divisional senior management team of grades awarded throughout PDR period. This will allow calibration of grades during the PDR window

Areas of focus 3 ***Mitigate disproportionate representation of BME people entering formal workforce procedures***	
Employee Relations Advisory Service (ERAS)	Introduce two check points to be carried out by senior managers in formal disciplinary process to respectively consider whether investigation is required and to decide whether a formal disciplinary hearing is warranted.
	Introduce additional training to Chairs and Investigators of potential disciplinary hearing
	Continue to review the reasons that people are facing formal procedures to establish whether further training and support can be offered to prevent staff from entering into formal procedures

Areas of focus 4 - Address the concerns about harassment and bullying reflected in the 2017-18 NHS staff survey	
Engagement	Re-energise Trust values and behaviours through 'delivering our promise 2' programme
Wellbeing	Develop a 'speaking up' strategy and action plan
	Continue to focus on 'prevention' through targeted actions based on analysis of incidents

Areas of focus 5 – Equality and diversity team objectives for 2018-9
Support the creation of an action plan to address the issues arising from the Gender Pay analysis report
Produce a Workforce Disability Equality Scheme
Produce a set of measures, annual targets and a reporting mechanism to track short and medium-term progress against or longer-term equality objectives

Imperial College Healthcare NHS
NHS Trust

Annual Workforce Equality and Diversity Report 2017/2018

(Incorporating Workforce Race Equality Standard)

Sebastiano Rossitto and Daisy Tsai

Directorate of People and Organisational Development

September 2018

Introduction

In line with the Equality Act 2010 the Trust is required to publish equality information annually to show how it has complied with the public sector equality duty. This annual report focuses on workforce and will provide the Trust with valuable insights into our workforce equality performance and identifies priority areas for improvement. In addition, this report has incorporated information required by the Workforce Race Equality Standard (WRES) which is mandated in the NHS standard contract.

The report is separated into four main parts:

- **Part 1** provides a summary of the workforce equality performance in 2017-18 with priority focus for the coming year.
- **Part 2** provides Imperial College Healthcare NHS Trust workforce profile in 2017-18 by different protected characteristics.
- **Part 3** reviews in details the Trust workforce equality performance in 2017-18 in various areas
- **Part 4** focuses on actions that have been taken and planned for the coming year

Table of Content

Executive summary

Imperial College Healthcare NHS Trust is committed to diverse and inclusive culture where people are valued and treated fairly and respectfully. The Trust has established an equality and diversity steering committee in early 2018 in order to progress further on the equality and diversity agenda. The Committee meets quarterly and has representatives from staff side, clinical divisions and corporate areas. Although at its fledgling stage, the Trust has made progress on raising awareness on equality and diversity agenda and various local initiatives have been taken forward, such as flying a Pride flag to support participation in London Pride and equality and diversity drop-in sessions for staff. We will continue working to create a culture of inclusion while at the same time take actions on priority areas for improvement based on the findings in this report.

This report reviews different aspects of the Trust workforce equality performance in 2017-18. Analysis and details of the performance is provided in the relevant sections of the report. While positive changes have been observed in some areas of focus from last year, the Trust recognises that continuous improvement requires lasting concerted efforts and satisfactory outcome takes time to achieve. For the coming year we will therefore continue focusing on the following priority areas that remain as some of the key challenges identified in the report:

- Improve workforce representation of BME people on Band 7 and above
- Improve the relative likelihood of BME people receiving D or E ratings (PDR)
- Mitigate disproportionate representation of BME people entering formal workforce procedures
- Address the concerns about harassment and bullying reflected in the 2017-18 NHS staff survey

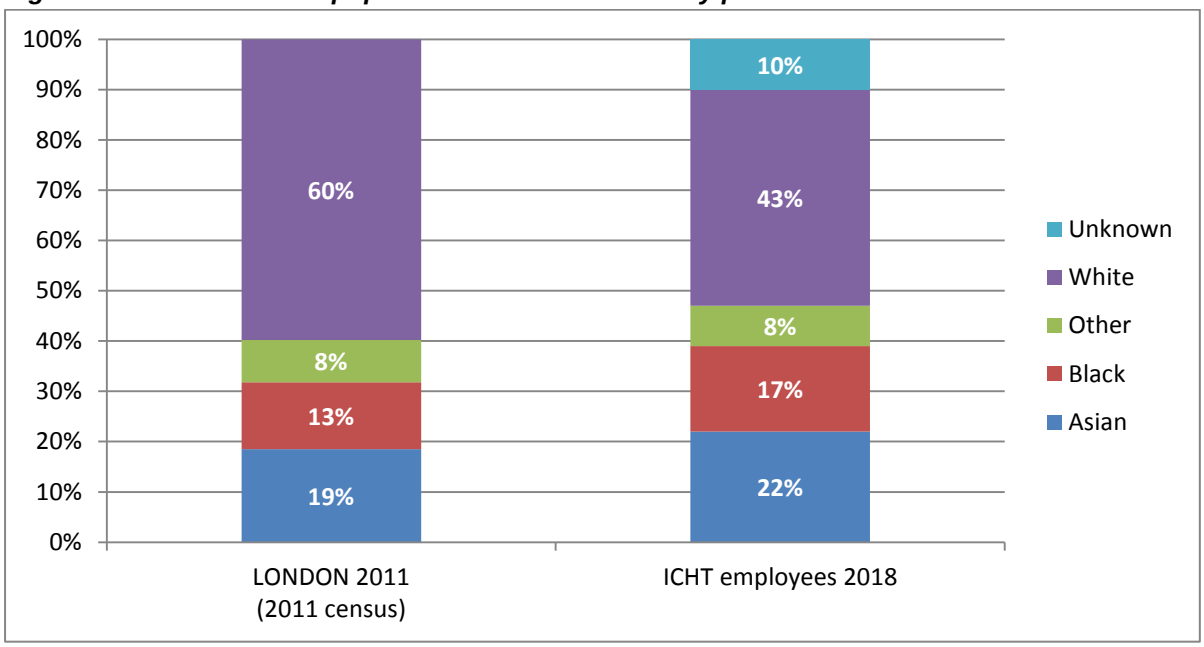
1. Trust Workforce Profile

1.1 Ethnicity

The percentage of staff employed by the Trust from Black and Minority Ethnic (BME) backgrounds accounts for 47%, White 43% and 10% were of unknown ethnicity. When excluding the unknown category and looking at only those who disclosed their ethnicity, 53% of those who disclosed their ethnicity were from BME backgrounds and 47% from White.

Comparing to London population using 2011 Census, 40% of the London population is of BME backgrounds and 60% is white.

Fig. 1 London local population and Trust ethnicity profile



When the workforce ethnicity data is split by clinical and non-clinical staff, it is largely comparable within bands. The majority of people in junior roles band 1 to band 6 are from BME backgrounds. This changes with seniority as the majority of people in bands 7 and above, both clinical and non-clinical are from white backgrounds. Similarly, there are more doctors, including consultants from white backgrounds than BME backgrounds. The disproportionate distribution can be seen from the representative lines in Fig 2 and Fig 3. Detailed breakdown with exact figures can be found in Appendix 1.

Fig.2 Percentage of staff by ethnicity in each AfC bands and Very Senior Managers (VSM)

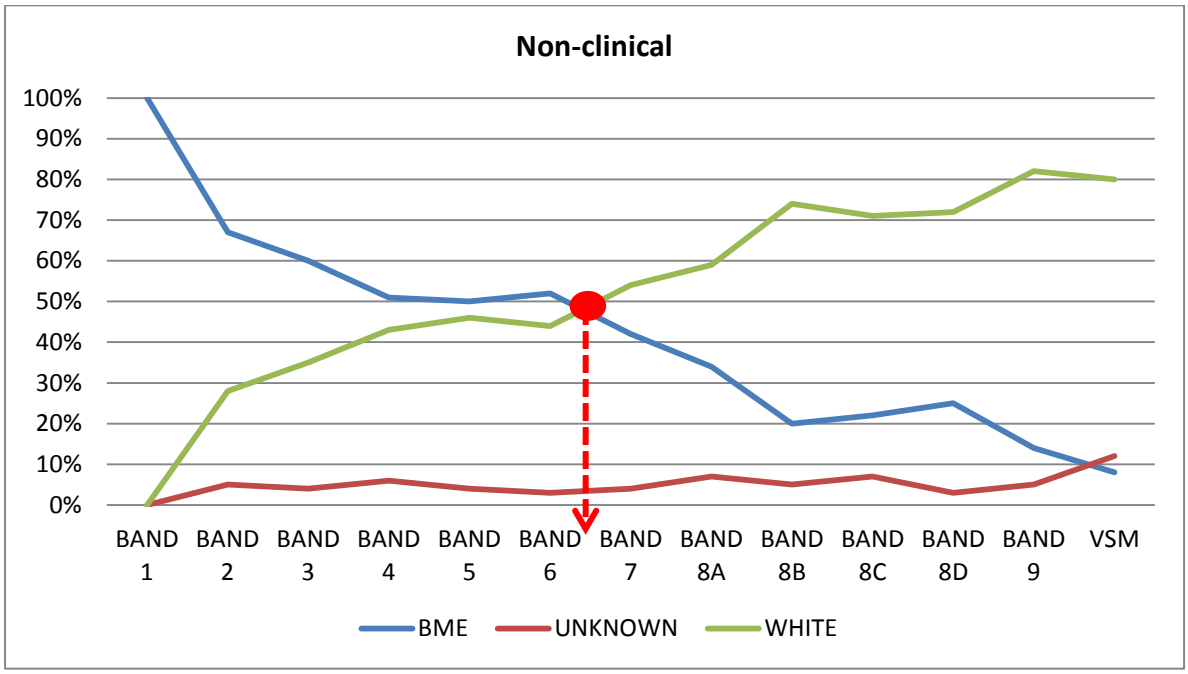
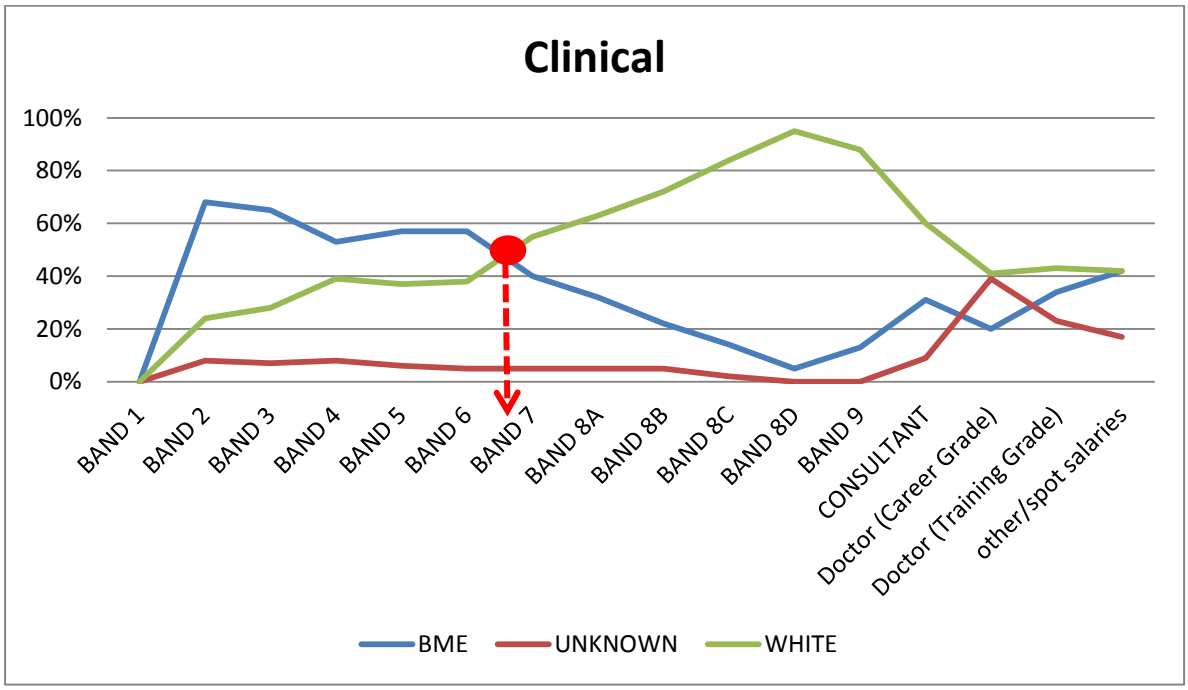


Fig.3 Percentage of staff by ethnicity in each AfC bands, medical grades and VSMs



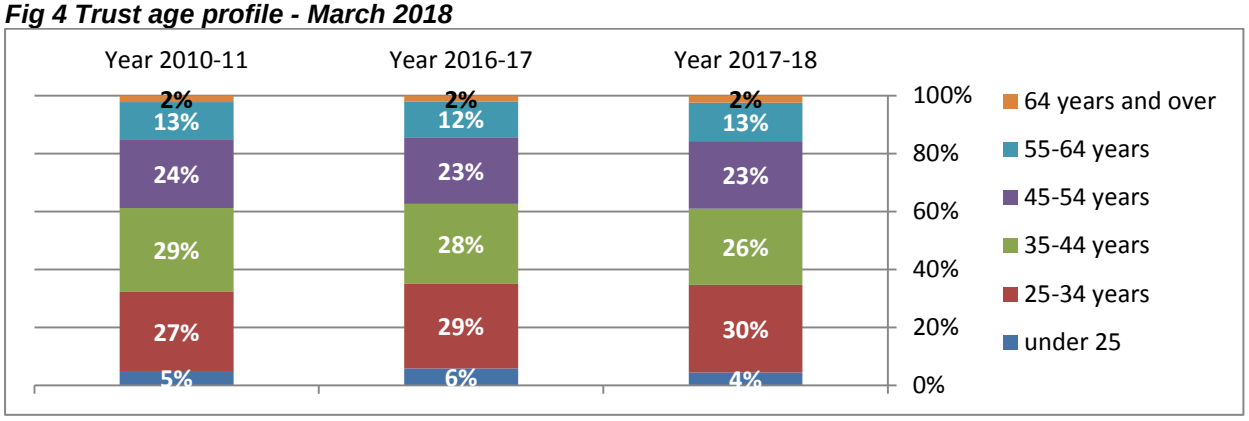
1.2 Age

There have been no significant changes in the workforce composition in regards to age since 2010/11. The majority of our staff, circa 80% are aged 25 to 54.

The most noticeable variation is the composition within the wider age group 25 to 44. When comparing year 2017-18 to year 2010-11, the overall percentage of this wider group remains the same 56%, with an increase of 3 % to age group 25-34 and a decrease of 3 % to age group 35-44.

The Trust seeks to increase its attractiveness to people of all age groups through a range of measures including the widespread provision of work experience opportunities and apprenticeships and the promotion of flexible working.

Fig 4 Trust age profile - March 2018

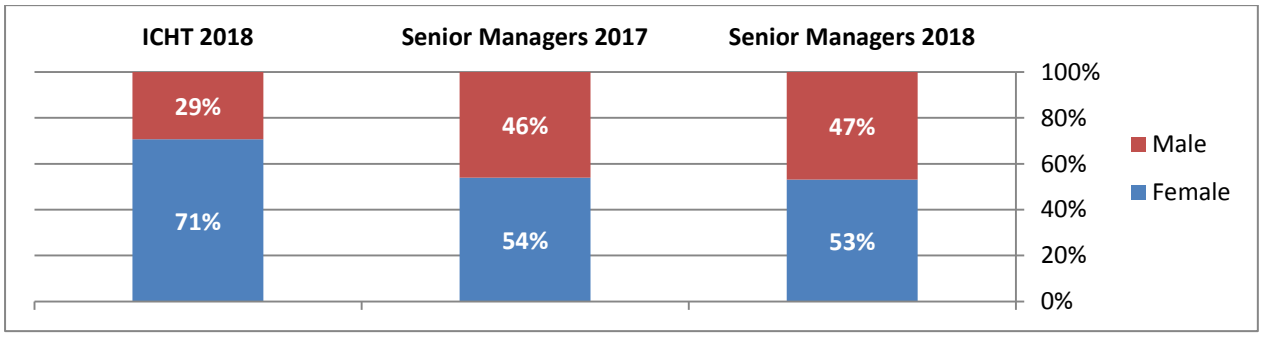


1.3 Gender

The workforce split in regards to gender has remained unchanged since 2010-11: 71% of our staff are female and 29% are male. The high proportion of female workers is typical of NHS organisations, reflecting the gender split of people entering healthcare professions. Figures published by NHS Employers in 2017 show that 77% of NHS workforce are women and 23% are men[1].

The proportion of male employees continues to increase in more senior roles. The figure below shows that 47% of people employed as senior managers are men and 53% are women. This is a slight increase from 46% in year 2017/18 and a continuous trend from 2014/15 when 34% of senior managers were men and 66% were women.

Fig 5 Gender profile – senior managers and ICHT population - March 2018



Note: Senior managers refer to band 8-9 AND includes senior medical staff and VSMs

[1] https://www.nhsemployers.org/-/media/Employers/Images/2018-D-and-I-infographics/Gender-in-the-NHS-2018.pdf

1.4 Trust Board of Directors Composition[2]: gender and ethnicity

The Board of Directors comprises 12 people, including 5 executive directors and 7 non-executive directors. All 12 Board directors are voting members.

Overall, white people account for 83% of Board Directors compared to 43% of the workforce as a whole. 75% are men and 25% are women compared to the overall Trust composition of 29% male and 71% female.

Separating the Board executive and non-executive directors shows that white people account for 100% of executive directors and 71% of non-executive directors. With regard to gender split, 20% of Board executive directors and 29% of Board non-executive directors are female.

This continues to be an important area of review for the Trust. We have included the equality and diversity policies as part of the criteria when selecting the talent sourcing providers for board executive recruitment and will continue to do so to ensure that they are fair, equitable and transparent.

Fig 6 Trust Board composition by gender and ethnicity 2018

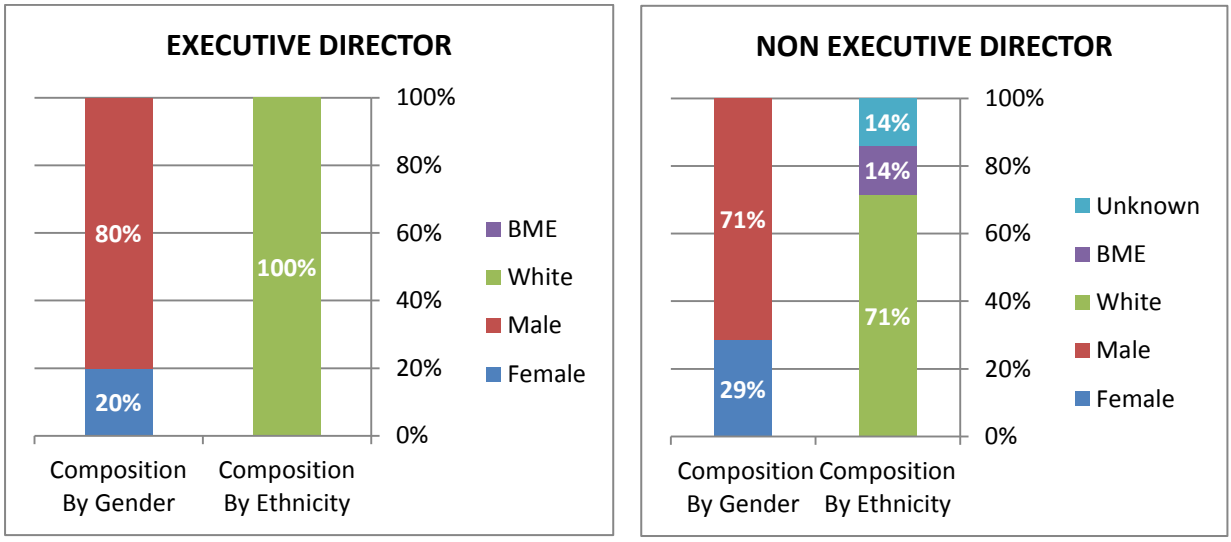
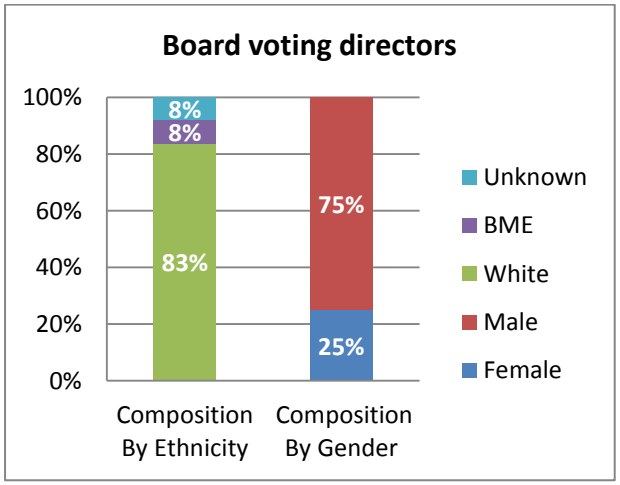


Fig 7 Trust voting Board directors by gender and ethnicity 2018



[2] Data is based on 31st March 2018

1.5 Data quality for disability, sexual orientation and religion – 2017/18

The Trust does not have sufficient workforce information on disability, sexual orientation and religion to run meaningful workforce reports on these protected characteristics. However, the workforce information has improved year on year. The records have increased from 40-46% in 2013/14 to roughly 70% in 2017/18. See Table 2 below.

The data quality for new starters 2017/18 stands at 88% for all three protected characteristics. This remains the same compared to 2016/17.

Table 2 Disability, sexual orientation and religion records for all staff including new staff

Protected Characteristic	Recorded demographic for all staff in 2013/14	Recorded demographic for all staff in 2014/15	Recorded demographic for all staff in 2015/16	Recorded demographic for all staff in 2016/17	Recorded demographic for all staff in 2017/18
Disability	40%	47%	56%	62%	66%
Sexual Orientation	46%	54%	60%	67%	70%
Religion	46%	54%	60%	67%	70%

Table 2.1 Disability, sexual orientation and religion records for new staff

Protected Characteristic	Recorded demographic for NEW staff in 2013/14	Recorded demographic for NEW staff in 2014/15	Recorded demographic for NEW staff in 2015/16	Recorded demographic for NEW staff in 2016/17	Recorded demographic for NEW staff in 2017/18
Disability	95%	89%	92%	87%	88%
Sexual Orientation	96%	88%	90%	88%	88%
Religion	96%	88%	90%	88%	88%

2. Recruitment and Selection

The Trust monitors the progress of applicants through the selection process by some of the protected characteristics. A summary of the monitoring information is shown in tables 3-10 (see Appendix 2 for tables 5-10).

2.1 Recruitment by ethnicity

68% of applicants throughout 2017/18 were from BME groups while 46% of those appointed were from BME groups. In comparison, 29% of applicants described their ethnic origin as white and 43% of those appointed were from white background. For more details of analysis at recruitment stages (application, shortlisting and appointing), please see Appendix 2.

2.2 Relative likelihood of being appointed from shortlisting

Table 3 Likelihood of being appointed from shortlisting by ethnicity – 2017/18

Descriptor	White	BME	Unknown
Number of shortlisted applicants	4634	7805	589
Number appointed	946	1014	231
Relative likelihood	0.2041	0.1299	0.3921

The likelihood of white applicants being appointed from shortlisting is 0.2041 and 0.1299 for applicants from BME groups. The relative likelihood of white applicants being appointed from shortlisting compared to applicants from BME groups is roughly 1.57 times greater; this is an increase from last year when the relative likelihood was 1.30 times greater.

Recruitment analysis by gender shows that conversion rate for female applicants' remains slightly higher than for male applicants. The percentage split of male and female applicants is almost identical to the previous year but there is a slight decrease in the percentage of male appointees.

Table 4 Recruitment analysis by gender 2017-18 and 2016-17

	2016-17			2017-18		
Gender	Applicants	Shortlisted	Appointed	Applicants	Shortlisted	Appointed
Male	32.38%	28.57%	26.43%	32.00%	27.69%	25.42%
Female	67.02%	70.80%	73.36%	67.57%	72.00%	74.35%
Not stated	0.60%	0.63%	0.21%	0.43%	0.31%	0.23%

Analysis of conversion rates by transgender, age, sexual orientation, religion and disability remain broadly in line with the ratio of applicants and those shortlisted. Please see Appendix 2 for more details.

Diversity training is mandatory for everyone working at the Trust. In addition recruitment training is provided for managers.

3. Training and Development

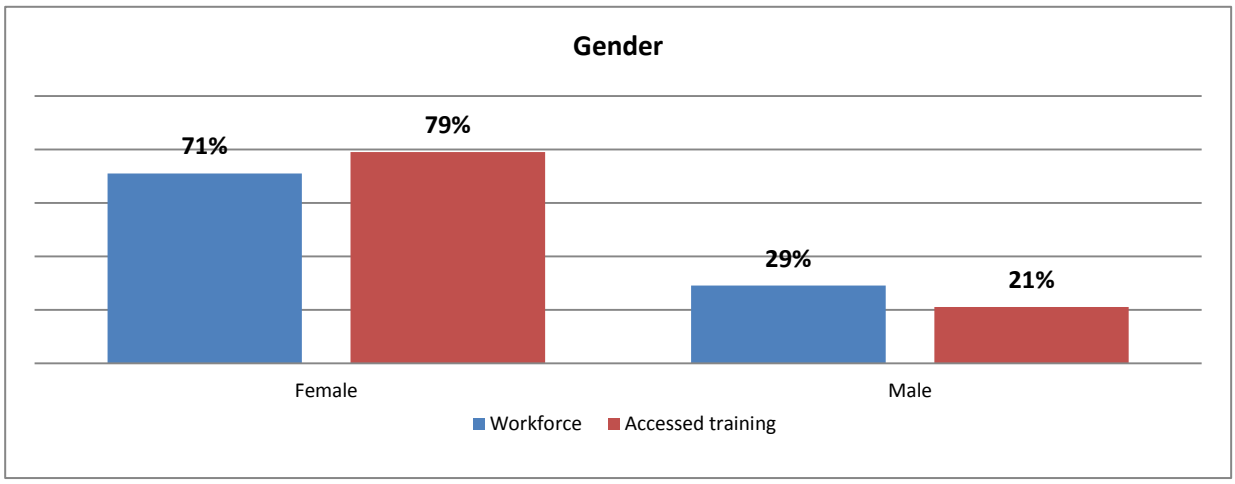
An analysis of people accessing non-mandatory training that is centrally recorded in HR has been undertaken. This includes leadership development and skills training, a total of 20 different courses running throughout the year provided by Learning and Development team. This is the only data which is centrally available for equality analysis. It does not include Core Skills training (i.e. statutory and mandatory training) as this is non-discretionary and required by all staff regardless of age, gender or ethnicity. It also does not include locally delivered training, professional and clinical education, or any externally provided training. The results are not therefore an indication of all training activity available within the Trust.

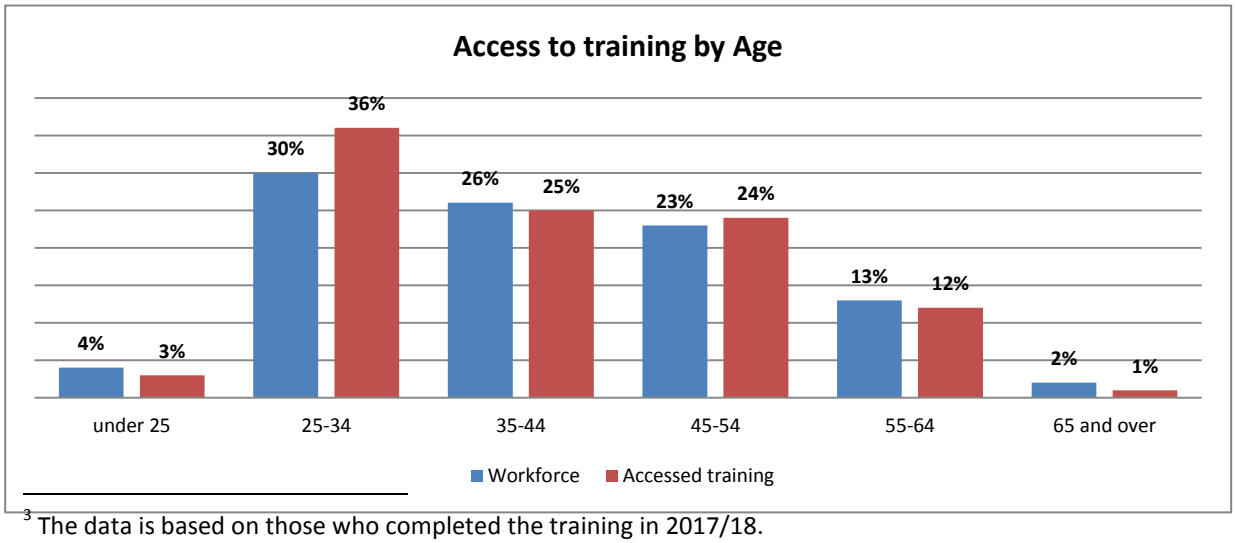
Access to courses which have been analysed shows that access is broadly in line with the workforce composition. The main outliers are:-

When the data is cut by gender, women are slightly more likely to access training than men within the organisation. This finding has remained the same for the past few years.

Access to training for people from different age groups shows that age group 25-34 are more likely to attend courses. This remains the same as last year.

Table 11 Access to training by gender, ethnicity and age 2018[3]





[3] The data is based on those who completed the training in 2017/18.

3.1 Relative likelihood of accessing non-mandatory training

The likelihood of BME people accessing non mandatory training was 0.1156 and for white people it was 0.1027. The relative likelihood of BME people accessing non mandatory training was 1.1256 times greater than white staff. This remains closely similar to that of last year (1.1364). However, the drop in the likelihood of people accessing non mandatory training in general was noticeable in both groups. For BME people, it decreased from 0.1541 last year to 0.1156 this year and white people it was 0.1356 to 0.1027 this year.

Table 12 Access to non-mandatory training by ethnicity

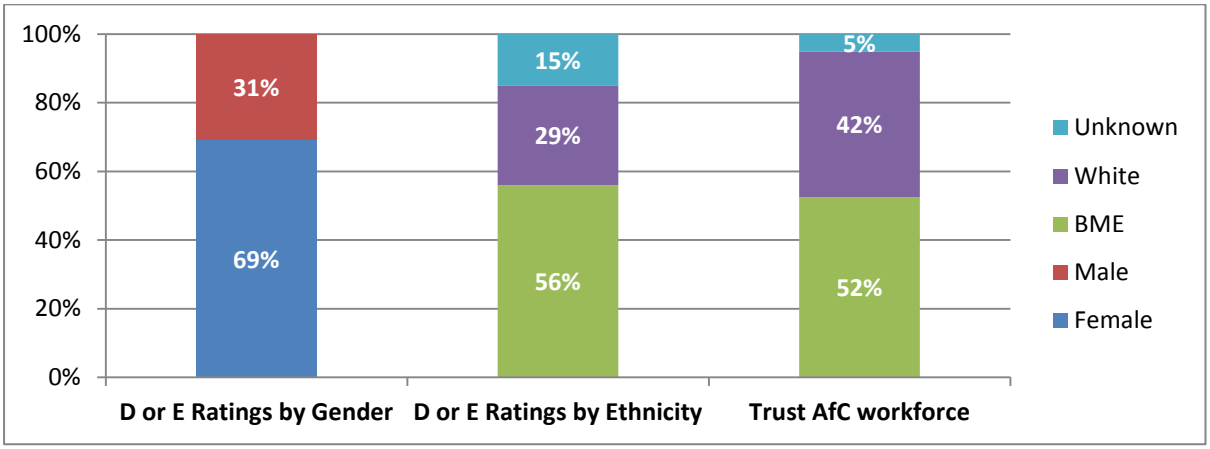
Descriptor	Number of Staff in Workforce	Staff accessing non mandatory training	Likelihood of accessing non mandatory training
White	4889	502	0.1027
BME	5457	631	0.1156
Unknown	943	1	0.0011

4. Performance Development Review (PDR) – D or E rating

PDR ratings have pay implications for people on Agenda for Change contracts because incremental pay increases are awarded to people who are given A, B or C ratings. 62 people (less than 1% of the Trust population) were awarded D or E rating in their PDR in 2017/18, compared to 50 people in 2016/17. D or E ratings indicate that performance is unsatisfactory and trigger formal performance management processes in line with the Trust poor performance management policy.

Fig.7 shows the data on people who were awarded a D or E rating on PDR by gender and ethnicity. When cut by gender, the likelihood of employees being awarded D or E rating is broadly in line with the overall workforce composition, with a slightly raised likelihood for male employees. When cut by ethnicity, people from BME backgrounds were more likely to be awarded a D or E rating. 56% of D and E ratings were awarded to BME staff, compared to 29% to White staff. Adopting the methodology applied in Workforce Race Equality Standard (WRES), the relative likelihood of BME people receiving D or E ratings is 1.55 times higher than people of white backgrounds.

Fig 7 People awarded D or E rating on PDR by gender and ethnicity 2017-18[4]



Descriptor	Number of AfC staff in workforce	Staff received D or E ratings	Likelihood of receiving D or E rating
White	3836	18	0.0047
BME	4785	35	0.0073
Unknown	495	9	0.0182
Relative likelihood of BME people receiving D or E ratings was 1.55 times greater than white staff			

When the data on those who received D and E ratings is cut by grade and professional group, there is a disproportionately high number of band 2 to band 4 admin and clerical and unqualified nursing staff (Fig.8 and Fig.9). This remains unchanged from last year.

[4] PDR does not apply to medical staff who have separate performance reviews. For the comparison purposes, medical staff is excluded from the overall workforce, hence referring to Trust AfC workforce specifically.

Grade and professional group may be contributory factors for the high proportion of BME staff amongst those who received low performance ratings but when these factors are taken into account, ethnicity may be a factor as shown in Table 10.

As Fig.10 shows, when comparing to the workforce composition, there is a higher proportion of people receiving D or E ratings from age groups 55 and above. Age group 55 and above constitutes 15% of the Trust workforce and accounts for 35% of the people receiving D or E ratings.

The Trust has entered into the 5th year of conducting PDRs in line with this process. This will be an important area of review in the coming year, in particular when the new NHS pay progression rule is implemented from April 2019. These findings will be of important reference to ensure that the progression rule is objective and fairly applied.

Fig 8 People awarded D or E rating on PDR by band 2017-18

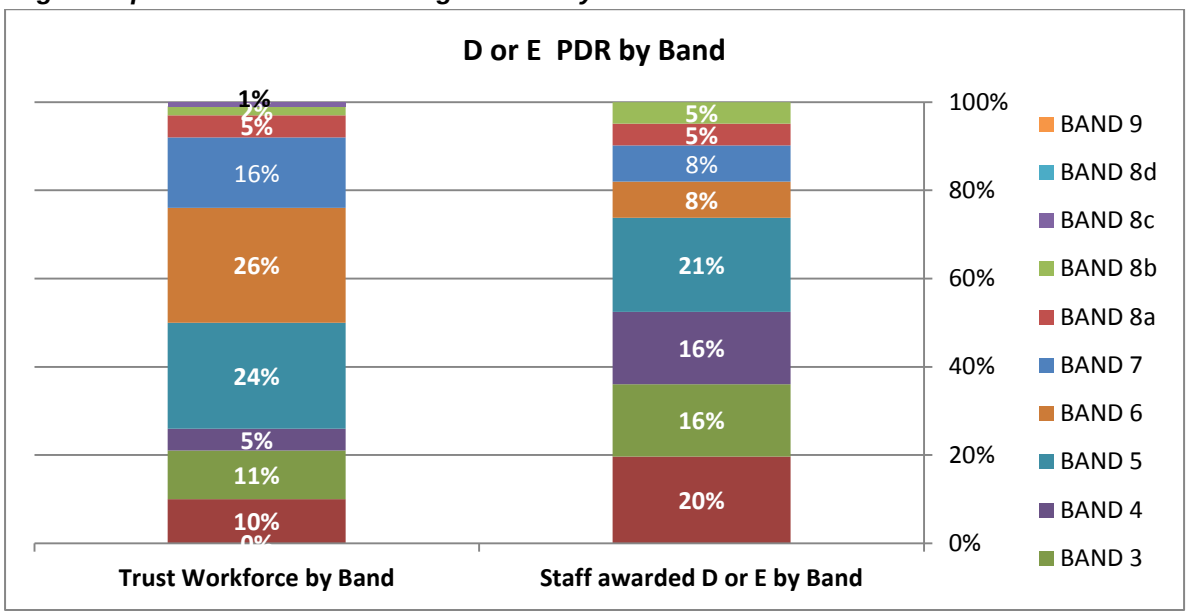


Fig 9 People awarded D or E rating on PDR by professional group 2017-18

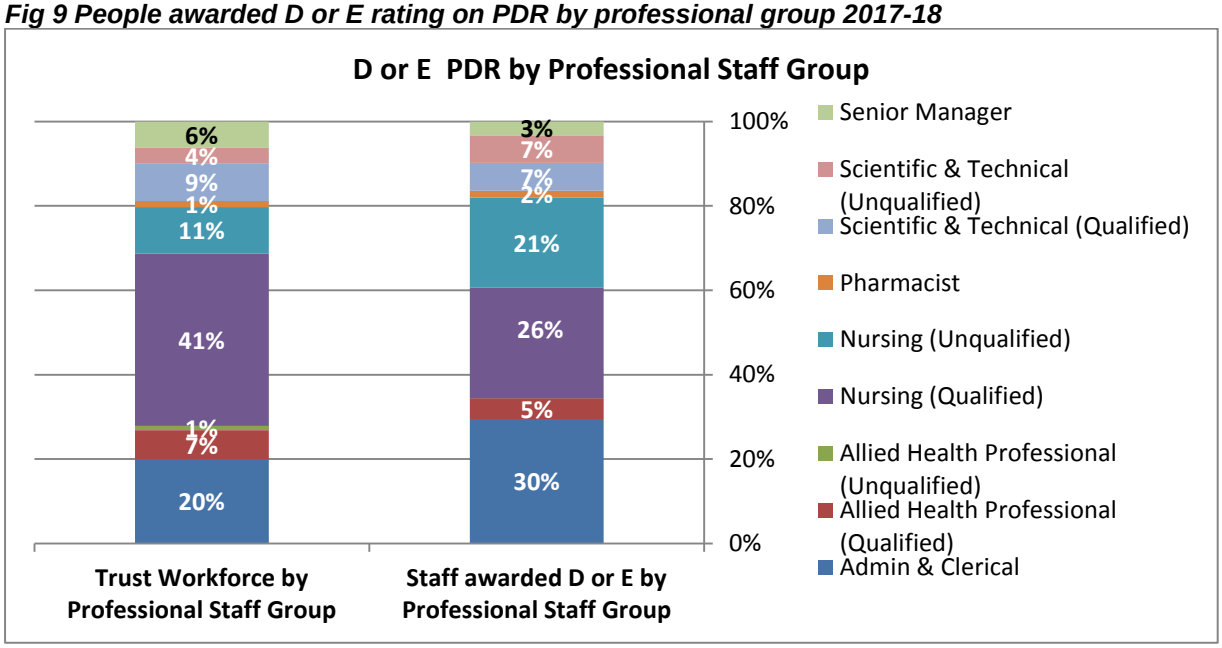
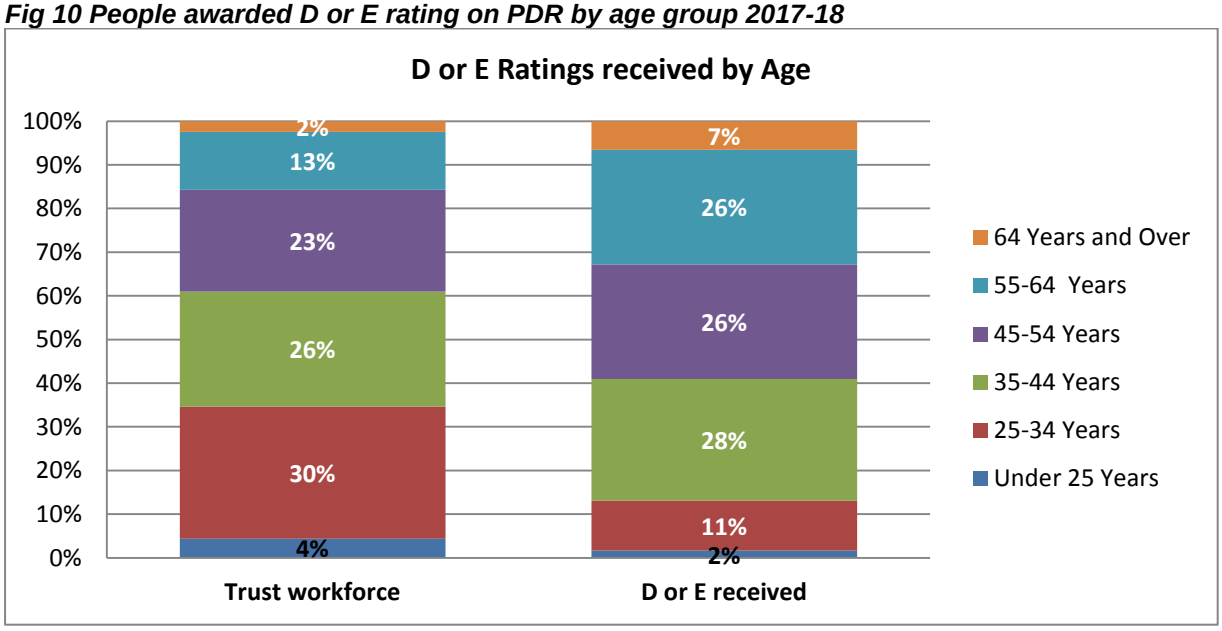


Table 13 People awarded D or E rating on PDR 2017-18 by Band and Ethnicity

	BME		White		Unknown	
	Workforce	Received D or E rating	Workforce	Received D or E rating	Workforce	Received D or E rating
B2	68%	58%	25%	33%	7%	8%
B3	62%	55%	32%	27%	5%	18%
B4	52%	70%	42%	20%	6%	10%
B5	56%	38%	39%	46%	5%	15%
B6	57%	100%	39%	0%	5%	0%
B7	40%	60%	55%	40%	5%	0%
B8a	32%	33%	62%	0%	5%	67%
B8b	21%	33%	73%	33%	5%	33%

Note – Total headcount of people receiving D or E rating in 2017-18 was **62.**

Fig 10 People awarded D or E rating on PDR by age group 2017-18



5. Promotion and Leavers

White staff members are more likely to leave than other ethnic groups, accounting for 49% of leavers in 2017/18. When the data is split by gender, women are marginally more likely to leave than men – women accounted for 73% of leavers compared to 71% the workforce. This is different from last year when men were more likely to leave by 3% when compared to the male workforce population.

The likelihood of people being promoted by ethnicity is broadly in line with the Trust workforce composition, with a slight raised percentage for people of white background. When promotions are cut by gender, women are more likely to be promoted than men.

Fig 11 Promotions and leavers by ethnicity 2017-18

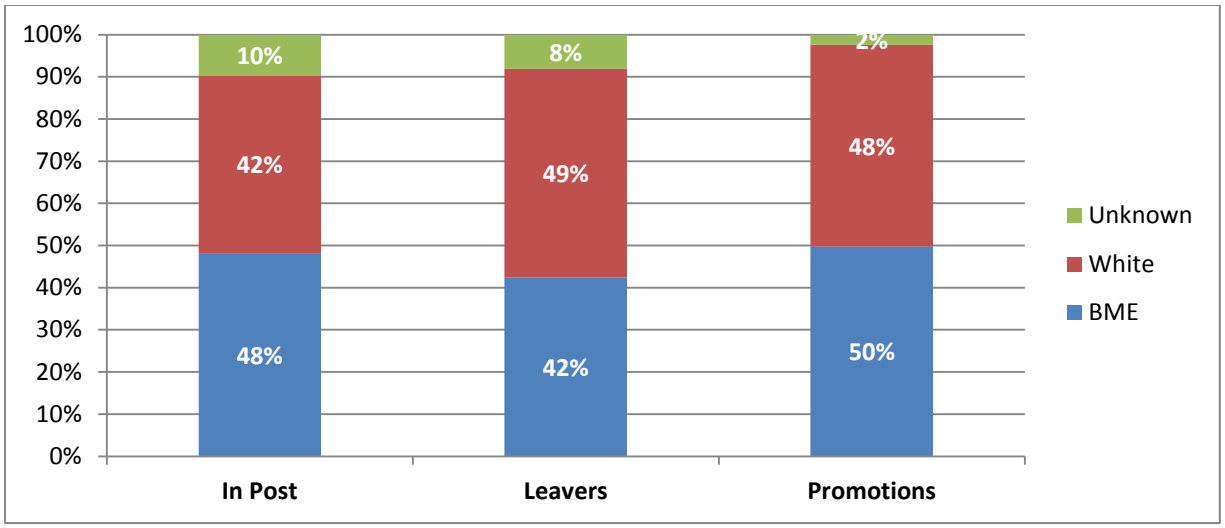
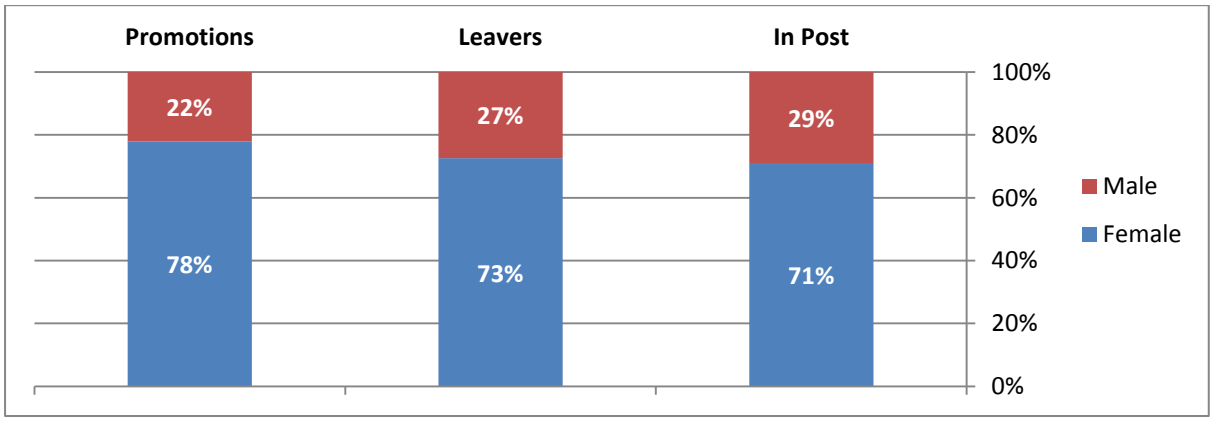


Fig 12 Promotions and leavers by gender 2017-18



6. Application of Formal Workforce procedures

The Trust monitors the formal application of workforce procedures by ethnicity, gender and age. In 2017/2018 (table 14), there were 382 formal meetings in total under the disciplinary, performance, grievance and sickness procedures. Figures in this report exclude capability and disciplinary cases under the Maintaining High Professional Standards framework for medical staff.

6.1 Ethnicity

Table 14 shows that in 2017/18, there were 87 formal disciplinary hearings, 20 (23%) involved Asian people, 19 (22%) involved Black people and 34 (39%) involved White people while the remaining 18% of cases involved other or unknown ethnic groups. The total number of disciplinary cases is similar to the previous year as in 2016/2017 there were 89 cases. The involvement of Asian people in disciplinary processes has increased from 13.5% to 23%, which is proportionate to the number of Asian people in the total workforce which is 22%. The involvement of Black people who constitute 17% of the overall workforce has reduced significantly from 34.8% to 22%.

This figure is therefore more proportionate than in the previous year when there were 34.8% of cases involving Black people who constituted 18% of total workforce. The number of formal disciplinary meetings involving White people increased from 36% in 2016/2017 to 39% in 2017/18. Given that White people constitute 43% of the workforce population in both 2016/17 and 2017/18, the distribution of the disciplinary cases this year is comparatively more proportionate than in the previous year.

In 2017/18, there were 17 formal performance meetings. There has been a drop in formal performance management meetings from 2016/2017 when there were 22 cases. In 2017/2018, White people who made up 43% of the workforce accounted for 47% of performance meetings. Although Black people's participation in such meetings is still disproportionate, it has reduced significantly from 40.9% in 2016/2017 to 29% in 2017/2018.

In 2017/2018, there were 253 formal sickness meetings, both long term and short term, of which 17% involved Asian people, 26% Black people, 40% involved White people. Although in 2016/2017, there were fewer sickness meetings (213), the participation of various ethnic groups in those meetings was similar to 2017/2018 although in 2016/2017 there were fewer Black people involved in the sickness meetings (21%) and more White people involved in such meetings (42%).

There were also 25 formal grievance hearings, of which 7 (28%) involved White people and 16 (64%) involved BME people. The involvement of White people in grievance processes has increased by 11.3 % since last year and the involvement of BME people has reduced by 13.8%.

Table 14 Formal meetings by ethnicity 2017/2018

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Ethnicity	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Asian	22%	20	23%	3	18%	43	17%	4	16%
Black	17%	19	22%	5	29%	66	26%	7	28%
White	43 %	34	39%	8	47%	102	40%	7	28%
Other	8%	11	13%	0	0%	25	10%	5	20%
Unknown	10%	3	3%	1	6%	17	7%	2	8%
Total	100%	87	100%	17	100%	253	100%	25	100%

Table 15 below suggests that both seniority and staff ethnicity are factors influencing participation in formal workforce procedures. Junior people (bands 2-5) from all ethnic groups are more likely to be involved in formal procedures than senior people. In 2017/18, white people at band 3, 5 and 6 accounted for the majority of the formal cases involving white people and BME people at band 2, 3 and 5 accounted for most cases within the BME group. Participation in all formal procedures is higher for BME people as a cumulative.

Table 15 Formal meetings by ethnicity and band 2017/18

Band	**No of meetings involving white people**	**% of meetings involving white people**	**% of white people by band in workforce**	**No of meetings involving BME people**	**% of meetings involving BME people**	**% of BME people by band in workforce**
2	17	5%	2%	43	12%	6%
3	26	7%	4%	50	14%	7%
4	14	4%	2%	20	6%	3%
5	27	8%	7%	42	12%	11%
6	32	9%	8%	36	10%	12%
7	21	6%	7%	12	3%	5%
8 and above	11	3%	6%	2	1%	2%
Medical & Dental	3	1%	11%	3	1%	7%
Total	151	42%	47%	208	58%	53%

Note: for the purpose of this table, 23 meetings involving people of “unknown” ethnic status were excluded.

Tables 16 to 19 (Appendix 3) suggest that both occupational group and ethnicity are factors influencing participation in formal workforce procedures. For some occupational groups, there were not sufficient numbers to draw meaningful conclusions, however for the other occupational groups, the following conclusions could be drawn.

Table 16 shows that admin & clerical employees are more likely to be involved in formal performance, grievance and disciplinary meetings than other occupational groups when the figures are compared to the Trust's population. Also, qualified and unqualified nursing staff are more likely to be involved in disciplinary meetings.

Table 16 highlights that admin & clerical staff, who made up 16% of the workforce, accounted for 29% of performance meetings, 38% of disciplinary meetings and 24% of grievance meetings. This disproportionate involvement is particularly the case for BME admin & clerical employees in all formal performance, grievance and disciplinary procedures (tables 17, 18 and 19).

Qualified nursing employees were more likely to be involved in formal disciplinary meetings, namely 36% of cases compared to 32% of qualified nurses in this occupational group. Table 18 shows that White qualified nurses were more likely to be involved in disciplinary hearings, namely 50% of cases compared to 43% of qualified White nurses.

Similarly, unqualified nursing employees were more often involved in formal disciplinary meetings, namely 15% of cases compared to 9% of unqualified staff. Within this group, White unqualified employees were more likely to be involved in disciplinary hearings, namely 38% of cases compared to 28% of unqualified White staff.

The Trust delivers Understanding Workforce Policies and Procedures training to ensure that managers are appropriately trained in fair application of workforce policies, including disciplinary, poor performance and dignity and respect policies. The Trust has also recently included training on unconscious bias in the training sessions. Two new check points have been added to the disciplinary process to ensure that all cases are dealt with fairly and consistently. On-boarding and a positive working relationship with the line manager and the team plays an important role here. Managers will continue to be reminded about the importance of undertaking a thorough induction for each new employee.

6.2 Relative likelihood of entering into formal disciplinary procedure

Table 20 shows that the likelihood of BME people entering the formal disciplinary procedure over the two year rolling period from April 2016 to March 2018 was 0.0095 and for white people it was 0.0066. Therefore the relative likelihood of BME staff entering the formal disciplinary procedure, compared to white people was 1.439 times greater. This demonstrates a downward trend as 2015-2017 figure was 2.125.

Table 20 Likelihood of entering the formal disciplinary meeting by ethnicity – two year average 2016-18

Descriptor	Average number of staff in workforce (2016-18)	Annual average of number of formal disciplinary meetings (2016-18)	Relative likelihood of entering formal disciplinary meetings
White	**4981**	**33**	**0.0066**
BME	**5385**	**51**	**0.0095**
Unknown	**1101**	**5**	**0.0045**

6.3 Gender

Comparing the figures against the Trust population, table 21 shows that men are more likely than women to be the subject to disciplinary and performance procedures. Women, on the other hand, are more likely than men to be involved in sickness and grievance procedures. This is the same as last year.

Table 21 Formal meetings by gender 2017/2018

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Gender	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Female	71%	55	63%	10	59%	214	85%	19	76%
Male	29%	32	37%	7	41%	39	15%	6	24%
Total	100%	87	100%	17	100%	253	100%	25	100%

6.4 Age

Table 22 demonstrates that the 35-44 age group were the most likely to raise grievances with 32% of all grievance cases in 2017/2018 emanating from this age group. This is disproportionate as they constitute 26% of the Trust population. This is a deviation from 2016/2017, where the highest number of grievance meetings involved the 45-54 age group.

The 45-54 age group had a slightly higher participation rate in performance meetings (29%) and sickness meetings (28%) in comparison to their Trust population (23%).

The 55-64 age group constitutes 13% of the Trust workforce but was involved in 21% of the total disciplinary meetings, 35% of performance meetings, 19% of sickness and 20% of grievance meetings. This showed a disproportionate involvement of the 55-64 group in all processes.

Table 22 Formal meetings by age 2017/2018

		Disciplinary		Capability (Performance)		Sickness		Grievance	
Age group	**% of Trust population**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**	**Number of cases**	**% of cases**
Under 25	4%	5	6%	1	6%	7	3%	0	0%
25-34	30%	27	31%	3	18%	67	26%	5	20%
35-44	26%	22	25%	2	12%	59	23%	8	32%
45-54	23%	13	15%	5	29%	70	28%	6	24%
55-64	13%	18	21%	6	35%	48	19%	5	20%
65 and over	2%	2	2%	0	0%	2	1%	1	4%
Total	100%	87	100%	17	100%	253	100%	25	100%

7. Staff experience: 2017 NHS National Staff Survey Results

The Trust monitors staff experience by protected characteristics through the annual NHS Staff Survey. The 2017 staff survey results revealed some differences in experience when analysed by disability status, ethnicity, age and gender.

7.1 Gender

There are few significant differences in experience by gender, except two areas: 1) violence, harassment and bullying; 2) equality and diversity. Overall women were more likely to report experiencing violence, harassment, bullying or abuse. It is also female group that reported higher proportion of discrimination at work in the last 12 months.

7.2 Disability

People with disabilities and those who do not report to have a disability provide similar answers to the majority of the key findings. Where the responses differ significantly, they are typically less favourable for disabled people.

Disabled people provide less favourable responses to questions relating to equality and diversity, health and well-being as well as harassment, bullying or abuse. For example disabled people were more likely than non-disabled people to report work related stress in the last 12 months (59% compared to 37%). Disabled people are also more likely to report experiencing harassment, bullying or abuse from both staff and patients, relatives or the public in the last 12 months.

7.3 Age

People of all age groups report similar experiences on the majority of the key findings. The area where responses differ most significantly relates to violence, harassment and bullying, as well as equality and diversity. The age group 16-30 were more likely to report experiencing physical violence and harassment, bullying or abuse from patients, relatives or the public in the last 12 months. The age groups 31-40 and 51 above had higher percentage of experiencing harassment, bullying or abuse from staff in the last 12 months.

It is also age groups 31-40 and 51 above who did not believe that the organisation provided equal opportunities for career progression or promotion.

7.4 Ethnicity

When the data is split by ethnicity, the biggest variation is on questions relating to equality and diversity. BME people were more likely to report experiencing discrimination at work (27% BME, 11% white) and felt less positive about the organisation's equal opportunities for career progression.

However, BME people report more positively than white people on job satisfaction and quality of appraisals.

7.5 NHS National Survey questions mandated by the WRES.

Under the Workforce Race Equality Standard the Trust is required to publish the responses cut by ethnicity to the following NHS staff survey results.

For comparison, the figures from last year's staff survey were also included: the responses were comparatively more positive in most of the areas in the 2017 survey outcome, with the most noticeable improvement in reduction in both White and BME staff experiencing harassment, bullying or abuse from staff in last 12 months (Table 24) and the increase in BME staff believing in Trust providing equal opportunities for career progression or promotion (Table 25). Reducing experience in bullying and harassment continues to be a key focus for the Trust.

Table 23: Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

	White	*BME*
2017	**35%**	**30%**
2016	33%	31%

Table 24: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

	White	*BME*
2017	**28%**	**28%**
2016	32%	32%

Table 25: Percentage of staff who believe that trust provides equal opportunities for career progression or promotion.

	White	*BME*
2017	**88%**	**83%**
2016	87%	74%

Table 26: In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

	White	*BME*
2017	**5%**	**17%**
2016	7%	19%

8. 2017-18 Action update

8. Progress on actions agreed last year 2017-18

A number of actions were agreed by managers and staff side colleagues following the analysis of the data contained in last year`s report. Actions and the progress relating to them are noted below:

ACTION 1: Improve workforce representation of BME people and female staff at Band 7 and above

1.1 Introduce values-based interviews, which includes new guidance on recruitment and selection and highlight the minefield of potential bias. Recruitment and selection training will be adapted to include the new guidance - Resourcing

The new guides were introduced from October onwards. They facilitate a structured interview and recommend the inclusion of another form of assessment to help the selection process to achieve a higher reliability and validity. Anecdotally the feedback is very positive and recruiting managers feel better supported and more confident in asking values based questions. The candidate feedback about the assessment and selection process is positive. We are in the process of developing assessment guides for medical appointments.

1.2 Review the language used on job adverts so it is more inclusive and target diverse groups - Resourcing

All rolling adverts have been redrafted and the Trust is in the process of producing templates to use for all posts. A wider use of social media is being used in addition to NHS Jobs and print adverts.

1.3 Monitor and report on the demographic breakdown of people on the talent plan - Talent

The Trust talent management process includes reviewing performance of senior people at Band 8C and above and placing people onto 9-box talent grids. Those who are identified as successors will then be put in the succession plan. Relevant data is submitted to the Executive Team on an annual basis. The data monitors the number of people reviewed in the talent management process compared with the number that make it onto the succession plan for gender and ethnicity for divisional director, divisional director of nursing and divisional director of operations roles. The data does not suggest that any staff group are more or less likely to be placed on the succession plan when participating in the Trust's talent process. This process will be repeated following the 2018 talent programme.

1.4 Review all leadership programmes and ensure that they promote a culture of inclusions and raising awareness of diversity issues - Talent

Although our leadership programmes do not include explicit content on managing diversity in the workplace, teaching on the importance of building inclusive teams and working environments, as well as valuing diversity of thought and experience are key aspects of our leadership and management development modules. This action is on-going.

1.5 Refresh skills and awareness of Diversity and Inclusion issues and unconscious bias across all our professional P & OD staff to ensure we are offering the best practice and consistent advice and support - Talent

This action will be carried over to the coming year with further discussion. A learning needs analysis will be undertaken of P&OD staff to inform the design of activities to improve understanding of diversity issues with activities undertaken by March 2019.

Action 2: Improve disproportionate representation of BME people receiving D or E rating (PDR)

2.1 The PDR training content will be reviewed to raise awareness of unconscious bias and best practice at PDR - Talent

PDR training content was reviewed and now included a video on unconscious bias where participants were asked to think about how bias can influence decisions in the workplace and to be aware of the biases they may have. The training then stresses the importance of using the ratings in a fair and equitable way, encouraging calibration of ratings to help remove bias in decision making. Models that are discussed in the training remind managers to make decisions on performance by using mutually agreed objectives, a good evidence base of work and behaviour through the year and ensuring the PDR is a two way conversation.

ACTION 3: Mitigate disproportionate representation of BME people entering formal workforce procedures

3.1 Review the reasons that people are facing formal procedures to establish whether further training and support can be offered to prevent staff from entering into formal procedures - Employee Relations

Detailed analysis of the reasons that people enter formal procedures, the occupational groups and the outcomes has now taken place. This analysis will inform a wider review of formal processes currently being undertaken.

3.2 Review the training provided for managing workforce procedures to include a focus on potential bias - Employee Relations

A section in unconscious bias has been included in the workforce policies and procedures training that we regularly deliver for managers. Participates are asked questions that challenge their unconscious bias and advised to be aware of how such bias may affect in the work setting.

ACTION 4: Actions will be developed to address the concerns about harassment and bullying reflected in the 2017-2018 NHS staff survey

4.1 A review of the national local survey results will take place with a targeted action plan aimed at prevention of harassment and bullying across the organisation

A detailed analysis was undertaken which included data from staff surveys both results national and local, datix reports and cases logged with the employee relations team. The following actions were implemented throughout last year:

- Leadership programmes and a focus on role modelling good behaviours and having the courage to tackle poor behaviours

- PDR process new focus on 80/20 - 80% what we achieved and 20% how we achieved it
- Conflict resolution training provided by CONTACT services
- Mediation services continue to made available
- A “How to engage and retain your staff” master class and toolkit for managers was launched in June 2017
- Training available for staff on dealing with violence and aggression
- Additional questions were added to local engagement survey to gather more information at ward/departmental level

9. Action Plan for 2018-19

We have observed some positive changes in some areas of focus from last year. However the Trust recognises that continuous improvement requires lasting concerted efforts and satisfactory outcome takes time to achieve. For the coming year we will therefore continue focusing on the following four priority areas from last year that remain as some of the key challenges identified in the report. At the same time, we will carry on work that helps create a culture of inclusion.

Areas of focus 1

Improve workforce representation of BME people on Band 7 and above

Resourcing	Carry out an analysis of the shortlisting to review all bands and all staff groups to better understand any hotspots
	Produce guidance on the panel mix to encourage a panel with diverse representation
	Review where all adverts are placed and broaden advertising to better target BME candidates
	Promote best practice assessment and selection guides to ensure all managers are using the materials
	Re-launch the Careers Clinics and promote the support that is given to help people secure a new role
	Review the Recruitment and Selection policy to ensure the end to end process fully supports diversity and inclusion
	Review Recruitment and Selection training to ensure that everyone is familiar with the new best practice guides and the principles of fair, objective and open recruitment and selection is fully embedded
	Review the internal promotion process and outcomes to encourage all managers to promote opportunities within the Trust in an open and fair way which facilitates as diverse as possible coming forward

Areas of focus 1 (continued from above)	
Talent	Proactively support and secure nominations for national BME programmes run by NHS Leadership Academy ("Stepping Up" and "ready now")
	Ensure that all participants on Trust leadership programmes who are from under-represented groups have access to a Mentor/Coach as part of the programme
	Develop Business Case for an online appraisal system to that in future, we can access records of objective setting and personal development plans for al staff, including those from under represented group in order to formulate future action
Talent **HRBPs**	Ensure that all leaders from underrepresented groups who are in scope for the Trust Talent management process have a PDP

Additional action to be added in:

- Develop and source funding for a pilot BME mentoring programme targeting those at band 7 and above who aspire to work in a more senior position.

Areas of focus 2 **Reduce the differential in the relative likelihood of BME and White people receiving D or E ratings (PDR)**	
Talent	Implement mid-year reviews to enable earlier notification of concerns and provide people with the opportunity to make the necessary improvements
	Provide monthly reports to divisional senior management team of grades awarded throughout PDR period. This will allow calibration of grades during the PDR window

Areas of focus 3 **Mitigate disproportionate representation of BME people entering formal workforce procedures**	
ERAS	Introduce two check points to be carried out by senior managers in formal disciplinary process. This will enable consideration of a number of factors prior to beginning an investigation or entering into a formal disciplinary hearing.
	Review the reasons that people are facing formal procedures to establish whether further training and support can be offered to prevent staff from entering into formal procedures
	Introduce mandatory training specifically for Chairs of disciplinary hearings and Investigators.

Areas of focus 4 **Address the concerns about harassment and bullying reflected in the 2017-18 NHS staff survey**	
Engagement	Re-energise Trust values and behaviours through 'delivering our promise 2' programme
Wellbeing	Develop a 'speaking up' strategy and action plan
	Continue to focus on 'prevention' through targeted actions based on analysis of incidents

Areas of focus 5 – Equality and diversity team objectives for 2018-9
Support the creation of an action plan to address the issues arising from the Gender Pay analysis report
Produce a Workforce Disability Equality Scheme
Produce a set of measures, annual targets and a reporting mechanism to track short and medium term progress against or longer term equality objectives

Appendix 1

Table 1 Ethnicity profile – percentage of staff in each of the AfC bands, medical grades and Very Senior Managers (VSM) – March 2018

Non-Clinical	BME	UNKNOWN	WHITE	Count
BAND 1	100%	0%	0%	2
BAND 2	67%	5%	28%	213
BAND 3	60%	4%	35%	648
BAND 4	51%	6%	43%	383
BAND 5	50%	4%	46%	309
BAND 6	52%	3%	44%	263
BAND 7	42%	4%	54%	190
BAND 8A	34%	7%	59%	115
BAND 8B	20%	5%	74%	129
BAND 8C	22%	7%	71%	55
BAND 8D	25%	3%	72%	36
BAND 9	14%	5%	82%	22
Spot Salary	0%	50%	50%	4
VSM	8%	12%	80%	25
Grand Total				**2394**

Clinical	BME	UNKNOWN	WHITE	Count
BAND 1	0%	0%	0%	0
BAND 2	68%	8%	24%	707
BAND 3	65%	7%	28%	541
BAND 4	53%	8%	39%	171
BAND 5	57%	6%	37%	1718
BAND 6	57%	5%	38%	1885
BAND 7	40%	5%	55%	1142
BAND 8A	32%	5%	63%	356
BAND 8B	22%	5%	72%	116
BAND 8C	14%	2%	84%	44
BAND 8D	5%	0%	95%	20
BAND 9	13%	0%	88%	8
VSM	0%	0%	100%	2
CONSULTANT	31%	9%	60%	722
Doctor (Career Grade)	20%	39%	41%	338
Doctor (Training Grade)	34%	23%	43%	1117
other	42%	17%	42%	12
Grand Total				**8899**

Appendix 2 Recruitment data 2017-18

Table 5 Recruitment analysis by ethnicity

Ethnic Origin by %	Applicants	Shortlisted	Appointed
White - Brit	13.41	17.95	23.96
White - Irish	1.20	2.22	3.83
Any other white	13.99	15.41	15.38
Asian/Asian Brit - Indian	10.94	9.99	8.49
Asian/Asian Brit - Pakistani	4.87	3.31	1.78
Asian/Asian Brit - Bangladeshi	4.29	2.78	1.64
Any other Asian	7.84	8.11	7.49
Black/Black Brit - Caribbean	6.40	5.85	4.34
Black/Black Brit - African	18.15	15.18	9.72
Any other Black	3.89	3.44	2.24
Mixed - White & Black Caribbean	1.14	1.17	1.00
Mixed - White & Black African	1.30	0.90	0.46
Mixed - White & Asian	0.70	0.80	0.73
Any other mixed	1.61	1.54	1.51
Chinese	0.80	1.03	1.64
Any other ethnic	5.67	5.80	5.25
Not stated	3.80	4.52	10.54

Table 6 Recruitment analysis by transgender 2017-18

Transgender by %	Applicants	Shortlisted	Appointed
No	22.66	23.18	25.29
Yes	0.20	0.21	0.18
Not stated	77.14	76.61	74.53

Table 7 Recruitment analysis by age 2017-18

Age by %	Applicants	Shortlisted	Appointed
Under 20	0.91	0.68	0.36
20-24	17.19	14.01	15.43
25-29	26.87	26.49	30.35
30-34	17.92	18.58	17.62
35-39	11.32	11.77	11.23
40-44	8.77	9.69	8.72
45-49	7.48	8.76	8.76
50-54	5.46	5.79	4.84
55-59	3.02	3.15	1.87
59-64	0.89	0.91	0.64
65+	0.14	0.14	0.18
Not stated	0.03	0.03	0.00

Table 8 Recruitment analysis by disability 2017-18

Disability by %	Applicants	Shortlisted	Appointed
No	94.81	93.38	87.91
Yes	3.29	3.48	2.14
Not stated	1.90	3.14	9.95

Table 9 Recruitment analysis by religion 2017-18

Religion by %	Applicants	Shortlisted	Appointed
Atheism	7.27	9.55	12.73
Buddhism	1.25	1.20	1.64
Christianity	48.65	49.41	44.32
Hinduism	7.73	6.73	5.16
Islam	17.78	13.74	9.77
Jainism	0.18	0.18	0.14
Judaism	0.29	0.31	0.32
Sikhism	1.30	1.41	1.41
Other	5.37	5.34	5.43
I don't wish to disclose	10.18	12.13	19.08

Table 10 Recruitment analysis by sexual orientation 2017-18

Sexual orientation by %	Applicants	Shortlisted	Appointed
Bisexual	1.10	0.91	0.77
Gay	1.72	2.14	2.65
Heterosexual	87.40	86.29	80.92
Lesbian	0.30	0.29	0.32
Not stated	9.48	10.37	15.34

Appendix 3 Application of formal workforce procedures by occupational group 2017/18

Table 16 Formal meetings by occupational group 2017/18

		Performance		Disciplinary		Grievance	
	% of Trust Population	No of meetings	% of meetings	No of meetings	% of meetings	No of meetings	% of meetings
Admin & Clerical	16%	5	29%	33	38%	6	24%
Allied Health Professional (Qualified)	5%	3	18%	-	-	1	4%
Allied Health Professional (Unqualified)	1%	-	-	-	-	-	-
Doctor (Career Grade)	-	-	-	-	-	-	-
Doctor (Consultant)	9%	-	-	-	-	3	12%
Doctor (Training Grade)	13%	-	-	3	3%	-	-
Nursing (Qualified)	32%	4	24%	31	36%	5	20%
Nursing (Unqualified)	9%	1	6%	13	15%	1	4%
Pharmacist	1%	-	-	-	-	1	4%
Scientific & Technical (Qualified)	7%	3	18%	2	2%	5	20%
Scientific & Technical (Unqualified)	3%	1	6%	4	5%	1	4%
Senior Manager	5%	-	-	1	1%	2	8%
TOTAL	100%	17	100%	87	100%	25	100%

Table 17 Formal performance meetings by ethnicity and occupational group 2017/18

Occupational Group	No of performance meetings involving **WHITE** people	% of performance meetings involving **WHITE** people	% of **WHITE** people in occupational group in workforce	No of performance meetings involving **BME** people	% of performance meetings involving **BME** people	% of **BME** people in occupational group in workforce
Admin & Clerical	1	20%	41%	4	80%	59%
Allied Health Professional (Qualified)	3	100%	68%	0	0%	32%
Allied Health Professional (Unqualified)	0	0%	44%	0	0%	56%
Doctor (Career Grade)	0	0%	53%	0	0%	47%
Doctor (Consultant)	0	0%	67%	0	0%	33%
Doctor (Training Grade)	0	0%	56%	0	0%	44%
Nursing (Qualified)	1	25%	43%	3	75%	57%
Nursing (Unqualified)	1	0%	28%	0	0%	72%
Pharmacist	0	0%	48%	0	0%	52%
Scientific & Technical (Qualified)	2	100%	47%	0	0%	53%
Scientific & Technical (Unqualified)	0	0%	32%	1	100%	68%
Senior Manager	0	0%	68%	0	0%	32%
Total	8	50%	47%	8	50%	53%

Note: For the purpose of this table, 1 meeting involving an employee of 'unknown' ethnicity has been excluded.

Table 18 Formal disciplinary meetings by ethnicity and occupational group 2017/18

Occupational Group	No of disciplinary hearings involving **WHITE** people	% of disciplinary hearings involving **WHITE** people	% of **WHITE** in occupational group	No of disciplinary hearings involving **BME** people	% of disciplinary hearings involving **BME** people	% of **BME** in occupational group
Admin & Clerical	11	34%	41%	21	66%	59%
Allied Health Professional (Qualified)	0	0%	68%	0	0%	32%
Allied Health Professional (Unqualified)	0	0%	44%	0	0%	56%
Doctor (Career Grade)	0	0%	53%	0	0%	47%
Doctor (Consultant)	0	0%	67%	0	0%	33%
Doctor (Training Grade)	1	33%	56%	2	67%	44%
Nursing (Qualified)	15	50%	43%	15	50%	57%
Nursing (Unqualified)	5	38%	28%	8	62%	72%
Pharmacist	0	0%	48%	0	0%	52%
Scientific & Technical (Qualified)	1	50%	47%	1	50%	53%
Scientific & Technical (Unqualified)	0	0%	32%	3	100%	68%
Senior Manager	1	100%	68%	0	0%	32%
Total	34	39%	47%	50	57%	53%

Note: For the purpose of this table, 3 meetings involving employees of ‘unknown’ ethnicity have been excluded.

Table 19 Formal grievance meetings by ethnicity and occupational group 2017/18

Occupational Group	No of grievance meetings involving white people	% of grievance meetings involving white people	% of white people in occupational group in workforce	No of grievance meetings involving BME people	% of grievance meetings involving BME people	% of BME people in occupational group in workforce
Admin & Clerical	1	17%	41%	5	83%	59%
Allied Health Professional (Qualified)	1	100%	68%	0	0%	32%
Allied Health Professional (Unqualified)	0	0%	44%	0	0%	56%
Doctor (Career Grade)	0	0%	53%	0	0%	47%
Doctor (Consultant)	1	50%	67%	1	50%	33%
Doctor (Training Grade)	0	0%	56%	0	0%	44%
Nursing (Qualified)	1	20%	43%	4	80%	57%
Nursing (Unqualified)	0	0%	28%	1	100%	72%
Pharmacist	0	0%	48%	1	100%	52%
Scientific & Technical (Qualified)	1	25%	47%	3	75%	53%
Scientific & Technical (Unqualified)	0	0%	32%	1	100%	68%
Senior Manager	2	100%	68%	0	0%	32%
Total	7	30%	47%	16	70%	53%

Note: for the purpose of this table, 2 meetings involving employees of ‘unknown’ ethnicity and 1 meeting involving multiple individuals have been excluded.

Appendix 4 GLOSSARY OF TERMS USED IN THIS REPORT

Unknown	A combination of Not stated and Unrecorded
Senior Managers	This includes people in bands 8-9, very senior managers and senior medical staff (consultants, career grade doctors)
Spot salaries	People who are not on NHS payscale, e.g. through TUPE
PDR	Performance and Development Review
New Starters	People who began working for the Trust between April 2017 and March 2018
Non-clinical support	Admin & Clerical, Estates and senior managers
Clinical support	Unqualified, Nurses, Scientific and Technical (S&T) and Allied Health Professionals (AHP)
Scientific & Technical	Qualified Scientific & Technical and pharmacists
BME	Black & Minority Ethnic (i.e. all ethnicity excluding White)
White	A combination of White British and White Other
Promotions	People who have an upward change of band/grade during the reporting year and are still employed at the end of the reporting year.

Appendix 5 Cross-referencing the Workforce Race Equality Standard requirements with the Annual Workforce Equality and Diversity Report

	Indicator For each of these nine workforce indicators, data is compared for white and BME staff	Section of the report
1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce (split by clinical and non-clinical staff).	1.1
2	Relative likelihood of staff being appointed from shortlisting across all posts.	2.2
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (a two year rolling average of the current year and the previous year).	6.2
4	Relative likelihood of staff accessing non-mandatory training and CPD.	3.1
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	7.5
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	7.5
7	Percentage of staff who believes that trust provides equal opportunities for career progression or promotion.	7.5
8	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/Team Leader or other colleagues.	7.5
9	Percentage of difference between the organisations' Board membership and its overall workforce (split by voting membership and executive membership)	1.4

NHS
Imperial College Healthcare
NHS Trust

TRUST BOARD – PUBLIC
BOARD SUMMARY

Title of report: Report from Finance and Investment Committee, 19th September 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 26th September 2018	**Item 19.1, report no. 15**
Responsible Non-Executive Director: Andreas Raffel	**Author:** Andreas Raffel, Non-executive Director and Ginder Nisar, Interim Deputy Board Secretary

Summary:

The Committee:

Finance Report for August 2018
Noted the Trust's financial report for August 2018. The position was £2m adverse variance to plan in month taking the position to £3.4m adverse year to date. This was mainly due to overspends within the clinical divisions driven by unidentified and non-delivery of CIP and planning gaps. The Divisions updated their forecast for the year which stands at a £7m adverse variance to plan. This is a further £3.4m deterioration of the position, following adverse movements in previous months of £2.2m in month 4 and £1.4m in month 3. There remain a number of risks to this forecast position. The forecast as stated requires a significant improvement in the Trust's run rate with both cost savings and increased activity in the position. The divisions attended the Finance Executive on 18th September 2018 to discuss their plans to recover the position in order that the Executive can come to a view on any further actions required to ensure the Trust meets its plan. The divisional directors outlined their plans to the Finance and Investment Committee to improve their divisional positions which were in the process of being quantified.

In relation to Provider Sustainability Funding, the Trust has received payment for Q1 for its financial performance, but not in relation to the 4 hour A&E trajectory. The Trust is clear that it met the trajectory and is awaiting a response from NHSI on when the remaining cash will be paid. The Trust will be forecasting to NHS Improvement (NHSI) that it will meet its financial plan and achieve 95% performance against the 4 hour A&E target by the end of the year for the full year total.

The Trust is £9m behind on the capital plan compared to the capital resource limit but plans to meet plan by the end of the year. The programme is closely monitored by the Capital Expenditure Assurance Group and Capital Steering Group.

Financial Recovery Plan – Draft Outline
Noted that the Trust has an undertaking to submit a 4 year financial recovery plan to NHSI by the end of November 2018 which should show the path to underlying sustainability. The timeline for production of this plan asked for a provisional draft view of the recovery plan to be presented to the Executive and shared with NHSI in September. The Committee received the report which clearly illustrated that achieving financial sustainability within 4 years will be a significant challenge, both in terms of identifying and then delivering the level of improvement programmes required to close the financial gap. The Committee noted the draft recovery plan which in its current form was a top down recovery plan for submission to NHSI and would be developed further to break down the spend and the ensuing actions.

Summary of Capital spending progress as at 31 July 2018
Noted that the Trust has spent a total of £11.238m against a planned position of £18.809m in month 4. The capital spend by month 4, whilst behind plan, continues to be much higher than in previous years and reflects the efforts taken to ensure the Trust spends capital earlier in the year. The Trust continues to pursue additional capital funding streams.

Procurement update
Noted the update on the emerging National Procurement Future Operating model to be implemented April 2019 and potential implications for the Trust. The current analysis suggests the Trust could have a financial loss in

FY 2019/20 (including missed opportunities) through the transition period. A regular update would be provided to the Committee as the project progresses.

Productivity update
Noted that the model hospital is increasingly being used as the framework by which the regulator monitors Trusts, including as part of the new 'Use of Resources' assessment. Therefore the Trust will seek to significantly increase its understanding and usage of the model hospital data as a measurement tool, both as a diagnostic tool, but also to help drive a culture of measurement for improvement, and use the model hospital data to compare against peers as a constructive improvement programme, underpinned by the Trust's established improvement methodology.

Noted that the specialty review programme, the Trust's clinically led process to develop a five-year clinical strategy, was nearing the end of phase 1 and has produced a large amount of insightful evidence and analysis upon which to develop draft clinical strategies. Phase 2 of the process focuses on delivering the savings through three different approaches which were detailed in the report - these will be an important contributor the Financial Recovery Plan. Next steps will include identifying the key areas of income generating and loss making services.

North West London Pathology (NWLP) update
Noted the key issues currently outstanding relating to the NWLP. There has been on-going work since the service went live to understand the initial financial model of the service and the practical application of that model. The owner Trusts and NWLP team are committed to resolving these issues and ensuring a fair and transparent financial model for the service. The NWLP is a joint operation with three owners of which Imperial Healthcare Trust ICHT has a 62% ownership. NWLP provides a pathology service for the three owners as well as a service to CCGs and other third parties, mainly based on contracts held by the owners. The organisation started operation in April 2017.

Strategic Imaging Asset Programme
Received an update on the significant challenges faced by the imaging service including the risks presented by an aging asset base, meeting growth in demand, and the need to maintain an acceptable environment for patients and staff. To meet these challenges and take advantage of the opportunities such as looking at models of service delivery, working more closely with the NWL sector, benefiting from new technologies, and leveraging the value of imaging data, the Trust needs to invest in, and implement an Imaging asset replacement programme. This would consider both service and financing models and seek innovative solutions to both. It was agreed that an abbreviated SOC would be produced to better understand the project and work performed thus far including exploring options to progress the project.

Summary of business cases approved by The Executive since 1st April 2018
Noted that 15 business cases have been approved by the Executive since the start of the 2018/19 financial year, with four of these cases being worth more than £2m and less than £5m in either expenditure and or capital.

Commercial directorate update
Noted the proposal to extend the scope of the IPH directorate into a Commercial Directorate co-ordinating and supporting commercial and business development activities across the Trust.

Committee workplan review (6 monthly)
Reviewed the workplan for the remaining part of the financial year.

Committee terms of reference (annual)
Reviewed and approved the Finance and Investment Committee Terms of Reference.

Recommendations:
To note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC BOARD SUMMARY	
Title of report: Report from Quality Committee, 12th September 2018	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 26th September 2018	**Item 19.2, report no. 16**
Responsible Non-Executive Director: Professor Andrew Bush	**Author:** Professor Andrew Bush, Non-executive Director Ginder Nisar, Interim Deputy Board Secretary

Summary:

Quality Committee Terms of Reference
The Quality Committee Terms of Reference were reviewed and chair's actions would be taken for approval after a review by the Deputy Director of Quality Governance to ensure the CQC domains are reflected across all Committee Terms of Reference.

2017-18 Annual report for equality and diversity and the workforce race equality standard (WRES)
In line with the Equality Act 2010 the Trust is required to publish an annual equality report to demonstrate compliance with the public sector equality duty. It is also a regulatory requirement that the Trust publishes annually a Workforce Race Equality Standard report. The Trust's equality and diversity agenda is progressing with an Equality and Diversity Steering Committee established in early 2018 to provide leadership and direction. The report outlined the key findings of the Trust's workforce equality performance and highlighted the priorities which were discussed at the Executive People and Organisational Development Committee.

Integrated quality and performance report
The bi-monthly integrated quality and performance report outlined the key headlines relating to the reporting months of June 2018 and July 2018. The Trust was achieving in the areas it expected to achieve in and areas that were not being achieved were the areas of focus. Significant work was underway to change the approach and culture towards safety.

Update on key divisional risks
The Committee received updates from the divisions on key divisional risks, current and new and the actions being taken forward.

Imperial College Healthcare Trust (ICHT) response to the report of the Gosport Independent Panel
Following the discussion at the previous Quality Committee, key learning points and outcomes were reviewed to seek assurance. The report does not include recommendations for Trusts however it has been fully reviewed with key learning points highlighted to enable an ICHT response to be written. The report is the beginning of a self-assessment for ICHT which is expected to be completed by November 2018 for submission to the next Quality Committee.

CQC update
The Committee received an update on CQC related activity at and/or impacting the Trust since the last update in July 2018 including the Trust-level headlines from the Trust's latest CQC Insight report (July 2018). A review of the critical care core service at the Trust was carried out in July 2018. The full report is currently with colleagues for factual accuracy checks. The Improving Care Programme steering group continues to meet and focuses on core service critical care, hand washing, medical devices and statutory and mandatory training. Work is underway with medicines management which includes mapping key lines of enquiries, auditing will take place including peer audits and 'white' wards will be visited which were identified as part of the ward accreditation programme.

Incident Monitoring Report
The incident reporting rate at ICHT for July 2018 was 52.16, placing the Trust in the highest quartile nationally based on the latest published NRLS data. Eight Serious incidents (SIs) were declared during July 2018 with 31 on-going (open) SI investigations and five overdue SI investigations were reported. Nine level one/internal investigations were declared by the Trust during July 2018, all are currently under investigation. One never event

was declared during July 2018. The Trust has reported three never events in five months, two of which relate to interventional procedures and the Medical Director has convened a working group to focus on improvements.

VTE Trust wide action plan update
The Trust met its 95% target for VTE assessment compliance in Q3 and Q4 2017/18 following the implementation of a Trust wide action plan in 2017 and assurance has improved.

Infection prevention and control, and antimicrobial stewardship quarterly report – quarter 1
There were no Trust-attributed MRSA BSI cases identified during Q1; 18 cases of Trust-attributed *C. difficile* identified during Q1; three CPE BSIs cases reported in Q1 compared with 11 during 2017/18. Healthcare-associated CPE BSIs have been selected as a new internal performance metric for the Trust so that the board are aware of the trend in serious infections due to CPE. 74 inpatient wards underwent the revised hand hygiene auditing in May, with wide variation in compliance observed. Hand hygiene champions are being identified on all 74 inpatient wards included in the May audits and each ward will undergo improvement activities during August and September – the report provided assurance that IPC within the Trust is being addressed in line with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance.

Clinical audit report: A multi-professional audit of compliance with the Trust Duty of Candour Policy across all specialties
The report detailed compliance with the Trust's Duty of Candour Policy following the completion of an annual audit between April and May 2018. The areas of good practice have been shared with the divisional teams, and an action plan has been developed to address the areas where there was no assurance.

2018 General Medical Council National Training Survey Results
The Committee received the results of the 2018 General Medical Council (GMC) National Training Survey. The results were published on 9 July 2018 and for ICHT show a significant deterioration. Unit Training Leads (UTLs) are currently working with their Medical Education Managers and Heads of Specialty (HoS) to understand the underlying cause of the flags, and to develop action plans. Deep dive meetings, led by education managers, with trainees are underway which will be reported to the UTLs and HoS to use in the development of action plans. External action planning is due on 28 September 2018 for training programmes. In view of the deterioration and to prevent any further decline, a new process for educational review and governance would be implemented.

Learning from deaths: Update on implementation and reporting of data
The Committee received an update on progress since the last report in July 2018 and this includes an updated 'learning from deaths dashboard' for 2017/18 and Q1 2018/19. The key points include Structured Judgment Review (SJR) compliance; staff training for SJR and further recruitment of reviewers; SJR progress report of activity including numbers of avoidable deaths; learning themes emerging from reviews; and LeDeR Compliance.

Flu Campaign
The flu campaign would be launched on 24th September 2018. A number of activities were taking place which include holding staff to account for their responsibilities; reiterating the importance of flu vaccinations acknowledging that this was in the interests of self and patients. Staff would be required to complete a form stating why they refuse the vaccination.

Recommendations:
The Trust Board is asked to note this summary.

Imperial College Healthcare NHS Trust

TRUST BOARD - PUBLIC REPORT SUMMARY	
Title of report: Redevelopment committee report (26th September 2018)	☐ Approval ☐ Endorsement/Decision ☐ Discussion ☒ Information/noting
Date of Meeting: 26th September 2018	**Item 20.3, report no. 17**
Responsible Non-Executive Director: Victoria Russell, Non-executive director	**Author:** Peter Jenkinson, Trust Company Secretary

Summary:

KEY ITEMS TO NOTE

The Committee received an update on key initiatives within the Trust's redevelopment programme.

The Committee received an update from Imperial Health Charity.

The Committee received a strategic update from the Chief Executive, including an update on the development of a London estates strategy and the work of the new London Estates Board and of Sir Robert Naylor.

The Committee discussed the development of the Trust's clinical strategy, noting the relationship between the clinical and estates strategies and the importance of alignment of the clinical strategy with future models of care. The Committee also noted that interviews had been held for the role of clinical lead for redevelopment and that an appointment would be made.

The Committee reviewed the risk of adverse impact on patient services from the Paddington Square redevelopment, noting the increase in impact from noise and vibration, and therefore the Trust's concerns. These concerns would be escalated to the developer and WCC as required.

The Committee also considered an update on the Triangle project. The Committee agreed that no further resource would be committed to the project until progress was reviewed further at the Committee's next meeting.

Recommendations:

The Trust board is requested to:

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